DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Giese	7-5-11

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000009	[X] Prepare reply for the Director's signature DATE DUE 7/11/11
2. DATE SIGNED BY DIRECTOR CC: Mr Keck, Deps, Jacobs, Stensland Close 7-15-11, see attached	[ ] Prepare reply for appropriate signature DATE DUE [ ] FOIA DATE DUE [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			Brian - we
2.			child action
3.			on this one - 7/6
4.			Thx Jon

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

* Brenda - As Alicia we can close bc as TX has met with him a few times since we received this. Think Angie 8/16/11

Log # 9

TO

Giese

Alicia & Jeff -

Tony received this late Friday and asked me to respond to each concern just yesterday morning. I would really appreciate your help.

BZ

DIRECTOR'

1. LOG NUMBER

2. DATE SIGNED BY DIRE

CC: Mr. Keck, D
Stensland

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7/11/11

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APPROVALS (Only when prepared for director's signature)			COMMENT
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SCHA South Carolina Hospital Association
1000 Center Point Road | Columbia, SC 29210-5802 | Ph. 803.796.3080 | www.scha.org

July 1, 2011

Anthony Keck, Director
SC Department of Health & Human Services
1801 Main Street, 11th Floor
Columbia, SC 29201

Dear Tony:

This letter is intended to convey the formal comments of the South Carolina Hospital Association to the South Carolina Department of Health and Human Services (the Agency) in response to the June 6, 2011 Public Notice announcing reductions in payments to providers and increases in beneficiary copayments. The Agency's Public Notice outlined reimbursement changes in a number of categories, and we will structure our comments in similar fashion.

General Comments

First and foremost, the leaders of the state's hospital community express their appreciation for the Agency's willingness to open a dialogue concerning the best ways to accomplish expense reductions in the Medicaid program. We realize you and your team could have achieved your spending targets through an across-the-board rate reduction, and we're grateful you invited our input as you considered alternatives to rate cuts.

From the outset, the leaders of the hospital community hoped to find alternatives that would lessen the overall impact of spending reductions. In essence, we hoped to offer cost reduction strategies that would permit the agency to mitigate the total rate cut. After the Agency announced a three percent (3%) rate cut in April, we all understood the July target was an additional seven percent (7%). We all agreed that vulnerable rural hospitals would need to be protected from further cuts. You also made clear that additional rate cuts could be offset or eliminated if we could identify equivalent savings through alternative cost reduction strategies.

Working together with your team, we have identified a number of viable cost reduction strategies that "bought down" the rate cut from seven percent (7%) to four percent (4%). As we've gathered feedback from our members in recent weeks, however, it appears our cost reduction strategies have accomplished a result we neither anticipated nor intended. Based on the programs and services they provide, some hospitals have estimated a cumulative impact in excess of the seven percent (7%) originally set as the target.

The South Carolina Hospital Association remains committed to exploring targeted cost reduction strategies with the Agency in an effort to forestall across-the-board rate cuts. The growth in enrollment could easily impact costs negatively even

though cost reduction strategies are identified and put into place. We would request you provide historical and projected enrollment data to assist hospitals in identifying and segregating cost into provider segments that can be controlled through behavioral changes initiated by hospitals and other care providers. Our commitment is predicated on our belief that our collaborative efforts to redesign the delivery system can reduce utilization and achieve savings for the Agency. However, SCHA does not support any plan that reduces the rate cuts to some hospitals at the expense of other hospitals.

Inpatient and Outpatient Rates

As noted in our general comments, the seven percent (7%) general rate reduction to hospital providers plus major cost savings initiatives in NICUs and other yet undefined areas will be a significant burden to all hospitals in the state. As a result, many hospitals will be forced to reduce or eliminate some costly but needed services. This could easily translate into longer waits for care for patients and an overall access problem for all patients including Medicaid beneficiaries. Many hospitals have already reduced staffing and future rate reductions will leave hospitals no choice but to further reduce staffing and potentially eliminate important services.

The Public Notice states that certain hospitals have been exempted from the rate reductions noted above, but there does not appear to be consistent criteria applied in determining which hospitals were exempted from the reductions. We support an exemption from further rate cuts for the most vulnerable of the state's hospitals. Our primary concern is that some hospitals were not exempted that appear to be eligible for exemption. We feel economic, social and demographic factors should be included when making a balanced decision concerning which hospitals should be exempted. We would like further clarification of how the exemptions were determined and applied including whether the need to fund Level I Trauma Centers was considered when the decision was made to protect the out of state burn center.

As to cost savings initiatives, we are very concerned how these savings will be tracked. Savings in the NICUs will impact large hospitals. How will we know if these NICU savings are achieved? This again is an additional burden only larger hospitals will bear.

The press release dated June 6, 2011 from DHHS states there is an additional $15.4 million in savings to be identified. We are concerned about how these savings will be determined and achieved.

A new payment grouper is to be implemented October 1, 2011. Will the new grouper change how hospitals are reimbursed and will it change the amounts reimbursed to individual hospitals?

Managed Care Organizations

We understand that the Managed Care Organizations (MCOs) will receive the same rate reductions as the hospital providers. Have the costs of the MCOs been evaluated to

determine if the same or a higher rate reduction is appropriate for them? SCDHHS has not released an updated MCO cost study to show that there are indeed real cost savings generated by the program or to show that the PMPM calculations are adequate or inadequate to cover the MCOs costs. Before further reductions are made we would encourage SCDHHS to evaluate the actual effectiveness of the managed care program to determine if there are cost savings available. We would like confirmation of what rate reductions the MCOs will receive as well as the date the MCO rate reductions will occur. In an effort to control costs, segregating or carving out the drugs from the MCOs to get the benefit of 340b pricing should be considered as well as structuring PMPM rate calculations to encourage MCOs to apply benefits and reimbursements that would promote patients and physicians choosing generics drugs over name brand drugs.

There being no limitations on MCO reimbursement to out-of-network hospitals, this can either further increase the impacts of the reductions on hospitals, impact hospitals' willingness to accept out-of-network patients or force hospitals to contract with MCOs that they would otherwise refuse to be considered. We would request restructuring of out-of-network reimbursement.
We would also respectfully request that the administrative fee paid to the MCOs be evaluated for possible additional reduction in lieu of some of the reductions to provider rates.

Graduate Medical Education

The Agency has proposed to reduce Graduate Medical Education (GME) payments to the state's teaching hospitals and reallocate the savings to mitigate the inpatient and outpatient rate cut. Changes to GME reimbursement rates historically have been negotiated between the Agency and the teaching hospitals without involving the hospital community at large, and SCHA believes GME reimbursement adjustments should remain separate from the overall rate discussions applicable to all hospitals. As such, SCHA recommends the GME proposal continue to be negotiated between the Agency and the teaching hospitals. SCHA does feel the proposed reduction of 13% (3% in April and 10% in July) will be very significant to teaching hospitals. This will limit the training of new physicians when the state and the nation are facing a shortage of physicians to care for children and newly covered individuals.

Disproportionate Share Hospital Program Adjustments

The public notice did not specifically address changes to the Disproportionate Share Hospital (DSH) methodology, but we understand there are changes under consideration for the next federal fiscal year to begin October 1, 2011. On behalf of all South Carolina hospitals, SCHA strenuously recommends leaving the current DSH program in place as it is currently structured.

We would encourage any potential changes to this program be addressed in a Public Notice allowing SCHA and all providers adequate input into any proposed changes.

Non-institutional Rate Reductions

Many hospitals in the state employ physicians and provide home health and other non-institutional services. Rate reductions in these areas from five percent (5%) to seventeen percent (17%) will have a significant impact on the reimbursement to hospitals which employ emergency room (ER) physicians, hospitalists and other physicians to cover ER, inpatient and outpatient services, as well as stand-alone providers. Many services may be reduced or eliminated.

Skilled Nursing Facility Reductions

Although not addressed in the Public Notice, the recent five percent (5%) reduction in Medicaid skilled nursing beds will also have a negative impact on hospitals in the State. It is already difficult at times to place Medicaid patients into skilled nursing facilities. The reduction in available beds will increase this problem as hospitals will have longer lengths of stay and additional costs for patients who do not require acute hospital care, as well as limit availability of beds for truly acute patients. How does the Agency plan to monitor the shortage of skilled nursing facility beds?

Summary

SCHA appreciates the opportunity to comment on the Public Notice. SCHA is committed to working with the Agency to provide solutions which will allow South Carolina's hospitals to provide cost effective care to Medicaid beneficiaries.

Sincerely,

Thornton Kirby, FACHE
President & CEO

Log - BZ

C: TK - Deps
Jacobs
Stensland

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Sincerely,

Thornton Kirby, FACHE
President & CEO

Log - BZ

C: TK - Deps
Jacobs
Stensland.

South Carolina Department of Health & Human Services

Follow up - ~~8/12~~ 8/18

Hold

Thornton Kirby, FACHE
President and CEO
South Carolina Hospital Association
1000 Center Point Road
Columbia, South Carolina 29210-5802

Dear Thornton:

This is in response to your letter of July 1, 2011 concerning the June 6, 2011 Public Notice announcing reductions in payments to providers and increases in beneficiary co-payments. We appreciate your candid feedback and support in these fiscally challenging times. We do not anticipate the Medicaid population will be adversely affected by these changes but we are closely monitoring access to care issues. In addition to reimbursement changes and increased beneficiary contributions, cost savings initiatives include quality improvement strategies, increased fraud and abuse enforcement and the elimination of duplicative efforts. It is not the intent of the South Carolina Department of Health and Human Services (SCDHHS) to decrease access to care but to address inefficiencies and budget concerns. We are grateful that you and the SC Hospital Association worked closely with us in developing some of these important initiatives. The department is eager to form new partnerships with public and private advocacy groups, community and provider organizations and the legislature to improve health literacy of our population, reduce health disparities, increase access to care and optimize utilization of healthcare services.

Enclosed is the historical and projected enrollment data that you requested.

Inpatient and Outpatient Rates

In response to comments received from the Public Notice and to ensure access to care for rural Medicaid beneficiaries, SCDHHS has exempted the following hospital categories from reductions listed in the public notice: South Carolina critical access and hospitals located in areas with Rural/Urban Commuting Area designations of isolated rural and small rural, and the qualifying burn intensive care unit hospital. In addition as a result of further analysis and public comment, South Carolina hospitals operating in areas with a Rural/Urban Commuting Area designation of large rural and designated as a "Primary Care Health Professional Shortage Area (HPSA) for the Total Population" will also be exempt from these reductions. Therefore, Chester Regional Medical Center, Columbia Colleton Medical Center and Marlboro Park Hospital have been added to the list of hospitals exempted from the July 11, 2011 hospital payment reductions.

We anticipate significant cost savings in the hospital budget line as a result of programs like the Birth Outcomes Initiative which include a reduction in length of stay in the NICU/PICU. As you are aware, the first Birth Outcomes Initiative meeting was held on July 12. Relegated as a priority of our agency, the primary goal of this initiative is to reduce the number of low birth weight babies in South Carolina. Small workgroups focusing on the areas of Data Capacity and Performance Measures, Reduction in Health Disparities, Patient Safety and Quality of Care, Care Coordination and Services, and

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(803) 898-2580 • Fax (803) 898-8235

Comprehensive Behavioral Health will support this initiative in developing the framework to organize the strategies that will produce the best results.

An internal tracking system is under development out of the SCDHHS Office of Reporting, Research and Special Projects designated to monitor and evaluate quarterly results of rate and service reductions implemented this year, using fiscal year 2010 as the baseline. This evaluation will help agency staff monitor and determine achievements of reduction goals as well as provide status reports to outside stakeholders.

At this time, the Department will remain with an overall cost based reimbursement system which will provide Medicaid inpatient hospital reimbursement at an amount less than one hundred percent of allowable Medicaid reimbursable costs. The allowable Medicaid cost recovery percentage for each SC general acute care hospital will depend upon whether or not the hospital is exempted from the July 11, 2011 four percent payment reduction or is a teaching hospital. However, in regards to the implementation of the APR/DRG grouper on October 1, 2011, all inpatient hospital claims will be paid on a DRG basis and there will no longer be any claims paid via a per diem. Additionally, the implementation of the grouper itself should not have any impact on each hospital's overall payments since the per discharge rate will be developed based upon a yet to be determined projected cost target. The projected cost target used in the development of the October 1, 2011 per discharge rates may cause a change in reimbursement among hospitals. Staff from the Bureau of Reimbursement Methodology and Policy plan will meet with members of your staff to go over our proposed rate setting process effective October 1, 2011. The new grouper will also allow the Department to process inpatient hospital claims with hospital-acquired conditions (HACs) at a reduced payment level.

ICD-10 Coding

SCDHH is currently engaged in an ICD-10 planning project that will evaluate existing policies, processes and system and prepare for the work required for SCDHHS to meet ICD-10 compliance on October 1, 2013. Given the limited time and broad scope of the ICD-10 implementation, along with the simultaneous Design, Development and Installation (DDI) of a Replacement MMIS system, SCDHHS plans to evaluate and remediate affected health care policies, implement a crosswalk (from ICD-10 to ICD-9) during the transition period between ICD-10 compliance (October 2013) until the Replacement MMIS is implemented which will process ICD-10 claims natively. This planning project will document, evaluate and remediate SCDHHS medical policies and related business processes, define the crosswalk, develop a Legacy MMIS remediation plan, develop a strategy for dual processing (ICD-9 and ICD-10 claims), and formulate a communication, training and provider outreach program to ensure a smooth transition from ICD-9 to ICD-10 for SCDHHS and its provider and partner communities.

Managed Care Organizations (MCO)

Because capitation premiums to the managed care plans are based on fee-for-service (FFS) rates, July rate adjustments will also reflect cost savings in managed care initiatives. MCO's will receive a 4.56% reduction in their capitated rates retroactively effective July 1, 2011. All MCO rate books are posted on our website at www.scdhhs.gov . We would like to have more discussions with you regarding 340b pricing.

We routinely communicate all Medicaid reimbursement and policy changes with Milliman as they develop and revise actuarially sound rates using national benchmarks.

Additionally, we have had serious discussion regarding the possibility of additional administrative fee reduction. Generics are not always less expensive due to large rebates that some manufacturers give DHHS/Magellan on their brand name drugs.

Graduate Medical Education (GME)

GME is considered an optional specialty revenue component for the hospital industry. Based on the data we have today we believe that we are one of the higher paying states. We plan to reevaluate our payment policies for GME in the near future and will seek input from the South Carolina teaching hospitals during this review process.

Disproportionate Share Hospital Program Adjustments

There are multiple other cost savings initiatives that we are still exploring We are evaluating the DSH program for potential cost savings that we project to implement in the immediate future. We commit to sharing our plans with you and Public Notice requirements would be followed as we make changes to this process.

Non-institutional Rate Reductions

While comments indicated reductions for ER physicians should be equal to those for primary care physicians because of the large number of non-emergent visits seen in the ER, SCDHHS believes emergency room usage for routine, non-emergent care must be discouraged. SCDHHS is convinced that inappropriate use of the emergency room is a multifactorial problem that must be solved working closely with hospitals, ER physicians, primary care physicians, Medicaid Managed Care and Medical Homes Networks, health centers and patients. Many of your members have expressed interest in addressing this problem and we look forward to your assistance in developing creative solutions that reduce costs and serve the interest of Medicaid recipients.

Skilled Nursing Facility Reductions

Placement of Medicaid patients into skilled beds has been an ongoing problem. SCHHS has convened a meeting on July 19 with nursing home and hospital industry stakeholders to discuss ways to monitor access to care between the hospital and nursing home settings. Specifically, DHHS is proposing three sources of tracking: (1) Monthly data compiled by our Community Long Term Care (CLTC) Program which indicates by setting the number of persons who have been evaluated by CLTC for a nursing facility level of care, which is prerequisite for placement; (2) Access to care data that will be compiled geographically by USC's Institute for Families & Society; and (3) It is our understanding from Diane Pascal of your staff that the SCHA will be collecting data from hospitals concerning complex care patients. Collectively, we hope this information will allow us to carefully monitor nursing facility admissions. Issues surrounding the 50 mile radius for placement of patients and other means to track access issues will also be discussed.

Thank you again for your continued support and valuable feedback throughout this process. We have received your second inquiry and are developing a response.

Sincerely,

Anthony E. Keck
Director

State of South Carolina
Department of Health and Human Services
Medicaid Financial Forecast

Medicaid Eligibility Summary by Program Type - Average Monthly Eligibles

	SFY 2009	Growth	SFY 2010	Growth	SFY 2011	Growth	SFY 2012
All Delivery Systems							
Sub-total							
Elderly	65,075	(1.0%)	64,411	(0.6%)	64,010	0.1%	64,085
Disabled Dual	53,009	2.3%	54,244	2.8%	55,777	1.7%	56,720
Disabled - Non-Dual	83,897	1.4%	85,110	(0.4%)	84,769	1.2%	85,758
LIF Adults	69,920	14.0%	79,733	14.2%	91,056	12.9%	102,832
LIF Children	123,849	11.5%	138,053	11.6%	154,087	6.9%	164,760
Pregnant Women	24,054	(0.1%)	24,021	(3.1%)	23,280	(0.3%)	23,204
Infants	37,519	(1.6%)	36,904	(5.6%)	34,853	(0.1%)	34,818
Children	242,409	(8.8%)	221,063	1.7%	224,925	4.4%	234,894
CHIP	141	28075.9%	39,728	40.3%	55,758	13.7%	63,376
Sub-total	*699,873*	*6.2%*	*743,267*	*6.1%*	*788,515*	*5.3%*	*830,447*
Healthy Connection Kids					963	(100.0%)	-
Family Planning					923	9.0%	47,874
TOTAL					*401*	*5.0%*	*878,321*

For Thorton Letter

7/15/2011