Meeting Agenda | Health Care Policy Committee

Thursday, February 16, 2017 | 10:00 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 12, 2017

IV. Musculoskeletal Review

V. Update on Patient Center Medical Homes

VI. Benchmark Communications Plan

VII. 2017 Goals

VIII. Old Business/Director’s Report

IX. Adjournment
Meeting Date: February 16, 2017

1. Subject: Musculoskeletal Review

2. Summary: Conditions classified as Musculoskeletal Disorders are the single largest medical cost driver in the State Health Plan. Dr. Shawn Stinson of Blue Cross will discuss the prevalence, cost, and interventions associated with this range of injuries and diseases.

3. What is Committee asked to do? Receive as information

4. Supporting Documents:
   (a) Attached:
       1. Musculoskeletal Deep Dive for PEBA Board
Musculoskeletal disorders: prevalence, cost and interventions
Musculoskeletal disorders - definition

• Injuries and disorders affecting the body’s musculoskeletal system: muscles, nerves, tendons, joints and cartilage in upper and lower limbs, neck and lower back

• Typically associated with one of three etiologies: trauma (acute and/or chronic), degenerative disorders, inflammatory disorders

• Can be work related, with back pain the most common disorder

1 - https://www.cdc.gov/niosh/programs/msd/default.html
Musculoskeletal disorders – magnitude of the problem

Proportion of the population with musculoskeletal disorders increased from 1996 through 2011 and is expected to continue to increase as the population ages.
Musculoskeletal disorders – magnitude of the problem

- An estimated 126.6 million adults (one in two) are affected by a musculoskeletal condition
- That number is comparable to the total percentage of Americans living with a chronic lung or heart condition
- Musculoskeletal disorders and diseases are the leading cause of physical disability in this country
- Musculoskeletal disorders result in an estimated cost of $213 billion in annual treatment, care and lost wages
- It is the single largest category of workplace injuries and represents 30% of all workers comp costs
- 2011 direct costs upwards of $50B with indirect costs at least five times that amount

3 - http://ergo-plus.com/musculoskeletal-disorders-msd
Top 12 medical cost drivers

Claims with a primary diagnosis of musculoskeletal or connective tissue disorder
Claims incurred October 1, 2015 - September 30, 2016, paid through 12/31/16
State Health Plan primary only, excludes MUSC Health Plan
State Health Plan: musculoskeletal disorder pharmacy cost

Top 12 pharmacy cost drivers

Claims incurred October 1, 2015 - September 30, 2016, paid through 12/31/16
State Health Plan primary only, excludes MUSC Health Plan
Specialty medications under the medical benefit also impact cost.

One example is Remicade, an anti-inflammatory agent used for rheumatoid arthritis.

For the period 8/1/2015 through 7/31/2016, SHP spend for Remicade was just over $2M.
Musculoskeletal disorder - current interventions

• Blue Distinction Centers for Spine and Knee/Hip
  • National designation through the BlueCross BlueShield Association for quality and cost
• Site of Care Initiative – Ambulatory Surgery Center
• Technology assessments for new, investigational and experimental services
  • Includes prior authorization for specific procedures
Musculoskeletal disorder - current interventions

- Limits/administrative procedures on chiropractic services
- Specialty radiology management (NIA)
- Radiology reference based pricing
- Orthopedics outbound call program
- The Standard – disability management
Musculoskeletal disorder future interventions - medical

• Rheumatology clinical pathway
  • No PA required if the physician follows the prescribed treatment plan
• Site of care intervention for specialty under medical
  • Encouraging/directing to a lower cost site of care
• PCMH+
• Expanding network of ambulatory surgery centers
  • Corresponding benefit design
Musculoskeletal disorder intervention (for an additional PEPM fee)

MSK Program through National Imaging Associates (NIA)

Spine Surgery
• Overuse of invasive lumbar fusions.
• Surgery occurring too soon.
• Variations in care-evidence base is not consistently followed by surgeon community.
• Evolving evidence base/standards of care.

Interventional Pain Management (IPM)
• Inadequate or no documentation of patient assessment/physical exam.
• Overutilization of IPM procedures.
• Repeat procedures without proper evaluation or impact of initial management.
• Evolving evidence base/standards of care
Disclaimer

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Meeting Date: February 16, 2017

1. **Subject**: Update on Patient Center Medical Homes

2. **Summary**: In July 2015, PEBA approved design changes to the State Health Plan effective for 2016 intended to encourage patient use of Patient Centered Medical Homes. Noreen O’Donnell of Blue Cross will present an update on the PCMH program and what we can expect to see in this initiative going forward.

3. **What is Committee asked to do?** Receive as information

4. **Supporting Documents**:
   
   (a) Attached:
       1. BlueCross and BlueShield of South Carolina Patient Centered Medical Home Program
BlueCross and BlueShield of South Carolina

Patient Centered Medical Home Program

Noreen O’Donnell, February 2017
Fundamentals of a Patient Centered Medical Home (PCMH)

Patient-Centered Medical Home

- Personal Physician
- Physician Directed Team
- Whole Person Orientation
- Coordinated, Integrated Care
- Emphasis on Quality and Safety
- Enhanced Access
- Appropriate Payment Structure

South Carolina PCMH providers by county

June 2015 – 156 practices

January 2017 – 239 practices
PCMH growth

PCMH Expansion since 2012

<table>
<thead>
<tr>
<th>PCMH Practices</th>
<th>SHP Chronic Members</th>
<th>SHP Total Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCMH</strong></td>
<td><strong>2012</strong></td>
<td><strong>2013</strong></td>
</tr>
<tr>
<td><strong>Practices</strong></td>
<td>56</td>
<td>111</td>
</tr>
<tr>
<td><strong>SHP Chronic Members</strong></td>
<td>9,562</td>
<td>13,227</td>
</tr>
<tr>
<td><strong>SHP Total Membership</strong></td>
<td>26,929</td>
<td>44,883</td>
</tr>
</tbody>
</table>
### BlueCross HEDIS results - PCMH vs. non-PCMH, 2016

<table>
<thead>
<tr>
<th>HEDIS Measure</th>
<th>PCMH</th>
<th>non-PCMH</th>
<th>Statistical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Compliant vs Assigned</td>
<td>40.42%</td>
<td>35.78%</td>
<td>*</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Eye Exam Screening</td>
<td>30.73%</td>
<td>28.03%</td>
<td>^</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Hemoglobin A1c Testing</td>
<td>90.38%</td>
<td>87.57%</td>
<td>*</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Hemoglobin A1c Value greater than 9</td>
<td>15.32%</td>
<td>14.56%</td>
<td>N/A</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Hemoglobin A1c Value less than 8</td>
<td>11.88%</td>
<td>11.58%</td>
<td>N/A</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Medical Attention for Nephropathy</td>
<td>87.96%</td>
<td>87.57%</td>
<td>N/A</td>
</tr>
<tr>
<td>Counseling for Activity for Children/Adolescents</td>
<td>14.92%</td>
<td>3.36%</td>
<td>*</td>
</tr>
<tr>
<td>Counseling for Nutrition for Children/Adolescents</td>
<td>35.17%</td>
<td>22.79%</td>
<td>*</td>
</tr>
<tr>
<td>Immunizations for Adolescents (Meningococcal and Tdap)</td>
<td>60.29%</td>
<td>47.45%</td>
<td>*</td>
</tr>
<tr>
<td>Testing for Children With Pharyngitis</td>
<td>86.52%</td>
<td>83.08%</td>
<td>N/A</td>
</tr>
<tr>
<td>Weight Assessment for Children/Adolescents</td>
<td>39.02%</td>
<td>31.26%</td>
<td>*</td>
</tr>
<tr>
<td>Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life</td>
<td>83.38%</td>
<td>74.50%</td>
<td>*</td>
</tr>
<tr>
<td>Well-Child Visits in the First 15 Months of Life (6 visits)</td>
<td>78.82%</td>
<td>77.93%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Statistical significance computed using a Fisher Exact two-sided p-value*

*Significance threshold <=0.05
^Significance threshold <=0.03
2016 patient satisfaction survey

Sample
Mixed adult commercial population – 729 respondents

Instrument
Mail in survey

Purpose
PCMH CAHPS survey conducted to measure member satisfaction

Comparison
BCBSSC scores compared to national CG CAHPS scores

Survey Period
Summer 2016
Patient satisfaction results - appointment scheduling

<table>
<thead>
<tr>
<th>Received appointment for routine care as soon as needed</th>
<th>Received appointment for urgent care as soon as needed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BCBSSC</strong></td>
<td><strong>Benchmark</strong></td>
</tr>
<tr>
<td>96%</td>
<td>69%</td>
</tr>
</tbody>
</table>
Patient satisfaction results - return phone calls

Called doctor’s office and received answer the same day

- BCBSSC: 85%
- Benchmark: 58%

Called after hours and received answer as soon as needed

- BCBSSC: 77%
- Benchmark: 59%
Patient satisfaction results - satisfaction with provider

Provider explained things in a way you could understand

- BCBSSC: 97%
- Benchmark: 94%

Provider listened carefully to you

- BCBSSC: 96%
- Benchmark: 94%
Patient satisfaction results - satisfaction with provider

Provider knew important information about your medical history

- BCBSSC: 96%
- Benchmark: 86%

Provider spent enough time with you

- BCBSSC: 95%
- Benchmark: 93%
BlueCross PCMH Program Transition to PCMH+
CMS CPC+ Initiative

• The CMS CPC+ model supports primary care practices along the continuum of their transformation to drive better health and smarter spending.

• Track 1 supports practices that are developing comprehensive primary care capabilities.

• Track 2 targets practices that are proficient in comprehensive primary care that are prepared to increase the scope of medical care delivered to their patients, particularly those with complex needs.
CPC+ Care Delivery Capabilities

Access and Continuity
- Patient Empanelment
- 24/7 Access
- Out-of-Office Care Options

Patient and Caregiver Engagement
- Patient and Family Advisory Council
- Self-Management Support Tools

Care Management
- Risk Stratification
- Hospital/ED Discharge Follow-Up
- Care Plans

Comprehensiveness and Coordination
- Coordination Across the Medical Neighborhood
- Integrated Behavioral Health
- Psychosocial Needs Assessment

Planned Care and Population Health
- Practice and Payer Data Insight
- Full Care Team Data Review

Track 1 requirements
Additional requirements for Track 2
• BlueCross is aligning with the CMS CPC+ initiative by transitioning to a PCMH+ model.

• By focusing practices on specific care delivery objectives and aligning payments accordingly, BlueCross expects practices will provide more comprehensive care, thereby reducing patients’ complications and overutilization in high cost settings – which, in turn, will lead to high quality and lower cost of health care overall.
## Transition to BlueCross PCMH+ model

<table>
<thead>
<tr>
<th></th>
<th>Current PCMH</th>
<th>PCMH + Track 1</th>
<th>PCMH+ Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Coordination Fees</strong></td>
<td>Care coordination fees for members with diabetes, CHF and hypertension.</td>
<td>Risk stratified care coordination fees for all attributed members.</td>
<td>Risk stratified care coordination fees for all attributed members.</td>
</tr>
<tr>
<td><strong>Performance Bonus</strong></td>
<td>Year end up or down adjustment to CCFs based on quality.</td>
<td>Year end performance bonus based on quality, cost and utilization.</td>
<td>Year end performance bonus based on quality, cost and utilization.</td>
</tr>
<tr>
<td><strong>Fee For Service</strong></td>
<td>Standard periodic fee for service increases.</td>
<td>No additional fee for service increases. Any increases come only from performance bonus.</td>
<td>Up front lump sum payment based on prior year costs. Decrease in fee for service rate to account for lump sum. Shared savings if quality, cost and utilization metrics are met.</td>
</tr>
</tbody>
</table>
• During 2017 BCBSSC will develop the evaluation and operational technical infrastructure for the PCMH+ program.

• A pilot practice group will be implemented in Q2 2017 and expanded thereafter.

• Full transition of all BCBSSC PCMH practices to the PCMH+ model is expected by year end 2018.
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Meeting Date: February 16, 2017

1. Subject: Benchmark Communications Plan

2. Summary: A benchmarking communications plan that will be promoted to members, employers, stakeholders, the website and social media is presented as requested.

3. What is Committee asked to do? Receive as information

4. Supporting Documents:

   (a) Attached:
       1. Benchmark Communications Plan
State Health Plan benchmarks: communications plan

Health Care Policy Committee
February 16, 2017
Communications plan

• Timeline for full implementation of the plan is December 31, 2017
Website and social media promotion

- Add the State Health Plan benchmark presentation to the Facts and figures page of the public website
- Schedule social media posts once a quarter to promote the favorability of the State Health Plan and link to the presentation on the website
Promotion to stakeholders

• Benchmark data is included in presentations for the following groups:
  • Governor’s Office and S.C. General Assembly – budget presentations
  • Bi-annual stakeholder meetings in collaboration with RSIC
  • Various associations and speaking engagements
  • C-suite contacts
Promotion to employers

• Include quarterly articles in *PEBA Update*, the weekly e-newsletter for employers, directing employers to the website

• Add as an agenda item in the monthly Employer Advisory Group hosted by Employer Services

• Include benchmark highlights in information packets for insurance benefits employer trainings

• Include benchmark highlights in new employer orientations

• Include benchmark highlights in general session at the Benefits at Work conference
Promotion to members

• Schedule an email to State Health Plan members to be sent in advance of open enrollment
• Develop benchmark highlights flyer for Field Services to distribute at benefit fairs
• Schedule quarterly social media posts directing members to the benchmark presentation on PEBA’s website
• Add benchmark highlights to member-facing insurance benefits overview presentations
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Meeting Date: February 16, 2017

1. Subject: 2017 Goals


3. What is Committee asked to do? Receive as information

4. Supporting Documents:
   (a) Attached:
       1. 2017 Health Initiatives Communications Goals
       2. 2016 Update
       3. PEBA Perks
2017 Health Initiatives communications goals

The following goals are for 2017 and data will be reported in May 2018.

Medical

On April 1, 2017, PEBA will launch Rally® for State Health Plan primary members age 16 and older. Rally is a consumer platform for health and well-being that inspires individuals to take steps that lead to better health through behavior change. Rally uses a variety of sources including claims, biometrics, self-reported data, clinical information and evidence-based guidelines to identify gaps in care and recommend health management programs or other interventions. Rally offers digital coach connections, a health survey, interactive well-being programming, device integration and rewards. PEBA will also use Rally to promote and educate members on the State Health Plan’s value-based benefits and other helpful resources to get them excited about their health.

PEBA will rely on Rally, PEBA Perks, member messaging and the PEBA Health Hub to encourage member engagement in all of the value-based benefits and health management programs offered as part of the State Health Plan benefits.

Goal 1

Promote Rally to encourage member engagement in the digital consumer platform. Target member engagement for incented members (those eligible for No-Pay Copay) is at least 18,000. Target member engagement for non-incented members is at least 10,000.

Target completion date: 12.31.17

Target engagement numbers are based on Rally Health’s benchmarks for average registration for both incented (No-Pay Copay) and non-incented members and will be based on three quarters of activity from April through December 2017.

Rally will be included when promoting each of the PEBA Perks that members may use through Rally (i.e. weight management, No-Pay Copay, etc.). There will be numerous marketing campaigns available on the PEBA Health Hub. We will promote Rally through BlueCross’ member messaging and featured promotional campaigns along with direct emails to members from PEBA.
Goal 2

Encourage at least 5 percent of eligible State Health Plan primary members to register for Blue CareOnDemand.

Target completion date: 12.31.17

Effective January 1, 2017, PEBA implemented a telehealth video visit platform, Blue CareOnDemand, which is offered by BlueCross for State Health Plan primary members.

Goal 3

Increase the number of worksites hosting a preventive screening by 6 percentage points.

Target completion date: 12.31.17

Health Initiatives staff will work with Employer Services to encourage participating employer groups to host worksite screenings. Staff will identify and recruit employer groups that have either not hosted a worksite screening with a PEBA-contracted provider or have not hosted a screening in longer than one year.

By conducting a geo-analysis of worksites who did not host a screening in 2016, we will target smaller groups to identify potential regional screenings and encourage collaboration between smaller groups to host screenings together. In addition, we are identifying mid- to large-size employer groups who have not used this benefit in longer than one year and will contact them directly to explain the importance of this benefit for their employees and the convenience of booking through PEBA.

Goal 4

Increase those enrolled in the State Health Plan maternity management program in the first trimester by 3 percentage points.

Target completion date: 12.31.17

The State Health Plan’s maternity management program, Coming Attractions, encourages participation in the program to improve pregnancy outcomes, reduce the number of premature births through better prenatal care and manage NICU infants. Prenatal education helps expectant mothers support a healthy diet, avoid harmful situations, recognize warning signs and symptoms and prepare for labor and delivery. In 2017, certain manual and electric breast pumps obtained from contracted providers will be available at no cost to State Health Plan primary members.

PEBA is working with BlueCross on ways to identify pregnant members earlier and target program materials to them earlier in their pregnancy. To increase participation in the maternity management program, all program communications will educate members about the breast pump benefit and encourage members to register to learn how to take advantage of this benefit. Coming Attractions will be included in the PEBA Perk’s marketing strategy and, in collaboration with BlueCross, we will promote
this program through Rally, the PEBA Health Hub and through BlueCross’ member messaging.

**Goal 5**

*Increase the number of State Health Plan adult members participating in the weight management health coaching program by 4 percentage points.*

**Target completion date: 12.31.17**

The weight management program is a confidential and individually-tailored health coaching program for adults. As of September 2016, there are 56.5 percent of identified adults participating in the weight management program. Participation is defined as members who have been identified through Rally or have self-enrolled, and who have completed their condition-specific survey to receive health coaching contacts and materials. This program will be included in the PEBA Perks marketing strategy and, in collaboration with BlueCross, we will promote this program through Rally, featured marketing campaigns on the PEBA Health Hub and through BlueCross’ member messaging.

**Goal 6**

*Increase State Health Plan member current rate for colorectal cancer screenings by 1.5 percentage points.*

**Target completion date: 12.31.17**

PEBA measures current rates for colorectal screening monthly based on the most recent 12 months of data. Based on claims incurred between January 2016 and December 2016 and paid through December 2016, the current colorectal cancer screening rate for eligible members is 53.4 percent. A member is considered current if they have received a colorectal cancer screening (colonoscopy, flexible sigmoidoscopy or Fecal Occult Blood Test (FOBT/FIT)) as defined by the Healthcare Effectiveness Data and Information Set (HEDIS) measurement definition. This definition considers age, continuous coverage period and screening period. Of the screenings considered to calculate the current rate of colorectal screenings in State Health Plan members, colonoscopies have represented approximately 97 percent.

The National Center for Biotechnology Information published a study in 2012 that showed waiving the copayments for colonoscopy screenings results in a statistically significant but modest increase of 1.5 percentage points.

Promotion of the colorectal cancer screening benefit, available at no member cost share, is a part of the PEBA Perks marketing strategy for 2017. This benefit will also be promoted in Rally and promoted through BlueCross’ member messaging. In 2017, the FOBT/FIT screening will also be offered at no member cost according to the United States Preventive Services Task Force (USPSTF) recommendations. PEBA, in collaboration with the Center for Colon Cancer Research at USC, the S.C. Cancer Alliance and DHEC have established a 5-year goal to increase the current rate by 1.5 percentage points each year.
Pharmacy

PEBA is always looking for ways to control the rising costs associated with the pharmacy benefits of the State Health Plan. Express Scripts website and mobile app offer a variety of tools and resources, such as the Price a Medication tool, to educate members on their prescription options. There are also easy steps a member can take to save money, including using generic drugs and filling maintenance medications for 90 days. PEBA will work collaboratively with Express Scripts in 2017 to promote these tools and benefits.

**Goal 1**

*Increase usage of the Express Scripts website and mobile application, which are resources for information about the prescription drug benefits and provides tools to help reduce costs for the plan and members.*

**Target completion date: 12.31.17**

**Key measures**

- Increase the total number of registered users on the website by 5 percent, or 4,865 users
- Increase the total number of registered users on the mobile app to 12,000

In collaboration with Express Scripts, we will promote the Express Scripts website and mobile app as resources for members. Marketing materials will also be developed and available on the PEBA Health Hub. Additionally, BlueCross and Express Scripts are working to implement single sign-on through My Health Toolkit on the BlueCross State Health Plan-specific website that will allow members to access their online Express Scripts account once logged in to their My Health Toolkit account. The single sign-on feature is scheduled to be implemented by March 23, 2017.

<table>
<thead>
<tr>
<th>Population</th>
<th>2016 maintenance users</th>
<th>2016 registered website users</th>
<th>2016 registered mobile app users</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>288,299</td>
<td>97,298</td>
<td>6,726</td>
</tr>
<tr>
<td>Commercial plan</td>
<td>213,937</td>
<td>77,369</td>
<td>6,137</td>
</tr>
<tr>
<td>EGWP plan</td>
<td>70,019</td>
<td>19,929</td>
<td>589</td>
</tr>
</tbody>
</table>

*Maintenance users indicates the number of members who are currently taking a maintenance medication.*
Goal 2

Increase the generic fill rate for the commercial plan by 0.5 percentage points by promoting use of generic medications through education and training to members that provides information about cost savings to the Plan and members.

Target completion date: 12.31.17

For 2016, the benchmark generic fill rate was 83 percent for government-state peers. Express Scripts will mail a letter to a targeted population of members who are currently filling a brand-name prescription even though there is a generic drug available. A marketing toolkit will be developed and available on the Health Hub. The key message for the targeted letter and marketing toolkit will be that generic drugs are as safe and effective as their brand-name counterparts and the member will save money by using a generic drug instead of the more expensive brand-name medication.

<table>
<thead>
<tr>
<th>Population</th>
<th>2016 generic fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial plan</td>
<td>84.8%</td>
</tr>
</tbody>
</table>

Goal 3

Increase number of maintenance medications being filled for the commercial plan using a 90-day prescription versus a 30-day prescription by 0.5 percentage points by educating members on the cost savings of moving maintenance medications from a 30-day non-maintenance fill to a 90-day fill.

Target completion date: 12.31.17

Express Scripts will mail a letter to a targeted population of members who are currently filling a maintenance medication every 30 days at a chain pharmacy. A marketing toolkit will be developed and available on the Health Hub. The key message for the targeted letter and marketing toolkit will be awareness that the member can fill maintenance medications for 90 days at retail pharmacies in the maintenance network. Benefits to the member of filling maintenance medications for 90 days include making fewer trips to the pharmacy and saving money on copayments. Additionally, filling maintenance medications for 90 days helps the State Health Plan control rising costs.

<table>
<thead>
<tr>
<th>Population</th>
<th>2016 30-day maintenance prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial plan</td>
<td>1,288,897</td>
</tr>
</tbody>
</table>
**2016 Health and wellness management initiatives**

**Strategic action plan**

1. **Increase SHP member current rate for colorectal screening by 1.5 percentage points, raising current rate to 54.2 percent. (Target completion date – 03.31.17)**

   Our current rate for colorectal cancer screenings is 53.4 percent; thus demonstrating a 0.7 percentage point increase. Please note, this data demonstrates claims incurred January 2016 through December 2016 and paid through December 2016. This data may show an additional increase after allowing for the three months runoff we recommend.

<table>
<thead>
<tr>
<th>Overall</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible members</td>
<td>Members current</td>
</tr>
<tr>
<td>January 2016-December 2016</td>
<td>79,937</td>
</tr>
<tr>
<td>January 2015-December 2015</td>
<td>78,223</td>
</tr>
</tbody>
</table>

2. **Increase the unique count of members participating in the SHP tobacco cessation program or utilizing tobacco cessation prescription drug products by 5 percent. (Target completion date - 03.31.17)**

   Through December 2016, we had a 34.73 percent increase in unique members participating in the SHP tobacco cessation program and the prescription drug benefit. In addition, in 2016, there has been a 38.26 percent increase in tobacco cessation prescription drug fills.
3. **Encourage participating employer groups to register for the PEBA Health Hub. Target employer registration such that the employers represent 40 percent of the active employees enrolled in the SHP. (Target completion date - 01.31.17)**

The PEBA Health Hub email list has 781 registered email addresses as of February 2, 2017. Of those 781 registered email addresses, 161 email addresses cannot be linked back to an employer group or is an invalid email address. The most common reason an email address cannot be linked back to an employer group is because the participant used a personal email address not related to the employer group’s email domain. We defined an invalid email address as showing an error or misspelling in the name. As of February 2, 2017, we far surpassed our goal with the percentage of active employees reached being 87.83 percent.

4. **Work with BCBSSC, the SHP’s TPA, and PEBA’s health care consultant to develop a reporting tool that demonstrates stratified risk scores for the non-Medicare primary SHP adult population and measure their enrollment and engagement in health management/coaching programs as well as utilization rates in appropriate value-based benefits. Create a baseline to establish trend and develop a strategic action item to address any opportunities to increase engagement in health coaching and utilization of PEBA’s value-based benefits. (TBD)**

This will continue to be an ongoing goal. We will begin receiving disease management engagement files that will be used to develop this reporting tool. The first file transfer from BlueCross will be February 2017.
**PEBA Perks initiatives**

All initiatives include eligible SHP and MUSC members.

**Adult vaccinations | incurred January-December 2016**

Cumulative total
2014 and 2015 only include the shingles vaccine.
2016 shows all adult vaccines (including shingles).

![Graph showing adult vaccinations by month from January 2014 to December 2016](image)

**Colonoscopy | January 2016-December 2016**

Paid through December 2016
2016 goal: Increase SHP member current rate for colorectal screening by 1.5 percentage points, raising current rate to 53.8 percent.

<table>
<thead>
<tr>
<th></th>
<th>Eligible members</th>
<th>Members current</th>
<th>Current rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>January 2016-December 2016</strong></td>
<td>79,937</td>
<td>42,665</td>
<td>53.4%</td>
</tr>
<tr>
<td><strong>January 2015-December 2015</strong></td>
<td>78,223</td>
<td>41,216</td>
<td>52.7%</td>
</tr>
</tbody>
</table>
Diabetes education | incurred January-December 2016

Cumulative participant total
ran on an incurred basis

<table>
<thead>
<tr>
<th>2016</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>18</td>
</tr>
<tr>
<td>Feb</td>
<td>39</td>
</tr>
<tr>
<td>March</td>
<td>58</td>
</tr>
<tr>
<td>April</td>
<td>78</td>
</tr>
<tr>
<td>May</td>
<td>96</td>
</tr>
<tr>
<td>June</td>
<td>111</td>
</tr>
<tr>
<td>July</td>
<td>131</td>
</tr>
<tr>
<td>Aug</td>
<td>148</td>
</tr>
<tr>
<td>Sept</td>
<td>166</td>
</tr>
<tr>
<td>Oct</td>
<td>185</td>
</tr>
<tr>
<td>Nov</td>
<td>195</td>
</tr>
<tr>
<td>Dec</td>
<td>202</td>
</tr>
</tbody>
</table>

Flu vaccines | incurred and paid July 2016-December 2016

Cumulative total (adults and dependent children)

<table>
<thead>
<tr>
<th></th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-'16 flu season</td>
<td>13</td>
<td>936</td>
<td>15,970</td>
<td>60,849</td>
<td>81,913</td>
<td>91,396</td>
<td>94,697</td>
<td>96,048</td>
<td>96,589</td>
<td>96,665</td>
<td>96,689</td>
<td>96,692</td>
</tr>
<tr>
<td>16-'17 flu season</td>
<td>1</td>
<td>1,793</td>
<td>21,144</td>
<td>59,888</td>
<td>81,920</td>
<td>90,332</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
No-Pay Copay | January-December 2016
This is a No-Pay Copay cumulative participation total. 7.6% of the eligible population is currently participating.

Preventive screenings | incurred and paid January-December 2016
This represents a preventive screenings cumulative total for eligible participants.
Tobacco cessation | January-December 2016

In 2016, the SHP began offering a $0 copayment for bupropion and Chantix.
2016 goal: Increase the unique count of members participating in the SHP tobacco cessation program or utilizing tobacco cessation prescription drug products by 5 percent.

In 2016, there has been a 34.73% increase in unique member participation.

<table>
<thead>
<tr>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>254</td>
<td>373</td>
<td>511</td>
<td>625</td>
<td>718</td>
<td>822</td>
<td>939</td>
<td>1,051</td>
<td>1,156</td>
<td>1,282</td>
<td>1,354</td>
<td>1,457</td>
</tr>
<tr>
<td>359</td>
<td>607</td>
<td>800</td>
<td>961</td>
<td>1,114</td>
<td>1,263</td>
<td>1,386</td>
<td>1,521</td>
<td>1,640</td>
<td>1,750</td>
<td>1,861</td>
<td>1,963</td>
</tr>
</tbody>
</table>