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

Board of Trustees Meeting
Thursday, November 19, 2015
4:00 – 6:00 p.m.

1.	Welcome	Janet Cowell, Chair
2.	Conflict of Interest Statement	Janet Cowell, Chair
3.	Introduction of New Board Member – Aaron McKethan	Janet Cowell, Chair
4.	Review of Minutes ***(Requires Board Approval)***	Janet Cowell, Chair
	A. August 27-28, 2015	
	B. October 28, 2015 Teleconference	
5.	Strategic Planning	Mona Moon Tom Friedman
	A. Strategic Plan Annual Update	
	B. Review Strategic Plan and Process	
	i. SHP Phase I Discovery Report January 2014	
	ii. SHP Strategic Plan Adopted September 2014	
	C. Strategic Plan Status Report Q3 2015	
6.	The Data Diet: Sharing Data with Providers to Enable Population Management	Tom Friedman Rachel Sokol Senior Consultant The Advisory Board Company
7.	Adjourn	Janet Cowell, Chair

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.

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

Board of Trustees Meeting
Friday, November 20, 2015
9:00 a.m. – 3:00 p.m.

1. Welcome — Janet Cowell, Chair

2. Conflict of Interest Statement — Janet Cowell, Chair

3. Legislative Report — Tom Friedman
   - A. Joint Legislative Program Evaluation Oversight Committee – Report Number 2015-05, Retiree Health
   - B. Local Government Participation in the State Health Plan
   - C. Final State Budget

4. Financial Report, Forecasting and Monitoring — Mark Collins, Tom Friedman
   - A. September 2015 Financial Report
   - B. CY 2015 3rd Quarter Actuarial Forecast Update
   - C. State Health Plan Trend Analysis

Break (10 minutes)

5. Member Experience and Communications — Caroline Smart, Beth Horner
   - A. 2015 Membership Satisfaction Results
   - B. 2016 Annual Enrollment
     - i. Telephone Town Hall Events
     - ii. Outreach and Results
   - C. 2016 Outreach and Education Strategy

6. Benefit Design, Plan Options and Premiums
   - A. Premium Contribution Rates
     - i. EA Action on 2016 Group Premiums — Mona Moon
     - ii. 2015 & 2016 COBRA Rates for HDHP ***(Requires Board Approval)*** — Mark Collins

B. Prescription Home Delivery Pilot Program	Sandy Wolf

Lunch (30 minutes)

C. Transition Specialty Medications from Medical to Pharmacy Benefit	Sandy Wolf
D. Potential Benefit Changes for CY 2017	Tom Friedman

7. Contracting and Vendor Partnerships

A. Pharmacy Benefit Manager (PBM) Request for Proposal	Sandy Wolf

8. Clinical & Program Operations

A. Pharmacy & Therapeutics Committee – August Meeting	Sandy Wolf Adam Root
B. Affordable Care Act Employer Reporting Requirements	Linda Forsberg

Break (10 minutes)

9. Strategic Planning — Tom Friedman
   - A. Future Planning
   - B. Strategic Plan Annual Update

10. Executive Session (for Board members only) — Janet Cowell, Chair
    Pursuant to: G.S. 143-318.11 and G.S. 132-1.2

A. Consultation with Legal Counsel – Contract Issue (Aon Hewitt) *(G.S. §143.318.11(a)(3) and G.S. § 132-1.2)*	Lotta Crabtree
B. Print and Mail Services, RFP #270-2015101601 Recommendation for Award ***(Requires Board Approval)***	Beth Horner

11. Adjourn — Janet Cowell, Chair

Next Regularly Scheduled Meeting: January 21, 4–6 p.m. and January 22, 9 a.m. – 3 p.m.

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North Carolina
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Strategic Plan Annual Update

Board of Trustees

November 19, 2015

Presentation Overview

- Review of Current Strategic Plan
  - Improve Members' Health
  - Improve Members' Experience
  - Ensure Financial Stability
- Progress Report of Priorities and Initiatives
- Why Refresh the Strategic Plan?
- Strategic Planning Updates and Evaluation
- Staff Observations of Strategic Plan
- Timing to Update Strategic Plan

Layout of the Strategic Plan

- Strategic Priorities
  - 3 broad goals
  - Each includes 3 to 4 Initiatives per priority
- Strategic Initiatives
  - What We Will Do
  - Each Initiative contains 1 to 3 Projects and/or Programs
- Projects and Programs Roadmap
- Strategic Metrics
  - Review in April with complete CY 2015 data

Strategic Plan Priority Areas

Strategic Priority	Key Initiatives
Improve Members' Health	• Maximize Patient Centered Medical Home (PCMH) Effectiveness • Assist Members to Effectively Manage High Cost High Prevalence Chronic Conditions • Offer Health-Promoting and Value-Based Benefit Designs • Promote Worksite Wellness
Improve Members' Experience	• Create Comprehensive Communication & Marketing Plan • Improve the Member Enrollment Experience • Promote Health Literacy
Ensure Financial Stability	• Target Acute Care and Specialist Medical Expense • Target Pharmacy Expense • Pursue Alternative Payment Models • Ensure Adequate, Stable Funding from the State of North Carolina

Strategic Plan Updates and Evaluation

Strategic Plan Tracking

- Staff prepares a quarterly status report to highlight progress/challenges on each of the key initiatives in the Strategic Plan
  - Typically produced a month after the end of each calendar quarter H
  - Highlights key topics to discuss with the Board
  - Executive team uses the document to assess overall progress and guide operational priorities

Strategic Plan Evaluation

- Staff developed a scorecard to evaluate how well the Strategic Plan initiatives are being addressed
  - Scorecard metrics are a calendar year basis
  - CY 2015 results should be available in April 2016 to allow proper claims run out

Review of Improve Members' Health Initiatives, Programs, and Projects (CY 2015)

Successes	Ongoing Project	Revising Approach	Future Project	Potential to Reconsider
• PCMH Pilot with 4 practices up and running • Transition of Care Program Implemented • Chronic HEP designed for CY 2016 • Wellness Champions Implemented • Wellness Wins Implemented	• PCMH Pilot • Transition of Care Program • HEP Programs in CY 2016 • Wellness Champions	• High Utilizer Program • PCMH Pilot Year 2	• Chronic Pain Pilot • Identifying areas for value based design integration • Further opportunities for provider partnerships	• Focus on PCMH versus broadly on high quality providers

Challenges to Success – Improve Members' Health (CY 2015)

- Maximize PCMH Effectiveness:
  - *Highly successful in implementing in CY 2015*
  - Challenge: There has yet to be broad statewide adoption of PCMH accreditation despite North Carolina being one of the most engaged states
  - Challenge: Identifying practices with the right level of engagement and mutual capacity
  - ***Potential Solution: Broaden PCMH to include more forms of high quality providers in a transparent and consistent manner***

- High Prevalence Chronic Conditions
  - *Key Success: Design of Health Engagement Program for members with chronic conditions for CY 2016*
  - Challenge: Communication and member uptake for high utilizers
  - Challenge: Member Plan election remains high in Traditional 70/30
  - Challenge: Staff capacity to implement and appropriately manage multiple initiatives

Challenges to Success – Improve Members' Health (CY 2015)

- Value-based Benefit Design:
  - *Key Success: Implementation of Health Engagement Program for CY 2016*
  - Challenge: General Assembly pressure to reduce cost growth limits flexibility to invest in health
  - Challenge: Member plan election
  - Challenge: Vendor capabilities and benefit integration
  - ***Potential Solution: Identify approaches to incorporate Enhanced 80/20***

- Worksite Wellness:
  - *Highly successful in CY 2015*
  - Challenge: Difficulty in being able to design and implement a worksite program that is able to attract and retain enough interest
  - Challenge: Lack of broad statewide policy to incorporate in a manner that can be duplicated

Review of Improve Members' Experience Initiatives, Programs, and Projects (CY2015)

Successes	Ongoing Project	Revising approach	Future Project	Potential to Reconsider
• BCBSNC transparency deployed • HEP Programs in place for CY 2016 • Re-implemented Benefitfocus and completed AE despite challenges • Awarded Communication & Marketing Services Contract • Communicated with more members through Telephone Town Hall meetings	• Improving the member enrollment experience and stabilizing the enrollment platform • HEP Programs in CY 2016 • Continuing to improve customer satisfaction • Meet regularly with provider community • Develop non-Medicare primary health literacy campaign	• Searching for a new benefits calculator tool • Improve member contact information	• Enhance Medicare Primary learning opportunities • Develop learning modules for all members • Implement a communications and marketing campaign	

Challenges to Success – Improve Members' Experience (CY 2015)

- Overarching Challenges:
  - Director of Global Benefits Communications Director position vacant
  - Enrollment and Eligibility Vendor Transition
    - Consumed staff resources and capacity
    - Issues with data transfer and file setup
    - Members are vendor transition weary
  - New programs and/or enhancements require technology development and vendor integration which must be prioritized and resourced by the vendors
    - Leads to longer implementation timelines

Review of Ensure Financial Stability Initiatives, Programs, and Projects (CY 2015)

Successes	Ongoing Project	Revising approach	Future Project	Potential to Reconsider
• Implement alternative payment models with 2 to 3 ACOs • Communication with State Gov't Leadership • Legislative Agenda • Identify opportunities to incent quality of care • Direct provider engagement • Act in an open and transparent manner • Ensure adequate funding • Partner with stakeholders	• Incent members to utilize appropriate providers • Communication with State Gov't Leadership • Legislative Agenda • Reduce Avoidable admissions • Partner to identify opportunities to incent quality of care • Direct provider engagement	• Communication with State Gov't Leadership • Reduce Avoidable admissions • Partner to identify opportunities to incent quality of care • Direct provider engagement • Proactively work with State Gov't to protect Plan's reserves and ensure adequate funding	• Specialty Rx programs • Enhanced Fraud, Waste, and Abuse • Partner to identify opportunities to incent quality of care • Direct provider engagement	• Implement a telehealth option

Challenges to Success – Ensure Financial Stability (CY 2015)

- Acute and Specialist Care:
  - Challenge: Opportunities are not emerging uniformly around the State
  - Challenge: Incorporating into benefit design and communicating benefit changes

- Target Pharmacy Expense:
  - Challenge: Specialty drug trends continue to drive overall trend
  - Challenge: Staff turnover, recruitment and onboarding

Challenges to Success – Ensure Financial Stability (CY 2015)

- Pursue Alternative Payment Models:
  - Challenge: Opportunities are not emerging uniformly around the State
  - Challenge: Incorporating into benefit design and communicating benefit changes

- Ensure Adequate, Stable Funding from the State of North Carolina
  - Challenge: General Assembly asking for short-term savings or cost-shifting at the expense of long-term planning
  - Challenge: Reserve for low employer contribution growth

Why Refresh the Strategic Plan?

- The Strategic Plan is designed to be a living document that reflects the priorities of the Board, the health care environment in North Carolina, and administrative capabilities of our current vendor partners
  - Reviewing the status of these factors annually:
    - Helps maintain relevancy of the Strategic Plan
    - Provides a useful tool to guide Plan staff and operational priorities
- Multiple lessons learned and Board feedback from the past year to incorporate that will enhance the Strategic Plan
- The healthcare space is rapidly changing
- Vendor and provider capabilities are changing at different rates

Next Steps

- Discussion following Friday's meeting
- Revise the Plan based on Board feedback
- Update metrics in April

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North Carolina
State Health Plan

Strategic Planning Process Recommendations

Phase I: Discovery Report

January 31, 2014
Final

Prepared by:
Tom Gualtieri-Reed, MBA
Lynn Spragens, MBA

North Carolina State Health Plan
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North Carolina State Health Plan
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Executive Summary

The State Health Plan (SHP) has undergone many changes over the past 18-24 months, including the creation of a 10-member Board of Trustees that has the responsibility to develop and maintain a strategic plan. The State Treasurer, Board of Trustees (BOT) and SHP leadership recognize that an effective strategic planning process and plan will enable the SHP to better fulfill the SHP's mission in the future. This document outlines the key findings from an initial discovery phase of planning work and provides a set of recommendations for developing a strategic planning process and plan for the SHP that can be implemented and maintained by the State Treasurer, the current and future BOT and leaders of the SHP. The following is a summary of the key content and recommendations included in this report:

Strategic Planning Guiding Principles

The guiding principles will be used to create a level of consistency in the planning approaches and may be modified from time to time throughout the planning process. The principles included in this report have been developed based on the input of the members of the BOT and SHP leadership team gathered through interviews, a review of previous planning work and discussions at recent board and staff meetings.

Strategic Planning Framework

The recommended process framework will be used to structure the analysis, synthesis and output of the strategic plan. It is important to note that not all planning processes follow a linear path but this structure will help ensure consistent steps are taken to develop and continuously refresh the strategic plan.

Preliminary Strategic Questions to Address

This report identifies and organizes a set of strategic questions that have already been identified through the work of the BOT and SHP leadership. It is recommended that these issues be the starter list used to drive an initial wave of analysis, measurement and strategic prioritization.

Strategic Plan Governance & Management

The recommendations included in this section are intended to leverage existing strategic planning resources and tools, to create a level of cross-training for BOT and staff to ensure consistency during board term transition periods and specifically recommends that an appropriate level of SHP staffing be assigned to support the development of the strategic plan.

2014 Timeline

The timeline outlined in this report targets the first release of a strategic plan to be in late May or early June 2014. This timeline takes into consideration the time required to allocate and organize staff and resources and the need to better understand and assess the 2014 changes that have been implemented. This timeline can be adjusted as needed, but at a minimum provides the initial steps that can be taken to implement this strategic planning process.

In addition to what is outlined above, this report includes several concept charts, important contract dates and other information that will be useful references during the planning process.

I. Background & Purpose

The State Health Plan for Teachers and State Employees (SHP) provides health care coverage to more than 668,000 teachers, state employees, retirees, state university and community college personnel, and their dependents. The SHP has undergone a significant amount of change over the past 18-24 months.

Effective January 1, 2012 the SHP became a division of the North Carolina Department of State Treasurer. Previously the SHP reported to a legislative oversight committee within the General Assembly. As part of this change, in December of 2011 a new 10-member Board of Trustees (BOT) was appointed by the Governor (2), Senate (2), House (2) and State Treasurer (2) and includes the State Treasurer and State Budget Director. The BOT is made up of a diverse group of current and former teachers, state employees and other experts in medicine and health administration. The board is responsible for decisions regarding vendor contracts and the design of employee health benefits as well as the development of a strategic plan.

During this period of time, the SHP has evaluated and awarded new contracts for third party administrator services for its self-funded plan offerings, added a fully-insured Medicare Advantage offering and two additional payers to administer the offering, transitioned to a January 1 benefit plan year, added a new health engagement offering with incentives for healthy behaviors and undergone a change in SHP administrative leadership. The health care industry is also experiencing unprecedented levels of regulatory and market changes due to the Affordable Care Act (ACA). As the ACA becomes a reality, market and healthcare stakeholders, including employers, individuals, payers, regulators, providers and legislators, are continuously seeking to understand and assess its impact. It is prudent that the BOT and SHP leadership team build such external factors into the strategic planning process.

In an effort to ensure that the SHP continues to fulfill its mission amidst all of these changes, the SHP is undergoing an assessment of its strategic planning process. The purpose of this document is to outline the key findings from an initial discovery phase of work and provide a set of recommendations for developing a strategic planning process and plan for the SHP that can be implemented and maintained by the State Treasurer, the current and future BOT and leaders of the SHP.

II. Phase 1 Discovery Key Findings

As part of this discovery phase, a series of steps were taken to understand the current situation of the SHP strategic planning process and plan. Included in these steps were interviews with the active SHP BOT, including the North Carolina State Treasurer, key staff members of the Treasurer's Office, the SHP Executive Administrator and the SHP Executive Team. In addition, a review was conducted of available BOT minutes, presentations and relevant SHP strategic planning material, the new SHP plan offerings for the January 1, 2014 plan period, the March 2012 report of key findings from the Treasurer's and Board's state-wide tour and other information such as the North Carolina Statutes and a draft dashboard to monitor the quality and experience and the Treasurer's Office strategic priorities.

The following is a summary of key findings from the initial interviews that were conducted:

Progress To Date & What's Going Well
❑ A lot of positive energy, momentum and relationships
❑ Diverse, committed and knowledgeable staff and Board of Trustees
❑ Passion for the member, the member's health and being a model for North Carolina
❑ Significant change is already underway (a "new chassis")
❑ 3rd party vendors have been selected and contracts are in place
❑ Dashboard development is progressing
❑ Long term financial model (underway)
❑ ….others

Challenges & "Natural Tensions"
❑ Diverse, committed and knowledgeable staff and Board of Trustees: How do we leverage this?
❑ Significant change is already underway (a "new chassis"): How do we stabilize while we create new momentum for the future?
❑ Premiums & affordability: What is the value proposition to our members and to other stakeholders (legislature)?
❑ Ability to directly influence price, quality and efficiency: What can we control?
❑ The need for data & information: How do we learn about the market, the business, our members, etc.
❑ Leadership and Board turnover: How do we maintain continuity of purpose and plan?
❑ Prioritization: The many versus the few.

The following is an additional set of strategic planning process observations that were identified and considerations that are factored into the final recommendations:

Topic	Observation	Considerations
Mission Statement	The BOT and SHP Leadership Team are supportive of and are using the Mission Statement to guide their thinking and actions.	No action necessary. Revisit as needed.
Vision Statement	While there is a stated vision in place, there were several comments regarding the desire to move the SHP from an administrator of benefits and insurer to having a more active role in supporting the health outcomes and lifestyle choices of its members.	Consider the revision of a vision statement at an appropriate time during planning.
Guiding Principle Observations	There is a strong desire and a recognized need by both the BOT and SHP leadership to develop a set of strategic planning guiding principles as they relate to: ▪ The reaffirmation of the Mission Statement as the primary guide to decision making ▪ A general statement on and commitment to ensure the strategic plan becomes an active part of the actions and decisions made by the BOT and SHP ▪ Appropriately listening to and considering the differing needs of specific member constituents while balancing what is in the best interests of all members ▪ Member cost sharing, particularly for preventive services ▪ The use of industry benchmarks to measure quality, cost and member experience ▪ The appropriate engagement with and support from the General Assembly, specifically as it relates to reserves and funding approvals ▪ An acknowledgement for the need to stabilize and evaluate current plan design changes while continuing to update, modify, and improve plan offerings and incentives as well as develop new plan designs where appropriate	Develop an initial draft set of Guiding Principles and revisit as needed at appropriate times during the planning process.
Governance and Strategic Management	There is a need to address, as part of the process, the efficient and effective use of the SHP Executive Leadership Team and staff as well as BOT expertise. This includes but is not limited to: ▪ Freeing up time for or allocating dedicated staff time to enable the Executive Administrator to engage in more frequent strategic planning activities ▪ Effectively engaging more of the BOT in the activities of strategic planning, including the effective and appropriate use of the BOT formal board meetings ▪ Enabling the BOT to fulfill their fiduciary role and set the precedence of this being an “active” oversight board	Consider redesigning the use of the BOT meeting time, BOT workgroups and allocation of staff to support strategic planning activities.

III. Strategic Planning Guiding Principles

These guiding principles will be used to enable the BOT and SHP leadership team to develop a strategic plan. These are intended to create a level of consistency in planning approaches and may be modified from time to time during the strategic planning process.

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 desire of the BOT and SHP leadership team to develop a strategic planning process and plan that is **sustainable** beyond the current BOT members and SHP leadership team.

3. The development and execution of a strategic plan is viewed as a **joint responsibility** of the BOT and SHP leadership team, with the BOT approving strategic measures and strategic priorities while providing the support and guidance to the SHP leadership team to execute on the strategic plan.

4. The development of a strategic plan is considered **a process** to help understand what is relevant. The strategic plan will serve as a guide in prioritizing what is done, what is measured and how BOT and SHP staff time and resources are allocated.

5. It is the intent of the BOT and SHP leadership team to utilize all reasonable information sources to support the development of the strategic plan. When and where possible and appropriate, **industry or market benchmarks** and data will be used to develop strategic measures and establish strategic priorities for the SHP, with a specific emphasis on state employee health plans with similar characteristics and of comparable size.

6. The BOT and SHP leadership team acknowledges the need to integrate the SHP strategic plan into the strategic plan of North Carolina's **Department of State Treasurer**.

7. The adopted Strategic Plan should take into account the following factors:

   a. 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.

   b. 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 most competitively priced offerings that **improve the health and well-being of its members**.

c. 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.

d. 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.

e. 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.

f. 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 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.

g. 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.

IV. Strategic Planning Process Recommendations

A. Existing Process Steps and Tools to Build Upon

Over the past year and a half the BOT and SHP leadership team have developed or started to develop several strategic planning process steps and tools that can be leveraged to maintain the positive and constructive progress that has been made to date. Listed below are some examples along with a description of the opportunity to integrate into a more formalized strategic planning process:

Workgroups & "Active" Board	• Balance workgroups with strategic discussions & operational pre-Board meeting input • Use workgroups to build relationships among BOT and SHP leadership team and staff • Focus formal Board meetings on fiduciary responsibilities, formal Board votes and member experience
Dashboard	• Transition dashboard to a "balanced scorecard" for SHP • Integrate strategic measures with operational and financial performance - one stop performance shopping • Consider developing composite measures for quality and cost performance for strategic planning purposes
Financial Model	• A multi-year modeling tool provides a channel to capture key strategic or business assumptions as well as a tool to develop scenarios for strategic decisioning • Continue to use the existing financial modeling tool to run scenarios on membership, pricing, medical expense, plan/ vendor admin expenses & reserve assumptions over a multi-year time horizon
Member Experience & Learnings From New Designs	• Integrate into regular Board meetings an update on member satisfaction, feedback from current designs and member engagement levels • Focus a portion of the formal Board meetings on member experiences and input as this is critical information that will ensure commitment to the Mission Statement

B. Strategic Planning Framework

The following is a high level framework that can be used by the BOT and SHP leadership team to develop, monitor and manage a strategic plan for the SHP. The outer circles are the main components of a strategic plan. The "circle" image is intended to set the context that the planning process is ongoing and one component flows into the next.

An assessment of internal and external factors and trends. Examples:
- Demographics
- Regulatory changes (ACA)
- Disease and cost trends
- Medical science developments

The areas of focus or priorities and actions that leadership believes will have the greatest impact on the measures. Examples:
- Targeted expansion of NC Health Smart & incentives
- Provider engagement on quality
- Low cost benefit design options

Key strategic issues and conclusions that are identified based on leadership's review of the environmental analysis. Examples:
- Growth in incidence of disease
- Inconsistent quality of care
- Affordability / value are key drivers of satisfaction

A limited number of strategic measures used to establish direction and measure success. Examples:
- Financial stability (target reserves)
- Member engagement levels
- Quality of care
- Total cost of care

C. Preliminary Strategic Questions to Address

In an effort to leverage the strategic planning work that has been conducted to date, the following table includes a proposed set of strategic and business issues and questions that have been identified. These issues can be used to drive an initial wave of analysis, measurement and strategic prioritization. This will allow the BOT and SHP leadership team to continue to build on the momentum of actions already underway while at the same time informing the development of a more formal strategic planning process for the SHP.

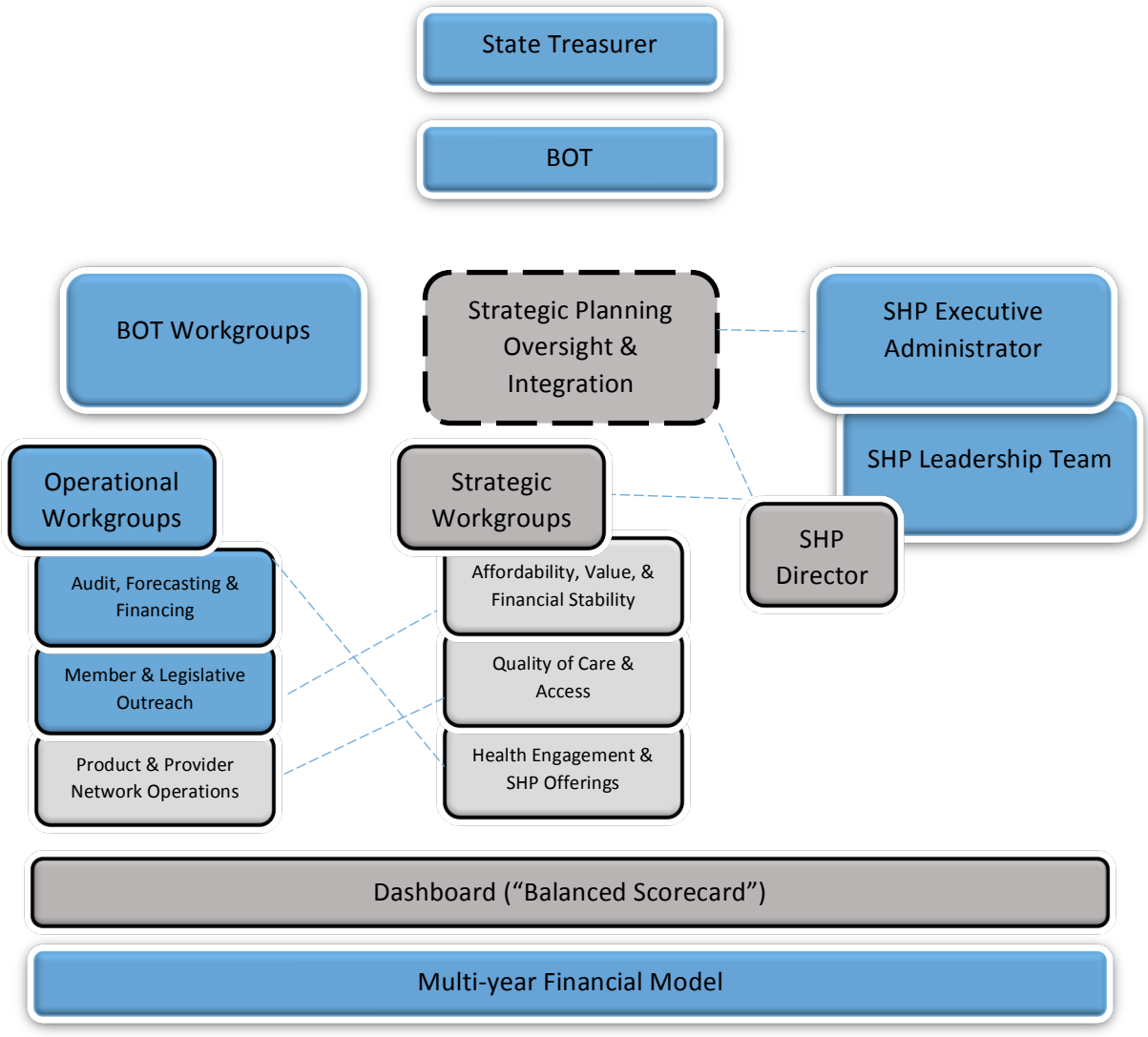
Issue	Example Strategic & Business Questions
Affordability & Member Value	▪ What are reasonable premium and out of pocket costs for members? o How does the SHP ensure out of pocket costs do not create dis-incentives to get needed care (e.g. meds for chronic conditions)? o How can incentives be used to drive value to the member? ▪ What is the SHPs premium strategy? o What premiums and out of pocket costs are other similar states' health plans and private employers establishing? How does the SHP compare? ▪ What are the top 10 drivers of medical costs? By demographic, region, provider, disease and health care services (hospitalizations, ER, Rx, etc) o What are appropriate medical and pharmacy expense trends for the SHP? How can the SHP affect medical and pharmacy expense trends for its members? ▪ Should the SHP attempt to factor in supplemental policies offered to members by other insurance carriers into its value story? If so, how? ▪ How can the SHP assess the effectiveness of affordability and value initiatives?
Quality of Care & Access	▪ What are the most significant gaps in quality of or access to care for SHP members? o How can the SHP drive the transition of provider reimbursement models to pay for outcomes (value)? o How does the SHP measure quality of and access to care for SHP members? What industry standard measures exist? o How can the SHP leverage existing measures or utilize the measures from 3rd party vendors? o What measures of quality and access will have the greatest impact on cost and quality? o How can the SHP assess the effectiveness of quality and access initiatives? ▪ How can the SHP effectively improve provider engagement with the SHP? o Which providers are best suited to work with SHP members to improve quality of care? Access to care? Which providers are seeing the highest volume of SHP members? o What should the relationship be between SHP and providers? ▪ What can the SHP do to drive the expansion of PCMH's and even integrate into accountable care organizations (ACOs)? ▪ How can the SHP partner with the 3rd party vendors and providers to improve quality of care and access?

Financial Stability	▪ What additional actions should be taken to obtain legislative support over the long term? ▪ How should financial stability be defined and evaluated? o What level or percentage of healthcare cost trend is sustainable? o What is a reasonable target reserve level to maintain for the next 3-5 years? o What is a reasonable period of time to project and assess financials? ▪ To what extent should benefit design be used to maintain financial stability? ▪ To what degree is the SHP willing to spend more in the short term to achieve long term stability or savings?
Member Health Engagement	▪ What is the SHPs strategy for member communication and engagement? o How can the SHP more effectively engage members, particularly those with chronic health conditions? o How can the SHP partner with the various state agencies to promote healthy lifestyles? o What are other large employers doing to increase member health engagement? What are examples of model worksite wellness programs? ▪ How can the SHP service model (web and phone) assist in ensuring members know how to access providers and who are the most effective providers? o How can health care cost and quality metrics become more transparent? ▪ How will recent enrollment and new product challenges influence longer-term strategies to engage members around new health programs? o How effective have the recent changes in benefit designs been in increasing member health engagement? o How can the SHP assess the effectiveness of member engagement initiatives?
Future of SHP Offerings	▪ How much can and should the SHP drive new models of care delivery and / or provider payment models? o With what strategic partners should the SHP be doing this? ▪ How will future Federal-level policymaking impact the SHP? ▪ How will future State-level policymaking impact the SHP? ▪ What are the implications of ACA, exchanges, subsidies, Medicaid expansion etc. on future new product designs and SHP offerings? ▪ Should the SHP consider defined contribution products, integration with Medicaid or any other significant changes to the operations or offerings of the SHP? o How effective have the 3rd party vendors been and who are the best partners for the future?

D. Strategic Plan Governance and Management

The following recommendations are designed to ensure both the BOT and SHP leadership team are able to fulfill their responsibilities while leveraging the momentum, energy and knowledge of the BOT and SHP staff. These recommendations are also designed to create a level of cross-training for BOT and staff to ensure consistency during board term transition periods. These recommendations take into consideration the requirements of the North Carolina statutes. A more thorough review of these recommendations in context to SHP budgets, SHP staff operational priorities, BOT availability, BOT board meetings and other such dependencies will need to be considered over time.

Proposed BOT and SHP Leadership Team
Strategic Planning Governance & Management Structure
Year 1 (2014)



The following are some of the key points of consideration as the BOT and SHP leadership work to implement these recommendations:

1. **Leverage existing structures.** The intention is to leverage existing structures and components that are in place already or where there are efforts underway. For example, the workgroups have been effective to date and the model should be modified to support the strategic planning process. In addition, the dashboard can be further developed to provide the source for developing and monitoring key performance measures.

2. **Operational and strategic workgroups.** Creating a separate set of strategic workgroups focused on analyzing the strategic issues will ensure the more "short term" responsibilities are appropriately managed while protecting time for the "longer-term" planning work.

a. **New operational workgroup – Product and Provider Network Operations**
Focus this workgroup on more immediate provider network quality and access challenges, 3rd party vendor delivery for current product offerings and other current product offering issues and challenges that would require BOT input or expertise. Keep the other 2 operational workgroups as is.

b. **Strategic workgroups**
Assign the longer-term strategic questions and issues to each strategic workgroup, organized by the broad categories as outlined in section IV. C. of this report. SHP leadership and staff would conduct analysis and provide recommendations to SHP workgroups for input and guidance. That workgroup would then bring forward to the full BOT a summary of key findings and recommendations for integration into the strategic plan. This allows for a level of expertise to be developed among the BOT and staff around specific subjects, particularly given the broad range and volume of topics that could be explored.

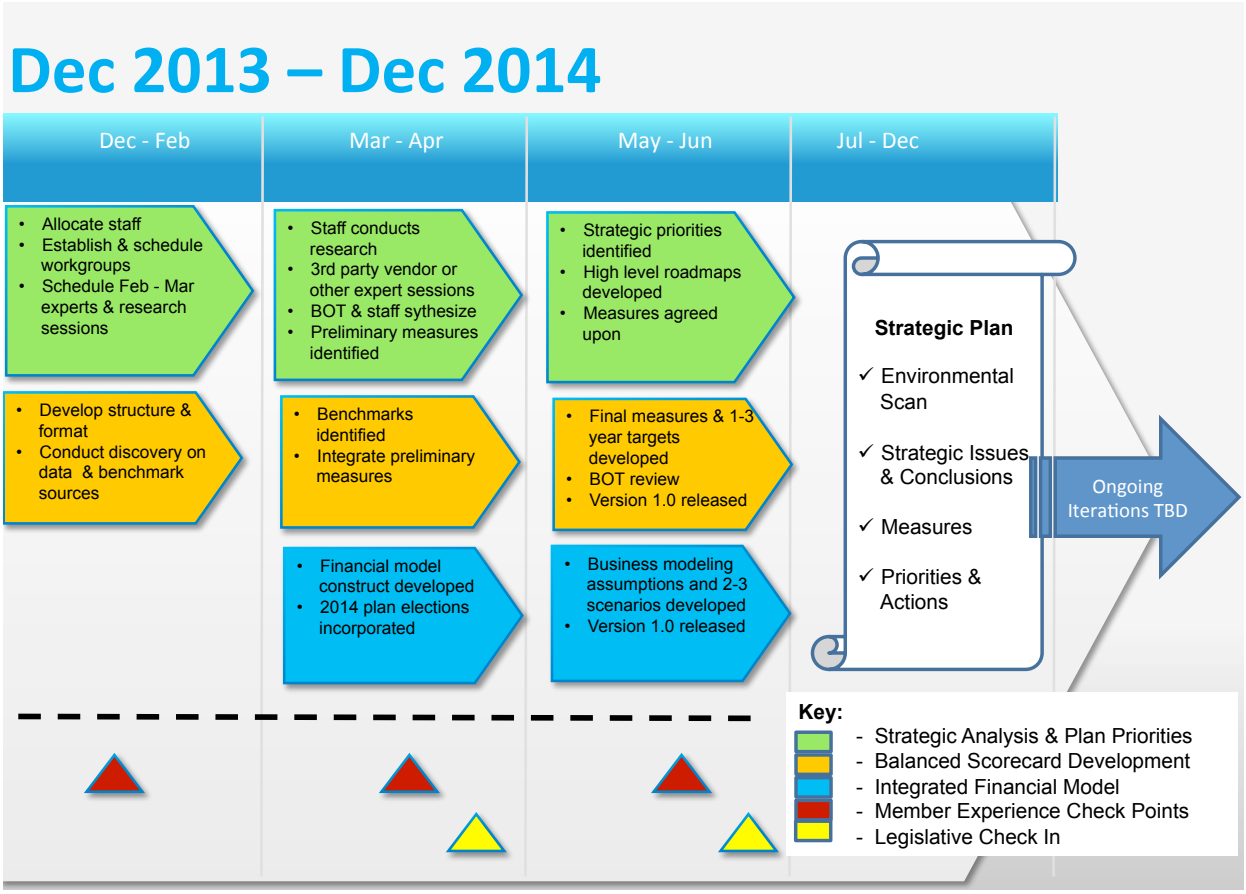
3. **Workgroup membership.** It is recommended that 3 BOT members be assigned to each operational workgroup and strategic workgroup with the BOT Chair (State Treasurer) participating as and where needed. In addition, if possible and with consideration of the expertise of BOT members, the membership of the operational and strategic workgroups will vary to enable all BOT members to work closely with each other. This will help ensure smoother transitions during scheduled BOT turnover and will also better leverage the diverse perspectives of the BOT and SHP staff members.

4. **SHP leadership staffing.** In order to effectively build an initial strategic plan, more dedicated SHP leadership resources will need to be allocated. The specific position (director-level) and responsibilities will need to be determined but generally, this will include a level of SHP leadership oversight for the administration of the strategic planning process and ongoing strategic plan management.

5. **Strategic Planning Oversight & Integration.** At this time, there is a Strategic Planning workgroup that can be repositioned. By establishing the strategic workgroups, all BOT will be able to participate in the development of the strategic plan. It is recommended that the Strategic Planning workgroup members initially function to ensure an appropriate level of oversight and integration is occurring but eventually that responsibility should transition to include the full BOT.

E. 2014 Timeline

This timeline assumes that the strategic plan development will be a process that will continue to evolve over time but that a reasonable first release of a more formalized strategic plan would be at the end of May or early June of 2014. This will allow time to set up the governance structure, complete the analysis of the strategic questions and ensure that the initial launch of the January 2014 offering is successful and member selections are understood.



REFERENCE MATERIALS

i. North Carolina General Statute 135-48.22. Board Powers and Duties.
ii. Macro-level Calendar of Dependencies
iii. Balanced Scorecard Concept
iv. Multi-year Financial Model

i. North Carolina General Statute 135-48.22. Board Powers and Duties.

The general statute information is included as a reference to document the authority and responsibility the Board of Trustees has to develop and maintain a strategic plan for the Plan. This also serves as a guide and reference in clarifying the role of the Board of Trustees as it relates to what requires Board approval.

§ 135-48.22. Board powers and duties.
The Board of Trustees shall have the following powers and duties:
(1) Approve benefit programs, as provided in G.S. 135-48.30(a)(2).
(2) Approve premium rates, co-pays, deductibles, and coinsurance percentages and maximums for the Plan, as provided in G.S. 135-48.30(a)(2).
(3) Oversee administrative reviews and appeals, as provided in G.S. 135-48.24.
(4) Approve large contracts, as provided in G.S. 135-48.33(a).
(5) Consult with and advise the State Treasurer as required by this Article and as requested by the State Treasurer.
(6) Develop and maintain a strategic plan for the Plan. (2011-85, s. 2.10; 2012-173, s. 4(a).)

ii. Macro-level Calendar of Dependencies.

The following calendar of dependencies highlights key externally or internally determined dates that should be considered as the strategic plan for the SHP is developed and maintained. This calendar is intended to be a reference point at this time and should not be considered approved or finalized by the BOT, SHP leadership, vendors or other stakeholders. These dates are subject to change and may be updated from time to time as part of the vendor contracting or strategic planning process.

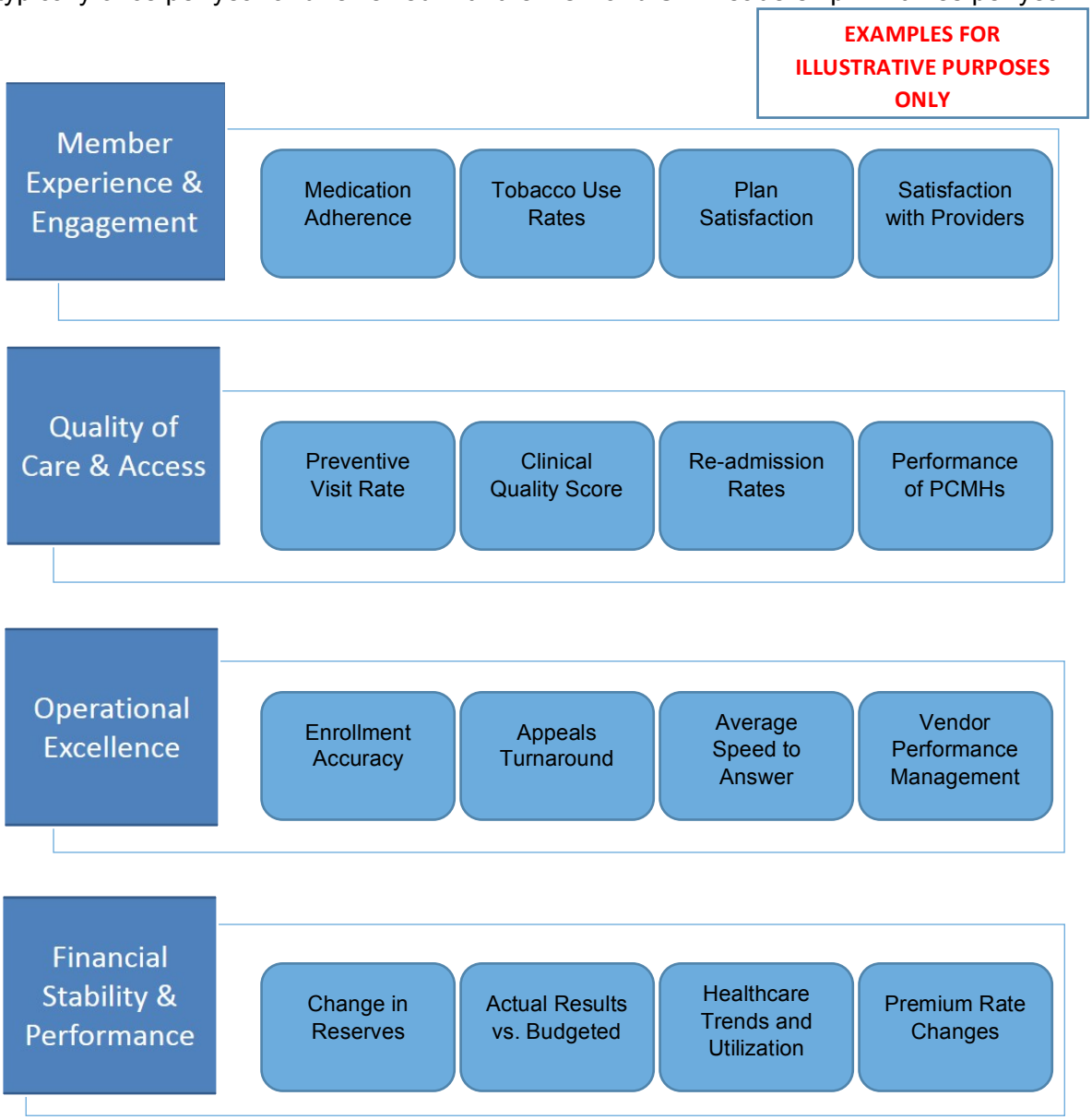
	Category	2014		2015		2016	
		Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
Operational	Final Designs	△		△		△	
	Open Enrollment		⇨		⇨		⇨
	BCBSNC						▲ 12/31/16
	Humana						▲ 12/31/16
	United						▲ 12/31/16
	Medco / Express Scripts				▲ 12/31/15		▲ 12/31/16
	Active Health		▲ 12/31/14		▲ 12/31/15		
	Cobra Guard						▲ 12/31/16
	Benefit Focus						▲ 12/31/16

△ - Internal or Plan deadline
▲ - Vendor contract termination or renewal

Legislative	Legislative Sessions	▬		▬		▬	
	Budget Approvals	⇨		⇨		⇨	
	State Elections		△ 2yr GA				△ 2yr GA 4yr Gov, Trs
BOT Terms	Initial 2.5 Year Terms	6/30/14 △ Hargett Johnson Medlin Rubin				6/30/16 △ TBD TBD TBD TBD	
	Initial 3.5 Year Terms			△ Cunningham Huffstetler Moore Newton			Note: New 6/30/17 →
"Wildcards"	ACA Employer Requirements			***TBD***			
	Other Regulatory Requirements			***TBD***			
	Market Trends			***TBD***			

iii. Balanced Scorecard Concept.

An important step in developing an effective strategic planning process and plan is to establish measures that will serve as a guide to setting priorities and monitoring progress. The concept is to establish a limited number of measures (10-15) whereby the SHP can monitor **trends** and establish longer term strategic **targets**. The diagram below is intended to build off of the work of the Dashboard and create a balanced scorecard that would enable the BOT and SHP leadership team to organize SHP measures into categories and identify strategic areas of focus and priorities. For purposes of this document, the following categories were used: **member experience & satisfaction**, **quality of care & access**, **financial stability & performance** and **operational excellence.** These measures would be revisited on a pre-determined basis, typically once per year and reviewed with the BOT and SHP leadership 1-2 times per year.



iv. Multi-year Financial Model.

The BOT and SHP leadership have recognized the value of developing a multi-year, dynamic financial forecast that is maintained on a regular basis. Expanding the forecasting time horizon of the current model will enable the SHP to continue to capture critical business assumptions and conduct scenario planning beyond the immediate term as well as establish annual and multi-year goals. The financial model creates an opportunity to understand both internal and external factors that could impact the strategic plan and measures of success. The table below outlines major components of the model and examples of key assumptions.

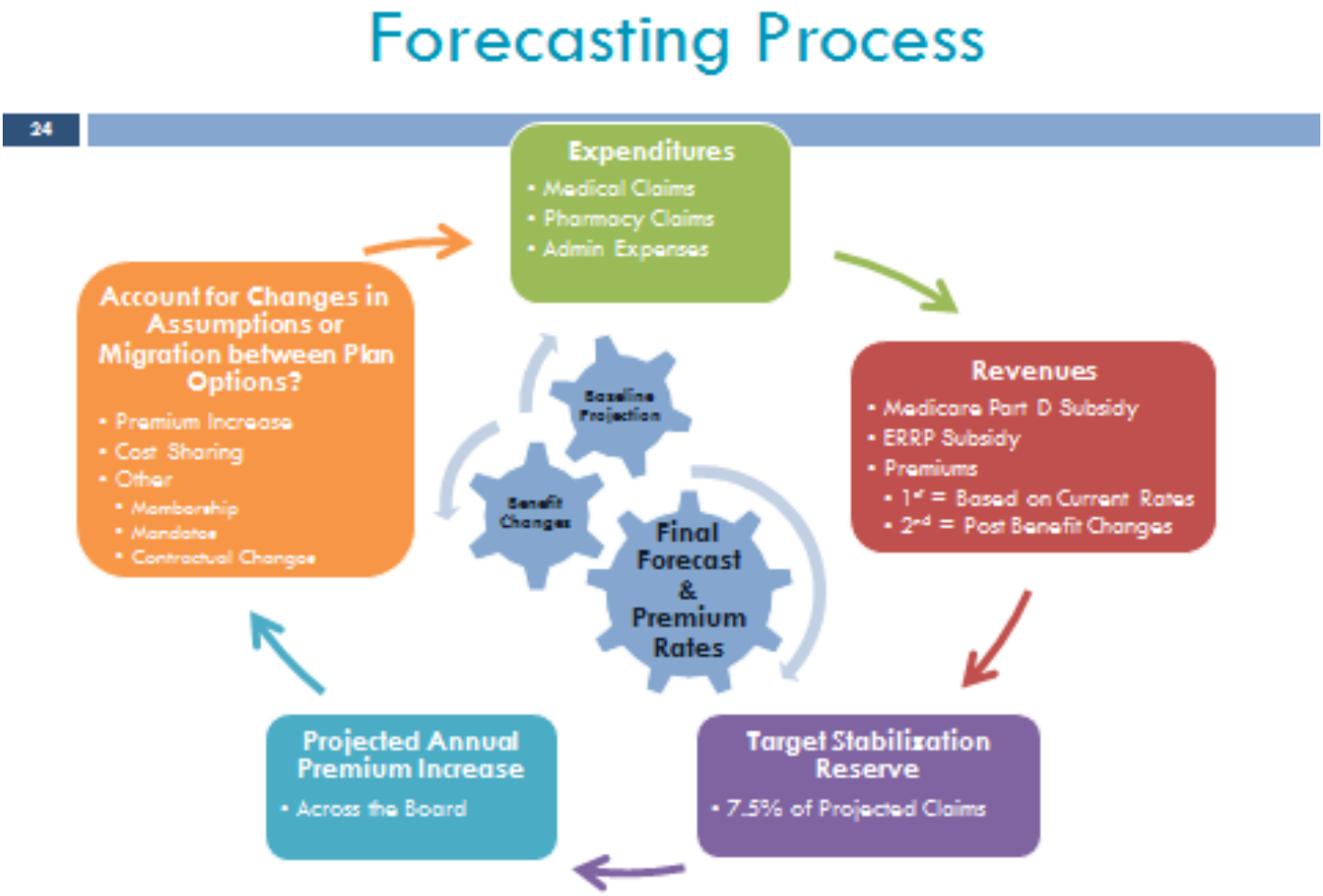
Section	Description	Sample Assumptions & Factors
Membership	Number of enrolled members by product	• Current membership by coverage type: active employees, non-Medicare retirees and Medicare retirees • % of members electing coverage in a particular plan • Average family size (family coverage election) • Membership by product (MA, CDHP) • State and local employment outlook • Likely impact of plan design and premium strategies on plan selection
Premium Revenue	Projected total premium contributions	• Required across the board premium adjustments (%) • Premiums paid by employing units/retirement system • Base employee/retiree premiums • Premium surcharges • Impact of plan design changes on contribution revenues Note: Amount paid per enrollee varies by coverage tier and plan selection
Other Plan Revenue	Non premium revenue	• Retiree Drug Subsidy • EGWP Subsidy • ERRP Subsidy • Investment Earnings

Continued on Next Page

Medical Expense	Total cost of care	• Separate trend assumptions for medical and pharmacy expenses – assumption designed to take into account the following:
		  ○ Medical CPI trends
		  ○ Provider contracted rates
		  ○ Projected utilization of health services & incidence of diseases
		  ○ Generic prescription fill rates
		  ○ Growth in specialty pharmacy
		  ○ Growth in MAPDP fully insured premiums
		  ○ Savings associated with population health management services
		• Also considerations for the impact of the following:
		  ○ Proposed changes in plan design and member cost sharing assumptions
		  ○ Anticipated changes in payment models
		  ○ Impact associated with new TPA/PBM/MAPDP contracts

Administrative Expense	Expenses for SHP staff and vendor costs	• Projected vendor contract terms • Administrative staff assumptions
Net Income	Total revenue – total expense	• Formula driven field
Reserves	Cash balance	• Formula driven field, but required premium adjustments established to meet target reserve level • Target stabilization reserve levels or ranges • Dependent on premium pricing strategy and 3rd party vendor contracting effectiveness and risk sharing

The following chart outlines the current forecasting process that will be used to further develop the multi-year financial model:



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

Board of Trustees
of the
State Health Plan for Teachers and State Employees

Strategic Plan
2014 – 2018

September 19, 2014

Adopted: Janet Cowell

Janet Cowell, Chair

North Carolina State Health Plan
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EXECUTIVE SUMMARY

The State Health Plan for Teachers and State Employees (Plan) was created by statute to make available comprehensive health benefits for eligible teachers, employees, retirees and their eligible dependents. The Plan is governed by the State Treasurer, Board of Trustees (Board) and the Executive Administrator, who carry out their duties and responsibilities as fiduciaries for the Plan. The Board is responsible, by statutory mandate, for developing and maintaining a strategic plan for the Plan. This document outlines the strategic plan for the years 2014 through 2018.

The strategic plan is organized by first identifying the Plan's mission, vision and values followed by "guiding principles" that describe the intent and motivation behind the Plan's actions. Next, the Board has identified three strategic priorities for 2014-2018: 1) Improve members' health; 2) Improve members' experience; and 3) Ensure a financially stable State Health Plan. A description of what each means, what will be done, and why it is important, is also included. Specific initiatives designed to achieve each strategic priority are then identified and described again in terms of what each means, what will be done, and why it is important. Finally, a roadmap is provided that identifies major projects and programs within each initiative along with key decision points regarding contracts or benefits, launch dates, and an indication of the magnitude relative to members impacted or resources needed.

This strategic plan is designed to align the mission and vision of the State Health Plan with the programs and services provided to its members, and along with the values expressed, will serve as a guide over the period identified. This document is considered a "living document." That is, specific projects and programs are expected to be modified on a frequent basis, as appropriate, with the priorities, initiatives and measures being revisited on an annual basis as agreed upon by the Board.

Ongoing performance monitoring, detailed project plans and other progress updates will be provided on a regularly scheduled or as needed basis. Background information, including environmental scans and other supporting analyses and conclusions used by the Board in the development of this strategic plan, are available on the Plan's website at www.shpnc.org under the Board of Trustees quick link.

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MISSION

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.

VISION

Our vision is to be a health plan that is a leader in North Carolina in providing access to cost-effective, quality health care and wellness programs on behalf of our membership.

VALUES

Member Focus *– Keeping the member at the forefront of our actions*

Collaboration *– Partnering with individuals and other stakeholders on behalf of our members*

Transparency *– Acting in an open manner with the highest possible degree of integrity in all we do*

Quality *– Striving for the best quality of care and service for our members*

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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 State Health Plan'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 Board and Plan leadership team to ensure that the **perspective of the member**, including experience and value, is factored into the strategic plan.
3. It is the intent of the Board and Plan 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 Board and Plan 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 Board and Plan leadership team recognize the responsibility to work to ensure that members have **access to quality care** and that their **patient experience is continuously improved**.
5. Given the Plan's responsibility to serve members across the state, the Board and Plan leadership team recognize the need to develop benefit offerings and programs that **balance cost and access to quality care**. Access includes addressing issues such as distance to providers, cost and length of time to schedule an appointment.
6. There needs to continue to be a **sense of urgency** to ensure the Plan remains financially stable to fulfill the mission of improving the health and health care of its members. That said, the Board and Plan 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 Board and Plan 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 Board and Plan leadership team to **develop a balanced portfolio of both near and long term strategic initiatives**.
8. It is the intent of the Board and Plan leadership team to effectively manage premiums that members are required to pay for coverage and for out-of-pocket health care expenses. The Board and Plan 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 health care services and improving the health of plan members. Ongoing communication and education will be critical.
9. The Board and Plan 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 Board and Plan leadership team will work collaboratively with that constituency to ensure the strategic plan fulfills the mission of the Plan.
10. Given the dependency on 3rd party vendors, business partners, providers and other stakeholders the Plan, working in the best interests of the Plan members and State of North Carolina, will take a **collaborative** and **partnership approach** with all stakeholders in developing and executing on the strategic plan. This will include utilizing others' areas of expertise and information to guide the decisions and actions of the Board and Plan leadership team.
11. The Board and Plan leadership team recognize their **fiduciary responsibility** first and foremost to the members of the Plan but also to the State of North Carolina and its citizens.
12. It is the intent of the Board and Plan leadership team to act in a manner that is in **the best interests of all members** of the Plan and actively work toward **consensus** that will enable the fulfillment of the mission of the Plan.

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STRATEGIC PRIORITIES

Priority	What It Means	What We Will Do	Why It Is Important
Improve Members' Health	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 health care providers in improving the quality and coordination of care • Identify and address gaps in access to quality care or in the care itself • Promote a culture of wellness	51% of members have at least one chronic condition and account for 76% 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 well-being and lower costs for both members and the Plan. In addition, offering programs and products that attract membership for all stages of health ensures a more stable Plan.
Improve Members' 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 including the provider's practice and staff.	• 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 members' experience with providers and practices	Members who are informed and satisfied with their 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 health care, the delivery of health care, and the utilization of benefits in order to minimize State and member premium contributions, provide a cost-effective and sustainable benefit and optimize the benefits offered to members within the financial resources available.	• 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 reducing 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 cost management 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 and cash flow. The Plan's expense trend has been at or below the medical Consumer Price Index for the last four fiscal years and reserves at the end of FY 2014 were approximately four times the targeted amount. Recent experience has allowed the Plan to offer more options and enhanced benefits for 2014 and forgo premium increases for the State and members in 2015.

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STRATEGIC INITIATIVES

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

Improve Members' Health	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 and practices 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 vendor partners) 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 delivery and coordination such as medication adherence, reduced ED use, hospital readmissions and nationally benchmarked HEDIS measures
			• Design and communicate incentives and other benefit designs that encourage members to have designated PCMHs 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 help ensure timely access to care and increase the focus on quality of care indicators such as:
				  • Diabetes HbA1c testing rate is 88.9% while the national benchmark at the 75th percentile is 91% and at the 90th percentile is 94%
				  • Cholesterol LDL-C testing rate is 81.3% while the national benchmark at the 75th percentile is 87% and at the 90th percentile is 89%

	Assist Members to Effectively Manage High Cost, High Prevalence Chronic Conditions	Focused programs designed to assist members and their providers to effectively manage a member's chronic condition(s). The targeted chronic conditions include asthma, COPD, cardiovascular diseases & diabetes. This includes a focus on members with multiple and complex chronic conditions.	• 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% • Members with one or more chronic conditions utilize $7,664 of services while healthy members (those without a chronic disease related claim) utilize about $1,283, roughly 1/6th the cost of those with a chronic condition • 2013 medication adherence rates for active members with diabetes was 46%, hypertension is 57% and high cholesterol was 65%

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Priority	Initiative	What It Means	What We Will Do	Why It Is Important
Improve Members' Health	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 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 cessation 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 • Create a culture of wellness to include participation and support from employing units and agency leadership	• 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 Members' 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 Annual Enrollment, to allow members the opportunity to maximize their experience and improve their access to the health care services available to them.	• 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 Plan services from BCBSNC services
			• Demonstrate the value of and promote Plan 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 increase the use of online communication channels because fewer than 1% of members now access NCHealth*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 and access 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 members' enrollment experience • Provide a customer service call center to provide members with timely and accurate enrollment and benefit information • Ensure that enrollment data is accurately collected, maintained and transmitted in a timely manner • 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 Acute Care 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. ○ Reinforce payment for necessary care only and minimize payment for unnecessary, duplicative care (e.g., preventable patient safety incidents otherwise known as "never events")	• 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 the medical and pharmacy benefits 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%

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Priority	Initiative	What It Means	What We Will Do	Why It Is Important
Ensure a Financially Stable State Health Plan	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 (TPA)/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
	Ensure Adequate, Stable Funding from the State of North Carolina	Work to secure the necessary stable funding sources by maintaining stakeholder confidence in and support for the Plan.	• Act in an open and transparent manner as appropriate in all interactions with the Governor, Office of State Budget and Management (OSBM), General Assembly, Fiscal Research Division (FRD), state agencies and the public • Use all reasonable tools, processes and assumptions to accurately forecast revenues, expenses, and required premium contributions • Proactively work with the Governor, OSBM, General Assembly, and FRD to protect the Plan's reserves and ensure adequate funding is appropriated each year to enable the Plan to achieve its mission • Partner with employee and retiree stakeholder groups to support the Plan's funding and legislative requests	• Maintaining the confidence in and support for the Plan by key stakeholders in a time of fiscal challenges and competing priorities will help ensure adequate funding is available over the long term, thereby producing a stable financial environment to support the mission of the Plan • Maintaining stable funding helps prevent against benefit erosion and allows the Plan to offer and evaluate the cost-effectiveness of alternative benefit designs, incentives and pilot programs as well as invest in programs and initiatives to improve the member experience and access to quality care

North Carolina State Health Plan
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STRATEGIC MEASURES OF SUCCESS

Priority	Description	Metric	Rationale	Timeframe/Baseline
Improve Members' Health	PCMH utilization	Increase % of members receiving care from a NCQA recognized PCMH	PCMH practices provide an opportunity to improve care and care coordination for members	Annual comparison to year-end 2013
	Quality of care measure	Increase % of members with targeted high prevalence conditions receiving care according to national clinical standards	Monitoring delivery of clinical quality of care standards ensures Plan members are receiving quality health care	Annual comparison to year-end 2013
	Worksite wellness	Increase number of worksites offering worksite wellness initiatives	The number of worksites offering onsite wellness initiatives are a proxy for measuring a culture of wellness across State agencies	Annual comparison to year-end 2013
Improve Members' Experience	Customer satisfaction	Maintain or improve overall customer satisfaction score	Overall customer satisfaction is a proxy to monitor the overall Plan's effectiveness	Annual comparison to year-end 2012
	Annual Enrollment service level agreements (SLA)	Improve Annual Enrollment customer service SLAs	Enrollment is the gateway to the provision of benefits and an opportunity to instill trust in the member	Annual comparison to year-end 2013 (from October 2013 enrollment period)
	Member engagement	• Increase in the number of active members registered as users on TPA's website • Increase in the usage of TPA's provider search and transparency tools by active members • Increase in attendance at educational roadshows	Measuring members engaged in communication and health literacy efforts is a proxy for measuring the Plan's effectiveness at targeted member outreach	Annual comparison to year-end 2013
Ensure a Financially Stable State Health Plan	Net income/loss	Net income/loss actual at or above certified or authorized budget (as forecasted by actuaries) for plan year	Provides a comprehensive measure of Plan finances	Annual comparison
	PMPM claims expenditures	PMPM claims expense at or below certified or authorized budget (as forecasted by actuaries) for plan year	Claims expense is the main variable driving financial performance	Annual comparison
	Member cost-sharing	% of total claims cost paid by members through copays, deductibles and coinsurance at or below benchmark	Member cost-sharing is an important component in member affordability	Annual comparison to year-end benchmark

Note: All years are based on the calendar year ending in December, unless specifically noted as fiscal year (FY). Measures will be reported as part of the Plan scorecard and updates will be provided according to the financial reporting schedule.

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VENDOR CONTRACT DEPENDENCIES

The following chart outlines the anticipated effective dates of new contracts as well as the optional renewal and termination dates for existing contracts that are important to the strategic plan. The timing of contract terminations and the length of time required to procure new vendors may impact the strategic initiatives as well as the sequence and timing of the initiatives. The estimated length of time to change vendors or make significant changes to existing contracts can take between 18 and 24 months including development, procurement and implementation. The Board is required to approve all contracts with a value of $500,000 or more.

Vendor dependencies and contract requirements will be continuously assessed as the details of the deliverables of specific projects and programs are developed. Depending on the final detailed design of each initiative as well as other contracting or vendor selection or negotiation issues, the vendor contract reference chart and the timelines associated with each initiative outlined in the roadmap on the following pages could be modified. In addition, the chart below only reflects active contracts. Additional vendor contracts may be required in order to implement the initiatives, and Board approvals will be acquired as needed.

Vendor Contract Reference Chart

Category / Contractor	2014		2015		2016		2017		2018	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
TPA / BCBSNC						△ 12/31/16		△ 12/31/17		▲ 12/31/18
TPA / MedCost LLC		▲ 10/1/14								
MA / Humana						△ 12/31/16		△ 12/31/17		▲ 12/31/18
MA / UnitedHealthcare						△ 12/31/16		△ 12/31/17		▲ 12/31/18
PBM / Express Scripts				△ 12/31/15		▲ 12/31/16				
PHMS / ActiveHealth Management		△ 12/31/14		▲ 12/31/15						
COBRA & Billing / COBRAGuard						△ 12/31/16		△ 12/31/17		▲ 12/31/18
EES / Benefitfocus				Termination Expected by 12/31/15		△ 12/31/16		△ 12/31/17		▲ 12/31/18
EES / Aon-Hewitt		▲ 8/31/14								

▲ New Contract △ Option to Renew Contract ▲ Contract Terminates

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STRATEGIC ROADMAP

July 2014 – December 2018

Background and Definitions

The charts on the following pages outline the high level roadmap for each of the strategic initiatives included in the strategic plan. Each chart includes a brief description of the project or program, any associated contract decisions and/or benefit approvals, an estimated launch date, and an indication of the magnitude of impact relative to the membership. Although not necessarily described in the charts, each of the projects or programs include planning (discovery interviews, market research, synthesis, and gaining consensus), building (developing detailed designs, acquiring necessary approvals, contracts, staff, and training), and implementation (communication, launch, and ongoing monitoring and management). Details on specific programs or benefit designs will be communicated as proposals are developed. The purpose is to organize the major work streams and key milestones, particularly those that will require Board approval. The Plan leadership team will provide updates to the Board proactively on progress as appropriate and as needed.

In addition, the estimated milestones take into consideration the dependencies on vendor contracts based on what is known at the time of planning. The dates on the charts that follow are **not intended to communicate actual contract dates or otherwise indicate that Board approval will be required for every contract decision.** As a planning document, the charts are intended to indicate the possibility of vendor contracts or Board action and final decisions and actions will depend on the details of each initiative.

The following reference table outlines the elements of the work and timelines included in the charts:

Term or Key Indicator	Definition
Projects & Programs	Short description of the major work efforts that will be delivered in support of the initiative
	Possible Board benefit approval point. The need for any approvals will depend on the final detailed design of any new project or program.
	Possible contract decision point – reflects the anticipated point in time when a decision regarding contract extensions or amendments or Board approval of a new contract is required. Contract decisions may or may not require Board action. The need for any approvals will depend on whether it is a new contract with a value of $500,000 or more.
	Indicates the estimated launch date for small or moderately sized projects or programs. For example, pilots, regional programs or projects impacting a relatively small number of Plan members.
	Indicates the estimated launch date for large, statewide projects or programs. For example new products or a disease management program available statewide that impacts a large number of members.

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Strategic Priority: Improve Members' Health

	Projects & Programs	Jul – Dec 2014	2015	2016	2017	2018
PCMH	**PCMH Pilot:** PCMH pilots established with at least 4 health care systems or provider groups. The goal of the pilot is to identify a statewide standard for the PCMH model, to inform the next iteration of the Plan's contract with its population health management vendor and to assess the readiness of these health care systems for alternative payment methods.	◆				
	PCMH Model: Implementation of the PCMH model statewide. This will take place through the contract with the population health management vendor.	Contract Decision- PHMS		◆		
High Prevalence Conditions	**High Prevalence High Cost Care Management:** Develop and implement a high utilizer care management/coordination plan for members with a diagnosis of diabetes, asthma/COPD, hypertension or CAD in partnership with the Plan's population health management vendor. The intent of the initiative is to promote the delivery of appropriate and timely care within appropriate settings.	◆		◆		
	Chronic Pain Pilot: Implement a new program designed to identify and address prescription abuse, improve the safety of members who are taking narcotics and identify care management options.			◆		
	Transition of Care Program: Target high priority members who are transitioning out of the hospital for care management to assist in reconciling prescriptions post discharge (Medication Therapy Management – MTM), coordinating follow-up appointments as necessary and to providing education and information on conditions. This will be accomplished through the contract with the population health management vendor.	Contract Decision - ADT feeds	◆			
Value-Based Benefits	**Value Based Benefit Design:** Implement the next generation of wellness activities, premium credits, and incentives to increase member engagement and accountability, improve medication adherence, reduce waste and encourage the use of quality providers.			◆		◆
Worksite Wellness	**Wellness Champions Pilot:** Develop a network of wellness champions within worksites to lead employees in worksite wellness initiatives. The Plan will provide incentives that reward those worksites with high levels of participation as well as support worksite with resources like speakers and toolkits.		◆			
	Multipronged Three County Pilot: A three pronged, two year pilot in Greene, Jones and Lenoir counties aimed at addressing the high prevalence, high cost chronic conditions of diabetes, asthma, COPD, hypertension, CAD, and stroke. The Plan and its vendors would help develop capacity to implement wellness initiatives within worksites in three counties, develop provider engagement with Plan membership and empower members in seeking appropriate health care and leveraging community resources.		◆			

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Strategic Priority: Improve Members' Experience

	Projects & Programs	Jul – Dec 2014	2015	2016	2017	2018
Communication & Marketing	**Coordinated Communication Campaign:** Implement a communication approach for Retiree Health Benefits that is coordinated with the Retirement System and the Department of State Treasurer.		◆			
	Medicare Primary Communication: Enhance current Medicare Primary learning module and develop additional outreach strategies.		◆	◆	◆	
	Active and Non-Medicare Primary Communication: Develop learning module for Active and non-Medicare Primary members to enhance their health literacy and understanding of Plan Benefits.		◆	◆	◆	
Enrollment Experience	**New Eligibility and Enrollment vendor:** Transition all eligibility and enrollment services to a new vendor no later than July 1, 2015. In order to launch the new services all testing must be completed by March 31, 2015, and the communication plan with members, vendors and other stakeholders completed by December 31, 2014.	▼ Contract Decision	◆			
	Annual Enrollment and Benefit Design Communication: Implement a comprehensive communication and marketing campaign each year regarding Annual Enrollment and benefit designs. Focus campaigns to emphasize the healthy activities required to earn premium wellness credits and value-based designs.		◆	◆	◆	◆
Health Literacy	**BlueConnect Launch:** BCBSNC is implementing a new member web portal in January 2015. Partner with BCBSNC to develop a communication strategy to increase engagement and utilization with the new functionality.	◆				
	Transparency & Literacy Tools Program: Implement programs that promote and incentivize members to utilize web-based transparency tools for identifying high quality, cost effective providers; calculate their best plan options based on expected utilization; and identify resources to assist with chronic conditions.			◆		
	Incentive Rewards Program: Implement a program that rewards members for healthy lifestyles, use of preventive benefits, and benefit engagement. An example of a potential reward is a Fitbit® for participating in a walking program or engaging with a health coach.				◆	

North Carolina State Health Plan
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Strategic Priority: Ensure a Financially Stable State Health Plan

	Projects & Programs	Jul – Dec 2014	2015	2016	2017	2018
Acute Care and Specialists	**Avoidable Admissions and Emergency Department Visits:** Implement a telehealth option to provide a less costly alternative to an ED visit but that also provides the member with direct and immediate access to a physician.					
	Place of Service: Incent members through benefit design to utilize the appropriate provider in the most cost effective setting for health care services. For example, incent members to choose a location without an associated facility fee.					
Pharmacy	**Specialty Pharmacy Management:** Implement programs that encourage the cost effective use of specialty pharmacy drugs including member and provider incentives regarding drug infusion site of care, equity in member cost share across pharmacy and medical benefits, and utilization management.					
	Enhanced Fraud Waste & Abuse Program: Replace the high utilization program, which restricts a member to one pharmacy due to the high utilization of targeted drugs (controlled substances and muscle relaxants) with a comprehensive Enhanced Fraud, Waste and Abuse Program. The Enhanced Program includes a review of both medical and pharmacy claims to accurately identify members who meet the robust criteria for restriction to one pharmacy and up to two prescribers for controlled substances and other drugs of abuse. The goal is to decrease fraud, waste and abuse (which includes improper use) of controlled substances and other drugs of abuse.					
Alternative Payment Models	**Alternative Payment Models:** Implement alternative payment models with 2 to 3 accountable care organizations (ACOs) and then expand.					
Adequate, Stable Funding	**Communication with State Government Leadership:** Provide the Governor, General Assembly and other key stakeholders with regular updates and targeted communications on the Plan's strategic plan and financial results as well as policy and programmatic priorities through contact with the Office of the Governor, committees and individual members of the General Assembly, leadership staff, OSBM, FRD and state agencies.					
	Legislative Agenda: Develop and communicate funding requirements and requests for statutory changes for the long and short sessions to address the Plan's administrative, financial and policy needs and provide information, actuarial notes, and educational sessions as needed and requested.					

LIST OF ACRONYMS

ACO	Accountable Care Organization
ADT	Admissions, Discharge and Transfer
BCBSNC	Blue Cross Blue Shield of North Carolina
CAD	Coronary Artery Disease
CDHP	Consumer-Directed Health Plan
COPD	Chronic Obstructive Pulmonary Disease
ED	Emergency Department
EES	Eligibility and Enrollment Services
FRD	Fiscal Research Division
HEDIS	Healthcare Effectiveness Data and Information Set
MA	Medicare Advantage
MTM	Medication Therapy Management
NCQA	National Committee on Quality Assurance
OSBM	Office of State Budget and Management
PBM	Pharmacy Benefit Manager
PCHM	Patient Centered Medical Home
PCP	Primary Care Provider
PHMS	Population Health Management Services
SLA	Service Level Agreement
TPA	Third Party Administrator

STATE HEALTH PLAN STRATEGIC PLAN
EXECUTIVE SUMMARY STATUS REPORT
For the time period of July 2015 - September 2015

Purpose:

The purpose of this report is to provide an ***executive level*** summary of the overall progress of the State Health Plan's (Plan's) Strategic Plan. This is intended to be a ***discussion document*** used to provide updates to the North Carolina State Treasurer, Plan Board of Trustees and Plan Executive Administrator.

Frequency:

This report will be prepared on a quarterly basis for the Plan Leadership team and at least three (3) times per year for the North Carolina State Treasurer and Plan Board of Trustees.

Time period:

The critical updates will reflect the changes over the time period since the most recent update was provided.

Key:

The overall status of an initiative is based on a review of measured outcomes or overall progress against key milestones as defined by the Plan leadership team.

Indicator	Description
	On track or making good progress against measures. No major challenges or risks.
	Challenges or risks exist but progress is being made.
	Major challenges or risks exist and there are concerns on the ability to achieve desired outcomes.
	Deferred or not yet started.

STRATEGIC PRIORITY: IMPROVE MEMBERS' HEALTH

Projects & Programs - Key Milestones				
2014	**2015**	**2016**	**2017**	**2018**
√ High Prevalence Care Management (Release 1.0)	☐ PCMH Pilot ☐ Transitions of Care ☐ Wellness Champions ☐ Wellness Wins	☐ High Prevalence Care Management (Release 2,0) ☐ Chronic Pain ☐ Value-Based Design (Release1.0)	☐ PCMH – Statewide Model	☐ Value-Based Design (Release 2.0)

Initiatives	Status	Status Summary	Key Accomplishments	Key Challenges/Risks	Major Next Steps
Maximize Patient Centered Medical Home (PCMH) Effectiveness		▪ The Plan is beginning preparations for year 2 of the initiative.	▪ Quarterly practice meetings were completed with 3 of the 4 practices. All practices demonstrate significant improvements in the quality metrics. ▪ Practices can partner with the Plan and other Statewide Partners on the Tobacco Affinity Group and the Choose Wisely Campaign.	▪ Care coordination work flows remain time intensive for AHM. ▪ AHM's involvement in the PCMH pilot has become more than envisioned in the pilot model.	▪ Planning a joint "Best Practice" meeting for the participants to share lessons learned to improve quality and efficiency. ▪ Design Y2 of the pilot and implement changes for metric options and definitions. ▪ Assist practices with preparation with assessments ▪ Reassess practice level care coordination work flows.
Assist Members to Effectively Manage High Cost High Prevalence Chronic Conditions		▪ High Utilizer (HU) Program is being redesigned for higher engagement and impact. ▪ TOC is limited by the quality of ADT data currently being received.	▪ Alternate approaches are being tested for enhancing engagement with high utilizers.	▪ Inability of the current AHM approach to reach and engage members into the HU program. ▪ Lack of current and correct contact information on members. ▪ Data translation challenges.	▪ Resolve data issues with ADT feed so TOC program can make more traction. ▪ Implement alternate strategies to further engage more high utilizers into CM.

Initiatives	Status	Status Summary	Key Accomplishments	Key Challenges/Risks	Major Next Steps
Offer Health-Promoting and Value-Based Benefit Designs		▪ CY 2016 Health Engagement Program (HEP) finalized for CDHP members.	▪ HEP and Incentives defined. ▪ Business requirements signed off prior to decision to include Rival Health as an option. ▪ AHM defined as vendor to implement program. ▪ BOT approval received. ▪ RTC approval received.	▪ Vendor capabilities. ▪ Timely communications for members with chronic conditions dependent of BF's ability to produce enrollment file in a timely manner after open enrollment. ▪ Communication on two programs for all members.	▪ Define business requirements. ▪ Coordination of data around incentives. ▪ Communication timing and plan. ▪ Finalize contracting requirements. ▪ Launch of program for members with chronic conditions in January 2016. ▪ Launch of all members program April 1, 2016.
Promote Worksite Wellness		**Wellness Champions:** Currently 150 Wellness Champions are registered. **Wellness Wins:** Successfully recruited 2 state agencies and 4 schools. CRN and Resource Inventory to address CDC Score Card topics in developmental stage with UNC and CCCPH.	**Wellness Champions** ▪ 52 Wellness Champions completed a second Quarterly Questionnaire. ▪ The program currently has the ability to reach approximately 12,591 members and engaged 3,337 members this past quarter. ▪ Wellness Champions now receive monthly newsletters on health topics. **Wellness Wins:** ▪ 62% of CDC Score Card topics have been addressed in the Resource Inventory being developed by UNC and CCCPH. ▪ Fully executed contract with Prevention Partners.	**Wellness Champions:** ▪ Staff and technical resources. ▪ Ability to provide the tools and resources to maintain engagement. ▪ Procurement and distribution of quarterly awards and incentives. **Wellness Wins:** ▪ Lack of participation of schools at the end of the school year (June-August). ▪ Vacant key positions at DPH and Prevention Partners.	**Wellness Champions:** ▪ Refining the program to streamline the procurement and distribution process for incentives. ▪ Create an evolving incentive design. ▪ Host meetings to facilitate collaboration, sharing of ideas, etc. **Wellness Wins:** ▪ Approve contracts with CCNC. ▪ Recruit additional agencies to participate. ▪ Finalize contracts. ▪ Worksite Wellness training. ▪ Annual Enrollment presentations for agencies and schools (Nov.). ▪ WorkHealthy America assessment completions by state agencies.

STRATEGIC PRIORITY: IMPROVE MEMBERS' EXPERIENCE

Projects & Programs - Key Milestones				
2014	**2015**	**2016**	**2017**	**2018**
√ New Enrollment Vendor √ Blue Connect √ Medicare Primary √ Active and Non-Medicare √ Annual Enrollment	☐ Coordinated Communication Campaign ☐ Medicare Primary ☐ Active and Non-Medicare ☐ Annual Enrollment	☐ Transparency and Literacy ☐ Medicare Primary ☐ Active and Non-Medicare ☐ Annual Enrollment	☐ Incentive Rewards Program ☐ Medicare Primary ☐ Active and Non-Medicare ☐ Annual Enrollment	☐ Medicare Primary ☐ Active and Non-Medicare ☐ Annual Enrollment

Initiatives	Status	Status Summary	Key Accomplishments	Key Challenges/Risks	Major Next Steps
Create Comprehensive Communication & Marketing Plan		▪ 2016 Annual Enrollment (AE) Communication Plan had to be reworked because of required re-implementation of the EES contract.	▪ Kick-off meeting held with Buck Consultants, the Plan's new marketing and communications vendor. ▪ Tele-Town Hall Meetings and Medicare Primary Annual Enrollment Meetings scheduled and communicated.	▪ Global Comm Director Position remains vacant. ▪ Had to modify communication strategy due to transition.	▪ Final tele-town hall meetings held. ▪ Execute Annual Enrollment Communication Plan. ▪ Development and implementation of a project strategy with Buck Consultants.
Improve the Member Enrollment Experience		▪ The June 1 transition of the EES contract has negatively impacted new member enrollment and existing members' changes.	▪ Decision made to re-implement Benefitfocus contract. ▪ Completed Member Satisfaction Survey. Overall service satisfaction increased from 59% to 61%	▪ Call service levels and the overall member experience were negatively impacted by the EES contract issues.	▪ 100% focused on re-implementing a new EES contract and restoring confidence and service levels.
Promote Health Literacy		▪ Developed and Implemented Health Benefit Calculator completed	▪ Hired new Product Manager to focus on health literacy. ▪ Took the first step in CDHP literacy by developing CDHP videos and mailers that highlighted CDHP Myths and Facts. ▪ Completed development, testing and implementation of HB Calculator.	▪ SHP 101 educational series postponed until EES contract fully implemented. ▪ Little progress made on health literacy due to AE challenges and focus.	▪ Refocus efforts on health literacy after AE.

STRATEGIC PRIORITY: ENSURE A FINANCIALLY STABLE STATE HEALTH PLAN

Projects & Programs - Key Milestones				
2014	**2015**	**2016**	**2017**	**2018**
√ Fraud, Waste, Overuse & Abuse √ Alternative Payment Models √ State Leadership √ Legislative Agenda	☐ Avoidable Admissions & Emergency Services ☐ Place of Service ☐ Specialty Pharmacy ☐ State Leadership ☐ Legislative Agenda	☐ Alternative Payment Models ☐ State Leadership ☐ Legislative Agenda	☐ State Leadership ☐ Legislative Agenda	☐ State Leadership ☐ Legislative Agenda

Initiatives	Status	Overall Status	Key Accomplishments	Key Challenges/Risks	Major Next Steps
Target Acute Care and Specialist Medical Expense		▪ Inconsistent results on current program from Segal and BCBSNC.	▪ Met with BCBSNC to review outcomes. ▪ Identifying regional opportunities.	▪ Many members not utilizing incentive. ▪ Impacting member choices going forward.	▪ Communicate CY 2016-17 benefits when final. ▪ Understand member concerns on narrow networks.
Target Pharmacy Expense		▪ PBM RFP completed and ready to post.	▪ New pharmacy director on boarded. ▪ Pharmacy RFP ready to post. ▪ Mail order pilot implemented.	▪ Transition in clinical pharmacy positions. ▪ Rising drug trends overall particularly with specialty drugs PBM and TPA.	▪ Mail Order Pilot results. ▪ Implement opportunities on specialty Rx. ▪ Selection of a Pharmacy Vendor for 1/1/2017.
Pursue Alternative Payment Models		▪ Process in review.	▪ Meeting with potential partners and discussing with vendors. ▪ PCMH Pilots improving quality of care. ▪ BCBSNC moving toward alternative contracting with ACO groups.	▪ Availability throughout the State. ▪ Quantifying savings in short and long-term.	▪ Identify actionable opportunities.
Ensure Adequate, Stable Funding from the State of North Carolina		▪ House and Senate require significant cuts.	▪ Second long session of NCGA funding Plan at higher than necessary increase. ▪ Final budget requires the Plan to hold substantial reserves. ▪ Final budget authorizes CY17 premium increase contingent upon sufficient reductions for FY17-19. ▪ Cash balance remains high.	▪ Increases costs to members in near term. ▪ Cost trend seems to be rising in recent months.	▪ Define sufficient. ▪ Determine future strategy. ▪ Modify benefit design as necessary. ▪ Approve CY 2017 rates.

VENDOR CONTRACT DEPENDENCIES

The following chart outlines the anticipated effective dates of new contracts as well as the optional renewal and termination dates for existing contracts that are important to the strategic plan. The Board is required to approve all contracts with a value of $500,000 or more. Vendor dependencies and contract requirements will be continuously assessed as the details of the deliverables of specific projects and programs are developed. The chart below only reflects active contracts. Additional vendor contracts may be required in order to implement the initiatives, and Board approvals will be acquired as needed.

Vendor Contract Reference Chart

Category / Contractor	2014		2015		2016		2017		2018		2019	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
TPA / BCBSNC						12/31/16		12/31/17		12/31/18		
TPA / MedCost LLC		10/1/14		12/31/15		12/31/16		12/31/17				
MAPDP / Humana						12/31/16		12/31/17		12/31/18		
MAPDP / UnitedHealthcare						12/31/16		12/31/17		12/31/18		
PBM / Express Scripts				RFP extended 12/31/15		12/31/16		12/31/17				
PHMS / ActiveHealth Management		12/31/14		Extended 12/31/15		12/31/16						
COBRA & Billing / COBRAGuard						12/31/16		12/31/17		12/31/18		
EES / Benefitfocus			Terminated contract 6/30/15	New contract 9/15/15						12/31/18		12/31/19

New Contract Option to Renew Contract Contract Expires

LIST OF ACRONYMS

Acronym	Name	Explanation
ACO	Accountable Care Organization	Provider-led entity focused on delivering coordinated care
AHM	Active Health Management (vendor)	State Health Plan Population Health Management Vendor
BCBSNC	Blue Cross Blue Shield of North Carolina	State Health Plan Population Third Party Administrator
BO	Blue Options	Program through BCBSNC where hospitals and specialists are tiered based on quality and cost
CDHP	Consumer Driven Health Plan	Benefit option that features deductibles and coinsurance versus copay driven benefit. Can be paired with additional dollars to offset member cost sharing
COBRA	Consolidated Omnibus Budget Reconciliation Act	Provides coverage for members following their leaving of the eligibility, member pays at least 100% of premium
CRN	Collaborative Referral Network	Provider arrangement that focuses coordinating member care through referrals to manage cost
CY	Calendar Year	January through December of a given year
DPH CCCPH	Division of Public Health, Community and Clinical Connections for Prevention and Health Branch	A branch of the Chronic Disease and Injury Section in the North Carolina Division of Public Health
EMR	Electronic Medical Record	Provides non-claims based medical data on members such as test results
FRD	Fiscal Research Division	Division of the General Assembly staff that prepares fiscal notes and financial information on the Plan to legislators
HBR	Health Benefit Representative	State employee that provides their agency or division information on the Plan
HEP	Health Engagement Program	Programs that incentivizes member engagement in high value medical care and healthy lifestyle choices
LOA	Letters of Agreement	Agreement between the Plan and a vendor to provide services
MA	Medicare Advantage	Benefit option for Medicare beneficiaries
NCGA	North Carolina General Assembly	The State Legislature
OSBM	Office of State Budget and Management	State Office that manages State Budget and drafts the Governor's Budget
OSHR	Office of State Human Resources	State Office that manages employee issues, staffing, and NC Flex
PBM	Pharmacy Benefits Manager	TPA that SHP uses for Rx discounts and pharmacy network
PCMH	Patient Centered Medical Home	A model for organizing primary care to emphasize care coordination, communication and patient centeredness in the delivery of care.
PCP	Primary Care Provider	Provider who serves as the entry point to members and coordinates care when necessary
PMPM	Per Member Per Month	Used to abbreviated costs/expenditures for members
RFP	Request for Proposal	A solicitation used to acquire bids for State Health Plan services
SHP	State Health Plan of North Carolina	Division of the Department of State Treasurer, also referred to as the Plan
SRD	State Retirement Division	Division of the Department of State Treasurer
TOC	Transitions of Care	Coordination of care as individuals' transition to and from one care setting to another.
TPA	Third Party Administrator	Entity tasked with providing the Plan with provider discounts and network access
UM	Utilization Management	Program decided to assist members receive care in the most appropriate setting

The Advisory Board Company

Health Plan Advisory Council

The Data Diet

Sharing Data with Providers to Enable Population Management

Road Map

1 The Data Diet

2 How to Sell Data to Providers

3 Questions

A Growing National Priority

Health Care Spending Billions to Take Advantage of Data

Data Investments from 2011-2016

Capture Data

$4B Wearables

$6B Electronic medical record systems

$21B Remote patient monitoring

Analyze Data

$3M IBM's Watson supercomputer

$35B Health information technology

Share Data

$1B Health information exchange platforms

$31B Meaningful use / interoperability

$101B Total estimated data spending

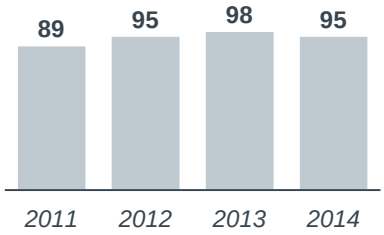
Source: Lieberman M, "The Wearable Future," PriceaterhouseCoopers LLP, available at: www.pwc.com; Wang T and Malay Gandhi, "Digital Health Funding: 2014 Year in Review," Rock Health, 2015, available at: www.rockhealth.com; "EMR/HER Spending to Hit $6 Billion by 2015," University of Illinois at Chicago, available at: www.healthinformatics.uic.edu; Lewis N, "Remote Patient Monitoring Market to Double by 2016," InformationWeek, July 24, 2012, available at: www.informationweek.com; Manos D, "Study: Health IT spending to top $34.5B," Healthcare IT News, August 29, 2013, available at: www.healthcareitnews.com; Mearian L, "Can anyone afford an IBM Watson supercomputer? (Yes)," Computerworld, Inc., February 21, 2011, available at: www.computerworld.com; "July 2015 Summary Report," Centers for Medicare and Medicaid Services, July 2015, available at: www.cms.gov; Covich J et al., "Determining the Path to HIE Sustainability," Truven Health, February 2011, available at: www.truvenhealth.com; Health Plan Advisory Council interviews and analysis.

Providers Closing Ranks

Larger Systems Taking on More Risk Each Year

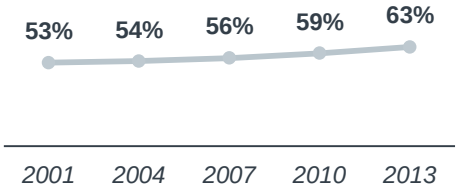
Hospital Mergers and Acquisitions

2011-2014



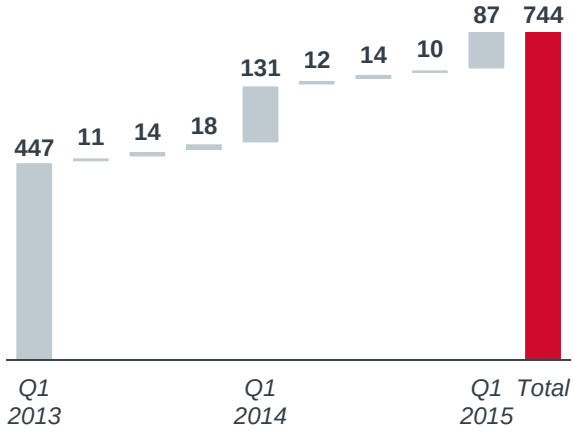
Share of Hospitals in a System

2001-2013



Total Number of New Public and Private ACOs by Quarter

Q1 2013 – Q1 2015

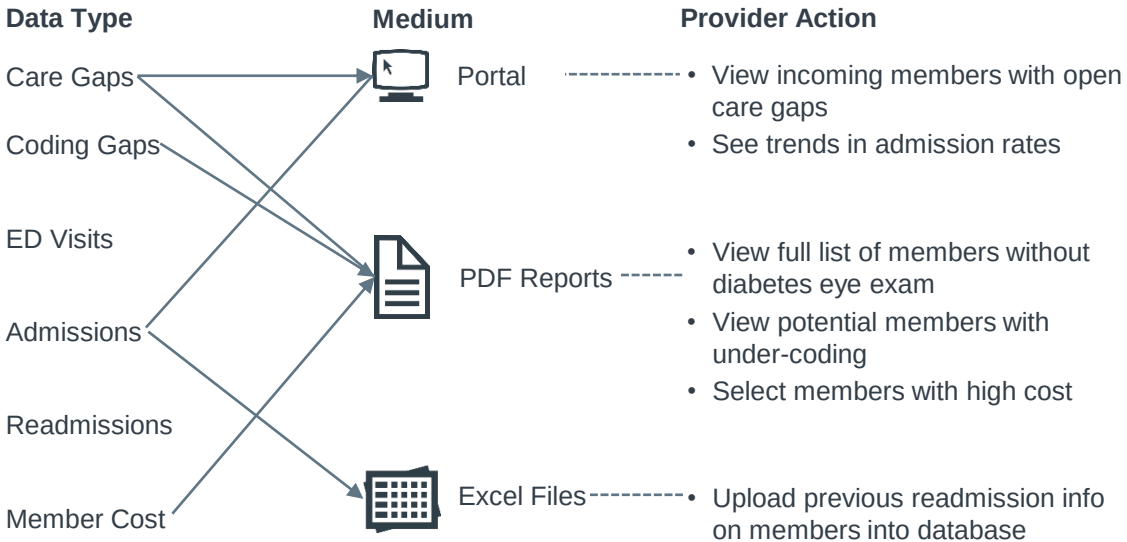


Source: AHA Chartbook, available at www.aha.org; Kaufman Hall, "Number of Hospital Transactions Remains High in 2014," available at: www.kaufmanhall.com; Muhlestein, D, "Growth and Dispersion Of Accountable Care Organizations In 2015," Health Affairs, March 31, 2015, available at http://www.healthaffairs.org; Health Plan Advisory Council interviews and analysis.

A Data Smorgasbord

Incalculable Combinations of Format and Content Available to Providers

Plan Data Shared with Providers



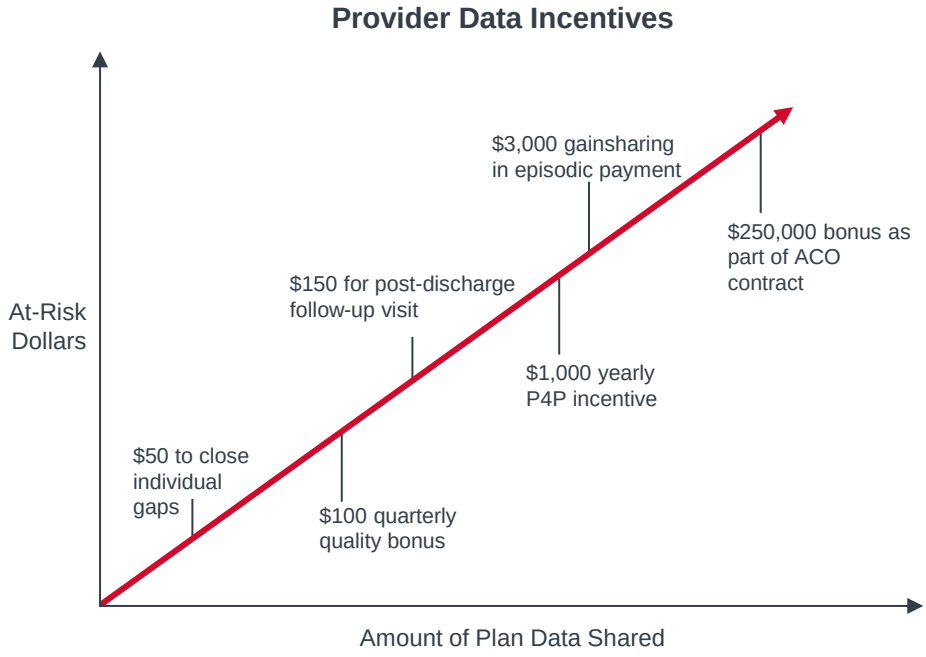
50-60% Growth in FTEs for plan analytics departments

1) ADT: Admission, Discharge, Transfer

Source: Health Plan Advisory Council interviews and analysis.

Throwing Money at Providers

Incentives Abound for Data

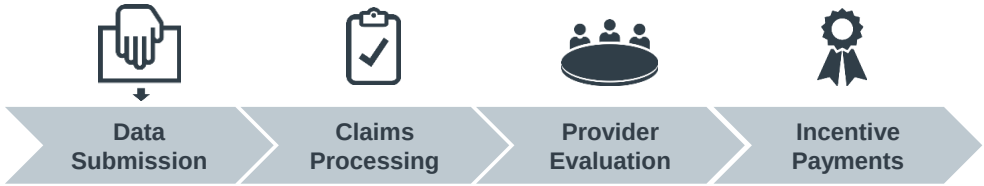


Source: Health Plan Advisory Council interviews and analysis.

Aching for a Better Solution

Plans Challenged by Inability to Effectively Motivate Providers

Plan View of Data Sharing



Frustration Points:	Data Submission	Claims Processing	Provider Evaluation	Incentive Payments
	• Not able to embed in provider EMR • Send unhelpful information to providers	• Not clear which gaps closed • Insufficient coding and clinical information	• Few providers measurably improving • Providers uninterested in discussing performance	• Incentives not correlated to improved plan performance • Lower star ratings due to inactivity

Source: Health Plan Advisory Council interviews and analysis.

Not Alone In Our Frustration

Providers Unable to Use Plan Data in Current Environment

Providers Agreeing That Care Gap Data Is[1]…

Not Worth Time

63%

"Our biggest challenge is **data overload**."

Senior Director of Quality, academic medical center

Unreliable

67%

"If physicians find data reports to be **inaccurate** or incomplete, they are less likely to review them the next time."

Family medicine physician, physician association

Untimely

79%

"Providers are always playing catch-up because of the **untimeliness** of data."

Family medicine physician, academic medical center

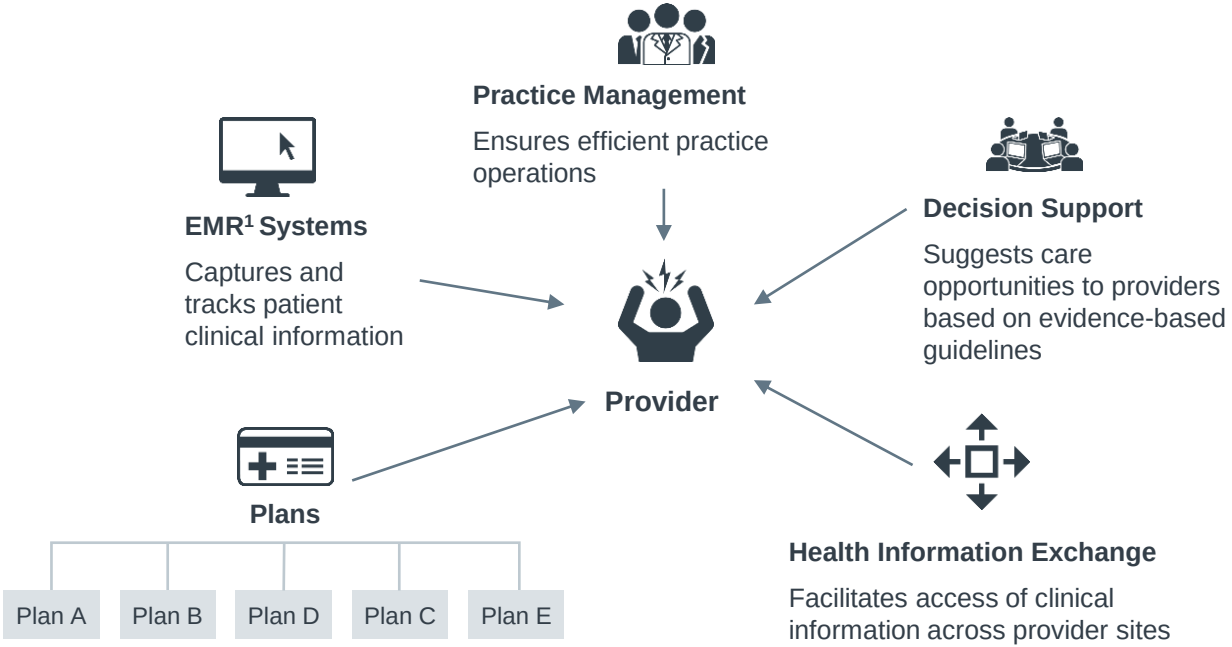
1) Based on Health Plan Advisory Council 2015 Plan-Provider Data Survey (n=63).

Source: Health Plan Advisory Council interviews and analysis.

When Everything is Important

Providers Receive Near-Daily Changes to Patient Picture

Provider Data Sources

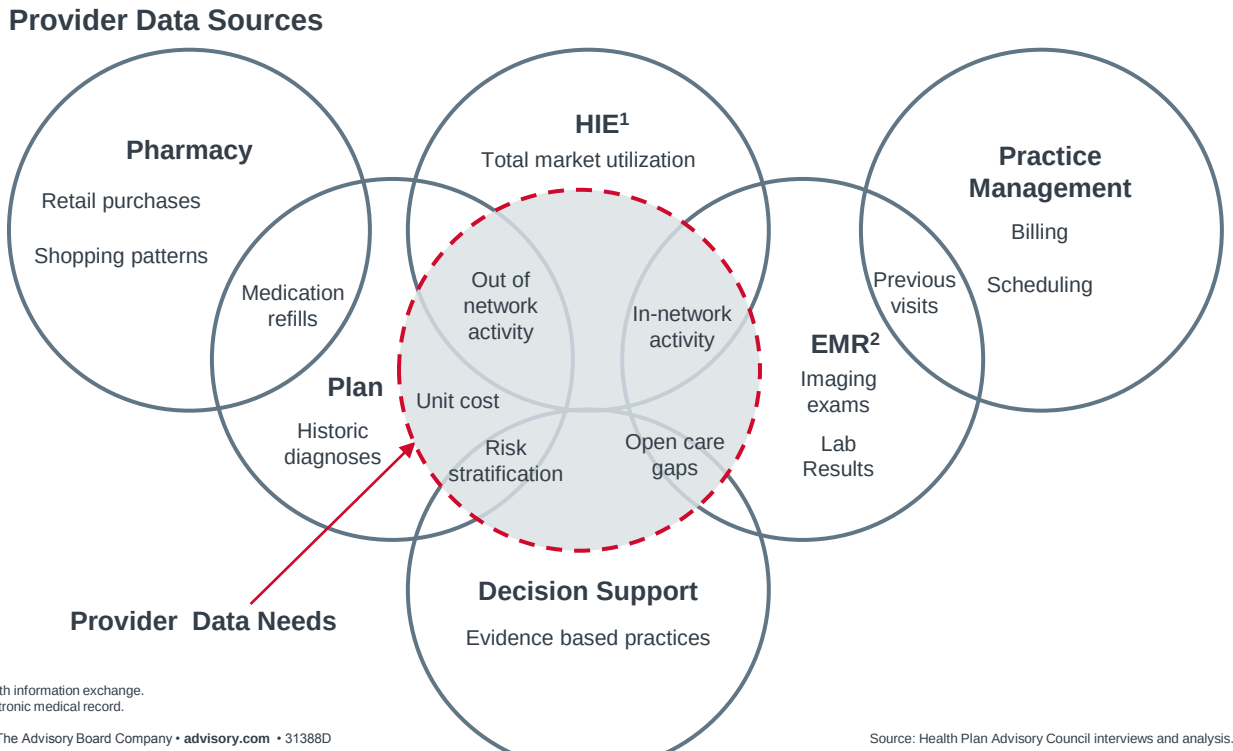


1) Electronic medical record.

Source: Health Plan Advisory Council interviews and analysis.

Lacking a Single Source of Truth

Duplicative Sources Occasionally Contradictory, Often Unnecessary



1) Health information exchange.
2) Electronic medical record.

Source: Health Plan Advisory Council interviews and analysis.

Selling Your Value

How Plans Need to Convince Providers to "Use Their Color"

Provider Data Strategy

Focused Reports

Make products intuitive and similar to others that they might use

Ingratiated Teaching

Demonstrate to providers how they can use this product to transform their practices

Effortless Interaction

Create a seamless process to make it easy to use the product

Reciprocal Benefits

Show how using the product will benefit providers' strategic priorities

Increased Data Demand

Providers requesting and using data to drive quality improvement initiatives

Source: Health Plan Advisory Council interviews and analysis.

How to Sell Data to Providers

1

Focused Reports

1. Reporting Consistency
2. Missed Earnings

2

Ingratiated Teaching

3. Personality Tests
4. Matched Resources
5. Leader Engagement
6. Autonomous Improvement

3

Effortless Interaction

7. Forced Prioritization
8. Meeting Management
9. Provider Pods
10. Financially-Aligned Plans

4

Reciprocal Benefits

11. Provider-Financed Consulting
12. Start-up Financing
13. Bonus Investing
14. Awards Incentive
15. Referral Management

Road Map

1 The Data Diet

2 How to Sell Data to Providers

3 Questions

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An Undue Burden

Report Diversity Slows Down Practice

Data Report Attributes

AESTHETICS

Organization

Length

Graphics

DATA

Content

Granularity

Customization

Time Period

Patient Panel

Time Drain

"It takes so much time on my part to learn how to read each health plan's data reports. It's a significant inconvenience."

Director, Quality Improvement and Care Management at Presto Health[1]

15

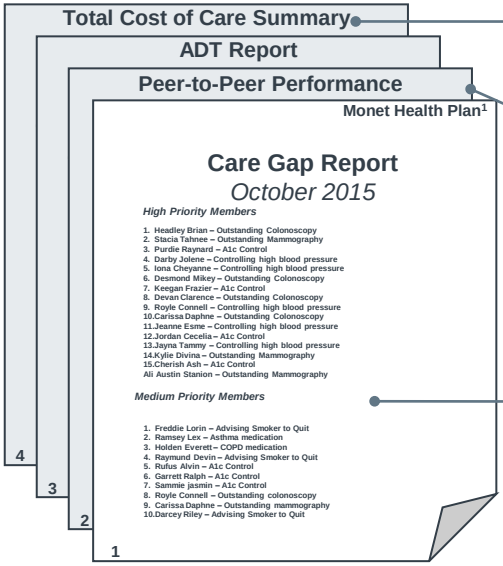
Average number of health plans that providers typically work with simultaneously

1) Pseudonym.

Source: Health Plan Advisory Council interviews and analysis.

Principles of Good Design

Ideal Data Report



Customized analytics based on provider priorities and interests

Quickly displays **relative performance** to highlight areas of improvement

Risk stratification provides insight into additional services and resources member might need

1) Pseudonym

Source: Health Plan Advisory Council interviews and analysis.

Collective Input

TennCare Gains Buy-in By Gathering Opinion

Case in Brief: TennCare

- Tennessee's Medicaid program that serves 1.3M members
- Requires MCO[1] participants in the Tennessee Health Care Innovation Initiative to adopt their data report template

TennCare Valued Feedback

160 Number of stakeholder roundtable meetings TennCare held over 14 months with 180 different groups.

Stakeholder Roundtable Participants

February 2013-April 2014

1) Managed care organization.
2) Pharmacy benefit managers.

Source: "Provider Stakeholder Group Meeting Presentation," State of Tennessee Health Care Innovation Initiative, August 13, 2014, available at: https://www.tn.gov/assets/entities/hcfa/attachments/AugProviderMeeting14.pdf; Health Plan Advisory Council interviews and analysis.

State-Mandated Consistency

TennCare Dictates Program and Report Terms

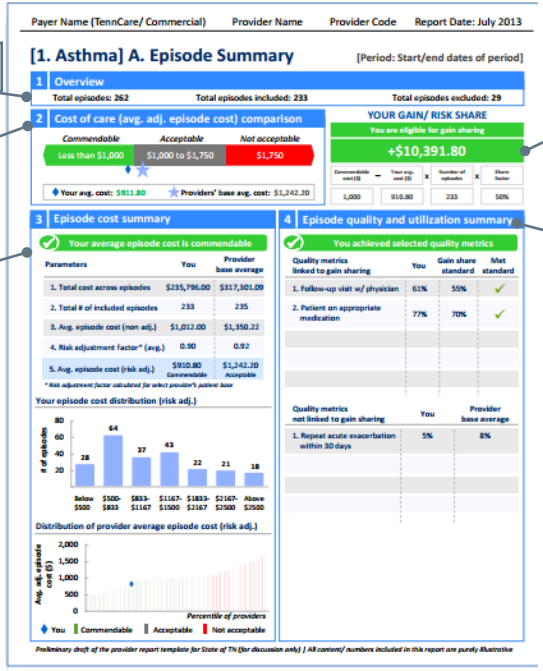
Provider Benefits

- Enhanced readability
- Decreased training

Plan Benefits

- Enhanced communication
- Decreased production costs

TennCare's Episode Summary Report



Overview

Cost of care comparison

Episode cost summary

Provider gain / risk share

Episode quality & utilization summary

Source: "Guide to Reading Your Episode of Care Report," State of Tennessee Health Care Innovation Initiative, available at: https://www.tn.gov/assets/entities/hcfa/attachments/Howtoguide.pdf; Health Plan Advisory Council interviews and analysis.

Focus on the Loss

Target the Right People with the Right Information

Health Partners Plans' Incentive Distribution

Target Finance Personnel → **Show Providers Missed Earnings** → **Package Check with Data Report**

Measure	Care Gaps	Missed Earnings	Actual Earnings[2]	Percentile Rank
Cardiovascular LDL Control	100/ 125	$2,500		90th
Pneumonia Vaccination Status for Older Adults	45/90	$4,500		50th
Diabetic Patients w/ Most Recent LDL > 100 mg/dl	25/ 100	$7,500		30th

Clear visual representation of missed revenue relative to total opportunity

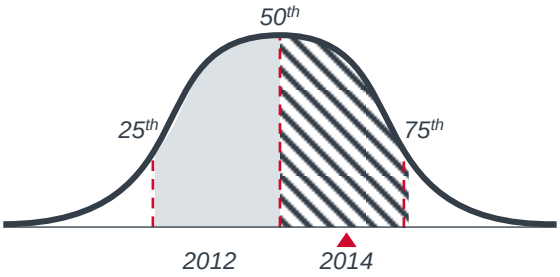
Network comparison incites competition

Source: Health Partners Plans; Health Plan Advisory Council interviews and analysis.

Highlighting True Physician Performance

Health Partners Plans' HEDIS[1] Score Performances

By Percentile; 2012-2014



1st Health Partners Plans' HEDIS score rank in Pennsylvania

Shining a Spotlight

"Physicians think they are performing above average and these missed earnings reports shed light on their true performances. These reports motivate them because they show how physicians could be doing better."

Dr. Steven Szebenyi
Chief Medical Officer, Health Partners Plans

1) Healthcare Effectiveness Data and Information Set.

Source: Health Partners Plans; Health Plan Advisory Council interviews and analysis.

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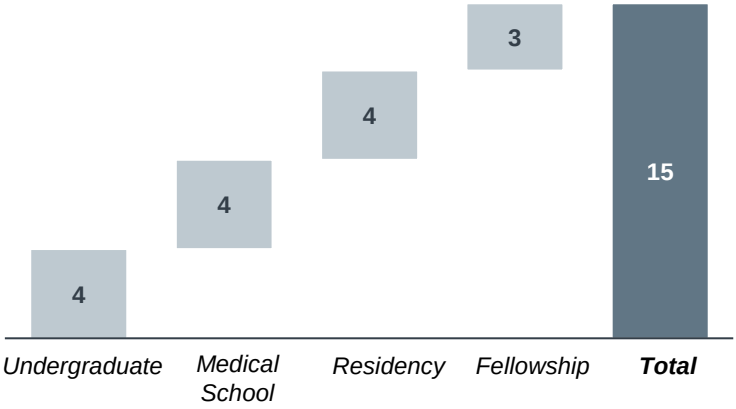
Providers are Natural Students

Years of Education Required to Become Physician



Lifelong Learners

"There's always more to learn, and no matter how hard any of us try, there's rarely enough time for one person to learn it all."

Theresa Brown, R.N.

Source: Brown, T, "Doctors and Nurses, Still Learning," New York Times Blog, April 29, 2009, available at: http://well.blogs.nytimes.com/2009/04/29/doctors-and-nurses-still-learning/?_r=1. Health Plan Advisory Council interviews and analysis.

Plans are Uneasy Teachers

Making Wrong Moves Turns Off Providers from Learning

Plan Actions To Support Providers in Data-Sharing

Current Practice		*Suggested Practice*
 Communicate with providers based on plan priorities rather than provider needs	→	Match teaching styles based on provider experience and current ability
 Ignore slow learners in provider network	→	Additional support services for low-performing providers to engage in data use
 Interact with provider leadership only when a problem arises	→	Initiate discussions at leadership level to disseminate efforts across organization
 Dictate the terms of performance improvement for the provider	→	Empower providers to self-identify areas for improvement using data

Source: Health Plan Advisory Council interviews and analysis.

Designated Analysts Boost Provider Capacity

Analysts Customize Teaching, Create Continuity of Relationship

Custom Pairings of Plan and Provider Staff

Providers

Beginners
"This report is so confusing. I don't understand it."

"How do I access the Provider Dashboard?"

Intermediate
"How can we run this analysis regularly?"

Advanced
"How can I use this data to see the types of people frequenting the emergency room?

Plan Staff

Patient Teacher and Communicator

"Let me run over it with you."

"Let me show you."

Motivator

"I can come next week to train your providers. Let's see if we can make this easier for you!"

Innovator

"Let me show you how to apply this information to other trends."

Source: Blue Cross and Blue Shield of Louisiana; Health Plan Advisory Council interviews and analysis.

No Provider Left Behind

Capital BlueCross Proactively Helps Providers Perform Better

Quality*First* Accountable Care Arrangement℠ Program

Provider Engagement Strategy	90th Percentile	25th Percentile
Meets quarterly to discuss clinical performance	✓	✓
Distributes performance-based incentives for achieving Triple Aim attainment and improvement levels	✓	✓
Identifies and communicates root cause(s) of low performing providers		✓
Deploys resources to implement best practices		✓

ACA[1] Program Results

35%
Reduction in inpatient admissions

8%
Reduction in readmissions

8.4%
Reduction in ER visits

1) Accountable Care Arrangement.

Source: Capital BlueCross; Health Plan Advisory Council interviews and analysis.

Leadership Investment Pays Dividends

Peer to Peer Engagement Bolsters Provider Confidence

Leadership Qualities

Picasso Health Plan[1] Medical Director

- In-depth knowledge of provider market
- Ability to use data to inform trouble-shooting
- Capacity to consult on short-term vision with long-term goals in mind

Practice Medical Director

- Interest in managing an aging population under risk
- Ability to campaign and get buy-in internally for data-sharing initiatives
- Knowledge of how to manage geriatric-specific conditions

Joint Activities

- Launched Medicare Advantage boot camp to onboard all new Medical Directors
- Met regularly during monthly Medical Directors Forum
- Decided on engagement strategy and co-created the terms of the informal consultation

1) Pseudonym.

Source: Health Plan Advisory Council interviews and analysis.

Reigning in Outliers by Reinforcing Leaders

Targets for Readmission Reduction

	SNF[1] Days	*Medication Adherence*
		
Intervention	Provider used SNF utilization data to create a list of preferred skilled nursing facilities.	Using patient discharge and medication lists, providers developed a customized platform using FaceTime for virtual pharmacist follow-up.
Plan Leader Role	• Offered SNF utilization data and highlighted areas of improvement • Advised on how to re-shape agreements with SNFs	• Consulted on how to best allocate resources • Advised on how to allot pharmacist time
Provider Leader Role	• Agreed to cut SNFs out • Disseminated list of preferred SNFs throughout the organization	• Rolled out innovation through staff delegation and project planning • Inspired buy-in from other provider staff

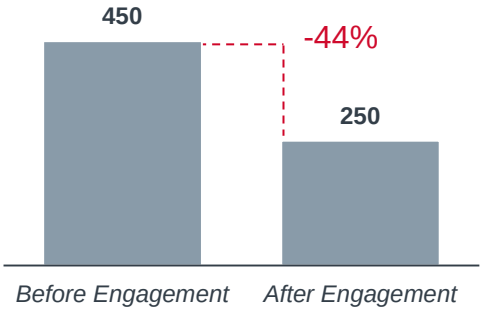
1) Skilled Nursing Facilities

Source: Health Plan Advisory Council interviews and analysis.

Keeping Good Results In-Network

Readmission Rate

Readmissions Per 1,000 Members



> "After a long two years, they really did turn it around. When we look at where they are now, especially for a smaller provider, they are one of the higher performers in our network, considering their utilization measures, risk score and overall financial performance in MA."
>
> *Executive in Network Contracting, Picasso Health Plan*

Source: Health Plan Advisory Council interviews and analysis.

Letting Providers Lead

MACIPA Instills Project Ownership to Enhance Clinical Performance

Project Selection Process

Performance Report		*Potential Initiatives*	*Provider Proposal*
↑ ED utilization	→	Increase NP[1] home visits	
↑ **Readmissions**	→	**Improve post-discharge follow-up**	1. Assign care managers 2. Schedule PCP appointment before discharge 3. Prioritize home visits
↓ Avoidable admissions	→	Coordinate with SNFs	
↑ Diabetics in poor control	→	Coordinate metabolic team with PCPs[2]	

Benefits of the QI Projects

- Improved care quality and member satisfaction
- Surplus distribution program eligibility
- Showcase at annual year-end conference

Case in Brief: Mount Auburn Cambridge Independent Practice Association (MACIPA)

- 500-physician multispecialty practice in Massachusetts
- MACIPA requires all specialty groups to conduct one QI[3] project annually on underperformance areas to be eligible for the surplus distribution program

1) Nurse practitioner.
2) Primary care physicians.
3) Quality improvement.

Source: Mount Auburn Cambridge Independent Practice Association; Health Plan Advisory Council interviews and analysis.

Providers' Own Results

Practice Autonomy Creates Sustainable Changes

Gastroenterologists' Opportunity:

Decrease variability in GERD[1] endoscope performance

Internal Operations

Developed a single protocol for treating GERD, consistent with national standards

External Community

Educated PCPs[2] on the new treatment algorithm and when to refer for endoscopies

Results

- Variability in endoscope performance
- Number of endoscopes performed

Seeing the Bonus

65% Average percentage of specialists who receive QI bonus

1) Gastroesophageal reflux disease.
2) Primary care physicians.

Source: Mount Auburn Cambridge Independent Practice Association; Health Plan Advisory Council interviews and analysis.

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Are You Too Much To Handle?

Physicians Overburdened by Numerous Plan Needs

Plan Obstacles to Provider Ambitions

Provider Priorities

- Patient care
- Clinical research
- Marketing
- Technology investments

Diversity - Most providers are working with an average of 8 to 15 plans

Time - Administration already takes too much of providers' time and attention

Analytics - Providers are in various stages of IT and analytic capability, hampering effective data use

PCPs and specialists feel **overwhelmed** and **frantic** by mountains of data sent by plans demanding action

Source: "Provider Attitudes Toward Value-Based Payment Models," Availity, April 2014, available at: http://www.availity.com/wp-content/uploads/2014/05/provider-attitudes-research-availity-may2014.pdf /; Health Plan Advisory Council interviews and analysis.

Avoiding Time Traps

Plans Can Find Opportunities to Save Providers Time

Perceived Time Wasters

1

Using Plan Data

Providers spend time figuring out which reports go with each member and what that member might need

2

Meeting on New Initiatives

Multiple stakeholders involved in each decision preventing efficiencies in working with the plan

3

Re-discussing Priorities

Plan turnover and non-dedicated staff create redundancy in repeating background with each new request

Source: Health Plan Advisory Council interviews and analysis.

An Extra Pair of Hands

Make it Easy for Providers to Prioritize Your Patients

Plan Navigator Process

Health Plan Mines Provider Schedule and EMR

Weekly Calls Identify Care Gaps

Practice Flags Action for the Provider

Patient Name	Insurance	Appointment Time
Jones, Clark	AHP	9:30 AM
Kasich, Joe	LHP	9:45 AM
Lamont, Kelsey	AHP	10:00 AM
Nesbit, Chelsea	LHP	10:15 AM

"Mr. Jones is coming in two weeks to your facility for an appointment. He has an outstanding diabetic eye exam that we'd like to flag for completion."

Patient Name	Outstanding Care Gap
Jones, Clark	Diabetes Eye Exam
Lamont, Kelsey	HbA1c Screening

Source: Blue Cross and Blue Shield of Louisiana; Health Plan Advisory Council interviews and analysis.

Working Behind the Scenes

Navigator Member Management

Compliance Check

1. Logs into population health management tool to pull percentage compliance[1] for each member on plan-wide select chronic conditions.
2. Uses compliance information to inform coaching and questions to the member.

12% Improvement on diabetes quality measures for all participating clinics

Member Calls

Weekly Call Report

- ❑ Identifies whether call was successful
- ❑ Notes type of care gap, intervention, and barrier
- ❑ Notes any additional provider education provided through phone conversation
- ❑ Notes any member complaint or reason for care gap

1) Percentage compliance is calculated by whether specific quality metrics have been met and care gaps closed for each chronic condition.

Source: Blue Cross and Blue Shield of Louisiana; Health Plan Advisory Council interviews and analysis.

Common Language Leads to Provider Progress

Meeting Stratification Maximizes Provider Capacity for Kahlo Health Plan[1]

	Monthly Data Meetings (1 hour)	*Quarterly Leadership Meetings (2 hours)*	*Monthly Quality Meetings (1 hour)*
			
Scope	Dig deeper into TCOC[2] data and determine areas of focus	Review high-level performance around TCOC and Quality	Dig deeper into quality data and determine areas of focus
Sample Attendees	*Plan:* Contract Manager, TCOC Consultant, Director of Finance *Provider:* Contract Manager, Finance Analyst	*Plan:* Director of Provider Relations, Quality Program Manager, Contract/Account Manager, Director of Finance, TCOC Consultant, Medical Director *Provider:* VP of Revenue Management, CMO, Director of QI, Director of Contracting, Contract Manager	*Plan:* Contract Manager, Medical Director, Quality Program Manager *Provider:* Provider Medical Director, Director of Quality, Quality Coordinator
Sample Agenda Items	• Follow-up from Leadership Meeting • Review High Tech Imaging Utilization and Outflow	• Quarter 1- TCOC Review • Quarter 2- Quality Review	• Follow-up from Leadership Meeting • Admissions: Top Diagnoses and Admissions by Clinic

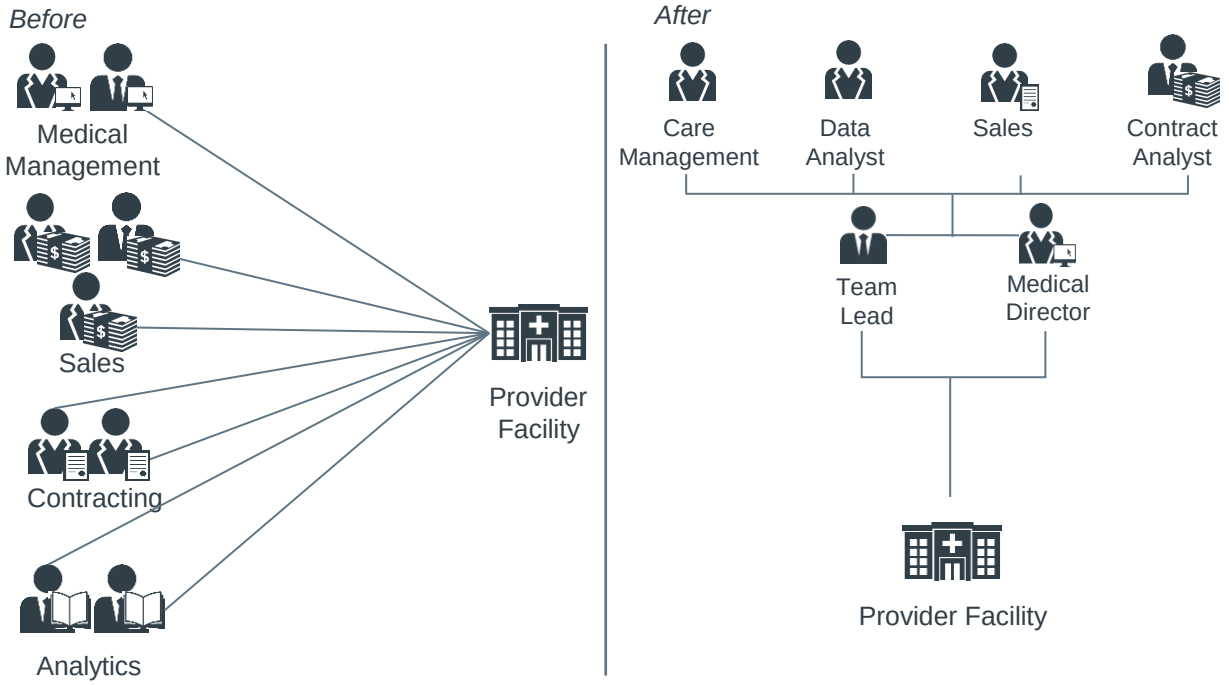
1) Pseudonym.
2) Total cost of care.

Source: Health Plan Advisory Council interviews and analysis.

Team-Based Care

Dedicated Teams for Accountable Care Networks

Priority Provider Staffing Model

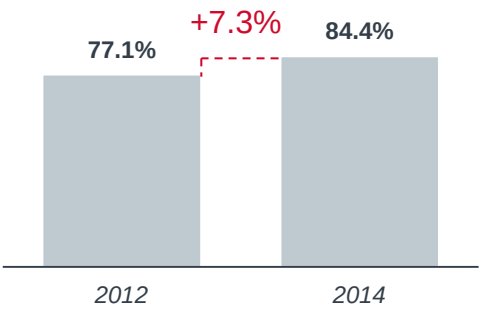


Source: Priority Health; Health Plan Advisory Council interviews and analysis.

Satisfied Customers

Reporting Structure Enables Productive Plan Help

Provider Satisfaction



> "Previously, we had numerous independent initiatives with our provider partners that were managed at the department level. The IDT teams have helped us collectively manage our portfolio of improvement activities and allowed us to get greater utility from our analytic resources."
>
> *Molly McCarthy, AVP*
> *Provider Network Performance*
> *Priority Health*

Interdisciplinary Team Benefits

- Improved **internal communication** of provider needs and strategies
- Strengthened **plan structure** through skillset specialization
- Enhanced **provider engagement** on pre-existing and new initiatives
- Focused **data analytics** efforts and incorporation into business strategy

Source: Priority Health; Health Plan Advisory Council interviews and analysis.

Fully Aligned Incentives

Tying Financial Stake for Plan Staff to Provider Performance

Provider Quality Specialists' Job Description at Dali Health Plan[1]

About The Role

- **Background:** Analytics savviness, ability to communicate successfully with both providers and business managers; familiarity with clinical care
- **Tools and reports:** Member roster; care gap reports; provider profiling data; "frequent flier" ED reports by member; MLR[2] and other cost of care data; incentive performance status
- **Metrics of success:** Provider group's clinical quality and cost performance

> We are seeing a more effective focus on the part of medical groups on what needs to be done to improve metrics that influence financial incentives.
>
> *Vice President, Network Management*

Provider Quality Specialists:

1. Provide timely data to the provider
2. Intervene proactively and engage with providers due to ongoing relationship
3. Understand both clinical and analytical data to translate actionable items for the provider
4. Communicate how improved performance can increase group's financial incentives

1) Pseudonym.
2) Medical loss ratio.

Source:; Health Plan Advisory Council interviews and analysis.

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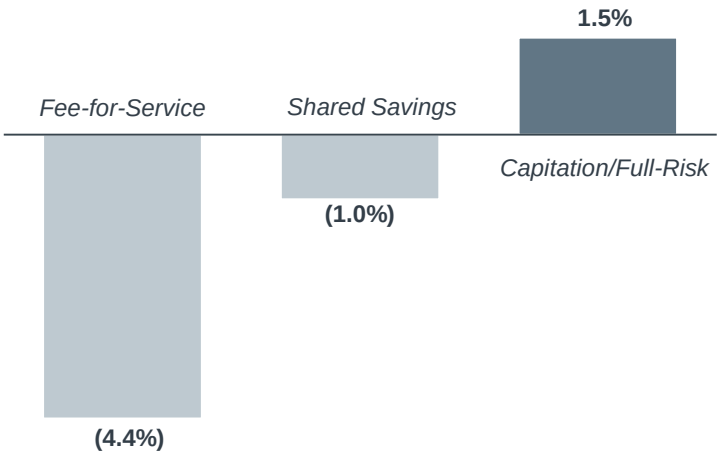
Hesitant to Take the First Step

Economics of Contracts Put Long-Term Sustainability Into Question

Margin Impact of 10-Percent Reduction in Inpatient Utilization

Under Various Payment Models



What's In It for Us?

There is no real upside. You are taking on risk and have to manage utilization. It's a cost reduction strategy – you won't find any benefit from taking on risk for capping your utilization.

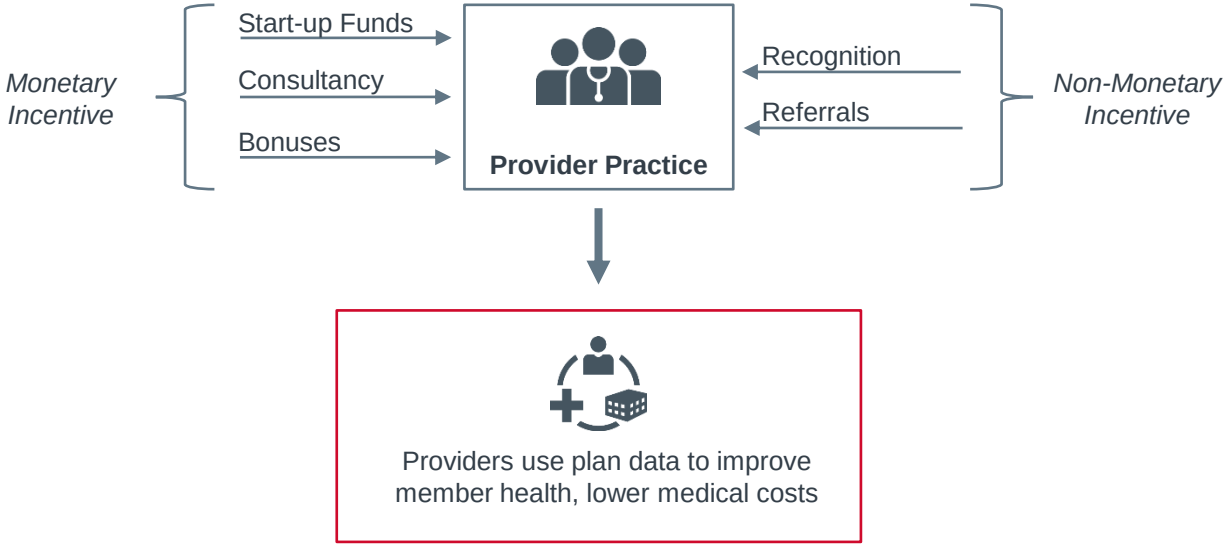
Chief Financial Officer, Small Health System in Northeast

Source: Health Plan Advisory Council interviews and analysis.

Show Me The Money (or Not)

Plan Incentives Designed to Accelerate Transition to Value-Based Care

Provider Incentives



Source: Health Plan Advisory Council interviews and analysis.

Committed Finances

Passport Requires Provider Investment in Collaboration

Passport Health Plan's Selection Process

125 Total Providers in Network

Questions

- *Does Passport have a good relationship with the provider?*
- *What is Passport's market share in the provider's market?*
- *How many high-risk members does the provider have in their market?*

7 Potential Provider Partners

Questions

- ***Is the provider willing to pay for assessment of opportunities?***
- *Is there buy-in from internal and external stakeholders for this project?*
- *Does the provider have adequate IT and data infrastructures?*

2 Provider Partners

Decision Factors

- ✓ Willing to finance consulting services
- ✓ Strong relationship with Passport
- ✓ Small, rural providers with strong internal and external buy-in

Source: Passport Health Plan; Health Plan Advisory Council interviews and analysis.

Peeking Under the Practice

Passport Assesses Providers Before Partnering

Readiness Assessment Survey[1]

Provider Questionnaire

Leadership
- What are your institution's revenues by payer type?
- What are your institution's inpatient admissions? Outpatient admissions?

IT Infrastructure
- What is your institution's EMR system?
- What are current interoperability challenges?

Diagnoses
- Please list the 10 most common diagnoses at your institution.

Physician Relations
- To what degree does your institution have physician alignment?

Internal Interviewees
- C-Suite
- Project champions (e.g., Project Managers from the Strategic Planning and Project Management departments)

Goal: Evaluate staffing and IT capabilities, and organizational willingness and readiness to change

External Interviewees
- Local pharmacists
- Post-acute care facilities
- Public health officials
- Social workers
- Community advocates

Goal: Determine community opinions of the provider and ability to support population health

1) Survey questions are generated and sent electronically to providers via SurveyMonkey.

Source: Passport Health Plan; Health Plan Advisory Council interviews and analysis.

Calculating Provider Returns

Show Providers Costs and Gains to Instill Confidence

Financial Inputs of Passport's Population Health Model

Cost Inputs

- Staff (e.g., data analysts, care navigators, and social workers)
- EMR and other IT upgrades
- Interventions
- Relationships with other community providers

Financial Model

Calculated return for providers in value-based contract

Potential Revenue

- Increased volumes
- Patient satisfaction bonuses
- Shared savings bonuses
- Coding efficiency bonuses

Reducing ED Utilization

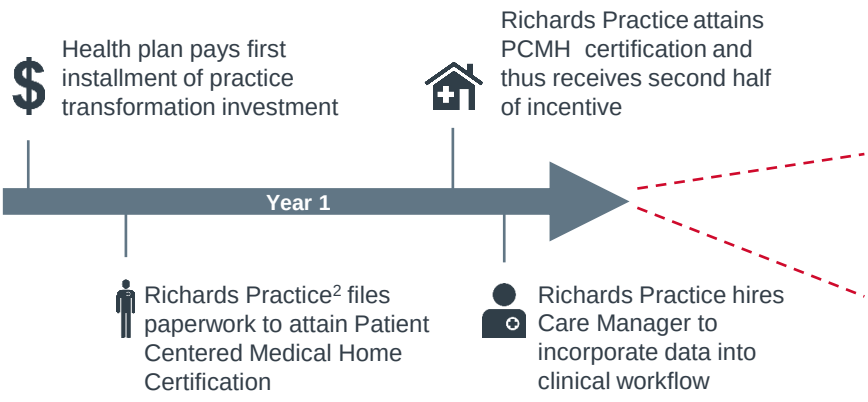
10% Target ED utilization reduction rate for Passport's two provider partners

Source: Passport Health Plan; Health Plan Advisory Council interviews and analysis.

Offering Bridge Financing to Get Started

Incenting Success by Tying Ask to Money

Degas Health Plan[1] PCMH Start Up Investment



- Plan achieves quality goal for the year
- Provider attains PCMH certification
- Funds can be used by providers to directly invest into further practice transformation

- Practice does not attain PCMH certification
- Practice does not receive second installment of practice transformation investment
- Practice is not eligible to earn Total Cost of Care Shared Savings or Quality Improvement incentives until certified

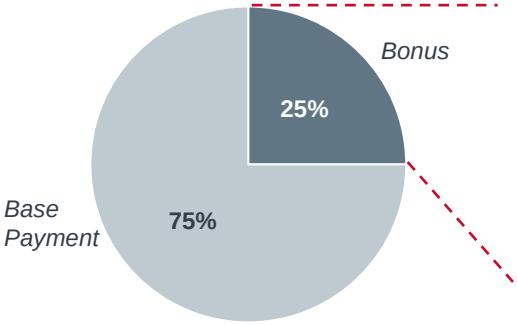
1) Pseudonym.
2) Pseudonym.

Source: Health Plan Advisory Council interviews and analysis.

Bonus Resources

Large Incentive Provides Funds for Practice Enhancements

Provider Payment Structure



Investments Possible

- Staff to access portal
- Extended practice hours
- Additional phone support

10%
Reduction in avoidable ED visits since 2013

Case in Brief: Central California Alliance for Health (CCAH)

- Non-profit health plan that serves over 325,000 members in the Santa Cruz, CA area
- Providers eligible for bonus if they meet or surpass clinical performance benchmarks set by peers
- ED utilization data available through CCAH portal

Source: Central California Alliance for Health; Health Plan Advisory Council interviews and analysis.

Complement Incentives with Recognition

Provider Efforts Applauded, Competition Inspires More Action

Quality Rewards Met With Enthusiasm

Blue Cross Blue Shield of Louisiana dedicates an entire day to recognizing provider quality efforts and disseminating best practices.

Providers receive annual rewards for best performance on four chronic diseases in quality program, propelling competition amidst providers.

Winning performers are featured in online provider listing, local and statewide press releases, and on social media.

Quality Blue Primary Care Promotional Toolkit

- Copies of Quality Blue program logo with instructions for proper use
- Template press release to announce program participation
- Template text and samples for social media posts

>200

Attendees at the Annual Rewards Collaborative Day

69%

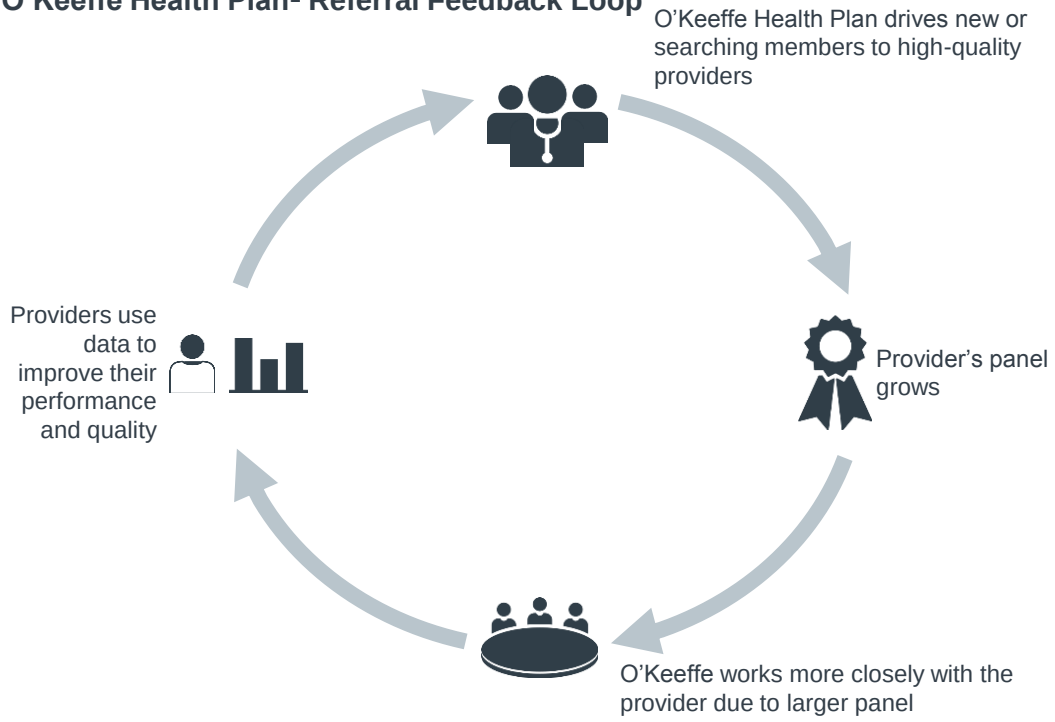
Improvement on chronic kidney disease measures

Source: Blue Cross and Blue Shield of Louisiana; Health Plan Advisory Council interviews and analysis.

Use Quality Performance as Referral Opportunity

Offer Members the Value of Your Highest Performers

O'Keeffe Health Plan[1] Referral Feedback Loop



1) Pseudonym.

Source: Health Plan Advisory Council interviews and analysis.

How to Sell Data to Providers

1

Focused Reports

1. Reporting Consistency
2. Missed Earnings

2

Ingratiated Teaching

3. Personality Tests
4. Matched Resources
5. Leader Engagement
6. Autonomous Improvement

3

Effortless Interaction

7. Forced Prioritization
8. Meeting Management
9. Provider Pods
10. Financially-Aligned Plans

4

Reciprocal Benefits

11. Provider-Financed Consulting
12. Start-up Financing
13. Bonus Investing
14. Awards Incentive
15. Referral Management

Road Map

1 The Data Diet

2 How to Sell Data to Providers

3 Questions