

HEARING PURSUANT TO TITLE 74 OKLAHOMA STATUTES  
SECTION 1325  
FOR THE STATE OF OKLAHOMA

HEARING HELD AT OMES-EGID OFFICE OF  
MANAGEMENT & ENTERPRISE SERVICES EMPLOYEE  
GROUP INSURANCE DIVISION  
IN OKLAHOMA CITY, OKLAHOMA  
ON OCTOBER 28, 2015

REPORTED BY: DAVID BUCK, CSR

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**A P P E A R A N C E S**

**The Panel:**

**Frank Wilson, EGID Administrator**

**Scott Boughton, Legal Counsel for  
OMES-EGID**

**Dana Dale, OMES Deputy Director of  
Performance and Efficiency**

**Teresa South, EGID Director of Network  
Management**

**Paul King, EGID Chief Compliance  
Officer**

**Joe McCoy, OMES Director of Performance  
and Efficiency**

**Dr. Frank Lawler, EGID Chief Medical  
Officer**

**JoAnna Younts, EGID Reimbursement  
Consultant with Berkeley Research Group**

1 (10:02 a.m.)

2 MR. BOUGHTON: Welcome, everyone. We're going to  
3 go ahead and start the public hearing now. I'm Scott  
4 Boughton, legal counsel for the Employees Group  
5 Insurance Department of the Office of Management and  
6 Enterprises Services. We go by the acronym OMES-EGID  
7 or sometimes just EGID.

8 We are here to discuss proposed changes to  
9 Outpatient Hospital Facility reimbursement  
10 methodologies for providers contracted with EGID and  
11 the Oklahoma Department of Corrections. OMES-EGID is  
12 at this hearing to listen to your views and concerns.

13 This is not an official meeting as defined  
14 by the State's Open Meeting Act. This is a hearing  
15 called pursuant to Title 74 Oklahoma Statutes Section  
16 1325 which provides, quote, the Office of Management  
17 and Enterprise Services shall schedule a hearing  
18 thirty days prior to adopting any major change in the  
19 reimbursement rates or methodology. The Office shall  
20 notify health care providers who provide services  
21 pursuant to a contract with the Office at least  
22 fifteen days prior to the hearing. The notice shall  
23 include proposed changes to the reimbursement rates or  
24 methodology. The Office shall also inform such health  
25 care providers at the hearing of any proposed changes

1 to the reimbursement rates or methodology. At the  
2 hearing the Office shall provide an open forum for  
3 such health care providers to comment on the proposed  
4 changes, end quote.

5 This meeting is being recorded and will be  
6 transcribed. The transcript of this meeting, along  
7 with EGID's responses to the comments offered today  
8 will be posted on EGID's website on or before  
9 December 11, 2015. If you have any additional written  
10 comments after today we ask that you deliver them to  
11 EGID by November 13, 2015. As of today EGID has  
12 received one written comment from Mercy Hospital, Ft.  
13 Smith.

14 There are sign-up sheets in the back. If  
15 you want your presence reflected in the transcript of  
16 this hearing, please be sure to sign in.

17 At this hearing EGID's Chief Medical  
18 Officer, Dr. Frank Lawler, will give a PowerPoint  
19 presentation on EGID's proposed Outpatient Hospital  
20 Facility reimbursements. This will be followed by  
21 public comments.

22 Any person who wishes to comment, after you  
23 are recognized please come to the center podium and  
24 speak into the microphone. Please give us your name  
25 and any organization you may represent.

1 Up on today who is here with me is Frank  
2 Wilson, EGID's Administrator, Paul King, EGID's  
3 Compliance Officer, Dr. Frank Lawler, EGID's Chief  
4 Medical Officer, Mr. Joe McCoy, OMES Director of  
5 Performance and Efficiency, JoAnna Younts, she works  
6 with Berkeley Research Group and is retained as our  
7 reimbursement consultant. Next to her is Dana Dale,  
8 OMES Deputy Director of Performance and Efficiency,  
9 and at the end is Teresa South, Director of Network  
10 Management.

11 I think at this time our Administrator,  
12 Frank Wilson, wants to say a few words.

13 MR. WILSON: Sure. Thank you, Scott.

14 I want to thank everyone for coming today,  
15 particularly those of you who have participated in  
16 this process with us as task force members. As many  
17 of you know, we try to utilize a very transparent  
18 process when we consider these types of changes to the  
19 plan's reimbursement. The proposed changes that  
20 you're going to see today are really a long time in  
21 the making. These changes have been considered and  
22 discussed with various representatives of the affected  
23 provider community for probably just over a year.  
24 They represent some of the more significant changes in  
25 reimbursement methodology that this plan has

1       undertaken in quite some time with the overarching  
2       goal of these changes being to move the plan away from  
3       reimbursement that is based on a percentage of billed  
4       charges and to set those fees for those services at a  
5       level that is more representative of other commercial  
6       payers in the state. And based on all of our research  
7       and our consultant's information and really everything  
8       else that we could get our hands on over the past  
9       year, we're very, very confident and we believe we  
10      have very good evidence that proposed changes that  
11      you're going to see today accomplish those goals in a  
12      very fair and equitable manner.

13                But again, thanks to all of you,  
14      particularly those members of the task force that have  
15      helped us along. Hopefully many of the changes that  
16      you see today have incorporated a lot of the feedback  
17      and suggestions that we received from many of you over  
18      the course of this past year. So thank you very much  
19      and we do sincerely appreciate your partnership with  
20      this plan in taking care of our public employees and  
21      their families.

22                So with that I'll turn it back over to  
23      Dr. Lawler. And if you'll excuse me, I have to be in  
24      a meeting at the Capitol here in about thirty minutes,  
25      so I'll participate for part of this, but I can assure

1 you you're in good hands for the rest of this meeting.

2 DR. LAWLER: As Mr. Wilson said, over the past  
3 several years we've been examining various areas of  
4 reimbursement. We've covered inpatient. We've  
5 covered injectables, dialysis. And our current task  
6 as Mr. Wilson said is outpatient reimbursement. It's  
7 been seven years since outpatient reimbursement was  
8 last reviewed. Surgical codes, CPTs 10000 through  
9 69999 and covered revenue codes are reimbursed using a  
10 percentage of billed charges. Urban is reimbursed at  
11 60 percent of billed charges and rural facilities are  
12 reimbursed at 70 percent of billed charges. Most of  
13 the remaining codes have established allowable fees  
14 ranging from 125 percent of Medicare to 300 percent of  
15 Medicare.

16 Also, no lesser of billed charges or  
17 allowable fees on a line item or claim level, which  
18 means, you're going to get paid the allowable if it's  
19 lower or the billed charge of -- billed charges if  
20 it's equal or above. There is no multiple procedure  
21 discounting. Also Department of Corrections, DOC, and  
22 HealthChoice use the same reimbursement methodology.

23 So our objective was to evaluate whether  
24 EGID payment levels for outpatient services are in  
25 alignment with common industry practices. We do not

1 propose any changes in methodology for injectables,  
2 per diem services or commonly-billed dialysis codes.

3 The steps that were taken included retaining  
4 external consulting services to assist in data  
5 analysis and to identify reimbursement options that  
6 are consistent with industry practices. We have  
7 reviewed our utilization, our reimbursement levels and  
8 historical cost trends both for us and for the  
9 industry. Outpatient cost increases have been  
10 disproportionate to utilization and case mix changes.  
11 Over 50 percent of outpatient reimbursement is at a  
12 percentage of billed charges.

13 Additional analytical steps include  
14 assessment of EGID reimbursement levels in the context  
15 of other commercial payers, actual line item or  
16 procedure level charges versus case level allowable  
17 fees. Also we looked at Medicare payment levels and  
18 policies. Under Medicare's Outpatient Prospective  
19 Payment System, OPPS, certain charges are packaged and  
20 are not reimbursed at the line item level. Medicare  
21 does discount secondary and tertiary procedures at  
22 50 percent. We do not do that and do not plan to  
23 change.

24 So, the task force process that has been  
25 used for other reimbursement methodology changes has

1       been followed in this case. We established an  
2       outpatient task force and presented the following  
3       proposed reimbursement changes in December of 2014.  
4       CPT codes 10000 through 69999 were to be billed  
5       eventually at 170 percent urban and 180 percent rural  
6       of the Medicare National Addendum B amounts. There  
7       would be discontinued payment of packaged services  
8       such as indicated by specific Medicare status  
9       indicators. Other proposed changes at that time were  
10      C-codes that were not packaged would be processed at  
11      170 percent of urban, 180 percent of rural of  
12      Medicare. We would plan to continue with no multiple  
13      procedure discount, no changes to the 70,000 or the  
14      90,000 series codes. We would continue with the urban  
15      and rural differential and there would be no outlier  
16      payment for outpatient services as there is in  
17      inpatient.

18               At that first task force meeting there was  
19      plenty of feedback. Among the most common task force  
20      feedback was to establish tiers similar to the  
21      inpatient tiers that have been established for  
22      reimbursement. Also it was recommended by our task  
23      force members to continue reimbursement for implants  
24      and high cost drugs, which are revenue codes 274  
25      through 279 and revenue code 636 on a couple of

1 different bases, the cost plus approach or as a  
2 percentage of billed charges approach with an annual  
3 cap on chargemaster increases. Another recommendation  
4 was to establish a fee schedule with an inflation  
5 factor rather than tying rates to Medicare. Another  
6 recommendation was to establish different markups over  
7 Medicare for different service lines. For example,  
8 higher markups for higher cost services such as  
9 orthopedics or even implants. There was also  
10 recommended a larger urban/rural differential and  
11 reimbursement. Another suggestion, recommendation was  
12 to exclude Critical Access and Sole Community  
13 Hospitals from the methodology and continue to pay a  
14 percentage of billed charges. Another recommendation  
15 as we have done in the outpatient -- as the inpatient  
16 changes is to phase in the percentages over three  
17 years.

18 So to continue with the task force process,  
19 in order to be responsive to our task force members'  
20 concerns, EGID and its consultant conducted additional  
21 data analyses and benchmarking and in July 2015 issued  
22 a revised proposal which incorporated many of the task  
23 force recommendations. Again, we received several  
24 comments from the task force members. Among these  
25 task force concerns are that the reductions are too

1 large. Our response to this concern are that shifting  
2 from a charge-based reimbursement approach to a  
3 fee-schedule approach will have a larger impact on  
4 those facilities that have the highest charges.  
5 Analysis was performed and sought to balance the  
6 impact as much as possible, but it's difficult to do  
7 so for facilities where high charges are in place.

8 Another task force concern on the revised  
9 proposal was that the fully phased-in rates will be  
10 among the lowest compared to other commercial payers  
11 in Oklahoma. The response is that the analysis  
12 indicates that the aggregate reimbursement under the  
13 proposed revised proposal will be in close range of  
14 market levels.

15 Continue with the task force process. The  
16 new concerns on the revised proposal was that the  
17 proposal does not account for high-cost devices,  
18 high-cost drugs or specialty services that some  
19 facilities provide. Our response is that the Medicare  
20 Outpatient Proposal System -- Payment System is based  
21 on resource costs and accounts for high cost devices  
22 and drugs within the APC, or Ambulatory Payment  
23 Classification rates, which are reviewed annually.  
24 Also, EGID will follow most of Medicare's policy  
25 regarding packaging and payments. However, select

1 implant-related revenue codes will continue to be  
2 reimbursed at a percentage of billed charges. Also,  
3 Medicare uses multiple-procedure discounting, known as  
4 MPD. Our proposal does not include this discounting  
5 which could result or definitely would result in  
6 additional reductions. The vast majority of  
7 outpatient services billed to EGID are routine  
8 surgical procedures.

9 One of the things that has been a point of  
10 perhaps contention is that some facilities are  
11 calculating a different financial impact from what  
12 EGID's modeling shows. The response to that concern  
13 is that facilities may be calculating the impact using  
14 different assumptions regarding inflation, Medicare  
15 rate increases and/or the anticipated chargemaster  
16 increases. Facilities may have misunderstood the pro  
17 forma fee schedule that was provided during the task  
18 force process. Many of the codes that currently  
19 allowed at 60 percent or 70 percent depending on  
20 rural/urban distinction will remain that way when  
21 indicated by the status indicator of by report, for  
22 example, code G0378. There are detailed claim  
23 examples that were provided during the task force  
24 process and these focused only on changes in allowable  
25 fees for those codes where there was a proposed

1 methodology change. Not all fees will be subject to  
2 the changes. And we do want to thank our task force  
3 members for their time and consideration. We have  
4 tried valiantly to address them.

5 So, having done the initial proposal, the  
6 revised proposal, the plan is to establish tiers  
7 similar to the inpatient tiers. Tier 1 would include  
8 network urban facilities with greater than 300 beds.  
9 Tier 2 would include all other urban and non-network  
10 facilities. Tier 3 would be Critical Access  
11 Hospitals, Sole Community Hospitals, Indian, Military,  
12 VA and other government facilities. Tier 4 would  
13 include all other Network rural facilities. For  
14 inpatient, Tier 4 remains frozen until Tier 2 base  
15 rate exceeds Tier 4, which is estimated to occur in  
16 2023. At that time the tiers will be collapsed and  
17 both inpatient and outpatient Tier 4 hospitals will be  
18 moved to Tier 2. The phase in changes will be over  
19 the next three years, April 1st, 2016, April 1st, 2017  
20 and April 1st, 2018. And we have some charts and  
21 graphs that will explain that.

22 The code ranges allowed are as a  
23 tier-specific percentage of Medicare. Surgery codes  
24 within the affected range, 10000 to 69999, that are  
25 not packaged by Medicare, cardiovascular and other

1 codes within 92900 to 93999 that are not packaged by  
2 Medicare, and HCPCS C codes that are not packaged by  
3 Medicare. You can see the distribution here by tier  
4 and by implementation date and these are all as a  
5 percentage of Medicare.

6 Revenue codes that are currently billed at  
7 60 percent or 70 percent of billed charges, generally  
8 Medicare packaged revenue codes, will initially be  
9 allowed at a reduced percentage of billed charges and  
10 for all tiers this will be 25 percent on April 1st of  
11 next year, 10 percent on the year after and then no  
12 payment on covered revenue codes that are packaged.  
13 Covered implants will be allowed at the CPT/HCPCS  
14 allowable fee or if there is no fee or code then  
15 revenue codes 275, 276, 278 and 279 will be allowed at  
16 30 percent for urban and 35 percent for billed  
17 charges. And then you can see, again, the tier  
18 distribution and the implementation schedule.

19 Also the revised proposal includes no change  
20 or no phase in for colonoscopy services. Allowables  
21 will begin at fully phased in levels effective April  
22 1st, 2016. Again, the tier level is shown in the  
23 graph and the implementation date and for those  
24 specific CPT and HCPCS codes these are the percentage  
25 of Medicare that will be implemented. Revenue codes

1 associated with colonoscopy procedures currently  
2 allowed at 60 percent or 70 percent depending on their  
3 urban/rural distribution will initially be allowed at  
4 reduced percentages of billed charges and then they  
5 will be phased out. And this is, again, referring to  
6 the revenue codes for all tiers, you see the schedule  
7 for April 1st of next year, for 2017 and then for  
8 2018.

9 As additional procedures are identified for  
10 HealthChoice Select program, and for those of you who  
11 are not familiar with that, we will be happy to  
12 explain that at a future time, these procedures will  
13 go to fully phased in reimbursement levels effective  
14 with the next quarterly fee schedule update with  
15 appropriate notification. Again, there are no  
16 methodology changes to the 70000, 80000 or 90000  
17 series codes. There are no plan changes to  
18 injectables, dialysis or per diem services. There is  
19 no plan to implement multiple procedure discounting.  
20 There is no lesser of billed charges or allowable fees  
21 based on a line or claim level. Clinical edits will  
22 still apply. Plan provisions and limitations for  
23 non-covered services will still apply.

24 So the timing of the fee schedule updates is  
25 April 1st, 2016 for the first one. Again, these will

1 be comprehensive updates based on the 2016 National  
2 Medicare Addendum B amounts. On July 2016, August --  
3 excuse me, October 1st, 2016 and January 1st, 2017  
4 updates will be implemented for adds, changes and  
5 deletes. The next major update after that will be  
6 April 1st, 2017, which will be comprehensive updates  
7 based on the National Addendum B amounts for  
8 January 1st, 2017. And then quarterly updates will be  
9 implemented and then finally April 1st, 2018  
10 comprehensive updates will be based on the  
11 January 1st, 2018 National Addendum B amounts.

12 So what is the impact of the proposed  
13 changes? While most hospitals will experience an  
14 increase at the line or procedure level, they may  
15 experience overall reductions in case level payments  
16 and this is primarily due to phase out of codes  
17 considered packaged by Medicare. There will be a  
18 greater impact for hospitals with relatively higher  
19 charges. The fully phased-in payment levels will  
20 result in a case payment level within the range of  
21 Oklahoma commercial payer levels, which is our  
22 objective.

23 So here's the timeline. Here we are today.  
24 Public hearing written comments are due November 13th.  
25 We will have these posted to the website

1 December 11th. And, again, you can see the  
2 implementation.

3 I'll turn it back over.

4 MS. DALE: Actually, I'm sorry, Dr. Lawler and  
5 everyone present, I need to make a couple of  
6 clarifications, please.

7 If you would go back, Jason, to Slide 13.  
8 That first column January 1, 2016, I believe this is  
9 also in the handouts if you all picked them up here,  
10 we're driving this presentation off the website and  
11 the printout I believe reflects that. Anyway,  
12 January 1st, 2016 is incorrect. It is April 1st, 2016  
13 and we'll make that correction and make sure it gets  
14 posted to the website.

15 The other thing I want to point out is I  
16 believe it's slide 16, Jason. That first bullet point  
17 may not be reflected in the written -- I'm sorry, the  
18 printed materials that you have in your hands right  
19 now, but obviously it's on the website and it is part  
20 of the final revised proposal.

21 MR. BOUGHTON: Did everybody understand what Dana  
22 was talking about there, the difference between your  
23 written materials and what's on the web there?

24 Thank you, Dana. Thank you, Dr. Lawler.

25 Anybody have a public comment? This is the

1 venue for it. Please step forward and give us your  
2 concerns.

3 (A brief pause.)

4 Okay. Well, I appreciate everybody being  
5 here and I guess we'll conclude the meeting. Thank  
6 you.

7 (Hearing concluded at 10:26 a.m.)  
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