

Georgia Department of Community Health
Hospital Advisory Committee Meeting
May 30, 2007

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

| HOSPITAL | MEMBER/DESIGNEE |
|----------------------------------|-----------------------|
| Ty Cobb Healthcare System | Chuck Adams, co-chair |
| Central Georgia Health System | Don Faulk |
| Children's Healthcare of Atlanta | David Tatum |
| Coffee Regional Medical Center | George Heck |
| Grady Health System | Otis Story |
| Piedmont Healthcare | Bob Cross |
| St. Joseph's / Candler | Paul Hinchey |
| Tift Regional Medical Center | Dennis Crum |
| Upton Regional Medical Center | Gene Wright |
| Wellstar Health System | Tim Beatty |

Co-chair Chuck Adams reviewed agenda items for the meeting:

- DRG rate update
- DSH payments
- Subjects for next meeting
- Other comments or general discussions

DRG Rate Update

Glenn Pearson, from GHA and chairman of the committee's DRG work group, presented a report on the work group's updated recommendations. A copy of the minutes for the DRG work group meeting on May 15, 2007, as presented by Mr. Pearson, are attached and included as a part of these minutes. The recommendations included that DRG rates updates should utilize data previously validated for DSH funding, that no stop loss policy should be applied and that the implementation date should be postponed until January 1, 2008. Carie Summers, Chief Financial Officer for the Department, stated that the recommendations were acceptable to the Department. After discussion, the committee then voted to accept the work group recommendations. Ms. Summers indicated that the Department would proceed by presenting a public notice regarding the DRG rate update at the July meeting of the Board of Community Health, using January 2008 as the proposed implementation date.

DSH Payments

Following the last meeting at which the hospital advisory committee had voted to recommend that the Department should continue to use the same eligibility and allocation policies as used for State Fiscal Year 2006, Grady Memorial Hospital sent a request to other committee members to ask for reconsideration of that decision. Committee members were polled as to whether a change

in vote should be considered for discussion at this meeting, and a majority of committee members indicated that no change to the recommendation for State Fiscal Year 2007 should be considered. However, several committee members indicated an interest in considering possible DSH policy changes for State Fiscal Year 2008. Ms. Summers indicated that approximately \$180 interim DSH payments had previously been paid to public hospitals and that remaining current DSH funds should be paid by June 30. She explained that payments would be made to public and private hospitals on the same date and that final DSH payment amounts would be posted on the Department's web site as soon as available.

Subjects for Next Meeting

Subjects identified for consideration at the next meeting of the hospital advisory committee included CMO payment issues, IGT financing for State Fiscal Year 2008 and DSH policies for State Fiscal Year 2008. With regard to CMO payment issues, co-chair Chuck Adams noted that it would not be sufficient to cite revenue reductions and recommended that a work group be convened to help identify top issues that would warrant consideration. In subsequent discussions, hospital representatives cited non-electronic claim data, payments for ER services and delays in reprocessing as some of the problems. Ms. Summers noted that a report on CMO payments for ER services was being prepared for the Department by an outside contractor and should soon be available for review. She also noted that, in response to concerns from Governor Perdue about unpaid claims for Children's Healthcare of Atlanta, the Department planned to use an independent contractor to evaluate any payment problems. Ms. Summers also reminded committee members that any Department's expectation for savings from CMO services would be due to improved utilization management and not from creating barriers for payments. The committee then agreed that the same members who served on the DRG work group would also consider CMO payment issues, with the understanding that hospitals may substitute other staff members, if needed.

With regard to IGT financing, Ms. Summers noted that CMS had published final regulations on May 29 that would impact IGT financed payments. Among the potential concerns were an effective date within 60 days, earlier than indicated in the draft regulations, and a restriction that IGT funds might only be acceptable if provided directly from tax revenues. It was noted that there was uncertainty about future impact due to a recently proposed Congressional moratorium on such regulations, and while a moratorium might provide some extended use of IGT financing, there could still be a need to identify other sources of funding within the next year. In subsequent discussions, the committee agreed that it should coordinate its efforts with a GHA provider tax group. Glenn Pearson indicated that the GHA group would be reconvened in June. Ms. Summers noted that any recommendations for funding alternatives dependent on legislation or State appropriations would need to be resolved by December, at the latest, to allow for consideration.

With regard to the DSH program for State Fiscal Year 2008, Ms. Summers explained that it would be preferable that any changes in policies for qualification or funding allocation should be identified by early summer in order to allow for consideration by both the Board of Community Health and by CMS. Related to allocation policies, she noted that it would be preferable that work on matters related to funding issues be resolved by late summer. In subsequent discussions, committee members noted that some legislators had indicated a willingness to consider provider tax funding arrangements, if hospitals could reach agreement about how the tax would be applied. Co-chair Chuck Adams noted that it may be appropriate to have the next committee meeting in June to begin discussions about DSH policies for qualification and funding allocation. Ms. Summers noted that the Department would present an update regarding the availability of CMO claim data that may need to be considered if updated source information should be used.

Other Comments or General Discussions

Otis Story from Grady Memorial Hospital addressed the committee regarding his hospital's request for reconsideration of State Fiscal Year 2007 DSH policies and about the committee consideration of DSH policy changes for future years. As requested by Mr. Story thanked the committee for their consideration, and, as he requested, both his comments to the committee and the hospital's request for reconsideration are attached and included as a part of these minutes.

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

DRAFT MINUTES

Department of Community Health Hospital Advisory Committee Data/DRG Sub Committee Meeting Tuesday, May 15, 2007, 10:00 a.m. GHA Board Room, Marietta, Georgia 30067

Members Present: Glenn Pearson – Chairman
Esther Bailes
Steve Barber
Tim Beatty
Todd Cox
Darcy Davis
Doug Moses
Rhonda Perry
Jesus Ruiz
Greg Schaack
Charlotte Vestal
John Williams
Georgia Hospital Association
Grady Memorial Hospital
Ty Cobb Healthcare System
WellStar Health System
Athens Regional
Memorial Health
Children’s Healthcare of Atlanta
Medical Center of Central Georgia
SunLink Health
St. Joseph’s/Candler
Crisp Regional Hospital
Upton Regional Medical Center

Guests Present: Rhonda Birenbaum
Charles Brumeloe
Sam Chambers
Greg Clark
John Cornell
Bob Cross
Brian Forlines
Lin Harris
Tarry Hodges
Jimmy Lewis
Linda Nicholson
Yvonne Powell
Rick Sheerin
Helen Sloat
Hans Schermerhorn
Craig Srsen
Grady Memorial Hospital
Columbus Regional Medical Center
Oconee Regional Medical Center
The Shepherd Center
Meadows Regional Hospital
Piedmont Healthcare
Medical Center of Central Georgia
Draffin and Tucker
St. Joseph’s/Candler
Hometown Health
Northeast Georgia Medical Center
Navigant Consulting
Floyd Medical Center
Nelson Mullins
Memorial Health
Navigant Consulting

DCH Staff: Jim Connolly, David Riddle

GHA Staff: Cal Calhoun

DRAFT MINUTES

- I. **Call to Order/Welcome:** Chairman Glenn Pearson called the meeting to order at 10:00 a.m.

- II. Mr. Pearson noted the past meeting's recommendations, and that the full Hospital Advisory Committee asked the subcommittee to revisit recommendations: 1) number 5 - dealing with use of verified as-filed cost reports or audited reports and the handling of malpractice costs; and 2) number 6 on whether a stop loss/stop gain or phase-in methodology should be considered when DRG payments are made using the up-to-date Champus grouper.

- III. Jim Connolly reported that there would be a meeting of the full Hospital Advisory Committee on May 30, 2007 at the Medical Center of Central Georgia, starting at 1:00 p.m.. The department would like to take a recommendation to the Board of Community Health (BOCH) at its June meeting to be issued for public comment; and, possible approval at the July BOCH meeting for implementation in August, or a later date if necessary.

IV. **Data Base**

Jim Connolly, Yvonne Powell, the committee and guests discussed the issues at length.

On use of the audited cost reports, Yvonne reported that another state had analyzed the error rate induced by use of a lengthened "trend factor" from a lagged base period. The state found the projections variance versus the actual costs to be 9%. It was noted that the last actually "audited cost" Medicaid Cost Report was in the 1990's. Use of the latest "as-filed" cost reports, which have been verified and used for DSH allocations would bring every hospital to within a common year.

A MOTION WAS MADE TO USE VERIFIED AS-FILED COST REPORTS AS THE BASE YEAR DATA. The motion passed unanimously.

V. **Stop Loss/Stop Gain or Blended Phase-in**

The committee discussed the various aspects and impacts of payment/cash flow changes that can occur after using one grouper for six years. A cluster chart of hospitals reflected concentration of cost coverage of payments under the new grouper to be around the 100% area. A bar chart which weighted the payment amounts reflected most payments being made at 95% of cost coverage (total budget neutrality is about 96% of costs in SFY 2005.)

A larger number of hospitals would have their payment increase curtailed than there were hospitals receiving the benefit of a stop-loss, in one scenario presented by Yvonne.

It was noted that “today’s” impact, would be different than the numbers being shown from Medicaid services in 2005. To allow hospitals to model their own impact, and to adjust their operations for changes in Medicaid payments, A MOTION WAS MADE TO IMPLEMENT THE REVISED CHAMPUS GROUPER ON JANUARY 1, 2008, WITH NO STOP LOSS/STOP GAIN OR PHASE-IN. The motion passed unanimously.

VI. Malpractice Costs

During the course of the day the handling of Medicaid malpractice costs was discussed, interlaced with the previous issues. Malpractice per cost report allocations can be 1) \$0 if no Medicaid settlements; 2) 7.5% per Medicare/Medicaid allowable costs; or 3) a higher % relative to actual Medicaid claims experience in that cost report year.

In modeling the DRG costs from verified as-filed cost reports, the department had included malpractice costs in the hospitals’ operating costs and stepped down those cost proportionately to the hospitals proportion of inpatient Medicaid costs using cost to charge ratios. It was noted that pulling malpractice costs out and allocating those costs directly based on Medicaid claims experience (which were higher than for other patients) helped increase the Medicaid payment for about half dozen hospitals. Feeling that a prospective payment system should treat malpractice as a general operating cost – A MOTION WAS MADE TO ADOPT THE DEPARTMENT’S ALTERNATIVE METHODOLOGY, WITH AS-FILED DATA AND WITH STEPPED DOWN MALPRACTICE COSTS. Motion Adopted.

VII. Adjournment - There being no other business, the meeting adjourned at 2:15 p.m.

Remarks to the Georgia Department of Community Health - Hospital Advisory Committee

Submitted for the record by: Otis L. Story Sr., FACHE
President/CEO – Grady Health System
May 30, 20007

I would like to take this opportunity to acknowledge the phone calls and conversations that I have had with several members of the committee to express concern regarding the 2007 allocation and the harsh impact on Grady. I am extremely sensitive to any delay of the 2007 distribution and the impact on cash flows for some facilities, including Grady. However, I would like to make some comments about the need for DSH reform. The need for reform has been building for years and, today it is more imperative because of significant swings occurring in DSH allocations. In this regard, I would like to highlight the following points.

- The formula recommended by the Hospital Advisory Committee (HAC) in 2006 was a first step in the reform process and would enable the department to make much needed payments to hospitals during the 2006 year. It was the intent of the HAC to continue working on DSH reform by returning the program to its core purpose and federal intent of supplemental payments to providers treating high volumes of Medicaid and indigent patients and, to recognize the varying degrees of disproportionality among providers.
- The Georgia DSH eligibility criteria that expands the DSH pool most significantly is the 15% of patient revenues from Medicaid and PeachCare. This threshold was established in 1983, a time when statewide Medicaid was 7% of patient charges. Currently, according to GHA, the statewide Medicaid utilization rate is 17%.
- The pool of DSH eligible hospitals continues to grow while DSH funding is shrinking or stagnant. Further, the allocation methodology doesn't recognize the significant degrees of disproportionality that exists among participating hospitals. The more disproportionate a hospital is, the more adverse the impact of the expanding pool of eligible hospitals.
- There should be recognition of the varying degrees of disproportionately among participating hospitals. As the pool of eligible hospitals continues to grow, the more disproportionate facilities will continue to be hit the hardest, particularly deemed facilities. The deeming premium, which was new in 2006, does not really reflect the degrees of disproportionality that exists among hospitals.
- Grady's Medicaid and uninsured patient mix is dramatically higher than other hospitals. Grady's Medicaid patient mix is greater than 40% compared to a statewide Medicaid patient mix of 17%. Grady's uninsured patient mix is significantly greater than the statewide-uninsured patient mix.

- In previous years (2005), there was recognition that facilities could not sustain multi-million dollar swings in their DSH distribution. The previous HAC and the department recognized that the current system was not working and that significant swings were detrimental to the entire statewide delivery system. Such swings are still detrimental and not sustainable by any healthcare facility, particularly facilities determined to be deemed and eligible since the creation of the DSH payment program. The same holds true for 2007.

In closing, I would like to suggest and recommend that we, (DCH, HAC and health care industry) need to develop a methodology that will add value to all hospitals and, more importantly recognize the varying degrees of disproportionality that exists in this State among hospitals. Grady Health System is critical to the health care delivery system in this entire state and serves a significant portion of the state's Medicaid and indigent patients, a combined Medicaid and uninsured patient mix of more than 60%.

Grady Health System®

80 Jesse Hill Jr. Drive S.E., Atlanta, Georgia 30303-3050

May 9, 2007

Ms. Rhonda Perry
Senior Vice President/Chief Financial Officer
Medical Center of Central Georgia
777 Hemlock Street
Macon, GA, 31201

Dear Ms. Perry:

I am writing to ask that the Hospital Advisory Committee (HAC) reconsider its action taken to endorse utilization of 2006 distribution methodology for the SFY 2007 Indigent Care Trust Fund (ICTF) disproportionate share hospital (DSH) payments. Under the recommended approach, Grady Memorial Hospital will suffer approximately \$ 20.5 million net decrease in payments from SFY 2006. Simply put, the amount of payments to Grady under the recommended distribution is inconsistent with federal DSH policy and the significant loss of DSH cannot be sustained by Grady. Grady cannot now absorb a loss of approximately \$20.5 million in DSH funds.

As you are aware, Grady Memorial Hospital is THE safety net hospital in Georgia. Grady provides the largest amount of services to Medicaid and uninsured patients of any hospital in the state. Grady is a federally deemed DSH provider, meeting both federal DSH criteria. Grady's DSH cap is almost five times (\$165 million; the next largest \$35 million) as large as the next largest ICTF recipient hospital. Grady's unique status, however, is not recognized in the recommended distribution methodology. To the contrary, Grady is forced to compete for DSH funds with hospitals with significantly lower volumes of low income and uninsured patients.

We respectfully request that the Committee reconsider its recommendation to utilize the 2006 DSH distribution methodology. A stop gain/stop loss phase-in methodology should be considered to avoid significant unanticipated losses in payments. As you know, the Department has in the past implemented such provisions to ensure that no hospital experiences a net loss or gain in excess of a specific percentage of the previous year's net payment.

In the longer term, Grady requests that the ICTF be completely overhauled to return it to its core mission of supporting safety net providers. Grady is unique and should be recognized as such in the distribution methodology – just as special recognition is given to critical rural hospitals that are paid their full DSH cap. Grady's uniqueness as the State's largest provider of care to Georgia's low-income and uninsured populations, as well as its teaching responsibility classifies the facility as "critical" to the State and its healthcare delivery network.

Exceptional Care. Remarkable Services. Extraordinary Grady.

Rhonda Perry
May 9, 2007
Page Two

The ICTF should be tiered to recognize "degrees of disproportionality." We recommend that hospitals meeting federal DSH criteria be guaranteed minimum levels of reimbursement and that a separate pool of dollars be allocated for these facilities. Remaining DSH funds would then be distributed to other qualifying hospitals.

In short, all DSH hospitals are not the same—even though the ICTF treats them as though they are. The draconian reduction in DSH payments to Grady will be devastating—to Grady and indigent Georgians and cause a ripple effect throughout the entire delivery system. We cannot absorb such losses in SFY 2007 and beyond.

I would appreciate the opportunity to discuss with you and other members of the committee this critical issue at your earliest convenience. I ask that this item be included on the committee's agenda for actions as soon as possible and for your favorable support in this request.

Sincerely,


Gus L. Stovall, President and Chief Executive Officer

CC: *Dr. Jim Tally, President/CEO-Children's Healthcare of Atlanta*
Mr. George Heck, CEO/Administrator-Coffee Regional Medical Center
Mr. Robert Bigley, CEO/Administrator-East Georgia Regional Medical Center
Mr. Thomas Gilbert, President/CEO - Johns Creek
Mr. Tim Stack, President/CEO- Piedmont Health Care
Mr. Paul Henchey, President/CEO - St. Joseph's/Candler
Mr. William Richardson, President/CEO - Tift Regional Medical Center
Mr. Chuck Adams, President/CEO - Ty Cobb Healthcare System
Mr. Gene Wright, President/CEO- Upson Regional Medical Center
Ms. Marsha Burke, Interim President/CEO - Wellstar Health System
Mr. Robert M. Trimm, President/CEO - Satilla Regional Medical Center
Mr. David Tatum, V P/Chief Public Policy Officer for Government Relations- CHOA
Ms. Katrina Wheeler, Chief Financial Officer-Satilla Regional Medical Center
The Honorable Rhonda Meadows, Commissioner - Georgia Department of Community Health
Ms. Carrie Summers, Chief Financial Officer - Georgia Department of Community Health