CITIZENS HEALTH CARE OVERSIGHT COMMITTEE

MINUTES

Note: these are longer then the usually summary minutes because of the subject matter.

August 25, 2008

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, Stacy Campbell Domineck, John McArthur, Tonja Mosley, Andrea Gordon, Steve Henderson, Dr. Nobo, and Ginger McNally.

COC Members Absent: Connie Kinnick

Other County Staff in attendance were as follows: Mike Kushner, Mike Herr, Lea Ann Thomas, Larry Skidmore, Dr. Saddler, Steve Yaskal, Wilma Daniels, Fran Peek, Gwen Hall, Debi Curry, Joy Johnson and Michael Duclos.

County Staff Absent: JoAnn Fioravanti

NOTE: Dr. Haight was unable to attend so Dr. Lynn Saddler was there representing The Health Department.

The meeting was called to order by Nancy Thompson at 8:30:35 AM.

Brian Hinton led the Prayer and the Pledge of Allegiance.

Nancy Thompson: Asked that all of the members introduce themselves and what group they represent.

N. Thompson: Requested a motion for approval of the minutes from June 20, 2008.

Motion: Brian Hinton made a motion for the approval of the minutes.

Second on the Motion: Steve Henderson

Additions or corrections: hearing none; all those in favor of accepting the minutes as presented say AYE.

All members stated AYE.

Minutes approved.

Nancy Thompson: Introduced Mike Herr

Mike Herr, County Manager: He gave his presentation to the Citizens Healthcare Oversight Committee; he started with some opening remarks then he went into his detailed presentation. He explained that the presentation would be given by Lea Ann Thomas, Assistant County Manager. He explained that the Human Services Department reports to Lea Ann and he told the committee that they will be getting to know Mike Kushner the Interim Director of Community Health and Social Services Division. Mr. Herr explained why

he selected Mike Kushner to be the Interim Director; he is currently the Director of the Risk Division too. Since Mike Kushner had done an excellent job managing the risk in County Government during this period of time it would be appropriate to turn to him for his leadership. He explained that Mike Kushner will be leading the Plan for at least one year and they will be reviewing that in about 6 months. He explained about the financial status of the Plan and that there is a 15 million dollar short fall, so the Plan will be taking a loan and that loan will have to be paid back; within one year. He stated some of the things that the staff did very well such as developing relationships in the HealthCare Community, identifying providers of service, networking very well, access into the community and linking our customers with the Plan. We did all those things very well. We increased enrollment, we started serving 2,500 customers and in one moment in time during the last 18 months or so we served as many as 21,000 enrollees and finally capped it at 19,000. We had done those things very well. The things that we didn't do so well which is not the fault of the committee, is the responsibility of our team to provide much better reports and information to the committee, we did not do that. He stated that he would accept responsibility for that, we should have and could have done an excellent job, and we did not do an excellent job. In the future you will see a series of reports each month. Those reports are not just going to be the typical pie charts that show you revenue and expenses and where we are spending money, even though that is part of it. He explained that the reports will show a demographic summary, age and gender of the group, key statistic reports that will provide you the medical paid during period and the amount paid per member and we will give you a large claims report which will identify the claims that are paid that response to catastrophic claim, membership enrollment, trend report, utilization reports, provider network experience, prescription drugs, and most importantly a report that deals with claim lag. Those are the things that we did not have in place and that the team and the system should have had in place. There will be quarterly reports to The Board of County Commissioners. Another thing that we did pretty well is we identified the skeleton of the Plan; our problems were we focused a lot on programming; we had a very healthy Plan one that provided a lot of benefits to it. What was lacking is that we did not provide the business side in terms of what are the expenses of this Plan. Let's not forget that the Plan served a lot of people and that was what the Plan was designed to do. The Plan was designed to serve the sickest of the population. As we move into fiscal year 2008/2009 that is going to be part of the presentation today is the budget, we are going to need to scale the program back, and we will not be able to serve as many people as we had hoped at least for fiscal 2008/2009. There must be a good sense of reporting and as we transition from fiscal year 2008/2009 to 2009/2010 then we can start looking at revving up the program and serving more customers. As part of servicing more customers, I think rather that we focus the presentations on is it primary care, is it secondary care and that sort of thing I think we need to work more closely with our Health Department and Dr. Haight and certainly other stake holders that are providers of service and focus on the healthcare of our community.

He stated that in fiscal 2009/2010 the first thing that needs to be done, along with deciding what benefits will be we provide? What can we afford, what kind of benefits can we provide, what diseases are we tackling after we decide those things that is where we need to direct our resources. What is very important, and he asked for the Committee's full support on this unanimous as well as the Community to stand behind us we will need to have a reserve, that is fiscally responsible not only do we need to decide what the benefits are and who gets what, we must have a reserve in this fund. That reserve can only be touched for emergencies it shall never be touched for recurring expenses. He stressed the importance of this fact. The reports will be very important and he encouraged the committee, he stated he would stay personally in touch with each member of the committee. He will be interviewing each member of the committee at least once quarterly, pick a time, have a cup of coffee, have lunch whatever would be convenient for the committee member he wants to make sure that each member is being served as a committee member and that you feel that you are satisfied that our team is stepping up to the plate and providing the leadership that is necessary to help you make decisions. This committee in addition to your individual talents and the brain power that you bring to

the setting can only be as good as in some respects as the information that we provide you. The information that we had provided you was not good enough. The creditability of all these people that are here today that we are responsible for maintaining the integrity and the creditability of this program, and he stated that as a leader you expect that, he made the commitment that as of this day that they will not be disappointed, we are moving forward, you will be provided with the right kind of information, it will be the kind of information that you can depend upon to help us to govern this Plan along with The Board of County Commissioners. He stated that one of the things that can be done in the future is to have a strategic planning retreat between the Citizens HealthCare Oversight Committee, The Board of County Commissioners and various stakeholders. He gave these examples: The Polk HealthCare Alliance, P.E.A.C.E, Health Department and various providers of services, mental health, Central Florida HealthCare, and others. This is important to have a day long retreat as we continue to map out and plan for the provision of services. This retreat will help to focus on the mission and what direction do we want to go. This might be more important for fiscal year 2009/2010, but it is important that this is done. The question has been asked if Mike Kushner will always be the Director of Community Health & Social Services Division, that won't be a bad thing; he is a very competent leader, but he stated that he didn't think that would be the case. Mike Kushner's expertise is in risk management, the Polk HealthCare Plan is only one dimension of the Community Health & Social Services, which it happens to be a large dimension, and we do not have all those answers right now. What we need is stability, consistency as we transition from fiscal year 2008/2009 to 2009/2010 we will map out what we need to do. He stated if he had to do it over again he would have brought in a third party administrator, they would have help us more than I thought, he stated that he thought that we had more capability than we did, we didn't we have to face that fact. A third party administrator would have helped us go through the claims more efficiently and probably would have given us access to a Medical Director then they could have gone peer to peer with the doctors especially if we had questions over claims. A Medical Director could have helped us negotiate contracts in the network, we certainly do have the network identified and got contracts out there, but there were things that we could have done to help ourselves. We should have hired an actuary to work with the Plan and we didn't. Those are some changes that we are going to be making to make better projections with respect to the performance of the Plan. In the future he has been asked by several what kind of models have you looked at, we have the model today where we go hire a Division Director run the program in house, we feel that we don't really need a third party administrator to help with an enrollment of only 3200 or so. I think if we were to get back up to the 10,000 enrollees we will need to go through the RFP process and retain a third party administrator, which will be a discussion down the road. He stated that there are e-mails therefore they are public records we don't hide anything in this organization, we have had discussion with Dr. Haight about maybe running the Polk HealthCare Plan from the stand point that I think that number one he is a physician and he understands the nature of medical care and all of the issues in the healthcare community, so it is an option that the County is exploring, but we are taking a look at a lot of options. The purse strings would never be given up by The Board of County Commissioners and the Citizens HealthCare Oversight Committee would continue to exist and provide its current function. The people that work today in the Polk HealthCare Plan would be merged with the Health Department that is a model that they are exploring. That is not a firm decision it is just one option among several that the County is taking a look at. As we look at these options we need to make sure we know what is the best way to administer this Plan, what kind of expertise do we need to manage this Plan. That will be the focus, which should be our focus. In terms of the model, we have a good model today with Mike Kushner as our Risk Manager wearing 2 hats, lets get through fiscal year 2008/2009, lets take a look at these models and he will be very open about it and he will discuss these models with you, he will not do this in a vacuum. He will follow through on this commitment that making sure and he will be speaking with each one of you through the year to make sure that you are getting the information that you need to make the very best decisions so you can fulfill your responsibilities. Unfortunately, as one of our cost reductions strategies we will need to lay off 25 individuals, we have informed those 25 individuals and tell you that the 1st week in

August when we were communicating with members of the Citizens HealthCare Oversight Committee about the financial status of the Plan we addressed all of the employees and now we have identified the individuals who most likely be laid off based on performance evaluations and based on seniority. Those individuals have been contacted we are committed to helping them through a transition so that is one of the things that we need to do because we are serving fewer customers therefore; we don't need the man power. He apologized to the committee you had the right to expect an excellent job and we didn't do it. The next time around it is going to be excellent.

Lea Ann Thomas, Assistant County Manager: A copy of the power point was given to each committee member; she started going over each item on the presentation.

Mike Kushner, Interim Director of Community Health & Social Services: He went over the reports that will be furnished to this group. He explained how there are new members entering the program and members that drop off, there many different components to a health plan that can affect the way we spend money. He explained all the different things that are important in the reporting method. Mike went over all the reports that were listed on the power point.

John McArthur: Requested that everyone stop the use of acronyms so that people that may be watching on TV will have a better understanding of what everyone is talking about.

Lea Ann Thomas: Asked if there were any questions?

Stacy Campbell Domineck: Asked about 2 words that had been used (to serve the SICKEST and the other is to serve the BIGGEST) are we talking about the most prevailing illness or are we talking about the sickest people.

L. Thomas: Stated that the sickest people are at the lowest income level because they haven't been to the doctor. The sickest will be the people at the 100% FPL not that at the 200% FPL they are not sick but they may have gotten some health care in the past.

S. Campbell Domineck: This should be included in the Retreat or at the Strategic Planning meeting and the difference between the two.

N. Thompson: Stated that she would like to structure this as and the staff has given this committee some specific recommendations on how they believe we can get to the amount of money that we expect that we have to spend for the 2008/2009 budget year. She stated that she would like to have some general discussion and questions and then we will go through each of the areas and recommendations one at a time which is when we can allow public comment on each of those areas. I think that would be most organized way unless someone has a different thought about it and I will begin with Dr. Nobo who has a question.

L. Thomas: She stated she would switch back and forward from the power point to the budget for talking points.

Dr. Nobo: He stated that he had taken some notes while Mr. Herr was speaking, he mentioned everyone in the Retreat except Physicians. I would hope that the Physicians of this County would be on the list to be included at this Retreat.

M. Herr: Yes the Physicians are an important group and they will be included.

Dr. Nobo: He stated that he and Connie Kinnick were the only 2 that had voted against the budget. They had concerns that the reserves were dwindling. He explained how he had had concerns about 1) utilization review, we had offered to be utilization review free of charge to the Plan. He continued to elaborate about that. He offered again today to do some type of utilization review. 2) Pharmacy, I asked about forming a PT committee, he asked the doctor from Lakeland Regional Medical Center, Chairman of the PT committee (Pharmacy and Therapeutic) to meet with Wilma to see how we could help on the pharmacy. There were a total of 4 doctors who were offering to help even though there is a national (Pharmacy and Review) that wasn't correct, Polk County patients are different, this was important these doctors were going to volunteer their time no cost to the Plan to see where we could save money. He stated that he suggested to have an increase to the co-pay would elevate some cost to the Plan, in fact he stated that the co-pay could be collected therefore reducing what the Plan paid the physicians. That way the co-pay increase would have some saving, I was told that the saving of 100 thousand it wasn't worth it. That is still one of my suggestions that I will later speak on. We need to work on the check and balance that we have on our patients, and he gave a few examples. He stated that his patient had come from Minnesota because her cousin told her that she could have a very difficult surgery done for free. This Plan needs utilization review, someone to look at these issues and these patients that are taking advantage of Plan that wasn't meant for that but it was meant to help those who live here in Polk County. He gave information regarding the length of stay in the hospital by the Plan members; this report was given to him by Steve Yaskal. He started to discuss this with Lea Ann. He stated that he wants to know the exact numbers using the 100% FPL and reducing the number of patients and going from the 10 days to the 6 days. He doesn't want to see the 150% FPL because we are doing that he wants to know the savings at the 100% FPL going from 10 days to 6 days? He wants the real number if you have 3000 patients at 100% going from 10 days to the 6 days I need to know that savings?

L. Thomas: Stated that she could not answer that today.

Dr. Nobo: He stated that they are not comparing apples to apples. We are comparing the huge numbers with the 19,000 when in reality we will be having 3,000 because his thinking is if the average that we have had within the last year is 3.85 I just don't see the huge numbers, we are comparing three things: comparing at 19,000 to 3,000 that is not the way it should be, from 150% to 100% no the comparisons that we need to have are: 3,000 patients what percentage of the 19,000 equals the 3,000, than go to 100% FPL figure out exacting what our saving will be on that group of people. There really will not be any huge savings going from 10 to 6 because the average hospital stay is the 3.85.

B. Hinton: That is the whole population; it is like Mr. Kushner said if you don't have the demographics of your client base you don't know if the 3,000 that you have left are the sickest of the group or the average.

Dr. Nobo: stated no he and the other doctors in the audience see these patients. The problem with the Plan all of the patients on this Plan are all sick.

L. Thomas: She started to go over the graph to see if this information was that Dr. Nobo is looking for.

S. Yaskal: Stated at 10 days with a 10 day cap on the stay at 3,000 clients we are looking at a total hospital cost of 2.8 million dollars if we cap it at 6 days we are projecting the total cost to be 2.6 million that would be a savings of 304,000 dollars less. The 304 is the difference between the 10 days and the 6 days.

Dr. Nobo: that would be a 300 thousand dollar savings, he suggested again to increase the co-pay and deduct that from the physicians pay so therefore; last time I think it was 100 thousand that is 1/3 more. He stated

what he thought that this Plan did. If you drop it to the 80% for the doctors most Specialists will drop out of the Plan. You will have patients going to the clinics that you are building but if I am not mistaking the Specialties that these patients will require will not be there for them. I don't think that is what we want to do. Most physicians in Polk County take well above 100% of Medicare and I think that cutting it to the 80% it is not in the best interest of the patients and the physicians I don't think that cutting it to the 80% is what we want. Increasing the co-pay and decreasing that from the Physician will help to save the money that the Plan needs to save and still have the access to care.

T. Mosley: Stated that she has only been with the committee less than one year, but being a financial officer and her business is in the details we are making very difficult decisions with limited information. She stated that she is glad that more reports or a better reporting will be done. She stated that her problem today in looking at some of the numbers and the variances are very large, she fears that with all of the reductions particularly the ER you will be seeing more of this cost just shifted to the Clinics. Most of the hospitals are willing participates in providing care through the emergencies for our citizens but as they are working their efforts to reduce non-emergent visits by screening and doing other things these patients are just going to go to our clinics. So I am not sure if we are really going to see these reductions, I think I will need more information what does an average visit cost; how do we say it will only be 300 thousand by moving to 3,000 members. Most of these 3,000 members are they going to have in patient stays or how do we get there. Seeing numbers on the page really doesn't help me to understand how we are getting there. I am certainly willing and I think that all of the committee members are committed to be responsible and please use us bring some sub-committees together and let us help you think through these things.

M. Kushner: Stated the fee schedule; the Medicare Fee schedule is a fee schedule that comes out every year; you will not precisely know what a patient needs. It is very difficult to know how much care will be provided in the office. When you reduce from the 19 thousand to 3 thousand the estimate that we came up was based on a percentage of the office visit, based on the average cost that we are seeing within our Plan. That may change it could be more or less.

More discussion ensued.

M. Kushner: stated that they will be looking at the ICD9 codes and the CPT4 codes and the billing. We will do a comparison of what the average cost per visit and than as Dr. Nobo suggested we should strongly consider doing utilization review. Because some physicians maybe performing test that may not be needed or maybe not enough tests. Reporting to you monthly and doing these key statistical reports as he had suggested, looking at the ICD9 codes and comparing that to the number of visits you are going to be able to see what these patients are costing and a lot more accurately going forward.

T. Mosley: Asked if there is a way for the committee to really know what the cost is in these different FPL's 100%, 4,900 patients can we know exactly what that number and what those patients cost us.

M. Kushner: We can just not today.

N. Thompson: Stated that we are using best available information right now on a different population, the more important thing to me is that we will have better available information as we go forward thanks to the new system.

M. Herr: Stated he will go to the expertise of these committee members the reports that we are talking about, (he listed all of the reports) he asked Tonja if those are the reports based on your expertise that you think that you need to see? He asked all of the committee members those same questions.

N. Thompson: We will need to provide feed back to the staff if there are other reports that we the committee members would find helpful in making decision as we go forward.

Steve Henderson: Asked about the counting of the 19,000 and the 3,000 are they counted the same? Attributes are they the same?

M. Kushner: Are we talking about unduplicated enrollment, yes

N. Thompson: Stated that the attributes are different the 3,000 are poorer than the 19,000 in general is that what you are asking.

S. Henderson: Stated that one of the impression that he had was anyone who entered the Plan in a given year was counted as a number and that number increased throughout the year to potentially having 19,000 people served within a given year verses having 19,000 active at a given time.

L. Thomas: The active at anytime is somewhere between 12 and 13 thousand so you are comparing that number to the 3,000.

S. Henderson: So that would mean that this time next year under some of these assumptions instead of having a head count of active participates of the 12,000 range we would have a head count per member per month of somewhere around 3,000.

L. Thomas: That is what we are estimating at this point it could be more or less that is what we will have to judge as we go through.

S. Henderson: It is great to have so many of the doctors participating, but the concern is it relates to the fee schedule just as Dr. Nobo stated if there is anyway that we could off set the fees that are calculated with a member co-pay and preserve the Medicare reimbursement, if you don't have a provider in the Plan you just don't have a Plan. You will always have sick people whether it is 3,000, 12,000 or 19,000 I think that it is critical that we preserve the relationship with the medical community to the best of our ability.

L. Thomas: the information that she has shows the co-pays currently $1, 2 or 10.00 we will certainly be willing to take a suggestion from the COC of as a group you can vote to change that.

N. Thompson: We are going to look at each of the recommendations individually once we get done with some general comments.

B. Hinton: In terms of the 3,000 number we have 3 thousand enrollees today and they all get a job, are we capping at 3,000.

L. Thomas: We have to get it down to the 3,000 that is our current estimates.

N. Thompson: Is it 3,000 at any given time or is it the 3,000 total for the whole year and if they all fall off will we have zero?

L. Thomas: Right now the estimate is based on a 3,000 for the year, hopefully that will change from month to month as we get a better grip on what they are costing us. We did 3,000 we are estimating it is about $3,500 per member so that is how we come up with the estimate, so yes that is how we come up with the 3,000 for the year. I hope that will increase but I can't tell you that today.

B. Hinton: stated that he would like to thank Lea Ann and Mike Herr and we all have to share in the responsibility (Inaudible) He asked Mike Herr about one of the question that you asked the committee to support you in terms of establishing a reserve and I do understand that next year we will have to make some significant cuts because we are in the hole and we have to pay back the debt. The hope is in the future and how big of a reserve where you thinking and have you come to that number yet, if that is reasonable number and we can support that and we could see some future out of this thing maybe a year or two down the road.

M. Herr: the 2009/2010 budget, we are not in a position today to say what is the amount that we should have in reserve, I don't want to give that figure today, we must get guidance from this committee, and we need to make a recommendation as well.

J. McArthur: We must all remember that this is a budget and this is an estimate it can go up or down, we must be concerned with that the bottom line must be within our budget.

Misilene Fulse: She thanked everyone for the figures and the information. In regard to the prescription prices as a pharmacist in the community she did see Caremark regulating the over utilization of different brands. The physicians in the community when they do stick to the formulary that has been presented by Polk HealthCare Plan, and then they do order the lesser expensive drugs and generic that won't make this budget be as high as the 9 million mark. A utilization review is definitely in order because I think there are some prescription products that we do need to limit and there are some people that are abusing the system as well as over utilization of the hospital, over utilization of the physicians, over utilization of the drugs. I would hope that none of the position that we are eliminating could be used in that manner.

M. Kushner: We are keeping all of the nurses in the Plan, as employees and they are the gate keeper that was the rational behind that decision. What is missing is part time medical director, it is very often that there are medical authorizations that are made that are close calls and nurses look for guidance from a physician, so a physician can talk to another physician to decide if the care is appropriate or not. That is one of the areas that he will be working on. The consultant from Buck has looked at the formulary and has been speaking with Caremark there will be recommended changes to the formulary; there is a lot of name brands that don't need to be there. The clinical pharmacist is from Buck Consultants.

M. Fulse: are they from Polk County?

M. Kushner: No

M. Fulse: I think that is the issue that the doctors have, we have people in this area who have a better grip on what is going on within our area. I think that is what Dr. Nobo is recommending that it needs to be someone from our area, so they can deal with the chronic illnesses that we have to deal with here in Polk County.

M. Kushner: Explained about Caremark and the pricing, etc., that contract may need to be renegotiated.

Dr. Nobo: you need to have the pharmacist and physicians that are seeing these patients not someone from a national group, it is for free why there is a reluctance not to have a group a pharmacist and physicians look at it.

M. Herr: There is no reluctance in the least bit keep in mind this is the first time that this part of the team has heard your recommendations, maybe you have been echoing those and that is fine, we are not reluctant on anything we are here to listen today.

S. Campbell Domineck: She asked Lea Ann questions from the power point. I am excited about the reports that we will be receiving but we must understand the reports that we get. She asked about the actual enrollment.

L. Thomas: made the explanation.

S. Campbell Domineck: Do we have a time line when the new reports will be implemented.

L. Thomas: Starting next month which ever ones are available

S. Campbell Domineck: is it possible of a training session on all of those reports so we can understand what we are looking at and be able to ask the appropriate question before we come before the public to have a meeting.

M. Kushner: I would be glad to meet with you individually or the committee as a whole on that.

N. Thompson: I would suggest that we do it as a whole this way the community also can hear what the reports are as we go forward.

L. Thomas: How about we do that at the next meeting? We will have a report on the budget but we will not know a lot of difference at that point, may be a good opportunity to walk through the different reports.

S. Campbell Domineck: Asked Dr. Nobo if they reduce to 80% of the Medicare that specialist will pull out is that a collective decision since you represent that group and we are sure that is going to happen so that we need to be thinking about what decision we make today or has that not come forth and that is just speculation?

Dr. Nobo: No, I have not written an e-mail to every Specialist but those Specialists that I have spoken to at different venues knowing that this would happen everyone of them said they would drop out. This is probably about 20 doctors not one said they would stay. The patients do not show and time is money.

Ginger McNally: We will get a report that will break down the age of those 3,000 people that are being served and the cost of the services rendered to each member?

L. Thomas: Age

G. McNally: Demographics this percentage are children this percentage are senior citizens?

M. Kushner: Associated with each of those age categories yes.

J. McArthur: He stated that there are 231 people terminating on the Plan will those people be referred to Central Florida HealthCare FQHC if so; will that present a problem for them?

L. Thomas: We will refer them to where ever we can get them service; she stated she couldn't answer for them. Gaye Williams stated that she will see everyone who presents.

Dr. Nobo: stated that they have a sliding scale, so if they are 150% FPL what would the sliding scale be?

Dr. Morsch: Chief Clinical Officer, Central Florida HealthCare (CFHC): stated it would be between 17 & 30% of usual and customary fees.

Gaye Williams: This would be collected if they have it.

Dr. Nobo: What would it be if it was 125%?

Dr. Morsch: Stated that he did not have every statistic memorized

Dr. Nobo: He stated that he is going to recommend that the co-pay be increased and he just wanted to know what CFHC was charging to be competitive or even less. This is important for us to have an idea.

N. Thompson: That is a standard sliding fee based on Federal Poverty Guidelines and that is given to you by the Feds.

Dr. Morsch: That is correct; as a provider of care almost exclusively with the poor or uninsured is if the suggestion is to ask the patient to absorb a 20% co-pay of usual and customary Medicare fees; these are folks that currently pay 1, 2 or 5 dollars a visit will be paying 20% of usual and customary Medicare fees which would be 30 or 40 dollars a visit, is that correct?

Dr. Nobo: No, most Medicaid fees which the average would be 214.

Dr. Morsch: It is Medicare; I believe that is the recommendation.

Dr. Nobo: Medicare is 52 dollars so 20% of 52 dollars I guess is 10 dollars and some cents.

G. Williams: Stated that later in the day they would provide the fees for their sliding fee scale.

N. Thompson: Stated that all of these things have been brought before us and now we are going to go through them, in logical order on each of these items there are a few folks that would like to speak from the audience for Public Comment. She set a few ground rules, etc.

Proposed Reduction Plan Benefits and Services

- Maximum of 3,000 enrollees
- Cap Eligibility at 100% of the FPL
- Reduce Physician's Reimbursement to 80% of Medicare
- Reduce Hospital's Inpatient Maximum Allowable to six days per admission
- Eliminate dental services
- Eliminate eyeglasses

- Eliminate Community Outreach Grant Funding
- Other plan benefit design changes will continue to be explored

The first items will be discussed as a group: Maximum of 3,000 enrollees and cap eligibility at 100% of the FPL.

N. Thompson: Asked if she had a motion?

S. Campbell-Domineck: Move to approve.

Dr. Nobo: Second, these numbers are not written in stone as the Plan gets more money and becomes more viable these numbers will be entertained.

N. Thompson: This is a temporary and emergency measure that we would be implementing until further notice.

S. Campbell-Domineck: 3,000 enrollees that is for the total year?

N. Thompson: Yes that is what we have been told by Lea Ann, if that changes we will know that as the year goes on.

Discussion ensued.

Ron Clark, Co-Chair of P.E.A.C.E.: Stated how the P.E.A.C.E. organization played a very big part in getting the sales tax passed. He stated that there is a concern about the number of patients seen in the past and now we will be seeing the same number of patients going back to the beginning number again and that is a grave misuse of these funds. What will we do to make our citizens healthier? We need better answers, what are we going to do pro-actively primary care verses specialty healthcare.

M. Herr: Stated that first thing that will be done differently is that we will providing this committee and all of the stake holders who attend the monthly meetings and stay engaged with the issues you will have a set of reports that will help us to gauge the performance of the Plan. Secondly; he stated that he was extremely disappointed to have to report today that we are regressing that we have to regress back to the numbers that we had started with at the time that the sales tax was considered by the voters and approved. But the reality is we are and we have to march forward and we have to do things right whether we are serving 19 thousand people or we are serving 3 thousand people. Our commitment, this board's commitment and The Board of County Commissioners commitment to spend dollars with respect to the primary care is still there, we haven't walk away from that the commitment is in the proposed budget with respect to the Central Florida HealthCare and the Lakeland Primary Care Clinic as well as the Winter Haven Clinic. We do not have the money to establish 5 clinics in the County right now. We are marching forward with 2 and that commitment to provide serve is still there.

N. Thompson: Any other discussion; it is grievous that we are in this position but I think the 16 to 18 thousand people who got services in the mean time won't feel that way.

Ron Martin – Public Comment: Stated his views, he was sad at the fact that the Plan is at this point. Was there any thought that sales tax would drop at any point during this Plan; we know economies go up and economies go down?

N. Thompson: We budgeted using the best available information based on sales tax revenue projections that are generally provided to you by the State. If you follow the State projections they have missed every time they try to make such projection. When the reality started to hit no one expected it to go as bad as it did.

Ron Martin – Public Comment: continued to explain his concerns.

Mike Herr: Stated did he think it was all because of the down turn in the economy, the Plan has some tremendous benefits to it, because you are dealing with the sickest of the sick. We over extended ourselves we had too many people enrolled for the Plan than what we could pay for that is the bottom line. The reporting system that we are proposing to this Committee is going to help us curtail that it is not solely the down turn in the economy, we over extended ourselves. The claims we under estimated what it was going to take to review those claims, process those claims, the other thing that really hurt us was the lag claims and not making those accurate projections.

Cedric Lewis – 1st Chapel – AME Church; also Attorney in the County: stated about the preparation to vote on a reduction number, some of the proposed reports that will be forth coming it seems that the information on those reports will have a huge baring on whether or not you can reduce the number of enrollees, whether you can cap the eligibility at 100%. You don't have a handle on who you are serving, what those needs are. Dr. Nobo made a point when he analyzed the number of days in the hospital. You are really not above that number anyway. You don't have sufficient information to know what impact you will have by reducing the number to 3,000. If the sickest people are the people you are trying to serve, if that number is above 3,000 what happens to those that are left in the gap.

Mr. Herr: He stated to that we should not take our eye off the target; it is about not being able to serve those folks that really need the help the most. But the bottom line is you have a deficiency of 15 million dollars and that is why you can't serve the same number that we tried to. We over extended ourselves so the 15 million dollar loan has to be paid back that is why you are in the whole, that is why you can only serve 3,000 people.

B. Hinton: The alternative if we don't pay it back it won't get paid to start with.

Mr. Herr: you don't have an option of not paying it back; you don't have the money to continue.

Dr. Nobo: If we see that these 3,000 again are not going to the hospital are not spending any money can we come back in a few months and revisit or expending or picking up 50 more patients or 100 patients.

Mr. Herr: We will do that.

M. Kushner: Stated that we did run a report based on what was received from the actuary on the average per member per month costs. We do know what those cost are right now. They are high and they have trended high sometimes with a 20% trend because these people are very sick. Until we see that Per Member Per Month cost come down, by controlling that cost you can serve more members in the long run.

Pastor Walter Laidler, Jr.- Christ Community Christian Center in Lakeland: When the hospital closed that was a concern to all of us, than the sales tax. We have a concern for specialty care and the abusive use of tax dollars to cover Specialty care at such a high rate. Given the 125 thousand people that are under insured or not insured at all and given the 3,000 people; if you are going to take this money we need to put it to better

use that to spend than much money on 3 to 5 thousand people, it is unconscious-able; it is a waste of stewardship and it is not in the best interest of the commonwealth of our County.

N. Thompson: **We have a motion and a second to: Maximum of 3,000 enrollee and Cap Eligibility at 100% of the FPL;** all those in favor say AYE: (all said AYE)

Motion Carries.

N. Thompson: the next bullet is: Reduce Physician's Reimbursement to 80% of Medicare Rate; we already had a good amount of discussion on this particular issue, if there is anyone to speak from the audience on this particular issue please come to the podium. That is a recommendation do I have a motion and a second for further discussion.

B. Hinton: Move to approve the recommendation to change the physician reimbursement to 80% of the Medicare Rate.

S. Campbell-Domineck: Second

Dr. Nobo: stated that it is access of care the American Medical Association and The Florida Medical Association are extremely concerned with access of care, I think this will reduce access to care tremendously. He continued on his thoughts about the amount of money that could be saved! He stated he thinks that this will just increase the use of the ER. He felt that if the co-pay is increased to a higher number and this may be a two part discussion: increase the co-pay that the patients will pay and take the amount of the co-pay off what you are paying the physicians. In reality even if you keep it at the 100% of Medicare; when you increase the co-pay by 5 or 10 percent; that is why I wanted the figures from the sliding scale that the clinics do. That will reduce the payment that you give to about 90 to 95%. He stated what about the co-pay for the ER visits. Increase the $50.00 co-pay that no one ever pays; make it $25.00 co-pay and inform the patient that there will only be so many times that they can not pay the ER bill and when they reached that level the will be dropped from the Plan. These are some more ideas that save money. He gave his explanation on what a Specialist is. He offered again a Utilization Review committee to be formed free of charge. He stated he is speaking against the 80% and he wants it to still remain at the 100%, increase the co-pay and deduct that from the physician.

S. Campbell-Domineck: Asked if this would be a temporary measure when we are talking about the 80% reduction?

L. Thomas: Stated yes

S. Campbell-Domineck: Asked if Dr. Nobo represents the collective voice of the Specialist but if they do fall off and we only have 3,000 patients do you think we will be ok to get the Plan back in order and than bring this back for discussion?

N. Thompson: Dr. Nobo is suggesting that the doctors fees be left at the 100% and than the next motion would be to substitute a higher co-pay from the Plan members to make up the difference.

Dr. Nobo: deduct this from the physicians so in reality you are dropping the Medicare to between 90 and 95%.

S. Campbell-Domineck: But there was a number connected to that to get to the balanced budget is that correct?

L. Thomas: Yes

S. Campbell-Domineck: So it is really not a saving based on your recommendation but it is a saving in the sense of saving the Specialist/doctors in the Plan. The recommendation that you (Dr. Nobo) is giving is not going to cover the amount that they are saying or it is?

Dr. Nobo: He stated that it will cover it may not reduce it all of it. He explained the procedure it takes to get a doctor credentialed. He explained that if you do $5 co-pay on a 214 level that is $52.00 that is almost 10%. What you are paying the doctor out of your pocket will be 90%. We are talking about $750 thousand dollars we are not talking about millions. He told the committee that the clients from this Plan do not show up a lot and that would be 5 slots that you have missed and that is very expensive to maintain them.

Misilene Fulse: Blue Cross, Cigna these people what is the physician reimbursement rate there is it as high as Medicare Rate, because I know a lot of my billings, they may bill $100 and my Plan will only pay $30. Where are we in line with other third party payers if we do reduce it to the 80% of the Medicare Rate? Are we in line?

M. Kushner: Generally in the commercial market the physician reimbursement is higher than Medicare could be 110% to 120% and for Specialist even more, that depends on the Specialist and the contract. However; when you consider the physicians that take Medicare; Medicare pays 80% the member has to pay a Medicare supplement or enroll in some type of Medicare Advantage Plan in order to get those costs paid. So when you are talking an indigent healthcare plan 80% of Medicare is what Medicare pays.

Dr. Nobo: Medicare pays 80% and the patient is responsible for the rest that is correct. You have to realize that this Plan we can not go back to the patient and charge the 20%, because when you participate that is not what you can do. I would like Susan to come over here; and it is very difficult for a physician to discuss what they get from insurance companies, it is illegal. He stated that he doesn't have any Plan that pays him less that 105% to 110% of Medicare and he has as high as 130% and 150% and I am not the only one. He asked Susan Earl who is the Executive Director of The Central Florida Physicians Alliance she can tell you that we have over 500 members and we will not talk to any insurance company unless they pay us 115% of Medicare.

Susan Earl – Executive Director, The Central Florida Physicians Alliance; from the physicians contract perspective, what Dr. Nobo said is absolutely correct. We have Specialist in our community getting 150 to 160% of Medicare. So those are rates that are extremely difficult to be competitive with so the insurance companies will do special models. Which I would really encourage this group to look at; for example there is a Medicare product, there are several, that actually pay a very high per member per month premium to the primary care specialists to see the more difficult and sicker patients. She explained how this works.

N. Thompson: Stated that going forward we would like to hear more about that but the question at hand there are no private party pays that pay less than the Medicare Rate. That the doctors don't have those kinds of plans nor do insurance companies.

B. Hinton: He stated (inaudible) in Hillsborough County their model was 80% of Medicare and we tried to do a little better than that, but it is obvious we can't continue that now. Do we know if that number had a co-pay?

N. Thompson: We have a motion and a second on the floor; they did the roll call vote on this: **The motion is to go to reduce physician reimbursement 80% of Medicare**

T. Mosley: **AYE**, S. Henderson: NAY (must reconsider this with additional data that has been requested earlier), B. Hinton: **AYE**; Dr. Nobo: NAY (He wants access to care, I want the chance to vote this down and bring back a motion to save the large number of physicians we have on the Plan), N. Thompson: NAY, J. McArthur: **AYE**, M. Fulse: **AYE** (with the intent that if the finances increase that we will increase it and hopefully we will keep our physicians with that hope), A. Gordon: **AYE**, S. Campbell-Domineck: **AYE**, G. McNally: NAY

N. Thompson: **6 AYES and 4 NAYS Motion Carries.**

N. Thompson: next item up for discussion is Reduce Hospital's Inpatient Maximum Allowable to six days per admission; we saw the saving that we would have. Any further questions on this issue, the average hospital stay is only 3.8 days, the impact would be fairly minimal.

B. Hinton: Made a motion to **Reduce Hospital's Inpatient Maximum Allowable to six days per admission** in accordance with the recommendation.

G. McNally: Second

N. Thompson: Further discussion

Dr. Nobo: I don't think that will give the savings I think would you give the savings is decrease back to the $600.00, going from $900.00 to the $600.00 that is what will really do the savings.

N. Thompson: Stated all those in favor of the above state motion:

T. Mosley: **AYE**, S. Henderson: NAY (I would be willing to readdress this with the data requested by Dr. Nobo), B. Hinton: **AYE**, Dr. Nobo: NAY, N. Thompson: **AYE**, J. McArthur: **AYE**, M. Fulse: **AYE**, A. Gordon: **AYE**, S. Campbell-Domineck: NAY, G. McNally: **AYE**

N. Thompson: **7 AYES and 3 NAYS**

Motion Carries.

N. Thompson: Eliminate dental services and eliminate eyeglasses these will be addressed together. Entertain a motion.

J. McArthur: **Motion**

T. Mosley: **Second**

N. Thompson: the motion is to eliminate dental services and eliminate eyeglasses coverage: further discussion.

Dr. Nobo: Asked who much money is being saved by eliminating dental? A lot of diseases are related to poor dental care. $120,000 on dental

Steve Yaskal: we only have one contract to pay for Dental and that is with Central Florida Healthcare, most of this is very insignificant. Most of the dental care is provided through the Polk County volunteer network $120,000 that we are paying to Lakeland Volunteers In Medicine was money so they could have a dentist and an assistant to triage the patients and then send them to the volunteer dentists.

Dr. Nobo: So there will still some dental in the County?

S. Yaskal: I hope so if the network continues.

N. Thompson: Cost of the savings for eye glasses

S. Yaskal: About $25,000 this is the cost of the past few months that doesn't include the doctors.

N. Thompson: Roughly 100 thousand the total saving between these 2 would be about 300 thousand. Are there any other comments or questions?

Bobby Yates – Lakeland Volunteers In Medicine (LVIM): The dental savings is the contract that you have with LVIM; that does pay for a dentist and a dental assistant they do see patients. The real impact for that would be the volunteer dentist they can see patients in their offices or come to LVIM. These patients get a patient treatment plan, there is continuity of care.

N. Thompson: Thank you for your service and we will revisit when our financial situation is rectified, comments or questions, hearing none all those in favor of the motion say AYE.

Eliminate dental services and Eliminate eyeglasses:

Motion Carries: (2 NAYS one was Dr. Nobo and one other member inaudible)

N. Thompson: Next item on the list is Eliminate Community Outreach Grant Funding;

S. Campbell-Domineck: Motion

B. Hinton: Second

N. Thompson: This is listed in your packet as well that would be a $400,000 savings; they asked for the detail that makes up the Outreach Grants.

Dr. Lynn Saddler; Polk County Health Department: 2 of the programs that make up the 400 thousand where their programs: The Teen Pregnancy Prevention and Diabetic Education Program.

L. Thomas: Put a slide up showing the different programs.

N. Thompson: All of the ones expiring would not be renewed and we will notice all of the others that they would be canceled. The recommendation is that all would be non-renewed with the October 1st budget.

L. Thomas: Stated that we did budget for the Haley Center because they did see patients and Med-Net.

M. Kushner: We advised to keep that one because it provides alternative prescription benefit services and it is funded through the Lip Grant.

L. Thomas: We did talk to Dr. Haight and we will be terminating The Teen Pregnancy now, but the others are through there termination dates. She continued to explain that process.

T. Mosley: Does the 400 thousand take it through the ending date and not some other date is that how we came up with the 400 thousand.

S. Yaskal: Explained about the 400 thousand and how it relates to the budget.

The members continued to discuss the Outreach Grants and what they are voting for.

N. Thompson: Gave an explanation on the net savings. Are any of these programs that we would no longer be funding was our money used as a match to bring in more money?

L. Skidmore: The LIP Grant with the Health Department and Central Florida HealthCare and Mental Health Grant those matching dollars are staying in the budget.

N. Thompson: **Motion: Eliminate Community Outreach Grant Funding which is an estimated savings of $400,000 all those in favor of that say AYE. Unanimously agreed; Dr. Nobo abstained.**

S. Campbell-Domineck: She asked if we can abstain for any reason or can we only abstain because there is a conflict?

N. Thompson: Technically according to Florida Statute you can only abstain if you have a conflict.

Dr. Nobo: Well let's see.

N. Thompson: Are you on any of the boards that we just voted on?

Dr. Nobo: No, so than I will vote no.

AYES: 9 NAYS: 1

MOTION CARRIES

Dr. Nobo: Stated that he would like to bring a motion; he stated that it took a long time to get the amount of physicians to participate in this Plan and I do not want to see that end. I am confused as the Hospital believing that this would work, because what will happen is these people will go to the ER repeatedly, because you will not have the Specialty care and their the ones that are going to hurt the patients the most. The ER's will be over crowded again as they have been. It is not a good process and I am surprise that why the hospitals don't agree going down to 80% is correct.

T. Mosley: Stated that she wanted to make a comment; all of the changes that we are making are going to impact the hospitals; we moving down to 3 thousand members in this Plan, so everything that we are doing will affect; I can't just say ok keep the doctors at 100% when we just approved to move the membership down that is going to impact us more than the 80%.

Dr. Nobo: We decreased the numbers down, but we don't want to make it even harder, what good is it to decrease it to one patient if they don't have a doctor to be seen. That is what you have to consider; you have to consider access to care, not the numbers that you are going to be accessing if you don't have access to care. In fact you spoke to five physicians and they all told you they would drop the Plan (someone stated that they would stay in the Plan – inaudible) the other issue is he had spoken to the patients that are in this Plan and they are willing to pay more of a co-pay and they want to continue the access. So saying that I would like to move the increase (but we just voted) so I would have vote to increase (right) to 90% of Medicare in fact 95% would be better. I just want to keep as many physicians as possible, that is what I would like to move and when that is passed hopefully I will bring a second motion and that is to increase the co-pay and deduct that from the physicians 90% of Medicare which I think will decrease tremendously the impact but still hopefully leave most of the physician in there and that is what I would like to do.

N. Thompson: I have a motion

S. Henderson: second for discussion purposes.

N. Thompson: The motion is to reduce the Doctor/Physician Reimbursement rate to 90% of Medicare Rate.

Dr. Nobo: We voted to make it 80% so it would be to increase it to 90%.

N. Thompson: Increasing it to 90%, a yes vote on this overrides the vote that we made shortly a little while ago. He does plan to make another motion to increase the co-pay too.

Dr. Nobo: State that therefore; it would even be less than the 90%.

J. McArthur: It seems to me that to bring a motion to reconsider a vote you have be on the side that prevailed and you were not on the side that prevailed, you voted against that.

Dr. Nobo: Well than have we used the rules that you are using always or are we just going to use this for this case.

J. McArthur: I have never seen this come up before this committee before.

Dr. Nobo: We have voted on different issues we have voted one day down and another day up and we can go back and table this until we can do an investigation on whether we have ever used this or not.

S. Campbell-Domineck: Why don't we just have the discussion and vote again.

N. Thompson: we are using the more informal version and I have never had a similar situation.

B. Hinton: The concern is the percentages are based on trying to match other programs and to bring the total dollars into play. His concern is towards the physicians maintaining (inaudible)

Dr. Nobo: No my concern is the access to care.

B. Hinton: I understand that but you are basically getting there by them being paid the difference between 80 and (inaudible). What might make a motion make more sense would be to authorize the physicians to collect co-pay that might make up the difference. The 80% comes out of the Plan, if we don't we will have to take more people off the Plan or cut other services.

Dr. Nobo: You are going to say that the physicians can collect 20% of what their bill is like a sliding scale like the clinics do.

N. Thompson: Up to 20% of the Medicare rate.

B. Hinton: That gives them the flexibility if that is something that is important to them staying in the Plan. I think that our thing is got to be over the dollars that this Plan is costing and trying to bring it into par right now. That number is 80% will works we can see 3,000 patients, if we go to 90% that 10% increment might mean we have to knock 500 patients off the Plan. That is part of what we have to consider. If we stay at the 80% and allow the physicians to collect a co-pay up to $25.00 at their choice; I don't know what the right number would be but the idea is to try to make up what you are trying to do without putting the Plan in harms way.

Dr. Nobo: Lea Ann how did you get to the 80%?

L. Thomas: (Inaudible)

M. Duclos: That because the state insurance laws we won't want doctors to be reviewed and than end up in trouble because they charged me more than you as a co-payment or a varied co-payment. All of these things are all in place in the State Insurance Law, we can't vary it.

N. Thompson: We would have to specify what they were allowed to charge.

M. Duclos: Than we would have to make it a requirement.

N. Thompson: What I keep hearing is that it is a requirement now and some pay and some don't and doctors continue to see the patients on paper it sounds good but in reality it is at some extent up to individual physicians.

Dr. Nobo: So Lea Ann how did you get to the 80%?

L. Thomas: We had the actuary look at the claim data we had for the last year and from that we could extrapolate what the cost was at 100% of Medicare based on the claims and that is how we backed it down to the 80% number and that is something that we could afford. The co-pay now for office visits is just one dollar.

Dr. Nobo: So your 80% was not looking at other Plans and it was not looking at

L. Thomas: Based on our actual numbers for the last year.

Dr. Nobo: So not looking at other Plans, I don't have a problem with what Hinton said; there is one confusion here and that is I do not think that going to 90% would affect the number of patients you are going to see; I think the numbers will stay the same. Brian stated to keep it at the 80% but increase the co-pay to about $20.00 or $15.00 so the Plan, but at least we will keep the physicians in.

N. Thompson: You made a motion that was seconded and Brian has proposed an amendment and I am hearing you say that this is acceptable to you.

Dr. Nobo: He stated that he would make a friendly amendment; I want a little more discussion on that.

N. Thompson: Who seconded the motion for discussion, Steve so he has to agree to your friendly amendment?

S. Henderson: Agreed

Dr. Nobo: The motion is: 80% of Medicare we will make a flat co-pay of $20.00, surgery would be included as a $20.00, it is a compromise it will not do that much of a saving; I still think that 90% of Medicare with a 10% would be better. I want to hear more from the committee to see if they what their thoughts are on the 80% plus a $20.00 co-pay.

N. Thompson: Our co-pay structure specifies office visits so I don't think it will apply to the surgical. So we have a friendly amended motion to maintain the doctor's rate of reimbursement at 80% of Medicare maintained by the vote we just took a little bit ago but to increase the co-pay per office visit from $1.00 to $20.00 for Specialty Care.

Dr. Nobo: Per office visit.

N. Thompson: It would be $20.00 across the board per office visit.

Dr. Nobo: I am going by the scale that was mentioned before any where from $17.00 to $30.00 of that visit, if the visit is one hundred dollars 30% would be $30.00 or.

Dr. Morsch: (Inaudible did not come to the microphone)

N. Thompson: Any comments or questions

S. Campbell-Domineck: It is a little convoluted; whether we are talking about office or surgery, we are sticking with the original vote of 80%, and could we not just make a motion to add an additional proposed benefit of raising the co-pay; could that be separate or are we talking about office and surgery and specialty care. It is a little confusing here.

N. Thompson: Our current co-pay structure applies to office visits. Regardless of type of care.

M. Herr: So right now; just to clarify we are talking about increasing the co-pay from one dollar to twenty dollars for an office visit, whether it is primary care or specialty.

N. Thompson: That is my understanding yes.

M. Herr: Is that what we are saying?

N. Thompson: Yes, which basically allows the physician the opportunity to collect up to twenty dollars; if they can collect that will help them to off set the reduction in the Medicare reimbursement rate.

Dr. Nobo: We need to talk, I am not sure there is going to be that much saving again going from what I just; or previously going from the 90 plus deducting the fee, increase to the five, because twenty dollars is twenty dollars. I am afraid that some of those primary care physicians; $52.00 visit 213 they pay 80% it would be $32.00 so the $20.00 would make up the $52.00. So in that aspect it hits right on nose. That would not be a problem and the Specialists of course they will take the referrals from the Primary Care physicians so hopefully, you will not lose any of the big numbers, you may still lose some but the question is are we putting a lot of responsibility on the patients that we want to take care of. That is why I want to debate this a little longer; he wants to continue the access. You have to understand we went from 69 or 89 doctors to over 500 doctors. Would 90% plus deducting what the patient pays and make it a much less co-pay; 5 or $10.00 which maybe more reasonable for this population; would that break the Plan? I want to hear your comments.

M. Herr: He requested that a break be taken; this will give them the opportunity to converse with staff rather than making a bullet decision in thirty seconds. Give us a moment to talk. The question you want us to look at if we reduce this physician reimbursement if we increase that to 90% what is going to be the fiscal impact and where do we make up that difference.

Dr. Nobo: Have a co-pay of $5.00 which it is acceptable and deducted that from the physicians so when you deduct on a 213 visit which is a frequent visit $5.00 from you pay that is 10%, so in reality you are going back to.

M. Herr: I think that; I don't think that increasing the co-pay is a bad idea, because what we are wanting to achieve financial stability for the Plan; yes that is true but I also think that people are saying day in and day out to us that rather than having everything free; if the enrollee is paying something and I am a tax payer my life has been a little bit better than somebody else who hasn't been quite as fortunate I still have a reasonable fee where that person is trying to help themselves and they are paying a little bit; I don't think that is unreasonable. The question is always going to go back to what should that be? If we are serving people in this Plan that are underinsured and unemployed; what is the magic mark is it $15.00, is it $10.00, but I think that you go through this; we set an amount and than we can track working with the doctors whether people are paying or not. If you set it at 20 and people are paying than you set it lower and people aren't paying that pretty much tells you.

N. Thompson: What ever the level is mentally it doesn't keep me from going to the doctor at all. There is a balance there and we have had some of those discussions in the past and I am perfectly willing to come up with it because I believe in the personal responsibility part of it as well. We just have to be careful where the number ends up being.

M. Herr: Stated he would not take it out of contingency to make up the difference.

N. Thompson: We understand that.

Ten minute break taken.

M. Herr: Stated that the fiscal impact if we increase the physicians reimbursement from 80% to 90% and establish a co-pay of $5.00.

L. Thomas: stated that is you go to 90% your saving would be about $350 thousand dollars, that much less of a saving for us. She explained about the saving verse what it would cost the Plan. I think that we could cover it, because of the saving from the Clinic and the Pharmacy. She did state that there would be a caveat that if we see a problem we will come back to you and say 80%. That is the answer so yes we can cover it at the 90%.

Dr. Nobo: It is only fair that if there is a problem we have always be open to suggestions from you. Dr. James Saunders who is the past president of the Polk County Medical Association he would like to say a few words.

Dr. James Saunders; Neurosurgeon, past President of The Polk County Medical Association, he is retired. He stated that he has always had a strong feeling to help our community with indigent care. He stated his feelings regarding the ½ cent sales tax. He stated that his fear is that if we reduce our base to such a point we are going to lose a number of these physicians that we have worked hard to build up to 4 to 500. He stated once we lose this base it might be very difficult to bring these people back on. That would be his concern about the 80%; if we could keep that reduction closer to the 90% he thought that there would be a better chance of preserving the number of these physicians. Bare in mind these people are not greedy they are just trying to maintain their practice. He explained that with We Care the physicians donate specialties of one million dollars a year to help. He urged to at least keep it at the 90%.

N. Thompson: From a protocol stand point I need to clarify. The last we left we had a motion and a second to have it at 90%.

T. Mosley: I thought it was 80% with $20.00 co-pay

Dr. Nobo: That was the original, was what you said; than we had a friendly amendment and the more I thought about the $20.00 that was really going to defeat my purpose, my purpose was to still keep access to care. Because a lot of people are not going to come up with 20%; I brought up the subject that may not work. We have to go back to his original motion which is the 90% followed by the second motion to increase the co-pay to the $5.00.

N. Thompson: Steve is it ok to go back to the original motion.

S. Henderson: Very happy to say yes.

Dr. Nobo: Doesn't this state require that we have Specialty Care for a continuation of care, to have this Plan be in effect; that if we lose the majority and we do not have a continuation of care that we may not have a Plan period.

M. Herr: Michael Duclos can answer that question.

M. Duclos: That would be correct; Dr. Nobo.

Dr. Nobo: So let's keep the Plan going.

N. Thompson: Further comment on this particular issue.

T. Mosley: Stated that she had a comment; we have the 500 physicians and we were given how the breakdown was; do we know how many we need in a particular specialty? If it heavy in one and not in another? How is it that we are saying that we are going to lose such a number; all of these numbers we are unsure of. If we are going to find some savings; why don't we reserve those savings to be able to serve more patients?

N. Thompson: her comment would be to know how many we need may be different because of the size of the County, maybe different from the volume. We spent a lot of time earlier on, looking at the map and where people were looking at access. She stated that she lives in Frostproof, access to here doesn't mean Polk City; that is a long way from my house. Keeping accessibility is important and secondly; I am very hopefully that a few years from now when we are able to serve a lot more patients that we will have the physicians there to do that.

Dr. Nobo: It is access to care so there is no point in getting rid of the physicians.

M. Herr: What the committee is now considering is that the staff recommendation was to reduce the physician's reimbursement to 80%, from 100% to 80% Medicare. So what we are doing is we are rescinding that vote in effect.

N. Thompson: Yes

M. Herr: Now we have a new motion on the table we had 2 considerations to keep it at 80% but increase the co-pay to $20.00, that wasn't affordable as far as the enrollee. Now we are talking about reducing the physicians reimbursement from 100% to 90% and a co-pay of $5.00.

Dr. Nobo: Correct

MOTION: reducing the physicians reimbursement from 100% to 90% and a co-pay of $5.00.

N. Thompson: That is the motion on the floor any further discussion, hearing none, we will do roll call.

T. Mosley: AYE, S. Henderson: AYE, B. Hinton: AYE, Dr. Nobo: AYE, N. Thompson: AYE, J. McArthur: AYE, M. Fulse: AYE, A. Gordon: AYE

Motion carries unanimously

N. Thompson: Motion carries unanimously; issue of business that needs to be done, there are still a few people who have asked to speak. Than we need to look at the forecast 2008/2009 which is basically the budget in the micro for next year. This would be a compilation of all the things that we have approved and any tweaks that we have made. We do need to take a vote on the overall budget because the budget that we approved a couple of meetings ago is not off the table and we have to have some consensus on budget to take to the Board of County Commissioners. There was a question raised about discontinuing Behavioral Services whether or not we were clear on the fact that the Mental Health and Behavioral Health Services contracts that end September 30th would under earlier action that we took would end; but those our outside services contracts even though they weren't outreach grants specifically. The concern was that they weren't

listed specifically that we saw. So I wanted to make sure that we were all clear on that and if there were any questions.

Dr. Nobo: Stated that he spoke to Wilma and she is willing to have that PT Committee like she was always willing to do. I think that we need to get it going it is free, so it will not affect the budget but it may cut even further the costs of pharmacy and increase the patient care since we do know our population better than someone out of state.

M. Herr: What does that acronym PT stands for?

Dr. Nobo: Pharmaceutical and therapeutics

M. Fulse: Pharmacy and Therapeutics

M. Herr: Ok, we plan to follow up and we will also be willing to meet with the appropriate physician entities to take a look at serving as a Medical Director or whatever.

Dr. Nobo: I had the chairman of the PT committee from Lakeland Regional Medical Center volunteer and that he would be more than happy and a couple other physicians and now we need to get some pharmacists and get them altogether.

M. Herr: We will work with Dr. Nobo and Ms. Fulse we will be glad to do that. Lea Ann Thomas and Mike Kushner will be the primary contacts we will follow up with you.

PUBLIC COMMENTS:

Linda McKinnon – CFBH Network; she thanked them for all the past help. She appreciated the vision that Polk County had. She stated that by cutting the behavioral benefit that primary care will rise.

N. Thompson: Brian has to leave for another meeting and Ginger had to leave as well.

Bob Rihn – Tri County Human Services: He spoke on the behavior health issue that was discussed.

Margaret Perry – Peace River Center: Spoke about being happy that behavioral health was included in the past; she gave her thoughts about the cuts.

Dr. Nobo: Commented that as a physician what all of the public comment speakers have said is 100% accurate. There will be an increase in patients going to the primary care physicians.

J. McArthur: Asked if the grants are they still in the budget?

N. Thompson: No they are not. When we voted earlier to cut outside agency funding they were among those that were cut. The last order of business that we need to take up unless Mr. Herr says otherwise, the forecast 2008/2009, this is an extreme macro it will be flush out in much more detail. We need a recommendation to take to the Board of County Commissioners on how we are going to pay back the money we owe and how are we going to spend the money we expect to get. We are recommending spending 8.2 million on the HealthCare Plan itself that would be on the 3 thousand people we will be able to support. 3.0 million in administration, 3.7 to other agencies. We have voted on those and based on staff recommendations primarily

limiting it to other agencies that provide primary care or excess to primary care with a total operating expense of 15 million. We will have to pay interest of 600 thousand on our debt and keep a contingency of 757 thousand which may or may not be the right number but we will keep tweaking that as we go forward. So our total budget for expense for next year would be 16 million 450 thousand. Comments or questions.

J. McArthur: He stated he sees not pay back of the 15 million that we have to borrow.

L. Thomas: that is found on the very top line. Beginning fund balance minus the 15 million that comes off the top that would leave you 16.4 million after we pay that back.

N. Thompson: How is the 15 million paid back is it a certain percentage of sales tax revenue every month as it comes in or is it revenue less expenses.

Mr. Herr: We are using reserves from the general fund and we are also using available cash from all funds.

N. Thompson: How will we be paying that back so much per month?

Mr. Herr: That is going to come in annually we are going to repay our fund back that is how it is going to happen.

L. Thomas: We only get about approximately 2.5 million in sales tax every month so.

N. Thompson: Basically the difference between 2.5 million and whatever we spend that month will go towards paying it back.

L. Thomas: when we projected it out over the course of the year by the end of the year we should be whole.

N. Thompson: but it will take all year?

L. Thomas: yes

T. Mosley: she asked about the details for the different line items we have a work sheet which gives us the different outside agencies adding up to 3.4 million but on this sheet other agencies 3.7; was something added afterwards. On page six which is the white papers.

L. Thomas: I see that now.

S. Campbell-Domineck: stated actually when you get down to that number you would reduce 75 thousand out of the 3.467 million; right to come from the Winter Haven Clinic.

L. Thomas: The overhead was from last week, she stated that she changes numbers this morning.

Dr. Nobo: Is that clinic going to built or are they going to rent space?

L. Thomas: They are going to build, hopefully we will come back to you with a contract to you next month and than according to Gaye if they can go ahead and start assuming the can start in October they hope the building will be complete and habitable in June.

Dr. Nobo: Does it cost more to build or does it cost, there are so many buildings available for rent.

L. Thomas: We are not building it.

Dr. Nobo: I know that.

L. Thomas: It is a build to lease.

Mr. Herr: Could we have Gaye Williams address that please.

Gaye Williams-Chief Executive Officer; Central Florida HealthCare: we are working with the owners of the property to get the building constructed, once we have the contract and the details will start to unfold for you next month or the following month.

Dr. Nobo: no my question was there is so much rental space in Winter Haven it is better to rent.

G. Williams: We have not explored rental space, we were trying to get as close to the hospital as possible. Their (CFHC) Board of Directors approved the location in Florence Villa as the ideal spot for the clinic. In that zip code area the uninsured runs about 20%.

Dr. Nobo: Since we all have to make changes; just a thought maybe you should look at some rental it may expedite you opening your clinic and may save you money since we are only giving you less and you never know what the budget is going to bring.

G. Williams; There would certainly be a budget adjustment should we find a location sooner. But that is up for further discussion, we would not rule any exploring of rental, Dr. Nobo.

N. Thompson: Asked if that was the correct number?

T. Mosley: We just don't have the details.

L. Thomas: stated that the HCRA's is not included in the other sheet and it should be.

N. Thompson: We have to have it we have to pay it, which kind of clears that up; the difference between the 3.4 and the 3.7 is the HCRA. Other comments or questions? Hearing none I will entertain a motion to accept the general budget as presented.

S. Henderson: So move.

N. Thompson: Steve made the motion; second?

J. McArthur: Second

N. Thompson: Further comments or questions, hearing no further discussion all of those in favor of the motion as presented say AYE, (everyone with the exception of Dr. Nobo stated AYE)

Dr. Nobo: NAY

Motion: passed to approve the 2008/2009 Budget

N. Thompson: Asked if there is any other business to come before the committee?

J. McArthur: Asked when someone comes in and talks to you about applying for admission to the Plan, they are checked to see if they are eligible for Medicaid, is there any follow up to that, 30, 60, 90 days later to see if they might be eligible now even though they were not in the beginning?

W. Daniels: Stated that they would only be given eligibility status for a short term based on their potential eligibility. If it is a man that came in and has no children, and not blind, disabled or over the age of 65 there is very little chance that they would get that. If they meet those other criteria depending children, blind, disabled over the age of 65 than we would give them a shorter term card so we could in fact follow up to see if they are eligible for that service.

J. McArthur: If that person turns out to have chronic condition does that mean they would than become eligible for Medicaid.

W. Daniels: Not necessarily, it depends what you consider a chronic condition such as: diabetes, hypertension no, even though they are chronic conditions, they must be disabled based on Social Security disabilities criteria. As a lawyer you know how stringent they can be. The case managers do follow up. She explained that procedure.

N. Thompson: Any other business to come before the committee?

Dr. Nobo: Is Geisler Clinic a member

N. Thompson: No they are not; thanked everyone; staff, thank you to our members we are adjourned.

Meeting Adjourned at 12:37:16 PM
Transcribed by: Debi Curry; Office Manager, IV
Community Health & Social Services Division