

DRAFT MINUTES
DSH Subcommittee Meeting of the Hospital Advisory Committee
Thursday, August 30, 2007, 1:00 – 3:00 p.m.
Floyd Building, Atlanta, Georgia

Members Participating:

Tim Beatty, Chair - Wellstar, Glenn Pearson, Facilitator – GHA, Steve Barber - Ty Cobb, Esther Bailes - Grady Memorial, Todd Cox - Athens Regional, Darcy Davis – Memorial, Kerry Loudermilk - Phoebe Putney, Bob McVickers - Medical College of Ga., Doug Moses – CHOA, Rhonda Perry - Medical Ctr. of Central Ga., Jesus Ruiz – Sunlink, Greg Schaack – St. Joseph’s/Candler, Bill Sellers – Archbold, John Williams - Upson Regional, Charlotte Vestal - Crisp Regional

Guests:

Chuck Adams – Ty Cobb Health Care, Michael Ayres - Grady Memorial Hospital, Deb Bailey – Northeast Georgia Medical Center, Teresa Barrett – Northeast Georgia Medical Center, Bert Bennett – Draffin & Tucker, Charles Brumbeloe – Columbus Regional, Jim Erickson – Myers and Stauffer, Bryan Forlines – MCCG, Lin Harris – Draffin and Tucker, Mark Hughes – West Georgia Health System, Jimmy Lewis – Hometown Health, Kevin Londeen – Myers and Stauffer, Linda Nicholson – Northeast Georgia Medical Center, Paul Perrotti – West Georgia Health System, Frank Powell – Houston Healthcare, David Riddle – DCH, Hans Schermerhorn – Memorial Health, Rick Sheerin - Floyd Medical Center, Andy Smith – Flint River Hospital, Mike Spivey – Spivey Harris, Carie Summers – DCH, Tish Towns - Grady Health System, Teri Von Waldner – Medical center of Central Georgia, Billy Walker - Memorial Hospital & Manor, Katrina Wheeler – Satilla Regional Medical Center, Julie Windom – Alliance of Community Hospitals, Phyllis Wright – University Hospital,,

The Department of Community Health held a meeting of the DSH Subcommittee at the Medical Center of Central Georgia on Thursday, August 30. The group discussed both eligibility criteria and distribution methodologies.

Three eligibility options were presented:

- Setting of a threshold based on the percentage of total allowable costs for each hospital with those facilities above the threshold being eligible and those below it not.
- Eligibility based on meeting both federal criteria and having EITHER its inpatient utilization rate greater than the mean rate (modified MIUR) OR its low income inpatient utilization rate greater than 25 percent (LIUR)
- Continuing to qualify facilities based on a series of criteria, determining which of them appropriately determine disproportionality

Kevin Londeen from Myers & Stauffer consultants presented a number of eligibility models and pointed out that the current eligibility methodology allows hospitals with 15.0% Medicaid

volume to participate in the DSH program while those with 14.9% cannot. One model discussed was one that eliminates the 15% threshold, thereby making every hospital eligible for the DSH program. The model he presented also reflects scalability. In other words, hospitals at the very lowest end of the eligibility continuum would receive a modest percentage of their DSH cap while those at the other end would receive a greater percentage. This model can be adjusted to either provide fairly equivalent percentages of payments based on DSH caps to all eligible hospitals or to allow a much higher percentage to go to hospitals with higher disproportionality.

Various eligibility and distribution models were discussed, and the special circumstances of private hospitals which are not eligible for intergovernmental transfers were also discussed.

Myers & Stauffer agreed to conduct additional modeling, considering a number of variables:

- Various scalability approaches
- Whether or not the existing pool for rural hospitals would be maintained
- Whether or not other subsidies hospitals receive would be factored in
- Various definitions of total costs
- A possible stop gain/stop loss or some other phase-in approach.

The group will meet again on Thursday, September 13 at 1:30 in Atlanta, following the next DCH board meeting.