

UNC Health Care's Proposal for State Health Plan Modernization

June 26, 2019

Purpose:

The intent of this document is to outline an alternative approach to the State Health Plan's proposed Clear Pricing Project. UNC Health Care believes that these principles, further modified in discussions with State Health Plan (SHP) leaders and other stakeholders including fellow providers across the state, could form the basis of a sustainable, high quality SHP that would be endorsed by patients, providers, the SHP leadership, and the State's leadership.

Core Principles:

1. Reduce total cost of care for the population
2. Improve clinical quality outcomes for the population
3. Improve pricing transparency
4. Balance the impact to at-risk providers to prevent destabilization of health care in NC
5. Provide a stable transition to a long-term sustainable State Health Plan

Principle 1 – Reduce total cost of care for the population

The SHP and healthcare providers in North Carolina agree that the total cost of care for state employees must decrease. Cost reductions can be achieved by organized groups of providers through rate reductions, network configuration and benefit plans, price transparency and a financial model that incentivizes improved management of the population as well as an engaged patient population committed to improving their health and helping to reduce the total cost of delivering their health care.

Financial Model:

1. Develop an expected benchmark total cost of care for the population based on historic cost, risk of the population, and expected future trend in healthcare costs, adjusted for known regional variations in healthcare costs. Similar work is already being done in the State's Medicaid program and in commercial plans in the state that offer shared savings or risk arrangements.
2. SHP enters into an equivalent of the current BCBSNC Blue Premier contract on a 3-year basis in the Triangle and Triad effective 1/1/20 – other regions may be added in subsequent year(s). Multiyear contracts are critical to developing appropriate infrastructure and redesigning care delivery to reduce total cost of care.

Financial Model Options:

1. Shared savings and/or an at-risk model based on financial performance of the providers compared to benchmark:
 - a. Shared savings: Performance better than benchmark generates savings that can be jointly shared by the SHP (who can share with its members) and the healthcare providers (who can invest in infrastructure to improve care).
 - b. At-risk model: Performance worse than benchmark results in repayment from providers to SHP, effectively capping the costs for the SHP. Performance better than benchmark provides financial incentives to the providers, which again can be invested into infrastructure to improve care for SHP members.
 - c. Create a pathway to risk for all participating health care systems, including an option to be at-risk as early as year 2.
 - d. Shared savings and risk amounts are adjusted based on clinical quality outcomes of the attributed population. If quality outcomes are below target thresholds, the amount of shared savings or positive risk payments to providers is reduced. Said another way, quality must be high to earn the full financial incentive.

2. Rate concessions:
 - a. Participating providers would accept a 2.5% rate reduction from current BCBS rates, implemented effective 1/1/20.

This plan significantly limits future rate increases. Rate increases under either option will be limited to select providers meeting one of two criteria which demonstrate that they are either in a very tenuous position financially or that they have been disadvantaged in past rate negotiations, leading to chronically low rates. To be eligible for rate increases, the provider must meet either criteria #1 or #2 below:

1. Providers with audited financials showing <1% operating margin in the previous year will be eligible for rate increases
2. Independent providers paid <175% of the current Medicare fee schedule appropriate to their business will be eligible for increases.

For those providers eligible for rate increases, the increase in all cases will be limited to no more than Medicare inflationary increases. Providers not meeting criteria in #1 or #2 above are not eligible for rate increases for the contract period of three years. Subsequent increases would be based on Medicare inflationary adjustments.

Attribution Methodology:

Primary Care Provider (PCP) selection would be required for SHP products. Attributing beneficiaries to primary care providers is foundational to managing populations, reducing cost, and improving quality of care. Prospective PCP selection, and therefore prospective beneficiary attribution, to a provider significantly facilitates application of the right care delivery to the right patient at the right time. This can be managed through the SHP enrollment process.

Principle 2 – Improve clinical quality outcomes for the population

The SHP and healthcare providers in North Carolina agree that clinical quality outcomes of care delivered to SHP members must improve. To achieve this goal, quality measures must be evidence-based, meaningful, and achievable. Quality performance must be integrated with financial performance to ensure that efforts to reduce cost do not negatively affect clinical outcomes. Healthcare providers must pursue clinically innovative services to address the healthcare needs of the population. For this to be successful, the quality goals put forward by the SHP should align with quality goals that are already in place with entities such as CMS, NC Medicaid, major hospital raters, and commercial partners. Creating an entirely new set of quality goals drives up costs by requiring creation of yet another parallel infrastructure by each provider system to meet the new goals. Synergy and harmony of quality goals across payers helps improve quality performance and reduce total cost of care.

Quality Program Requirements:

1. Defined set of clinical quality measures that cross preventive care, acute care and various populations including adults, children, and maternity care.
2. Performance thresholds based on state and national norms and designed such that 100% quality performance is realistically achievable. These metrics should be coordinated with the metrics of the Medicaid program, the major commercial products in the state etc., so providers can focus on meaningful quality improvement driven by a focused set of important quality targets.
3. Obtaining high quality performance is essential for the well-being of the SHP members, and the system should provide the opportunity to earn incentive for high quality performance independent of meeting total cost of care metrics.
4. In order to achieve cost savings for complex patients, the plan should strongly consider a care management fee. For example, NC Medicaid is paying roughly \$12 per member per month for advanced medical homes, where the sickest patients are managed.

5. Quality performance has direct financial impact for the provider. A provider with low quality will see a significantly reduced financial benefit for participating. Said another way, those providers who reduce cost and achieve high quality will be successful in the plan. Examples include:
 - a. Shared savings payments are impacted by quality performance. If a system achieves 90% of their quality performance target (out of a possible 100%), any shared savings are correspondingly reduced.
 - b. Expected cost of care benchmark is reduced by X% (2% for example), and the ability to “earn back” that 2% is directly related to quality performance. If aggregate quality performance is 90%, then the provider earns back only 90% of the 2% (i.e. can only earn back 1.8%).
6. Any funds that do not go to providers based upon this payment reduction attributed to missing 100% quality could be contributed to an SHP Membership Support Fund (i.e. if an ACO achieves 80% quality on \$1m savings, the ACO would receive only \$800k in savings, with the remaining \$200k going to the Membership Support Fund). Members could seek grants from fund in support of clinical-related expenses causing financial hardship.

Clinical Innovation:

The SHP commits to engaging in quality programs that improve care delivery and reduce total cost of care to meet population needs.

1. Investments in behavioral health, including integrated behavioral health, management of severe mental illness and innovative solutions for family and community support of mental illness.
2. Designating statewide high quality centers of excellence such as for opioid use disorder treatment, with enhanced financial models to support.
3. Support virtual health platforms to extend high value services to rural communities thereby limiting the impact of specialty coverage gaps in communities with limited scope of services.
4. Co-create enhanced financial models to incentivize reducing cost for highly complex care.

Principle 3 – Improve pricing transparency

The SHP and healthcare providers in North Carolina agree that increased transparency of the pricing of healthcare services can facilitate employer, patient, and provider choice about utilizing the highest value healthcare services, and reduce the overall cost of healthcare.

Price Transparency Pledge:

All participating providers agree to develop with the SHP and publish the following programs designed to enhance transparency:

Price Estimator for Services Provided by Participating Hospitals

Description:

1. Out-of-pocket cost estimates based on the members’ specific benefits, starting with a fixed set of frequently produced episodes of care (i.e. estimate the cost of an uncomplicated colonoscopy)
2. Estimates provided by phone or patient portal; self-service online tool co-developed with the SHP during 2020
3. Providers can chose to offer out-of-pocket cost guarantees

Member Benefit:

1. Know estimated out-of-pocket cost of service in advance and at time of service
2. Ability to compare member costs across providers

Financial Navigation Provided by Participating ACOs / Health Systems

Description:

1. Dedicated service for SHP members
2. Available by phone or in-person with eventual expansion to online chat
3. Assistance in accessing resources for insurance coverage clarification, patient liability solutions (payment plans, grants, drug replacement, financial assistance)

Member Benefit:

1. Simplified access to a participating ACO / Health System's financial support services
2. Reduced out-of-pocket expense, particularly for lower income households
3. Higher participant satisfaction

Price / Rate sharing for ACOs / Health Systems entering the at risk model

Description:

1. Allow ACOs / Health Systems that choose to engage with SHP in the value-based care model to see the costs of services for their attributed patients seen elsewhere (i.e. other providers' rates)

Member Benefit:

1. Enables providers to better identify high value care options for members
2. Lower out-of-pocket costs to members referred to higher value provider options
3. Lower premiums as effectiveness of value-based care delivery improves

Publish SHP Rates

Description:

1. Each participating hospital will publish average allowable levels for SHP members expressed as a percentage Medicare for OP and IP services, or SHP will publish the same information on a single site

Member Benefit:

1. Ability to more easily shop for lower cost facilities

Hospital-based Clinic Clarity Statement

Description:

1. Display hospital-based clinic emblem at all hospital-based clinics
2. Provide a simplified explanation of each hospital's approach to hospital-based clinics
3. Provide SHP members with explanation of how "Independent Clinic" status impacts billing and reduces members' out-of-pocket expense

Member Benefit:

1. Reduced member confusion and potential reduced costs

Principle 4 – State Health Plan and partner to implement full financial plan

Providers that sign up for this plan will be agreeing to reduced rates, limited ability for future rate increases, as well as potential payments to the State Health Plan for failure to provide care below a benchmark cost. These commitments create heightened risk to the providers that sign on. The State Health Plan and healthcare providers in North Carolina agree that members meeting their financial obligations is an important element of the overall financial health of providers and members alike, and commit to programs to reduce these impacts including:

1. SHP would assist in reducing bad debt through program similar to SODCA
2. Members with debt obligations would have to maintain good financial standing by participating in a payment plan
3. Members with certified bad debt would be placed on a payroll withholdings of up to 10% of net monthly income
4. Members with family income below 200% of FPL would be exempted from program

5. SHP would use the withholdings to reimburse a fixed percent of bad debt for participating providers (similar to Medicare)
6. SHP would engage with participating providers to design and test options to enhance member affordability of health care.

Such a program will ensure that members meet their obligations, while also contributing to a model that can hold down future rate changes.

Principle 5 – Provide a stable transition to a long-term sustainable State Health Plan

The State Health Plan and healthcare providers in North Carolina agree that a fiscally sustainable and properly funded State Health Plan as well as a fiscally sustainable provider community is vital to North Carolina's economic future.

The state will instruct the Sheps Center to conduct an annual assessment of the sustainability of the State Health Plan and the provider community. This assessment will include an analysis of SHP's funding levels and projected needs as well as the fiscal health of North Carolina's provider community to include but not be limited to rural health providers (hospitals included) and other vital health care providers.

FAQ for UNC Health Care's Proposal for State Health Plan Modernization

1. What are the proposed cost savings under this plan versus the Clear Pricing Project?

We are working on models to estimate the statewide savings, but at this time we do not have all the data necessary to answer this accurately. We have heard that BCBSNC estimated statewide implementation of their Blue Premier model would result in \$200 million total cost savings over five years as a comparison. Our proposed program builds in a rate reduction by reducing provider rates 2.5% and limiting future rate increases in addition to creating a value-based care model with strong incentives to further moderate costs. The 2.5% rate reduction is estimated to be worth \$10 million in savings across UNC Health Care entities alone in the first year. Our proposal does address and limit future rate growth in a manner that would further ensure total costs of care below industry trend levels.

2. Does this plan disproportionately benefit UNC Health Care?

This proposal was written without consultation of other health systems, though it is intended to create a structure that may generally be viewed as acceptable. The design is not intended to advantage UNC Health Care relative to other health systems. However, as the State's health system and a major employer of state employees, we would seek the opportunity to partner with SHP on unique opportunities that further improve the health and affordability of their health plan or improve the administrative efficiency of the plan.

3. Several important elements of this program are limited to the Triangle / Triad for the initial three years. What happens for the rest of the state?

Ideally, this program could be rolled out statewide within three years. If there are regions with no willing participants, we would need to explore alternatives to entice greater interest. Other providers across the state are eager to find suitable solutions for the SHP. As such, we would propose to work in collaboration with other like-minded provider groups to hone this proposal to ensure it is widely accepted.

4. Will BCBSNC be involved in this? Have we talked to them about this proposal?

We have not discussed this specific proposal with BCBSNC, but acknowledge we would need their engagement in order to make this model viable. BCBSNC would be involved in this as the program administrator for the first three years, but this model could transition to another third party administrator in the future.