From: Patel, Swati <SwatiPatel@gov.sc.gov>
To: Templeton, Catherine <templecb@dhec.sc.gov>
CC: Veldran, Katherine <KatherineVeldran@gov.sc.gov>
Jonathan Yarborough <yarborjw@dhec.sc.gov>
Date: 3/24/2014 9:06:47 AM
Subject: RE: CON Language

Catherine - I did not get a redline from you on DHEC's suggested changes to the Peeler amendment. Can I get that as soon as possible this morning. We are meeting with Martha at 10:30.

Swati

-----Original Message-----
From: Patel, Swati
Sent: Thursday, March 20, 2014 11:50 AM
To: 'Catherine Templeton'; 'Tony Keck'
Subject: RE: CON Language
Importance: High

Catherine and Tony,
I'm looping you both in to the comments you have both made. As it relates to the Project Review Criteria you both have similar concerns. Are you okay with striking or rewording (1)? How would you change (4) and (5)?

SECTION 2. Section 44-7-190 of the 1976 Code, as last amended by Act 278 of 2010, is further amended to read:
"Section 44-7-190. (A) The department shall adopt, upon approval of the board, Project Review Criteria which, at a minimum, must provide for the determination of need for:
(1) the need for the health care facilities and services being proposed;
(2) the availability, quality of care, accessibility, and the extent of utilization of existing health care facilities and health services;
(3) the extent to which the proposed health care facility will enhance access to health care for residents;
(4) the extent to which the proposal will foster competition that promotes quality and cost-effectiveness; and
(5) the applicant's past and proposed provision of health services to Medicaid patients and the medically indigent

Catherine - could you/Ashley do a redline of Peeler's amendment and make the changes you want today?

Finally, did you both notice that Peeler kept home health services to require a CON? Very odd. Do you know a back story/basis here? I'd like to keep it out.

Keck Comments

I generally like the criteria that should be considered. Number 1 should be removed - it is too generally and actually "need" is wrapped up in numbers 1-4. I really do not think number 5 should be there. Hospitals may not like "cream-skimming" but they do it all the time also and will continue to do so. If Medicaid can't pay rates that get me into an ASC, that's my problem to deal with through rates. Also, past performance is in no way a guarantee of future performance here. And neither are promises of proposed performance. If it has to stay I would say two things. First remove the word uninsured. The hospitals get paid a lot if money through DSH for the uninsured and also have community benefit requirements as non profits. Second, this criteria has to be evaluated by DHHS that actually make the Medicaid and DSH payments.

I also worry about the term cost-effectiveness. Hospitals may argue cost effectiveness may be some complicated bull about cross subsidization etc. and that can't simply be measured in lower price. The simple measure needs to be lower cost and price. If the prices paid in the new facility will be lower than that is good - period.

-----Original Message-----
From: Catherine Templeton [mailto:templecb@dhec.sc.gov]
Sent: Wednesday, March 19, 2014 10:25 PM
To: Patel, Swati
Subject: Fwd: CON Language

Swati,

Please see DHEC's comments:

> Section 2- Project Review Criteria- these are broad. at this point, have the parties that have collaborated on this indicated what kinds of data, measurements, etc. staff should accept or request from an applicant to get at especially (4) and (5)? Also, don't know why we want to include wording like 'Medicaid' in a statute. Why can't it just say indigent populations or uninsured, underinsured? The reference does not make sense to me since I think the point is how facilities are going to serve those populations that are historically underserved and that is not just a Medicaid population thing. Medicaid is insurance like BCBS just needs/income determined/gov't paid for.
>
> Section 8- why isn't this written such that we keep all fees we collect? why is it capped at $50K?
>
> Has there been any discussion about how this statute only gives staff 30-60 days to make decision, and if/when CON decision comes down and this is signed into law, the already prepared CON applications that will be rolling in? Not sure how we will be able to turn around decisions with the volume I anticipate that quickly. I understand how removing state health plan and weighting will make the process easier for staff but just thinking ahead.
>
> And will RFRs come to Board for CON decisions (either for denials or a competitor challenging staff decision) or will they go straight to ALJ.

Catherine