



## **AGENDA**

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

**February 12, 2019**

**1:00 p.m.**

**EBD Board Room – 501 Building, Suite 500**

- I. Call to Order.....Margo Bushmaier, Chair*
- II. Approval of January Minutes.....Margo Bushmaier, Chair*
- III. Choosing Wisely Analysis ..... Mike Motley, Izzy Montgomery, ACHI*
- IV. Director’s Report ..... Chris Howlett, EBD Executive Director*

#### ***Upcoming Meetings***

***March 12, 2019, April 9<sup>th</sup>, 2019, May 14<sup>th</sup>, 2019***

***NOTE: All material for this meeting will be available by electronic means only [ASE-PSE BOARD@dfa.arkansas.gov](mailto:ASE-PSEBOARD@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

### February 12, 2019

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Date | time 2/12/2019 1:00 PM | Meeting called to order by Margo Bushmiaer, Chair

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#### Attendance

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##### Members Present

Michelle Murtha - Vice-Chair

Margo Bushmiaer - Chair

Dr. Arlo Kahn

Dr. Terry Fiddler

Melissa Moore

Cindy Gillespie - Teleconference

Pam Brown

Dr. Namvar Zohoori

Zinnia Clanton

Chris Howlett, EBD Executive Director, Employee Benefits Division

##### Members Absent

Dr. John Vinson

##### Others Present:

Eric Gallo, Rhoda Classen, Theresa Huber EBD; Mike Motley, Elizabeth Montgomery, ACHI; Takisha Sanders, Jessica Akins HA; Ronda Walthall, ARDOT; Micah Bard, Dwight Davis, UAMS

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#### Approval of Minutes by: Margo Bushmiaer, Chair

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##### MOTION by Dr. Fiddler

I motion to approve the January 15, 2019 minutes.

Clanton seconded. All were in favor.

##### Minutes Approved.

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#### ACHI Updates by: Mike Motley, Elizabeth Montgomery, ACHI

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Mike Motley and Elizabeth Montgomery presented updates for the top 8 low-value services and discussed next set of analyses for subcommittees.

##### Discussion:

Dr. Fiddler: If you continue to have providers with high volumes of low risks, what do you tell them? When they still do it after being told, where do you go?

Dr. Kahn: Well I think the progression is, first you show them how they stack up with their peers and how many low value services they are doing. A certain number of them will look back and realize that society are telling them not to do it and stop. For those who refuse to stop, I think that is the next step in that the Plan and Health Advantage would want to say that we aren't going to pay for that.

Dr. Fiddler: So, it would be up to Health Advantage to do that?

Dr. Kahn: I think the EBD Board would eventually have to go along if Health Advantage made that determination. According to what we just learned then it automatically becomes the Board position too. If Health Advantage didn't change and continued to pay for unnecessary tests, the Board could override that.

Dr. Zohoori: How does 2017 low-value cervical screenings compare to 2016?

Montgomery: It did trend down. In 2016, there were about 10,000 low-value service cervical cancer screenings and in 2017 there were 7,700.

Dr. Fiddler: How much will it reduce on coronary angiography if we were not providing those services; how many millions of dollars? What about annual EKG's and cardiac screenings, the cervical cancer screenings, and the unnecessary labs?

Motley: For the coronary angiography it is about 200 services a year which comes to approximately \$400,000. \$1.6 million across about 10,000 services, but as a caveat these are ballpark numbers. It would be \$740,000 across 7,700 services for the cervical cancer screenings. Lastly, it would \$4,013,000 services for the unnecessary labs.

Murtha: You cannot tell specific physician but, you can tell what facility. Can you tell if it is more hospital-based facilities or free standing?

Motley: We have made some reasonable judgements based on the name of the facility that is listed there. It's fairly easy to tell but, can sometimes be a little tricky.

Montgomery: If it is billed through a hospital system, it is more difficult to discern. On the other hand, if there is a standalone clinic, it would be easier.

Murtha: **Can you tell if it was through an emergency department or a committed admitted patient.**

Montgomery: I am not sure but, we could have that as a takeaway.

Motley: With further investigation into the claims, that is something we could look for, those revenue codes specific to those settings.

Howlett: It would depend on if it is something that is in a bundled service versus unbundled. We might be able to look at the claims load and see if the origination was in an ER with an inpatient stay. Some of the larger facilities may have multiple partners that would be harder to determine.

Dr. Kahn: The solution for all these issues where we can't identify who ordered these tests would be to require the claims to contain the ordering physician. I don't know if that requires legislation, or if the EBD Board could say we aren't paying claims unless the provider is listed. There are so many different aspects of what we are trying to do to control waste that we can't really get to the person who is wasting because we don't know who they are.

Howlett: When you have a multi-based provider clinic where they are using the same provider number, that might get complicated. On the surface it may seem logical but, there might be a better way to arrive at the same information that doesn't require legislation.

Dr. Fiddler: What if we didn't put it all on the physicians? In my view, insurance companies don't necessarily like to pay claims. For them to gain something back, Health Advantage should be the major partner in saying we're not going to pay these anymore because they are unnecessary.

Howlett: That is part of why we have arrived at amping up the plan's partnership in trying to do peer to peer evaluations with potential misuse. Internally, it will be interesting to see how we can fully put something out. We are continuing to produce follow-up data every quarter as much as we can to have the revised data and output to see how it is producing. Another piece to look at is how we are going to partner with Health Advantage for the network provider reps that will go out and do that along with the AHEN system. Something we can do is ask what we can do as a plan ask Health Advantage to do beyond their contracted relationship with their providers as well as our contract and look at how can we put things in place that say the very same thing.

Murtha: Going back and looking at the cholesterol and the lipid panels. They draw them one time and if they need statins, put them on statins, and if they don't they don't ever draw them again. The recommendation is for every five years. I understand not doing them annually, but is there not a recommendation that at a certain age where they should be retested?

Dr. Kahn: Those studies haven't been done that tell if someone who is borderline should get retested every three years, five years, or 10 years. It is between the patient and provider to determine when to have it done again.

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

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Howlett spoke on the calendar change of the Benefits Sub-Committee meetings. They have been moved to the Friday after the Quality of Care meetings. We have already worked on improving communications and literacy. We are also keeping an eye on the EEOC AARP and as of right now there are no changes. The only other thing is the gender reassignment, but it is still tied up in the Texas courts.

**MOTION** by Brown

Move to adjourn.

Murtha seconded. All were in favor.

**Meeting adjourned.**

# FEBRUARY 2019 QUALITY OF CARE SUBCOMMITTEE PRESENTATION

Mike Motley, MPH

Assistant Director of Health Policy

Izzy Montgomery, MPA

Policy Analyst

02.14.2018



# AGENDA

- Present recommendations for top 8 low-value services
- Discuss next set of analyses for subcommittee presentation



# MEASURE-SPECIFIC RECOMMENDATIONS FOR TOP 8 LOW-VALUE SERVICES



# UNNECESSARY PREOPERATIVE BASELINE LABS

- Work with Health Advantage to notify providers that specialty society organizations recommend against baseline lab studies in patients without significant systemic disease undergoing low-risk surgery (e.g. blood counts, metabolic panels, coagulation studies)
- Work with Health Advantage on member education and outreach, suggesting that members ask their physicians about the necessity for any blood test ordered in association with low-risk surgery
- Quarterly, evaluate progress in decreasing these low-value tests
  - Consider implementing other strategies if not successful

*\*Specific ordering providers of preoperative baseline lab tests cannot be identified in the EBD claims data*



# ANNUAL EKG'S AND OTHER CARDIAC SCREENINGS

- Work with Health Advantage to contact providers with high volumes of annual EKGs in low-risk patient populations
- Previously, ACHI recommended to the Wellness Subcommittee that lipid panels and blood glucose tests should only be performed one time for existing employees in 2018 and for new hires in subsequent years
- To align with *Choosing Wisely*, consider eliminating annual lipid panels & blood glucose tests in future years

*\*Evaluation of 2018 lipid panels is likely to show high-volume of unnecessary services due to new wellness incentive program*



# IMAGING FOR EYE DISEASE

- In last month's meeting, EBD Leadership clarified that all EBD plans are subject to Health Advantage coverage policies
- Health Advantage already has a coverage policy in place for anterior segment optical coherence tomography
- Work with Health Advantage to ensure that other routine low-value eye imaging services are not paid for in patients without signs or symptoms of eye disease, including:
  - Posterior optical coherence tomography
  - Fundus photography
  - Visual field testing
  - External and internal eye photography



# TOO FREQUENT CERVICAL CANCER SCREENINGS

- EBD adopted Blue Cross Blue Shield cervical cancer screening policy in 2016, which covers pap testing every 3 years in low-risk women
- Since analyses showed that many low-value cervical screenings were paid for in 2017, further evaluate why pap tests have continued to be paid for contrary to the adopted coverage policy change

*\*The frequency of low-value pap tests has declined but several thousand were paid for in 2017*



# CORONARY ANGIOGRAPHY

- Work with Health Advantage to directly contact providers with high volumes of low-value angiography
- Evaluate progress in decreasing volume of these low-value tests
  - Consider implementing other strategies if not successful

*\*Previous analysis identified 67 providers who ordered these low-value services in 2017*



# IMAGING FOR UNCOMPLICATED HEADACHES

- Review prior authorization criteria for imaging for headaches to identify and influence those who order a high-volume of low-value imaging services

*\*Specific ordering providers of head imaging tests cannot be identified in the EBD claims data*



# VITAMIN D SCREENING

- In last month's meeting, EBD Leadership clarified that all EBD plans are subject to Health Advantage coverage policies
- Health Advantage does not cover population-based screening for Vitamin D deficiency in low-risk patients, as of June 2018
- Since coverage policy just went into effect in 2018, recommend evaluating change in utilization for last half of 2018 and all of 2019



# ANTIBIOTICS FOR UPPER RESPIRATORY INFECTION (URI)

- Work with Health Advantage to notify all providers that their own societies recommend against prescribing antibiotics for low-risk URI or external ear infections
- Work with Health Advantage on member education and outreach, suggesting that members ask their physicians about the necessity for antibiotics for URI and external ear infections
- Reevaluate progress quarterly in decreasing the use of this low-value service
  - Consider implementing other strategies if not successful



# UPCOMING ANALYSES

