

Board of Community Health
Meeting
November 14, 2013

Members Present

Norman Boyd
William Wallace
Clay Cox
Kiera von Besser
Rick Jackson
Allana Cummings

Members Absent

Jamie Pennington
Donna Moses
Jack Chapman
Rick Jackson

The Board of Community Health held its regularly scheduled meeting at the Department of Community Health, Fifth Floor Board Room, 2 Peachtree Street, N.W., Atlanta, Georgia. Commissioner Clyde L. Reese, III was also present. (An agenda and a List of Attendees are attached hereto and made official parts of these Minutes as Attachments #1 and #2). Chairman Norm Boyd presided and called the meeting to order at 10:33 a.m.

Minutes

The Minutes of the October 10, 2013 meeting were UNANIMOUSLY APPROVED.

Committee Reports

Chairman Boyd gave the report of the Audit Committee. Mr. Boyd stated that the outside auditing firm reviewed with them the final draft of the audit. The final audit anticipated date of completion will be next week. Mr. Boyd stated that the audit reflected that great improvement has been made. There were no financial statement findings or material weakness within the audit. The findings that were noted are related to eligibility and rate issues in Federal programs and Federal regulation. The Audit Committee has asked for a review once the final audit is completed.

Chairman Boyd called on Mr. Wallace to give the report of the Policy Committee. Mr. Wallace announced that Mr. Kelly McCutchen, President and CEO of Georgia Public Policy Foundation was the guest speaker for the meeting. Mr. McCutchen and Georgia Public Policy Foundation have developed expertise in tax, economic and healthcare issues.

The Committee asked Mr. McCutchen to share his thoughts on what type of issues might be addressed during the next legislative session. The Committee and meeting attendees were particularly interested in any data projecting changes affecting the remainder of this decade and the following decade related to long term care. Mr. McCutchen shared demographic data with the committee which indicated Georgia has an aging population and is now in 5th place in the nation for people 85 years and older. Georgia will transpire to become 3rd in the nation for the same age group by the end of the decade. We will be seeing an aging population, very quickly, that will affect our long term care, Medicaid and Healthcare Facility Regulation.

The Policy Committee is also working to develop some Guiding Principles that will be presented to Commissioner Reese and the Board for consideration and comment.

Commissioner's Report

Commissioner Reese informed the Board in the past year the Department of Community Health (DCH) has gone through the procurement process for State Health benefits. The Department of Community Health (DCH) chose Blue Cross Blue Shield of Georgia (BCBS) as the primary third party for State Health Benefit Plan and Medical Management, Express Scripts for PBM Pharmacy Benefit Manager and Health Ways for Wellness. Commissioner Reese also stated the Department of Community Health (DCH) has gone through the Administrative appeals process for vendors not selected and whoever wanted to protest the awards. The process ended last week with a issuance of a decision to uphold the contracts and the process during the procurement. Parties can go to Superior court for litigation if they desire, but the administrative piece is over.

Commissioner Reese informed the Board that the Department of Community Health (DCH) has completed the process for open enrollment that began on October 1st and ended on November 8th for the plan year that will begin on January 1, 2014. Commissioner Reese thanked Lurline Craig-Burke, Chief of State Health Benefit Plan (SHBP), her staff and all others that worked on the State Health Benefit Plan (SHBP) process.

Commissioner Reese informed the Board that we are in the midst of the budget cycle for FY 14 amended and FY 15 State budgets. The Board previously approved this summer the proposal to go to the Office of Planning and Budget on December 4, 2013. Commissioner Reese stated that the Department of Community Health's (DCH) budget will be included in the larger State budget and then it will be presented to the General Assembly in January.

Commissioner Reese welcomed new Board member, Allana Cummings and expressed that he is looking forward to working with Ms. Cummings and welcomed her expertise in helping the Department of Community Health Board moving forward.

Commissioner Reese introduced Mary Scruggs to the Board. The Commissioner stated that Ms. Scruggs would assume the role of Chief of Healthcare Facility Regulation Division (HFRD) on November 18, 2013 and that she will be a tremendous asset to the Department of Community Health (DCH). Commissioner Reese further stated that the Healthcare Facility Regulation Division (HFRD) is an important area that licenses and regulates healthcare facilities and includes the Certificate of Need program. Commissioner Reese stated that it is important that the Department of Community Health (DCH) find a better method of accountability for unscrupulous enterprises across the state that are operating unlicensed personal care homes and preying on vulnerable elderly adults and keeping them in substandard conditions. The full weight of regulatory authority will need to be imposed on these enterprises and to find out where these businesses are located and prosecute them when warranted.

Dr. Dubberly presented an update on the Medicaid Redesign Program, the ABD Care Coordination Program Public Notice - Final Adoption and the Georgia Hospice Program and Pediatric Concurrent Care – Final Adoption.

He states that there are two major efforts right now that we are seeking to undertake. Foster Care, adoption assistance and juvenile justice and the movement of those children into a more managed environment in or Care management Organization. The second is the Aged, Blind and Disabled which was discussed in a previous Board meeting.

Dr. Dubberly mentions that a name is being sought for the Foster Care Adoption program. This program moves 27,000 children to a single statewide Care Management Organization. These children belong to the Department of Family and Child Services, Foster Care, Adoption Assistance A category, and certain children in juvenile justice who are in a residential placement who are Medicaid eligible.

Dr. Dubberly states that with the approval of our Department of Administrative Services and CMS, a process has been designed to interview our three existing CMO's and to select among those three. Amerigroup has been selected and has been working with DCH on the implementation activities at this point moving toward the January 1, 2014 date. Part of that effort, will include the development of a portable health record that follow the child and can be carried with them after they leave Medicaid into adulthood. It will be available to the Department of Family and Child Services case worker as well as to the family who receives that child. The need to have a better understanding of the medical needs of the children and better coordination of their care has been identified. This effort will also increase preventive screening rates, well-care visits, immunizations, etc. It is believed that we will see some improvement in behavioral health conditions. Over 70% of the expenditures for the children who are in foster care are behavioral

health related and over 81% of the expenditures for the children who are in juvenile justice and residential placement are behavioral health related. There is a strong need to identify behavioral health needs and inter-direct physical and behavioral health for these populations.

Dr. Dubberly discusses the collection of partners to include, DCH, DBHDD, Public Health, DBHDD, Public Health, DHS, Dept. of Education and DECAL all discussing the needs of the child and all the different aspects of the program and how we can better coordinate and improve the outcomes of the situation of the children. The Foster Care Program was previously brought to the Board for approval which was received. Approval from CMS for the State Plan Amendment which gives us the authority to move forward with the project from a Federal perspective was also approved. CMS has given approval for the contract amendment with Amerigroup, as well as the capitation rates.

Dr. Dubberly explains that implementation activities are currently underway. A pre-readiness review will be held next week to review some of the activities. A larger readiness review will be held in December which will involve bringing back the task force who has helped with the needs of the population and design of the program itself. The December review will involve the individuals who have provided input and guidance about the needs of the population and how to best design the program.

Board member Dr. Von Besser asked if there would be outcome measures to report out and what they might be. Dr. Dubberly explains that the HEDIS NCQA measures will be one aspect. There are fifty-four HEDIS NCQA Quality Metrics that are measured for the population. We work to stratify. This population has separate reporting measures related to those quality measures that we are already monitoring measuring and influencing. We also have new items that will be brought to the table that have not been part of the Medicaid review before. Trauma informed care and the development of treatment plans that are trauma influenced. Also the child/family assessments that have to be performed a certain number of times. While we can talk about true clinical metrics with the HEDIS NCQA measures, there are other outcome measures we are looking for. Do we have trauma informed care, do we have the assessments done in a timely manner, and do we have the transfer information in a timely manner from the parties who are taking care of the child so there will be other measures.

Board member Rick Jackson asked if Amerigroup would be involved in the mental health issues and if this is part of the capitation rate? Dr. Dubberly states that the mental health and the physical somatic health are included and inter-related. They need to be more integrated and we believe that Amerigroup can help force that integration. (A copy of Medicaid Redesign Update Power Point Presentation is attached hereto and made an official part of these minutes as Attachment #3).

Dr. Dubberly states that care coordination is also being prepared for the Aged, Blind and Disabled population. There are a little less than 30% of the population who drive about 60% of the expenditures. These individuals today are in the fee for service

environment and are not part of the care management organizations. Financially, the cost trends between Aged Blind and Disabled, LIM population and PeachCare for Kids show ABD expenditures in billions of dollars in a projected growth to 2017. This shows a population with high acuity, high expense and high needs and we see that continuing into the future. We need to be able to impact this in a meaningful way.

He continues to explain that the approach in terms of the program itself, is by having a vendor or partner who can help with the care coordination effort, we believe that the claims should remain in a fee for service environment where we are controlling Medicaid payments and policy, reimbursement methodologies, as well as utilization management tools and that will remain in a fee for service environment. The vendor will work with care coordination, case management and disease management activities, but taking a much more holistic view than what we have seen in the past with traditional care coordinators recognizing the fact that there are more than just medical components that drive medical expenditures. There are social and environmental components and getting to the heart of the drivers versus just the clinical interventions.

He states that the patient centered medical home model is involved in this for the higher level, high intensity members. There will be primary care case management model that recognizes those physicians who are seeing those patients as the center of the team who is coordinating care and recognizing that from a financial perspective. There will be strong provider engagement tools and we also have to work on member engagement which is a voluntary program. We will use the value based purchasing approach to align what we are looking for along with incentives for the vendor as well as the provider.

Dr. Dubberly mentions the services that will be available through the ABD Care Coordination program. All members will have access to the member care coordination call center that will help them with connecting services with resources addressing issues where they have gaps in care they are trying to bridge. There will be a 24/7 nurse call line to get people connected to care earlier, identifying needs and avoiding some of the unnecessary emergency room use we currently have. All members will have outreach and education efforts that will be relevant to the patient's healthcare and disease state(s). Providers will be able to use this as a resource for better coordination to the vendor for follow-up and intervention. Certain members will have access to intensive medical coordination services. This service will engage members and conduct health risk assessments, form treatment plans utilizing interdisciplinary treatment teams, connect members with medical homes by developing, engaging and incentivizing a provider network, as well as improve coordination of care.

He presented a brief timeline of the ABD Care Coordination program from November 2013 with the RFP release to the projected Go Live date of October 1, 2014. The Go-Live date will be decided during the implementation phase in September 2014.

Board member Dr. Von Besser asked about the rationale behind the decision of not making the opt-in, opt-out process mandatory and why not go with more of a CMO like we see with the fee for service.

Dr. Dubberly explained that under the federal requirements we are not allowed to have a mandatory year end and you can't opt-out short of getting an 1115 waiver from CMS. This is a long process and there is some reluctance to limit choice from CMS. Giving the timeframe in which was needed to take action and the fact that 1115's take at least nine (9) months; we wanted to go ahead and start our program. We also realize that for this program to be successful, we have to have member engagement. So, if we went the route of getting the 1,115 mandating people in and they weren't participating, because is going to take member involvement in their healthcare, have we really accomplished anything by going through the 1,115 and mandating individuals to be in there? Part of that decision was because this is also what we heard from advocacy that in this population you have individuals who are very sick, have high acuity and some with low acuity. At that lower end, you may not need some of these services. Mandating you into a program that you may not necessarily need at this time was also viewed negatively. At the end of the day, the timeframe to get CMS's approval to do the mandatory was an issue and then the issue of the member engagement.

Dr. Dubberly answers the question of why full risk managed care is not recommended. He stated that there are concerns and cautions that are out there which we've heard from stakeholders. There is nothing worse than risk based managed care done poorly and with this vulnerable population, we felt this was a more proven step to see what we can do and how we can accomplish and we will learn that if we did decide in the future we wanted to move it will be a much more informed consumer and then we'll move full force. We've looked at other programs in other states that have been successful and we think we can be successful as well.

Chairman Boyd asked about other states that DCH has looked and where we are in Georgia with our best practices compared to other areas or other states. Dr. Dubberly explained that states like Oklahoma where they actually had full risk managed care brought everything in-house and they are doing everything outside of a full capitated rate with our arrangement, but with some vendor assistance as well. Some aspects of their program have been looked at. The Oregon program is one that was focused on and note worthy. Their model is a little different, but the philosophy behind the model is a real holistic model looking beyond jus the pure medical aspect, putting together care coordination teams that work together, that recognize the local needs and recognizing that there are aspects of the state where you may not know all the resources and various pockets of the state. Oregon and Oklahoma are two that I would point to immediately. We've also done a fair amount of work at looking at Pennsylvania's project as well as South Carolina.

Dr. Dubberly presented oral and written comments from the October 10, 2013 Board meeting regarding the project. Three (3) of the four (4) oral comments received from individuals who were associated with the coalition to ensure redesign effectiveness for

Medicaid or CareM as we refer to them. They mentioned their support of the voluntary approach to the program, giving individuals the opportunity to opt-out for and including members in an institutional setting. They also support having a single state-wide vendor stating that it would help with minimizing confusion with providers, making them more willing to participate in the program. In terms of the opt-out and opt-in procedures, they did ask us to make sure that we were very clear in identifying what the procedures were and how individuals could go about that process and making sure that the communications were appropriate to the populations, both culturally, as well as to individuals in hospice or with disabilities. Caregivers were mentioned as well.

He states that CareM assures adequate staff capacity to implement and oversee the program. Stakeholder participation beyond the implementation is also a point that was made. This is something that we are looking to do both for Go-Live readiness, but also as we go into monitoring and oversight. Inclusion in the monitoring oversight activities were also part of their comments. They did voice concern that there was only a two week period for comments since the public notice and offered further discussions with us about the program and the needs of the program. There was also a point that medical necessity standards should be considered for individuals greater than twenty-one particularly related to home and community based waiver services to keep individuals stable and successful in their home environment. The need for independent ombudsman was also presented through this and making sure that those individuals had experience in both Medicare and Medicaid environments with seniors and with those with disabilities. There was also a mention that we need to make sure we have adequate network of providers with physical health, behavioral health, as well as home and community based providers and also support providers to help individuals to be successful and to also maintain those existing relationship with the providers.

Dr. Dubberly continues by stating that CareM also asked for consideration regarding a phased in approach to the program, similar to the comments that were mentioned here about quality. Also making sure we have quality and outcome metrics that we measure both to the baseline and periodically and reported out to the Board of Directors publically as well. Financial measures of the program and financial success was also mentioned in making sure we are monitoring and reporting those as well. We were encouraged to maintain adherence to the infrastructure as well as the intent of the DOJ settlement.

He mentions that another member of the CareM group representing the Carter Center mentioned that a review had been performed regarding the State Plan Amendment we published along with the public notice as well as CareM concerns and recommendations and noted a few points of the gap that was pointed out. One was regarding procedures for performance improvement, quality review and grievance systems within the program. The second was regarding the detailed disenrollment counseling for individuals who wish to disenroll and the third was the definition of the auto assignment process. And that gets to the point of connecting people with medical homes. If they do not choose a medical home, one is assigned to them.

He mentions that another CareM partner, the Georgia Dental Association, mentioned again the need to include preventive and restoring of dental services in the program for adults and while not subject to this action, also wanted to point out their desire to have dental carved out of the existing CMO to a single state-wide vendor administrator. The final comment in the public hearing was from G4A, which is the Alliance of Georgia Area Agencies on Aging. They noted the importance of collaborating home and community based services and the ability for those providers to provide wrap around services and support for those individuals that would be subject to this program. They also stressed the importance of the intake process, providing timely assessments at the local level for individuals coming in to this program as well as reiterating the opt-in, opt-out clarity that needed to be there.

Dr. Dubberly moves to the written comments, both CareM and the Georgia Dental Association provided comments that neared their oral comments. The G4A, in addition to their oral comments, had also mentioned that in contracting with a single vendor, having a local presence is very important in making sure that the network adequacy is there for individuals to access the services and providers, not only the medical services, but the home and community based agencies as well. Another written comment was received from the Georgia Healthcare Association. They had suggested that we exclude members in skilled nursing facilities and labor programs from this project and redirect those funds to possibly increase provider payments. They also encouraged us to have transparency regarding the RFP documents, the bid documents, our expectations and the budget associated with this program.

He states that Amerigroup was the next comment, who supported their Medicaid redesign goals, however they advocated for full risk care coordination yield the best outcomes and financial savings. They also advocated for mandatory enrollment of the population and for continued consumer involvement throughout the project.

He explains that ValueOptions who presented themselves as a health improvement company voiced their support of a single state-wide vendor and that would result in administrative cost savings to the state and allow the state to work more closely with the vendor to effectively achieve the program goal. Other benefits of the single vendor included reduction in DCH contracting and administrative oversight burden, minimization in member and provider confusion, greater ability to implement program improvements and enhancements state-wide basis, simplification in program analysis and evaluation. Also it prevents the potential where vendors are selected where the members that they try to attract to their program based upon the level of their healthcare needs.

Dr. Dubberly delivered responses to the comments by saying the belief of the holistic view regarding physical health, behavioral health, home and community based waiver services, community services and community partners all have to be part of the solution. In terms of the opt-out provisions, we work closely with CMS and they have been very clear with us about their expectations regarding educational tools and the level of awareness that they expect to be in place regarding numerous rights to opt-out

and what we have to do to accomplish that. That is clearly defined in our procurement intent. The vendor will clearly be required to communicate this information not only in writing, but in other mechanisms that are related to an individual's disability or needs.

He states that there will be opportunities provided for members to opt back in the program even if they have opted out.

The provider network that members will have access to is the same provider and network that they have today. We will retain the network, policies, procedures, reimbursement methodology, etc. Through our partner we may identify opportunities where we don't have sufficient providers and we need to attain a provider in a certain area. This could help us with building our network adequacy in the fee for service environment.

Dr. Dubberly states that it is strongly believed that maintaining the relationship between the Medicaid member and provider is important. There may be situations where the provider does not wish to continue to in that capacity, but we certainly intend for the member's choice of providers to be honored.

Regarding Ombudsman support, Dr. Dubberly says there will be an ombudsman staff that will be experienced and have expertise in both Medicare and Medicaid components. There are about 113,000 or so individuals in this population who are dual eligible, so the knowledge of Medicare and Medicaid is going to be essential in this role.

He explains that in regard of the implementation of the program itself, we hadn't planned on a phased and approach, but are certainly open to that if it proves success of the program. We are monitoring outcomes and have outcome measures that the vendor will be held to. This will be tied to their financial performance and payments. We have a monitoring outcome committee who is tied to our task force. We plan to continue with Stakeholder involvement.

Board member Clay Cox asked how does this program save us money. Dr. Dubberly responds by explaining that there will be an investment in the beginning, but quality and outcome improvement will result in long term savings.

Board member Rick Jackson had a question regarding the opt-in and opt-out process. Dr Dubberly explains that individuals would be automatically alerted of the program and that they will have access to it. They will have a ninety (90) day period in which to opt-out of the program and after that ninety (90)day period, they would remain in that program for the remainder of the twelve (12) month period. After this, they will have an opportunity on an annual basis to opt-out. There are other opt-out provisions included.

Rick Jackson MADE a MOTION to approve for final adoption ABD Care Coordination Program Public Notice. Bill Wallace SECONDED the MOTION. ON THE MOTION, the yeas were 6, nays 0, and the MOTION was APPROVED. (A copy of the Georgia

Hospice Program Public Notice is attached hereto and made an official part of these minutes as Attachment #4).

Dr. Dubberly presented a review regarding changes of the Georgia Hospice Program and Pediatric Concurrent Care Final Adoption. He shared a collection of items that are necessitated directly through review of our state plan amendment and reconciliation of that state plan.

Kiera von Besser MADE a MOTION to approve for final adoption Georgia Hospice Program and Pediatric Concurrent Care Public Notice. Clay Cox SECONDED the MOTION. ON THE MOTION, the yeas were 6, nays 0, and the MOTION was APPROVED. (A copy of the Georgia Hospice Program Public Notice is attached hereto and made an official part of these minutes as Attachment #5).

Tim Connell, CFO briefed the Board on the request for approval of a public notice period for the Inpatient Hospital Prospective Payment System update. Mr. Connell explained that DCH was required by the federal government to begin using International Classification of Diseases version 10 (ICD-10) effective October 1, 2014. To achieve that objective, DCH must update its current Diagnostic Related Group (DRG) version 24 to an ICD -10 compliant DRG version 30. The updated DRG must be in place by April 1, 2014 to meet a deadline set by HP for testing the MMIS system ability to correctly process inpatient hospital claims using ICD-10. Mr. Connell noted that DCH last updated its DRG in January 2008. The 2008 update was based upon 2004 and 2005 cost reports. The DRG version 30 will be based upon 2011 cost reports. Because of the time interval between the DRG updates, hospitals will be affected individually with some seeing their payments go up while others will see their payments go down. Overall, the cost changes for all 152 hospitals collectively will be cost neutral. The public comment period under the notice will expire on November 25, 2013. A report to the board on any public comments will be made at the next Board meeting on December 1, 2013. Upon a motion and second, the board unanimously approved the issuance of the public notice.

Bill Wallace MADE a MOTION to approve for final adoption Inpatient Hospital Prospective Payment System Methodology Update Public Notice. Allana Cummings SECONDED the MOTION. ON THE MOTION, the yeas were 6, nays 0, and the MOTION was APPROVED. (A copy of Inpatient Hospital Prospective Payment System Methodology Public Notice is attached hereto and made an official part of these minutes as Attachment #6).

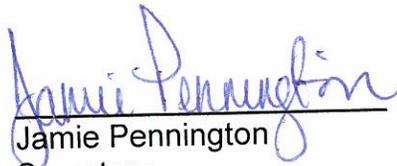
New Business

None to report.

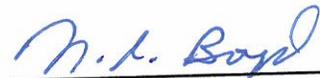
Adjournment

There being no further business to be brought before the board, Chairman Boyd adjourned the meeting at 11:25 a.m.

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED THIS THE 14th DAY OF November, 2013.



Jamie Pennington
Secretary



Norm Boyd
Chairman

Official Attachments:

- #1 List of Attendees
- #2 Agenda
- #3 Medicaid Redesign Update Power Point Presentation
- #4 Georgia Hospice Program and Pediatric Concurrent Care Public Notice
- #5 ABD Care Coordination Program Public Notice
- #6 Inpatient Hospital Prospective Payment System Methodology Update Public Notice