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# **Health & Family Services Policy Council**

**Tuesday, November 3, 2009  
8:00 AM - 9:45 AM  
Webster Hall (212 Knott)**

**Larry Cretul  
Speaker**

**Ed Homan  
Chair**

# **Council Meeting Notice**

## **HOUSE OF REPRESENTATIVES**

### **Health & Family Services Policy Council**

**Start Date and Time:** Tuesday, November 03, 2009 08:00 am  
**End Date and Time:** Tuesday, November 03, 2009 09:45 am  
**Location:** Webster Hall (212 Knott)  
**Duration:** 1.75 hrs

Progress report by the Agency for Health Care Administration on the implementation of the encounter data system.

Workshop on medical homes.

**NOTICE FINALIZED on 10/27/2009 16:13 by Alison.Cindy**



# The Florida House of Representatives

## Health & Family Services Policy Council

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### AGENDA

November 3, 2009  
8:00 AM – 9:45 AM  
Webster Hall (212 Knott)

- I. Opening Remarks by Chair Homan
- II. Progress Report by the Agency for Health Care Administration on the Implementation of the Encounter Data System

Phil Williams  
Interim Deputy Secretary for Medicaid  
Agency for Health Care Administration

- II. Workshop on Medical Homes

Andrew R. Behrman, MBA, President and CEO  
Florida Association of Community Health Centers

Jose Armas, M.D.  
MCCI Medical Group

Dan Plascencia, M.D.  
St. Joseph's Children's Hospital of Tampa

Brian Klepper, Ph. D.  
Healthcare Performance, Inc.

- III. Closing Remarks
- IV. Adjournment

Encounter Data  
AHCA



# ***Medicaid Encounter Data – Status Update***

***Phil E. Williams***

***Interim Deputy Secretary for Medicaid***

***Presented to the House Health & Family Services Policy  
Council***

***November 3, 2009***

## ***Encounter Data***

- **Encounter data** are electronic records of covered services provided to the enrollees of a health plan.
- **An encounter record captures the interaction between a patient and provider** (health plan, physician, pharmacy, hospital, laboratory, transportation, home health services, etc.) who delivers services or is professionally responsible for services delivered to a patient.

## ***Compared to Fee-for-Service***

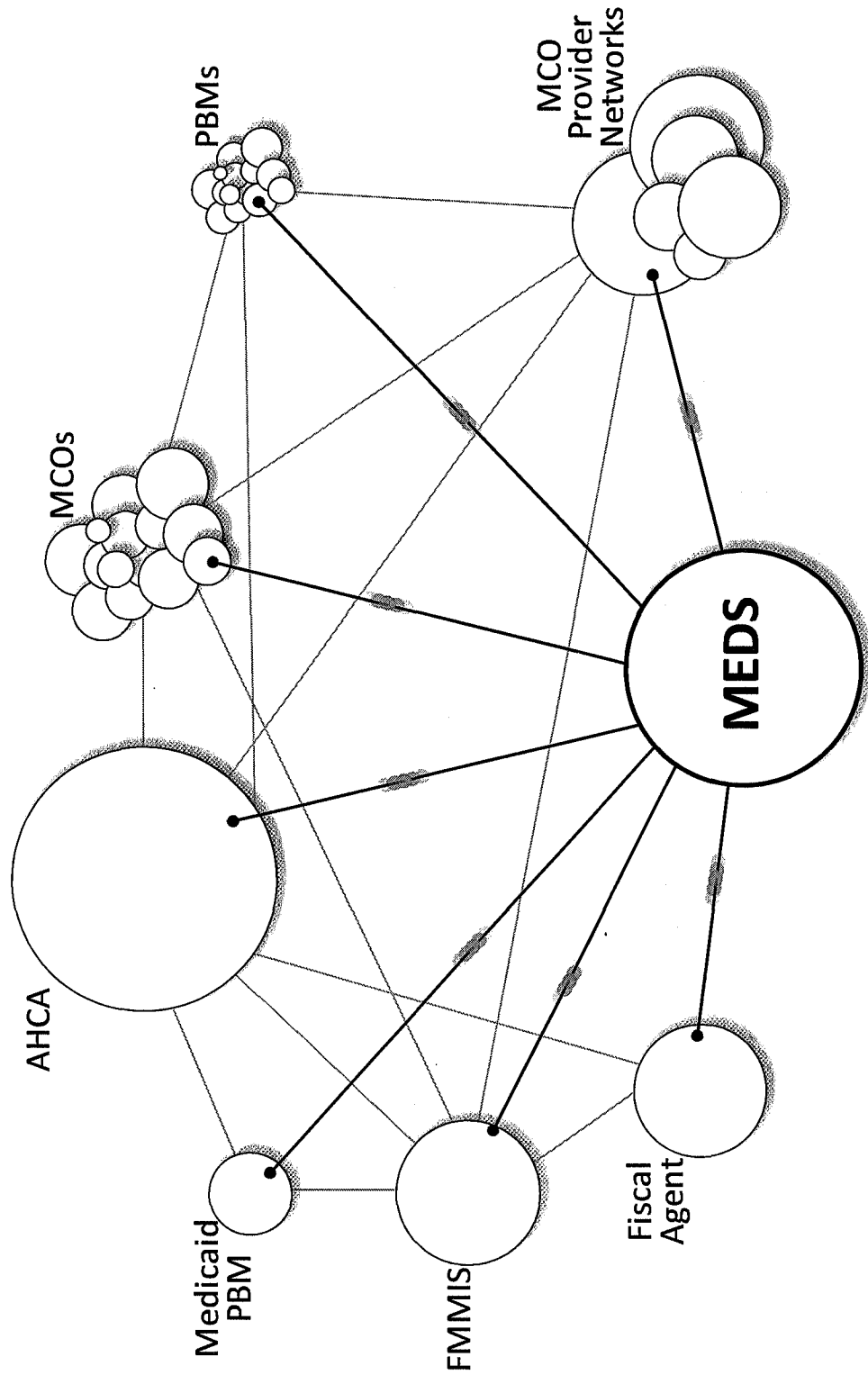
- Encounter data are comparable to claims data collected under fee-for-service (FFS); however, there is one big difference – encounter data provide information on services for which payment has already been made.
  - Florida Medicaid pays contracted managed care organizations (MCO) a monthly per-enrollee amount (capitation payment) before services are delivered. The MCOs employ or subcontract with primary care physicians, who coordinate the delivery of health services.
  - The Medicaid MCO contracts require the MCOs to collect encounter data from their providers, including subcapitated providers, and to include this requirement in MCO contracts with MCO providers.

## ***Medicaid Encounter Data System***

- Florida's Medicaid Encounter Data System (MEDS) is a statewide system and process to receive, accept, store, and validate encounter data.
- MEDS describes the complex interconnection between the Agency for Health Care Administration (Agency) and the Medicaid Managed Care Organizations (MCOs), along with the processes used to get Medicaid encounter data into a centralized location for program use.
- MEDS consists of the Agency, each of the Medicaid MCOs, each of the MCO networks providing covered services, the Medicaid fiscal agent, the Medicaid pharmacy benefits manager (PBM), and the Florida Medicaid Management Information System (FMIMS).



# Medicaid Encounter Data System



## ***Encounter Data Format***

- In compliance with federal requirements, MEDS requires MCOs to submit encounter data electronically and in HIPAA-compliant format.
- Prior to MEDS, Medicaid MCOs functioned as “payers” and collected information from their providers in order to pay fee-for-service claims or make capitation payments. They were not required to submit this information to the Agency.
- For the MCOs, becoming “submitters” rather than “payers,” and learning to create and submit outbound HIPAA-compliant transactions, was technically challenging. (HIPAA is a national standard that strictly defines the data elements, file structure, and format for health care claims.)

## ***Data Submission***

- The Agency notified all health plans in May 2009 that encounter data resubmission would resume in July 2009 for both historical and current encounter data.
- Medical services encounter data submissions resumed July 9, 2009.
- Pharmacy services encounter data submissions started August 14, 2009.
- MCOs are required to submit Reform and non-Reform historical encounter data to the Agency for defined periods by October 31, 2009.
  - All historical medical services encounter data for Reform (January 1, 2007 – June 30, 2009) due to AHCA (in FMMIS) by October 31, 2009.
  - All historical medical services encounter data for non-form (July 1, 2008 – June 30, 2009) due to AHCA (in FMMIS) by October 31, 2009.
  - All historical pharmacy encounter data for Reform and non-Reform (July 1, 2008 – June 30, 2009) due to AHCA (FMMIS) by October 31, 2009.

## ***Data Submission***

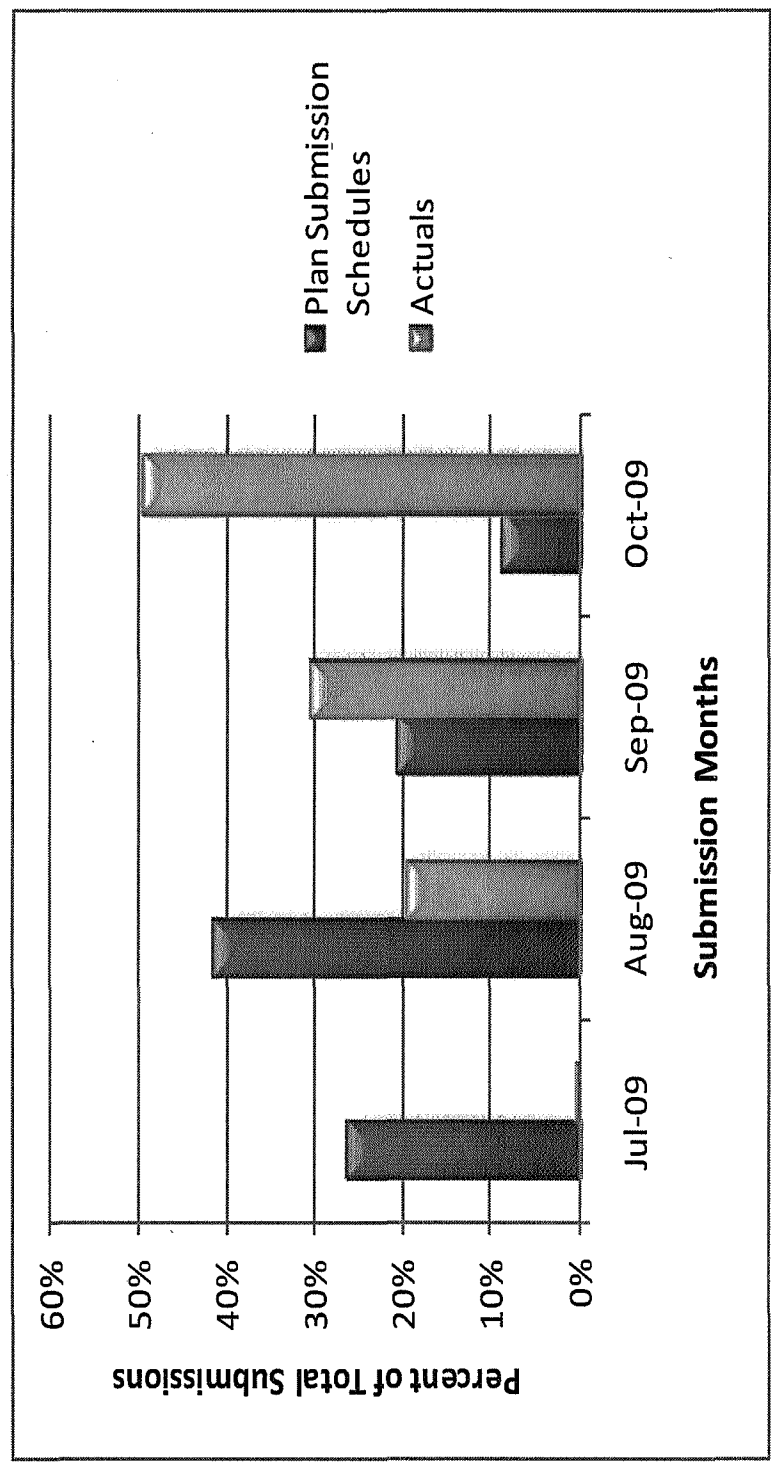
- MCOs must submit their ongoing (current) encounter data beginning with July 1, 2009, paid dates as described in the Medicaid HMO contracts.
- Both claims systems (medical services and pharmacy) are processing and accepting historical and current day encounter claims.

## ***MCO Data Certification***

- MCOs are required to certify the completeness and accuracy of their own encounter data submissions based upon the provider encounter data.
- The purpose of this requirement is to ensure that the MCOs will confirm to the best of their knowledge the accuracy and completeness of the encounter data received from their providers.
- Data certification is required by federal law when payments to MCOs are based on the data submitted. Data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the State and contained in contracts, proposals, and related documents.

# Encounter Data Submitted vs. Scheduled at 10-26-09

Although some MCO medical services encounter data submissions are behind their approved schedules as shown by the chart, intensified work with those plans, including a MEDS technical assistance workshop held on September 2-3, 2009 by the Agency, has helped increase plans' submission success.



50% of total volume to date submitted since October 1, 2009

## ***Submission Volume at 10-26-09***

- As of October 26, 2009, Agency staff have reviewed approximately 12 million medical services encounter claims and approximately 7 million pharmacy services encounter claims.
- Approximately 10.8 million medical services encounter claims and 5.1 million pharmacy services encounter claims have been processed by FMMIS as of October 26, 2009.

## ***Agency Support***

- Agency staff are working with the MCOs to facilitate encounter data submission activities. Efforts include:
  - Data assessment activities to support encounter data collection and processing in the EDS FMMIS. These activities include pre-review of production MCO medical services and pharmacy files to verify the accuracy of the data submitted.
  - Ongoing efforts with the managed care organizations, the Fiscal Agent (EDS), and the Pharmacy Benefits Manager (First Health) to coordinate the collection of pharmacy and medical services encounter data.
  - Updates to the encounter data Companion Guides and other documents on the MEDS website  
<http://ahca.myflorida.com/Medicaid/meds/index.shtml>).
  - Technical assistance meetings, including Technical Assistance Workshop, with each health plan to discuss encounter data submission specifics and address their potential issues and concerns.



## ***Encounter Data Editing***

- MCOs submit their encounter claims to FMMIS in the same way Medicaid providers submit their fee-for-service (FFS) claims to FMMIS. Encounter claims must successfully pass several editing steps in order to be accepted in FMMIS and sent to claims history, where they are then available for use by the Agency.
  - The first data editing step is upon file submission.
  - The second data editing step occurs during encounter claim “processing.”
- Encounter data editing only ensures that the data elements being reported are valid entries, i.e., that diagnosis codes are valid ICD-9 codes, and that procedure codes are actual CPT codes, but cannot validate that the encounter data submitted are an accurate representation of the services the enrollee actually received.

## ***Encounter Data Completeness, Assessment and Validation***

- Encounter data are considered complete when they can be used to describe the bulk of services that have been provided to Medicaid recipients who are enrollees of an MCO; however, development of accurate and complete encounter data is an iterative process.
- Before encounter data can be used to make management or policy decisions, the data must be assessed for quality (i.e., completeness and accuracy).
- Because encounter data are self-reported, it is essential to have in place a comprehensive back-end validation system to look for statistical anomalies and to evaluate data integrity and reasonableness.

## ***Encounter Data Completeness, Assessment and Validation***

- Once all historical encounters have been accepted in FMMIS and have been sent to claims history, the Agency's back-end data validation begins via internal work group.
- Completeness – 95% completeness submission rate for covered services.
- Accuracy – 95% of claims are required to be accepted by FMMIS.
- Parallel review of pharmacy encounter data compared to Medicaid Rx Model data in use for risk adjustment purposes.
- Volume of pharmacy data submitted.
- Macro validation to identify any data inconsistencies within MCOs.
- Micro validation by sampling of chart review.

## ***Encounter Data Utilization Team***

- Preliminary uses identified by the internal work group include:
  - Replacing quarterly pharmacy data with HIPAA-compliant encounter data for risk adjusted rates in the Pilot counties (early 2010);
  - Tracking History and Physical procedure codes to identify automatic recipient disenrollment if the initial visit does not occur within 90 days after HMO enrollment (early 2010);
  - Verifying MCO compliance with Medicaid Managed Care contract requirements (SFY 2010-11);
  - Supporting the electronic health record (SFY 2010-11);
  - Comparing preventive services provided by MCOS versus the audited HEDIS measures (SFY 2010-11);

## ***Encounter Data Utilization Team***

- Identifying recipients with chronic illnesses based on HEDIS guidelines (SFY 2010-11); and
- Identifying specialty services provided by plans by areas of the State (SFY 2010-11).

## ***Moving Forward***

- The 2009 Managed Care Reimbursement Workgroup identified encounter data as the preferred base data source as the basis for setting capitated managed care rates.
  - The Agency recognizes the need to transition from a FFS basis to an encounter data basis as the base data for setting rates. However, additional tests and milestones are required before the Agency or its actuaries can determine the validity, completeness, and soundness of the encounter data to be used for rate setting purposes.
  - Beginning with the SFY 2010-11 rate cycle, encounter data will be incorporated into the rate setting process as a contributing data source (percentage to be determined) at levels that maintain actuarial soundness.



# *Questions?*









**Florida's Federally Qualified Health Centers:  
A Medical Home Approach**

**Presented to the Health and Family  
Services Policy Council  
November 3, 2009**

**Andrew R. Behrman  
President and CEO  
Florida Association of Community Health Centers**



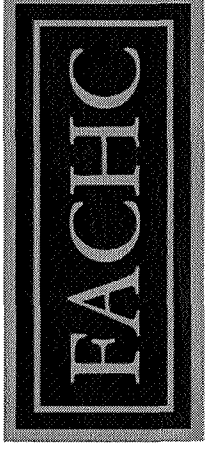
# Florida FQHCs

- **FQHCs have been recognized for efficiency and effectiveness by the federal Office of Management and Budget as the #1 Health and Human Service program of all time.**
- **Florida's FQHCs are committed to expanding access to primary health care and establishing a medical home for patients while further developing patient responsibility for personal health care. This effort enhances improved health outcomes which reduce costs and extend public and private health care resources.**
- **FQHC's accept all insurance products, and uninsured patients are charged service fees based on a *local board approved* sliding-fee scale. Through this, FQHC patients are given a level of accountability that promotes self reliance and an interest in personal wellness.**



## Why A Primary Care Focus in Florida?

- Growing inequity in primary care funding, education & training
- Health care delivery system is too costly and fragmented
- Improving health outcomes must be addressed especially in uninsured minority populations



# **Benefits of a Primary Care Medical Home Strategy**

- Improved health outcomes
- More efficient use of healthcare dollars
- Reduction of inefficient episodic care that may be unnecessary

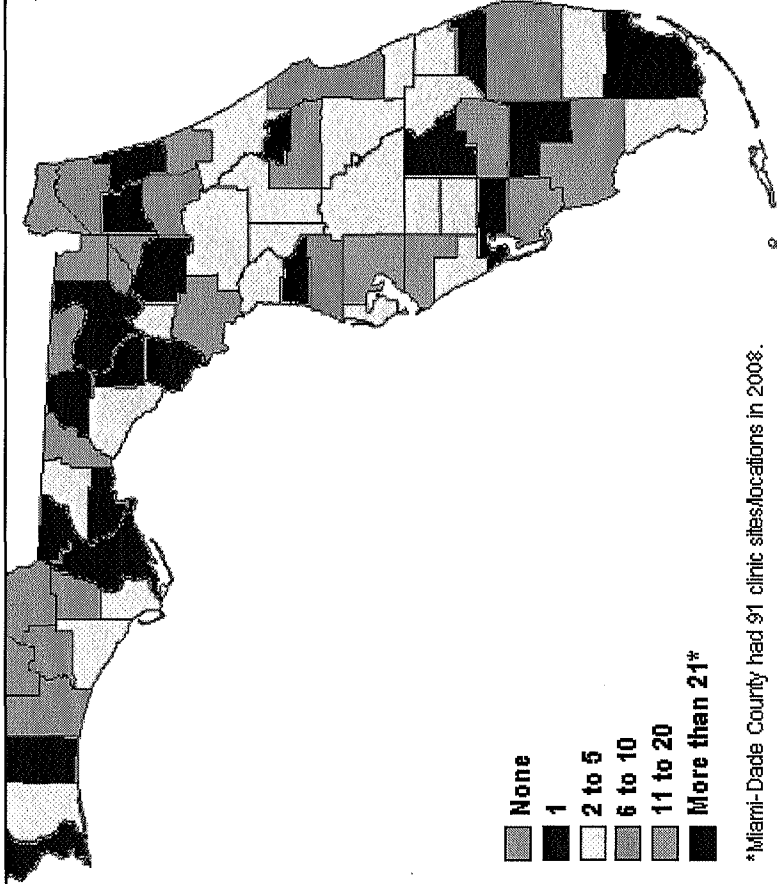


## Florida FQHCs

- **856,738 patients**
- **3,230,154 visits**
- **44 FQHCs in Florida**
- **280 service locations**
- **69.8% of patients are at or below 200% of FPL**
- **50% of patients are uninsured**
- **Community-based health care**



## 2008 Geographic Distribution of FQHC Sites

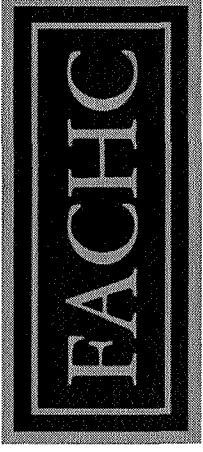




## **Florida FQHC Services include but are not limited to:**

- Diagnostic Laboratory
- Diagnostic Tests/Screenings
- Urgent Medical Care
- 24-Hour Coverage
- Family Planning
- HIV Testing and Counseling
- Testing for Blood Lead Levels
- Immunizations
- Following Hospitalized Patients
- Gynecological Care
- Dental Care (Preventive, Restorative, Emergency)
- Mental Health/Substance Abuse Services
- Hearing Screening
- Nutrition Services Other than WIC
- Pharmacy
- Vision Screening
- Case Management
- Eligibility Assistance
- Health Education
- Interpretation/Translation Services
- Outreach
- Parenting Education
- Preventative Services Related to Target Clinical Areas (Cancer, Diabetes, Cardiovascular Disease, HIV/AIDS, Infant Mortality, Immunizations, etc.)

(2008 Uniform Data System) (UDS)



## Selected Services

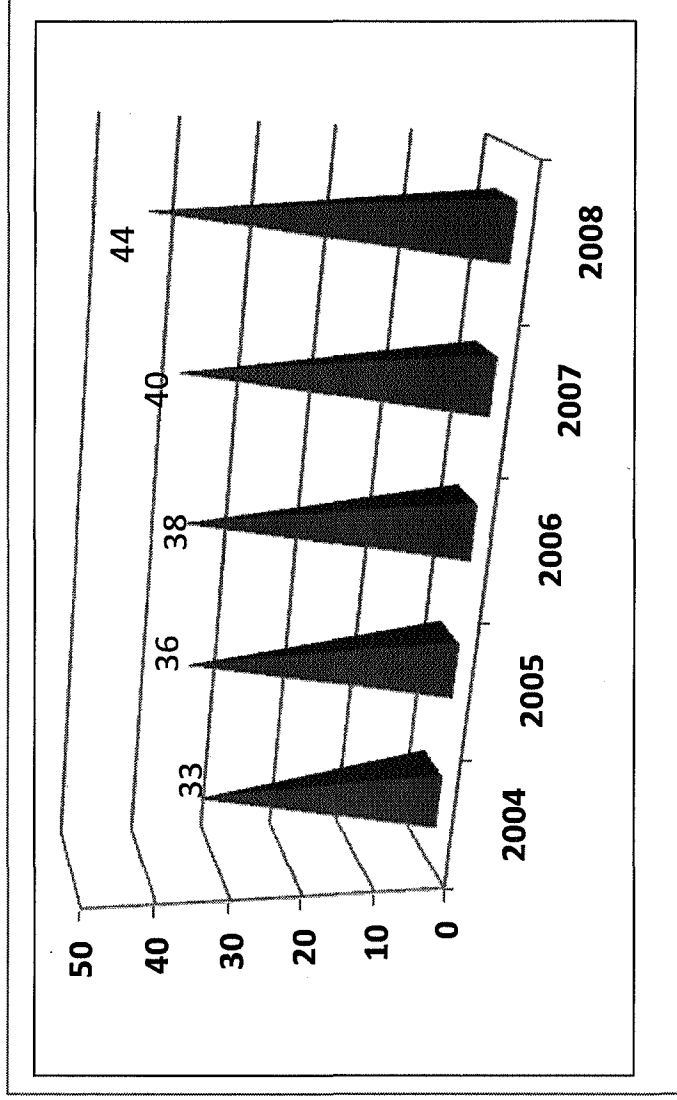
- 72% Dental Services are provided in house –
- Case Management - 100% completed in house
- Eligibility Services – 97% in house
- Nutritional Planning – 72% in house
- Preventive Care –
  - Cancer Screenings (Pap Tests) 97.5%
  - DM A1c 97% , Foot exams 73%
  - CVD Screenings: BP -100%
  - Cholesterol Screening – 93%

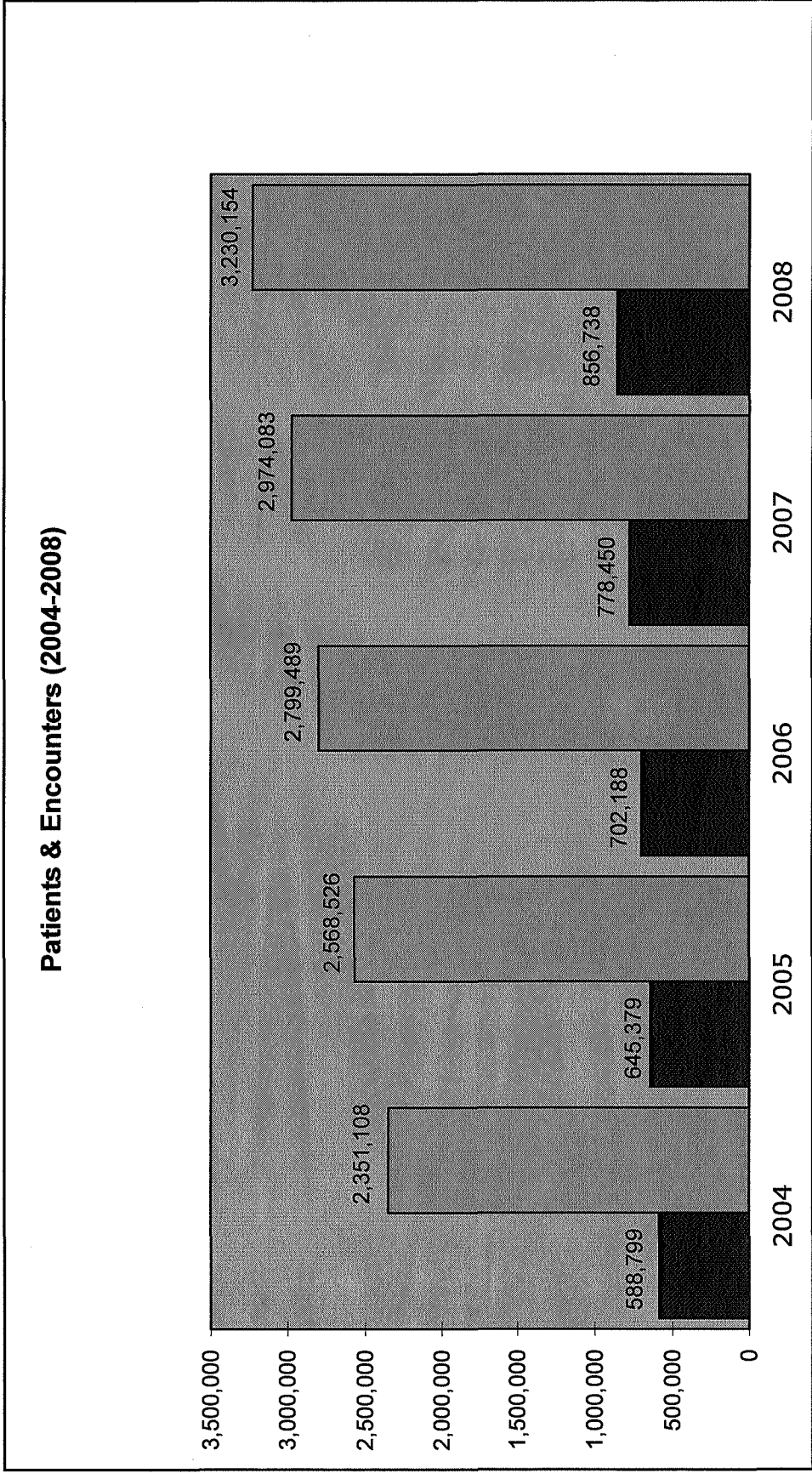




## Community Health Center Grantees

	Grantees	Total Patients
2004	33	588,799
2005	36	645,379
2006	38	702,188
2007	40	778,450
2008	44	856,738

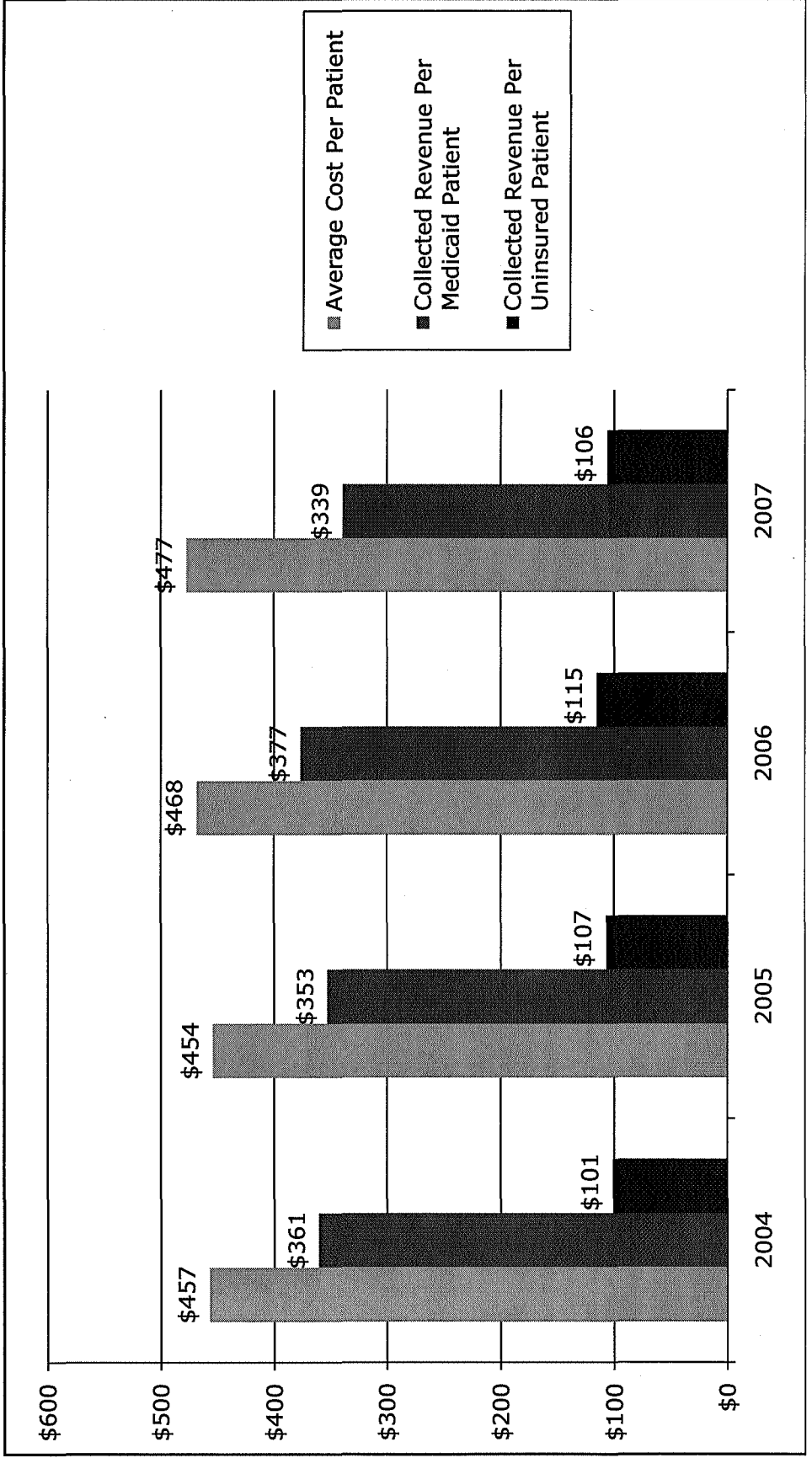




(2004-2008 Uniform Data System) (UDS)

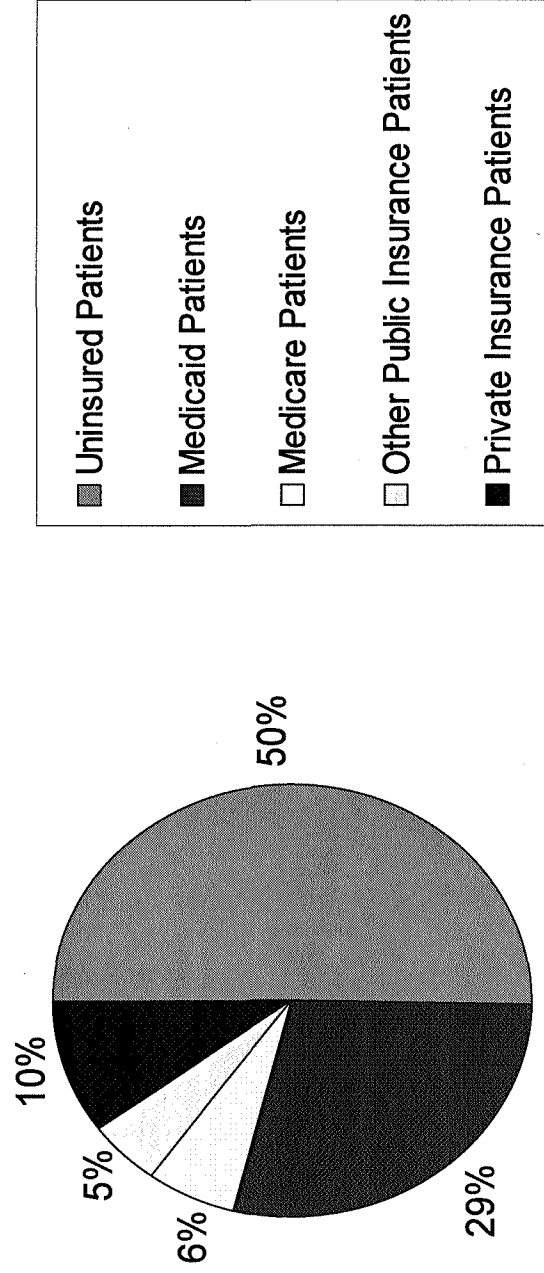


## Cost/Revenue Analysis



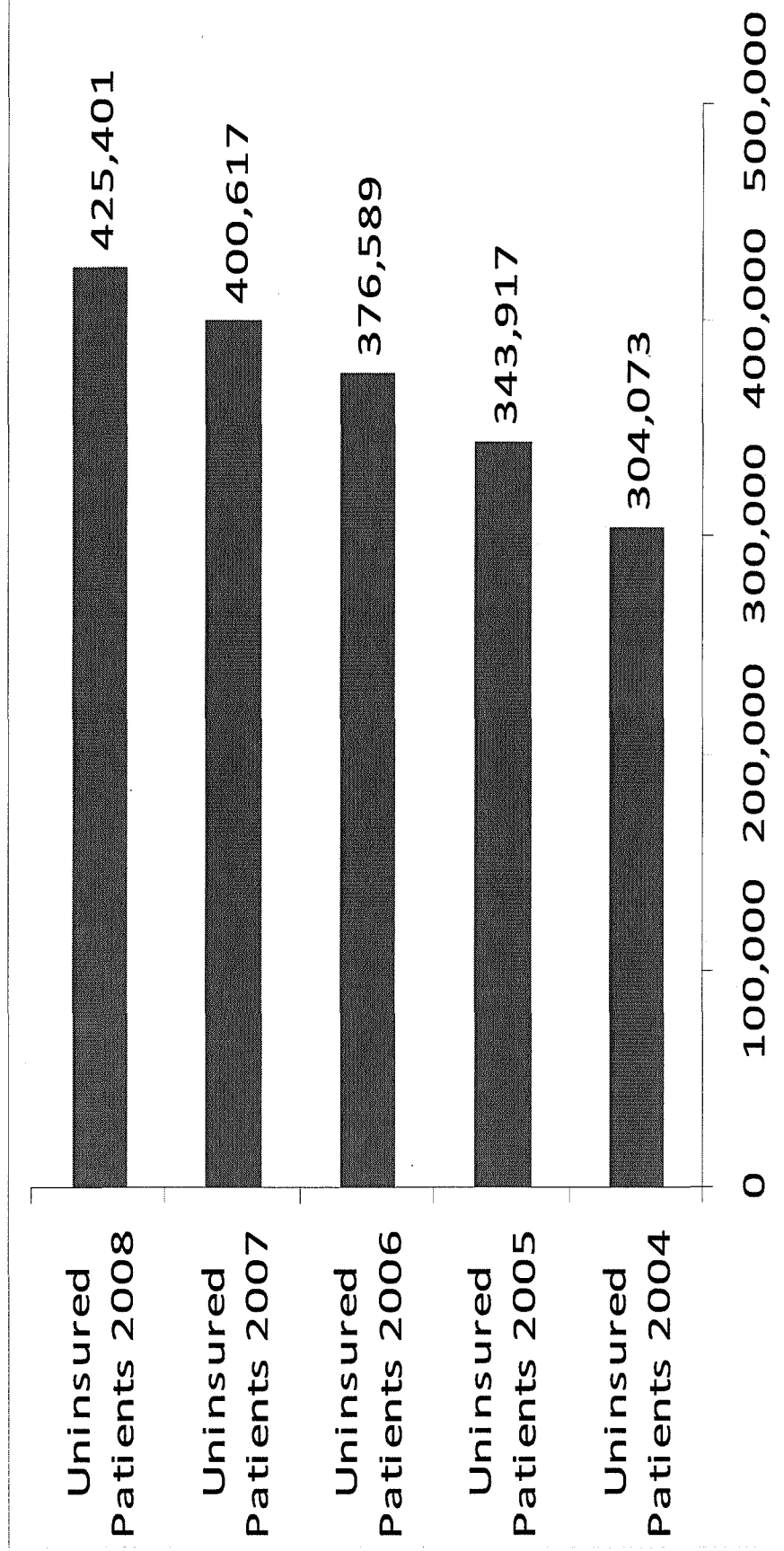


### Health Center by Principal Third Party Insurance (2008)





## Uninsured FQHC Patient Trend 2004-2008



(2004-2008 Uniform Data System) (UDS)



## **The Health Disparities Collaboratives™: A Key Element of the Medical Home**

- Differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation
- Florida's FQHCs implement the principles of the Health Disparities Collaboratives™

\*As defined by the US Department of Health and Human Services



## The Health Disparities Collaboratives™

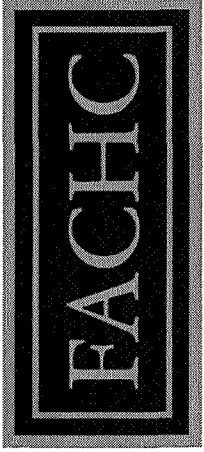
- Quality Improvement (Planned Care) Model that improves outcomes by integrating:
  - Delivery Systems design
  - Clinical Information Systems
  - Self-Management principles
  - Community Resources and Policies
- Transforms delivery systems from reactive to proactive by redesigning processes to improve delivery of care
- Centers strive to reach nationally benchmarked indicators
- Aligns closely with NCQA Medical Home standards



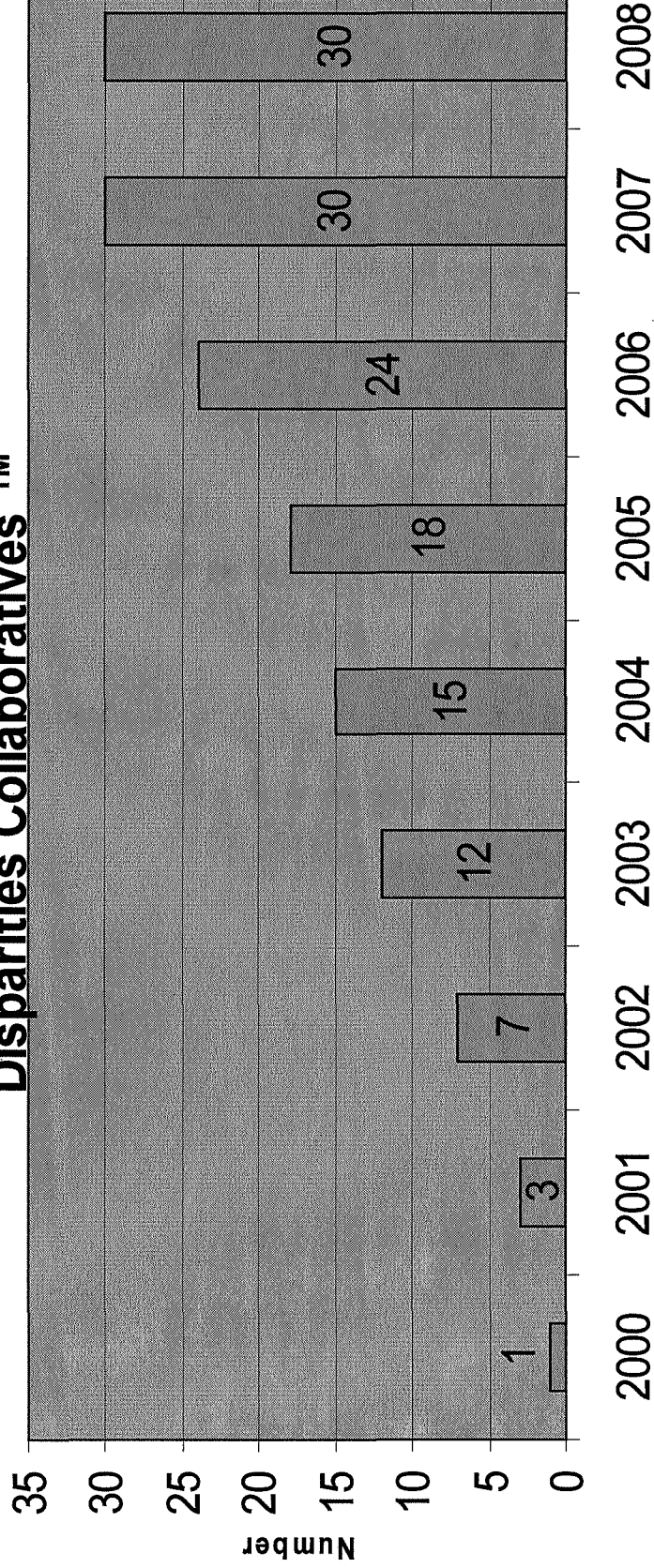
## FQHCs Meet NCQA Standards

	NCQA	FQHCs MHM/Collaboratives
Increased Access	✓	✓
Patient Tracking	✓	✓
Care management/planned care	✓	✓
Self management support	✓	✓
Test tracking/test of change	✓	✓
Performance reporting/improvement	✓	✓
Advanced electronic communications	✓	✓
Electronic Prescribing	✓	✓



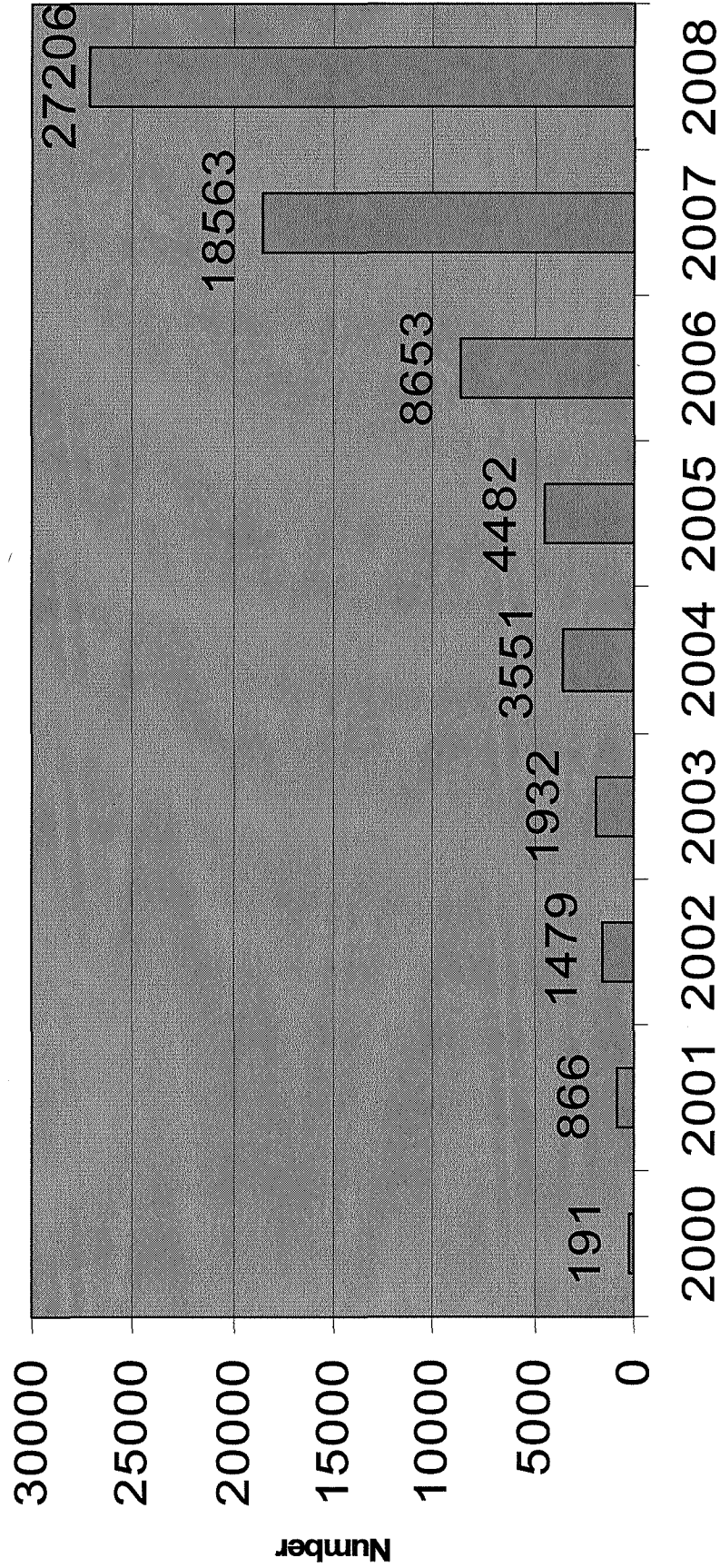


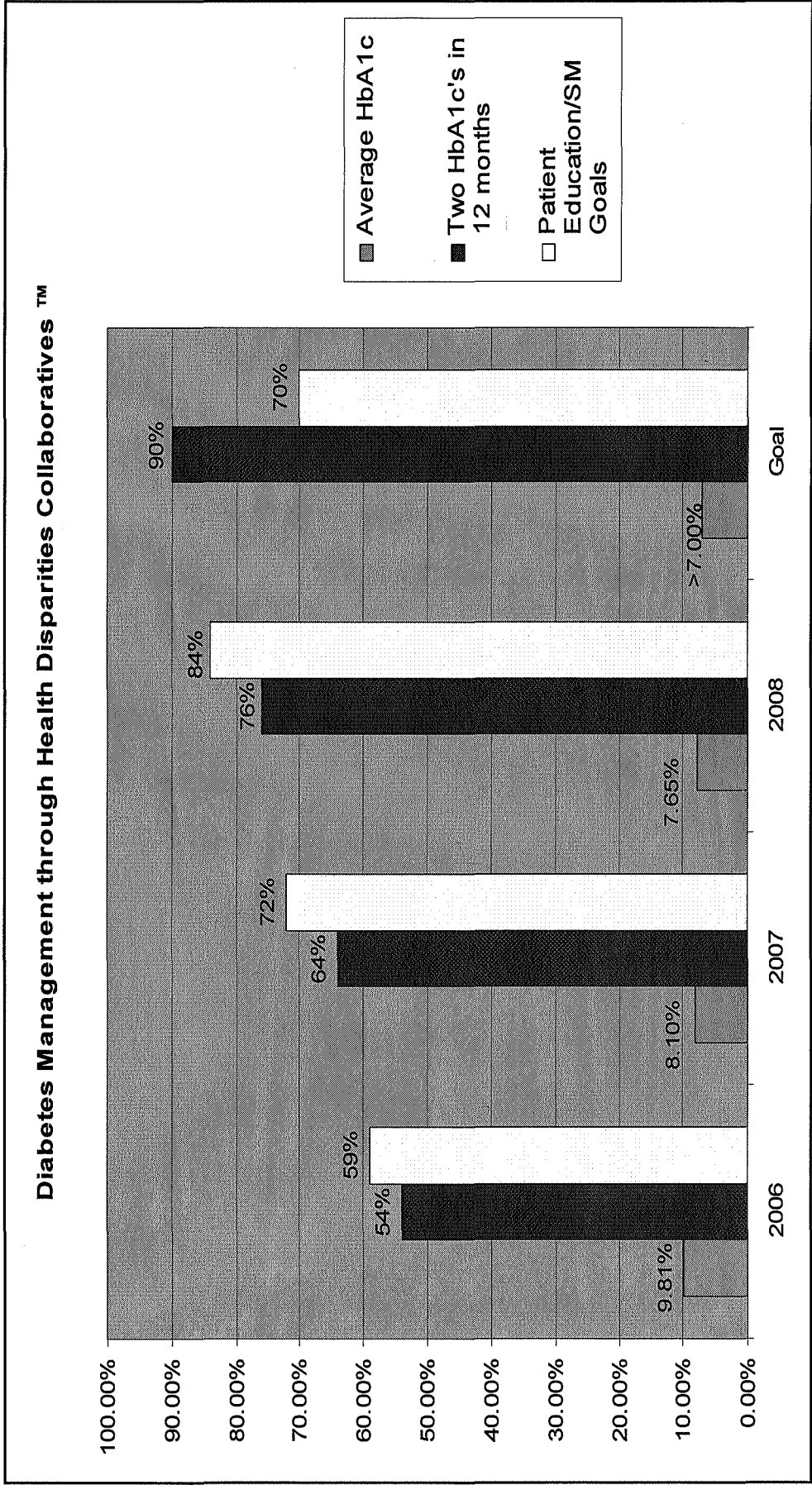
### Number of Florida FQHCs participating in Health Disparities Collaboratives™





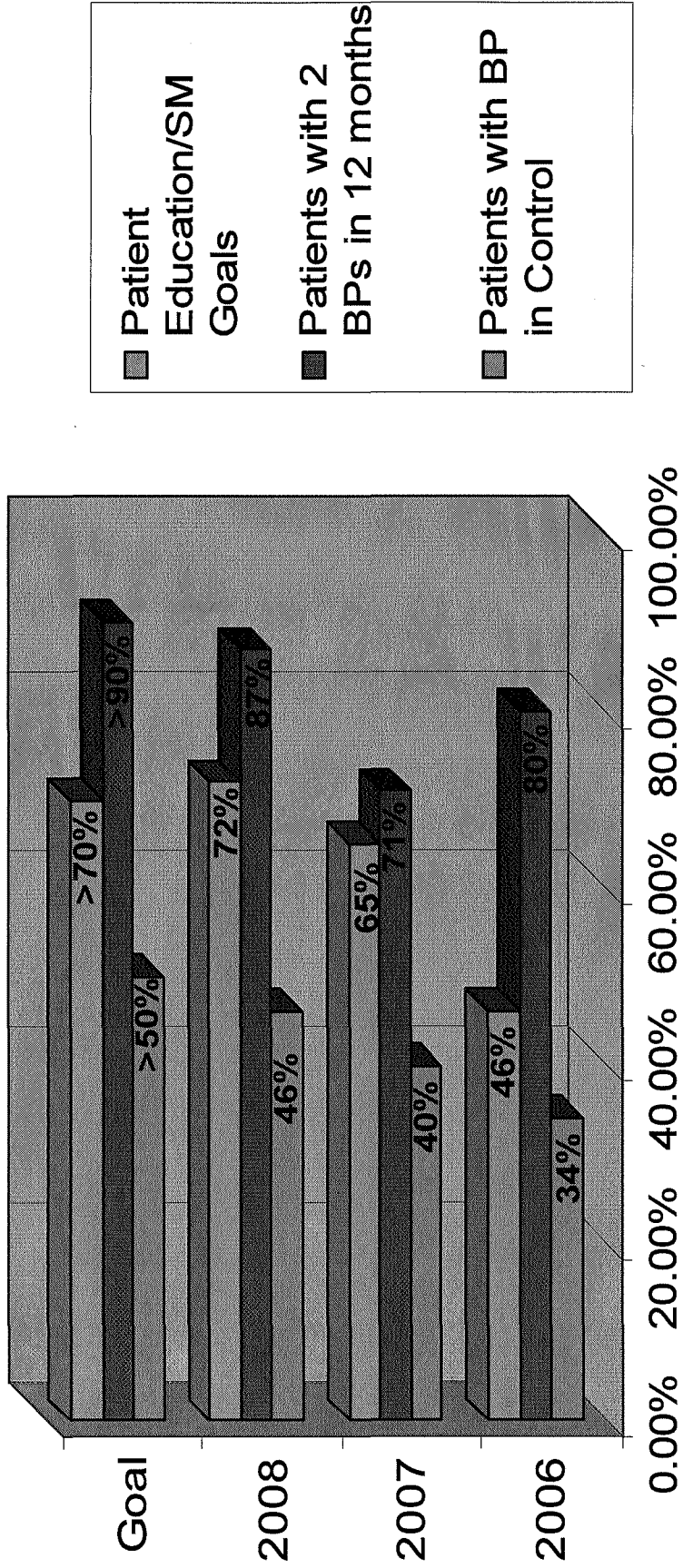
### Number of Patients in a Registry







## Cardiovascular Disease Management through Health Disparities Collaboratives™





## Health Disparities Collaboratives <sup>TM</sup> Expansion Efforts

- Partnership with Florida Department of Health Heart Disease and Stroke Prevention Program to offer Expanded Collaborative model to Cardiovascular Disease
- Since 2006, eleven health centers received funding to expand services for CVD due to this partnership



## **A Working Model: The Primary Care Access Network (PCAN)**

- 200,000 people in Orange County do not have health insurance
- PCAN is a collaborative between Orange County, FQHCs and other primary care providers, community organizations, and hospitals to serve uninsured and underinsured patients
- Includes 1,200 healthcare professionals
- To Date:
  - More than 50,000 uninsured patients have established contact with a primary care doctor since April 2001
  - The shift in care from the ER to primary care centers decreased the cost of care from \$3,000 to \$1,000 per patient
  - Reduced ER visits for routine care by over one third

The Gingrich Group and Center for Health Transformation



## **FQHC Networks**

- FQHCs have been using medical home concepts since their inception in 1968.
- Additional Key points:
- FQHCs work through networks to provide coordinated clinical data – Health Choice Network and Community Health Center Alliance.
- Patients who have an FQHC as a medical home CONTINUE to get the same quality care when they are removed from their insurance program such as Medicaid.
- Insurance does not dictate the care given at an FQHC, the needs of the patient are the only factors.





**A Provider Service Network Plan  
Owned by  
Community Health Centers**

**Prestige**

**HEALTH CHOICE®**

*Leading the Way to Quality Care*

**Supporting a Medical Home  
Delivering Care, Data and Savings**



HEALTH CHOICE®

Leading the Way to Quality Care

**Health Choice Network  
Formed Prestige Health Choice, LLC  
in partnership with its  
FQHC Owners**

**Overview**



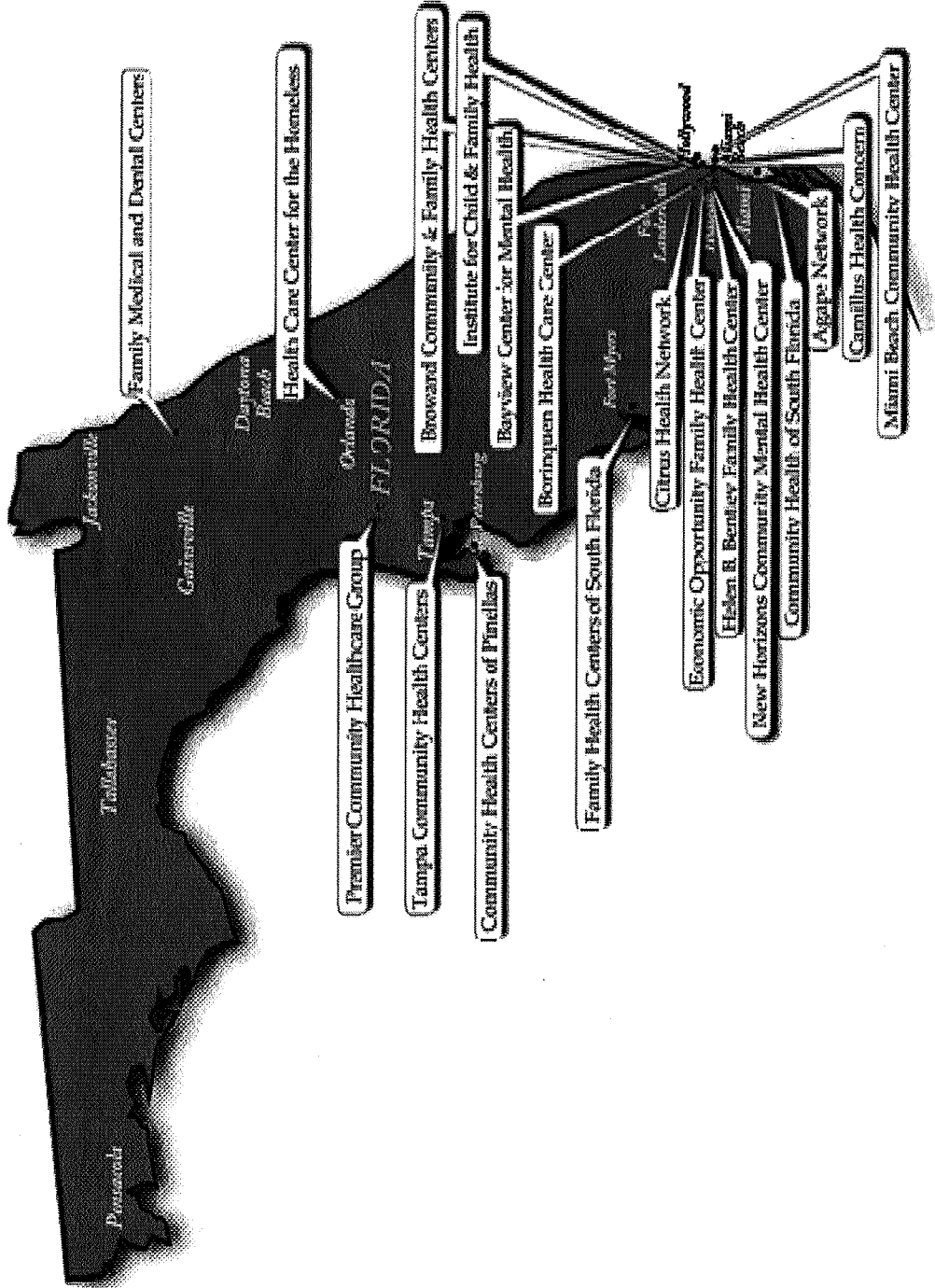
- Health Choice Network was formed in 1994
- Governed by its community health center members, who serve as Board of Directors
- 501c(3) not for profit organization
- HCN FQHC owners serve over 400,000 Floridians: 1.4 M patients Nationwide
- HCN is a national leader in HIT

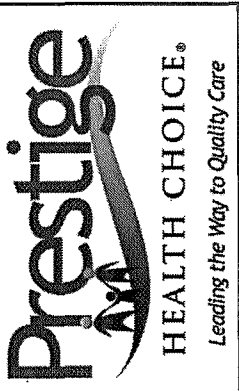


HEALTH CHOICE.

Leading the Way to Quality Care

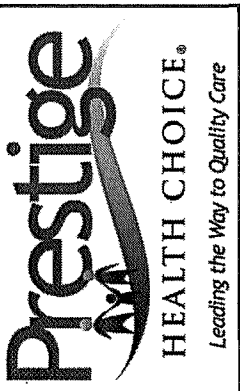
# HCN FQHC Centers





## **What Is Prestige Health Choice, LLC**

- A capitated Provider Service Network serving Medicaid members
- PHC meets the same financial and contractual obligations of any other regulated at-risk entity (OIR/AHCA regulated)
- Owned and controlled by Health Choice Network and its member centers
- Began operations in December 2008
- Approximately 36,600 Members in November 09
- Active In:
  - Miami-Dade, Lee, Hillsborough, Pinellas, Orange
  - Plans expansion into rural Counties



# PHC Unique Model



*Integrated  
delivery system*



- FQHC owned Payer
- Case management across continuum of care
- Medical Home integration
- Comprehensive network
- Integration of data: Payer /FQHC /PCP for enhanced care coordination

- FQHC Medical Home
- Primary Care
- OB/Gyn
- Dental
- Vision
- Pharmacy

EMR/HIT/HIE Technology support

Centers Meet most Meaningful Use Criteria

# Test Patient Screen Shot

## EHR Provider snapshot

Intergy EHR by Sage: - Intergy Support Admin User

IEHR Patient Tools Setup Medscape Reports Help

Provider Desktop Patient Chart Orders/Charges Encounter Note

### Medications

Medication	Dosage
Aldactone 50 MG TABS	bid 30 days 1 refill
BD U/F Short Pen Needle 31G X 8 MM MISC	bid 50 days 3 refills
BD U/F Short Pen Needle 31G X 8 MM MISC	wed 50 days 5 refills
Byetta 10 MCG Pen 10 MCG/0.04ML SOLN	30 days 3 refills
Crestor 20 MG TABS	60 days 0 refills
Liovan 320 MG TABS	ed 30 days 3 refill

### Orders

Order	Pri	Due/Closed	Status
CMP	3	11/27/09	Requested

### Documents

Date	Description	Status	Provider
10/28/09	ADULT EST PATIENT	ARC	ALIDO, EDITH B. ARNP
09/30/09	ADULT EST PATIENT	ARC	ALIDO, EDITH B. ARNP
09/09/09	ADULT EST PATIENT	ARC	ALAM, AMBREEN DO
07/14/09	ADULT EST PATIENT	ARC	ALIDO, EDITH B. ARNP
06/08/09	NOTES	ARC	ALAM, AMBREEN DO
06/05/09	ADULT EST PATIENT	ARC	ALAM, AMBREEN DO

### Lab Tests

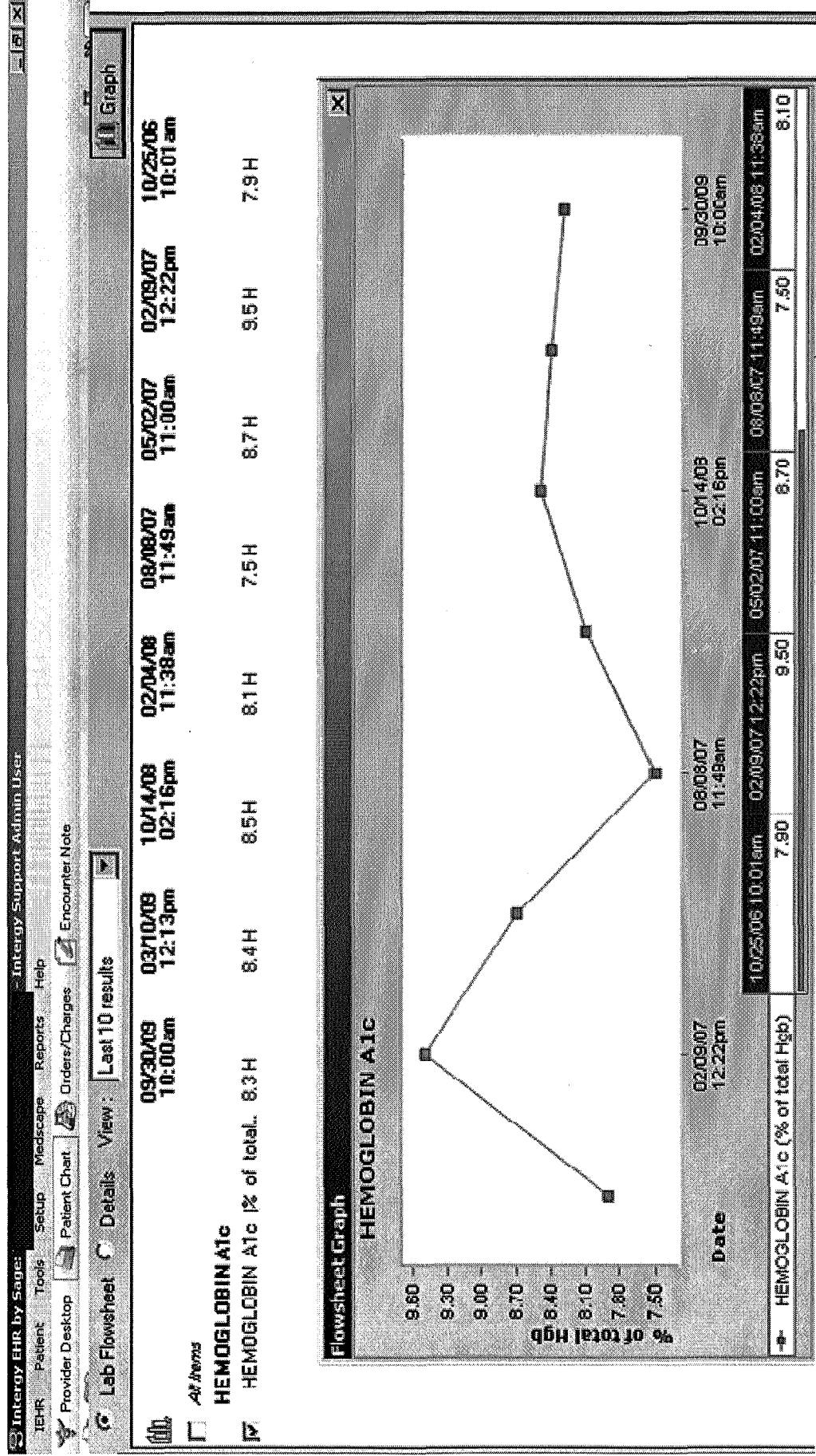
Date	Description	Status
10/28/09	Blood Glucose, fingerstick	Abnormal
10/28/09	COMPREHENSIVE METABOLIC PANEL...	Abnormal
10/28/09	NOTE	
10/01/09	NOTE	
09/30/09	CBC (INCLUDES DIFF/PLT)	Abnormal
09/20/09	HEMOGLOBIN A1c	Abnormal

### Vitals

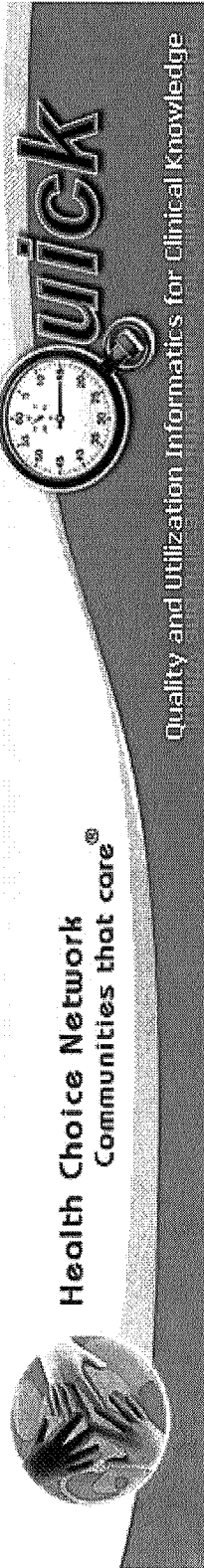
Date	Time	Systolic BP-Sitting (mmHg)	Diastolic BP-Sitting (mmHg)	BP Cuff Size	Pulse Rate-Sitting (bpm)
10/28/09	10:00am	130	68	Regular	92
09/30/09	10:00am	160	80	Large	80
09/09/09	08:30am	130	70	Large	80
07/14/09	08:30am	130	80	Regular	70
06/05/09	12:09pm	222	114	Large	72
06/05/09	09:30am	160	90		
03/05/09	01:30pm	160	90		

# Test Patient Screen Shot

## EHR results trending to support provider point-of-care decision making



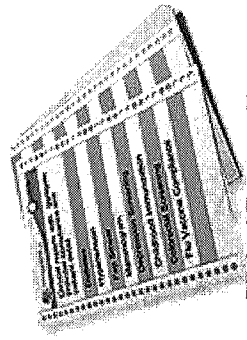
# Center level Detail reports



User Name: HCN\Anvuser

Start Date							End Date						
February 2009							May 2009						
Su	Mo	Tu	We	Th	Fr	Sa	Su	Mo	Tu	We	Th	Fr	Sa
25	26	27	28	29	30	31	26	27	28	29	30	1	2
1	2	3	4	5	6	7	3	4	5	6	7	8	9
8	9	10	11	12	13	14	10	11	12	13	14	15	16
15	16	17	18	19	20	21	17	18	19	20	21	22	23
22	23	24	25	26	27	28	24	25	26	27	28	29	30
1	2	3	4	5	6	7	31	1	2	3	4	5	6

Office Id:



[Clinical Reports Page](#)  
[Specifications of Clinical Reports](#)

Main Report

6/1/2009 11:32:56AM

## PAP\_Measures

Anycenter

*Female patients (ages 21-64) with at least 1 medical encounter from 2/1/2009 to 5/31/2009*

Patients	<u>PAP Recorded in Billing</u>	<u>PAP Recorded in Labs</u>	<u>PAP Recorded in EHR</u>	Compliance	Percent Compliance
454	223	194	28	230	50.66

To see Providers with panel of patients move the mouse over the gray box and click when you see the hand icon ...



# Provider dashboard

User Name: HCMUser

Start Date: February 2009  
 End Date: May 2009

Office Id:  Get Data

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

100%

6/2009 11:52AM

Specifications of Clinical Reports

From: patients (age: 21-60 with at least 1 medical encounter from 2/2009 to 5/2009)

PROVIDER (last Provider area)

Patient No	Patient Name	Panel Location	Panel Number	DOB	Compliance
10001.0	MEGAN ROBEI, MD	Anycenter	135		14.1%
11344.0	MARC JACOBS, MD	Anycenter	55		6.7%
11449.0	ELENGR GUTIERREZ, MD	Anycenter	181		29.1%
11623.0	JOSIE SANCHEZ, MD	Anycenter	49		25.8%
12457.0	JILL HINGSON, ANP	Panel Under 13	5		29.4%
12458.0	BLANCA SMITH, MD	Panel Under 13	3		16.4%
12459.0	ROBERT GARLIN, MD	Panel Under 13	107		65.7%

Patient	PAP Recorded in Billing	PAP Recorded in Lab	Compliance	Percent Compliance
454	223	194	28	60.5%

To see patients with panel of patients move the mouse over the gray box and click when you see the hand icon.

# Patient level detail to support outreach/ follow-up

User Name: HCMUser

Start Date: February 2009  
 End Date: May 2009

Office Id:  Get Data

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

100%

6/2009 11:52AM

Specifications of Clinical Reports

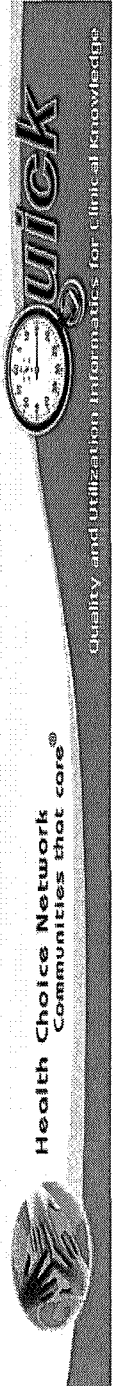
From: patients (age: 21-60 with at least 1 medical encounter from 2/2009 to 5/2009)

PROVIDER (last Provider area)

Patient No	Patient Name	Panel Location	Panel Number	DOB	Compliance
10001.0	MEGAN ROBEI, MD	Anycenter	135		0
11344.0	MARC JACOBS, MD	Anycenter	55		0
11449.0	ELENGR GUTIERREZ, MD	Anycenter	181		0
11623.0	JOSIE SANCHEZ, MD	Anycenter	49		0
12457.0	JILL HINGSON, ANP	Panel Under 13	5		0
12458.0	BLANCA SMITH, MD	Panel Under 13	3		0
12459.0	ROBERT GARLIN, MD	Panel Under 13	107		0

To see patients with panel of patients move the mouse over the gray box and click when you see the hand icon.

# Trending and Benchmarking



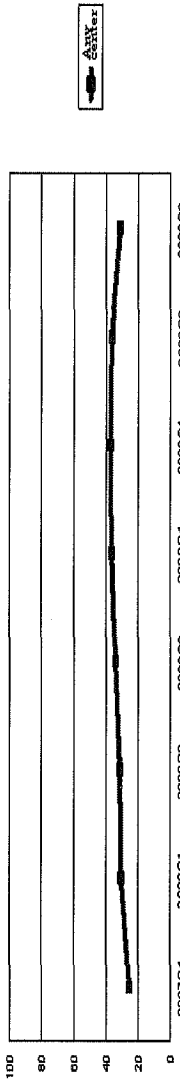
User Name: HCN User

Office Id:

[Home](#)

## Anycenter TRENDLINES

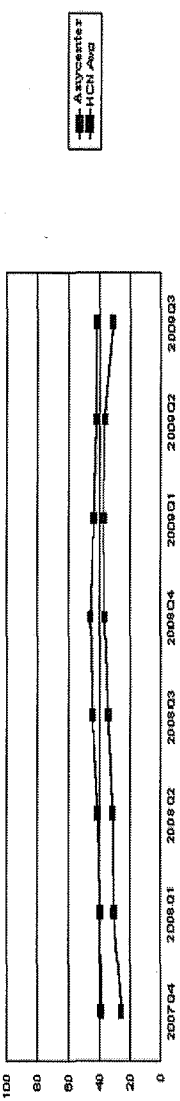
*Diabetes Compliance  
Percentage of Diabetic patients 18 years and older whose last A1C value was <7%.*



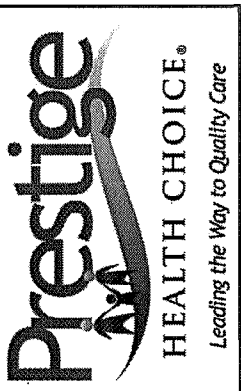
	2007Q4	2008Q1	2008Q2	2008Q3	2008Q4	2009Q1	2009Q2	2009Q3
Anycenter	25.66	30.51	31.44	34.33	36.60	37.50	36.68	31.30

## Anycenter BENCHMARKS

*Diabetes Compliance*



	2007Q4	2008Q1	2008Q2	2008Q3	2008Q4	2009Q1	2009Q2	2009Q3
Anycenter	25.66	30.51	31.44	34.33	36.60	37.50	36.68	31.30
HCN Ave	39.27	39.53	41.07	44.63	45.83	43.60	42.00	41.53

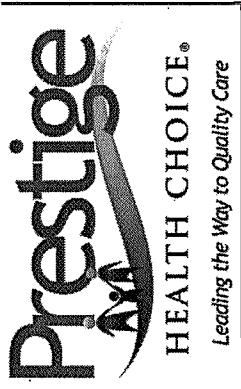


# Prestige Supports EHR *(In Process of Design)*

## Prestige Claims and Encounter Data:

- Hospital Admissions
- ER Utilization
- Prescription Drugs
- Specialist Care outside of Centers

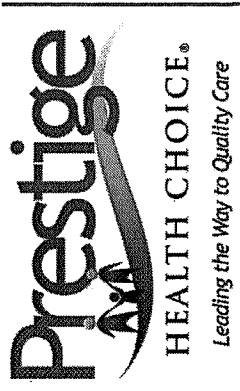
**PHC  
integrated  
patient EHR  
record**



## **How Does the PHC Serve Florida** **Focus on Patient not the Claim**

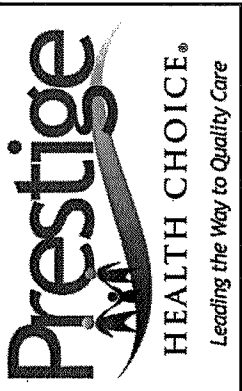
- FQHC Owned and controlled
- Most of our revenues remain in the community to support additional health care services.
- Physician/Patient Centered Care: Support Physicians in building a Medical Home.

***If A PHC Member Loses Medicaid Eligibility : That Member Continues To Receive Care And A Medical Home Through Our FQHC Center Owners***



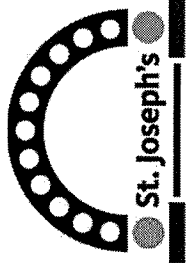
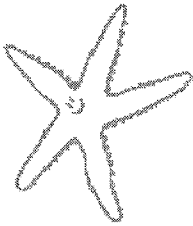
## **How Does the PHC Serve Florida**

- Use health analytics, meaningful use standards, peer review, care management, HIT, and other strategies to drive useful information to the treating physician as well as ACHA.
- Save the State money by facilitating the best care in the most efficient way possible:  
Principally through the PCP integration of care.



# Questions?

St. Joseph's  
Children's Hospital



St. Joseph's  
Children's Hospital  
of Tampa

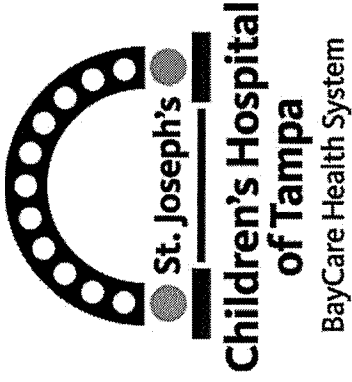
BayCare Health System

*Plascencia*



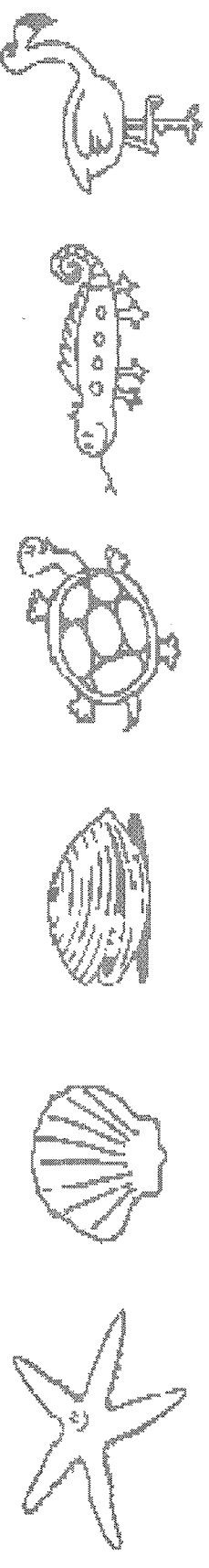
Nurse providing care to  
Chronic Complex Clinic patient, Diana

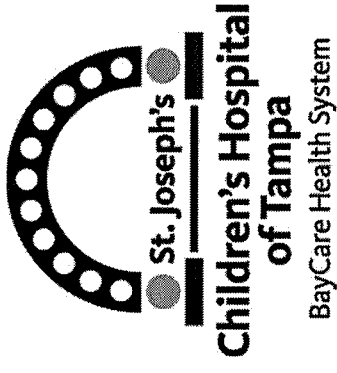




Dr. Daniel J. Plasencia, F.A.A.P.

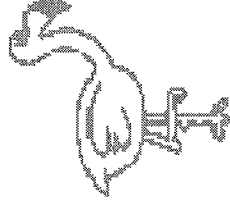
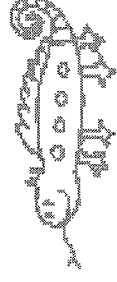
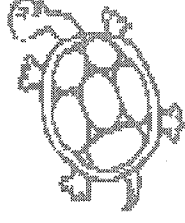
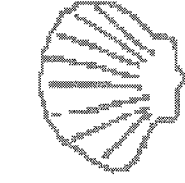
- Medical Director and Founder of Chronic Complex Clinic.
- Commitment to Chronic Complex medical field.
- Passion for care.



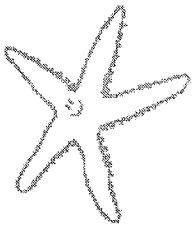
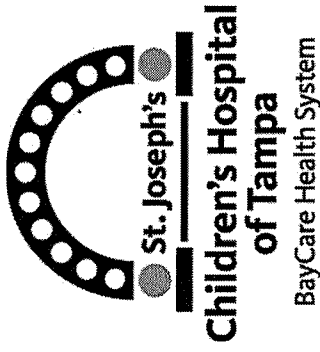


## Definition of Chronic Complex patient:

- Severely compromised child battling multiple medical conditions simultaneously (i.e. tracheotomy, developmental delays, cystic fibrosis, cerebral palsy, convulsions, severe prematurity, post-trauma patient with significant neurological sequela, drowning, etc.).
- 20,000 chronic-complex patients in Florida.
- Patients tend to be under-insured and highly dependent on



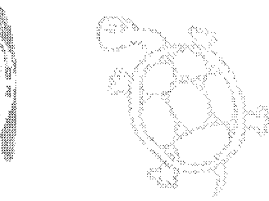
Medicaid.



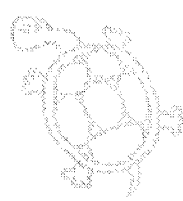
## Medical Home: Organizational Capacity



10 General Pediatricians



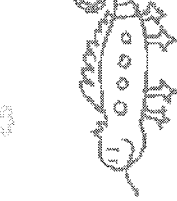
Pediatric Nutritionist



Pediatric Pharmacist



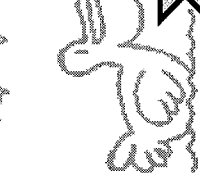
2 1/2 Pediatric Nurses



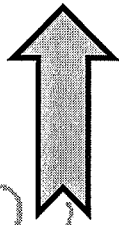
Child Life Specialist



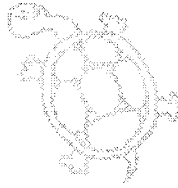
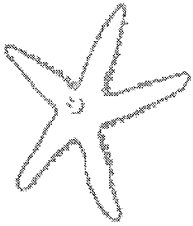
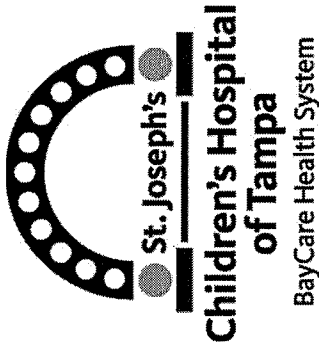
Social Worker



Receptionist

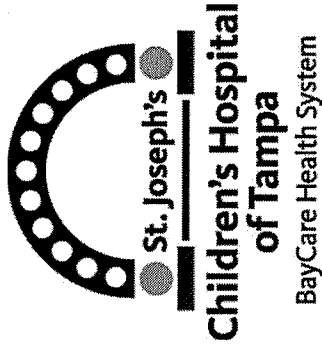


Capacity is 100 visits per week (500 active clinic patients)



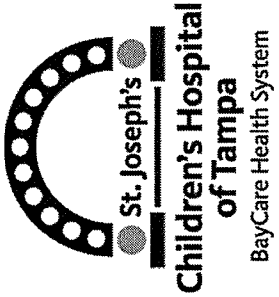
## Medical Home: Benefits

- Allows for coordinated care in one location by a team of specialists allowing multiple visits in one day.
- Longer scheduled appointments (1 hour minimum versus 15 minutes in standard pediatric practice).
- 24-7 telephone triage service staffed by nurses and doctors to provide guidance between appointments and avoid unnecessary emergency room visits.
- Sibling and family support.

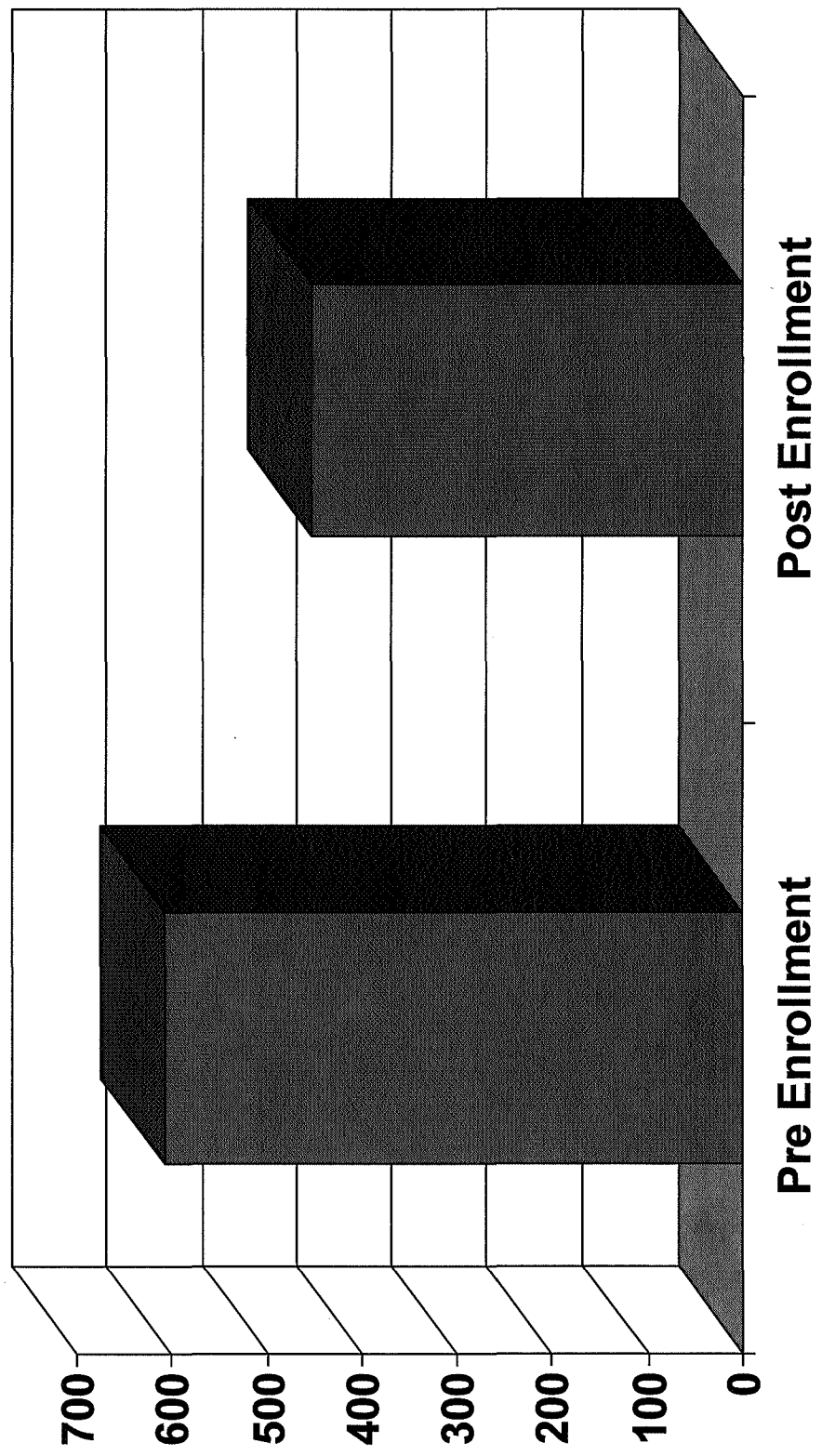


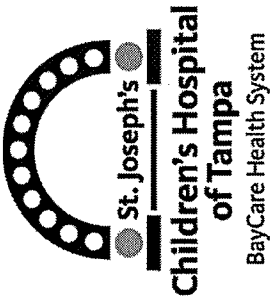
## Access Challenges

- Access to pediatric specialists is impeded by Medicaid reimbursement limitations.
- In Florida, 75% of Chronic Complex patients are on Medicaid.
- Medicaid reimbursement to pediatric specialists is about 50% of what Medicare pays and it does not come close to covering the true cost of the service.
- Medicaid reimbursement to Chronic Complex Clinics is billed the same as that of a primary pediatrician visit (\$30 per visit).
- Reimbursements rates are not sustainable, prevent access to care, and offer no incentive for the innovative care that Chronic Complex Clinics offer.

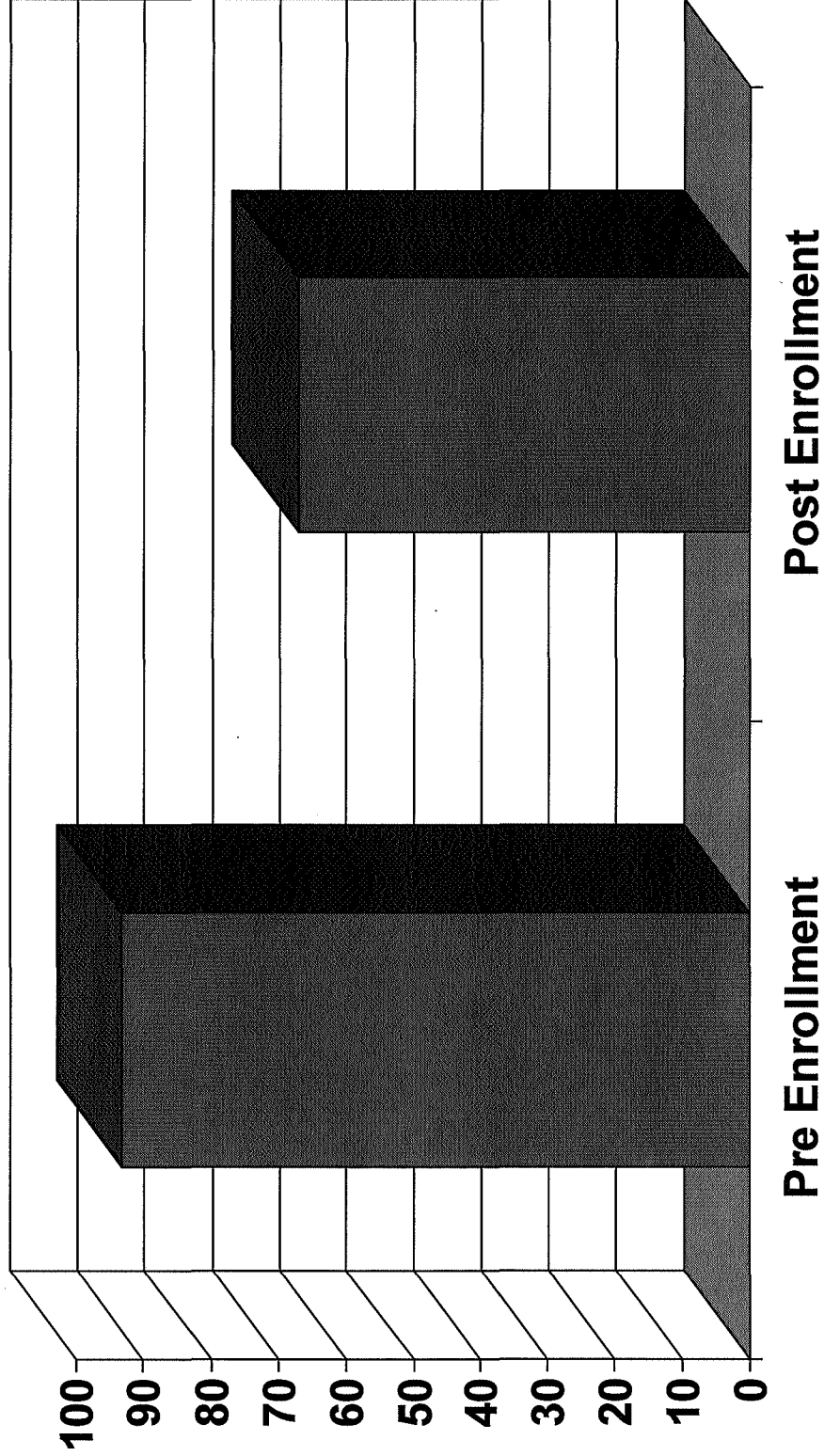


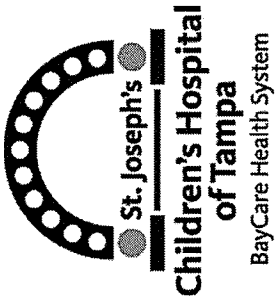
# Utilization of Services: Total Days in Hospital



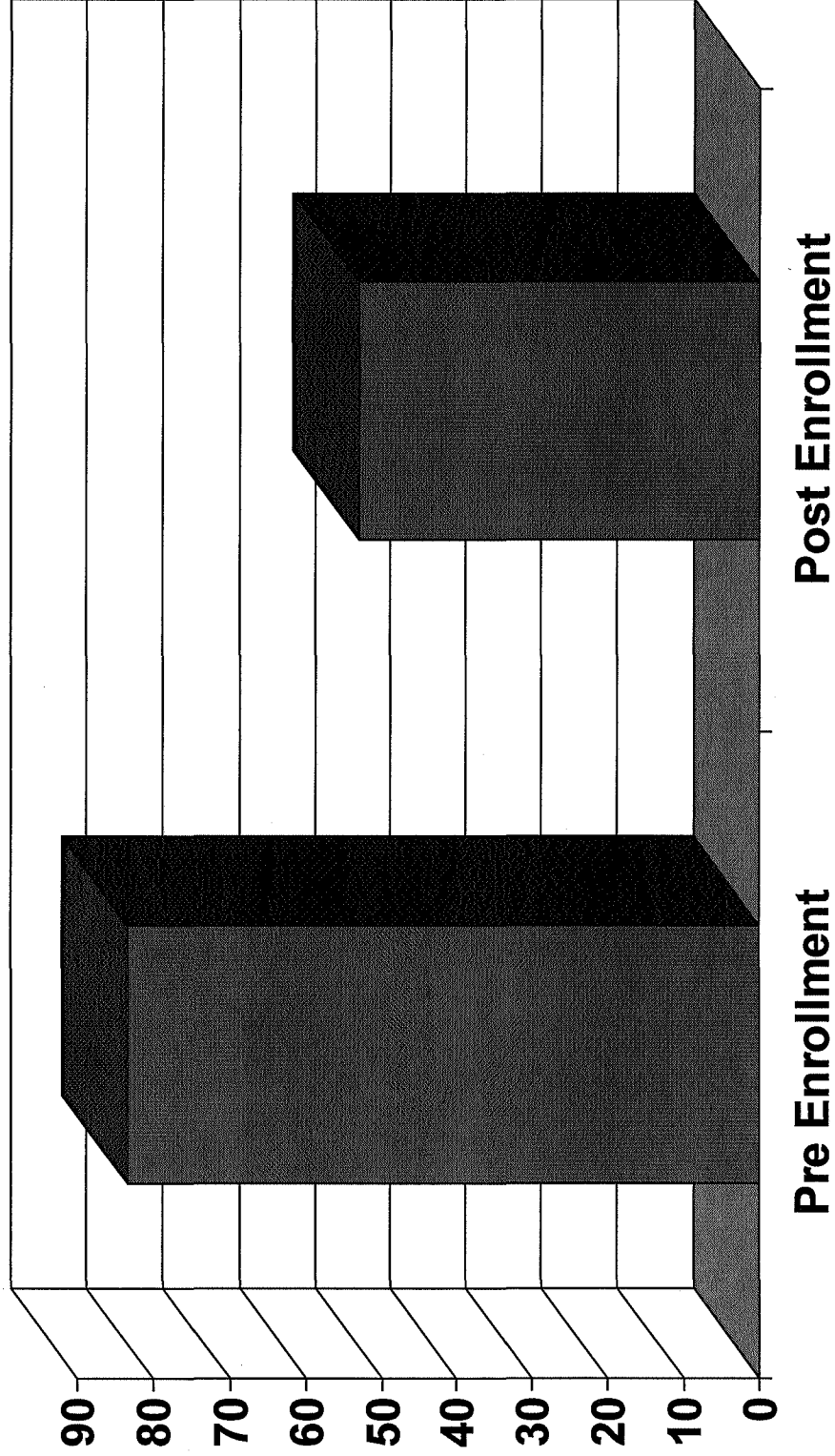


# Utilization of Services: Total Hospital Admissions

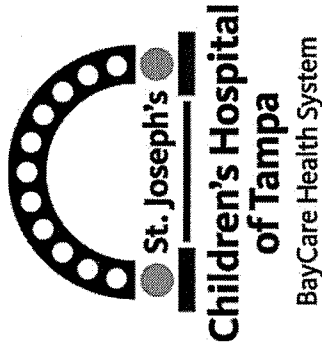




# Utilization of Services: Total ER Visits

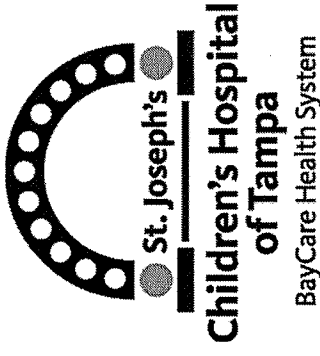






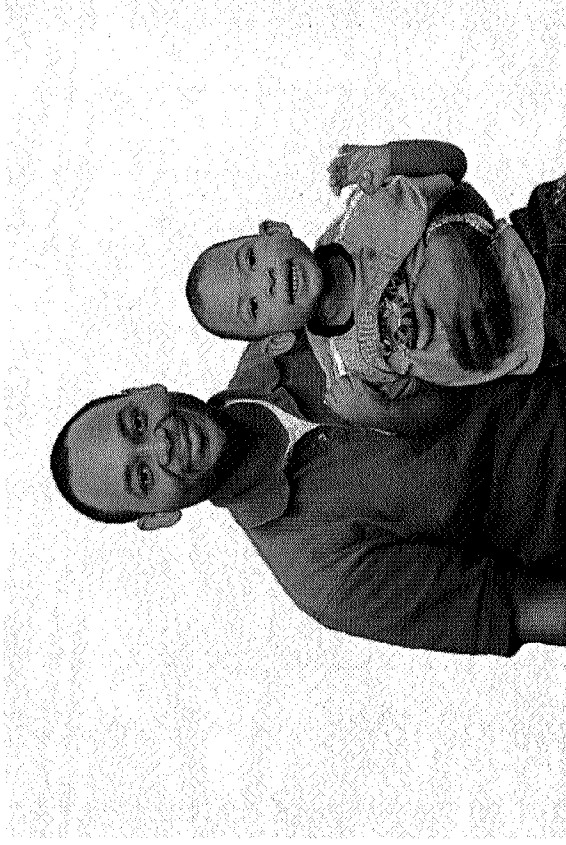
## Efficiency of Services

- While reimbursement problems are impeding care, our Chronic Complex Clinic is saving Medicaid money.
- Our patients are using the emergency room less, and being admitted less often.
- **This efficiency of services is saving \$3,600 per patient, per year, in hospital costs alone.**

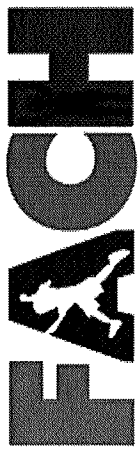


# Solutions

- ◆ Reimburse pediatric doctors that support Chronic Complex Clinics a set amount per patient, per year (minimum of 3 visits per year) for outpatient treatment services .
- ◆ Increase accessibility to pediatric specialists by increasing Medicaid reimbursement levels for pediatric specialists.
- ◆ Increase accessibility to pediatric specialists by incentivizing doctors to go into pediatrics through federal incentives, such as tuition reimbursement and loan repayment assistance.

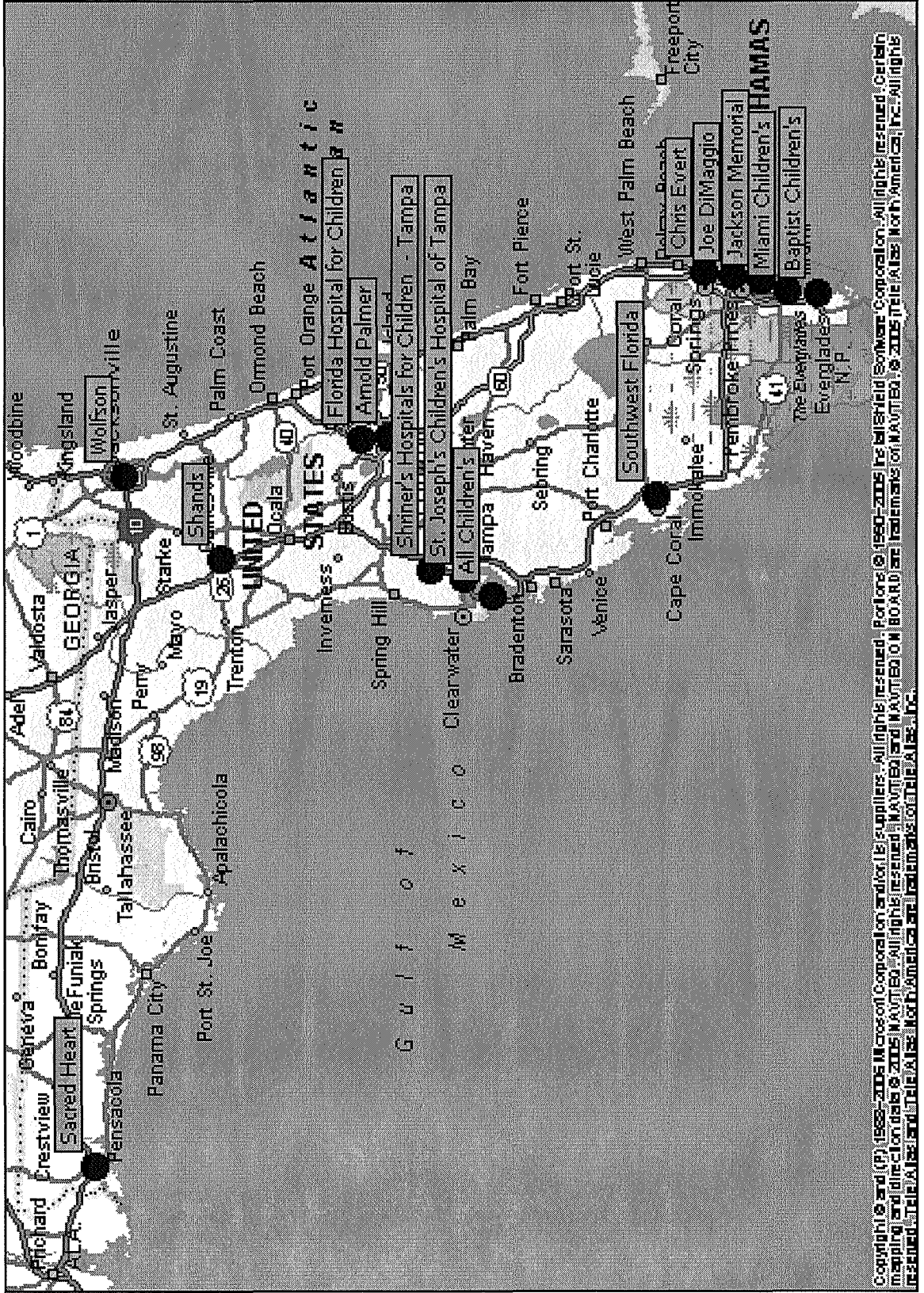


Chronic Complex Clinic patient Braelyn, and his father

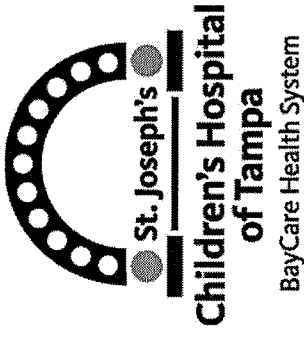


Florida Association of Children's Hospitals, Inc.

2009



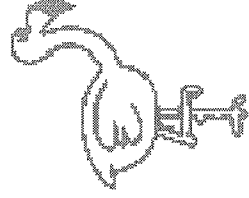
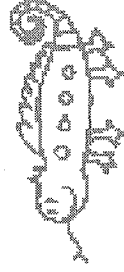
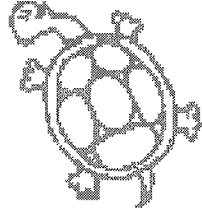
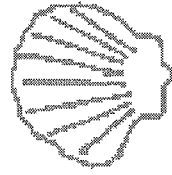
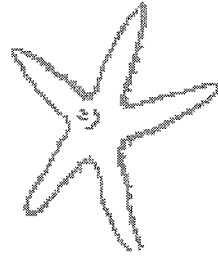
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## Further Questions on Chronic Complex Care

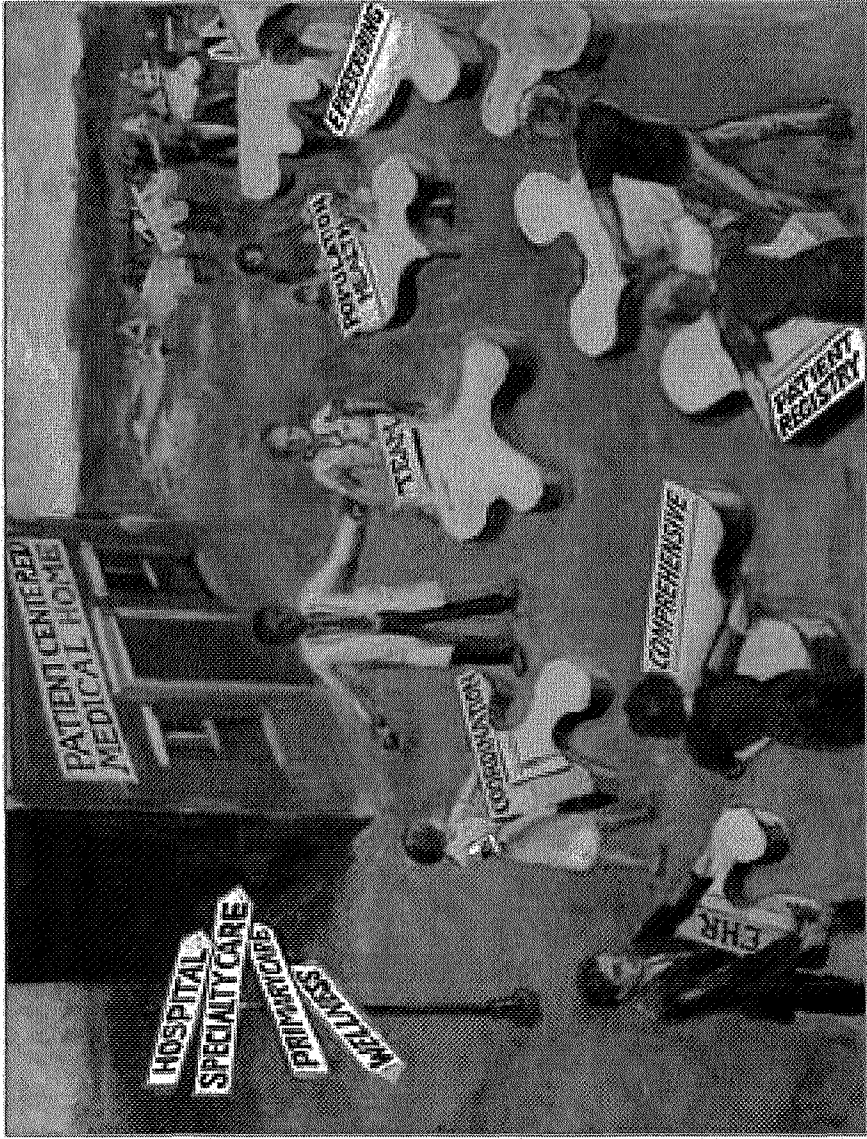
Dr. Daniel J. Plasencia, F.A.A.P.  
Medical Director  
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CASE MANAGEMENT • CHRONIC CARE • COMPARATIVE EFFECTIVENESS • DISEASE MANAGEMENT



HEALTH INFORMATION TECHNOLOGY • INCENTIVES • MEDICAID • MEDICARE

PATIENT ADVOCACY • PAYMENT REFORM • PHYSICIAN DIRECTED • PREVENTIVE CARE • WHOLE PERSON APPROACH

# Developing A Fully-Realized Medical Home: Practical Considerations From the Marketplace

Florida House of Representatives  
Health & Family Services Policy Council

Brian Klepper, PhD

November 3, 2009

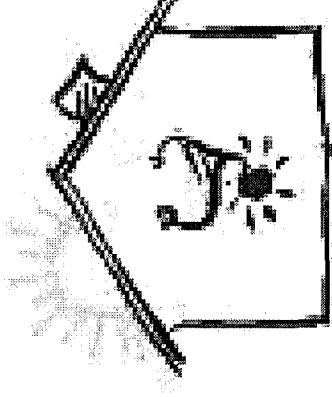
**Florida House  
Health & Family Svcs Policy Council**



“When a health care purchaser sits down with his health care relationships – the broker, the health plan, the doctor, the hospital, the drug and device firms – everyone in the room but him wants it to cost more, and they’re all positioned to make that happen.”

*Lynn Jennings  
WeCare TLC  
Lake Mary, FL*

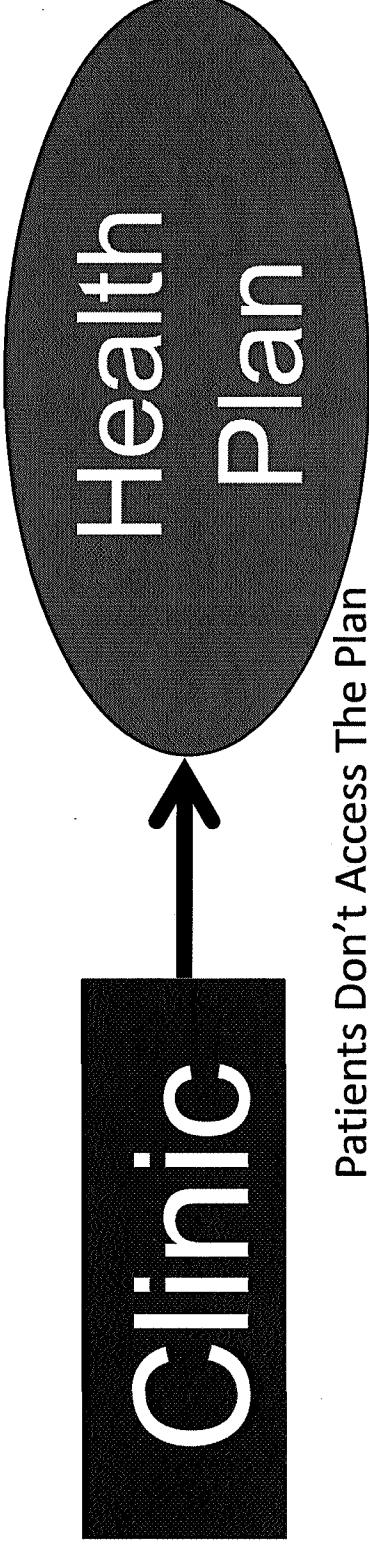
# **A Medical Home Is A Place**



- Where patients feel they can turn anytime about their health
- Clinicians are continually thinking about their patients' well being.



The Clinic Is Separate From  
And In Front Of The Health Plan



Patients Don't Access The Plan  
Until They Leave The Clinic.

So Clinics Can Be Implemented  
At Any Time and Do Not Require Plan Changes.

**Florida House  
Health & Family Svcs Policy Council**

# **Re-Empowering Primary Care Using Clinics**

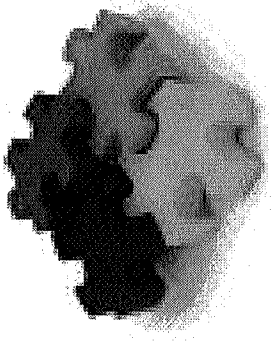


## **7 Operational Pillars**

- Get Beyond FFS Medicine's Perverse Incentives
- PCP Empowerment as Patient Advocate/Guide
- Enrollee Incentives That Drive Their Clinic Use
- Onsite Face-to-Face Health Management Programs
- Comprehensive Information Technology Tools
- Creative Purchasing Arrangements
- Transparent, Accountable Client Relationship



## 4 Major Impacts



### An Integrated Platform

- Replace Higher Network Costs With Lower Clinic Costs
- Aggressively ID/Manage Chronic/Acute Care Opportunities
- Collaborate On & Influence Downstream Care & Cost
- Occupational Health/Productivity Costs.

**Florida House  
Health & Family Svcs Policy Council**

# **The Harder Question**



## **How To Revitalize Florida' Primary Care Practices?**

## **Primary Care Needs Simple, Major Changes**

- **Pay PCPs Significantly More and Give Them More Authority.**
- **In Return, Make Them Accountable For**
  - Spending More Time With Patients
  - Acquiring/Using Health IT Medical Mgmt Tools
  - Collaborating with Specialists To Manage Downstream (Referred) Care



## Brian Klepper PhD

through Healthcare Performance, Inc. and Health 2.0 Advisors, advises government, health care firms and employers nationally on approaches that can leverage market trends, reduce cost and improve quality. Through WeCare TLC, he develops and manages comprehensive worksite primary care clinics. And he actively writes and speaks on health care change.

Early in his career Dr. Klepper led a health care consulting practice that developed or repaired health care companies and programs. Then, in 1999, realizing that health care was headed for massive systemic disruptions, he changed course to work on reform. That experience allowed him to begin to understand the deep structural mechanisms that underlie the crisis, and what it will take to put the system on a stable footing again.

He is an Aspen Institute Health Forum Fellow, one of three non-physicians on the Medscape Journal of Medicine Editorial Board, an Editor of Medpedia, Editor-at-Large for Community Oncology, and columnist for American City Business Journals. He writes on two widely-read expert health care blogs: The Health Care Blog and Health Policy and Marketplace Review. and regularly provides commentary in professional publications and the mainstream media.

He is an Aspen Health Forum Fellow, an advisor to the Patient Centered Primary Care Collaborative and the only non-physician Board member of COSEHC, cardiologists providing translational vascular management.

**[www.brianklepper.net](http://www.brianklepper.net), [904.343.2921](tel:904.343.2921), [bklepper@gmail.com](mailto:bklepper@gmail.com).**