North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Provider Payment Methodologies and Strategies

Board of Trustees Meeting

January 31, 2014

A Division of the Department of State Treasurer

Presentation Overview

- Executive Summary
- Current Payment Model
- Environmental Scan of Payment Methodologies
- Next Steps and Recommendations

Executive Summary

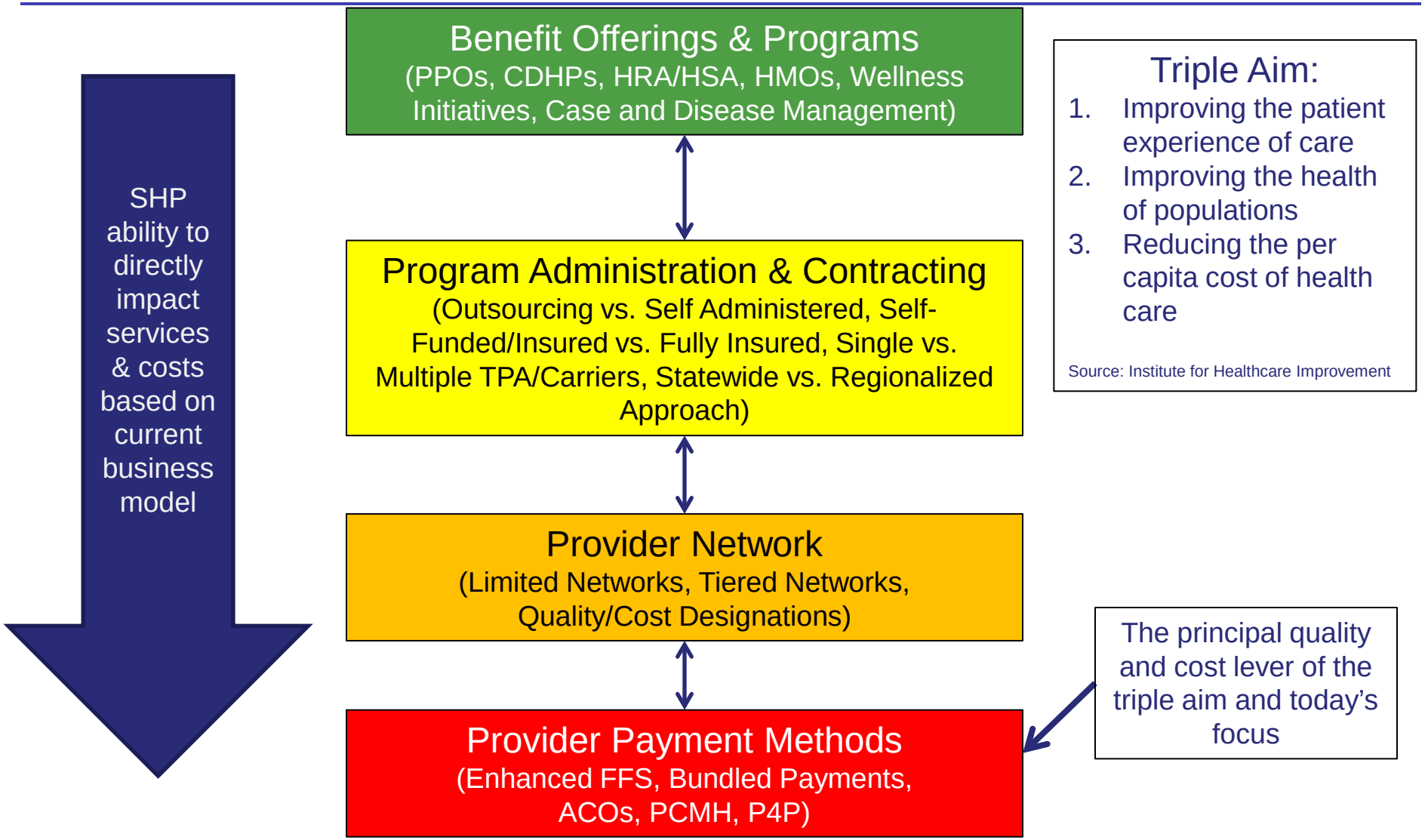
Purpose

- As part of the Strategic Planning process the Strategic Planning Workgroup and Board of Trustees requested an environmental scan of emerging alternative provider payment methodologies and strategies that focus on quality, cost, and member experience

Key findings

- The current SHP model is a Fee for Service (FFS) approach which places almost all of the financial responsibility associated with members' health risk on the Plan while paying providers for volume (i.e. per service basis) rather than quality or outcomes
- Emerging provider payment strategies focus on sharing or spreading the financial risk among the payers of health care (SHP, our carriers, and our members) and those providing care
  - Providers have a greater incentive to provide cost-effective, high quality, outcome driven care if there are financial incentives and expectations
- The goal of alternative payment arrangements is to shift some or all of the risk to providers of care to incentivize the use of high quality, lower cost solutions to keep members healthier
- Emerging strategies enforce a **balance** of access and choice with affordability and quality/outcomes

Methods to Address the Triple Aim & The Cost of Health Benefits



The 2014 SHP Service Model

	Active Employees & Pre-65 Retirees		Medicare Retirees 70/30		Medicare Retirees MAPDP	
	Responsible Vendor/Party	Payment Type & Basis	Responsible Vendor/Party	Payment Type & Basis	Responsible Vendor/Party	Payment Type & Basis
Eligibility & Enrollment Services	Benefitfocus	Admin Fee, PSPM	Benefitfocus	Admin Fee, PSPM	Benefitfocus	Admin Fee, PSPM
Medical Benefit Management Network Management and Discounts Claims Processing, COB Medical Policies, PA & UM Programs Customer Service	BCBSNC	Admin Fee, PSPM	BCBSNC	Admin Fee, PSPM	Humana or UHC	Fully Insured Premium, PMPM
Pharmacy Benefit Management Network Management and Discounts Claims Processing, COB Rx Policies, PA & UM Programs Customer Service	ESI	Admin Fee, Per Claim	ESI	Admin Fee, Per Claim	Humana or UHC	Fully Insured Premium, PMPM
Population Health Management Disease & Case Management Wellness Supports & Programs	ActiveHealth Management	Admin Fee, PMPM	Not Available		Humana or UHC	Fully Insured Premium, PMPM
Cost of Claims	Members	Applicable Copays, Deductible, Coninsurance	Members	Applicable Copays, Deductible, Coninsurance	Members	Applicable Copays, Deductible, Coninsurance
	SHP/Members	Plan Pays Allowed Charges Less Member Cost Share	SHP/Members	Plan Pays Allowed Charges Less Member Cost Share	Humana or UHC	Carriers Pay Medicare/Network Allowed Charges Less Member Cost Share
Financial Risk	Members	Limited to Cost Sharing Provisions of Benefit Design	Members	Limited to Cost Sharing Provisions of Benefit Design	Members	Limited to Cost Sharing Provisions of Benefit Design
	SHP	Limited by Network & Negotiated Rates, but Unlimited Regarding Health/Actuarial Risks	SHP	Limited by Network & Negotiated Rates, but Unlimited Regarding Health/Actuarial Risks	SHP	Limited to Premium Cost
					Humana or UHC	Managed by Network & Medicare Provisions, but Unlimited Regarding Health/Actuarial Risks

State Health Plan Payment Model

Current Statewide Risk Model:

- The State Health Plan partners with one third party administrator (TPA), Blue Cross and Blue Shield of North Carolina, and two carriers, Humana and United, to provide members with broad access to care
  - BCBSNC: State Health Plan assumes the financial/actuarial risk
  - Humana/United: Carriers assume the financial/actuarial risk
    - **HOWEVER,** utilization under Medicare Advantage plans is more tightly managed and there are significant financial subsidies at risk for plan performance, similar to many of the components to be discussed

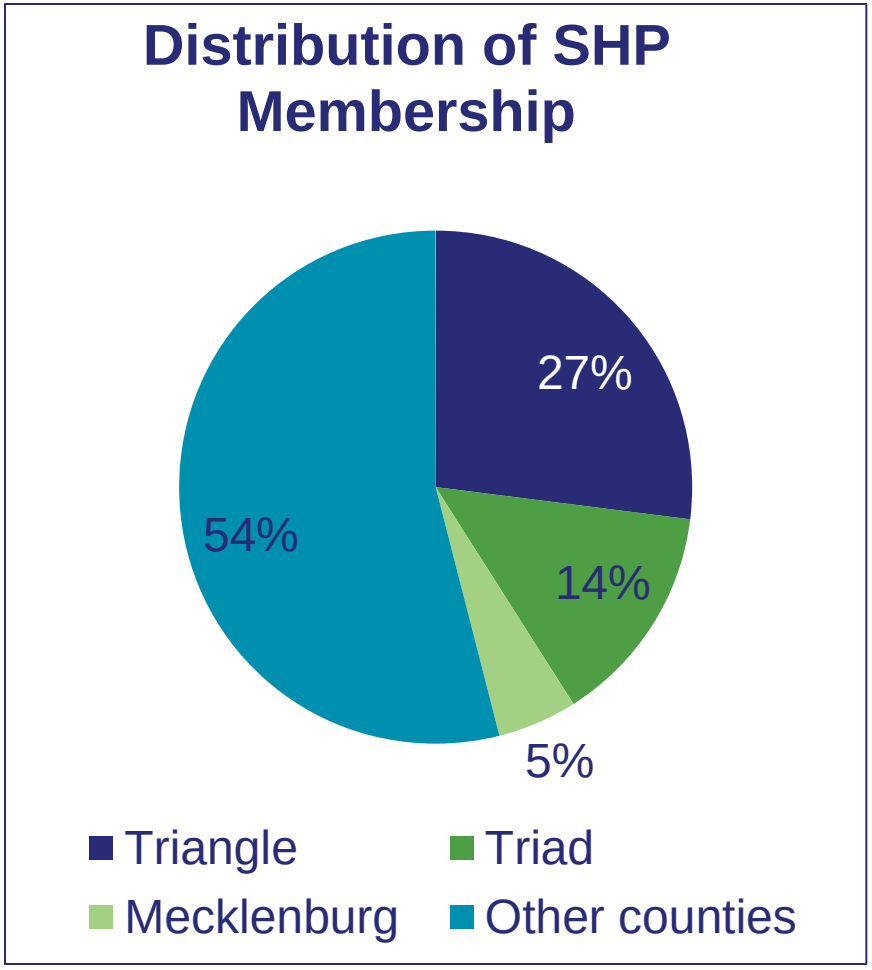
Economies of Scale:

- The State Health Plan benefits from the additional membership available through our vendor partners in negotiating provider rates
  - Providers in Swain County (831 members) do not have access to the entire Plan membership but partnering with a TPA like BCBSNC increases our ability to negotiate lower rates (SHP members only represent approximately 17% of BCBSNC book of business in that area)

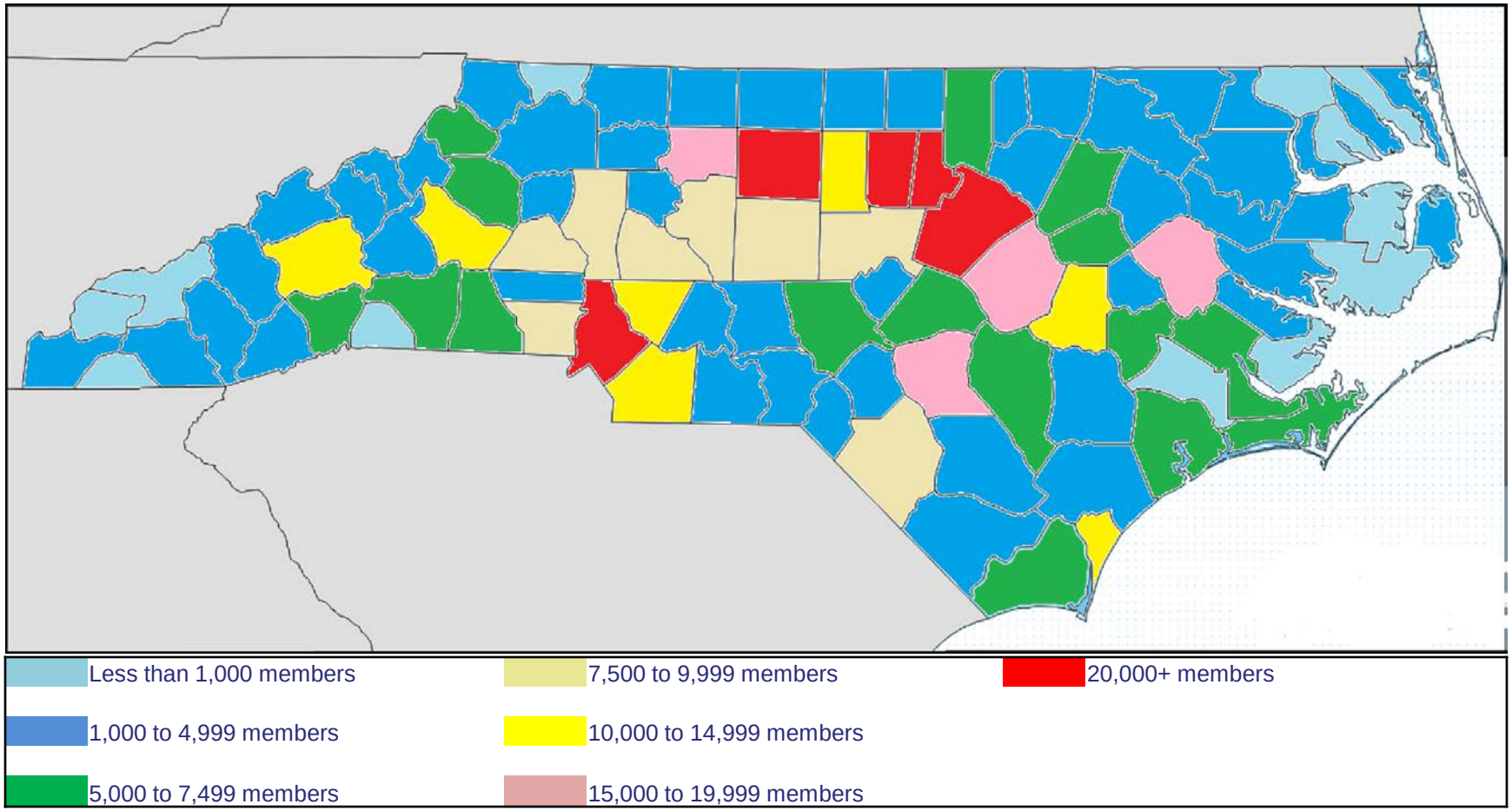
State Health Plan Membership

Current Membership:

- Over 670,000 members located throughout North Carolina's 100 counties and out of the State
- Despite the Plan's large size, the State Health Plan membership only made up about 27% of BCBSNC membership in 2013
- There are a significant number of counties with less than 1,000 SHP members
- Of the remaining counties not shown in the graph, *no county represents more than 3% of SHP membership*

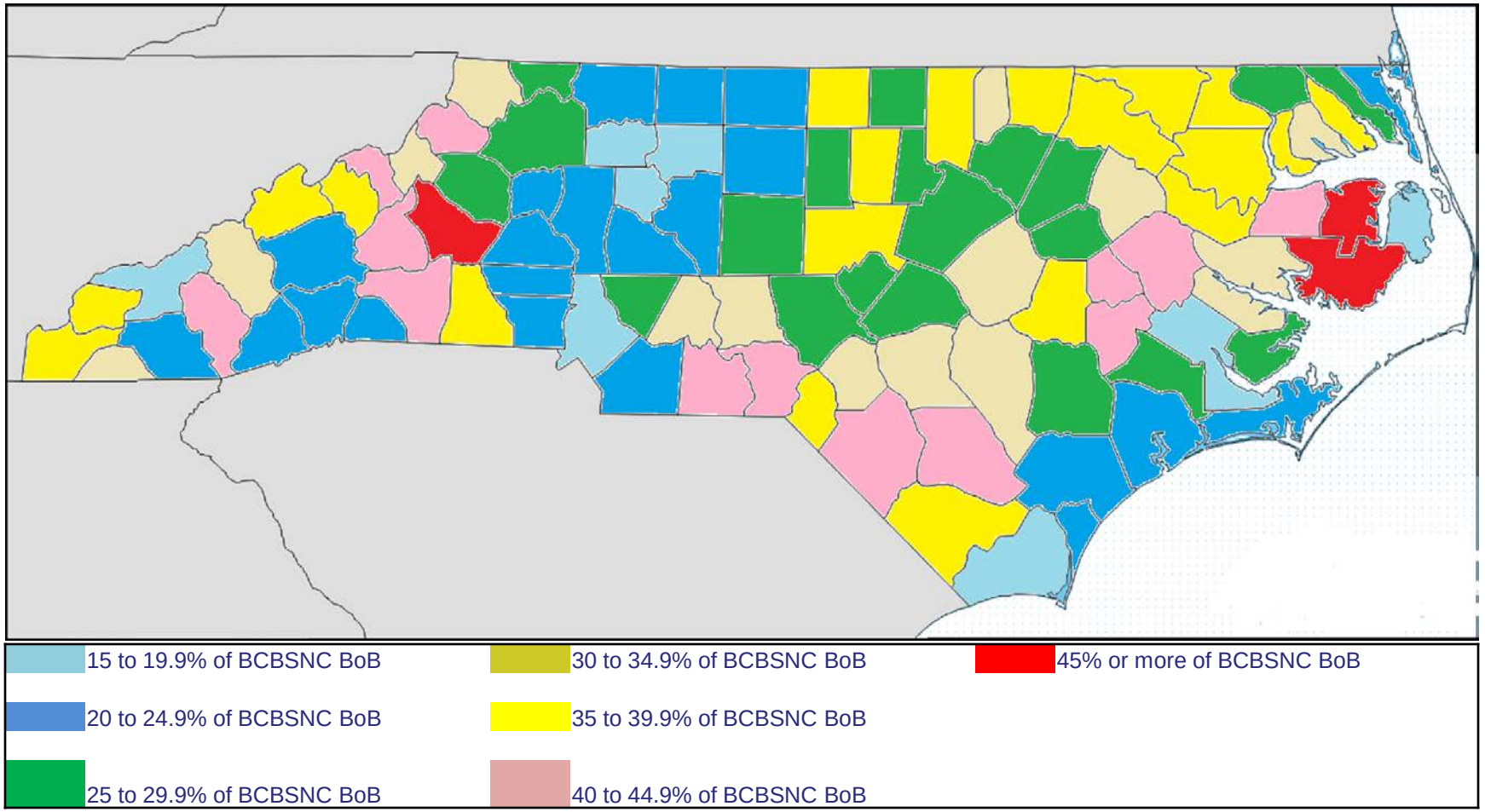


CY 2013 Average Distribution of SHP Membership



- Plan members live throughout the State and utilize multiple providers throughout the State

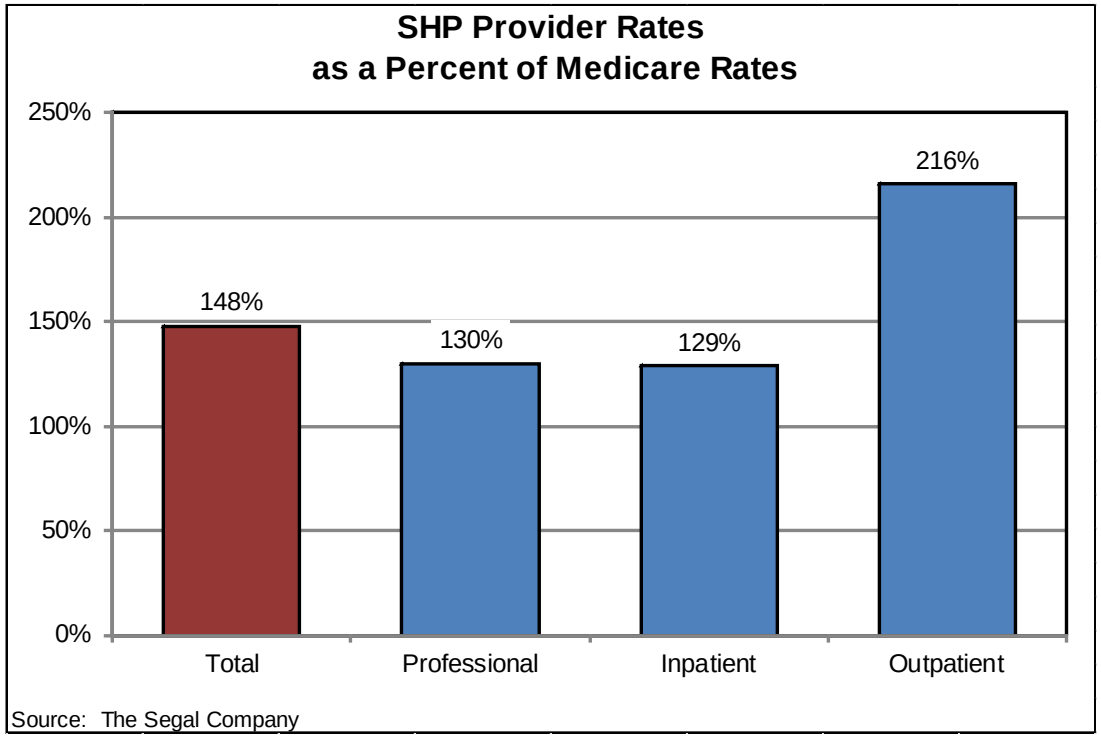
CY 2013 SHP Membership as a Percentage of BCBSNC's Book of Business



- In CY 2013 SHP membership accounted for 27% of BCBSNC's total membership
- Partnering with a TPA like BCBSNC improves the Plan's buying power

SHP Payments Under Fee for Service

- Combining professional and hospital rates, Segal concluded that, on average, the Plan pays providers at approximately 148% of Medicare rates; which is in line with expectations
- Medicaid pays approximately 90% of the Medicare provider rates; the Plan's rates would be about 164% of Medicaid rates



From May 2013 BOT Meeting

Current SHP Risk Sharing

Self – Funded

Currently, the State Health Plan (through BCBSNC) bears almost all of the financial & actuarial risk for our members' care.

MA Plans

Currently, our MA Carriers bear almost all of the financial & actuarial risk for our members' care. The Plan's financial exposure is limited, but premiums could increase in the future.

Spectrum of Potential Payment Methodologies

- The goal of many alternative provider payment arrangements is to shift from paying for productivity and each procedure (i.e. the FFS model) to paying for quality and outcomes
  - Additional benefits include better member experience and engagement as well as overall efficiency in the health care system
  - Currently, providers are not compensated if all their members are healthy
- The alternative payment models take various approaches to addressing quality but some key themes include:
  - Coordination of care
  - Enhanced focus on primary care
  - Incentives for reducing undesirable outcomes and bonuses for positive outcomes and use of appropriate settings of care
  - Payment withholds for lower quality care and/or redundant care

Capitation Risk Sharing Arrangement

Capitation Features:

- Fixed per capita payments to provide member care
- Tight networks
- Full risk on providers to manage and coordinate care

Payer of health care – 100% of risk

Provider of health care – 100% of risk

Traditional Capitation

- Capitation pays provider(s) a fixed fee for a designated period of time to provide all of a member's care
  - If a member has no services the provider still receives payment
- Popular in the US in the 1990s
  - Some models currently exist
- Concerns about providers being incented to withhold care or severely limit the amount of care provided
  - The opposite of the Fee For Service issue/concern
- Doesn't account for member acuity or complex care needs
- Significantly limits member choice of providers

ACO Risk Sharing Arrangement

ACO Features:

- Fixed capitated payments with the flexibility to adjust amounts to address acuity needs of populations
- Provider "stop loss"
- Bonuses and withholds depending on outcomes

Payer of health care – 100% of risk

Provider of health care – 100% of risk

Accountable Care Organizations (ACO)

- CMS defines an ACO as:

  Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors

  If savings are generated then they are shared throughout the system, If they are not then the responsibility for the cost is also shared

- Local and national marketplaces are using multiple approaches and methods for defining and establishing ACO-like entities
  - The market definition has significant variation

- ***ACOs need a captive population and tight integration to be effective***
- ***Based on geography and provider readiness it would be extremely difficult for the Plan to create an ACO***

How ACOs Differ From Traditional Capitation

- ACOs can address and compensate for acuity differences between populations
  - Per member payments can be based on member conditions versus a flat per patient fee – *Capitation payments are flat*
- ACOs can adjust for complex cases or higher needs populations by putting limits on risk to providers
  - Provider “stop loss” – *Capitation requires the Provider to take inappropriate risk*
- ACOs can include bonuses and penalties based on the quality of care provided
  - Reduces incentives to withhold care
  - Providers are compensated for keeping patients well
- ACOs combine elements of multiple payment models
  - Bundling, episodes of care
- ACOs can be designed for specific sets of care or a global payment
  - Primary Care
  - Acute Care +/- Primary Care
  - Post-Acute +/- Acute Care +/- Primary Care
  - Other combinations
- ACO systems greatly benefit from advances in Health Information Technology and data analytics

Bundled Payment/Episode of Care Risk Sharing Arrangement

Bundled Payment/Episode of Care Features:

- Providers and payers agree on a bundled rate of payments for either a condition or procedure
- Providers manage expenditures and appropriate care settings
- Providers are not compensated if quality care is not provided
- Allows for price adjustments

Payer of health care – 100% of risk

Provider of health care – 100% of risk

Episode of Care/Bundled Payments

- Under Bundled and Episode of Care payments, a single, aggregate payment is made to two or more providers, who otherwise are typically paid separately, for a single episode of care and/or a specific period of time
  - Bundled payment example: Knee Surgery
  - Episode of Care payment example: Cardiac Care and Rehabilitation
    - Medicare utilizes this approach for inpatient care
  - Providers are responsible for distributing payments amongst themselves for care rendered
    - Incents lower cost, higher quality care and utilization of appropriate care settings
    - Cannot easily be applied to all forms of care
- Currently, SHP makes DRG payments to several NC hospitals for inpatient care and bundled payment approaches are developing in certain NC hospitals

Fee for Service vs. Bundling vs. Episode of Care

Fee for Service

Providers	Payments
Primary Care Visits	Paid for each service
Specialist Visits	Paid for each service
Inpatient Care	Paid for each service
Rehabilitative Care	Paid for each service

Bundling

Providers	Payments
Primary Care Visits	Single Payment
Specialist Visits	
Inpatient Care	
Rehabilitative Care	Paid for each service

Episode of Care

Providers	Payments
Primary Care Visits	Single Payment
Specialist Visits	
Inpatient Care	
Rehabilitative Care	

Pay for Performance & Value Based Contracting Risk Sharing Arrangement

Pay for Performance Features:

- Payments may still be made on a fee for service basis
- Partial payment withholds may be used to provide additional funds to high performing providers
- Providers are at risk for payment withholds if they do not meet selected performance measures

Payer of health care – 100% of risk

Provider of health care – 100% of risk

Pay for Performance (P4P) & Value Based Contracting

- *"Pay for performance" is an umbrella term for initiatives aimed at improving the quality, efficiency, and overall value of health care. These arrangements provide financial incentives to hospitals, physicians, and other health care providers to carry out such improvements and achieve optimal outcomes for patients*
- Popular in Medicare and some Medicaid programs; expanding in Medicare under the ACA
- Provides bonus payments to providers if they meet or exceed quality or performance measures
  - Specific to disease: reduction in hemoglobin A1c in diabetic patients
  - Annual markers: reduction in avoidable hospital readmissions
- Imposes financial withholds on providers that fail to achieve specified goals or cost savings
  - Specific to episode: no payment for preventable hospital infections
  - Annual markers: increases in avoidable hospital readmissions

Patient Centered Medical Home Risk Sharing Arrangement

Patient Centered Medical Home Features:

- PCMH exists in a fee for service model
- Primary care providers (PCPs), or other entry point caregivers, receive enhanced payments or PMPMs to coordinate care throughout the health care system
- May include outcome based bonuses

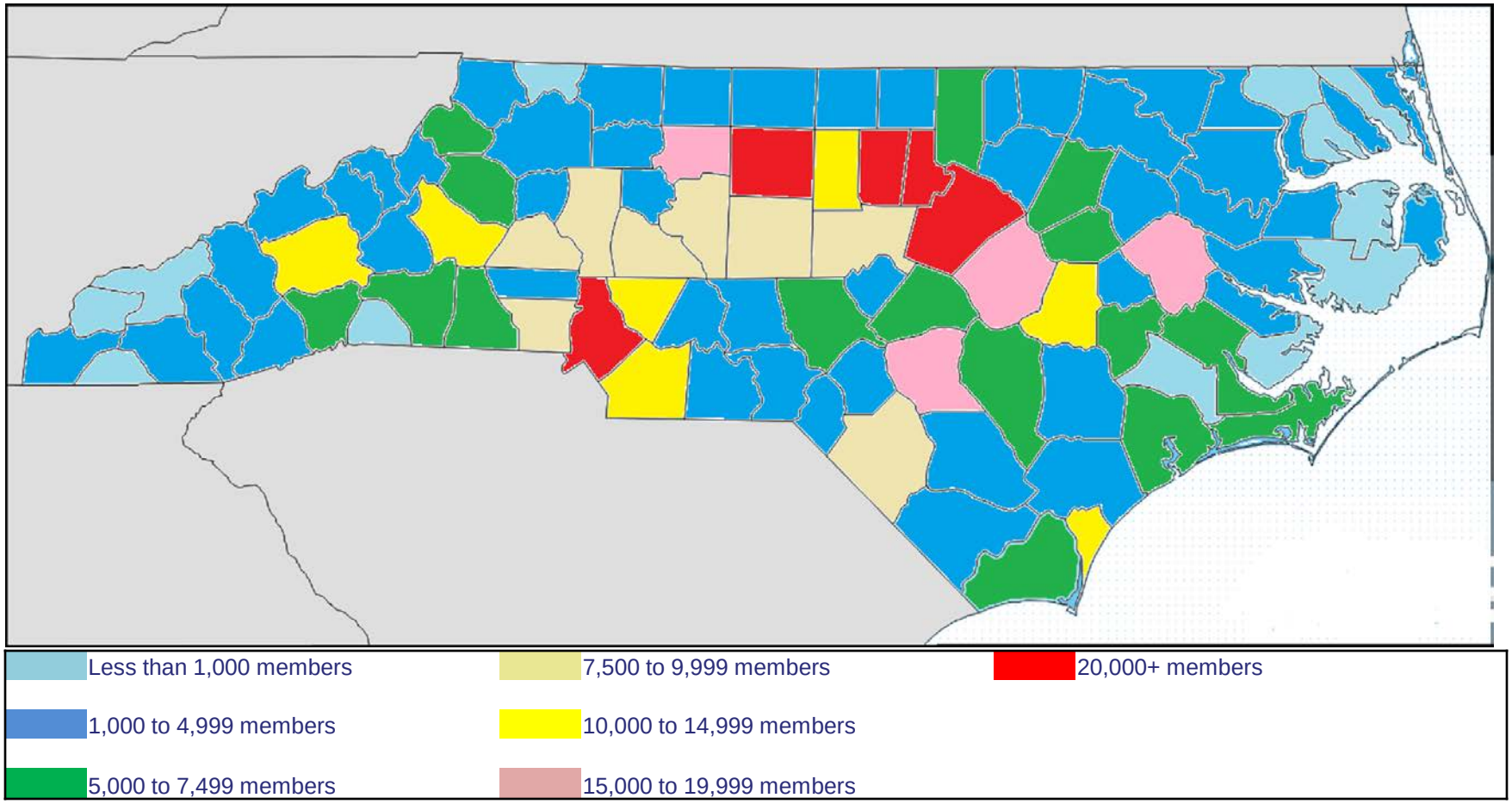
Payer of health care – 100% of risk

Provider of health care – 100% of risk

Patient Centered Medical Home (PCMH)

- The patient centered medical home is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into “what patients want it to be.” Medical homes can lead to higher quality and lower costs, and can improve patients’ and providers’ experience of care
  - Fixed supplemental payments administered on a per member per month (PMPM) basis or enhanced fees for service to be used for care coordination and performing the functions of a medical home
  - Pay for performance bonus payments for meeting agreed upon medical home metrics (usually process measures, sometimes enhanced to include clinical outcomes measures)
- CCNC is the most recognizable model in North Carolina

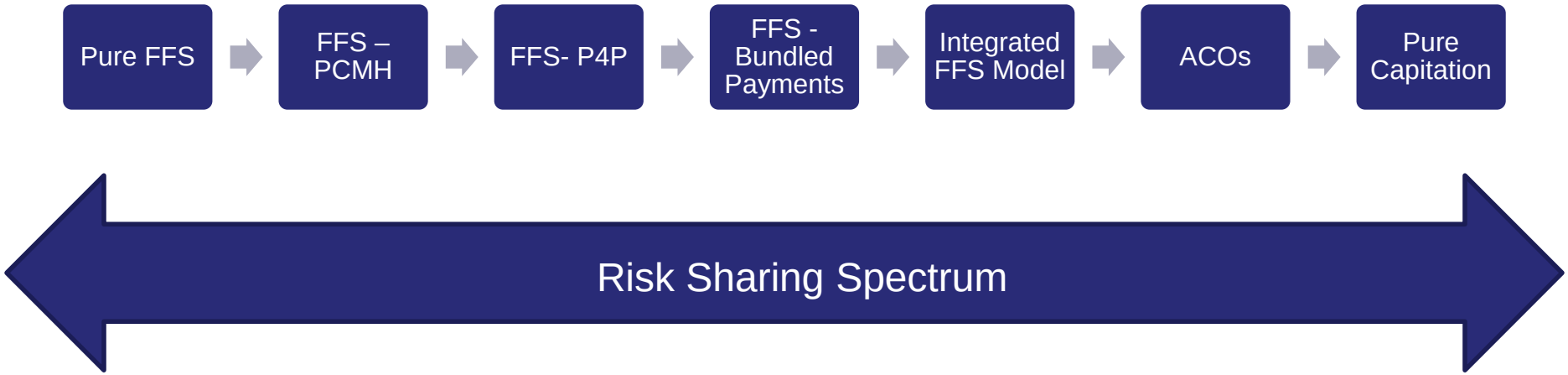
Consider Different Strategies for Different Areas of the State or Populations



Spectrum of Payment Methodologies: What is the Right Balance?

Current model is predominantly FFS

To what degree should the Plan move to the right?



Payer(s) of health care – 100% of insurance and performance risk

Provider of health care – 100% of insurance and performance risk

Summary of Findings

- Alternative payment opportunities are emerging in North Carolina in different parts of the State and at different levels based on the provider groups; SHP members have access to these
- Payment strategies that focus on quality and costs can have an impact on member choice and access – Need appropriate balance
- Alternative models require effective data analytics to monitor performance
- The size of the SHP member population offers opportunities when considering alternative payment methodologies and arrangements; however, the geographical dispersion of members throughout the State presents challenges

Next Steps and Recommendations

- Alternative payment opportunities are emerging in North Carolina in different parts of the State and at different levels based on the provider groups – *Do we promote utilization of these models?*
- A global, statewide strategy toward alternative payments does not appear to be possible in the short-term
- The State Health Plan should work with current and future TPAs/carriers to identify opportunities to incent quality of care and pay for outcomes while facilitating the development of successful evidence-based practices that are emerging in NC
- Investigate the use of alternative network arrangements and plan designs that can reward members for using higher quality and lower cost facilities
- Consider pursuing condition-based partnerships to reduce avoidable hospitalizations and help members manage conditions