THE STATE OF OKLAHOMA
EMPLOYEES GROUP INSURANCE DIVISION
OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES

HEARING REGARDING CHANGES IN REIMBURSEMENT RATES AND/OR METHODOLOGY FOR HEALTHCHOICE AND DEPARTMENT OF CORRECTIONS DENTAL FACILITIES

IN RE: INJECTABLE DRUGS - FACILITY REIMBURSEMENT
AND
DIALYSIS - FACILITY REIMBURSEMENT

TAKEN IN OKLAHOMA CITY, OKLAHOMA

ON OCTOBER 5, 2012

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A P P E A R A N C E S

EGID OMES ADMINISTRATION MEMBERS:

Frank Wilson, Administrator
Scott Boughton, Legal Counsel
Dr. Frank Lawler, Chief Medical Officer
Teresa South, Director of Provider Relations
Dana Dale, Senior Insurance Auditor
Diana O'Neal, Deputy Administrator of Finance
Paul King, Director of Industry Practice and Compliance
Joe McCoy, Director of Internal Audit
Bo Reese, Deputy Administrator of Administration
Carol Bowman, TPA Liaison

ALSO PRESENT:

Donna Kinzer, Berkeley Research
JoAnna Younts, Berkeley Research

AUDIENCE MEMBERS PRESENT:

Melissa Gonzales, HPES
Christine Brown, Oklahoma Spine Hospital
Randy Ison, Integris Health
Rick Snyder, Oklahoma Hospital Association
Rejeana Allford, Norman Regional Health System
Jane Bolton, DOC
Dr. Miller, DOC
Lisa Coleman, HPI
Liz Lindsey, HPI

I N D E X

(Hearing commenced at 8:30 a.m.)

MR. BOUGHTON: Good morning, everybody. I think it's time to start. Thank you for coming. My name is Scott Boughton, legal counsel for the Employee Group Insurance Division of the Office of Enterprise and Management Services. We go by the acronym OMES EGID or sometimes just EGID. Prior to recent legislative changes the organization used to be called the Oklahoma State and Education Employees Group Insurance Board. We are that group.

We are here to discuss proposed changes to reimbursement methodologies for provider's contract with EGID. OMES EGID is here to listen to your views and concerns. This is not an official meeting under the Open Meeting Act with the State of Oklahoma.

This is a hearing called pursuant to Title 74 Oklahoma statute, Section 1325 which provides, "The Office of Management and Enterprises 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 days prior to the hearing. The notice shall include proposed changes to the reimbursement rates or methodology. The office shall also inform such

healthcare providers at the hearing of any proposed changes to the reimbursement rates or methodology. At the hearing the office shall provide an open forum for such healthcare providers to comment on proposed changes."

This meeting is being recorded and will be transcribed. The transcript of this hearing, along with any of the EGID's responses to the comments raised today will be posted on EGID's website during the week of October 22nd. There are signup sheets in the back. If you want your presence reflected in the transcript of this hearing please be sure to sign in.

At this hearing the EGID is going to provide information on injectables and dialysis. Our medical director, Dr. Frank Lawler will give a PowerPoint presentation on injectables followed by public comments. After that is all completed he will give a separate PowerPoint presentation on dialysis, which will also be followed by public comment. Both of these PowerPoints are available on our website at www.ok.gov\sib\providers, under the Network News section of our website under the link Public Hearings.

Any person who wishes to speak or comment after Dr. Lawler's presentation, after you are recognized please come to the center podium and speak

into the microphone clearly. Please give us your name and any organization you may represent. We hope to conclude the meeting by 10:30 a.m., hopefully sooner.

At this time I would like to introduce Frank Wilson, our administrator of OMES EGID.

MR. WILSON: Thank you, Scott.

Good morning. I'm Frank Wilson, the administrator here at the Oklahoma Employees Group Insurance Division. And what we'd like to do first is kind of just go through some introductions of our staff this morning who have been involved with this project, along with our consultants from Berkeley Research.

As you know, to the far right is Scott Boughton, our legal counsel. To my right is Dr. Frank Lawler, our chief medical officer. And to my left is Ms. Donna Kinzer with Berkeley Research. To her left is JoAnna Younts with Berkeley Research. Teresa South, our director of provider relations; and Dana Dale, our senior insurance auditor at Employee's Group Insurance.

Over to the bottom row to the right is Ms. Diana O'Neal. She's deputy administrator of Finance. And Mr. Paul King, who is our director of Industry Practice and Compliance. And Joe McCoy, director of Internal Audit. Bo Reese, deputy administrator of Administration. And Ms. Carol Bowman,

our TPA liaison and I think a much longer title than I'm prepared to say at this time.

Again, welcome. Thank you for coming this morning. We're here today to look at some changes in our reimbursement methodology. Most of you know the plan that we're talking about here today is the HealthChoice plans. Health Choice plans, as we all know, are the self-funded plans for the public employees, most public employees in the State of Oklahoma.

The changes we're talking about today are a result of several months of research and analysis of our own claim data. And I want to say thanks to all the providers for participating in the task force. Several task force meetings that we had provided lots of good feedback, and I hope you will see some of those things that are incorporated into the proposed changes that you'll see presented this morning.

With that, I will turn it over to Dr. Lawler to kind of walk us through the proposed changes in reimbursement.

DR. LAWLER: There are three ways you can look at this at least. There's a handout at the back. We're going to project it on the screen. And if you have an iPad or iPhone with those capabilities you can

go to our website and follow along. Some of the slides are challenging in some respects to see. Again, I would urge you to get a handout so you can follow along. I will probably refer to the handout myself. So, anyway, we have plenty of handouts at the back.

I'm not too fussy, but you might set your phone to stun or put it on airplane mode, if you would.

So let me walk you through the presentation on facility reimbursement for injectable drugs. Our current reimbursement was instituted on April 1st. HealthChoice, now known as EGID, implemented an outpatient fee schedule with an urban/rural distinction. The hierarchy for establishing injectable outpatient fees is 150 percent or 175 percent depending on urban/rural distinction of the Medicare Ambulatory Payment Classification known as APC. There are four HCPCS codes at 225 percent or 250 percent for urban/rural.

The second approach is 160 percent/175 percent for urban/rural for Medicare Part B drugs. 160 percent/175 percent for urban/rural of Average Sales Price, and 135 percent/150 percent of urban/rural for Average Wholesale Price. Drugs for which none of the above is available are billed out at 60 percent of billed charges. Medicare's rate is ASP plus 6 percent

for codes that do not have an APC rate.

Our objective was to determine whether our reimbursement for injectables is in line with common industry practices. The steps that were taken were to obtain external consulting service, the BRG Consultants, to assist the data analysis and to identify options for reimbursement approaches that are consistent with industry practices.

We wanted to review our current injectable reimbursement levels and explore historical cost trends per our data analytics. The per member per month for injectables increased 38 percent from 2009 to 2010 and increased 58 percent from 2010 to 2011.

So our goal is to compare our current reimbursement rates to billed charges, compare them to Medicare rates and to compare them to commercial payer ranges.

So HealthChoice has developed proposed rates based on data analysis and on consultant recommendations. A really big part of this was to establish a provider task force to obtain feedback on analysis and recommendations. We identified the task force members by reviewing utilization, so our top utilizers and specific parties with a known interest were invited.

Next one is for APC rates and ASP drugs. The recommendation of proposed rate was 120 percent of Average Sales Price, or ASP, for urban facilities, and 130 percent of ASP for rural facilities. The considerations behind this recommendation were that the Icore Trend Report, which is based on a national survey of payers, found that the most prevalent markup over ASP is 10 percent. The Journal of Managed Care Pharmacy reports that increasing use of ASP-based approaches with mark-ups averaging 9.4 over ASP for non-oncology drugs and 10.3 percent for oncology drugs.

The recommendation for non-ASP priced drugs, EGID proposes 100 percent of average wholesale price for both urban and rural facilities. The consideration behind this recommendation are the typical payer industry practice for non-ASP drugs is to establish reimbursement rates at average wholesale price minus a percentage, for example AWP minus 15 percent, to establish a fee schedule based on average wholesale price.

If there is no ASP nor AWP, published rates specific to CPT or HCPCS code that is submitted, HealthChoice proposes that claims above a threshold of $500 be evaluated manually. Again, the rationale is, for claims that are less than $500, the current practice

of 60 percent for urban and 70 percent for rural facilities billed charges will be continued.

For claims above the threshold, providers will be required to submit the drug name, the generic name, the NDC, or National Drug Code, strength, dosage and route of administration in order to price using AWP.

Additional considerations taken into account, comments from the task force is that national payers were used and the analysis failed to determine if proposed reimbursement rates were commensurate or comparable to Oklahoma commercial payers.

HealthChoice response is that national pricing trends are an appropriate indicator of drug costs, because acquisition costs are not necessarily determined locally. Secondarily, based on an analysis of coordination of benefits for professional services where other commercial payer were primary and we were secondary, a large majority of codes reviewed showed 120 percent of ASP for the billed prices -- reimbursed prices. Excuse me.

Another task force comment was that the proposed rates were below acquisition costs. HealthChoice response is that disproportionate share data, DSD, shows that 37 Oklahoma hospitals qualify to acquire drugs under the 340B program, which may enable

them to offer high quality cost effective programs in the outpatient setting. Purchase prices under any -- under the 340B program are well below average sales price.

In addition, for any particular drug in which a provider's cost significantly exceed the reimbursement, the provider should contact EGID Provider Relations to seek an exception process based upon supporting documentation of costs. Certainly, we don't want people to take a loss by serving our members.

Another task force comment was that the increased cost suggest the members are being diagnosed at a higher rate of illnesses treated by the injectables and utilization should be addressed first.

HealthChoice response is that utilization is a factor determined between the provider and the member. However, HealthChoice welcomes the opportunity to work with providers who are willing to identify utilization issues that we can better manage based on objective outcome measures and the standard of care.

Another task force comment was that reductions in reimbursement should be offset with increases in other rates such as administration codes.

HealthChoice response is that administration codes 963 and 964 series, facilities

receive 175 percent or 200 percent of Medicare based on urban/rural distinction. This is projected to be adequate reimbursement for administration codes and will not change at this time for facilities.

Another task force comment was that due to the significant financial impact of this change please consider a two-year phase-in period.

HealthChoice response is that we will implement the rates over a two-year phase-in period. For APC and ASP-priced drugs for 2013 the urban facility percentages will be 135 percent and then 120 percent for 2014. Four codes will be at 175 percent for 2013. For 2013 the rural percentages will be 155 percent and then 130 percent for 2014. Four codes for the rural facilities will be at 190 percent for 2013.

So in conclusion, these reimbursement levels fall within the common commercial level payment range and are significantly above Medicare rates. The proposed rates will provide relative parity for injectable drugs between facilities and professional offices.

The next slide, which is probably unreadable from just about anybody in the room, shows the top 20 codes and the various reimbursements and fees and the proposed fees. And so I would encourage you to

refer to your handout for that.

So let me turn it back over to Mr. Boughton for consideration of comments.

MR. BOUGHTON: If anybody would like to comment, like I said earlier, please come up to the podium and speak into the microphone clearly and tell us who you are and who you represent. We would like to hear from you.

(No response.)

MR. BOUGHTON: If there is no comments I guess we will go on to the next portion of our program. And Dr. Lawler will go ahead and do his presentation on dialysis.

DR. LAWLER: And I do want to thank the task force members for their hard work and input. Hopefully we have been able to address the major concerns. Again, some of these are hard to read and I would urge you to get a handout if you need one.

So let's talk about dialysis reimbursement. On the second slide, which is where we are at here, dialysis providers are currently reimbursed under the outpatient portion of the EGID's facility contract. Network providers receive the higher reimbursement -- rural reimbursement. So whether you're urban or not, if you're network you get the higher

reimbursement rate. Non-network providers receive the lower urban reimbursement rates.

Most payments are made based on a fee schedule for each dialysis unit based on CPT or HCPCS codes. Drugs and laboratory tests are reimbursed separately by CPT or HCPCS code. Codes for which no fee has been established are reimbursed as a percentage of billed charges. The highest utilized code, 90999, which is an unlisted dialysis procedure, is currently reimbursed as a percentage of billed charges.

Our objective in the analysis was to determine whether HealthChoice reimbursement was in line with common industry practices. The analytical steps that we used were to obtain external consulting services to assist in data analysis and to identify options for reimbursement. Again, we wanted to be consistent with standard industry practices as much as possible.

Also, we plan to review the current dialysis reimbursement levels and historical cost trends. According to our data analytical approach the average charge per unit for 90999 has substantially increased over the last three years. And our final goal was to compare reimbursement levels to billed charges, to Medicare rates, and to commercial payer ranges.

Health Choice has developed proposed

rates based on the data analysis and upon consultant recommendations. We've also established a provider task force to obtain feedback on the analysis and recommendations. Again, task force members were identified by reviewing utilization. And, again, I do wish to express my appreciation for the efforts of the task force members.

So where did this get us? Proposed Rates. HealthChoice proposes to accept only CPT 90999 for billing of dialysis treatments. And CPT codes 90935, 90945 and 90947 should be non-covered. The considerations here are that Medicare requires that 90999 be used exclusively to bill for dialysis treatment. A common industry practice is to use 90999 for the facility dialysis treatment, and 90935, 90945 and 90947 for physician evaluation services.

HealthChoice proposes a fee allowable for 90999 of 225 percent of the current Medicare bundle rate for network providers based on the 2012 Medicare rate of $234.52. The 2012 network -- that should probably be the 2013 network rate should be $527.67.

The rationale behind this is that HealthChoice has not established a fee for 90999. Medicare's 2012 bundle payment is equal to $234.52, includes a visit code as well as drugs, labs and other

services.

HealthChoice's rate would apply only to the dialysis visit. And drugs and lab would not be bundled and will continue to be reimbursed separately. This rate would fall within the typical commercial payment per visit.

Next is that under the proposed rates we would propose that 90989 and 90993, which are training codes, will be non-covered. The rationale behind this is that Medicare bundles these codes and then includes a training add-on in its bundled rate. There is virtually no utilization of these codes in our billing history.

Another recommendation is that HealthChoice proposes to continue to reimburse CPT 90940, which is a hemodialysis access flow study at the current percentage of charges. The rationale is that Medicare does not reimburse separately, but it is acceptable to us to have it billed separately.

Another recommendation of HealthChoice proposes a fee allowable for A4657, which is a syringe with or without needle, of $2.50. We believe this better reflects actual cost of the supply kit. The EGID's current allowable -- average allowable, because this is based on billed charges, is 37.30.

So our rationale is that $2.50 is much

closer to the actual cost for the supply kit, but remains well above the Medicare level. Medicare does reimburse separately, but caps payment at 50 cents.

Another recommendation is that HealthChoice proposes to continue to reimburse for drugs separately according to our fee schedule. The rates recommended for consideration for all injectable drugs, including dialysis drugs, are for network dialysis facilities, as we talked about in our last presentation, 155 percent of average sales price for 2013, 130 percent of average sales price for 2014.

For non-network facilities it will be 135 percent of average sales price for 2013 and 120 percent of average sales price for 2014. The rationale or consideration behind this are that although most drugs, including the most commonly used dialysis drugs, especially epoetin alfa, are included in the Medicare bundled rate. A number of commercial payers continue to reimburse separately for the cost of drugs. And, again, I would refer you to our previous presentation regarding the injectable drugs under facility reimbursement.

Another consideration is that EGID proposes to continue to reimburse for laboratory tests according to the fee schedule. The rationale is that many commercial payers continue to reimburse separately

for lab tests, although there are some payers, such as Medicare, who now pay a bundled rate and include labs tests in the bundle.

Another consideration is that we got task force recommendations. And from the task force the comment was that accepting only 90999 is not an accurate reflection of dialysis modalities and billing regulations. CMS reimbursement methodology for peritoneal dialysis is different from that for hemodialysis.

The response is that the unit of payment used by Medicare as a single dialysis treatment. And although different equipment, supplies and labor are needed for hemodialysis and peritoneal dialysis, the payment system that began in 2011 does not differentiate payment based on dialysis method for adults. And there is a reference there from the Medicare Payment Advisory Commission.

An additional consideration is that most dialysis services are billed using the CPT code 90999. Both hemodialysis and peritoneal dialysis are paid the same unit -- same per visit under the CMS bundled care system. There is a difference in revenue codes, but CMS requires CPT 90999 to appear on all claims with a billed type of 072X, which is a hospital-based freestanding

dialysis clinic.

For continuous treatments performed at home, such CAPD, which is the peritoneal dialysis, and the cycling peritoneal dialysis, which is CCPD, Medicare pays for three visits per week. For 2013 HealthChoice will pay the established rate per visit. Beginning in 2014 we will cap the payment for CAPD and CCPD.

Additional task force comments. Using Medicare rates as a basis for commercial product reimbursement is not common industry practice. Another comment was that negotiating a mutually agreed contracted rate is the common preferred method for contracting for a commercial population. Another comment was that the proposed rate is less than the large commercial payer. And there is a consideration HealthChoice members might have reduced access to care as a result.

The response to these concerns is that HealthChoice currently allows a percentage of billed charges for 90999. We'd also seek to set a fee allowable that is comparable to other commercial payers.

The information available indicates that the range for other commercial payers is from 250, which is after Medicare, to 525 for some commercial payers.

Commercial payment rates are typically

expressed as a percentage of current Medicare rates across many types of services, mainly to provide a comparison, not meant to separate the two, but provide an easy comparison.

HealthChoice desires to stay competitive with other commercial payers in the market and we want to provide the best value for our members' premium dollars.

Another task force comment was that 90993 should be used for the training aspect of all dialysis modalities. Training is very intensive, it's one-on-one between a nurse, patient and caregiver. The use of home dialysis treatments is increasing.

Our response is that Medicare bundles the training codes, but allows a training add-on in its bundled rate. HealthChoice's volume for training codes has historically been very low. And if use of training increases HealthChoice will review the need for covering that service and set an appropriate allowable. We want to hear from our provider community.

So, in conclusion, the proposed reimbursement level falls within the common commercial level payment range. And establishing a fee for the principal dialysis code of 90999 represents a reduction from the current payment levels that are based on the

percentage of billed charges.

And, again, there is an appendix that has the current fee structure and the proposed fee structure. And I'll turn it back to Mr. Boughton for comments.

MR. BOUGHTON: Would one anyone like to come forward and comment about the dialysis presentation just given by Dr. Lawler?

(No response.)

MR. BOUGHTON: Back to you, Mr. Wilson.

MR. WILSON: Thank you again. I would just close by saying that the goal, of course, of this project was to ensure that the reimbursement for the HealthChoice plans are in line with industry. These decisions that we make in this area, of course, are never easy. We take them very seriously.

And the treatments and medicines that we're talking about here today save lives, they change lives, they allow our public employees to keep doing what they do. In light of that, it's very difficult sometimes from this perspective to put a price on that. It always amazes me how complex this process can be in terms of reimbursement for a health plan. But it is a very critical process and a very important responsibility of this agency.

Again, thank you. Thanks in particular to Rick Snyder and the Hospital Association. We very much value the relationship that we have with our hospitals across the state. That relationship is critical in allowing this plan to continue to provide quality healthcare for all of our public employees across the state. So, again, thank you very much.

With that, I guess we're done.

(Hearing concluded at 9:00 a.m.)

C E R T I F I C A T E

STATE OF OKLAHOMA)
) SS:
COUNTY OF OKLAHOMA)

I, Trena K. Bloye, Certified Shorthand Reporter for the State of Oklahoma, certify that the foregoing transcription is a true and correct transcript of the proceedings; that I am not an attorney for nor a relative of any said parties, or otherwise interested in the event of said action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office on this the 12th day of October, 2012.

Trena K. Bloye
State of Oklahoma
Certified Shorthand Reporter
CSR # 1522
My Certificate Expires DEC 31 2012

Trena K. Bloye, CSR
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