

**MINUTES OF THE
BOARD OF COMMUNITY HEALTH MEETING
April 16, 2009**

Members Present

Ross Mason, Vice Chairman
Kim Gay, Secretary
Dr. Inman C. "Buddy" English
Raymond Riddle

Members Absent

Richard Holmes, Chairman
Dr. Ann McKee Parker
Archer Rose

The Board of Community Health held its monthly meeting at the Department of Community Health, Fifth Floor Board Room, 2 Peachtree Street, N.W., Atlanta, Georgia. (An agenda and a List of Attendees are attached hereto and made official parts of these Minutes as Attachments #1 and #2). Vice Chairman Mason called the meeting to order at 10:31 a.m.

Minutes

The Minutes of the March 12 meeting were acknowledged.

Committee Report

Kim Gay, Chair of the Care Management Committee, reported that Dr. Jerry Dubberly provided an overview of the Managed Care Performance Reports and Adriane Saunders provided an EQRO update.

Commissioner's Comments

In Commissioner Medows' absence, Dr. Carladenise Edwards, Chief of Staff, offered a few comments. She welcomed Dr. Janice Carson, the new Director of Quality, Division of Medical Assistance Plans. Dr. Edwards said the Department is anticipating the Governor's signature on House Bill 228, the Health and Human Services Reorganization legislation. She said the Division of Public Health will become a part of the Department of Community Health, and the Department will complete the transition work for the Office of Regulatory Services health care units to move to DCH effective July 1.

Department Updates

Carie Summers, CFO, began discussion on the final FY 2010 Budget. The FY 2010 budget increased in total funds by \$800 million or a 7 percent increase; however, the appropriations consider the movement of the Division of Public Health from the Department of Human Resources to DCH as well as the Office of Regulatory Services; consequently the majority of the increases relate to the Department assuming these functions that will be transferred to DCH. State fund appropriations decreased by \$225 million or -9 percent in recognition of enhanced federal financial participation in the Medicaid benefits programs due to the American Recovery and Reinvestment Act (ARRA). Ms. Summers reviewed the additions (general state funds), reductions (general state funds), fund source adjustments, and transfers in the administration/health care access and improvement budget. She also listed other items of importance: instructions from the Legislature to evaluate the cost effectiveness of the new Medicaid Management Information System contract; elimination of the nursing home provider fees budget program and show as a fund source; reduce the CMO Quality Assessment Fee to 0 percent effective October 1, 2009; increase SHBP member premiums by 5 percent on January 1 for those members who are not enrolled in the Consumer Directed Health Care plans; utilize FY 2009 SHBP net assets; sets employer contribution rates for the SHBP; implements a direct bill revenue collection system for the SHBP; and designates the SHBP as the sole administrator of COBRA for providing the COBRA subsidy made available through the ARRA. Ms. Summers concluded the overview after addressing questions about one of the budget reductions – relocating 10 percent of long stay ventilator patients out of acute care settings and the Department's plans to assist the patients. (A copy of the Final FY 2010 Budget Memo is attached hereto and made an official part of these Minutes as Attachment # 3).

Russell Crutchfield, Director of Legislative and External Affairs, gave an update on bills that affect the Department. Senate Bill 122, the Department's bill, divides the existing Other Post Employment Benefits (OPEB) Trust Fund into two retiree health benefit funds; State Employee Retirement Fund and School Employee Retirement Fund. This will ensure that OPEB contributions are appropriately linked to the intended beneficiaries. The Department is interested in three Senate study committees: SR 334 Health Care Transformation, SR 665 Administration of Dental Benefits for Medicaid and PeachCare for Kids, and SR 672 Autism. House Bill 228 creates a Department of Human Services and will contain the current Division of Family and Children's Services, Child Support Services and the Division of Aging Services; reestablishes the Department of Community Health and retains all current functions of DCH, the Division of Public Health and the remaining healthcare functions within the Office of Regulatory Services. Senate Bill 133 amends the Health Share Volunteers in Medicine Act and grants sovereign immunity to paid nurses who are in the employ of a safety net clinic and physicians who are on staff at a local hospital who provide services at a safety net clinic and do not receive compensation from the clinic. Senate Bill 165 authorizes the Department of Community Health to obtain income eligibility verification from the Department of Revenue for Medicaid and PeachCare for Kids Program applicants.

Mr. Crutchfield briefly described legislation that did not pass that had the potential to affect the Department: HB 307, HB 523, SB 03, SB 92, SB 146 and SB 161/HB 426. He asked the Board to keep in mind that this is the first year of the election cycle; consequently some of these bills are open to be heard during the next Session. Mr. Crutchfield concluded his overview after addressing questions from the Board. (A copy of the 2009 Legislative Summary is attached hereto and made an official part of these Minutes as Attachment # 4).

Dr. Edwards acknowledged Mr. Crutchfield, Ms. Summers and the entire management team for working tirelessly during the Legislative Session.

Nancy Goldstein, Chief, State Health Benefit Plan, gave an update on several policies that the SHBP is currently undertaking. She reviewed the three policies that were presented at the October 30 Board meeting to address the \$16 billion OPEB liability: effective January 1, 2009, mandatory CDHP for new hires/entrants for their first calendar year; higher premiums effective July 1, 2009 for Medicare-eligible retirees who do not enroll in Medicare Part B; and effective January 1, 2010, Medicare-eligible retirees will be required to enroll in one of the Medicare Advantage (MA) options if they want to continue to receive the 75 percent subsidy.

Currently there are two optional Medicare Advantage Private Fee-for-Service (PFFS) plans offered by United Health Care and CIGNA. The plans automatically cover all parts of Medicare Parts A, B and D and are customized plans for SHBP that offer enhanced benefits over standard Medicare. In 2010 all Medicare-eligible retirees will be required to enroll in one of the MA options if they want to continue to receive the 75 percent state subsidy; SHBP is looking into expanding options so retirees have a choice of four options (two from each vendor). The two new options would have lower co-pays and out-of-pocket costs, but higher monthly premiums. SHBP will expand the MA Plans to include Part B Only to accommodate retirees not enrolled in Medicare Part A. Utilizing 2009 costs, the monthly premium savings for most retirees under SHBP are about \$45.50 per month. Medicare PFFS plans have deemed providers rather than contracted networks. Any provider who accepts Medicare can become a deemed provider as long as he agrees to accept UHC or CIGNA's terms and conditions. UHC and CIGNA reimburse providers at the Medicare rates, claims are paid faster than the Medicare Coordination of Benefits process and providers have the added convenience of only filing the claim with the health carrier rather than Centers for Medicare and Medicaid Services (CMS) and then the health carrier.

Ms. Goldstein stated that Medicare-eligible retirees who do not enroll in Medicare Part B will face a significant premium increase in July 2009. They will also lose the 75 percent state subsidy on January 1, 2010 since they will be unable to move into an MA plan until they have enrolled in Medicare Part B. SHBP will pay any late entry penalties for enrolling in Medicare Part B during the 2009 annual Medicare enrollment period of January 1 through March 31.

Next steps are finalizing plan design for the new MA option and receive 2010 renewal rates from vendors. UHC and CIGNA will file the new SHBP plans with CMS in June to obtain the new rates. Over the summer SHBP will send communication packets to retirees impacted by this change. The SHBP will conduct extensive meetings and educational sessions statewide for the retirees. The Department will present a Board resolution in May for July 1, 2009 retiree rates that considers Part B coverage. (A copy of the State Health Benefit Plan Update is attached hereto and made an official part of the Minutes as Attachment # 5).

Ms. Goldstein reviewed the proposed rule change to SHBP Rule 111-4-1-.06(6). The proposed rule change would allow the Department more flexibility to permit employees to switch options and tiers when the qualifying event involves cost increases or coverage losses or curtailments resulting from employment or compensation decisions of employing entities. A public hearing was held on March 17, but the Department received no public or written comment. Ms. Goldstein said the Department will ask the Board to approve the rule for final adoption at a later date.

Mr. Clyde Reese, General Counsel, began discussion on the proposed rule change to Certificate of Need Rule 111-2-2-.03 that implements a statutory exemption that was inserted in the CON legislation in 2008 for the Department to promulgate standards to allow hospitals that wanted to perform therapeutic cardiac catheterization procedures at their facilities without open heart backup. The exemption has two parts: 1. allows hospitals that are participants in the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT) Study prior to July 1, 2008 to continue performing those procedures; and 2. allows the Department to promulgate standards to assess hospitals that would like to do these type procedures without open heart backup but are not active participants in the C-PORT Study. The Department first brought these rules to the Board in December; the Board approved the rules for initial adoption; a public hearing was held in December. Due to the tenor of the comments, the Department revised the proposed rules and brought them before the Board on February 12; another public hearing was held in March; and today, in the absence of a quorum, the Department will ask the Board for an official vote for final adoption by conference call as soon as possible to transmit the rules to the Secretary of State.

Dr. Jerry Dubberly, Chief, Medical Assistance Plans, presented the Community Mental Health Services Public Notice. He said CMS has directed Medicaid agencies to move away from a bundled arrangement for methodologies to an unbundled arrangement which uniquely identifies services and the units of those services that are delivered. Effective for services provided on and after July 1, 2009, and subject to payment at FFS rates, DCH is proposing to move to an unbundled reimbursement methodology based upon the practitioner type, service costs, location of services, and productivity factors. The Department will ask the Board for approval of this public notice at the soon-to-be scheduled conference call.

Adjournment

Vice Chairman Mason said any conference calls scheduled will be subject to public notice. The next regularly scheduled board meeting will be held May 14. There being no further business to be brought before the Board, Vice Chairman Mason adjourned the April 16 meeting at 11:29 a.m.

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED THIS THE _____
DAY OF _____, 2009.

RICHARD L. HOLMES
Chairman

KIM GAY
Secretary

Official Attachments:

- #1 List of Attendees
- #2 Agenda
- #3 Final FY 2010 Budget Memo
- #4 2009 Legislative Summary
- #5 SHBP Update