EMPLOYEES GROUP INSURANCE DIVISION

OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES

HEARING FOR INPATIENT FACILITY REIMBURSEMENT CHANGES

EMPLOYEES GROUP INSURANCE DIVISION

OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES

HELD IN OKLAHOMA CITY, OKLAHOMA

ON FEBRUARY 12, 2014

REPORTED BY: DAVID BUCK, CSR

APPEARING FOR EGID

Administrator: Frank Wilson

Legal Counsel to EGID: Scott Boughton

Chief Medical Officer: Frank Lawler

Director of Network Management: Teresa South

Berkley Research Group: JoAnna Younts

Performance & Efficiency Division: Dana Dale

Deputy Administrator: Diana O'Neal

Performance & Efficiency Division: Kelly Wilson

Director of Internal Audit: Joe McCoy

Chief Compliance Officer: Paul King

Senior Plan Analyst: Carol Bowman

Appearing Speakers: Rick Snyder
(Oklahoma Hospital Association)

Greg Meyers
(Integris Health)

Appearing by Telephone: Heather Clark
(OU Medical Center)

Dave Bennett
(St. John's Health Systems)

(Beginning of Hearing at 10:00 a.m.)

MR. BOUGHTON: Good morning everyone. Can you hear me okay?

MR. BENNETT: Yes.

MR. BOUGHTON: Thanks.

I am Scott Boughton, legal counsel for the Employees Group Insurance Division of the Office of Management and Enterprise Services. We go by the acronym OMES-EGID or sometimes just EGID. We are here to discuss proposed changes to reimbursement rates and methodologies for providers contracted with EGID. EGID is at this hearing to listen to your views and concerns.

This is not an official meeting as defined by the State's Open Meeting Act. This is a hearing called pursuant to Title 74 Oklahoma Statutes Section 1325 which provides, quote, the Office of Management and Enterprise Services shall schedule a hearing 30 days prior to adopting any major change in the reimbursement rates or methodology. The Office shall notify healthcare providers who provide services pursuant to a contract with the Office at least 15

23 days prior to the hearing. The notice shall include
24 proposed changes to the reimbursement rates or
25 methodology. The Office shall also inform such

1 healthcare providers at the hearing of any proposed
2 changes to the reimbursement rates or methodology.
3 At the hearing the Office shall provide an open forum
4 for such healthcare providers to comment on the
5 proposed changes, end quote.
6 This meeting is being reported and will be
7 transcribed. The transcript of this meeting, along
8 with EGID's responses to the comments offered today
9 will be posted on EGID's website by March 26th, 2014.
10 There are sign-up sheets in the back. If
11 you want your presence reflected in the transcript of
12 this hearing please be sure to sign in. We have a
13 few providers who asked to dial in for this hearing.
14 At this time we'd ask you to go ahead and identify
15 yourself. Folks on the phone, please.
16 MS. CLARK: This is Heather Clark for OU
17 Medical Center.
18 MR. BOUGHTON: Dave, are you still there?
19 We earlier had Dave Bennett on the line.
20 MR. BENNETT: Oh, I'm sorry, I had you on

mute. Yeah, Dave Bennett with St. John Health Systems in Tulsa.

MR. BOUGHTON: Anybody else on the line?

Okay. If you would, go ahead and put your phones back on mute, it will help us out.

At this hearing EGID is going to provide information on proposed inpatient Hospital Facility Reimbursements. Our medical director, Dr. Frank Lawler, will give a PowerPoint presentation followed by public comments. This PowerPoint is available on the OMES EGID website at www.ok.gov/sib/providers. From there you click on the Notice of Hearing under the announcements section of that website and then you click on details of the proposed changes for Inpatient Reimbursement. That will give you Dr. Lawler's presentation.

After Dr. Lawler concludes his presentation here in a minute, the healthcare providers will be asked to comment on the proposed changes. We would ask that any person wishing to provide input come to the center podium and speak into the microphone. Please state your name and any organization you may represent. After those comments have been made we will ask the dial in folks to make my comments they'd

like.

We're going to try to end the meeting by 11:30 if possible, hopefully sooner.

And at this time I'd like to introduce EGID Administrator, Frank Wilson.

MR. FRANK WILSON: Thank you, Scott.

I thought real quickly I'd like to introduce our staff here from EGID, or HealthChoice as most of you know us. To my right, Dr. Frank Lawler, chief medical officer, Ms. Diana O'Neal, Deputy Administrator, and to her right Teresa South, Director of Network Management, of course, Scott Boughton, Chief Legal Counsel, and to Scott's left JoAnna Younts with Berkeley Research, and Dana Dale, Senior Auditor with our Performance and Efficiency Division. Down in front Kelly Wilson, Data Analyst with the Performance and Efficiency Division, Joe McCoy, Director of Internal Audit, Carol Bowman, Senior Plan Analyst. So, that is our team here today.

Just very briefly, Scott said our objective today is to present the proposed changes to the Inpatient Facility Reimbursement and real quickly I'd

just kind of like to remind everyone of what our process has been to get to this point. For the better part of a year now our consultants with Berkeley and our team here at EGID have done a great deal of work analyzing various cost data as it relates to our inpatient claims working closely with our consultants, with Berkeley to compare all the different cost data to various benchmarks that we

have access to and that culminated in an original proposal or recommended changes at which time we gathered a task force of providers, hospitals in this case. Most of you -- many of you are represented here today. We want to thank you very, very much for helping us and participating in that task force. As you know, we solicited feedback from the original proposal and we got a great deal of very, very useful constructive feedback and we very much appreciate that. And as you have seen and hopefully you'll see again here today, we have incorporated much of that feedback into the ultimate recommended, recommended changes.

So, with that I want to turn it over to Dr. Lawler at this time to take us through the proposed changes and we'll -- Dr. Lawler, are we

going to go through the entire presentation before we take questions?

MR. LAWLER: Yes, sir.

MR. FRANK WILSON: Okay.

MR. LAWLER: One housekeeping issue. If you have a phone with you put it on silent or airplane mode if you would.

First slide, please. HealthChoice inpatient background, on October 1st of '07

HealthChoice implemented Medicare Severity Diagnosis Related Groups, MS-DRGs, and changed the outlier formula by increasing the threshold and the marginal factor.

On April 1st of '08 HealthChoice implemented an urban/rural distinction for inpatient reimbursement in conjunction with an outpatient fee schedule reimbursement methodology.

Last October, October 1st, the base rates effective are 8,417 for urban reimbursement and 10,824 for rural reimbursement. The MS-DRG allowable is the base rate applied to Medicare's relative weights.

It's important to make note that the

Department of Corrections, DOC, reimbursement utilizes HealthChoice's reimbursement methodology.

Historically, the base rate and outlier threshold have increased an average of two percent annually.

Outlier claims are those claims in which billed charges exceed the MS-DRG allowable plus the outlier threshold. The outlier threshold effective October 1st of '13 are 82,648 for urban reimbursement and 64,256 for rural reimbursement with a marginal factor of 0.8.

The current base rate/outlier combination results in overall high payment levels with the primary driver being outliers.

HealthChoice established an inpatient task force in October of 2013 to provide feedback on the proposed reimbursement changes. The primary objective of this analysis was to determine whether HealthChoice's reimbursement methodology and payment levels for inpatient facilities are in line with common industry practices. The steps that were taken, including the analytical steps, were to obtain external consulting services to assist in data analysis and to identify options for reimbursement

approaches that are consistent with industry practices.

A second step was to review HealthChoice's current reimbursement levels and historical cost trends. Among these trends are from 2009 to 2012, inpatient utilization has decreased by 17 percent. At the same time, average billed charges have increased 24 percent while the base rates have increased six percent.

Another step is to assess reimbursement levels relative to charges, costs, and Medicare and commercial payer ranges. Also we wanted to identify

long term objectives to include reimbursement methodology and payment level assessments for one day stays, observations cases, mental health, rehabilitation, skilled nursing facilities, readmissions, Hospital Acquired Conditions, transfer cases, quality and outcomes measurements, and bundled payments.

HealthChoice's proposed changes to inpatient reimbursement are based on data analysis, its consultant's recommendations, and professional feedback from the task force.

A concern expressed by the task force were, issue one, which is the urban/rural distinction, there are four issues primarily that we are concerned with today, but our primary concern on the rural/urban distinction is that the current urban/rural distinction does not adequately address the difference in facility characteristics such as size, cost structure, and service mix. There is a very large differential between urban and rural base rates.

The recommendation was to establish a four tier system for acute facilities. Tier 1 would include network urban facilities with greater than 300 beds. Tier 2 would include all other urban and

non-network facilities. Tier 3 would include Critical Access Hospitals, Sole Community Hospitals, and Indian, military and VA facilities. Tier 4 would include all other network rural facilities.

So our recommendation is to provide annual updates to the base rate. Tier 1 and Tier 2 would receive 100 percent of Medicare's full market basket percentage with no issue respecting productivity, ACA or other reductions. Tier 3 would receive 50 percent of Medicare's full market basket. Tier 4 would

remain frozen but both Tier 3 and Tier 4 base rates will be reevaluated annually.

This table on slide eight shows the various tiers, the number of facilities, the operating and capital cost-to-charge ratios, the average case mix index, the number of beds and provider type. Provider type is outlined in the footnote that there is a classification that is standard.

Also on the rural/urban distinction the rationale was that the tiered reimbursement approach is responsive to task force recommendations to develop a categorical system. HealthChoice recognizes the important role that rural hospitals, rural facilities play in Oklahoma's health system by providing access to residents in less populated

areas. Medicare reimburses 101 percent of the costs to Critical Access Hospitals. Temporarily freezing base rates for larger rural facilities, those in Tier 4, and providing modest increases to Tier 3 facilities aligns with these policies.

A concern expressed by the task force was that the current urban base rate needs to be updated in order to provide a more appropriate level of

payment for non-outlier cases. So the recommendation that HealthChoice has formulated is to provide Tier 1 facilities with a 13 percent increase in the base rate, Tier 2 facilities with a five percent increase in the base rate.

The rationale for these recommendations is the tiered base rates are designed to account for differences in facility size, services and patient severity. Also, proposed adjustments to the base rates are estimated to result in payments that are well above costs for non-outlier cases. Proposed increases to the base rates are also well above Medicare's average base rates for each tier. And proposed base rate adjustments are estimated to result in payments for non-outlier cases that are within close range of other commercial payers in Oklahoma.

The third issue that was addressed was neonatal reimbursement. The concern was expressed that the Medicare MS-DRG relative weights for neonatal DRGs do not appear to be appropriate for HealthChoice's service population. As a result, the allowed amount is almost always more than the billed charges for neonatal DRGs.

The recommendation that has been formulated is that MS-DRG 789 through 794 will be reimbursed at 70 percent of billed charges for all tiers and for MS-DRG 795, which is normal newborn, hospitals or facilities will receive the allowable for each tier.

The rationale for this recommendation is that paying a percentage of billed charges for neonatal care provides a consistent approach for all types of facilities across all tiers.

The fourth issue that was addressed was outlier claims. The concern expressed by the task force was that HealthChoice's charge based outlier formula is susceptible to higher outlier payments compared with other payers, particularly for facilities with relatively high billed charges. Alternatively, Medicare's outlier policy is cost based.

The recommendation was to establish

thresholds for each tier based upon Medicare's current IPPS impact file averaging operating cost-to-charge ratio and capital cost-to-charge ratio for Oklahoma network providers and Medicare's published threshold. The threshold will be updated

each year with implementation of the new MS-DRG version, which obviously comes out annually. The table shows each tier the Medicare Version 31 threshold, the proposed threshold and the current threshold for each tier.

The recommendation also was to establish a marginal factor for each tier based upon Medicare's current IPPS impact file averaging operating cost-to-charge ratio and capital cost-to-charge ratio for Oklahoma network providers. Also to establish a phase in period for the marginal factor. The marginal factor, again, will be updated each year with implementation of the new MS-DRG version. The table shows each tier, the current marginal factor, the phase in schedule and the ultimate full phase in marginal factor in the last line for each tier.

The reasoning for the recommendations is that a tiered approach to the outlier methodology along with tiered base rates considers both the costs and charges for similar facilities within each tier.

The proposed tiered thresholds are based upon Medicare's fixed cost or loss threshold and the cost-to-charge ratio for each tier and results in lower thresholds than the current methodology.

Payments under the proposed outlier formula are estimated to be well above Medicare payment levels.

The impact of these proposed changes are that 71 percent of urban facilities would experience a modest increase in reimbursement. Seventy-four percent of rural facilities would experience no change in payments, noting that decreases experienced by rural facilities would be due to proposed changes to neonatal MS-DRGs, that is payments will be made at 70 percent of billed charges rather than amounts greater than billed charges. Additionally, payments for outlier, non-outlier, and neonatal claims are estimated to be well above costs and Medicare payment levels, and within close range of other commercial payer payments. Payments for non-outlier cases for all urban facilities would increase. Payments for outlier cases would be reduced for all facilities. Urban facilities with substantial outlier volume would experience larger reductions.

The proposed timeline is as follows. The

meeting was published on the website January 22nd, '14. The public meeting obviously is today. The

comments are due within 10 days, or end of business on the 21st, which is a Friday. HealthChoice's responses to comments will be posted to the website on March 26th. The fee schedule notice to providers will be out by April 1st and the proposed implementation date is June 1st. Next slide.

In conclusion, the current base rate/outlier combination results in overall high payment levels with the primary driver being outliers. The proposed base rate/outlier combination will bring HealthChoice's urban payments within close range of other Oklahoma commercial payers and substantially above Medicare rates. HealthChoice's rural payments will continue to be above Medicare and commercial payer ranges for several years.

And we'd like to open up for comments. We'll take the in person comments, if someone has any comments, to come up to the podium and please state your name and location and we'll get them on the record and then we'll take phone comments.

MR. SNYDER: Good morning, Rick Snyder from the Oklahoma Hospital Association.

I'd like to echo in a way some of

Mr. Wilson's opening comments of appreciation and

gratitude for the process. I've heard from several hospitals that think that they have had a good opportunity to express their concerns and that EGID has been sincere about listening to those concerns, responding to them to the extent that you can and if nothing else explaining the rationale behind some of the changes. So we do appreciate that.

For the inpatient facility reimbursement recommendations, the outlier payment change, issue four, is going to be a significant payment reduction for some of the urban hospitals. We appreciate that there has been a phase in period added for those reductions but feel that the timeline is very compressed. You get from the current marginal factor to the ultimate where you want to end up in three phases but that's really over a period of just 16 months. The Medicare program when it makes a significant policy change will often phase that in over a period of three years. I've seen some significant policy changes by Medicare phased in over even up to a 10 year period. So, we would like to recommend that you consider a three year phase in for the outlier payment change. One approach you may consider is decreasing the marginal factor by no more

than 10 percent per year. So, if you're at 80 percent now, perhaps 70 percent as a first step, 60 percent following that. This may make the phase in period larger, or longer rather for the larger of the Tier 1 and Tier 2 hospitals than for Tier 3 and Tier 4, but those hospitals are facing larger reductions so I think that's appropriate.

Over the longer term hospitals do want to work with EGID on ways to control expenses in ways other than rate reductions. And you had a slide in the presentation that mentioned some of the long term objectives and we support those objectives. Hospitals support well designed quality reward programs and we'd like to work with the agency in designing these changes in the future.

Patient utilization is really key and we would encourage you to emphasize programs that manage chronic disease and improve health of your members and outcomes to reduce utilization rather than focusing on rate decreases in the future.

Thank you.

MR. LAWLER: Thank you.

MR. MEYERS: Good morning. I'm Greg Meyers. I am senior vice-president with Integris Health. We have several of the hospitals that

Mr. Snyder was talking about impacted by the significant reduction in the outlier calculation and so I wanted to echo his request that EGID consider a phase in period. One of the things that you may or may not be aware of is that larger institutions that have a lot of debt funding are required pretty much by the rating agencies to submit five year budgets to the rating agencies to allow us to keep our bond ratings, which has a direct impact on our finance costs and being able to borrow significant amounts of debt. An aggressive implementation schedule that's proposed right now for Integris in reality creates quite a bit of financial disruption in the five year budgeting process that we've already submitted to the rating agencies and would also request that the EGID take into consideration perhaps extending the phase in period.

The other issue that is perhaps more of a question than a complaint -- and again, I want to echo Mr. Snyder's comments. It's a rare occasion for any payer to allow us to sit down and give some input into our financial future and we really appreciate you all's willingness to do that and especially appreciate the ability and the obvious way that you guys did listen to us and take into consideration a

lot of our comments.

There was sort of an open ended question on one of the slides that Dr. Lawler talked about on the outlier claims on Slide Number 14. There was a comment that says the threshold will be updated each year with the implementation of a new MS-DRG version. I guess my question is to intent. Are you indicating that perhaps that the Tier 1 threshold could be reduced in subsequent years as new DRG versions are released? I was a little unclear as to the intent of that statement.

MS. YOUNTS: I'll answer that.

I think the intent has to do with the timing of the federal fiscal year in terms of October 1st, the MS-DRG version coming out, the published publication of various datasets that are needed in order to do the calculations such as cost-to-charge ratios and so forth, and so all of those things will be brought together on October 1st in order to make any changes to the threshold. So I would answer your question, I think it does leave open the possibility for changes but I don't think that's the intention once the full -- once the full

implementation takes place on October 1st, 2015. So, that's when the full phase in is in effect and then

and so that's -- it's really designed to deal with the phase in on that October 1st and the publication of Medicare's datasets.

MR. MEYERS: But the other issue we face is we've got a methodology based on a federal fiscal year. Most hospitals in Oklahoma the fiscal year mirrors the state's fiscal year, which begins July 1st. So my final request would be that any changes be implemented effective July 1st going forward instead of a midyear change as being proposed right now. A change in the middle of the fiscal year is very difficult from a budgetary standpoint going forward. So, since I'm sure your agency's funding and expenses are based upon a fiscal year, although you have to operate on a planned year, which I understand is different, if you could standardize around the state's fiscal year I think it would be worthwhile and beneficial to us.

Thank you.

MR. LAWLER: Any other comments?

I'd like to solicit phone comments if we could.

MR. FRANK WILSON: Heather, are you there?

MS. CLARK: I am here.

MR. FRANK WILSON: Okay. The floor is

yours if you would like to make any comments at this time.

MS. CLARK: I think that basically I echo some of the comments that have previously been made by Rick and Greg as to the disruption the change in the outlier payment will have to OU Medical System as we've discussed previously and also appreciate the openness and willingness of EGID to work with us and give us opportunity to comment. So, you know, obviously a longer phase in period would benefit us as well.

MR. FRANK WILSON: Okay.

MR. LAWLER: Mr. Bennett, any comments? We may have lost him.

MR. FRANK WILSON: Any other comments from any of our guests on the phone?

Okay, hearing none --

MR. BOUGHTON: We also have here any questions. Does anybody have any questions about the process or about what you've heard today?

I guess we stand adjourned then. Thank you all for coming.

MR. FRANK WILSON: I would like to make some final comments.

MR. BOUGHTON: Okay, Frank, I'm sorry.

MR. FRANK WILSON: I do also want to again thank all of our hospitals that participated in this process. Hopefully, as some of you have indicated, we do appreciate very much the partnership that we have with all of our hospitals across the state. As you can imagine, operating this size of a plan and all the things that we do from an administrative standpoint on one hand as a very large employer of all of our public employees but then on the other as essentially operating very much like a commercial insurance plan presents many challenges for us, not the least of which is attempting to put a price on the extraordinary services that all of our hospitals provide for our public employees and their families across the state. We absolutely do recognize that.

One of our primary charges, of course, as administrators of the plan is to ensure that our teachers, state employees and many other public employees across the state have adequate access to

healthcare services at reasonable, at reasonable cost. I wanted to point out that less than 50 percent of the premiums that are received by this plan are actually received from employers or the state. About half, probably a little bit more are actually received from direct premium contributions

from our employees themselves and our retirees. So, our costs for the plan are certainly directly felt by our members and certainly in the form of premiums. As a self funded nonprofit plan 96 percent of the premium dollars received by this plan are paid out to providers for their services. We certainly understand that this plan will not expect to achieve the most aggressive pricing and that we have to offer a very broad comprehensive network for all of our employees, about 180,000 employees and members in every corner of the state. But at the end of the day we are confident, we certainly take into consideration all of the comments that we heard today, we do remain confident that what is being proposed is in line with industry standards. And certainly one of our missions, one of the missions of our board is to ensure that the provider

reimbursement is appropriate.

I wanted to finally mention the public comments may also be submitted in writing by February 21st.

So, and with that, again, thank you guys very, very much. We do appreciate you. Thank you.

MR. BOUGHTON: We're adjourned. Thank you.

(End of Hearing at 10:34 a.m.)

C E R T I F I C A T E

STATE OF OKLAHOMA)
) SS:
COUNTY OF OKLAHOMA)

I, David Buck, Certified Shorthand Reporter for the State of Oklahoma, certify that the foregoing hearing was taken by me in stenotype and thereafter transcribed and is a true and correct transcript of the hearing to the best of my ability to hear; that I am not an attorney for nor a relative of any said parties, or otherwise interested in said action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office on this 18th day of February, 2014.

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23 David Buck, CSR #1585
for the State of Oklahoma

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