DRAFT

Summary of Statements from Meeting Minutes Related to the Charges in Executive Order 15-99

INVESTIGATE THE EXTENT TO WHICH TAXPAYER FUNDING FOR HEALTHCARE SERVICES IS PATIENT-CENTERED

How are hospitals and healthcare providers ensuring that care is patient-centered? How do they define patient-centered health care?

Patient-centered care supports active involvement of patients and their families in decision-making about individual options for treatment. The Institute of Medicine (IOM) defines patient-centered care as: "Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."[1]

- Financial data has been presented and discussed during several meetings and included both operating and total profit margins, total and net revenues, estimates of costs, and calculations intended to estimate the *average cost per patient per day* and similar figures that relate healthcare spending and hospital revenues to episodes of care at the patient level. The Commission noted that much of this information is already available publically, but may not be in a readily usable format for consumers to utilize in decision making.
- Presentations from hospital executives included the types of services offered by each facility, how they ensure high quality patient care, and how they ensure the provision of healthcare services to all patients - including those who are unable to pay for their care. Several of the facilities discussed how they coordinate care within and outside of their hospitals to ensure smooth linkages and transitions of care for patients, and to help reduce readmissions and unnecessary hospitalizations.
- Industry experts and Representative Jason Brodeur discussed the characteristics and growth of Ambulatory Surgery Centers (ASCs) across the nation and in Florida. ASCs can offer a lower cost alternative for elective surgeries and other procedures. Proposed legislation may expand the ability of patients to utilize ASCs.
- Presentations from the Northeast Business Group on Health, the Florida Healthcare Coalition [and Associated Industries Florida] provided corporate and business sector perspectives from large employer groups related to purchasing insurance and healthcare services for employee groups – including a need for greater market transparency in order to ensure the highest possible value.

HIGHLIGHTS FROM MEETING MINUTES RELATED TO PATIENT CENTERED CARE

- The Commission would like to examine actual payments made to hospitals and not just billed charges.
- The Commission would like to start by finding a way to drill down the real cost for one patient, for one day in the hospital—adjusted by acuity—and comparing those costs with patient outcomes and satisfaction.
- The Commission agrees that at the basic level, there is a need to find the best health care access [and quality] that taxpayers are willing to pay for.
- Case Mix Index is an important factor for analysis purposes as a variable to "level the playing field"… Case mix index does somewhat enable a cost comparison, but it is imperfect and quality outcomes (relative to cost) should be kept in mind as well.

[1] Institute of Medicine. "Crossing the Quality Chasm: A New Health System for the 21st Century". Retrieved 26 November 2012.

- Members noted that overall, revenues from outpatient services tended to trend at twice as much as inpatient revenue when figures from all acute care general hospitals are aggregated.
- Length of Stay (LOS) is influenced by patient acuity (complexity) as well as payer mix – as both of these may influence the attending providers' ability to arrange for adequate care after discharge.
- Hospital accounting and reimbursement is not really understood, except by a very small proportion of the population, those in the industry; thus transparency of information is needed.
- Presenters to the Commission, including Dr. Makary, referenced studies showing that between 15 to 30 percent of treatment provided to patients is unnecessary – a result of the current fee-for-service market environment.

INVESTIGATE THE EXTENT TO WHICH TAXPAYER FUNDING IS CAUSING HEALTHCARE COSTS TO RISE OR FALL FOR FLORIDA FAMILIES

Does taxpayer funding support to hospitals and other providers make healthcare more or less affordable for Florida families?

- Hospital executives presented on the role of Medicare, Medicaid (including LIP), and other public support in relation to both private health coverage and the uninsured in the overall financial health of their hospital systems. There was much discussion around the cost shifting that occurs due to utilization among uninsured residents and the need to make up those costs to ensure long term sustainability of hospitals.
- Agency staff provided detailed data and presentations about hospital finances and trends, including specific information related to the state's Medicaid program and the Low Income Pool (LIP). The presentation covered recent changes in the Medicaid program including a transition to DRG based reimbursement for hospitals and statewide Medicaid Managed Care – both intended to contain spending of taxpayer dollars.
- Commission members received a copy of the Navigant Study of Hospital Funding and Payment Methodologies for Florida Medicaid.
- Agency staff provided data and information related to hospital and healthcare services utilization, including information on the most common procedures and conditions and associated charges.
- Dr. Marty Makary, author of *Unaccountable*, discussed cost and quality trends in healthcare along with some of the underlying root causes.
- A representative from the Florida Office of Insurance Regulation discussed the extent to which the state regulates health plans, and also presented on the primary cost drivers of increasing insurance premiums.
- Members were provided with a table of various State and Federal regulations and programs that act as behavior and cost reduction drivers for different provider types. Examples include the Medicare Hospital Readmission Reduction Program, the Hospital Value Based Purchasing Program, required routine data reporting and public disclosure, DRG based payments to hospitals, and other similar policies/programs.
- Representatives from the Northeast Business Group on Health and the Florida Healthcare Coalition, and Associated Industries of Florida discussed with members the trends and challenges among large employer groups related to providing health coverage and healthcare services to their employees, including continually rising costs.

HIGHLIGHTS FROM MEETING MINUTES RELATED TO HEALTHCARE COSTS FOR FLORIDA FAMILIES

- Overall, hospital facilities that earned at least 4% profits tend to provide less charity care than hospitals that have negative profit margins. Similarly, hospitals with an operating loss of 1% or more had higher levels of bad debt, charity and Medicaid utilization than hospitals that had a profit of four percent or more.
- By volume, more than 70% of hospital admissions in Florida are covered under a government sponsored resource such as Medicare, Medicaid, or private insurance that is purchased or supplemented by a tax funded source. Despite this fact, hospitals in Florida achieved record profits during 2014.
- The Commission would like a clear breakdown of all taxpayer funding going to each hospital and how those funds are spent in each facility.
- Commission needs to find where taxpayer money is going and what are the expectations (ie. accountability of providers) attached to it.
- The Commission questioned what incentives exist to keep hospital leadership efficient and how do hospital executives' contracts address their own effectiveness and efficiency.
- The Commission inquired whether there was a way to establish an efficiency ratio through existing data to effectively compare hospitals' financial performance. In response, Agency staff calculated an Average Cost per Patient Day from available data as one way to compare costs across facilities.
- Facilities that are profitable without LIP funding tend to remain profitable with LIP funds; and facilities that have not been profitable without LIP funding tend to remain unprofitable with LIP funding.
- The Commission noted that facilities which have a higher proportion of patients who are charity care or Medicaid recipients often serve to divert those patients from other facilities in the area - who in turn have a much smaller proportion of those payer mixes—and we need to keep in mind how those factors affect all facilities' profitability and performance… For example, the percentage of combined charity care and Medicaid recipients treated at Jackson Memorial was 34.8% of all inpatient revenue during 2014 and they achieved a total margin of 9.17%; while other providers in Miami-Dade who saw a lower percentage of charity and Medicaid patients achieved higher profit margins; **OR** UF Health Jacksonville which saw a payer mix of 51.8% percent charity care and Medicaid patients and had a negative profit margin of -1.32%, while Baptist Medical Center nearby saw 26.5% charity care and Medicaid during the same time period and achieved profits of 19.63%.
- Overall, hospital profits/total operating margins have trended upward over the past 10 years, with the exception of Government owned hospitals which have remained stable.
- The Commissioners question why the financial performance and cost to patients across the health care industry isn't regulated better, and why the billing side is completely shrouded from the consumer.
- Presentations from hospital executives confirm that hospitals routinely cost shift the expense of caring for the uninsured and underinsured to customers who pay for their care either as self-pay or through insurance.
- The hospital executives noted that the largest cost drivers in a hospital are staff and supplies.
- Health care needs a competent market place where hospitals compete based on value—outcome over price.
- An All Payer Claims Database (APCD) would collect the data/information needed to determine the average payments for services across all payer types, and to compare pricing across different facilities and providers – Florida does not currently have an APCD.

INVESTIGATE THE EXTENT TO WHICH TAXPAYER FUNDING IS CONTRIBUTING TO HEALTH OUTCOMES FOR FLORIDA FAMILIES

Does taxpayer funding contribute to health outcomes?

- Agency staff presented on publically available hospital and healthcare provider quality and outcomes data that is hosted on FloridaHealthFinder.gov.
- Agency Medicaid staff presented on specific quality and outcome related performance expectations that have been built into Medicaid Managed Care contracts.
- Dr. Marty Makary, author of *Unaccountable*, discussed how variations in treatment practices can impact both health outcomes and costs. He stated that medical errors are the third leading cause of death in the United States. He also indicated that American physicians have created at least two distinct standards of care and that not everyone is a candidate for the better approach (based on their ability to pay).
- Dr. Makary mentioned that Florida is ahead of the curve in collecting and reporting data and quality metrics.
- Presentations from health plan representatives (Florida Blue and Molina) discussed how plans are helping to incentivize more patient-centered care through a shift toward reimbursing providers for quality outcomes and away from the traditional fee-for-service model of paying for the volume of services provided.
- A representative from 3M Health Information Systems presented on the use of data to measure outcomes such as hospital readmissions, potentially preventable hospitalizations, and other potentially preventable events. When used appropriately, these metrics can assist healthcare providers in improving outcomes.

HIGHLIGHTS FROM MEETING MINUTES RELATED TO HEALTH OUTCOMES FOR FLORIDA FAMILIES

- The state of measuring health care is poor but Florida is ahead of the curve in collecting data as well as measuring and reporting metrics.
- The healthcare system needs to align incentives to desired outcomes.
- Health insurers and government (Medicare and Medicaid) are driving an overall paradigm shift in the industry from paying for volume of services toward paying for performance (quality outcomes).
- The Commission suggested that it would be nice if [they] could recommend a group to create core measures for measuring hospitals that receive state money.
- In broad terms, medical mistakes is the third leading cause of death in the United States.

INVESTIGATE THE EXTENT TO WHICH TAXPAYER FUNDING IMPACTS ACCESS TO AND QUALITY OF CARE FOR FLORIDA FAMILIES

What is the impact of taxpayer funding on healthcare access and quality for Florida families?

- Presentations from hospital executives, specifically during the Transparency Tour, covered issues related to access to care for all residents with emphasis on ensuring access to needed emergency and hospital services to the uninsured. The hospital representatives also discussed their various programs to monitor and improve quality.
- At least one Commission meeting focused on quality and included presentations and discussion with representatives from the National Surgical Quality Improvement Program and Florida Blue.

- Representatives from the Northeast Business Group on Health and the Florida Health Care Coalition discussed various methodologies of quality rating for hospitals, and provided detailed information on LeapFrog and Hospital Safety Scores.
- Multiple public commenters expressed a need for greater access to health coverage and/or healthcare services for the state's working uninsured. Members were reminded that individuals who do not have insurance often forego needed primary and ambulatory acute care due to cost, and that delay of care can often lead to more serious illness or complications that require more costly hospital based intervention – subsequently providing a greater strain on the system overall.

HIGHLIGHTS FROM MEETING MINUTES RELATED TO ACCESS AND QUALITY FOR FLORIDA FAMILIES

- Facilities often close wings or floors depending on occupancy; the Agency calculates occupancy based upon licensed beds, not of active/inactive beds.
- The federal government has noted that [LIP] money should follow the patient.
- Large employer groups, especially self-insured employers, are actively seeking ways to reduce healthcare spending – through value based benefit design (paying for outcomes versus volume of services) and also through employee engagement and wellness initiatives.
- In terms of Worker's Compensation, for every $.70 spent on treatment, only $.30 is payment to the injured worker for lost wages…the ratio should be 50/50, but Florida is an outlier state.
- The Commission has requested the top 10 quality indicators that could be examined across all hospitals. The Governor's proposed Transparency bill includes a provision to consult with the State Health Information Policy Advisory Council to determine the best ten indicators/metrics to display for consumers.

INVESTIGATE THE EXTENT TO WHICH PATIENTS ON MEDICAID EXPERIENCE BETTER OR WORSE HEALTH OUTCOMES COMPARED TO OTHER PATIENTS.

Do Medicaid patients experience better or worse healthcare outcomes compared to patients that are not on Medicaid?

- Presentations from the state's Medicaid program discussed a paradigm shift in how hospitals are paid – moving to a DRG (Diagnostic Related Group) model for inpatient services where hospitals are reimbursed for an episode of care regardless of cost or volume of procedures. The presenters also discussed the state's Medicaid Managed Care program moving from a fee-for-service model and the anticipated cost savings to taxpayers that will be achieved through this model. Both models better incentivize providers to improve patient outcomes through better care coordination and ultimately to reduce costs.
- Agency Medicaid staff presented on specific quality and outcome related performance expectations that have been built into Medicaid Managed Care contracts.
- A representative from Molina Healthcare, one of the larger Florida Medicaid health plans, discussed how their organization is helping to incentivize higher quality care through a shift from paying for volume (fee for service) to paying for value (outcome based reimbursement).
- Recent HEDIS (Healthcare Effectiveness Data and Information Set) findings indicate that Florida's Medicaid Managed Health plans scored higher than the national average in more than half of the performance metrics measured by the National Committee for Quality Assurance (NCQA). **In 2014, Florida's Medicaid plans performed as well as or better than the national Medicaid average on 65% of HEDIS measures**.

HIGHLIGHTS FROM MEETING MINUTES RELATED TO MEDICAID OUTCOMES FOR FLORIDA FAMILIES

- The Commission queried whether different payer classes tend to receive different treatment—and whether there is any data that can be used to determine this.
- The Commission suggested that Medicaid encounter data (now being collected under Medicaid Managed Care) would be useful to assess for quality, and implement quality improvement measures as needed.
- Agency staff provided information that 44 performance measures are in the Medicaid Managed Care contracts with health plans, based on HEDIS (Healthcare Effectiveness Data and Information Set) measures.

INVESTIGATE THE EXTENT TO WHICH CERTIFICATE OF NEED (CON) LAWS IMPACT THE AFFORDABILITY, ACCESS, AND QUALITY OF HEALTHCARE SERVICES FOR FLORIDA FAMILIES

Do CON laws impact the affordability (cost), access and/or quality of healthcare?

- Agency staff provided a detailed overview of CON regulations in Florida – including the history, evolution, current status, and comparisons to regulation in other states.
- Nearly all guest speakers have been invited to provide their opinions on CON regulations.
- State Representative Jason Brodeur presented to the members information about proposed legislation. He mentioned that a bill had passed in the House during this year's first special session to eliminate CON, but there was not movement in the Senate on the topic.

HIGHLIGHTS FROM MEETING MINUTES RELATED TO CERTIFICATE OF NEED

- Hospitals that tend to maintain lower occupancy percentage rates tend to be less profitable than hospitals with higher occupancy percentage rates.
- The CON program currently regulates entry into the marketplace for state licensed hospitals, nursing homes and hospices.
- Hospital executives that presented to the Commission indicated that CON is complex and should be improved or eliminated… One executive noted that without the program, he believed specialty hospitals and suburban hospitals would be free to siphon off patients that currently subsidize urban hospitals through cost shifting. He also noted that there is a limitation of some resources, noting transplant services as a specific example, and that there is a limited source of organs.
- When asked if CON was eliminated, what would prevent a hospital located in a poor area from moving to a more affluent area? Hospital executives explained that nothing would prevent a hospital from moving to a more affluent area in order to increase profits.

INVESTIGATE THE EXTENT TO WHICH TAXPAYER-FUNDED HOSPITALS PAY FOR LOBBYISTS, CAMPAIGN CONTRIBUTIONS, AND ADVERTISING

How much do Taxpayer Funded hospitals pay for lobbyists, campaign contributions, and advertising?

- As a finding - This information has proven to be largely unavailable across the industry, and the majority of providers have been reluctant to provide the information upon request.

- The Commission has been provided with available information on the salaries of hospital CEOs in Florida, as primarily compiled from IRS 990 filings from the non-profit hospitals. No information was provided from for-profit hospital systems related to executive compensation or other administrative expenses including campaign contributions, lobbying, or marketing costs.
- Hospital executives indicated that labor costs and supplies are the largest drivers of hospital costs.
- Presentations from hospital executives indicate that non-profit hospital CEO salaries are typically set by Board or committee, and are contained within the 50th to 75th percentile of salaries for executives of similar sized institutions.

HIGHLIGHTS FROM MEETING MINUTES RELATED TO SPENDING FOR LOBBYISTS, CAMPAIGNS, AND ADVERTISING

- Hospitals and other healthcare providers should be more transparent about their costs, including key administrative costs such as executive salaries, funding for lobbyists and campaigns, and marketing.
- Available data on hospital staffing counts only directly employed full time equivalents (FTEs) and does not account for staff associated with services that are provided in the hospital under contracts with other organizations. There are an unknown number of staff working in facilities under these contracts.
- Available data shows that during the national economic recession, hospital FTE salaries tended to remain flat across all hospitals, but then started to rise as the economy began to recover and revenues improved - with the exception of for-profit facilities whose salaries remained flat.
- The Commission noted that hospital executive salaries should be tied more closely to hospital performance and patient outcomes.

INVESTIGATE THE EXTENT TO WHICH TAXPAYER FUNDING IMPACTS FLORIDA FAMILIES' SATISFACTION WITH THEIR HEALTHCARE SERVICES

How does Taxpayer Funding impact patients' satisfaction with their healthcare?

- Information and available scores from the national Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) program was shared with members. Hospital HCAHPS scores are available on FloridaHealthFinder.gov and also through other public sources. Individual hospital HCAHPS summary scores (star ratings) were included as a key metric for hospitals that presented during the Transparency Tour.

HIGHLIGHTS FROM MEETING MINUTES RELATED TO PATIENT SATISFACTION FOR FLORIDA FAMILIES

- Hospital and provider quality information, including patient satisfaction, should be readily available for consumers, and should be used alongside cost/pricing information when evaluating a hospital.
- 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.