CENTRAL HEALTH

M E M O R A N D U M

To: Central Health Board of Managers
From: Pat Lee, MD, President & CEO
CC: Travis County Commissioners Court
Date: September 9, 2024
Re: Management Response to Mazars Performance Review

Introduction:

On September 27, 2022, the Travis County Commissioners Court ordered a comprehensive, independent performance "audit" of Central Health and ordered Central Health to reimburse Travis County (the County) for the costs of the review. The County engaged Mazars USA LLP (Mazars) to perform the performance review on its behalf and act as its agent for the review. Central Health was not a party to the contract between Mazars and Travis County for this review, and Central Health staff did not have input into the development of the scope of work.

Despite the fact that Central Health was excluded from the design of this project and was not a party to the contract for its implementation, Central Health worked with the Mazars team in good faith. Central Health devoted more than 1,000 hours of staff time to meetings with Mazars, document sharing, and ultimately error correction in response to Mazars' draft report. As demonstrated in 2018 with its most recent prior performance review, Central Health values objective, impartial review of our systems and comparative benchmarking against peer organizations to identify ways we can improve the healthcare safety net in Travis County.

Substantively, Central Health agrees with Mazars' primary conclusion that there are no violations of law or significant deficiencies in how Central Health operates as it works tirelessly to improve the health of our entire community by caring for those who need it most. Central Health also agrees with Mazars that the Dell Medical School's use of the $35 million it receives annually is in line with the terms of the Affiliation Agreement. We acknowledge relevant best practices identified, particularly related to process documentation and the expansion of quality metric reporting. We will consider those as we continue to develop our system of care.

While Central Health agrees with the above aspects of the report, we have serious concerns about the report's methodology, its characterization of key elements of our delivery system, and the lack of foundation for some of its recommendations. Central Health provided detailed corrections and comments on the draft report. Yet, the final report continues to mischaracterize key aspects of how Central Health, as a taxing hospital district formed and operating under Chapter 281 of the Texas Health and Safety Code, works to provide care to the safety net population in Travis County. Despite the inclusion of some Central Health corrections, the report still contains many errors, misconstrues key partnerships, omits important information, and selectively examines contracts. The net effect of these errors and shortcomings is that the report fails to provide a clear, complete picture of Central Health's delivery system. This is an unfortunate lost opportunity.

While this letter contains Central Health's response to several aspects of Mazars' final report, these written comments are not intended to be either comprehensive or exhaustive.

Failure to Benchmark to Texas Chapter 281 Hospital Districts:

In the original request for services, as stated under Scope of Services on page 8, Mazars' instructions were to assess how Central Health's "performance compares to similar healthcare and hospital districts' healthcare services." This request was consistent with past performance reviews of Central Health and our Board-adopted Healthcare Equity Plan. A meaningful review of Central Health's systems would recognize Chapter 281 requirements and compare our performance to other entities in the state operating under the same requirements and restrictions. However, the report does not contain a single reference to—or even mention of—any of the other large Texas hospital districts such as Harris Health System (Harris County), Parkland Health & Hospital System (Dallas County), University Health System (Bexar County), JPS Health Network (Tarrant County), or El Paso County Hospital District (El Paso County). Unfortunately, given the lack of comparison to peer entities, the report repeatedly makes inappropriate, acontextual comparisons to tangentially relevant standards. These inapt comparisons leave the impression that Central Health is not operating a high-quality system. Several examples of these comparisons pervade the report.

First, the report contains numerous observations and comments on Central Health's "provider network" and "provider directory"—and then criticizes the scope and reach of Central Health's care agreements. Provider networks and provider directories are insurance company concepts. Central Health is not an insurance company, and so those concepts—and the criticisms in the report that flow from those insurance-company concepts—simply miss the mark when applied to a Chapter 281 hospital district. In addition to serving low-income Medicaid and Medicare patients, Central Health is also responsible for providing access to healthcare services to the primarily adult, uninsured safety net population. This population differs significantly from defined groups eligible for Texas Medicaid (primarily children, pregnant women, or people with disabilities) or Medicare (people 65 and older), around which insurance company network adequacy standards are established.

Rather than remove these comparisons and criticisms at Central Health's request, Mazars chose to continue its use of insurance company concepts, claiming that as a result of our inadequate provider network, there are gaps in care for Central Health's patients. See page 40. While gaps in care access for Central Health patients do exist, they are primarily the result of Ascension's sustained failure to meet its obligations to provide specialty and hospital care—not the result of a poorly constructed or managed "provider network." Indeed, largely in response to those systemic failures by Ascension, Central Health has delivered on its promise to the community to provide direct care services to address the failures of our contracted partner. Throughout the report, Mazars not only misunderstands Ascension's obligations but also ignores Central Health's direct service strategy.

Further, Mazars relied on data sets and delivery structures that do not match or compare with Central Health. For example, policies and procedures were evaluated based on Medicare and Medicaid Managed Care Organizations requirements, which are not relevant to Central Health's governing requirements under Chapter 61 and 281 of the Texas Health and Safety Code. Again, to reiterate the point, Central Health is the entity primarily responsible for providing healthcare services, not just coverage, to adults at or below 200% of the Federal Poverty Level.

Mazars also recommends that Central Health should consider expanding or developing elements to support an ACO (Accountable Care Organization) model. See page 37. An ACO is a group of health care providers that work together to provide coordinated care for a specific group of patients, and in exchange receive a portion of achieved savings. Again, this structure is typically seen in the insurance industry, where participating members have more mature data systems to take on and manage risks. In a safety net system, a larger portion of the patient population is likely to be more complex, presenting a higher degree of risks for potential members of an ACO. In addition, most providers of a safety net health system do not have the mature data systems or the financial capacity to take on additional risks that may impact other patient populations they are responsible for.

By failing to benchmark Central Health against Chapter 281 hospital districts and using inapt comparisons (principally in the insurance context), many of the report's claims regarding Central Health's performance are neither well-informed nor actionable.

Failure to Understand and Describe Central Health's Care Delivery System:

From its inception, Central Health has implemented a contracting model to provide healthcare services to the safety net population. Central Health provides the majority of primary care services to our population through our public center, co-applicant Federally Qualified Health Center (FQHC), CommUnityCare. Our Master Agreement and Omnibus Healthcare Services Agreement with Ascension are designed to ensure broad-based access to specialty and hospital care. Along with these two major contracting structures, Central Health also contracts with approximately 125 additional service providers to deliver services to more than 155,000 patients annually, across the continuum of care. Unfortunately, Mazars did not accurately describe Central Health's contracting model and the relationships created via that model.

For example, Mazars mischaracterized Central Health's foundational agreements with Ascension as "Affiliation Agreements," even though that is not what they are. Mazars completely omitted the FQHC Co-Applicant Agreement and Administration Equipment and Facilities Agreement with CommUnity Care from the report's catalogue of Central Health's contracts.[1] Also, Mazars refers to Central Health's agreements with the University of Texas as "Master Services Agreements" even when describing small, single-staff member contracts.

Particularly problematic is the discussion of Central Health's agreements with Ascension. At their core, those agreements reaffirm Ascension's long-standing contractual obligation to serve as the entity primarily responsible for clinical specialty care and hospital services (meaning outpatient, inpatient, and emergency services) for the safety net population. Mazars does not appear to have understood this, and the report has several errors as a result. Moreover, given Central Health's current lawsuit against Ascension for breach of contract, it is concerning that Mazars attempted to describe "relevant" parts of these complex agreements. Again, if Mazars misunderstands the big picture nature of the agreements, it is hard to understand how it could identify their "relevant" parts or draw any related conclusions about those agreements.

These errors and mischaracterizations create confusion where none should exist and leave incorrect impressions about the true breadth of Central Health's contracts. More significantly, the failure to understand and describe Central Health's system calls into question not only the accuracy of the report's observations but also the credibility of its recommendations.

Central Health's Relationship with Ascension:

This section explains some of Central Health's concerns with the report's characterization of Ascension's role in the safety net delivery system.

[1] Central Health provided Mazars with contract documents for 45 different organizations as a representative sample. As noted above, Central Health contracts with more than 125 different organizations and services providers to deliver services. In its review, Mazars appears to have misinterpreted that representative sample as the entirety of Central Health's contractual footprint. Further, in Section 2.4, Mazars disproportionately focuses on the $35 million payment to the UT Dell Medical School rather than a broader, more balanced approach.

In the Executive Summary on page 7, the report states that a performance review of Ascension is out of scope and thus was not done. Given the fact Mazars didn't conduct any review of Ascension, it is difficult to understand how Mazars is able to conclude in Section 2.1 (page 21) that there are "gaps created by what Ascension was unable to provide"—as opposed to care gaps created by what Ascension was obligated to provide but did not. While Central Health has several concerns with the report's characterization of Ascension's role in the delivery system, the assumption highlighted by the above quote is as unnecessary as it is uninformed. On top of that, it implicates subjects at issue in Central Health's lawsuit against Ascension—all in the context of a report that makes clear that Mazars did not conduct fact-finding or assessment related to Ascension.

For clarity, Central Health has two major, foundational agreements with Ascension. These agreements are called the "Master Agreement" and the "Omnibus Healthcare Services Agreement." These agreements—in addition to reaffirming Ascension's primary responsibility for clinical specialty care and hospital services—also discuss the concept of an "integrated delivery system" (IDS). In 2023, after years of problems followed by additional years of negotiation and mediation, Central Health took the extraordinary step of suing Ascension for various material breaches of these agreements—but most importantly for not providing the obligated levels of health care services to Central Health patients.

The IDS—and the extent to which the parties are (or are not) living up to their obligations under it—is directly at issue in the lawsuit.

Despite Mazars' awareness of that fact, on page 11, the report includes a highlighted finding that "it appears the IDS is not currently active as the parties intended and accountability issues need to be addressed." Mazars' findings and recommendations related to the IDS are direct incursions into territory that is the subject of that active litigation. Central Health has serious concerns with any third-party comment on these legal issues—much less comment by Mazars, which has demonstrated in the report that it does not understand Central Health's contracts generally or with Ascension specifically.[2] The bottom line is that the report's characterizations of and comments on Ascension, its obligations and responsibilities, and the IDS are incorrect.

Beyond its misunderstandings of Central Health's relationship with Ascension[3] and the role of the IDS, the report also lacks important context. In 2018, the Germaine Solutions' performance review of Central Health found that the IDS would improve if Central Health worked to reduce its reliance on contracted partners and implemented more direct control of the safety net delivery system. Following that recommendation, Central Health sought and received legislative authority to hire clinicians and provide services to the community directly. The result of these efforts is bearing fruit today, as Central Health makes good on the promise of its Health Equity Implementation Plan. Ascension's long-standing failure to meet its care obligations was one of the major reasons why Central Health has had to move towards this direct care approach. Yet throughout the report, Mazars ignores Central Health's efforts to provide care directly to the people it exists to serve as one mechanism for eliminating the gaps in care that exist primarily due to Ascension's shortcomings.

<u>The Affiliation Agreement with the University of Texas:</u>

[2] To that point, on page 36, Mazars claims there is "lack of clarity" regarding aspects of the IDS. No such lack of clarity exists on Central Health's part .

[3] As another example, on page 21, the report mischaracterizes Ascension's care obligations as obligations of UT Health when it claims "it would be a fair assumption that [certain providers and services for which Central Health has contracted] are meant to supplant the services provided by UT Health in order to close gaps in care..." So there is no confusion, Central Health's contracts are not designed to supplant services that are supposed to be provided by Ascension.

Central Health, the University of Texas at Austin (UT), and the Community Care Collaborative (CCC) are parties to the 2014 Affiliation Agreement. The Mazars report spends a significant amount of time discussing, analyzing, and making recommendations concerning this agreement and Central Health's relationship with UT and the Dell Medical School (DMS).

As with other aspects of the report, there are too many problems to address comprehensively here. So, for purposes of this written response, Central Health will focus on the Findings and Recommendations Summary in Section 2.4 (page 57), where the Mazars' report states that "Central Health should be afforded sole governmental authority in the Affiliation Agreement to properly oversee the use of funds." The funds referenced here are the $35 million annual payment to UT/DMS that the CCC (or, if the CCC lacks sufficient funds, Central Health) under the Affiliation Agreement. This recommendation has substantial problems.

First, as the report recognizes on page 55, under the terms of "the Affiliation Agreement Central Health does not have full control over how funds allocated to its partner institutions are used." The Affiliation Agreement was a heavily-negotiated contract with an initial 25-year term. Central Health cannot unilaterally make changes without the agreement of UT. It is impossible for Central Health to implement this recommendation.

Second, neither the "full control" nor the "sole governmental authority" standard that Mazars cites in its recommendations is the relevant standard for Texas public-entity spending. This is especially true in dealings between two governmental entities, like Central Health and UT/DMS. Central Health's requirement is to ensure funds are used for a public purpose, for the mission of Central Health, and that Central Health have sufficient control—not full control or sole authority.[4] Central Health does not know how or why Mazars decided that "full control" or "sole governmental authority" was the relevant standard, but it is not.[5] Central Health cannot implement any recommendation that is based on an erroneous standard.

<u>The Community Care Collaborative (CCC):</u>

The report contains several errors regarding the CCC. Here again, there are too many problematic statements and conclusions to address in this response. However, so that there is no confusion, the CCC continues to exist, function, and play a key role in care coordination between Central Health and Ascension as the virtual organization it was created to be. The CCC currently serves as a platform for ongoing, important discussions between Central Health and Ascension on issues that range from individual patient care to broader collaborative care initiatives to contractual and organizational governance.

Despite that, in Section 2.4 under Recommendation AA.5 (page 55), Mazars recommends dissolving the CCC if it remains unfunded.[6] Nowhere in the report is there evidence of any analysis of the practical or legal implications

[4] Central Health has multiple mechanisms (including but not limited to the Agreed Upon Procedures process, which is performed by the independent audit firm Atchley & Associates) to demonstrate sufficient control and to monitor the use of public dollars under the Affiliation Agreement.

[5] The report also states that Central Health "does not have direct governance and oversight responsibilities for the Affiliation Agreement" and instead states that is the domain of the CCC. This is both misleading and inaccurate. It is misleading because it ignores Central Health's role in the CCC. It is inaccurate because the Affliation Agreement has dispute resolution and termination provisions that Central Health may invoke if the circumstances warrant.

[6] Mazars makes a reference to a concern about transparency if the CCC continues to exist. This concern – which again demonstrates Mazars' lack of understanding of how Central Health and its partnerships operate – is easily addressed. The CCC is a partnership between Ascension and Central Health, and any advisory committee or

of dissolving the CCC. Nor did Mazars engage Central Health in any discussion of what impact the dissolution of the CCC would have. Accordingly, Central Health is unaware of—and doubts the existence of—any analysis by Mazars of what implementation of this recommendation would entail. Central Health wishes to make clear that it does not agree with this recommendation.

Conclusion:

By focusing on the report's errors and shortcomings in this written response, Central Health does not wish to suggest or imply that the report is wholly without merit or value. On the contrary, it should give our community comfort and reassurance that Mazars concluded that there are no violations of law or significant deficiencies in how Central Health operates. Likewise, our community should appreciate Mazars' further independent validation that DMS' use of the $35 million it receives annually is consistent with the terms of its contract with Central Health. Those are weighty and important pronouncements with which Central Health agrees.

Moreover, despite Central Health's many serious concerns with the Mazars report and some of its recommendations, Central Health is committed to internalizing and addressing several of the findings and recommendations in the report.

Finally, Central Health wishes to reiterate that it remains committed to ongoing improvement and operational excellence. We value our relationship with the Travis County Commissioner's Court and acknowledge the value of regular performance reviews when they are done well.

Board meeting notes are subject to the Public Information Act. There is no circumventing of transparency. There are no conversations regarding UT/DMS that are "hidden" by virtue of the fact that they may take place in the CCC. (As a practical matter, conversations regarding UT/DMS do not take place within the CCC.) Rather, CCC conversations almost exclusively focus on Ascension's obligations under its agreements with Central Health.