

Georgia Department of Community Health
Hospital Advisory Committee Meeting
July 12, 2007

The meeting was called to order at 1:30 p.m. Committee members attending were:

HOSPITAL	MEMBER/DESIGNEE
Central Georgia Health System	Rhonda Perry, co-chair
Ty Cobb Healthcare System	Steve Barber
Children's Healthcare of Atlanta	David Tatum
East Georgia Regional Medical Center	Robert Bigley
Grady Health System	Otis Story
Piedmont Healthcare	Bob Cross
St. Joseph's / Candler	Tarry Hodges
Satilla Regional Medical Center	Katrina Wheeler
Tift Regional Medical Center	Dennis Crum
Upton Regional Medical Center	Gene Wright
Wellstar Health System	Marsha Burke

Carie Summers, Chief Financial Officer for the Department, provided opening comments. She also distributed copies of a public notice issued by the Board of Community Health at its meeting earlier in the day for proposed changes in DRG payment rates. The proposed changes were in accordance with the previous recommendations of the Hospital Advisory Committee.

Co-chair Rhonda Perry asked committee members for comments on the draft minutes for meetings held on April 19, 2007, May 3, 2007 and May 30, 2007, and the minutes were approved without changes. As referenced in the meeting notice sent to committee members, the following agenda items were presented for the meeting:

- Report on GHA Hospital Tax Work Group
- Begin discussions on FY 2008 DSH program eligibility and allocations
- Report on the CMO work group

Report on GHA Hospital Tax Work Group

Glenn Pearson, from GHA, reported that the Hospital Tax Work Group had met on June 25, 2007 and that the group's work was still in process. He noted that:

- Federal policies regarding permissible financing arrangements were uncertain
- Data modeling would continue and
- The work group as well as the GHA board would be studying these matters.

Discussion on FY 2008 DSH Program Eligibilities and Allocations

Ms. Perry reminded committee members of the importance of resolving eligibility and allocation policies as soon as possible in order to avoid any unnecessary delay in the distribution of DSH

funds for State Fiscal Year 2008. As a possible starting point for its discussions, Ms. Summers provided the committee with a copy of guiding principles for DSH policies that were previously identified by the Hospital Advisory Committee in September 2005:

1. DSH payments should be directed in proportion to uncompensated care provided.
2. DSH payments should be based on uncompensated care.
3. All hospitals should be reimbursed based upon a uniform methodology.
4. DSH payments must be based upon available, transparent and easily verifiable data.
5. The state should maximize DSH and UPL payments.
6. Changes in DSH payments should not put an undue burden on any hospital group

Ms. Summers also noted that the Department had contracted with Myers and Stauffer, a national CPA firm, to continue to provide technical assistance on DSH-related matters. Ms. Perry then asked that Kevin Londeen, from Myers and Stauffer, to provide introductory comments about Georgia's DSH policies.

Mr. Londeen noted that the previously approved guiding principles may need modification so as to provide guidance regarding eligibility for funding. He explained that Georgia's current eligibility criteria fall between the maximum and minimum qualification restrictions that are permitted under federal requirements. He suggested that the committee may want to consider loosening qualification criteria to avoid abrupt differences in funding. As an example, Mr. Londeen noted that if one hospital that barely met a specific criterion while a second hospital barely missed meeting that same measure, the first hospital could be eligible to receive a significant amount of DSH funds while the second hospital would receive none at all. He also suggested that the committee consider whether it is appropriate, as may occur under current allocation policies, that a hospital that barely meets a single qualifying DSH criterion can be funded at the same rate as hospitals that well exceed the qualifying threshold or that meet multiple criteria.

In its discussions regarding the guiding principles, the committee approved that the first five principles should continue to be used. For the final principle, the committee initially rejected a proposal that it also be approved. After further discussion and reconsideration, the final guiding principle was also approved by a vote of 6 to 4.

The committee then discussed whether the guiding principles should be expanded to address DSH eligibility criteria. After an extended discussion, the committee voted that a work group should be directed to make recommendations about qualification criteria for the committee's consideration. The alternative of addressing eligibility solely as a guiding principle might require that eligibility be reconsidered every year, which was not acceptable.

With regard to the availability of updated information that could be used for eligibility and allocation measures, Ms. Summers reported that data for services provided during 2006 Medicaid patients covered by CMO plans would not be available by October, when data would typically be collected. The committee agreed that the work group considering eligibility criteria should also provide recommendations regarding data sources for DSH measures. Additionally, the work group would also be asked to consider alternatives for the allocation of DSH funds. Ms. Perry noted that Myers and Stauffer should provide technical assistance for the work group and that the work group members would provide guidance about any alternatives that should be modeled by Myers and Stauffer. Ms. Perry advised that the work group membership and future meeting dates would be reported on the Department's web site.

Report on the CMO Work Group

Mr. Pearson presented a copy of the minutes for the CMO work group meeting on June 21, 2007, which are attached and included as a part of these minutes, and provided explanatory comments on the policy and technical issues identified by the work group. Ms. Summers advised that these issues may also be the subject of reviews of CMO plans being performed for the Department by consulting actuaries and by an external quality review organization. Additionally, a detailed review of CMO claims processing will be performed for the Department by Myers and Stauffer, in response to a recent inquiry from the Governor's office regarding CMO operations. Ms. Summers reported that the results of these reviews might not be available for a few months. She also advised the committee that she would follow up with the Department's Managed Care regarding the concerns identified by the CMO work group.

Future Meetings

Following a discussion about locations for future meetings, the committee agreed that meetings should be held in either Atlanta or Macon and that meetings in Atlanta should be coordinated with the meeting dates of the Board of Community Health. The next meeting of the advisory committee might be held in late August or early September, but the meeting date would be dependent on when recommendations from the work group will be available for consideration. Ms. Perry also asked that the Department present a report on its follow up to the issues identified by the CMO work group.

There being no other business, the meeting was then adjourned.

Medicaid CMO Issues Results of June 21, 2007 Meeting

Introduction

At the request of DCH staff, the DCH Hospital Advisory Committee was asked to develop a list of top issues and concerns related to the Medicaid transition to CMOs. The Hospital Advisory Committee, in turn, asked the Data Subcommittee to identify the issues. Providers would like to work in a collaborative and constructive manner with DCH and the three CMOs to resolve operational issues that have resulted from the implementation of the Georgia Healthy Families program. Providers believe that problems associated with payments should be solved jointly in a partnership-type relationship. Listed below is a summary of the discussion of the Subcommittee members at the June 21, 2007 meeting. The group divided the issues into two categories: policy issues and administrative issues. Within each category, the issues are presented in descending order of importance.

Policy Issues

1. It appears that CMOs are not paying emergency room claims in accordance with the historical prudent layperson definition of an emergency medical condition. The triage rate is paid for what is an emergency medical condition, and then the hospital has to go to the expense of filing an appeal. A high percentage of appealed cases are overturned, indicating that they should have been paid appropriately in the first place.
 - One of the selling points for CMOs was that there would be active case management. We have seen no evidence of such care management or physicians performing the gatekeeper function.
 - There are inconsistencies among how the CMOs apply the prudent layperson definition and also how the definition is interpreted in Georgia versus other states.
2. A number of issues such as resolving problems that result from CMO IT issues, denials/appeals, enrollment, pre-certifications/authorizations, educating members have fallen to the provider, increasing rather than easing the burden on hospitals.
3. There are examples of where hospitals are held accountable for situations beyond their control.
 - For example, pre-authorizations are sometimes voided because the clinician decides in the end to switch to a medically appropriate related procedure (e.g. – radiology procedure **without** contrast instead of **with** contrast).
 - CMO administrative issues which lead to denials or delays payments.
 - CMO representatives often reference policies and procedures that contradict specific contract terms.
 - Some CMOs are basing hospital claims submission timeliness on admit date, not discharge date. This creates a situation where claims for patients with extended lengths of stay are denied due to unreasonable timeliness criteria.

- Patients sometimes change CMOs during an inpatient stay. Sometimes the CMOs won't recognize the change. This is especially common with newborns where they have a different CMO than the mother.
4. Hospitals are also concerned about the upcoming DRG rebasing. Since timing of the implementation is governed by individual CMO/hospital contracts, hospitals will probably have to use both the old and the new groupers during the transition. We hope DCH will consider mandating a universal implementation date for all CMOs.
 5. Providers support the original goal to control costs and achieve budget predictability by managing utilization and we'd like to assist in an interim review and in re-focusing where necessary to assure success. Perhaps we could collaborate to determine the measures of success. Are there any studies available that document if these goals are being met?

An analysis of program inputs along with anticipated positive outcomes could provide the information to make the corrections where needed in achieving our mutual goals.

6. There continues to be anecdotal evidence regarding issues with access to services, especially certain medical specialties in certain geographies.
 - Obstetrical services in rural areas
 - Neurosurgery
 - Orthopedics

The committee unanimously felt the situation is worse than the pre-CMO days. An in-depth analysis of these issues may help us work together to structure actions that could lessen the additional financial and administrative burden for hospitals.

7. Local CMO representatives (including the local presidents) are not empowered to resolve issues—decisions made at corporate national level may not take into consideration unique local situations and/or factors.
8. Many contracts were signed without a finalized Provider Manual available. As the program has progressed and provider manuals became available, inconsistencies with agreed-upon terms have been found. It would be helpful to have an opportunity to revisit these issues.
9. CMOs not retroactively recognizing physician enrollment creates major frustrations.
 - Many physicians still not properly enrolled even after a year of operation. This is perceived as a wide-spread problem.
 - CMOs claim they can't retroactively cover patient enrollment until the application date, citing NCQA.
10. Based upon hospitals' experience so far, there is a strong sense that CMOs are relying on denial of payments to reduce costs instead of managing utilization.

Technical Issues

1. A method to obtain the data needed for Medicare DSH, ICTF, and Hospital Financial Survey is necessary.
 - Hospitals must be able to essentially replicate the HS&R format. The existing ACS format is fine.
 - This data is not only ESSENTIAL for the Medicare DSH Program, but also has cash flow and GME payment implications
 - Lack of data can also create compliance and reconciliation issues.
 - Needs to be broken out by CMO, traditional Medicare, and PeachCare for Kids.

To put the importance of this issue in perspective, the aggregate approximate Medicare DSH operating payments for Georgia hospitals is around \$400 million dollars.

2. CMO IT systems aren't standardized and don't have all of the functionality equal to the ACS system, which is what the providers were promised.
 - Lack of IT capability means many claims revert to paper
3. Contract payments—there are growing reports that CMOs not paying claims in accordance with the contracts they have negotiated. Providers would like to work with DCH to establish a process to appropriately deal with these issues on a statewide vs. an individual hospital level.

In summary, we thank you for the opportunity to bring these issues to DCH's attention. We are being faced with the usual start up issues related to any program of this magnitude and look forward to working together to make the program the best that it can be.