



AGENDA

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

August 10, 2018
10:00 a.m.

EBD Board Room – 501 Building, Suite 500

- I. *Call to Order* *Claudia Moran, Chairman*
- II. *Approval of June Minutes.....* *Claudia Moran, Chairman*
- III. *Choosing Wisely Update/Cost Drivers* *Mike Motley, Izzy Montgomery, ACHI*
- IV. *Naturally Slim Update* *Erica Patterson, Austin Wilcox, Naturally Slim*
- V. *Kannact.....* *Krishna Rao, Mike Pohl, Kannact*
- VI. *Director's Report.....* *Chris Howlett, EBD Executive Director*

2018 upcoming meetings:

September 7, 2018, October 5, 2018, November 9, 2018

***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 August 13, 2018, at 10:00 a.m. in the EBD Board Room, 501 Woodlane, Suite 500, Little Rock, Arkansas.

Date / time 8/10/2018 12:00 AM | Meeting called to order by Claudia Moran, Chair

In Attendance

Members Present

Claudia Moran
Susan Gardner
Carla Haugen - Teleconference
Stephanie Lilly-Palmer
Herb Scott
Ronnie Kissire
Jeff Altemus
Chris Howlett, Executive Director, Employee Benefits Division (EBD)

Members Absent

Becky Walker

Others Present

Eric Gallo, Allie Barker, Shalada Y. Toles, Jessica Beck, Rhoda Classen, Jamie Levinsky, Ellen Justus, Terri Freeman, EBD; Ronda Walthall, AHTD; Milton Hammerly, Karyn Langley, QualChoice; Jennifer Vaughn, ComPsych; Suzanne Woodall, MedImpact; D.J. Bradley, Health Advantage; Mark Watts, ASEA; Andy Davis, Ark Democrat-Gazette; Sean Seago, MERCK; Sylvia Landers, Securian; Sandra Wilson, AHM; Treg Long, ACS

Approval of Minutes by: Claudia Moran, Chair

MOTION by Altemus:

Move to approve the June 8, 2018, minutes.

Kissire seconded; all were in favor.

Minutes Approved.

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

Choosing Wisely is a national initiative to promote conversations between patients and physicians about choosing care that is evidence based and medically necessary and cost efficient. These recommendations come from provider specialty societies. Since 2012 when this was launched, there have been over 555 recommendations made. Act 1089 of 2017, is the piece of legislation from emerging therapies, but it also included Choosing Wisely offering a framework for patients to consider.

There were preliminary results presented, including some of the most common wasteful, low-value services, and when looking at the EBD members enrolled in 2016, 65,135 had at least one of these low value services. Motley explained that over the next few months, they would like to break down these services maybe two at a time.

Discussion:

- Altemus Is there a price tag on the one year aggregate?
- Motley It is being finalized. Generally, among the E-Services, these are in the ballpark of \$14 or \$15 million with any individual service ranging from \$5 million approximately on the baseline labs to \$400,000 for the lower ones. We didn't want to present any real hard numbers without validating it.
- Altemus **Could we see the hard numbers for the 65,135 in 2016 that had at least one of the low value services when they are done?**
- Motley Yes, we will do that.
- Howlett In 2016, certain cost drivers for the plan were evaluated. They use specific software to see where the money is being spent and what is the value of those services being purchased. No one can override a physician's prescriptive authority, so there is a fine line there. We have been looking at the diabetes population with the Quality of Care Committee, and I am hoping we can tie these two together with no conflicting decisions from two sub-committees before the Board. This is a prelim list in a ledger style, and we will report back on these top eight.
- Moran Does the number regarding cardiac imaging represent all of them (indicated and ineffective) or just the ones that were ineffective?
- Montgomery The tool that we use is called the MedInsight Health Waste Calculator. The top 8 represented about 80% of the overall volume of services and associated costs which is the rationale as to why these are prioritized.
- Moran Does that include everyone that had imaging or just wasteful imaging.
- Motley We are only looking at the numbers that were considered wasteful and maybe should not have been done at all.
- Howlett Some of these services may add duplicative services when sent to specialists.
- Altemus Is the medical community requesting these services is what is driving this, is it patient driven, or a combination?

Montgomery If we look more broadly at what the initiative is aiming at it is a combination. It may be labs drawn by multiple physicians. The initiative is focused on both providers and consumers.

Naturally Slim Update by: Austin Willcox, VP of Business/Product Development

Wilcox gave an overview of Naturally Slim, the digital behavioral based program that has proved to prevent Diabetes and reverse Metabolic Syndrome for the last 12 years. The pilot program launched for ASE/PSE with a total of 2,400 in the program, and 243 never started the program. 91% were women, and 9% were men. The total weight loss for the program is 11,000 lbs., and females lost an average of 8.2 lbs. while men lost an average 11.9 lbs. 37% of members lowered their diabetes risk, and 91% of individuals felt more in control their weight.

Wilcox also discussed what was next for Naturally Slim with Phase II, III, IV and V, as well as testimonials from members.

Discussion:

Moran What would your Phase II pilot size be? Do you limit it to the same number?

Wilcox Since we are an in-network provider and it is preventive care benefit. It is unusual to limit the group after the pilot. You will see anywhere from 5-10% of the population sign up. The pilot gives you an idea of the participation, and the pilot group gave us an indication that this is great for your population.

Kissire We know about the pilot population, but what about the population that got turned down? Do we have any information on the waiting list?

Howlett We did 1,000 on PSE and ASE, and they gave us an additional 200 on each side. We averaged about the same on a waiting list. From a plan perspective, the request would be how do we want this to go to the Board for a recommendation to execute. Do we take care of the first population from the first ten weeks, or do we roll this out to the whole population? We have a gap in some respects with the non-Medicare eligible retirees. We did the active and the employees, but there is a segment between the actives, the non-Medicare eligible retirees that sometimes have a significant cost at times and this would be something to consider for them. This is something to consider for the next go around. We are somewhere around 2,800 that did not get included in the pilot.

Moran When you say, you do it in classes, that means you like to do it as a group?

- Howlett You have a 10-week foundation, the reinforcement period, and then the maintenance which is life-long. Even if they leave state government, the log in is good for the rest of that individual's life. We can look at doing a second round and will be able to compare the two groups.
- Lilly-Palmer If we do a second group to include the waitlist, can we extend the numbers to add more participants? Could we add more number than just the waitlist?
- Howlett 810 ASE and 1,441 PSE were waitlisted.
- Kissire Could we look at doubling the size of the pilot group? We need to include the retirees to help lower medications and give benefits back to the program.
- Palmer Could we launch the active and do a pilot with the non-Medicare retirees?
- Howlett We can shape this up any which way. We can build them as a sub set in the reporting if they are added in.
- Altemus What is the cost of the program, and how do we analyze the benefits to the program. Ultimately, we want healthy individuals, but we should fiscally be responsible to create a savings for the program.
- Howlett As you may recall, it was based on the number of weeks they stayed in the program. The average was about \$280 per individual. I used Diabetes as an example, and looking at an average of 37½ out of the 2,400 individuals collectively, reversing something on a diabetic condition, would cover or being at a wash for the program. I can go back and get an exact cost, but it was probably closer to \$600,000.
- Altemus We had 10% sign up and received the packets, and then they never did anything. Would we want to make them pay a fee for not starting?
- Howlett We are not charged if they don't participate, but it did keep someone from participating. That is something you would need to consider.
- Moran The best thing about this was it was so easy to access the program. I don't think a fee will make that big of a difference for the people signing up.
- Haugen Could it be that if they do not sign on after so many weeks, we can drop them and goes on to the next person.
- Moran If we do it in phases, it will not limit the people.
- Haugen If we continue the pilot, we could do that.

- Wilcox You need to be careful since this is so simple and easy, and some customers move the dial around penalties and incentives. I would encourage to keep it as a voluntary approach as it starts. In a year two or year three, it would be more typical to introduce an incentive or penalty. When you give an incentive, it attracts people and the enrollment rates go up.
- Lilly-Palmer Instead of looking at a monetary or a penalty, could we put a six month hold on them re-enrolling in the program. There are a lot of people that will participate and maintain it.
- Kissire We are trying to get the people who do not want to lose weight because they are causing the problems. The people who really want to lose weight will find a program. I think we need to say if you stay on the program, we will give you something.
- Altemus I recommend we do another round, not necessarily a pilot. Do we limit the number? I am still worried about the cost.
- Howlett If you want to do up to a certain amount, you can do it.
- Moran When you look at this one person that is off their medication, they have saved money for us. I have no idea how much the medicine cost, but it has probably already paid for the program.
- Wilcox When you roll this out, you look at 0.1-0.3% of total medical claims cost.
- Lilly-Palmer If we do go down this path of launching numbers again, and do a group from September through December, what will everyone want to do in January? Everyone wants to lose weight and get right with themselves at the first of the year. There will be an influx of numbers. This may be the best way to do it, capping a group off for September through December. Then we would have testimonials and better responses from ASE/PSE.
- Kissire We are only taking three months, so after another three months we will have more data. To open it wide now, we do not have the information. We want to see the information after a year or two, so we will really know what we need to do.
- Altemus I suggest we do 2,000 for PSE and ASE and include the early retirees in that.
- Howlett Let me recap what I am hearing, 2,000 for PSE and ASE and be inclusive of non-Medicare eligible retirees on both sides. The secondary piece will be to continue monitoring the first pilot. This will just be a second round.
- Kissire Are we going to make those who were on the waiting list sign up again or is there some way to include the waiting list first?

- Wilcox We still have that waitlist and can prioritize them for the second round.
- Lilly-Palmer Could we consider doing 3,000 on each, since we have 2000 of each on the waitlist. Is that going too high?
- Moran We also are including the non-Medicare eligible retirees.
- Altemus I was just looking at the cost, but I do not object to that.
- Howlett We are looking at 3,000 ASE/PSE on each side, first consider the wait list from last time, and to include the non-Medicare retirees.
- Gardner After looking at Kansas, what is the logical time frame to tell if it has been cost effective and we need to keep going forward?
- Wilcox It is hard to say, but it could be easier to see after a year. Pharmacy will be the first place you still start to observe. We partner with you all, and would work on analyzing that.
- Moran There is also some cost that we cannot quantify due to the person getting control of their weight before more problems come up.
- Altemus It is cost avoidance.
- Howlett We need to consider that ROI and better health outcome. It is not always about dollars and cents, but for our plan we need to see some of that.

MOTION by Altemus:

The motion is to roll out Phase II, limiting 3,000 PSE and 3,000 ASE and include non-Medicare retirees to have the option of joining and start in September.

Kissire seconded. All in favor.

Motion approved.

- Kissire When we get Catapult information, maybe we could cross reference that with the people in the program. We might be able to break that down, as far as BMI and enrolling in the program.
- Howlett We should have a baseline established from different collection points and we should see some bleed over with a positive effect.

Kannact by: Krishna Rao, CEO & Mike Pohl, Dir of Marketing, Kannact

Allie Barker, EBD RN, gave a brief introduction for Kannact, and she went over numbers for the EBD Diabetes population. In 2016, 15,000 members with or without complications cost our plan \$110 million in plan costs. There is a need for a more hands-on management of this condition for our members. Kannact really stood out to help manage the day-to-day care of these members.

Kannact gave an overview of their patient centered model that is designed and proven to engage participants. They have behavior change programs for chronic and pre-chronic conditions. In this program, you coordinate with a dedicated coach to create a personalized care plan. They have easy online enrollment, supplies shipped directly to your home and you will have 24x7 support to communicate on your schedule. Kannact also has a population reporting back to the health plan as early as month three, and they coordinate with other programs. They provided a transition schedule of what to expect from the program setup, enrollment, engaging with the coach and ongoing monitoring, and the claims billing set-up details.

Discussion:

- Altemus This sounds like a great program, but I think if I am understanding correctly that we already have a program in place for certain people with Diabetes or is it all the people with Diabetes that we are providing with supplies.
- Howlett On the medical management side, if a member enrolled in the program, the plan would pay for the supplies. The issue that we run into is a compliance factor. We are not seeing a change in cost of those individuals being in the program rather than the cost before the program. I think the supplies meet the basic need, but we need to find a more proactive way to still engage the population with similar costs. There is no mechanism to track the individuals that we give free supplies to, nor were they required to be enrolled in something.
- Altemus We think this program they are presenting will give us tracking information and cost around the same as the program in place now.
- Howlett I think it will cost a little more than what we are currently spending now, but I am not sure that we have fully captured a true spend because we are not enrolled or tracking.
- Altemus This program should after a period of 2 years turn the cost, is that correct?
- Howlett We will see effects after six months of this program. This is something that we can add to or pull back from another approach after we see some data. The most advantageous is the tracking, monitoring, and tying back to the medical management side. Data to be used on a disease management

platform and share responsibility on managing that patient besides just Diabetes. The clinical side on the medical management side can increase the chances for engagement for the member. I think it would be wise to consider a program like this, but we have not found another one like this.

Altemus So right now, we would like to replace our current program with Kannact, and any members who have Diabetic conditions and choose not to participate, will be required to cover the expenses of their supplies.

Howlett Part of my piece on the management side, a logical step would be if this recommendation comes from this committee to the Board and the Board approves, then we could transfer them over month by month.

Altemus This may be a three-month period of adjustment, so we may be eight or nine months out in seeing cost differential to the program?

Howlett Potentially, and we could assess if we can do it more quickly. The other piece is member disruption and disruption of services. If we got the go ahead, we would do a phased approach. Another other piece is that these are just actively participating that can be identified, and then the other piece is the pre-Diabetic population.

Altemus I am hoping that our Naturally Slim population will pick up some of that as well.

A service that can be ramped up or ramped down as part of our contract.

Kissire You will see an increased cost because this current plan is not used. Anything like Kannact, where people can get help without having to go to the doctor will help members. This will probably make the cost go up because there are so many not utilizing the plan now but helping them will be better in the long run.

Howlett Let's not only focus on the dollars and cents but also look at the medical outcome. The fees Kannact discusses, I used 69 on average and some other numbers that we must assume, it will be about \$20 per person per month.

Kissire If you are pre-Diabetic, do you ever get out of paying that \$20 per month?

Pohl Yes, we evaluate every three to six months, and graduating from pre-Diabetes is possibly due to managing medications and even lifestyle improvement.

- Altemus Do you see a good change in the A1-C for pre-Diabetic patients to move off the program after they have learned the management skills?
- Pohl You don't see a large decrease in those numbers because they are already low, but you do see a decrease in risk factors.
- MOTION** by Altemus I recommend to the Board that we move our Diabetic chronic conditions to Kannact as quickly and reasonably as possible.
- Kissire seconded.
- Scott I know we are talking about current individuals, but can we expand that to new members?
- Howlett Yes, I don't want to call it a pilot but if we must. I think before we roll it out to 30,000 people, it would be more prudent to take the population we have with already associated costs and fine tune what we are missing for those on the grandfathered piece. Then we will have something for cost and outcome based. After, we can look at those in a pre-Diabetic state.
- Altemus In this move, if our members choose not to move, they become responsible for their own supplies.
- Howlett Yes, if they are not actively participating in the new program, they will be responsible for their own supply costs.
- Moran So, if you are not enrolled in the current plan and next month you want to enroll but the plan is not available? What will they do?
- Howlett From an operational standpoint, we will have to deal with members that then become required.
- MOTION** Restate the motion; All current active participants in the diabetic program now will be transitioned to Kannact, any of the individuals that do not transition will be responsible for their own supplies, and any newly identified people will be offered an opportunity to go into the program.
- Moran All in favor of this recommendation to the Board.

Motion Approved.

Director's Report: Chris Howlett, EBD Executive Director

EBD Director Chris Howlett reported that he will have new Catapult information next month. We will have more information for you on telemedicine. We will also have new contract information for you next month.

MOTION by Scott:

Move to adjourn the meeting.

Walker seconded. All in favor.

Meeting adjourned.

EBD Benefits Subcommittee Updates

Mike Motley, MPH
Assistant Health Policy Director

Elizabeth Montgomery, MPA
Policy Analyst



August 2018

Objectives for Presentation:

- Present background on the Choosing Wisely Initiative and its framework
- Review preliminary analysis of the 8 most common low-value healthcare services provided to EBD members
- Discuss next steps for further assessment of low-value services and opportunities for improvement within plan



Choosing Wisely Initiative Background

Choosing Wisely Background

- Choosing Wisely is an initiative of the American Board of Internal Medicine (ABIM) Foundation
- Aims to promote conversations between clinicians and patients by helping patients choose care that is:
 - Supported by evidence
 - Not duplicative of other tests or procedures already received
 - Free from harm
 - Truly necessary

Source: Choosing Wisely Initiative Website, “About” Section.



Choosing Wisely Background

- Recommendations are developed by provider specialty societies
- Based on specialty societies' lists of recommendations of tests and treatments that may be unnecessary
- Since 2012, over 80 provider groups have published over 550 recommendations

Source: Choosing Wisely Initiative Website, "Our Mission" Section.



Choosing Wisely Background

- Intended to spark discussion about the need—or lack thereof—for many frequently ordered tests or treatments
- Consumer Reports has developed patient-friendly materials based on these recommendations for consumer use
- Provider-oriented materials available to assist with patient engagement on these issues

[Source: Choosing Wisely Initiative Website, “About” Section.](#)



Choosing Wisely In Action

- Act 1089 of 2017:
 - Directs the EBD Board to explore evidence supporting opportunities for benefit modification informed by the Choosing Wisely Initiative

Source: Act 1089 of 2017, Arkansas General Assembly.



Assessing Wasteful Services within EBD⁸

- MedInsight Health Waste Calculator is a tool which identifies low-value services and spending
- Examined 42 common treatments deemed by providers to be commonly overused
- Two additional states have published reports based on findings from this tool, including Washington and Virginia

Source: Choosing Wisely Initiative Website, “About” Section.



Results

Findings within EBD Plan

- Of the 42 common wasteful services, 8 measures account for **82%** of low-value services
- The top 8 most wasteful (based on cost) represent at least **50%** of the cost of low-value services
- Among all EBD members enrolled in 2016, **65,135** had at least one of the 42 low-value services



Findings within EBD Plan

Low-Value Service	Number of Distinct Members with a Low-Value Service	Number of Low-Value Services
Don't prescribe oral antibiotics for members with upper URI or ear infection (acute sinusitis, URI, viral respiratory illness or acute otitis externa)	22,230	29,144
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/are expected to be minimal	11,122	18,292
Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.	10,149	11,235
Don't order unnecessary cervical cancer screening (Pap smear and HPV test) in all women who have had adequate prior screening and are not otherwise at high risk for cervical cancer	10,130	10,238
Don't routinely order imaging tests for patients without symptoms or signs of significant eye disease.	9,172	15,265
Don't obtain EKG, chest X rays or Pulmonary function test in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery	3,428	6,372
Don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.	2,201	2,343
Don't perform coronary angiography in patients without cardiac symptoms unless high-risk markers present.	1,023	1,093



NATURALLY SLIM®

Foundations® Report

Outcomes as of 8/7/18

State of Arkansas
ARBenefits PSE & ASE

Program Start Date
05/28/2018



OUR GOAL

Objectives: Achieve measurable weight loss, significant program engagement and receive positive participant feedback for Naturally Slim as a valuable benefit for your health plan members.

Purpose of this report:

1. Foundations™ Phase Outcomes
2. Testimonials
3. Next Steps for Participants and ARBenefits

PARTICIPATION



Participation Overview



2,400

Accepted

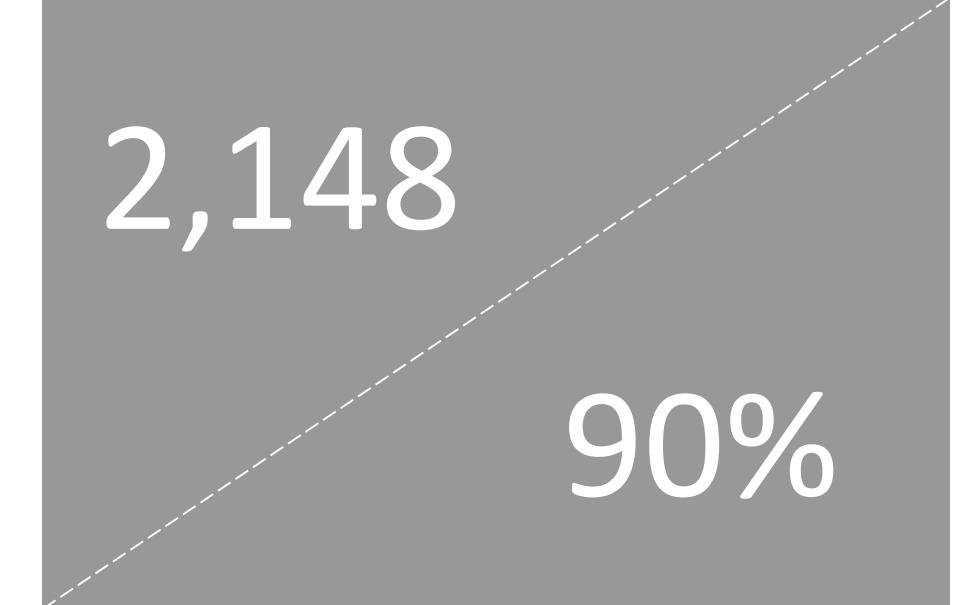
Number of individuals that applied and were accepted.



243

Never Started

Number of individuals that were accepted but never started.



2,148

Started

Number of individuals that were accepted and started Week 1 of program.

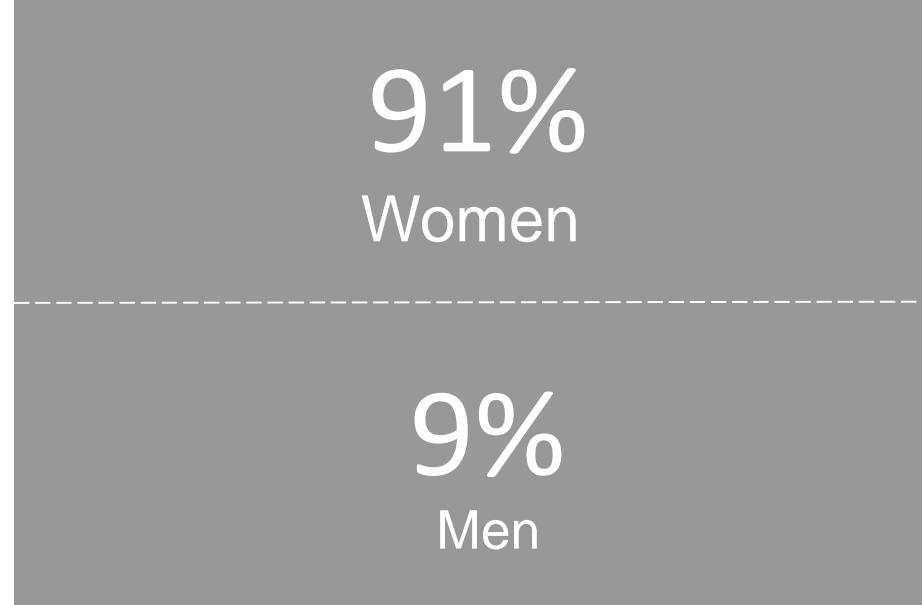
Started Demographic Highlights



48



35.7



91%

Women

9%

Men

Average Age

The average age of the U.S. Workforce is 41

Average BMI

Normal: BMI 18.5 to < 25.0
Overweight: BMI 25.0 to < 30.0
Obese: BMI \geq 30.0

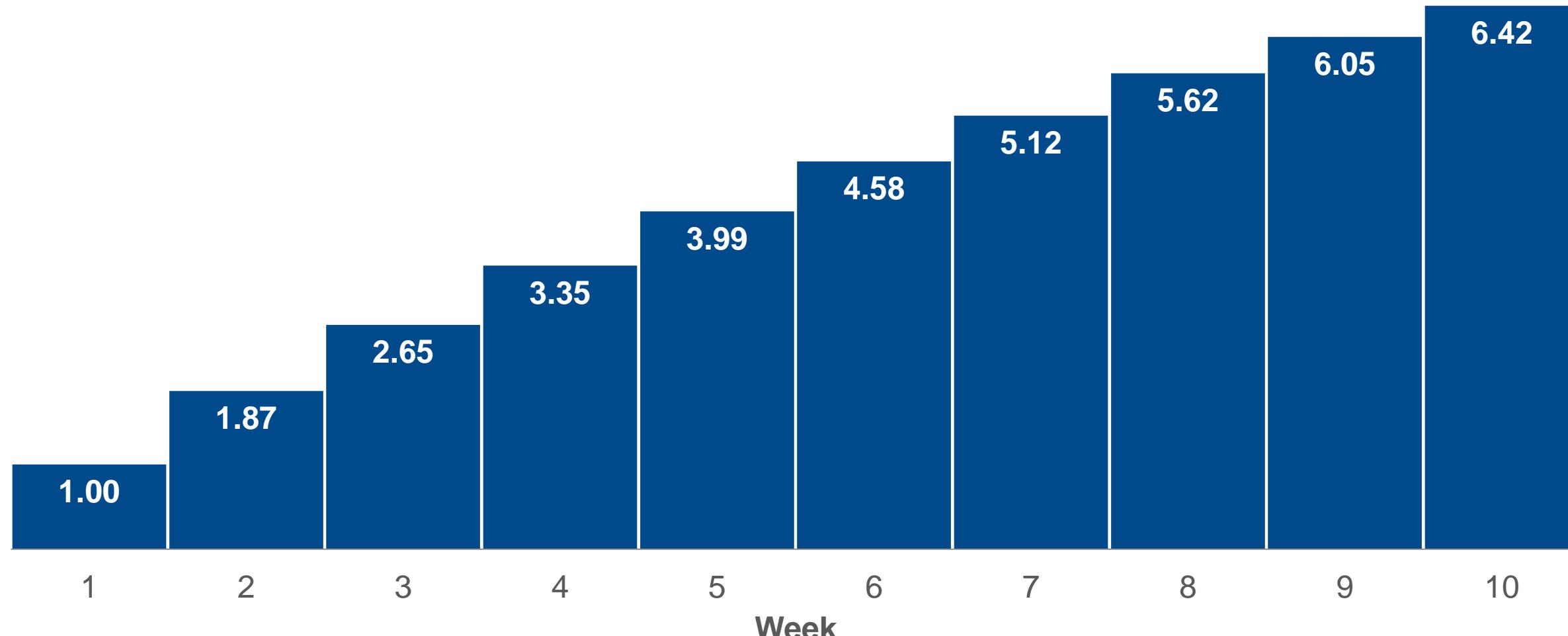
Participants

On average, male participants lose more weight than female participants.

Participation Report

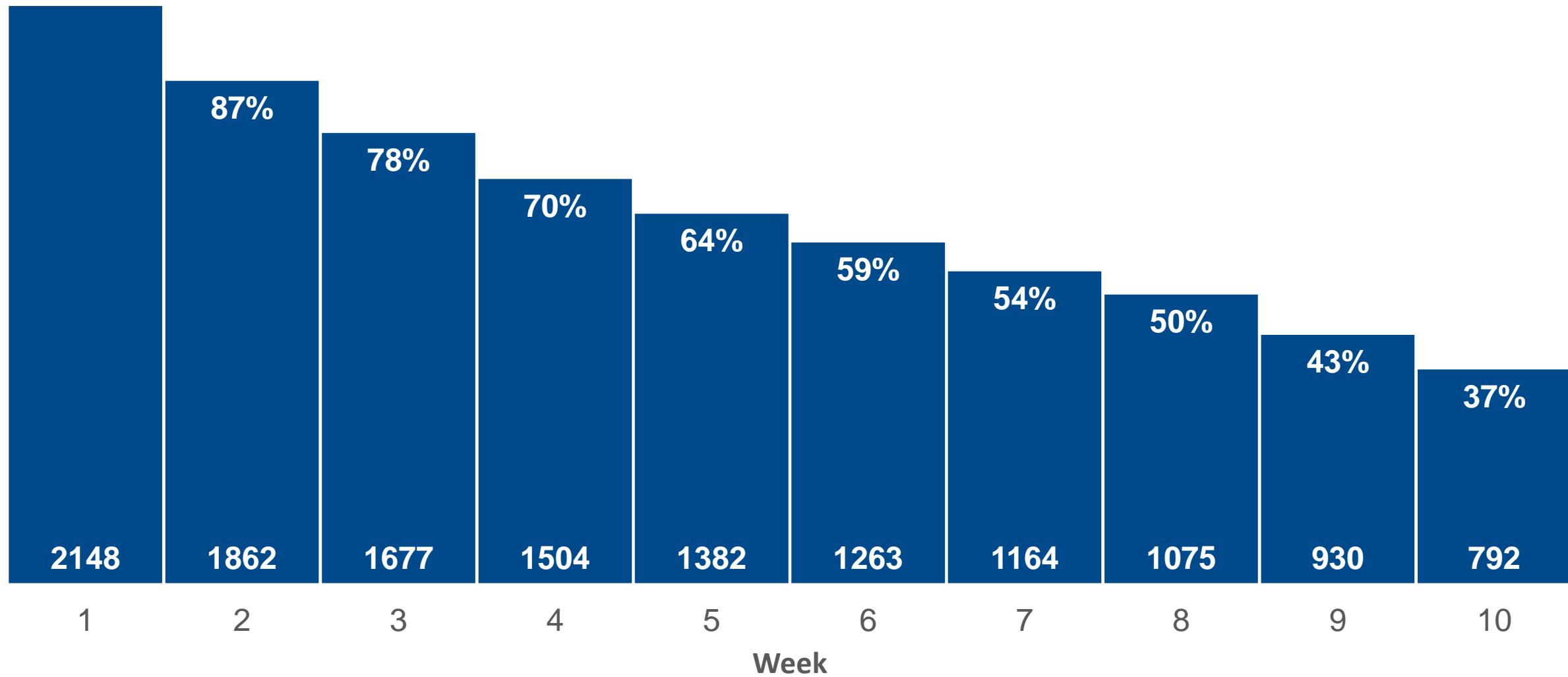
Average total of classes participated per participant per week

Participants completed an average of 6.42 classes



Participation Report

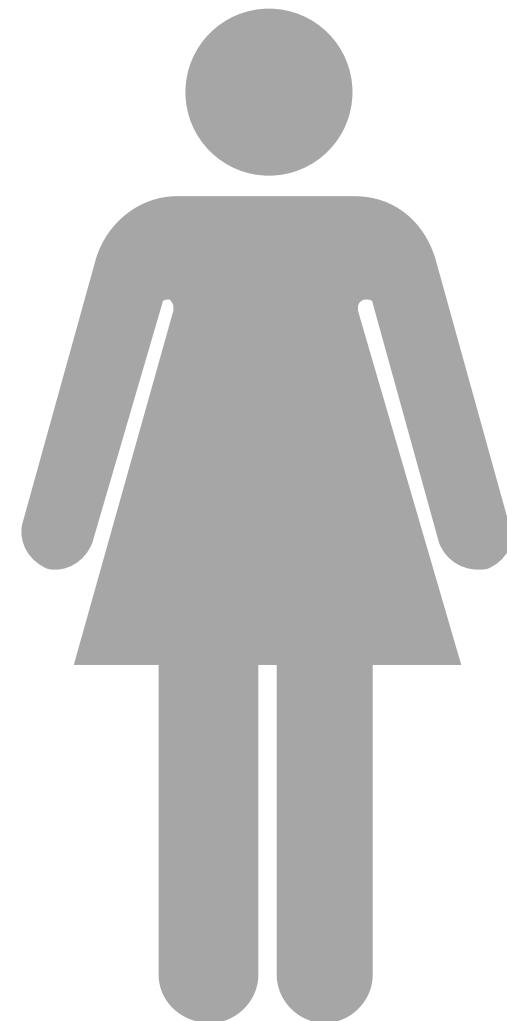
Participation in a Specific Week



Participation Report: Female vs. Male

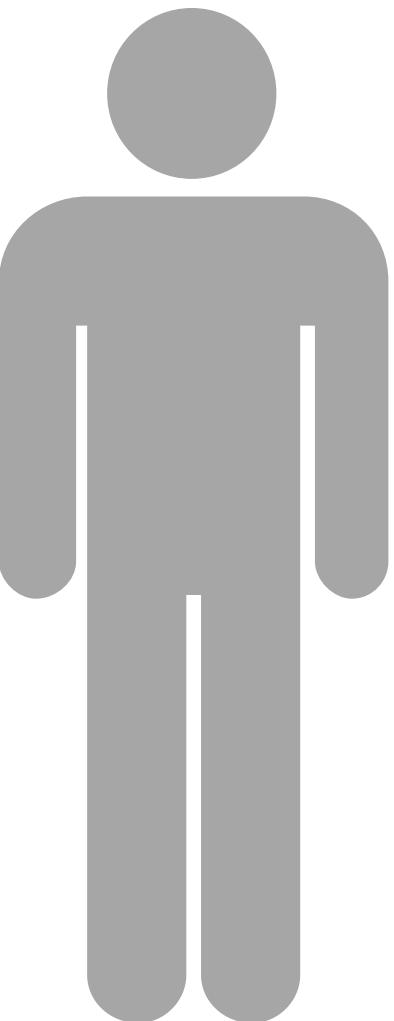
49%

955 Participated in 8
or More Weeks



33%

652 Participated in all
10 Weeks



47%

96 Participated in 8
or More Weeks

39%

80 Participated in all
10 Weeks

49%

1,051 Participated 8 or
more Weeks

34%

732 Participated in all
10 Weeks

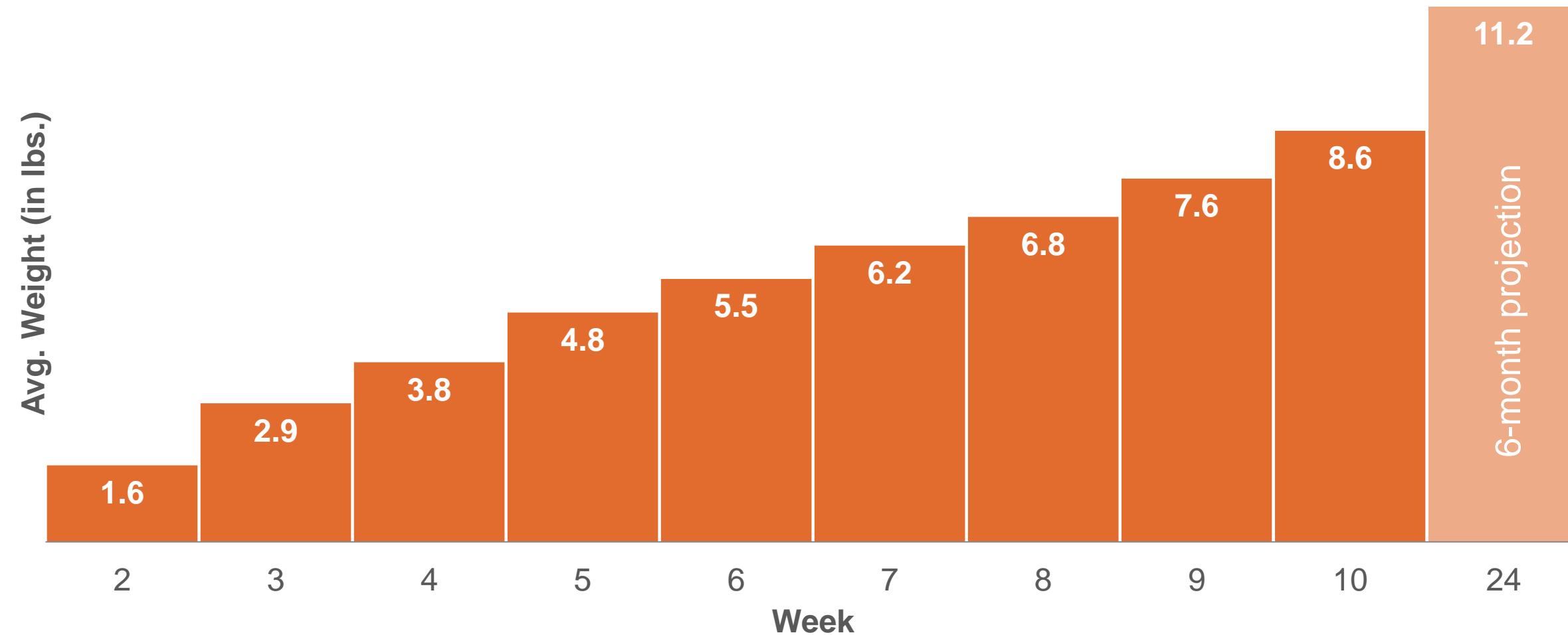
A woman with dark hair tied back, wearing a white lab coat over a pink collared shirt, is smiling at the camera. She is holding a black, rectangular medical device with a screen and a keypad in her right hand. The background is a bright, clinical setting with a window and a framed picture on the wall.

WEIGHT LOSS

Weight Loss by Week

For active participants

Total Weight Loss Greater Than 11,000 lbs.



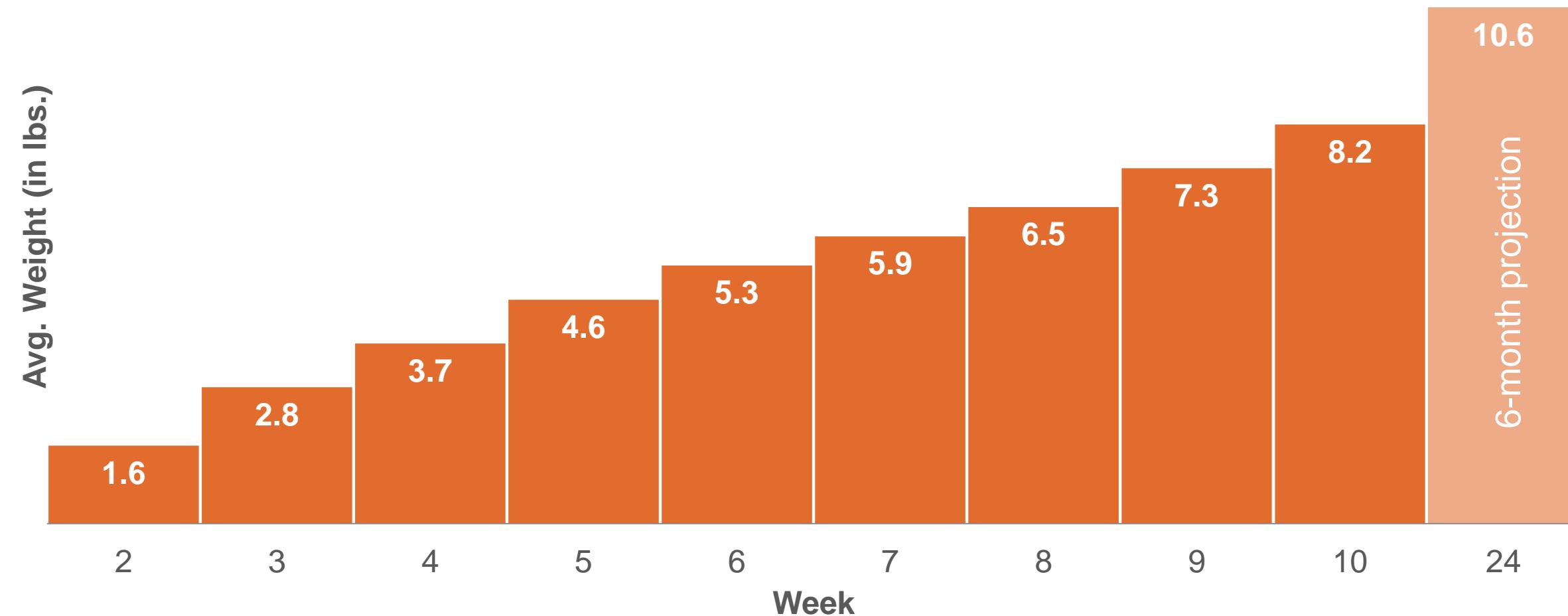
natura)(yslim®

offered by acaphalth.

Female Weight Loss by Week

For active participants

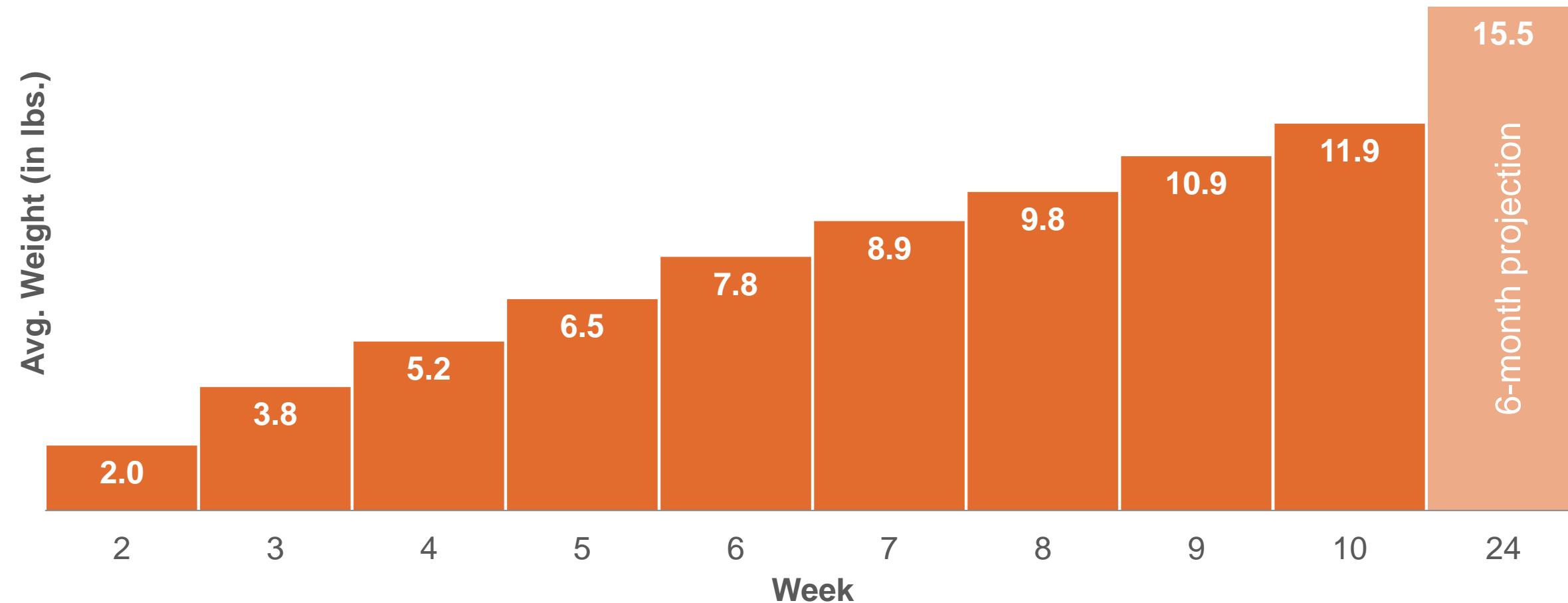
Total Weight Loss Greater Than 9,600 lbs.



Male Weight Loss by Week

For active participants

Total Weight Loss Greater Than 1,300 lbs.



**37% of individuals lowered their
Diabetes risk.**

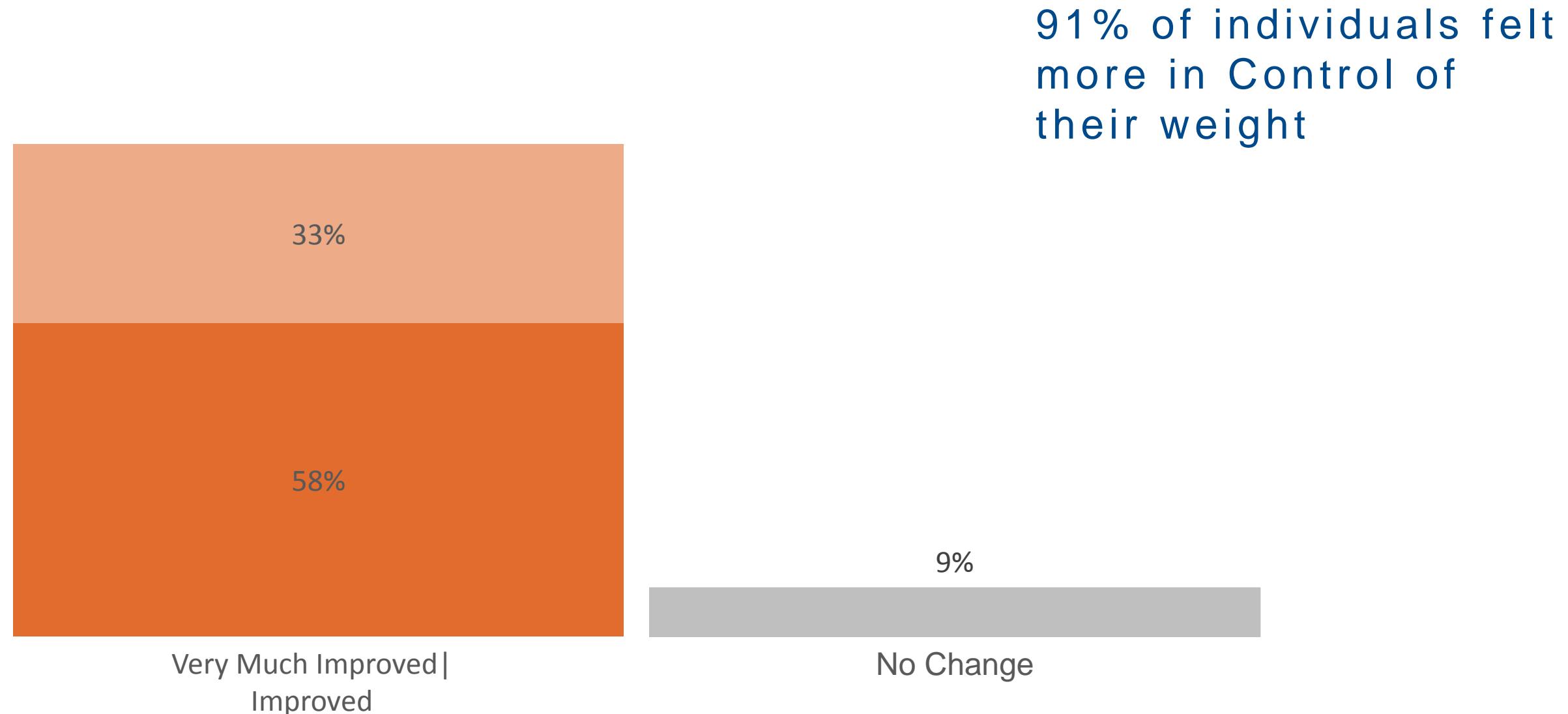
* Refer to “Federal Treatment Guidelines: How much weight loss is clinically significant?” slide in the glossary for further explanation

Post Foundations™ Quality of Life Survey



Feeling Weight is Out of Control

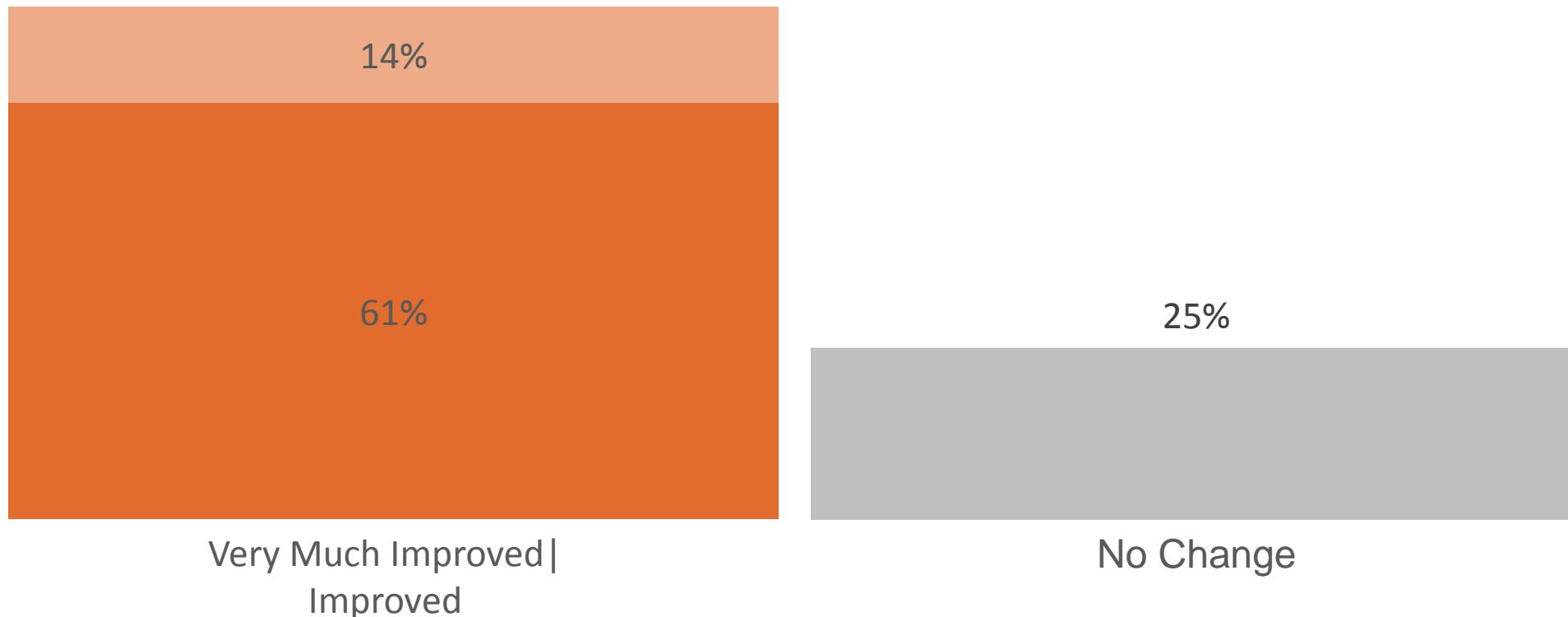
How has your feeling that your weight is “out of control” changed compared to before starting the Naturally Slim program?



Energy Level

How has your energy level changed compared to before starting the Naturally Slim program?

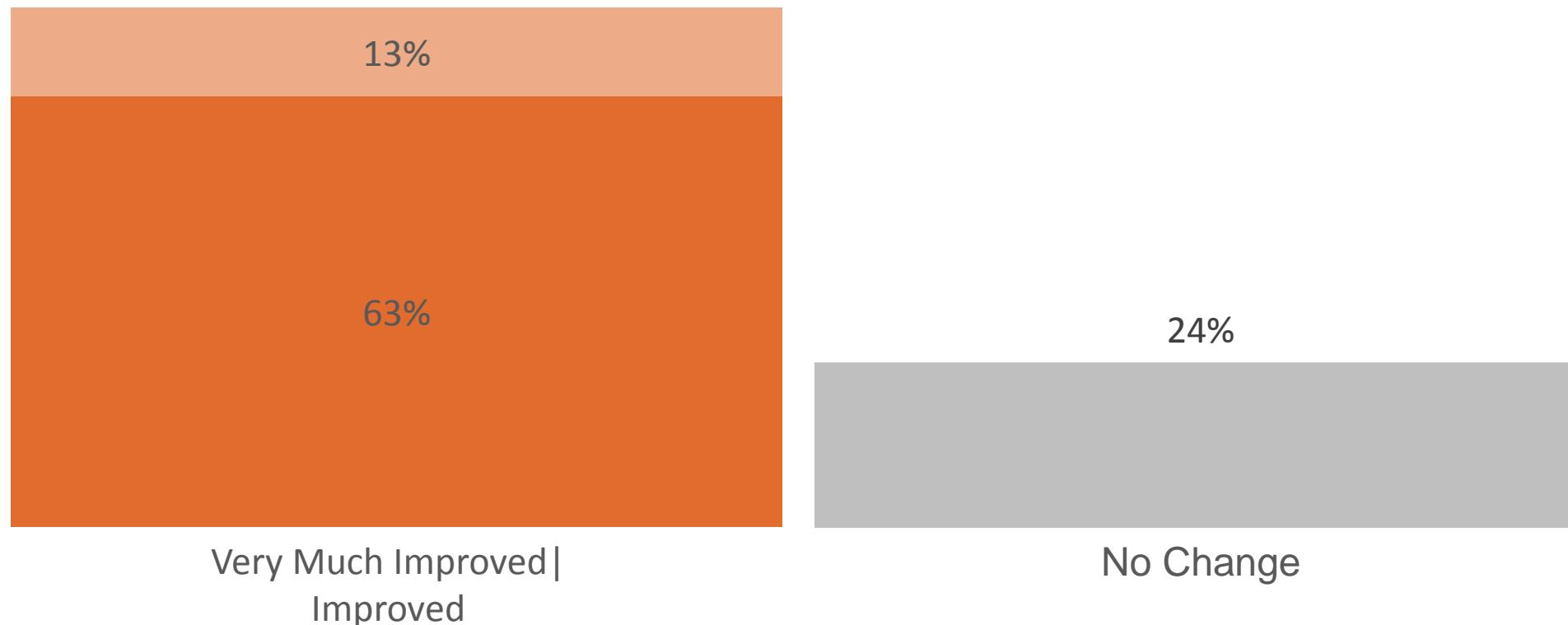
75% of individuals experienced a newfound burst of energy.



Self-Confidence

How has your self-confidence changed compared to before starting the Naturally Slim program?

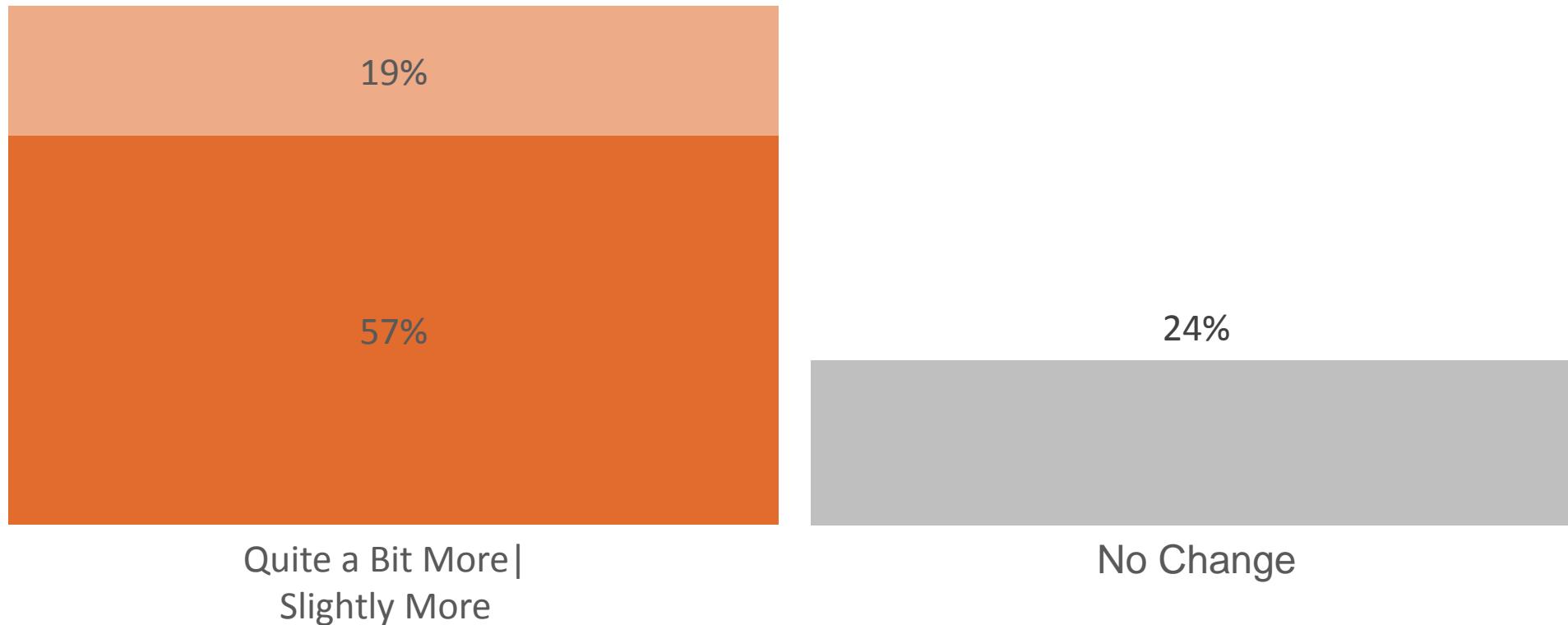
76% of individuals experienced a boost in confidence.



Physical Activity

How has your level of physical activity changed compared to before starting the Naturally Slim program?

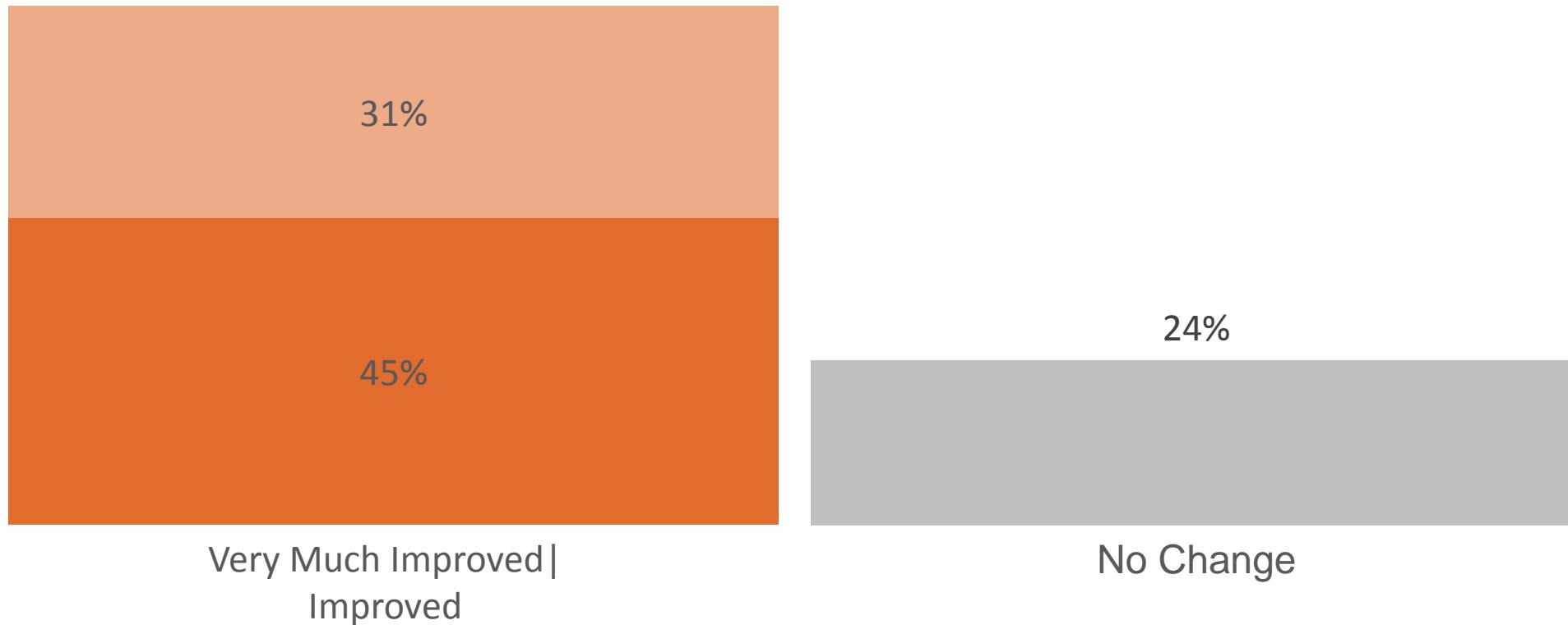
76% of individuals increased their level of physical activity.



Indigestion

How has your indigestion changed compared to before starting the Naturally Slim program?

76% of individuals' indigestion has improved.



TESTIMONIALS



Thank you so much for all you do. This has been a life-changing experience and has given me skills for life! I'm so grateful. I'll never be the same!

-ARBenefits Participant

due to change in high blood pressure medication ringing in ears
has decreased
-ARBenefits Participant

I think my Diabetes is better. I love this program and will continue
to use it!
-ARBenefits Participant

I'm on cholesterol meds, but, at my recent insurance/employer
health, it was so much lower I may ask my doctor if I can come off
the meds.
-ARBenefits Participant

A1C in March was 7.3; A1C in June (after 4 weeks on NS) was 6.5. I still take full dosage of Tujeo at night, but have eliminated Humalog 10 units 3x per day and reduced Metformin from 2000mg/day to 1000 mg/day.

-ARBenefits Participant

This was one of the best things I've been offered. I feel it has literally changed my life. I'm not where I want to be yet, but I met my initial goal and feel this is very sustainable. I would probably never have heard of the program had it not been for my employer.

-ARBenefits Participant

This is a great opportunity. I feel blessed that it was offered by my employer. I hope they offer it to more people who did not get the chance to take advantage of it this time.

-ARBenefits Participant

NEXT STEPS

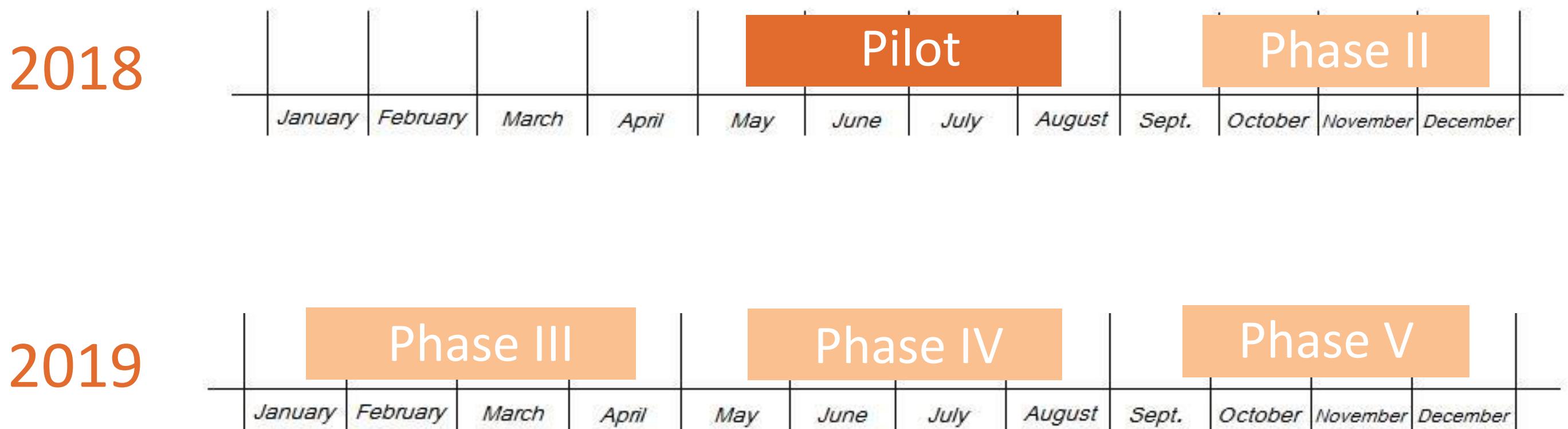


What's next for participants?



What's next for ARBenefits?

With an estimated 70%+ of ARBenefits adults pre-diabetic, obese, and/or overweight, leveraging the momentum of the pilot success will be important in engaging those that need our help.



What's next for ARBenefits?

At no cost, Naturally Slim will create a testimonial video and capture the engagement that has been demonstrated with other State health plans:



Recently, the Naturally Slim team
came to Topeka to meet with
State of Kansas employees,
and to share success stories.

1. Introduction

2. Naturally Slim & Kannact

We've heard impressive results from Naturally Slim and how the program helped to decrease the risk of developing metabolic syndrome. A preventative program like NS, if approved by the board, will continue to improve the overall health of our members by working to decrease the mentioned risk factors.. There is certainly an ROI that could be shown to evaluate plan savings by preventing the progression or development of metabolic syndrome in members. However, there is still a large subset of our population that are desperate for a more high touch/ hands on, long term management of chronic disease and conditions.

3. **ACHI** reported back in May that 11% of our member population has a diagnosis of Type 2 Diabetes. (+23% who are unaware/undiagnosed which would total to an additional 30,000 members affected by T2DM)

- 8,295 T2DM without complications
- 6,695 T2DM with complications

These 15,000 members cost the plan \$110 million in medical claims from 2016-2017

**in addition to these costs; our current UM provider is managing a group who receive free supplies to the member for participating in our voluntary diabetes management program. These costs add up to:

From January 1-July 31 of 2018

- \$266,708.31 on test strips
- \$184,172.89 on needles and pen tips
- \$29,575.52 on syringes
- \$15,162.68 on lancets

If we assume this trend to hold true, we are on track to spend near 1 million dollars on Diabetic supplies.

These are the facts and dollar amounts that lead our leadership team to request information on programs that can provide resources and tools to not only improve the health and overall well being of our members but also to prevent unnecessary claims cost. After using a very specific set of criteria in our search, Kannact stood out in many aspects. To mention a few, they are the only company that can provide raw, Clinical data to the member, provider and EBD in real time. They use a team of MD's, pharmacists, dietitians, psychologists, and nurse coaches to provide a holistic care approach to bridge the gap for these members between physician visits & they provide all of the supplies mentioned above to the members at no additional cost to the plan.

Should the plan choose to transition these members from our current program to Kannact, we could see initial cost savings of \$495,617 on 6 months / \$1 million annually for supplies alone. As time passes, EBD should begin to see a decrease in costs related to multiple provider visits, ER costs, dialysis, inpatient hospitalizations, and other complications/ effects of an un-managed disease state. Kannact also has a targeted approach to identify and engage pre-diabetics which works to de-escalate or prevent the occurrence of T2DM.

I hope this information serves as adequate detail on the instant cost savings a company like Kannact would bring to our plan while providing a proactive program to this underserved population.

Introduction: CEO Krishna Rao & Director of Marketing, Mike Pohl

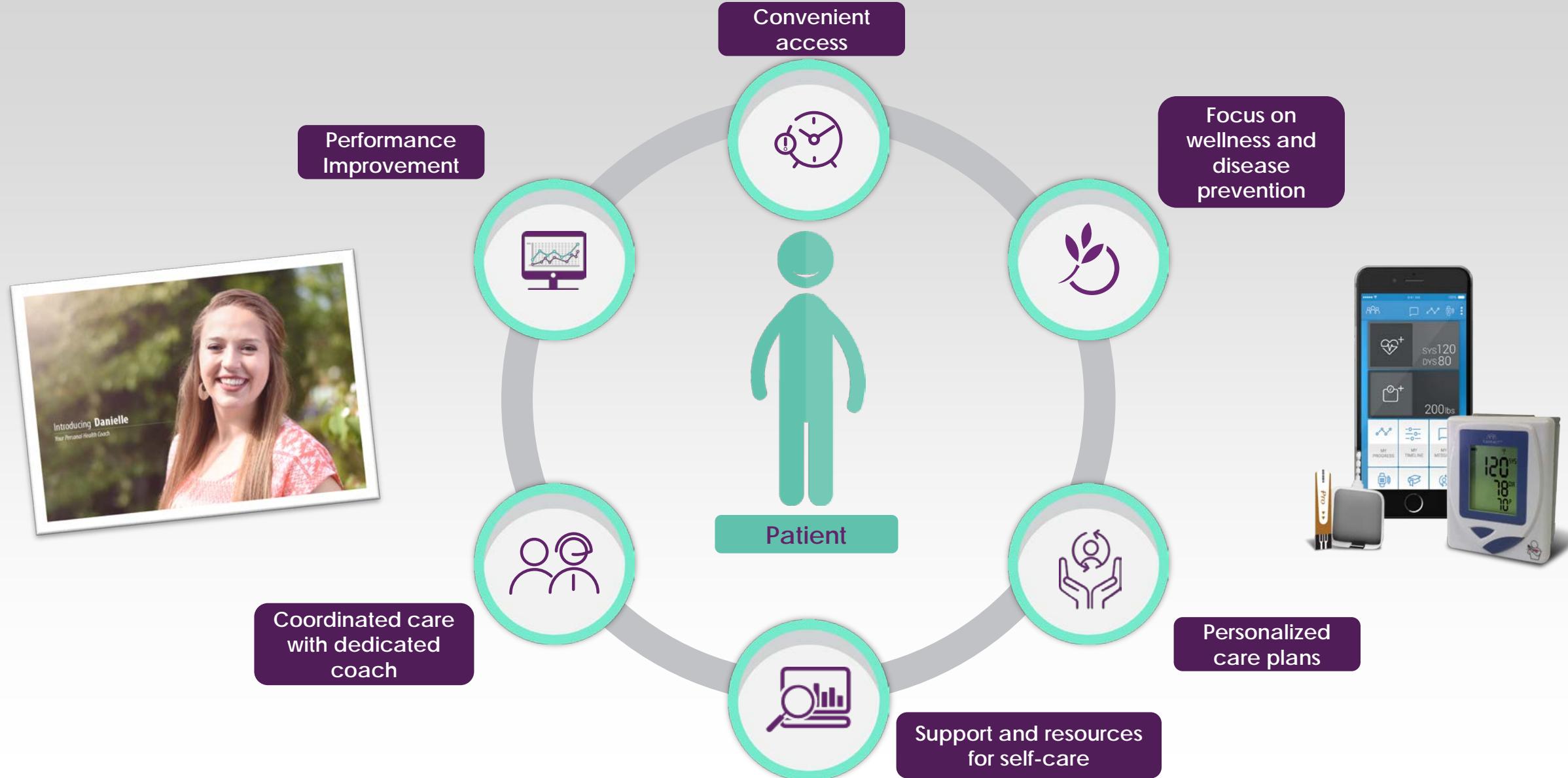


Kannact

Patient Centered Care –
Designed and Proven to
Engage Participants

Behavior Change Programs for
Chronic and Pre-Chronic
Conditions

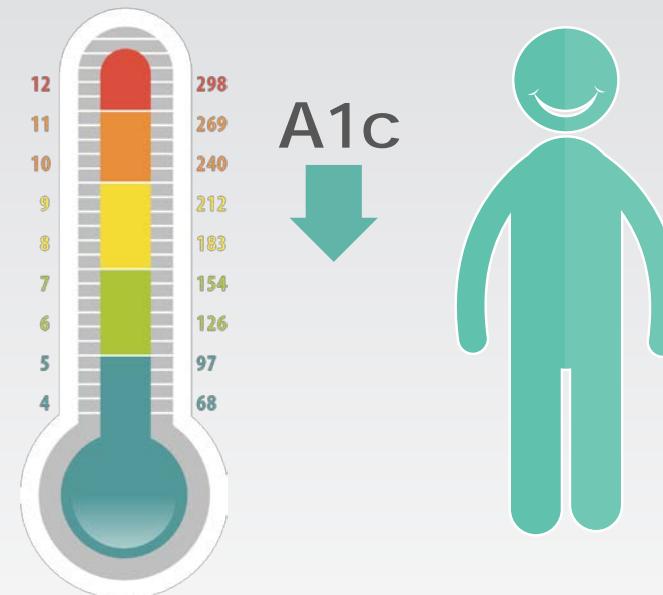
Key Elements Of Kannact Patient Centered Care



Client Description

Self-Insured Employer:
Large City in Texas 
Business with 10K employees 
80% were engaged and adherent 
Significantly reduced blood glucose in 90% of the population! 

Participants Experience

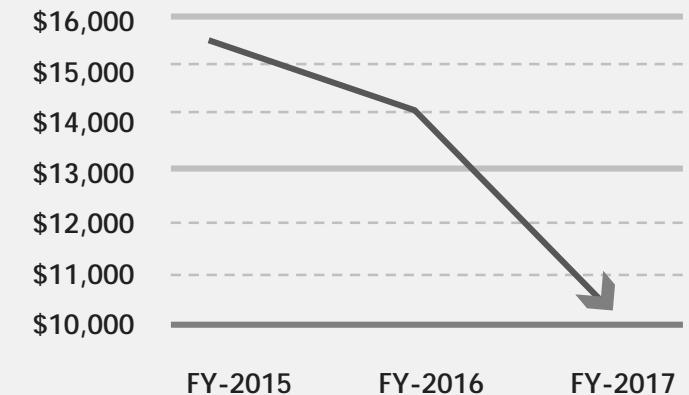


Outcomes for Diabetes patients **improved 37%**

Glucose levels dropped 35 mg/dl or HbA1c improved by 1 point

Impressive Client Results

Average Cost of Care



Cost dropped \$15.2K to \$10.3K (32%)



Convenient Access

Easy Online Enrollment



- ◆ Customized State of Arkansas landing page
- ◆ Enroll in under 5 minutes
- ◆ Support staff available on email and phone
- ◆ Engaging content, videos and emails to introduce the program

Supplies Shipped Directly to Home



- ◆ Tracked and delivered automatically as needed
- ◆ Unlimited supply
- ◆ No cost to participant

Communicate on your schedule



- ◆ 24 x 7 Support
- ◆ Multiple different methods (secure text, phone, email)
- ◆ System and coaches in English and Spanish
- ◆ Access all program data on smartphone



Focus On Wellness & Disease Prevention



- ◆ Diagnosis/Procedure Codes
- ◆ Hospitalization/ER visits

MEDICAL
CLAIMS
HISTORY



- ◆ Medication Possession Ratio
- ◆ Medication Compliance

PHARMACY
CLAIMS
DATA



- ◆ Weight/Height (BMI)
- ◆ Blood Pressure
- ◆ Blood Glucose

HEALTH
DATA



- ◆ Nutrition Management
- ◆ Appropriate Activity
- ◆ Family & Support System
- ◆ Level of Disease Knowledge
- ◆ Level of Sleep & Stress

BEHAVIORAL
ASSESSMENT
DATA



Data



Medical Claims



Rx Claims



Biometrics



Health and Behavior Risk Assessment



PARTICPANT



Profile



DIABETES



85% adherent
to oral diabetic



A1C 7.5

BMI 34

BP 138/93

HYPERTENSION

+6 Months
non-adherence to
hypertension Rx



High-stress
work
environment

Average sleep
6 hours/night



PERSONALIZED CARE PLANS



Guided by the coach and medical team





Support & Resources for Self Care



Ability to take measurements anytime anywhere – automatically logs, charts, and reports data



Participants learn how the biometric data is tied to their behaviors and habits



Accurate data allows the coaching team to adjust guidance in real time



Platform tracks wearable activity data from any device



Learning modules are adaptable to the participant's style of learning, and current knowledge level





Coordinated Care with Dedicated Coach



*Coach conducts Health and Behavior Risk Assessment
and is guided by pharmacists and clinicians*

*Personal coach creates relationship, accountability
and helps build new skills in dealing with :*



Disease
knowledge



Lifestyle
management



Home biometric
testing



Managing
personal plan
& goals



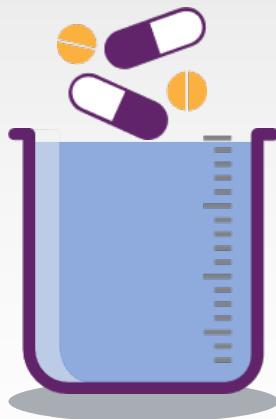


Coordinated Care – Medication Compliance



Medical and Pharmacy claims provide history, and pharmacists guide coach to provide medication compliance support

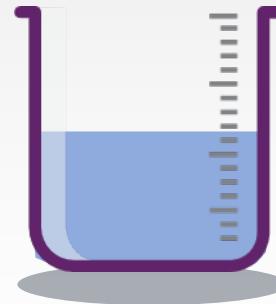
For every 100
Prescriptions
written



50-70
Go to a
pharmacy



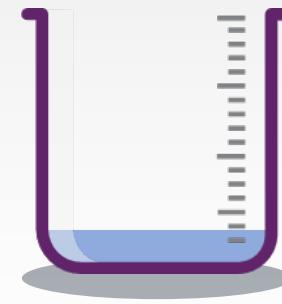
48-66
Come out of the
pharmacy



25-30
Are taken
properly



15-20
Are refilled
As prescribed



Source: National Association of Chain Drug Stores, Pharmacies,
Improving Health, Reducing Costs, July 2010. Based on IMS Health data





Participants can share portal access to the friends and family that will help them stay on track by receiving health related alerts & notifications





Performance Improvement

On-Demand Detailed and Summary Reports to Physicians

Patient Biometric Detailed Report
March 19 - April 18 2017

Patient: Debra Parker
DOB: 05/01/1962

Report Generated at 09:02 AM Apr 18 2017
All times are in Pacific Standard Time

Glucose Metrics Summary (90 days)

Prescribed Readings Per Day: 1		Breakfast (6 am - 11 am)		Lunch (11 am - 4 pm)		Dinner (4 pm - 9 pm)		Bedtime (9 pm - 6 am)	
Glucose Statistics		PRE	POST	PRE	POST	PRE	POST	PRE	POST
Highest		354		489					
Lowest		354		356					
% within Target		0%		0%					
Reading		354		423					

Glucose Logging

Date	Time	Glucose (mg/dL)	Reading Context	Insulin (Units)	Notes
04/07/2017	02:24 PM	356	Pre-Lunch		
04/06/2017	11:04 AM	354	Pre- Breakfast		

* manually entered reading

Bottom navigation bar: back, forward, search, print, download, etc.

Population Reporting Back to the Health Plan

- ◆ Initial Enrollment
- ◆ Month 3 – Early Program Engagement
- ◆ Month 6 – Phase 1 Review
 - Engagement
 - Testimonials and satisfaction
 - Early outcomes and trends
- ◆ Month 9 and ongoing quarterly
 - Health outcomes





PRE-CHRONIC PROGRAM

People with Pre-Diabetes are at higher risk for diabetes, cardiovascular diseases, and other chronic conditions

Members are identified using a combination of **claims data, wellness data, and HRA**

Lifestyle change with an emphasis on activity and nutrition

Self-monitoring to create self-awareness about how behaviors are directly effecting health scores



Coordinate With Other Programs

The Kannact platform **complements other programs** with a holistic approach to chronic care. Our focus will be coordinating in these areas with other State-implemented programs. The Kannact coach works directly with each individual to identify barriers and motivate change.



Mental Health



Wellness



Nutrition
management





A BETTER WAY TO CARE
Transformational. Personal.

Over
80%
Engagement

1 full point drop
in A1C

\$90
cost savings PPPM
over 2 years



Family/Friends
Social Circle Support



UNLIMITED
SUPPLIES
FOR DIABETES
& CARDIO

MEDICAL CLAIM
In network billing



Medical/Pharmacy/Data
review and guidance



Customizable
For client needs

ZERO
Implementation fees



Outcome
reporting



Mobile
platform is
scalable &
easy to use



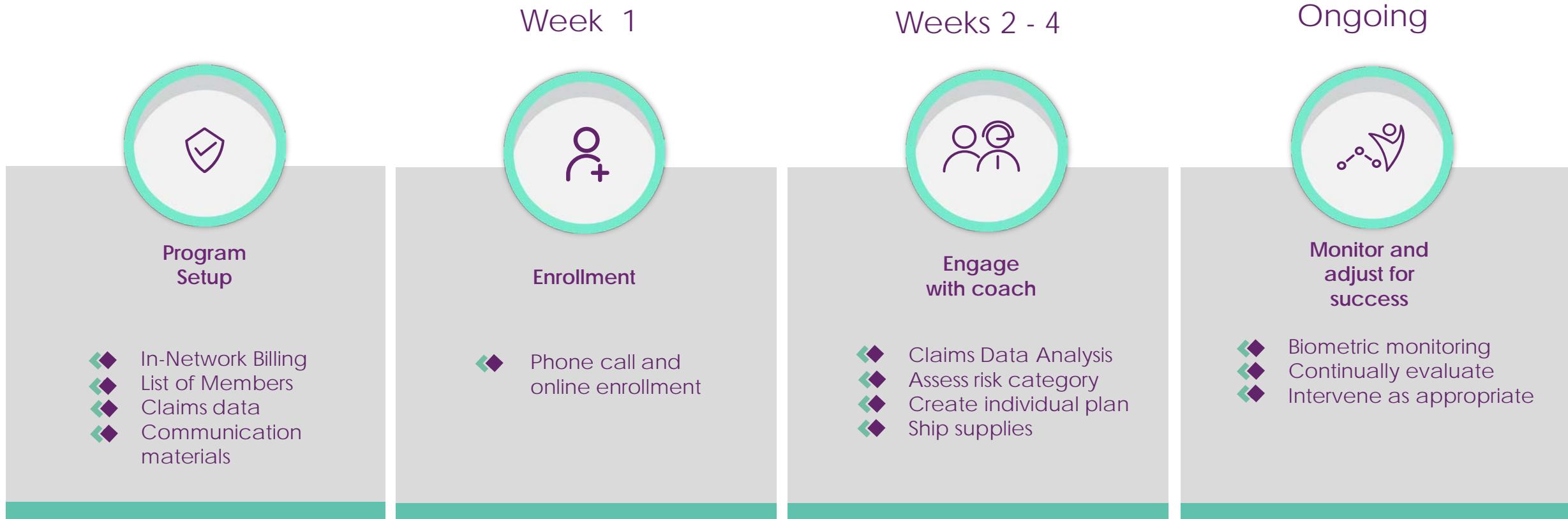
Tailored Marketing
Enrollment Campaign



Dedicated
personal COACH

Implementation

Transition Schedule





Customized Marketing and Communication



Claims Billing set-up Details

The following is the detailed information that we provide to the Claims Administrator (CA) to set up the In-network billing. We provide backup codes and modifiers as needed for each CA's specific system needs.

- CPT code for Chronic Care Program is S0317
 - There are 3 levels of service - each would use a different modifier according to the price of service.
 - Diabetes and Cardiovascular \$79
 - Diabetes \$69
 - Cardiovascular \$59
- CPT code for Pre-Diabetes program is 0488T
 - No modifier – billed at \$49
- Benefit level: pay at 100% with NO employee deductible/copay/co-share
- Benefit plan year max is 12 claims
- ICD10 / Diagnosis codes –
 - E13.00 – Diabetes
 - I99.9- Cardiovascular
 - R73.00 – Pre-Diabetes

Thank You
