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North Carolina Hospital Association

October 10, 2016

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

Dear Chairman Allen and Commissioners:

Thank you for the opportunity for NCHA to comment on the am-surg fee schedule at the October 3rd public hearing. We are providing the following information to supplement and further elaborate on a few issues that were discussed at the hearing.

NCHA recommends that the Commission adopt the same rule that it had adopted earlier for payment of ambulatory surgery rates. NCHA does not support a rate lower than 200% of Medicare for hospital outpatient or am surg rates for reasons noted at the hearing and in our previous comment letter.

Hospital outpatient rates versus am-surg rates

There was quite a bit of discussion at the hearing on the difference between hospital outpatient rates and am-surg rates. Under the Medicare fee schedules, hospital outpatient rates are on average higher than those for am-surg centers. NCHA does not support tying am-surg rates to the hospital outpatient fee schedule for several reasons:

- If Medicare is going to be used as the basis for the fee schedule, then Medicare's fee schedules (with the 2x multiplier for workers' compensation) need to be adhered to, without changing the payment differentials between various providers. The Medicare fee schedules have been actuarially developed by CMS, and as discussed below, there are reasons for the differences in reimbursement levels between hospital outpatient and am-surg facilities under those fee schedules.
- Hospital outpatient services are costlier than am-surg services for several reasons. Hospitals incur substantial costs relating to keeping an emergency room open 24/7 and maintaining service lines that are needed by the community but unprofitable. ASCs are also typically able to schedule surgery during normal business hours, whereas hospitals have less predictive scheduling, which results in higher costs. Hospitals also provide charity care to the indigent and are reimbursed below cost for serving Medicaid recipients.
- In addition, as noted in the attached memorandum from Optum, Medicare uses relative weights as one of the factors in determining payment rates for hospital outpatient facilities and ASCs. Relative weights establish how costly any one service is in relation to any other service. Optum examined the relative weights of 3,077 procedures performed by hospital outpatient departments and ASCs. Of those, the hospital outpatient relative weights were higher than ASC relative

weights 2,952 times. The ASC relative weights were higher only 125 times. The relative weight is higher for hospital outpatient because the hospital payment generally includes additional bundled services – such as clinic, emergency department, radiology, MRIs, CTs, laboratory and other services – that are often not performed in an ASC-setting. As noted by Optum, adopting the hospital outpatient relative weights for ASCs would mean paying ASCs for services they often do not – and cannot – perform.

- Hospital outpatient departments must meet the provider-based requirements under federal regulations (42 CFR § 413.65(d) and Transmittal A-03-030). Those requirements include the following:
 - The outpatient department operates under the same license as the hospital.
 - The outpatient department has integrated clinical services with the hospital. This includes requirements that the hospital maintain the same monitoring and oversight of the outpatient facility as it does for any other hospital department. The hospital medical staff committees are responsible for overseeing medical activities and quality assurance at the outpatient department.
 - The hospital and outpatient department have a unified retrieval system for medical records.
 - Patients of the outpatient department have full access to all services of the hospital.
 - The hospital and its outpatient department are fully financially integrated.
 - The hospital outpatient department must comply with hospital rules such as anti-dumping, nondiscrimination, and health and safety rules.
 - Additional rules apply when the outpatient department is located off the hospital campus.

NCCI Analysis

NCHA asked Optum to review NCCI's analysis. Optum's comments and questions on the analysis are included in the attached memo. Optum noted that without more explanation of the analysis, "it is difficult to determine whether the models reflect what may happen should any of the various methodologies or percentages be adopted. Generally, models staying within ASC-PPS system are most likely to have some reliability, but cross-system comparisons of ASC-PPS and OPPS need an explanation of discounts and bundles to determine reliability."

Thank you for the opportunity to comment. Please feel free to contact us if you have additional questions.

Sincerely,



Linwood Jones
General Counsel

Oct. 6, 2016

To: Linwood Jones

From: Eric Anderson
Managing Consultant
Reimbursement Analytics

Re: Discussion of NCIC-requested analysis and SCA Response

At the request of the North Carolina Hospital Association, Optum was asked to perform a technical review of a workers' compensation Ambulatory Surgical Center (ASC) analysis provided to the North Carolina Industrial Commission as well as a response from Surgical Care Associates (SGA).

As background, Optum has provided assistance to more than a dozen states in developing and implementing facility (hospital and ASC) workers' compensation payment methodologies.

Discussion of analysis for Industrial Commission

Modeling changes in reimbursement methodologies can be extremely difficult, particularly for facility outpatient payments. While Medicare's hospital outpatient prospective payment system (OPPS) and the ambulatory surgery center system (ASC-PPS) are similar, they also differ in significant ways. How those differences are accounted for in the modeling process can make a considerable difference in the results.

The only completely accurate method is to have claim-level detail (all items on the claim), with a sufficient number of claims, and to process those claims through commercially available pricing software with different payment models selected. It appears this option was unavailable. Lacking that, an analyst is confronted with making assumptions in reconciling disparities between OPPS and ASC-PPS.

The reimbursement models provided to NCIC have insufficient documentation how differences between OPPS and ASC-PPS were accounted for. These unanswered questions preclude definitive conclusions on the reliability of cross-system comparisons between ASC-PPS and OPPS.

The following bold-face items are from the analysis with an examination of how different assumptions may produce differing results.

Page 2: Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code

The documentation does not detail how many claims, services, or providers were present in the data. Also missing is explanation of what detail level was used. If a low claim volume is used, there is an increased likelihood of variability between the model and the eventual real-world implementation. If summarized volumes instead of actual claims were analyzed, then certain steps are required to account for the impact of discounts and bundles.

The lack of volume information and use of summarized information does not negate the analysis, but low and/or summarized volumes potentially diminish reliability.

Page 2: ... “The Impact of Physician Fee Schedule Changes in Workers Compensation: Evidence from 31 States”, suggests that a portion of a change in maximum reimbursements is realized on payments impacted by the change.

The physician study cited concludes when a decrease in maximum reimbursement for physician services occurs, only 50% of the decline is realized. Conversely, when an increase in maximum reimbursement for physician services occurs, only 80% of the increase is realized. This physician study becomes the basis for implementing a “price realization factor” which adjusts the impact of any reimbursement methodology changes. Declines are reduced by half; increases are set at 80%.

The referenced study specifically did not consider hospital or ambulatory surgical center transactions. On Page 5, the study noted: *“The data set excludes transactions associated with medical services provided by hospitals and ambulatory surgical centers, but includes transactions related to services delivered by physicians (the provider type) at these places of service.*

OPPS and ASC-PPS are facility fee schedules. Unlike physicians, hospitals and ASCs generally have less flexibility in charging different prices to different payers as physicians might.

Because of payer networks and other factors, the full impact of any methodology change is unlikely to occur. However, applying estimates from physician study to a facility methodology merits further explanation as to its appropriateness.

Using a physician price realization factor may understate the lower boundary by as much as 50% (the reduction may be more than expected) and also underestimate the upper boundary by 20% (the increase may be more than expected).

Page 3 “Prior MAR”

There are several questions relating to the MAR calculations.

1. The Prior MAR calculation uses the 2015 ASC-PPS schedule while the proposed MAR calculations use the 2016 ASC-PPS schedule. Although Medicare makes

adjustments to achieve the same results year-over-year, workers' compensation utilization differs from Medicare's. As the result, weight changes for workers' compensation services might not be neutral and could represent an increase or decrease. This can be tested using North Carolina workers' compensation volumes to determine whether Medicare weight changes impact reimbursement. The documentation does not explain whether this was done. If it was not done, some reimbursement impact may be driven by changes in Medicare's weighting, not changes in reimbursement methodology or percentages.

2. The Proposed MAR – ASC-Based Alternatives does not state whether wage indexes were considered when modeling payments. Because they are not mentioned, presumably they were not. However, if wage indexes were considered they may have created another inadvertent issue. Core Based Statistical Areas (CBSAs) were revamped as the result of the 2010 census. These resulted in changes to CBSA compositions. That, in turn, brought about wage index changes with most occurring between 2014-16. If wage indexing was done, then payment changes as any CBSA changes ought to be noted in the modeling.
3. The Proposed MAR – Hospital-Based Alternatives lacks a pertinent discussion. While ASC-PPS and OPSS are similar, they differ in discounting and bundling. Because hospitals provide a broader range of services than ASCs, hospital bundles are often larger and more comprehensive. There is no discussion how the disparities between the two systems were reconciled. A reasonable presumption might be that the analysis used the multiple procedure discount flag from ASC-PPS, but strictly speaking that is not following OPSS payment rules. Without clarity on discounting and bundling, the analysis of MAR—Hospital-Based Alternatives should be regarded with some skepticism.

Summary

The modeling produced one seemingly unlikely result. One model estimated what happens if payments increased from 220% of ASC-PPS (using 2015 weights) to 235% of ASC-PPS (using 2016 weights). The lower boundary calculation projected overall ASC payments might drop 4.1% or a \$1.9 million.

An increase in payment results in less expenditure seems an unlikely result. Although there are ways this might be achieved, an explanation as to how the model creates this counterintuitive result would be helpful. Without further explanation, it is difficult to determine whether the models reflect what may happen should any of the various methodologies or percentages be adopted. Generally, models staying within ASC-PPS system are most likely to have some reliability, but cross-system comparisons of ASC-PPS and OPSS need an explanation of discounts and bundles to determine reliability.

Discussion of Surgical Care Associates response

Surgical Care Associates LLC (SCA) offered a response to the payment modeling presented to the Industrial Commission. While the SCA response covers details beyond a technical analysis, the hospital association asked that Optum review the technical components of SCA's response. The bold-face text is from the SCA response.

Page 2: For those services that are covered under Medicare, the invalid fee schedule contains reimbursement that is inadequate and that would create a significant disparity between ASCs and hospital outpatient departments for the same services.

The disparity is created by the adoption of a Medicare-based system.

Page 2: (g) For those procedures for which CMS has established a Medicare rate, the schedule of maximum reimbursement rates for services provided by ambulatory surgical centers ("ASC") should be the same as the schedule of maximum reimbursement rates for hospital outpatient institutional services as set forth in sub-part (c) above.

This sentence and further discussion equates payments for services in hospital outpatient departments (HOPD) with services provided in ambulatory surgical centers.

There are two components to Medicare's payment policy:

- A relative weight which establishes how costly any one service is in relation to any other service.
- A conversion factor which accounts for differences among hospitals and among ASCs. For outpatient, the only adjustment to the conversion factor is the wage index that adjusts for geographical salary differences.

SCA's suggestion does not say but presumably wishes adoption of both the hospital relative weights as well as hospital conversion factors. Of these two, relative weights present a more complex issue. Medicare's comprehensive and consolidated bundling payment methodology is different between ASCs and hospital outpatient.

In general, what may appear to be equivalent services may not be because Medicare's bundling system includes services beyond just the HCPCS code itself. In other words, while the HCPCS codes for ASCs and hospitals may be the same, the payment often includes a different range of services bundled in the payment.

The chart below illustrates. It shows the difference in relative weights for some common workers' compensation procedures performed in hospital outpatient departments and ASCs.

Comparison of Relative Weights, April 2016 OPSS and ASC-PPS (Addendum AA/Addendum B)				
HCPCS Code	Short Descriptor	ASC Weight	OPSS Weight	Status Indicator
29806	Shoulder arthroscopy/surgery	56.2787	67.4027	J1
29807	Shoulder arthroscopy/surgery	56.2787	67.4027	J1
29827	Arthroscop rotator cuff repr	56.2787	67.4027	J1
29828	Arthroscopy biceps tenodesis	56.2787	67.4027	J1
29855	Tibial arthroscopy/surgery	79.9669	95.8165	J1
29856	Tibial arthroscopy/surgery	79.9669	95.8165	J1
29862	Hip arthro w/debridement	56.2787	67.4027	J1
29866	Autgrft implnt knee w/scope	56.2787	67.4027	J1
29885	Knee arthroscopy/surgery	56.2787	67.4027	J1
29888	Knee arthroscopy/surgery	79.9669	95.8165	J1
29899	Ankle arthroscopy/surgery	79.9669	95.8165	J1

The OPSS (hospital outpatient) relative weight is higher than the ASC-PPS weight because the hospital payment usually includes additional bundled services – typically clinic, emergency department, radiology, MRIs, CTs, laboratory and other services – that are often not performed in an ASC-setting.

In the April 2016 Medicare update, OPSS relative weights are higher than ASC relative weights 2,952 times. Conversely, ASC relative weights were higher 125 times.

Because of their nature, ASCs do not perform many of the services included in hospital outpatient bundles. Adopting the OPSS relative weights for ASCs would mean paying ASCs for services they often do not – and cannot – perform.

Page 3: The amendment being proposed by SCA would have a positive effect on the procedures of the Commission because it will eliminate the confusion that currently exists whereby some insurance carriers have determined that some procedures currently being performed at ambulatory surgical centers are not covered in the current invalid fee schedule based on ASC Medicare rates.

While the proposed change may or may not eliminate some confusion that currently exists, it would create another type of confusion in determining how to apply a different set of bundling rules – notably the comprehensive status indicator, J1 – that apply in OPSS but is not present in ASC-PPS.

Medicare's J1 status indicator in hospital outpatient has no comparable methodology in ASC-PPS. In general, if a code with a J1 status indicator appears on a claim, that is paid and

nothing else. There are complex rules relating to payment when two or more HCPCS codes with J1 status indicators appear on a claim. Medicare is greatly expanding HCPCS codes covered by the J1 status indicator. For 2017, more than 2,500, mostly surgical, HCPCS codes will have a J1 status indicator.

Beyond the bundling issue, there are also differences in how OPSS and ASC-PPS handle wage index adjustments and which wage indexes would apply. Additional rules would need to be developed to handle these disparities.

Page 4: As noted by the Commission, discrepancies in payments between ambulatory surgical centers and hospital outpatient departments would “potentially diminish the pool of doctors available to treat injured employees, and reduce the quality and timeliness of care.

Presumably the quoted material accurately reflects the commission’s statement.

That notwithstanding, it begs the question of how a discrepancy in facility payment affects the pool of doctors. For most hospitals and some ASCs, workers’ compensation is a relatively small portion of their patient volume.

Hospitals make decisions based on their overall patient volume as do some, perhaps most, ASCs. Clearly, a discrepancy in physician payment could impact the availability of physicians, but the contention on facility payments is less clear.

Page 5: Specifically, NCCI improperly uses the invalid ASC fee schedule as the baseline for calculating the cost or saving related to the proposed changes. The ASC fee schedule required by the August 9, 2016 court decision reimburses providers at 67.15% of billed charges. The NCCI analysis uses the invalid ASC fee schedule reimbursement of 210% of Medicare ASC rates as the baseline for the proposed fee schedule changes. Therefore, NCCI’s analysis using the invalid fee schedule understates the total impact on the overall workers compensation system when adopting a ASC fee schedule that reimburses ASC at a lower rate than the current fee schedule reimbursement of 67.15%.

Our analysis generally agrees with this point. It was unclear from the documentation whether there was an adjustment for the time period. Our reading of the methodology was that 220% of Medicare was used as the basis for the previous MAR calculation.

Page 5: SCA conducted independent analysis using internal data and NCCI’s methodology to evaluate the impact of SCA’s proposed fee schedule change from the current ASC fee schedule reimbursement rate of 67.15% of billed charges to the 2017 Service Year reimbursement rate of 200% of HOPD Medicare. The analysis concluded that the resulting overall savings in 2017 to the overall workers comp system would be \$8.8M (-0.5%).



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The description of the SCA analysis does not state whether it used the hospital conversion factor, whether it made wage index adjustments, whether it used the hospital relative weights or how it handled hospital bundled payments. As with the analysis for the Industrial Commission discussed earlier, without this information it is difficult to determine whether SCA's analysis reliably models the impact to changes in payments.