DRAFT MEETING MINUTES

COMMISSION ON HEALTHCARE AND HOSPITAL FUNDING

Meeting Date: July 1, 2015

Time: 8:00 a.m. – 1:00 p.m.

Location: Jacksonville University

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

Members Absent: Robert Spottswood

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

Interested Parties Present: Kelly James, Florida Blue; Sue Nussbaum, MD, We Care Jacksonville; Gleanson Micheal, UF Health; Kelly Pray, Wolfson Children Hospital; Lesley Seaton, Wolfson Children's Hospital; Representative Cyndi Stevenson, Florida House of Representatives – District 17; Illiana Tidd, Jacksonville Civic Council; Colin Murphy, Jacksonville Children's Commission; Angela Demonbreun, Health Planning Council of Northeast Florida; Tony Penna, Enroll America; Alan Hubbard, St. Vincent's HealthCare; Representative Richard Pra, Florida House of Representatives – District 16; Jannifer Harper, Florida Blue; Representative Mia Jones, Florida House of Representatives – District 14; Joe Costa, DO, UF Health, College of Medicine; Sumayya Harris, Enroll America; Terri Devlantes, Jacksonville University; Mark Lloyd, Florida House of Representatives – District 12; TF6, Deanna McDonald, Health Planning Council; Jay Millson, Florida Academy of Family Physicians (FAFP); Betty Lustig, We Care Jacksonville; Mary Pat Corrigan, Volunteers in Medicine; Chris Bond, F Group; Ann Carey, St. Vincent's HealthCare; Beth McCague, UF Health; Donnie Romine, St. Vincent's HealthCare; Sam Young, Jacksonville University; Brenda Bradley; Nikki Pontello for Paul Renner, Florida House of Representatives – District 24; Andy Godwin, UF and UF Health Jacksonville; Kristal Bowen, Wolfson Children's Hospital; Suzy Jackson, First Coast Multilines Agency; Kim Streit, Florida Hospital Association; Cheryl Bergman, Jacksonville University, College of Health Sciences Russell Armistead, CEO, UF Health; David Vukich, MD, UF Health Jacksonville; Martha Santoni, Nemours; Linda Chrisman, MD, Consultant; Dan Ross, Med-Vision, LLC; Pam Chally, University of North Florida; Joyce Case, Health Planning Council; Bryan Campbell, Duval County Medical Society; Kyle Sanders, SVHC; Jamie Miller; Rachel Kohl, Health Planning Council; Al Diaz; and Erin Vanwey, UF Health.

Media: The Florida Channel; Cyd Hoskinson, WJCT; John Finley, WJXT; Marques White,WJXT; Chris Davis, WJXT; Charlie Gatton, Times Union; Sebastian Kitchen, Times-Union/Jacksonville.com; Charlie Patton, Times-Union/Jacksonville.com

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

Review and Approval of June 4th and June 17th Meeting Minutes: Minutes from both meetings were approved.

Jacksonville University's Director of Public Policy Institute, Rick Mullaney, welcomed the Commissioners to the campus and stated that public policy and health care funding is important to the university. He provided background information regarding the university and that the university is one of 16 schools considered to host the 2016 Presidential Debate. Members thanked Mr. Mullaney for the use of the facility on their beautiful campus.

Presentation from Florida Agency for Health Care Administration: Mr. Ryan Fitch, Chief of Central Services, provided data regarding the comparison of indigent care levels versus average length of stay to investigate hospital comments that indigent care drives up average length of stay. He found that the financial data did not support the hospitals' assertion but cautioned that the financial data may not be sufficient alone to reach a conclusion.

Mr. Fitch will take an in-depth look of the longer length of stays by using the hospital data reported to the Florida Center for Health Information and Policy Analysis instead of the hospital financial data to see if he can confirm the hospitals' assertion of average length of stay being higher for indigent patients vs the rest of the population.

Mr. Fitch provided an overview of the cost and revenue trend over a 10 year time period. He stated that the cost and revenue tracked closely. The hospitals overall are doing well in adjusting for cost over the years. He recommended that the Commissioners consider and recognize that the high level of government funded care makes traditional competitive market forces non-existent in health care/hospital industry. He found that the more money that is put in the system resulted in more money spent and vice versa.

Commissioners requested that Mr. Fitch clarify if the Low Income Pool and fund raising money are reported in the revenue of the hospital financial data. In addition, Commissioners requested more information regarding when the government started dominating the funding of healthcare.

Mr. Fitch provided information regarding full time employees and average salaries per adjusted admission. He stated that the full time employee's data does not represent the contracted employees. He found that during the recession that the salaries were flat but then started to rise with the exception of for profit facilities who's salaries remained flat. The hospitals adjusted to the conditions however he cautioned that the data did not account for quality of care. Members also requested the charts be included in the meeting packet for future meetings.

Update on Low Income Pool (LIP): Molly McKinstry, Deputy Secretary for the Agency, stated that there has been an adjustment in the Low Income Pool (LIP) funds with the federal government providing 1 Billion dollars in LIP funds (compared to 2.3B for the prior year). In addition to the revised LIP funding, the Legislature appropriated $400 million of General Revenue for hospitals which will draw a match of approximately $600 million in additional federal funding. The total hospital funds from these sources will be 2 Billion. The 1B LIP will be distributed in a similar manner as last year LIP funds; the 1B (GR+federal match) will be distributed based on Diagnosis Related Groups (DRGs) tied to trauma care and other

factors. Negotiations are ongoing regarding the future of LIP from the federal government. She also stated that the Commission website has additional information regarding the estimate of reimbursement of hospitals with the new funding method.

Presentation, University of Florida Health Jacksonville: Mr. Russ Armistead, CEO of University of Florida Health Jacksonville, stated he wanted to discuss their efficiency and that his hospital provides high quality care with more than half of their patients with Medicaid or uninsured. The hospital is the sixth largest employer in Jacksonville and keeps many of its medical residents in the area when their education is complete. The hospital has provided care with declining LIP funding over the years. The hospital's emergency department is a source of care for patients that do not have health insurance or money.

Mr. Armistead stated that he responded to Governor Scott's letter and encourages the Commissioners to read his response which is provided in their meeting materials. He stated that his hospital is efficient with the lowest cost per discharge of all academic hospitals in the University HealthSystem Consortium.

Mr. Armistead stated that he has 140 days of cash in reserve and has a low level of community support however Jackson Memorial Hospital in comparison has 13 times more money because of their local support.

He introduced two of his physicians to discuss the hospital's operations and participation in quality of care initiatives. Dr. David Vukich, Chief Medical Officer, stated that the hospital participates in numerous programs for quality of care and performance improvement. The hospital is a member of the University HealthSystem Consortium, however not Leapfrog. The Consortium provides the hospital with the tools to track their quality of care and allows comparison and ranking for mortality, effectiveness, safety, patient centeredness, efficiency, and equity. The hospital has seen a significant decline in sepsis mortality which is a leading killer in hospitals over the past few years. Dr. Vukich also stated that as an inner city hospital, they are at a major disadvantage in readmissions due to their high intake of patients with psychosis, alcoholism, drug abuse and homelessness.

Dr. Steven Godwin then spoke about their emergency department and that the issue is that patients use the emergency department as a point of access to health care. The hospital is a Level 1 trauma center, Stroke Center and Chest Pain Center that provides care to the sickest and most underserved population.

The hospital receives $26 million from the city; $192 million from Medicaid; $77 million from LIP funding; and $1 million in fund raising. The LIP funding money is used to cover the care for the uninsured patients. The hospital's emergency department serves 250 to 300 patients per day and provides 1,300 prescriptions per day without payment. Mr. Armistead stated that the hospital provides great service but the hospital needs structural repairs. He also stated that without LIP funding, they would start out at a $125 million deficit.

There was a discussion regarding the reason the hospital cannot receive funds by having a local tax. Mr. Armistead stated that due to Florida's Statute that consolidated governments with a population greater than 750,000 cannot have an indigent care tax.

Mr. Armistead stated that if the LIP funds cease that the hospital will go through bankruptcy and reorganization where they would possibly lose their educational program and much more and would be practically impossible to ever get back. He recommends that the state find a solution to provide insurance to the 140,000 uninsured citizens and for the citizens that do not qualify that they provide money to cover their care. Dr. Rosenberg asked Mr. Armistead what the solution would be and he responded that the best case scenario is that the state provide insurance for those without it and to receive more money from the city (and for the infrastructure to be more efficient).

In summary, Mr. Armistead stated that he reports to the UF board and that their building is owned by the city of Jacksonville. The UF Board meets quarterly and the finance team of the board meets six to eight times a year. The staff is part of a union that negotiates annually with the hospital for their benefits. The executive's salaries are based on meeting the quality goals. He also stated that the hospital has a 3 star rating out of 5 stars and that relative to the demand and financial resources, the overall care at their facility is safe, efficient, and high quality.

Ms. Seevers asked for clarification on the FHURS report and what is included in net revenue. Including, is the $26 million received from the city in there, fundraising money and any grant money received. Mr. Fitch will provide further clarification on this.

Presentation from St. Vincent's HealthCare: Mr. Donnie Romine, Interim President and CEO of St. Vincent's HealthCare, provided an overview of the hospital. St. Vincent's Healthcare System is a member of the Ascension Health, the largest faith-based healthcare system and the largest non-profit healthcare system in the country. The St. Vincent's Healthcare System has four facilities. The facilities are St. Vincent's Riverside with 528 beds; St. Vincent's Southside with 311 beds, previously known as the Mayo Clinic Hospital; St. Vincent's Clay County with 64 beds and plans to expand to 106 beds; and St. Catherine's Laboure' Manor with 240 beds.

St. Vincent's Healthcare System's mission is to commit to serving all persons with special attention to those who are poor and vulnerable. The hospital has many components to meet the mission that include a physician enterprise, residency program, medical science schools, clinical affiliations, community outreach services, foundations, and other services. The hospital has a very strong foundation that is successful in fund raising.

The volume of discharges growth rate is 3% per year. The average daily inpatient census increased by 2% per year. The hospital is working to reduce the number of observation days. The hospitals case mix is 1.5. The hospital is tracking the length of stay every day which is currently 2.8 days with the goal of having length of stays less than 3 days.

Mr. Romine discussed the efficiency of the hospital. He stated that the labor and supplies are 65% of the cost. The full time employee's growth rate has increased by 3.8% per year. The cost has increased to retain staff and the overtime has increased due to the Baby Boomers retiring.

The hospital has found that nursing schools can't keep up with the demand as 1 in every 10 applicants is accepted to the programs. The nursing schools do not have the resources to train a lot of nurses which results in the hospital having to pay nurses over time.

St. Vincent's pays approximately $343 million in labor and $160 million in supplies. They are able to control their cost of supplies due to contracting on a national level. The hospital has an Innovation and Action Team that has the task of finding ways of being more efficient by increasing the level of care and decreasing cost.

Mr. Romine stated that the executive compensation is subject to the Internal Revenue Service rules. The Board Compensation Committee is composed of the Board Chairman and members of the Board with no conflict of interest. A portion of the executive compensation is considered at-risk and are only paid if quality, patient safety, patient experience, mission, and financial goals are met.

The hospital is committed to the poor and vulnerable and spends $12 million in charity care; $38 million in unpaid cost of public programs; and $20 million in mission work.

The community outreach services are provided through the Mobile Health Outreach Ministry that has five mobile units that serve five counties with 32,000 visits per year. The hospital provides nurses in the community through the Faith Community Nursing and School Nurse Program. The Good Samaritan Fund provides assistance for medications/medical equipment, transportation, and temporary housing. Additional programs include Brighter Beginnings; Vincentian Food Pantry; Outreach International Mission Support; Seasonal Programs; and other programs such as adopt a family, cancer screening, counseling, and literacy programs.

Mr. Romine stated St. Vincent's is committed to quality and patient safety. The hospital is a top performer on key quality indicators and has won numerous awards. He stated that the hospital has prevented 3,200 infections and adverse events with a savings of $37.2 million and saved 329 lives as a result. The hospital has also seen a remarkable decline in early elective deliveries; falls with serious injury; neonatal morality; anticoagulation complication events; central line infections; deep venous thrombosis; hysterectomy surgical site infections; colon surgical site infections; and 30 day readmission rates.

Mr. Romine discussed the health care industry of today and of tomorrow. The health care industry of today receives payment for how much they do and not how well they do it. There is poor coordination and communication of providers. He recommends that the health care industry of tomorrow be paid on health outcomes rather than fees for service. Hospitals, physicians, employers and payers must partner to develop a new model of care. He stated that transparency and care through a regional integrated care delivery network that delivers high quality, low cost, and is person centered care must occur.

The hospital is currently participating in a federal pilot program to bundle payments for care to drive cost down by accepting payments for services provided to patients that cover pre and post care services.

Mr. Romine stated that the payer mix for the hospital is 50% Medicare; 12% Medicaid; 21% Commercial; and the remainder is uninsured. He stated that if the hospital had to cut everything to the bare bone that the hospital would find a way to still fulfill their mission.

Presentation on Hospital Quality Measures: Ms. Nikole Helvey, with the Agency's Florida Center for Health Information and Policy Analysis presented on quality metrics made available to consumers through FloridaHealthFinder.gov. She stated that FloridaHealthFinder is continuously improving to meet the needs of consumers and providers.

Ms. Helvey walked the members through the website's hospital comparison tool and stated that metrics available through FloridaHealthFinder are based on administrative data submitted quarterly by Florida hospitals and the results are displayed in star ratings similar to ratings used by CMS. She added that FloridaHealthFinder also displays infection rates for every facility in the state. She also noted that some quality measures such as infection rates are compared on a national benchmark, and complications and mortality rates are compared at the state level.

Ms. Helvey displayed risk adjusted 15-day readmission rates using Tableau. Vice Chair Kuntz asked if it had been considered that there was too much data out there? Ms. Helvey stated that a great deal of time was spent with the State Consumer Health Information and Policy Advisory Council, considering what is important to display and how the data should be displayed. She said that disclaimers are also included to make sure the data is not misleading.

Vice Chair Kuntz asked if Ms. Helvey, or another group of people, could identify more less than 5 but no more than 10 relevant measures that hospitals should meet to determine good performance. Ms. Helvey replied that it would be difficult for her to make that determination but that readmissions and mortality rates was a start. She also stated that physicians should be part of making the decision.

Vice Chair Kuntz suggested that it would be nice if the Commission could recommend creation of a group (of hospital administrators or doctors) to create core measures for measuring hospitals that receive state money. Ms. Helvey noted that CMS creates a blended formula based complication rate to wrap up several indicators in to a single indicator.

Dr. Rosenberg asked how to factor in that safety net or teaching hospitals have different goals and don't compete in the same ways? Vice Chair Kuntz stated that hospitals could be measured against themselves to show improvement over time.

Dr. Rosenberg wondered if some hospitals should curtail certain activities to focus their mission on things they do well such as providing great heart or indigent care. Vice Chair Kuntz noted that if you build a system that respects individual missions, metrics will drive hospitals to exit operations that are not related to their core mission. Chair Beruff agreed that there should be commonality amongst measures.

Chair Beruff, referring to charts comparing UF Health Jacksonville and St. Vincent's HealthCare, noted that there was a difference of 34,000 ER admissions and asked if this reflected profitability. Mr. Ryan Fitch stated that the chart was missing payer-mix and UF Jacksonville was significantly high in charity care.

Chair Beruff then referred to a chart of Hospital CEO salaries and asked if there was any relationship to responsibilities and pay – considering hospital beds, and the number of employees? He cited a salary that decreased from $1,700,000 to $800,000 with no change in responsibilities and said that executive pay needs to be addressed in relation to hospital outcomes, as well. Vice Chair Kuntz agreed that salary pay could be influenced by outcome measures.

Ms. Sam Seevers commented that cities did not have the luxury of non-transparency in budgeting, and asked if there is a mechanism for penalizing or following-up with hospitals that are not reporting state and federal funding? Deputy McKinstry said the types of details the Commission was looking for are not required to be disclosed. She added that some reporting is done but the level of reporting is based on the organization and it is not a current requirement to report where LIP funding is spent as a condition of receipt. Deputy McKinstry concluded that Medicaid could explore putting a mechanism in place but regulatory requirements would need statutory changes. Ms. Cancio Johnson stated that a third of the budget was Medicaid and agreed that there was room to explore transparency of LIP fund spending with Medicaid plans.

The next presentation was from Dr. J.J. Tepas regarding the National Surgical Quality Improvement Program (NSQIP). He provided the following 2014 statistics on the health care system - $129.8 million ED visits, $2.9 trillion spent on healthcare, $26 billion spent by Medicare on readmissions, and $1 trillion projected spent on drugs. He provided that surgery is a very costly element of health care.

Chair Beruff asked Dr. Tepas to clarify that Leapfrog's reporting of 440,000 deaths from medical errors which was different from Dr. Marty Makary's previous presentation of 210,000 deaths. Dr. Tepas stated that a problem was that different groups report the same data from different perceptions. He said NSQIP provides a perception of patient-centered better care.

Dr. Tepas stated NSQIP is the largest quality cooperative in the United States - 700 hospitals, and 9 out of 10 hospitals ranked #1 by US News and World Reports are NSQIP hospitals. NSQIP has established itself as a nationally validated risk-adjusted outcomes-based program to determine and improve the quality of surgical care.

Dr. Tepas stated that higher quality and lower costs are both achievable and that collaboration works. He also provided the 4 key principles of NSQIP:

- Set the standards;
- Build the right infrastructure;
- Use the right data; and
- Verify with outside experts.

He noted that Florida is the leading state in health care measuring and reporting and has embraced NSQIP. Dr. Tepas stated that through the NSQIP Lite -Florida Surgical Care Initiative,54 Florida hospitals committed to NSQIP and measured surgical site infections, urinary tract infection (CAUTI), colorectal surgery and elderly care. The result was morbidity rates decreased (89 lives saved) and $6.6 million in expenses were avoided.

Dr. Tepas stated a reality is that there are 77.3 million baby-boomers - there needs to be a patient-based open transparent and patient data driven process. He added that as quality

improves, expected and observed incidences decreases, stimulating strategies and driving improvement.

He then stated that NSQIP compared 2013 single Florida safety-net hospital data to National data and analyzed comorbidity factors; to determine those factors greater than 50%. He stated that in the safety net hospitals, the patients were sicker and patients are seeking help depending on the resources available to them.

Dr. Tepas said NSQIP lowers cost but most importantly leads to better care. He added that the end result of surgical care is higher quality, lower costs and population wellness. Dr. Tepas concluded that NSQIP allows monitoring, measuring and managing surgical care to affect changes and is a program that's presence in a hospital shows the hospital recognizes that the patient is the core.

Ms. Cancio Johnson asked why only 55 hospitals participated in the NSQIP Lite program. Dr. Tepas answered that hospitals requires a full time surgical care case registrar to train and perform NSQIP analysis. He noted that 102 hospitals indicated willingness to participate - only 54 hospitals had completed the questionnaire and had adequate data.

Dr. Ken Smith asked if there was a minimum hospital size for participating in NSQIP? Dr. Tepas replied that NSQIP can be designed for hospitals of different sizes and that every surgical patient should be receiving the level of surveillance regarding quality outcome and effective care NSQIP offers.

Ms. Cancio Johnson asked if there was a place online to see which hospitals participate in NSQIP? Dr. Tepas replied that the information is available online and that he could provide the contact information for a liaison.

Mr. Eugene Lamb asked who determines if the hospital joins NSQIP? Dr. Tepas answered that it was the hospital's decision to join NSQIP.

When asked about the cost to participate in NSQIP, Dr. Tepas said the normal cost of participating is about $30,000 a year plus a full time employee.

The last presentation was from Dr. Jannifer Harper, Chief Medical Officer at Florida Blue who spoke to the Commission on value-based programs. She stated Florida Blue believes that pay-for-performance or value is the path to improving quality. She stated that the incentives are aligned with physicians and hospitals to deliver high value care.

She noted that value based performance is not just based on reimbursement but changing practice and behavior. There has to be data and a level of transparency as well as a focus on population health. A third of Florida Blue commercial medical spend flows through a pay for value model and 90% of Florida Blue members have access to value based providers.

Dr. Harper said that the goals of Florida Blue's value based performance are improve quality, member experience and patient outcomes. Additionally, avoiding waste and bringing new product to the insurance market is a focus as well.

Dr. Harper revealed and detailed some value-based methodologies, including:

- Patient Centered Medical Homes;
- Accountable Care Models;

- Episode-based or Bundled Payments;
- Pay-for-Performance or Quality–Based Incentive Programs; and
- Collaborative Care Models (for seniors and Medicaid advantage populations).

As a result of one of these methodologies, Patient Center Medical Homes (PCMH), Dr. Harper noted Florida Blue has the third largest PCMH in the United States. She added that last year 2,400 primary care physicians touched over 1.2 million lives in Florida, ER utilization lowered by 15% - saving approximately $50 million dollars, lowering medical spend which helps control cost.

Dr. Harper reflected Chair Beruff's thoughts on measurement commonality and said that Florida Blue selected certain Healthcare Effectiveness Data and Information Set (HEDIS) Quality Metrics to watch. She stated that quality performance is the gateway to receive financial incentive awards.

Dr. Harper concluded by summarizing that providers can focus on closing the care gap and increase practice size, capacity and make more money by changing practice patterns and processes of care delivery in the office, as well as building a team with nurse practitioners.

Ms. Cancio Johnson asked if Florida Blue negotiates rates with hospitals of larger systems such that they end up charging more than a single hospital? Dr. Harper stated that rate negotiations are based on the clout of the hospital system and may vary but that Florida Blue understands it has to be fiscally responsible and is not in the business to continually escalate rates.
Ms. Cancio Johnson also asked if Florida Blue is a part of Medicaid Managed Care and Dr. Harper stated that they have a sister-company that is part of it.

Dr. Rosenberg commented on Florida Blue's $50 million dollar savings and a rate increase request from Florida Blue last year. He continued that he would like to know where the money that is spent on Medicaid managed care goes and more about how the rate increases work.

Chair Beruff questioned if there were items the Commission would like to discuss in the next meeting.

Mr. Lamb inquired as to what could be done to increase LIP funding for rural hospitals and wanted to explore funding for smaller hospitals in the next meeting.

Vice Chair Kuntz stated that the meetings have been valuable and asked that in the next meeting the Commission begins to get an idea of what recommendations they will make. Chair Beruff added that he would like to know more about administrative costs in the insurance industry which we will defer to the Office of Insurance Regulation.

Ms. Seevers suggested that another request be made to the non-responsive hospitals so the Commission has all data for review. Ms. Cancio Johnson supported this and stated that an emphasis be placed on transparency. Chair Beruff responded that a letter could be sent to the hospitals referencing Florida's public records "Sunshine Laws".

Public Comments: Chair Beruff opened the floor to public comment. There were none.

Meeting Adjourn: Chair Beruff adjourned the meeting at 1:02 p.m and stated the next meeting will be July 23rd in Miami from 9am-2pm.