DRAFT MEETING MINUTES

COMMISSION ON HEALTHCARE AND HOSPITAL FUNDING

Meeting Date: August 12, 2015

Time: 9:00 a.m. – 12:30 p.m.

Location: Florida Capitol – Cabinet Meeting Room, Tallahassee, Florida

Members Present: Carlos Beruff, Chair; Tom Kuntz, Vice Chair; Marili Cancio Johnson; Eugene Lamb; Dr. Ken Smith; Robert Spottswood (via phone); Sam Seevers

Members Absent: General Chip Diehl, Dr. Jason Rosenberg

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

Interested Parties Present: Dean Watson, MD, Tallahassee Memorial HealthCare; Warren Jones, Tallahassee Memorial HealthCare; Mike Cusick, FSASC – Florida Society of Ambulatory Surgical Centers; Peter Lohrengel, FSASC; David Shapiro, MD, FSASC; Diana Schmidt; Glenn Thomas, Florida Association of Nurse Anesthetists; Craig Hansen, WellCare Health Plans, Inc.; Bill Bell, Florida Hospital Association; Aimee Diaz Lyon, Metz, Hauser & Husband, P.A., Cande Duncanson, and South Broward Hospital District; Laura Lennart, Moffitt Cancer Center.

AHCA and DOH Staff Present: Beth Eastman, Nikole Helvey, Molly McKinstry, Cruz Conrad, Nathan Dunn, Aaron Parsons, Haley Priest, Katherine Riviera, Jamie Sowers, Josh Spagnola, Dana Watson.

Media: The Florida Channel; Jim Ash, Florida Public Radio; Matt Galka, Capital News; Brittany Litchfield, WXTL; Jon Manson-Hing, Florida Video News; Kathleen McGrory, Tampa Bay Times; Tia Mitchell, Florida Times Union; Christine Sexton, Politico; Rick Flagg, Florida News Network.

Call to Order: Carlos Beruff, Chair, called the meeting to order and called role.

Review and Approval of Meeting Minutes: Minutes from the July 23, 2015 meeting were approved.

Overview of Outpatient Care Settings and Ambulatory Surgery Centers: Molly McKinstry, Deputy Secretary of Health Quality Assurance, with the Agency for Health Care Administration thanked the Commissioners for their service and gave them a presentation on Outpatient Care settings and Ambulatory Surgery Centers (ASC). Deputy Secretary McKinstry began with an overview of the Florida statutes regulating ASCs. Section 395.02(3), Florida Statutes, states that the primary purpose of ASCs is to provide elective surgical care outside of a hospital setting. The patient is admitted to and discharged from the facility within the same working day, and overnight stays are not permitted. The facilities are licensed separately from hospitals and do not include offices maintained by physicians for the practice of medicine.

Deputy Secretary McKinstry stated that there is not a specific list of ASC allowable procedures in state regulation. A governing board determines policies and activities of each ASC; and organized medical staff review and approve policies and activities of all departments. She noted that anesthesia policies and procedures must be developed by the anesthesia service, approved by the medical staff and the governing board, and reviewed annually.

Federal regulations, 42 CFR § 416.2, apply to all of the ASC surgical services, not just to surgeries for Medicare beneficiaries. The code requires each facility to be state licensed and to operate exclusively for the provision of surgical services to patients not requiring hospitalization, not to exceed 24 hours including pre- and post-operative. In addition, a physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed.

Deputy Secretary McKinstry continued on to describe the ASCs state reporting requirements. The centers must report on overall operations, surgical, anesthesia, and nursing services, medical record maintenance, quality assurance, risk management and adverse incidents, recovery and discharge, infection control and construction standards. In regard to the surveys of ASCs, Deputy Secretary McKinstry reported that annual state licensure inspections are conducted at all non-accredited ASCs and the accrediting organization survey reports are provided to the Agency. State validation inspections are conducted annually on 5% of accredited ASCs to determine ongoing compliance with state licensure regulations as well as federal validation and re-certification surveys for those facilities that are Medicare certified.

Deputy Secretary McKinstry reported that as of August 2015, there were 429 licensed ASCs in Florida. Of those, 411 are Medicare and/or Medicaid certified. Nationally, there are 379 organizations accredited by one of the following organizations: the Accreditation Association for Ambulatory Health Care, the Joint Commission or the American Association for Accreditation of Ambulatory Surgery Facilities.

Vice Chair Kuntz inquired if any ASCs had had their licensure revoked. That data was not available at that time and Deputy Secretary McKinstry will provide that information to the Commission as soon as possible.

Commissioner Sam Seevers inquired as to who inspects locations that are not required to send reports. Deputy Secretary McKinstry responded by describing the different types of surgical and treatment centers and the pricing involved. She began with the physician office surgeries. She stated that physicians must register with Department of Health (DOH), which inspects certain office surgery settings. The Board of Medicine sets Standards of Care for Office Surgery regarding anesthesia monitoring, education, and the scope of office surgery. Vice Chair Kuntz inquired as to how many ASCs were owned by doctors. Deputy Secretary McKinstry offered to obtain that data and share it with the Commission post meeting.

The difference between emergency and urgent care was explained to the Commission. She reported that 243 hospitals have emergency departments and 86 hospitals do not. 22 of these 243 hospitals have off-site emergency departments. Urgent care centers are not specifically

defined in statute, but they may include physician offices, health care clinics and health maintenance organizations.

Vice Chair Kuntz asked if all of the off-site emergency departments were affiliated with a hospital. Deputy Secretary McKinstry answered that they are and that only a hospital can have an emergency department. In Florida, an emergency department must operate under a hospital license, treat emergent medical conditions and provide 24/7 operation with on-call specialists.

Urgent care centers are not authorized to provide emergency department services and ambulances cannot deliver patients to the centers. Vice Chair Kuntz asked what happens to patients if a hospital does not have an emergency room. Secretary Dudek responded that an emergency department must meet federal emergency access requirements and stabilize any patient who arrives at the center, and then they may have the patient transported elsewhere for additional care. She said that the procedures allowed depend on the title of the facility and the billing code for the procedure. Commissioner Seevers asked if the facilities were exempt from reporting receipt of LIP funding. Deputy Secretary McKinstry will obtain the answer and provide it to the Commission. The Commission discussed any savings that might be incurred through the use of urgent care centers rather than emergency departments.

The next topic was the posting of prices for specific procedures and who is required to post. Hospitals are not required to post their prices. Hospital licensure requires good faith estimate of charges for nonemergency medical services upon written request. Deputy Secretary McKinstry stated that 2011 Florida legislation requires urgent care centers publish and post a schedule of charges for medical services offered to patients. Procedure pricing is required at an offsite emergency department of a hospital that is presented to the general public in any manner as a department where immediate and not only emergent medical care is provided. Pricing is also required at an offsite facility of a hospital or a joint venture between a hospital and a provider licensed under Chapters 458 or 459, Florida Statutes, which does not require a patient to make an appointment. Health care clinics that maintain three or more locations using the same or a similar name, which does not require a patient to make an appointment, and holds itself out to the general public in any manner as a facility or clinic where immediate but not emergent medical care is provided must also post their prices. The posting of charges are required to include a layperson description of the procedures, as well as prices for uninsured persons for the 50 most frequently provided services. The posting must be conspicuously posted in the reception area.

Commissioner Cancio Johnson asked Secretary Dudek for a history of fines for failure to post charges and Vice Chair Kuntz stated that he would like to see clarity of the definitions for healthcare facilities and how they are branded, so the public will understand what services they may expect to get.

Overview of Proposed Legislation on Ambulatory Surgical Centers: Representative Jason Brodeur, Florida House of Representatives gave the Commission an overview of legislation filed regarding ASCs. He prefaced the conversation by explaining that the 2015 legislation passed the House of Representatives, but was not approved by the Florida Senate and would therefore be filed again for the 2016 legislative session. He began by providing the statutory definition of

an ambulatory surgery center pursuant to s. 395.002, Florida Statutes, and noted that the Medicare reimbursement is generally limited to stays of no more than 24 hours. The legislation will change the allowable length of stay in an ASC from less than one working day to no more than 24 hours, which is the Federal Medicare length of stay standard. The bill creates a new license for a Recovery Care Center (RCC), defined as a facility the primary purpose of which is to provide recovery care services, to which a patient is admitted and discharged within 72 hours, and which is not part of a hospital. All patients will need to be certified as medically stable and not in need of acute-hospitalization by their attending or referring physician prior to admission in an RCC. A patient may receive recovery care services in an RCC upon discharge from an ASC after surgery; discharge from a hospital after surgery or other treatment; or receiving an out-patient medical treatment such as chemotherapy.

The proposed RCC license is modeled after the current licensing procedures for hospitals and ASCs, subjecting RCCs to similar regulatory standards, inspections, and rules. RCCs must have emergency care and transfer protocols, including transportation arrangements, and referral or admission agreements with at least one hospital.

Vice Chair Kuntz asked why, if Medicare already pays for a 24-hour stay, the bill would have opposition. Representative Brodeur responded that some believe that patient safety would be compromised.

Commissioner Lamb asked if RCC services were covered by Medicaid and if the legislation had passed. Representative Brodeur responded that he believes Medicaid covers ASCs, not an RCC, and the bill had passed the House of Representatives during the 2015 session but not the Senate. Commissioner Lamb inquired as to how RCC services would affect the survival of rural hospitals. Representative Brodeur replied that there could be a review of reimbursement models for under and uncompensated care for rural hospitals, as well as consideration of alternative funding from block grants or other federal funding sources.

Vice Chair Kuntz asked about advertising emergency room wait times as opposed to dissuading emergency room usage and clarifying definitions for the use of facilities for consumers. Representative Brodeur stated that a lack of transparent understanding of consumer education of the healthcare marketplace makes it difficult to understand what metrics are meaningful to consumers.

Vice Chair Kuntz inquired if removing some or all Certificate of Need (CON) requirements would improve the current health care environment. Commissioner Seevers suggested that CON requirements be eliminated, at least for hospitals, and Chair Beruff reminded the Commission that California and Texas no longer have CON regulation. Representative Brodeur responded by stating that while the House passed a bill during special session to eliminate CON regulations for hospitals, that he would be in favor of eliminating the CON program altogether.

Commissioner Seevers inquired whether ASCs currently receive intergovernmental transfers (IGTs). Representative Brodeur noted that approximately 39% of all charges to an ASC is

commercial pay, 30% is Medicare, and 19% is a combination of Medicaid Managed Care and Medicare Managed Care. Secretary Dudek added that ASCs did not receive any LIP funding.

Commissioner Lamb asked if the legislation allowed a physician to refer a patient to a recovery care center in which they had ownership. Representative Brodeur responded that the practice would be allowed as there is no law prohibiting it.

Commissioner Ken Smith asked how to create more transparency. Representative Brodeur replied that he would like to see publishing of prices and consequences for those hospitals that do not publish them. He added that payments should be tied to outcomes rather than to procedures, and suggested that payments be based on readmissions and infection rates because payments based on procedures are not always aligned with the best outcomes.

Commissioner Marili Cancio Johnson stated that Florida health plan contracts with hospitals need to be more transparent and should be required to publicly release the details of their payment arrangements with hospitals.

Vice Chair Kuntz asked Representative Brodeur if hospital funding could be determined by performance metrics. Representative Brodeur agreed that performance metrics could be a funding factor.

Update on Medicaid Rate Certifications: Secretary Dudek gave a brief report on Medicaid rate certifications. She stated that on July 17, 2015, she sent a letter to all Florida hospitals and managed care plans participating in Statewide Medicaid Managed Care to certify that they were meeting the provisions of s. 409.975(6), Florida Statutes, relating to hospital reimbursement levels. In her letter, she stated that failure to submit the requested certification by August 1, 2015 would be treated as acknowledgement of non-compliance with the request. Seven hospitals did not respond, and 24 responded after the deadline. The Secretary reported that Governor Scott asked her to direct the Office of Medicaid Program Integrity (MPI) to audit all hospitals and plans that did not certify their compliance as of August 1. Pursuant to the Governor's request, she requested that MPI develop an audit plan, including any and all applicable sanctions related to non-responsiveness, and commence the audit of the facilities listed above immediately, so it can be determined whether hospitals and insurance plans have entered into contractual agreements that are fully compliant with state law.

Chairman Beruff asked what would be the remedy for facilities charging more than 120% of the Medicaid rate. Secretary Dudek responded that the plans could renegotiate the contracts with the hospitals. Vice Chair Kuntz asked if there was a way to punish those non-compliant entities, and the Secretary noted that the MPI office is looking into a response to non-compliant facilities. Commissioner Seevers asked what the Agency considered to be responsive, as she didn't feel the responses stating that the state already has access to the information as an acceptable response.

Dr. David Shapiro Presentation: Dr. David Shapiro from Red Hills Surgery Center in Tallahassee, Florida gave the Commission a presentation on freestanding ASCs. He reminded the Commission of the definition of an ASC and some of the limitations due to current law,

specifically discussing the law regarding no overnight stays for patients. He suggested that the centers be able to allow patients to stay up to 24 hours following an admission, which is in line with federal Medicare regulations. He noted that the current definition is unique to ASCs and does not pertain to other outpatient surgical service locations, such as office surgery or hospital outpatient departments (HOPD). Vice Chair Kuntz asked if other states allowed the 24-hour stay. Dr. Shapiro responded that 35 state laws do allow for the 24-hour stay. Commissioner Cancio Johnson inquired if Florida's laws are currently the same as the 35 states. Dr. Shapiro stated that the laws in Florida are not the same, but that the proposed legislation Representative Brodeur discussed would accomplish the change and would not change the way care is delivered in ASCs. Dr. Shapiro highlighted the benefits to the providers and patients.

Chair Beruff inquired if the procedures were recorded. Dr. Shapiro responded that while the procedures are not actually recorded, Red Hills Surgical Center has an observation deck where people can observe surgery. He did qualify his statement by reminding the Commission that laparoscopic procedures are in fact recorded by a video camera.

Dr. Shapiro stated that three hallmarks patients are looking for are safety, convenience and outcomes; and that Red Hills Surgical Center provides these things. Commissioner Cancio Johnson asked about quality reporting, infection rates and readmission rates. Dr. Shapiro answered that Florida does not require ASCs to report, as they are very difficult to track in a surgery center; but Red Hills does track infection rates within the ASC.

Dr. Shapiro next discussed the different ownership structures of ASCs. He stated that there are usually multiple owners and owner types. He pointed out that ASCs are comparable to Hospital Outpatient Departments (HOPD). He noted their similar range of services and clinical equivalencies. While the two are quite similar, on average, Medicare pays significantly less, approximately 53% less, for procedures performed in ASCs than it pays to HOPDs.

Commissioner Cancio Johnson asked if Medicare and Medicaid have the same reimbursement schedules. Dr. Shapiro answered that they do not and there are negotiations involved with Medicaid. He referred the Commission to the Florida Health Finder website to see the savings earned on specific procedures through the use of ASCs. He noted that according to the Department of Health and Human Services, Office of Inspector General, as a result of the payment differential, Medicare saved almost $7 billion and beneficiaries saved an additional $2 billion from 2007 to 2011.

Dr. Shapiro moved on to discuss ASC regulation and oversight. He reported that all ASCs are subject to rigorous oversight and independent inspections to assess each center's level of compliance with both state and national standards. He also reported that ASCs that treat Medicare beneficiaries must meet federal government standards and demonstrate continual compliance with Medicare's standards as well as state specific licensure and reporting requirements.

Dr. Shapiro stated that the ASC industry supports disclosure of pricing information. Typically, ASCs make pricing information available to their patients in advance of surgery. The industry is eager to make price transparency a reality, not only for Medicare beneficiaries, but for all patients. To offer maximum benefit to the consumer, these disclosures should outline the total price of the planned surgical procedure and the specific portion for which the patient would be responsible. This will empower health care consumers as they evaluate and compare costs for the same service amongst various health care providers.

In closing, Dr. Shapiro stated that due to the continued fiscal challenges posed by administering health care programs, policy makers and regulators should continue to focus on fostering innovative methods of health care delivery that offer safe, high-quality care. Support should be reserved for those policies that foster competition and promote the utilization of sites of service providing more affordable care, while always maintaining high quality and stringent safety standards. In light of the many benefits ASCs have brought to the nation's health care system, policymakers should develop and implement payment and coverage policies that increase access to, and utilization of, ASCs.

Presentation, Dr. Dean Watson – Tallahassee Memorial Hospital: Dr. Dean Watson from Tallahassee Memorial Hospital (TMH) gave the Commission a brief overview of TMH. He mentioned that TMH has a Level II Trauma Center, a Level III Newborn Intensive Care Unit, Specialized Intensive Care Units and Advanced Endovascular Neuro and Heart Procedures are available. He went on to report that TMH provides $20,440,100 in charity and uncompensated care. Dr. Watson told the Commission that TMH houses three physician residency programs as well and nursing and pharmacy residency programs.

Dr. Watson told the Commission that Tallahassee physicians determine where to perform a patient's surgery based on the type of procedure, the case complexity, and the support services required. By partnering with local ASCs there are efficiencies gained, such as shared administrative support, medical staff support, and the avoidance of process duplication. TMH also advocates the use of transition centers for patients with 3 or more admissions in the past year, patients with no primary care, patients who are not insured, patients with chronic diseases, and patients unable to arrange follow up within 7 days of discharge. The impact of the transition center is the reduction of visits and costs in the first 90 days after discharge. The total variable cost avoided is $273,759.

Next, Dr. Watson discussed the use of telemedicine at TMH. He described the goals of telemedicine as an improvement of overall health and quality of life for patients while increasing patient access to primary and specialty care. The use of telemedicine increases efficiencies within the regional health system to promote successful transitions of care and reduce readmissions and unnecessary transfers to the emergency department. Telemedicine is currently being used to expand behavioral health services to rural community and work with rural emergency departments on Baker Act evaluations. Telemedicine allows the hospital to partner with primary care providers as well as follow-up on outpatients.

Other benefits gained by using telemedicine include reducing unnecessary readmissions and visits to the emergency department by connecting medical directors to Long Term Care, Specialized Nursing Facilities, and rehabilitation facilities. Thereby reducing transfer costs, increasing patient safety, and increasing both the patient and the provider's satisfaction.

Dr. Watson explained to the Commission that telemedicine and tele-monitoring are similar but not the same. Tele-monitoring allows providers to remotely monitor key health indicators such as weight, blood pressure, oxygen levels, glucose, and health behaviors. Interventions are provided quickly to prevent health episodes that result in hospitalization or a visit to the ER. This empowers the patient be an active participant in managing their own health.

In closing, Dr. Watson stated that the remote monitoring pilot project monitored 23 high emergency department users for 30-60 days. There were 105 emergency department visits prior to remote monitoring and only 18 visits after having remote monitoring for an 83% impact.

Commissioner Smith asked if the use of telemedicine would decrease the need for physicians and nurses. Dr. John Armstrong asked what workforce efficiencies could be anticipated through adoption of team-based care and telemedicine. Dr. Watson responded that there will always be a need for more physicians and nurses. However, by using telemedicine, the support of one physician can provide care across the panhandle and see patient vitals as well as the patient without having to drive across town.

Dr. Watson suggested telemedicine legislation to support reimbursements on both ends of the transmission, as well as legislation to correct the shortage of physicians and nurses in Florida.

Vice Chair Kuntz asked if TMH was part of an organization participating in telemedicine, or if the facility was leading the way. Dr. Watson responded that TMH was leading the way in telemedicine for Florida. He added that telemedicine can reduce costs, readmissions, and increase efficiency. It allows expansion of behavioral health services to rural communities, partnerships with primary care providers and outpatient follow-up.

Commissioner Lamb inquired if the savings were seen by the hospital or the patient. Dr. Watson replied that there are cost savings, and because telemedicine is innovative they were able to write for LIP grant funding to cover some costs.

Commissioner Smith asked if the ability to use telemedicine really affects patient outcomes. Dr. Watson responded that ultimately the patient's behavior is what needs to change. A patient who has not had a primary care physician will usually go to the nearest emergency department for treatment.

Commissioner Cancio Johnson noted that the TMH service area included parts of southern Georgia. She asked who pays for their care. Dr. Watson clarified that Georgia Medicaid would pay for a Georgia patient. However, those out of state patients without insurance or Medicaid would receive treatment as required by EMTALA.

Next meeting: The next meeting of the Commission on Healthcare and Hospital Funding will be held on August 31, 2015 at 9:00 am in Orlando, Florida.

Meeting Adjourn: There being no further discussions, the meeting adjourned at 12:30 p.m.