University Health System

BEXAR COUNTY HOSPITAL DISTRICT
BOARD OF MANAGERS

Tuesday, February 19, 2019
2:00 p.m.
Cypress Room
University Hospital
4502 Medical Drive
San Antonio, Texas 78229
MINUTES

BOARD MEMBERS PRESENT:

Ira Smith, Vice Chair
Dianna M. Burns, M.D., Secretary
Robert Engberg
Janie Barrera
James C. Hasslocher

BOARD MEMBERS ABSENT:

James R. Adams, Chair
Roberto L. Jimenez, M.D, Immediate Past Chair

OTHERS PRESENT:

George B. Hernández, Jr., President/Chief Executive Officer, University Health System
Bryan Alsip, M.D., Executive Vice President/Chief Medical Officer
Edward Banos, Executive Vice President/Chief Operating Officer, University Health System
Tommye Austin, Ph.D., Chief Nurse Executive, University Health System
Dallas Connor, Administrative Resident, Texas State University
Ted Day, Executive Vice President, Strategic Planning and Business Development, University Health System
Theresa De La Haya, Senior Vice President, Health Promotion/Clinical Prevention, University Health System
Sergio Farrell, Senior Vice President/Chief, Ambulatory Services, University Health System – Robert B. Green Campus
Reed Hurley, Executive Vice President/Chief Financial Officer, University Health System
Luci Leykum, M.D., Professor, Department Medicine/Hospital Medicine, UT Health San Antonio
Monika Kapur, M.D., M.P.H., President/Chief Executive Officer, University Medicine Associates
Virginia Mika, Ph.D., Executive Director, CareLink Financial Assistance Program, University Health System
Leni Kirkman, Senior Vice President, Strategic Communications and Patient Relations, University Health System
Bill Mundt, Deputy Chief Information Officer/Information Services, University Health System
Charles Reed, Associate Chief Nursing Officer, Clinical Excellence and Ancillary Services, University Health System
Serina Rivela, Associate General Counsel/Legal Services, University Health System
Michael Roussos, Hospital Administrator, University Hospital

Armando J. Sandoval, Chief of Police, Protective Services, University Health System
Stephanie Stiefer, Executive Director/Dialysis Services, University Health System
Christine Stoufle, Director, Ambulatory Operations/Renal Dialysis, University Health System - Texas Diabetes Institute
Emily Volk, M.D., Senior Vice President/Clinical Services, University Health System
Shelby Walker, Administrative Resident, Texas State University
Jim Willis, Vice President/Associate Administrator, University Hospital
Stan Studer, Chairman of the Board, Touchstone Communities
Bryon Sehlke, President, Touchstone Communities
And other attendees.

CALL TO ORDER AND RECORD OF ATTENDANCE: IRA SMITH, VICE CHAIR, BOARD OF MANAGERS

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

INVOCATION AND PLEDGE OF ALLEGIANCE

Mr. Daryl Green, Resurrection Baptist Church in Schertz, Texas, said the invocation and Mr. Smith led the Pledge of Allegiance.

APPROVAL OF MINUTES OF PREVIOUS MEETING(S): November 6, 2018 (Regular Meeting); November 13, 2018 (Regular Meeting); December 4, 2018 (Special Meeting); December 6, 2018 (Special Meeting), and December 18, 2018 (Special Meeting).

SUMMARY:	Five (5) sets of 2018 Board minutes, listed above, were submitted for approval.
RECOMMENDATION:	Staff recommends approval of the minutes as submitted.
ACTION:	A **MOTION** to approve staff's recommendation was made by Mr. Engberg, **SECONDED** by Ms. Barrera, and **PASSED UNANIMOUSLY**.
EVALUATION:	None.
FOLLOW-UP:	None.

NEW BUISNESS - CONSENT AGENDA:

CONSIDERATION AND APPROPRIATE ACTION REGARDING THE APPOINTMENT/REAPPOINTMENT(S) TO THE BOARD OF TRUSTEES OF THE UNIVERSITY HEALTH SYSTEM PENSION PLAN — *ROBERT ENGBERG, CHAIR, NOMINATING COMMITTEE*

CONSIDERATION AND APPROPRIATE ACTION REGARDING THE APPOINTMENT/REAPPOINTMENT(S) TO THE BOARD OF DIRECTORS OF THE UNIVERSITY HEALTH SYSTEM FOUNDATION — *ROBERT ENGBERG, CHAIR, NOMINATING COMMITTEE*

SUMMARY: The items above were presented for the Board's consideration as consent items. The following details are associated with these consent items:

Consideration and Appropriate Action Regarding the Appointment/Reappointment(s) to the Board of Trustees of the University Health System Pension Plan — *Robert Engberg, Chair, Nominating Committee* - The Bylaws of the University Health System Pension Plan

Board of Trustees state that the Board of Managers as the governing body shall approve the appointments of Pension Plan Trustees. There are currently eight members on the Pension Board of Trustees. The Nominating Committee of the Board of Managers recommends that Mr. Kevin Harris, Mr. Reed Hurley, and Ms. Theresa Scepanski be re-appointed to the Pension Board of Trustees, effective immediately through December 31, 2023.

Consideration and Appropriate Action Regarding the Appointment/Reappointment(s) to the Board of Directors of the University Health System Foundation — *Robert Engberg, Chair, Nominating Committee* - The University Health System Foundation is a 501(c)(3) charitable organization founded in 1983 to solicit, receive and maintain funds exclusively for the benefit of University Health System and the community served through its charitable mission. The Board of Managers, as the governing body, shall approve appointments to the Board of Directors of the Foundation. The Nominating Committee of the Board of Mangers recommends approval of the appointment of community leader, Mr. Gerald Lee to serve a three-year term on the University Health System Foundation Board effective immediately through December 31, 2021.

RECOMMENDATION: The Nominating Committee recommends approval of the appointments and re-appointments to the Pension Plan Board of Trustees, and the University Health System Foundation, for the respective terms indicated above.

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

EVALUATION: None.

FOLLOW-UP: None.

PRESENTATIONS AND EDUCATION:

OPERATIONS AND PATIENT FAMILY ADVISORY COMMITTEE REPORTS — *EDWARD BANOS*

SUMMARY: Mr. Banos introduced Dr. Luci Leykum, Professor, Medicine/Hospital Medicine. She reviewed the establishment of a patient family advisory council (PFAC) is a requirement for Patient Center Medical Home (PCMH) certification. The Inpatient Patient Family Advisory Council (IP PFAC) at University Hospital started in 2015 with a collaborative effort of UT Health San Antonio physicians. The goal of this council was to create an environment where patients, families, and clinicians provide feedback in a collaborative care methodology. Patients, families, and providers partner in creating high-quality care integrated across professions and responsive to the needs of individual patients. Mr. Banos and Dr. Kapur recalled that as the IP PFAC developed, leadership saw the opportunity to enhance the Primary Care Patient Family Advisory Council (PC PFAC) for ambulatory. In 2018, the journey to expand the PC PFAC began. Currently, there are monthly meetings that occur for the following regions: Southeast, Southwest, and the Texas Diabetes Institute. Mr. Banos reviewed the timeline starting October 2015 with the first IP PFAC meeting at University Hospital, expansion of scope in 2016, to 2017 when Pediatrics joined IP PFAC, 2018 when

ambulatory PC PFACs were implemented, Robert B. Green Campus PC PFAC mission statement was created, and outcome evaluation tool was implemented. He reviewed the current PFAC structure with UT Health and University Hospital IP PFAC as the leaders on the organizational chart.

Mr. Banos also reviewed the impact the PFACs have on University Health System and the described the various projects worked by the PFAC for the period 2012 to present, and reviewed successful PFAC projects and respective outcomes. He explained the concept of "Design Thinking to Improve the Patient Experience," a three-pronged approach to complex problem-solving. He also reviewed recruitment practices by both UT Health and the Health System for enlisting health care providers who wish to improve the quality of patient care, help plan changes to benefit patients, and provide feedback on various projects. Future PFAC initiatives include:

- Greater coordination across PFACs
  - Increase number of projects per year - Implement process to measure outcomes of PFAC-partnered projects
- Expand to specific population ex: Pediatric PFAC, Women's Health PFAC
- Expand community outreach
- Implement recruitment process with Volunteer Services

Finally, Mr. Banos reviewed a proposed PFAC structure with one master Steering Committee comprised of UT Health/Health System senior staff and one staff liaison to oversee three Steering Subcommittees (UMA, RBG Campus, and University Hospital.)

RECOMMENDATION: This report was provided for informational purposes only.

ACTION: No action required by the Board of Managers.

EVALUATION: Mr. Banos acknowledged the assistance of all PFAC partners - Health System Administration, Nursing Administration, and Physicians partners, for their dedication to generating new and innovative ideas to advocate and enhance patient-centered care across the Health System. Ms. Barrera found the presentation to be very informative. She asked if PFAC duties were in addition their regular duties, in terms of budget. Yes, it is a labor of love. Mr. Hernandez praised the collaborative model that was selected by the Hospitalists; it encourages collaboration with patients. The same group will return to make a more formal presentation to the Board of Managers at a later date.

FOLLOW-UP: None.

AMBULATORY UPDATE — *SERGIO FARRELL*

SUMMARY: The Health System's ambulatory network is configured with University Medicine Associates (UMA) primary, urgent and outpatient specialty care along with UT Health San Antonio resident clinics. UMA in collaboration with UT Health San Antonio continues to provide accessible, comprehensive, quality primary and specialty care services in a compassionate manner. In response to the continuous demand for access over the years, the UMA provider group practice has grown from 15 physicians in 1999 to 92 physicians, 79 advanced practice providers (APPs) and 88 leased providers from UT Health San Antonio at the conclusion of

2018. The Health System and UT Health San Antonio work together each year on providing faculty coverage for the resident clinics. In 2018, there were 733,970 patient visits provided by UMA and the Health System supported UT Health San Antonio clinics. UMA has 143,067 unique patients driving 505,142 visits across all Health System locations. UT Health San Antonio resident clinics saw 228,828 patient visits across all locations. To provide an alternative to emergency room care, UMA has two express meds locations (RBG downtown and pavilion sites) of which have grown from 79,132 visits in 2017 to 84,484 visits in 2018. In October 2018, template appointment-type slots were changed to time slots, which allows for same day availability and increased the fill rate from 84 percent to 90 percent. Mr. Farrell reported that a Vizient Median Performer facility schedules 56.91 percent of their new patient visits within 10 days of booking the appointment. He reviewed the Health System's percentage of new patient visits that are scheduled within 10 days of booking appointments for prior years: 2016 - 64 percent; 2017 - 63.4 percent; and 2018 - 63 percent.

Patient Experience - The Health System utilizes NRC as the vendor to survey and benchmark on patient satisfaction. NRC Connect was the platform utilized from 2016 through 2018. Ambulatory Services selected the question "would recommend clinic" as the performance metric to monitor overall patient satisfaction. Ambulatory Services experienced a 7.7 basis point improvement from 2016 and 2018 (80.9% to 88.6%). In an effort to standardize, simplify, and encourage a higher response rate, the Health System and UT Health San Antonio collaborated to consolidate the different surveys sent to patients. The survey was made exponentially shorter with standardized questions and moved to a real-time NRC platform. Along with the NRC patient satisfaction tool, the Health System utilizes social media reviews and Google star ratings for 2018. Mr. Farrell provided star ratings for all Health System ambulatory facilities, star ratings ranged from 5 (the highest) to 3.4. The lowest star rating is 1.

Cost and Efficiencies - Ambulatory Services has experienced a significant improvement in payer mix over the last six years, while still providing access to care to all patients regardless of coverage. In 2012, 50.7% of the patients seen at UMA had a funding source. In October of 2013, when the Affordable Care Act was implemented, Ambulatory Services increased funded patients by 10% to 60.8%. At the conclusion of 2018, greater than 70% of Ambulatory Services patients are funded. A focus for the Health system is to attract and retain the Medicare population. Since 2013, Medicare unduplicated patients grew from 11,195 to 14,089 in 2018, a 26% increase. To address provider productivity, starting in 2016, UMA set the base benchmark for provider productivity to be the 50th percentile of Medical Group Management Association (MGMA). In 2016, 22% of the UMA providers were at the 50% percentile of MGMA and in 2018, 34% achieved the 50th percentile of MGMA.

Quality Delivery System Reform Incentive Payment (DSRIP) Program - The Section 1115 Transformation Waiver approved by CMS in 2011 expanded the Medicaid managed care program statewide and created two new supplemental payment programs called the Uncompensated Care (UC) Pool and the Delivery System Reform Incentive Payment (DSRIP) program. The first DSRIP Program was 5-years in length and provided funding from

December 2011 to September, 2017. In December, 2017, CMS approved the second five-year renewal of Texas' 1115 Transformation Waiver from October 2017 through September 2022. This renewal included the continuation of the DSRIP program with four years of federal matching dollars. Whereas the first six years of DSRIP emphasized the implementation of transformation projects, the second phase of DSRIP prioritizes the achievement of outcome measures at the system level, transitions to alternative payment models, and the sustainability of healthcare transformation after the waiver authority ends. Since this program is outcome based, UMA made the decision to utilize these metrics as part of their quality based metrics. Mr. Farrell reviewed achievement of outcome metrics for the Health System's second phase of DSRIP projects:

- 5 Measure Bundles
- Total Measures - 35 (4 Clinical Outcomes, 25 Process Outcomes, 6 Population-based Clinical Outcomes)
- Baseline: Calendar Year 2017
- Improvement Years - DY7 - Calendar Year 2018; DY8 - Calendar Year 2019
  - Improve Chronic Disease management: Diabetes Care
  - Improved Chronic Disease Management: Heart Disease
  - Primary Care Prevention
  - Healthy Texans
  - Hepatitis C
  - Pediatric Primary Care

Achievement of Metrics - By the end of July 2018, ambulatory had met 13 out of 35 metrics. At the end of DY7 (December 2018), ambulatory services achieved 32 out of 35 metrics and secured 97 percent available funds, or $21.6m for the program. The three metrics that were not achieved included well child visits within the first 15 months of life, body mass index (BMI) screening for adults, and heart failure admission rate. Pediatrics has accommodated their scheduling templates to see more well child checks, BMI is currently achieving the established goal by modifying fields within the current electronic medical record, and the heart failure patients are being managed by a dedicated care transition team.

Opportunities – Care coordination integration for sustained DSRIP achievement; and ambulatory Epic EMR (Quality). Improve show rates; predictive scheduling; provider productivity; and ambulatory Epic (Access). Wait times-throughput; Facilities master plan updates; and ambulatory Epic (Patient Experience).

RECOMMENDATION: This report was provided for informational purposes only.

ACTION: No action required by the Board of Managers.

EVALUATION: Administrative and medical leadership feel confident that all metrics will be met in 2019. Mr. Hernández applauded ambulatory staff for their performance since the Health System loses money on the ambulatory side. DSRIP projects that the staff has been able to implement are a win for the patients and earn money for meeting quality metrics; they create new dollars for the ambulatory team to earn. DSRIP information was received from HHSC 6 months into the year and staff was still able to meet metrics. Dr. Kapur agreed that the staff must be nimble and innovative to carry these projects past DSRIP. Discussion ensued regarding quality metrics models versus cost saving models.

FOLLOW-UP: None.

ACTION ITEMS:

CONSIDERATION AND APPROPRIATE ACTION REGARDING SELECTED PURCHASING ITEMS:

CONSIDERATION AND APPROPRIATE ACTION REGARDING A CONTRACT WITH SELECTED VENDORS FOR AN ENTERPRISE IMAGING SYSTEM — *BILL PHILLIPS*

SUMMARY: Mr. Hernandez presented on behalf of Mr. Phillips. As the Health System transitions to an Epic Electronic Health Record (EHR) with a single source solution for its clinical imaging needs, physician partners have identified a need to store more than radiology images. The Health System currently uses Fuji Synapse Picture Archive Communication System (PACS). While adequate for radiology imaging storage, Fuji PACS does not support other Health System imaging needs. As a result, staff searched for a more comprehensive imaging solution in collaboration with interim Dean Rodriguez and later with Dean Hromas. Staff recommends an integrated imaging suite using a single platform design for imaging across the Health System that will facilitate integration with physician partners at UT Medicine, and interface much easier with the Epic EHR suite across multiple hospital service lines. The sole vendor providing this true enterprise imaging solution is AGFA Enterprise Imaging. AGFA's Enterprise Imaging solution focuses on cost, patient care, clinical efficiency, and ease of use across multiple service lines. UT Medicine has made a similar decision and plans to migrate to AGFA after its current vendor contract expires. Staff recommends implementing AGFA in three phases occurring over the next three years. Mr. Phillips provided a table describing the three Project Phases: Phase I (2019) Radiology & Infrastructure at a cost of $3,704,179; Phase II , (2020) Enterprise at a cost of $1,800,000; and Phase III (2021) Cardiology at a cost of $1,630,547, for a total of $7,134,726 over a three year period. Phase I expenditures include software and hardware. The cost of the software for year one is $2,269,427. The cost for hardware is $1,434,752 and includes servers and data storage. The total cost for Phase I is $3,704,179. Phase II and Phase III will be for additional software at a cost of $1,800,000 and $1,630,547 respectively. This is a planned capital expense and the dollars for Phase I and are included in the approved 2019 capital plan. The remaining funds for Phase II and III have been designated in the 2020 and 2021 capital plan. The vendor's workforce composition data was provided for the Board's review.

RECOMMENDATION: Staff recommends the Board of Managers approve procurement of the Enterprise Imaging Project Phase I in the amount of $3,704,179. This project and budget of $3,704,179 are included in the 2019 Capital plan previously approved by the Board of Managers. The costs will be expensed as follows:

- AGFA Healthcare Enterprise Imaging System $2,269,427 for software and implementation. This purchase is a sole-source acquisition.
- Sirius Computer Solutions $1,099,818 for data storage. This purchase is Exempt from the competitive bid process because this item is being purchased through the Group Purchasing Organization, State of Texas Department of Information Resources (DIR) Contract #DIR-TSO-4092 and is therefore considered to have been competitively bid.

- Presidio $334,934 for server environment. This purchase is Exempt from the competitive bid process because this item is being purchased through the Group Purchasing Organization, State of Texas Department of Information Resources (DIR) Contract #DIR-TSO-4167 and is therefore considered to have been competitively bid.

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

EVALUATION: Staff will return in 2020 and 2021 to request funding to finalize the project. However, time is of the essence. Mr. Engberg asked about reference information regarding AFCA and their historical experience in providing this broader service. Staff contacted other hospitals that have specific experience with AFGA and did not receive any negative feedback. AFGA has the longest history and they are a true enterprise radiology system, whereas other systems by other vendors are third party systems, not true enterprise radiology systems. AFGA is very much like Epic, one system across the whole continuum that comprehensively deals with all service lines. UT Health will sign a separate contract with AFGA when their contract with Fuji expires.

FOLLOW-UP: None.

CONSIDERATION AND APPROPRIATE ACTION REGARDING THE PROCUREMENT OF THIRD-PARTY SOFTWARE PRODUCTS FOR THE EPIC ELECTRONIC HEALTH RECORD PROJECT — *BILL PHILLIPS*

SUMMARY: The Health System will need to procure third party software that provides knowledge based/best practice content as part of its Epic enterprise suite build efforts. It will acquire some software products directly from the third party vendor of the product without Epic's involvement. However, Epic has assimilated certain products into the core Epic enterprise suite. Epic arranges and facilitates the purchase of these software products. Staff recommends procurement of Data Innovations Business Intelligence Suite software. Data Innovations is an Epic required product that allows for communication between Epic's Beaker lab and Health System's lab instruments. This product is middleware software that converts messages from different makes and models of lab instruments into a standard format and provides communication with the Epic system. This software product is required by Epic as part of the Epic implementation. The cost for this software acquisition is $379,667 one-time. The annual maintenance fee is $35,108. The total cost of this acquisition including maintenance is $414,775. The workforce composition data was not available at this time.

RECOMMENDATION: Staff recommends the Board of Managers approve procurement of Data Innovations Business Intelligence software in the amount of $414,775.

ACTION: A **MOTION** to approve staff's recommendation was made by Mr. Hasslocher, **SECONDED** by Ms. Barrera, and **PASSED UNANIMOUSLY**.

EVALUATION: None.

FOLLOW-UP: None.

CONSIDERATION AND APPROPRIATE ACTION REGARDING PARTICIPATION IN THE THIRD YEAR OF THE QUALITY IMPROVEMENT PAYMENT PROGRAM (QIPP) FOR SKILLED NURSING FACILITIES WITH LICENSES OWNED BY THE HEALTH SYSTEM AND MANAGED BY TOUCHSTONE COMMUNITIES AND AUTHORIZING ALL ACTIONS IN SUPPORT THEREOF— *TED DAY/BRYAN ALSIP, M.D.*

SUMMARY: Under the Quality Incentive Payment Program (QIPP), skilled nursing facilities can earn supplemental payments based on improved performance on four specific quality indicators currently utilized by the Centers for Medicare and Medicaid Services' (CMS) star ratings for nursing facilities. Year 1 of the QIPP program began September 1, 2017, and ended August 31, 2018. The Board approved QIPP program participation for Year 2 on March 27, 2018, for the period September 1, 2018 through August 31, 2019. In an effort to address the input of multiple stakeholders, HHSC has proposed and adopted new rules related to the upcoming Year 3 of the SNF QIPP program, set to begin in September, 2019. Based on input from a workgroup composed of representatives from private and public nursing facility owners and operators, managed care organizations and advocacy groups representing nursing facility providers and clients, Health & Human Services Commission (HHSC) proposed a redesigned Skilled Nursing Facility (SNF) QIPP program to include higher standards for improvement and widened eligibility requirements to include more Medicaid nursing facility clients. Facilities participating in SNF QIPP will now be measured against four different components as follows:

- *Quality Assurance and Performance Improvement (QAPI) Meetings*: SNF holds these meetings monthly;
- *Infection Control Program*: SNF demonstrates improvement/compliance with three quality metrics against quarterly targets;
- *Workforce Development*: SNF demonstrates compliance with three staffing-related metrics; and
- *CMS Five-Star Quality Metrics*: SNF demonstrates improvement with three quality metrics against quarterly targets (5 percent improvement each quarter).

The quality metrics for SNF QIPP Year 3 include rates for the following:

- Residents whose ability to move independently has worsened;
- Residents with a urinary tract infection,
- Residents whose pneumococcal vaccine is up to date, and
- Infection control program that includes antibiotic stewardship.

The Health System has also required the linkage of selected financial incentives for Touchstone Communities based on their performance around readmission rates. Furthermore, Health System clinical leadership also continues to routinely monitor overall performance related to other governmental requirements such as Value Based Purchasing and CMS Star Rating Programs. The primary financial obligation for the Health System under this partnership arrangement is to provide the Intergovernmental Transfer (IGT) funds to support the state portion of the supplemental Medicaid payment. The funds are then returned to the Health System through the payments made by the managed care organizations (Amerigroup, Molina, and Superior HealthPlan). The Health System recoups the IGT funds as well as 50 percent of supplemental payments.

The other 50 percent of the supplemental payments are paid to Touchstone Communities. These funds are at risk and tied to the quality and access measure performance described above. Estimates for the IGT required for participation in the third year have not yet been provided; however, the amount is anticipated to increase since the overall funding pool allocated to this program will increase from $446M in Year 2 to $600M in Year 3. The Health System will receive a return of 10 percent on the IGT amount submitted and will receive the IGT funds back within several months.

RECOMMENDATION: Staff recommends that the Board of Managers approve participation in the third year of the Quality Incentive Payment Program (QIPP) for Skilled Nursing Facilities with Licenses Owned by the Health System and Managed by Touchstone Communities and authorize the President/Chief Executive Officer to execute all actions in support thereof.

ACTION: A **MOTION** to approve staff's recommendation was made by Mr. Hasslocher, **SECONDED** by Ms. Barrera, and **PASSED UNANIMOUSLY**.

EVALUATION: Due to the changes to the design of the Year 3 SNF QIPP program, the Health System's financial estimates may be similar to payments in Years 1 and 2, but that amount is not yet confirmed. Variables still in play include the final number of participants, volumes of Medicaid days, and performance of participating facilities against the new metrics for Year 3.

FOLLOW-UP: None.

CONSIDERATION AND APPROPRIATE ACTION REGARDING A DONATION TO THE AMERICAN KIDNEY FUND IN SUPPORT OF CARELINK MEMBERS FOR CONTINUOUS MEDICAL INSURANCE COVERAGE — *VIRGINIA MIKA, PHD/ THERESA DE LA HAYA*

SUMMARY: The Health Insurance Premium Program (HIPP) was initiated by the American Kidney Fund and pays premiums for Medicare Part B, COBRA, Medigap, and commercial policies and is authorized by the Centers for Medicare & Medicaid Services (CMS). Over 72,000 patients nationwide receive assistance annually and over 250 dialysis facilities participate. Blue Cross/Blue Shield (BCBS) is the only health plan that provides a Marketplace product to the undocumented population and to individuals who have a pre-existing condition. For this reason, the Health System has chosen to work with BCBS to enroll the Health System's unfunded dialysis patients. CareLink has approximately 140 patients with kidney failure in need of dialysis and other specialty services. To date, staff has been able to enroll 134 patients into private insurance. The purpose of this donation is to help provide medical insurance to high cost, high need patients who have diabetes and require dialysis. The total monthly premium for these 134 patients is $138,612. To cover a year of premiums the cost is $1,663,344 plus a 5.75 percent programmatic fee required by AKF for a total of $1,758,986. This is a planned expense and funding was included in the 2019 Operating Budget. The increase in revenue will more than offset the cost of the donation. Since January 2017, the Health System Dialysis Services and CareLink have been successful in obtaining funding for dialysis patients who could not afford coverage. In 2017, the number of BCBS/American Kidney Fund patients was 47, and the Health System's

contribution was $447,384. In 2018, the number of BCBS/American Kidney Fund patients was 120, and the Health System's contribution was $1,727,595. The American Kidney Foundation's workforce composition was provided for the Board's review.

RECOMMENDATION: Staff recommends Board of Managers' approval of a donation to the American Kidney Fund for a one-year period for an estimated amount of $1,758,986.

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

EVALUATION: Mr. Smith asked if the Health System is currently meeting the dialysis needs of its patients. Yes, considering the size of the service area. Staff continues to look at the number of chairs available. When the Health System loses a patient, staff reviews the data to ensure it has chairs available at the right location. The staff strives to keep these patients safe and healthy, and also out of the Emergency Department. At the present time, the Health System has a total of 476 patients at the four outpatient dialysis centers, and every center has chairs available. Many patients with commercial insurance receive dialysis on a daily basis. Ms. Barrera observed that the staff's written report indicates 68 people work for AKF, and the local office has had some issues due to availability of funds. This program is handled by the national office, however; staff also deals with the local office. Health System donations to AKF are made quarterly, and staff focuses on ensuring that the cost per treatment aligns with the benchmark of $150 each (or $23,000 per patient per year). However, Mr. Engberg noted that there is more to the cost side of this arrangement when the contribution and cost associated per treatment is taken into account, does not include, example, equipment and overhead.

FOLLOW-UP: None.

ADJOURNMENT:

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

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Ira Smith
Vice Chair, Board of Managers

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Dianna M. Burns, M.D.
Secretary, Board of Managers

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Sandra D. Garcia, Recording Secretary