



AGENDA

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

January 14th, 2020

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

- I. Call to Order.....Dr. John Vinson, Chair*
- II. Approval of November Minutes.....Dr. John Vinson, Chair*
- III. Flu Shot/Health Waste Calculator Update....Elizabeth Montgomery & Mike Motley, ACHI*
- IV. Director's Report Chris Howlett, EBD Director*
- V. Adjournment.....Dr. John Vinson, Chair*

Upcoming Meetings

February 11th, March 10th, April 7th

NOTE: All material for this meeting will be available by electronic means only.

Notice: 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

January 14, 2020

Date | time 01/14/2020 1:00 PM | Meeting called to order by Dr. John Vinson, Chair

Attendance

Members Present

Dr. John Vinson – Chair
Margo Bushmiaer – Vice-Chair
Michelle Murtha
Dr. Arlo Kahn
Cindy Gillespie - Teleconference
Zinnia Clanton
Dr. Terry Fiddler
Dr. Appathurai Balamurugan - Teleconference
Pam Brown
Chris Howlett, Employee Benefits Division (EBD) Director

Members Absent

Others Present:

Rhoda Classen, Theresa Huber, EBD; Elizabeth Montgomery, Mike Motley, ACHI; Jessica Akins, HA; Micah Bard, UAMS EBRx

Approval of Minutes: *Dr. John Vinson, Chair*

MOTION by Dr. Fiddler

I motion to approve the November 12, 2019 minutes.

Clanton seconded. All were in favor.

Minutes Approved.

Flu Shot/Health Waste Update: *Mike Motley and Elizabeth Montgomery, ACHI*

Motley and Montgomery addressed follow-up questions from the last meeting and discussed the upcoming update of Health Wasted Calculator analysis.

Discussion:

Flu Shot

Dr. Kahn: It's not too late to try and engage our members to get a flu shot, however we go about doing that.

Howlett: We put out communication with our newsletter and face-to-face as well. We have done some flu clinics here as well.

Dr. Fiddler: When you have this late of a flu period, have they gone into a large amount of reformulation of the vaccine or does it remain the same?

- Dr. Kahn: They usually reformulate before the season starts and then they won't change it again until the next season.
- Dr. Fiddler: How long does it take to do a reformulation? About 90 days?
- Dr. Kahn: I would think that it would take at least that long.
- Dr. Vinson: Is there a way to compare each department to how the plan is doing overall? It would help to know where the weak spots are so that we can move the needle.
- Gillespie: What about booster shots? Are there rules we could include in terms of people who have very young children or older people to encourage them to get the flu shot?
- Dr. Kahn: There is. People over age 60-65 are supposed to get a special kind which has a much higher amount of flu vaccine. In a sense, that is a boosted immunity for those who tend to have less response to the vaccine. It takes about two weeks to kick in. The only reason you would want to get a booster is if you got it early on and then the outbreak continues longer than expected.
- Dr. Vinson: There is no solid recommendation from the CDC about giving a second shot other than the physician judgement call in a specific patient situation.

Low-Value Services

- Brown: There was an increase in the number of members with that service and also an increase in the number of services, yet the cost went down.
- Montgomery: When we looked at the output for that and see a lower unit cost, looking at each of those measure the actual dollar amount that was attributed to a preoperative baseline lab was lower for each individual service. The cost is something we have to take with a grain of salt, since it is just that unit cost being presented. I would assume there are members who are getting multiple preoperative baseline lab studies more than once a year.

Annual EKG's

- Dr. Fiddler: Would the 5,027 be a different demographic group of people than the 2,204, because it is not a year apart?
- Dr. Kahn: It would really be too bad if people were getting more than one unnecessary EKG a year. It may be that everybody got their EKG's in November or December because they wanted to have their annual visit to get the discount.
- Dr. Fiddler: If we were not changing the minds of the physician or the patient then you would expect in the 3rd quarter of 2019 to see 5,027 people that would be doing that again.
- Dr. Kahn: Yes, if we haven't changed anything then it should look the same in quarter three of 2019.
- Howlett: If you were to look at seasonality of the claims and when a member hits the maximum out-of-pocket the plan picks up the 100%; When that happens, predictably in the 3rd and 4th quarter, you have an artificial piece happening with couponing and patience assistance on the pharmacy side that artificially creates a maximum out-of-pocket for the plan. We have taken steps in the last seven months to mitigate that so starting 1/1/2020, we shouldn't see where anything artificial would be impacting the maximum out-of-pocket. We will have a true head count of what that is year in and year out going forward.
- Dr. Fiddler: Do you have a 4th quarter of 2017? I'm curious to see what that number would be? It would give us another year to see where we are.
- Montgomery: We could add one to two more quarters previously.
- Dr. Fiddler: That would give us at least two factors that would give us a baseline.

Montgomery: That is something that we can bring back.

Dr. Vinson: In theory, could you have separate deductibles from medical and pharmacy where they didn't intertwine? Do the rules allow you to do that? Is the cost represented here the plan spend and what is the total cost of an EKG? We are always putting PA's on drugs or stop covering drugs or stop doing this or that, but on the medical side of the plan it's always not doing anything to block the coverage or payment of something and make it as easy as possible. We educate the prescribers and patients, but yet we still have thousands and millions of dollars spent. Is there something we can do?

Motley: That is the plan paid amount that you are seeing.

Brown: I think that there are things that are happening with Medicare, beginning in January, they started using the checklist for CT scans and if you don't meet that they won't pay for it.

Howlett: On some of the wasteful services being reviewed, we have placed pre-certifications and PA criteria on procedures and other things on the medical side. It might not be at the same percentage of gain, but we don't have a whole lot of new procedures coming out like we have new drugs. I would say that drugs have more PA criteria to them than the medical procedures because a lot of it is status quo. The same procedures that were being done 10 years ago are still being done now, it just may be in different form or fashion. As far as cost, the plan spend is plan dollars expelled from this plan absent or minus any copays or deductibles by the member.

Dr. Vinson: If we wanted to make a recommendation, in theory, that all EKG's require a PA. I would like to know how many EKG's have been done that didn't show up on this list. What percent of the total EKG's are these 13,000?

Montgomery: That is something the tool does provide as well so we can look at the flip side of that.

Dr. Vinson: We have to weigh in how disruptive it is to all the people getting them for appropriate reasons before we make a recommendation.

Brown: When we look at this and dollars spent, we also need to look at what is happening. If we have a downward trend it might not be something, we want to take a stance on if we continue to see that trend. Do you ever give providers feedback reports?

Howlett: Nothing directly by specialty, there are provider satisfaction scores and things that do come out.

Cervical Cancer Screenings

Brown: Just as a balancing measure, have you ever followed the diagnosis of cervical cancer to see what is happening with it in correlation to the decrease in screening?

Montgomery: When we did the analysis, we didn't track it that way, but we did look at the flip side of how many women were getting appropriate Pap tests and I know that we were a little below that. I think we did also look at cervical cancer prevalence rates within the plan.

Coronary Angiography

Howlett: Is that number not low? What is the protocol that leads up to that?

Dr. Kahn: This is people who are getting coronary angiograms who really shouldn't have them. It's somebody who comes in and says he is worried about his heart and states that he should have an angiogram and the doctor allows it. There is no justification for it at all.

Howlett: If they shouldn't be done, what would be a correct way to offer that? If they shouldn't be done, why is it an offered service? Why are doctors doing them?

Dr. Fiddler: There are specific services that have specific coding and if this is not included, but there is a situation that you really needed an exception can be made.

- Howlett: Out of principle, if it's not something that would ever be warranted, why would we not want to have it being paid.
- Dr. Kahn: You would have to look at their charts. The coding says they didn't put an appropriate code to allow them to have done that angiogram. If you wanted to do a chart review and you could find out what the reason was. It could be as simple as not coding it right.
- Howlett: Do you have provider counts on all of these? From my standpoint, clinically there are needs for the angiogram.
- New Low-Value Services*
- Dr. Bala: On slide 14 number 4, would that include the employment insurance physicals done by companies or is that separate.
- Dr. Kahn: The key phrases in here are "that include comprehensive physical examination and lab testing" and what they are saying is, if you want to do annual visits don't do comprehensive physical exams and lab work in asymptomatic patients. Our annual wellness visit doesn't require physical exams I don't think.

Director's Report: Chris Howlett, EBD Director

Howlett provided an update on the 2020 wellness. 83% of the population completed their wellness requirements which is slightly lower than last year, about a 300-person difference. One of the things that you can expect is looking at the tobacco testing and cessation and how we can potentially work through those nuances.

- Dr. Fiddler: Is it possible the reason we had this 6% drop was because you put in the tobacco monitoring and those represent those that don't have any interest in quitting?
- Howlett: It would be false to assume at this stage without looking at it that tobacco had any play in it. We are not sure why we had this reduction yet.
- Dr. Kahn: Could that be a good thing that we reduced by 6% the number of people who got the discount?
- Howlett: No, I believe when you look at it actuarially, we are still going to have some form of cost because it doesn't mean we are healthier. It doesn't mean they are decreasing their spend. We are looking to determine where these people lay and why. Everyone has an individual right to make their own decisions. Where I think it will become more of an issue over diabetes or any other co-condition is under ACA where tobacco use is allowed to be surcharged. If you go back to 2017, the average smoker costs the plan \$6,348 more than a nonsmoker.

MOTION to adjourn by Dr. Fiddler

Bushmiaer seconded. All were in favor.

Meeting Adjourned.

JANUARY 2020

QUALITY OF CARE PRESENTATION

Mike Motley, MPH
Director, Analytics

Izzy Montgomery, MPA
Policy Analyst

1.14.2020

FLU VACCINATION RATES AMONG EBD MEMBERS

Flu Season	Total Members with Flu Vaccine	Total Member Enrollment	Percentage of Total Members
FY 2013	51,574	148,180	35%
FY 2014	62,444	148,510	42%
FY 2015	51,481	146,293	35%
FY 2016	52,361	147,704	35%
FY 2017	46,100	150,002	31%
FY 2018	57,452	152,724	37%
FY 2019	59,626	156,983	38%



OBJECTIVE

Review updated Health Waste Calculator analysis assessing low-value services within the plan



HEALTH WASTE CALCULATOR BACKGROUND

- MedInsight Health Waste Calculator is a tool which identifies low-value services and spending
- ACHI utilized tool to examine common treatments deemed to be low-value or potentially unnecessary
- Two additional states have published reports based on findings from this tool, including Virginia and Washington



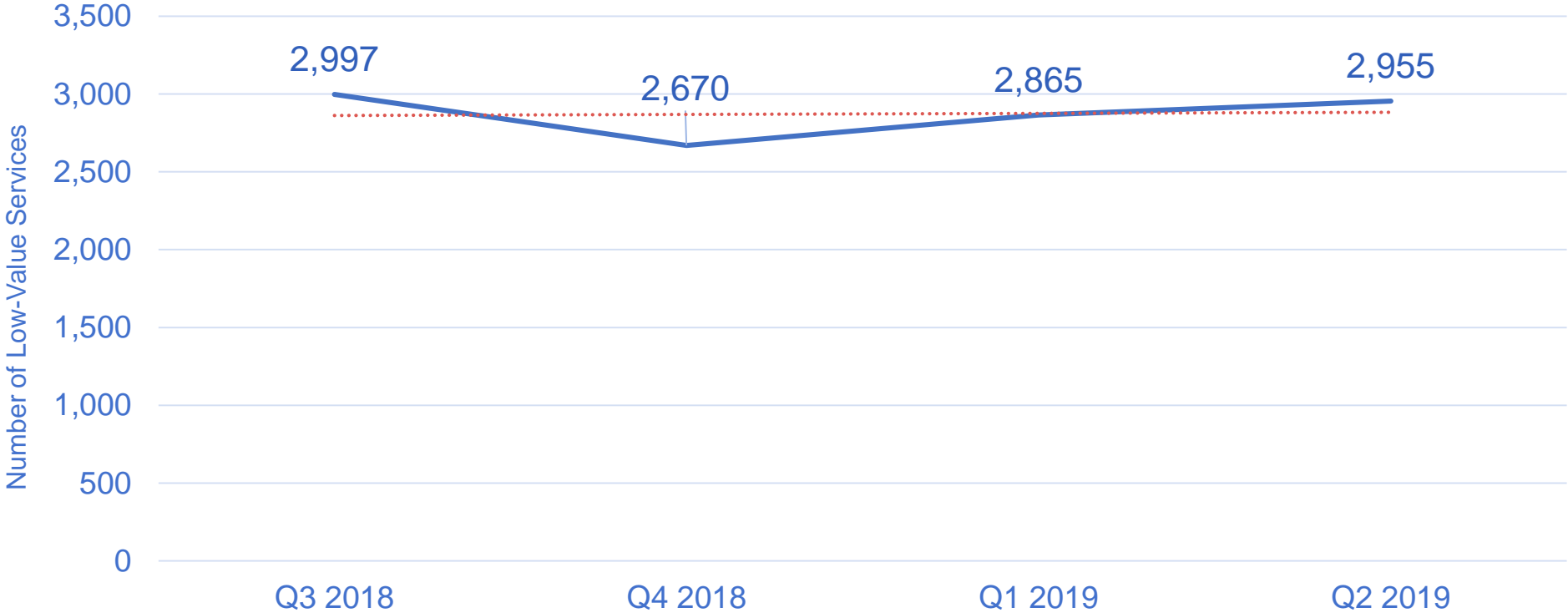
PREVIOUS 8 LOW-VALUE SERVICES

*Values in red reflect updates based on July 2018 – June 2019 output.

Low-Value Service (July 2017 – June 2018 Vs. July 2018 – June 2019)	Distinct Members with Low-Value Service	Number of Low-Value Services	Low-Value Dollars
1. Don't obtain baseline lab studies in low-risk patients 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.	9,243 9,625↑	10,970 11,532↑	\$1,957,979 1,636,242↓
2. Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.	11,335 12,465↑	12,545 13,686↑	\$1,769,594 \$2,035,939↑
3. Don't routinely order imaging tests for patients without symptoms or signs of significant eye disease.	6,907 6,622↓	10,430 9,528↓	\$1,061,830 \$1,048,872↓
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.	7,641 6,499↓	7,777 6,623↓	\$735,239 \$515,631↓
5. Don't perform coronary angiography in patients without cardiac symptoms unless high-risk markers are present.	215 193↓	220 195↓	\$452,377 \$333,337↓
6. Don't do imaging for uncomplicated headache.	385 413↑	396 425↑	\$121,819 \$161,720↑
7. Don't perform population-based screening for 25-OH-Vitamin D deficiency.	3,398 2,462↓	3,533 2,569↓	\$201,953 \$116,358↓
8. Don't prescribe oral antibiotics for members with upper URI or ear infection (acute sinusitis, URI, viral respiratory illness, or acute otitis externa).	23,993 18,956↓	30,796 23,083↓	\$110,931 \$77,763↓



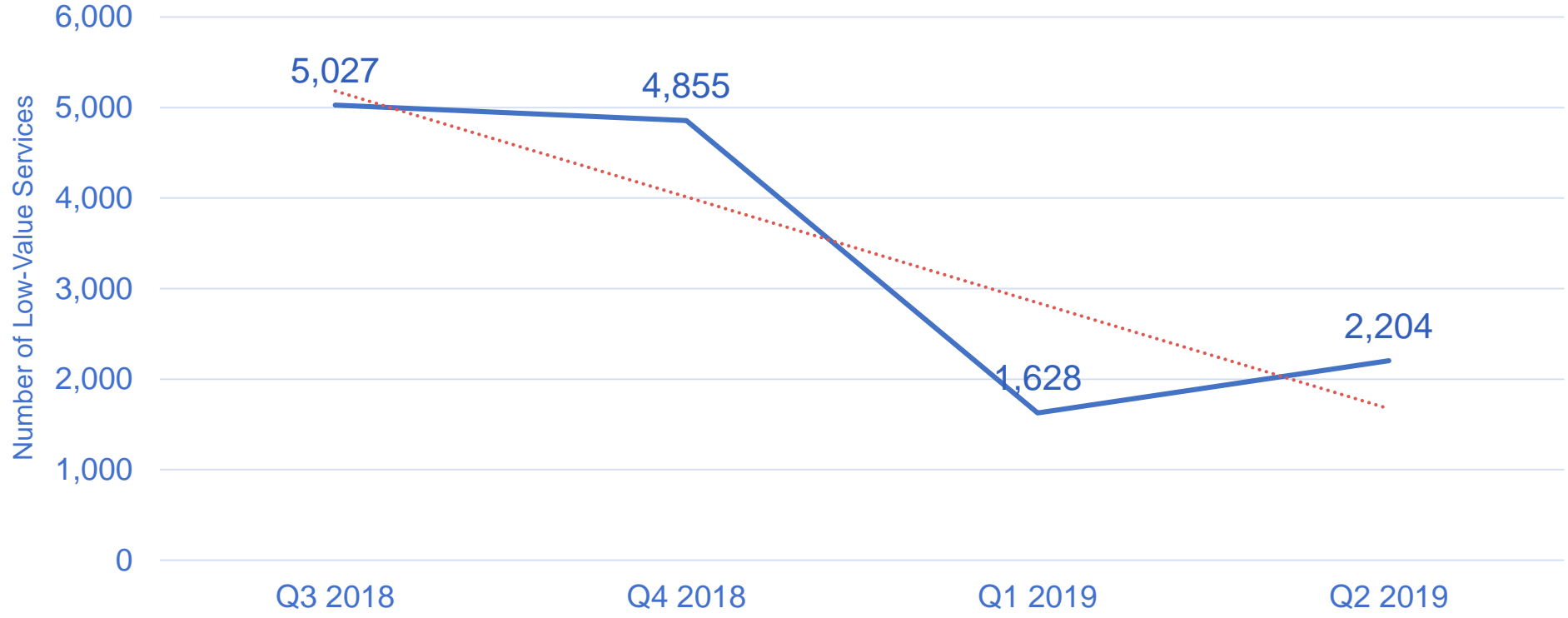
LOW-VALUE SERVICES QUARTERLY TREND: PREOPERATIVE BASELINE LABS



Note: Quarters represent calendar year quarters, not state fiscal year quarters.



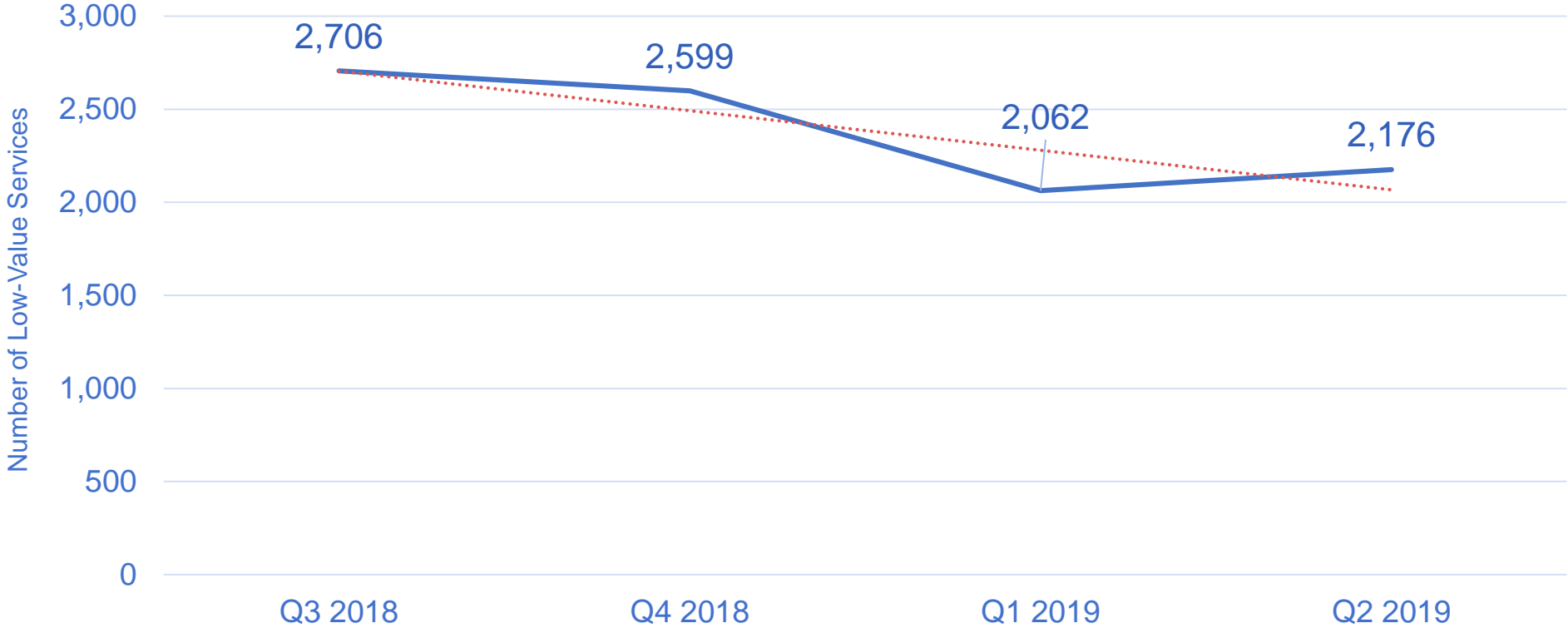
LOW-VALUE SERVICES QUARTERLY TREND: ANNUAL EKG'S



Note: Quarters represent calendar year quarters, not state fiscal year quarters.



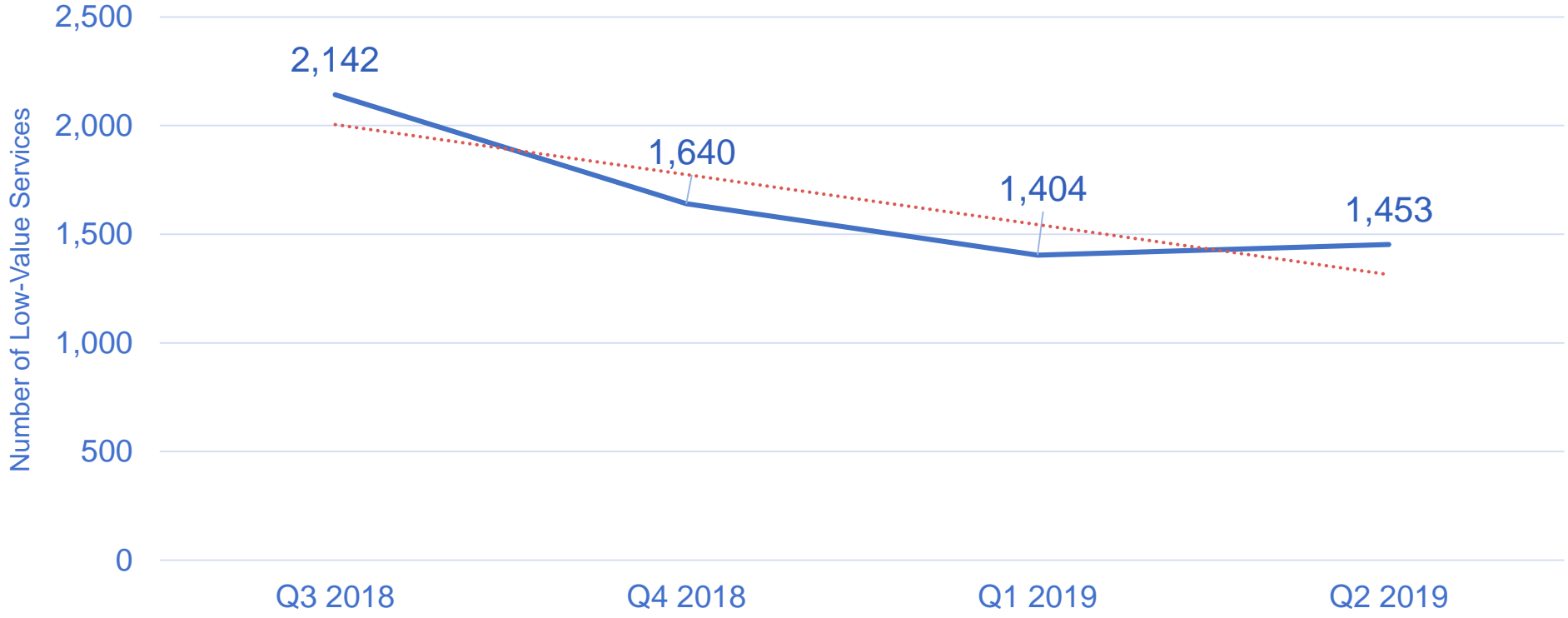
LOW-VALUE SERVICES QUARTERLY TREND: EYE IMAGING



Note: Quarters represent calendar year quarters, not state fiscal year quarters.



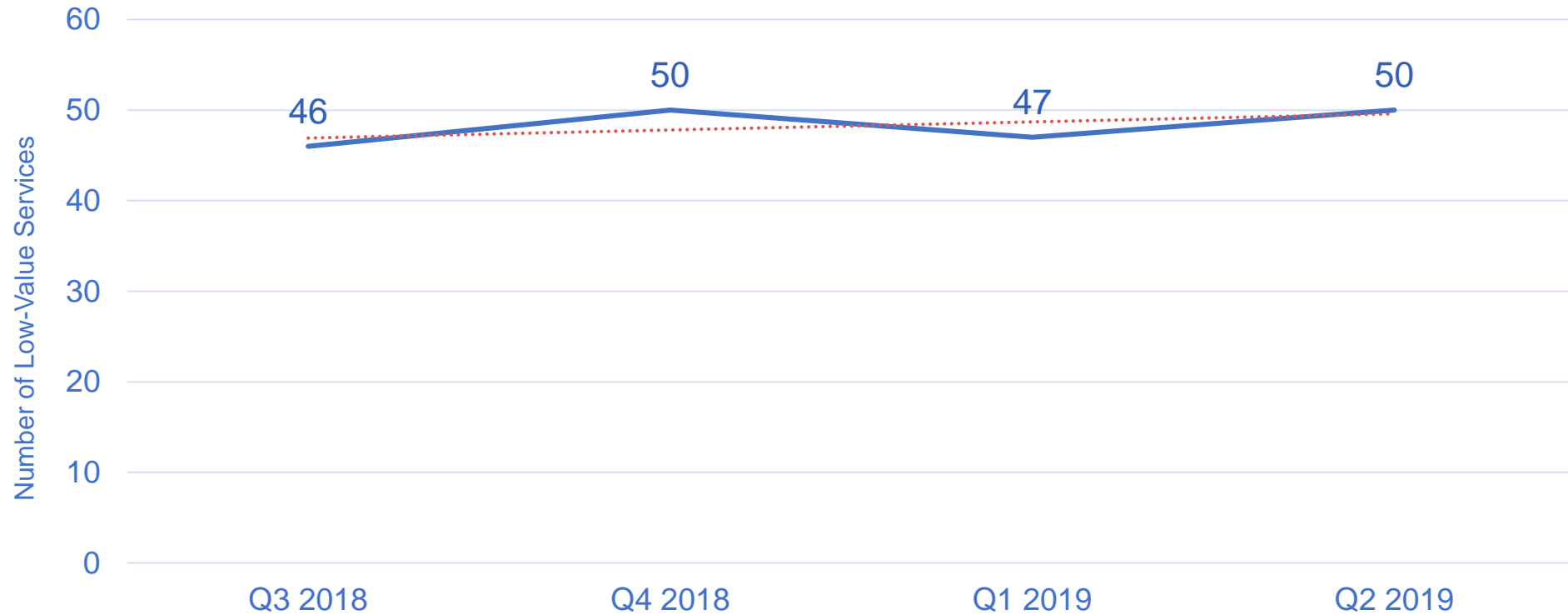
LOW-VALUE SERVICES QUARTERLY TREND: CERVICAL CANCER SCREENINGS



Note: Quarters represent calendar year quarters, not state fiscal year quarters.



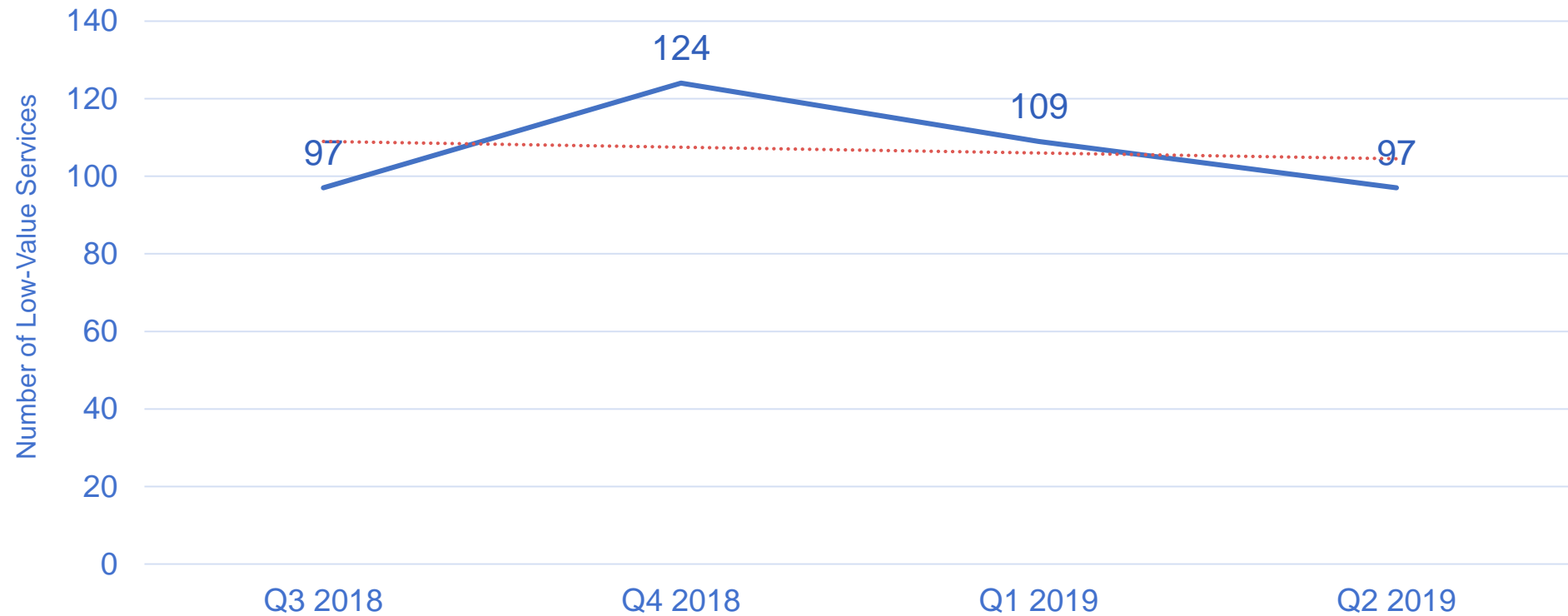
LOW-VALUE SERVICES QUARTERLY TREND: CORONARY ANGIOGRAPHY



Note: Quarters represent calendar year quarters, not state fiscal year quarters.



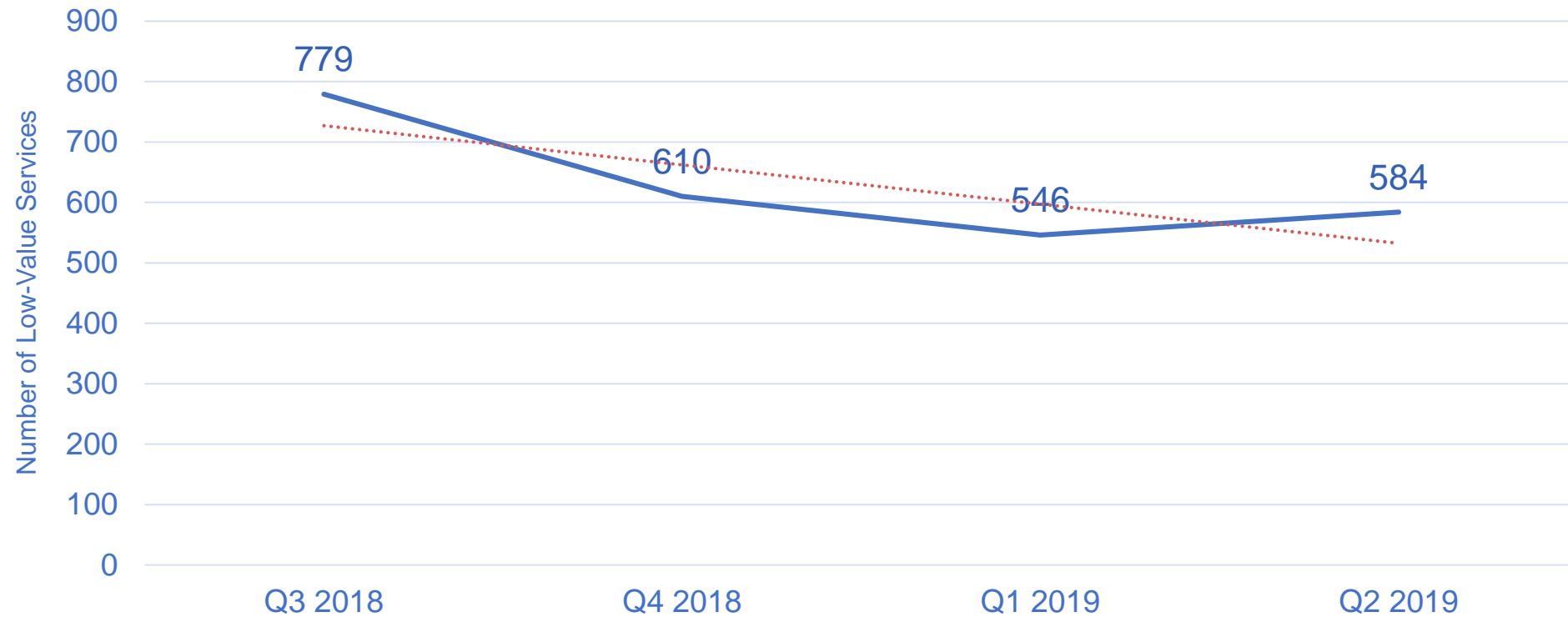
LOW-VALUE SERVICES QUARTERLY TREND: IMAGING FOR UNCOMPLICATED HEADACHE



Note: Quarters represent calendar year quarters, not state fiscal year quarters.



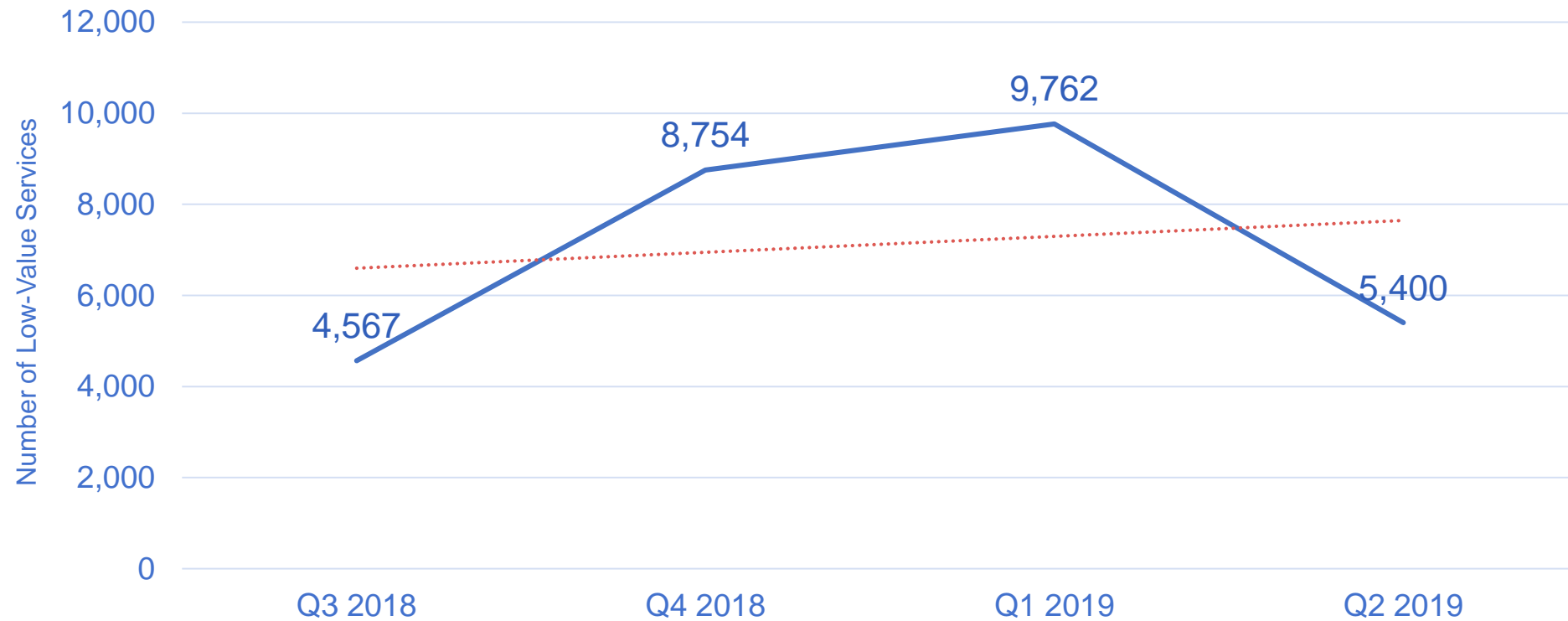
LOW-VALUE SERVICES QUARTERLY TREND: POPULATION-BASED VITAMIN D SCREENING



Note: Quarters represent calendar year quarters, not state fiscal year quarters.



LOW-VALUE SERVICES QUARTERLY TREND: ANTIBIOTICS FOR URI & EAR INFECTION



Note: Quarters represent calendar year quarters, not state fiscal year quarters.



NEW LOW-VALUE SERVICES WITHIN EBD

Low-Value Service (July 2018 – June 2019)	Distinct Members with Low-Value Service	Number of Low-Value Services	Low-Value Dollars
4. For asymptomatic adults without a chronic medical condition, mental health problem, or other health concern, don't routinely perform annual general health checks that include a comprehensive physical examination and lab testing.	5,389	5,487	\$873,053
7. Don't prescribe opiates in acute disabling low back pain before evaluation and a trial of other alternatives is considered.	3,890	7,650	\$313,964
8. Don't do imaging for low back pain within the first six weeks, unless red flags are present.	1,546	1,547	\$184,456



CONCLUSIONS

- Most of the previous top 8 low-value services have trended downward based on most recent data
- Annual EKGs remain a costly low-value service area
- Ongoing monitoring is warranted for previous top 8, as well as two new measures entering the top 8, along with review of current coverage policies



RECOMMENDATIONS

- Add two new measures to the previous 8 for ongoing monitoring
- Look for opportunities to continue reductions in all low-value services, especially these new measures
- Review patient cost share components related to each of the measures

