

FY 2008 Disproportionate Share Hospital Program

Presentation to
Senate Appropriations Health Subcommittee
December 18, 2007



Disproportionate Share Hospital Program

What does the DSH program do?

Provides additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment.

What does DSH not do?

DSH is not designed to reward providers who have minimized their uncompensated Medicaid and uninsured care by effectively pursuing Medicaid and self-pay revenue.

FY 2007

Eligibility

- 2 Federal Criteria and 1 of 9 state criteria

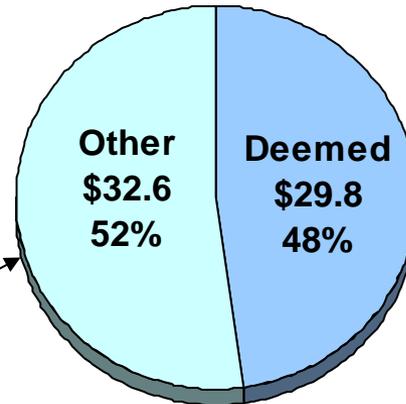
Allocation

- Two Pools – Small Rural and Everyone Else
- Premium for being a “Deemed” facility
 - Facilities that exceed certain thresholds for low income and Medicaid utilization
- Within pools, allocations based on hospital’s share of the total DSH limit

FY 2007 Allocation of DSH - \$408.5M

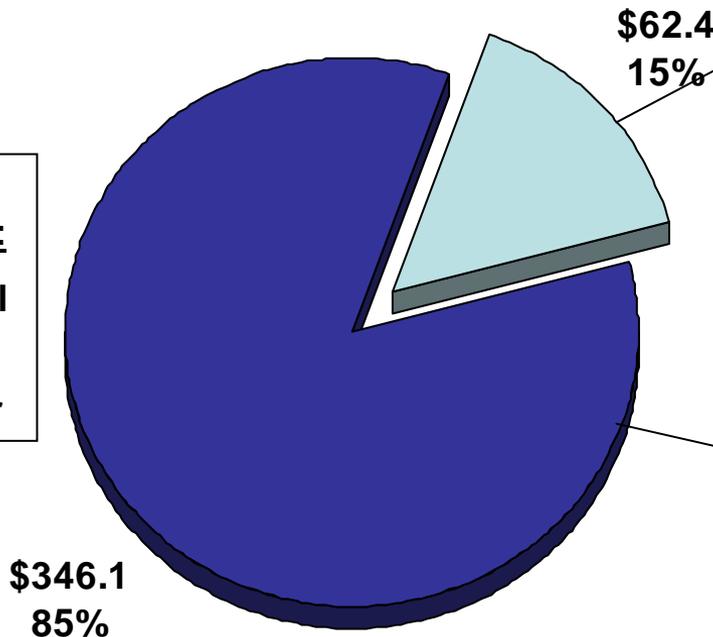
Small Rural Hospitals Pool #1 - \$62.4M

■ Small Rural Hospital Pool
■ All Other Hospitals

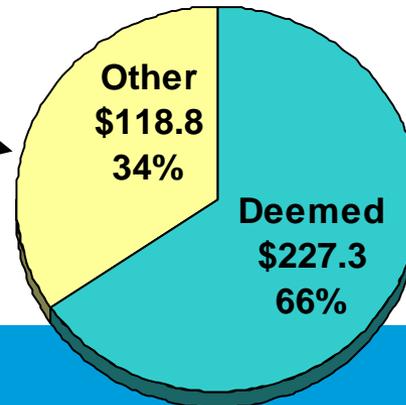


of Small Rural Hospitals:
 22 – Deemed
 41 - Other

of Hospitals:
 63 – Small Rural
 47 - Other



All Other Hospitals Pool #2 - \$346.1M



of Hospitals in 2nd Pool:
 19 – Deemed
 28 - Other

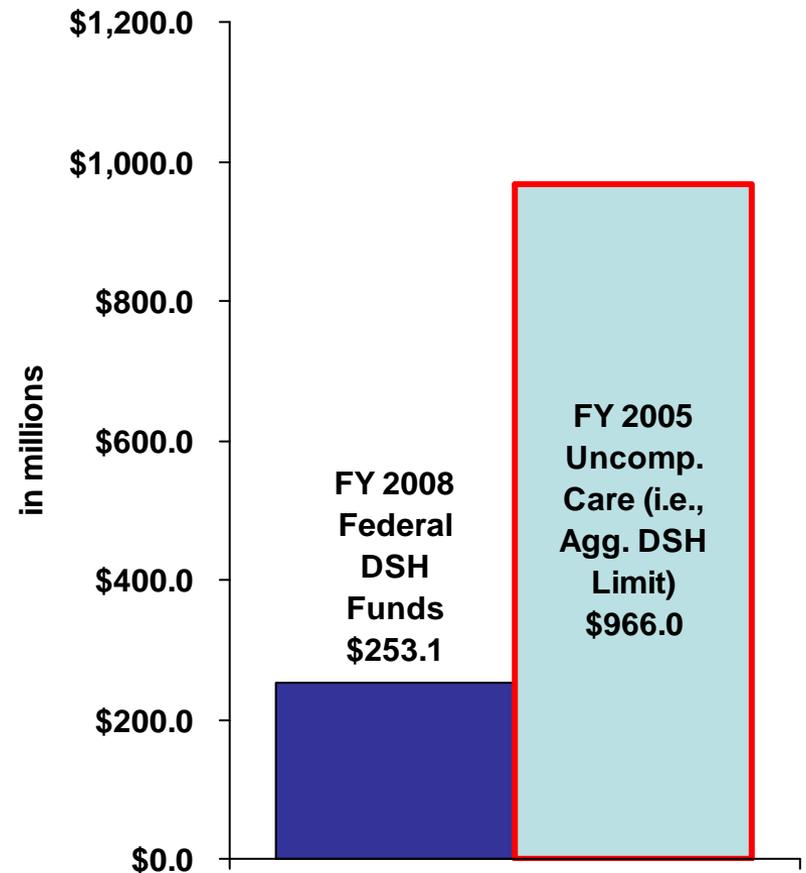
Challenges of the DSH Program

No growth in federal funds available to the state.

- Annual allotment of \$253.1 million not changed since FY 2004

Uncompensated costs historically greater than available funding:

- Most hospitals not paid at cost for Medicaid members.
- The number of uninsured Georgians is increasing.



Goals of DSH Reform in FY 2008

With static resources:

- Consider changes that will direct DSH funds to hospitals most impacted by uncompensated Medicaid and uninsured costs (i.e., those who are the most disproportionate)
- Recognize that hospitals rely on DSH as a Medicaid subsidy, even if they aren't the most disproportionate

Industry Input

DCH utilized the advice and counsel from the Hospital Advisory Committee

13 Representatives:

- 5 Urban Reps for 12 hospitals
- 6 Rural Reps for 6 hospitals
- 2 Joint Reps for 14 urban and 2 rural hospitals
- Hospitals in 23 counties throughout the state

DSH Subcommittee

Hospital Advisory Committee appointed a subcommittee to study DSH

Representatives:

RURAL:14 Hospitals,14 Counties, 8 Reps

URBAN:14 Hospitals,10 Counties, 9 Reps

6 Meetings from August 2007 through early October 2007

DSH Reform - Guiding Principles

DSH payments must be based upon available, transparent and easily verifiable data.

1. Use of 2005 Hospital Financial Survey for OB status and uncompensated uninsured care
2. Use of 2005 Medicaid data
3. 2006 data disregarded due to concerns that CMO impact not fully realized yet
4. 2006 data for uninsured and OB status not yet collected
5. Perform data reviews on previously unaudited facilities and data elements used in the allocation formula



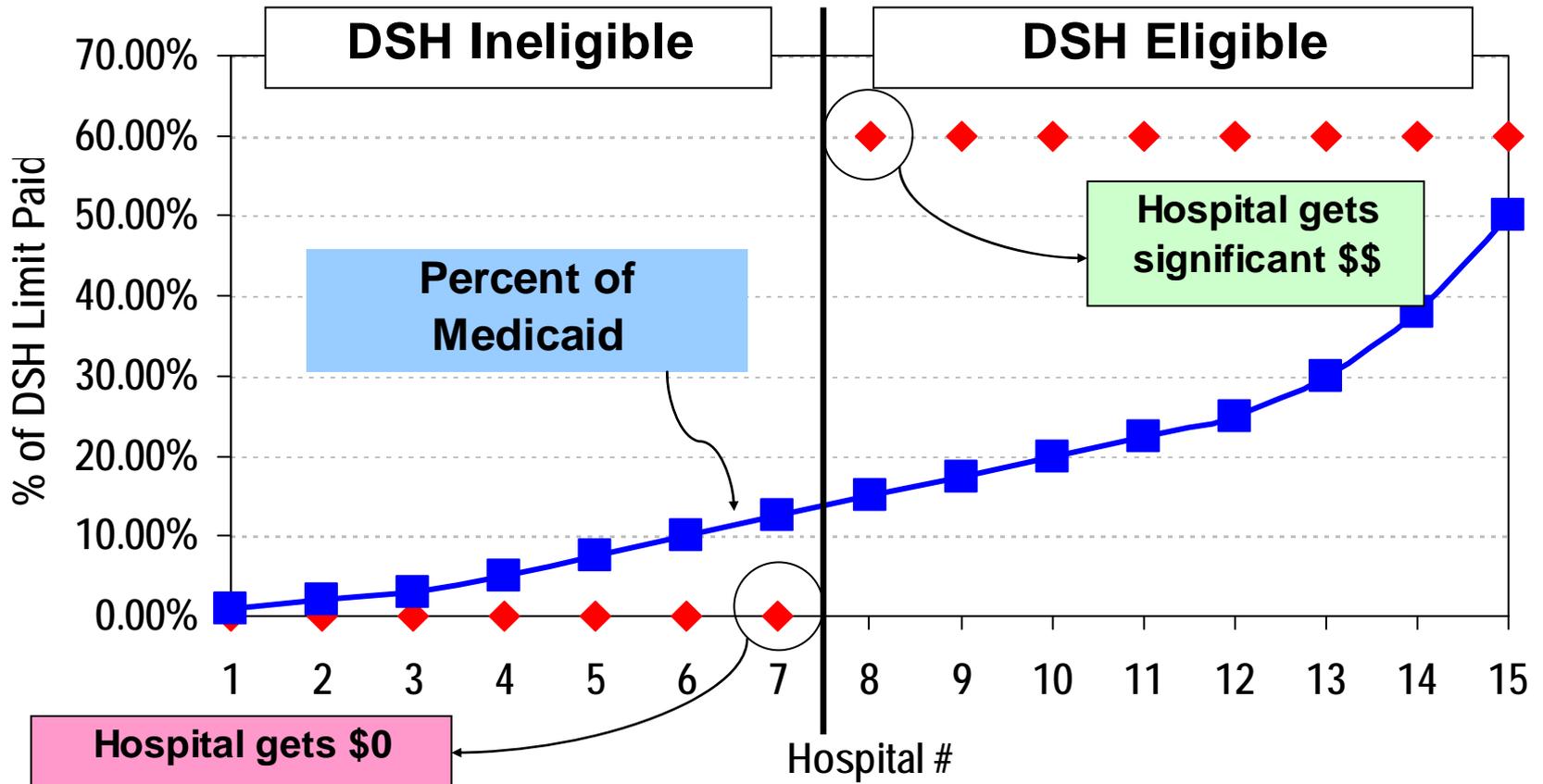
DSH Reform - Guiding Principles

Eligibility criteria should be reconsidered.

1. Eliminate all state criteria and use only federal criteria
2. Previously ineligible hospitals considered disproportional (as measured by their individual DSH limit as a percent of their total cost) now eligible for a DSH payment



Illustration of FY 2007 Eligibility



DSH Reform - Guiding Principles

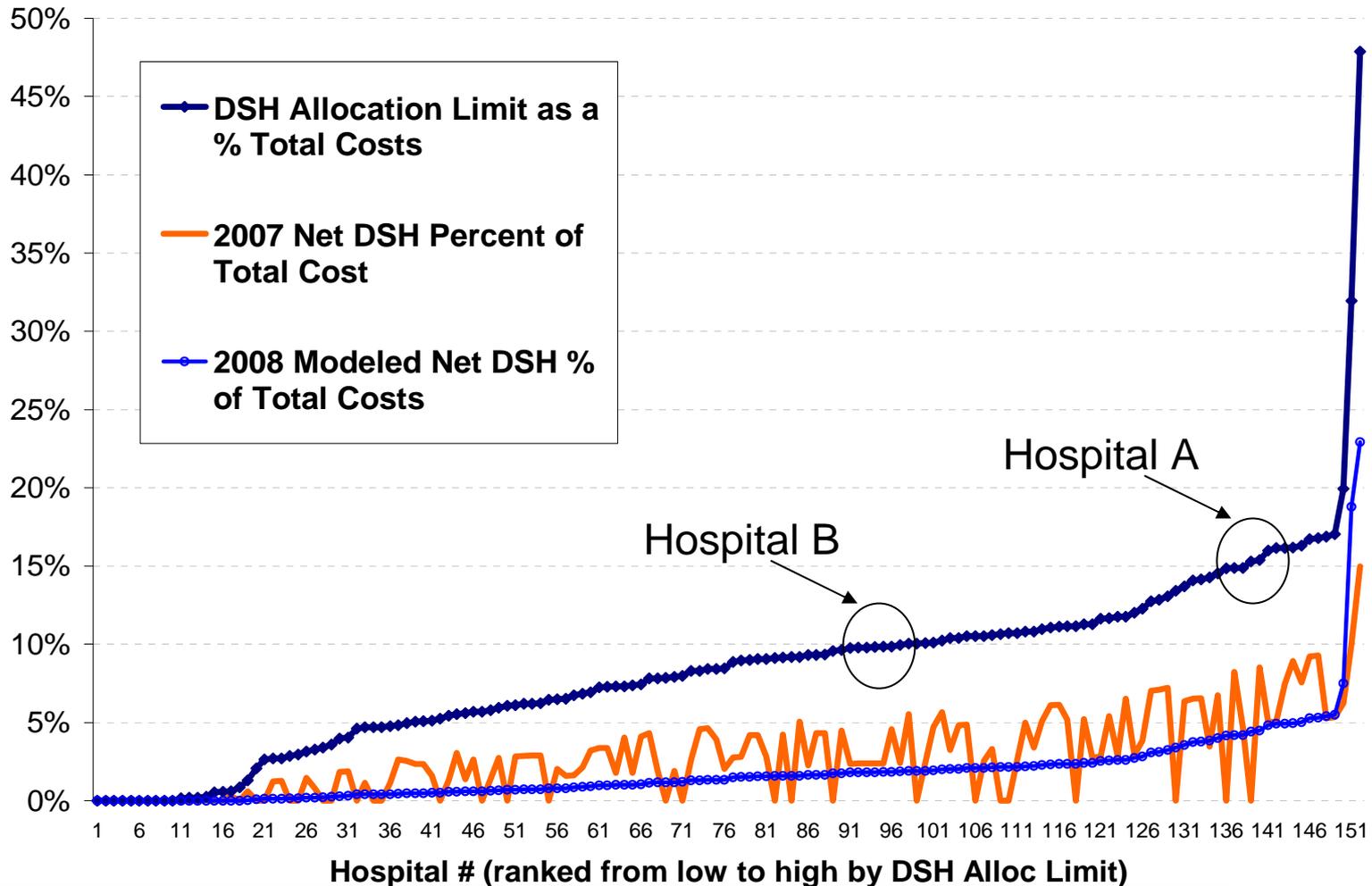
DSH payments should be directed in proportion to uncompensated care provided.

1. Measure of disproportionality = DSH Limit (i.e., uncompensated care) as a percentage of total cost
2. Scalability – the more disproportionate receive a larger percentage of their cost from the DSH program

EXAMPLE	
Hospital A	
DSH Limit	\$75
Total Cost	\$500
DSH Factor	15%
Hospital B	
DSH Limit	\$1,000
Total Cost	\$10,000
DSH Factor	10%



Example of Scalability



DSH Reform - Guiding Principles

DSH payments should be based on uncompensated care.

1. Use of DSH Limit in scalability
2. Recognition of IGT's used for UPL payments
3. Hold harmless for hospitals receiving rate adjustments for medical education and neonatal care
4. Counties the payers of last resort



DSH Reform - Guiding Principles

All hospitals should be reimbursed based upon a uniform methodology.

1. Application of scalability and measurement of disproportionality the same
2. Different pools for Grady and small rural hospitals



DSH Reform - Guiding Principles

The state should maximize DSH and UPL payments.

1. No changes.

DCH Note:

All available DSH funds being expended

UPL maximized for public and critical access hospitals

DSH considers UPL payments



DSH Reform - Guiding Principles

Changes in DSH payments should not put an undue burden on any hospital group.

1. Use of separate pools to help protect small rural hospitals and Grady
2. Consideration of transition from FY 2007 to new methodology over time
3. Floors and Ceilings on amount of DSH limit that can be covered for any one hospital



Hospital Advisory Committee Policy Questions

- Recognizing DISPROPORTIONALITY
- How to TRANSITION FROM OLD TO NEW
- FLOORS and CEILINGS for payment amounts
- HOLD HARMLESS any one group of hospitals
- Treating NEW ELIGIBLES



Question #1 - Disproportionality

Question	Should the model recognize disproportionality based on a percentage of uncompensated Medicaid and Uninsured to total cost?
Vote	Yes – 9; No – 0
DCH Recommendation	Adjusted DSH Limit as a percent of total cost used for allocation of available DSH funds

Fourth Quartile Comparisons		
Group	DSH Factor	Net DSH
Small Rural	14.3%	7.4%
Non-Small, Rural	13.3%	4.2%
Grady	47.8%	16.6%
Newly Eligible Small Rural	12.6%	0.2%
Newly Eligible Other	14.8%	0.2%



Question #2 - Disproportionality

Question	Is it acceptable if less disproportionate hospitals receive less payment if those funds go to more disproportionate hospitals?
Vote	Yes – 7; No – 2
DCH Recommendation	Winners and losers exist within each pool due to shifting of funds from less disproportionate to more disproportionate.

As Compared to FY 2007 (#/\$)		
153 Hospitals Evaluated		
Group	Gains	Losses
Small Rural	1 +\$53.0 k	63 -\$1.6 m
Non-Small, Rural	14 +\$4.9 m	31 -\$12.5 m
Grady	1 +\$5.6 m	n/a
Newly Eligible	33 +\$2.0 m	n/a
Ineligible	8	
Closed	2	



Question #3 - Transition

Question	Should the FY 2008 allocation be based on a blend of the new model and FY 2007 payment amounts?
Vote	Yes – 8; No – 1
DCH Recommendation	For rural facilities: 75% of FY 2007 and 25% of FY 2008 For non-small rural facilities: 50% of FY 2007 and 50% of FY 2008
DCH Comments:	For rural facilities - Assumed they will need more time to adjust to the new methodology given their prior DSH payment level and ability to make up DSH losses with other revenue sources For non-small rural facilities - 50/50 blend needed in the non-small rural pool to better recognize Grady disproportionality in FY 2008

Question #4 - Transition

Question	Should the gains or losses (as a percentage) between FY 2007 and FY 2008 by any one group be comparable?
Vote	Yes – 7; No – 2
DCH Comments	Deemed Facilities take bigger losses due to 10% premium applied last year

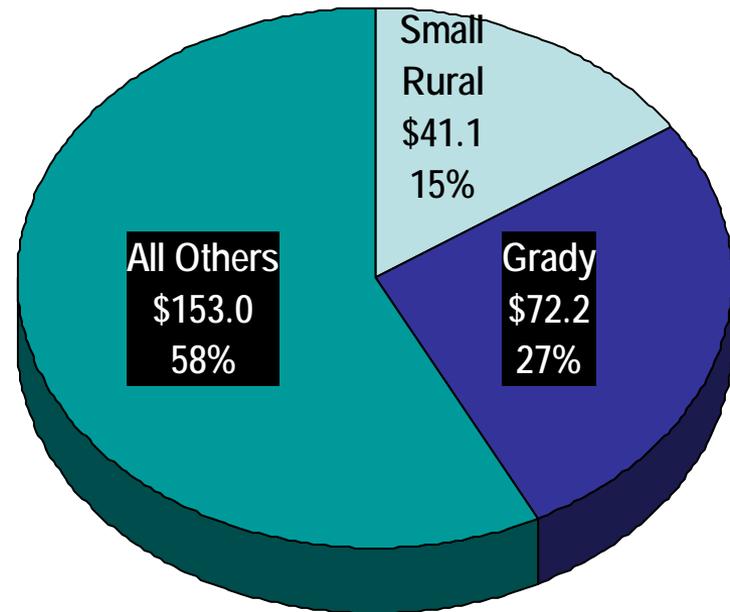
As Compared to FY 2007 Net Payments		
Group	Deemed	All Others
Small Rural	-5.2%	-2.0%
Non-Small, Rural	-5.3%	-4.4%*

* Higher decrease due to closure of Emory Dunwoody

Question #5 - Transition

Question	Is it acceptable to use separate pools as a way to mitigate substantial losses or gains for any one group of hospitals?
Vote	Yes – 7; No – 2
DCH Recommendation	Maintained separate small rural pool; created a pool for Grady

Allocation of
FY 2008 Net DSH Funds
(n=\$266.3 million)



Question #6 - Ceilings

Question	Should there be a limit on the percentage of the DSH limit that any one hospital can receive?
Vote	Yes – 8; No – 1
DCH Recommendation	75% for Grady; 80% for everyone else
DCH Comments	A DSH cap lower than 80% would have resulted in ALL small rural hospitals taking a loss as compared to last year.

Question #7 - Floors

Question	Should there be a minimum level of disproportionality to receive a DSH payment?
Vote	Yes – 1; No – 8
DCH Recommendation	No floor



Question #8 – Hold Harmless

Question	Should any one group of hospitals be held harmless from any change to the allocation methodology?
Vote	Yes – 5; No – 6
DCH Recommendation	Small rural DSH pool reduced to 90% of last year



Question #9 – New Eligibles

Question	Should newly eligible facilities receive some level of DSH payment in FY 2008?
Vote	Yes – 8; No – 1
DCH Recommendation	Newly eligible limited to 10% of their allocation; however, with a blend of FY07 and FY08 at 50/50; new, non-small rural hospitals get 5% of their allocation or \$2.0m; small rural hospitals get \$48k

Summary

Facility Type	# of Providers Under 2007 Criteria	2007 Net DSH Payment	2008 Net DSH Payment
<u>Small Rural</u>			
Eligible both 07 and 08	64	\$42.6	\$41.1
Not Eligible in 07	3	-	0.05
Not Eligible in 07 and 08	0	-	-
Total Small Rural	67	\$42.6	\$41.1
<u>Non-Small Rural</u>			
Grady	1	\$66.6	\$72.2
Eligible both 07 and 08	45	156.7	151.0
Not Eligible in 07	30	-	2.0
Not Eligible in 07 and 08	8	-	-
Closed	2	2.0	-
Total Non-Small Rural	86	\$225.3	\$225.2



Recent Actions

- DCH Board Approval on November 8
- Data verification for newly eligible facilities completed in November
- Submission to CMS November 28 – started 90-day CMS clock for approval
- \$174 million in Interim Payments to Public Providers December 14
 - Lesser of 50% of FY 2007 DSH Payment or FY 2008 Proposed DSH Payment
- Final Payment of remaining DSH funds upon CMS approval for public facilities and upon state fund appropriations made available for private facilities