Parker Poe

Renee J. Montgomery
Partner
Telephone: 919.890.4162
Direct Fax: 919.835.4554
reneemontgomery@parkerpoe.com

Atlanta, GA
Charleston, SC
Charlotte, NC
Columbia, SC
Greenville, SC
Raleigh, NC
Spartanburg, SC

October 10, 2016

Via Hand Delivery

Charlton L. Allen, Chairman
Rincon Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Re:

Dear Chairman Allen and Commissioners:

On behalf of Surgical Care Affiliates, LLC ("SCA"), we are submitting SCA's comments in response to proposals submitted to the North Carolina Industrial Commission addressing fees for ambulatory surgical center services in workers' compensation cases. We also are submitting a number of letters supporting the proposal that was submitted by SCA and opposing the three other proposals that were submitted to the Industrial Commission.

Thank you for the opportunity to provide these comments.

Sincerely,

Renee J. Montgomery

RJM:rms

cc: Kendall Bourdon (via e-mail)
Meredith Henderson (via e-mail)

SURGICAL CARE AFFILIATES' COMMENTS
IN RESPONSE TO PROPOSALS SUBMITTED
TO THE NORTH CAROLINA INDUSTRIAL COMMISSION

October 10, 2016

To: Kendall Bourdon
IC Rulemaking Coordinator
North Carolina Industrial Commission
Delivered via email to kendall.bourdon@ic.nc.gov

Pursuant to the North Carolina Industrial Commission's ("Commission") September 2, 2016 Notice of Public Comment Meeting, Surgical Care Affiliates, LLC ("SCA") respectfully submits the following comments in response to the proposals submitted to the Commission addressing fees for ambulatory surgical center services in workers' compensation cases.

SCA manages seven ambulatory surgical centers in North Carolina and has an ownership interest in each of these centers through wholly-owned subsidiary corporations (hereinafter "SCA ambulatory surgical centers"). The SCA ambulatory surgical centers are located throughout North Carolina and include Blue Ridge Day Surgery in Raleigh, Charlotte Surgery Center, Fayetteville Ambulatory Surgical Center, Greensboro Specialty Surgery Center, Surgical Center of Greensboro, The Eye Surgery Center of the Carolinas in Southern Pines, and Eastern Regional Surgical Center in Wilson.

SCA and the ASCs in North Carolina that support SCA's proposal submitted to the Industrial Commission on September 26, 2016 represent the majority of ASCs in North Carolina that provide surgical services to injured workers covered by the Workers' Compensation Act.

THE OTHER THREE PROPOSALS ARE NOT COST EFFECTIVE AND DO NOT MEET NORTH CAROLINA STATUTORY REQUIREMENTS

North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act and that providers are reimbursed reasonable fees for providing these services. The other three proposals do not meet these requirements.

The other three proposals do not address all procedures that can be performed in ambulatory surgery centers. By crafting a fee schedule that uses only Medicare as its foundation, the other proposals do not recognize that a wide variety of procedures can be performed safely and cost-effectively on the working-age population. The workers' compensation population is typically younger and healthier than the Medicare population, meaning that there are additional procedures that can be performed safely and effectively with a shorter stay. As noted by NCCI "WC claimants have very different demographics, medical conditions, and priorities than retirees.

It would be a mistake to blindly rely on Medicare rates as perfect measures of resources appropriate to treat work-related injuries."[1]

Additionally, for Medicare patients nationwide, covered surgical procedures include "surgical procedures . . . for which standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure."[2] For non-Medicare patients in North Carolina, ASCs are permitted to keep patients for up to 24 hours.[3] This means a non-Medicare patient can stay in the facility overnight, provided they are released within the specified time frame.[4] The ability to keep workers' compensation and commercial patients in the facility overnight broadens the list of procedures that can be performed safely and effectively in the ASC setting.

The failure to include all procedures that can be safely performed on an outpatient basis results in a significant cost to the system. Particularly impactful in the context of workers' compensation injuries are a number of spine codes, many of which are not covered under the Medicare ASC fee schedule but are commonly performed in the ASC setting on working age patients. Total joint replacements (knee, hip, and shoulder) also are paid by Medicare only in the inpatient setting and these cases are routinely performed on patients – especially young and otherwise healthy patients like many injured workers – in the ASC setting.

When confronted with an injured worker who needs a procedure not paid for under Medicare's HOPD payment methodology, a hospital can choose to perform the case in its inpatient setting. The result is a much higher cost to the system of an inpatient stay and procedure. Allowing an ASC to perform cases not on the Medicare ASC list provides an alternative setting for these procedures, and allows the injured worker's doctor to make the decision for his or her patient about the best site of service for these procedures.

The impact of not having a fee schedule that includes all procedures can be shown by the drop in Workers' Compensation cases performed in ASCs since April of 2015 when the invalid fee schedule began being used. SCA's Workers' Compensation cases declined by 4.2% between April 1, 2015-March 31, 2016. An NCCI analysis of volume recently obtained by SCA shows a decline in volume of Workers' Compensation cases by all North Carolina ASCs in 2015 of 8.2%.[5]

SCA's proposed amendment to the regulation serves to align payments for ambulatory surgical procedures with the Medicare fee schedule while at the same time acknowledging that Medicare has not created an allowance for certain procedures that are routinely and safely provided to non-Medicare patients in the ASC setting. As such, SCA is proposing a rate for these services that is consistent with the resources and time involved in providing such procedures. In order to limit the uncertainty of the state's exposure on reimbursement, charge master increases will be limited to 0% increase for these procedure codes for the first 3 years, or a revenue neutral adjustment will be applied to the percent of charge paid.

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[1] NCCI, Effectiveness of Workers Compensation Fee Schedules - A Closer Look, February 11, 2009

[2] 42 C.F.R. §416.166 (b).

[3] G.S. §131E-176 (1)(b).

[4] Federal regulations allow for stays up to 24 in ASCs. See 42 C.F.R. §416.2.

[5] NCCI data includes one quarter of payment not under the invalid fee schedule.

Additionally, the unintended consequences of the cost to the system that would be caused by accepting the other three proposals were not considered in the NCCI analysis. Patients are commonly seen much more quickly in the ASC setting than they can be accommodated in the hospital. None of the costs of this system that result from an injured worker having a delay in access to services were included in the NCCI analysis. Additionally, the costs of having services performed in the more expensive inpatient environment as a result of procedures not contemplated in the outpatient methodology were also considered in NCCI's analysis.

Also, as SCA set forth in its proposal, the cost analysis requested by the Commission wrongly compares new ASC fee schedules to the ASC fee schedule that has been declared invalid.

THE OTHER THREE PROPOSALS ARE OUT OF STEP WITH TRENDS IN MEDICARE REIMBURSEMENT

The other three proposals fail to recognize recent federal Medicare payment policy reforms. In 2015, Congress passed the Bipartisan Budget Act of 2015 (Pub. L. 114-74). The legislation contained a provision that changed the reimbursement methodology for new off-campus hospital outpatient departments. Specifically, Section 603 "would codify the Centers for Medicare & Medicaid Services (CMS) definition of provider-based (PBD) off-campus hospital outpatient departments (HOPDs) as those locations that are not on the main campus of a hospital and are located more 250 yards from the main campus. The section defines a "new" PBD HOPD as an entity that executed a CMS provider agreement [after the date of enactment]. Any PBD HOPD executing a provider agreement after the date of enactment would not be eligible for reimbursements from CMS' Outpatient Prospective Payment System (PPS). New PBD HOPDs, as defined by this section, would be eligible for reimbursements from either the Ambulatory Surgical Center (ASC PPS) or the Medicare Physician Fee Schedule (PFS)."[6] Congress has recognized that ASCs and HOPDs should have parity in their reimbursement by Medicare.

The workers' compensation system should not be responsible for hospital overhead. It has been argued that hospitals have an infrastructure and overhead that necessitates payment for workers compensation cases at higher rates than ASCs. Payment should be equivalent between the two settings for equivalent procedures. When an injured worker requiring surgery visits an ASC, he or she receives the same care as he or she would in a hospital environment. For these cases, the direct costs are equivalent – implant and supply costs, nursing staff, anesthesia costs, etc. Payment for surgery for the same patient, receiving the same treatment – in many cases even performed by the same surgeon – should not be differentiated based on factors and costs unrelated to the workers' compensation system and should be the same regardless of location.

Other states are recognizing the importance of addressing the two sites using the same methodology in setting their medical fee schedules. Alaska and Connecticut, two of the most recent states that enacted legislation related to workers' compensation medical fee schedule reforms specific to ambulatory surgical centers, used the hospital outpatient fee schedule. In 2014, the Medical Services Review Committee in Alaska was directed to create a medical fee schedule

[6] U.S. House Committee on Ways and Means, Bipartisan Budget Act of 2015 Section-by-Section Summary, http://docs.house.gov/meetings/RU/RU00/CPRT-114-RU00-D001.pdf

based on Medicare-based conversion factors. The new schedule became effective December 1, 2015. The Medical Services Review Committee determined that hospital outpatient department and ambulatory surgical centers should be reimbursed as a percent of the Medicare hospital outpatient fee schedule.[7] Similarly, effective April 1, 2015, the Connecticut Workers' Compensation Commission established a medical fee schedule for ASCs based on the Medicare hospital outpatient fee schedule.[8]

SCA's PROPOSAL WILL SAVE THE SYSTEM MONEY

The analysis done by SCA shows that there will be significant savings in adopting the proposal that SCA has submitted. In crafting this analysis, SCA reviewed historical case volume performed at our seven facilities. Cost comparisons were conducted on payments for these procedures under the former methodology of 67.15% of billed charges for procedure codes versus the same procedures paid at the 2017 Service Year reimbursement rate of 200% of hospital outpatient department Medicare rates. SCA estimated a 40% reduction in payments. Using NCCI's methodology to estimate the impact of the fee schedule reforms, the analysis concluded that the resulting overall savings in 2017 to the overall workers' compensation system would be $8.8M (-0.5%).

As noted by the Commission, discrepancies in payments between ASCs and HOPDs would "potentially diminish the pool of doctors available to treat injured employees, and reduce the quality and timeliness of care. That impact will likely be most severely realized in our State's more rural areas, where the quality and availability of effective treatment is already a greater concern."[9] SCA agrees with the Commission that the only way to ensure injured workers access to high-quality, effective care is to create parity between the ASC and hospital outpatient medical fee schedules.

THE REDUCTION IN RATES TO 150% OF THE MEDICARE ASC FEE SCHEDULE PROPOSED WOULD BE VERY HARMFUL TO THE SYSTEM

Reducing the fee schedule to 150% of ASC Medicare as suggested by one proponent would have an even greater negative affect on workers access to surgical care. As noted by NCCI: "The Medicare fee schedule is very useful as a starting point for the design of WC medical fee schedules, but has notable shortcomings for WC, including too little emphasis on return to function and too little sensitivity to cost differences among states."[10] WCRI noted that "if workers' compensation fee schedule rates are higher than Medicare, this does not necessarily mean that the workers' compensation rates are high enough to avoid access-to-care issues for injured workers. The latter limitation arises because providers' decisions about which patients to see are influenced in part by reimbursement rates from alternative payors.

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[7] HB316, Chapter 63 SLA 14.
[8] CT Public Act 14-167.
[9] North Carolina Industrial Commission, Memorandum of Law In Support of Motion To Stay, August 17, 2016.
[10] NCCI, Effectiveness of Workers Compensation Fee Schedules - A Closer Look, February 11, 2009.

If workers' compensation pays higher than Medicare but lower than commercial insurers, there still might be legitimate concerns about access.[11]

In Texas, following drastic cuts in the fee schedule, the number of physicians willing to treat all work-related injuries dramatically declined from 2002 to 2004. Specifically, "[t]hree quarters (77%) of orthopedic surgeons in Texas now limit workers compensation cases, dramatically up from (29%) two years ago. Similar declines in access have occurred for general surgeons and other surgical specialists.[12]

Hawaii experienced similar access issues when its workers' compensation fee schedule reimbursements were inadequate. As noted in a comprehensive review conducted by the state:

> While the impact of the change in the medical fee schedule may not have reached overwhelming proportions, it appears to have affected the treatment of injuries in workers' compensation cases. Health care providers are struggling with a duty to heal, while juggling fiscal responsibilities that will afford them to stay in business to continue to practice medicine. This trend of turning away workers' compensation patients should be given attention before it becomes critical. The medical fee schedule definitely appears to have had a negative impact on an injured employee's access to specialty care and diminished access to more experienced health care providers.[13]

Workers' compensation medical cost variation is not solely driven by the medical fee schedule. As noted by the National Academy of Social Insurance, "the tremendous interstate variation in the share of total benefits going to medical care reflects between-state differences in: average weekly wages; the nature and severity of work-related injuries; the quantity and prices of medical services provided to injured workers; and the dollar value of cash benefits (driven by factors such as benefit replacement rates, maximum and minimum weekly benefits, the waiting period, and duration of TTD benefits). If, therefore, changes to the workers' compensation law in a given state reduce the dollar value of cash benefits, but medical benefits are stable, the share of benefits accounted for by medical care increases."[14] Additional factors such as strong employment growth also increase medical benefits since more employed workers will be covered under workers compensation.

A significant reduction in ASC rates will benefit the carriers at the expense of providers and employers. Well before the workers compensation fee schedule reforms enacted in 2013, the workers' compensation carriers realized a sharp increase in profits. As reported by the National Association of Insurance Commissioners, underwriting profits and profits on insurance transactions have increased sharply since 2005.

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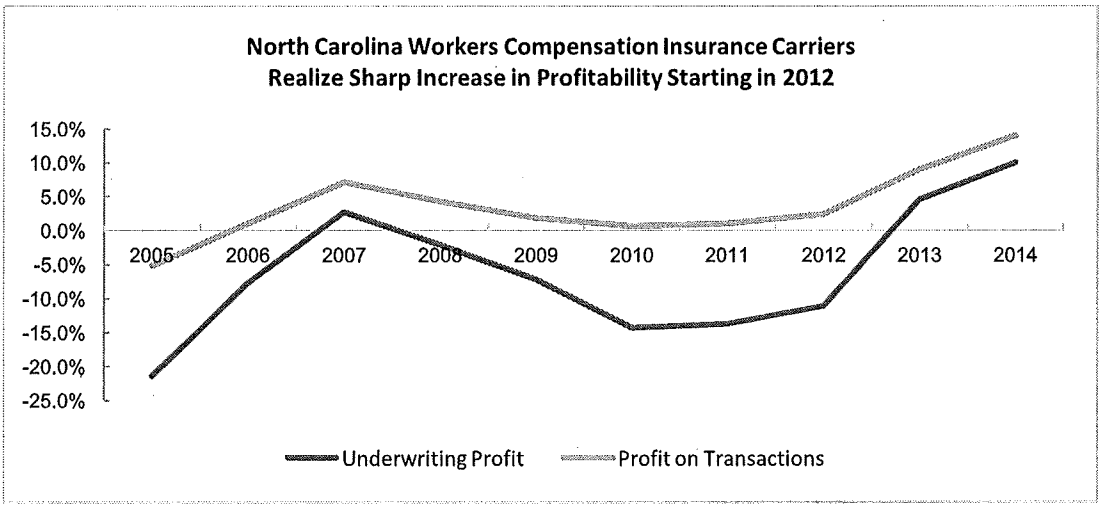
[11] WCRI, Designing Workers' Compensation Medical Fee Schedules, June 2012.

[12] Texas Medical Association, Workers' Compensation Special Report – 2004 Survey of Texas Physicians."

[13] The Medical Fee Schedule Under the Workers' Compensation Law, Legislative Reference Bureau State Capitol, Honolulu, Hawaii

[14] National Academy of Social Insurance, Workers' Compensation: Benefits, Coverage, and Costs, 2014

	2005	2006	2007	2008	2009	2010	2011	2012
Underwriting Profit	-21.4%	-7.7%	2.7%	-2.1%	-7.2%	-14.3%	-13.7%	-11.1%
Profit on Transactions	-5.2%	1.0%	7.1%	4.3%	1.9%	0.7%	1.0%	2.4%



CONCLUSION

For the reasons set forth above, the Commission should adopt SCA's proposed fee schedule and reject the fee schedules proposed by the other three proponents. SCA's proposed fee schedule is consistent with North Carolina statutory requirements, accounts for all procedures that can be performed in ASCs, and results in substantial savings to the Workers' Compensation system in North Carolina.

Respectfully submitted this 10th day of October 2016.

K. Collins

Kelli Collins, Vice President Operations
Surgical Care Affiliates, LLC
3820 North Elm Street #102
Greensboro, NC 27455
(336) 854-1663 office
(336) 202-6681 mobile
(866) 367-3168 fax
kelli.collins@scasurgery.com