AGENDA

State and Public School Life and Health Insurance Board
Quality of Care Sub-Committee
Meeting

December 11, 2018
1:00 p.m.

EBD Board Room – 501 Building, Suite 500

I. Call to Order.................................................................Margo Bushmaier, Chair

II. Approval of August Minutes..............................................Margo Bushmaier, Chair

III. Choosing Wisely Analysis..............................................Mike Motley, Izzy Montgomery, ACHI

IV. Director’s Report.........................................................Chris Howlett, EBD Executive Director

Upcoming Meetings

January 15, 2019, February 12, 2019, March 12, 2019

NOTE: All material for this meeting will be available by electronic means only ASE-PSE BOARD@dfa.arkansas.gov. Please silence your cell phones. Keep your personal conversations to a minimum.
State and Public School Life and Health Insurance Board  
Quality of Care Sub-Committee Minutes  
December 11, 2018

Date | time 12/11/2018 1:00 PM | Meeting called to order by Margo Bushmiaer, Chair

Attendance

Members Present
Michelle Murtha - Vice-Chair
Dr. John Vinson
Margo Bushmiaer - Chair
Dr. Arlo Kahn
Dr. Terry Fiddler
Melissa Moore
Cindy Gillespie - Teleconference
Pam Brown
Zinnia Clanton
Chris Howlett, EBD Executive Director, Employee Benefits Division

Members Absent
Dr. Namvar Zohoori

Others Present:
Eric Gallo, Rhoda Classen, Shalada Toles, EBD; Mike Motley, Elizabeth Montgomery, ACHI; Marc Watts, ASEA; David Kizzia, AEA; Takisha Sanders, HA; Sean Seago, MERCK; Ronda Walthall, ARDOT; Karyn Langley, QualChoice

Approval of Minutes by: Margo Bushmiaer, Chair

MOTION by Dr. Fiddler

I motion to approve the November 13, 2018 minutes.

Clanton seconded. All were in favor.

Minutes Approved.

ACHI Updates by: Mike Motley, Elizabeth Montgomery, ACHI

Mike Motley and Elizabeth Montgomery presented updates using the updated Health Waste Calculator output, follow-up analyses from previous meeting, three additional low-value services, and they discussed next steps for analyses and recommendation. Potential considerations to address overuse are member and patient engagement strategies, benefit design strategies, and provider engagement strategies.
Discussion:

Dr. Fiddler: Because of our policy change regarding cervical cancer screenings, we quit paying for them and they quit giving the service?

Motley: No, for individuals without certain risk factors, the recommendation was once every three years. The services were still paid for at least once every three years. That policy started on 01/01/2017, but the associated lookback period could go back in to 2016.

Dr. Fiddler: So, in 2020 it could go back up then, if it's every three years.

Motley: It would depend on when the individual had their last screening along with their clinical and diagnoses history.

Dr. Kahn: Each of these numbers represent a wasteful service. If you have one screening in three years, that would be no wasteful service. If you have two screenings in three years, that would be one wasteful service. This only counts people who have had more than screening in a three-year period.

Dr. Fiddler: If the EBD Board came back and stated that they agree with the recommendations, would you expect in 2019 for the numbers to continue to go down?

Howlett: I believe that number could ever be fluctuating, but as far as wasteful services, yes. There are multiple values of input that can come in and make that number fluctuate.

Dr. Vinson: Theoretically, if the policy was implemented according to those guidelines, it would be zero, unless you got overrides.

Montgomery: It's a downward trend and there are a lot of potential caveats and assumptions to be made here. Looking at an individual low value test, we are looking at an individual claim that a person received. That exclusion criteria would have had a look back period to see if they have had history of abnormal Pap tests and when they would have last received. There are a couple scenarios for this but will have this as a takeaway.

Brown: Do we know what age group cervical cancer normally occurs in? Is there a correlation between the test and the age group?
Dr. Kahn: Cervical cancer can occur at almost any age but not before age 21. In women over 65, it almost never occurs in women who have been screened every three years. It is a slow growing cancer.

Brown: When you talk about population-based screening, is that just part of routine lab work? If I go to doctor and I’m symptomatic, even though I’m not in the high risk, how do you know that? As we have seen with certain data there are a lot of things that get missed. So, when we think it’s inappropriate testing, it may be more of a coding issue.

Montgomery: Yes, that is a good point to make. I think that comes back to the methodology that is used, and I believe that they do try to be fairly generous in the exclusion criteria that is used.

Brown: I think that is important to look at when we are talking about making a recommendation, especially when reducing higher dollar unnecessary tests.

Dr. Kahn: If the provider doesn’t code the diagnosis, then it does look wasteful.

Murtha: With the ear infections, what are the criteria behind this?

Dr. Kahn: This one only looked at upper respiratory infections and external ear or swimmers ear.

Dr. Vinson: I’m certainly comfortable with provider education on any of these that you feel meaningful, especially with the Vitamin D one. We don’t need an exhaustive report, but just to see how it changes over time.

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**Director’s Report by: Chris Howlett, EBD Executive Director**

Howlett provided an update on the AARP EEOC. The main issue that we will have to look at will be the 30% incentivization by that population with the dollar amount we are giving as an incentive for the wellness discount to the premium on the plan.

Dr. Vinson: What percentage are we?

Howlett: Everything is fine; the only exception would be the Basic plan on the PSE side. When you look at the numbers, it’s of the unsubsidized dollar amount so we fell way below.
MOTION by Murtha.

Move to adjourn.

Dr. Vinson seconded. All were in favor.

Meeting adjourned.
December 2018
Quality of Care Subcommittee Presentation

Mike Motley, MPH
Assistant Director of Health Policy, ACHI

Izzy Montgomery, MPA
Policy Analyst, ACHI
Objectives for Presentation

• Review the following items:
  – Follow up items from previous meeting
  – 3 additional low-value services

• Discuss next steps for analyses and recommendations
Follow up Question: Provider Variation Trends

• Providers in Top 10 of low-value services (comparing 2017 to 2016):
  – Annual EKG: 9 of the same providers in 2016
  – Coronary Angiography: 3 of the same providers in 2016
  – Eye Imaging: 9 of the same providers in 2016
  – Antibiotics: 6 of the same providers in 2016
# Top 8 Low-Value Services Within EBD (2017)

<table>
<thead>
<tr>
<th>Low-Value Service</th>
<th>Number of Distinct Members with a Low-Value Service</th>
<th>Number of Low-Value Services</th>
<th>Low-Value Total Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Don’t obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery — specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss (or fluid shifts) is expected to be minimal.</td>
<td>9,118</td>
<td>13,060</td>
<td>$4,028,766</td>
</tr>
<tr>
<td>2. Don’t order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.</td>
<td>9,643</td>
<td>10,274</td>
<td>$1,612,932</td>
</tr>
<tr>
<td>3. Don’t routinely order imaging tests for patients without symptoms or signs of significant eye disease.</td>
<td>8,187</td>
<td>12,875</td>
<td>$1,236,098</td>
</tr>
<tr>
<td>4. Don’t order unnecessary cervical cancer screening (Pap smear and HPV tests) in all women who have had adequate prior screening and are not otherwise at high risk for cervical cancer.</td>
<td>7,676</td>
<td>7,762</td>
<td>$740,322</td>
</tr>
<tr>
<td>5. Don’t perform coronary angiography in patients without cardiac symptoms unless high-risk markers are present.</td>
<td>202</td>
<td>205</td>
<td>$372,219</td>
</tr>
<tr>
<td>6. Don’t do imaging for uncomplicated headache.</td>
<td>557</td>
<td>584</td>
<td>$258,925</td>
</tr>
<tr>
<td>7. Don’t perform population-based screening for 25-OH-Vitamin D deficiency.</td>
<td>2,925</td>
<td>3,050</td>
<td>$193,703</td>
</tr>
<tr>
<td>8. Don’t prescribe oral antibiotics for members with upper URI or ear infection (acute sinusitis, URI, viral respiratory illness, or acute otitis externa).</td>
<td>24,853</td>
<td>32,503</td>
<td>$186,219</td>
</tr>
</tbody>
</table>
Too Frequent Cervical Cancer Screening
Too Frequent Cervical Cancer Screening

• Measure based on Choosing Wisely recommendations from 4 physician specialty societies:
  – American College of Obstetricians and Gynecologists: Don’t perform routine annual cervical cytology screening (Pap tests) in women 30–65 years of age
  – American Academy of Family Physicians: Don’t screen women older then 65 years of age for cervical cancer who have had adequate prior screening and are not otherwise at high risk for cervical cancer

Source: Choosing Wisely, American College of Obstetricians and Gynecologists (released February 2013) and Choosing Wisely, American Academy of Family Physicians (released February 2013)
Too Frequent Cervical Cancer Screening

– American Academy of Family Physicians: Don’t perform Pap smears on women younger than 21 who have had a hysterectomy for non-cancer disease
– American Academy of Family Physicians: Don’t screen women younger than 30 years of age for cervical cancer with HPV testing, alone or in combination with cytology
– American Society for Clinical Pathology: Don’t perform low-risk HPV testing

Source: Choosing Wisely, American Academy of Family Physicians (released April 2012), American Academy of Family Physicians (released February 2013), and American Society for Clinical Pathology (released February 2013).
Too Frequent Cervical Cancer Screening

• Rationale for recommendations:
  – Pre-cancerous changes of the cervix lead to cervical cancer, but progression of these changes to invasive cancer is slow
  – Sufficient evidence to suggest that too frequent testing does not add clinical value and is considered wasteful
  – Observed but benign abnormalities can lead to unnecessary anxiety, additional testing, excessive cost

Source: Washington Health Alliance, “First, Do No Harm” (released February 2018)
## Too Frequent Cervical Cancer Screening

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Low-Value Services</th>
<th>Number of Distinct Members with a Low-Value Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>7,762</td>
<td>7,676</td>
</tr>
</tbody>
</table>

### Percentage of Low-Value Services by Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>3.1%</td>
</tr>
<tr>
<td>25-34</td>
<td>12.7%</td>
</tr>
<tr>
<td>35-44</td>
<td>23.9%</td>
</tr>
<tr>
<td>45-54</td>
<td>26.6%</td>
</tr>
<tr>
<td>55-64</td>
<td>26.2%</td>
</tr>
<tr>
<td>&gt;= 65</td>
<td>7.5%</td>
</tr>
</tbody>
</table>
Too Frequent Cervical Cancer Screening

2016 and 2017 Low-Value Service Volume Trend

2016: 10,347
2017: 7,762

Number of Low-Value Services
Population-Based Screening for Vitamin D Deficiency
Population-Based Screening for Vitamin D Deficiency

- Measure is based on Choosing Wisely recommendation from American Society of Clinical Pathology:
  - Don’t perform population based screening for Vitamin D deficiency

Source: Choosing Wisely, American Society for Clinical Pathology (released on February 2013)
Population-Based Screening for Vitamin D Deficiency

• Rationale for recommendation:
  – Inadequate evidence that screening improves outcomes, except in high-risk patients
  – Examples of high-risk patients include individuals with bone disease, kidney disease, liver failure, obesity, history of falls, or use of certain medications

Source: Choosing Wisely, American Society for Clinical Pathology (released on February 2013)
## Population-Based Screening for Vitamin D Deficiency

<table>
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</thead>
<tbody>
<tr>
<td>2017</td>
<td>3,050</td>
<td>2,925</td>
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### Percentage of Low-Value Services by Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 18</td>
<td>4.3%</td>
</tr>
<tr>
<td>18-24</td>
<td>4.8%</td>
</tr>
<tr>
<td>25-34</td>
<td>8.8%</td>
</tr>
<tr>
<td>35-44</td>
<td>17.3%</td>
</tr>
<tr>
<td>45-54</td>
<td>23.8%</td>
</tr>
<tr>
<td>55-64</td>
<td>30.7%</td>
</tr>
<tr>
<td>&gt;= 65</td>
<td>10.4%</td>
</tr>
</tbody>
</table>
Population-Based Screening for Vitamin D Deficiency

2016 and 2017 Low-Value Service Volume Trend

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Low-Value Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>3,368</td>
</tr>
<tr>
<td>2017</td>
<td>3,050</td>
</tr>
</tbody>
</table>
Antibiotics for Acute Upper Respiratory and Ear Infections
Antibiotics for Acute Upper Respiratory and Ear Infections

• Measure based on Choosing Wisely recommendations from 6 physician specialty societies:
  – American Academy of Pediatrics: Antibiotics should not be used for apparent viral respiratory illnesses (sinusitis, pharyngitis, bronchitis)
  – Infectious Disease Society of America: Avoid prescribing antibiotics for upper respiratory infections
  – American Academy of Allergy, Asthma & Immunology: Don’t order sinus CT or indiscriminately prescribe antibiotics for uncomplicated acute rhinosinusitis

Antibiotics for Acute Upper Respiratory and Ear Infections

– American Academy of Family Physicians: *Don’t routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for seven or more days, or symptoms worsen after initial clinical improvement*

– American College of Emergency Physicians: *Avoid prescribing antibiotics in the emergency department for uncomplicated sinusitis*

– American Academy of Otolaryngology: *Don’t prescribe oral antibiotics for uncomplicated acute external otitis*

Antibiotics for Acute Upper Respiratory and Ear Infections

• Rationale for recommendation:
  – Most acute upper respiratory infections (URIs) are viral and the use of antibiotic treatment is ineffective, inappropriate and potentially harmful
  – Misusing antibiotics in viral infections may lead to increased costs, antimicrobial resistance, adverse effects

Source: Choosing Wisely, Infectious Disease Society of America (released February 2015).
Antibiotics for Acute Upper Respiratory and Ear Infections

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Low-Value Services</th>
<th>Number of Distinct Members with a Low-Value Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>32,503</td>
<td>24,853</td>
</tr>
</tbody>
</table>

Percentage of Low-Value Services by Age Group

- < 18: 14.4%
- 18-24: 7.2%
- 25-34: 12.1%
- 35-44: 16.5%
- 45-54: 19.3%
- 55-64: 21.2%
- >= 65: 9.4%
Antibiotics for Acute Upper Respiratory and Ear Infections

2016 and 2017 Low-Value Service Volume Trend

- 2016: 30,929
- 2017: 32,503

Number of Low-Value Services
Antibiotics for Acute Upper Respiratory and Ear Infections

2017 provider variation of low-value services

- 113 providers
Potential Considerations to Address Overuse

• Member and patient engagement strategies:
  – Disseminate information to members about the risks and potential harms of receiving low-value services
  – Engagement can be done through existing EBD communication channels (member newsletters, targeted or general direct mail, etc.)

Vitamin D tests
When you need them—and when you don’t

Many people don’t have enough vitamin D in their bodies. Low vitamin D increases the risk of broken bones. It may also contribute to other health problems. That’s why doctors often order a blood test to measure vitamin D.

But many people do not need the test. Here’s why:

A test usually does not improve treatment. Many people have low levels of vitamin D, but few have seriously low levels. Most of us don’t need a vitamin D test. We just need to make simple changes to get enough vitamin D. We need to get a little more sun and follow the other advice on the next page.

Source: Choosing Wisely, Vitamin D Tests: When you need them—and when you don’t & Excellus Vitamin D Handout.
Potential Considerations to Address Overuse

• Benefit design strategies:
  – Identify any existing coverage policies which may be out of line with recommendations and modify accordingly
  – Incentivize members to use online decision-making tools when considering the appropriateness of certain health services
  – Work with third-party administrator on value-based payment design

Potential Considerations to Address Overuse

• Provider engagement strategies:
  – Reminders for clinicians and their staff on the risks and potential harms of low-value services
  – Collaborate with local chapters of physician specialty societies on a broader education effort around Choosing Wisely
  – Provide patient education materials to physicians
  – Provide information to clinicians on how often they screen relative to their peers

Addressing Unnecessary Antibiotic Use: Medicaid Episode of Care Example

• Arkansas Medicaid launched a URI episode of care payment model in 2012

• Quality measures include rate of antibiotics filled

• About 600 providers receive quarterly reports detailing their performance compared to peers

• From 2012–2015, prescribing rate decreased from 45% to 32% — a reduction of 28%