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*North Carolina Hospital Association*

September 26, 2016

The Honorable Charlton Allen, Chairman  
North Carolina Industrial Commission  
430 N Salisbury St.  
Raleigh, NC 27603

Dear Chairman Allen and Commissioners:

The North Carolina Hospital Association (NCHA) recommends to the Commission, as it considers a new rule for ambulatory surgical facilities, that the ambulatory surgical fee schedule should follow the language, percentages and schedule previously adopted by the Commission in Rule 04 NCAC 10J .0103 (see attached). For 2017 and beyond, that rule had provided for 200% of the applicable Medicare rate for ambulatory surgical centers, with the applicable am-surg fee schedule determined pursuant to subsection (g).

As the Commission is aware, the language of this Rule and the fee schedule amounts were developed over a nearly 3-year period after studies of fee schedules in other states; impact analyses by providers, employers and insurers; and consideration of related issues. The impact of moving to 200% of Medicare was a substantial reduction for hospitals and ambulatory surgery facilities, thus leading to the phase-in of the reductions over the 2015 to 2017 period.

NCHA does not support a lower percentage than 200% for hospital outpatient and ambulatory surgery centers. Medicare's outpatient payments are low in comparison to costs, thus requiring a 2x multiplier to provide adequate reimbursement. Even at 200%, the workers' compensation fee schedule rates are lower than what commercial managed care plans pay hospitals for the same services. The rates were set at that level in order to balance adequate reimbursement with the Commission's duty to control medical costs. Rates lower than 200% will likely create an access problem, as facilities providing services to workers' compensation patients cannot sustain lower levels of payment and would need to consider discontinuing providing costlier services or procedures to injured workers. Ensuring an adequate rate is therefore critical in enabling the Commission to meet the third prong of its duty in developing a fee schedule: ensuring that injured workers are provided the services and standard of care required by the Workers' Compensation Act.

NCHA and others have previously provided the Commission with data and studies used in the development of the fee schedule that was recommended to and adopted by the Commission in 2014. Those studies included the following:

(1) NORTH CAROLINA WORKERS COMPENSATION INSURANCE: A WHITE PAPER REVIEWING MEDICAL COSTS AND MEDICAL FEE REGULATIONS, prepared for the National Foundation for Unemployment Compensation and Workers' Compensation; prepared by Philip S. Borba, Ph.D. and Robert K. Briscoe, WCP, Milliman, Inc.; May 23, 2013.

(2) CompScope Medical Benchmarks, 15th Edition, for North Carolina, published by the Workers' Compensation Research Institute, August 2014.

(3) North Carolina Hospital Association/Optum Group Health survey data, June 2013 and July 2014.

(4) Review of states' fee schedule structures, nationally and regionally.

We have reviewed the NCCI/NCRB data, and it is unclear on a number of its assumptions and methodologies, which can significantly impact its findings. NCHA is continuing to review the data with our consultant.

If you have any questions, please feel free to contact me.

Sincerely,

A handwritten signature in cursive script that reads "Linwood Jones". The signature is written in black ink and is positioned above the typed name and title.

Linwood Jones  
General Counsel  
North Carolina Hospital Association

cc. Kendall Bourdon  
Meredith Henderson

04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES

(a) Except where otherwise provided, maximum allowable amounts for inpatient and outpatient institutional services shall be based on the current federal fiscal year's facility-specific Medicare rate established for each institutional facility by the Centers for Medicare & Medicaid Services ("CMS"). "Facility-specific" rate means the all-inclusive amount eligible for payment by Medicare for a claim, excluding pass-through payments.

(b) The schedule of maximum reimbursement rates for hospital inpatient institutional services is as follows:

1. (1) Beginning April 1, 2015, 190 percent of the hospital's Medicare facility-specific amount.
2. (2) Beginning January 1, 2016, 180 percent of the hospital's Medicare facility-specific amount.
3. (3) Beginning January 1, 2017, 160 percent of the hospital's Medicare facility-specific amount.

(c) The schedule of maximum reimbursement rates for hospital outpatient institutional services is as follows:

1. (1) Beginning April 1, 2015, 220 percent of the hospital's Medicare facility-specific amount.
2. (2) Beginning January 1, 2016, 210 percent of the hospital's Medicare facility-specific amount.
3. (3) Beginning January 1, 2017, 200 percent of the hospital's Medicare facility-specific amount.

(d) Notwithstanding the Paragraphs (a) through (c) of this Rule, maximum allowable amounts for institutional services provided by critical access hospitals ("CAH"), as certified by CMS, are based on the Medicare inpatient per diem rates and outpatient claims payment amounts allowed by CMS for each CAH facility.

(e) The schedule of maximum reimbursement rates for inpatient institutional services provided by CAHs is as follows :

1. (1) Beginning April 1, 2015, 200 percent of the hospital's Medicare CAH per diem amount.
2. (2) Beginning January 1, 2016, 190 percent of the hospital's Medicare CAH per diem amount.
3. (3) Beginning January 1, 2017, 170 percent of the hospital's Medicare CAH per diem amount.

(f) The schedule of maximum reimbursement rates for outpatient institutional services provided by CAHs is as follows :

1. (1) Beginning April 1, 2015, 230 percent of the hospital's Medicare CAH claims payment amount.
2. (2) Beginning January 1, 2016, 220 percent of the hospital's Medicare CAH claims payment amount.
3. (3) Beginning January 1, 2017, 210 percent of the hospital's Medicare CAH claims payment amount.

(g) Notwithstanding Paragraphs (a) through (f) of this Rule, the maximum allowable amounts for institutional services provided by ambulatory surgical centers ("ASC") shall be based on the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register ("the Medicare ASC facility-specific amount"). Reimbursement shall be based on the fully implemented payment amount in Addendum AA, Final ASC Covered Surgical Procedures for CY 2015, and Addendum BB, Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for 2015, as published in the Federal Register, or their successors.

(h) The schedule of maximum reimbursement rates for institutional services provided by ambulatory surgical centers is as follows:

1. (1) Beginning April 1, 2015, 220 percent of the Medicare ASC facility-specific amount.

2. (2) Beginning January 1, 2016, 210 percent of the Medicare ASC facility-specific amount.

3. (3) Beginning January 1, 2017, 200 percent of the Medicare ASC facility-specific amount.

(i) If the facility-specific Medicare payment includes an outlier payment, the sum of the facility-specific reimbursement amount and the applicable outlier payment amount shall be multiplied by the applicable percentages set out in Paragraphs (b), (c), (e), (f), and (h) of this Rule.

(j) Charges for professional services provided at an institutional facility shall be paid pursuant to the applicable fee schedules in Rule .0102 of this Section.

(k) If the billed charges are less than the maximum allowable amount for a Diagnostic Related Grouping ("DRG") payment pursuant to the fee schedule provisions of this Rule, the insurer or managed care organization shall pay no more than the billed charges.

(l) For specialty facilities paid outside Medicare's inpatient and outpatient Prospective Payment System, the payment shall be determined using Medicare's payment methodology for those specialized facilities multiplied by the inpatient institutional acute care percentages set out in Paragraphs (b) and (c) of this Rule.