STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS

DIVISION OF WORKERS' COMPENSATION

PUBLIC HEARING

Notice of Proposed Rulemaking

Title 8, Calif. Code of Regulations

Sections 9789.30 et seq.

January 25, 2011

Scheduled Time: 10:00 a.m. - 5:00 p.m.

Oakland, California

Appearances: Jarvia Shu, Industrial Relations Counsel

Destie Overpeck, Chief Counsel

John Duncan, Director, DIR

Official Hearing Reporters:

Lisa Greenwald, pgs 1 - 34

Carol Mendez, pgs 35 - 84

P R O C E E D I N G S

DESTIE OVERPECK: Good morning, everyone. We'll officially begin, and I also would like to thank you for coming today. This is a hearing on two separate sets of regulations that fall under the Official Medical Fee Schedule. The first are the proposed revisions to the Inpatient Hospital Fee Schedule related to when and how allowance is permitted for implantable spinal hardware used in complex spinal surgery, and the second are the proposed regulations to revise the facility fees subject to the Hospital Outpatient Department and Ambulatory Surgical Centers Fee Schedule.

I'm Destie Overpeck. I'm the chief counsel here. To my right is Jarvia Shu, who is the attorney who has been working the hardest on these regulations. And, of course, we have John Duncan, our director. The court reporters are Lisa Greenwald and Carol Mendez, and they have requested that when you testify you try to avoid using arconyms, which I know is going to be a struggle, but do your best or speak very slowly when you're using letters or acronyms. Maureen Gray, who is down in the front row with the purple shirt, is our regulations coordinator. If you're turning in written comments that you have with you today, please hand them to her.

I want to make sure that everybody who came signed in on the sign-in sheet. If you don't plan on testifying, just check the NO box. If you do, please check the YES box. I will -- even if you change your mind later, you can come up and talk, but it helps us keep track of who would like to make a comment so we call the right people.

The hearing today will continue as long as there are people to comment, but we will close by five o'clock. However, looking at the audience, I think we'll be done before that. If the hearing continues for a couple of hours, we'll take a lunch break; so let's see how we're doing before we make that decision.

Written comments will be accepted up until five o'clock today. You can E-mail them in or you can hand them in on the 17th floor of this building. All of the comments that you give today, whether oral or written, will be given equal weight. We will review them all and make a determination after reading them if there are additional revisions that we need to make to these regulations. If we decide we need to make additional revisions, we will send you notification of that with the proposed changes and have an additional fifteen (15) day period in which we accept written comments.

When you comment, please restrict your comments to the subject of the regulations and any suggestions you may have regarding them, and please also limit your comments to ten

(10) minutes in length. We won't be discussing them with you. It's possible we might ask you to clarify a point, but unlike the stakeholder meeting, we're here just to listen to your comments today. Okay. So when you come up to give your testimony, please give your business card to the court reporters and please state your name and the group that you're associated with. Okay.

So we're going to start. I'm going to start with the spinal implant regulations, listen to those testimonies and then move over to the ambulatory surgery center regulations, and then come back and make sure that we didn't miss anybody. So first is Kathryn DiStefano.

KATHRYN DiSTEFANO: Did I sign on the wrong sheet?

DESTIE OVERPECK: So you're really -- I'll come back to you. Matthew Absher.

MATTHEW ABSHER: I think I'm on the right sheet. Okay. Thanks. All right. Well, thank you for having us here today. Appreciate it. My name is Matt Absher. I work for the California Hospital Association and we represent over 400 hospitals here in California. We do want to acknowledge the Division for taking some of the suggestions that we had put in during prior sessions, specifically to -- related to the implant add-ons for all spinal DRGs under option one of the payment methodology. We do thank the Division for incorporating those changes.

The biggest issue we have with the current proposed regulations is related to option number two that the Division has put together, specifically related to the multiplier. As folks in the audience probably know, there's -- in the first year the proposed multiplier goes down to 1 and subsequently down to .8 with the invoice -- with the option to include an invoice for payment as well on the implants. We think that the Division needs to take a very close look at the number of hospitals that provide these surgeries currently.

There are about 19 hospitals that provide over half of these spinal surgeries to injured workers in the state, and we're concerned that the reduction of those two multipliers may severely limit the ability of those providers to continue offering those services. We're primarily concerned with the access to care that some patients may have with the severe reductions being proposed. A number of our hospitals, especially those that provide a significant number of these types of surgeries, have also provided comments with some specific data showing the margins or lack thereof under a couple of different scenarios, and so we hope that the Division takes those into consideration as they go through the formal rule-making process.

A couple of other items that are -- may be less important to us but important nonetheless are related to how

a hospital would elect to choose either option one or option two that the Division has put forth. Ultimately we would think it would be better on a case-by-case basis should a hospital be able to choose which of the two options they would like for payment. That's the way that the Texas Division of Workers' Compensation does it and we found it to be relatively effective, although, you know, obviously not ideal, but I think it's better than an annual election. An annual election makes it really difficult for hospitals in dealing with suppliers to make sure that rates are maintained at a lower rate without taking a significant loss providing services.

Two other items. One, it looks like there's been a narrowing of the definition of spinal implants, specifically to hardware. We would ask that the Division consider including biological implants which are items that are not necessarily made of a piece of metal but are implanted and stay in the patient nonetheless. Studies have shown that they can be very effective in improving the amount of time that it takes for an injured worker to get back to work. And we just want to make sure that as technology continues to improve that such items are included for pass-through payment.

I think that's about all I have for now. We do thank you for your time and thank you for considering all of our

comments.

DESTIE OVERPECK: Thank you, Matt. Tom Wilson.

TOM WILSON: I am sorry. I signed up for the wrong one.

DESTIE OVERPECK: Barbara Jones.

BABBARA JONES: Thank you. Good morning. I'm Barbara Jones. I'm here representing Tenet Health Care. Tenet has 11 hospitals and the majority of these facilities will be impacted by the change in the proposed regulations. We have spine programs of all sizes, so some facilities will be impacted more than others and we're interested in looking in that broad spectrum.

Tenet supports the comments of CHA. I have submitted detailed written comments so I'll kind of keep it brief this morning to hit the highlights of your proposal.

The first, the default add-on payment. In evaluating that, really this add-on is too low to be feasible for an option in any of our facilities. The reduction to a 1.0 multiplier is going to move the majority of our programs into negative margins. Our largest program will have to look very carefully about whether they will be able to break even under that option or not. So obviously when we look at the consideration of moving to a .8 multiplier, that will have a severe impact on our facilities. It will impede access. We will have no option but to re-engineer and

relook at those programs.

So to kind of wrap up, some of the proposals that we think would make this more feasible would be to realign your default payment on the add-ons so it is actually covering the cost for the average spine surgery. We need to be protected from the losses. This could be structured with potentially a case-by-case option for billing. There is also the possibility that -- of looking at an annual election by DRG. We're going to stick with the annual election might be a possibility that could ease some of the losses for the programs. And finally we need to take the .80 multiplier off the table to preserve access to these services.

Thank you for consideration of these comments and taking your time to continue to work through these regulations.

DESTIE OVERPECK: Thanks, Barbara. Mike Drobot.

MIKE DROBOT: Good morning. I'm the CEO of Pacific Hospital of Long Beach. Thank you for having me here to talk on this issue. I agree with the CHA and the Tenet presentations. The only thing I'd like to add is that we've presented in our paper to you this morning the fact that we've taken the 1.2 with no pass through, the 1.0 with the pass through and the .8 with the pass through. We've taken our costs from our Medicare cost report and we've taken the

RAND Study and the Department of Workers' Comp's average cost for implants and we've calculated all three of those scenarios for both a lumbar fusion and a cervical fusion. All six of those, all lumbar fusions, whether you use the 1.2, 1.0 or the .8, are negative. We would not be doing those any more. The cervicals are all negative also. We would not be doing those any more if we couldn't get a pass through for the implants.

We have a number of suggestions. They are in our proposal. Hopefully you can take a look at those and see if they might be an item for discussion into the future. Our recommendation would be to hold things the way they are, keep the existing reimbursement program and then work on either -- if we're not going to have the pass through, perhaps increase the multiplier times the DRG or keep the multiplier in and perhaps put some other issues on the table.

We do about 80 fusions a month and I think in the Los Angeles area we've got to be in the top five producers and, just as the California Hospital Association indicated, there would be a disastrous change in our activity and we would not take it. We would not be doing any more spine surgeries. And if we're doing 80 a month, these are all authorized. Obviously these people need the surgery in order to get back to work. By putting this proposal in

action, they would not get the surgeries probably from any hospital that knows what they're doing. So thank you very much.

DESTIE OVERPECK: Thank you. Steve Cattolica.

STEVE CATTOLICA: Hi. I'm Steve Cattolica. I represent the California Society of Industrial Medicine and Surgery and the California Society of Physical Medicine and Rehab, and our comments with respect to the spinal hardware all center on access to care. We would defer the technical discussions and certainly the economic discussions to the Hospital Association and those that have already spoken, but we take them to heart and we know that our members that are involved in spinal surgery are quite concerned.

We aren't sure how you folks will actually end up landing on this. We would, I think, opt or wish you would opt for a delay to study the situation a little further. We have a suggestion on how to do that. The Division is charged with creating an annual access to care study from Labor Code 5307.2. We suggest that that study this coming year begin to access -- to poll the industry with respect to this particular activity to see, number one, if there's a problem, what the problem is and whether access to care is going to be or does actually get affected by whatever the result is that you may choose to do. That's the major point we'd like to make on this particular situation, but we do

ask caution as we know that you'll -- your decision is going to have a grave effect on a number of very hard-pressed individuals. Thank you.

DESTIE OVERPECK: Dena Scearce?

DENA SCEARCE: Close. Dena Scearce. I'm with Medtronic Spinal and Biologics and we develop and manufacture spinal implants and biologics. They are used in the complex spine surgery, the DRGs that are addressed here. We support the comments of the CHA and our hospital customers who you've heard from today. I do want to bring up one issue about the definition of implants, and in your definition you use U.S. Pharmacopeia National Formulary, and I think that's the definition that has always been used and just with some slight tweaks. We have heard from some of our hospitals that when they use biologics within those DRGs that they haven't been covered due to the definition, and we would encourage you to relook at that definition and possibly use the National Uniform Billing Committee's standard and definition. This includes hardware and is used by Medicare. It's also used by most large payers so our hospital customers would be very familiar with this. They already are using it. I think it would be very simple. That's the only additional comment we have for today and I appreciate your time. Thank you.

DESTIE OVERPECK: Thank you, Dena. So that's everybody

I show listed for this issue. Is there anybody else who at this time would like to comment? Come on up.

MIKE TICHON: Hi. I'm Mike Tichon from Pacific Hospital and at the risk of contradicting Mr. Drobot, I thought I'd add a few things. I agree -- I tried all weekend to find the relevance of the Pharmacopeia -- the U.S. Pharmacopeia, otherwise known, I guess, as USP. So I suggest that that be looked at. I didn't get much further than Wikipedia on it but didn't see how that fits with hardware.

I think the whole issue of the technology and the regulations and the definition of what is allowable or not is a technology issue. The medical field is moving. Surgeries that some of our physicians do are called 360's which is essentially a front and a rear surgery. Some other physicians are doing a one entry front and back now and we're having difficulty with reimbursement. And here you have a new technology coming along and they should not be blocked by the regulations. In addition, the market has handled some of the problem.

In our paper, you'll see I have added a managed care discount. I would say at least 60 percent of the spine surgeries we do that are authorized are done pursuant to managed care contracts meaning preferred provider organization or medical provider network organization

contracts. One of those is a five-year contract. We're about a year into that contract. No way to terminate it. It's a very substantial discount. And I'd tell you except for confidentiality, so I used an average in our paper to show you the impact of it. That contract covers almost all the major companies you could think of that are either California based or out of state. That needs to be really looked at and I think it severely impacts all the options.

As Mr. Drobot said, when we ran the numbers, we couldn't get them to be positive with any of the three options. The middle option, the 1.0 with the pass through, we got kind of close on lumbar but on cervical we couldn't, and part of the reason is this managed care discount. So please take a look at that.

I think some other mechanism needs to be developed to address the technology issue as well. There are some legal issues and I won't lawyer up on you, but I'd look at this impact on contracts. I don't know what's happening with the retroactivity of the proposed regulations, whether that's still on the table or not, but that's certainly going to be an issue and I think just the general Labor Code provisions that say that the department is supposed to provide care that's reasonably necessary, if you essentially eliminate a major treatment modality, like spine surgery, which is what this will do, it's going to cause problems under the Labor

Code. If 19 hospitals have half of the work, you've got a very concentrated sample of hospitals and if they're negatively impacted, there's an immediate negative access potential. It's not crying wolf. There's a very small group that does most of the surgeries for one reason or another. So please take a look at all the issues that surround the Labor Code. I think it's -- well, I won't even try to cite it. It's in our paper, but there's a specific section that I think you ought to take a look at. And that's basically the comments that I have.

I agree with Mr. Drobot that the current system should stay in place until -- I know we've studied this and studied this, but I think there needs to be more specific study of actual hospital numbers as opposed to the RAND approach using kind of generic general numbers; and then I don't know how you solve the managed care issue. On one hand you cause us to cancel contracts which then turns into us not being able to take patients from that network so we're caught in kind of a dilemma if this proposal goes forward. Thank you.

DESTIE OVERPECK: Thank you. Are there any other people who would like to make a comment with regard to the spinal implant regulation proposals? Okay. So I'm going to switch over to the ambulatory surgery centers. I'm going to start with the names that were on the other list so we don't forget them. Tom Wilson.

TOM WILSON: Thank you. Good morning. I didn't expect to be first. The acronyms that I'll be using today are ASCs, ambulatory surgery centers; CMS, Center for Medicare Services; DWC, Department of Workers' Compensation; Government Accounting Office, GOA. I think off the top of my head -- HOPD, Hospital Outpatient Departments.

First off, I want to thank the DWC for hearing us in the past and the adjustments that were made. I mean originally the proposal was about a 50 percent reduction and now it's down to 20 percent, so I'm very appreciative that the commissioner looked at our comments and reacted.

And I'd like to talk a little bit today about the internal costs of surgery centers as they compare to hospitals. I was asked by the California Ambulatory Surgery Association, CASA, to take a look at the cost structures. As I understand, the reasons for doing this are solely because the DWC feels that workers -- that ASCs, their internal cost structure is such that they are less expensive and they're less costly than a hospital outpatient department. It has nothing do with the quality of care, patient satisfaction levels, morbidity, complication rates, et cetera. So if we just focus on -- and I would be willing to present data that would show that the morbidity and complication, patient satisfaction levels, studies that have been put out by CMS have shown that ASCs are actually higher

than HOPDs. But if we take a look at the internal cost structure, I looked at the 2009 OSHPD -- I'm not sure, Office of Statewide Health Care Planning, I believe -- data, the financial that it's put out. There are 501 hospitals involved, so I couldn't assimilate all that data, so I just looked at the three hospitals in Monterey County, the major hospitals. One is a district hospital. The other is a county hospital and the third one is a community not-for-profit. They did about 10,000 outpatient procedures in 2009, and I compared it to three centers that I'm involved with in Monterey County. We did about 9,200 procedures last year. I looked at 2010 data.

The first area we looked at was salary, benefits and supplies. We have nurses who work at our surgery centers who work at the hospital, different shifts. The area is extraordinarily competitive. We want to hire the best people, the hospital wants to hire the best people and I am positive that the wages and the benefits are comparable. And when we're doing different cases, the same doctors are doing the surgeries, they're using the exact same implants, the same equipment. I assume that the supplies would be very similar too.

So when we looked at salary, benefits and supplies for the hospitals, the expense for those items as a total -- as a percent of their total expenses was 74 percent. For the

surgery centers it was 69 percent. And I was generally surprised by that number. I thought that they would be much, much closer.

And then we looked at purchase services, which are things like laundry, linen, transcription. And the surgery center was nine percent of its total expenses and the hospitals were five percent; and it dawned on me that the hospitals have their linen service internal and their transcriptions, et cetera, where the ASCs -- we outsource that as such. So if you add up salaries, benefits, supplies and purchase services, the hospitals' total expenses, it was 79 percent of their total expenses; the surgery center was 78 percent. Statistically very, very close.

When we looked at professional fees -- that's attorneys, architects, accountants, et cetera -- the surgery center ran two percent and the hospital ran six percent. And my speculation is -- well, the second most heavily regulated health care facilities in the country are ASCs, but the most regulated are hospitals. We build ASCs to very, very substantial standards so that they can withstand a major, major earthquake. We build hospitals so that they can not only withstand the earthquake but then go on providing care. So I think they spend more money on attorneys, accountants, architects than ASCs do, by about four percent there.

The three hospitals -- their land was donated. They own their own buildings. The three surgery centers we lease. So you find that our lease and rental expenses were eight percent of our total expenses and the hospitals was only two percent. And you see correspondingly in depreciation the ASCs depreciating expense was four percent and the hospitals was six percent. And then all other items -- that's a category that OSHPD has -- the hospitals ran seven percent and the ASCs ran eight percent.

So my conclusion is that even if you look at this very, very aggressively, the most that you would say, at least in Monterey County where the data that we had, is that the hospitals' internal operating expenses might be four to five percent more than an ASCs but no more than that. So the rationale that the Department of Workers' Compensation is coming up with a 20 percent reduction just doesn't seem plausible or reasonable from that standpoint.

A couple of other quick comments I'd like to make is that when I read the material put out by DWC, there was an implication in there that there is a correlation between physician ownership of an ASC and utilization. In fact, the paper quoted an article by Hollingsworth and five cohorts out of the University of Michigan. That is an extraordinarily controversial article. It has been heavily criticized by academia. A couple of points that have come

out is that the authors did not check and see -- actually check on physician ownership. They just assumed if 30 percent of a surgeon's volume was being done at an ASC, that person was an owner. I can tell you in Monterey we have about 60 owners, including the local hospital, and we have 118 physicians on staff, and there are quite a few -- at least 18 -- surgeons who do more than 30 percent of their cases at our ASC and the reasons they do it are because of quality care, patient satisfaction, convenience, et cetera. And in this article the authors didn't -- they attributed volume correlation solely to financial reasons. They didn't look at patient demand, they didn't look at advancements in technology, they didn't look at preference or convenience.

The other thing in that article is that the authors -- one of their conclusions was that there should be a law that surgeons needed to disclose their ownership in an ASC. And of course the authors were not familiar with the current law that that's what happens in ASCs. At least 24 hours before the case the patients need to be informed and they need to sign a document stating that they are fully aware that the physician is an owner in the ASC. All the centers here are familiar with that and those authors should have been also.

So in conclusion I'd just like to say that I think that the idea that to base this on the fact that because surgery centers are more efficient they should be paid less -- to me

that would be like if you had two airlines flying between San Francisco and Los Angeles and one airline invested in turbo props and the other used a different type of engine that got -- were 50 percent less fuel efficient and one airline trained their staff to turn the planes around very quickly, in say 20 minutes versus 40 minutes, then the State of California would come and say, "Well, we're going to pay this airline $200 for that flight but we're going to pay this airline $160 because they're more efficient." Seems like we're rewarding inefficiency from that stand point.

But even given that, if you want to move in that direction, the statistics that I've looked at and I would encourage you to look at the OSHPD data throughout the state, shows that there's very little difference in internal cost structure, maybe four or five percent at most. So I thank you for your time and I thank you for listening to us in the past and today.

DESTIE OVERPECK: Thank you for your comments. Kathryn DiStefano.

KATHRYN DiSTEFANO: Okay. I'm Kathryn DiStefano. I'm the administrator of Advanced Surgery Centers in southern California in the inland empire. It's primarily orthopedic surgery with a little bit of pain management. But I'm glad Mr. Wilson went first because I agree with everything he said, and that was in my written comments that I submitted.

I want to point out one other thing. It's one thing to base the fee schedule on Medicare.

(Whereupon there was an interruption on the intercom)

DESTIE OVERPECK: Wait until they finish.

(Whereupon the interruption continued)

DESTIE OVERPECK: Okay. Go ahead.

KATHRYN DiSTEFANO: In orthopedics the types of outpatient surgery that are done are not necessarily the same types of procedures that Medicare members would be seeking. So Medicare is already insufficient for quite a few of the procedures that we do, specifically shoulder arthroscopy involving any implants for rotator cuff tear instability and also anterior cruciate ligament reconstruction with allograft. And I can say as an administrator already fighting the implant language within the Official Medical Fee Schedule, if the fee is reduced any further those procedures will be diverted to an inpatient setting or a hospital outpatient department.

In our area the access to those operating rooms is limited and that will lead to a delay in care and maybe even a degree of unwelcomeness with the orthopedic surgeons to treating those patients -- those injured workers for those conditions. That's it.

DESTIE OVERPECK: Thank you. Jot Hollenbeck.

JOT HOLLENBECK: Jot Hollenbeck, Senior Vice-President

with United Surgical Partners International. We are an owner and operator of 13 ambulatory surgery centers in the State of California. Nine of these facilities are in partnership with major not-for-profit health care systems -- Catholic Healthcare West, Providence and Scripps Health. We have submitted previously written comments and also want to express our support for the written comments and soon-to-be verbal comments as expressed by the California Ambulatory Surgery Association as well.

USPI is pleased to support refinements to the ambulatory surgery center reimbursement for workers' compensation that improve and contribute to the maintenance of an affordable and accessible system. However, we believe there should remain parity in the reimbursement between ambulatory surgery centers and the hospital outpatient departments when performing the same procedures on injured workers as do the states of Georgia and Tennessee.

We believe workers' compensation patients are much different than Medicare patients and result in ASCs having much similar costs to hospital outpatient departments, as Mr. Wilson previously expressed. USPI recommends that the Division of Workers' Compensation maintains the current ASC workers' compensation payment rate at 120 percent of the Centers for Medicare and Medicaid Services HOPD Fee Schedule. This recommendation will encourage high quality

patients under ambulatory surgery centers to stay in the workers' compensation program. We believe establishing a differential for outpatient surgical reimbursement under the workers' compensation system would introduce incentives to keep cases in the higher paying hospital outpatient department or inpatient setting.

Many ambulatory surgery centers would no longer accept workers' compensation cases at the proposed rates if fees are reduced. Therefore, there would be no savings realized if those cases were moved to the hospital outpatient department at the existing fee schedule rate and costs would dramatically increase if these cases were performed in an inpatient hospital environment. We believe maintaining the current reimbursement structure will help maintain the goal of assuring quality care in workers' compensation cases and much needed access to the injured workers while controlling prices and system costs. Thank you.

DESTIE OVERPECK: Thank you. Peggy Wellman.

PEGGY WELLMAN: Hello. I'm Peggy Wellman, Regional Vice-President for United Surgical Partners. I work with Jot Hollenbeck and echo his comments on behalf of USPI, and I thank the Division of Workers' Comp for allowing us to testify today.

I work with six surgery centers that are joint-ventured with either Catholic Healthcare West or Providence Health

Systems in California. These hospital systems are involved with surgery centers so as to improve access to outpatient surgery in their community which was limited prior to their joint venture.

I evaluated cases across the state in our facilities and the reduction in reimbursement shows that many orthopedic procedures involving fixation will result in our centers incurring a loss. These cases will be redirected to either the hospital outpatient department at the rate currently paid or they will convert to inpatient hospital stays at approximately a 40 percent increase in workers' comp reimbursement. I believe this redirection will cause injured workers with the need for orthopedic surgery to encounter significant access issues as a result of this redirection.

It's important that parity between ASCs and HOPDs be maintained to ensure that patients receive care in the most appropriate setting. Thank you.

DESTIE OVERPECK: Thank you. Debbie Mack.

DEBBIE MACK: Good morning. Thank you for having us. I'm Debbie Mack and I'm Vice-President of Operations for National Surgical Hospitals, which is a management company that owns and develops ambulatory surgery centers. I have oversight for five of those ambulatory surgery centers in the State of California and I want to just speak

specifically to a surgery center that I oversee in Walnut Creek which performs about 841 workers' compensation cases per year; and the analysis that was done for this facility showed us with a loss of about half a million dollars from the current payment schedule to the proposed.

The procedures with which we have the greatest risk of losing dollars are shoulder cases, could be arthroscopy, could be open rotator cuff repairs, tendon repairs, and also anterior cruciate ligament repairs, which is the major ligament in the knee. The analysis will probably be done on a case-by-case basis to review exactly how much those high implants are going to cost and if the proposed work comp fee schedule is going to be enough to cover those costs. It's -- typically an anterior cruciate ligament costs anywhere from $2,500 to $4,500, so if you get a reimbursement of $5,000, that's obviously going to be one of those cases that we ask our surgeons to send to the local hospital.

Which brings me to the fact that the local hospital, which is John Muir Health, it serves a community of about 400,000 lives and is a major trauma center. So what happens when those patients who are not going to be done at one of the three or four local surgery centers is those patients are going to be put on the schedule at the local hospital, which is about two to three weeks behind in elective operating room schedule. They only have ten operating rooms

so there are -- it's quite impacted on a day-to-day basis.

The second scenario that I think is going to be a significant problem is the surgeon is going to schedule a case that's going to be three o'clock in the afternoon; major trauma is going to come in and that case is all of a sudden going to be moved because it's obviously not -- it is elective still. It will be moved to eight or nine o'clock at night. And then that patient is going to be changed from an outpatient to an inpatient, which is going to increase your costs, just like my colleagues stated, by about 40 percent. So I think that you should keep those sorts of things in mind of what kind of impact is going to happen when we're no longer being able to do -- perform those cases where we have high-end implants and what happens when those cases go to the local hospital. I think that's all my notes. All right. Thank you so much for having us today.

DESTIE OVERPECK: Thank you. Marian Lowe.

MARIAN LOWE: Thank you. Good morning. My name is Marian Lowe. I represent the Ambulatory Surgery Centers Association, Washington, D.C., and you pulled on several studies that we have been involved with in production of your rationale for some of the changes that you're proposing, so I wanted to come out here and address some of the issues that you raised and present a couple of new data points. We've submitted some written testimony for the

record already electronically and I'll just summarize some of those statements.

So I want to talk about four basic things today. The Medicare Fee Schedule, growth in the number of surgery centers and growth in the volume of surgeries done in ASCs --

REPORTER: Excuse me. You're going to have to slow down a little bit.

MARIAN LOWE: Oh, I'm sorry. Slow is not my MO, so I'll do my best. Some of the literature that was used to support some of the decisions in the proposal, as well as just some caveats about making comparisons between costs and price when talking about the fee schedule rates.

So let me first talk about the Medicare Fee Schedule. The fee schedule is imperfect at best and I think my colleagues in the hospital setting would agree with that statement as well. The Hospital Outpatient Department Fee Schedule relative weights do form the basis for payment in the ambulatory surgery center, and those are a proxy for the relative complexity of services that I think is very different than talking about the relative price of services between ambulatory surgery and hospital outpatient settings.

The ambulatory surgery center conversion factor is not intended to be a proxy for the relative costliness of ASC services. It is intended merely as a product of a budget

neutrality calculation so that payments to ambulatory surgery centers in 2007 are equal to payments to ambulatory surgery centers in 2008, the year in which the revised Medicare payment system was implemented. The result of that set payments significantly lower than the hospital outpatient department conversion factor, but it is not --

REPORTER: I'm sorry. You are still going to have to go slower.

MARIAN LOWE: I'm sorry. The results of setting the payments lower than the hospital outpatient department is purely a budgetary calculation and not a policy determination. The surgery center conversion factor fails the ASC industry in a couple of places, and my colleagues have spoken to that already. Number one, on low complexity cases many of these things are paid off the Physician Fee Schedule. They are done secondary to another procedure and so therefore discounted 50 percent which sets those rates extremely low.

The higher complexity cases have been spoken to by some of my colleagues. In particular, when you think about a surgery center payment rate for a costly orthopedic surgery in which the implant represents a high degree of fixed cost within that, the conversion factor for ASCs is simply a reduction off of that. It is not taking into account that 60, 70, 80 percent of the base payment rate is made up of a

high fixed cost. So therefore the extra payment, if there is any left on the payment rate, is simply insufficient to cover the other overheads, supplies and services that are necessary for the ASC to provide that case.

Okay. Moving onto growth, topic number two. Your summary of facts very accurately depicted the fact that growth in the surgery center industry was very high the 90's into the first part of 2000, 2001; however, growth has trailed off significantly since then. I think the most recent data that was included in the department's work stopped before we had information on growth in 2009 and 2010. The third quarter of 2010 from the Medicare Provider Services file showed zero growth in surgery center industry. So I think it's important to note that after seven years of payment freezes and very, very small updates to payments -- 1.2 percent in 2010, 0.2 percent in 2011 -- that there's basically no growth in surgery centers and I think that's an important component of thinking about access to the surgery center industry. And so, you know, payments to centers have had, I think, a very direct impact on the beneficiaries' access to services.

And I think the other trend that we're seeing start to emerge and the Medicare Payment Advisory Commission is beginning a discussion of this which you'll see in their March report to Congress this year or in the public

transcripts of their recent meetings, a discussion that surgery centers are beginning to convert to hospital outpatient departments. Physician owners are being bought out, employed by the hospital and the hospital -- the surgery center is now operating under the hospital license from the state or Medicare program's perspective. This is a change in payment rate, not a change in operation, and that's something that we think is a very bad trend for providers, for beneficiaries and for the payers and taxpayers who support that. So I think being cognizant of the impact of those payment changes on centers.

Third topic, some of the literature that was cited. Some of my colleagues have spoken to this before. Couple of points I want to make. Some of the literature quoted by MedPAC and Health Affairs talked about the relative complexity of patient's underlying medical conditions and the types of services that were being done there.

It's important to note that all of the references to medical complexity of patients in MedPAC and Health Affairs represents work looking at data from 1998 and 1999. This is a much different era in the ASC payment system and in the industry and I think is not representative of the relative complexity of patients now.

Induced demand. There are several studies -- Hollingsworth, others -- that accuse or intimate that

surgery centers are doing more volume than is medically necessary because physicians have an ownership interest in those centers. These studies fail to control for self-selection of physicians into ownership status. They lack data on the ownership of surgery centers, on the ownership status of physicians, and so therefore assume that volume equates to ownership and then they measure volume. This is a terribly circular argument and one that we don't think should be used as a basis for any kind of justification.

These studies are very geographically isolated. They're not necessarily nationally representative. They're looking at data in a certain -- in various states and they're looking at a small scope of procedures, many of which -- cataracts, colonoscopies -- may not be representative of the population that you're talking about here.

Okay. Cost and quality. I promise I'm almost done. The literature that you've cited mentions the National Ambulatory Surgery Center legislation that was introduced in the House of Representatives several years ago which would set the ASC payment rate at 59 percent of the comparable rate for the hospital outpatient department's services. This is hypothesized as justification that their costs are in fact lower. That legislation is intended

merely to stop the bleeding because the Medicare payment rate for surgery center services is diverging from the hospital outpatient department rates, so 59 percent is basically a stop-the-bleeding methodology.

In the past couple of years in Washington, and I'm sure out here, we've been operating in a very tight budgetary environment so the idea of proposing a payment rate that gets towards the parity that we think is appropriate is just not something that would be well received in the Congress or with our champions. So please don't think of 59 percent as a proxy for what we think our costs are relative to the hospital's base.

It is true that ASCs are presently a less expensive setting for the Medicare program to have services performed in. Again this is a price differential and not a cost differential. We saw last year ASC volume for some of the high volume surgical services for the Medicare population declined significantly. Volume for colonoscopies fell 10 to 12 percent in the Medicare population. Those same services have seen double-digit declines in prices over that same period. You know, I can't say for sure that that is the reason, but I think it's something to be cognizant about when you talk about significant price decreases here, the impact that that may have on where volume goes.

And then the last piece I want to talk about is the GAO

study that was mentioned. The Government Accounting Offices, I believe it was then called, did conduct a study at the request of the Congress looking at ASC services and whether the hospital outpatient department ambulatory payment classification, APC, was the appropriate relative measure of price amongst surgical services. GAO had basically two tasks in that report, determine if the APC was appropriate and determine how much of the payment base rate should be adjusted by the geographic adjustment factor, the Medicare wage index.

GAO went beyond that to look at the relative costliness of services in both settings and in doing so created a measure that was an unweighted measure of ASC and hospital outpatient department costs. The number they came up with and the number that's represented in the report is 39 percent. This is an unweighted number in MedPAC and most of the other policy circles. No one would justify putting an unweighted number. That's like lining up 100 providers, counting their margins and saying the average margin is that number divided by 100. If 90 percent of your volume is in one provider, that's not representative of the population. It's the same situation here, how GAO did that. If they had weighted their sample, which they did show later in that report, the relationship was 84 percent. So that was, you know, significantly different and I think it's also

important to note that that was then a measure of what ASCs were doing.

That is not -- the mix of services that they were doing is not representative, I don't think, of the mix of services in the BWC population or -- I'm sorry, DWC here in California. It's representative of the mix of Medicare patients, and so I would caution you against using that relationship as a proxy for relative costliness. And that's what I wanted to mention here today. I appreciate your time. I appreciate the thoroughness of your work in looking at this. You've clearly done a lot of work to get to these issues and if there's any questions that we can answer and follow up with, we'd be happy to.

DESTIE OVERPECK: Let's at this time take a ten-minute break. Thank you.

(Whereupon a short recess was taken and the remainder of the proceedings were reported by the second court reporter)

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DESTIE OVERPECK: If everyone will sit back down, we'll get going again. We're going to call Fred Hekmat next. And I'd just like to mention that when you're speaking, if you see the court reporter go like this, it doesn't mean talk softer, it means talk more slowly.

FRED HEKMAT, M.D.: Hello. I am Dr. Fred Hekmat. First, thank you for the Committee for allowing us to talk here. And after I heard about this proposal, I thought about it and wrote several comments that I would like to state.

The proposed plan to revise the payment schedule to surgery centers needs to be revisited. It will not only result in any saving, contra-indicated in the long term, it will result in higher costs. Unfortunately in 2005, due to predatory business practices by some unscrupulous outpatient surgery centers, a rather draconian Fee Schedule was implemented in order to offset the unreasonable fee charges by these facilities. As a consequence, the legitimate outpatient surgery centers have been forced to endure drastic -- sometimes drastic losses in revenue. However, implementation of the proposed plan in its current state will result in staggering financial losses to the few remaining outpatient surgery centers. As a consequence, you will put surgery centers out of business and patient care will have to be given in the hospitals, which will culminate

in higher costs, not the initial cost savings envisioned by this esteemed Committee.

At the present time, outpatient surgical centers are running close to going bankrupt and this is true for the orthopedic centers. It should be noted that 70 percent of the workers' comp injuries are orthopedic injuries. And there are several factors which needs to be considered.

First, the payment for surgical centers paid by the workers' comp in California is 30 percent of what national insurance companies pay for similar procedures.

Number 2, for every $7 paid to surgical centers for any one particular procedure, insurance companies pay $3 more to the hospitals, which translates to 43 percent higher costs.

No orthopedic surgical center can survive on Medicare rate payment. And I will describe this later. Many hospitals have been forced out of business and some are surviving only because of Federal State subsidies, research grants, donations, and also because of higher cost of surgical procedures such as spine fusion, that they survive.

The cost for orthopedic surgery centers are higher than those dedicated for plastic or other general surgery procedures.

The next item is that the cost of collection in workers' comp patients is substantial because of the delayed

payment and payment which is disproportionate to the expense incurred to provide the services.

Now to elucidate what involves in cost of running a surgical center, I divided the cost of surgical center in three parts. One is the first part, is the part of construction. An orthopedic center right now will cost a million and half to construct. This is cost of construction, sterilizer, special orthopedic equipment, orthopedic table, anesthesia machine, etc.; the second cost is the fixed cost of the running the surgery center. This is a cost whether you do one case or a hundred cases. That includes rent, malpractice insurance, liability insurance, care and upkeep of all general and orthopedic equipments, the permanent staff, which includes nurses, scrub technicians, orderlies, radiology techs, secretaries, administrators and collectors.

What we did was we divided this cost by the number of the cases that we did in a year. And this fixed cost came to $2,620 for each case that we did in our center. Now the third cost is a variable cost. This cost varies from case-to-case. The carpal tunnel will cost less and some other procedure will cost a lot more.

I'll talk here about, for example, rotator cuff repair that the other speakers talked about it. In this operation, since I'm a surgeon and I know exactly what's used, we have

to use implants, the cost is $600 and we have to use usually three implants, sometimes five. So that's $1,800 just for implants. There's thermal ablator under $65, shaver $60, bur $60, drapes $200, cannulas $120, tubing $60, anesthesia medication $425. So for doing a rotator cuff repair, the variable cost alone is $2,890. So if we add the variable and fixed cost together, that comes to $5,510. Now let's see what Medicare pays. Medicare pays $1,876. The difference is $3,633 loss for doing an orthopedic procedure with Medicare payment.

So, in conclusion, if -- right now the centers are surviving because of the payment from the old cases and doing non -- not workers' comp cases; that's how we're surviving. You pass this law, we are not going to survive or we have to shift to another avenue of income and these patients will have to go to hospital with higher costs. Thank you.

DESTIE OVERPECK: Thank you, Doctor. Jay Hekmat?

JAY HEKMAT, M.D.: Good morning.

DESTIE OVERPECK: Do you have a business card?

JAY HEKMAT, M.D.: Yes, I do actually. I left it somewhere.

I'm Jay Hekmat. I'm an orthopedic surgeon. You just heard my brother Fred Hekmat, who is also an orthopedic surgeon. We founded an orthopedic outpatient surgery center

about 14 years ago, probably one of the very first ones in the United States to serve and perform complex orthopedic procedures as an outpatient. The idea came about as I served as a member of the Board of Surgery at Cedar Sinai Medical Center, and the idea was to defer surgeries from inpatient to outpatient to minimize the costs, and it did work. And the idea was so good, it spread across the country. And you can see how many surgery centers are in the United States. The problem came about, to provide good services and the high maintenance of the costs being compromised by cutting the reimbursements. In 2004, the substantial cut reimbursements in the Fee Schedule affected a lot of surgery centers. And some of them closed down. We managed to survive by maintaining very close observation of the cost. The numbers you heard from my brother is very accurate. We do the surgeries ourselves in our center.

To repair a rotator cuff, he mentioned, takes few anchors, people who are familiar with it, to repair them, the rotator cuff. And most surgeons nationwide are using these anchors, the cost $650 each. You tell us how we can survive, if we repair rotator cuff with four anchors, and we pay almost $2,600 in just anchors alone, not to mention the nurses, not to mention the technicians, not to mention the billing and collection, and all the trouble we go through to collect the money for the services? And all of this have

been said by many other people.

I have to bring another factor into this picture. There was some statistics prepared by my biller in the billing department of our surgery center. From July first of 2009 through June 30th of 2010, this is exactly a year, in our facility we did about 331 orthopedic cases, and we do very complex orthopedic cases, out of which -- and these are all workers' compensation cases, I'm not not talking about private cases -- out of which, 112 cases so far as of today, has not been paid, all authorized cases; 159 cases have been paid below the bare minimum Fee Schedule. You can see, for us to collect this, we have to endure additional costs of hiring collectors, going to hearings, trying to retrieve this money maybe three to five years down the road, in some cases. I don't say all of them. And to pay all that amount mentioned by my brother, maybe almost $5,000 per case out-of-pocket and sitting and waiting for another three to five years to collect that, and in most cases, the State compensation doesn't allow penalties, because as long as they have made some payments, we're not entitled to penalties, so all we can collect is our fee, it doesn't make any business sense.

I'm trying to bring this down that if we go with Medicare, Medicare is electronic billing which pays within two weeks. We do have that. With workers' compensation,

that doesn't apply. We have to bill and go through this very difficult process to collect the money. And everyone who is here, I'm sure every single person who is involved with surgery centers have gone through this. They have lien collectors or guys to go to collect these cases.

Everyone that is here knows the process. When you perform a surgery on a workers' compensation patient, in order to collect your money as a center, you file a DOR. That means they have to wait until the case in chief is settled before you're entitled to get compensation for your money. And some of these cases could go on forever.

So adding this to all the numbers that my brother presented and other speakers earlier, you can realize there is no way that we can go with the Medicare rate. Either we have to walk out and defer care of patients of workers' comp to others or go bankrupt, and it would be totally unacceptable, because most of these centers are providing very high quality of care and very close to what they do at the hospitals. And I did work at the hospital for many years and I know the costs because I served at the Board of Cedar Sinai for many years. And the existing surgery centers, with the numbers that we receive, are very much competitive with the rates that hospitals are. The costs to us is about the same, and the rates are very close to the the hospitals, and I think it would be very unfair to

jeopardize us and to lower the reimbursement to us. Thank you.

DESTIE OVERPECK: Thank you. James De Ciutiis?

JAMES V. DE CIUTIIS, MBA: De Ciutiis. Hi. My name is James De Ciutiis. I'm a Regional Vice President with Am Surg Corporation. Currently I oversee four multi-specialty surgery centers, all of which see orthopedic and workers' comp patients. And some of the other colleagues mentioned about rewarding efficiency. I'm going to share with you some of the physicians' sentiment that I received, when I've discussed these cuts with them, and also mentioned to them some of what you've already heard, is that this may end up moving cases over to the hospital. Some of the physicians said, "Well, I'll just end up going to the hospital, to do these cases." Other physicians said that they would stop seeing workers' comp patients altogether.

Partner and nonpartner physicians tend to prefer to do their cases at the ASCs. They're able to do more cases in less time, to do either one of two things, either to have more personal time to themselves to do whatever they want, or to get back to their office to see even more patients.

What this essentially will do for workers' comp is it will decrease the supply of the physicians for the patients. It causes the patients to end up waiting longer and to be out of work longer and to be in pain longer.

I think that actually the focus should be turned towards more -- towards incentivising or increasing the incentives or expanding the services available to be done at the ASCs, instead of doing what this, as clearly you've seen, you've heard from other physicians and I've shared some of the sentiments from the physicians that I have worked with, is that workers' comp is going to end up not being part of their practice. So I just think that should be more the key to look as to how to increase the supply of physicians available to workers' comp.

Some people mentioned the predatory practices of some centers in 2004. Some physicians after 2004 when the workers' comp rates were cut, stopped seeing workers' comp patients at that time. There's physicians that I know that don't see workers' comp patients because of the amount of paperwork that they have to do. I just think that there's better ways to do it, to try to drive business into the ASCs instead of out. Thank you.

DESTIE OVERPECK: Thank you. Beth LaBouyer.

BETH LaBOUYER: My name is Beth LaBouyer and I'm the Executive Director of the California Ambulatory Surgery Association. I also will be speaking to you as an RN, dare I say 26 years, and most of that in the Operating Room environment, both within the inpatient, hospital Outpatient Department and the ASC.

The California Ambulatory Surgery Association represents Ambulatory Surgery Centers throughout the state of California. We have done so for 24 years. We really appreciate and respect the work the Division is doing in looking at providing reasonable costs for our patients. Our 345 members strongly believe that all injured workers deserve access to the best medical care possible, and we remain committed to successfully accomplishing that objective.

We at CASA have reviewed the Division's proposal and we believe the following points really need to be addressed before moving forward: Outpatient surgery should be paid the same fees regardless of the facility setting. ASC outpatient surgery cases would be removed to the hospital HOPD environment or the inpatient at a higher cost. An injured worker's access to outpatient surgery would violate a reasonable standard of care.

For the first point, outpatient surgery should be paid the same fee regardless of the facility setting. The exact same services are being provided to the exact same patients by the exact same physicians and surgeons. Costs associated performing surgery in an ASC or an Outpatient Department are comparable, and I believe Mr. Wilson articulated that very well earlier this morning. We encounter practically the same costs for labors and supplies and often ASCs will pay a

higher amount for their supplies because they don't have the purchasing power of a larger hospital system. HOPDs do have some higher overhead, but this increase is also offset by the fact that ASCs will pay Federal and State taxes. Creating a gap in the ASC and HOPD payments will create inequities and establish a system with inappropriate incentive for the site-of-service selection.

As Ms. Lowe testified earlier, the Medicare Payment Advisory Commission, MedPAC, has recognized the problem created by the new payment system for ASCs and has opened a dialog on how to address the issue. Replicating these flaws in the proposed workers' compensation reimbursement will be damaging to the injured worker and to those that provide their care.

By moving forward with this proposal, we will only encounter duplication of these current problems that the Medicare system is realizing. In reviewing the typical workers' compensation patient, we can quickly see how this -- these problems are materializing, particularly if you look at the specialty of Orthopedics. In the report, Orthopedics account for about 50 percent of the workers' comp cases, and the Medicare system, it's 7 percent. This is an extremely significant disparity and we really need to look at it seriously.

Orthopedic cases are extremely supply intensive, labor

intensive and implant intensive. If this proposal of reducing the fees by 20 percent actually is implemented, as it's been testified earlier, orthopedic cases will be reviewed individually to determine if the ASC can even provide the care to cover their costs. And I would go on to say if this proposal goes through, every workers' compensation case will be individually evaluated to make sure that they can provide those services.

Our second point of ASC outpatient surgery cases will be moved to the HOPD or an inpatient at a higher cost. We just, you know, by those reviews, they can't cover their costs, they're going to be moved to the outpatient department. By doing this, the anticipated savings will not be realized.

Ms. Mack testified earlier about the Walnut Creek area. Right now, before the proposal is in place, they already have a three-week window to being able to get into those surgeries in the inpatient world. If the proposal goes through, there's a glut of cases that are put into that system and it's going to be even a further delay in getting those services.

What also can happen, so you're not going to receive the savings by the proposal because now they're inpatient, but often what easily happens is these patients move from the Outpatient Department into the Inpatient. And I speak

to this, it sounds -- might sound far-fetched, but as working in the OR for as many years as I have, I can tell you it happens quite easily. We've already spoken to the fact that they are going to have difficulty getting on the schedule. And in the ASC, the surgeon has a blocked time, and he's able to look and say, "Wednesday is my day. I can put these cases where they belong, so I'll put the most difficult cases starting at 8:00 o'clock." And they can be easily discharged in an outpatient manner. If they're having trouble getting those cases on the schedule, they may be lucky to get them on by 12:00 o'clock into the hospital arena. And what happens is they're on for 12:00 o'clock, but then we have the ER, we have the inpatients that have certain-need priority surgery, and these cases essentially get bumped for the more medically-urgent procedures because they're elective. So now you have these procedures being done later in the afternoon; you have staff that aren't as familiar with these procedures because they were meant to be done earlier when the staff that was familiar with them are on -- on the payroll. So, they hit the recovery room later in the evening and what's the prudent thing and the safe thing to do for the patient is to keep them overnight, and they miss that window of being able to be discharged as an outpatient, and now you have an inpatient procedure. And as was testified earlier, those costs can be up to 40 percent

higher than the hospital outpatient.

We believe injured workers' access to outpatient surgery would violate a reasonable standard of care, and existing law establishes that rates or fees should be adequate to ensure this reasonable standard of care, and at CASA we feel this 20 percent reduction is -- violates the mandate that was set by the Legislature in 2003. The injured worker in many cases will no longer have access to the standard of care they're receiving at the present. They will likely have to wait longer for surgical treatment, medical resolution and turned into a longer period before returning to work; all costs that are difficult to quantify. By reducing fees to the ASCs by 20 percent, the workers' compensation system and many of the injured workers will miss out on the benefits of the ASC industry. They'll miss out on the 90-plus patient satisfaction results that ASCs receive. They'll miss on the documented lower infection rates that ASCs have. They will not have access to a lot of the staff that specialize in these procedures and these technologies.

We really strongly urge you to reconsider this proposal of reducing the fees by 20 percent. We stand ready and more than willing to participate in -- with the Division and any other stakeholders to further reform the system and assist with reducing unnecessary medical expenses, while at

the same time maintaining the standard of care. Thank you for your time.

DESTIE OVERPECK: Thank you. Shannon Blakeley?

SHANNON BLAKELEY: Good morning. I'm here today wearing two hats. I work for Surgical Care Affiliates, a surgery center company, which I believe is the largest in the State of California. We have 31 surgery centers, 1,200 teammates and 1,400 physicians that work in our facilities. We do -- currently do about 22,000 work comp cases a year, six -- approximately six to 7,000 of those are done in the state of Californa. So this is a big deal for us. I also am the current President of CASA and many of my colleagues have expressed sentiments today and I'm going to echo some of those, but the 345 members of CASA, I'm also here to represent.

We're very concerned about the proposed fee reduction on a number of fronts. I agree with Beth. I think you need to start with the parity argument. If you're going to reduce the Fee Schedule, it needs to be reduced across the board. I don't think ASCs should be singled out. I think if we're going to talk about a fee reduction, again that should be across the board, and we should include HOPDs in that discussion.

By decreasing fees in the ASC setting, you're going to create a two-tiered system, one that will reward

inefficiency and discourage efficiency. I think Ms. Lowe touched on this earlier. We already have that on a national level, and one of the fears I think we have as an organization and through SCA is that once this system is created, you may have a situation where hospitals will be allowed to participate in market increases and ASCs may not. Again, we've seen that in other areas.

Basing reimbursement on Medicare Fee Schedule is not the Gold Standard. Again, we have talked about this. It's a much different population. For the most part, workers' comp patients are much younger, much more labor-intensive to treat those types of patients, and they're primarily orthopedic and pain in nature. I know for our company we will be taking a hard look at most orthopedic and pain cases that we do that are workers'-comp based, because we just won't be able to perform some of those procedures based on the cost.

Finally and probably most importantly, I worry about access. Currently, workers' comp patients have access to pretty much the, I would say the entire state of California. There's 800 to 900 surgery centers in the state. Most of those centers accept or participate in the workers' comp program. Access, due to cost reduction, will be limited. This is going to create a backlog in the system. I think Mr. De Ciutiis talked about this a little bit as well. You

have a physician component, where I think the physician pool will be lessened, thus affecting access and the backlog. The injured worker will ultimately have to wait. There will be delay in care and finally can end up, as Beth spoke, in the inpatient setting, which again will lose efficiency in the system.

So, in closing, I would just strongly urge the DWC to consider these issues carefully, go into this with eyes-wide-open approach. Again, I think the rate reduction should be across the board for ASCs an HOPDs. Thank you for your time and consideration.

DESTIE OVERPECK: Thank you. Bryce Docherty?

BRYCE W.A. DOCHERTY: Let us pray. Just kidding!

My name is Bryce Docherty. I am the Legislative Advocate for the California Ambulatory Surgery Association. I want to thank the Division for your due diligence on this issue, dating back to May of last year when we started discussing the issue and the role that Ambulatory Surgery Centers play in the work comp system, particularly as it pertains to our Fee Schedule.

I think what you've heard this morning is examples of what we've been talking about and what Beth and Shannon capsulized and what we've been saying since May.

I want to give you a little bit of a brief background on how we got here and trying to discern what we're doing.

2003, 2004, the prior administration, Schwarzenegger Administration, spent a two-year process implementing Workers' Compensation Reform, the first time there had been any major work comp reform in about a five-to-seven year period. In 2003, SB228 and 229 were Legislative proposals that gave the Administrative Director the authority to augment the Official Medical Fee Schedule as it pertains to Ambulatory Surgery Centers and hospital Outpatient Departments in particular. In setting that authority, they gave the Administrative Director a ceiling, if you will, in terms of a maximum reimbursement that's allotted for outpatient surgery, which includes the HOPD and the ASC at 120 percent of the Medicare HOPD rate.

Having been working for the California Medical Association, at the time responsible for workers' compensation issues, I was there when these discussions were happening. The discussion regarding outpatient surgery and what the fee should be was not a discussion about whether or not Ambulatory Surgery Centers should be paid their portion of the Medicare Fee Schedule. The discussion was one of removing gamesmanship and perverse incentives in the work comp system that has plagued the system for decades and establish a reimbursement methodology for outpatient surgery as a category that treated procedures done in a hospital Outpatient Department and an Ambulatory Surgery Center the

same. That was the intent of the Legislature at that time.

I would differ with the Division of Workers' Comp assessment on what that intent was. To that end, I think the Division, throughout this process, has heard from members of the Legislature opposing this proposal and speaking to what that intent was. And I think the Legislature's understanding of what the intent was in establishing a Fee Schedule, and the authority that the Administrative Director had in augmenting that Fee Schedule, is congruent with what our understanding is.

I think in response to some of those inquiries, the Division has the position of respectfully disagreeing, and in terms of establishing the need and/or necessity for moving forward with an official regulatory package that must, at the end of the day, be approved by the Office of Administrative Law; the need and necessity statement was based on the fact that they feel Ambulatory Surgery Centers are woefully overpaid and that we need to find savings in the work comp system. I think from the testimony you have heard today, that you have been disavowed of the notion that these savings will be realized, based on what in poker terms is an all-in assessment from the Division of Workers' Comp. And that assessment is one that I think you have admittedly, openly admitted that the important question is whether or not the allowances and the Fee Schedule that's being

proposed, provides mutual incentives with regards to the site of service so that care can be provided in the most appropriate setting for the patient. And I think what you're hearing is that's a gamble that the California Workers' Compensation System, the DWC, is going to lose at the end of the day.

Furthermore, I just want to punctuate a point that Beth made with regards to what may very well be an overreaching authority of the Administrative Director in establishing these fees. We will concede that the Administrative Director does have the statutory authority to augment the Fee Schedule in workers' comp. 5307.1, et. al, is pretty specific in that regard. The maximum fee shall not exceed 120 percent of the Medicare HOPD rate for outpatient services. However, I think some of these proposals, this proposal in particular, does not take into account the full ramifications of subdivision (f) of that same section. Subdivision (f) of that section stipulates within the authority granted to the Administrative Director in augmenting certain elements of the Office Medical Fee Schedule, OMFS, the rates for fees established pursuant to that authority shall be adequate to ensure and I quote "reasonable standard of service and care for injured employees." CASA would argue that if this proposal moves forward and is implemented, and we indeed see cases being

deselected in workers' comp by Ambulatory Surgery Centers, and therefore no other option but to be done in a hospital Outpatient Department or Inpatient at the same cost as today, or a higher cost, would not only violate the necessity standard and moving forward with the official regulatory package but would also be a clear violation of what the Legislature has deemed would be an excessive use of that authority in establishing those fee schedules and we believe would violate a reasonable standard of ensuring injured workers' access to outpatient surgery services.

With all that being said, I think we're here appreciative of the process but a little disappointed and frustrated that we feel we're fighting on behalf of our injured workers to maintain the access that we think would make the workers' compensation system solvent and would maintain the integrity of injured workers, and we appreciate the Division's attempt to make this as transparent of a process as possible, and I have been working with you on this since May and hope to continue to work on a going-forward basis with all of you or anybody else under the new Administration that takes responsibility for some of these issues. Thank you.

DESTIE OVERPECK: Thank you. So it's almost 12:00, but I think we'll be done in another half hour or so. So if it's okay with all of you, I'm going to keep going. Okay.

Ted Durden?

TED DURDEN: How are you doing? First of all, I want to thank you for the opportunity to speak here today to address the issues of the proposed regulations regarding the Ambulatory Surgery Centers.

I only have a few things to add to what's already been said by the -- my associates that have showed up here today. I represent about five surgery centers in Southern California and about five medical supply companies also in Southern California. I think the most important thing that has to be remembered is that the purpose of workers' compensation system in general was to make sure that our injured workers were afforded access to adequate medical care. With some of the proposals that are set forth as far as reducing the reimbursement level of the surgical centers, there is a great risk of their access to medical care being compromised severely.

From some of the numbers that I've seen and I have looked at, the proposed regulation and level of reimbursement is about -- represents a 60 to 65 percent reduction in the actual costs. For example, an ACL repair at the surgery centers that I represent is approximately $9,100. The level of reimbursement on the Medicare would be about 3,447. That's a dramatic difference.

I think we all have to recognize here that we're a

capitalist society. You go into business to make a profit, even hospitals, surgery centers, whatever the business is. That's why we're here. I think it's admirable and notable that surgical centers, like hospitals, also provide a needed service and that is surgery to make sure that the injured worker is able to return to work at as close to his condition prior to being injured.

What's at risk here with these proposed regulations and level of reimbursement is that, as you've heard, hospitals, as well as Ambulatory Surgical Centers, will have to reconsider whether or not they will incur these costs and suffer these losses.

Of the five surgical centers that I represent, between 2008 and 2010, each facility is running about between a $100,000 and $200,000 in the red, even based on what the current reimbursement level is. Some of that has to do with delay in payments, on admitted and accepted and authorized injuries and surgeries. I think that at the time when you looked at the Medicare reimbursement level, I don't think the Committee took a -- were willing to take into consideration what the cost is of doing business, the overhead, the nurses, the transcribing, the transcriptions; all of these things have to come into play. They cannot be easily dismissed. By the very same token, those companies that provide the hardware, the burs, the screws, the graphs,

the plates, their level of reimbursement has dropped dramatically as well. And they have two choices at that point. They can either get materials that are substandard in quality, resulting in additional surgeries to replace the lower-quality products, or incur additional losses. I have some that no longer even provide hardware to the surgical centers because they can't afford it anymore.

Of the five surgery centers that I represent, three of them no longer take workers' compensation patients. They are slowly and methodically moving towards personal injury cases where the reimbursement level is closer to what their costs are.

With all due respect to the time and the effort that this Committee has put in and the hours and the time to come up with these proposed regulations, I will strongly urge you to take a closer and harder look before you actually implement them, because as has been communicated by my associates here, you're going to look at a mass exodus of either hospitals, surgery centers and medical supply companies, and the cost savings that you had envisioned that you had hoped to enjoy, will never, ever be realized. Thank you very much for your time.

DESTIE OVERPECK: Thank you. Marc Jang.

MARC D. JANG: Hi. My name is Marc Jang and I'm a founder of a company called Titan Health Corporation. We

are an owner operator of 19 facilities throughout the country, three in California. What I would like to do is give you a perspective from a small business operator's, you know, perspective and compare two of Titan facilities that are really at different ends of the -- what I'd say the company-maturity curve, in that one of our facilities is an 11-year-old facility, and the other facility that I'll compare it to is a little over one-year-old. And, obviously, given the maturity -- the differences in maturity of these two facilities, they also have very, very different cost structures. What I'd like to do is correlate those cost structures though to some very common procedures that are being performed in ASCs for this particular patient population.

So, like I said, our first facility is in Northern Californa, an 11-year-old facility, no debt. All the debt's paid off. And so it's a very, very cost-efficient facility at this point in time. If you look at the proposed rates or the fact of the matter is even the common rates, what we receive for single-level epidural steroid injections, and this particular facility does a lot of pain medicine, the fact of the matter is, we lose money on both of those, at both the current and the proposed rates.

The second facility, like I said, is a little over one-year-old. And it's a multi-specialty facility

performing orthopedics, spine and pain. It has a very, very heavy worker comp population or patient base, given our specialty mix, but also as a newer facility also has a very, very significant debt load on top of that. So, for this facility what I considered was three -- three other primary procedures that I know are common to worker comp population, in that they're the rotator cuff, carpal tunnel and ACL repairs.

Very simply, rotator cuff, we make a whopping $54 per case on those proposed reimbursements. Carpal tunnels, we basically lose money on them. And for ACL repairs, it reduces our profit to a little over $500 per case.

So you can see it's, you know, while our centers are financially viable, you know, the reason we are able to survive though is because of the case mixes and specialty mixes, I mean payer mixes that we have.

And so, what I think you're hearing today is that, from me and all the colleagues, are that I think our industry has been a very faithful provider of services to this -- to the worker comp, you know, population. I think you also are hearing that we want to continue to serve as a faithful provider, but if these continued downward pressures occur -- continue to occur, inevitably you're going to see a shift. You know, you're going to see a shift to the hospitals, or you're just going to see a shift within our

surgery centers alone. We're going to look to focus in other areas where our margins are better. So I respectfully submit or request that the Division preserve the existing Fee Schedule because it's, you know, it's very tough as a small business operator these days already. Thank you.

DESTIE OVERPECK: Thank you. Jessica Holmes.

JESSICA HOLMES: Hello. My name is Jessica Holmes. I'm the Regional Reimbursement Manager in Health Economics and Reimbursement for Boston Scientific Neuromodulation. Excuse me. Boston Scientific is a founding member of the Neuromodulation Therapy Access Coalition, who you'll hear from shortly and one of the world's largest medical-device companies. Our mission is to improve the quality of patient care and the productivity of healthcare delivery through the development and advocacy of less invasive medical devices and procedures that can reduce risk, trauma, cost, procedure time, and the need for aftercare.

We are not only here as a partner to healthcare providers and the DWC, but as an employer in the state of California, with thousands of employees throughout California developing products to treat aneurysms, arythmias, artery blockages and chronic pain.

I'd like to focus my comments on chronic pain, using spinal cord stimulation as an example, since pain is a significant issue for many sick and injured workers and the

workers' compensation program as well. Spinal cord stimulation is a minimally-invasive procedure that provides a safe and effective treatment option for certain chronic pain patients. It's often considered a late or last-resort procedure and at times it's the only treatment that provides the pain relief necessary to allow a chronic pain sufferer to return to work.

Since these procedures are minimally invasive, they are performed in the ASC setting, as well as the hospital setting. The proposed reduction in payment rates from 120 percent to 100 percent of Medicare OPPS could make it cost-prohibitive for surgery centers to treat patients covered under the workers' compensation system with device-intensive procedures like spinal cord stimulation. At the risk of sounding redundant, significantly lowering payment rates in this way may result in unintended negative consequences, such as (1) procedures that could be performed in the more cost-effective surgery center setting may be shifted to the hospital setting, resulting in higher medical cost to the work comp system; and (2), if surgery centers cannot afford to treat patients covered under the workers' compensation system, some ASCs may reduce their services or discontinue treating injured workers altogether. And without timely access to necessary healthcare tests and treatments, patients' ability to return to work could be jeopardized.

Based on the potential of these changes to negatively impact healthcare access, we recommend postponing implementation until further studies can be performed related to the likely impact of this reduction in payments.

We at Boston Scientific look forward to working with the DWC and other policy makers on solutions that allow for continued patient access to care.

We thank you for allowing us to have a continued dialog with you during this rule-making process and we thank you again for your time and your consideration.

DESTIE OVERPECK: Thank you. Eric Hauth?

ERIC HAUTH: Good afternoon. My name is Eric Hauth. I'm the Executive Director of the Neuromodulation Therapy Access Coalition or NTAC for short. NTAC is a national multi-state holder coalition comprised of consumer advocates, which includes the American Pain Foundation, which is the nation's leading advocacy group for those living with chronic pain, several national pain physician organizations, interventional pain societies and manufacturers of implantable neuromodulation devices used to treat certain forms of chronic pain, including spinal cord stimulation, as Jessica just mentioned. I would also note that the industry members of our coalition also have significant manufacturing presence here in the state of California.

NTAC is -- excuse me -- is dedicated to ensuring appropriate access to neuromodulation therapies, including spinal cord stimulation, again, an important therapy option for those living with chronic pain. I'm accompanied today by Dr. Francis Riegler, who is the President of the California Society of Interventional Pain Physicians, and his practice manager Lance Jackson, so I'm going to let them speak some more to the specifics around this issue.

I would just say that NTAC is relatively new to this issue, so we wanted to introduce ourselves in the public record and just note that several of our coalition members have in the past testified on this issue back in May and August of last year. So, again, I will let Dr. Riegler and Lance Jackson speak to the more specific issues.

I guess we would just say we would echo many of the concerns that have been talked about today and would urge the DWC to evaluate this process, slow it down and delay it so that there can be a more full discussion and full understanding of the implications of the proposed rules, in particular for those living with chronic pain and again many of whom are going to have a very difficult time if they don't have access to the more efficient ASC setting, to not only get the treatments that they need, but ultimately get back to work, which is a big issue for -- for those living with chronic pain.

So, again, with that, what I'd like to do, if it's okay with you, is just turn it over to Dr. Riegler.

FRANCIS X. RIEGLER, M.D.: Good afternoon ladies and gentlemen. My name is Dr. Francis Riegler. I am a specialist in pain management, and I would like to say, first and foremost, that I am here on behalf of my patients, many of whom are injured workers here in California. I'm also obviously here on behalf of myself just as a practicing physician and also on behalf of our practice which is known as Universal Pain Management and we're going to be hearing from Mr. Lance Jackson, who is our Chief Executive Officer, immediately following myself. And not to be too long-winded about it, but I would like to also note that I am currently the President of the California Society of Interventional Pain Physicians, which is an organization of approximately 400 physicians, a state component society of the American Society of Interventional Pain Physicians, and so I do speak this afternoon on their behalf as well.

Now, you have heard lots of things this morning about the adverse effects of the possible implementation of the Fee Schedule that we have been talking about here. What I would like to do is to focus on the issue of spinal cord stimulation, which you've just heard about from an industry representative, but it's not just spinal cord stimulation. I'm using spinal cord stimulation as a case example or as a

proxy for the larger context of what it is that we do.

Now it may seem old-fashioned to you, but as a physician, as a practicing physician, I really do get up out of bed every morning and I go in to the clinic to change people's lives. I really do. I know it sounds silly, but that's what I do. And I can tell you that in properly-selected patients, spinal cord stimulators, intrathecal drug pumps and any number of the other interventions that we do, change people's lives.

If my understanding of the proposed changes in the Fee Schedule is correct, what's going to happen is that if it gets implemented, Ambulatory Surgery Centers will not allow us to perform these procedures in Ambulatory Surgery Centers. You might think to yourself, "Well, so what? The guy can go over to the local hospital and do the same case over at the local hospital." Well, unfortunately, that's where the law of unintended consequences kicks in. And you heard a little bit about that from the representative of the California Ambulatory Surgical Association.

Just to repeat some of those things, there is the whole issue of emergency cases that can come into the hospital and bump us. That's a problem. Hospital Outpatient Departments just don't operate as efficiently as Ambulatory Surgery Centers do. And on top of that, I'm sure

that you're aware, I don't need to rehash the administrative burden that's involved with even getting to the point with one of my patients whom I've typically known for a long time, in order to be in a position to even be able to put one of these devices into a patient. If you add the additional burden of having to work in a hospital Outpatient Department, it's just going to make it that much less likely that I, and my colleague physicians around the state, are going to be willing to do this for our patients. It's probably just not going to happen. And I'm very, very concerned about timely access to quality care for injured workers, because that's why we're all here today. That is what the program is all about, is to serve injured workers, who through no fault of their own have various medical conditions, which I won't go into the details of it, but make it appropriate for us to do these things. And I'm very, very concerned about the patients and that's why I'm here. I probably had more things to say, but I forgot.

Do any of you all have any questions or comments? Does anybody want to say anything?

DESTIE OVERPECK: No.

JOHN DUNCAN: No.

JARVIA SHU: No.

FRANCIS X. RIEGLER, M.D.: Thank you.

DESTIE OVERPECK: Just as an update, I see three more

people. We'll check, but so you kind of know where we all are. All right. Lance Jackson, right?

LANCE JACKSON: Yes. Hi. Lance Jackson. I'm the CEO of a company called Universal Pain Management which provides services to the underserved areas of the Antelope Valley, Santa Clarita Valley, and Apple Valley and the Southern California region.

You basically heard pretty much everything I'm going to have to say today from other colleagues of mine today. But what I just would like to emphasize, and it's really from my perspective as the business manager of a private practice, it's my job to evaluate what's the most cost-efficient manner which provides services for my physicians and my patients. And these cuts that you're indicating that you would like to enforce with this ASC, will not allow us to perform these procedures in an ASC setting. It's just feasibly impossible. And what's going to happen is that it's going to be forced into the outpatient setting, and from my perspective, having a physician, that if I had them scheduled in an ASC setting that might take an hour, have them into an outpatient setting that's going to take possibly four to five hours, possibly six hours to perform the exact same procedure, it doesn't make sense from a business perspective to have my physicians go into that setting to perform these services.

So, I'm going to suggest, which I'm already at the teetering point of telling my physicians and the people that I give comment to, to not serve workers' compensation patients anymore. It's already an administrative nightmare from a private practice perspective to get things authorized to go through the hassle of the paperwork and the Utilization Review, and the bill review and trying to collect the money that you're expected to get. But this shifting our services into a hospital setting which is very, very inefficient, just seems to be completely counter-productive of what you're trying to do as a cost-cutting measure. You're going to make those services in the outpatient setting which can be paying the exact same rate that what you're doing right now. So from the perspective -- I just don't get that perspective of what is really trying to be done here.

So, I just don't want access to be limited to our patient population, especially in the Antelope Valley, you know, we serve a lot of Department of Labor patients, a lot of people in the military. Those people will not have access to our services anymore. So thank you for your time.

DESTIE OVERPECK: Thank you. Michael Tichon? Yeah, I think he was actually on the other schedule.

PERSON IN AUDIENCE: He spoke earlier.

DESTIE OVERPECK: Steve Cattolica?

STEVE CATTOLICA: (STATEMENT MADE TO REPORTER: I know that last name -- that last name really will get you!)

Good morning. Again, my name is Steve Cattolica. I represent the California Society of Industrial Medicine and Surgery, the California Society of Physical Medicine and Rehabilitation. You've heard, as has been said, a lot of authoritative information with respect to costs and we certainly support the position of the California Ambulatory Surgery Association that this proposal will likely not result in any appreciable savings and in fact may cause a critical loss of access and unnecessary cost increases.

There's clearly a lack of data that indicates that ASCs are over-reimbursed, when fully adjusted for their case mix and the cost of doing business in the workers' compensation arena. The result will be operators of ASCs will be compelled to deselect those procedures that do not pay for themselves, with the result being that hospitals become the most common venue for procedures to be done at a much higher reimbursement rate, scheduling delays, the possibility of even more costly inpatient admissions and increased health risks to the patient may also result.

And we certainly applaud and have participated in the review of all aspects of this system to look for savings and efficiencies. However, there doesn't seem to be any factual basis for the proposed adjustment, and faced with data that

clearly indicates a mismatch in the fundamental costs and basis for decision-making in the healthcare delivery systems between Medicare and California's Workers' Compensation System, we believe that the basis for this proposal should be reconsidered.

On a slightly different note, we would request that the Division review proposed section 9789.39 which quote "provides for updates to the Federal regulation and Federal register references made in the hospital Outpatient Departments and ASC Fee Schedule updates by order of the Administrative Director in order to conform to changes in the Medicare payment system as required by Labor Code Section 5307.1" Close quote.

This section would allow the Division to amend the ASC reimbursement rate going forward by incorporating ongoing references found within the Federal register without a formal rulemaking. While it would appear that 5307.1 may allow adoption of reimbursement rates in such a manner, we believe it's prudent for the Division to include language within this regulatory package, if it goes forward, that requires the Administrative Director to review informal public hearings of relevance and applicability of any changes to the Medicare payment system potentially applicable to ASCs. It's been conclusively shown that Medicare reimbursement data and the political decisions that

result within the Medicare system do not take the demands of the Occupational Healthcare Delivery System into account in any manner. The 2003 Lumen Study and even the two-year-old access study commissioned by the Division and performed by the University of Washington indicate a large increase in the overhead and resulting provider attrition solely attributable to the demands of the Workers' Compensation System. Labor Code Section 5307.1(g)1(a) states clearly that the Fee Schedule shall be adjusted to conform to any relevant, emphasis added, changes in the Medicare payment systems. Our suggestion will provide the community with the opportunity to test the relevance of any such change, rather than allowing the Division to follow Medicare in lockstep.

And finally, we again, as we did with the spinal implant comments, we encourage the Division to take advantage of the tools that already exist in their toolbox, to assess how problems actually are showing up in patient satisfaction and access to care. Labor Code Section 5307.2 calls for an annual assessment -- mandates an annual assessment of the availability, costs and patient satisfaction, vital services provided by ASCs, amongst others. We believe that combining that data with frequency data and hospital-based outpatient facilities, would focus data to be gathered from which a decision about exactly how ASCs should be reimbursed, or if any changes should take

place at all, may go forward.

And with that, I will close. Thank you very much.

DESTIE OVERPECK: Thank you, Steven. Scott from Surgery One?

SCOTT LEGGETT: I'm from the South. I used to talk really slow, but I've lived in California for 20 years so I've just kind of sped up, so I'll try to revert back!

So, thank you, actually, and actually I just started wearing these, so I'm not quite used to going back and forth, so I apologize. Thanks for listening to comments as was talked about earlier from previous submitted comments and --

DESTIE OVERPECK: Could you state your name?

SCOTT LEGGETT: Oh, I'm sorry! See, I'm already speeding up! Scott Leggett. I'm representing Surgery One. We have four centers, small business down in San Diego.

So thanks for listening and incorporating our comments. I urge you in the same spirit to listen to all the comments. There's been some great testimony here today and a few comments that I'll try to add to that.

(COMMENT MADE TO REPORTER: Can you get my slides now?)

The GPCI, which is a Geographic Practice Cost Index is something that hasn't been talked about. There's a few areas in California that are affected by this, with Medicare. It affects the salary and wage index. San Diego

is impacted by that. We have very similar costs and salaries with our nursing and facility costs, as a lot of the areas of California, but we're reimbursed less because of this kind of inefficiency in the system that's kind of been caught up in the politics and Congress for a number of years. So a cut in Medicare to us is more impactful down in the San Diego area. So, I urge you, please do not overlook the GPCI factor.

So, the direct impact to us, we've run our analysis and it's very consistent with the testimony that I've heard already. Trauma cases, we do a lot of orthopedics. Our trauma cases, the open reduction internal fixations, ORIFs, you know, a lot of wrists, elbows, tendon repairs, which include shoulders, knees, Achilles repairs. These are all of the types of cases that are going to be impacted for us, which is very costly cases. I think that's the testimony consistency that you've heard today.

So, the -- these -- the reality is that these cases will be looked at very closely as they come through and they'll be deselected. It's about ten different types of cases that we're looking at. They will be deselected and they will go to the hospitals. Down in our area, Scripps Hospital has recently been quoted in the New York Times as one of the most costly hospitals in the United States. So these are, you know, cases that are going to go into very

costly systems because we won't be able to afford to do them.

Second point, or second big impact, you know, it would be foolish for us to say that, you know, we're going -- we'll continue, you know, we'll just cut workers' comp out. I mean we're a small business and we need to look at every aspect of the business and select the appropriate business that, you know, that we can make a profit on.

But, the reality is that a 20 percent cut is a big cut for any business. I mean for a small business -- I mean have any of you guys cut your budgets by 20 percent before? John, have you had to cut your budget by 20 percent?

MR. DUNCAN: Yes.

SCOTT LEGGETT: You have? 20 percent? Okay. I commend you. That's a big cut, I mean in a small business. In a big, you know, bureaucracy, it's a lot easier to swallow, but in a small business that's very tough, and the brutal reality is that that will impact jobs. That's a job killer because we will have to tighten the belts and there will be jobs at stake. It's the, you know, the unintended consequences that was talked about earlier.

The overall savings, I mean I know you guys don't like to hear the parity issue. We've been through this before. It's been talked about, but parity is a really key thing for us because without the parity issue with the hospitals, and

an even cut across the board, you're not going to realize all the savings that you're trying to accomplish because these cases will go there.

For the medical cost care -- for the medical care cost to truly start decreasing, you know, Federal, State governments, health plans must fundamentally change processes and not reward inefficiencies and punish the ones that are efficient.

This point was made earlier, but I just want to reinforce it, Medicare patients are a different type of patient. 70 to 80 percent of the cases that are done Medicare are GI and ophthalmology; 6, 7 percent are orthopedic. It's just a different type of patient. This is recognized in our healthcare contracts. Anthem, Blue Shield, United, all of our healthcare contracts pay us significantly above Medicare, and they also have specific -- they address specifically implant costs and give us carte blanche for the real high, expensive cases. So, you know, the health plans have recognized that, and that we're not treating Medicare patients. So this is something that I think has totally been missed by making a direct analogy to Medicare.

Ultimately, the ASCs are more efficient because the physicians run them. Physicians know what they need. They like the efficiency of the ASC. They like the fact that

there's less infection rates. The patient satisfactions are high. Their time is important to them. And the points have been very well made. It's border-line right now, being worth their time if they have to go to the hospitals to do these cases where they have longer times there for turnover times, they just won't do it. It won't happen. So ultimately there will continue to be attrition and access issues for workers' comp.

So we understand that there's, you know, real complicated problems in California, there's lack of money, there's a lot of stuff going on, and we probably should make a contribution somehow, but a 20 percent cut is significant. I would urge you to consider, you know, perhaps a 5 percent cut, or something reasonable and hit it as a whole. Be fair to us. Be fair to the -- to the -- be in parity with the hospitals and the surgery centers. So, 20 percent cut is a job killer. Thank you.

DESTIE OVERPECK: Thank you. Now is there anybody else who would like to comment at this time on the Ambulatory Surgery Center Regulations?

GREG HORNER, M.D.: Can I summarize for a few minutes?

DESTIE OVERPECK: Sure. Come up. And there's another person behind you.

GREG HORNER, M.D.: Hi. I'm Greg Horner, and I am a hand surgeon, which happens to be probably one of the

busiest in terms of volume of workers' comp cases in medicine and I also manage three surgery centers in California in addition to another three outside of California.

After hearing about this proposal and taking a look at the numbers in my own surgery centers, I realize that it would be extremely erratic; there would be a lot of cases that would be break even and many that would be a significant loss.

My main surgery centers are in place called Pleasanton, not far from here. It's about a 25, 30-minute drive. It's part of the 680 corridor. And in that corridor we have really big companies, Chevron, Safeway head-quarters. And among those companies, they have -- they generate quite a bit of workmen's compensation claims. We, as at my surgery center, it would be very difficult for us to do the workers' comp. The ones at a loss, the ones that break even, it would be for me to encourage those doctors to take those cases to the hospital.

Unfortunately, and I can speak for the physicians, it just doesn't work that way, because we have been working and we've become accustomed to working in our surgery center and doing all of our cases there. I personally do not even have block time at a hospital. I do 95 percent of my cases at the surgery center. As a result, if I had to pick some that

were going to be the serious money losers and try to cut the trend that could, you know, cut down in the profitability of the center, I would just as soon as stop doing those cases. It turns out that in my area there's actually a shortage of physicians, and so the physicians are particularly busy, and I think the vast majority of them, and I can speak for those nine physicians in my group and an additional several physicians in the three surgeries centers that I manage, they would rather stop doing workers' comp altogether than to take some of the cases to the hospital.

The reason why I built Pleasanton Surgery Center was because the hospitals were so incredibly inefficient for hand surgery cases, five cases taking an entire day; whereas now I can do 10, 15 cases in my surgical day.

So that being said, it of course is just a reiteration of what you've heard from all these other very eloquent speakers, but I just want to put emphasis on it from a perspective of an actual practicing hand surgeon, that those cases will most likely be moved out of the area.

And just another point on the academic paper that we've been referring to that suggests that there's increased utilization for those physicians with ownership interests, I think that this is -- it's kind of a really difficult piece of data to interpret. I happen to have an extremely operative practice. And so I had to build an outpatient

surgery center. So it was the chicken-and-egg scenario. It suggests that since I do an awful lot of surgery and I'm in an Ambulatory Surgery Center, that the incentive, the additional incentive, this marginal profit that we make on workers' comp cases, could somehow be the reason why I'm more operative in my practice. But, in actuality, my practice was highly operative long before we had the surgery center and was actually the reason for the surgery center. And I'm sure that this is not an uncommon scenario and is not anecdotal.

So I hope that all the comments that were made and hopefully our summary coming soon will be taken into serious consideration, because I do feel that it will decrease the pool of physicians that will be interested in doing workers' comp, count me in as part of the pool to separate out and not do workers' comp; it just won't make sense to me. And with that decreased pool of physicians to do workers' compensation cases, then there will either be significant delays in care or God-forbid a significant reduction in the quality of care that the patients receive. Thank you.

DESTIE OVERPECK: Thank you. Are there any other new comments on this set of regulations? Okay. So you can do your summary.

(REPORTER REQUESTS A BREAK)

DESTIE OVERPECK: I'm sorry. We're going to take a

quick break for our court reporters we have. So give us 10 minutes.

(10-MINUTE RECESS)

DESTIE OVERPECK: Did David Lau want to make a comment? I'm sorry. I noticed your name was checked.

DAVID LAU: I'll defer just because I think my sentiment has already been expressed.

DESTIE OVERPECK: Okay. All right. So come on up. Be sure and state your name again.

TOM WILSON: I'm Tom Wilson. I'm on the CASA Board, past president of CASA and I run three surgery centers in Monterey County. I had the privilege of going first. I just want to wrap up two quick statements and then some conclusion remarks. I think I can do it in about three minutes.

When you look at the area of physician utilization versus ownership, the gold standard study that you guys should go back and look at was put out by the state of Florida, the Cost Containment Commission, and Pete Stark and other people in Congress have used that for years. And essentially it showed for outpatient surgeries there wasn't a correlation between ownership and utilization.

Secondly, when we talk about costs here, and we look at the data that you had in your reports, I don't think there is any definitive data out there that says that

surgery centers, their internal cost structure, is significantly lower than hospitals. The GAO report essentially looked two or three years ago and at that time, there were about 1600 procedures that could be done in ASCs, and when you looked at the procedures that surgery centers were doing, and they're self-selecting those procedures, the ones that they were doing, they're getting reimbursed close to their costs. They didn't do the cases that they weren't getting close to their costs, so those went off to the hospitals. And the other thing you quoted was the data from the ASC Association. And Ms. Lowe was here to say that there's a difference between saying we're the low-cost leader and saying that we have lower internal costs and saying our prices, or what we get paid for Medicare is less, therefore we save money for the Medicare Beneficiary Program.

The final thing I just want to bring home is that surgery centers self-select. Okay. So, if you have a Medicare system where 93 percent of all the orthopedic cases, outpatient cases are done in hospitals, and only 7 percent are done in ASCs, that's because the ASCs look at those cases and decide if the reimbursement is close to their costs and if they can do them. So I mean there's a history that surgery center's self-select. And so if you initiate this program in which about 50 percent of all the

work-related injuries and disease surgeries are orthopedic and about half of them I think are done according to the 2007 data by OSHPD are done in ASCs, the same thing's going to happen. The orthopedic cases are going to be driven into the hospital because of low reimbursement rates.

The final thing I want to say is just a comment on your paper, there was a referral in there about hospitals have higher costs because they do more charity care, and I've submitted written documents, but just to go over that, according to 2007 data in OSHPD, 5 percent of the cases that were done in ASCs were indigent or Medi-Cal and Medi-Cal essentially pays ASCs about $250 no matter would you do, which just doesn't even begin to cover your costs, and it was about 8 percent in HOPDs. So that was the difference and I thought that was rather amazing. The cases that are done in surgery centers are all elective surgeries. And most surgery centers are for-profit institutions. I don't know of too many organizations, and I've thought about this quite a bit, where a for-profit institution, that four percent of their client-base patient-base are indigents, as such. So I think that's rather remarkable, and I know when I've had discussions with Anthem Blue Cross and Blue Shield and we've looked at this data, they're very pleased that surgery centers do this much indigent care, and I know that in our area, the local hospital owns 20 percent of us and

they're very happy that we're doing this much indigent care. So I think ASCs do quite a bit in that area, when you look at the data, the statewide data from the state.

So, again, thank your for your time. Thank you for listening. And again CASA Board or other people will be happy to work with you on these very tricky issues. Thank you.

DESTIE OVERPECK: Thank you. So, I want to confirm that there's no more comments on either of the sets of rulemaking. Okay. No one's raised their hand. So we're going to close this hearing. I would like to remind you if you have any additional written comments that you haven't turned in, you have until 5:00 p.m. You can email them to us or you can bring them up to the 17th floor. So thank you all.

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REPORTER CERTIFICATE

I, Lisa Greenwald, hereby certify:

That I was present at the hearing of the matter entitled on the first page hereof;

That I took stenotype notes of the proceedings had;

That thereafter, upon request, I used the AristoCAT Computer-Aided Transcription System which translated the proceedings into printed form;

That the foregoing pages are a full and correct transcript.

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Lisa A. Greenwald

Official Reporter

Workers' Compensation Appeals Board

REPORTER CERTIFICATE

I, Carol Ann Mendez, hereby certify:

That I was present at the hearing of the matter entitled on the first page hereof;

That I took stenotype notes of the proceedings had;

That thereafter, upon request, I used the AristoCAT Computer-Aided Transcription System which translated the proceedings into printed form;

That the foregoing pages are a full and correct transcript.

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Carol Ann Mendez

Official Reporter

WORKERS' COMPENSATION APPEALS BOARD

February 9, 2011

Oakland, California