

**Proviso 33.33 - Hospital Transformation
Comments on the October 17, 2014 Public Notice
and Responses from SCDHHS**

1. Each transformation plan should identify a business model that (1) is tailored to meet the needs of the community and (2) is sustainable without requiring ongoing subsidies from the state, from local government, or from another hospital.

SCDHHS response: SCDHHS agrees.

2. Small and rural hospitals with relatively stable business models are probably less inclined to take advantage of the Hospital Transformation Fund if doing so would require a formal long-term partnership (acquisition, lease, etc.) with a larger hospital.

SCDHHS response: Small and rural hospitals with stable business models are not obligated to participate in the hospital transformation incentive program. SCDHHS understands that there may be some small and rural hospitals with relatively stable business models that may not want to participate in the program.

3. The Hospital Transformation initiative should prioritize the most vulnerable hospitals—those likely to fail within the next few years unless they receive an ongoing subsidy or redesign their business model to become financially self-sustaining.

SCDHHS response: Through the criteria language posted in the public notice, SCDHHS has attempted to target the hospitals most likely to be under financial distress or to have the potential to be under financial distress in the near future.

4. We are concerned the larger Advising Hospitals may not see enough potential growth to warrant heavy upfront investments in high risk areas. We encourage SCDHHS to consider increasing the \$4 million incentive payment for each qualifying contract, even if it means reducing the number of qualifying programs in the first year.

SCDHHS response: SCDHHS has established a \$4 million cap to avoid committing too many funds to one specific facility. The \$4 million payment represents Medicaid's contribution to the cost of the project.

5. We encourage SCDHHS to better define a "long-term financial commitment." We believe hospitals should be allowed to determine the contractual agreement that best suits the needs of both the Advising and Target Hospitals. Requiring a long term relationship will severely limit the number of needy hospitals that will be allowed to participate in a Transformation Project, even if it is a viable option that meets all of the other criteria of the SCDHHS Transformation Proposal.

SCDHHS response: SCDHHS has revisited this issue and has defined a long- term financial commitment as a commitment period of at least ten (10) years.

6. We encourage SCDHHS to allocate limited funds to offset administrative costs incurred in the review of these projects by the 16 Target Hospitals. Understanding that not all target hospitals investing money in the consideration of a transformation plan will finalize a project, we encourage SCDHHS to develop a process by which Target Hospitals can seek funding for legitimate transformation-related expenses, whether or not a final agreement is reached with an Advising Hospital.

SCDHHS response: SCDHHS is currently focused on incentivizing long-term partnerships and maximizing funding for this program. Proviso 33.33 expressly references long-term partnerships, and SCDHHS anticipates being able to secure matching federal funds to provide for an appropriate payment relating to each project.

7. If small and rural hospitals are to remain financially viable, they must be paid adequately for delivering the services needed in their communities.

SCDHHS response: SCDHHS understands the financial needs of small and rural hospitals. SCDHHS also notes that under federal rules, hospitals which participate in the SC Medicaid Disproportionate Share (DSH) Program at best can be paid no more than the costs incurred for providing inpatient and outpatient hospital services to Medicaid eligible and uninsured individuals. Therefore SCDHHS continues to reimburse most small and rural hospitals at 100% of its allowable Medicaid inpatient and outpatient hospital cost for its Medicaid fee for service population while at the same time increase the SC Medicaid Rural Hospital DSH Pool from \$20 million to \$25 million for the October 1, 2014 through September 30, 2015 DSH payment period. These two actions will closely reimburse most small and rural hospitals the maximum amount allowed under the Medicaid Program.

8. In addition to adequate reimbursement, we believe a successful transformation plan must address the following elements, at a minimum.
 - a. Outline of the new business model and why the organization believes it will be sustainable
 - b. Medical staff requirements of the new business plan (is physician recruitment required?)
 - c. Replacement or modernization of the physical plant, if necessary
 - d. Strategies to increase access to specialty care using telemedicine
 - e. Clinical partnership with at least one larger hospital system to ensure seamless patient care
 - f. Transportation of patients between the rural hospital and its clinical partner hospital(s)
 - g. Experience and background of the governing board of the new business model (does the governing board have the right background and training to execute the new business model?)

- h. Appropriate measures of quality, safety and financial performance to ensure ongoing success

SCDHHS response: SCDHHS has kept the requirements for participation in the hospital transformation incentive program to a minimum in order to allow hospitals flexibility in designing transformation plans.

9. Item 3bi under the “Hospital Transformation” heading refers to a “long-term financial commitment” between the Advising Hospital and Target Hospital Community. It is our opinion that this phrase should be further clarified to include options for engagement other than a long-term lease or purchase of the Target Community Hospital. Small and rural hospitals with relatively stable business models are probably less inclined to take advantage of the Hospital Transformation Fund if doing so would require a formal long-term partnership (acquisition, lease, etc.) with a larger hospital. In allowing options other than “lease or purchase”, both the Advising Hospitals and the Target Hospital Communities will have a reasonable opportunity to truly pursue a fit for the local communities’ needs, still within the guidelines of this opportunity.

SCDHHS response: See responses to Comment 5 and Comment 6. SCDHHS will not consider a management contract between the “Advising Hospital” and “Targeted Hospital Community” as meeting the requirements of a long-term financial commitment but will recognize an acquisition or lease to meet the requirements of this program.

10. Complementary to this, the SCORH suggests that item 8 be amended to include a requirement that Advising Hospitals enter into a non-compete clause such that if the Advising Hospital does not comply with terms of the Qualifying Contract, that Advising Hospital is not able to start another project (or compete) in that Target Community using DSH funding within a certain period of time (suggested 5 years). Furthermore, if the Qualifying Contract is broken by the Advising Hospital, the permanent physical assets of the project (paid for with Hospital Transformation Funds) will convey to the Target Hospital Community.

SCDHHS response: SCDHHS will take this suggestion under consideration when developing a template for the Qualifying Contract.

11. While virtually all of the Target Hospitals face serious challenges and should closely examine their long term business plans in the near future, not all of the communities listed in the notice have hospitals that are in grave peril of closure. We feel strongly that the Hospital Transformation Initiative should prioritize our state’s most vulnerable hospitals—those that are likely to close within the next few years unless they receive an ongoing subsidy and/or redesign their business model to become financially self-sustaining.

SCDHHS response: See response to Comment 3. Through the criteria language posted in the public notice, SCDHHS has attempted to target the hospitals most likely to be under financial

distress or to have the potential to be under financial distress in the near future.

12. In addition to targeting the initial Hospital Transformation Fund to those facilities most at risk, the SCORH would like to emphasize and enhance the capacity of local leadership in all of the Target Hospital Communities, especially in the areas of financial and legal expertise. In order to develop the best plans for their communities, the Target Hospitals should ideally have ample resources prior to any engagement with an Advising Hospital to develop potential business plans, review the legal implications of any contracts, conduct a financial impact or feasibility study for the hospital and/or community, and should a contract be executed, be ready to communicate and market the new opportunity to the community in an effective manner. In many of the selected communities, the cost of these resources is insurmountable. As a result, the Target Hospital Community is currently at a supreme disadvantage in the negotiation process, which should be taken into consideration in reviewing the proposed Qualifying Contracts.

SCDHHS response: SCDHHS will take these factors into consideration when reviewing and developing Qualifying Contracts.

13. To provide better support for these communities as this initiative moves forward, the SCORH supports the formation of a panel of advisors who can help Target Hospital Communities explore options and develop proposals for consideration. This panel of advisors might include financial and legal professionals, as well as representatives from organizations that work closely with rural hospitals such as SCORH, SCHA, DHEC and DHHS. While we would expect these advisors to offer their input without compensation, we believe some of the Hospital Transformation Fund dollars should be made available to help the small and rural hospitals defray the professional expenses that are likely to be incurred in the development and implementation of their proposals.

SCDHHS response: See response to Comment 6. SCDHHS is currently focused on incentivizing long-term partnerships. Proviso 33.33 expressly references long-term partnerships, and SCDHHS anticipates being able to secure matching federal funds to provide for an appropriate payment relating to each project.

14. If small and rural hospitals are to remain financially viable, they must be paid adequately for delivering the services needed in their communities. We know from experience that these needs are overwhelmingly in the form of emergency and primary care services. However, the current payment rates for these services are simply inadequate to keep a hospital alive, which is why small and rural hospitals across the state spend so much time trying to build surgical programs and add new advanced imaging modalities. If South Carolina wants to ensure its most vulnerable hospitals remain viable through this Initiative, we suggest that the state consider altering its current payment system for these organizations. If the community needs primary and emergency care but not a surgical program, the hospital needs to be rewarded adequately for delivering primary and emergency care. This adjusted payment methodology will serve to align the facilities' offerings

with true community needs. We also feel that SCDHHS should work with the large commercial payers in the state and CMS (Medicare) to ensure that as many payers as possible reimburse similarly.

SCDHHS response: See response to Comment 7. SCDHHS can only control the Medicaid payment rates that it establishes within the boundaries of federal laws and regulations. Also note that if an “Advising Hospital” enters into a long-term financial commitment with a “Targeted Hospital Community” then the expertise of the Advising Hospital could result in higher reimbursement from other payors outside of Medicaid. Finally, the SC Medicaid Program is only responsible for paying their share of the hospital costs incurred by Medicaid eligible and uninsured patients and thus cannot be responsible for addressing the financial related issues related to lower payment rates by other payors.

15. In addition, Year 2 funding for Hospital Transformation Initiatives is very much needed to accelerate any models put forth in this first year of the Initiative as well as to provide support for those Target Hospital Communities who will likely spend the next year putting together plans for the future of health care in their communities as a result of this opportunity.

SCDHHS response: The SCDHHS has committed to rolling over any unspent Transformation Funds not expended by September 30, 2015 into the October 1, 2015 through September 30, 2016 DSH payment period. However, please note that only one transformation grant will be available to each acquisition and/or lease of a “Targeted Hospital Community”. The authority to provide funding for hospital transformation plans is granted by Proviso 33.33’s budget implementation language for Fiscal Year 2014-15. Funding for future-year plans would need to be separately provided by law.

16. In order to successfully transform, each Hospital Transformation Initiative will require a new business model for the Target Hospital as the foundation to its overall plan. Specifically, we believe a successful transformation plan must address the following elements, at a minimum:
- a. The needs of the community should be included in the plan, defined in a systematic and rigorous way, using the best available and most current data, and include those needs that extend beyond the traditional walls of a hospital. The Target Community Hospital (with other community representation) must drive this part of the process as they will be the ultimate users of said services and they undoubtedly know their needs best.
 - b. The new business model should be based on best practices and include an explanation as to why the organization believes the new business model will be sustainable.
 - c. The plan should include medical and clinical staff requirements of the new business plan to include physician or other professional recruitment needs.
 - d. There should be discussion as to whether replacement or modernization of the physical plant is or is not needed.

- e. Strategies to increase access to specialty care using telemedicine should be incorporated.
- f. Clinical partnerships with at least one larger hospital system to ensure seamless patient care should be defined.
- g. Transportation of patients between the rural hospital and its clinical partner hospital(s) – both emergent and non-emergent transport – should be discussed and defined.
- h. Experience and background of the governing board of the new business model, to include any experience and training of the board to execute the new business model, should be noted.
- i. Appropriate measures of quality, safety and financial performance to ensure ongoing success, and a plan for reporting on these outcomes, should be addressed.
- j. A sustainability plan that includes strategies that do not rely heavily on ongoing subsidies from state or local government should be included.

SCDHHS response: See response to Comment 8. SCDHHS has kept the requirements for participation in the hospital transformation incentive program to a minimum in order to allow hospitals flexibility in designing transformation plans.

17. SCDHHS is attempting to force community hospitals and their boards into taking actions that they otherwise may not want to embark on. There should be communication and cooperation between the state and these hospitals prior to being included on the list. The length of time required by the agreement should also have been agreed to by these hospitals; any multiple year deal will be viewed as a takeover and this may not be acceptable to them.

SCDHHS response: See response to Comment 2. Community hospitals are not obligated to participate in the hospital transformation incentive program. SCDHHS understands that many community hospitals may not want to participate in the program.

18. There are mechanisms/methods in place that are available to struggling and underperforming hospitals when they decide they need help from another entity. Rather than force these hospitals into taking this action, SCDHHS should create a department that will work with any hospital it thinks is underperforming and help them seek an adequate partner that will help them turn their financials around.

SCDHHS response: See response to Comment 6. SCDHHS is currently focused on incentivizing long-term partnerships. Proviso 33.33 expressly references long-term partnerships, and SCDHHS anticipates being able to secure matching federal funds to provide for an appropriate payment relating to each project.

19. Furthermore, the \$4m dollars proposed for each qualifying contract may not be sufficient to cover the costs associated with this project. When you consider what it will take in new infrastructure, equipment, personnel, etc. and the length of time it will take to achieve the objective, the stated amount does not make the project attractive to "Advising Hospitals."

SCDHHS response: See response to Comment 4. SCDHHS has established a \$4 million cap to avoid committing too many funds to one specific facility. The \$4 million cap represents Medicaid's contribution to the cost of the project.

20. It's important to remember that larger hospitals are not necessarily interested in committing to long-term financial commitments to small rural hospitals. They are very happy to include small rural hospitals in GPOs, transfer agreements, and other services of this sort. However, they are NOT interested in a merger, purchase, lease, or other arrangement that would cost them lots of dollars over any given time. The sticker in the proposed plan is the statement that the agreement must include "Long-term financial commitment." The larger hospitals are not "buying" the \$4 million due to the fact they know they will spend much more than that. So they view it as a drop in the bucket. Maybe we could design an agreement that would not tie the larger hospital to a large financial commitment?

SCDHHS response: SCDHHS views a long-term financial commitment as essential to ensuring that the Advising Hospital is committed to transformation in the Target Hospital Community. Additionally, Proviso 33.33 expressly references "long-term partnerships between rural hospitals and community, tertiary and teaching facilities." See response to Comment 5 relating to the definition of a "long-term financial commitment" and note that the \$4 million payment represents Medicaid's contribution to the cost of the project.

21. We recommend an amendment or addendum to your model to allow a direct SCDHHS grant of \$100,000 per "Target Community Hospital" for: local definitions of need; identification of access barriers; technology / telemedicine efficiencies; capital investment requirements; strategic initiatives; recruitment / retention; financial modeling; two way referral systems; and acknowledgement of their weaknesses.

SCDHHS response: See response to Comment 6. SCDHHS is currently focused on incentivizing long-term partnerships. Proviso 33.33 expressly references long-term partnerships, and SCDHHS anticipates being able to secure matching federal funds.

22. We are pleased to see that the SCDHHS proposes to expend 100% of the FFY 2015 allotment to cover a portion of the costs to hospitals for treating the uninsured. Currently hospitals with the exception of certain rural defined hospitals, are reimbursed less than fifty percent (50%) of their uninsured uncompensated care costs to serve Medicaid beneficiaries and the uninsured. Therefore it is important for hospitals to receive all funds possible to be more adequately reimbursed and avoid the transfer or shift of these funds to other payors.

SCDHHS response: The SCDHHS has committed to rolling over any unspent Transformation Funds not expended by September 30, 2015 into the October 1, 2015 through September 30, 2016 DSH payment period.

23. We question the proposed change to exclude the SC Medicaid fee-for-service unreimbursable cost pools to determine the FFY 2015 DSH payments. Additional clarification is needed as to the impact of this proposed revision. On one hand, you propose to exclude fee-for-service unreimbursed cost pools in calculating the DSH payments, while on the other hand will include/take into account any "profits" hospitals may realize in its fee for service Medicaid population.

SCDHHS response: Based upon the review of this DSH payment model, the SCDHHS did not see any significant payment swings due to the exclusion of the Medicaid fee for service unreimbursed cost in the calculation of the proposed DSH payments for FFY 2015. However after further consideration, the SCDHHS has reversed its decision and will include the Medicaid fee for service unreimbursed cost in the calculation of the FFY 2015 DSH payments.

24. We are cognizant that a number of rural hospitals across the state are struggling financially and appreciate the need to explore innovative solutions. However, as previously indicated, we are concerned about the inequity created by reducing DSH revenue while maintaining the same tax burden for some hospitals.

SCDHHS response: The SCDHHS has attempted to offset the DSH revenue loss from the creation of the Rural Hospital and Transformation Pools by providing rate increases of 2.75% effective October 1, 2013 and 2.50% effective October 1, 2014. Additionally, please note that each year DSH payments are calculated a shifting of DSH revenue among hospitals will occur.

25. Using hospital tax funds to back fill Medicaid or create reserves does not meet the spirit of their intended use. The General Assembly set a standard that these funds are to be expressly supplemental, may not be used to replace general or other funds to support Medicaid, and are exempt from any budgetary cuts, reductions, or eliminations caused by the lack of general fund revenues.

SCDHHS response: Please note that the hospital tax revenue is used by the SCDHHS to provide health care coverage to the Medicaid eligible and uninsured populations in South Carolina. The SCDHHS expends 100% of the hospital provider tax revenue via Medicaid service payments and DSH payments in addition with the federal funds that are drawn. Providers should remember that the increase in the hospital provider tax revenue (from \$49.5 million to \$264 million which occurred during state fiscal year 2006) was used to provide the state matching funds for the non-state owned SC general acute care hospital DSH payments as well as the retrospective cost settlements that DSH eligible hospitals were receiving. DSH payments alone (excluding increases in Medicaid FFS and Medicaid MCO hospital related payments) have increased by \$57 million total dollars (from approximately \$445 million in FFY 2006 to approximately \$502 million in FFY 2015) without any corresponding increase in the hospital provider tax.

26. We hope the Medicaid agency will seek to restore equity among the DSH program rather than continuing to establish different payment pools whereby some hospitals have payments reduced in order to be redistributed to other facilities. We believe that many of the initiatives outlined in the public notice could be funded from recurring funds that have been carried forward for the past two state fiscal years.

SCDHHS response: See response to comment #25. The SCDHHS intended to draw down sufficient federal funding in order to provide what it believes to be sufficient funding to create the Transformation Pool. If only state funds would have been used we would have severely limited the amount of funds available under this program.

27. We encourage SCDHHS to ensure that this change will meet CMS DSH audit requirements and indemnify hospitals from audit adjustments that result from this change (i.e. elimination of unreimbursed Medicaid fee for service cost from the hospital specific DSH limit). As Medicaid payments do not currently reimburse hospitals 100% of cost, we understand that payments on Medicaid fee for service accounts will likely not cause Medicaid payments to exceed cost. We are concerned however that this change can cause an unwarranted redistribution of DSH payments among hospitals. It is a widely known fact that Medicaid payment is always less than Medicaid costs, your proposal to discontinue reflecting any Medicaid shortfall in the calculation but to include a Medicaid payment overage whenever it occurs is not acceptable. We do not support this proposal and we feel that it does not promote the state in a positive light amongst hospitals.

SCDHHS response: Based upon the review of this DSH payment model, the SCDHHS did not see any significant payment swings due to the exclusion of the Medicaid fee for service unreimbursed cost in the calculation of the proposed DSH payments for FFY 2015. However after further consideration, the SCDHHS has reversed its decision and will include the Medicaid fee for service unreimbursed cost in the calculation of the FFY 2015 DSH payments.

28. We encourage SCDHHS to reconsider making DSH payments to out-of-state hospitals, except for services not currently available in S.C. We do not support an increase in payment from 50% to 60% in 2015. At the least, we urge SCDHHS to consider reciprocity in determining out-of-state DSH reimbursement. We suggest that SC only reimburse NC border hospitals for DSH and this should be based on a certain percent of Medicaid claim payments as an add-on, e.g. 2.5% of Medicaid payment for each claim paid.

SCDHHS response: Many years ago an out of state (OOS) border hospital challenged a SCDHHS decision to exclude them from participation in the SC Medicaid DSH Program via an administrative appeal. The hearing officer ruled in favor of the OOS provider, thus allowing qualifying OOS border hospitals that meet the federal Medicaid DSH qualification criteria to participate in the SC Medicaid DSH Program. Because the qualifying OOS border DSH hospitals cannot be assessed the hospital provider tax by the state of SC, the hospital specific DSH limit is reduced by 40% before

determining its SC Medicaid DSH payment. If a SC general acute care hospital borders North Carolina or Georgia and feel that they are not being adequately reimbursed for OOS uninsured individuals via the state's Medicaid DSH program, then that hospital should challenge/petition the particular state's Medicaid Program for resolution of this problem.

29. Hospitals exceeding the 75th percentile should be made aware of a potential cap on costs as part of a normalization program and be given an opportunity to justify their high costs relative to other hospitals in the state. In order to allow hospitals time to make the appropriate changes without putting them at financial risk, reductions should be phased in over a period of time. We suggest that SCDHHS be cautious here in view of the light that it just reduced claims reimbursement rates to these hospitals. A cut in Medicaid DSH may create a situation that will no doubt cause financial hardship to them.

SCDHHS response: The SCDHHS believes that it is justified in capping the Medicaid fee for service, Medicaid MCO, and Uninsured cost pools for the impact of the July 1, 2014 Medicaid fee for service normalization action. The normalization process removes unnecessary Medicaid eligible and uninsured individuals' costs (and adjusts payments if applicable) that have been deemed to be excessive from the computation of the SC Medicaid DSH payments for FFY 2015.

30. Due to the fact that the Healthy Outcomes Program is relatively new, and considering that there is currently no mechanism for paying claims for services provided to the participants, we encourage the state not to tie the Medicaid DSH Program to it. At such a time when the objectives are clearer and payment issues have been worked out, it will then make sense to begin to look for and discuss ways to tie them together.

SCDHHS response: The SCDHHS only requires participation in the HOP Program during FFY 2015 in order to receive its calculated DSH payment.