DRAFT MEETING MINUTES

COMMISSION ON HEALTHCARE AND HOSPITAL FUNDING

Meeting Date: September 28, 2015

Time: 1:00 p.m. – 5:00 p.m.

Location: University of South Florida - USF Gibbons Alumni Center - Tradition's Hall, 11810 USF Sago Drive, Tampa, Florida 32620

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

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

Interested Parties Present: Mike Moran; Joel Brown, DFS; Donald Mullins, USF Health; Merritt Martin, Moffitt; Lane Leonard, Moffitt; Josh Cherok, Wellcare Health Plans, Inc.; Jamie Wilson, Moffit; Kim Streit, FHA; Richard Conrad; and Melanie Brown, Johnson & Blanton; Elizabeth Miller, Wellcare; Wendy Hedrick, Sunshine Health

AHCA and DOH Staff Present: Deputy Secretary Molly McKinstry; Inspector General Eric Miller; Jamie Sowers; Nikole Helvey; Beth Eastman; and Nathan Dunn

Media: Daylina Miller, WUSF/Health News Florida; Bert Moreno, WTSP-Channel 10; and Jerry Stockfisch, Tampa Tribune

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

Review and Approval of Meeting Minutes: Minutes from the August 31, 2015 meeting were approved.

Helping Florida Employers Define and Discover Value in Health Care

Ms. Tammy Purdue, General Counsel for Associated Industries spoke to the Commission about how employers need to derive value from the investment on the health care they provide for their employees and families. Employers are looking for the highest quality for the lowest cost, because a healthy workforce benefits the employer.

Ms. Purdue shared the Florida employer breakdown in a table. The table clearly shows that more individuals work for companies with fewer employees. She noted that in Florida there are 596,092 employees working at organizations with 99 or fewer employees.

Large employers retain or have access to benefits expertise specialists, while small employers are guided solely by their budget. Many use the services of an insurance agent to secure benefit packages for their employees.

It is very important to find information to distinguish differences in value between network offerings, or get the most for your money. Employers must understand the differences in quality among providers. The following measurements should be considered: the right care and outcome; the right costs; and the fact that the market controls subjective elements.

DRAFT

Most information focused for employers is not readily accessible today from public sector. The Agency for Health Care Administration (AHCA) Florida Health Finder is a consumer-focused website with a plethora of information about health care facilities in Florida and the AHCA Event Notification Service (ENS) program is a tool used by carriers to monitor their patient's hospital admission, transfers and discharges. The best information is from private sector resources and tools, such as: Know before You Go; My Healthcare Cost Estimator; and Member Payment Estimator.

Ms. Purdue mentioned pharmaceutical cost controls; workers' compensation stability; and tort reform, as initiatives Florida employers can use to improve the value of the health care their employees receive.

Dr. Jason Rosenberg asked about Florida's Workers' Compensation, and the 70/30 split. Ms. Purdue answered that for every $.70 spent on treatment, only $.30 is payment to the injured worker for lost wages. Ms. Purdue responded that the ratio should be 50/50, but Florida is an outlier state and that Florida's physician fee schedule is statutorily low. The patient seeing a physician under workers' compensation is more expensive than someone not on workers' compensation. The patient's visit is considered a specialty visit, which allows the provider to charge more. The volume of services that the workers' compensation patient might receive is also higher, because of the ability to charge higher rates. Dr. Rosenberg asked if this fee schedule discrepancy was due to tort reform. She answered that in 2003 Florida law changed the lawyer's fee schedule to pay the attorneys involved in a workers' compensation case a percentage of the benefits, rather than an hourly rate, which incentivized the lawyers to close the cases more quickly. Ms. Purdue noted that the 2003 law changes are currently being challenged and they are waiting for an opinion from the Supreme Court of Florida.

Commissioner Marili Cancio Johnson asked if there are any proposals regarding pharmaceutical cost controls. Ms. Purdue responded affirmatively and said that the Associated Industries of Florida legislative proposals would be released in October. Mr. Robert Spottswood asked how many people in Florida were on employer sponsored plans. Ms. Purdue did not know, but offered to find out and report back to the Commission.

Public Records Request

Ms. Johnson told Secretary Dudek that she had seen an article in Politico about the Commission's lack of transparency and slow response to public records requests for emails. Secretary Dudek responded that the Agency for Health Care Administration receives many public records requests every day and that they are answered in order they arrive. She explained that part of the information requested had to have information redacted prior to being released. Ms. Johnson asked what the requester was asking for. Secretary Dudek said that the request was for email between Agency employees and the Commissioners. Chair Beruff commented that he didn't see how their emails had anything to do with HIPAA. Ms. Johnson stated that the article implied that the emails being requested would be between the Agency and the invited speakers.

Public Comment

Mr. Mike Moran, a certified insurance counselor representing himself reported that there is an epidemic of physician's and physician practices who are billing the patients over and above their co-payment. While the practice has agreed to specific terms to be an in-network provider, it is not accepting the negotiated fees as full payment.

Mr. Moran went on to suggest that the laws be changed to punitively punish providers that participate in this practice.

DRAFT

Commissioner Sam Seevers shared her experience with hospital billing. Chair Beruff explained that the contract between the provider and insurance company has been set. Any billing for the amount over the negotiated amount is a violation of contract.

Commissioner Rosenberg assured the Commission that the number of providers participating in this practice is very, very small. He doesn't believe that any new legislation needs to occur. The current laws are sufficient, they simply need to be enforced.

The State of Price Transparency and Payment Reform

Ms. Andréa Caballero is the Program Director for Catalyst for Payment Reform. Ms. Caballero began by describing her organization. Catalyst for Payment Reform (CPR) is a national, nonprofit corporation working on behalf of large health care purchasers, both public and private to catalyze improvement to how health services are payed for and promote better and higher value care in the U.S. She directed the Commission to a section of her Power Point presentation that lists 38 organizations who are CPRs clients. She stated that bringing all of the organizations together creates a critical mass of voices all asking for the same thing at the same time. She noted that CPR works on many objectives for the companies and are currently focused on payment reform; parings for payment reform with benefit and network design; price transparency; and enhancing provider competition.

Ms. Caballero started with the demand side when discussing quality. When developing a public facing resource the quality and the price matter. She noted that in Florida, patients only get recommended care 55% of the time, which leads to 44,000 – 98,000 deaths per year. It is very difficult to improve value without proper benchmarks and difficult to pay providers based on value.

Ms. Caballero next discussed the demand side in regards to price inefficiencies. She stated that prices for services are not standardized. She gave the example of a lipid panel blood test; in California can cost from as little as $10 to $10,169. Price variations are very significant when considering price transparency because the differences have no rational. Consumers see no increase in value based on the increase in costs. She then suggested that if a person is giving a consumer a price estimate, it should include the complete health care costs that the consumer will have to pay out of pocket. Ms. Caballero said that CPR hopes that the experience of finding health care should be similar for everyone, providing the same data to everyone.

Ms. Caballero said that nationally, 97% of the large commercial plans have cost calculators for its members to use. However, when CPR reviewed the use of the tools, only 2% of their members are using the tools.

Next Ms. Caballero discussed the challenges to pricing transparency. She noted that inaccurate estimates are an issue. Consumer trust is another issue, because the tool is being provided by a health plan, the consumer is less likely to trust it. Provider market power allows providers to refuse to post prices through possible contractual obligations with the health plan. Collusion is another issue; if everyone is posting their prices, what is to stop some of the organizations from artificially increasing the costs together? Oversight is very important.

Purchasers are increasingly looking to hold down health costs by shifting more financial responsibility to the consumer using CDHPs and high deductible plans; encouraging consumers to "shop around for care"; and restricting provider access using narrow networks.

Ms. Caballero told the Commission that CPR released its third annual Report Card on State Price Transparency Laws, reflecting how well states ensure that consumers have access to health care prices.

DRAFT

The Report Card reflects that there has been little progress. Much more needs to be done to provide price and quality information to consumers. However, several states are ahead of the others in offering price and quality information to their residents. Ms. Caballero showed the Commission a map of the United States depicting what "grade" each state was given in regards to price and quality transparency. Of the 50 states, 45 states, including Florida, received the letter grade "F". She said states using an all-payer claims database (APCD) have access to much more data which provides the researchers with more accurate data.

Ms. Caballero transitioned to payment reform. CPR defines payment reform as payment that reflects provider performance, especially the quality and safety of care that providers deliver; and payment methods that are designed to spur efficiency and reduce unnecessary spending. It is not considered value-oriented payment, if a payment method only addresses efficiency - it must include a quality component. She noted that fee-for-service is not considered payment reform because there is no quality component.

Next, Ms. Caballero told the Commission that there are three main types of payment reform: Financial Upside, which provides a "carrot" for behaviors, a Financial Downside which imposes a "stick" for certain behaviors, and a financial two-sided reform that provides both rewards and punishments for behaviors and outcomes.

Ms. Caballero reviewed where the nation is in regards to value oriented payments. Nationally about 40% of all commercial payments to hospitals are considered value oriented. She noted that these changes have come about through specific contracting between the providers and the payers. She also reviewed Medicare payments. 42% of all Medicare payments are considered value oriented, which shows that the commercial insurances are tracking alongside with Medicare in payments.

Dr. Rosenberg asked if the amount spent on payments tied to value came down. Ms. Caballero responded that the amount had not changed. Dr. Rosenberg inquired if insurance costs had gone up or down, to which Ms. Caballero stated they had increased. Dr. Rosenberg remarked that consumers are paying more for their insurance now, but may not be receiving better health care. He said that as a provider he has to go down a required list when seeing a patient to supposedly improve the value of the patient's health care, his premiums are going up for himself and his employees and he doesn't see an improvement. He said that the Commission is there to look at what care patients receive and at what cost they receive it.

Ms. Caballero reviewed results from the 2015 New York Commercial and Medicaid Scorecards. 34% of the commercial payments are value-oriented; but 94% are still fee-for-service. 32.7% of New York Medicaid's payments are value-oriented; but 72.6% is still based on fee-for-service.

Commissioner Kuntz inquired what the difference is between fee-for-service and value oriented. Ms. Caballero answered that fee-for-service is paid for the actual medical service and that there is no value metric attached. Mr. Kuntz asked if the value was based on outcomes. Ms. Caballero responded that there are process metrics that are included in the metrics. Dr. Rosenberg stated that the payment reform metrics should be based on outcomes.

Secretary Dudek noted that since the implementation of the Medicaid Managed Care Assistance, metrics have been collected on outcomes and she will be sure to include the information for the next Commission meeting.

Ms. Seevers asked what tools were used to get the measurements. Ms. Caballero responded that CPR surveys health plans and hospitals and have developed the metrics. The national scorecard represents approximately 68% of the commercial market. Ms. Seevers asked to what extent CPR uses Leap Frog. Ms. Caballero explained that currently they are not measuring the quality, just the quantifying the dollars

spent. Ms. Seevers next asked about a statement from the beginning of the presentation that only 55% of patients receive what they need. Ms. Caballero explained that patients are receiving unnecessary tests and care that is not required for a specific ailment. Commissioner Spottswood asked how a patient can receive unnecessary care. Ms. Caballero stated that a service can be ordered by the patient's physician, while it is not listed in a specialist's standard of care.

All-Payer Claims Databases (APCD): An Overview

Ms. Denise Love, BSN, MBA, is the Executive director of the National Association of Health Data Organizations (NAHDO), a national nonprofit membership and educational organization, established in 1986 and dedicated to improving the collection and use of health care data for market, consumer, and policy and research purposes. Ms. Jo Porter, MPH, serves as Interim Director for the Institute for Health Policy and Practice in the College of Health and Human Services at the University of New Hampshire. Both are co-directors of the APCD Council (www.apcdcouncil.org).

Ms. Love reported that the APCD Council is a learning collaborative of government, private, non-profit, and academic organizations focused on improving the development and deployment of state-based all payer claims databases. The APCD Council is convened and coordinated by the Institute for Health Policy and Practice (IHPP) at the University of New Hampshire (UNH) and the National Association of Health Data Organizations (NAHDO).

She noted that most databases are usually created by state mandate, and typically include data derived from medical, pharmacy, and dental claims with eligibility and provider files from private and public payers such as, insurance carriers (medical, dental, TPAs, PBMs) and public payers (Medicaid, Medicare).

State-based all payer claims databases (APCDs) include the following data elements: encrypted social security; patient demographics (date of birth, gender, residence, relationship to subscriber); type of product (HMO, POS, Indemnity, etc.); type of contract (single person, family, etc.); diagnosis codes (including E-codes); procedure codes (ICD, CPT, HCPC, CDT); NDC code / generic indicator / other Rx; revenue codes; service dates; service provider (name, tax id, payer id, specialty code, city, state, zip code); prescribing physician; plan charges & payments; member liabilities (co-pay, coinsurance, deductible); date paid; type of bill; and facility type.

The following would not be found in an APCD: Services provided to uninsured; denied claims; workers' compensation claims; referrals; test results from lab work, imaging, etc.; provider affiliations; premium information; capitation fees; administrative fees; back end settlement amounts; and back end P4P or PCMH payments.

Ms. Jo Porter reviewed some of the key considerations when developing an APCD. She described the different benefits stakeholders receive through the use of an APCD. She stated that policy makers can be a "champion" of the APCD program because they can write informed policies regarding payment methodologies and health care reforms. Payers supply the data, as well as the technical and content experts. Providers will also use the data. Employers can see the costs of health services. Consumers are enabled to make informed choices based on pricing information.

Ms. Porter stated that while participation in some APCDs is voluntary, the development and participation in most states' APCDs are mandated by state Legislatures. The Legislatures can also set standards regarding the data collection, data release, and stakeholder reporting requirements. Rules and regulations must be drafted regarding data elements; thresholds submission formats and timelines, penalties and release policies. Ms. Porter noted that they have published a paper on model legislation.

DRAFT

Another key consideration in developing an APCD is funding estimates. You must ask what are the cost drivers and considerations, and what does startup through sustainability look like. Knowing the available funding sources is also important. Will the project use general appropriations, or fee assessments? Do you have funding for a Medicaid match? Are there any federal, state or local grants available? Should you take on a partner, and should you sell the data?

There are also technical considerations when setting up an APCD. First, the APCD needs to align with payer capabilities and assess capacity needs. There will need to be technical standards, specific data elements, and formats which will ensure data quality. Edit and error thresholds must be set, as well as testing for data completeness and continuity of data over time.

A Request for Proposal (RFP) will be developed. When drafting the RFP scope, consideration should be given to aggregation, warehousing, and analytics, as well as any other key necessary RFP components. The RFP should allow for APCD enhancement such as non-claims based payments; premiums; benefit design; and clinical data elements.

A successful APCD requires continuous engagement with the stakeholders. The APCD must be inclusive, transparent and open, and provide a channel for feedback.

At this point in the presentation the presenters answered questions from the Commissioners. Commissioner Seevers asked about a return on investment (ROI). Ms. Porter responded that the states with an APCD have access to more information than states without an APCD. Ms. Seevers responded asking about the importance of the information gathered by the APCD, and can there be a monetary value placed on that information.

Secretary Dudek responded that the state has “tons” of data and it is for us to ask, what do we have that is useful, who it is useful for, and how is it useful.

Commissioner Eugene Lamb asked where the funding came from. Ms. Porter explained that it came from the State’s general revenue, or grants. She noted that New Hampshire’s funding for their ACPD comes from a mix of general revenue and Medicaid.

Dr. Celeste Philip, proxy for Surgeon General Dr. John Armstrong asked what benefits early adopters have seen. Ms. Porter responded that the APCD gives providers the ability to leverage other data to see any ongoing issues. For example, the database can alert a provider that there has been a readmission or a discharge; and if a patient is filling their prescriptions.

Chairman Carlos Beruff stated that the costs are driven by population. Commissioner Dr. Rosenberg asked why the insurance companies would share their information. Ms. Porter reminded him that most states with an APCD have legislatively mandated that they provide their claims data to the database.

Commissioner Robert Spottswood noted that Colorado spent $2 million in start-up funding before they met sustainability. He questioned why a state would choose to have an ACPD. Ms. Porter replied that with an APCD, a user can see the whole state picture and identify any intra-state variations in patterns.

Commissioner Tom Kuntz asked why institutions would choose to participate. Ms. Love reminded the panel that several states have made reporting to the database a mandate, and compliance is very important to view the whole picture.

DRAFT

Agency Follow up

Chair Beruff directed the Commission to the recommendations document in their packets. He would like to review this at the next meeting and develop a final draft. Secretary Dudek responded to a question asked earlier in the meeting about the public records requests. She explained that the reported from the Politico article had submitted 10 public records requests and has received responses to 7 of the 10 requests. The Communications Office has been in communications with the reporter.

Secretary Dudek next directed the Commission to a document in their packet containing the requested information on hospital CEO compensation as well as an attempt at combining all of the information gathered on each hospital.

Future Meetings

Vice Chair Kuntz noted that some of the recommendations that he thought were being made, were not included in the recommendation list provided. He said he believes they are running out of time to influence the legislature.

Commissioner Seevers stated that the Commission had not made any recommendations but had only been making statements and asking questions. She would like to ask questions of other Commissioners and they need to have time that they can talk "in the Sunshine."

Chair Beruff would like a revised list of actionable item for the next meeting. Many of the Commissioners agreed that they were not interested in hearing from any more speakers and would like to have a workshop and spend their meeting time reviewing and discussing the information that has been provided.

Commissioner Kuntz suggested going through the 9 topics included in the Governor's call for the Commission, and then add on to the list with the other concerns of the Commission.

Commissioner Ken Smith wants to spend time on Certificate of Need.

Commissioner Kuntz voiced his concern that a Senate representative had not been invited to come to speak to the Commission.

Commissioner Seevers reminded the Commission that the House of Representative member had legislation filed regarding the Commission topics. She also noted that there seems to be multiple organizations gathering data and trying to determine how to save money. She is concerned that the Commission could be adding another layer to that.

Commissioner Johnson feels that all of the gathering and analyzing of the data is not decreasing health care costs, or improving health care outcomes. She wants the Commission to not add to the regulatory burden.

Chair Beruff told the Commission to go through the recommendations and make comments and also note any other topics they feel they need to cover and be ready to discuss at the next meeting.

The next meeting will be held in Tallahassee on October 20th at 9 A.M.

The Commission adjourned at 4:20 P.M.

DRAFT