

CITIZENS HEALTH CARE OVERSIGHT COMMITTEE
August 21, 2009

Citizens Health Care Oversight Committee meeting was held in the County Commissioner's Chambers, Neil Combee Administration Building, Bartow.

The members present were as follows: Nancy Thompson, Brian Hinton, Misilene Fulse, John McArthur, Tonja Mosley, Gabriella O'Toole, Dr. Seoane, Connie Kinnick and Stacy Campbell Domineck.

COC Members Absent: Dr. Nobo and Jim Moody

Other County Staff in attendance were as follows: Mike Kushner, Dr. Haight, Dr. Saddler, Debi Curry, Joy Johnson and Michael Duclos, ACA.

The meeting was called to order by Nancy Thompson at 8:30 AM.

Brian Hinton led the Prayer and the Pledge of Allegiance.

Introductions of the members.

N. Thompson: asked for a motion to accept the minutes.

B. Hinton: So Moved

C. Kinnick: Second

S. Campbell-Domineck: She requested that a correction be made to page 7, 4-5th paragraph down, 5th line down correct (**interruption** to [interpretation](#)). That is important.

Hearing no other amendments or corrections the committee voted unanimously to accept the minutes as written.

Old Business: Housekeeping Update

J. Howell: She made a small presentation that they are looking at providing the COC nominee names to the Board for selection for the October term that begins. Several folks will be ending their terms on September 30th of this year. We have spoken to and have gotten several names from some COC members as well community members. There are some other folks in the community that are excited to join this committee and I am very pleased and I hope you will be as well. She asked for additional feed back by this committee at a later point. She stated that they did meet with TPA that is called First Services Administrator; they are the one that was referred to in the July meeting. Dr. Nobo had mentioned that they were willing to do their services for free. We have asked them to come and provide this group with an interpretation of their suggestion that they can provide services for free in September. I think you will be excited and interested in what they have to say.

Dr. Seoane: Requested that we asked the Polk County Medical Association they might know people who are involved maybe not necessarily physicians but the Medical Association has been here 100 years and I would suggest that we contact them for some possible names.

J. Howell: COC nominees, absolutely.

N. Thompson: If you have specific suggestions you can get with Jan individually after this meeting or give her a call.

J. McArthur: The Ledger Article – “Clinic Saves Lakeland \$1.1 Million in Health Insurance Cost” published August 4, 2009 8:26 p.m. He explained that this is the type of thing that P.E.A.C.E. has been talking about since before the sales tax in place.

M. Kushner: Explained about the Wellness Center that the County has which sees employees and will be seeing dependents in October. He explained that the County has saved at least that amount of money or perhaps more, we have a pharmacist on site that is providing clinical advice and nurse educators, a whole system of prevention and wellness for our staff.

Dr. Seoane: He would caution people about statistics and money with healthcare even though they might have saved 1.1 million dollars it is possible that the 600 people that did not use the clinic may have not used it because they required specialty services, complex medical conditions which require a higher level of care. The City of Lakeland has self selected out the healthiest population and the people with more complicated diseases more difficult to manage problems that require surgery or complicated care they can't get at a Family Practice or and Internal Medicine Practice office that the city runs. So I would be careful to assume that automatically the people that didn't get care at that clinic somehow the reason they cost more money is because they didn't get care there. You have to be careful with this type of data.

M. Kushner: Gave a brief overview of what is done at the Wellness Clinic which is Population Management, when people come to our clinic we identify these diseases and do refer people to specialist when needed. It needs to work that way I agree you can't just focus on people that are well.

New Business:

Mike Kushner did the Financial Update. He reported that the Health Plan has recovered and is in a positive territory when it comes to our cash, things are looking a lot better. Even with the down economy we have been able to manage our program with fiscal conservatism that has enabled us to turn this plan around in a short period of time. Presented the financial slides - he stated that the membership of the plan is at about 1,118 members but starting in October growing that membership gradually to about 2,500 to 3,000 members next fiscal year. The membership ages are between 40 and 60 year old.

Dr. Seoane: How many county employees are assigned to the work directly for the plan?

M. Kushner: There are 43 employees and there are some vacancies right now.

Dr. Seoane: The 1.7 million that is the salary and benefits.

M. Kushner: Correct we are a little below budget on that remember we eliminated 25 people from the Plan.

T. Mosley: Stated that this is the first time we are seeing that the hospitals are receiving less than the physicians are and you were giving us those bulks reports that would show us visits to the physicians and are you seeing that more patients are going to the physicians offices and doing some of these preliminary visits

rather than coming to the ER's how has this swing occurred. I know part of it is that the physicians are getting Medicare and the hospitals are getting Medicaid but I am curious how the visits have changed over this period hospital verses physicians?

M. Kushner: Asked that Jan Howell answer that question.

J. Howell: I think that you are going to see one change simply because we eliminated 4 of the hospital days that were part of the benefit we went from 10 hospital days to 6 so that is going to be part of it. We are not going to tell you that we have seen a decrease in the number of ER visits, one thing we need to work through with some of the local hospitals you get the uncompensated care. So that is going to have to be part of the discussion that we have going into next year with the contracts.

T. Mosley: When you say uncompensated care are you talking about the LIP program? Because each hospital in the County are not the same, we have some not for profit and we have some profit. LRMC for instance will get Hill Burton, Bartow and Haines City is not I think that Winter Haven would get it as well. Uncompensated care is not the same for all of the hospitals we are all participating in the LIP Program and we are trying last year to get the funds from this system transfered so we can all do better in that. But it is not apples to apples when you talking uncompensated care. Some of the hospitals surely are hurting for the lesser days, because we are going to get the patients when there is no one else that wants them. They can't go to a clinic, they are chronic, and the stays are longer, because they have had no wellness care. I don't think that any hospital is talking about not being part of the Plan because we certainly appreciate the efforts and we want to continue, just to be fair to everyone as we move forward that maybe something you want to consider.

N. Thompson: We have seen the gap grow as time as gone on.

J. McArthur: Has the loan been repaid?

M. Kushner: No sir

J. McArthur: When is that due to be paid?

M. Kushner: That is due to be paid, the County Internal Audit Section – Finance and Accounting, when the books are closed there will be a transfer at the end of the year. They do it one time and then the loan will be paid.

N. Thompson: Although these financials are as if it has been repaid you would have a 2.8 million dollar excess of revenue over expenses because they took it out.

M. Kushner: We need to be real careful about how many members we want to enroll and measuring the cost of these members they are expensive to take care of. When you add new members you are going to see initially those costs will probably be a little higher until they remain in the plan for a while. Most of the costs are incurred up front we need to be real careful about that.

B. Hinton: You have done a great job with the cash and the budgeting this year.

N. Thompson: I agree we appreciate you getting us out of debt.

FY 08-09 Budget Item Request from Central Florida HealthCare – Bernard Fulse, CFO

B. Fulse: Did the presentation. He explained they have operated their site for some 22 months through 10 months of the current year. They are going to be some additional changes in our operation trying to get our costs in line with our anticipated revenue. (Slides Presented). The total revenue is about 1,707,880 dollars their projected expenses through the end of the contract period is about 2,053,726 dollars.

N. Thompson: For clarity this is all related to the Lakeland clinic nothing related to the Winter Haven clinic?

B. Fulse: All Lakeland, we are showing a short fall of \$345,846 they are going to cut hours as a method to try to reduce their costs and to align with what is coming in the door. Dr. Nobo requested that they take a look at the patient that are presenting on the weekend to see if they could be included in their weekly activities and after looking at their diagnosis of a lot of those patients they can be rolled into the weekly activities. We have talked with LRMC and DCF about an outreach person to assist us in the conversion of our self pay patient to Medicaid. Doing a rough analysis of that we had over 6,000 self paid visits if we can convert 50% of those visits we are looking at better than \$400,000 based on 141 dollars a Medicaid visit that we receive. We have an opportunity there and it is probably the more direct opportunity we have in turning our revenue sources around and receiving more Medicaid dollars.

Dr. Seoane: On slide Projected Activity through September 2009 the Medicare and Medicaid rates are these standard rates? What the Federal Government publishes and what they pay or are these enhanced for FQHC.

N. Thompson: So on the self pay that is the amount of services that you have provided but that is not necessarily the amount of revenue that you have collected. So you have provided 371,934 dollars worth of services to people that have who have no coverage of any kind, so who could be Medicare or Medicaid eligible but haven't gone through the process.

B. Fulse: That is correct.

N. Thompson: Why would LRMC be the one to help do that with the out reach wouldn't that be a DCF responsibility.

B. Fulse: They have some out reach workers that they work with DCF and we have talked to LRMC because they have the expertise. We have contacted DCF we have a copy of the contract that LRMC has with them and we are going to tailor our contract in a fashion that we can work within.

N. Thompson: I am wondering that whole application process is pretty much automated on line you have to mail documents in if you want look at that expense even if you don't get the money from some where else whether it would be CFHC time to hire someone part time or full time to just facilitate getting those applications processed.

B. Fulse: That is one other area that we are going to be talking to DCF about even trying to get an in house employee such that we can tap directly in to DCF. Direct some of the existing staff that we have on board to see if they can do it that would streamline activities also.

Dr. Seoane: How many employees do you have at the Lakeland Clinic?

B. Fulse: From 24 to 26

Dr. Seoane: How many of those are medical care providers PA's, ARNP and physicians?

B. Fulse: It ranges from 4 to 6.

B. Hinton: Out of the 2,053,726 that you are showing expenses how much of those are indirect? Corporate that gets pushed down to the clinic?

B. Fulse: See slide number 4, about 12 to 13% would be considered in direct including that bad debt. Bad Debt is looking at the self pay and trying to determine how much is ultimately going to be collected. That is very optimistic.

N. Thompson: Do you use a third party collection?

B. Fulse: We try to but that is not very successful it is almost that you have to have someone on board beating the pavement trying to collect. Considering the population that you are trying to collect from is slim to none.

N. Thompson: What is your percentage of collected on cash – self pay folks.

T. Mosley: Self pays we probably collect about 4% unfortunately most of these patients are coming through our ER and as a hospital we have very little opportunity to turn anyone away if they come through the ER. We can control it through our scheduled services, which we have very little bad debt there. Patients that come through ER we can not delay their treatment and do all of these things to try and collect. As a hospital we do have agencies that we work with it is based on percentage of collections so it is very low risk, it is a very difficult population to collect from. They don't care about their credit.

B. Fulse: It slows up the process of getting the patients in because we are trying to find out as much information about their ability to pay and for the most part you are digging a deeper hole because you are hindering the progression of the patient through the clinic.

T. Mosley: Do you have a baseline someone comes in they have to pay \$5 or \$10 before they can have any services or do you have to see the patients that show up.

B. Fulse: We do have a baseline \$15.00 we have patients that don't have that, what we try to do depending on the nature of the visit. We have a patient that has outstanding balances and the word gets around if one person comes in free the next time, it is a snowball. We try our best to assess each patient especially with outstanding balances but if they come in with something that needs to be triaged once they are triaged they are patients.

B. Hinton: Are you required to see them without the money by being a FQHC.

B. Fulse: Right we are and we also have the ability to discharge a patient and the effort you have to go through you must exhaust all remedies, the effort to try to do that is more costly.

S. Campbell-Domineck: Should you desirer to or decide to hire someone to assist in that eligibility for Medicare or Medicaid what qualifications or skills would that individual need. Is there something that is a prerequisite that would be required?

B. Fulse: From my understanding we are looking at a Social Worker we have some staff in side may necessitate not going outside to do that we are trying to stay within this budget. If I don't have to bring in any additional staff we have existing staff that can assume those responsibilities with no cost attached to it. However; with the DCF what they have is an outreach worker that we would have to contract with and pay 50% of their salary.

S. Campbell-Domineck: But if you could get a staff member and you didn't have to pay the cost or you had to only pay 50% of that cost for that individual are they required to have a Social Workers degree or certification?

N. Thompson: DCF at that level hire people with a degree and they train them to do that job.

Dr. Seoane: Under facility cost what is that – is that the lease, electric what does it include?

B. Fulse: It includes the lease which is about 200 thousand dollars a year; we are looking at about 16,500 square feet of space and utilities. Sorry it includes the maintenance of the facility, rent those types of costs are included in there.

Dr. Seoane: Just to clear up my earlier question of the 6 providers how many are physicians?

B. Fulse: Any where between 2 – 4.

G. O'Toole: What are the Administration Allocation costs?

B. Fulse: Those are the costs associated with finance department, the billing, the administrative services, HR and we allocate that all the way across the organization based on the number of encounter visits.

N. Thompson: Your allocation formula for your overhead costs is tied to patients.

B. Fulse: Right

N. Thompson: Not staffing and size of facilities.

B. Fulse: That includes the CEO's office, the CFO's office, HR.

N. Thompson: Since they run a number of clinics they centralize their overhead and than allocated it back to the different facilities. So Lakeland's fair share is 163,882 of what would you annual overhead costs be?

B. Fulse: It would be about 18%

Dr. Seoane: So that administrative allocation doesn't include salaries.

B. Fulse: Yes

Dr. Seoane: That does include salaries

B. Fulse: Right

N. Thompson: For staff that aren't directly in that building staff that pooled overhead, their fiscal, the administrative, the back office support people.

B. Hinton: Organizationally you would still have that cost if Lakeland wasn't there

B. Fulse: Yes it would just get allocated to the other clinics.

T. Mosley: Finally on that DCF worker in my experience that is going to be your best option, because they are going to be connected exactly where you want to get some things finalized. We finally have one at Heart of Florida we have had them there for a couple of months now and I can't tell you how positive it has been. We have had claims that were a year old that Medicaid had just gotten overwhelmed with the applications and having this DCF worker someone that is directly connected to get those things done has been great. We are only paying 22 thousand dollars a year, which is the 50% of their salary. We looked at having someone in house but that person is not going to travel all around the County and do all of those things that really are required to get these patients on. The DCF worker will certainly be the better person it will be cheaper to in the end.

B. Fulse: I can tell you just looking at the revenue side, the possibilities and what it would do for me the CFO, if it means throwing some additional dollars to hire someone I would welcome that with open arms. I know the responsibility of this committee is a serious one and what I have to do to compete with other CFAC and other FQHC is very challenging when it comes to receiving additional dollars even requesting additional dollars it is a task. I welcome the opportunity to be part of contributing to the community in terms of taking care and providing services for the less fortunate but sometimes you are between a rock and a hard place and you just don't have any place to go.

T. Mosley: I think too that today I have different appreciation for you clinic because I didn't realize that you couldn't turn anyone away. I just thought that was just something that we struggled with at the hospital; I thought we were the only ones.

B. Fulse: We struggle with that, the stories that you get from the patients it is really tuff. On the slide where the Projected Activity through September 2009-cont. page 3 is my request of \$300,000 to assist us in balancing this budget, based on my projection. This is strictly a projection we would have our final reports to submit to the committee to verify that request, whether it is lower, we are only going to request what it is going to take up to the 300 thousand dollars to balance this budget for this year. We are asking the funds that were earmarked for the Winter Haven, since we did not open that site if those funds would be available to justify this transfer on this request.

J. McArthur: What is the projected time on the Winter Haven Clinic?

B. Fulse: I have not talked with the Architects in terms of clearing the right of way, I don't know where that is.

N. Thompson: We are going to need to ask Mike and Jan probably to understand the status of that money before we can even consider any kind of request.

Dr. Seoane: The number of visits from the previous data that you had presented I think that it was around 5 thousand visits that the Lakeland did is that right. More or less 55 hundred are those all medical visits or are some of those visits Social Service visits, pharmacy visits.

B. Fulse: Strictly medical visits.

M. Kushner: We have budgeted 225 thousand dollars anticipating that this year that the Winter Haven Clinic would have opened for that pro-rata portion of time as start up costs for that clinic. But apparently that didn't happen so there is this 225 thousand dollars that has not been spent for the Winter Haven Clinic.

S. Campbell-Domineck: I move to approve that we allocate that 225 thousand or ask the staff to transfer that to the Lakeland facility.

N. Thompson: I have a motion do I have a second?

J. McArthur: Let me see if I understand the request, Bernard has just asked for 300 thousand and we are saying 225.

N. Thompson: Yes that would be my understanding yes.

S. Campbell-Domineck: Bernard did say that was a projected number and they may spend up to but they will only request what they use is that correct.

B. Fulse: Exactly, because this reflects 9 months actual and 3 months projection.

J. McArthur: I don't know if I understand it well enough to second it or not.

N. Thompson: I am the chair and I can't second the motion, but I can only keep asking. My understanding is one of the reasons they are in the situation that they are in is likely because they were going to recoup patient expenses by serving people who were part of the Polk HealthCare Plan and right about the time that they open their clinic we had to reduce our membership so severely that they have now come into a position of having to serve those folks but there is no place for them to bill those costs too.

B. Fulse: That is part of it.

S. Campbell-Domineck: A second of the motion doesn't mean you agree with the motion it means that you are ready to open the floor to discuss it.

N. Thompson: Thanks for that Robert's rules.

G. O'Toole: I will second it.

N. Thompson: Now we can discuss

B. Hinton: I asked the question about administrative allocation because that is the cost you are going to bear whether this clinic is open or not. I would feel comfortable maybe bringing the thing to break even on an operating basis, but to pay for the operations plus administrative allocation I would be uncomfortable with, so their request is 300 hundred thousand, if you pulled the 163 thousand away 137 would put them on break even operationally and that still falls within our budget parameter if everybody would agree with that.

Dr. Seoane: I am very sympathetic I run a small business too and it is very difficult to run a business particularly and FQHC you are really serving a very poor population, they are economically needy, I use to work for an FQHC on an Indian reservation in Arizona. I have several concerns one of my concerns not being an accountant although I do run a small business the County has 43 employees and their employing cost are 1.7 million, Lakeland Primary Care FQHC has 26 employees and their cost is 1.3 million. Just on the surface it seems that their overhead costs are very high. That is where their problem is, I just have concerns about County money being used for non-patient care. We have had this discussion and I remember being an audience member about taxes payers money being used wisely, being used in the appropriate manner and really it seems that this are administrative costs, rent whatever; these are real costs you have to pay them they are not really for patient care that is my concern. We have gone over and over about this about the Plan paying for "brick and mortar" and things like that. It doesn't seem that this is going to change if they receive 740 thousand dollars already and now another 300 thousand is this ever going to stop. That is my concern we are just getting out of debt as the Plan and we got into debt this is our fault we over extended the Plan's economic resources and we had to borrow money and we really look bad and I don't want that to be repeated. That is my concern are we really paying for actual patient care are we actually paying for administrative costs, overhead cost, which was not in the original proposition that was placed to the voters.

B. Fulse: In terms of comparing our costs in terms of salary and wages to the County number one the County's projection was only 10 months if I am not mistaken nine to ten months. To what extent that the County hires physicians, mid levels I don't know but majority of the costs is in the physicians and the mid levels. The support the nurses it doesn't add up to what we are trying to pay the providers and I say ours is projected through 12 months we also as a result of the Plan's problems we had to give up and handle the influx of patients and the requests that we were getting come July, August, September of last year our cost in our estimation trimmed next year because we are not going to be at the point where we need to use locum tenens we had to use a lot of locums this year to insure that we had the providers to take care of the patients and we are looking at paying a lot more for a locum than we would for a regular physician because there is a shortage of primary care physicians so we were strapped with the task of finding providers and we didn't have providers available so we had to resort to hire locum tenens to come in and handle the population. Those are the costs that we didn't anticipate but in order to serve the patients we incurred those costs. Locum tenens being contracted physicians.

N. Thompson: I was not familiar with that term.

Dr. Seoane: I am a person who likes details and likes data I will tell you that the average FQHC in the United States the average physicians sees about 3,200 patients a year. It is about 23 or 24 hundred for a ARNP or PA, my question is let's say you had 4 physicians but only had 5 thousand patient visits with 4 physicians you should have had 15 to 20 thousand patient visits that is my concern, my point is made. The overhead is very high it is an inefficient operation and I understand that the start ups they are going to be some inefficiency's but is that really the goal of the health plan. Is the goal of the health plan to support infra-structure, to support labor costs, is that really the goal as County and as the Citizens of Polk County payers is that really our goal. It's not going to be fixed in 2 months, I own my own business, overhead costs you can't fix them in 2 months, maybe a year or maybe 18 months before you establish a stable force and your overhead cost match your revenue stream or grants. That is my concern.

B. Hinton: Are the locum tenens still around?

B. Fulse: Yes but we have dropped off our utilization of the locum. Also, if I may comment the average for a physician Family Practitioner is around 42 to 45 hundred visits annual and the mid levels is about 32

hundred those are our figures that we have to report back to the feds, I have my US Report that reflects those numbers.

N. Thompson: That is across your organization at all of the locations.

B. Fulse: Right that is a National Federal Requirement.

N. Thompson: That is a performance threshold that FQHC's have to meet, in CFHC's case that is across all of your clinics so you might have a much higher ratio in Avon Park, Frostproof and much lower in Lakeland but it all averages out.

B. Fulse: Depending on the make up of the clinical staff those numbers fluctuate if I have more docs in one location their visits are going to be higher than another site with fewer clinical staff.

Dr. Jerry Brandt: Chief Clinical Officer CFHC: For the record I would question Dr. Seoane what is your overhead?

Dr. Seoane: As a percentage of business, right now 65%.

Dr. Brandt: Your patient care?

Dr. Seoane: I would have to figure it out; I didn't know I was going to be questioned today.

Dr. Brandt: The reason for my question is with all do respect sir; classically overhead is anywhere between 55 and 65% of the physicians income that includes: staff, rent, facility if you don't have a facility you have no practice, you don't have a facility you have no patients. Have you been to Lakeland Primary Care.

Dr. Seoane: No I have not.

Dr. Brandt: The majority of the people here on this committee have not.

C. Kinnick: No I think most of us have.

Dr. Brandt: I submit to you no the last time I spoke when Dr. Nobo sat in the chair there was no response to my invitation to come. Because it was obvious that you folks have not been there, you had been to LVIM working but you have not come to visit Lakeland Primary Care to see this facility. Now you can complain about overhead costs but come and look at the facility this is what was built. Money put in by LRMC and other sources. You can not criticize overhead in a practice because it is part of the practice. You just admitted that yours is about 55% or so of your entire practice. There is staff to pay, A/C to pay, medicines to buy, materials for the exam rooms to buy, this is all part of patient care. Hand washing, soaps, towels, this is all part of the overhead. You can not criticize this; I don't understand why it is even brought up.

N. Thompson: Doctor, I didn't hear anyone question that there needs to be overhead to run a business, it is whether or not we believe that's an expense that should be covered by this committee or not.

Dr. Brandt: If you are going to sponsor, it is just me I am a patient advocate, I am a physician and I have been a physician for over 40 years. I can tell you that if you are going to provide funds for patient care you have to understand that part of those funds have to go into the facility where that patient is coming into.

N. Thompson: We do understand that but typically the way we operate is that we are paying like an insurance company claim and the doctor is responsible for their overhead, this is a different arrangement where we are being asked to directly to give money to covered those costs rather than on a claims basis. So that's I think where we are in our discussion and the dilemma of tying these dollars to specific units of patient care that we have received.

Dr. Brandt: What was the, I will leave right after this question, when that 740 thousand dollars was allocated for Lakeland Primary Care what was the thinking about where that money was going to be?

N. Thompson: To help them start the clinic in return for patient care of that our eligible patients would receive.

J. McArthur: 6 of the committee have been to the CFHC Lakeland Primary Care Clinic, half of the total committee has been there.

M. Fulse: I know that when we were talking about 700 some odd thousand dollars, I know that the leadership in the Plan guided the staffing model. They guided the staffing model based on the fact that the health plan was viable, they were able to handle many of the patients throughout the County they were viable. They limited the number of providers to whatever like one or 2 docs and midlevel, they limited many of the things that was going to be covered by the 700 hundred thousand. Ed Smith and Mr. Yaskal they trimmed the budgeted they cut it back, they trimmed the number of providers a lot of these things were done based on the fact that all that they were going to be able to present to this committee was 700 hundred thousand whatever. A lot of the trimming came forth early, I am not one to beat the same drum, all of that trimming was done when the Plan was viable and there was 31 or 32 million dollars worth of doctors in the community and so when the newspaper article came out and said 8-12 thousand people were being cut off the Plan their cards were going to be withdrawn. The only provider in this County who could not close their doors or send patients letters was CFHC. So we all got a month or two notice they got a month or two notice and then they were suppose to gear up for all of these people. Everybody LRMC, Winter Haven and Heart of Florida everybody sent everybody to CFHC whether it was Lakeland Primary or not. They all came to CFHC. Remember your budget we can go back into the minutes if we want to get, they said one or two docs and a mid level. One or two docs and a mid level couldn't take care of all of these people who were disenrolled. So all of a sudden you've got one month, you've got to get people on board, you are calling every type of loco tenens you can find, you have people calling the Plan screaming that they can't be seen and CFHC can't see them they are all hanging outside of the courthouse and all over the place. That is the part that nobody came to visit than it looked like a massacre. Some days this week it has looked like a massacre and those people a lot of them were on the Plan you ask them and they say they were on the Plan. But you limited the number of providers, you limited the number of staff on that 700, so a lot of people had to be brought in to take care of these people. The overhead is high it takes 6 months or so to get a good doctor, there is a lot of loco tenens like least 3 or 4 loco tenens that have been in our other clinics nobody is talking about the cost of to the whole organization in taking care of the problems of this Plan. I am going to withhold from saying too much more about it but the doctors from Dundee, come to Lakeland trying to help, the doctors from Frostproof come to Lakeland trying to help and their salaries are not even included in there. Everybody is trying to take care of this problem but we are sitting here and acting as if nothing ever happened everything was status quo. Don't forget, just like if you file Bankruptcy your not allow to forget so don't forget that this problem was dumped on CFHC and they were not allowed by the Dept. of Health and Human Services or the Federal Government to stand up here and say we are not accepting patients. They are not allowed everybody else is.

N. Thompson: I want to make sure Mr. Duclos that we are following proper sunshine and disclosure procedures. Misilene when you started speaking I should have asked you to disclose that there is a connection between you and CFHC.

M. Fulse: Everybody in Polk County and half of Hillsborough and half of Orange know that I am Misilene Fulse, Bernard's wife I don't vote on clinics ok, I am just clarifying some things because I have say.

N. Thompson: I am not stopping you from discussing but the law says

M. Fulse: I do not vote

N. Thompson: You declare the conflict and than you discuss.

M. Fulse: I don't know if this is a conflict because if you recall we might go on and say I have never voted for it and I didn't come to the RFP meeting.

N. Thompson: I know that.

M. Fulse: I am just an observer

M. Duclos: Yes

N. Thompson: You are allowed to say anything you want just as long as you declare that you have a conflict you have done that and we are fine.

M. Fulse: Ok, and I have one more comment I want it declared that the physicians on the committee also see patients and they receive funding from the Plan and they have never been asked to declare a conflict. Let the record show that we all have a conflict.

Dr. Seoane: Actually that is not true Dr. Nobo he was seeing patients he never saw patients on the Health Plan for several years and only recently did he go back on the Plan because there was not Gynecologist on the west side of this County, the only Gynecologist the Plan had was in Haines City. So I asked Dr. Nobo you know these patient have a lot of trouble please go back on the Plan but that is not true. Dr. Nobo had not received any funds from this Plan for quite a long time. So I just want to the facts to be correct.

M. Fulse: We might want to check the record on that.

N. Thompson: Well it is not for this meeting.

B. Hinton: I was just going to offer something in terms of my personal background that helps me analyze this. I have been involved with physician recruiting over the years from hospitals. Very rarely does a physician walk into town hang up a sign open a practice and start up cold. Typically they have funding that has come to them from a hospital to come to the area. There are 2 different types that I have seen; one is an income guarantee which means that we are going to guarantee that you are going to make this much money and than we will pay you 1/12th of that each month. Or alternatively it is a collection guarantee where we are going to guarantee this many dollars of net collections and we will pay you 1/12th of that each month. If you stick around for 5 years you don't have to pay it back if you leave before 5 years you do. In those plans

you are paying for everything in that office, rent, utilities, water, garbage, supplies that is they way I look at this deal with the clinic initially. We encouraged them to open the clinic, Lakeland helped to fund it, I saw it as a one year guarantee or one year course of income to get it open and get it started just like if I was recruiting a physician to town. A lot of the dialogue that we are having if we pay for this or pay for that I think if you compare the two we are on par with what we are doing.

Dr. Seoane: Referred to a memo that Mr. Michael Duclos wrote on November 24, 2004 and I will quote: "The funds collect through the Indigent HealthCare Tax are to be disbursed to any provider of healthcare services upon the directive from the county. This seems to contemplate that the primary purpose of the funds is to pay for only reasonable and necessary health care services, not *bricks and mortar clinics*. The **general rule** of statutory construction for any tax laws holds that **tax revenues must be expended for the purposes for which they were collected**, that is funds raised by taxation for one purpose cannot be diverted to another use". It is my understanding at the time I was the president of Polk County Medical Association that we really tried to pass this ½ penny sales tax the reason the money was paid was to pay for the indigent care of patients in Polk County was not for anybody's salary, not for anybody's overhead it was to pay for direct patient care.

T. Mosley: I accept all of these things, of course you are going to need some operating cash and things like that but you have also informed us that you do have some inefficiencies possible able to collect some cash and Medicaid and things like that. I don't think that we ever decided that we were going to be a 100% funding, because you are getting revenues from other streams. But what we did agree was that or I should say that historically we have made more money because there were more members in the plan that came to your clinic. I think for me to be able to agree to any amount I would like to know what that difference is, last year you had 300 patients that were ours Polk HealthCare patients. This year you only had 50 and than we can easily say this is a shortfall last year we gave you 500 dollars for those patients because we had to terminate those patients this year you are only getting 100. Than I think we can make an educated give you an amount that we can feel comfortable with. At this point all we know is that you have a 300 thousand dollar shortfall which comes from everything. Our responsibility and I think what we have acknowledged is that you were going to provide services for patients that were going to be in our plan. So to be responsible in executed that responsibility I think we need to know what that shortfall is.

B. Fulse: As I stated before the contract did not call for Polk Plan patients only. It has come up to try to develop something that we could identify those plan patients. The method of identifying those patients was the Plan card. But when that card went away and we had patients coming in we lost the ability to identify those patients that is why we were trying to work with the county to get a list of names of all of the patients who were dropped from the plan so that we can go into our data base and match names. We have began to do that I can say from a list of almost 120 patients we were able out of the list that was provided to us by the county about 50 of those patients that were on that list had been to CFHC. Once we can get more of that information we can be able to see exactly how many. Another thing when the budget was devised last year in the budget it included administrative cost and it was approved. I talked with the staff at that point in time and it was more than that and we reduced it to the 160 thousand dollars in terms of administration sure if we didn't have LPC we would have still incurred administrative costs but we wouldn't have had to operate and spend time on LPC. In any organization that has administration there is always overhead I can guarantee you that in the administration of the county's budget they have overhead.

T. Mosley: I am the Chief Financial Officer at a large hospital so I understand some of those things are fixed but we at our hospital are also challenged because we are seeing more patients that last year and we know who they are we know are completing visits this year and as you also have to see those patients we have to also see them in the ER as well so we are managing we are increasing our services in the DCF employee we

are working hard to get eligibility. All of these things that you are talking about doing to try to minimize that risk. All I am saying is that as a committee member here responsible for the funds of this particular fund I think for me to responsibly agree to any amount we need to focus on that amount of patients that you were initially receiving funds. I understand it wasn't the 740 thousand wasn't based on a patient number but part of your presentation is you were getting funds from the plan now you are not because we have terminated a lot of cards. So I think we just need to understand really what the number is because it could be that a lot of the people who had a card just aren't getting any services or they are going to the ER I can tell you that Heart of Florida is up 25% from the prior year a lot of that is probably plan patients. So I think for me to really be responsible in duty here I just need a little bit more information, I accept that you are operating in the red a lot of us are and Misilene is right a lot of the physicians have decided to get out of the plan for whatever reason. We really didn't do much to the reimbursement but they are seeing more patients that don't have a card. The hospitals certainly never said they weren't going to take anymore patients. They are showing up in our ER's Lakeland, Winter Haven are busy so the hospitals are certainly trying to move forward but just a little bit more information so that we can properly assess what amount we should give you to help with the short fall that is all I am asking.

M. Kushner: I had a question mainly for Bernard, initially having read through the purpose of the FQHC and having read historically when I came into this plan the intent of the FQHC was to generate enough revenue and we were all focusing on expenses. I want to think about revenue for a second over the long term that 739 were not supposed to be there forever. It was suppose to be reduced by the amount of other revenue either federal revenue that has been received by the clinic or other revenue so that it becomes a self sustaining clinic. My question is to Bernard is what plans are there for the future we are looking at something for one year but if Bernard can assure us that there are plans for the future for this clinic to be self sustaining and we are looking at a temporary situation that is a lot different then just a one year at a time thing. So I want to know about revenue what the plan is for generating future revenue.

B. Fulse: We are constantly and Ms. William has been in contact with our project officer about our situation especially as it pertains to generating additional dollars for increase in demand for services that is what we have done in adding the facility in Lakeland as stated in my prior presentation. We've submitted application do to the economy we were not fortunate enough to receive those but this is a new day there is stimulus dollars out there, we are receiving information about funding all of the time and we have a consultant that we were able to write and request additional dollars for this site that is why you see the 100 thousand dollars for the stimulus grant that is a 2 year grant we received 600 thousand dollars and that total is going to be used to help support the activities at Lakeland Primary those are 2 year grants but we are continuously writing for expansion dollars there at Lakeland. Our anticipation that with the increase that we have been able to show through our reporting they are going to look at us favorably and be able to give us those dollars if not than we are going to be in a position where we would have to drastically cut our services if not close the site. I really think also with that our efforts would bring in the DCF staff it is going to be paramount to that also.

N. Thompson: Stated that it is 10 AM and we are going to have wrap this up because we have a budget discussion that we have to have today.

S. Campbell-Domineck: This same discussion came up at the last meeting and my recommendation is that we get with staff instead of those who come up here to present as a committee understand the contract. The contract deliverables so we don't confuse what's expected. From what I have heard in the last meeting the contract is with the Board of County Commissioners and that we have limited say because it has already been established but we will have more input in the next contract that is being developed but we were asking for this group to provide something that wasn't in their contract yet holding them accountable. I am not sure

if everybody on this committee is aware of what the expectations were and are for this particular provider I think that is important for us to know and we are asking him the questions but the staff should be providing it to us so maybe we can get together in a little brief training system for us and I think it would be helpful.

J. Howell: Of course we would be happy to do that at whatever time and venue and we can certainly investigate doing that as a presentation during one of these meetings or an alternate workshop.

N. Thompson: I think it needs to happen at our next meeting because we are in a timing issue.

Dr. Seoane: That is a very good idea I agree.

N. Thompson: We are in a timing issue and then October 1st will be here which will be your new contract and budget year for CFHC.

J. Howell: We will plan to do that then.

B. Hinton: Does staff have a recommendation with regard to this request.

J. Howell: We will provide you with an update in September.

N. Thompson: So that means you don't have a recommendation now.

J. Howell: That is correct.

N. Thompson: We have motion and a second being now further discussion we are going to do a roll call vote.

J. McArthur: What are we voting on exactly?

N. Thompson: The motion was to provide CFHC with the 300 thousand dollars that they requested. I'm sorry 225 thousand.

B. Hinton: I was just going to suggest that since we are waiting on the information next month why don't we just hold the discussion.

N. Thompson: So we have a motion to table the discussion what about a second.

J. McArthur: I'll second that.

N. Thompson: The motion tabled until the September meeting.

Dr. Seoane: Should we vote on that?

N. Thompson: **Yes, all of those in favor of tabling the motion say AYE? (Committee voted unanimously to table the motion).** If there are specific types of information related to this decision that you would like to have before the September meeting, please do provide that to Jan so that she can collect that for us. Whatever the open questions are in your mind as we sit here today, it is up to us to ask and not sit here a month from now and still not be in a position to make a decision because we think that we do not have the

information that we need. Jan and I spoke for those of you who were able to be here at the joint meeting with the BoCC this is going to look familiar to you there has been a few changes and she will point those out to us as we go on so we have seen this before.

J. Howell: Budget – she stated that she will be brief today if she is moving too quickly don't hesitate to stop me and ask a question. She presented the budget slides:

S. Campbell-Domineck: Was intentional for Endocrinology Services to be \$3.00.

J. Howell: Yes

Dr. Haight: For diabetes it is such an important issue.

J. Howell: I apologize it is intended to be on the chronic care page.

B. Hinton: It is just that all of the other co-pays were \$5 except that one was \$3.

J. Howell: That is correct. Continued on the presentation!

M. Kushner: Asked that at the end this next year it would be 5.7 million the beginning cash would be 6.47 million.

B. Hinton: Asked about the reserve level that you have agreed that you want to reach? I know that Mike had talked about that before.

M. Kushner: Yes generally 16% is the industry standard.

J. Howell: continued on the presentation!

N. Thompson: Before we get to the budget you have now said 3 or 4 times that we need to approve the new benefits design and benefits package as presented here, Jan did share with us that has been approved by and assume that it is also coming to us as a recommendation from a sub-committee of ours the Utilization Review Committee so I would entertain a motion to approve the Plan Design.

B. Hinton: Motion to approve the Plan Design.

S. Campbell-Domineck: Second

N. Thompson: Questions or further discussions?

Dr. Seoane: I have looked at the Plan over a period of time this is not the first time that the plan administrator Ms. Howell has been here and they need a plan, they need a structure. Essentially they are doing this anyway it is just not written down. They just need as long as they are flexible in the future that is my only caveat that nothing is written in stone that we must be flexible to our patient population and our economic needs and things like that. They do need a plan they need something written down, they need policies, they need a system and this seems to be a reasonable system.

N. Thompson: Comments or questions.

Dr. Haight: I would like to comment just a process that is working here for this committee is that in the Utilization Review Committee which is the one that I attend although I am not on the COC I have to say that the amount of input that I am seeing and ability to walk through these processes with the physicians from the community that have attended Dr. Swygert, Dr. Rodriguez, Dr. Ruiz, Dr. Philip others and myself these are very active meetings. Having this sub committee is doing the job that you had intended to hash out all of the pros and cons, come to a decision and get the input from staff, get the input from the Medical Director and move forward with a recommendation.

N. Thompson: I can give you our appreciation to you and all of the other physicians like Dr. Seoane who has served. **Further discussion, all of those in favor of the motion say AYE – none opposed – Motion Carries.**

J. Howell: Continued on the budget presentation.

N. Thompson: We have a budget before us before discussion I would entertain a motion?

S. Campbell-Domineck: Move to approve.

B. Hinton: Second

N. Thompson: I have a motion and a second now we will have discussion.

Dr. Seoane: I just wanted to make sure that I didn't misunderstand something, are we paying for in-mates?

J. Howell: No

C. Kinnick: What I am looking at here is 1.4 for primary care clinics and 4.5 for additional primary care clinics.

J. Howell: No the 4.5 is either for additional services to members. To the extent that we can as we begin to work through the year and all of these operation components these moving pieces and parts come into an organized fashion we are going to be able to add more people into the plan but we want to be able to keep our eye on that number. We want to have some flexibility there and we are being conservative here in the way that we are estimating because we don't want to make a commitment that we can't keep. Certainly when it comes to the clinics that amount of money also whatever is used for an RFP for primary care clinics will be taken out of this fund as well. We still don't know how much that is going to be we know that the board has approved that it is going to be important to work through these details in the future.

N. Thompson: This is a place holder for one of 2 things or a combination of those things, it will either go to expending members beyond 3,000 or to fund clinics if we decide to do that. But they are not going to allocate those dollars without that coming back to the committee.

J. Howell: That is correct we are still in an information gathering process when it comes to some of those things.

C. Kinnick: Her second part of the question was regarding Carescope I do not remember the figure of the Grant that we got for Carescope but I do know that it was substantial amount over 3 years. I know that

Carescope was instituted in the Polk HealthCare Alliance in the facilities of many of their members. Are you talking about revamping that which is already in existence?

J. Howell: I think a lot of people have questions about Carescope and it can lead to some confusion I see Carescope something that requires – we have to separate Carescope into 2 different projects the scope of the first project for us the health plan is to use the eligibility system that we have already bought that has already been built out we simply haven't used that eligibility system we have been on an old system called ACMS – Automated Case Management System. When we are able to move to the new system there are going to be some efficiencies that we hope to gain but we already own that and sometimes when you work through an implementation process you need to be able to make changes. If we need to make changes we are in an investigation process we don't even know if we need to make changes we just begun that project several weeks ago (1 ½ months ago this was assigned to one of the Case Managers). She is tasked with the project of leading the group to begin to understand the business decisions that need to be made, identify any wholes that exist with regard to what is currently there, if already works as it is it will translate nicely into our claims processing system MCO than we won't worry with making changes we will keep what is already there utilize it and minimize all expense.

N. Thompson: But if changes have to be made you will have to give Carescope money to do the customization piece.

J. Howell: That is something that is going to occur without a lot more discussion and we have to educate ourselves internally before we can make good recommendations to the committee. She began discussion the second piece of this system which is the Community Module which she is not yet talking about building that module, which will be another education process I know that there are some community partners that are using that. The Case Manager who is working on the first project has been tasked with thinking forward to the future about how the community module also needs to work. We have talked to the Health Department about that and I have to say that I am very excited about the possibilities to be able to gain efficiencies community wide if I can be sure that someone owns the contractual liability for insuring that system has accurate security measures in place.

C. Kinnick: Since you are investigating Carescope and all that this entails I know that you have been to some of the Polk HealthCare Alliance meetings the sub group that I am on is looking at avenues to disseminate information about local community health fairs and there is no place to house that information. The other piece of that which we are looking at is where to post information about educational opportunities for individuals where everyone can go to it and look. In the future when Carescope does hopefully get back the way we had intended originally maybe that information could be housed there and everyone throughout Polk County who has a computer would have excess to that.

J. Howell: I think that is a great idea.

M. Kushner: Wanted to make a clarification the 16.992 million for the PHP on your line item area under expenditures that's contemplating 3 thousand members, the County Manager asked that I clarify that.

B. Hinton: I hate to add anything to the budget but I kind of wonder with the H1N1 issue out there Dr. Haight with regard to your funding should we not set aside some reserves to handle maybe some incremental costs that this plan is going to incur for our population.

Dr. Haight: My staff at the Health Department has been eating, drinking, sleeping H1N1 for now probably 4 or 5 months. I think that it is really too early we know that this flu is everywhere, we know that it is unstoppable, we know that it can be slowed down with community efforts and we already have investments in that process already. There is funding from other areas that are coming down when it comes to the ability to mount a vaccination campaign for the voluntary vaccine. Your usual flu shot will not protect you from this new flu so this new vaccine that they are trying to develop and deliver has some funding attached to it, to promote it, to organize it and to develop it and to answer everyone's questions so that it is a safe process and it targets the groups that we need to target such as pregnant women, chronically ill that are elderly along with the children in schools and than make it available to everybody.

Dr. Seoane: There is no cost for the vaccine?

Dr. Haight: So far they are still waiting and they have not provided all of the information on how it is going to come down and the actual distribution. We are already working on plans and we have activated our instinct to man structure as had the schools and we are working closely with them. Right now it is mainly a communication issue the newspapers are reporting very accurate information and are getting that out. Right now the costs I think are really more the social costs of what happens in our society when we are having flu go through it, people not showing up for work and work not getting done. Fortunately I think that for you at this point there is no request that I would make at this time. But public health in general that is why the funding that we receive for public health allows us this flexibility because we can not budget for this kind of problem. Who knows we may have a hurricane issue requiring public health activities, we may have hepatitis situation we can't budget for that. Thank you for your interest we will come to you if we start to foresee financial difficulties that weren't well planned.

Dr. Seoane: I was on a telephone call yesterday a conference call yesterday it wasn't just me there were a million other people on the line too with the Assistant Secretary of Human Services there is no plan that they are going to give the vaccine to any provider in the U.S. 50 million doses will be available in mid October they say and 29 million doses every week after that, they say so we will see. The government the Federal Government has thought this out.

B. Hinton: What about the Tamiflu on the other one.

Dr. Seoane: You have to pay for that.

Dr. Haight: We do ask our local physicians to let us know if there are people who are at high risk of getting severely ill or who in critical positions that have medicine problems obtaining it come to The Health Department so we can help address that. It is widely available but we do not want it over used because Tamiflu resistance can develop and it will become a useless medicine if it is overused but it certainly has it's uses and we work very closely with our local physicians to make sure that they get the message on how that is best used. There are stock piles that are prepositioned throughout the United States and right now there is no shortage. Between you and your doctor if your doctor decides to prescript it, it is available it is about \$116.00 you may have a co-pay you may have it free depending on your insurance. If there is any problem obtaining it let us know at the Health Department.

B. Hinton: From our population is it on our Formulary that is my last question?

Dr. Seoane: Tamiflu is not on the formulary as far as I know.

Dr. Haight: That is a good point as we have gone through the planning of it we have prioritized issues and you are dealing with 1,000 patients which is relatively small for the county but I have not specifically addressed that I think I would like to speak to this group after this meeting just about that one fine detail should it be considered on the formulary maybe with the provision that it is for a high risk individual, someone who has asthma, exposed or sick, pregnant that it could be available.

N. Thompson: So the Utilization Review Committee can take that up at their meeting (P&T Committee)

T. Mosley: Just looking at the salary line and understanding that in this current fiscal year you had a reduction in work force and if I am correct going into the next fiscal year the county employees are forced to take 5 unpaid days and if I am correct again the merits have been suspended is that right, so how do you estimate an increase into next fiscal year over this year. I know that the furlough and the merit increases aren't in this actual number so I would have anticipated a little reduction to this year.

M. Kushner: No it is the cost of benefits.

T. Mosley: The benefits are going up I thought you were passing more costs on to the employees.

M. Kushner: We are

B. Hinton: The other thing could be the people who entered into your staffing model late in the year before the hiring freeze went on and you only had part of their year last year and you are going to have a full year next year that could account for the small change.

N. Thompson: Timing on benefits

T. Mosley: The benefits have been so reduced, I am just curious on how you anticipate an increase. Most of us are doing the same things that you are and we are budgeting less salaries because those actual things weren't in there, so I am just curious how they came up with these figures.

J. Howell: I think some of that is due to some internal reorganization and restructuring as well as the fact that we had asked for requested and gotten an approval for a Health Plan Analyst and then the cost of benefits are increasing both for the employees and internally for the county as an organization that money is an increase based on those 3 items.

M. Kushner: The benefits we have reduced the actual benefits. Our health plan has reduced the benefits by 7.4 million dollars that is true. However, there are other things like the Florida Retirement System costs and other costs that don't go away. I am not sure how that plays into this, you see just a modest increase here it is not a big number. **A lot of it could be do to timing that is something I could investigate and get back to you.**

J. McArthur: Right below the Polk County Health Department are 2 items listed as grants, when I see the word grant I see that as an income but they are there under expenditures.

N. Thompson: Remember the LIP grant we put money up and then we get it back. So we have to show the money that we are going to put up.

J. McArthur: What about the Mental Health and Substance Abuse 275,000 what do we get for that.

J. Howell: That is one of those things that the Department of Children and Families worked with Peace River Center I believe to work to do a grant proposal together to bring money into the county and the county gives a match for some of that money. It is an infusion into the community so basically we are leveraging our dollars as a community.

J. McArthur: We are getting some services for that in those areas.

J. Howell: Yes absolutely and they are very detailed line items in those contracts on how much they are going to charge for each type of practitioner for an hour.

Dr. Seoane: Peace River is unique they see people that no one else is seeing and they have expertise to see, we need them and we need them to keep going. They see Polk HealthCare patients, Medicaid patient they see anyone that doesn't have any money or real insurance. We need to keep that organization going.

N. Thompson: At some point that grant at some point the grant will sunset.

J. Howell: This is the second year for the LIP grant under other revenues 562 thousand there is some nearly 300 thousand up there that accounts for the match that we get back.

N. Thompson: Other questions, hearing none all of those in favor of approving the budget as submitted say **AYE, MOTION: (Budget was unanimously approved).**

J. Howell: Stated that she had one additional item Nancy; and that is the 90% verses the 100% payment for the physicians.

N. Thompson: Just for our committee members and audience benefit you have a copy of a letter from the Polk County Medical Association requesting that physician rates be restored to 100% of Medicare rate. Remember when the plan was in trouble one of the measures that we took to get by our budget crisis was to reduce physician reimbursement rates to 90% of Medicare.

J. Howell: That is correct. The one thing there are advantages and disadvantages to the plan internally and the way that we move forward whatever the discussion of the committee is but one thing that I would call to your attention is that \$472.00 accounts for one patient so to the extent that the people receive 100% Medicare as opposed to 90% that money will be taken out of the future plans services expansion which is direct care to members.

J. McArthur: The budget that we just voted on does that include this 90% or the 100%?

J. Howell: It includes the 90%.

N. Thompson: 3,000 at our current rate which 90%.

B. Hinton: So if we agree to do that as an example than the 4 million or whatever it was down at the bottom (inaudible)

N. Thompson: It would move up to cover plan services is that correct Mike is that the way you would see it. The money below for plan expansion and or clinic would be a piece of that would be used to cover the increase in the physician's reimbursement.

M. Kushner: The 4.5 million dollars part of that would be used for the additional to adjust to the Medicare fee schedule that was the way it was prior to the plan being in crisis. I don't have any opposition to that I think it is not unreasonable.

N. Thompson: The requests from the physicians?

M. Kushner: Right

Dr. Seoane: It is not a lot of money because you are talking about 10% of 80 dollars, 70 dollars, 50 dollars it is not millions or hundreds of thousands it is not unreasonable and the physicians they supported going down to 90% there was really no opposition with the understanding that when the plan becomes more stable that it would go back up to Medicare rates. We went from a hand full of physicians to several hundred physicians involved in the plan. We never know what is going to happen in the future, with the plan or anything else for that matter. I think that it would be appropriate to go up to 100% or Medicare.

S. Campbell Domineck: Move to approve

N. Thompson: I have a motion

C. Kinnick: Second

N. Thompson: And a second further discussion.

M. Fulse: My question is that with the 1,100 members that we have now we have some stability 1,100 members isn't nearly what we expect to serve with 35 million dollars so are we are we saying that we are going to have to move more cautiously toward taking care of 3,000 people if we increase these rates or can you definitely say you can at least serve 3,000 people regardless to the physician rates?

M. Kushner: We can serve 3,000 regardless of physician rates.

M. Fulse: The moving passed that would be cautious

M. Kushner: Yes

C. Kinnick: It is going to be cautious rather this 90% or this 100% is approved, it still you've said it is going to be cautious after that 3,000 to see what happens.

M. Fulse: If you take out the clinics and you take out some of the other things so we are going to take care of 3,000 people approximately, if you take 10 million off for the clinics right now they are not stuck with having to take care of only the plan. If you take off let's say 10 million you are going to take care 3,000 people with 29 million dollars in ½ cent sales tax?

M. Kushner: No it is 16.9 million dollars is what we are proposing to take care of 3,000 members.

M. Fulse: So the rest of the budget doesn't take care of members?

M. Kushner: It does in a different way

C. Kinnick: Indirectly

M. Fulse: But I am just saying truthfully we are going to take care of 3,000 people give or take for 25 million dollars regardless to whether it is administration, salaries or whatever that is really what we are saying.

B. Hinton: No I don't think so, because you have people being covered through the other programs whether it is HCRA, Polk Health Department the 16 million that we are really talking about in terms of taking care of 3,000 people.

M. Fulse: So how much is that per member?

M. Kushner: \$472.00

M. Fulse: Per year

M. Kushner: \$472 per month (per member per month) that is conservative that is an actuarial figure remember I said that currently our costs are well below that we have to move cautiously but when we bring new members into the plan that is when you expend at a higher rate but I think that there is some room. I can't tell you how much room but right now we are running about 3,700 hundred dollars a member per year so well below the 472.

N. Thompson: So we based the budget on the 472 per member per month we expect based on our actual that it is lower now it might bump up when we add new people but there is still room to breath in that per member per month rate that would allow for that increase if that is what we chose to do.

B. Hinton: I was just going to offer on the original financials that we paid physicians 3.3 million dollars in terms of the normal reimbursement and rounding it simple 10% of that is 330 so that would be maybe our upper limit of exposure.

N. Thompson: So increasing that by 10% roughly 350 in that range.

B. Hinton: Either way it still works out.

M. Fulse: It is only increasing 10% for the specialist you know when you go 10% for from 80 dollars to 88 is one thing but if a specialist Medicare rate goes from 100 to 150 is it only 10%.

M. Kushner: No the way it works is there is a Medicare fee schedule that comes out. In this motion I would ask that you consider not amending it until the new Medicare fee schedule comes out so that we can administratively tie that in so that when we program we don't have to program it twice.

N. Thompson: When does that happen October 1st?

M. Kushner: Usually October 1st.

N. Thompson: With the Federal Fiscal Year.

M. Kushner: Right so basically there is a fee schedule that comes out by CPT codes and those codes some of those go down some of them go up. I haven't seen the new fee schedule.

Dr. Seoane: They generally go down.

M. Kushner: There has been some pressure on Medicare that is for sure especially with hospitals right now. The hospitals are having a lot of pressure, I don't know about the docs I am sure they are having the same pressure. If the fee schedule goes down it could actually result in a lower Medicare cost so it is 10% of a lower cost. I just wanted to clarify that it is not necessarily if the Medicare fee schedule goes up than you could be paying more than that so it just depends on what the fee schedule is when it comes out.

N. Thompson: So since we are acting on a request that would go against our next year budget we can build in the assumption that it is a 10/1 and beyond. It wouldn't be implemented until the new Medicare schedule is out nor would it be implemented before 10/1 because it would come out of our new budget year. Does that make sense?

M. Kushner: Yes it does

N. Thompson: So for the record for clarification when we vote on the motion that would be our clarification are there any other questions.

J. McArthur: Do we want to vote on that motion or do we want to table another one. I am agreeable

N. Thompson: **Ok I have a motion and a second all of those in favor of the motion as stated with the clarification say AYE – (Motion unanimously passed)**

Dr. Lynne Saddler, Assistant Director Polk County Health Department – LIP Grant presentation overview and year 2 of the project.

Sheryl Cooper, Division Director – Health Promotion and Preparedness at the Health Department: She discussed the year one project.

N. Thompson: Comments or questions? Misilene I understand that you want to make a comment at the end of this presentation is that still the case? Since there aren't any questions we will move to that.

M. Fulse: I wanted the opportunity to share this with our P&T committee but since our meeting was canceled and since I can't wait another month I am going to share it with everyone. As you all know I work for Central Florida HealthCare I am the Pharmacy Director. I had the wonderful opportunity of participating in this LIP Grant and I would be remiss if I didn't share some of the accomplishments of the pharmacy in participating in this LIP grant at the same time it will increase your education of what I have perceived as the community knows the pharmacist receive all of the information from within the patients home and the hospitals everywhere. The pharmacy was a contracted partners originally they were one of the three partners who wrote the LIP grant. But we became as you know last October it was announced to you that the Health Department would contract us to provide pharmacy services for the population of Polk County. I might add that Polk County has 20,100 square miles and so we looked at this as huge job. The specifics of the contract I won't get into but I will say that we started talking about this in October the contract was signed January 9,

2009. So from October to January we experienced the population issues of Polk County at our pharmacy in Avon Park that included us preparing patient assistance, etc. It was an overwhelming task I actually lost one worker in the midst of this whole thing it was a tremendous burden. So we were excited to say the least on the opportunity to participate as a partner to take care of this community in another way. A way, by the way Lakeland Regional when they designed that clinic and they paid for all of the construction they made a pharmacy I might add that it was the same size as the closet that you clean in. On January 9th after the contract was signed we had to take an office and expand the pharmacy to be big to contain medication. The small closet is where we actually take care of patient in the window. For those of you who had seen it you can see that we were creative in that. On January 9th we began to haul I can actually say haul medication; we hauled medication from January 9th until April 1st to patients of Polk County who were hurting. Some of the prescriptions were as old as 3, 4 months old all balled up and crinkled up where they had been coming to our clinics all over this county and could not afford their medication. So we carry 790 some odd prescriptions from our Avon Park branch to the Lakeland clinic and dispensed them to those hurting people. That was given as a report to our LIP partners and it was accepted because by us signing the contract on January 9th we missed the federal cut off date to become a 340B covered entity so April 1st was our actual start date. After April 1st we opened the doors we took care of 1,533 patients we provided over 9,000 prescriptions including the 790 plus 8,900 sum odd prescriptions from April 1st until June 30th I might add that is the period of operation here. The prescriptions cost 100 thousand dollars in medication costs. The value of those prescriptions was over 600 thousand dollars. We prepared over 400 applications for patient's assistances at the same time that we were taking care of your patients. The value of the medication that we are currently receiving and we are overwhelmed receiving them the value is 1.3 million dollars and for my partner on the P&T that is a return of 12 to 1. These patients were reported to our national collaborative we have 450 diabetics who have been on monitoring supplies many of the patients receive 3 months supply of all of their medication and of all their diabetic monitoring supplies. In the contract that we had made verbally with them is if you do what you are suppose to do on the 91st day and come in and get your hemoglobin A1C taken we will refill medication and we will help to take care of you. We reported a 25% drop in hemoglobin A1C's we reported that 300 of those 400 patients was able to tell me their hemoglobin A1C so that they could get their medication again. We had by the time the patients came back the second month we had most of the high priced medication that that population is on in patient assistants such that we able to not charge the LIP grant for those medications the 1.5 million dollars worth of medication those medications are now coming every 3 months free to the patients being administered to the patients through 3 pharmacists with a total of 75 years of clinical experience at Lakeland Regional. This pharmacist oversight and these 2 technicians I might add that one of the technicians is a graduate in gerontology from the University of South Florida and she has a real compassion for patients. So we have one full time pharmacist, 2 technicians reduced to 1 by our CFO, because we can't operate so far in the red so we had to reduce by 1. We are receiving 10 to 12 packages of compassionate drugs a day. We are talking to each and every patient we are making sure they do what they are supposes to do. We have healthier community we have invited them all here but most of our patients even when we were inviting them to the Stafford Chronic Disease model they said the bus is all I have. I can't get anybody to bring me here to do that. All they needed was their doctor visit, their medication and we have a healthier community. We continue to provide these services absolutely in the red. My request for the Board and if we ever have a P&T committee again I will be glad to bring all of this to you is for the Board to consider financing this pharmacy that should have been financed at the time that the clinic was opened but it was put on the back burner. We are the only the 340B clinic pharmacy right now taking care of this population and since our last meeting I started asking all of my patients have you ever been on the health plan, have you ever been on the health plan most of them have. In terms of wanting to know our return on investment the first patient that I took care of who was suppose to be here today she experienced massive wounds 51 days of hospitalization over a 1/2 million dollar bill at LRMC she was 55 pounds over her normal body weight just by experiencing her medicine alone she has had zero I said zero ER visits, she is at her

normal weight her hemoglobin A1C is 9 when it was 13 and this one patient alone cost this county maybe it was just LRMC she cost more than this pharmacy, this one patient cost more than this pharmacy would cost for the entire year. So I beg of you all to consider whatever way you can whether it is through the LIP grant or I don't even care how you figure it out we need this pharmacy. Further, I might add Dr. Swygart and the other hospitalists they have 2 places to send there Atrial Fib, Coumadin and diabetics etc. they send them to their clinic if they have payment and our clinic if they don't. Right now I am taking care of over 30 patients on Coumadin therapy with zero money, zero money and they are getting labs and they are getting Coumadin monitoring and they are not going to the ER. All of this documentation, analysis or whatever can be discussed at a later time. Thank you for the opportunity to serve your people.

N. Thompson: Thank you Misilene for that information and certainly for your passion for what you do. I know that it has been a long day and we want to get to Connie and be able to get out of here. We do appreciate everyone's time, I just have a real quick comment I had overheard someone who I really respect a business person here in Polk County say something that kind of bothered me a little bit that we are going to have think about strategically if we get federal approved healthcare then the sales tax goes away, that was his belief that the Polk County HealthCare Plan becomes a moot point at that point. So I think that is just a public perception going forward that we need to be aware of and maybe strategically start thinking about how we address that. My answer was no it doesn't and that was the end of the conversation.

Dr. Seoane: A lot of things might go away; I might not even be here depending on how things go.

J. McArthur: First of all I think that we need to wait and see what comes out before we make any plans at all. It may be nothing.

N. Thompson: Mike has been the most involved. Just the general idea that there is really no connection between those 2 things the voters of Polk County approved this for a purpose. If they decide that the purpose no longer exists they could get rid of it but that isn't happening now.

M. Kushner: If you have read the papers there is a 60% likely hood that the healthcare reform will be split into 2 parts at this point. One part where everybody can agree upon I think that there will be universal healthcare I think that is going to be virtual certainty how that is going to be funded that is going to be another question. I think there will be mandated universal healthcare as far as the government plan that is up in the air. Whether that becomes part of part 1 or part 2 I can't say most likely it won't be. I think part 2 is going to be the area of contention but I think that part 1 you probably see some legislation in October for part 1. By the end of the year maybe a watered down version of part 2 that is my guess but I can't say I am not in Congress. It is basically what we are hearing out on the hill.

N. Thompson: Thank you for that update. Connie

C. Kinnick: She gave an update on the last meeting of the Polk County HealthCare Alliance, it was fairly well attended and Jan Howell gave a presentation on the PHP, it's current status and future direction. We met in our sub groups to further work on the MAP and CHIP process. We meet the 2nd Thursday of every month at the United Way in Highlands City 8:30 AM.

N. Thompson: Asked about Public Comment, we appreciate the time that you have given us today and thank you for your participation. Motions and seconds all around meeting is adjourned.

Citizens Health Care Oversight
Committee Meeting Minutes

August 21, 2009

Meeting Adjourned at 11:39:00 AM

Transcribed by: Debi Curry; Office Manager, IV
Risk Management Division