

FY 2008 Disproportionate Share Hospital Program

Presentation to
Hospital Advisory Committee
October 4, 2007



DSH Reform - Guiding Principles

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

DSC

1. Measure of disproportionality – DSH Limit as a percentage of total cost
2. Scalability – the more disproportionate receive a larger percentage of their cost from the DSH program



DSH Reform - Guiding Principles

DSH payments should be based on uncompensated care.

DSC:

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.

DSC:

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

DSH Reform - Guiding Principles

DSH payments must be based upon available, transparent and easily verifiable data. (VOTE: Yes – 9; No – 0)

DSC:

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

The state should maximize DSH and UPL payments.

DSC:

1. No new recommendations

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.

DSC:

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

DSH Reform - Guiding Principles

Eligibility criteria should be reconsidered

DSC:

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

Questions for a Vote

1. Should any one group of hospitals be held harmless from any change to the allocation methodology?
2. Should there be a limit on the percentage of the DSH limit that any one hospital can receive?
3. Should newly eligible facilities receive some level of DSH payment in FY 2008?
4. Should the FY 2008 allocation be based on a blend of the new model and FY 2007 payment amounts?



Questions for a Vote

5. Should there be a minimum level of disproportionality to receive a DSH payment?
6. Should the gains or losses (as a percentage) between FY 2007 and FY 2008 by any one group be comparable?
7. Is it acceptable if less disproportionate hospitals receive less payment if those funds go to more disproportionate hospitals?



Questions for a Vote

8. Is it acceptable to use separate pools as a way to mitigate substantial losses or gains for any one group of hospitals?



Order of Discussion of Questions and HAC Vote Outcome*

- a. Should the model recognize disproportionality based on a percentage of uncompensated Medicaid and Uninsured to total cost? (VOTE: Yes – 9; No – 0)
- b. Is it acceptable if less disproportionate hospitals receive less payment if those funds go to more disproportionate hospitals? (VOTE: Yes – 7; No – 2)
- c.
 - 1. Should the FY 2008 allocation be based on a blend of the new model and FY 2007 payment amounts? (VOTE: Yes – 8; No – 1)
 - 2. 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)
 - 3. 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)
- d.
 - 1. Should there be a limit on the percentage of the DSH limit that any one hospital can receive? (VOTE: Yes – 8; No – 1)
 - 2. Should there be a minimum level of disproportionality to receive a DSH payment? (VOTE: Yes – 1; No – 8)
- e. Should any one group of hospitals be held harmless from any change to the allocation methodology? (VOTE: Yes – 5; No – 6)
- f. Should newly eligible facilities receive some level of DSH payment in FY 2008? (VOTE: Yes – 8; No – 1)

10/4/07 Attendance Roster

Hospital Advisory Committee – Present

Chuck Adams, Co-Chairman – Ty Cobb

Rhonda Perry*, Co-Chairman – MCCG

Greg Schaack* for Paul Hinchey – St. Joe's/Candler's

Otis Story – Grady Health

Marsha Burke – Wellstar

Katrina Wheeler* – Satilla Regional

David Tatum – CHOA

Dennis Crum for Bill Richardson – Tift Regional

Bob Cross – Piedmont Healthcare

Gene Wright – Upson Regional

Spencer Thomas for Bob Bigley - East Georgia Regional

* Also on DSH Subcommittee



10/4/07 Attendance Roster

DSH Subcommittee – Present

Tim Beatty, Chairman – Wellstar

Doug Moses – CHOA

Todd Cox – Athens Regional

Kerry Loudermilk – Phoebe Putney

Darcy Davis – Memorial Health

Dudley Harrington – MCG

John Williams – Upson Regional

Michael Ayres – Grady Health

Charlotte Vestal – Crisp Regional

Bill Sellers – Archbold

Jesus Ruiz – Sunlink Healthcare

Andy Smith – Flint River



10/4/07 Attendance Roster

Hospital Advisory Committee - Absent

George Heck – Coffee Regional

Les Beard – HCA

DSH Subcommittee – Absent

Steve Barber – Ty Cobb

