



## **AGENDA**

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

**December 13, 2016**

**1:00 p.m.**

**EBD Board Room – 501 Building, Suite 500**

- I. Call to Order .....Margo Bushmiaer, Chairman*
- II. Approval of November 8, 2016 Minutes.....Margo Bushmiaer, Chairman*
- III. New Committee Member Acknowledgement.....Margo Bushmiaer, Chairman*
- IV. ACHI Updates ..... Michael Motley, Izzy Whittington, ACHI*
- V. New Topic Discussion .....Margo Bushmiaer, Chairman*
- VI. Director’s Report..... Chris Howlett, EBD Executive Director*

#### ***Upcoming Meetings***

***January 10, 2017, February 14, 2017, March 14, 2017, April 11, 2017***

***NOTE: All material for this meeting will be available by electronic means only  
[ethel.whittaker@dfa.arkansas.gov](mailto: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  
December 13, 2016**

The State and Public Life and Health Insurance Board, Quality of Care Committee met on December 13, 2016 at 10:00 a.m. in the EBD Board Room, 501 Woodlane, Little Rock, Arkansas.

**Members Present**

Margo Bushmiaer  
Dr. John Vinson  
Michelle Murtha  
Pam Brown – Proxy- Nancy Godsey  
Don Hollingsworth  
Dr. Joseph Thompson  
Robert Boyd  
Dr. Namvar Zohoori

**Members Absent**

Frazier Edwards  
Dr. Andrew Kumpuris  
Zinnia Clanton

Chris Howlett, EBD Executive Director, Employee Benefits Division

**Others Present**

Geri Beth Bemberg, UAMS; Ethel Whittaker, Janna Keathley, Marla Wallace, Eric Gallo, Terri Freeman, Gretchen Baggett, Stella Greene, Drew Higginbotham, Cecilia Walker, EBD; Kristi Jackson, Jennifer Vaughn, ComPsych; Suzanne Woodall, MedImpact; Nancy Godsey, AHA; Mike Motley, Elizabeth Whittington, Randy Loggins, Arlo Kahn, ACHI; Trey Long, ACS; Marc Watts, ASEA; Win Hammerly, Karyn Langley QCA; Katrina Collins, Health Advantage; Wayne Whitley, AHTD

**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 November 8, 2016, minutes. Dr. Thompson motioned for adoption of the minutes. Boyd seconded. All were in favor.

**Minutes Approved.**

**WELLNESS BENEFITS DISCUSSION:** *BY: Elizabeth Whittington, Mike Motley, ACHI*

Whittington reported on background on Pap Testing Coverage Policy Exploration. Cancer is a disease in which cells in the body grow out of control. They type of cancer is always named after the part of the body where it starts, even if it spreads to other body parts later.

A pap test is a test of cells in the cervix. Pap tests usually don't help low-risk women. Pap test can have risks and cost the patient potential unnecessary funds.

The ages for Pap test are: (1) Ages 21 – 30 should have a Pap test every three years. (2) Ages 30 -65 the new guidelines from the American Cancer Society and others say that you can have the Pap test every five years as long as you have a test for the human papillomavirus or HPV, at the same. (3) Ages 65 and older do not need Pap tests if your recent ones have been normal.

In 2010, about 12,000 women were diagnosed with cervical cancer and about 4,000 women died. Cervical cancer is most common in women ages 35 to 55 and it is almost caused by a virus called human papillomavirus (HPV).

The main benefits of screening is that it can prevent cervical cancer by finding abnormal cells before they become cancer. If cancer has developed, screening can find it early, when treatment works best. Cervical cancer screening also has some possible harms. The test may cause bleeding, pain, or infection.

Dr. Vinson reported the Medicaid population rate is 36.45%. Therefore, the PSE plan is performing more efficient than Medicaid.

Dr. Vinson inquired about the override process. If Choosing Wisely is implemented, and a member has a family history of cervical cancer and would possibly need a Pap Test more often than the requirements, how would the override protect the members.

Baggett reported the Division will research to provide more information.

Dr. Thompson reported for routine screenings, if the patient present symptom's it is no longer considered a screening it is now considered a diagnosis.

Dr. Zohoori inquired about with the number of claims paid compared to the number of members with cervical cancer.

Dr. Vinson motioned for a recommendation for cervical cancer screening according to the USPTF guidelines. Dr. Bala seconded; all were in favor.

**Motion approved.**

Dr. Zohoori inquired regarding the reason between the discrepancies for the same age groups with ASE and PSE. Motley will research and provide additional information at a later date.

Motley reported that a final recommendation to meet the wellness visit requirement has been acquired.

- In year one of implementation (2017) count any office visit to any PCP (excluding ER, hospital, and urgent care centers) with an evaluation and management or preventive visit CPT code.
- In year two, count any preventive visit CPT code at any CPT (for new patients codes are 99381 through 99387, for established patients codes are 99391 through 99397).
- In year three, count any preventive visit CPT code at beneficiaries' attributed PCP/clinic.

Whittington reported on revising medical policies so that repeat Pap tests are only covered before 30 months if certain clinical indications are present.

Whittington recommended to follow the Choosing Wisely guidelines as the division moves forward with opportunities for improvement instead of creating a crosswalk.

Six baseline reports available:

- Annual PAP testing in women 30-65 years of age
- Carotid Artery Stenosis screening in asymptomatic patients
- PCI for stable ischemic heart disease
- Imaging for nonspecific low back pain
- Imaging for uncomplicated headache
- Preoperative stress testing

Whittington spoke about the Blue & You fitness challenge designed to encourage good exercise habits and healthy living. Individuals and groups will compete against similarly sized teams from across the country to earn points by completing a variety of cardiovascular exercises.

**NEW TOPIC DISCUSSION:** *by Margo Bushmiaer, Chair*

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

**DIRECTOR'S REPORT:** *by Chris Howlett, EBD Executive Director*

Baggett reported that EBD has asked for a 3-month extension for American Health Holding's contract to get through the implementation of Active Health and Howlett is obtaining approval today.

**Meeting adjourned.**

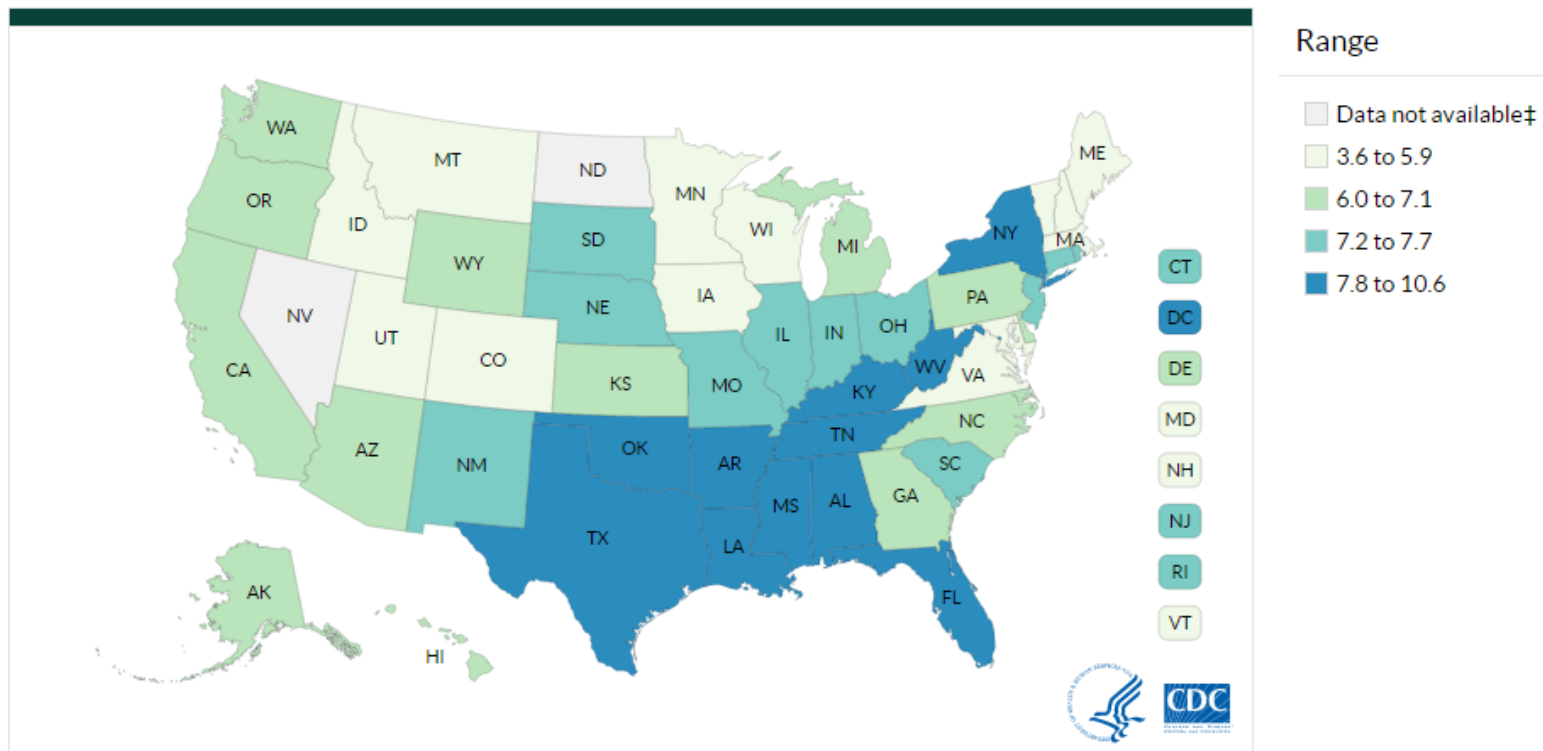
**Policy & Analytic Support Update**  
**Quality of Care Subcommittee, December 13, 2016**

Packet Contents:

- I. Delivery System Design:
    - a. Pap Test Exploration-
      - i. Background on Pap Test Coverage Policy Exploration:
        - 1. National Cervical Cancer Incidence Rates.....**p. 2**
        - 2. Cervical Cancer Mortality Rates-Arkansas .....**p. 3**
      - ii. Consumer Education Materials/Downside Risks:
        - 1. Choosing Wisely/Consumer Reports Pap Tests.....**p. 5-6**
        - 2. USPSTF Cervical Cancer Screening.....**p. 7-9**
      - iii. EBD Population Analyses:
        - 1. Pap Testing Freq. & Cervical Cancer Screening.....**p. 11-12**
        - 2. Cervical Cancer Diagnosis & Cost Information.....**p. 13-16**
    - b. EBD Colorectal Cancer Screening Analyses:
      - i. Colorectal Cancer Screening.....**p. 18**
      - ii. Colonoscopies and Anesthesia.....**p. 19**
- II. Health Risk Mitigation:
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      - i. ICER Pap Testing Report.....**p. 22-32**
- III. Other Topics:
    - a. Blue and You Fitness Challenge.....**p. 33-35**

# **Background on Pap Testing Coverage Policy Exploration**

**Cervical Cancer  
Incidence Rates\* by State, 2013†**



Location	Range	Rate
Arkansas	7.8 to 10.6	10.6
Oklahoma	7.8 to 10.6	9.5
Tennessee	7.8 to 10.6	8.9
Texas	7.8 to 10.6	8.7
Alabama	7.8 to 10.6	8.5
Florida	7.8 to 10.6	8.4
District of Columbia	7.8 to 10.6	8.3
Louisiana	7.8 to 10.6	8.2
West Virginia	7.8 to 10.6	8.1
Mississippi	7.8 to 10.6	8.1
New York	7.8 to 10.6	8.0
Kentucky	7.8 to 10.6	7.9

Rates are per 100,000 and are age-adjusted to the 2000 U.S. standard population.

Source: U.S. Cancer Statistics Working Group. [United States Cancer Statistics: 1999–2013 Incidence and Mortality Web-based Report](#). Atlanta (GA): Department of Health and Human Services, Centers for Disease Control and Prevention, and National Cancer Institute; 2016. Available at: <http://www.cdc.gov/uscs>.

Accessed from <https://www.cdc.gov/cancer/cervical/statistics/state.htm>



## Cervical Cancer in Arkansas

Cancer is a disease in which cells in the body grow out of control. The type of cancer is always named after the part of the body where it starts, even if it spreads to other body parts later.

The test that is used for cervical cancer screening is called the Pap test. The Pap test can find pre-cancer so that it can be treated early and the cancer can be stopped.

### 2003-2007

#### Age-Adjusted Female Breast and Cervical Cancer Mortality Rates\* by Race: Arkansas and United States

	Breast		Cervical	
	Arkansas	U.S.	Arkansas	U.S.
All Races	24.6	24.1	3.3	2.4
White	23.3	23.5	3.0	2.2
Black	33.8	32.4	5.8	4.4

\*Rates are expressed as cases per 100,000. Age-Adjusted to 2000 US Standard Population.

Sources: 2003-2007 AR Center for Health Statistics, Online Query System; <http://www.healthy.arkansas.gov/> 2003-2007 CDC WONDER On-line Database; <http://wonder.cdc.gov/>

### 2008-2012



#### Age-Adjusted Female Breast and Cervical Cancer Mortality Rates\* by Race: Arkansas and United States

	Breast		Cervical	
	Arkansas	U.S.	Arkansas	U.S.
All Races	22.2	22.0	3.3	2.3
White	21.2	21.4	2.9	2.1
Black	30.3	30.2	5.9	4.0

\*Rates are expressed as cases per 100,000. Age-Adjusted to 2000 US Standard Population.

Sources: 2008-2012 AR Center for Health Statistics, Online Query System; <http://www.healthy.arkansas.gov/> 2008-2012 CDC WONDER On-line Database; <http://wonder.cdc.gov/>

# **Consumer Education Materials/Downside Risks**

 <p><b>Choosing Wisely</b><sup>®</sup></p> <p><i>An initiative of the ABIM Foundation</i></p>	 <p><b>ConsumerReports</b><sup>®</sup></p> <p>AMERICAN ACADEMY OF FAMILY PHYSICIANS</p> <p><b>ABIM</b> FOUNDATION</p>
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# Pap tests

## When you need them—and when you don't

**A** Pap test is a test of cells in the cervix. The cervix is the opening between the vagina and the uterus. The Pap test looks for cells that are not normal and can cause cancer of the cervix. This is also called *cervical cancer*.

Most women ages 21 to 65 need regular Pap tests. But teenage girls and older women usually don't need them. Here's why:

### **Pap tests usually don't help low-risk women.**

Many women have a very low risk for cervical cancer.

- Cervical cancer is rare in women younger than 21, even if they are sexually active. Abnormal cells in younger women usually return to normal without treatment.
- Cervical cancer is rare in women over 65 who have had regular Pap tests with normal results.
- Pap tests are not useful for women who have had their cervix removed during a hysterectomy, unless the hysterectomy was done because there were cancer or pre-cancer cells in the cervix.

### **Pap tests can have risks.**

A Pap test can be uncomfortable and cause a little bleeding.



The test may show something that does not look normal but would go away on its own. Abnormal results cause anxiety. And they can lead to repeat Pap tests and follow-up treatment that you may not need.

### The tests cost money.

A Pap test is done during a pelvic exam. Although costs vary across the country and even from practice to practice, any money spent on an unnecessary test is money wasted.

### So, when do I need a Pap test?

That depends on your age, your medical history, and your risks.

- **Ages 21 to 30:** You should have a Pap test every three years. Cervical cancer takes 10 to 20 years to develop, so you don't need the test each year. You do not need a pap test before age 21, even if you are sexually active.
- **Ages 30 to 65:** The new guidelines from the American Cancer Society and others say that you can have the Pap test every five years—as long as you have a test for the human papillomavirus, or HPV, at the same time. HPV is a sexually transmitted infection that can cause cervical cancer.
- **Age 65 or older:** You do not need Pap tests if your recent ones have been normal. If you have risk factors for cervical cancer, ask your doctor how often you need a Pap test. Risk factors include: pre-cancer cells in your cervix, a history of cervical cancer, or a weak immune system.

This report is for you to use when talking with your health-care provider. It is not a substitute for medical advice and treatment. Use of this report is at your own risk.

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[ConsumerHealthChoices.org/about-us/](http://ConsumerHealthChoices.org/about-us/).

## Advice from Consumer Reports

### How can you protect yourself against cervical cancer?

The best way to protect yourself against cervical cancer is to protect yourself against the human papillomavirus, or HPV. HPV is a sexually transmitted infection that can cause cervical cancer.

**Get the HPV vaccine.** Girls and boys should get the vaccine when they are 11 or 12. It is given in three shots over six months. Girls and women ages 13 to 26 should get the vaccine if they have not yet had it. All boys and men ages 13 to 21, and men ages 22 to 26 who have sex with men or have problems with their immune systems should get the vaccine if they have not yet had it.

Women who get the vaccine still need regular Pap tests because the vaccine does not protect against all types of HPV that can cause cancer.

**Limit your sexual partners.** The fewer partners you have, the lower your risk of getting HPV.

#### Use condoms.

Condoms help reduce the risk of getting HPV. Men who use them are less likely to be infected and to infect their partners.

Condoms do not prevent all infections, however.

**Don't smoke.** Smoking cigarettes and breathing second-hand smoke increases your risk of cervical cancer. Women who smoke are two times more likely to get cervical cancer.

#### Take these steps to make your Pap test as accurate as possible.

- Make your appointment for at least five days after your menstrual period stops.
- For 48 hours before the test: Don't have sex, and don't use douches, tampons, birth control foams or gels, vaginal creams, moisturizers or lubricants, or vaginal medicines.



## Screening for Cervical Cancer

The U.S. Preventive Services Task Force (Task Force) has issued final recommendations on *Screening for Cervical Cancer*.

These recommendations are for women who have a cervix and who do not already have an increased risk for cervical cancer, whether or not they are sexually active.

The Task Force reviewed many research studies on screening tests for cervical cancer. The recommendations summarize what it learned about the benefits of these tests as well as the possible harms, both of which are explained below. This fact sheet explains the recommendations and what they might mean for you.

What is cervical cancer?

Cervical cancer is cancer that occurs in the cervix. The cervix is the lower, narrow end of the uterus (womb). It connects a woman's uterus to her vagina.

### Screening for Cervical Cancer

In 2010, about 12,000 women were diagnosed with cervical cancer and about 4,000 women died from it. Cervical cancer is most common in women ages 35 to 55 and it is almost always caused by a virus called human papillomavirus (HPV). There are many different types of HPV, and some types of HPV can lead to cervical cancer. HPV is passed from one person to another during sex.

Two tests are used to screen for cervical cancer:

- **Cytology:** This test, also called a Pap test or Pap smear, looks for abnormal changes in cells in the cervix. These changes may suggest that cancer may develop in the future.
- **HPV test:** This test looks for the type of HPV virus that causes cervical cancer.

To learn more about these tests and what happens during them, visit the Web sites listed at the end of this fact sheet.

Women who have never been screened for cervical cancer should visit their doctor to talk about getting screened. Most women who develop cervical cancer have not been screened at all, have not been screened recently, or did not have proper follow-up after receiving abnormal test results.

### Benefits and Possible Harms

The main benefit of screening is that it can prevent cervical cancer by finding abnormal cells before they become cancer. If cancer has developed, screening can find it early, when treatment works best.

Cervical cancer screening also has some possible harms. The tests may cause bleeding, pain, or infection. Abnormal results may make women feel anxious or upset. Screening may also lead to additional tests or procedures that aren't needed or that may cause harms for some women, including problems with future pregnancies.

## The Task Force Recommendations on Screening for Cervical Cancer: What Do They Mean?

Here are the recommendations. When the Task Force recommends screening, it is because the screening has more possible benefits than possible harms. When the Task Force recommends against screening, it is because the screening has more possible harms than possible benefits. The notes to the right help to explain key ideas.

Each recommendation has a letter grade. The grades are based on the quality of the evidence about the benefits and harms of the test. The grades are explained in the box at the end of this fact sheet.

Visit the Task Force Web site to read the [full recommendation statement](#) on screening for cervical cancer. The statement explains the evidence that the Task Force reviewed and how it decided on the grades. An [evidence report](#) on this topic provides more detail about the studies the Task Force considered.

- 1 The USPSTF recommends screening women ages 21 to 65 years with *cytology every 3 years* or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a *combination of cytology and HPV testing every 5 years*. **Grade A**
- 2 The USPSTF recommends against screening for cervical cancer in *women younger than age 21 years*. **Grade D**
- 3 The USPSTF recommends against screening for cervical cancer in women older than age 65 years who have had *adequate prior screening* and are not otherwise at high risk for cervical cancer. **Grade D**
- 4 The USPSTF recommends against screening for cervical cancer in women who have had a *hysterectomy* with removal of the cervix and who do not have a history of *CIN 2, CIN 3*, or cervical cancer. **Grade D**
- 5 The USPSTF recommends against screening for cervical cancer using *HPV testing, alone or in combination with cytology*, in women younger than age 30 years. **Grade D**

### Notes

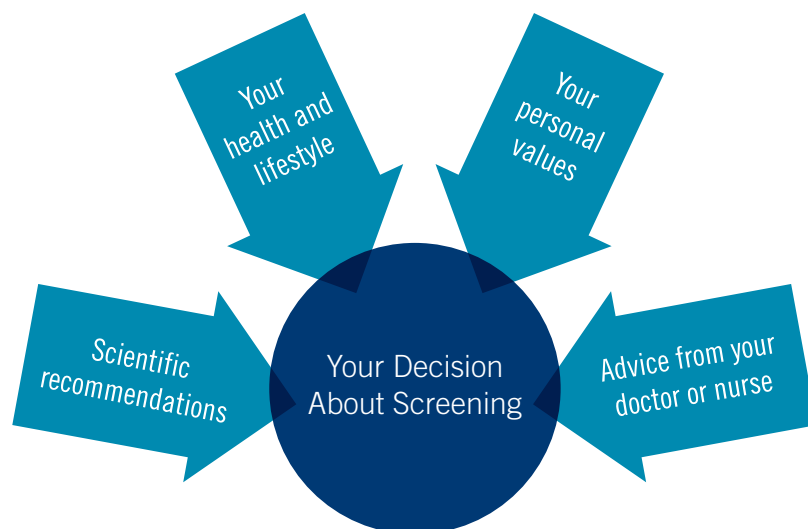
- 1 *cytology every 3...*  
For women ages 21 to 65, screening with a Pap test every 3 years has the highest benefits with the lowest harms.
- combination of...*  
For women ages 30 to 65, getting a Pap test and an HPV test together every 5 years has similar benefits and harms to getting a Pap test every 3 years.
- 2 *women younger...*  
Cervical cancer is rare in this group. Also, abnormal cells that might be found during screening often return to normal over time, making follow-up treatment unnecessary and possibly harmful.
- 3 *adequate prior screening*  
For women over 65, this means three normal Pap tests in a row, or two normal HPV tests in a row within the 10 years before stopping screening. The most recent Pap/HPV test should be within the past 5 years.
- 4 *hysterectomy*  
Operation to remove the uterus.  
*CIN 2, CIN 3*  
Abnormal cells in the cervix that can become cancer.
- 5 *HPV testing alone...*  
For women younger than age 30, HPV testing alone or with a Pap can lead to follow-up treatment that may be unnecessary or harmful.



## Should You Be Screened for Cervical Cancer?

Getting the best health care means making smart decisions about what screening tests, counseling services, and preventive medicines to get and when to get them. Many people don't get the tests or counseling they need. Others get tests or counseling they don't need or that may be harmful to them.

Task Force recommendations can help you learn about screening tests, counseling services, and preventive medicines. These services can keep you healthy and prevent disease. The Task Force recommendations do not cover diagnosis (tests to find out why you are sick) or treatment of disease.



### How should you decide whether and how often to be screened for cervical cancer?

Consider your own health and lifestyle. Think about your personal beliefs and preferences for health care. Talk with your doctor or nurse about your risk for cervical cancer and how often screening should fit into your ongoing health care, especially if you have never been screened for cervical cancer. And consider scientific recommendations, like this one from the Task Force. If you do get a screening test, talk with your health care provider about the results of your test and next steps you may need to take.

## What is the U.S. Preventive Services Task Force?




The Task Force is an independent group of national experts in prevention and evidence-based medicine. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, or preventive medicines. The recommendations apply to people with no signs or symptoms of the disease being discussed.

To develop a recommendation statement, Task Force members consider the best available science and research on a topic. The Task Force posts draft documents for public comment, including a draft recommendation statement for each topic. All comments are reviewed and considered in developing the final recommendation statement. To learn more, visit the [Task Force Web site](#).

### USPSTF Recommendation Grades

Grade	Definition
A	Recommended.
B	Recommended.
C	Recommendation depends on the patient's situation.
D	Not recommended.
I statement	There is not enough evidence to make a recommendation.

### Click Here to Learn More about Cervical Cancer and What Happens During Screening Tests

- 
**Get Tested for Cervical Cancer**  
(healthfinder.gov)
- 
**What You Need to Know About™ Cancer of the Cervix**  
(National Cancer Institute)
- 
**Cervical Cancer**  
(Centers for Disease Control and Prevention)

# **EBD Population Analyses**



### Pap Smear Testing Frequency

Description of Methods Used:

- Population – Population for this analysis was set to female member's age 21-65 who did not have claims data reporting abnormal Pap smear test results. This study was done with a 3 year snapshot from 10/1/2012-9/30/2015. Members also had to be continuous enrolled in the plan during final two years of measurement period.
- Claims were validated using the following CPT and HCPCS codes: 88141-88155, 88164-88167, 88174-88175, G0123, G0143, G0144, G0145, G0147, G0148, P3000, G0124, G0141, P3001
- The Following codes were used to remove members with abnormal rest results from the population for this study: v7232, 79501, 79502, 79503, 79504, 79505, 79508, 79509, 62210, 62211, 62212, 2331, 6266, 6271, 1801
- Cost as reported represents only the procedure indicated on the claim.

Plan	Total study population	Members who had at least 1 pap smear in 3 year period	Members with more than one pap smear in 3 year period	Average number of pap smears in 3 year period for those who had at least 1 paid claim	Average paid by plan per pap smear in 3 year period
<b>PSE</b>	30,381	60.2%	34.7%	2	\$29.00
<b>ASE</b>	15,806	57.7%	32.7%	2.7	\$28.21
<b>Total</b>	46,187	59.3%	34.0%	2	\$28.73

Year	Plan	Pap smear screenings performed	Average cost to plan per Pap smear	Total paid by plan for pap smear
<b>10/1/2014 - 9/30/2015</b>	<b>PSE</b>	13,062	\$29.39	\$383,943.01
	<b>ASE</b>	6,140	\$28.94	\$177,699.51
	<b>Total</b>	19,202	\$29.25	\$561,642.52
<b>10/1/2013 - 9/30/2014</b>	<b>PSE</b>	11,691	\$28.62	\$334,539.39
	<b>ASE</b>	6,099	\$27.71	\$168,999.57
	<b>Total</b>	17,790	\$28.30	\$503,538.96
<b>10/1/2012 - 9/30/2013</b>	<b>PSE</b>	11,227	\$28.94	\$324,859.75
	<b>ASE</b>	5,763	\$27.96	\$161,113.00
	<b>Total</b>	16,990	\$28.60	\$485,972.75

### Cervical Cancer Screening Rates

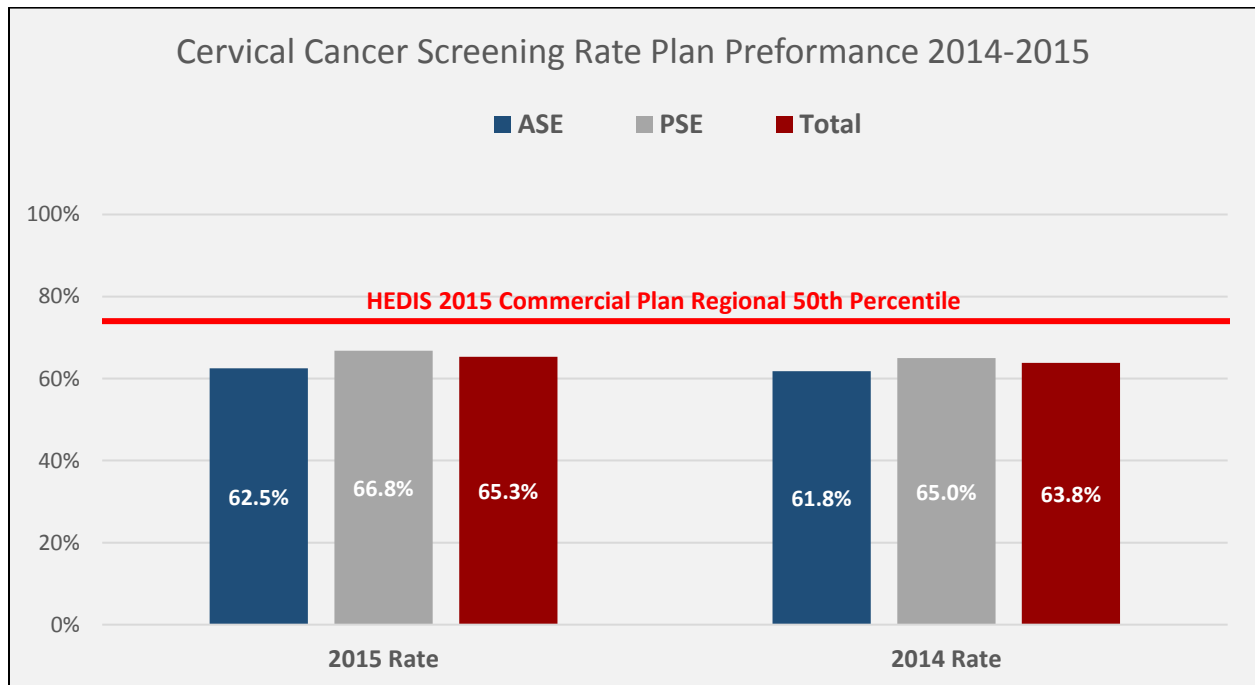
Description of Methods Used: The below information was generated using methods from HEDIS 2015, Volume 2 as published by the NCQA. The CPT and HCPCS codes used were taken from the HEDIS Value set from 2015.

The NCQA Benchmarks for 2015 HEDIS measures would place both plans under the 50<sup>th</sup> percentile for commercial plans in the region and under the 25<sup>th</sup> percentile for commercial plans in the nation. <sup>1</sup>

The qualifying population for this study are women aged 24-64 as of December 31<sup>st</sup> of the measurement year who were continuously enrolled for the measurement year and the two years prior to the measurement year.

Criteria for a Cervical Cancer Screening as defined by HEDIS:

- 1.) Women 24-26 years of age as of December 31<sup>st</sup> of the measurement year who had a cervical cytology during the measurement year or the two years prior to the measurement year. OR
- 2.) Women 30-64 years of age as of December 31<sup>st</sup> of the measurement year who had a cervical cytology **and** a HPV test with service dates four or less days apart during the measurement year or four years prior **and** who were 30 years of older on the date of both tests.



<sup>1</sup> [https://www.ncqa.org/Portals/0/HEDISQM/2015%20BenchmarksAndThresholds\\_Initial\\_Updated2.4.pdf](https://www.ncqa.org/Portals/0/HEDISQM/2015%20BenchmarksAndThresholds_Initial_Updated2.4.pdf)

**Purpose:** To report the annual number of plan members with claims data that have appropriate ICD-9/ICD-10 codes indicating cervical cancer, for both ASE and PSE plans in Arkansas.

**Population Criteria:** Female members 18 years of age and older who were enrolled for the entire year that is being reported.

**Summary of Data Collection Methodology:** Members in the selected population with a medical claim showing a diagnosis of cervical cancer, using the diagnosis codes below, were counted for each year being measured. Claims that included the diagnosis code were counted in cost reporting.

**ICD-9:** 180.0, 180.1, 180.8, 180.9

**ICD-10:** C53.0, C53.1, C53.8, C53.9

**Study Results by Year and Plan:**

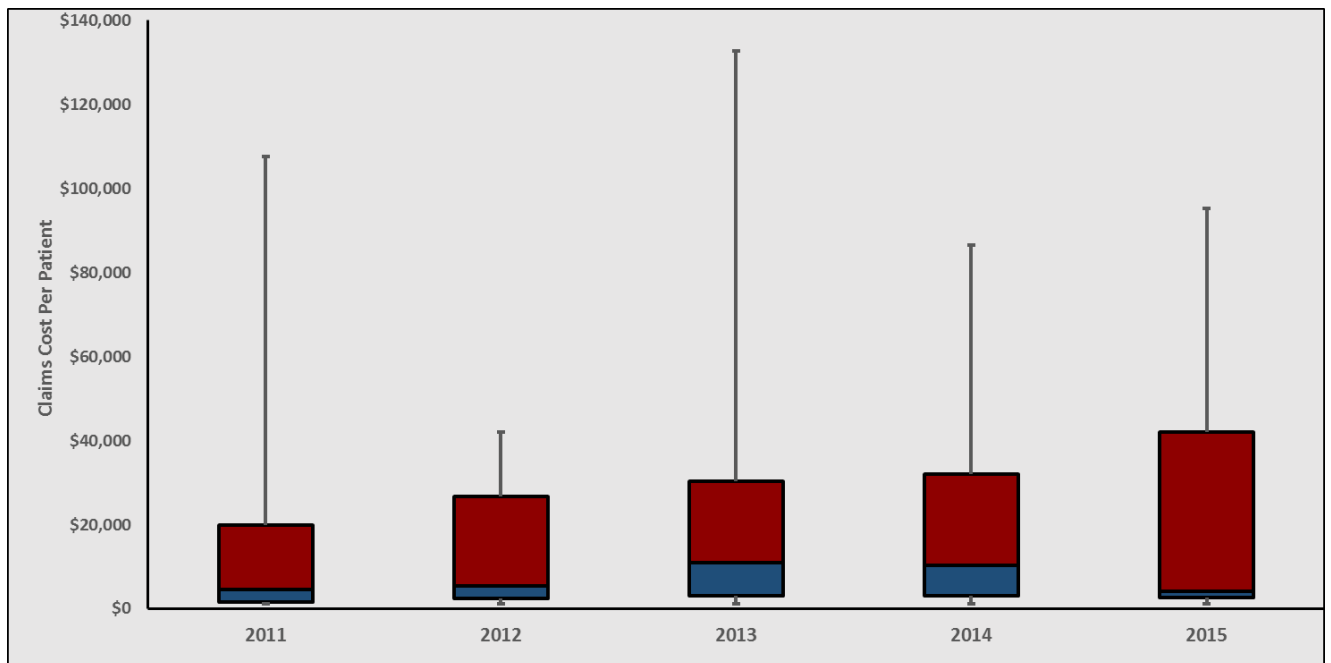
At Risk Population by Plan					
Plan	2011	2012	2013	2014	2015
ASE	25,049	25,176	25,181	25,005	22,599
PSE	40,303	41,374	41,826	41,103	39,182
Total	65,352	66,550	67,007	66,108	61,781

Count of EBD Plan Members with Cervical Cancer Diagnosis Code in Claims Data by Plan					
Plan	2011	2012	2013	2014	2015
ASE	17	24	19	19	14
PSE	23	23	28	28	17
Total	40	47	47	47	31

### Study Results for Cost of Claims by Year:

Cost of Cervical Cancer Diagnosis to Plan Per Year			
Year	Cost of Claims Paid	Number of Members with Cervical Cancer Diagnosis	Number of Claims Paid
2011	\$292,360.36	40	522
2012	\$228,245.40	47	494
2013	\$558,479.56	47	1315
2014	\$523,089.54	47	1160
2015	\$273,153.85	31	512

### Cost of Claims per Member per Year<sup>1</sup>:



<sup>1</sup> Members with less than \$1,000 dollars of claims paid by EBD were not included.

**Study Results by Age Range:**

2011 Members with Cervical Cancer Diagnosis Code in Claims Data							
Plan	18 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 +	Total
ASE	0	2	3	5	7	0	17
PSE	0	0	10	6	5	2	23
Total	0	2	13	11	12	2	40

2012 Members with Cervical Cancer Diagnosis Code in Claims Data							
Plan	18 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 +	Total
ASE	1	3	2	5	13	0	24
PSE	0	1	5	6	10	1	23
Total	1	4	7	11	23	1	47

2013 Members with Cervical Cancer Diagnosis Code in Claims Data							
Plan	18 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 +	Total
ASE	1	0	3	8	6	1	19
PSE	0	3	7	9	8	1	28
Total	1	3	10	17	14	2	47

2014 Members with Cervical Cancer Diagnosis Code in Claims Data							
Plan	18 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 +	Total
ASE	0	0	4	7	8	0	19
PSE	0	6	7	9	6	0	28
Total	0	6	11	16	14	0	47

2015 Members with Cervical Cancer Diagnosis Code in Claims Data							
Plan	18 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 +	Total
ASE	0	1	1	5	7	0	14
PSE	0	4	4	4	2	3	17
Total	0	5	5	9	9	3	31

**ICD-9 and ICD-10 Codes Used:**

<b>ICD-9</b>	<b>ICD-10</b>	<b>Description</b>
180.0	C53.0	Malignant neoplasm of endocervix
180.1	C53.1	Malignant neoplasm of exocervix
180.8	C53.8	Malignant neoplasm of overlapping sites of cervix uteri
180.9	C53.9	Malignant neoplasm of cervix uteri, unspecified

# **EBD Colorectal Cancer Screening Analyses**

Description of Methods Used: The below table was generated using standards from HEDIS 2015, volume 2 as published by the NCQA. The CPT and HCPCS codes used were taken from the HEDIS Value set from 2015.

The NCQA Benchmarks for 2015 would place ASE near the 75<sup>th</sup> percentile and PSE just under the 50<sup>th</sup> percentile for screening rates for commercial plans in our region. <sup>1</sup>

According to information released by the CDC on May 8<sup>th</sup> 2015, the national average Colorectal Cancer Screening Rate in 2013 was 56.7% for men and 58.9% for women <sup>2</sup>

The Qualifying population for the study are members age 51-75 on the last day of the measuring year ( 10/1/2014-9/30/2015) that were continuously enrolled for the measurement year and the year prior to the measurement year.

Criteria for a Colorectal Screening are as follows:

- 1.) A Fecal occult blood test during the measurement year. OR
- 2.) A Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. OR
- 3.) A Colonoscopy during the measurement year or the nine years prior to the measurement year.

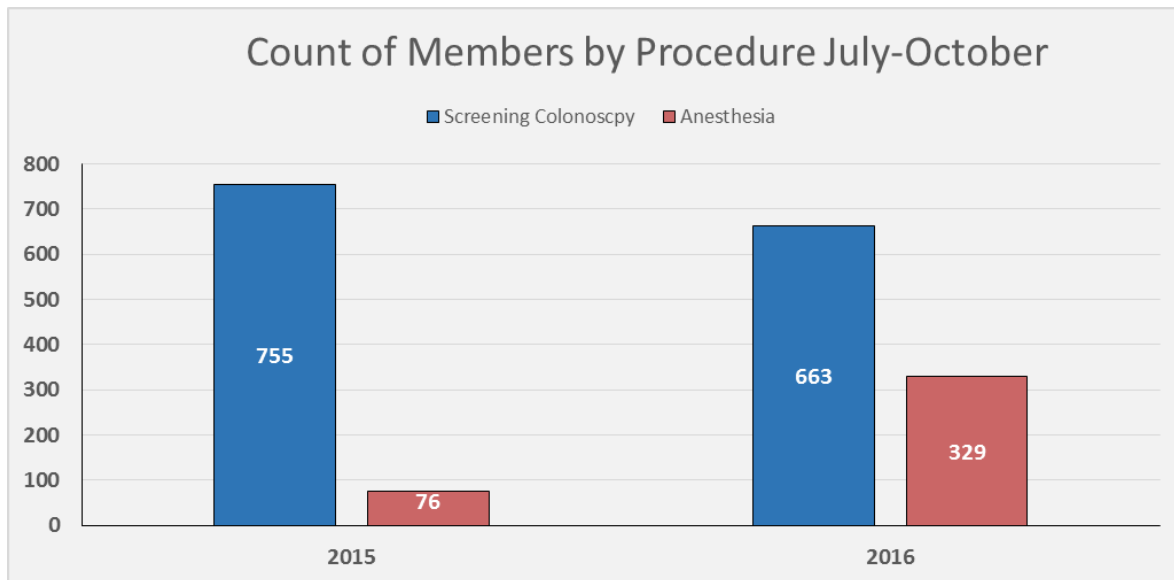
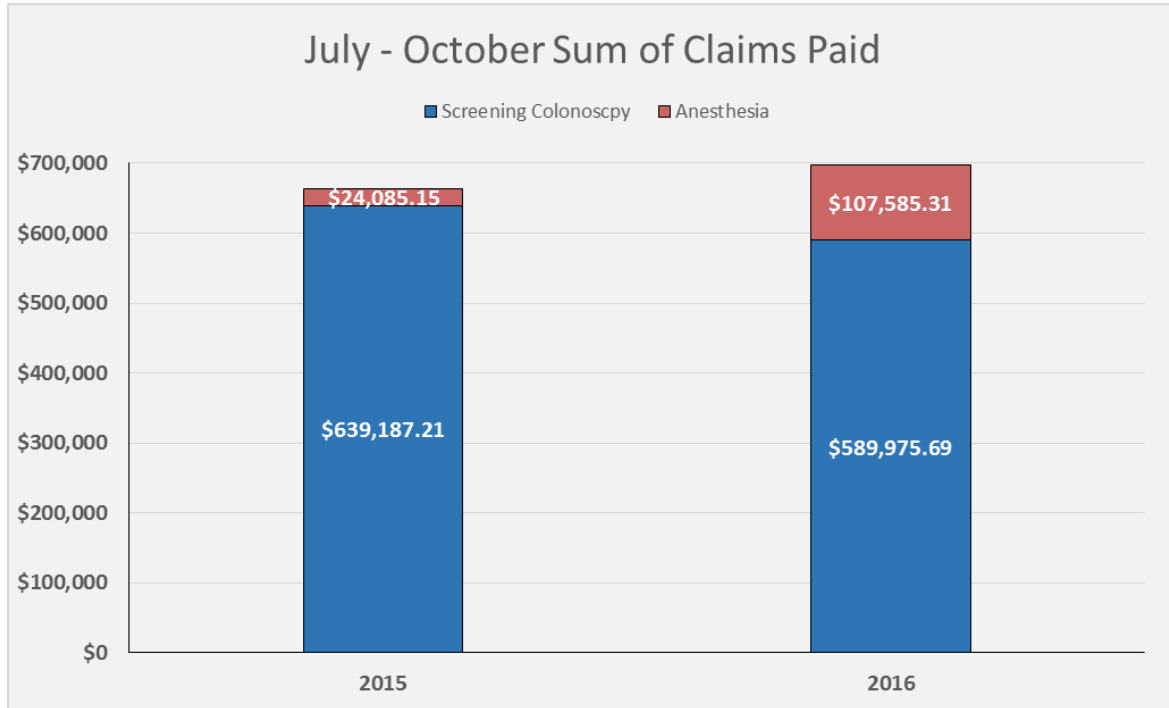
Plan	Population Age 50-75	% of Members who has a Current Colorectal Screening	% of Members who had a Colonoscopy in the last 10 years
ASE	M: 5,323	M: 60%	M: 56%
	F: 7,460	F: 62%	F: 58%
PSE	M: 5,028	M: 53%	M: 49%
	F: 12,394	F: 56%	F: 52%
Total	M: 10,351	M: 57%	M: 53%
	F: 19,854	F: 58%	F: 55%

<sup>1</sup> [http://www.ncqa.org/Portals/0/HEDISQM/2015%20BenchmarksAndThresholds\\_MidYearUpdate.pdf](http://www.ncqa.org/Portals/0/HEDISQM/2015%20BenchmarksAndThresholds_MidYearUpdate.pdf)

<sup>2</sup> <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6417a4.htm>



Description of Methods Used: Based on codes provided by the third party administrator for the EBD health insurance plans, claims data was pulled from July 1<sup>st</sup> through October 31<sup>st</sup> for 2015 and 2016. Claims that showed procedure codes<sup>1</sup> for screening colonoscopies and anesthesia for lower intestinal endoscopic procedures were used in conjunction with the proper ICD-9/ICD-10 codes<sup>2</sup> for screening colonoscopies. Only claims in which the plan has paid out were included in this analysis.



<sup>1</sup> CPT/HCPCS Codes: '00810', '45378', 'G0105', 'G0121' as well as modifiers 33 and PT

<sup>2</sup> ICD-9 Code: V7651 and ICD-10 Code: Z1211

# Health Risk Mitigation

### **1. Update on Arkansas Works program wellness visit requirement**

- As previously reported to the Board, the AR Works legislation requires an annual wellness visit – the incentive is an additional benefit, likely to be dental coverage
- ACHI has convened a working group of qualified health plan (QHP) carriers including, BCBS, QualChoice, Centene. Arkansas Medicaid and EBD have also been participants in these discussions
- The group has landed on a final recommendation to meet the wellness visit requirement
  - In year one of implementation (2017) count any office visit to any PCP (excluding ER, hospital, and urgent care centers) with an evaluation and management or preventive visit CPT code
  - In year two, count any preventive visit CPT code at any PCP (for new patients codes are 99381 through 99387, for established patients codes are 99391 through 99397)
  - In year three, count any preventive visit CPT code at beneficiaries' attributed PCP / clinic
- We conducted an exploratory analysis with EBD claims as previously shared with group; Found that around 90% receive the visit under current EBD definition, restricting to PCP only or attributed PCP significantly reduced the proportion of those that would have been deemed eligible for the incentive

### **2. Health Risk Assessment Survey Analysis**

- This activity is related to the wellness strategy alignment and also establishing a mechanism to evaluate the existing wellness program; Can help to further shape where the board wants to take the wellness program
  - ACHI has received 2015 data from ComPsych and have begun the analysis of responses and risk-factor associated costs
  - This analysis will link de-identified medical claims with self-reported risk factors
  - Looking at **January** for preliminary results we can share

### **3. Choosing Wisely Approach**

- Institute for Clinical and Economic Review (ICER) received funding in 2014 to provide analyses on selected Choosing Wisely recommendations
- Reports are titled "Choosing Wisely Recommendation Analysis: Prioritizing Opportunities for Reducing Inappropriate Care"
  - Reports explore variation in practice/costs
  - Examine factors that contribute to overuse of tests/treatments
  - Include summary rating of the extent and harms of overuse and potential for savings
- Six baseline reports available:
  - Annual PAP Testing in Women 30-65 Years of Age
  - Carotid Artery Stenosis Screening in Asymptomatic Patients
  - PCI for Stable Ischemic Heart Disease
  - Imaging for Nonspecific Low Back Pain
  - Imaging for Uncomplicated Headache
  - Preoperative Stress Testing
- In moving forward with Choosing Wisely, want to start with these baseline reports to evaluate current coverage policies of EBD and utilization within EBD population
  - Pap testing already in progress; Next steps will include creation of crosswalk for preventive services listed above and determining analytic strategy for addressing issues noted in other reports



# Choosing Wisely® Recommendation Analysis: Prioritizing Opportunities for Reducing Inappropriate Care

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## PAP TESTING

Sarah Jane Reed, MSc and Steve Pearson, MD, MSc  
INSTITUTE FOR CLINICAL AND ECONOMIC REVIEW

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# PAP TESTING IN WOMEN 30-65 YEARS OF AGE

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## Evidence Justification

*The American College of Obstetricians and Gynecologists recommends against the routine annual cervical cytology screening (Pap tests) in women aged 30 to 65. We summarize the reasoning provided by this society to justify the inclusion of this service, including assignment of this service into one of five evidentiary categories of “wasteful” services arising from the evidence on benefits, risks, and costs (Gliwa, 2014).*

### **American College of Obstetricians and Gynecologists**

Don't perform routine annual cervical cytology screening (Pap tests) in women 30-65 years of age.

### **Specialty Society Rationale**

*Current guidelines recommend Pap tests every three to five years in women aged 30-65 years without risk factors for developing cancer such as genetic markers or family history (Saslow, 2012). For these women, there is no advantage to having annual exams versus exams every three years, as similar numbers of cancers are found (American College of Obstetricians and Gynecologists, 2012). Annual Pap tests may cause more anxiety for women, and there are increased chances for unnecessary follow-up testing for false positive results, including repeat Pap test and colposcopies, which can cause discomfort and bleeding (Saslow, 2012).*

**Table 1. “Wasteful Care” Evidence Category**

1. Insufficient evidence to evaluate comparative benefit for any indication
2. Insufficient evidence to evaluate comparative benefit for use beyond the boundaries of established indications, frequency, intensity, or dosage
<b>3. Adequate evidence demonstrating equivalent benefit with higher risk, higher cost, or both</b>
4. Adequate evidence demonstrating a small comparative benefit not large enough to justify the higher risk to patients, higher cost, or both
5. Adequate evidence demonstrating improved comparative benefit, lower risk, lower cost, or both when using the intervention

Source: Gliwa and Pearson, 2014

## Current Use and Variation in Practice

- *Estimated Population Affected: 32,700,000 – 45,800,000*
- *Excess Cost of Practice: \$2.6 million – \$7.3 million*

Data from the U.S. Census indicate that there are approximately 72.8 million women in the target age range for cervical cytology screening via Pap smear. An analysis of screening patterns among 8,000 women at UCLA Medical Center suggested that 45% were receiving Pap smears at intervals <3 years without clinical indication (Almeida, 2013), a rate which would equate to 32.7 million women in the U.S. ICER commissioned an analysis of Pap utilization from a 10 million-person dataset of employees of self-insured companies nationwide (Truven Health MarketScan® Research Databases, 2013). In this dataset, repeat Pap testing without a clinical indication within 30 months is very prevalent, occurring among 63% of screened women (which would equate to approximately 45.8 million women nationwide).

The costs of too-frequent Pap testing have not been well-studied, but include both unnecessary repeat Pap testing and follow-up care for subsequent false-positive findings, including colposcopy. Pap test costs have been reported to range from \$40-\$80 (Costhelper.com, 2013), and colposcopy costs range from \$200-\$400 (Costhelper.com, 2013). Based on current estimates for false-positive rates for Pap tests (20%) (Arbyn, 2008) and rates of unnecessary colposcopy (4 per 1000 screened) (Mathias, 2012), the excess cost per false-positive screen may range from \$80-\$160, or \$2.6 million – \$7.3 million for the entire screening eligible population.

## Sociology of Practice

*We conducted unstructured interviews with national clinical and policy experts representing the fields of obstetrics and gynecology and family practice to understand the multi-faceted influences that drive the use of this service and to gather diverse opinions on the most effective methods to reduce inappropriate use of these services.*

Experts were mixed in their responses to whether or not annual Pap tests are overused in practice. Some OB/GYNs and family doctors sensed that the revised guidelines on Pap tests are generally accepted by the physician and patient communities, whereas others observed annual Pap tests remain a common practice. When describing potential factors contributing to overuse, experts highlighted patient demand and a lack of patient education on the risks of over screening. Family doctors and OB/GYNs alike find it difficult to reverse the message that patients need a Pap test every year when this contradicts what women have been consistently told over the past decade. Many patients, particularly those that are especially cancer-phobic, often push back, noting that they would rather be screened than potentially miss cervical cancer. Other physicians noted a general cultural suspicion from patients that physicians are withholding care when they are denied an annual Pap test, though this is less of an issue in practices where patients have a longstanding history with their physician. Clinicians also highlighted that insurer reimbursement for annual Pap testing and requirements from the Affordable Care Act that Pap tests are provided without co-payment have reinforced patient demand for annual testing.

To help address issues of patient demand, regional experts cited the need for clear communication and education strategies that articulate the risks of overtreatment and over screening. Experts agreed that education strategies should also target medical assistants, nurse practitioners, and other clinicians that spend more time with patients. Many practices cited the lack of publicly available resources and tools that help women understand what to reasonably expect from screening and how they can be harmed by false-positive test results. Some physicians felt that framing the message about annual Pap testing in relation to advances in HPV screening has been helpful. For example, physicians recommended articulating to patients that the Pap test is not particularly accurate, which is why experts once thought it needed to be performed annually, but that performing a Pap with the HPV screening test offsets the need to test as often. We identified no formal programs for reducing overuse and variation of annual Pap testing in women between ages 30 and 65 in our interviews with experts. However, Consumer Reports®, in partnership with the ABIM Foundation as part of the Choosing Wisely®



campaign, has created a range of consumer resources to help frame patient conversations about unnecessary Pap testing.

Experts noted that Pap tests are likely used unnecessarily because the risks of overuse seem relatively insignificant, both to patients and physicians. Moreover, since annual pelvic exams are still recommended, Pap tests are often automatically scheduled or easy to tack on during the visit. Clinicians also noted a general reluctance among OB/GYNs to reduce annual Pap testing since it is seen as a way to motivate patients to attend their annual women's health visit. There is a fear among some OB/GYNs that without annual Pap testing they will lose consistent patient contact and may end up missing something important or lose the opportunity to discuss with women other reproductive, menopausal, or bladder health concerns. Financial incentives may also be at play here, since patients would be less likely to maintain annual OB/GYN visits without the perceived need for a Pap test. Clinical experts also highlighted that clinical guidelines on Pap test frequency have changed multiple times in the past decade, making it difficult for physicians to keep abreast of the standard of care, and contributing to patient confusion.

For practices with transient patient populations, managing multiple-year screening intervals has been difficult or infeasible in some cases. It is sometimes impossible for physicians to know if patients who frequently move or change practices are up to date on screening. Without further information on screening history, physicians tend to screen these patients annually to avoid missing something potentially important. The implementation of electronic medical records (EMR) is designed to make it easier to manage screening intervals, but some practices have noted that information is not always appropriately transferred to the medical record, making it difficult to find patient history even in practices with electronic records. Clinical experts suggested that presenting clinicians with how many tests they perform relative to their peers would be welcomed and effective in reducing regional variation. They sensed that clinicians want to know when they are not in step with standards, but that payer-led initiatives like pay-for-performance strategies can often put physicians on the defensive and make them less receptive to messaging about their individual performance.

Experts we spoke with believed that growing use of global payment and other reimbursement mechanisms that move away from fee-for-service will help improve the chances of reducing the overuse of Pap tests. Regional and national insurers are also optimistic that the roll-out of ICD-10 coding will make it possible for them to identify when more frequent Pap tests are performed

without a clinical indication and make it easier to recognize outliers. We identified no formal insurer-led initiatives to reduce unnecessary Pap testing.

## Summary Statement: Drivers of Overuse and Opportunities for Improvement

*Based on our research and conversations with national experts, this section synthesizes the major factors related to overuse, as well as any opportunities for improvement or existing best practices for reducing wasteful care.*

Factors Related to Overuse		
Patient Factors	Physician Factors	Payer Factors
<ul style="list-style-type: none"> <li>• Patient demand</li> <li>• Financial incentives (i.e. no co-payments for Pap tests under ACA )</li> </ul>	<ul style="list-style-type: none"> <li>• Reluctance from clinicians to stop performing Pap tests when it is what gets women to attend their annual visit</li> <li>• Difficulty of changing behavior of clinicians trained to perform annual Pap tests</li> <li>• Automatic scheduling of annual pelvic exams</li> <li>• Lacking knowledge of current standards due to history of conflicting guidelines and recommendations over the past 10 years</li> <li>• Transient patient populations making it difficult to track long-term screening history</li> </ul>	<ul style="list-style-type: none"> <li>• Administrative challenge for payers to distinguish when Pap tests are medically necessary</li> </ul>
Opportunities for Improvement/Current Best Practices		
Opportunities for Improvement	Current Best Practices	
<ul style="list-style-type: none"> <li>• Establish clear communication strategy with patients to explain changed guidelines</li> <li>• Educate patients on the risks of over testing</li> <li>• Maintain consistent clinical guidelines</li> <li>• Use ICD-10 roll-out to recognize when Pap tests are unnecessary, and identify outliers for targeted campaigns</li> <li>• Provide information to clinicians on how often they screen relative to their peers</li> <li>• Revise medical policies so that repeat Pap tests are only covered before 30 months if certain clinical indications are present</li> <li>• Educate medical assistants and other clinicians who have more one-on-one time with patients on how to discuss changed guidelines</li> <li>• Make use of global payments that reduce incentives for clinicians to perform extra tests</li> </ul>	<ul style="list-style-type: none"> <li>• Simple patient messaging displayed in physician offices that reinforce idea that patients no longer need an annual test</li> </ul>	

## Summary Rating

This section synthesizes the information provided previously and presents a recommended priority ranking of whether this service is likely to represent the best opportunity for policy makers to improve practice and drive change. These rankings are based on considerations of 5 factors illustrated in the table below.

<i>Criteria</i>	<i>Ranking</i>
<i>Level of overuse</i>	★ = Limited overuse ★ ★ = Moderate overuse ★ ★ ★ = Substantial overuse
<i>Magnitude of individual patient harm</i>	★ = Limited harm ★ ★ = Moderate harm ★ ★ ★ = Substantial harm
<i>Ease of overcoming patient, clinician, and system barriers to reduce inappropriate care</i>	★ = Limited ease ★ ★ = Moderate ease ★ ★ ★ = Substantial ease
<i>Potential to leverage existing change programs and policy efforts</i>	★ = Limited potential ★ ★ = Moderate potential ★ ★ ★ = Substantial potential
<i>Amount of potential savings</i>	★ = Limited savings ★ ★ = Moderate savings ★ ★ ★ = Substantial savings

<i>Category</i>	<i>Score</i>	<i>Rationale</i>
<i>Level of overuse</i>	★ ★ ★	<ul style="list-style-type: none"> <li>• Large proportion of women estimated to receive annual or bi-annual Pap tests</li> </ul>
<i>Magnitude of individual patient harm</i>	★	<ul style="list-style-type: none"> <li>• Potential harms from false positive results relatively insignificant</li> </ul>
<i>Ease of overcoming patient, clinician, and system barriers to reduce inappropriate care</i>	★ ★	<ul style="list-style-type: none"> <li>• Difficult to monitor using existing coding systems, but potential for opportunities with ICD-10 and improved patient/clinician education</li> </ul>
<i>Opportunity to leverage existing change programs and policy efforts</i>	★ ★	<ul style="list-style-type: none"> <li>• Availability of some patient resources, but no existing change programs identified at either the national or regional level</li> </ul>
<i>Amount of potential savings</i>	★ ★ ★	<ul style="list-style-type: none"> <li>• Low cost per case but large eligible screening population creates significant opportunity for savings</li> </ul>

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# Other Topics



# Blue & You fitnessChallenge

A program of Arkansas Blue Cross and Blue Shield,  
Arkansas Department of Human Services  
and the Arkansas Department of Health

[BlueandYouFitnessChallenge-ark.com](http://BlueandYouFitnessChallenge-ark.com)

## WHAT IT IS

The **Blue & You Fitness Challenge** is a three-month (March 1 – May 31) contest designed to encourage good exercise habits and healthy living. Individuals and groups will compete against similarly sized teams from across the country to earn points by completing a variety of cardiovascular exercises. Winning teams are named based on accumulated points.

## WHO IT'S FOR

Everyone! Companies often use the Challenge to launch their own wellness programs. With options to create teams within a group and motivate participants through peer encouragement, the Challenge makes it easy to manage fitness goals for large groups. Smaller groups, families and individuals also benefit from the easy-to-use logging functions that help keep track of their activities. Anyone who wants to be healthy through consistent exercise will be helped by the Challenge!

## HOW TO PARTICIPATE

### ■ CREATE AND NAME YOUR GROUP

A group can be as small as two people, with no maximum number. You can look to your family, friends, co-workers, church or business for group members. All participants must be age 13 or older.

### ■ ASSIGN A GROUP ADMINISTRATOR TO REGISTER YOUR GROUP BY MID FEBRUARY

The group administrator is responsible for registering the group at [www.BlueandYouFitnessChallenge-ark.com](http://www.BlueandYouFitnessChallenge-ark.com) and managing the participants throughout the contest. Group administrators must be age 18 or older.

### ■ REGISTER MEMBERS BEFORE MARCH 1

When the group administrator registers your group, he/she will receive a special group code to distribute to the group's participants. Each person will register at the link above using the group code.





## MOVE, LOG AND PROMOTE – MARCH 1- MAY 31

Participants complete the eligible exercises and log them online. Group administrators should encourage members to stay active and enter their exercises. Newsletters, emails, posters, meetings and even fitness fairs are good ways to promote the Challenge for larger groups. There are also a number of resources in the Contest Kit online to help.

Each groups' progress is shown on the website's Leaderboard and will motivate participants to maintain their exercise routines!

## CHALLENGE DETAILS

### # OF POINTS:

To complete the Challenge, participants must log at least 30 points. The maximum number of points is 276!

### EXERCISE POINTS AND LOGGING:

Participants can earn up to three points a day depending on intensity and duration of their exercise and activity, or based on the number of their steps if using a fitness tracker. To keep the leaderboard updated, participants are encouraged to log their activity each week.

### EXAMPLES OF ELIGIBLE EXERCISES:

#### ■ Moderate

(.5 point for 15 minutes, up to 3 points)  
*Boxing, dancing, hiking, mowing, softball, tennis (doubles), walking, water skiing*

#### ■ Vigorous

(1 point for 15 minutes, up to 3 points)  
*Basketball, bicycling 10+ mph, football, jogging, mountain climbing, racquetball, soccer, step aerobics*

### EARNING VIRTUAL MEDALS

The Blue & You Fitness Challenge now has virtual medals to keep your team motivated past completion. Participants will receive virtual medals in the following intervals:

Bronze: 30 points • Silver: 60 points • Gold: 120 points • Platinum: 184 points

## EVALUATING SUCCESS

Group members will have access to real-time progress data on the Leaderboard that shows how the group is doing compared to others.

Group administrators can access a post-contest survey online that group members complete anonymously. This information helps determine the success of your group's contest as a whole and your teammates' personal success.

## PROMOTING AS A PARTNER

The Blue & You Fitness Challenge name and logo are registered by Arkansas Blue Cross and Blue Shield. If your company or group holds its contest during the same time as the Blue & You Fitness Challenge, please contact Arkansas Blue Cross (1-800-686-2609) for information on how to include the logo and/or language in your communication pieces so that your contest may be identified as being held "in conjunction with," "as part of" or "along with" the Blue & You Fitness Challenge.

*Easy to use!*

**YOU CAN LOG YOUR EXERCISE WITH YOUR SMARTPHONE.**

[BlueandYouFitnessChallenge-ark.com](http://BlueandYouFitnessChallenge-ark.com)

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