

Ambulatory Surgical Centers Stakeholder Meeting May 27, 2010

Bryce Docherty for the CA Ambulatory Surgery Association (CASA): CASA represents over 200 ASCs ranging from single and multi-specialty to physician-owned to joint ventures between hospitals and physicians. These centers range from the very small to the very large and are located throughout California.

Methodology: The Capen decision forced many centers to no longer be state licensed. Concerned data does not include all ASCs. Population in workers' compensation different than Medicare. At least half of California WC cases are orthopedic. Only 7% in Medicare ASCs are orthopedic. Need to be paid same rate as outpatient hospitals. ASCs procedures will move to outpatient or inpatient hospitals. Adopting 120% of ASC rate would reduce fees by 40-50%. There will be no savings if procedures all go to hospital outpatient departments and costs will increase when cases go to the inpatient hospital setting. Existing law [Labor Code Section 5307.1(f)] stipulates that within the authority granted to the Administrative Director in augmenting certain elements of the OMFS that rates or fees established pursuant to that authority shall be adequate to ensure a "reasonable standard of service and care for injured employees." CASA would argue that reducing fees by 40-50 percent to ASCs for outpatient surgery in workers' compensation by adopting a rate of 120 percent of the ASC Medicare fee schedule unequivocally will violate said access mandate adopted by the California Legislature in 2003.

Most recently, the DWC released an annual access to care study as mandated by existing law [Labor Code Section 5307.2] for calendar year 2008. The University of Washington, whom the DWC contracted to perform the study, found that over one-third of providers reported that they intend to decrease their workers' compensation volume or quit treating injured workers all together. It was also reported in the same study that nearly half or 47 percent of injured workers reported experiencing one or more access barriers at some point during their treatment.

Therefore, CASA would agree with the conclusions made by the University of Washington regarding injured workers' access to quality care is not adequate and improvements are desperately needed to ensure the needed outpatient surgery that injured workers deserve and ASCs are ready and able to provide. Unfortunately, reducing fees to ASCs by 40-50 percent does not successfully accomplish that objective.

[RAND reports conclude payments are higher than necessary. ASC costs are less than out patient hospital costs.]

Dr. Jay Pruzansky for Alpine Healthcare, LLC stated that Medicare rates are at least 30% below an ASC's full cost of doing business. If an orthopedic surgery focused surgery center had to depend on Medicare rates for their entire book of business they could not stay in business. Other payors subsidize Medicare patients having surgery. The CHSWC report didn't have accurate and recent cost data. During the hearings that preceded the 2004 Surgery Center Fee Schedule there were discussions of the importance of collecting Surgery Center cost data. That initiative was never implemented.

Tom Wilson of Wellspring Associates Inc. and past president of ASCA (formerly FASA) and a current CASA board Member expressed concern about some of the assertions presented in the Rand Working Paper. According to comments made earlier by Barbara Wynn, the author of the Rand Working Paper commissioned by the California DWC, the basis for the proposed reduction in the reimbursement rate to ASCs for surgical services to CA Workers' Compensation (W.C.) beneficiaries is because ASCs cost structure is 29-34% less than that of Hospital outpatient departments (HOPDs). The Rand Working Paper's cost data to support this conclusion is deeply flawed and inaccurate. There is no national data to support this assertion. CMS has on two occasions collected detailed cost data from ASCs and on both occasions chose to not publish the data. The GAO reviewed the data and reported ASCs and HOPDs operating costs were comparable indicating HOPDS were 10-15% higher. In fact, when Congress passed the 2010 Health Care Reform Bill, they asked if CMS would like to include a cost data reporting requirement for ASCs and CMS requested that the provision be dropped. The OSHPD macro data is inappropriately manipulated in the Rand Working Paper to maximize the difference between the operating costs of ASCs versus HOPDS. The study looks at all ASCs including single specialty ASCs and multiple specialty ASCs that do not perform procedures on W.C. beneficiaries or do very little orthopedic cases.

Approximately 50% of all ASCs in Ca are single specialty facilities (GI, ophthalmic, plastic surgery, etc) that perform little if any W.C. cases. As Bryce Docherty stated earlier, nearly half of all CA W.C. cases performed in ASCs are orthopedic. Inclusion of the lower operating cost single specialty ASCs into the Rand Working Paper distorts the data. The cost structure for these facilities are much lower as the procedures performed are often relatively short (i.e. cataract removal) and often preventative screenings (i.e. colonoscopy), that do not require expensive medical supplies including implants and single use items. They are not labor intensive and frequently do not require a general anesthetic administered by an anesthesiologist (i.e. colonoscopy). Therefore, their internal cost structures are much lower than multispecialty ASCs performing intensive orthopedic procedures, such as major joint repairs that are commonly performed on injured workers. Inclusion of these facilities in the Rand Working Paper greatly skews the data producing a distorted comparison. This would be similar to comparing the cost structure of an intensive care unit (ICU) with a medical –surgical unit. Both treat patients in a hospital environment but the ICU requires greater concentrations of labor, monitoring equipment and laboratory testing, generating a much higher internal cost structure. An appropriate study would compare multi-specialty ASCs performing common workers' compensation orthopedic cases with HOPDS with a similar case mix. Such an analysis would demonstrate that those ASCs have a very similar internal cost structure as HOPDs because 65-70% of the operating costs of both multi-specialty ASCs performing orthopedic joint repairs and HOPDS are salary related costs (wages, benefits, withholding taxes etc) and medical supply costs. ASCs hire from the same labor pool as HOPDs and must provide competitive salary and benefit packages. ASCs must purchase the same medical supplies as HOPDs including implants. Often the hospitals large purchasing power enables them to purchase these medical supplies at reduced rates. The other major expense items consist of insurance, utilities, rent or mortgage, laundry, transcription and janitorial services, all of which are comparable. The HOPD will have

higher overhead expenses, but the ASCs pay taxes of 8.5% to the state of CA and 20-35% to the federal government.

ASC Medicare utilization patterns support these internal operating expense calculations. According to published CMS data in 2008, ASC were reimbursed only 51% of the HOPD rate for orthopedic procedures. In that year only 7% of all CMS cases performed in ASCs were orthopedic while over 70% of the CMS procedures performed in ASCs were ophthalmic and G.I. (preventative colon screening). The CMS rate paid to ASCs for most orthopedic cases involving major joint repairs often is less than the cost of the implants and medical supply items alone, thus these cases are most often performed in the hospital.

The Rand Working Paper stated that CMS pays ASCs 67% of the HOPD rate. This is inaccurate. In 2009 this rate according to CMS was 57% and according to ASCA it is projected to decline to 51% in four years because of CMS “rescaling formula” and because HOPDS enjoy a medical market basket inflation rate that is approximately two (2) basis points greater than the inflation rate used for ASCs. In 2010 HOPDS received an inflation factor of 2.6% while ASCs received a 0.6% adjustment.

The projected decrease to ASC for workers’ compensation cases under the CA DWC averages 43% not the 40% reported in the Rand Working Paper. A decrease of this magnitude will drive orthopedic cases, (that for injured workers’ access purposes, are arguably best performed in ASCs) into the hospital setting. Many cases, especially spine and major joint repairs will migrate to the inpatient setting, costing the CA workers’ compensation system millions of dollars annually. For example, spinal cases that ASCs routinely perform for \$12,000-\$20,000 cost an average \$50,000 in the hospital according to the Rand Working Paper.

Assuming the GAO most aggressive scenario regarding ASCs operating costs are correct, specifically that HOPD’s internal cost structure are 10-15% greater than ASCs, there is nothing that can possibly support a 43% decrease to ASCs. Such a decrease would be draconian in nature and materially change the access patterns for injured worker’s needing surgery.

The Rand Working Paper by its own admission is not a scientific paper. It has not undergone peer review or independent scientific analysis. In the scientific community this working paper would merit similar consideration as an editorial or a science oriented blog. The working paper contains numerous inaccuracies including overstating the CMS payment rates to ASCs compared to HOPDs and dramatically distorts the internal operating costs of ASCs frequently performing W.C. orthopedic cases. The latter is the seminal argument used to support the proposed payment rate reductions. By lumping all ASCs into one group, including nearly 50% of which are single specialty centers with significantly lower operating costs, the Rand Working Paper systematically and inaccurately reduced the average projected operating costs of the ASCs performing orthopedic procedures to workers’ compensation beneficiaries. Rigorous peer review conducted by an independent scientist would have identified this distortion and insisted the methodology be modified to directly compare ASCs performing orthopedic procedures on workers’ compensation beneficiaries to HOPDs.

It would be inappropriate for the DWC to base its decision upon skewed data. Such a decision would lead to a significant volume of cases shifting to the hospital, with some migrating to the more costly inpatient setting. This will mitigate much of the

proposed savings and generate access problems. Shifting these cases will impact the HOPD capacity and frustrate surgeons as their productivity is greatly reduced due to exposure to clinical teams unfamiliar with their techniques and equipment, scheduling delays and slower surgical theatre turn-over time between cases.

I urge you to examine the data closely and work with CASA and CHA leadership to develop a workable solution that generates desired efficiencies while maintaining injured workers' access to quality care at reasonable rates.

[Device costs would be paid at same rate as hospitals. New Medicare fee schedule is increasing device costs.]

Michael Klassen, M.D. (orthopedic surgeon) from Monterey Peninsula Surgery Center: Access is already a major issue for Medicare patients and we currently ration appointments. **We also ration follow up appointments for California workers** and if the outpatient surgical centers stop taking my workers' compensation patients will have major rationing. Using a hospital takes twice as long for the physician, in my hospital I can only schedule 4 surgeries per day, the turn over time between cases is 2 to 3 times longer and the operative system gets overloaded. In the outpatient ambulatory facilities I can schedule 6 to 8 surgeries done, stay on schedule and therefore get the patients repaired and back to work. If workers' comp stop paying the appropriate facility fees the surgeon will be less efficient and therefore, physicians will stop doing the procedures and stop treating WC patients.

Dr. Basil Besh, M.D.-Orthopedic surgeon

1. Faulty to compare to Medicare rates, more accurate to compare to private insurance, which pays routinely 200-250% of Medicare rates for ambulatory surgery center fees as compared to 100-120% of Medicare fees for professional services.
2. Medicare is essentially done as charity work, as cases done in ambulatory surgery centers for Medicare actually do not cover the costs and lose money for the surgery center.
3. As 50% of work comp at ambulatory surgery centers is orthopedics and since most orthopedic surgeons are surgery center investors, surgery center income is vital to support the labor effort required to deliver work comp care, as work comp care requires significantly more labor than non-industrial medicine.
4. One could argue that these fees should actually be increased to incentivize inpatient cases to the outpatient realm. Fifteen years ago, anterior cruciate ligaments were routinely done inpatient at significantly increased costs and now are almost exclusively done outpatient; and I predict that in the future, total knee and total hip replacement as well as spine surgery will also significantly shift to the outpatient realm resulting in significant healthcare cost savings.
5. Cutting ASC work comp fees is simply a bad idea because of consequences similar to the utilization review debacle, which as Sue Honor has been quoted, "What is spiraling out of control is the cost of cost containment."

Douglas Chin, M.D.:

1. The Rand study is fatally flawed in that it tries to extrapolate data from the study of one population (less active Medicare patients, over 60 years of age, often retired with lower functional demands) to an entirely different patient population (active, young, injured workers with higher functional demands), whereas:

a. The range of orthopedic problems within the >60 population is VERY different from those seen in the workers' compensation population (different fracture patterns, greater likelihood of associate soft tissue injuries in the WC population, etc.)

b. Even for similar (ICD9-matched) problems, the costs of treating workers' compensation patients is arguable greater due to:

- i. higher functional demands
- ii. more complex orthopedic problems within the same ICD9 grouping
- iii. greater complexity of orthopedic solutions (for example, much greater likelihood that a WC distal radius fracture will require orthopedic hardware (ORIF) than a similar fracture in an elderly patient

2. There is a selection bias in the Rand study. For example, in the Rand study only 7% of the Medicare services performed were of an orthopedic nature, whereas 80% of WC services are orthopedic. Has Rand considered the possibility that this is because it is financially untenable for ASC's to perform some orthopedic procedures under current Medicare facility reimbursement rates?

3. There already is a shortage of operating room time for WC patients. Even with the current WC facility reimbursement schedule, it is increasingly difficult to find ambulatory surgery centers who are willing to accept WC patients, particular for cases requiring the use of hardware, bone grafts, and other implants. The proposed change in reimbursement schedule would result in greater times to surgery, resulting in greater pay-outs in temporary disability payments and possible permanent disability payments.

4. As a result of a Medicare-based facility reimbursement schedule, more and more WC cases would be shifted to an inpatient hospital venue. This appears to be the political motivation behind the recommended change. However, the result would be that cases currently performed at ASC would then be reimbursed under a hospital outpatient fee schedule, which would result in a 40% increase in reimbursements for the exact same services.

Jot Hollenbeck, Senior Vice President, United Surgical Partners, International:

We have previously submitted written comments to Carrie Nevans on May 24th..

United Surgical Partners is an owner and operator of 15 ambulatory surgery centers in the state of California, with more than 425 employees and 700 credentialed physicians. In 2009 our ASCs performed services for over 3000 injured California workers' compensation patients.

Our primary concern is that the proposed change in the ASC fee schedule will result in an average 49% reduction in reimbursement and make the continued provision of these services unaffordable for our surgery centers.

I have a list of the top 10 CPT codes performed in our ASCs; these were submitted with our written comments earlier. In summary:

- these are all either orthopedic or pain related procedures
- frequently these procedures involve specialized equipment, costly hardware and implants
- as we evaluate our costs of performing these procedures and the proposed reimbursement, the proposed payments are below our costs.
- there will not a “reasonable return” on these procedures, there will be no return
- our ASCs will not be able to continue to perform these cases, and that will have a direct impact on patient access to these services

Steve Moore, M.D. (hand surgeon): Believes rationing will take place. If don't have best care result will be higher PD. Decrease in payments will results in less physicians. Hospitals are less efficient setting for physicians.

(Dr. Moore writing-) Up until now the DWC has not taken seriously the statements made by Ambulatory Surgery Center-based Surgeons who have said they would limit or eliminate their workers' compensation population in their practices if the declining levels of reimbursement become offset by increases in difficulties with paperwork, communication with industrial carriers and claims adjusters, and delays in treatment brought on by denials, etc. It is my belief that there are many surgeons who have been in practice for 20 plus years who are quietly preparing for just that scenario. I am one of them. Prior to 2004, the care and treatment of industrial injuries and illnesses comprised 85% of my office based orthopaedic hand surgery practice. Now it represents 20 percent. From 2004 until 2006 it was zero percent.

The state should prepare for similar rationing if the fees paid to the surgery centers are drastically reduced. Surgeons will be required to shift those patients to the hospital setting, thereby increasing costs and decreasing access by way of decreased efficiency.

Shea Lansberry, Surgery Center Administrator, Bay Area. We currently have 7 Surgery Centers in the Bay Area, all performing WK cases. Medicare is 5-10% of our current patient population. On average our reimbursement per Medicare is \$734/case, yet our average cost per case is \$2015. This is at a loss every time. We do this for our community. At only one of our facilities, we perform an average of 1300 WK cases per year. With the proposed fee schedule, based on this WK case volume, we would lose an average of \$1134/case, annually that is 1.5M per year.

If ASC's are no longer WK providers the results will be extended time to surgical interventions and likewise extended disability payments. The worker will be impacted by loss of full wages and the related financial setbacks. Injuries may be exacerbated by delay in surgical intervention resulting in extended recovery time. This problem will create the worker being off on disability longer due to decreased access of care, a longer time period of loss of full wages for the worker and his family, and increased risk for

compromised care and potential infection. Cost to the system will be increased and not decreased as hoped.

I urge the members of this hearing to leave the fee schedule unchanged and focus their efforts elsewhere where it does not have such negative and costly impacts

Tom Wilson briefly stated that although Medicare pays very little it does pay promptly usually in 13 days compared to 45 working days (nearly 2 months) for W.C. Additionally, the administrative burdens are much greater for W.C. cases compared to Medicare. Please see Bone and Joint Journal article documenting that administrative costs are doubled for W.C. versus CMS cases. Also, to provide services to W.C. Beneficiaries, most ASCs must join a medical provider network at a cost of 5-10% of the facility fee. This requirement provides no additional service to the injured worker and unproductively adds considerable costs to the system. Elimination of this element could save the system 5-10% of facility fees.

Jessica Holmes for Boston Scientific: Spinal cord simulation for chronic pain. Two solutions: high cost outlier for device-intensive procedures; and trigger to adjust payment rate to revert back if negative impact to procedures.

David Awerbuck, M.D. for Monterey Peninsula Center – ENT – Patient safety and patient satisfaction are important factors. ASC system works.

James de Ciutiis for Amsurg: For Work Comp, if the case has to go to the hospital, the patient/work must wait longer for a surgery date. If the proposed change goes forward, this will create a further backlog. If the physicians choose to not see the patients at all, this will further increase the backlog with a decreased supply of physicians. Turn over times are slower at the hospital allowing for fewer cases to be done in the same amount of time. If more physicians are using out-patient hospitals, there will be even more backlog and scheduling problems. With income leaving the surgery center and some forced to close, you will be eliminating what has been a leader in innovations and high quality care.

Tony Knapp for Beach District Surgery Center: Manages surgery centers in So. Cal. Lose money on Medicare – won't do that for injured workers. Workers should not have to wait in line to get into hospitals. Injured workers deserve the same care all patients get. Hospitals have a higher infection rate and lower satisfaction rate than ASCs.

Steve Cattolica for CSIMS and CSPM&R: Bone and Joint Journal study cost data may be of assistance. DWC access study says that the loss due to delays costs lost days of work resulting in a loss of approximately \$348 million dollars. Regarding the e-billing regulations – if carrier finds flaw in bill, bill won't be paid for 45 days. New bill will be introduced to address this.

Sunny Sutton for Medtronic: Implantable pain devices. Cost of high tech devices will not be covered under the new methodology, nor will acquisition costs or other expenses incurred by ASC. Separate device payments, or higher multipliers for device-dependent cases, will be needed if patient access in this setting is to be ensured.

Michael Klassen, M.D. (orthopedic surgeon) from Monterey Peninsula Surgery Center: As a physician, my hospital will only allow me to schedule 4 cases per day in hospital, however, in the surgery center I am at I can get 6 to 8 cases done per day. My surgery schedule is 6 to 8 weeks out now, if I become even more inefficient because the ambulatory center will not accept WC cases then, there will be a **MAJOR ACCESS PROBLEM**. Injured workers will get cases handled quicker at ASC

Kathryn Di Stefano, RN Administrator for Advanced ASC: Adjustors will not authorize an ASC as the facility unless the ASC belongs to a Medical Provider Network (MPN). In order to belong to a MPN, the ASC must agree to discount o the fee schedule at least 5%.

Scott Leggett for Surgery One in San Diego, past president of CASA: Scott supported and agreed with comments of Tom Wilson that the costs at ASC very similar to hospitals. When you break down the largest cost components you wonder how the argument is made that hospital costs are higher than ASCs. ASCs hire nurses and employees from the same pool of applicants that hospitals hire from. The second largest surgical cost is medical supplies. Hospitals have far better purchasing power than ASCs so it can be easily argued that medical supply cost for hospitals should be lower than ASCs. The methodology that Medicare uses to obtain and calculate costs is largely based on hospital costs which incorporates the larger overhead / inefficiencies of the hospitals. A GAO study released in 2006 supports our point.

Additionally, Medicare projects what ASCs should get paid on an estimate of lower costs than hospitals BUT a major assumption is that high volume lower cost cases are performed at all ASCs (ophthalmology & GI) to help buffer some of the lower reimbursements on high cost Orthopaedic cases and that ASCs are more efficient. Not only is this a flawed assumption, most ASCs performing Orthopaedic work cases do not even do ophthalmology, GI etc.

Bottom line: Dropping the work comp ASC fee schedule to the proposed level would force many cases to back to the hospital which is a step backwards. This would create inefficiencies for surgeons to schedule the cases and increase overall costs by forcing them to the hospital. Another big issue is the access many physicians would have to hospital OR time. Many choose ASCs due to better efficiency, lower infection rates and better patient satisfaction but there are many surgeons who just don't have access to the OR time necessary to do the cases in the hospital. This could create some restriction of trade issues.

Parity with ASCs and hospital fees schedules is imperative to maintaining a level playing field so that access to the work comp system is maintained. Why should hospitals be rewarded for their inefficiency?

The second point that Scott Leggett discussed was the fact that the major intent of the fee schedule creation in 2004 was to cut abuse out the system. That was successful and most if not all rogue ASCs are out of business and we all are still adjusting to that change in our payment schedule. Further changes this quickly will have detrimental affects too many centers thereby affecting many jobs.

We feel that the overtures being made that the wrong incentives are in place for surgeons to use ASCs is a gross mis-representation of the facts. Surgeons prefer ASCs because they are more efficient, they can get OR time that is consistent and agreeable to their schedules, lower infection rates and patients are happier. Better quality of care – period!! The hint of bringing physician ownership issues into the discussion is not only concerning but also out of the jurisdiction of this department.

Peggy Wellman for Summit Surgery Center and United Surgical Partners:

- 1) I appreciate the Division soliciting comments and input from ASCs. The Division has a long history of working with our industry to support quality care and patient access.
- 2) Our surgeons choose site of surgery – HOPD or an ASC based upon patient acuity. While the surgeons prefer the convenience of the ASC due to more efficient scheduling, they choose the safest place for their patients. Parity in payment rates supports this decision process. However, if payment rates were reduced to ASCs, we would no longer be able to afford to care for the WC population as the proposed rates are below our costs. The rates proposed would reduce Summit Surgery Center’s reimbursement to 49% of current rates and Roseville Surgery Center’s reimbursement to 46% of current rates.
- 3) As noted by other speakers, the workers’ compensation patient population is much different than that of a Medicare population and the current WC payment rates reflect the costs of providing surgical care to this population.
- 4) The centers that I work with, Roseville Surgery Center, Folsom Surgery Center and Summit Surgery are joint ventured with hospital partners. The hospitals are involved as they needed additional outpatient surgery capacity as they do not have sufficient room in their HOPDs. Many have added inpatient beds, without adding additional operating room capacity and require their operating rooms for inpatient surgeries. There will be access issues for WC patients if the ASCs can no longer afford to care for them.
- 5) In response to an earlier comment that was made by the Rand Corporation Representative, which reflected that data gathering was difficult as many centers are not licensed, it is important to note that currently California does not license surgery centers that have physician ownership. Prior to this decision our centers sought licensure and maintained licensure. We would welcome state regulations that support licensure. All our centers are Medicare Certified and accredited by JCAHO or AAAHC.