DRAFT MEETING MINUTES

COMMISSION ON HEALTHCARE AND HOSPITAL FUNDING

Meeting Date: December 1, 2015

Time: 9:00 a.m. – 1:00 p.m.

Location: The Florida Capitol, Lower Level Cabinet Room, Tallahassee, FL 32399

Members Present: Carlos Beruff, Chair; General Chip Diehl; Marili Cancio Johnson; Eugene Lamb, Jr.; Dr. Jason Rosenberg; Sam Seevers; and Dr. Ken Smith

Members Present via Telephone: Tom Kuntz, Vice Chair; Robert Spottswood

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

Interested Parties Present: Phillip Baker; Bill Bell, Florida Hospital Association; Marti Coley Eubanks, Nemours; Jules Kariher, Sacred Heart Health System; Laura Lenhart, Moffitt Cancer Center; Rich Romanski, Fair Health; Ron Watson, Florida CHAIN

AHCA and DOH Staff Present: Nathan Dunn; Beth Eastman; Nikole Helvey, Elizabeth Keating; Josh Spagnola

Call to Order: Carlos Beruff, Chair, called the meeting to order at 9:00 a.m. and called the roll.

Review and Approval of Meeting Minutes: The minutes from the November 10th, 16th and 19th meetings of the Commission on Healthcare and Hospital Funding were approved.

Intermountain Healthcare

The Commission received a report from Brent C. James, M.D., M. Stat., the Chief Quality Officer and Executive Director of Intermountain Institute for Healthcare Leadership. Intermountain Healthcare is a charitable non-profit integrated care delivery system located in Utah and Idaho. The health care system delivers a disproportionate share of all unreimbursed care in the region. The system's Board of Trustees is unpaid, and community-based, whose mission includes "be a model system." Intermountain was founded in 1975 and currently includes 22 hospitals, over 185 clinics ranging from small critical access rural facilities to large quaternary academic teaching / research hospitals. There are more than 1,200 employed MDs, with approximately 1,600 aligned affiliate MDs (community-based independent physicians), with approximately 2,000 loosely affiliated MDs.

Intermountain's health system also houses an integrated Health Maintenance Organization (HMO), SelectHealth with more than 750,000 members. SelectHealth funds 27% of all of Intermountain's care delivery.

Dr. James described a study that Intermountain conducted regarding the costs of healthcare, and their findings. He listed 5 healthcare situations that contribute to poor healthcare. They are: massive variation in clinical practices; high rates of inappropriate care; unacceptable rates of preventable care-associated patient injury and death; inability to do what is proven to work; and huge amounts of waste, leading to

spiraling prices that limit access to care. He told the Commission that he would show them the tools used in the study to deal with the complexity of healthcare.

He described the concept of Shared Baseline Lean protocols as identifying a high-priority clinical process to build an evidence-based best practice protocol. Blend the protocols into existing clinical workflows and develop a data system to track protocol variations and short and long term patient results. Demand that clinicians vary based on the individual patient's needs. Finally, feed the data back in a lean learning loop; or a feedback system.

The results of this practice is a survival rate improvement from 9.5% to 44%; lower costs, approximately 25%; and physician time decreased by approximately 50%, allowing the physician to increase their productivity. Dr. James remarked that implementing changes puts the professional back in control, rather than the administrators.

Dr. James described cutting waste as one of the best ways to improve a healthcare practice's finances. He said that often times, practices focus on growing their revenue, rather than decreasing waste and improving the quality of care and the profits of the practice.

Commissioner Sam Seevers inquired about charity care, bad debt and uncompensated costs. He responded that they do charity work, and their bad debt was around 2% - 4%. He went on to say that Intermountain evaluates each patient at the onset to determine if their care can be charity care, rather than having bad debt, simply because collection is impossible. During the initial evaluation, Intermountain will determine if the care will be free, or discounted or full. He said they never charge anyone higher prices, simply because they don't have insurance.

Dr. James remarked that policy changes alone may not improve the healthcare situation in Florida, but if one or two physician practices would begin to follow Intermountain's model, it may take off. He noted that capitated payment rates had helped.

Dr. John Armstrong, State Surgeon General and Secretary of Health asked if the Utah Legislature had offered any incentives to other organizations to operate their practices under this model. Dr. James responded that the Utah Legislature converted the State's Medicaid program into an Accountable Care Organization, thereby encouraging the capitated model. Utah law mandates that the Utah Medicaid population and costs can only grow at the same rate as the state budget. The Utah Legislature determines what the State's Medicaid costs will be.

Chair Beruff asked how many of the efficiency decisions were conducted internally or if external consultants had been used. Dr. James responded that the decisions were predominately internal. He stated that there are other organizations transitioning into this model and gave a few examples.

Next, Dr. James reviewed the theories of William Edwards Deming, whose theories revolve around process as a way to improve quality and lower costs. He reviewed the measurement of physical outcomes, cost outcomes and service outcomes and stressed that service outcomes were extremely important and are easily measured.

Commissioner Sam Seevers asked Dr. James if Utah has a Certificate of Need program. He responded that he thinks they do, but it is a box that is checked on a form prior to increasing the size of a hospital. He didn't feel it had any impact on the building of hospitals in Utah. He went on to comment that Florida is built out in terms of the number of necessary beds.

Commissioner Dr. Ken Smith asked Dr. James why the medical profession does not police itself in regards to fraudulent charitable care reporting. Dr. James asked in response how that could be accomplished, what mechanism is available for him or any other physician to self-police. He stated that his only action is to be a good example and tell the truth. He predicts that at some time in the future the state or federal agencies will put enough pressure on hospitals that will cause them to step up and make changes.

Chair Beruff reminded Dr. James that he stated that 50% of all healthcare is waste. He asked if that were true on a national level. Dr. James responded that he believes that it is, but a lot of other healthcare professionals don't agree. Dr. James repeated that he believes that Florida's built out and the waste percentage is higher.

Chair Beruff thanked Dr. James for coming from Utah and trying to help Florida set goals for the citizens of Florida so the Commission can do what it thinks is the perfect outcome which is efficiencies by driving down costs and delivering better care in the process.

Public Comment

The Commission heard from Lindsay Barrack, a Floridian who feels she has been price gouged at Tallahassee Memorial Hospital. Lindsay broke her finger and went to the hospital for surgery. Lindsay said that she requested to know the price for the operating room up front, but did not get a response. After the surgery, she received a bill for almost $18,000 with no itemization of charges and a deadline of four days to make the payment.

She was in the hospital for a total of three hours and was charged for way more than a total of three hours. She had to be anaesthetized longer than expected which lead to the use the room longer, because they had to wait for the proper hardware to be delivered down to the operating room. She is not saying she doesn't think she should be charged, but not $18,000; which does not include the anesthesiologist, and does not include the radiologist or the surgeon.

Secretary Dudek thanked Ms. Barrack and commented that the Agency would reach out to Tallahassee Memorial Hospital to help arrange a meeting to discuss the costs included in Ms. Barrack's bill.

The Commission next heard from Mr. Rich Romanski, representing Fair Health. He reported that Fair Health currently worked with several states on All Payer Claims Databases (APCD). He stated that he expects that the Commission will be looking at ACPDs in the future, and thanked the Commissioners for the job they are doing.

Hospital Consolidation

Mr. Averik Roy with the Manhattan Institute spoke to the Commission about hospital consolidation and the role it plays in the high costs of healthcare. While a lot of attention has been paid to the need for payment reforms, attention should be shifted to the way healthcare is sold. He noted that federal policies control how healthcare is paid for and the states don't have much authority to change that. However, the states have an opportunity to determine what the policies will be regarding how healthcare can be sold, so he feels that it is a more relevant topic for the Commission to focus on.

Mr. Roy stated that the public perception is that money could be saved if the profits of the insurance companies were wiped out. However, the large insurance company's profit margins are quite low, averaging 3.5%. So, the pursuit of higher profits for the insurance companies is not what is driving the healthcare costs so high.

Another false perception is that American's over use hospitals. The thought is that there is a lot of waste in a hospital, so if they can keep their patients out of hospitals by managing their care more efficiently, it would cut waste. Mr. Roy shared that the United States is already one of the most efficient countries in the world in regards to utilization of hospital care. He compared America's average hospital stay length of 4.8 days to the world average of 7.7 days. This difference is due to the good job the American health care system is doing through technology and other healthcare advances. He noted that the longer a patient is hospitalized, the more expensive the bills become due to the unnecessary daily charges that come with being in a hospital. Mr. Roy stressed that the difference in healthcare received in America compared to most advanced, industrialized countries is cost of the MRI, the cost of the pharmaceuticals, and all of the high, individual costs for each service received.

Mr. Roy went on to say that hospitals are not the only thing in American healthcare that is high priced. He noted that the average primary care visit is over 3% higher than most other advanced industrialized countries.

Mr. Roy explained to the Commission the reason for such high healthcare costs. He said it began in the early 1960's with Medicare and Medicaid. Because the healthcare being received by these populations was free, the patients became insensitive to the costs of the healthcare they were receiving and began to use much more healthcare, which led to many hospitals expanding to handle the demand. When it came time to pay the bills for the Medicare and Medicaid healthcare, the governments realized that the programs were unsustainable due to the patient behaviors. So, Medicare, Medicaid, and insurance companies negotiated with the hospitals to charge their patients lower fees for services. This led hospitals to merge to gain power over the insurance companies in negotiations. Since the insurers could not get prices as low as they wanted, they raised customer premiums; leaving many people priced out of health insurance.

Mr. Roy reminded the Commission that even though they can clearly see where and how the pricing became out of control, they need to find a way to stop providers from charging whatever they want regardless of the actual costs.

Next, Mr. Roy showed the Commission a chart indicating that healthcare costs were dramatically cut in the 1990s when Health Maintenance Organizations became very popular over the standard insurance policies. At the same time HMOs were becoming popular, hospitals were merging, creating local monopolies, giving them the ability to raise healthcare prices dramatically. He noted that in any other industry, the Federal Trade Commission (FTC) would not allow the mergers due to anti-trust laws.

Mr. Roy explained the Herfindahl-Herschman Index (HHI) market concentration which shows the concentration hospital monopolies in specific areas. He showed the Commission an HHI map of Florida that indicated that most of Florida is highly concentrated; meaning there are many large hospital systems. The merging hospitals often claim that the merger is to improve quality of care and access. However, data shows that the quality of care is unaffected. Hospital mergers have no impact for patients, but there has been a dramatic impact on prices. Mr. Roy said that large hospital systems charge approximately 44% more than hospitals in areas with more competitive markets.

This trend is also affecting physician's offices. Large hospital systems are acquiring medical practices from physician groups. Mr. Roy noted that in the past, most physicians worked for their own practices or small practice groups. Now, more and more physicians work for a hospital. This is allowing the practices to charge higher amounts as there is no local competition.

Mr. Roy told the Commission that the Medicare Payment Advisory Commission (MedPAC) is beginning to look at this trend and are attempting to pass laws to prohibit the monopolies from forming. MedPAC is also looking at rules to prohibit hospital systems from differentiating costs between Medicare A and Medicare B by allowing the lower of the two fees.

Mr. Roy said that there are two ways to tackle hospital consolidation. First, have the payers consolidate. Communities with single payer health care systems can keep the hospitals from artificially inflating prices. Another solution would be to increase the power of the payer and decrease the power of the hospitals.

Mr. Roy next discussed anti-trust in hospitals. He reiterated that in any other industry, the FTC would not allow the monopoly building mergers. He said that currently, states are monitoring the large hospital systems to try to ensure that prices don't become falsely inflated.

Next, Mr. Roy explained that the Affordable Care Act has language that helps shift the power to the payers. As in the case with the hospitals merging to gain leverage, payers can do the same thing. They can come together and refuse to pay the hospital fee increases.

Mr. Roy reported that an important element to lowering costs is price transparency. If prices were posted, patients would choose to pay the lower price, eventually forcing the higher costs down.

Direct primary care is an efficient and low cost way to provide an upgrade and access to care for Medicaid patients. The primary care provided would lower costs down the road as the patient won't become so sick that they need hospitalization.

On a federal level, despite the debate in Washington D. C. the actual chances of healthcare reform is very low due to the partisan make-up of the Congress and the probable outcomes of the 2016 election.

Commissioner Lamb asked Mr. Roy if the government should encourage consolidation. Mr. Roy responded that the government should discourage consolidation.

Dr. Rosenberg asked where to start to move toward transparency. He noted that patients don't tend to use the transparency tools provided. Dr. Roy stated that the typical way to deal with transparency is to make the hospitals post average prices for the 50 most common procedures. These lists are not very helpful because the patients know what their premium and deductions are, so they don't actually care what the costs are beyond their own.

Commission Discussion

Ms. Nikole Helvey, Bureau Chief, Florida Center for Health Information and Policy Analysis shared that there are 13 states with legislation similar to the 'direct primary care' legislation the Commission reviewed in Ft. Myers. Six of the 13 bills were passed in 2015; including Idaho, Kansas, Mississippi, Missouri, Oklahoma and Texas. She told the Commission that a brief analysis of the legislation will be provided to them.

Chair Beruff inquired if members of the Florida House of Representatives and the Senate had formally been invited to speak to the Commission? He requested that a letter of invitation be sent to the President of the Senate and the Speaker of the House of Representatives. Chair Beruff also asked staff to email the previous letter regarding the transparency legislation that was sent to the Legislative leaders and members of the health care committees.

Mr. Josh Spagnola, Legislative Affairs Director, from Agency for Health Care Administration provided the Commission an overview of upcoming legislation that included bills related to price transparency, the certificate of need program, expansion of scope for prescribing and recovery care centers. Mr. Spagnola offered to keep the Commission up to date through weekly emails.

Dr. Smith inquired if staff could provide analysis to the legislation they have been discussing to determine how closely aligned the language is to what the Commission has been discussing. Secretary Dudek directed Dr. Smith to the bill analyses included in the Commissioner's packets and offered to provide more detailed analyses if requested. Dr. Smith asked the staff to provide the Commission with color copies of Mr. Roy's presentation.

Commissioner Seevers commented that the Commission has heard a lot of information, but has yet to make any formal findings. She would like to have the Commission issue their final findings. She voiced her concern that the Legislative Session is about to begin and the Commission has not discussed their concerns or come to any findings or conclusions.

Chair Beruff asked the staff if the Legislature is hearing and reacting to the presence of the Commission. Mr. Spagnola responded that the Agency staff refers to the Commission when discussing legislation with the Legislators. Chair Beruff inquired if the Commission has had an impact on the bills filed. Mr. Spagnola stated that regardless of if the bill would have been filed, the issues have had a spotlight put on them by the Commission.

Commissioner Seevers asked the other Commissioners if their intention was to produce findings. Secretary Dudek directed her to a summary of findings included in the Commissioner's meeting packets. She noted that the findings in the document had been pulled from meetings minutes and would provide a good starting point for any conversation on the points included in Governor Scott's Executive Order.

Commissioner General Chip Diehl voiced his concern that future Commissions may look back and try to determine what this Commission has done. Without a final report or findings, there will be no record of all of the very important topics we heard about and discussed. He would like the Legislature and the Governor's office to have a record of what they believe Florida should continue to work on. Chair Beruff suggested that the Commissioners provide their edits and comments to staff. He stated that he prefers to use the verbiage describing the Commission's observations over the Commission's findings.

Co-Chair Tom Kuntz supports developing a final report of what the Commission has been presented with and what ideas should be investigated. The document should include summaries, observations, and recommendations along with next steps to evidence what the Commission has done. Chair Beruff requested that the staff develop a draft document with a paragraph or two on each of the topics discussed.

Secretary Dudek directed the Commission to the document in their packet to look at the highlighted portions pulled from past meeting minutes. She requested that the Commission read the document and submit their comments to staff to be included in the next Commission discussion. She noted that at the next Commission meeting the Agency is arranging to have someone from infection control come and discuss quality.

Chair Beruff directed the staff to pull together all of the information gathered on the top specific topics that appear to imply that the Commission has come to a consensus on. At the January 2016 meeting, the Commission will discuss the topics, one by one and develop a final report of observations with possible solutions.

Co-Chair Kuntz suggested that the summary document be drafted in a format that lists the 9 directives from the Governor's Executive Order and responds to each topic with what the Commission has observed and suggest. He would like to present this back to the Governor.

Dr. John Armstrong, State Surgeon General and Secretary of Health suggested that the Commission work to use the Governor's Executive Order as a framework and use the past meeting agendas to show how each of the Governors objectives has been fulfilled, and identity points from the meeting minutes where there was consensus on specific topics and where the Commission lacks clarity on its observations and requires more discussion to provide an accurate reflection of the Commission's observations.

Dr. Smith commented that he believes that the Executive Order does not ask for recommendations and the term observation is a more descriptive term for what the Commission has been doing. A Summary of Observations could be used by legislators or future Commissions to assist with drafting legislation to reform Florida's healthcare.

Commissioner General Chip Diehl suggested that all of the meeting minutes and presentations be included in the back of the Executive Summary packet. Chair Beruff responded that he believes that the entire Commission agrees with the General's conclusions.

Adjournment
There being no further business to discuss the Commission adjourned at 1:00 p.m.