DRAFT MEETING MINUTES

COMMISSION ON HEALTHCARE AND HOSPITAL FUNDING

Meeting Date: August 31, 2015

Time: 9:00 a.m. – 3:00 p.m.

Location: University of Central Florida - College of Medicine
Medical Education Building, Lewis Auditorium, 6850 Lake Nona Boulevard, Orlando, FL 32827

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

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

Interested Parties Present: Richard Conard, University of Central Florida; Richard Crotty, Florida Hospital –Florida Hospital Health Village; Dr. Deborah German, University of Central Florida; Glen Gibellina, Remote Arca Medical Volunteer Corps; Dr. Norbert Goldfield, 3M Health Information Systems; Jack Ijams, 3M Health Information Systems; Laurel Pickering, Northeast Business Group on Health; Martha Santani, Nemours Children's Health System; Jeanette Schreiber, University of Central Florida; Kim Streit, Florida Hospital Association; Michelle Strenth, Orlando Health Hospital System; Julia Swanson, Florida Hospital; Karen van Caulil, Florida Health Care Coalition; Josh Willson, Nemours Children's Health System

AHCA and DOH Staff Present: Cruz Conrad, Jennifer Miller, Ryan Fitch (via phone), Nathan Dunn
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Media: Mike Synan, Fox 35 News Orlando

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

Review and Approval of Meeting Minutes: Minutes from the August 12, 2015 meeting were approved.

Paying for Quality Outcomes: Commission Chair Carlos Beruff introduced Dr. Norbert Goldfield from 3M Health Information Systems to give a presentation on Paying for Quality Outcomes. Dr. Goldfield said he would be specifically discussing Information on potentially preventable readmissions and the other types of outcomes measures that are available to assess quality of care across health care providers. He provided an overview of 3M's background with a focus on why Diagnosis Related Groups (DRGs) worked; information on the types of outcomes measures that are available; background information on 3M's work

connecting payment and quality throughout the country with a focus on Texas; and a path forward to pay for outcomes that would be useful for all payers in Florida that is fair, flexible, and understandable.

Dr. Goldfield described 3M as an industry leader in coding, classification and payment systems linking payment and outcomes quality used by federal agencies, by 35 state agencies, by many Blue Cross Blue Shield plans, and by 75% of the nation's hospitals. He said 3M created the original Medicare DRGs – the original "bundled payment" system, and designed most Prospective Payment Systems in widespread use in the U.S. 3M APR-DRGs are widely used in government and commercial quality based payment programs. The outcomes quality based payment work expanded to all major care settings with creation of Potentially Preventable Events (PPE). Dr. Goldfield reported that while 3M does work with the federal government, the real action is on a state level. He said that using the 3M HIS Incentive system, both Texas and New York pay facilities for better outcomes.

Dr. Goldfield discussed how to control health care costs while improving outcomes quality. He stated that 3M's vision is to improve health care outcomes quality in our state, plan, medical, group and country. This can be done by changing the way all sectors of the health care economy are paid, rewarding for better outcomes such as fewer complications and readmissions and making data available to consumers. An active, engaged, confident consumer is the best guarantee of better outcomes and lower costs. All consumers of health care want quality care, good outcomes and no complications. Consumers are individuals, businesses – anyone or anybody that has any stake in improving health care outcomes.

Dr. Goldfield explained that 3Ms system is based on the approach to development and implementation of Diagnosis Related Groups (DRG), recognized as the classification system which, together with its implementation, has had the greatest impact on cost and quality of any intervention to date causing the length of stay, cost, and mortality to decrease. Financial savings were achieved because behavior changed resulting in greater efficiency. Proper implementation is key to success.

Dr. Goldfield quoted the 2014 Chair of MedPAC stating that "Current quality measures are overly process oriented and too numerous, they may not track well to health outcomes, and they create a significant burden for providers." Even worse, he said that the Federation of American Hospitals (Health Affairs article) and Rajaram et al (JAMA article) stated that hospitals under the Centers for Medicare and Medicaid Services (CMS) approach are unfairly penalized under conflicting and overlapping measures.

3M believes quality outcomes can be easily translated into dollars by avoiding potentially preventable events (PPEs) which are – Potentially Preventable Complications, Initial Admissions, Readmissions, Emergency Room (ER) Visits and Outpatient Services. Other outcomes that are equally important but not as easily translated into dollars include engagement, empowerment, and confidence. Every senior health care leader should have a monthly dashboard summarizing results of these eight metrics (5 PPEs, Consumer Activation,

Change in Health Status, and Mortality). No other information is needed as long as the user can be drilled down from the overall measure to the individual consumer.

Dr. Goldfield next discussed 3M's Potentially Preventable Events (PPEs). He said that a prime component of health care inefficiency and waste is the delivery of services that would be unnecessary if effective and/or timely care was delivered. Unnecessary services often lead to an increased payment. In the context of a payer with a fixed expenditure budget, payments for unnecessary services result in lower payments to those providers who are delivering only necessary services. Since there are no mandated care processes, care decisions are made by hospitals or health plans to determine path to outcomes targets.

Dr. Goldfield stated that PPEs will never be totally eliminated even with optimal care. Proper risk adjustment and scoring is therefore required in order to use PPEs in provider profiling and payment systems. Risk adjustment, he said, is key. He stressed that he could not overemphasize the importance of comprehensive and detailed risk adjustment for EACH of the PPEs. Even with excellent risk adjustment health care leaders must look at rates and must have outlier policy. For example: an individual who is admitted for Gastro Intestinal (GI) surgery with multiple co-morbidities has a much higher risk of developing a post admission complication than a patient admitted for uncomplicated GI surgery. Risk adjustment must take into account the condition of the patient at admission including not only the diagnosis, age, sex, interaction between diagnoses and other factors not necessarily coded.

Dr. Goldfield used Texas as an example in taking the challenge to improve outcomes. In June 2011, Texas enacted Senate Bill 7, which mandated a Medicaid quality-based outcomes payment program that apply to all types of provider systems including hospitals, managed care plans, medical homes, long-term care plans. The quality-based outcome measures focus on potentially preventable events. In 2012, the Texas study using 3M PPEs identified potential excess expenditures of $280 million. In 2013, quality outcomes performance reports were shared with 20 managed care plans. In 2015, the quality rate adjustment begins: 4% of payment at risk (2% on 3M PPE measures; and 2% on HEDIS measures). Betsy Shrinker from the University of Florida was very involved in many aspects of implementation. Currently, Texan health plans focus on PPE performance and interventions to reduce PPEs by aligning hospital and managed care performance incentives with CMS funded delivery system reform. Dr. Rosenburg inquired if tort reform in Texas had made any difference, which Dr. Goldfield responded it had not.

Dr. Goldfield gave a brief overview of what other states are doing in regards to the use of PPE quality measures. Six Medicaid programs have established hospital quality based payment programs using Potentially Preventable Readmissions (PPRs) and Potentially Preventable Complications (PPCs). Seven state hospital associations have created PPR quality improvement programs. New York and Texas have implemented managed care quality based payment on PPRs, Potentially Preventable Admissions (PPAs), Potentially Preventable Emergency Department Visits (PPVs), and Potentially Preventable Ancillary Services (PPSs). They use PPEs as core measures in comprehensive value based purchasing programs for

hospitals, Managed Care Organizations (MCOs) and Accountable Care Organizations (ACOs). Over 25 Blues and/or other MCOs are using PPEs in quality monitoring or pay for outcomes programs. Finally, the Medicare Payment Advisory Commission (MedPAC) is using PPRs, PPAs and PPVs in population health studies for CMS and Congress.

Dr. Goldfield gave a few other examples and closed by summarizing that the use of PPEs for all services, All Patient Refined (APR)-DRGs in Hospitals, Enhanced Ambulatory Patient Grouping System (EAPGs), and Clinical Risk Groups (CRGs) together can lead to improved health care outcomes and can stabilize costs. He stated that having clinicians participate in the process and also having leadership, clinical data, and incentives are key in reducing complications and saving money. He reminded the Commission that engaged, confident consumers lead to better outcomes and the outcomes measures need to be transparent to all. Having the right approach (i.e. pay for better outcomes) is critical.

Welcome and Overview of the University of Central Florida College of Medicine: Dr. Deborah German, Vice President for Medical Affairs and Dean, welcomed the Commission to the college. She reported that the University recently obtained approximately 7,000 acres, next to the Orlando International Airport. She said that the intention is to build a medical city on the land through partnerships with Florida Hospital and the University of Florida, School of Pharmacy.

Dr. German noted that the University of Central Florida (UCF) was the 2nd largest university in the country and offers over 100 different degrees. The medical school alone is larger than Rollins College.

She reported that due to the location of the UCF medical school, students have the options to work and learn in the Orlando Hospital system, the Florida Hospital system, Nemours, HCA in Osceola, as well as the Veteran's Administration in Bay Pines, Flagler and Winter Park.

Dr. German stated that their scores for medical exams are above the national average among the clinical and subject exams. The college has a current partnership with the University of Virgin Islands to help it build a medical school. The University of Central Florida will be paid $6 million over four years to assist with the project.

In regards to state funding, Dr. German stated that UCF funding increased over the years from $2 million to $30 million. The college takes the dollars the state provides and builds upon it. Dr. German was complimented on the building and she stated that the building came in under budget.

How Employer Coalitions are Transforming Health Care Quality: Ms. Laurel Pickering, MPH, President and CEO of Northeast Business Group on Health (NEBGH) spoke to the Commission about employer coalitions and their effect on health care quality. She gave a brief history of regional business coalitions and summary of what coalitions do.

Ms. Pickering reported that the Northeast Business Group on Health represents 70 employers based in New York, New Jersey, Connecticut and Massachusetts; many of which are large national, self-insured employers. NEBGH is employer driven and has many stakeholders. NEBGH has 180 members whose benefits include health plans, providers, benefit consultants, suppliers and other stakeholders. NEBGH represents about 12 million covered lives, which gives them employer purchasing leverage to drive value in the system.

Ms. Pickering reviewed the types of activities NEBGH provides. Among those activities are education opportunities; vendor management; opportunities for multi-stakeholder collaborations; access to Leapfrog; and access to the private exchange HealthPass, New York.

Commissioner Seevers asked if NEBGH provided a wellness program. Ms. Pickering explained that NEBGH does not provide the program, but they would work with the members to select a vendor to provide the program. She pointed out that while there is no "hard" return on investment (ROI), the activities help retain employees.

Ms. Pickering next gave the Commission a more detailed description of NEBGH's private exchange, HealthPass New York. She began by describing the New York State Health Innovation Plan (SHIP) Goals. They are to identify and stimulate the spread of promising innovations in health care delivery and finance that result in optimal health outcomes for all New Yorkers. Specifically, to improve population health through strengthened capacity and improved screening and prevention through closer linkages between primary care, public health, and community based supports. In regards to payment, NEBGH suggests a shift from the current fee-for-service to payment for value. This change would lead to better practice of medicine and better outcomes drive higher payments. Another benefit is that coordination of care will be paid for, allowing the focal point to be on the 'whole person'.

Ms. Pickering told the Commission about a grant opportunity included in the Affordable Care Act. The Act created the State Innovation Model (SIM) grants. To qualify, states must demonstrate a commitment to multi-payer health care payment and delivery reform to improve health system performance, increase quality of care and decrease costs.

New York received a $100 million four-year grant. Two-thirds ($67 million) of the funds will be invested in practice transformation for primary care doctors using the Advanced Primary Care (APC) approach. She stated that the state goal is to provide 80% of residents with access to primary care under a value-based payment model by 2019.

Ms. Pickering stated that multi-payer collaboration is necessary. Collaboration allows for greater impact on health care delivery; less complexity for primary care practices – particularly smaller practices and more consistency for consumers/patients. Ms. Pickering used a series of graphics to demonstrate how New York used the SIMs structure to create benefits across the health care system.

Ms. Pickering reviewed some of the challenges to measuring quality. She said that hospitals are easier to measure than physicians; and groups of physicians are easier to measure than individual physicians. If individual physician data is publicly reported, data accuracy is critical Not many public sites report individual physician performance.

Ms. Pickering shared the reasons why All-Payer Claims Databases (APCD) are critical. She mentioned that the states benefit by having a complete picture of what care costs, how much providers receive from payers for same and similar services, the resources used to treat patients and variations across the state and among providers in the total cost to treat an illness or medical event. Providers benefit by having a complete picture of their population. If insurers provide their own reporting, providers may look different across insurers. Benefits to consumers and businesses include performance and cost data available regardless of insurer, which can be used to make better-informed decisions about cost-effective care. Finally, insurers have more comprehensive data to make better-informed decisions about cost and effective care.

Ms. Pickering presented on the Leapfrog Group and stated that the group is a purchaser-driven nonprofit, publicly reporting on hospital quality and safety. Leapfrog was founded by purchasers in 2000 in response to 1999 Institute of Medicine report, "*To Err is Human".* Ms. Pickering described the three main measures used in the hospital survey as: how patients fare, resources used in caring for those patients and management practices that promote safety. The Leapfrog Hospital Survey is a free, voluntary survey on measures of hospital performance important to purchasers. The survey is completed annually by over 1,500 hospitals from across the country. Health plans, vendors and purchasers all use the safety scores.

Commissioner Rosenberg commented that only one-third of New York's work force is insured through an employer and the other two-thirds are covered by either Medicaid or Medicare.

Ms. Pickering closed by reporting that on June 3, 2015, the Michigan Legislature passed a law effectively requiring hospitals to fully complete the Leapfrog Hospital Survey to be eligible to receive graduate medical education funding. 57 Michigan Hospitals receive this funding, and a good number of them currently decline to report. This is the first time any state has required Leapfrog.

The Health Care (R) Evolution: How Florida Health Care Coalition Employer Members are Improving Value and Quality in Health Care: Dr. Karen van Caulil, President and CEO of the Florida Health Care Coalition (FLHCC) reported that the FLHCC is an Orlando-based, 501c3 non-profit business coalition on health, established 31 years ago to improve community health. FLHCC is a community catalyst that uses its collective employer power to effect change in health care delivery, striving to work collaboratively with our community partners to improve the quality of health care in Florida and to keep health care affordable and sustainable. The Board of Directors is comprised of public and private sector employers in Florida, predominately self-insured large employers. The FLHCC provides education, research and program support to our members, as well as conducting demonstration and research projects that test innovative benefit design, care coordination and management, and payment reform. Dr. van Caulil stated

that FLHCC's mission has always been about striving to make Florida a world class leader in health care quality, and as a leading global destination where millions come to live, work, play and retire. Florida should offer nothing but the very best for its citizens and visitors. She noted the new tag line, “Employers Who Care About Health Care!” in their logo.

Dr. van Caulil stated that as the second largest purchaser of health care, after the federal government, large employers are the voice of millions of consumers who expect the best quality health care at the best price. FLHCC has the unique ability to leverage its strategic partners to identify and implement meaningful changes in the health care delivery system. FLHCC's initiatives benefit all consumers in the community when health care quality is improved.

The FLHCC provides the means for public and private employers to work together to contain and reduce rapidly increasing health care costs as well as improve the quality and accessibility of health care services in Florida. She stated that the FLHCC works with their members to develop health care cost containment strategies, evidence-based guidelines and quality improvement and management programs and share that information among the members and with the community in general. The coalition interacts with health care stakeholders to foster cooperation and understanding with respect to the need to contain health care costs, improve health care quality and the education, empowerment and engagement of consumers in their health and health care decision-making.

Like the New York coalition, the FLHCC is seeking to achieve better care and lower health care costs by replacing the current volume-based purchasing model with one based on quality, patient safety, increased care coordination and communication. The FLHCC is also a member of the Leapfrog group. The FLHCC regional roll out is the 2nd largest in the US. The FLHCC has held meetings with health plans and employers to determine how they should use Leapfrog data in contracting and in configuring value based payment. It is important to create a “value factor” for each hospital using cost data plus quality (Leapfrog data), developing an index with patient safety data combined with patient satisfaction, cost and quality data to identify the best health care providers. Leapfrog will be used to develop a hospital quality report, identifying four to six measures that our employer members will address with the hospitals to improve performance measure results.

The current FLHCC research agenda includes oncology projects for studying cost and utilization patterns, the use of evidence based medicine, site of care, care management strategies and development of an employer toolkit and a profile of providers to assist with analysis of key data points and metrics which has a value-based benefit design, patient satisfaction with treatment modalities and the business case for covering the CDC’s Diabetes Prevention Program. FLHCC is also looking at research in a specialty pharmacy study of the impact of benefit design on adherence, and the SMARTCare Innovation Grant from the Center for Medicare and Medicaid Innovation – a Florida and Wisconsin cardiology effort to reduce variation in care and cost through appropriate use criteria.

The Commissioners discussed the challenges of care for cancer and heart disease. Surgeon General Armstrong commented that Florida needs more oncologists and cardiologists. They also discussed the importance of the transparency of cost and quality for all payers. The All Payer Claims Database was mentioned as a possible solution for identifying unnecessary care.

Public Comment: Manatee County Tax Payer, Glen Gibellina stated that hospitals should be more responsible and should match prices like Walmart. He stated that preventive care should occur and that consumers that do not do what the doctor says should not have care. He feels that tax payers should not fund health care in particular for illegal immigrants. He stated that it should be the problem of the Federal Government.

Commission Discussion: Surgeon General Armstrong led the discussion of what the Commission's next steps would be by summarizing the past 8 meetings of the Commission. He reminded the Commission that there have been 3 on finance, 3 on the eco-systems of the different areas across the state and the last 2 have been on the delivery of care and the quality of care respectively.

Chair Beruff directed the Commission to a spreadsheet in their materials on hospital margins and Mr. Ryan Fitch described what was in the spreadsheets and answered questions. For the next meeting, the Commission asked Mr. Fitch to provide specific metrics and a spreadsheet depicting who receives what monies from the State of Florida. They further requested that Mr. Fitch break down the information by private and public hospitals, distinguish net revenue between Fee-for-service and Medicaid Managed Care plans, and include revenue received by hospitals from local tax district funds.

The Commissioners requested that the Agency staff look at hospital's Leapfrog survey scores in relation to available financial data. In addition, the Commissioners requested more information on the Leapfrog survey regarding which hospitals participate in the survey; data sources and scores of the hospitals that participate versus the scores of those that do not. Deputy Secretary McKinstry stated that the Agency's Florida Center for Health Information and Policy Analysis would work to provide the data.

Commissioner Seevers suggested the Commission go back to Executive Order 15-99 and identify issues and objectives they need to discuss going forward. She stated that she would like a focus on the Certificate of Need (CON) program and Surgeon General Armstrong responded that there will be CON experts at future meetings. They will also discuss the 10 most common procedures and laws pertaining to where specific procedures must occur.

Commissioner Eugene Lamb would like to see the pricing of the 10 most common procedures posted in hospital's Emergency Departments. Surgeon General Armstrong responded that the posting of prices could have a negative effect on patients staying to receive the required health care.

The Commission discussed which patients use the emergency departments and why they choose to go to the hospital rather than a primary physician. Commissioner Lamb gave the example of a rural hospital emergency department possibly being the only good choice a person may have, whether they are insured or not.

The Commissioners discussed how to guide consumers to the appropriate care through educational initiatives. Deputy Secretary McKinstry noted that FloridaHealthFinder.gov includes consumer tools for long term care facilities, assisted living facilities and home health providers. She added that the Agency is working to expand information on the various services and will provide a draft to the Commissioners for review.

Chair Beruff stated that prior to the next Commission meeting, he would like to see a template combining topics included in the executive order with any recommendations the Commission may have made. Surgeon General Armstrong suggested creating a crosswalk with the agenda topics from the executive order as well as the action suggested or recommendations made.

The Commissioners requested that hospitals complete a short questionnaire regarding how much is paid for lobbying, advertising, and marketing. They discussed the possibility of recommending hospitals be required to give a detailed account on how they spend state money.

Vice Chair Kuntz asked if the Commission would be hearing from anyone in the Senate to discuss its health care agenda, to balance the report received from Representative Brodeur. Chair Beruff responded that Representative Brodeur volunteered to come to the meeting and that Senator Rene Garcia had greeted the Commission in Miami.

Commissioner Seevers would like the Commission to take a vote on Representative Brodeur's bill after hearing from the Senate.

Chair Beruff suggested holding all recommendations until November, when they would draft Commission recommendations and suggestions.

Next Meeting: The Commission agreed that the UCF accommodations were excellent and the meeting in Orlando worked well for all.

There being nothing further to discuss, the Commission adjourned at 2:30 P.M.