AGENDA

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

January 12, 2016

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

I. Call to Order .....Margo Bushmiaer, Chair

II. Approval of Aug. 21, Oct. 13, Nov. 10, 2015 Minutes .....Margo Bushmiaer, Chair

III. Primary Care Physician Assignment ... Alicia Berkemeyer, Blue Cross Blue Shield

IV. Anesthesia for Colonoscopies ..... Dr. Creshelle Nash, Blue Cross Blue Shield

V. Wellness Requirements 2016 ..... Janna Keathley, EBD Quality Assurance Officer

VI. New Business/Topics .....Margo Bushmiaer, Chair

Upcoming Meetings

February 9, 2016

NOTE: All material for this meeting will be available by electronic means only ethel.whittaker@dfa.arkansas.gov

Notice: Silence your cell phones. Keep your personal conversations to a minimum. Observe restrictions designating areas as "Members and Staff only"

State and Public School Life and Health Insurance Board Quality of Care Sub-Committee Minutes January 12, 2016

The State and Public Life and Health Insurance Board, Quality of Care Committee met on January 12, 2016 at 1:00 p.m. in the EBD Board Room, 501 Woodlane, Little Rock, Arkansas.

Members Present	**Members Absent**
Margo Bushmiaer	Marjorie Greenberg `
Zinnia Clanton	Dr. Tony Thurman
Michelle Murtha	Dr. Eric Crumbaugh
Pam Brown	
Don Hollingsworth	
Dr. Joseph Thompson	
Robert Boyd	
Dr. Namvar Zohoori	
Frazier Edwards	
Lori Eden, Deputy Director, Employee Benefits Division	

Others Present
Dwight Davis, David Keisner, Geri Bemberg, Arlene Chan-Monton, UAMS; Ethel Whittaker, Lori Eden, Ellen Justus, Janna Keathley, Stella Greene, Matt Turner, EBD; Pam Lawrence, AHH; Dr. Creshelle Nash, ABCBS; Marc Watts, ASEA; Steve Althoff, MTI; Kristi Jackson, ComPsych; Takisha Sanders, Jessica Akins, Health Advantage; Jackie Baker, ASP; B.J. Himes, Karyn Langley, Qual Choice; Leo Hauser, Marvin Parks, BPS; Ronda Walthall, Wayne Whitley, AHTD, Rusty Filey, Merck; Andy Davis, Arkansas Democrat Gazette; Bridgette Johnson, Mike Latran, Pfizer; Sean Sbago, Merck; Treg Long, American Cancer Society; Leah Ramirez, Mike Motley

CALL TO ORDER
The meeting was called to order by Margo Bushmiaer, Chair

APPROVAL OF MINUTES: *by Margo Bushmiaer, Chair*

Bushmiaer motioned for the approval of the August 21, October 13, & November 10, 2015 minutes. Murtha motioned for approval the minutes. Boyd seconded. All were in favor.

Minutes Approved.

PRIMARY CARE PHYSICIAN ASSIGNMENT: *by: Laura Thompson Manager, Arkansas Blue Cross & Blue Shield*

Thompson provided updated information regarding the alignment of the PCP program.

Thompson reported 80% (96,293) of the plans population is assigned to a Primary Care Physician. Statewide there are approximately 122,806 members enrolled in the plan. Of those only 24,528 (20%) are not assigned to a PCP. There are 34,277 attributed to the State Patient-Centered Medical Home. There are many benefits to the program for the member and the plan.

Brown recommended the Board adopt a process for alignment for assignment of a PCP. Dr. Thompson seconded. All were in favor.

Motioned Approved.

ANESTHESIA FOR COLONOSCOPIES: *By: Dr. Creshelle Nash, Medical Director, Blue Cross and Blue Shield & Lori Eden, EBD Deputy Director*

Eden briefly reported today's discussion is a continuation from previous meetings. Standard of care is considered conscious sedation for colonoscopies. In today's industry a vast number of clinics automatically administer propofol for anesthesia and the cost is passed on to the member. Of the 1750 preventive colonoscopies performed in 2014, 175 were billed separately for anesthesia. The plan will cover propofol only if it's medically necessary, which must be verified by clinical documentation. The goal is to balance standard of care with the cost not allocated to the members.

Dr. Nash reported one of the main concerns is general anesthesia and the current guidelines. The death rate for colorectal cancer in Arkansas is higher than national averages. Colorectal Cancer is the 3rd most common cancer in men and women. The US Preventive Task Force recommends men and women between the ages of 50-75 receive colonoscopies.

Dr. Nash reported the following claims data from 01/01/2014 - 06/30/2015:

Members with Claims for colonoscopies	Allowed/Denied	Paid	Cost Member
2538	2512 - 26 (1%)	$1,507,373.99	$593.91

***99% were medically indicated in 18 months for colonoscopies.**
The following is a review of the cases with general anesthesia:

Members	Allowed	Paid	Cost per Member
2035	1602 - 433	$330,990.74	$162.65

***79% were allowed and 21% denied based on AGA criteria.**

After extensive discussion Hollingsworth requested general information regarding the clinics involved; identify the clinics, their locations, and how many procedures are performed for the members. Dr. Nash reported some locations include Little Rock, Hot Springs, and Fort Smith. Hollingsworth would like more detailed information. Dr. Nash will present the report at the February 2016 meeting.

WELLNESS REQUIREMENTS 2016: *BY: Janna Keathley, EBD Quality Assurance Officer*

Keathley reported the wellness program began in 2014. The ARBenefits Well program encourages members to have an annual exam with a provider. The goal is to establish a relationship with a provider and potentially reduce ER visits. The program has proven helpful in identifying chronic conditions that could become costly to the member and the plan. Keathley gave a couple of examples of members notifying EBD of their positive impact as a direct result of the ARBenefitsWell program.

Over 71,400 members are eligible for the wellness discount. Of these over 63,700 (89%) completed the requirements of the program. Over 7,600 have not yet met the requirements. The goal is to migrate toward more measurable outcomes in the future. Bushmiaer requested information on wellness programs and their incentives from UAMS, AFMC, Nabholtz, Children's Hospital, and Windstream.

NEW BUSINESS TOPICS: *by Lori Eden, EBD Deputy Director, Dr. Joseph Thompson, Director ACHI*

Eden requested additional information regarding the upcoming case management RFP. Eden has concerns with the amount of time allocated for the process which can take up to 1 year. The Quality of Care committee will provide direction as well as the Board.

Dr. Thompson briefly discussed ACHI and EBD will meet to discuss the various options for case management and provide guidance to the Board and for the RFP process.

Bushmiaer thanked the members for their participation and motioned to adjourn.

Dr. Thompson seconded. All were in favor.

Meeting Adjourned.

ASE/PSE Report

Anesthesia for Lower Endoscopic Procedures

Creshelle R. Nash, MD, MPH
Medical Director, Arkansas Blue Cross and Blue Shield

January 12th, 2016

Overview

- Background
- The Use of General Anesthesia
  - American Society of Gastrointestinal Endoscopy
- The Question of the Quality of Care Committee
- The Arkansas Blue Cross Analysis and Findings
  - Claims and Medical Record Review
- Conclusions

- Colorectal Cancer (CRC) is the 3rd most common cancer in men and women
  - The death rates for CRC is high than national averages
- Colorectal Screening Reduces Deaths
- US Preventive Task Force Recommendations:
  - Screening for men and women aged 50-75
  - FOBT, Sigmoidoscopy or Colonoscopy
- Colonoscopy is also utilized in diagnosis and treatment of many GI disorders

- Sedation improves the quality of an endoscopic examination

Mild to Moderate to Deep Sedation or General Anesthesia

- Increased risk of cardiopulmonary complications with general anesthesia
- Level of sedation is influenced by:
  - The Procedure
  - Patient Age and Health Status
  - Concurrent Medications
  - Anxiety and Pain Tolerance

- The American Society for Gastrointestinal Endoscopy states that:

  "The routine assistance of an anesthesiologist for average risk patients undergoing standard upper and lower endoscopic procedures is not warranted"

However general anesthesia is recommended in:

- Patients with more extensive GI endoscopy procedures (e.g., ERCP);
- Patients with complicated co-morbid medical conditions;
- Patients who cannot tolerate conscious sedation; and
- Patients with an increased risk for airway obstruction due to an anatomic variant.

Review the medical necessity of anesthesia with colonoscopy within the ASE/PSE population

- The Current Process: Monitor for use of General Anesthesia
  - –Any claim that is received is denied
  - –The provider is able to appeal the denial
  - –The case is reviewed for medial necessity
    - •If denied: Member responsibility and may generate member appeals

- From Claims Data: 1/1/2014-6/30/2015

Members with Claims for colonoscopies	Allowed /Denied	Paid	Cost per member
2538	2512/26(1%)	$1,507,373.99	$593.91

- Point here 99% are medically indicated in 18 months

Top 5 Diagnosis
Screening for Malignant Neoplasm
Diverticulosis of the colon
History of Colon Polyps
Blood in Stool
Iron deficiency anemia
Other symptoms involving the digestive system

Review of the 2035 cases with general anesthesia:

Members	Allowed /denied	Paid	Cost per Member
2035	1602/433	$330,990.74	$162.65

- 79% were allowed and 21% denied based on AGA criteria
- Approximately $70,427 in costs were avoided by the plan over the time period
- Cost saved : $46,951 per year or $3,913 per month
- Does **not account for** the administrative cost of member and provider appeals

Conclusion

- There is growth in the use of General Anesthesia in endoscopic procedures in Arkansas and the nation.
- Professional societies continue to debate the issue and have developed guidelines.
- We utilize those guidelines in our policy for ASE/PSE and our evaluation.
- We found that 79% of the endoscopy cases met medical criteria for the use general anesthesia.
- Arkansas Blue Cross and Blue Shield has done a cost/benefit analysis for other health plans
  - Discontinued medical review of general anesthesia claims with endoscopic procedures.

Thank You

Payment Innovation

Laura Thompson
Manager, Primary Care Programs
January 2016

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Payment Innovation

Building a healthier future for all Arkansans

Arkansas Healthcare Payment Improvement Initiative

- Improve the **health** of the population
- Improve **patient experience** of care (quality and access)
- Reduce, or at least control, and **cost** of health care

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Primary Care Alignment

Primary Care Alignment- ASE/PSE membership

Statewide				CPC	State PCMH
Members	Unaligned	Attributed	%Members	Attributed	Attributed
122,806	24,528	96,293	80%	14,640	34,277

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Comprehensive Primary Care initiative

CPCi

Program Overview

Comprehensive Primary Care initiative

- The CPC initiative will test a practice redesign model supported by a new payment model over 4 years (2013-2016):

Practice Redesign

- Provision of core primary care functions
- Better use of data

Payment Redesign

- PMPM care management fee
- Shared Savings opportunity

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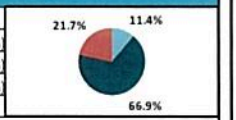
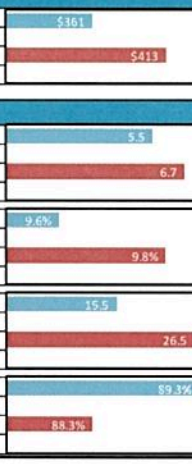
	Qtr 1	Qtr 2	Qtr 3	Qtr 4
YEAR-TO-DATE PROGRAM SUMMARY				
Total Active Members	137,348	137,669	124,548	122,511
CPC Attributed Members	12,402 (9.0%)	13,429 (9.8%)	13,471 (10.8%	13,934 (11.4%)
Other PCP Attributed Members	78,643 (57.3%	97,366 (70.7%	81,044 (65.1%	81,947 (66.9%)
Active Non-Attributed Members	46,303 (33.7%	26,874 (19.5%	30,033 (24.1%	26,630 (21.7%)



		Rolling Year Ending:	9/30/2014	12/31/2014	3/31/2015	6/30/2015
TOTAL COST OF CARE						
Group CPC Attributed PMPM			$371	$360	$357	$361
State CPC Attributed PMPM			$374	$377	$402	$413
UTILIZATION						
Hospital Inpatient - Admits per 1,000 per month	Group CPC Attributed		5.6	5.4	5.5	5.5
	State CPC Attributed		5.5	5.6	6.5	6.7
Hospital Inpatient- Re-Admit Rate	Group CPC Attributed		9.4%	8.1%	10.4%	9.6%
	State CPC Attributed		8.7%	8.0%	9.6%	9.8%
Emergency Room Visits per 1,000 per month	Group CPC Attributed		16.0	16.1	15.3	15.5
	State CPC Attributed		16.8	17.5	25.4	26.5
Prescriptions - Generic Rate	Group CPC Attributed		87.8%	88.5%	88.9%	89.3%
	State CPC Attributed		87.3%	87.7%	88.2%	88.3%



Patient-Centered Medical Home

PCMH

Patient-Centered Medical Home

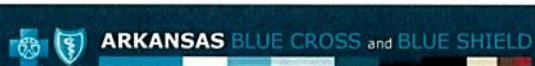
- State PCMH program
  - Effective date 4/1/15
  - Multi-payer participation
  - Alignment of metrics

- 2016 CPC / PCMH Numbers
  - 210 Clinics
  - 979 providers

2016 Program Overview
Activity Metrics

Patient-Centered Medical Home

- Identify top 10% of high-priority patients
- Clinical Quality Measures (CQM) report generation
- Assess operations of practice and opportunities to improve
- Develop strategy to implement care coordination and practice transformation
- Identify and address medical neighborhood barriers to coordinated care (including BH professionals and facilities)
- Provide 24/7 access to care
- Document approach to expanding access to same-day appointments
- Childhood/Adult Vaccination Practice Strategy
- Establish processes that result in contact with beneficiaries who have not received preventative care
- Complete a short survey related to patients' ability to receive timely care, appointments, and information from specialists (including BH specialists)
- Document investment in healthcare technology or tools that support practice transformation
- Incorporate e-prescribing into practice workflows
- Integrate EHR into practice workflows
- Ability to extract data from EHR
- Care Plans for High Priority Beneficiaries



2016 Program Overview
Quality Metrics

Patient-Centered Medical Home

- Percentage of beneficiaries who turned 15 months old during the performance period who receive at least four wellness visits in their first 15 months.
- Percentage of beneficiaries 3-6 years of age who had one or more well-child visits during the measurement year.
- Percentage of beneficiaries 12-21 years of age who had one or more well-care visits during the measurement year.
- Percentage of beneficiaries 6-12 years of age with an ambulatory prescription dispensed for ADHD medication that was prescribed by their PCMH, who had a follow-up visit within 30 days by any practitioner with prescribing authority.
- Percentage of beneficiaries prescribed appropriate asthma medications.
- Percentage of CHF beneficiaries age 18 and over on beta blockers.
- Percentage of beneficiaries 1-17 years of age who were given a diagnosis of non-specified URI, and who had antibiotic treatment for it during the measurement period.

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2016 Program Overview
Quality Metrics Continued

Patient-Centered Medical Home

- Percentage of diabetes beneficiaries who complete annual HbA1C, between 18-75 years of age.
- Percentage of diabetic beneficiaries between 18-75 years of age who are on statin medication.
- Percentage of a practice's high priority beneficiaries who have been seen by any PCP within their PCMH at least twice in the past 12 months.
- Percentage of beneficiaries who had an acute inpatient hospital stay who were seen by a health-care provider within 10 days of discharge.
- Percentage of beneficiaries age 18 years and older who were prescribed chronic Alprazolam (Xanax) during the measurement period.
- Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.
- Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) whose most recent HbA1C level during the measurement period was greater than 9.0% (poor control) or was missing the most recent result, or an HbA1C test was not done during the measurement period.
- Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of height, weight, and body mass index (BMI) percentile documentation during the measurement period.

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Episodes

Arkansas Blue Cross and Blue Shield

Episode-Based
REIMBURSEMENT

Episode Summary as of 01/01/2016

Arkansas Blue Cross and Blue Shield now has **10 Episodes**

1. Total Knee & Hip Replacement (TJR)
2. Congestive Heart Failure (CHF)
3. Perinatal
4. Colonoscopy (on hold for 2016)
5. Cholecystectomy
6. Tonsillectomy & Adenoidectomy
7. Percutaneous Coronary Intervention (PCI)
8. Coronary Artery Bypass Graft (CABG)
9. Asthma
10. Chronic Obstructive Pulmonary Disease (COPD)

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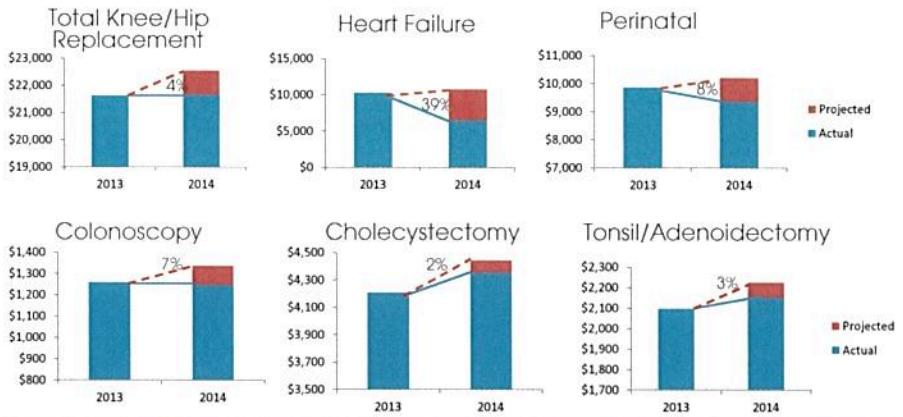
Wave 1 and Wave 2 Costs

- All episodes live in 2014 had an average cost between 2% and 39% under the projections for 2014



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Episode-Based
REIMBURSEMENT

Wave 3 Development

Currently exploring development of additional episodes & maintaining close alignment with Medicaid.

Episode	AR Blue Cross	Medicaid
Appendectomy		✓
Hysterectomy	✓	✓
Major Bowel	✓	
Non-Cervical Spinal Fusion	✓	
Pneumonia	✓	✓
Urinary Tract Infection (with ER)		✓

Projected Implementation: January 2017
Preparatory Reporting beginning Mid-2016

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Episode-Based
REIMBURSEMENT

Wave 3 Development (continued)

Quality Metrics for Existing Episodes

- AR BCBS is also evaluating the Quality Metrics for the existing 10 Episodes.
- Changes to these metrics may include:
  - Measures to ensure medically necessary/appropriateness
  - Industry 'best practices' for ensuring quality Episode outcomes

Episode-Based
REIMBURSEMENT

Increasing Cost Transparency

- Principle Accountable Providers (PAPs) are more selective in facilities they choose
- Facilities are now encouraged to be more competitive in negotiated costs
- Providers are more engaged with AR BCBS and are collaborating to help shape the program
- 2016 Cost Transparency Goals
  - Provide Cost Data for Primary Care Physicians for Referrals and Other Medical Costs
  - Increasing Accessibility to Cost Data for Members, Providers, and Employers with National Utilization Data

Episode-Based
REIMBURSEMENT

2015 Performance Reporting

All 10 Episodes live in 2015 will be reported and finalized on the following schedule.

Report Quarter	Report Date	Report Span
Qtr 1 2015	Jul 31, 2015	Jan- Mar 2015
Qtr 2 2015	Oct 31, 2015	Jan- Jun 2015
Qtr 3 2015	Jan 31, 2016	Jan – Sep 2015
Qtr 4 2015 (Preliminary Year End Report)	Apr 30, 2016	Jan – Dec 2015
Qtr 4 2015 (Final Settlement Report)	Jun 30, 2016	Jan – Dec 2015

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Thank you!

Arkansas Blue Cross and Blue Shield