

Georgia Department of Community Health
Hospital Advisory Committee Meeting
December 20, 2005

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

HOSPITAL/ASSOCIATION	MEMBER/DESIGNEE
Athens Regional Medical Center	Larry Webb
Children's Healthcare of Atlanta	David Tatum
Columbus Regional Healthcare System	Charles Brumbeloe
Crisp Regional Hospital	Wayne Martin
East Georgia Regional Medical Center	Bob Bigley
Flint River Community Hospital	Andy Smith
Floyd Medical Center	Rick Sheerin
Georgia Alliance of Community Hospitals	Julie Windom
Georgia Hospital Association	Joe Parker
Grady Health System	Tish Towns
HomeTown Health	Jimmy Lewis
Medical Center of Central Georgia	Rhonda Perry
Medical College of Georgia	Don Snell
Phoebe Putney Memorial Hospital	Kerry Loudermilk
Shepherd Center	Dr. Gary Ulicny
Sumter Regional Hospital	David Seagraves
Wheeler County Hospital	Brenda Josey

The minutes for the meeting on November 21, 2005 were approved without changes. The committee then received a report from Jim Connolly, Director of Reimbursement Services for the Department, regarding training programs for the recently released DSH Survey. The programs were organized by GHA, cosponsored by the Georgia chapter of HFMA and presented by Kevin Londeen of Myers & Stauffer, the CPA firm providing technical assistance to the Department. There were 3 training programs presented during the week of December 5 at locations in different areas of the state: at GHA offices in Marietta, at the Medical Center of Central Georgia in Macon and at Crisp Regional Hospital in Cordele. There were approximately 150 attendees at the 3 training programs. As a part of discussions later in the meeting, committee members expressed concerns that several hospitals that have previously received DSH funds were not represented at any of the training programs. The committee recommended that an additional training program be offered, possibly by a telephone conference call. Additionally, the committee recommended that a telephone conference call be offered as a means for hospital representatives to present additional questions about the DSH survey.

The committee then received a report from Carie Summers, Chief Financial Officer for the Department, and from Mr. Connolly regarding the status of the IGT Survey. The survey was intended to collect information regarding the nature of ownership of public hospitals and nursing homes in Georgia. It is expected that the survey results would be provided to the federal Centers

for Medicare & Medicaid Services (CMS) as documentation of the ability of these public entities to make intergovernmental transfers, a key source of State matching funds for both the Upper Payment Limit (UPL) and DSH programs. Initially due on December 2, the filing date for the IGT Survey was extended to December 16 at GHA's request in order to assure that hospitals had sufficient time to complete the survey in an accurate manner. Approximately 130 surveys had been received to date, about 30 less than expected when compared to the number of public providers that received UPL or DSH funds in prior years. The Department planned to conduct an inventory of surveys on file to identify any public providers for which a survey was not on file. Joe Parker of GHA offered his association's assistance in contacting any hospitals for which an IGT survey had not been received. As a part of discussions later in the meeting, Ms. Summers advised the committee of reports that CMS was imposing restricted criteria for the identification of public providers for Medicaid programs in other states. Ms. Summers reported that she had contacted Mr. Jim Frizzera, team leader for CMS's National Institutional Reimbursement Team, to inquire about Georgia's status. Ms. Summers explained that Mr. Frizzera confirmed that CMS would allow Georgia to continue to accept intergovernmental transfers in State Fiscal Year 2006 on behalf of the same public providers that had been designated as public in prior years, with the understanding that documentation was being gathered by the IGT Survey. Ms. Summers also reported that Mr. Frizzera advised that CMS requirements that could be applicable by State Fiscal Year 2007 could be communicated in regulation or by a formal letter from CMS to State Medicaid directors.

Mr. Parker provided the advisory committee with information regarding GHA's Hospital Tax Task Force. The GHA task force met earlier in the month and is considering working with a consultant who would compile data for future evaluation. Mr. Parker emphasized that GHA was not promoting a provider tax and its efforts were confined to evaluating such an alternative. Mr. Parker expected that the Hospital Tax Task Force would likely meet again in mid-January and that the Hospital Advisory Committee would continue to be updated about any developments, noting that David Seagraves and Bob Colvin were ex-officio members of the task force due to their roles as co-chairmen of the advisory committee.

C-Chairman David Seagraves asked Ms. Summers to provide the advisory committee with a status report regarding the timing of future UPL and DSH payments. Concerning UPL payments, Ms. Summers reported that the Department had submitted state plan amendments to CMS in September 2005, and CMS has advised that a request for additional information would be sent later in December that would include questions about documentation regarding the classification of providers as public or private facilities. The results of the IGT survey would be used as the basis for responding to this issue. Additionally, Department staff members have been in discussions with CMS representatives concerning data elements that may be used in UPL calculations. The Department has requested a meeting with CMS in order to determine any remaining questions concerning the UPL calculation data. While completion of the UPL

calculations will be dependent on the CMS review, the Department's has targeted the end of January completing these calculations.

With regard to the timing of DSH payments, Ms. Summers noted that the availability of DSH survey data would be a key factor. While survey responses are due in mid January, additional time may be required to aggregate the data before the possible application of data validation procedures. Several decisions about the data validation efforts, such as whether desk review or onsite reviews are needed or how many reviews should be conducted, have not yet been made. Assuming that preliminary data could be available for financial modeling by February, the following timetable may be possible:

- Hospital Advisory Committee recommendations completed by end of February;
- DSH policy presented to Board of Community Health in March for possible approval in April;
- State plan amendment submitted to CMS concurrent with Board of Community Health review;
- Final data available for distribution to hospitals in May;
- Allocation notices issued in May;
- Intergovernmental transfers requested in May as source of State matching funds for DSH payments to public providers;
- Appropriation in Department's amended budget for State Fiscal Year 2006 as source of State matching funds for DSH payments to private providers possibly available in May;
- Earliest DSH payment date would be about the end of May.

Time required to obtain CMS approval of the proposed DSH policy would impact this optimal timetable. Concerning the data validation process, after discussion of possible options, the advisory committee agreed that when preliminary DSH survey data was available, the data subcommittee should meet with the Department to discuss thresholds that could be used in reasonableness testing of self reported data as well as reviewing options for possible onsite reviews. The data subcommittee would then present its recommendations to the full committee in either January or February.

Mr. Seagraves introduced Kevin Taylor from the Archbold Medical Center who presented information on behalf of Critical Access Hospitals and other small hospitals located in rural areas of the state. Mr. Taylor spoke about the erosion of funding that these hospitals are facing and noted that, since many rely heavily on UPL and DSH funding, changes in available funds would cause major problems. A copy of supporting information provided to the advisory committee members by Mr. Taylor is attached. Mr. Seagraves noted that whenever funding data would be available, it was the intent of the hospital advisory committee and the Department to share this information with all hospitals so that they will be fully informed about possible recommendations. Mr. Seagraves also extended an invitation to others who may want to present information to the advisory committee, noting that such a process may be helpful for the

committee's goal of reaching consensus about any recommendations. In order to allow the advisory committee to address all of its tasks, the time allotted for such presentations may need to be limited.

For the discussion regarding allocation options, Mr. Seagraves requested that Mr. Londeen provide a summary explanation of an option of allocating funds by pools of provider groups. Mr. Londeen explained that there were numerous options for classifying hospitals into provider pools, such as location (rural/urban) or ownership type (public/private). An allocation process could be designed so that a fixed percentage or amount of funding would be designated for each pool of providers, with a subsequent allocation process being used to divide the designated aggregate amount among all of the hospitals within the pool. The following summary presents some of the discussion issues regarding the alternative of provider pools:

- Carving out funding for small rural hospitals might not be a large portion of total funds available.
- Funding for private hospitals could be based on the amount of State matching funds available.
- Due to dissatisfaction regarding ICTF allocations for State Fiscal Year 2005, it would not be a popular solution to establish provider pool amounts based on prior year funding.
- Any change in funding is likely to create winners and losers, so the goal may be to optimize toward what would be the fairest approach.

For the development of allocation models, Ms. Summers asked advisory committee members for comments about possible sources for allocation, citing the following examples – cost, volume of services, utilization measures, Medicaid loss or uninsured loss. Ms. Summers also asked for committee comments about an alternative of each qualifying hospital receiving an identical base amount plus an additional payment component determined by an allocation. The following summary presents some of the discussion for this issue:

- While the different allocation examples are acceptable, it would be best to select a straight forward approach that is not complicated.
- Cost-based measures may reflect inefficiencies of operations, so volume-based measures would be more appropriate.
- Inpatient days would not be an appropriate basis for a utilization measure, since it might not recognize the heavy share of outpatient services provided by small rural hospitals.
- The allocation process should match the advisory committee goal of recognizing proportionality, which would not occur if each qualifying hospital was guaranteed to receive any base amount.
- Since State Fiscal Year 2005 allocation amounts were disputed, funding amounts for multiple prior years may need to be considered.

For the identification of qualification criteria to be used in data modeling, the advisory committee discussed the following points:

- Discussion of alternative criteria for State Fiscal Year 2006 would likely cause significant delays to the timetable for DSH payments for the current year.
- In order to avoid such delays, the qualifying criteria should be the same as used for State Fiscal Year 2005.
- Data being compiled for the base period of FY2004 should be used to determine whether a hospital may qualify for DSH funds in State Fiscal Year 2006.

Also, committee members were asked to be prepared at the next meeting to make a recommendation about whether or not to continue to use last year's ICTF criteria for state fiscal year 2006.

In order to proceed with the data modeling efforts, Mr. Seagraves recommended that the previously designated consultant representatives (Jeff Harris, Lin Harris, Kevin Londeen and Gary Redding) meet with the Department to develop specific alternatives for the committee's consideration. The members of the advisory committee concurred with the recommendation and each of the consultants agreed to participate in this planning effort.

The next meeting of the Hospital Advisory Committee may be held in mid-January, with additional meetings to be scheduled for late January and/or February. The co-chairman will work with the Department on planning these future meeting dates which may be selected based on the availability of hospital survey data or preliminary financial models. In addition to continued discussion of DSH funding, the next meeting of the advisory committee will also include an update from EP&P Consulting, Inc., regarding the Department's updates for inpatient and outpatient rate setting.

The meeting was adjourned at approximately 4:00 p.m.