

Georgia Department of Community Health
Hospital Advisory Committee Meeting
November 21, 2005

The meeting was called to order at 10 a.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	Roland Thacker
Crisp Regional Hospital	Wayne Martin
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
Memorial Health University Medical Center	Bob Colvin
Phoebe Putney Memorial Hospital	Kerry Loudermilk
Shepherd Center	Dr. Gary Ulicny
Sumter Regional Hospital	David Seagraves
Tanner Medical Center/Carrollton	Lee Sherseth
Wheeler County Hospital	Brenda Josey
Habersham County Medical Center	Dick Dwozan
Meadows Regional Medical Center	Alan Kent

The minutes for the meeting on October 25, 2005 were approved without changes. The committee then discussed measuring the ratio of a hospital's cost and charges, a data element that would likely be used in DSH funding calculations, reviewing possible differences if a ratio is calculated for all patients in a hospital or if the ratio is for Medicaid patients only. The committee recommended that both alternatives should be considered in future data models and that any selection of either alternative could be deferred until a later date.

The committee then received a report from Glenn Pearson, chairman of the data subcommittee, regarding the proposed data survey. A copy of Mr. Pearson's presentation and the survey are attached. The draft survey included the following components:

- A. Summary of Inpatient Days, Payments, and Charges Attributable to Patients Eligible for Medical Assistance
- B. Cash Subsidies for Patient Svcs. Received Directly from State/Local Government
- C. 1. Charges and Payments Received from the Uninsured
- C. 2. Charges and Payments Received from the Underinsured
- C. 3. Additional Charitable Based Services Provided Free to the Public

- D. Unduplicated Count of Medicaid Eligible Individuals
- E. Contractual Adjustment Reconciliation
- F. Bad Debt Expense
- Certification

Mr. Pearson noted that section C.2 and C.3 of the draft survey were for informational purposes only. Because of potential difficulties that hospitals might have when sorting claim data from prior periods into subsets required for these two survey items, the data would not be intended for use in allocation models. Mr. Pearson reported that GHA had made tentative arrangements to conduct survey training programs at the GHA offices in Marietta, at the Medical Center of Central Georgia in Macon and at Crisp Regional Hospital in Cordele. After discussion, the committee accepted the survey as recommended by the data subcommittee, with the exception that the certification statement should be modified to limit assurances that would be made for items C.2, C.3 and D. With an understanding that the survey would be distributed by December 1, 2005, the committee recommended that a completion date around January 15, 2006 would be appropriate.

The committee then received information regarding ICTF / DSH policies and payments for prior periods. Jim Connolly, Director of Reimbursement Services for the Department, reviewed criteria previously used to determine hospital eligibility and also presented a summary of payments by type of hospitals for State fiscal years 2002 through 2005. Copies of the materials presented by Mr. Connolly are attached.

Kevin Londeen, a partner with Myers & Stauffer, the CPA firm providing technical assistance to the Department, provided the committee with example data demonstrating how the coordination of UPL and DSH payment policies can impact the aggregate amount of funds available to hospitals. A copy of the example data is attached. During the discussions on this subject, Carie Summers, Chief Financial Officer for the Department, noted the following items that would also impact the amounts of funds available to hospitals in SFY2006 and future periods:

- Because intergovernmental transfers will be limited to the state matching rate, the rate of net funds available to public hospitals may increase. This change would not be applicable for UPL payments to Critical Access Hospitals, since no intergovernmental transfers have been required.
- Pending review and approval by the federal Centers for Medicare & Medicaid Services (CMS), changes in methodologies for UPL calculations may result in reduced UPL payments.
- Coordinating UPL and DSH payment policies to maximize the aggregate amount of funds available to hospitals would likely be dependent on identifying financing arrangements to provide the required source of state matching funds.

- Based on the Department's agreement with CMS that the required use of 15% of DSH payments for primary care plans could not be continued after SFY2005, there may be an increase in net DSH funds available to hospitals.

The committee had extended discussions that addressed several issues regarding future planning and possible policy recommendations, including the following:

- Should hospital survey data be available by mid-January, after allowing a few weeks for cursory data testing, preliminary data models could be available as early as mid-February.
- If provider fees would be used as a source of state matching funds for DSH or UPL payments, since legislative authorization would be required, such funds would likely not be available until SFY2007 at the earliest. Also, if such funds are a component of strategies to coordinate UPL and DSH policies, any related policy proposals would also need to be deferred until SFY2007 at the earliest.
- While UPL and DSH policies may be dependent on development of a provider fee alternative, it may be difficult to gain support for a provider fee alternative until the impact of UPL and DSH policies can be known.
- For SFY2006, key financing issue will be CMS's continued recognition of public hospitals authorized to make intergovernmental transfers.
- The availability of state appropriations that could be used as the source of state matching funds for DSH payments to private hospitals could be an important factor regarding eligibility criteria.
- The practice of adjusting DSH calculations for private hospitals to simulate impact of intergovernmental transfers for public hospitals could be continued.
- The timing of any expansion of qualification criteria may need to be coordinated with timing of financing alternatives that would expand how state matching funds are made available.
- The impact of changes on Critical Access Hospitals may require special consideration. Any change in UPL intergovernmental transfer rates would not be applicable since transfers have not been required, and inclusion of UPL payments in DSH limit calculations could reduce DSH funds available.
- Because of risks related to financial viability, impact of UPL and DSH policies on small rural hospitals, including those not designated as Critical Access Hospitals, may require special consideration.

The committee agreed that the discussions should be continued during a meeting to be scheduled for December 2005. Among the specific topics identified for review at that meeting were provider fees, review of UPL policies and preliminary results that would be available from the recent survey of public hospitals regarding ownership status.

A final item considered by the committee was a Department request presented by Ms. Summers regarding hospital representatives that would be available for discussions regarding the possible

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reviews of hospital charge practices for outlier claims. The following hospital representatives were appointed: Doug Moses (Children's Healthcare of Atlanta), Hans Schermerhorn (Memorial Health University Medical Center), Ozzie Gilbert (Grady Memorial Hospital) and Jesus Ruiz (Sunlink Health Systems).

The meeting was adjourned at approximately 1:00 p.m.