



AGENDA

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

March 10th, 2020

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

- I. Call to Order.....Dr. John Vinson, Chair*
- II. Approval of November Minutes.....Dr. John Vinson, Chair*
- III. Follow-up Analysis.....Elizabeth Montgomery & Mike Motley, ACHI*
- IV. Director’s Report..... Chris Howlett, EBD Director*
- V. Adjournment.....Dr. John Vinson, Chair*

Upcoming Meetings

April 7th, May 12th, June 9th

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

March 10, 2020

Date | time 03/10/2020 1:00 PM | Meeting called to order by Dr. John Vinson, Chair

Attendance

Members Present

Dr. John Vinson – Chair
Margo Bushmiaer – Vice-Chair
Michelle Murtha
Dr. Arlo Kahn
Cindy Gillespie – proxy – Damian Hicks
Zinnia Clanton
Dr. Terry Fiddler
Dr. Appathurai Balamurugan
Pam Brown
Chris Howlett, Employee Benefits Division (EBD) Director – proxy – Terri Freeman

Members Absent

Others Present:

Rhoda Classen, Theresa Huber, Mary Massirer, EBD; Mike Motley, ACHI; Jessica Akins, Takisha Sanders, HA; Micah Bard, Oktawia DeYoung, UAMS EBRx; Treg Long, ACH; Ronda Walthall, ARDOT

Approval of Minutes: *Dr. John Vinson, Chair*

MOTION by Dr. Fiddler

I motion to approve the January 14, 2020 minutes.

Brown seconded. All were in favor.

Minutes Approved.

Follow-up Analysis: *Mike Motley, ACHI*

Motley addressed follow-up questions from the last meeting and discussed the upcoming update of Health Wasted Calculator analysis.

Discussion:

Flu Shot

Dr. Vinson: I saw where there was an interim study proposal in Public Health on this topic related to flu shots specific to Medicaid, but there was some interesting information. There have been 41 school districts that have closed due to flu this year in Arkansas and 69 deaths, thus far, with a couple being pediatric deaths. I have gotten feedback from pharmacies, who have been kind-of locked out of public schools, that are offering to try to come and do flu shots on site but are being told that they are not needed because the Health

Department comes. That's great but they may only be there a day and doesn't give you very many options. I would love for our schools to be more open-minded about local physicians and/or pharmacies that want to come on additional days to give the employees more options. I would like for this plan to encourage state employees and school employees to allow that.

Dr. Fiddler: For the last two weeks we have been doing a national survey out of Chicago and D.C. The survey asked, "If there was a shot for the coronavirus, would you take it?" 90% of the people stated that they would. "Did you take the flu shot this year?" The people answered no. But because it got press, the people and children that die from the influenza A, or whichever one it is, now the coronavirus is that death threat to everyone. What you have here, where you have a minority of EBD members are receiving the flu vaccines, the flu vaccine options that you are about to talk about, I would certainly like to continue our conversation on this. This has been the most frustrating thing that I have been dealing with for 14 years. I have had several physicians cancel due to being worried about the coronavirus and are healthier than any of us. It's that mindset that we are dealing with. We really need to encourage the flu vaccine, because this other thing is the most frustrating thing I've ever had to deal with.

Dr. Kahn: Your idea is a good one and anything that we can do to get more mass flu clinics set up in schools and agencies, including pharmacists and private doctors, but especially the Health Department. I don't know what their schedule is and if they are only going to each school once.

Bushmiaer: They are. It's just one time. I was just making a note to share with the school nurse's association, because I have been guilty of saying, "no, we've got it covered". But I do think that having someone come at a later date would be excellent. I have information through another committee how many days of school time was lost and how many seat hours and kids' education was interrupted because of the school closings. I think we should put that data together somehow. I have always been very disappointed in the number of teachers that don't get vaccinated and don't feel the need, and yet they are front line with 25-30 kids every day.

Dr. Kahn: I am not sure if the best approach is legislative mandate or an incentive or even encouraging the teachers retirement plan or union to hire private vaccinators if the health department can't meet the needs, but I think all avenues should be explored to make it easier for people to get flu shots.

Dr. Fiddler: The inadequate information that the flu shot gives them the flu. So many people stay away from the flu shot because they have some scenario that someone said they were perfectly healthy until they got the shot and was sick as a dog for three hours. Well, it didn't have anything to do with that. You may have had an allergic reaction or something. How can you justify the 41 schools that have had to close, and you find out that 20%-25% of the teachers didn't get the flu shot? However, you closed down a school system and exposed all those children because of a personal disagreement with getting a shot. As you said being the front line and really if you get in a cafeteria and you have every kid in that school exposed. Something should be able to be added to that plan that requires that injection. I know if I go out of the country, I have to take certain shots. I have to take those, or I can't go do that. It's the same thing, if you're in an area that you're teaching and you're going to be exposed to that, in order for you to be around that, you have got to take that particular drug that's given. Why would that

not be any different for a teacher that is in the classroom to not have to take that if you know that you are closing down the educational system for a week or two. Because if that one teacher got the flu and he/she did not take that shot to prevent that and became typhoid Mary that carries everything around.

Bushmaier: Maybe we could start with a recommendation this year, since it is not legislative session and see how it goes. Then we can see if we do need legislation.

Murtha: This is all done by claims data, correct?

Motley: Yes, that is correct.

Murtha: Are there people who get the flu shot at their church, health fair, etc. that is not reported through claims? I'm not saying that's 75%, but I'm saying that's a possibility that could raise it some. Can we look at other states schools and see if they mandate it? I know the hospitals mandate. You can't go to work in a hospital if you have not had your flu shot. You are fired if you say you don't want it. Are there other states around us that mandate that their teachers have flu shots because of this reason? That may give us something to help.

Dr. Vinson: If you're going to research that for teachers, I would also look into it for preschools and daycares as well. I know that is outside the purview of this Board, but it's the same concept of being around kids. It would just be interesting to see what states do anything around daycares and preschools too.

Motley: I don't know that off hand, but we can take a look at that and what surrounding states are doing.

Dr. Vinson: I was curious, you know Rhode Island has the highest percentage of flu shots in the country in their population. Are they having the kind of school closures that we are? I know there is a few states like that, on the survey data, stand out as having high rates in their overall population.

Motley: We could take a look at that.

Dr. Fiddler: While you're doing that, anti-vaxxers. Those people who will not let their children or they won't take a shot because of whatever reason they have. You cannot find out that individuals name, but you can find out the percentage of those individuals attending a particular area that are anti-vaxxers. At UCA, we deal with that all the time. They can't keep going into the next class or the next semester unless they took care of the situation previous to that. I was just wondering if there was something up there that deals with how many anti-vaxxer children there are or teachers in school districts across the state.

Bushmaier: That data is available for public schools, but homeschoolers are not required to report. So, we're missing a population of children.

Motley: We can look at what sources might be available for that as well.

Dr. Fiddler: I can't make a motion because I am on the EBD Board, but I would really like to look at the first recommendation (Add a flu vaccination requirement as part of the plan's wellness program criteria).

Dr. Vinson: Would you do medical exemptions only or would you let a medical or philosophical exemption in order to still qualify for the wellness discount.

Dr. Kahn: It seems to me that this came up before. How did that pan out?

Dr. Vinson: It was discussed and considered but it ultimately wasn't included. There wasn't a dramatic opposition, it was just we have to get something started. We didn't know all of the data yet and we want to try some other types of programs, initially to increase the

rates before we added that into the wellness requirement. We decided to address it a future date if we aren't successful with other efforts to increase the rates.

Murtha: I remember you all saying that they can't mandate it. I had said that hospitals mandate it. But with the first option, I think you would have to have some kind of incentive.

Freeman: I also think before that when the flu shots became available and when the wellness deadline was had a lot to do with it as well. It had to deal with the deadlines and the time frame and claims. Right now, it is either by Catapult or a PCP form and we don't look at claims data like we did previously. We don't do the wellness discount like we did in years prior. They either do a Catapult visit or the PCP form which we put in the system wherein years prior we would use CPT codes and claims data.

Dr. Kahn: Is there any plan to do away with or change the wellness for 2021?

Freeman: That would be up to the Board.

Dr. Kahn: Right now, it hasn't been established about whether there is going to be a wellness discount at all?

Freeman: No.

Dr. Fiddler: At the EBD Board if the committee does not make a recommendation, I can do it at that place. I just think it would hold some value if I have 10 people saying it rather than just me. It's worth the effort to at least look into that for what can be done because we don't want those kids to be out of class because someone chooses not to get their shot.

Dr. Vinson: Everyone knows if we make a recommendation, it doesn't mean it will pass at the EBD Board.

MOTION by Brown:

I would like to make a motion that we recommend the Board that they include the flu vaccination requirement as part of the wellness program criteria and that the Board will determine at what level.

Bushmaier seconded. All were in favor.

Motion Approved.

Dr. Vinson: Was that sufficient to move the needle or do we need more. At least on bullet three (expand mass flu clinic access) about communication out to state employees and public schools to not just limit it to a single day or single provider and to be open-minded.

MOTION by Brown:

I make a motion that we expand mass flu clinic access by expanding that beyond the Department of Health.

Murtha seconded. All were in favor.

Motion Approved.

Annual EKG's

Dr. Fiddler: What is the cost per patient? I know what a physician's office normally gets for doing this when they don't even walk in and look at it. how much would that cost save us if we didn't do the low value?

Motley: I don't have that one with me today, it was part of a previous presentation. I think it was around \$800,000-\$1,000,000 per year for those.

Dr. Kahn: Those are just EKG's. It's anything that a low-risk patient got that they didn't really need for cardiac screening. There would be a lot of variation in the price depending on which test they did.

Murtha: Can you look at the people that abuse it the most? If you knew who it was, you could do outreach to those people.

Motley: We have done that in the past. We have looked at the top 25 that did the most at the individual provider ID level.

Murtha: What about for this specific service?

Motley: I don't think we have don't it for this one, I am not sure why, but we could look into it. We have always thought about provider variation on these and who are doing more of these versus not.

Brown: If they are an outlier, I think they would either need to know that to find out if it's poor documentation in their record or if it truly is unnecessary. That need to be looked at, because we aren't getting reliable information if it's a documentation issue.

Motley: we can take this back and look at what it would take to drill down to the provider level. I know we have done it in the past, but we don't have it today.

Brown: I don't think I know enough or see enough to make a recommendation. We do see some downward trends and that's a good thing. I would like to know more about provider outreach and look at drilling down to that level.

Dr. Kahn: Do we know why EBD or our third-party administrator is paying for some of these things that they shouldn't be paying for? It has been talked about many times about why we are paying for unnecessary pap smears.

Dr. Vinson: Right, if the coding doesn't support it or meet the necessary guidelines.

Dr. Kahn: I don't know how we find that out, but I would like to know why EBD is continuing to pay for unnecessary services.

Dr. Vinson: We did have some discussion last time, specifically, on the EKG such as what the problems are with prior authorizations (PA) and the unintended consequence of preventing one that was actually needed. I know we also talked about getting with our TPA to figure out what the coding issues are. If there are specific codes that should be documented to get the EKG paid for. I'd like to drill down to that and see what codes they are using that triggers this to think it's unnecessary and is there a code that should be used when they are necessary. Dr. Bala, I don't know if you drill down into the coding, but it was brought up at our last committee meeting.

Dr. Bala: A lot of providers don't document.

Dr. Kahn: The tool that was used to do this has all of the codes documented that are listed as exclusions. If you diagnosed that suggested that a person needed a lipid panel or an EKG, then it passed with no problem. These are ones that have no documentation, but this was necessary. All of the information that is in the coding from the office shows no reason why this person needs it. If you're looking for all of the reasons why a person might have qualified to have these things accepted, there is going to be a lot of reasons. The bottom line is you have got to document a reason, or you shouldn't be getting paid.

Dr. Vinson: In theory, you would have to take a hardline stance to say there shouldn't be any surprise medical billing either whether the patient gets stuck with the cost. If we just blocked payment because it didn't have a certain code then the patient could end up

footing the entire bill because our health plan didn't cover it. I think you would have to have something in the provider contracts or something between the TPA and the physicians that were very clear that if we are going to exclude unless these codes were there then the patients wouldn't be responsible either.

Dr. Fiddler: Did you not say that you're wondering why we still pay this? If you had been at the EBD meeting three meetings ago, that was my same question. Chris explained that we have a contract and you get to a certain date and that contract runs out and you start again. There has to be somebody that says you cannot get this money anymore because you're not providing documentation. If you would provide documentation for doing that procedure, we would love to pay you, but you're not giving that to us. Somebody needs to be responsible for that, but it can't be the administration but instead, someone in between there that looks at those policies.

Murtha: On all of these low-value services, should they add up to 13,786

Motley: That was specific to the EKGs and they should not. That 13,000 should be for a year and the trend is looking at two years plus.

Brown: I would like to see the provider level breakdown. With the codes, I would like to see what the most common problem is. Is there something we're not seeing?

Motley: With a diagnoses code?

Dr. Vinson: Is there no code or a code that is so general that it doesn't demonstrate why they really need it.

Motley: We can easily look at what the most prominent ones are coded that make it warranted if that's is what you're asking.

Brown: I'm just trying to understand the difference.

Colonoscopy

Dr. Vinson: When we looked at this a few years ago there was some discussion about CMS moving to a specific policy around this. Have they done that?

Dr. Kahn: Yes, if you give Propofol, which is what this is all about, you cannot give that unless there is an anesthesiologist or nurse anesthetist in the room administering it and monitoring the patient throughout. That is a CMS rule.

Brown: Why do you think the median cost is going down?

Motley: My first thought is the function of the amount that is being reimbursed for that, what's being paid for that and what's being negotiated. We would have to look further into that to see.

Dr. Vinson: Another question was, could it be the type of anesthesiologist that is used, whether it is a physician or nurse anesthetist.

Dr. Bala: The change from sedation without MAC to MAC, does it have anything to do with the changing of screening to diagnostic?

Dr. Kahn: If you start off with a screening colonoscopy and you have to biopsy a polyp, that is supposed to stay a screening colonoscopy, because biopsying the polyp was part of the determining whether or not there was a problem.

Dr. Bala: How do they determine with and without monitored anesthesia.

Dr. Kahn: There are two different codes. If the gastroenterologist administers Benzo's and pain medicine, it is a specific code. If the anesthesiologist administers Propofol, it is a different code.

Brown: When we first talked about this years ago, I remember BlueCrossBlueShield came and spoke and it was interesting because there are certain criteria that would be okay to use

monitored anesthesia for colonoscopy. When they went in and looked at it, there was so few numbers that were unnecessary, that they decided they would quit doing that review.

Motley: There also was not a very significant difference in quality outcomes either way.

Brown: There was nothing to justify denial.

Dr. Kahn: So historically, nobody did Propofol 10 years ago. Then someone figured out that if you did use Propofol, you could move patients through the clinic a lot quicker. It was a good deal for the anesthesiologist and the gastroenterologist, they could do more scopes. I don't know if the Board really intended for the sedation by the gastroenterologist to be starting to get paid for at a reasonable rate. In the past, according to the coders I talked to, if they submitted a code for conscious sedation with Benzo's and pain medicine, you didn't get reimbursed worth a darn and a lot of people didn't even bother submitting claims for those. I don't know if the Board intended to pay for all kinds of sedation at that point but that's apparently what we are doing. We are paying well for monitored anesthesia as well as when there is no anesthesiologist.

Brown: I made some calls to Pearce and other states. What we know is that there is a national trend to move towards that. It does benefit at moving patients through, but it also helps them recover quicker and not have the hangover effects either, which is better for the patient. The thing that I think is concerning is we talk about the Medicare issue. There was a time when people would go in for the screening and because they did polyps, Medicare would end up not paying it 100%. So, it did end up causing a problem for patients. When you look at plans, what you fear is having to pay \$600 because a gastroenterologist uses monitored anesthesia and my plan won't pay it, I'm not having a colonoscopy.

Bushmaier: That was part of the data that we got that customers were being responsible for bills.

Dr. Kahn: One of the important things to note is that patient satisfaction is very high, like 85%-90%, with either kind of anesthesia, it is just a little higher with Propofol. You could say that you could do entirely without Propofol and go back to what we were already doing, but you still have the question of should there still be payment even that kind of sedation.

Clanton: When we discussed this previously, I made phone calls to several different gastroenterologist and the waiting time to get in to see them for a screening was two months.

Dr. Vinson: Whatever type of procedure is done using Propofol if the plan excludes certain codes or excludes Propofol or makes a decision, then the provider network is notified, and the difference of cost wouldn't fall to the member. It would just not be covered.

Bushmaier: We were told the patients were responsible for part of the bill.

Dr. Vinson: Unless the contract doesn't allow that. It happens in pharmacy all the time where the pharmacist can't do that. You're in a contract that says you've accepted the terms of the contract.

Dr. Kahn: If you, as a plan, told the provider the we will not pay for Propofol on the front end and they said they wouldn't do that. Then the just be excluded as your approved provider. The Affordable Care Act says you have to provide screening colonoscopy at no cost to the patient. It does not address in any way whether or not you have sedation. You can set it up any way you want.

Murtha: There is not hardly any gastroenterologist that will do just conscious sedation anymore. They have a nurse anesthetist or anesthesiologist in there, and they get Propofol. A screening is just because it's my first time to go and I'm of age, but since my mom had colon cancer. Right away, they say it's not a screening.

Dr. Kahn: What that should be is the first time is a screening and if you go back more than every 10 years because you are high risk, that is a different category.

Murtha: I don't understand a no sedation claim.

Brown: Some older physicians don't give any sedation. I could name two or three that I know of.

Murtha: With conscious sedation, that has to be your only job. So, if a gastroenterologist is doing the procedure, they cannot give medication and monitor the patient.

Dr. Kahn: Actually, he is required to give it, but he has to have a nurse in there monitoring the patient the entire time.

Dr. Vinson: Does Medicare pay at the higher rate with conscious sedation? Does Medicare allow for coverage of Propofol with the monitored anesthesiologist at a higher rate of pay or is it reference-based where there is a single pay and the physician or provider gets to choose which they want to do with the patient?

Dr. Fiddler: I may be wrong, but I think it is reference-based.

Dr. Kahn: I called two endoscopy centers in Little Rock. With one of them, all of their providers are using Propofol for all cases and the other one, most of them are.

Brown: If we go back and look at the number of screenings that have occurred, those are going up and the costs are going down. So, for me, it's a good thing to know that more people are getting screened and overall costs going out is low.

Brown: I don't see, just because of access and the importance of getting this screening done and especially given that when we have called around and checked, most are using it. I don't think there is any option other than option 1 (No change in policy; continue coverage for MAC).

Dr. Vinson: Is that a motion?

MOTION by Brown:

I make a recommendation to the Board for option 1 (No change in policy; continue coverage for MAC).
Clanton seconded.

Murtha: So, members are not being billed anything for a screening?
Brown: Not for the screening.

All were in favor.

Motion Approved.

Recap on Flu Shot

Dr. Vinson: On flu shots, the committee recommended, with the help of Chris and the Board, to require some percentage of the wellness benefit to be at risk if you don't get a flu shot. One thing we forgot to address in the recommendation, and the committee may not want to at this point, is what to do about exemptions and what you would allow. I would think you would want to allow medical exemptions and then what to do about philosophical or religious exemptions. I know at UAMS, it is a totally different thing

because it is not related to their wellness benefit, but related to working there, they do allow medical exemptions but you have to wear a mask and they allow religious exemptions but they have to fill out a two-page form that has to be approved by HR. Does this committee want to make any recommendation related to that?

Dr. Bala: If you pick the top ten causes of death, other than tobacco and obesity which we are still trying to wrap our head around on how to address, flu and pneumonia are the leading causes, I think 8 and 9. We are addressing the tobacco by having the pledge and the discount, and similarly we could use a positive reinforcement to say that everyone who wants to have that waive will have to have that exemption. We can play by the book and say they have to produce an exemption or get it. I think the 38%, not all of the other 62% have submitted an exemption it's just because it's not part of it, they just didn't do it. If you at least do it, I think it will increase from 60% to maybe 60%-70% and match with the state.

Dr. Kahn: I would say you could have a philosophical exemption and you can't get that portion of the wellness discount if you do. With a medical exemption, you can still get the full amount, but any other kind of exemption you can't get the full amount.

Dr. Fiddler: We need to do something about those individuals who cannot deny getting the shot. I want to bring it up to the EBD Board and I'll be the heavy on this.

Brown: If I'm a parent and my child's in your class and you've got the flu, then my child gets the flu and dies.

Howlett: I would draw your attention back to '16 and '17 when it was originally discussed and was discussed in this committee several times and Jamie Mayo had come here. If flu-related issues are where your plan is spending its money, then you need to tackle the flu. I would contend based on the claims experience that it doesn't. I don't have an issue with flu vaccinations, but I think we will run afoul with philosophical and religious differences. I also believe we will run afoul with the justification of it being a mandate. I am just trying to draw attention to the fact that there are things that need to be considered above all before we start going down that path again. I think it needs to be set up and positioned appropriately, as well as vetted out appropriately. I am not discounting the fact that I think that the flu and vaccinations have its place.

Brown: What accountability does the plan have to the fact that we have had how many schools have to close because of the flu.

Dr. Vinson: Jamie Mayo's company's employees don't have kids, meaning she's not a public-school employee. Part of the discussion was, in theory, you could go to the legislature, which is outside the scope of this discussion for this board and do X with this.

Howlett: The plan, my administrative staff, the Board and subcommittees at the Insurance and Commerce House and Senate's leisure can be requested to come and testify. I would say there is a balancing act. I don't discredit what is being said but are you prepared to come to the Board or come and take the calls because we increased rates or we didn't do it for everything that we actually, from a health-related stance, takes effect on the membership as a whole? Yes, we have closed schools and they have made precautionary areas. I don't know the evidence of how many were out sick and otherwise, but from that standpoint what is the responsibility of the plan? That is to offer the benefit. Mandating you do it. Some would contend that this plan would be overreaching. Mandating something when it is already out there for the population to

actually take part of, that's the difference. If you go there, where are you going to go when you smoke?

Brown: Why do we have a wellness benefit if we don't support it by our recommendations and what we pay.

Dr. Vinson: Our committee didn't feel like it was a mandate. It felt like it was the wellness incentives.

Howlett: It wasn't a mandate because that's why it didn't pass. We can all come in at different points. I come in in 2016 and we had a wellness program and a wellness benefit that you could go to your eye doctor and get an ICD 9 code that's preventative and you achieve wellness by going to your doctor and there wasn't a lipid panel. No one had a problem with that for years and years. The problem lies in application and what we are trying to do and that is what I want to impress upon you as a group as you move forward with recommendations. It was April of 2016 that this committee actually passed the recommendation. If you go back and review, this committee passed the colonoscopy with anesthesia. Dr. Rick Smith and Dr. Nash from HealthAdvantage provided some guidance there. It did take effect in June of 2016 and by the end of that year, in addition to the traditional cost of the services, there was about \$700,000 that was additional because of the benefit. I don't have a problem with that benefit. I would have a problem if we don't look at services being offered, equitable fair, and patient-centered, but also you have to think of the fiscal cost of everything we do. There is going to be a cost to everything. It's outlaid here. One thing I would like to draw attention to is the cyclical pattern. Pam, you made a valid point in response to the services and the increase and it wasn't a significant increase in the overall cost, but it was you don't have people taking them year over year. You're in a five-year pattern. From that standpoint, I think there is a balance. Michelle, to your particular comment about the individuals not having it, there are some that have that. There are some that have it with just limited sedation and then I learned a little bit more on the claims data where there was a midrange. It still goes back to the patient and their doctor and what procedure works best for them. As to the cost-sharing component, I would say that if a provider, for any service, looks at what is set up for the member and where they are at the time of year for out-of-pocket deductible and all that, they have the ability to charge upfront. There was a time when they never did that, but they balanced billed or billed the member after the services. So, in some quest to get their money upfront so they don't have to chase it later, they started doing that. Arlo, you were accurate in saying that it is an essential benefit, not an essential health benefit, but a benefit that is covered due to ACA and covered overall as preventative. However, some of the luxury pieces to that are a little bit different. So, if we were not covering anesthesia, anesthesia would be balanced billed to the member because it would be above what the plan was paying. In this case, you have seen the analytics and actual claims data, we actually paid that. To me, if it's not broken, let's not fix it and in that sense, I believe what has been working, albeit your seeing a little bit of an increase and a decrease, you're not seeing it in people year over year, you're seeing people as they age into them get them and are electing to do the anesthesia, the midrange, or the sedation. If you looked at the average claim spend on all that, you are looking at about \$3.5 million dollars. From my standpoint, you are looking at a three and a half percent rate increase. Every million dollars on this plan runs a percent of rate increase. I'm not saying that it's causing it, but

cause and effect, every action has an equal and opposite reaction to that. You spend it, you have to supply it.

Dr. Fiddler: I can prove by legislative notes that I don't mind running afoul of the legislature and sitting in front of those committees. I have done that many times, but I will tell you that evidence-based and fact-based says flu vaccinations work. There is a percentage sometimes that they work better than other times. Our federal government has mandated \$8.3 billion dollars to work on something that hasn't been prove it's going to be a pandemic. I think that we could spend a little bit of money out of our committee to say that we know that flu kills people. We know flu kills children and if you're responsible for a child, your personal health responsibility should be to that child. If you are trying to teach them something, you should be able to watch over their self-worth, therefore I would have no problem with the flu vaccination requirement as part of the plan's wellness program criteria. I would have no problem saying that it's going to cost us \$1 million dollars or 1% more and there is going to be a raise in how we are going to charge our members on doing that. If we can fix this with money, how can I justify not fixing it if it saves a child's life or a person's life? I would go there completely.

Howlett: I would just state if we were denying a service or the benefit, I would say you are absolutely correct. We provide the service; people are electing not to do it. I think there is going to be a potential issue and a lot of feedback. We are not denying the benefit, it is offered. From a preventive standpoint, it is still a service that anyone can maintain. I would be cautious in the fact of how we are driving or steering a population to do that.

Dr. Fiddler: I would want to go on record in front of the legislative board or in front of this committee or audience to say that we think this is the best option. If they disagree, well we went on record saying it was.

Dr. Bala: For tobacco cessation counseling or quitting that, we are giving a benefit, right? Like \$10-\$20 off or something. Would there obstacles in doing the same approach here to have some shaved off money to positively impact. These are adults and they choose that. You're right, this is an offered benefit and only \$38 are using it. There is economical benefit for moving that 38% to 60% by giving positive incentive, not just saving lives but also it helps with the bottom line. Will we still have a pushback with the positive incentive and having exemptions to offset that? If they have a philosophical/religious or medical exemption, then you could give them the benefit.

Howlett: I would have to defer to Dr. Vinson who was chair of the wellness subcommittee. I don't believe the flu shot, at that point, passed the wellness committee to even go to the other two subcommittees.

Dr. Vinson: It did not. I didn't remember it being controversial in terms of being a mandate or not, because I don't even think of this as a mandate. It's a benefit for a discount. I do remember with Jamie Mayo, that you can't prove in you plan that flu itself is the main thing that is driving up your cost, it's obesity and diabetes and heart disease. Let's focus on the things that save dollars first, and in my mind, later on you could look back at this issue and we didn't even discuss schools being closed or kids dying.

Brown: What percent of those cardiac patients were hospitalized with pneumonia or the flu. If you look at that, then you are impacting population and you do have more dollars involved your plan. I think that is a huge thing. The other thing is, not necessarily that it is our responsibility, but I do think just like in healthcare, you don't work if you don't get your flu shot and you're taking care of patients, you don't work if you don't get your flu

shot and you are taking care of kids. That is out of this purview, but who is going to pay for that flu shot when you have laws that say because you interact in a public way and you're putting this group at risk like you do in healthcare. I just think it's the right thing to do.

- Howlett: I would tell you the availability and when the flu shot strain is actually being mass-produced was a barrier to why we did it because our range starts 12-1 of a year and runs through 10-31 of the next. Philosophical and religious exemptions and pieces to that and the actual fact that making it a requirement for that is where the push back came from. The argument was, did you want to mandate it or not and we backed off.
- Dr. Bala: I didn't mention it as a mandate.
- Howlett: If you tell them to get the \$75 discount a month, that is a mandate. That's how they looked at it. That's \$900 a year. We are still getting letters today about people just realizing they are not getting the discount.
- Dr. Fiddler: In my heart, I feel like it's right to go to that battle. The definition of mandate, health wellness, or benefit, we will all have to argue that term. But in order to help somebody, some program, or something get better, I think it's worth giving it a shot.
- Brown: When we say that the plan is not spending money on the flu, have we captured that? have we looked at those people who got coded cardiac that might have had a secondary or down the road.
- Motley: We have not looked at flu as a secondary or tertiary diagnosis or anything like that, only as a primary.
- Brown: Based on what I know about coding and what I have seen in hospitals, the cardiac code is going to get the higher pay, so that's where I would put it. I would wonder if in the billing what really is the cost?
- Howlett: It really depends on how that hospital files the claim. We can definitely look at that.

Director's Report: Terri Freeman, EBD Operations Manager

Freeman stated that there was nothing to report today.

MOTION to adjourn by Brown

Dr. Fiddler seconded. All were in favor.

Meeting Adjourned.

MARCH 2020 QUALITY OF CARE SUBCOMMITTEE PRESENTATION

Mike Motley, MPH
Director, Analytics

Izzy Montgomery, MPA
Policy Analyst

3.10.2020



OBJECTIVES

- Answer follow up questions from January meetings
- Present new analyses regarding screening colonoscopy service utilization



QUESTION 1

- What percentages of state employees and public school employees received a flu shot?



FLU VACCINATION RATES AMONG EBD MEMBERS

Flu Season	Total Members with Flu Vaccine	Total Member Enrollment	Percentage of Total Members
FY 2013	51,574	148,180	35%
FY 2014	62,444	148,510	42%
FY 2015	51,481	146,293	35%
FY 2016	52,361	147,704	35%
FY 2017	46,100	150,002	31%
FY 2018	57,452	152,724	37%
FY 2019	59,626	156,983	38%



FLU VACCINATION RATES AMONG ASE/PSE MEMBERS (FISCAL YEARS 2018 & 2019)

Flu Season	ASE Flu Vaccination Rate	PSE Flu Vaccination Rate
FY 2018	22,659 (37%)	20,870 (38%)
FY 2019	20,870 (34%)	38,756 (41%)



FLU VACCINE CONCLUSIONS

- The minority of EBD members are receiving flu vaccines
- More PSE members are receiving flu vaccinations than ASE members



FLU VACCINE OPTIONS

- Add a flu vaccination requirement as part of the plan's wellness program criteria
- Intensify provider and member education efforts
- Expand mass flu clinic access
- Consider other incentives to increase flu vaccination rates



QUESTION 2

- For the “annual EKG and other cardiac screening” measure, what were the total number of services assessed?
- Of those, how many were necessary and how many were unnecessary?



ANSWER

- There were a total of 86,752 services assessed for this measure by the Health Waste Calculator for the latest year of analyzed data (7/1/2018–6/30/2019)
- 73,066 were deemed necessary
- 13,686 were low-value

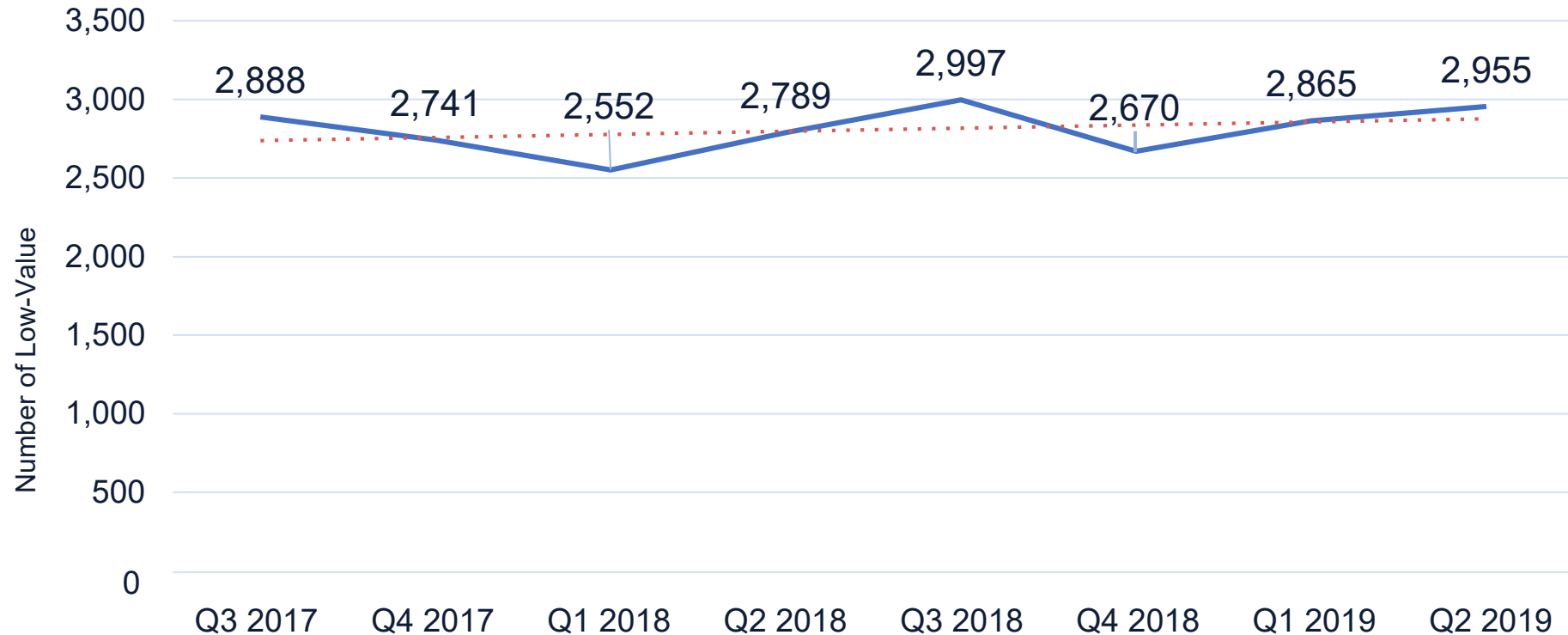


QUESTION 3

- What does additional historical quarterly trend data show for each of the top 8 low-value measures?



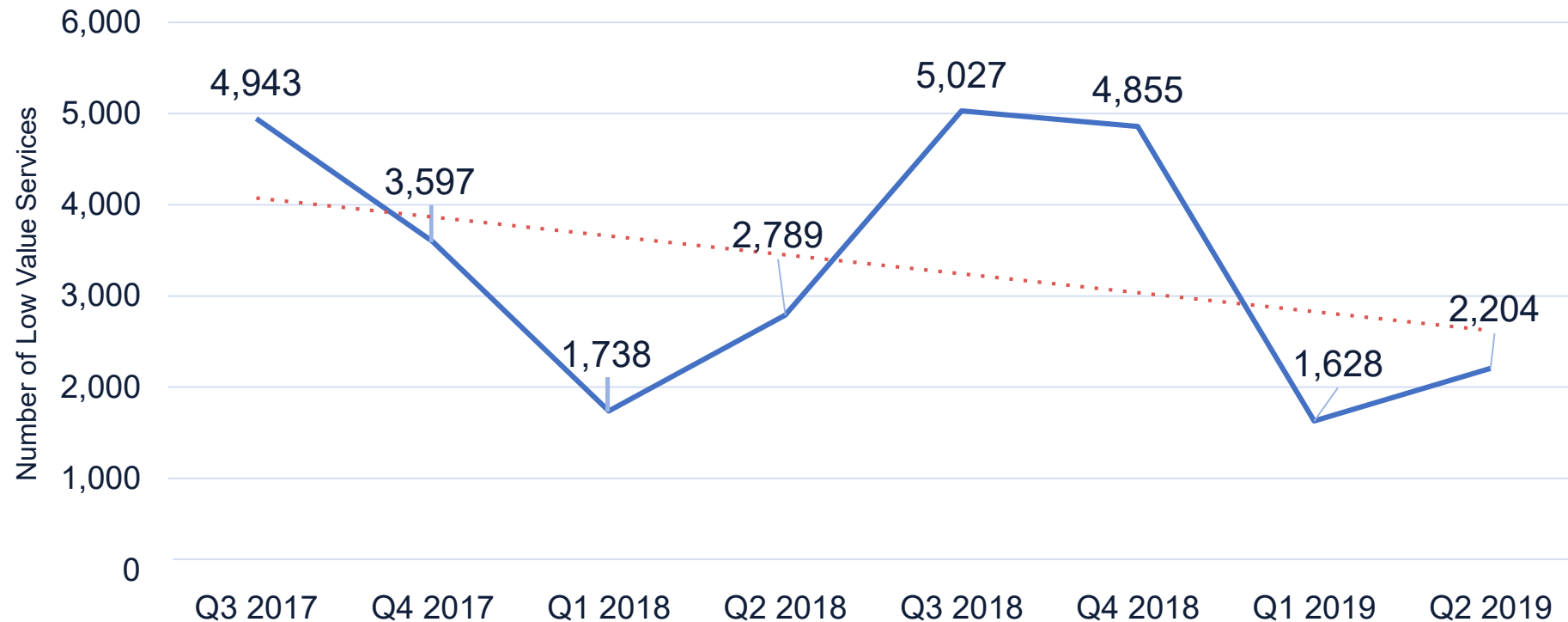
LOW-VALUE SERVICES QUARTERLY TREND: PREOPERATIVE BASELINE LABS



Note: Quarters based on a calendar year, not fiscal year.



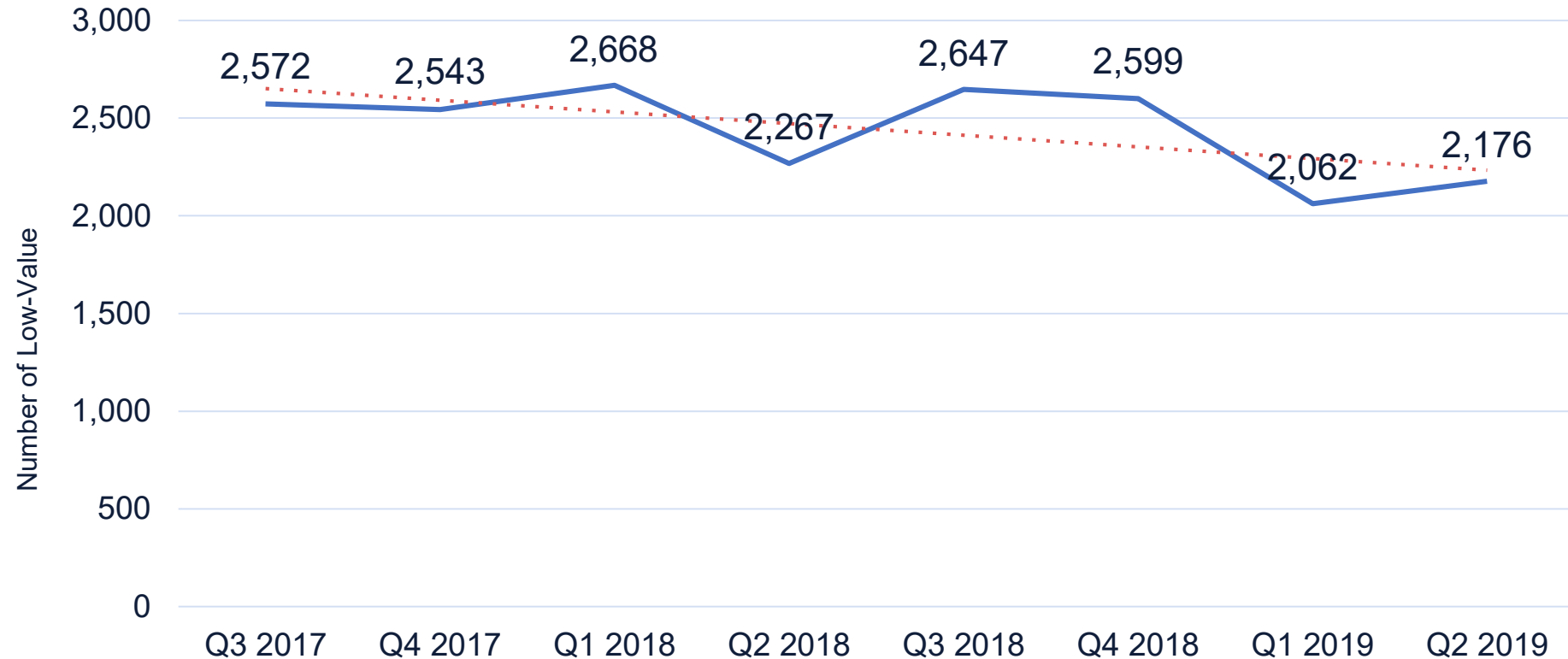
LOW-VALUE SERVICES QUARTERLY TREND: ANNUAL EKG'S AND OTHER CARDIAC SCREENINGS



Note: Quarters based on a calendar year, not fiscal year.



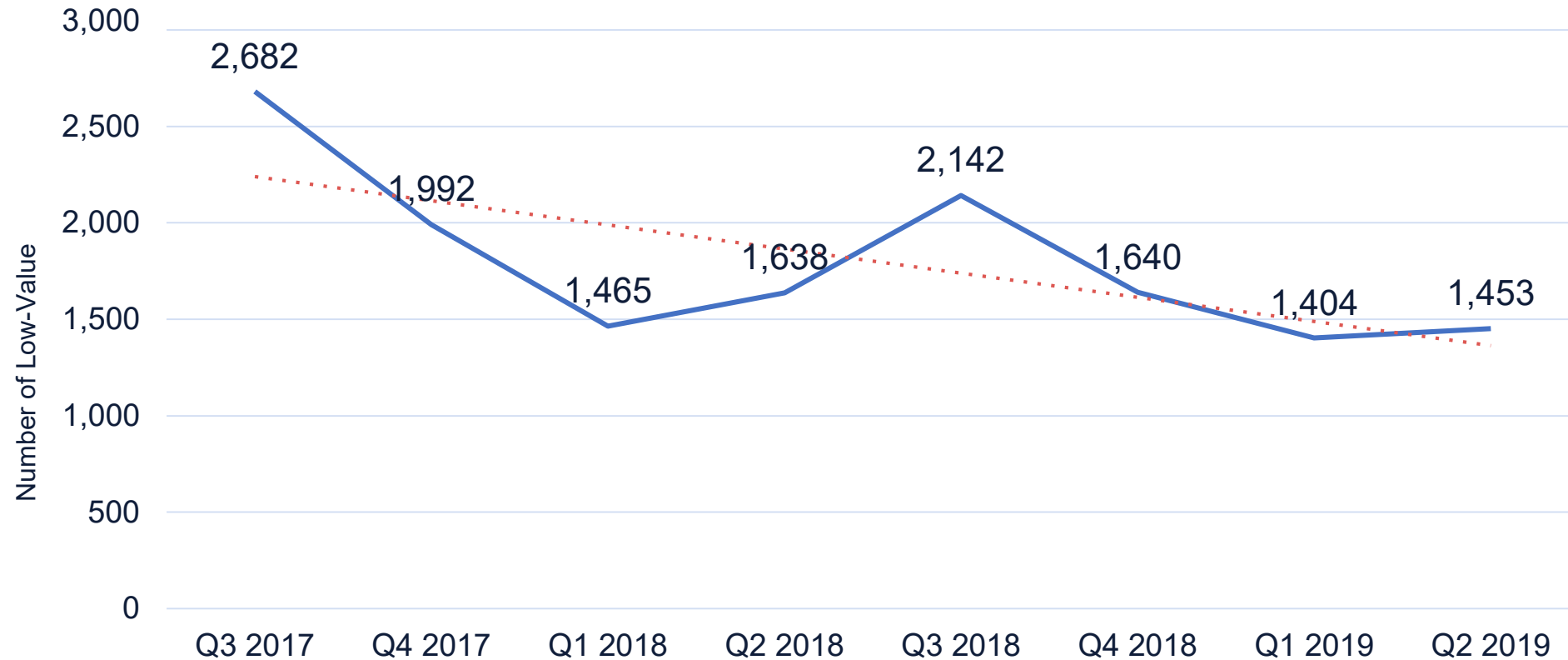
LOW-VALUE SERVICES QUARTERLY TREND: EYE IMAGING



Note: Quarters based on a calendar year, not fiscal year.



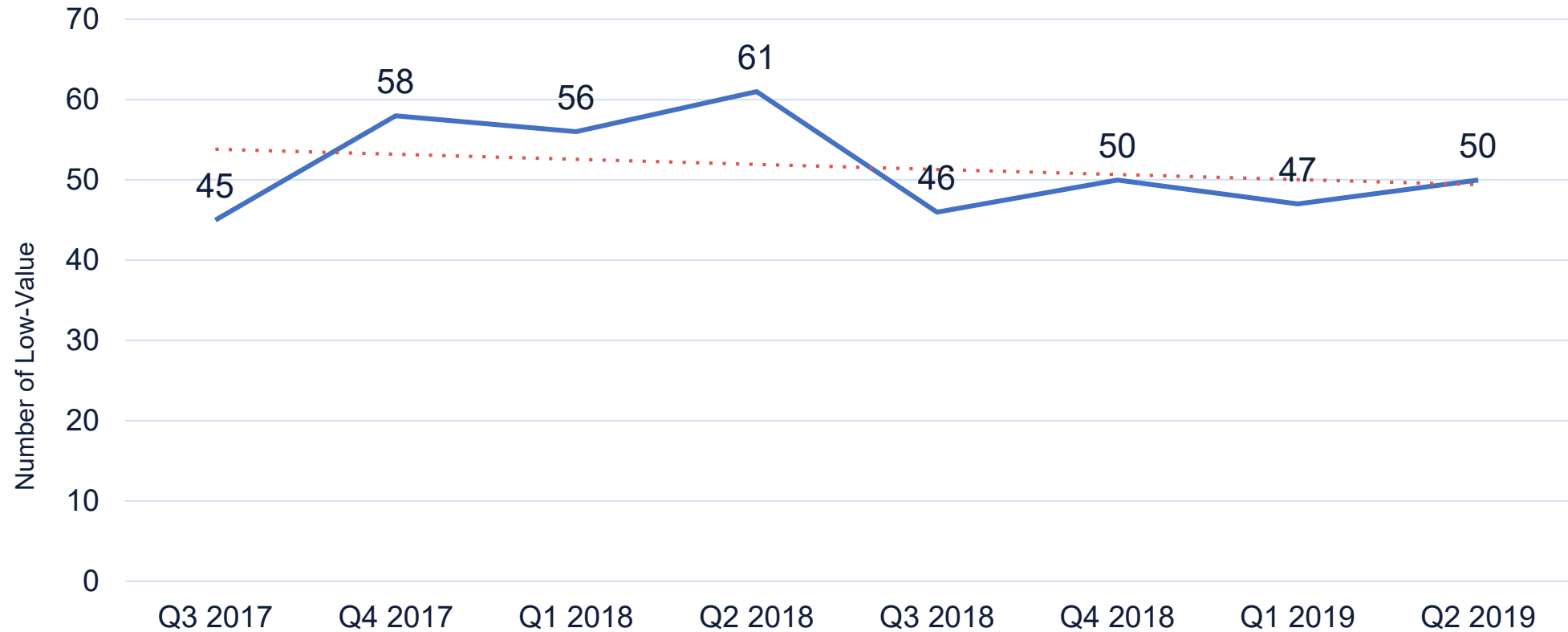
LOW-VALUE SERVICES QUARTERLY TREND: CERVICAL CANCER SCREENINGS



Note: Quarters based on a calendar year, not fiscal year.



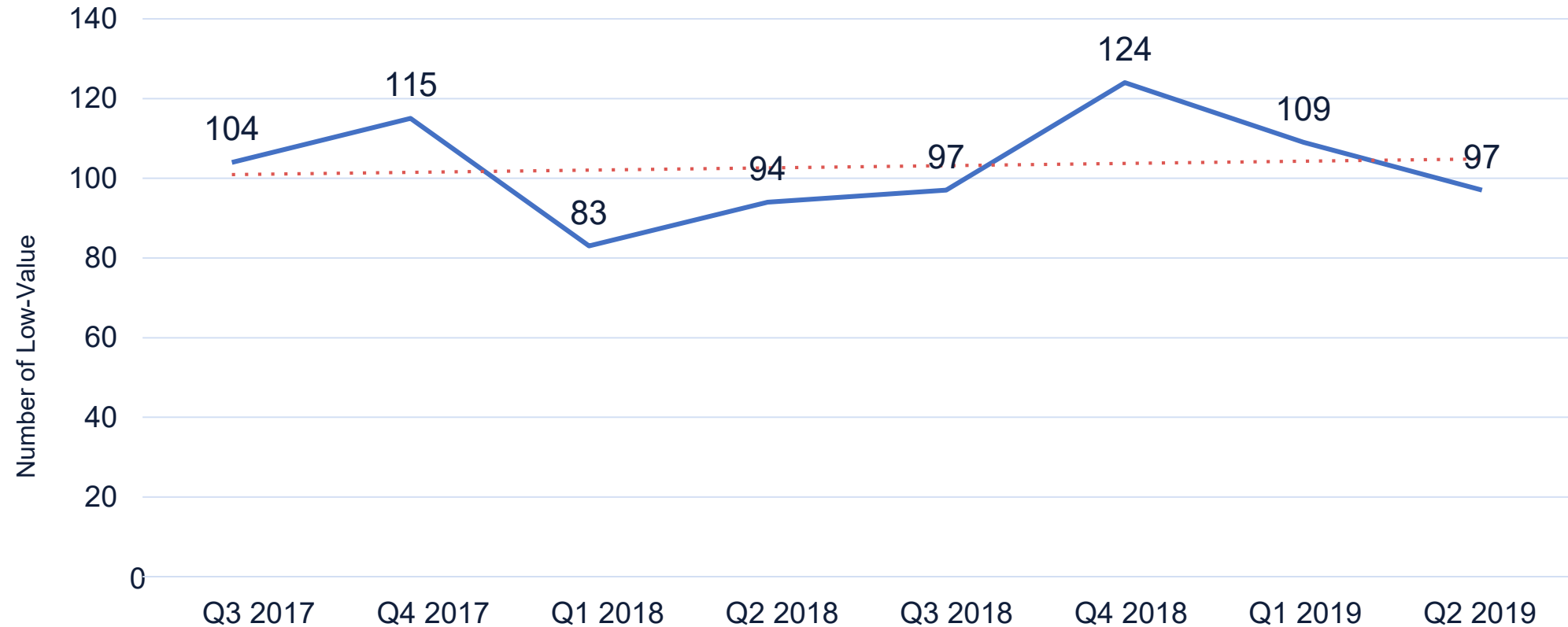
LOW-VALUE SERVICES QUARTERLY TREND: CORONARY ANGIOGRAPHY



Note: Quarters based on a calendar year, not fiscal year.



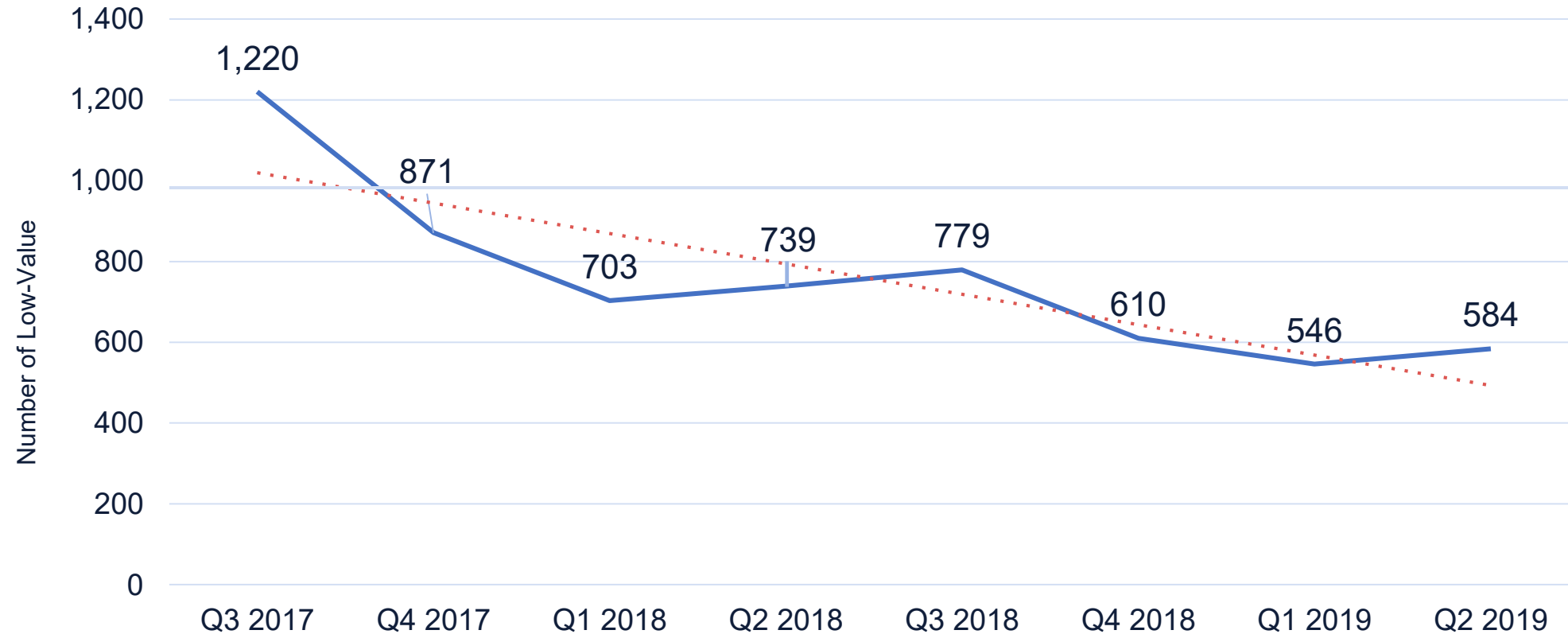
LOW-VALUE SERVICES QUARTERLY TREND: IMAGING FOR UNCOMPLICATED HEADACHE



Note: Quarters based on a calendar year, not fiscal year.



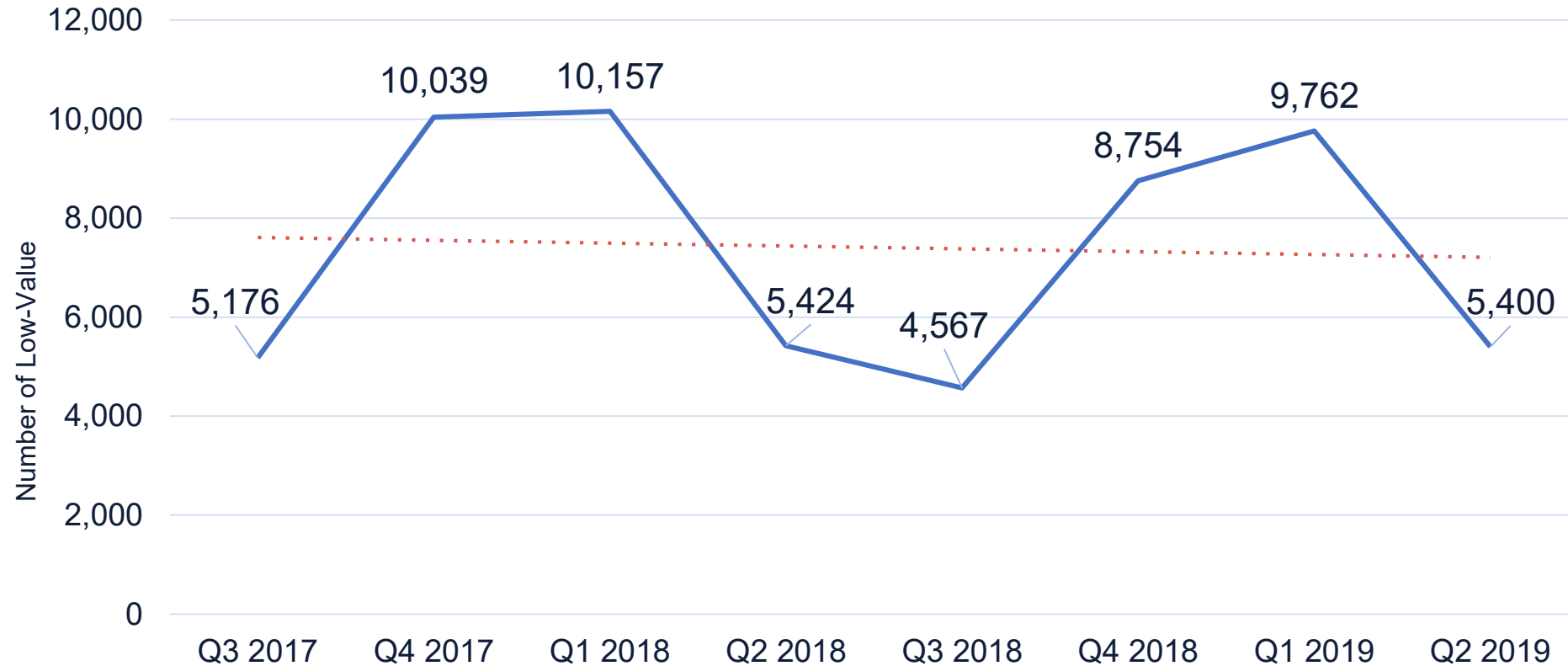
LOW-VALUE SERVICES QUARTERLY TREND: POPULATION-BASED VITAMIN D SCREENING



Note: Quarters based on a calendar year, not fiscal year.



LOW-VALUE SERVICES QUARTERLY TREND: ANTIBIOTICS FOR URI & EAR INFECTION



Note: Quarters based on a calendar year, not fiscal year.



LOW-VALUE SERVICES CONCLUSION

- The number of low-value services are trending downward for most services, but are still high



LOW-VALUE SERVICES OPTIONS

- Intensify provider and member education efforts
- Consider member and provider incentives/disincentives
- Consider additional prior authorization requirements



SCREENING COLONOSCOPY GUIDELINES

- The U.S. Preventive Service Task Force recommends screening colonoscopies every 10 years for adults age 50 to 75 as an A recommendation (“high certainty that net benefit is substantial”)



EBD POLICY ON ANESTHESIA WITH SCREENING COLONOSCOPY

- Until 2016, monitored anesthesia care (MAC) with screening colonoscopy was not a covered benefit (anesthesia clinician continually monitors and supports the patient's vital functions)
- Some providers in the state were using MAC when performing screening colonoscopies



EBD POLICY ON ANESTHESIA WITH SCREENING COLONOSCOPY

- When colonoscopy claims with MAC were denied, EBD members were responsible for those additional costs (although some were paid on appeal due to medical necessity)
- Following discussion, the EBD board decided to begin covering MAC with screening colonoscopies



LEVELS OF SEDATION FOR PROCEDURES

- Minimal sedation: drug-induced state during which patients respond normally to verbal commands
- **Moderate sedation (conscious sedation): drug-induced depression of consciousness, during which patients respond purposefully to verbal commands**



CONTINUED

- Deep sedation: drug-induced depression of consciousness during which patients cannot be easily aroused
- General anesthesia: refers to a drug-induced loss of consciousness during which patients are not able to be aroused



MODERATE SEDATION

- Traditional for screening colonoscopies
- Performed with a variety of drugs, including benzodiazepines, opiates, propofol, and others
- With or without **monitored anesthesia care (MAC)**



MONITORED ANESTHESIA CARE (MAC)

- Anesthesia clinician continually monitors and supports the patient's vital functions
- Approximately one-third of ambulatory anesthesia services in the U.S.

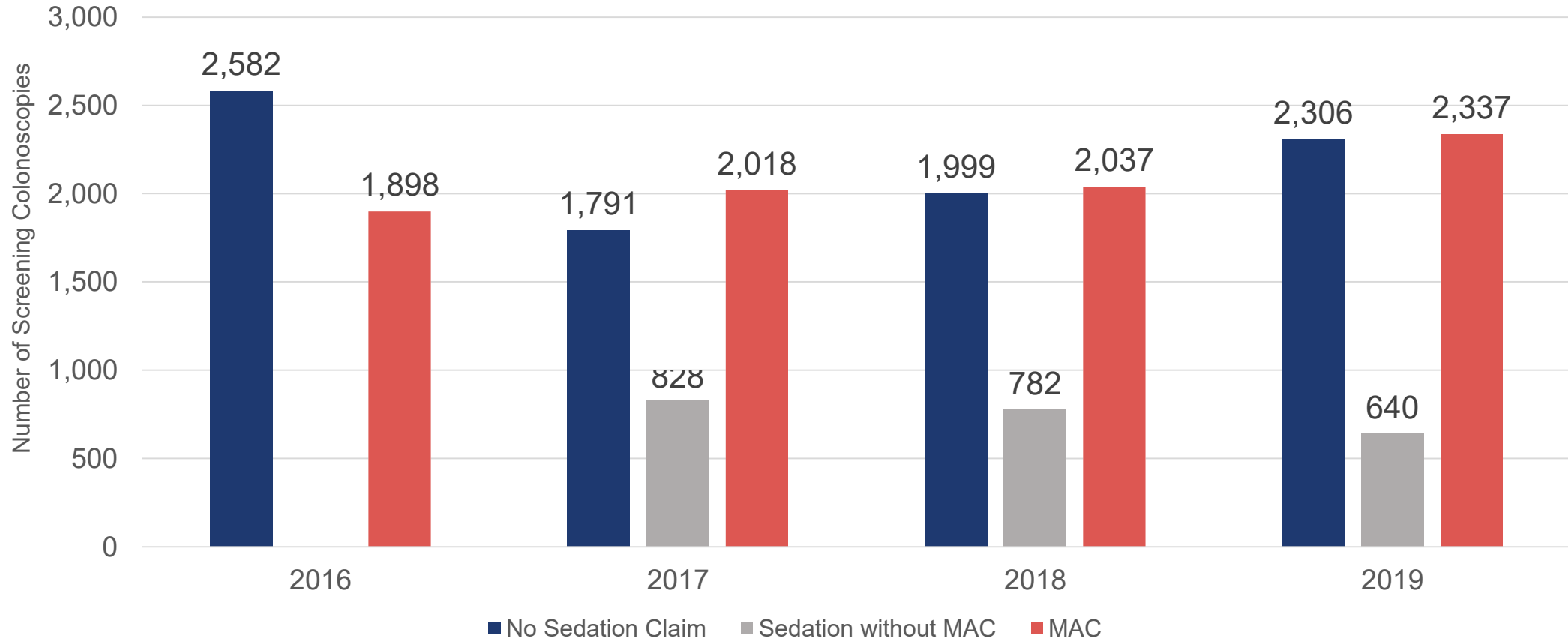


MONITORED ANESTHESIA CARE (MAC)

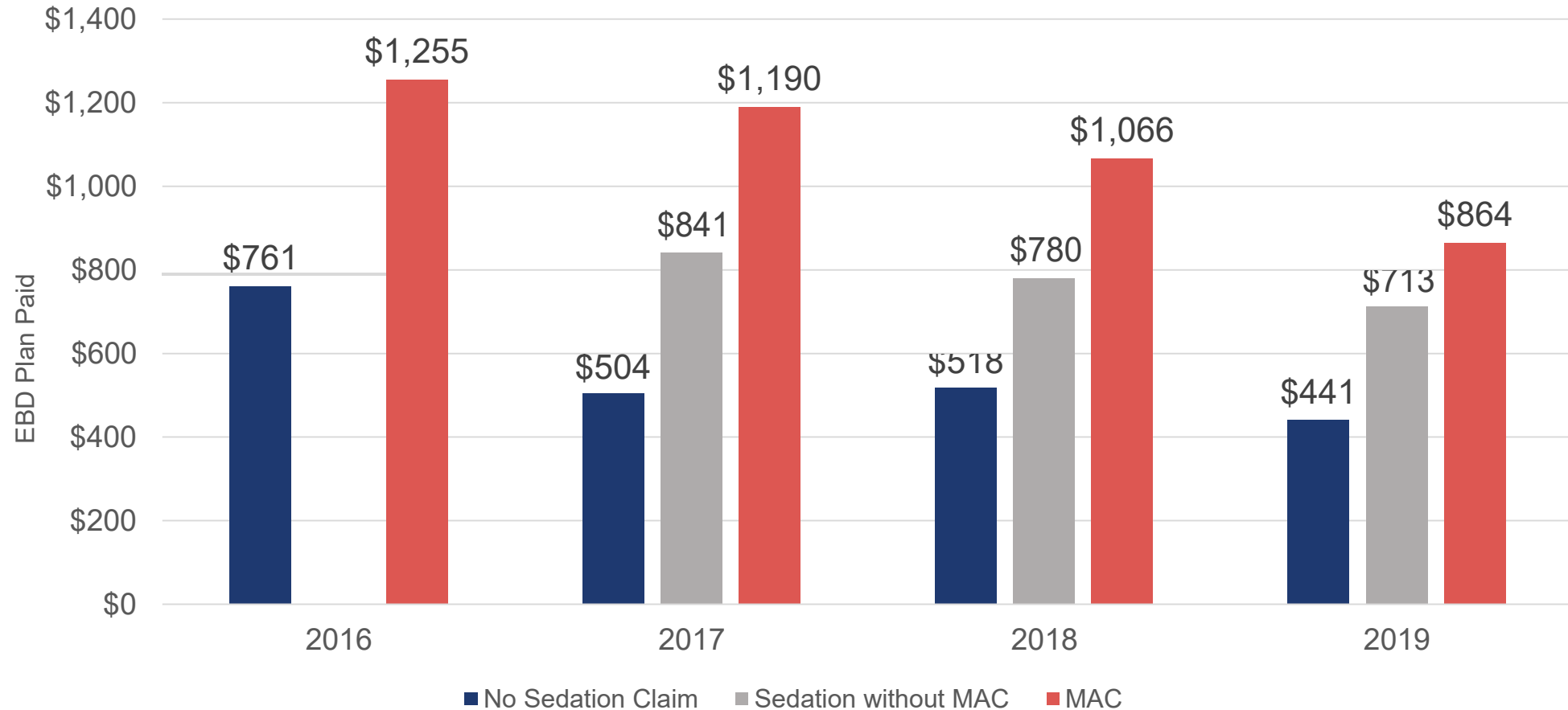
- Commonly performed with propofol
- CMS requires that propofol be administered by a practitioner qualified to administer anesthesia
- Propofol sedation associated with faster recovery and discharge times and increased patient satisfaction without an increase in adverse events



NUMBER OF SCREENING COLONOSCOPIES BY TYPE OF SEDATION



MEDIAN PLAN PAID AMOUNT FOR SCREENING COLONOSCOPIES BY TYPE OF SEDATION

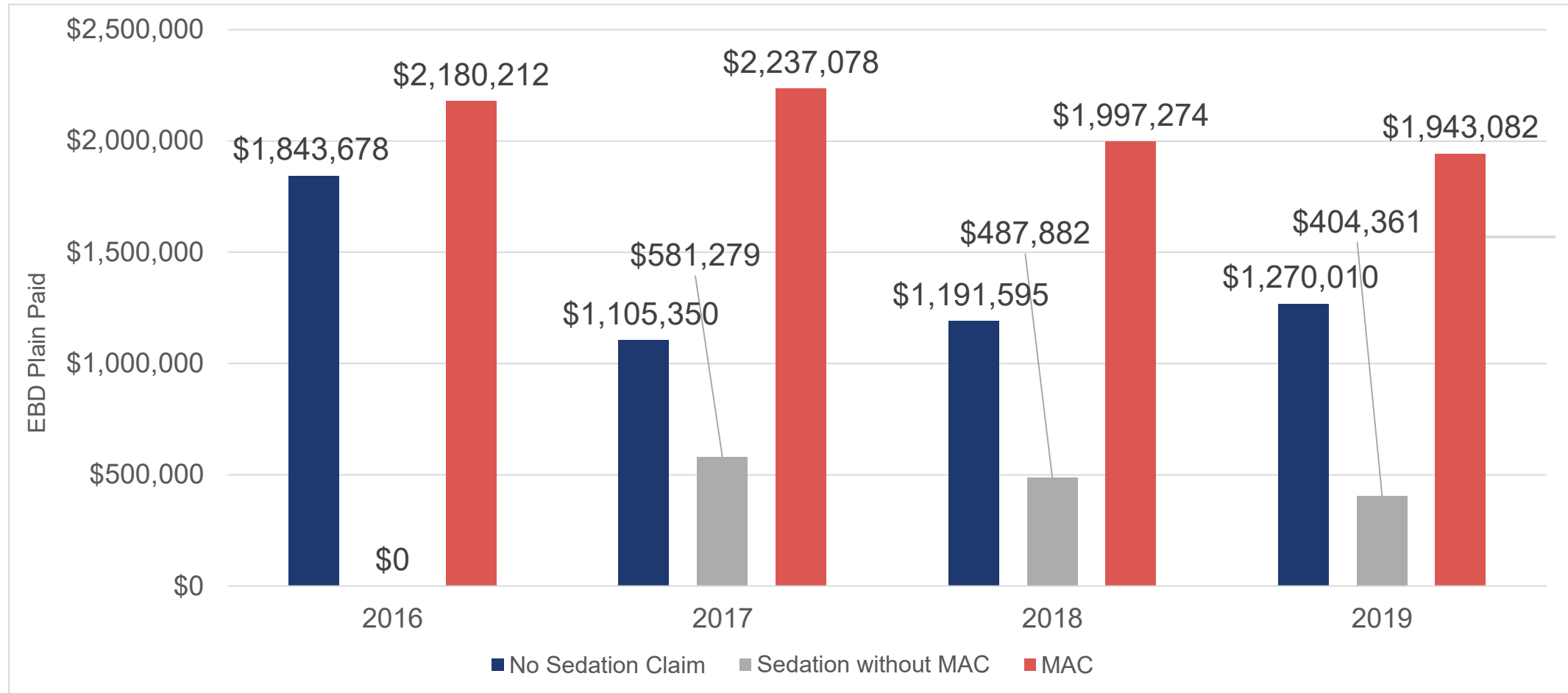


COST DIFFERENCE FOR MEDIAN PLAN PAID AMOUNT FOR SCREENING COLONOSCOPIES BY TYPE OF SEDATION

	No Sedation Claim	Sedation without MAC	MAC	No Sedation Claim/ Sedation without MAC Cost Difference	No Sedation Claim/ MAC Cost Difference
2017	\$504	\$841	\$1,189	\$337	\$685
2018	\$518	\$780	\$1,066	\$262	\$548
2019	\$441	\$713	\$864	\$272	\$423



TOTAL PLAN PAID AMOUNT FOR SCREENING COLONOSCOPIES BY TYPE OF SEDATION



SCREENING COLONOSCOPY CONCLUSIONS

- Plan is paying more per screening colonoscopy because of additional costs of MAC and sedation without MAC
- Members are not being billed for MAC and sedation without MAC, consistent with policy change adopted by the EBD Board in June 2016



OPTIONS ON SCREENING COLONOSCOPY

- Option 1: No change in policy; continue coverage for MAC
- Option 2: Not pay for MAC or sedation without MAC
- Option 3: Exclude providers routinely utilizing MAC
- Option 4: Have TPA negotiate reimbursement rates based on the cost of the lowest acceptable level of sedation

