DRAFT MEETING MINUTES

COMMISSION ON HEALTHCARE AND HOSPITAL FUNDING

Meeting Date: October 20, 2015

Time: 9:00 a.m. – 1:00 p.m.

Location: The Florida State Capital, Cabinet Meeting Room

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

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: Brett Bacot, Buchanan Ingersoll & Rooney PC; Phillip Baker, Robert M. Levy & Associates; Bill Bell, FHA; Steve Birtman, Florida Association of Nurse Anesthetists; Ashley Boxer, Memorial Healthcare; Melanie Brown, J. B.; Brittney Burch, Florida Chamber; John Couris, Jupiter Medical Center; Mary Kay Detzner, Nemours; Tim Elliott, Smith & Associates; Marta Eubanks, Nemours; Derex Falcon, Rutledge Genia; Jan Gorrie, Ballard Partners; Sheila Jackson, Speaker Pro Tem office; Laura Lenhart, Moffitt Cancer Center; Allison Mawhinney, Gray, Robinson; Phillis Oeters, Baptist Health South Florida; Rob Shave, Lee Memorial Hospital; Burt Saunders, Gray Robinson; Dr. Keith Smith, Surgery Center of Oklahoma; Ron Watson, Watson Strategies

AHCA and DOH Staff Present: Cruz Conrad; Nathan Dunn; Beth Eastman; Marisol Fitch; Ryan Fitch; Nikole Helvey; Elizabeth Keating; Jamie Sowers; and Dana Watson

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

Review and Approval of Meeting Minutes: The minutes from the September 28, 2015 meeting of the Commission on Healthcare and Hospital Funding were approved.

Surgery Center of Oklahoma Report

Dr. Keith Smith, representing the Surgery Center of Oklahoma is an anesthesiologist from Oklahoma City. Prior to opening the center, he was a cardiac anesthesiologist at an Oklahoma City hospital. Seeing the price of health care increasing and the quality of care decreasing, he found himself in the operating room with surgeons who were substandard and wished that the free market model of business would apply to health care. In 1997, he and another physician opened the Surgery Center of Oklahoma and were determined to provide high quality health care for a reasonable price without accepting government money. Knowing the public's inability to find out the cost of specific procedures, he and his cohorts set out to generate a list of procedures and the prices they would charge and post them on the surgery center's website. The one charge would cover all of the expenses of the surgery, from the anesthetists, and operating room to the surgeon and supplies. They discovered rather quickly that the costs ratio between what the hospitals and the surgery center were charging was approximately 10:1.

The news of the high quality health care and reasonable prices the center was providing spread quickly. Dr. Keith Smith noted that the surgery center did receive negative feedback from the hospitals and the insurance companies would not contract with them. Everything they did was considered out of network by insurance providers. The feedback from the patients was that their experience with the out of network

facility was much better than at their in network facilities. There were multiple legal and legislative attacks from the hospitals. One particular attack was a ruling to allow insurance companies to stack deductibles on people so in and out of network deductibles piled up. This created a cost barrier for patients wishing to use the surgery center. The surgery center also acknowledged that the low reimbursements from Medicare were not worth dealing with Medicare, so they quit the Medicare system. They continued to treat patients who may have had Medicare, but he did not charge them. He and his partners determined that they would treat Medicare patients for free.

Next, the surgery center began to look at their own employees' health care benefits and at self-insured businesses. They decided to get rid of their insurance carrier and self-insure the office. Which, Dr. Keith Smith explained means that the surgery center pays for its employees' health care costs out of the operating budget. Through this transition, they realized that there are many large self-insured companies paying much more for their health care and that the surgery center could provide their care for less. To reach the public, the surgery center set up a website listing all of the procedures and prices, which lead to a price war in the state of Oklahoma. Surprisingly, the first new patients to arrive were from Canada, as access to care is an issue for Canadians. Rather quickly, health care facilities closer to the Canadian border began to decrease their prices due to the competition from the Oklahoma City Surgery Center.

Hospitals accused the surgery center of catering to the rich and not taking care of the poor and then stated that the accusations were false. When a patient came to the surgery center, they would be treated, even if they were poor and couldn't pay.

Dr. Keith Smith told the Commission that he was invited to appear on multiple television news shows to discuss free market health care. These appearances lead to a much higher volume of patients, several requesting procedures that are not appropriate in an ambulatory setting, such as a total knee or total hip replacement. So, he called an orthopedic surgeon who owned an orthopedic hospital and asked what he would charge for the procedures when Dr. Keith Smith suggested that the orthopedic hospital post the low prices on their website. However, the orthopedic hospital could not legally post prices due to the multiple contracts it had with insurers. So, they posted the price on the surgery center's website, which is allowed because they don't accept government money. When new patients would call the surgery center, they would coordinate the procedures. The same situation occurred with other specialty hospitals and the surgery center was able to coordinate the low cost, high quality procedures for the patients.

Dr. Rosenberg asked a series of questions regarding what a physician is allowed to charge a Medicare patient as there are restrictions as to what physicians are allowed to charge. Dr. Keith Smith explained that the patient leaves their Medicare card at home and comes in and pays either the posted prices for the procedures or a negotiated price depending on the patient's ability to pay.

Next, Dr. Keith Smith told the Commission that he was contacted by large self-insured companies and were now treating patients from all over the country. People are referring to the surgery center as domestic medical tourism. He has been asked about spreading or franchising throughout the country, to which he says he is not interested. This concept is spreading however and he hopes to see national group form to provide resources and other functions for those interested in the movement.

He noted that patients nationwide have been taking the price quotes to their physicians and demanding lower costs. Eventually several physicians formed the Free-market Medical Association. The association is not only physicians but rather all players in the health care arena. They have held two standing room only meetings. This movement had decimated the idea that prices can't be listed. Oklahoma County approached the surgery center about extending the website prices to the Oklahoma County employee benefit package. Oklahoma County's health plan saved $2.1 million in costs the first year. Since that time, multiple private companies have formed relationships with the Oklahoma City Surgery Center. An

Oklahoma think tank determined that if the state of Oklahoma partnered with the surgery center it would save over $200 million the first year. Unfortunately, last year, an amendment to the Oklahoma state employee benefits plan to allow this was defeated in the legislature. However, this year the amendment was adopted and the employees are allowed to the no out of pocket option at transparent facilities beginning in 2016.

Chairman Beruff asked Dr. Keith Smith how the idea scales up. He responded that they believe that if you want a job done well and quickly, give it to the guy that is busy. They have discovered efficiencies over time.

Next, Dr. Keith Smith spent some time reviewing the Oklahoma City Surgery City website prices. He reminded the Commission that hospitals and insurance companies are in existence to make a profit. He used a $100 aspirin as an example. The hospital may collect $5 for that aspirin. They then consider the $95 a loss to be written off. On the insurance side, the insurance companies love being charged $100 for an aspirin. They are charged the $100 and negotiate a lower cost with the hospital and then call the negotiated price a savings. This is called claims repricing and the insurance company makes a profit from a percentage of the difference between the hospital charge and the negotiated insurance payment.

Commissioner Robert Spottswood inquired who is making the payment on the additional funds to be shared between the hospital and insurance companies. Dr. Keith Smith replied that the consumers are paying the funds in their insurance premiums.

Dr. Keith Smith said that when asked for the role of government in health care, he answers that the largest "tool" a state has to control health care costs is in self-funded plans for employees.

Dr. Rosenberg asked if the market is working in Oklahoma and if the prices are coming down. Dr. Keith Smith answered that Integris Health, the largest health system in Oklahoma has been decreasing their prices and they have posted their prices on line. Dr. Rosenberg asked what types of payments they accept and Dr. Keith Smith responded that people have paid with cash, check, bit coin and gold bullion.

Dr. Rosenberg asked who the largest insurer in Oklahoma is and what their premiums are doing. Dr. Keith Smith responded that the premiums continue to rise. He explained that the market share was not what was driving the success of the surgery center but rather consumer knowledge.

Dr. Rosenberg asked about complications. Dr. Keith Smith stated that the patient's self-insured employer has a stop loss policy and will cover whatever extra charges incurred do to a complication. The surgery center lets the employers and the patients know prior to any procedures that the work is not guaranteed and the costs will increase if there are complications.

Chairman Beruff thanked Dr. Keith Smith for sharing the Oklahoma Surgery Center experience with Florida.

Hospital Certificate of Need Program

Ms. Marisol Fitch addressed the Commission to bring them up to date on the current Certificate of Need (CON) program. She explained that not all hospital programs are regulated by CON. She stated that the New/Replacement Acute Care Hospital; New/Replacement Long Term Care Hospital; Freestanding Specialty Hospital (ex. Rehabilitation, Psychiatric); Neo-Natal Intensive Care Units (NICUs); Mental Health Services (Psychiatric or Substance Abuse); Comprehensive Medical Rehabilitation (CMR) Beds; Transplant Programs; and Pediatric Cardiac Services are regulated by CON. Ms. Fitch stated that beds can be added through the notification or exemption process for some the above services. She said that the

addition of Acute Care or Long Term Care Beds; the addition of NICU beds to an existing NICU; the addition of Medical Equipment; the Replacement or New Rural Hospital pursuant to the provisions of s. 395.6025 F. S.; Burn Units; Adult Cardiac Services; and Outpatient Services are not regulated by CON. Ms. Fitch told the Commission that Florida has delved into CON deregulation. Home Health Agencies were deregulated in 2000. Acute Care Beds were deregulated in 2003. Finally, Adult Cardiovascular Services were deregulated in 2007.

Provider licensure imposes standards which can be enforced during the validity period of a license. If these standards are not maintained, the license can be revoked for failure to perform minimum standards established by rule.

If CON were repealed, rulemaking authority would need to be established for the appropriate licensure unit in order to establish minimum standards for programs—NICU, CMR, pediatric cardiac services, transplant services and mental health services.

Commissioner Seevers asked why new rural hospitals were exempted. Ms. Fitch responded that in 2003, 15 rural counties were exempted to set up a new rural hospital based on the population density.

Secretary Dudek gave the Commission an overview of CONs history. She said that when the Agency removed the CON requirement for adding beds, they also changed the licensure for hospitals to prohibit facilities from setting up medical boutiques. She used cardiac and orthopedics as an example.

Secretary Dudek told the Commission that the facility seeking a CON would have to go through licensure. She explained that with the licensure, the Agency could set specific minimum license standards to be followed while in operation.

Ms. Fitch explained that CON regulates program entry and sets standards for program establishment, including many tertiary services such as neonatal intensive-care units (NICU), comprehensive medical rehabilitation (CMR), mental health, transplants and pediatric cardiac services. A CON does not impose standards once implemented and cannot be revoked unless a program is ceased or fails to renew. During the application process, a program can self-impose a condition for approval which will be monitored on an annual basis once a CON has been implemented. Conditions are voluntary commitments/obligations that surpass the minimal requirements and that applicants believe give them a competitive advantage in the Agency's review process. Most conditions are tied to a provision of Medicaid/indigent patient days and/or provisions of specific services. Conditions can be modified or removed when good cause is shown by request of the applicant.

Ms. Fitch stated that the difference between CON requirements and licensure is that licensure imposes standards which can be enforced during the validity period of a license. If these standards are not maintained, the license can be revoked for failure to perform minimum standards established by rule. If CON were repealed, rulemaking authority would need to be established for the appropriate licensure unit in order to establish minimum standards for programs—NICU, CMR, pediatric cardiac services, transplant services and mental health services.

Commissioner Dr. Ken Smith asked how CON affects costs to the patients. He asked if the Commission could hear from other states that have deregulated their CON. He made reference to the State of Texas and all of the tort reform that went along with the deregulation of their CON. Dr. Ken Smith stated that while he appreciated the presentation, he really wants to know how to get Florida to the place that has healthcare like that provided in Oklahoma City.

Secretary Dudek explained that gathering information from other states that have deregulated has been challenging since they don't collect the data that would show savings. She reminded the Commission that while making their considerations, they need to look at both costs and quality. Costs are dependent on many other things besides CON. She stated that she intends to continue the conversation with Dr. Smith from Oklahoma.

Commissioner Marili Cancio Johnson inquired about mental health and substance abuse beds. She noted the decrease in beds and questioned how, if the problem of substance abuse is increasing, how can the number of beds decrease.

Secretary Dudek responded that review for bed types used to be broken down further into long term and short term substance abuse beds and long and short term psychiatric beds. In the 1980's several free standing hospitals or psychiatric treatment centers were opened. When insurance companies stopped paying for the substance abuse and psychiatric patients throughout the 1990s, the priority of having such beds decreased, and many of the free standing hospitals closed as well as the treatment centers. At that time, the state began to refer to the bed type as a mental health bed as the two conditions are very often intertwined.

Ms. Johnson asked if mental health is covered by any insurance. Ms. Dudek responded that some companies have begun to offer the coverages, but the number of beds decreased dramatically in the 1980s and early 1990s when the insurance companies stopped paying for the services. Ms. Johnson inquired if the State health insurance plan covered these services. Secretary Dudek answered in the affirmative.

Ms. Fitch noted that there had been a marked increase in acute care hospitals adding psychiatric beds. The hospitals do not have to go through the CON process to add beds; they only have to report them for inventory reasons.

Dr. Rosenberg asked Ms. Fitch to clarify that if CON were to be repealed, all of the regulations and standards would have to be put into rule. Ms. Fitch answered that currently minimum standards for certain procedures were contained within the CON statute. If the statute were repealed, the minimum standards for comprehensive medical rehabilitation, NICU, Mental Health services, Pediatric Cardiac services and transplant services would be gone. Dr. Rosenberg stated that he wants there to be minimum standards. He does not want the "wild, wild, west in medicine" to occur with the repeal of CON.

Secretary Dudek agreed and stated that there would be a transition from a regulated market entry program to licensure with ongoing monitoring. Ms. Fitch noted that the Agency currently does not have rulemaking authority, and that it would have to be put in statute. Chairman Beruff stated that since all of the regulations were in statute, it would be a simple cut and paste job. Ms. Fitch responded that there would have to be updates and minor changes. Chairman Beruff reiterated that if CON were to be repealed, it would still be a cut and paste job of the basics with some changes in the process. Ms. Fitch explained that the rule making process included a lot of input from the public and that the finished product would not necessarily be the same as the current statute.

Commissioner Seevers remarked that she was impressed by Ms. Fitch's enthusiasm for the CON process. She asked for Ms. Fitch's personal opinion what would be the biggest drawback of repealing CON. Ms. Fitch responded that the unknown is what worries her. She thinks of the CON process as a tool in health planning for the state's health care needs. She noted that duplication of services and efforts could become a problem without CON. She gave the example of not wanting to have an MRI on every corner. She said that CON allows for regulation in a "non-free market" health care environment. Commissioner Seevers stated that as with any business, it will come down to quality of service when determining which facilities will be successful and those that will not.

Secretary Dudek stated that she agrees with Commissioner Seevers. The Agency has seen that facilities that do well do so because of their attention to patients and the quality of services. In the areas of health care where CON has been removed, the market seems to be doing fine.

Chairman Beruff commented that he does not feel like it is the government's job to regulate free-enterprise. The government's job is to be sure that whoever is providing services or products does so at a specific level of standards. He said that if there are 10 MRIs on every corner, the free market will sort out who will be successful based on quality of care. The unsuccessful businesses will close and the successful ones will thrive. The government should not have a say about who opens what facilities, or who provides what services. The government should only have the oversight to ensure patients are being treated safely. Ms. Fitch responded that due to the fact that the facilities are receiving government money, the government would be paying for a failing business. Chair Beruff pointed out that the funding would stop when the facilities closed.

Secretary Dudek noted that she believes that the quality is paramount and the free market will indeed take care of itself. She noted that she has been involved in and supportive of CON in the past. However, she has watched, over time, CON be removed from some programs without devastating outcomes and has seen facilities make better choices based on patient needs and quality. Chair Beruff added that due to the growth in technology, things can't be run the way they were 20 years ago.

Commissioner Seevers stated that she is in agreement with the other Commissioners regarding CON. The greater concern is the amount of money that the government is putting in to healthcare through Medicaid and Medicare and that there is no accounting for where or how the money is being spent. She noted that once a hospital receives its Lower Income Payment (LIP) funding, they don't report on how it is spent. She also stated that after all of the interviews the Commission has had with hospitals, none of them are in favor of CON. She stated that she is not clear on the benefits of having CON.

Commissioner Johnson asked about how the states where CON had been deregulated had gone about deregulating it. She asked if it was just suddenly changed or if there were transitions. She asked how much time would it take the Florida Legislature to make the statutory and rule changes to implement the repeal of CON. Secretary Dudek responded that the Agency would check, but that she believes that most went through a transitional period. She also noted that she is not sure that the states without CON put the licensure standards in to rule. Ms. Fitch added that each state is different.

Dr. Rosenberg stated that Florida hasn't been perfect in health care and that some believe that government planning and top down thinking is the correct way. However, as a physician and a consumer of health care services, the status quo does not seem to be working. He stated that he is ready to have the free market shape healthcare rather than the government, as the government has been in healthcare for a long time and it is not working.

Public Comment

No members of the public requested time to speak.

Secretary Dudek directed the Commission as well as the public audience to visit the Healthcare and Hospital Funding Commission site to obtain a form to report price gouging.

Data Discussion: 2014 Hospital Financial Data and Quality Scores

Mr. Ryan Fitch directed the Commissioners to the charts and tables on the Florida Healthcare and Hospital Funding Commission website. He noted that the 2014 data had been uploaded into all of the charts the Commission has reviewed. He said he is available to answer questions on any of the updated data. Chairman Beruff inquired if the Hospital CEO comparison data was on the website and Mr. Fitch answered in the affirmative.

Commissioner Seevers stated that she is upset that some hospitals have not provided the requested information as of yet. Some of those hospitals received LIP money and Medicare and Medicaid. She wants to know what can be done to force the hospitals to comply with the requests. Secretary Dudek responded that there are statutory changes that could be made to force the hospitals to be more transparent. Chairman Beruff asked if there are any public hospitals that have not provided all of the requested information. Mr. Fitch answered that they were all in compliance. Commissioner Seevers stated that Mr. Fitch's answer was incorrect and she directed the Commission to the reports provided. She said that she selected two hospitals to compare "apples to apples" to attempt to get a fuller picture. She noted that some of the hospital responded by referring the Commission back to annual reports they have submitted to the Agency. The hospital systems don't break down their leadership compensation; they submit one number to cover the compensation for all of the hospitals beneath the umbrella of the hospital system. She believes that if the hospitals are receiving government money and they are not providing the individual hospital CEO salary information, they should be penalized.

Chairman Beruff asked if the Agency received copies of the CEO contracts. Secretary Dudek responded that she didn't think the Agency received contracts, but the Agency did not request the contracts. Commissioner Spottswood commented that the CEO total compensation reported is not structured as most compensation packages are structured; they only show the salary. Typically, large compensation packages are based on performance. Chairman Beruff stated that if a hospital is receiving government funding, the CEO's contract should be based on performance.

Commissioner Dr. Ken Smith commented that when comparing the compensation for the hospital CEOs, he feels their compensation is on point for the jobs that they do taking in to consideration the size of the business and the risks assumed by the CEOs. He suggests submitting new, more specific questions to get the detail the Commission is looking for. Commissioner Seevers responded that if she could see all of the CEO salary information, she might be able to understand it, but that since it was not all provided, she cannot. Dr. Ken Smith used Lee Memorial Hospital as an example. He said that there is only one CEO salary listed, but in reality the CEO is over 5 different hospitals in the system and the salary is only listed with the one large hospital instead of being broken out over the five hospitals. Chairman Beruff asked about the liability a CEO incurs. Dr. Ken Smith responded that the CEO is held accountable. He stated he would have to speak with an attorney to determine actual legal liability. Commissioner Johnson commented that when the banking system collapsed, no CEOs were incarcerated. Chairman Beruff responded that he was interested in looking at the size and scope of the facilities to determine what the salaries were based on. Commissioner Johnson asked if they really wanted to see the government setting salaries, to which Chairman Beruff answered negatively. Mr. Fitch responded that he would try to gather the data to determine if facilities expenditures were on actual healthcare costs or administrative costs. Commissioner Seevers reiterated her feelings that the facilities receiving government funding should provide them with enough proper information to allow the Commission to do what they were charged to do, and that is to look at the hospital funding.

Chariman Beruff compared the deregulation of the Federal Aviation Authority to the healthcare market. He believes that after deregulation, the healthcare market will sort itself out as long as Florida has enough safety standards in place.

Commissioner Spottswood commented that they were all struggling with the data and that as they understand more of the elements in healthcare funding; he realizes that there is enough funding from federal, state and local governments; the data doesn't show what the funding is being spent on. He noted that price transparency seems to be the place to start and would like to see more transparency from healthcare facilities and providers.

Commissioner General Chip Diehl agreed with Commissioner Spottswood's comments but feels that all Floridians should be able to obtain the data and make their decisions based on that data.

Chairman Beruff asked Dr. Keith Smith how many procedures the Oklahoma Surgery Center had listed on its website. Dr. Smith responded that it has 221 procedures and prices listed. Chairman Beruff stated that he asked as a starting point for how many procedures does Florida need to post prices too. Secretary Dudek responded that a statutory change is required to gather costs from hospitals. She noted that the Agency does have a website that could easily house a price list.

Chairman Beruff asked Dr. Keith Smith to give an estimate in the amount of waste in healthcare. Dr. Smith answered at least 50%. He stated that by getting self-funded organizations to use facilities with transparency, the costs would decrease. Commissioner Spottswood stated that the data the Commission reviewed shows approximately a 32% collection rate on charges. He wanted to know what happens to the other 68% of the charges. Dr. Smith responded that it is written off as a loss, which helps the hospital keep their not-for-profit status. Commissioner Johnson asked Dr. Keith Smith if he carried health insurance. He answered that he did indeed have a catastrophic event policy. Commissioner Johnson stated that her own physician suggested she drop her health insurance. The physician suggested that she check prices. Dr. Rosenberg said added that prices have dropped dramatically in plastic surgery because people price shop.

Commissioner Diehl next asked Dr. Keith Smith about waste in pharmaceuticals. Dr. Smith responded that the pharmaceuticals are a huge quagmire of waste in healthcare and that the industry is not one that is easy to take on. He gave an example of direct care primary care, which includes the dispensing of needed pharmaceuticals as one way to cut waste in pharmaceuticals.

Executive Order

Chairman Beruff suggested that the Commission review the 9 points included in the Governor's Executive Order. He asked the Commission if they had any changes to the document staff provided at the last meeting. Secretary Dudek inquired if there was any additional information the Commission would like to have. She explained that the document was the Agency's attempt to put all of the facts in one place organized by the individual points set forth in the Executive Order. Commissioner Spottswood suggested going through each of the items listed in conjunction with each of the 9 points and come up with a finding of fact and to move the findings forward. Chairman Beruff noted that the amount of information provided for each point is different. He used CON as an example, describing what he would like the Commission to do with the information provided. Commissioner Diehl stated that he has given thought to how the final report should be formatted and the positive tone in which it should be written. He suggests that the report highlight the changing healthcare landscape and the ways Florida is leading the charge. The report should also include the Commission's suggestions.

Commissioner Seevers agreed with Commissioner Diehl regarding the document provided. She questioned if the Commission's findings might be another layer of government imposed on the healthcare industry. She suggested focusing on points 1, 2 and 3 at the next meeting to come up with their findings and cover all of the points over the next few Commission meetings to eventually come up with a final report to provide to the Governor.

Secretary Dudek told the Commission that they had already had a positive impact, as the Agency had developed and produced a new consumer awareness guide on emergency and urgent care, which she provided a draft copy to the members.

The Commission on Healthcare and Hospital Funding will next meet on Tuesday, November 10, 2015 at 10:00 a.m. in Fort Myers, Florida. The specific location is yet to be determined.

There being nothing further to discuss, the Commission adjourned at 12:20 p.m.