MINUTES

BOARD MEMBERS PRESENT:

Jim Adams, Chair
Rebecca Q. Cedillo, Secretary
Robert L. Jimenez, M.D., Immediate Past Chair
Ira Smith
Robert Engberg
Alex Briseño

BOARD MEMBERS ABSENT:

Linda Rivas, Vice Chair

OTHERS PRESENT:

George B. Hernández, Jr., President/Chief Executive Officer, University Health System
Bryan Alsip, M.D., Executive Vice President/Chief Medical Officer, University Health System
Francine Crockett, Vice President, Materials Management, University Health System
Peggy Deming, Executive Vice President/Chief Financial Officer, University Health System
Michael Hernandez, Vice President, Legal Services, University Health System
Donna Hopkins, Vice President, Care Coordination, University Health System
Sherry Johnson, Vice President/Chief Integrity Officer, University Health System
Leni Kirkman, Vice President, Strategic Communications and Patient Relations, University Health System
Mary Ann Mote, Senior Vice President/Chief Revenue Officer, University Health System
Richard Rodriguez, Vice President, Facilities and Support Services, University Health System
Christann Vasquez, Executive Vice President/Chief Operating Officer, University Health System
Mark Webb, Vice President, Facilities Development & Project Management, University Health System
And other attendees.

MEDIA:

Don Finley, San Antonio Express News
CALL TO ORDER AND RECORD OF ATTENDANCE:  JIM ADAMS, CHAIR, BOARD OF MANAGERS

Mr. Adams called the meeting to order at 2:00 p.m.

INVOCATION AND PLEDGE OF ALLEGIANCE:

Volunteer Chaplain Tomas Hernandez said the invocation and Mr. Adams led the pledge of allegiance.

CITIZENS’ PARTICIPATION: None.

APPROVAL OF MINUTES OF PREVIOUS MEETING:

FEBRUARY 21, 2012 – SPECIAL BOARD MEETING:

SUMMARY: The minutes of the special Board meeting of Tuesday, February 21, 2012 were submitted for approval by the Board of Managers.

RECOMMENDATION: Mr. Adams recommended approval of the minutes as submitted.

ACTION: A MOTION for approval of the recommendation was made by Mr. Briseno, SECONDED by Ms. Cedillo, and PASSED UNANIMOUSLY.

EVALUATION: None.

FOLLOW-UP: None.

ACTION ITEMS (SEE ATTACHMENT A):

CONSIDERATION AND APPROPRIATE ACTION REGARDING A CONTRACT WITH ACADIAN AMBULANCE SERVICES, INC. FOR EMERGENCY MEDICAL SERVICES IN UNINCORPORATED AREAS OF BEXAR COUNTY—RICHARD RODRIGUEZ

SUMMARY: Modification #1 provides continued 911 Emergency Medical Services (EMS) to unincorporated areas of Bexar County. This is a planned expense and operating funds have been included in the Year 2012 Operating Budget. The original contract was approved by the Board of Managers in March 2009 for $4,725,000 and included the option to renew for one additional two-year terms; this modification exercises that option. Total value of this contract including Modification #1 is $8,055,000. As compared to the previous contract, there is no increase in contract fees. Acadian Ambulance Service, Inc., has an Affirmative Action Plan or Policy in effect, and has a total of 2,665 employees. The Workforce Composition Data was reviewed by the Board.

RECOMMENDATION: Staff recommends Board of Managers approval of the two year renewal option with Acadian Ambulance Service, for the Emergency Medical Services in Unincorporated Areas of Bexar County in an amount not to exceed $3,330,000.

ACTION: A MOTION to approve staff’s recommendation was made by Ms. Cedillo, SECONDED by Mr. Engberg, and PASSED UNANIMOUSLY.

EVALUATION: Discussion ensued regarding the quality of the services provided by Acadian Ambulance Services and the monitoring of such. In 2009, the
Board expressed an interest in reviewing basic fees and transport charges, standard customary rates, and now would like to know more about the vendor’s collection rates. Additionally, the Board would like to review medical data, such as, what are the types of calls and how often do they transport the patients? Of the calls received, how many of those patients do not get transported? To what facilities do they transport? How critical are the patients they transport?

Dr. Jimenez noted that many of the questions raised by the Board today are questions that were initially raised in 2009, specifically: How is cost transferred to the patient? How does the company’s financial viability link to the ability of the company to provide the service? How do we make sure the company delivers what it promises? What happens if the vendor fails? What are the parameters for evaluating a contract and the vendor’s performance? Can a contract be terminated without cause? What are the fees charged by the City of San Antonio EMS?

Dr. Jimenez requested a formal performance report on operational issues and would like to know more about the challenges faced by the ambulance industry. He suggested that staff obtain feedback from patients in unincorporated Bexar County via surveys or focus groups to measure customer satisfaction.

**FOLLOW UP:** Dr. Alsip will follow up with the medical director at Acadian Ambulance Services to review metrics that are currently in place for monitoring the quality of the service. Mr. Rodriguez will return to the Board of Managers with an executive summary regarding the issues discussed today.

**CONSIDERATION AND APPROPRIATE ACTION REGARDING A CONTRACT WITH EXECUTIVE HEALTH RESOURCES FOR PHYSICIAN ADVISOR SERVICES—MARY ANN MOT/E BRYAN ALSIP, M.D.**

**SUMMARY:** This is a new contract which provides support to the access nurse and admitting physician during the hospital intake process. This additional support will further limit the denials for medical necessity by allowing the admitting physician to more appropriately differentiate between the observation and intake status. Physician Advisors are physicians trained and experienced in understanding the guidelines for admission and assuring that the specific characteristics of the patient are incorporated effectively in the documentation to support the admission. If the admission is later denied, the Physician Advisors will be responsible for the appeal process on behalf of the Health System which is included in the fee. This is not a planned expense; however, a projected increase in revenue will offset the cost. The value of this contract is based on an estimated activity of 175 patients a month with a cost of $240 per patient and includes appeal process when applicable. Based on an analysis of the current patients placed in observation it is believed that approximately 25% of the patient care appropriate for admission would result in an additional annual cash flow of $1,050,000. Executive Health
Resources has an Affirmative Action Plan or Policy in effect, with a total of 2,119 employees. The Workforce Composition Data was reviewed by the Board.

**RECOMMENDATION:** Staff recommends the Board of managers approve a one year contact at an annual estimated cost of $511,500 with Executive Health Resources.

**ACTION:** A **MOTION** to approve staff’s recommendation was made by Mr. Engberg, **SECONDED** by Ms. Cedillo, and **PASSED UNANIMOUSLY**.

**EVALUATION:** None.

**FOLLOW UP:** None.

**CONSIDERATION AND APPROPRIATE ACTION REGARDING A CONTRACT AMENDMENT WITH ASSOCIATED REGIONAL & UNIVERSITY PATHOLOGISTS, INC. (“ARUP”) FOR REFERENCE LABORATORY TESTING SERVICES—**

**ALLEN STRICKLAND**

**SUMMARY:** Modification #3 provides reference laboratory services for specialized testing that is not feasible to be done on site. Testing that is performed by the reference laboratory includes antibody testing for Multiple Sclerosis, West Nile Virus, Lyme disease, fungus infection testing in HIV patients, studies for HIV genotyping and phenotyping, Hepatitis C Viral genotype, and Human Papilloma Virus. This is a planned expense and operating funds have been included in the Year 2012 Operating Budget. The original contract in the amount of $3,239,200 was approved by the Board of Managers in September 2007 for a five year term. Modifications #1 and #2 in the amount of $848,256 added funding to cover August 2011 through January 2012 invoices. Modification #3 in the amount of $550,000 adds funding to cover February through May 2012 invoices. Total of the contract including Modification #3 is $4,637,456. The increase in contract value is directly related to increased activity and expansion of the test menu. Staff has met internally and with ARUP representatives to discuss viable solutions of rectifying the increases in activity and cost. MedAssets pricing has been implemented into the current contract and the Health System is realizing 15% savings. Additionally, staff plans to utilize the services of a consultant who has extensive experience and expertise in the reference laboratory testing industry. Staff is also working on a request for proposal (RFP) for the reference laboratory services currently provided by ARUP. ARUP Laboratories has an Affirmative Action Plan or Policy in effect, and a total of 1,884 employees. The Workforce Composition Data was reviewed by the Board.

**RECOMMENDATION:** Staff recommends Board approval to modify contract # 2708228-IF for additional funds in the amount of $550,000 for payment of February through May 2012 invoices.

**ACTION:** A **MOTION** to approve a modification of this contract for additional funds in the amount of **$700,000** for payment of **February through June 2012** invoices was made by Ms. Cedillo, **SECONDED** by Mr. Briseno, and **PASSED UNANIMOUSLY**.
EVALUATION: Mr. Adams commended staff for the serious efforts to reduce the cost of laboratory services. He congratulated his Board colleagues for asking tough questions, and reiterated to staff that the Board does not like to see retroactive invoices. To conclude the arrears approval process related to this contract, Mr. Adams suggested increasing the amount of the funds approved by the Board today through June 2012.

FOLLOW UP: Staff will return in June with a summary of the responses to the RFP, and with data that compares the costs of running a laboratory in an academic hospital as opposed to a non-academic hospital. Dr. Jimenez suspects that it is more expensive to run a lab in an academic facility and he would like the increased costs justified as such. Mr. Briseno suggested that in the future, staff might negotiate these costs with the Health Science Center as something that the Health System provides as part of the joint teaching missions. Drs. Bryan Alsip and John Olson will work with the medical staff on the utilization management of reference lab testing and in-house lab testing. They will continue to work with the Lab Utilization Advisory Subcommittee and the consultant to develop procedures that address overall lab utilization as well as long term solutions and ideas.

REPORTS AND EDUCATION:

REPORT ON REGIONAL UPL PROGRAM – PEGGY DEMING:

SUMMARY: Mr. Deming provided a summary of the benefit and value that the Bexar Regional UPL Program brought to the hospitals that participated in Bexar County since inception. With the approval by CMS of the 1115 Waiver that became effective October 1, 2011, the Bexar UPL Program has ended.

UPL programs existed and became critical as a means to reimburse hospitals for Medicaid patients up to the amount the Federal government would pay for similar services funded by Medicare (the Upper Payment Limit). Over the life of the Regional UPL program the Texas Legislature enacted several rounds of payment cuts to hospitals who are now reimbursed at an average, 56% of their cost.

On March 3, 2005 the Health System entered into a Bexar County Indigent Care Affiliation Agreement with the County’s largest providers of health care services to the poor (Affiliated Hospitals) to design and implement the Regional UPL Program for the benefit of the local community. The Regional UPL Program created a collaborative working relationship amongst the Affiliated Hospitals that allowed for an expansion of health care services to the poor by bringing additional Federal funds to Bexar County at no additional cost to taxpayers. Over the life of the program, the Board took the following actions on matters related the Regional UPL Program:

- Approved for development in August of 2006
- Approved the Conditions of Participation in August of 2008
- Approved continuing participation in August 2009
• Approved expansion of Christus Affiliates in November 2009
• Approved expansion of Baptist Affiliates

Participating hospitals included:

• Christus Santa Rosa
  o Added affiliated St. Elizabeth, St. Michael and Spohn Beeville hospitals in November 2009
• Methodist Healthcare System
• Vanguard – Baptist Health System
  o Added affiliated Valley Baptist Medical Center in Brownsville and Harlingen
• Southwest General Hospital
• Nix Hospital

On a quarterly basis, the Affiliated Hospitals provided information regarding the indigent care services that their respective organizations provided in the Community. Contributing to their ability to help address a growing need of services to the poor in our community was an overall benefit of $89 million to each of the larger systems from new Federal funding made available by the program. The value to the Health System was a similar amount of $89 million in relieved services.

RECOMMENDATION: None.
ACTION: None.
EVALUATION: None.
FOLLOW UP: None.

REPORT REGARDING THE 1115 WAIVER PROGRAM—GEORGE B. HERNANDEZ, JR./PEGGY DEMING

SUMMARY: In advance of today’s meeting, staff provided a detailed, written report identifying the key components of the 1115 Waiver (the Waiver) that was developed by the Code Red Task Force on Access to Health Care in Texas. At today’s meeting Mr. Hernandez and staff provided a graphics presentation on how the Waiver can help the Health System achieve its strategic goals and initiatives aimed at improving: quality and outcomes; the patient experience; efficiency; and access across the continuum of care.

Background information included Texas legislative direction to the Health and Human Services Commission to achieve cost savings by providing Medicaid through a managed care program throughout the state, a change which shift operations from a fee-for-service model to a capitated managed care delivery system. The phase in of this capitated model began in September 2011 and will be completed in March 2012. To achieve avoid the loss of more than $2 billion in UPL payments to hospitals, the Health and Human Services Commission worked with the federal Centers for Medicare and Medicaid Services (CMS) to both keep the funding for hospitals and expand Medicaid managed care. To
achieve these goals, CMS required the state to submit and negotiate an agreement in what is called a federal 1115 waiver. CMS approved the 5-year waiver on December 12, 2011 (October 1, 2011 to September 2016). During year 1, HHSC will make transition payments to hospitals and physician groups that received supplemental payments. During year 2, the waiver will replace the UPL program methodology with two pools, 1) Uncompensated Care (UC) Pool; and 2) Delivery System Reform Incentive Payment (DSRIP) pool.

UC Pool Payments are designed to help offset the costs of uncompensated care provided to Medicaid eligibles or to individuals who have no funds or third party coverage for services provided by the hospital or other providers.

DSRIP Pool Payments are available as incentive payments to hospitals that develop programs or strategies supporting hospitals’ efforts to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served.

Under the waiver program, eligibility to receive payments from either of the funding pools described above will require participation in a Regional Healthcare Partnership (RHP). RHP regions will be developed throughout the state with each RHP. Each RHP will be ‘anchored’ by a public hospital or by the governmental entity providing IG. The ‘anchor’ will be responsible for coordinating with other participating entities in the development of the RHP plan and for being the single point of contact for reporting with HHSC.

At a minimum, the RHP plans for DSRIP will identify the participating partners, community health care needs, the proposed projects, and funding distribution. There are four program categories from which RHPs may select to receive DSRIP funding. HHSC is working with hospitals and other organizations to develop a list of DSRIP projects for approval by CMS. The DSRIP Project Categories are as follows:

**Category 1: Infrastructure Development** – addresses investments in people, places, processes and technology (i.e. expand primary care/behavioral health capacity).

**Category 2: Program Innovation and Redesign** – includes the piloting, testing and replicating of innovative care models (i.e. primary care redesign, medical homes).

**Category 3: Clinical Quality Improvements** – major improvements in care provided in hospitals that can be achieved within a four year time span, e.g., reduced central line infections

**Category 4: Population Focused Improvements** – includes reporting measures across several domains based on regional/community needs that will favorably impact the healthcare delivery system (i.e. patient experience, preventive health).
Waiver funding from both pools requires a state funds match. Public hospitals and other public entities can provide a state funds match by making an Intergovernmental transfer (IGT) provided state law permits. Private entities (e.g., private hospitals) are not permitted to make an IGT under federal law. Texas public entities must develop mechanisms in collaboration with private entities to grow IGT in order for the waiver to be successful.

Finally, Mr. Hernandez reviewed the HHSC implementation schedule in detail with the Board.

**RECOMMENDATION:**  None.  
**ACTION:**  None. This report was provided for informational purposes only.  
**EVALUATION:** None.  
**FOLLOW UP:** None.

**ADJOURNMENT:**

There being no further business, Mr. Adams adjourned the public meeting at 3:50 p.m.

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James R. Adams    Rebecca Q. Cedillo  
Chair, Board of Managers   Secretary, Board of Managers

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Sandra D. Garcia, Recording Secretary