

DRAFT MEETING MINUTES

COMMISSION ON HEALTHCARE AND HOSPITAL FUNDING

Meeting Date: July 23, 2015

Time: 9:00 a.m. – 2:00 p.m.

Location: Miami Dade College – Medical Campus

Members Present: Carlos Beruff, Chair; Tom Kuntz, Vice Chair; General Chip Diehl; Marili Cancio Johnson; Eugene Lamb; Dr. Ken Smith; Dr. Jason Rosenberg; Robert Spottswood; Sam Seevers

Executive Directors Present: Secretary Elizabeth Dudek of the Agency for Health Care Administration; Dr. John Armstrong, Surgeon General and Secretary of Health

Interested Parties Present: Marion Thorpe; Alex Alamo, Florida House of Representatives; Giselle Hernández, Miami Dade College; Nicole Marrero, Miami Dade College; Barney Castellón, Miami Dade College; April Andrews-Singh, Nicklaus Children's Hospital; Sidney Goldin; Daniel Boston, Aventura Hospital; Steve Ullmann, University of Miami – Center for Health Sector Management and Policy; Ashley Boxer, Memorial Healthcare; Kathy Reep, Florida Hospital Association; Steven Sonenreich, Mount Sinai Medical Center; Melina Pardo, Florida Groundswell Public Strategies; Eric Johnson, Florida Office of Insurance Regulation; Enrique Del Riego, Florida International University; Krista Lawrence, Merck and Company, Inc.; David Lancz for Florida Representative David Richardson; Cristine Teuvo, HCSF; Alex Méndez, Mount Sinai Medical Center; John Benz, Memorial Healthcare; S. Steven, MHS; Terese West; Pam Tahan, Wellington Regional Medical Center; Nathan Dunn, Department of Health; Lauren Pardo, Groundswell Strategies; Marti Coley, Nemours Children's Health; Brian Delburn, Tenet Healthcare; Alex Barrio, SEIU Local 1991 – United for Quality Care; Esther Abolila, Jackson Health System; Mark Knight, Jackson Health System; Matthew Pinzur, Jackson Health System; Miller James; Jaime Caldwell, South Florida Hospital and Healthcare Association; Doug Harrison; Loren Parra, Regional Director, U.S. Senator Bill Nelson; Brittney Branam, MDC; Cara Lively, MDC; Robert C. Goldszer, Mount Sinai Medical Center; Dayron Barzaga, MDC; Raena Wright, UM; Martha Baker, SEIU Local 1991; Kevin Cooper, Groundswell Strategies; Duane Fitch, Fitch Healthcare; David Pollack, Molina Healthcare of Florida; George Andrews, Miami Dade College; Katerina Bryant, Florida International University; Lea Padron for Senator Marco Rubio; Janice Johnson, Miami Dade College; Viergina Berlus, Miami Dade College; Jorge Chamizo, North Broward Hospital District; Senator Rene Garcia, The Florida Senate; Lani Ferro, Miami Children's Health System; Anthony Bustamante; Jessica Bern, Baptist Health; Laurene Ramos, CSR; and Jose A. Cancio.

AHCA: Justin Senior, Nikole Helvey, Katherine Riviera, Tina Green, Lidia Cardelle, Kira Lucrezi, Raquel Ribera, Teresa Yoder-Trau, Arlene Mayo-Davis, Héctor Gutierrez and Lisette Rodriguez.

Media: The Florida Channel; Patrick Farrell, Miami Herald; Daniel Chang, Miami Herald; Kenny Malone, WLRN; Hector Labrador, Miami News 24; Ismael Louis, WPIG/Channel 10

Call to Order: Carlos Beruff, Chair, called the meeting to order and called role. He thanked Miami Dade College for hosting the meeting.

Dr. Armando J. Ferrer the President of Miami Dade College's Medical Campus welcomed the Commissioners to the campus.

Review and Approval of Meeting Minutes: Minutes from the July 1, 2015 meeting were approved.

Presentation from Jackson Memorial Hospital: Mr. Carlos Migoya, Chief Executive Officer, thanked the Commissioners and Miami Dade College. Mr. Migoya stated that Jackson Memorial Hospital is a beacon for cutting edge healthcare. Jackson Memorial Hospital has on average 76,000 inpatient admissions and 200,000 emergency department visits. The hospital has 11,000 staff; 1,100 residents; and 2,000 physicians. The hospital is owned by Miami Dade County and provides care regardless of the patient's ability to pay. The hospital's academic component is a huge part of the hospital. Jackson Memorial Hospital has training partnerships with University of Miami and Florida International University. The hospital's acuity level is 25% higher than the national average and accepts approximately 160 patient transfers every month of complex cases from other area hospitals.

Mr. Migoya provided several examples of the critical care that Jackson Memorial Hospital has provided. He also stated that the hospital has seen significant improvements in ventilator associated pneumonia; blood stream infections; and readmissions. There are initiatives underway to improve other measures such as immunizations and strokes. The hospital also has a challenge in improving patient satisfaction and is addressing it by including it in the new employee's orientation.

The hospital has improved in quality of care and finances since the late 90s. It has in past years lost up to \$80 - \$90 million, however it currently has a surplus of \$150 million. Mr. Migoya stated that the surplus is reinvested in programs and used to reduce its dependence on government assistance.

In 2011, the hospital's staff was reduced by 1,200 FTEs in order to reduce overall costs. Today staffing levels are dictated by the volume of patients and services, not the economy. The hospital has also utilized group purchasing of supplies as another method to control cost. The hospital's executive compensation is below the median when compared to peer groups nationally. The hospital's revenue is mostly from Medicare, Medicaid, and a half-penny sales tax in Miami-Dade County. Mr. Migoya has seen a huge gap in funding in the past two years due to House Bill 711; however the hospital is making great strides in neuro surgery, newborn care, rehabilitative services, and trauma care. The hospital has had great success with its transplant program. The transplant program has a paired donation system that coordinates and allows for

multiple transplant surgeries to take place simultaneously allowing two or more individuals to benefit from the donations at the same time.

Mr. Migoya informed the Commissioners of their process for assessing patients to determine the patients who are unable to pay for services versus those are unwilling to pay. The process helps to identify resources for patients that are unable to pay to assist them with their health care needs including health insurance and primary care.

The Commissioners were informed that Jackson Memorial Hospital will be expanding services in the areas of urgent care; a freestanding emergency department; pediatric specialty care; ambulatory surgery; imaging and diagnostic services; rehabilitation services; and transplant services.

There was discussion about how Mr. Migoya was able to turn around Jackson Memorial Hospital. Mr. Migoya stated that his experience as a banker and Mayor of Miami prepared him for dealing with the issues. He also gave credit to his Chief Financial Officer and Chief of Strategy for turning the hospital around. He stated that quality management is key. He stated that the managers for each department determined where the cuts were needed and have taken ownership in their operation.

Vice Chair Kuntz asked Mr. Migoya about his strategy with opening more urgent care centers. Mr. Migoya stated that the hospital is opening more urgent care centers to provide more access to citizens in the surrounding areas. He stated that having access to the health care centers can mean life or death for residents. The facilities will also allow more paying patients to help supplement those that cannot pay.

Vice Chair Kuntz questioned Mr. Migoya regarding his thoughts on the Certificate of Need (CON) process and if it was good for competition. Mr. Migoya stated that CON needs some degree of change however the process works well for specialized care. Specialists need high volume of patients to survive and also to ensure that their skills are as highly trained and practiced as possible. In addition, he also provided another CON scenario regarding deregulation stating that some hospitals may end up with all the paying patients and other hospitals may have all indigent patients.

Commissioner Chip Diehl asked Mr. Migoya about the future of healthcare. Mr. Migoya stated that he envisions more access to healthcare. He stated that it would also be quicker as there will be more companies such as CVS, Publix, and other walk-in clinics that will provide quicker and easier to access care.

Commissioner Marili Johnson stated her concerns regarding the quality and transparency of the hospitals. She requested that Jackson Memorial Hospital begin thinking about participating in a quality improvement program.

Commissioner Eugene Lamb asked about the tax revenue that Jackson Memorial Hospital receives versus other hospitals. Mr. Migoya stated that he received a higher percentage of Low Income Pool dollars; the half-penny sales tax revenue from the County for specialty services; and an ad valorem tax for indigent care.

Presentation from Mount Sinai Medical Center: Mr. Steven Sonenreich, President and CEO of Mount Sinai Hospital, thanked the Commission for the opportunity to present and acknowledged Secretary Liz Dudek for being a friend of the hospital industry.

Mr. Sonenreich presented that Mount Sinai is the lowest cost full-service hospital in the county and the only hospital on Miami Beach, and provides the only emergency services on the barrier island. He added that Mount Sinai is the largest employer on Miami Beach, with over 3,700 employees. He noted that only 9% of Mount Sinai employees live in Miami Beach and access health services there; although Mount Sinai Hospital is self-insured. Because many of its employees receive their health care from other area hospitals, Mr. Sonenreich has observed the cost of care increasing due to hospital consolidations and lack of price transparency.

Mr. Sonenreich stated that Mount Sinai is a great example of the nexus of efficiency and quality. He said that Mount Sinai is a mission-driven tax exempt organization with a mission to provide high-quality health care to the entire community, to be a teaching institution, to provide care to the less fortunate, and to be financially responsible to all constituencies.

Mr. Sonenreich discussed Mount Sinai's Moody and Fitch financial ratings, which the hospital uses to benchmark financial appropriateness and efficiency. He stated that Mount Sinai was Investment Grade rated and profitability margins are in the 3% range. The budget for 2015/2016 is expected to be in the 3% range with an EBITDA margin of 10.5%. He added that because hospitals are extraordinarily capital-intensive, Mount Sinai maintains appropriate debt service coverage, capital spending ratio, and day's cash-on-hand.

Mr. Sonenreich said Mount Sinai is one of the most efficient hospitals in Miami-Dade County, and Mount Sinai proactively seeks new cost saving initiatives. He noted that Mount Sinai's cost per patient day is lower than 19 of the 22 hospitals in the county, and at \$1,217 cost per patient day, is 50% lower than the 5 most expensive hospitals in Miami-Dade County. It is 20% lower than the state-wide average. Mr. Sonenreich added that the hospital's low cost structure allows for affordable access to quality healthcare for the entire community.

Mr. Sonenreich provided some of Mount Sinai's history, noting that the hospital was started by philanthropists to give care to all persons regardless of race, religion, or nationality and was opened in December 4, 1949. He presented that the number of visits to Mount Sinai's Emergency Department has grown from approximately 29,000 in 2012 to nearly 50,000 in 2013. He provided that 1 in 4 people in Miami Beach are without insurance coverage and that 25% of the visits to the Emergency Department have no health insurance coverage. Mr. Sonenreich also presented data that compared Miami Beach to the State of Florida. He noted Mount Sinai's commitment to charity and uncompensated care, and that the hospital tracks the demographics of their charity care recipients. The hospital provided \$136 million in charity and uncompensated care to Miami Beach and the greater Miami community last year.

Mr. Sonenreich shared Mount Sinai's strategic priorities for the coming years and said Mount Sinai is building transformational facilities, including a new surgical tower, a replacement emergency department and \$75 million dollars invested in electronic medical records. He noted

that the emergency department was originally built to accommodate 25,000 visits per year and now sees 50,000 visits each year.

Mount Sinai is also geared towards financial stability and has a strong balance sheet. The hospital has also made strides to normalize debt, has a strong endowment and consistently fundraises for the future.

Mr. Sonenreich said Mount Sinai is developing an accountable care organization, a clinically integrated network in preparation for population health, and a strong primary health care network. The hospital also focuses on satellite facilities and opened the first free-standing emergency department in northeast Miami-Dade County. He continued that Mount Sinai achieves clinical excellence through recruitment of medical doctors and allied health professionals, making sure to meet CMS quality metrics, and maintaining strategic affiliations to improve the quality of care at the hospital.

Mr. Sonenreich presented that the hospital had 22,613 inpatient visits; 181,225 outpatient visits; and 69,147 emergency department visits, and noted that Mount Sinai was the Miami-Dade Medical Management Facility for electricity and oxygen dependent individuals during an emergency event or natural disaster. Mr. Sonenreich said that Mount Sinai has 672 licensed beds, net revenue of \$529 million, normalized operating margins of 2.5% to 3%, and 7% of the Miami-Dade County market share. Mount Sinai is also the market leader in cardiac surgery, invasive cardiology, thoracic and vascular surgery, and rehabilitation services. He added that Mount Sinai has the largest behavioral health unit in the county and has the number one heart attack survival rating in the state of Florida.

Mr. Sonenreich stated that Mount Sinai is proud to be 1 of 6 original academic teaching hospitals in Florida and guessed that 80% of physicians on medical staff in the tri-county area were trained at Jackson Memorial or Mount Sinai Medical Center. He said Mount Sinai is an independent teaching hospital with wholly owned residency programs and partnerships.

Mr. Sonenreich stated that Mount Sinai's Comprehensive cancer center has 155 active clinical research studies to improve cancer treatment and that Mount Sinai medical center sees more patients for memory disorder and Alzheimer's disease than any other medical center in the world.

Mr. Sonenreich said that Mount Sinai has satellite facilities in several cities and added that new facilities would open over the next three years, including a \$260 million building project with 12 state-of-the-art operating rooms, 154 private patient rooms, and a new Emergency Department with a clinical decision room, and a 750 space parking garage.

Mr. Sonenreich provided that Mount Sinai receives over 35,000 unduplicated individuals with low-income pool resources in FY 2013/14, and that low-income funding helped supplement care for over 30% of inpatients- nearly 43,000 hospital inpatient days, 27,000 emergency room visits, 29,000 outpatient services, 13,000 in diagnostic and outpatient surgical care areas, and 11,000 in primary care and specialist.

Mr. Sonenrieck stated that operational efficiency was a culture at Mount Sinai, created through ongoing monitoring of financial measures, comparison to regional and national peers, benchmarking against comparable national institutions, and constantly identifying best practices. He added that Mount Sinai has a project management officer that identifies and eliminates process inefficiencies.

Mr. Sonenreich shared that Mount Sinai utilized a number of approaches regarding capital acquisition, such as validating capital equipment costs by comparing to national benchmarks using ECRI or Economic Cycle of Research Institute, validating supply service and equipment cost utilizing Premier and Yankee Group Purchasing Collaboratives. Mount Sinai makes every effort to change to the most effective products when appropriate and used multi-disciplinary teams look at efficiency area by area, reducing length of stay 30% and driven down cost of care.

Mr. Sonenreich stated that the two keys to hospital efficiency are labor costs and supply chain. He said Mount Sinai staffed departments based on the volume needs for those areas, minimizes the use of contract labor, used forecasting models to reduce overtime and consider skill mix in the treatment of patients and executing services. Utilize hourly and daily productivity measures to drive real time behavior and improving department efficiency and reducing or increasing positions when appropriate.

Mr. Sonenreich said Mount Sinai benchmarked their quality and participates in the Joint Commission Surgical Care Improvement Project (SCIP) as well the Centers for Medicaid and Medicare Services value-based purchasing program.

He continued that Mount Sinai is sensitive to HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) to assure patient satisfaction and Quality improvement committees. Mr. Sonenreich stated Mount Sinai is proud of their peer review process and promotes a culture of transparency and not fear of reprisal. He stated a primary goal of Mount Sinai, as a transparent organization, is to communicate hospital-wide and individual performance.

Mr. Sonenreich concluded by applauding the efforts of the commission and hoped part of the Commission's findings made certain to reward efficiency and quality.

Vice Chair Kuntz asked Mr. Sonenreich to provide two or three reasons why Mount Sinai was an efficient hospital? Mr. Sonenreich replied that it was a combination of efficiencies from the for-profit world- a culture of measurement, and mission commitment from the not-for-profit world.

Vice Chair Kuntz asked if there was correlation between financials and hospital ratings. Mr. Sonenreich said the ratings systems are monitored because they are an important component of reimbursement and perception but are difficult and a popularity contest. He said Mount Sinai's overall focus is quality.

Vice Chair Tom Kuntz inquired as to Mr. Sonenreich's perspective on Certificate of Need (CON). Mr. Sonenreich replied that CON has a place, and there are certain specialty procedures where it is advantageous. He thinks that there are problems with the current cardiac

surgery regulation as some facilities were approved that may not have met the minimum requirements. He suggested the Commissioners look at the hospitals that have closed and felt that if CON regulations are relaxed, people will build hospitals in areas that are already well served and not the underserved areas.

Vice Chair Kuntz asked about states that have eliminated CON and Mr. Sonenreich said that Texas eliminated CON with tremendous challenge but Texas has very special medicine with hospitals like Baylor, and great wealth and philanthropy. Vice Chair Kuntz added that as jobs grow philanthropy grows to which Mr. Sonenreich noted that the affordability of health care is another challenge and he urged that transparency be a component of driving healthcare costs down.

Commissioner Cancio Johnson asked about Mr. Sonenreich's experience as an employer negotiating rates with insurance companies. Mr. Sonenreich said that as a self-insured employer they utilize rates of other hospitals through their United Health contract but do not get to negotiate. He added that contracts have gag clauses, which do not allow publishing rates.

Commissioner Seevers asked if Mount Sinai hires lobbyists. Mr. Sonenreich confirmed that lobbying is how business is done and that it is done in a responsible way to protect the hospital's reimbursements. He noted that specific asks included rebuilding the power plant for uninterruptable power during storms.

Commissioner Lamb asked how teaching was funded at the hospital. Mr. Sonenreich said that teaching was funded through the Medicare program.

Commissioner Ken Smith stated that the hospital industry needs a rating metric. Mr. Sonenreich agreed and stated he will discuss this with his hospital association.

Public Comment: The Commissioners recognized the attendance of Senator Rene Garcia and representatives for Senator Bill Nelson, Senator Marco Rubio, and Representative David Richardson.

The Commissioners acknowledged the citizens that requested to make public comments.

Mr. Anthony Bustamonte commented that he was frustrated over the lack of transparency and asked what could be done to empower consumers? He added that he was hoping to see more of an exchange of ideas or dialogue to develop ideas and solutions.

Mr. Jamie Caldwell noted the difficulty in the Commission's task and presented a resolution drafted by the board of directors of the South Florida Hospital and Health Care Association.

Ms. Lauren Pardo commented on transparency and the inability to find information on doctor records and previous procedures.

Senator Garcia asked the Commission to think about access alongside quality and cost. He said it is extremely important to remember with regards to CON, that healthcare is not on the same competitive field as other sectors of the economy. He continued that without regulatory components, competition in healthcare could drag down quality.

Presentation from Florida Office of Insurance Regulation: Mr. Eric Johnson, Chief Actuary and Director of Life and Health Product Review, gave an overview of the regulatory measures that ensure consumer protection and health plan transparency. The Office of Insurance Regulation's health product review ensures that all health policy forms provide all statutorily required consumer protections. The rates cannot be inadequate, excessive, or unfairly discriminatory. The Florida commercial health insurers have been governed by minimum medical loss ratios (the percentage of premiums used to pay for healthcare services) for several decades. The regulatory minimums range from 65% to 70%. The Florida medical loss ratios for the commercial health industry ranged from 82% to 87% from 2012 to 2014. The Florida Agency for Healthcare Administration uses an alternative methodology called an Achieved Savings Rebate where companies return 50% of profits above a 5% margin and 100% of profits above a 10% margin.

Commissioner Rosenberg asked about health plan rate increases when the providers are receiving the same reimbursement. Mr. Johnson stated that insurance companies are held to target MLR for the life of the product. He added that there is a five-year prohibition against starting a new product that is the same as an existing product. He added that the increase of utilization of services and cost of prescription drugs can affect the premiums and deductibles.

Chair Beruff asked about controlling the administrative expenses that can be charged and if administrative costs go down in economies of scale as technology evolves? Mr. Johnson replied that administrative cost is controlled through the Medical Loss Ratios. Economies of scale help with fixed costs such as technology or rent but several things scale with premium and claims: commission and adjudication of claims- these administrative costs scale with revenue, and as such the economies of scale are muted.

Mr. Johnson discussed the forces behind premium change, which he stated were cost of care, which includes drug costs, hospital and provider contracts, and new technology; the utilization rates; and cost-sharing leverage. Mr. Johnson said the utilization rate is an over looked factor and includes new technology, number of visits and number of tests. Whereas cost sharing leverage between the consumer and insurance company results from fixed dollar amounts in deductibles and copays as the insurance pays a higher percentage of claims as the policy ages. Mr. Johnson stated these have a significant impact on the annual changes in price for the product.

Commissioner Cancio Johnson asked Mr. Johnson if OIR saw hospital provider contracts, or if OIR knew what hospitals charged providers? Mr. Johnson replied that they did not routinely see contracts on the rate-setting side but they did review contracts for material changes or adverse impact on financial position.

Commissioner Seever asked about cost-sharing leverage and increasing her deductibles to afford insurance? Mr. Johnson explained that cost-sharing leverage applies when you have the same policy over several years, and the actual value (the amount of claims paid by the insurance company) is 80%. While the policy stays the same over the years, expected claims increase with changes in utilization and cost of care increases through contracting and new technology. He said the insurance company ends up paying more for their share since the

individual's share is a fixed dollar amount. He added that in return, the individual may look at a higher deductible to keep a premium from going up as much.

Commissioner Rosenberg commented on how an insurance company that saved \$50 million dollars in a year asked for a rate increase in the following year. He noted that five-year contracts are typical in the medical industry with premium increase but no increase in compensation. Commissioner Rosenberg said he did not see where the money was going. Mr. Johnson said that utilization and deductible leverage is part of the equation but that there are portions of premium rates that do not have relation to provider reimbursement.

Commissioner Rosenberg asked if there is some kind of sliding model or scale to demonstrate rate increase drivers and their effects on premiums? Mr. Johnson stated that prescription drugs or use of preferred drugs drive cost, as well as utilization.

Mr. Johnson provided a breakdown of insurance claims that showed hospitals account for 50% of claims, professional care was 25%, and 15% for prescription drug costs.

Mr. Johnson spoke on the Health Financial Oversight unit which he said monitors the financial condition of health insurers and HMOs, reviews financial statements and performs on-site financial examinations, and reviews reserve liabilities for actuarial soundness.

Commissioner Cancio Johnson asked about the request from Managed Care Plans wanting a 12% increase. Secretary Dudek indicated that AHCA had reviewed the plans and realized that their first year in Medicaid Managed Care was different than the subsequent years, certain drugs were expensive, and that some of plans were contracting with hospitals for over 120% of the traditional Medicaid Fee for Service rates. Secretary Dudek stated AHCA asked plans to certify that all Medicaid Managed Care contracts are below 120%. The Secretary added that by law AHCA must approve rates above 120% but had not received any such requests.

Mr. Johnson discussed Life and Health Financial Oversight tools used to regulate the insurance market and stated that health insurances were subject to a risk based capital framework, a dynamic solvency tool that categorizes risk into three categories: asset, underwriting and other. He added that Health Insurers have minimum capital surplus requirements of greater than \$2.5 million or 4% of total liabilities and 6% liabilities relative to health insurance. HMOs require a surplus of greater than \$1.5 million, with 2.5% of premiums and 10% of liabilities.

Mr. Johnson provided some metrics for the Health Insurance Industry which indicated that Medicaid and the commercial market is losing profit margins for 2014. Nationwide medical and hospital spending as a percentage of earned premiums increased to 87% for the commercial market in 2014 and 95% for Medicaid. Mr. Johnson said he would have to confirm numbers but noted that the relative size of the three categories in dollar amounts was \$10 billion for the commercial market and \$5-10 billion for Medicare. Secretary Dudek confirmed that it was \$14-15 billion for Medicaid.

When asked about market size in terms of profitability, Mr. Johnson said the entire market is profitable but carriers have significant foot prints in each of the three market lines. He agreed that risk is priced better for the Medicaid Managed Care programs and added that two things

impacted the commercial and Medicaid markets which made for difficult pricing projections resulting in high loss ratios: the introduction of the Affordable Care Act and the roll-out of Medicaid Managed Care.

Presentation from Molina Healthcare: Mr. David Pollack, Regional Vice President, of Molina Healthcare stated that the organization was founded 35 years ago by Dr. C. David Molina and the company is committed to providing quality healthcare for individuals that are most in need and least able to afford it. Molina Healthcare serves over 3 million beneficiaries in 11 states and the Commonwealth of Puerto Rico. It exclusively has government-sponsored healthcare programs for low income individuals and families.

Molina monitors quality through a series of healthcare measures such as Healthcare Effectiveness Data and Information Set (HEDIS); Medicaid's Managed Medical Assistance Program/Long Term Care Program; Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys; Medicare's Stars Program; provider surveys; and accreditation. Mr. Pollack said that Molina also continuously reviews phone calls, formal complaint data, and has a robust committee that tracks trends.

Molina also offers outreach proactively by identifying preventive needs; removing barriers of care; ensuring that health plan members do not fall through the cracks; and providing care to divert the use of emergency rooms.

Vice Chair Koontz commented as to why are there so many emergency room wait times advertised when the idea is to keep people out of them, and Dr. Rosenberg asked the cost of providing a service in an emergency room diversion program versus providing care in the emergency room? Mr. Pollack responded with regards to health plans, that the cost was probably 5 or 7 times the cost for a basic visit versus a standard primary care visit.

Mr. Pollack said they have about 170,000 covered Medicaid patients. Mr. Pollack confirmed that Molina is not doing well in the Medicaid market but does have a strong commitment to staying in Florida. He added that Molina is operating under a five-year contract and questions how they will end the year. When asked if they are losing money on Medicaid, Mr. Pollack confirmed that Molina is losing a significant amount of money.

Mr. Pollack addressed network adequacy and advised that the Agency has placed strict standards on health plans on the number of providers per members and how far consumers have to go for care. As a result, there are large broad networks. He noted that in large networks, it is a struggle to get physicians to work with the health plan on quality initiatives. Mr. Pollack added that network size impacts unit cost. He said that Molina will continue to work with AHCA to make sure there is the right balance on choice and adequacy while maintaining quality and efficiency.

Mr. Pollack discussed contracting and introduced the value based reimbursement (VBR) continuum which he said would be a future model. He said it shifts the focus from volume to quality. The first component in the initiative is event-based compensation wherein the hospital is willing to pay more for services that meet HEDIS measures. Next is care management, or

outcomes based reimbursement compensations. Mr. Pollack indicated that longer standing relationships are based on quality to begin.

Mr. Pollack provided a summary of their finances. A series of questions was asked regarding Molina's medical loss ratio in regard to participating in Florida's Medicaid Managed Care Program. Mr. Pollack stated that the company is experiencing a loss in profit. The medical loss ratio moved from 81.6% under the Fee for Service Program to 99.6% under the new Medicaid Managed Care Program. Mr. Pollack indicated that Molina is saving the state 5.1%, and the state is getting increased utilization.

Mr. Pollack discussed the company's experience with the new Medicaid Managed Care procurement process in which it was more favorable for health plans that had a contract in place with providers. Molina secured a contract with providers for five years. He also stated that a contract was not secured with the Baptist Health System in Miami because they do not contract with Medicaid health plans.

Mr. Pollack closed his presentation on Molina's commitment to providing care to the members of the health plan by offering transportation and providing home visits to ensure that they received preventive care and to link families with community resources.

When asked about quality measures, Mr. Pollack said Molina does measure their own quality primarily through review HEDIS measures but that he had not compared their results to what hospitals report and was not familiar with quality metrics for hospitals.

Secretary Dudek asked how Molina determined when to eliminate a practitioner or provider from the network, on a quality perspective. Mr. Pollack responded that a provider would be released for poor CAHPS surveys, if a provider is unwilling to work on expedited appointments, or not meeting HEDIS measures.

Mr. Pollack confirmed that they pay Medicaid rates but pays more for specialties where there is not a large demand.

Molina provides services to Medicaid, Medicare Special Needs plans, as well as affordable care act plans on the exchange only. He confirmed that most of Molina's income is government assistance.

The Commissioners requested that staff look at the Medicaid Managed Care Program to determine if it is good or bad. In addition, the Commissioners requested a review of the Medicaid versus Medicare rates.

Review of Executive Order 15-99: Dr. John Armstrong, Florida Surgeon General, reviewed the Executive Order and stated what the Commissioners needed to accomplish through their investigative role of taxpayer funding.

Commission Member Discussion: Commissioner Seevers requested a review of CON in regard to creating a monopoly and preventing access to quality of care; a review of contributions

to lobbyist; and to address transparency issues and the need for standardized charge and cost information.

Commissioner Rosenberg requested that the Commissioners send a list of items for discussion to the Directors and have a working session without presentations. He also requested information regarding aligning incentives, risk-sharing, and how health plans can deliver care in an affordable way. Commissioner Smith agreed but added that their needs to be incentive alignment but the different groups also need to be aligned.

Chair Beruff stated it all start with transparency and that data on costs of procedures and quality must be made available to the public. He requested a report from the Agency for Health Care Administration regarding where the 30% of waste is coming from.

Commissioner Cancio Johnson stated it was troubling that some hospitals decide not to deal with government funded care and that their needs to be more transparency as the burden of tax payer funded care are left to certain hospitals. She stated that the entire legislature has to be on board and that there is too much influence from lobbyist and special interest.

Commissioner Diehl requested that the Commissioners go through the Executive Order and answer it and address transparency for the future.

Secretary Armstrong directed the Commissioners attention to Tab H and Tab I regarding the sources for the information presented in the meetings and the key findings of the meetings. Chair Beruff requested staff revise the documents to make them public friendly such as not using acronyms to ensure that the message is concise.

The Commission discussed hospitals that were unresponsive to the survey and requested that another letter be sent to the hospitals. The Commissioners are also requested information on the statutory requirements regarding the public records law in regards to the deadline for hospitals to respond; and any cost for producing the documents.

The Commissioners proposed several meeting dates: the week of August 12th in Tallahassee; the week of August 31st in Orlando with a workshop; the week of September 28th in Palm Beach; and the week of October 19th in Tallahassee.

Secretary John Armstrong and Secretary Liz Dudek thanked the Commissioners and the Miami Dade College.

Meeting Adjourn: The meeting was adjourned at 1:55 p.m.