AGENDA
State and Public School Life and Health Insurance Board
Benefits Sub-Committee

January 18th, 2019
10:00 a.m.

EBD Board Room – 501 Building, Suite 500

I. Call to Order ......................................................... Claudia Moran, Chairman
II. Approval of October Minutes ........................................ Claudia Moran, Chairman
III. Choosing Wisely Analysis................................. Mike Motley, Izzy Montgomery, ACHI
VI. Director’s Report............................................ Chris Howlett, EBD Executive Director

2018 upcoming meetings:

February 15th, 2019, March 15th, 2019, April 12th, 2019

NOTE: All material for this meeting will be available by electronic means only ASE-PSE Board@dfa.arkansas.gov

Notice: Silence your cell phones. Keep your personal conversations to a minimum.
BENEFITS MEETING MINUTES

The Benefits Sub-Committee of the State and Public School Life and Health Insurance Board (hereinafter called the Committee) met on January 18, 2019, at 10:00 a.m. in the EBD Board Room, 501 Woodlane, Suite 500, Little Rock, Arkansas.

In Attendance

<table>
<thead>
<tr>
<th>Members Present</th>
<th>Members Absent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claudia Moran</td>
<td>Herb Scott</td>
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<tr>
<td>Susan Gardner - Teleconference</td>
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<tr>
<td>Carla Haugen - Proxy - Cayce Rainey</td>
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<tr>
<td>Stephanie Lilly-Palmer</td>
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<td>Ronnie Kissire</td>
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<td>Cindy Allen</td>
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<tr>
<td>Chris Howlett, Executive Director, Employee Benefits Division (EBD)</td>
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</table>

Others Present
Rhoda Classen, Eric Gallo, EBD; Suzanne Woodall, MedImpact; Takisha Sanders, Health Advantage; Ronda Walthall, Wayne Whitley, ARDOT; Elizabeth Montgomery, Mike Motley, ACHI; Bill Clary, ARSEBA; Jenae Hernandez, ConnectYourCare; Treg Long, ACS; Sylvia Landers, Securian

Approval of Minutes by: Claudia Moran, Chair

MOTION by Kissire:

  Move to approve the October 5, 2018 minutes.

  Lilly-Palmer seconded; all were in favor.

Minutes Approved.

Choosing Wisely Update/Cost Drivers by: Mike Motley & Izzy Montgomery, ACHI

Montgomery and Motley provided an overview analysis of the eight most common low-value healthcare services provided to EBD members. They also provided three general recommendations and two specific recommendations as follows:

General recommendations

1. Continue engagement with third-party administrator regarding changes to coverage policies:
   - Review any Blue Cross Blue Shield (BCBS) policy changes in Benefits and Quality of Care Subcommittees to consider for EBD plan adoption.
Consider any policy changes in context of applicable Choosing Wisely and/or United States Preventive Service Task Force (USPSTF) recommendations.

2. Perform annual follow-up reports on all low-value services:
   - Re-run Health Waste Calculator output annually.
   - Assess the impact of policy changes made from the recommendations adopted by the Board annually.

3. For each of the top 8 low-value services, utilize the following framework:
   - Provider outreach
     - When applicable, request that third-party administrator notify all providers of policy change.
     - Incorporate Choosing Wisely provider education materials when messaging providers about unnecessary/low-value population-based screening.
     - Consider targeted communications to those who are providing the highest volume of low-value services.
   - Patient outreach
     - When applicable, request that third-party administrator notify all beneficiaries of policy change.
     - Utilize Consumer Reports handout to include in member messaging efforts, including EBD quarterly newsletter.
     - For all low-value services listed in top 8, include “5 things to ask your doctor” handouts for member education.
   - Evaluation
     - After implementation of policy change, complete annual analyses to assess impact of change.

Specific Recommendations

1. Adopt Blue Cross Blue Shield (BCBS) coverage policy on population-based screening for Vitamin D deficiency.
   - Benefits design component - Adoption of BCBS coverage policy
2. If not already in place, adopt BCBS coverage policy for anterior segment optical coherence tomography.
   - Engage appropriate individuals at third-party administrator in designing and implementing policy changes for:
     - Posterior optical coherence tomography;
     - Fundus photography;
     - Visual field testing;
     - External eye photography and;
     - Internal eye photography.

Discussion

Moran: Why did you link viral and the ear infections?

Montgomery: That is how this particular analytic tool categorized it. I believe it has to do with the bacterial infections versus the viral infections. Don’t provide oral antibiotics for uncomplicated acute external otitis. So, it’s also ear infection which is why it is also incorporated into the measure. It’s looking at antibiotic use for URI which is inclusive of, in this instance, ear infection as well.

Kissire: I know it is a minor cost, but do we have an idea on the age? Are we seeing a lot of children being overprescribed that or going back to the adults?

Motley: We did see about 15% of those were kids, rather those under 18, and then a slight rise in the next group.

Moran: I would be interested to see more on this. Early on I can see ear infections, but later in life it is upper respiratory. To me, that is two very different things.

Motley: The software we are using for this includes them both. We compared this to the Arkansas Medicaid Episodes Program which doesn’t include ear infection. One caveat with all the antibiotic use ones is that our program looked at anyone that had an antibiotic prescribed within seven days of an initial visit. From a claim perspective, we can look at that and see that is what the claims say, but we can’t know if a patient waited for three weeks, suffered, and then went to their doctor who rightfully believed them and then gave them antibiotics. Those would show up in here as wasteful, but they might not be.
Howlett: From a carrier perspective, they will have a coverage policy that they adopted and over time if different changes are made, when they review them, and changes are needed, they would make those. We found that with the Vitamin D deficiency, we were basically a series behind. We are now in alignment with it. One of the other components, from the Quality of Care committee perspective is, we are going to partner with Health Advantage as our full partner and we are going to stay in alignment with those. If there is anything substantive that changes, it will come back through Quality of Care and/or Benefits for a review.

Allen: How do your subscribers to the service know if it has been changed in the last year? How do you let them know there has been changes?

Howlett: As far as coverage policy changes, those are posted online, and we house all that on our website. One of the suggestions from the recommendation is that we look at this from a wasteful service perspective, Shalada and my team, have already been working towards a better communication strategy and partnership. We have upped our communication online, email blasts, and educate through other mechanisms when they call in. Our policy that we adopted last fall is to look for revision dates and make sure those dates are on the policy when it is changed. The other component is from our carrier and partner perspective, which is Health Advantage in this case. They have a provider tool that they can go in and look at claims and review things. That has a communication mechanism where they have provider alerts that go out when there is a change. There is a provider newsletter that goes and maybe it hasn’t been utilized fully in the past. They also have network provider reps that go out and communicate and work with provider relationships. We feel that doing those three things can put that out there. From an education standpoint, from a member perspective, is to ask questions and be engaged. My Blueprint through Health Advantage is another portal you have and would be all encompassing of those changes.

Lilly-Palmer: I keep hearing the Wellness and the My Blueprint, but the employee and retiree factor in this is that there are not a lot of tools out there to guide them on step by step on how to get to these things. Employees would love to have this knowledge, but it would help to have an understanding of how the My Blueprint works. If we are going to do this, let’s make sure they have information as well.

Howlett: In member services at EBD, when they call in and need help navigating through this, they will walk you through the respective piece. We can put other tools out there as well.

Moran: When you go to the EBD website, I think it would be good to have a link to get to these different websites, like a single sign-on.
Director’s Report: Chris Howlett, EBD Executive Director

EBD Director Chris Howlett reported on the change in dates for the Benefits Sub-Committee meetings. From a fiscal standpoint and prepping the financials, you run into a struggle with having the data available in that first week of the month. For the remainder of the year and ongoing, the Benefits meeting will be the Friday after the Quality of Care meeting. Lastly, the AARP EEOC has not had any ruling thus far, but if there is a modification or change needed we will make you aware.

MOTION by Kissire:

   Move to adjourn the meeting.

   Lilly-Palmer seconded. All in favor.

   Meeting adjourned.
January 2019
Benefits
Subcommittee
Presentation

Mike Motley, MPH
Assistant Director of Health Policy, ACHI

Izzy Montgomery, MPA
Policy Analyst, ACHI
Objectives for Presentation

• Review top 8 low-value services and related analyses
• Review and discuss draft recommendations
• Discuss next steps for EBD Board consideration
• Consider additional items
Choosing Wisely Initiative Background

• Promotes conversations between clinicians and patients by helping patients choose care that is:
  – Supported by evidence
  – Not duplicative of other tests or procedures received
  – Free from harm
  – Truly necessary

• Recommendations developed by specialty societies

• Sparks discussion about need — or lack thereof — for many frequently ordered tests or treatments

Assessing Wasteful Services Within EBD

• MedInsight Health Waste Calculator is a tool which identifies low-value services and spending

• ACHI utilized tool to examine 42 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

Disclaimer: Due to inherent variation in billing and related claims data, the costs included in this presentation should be considered close estimates.
## Top 8 Low-Value Services Within EBD (2017)

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<th>Number of Low-Value Services</th>
<th>Low-Value Total Dollars</th>
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<td>9,118</td>
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<td>2. Don’t order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.</td>
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<td>3. Don’t routinely order imaging tests for patients without symptoms or signs of significant eye disease.</td>
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Unnecessary Preoperative Baseline Lab Studies
Unnecessary Preoperative Baseline Lab Studies

• Measure based on Choosing Wisely recommendations from 2 physician specialty societies:
  – American Society of Anesthesiologists: Don’t obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery.
  – American Academy of Ophthalmology: Don’t perform preoperative medical tests for eye surgery unless there are specific medical indications.

Source: Choosing Wisely, American Society of Anesthesiologists Recommendation (released October 12, 2013) and Choosing Wisely, American Academy of Ophthalmology (released February 21, 2013)
Unnecessary Preoperative Baseline Lab Studies

2015–2017 low-value service volume trends

Number of Low-Value Services

- 2015: 13,860
- 2016: 14,077
- 2017: 13,060
Annual EKGs and Other Cardiac Screenings
Annual EKGs & Other Cardiac Screenings

• Measure is based on Choosing Wisely recommendation from 1 physician specialty society:
  – American Academy of Family Physicians: Don’t order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.

• Other types of cardiac screenings may also include lab tests such as lipid panels, C-reactive protein tests, etc.

Source: Choosing Wisely, American Academy of Family Physicians (released on April 4, 2012)
Annual EKGs & Other Cardiac Screenings

2015–2017 low-value service volume trends

- 2015: 10,349
- 2016: 10,606
- 2017: 10,274

Number of Low-Value Services
Imaging for Eye Disease
• Measure based on Choosing Wisely recommendations from 2 physician specialty societies:
  – American Academy of Ophthalmology: Don’t Routinely order imaging tests for patients without symptoms or signs of significant eye disease.
  – American Association for Pediatric Ophthalmology and Strabismus: Don’t order retinal imaging tests for children without symptoms or signs of eye disease.

2015–2017 low-value service volume trends

- 2015: 8,775
- 2016: 10,511
- 2017: 12,875

Number of Low-Value Services
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 than 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

2016 and 2017 Low-Value Service Volume Trend

- 2016: 10,347
- 2017: 7,762

Number of Low-Value Services
Coronary Angiography
Coronary Angiography

• Measure based on Choosing Wisely recommendations from 2 physician specialty societies:
  – American Society of Nuclear Cardiology: *Don’t perform stress cardiac imaging or coronary angiography in patients without cardiac symptoms unless high-risk markers are present.*
  – Society for Cardiovascular Angiography and Interventions: *Avoid coronary angiography to assess risk in asymptomatic patients with no evidence of ischemia or other abnormalities on adequate non-invasive testing.*

Coronary Angiography

2015–2017 low-value service volume trends

- 2015: 219
- 2016: 173
- 2017: 205

Number of Low-Value Services
Imaging for Uncomplicated Headache
Imaging for Uncomplicated Headache

• Measure based on Choosing Wisely recommendations from 1 physician specialty society:
  – American College of Radiology: *Don’t do imaging for uncomplicated headache.*

2015–2017 low-value service volume trends

- 2015: 585
- 2016: 659
- 2017: 584

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

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

2016 and 2017 Low-Value Service Volume Trend

Number of Low-Value Services

- 2016: 30,929
- 2017: 32,503
General Recommendations
General Recommendation 1

• Continue engagement with third-party administrator regarding changes to coverage policies:
  – Review any Blue Cross Blue Shield (BCBS) policy changes in Benefits and Quality of Care Subcommittees to consider for EBD plan adoption
  – Consider any policy changes in context of applicable Choosing Wisely and/or United States Preventive Service Task Force (USPSTF) recommendations
General Recommendation 2

• Perform annual follow-up reports on all low-value services:
  – Re-run Health Waste Calculator output annually
  – Assess the impacts of policy changes made from the recommendations adopted by the Board annually
General Recommendation 3

• For each of the top 8 low-value services, utilize the following framework:
  – Provider outreach
    • When applicable, request that third-party administrator notify all providers of policy change
    • Incorporate Choosing Wisely provider education materials when messaging providers about unnecessary/low-value population-based screening
    • Consider targeted communications to those who are providing the highest volume of low-value services
General Recommendation 3 (continued)

• For each of the top 8 low-value services, utilize the following framework:
  – Patient outreach
    • When applicable, request that third-party administrator notify all beneficiaries of policy change
    • Utilize *Consumer Reports* handout to include in member messaging efforts, including EBD quarterly newsletter
    • For all low-value services listed in top 8, include “5 things to ask your doctor” handouts for member education
General Recommendation 3 (continued)

• For each of the top 8 low-value services, utilize the following framework:
  – Evaluation
    • After implementation of policy change, complete annual analyses to assess impact of change
Specific Recommendations
Specific Recommendation 1

- Adopt Blue Cross Blue Shield (BCBS) coverage policy on population-based screening for Vitamin D deficiency
  - Benefit design component—Adoption of BCBS coverage policy
Specific Recommendation 2

• If not already in place, adopt **BCBS coverage policy** for anterior segment optical coherence tomography
  – Engage appropriate individuals at third party administrator in designing and implementing policy changes for:
    • posterior optical coherence tomography
    • fundus photography
    • visual field testing
    • external eye photography
    • internal eye photography
Appendix — Previous Presentations
November 2018
Quality of Care Committee Presentation

Mike Motley, MPH
Assistant Director of Health Policy, ACHI

Izzy Montgomery, MPA
Policy Analyst, ACHI
Objectives for Presentation

• Review the following items:
  – Updated Health Waste Calculator output
  – Follow-up analyses from previous meeting
  – 3 additional low-value services

• Discuss next steps for analyses and recommendations
Choosing Wisely Initiative Background

- Promotes conversations between clinicians and patients by helping patients choose care that is:
  - Supported by evidence
  - Not duplicative of other tests or procedures received
  - Free from harm
  - Truly necessary

- Recommendations developed by specialty societies

- Sparks discussion about need — or lack thereof — for many frequently ordered tests or treatments

Assessing Wasteful Services Within EBD

- MedInsight Health Waste Calculator is a tool which identifies low-value services and spending
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Unnecessary Preoperative Baseline Lab Studies
Unnecessary Preoperative Baseline Lab Studies

- Measure based on Choosing Wisely recommendations from 2 physician specialty societies:
  - American Society of Anesthesiologists: *Don’t obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery.*
  - American Academy of Ophthalmology: *Don’t perform preoperative medical tests for eye surgery unless there are specific medical indications.*

Source: Choosing Wisely, American Society of Anesthesiologists Recommendation (released October 12, 2013) and Choosing Wisely, American Academy of Ophthalmology (released February 21, 2013)
Unnecessary Preoperative Baseline Lab Studies

• Rationale for recommendations:
  – For many, preoperative tests are not necessary because some surgeries are short in duration and do not pose serious risks (such as eye surgeries)
  – Tests typically include complete blood panel, basic or comprehensive metabolic panel, urine testing, and/or coagulation studies
  – However, exceptions arise when an individual’s medical history or exam indicate need for preoperative testing (e.g., blood glucose test for individuals with diabetes)

Unnecessary Preoperative Baseline Lab Studies

• Some necessary services are excluded from the analysis based on conditions and other criteria, for example:
  – Services where low-risk surgery is on, or one day after, the evaluation visit for emergency care or urgent care visit
  – Diagnosis of endocrine, liver, or renal disorders
  – History of anemia or recent blood loss
  – Diagnosis of coagulation disorders
# Unnecessary Preoperative Baseline Lab Studies

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<th>Year</th>
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<th>Number of Low-Value Services</th>
<th>Number of Distinct Members with a Low-Value Services</th>
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<td>2017</td>
<td>$4,937,308</td>
<td>13,060</td>
<td>9,118</td>
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**Percentage of Low-Value Services by Age Group**

- < 18: 1.1%
- 18-24: 2.9%
- 25-34: 7.8%
- 35-44: 10.6%
- 45-54: 17.3%
- 55-64: 31.1%
- >= 65: 29.3%
Unnecessary Preoperative Baseline Lab Studies

2017 provider variation of low-value services

- 137 providers
Unnecessary Preoperative Baseline Lab Studies

2015–2017 low-value service volume trends

Number of Low-Value Services

- 2015: 13,860
- 2016: 14,077
- 2017: 13,060
Annual EKGs and Other Cardiac Screenings
Annual EKGs & Other Cardiac Screenings

• Measure is based on Choosing Wisely recommendation from 1 physician specialty society:
  – American Academy of Family Physicians: *Don’t order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.*

• Other types of cardiac screenings may also include lab tests such as lipid panels, C-reactive protein tests, etc.

Source: Choosing Wisely, American Academy of Family Physicians (released on April 4, 2012)
Annual EKGs & Other Cardiac Screenings

• Rationale for recommendation:
  – Little evidence that detection of coronary artery stenosis (blocking or narrowing of the arteries) in low-risk patients improves health outcomes
  – False positive tests are likely to lead to unnecessary invasive procedures, overtreatment, and misdiagnosis
  – Potential harms of routine annual screenings exceed potential benefits

Source: Choosing Wisely, American Academy of Family Physicians (released on April 4, 2012)
Annual EKGs & Other Cardiac Screenings

• For this measure, cardiac screening tests were deemed appropriate (and excluded from analysis) for a number of clinical circumstances, for example:
  – History of coronary heart disease (CHD)
  – Presence of risk factors suggestive of intermediate CHD risk
  – Inflammatory conditions such as arthritis, joint pain, or muscle inflammation
## Annual EKGs & Other Cardiac Screenings

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

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<td>5.8%</td>
</tr>
<tr>
<td>25-34</td>
<td>18.3%</td>
</tr>
<tr>
<td>35-44</td>
<td>27.1%</td>
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<tr>
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<tr>
<td>&gt;= 65</td>
<td>3.7%</td>
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Annual EKGs & Other Cardiac Screenings

2017 provider variation of low-value services

- 135 providers
Annual EKGs & Other Cardiac Screenings

2015–2017 low-value service volume trends

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- 2016: 10,606
- 2017: 10,274
Imaging for Uncomplicated Headache
Imaging for Uncomplicated Headache

• Measure based on Choosing Wisely recommendations from 1 physician specialty society:
  – American College of Radiology: *Don’t do imaging for uncomplicated headache.*

Imaging for Uncomplicated Headache

• Rationale for recommendation:
  – Imaging patients, absent risk factors for structural disease, is not likely to change management or improve outcome
  – Incidental findings lead to additional medical procedures and expense that do not improve patient well-being
  – Imaging is recommended under certain circumstances, such as sudden onset of severe headache, suspected carotid or vertebral dissection, etc.

Source: Choosing Wisely, American College of Radiology (released April 4, 2012)
### Imaging for Uncomplicated Headache

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Low-Value Dollars</th>
<th>Number of Low-Value Services</th>
<th>Number of Distinct Members with a Low-Value Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>$258,925</td>
<td>584</td>
<td>557</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>13.3%</td>
</tr>
<tr>
<td>25-34</td>
<td>20.7%</td>
</tr>
<tr>
<td>35-44</td>
<td>28.3%</td>
</tr>
<tr>
<td>45-54</td>
<td>25.3%</td>
</tr>
<tr>
<td>55-64</td>
<td>12.4%</td>
</tr>
</tbody>
</table>
Imaging for Uncomplicated Headache

2017 provider variation of low-value services

- 68 providers
Imaging for Uncomplicated Headache

2015–2017 low-value service volume trends

Number of Low-Value Services

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>585</td>
</tr>
<tr>
<td>2016</td>
<td>659</td>
</tr>
<tr>
<td>2017</td>
<td>584</td>
</tr>
</tbody>
</table>
Imaging for Eye Disease
Imaging for Eye Disease

- Measure based on Choosing Wisely recommendations from 2 physician specialty societies:
  - American Academy of Ophthalmology: *Don’t Routinely order imaging tests for patients without symptoms or signs of significant eye disease.*
  - American Association for Pediatric Ophthalmology and Strabismus: *Don’t order retinal imaging tests for children without symptoms or signs of eye disease.*

Imaging for Eye Disease

• Rationale for recommendation:
  – In patients without symptoms or signs of significant disease, clinical imaging tests are not needed
  – Comprehensive history and physical examination will usually reveal if eye disease is present or getting worse

• Examples of routine imaging:
  – Visual-field testing
  – Optical coherence tomography (OCT)
  – Retinal imaging of patients with diabetes
  – Neuroimaging or fundus photography

Source: Choosing Wisely, American Academy of Family Physicians (released on April 4, 2012)
## Imaging for Eye Disease

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Low-Value Dollars</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>$1,236,098</td>
<td>12,875</td>
<td>8,187</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>&lt; 18</td>
<td>1.3%</td>
</tr>
<tr>
<td>18-24</td>
<td>1.0%</td>
</tr>
<tr>
<td>25-34</td>
<td>1.9%</td>
</tr>
<tr>
<td>35-44</td>
<td>3.8%</td>
</tr>
<tr>
<td>45-54</td>
<td>7.8%</td>
</tr>
<tr>
<td>55-64</td>
<td>19.7%</td>
</tr>
<tr>
<td>&gt;= 65</td>
<td>64.5%</td>
</tr>
</tbody>
</table>
2017 provider variation of low-value services

- 151 providers
2015–2017 low-value service volume trends

- 2015: 8,775
- 2016: 10,511
- 2017: 12,875
Coronary Angiography
Coronary Angiography

- Measure based on Choosing Wisely recommendations from 2 physician specialty societies:
  - American Society of Nuclear Cardiology: Don’t perform stress cardiac imaging or coronary angiography in patients without cardiac symptoms unless high-risk markers are present.
  - Society for Cardiovascular Angiography and Interventions: Avoid coronary angiography to assess risk in asymptomatic patients with no evidence of ischemia or other abnormalities on adequate non-invasive testing.

Coronary Angiography

- **Rationale for recommendation:**
  - Asymptomatic patients who have no evidence of ischemia or other abnormalities on adequate non-invasive testing are at very low risk for cardiac events.
  - Physicians should discuss goal of angiography with patients before it is performed, including possible role of revascularization with bypass surgery or coronary intervention.

- **Perform tests in asymptomatic patients only when the following are present:**
  - Diabetes in patients older than 40.
  - Peripheral arterial disease.
  - Greater than 2% yearly coronary heart disease event rate.

## Coronary Angiography

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Low-Value Dollars</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>$372,219</td>
<td>205</td>
<td>202</td>
</tr>
</tbody>
</table>

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

- 25-34: 2.7%
- 35-44: 9.9%
- 45-54: 27.0%
- 55-64: 34.2%
- >= 65: 26.1%
Coronary Angiography

2017 provider variation of low-value services

- 67 providers
Coronary Angiography

2015–2017 low-value service volume trends

- 2015: 219
- 2016: 173
- 2017: 205

Number of Low-Value Services
Potential Considerations to Address Overuse

• Tailored member education
• Provider education
• Review of prior authorization criteria or medical management utilization management practices
• Provider-level assessment of variation
• Review of value-based payment models
Coronary Angiography

– Society for Cardiovascular Angiography and Interventions: *Avoid coronary angiography risk assessment in patients with stable ischemic heart disease (SIHD) who are unwilling to undergo revascularization or who are not candidates for revascularization based on comorbidities or individual preferences.*

– Society for Cardiovascular Angiography and Interventions: *Avoid coronary angiography in post-coronary artery bypass graft (CABG) and post-PCI patients who are asymptomatic, or who have normal or mildly abnormal stress tests and stable symptoms not limiting quality of life.*

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</td>
<td>9,118</td>
<td>13,060</td>
<td>$4,028,766</td>
</tr>
<tr>
<td>systemic disease (ASA I or II) undergoing low-risk surgery — specifically</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>complete blood count, basic or comprehensive metabolic panel, coagulation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>studies when blood loss (or fluid shifts) is expected to be minimal.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Don’t order annual electrocardiograms (EKGs) or any other cardiac screening</td>
<td>9,643</td>
<td>10,274</td>
<td>$1,612,932</td>
</tr>
<tr>
<td>for low-risk patients without symptoms.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Don’t routinely order imaging tests for patients without symptoms or</td>
<td>8,187</td>
<td>12,875</td>
<td>$1,236,098</td>
</tr>
<tr>
<td>signs of significant eye disease.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Don’t order unnecessary cervical cancer screening (Pap smear and HPV tests)</td>
<td>7,676</td>
<td>7,762</td>
<td>$740,322</td>
</tr>
<tr>
<td>in all women who have had adequate prior screening and are not otherwise at</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>high risk for cervical cancer.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Don’t perform coronary angiography in patients without cardiac symptoms</td>
<td>202</td>
<td>205</td>
<td>$372,219</td>
</tr>
<tr>
<td>unless high-risk markers are present.</td>
<td></td>
<td></td>
<td></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</td>
<td>24,853</td>
<td>32,503</td>
<td>$186,219</td>
</tr>
<tr>
<td>(acute sinusitis, URI, viral respiratory illness, or acute otitis externa).</td>
<td></td>
<td></td>
<td></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

### Year | Number of Low-Value Services | Number of Distinct Members with a Low-Value Service
--- | --- | ---
2017 | 7,762 | 7,676

### 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>
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<tr>
<td>25-34</td>
<td>12.7%</td>
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<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

- Number of Low-Value Services

<table>
<thead>
<tr>
<th>Year</th>
<th>Low-Value Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>10,347</td>
</tr>
<tr>
<td>2017</td>
<td>7,762</td>
</tr>
</tbody>
</table>
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>
<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>3,050</td>
<td>2,925</td>
</tr>
</tbody>
</table>

Percentage of Low-Value Services by Age Group

- < 18: 4.3%
- 18-24: 4.8%
- 25-34: 8.8%
- 35-44: 17.3%
- 45-54: 23.8%
- 55-64: 30.7%
- >= 65: 10.4%
Population-Based Screening for Vitamin D Deficiency

2016 and 2017 Low-Value Service Volume Trend

Number of Low-Value Services

- 2016: 3,368
- 2017: 3,050
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.)

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%