REGION 15-REGIONAL HEALTHCARE PARTNERSHIP

Friday, April 19, 2013

1:00 p.m.

El Paso First Health Plans, Inc.

1145 Westmoreland Drive

El Paso, Texas 79925

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| PRESENT | PRESENT |
| James N. Valenti, President & CEO, Region 15 AnchorCathy Gibson, CCO, Lead Waiver Representative-UMCMichael Nuñez, Chief Financial Officer-UMCFrances Hansen, Gjerset & Lorenz (Via conference call)Carissa Magee, HHSC (Via conference call)Bruce Parsons, City of El Paso Health DepartmentRobert Taylor, El Paso Health DepartmentJim Paul, Hospice of El PasoDomingo Betancourt, Tender Home HealthTom McConnell, Tender Home HealthAna Rodriguez-McConnell, Tender Home HealthCynthia D. Horton, VNADavid Palafox, El Paso County Medical SocietyFrank Dominguez, El Paso FirstMargaret Althoff-Olivas, UMCJavier Gonzalez, UMC, Care ManagementMaria Sanchez, UMCJoe Garcia, UMC, Cardiovascular Svcs Director | Maria Zampini, VP Operations, UMCSarah Allen, Outpatient Clinic DirectorBlas Meza, UMCDavid Smead, UMCLorrie Giessel, UMCLeticia Flores, UMC, ControllerRene Navarro, EHNMaj. Mark Morton, Salvation ArmyPatricia Duran, Sierra Providence Health NetworkDaniel Jackson, SPHNHomero Guaderrama, Sierra Providence EastM. Romano, M.D., TTUHSCOscar Perez, TTUHSC, Project ManagerPaul Ocon, EPCH **SUPPORT STAFF**Betsy Castillo, Executive Assistant, CEOVeronica Candia, Compliance GeneralistMaria Luisa Escobar, Recording Secretary |

###### 1. CALL TO ORDER & WELCOME

Ms. Gibson called the meeting to order at 1:05 p.m. and proceeded to the conference call with HHSC representatives and Ms. Frances Hansen from Gjerset & Lorenz. She noted that feedback from CMS had just been received and was distributed to the attendees. CMS is hopeful that the projects can be approved with some modifications and it was noted that CMS was very positive on the ability to make changes to the items that were in the “other category” and did not have sufficient justification for evidence based projects and no strong documentation. CMS also wants to assure that there is a clear evidence based outline that explains a compelling justification for why they have the planning protocols and they want to see that it truly benefits the Medicaid or uninsured population in the area. CMS would like to see evidence based with some literature sited in the past ten years for that project. If the project already existed for DSRIP, how is that project being improved and it is a matter of just providing more details on those particular projects.

It was noted that they received the evaluation at the same time that Region 15 did and most of these areas sited were for patient satisfaction outcomes in projects that CMS has looked at a few different factors for evaluation; among those is the population served and an evaluation for a hospital versus a community health center. CMS is grouping different types of projects to see what they need to access the care projects or to redesign and improve the grouping of the project options that were similar. They are looking at the various projects based on the provider side and the outcomes if we were a common band of values for similar projects. If you did fall outside of those i.e. you had patient satisfaction, they are looking for providers to choose as a measure and for customer satisfaction to be removed from Category III and focus more on outcomes. They want to see more justification for patient satisfaction.

It was noted that the way that they structured the feedback is the project being labeled “non-approval” and will have an initial focus on the recommendations to the project as made by CMS to the providers and these will be the priorities. In order to approve the evaluations and be able to identify the alternative core measure for this project.

Ms. Hansen noted that in a couple of past calls there was the impression that CMS is trying to change the structure or wrap that around the “Category III” and could Ms. Magee provide any information on what the “Category III” shift might be. Ms. Magee noted that HHSC continues to work with CMS on the overall changes in the methodology for Category III and in general they continue to work with the same measures you see on the menu. When providers are looking for alternative measures they can look at the various measures on the menu; i.e. the primary care measures. Ms. Magee added that another thing they will be doing is working with some of the “other outcomes” for healthcare providers and working with those they can add a protocol and define those measures with a common methodology for calculating. They will be working with CMS on the actual achievement level related to Category III Outcomes but they have not fully defined that aspect of Category III Methodology. The providers initially can identify a clinical outcome that could be relevant to the project activity and they can gather data but they need measures and the existing protocols.

Ms. Hansen noted that there were a lot of providers providing clinic projects, were there any outcomes that could be measured for those outpatients easily. Are there any recommendations on what they could look for in outpatient clinics? Ms. Magee responded that one recommendation would be to target more outpatient measures, such as blood pressure, medication measure, etc. as that would be a good starting place. She added that providers can, if they see that there could be long term effects in other areas related to the outpatient/primary care setting. These are clinic related to hospitals with the potential domains where they could make a long term impact. Ms. Magee added that there could be additional resources and they will talk to a physician they have on the team who is part of the clinical foundation to make suggestions for specific measures.

Ms. Gibson noted that RHP15 would need to work with Ms. Magee on several items specifically the “Other Choices”. It was understood that evidence based criteria was requested however it looks like every “Other Choice” was denied whether or not it had criteria and they need to work with HHSC to clarify what is requested. She added that what they did with the clinics was to take the PPR’s and preventable complications and put it in an “other category” so as to focus on those patients discharged to our clinics and prevent readmissions of the hospital. Is it being suggested that they utilize hospital statistics for the clinic outcomes? Ms. Magee responded that it depends on how it is going to be related to the project but you can use the measures if it is client involved with that particular intervention and if you are able to track the PPE events related to that specific client population. Ms. Magee added that if they could apply the PPR information to that population it could help a lot.

Ms. Gibson stated that it looks like CMS will not be approving projects on a basis of patient satisfaction and Ms. Magee explained that there would not be a problem with patient satisfaction as long as there are documented outcomes and also there could be a problem when that is tied to a high value end project. Ms. Gibson explained that Region 15 is utilizing HCAPS.

Ms. Sarah Allen, UMC Clinics Director noted concern on ruling out something that was in the guidelines as a choice and patient satisfaction is gaining incredible attention and noted that the HCAPS questions are very tough and cover a variety of things and she read and excerpt of the questions. She added that many of the patients only come in on an urgent nature, which they are trying to change, it can be very hard and it is important to look at what is a good measure as well as the clinical growth Ms. Magee responded that they are aware there was a menu option and reviewing the projects that were identified that were initially throughput and project value. She noted that some of the projects were related to patient satisfaction. Ms. Magee added that they are not rejecting on a basis of patient satisfaction but they are asking to adjustment to the values and measures. The other thing related to Category III denial specifically will need to be looked at closely on the basis of the outcome and how these were proposed as there are several that are included without physician justification..

Ms. Magee stated that there are some measures that providers thought were more appropriate but they did not find in the menu and they are willing to look at alternative measures to look at unique needs in the area.

Dr. Romano expressed some concern on the project options and being off menu as it was said initially that it was preferable to find one, define project options and then explain, in the narrative as why you did not do a certain element in that project option and Ms. Magee noted that was correct. He added that the PFN now says that you have to do every single one of those elements and Ms. Magee added that in the initial protocol it is addressed and she will look up the exact language. Dr. Romano added that his second point includes where a number of critiques on how a particular project addresses an area of heightened need for Medicaid and uninsured and is the issue whether the patient served or is going to be heavily represented by Medicaid or are uninsured, or is the question, you serve this population but why do they need this service or both. The general approach that Texas Tech took was to provide information on what the historical population has been and where they are putting these people into and the language used in all of the projects was essentially the same in terms of what the patient population is. Therefore they were surprised to see this as an issue making a project unapprovable on some but not an issue of others. Ms. Magee noted that in some of the cases they did not comment on some of the projects but there were others where they wanted to see more specific Medicaid/uninsured impact. She noted that CMS would like to see community need and specific service in that area. A separate participant in the call noted that specifically specialty care, what CMS is looking for is if there are tons of projects they want to assure that there is a focus on patients that would not be billed for those services such as the uninsured population.

Dr. Romano further inquired of projects that are non-approval at this point can they assume that the valuation is OK if they address the CMS concern or is there going to be a review after that? Ms. Magee noted that they would like to see beforehand that they are going to get feed back as to what you are going to do to try and meet the requests of CMS but they are still defining the final rules especially with DY 4 and DY5.

Ms. Hansen inquired if there was a project that was valued at $5M and CMS reduced the value to $3M from her understanding there are a couple of options 1) they could modify the project and add more pieces and give more details. 2) you could substitute it with a totally different project for the total of the $5M and 3) to propose a project for the difference, being the $2M. Is that something that CMS is looking into and Ms. Magee responded that at this point if the project has to meet approval with the exception of the evaluation they will not be able to add an additional project therefore you would have “beef up” the original project or change it out for another project.

Ms. Hansen inquired if there was a point person assigned to Region 15 that they could contact or is it all done through HHSC. It was noted that HHSC representatives would be working with Region 15 rather than having direct contact with CMS. If there is a point in time where coordinated conversations are required with CMS you could do that but there is no direct communication from a provider to CMS. If a reduced value for a project is proposed those projects at this time they are not looking that will have potential replacement. These are only for the projects that were not approvable at this time. They are looking at if a project has an alternative valuation that they strengthen that project or accept that project at a lower value.

Mr. Valenti inquired of Table V with the projects that have a lower adjustment value according to CMS and so the mission on Table V is to keep the project but try to strengthen the project so that you can obtain the increased valuation or just be satisfied with what CMS has agreed to. Ms. Magee so noted adding that they have included comments on what is needed to get to the full valuation.

Mr. Valenti inquired if CMS is in a bonafide way really going to look at the strength of a project or are they really not open. Everyone is going to go back and see how they can strengthen a project but they want to make sure that they are not blown off by CMS. Ms. Magee noted that they have had conversations with the other regions and the expectations at this time for example if patient satisfaction is a value that is proposed, CMS has indicated that if there is a proper outcome for patient satisfaction that the proposed value would then be accepted. Mr. Valenti noted that he would like to makes sure as they have spent thousands of hours to submit the information with another hundreds of hours to redo, they would like to know that CMS in a bonafied way will be able to evaluate and possibly grant, depending on the strength of the project in satisfying the comments received and is flexible and that it is not a fruitless effort.

Mr. Valenti noted that Table VI shows projects that were absolutely not approved and Ms. Magee clarified that those projects are currently not initially approved but CMS is looking at those projects is providing recommendations rather than start on new projects and by reviewing the changes that they are proposing to change to the project to help providers before they make the changes.

Mr. Valenti inquired on the roadmap from this point to October 1, 2013 and Ms. Gibson noted that there will be some work sessions with HHSC to address some of the issues and now would be a good time. Ms. Magee explained that they are looking towards making revisions to the plans and will work with those whose projects were on the not approved list in general and also those projects that initially went through with the exception of the change to the evaluation to make the necessary revisions. They will taking the revisions to the project by October 1, 2013 and will be reviewed and have the final issues reviewed by March 31, 2014 by CMS.

Ms. Gibson inquired as to how they begin the process of working through the identified issues and Ms. Magee recommended that they can send a request for a textbook session to review the questions submitted. It was noted that HHSC is working on a guidance document on the organized process for managing the CMS results letter.

Ms. Gibson stated that starting today at noon, Region 15 has 30 days to resubmit the plan and CMS has 15 days to respond back and Ms. Magee noted that they have a lot of plans to get back to CMS and will be working with regions to establish a feedback timeline but there are no specific dates for specific regions.

Mr. Valenti stated that in reading through some of the comments it is hard to understand the recommendations made and he recommended that the attendees list their questions specifically or series of questions specifically to each project to Ms. Gibson and between Ms. Gibson and Ms. Hansen they will look at them and package all the questions together to either do the workshop or submit to their mailbox for answers. He added that his philosophy was to work in the most expeditious manner to comply with the deadlines and as such this region has been meeting once per month through all the developments. Ms. Magee stated that the region is going down the right path and it efforts are appreciated and specifically if they can get a specific list of questions to review to prepare for any technical assistance that may be required. The responses would then be submitted back to the regions at the same time they are submitted to CMS.

Dr. Romano inquired if there is a resubmission document available that would be taking the plan that has gone through CMS review and was redlined or will it be a two page summary addressing specific points? Ms. Gibson responded that it would be the entire plan and Ms. Magee added that they are working on the approach and putting together the clean version that they submitted and it will be more on the individual questions submitted.

**2. APPROVAL OF THE MINUTES FROM THE MARCH 27, 2013 MEETING.**

Mr. Valenti noted that the minutes were on the website at [www.epchd.org](http://www.epchd.org) and invited any comments from the audience. Hearing no comments the minutes for March 27, 2013 were adopted as presented.

**3. CONFIRMATION OF PARTICIPANTS – ROLL CALL**

Mr. Valenti noted that in the interest of time there would be no Roll Call as everyone present had signed in.

**4. RECAP FROM ANCHOR CALL 4/12/2013 AND PFM PPROTOCOL REVISED 4/4/13.**

 Mr. Valenti noted that only 30% of Region 15’s Plan has been approved at $150M of a total valuation of $500M for the Region. He added that there is a lot of work to be done and Ms. Gibson noted that some of the rules were changed and they are now providing some flexibility. Mr. Valenti noted that we need to utilize their mailbox to submit our questions. Ms. Gibson added that additional data can be compiled to justify the amount of the unfunded population that would require services in a lot of specialty areas. Dr. Romano requested that Ms. Gibson email CMS on further clarification of the comments. Mr. Parsons noted that for Category III it seems that the improvements were an older generation of the project because changes were made but apparently they were operating off an early version of those documents.

 Ms. Hansen noted that this is the fourth plan that she has reviewed and the percentage of projects rejected or needing fixes and CMS is rejecting a lot of projects. It is about moving targets and CMS changing its mind and not communicating everything on a timely basis. She anticipates that they will be able to move all the projects to the approved column.

 Ms. Gibson noted that all the plans are loaded on the website in the event that they want to replace some of the projects. She stressed that questions need to be submitted to her within the next two weeks. Revisions were made to the protocol and it is on the website with changes particular to Section IV and VII. DY4 and DY5 will be the justification of the patients’ perspective benefits and that will be done by the end of September. HHSC will be holding a webinar in the next few weeks to address the changes made to the protocol. There will be a requirement to submit a semi-annual report on the progress of our projects in a form of a narrative due in the middle of each year going forward. HHSC will be contracting with an outside entity to monitor the progress of the projects and this will be another opportunity to modify the projects with possible changes recommended in the last two years. She noted that if they do a replacement project it cannot be an “other” but must be directly from the menu. She reviewed the areas for correction adding that most of these passed through HHSC however what CMS is focusing on is the “other” category and patient satisfaction valuations. There are four options available 1) replace the project on the non-approved list, 2) justify the original value with more data, 3) change category 3 which will bump up the value of the project or 4) mix up the values. If we do not receive the full evaluation by September we will still have an opportunity through March 2014 to modify the project.

**5. CMS REVIEW PERIOD FOR REGION 15**

 Discussed above.

**6. UC AND DSRIP PAYMENT TIMELINES**

Ms. Gibson provided the attendees with a slide on the DY1 payments along with accompanying IGT. She noted that Region 15 has been approved for DY1 DSRIP payment. Mr. Nuñez noted that they will be coming back with an updated fee schedule within the next couple of weeks. Ms. Gibson noted that CMS will be providing guidelines on what they want for a learning collaborative, as they want to see successes, challenges, community involvement, and input from the RHP.

**7. LEARNING COLLABORATIVE TOPIC FOR REGION 15**

Expansion of Urgent Care Centers

UMC Neighborhood Health Clinics: extended hours and weekends, improving reporting capacity, expand/enhance medical homes; VNA/Salvation Army, VNA/Rescue Mission

VNA-Cynthia D. Horton

She noted that their proposal is to place nurses at both the Salvation Army and the Rescue Mission; the current problem is that the homeless access the ER for primary care. Commander Mike Morton and their staff have 250 ambulance visits per year and the same with the Rescue Mission, to the UMC ER per year. By stationing a nurse there they will be able to help the residents of these two locations manage their chronic diseases on site. The will look at the sites for communicable diseases, infections, and the primary goal is education and teaching them how to manage their diseases especially in a transit population so that when they go from place to place they will be able to manage their diseases properly and know the community resources available to them.

Salvation Army-Commander Morton

The wellness of the homeless and those in the care of the center is a priority as they don’t have insurance companies or companies that work on their wellness. The Salvation Army all through the southern territory is currently developing the “Wellness Effort” that will focus on providing them the same sort of incentives that we get in our companies in the private/public sector. Some of these include smoking cessation, etc. This will be a two prong approach by having the primary care provided by VNA and the second is the wellness side which will positively impact that population to keep them away from the ERs.

Neighborhood Health Centers-Sarah Allen

Ms. Allen provided the attendees with a presentation (it appears in the backup) with the various initiatives that are planned to improve the patient satisfaction scores at the various outlying clinics. They are focusing on trying to establish a personal relationship with the patients.

3. Expansion of Pediatric Primary Care, Development of a Primary Care Medical Home-Dr. Michael Romano

Dr. Romano introduced Mr. Oscar Perez, newly hired Project Manager for the DSRIP Project Portfolio and he provided the attendees with a detailed presentation as it appears in the backup. Family Medicine has a well established open access scheduling system where about 30% of the appointments are available the same day and when you want to coordinate care they can see a physician the same day.

One other project that Texas Tech is working on is the Pediatric Primary Care issue to address the necessary well-child exams beginning at birth through 24 months; however parents are not utilizing these exams. Texas Tech has developed a project where they will utilize an existing acute care walk-in clinic seeing about 10,000 children per year. Dr. Romano provided the group with statistics associated to the number of children that do not receive the necessary exams. The model they will establish in their walk-in clinic is to screen the child that came in for the acute care visit and off the parent the opportunity to screen the other children to see if they are eligible or an exam. If they are eligible they will provide the exam and provide the necessary shots, etc.

Ms. Althoff-Olivas inquired if there were plans to implement the “medical home model” into the other Texas Tech clinics, i.e. scheduling, getting people appointments with specialists, and Dr. Romano explained that they are currently focusing on Family Medicine as part of the DSRIP Projects and the next one that they will begin to explore is medicine and there is some interest in doing this in pediatrics.

4. Expansion of Oral Health Services-Bruce Parsons

Mr. Parsons explained that the Rawlings Dental Clinic in Central El Paso cares for the underserved pediatric population. The proposed project is to add a mobile dental clinic to the service deployed strategically to make best use of the time and money invested. Critical to the staffing is to get the dentist, hygienist, and dental assistant. They have been successful in hiring a dentist to work on the mobile dental van once it gets fully operational. The goal is to utilize the existing van to work in Canutillo with the migrant workers and provide them with dental care. He added that there is an ongoing initiative with head-start to engage for the dental health provider.

**8. ROUNDTABLE DISCUSSION**

Mr. Valenti noted that they would like to have the questions submitted to Ms. Gibson by May 3, 2013 and they will be dispatched to the state.

**9. PERFORMANCE LOGIC-DSRIP TRAINING PROGRAM**

**10. Next Meeting Date-**

 RHP participants will be notified of the next meeting.

**11. ADJOURNMENT**

Mr. Valenti adjourned the meeting at 3:15 p.m.

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Mr. James N. Valenti, Region 15 Waiver Anchor