Memorandum

To: File

cc: Stanley S. Jones, Jr.

From: Helen L. Sloat

Date: November 15, 2013

Re: Department of Community Health ("Department" or "DCH") Board meeting of November 14, 2013

The Department of Community Health Board met in Atlanta on November 14, 2013. Chairman Norm Boyd presided over the meeting; Commissioner Clyde Reese represented the Department.

Commissioner Reese introduced the newest member of the Department's Board, Allana Cummings, who is the Chief Information Officer at Northeast Georgia Health System in Gainesville.

Committee Meeting Reports

The Audit Committee met earlier in the morning. Chairman Boyd reported that they received a report from the Department's outside auditors and reviewed a final draft of that audit. The auditors reported that it was anticipated that the audit would be completed next week. Chairman Boyd reported that there was great improvement overall. There were no financial statement findings and the Department would receive a clean audit. There were also no weaknesses found. There were four "findings" related to eligibility and rates in federal programs which the Department is addressing.

Bill Wallace reported that the Policy Committee also had met earlier. That Committee received a presentation from Kelly McCutchen at the Georgia Public Policy Foundation. Mr. Wallace described Mr. McCutchen as an expert in the areas of tax, economics and healthcare who shared data on issues to come before the General Assembly in the 2014 Session. He noted that Mr. McCutchen stated that Georgia would have a surge of folks needing long-term care in the next two decades. Georgia will be the third largest state as to the number of individuals who are 85 years and older at that point (today, Georgia's is the fifth largest state with such population), but the 9th most populous state overall.

Commissioner's Report

Commissioner Reese reported on the procurement process for the State Health Benefit Plan, noting that the administrative phase has been completed. The Department has selected Blue Cross Blue Shield as its third-party administrator; Express Scripts as the pharmacy benefit manager; and Health Ways for its wellness provider. Commissioner Reese upheld the

Department's Procurement Officer and staff selections. The parties are now free to pursue this decision with the Superior Court.

State Health Benefit Plan's open enrollment has concluded. It worked successfully according to Reese. The new plan year begins on January 1, 2014. There have been few glitches in the enrollment process.

The Department is preparing for the State's budgeting process. Reese will meet with the Governor on December 4, 2013 about DCH's requests for the FY 2014 Amended Budget and FY 2015 Budget.

Commissioner Reese introduced Mary Scruggs, an attorney with the Department, to the Board. Ms. Scruggs has assumed the duties previously held by Brian Looby. She will oversee the Department's Healthcare Facility Regulation efforts. Commissioner Reese described Ms. Scruggs as a brilliant lawyer. Looby left DCH to work for McGuire Woods.

Action Items

Medicaid Reform

Jerry Dubberly presented information on the Department's Medicaid Redesign. Initially, he provided an overview of the work done, describing the move of the foster care, adoption assistance children and Department of Juvenile Justice-involved children into managed care and the proposal to implement care coordination for the Aged, Blind and Disabled Medicaid population.

The Department is trying to come up with a name for the "foster care" project. It involves the movement of 27,000 children into a single CMO. The CMO selected to oversee the population is Amerigroup and the actual implementation of this new managed care effort starts on January 1, 2014. It will include portable health records which will be available to the Division of Family and Children's Services and to families of the children. The goals are to have improvements with screenings, immunizations and with behavioral health medications. In addition to DCH, there are several State agencies involved with this effort including the Departments of Early Care and Learning, Juvenile Justice, Human Services, Behavioral Health and Developmental Disabilities and Education.

The Board has already approved the foster care proposal. CMS has also approved the Department's proposed State Plan Amendment and the contract establishing the capitation rate to be paid to Amerigroup. Pre-readiness review starts next week, and in early December, full readiness review with the task forces will commence.

Board member, Kiera von Besser, M.D., noted that this was exciting but wanted to know if the Department would be tracking outcome measures and improvements of the child. Dubberly noted that there were 54 HEDIS and NCQA measures to be reviewed. There are separate reporting measures which are new, including trauma-informed care and child and family assessments.

Board member, Rick Jackson, inquired how and if Amerigroup would address mental health issues. Dr. Dubberly stated that Amerigroup would take care of the mental health needs of the children in addition to their physical health needs. Mr. Jackson stated that was of particular interest to him as he currently chairs the board of directors for Faith Bridge, a nonprofit which deals with foster care children and on any given day has 100 children in beds. Mr. Jackson believes this will be a wonderful improvement. Creation of a medical record could be piloted for expansion to all of the DCH populations. Dr. Dubberly noted that the creation of the health record can also help the Department with any "alerts" that might be necessary.

Dr. Dubberly discussed the Aged, Blind and Disabled program and the proposed care coordination initiative. He explained individuals in this program constitute approximately 30 percent of the Medicaid population but drive 60 percent of the Medicaid expenditures. The Department intends to select a statewide vendor; use a fee-for-service environment; and require care coordination, case management and disease management; a patient-centered medical home; primary care case management; provider engagement; and value-based purchasing.

The vendor will have to work with the members and with providers. The Department cannot mandate membership in this care coordination effort as it would require an 1115 waiver to be submitted to CMS to do so.

There will be a call center; a 24/7 nurse call center and outreach and education relevant to the children.

Providers have to be engaged by the vendor and should see this as a resource for their patients.

There will be intensive care coordination for ABD enrollees who can benefit from it, including analytic tools and modeling to be required of the vendor. Additionally, there will be health risk assessments; treatment plans; connections of folks with medical homes and incentives for providers; and improvement in the coordination of care.

The timeline outlined for the Board was:

November 15, 2013 – release of a request for proposal (or soon thereafter)
February 10, 2014 – responses to the request for proposal will be due
May 7, 2014 – contract with the vendor to be executed
May 7, 2014 – September 30, 2014 – implementation

September 1, 2014 – go live/no go live decision as part of a final readiness review
October 1, 2014 – go live date

Dr. Dubberly noted that the Department did not intend to use an "off the shelf product." DCH also intends for this program to be done well rather than fast. Therefore, the relevant Navigant task force stakeholder groups will be brought back together to help decide whether to "go live" with the initiative at the proposed time.

Dr. von Besser asked about the "opt-in and opt-out" provisions as members will be permitted to do so. She also asked why the Department was not contracting with a CMO like it had done with the foster care program. Dr. Dubberly replied that there are federal requirements governing the opt-in and opt-out provisions. It is also a very lengthy process to secure a waiver (about nine months) and CMS is reluctant to limit choice (that is why there is no single CMO selected). The Department also needs voluntary member engagement for this to work. Advocacy groups also supported the opt-in and opt-out provisions. Dr. von Besser also asked why not move to full-risk managed care. Dr. Dubberly explained that the Department sees this as an evolution process and this effort as a more prudent step. The Department will learn if they want to move forward with full-risk managed care in the future by implementing this effort.

Chairman Boyd asked DCH what other states they reviewed in this process and what best practices were found. Dr. Dubberly explained that the Department had looked at Oklahoma's program as well as the programs in Oregon, Pennsylvania and South Carolina (South Carolina is now moving to full-risk managed care).

At last month's meeting, the Board had approved for initial adoption the public notice on this care coordination effort. There were four individuals who spoke at the public hearing on the notice and six entities submitted written remarks.

CARE-M spoke at the hearing and supported the voluntary approach and single vendor. They asked to clarify the opt-in and opt-out procedures – making sure such were culturally sensitive for instance. They also asked about adequate staff for the program and asked for stakeholder participation after implementation. CARE-M was concerned about monitoring of the program and raised concerns about the limited comment period, feeling that two weeks was relatively short. They also highlighted the medical care standards for the individuals in the home and community-based services waivers as well as needing an ombudsman. They wanted assurance of an adequate network of providers (physical health, mental health and home and community-based services). CARE-M further suggested a phased-in approach for the program. They asked for quality and outcome measures to be reported to the public as well as the financial measures of the vendor to be made public. They also inquired about the linkage of the program with the State's Department of Justice Settlement for the Department of Behavioral

Health and Developmental Disabilities. Care-M also asked for improved access to dental care for members.

The Carter Center also supplied comments. It took issue with the State Plan Amendment and asked about "gaps" in the performance improvement and grievance procedures. The Carter Center also raised concerns about auto-assignment for a medical home.

Another speaker was the Georgia Dental Association. It asked questions about restorative dental work and asked again about a carve-out for dental services.

G4A, the Alliance on Aging, inquired about wrap around services; the in-take process for members; and opt-in and opt-out clarity.

Dr. Dubberly noted that written materials were received as well. CARE-M and Georgia Dental Association's written remarks mirrored their public comments. In the Carter Center written remarks, they also asked that the entity have a local presence and have network adequacy.

Georgia Health Care Association also submitted written remarks. It asked for the exclusion of skilled nursing facilities from the program and that money saved be transferred to provider payments.

Amerigroup submitted written remarks. It advocated for full-risk managed care and also asked for members' mandatory enrollment in the program.

Value Options asked for a single, statewide vendor so as to limit oversight issues and lower confusion.

Dr. Dubberly indicated that the Department had a holistic view of this effort. It has worked with CMS on its expectations for opt-out and members' rights. The vendor will have to communicate about opt-out processes; opt-in will be permitted. The provider network will remain as it is today. The Department may actually identify where there are problems with provider adequacy. There will be ombudsman support and staff with Medicare and Medicaid knowledge. There will be no phased-in approach for implementation (but it has not been ruled out and the Department is open to the idea). The Department will require monitoring of outcomes as those will be tied to financial performance. Stakeholders will continue to be involved – including parents, providers, etc.

Board member, Clay Cox, asked about what money the Department will save with this effort. Dr. Dubberly acknowledged that in the first year it will cost the Department but they believe that the savings will come in year two with improved quality and better patient outcomes. Thus, the savings will be long-term.

Dr. von Besser asked more about the opt-in and opt-out procedures. Dr. Dubberly acknowledged that members have to be engaged for this to work; the individual must be ready for change.

Mr. Jackson asked about the percentages expected to opt-out. Dr. Dubberly explained that other states saw anywhere from 15 to 40 percent; it will align with the incentives to keep folks engaged. Dr. Dubberly explained that once the vendor alerts the members to the program that they will have 90 days to opt-out. Otherwise, they will remain in the program but have an annual opt-out after that. Members can also opt back in to the program.

Mr. Wallace commended the Department for releasing the specific claims data to the vendors in the request for proposal. He cautioned the Department to be aware of the physician network as the Department needs a stable physician network or they will otherwise place the State at risk.

Mr. Jackson moved that the Board accept this notice for final adoption; Mr. Cox seconded his motion. The motion carried unanimously.

Georgia Hospice Program

At last month's meeting, the Board approved a notice for initial adoption involving the hospice program. It essentially was a State Plan Amendment reconciliation involving:

- ACA's requirement for palliative and curative care for children
- Elimination of diagnosis for failure to thrive
- Face-to-face encounters
- ARRA changes on wage index

There were no public comments at the hearing on this notice.

The Board raised several questions:

- Credentials of hospital physicians – Dr. Dubberly indicated that the Code of Federal Regulations addresses such, requiring a medical doctor or doctor of osteopathy acting within their scope of their license and that the patient not be expected to sustain life longer than six months.
- Hospice eligibility determination – Dr. Dubberly explained that it would be included in the narrative disease state; again, the patient would not be expected to live six months.
- Average hospice stay – Dr. Dubberly noted that those were generally 93 days; otherwise taking out the non-specific, those were 150 days. Hospice numbers have

almost tripled over a twelve year period going from around 500,000 to more than 1.3 million.

- Face-to-face assessments – Generally, those are conducted by physician or can be done by a hospice nurse but the physician has to certify. This is currently Medicare practice. It currently does not apply to Medicaid but Dr. Dubberly believes that Medicaid will align soon with Medicare on this.

Dr. von Besser asked why curative care for children was added. The Board then took action on final adoption of this notice for hospice; Dr. von Besser made the motion for final approval and Mr. Cox seconded it. The motion carried.

Inpatient Hospital Prospective Payment

Tim Connell presented the notice for *initial* adoption for changes to the Inpatient Hospital Prospective Payment program. Currently, DRG 24 is the basis of how the Department pays claims. This DRG system has been in use since January 1, 2008 and is based on 2004-2005 claims data. The proposal is to move to DRG 30 effective April 1, 2014 which will also be based on newer claims data and map over to ICD-10. A public hearing on this notice is to take place on November 18; the Board will consider final action on the notice at its December 12, 2013 board meeting. The Board then moved for initial adoption; Mr. Cox made the motion with Ms. Cummings seconding his motion. The motion carried for initial adoption.

Chairman Boyd adjourned the meeting when there were no further Board comments.