

## **Meeting Agenda | Health Care Policy Committee**

Thursday, February 18, 2016 | 8:30 a.m.

200 Arbor Lake Dr., Columbia, SC 29223 | Second Floor Conference Room

- I. Call to Order
- II. Adoption of Proposed Agenda
- III. Approval of Meeting Minutes- January 21, 2016
- IV. Executive Session pursuant to S.C. Code Ann. Section 30-4-70(a)(2) for the specific purpose of receiving legal advice regarding PEBA's statutory authority as it relates to the State Health Plan
- V. Strategic Planning Discussion
- VI. Old Business/Director's Report
- VII. Adjournment

### **Notice of Public Meeting**

This notice is given to meet the requirements of the S.C. Freedom of Information Act and the Americans with Disabilities Act. Furthermore, this facility is accessible to individuals with disabilities, and special accommodations will be provided if requested in advance.

**PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM**  
**Health Care Policy Committee**

**Meeting Date: February 18, 2016**

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**1. Subject:** Strategic Planning Discussion

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**2. Summary:** Bobby George from Human Resources will facilitate a strategic planning discussion

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**3. What is Committee asked to do?** Make changes to strategic plan as needed

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**4. Supporting Documents:**

(a) Attached:

1. Health Care 2016- with Schedule
2. Enabling Legislation
3. Health Care Policy Charter
4. Venn Diagram
5. Health Board Member Suggestions
6. Health Committee Performance Dashboard
7. Best Practices Cover Sheet
8. Strategic Initiatives
9. PEBA Strategic Plan Progress Report 2-16-16
10. Board Strategic Plan

## Health Care Policy Committee Meeting Agenda Suggestions

Strategic Items – Discuss in a facilitated session at the Feb. 18, 2016 meeting. Meeting will be adjusted to a 4 hour session.

### Mission (1 hour)

#### Dialogue

- Review the current mission statement in the health care committee charter.
- Review PEBA's statutory guidance
- Review what is within PEBA's control and what is outside of PEBA's control
- Review what is within PEBA's influence
- Review the key mission expectations (measurable)

#### Expected Result

- Gain consensus on the mission and key mission expectations

### Goals (1 hour)

#### Dialogue

- Review PEBA's current goals for the health care committee
- Discuss any new goals for the health care committee

#### Expected Result

- Gain consensus on the goals for the health care committee

### Action Items (2 hours)

#### Dialogue

- Review the process from 2015 (do we have an updated Segal report?)
- Review the current action items
- Review items from December 2015
- Review and prioritize any new action items

- Review any additional measurements that are needed

#### Expected Result

- Consensus on action items for 2016
- Consensus on direction of action items for 2017-2018

**Reporting (3 hours) – Discuss in a facilitated session at the March 17, 2016 meeting. Meeting will be adjusted to a 4 hour session.**

Goal: Gain consensus on how staff should communicate with the Board to support effective communication, the accomplishment of strategic goals and the fulfillment of the mission.

Expected Result: At the end of the meeting there will be a clearly identified set of reports to meet the purpose of on-going standard reporting to the Board. Current reports will either be accepted or modifications will be identified. A specified cycle for each report will be developed. Dates for delivery will be determined.

- Plan Status Report (are changes needed?)
- Dashboard (are changes needed?)
- Provide more data on the highest cost drivers
  - Prioritize the top 5 conditions and have an operating plan to address and improve each condition
- Develop Population Health Reports
  - What do we want to measure?
    - Metabolic risk factors?
  - What do we want to improve?
- Develop overall list of VBID Items
  - Determine our compliance with VBID Items
  - Identify any gaps
    - Develop a roadmap to close those gaps
- ACA (plan design) roadmap
  - Show roadmap since PEBA's inception
- Public Policy Communications
  - Finalize format for providing options on plan design and cost to the Legislature and Governor's Office
- Quarterly Reports from BC/BS on the following (should include dollar impact, number of members and overview of the current aspects of each program.):
  - UM
  - CM

- Behavioral Health CM
- Maternity CM
- Recommendations for cost savings
- Quarterly from ESI on the following (should include dollar impact, number of members and overview of the current aspects of each program):
  - Drug Utilization
  - Rx Count
  - Quantity
  - Unit cost
  - Generic dispensing rate
  - Recommendations for cost savings
- Quarterly reports on active health
- Progress on strategic goals
- Communications Update (with employers and members)
- MUSC Pilot Review

On-going Health Care Agenda Items (1 hour) – Discuss in a facilitated session at the March 17, 2016 meeting. Meeting will be adjusted to a 4 hour session.

## Normal Schedule

### January

- Communications update – Goals for the Year
- Active Health Quarterly Presentation
- Strategic Action Plan Review

### February

- Benchmark Update
- Strategic Plan Review
- ASO TPA Quarterly Presentation

### March

- Financial Overview
  - Presentation of Financial Statements
  - Presentation of Plan Summary Report
- OPEB education session and annual valuation review
- Pharmacy TPA Quarterly Presentation

#### April

- Active Health Quarterly Presentation
- Strategic Action Plan Review

#### May

- ASO TPA Quarterly Presentation

#### June

- MUSC plan review
- Strategic planning updates (if needed – are there any recommended changes from February?)
- Pharmacy TPA Quarterly Presentation

#### July

- Approval of plan design
- Active Health Quarterly Presentation
- Strategic Action Plan Review

#### August

- Review 5 largest cost drivers and current and future plans to address them
- ASO TPA Quarterly Presentation

#### September

- Pharmacy TPA Quarterly Presentation

#### October

- Active Health Quarterly Presentation
- Strategic Action Plan Review

#### November

- Finalize funding requirements
  - Need to do a plan accounting that shows money saved
  - Format with options
- ASO TPA Quarterly Presentation

#### December

- Pharmacy TPA Quarterly Presentation

### 2016 Schedule – Additional Topics

### Communications Review

- Health Hub Overview
- New Website Overview
- BC/BS Website Overview
- ESI Website Overview
- Employer Services Overview
- Communications Collaboration Overview

### OPEB education session and annual valuation review

- What is OPEB?
- How does the trust fund work?
- What are the statutory constraints?
- How is it funded?
- Which employers/members are covered?
- How do we compare with other states?
- How is our plan different from private sector? How is it the same?
- How will the new GASB statements work?



# Enabling Legislation

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**SECTION 1-11-710.** Board to make insurance available to active and retired employees; Insurance Reserve Fund to provide reinsurance; cost to be paid out of appropriated and other funds.

(A) The board shall:

(1) make available to active and retired employees of this State and its public school districts and their eligible dependents group health, dental, life, accidental death and dismemberment, and disability insurance plans and benefits in an equitable manner and of maximum benefit to those covered within the available resources;

## Health Care Policy Committee Charter

[As adopted by the PEBA Board on 6.17.15]

**(A) Mission:** To ensure a financially sustainable health program that improves member health, provides a positive member experience (outcomes; safety; satisfaction), and gives the participating employers a competitive, productively engaged workforce.

**(B) Authority:** The authority of the Health Care Policy Committee is limited to information-gathering and advice and recommendations to, and on behalf of, the Board, and to ministerial acts. The Committee may invite administrators, consultants, staff, external auditors, and/or others to attend meetings and provide pertinent information as necessary. PEBA Board of Directors Bylaws, Section V(C).

**(C) Composition:** The Health Care Policy Committee shall be established pursuant to the process defined in the PEBA Board of Directors Bylaws.

**(D) Meetings:**

- (1) The Health Care Policy Committee will meet as circumstances require upon the call of the Committee Chair.
- (2) Health Care Policy Committee meetings shall adhere to the rules outlined in the PEBA Board of Directors Bylaws and with applicable law.

**(E) Responsibilities:** The Health Care Policy Committee will carry out the following responsibilities:

- (1) Develop a strategic plan for PEBA insurance functions in conjunction with PEBA staff and consultants, make recommendations to the PEBA Board, and evaluate the implementation and success of the plan.
- (2) Approve pilot projects for upcoming plan years that focuses on improved health and lower costs, with appropriate evaluation methods of health outcomes, costs, and resources identified;
- (3) At least quarterly, meet with the PEBA Executive Director, or a designee, regarding the operational and financial performance of the PEBA insurance programs to monitor progress toward strategic objectives and make recommendations to the PEBA Board;
- (4) No later than November of each year, develop recommendations to the PEBA Board concerning proposed premiums for the proposed State Health Plan for the Plan Year beginning thirteen months later for purposes of the State's budgeting process;
- (5) No later than July of each year, considering the final State budget, make recommendations to the PEBA Board regarding the final State Health Plan design and final premiums for the State Health Plan for the Plan Year beginning six months later;
- (6) Receive information from the actuaries concerning the Other Post Employment Benefits (OPEB) valuations for retirees in the State Health Plan and for beneficiaries of Long-Term Disability benefits and make recommendations to the PEBA Board; and

(7) Oversee agency communications involving areas of Health Care responsibilities.

**As approved and adopted:**

**SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY  
BOARD OF DIRECTORS**

By: \_\_\_\_\_  
Arthur M. Bjontegard, Jr., Chairman

By: \_\_\_\_\_  
Frank W. Fusco

By: \_\_\_\_\_  
Stacy Kubu

By: \_\_\_\_\_  
Steve A. Matthews

By: \_\_\_\_\_  
Audie Penn

By: \_\_\_\_\_  
David J. Tigges

Dated: \_\_\_\_\_

By: \_\_\_\_\_  
Peggy G. Boykin, CPA

By: \_\_\_\_\_  
Stephen Heisler

By: \_\_\_\_\_  
Sheriff Leon Lott

By: \_\_\_\_\_  
Joe W. "Rocky" Pearce, Jr.

By: \_\_\_\_\_  
John A. Sowards

# Who are we?

## State Health Plan

**Statue in Section 1-11-710 of the S.C. Code of Laws**  
PEBA shall make available to active and retired employees of this State and its public school districts and their eligible dependents group health, dental, life, accidental death and dismemberment and disability insurance plans and benefits in an equitable manner and of maximum benefit to those covered within the available resources.

## Insurance company

## Self-insured employer



| Item number | Category                                   | Health Plan and Related Opportunities Board Suggestions   |
|-------------|--|---|
| 1           | ACA Plan Design                            | Develop an ACA compliant replacement plan that will be cost neutral with offsetting savings from new contracts (i.e. PBM changes), wellness initiatives, higher co-pays, deductibles, etc.  |
| 2           | ACA Plan Design                            | Same concept as above, but offer as an alternative plan (determine if OK under ACA) with same design, but with lower employee contributions & assume certain levels of participation (10%, 20%, etc.)   |
| 3           | ACA Plan Design                            | I think there needs to be a transition from the current budgeting process of providing the two extremes (i.e. cost to continue previous year's benefit and cost of ACA). We should provide option in between these extremes, bridging the ACA gap, with PEBA's recommended option.  |
| 4           | Legislative Communication                  | Formalize the process of communicating options and recommendations documenting our fiduciary actions.   |
| 5           | New projects                               | Identify up to five of the most significant wellness and health management initiatives that can demonstrate a three year break even ROI   |
| 6           | Work-site Clinics                          | Determine the viability of work-site clinics in areas with high concentrations of employees and calculate potential ROI   |
| 7           | Communications                             | Brand all health care communications with a focus on wellness, prevention & early detection   |
| 8           | Communications                             | Communication needs to be a continuing priority....that is "it's your money (the self insured idea)" and "how to spend it in the wisest manner". All communicators should be aligned around the message.  |
| 9           | Communications                             | Provide easily accessible, fact based, useful information for for health plan participants to make the best health outcome choice in key medical decisions. (this discussion is underway with Rob Tester) I think our mission statement could use some emphasis as to this.   |
| 10          | Targets                                    | During our offsite, we need to give the staff rolling 3-5 year targets for population health improvements and PMPM costs. We can adjust the actual targets in a specific budget year, if necessary. Included should be actions associated with tracking and managing our performance.   |
| 11          | Targets                                    | There should be specific objectives that impact our top 3-5 cost and/or health drivers. Included should be actions associated with tracking and managing our performance.   |
| 12          | Reporting                                  | There needs to be a process of tracking, reporting and managing the various pilots, initiatives, programs, etc. to validate they a delivering/meeting expectations.   |
| 13          | Mission Statement                          | My primary interest area is that we have a meaningful mission statement that is tied to key measures (a dashboard is a general term for this)...the attachment explains it...i think this would require, and benefit us more if we had a facilitator for the process to enable us to develop consensus, and we should include key health staff in the conversation. |
| 14          | Best Practice Review/Strategic Initiatives | Complete Medical TPA RFP process and implementation with assurances that claims administration, utilization management, and provider contracting management functions are adequately addressed, with new programs related to population health management and member engagement (continued focus on wellness) and other cost containment initiatives                |
| 15          | Strategic Initiatives                      | High-Value Provider Contracting: Patient-Centered Medical Homes: patient cost share incentive approved for 2016: continued growth and evolution of program and analysis of results into 2016 and beyond   |
| 16          | Strategic Initiatives                      | Specialty Pharmacy Management: Largest current cost challenge for health plan sponsors; we are speaking with ESI (2016 PBM) and BCSSC to evaluate potential solutions; there will be recommendations presented in 2016 to address specialty cost  |
| 17          | Strategic Initiatives                      | Reference Based Pricing: Hospital pricing for endoscopy reduced to non-facility level for 2016; hospital pricing for radiology and pathology moved in direction of non-facility with 10% max cut; gradual reduction will continue in 2017 and beyond until non-facility levels are reached  |
| 18          | Strategic Initiatives                      | Physician Dispensing and Pharmacy Network Management: When transition to new PBM is complete, we will work with ESI to assess new programs available to more effectively manage our pharmacy spend  |
| 19          | Best Practice Review                       | Analysis of the viability of replacing the current Savings Plan with a more viable High Deductible Health Plan that would likely draw more subscribers  |
| 20          | Best Practice Review                       | Increase engagement in disease management   |
| 21          | Best Practice Review                       | Analysis of the State Health Plan vs. the North Carolina Plan   |
| 22          | Best Practice Review                       | Analysis of the State Health Plan vs. another best in class plan identified by GRS  |

**Frank Fusco's Suggestions on designing a dashboard of key performance measures:**

The objective is to find 20 or less key measures that present a holistic view and easily comprehensible picture of the direction and level of success of the program based on the mission. A graphic format is preferred showing current level, trend, and comparative data/benchmark (Best not average).

Start with the Health Committee Mission:

**1) Is it a concise but comprehensive statement of what is truly desired to be accomplished? If it's not clear and understandable get agreement on what it should say.**

The Health Committee Charter states...

"Mission: To ensure a financially sustainable health program that improves member health, provides a positive member experience (outcomes: safety; satisfaction), and gives the participating employers a competitive productively engaged workforce."

**2) Identify the key mission expectations (key measurables) to frame a dashboard of what is to be achieved. For example...**

1. Financially sustainable
2. Improves member health
3. Positive member experience and satisfaction
4. Member Safety
5. Employers productive workforce
6. Employers competitive workforce

**3) Determine the highest level of data that proves the current level of attainment for each key mission-based expectation. Ensure that data can be accurately, timely, and easily/efficiently obtained. For example...**

1. Financially sustainable....costs lowest in the comparative group and trend is positive
2. Improves member health....population health is the highest by segment, by comparative group and trend is positive
3. Positive member experience and satisfaction.....member satisfaction surveys at 100%, trend maintained
4. Safety.....safety at 100% in all key factors, trend maintained
5. Employers have competitive workforce....health plan offerings and costs are best in class, a recruiting advantage.
6. Employers have productively engaged workforce...workforce health and on job time is increased to best in class, and trend is positive.

**4) Consider adding measures for key processes for key support, service design and delivery. For example...plan design process steps, timeline; service delivery processes state, local and contractor. The purpose is to evaluate complaints/problems and create solutions to track and improve performance.**

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# STATE HEALTH PLAN BENCHMARKING AGAINST NATIONAL BEST PRACTICES

| Strategy  | Strategies Already Implemented | Strategies in Progress | Strategies to Pursue in 2016-2017 | Strategies to Pursue in 2018 and Beyond |
|---|--------------------------------|------------------------|-----------------------------------|---|
| EGWP Implementation   | ✓                              |                        |                                   |   |
| Formulary Management  | ✓                              |                        |                                   |   |
| Prior Authorization   | ✓                              |                        |                                   |   |
| Step Therapy  | ✓                              |                        |                                   |   |
| RetroDUR Program  | ✓                              |                        |                                   |   |
| Follow the Medicare Hospital Readmissions Reduction Program to Reduce Hospital Readmissions |                                | ✓                      |                                   |   |
| Value Based Contracting: Patient-Centered Medical Homes                                     |                                | ✓                      | ✓                                 |   |
| Continued Focus on Wellness   |                                | ✓                      | ✓                                 |   |
| Medication Therapy Management Program   |                                | ✓                      |                                   |   |
| Telemedicine (Telehealth)   |                                | ✓                      |                                   |   |
| Value-Based Contracting: High-Performance Networks (Use of Narrow/Tiered Networks)          |                                |                        | ✓                                 |   |
| Reference-Based Pricing   |                                |                        | ✓                                 |   |
| Specialty Pharmaceutical Management   |                                |                        | ✓                                 |   |
| Physician Dispensing and Pharmacy Network Management  |                                |                        | ✓                                 |   |
| Value-Based Contracting: Accountable Care Organizations                                     |                                |                        |                                   | ✓                                       |

## 2016-2017 STATE HEALTH PLAN INITIATIVES

| <b>VALUE-BASED CONTRACTING: HIGH-PERFORMANCE MEDICAL NETWORKS</b> |   |
|---|---|
| <b>Description</b>  | These medical networks are made up of providers selected based upon predetermined criteria. Cost, quality and outcomes are typical criteria applied for participation in a high-performance network. A high-performance network may consist of hospitals, physicians, or both.  |
| <b>Status</b>   | PEBA staff, consultants and contractors have for months been in the process of analyzing opportunity for creating a high-performance hospital network, and a high-performance network for primary care.   |
| <b>Member Impact</b>  | Members obtaining services from participants in a high-performance network would receive favorable patient cost sharing in a manner yet to be determined. For example, on the hospital side, high-performance network services may be paid at 85%, rather than 80% as in the remainder of the SHP. Because of ACA grandfathered status, patient cost sharing could not be increased at non-participating facilities.  |
| <b>Risks and Considerations</b>                                   | <ul style="list-style-type: none"> <li>• Because of the SHP’s longstanding practice of treating all providers the same, differential treatment, even based on sound objective criteria, will be controversial.</li> <li>• Providers not selected for the high-performance network will likely pressure PEBA for inclusion.</li> <li>• Key legislative stakeholders would need to be briefed and advised as to considerations well in advance of rollout.</li> <li>• Providers qualified to participate in a high-performance network may not be distributed equally geographically, that is, there may be some regions of the state in which no providers qualify, and others in which qualifying providers are concentrated.</li> <li>• An extensive communications/marketing plan would need to be developed to promote the high-performance network and accurately inform SHP members about the change.</li> <li>• Although non-high-performance network providers will be paid at the present rate, one can expect misinformation regarding this fact, given the decentralization of the SHP group.</li> <li>• If the SHP is able to implement a high-performance network with patient incentives to obtain services within this network, it will elevate the issue of quality among both providers and members.</li> </ul> |
| <b>Target for Implementation</b>                                  | We are aiming for a January 1, 2016 effective date for the high-performance network(s). A final decision on detailed design would need to be made no later than July 15, 2015 for January 1, 2016 implementation.   |
| <b>Fiscal Impact</b>  | <ul style="list-style-type: none"> <li>• Around 40% of SHP expense (\$800 M in 2016) is located in the hospital sector (inpatient and outpatient combined). Recent efforts related to hospital quality have provided anecdotal evidence of material savings for Medicare and private insurers, but there is no literature that suggest a certain percentage savings. Actual savings for the SHP in this initiative will depend on movement of members to high-performing facilities and the enhancement of quality efforts on the part of hospitals to respond to this initiative.</li> <li>• It is considered most important to get the foundation in place that provides a patient incentive for obtaining services from providers identified as high quality, rather than obtaining immediate significant fiscal impact. A similar gradual approach was used when the SHP hospital and physician networks were established in the 1990s; these networks remain in place and are a key driver of the SHP’s cost effectiveness. The high-performance network will provide more infrastructure for control of expenditure growth, a highly effective strategy for PEBA since the inception of the direct contracted networks.</li> </ul>  |

**Effect on Grandfathering Status:**

For any of the options presented, grandfathering status will be lost if any components of plan benefits are reduced from the member’s perspective (e.g. increase in deductible, copayment or coinsurance) beyond the limitations in the Affordable Care Act (ACA).

## 2016-2017 STATE HEALTH PLAN INITIATIVES

| REFERENCE-BASED PRICING          |  |
|----------------------------------|--|
| <b>Description</b>               | Reference-based pricing refers to uniform setting of allowable prices across all types of providers, whether hospital, ambulatory surgery center or physician office. There remain differences in SHP allowables for the same service performed in a facility versus an office setting, most prominently in radiology and lab in which there may be opportunity to establish reference pricing and achieve Plan savings.   |
| <b>Status</b>                    | Recent literature suggests that plan savings can be achieved by focusing on knee and hip replacement, colonoscopy, MRI of the spine, CT of the head, nuclear stress test of the heart and echocardiograms. By focusing provider reimbursement on these services (which have fairly uniform protocols), the literature suggests savings of 1.6% on total spend for a health plan. It should be noted that approximately 40% of the savings documented in the research is attributed to knee and hip replacement. PEBA has already entered into an agreement with one ambulatory surgical center for such services and is analyzing options for expanding that arrangement to other providers. |
| <b>Member Impact</b>             | Members will have a lower coinsurance amount for services at hospitals if those prices are reduced to or near those in force at freestanding centers.  |
| <b>Risks and Considerations</b>  | Hospitals that are accustomed to receiving a higher rate for these services will likely complain about its rates being equalized with those of non-facility providers.   |
| <b>Target for Implementation</b> | We are targeting implementation of our reference pricing strategy for January 1, 2016. Changes that solely affect provider pricing can wait to be finished as late as September 1, 2015 for a January 1, 2016 effective date.  |
| <b>Fiscal Impact</b>             | Given the aggressive unit cost reimbursements already in place, actual savings for such this overall strategy for PEBA is projected to be approximately 0.75% (\$15 M in 2016) on total plan cost. The SHP will likely phase reference pricing in over a two-to-three year period, so these savings will not be achieved in full until the phase-in is complete.   |

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For any of the options presented, grandfathering status will be lost if any components of plan benefits are reduced from the member's perspective (e.g. increase in deductible, copayment or coinsurance) beyond the limitations in the Affordable Care Act (ACA).

## 2016-2017 STATE HEALTH PLAN INITIATIVES

| <b>VALUE-BASED CONTRACTING: PATIENT-CENTERED MEDICAL HOMES (PCMHs)</b> |   |
|--|---|
| <b>Description</b>   | <p>A medical home is a care delivery model in which a member’s primary care provider serves as the member’s gateway to the health care delivery system. Practices can earn NCQA’s PCMH Recognition, the most widely recognized accreditation. This model is designed to strengthen the physician-patient relationship. With the PCMH model in place in the SHP, the member is attributed to the medical home based on analysis of claims data. The physician or practice that the member utilizes most is designated as that member’s medical home.</p>   |
| <b>Status</b>  | <p>The SHP has utilized BCSSC’s PCMH product since 2012. As the end of 2014, there were 176 physician practices, over 65,822 SHP members and over 29,434 SHP members with a chronic condition participating in the PCMH program. There are provider incentives in place for achieving clinical objectives, but there are no patient incentives at present to obtain services at a PCMH. PEBA staff, consultants and contractors are currently investigating the idea of using the PCMH program as the foundation for a high-performance network of primary care, with PCMHs with demonstrated positive patient outcomes invited to join this network. In this proposal, members would receive an incentive in the form of lower patient cost sharing to obtain services at a high-performing PCMH.</p>  |
| <b>Member Impact</b>   | <p>Members obtaining services from participants in a high-performance primary care network with PCMHs as the foundation would receive favorable patient cost sharing in a manner yet to be determined. Because of ACA grandfathered status, patient cost sharing could not be increased at non-participating facilities.</p>  |
| <b>Risks and Considerations</b>  | <ul style="list-style-type: none"> <li>• Because of the SHP’s longstanding practice of treating all providers the same, differential treatment, even based on sound objective criteria, may be controversial.</li> <li>• PCMH providers are not distributed equally geographically throughout the state.</li> <li>• An extensive communications/marketing plan would need to be developed to promote the PCMHs and accurately inform SHP members about the change.</li> <li>• The medical home concept is popular among the physician community, and SHP action to advance PCMHs should be well received by this audience.</li> <li>• On the other hand, providers may complain of financial and timing barriers to accreditation. There is a significant practice investment to become a medical home (e.g., EMR, staffing, etc.).</li> <li>• Shared savings (a.k.a. gain/loss share) arrangements are typically implemented in a PCMH framework. Generally speaking, the shared savings calculations are complex and the framework needs to be carefully considered. These systems have gain/loss sharing around mutually agreed upon per member cost per month targets. The per member month cost is net of exclusions (e.g. catastrophic claims, specialty pharmacy, transplants, etc.) and includes provisions for administrative expenses. In addition to the cost component, entity’s quality and outcomes are measured using agreed upon measures (e.g., HEDIS, CAHPS, etc.). Savings are not shared in the event quality and outcome levels are not achieved.</li> <li>• SHP action to promote PCMHs will elevate the issue of quality and coordinated care among our membership.</li> </ul> |
| <b>Target for Implementation</b>                                       | <p>We are aiming for a January 1, 2016 effective date for the PCMH-based high-performance network for primary care. A final decision on not just concept, but actual design, would need to be made no later than July 15, 2015 for January 1, 2016 implementation.</p>  |

**Effect on Grandfathering Status:**

For any of the options presented, grandfathering status will be lost if any components of plan benefits are reduced from the member’s perspective (e.g. increase in deductible, copayment or coinsurance) beyond the limitations in the Affordable Care Act (ACA).

## 2016-2017 STATE HEALTH PLAN INITIATIVES

### VALUE-BASED CONTRACTING: PATIENT-CENTERED MEDICAL HOMES (PCMHs)

#### Fiscal Impact

- When a provider group moves to a model predicated upon a much higher level of coordinated care, savings of up to 1.75% of Plan expense (\$35 M in 2016) have been observed in addition to overall healthier outcomes for patients. However, academic literature is mixed on actual cost advantages, and broad PCMH practices with long operating records are relatively rare.
- Again, actual sustainable SHP savings depends on introducing members to and embracing a PCMH model of care. There is merit and likely long-term cost advantages to advancing the idea of coordinated care through PCMH, as well as promoting the concept among both SHP membership and the provider community.

#### Effect on Grandfathering Status:

For any of the options presented, grandfathering status will be lost if any components of plan benefits are reduced from the member's perspective (e.g. increase in deductible, copayment or coinsurance) beyond the limitations in the Affordable Care Act (ACA).

## 2016-2017 STATE HEALTH PLAN INITIATIVES

| <b>SPECIALTY PHARMACY MANAGEMENT</b> |  |
|--------------------------------------|--|
| <b>Description</b>                   | Specialty pharmacy is defined as medication which requires a difficult or unusual process of delivery to the patient or, patient management prior to or following administration, and has unusually high cost. Specialty pharmacy is a trend driver in the SHP (10.7% growth in expense per member in 2014) as it reportedly is for plans throughout the country. The majority of specialty pharmacy expense flows through the PBM, but a significant amount runs through the medical plan administration. Typical management approaches involves some restriction on distribution channel and establishment of clinical rules. Programs are designed to assure appropriate prescribing of specialty drugs, including control of unit cost, monitoring of patient adherence and management of site of service. |
| <b>Status</b>                        | Catamaran is the SHP's pharmacy benefits contractor through 2015. There is an ongoing RFP process to select the SHP's PBM for a January 2016 performance date with an initial 3-year term. We continue to work with our incumbent contractor on specific items as they arise, and will commence with our 2016-2018 contractor when that selection process is complete for a more comprehensive strategy, working with the PBM as well as our medical administrator to arrive at a comprehensive strategy.  |
| <b>Member Impact</b>                 | Depending on the strategy adopted, members may face restrictions on the distribution channel for specialty pharmacy, and may be subject to more clinical rules regarding approval for coverage.  |
| <b>Risks and Considerations</b>      | <ul style="list-style-type: none"> <li>• Specialty drugs in many cases bring about material cost savings by reducing hospitalizations and other medical services, and can enhance quality of life for SHP members.</li> <li>• It is unusual for locally-owned independent pharmacies to dispense specialty pharmaceuticals; however, if there are any local pharmacies affected by a change in distribution channel, there will likely be resistance to the policy.</li> <li>• Specialty pharmacy is a trend driver and action is imperative to address this cost sector in order to manage overall SHP expenditure growth.</li> </ul>   |
| <b>Target for Implementation</b>     | Management actions are not required to coincide with calendar year start-up, so the SHP can enact measures when ready. We will target January 2016 but if not ready by then we can move forward anytime during the year. Any plan design actions that affect patient cost sharing require January 1 implementation.  |
| <b>Fiscal Impact</b>                 | Aggressive specialty management programs that guarantee reductions in per capita trend are common in the marketplace. Actual projected savings for the SHP are largely dependent on the capabilities of the PBM, whose identity is not known at this time, as well as how restrictive the SHP is willing to be. We believe savings amounting to 0.65% (\$13 M in 2016) of overall plan expense is realistic.   |

**Effect on Grandfathering Status:**

For any of the options presented, grandfathering status will be lost if any components of plan benefits are reduced from the member's perspective (e.g. increase in deductible, copayment or coinsurance) beyond the limitations in the Affordable Care Act (ACA).

## 2016-2017 STATE HEALTH PLAN INITIATIVES

| <b>VALUE-BASED INSURANCE DESIGN (VBID)</b> |   |
|--|---|
| <b>Description</b>                         | Value-based insurance design (VBID) is a feature of health plans in which patient cost sharing is reduced for services evaluated as high value (e.g., prevention of disease or condition, treatment of targeted chronic conditions, etc.) and increased for those assessed as lower value (e.g., non-emergency ER services). The SHP includes some VBID-principled benefits, described in the Status section below. The SHP is limited in its approach to VBID while in ACA-grandfathered status in that while it can reduce patient cost sharing for high-value services, it cannot increase patient cost sharing for low-value services under grandfathering.   |
| <b>Status</b>                              | <p>SHP covered services treated in accord with VBID principles:</p> <ul style="list-style-type: none"> <li>• Free Preventive Biometric Screening (waived copay effective 2015)</li> <li>• Free Shingles Vaccine for members age 60 and above (waived copay effective 2015)</li> <li>• Free Flu Shot (Standard Plan effective July 2015)</li> <li>• Generic Copay Waiver Program: Eligible members with cardiovascular disease, congestive heart failure or diabetes can qualify for free generic drugs that treat those conditions. Diabetes testing supplies are also covered at no charge.</li> <li>• Well Child Care: visits and immunizations paid at 100%</li> <li>• Infertility Coverage: \$15,000 lifetime benefit limit and 30% coinsurance for medical and prescription drug coverage</li> <li>• Routine Mammography Benefit: paid at 100% at participating mammography providers for members ages 35-74 based on coverage benefits</li> <li>• Pap Test Benefit: cost of the lab is paid at 100% for members ages 18-65</li> </ul> |
| <b>Member Impact</b>                       | <ul style="list-style-type: none"> <li>• Members obtaining high-value VBID services would receive favorable patient cost sharing</li> <li>• Members obtaining low-value VBID services would receive less-favorable patient cost sharing compared to current cost sharing arrangements</li> </ul>  |
| <b>Risks and Considerations</b>            | <ul style="list-style-type: none"> <li>• There would likely be a lack of consensus among our membership as to “low-value” services with increased patient cost-sharing.</li> <li>• The notion of reduced cost-sharing for members based on targeted chronic conditions is not typical practice for the SHP and could be expected to bring about disagreement from other SHP membership.</li> <li>• An extensive communications/marketing plan would need to be developed to promote the VBID services and accurately inform SHP members about the change.</li> </ul>  |
| <b>Target for Implementation</b>           | PEBA staff is working with its contractors and consultants to explore opportunities for expanding VBID services through an evidence based approach. Expansion of this initiative to include increasing patient liability for low-value services is dependent on the SHP’s ACA grandfathered status.   |
| <b>Fiscal Impact</b>                       | Fiscal impact is dependent upon plan design features.   |

**Effect on Grandfathering Status:**

For any of the options presented, grandfathering status will be lost if any components of plan benefits are reduced from the member’s perspective (e.g. increase in deductible, copayment or coinsurance) beyond the limitations in the Affordable Care Act (ACA).

## 2016-2017 STATE HEALTH PLAN INITIATIVES

| <b>CONTINUED FOCUS ON WELLNESS</b> |   |
|------------------------------------|---|
| <b>Description</b>                 | <p>PEBA has recently initiated several actions to revitalize its wellness efforts. The Health and Wellness Programs unit is responsible for administering worksite screenings, the Generic Copay Waiver program, health education and outreach programs, workplace wellness programs and implementing new health promotion initiatives as they are introduced. In 2015, this unit is focusing on increasing participation in current and new wellness initiatives and on how it can more effectively and efficiently provide educational materials and resources for the approximately 680 participating employer groups.</p>   |
| <b>Status</b>                      | <ul style="list-style-type: none"> <li>• PEBA staff is looking to pursue procuring a wellness vendor to help align health and wellness programs offered to members enrolled in the SHP. Staff will develop the scope of business to include at a minimum the ability to manage a wellness program across a decentralized membership using data integration with other SHP vendors, flexibility/customization and innovation in the market place.</li> <li>• PEBA staff is working with vendors to develop consistent marketing and communication materials for the “Free in ‘15” campaign to cover the worksite screenings, Generic Copay Waiver, free Shingles vaccine (January 2015) and free Flu shot beginning July 2015. The “Free in ‘15” campaign will be modified in communicating wellness initiatives in upcoming years.</li> <li>• The Health and Wellness Unit is working to recruit providers that can accommodate a “walk-in” biometric screening in an effort to increase accessibility for eligible members where a worksite screening is not convenient, in particular pre-65 retirees and eligible spouses. The first walk-in screening provider is scheduled to start offering this service in April 2015.</li> <li>• PEBA is working with vendors to boost enrollment in the Generic Copay Waiver program and will analyze the value/impact of the current program on the SHP.</li> <li>• PEBA is working to increase participation in the SHP’s Quit for Life® program, and to develop a Tobacco-Free Workplace tool kit for employers to use.</li> <li>• Staff will develop online, self-administered health education campaigns for employers to implement in their workplace.</li> <li>• We have observed encouraging initial results from the biometric screening copay waiver and the Shingles copay waiver in 2015.</li> </ul> <p><b>Worksite Screenings</b><br/> <b>2014:</b> 591 worksites hosted events; 15 regional events were held<br/> <b>2015:</b> 529 scheduled worksite screenings through June, up 23% since June 2014; 17 regional events scheduled to date (targeting employers to host additional regional screenings)</p> <p><b>Shingles Vaccine</b><br/> <b>2014:</b> 6,757 Shingles vaccines<br/> <b>Jan.–Feb. 2015:</b> 1,849 shingles vaccines compared to 912 during the same period last year (103% increase)</p> |
| <b>Member Impact</b>               | <p>Continued improvement in opportunities for members to engage in activities positively affects health outcomes.</p>   |
| <b>Risks and Considerations</b>    | <ul style="list-style-type: none"> <li>• As a health plan, the SHP does not control, or even necessarily influence, employer worksite policies.</li> <li>• The key is to identify areas in which return is likely to at least match investment and devote resources accordingly.</li> <li>• The dispersed nature of the SHP membership makes promoting these initiatives difficult.</li> </ul>  |

**Effect on Grandfathering Status:**

For any of the options presented, grandfathering status will be lost if any components of plan benefits are reduced from the member’s perspective (e.g. increase in deductible, copayment or coinsurance) beyond the limitations in the Affordable Care Act (ACA).

## 2016-2017 STATE HEALTH PLAN INITIATIVES

### CONTINUED FOCUS ON WELLNESS

|                                  |  |
|----------------------------------|--|
| <b>Target for Implementation</b> | Ongoing  |
| <b>Fiscal Impact</b>             | The RAND Workplace Wellness Programs Study, released in 2013, found that lifestyle management programs can achieve improvements in risk factors, such as reductions in smoking, and increases in healthy behavior, such as exercise. The study, however, did not find that lifestyle management programs achieve statistically significant reductions in health care costs. Also, a three-year evaluation of the University of Minnesota's wellness program completed in 2012 also found no evidence that lifestyle management lowers health care costs. |

**Effect on Grandfathering Status:**

For any of the options presented, grandfathering status will be lost if any components of plan benefits are reduced from the member's perspective (e.g. increase in deductible, copayment or coinsurance) beyond the limitations in the Affordable Care Act (ACA).

## 2016-2017 STATE HEALTH PLAN INITIATIVES

| <b>PHYSICIAN DISPENSING AND PHARMACY NETWORK MANAGEMENT</b> |  |
|---|--|
| <b>Description</b>  | The Physician Dispensing piece of this strategy involves analysis of physician prescribing patterns to determine where savings may be achieved through detailing physicians to either a) prescribe more generics where appropriate and/or b) prescribe more cost effective versions of brand drugs where appropriate. When the PBM RFP process for 2016 performance is complete, the SHP will work with the PBM contractor to determine opportunities for addressing pharmacy spend through physician detailing. The Pharmacy Network Management piece is complicated since South Carolina is an “any willing provider” state; it is our understanding that any pharmacy willing to accept terms is obligated to be included in the network. |
| <b>Status</b>   | PEBA is in the midst of a procurement for a PBM contractor for the initial term of 2016-2018. When this process is complete, we will work with our contractor to evaluate opportunities that would provide savings to the SHP and/or enhance quality of care and patient safety. At present, Catamaran, the current PBM contractor is installing an accreditation requirement for compounding pharmacies to be effective July 2015. There have been safety issues reported nationally regarding compounding, and the accreditation process seeks to ensure proper procedures in the preparation of compounds.  |
| <b>Member Impact</b>  | PEBA and PBM actions to address pharmacy management are not expected to have direct visible impact on members. However, assessment of member impact will need to wait until it is known what specific initiatives will be pursued.   |
| <b>Risks and Considerations</b>                             | <ul style="list-style-type: none"> <li>• Complete evaluation of risks and considerations will need to wait until it is known what specific initiatives will be pursued.</li> <li>• Any network management action will need to be assessed in the context of the state’s “any willing provider” law.</li> </ul>   |
| <b>Target for Implementation</b>                            | PEBA and PBM actions can be implemented throughout the year, so will we pursue worthwhile opportunities throughout 2016 and 2017.  |
| <b>Fiscal Impact</b>  | Fiscal impact cannot be evaluated until opportunities are known.   |

**Effect on Grandfathering Status:**

For any of the options presented, grandfathering status will be lost if any components of plan benefits are reduced from the member’s perspective (e.g. increase in deductible, copayment or coinsurance) beyond the limitations in the Affordable Care Act (ACA).

# Open Items

## PEBA Board Strategic Plan - Staff Action Plans (Health Care Policy)

| Committee          | Strategic Category     | Actions   | Target Completion Date | Implementation Date | S<br>t<br>a<br>t<br>u | Responsible Staff Leader                       | Seq # |
|--------------------|------------------------|---|------------------------|---------------------|-----------------------|--|-------|
| Health Care Policy | Compliance             | Complete additional reporting required by the ACA   | 3/1/2016               |                     |                       | Phyllis Buie<br>Denise Hunter                  | 62    |
| Health Care Policy | Compliance             | Complete operational requirements for new GASB OPEB standards (drafts)  | 6/30/2018              |                     |                       | Phyllis Buie                                   | 63    |
| Health Care Policy | Data Analysis          | Collect and analyze applicable health care data in order to appropriately measure the effectiveness of current and future health care initiatives: <b>require workplace screening providers to electronically provide biometric data to the plan and / or the ASO</b>   | 6/1/2016               |                     |                       | Laura Smoak<br>Ken Turnbull<br>Elliot McElveen | 61    |
| Health Care Policy | Planning and Execution | Complete <b>Behavioral Health</b> contracting process in a timely manner that permits sufficient time for implementation; conduct process in a manner which serves the best interest of the SHP and its membership  | 1/1/2017               |                     |                       | Rob Tester<br>Georgia Gillens                  | 149   |
| Health Care Policy | Planning and Execution | Complete <b>medical ASO</b> contracting process in a timely manner that permits sufficient time for implementation; conduct process in a manner which serves the best interest of the SHP and its membership; contract includes wellness programming to enhance product offerings which promote employee wellness | 1/1/2017               |                     |                       | Rob Tester<br>David Quiat                      | 148   |
| Health Care Policy | Planning and Execution | Research alternate PBM structures   | 3/31/2016              |                     |                       | Rob Tester                                     | 77    |
| Health Care Policy | Planning and Execution | <b>Specialty Pharmacy:</b> develop strategies to address specialty pharmacy spend and to better manage specialty pharmacy sector; work collaboratively with pharmacy and medical contractors  | 6/1/2016               |                     |                       | Rob Tester<br>Laura Smoak                      | 156   |
| Health Care Policy | Planning and Execution | Wellness Health Management Initiatives: understand and document the current level of wellness participation to create an accurate baseline: develop a wellness scorecard to provide employers: <b>score card communicated</b>   | 12/31/2016             |                     |                       | Laura Smoak                                    | 79    |

# Open Items

## PEBA Board Strategic Plan - Staff Action Plans (Health Care Policy)

| Committee          | Strategic Category | Actions  | Target Completion Date | Implementation Date | S<br>t<br>a<br>t<br>u | Responsible Staff Leader      | Seq # |
|--------------------|--------------------|--|------------------------|---------------------|-----------------------|-------------------------------|-------|
| Health Care Policy | Planning Support   | Identify and implement a comprehensive health care consultant relationship for the health care plan: <b>complete procurement for consultant relationship</b>   | 2/28/2016              |                     |                       | Georgia Gillens<br>Rob Tester | 71    |
| Health Care Policy | Planning Support   | <b>MUSC Health Plan Pilot:</b> continue financial analysis of plan performance and work collaboratively with MUSC on plan management   | 7/31/2016              |                     |                       | Rob Tester<br>Laura Smoak     | 151   |
| Health Care Policy | Planning Support   | <b>Opioid SCRIPTS Program:</b> require medical and dental providers who prescribe opiates to SHP and Dental Plan members to register and utilize the SCRIPTS database and develop methodology to evaluate compliance | 3/1/2016               |                     |                       | Rob Tester<br>Laura Smoak     | 153   |
| Health Care Policy | Planning Support   | <b>PCMH Initiative:</b> evaluate plan effectiveness , provider accessibility and member participation; continue to evaluate PCMH cost effectiveness  | 12/31/2017             |                     |                       | Rob Tester<br>Laura Smoak     | 152   |

# South Carolina Public Employee Benefit Authority

## Strategic Plan: 2015-2018

[As approved by the PEBA Board on 8.21.2013]

[Technical Change on 10.16.13 by Board]

[Adopted by PEBA Board 12.17.14]

### **PART I – BASIC PRINCIPLES**

#### **Mission/Vision Statement**

PEBA's mission is to recommend, offer and administer competitive programs of retirement and insurance benefits for SC public employers, employees and retirees. In establishing or recommending the design of benefits to be offered, the Public Employee Benefit Authority seeks to provide the retirement and insurance components of an overall compensation package for public employees that will allow South Carolina governmental employers to compete, on a cost-effective basis, for the excellent employees needed to provide high-quality government services to the citizens of the State of South Carolina. In administering these benefits, the Public Employee Benefit Authority seeks to effectively and efficiently operate sustainable retirement and insurance plans in accordance with the terms of those plans and its fiduciary duties to the beneficiaries of those plans.

#### **Core Values**

- **Quality Customer Services and Products** – We consistently provide outstanding products and excellent customer services, as defined by our customers, and we strive for continuous improvement. Our interaction with customers is fair, fast, accurate, and understandable.
- **Innovation** – We are receptive to and flexible with the changing environment and the evolving world of technology. We welcome challenges, embrace innovation, and encourage creativity.
- **Professionalism** – We perform our work with honesty, integrity, and loyalty. We are committed to performance that is credible, thorough, competent, and worthy of customer confidence.
- **Strong Workforce** – We are committed to having a strong workforce, with our employees placed in the right positions, well-trained, and motivated to consistently achieve high performance.

#### **Key Strategic Objectives**

At the broadest level, PEBA's strategic objectives are to:

- Create an organization driven by the pursuit of excellence in all areas.
- Design and implement an updated health care plan that focuses on improving health outcomes and reducing costs.
- Provide for the efficient and cost effective administration of the retirement systems for active and retired members of the systems.
- Ensure the highest fiduciary, legal and ethical standards are known and applied across the organization.

#### **Expected Results**

PEBA expects that, by pursuing the goals and objectives set out in this and future strategic plans, it will achieve the following results:

- Satisfied members, beneficiaries and stakeholders
- Engaged employees
- Improved fiscal and financial positions of the plans and programs administered by PEBA
- Long-term success for South Carolina's governmental employee insurance and retirement plans

### **PART II – SPECIFIC INITIATIVES**

#### **I. STRATEGIC PLANNING**

##### **Goal**

- a) Annually in December, PEBA will conduct an organized process to create and update a

comprehensive strategic plan.

## **II. LEADERSHIP AND GOVERNANCE**

### Goals

- a) The fiduciary responsibilities of the Board and its committees are clearly defined and they are able to satisfy them.
- b) The PEBA Board is provided with education regarding its role as a Board of Trustees, and the Board focuses on policy-level activities under their authority.
- c) The PEBA Board anticipates and develops creative solutions to challenges faced by public employee insurance and retirement plans.
- d) PEBA maintains an engaged and open relationship with the South Carolina Retirement System Investment Commission, the Budget and Control Board, and the South Carolina Executive and Legislative Branches of government.

## **III. Customer Focus**

### Goals

- a) The opinions and concerns of stakeholders are actively solicited and actions are appropriately taken to improve processes maximize benefits within available resources.
- b) Stakeholders understand the rationale behind policy decisions regarding PEBA products and services.
- c) Members are educated on the nature of their benefits in order to make sound decisions regarding their benefit plans and service choices.
- d) Internal staff is informed of policy decisions and understand the impact on their work.
- e) Members and benefits administrators are able to receive services through a “one-stop shop.”
- f) PEBA services are rated both cost effective and of high quality.

## **IV. PLAN MEASUREMENT AND ANALYSIS**

### Goals

- a) Provide the maximum competitively-necessary benefit within the available resources on the most cost-efficient basis.
- b) Plans are equitable.
- c) Funding mechanisms established for the plans are fiscally sound.
- d) There is progress toward eliminating unfunded liability.
- e) Contributions are predictable and reasonable.
- f) All participants are retirement-ready.

## **V. WORKFORCE PLANNING**

### Goals

- a) PEBA has the ability to recruit and maintain a stable, sufficient, and proficient workforce to carry out the strategic goals of the agency.
- b) Integrate EIP and Retirement staffs’ functions and responsibilities as appropriate.

## **VI. OPERATIONS MANAGEMENT**

### Goals

- a) PEBA will have a new, integrated system that improves efficiency in operations and effectiveness in service delivery.
- b) PEBA will, at all times, ensure that its information technology resources are deployed in the most safe and secure manner feasible.