



AGENDA

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

April 12, 2016

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

- I. Call to OrderMargo Bushmiaer, Chairman*
- II. Approval of March 11, 2016 MinutesMargo Bushmiaer, Chairman*
- III. 2017 ARBenefits Well Program...Janna Keathley, Chief Quality Assurance Officer
& Cecilia Walker, RN, EBD*
- IV. Continued Review of Anesthesia for Colonoscopies... Dr. Richard Smith,
UAMS, Chair of Medical Utilization and Evaluation Workgroup
and Dr. Jill Johnson, PharmD, UAMS*
- V. Overview of the Medical Utilization and Evaluation Workgroup .Dr. Richard Smith*

Upcoming Meetings

May 10, 2016

June 14, 2016

July 12, 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
April 12, 2016**

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

Members Present

Margo Bushmiaer
Dr. John Vinson
Michelle Murtha
Pam Brown
Don Hollingsworth
Dr. Joseph Thompson
Robert Boyd
Dr. Namvar Zohoori

Members Absent

Marjorie Greenberg
Dr. Tony Thurman
Frazier Edwards
Zinnia Clanton

Janis Harrison, EBD Interim Director, Employee Benefits Division

Others Present

Dwight Davis, David Keisner, Jill Johnson, Richard Smith, Marti Morrison, UAMS; Ethel Whittaker, Janna Keathley, Stella Greene, Marla Wallace, Andrew Carle, Cecilia Walker, Terri Freeman, EBD; Pam Lawrence, AHH; Kristi Jackson, Jenifer Vaughn, ComPsych; Mike Motley, EBDMed; Dr. Creshelle Nash, ABCBS; Marc Watts, ASEA; Steve Althoff, MTI; Kristi Jackson, ComPsych; Takisha Sanders, Jessica Akins, Health Advantage; Karyn Langlely, Qual Choice; Ronda Walthall, Wayne Whitley, AHTD, Sean Seago, Merck; Andy Davis, Arkansas Democrat-Gazette; Sean Sbago, Merck; Leah Ramirez, ACHI; Robyn Keene, AAEA; John Vinson, APA; Martha Hill, Shaneca Smith, AFMC

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 March 8, 2016 minutes. Boyd motioned for adoption of the minutes. Murtha seconded. All were in favor.

Minutes Approved.

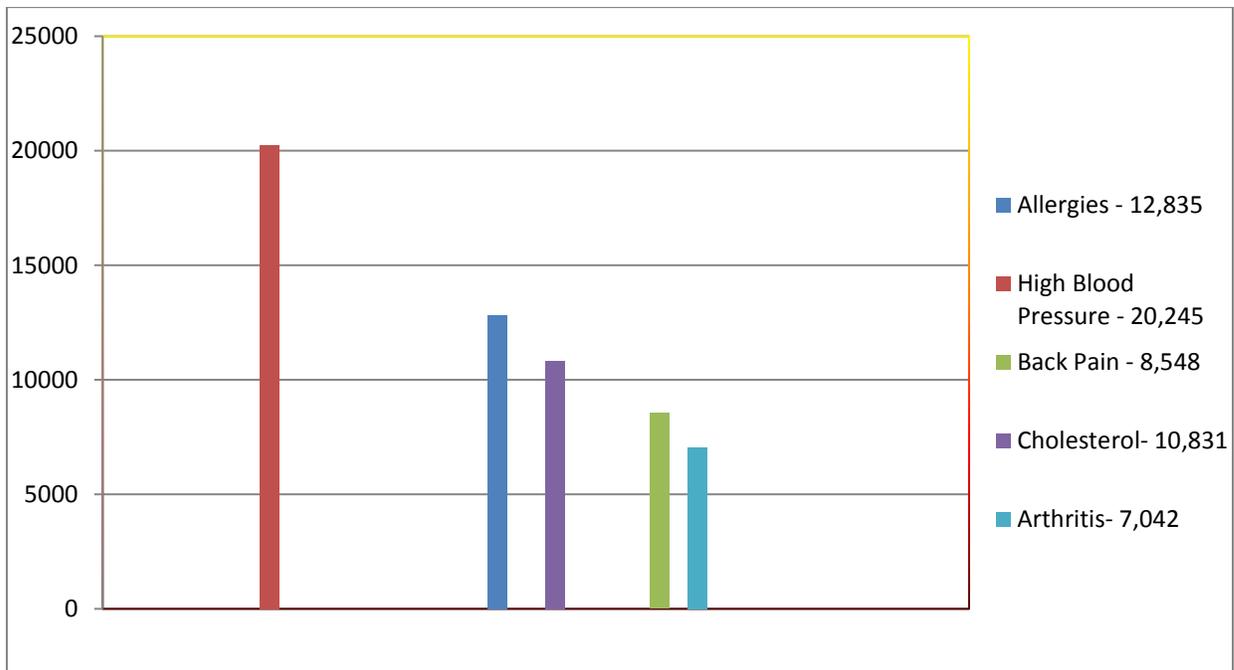
2017 ARBENEFITS WELL PROGRAM: By: Janna Keathley, EBD Quality Assurance Officer, Cecilia Walker, EBD Registered Nurse

Keathley and Walker completed an overview of the 2017 well program. The recommendations are as follows:

Keathley and Walker provided an update of the Program that included:

- Qualification statistics
- Agency reporting statistics
- Summary of findings provided by Guidance Resources from the Health Assessments completed in 2015
- Additional organizational comparison information
- Recommendation for no change to existing Program for 2017, but look at changes for 2018

Health Assessment – Number of Top Health Ricks (aggregate data)



Murtha inquired what Biometrics is involved in the Health Assessment and the Wellness program? Keathley reported Biometrics is not implemented in the well

program at this time. Keathley reported the plan would like to move forward with Biometrics; however; it will be delayed until 2018.

Dr. Kirtley inquired about the home testing procedures for Biometrics. Keathley reported home testing kits are declining regarding use.

Keathley reported 90% of members met the requirements of the health assessment. In addition, there are over 3000 members enrolled in the healthy guidance program.

Bushmiaer reported many teachers did not take the health assessment due to lack of understanding.

Dr. Vinson inquired how long has the wellness and the health assessment been in use? Keathley reported since 2014 for the wellness program and since 2015 for both the wellness and health assessment.

Boyd said many companies are not using health assessments due to the overall value of self-reporting. Members have concerns with the privacy of self-reporting.

Murtha inquired what visits qualify for a wellness checkup? Keathley reported the visits that are coded as wellness. Visits that are not considered wellness could possibly be treated as such, depending on how the treatment code classifies the visit. Keathley stated most members adhere to their wellness visit because the plan pays 100%.

Moving forward the recommendations are as follows:

- 1). Continue gathering information from other organizations that have already implemented biometric screening to help determine what may be best practice for the State of Arkansas in logistics, cost and convenience for members.
- 2). Meeting with the Health Department to discuss the possibility of a partnership relating to wellness.
- 3). ComPsych is in process of connecting us with another organization in their portfolio that uses physician's form.

CONTINUED REVIEW OF ANESTHESIA FOR COLONOSCOPIES:

By: Drs. Richard Smith and Jill Johnson, UAMS

Dr. Smith reported on the debate between the current benefit coverage of conscious sedation for screening colonoscopies and whether anesthesia should or should not be a covered benefit for screening colonoscopies:

- For decades, conscious sedation has been used routinely with screening colonoscopies. Anesthesia is an alternative to conscious sedation.

- Screening colonoscopies are recommended by the U.S. Preventative Services Task Force every ten years for those 50-75 years old.
- ACA requires most plans to cover screening colonoscopies at no charge to the patient.
- Best interest of the patient and the plan's financial interest.
- Trend moving to use of anesthesia, but patient does not realize the out of pocket costs.
- Evidenced base for anesthesia versus conscious sedation.
- Ancillary/anecdotal information.
- Plan experience.
- Options and impacts.
- Recommendation

Dr. Johnson reported on the use of propofol versus conscious sedation for colonoscopies:

- Dr. Johnson's conclusion is: it appears the use of propofol instead of a traditional agent (benzo) during colonoscopy results in a shorter recovery. Pain control favored the traditional agents. In a population of EGD patients (may not apply to colonoscopy patients), 12-13% more patients achieved deep sedation with propofol than with midazolam. The literature states sedation deeper than intended is more frequently associated with a higher rate of complications. In one trial, more patients on propofol than on midazolam experienced mild transient hypoxemia for >30 seconds after the jaw thrust maneuver. However, there was no serious complication in either group. Although endoscopists may process more patients per day with propofol, there were no data in the literature to assess the cost-effectiveness of propofol from a plan's perspective (or from any perspective).

OVERVIEW OF THE MEDICAL UTILIZATION AND EVALUATION WORKGROUP: *By: Dr. Richard Smith, UAMS*

Dr. Smith presented and discussed the workflow of the Medical Utilization and Evaluation Workgroup with the Quality of Care Subcommittee and the Board to include:

- Evaluate topics of concern
- Provide literature reviews
- Discuss standards of care
- Develop options
- Estimate impacts
- Please see the attached Workflow Proposal

Dr. Smith stated the increased cost of the anesthesia could potentially be an offset if the change in coverage resulted in more employees receiving colonoscopies and cases of colon cancer are caught or prevented.

Dr. Smith provided the following recommendations:

Option 1: Increase member education, continued negative member reaction to unexpected out of pocket costs, and limited immediate increased costs to the plan.

Option 2: Cover anesthesia for screening colonoscopies with requirement of no added out of pocket cost to patient by physician or facility. Cost: \$2.77 per member/per year to \$8.12 per member/per year.

Option 3: Increase reimbursement for screening colonoscopies with or without anesthesia at an intermediate rate (Medicare approach).

Boyd recommended option 2 be presented to the Board for consideration: cover anesthesia for screening colonoscopies, with requirement of no added cost to patient by physician or facility. Cost: \$2.77 per member/per year to \$8.12 per member/per year. Brown seconded.

Discussion:

Dr. Zohoori inquired if the Medicare option to increase reimbursement for screening colonoscopies with or without anesthesia at an intermediate rate; would deliver more benefits for the plan?

Dr. Smith reported if the patient requests not to have anesthesia, the request should be honored by the physician. However, Dr. Smith does not feel the Medicare option would be the best recommendation for the plan.

Dr. Thompson commented the Board is currently setting rates without tight budget restraints. Therefore, Dr. Thompson believes the guidance is appropriate and may be received with a positive reaction from the Board.

Brown recommended the Board track the cost of treatment for colon cancer and evaluate the measurements.

Dr. Vinson requested data regarding the current screening rates.

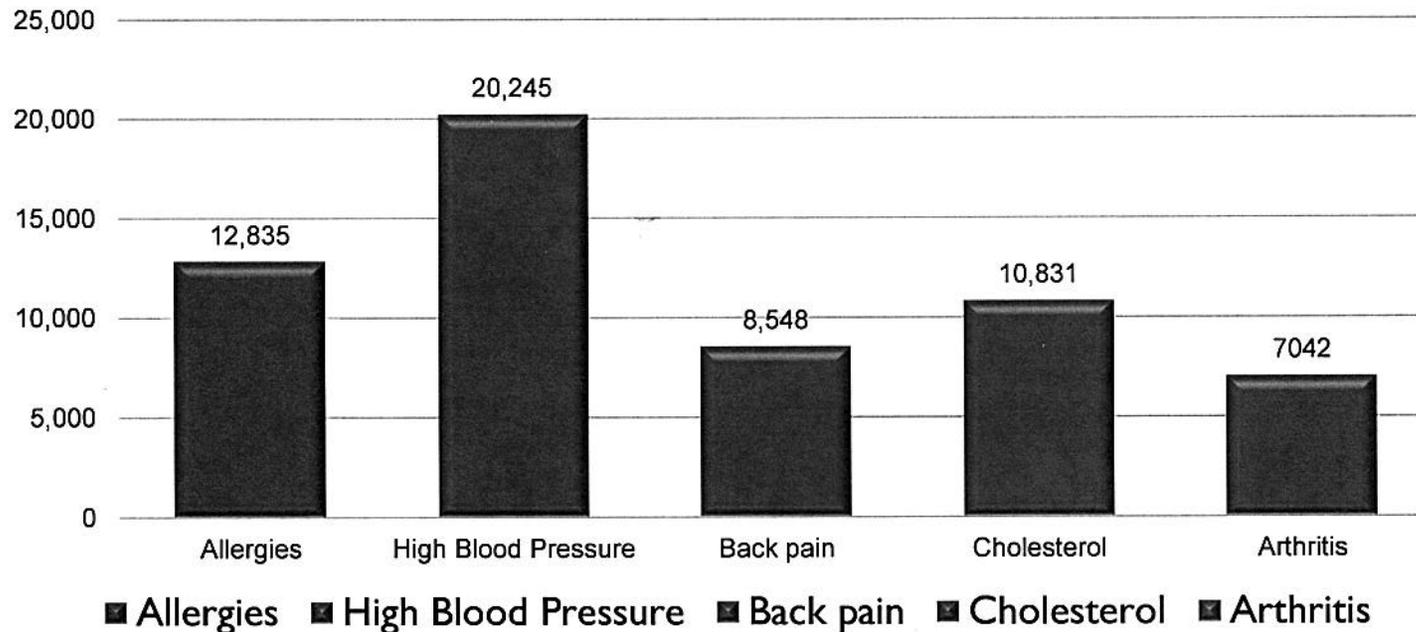
After discussion all members were in favor of the vote.

Motion approved.

Bushmiaer opened the floor for additional discussion from the audience. There was no further discussion.

Meeting adjourned

Health Assessment – Number of Top Health Risks (aggregate data)



- › Other health risks (not on the chart) include Anxiety, Depression, Diabetes and GI Disease
- › High Blood Pressure, Cholesterol, Back Pain and Diabetes are all lifestyle diseases and can be prevented/delayed by behavioral changes
- › GuidanceResources offer telephonic and online coaching programs to deal with many of these health risks

Colonoscopy Sedation
Jill Johnson, Pharm.D., BCPS
2/2/15

Several high quality publications in the medical literature address the comparative effects of using propofol vs another sedative during colonoscopy and other endoscopy with regards to effectiveness, safety, and patient acceptance.

Summary:

1. Singh H, Poluha W, Cheang M, Choptain N, Inegbu E, Baron K, Taback SP. Propofol for sedation during colonoscopy. Cochrane Database of Systematic Reviews 2008, Issue 4. Art. No.: CD006268. DOI: 10.1002/14651858.CD006268.pub2.

This article is a Cochrane systematic review.

Notes:

- Most included studies included only healthy outpatients.

Included trials:

Trial	Drug	Comparator	
Akcaboy 2006	Propofol 161.06 and midazolam 2mg	Remifentanyl 98.7mcg + midazolam 2mg	
Amornyotin 2010	Propofol 5.98 mg/kg/h + meperidine 1.74mg/kg/h	Midazolam 0.08 mg/kg/h + fentanyl 0.003mg/kg/h	
Bright 2003	Propofol PCS 5.5mg/kg/h + alfentanil 13.8mcg/kg/h	Midazolam 0.06mg/kg + pethidine 50mg	
Germain 1989	Propofol 1.25 (age >65) or 1.5 (age <65)mg/kg induction then 6mg/kg/h + alfentanil	Midazolam 0.15mg/kg + alfentanil	
Heuss 2003	Propofol 117mg + alfentanil	Midazolam 5mg + alfentanil	
Heuss 2005	Propofol + alfentanil	Midazolam + alfentanil	
Jimenez-Perez 2000	Propofol	diazepam	
Kostash 1994	Propofol 1.3mg/kg + fentanyl 2.2 mcg/kg	Diazepam 0.12mg/kg + meperidine 2mg/kg	Midazolam 0.07 mg/kg + fentanyl 2.2mg/kg
Kulling 2001	Propofol PCS 78 mg + alfentanil 198 mcg	Propofol continuous + alfentanil 227 mcg	Midazolam 2.7mg + meperidine 27mg
Laquiere 2006	Propofol 94mg	Propofol 260mg	
Liu 2000	Propofol 400mg + alfentanil 1mg PCA	IV diazepam + pethidine 0.5mg/kg	
Liu 2009	Propofol 40-60mg or 0.8mg/kg, then 14.3mg + alfentanil 35mcg	IV diazepam 0.1mg/kg + pethidine 0.5mg/kg	
Mandel 2006	Propofol 10mg/mL + remifentanyl 10mcg/mL	Midazolam 0.5mg/mL + fentanyl 12.5mcg/mL	
Martinez-Palli 2005	Remifentanyl 0.1mcg/kg/min + propofol 0.5mg/kg	Fentanyl 10mcg + midazolam 2mg	Meperidine 100mg + midazolam 2mg
Moerman 2003	Propofol 273mg	Remifentanyl 246mcg	
Munoz-Navas 1994	Propofol 191.79mg	Midazolam 18.93mg + flumazenil 0.28mg	
Ng 2001	Propofol 98.2 mg	Midazolam 4.33mg	
Paspatis 2002	Propofol 80mg + Midazolam 2-3mg	Midazolam 5mg + Pethidine 75mg	
Pohlmann 2993	Propofol 2.5mg/kg or less depending on age	Midazolam 12.5mg max	
Reimann 2000	Propofol 100mg + midazolam 2mg +/- ketamine	Midazolam 9mg + nalbuphine 20mg +/- ketamine	
Roseveare 1998	Propofol PCS 105mg + alfentanil 0.13mg	Diazepam 15mg + pethidine 50mg	
Sipe 2002	Propofol 214mg	Midazolam 4.7mg + meperidine 89.7mg	
Ulmer 2003	Propofol 277mg	Midazolam 7.2mg + fentanyl 117mcg	

Results, including weighted mean differences (WMD):

1. Recovery time was statistically shorter for propofol. The WMD was 16.59 min. shorter for propofol.
2. Discharge time was statistically shorter for propofol. The WMD was 20.86 min. shorter for propofol.
3. There was no difference between groups for procedure duration.
4. Patient satisfaction was greater for propofol; the WMD was slight (0.43, 95%CI 0.00, 0.85).
5. Pain control favored the traditional agents, 0.38 (95%CI, 0.03, 0.74). Further, the odds ratio for pain control was 1.71 (95%CI,1.02, 2.88), favoring traditional agents.
6. Outcomes in which there was no difference that could be seen between propofol and traditional agents: Hypoxia, apnea, resp depression requiring intervention, arrhythmias, hypotension, colonic perforations, and failure to sedate,

2. McQuaid KR, Laine L. A systematic review and meta-analysis of RCTs of moderate sedation for routine endoscopic procedures. *Gastrointest Endosc* 2008;67:910-23.

Notes: This meta-analysis included trials including patients undergoing EGD or colonoscopy.

Table 3 has results broken out according to type of procedure. For colonoscopy only, the results are summarized here:

Sedative	Procedure	Mean Sedation time (min)	Mean Procedure time (min)	Mean Recovery time (min)
Midazolam + narcotic	Colonoscopy	6.5	25	54.9
Propofol	Colonoscopy	2.1	29.4	15.6
Propofol + narcotic	Colonoscopy	Not stated	19.5	14.3
Propofol + midazolam	Colonoscopy	Not stated	19.1	Not stated

Endpoints without regard to whether the population was EGD or colonoscopy:

Comparator treatment arms	End points	No. of studies	Summary RR (95%CI)
Sedation vs no sedation	Patient satisfaction	2	2.29 (1.16-4.53)
	Patient: willingness to repeat exam	2	1.25 (1.13-1.38)
Midazolam vs diazepam	Physician: patient cooperation	3	1.20(0.75-4.91)
	Patient satisfaction	2	1.18 (1.07-1.29)
	Patient willingness to repeat	4	1.08 (1.04-1.13)
	Patient memory of exam	5	0.57 (0.50-0.65)
	Patient > mild pain	2	0.44 (0.03-6.53)
Midazolam + narcotic vs diazepam + narcotic	Hypoxemia	2	0.97 (0.41-2.31)
	Need for sup oxygen	2	0.87(0.47-1.63)
	Physician satisfaction w/ exam	2	1.06(0.96-1.18)
	Patient > mild pain	3	0.91(0.61-1.37)
Midazolam vs propofol	Hypoxemia	2	1.11 (0.71-1.74)
	Patient satisfaction	2	0.99 (0.86-1.14)
	Patient willingness to repeat	2	1.11 (0.98-1.25)

	Patient memory of exam	3	0.63 (0.35-1.19)
Midazolam + narcotic vs propofol	Hypoxemia	3	0.82(0.22-2.98)
	Bradycardia	3	1.00(0.30-3.36)
	Hypotension	3	1.28(0.51-3.26)
	Md: satisfaction w/ exam	2	0.84(0.68-1.04)
	Patient satisfaction	2	0.90(0.83-0.97)
	Patient > mild pain	2	0.90(0.37-131.3)
	Patient memory of exam	2	3.00(1.25-7.21)

3. Santos ME, Maluf-Filho F, Chaves DM, Matuguma SE, et al. Deep sedation during gastrointestinal endoscopy: propofol-fentanyl and midazolam-fentanyl regimens. World J Gastroenterol. 2013;19(22):3439-3446.

This large RCT (n=262) evaluated propofol vs midazolam during EGD. A level of sedation deeper than that intended is associated with a higher rate of complications. In 2002, the American Society of Anesthesiologists recommended a distinction be made between conscious sedation and deep sedation. The observer's assessment of alertness/sedation (OAA/S) score ranks sedation as mild, conscious, or deep. Bispectral index (BIS) is another way to assess consciousness and takes complex mathematical calculations of EEG waves and transforms them into numbers of 0-100. This trial compared propofol-fentanyl vs midazolam-fentanyl. The primary endpoint was the frequency of deep sedation in each group. Secondary endpoints were: time to induction, time to recovery, time to discharge, efficacy and safety, as well as satisfaction.

Results: Deep sedation based on OAA/S scores: 11% vs 25% (p=0.014), midazolam and propofol, respectively.

Deep sedation according to BIS rating: 7% vs 19% (p=0.039), respectively.

On average, patients in the propofol-fentanyl resumed domestic activities 60 min after discharge compared w. 80min for midazolam-fentanyl, (p<0.001).

No serious complications in either group, however, 42% of the propofol-fentanyl patients had mild transient hypoxemia for >30s after the jaw thrust maneuver, while only 26% of midazolam-fentanyl, (p=0.025).

There were no differences in satisfaction, pre/post discharge questionnaires. There were no arrhythmias, perforation, bleeding, death, or need for ventilator support or hospitalization.

Conclusion:

It appears the use of propofol instead of a traditional agent (benzo) during colonoscopy results in a shorter recovery time amounting to 16.59 minutes and a discharge time of 20.86 minutes sooner. Pain control favored the traditional agents. In a population of EGD patients (may not apply to colonoscopy patients), 12-13% more patients achieved deep sedation with propofol than with midazolam. The literature states sedation deeper than intended is more frequently associated with a higher rate of complications. In one trial, more patients on propofol than on midazolam experienced mild transient hypoxemia for >30 seconds after the jaw thrust maneuver, however, there were no serious complications in either group. Although endoscopists may process more patients per day with propofol, there were no data in the literature to assess the cost-effectiveness of propofol from a plan's perspective (or from any perspective).

EBMed

COLONOSCOPY SCREENING ANESTHESIA



QUESTION

Should the plan routinely cover anesthesia for screening colonoscopies? Anesthesia is currently not covered as a benefit and is routinely denied. It may be paid on appeal due to medical necessity (283 paid/1,529 billed)

CONTEXT

1. The decision only involves screening colonoscopies.
 - In contrast to diagnostic and/or therapeutic colonoscopies
 - For decades, conscious sedation has been used routinely with screening colonoscopies. Anesthesia is an alternative to conscious sedation.
2. Screening colonoscopies are recommended by the U.S. Preventative Services Task force for every 10 years for those 50-75 years old.

CONTEXT

3. The Affordable Care Act requires most plans and all Marketplace plans to cover screening colonoscopies at no charge to the patient, even co-pays and deductibles.

4. It is in the patients best interest and the plan's best financial interest for patients to receive routine screening colonoscopies because:
 - Patient morbidity is reduced
 - The plan savings from avoiding colon cancer treatment presumably outweigh the cost of screening.

CONTEXT

5. Currently medical practice appears to be incorporating anesthesia and many doctors and health facilities are asking patients if they want "anesthesia" with their screening colonoscopy. Our understanding is that patients often understandably say "yes" not knowing the difference between anesthesia and conscious sedation. Thus, resulting in a denied anesthesia claim and fee that is the patient's responsibility.

EVIDENCED BASE FOR CONSCIOUS
SEDATION VERSUS ANESTHESIA (PROPOFOL)
FOR SCREENING COLONOSCOPIES

1. Recovery and discharge time shorter (better) for anesthesia
2. Patient satisfaction slightly better with anesthesia
3. Procedure duration was not different between anesthesia and sedation
4. Generally, no difference in complications between anesthesia and sedation
5. Amnesia and sedation are greater with anesthesia

ANCILLARY/ ANECDOTAL
INFORMATION

1. Physicians are being trained to use both conscious sedation and anesthesia.
2. Some physicians believe that they can obtain a more thorough exam with anesthesia.
3. Some members complain for being billed for what they thought was a no cost service.
4. BC/BS covers anesthesia for screening colonoscopy for other lines of business.

ANCILLARY/ ANECDOTAL INFORMATION

5. Medicare is changing to a higher reimbursement rate that it will pay regardless of whether anesthesia is used or not.
6. Efficiency of procedure with anesthesia has financial incentives for providers.

PLAN EXPERIENCE

10/1/2014 – 9/30/2015 Colonoscopy Data for ASE & PSE
Service Volume for Screening Colonoscopies

	# of Members w/ GI Doctors - Paid	# of Members w/ Anesthesia
With Anesthesia	1,529	283 allowed-paid (1,246 not paid by plan)
W/O Anesthesia	1,562	0

Payment Amount \$ for Screening Colonoscopies

	A+B Total Amt. Pd.	(A) Total Amt. Pd. To GI Doctors	(B) Total Amt. paid for Anesthesia	(C) Total Amt. of patient responsibility
1,529 with Anesthesia	\$1,614,443.	1,521,247.	93,195.	129,229.
1,562 w/o Anesthesia	1,453,352.	1,453,352.	0	126,560.
Total	3,067,795.	2,974,599.	93,195.	255,789.

Average Unit Cost (Amount paid)

Average Screening Colonoscopy cost with conscious sedation	\$962
Average cost of Anesthesia for screening colonoscopy when paid	\$329
Average total plan cost for screening colonoscopy with anesthesia	\$1,291

OPTIONS FOR FUTURE AND PROBABLE IMPACTS TO PLAN

1. No coverage change
 - a. Increase member education
 - b. Continued negative member reaction to unexpected out of pocket costs
 - c. Limited immediate increased costs to plan

OPTIONS FOR FUTURE AND PROBABLE IMPACTS TO PLAN

2. Cover anesthesia for screening colonoscopies with requirement of no added out of pocket costs to patient by physician or facility
 - a. Increase patient satisfaction and decrease recovery and discharge time
 - b. Eliminate negative member reaction
 - c. Initial additional plan costs will be $\$1,246 \times \$329 = \$410,000$ (\$2.77 per member, per year*) but would likely rise to $2,808 \times \$329 = \$924,000$ (\$6.25 per member, per year*) and probably increase to \$1.2M (\$8.12 per member, per year*) as number of screenings increase.

*Based on 147,829 members

OPTIONS FOR FUTURE AND PROBABLE IMPACTS TO PLAN

3. Increase reimbursement for screening colonoscopies with or without anesthesia at an intermediate rate (Medicare approach)
 - a. Increase patient satisfaction and decrease recovery and discharge time
 - b. Eliminate negative member reaction
 - c. Additional yearly costs of $\$200 \times 3091 = \$618,000 - \$800,000$ as number of screenings increase
 - d. Restrict network providers to those who primarily use conscious sedation not anesthesia.

STAFF/EDMed RECCOMENDATION

Cover anesthesia for screening colonoscopies with requirement of no added cost to patient by physician for facility. Cost: \$2.77 per member/per year to \$8.12 per member/per year