AGENDA

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

September 10th, 2019

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

I. *Call to Order.....Dr. John Vinson, Chair*

II. *Approval of August Minutes.....Dr. John Vinson, Chair*

III. *Diabetic Population Update.....Elizabeth Montgomery & Mike Motley, ACHI*

IV. *Director's Report.....Chris Howlett, EBD Director*

V. *Adjournment.....Dr. John Vinson, Chair*

Upcoming Meetings

October 15th, 2019, November 12th, 2019, December 10th, 2019

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
September 10, 2019

Date | *time* 09/10/2019 1:00 PM | *Meeting called to order by* Dr. John Vinson, Chair

Attendance

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

Others Present:
Rhoda Classen, Shalada Toles, Theresa Huber, Sharon Parker, Shar Webb, Donald Alexander, Lanita Wasson, Kimberly Williams, EBD; Elizabeth Montgomery, Mike Motley, ACHI; Jessica Akins, HA; Marc Bagby, Bruce Christian, Lilly; Ronda Walthall, ARDOT; Sidney Keisner, UAMS

Approval of Minutes by: Dr. John Vinson, Chair

MOTION by Murtha

I motion to approve the August 13, 2019 minutes.

Bushmiaer seconded. All were in favor.

Minutes Approved.

Diabetic Population Update by: Elizabeth Montgomery & Mike Motley, ACHI

Montgomery and Motley addressed follow-up questions and analyses from the previous Quality of Care meeting.

Discussion:

Murtha: Is the total claims cost for both medical and pharmacy?

Motley: Yes, it is for both.

Howlett: We deal with everything on a gross perspective. It's of no interest to the committee at this present moment. The pharmaceutical cost for the plan averages $128-$132 million a year gross off of about $557-$558 million.

Dr. Vinson: I think part of the reason you might be asking that is if you were to design or track an intervention to improve statin use in patients with diabetes, for example, over time. Did it prevent cardiovascular disease and save money, or not? Your pharmaceutical cost in that example would actually go up initially but savings would be generated down the road.

Howlett: Other EBD members represent the aggregate claims cost overall not exclusive to diabetic, right?

Motley: That would be those without the type 2 diabetes diagnosis.

Murtha: Only 8,600 diabetics have complications?

Motley: Yes, that's right.

Dr. Vinson: There is probably some coding issues too, like anything else.

Dr. Kahn: Well it's coding and depending on how you group complications, all kinds of things show up as complications but they're really just co-diagnoses. Hypertension is common in diabetics and nondiabetics, if you look at the total number of complications it might be listed as a complication, but it isn't really a complication of diabetes. They complicate the patients care but are not a complication of diabetes.

Dr. Vinson: I know we talked before about patients with type 2 diabetes that getting eye exams was recommended yearly, but I thought they updated for type 2 patients that had a normal finding that it might not need to be done but every two to three years.

Montgomery: We can review that, and it could explain why it isn't a little higher.

Dr. Kahn: The ADA guidelines shows that in 2016 and 2017 it was changed. It says you should have an initial exam and if there is no evidence of retina problems on that exam, you should consider to going to every two years. It's possible that HEDIS will change in the upcoming years as well.

Murtha: What if I am a diabetic and my PCP does not treat my diabetes, but internal medicine does.

Montgomery: There are two ways to look at that. Some would argue that the PCP is in control of some of these things and should make that referral to an ophthalmologist for an eye exam. We are making a jump and looking at the claims and associating that with the PCP. You are certainly correct, it could be an internal medicine doctor that is doing some of that management.

Murtha: What if I go to a cardiologist and they provide my statin. Would that still show up or it would only show up with a PCP.

Motley: That would show up in terms of if they had the statin therapy or not.

Dr. Kahn: What is our current diabetes management program, and what are they doing to manage our diabetic patients?

Howlett: Kannact has a proactive engagement model that is based on condition level. They send the supplies, do outreach to the population based on the information submitted to them, they have a glucometer and take readings and submit that information.

Dr. Kahn: Do we get a report from them about who they have contacted and how often and whether or not these metrics we are looking at here are being addressed and how.

Howlett: They would be able to address those.

Dr. Kahn: I would like to see them come to the committee and report to us.

Howlett: We can do that. The approach has been a measured approach for what we are offering to the members. For years, this plan provided diabetic supplies for free as long as they enrolled into a program, but we had little to no data to show and diabetic costs were steadily increasing year over year. We can look at other potential approaches to come alongside if needed.

Bushmiaer: I would be curious of how many of our members are taking advantage of that. I know years ago our school nurses were managing a lot because we had so many people that

really didn't understand and couldn't get the equipment, so there have obviously been some changes.

Dr. Kahn: If you look at these three measures, the one furthest from the national benchmark was the statins. Maybe the plan could figure out a way through the diabetes management program or elsewhere to approach providers and patients to get on statins if they are the right age. If we are currently 12% below the HEDIS benchmark which isn't ideal. 60% of people nationally are taking statins. We probably should up our efforts.

Howlett: There are a lot of components in the equation. From a plan perspective, I would wonder why that doctor isn't taking the fortitude to work on that with their patient. It's more of a medication compliance issue if they are being prescribed it and not taking it and it's not showing up. I would like to see that HEDIS measure broken out to see how that comes down with the population. Is it that they're prescribed it, or they should be on it?

Dr. Kahn: I believe it is whether there was ever a prescription filled, isn't that how it works.

Motley: Yes, that's correct.

Howlett: Who is going to make them take their drug when they get it?

Dr. Kahn: Well, that is another question, but first we have to get the doctors to prescribe them.

Howlett: If it's being filled then someone has prescribed it.

Dr. Kahn: That is my point. Only 48.4% are getting them filled.

Howlett: If it is based on claims utilization, it means it is being filled. There is still a combination. The plan has no clinical expertise to override a doctor.

Dr. Vinson: From a provider perspective, it goes back to population health. If the physicians know who the patients are, and the pharmacies know who the patients are then I think one or the other could move the needle on this.

Dr. Kahn: There are all kinds of different possible protocols including the pharmacist, educating providers directly, getting the AAFP and internal medicine society to do that at their CME, and could involve incentives to providers to those who have a better track record of providing statins to the eligible patients. I think it would be worth the plan putting together a subcommittee to suggest to the Board a way of approaching this problem.

Howlett: I don't believe we need another committee for this plan. This subcommittee should suffice, and we just need to bring things to the table to move the needle.

Director's Report by: Chris Howlett, EBD Director

Howlett provided an update on the wellness as listed below.

2020 discount thus far:	2019, at this point:
50% Completed	45% With Discount
50% Without Completion	55% Without Discount

For catapult visits we are just shy of 37,500 and the PCP forms are 10,310.

MOTION by Dr. Kahn

Move to adjourn.

Bushmiaer seconded. All were in favor. **Meeting adjourned**.

SEPTEMBER 2019
QUALITY OF CARE PRESENTATION

Mike Motley, MPH
Director, Analytics

Izzy Montgomery, MPA
Policy Analyst

09.10.2019

ACHI
INSPIRING HEALTHY ACTS

AGENDA

- Address follow-up questions and analyses from previous Quality of Care meeting

TYPE 2 DIABETES COSTS FOLLOW-UPS

- What is the distribution of type 2 diabetes costs (for those with and without complications), inclusive of member cost share?
- What are the top 10 most frequent diagnoses (for those with complications)?

TYPE 2 DIABETES: EBD POPULATION PROFILE (2018)

Category	Number of Members	Median Cost	EBD Paid Amount (Medical & Pharmacy)
Members with type 2 diabetes (without complications)	7,184	$1,402	$38,853,910
Members with type 2 diabetes (with complications)	8,604	$3,400	$83,204,558
Other EBD members	139,256	$585	$436,438,756

TYPE 2 DIABETES: COST DISTRIBUTION BY AGES 18-64 (2018)

Category	Number of Members	Average Cost	Median Cost	Total Claims Cost for Group*
Members with type 2 diabetes (without complications)	4,376	$8,016	$2,845	$35,077,320
Members with type 2 diabetes (with complications)	5,234	$13,705	$5,785	$71,730,379
Other EBD members	118,028	$4,118	$1,165	$486,073,339

**Note—This cost distribution includes EBD paid amount (for both medical and pharmacy) along with patient cost component reflected in medical and pharmacy claims.*

TYPE 2 DIABETES: COST DISTRIBUTION BY AGES 65+ (2018)

Category	Number of Members	Average Cost	Median Cost	Total Claims Cost for Group*
Members with type 2 diabetes (without complications)	2,809	$4,593	$1,765	$12,901,640
Members with type 2 diabetes (with complications)	3,370	$7,756	$3,431	$26,136,501
Other EBD members	21,255	$3,796	$1,295	$80,674,131

**Note—This cost distribution includes EBD paid amount (for both medical and pharmacy) along with patient cost component reflected in medical and pharmacy claims.*

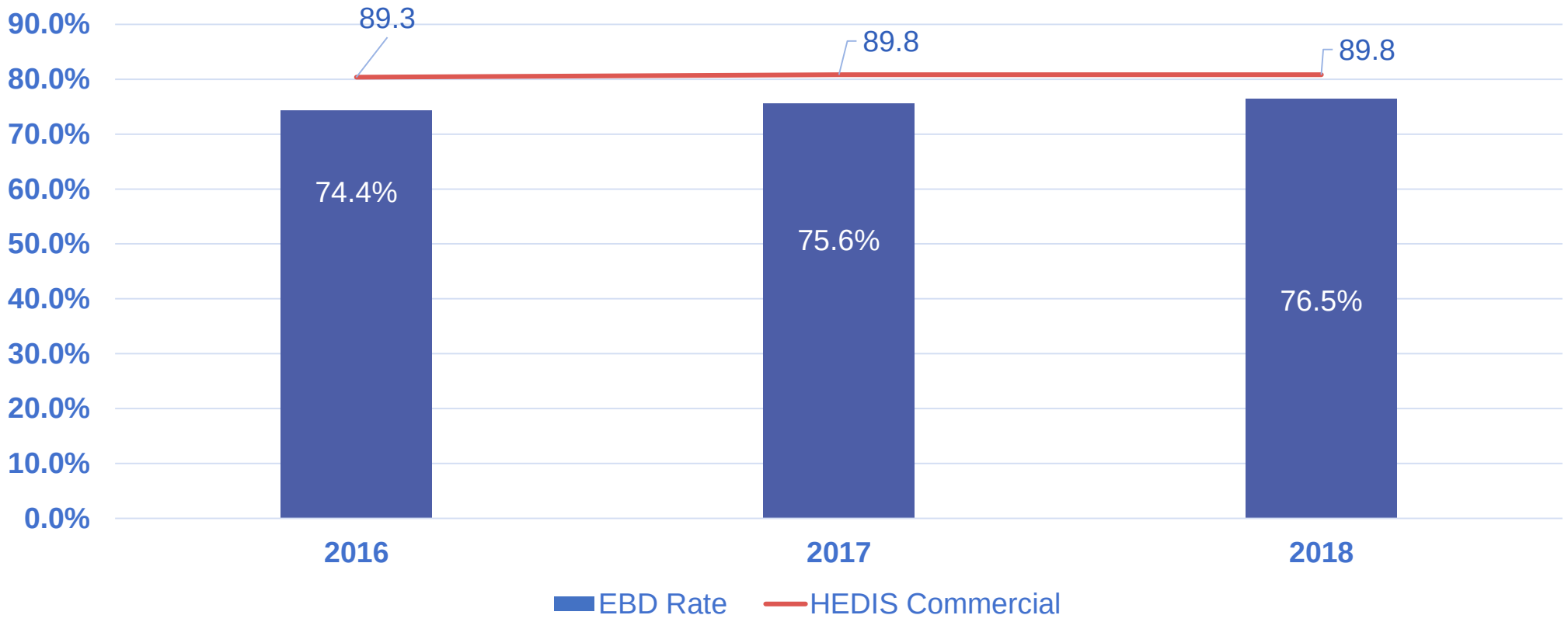
MEMBERS WITH COMMON COMPLICATIONS OF TYPE 2 DIABETES (2018)

Diagnosis	Unique Members with Diagnosis
Neuropathy	1,687
Atherosclerotic heart disease	1,461
Kidney disease	521
Type 2 diabetes mellitus with foot ulcer unspecified	261

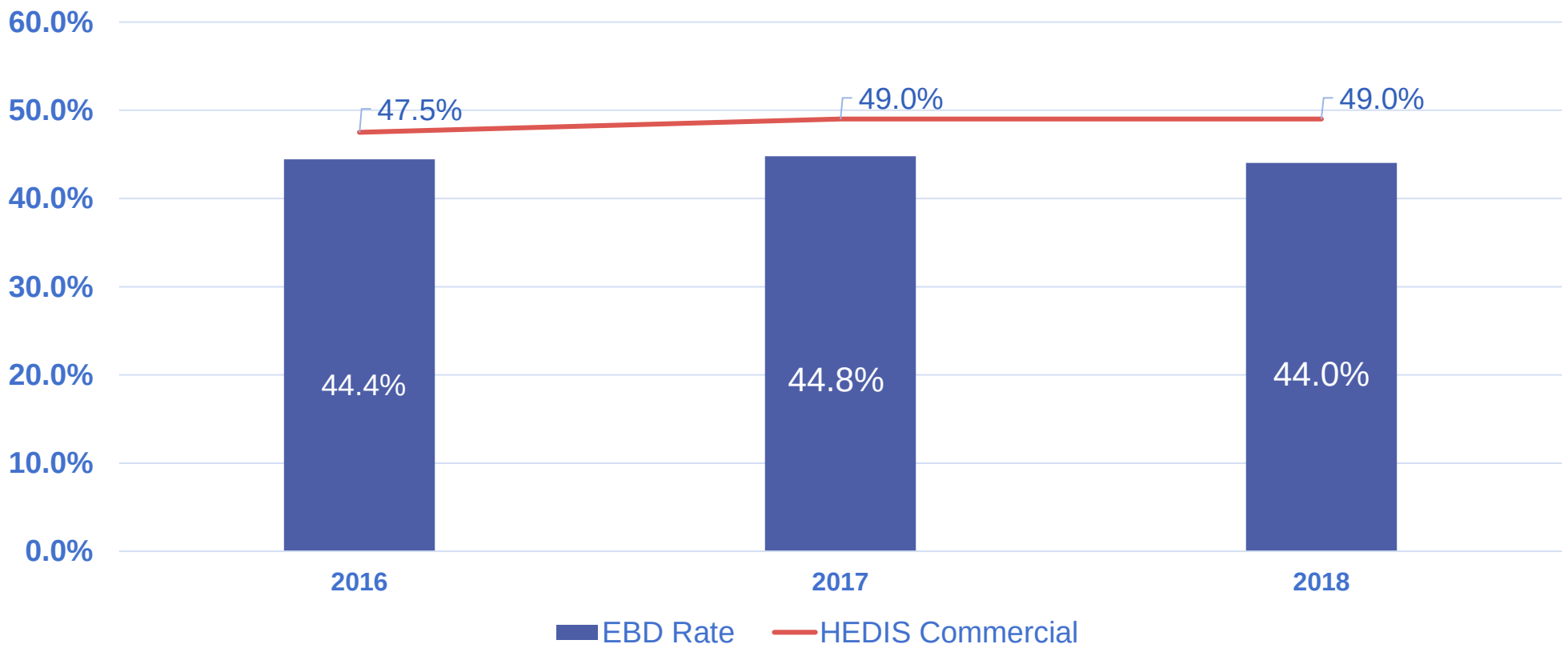
HEDIS MEASURES FOLLOW-UPS

- What proportion of members with type 2 diabetes received all three measures (HbA1c screening, eye exam, and statin therapy) in 2018?
- Of EBD members with type 2 diabetes who did not receive any of the three measures in 2018, what percentage saw a PCP during the year?
- What is the level of provider volume in primary care visits for members who did not receive any of the three measures?

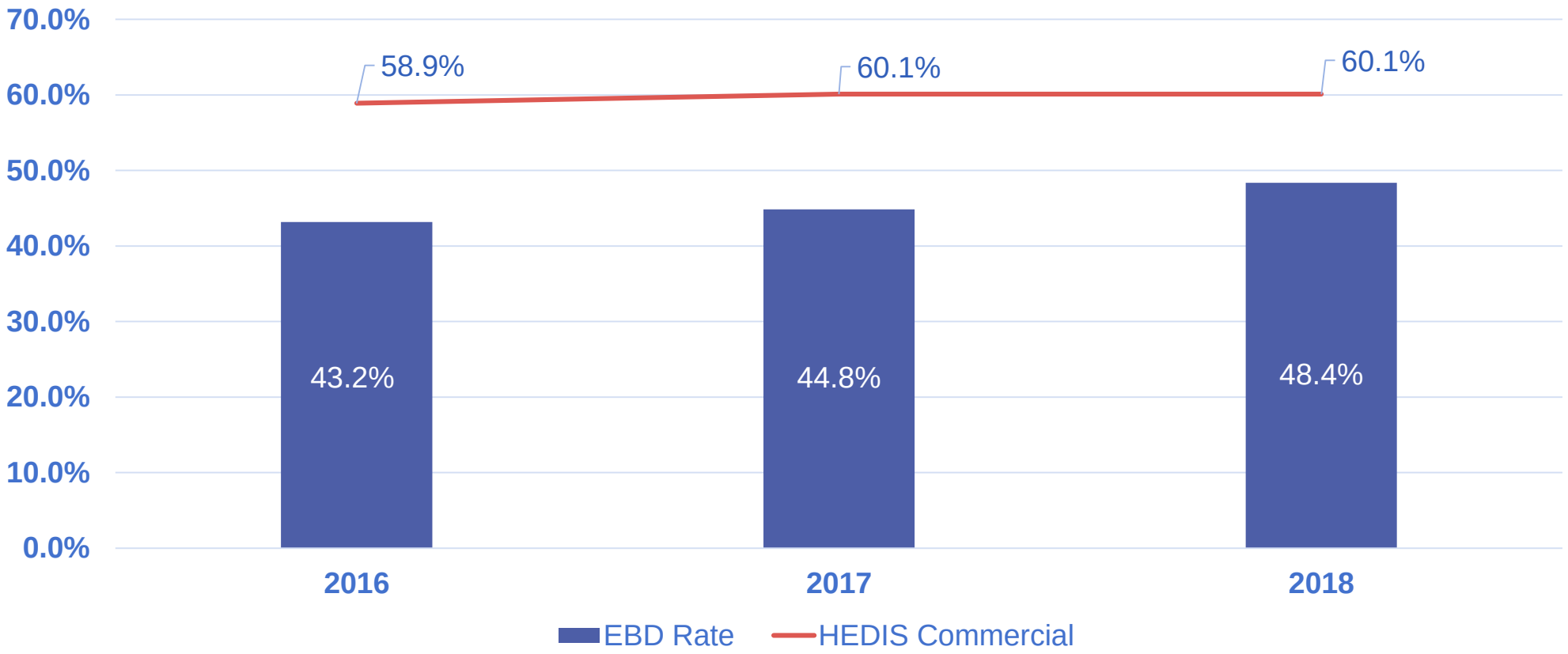
HBA1C SCREENING: EBD RATES AND HEDIS BENCHMARKS (2016–18)



EYE EXAM: EBD RATES AND HEDIS BENCHMARKS (2016-18)



STATIN THERAPY: EBD RATES AND HEDIS BENCHMARKS (2016-18)



MEMBERS WITH TYPE 2 DIABETES: RECEIVING HBA1C SCREENING & EYE EXAM (2016–18)

Year	Numerator	Denominator	Rate
2016	3,093	9,936	31%
2017	3,714	11,510	32%
2018	4,160	12,900	32%

MEMBERS WITH TYPE 2 DIABETES: RECEIVING HBA1C SCREENING, EYE EXAM, & STATIN THERAPY (2016–18)

Year	Numerator	Denominator	Rate
2016	767	5,396	14%
2017	1,009	6,451	16%
2018	1,260	7,542	17%

MEMBERS WITH TYPE 2 DIABETES: DID NOT RECEIVE HBA1C SCREENING, EYE EXAM, OR STATIN THERAPY BUT HAD A PRIMARY CARE VISIT (2018)

HEDIS Measure	Numerator	Denominator	Rate
HbA1c screening	2,847	3,034	94%
Eye exam	7,011	7,221	97%
Statin therapy	3,770	3,895	97%

PROVIDER VOLUME: MEMBERS WITH A PCP VISIT WHO DID NOT RECEIVE HBA1C SCREENING (2018)

Provider	Unique Members with a Primary Care Visit*
Provider A	48
Provider B	40
Provider C	37
Provider D	36
Provider E	34
Provider F	27
Provider G	26
Provider H	25
Provider I	24
Provider J	23

*Out of 2,847 total members

Note—Provider variation slides represent members with type 2 diabetes who saw their primary care physician (PCP) at some point during 2018 but did not receive an HbA1c screening.

PROVIDER VOLUME: MEMBERS WITH A PCP VISIT WHO DID NOT RECEIVE AN EYE EXAM (2018)

Provider	Unique Members with a Primary Care Visit*
Provider A	410
Provider B	258
Provider C	231
Provider D	226
Provider E	221
Provider F	217
Provider G	202
Provider H	183
Provider I	183
Provider J	155

*Out of 7,011 total members

Note—Provider variation slides represent members with type 2 diabetes who saw their primary care physician (PCP) at some point during 2018 but did not receive an eye exam.

PROVIDER VOLUME: MEMBERS WITH A PCP VISIT WHO DID NOT RECEIVE STATIN THERAPY (2018)

Provider	Unique Members with a Primary Care Visit*
Provider A	157
Provider B	119
Provider C	115
Provider D	112
Provider E	99
Provider F	90
Provider G	84
Provider H	78
Provider I	77
Provider J	68

*Out of 3,770 total members

**Note—Provider variation slides represent members with type 2 diabetes who saw their primary care physician (PCP) at some point during 2018 but did not receive statin therapy.*

RECOMMENDATIONS

- Provider engagement opportunities
- Member education opportunities
- Further leveraging existing diabetes management program