

The State Health Benefits Quality and Value Task Force: Short-term Recommendations

In June 2018, Governor Phil Murphy signed Executive Order No. 31 creating the State Health Benefits Quality and Value Task Force. The Executive Order noted that New Jersey's state government, local government, and school employees deserve health care coverage that delivers quality health outcomes while being a good value for enrollees and taxpayers. The Governor charged the Task Force with undertaking a comprehensive review of public employee and retiree health benefits programs. The goal of the review is to identify strategies to achieve better health outcomes and better management of the costs of employee and retiree health benefits.

The State Health Benefits Program (SHBP) and the School Employees' Health Benefit Program (SEHBP) provide health coverage to State employees, retirees and eligible dependents as well as to employees, retirees and eligible dependents of local governments and school districts that have elected to purchase coverage through the plans. Together, SHBP/SEHBP cover more than 800,000 lives. The total cost to the State and local participating employers is estimated to be \$6.9 billion in 2018. The State of New Jersey spends about 8.4 percent of its budget or about \$3.4 billion a year on these programs.

The Task Force is comprised of State leaders, academic experts, labor leaders, and employer representatives (See Appendix A). It initially convened in July and has met regularly in the intervening months. The Task Force has sought public input through its [Web site](#), and hosted three listening sessions with public employees, retirees and other stakeholders in Hamilton, Rutherford, and Mount Laurel.

The Task Force is using this input to inform its larger charge of identifying long-term reforms of the employee and retiree health benefits system. In the short-term, the Task Force has identified a series of quickly actionable recommendations to improve the contracting and management of SHBP/SEHBP. The State manages SHBP/SEHBP through a contractual relationship with a third-party that is responsible for claims administration, provider network oversight, and other administrative functions. These Task Force's short-term recommendations focus on changes to the SHBP/SEHBP third-party administrator (TPA) contract to:

- Support innovation to improve health outcomes and costs;
- Improve contractor accountability;
- Prioritize quality;
- Ensure access to care; and,
- Use data and analytics to improve outcomes and reduce costs.

Support Innovation to Improve Health Outcomes and Costs

The State/TPA and provider network vendor relationship is currently governed by a contract let by the State in 2012. In the intervening years, much has changed about the nature of health care delivery and organization, including the significant delivery system and market changes that have occurred as a result of the Affordable Care Act (ACA).

For example, the ACA launched a number of pilot programs and demonstrations to test new ways to deliver and organize care, including Accountable Care Organizations, episodes of care models, and advanced primary care practice models. These models offer the opportunity to test new ways to get better value from the health care system and to identify strategies for organizing how care is delivered to achieve health care's "triple aim" of improved health, better care, and lower costs.

The current SHBP/SEHBP contract fails to provide the flexibility necessary for the programs to undertake similar pilots and demonstrations. Under the current contract, SHBP/SEHBP has attempted to implement a direct primary care pilot program, yet TPA contract obstacles have affected the implementation of the pilot. A notable barrier has been limited access to data to support recruitment, care management and evaluation. Absent broader flexibility, the SHBP/SEHBP has had limited ability to test innovations that would make the SHBP/SEHBP a more active purchaser of benefits and better positioned it to get efficiencies and value for its health care dollars.

Recommendations:

The Task Force believes that the SHBP/SEHBP should use its leverage as a payor that spends almost \$7 billion in total state and local expenditures a year on health care to drive better health outcomes at lower costs. The Task Force believes well-designed and evaluated pilot programs are essential to realizing that goal.

- The Task Force recommends that the State's third-party contract for administering SHBP/SEHBP specifically include the ability of the SHBP/SEHBP to contract directly with select providers or vendors for the purpose of pilot testing, surveying, and evaluating care delivery and payment innovations to achieve higher quality and more efficient care.
- The Task Force recommends continuing the direct primary care pilot while addressing implementation barriers, expanding patient recruitment efforts, and providing data to support strategic program growth.
- The Task Force recommends that one of the initial pilots focus on behavioral health, including a focus on trauma informed care, and that the pilot be informed by direct engagement with enrollees. The Task Force notes the role that collective bargaining units can play in engaging enrollees in this work, especially with respect to identifying where and what type of access issues enrollees have encountered.
- The SHBP/SEHBP should invest in the development, design, and implementation of innovative pilots and take to scale those that prove effective at reducing costs and maintaining or improving health outcomes.

- The contract also should ensure that historical and current claims and other data maintained by the contractor is readily available to the SHBP/SEHBP or its designee to ensure the effective execution and evaluation of the pilot projects.
- Further, the Task Force strongly recommends that the State and vendor contractual relationship is clear that the TPA has a fiduciary responsibility to the State to act without conflict and in the best interest of the State.

Improve Contractor Accountability

The Task Force is concerned about the length of the current third-party administrator and provider network contract and the effect such a long contract has had on the management of the benefit programs. It also is concerned about the contract's limited expectations for vendor oversight and management of the provider network.

A long-term, fixed contract provides little to no opportunity for innovation or re-negotiation based on the changing dynamics in the health care delivery system, the economy, or other external factors. It also does not allow the SHBP/SEHBP to implement new tools to increase management and oversight of the contractor as novel issues arise during the contract term.

Further, while the current contract prioritizes the important task of claims administration, in doing so, it puts less emphasis on network management, on leveraging the size of the SHBP/SEHBP's business to negotiate best prices with providers, on innovation, and on ensuring program integrity by validating that the SHBP/SEHBP is paying the appropriate negotiated prices.

Recommendations:

The Task Force believes the purpose of the third-party administrator (TPA) and provider network contract(s) should be to get SHBP/SEHBP the best possible access to services for the most reasonable cost. It is not clear to the Task Force that the current structure of the TPA and provider network contract produces that outcome.

- The Task Force recommends reducing the length of the contract term to three years with a one-year extension option. The contract should be long enough to ensure time to learn from new pilots and other innovations put in place, but short enough to allow for adjustments to the contract terms as changes are needed. The timeframe also needs to allow reasonable time for the Treasury to manage soliciting and awarding contracts.
- The Task Force also recommends better vendor accountability in the contract. Options for increasing accountability include:
 - Real-time or near real-time auditing of claims data to ensure the SHBP/SEHBP is paying the appropriate negotiated price for services with access to data on allowable charges to facilitate timely auditing; and

- Unbundling the management of the provider network function in the current contract from the claims administration function to ensure that the winning vendor or vendors bid separately for each function.

Prioritize Quality

Together, the SHBP and SEHBP provide health care coverage to more than 800,000 New Jerseyans. The SHBP/SEHBP pays almost \$7 billion in total state and local costs for their care. Yet the SHBP/SEHBP's expectations from its vendors for the quality of the care provided are not well articulated. The quality management expectations in current contract are as follows:

“The Contractor must monitor, evaluate and take action to address improvements in the quality of health care delivered by all network providers through the implementation of a continuous quality assurance program. The Contractor must provide the State Contract Manager with all updates to its quality management program.”

Although the contract includes performance standards, financial guarantees and liquidated damages (financial penalties for non-performance) for other provisions, it does not specifically apply these accountability tools to the clinical quality of the benefits delivered. While contractors are encouraged to apply more stringent performance standards/liquidated damages than the contract outlines, the contractor is not required to be more specific and the SHBP/SEHBP does not take an active role in setting these expectations. Without clearly identified quality expectations and metrics, there is limited accountability for prioritizing and improving the quality of care delivered in SHBP/SEHBP.

Similarly, the current contract requires the vendor to provide voluntary disease and case management programs, but offers little in the way of expectations for what the programs should do, or what outcomes are expected from this requirement. Case management can be a valuable tool in helping to improve the health of individuals with chronic and complex conditions, individuals with behavioral health conditions, and those transitioning from hospitals or other institutional care settings to the community. The contract does not identify populations, services or metrics for case management services.

Recommendations:

The Task Force believes that the SHBP/SEHBP must set clear expectations for clinical quality improvement and that its provider network must include metrics, goals and penalties for achieving or failing to achieve these expectations.

- The Task Force recommends that the contract include performance standards for clinical quality outcomes.
- SHBP/SEHBP should set well-defined clinical quality metrics, measure the contractor's performance based on these metrics, and hold it accountable for the outcomes, including through quality incentive payments/penalties, liquidated damages, or additional financial tools.

- The Task Force encourages the SHBP/SEHBP to target these quality initiatives toward high cost chronic conditions and other disease states with significant disparities in health outcomes.
- The Task Force recommends that the contract set clear expectations and metrics for the development, implementation and evaluation of case management programs. For example, there are opportunities to use case management to deliver better outcomes and potentially reduce costs for key populations by better managing and coordinating their care to reduce hospital readmissions, emergency department utilization, and/or complications from poor medication management and adherence.
- The plan design committees should consider requiring participation in care management programs for members with complex, high cost conditions where evidence from other research suggests better coordination of care would improve patient outcomes and reduce costs.

Ensure Access to Care

The Task Force is concerned about enrollee access to critical behavioral health services, including mental health and substance use disorder prevention, treatment, and recovery supports. The current contract requires the vendor to provide a network of behavioral health providers based in, but not limited to, the following settings: inpatient hospital, outpatient hospital, day/partial hospitalization, residential care, short-term therapy, and crisis intervention.

Although the contract is very specific with respect to behavioral health care settings, it otherwise treats network requirements for behavioral health as it does any other medical specialty. In contrast, the current contract is very specific about its expectations for the vendor's primary care physician network, including requiring that it is sufficient to "assure that the following criteria shall be met:

- a) emergencies must be triaged immediately through the primary care physician or by a hospital emergency room through medical screening or evaluation;
- b) urgent care must be provided within 24 hours of notification of the primary care physician or Contractor;
- c) in both emergent and urgent care, primary care physicians must be required to provide seven day, 24 hour access to triage services;
- d) routine appointments must be scheduled within two (2) weeks; and
- e) routine physical exams must be scheduled within four (4) months."

Recommendations:

The Task Force believes that access to mental health and substance use disorder services is a critical concern and that the SHBP/SEHBP should be much more detailed in setting parameters for what constitutes network adequacy for behavioral health.

- The Task Force believes mental health and substance use disorder warrant dedicated language in the contract similar to the primary care section that clearly defines expectations for the timely access to emergent and urgent care and to routine care services.
- Similar to the current contract section on obstetrics/gynecology, the Task Force recommends that going forward the contract should be clear about the scope of services that must be covered for mental health and substance use disorders and the levels of prior authorization required.
- The Task Force firmly believes that the network manager must have a behavioral health network that meets member needs as defined in the vendor contract. Although plan members may choose to go out-of-network for services in plans that provide out-of-network coverage, plan members should never feel compelled to go out-of-network because the network manager failed to meet access requirements. On-line provider search tools must include and customer service representatives must convey up-to-date information about who is in-network. The TPA also should have a process in place and clearly explain the availability of single case agreements to enrollees, so that the plan will facilitate and the enrollee can see an out-of-network provider with in-network member cost sharing should issues arise with the plan meeting adequate in-network access. This option must be clearly conveyed to enrollees in plan material, handbooks, etc. and customer service staff must be trained to give enrollees this information Plan design committees should continue to monitor and address behavioral health network adequacy.
- The Task Force urges the plan design committees to evaluate access to mental health and substance use disorder payment rates relative to market rates and Medicare/Medicaid rates and access to services to determine their adequacy.

Use Data and Analytics to Improve Outcomes and Reduce Costs

The SHBP/SEHBP's current contract does not provide the SHBP/SEHBP timely access to claims and cost data to evaluate critical issues that affect the SHBP/SEHBP's health care costs and enrollees' clinical outcomes. Key issues where the SHBP/SEHBP would benefit from better real-time data and analytics include in-and-out of network utilization patterns and other cost drivers.

Without timely data, the SHBP/SEHBP and its plan design committees are limited in their ability to make informed decisions about changes in the structure of plan benefits to produce better outcomes and lower costs.

Recommendations:

The Task Force believes that the SHBP/SEHBP plan design committees need to make evidence-informed decisions about plan design and that timely claims and payment data is essential to these decisions.

- The Task Force recommends that the third-party contract for managing claims payment and administration clearly provide for real-time cost and utilization data and that SHBP/SEHBP conduct continuous ongoing analysis of this data to identify and pursue steps to lower costs across the programs.
- The Task Force recommends that penalties should accrue to the vendor for any failure to produce timely data to the SHBP/SEHBP.

Conclusion

The Task Force believes that the actionable, short-term steps identified in these recommendations will make a meaningful difference in the value of the State's and other public employer's investment in SHBP/SEHBP. Action on these recommendations will help improve the quality of the programs, identify opportunities to reduce costs, and strengthen the SHBP/SEHBP's management and oversight of the programs. The Task Force looks forward to continuing its work on the larger charge from the Governor of identifying broader program reforms.

Appendix A: Members of the State Health Benefits Quality and Value Task Force

- Carole Johnson, Commissioner, Department of Human Services, Chair
- Mark Blum, America's Agenda
- Joel Cantor, Rutgers Center for State Health Policy
- Marlene Caride, Commissioner, Department of Banking and Insurance
- Michael Cerra, NJ League of Municipalities
- Donna M. Chiera, American Federation of Teachers
- Philip J. Degnan, Comptroller, State Comptroller's Office
- Shereef Elnahal, Commissioner, Department of Health
- Heather Howard, Princeton's State Health and Value Strategies
- John Jacobi, Seton Hall Center for Health Law and Pharmaceutical Policy
- Kevin Kelleher, New Jersey Education Association
- Kevin Lyons, Policemen's Benevolent Association
- Elizabeth Muoio, Treasurer, Department of Treasury
- Pete Nowak, International Association of Fire Fighters
- Jonathan Pushman, NJ School Boards Association
- Hetty Rosenstein, Communications Workers of America
- Steve Tully, American Federation of State, County and Municipal Employees

Appendix B: Executive Order No. 31

EXECUTIVE ORDER NO. 31

WHEREAS, New Jersey's state government, local government, and school employees deserve health care coverage that delivers quality health outcomes while being a good value for enrollees and taxpayers; and

WHEREAS, the State Health Benefits Plan ("SHBP") and the School Employees' Health Benefits Plan ("SEHBP") together cover over 800,000 active and retired members in New Jersey, nearly one-tenth of the State's population; and

WHEREAS, these employee and retiree health benefit costs are projected to be approximately 8.4 percent of the State's overall FY 2019 Budget, at \$3.2 billion; and

WHEREAS, New Jersey is committed to producing fiscally responsible budgets that continue to invest in the health and welfare of a strong public workforce, while also ensuring resources are available for vital new initiatives such as modernizing our transit system, strengthening our schools, and making higher education more affordable; and

WHEREAS, to achieve these goals, New Jersey seeks to support public employees and be a good steward of state resources, while identifying new ways to get the best value for our health care dollars; and

WHEREAS, unions representing public employees are rightfully

concerned with ensuring that health care coverage for their members is sufficiently comprehensive, and should be seen as partners in the effort to maximize the value of health care expenditures; and

WHEREAS, a comprehensive review of employee and retiree health benefits programs is necessary to identify strategies to improve the value of our state government, local government, and school employee health care investments to achieve better health outcomes and better management of the costs of employee and retiree health benefits; and

WHEREAS, such a review should be conducted by State officials and stakeholders who represent a variety of perspectives and who have the expertise to develop innovative solutions; and

WHEREAS, this review will provide the State Health Benefits Commission ("SHBC") and the School Employees' Health Benefits Commission ("SEHBC") Plan Design Committees with opportunities for the State to be a leader in the broader effort to design, purchase, and deliver health care services more efficiently and effectively;

NOW, THEREFORE, I, PHILIP D. MURPHY, Governor of the State of New Jersey, by virtue of the authority vested in me by the Constitution and by the Statutes of this State, do hereby ORDER and DIRECT:

1. There is hereby created the State Health Benefits Quality and Value Task Force (the "Task Force") that will evaluate the employee and retiree health benefits systems and make recommendations to provide quality and value in the State's health benefits in a cost-effective manner.

2. The Task Force shall be composed of at least 16 member|s, including the State Treasurer or a designee, serving ex officio; the Commissioner of Banking and Insurance or a designee, serving ex officio; the State Comptroller or a designee, serving ex officio; the Commissioner of Human Services or a designee, serving ex officio; and 12 public members, who shall be appointed by the Governor and shall serve at his or her pleasure, as follows: four individuals who have experience, knowledge or expertise in the areas of health policy and/or procurements; six representatives from six different employee organizations; one representative from the New Jersey League of Municipalities; and one representative from the New Jersey School Boards Association. The Governor shall select a chairperson from among the members of the Task Force. All public members of the Task Force shall serve without compensation.

3. The Governor may, as determined to be appropriate, appoint additional members to the Task Force, who shall serve at the pleasure of the Governor.

4. The Task Force shall organize as soon as practicable after the appointment of its members, and shall convene as often as practicable and as requested by the Governor or chairperson.

5. The Task Force is authorized to call upon any department, office, division or agency of this State to supply it with data and any other information or assistance available to such agency

and any other information or assistance available to such agency as the Task Force deems necessary to discharge its duties under this Order. Each department, office, division or agency of this State is hereby required, to the extent not inconsistent with law, to cooperate fully with the Task Force within the limits of its statutory authority and to furnish it with such assistance on as timely a basis as is necessary to accomplish the purposes of this Order. The Task Force may consult with experts or other knowledgeable individuals in the public or private sector on any aspect of its mission.

6. The Department of the Treasury shall provide staffing for the Task Force to the extent permitted by law and within existing appropriations.

7. The objectives of the Task Force shall include, but not be limited to, the following:

a. Examining the current and future costs of employee and retiree health benefits to State and local government workers and to the State and local governments;

b. Identifying opportunities for short-term improvements, including best practices in health management, potential efficiencies to improve health outcomes, and plan design opportunities; and

c. Exploring long-term reforms for the broader employee and retiree health benefits system.

8. The Task Force shall be purely advisory in nature, and shall release recommendations as appropriate.

9. This Order shall take effect immediately.

[seal]

GIVEN, under my hand and seal this
20th day of July,
Two Thousand and Eighteen,
and of the Independence of
the United States, the Two
Hundred and Forty-Third.

/s/ Philip D. Murphy

Governor

Attest:

/s/ Parimal Garg

Deputy Chief Counsel to the Governor