STATE OF NORTH CAROLINA

BEFORE THE NORTH CAROLINA INDUSTRIAL COMMISSION

OCTOBER 3, 2016

PUBLIC COMMENT MEETING BEFORE THE FULL COMMISSION

REGARDING

PROPOSALS FOR THE MEDICAL FEE SCHEDULE

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A P P E A R A N C E S

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Tammy R. Nance

I N D E X

P R O C E E D I N G S

CHAIRMAN ALLEN: We are on the record. I'm Charlton Allen. I serve as Chairman of the North Carolina Industrial Commission. With me today are my fellow Commissioners. I'll start on my right - Commissioner Linda Cheatham, and then Commissioner Bill Daughtridge. And then on my left will be Commissioner Ballance – Bernadine Ballance, Commissioner Christopher Loutit and Commissioner Tammy Nance. And we want to thank each of you for being here today. This is a public hearing regarding some issues that have arisen with our Fee Schedule, and we want to thank all the interested parties who have submitted proposals and for your presentations to come today. It's my understanding - and if there are any additions or corrections to this, feel free to let me know – that the first speaker this afternoon will be Kelli Collins, who is the vice-president of operations for Surgical Care Affiliates, and also with Ms. Collins will be Renee Montgomery, who's a lawyer with Parker Poe, and Stacey Smith with Liberty Partners Group, and it's my understanding that Ms. Montgomery and Ms. Smith will be available to answer any questions or supplement that comment period. The second speaker will be John McMillan of

Manning Fulton, and he is representing other stakeholders who have expressed, you know, a proposal to the Commission. And finally, Linwood Jones with the Hospital Association will be speaking as well. As a reminder, any person or entity wishing to present written comments or other documentation to the Commission in response to a proposal or discussion here today should file the comments and corresponding documentation with the Industrial Commission Rulemaking Coordinator Kendall Bourdon. Ms. Bourdon is at – sitting over at the table to my right. These comments and documentation should be submitted no later than October 10th, 2016, and these responses will be published on the Commission's website within two business days of that deadline. If you are making comments, I will ask you to stay for the entirety of the meeting today. This is to help facilitate, if the Commissioners have any questions that arise after a follow-up speaker, that, you know, there's an opportunity to have those questions answered by the appropriate party. As we articulated in the notice of the meeting, the purpose of this meeting is to take public comment on and consider rulemaking options to address the effects of the August 9th, 2016 court Decision by Judge Ridgeway invalidating the April 1,

2015 Medical Fee Schedule provisions for ambulatory surgery centers. By way of a brief history, Surgical Care Affiliates filed a Petition for Declaratory Ruling regarding the Commission's enacted Medical Fee Schedule last fall. The Commission issued its Declaratory Ruling denying the requested relief. SCA filed a Petition for Judicial Review in Wake County Superior Court. Judge Paul Ridgeway ruled the Commission's Medical Fee Schedule to be invalid as applied to ambulatory surgery centers based on a rulemaking procedural issue going back to the language of the General Assembly Session Law instructing this transition to a Medicare-based Fee Schedule. The Judge granted the Commission's Motion for Stay of the Decision pending the outcome of this litigation on appeal. I say all this to ensure that we are all on the same page moving forward. First of all, we are not here to discuss the validity of the current rule or any of the currently pending litigation. It would be improper and inappropriate to discuss the merits of that litigation in today's setting and would defeat the purpose for which we are all gathered here today, so let's be clear. We are here to allow the public to make proposals, presentations and give oral comments and responses on what to do in light of the ruling.

Although the lower court ruling has been stayed, based on the contingency that Judge Ridgeway's Decision could be upheld on appeal, it is the Commission's responsibility to determine what to do in that potential eventuality. We are operating under the assumption that you all received the analysis provided by NCCI. I would like to provide a few comments on that analysis. As we contemplated eliciting proposals in advance of this public comment meeting, we contacted NCCI to ask if they would be willing and able to price out the various proposals that we would receive. They suggested that instead they provide a range of price proposals because that would provide a better set of benchmarks in evaluating proposals received. We understand that there is a lot of noise in these numbers. The Commission is not taking these analyses to be more than a set of benchmarks, fully aware of all the complications and factors behind these numbers. At this point, this is the best data set that we have to work with as 2015 was a transitional year in that the Medicare-based Fee Schedule went into effect on April 1st, 2015, and, of course, 2016 isn't complete, so there is no complete set of data on the Medicare-based Fee Schedule by which to analyze and compare. In addressing the

baseline use in the analysis and consultation with the actuaries and data analysis experts, the two hundred and ten percent of the Medicare ASC Fee Schedule – or fee rate was selected to be the baseline for this analysis. Because of the effect of Judge Ridgeway's Decision is to invalidate the Commission's Fee Schedule as applied to ambulatory surgery centers, meaning that the maximum reimbursement rate for ASCs revert back to the percentage of charges model, a percentage of charges analysis was not requested from NCCI because it is not a stable model or benchmark in that it is not an easily controllable metric because charges can fluctuate. From the Commission's perspective, our approach to the Medical Fee Schedule is as it should be that it requires us to balance three factors: Number one, appropriate care for injured workers; two, adopting a reasonable reimbursement rate and, three, medical cost containment. Those of you who have experience within rulemaking know that it goes much more smoothly if all stakeholders are in some sort of an agreement or can come to an agreement. The Commission recognizes that there are many competing interests involved, and the Commission hopes that this public comment meeting will allow those interests to be aired in the hopes that

the stakeholders can better understand each other's positions and potentially establish some lines of communication that will result in a reasonable compromise. We will take presentations and comments in the order that people signed up to speak, and I just went over that list. Presentations are limited to ten minutes. That does not necessarily include time spent answering questions from the Commissioners. To help facilitate that time period, to my right, Executive Secretary Meredith Henderson will be tracking that time. When each speaker is at the two-minute mark, she will raise her hand with two, and then likewise one minute, and then she will alert you when your time is up, and then we will ask you to immediately conclude your remarks. With that said, I will now yield the floor to Ms. Kelli Collins with Surgical Care Affiliates for time not to exceed ten minutes---

KELLI COLLINS

MS. COLLINS: Thank you.

CHAIRMAN ALLEN: ---and then questions to follow.

MS. COLLINS: Good afternoon.

CHAIRMAN ALLEN: Good afternoon.

MS. COLLINS: Thank you for allowing me the opportunity to speak with you today. My name is Kelli

Collins, and I'm here on behalf of Surgical Care Affiliates, which is proud to operate seven ambulatory surgery centers – or ASCs – in North Carolina. The question before this panel today is two important parts: Process and patients. And I'd like to take the opportunity to address both of those. With respect to process, three years ago, the Commission tasked a stakeholders group with developing a Fee Schedule for ambulatory surgery centers among others, but did not invite the ambulatory surgery centers to participate. This flawed process was itself without basis since the underlying 2013 legislation did not direct that the ASC Fee Schedule had to be changed. The fact was even underscored by the North Carolina Hospital Association which wrote in a memo, "The legislation did not specify that am surge rates would be changed." As a result, SCA had no option but to file a Request for Declaratory Ruling asking that Commission invalidate its new ASC Fee Schedule. The Commission refused to do so. As suggested by Chairman Heath, SCA then filed a Petition for Rulemaking with the Commission, but the Commission denied SCA's Petition. SCA appealed, and Wake County Superior Court Judge Paul Ridgeway ruled this August that the new SCA Fee Schedule is invalid and that the prior Fee

Schedule should remain in place. Since then, the Commission has filed an appeal to reverse Judge Ridgeway's Decision and is proceeding as if the Judge ruling has never been issued. Throughout this regrettable process, SCA has tried in every way to achieve resolution. Even now, we are seeking an amendment to address procedures that are not currently covered in the invalid Fee Schedule and to ensure that reimbursement allows for site of service decisions to be based solely on clinical judgment, quality outcomes and scheduling efficiencies, all for the sole benefit of the injured worker. And that brings me to the second and most important aspect of this issue: Patients. The Commission's invalidated Fee Schedule creates a significant reimbursement disparity between ASCs and hospital outpatient departments for the same services. Given how many injured North Carolinians depend on a community-based surgical care that ASCs provide, that represents a real threat to patients in our state. Currently, injured workers are forced to receive treatment in a more expensive inpatient setting where scheduling services also takes longer and results in delays of care. Even the Commission admits this since it has said the reimbursement disparity would, and I quote, "…potentially diminish

the pool of doctors available to treat injured employees and reduce the quality and timeliness of care." The Commission went on to concede, and again I quote, "That impact will most likely severely be realized in our state's more rural areas where the quality and availability of effective treatment is already a greater concern." SCA agrees that the only way to ensure injured workers across – access to high quality care and effective care is to create parity between the ambulatory surgery and hospital outpatient Fee Schedules. We therefore urge you to adopt the amendment we have proposed, which includes the following: For those procedures for which CMS has established a Medicare rate, the schedule of maximum reimbursement rates for services provided by ASCs would be the same as the maximum reimbursement rates for hospital outpatient institutional services and, two, for those procedures for which CMS has not established has not established a Medicare rate for hospital outpatient institutional services, the maximum allowable amounts for services provided by ASCs would be fifty percent of bill charges up to a cap of $30,000. Charge master increases would be limited to a zero percent increase for these procedures for the first three years or a revenue

neutral adjustment would be applied as a percentage of a charge paid. In its proposal, SCA has shown how the partially invalid rule on fees for institutional services would be amended to set forth this Fee Schedule for ASCs. The amendment would eliminate the confusion that currently exists, lower the cost for surgical treatment and increase access to timely community-based care. Moreover, an independent analysis has determined that this approach will generate overall savings to the workers' comp system in 2017 of 8.8 million dollars. In closing, we believe the proposed action should be taken both to correct serious procedural flaws and, even more important, to give North Carolinians – injured workers access to the high quality community-based care they want and deserve. Thank you again for the opportunity. I would be more than happy to address any questions you may have. I also have with me Renee Montgomery, our legal counsel, and Stacey Smith with Liberty Partners, both of whom are also available to answer questions. And I did want to take a moment to introduce the administrative members of the SCA team that are in attendance: Jenny Graham, Cathy Libel (phonetic), Debbie Murphy, Tom Lowey (phonetic), Cathy Stout and/or – and Corey Hess and Colleen Lochamy.

And I want to thank the rest of the team for attending. And again, thank you for your time today.

CHAIRMAN ALLEN: Good. And you stayed under ten minutes. Thanks.

MS. COLLINS: Yay.

CHAIRMAN ALLEN: I have a few questions---

MS. COLLINS: Okay.

CHAIRMAN ALLEN: ---if that's all right.

MS. COLLINS: That's – of course.

CHAIRMAN ALLEN: We understand that there is noise, as I mentioned - the NCCI analysis – and it's just one way of looking at things. Can you please explain your statement that the NCCI analysis overstate the costs and understates potential savings of a change to the ambulatory surgical care Fee Schedule?

MS. MONTGOMERY: That was actually – if I may, I'm Renee Montgomery.

CHAIRMAN ALLEN: Ms. Montgomery, if you could step up to the microphone and make sure---

MS. MONTGOMERY: I can do that. The – Chairman Allen and Commissioners, again, I'm Renee Montgomery, representing SCA, and I was involved in the Judicial Review matter on behalf of SCA. The – that point has to do with the fact that the National Council on

Compensation Insurance – the cost analysis it did – it assumed that an invalid Fee Schedule was a valid Fee Schedule, and so they used the invalid Fee Schedule as the baseline, and that is the concern. By using the invalid Fee Schedule as the baseline, it overstated the costs involved and the potential savings. It overstated costs, so it actually is just not a valid comparison. To use that as the baseline makes it appear that it will be much more costly than it really will. As we said in our proposal, and I think Ms. Collins eluded to, SCA has done an analysis that shows that the savings with what it is proposing is in excess of eight million dollars, so that's---

CHAIRMAN ALLEN: I don't want to interrupt---

MS. MONTGOMERY: Okay.

CHAIRMAN ALLEN: ---but if this is a good point, have y'all provided that independent analysis?

MS. MONTGOMERY: We have. We have.

CHAIRMAN ALLEN: Okay.

MS. MONTGOMERY: I believe it was set forth in the proposal itself.

MS. COLLINS: It was. Yes.

CHAIRMAN ALLEN: Okay.

MS. MONTGOMERY: And that is what we think that the Commission should take into account in determining

the rule. And I might also while I'm – while I'm up here, we also had a concern, which was also stated in the proposal, regarding the timing of what was asked of the proponents. It was – the proponents were – if there was proposals to be submitted, the proponents were to assume an effective date of January 2017, and we don't think that's a realistic assumption for a new Fee Schedule. Because of the requirements of permanent rulemaking, that will take significantly longer than the two and a half – three months, and I don't think reading the requirements for a temporary rule – that it would meet the – any of the criteria that would need to be met before a temporary rule could be put in place, so that's a second concern we have about the cost analysis that was done, as well as the directions given to the interested parties.

CHAIRMAN ALLEN: All right. I also wanted to ask – it's my understanding - and perhaps y'all can correct me if my understanding is incorrect – that the – for the states that utilize a Medicare-based Fee Schedule for workers' compensation, for ambulatory surgical centers, the nationwide average rate is 146.7 percent, which is substantially lower than the rule that was adopted by this Commission. Do you have any explanation for why the rule that was adopted by North

Carolina that has been argued to be inequitable is substantially higher than the nationwide average?

MS. MONTGOMERY: Okay. Stacey---

MS. SMITH: You want me---? Oh.

MS. MONTGOMERY: Ms. Smith could respond to that. She works with a lot of other states and is very familiar with workers' compensation schedules.

CHAIRMAN ALLEN: Sure.

MS. SMITH: Hi. Thank you, Chairman Allen. Stacey Smith with Liberty Partners. I work with SCA. I appreciate the opportunity. I – and that point was made both in – well, along the way as far as what the averages are on a state-by-state basis. I think looking at that analysis is just a piece of taking a very small segment of Fee Schedules that exist. I think that analysis is based on NCCI data and not all states are NCCI states, so you're getting a snapshot of those. The two most recent states that went to a Fee Schedule were Connecticut and Alaska. Connecticut went to a percent of Medicare, and they had parity between outpatient and ASC, so they are both paid – I believe it's two hundred and ten percent of Medicare HOPD - ASCs and HOPDs. Alaska did the same thing. They went through quite a process in rulemaking. They did not have a Fee Schedule, and so they just issued a

rule where HOPDs and ASCs are paid at the same rate, which is around – they have a – they do something very specific in Alaska, so they use the Medicare as kind of a baseline, and then they add an Alaska-specific regional code to that, and it's a little bit over two hundred and – it's around two hundred and thirty percent of Medicare, so it varies from state to state. And I said – and I would also say that if the analysis will be done – if that analysis is what's going to hold on part of ASCs, I would like to maybe know what the national average is for HOPDs and if the current HOPD Schedule is higher. So I think it's – you know, I think there's also a lot of dynamics as far as each state is very different on workforce issues, as you well know. I mean North Carolina has a thriving economy. Some states may not be as strong. Rates will be different. Workforce issues are different, injuries, your whole classification of the industries, so it's very hard to look at a state-by-state basis when you look at what the rate is.

CHAIRMAN ALLEN: And I understand that, but I was just intrigued and - you know, for instance, South Carolina, one of our neighboring states, utilizes a Medicare ASC payment rate of a hundred and forty percent.

MS. SMITH: Yeah, yeah. And South Carolina went through some real challenges with their Fee Schedule. When they went through changes and reforms, because of the rates that they set and how low the rate was, ASCs exited the market, and then the hospital outpatient departments exited the market as well, and they had to come back into session and fix their Fee Schedule to make some modifications, and that was specific to some other issues, but there are some very unintended consequences when you don't look at the real needs of an injured worker and what can happen. So there are some very specific – Texas is another example where they put in some pretty significant cuts and had to come back and readjust that Schedule because they saw providers moving out of the market, and it ends up costing employers more at the end because they're going to kick it on the indemnity side if they don't – if they don't get their workers back fast enough.

CHAIRMAN ALLEN: Okay. And can you explain the statement that was made that aligning the ASC reimbursement schedule with outpatient allows for site of service to be based purely on clinical judgment, quality outcomes and scheduling efficiencies?

MS. SMITH: Yes.

MS. COLLINS: Yeah, I can actually take that. We

believe that if there's parity across the Fee Schedule, then the physicians can decide where the patient should be cared for, and, you know, obviously, in an ambulatory surgery environment, we think that's a faster access, you know, higher clinical quality situation than we can create in other places.

CHAIRMAN ALLEN: Okay. And do you have any, you know, backup documentation that can be submitted on that?

MS. COLLINS: I don't. I mean I know that in the document it said that the Fee Schedule changes were limiting access and - by making it more difficult for folks to come to the ambulatory surgery center environment, and if we change that and we have parity in the Fee Schedule, obviously, that would open up access to those operating rooms.

CHAIRMAN ALLEN: Okay. And can you explain why the importance is placed on being paid the same as a hospital outpatient facility?

MS. COLLINS: I think we should be paid the same thing for the same services provided and, again, don't want to not be able to provide the care and the access for the injured workers.

CHAIRMAN ALLEN: Okay. Is that disparity that's based upon the Medicare Fee – well, Medicare's rubric

that has a different rate for hospital outpatient versus ASCs?

MS. COLLINS: I'm not sure I understand what you're asking.

MS. SMITH: I think I understand what you're saying. I think what you're saying is the disparity if you go to an ASC versus HOPD and how the Medicare Fee Schedule is a different Fee Schedule.

CHAIRMAN ALLEN: Right.

MS. SMITH: I think what – the states that you are seeing that – you know, Medicare gives you all good baseline because it's kind of a standard measure, right, so every year, you know, you have a certain amount of codes that are covered at a certain rate coming out of CMS, but I think what's important when you – when you look at a Medicare Fee Schedule is it's not intended to be a Fee Schedule for injured workers. A Medicare Fee Schedule is for patients over the age of sixty-five, and they have very different needs, but it does – it can and does create – could create a baseline of measure, but an injured worker is very different than, you know, a sixty-seven-year-old, you know, woman who hurts her knee or needs a procedure done in an ASC. So while it is in – a good baseline – and I understand what the approach is to the point –

to your question, is why parity – why is parity important. And I think the Commission said it best in its statement of law in regards to the case that "If you don't have parity" – and I'm just using the Commission's words – "you will have behavioral patterns take place." You will have employers shifting patients into a lower side of service because that's for – beneficial to them. You may have, you know, then the higher side of service have access issues or there may be a diminishing – you're going to set up tremendous behavioral issues unless there's parity, and which that was confirmed by the Commission. And you want site of service neutrality. You want an injured worker to be able to go where they feel that they want to go and not having those decisions being made based on the finances of the system. Does that help answer that a little bit for you? Is that---?

CHAIRMAN ALLEN: I think so. Okay. I also wanted to ask about one of the aspects of the proposal that was made, was that, you know, fifty percent of bill charges up to a cap of $30,000 for, as I understand it, the codes that there is not a Medicare reimbursement rate for.

MS. COLLINS: So, again, just asking for parity.

And the way that we interpreted the change that happened on April 15th was that there are certain CPT codes or procedures that are assigned to CMS as considered approved for an ambulatory surgery environment and certain ones that are not. So when NCIC adopted the new Fee Schedule and followed Medicare standards, we removed about thirty-seven procedures from our eligible list that we had been able to do prior in our environment, and those are some pretty high acuity cases.

CHAIRMAN ALLEN: Were there any efforts to try to resolve that with the carriers – the insurance carriers or through UCR?

MS. COLLINS: Through our conversations, and then also in our proposal.

CHAIRMAN ALLEN: Okay. But I take it there was no resolution with those.

MS. COLLINS: There was not.

CHAIRMAN ALLEN: Okay. Do you have any idea of what the percentage of the ASC market SCA represents in North Carolina?

MS. COLLINS: I know that – I think they're on record about a hundred and twenty ambulatory surgery centers in this state. I – we are seven of those. One of our facilities is single specialty, and about

fifty percent of the others are single specialty, either GI or I, so pretty significant portion---

CHAIRMAN ALLEN: Okay.

MS. COLLINS: ---of the multispecialty market, I should say.

CHAIRMAN ALLEN: And, also, I noted in the proposal and in prior documentation that there was the assertion the ASCs provide better quality outcomes and improved return-to-work metrics. Do you have any information to substantiate that?

MS. COLLINS: Well, I do, and would be happy to provide that for you.

CHAIRMAN ALLEN: Okay. Very good. Could you describe to us how and why the discrepancy in payments impact the doctors providing care?

MS. COLLINS: I think the doctors are concerned with the cost to their patients and the cost to the employers, and they're going to choose to take these – or would like to have the ability to choose to take these patients to a lower cost environment. And when we can't do things, they're not on the Medicare-approved list, obviously, that pushes those to a higher cost environment, and if we're not paid in a way that allows us to have a margin on our business or to afford to do the volume, then those things are

going to be pushed into the hospital. So the physicians are making – being forced frankly to make those decisions based on finances rather than the best environment of care.

CHAIRMAN ALLEN: Okay. Help me to understand how if we were to adopt a proposal that has parity between the hospital outpatient rate and the ASC rate that that would create a lower cost environment in the ASC.

MS. COLLINS: Do you want to help me with this?

MS. SMITH: So I think – I think the proposal from SCA presents the parity issue between ASCs and HOPDs. I think that you get into cost savings by providing access to care. If you limit access to care to injured workers, you will see, you know, lower return to work and – longer return-to-work statistics, and what you may be saving on the medical benefit side you're going to – you're going to end up seeing on the cash benefit side. You're not going to have workers going back to work as soon as possible and having greater indemnity benefits paid to them. I think for the SCA proposal of a lower cost site really goes to these codes that were – these procedures that were being done in ASCs prior to the implementation of the April 1st Fee Schedule. And what's happening now is that those codes are being done in a much higher cost

setting of a hospital inpatient. So that's where you get the real savings and a lower cost environment, is allowing these procedures to go back into an ASC setting, putting a cap on what can be spent, keeping the control of the costs with reviews and getting them back into the setting where you can save money through those.

CHAIRMAN ALLEN: Okay.

MS. COLLINS: Our return-to-work data will help you – help shed light on that as well.

CHAIRMAN ALLEN: Okay. And who provided the analysis of that return-to-work data?

MS. COLLINS: We have – we do – we measure clinical metrics, and we work with our physicians' offices to determine all – several (unintelligible) measures.

CHAIRMAN ALLEN: So it's an internally-developed document?

MS. COLLINS: It is.

CHAIRMAN ALLEN: Okay. Also, is it truly the case that ASCs won't do these type surgeries anymore?

MS. COLLINS: The thirty-two on the---?

CHAIRMAN ALLEN: Right.

MS. COLLINS: Yeah, we can't. I mean we are not – we're not being reimbursed in a way that allows us to

even cover the cost of implants for those---

CHAIRMAN ALLEN: Okay.

MS. COLLINS: ---procedures.

CHAIRMAN ALLEN: And, if so, how does that diminish the pool of doctors available?

MS. COLLINS: It doesn't diminish the pool of doctors. It diminishes the access.

CHAIRMAN ALLEN: Okay. Okay. So, in effect, this is really an issue about inpatient versus ASC under Medicare.

MS. COLLINS: Part of the issue is that. Yes.

CHAIRMAN ALLEN: Okay. Were ASCs really getting paid the same under the bill charges model as the outpatient facilities?

MS. COLLINS: I don't believe that Schedule was the same either. No.

MS. SMITH: Well, no, the procedure – it was – let me – since those bill charges. I mean ASCs were paid a hundred percent of bill charges in - around 2008. You all made some reforms in 2009, I believe, and---

MS. COLLINS: And it went to sixty-seven percent of bill charges.

MS. SMITH: Wait. It was seventy-nine percent then. Yeah. And then ASC and HOPD were at - both at seventy-nine percent. And then a couple of months

later, there was the fifteen percent reduction to 67, I think, .15 of---

MS. COLLINS: 15.

MS. SMITH: ---bill charges.

CHAIRMAN ALLEN: Okay.

COMMISSIONER CHEATHAM: Even after---

CHAIRMAN ALLEN: Commissioner---

COMMISSIONER CHEATHAM: Even after sixty-seven percent of bill charges, were not outpatient hospital bill charges higher than ASC?

MS. COLLINS: The Fee Schedule for hospitals typically is higher than it is for ambulatory surgery centers, so, yes, because of that.

COMMISSIONER CHEATHAM: So the Fee Schedule today – you'll be getting less than the hospitals?

MS. COLLINS: That's correct.

COMMISSIONER CHEATHAM: The Fee Schedule that you are proposing – you would be getting the same thing?

MS. COLLINS: Correct.

COMMISSIONER CHEATHAM: And how much of an increase would that be?

MS. COLLINS: Do you know? Do you have that math?

MS. SMITH: It's a forty percent – it's a forty percent reduction actually off of the bill charges number.

COMMISSIONER CHEATHAM: But---

MS. COLLINS: From where we were in April---

MS. SMITH: Yeah.

MS. COLLINS: ---of 2015.

MS. SMITH: From the valid Fee Schedule in effect right now, which is 67.15 percent of bill charges, to the SCA proposal is a forty percent reduction in medical costs.

COMMISSIONER CHEATHAM: I'm sorry. I still missed it. Let's back us up two years. Sixty-seven percent is in place. How much were hospital outpatient receiving for - on the whole, on the average for---

MS. SMITH: I don't – I don't think---

COMMISSIONER CHEATHAM: ---same service as – at an ASC?

MS. SMITH: Yeah. I don't think - we can – we can look up that data, but I don't think we can provide that answer to you right now. All we can do is quote a relative basis of what was happening in the ASC space.

COMMISSIONER CHEATHAM: My sense is that back then the fees going to hospitals were a good deal higher than ASCs which in fact recognized the lower cost structure and that that's what you're talking about eliminating. Correct?

MS. COLLINS: Well, what we're – I would – my impression is that the hospitals were reimbursed higher than us at that time. Yes.

COMMISSIONER CHEATHAM: Right. That's mine as well.

MS. COLLINS: Yes. Yes.

COMMISSIONER CHEATHAM: Thank you.

CHAIRMAN ALLEN: All right.

MS. COLLINS: Thank you.

CHAIRMAN ALLEN: Thank you.

MS. COLLINS: Thank you all very much.

CHAIRMAN ALLEN: Next, I'll recognize and yield the floor to John McMillan.

JOHN MCMILLAN

MR. MCMILLAN: Thank you, Mr. Chairman, members of the Commission. I'm John McMillan. I'm speaking this afternoon on behalf of employers, employer associations and insurance carriers, those who pay the workers' compensation benefits to injured workers and their healthcare providers. The list of these entities appears on page five of the written comments submitted to the Commission on September 26th. The medical costs for the North Carolina workers' compensation system have been an issue for decades, and there have been numerous attempts to bring them in

line with other states, states with which North Carolina competes for economic development. Beginning in 2012, the employer and insurer communities began meeting with representatives of the providers in a negotiation process that lasted almost three years. We agreed to and jointly paid for a consultant who assisted with providing relevant information to all of the parties. We engaged a prominent mediator who met with both sides and with Chairman Heath to help develop Fee Schedules that, one, ensured that worker – injured workers are provided the services and standard of care required by the Workers' Compensation Act; two, providers are reimbursed reasonable fees for providing these services and, three, medical costs in workers' compensation claims are adequately contained. Agreements were reached on the revised Fee Schedules. It was a negotiation process in which there was give and take on all sides with the objective being to meet the statutory standards. Proposed rules were promulgated by the Commission and published in the *North Carolina Register*. A public comment period was noticed, a hearing was held, and the rules with the new Fee Schedules were adopted. Under the previous North Carolina Fee Schedule, ambulatory surgery centers' reimbursement for workers' compensation

injuries was thirty-one percent higher for knee arthroscopy and forty-nine percent higher for shoulder arthroscopy than the thirty-three state median reported by the Workers' Compensation Research Institute. Employers and insurers agreed to the mediated settlement in an effort to avoid litigation on these issues. That has been successful except for one group – Surgical Care Affiliates, LLC. They claim that they did not participate in the Fee Schedule discussions or rulemaking process; our position is set out in our written comments, is that they did through their representatives at the Medical Society, but that is a discussion for another day. As you consider the proposed rule for ambulatory surgery centers, we would ask that you consider adopting the Schedule previously adopted through the rulemaking process or, in the alternative, adopt a phased-in Fee Schedule that would provide for reimbursement rates of a hundred and fifty percent of the Medicare ASC facility specific amount when fully implemented. That would put North Carolina in line with our neighboring states of South Carolina, which is one hundred and forty percent, and Tennessee, which is a hundred and fifty percent; closer to the median of the states that use Medicare reimbursement methodology. For our complete statement, please refer

to our written comments previously submitted. And I'll be glad to attempt to respond to any questions you might have.

CHAIRMAN ALLEN: I have often heard that the Fee Schedule as it was adopted – and I think it's an apt analogy – it's like a finely-woven rug and that once you pull one thread out, the rest of it can become unwoven. Is that a fair assessment?

MR. MCMILLAN: I think it is. I don't want to spend a lot of time on who was representing who at these – at this long, drawn-out, three-year process. Linwood Jones is going to speak for the Hospital Association, and the hospitals own ambulatory surgery centers, so they were participating. ASCs were participating through their representatives in the Hospital Association. The Medical Society was actively participating, was a principal participant in all of the discussions. And hiring the consultant in the mediation, an agreement was reached, and it was a landmark agreement, and we came to a resolution based on Medicare Fee Schedule which is in place in most other states and works.

CHAIRMAN ALLEN: And what is the position, if there is a unified position, amongst your groups that you represent on the adoption of a rule provision that

would account for procedures that could be done at ASCs that are not paid for by Medicare?

MR. MCMILLAN: I've asked that question. My understanding is two things: One is the Commission can adopt a Fee for any such procedures that fall into that category, but, second, that virtually all procedures are included in the Medicare Fee Schedule. Where we get into issues is some of these procedures are bundled, and they include all aspects of the procedure, and sometimes some pieces of that are pulled out. I don't think that's a separate procedure as such, and it's – in the Medicare Fee Schedule, it's woven into the – into the overall price. When they pull it out, then they create an issue.

CHAIRMAN ALLEN: And have any of the proposing entities worked out contractual arrangements with ASCs outside the Fee Schedule that you are aware of?

MR. MCMILLAN: I don't know.

CHAIRMAN ALLEN: Okay. Given that we are supposed to balance the three factors that I talked about earlier and the two hundred percent Medicare ASC rate was acceptable for cost containment purposes in 2014, 2015, what is the impetus now to move it further at this time?

MR. MCMILLAN: Well, the two hundred percent was a

negotiated settlement with the give and take, and the one hundred and fifty is more aligned with what the average is. I think you correctly stated that the average is slightly under a hundred and fifty percent – one forty-six – one forty-seven, and our neighboring states of South Carolina and Virginia are one forty and one fifty percent – South Carolina and Tennessee. Virginia is undergoing rulemaking as we speak, and the General Assembly in Virginia instructed the Commission to adopt a Fee Schedule, and they're in the process of doing that, so they – I think they have a meeting within the next two weeks to discuss the Virginia's Fee Schedule.

CHAIRMAN ALLEN: Okay. Are you aware of any states that have switched to a Medicare – percentage of a Medicare-based Fee Schedule that have later gone back and revised the Fee Schedule rate?

MR. MCMILLAN: I'm sure there may be some, but I don't – I don't know that.

CHAIRMAN ALLEN: Okay.

MR. MCMILLAN: I will point out that Surgical Care Affiliates does business in many, many states that are under the thirty-three state average, and there's a list of those in our written comments, but there are a lot of states in which they have facilities that

operate.

CHAIRMAN ALLEN: Are you aware of any state that has---? I'm sorry. Were you about to say something?

MR. MCMILLAN: No. No.

CHAIRMAN ALLEN: Okay. Are you aware of any state that has subsequently adjusted the rate significantly downward as---

MR. MCMILLAN: I'm not.

CHAIRMAN ALLEN: ---one of y'all's proposals---

MR. MCMILLAN: I am not.

CHAIRMAN ALLEN: ---suggested?

MR. MCMILLAN: I am not.

CHAIRMAN ALLEN: Okay. Do you think that our workers' compensation system in North Carolina is structurally similar to that of the other states, such as South Carolina and Tennessee or Virginia?

MR. MCMILLAN: Every state is a little bit different, but when you say substantially similar, I would say that they are substantially similar.

CHAIRMAN ALLEN: Okay. Y'all have any further questions? Okay.

MR. MCMILLAN: Thank you very much.

CHAIRMAN ALLEN: All right. Thank you. Thank you, Mr. McMillan. Mr. Linwood Jones.

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LINWOOD JONES

MR. JONES: Thank you, Mr. Chairman, and Commissioners. I'm Linwood Jones, general counsel with the North Carolina Hospital Association. Commissioner Ballance, I know you're getting tired of seeing me here. It's like fifteen years I've been over here talking about Fee Schedules for hospitals. I did – we did file a comment letter last week, and it's - the proposal - at least part of the proposal was the same as Mr. McMillan had stated. Let's, you know, adopt the rule we had in place that was negotiated before, which would have hospitals and am surges at two hundred percent of Medicare beginning in January of next year. That is still our proposal. I'll get to the hundred and fifty percent issue in a minute. There are some areas where we – despite that being our proposal, there are actually some areas we agree with some points SCA has made, but, overall, those don't change our opinion about what we've already negotiated and agreed to and what we think is right here. First of all, we don't like Medicare – being tied to the Medicare Fee Schedule for the very reason they've stated. It was developed for elderly Medicaid - Medicare patients, not for a workers' comp population that's typically younger and has different

needs. So that's – it's – you know, we debated a long time, as John talked about. It took a long time for the Hospital Association to agree to a – to get to the Medicare Fee Schedule system to tie our rates to because it presents several – a number of problems for us; the biggest of which I think – and this is what drove the rates more than anything else – is looking at what the rates were in other states. If we had to agree or disagree on a settlement with the payers based on how much financial impact this had on hospitals, we never would have come to an agreement. It was huge. It was a fifty – sixty – seventy million dollar hit just in the first year, so it was a substantial reduction moving from the sixty-seven percent of charges in the implant carve-out to the – what was two hundred and twenty percent of Medicare and what could be two hundred by next year. Another point on that: Most what hospitals are looking at - and am surges may do the same; physicians, too – they're looking at what the other commercial payers are paying and what is BlueCross paying me, what is United paying me for this business. Those are their benchmarks for what they consider to be an appropriate payment. Medicare at two hundred percent is lower than what hospitals are typically paid on Medicare

outpatient, but, again, if that were the only factor driving this, then we wouldn't have been able to agree to it, but we obviously had to look at the plain numbers of what other states were looking at as far as percentages, and you just don't see many percentages above two hundred percent in the other states that we looked at. So there is some – there is an issue there about using Medicare, but we've sort of agreed to it because it's a transparent system, and, frankly, we couldn't find another system to tie it to. We looked at the State Health Plan. We looked at tying hospitals for workers' comp to their commercial plans, but none of that's transparent to payers; Medicare is. All their rules are published. The rates are published. You know what you're dealing with as a payer, and so a lot of that played a big part in driving what we eventually agreed to and recommended to the Commission. A few other notes - and these are more about comments and questions I've heard as we've been sitting here. There was some reference to a memo we had in – that the Hospital Association had in 2012 or 2013 saying am surge is not in the legislation. That's – I probably wrote that. I don't remember that, but that's probably true. At the time we were dealing with this in the legislature, the focus just

at that time was physicians and hospitals, with the understanding that the Commission had the authority to deal with everybody else without us having to put it in legislation, so that's part of the thinking behind why that wasn't in the legislation. Another point where we are – we're still looking at it - and we put this in our comment letter – is we're still unclear on NCCI's analysis, and that's mostly because we don't know what documentation they used, what factors they looked at. We've had a consultant that does workers' comp Fee Schedules in other states, including Georgia and some of the other southern states, take a look at this. We're not saying it's not valid. We're just saying we don't know some of their assumptions yet, and we'll try and dig into that a little more this week and follow-up with you all by written comment on that. There was some comment about a hundred and forty-six percent national average, a hundred and fifty percent. We had a long discussion about that during the mediation and in the year or two leading up to mediation that while some reports, including WCRI, may show that as the average, you – so I think the ASC said you can't really compare a state to state. Some of these states carve out implants and treat those differently, and that makes a huge difference

comparing one state to another. We heard the same thing in South Carolina that the ASCs did after they passed a rate that low at a hundred and forty percent. I wasn't aware of what happened to the ASCs, but we knew the hospitals were exiting the market, didn't want to take the business anymore, and that did go through litigation there, too, I think, and may have been resolved by adding implants back into the hundred and forty percent. I forgot how it was resolved, but there was an issue with going to a rate that low. There was some discussion about ASC rates versus hospital outpatient rates, and, Commissioner Cheatham, I think you kind of seized on the difference there. A lot of that – it's all driven by Medicare, and the reason there's a difference in Medicare is because of the costs. The hospitals are going to have higher costs. That was true when we were billing charges, too. We're always going to have higher costs because we're bringing in the costs of the ED, operating the facility twenty-four/seven. There are a lot of overhead costs that go into everybody's rates whether it's a workers' comp payer or BlueCross making the payment. So Medicare has that difference there, but there are other reasons for that other than just the overhead. We had our consultant – and we'll follow-up

in more detail on this. We had our consultant look at over three thousand procedures that are done by ASCs and hospitals, and out of those – well, let me back up a minute. Medicare determines – looks at these costs in coming up with what they call a weight, and that weight goes into setting these rates. They set it for hospitals, am surges and probably any other facility that's on some kind of Medicare Fee Schedule. So we had our consultant look at the weights. There were about three thousand of them, and two thousand, nine hundred and fifty-two times the hospital outpatient rate – or weight was higher than the ASC weight. A hundred and twenty-five times it was the other way around. So I think what's driving that is that the procedures may look the same. It may be a knee surgery here and a knee surgery there, but you may have lab, imaging and other services that are working their way into the hospital outpatient procedure that aren't necessarily captured in the ASC procedure, so there's some – there's some cost reason for the difference there by Medicare. The thirty – I heard thirty-two and I heard thirty-seven procedures not covered by Medicare. I'm not – I'm not sure exactly what that is. If – it could be as John said. It's things that Medicare considers you to already be paid

for on the overall procedure rate. I don't know that. I haven't – we haven't looked at what those are. We'd be interested in knowing more about that. Certainly, if it's a full procedure and Medicare is not covering it, it needs to be paid for by workers' comp, but if it's something that's gotten – if it's a procedure that's been bundled up into a rate you're already being paid, that's a different issue that would have to be looked at, I think. I'll stop there. I've tried to tackle the questions I heard, but I don't know if you have more.

CHAIRMAN ALLEN: Do you know what percentage of ASCs are hospital-owned in North Carolina?

MR. JONES: I don't, but we think they're around half, maybe more.

CHAIRMAN ALLEN: And I - and I believe the other Commissioners - heard – and, perhaps, we would learn for the first time at a recent WCRI conference that hospital-based ASCs are billing as outpatient entities. Is that correct?

MR. JONES: That's correct.

CHAIRMAN ALLEN: Okay.

MR. JONES: Well, most of them are. Some of them bill the exact same way an SCA facility would bill. It depends on how they're structured and whether they

qualify under Medicare to do that.

CHAIRMAN ALLEN: Okay.

MR. JONES: So this is all driven by Medicare.

CHAIRMAN ALLEN: Right. Is it equitable for a hospital-owned ASC to be billing at an outpatient rate when an ASC – or for the purpose of this question, an SCA-owned ASC is billing at a reduced rate?

MR. JONES: Well, we think so because the hospital outpatient is capturing additional costs an ASC is not going to have. That's the overhead that's coming in from running the ED and the other facilities. There's also – there may also be – and I'm not familiar with them all, but there are requirements a hospital outpatient facility, even an ASC operating as an outpatient facility, has to meet that an ASC doesn't necessarily have to meet. Now I having said that, Congress has just changed the rule for off-campus hospital outpatient departments to put them on the same billing as an ASC, and that's because the hospital off-campus department doesn't have these ED costs and other things to work into their rate. So they're – Medicare is kind of going the other way. They're bringing the off-campus hospital outpatient rates down towards the ASC rate going forward. They've grandfathered in the existing facilities.

COMMISSIONER CHEATHAM: I just – a quick follow-up. You have mentioned that there are certain requirements of outpatients – outpatient departments that differ from ASCs. Did I understand that correctly?

MR. JONES: I believe that's right. Now I don't – I don't – are you about to ask what they are or---?

COMMISSIONER CHEATHAM: I am.

MR. JONES: Okay. Well, we'll have to follow-up, and I think it's more being tied into the emergency department, having call ensured around the clock, certain clinical requirements of having your medical records tied into the hospitals. Some of that's going to drive costs, and some of the additional costs are just being driven by the overhead from the ED and other---

COMMISSIONER CHEATHAM: Okay.

MR. JONES: ---facilities moving into that rate.

COMMISSIONER CHEATHAM: That's enough.

MR. JONES: Right.

COMMISSIONER CHEATHAM: I just needed an example.

CHAIRMAN ALLEN: The Fee Schedule in 2015 was a substantial reduction for all medical facilities. How has that gone?

MR. JONES: It didn't go well when I informed my

members about it, but they've – as far as I know, they've learned to live with it. The payment issues we were anticipating have not been as bad as we expected because no one else – BlueCross, no one else uses Medicare as their fee payment system, and so the concerns were, were the payers ever going to be able to tap into the Medicare system and figure out the payments. And there have been some issues with it, but I think most of the larger payers have it figured out.

CHAIRMAN ALLEN: Do you have any information regarding how it has affected patient care in any way or changed site of service selection?

MR. JONES: We wouldn't know about any change between hospital outpatient and am surge. I don't think it has created access problems, at least not among our members that we know of.

CHAIRMAN ALLEN: Yeah. Are there any hospitals that you're aware of that are refusing or choosing not to take workers' compensation patients due to the reduction in fees?

MR. JONES: Not that we've heard.

CHAIRMAN ALLEN: Okay.

COMMISSIONER CHEATHAM: And I presume all hospitals are continuing to take Medicare patients?

MR. JONES: They all – out of all of them that I know take Medicare.

COMMISSIONER CHEATHAM: Just as they – I mean, there's no denial of access to care there that you know of?

MR. JONES: Right. It's – that's a much bigger volume, and that's part of the reason they will continue taking it at lower rates. Yeah.

CHAIRMAN ALLEN: All right. Thank you, sir.

MR. JONES: Thank you.

CHAIRMAN ALLEN: We would like to take about a ten-minute recess, see if there are any follow-up questions for the other participants. So we'll go off the record, and everyone will stand at ease for about ten minutes, so we'll get back on the record about two ten.

(OFF THE RECORD)

CHAIRMAN ALLEN: All right. We're back on the record. Before we go into any additional questions, it's my understanding no other persons have signed up to speak. Is that consistent with everybody's views here? All right. There are a few additional questions, and, first of all, this is directed at SCA. The independent analysis – we do not seem to have received that here at the Commission. Can that be

forwarded to us? It's referenced---

MS. SMITH: I---

CHAIRMAN ALLEN: Yes, please come.

MS. SMITH: Yeah. Sorry. I think what we provided was the broad range numbers, so how the analysis was conducted is we took the NCCI modeling, you know, because they take the percentage of what ASCs are within the Medical Fee Schedule, what the savings or costs would be; then they apply the discount based on the outliers, so fifty percent discount on reduction, eighty percent increase based on a Fee Schedule increase. We used that methodology and gave you the high top line numbers, but we'll be more than happy to provide the more granular data, and I think that will help, and maybe even getting NCCI involved and using some of the data from the ASC community that they can provide to NCCI and using that data to provide – I think that may give you all a better baseline.

CHAIRMAN ALLEN: Yes, if you would provide that data. What's a reasonable timeframe for that---

MS. SMITH: I'll have to check with---

CHAIRMAN ALLEN: ---to be produced?

MS. SMITH: I'll have to check with SCA and I think some of the other providers, but we'll get back

with you tomorrow on the timeline.

CHAIRMAN ALLEN: Very well. If you could let Kendall Bourdon know that information, please.

MS. SMITH: Sure. Thank you.

CHAIRMAN ALLEN: Okay. And, also, are y'all aware of any circumstance where an SCA has stopped providing care to injured workers in states that have a lower than two hundred percent rate?

MS. SMITH: Yeah, that's a great question as well, Chairman Allen. I think what we would like to be able to provide - and I think some analysis that should be conducted prior to moving into a new schedule is when you look at these averages – what, the hundred and thirty, the hundred and forty percent ASC - is what happened in those states to patients getting care on ASCs' markets. For instance, in Texas, when Texas did some pretty significant cuts, both on the HOPD and ASC Fee Schedule, ASC stopped seeing patients, so there were some real negative consequences, and so I know there are some deadlines coming up on the 10th, but maybe it's something we should do a deeper dive in to see what happened and how injured workers' access to care and ASCs were impacted when those rates went to a certain level. I think that's an important analysis because we can talk about a hundred and thirty, a

hundred and fifty, a hundred and seventy; the real question is when you move to that rate, what does it do to access? And I think the only way you can do that is to go back in some of these states and look at some historical context. There was some data that was provided in Hawaii. Texas referred – used this data in their – when they went through these Fee Schedule changes where you saw some real changes in the quality of providers when the Fee Schedule was reduced. You ended up – you may have some providers out there providing the care, but they're not necessarily the quality of care, and you're not getting the clinical outcomes, but Hawaii did do some pretty extensive research on that, and we'll be more than happy to provide that to the Commission for you to look at.

CHAIRMAN ALLEN: Yes, if you would, and also provide the data from other states to the degree that y'all have that. That would be very helpful.

MS. SMITH: Just a caveat on that. It is very, very difficult to get workers' comp data because the carriers hold it and NCCI holds it, and so maybe the Commission can help assist in that matter as far as finding – getting us some access to the Medical Fee Schedule component of the whole workers' comp spend historically and what portion of that was ASCs. Maybe

we can – it's just very, very difficult. It's a very opaque data system - data set.

CHAIRMAN ALLEN: Okay. I understand. If you could, walk us through the site of service selection process and how parity between hospital outpatients' and ASC rates is so important in that. So, you know, we're – we don't operate in the environment where y'all are coming from, obviously, so it's hard for us to understand. We'd like to have y'all have the opportunity to explain that.

MS. COLLINS: Yeah. I mean I think I understand what you're saying, and it's a good question. I think that where we're coming from is that, again, we think that we should be paid in our environment the same as the care that's provided in other environments. And as far as how that limits determination of where care is administered, I think a physician is going to choose to go to the most convenient place that he can go, and I think, for example, if he has the ability to come to an ambulatory surgery center, that ambulatory surgery center is not reimbursed at a level that allows the costs of that care to be covered, those cases are going to go to the hospital. They're going to go to the hospital environment, and that's the part that we could control if we were paid equitably.

CHAIRMAN ALLEN: And is there any documentation showing the asserted delay in care that is alleged because of the differential in rates?

MS. COLLINS: I don't know that there's anything specific---

MS. SMITH: Yeah. So it---

MS. COLLINS: ---to North Carolina.

MS. SMITH: Yeah. And we can – this all goes back to data sets. I think a broader question is that we – the ability for this sector – or for providers to get data to give you the answers that you're asking is so limited because of who holds that data set, but we can – we'll do our best to try to find you some answers on – I know that SCA has some internal return-to-work statistics, care statistics. I do just want to touch on one point that was brought up during the earlier discussion, and that's just some questions about HOPDs, hospital outpatient, hospital-owned ASCs, you know, SCA ASCs, other ASCs. An ASC is a licensed legal entity, and if a hospital owns an ASC, they own a Medicare-certified ASC, and if they are billing at HOPD rates, they are – they basically are committing Medicare fraud. They have to bill at the ASC Fee Schedule rate. Now a hospital can have an outpatient center, and it can be – if they want to call it

ambulatory surgery center, that's fine, but it's – if it's not a licensed Medicare-certified ASC, it is an HOPD and they're billing at the higher rate, so I think it's real - and physicians cannot have ownership in HOPDs. The hospitals can have ownership in ASCs, so there's – they are very distinct legal entities, and there's no squishiness on how you bill because it is set up by - an ASC is a Medicare-certified facility and the licensing is such, so I just wanted to provide that clarity.

CHAIRMAN ALLEN: Okay.

COMMISSIONER CHEATHAM: I've got a couple of questions. Sorry. I want to go back to a statement that I believe maybe Ms. Smith made that - you know, we talked about the different percentages as multipliers and the real question being what does that do to access. I'm really interested in what does that do to revenues. When you were at the sixty-seven percent level, what multiplier of a Medicare rate would it have taken to break even?

MS. SMITH: I don't think – I don't have that historical data, and I think it varies from ASC to ASC. I think it depends on the provider. So I think - is – so your question is as far as what would a – what would that revenue rate have been translated

to an ASC Schedule, right, and that's what you---?

COMMISSIONER CHEATHAM: Translated to a multiplier times---

MS. SMITH: Multiplier, right, right.

COMMISSIONER CHEATHAM: ---the Medicare rate.

MS. SMITH: Right. And we don't – I don't have that data with me, but we can – but we---

COMMISSIONER CHEATHAM: Could you get it?

MS. SMITH: I think we can try. Yeah.

COMMISSIONER CHEATHAM: I'd be very excited. That would be great.

MS. COLLINS: And please understand that our goal is not to break even at that rate.

MS. SMITH: Yeah.

MS. COLLINS: That's not our goal, even remotely.

COMMISSIONER CHEATHAM: Right. I understand that, but I think that would be helpful and---

MS. SMITH: Well, I – what I can provide for you is the analysis that we did based on going to a two hundred – to going to a parity with the HOPD based on bill charges to the two hundred percent of Medicare HOPD starting in '17, and that would be a forty percent reduction in savings to the workers' comp system.

COMMISSIONER CHEATHAM: I'm probably less

interested in that than my other question, but okay.

MS. SMITH: But I think it's almost relatable, but I think - so we can back out that data for you because if we can – if we can show savings based on a Medicare Fee Schedule from bill charges, then we can probably provide what that rate may have been. Now, given that the codes have changed, the payment underlying Medicare codes have changed from year to year because of CMS's annual adjustments to the Fee Schedule every calendar year.

COMMISSIONER CHEATHAM: Do you generally agree that your overheads at ASCs are less to some---

MS. SMITH: Oh, I can't---

COMMISSIONER CHEATHAM: ---magnitude than hospital outpatient?

MS. COLLINS: I'm sorry. I was talking to (inaudible).

MS. SMITH: Oh. I – no, she asked if the overhead is less in an ASC than a hospital. I think – I think that is a generally discussed – that is a general assumption, yeah, but I---

COMMISSIONER CHEATHAM: Do you know---

MS. SMITH: ---don't think that's---

COMMISSIONER CHEATHAM: ---how much less?

MS. SMITH: ---relevant to the workers' comp

system because I don't – I don't think the employer should be subsidizing a - you know, should they be subsidizing a hospital emergency room? So, you know, I think you have to look at it in the context of care to workers, right, and getting injured workers back, and there's always all these other issues of uninsured patients and, you know, the overhead that hospitals do have because they are, you know, Charity Care, and they are those emergency room providers, but I think in the context of a workers' comp system we have to talk at – what is at heart is getting injured workers back on the job as quickly as possible, which saves employers money.

COMMISSIONER CHEATHAM: So do you have any idea what the difference in overhead percentage might be?

MS. SMITH: I don't.

COMMISSIONER CHEATHAM: No?

MS. SMITH: No.

COMMISSIONER CHEATHAM: Have you had any access to care issues for just Medicare patients at all?

MS. SMITH: Well, Medicare is a totally different patient population.

COMMISSIONER CHEATHAM: I agree.

MS. SMITH: Right.

COMMISSIONER CHEATHAM: I've recently become well

aware of that. Thank you.

MS. SMITH: I just – I - it's just a different – I think it's a different patient population. There are – there are---

COMMISSIONER CHEATHAM: But there are no access to care issues for Medicare in the ASCs?

MS. SMITH: I can't answer specifically to ASCs, but I can answer on a more broadly point. I think if you just moved into Medicare, what you are – you will find is that there are a lot of providers that don't take Medicare, and it is a problem that policymakers contemplate all the time, is – you know, with the spend in the Medicare Program and making sure reimbursement is sufficient in guaranteeing access and what we have seen specifically in the Medicare Program – and we can provide that data to you – is providers leaving the Medicare system because it doesn't reimburse high enough. You see it in cardiology. You see it in general practitioners. You see it across the board in the provider spectrum that they are withdrawing from the Medicare system because it doesn't reimburse at a higher – a high enough level to cover their costs, so we'll be more than happy to provide that data - how many providers are leaving the general Medicare system because of low reimbursement.

And Washington is actually taking this into consideration. They're moving to all these alternative payment models and, you know, bundled payments and – because they know – they're trying to address this.

COMMISSIONER BALLANCE: Are ambulatory surgical centers more likely than, say, hospitals or hospital outpatient facilities to be located in rural, underserved areas?

MS. SMITH: You can answer that?

MS. COLLINS: No, not typically. We're seeing actually more and more of those models; obviously, very restricted in a CON state, as you all know. Typically, they're located within about a three-mile radius of a hospital.

COMMISSIONER BALLANCE: Thank you.

MS. COLLINS: And we do take care of Medicare patients. I want to make sure you know that.

MS. SMITH: Yeah, yeah, yeah.

CHAIRMAN ALLEN: And I have a follow-up to Commissioner Ballance's question. Does SCA have any facilities that are in a rural or underserved area?

MS. COLLINS: Well, I'm going to offend one of my facilities that's represented here, but, yes, we do. We have – in Wilson, North Carolina.

CHAIRMAN ALLEN: Wilson. Okay. No further questions, so we will go off the record momentarily. I want to thank everybody for being here today and the comments that we've received and the material that has been provided to date and will be provided after today's date. It has been especially helpful, and, you know, the Commission will take it under consideration, and, you know, if you're going to be submitting any additional comments, as I stated before, be sure to check in with Kendall Bourdon to do that. Also, we have a rulemaking list serve that Kendall helps maintain. I would suggest that you sign-up for that as well to be apprised of any rulemaking developments, you know, whether in regards to this or any other things, including E-filing. We have some rules that are upcoming with that. So, with all that said, thank you all for being here and thanks for coming. We'll go off the record.

(WHEREUPON, THE HEARING WAS ADJOURNED.)

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STATE OF NORTH CAROLINA

COUNTY OF GUILFORD

C E R T I F I C A T E

I, Kelly K. Patterson, Notary Public, in and for the State of North Carolina, County of Guilford, do hereby certify that the foregoing fifty-six (56) pages prepared under my supervision are a true and accurate transcription of the testimony of this trial which was recorded by Graham Erlacher & Associates.

I further certify that I have no financial interest in the outcome of this action. Nor am I a relative, employee, attorney or counsel for any of the parties.

WITNESS my Hand and Seal on this 5th day of October 2016.

My commission expires on December 3, 2018.

Kelly K. Patterson

NOTARY PUBLIC

Kelly K. Patterson
Notary Public
Guilford County
North Carolina
My Commission Expires 12/3/2018