

AMENDED AND RESTATED MEMORANDUM OF UNDERSTANDING

October 3, 2011

THIS AMENDED AND RESTATED MEMORANDUM OF UNDERSTANDING (the "Amended and Restated Memorandum") is entered into by THE FULTON-DEKALB HOSPITAL AUTHORITY, a public body corporate and politic, created and existing under the laws of the State of Georgia (the "Authority"), and FULTON COUNTY, GEORGIA, a political subdivision of the State of Georgia ("Fulton"), regarding clarifications to the hereinafter defined Operating Contract. All defined terms shall have the meaning ascribed to such terms under the Operating Contract unless herein defined.

1. Purpose.

1.1 The Authority and Fulton (collectively, the "Parties") each confirm that they are entering into this Memorandum for the purpose of clarifying the provisions of a Contract, dated June 20, 1984, as amended by Amendment Number 1 to Contract, dated December 30, 1987, by Amendment Number 2 to Contract, dated July 14, 1988, by Amendment Number 3 to Contract, dated December 29, 1988, by Amendment Number 4 to Contract, dated June 22, 1989 and by Amendment Number 5 to Contract, dated December 14, 1989 (collectively, the "Operating Contract"), under the terms of which the Authority has agreed that it will at all times during the term of the Operating Contract provide facilities for the indigent sick and emergency services on behalf of Fulton and DeKalb County, Georgia (collectively, the "Counties") in exchange for payment from the Counties for such care and services.

1.2 Fulton has heretofore also entered into certain service agreements relating to the provisions of additional facilities for the indigent sick of Fulton. For purposes of this Amended and Restated Memorandum, "Service Agreements" mean (i) the Crestview Nursing Home Operating Agreement between Fulton and the Authority; and (ii) the contract or contracts between Fulton and the Authority relating to outpatient clinics located in Fulton.

1.3 The Parties further acknowledge that the Authority entered into that certain Lease and Transfer Agreement, dated as of April 7, 2008, and effective as of May 20, 2008, between the Authority and the Grady Memorial Hospital Corporation (the "Corporation"), as may be amended (the "Lease Agreement"). Under the terms of the Lease Agreement, among other things, the Authority leased its facilities to the Corporation which now operates such facilities. However, the Service Agreements have not been assigned under the Lease Agreement. The Operating Contract and Service Agreements are herein collectively referred to as the "Agreements". The Authority has appointed the Corporation as its agent to perform the services under the terms of the Agreements among other things.

1.4 The Parties previously entered into a Memorandum of Understanding as approved by the Authority on April 27, 2009 and as finally approved by Fulton on May 6, 2009, "in order to provide guidance in interpreting certain terms or provisions in the Agreements without amending

the Agreements”, and the Parties subsequently amended said Memorandum of Understanding by way of a First Amendment to Memorandum of Understanding approved by Fulton on November 18, 2009.

1.5 On March 2, 2011, the Fulton County Board of Commissioners approved, as Agenda Item 11-0172, a resolution creating a committee to review and make recommendations to the Board regarding the Memorandum of Understanding, as amended. The committee was comprised of ten (10) members, including three (3) Fulton County staff members, three (3) members representing the Authority, and four (4) members representing the Grady Memorial Hospital Corporation. The purpose of the convening the committee was to review the Memorandum of Understanding and First Amendment thereto, and to make recommendations to reconcile existing disagreements between the Parties as to the intent and application of the Operating Contract, the Memorandum of Understanding and the First Amendment thereto.

1.6 On April 6, 2011, the Fulton County Board of Commissioners received and approved, as Agenda Item 11-0307, the recommendations of the committee convened pursuant to Agenda Item 11-0172. In a desire to avoid confusion over the latest version of the Memorandum of Understanding, the Parties hereby enter into this Amended and Restated Memorandum which supersedes the May 6, 2009 Memorandum of Understanding and the November 11, 2009 First Amendment to Memorandum of Understanding.

1.7 The parties desire to enter into the Amended and Restated Memorandum in order to provide guidance in interpreting certain terms or provisions in the Agreements without amending the Agreements, in a manner intended to (i) preserve and protect the historic role and mission of Grady Memorial Hospital in the provision of health care services to the indigent and poor populations of Fulton and (ii) promote levels of financial transparency and accountability sufficient to permit continued financial support of Grady Health System by Fulton County in accordance with the Agreements.

1.8 Upon the approval and adoption by the Parties of this Amended and Restated Memorandum, the previously approved May 6, 2009 Memorandum of Understanding and the November 11, 2009 First Amendment to Memorandum of Understanding shall no longer be in force and effect, and shall be superseded by this Amended and Restated Memorandum of Understanding.

2. Definitions.

2.1 The following terms shall have the following meanings and shall be applicable to the Agreements unless the context indicates a different meaning.

“Adjustment Factors”: Mutually agreed upon estimated third party payment factors derived in consideration of the fact that some uninsured patients may become eligible for medical assistance or other form of third party reimbursement subsequent to the time services were rendered, or that not all uninsured patients are indigent. There shall be two classes of Adjustment Factors: a “subsequent payment adjustment factor”, and an

“indigent uninsured adjustment factor”. The subsequent payment adjustment factor will be derived based upon Grady Health System’s actual historical experience by analyzing relevant data for services provided to uninsured patients during a period at least two years prior to the measurement period and identifying what percentage of these patients’ costs subsequently became eligible for some form of third party coverage at any time in the subsequent two year period. Said adjustment factor shall be updated annually. A separate adjustment factor shall be developed for the subsets of Eligible Patients including Fulton County residents seeking emergency services, and for other uninsured Fulton County residents (including those pending Medicaid eligibility determination). This indigent uninsured adjustment factor shall be derived based upon data regarding the percentage of nonelderly uninsured in Georgia at or below 250% of the federal poverty level (by way of example, data from 2008-2009 indicates that the nonelderly uninsured population in Georgia living at or below 250% of the federal poverty limits accounts for 80% of the total uninsured. Accordingly, this adjustment factor would be 80%. See Exhibit “A”, attached hereto), as found on the website: statehealthfacts.org, or other similar authority. Said adjustment factor shall be updated annually based upon the latest available data. Adjustment Factors shall not be applicable to the subsets of Eligible Patients having a Certificate of Need or to detainees or inmates of Fulton County. An example of the calculation of Uncompensated Care, including the indigent uninsured adjustment factor and the subsequent payment adjustment factor, is attached hereto as Exhibit “B”.

“Certification of Need”: Written evidence showing that a low-income patient who is a verified resident of Fulton met the criteria established and maintained by the Corporation under its current written policies and procedures pertaining to qualification of patients for free or discounted services. The certification process shall apply to patients whose individual or family income is less than 250% of the Federal Poverty Limit Guidelines and therefore eligible to receive the services provided on a sliding scale basis, with those patients at or below 125% of the Federal Poverty Limit Guidelines receiving a 100% discount.

“Costs”: The amount of expenditures to provide an item or service, including but not limited to allocable Overhead Costs.

“Eligible Patient”: A patient who is A) a verified resident of Fulton County who 1) has resided in Fulton for at least thirty (30) days at the time of provision of services by the System; 2) has a Certification of Need, and 3) received services at the System; or, B) a patient who is either a resident of Fulton or a homeless individual provided emergency services and any resulting inpatient medical services; or, C) a detainee or inmate of Fulton County for which the County has requested Grady to provide services (as evidenced by presenting at the facility for care or pursuant to any other form of request); or, D) other uninsured Fulton County residents provided care by Grady Health System who are uninsured (including those pending Medicaid eligibility determination). For purposes of determining the residence of homeless individuals, the Parties will rely upon compliance by the Authority and/or Corporation, as applicable, with Grady Health System’s Operational Policy regarding Identification of Homeless Patients, as adopted December 14, 1998 and

last revised on November 16, 2008, or as hereinafter amended. (See Exhibit "C" attached hereto.)

"Federal Poverty Limit Guidelines": Guidelines for determining financial eligibility for certain federal programs as issued each year in the Federal Register by the Department of Health and Human Services.

"Overhead Costs": Costs not directly attributable to service to a particular patient, including utilities, maintenance, insurance (other than as limited in the following sentence), information technology systems and support, administration support, and other overhead costs contained in the annually approved Medicare Part A reimbursement forms filed by the System. Overhead Costs shall not include 1) payments by the Corporation to the Authority pursuant to the Lease Agreement; 2) interest and/or principal on any debt of the Corporation; and 3) costs or premiums associated with medical malpractice insurance for faculty or physicians affiliated with any medical school. Allocation of Overhead Costs is described in Section 4.1(b).

"System": The meaning ascribed to such term in the Lease Agreement.

"Uncompensated Care": The total amount of Costs resulting in nonpayment from any applicable source to the Corporation for services rendered. In calculating Uncompensated Care, credit shall be given for the appropriate pro rata share of payments from the Georgia Indigent Care Trust Fund (ICTF) and grant funds specifically covering services to Eligible Patients but only to the extent that the specific category of Eligible Patients is included in the ICTF or grant funding (for example, detainees and inmates are not funded by ICTF or grant funding). The allocated ICTF and grant funds shall be distributed evenly on a monthly basis and with Fulton County's credited amount of such ICTF and grant funds being determined by using a fraction the numerator of which is the total Costs for: Eligible Patients from Fulton (only to the extent that they are considered eligible for ICTF funding by the State (detainees and prisoners are excluded)), and using as a denominator the total costs of indigent care for the System as a whole.

For purposes of allocating the ICTF and grant funding, the costs related to Eligible Patients and the total costs of indigent care for the System as a whole shall be derived from the most recent data provided to the State in the DSH Hospital Survey and other information needed to determine what portion of the uninsured patients used in the survey are considered indigent for the purpose of this calculation. The Authority shall cause the allocation formula and numbers to be updated annually by Grady with the most recent survey and ICTF funding data available in January of each calendar year for use in that calendar year, and shall be mutually agreed upon by both parties.

Also, in calculating Uncompensated Care, credit shall be given based upon mutually agreed upon calculated Adjustment Factors applicable only to the uninsured Fulton County residents and homeless seeking emergency services and to the other uninsured residents (including those pending Medicaid eligibility determination) provided services by Grady Health System.

3. Standard of Care and Quality of Care.

3.1 Article II, Section A(4) of the Operating Contract provides that the rendering of medical aid and hospitalization as required under the Operating Contract shall be in keeping with *“usual services rendered by hospitals of like size and character and to the extent facilities are available.”*

3.2 The Parties acknowledge that Section 5.4 of the Lease Agreement provides that the Corporation will (i) irrevocably, absolutely and unconditionally provide indigent care and charity care in accordance with the provisions of the Operating Contract and (ii) operate the hospital as a Safety Net Hospital. “Safety Net Hospital” means a hospital with the following characteristics: (i) an underlying mission to provide medical services to uninsured, underinsured or indigent patients; (ii) an open access policy for residents of the County regardless of their ability to pay; (iii) provision for significant uncompensated indigent or charity care; (iv) an open emergency room; (v) level of trauma services comparable to that currently provided at the hospital; and (vi) a mission to provide opportunities for the teaching of medical or health care professionals. Under the Lease Agreement, the Corporation covenants to aspire to reach, in the shortest time possible, *“a standard of healthcare quality and service benchmarked to and comparable with similar urban teaching hospitals in the southeastern United States.”*

3.3 Recognizing the ambiguity and lack of objective standards of the provisions of the Operating Agreement and Lease Agreement described above in Sections 3.1 and 3.2, the parties hereby agree that the System shall achieve and maintain compliance with the following standards:

(a) The most current version of the Joint Commission’s Hospital Accreditation Standards (“HAS”) including but not limited to the following Requirements for Accreditation:

- Accreditation Participation Requirements (APR);
- Environment of Care (EC);
- Emergency Management (EM);
- Human Resources (HR);
- Infection Prevention and Control (IC);
- Information Management (IM);
- Leadership (LD);
- Life Safety (LS);
- Medication Management (MM);
- Medical Staff (MS);
- National Patient Safety Goals (NPSG);
- Nursing (NR);
- Provision of Care, Treatment, and Services (PC);
- Performance Improvement (PI);
- Record of Care, Treatment, and Services (RC);
- Rights and Responsibilities of the Individual (RI);
- Transplant Safety (TS); and

- Waived Testing (WT)

(b) The most current version of the Centers for Medicare and Medicaid Services' ("CMS") Conditions of Participation and Interpretive Guidelines.

3.4 In order to meet the requirements as set forth above, the Authority shall cause the Corporation as its agent to (i) maintain accreditation under The Joint Commission (ii) meet all appropriate federal, state and local operating licensure requirements, and (iii) in annual public meetings or otherwise, show evidence of progress towards or of meeting the standards described in this Article 3.

3.5 Within thirty (30) days of execution of this Memorandum, the Authority shall submit to Fulton County a plan that sets forth benchmarks and timelines for achieving full compliance with the standards of care described in this Article 3.

3.6 The parties hereby agree that in specific terms the System shall achieve and maintain the highest quality of care in patient safety and specialty areas including but not limited to compliance with Joint Commission 2009 National Patient Safety Goals.

4. Budgeting and Contributions of Fulton.

4.1 The Parties acknowledge that the method of estimating the contribution of Fulton each year shall be clarified as follows:

(a) In each year, an annual budget shall be presented to Fulton showing the proposed contribution of Fulton within an annual budget of the Corporation (as agent for the Authority pursuant to the Lease Agreement). A preliminary budget shall be prepared by the Corporation and submitted to the Authority, which shall then review, approve and present the same to Fulton by no later than October 1 of each year. A final annual budget shall be similarly prepared by the Corporation for review and approval by the Authority, which shall present the same to Fulton no later than November 1 of each year.

(b) The proposed contribution amount from Fulton for each year shall be determined as the total Uncompensated Care provided only to Eligible Patients less any allocable amounts for malpractice insurance premiums for medical school faculty physicians (the "Contribution Amount"). It is the intention of the Parties that the Contribution Amount includes a reasonable allocation applicable to Eligible Patients for Overhead Costs as defined in Section 2.1. For purposes of determining the proposed annual Contribution Amount, allocable Overhead Costs shall be determined by multiplying the System's total Overhead Costs by a fraction whose numerator is the total number of patient visits for Eligible Patients receiving services from the System in the preceding year, and whose denominator is the total number of patient visits for all patients (regardless of residency or indigency) receiving services from the System in the preceding year. Fulton will consider other allocated amounts necessary pursuant to applicable accounting principles. Additionally, Fulton reserves the right to determine a different formula/standard for the calculation of Overhead Costs allocable to Fulton. If Fulton determines to use such a different

formula/standard, Fulton will provide notice of such new formula/standard to the Authority no later than July 1st for use by the Authority in developing the proposed Contribution Amount for the ensuing budget year.

(c) The proposed Contribution Amount for any year shall be determined based on actual amounts of the total Uncompensated Care provided only to Eligible Patients for the previous twelve months of the preceding year. For example, the fiscal year budget for 2010 shall be based on the results from October 1, 2008 to September 30, 2009.

(d) In establishing the final Contribution Amount, nothing herein shall limit the right of Fulton to decline, modify, or reduce the amount of their contribution under the Operating Contract as set forth in Article III, Section C(1)(a); provided, however, that compliance with the information reporting as set forth in Section 5.1 hereof shall be required prior to disbursement of the Contribution Amount on a month-by-month basis.

(e) Fulton County shall annually approve the final Contribution Amount for services provided by Grady as part of the annual budget process. Payments to the Authority for the calendar year shall be made monthly based upon 1/12th of the annual approved amount. Such monthly payments shall begin January 2012. The January 2012 payment shall be equal to 1/12th of the final budgeted Contribution Amount for 2011. Any payments made to the Authority in the early months of a new calendar year shall continue at the same rate as the prior year until the Fulton County budget for the new year is finalized. After finalizing Fulton County funding for Grady Health System for the new year, a reconciliation shall be performed and an adjustment made to the February monthly payment to correct for any difference between the amounts paid for the first month of the new year based upon prior year funding levels versus the approved funding level for the new year. In addition, Fulton shall perform an annual audit of the information required to be produced pursuant to Paragraph 5 below, for purposes of determining the amount of reconciliation, if any, required for the following year. For purposes of such audits, the audit period for budget year 2012 shall begin on October 1, 2011, through September 30, 2012; and shall be for a twelve month period beginning October 1 each year, and ending September 30 of the following year. If the results of such audit show that Fulton's Contribution Amount exceeded the total Uncompensated Care provided to Eligible Patients in the current budget year, the difference shall be deducted from the proposed Contribution Amount for the following budget year.

5. Information.

5.1 The Parties acknowledge that the Authority, on behalf of Fulton County, will conduct an independent review of financial or other information reasonably necessary to verify the Contribution Amount (including all underlying computations) at the Authority's expense. In particular, (i) the Authority shall cause the Corporation in accordance with its written policies and procedures to provide monthly to the Authority, which shall review and present the same to Fulton in arrears, a report substantially containing income verification, residency documentation and other information relating to standard of care of the subset of Eligible Patients who have a Certificate of Need; as well as a report containing a listing of patients included in the other

categories of Eligible Patients that do not have a Certificate of Need within thirty (30) days after the reported month (i.e. data through January 31 is due on or about March 1); and (ii) the Authority shall perform an annual audit conducted by an independent auditor verifying that the Contribution Amounts were expended for Eligible Patients. The Authority shall cause the Corporation to provide to Fulton a copy of the current written policies and procedures qualifying a patient for free or discounted services and for establishing residency. The Authority represents and agrees that, as the Authority's agent, the Corporation shall cooperate with the Authority or its agents to carry out the purposes of this Section 5.1 under the terms of Section 5.15(e) and (f) of the Lease Agreement or any other separate written agreement. To the extent prohibited by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other applicable laws, the information (or such applicable parts) in this Section 5.1 shall not be required.

The parties agree to review the reporting and review frequency and review procedures once per year to validate that the reporting and review frequency and the related review procedures are reasonable and to mitigate administrative burdens and associated costs. The parties agree that the review of the subset of Eligible Patients that do not have a Certificate of Need will: for emergency patients – include verification of Fulton County residency or, in the case of the homeless, evidence of homeless status; for detainees or inmates of Fulton County - may include verification of Fulton County records; and for other Eligible Patients without a Certificate of Need - may include verification of residency. Review of the subset of Eligible Patients that do not have a Certificate of Need shall not include verification of income level or family size, nor shall a Certificate of Need be required, as they are not applicable.

5.2 The Authority shall cause the Corporation to use its best efforts to negotiate written arrangements for payment from the other Georgia counties (based on total Uncompensated Care provided) whose residents have received Uncompensated Care from the System. A report on the results of such negotiations shall be prepared by the Corporation within ninety (90) days. Such report shall be presented to Fulton.

5.3 With the initial monthly report described in Section 5.1, the Authority shall provide to Fulton a copy of the current written policies and procedures referenced in Section 2.1, Certification of Need, and shall provide additional copies of such policies and procedures as they may be adopted or amended from time to time.

5.4 In addition to any other information required by this Article, the monthly reports and annual audits described in Section 5.1 shall include line items showing expenses and revenues related to Eligible Patients for each of the following: 1) Grady Hospital, 2) Crestview Nursing Home, 3) the neighborhood clinics, and 4) any other components of the System.

6. Miscellaneous.

6.1 This Memorandum shall be governed by, and construed and interpreted in accordance with, the laws of the State of Georgia.

6.2 Unless specifically clarified herein, the terms and provisions of the Agreements shall remain in full force and effect without any change whatsoever. This Memorandum shall not be construed in any manner as an amendment to the Agreements.

6.3 Should any provision of this Memorandum be determined to be illegal, unenforceable or in conflict with any law by a court of competent jurisdiction, such paragraph shall be deemed severed herefrom and the validity of the remainder of this Memorandum shall not be affected thereby.

6.4 This Memorandum may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same instrument.

6.5 Dispute resolution process. In the event of a dispute arising between the parties regarding the interpretation or administration of the Amended and Restated Memorandum, which has not been resolved by general discussion between Fulton County, the Authority and Grady Health System staff, the matter shall be referred to a three (3) member panel comprised of the Chairs of the Fulton County Commission, Fulton-DeKalb Hospital Authority Board of Trustees and Grady Memorial Hospital Corporation Board of Directors for resolution. The panel shall meet to discuss the disputed issue and shall make recommendations to resolve the dispute to the Authority Board of Trustees and the Fulton County Commission.

6.6 Except as otherwise specified herein, this Amended and Restated Memorandum shall have an effective date of January 1, 2012.

FULTON COUNTY, GEORGIA

By: _____
Chairman, Board of Commissioners

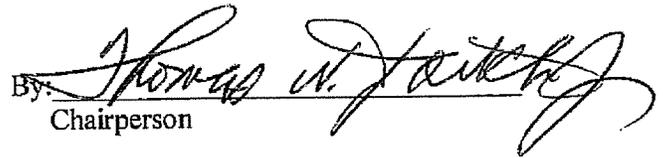
ATTEST:

Clerk

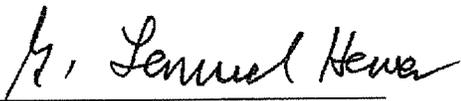
APPROVED AS TO FORM:

By: _____
Name:
Title:

THE FULTON-DEKALB HOSPITAL
AUTHORITY

By: 
Chairperson

ATTEST:


Secretary

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Georgia: Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL), states (2008-2009), U.S. (2009)

Compare Georgia to: Unk States

Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL), states (2008-2009), U.S. (2009)							Compare to US
	GA #	GA %	GA % of US Total	US #	US %	US % of US Total	
Under 100%	808,100	44%	4%	19,831,500	40%	100%	
100-139%	218,900	12%	4%	5,050,700	12%	100%	
139-250%	437,500	24%	3%	12,877,100	26%	100%	
251-359%	210,700	12%	3%	6,476,400	13%	100%	
>400%+	145,600	8%	3%	4,751,900	10%	100%	
Total	1,819,800	100%	4%	49,997,900	100%	100%	

(show table notes)

Notes: For all topics based on the CPS on statehealthfacts.org, the grouping used for analysis is the health insurance unit (HIU), which groups individuals according to their insurance eligibility, rather than by relatedness or household. For more details, see "Notes to Topics Based on the Current Population Survey (CPS)" at <http://www.statehealthfacts.kff.org/notes/default.cfm>.

Percentages may not sum to 100% due to rounding effects.

For current Medicaid and Medicare enrollment figures, please refer to the Medicaid & CHIP and "Medicare" sections, respectively, which report enrollment data from the Centers for Medicare and Medicaid Services (CMS).

CHIP and individuals eligible for both Medicare and Medicaid (dual eligibles) are included in Medicaid.

Other Public (Federal) includes individuals covered through the military or Veterans Administration in federally-funded programs such as TRICARE (formerly CHAMPUS) as well as some non-elderly Medicare enrollees.

All five-year health coverage estimates are based on the Annual Social and Economic Supplement (ASEC) to the US Census Bureau's Current Population Survey (CPS). The ASEC is a survey of around 70,000 households that can be used to examine state-level trends (through multi-year averages), though with large sampling errors. It is useful for producing national estimates of the insured and uninsured populations and historical time series data.

All single-year health coverage estimates are from the American Community Survey (ACS). The ACS is an ongoing survey of about 2 million households annually and is increasingly relied upon for more robust estimates of state-level data. Data at the county and sub-county levels are also available. Since the ACS health coverage module was implemented in 2008, there are no historical data available. Please see the [U.S. Census Bureau](http://www.census.gov) for additional details on both surveys.

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2009 and 2010 Current Population Survey (CPS: Annual Social and Economic Supplements).

Definitions: NSD: Not Sufficient Data

Persons in poverty are defined here as those living in "health insurance units" with incomes less than 100% of the Federal Poverty Level (FPL) as measured by the U.S. Department of Health and Human Services' (HHS) poverty guidelines. Health insurance units are related individuals who would be eligible as a group for "family" coverage in a health plan. The federal poverty guideline for a family of four in the 48 contiguous states and D.C. was \$21,200 in 2008 and \$22,050 in 2009. The U.S. Census Bureau produces simplified - but very similar - versions of federal poverty guidelines called "poverty thresholds." For more information on measures of poverty, please see the detailed description provided by HHS available at <http://aspe.hhs.gov/poverty/faq.shtml>.

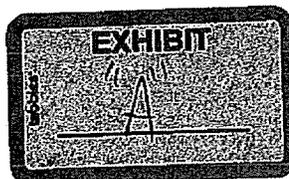


EXHIBIT B

Example of Calculation of "Uncompensated Care" for "Eligible Patients"

In accordance with Revised MOU
September 2011

Eligible Patient Categories *	A	B	C		D	E	F	G	H
	Costs	Indigent Uninsured Adjustment Factor	Costs reduced to estimate of indigent Uninsured Costs as applicable	Actual Payments from third parties & patients	Subsequent Payment Adjustment Factor	Estimated Total Payments including Subsequent Payments	Pro-rated Share of ICTF & Grant Funding	Uncompensated Care	
1) Uninsured - Certification of Need	75,000,000	not applicable	75,000,000	3,500,000	not applicable	not applicable	28,000,000	43,500,000	
2) Uninsured - Emergency Services	24,000,000	80%	19,200,000	not applicable	5.04%	967,680	5,000,000	13,232,320	
3) Uninsured - Other	6,000,000	80%	4,800,000	not applicable	5.04%	241,920	3,000,000	1,558,080	
4) Uninsured - Pending Medicaid	9,000,000	80%	7,200,000	not applicable	49.55%	3,567,600	2,000,000	1,632,400	
5) Inmates & Detainees	2,500,000	not applicable	2,500,000	10,000	not applicable	not applicable	not applicable	2,490,000	
Total	116,500,000		108,700,000	3,510,000		4,777,200	38,000,000	62,412,800	

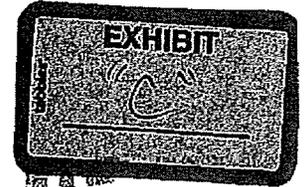
Notes:

numbers are examples for purposes of illustration only

* **Eligible Patient Categories are based upon the definition of "Eligible Patients" and include any patient that is:**

- 1) a verified resident of Fulton County who has resided in Fulton at least thirty days at time of provision of services by the System, and has a Certification of Need, and received services at the System; or
- 2) either a resident of Fulton County or a homeless individual provided emergency services and any resulting inpatient medical services; or,
- 3) any other uninsured Fulton County residents provided care by Grady Health System who are uninsured (and do not fall into any other category); or,
- 4) any other uninsured Fulton County residents provided care by Grady Health System who are uninsured and are pending Medicaid eligibility determination; or,
- 5) a detainee or inmate of Fulton County for which the County has requested Grady to provide services (as evidenced by presenting at the facility for care or pursuant to any other form of request)

GRADY HEALTH SYSTEM® OPERATIONAL POLICY



**SUBJECT: IDENTIFICATION OF HOMELESS
PATIENTS**

REV: 3/9/99, 2/27/04, 3/24/04, 10/5/05, 11/16/08

DATE: 12/14/98

Page 1 of 4

I. POLICY STATEMENT

It is the policy of the Grady Health System® to accurately identify/assess homeless patients, assign the appropriate Eligibility Code and VIP code in accordance with the Federal Definition of Homeless individuals and the Grady Health System's Financial Assistance Program and Financial Eligibility Scale guidelines.

II. PURPOSE

To ensure that homeless patients are consistently identified and financially assessed in accordance with the criteria of the Financial Assistance Program.

III. SCOPE:

This policy applies to all who have responsibility for explaining the Financial Assistance Program and Grady Care Card issuance process and the Social Workers who have responsibility for assisting with verification of homeless status.

IV. DEFINITION:

**U.S. Department of Housing and Urban Development (HUD)
Federal Definition of Homeless**

"The term 'homeless' or 'homeless individual or homeless person' includes -

1. an individual who lacks a fixed, regular, and adequate nighttime residence;
and
2. an individual who has a primary nighttime residence that is —
 - A. a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
 - B. an institution that provides a temporary residence for individuals intended to be institutionalized; or
 - C. a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings."

V. ADMINISTRATIVE RESPONSIBILITY:

It is the responsibility of the Financial Counselling Managers/Supervisors and the Social Work Managers to conduct quality checks and ensure compliance.

*Homeless remain
for over night stay
and day shelter*

VI. PROCEDURES AND/OR GUIDELINES

6.1 HOMELESS IDENTIFICATION/THIRD PARTY ELIGIBILITY/FINANCIAL ASSESSMENT

6.1.1 The Financial Counselor will determine if the patient presenting for care and communicating that he/she is homeless has third party coverage or meets criteria for any third party assistance program. If the patient meets criteria for assistance, the Financial Counselor will refer the patient to the on site Grady Outreach Social Security Administration (SSA) Unit. The SSA representative will determine the eligible program and complete an application as appropriate.

6.1.2 Once the Social Security Disability (SSD), etc., claim is complete, the SSA representative will communicate this information and provide supporting documentation of claim to the Financial Counselor. The Financial Counselor will update the hospital's ADT/PA system, i.e., INVISION® to reflect Financial Class "T," VIP Indicator – PH (Patient Homeless) and Eligibility Code in accordance with the Financial Assistance Program - Financial Eligibility Scale guidelines and county of habitation.

with. SSI

6.1.3 A patient who states that he/she is homeless and living in a shelter is required to provide a letter from the shelter. This letter must be an original, on company letterhead and signed by the program director or designee. The original letter is to be maintained in the patient's financial record. If the patient requests a copy of the letter, the Financial Counselor will provide a copy to him/her. If the shelter is located in Fulton or DeKalb County a patient has no third party coverage or is ineligible for any third party assistance program with a Financial Scoring Criteria Code indicating no resources/income, the counselor will assign Financial Class "U" with a discount up to 100% and enter "PH" in the VIP field of INVISION®.

*with
no income
or other
resources*

NOTE: A patient who is identified as "homeless" with no third party coverage or pending third party coverage will be assigned a Financial Class "U" with a discount up to 100% and expiration date of 3 – 6 months depending on the documentation and circumstances.

6.1.4 If a patient states that he/she is homeless and lives on the streets of Fulton or DeKalb County, it is critical that the Financial Counselor or Social Worker recognizes **visible evidence that supports this narrative.**

The Financial Counselor will **CLEARLY** document in the patient's financial record and enter comments into the INVISION® system narrating the patient's circumstances. This includes entering comments relative to the Social Worker's documentation and placing said document in the patient's financial record.

6.1.5 Once the patient has been properly identified as homeless with no third party coverage, the Financial Counselor will assign Financial Class "U" with a discount up to 100% and enter "PH" in the VIP field of INVISION®.

VII. NON-RESIDENTS

7.1 Patients housed in shelters or living on the streets **outside** of Fulton or DeKalb County will be assigned a Financial Class in accordance with, without or pending third party coverage, the Eligibility Code in accordance with guidelines and the Financial Eligibility Scale for non-residents. **IMPORTANT MESSAGE:** The Financial Counselor **will not enter PH** in the VIP field of INVISION®.

7.1.1 Patients who move to Atlanta – Fulton or DeKalb County seeking employment with the intent to reside, become homeless during their search and living in a shelter for at least 30

days are considered to be a resident of said county.

Travelers Aid of Metropolitan Atlanta will assist individuals who are homeless and want to return home.

VIII. DISCHARGING HOMELESS PATIENTS TO PERSONAL CARE HOMES

- 8.1.1 Based on a homeless patient's medical/mental discharge instructions, a Social Worker may arrange for the patient to be housed in transitional housing, i.e., a personal care home for 30 days whereby Grady pays the monthly expense in Fulton or DeKalb County.
- 8.1.1 The Social Worker will provide documentation to the Financial Counselor when a homeless patient is discharged to a personal care home sponsored by Grady. The counselor will assign a Financial Class in accordance with third party coverage, lack of coverage or pending coverage.
- 8.1.2 If there is no coverage or pending coverage, the counselor will assign Financial Class "U," with a discount up to 100% and enter "PH" in the VIP field of INVISION® with a 30-expiration date.

IX. DAY SHELTERS/SPECIAL PROGRAMS

- 9.1 The Financial Counselor will **not** honor letters from Day Shelters. The patient must provide a letter from a shelter where he/she has been living for more than one night.

X. PENDING THIRD PARTY COVERAGE

- 10.1 If a patient has documented proof that he/she is homeless in Fulton or DeKalb County or any outside county and has proof that he/she has applied for assistance with Social Security Administration, Department of Family Children Services or Chamberlin Edmonds has taken a claim, the Financial Counselor will assign a **Financial Class of "E," "D" or "T"** and a **"Eligibility Code - Patient Share"** in accordance with the Financial Assistance Program, Financial Eligibility Scale and county of residence.

NOTE: If a patient is homeless living in a shelter outside of Fulton/DeKalb County or homeless living on the streets outside of said counties, the Eligibility Code must be assigned based on supporting documentation for non-residents. The "PH" indicator does **not** apply.

- 10.1.1 Regardless of county of residency, the Financial Counselor will assign an expiration date **up to 6 months** for homeless patients with verifiable proof of pending disability claims.

EXAMPLE: Pandora Boxx lives in the Gwinnett Women's Shelter located at 246 Pleasant Hill Road, Duluth, Georgia 30043.

Upon verification of her pending disability claim, the Financial Counselor will request and review Georgia's Department of Labor file and determine the possibility of income and other available tool to determine resources. Based on the current Financial Eligibility Scale, the "Patient Share" assignment to Ms. Boxx is 30%.

IMPORTANT MESSAGE: DO NOT value the VIP field with "PH."

10.1.2 A patient who is mentally ill that meets disability criteria and lacks the ability to apply for assistance will be referred to a Social Worker or to a FIRST STEP representative to assist with the application process.

10.1.3 Social Workers assigned to the Emergency Department will screen uninsured homeless patients to determine if they meet disability criteria. Patients who meet disability criteria will be referred to FIRST STEP.

IMPORTANT MESSAGE: When a "PENDING" status is assigned to a homeless patient of Fulton or DeKalb County, the **VIP INDICATOR** must reflect "PH."

XI. HOMELESS EXEMPTIONS/NON-EXEMPTIONS

11.1.1 Patients who have been identified as "HOMELESS" are exempt from co-payments in the clinics, ancillary areas, supplies & distribution and the Pharmacy. The "PH" indicator will appear on the Grady Care Card and will notify the Supply Technician or Pharmacy Representative that the patient is homeless and exempt from co-payments.

PH NON-COVERED: Homeless patients are required to pay for over-the-counter medications available on a cash and carry basis from Grady Health System Pharmacies. Homeless patients who have lost critical medications, e.g. insulin, anticonvulsants, inhalers, cardiovascular medications, etc., may be provided replacement medications at no cost at the discretion of the charge pharmacist or pharmacy supervisor.

11.1.2 If a patient presents and communicates that he/she is homeless and it is determined that he/she is receiving a monthly income, i.e., Social Security Disability, working, etc., the "Patient Share" must be determined based on the gross income, county where he/she is receiving check, etc. The patient is then responsible for his/her share for all services rendered including prescriptions.

NOTE: Patients who communicate or show proof that they are homeless with income are **NOT ELIGIBLE** for the "PH."

11.1.3 If a patient is identified as homeless and receives General Assistance (GA) of \$80.00 per month, the Financial Counselor will assign Financial Class "U" with a discount up to 100% and enter "PH" in the VIP field.

NOTE: Individuals will usually receive \$80.00 to \$225.00 per month from GA. Homeless individuals will usually receive only \$80.00.

XII. REFERENCE

This policy has been developed using the following website:
www.hud.gov/homeless/definition.

XIII. COMMITTEE APPROVAL

Emergency Department Operations Committee

Date: 11/17/08, 11/24/08, 12/1/08