

# Polk HealthCare Plan

## Board of County Commissioners

### FY 2009/2010 Budget Meeting



*Neil Combee Bldg.  
Boardroom  
June 19, 2009*



*Presented by:  
Jan Howell, Polk HealthCare Plan*



# History and Context of the Plan

- The Polk County Indigent HealthCare Plan was approved by the Polk County Board of County Commissioners and became operational in 1999.
- In 2004, the voters approved funding this program by a ½ cent discretionary sales surtax.
- Due to the recent economic events, the health Plan's enrollment in 2008 was frozen and decreased significantly.
- As reserves of the ½ cent surtax accrue, new eligibility policy has been developed to define membership for Polk County citizens who are financially & medically vulnerable.
- A new Plan benefit design and two basic benefits packages are proposed and recommended to ensure the greatest number of deserving potential members are served.

# Organizational Mission

The Polk HealthCare Plan will provide the greatest quality of care for plan members based on industry standards for quality of care and cost efficacy.

The new Plan design demonstrates the crucial role of member choice in healthcare decision making.

The plan will transition to a member-centric philosophy, recognizing the crucial role of member choice in healthcare decision making and the importance of local provider collaboration & investment in member care.

This approach will encourage members to make changes in health behaviors & lead to improved health outcomes & lower cost.

The winning stakeholders include the members, providers, & taxpayers.

# A Vision of Value, Choices & Care

While the Plan transitions to a member-centric philosophy, simultaneously recognizing the vital significance of the provider community & the importance of provider investment in member care, it is ultimately not the taxpayer or the providers who can make the greatest strides in changing health status in our communities---- it is those members who are empowered to take ownership of their own healthcare decision making who will make the greatest strides in improving their health status.

# History & Success Stories: August – December 2008

- In August 2008, Risk Management Director Michael Kushner, who has over 20 years of experience in oversight of the Employee Health Plan, is assigned to oversee the Polk HealthCare Plan.
- Some additional limits of the eligibility classes and covered benefits are made to insure the fiscal solvency of the plan. Enrollment continues to be frozen and drops to coverage of 100% FPL only.
- In September 2008, Buck Consultants with ACS are utilized for their reporting and auditing services. Beg'g Oct. 1, 2008, monthly Buck reports are provided with actionable information detailing service utilization and plan expenditures.
- In the Fall 2008, the plan creates the Utilization Review Committee and Pharmacy & Therapeutics Committee to provide clinical expertise to the plan.

# January 2009 Success Stories

- At the end of December 2008, Jan Howell joined the organization, bringing a background in serving low-income populations.
- In early January, PHP developed a draft plan manual & plan design with accompanying benefits packages for a chronically ill & healthier uninsured population.
- At the January 2009 Citizens Oversight Committee, PHP provided a presentation to the COC outlining the vision for the health plan emphasizing member responsibility, provider collaboration, & community partnership.
- In January 2009, the COC accepted the eligibility criteria recommended by the plan with several revisions.
- Buck produced an annual review of Fiscal Year 2007/08 and provided the report to the Citizens Oversight Committee at the January 23, 2009 retreat.

# Successes: Communication/Operational Changes

- Vastly improved channels of communication from plan leadership to employees & accompanying improvement of employee morale
- Destruction of prior silo-driven mode of operation & development of cross-functional team atmosphere currently in operation
- Development of open communication channels to providers and members in obtaining feedback for plan policy development
  - Cross-functional teams have visited providers & members
- Active cultivation of community partners engaged in serving Polk County citizens from Polk HealthCare Plan leadership
  - Identification of mutually exclusive goals of PEACE, Polk Health Care Alliance, Polk Health Department, COC, the Polk HealthCare Plan

# Successes: Financial/Operational Changes

- Tight management of vendors & invoice processing
- Enforcement of requirement for reports from all vendors regarding performance
- Opportunities for recoupment of monies identified due to basic enforcement of policy to monitor programs
- Realignment of pharmacy duties
- Identification of next steps regarding utilization review & audits

# January COC Retreat Outcomes

- Citizens Oversight Committee Mission
  - “Promoting the health of Polk County by ensuring the integrity and quality of the healthcare plan”
- Citizens Oversight Committee Vision
  - “All Polk County residents have access to a medical home providing quality, affordable, preventive healthcare
    - Polk County leads the state in quality health indicators
    - Polk County has the highest quality and most accessible network of healthcare providers”

## February–April 2009: Essential Building Blocks

- In February, the COC approved the plan's recommendation to contract with a Medical Director & adopted the Member Contract for Care.
- In early April, the Board of County Commissioners approved the contract with Dr. Michael Yanuck, who has been providing expertise in plan policy design & oversight of medical management internal processes.
- In April, the COC approved the purchase of basic health plan software packages to standardize medical management decision making and to identify provider coding errors/issues.

# Vision: Value, Choices & Care

- Value:

- The new Plan design signifies a transformation in the health Plan's culture to a focus on value.
- Value = Quality of Care/Cost of Care
- This focus will provide the greatest value based on industry standards for quality of care and cost efficacy.

# Vision: Value, *Choices* & Care

- Choices:
  - Member choice has a crucial role in healthcare decision making.
  - The new Plan is designed to encourage members to make changes in health behaviors.
  - Ultimate Goal:
    - Engagement of Members + Changes in Member Behavior (based on active involvement) = Return on Value (improved health outcomes and lower cost)

# Membership/Exclusion Criteria

## ● PLAN MEMBERSHIP CRITERIA

- Individuals who are residents of Polk County.
- Individuals aged 19-64.
- Low-income individuals meeting Medicaid < or = 100% FPL.
- Individuals with Social Security card/proof of employment.
- In the future, individuals who sign the Member Contract for Care.

## ● PLAN EXCLUSION CRITERIA

- Individuals who are incarcerated.
- Individuals who relocate to another county, state, country.
- Plan members who do not demonstrate compliance with plan rules.
  - Movement to verifying eligibility on the front end

# Member Contract for Care

- Each member will be responsible for signing a Member Contract for Care
- Includes Member Rights of Care, Member Responsibilities, and Basic Eligibility Considerations
- Includes reference to elimination from plan membership
  - Fraud
  - Other Insurance

# Vision: Value, Choices & Care

- Care:

- The plan will actively engage the provider community in a dialogue to seek a collaborative approach to care for our members
- The plan will identify those providers who will invest their time & services to assist in building a safety net for those citizens in our community who are most vulnerable in terms of health status and those citizens eligible for the plan
- The plan will cultivate those providers who can support the provision of services at a rate characteristic of an indigent health plan

# Comparison/Contrast: Plan Design

<u><i>CURRENT SERVICE PROVISION</i></u>	<u><i>FUTURE PLAN DESIGN</i></u>
<b>Covered/Excluded Services</b>	<b>Covered/Excluded Services</b>
-Rich for indigent plan	-Based on Previous Services Provided -Difficult Balance due to Chronically Ill
<b>Member Copays</b>	<b>Member Copays</b>
<ul style="list-style-type: none"> <li>- \$5 copay for office visit</li> <li>- Copay amount could prohibit access to primary care</li> <li>- May prevent members from seeking needed care (more expensive later-ER)</li> <li>- Copay amount could be prohibitive for chronically ill</li> </ul>	<ul style="list-style-type: none"> <li>- General Rule - \$5 copay for office visit</li> <li>- Exception - \$1 copay for primary care office visit</li> <li>- Will encourage appropriate use of care in right setting</li> <li>- Exception - \$3 copay for chronic illnesses (office visit)</li> </ul>
<b>Service Limits</b>	<b>Service Limits</b>
-Costs skyrocketed in FY 2008 due to lack of service limits, which provide some control of utilization	<ul style="list-style-type: none"> <li>- Still generous; Mirrors usual insurance plan</li> <li>- Prevent fraud, waste &amp; abuse</li> <li>- Assists in ensuring quality of care</li> <li>- Assists with Return on Value</li> </ul>

# Benefits Packages

- Essential Care Choices (Basic)

- Very little medical management
- Focus on primary care for healthier population with some access to specialty care
- Prior authorizations may be necessary for specialty care for this benefits package
- May be realigned in Chronic Care Choices if necessary at a later date

- Chronic Care Choices (Chronic)

- Focus on medical management for this chronically ill population.
- Prior authorizations necessary.
- Prior authorizations provide a tool to identify the target population and their need for more focused medical case management of chronic conditions.
  - Diabetes, Asthma/COPD, CAD/CHF, Hypertension

# Communication Strategy

- Health plan associates are working to provide a seamless transition when the new plan design and benefits packages become effective
- A communication strategy will be rolled out to plan providers and members
- New Member Handbook
  - Plan Design/Packages
  - Member Contract for Care
  - Member Education by Video & Case Manager
- New Provider Manual
- Provider Contracting Strategy
  - Working with providers to ensure access, quality reviews, measurement of quality health indicators and health outcomes data, and timely contract renewals

# Essential Building Blocks of the Plan

**These will be reviewed at the end  
of the presentation in detail for approvals:**

- Automated Claims Processing System – MCO
- Medical Director
- Medical Management Criteria Software – Milliman Care Guidelines
- Claims Coding Software – McKesson ClaimCheck
- Creation of balanced plan benefits design/packages
- Development of comprehensive medical management strategy
- Efficiency in operations/management of resources

# Building Block: Actionable Information

- In the near future, PHP will possess greater reporting capabilities based on actionable information from the new claims processing system MCO (Managed Care Optimizer).
- As MCO is fully tested and implemented to pay claims processing, the Plan will continue to obtain provider and member input regarding new Plan policy.
- The majority of claims will not be processed automatically but will require an approval prior to service being rendered.
  - Physician community will receive notice of potential disapprovals prior to rendering service.
- With introduction of Milliman and ClaimCheck, decisions regarding service requests and claims payment will be standardized according to national industry standard.

# Building Block: Medical Director/Policy

## ✓ Medical Director

- ✓ Dr. Yanuck has provided many recommendations for development of plan benefits design, services, benefits packages
- ✓ Dr. Yanuck has assisted the plan in structuring medical management policy, utilization review, quality management, pharmacy and therapeutics review, etc.
- ✓ Dr. Yanuck has provided ideas regarding quality of care benchmarking and the Utilization Review Committee adopted national quality standards on May 20, 2009
- ✓ Dr. Yanuck's ideas will improve efficiency and ensure quality of care for Polk HealthCare Plan members



# **COVERED/EXCLUDED SERVICES**

Covered Services		Excluded Services
Allergy	Nephrology Services	Ambulance Services
Cardiology Services	Neurology Services	Allergy Testing or Injections
Cardiothoracic Surgery	Neurosurgery Services	AIDS Services
Dermatology Services	Nutritional Counseling Services by a Registered Dietitian (chronic conditions - as medically necessary)	Alternative Medicine Services
Diagnostic Services	Ophthalmology Services (Eye Disease and Injury) **	Behavioral Health Services
CT Scans	Optometry Services	Chemotherapy/Radiation; Drug Enhancers for Advanced Oncology Services
MRI	Orthopedic Services	Chiropractic Services
PET Scans	Pain Management Services	Dental & Orthodontia & TMJ Services
Ultrasound	Physical Therapy/Occupational Therapy/Speech Therapy	Dialysis Procedures
Durable Medical Equipment	Plastic Surgery (Non-Cosmetic Only)	Durable Medical Equipment/Supplies
Post Surgical Back Brace	Podiatry Services	* not covered except listed exceptions
Knee Immobilizer	Prescription Drugs	Hearing Services
Short Wrist Splint	Preventive Screening Services	Home Health Services
Air Cast Splint for Ankle	Pap Smear	Hospice Services
Cam Walker Boot	Mammogram Screen	Infertility Services
Ear, Nose, & Throat Services	Prostate Specific Antigen	Inpatient Rehabilitation Services
Endocrinology Services	Bone Density DexaScan	Non-emergent Services in Emergency Room Setting
Gastroenterology Services	Lipid Profile	Nutritional Services by a Registered Dietitian (routine care)
General/Vascular Surgery Services	Colorectal Cancer Screen	Obstetrics/Pregnancy Care
Gynecology Services	Primary Care Services	Ophthalmology/Optometry Services (Eyeglasses/Routine Eye Exams)
Hematology/Oncology Services	Pulmonology Services	Organ Transplants
Hospital Services	Radiology Services/X-rays	Plastic Surgery (Cosmetic)
Hospital Services - Inpatient	Rheumatology Services	Prosthetic Appliances
Hospital Services - Outpatient	Specialized Wound Care Services (Hospital)	Preventive Screening Services
Hospital Services - Emergency Room	Transportation Services	* not covered except listed exceptions
Infectious Disease Services	Urology Services	Skilled Nursing Facility Services
Laboratory Services		Weight Management Services (surgery and medication)



# **MEMBER COPAYS**

# General Rule: \$5 Copay - Physician Office Visits

Covered Services	Costsharing/Copays	
	ESSENTIAL CARE CHOICES	CHRONIC CARE CHOICES
Allergy Services	\$5.00 copay	\$5.00 copay
Dermatology Services	\$5.00 copay	\$5.00 copay
Ear, Nose, & Throat Services	\$5.00 copay	\$5.00 copay
Gastroenterology Services	\$5.00 copay	\$5.00 copay
General/Vascular Surgery Services	\$5.00 copay	\$5.00 copay
Gynecology Services	\$5.00 copay	\$5.00 copay
Neurology Services	\$5.00 copay	\$5.00 copay
Neurosurgery Services	\$5.00 copay	\$5.00 copay
Nutritional Counseling (Registered Dietitian)	\$5.00 copay	\$5.00 copay
Hematology/Oncology Services	\$5.00 copay	\$5.00 copay
Optometry Services	\$5.00 copay	\$5.00 copay
Orthopedic Services	\$5.00 copay	\$5.00 copay
Physical Therapy/ Occupational Therapy/ Speech Therapy	\$5.00 copay	\$5.00 copay
Plastic Surgery (Non-Cosmetic)	\$5.00 copay	\$5.00 copay
Podiatry Services	\$5.00 copay	\$5.00 copay
Rheumatology Services	\$5.00 copay	\$5.00 copay
Specialized Wound Care Services (Hospital)	\$5.00 copay	\$5.00 copay
Urology Services	\$5.00 copay	\$5.00 copay

# Copays: Primary Care, Prescription Drugs, Chronic Illness, Pain Management

Covered Services	Costsharing/Copays	
	ESSENTIAL CARE CHOICES	CHRONIC CARE CHOICES
Primary Care Services	\$1.00 copay	\$1.00 copay
Pain Management Services	\$10.00 copay	\$10.00 copay
Prescription Drugs	\$1.00 copay for generic \$5.00 copay for brand	\$0 copay for generic \$3.00 copay for brand
Transportation Services	\$1.00 one way for each in-network visit; \$1.50 one way for each out-of-network visit	\$1.00 one way for each in-network visit; \$1.50 one way for each out-of-network visit
Cardiology Services	\$5.00 copay	\$3.00 copay
Cardiothoracic Surgery	\$5.00 copay	\$3.00 copay
Endocrinology Services	\$5.00 copay	\$3.00 copay
Nephrology Services	\$5.00 copay	\$3.00 copay
Ophthalmology Services (Eye Disease and Injury)	\$5.00 copay	\$3.00 copay
Pulmonology Services	\$5.00 copay	\$3.00 copay

# Other Copays: Diagnostic, X-ray, Hospital, ER

Covered Services	Costsharing/Copays	
	ESSENTIAL CARE CHOICES	CHRONIC CARE CHOICES
<b>Diagnostic Services</b>		
CT Scan	\$5.00 copay per CT Scan	\$5.00 copay per CT Scan
MRI	\$10.00 copay per MRI	\$10.00 copay per MRI
PET Scan	\$20.00 copay per PET Scan	\$20.00 copay per PET Scan
Ultrasound	\$5.00 per Ultrasound	\$5.00 per Ultrasound
<b>Radiology Services/X-rays</b>	\$3.00 per X-ray	\$3.00 per X-ray
<b>Hospital Services</b>		
Hospital Services - Inpatient	\$0 copay upon admission - Hospital charges above plan limit of 6 days per inpatient hospital admission & 30 days per plan FY may be charged to individual patient.	\$0 copay upon admission - Hospital charges above plan limit of 6 days per inpatient hospital admission & 30 days per plan FY may be charged to individual patient.
Hospital Services - Outpatient		
Hospital Services - ER	\$25.00 per visit unless admission	\$25.00 per visit unless admission



# **SERVICE/VISIT LIMITATIONS**

# SERVICE LIMITS

Covered Services	Soft Limits	Hard Limits	Soft Limits	Hard Limits	Other Limits
	ESSENTIAL CARE CHOICES	ESSENTIAL CARE CHOICES	CHRONIC CARE CHOICES	CHRONIC CARE CHOICES	
	(Subject to Written Prior Authorization)		(Subject to Written Prior Authorization)		
Allergy Services	2 visits	4 visits	2 visits	4 visits	
Cardiology Services	2 visits	4 visits	4 visits	9 visits	
Cardiothoracic Surgery	3 visits	6 visits	6 visits	9 visits	Medical necessity required for all surgeries
Dermatology Services	3 visits	6 visits	5 visits	9 visits	
Diagnostic Services					
CT Scans	3 CT Scans per year		3 CT Scans per year		
MRI	2 MRIs per year		2 MRIs per year		
PET Scans	2 PET Scans per year		2 PET Scans per year		
Ultrasound	2 per body part per year		2 per body part per year		
Durable Medical Equipment					1 piece of DME equipment per body part per year
Ear, Nose, & Throat Services	3 visits	6 visits	6 visits	9 visits	
Endocrinology Services	2 visits	4 visits	6 visits	9 visits	
Gastroenterology Services	2 visits	4 visits	6 visits	9 visits	
General/Vascular Surgery	4 visits	6 visits	6 visits	9 visits	Medical necessity required for all surgeries
Gynecology Services	3 visits	6 visits	6 visits	9 visits	One (1) annual well-woman exam

# SERVICE LIMITS

Covered Services	Soft Limits	Hard Limits	Soft Limits	Hard Limits	Other Limits
	ESSENTIAL CARE CHOICES	ESSENTIAL CARE CHOICES	CHRONIC CARE CHOICES	CHRONIC CARE CHOICES	
	(Subject to Written Prior Authorization)		(Subject to Written Prior Authorization)		
Hematology/Oncology Services	2 visits	4 visits	6 visits	9 visits	Chemotherapy & Radiation Therapy are not covered
Hospital Services					
Hospital Services - Inpatient	Limited to 6 days per inpatient hospital admission and 30 days per plan fiscal year				
Hospital Services - Outpatient	Limited to 24 hours for surgeries/ procedures & up to 48 hrs for admissions				
Hospital Services - Emergency Room	\$1500 annual cap per member; Emergent condition required to demonstrate medical necessity				
Infectious Disease Services	3 visits	6 visits	6 visits	9 visits	Hospital Setting Only
Laboratory Services					
Nephrology Services	2 visits	4 visits	6 visits	9 visits	
Neurology Services	3 visits	6 visits	6 visits	9 visits	
Neurosurgery Services	3 visits	6 visits	3 visits	6 visits	
Nutritional Counseling (Registered Dietitian)		1 visit	3 visits	6 visits	Conducted by registered dietitian

# SERVICE LIMITS

Covered Services	Soft Limits	Hard Limits	Soft Limits	Hard Limits	Other Limits
	ESSENTIAL CARE CHOICES	ESSENTIAL CARE CHOICES	CHRONIC CARE CHOICES	CHRONIC CARE CHOICES	
	(Subject to Written Prior Authorization)		(Subject to Written Prior Authorization)		
Ophthalmology Services	2 visits	4 visits	6 visits	9 visits	Eye Injury and Disease only; Member should see an optometrist prior to seeing an ophthalmologist
Optometry Services	2 visits	4 visits	6 visits	9 visits	Eye Injury and Disease only; Member should see an optometrist prior to seeing an ophthalmologist
Orthopedic Services	3 visits	6 visits	6 visits	9 visits	
Pain Management Services	3 visits	6 visits	3 visits	6 visits	Subject to Written Prior Authorization
Physical Therapy/ Occupational Therapy/ Speech Therapy	9 visits per body part per plan fiscal year	36 visits total body per plan fiscal year	9 visits per body part per plan fiscal year	36 visits total body per plan fiscal year	Subject to Written Prior Authorization
Plastic Surgery (Non-Cosmetic)	2 visits	4 visits	2 visits	4 visits	Non-cosmetic services only (For Wounds and Flaps, Blepharoplasties)
Podiatry Services	2 visits	4 visits	4 visits	9 visits	
Prescription Drugs		\$2,500 pmpy; All drugs provided via plan CVS Caremark formulary		\$5,000 pmpy; All drugs provided via plan CVS Caremark formulary	Formulary Drugs Only
Preventive Screening Services					

# SERVICE LIMITS

Covered Services	Soft Limits	Hard Limits	Soft Limits	Hard Limits	Other Limits
	ESSENTIAL CARE CHOICES	ESSENTIAL CARE CHOICES	CHRONIC CARE CHOICES	CHRONIC CARE CHOICES	
	(Subject to Written Prior Authorization)		(Subject to Written Prior Authorization)		
Primary Care Services	NA	NA	NA	NA	
Pulmonology Services	2 visits	4 visits	4 visits	9 visits	
Radiology Services/X-rays	NA	NA	NA	NA	
Specialized Wound Care Services (Hospital)		9 visits per body part per year		15 visits per body part per year	Hyperbaric treatments, oxygen & wound VACS not covered
Rheumatology Services	3 visits	6 visits	6 visits	9 visits	
Transportation Services	\$1.00 in network fee; \$1.50 out of network fee		\$1.00 in network fee; \$1.50 out of network fee		\$1.00 in network fee; \$1.50 out of network fee
Urology Services	3 visits	6 visits	6 visits	9 visits	

***Assumption:*** All surgeries, procedures, imaging, and PT/OT will be subject to Prior Authorization unless they are identified on the Non-Required Pre-certification List. All services subject to Soft Limits do not require a Prior Authorization.

***Assumption:*** Prior to service, all services subject to hard limits must be determined to be medically necessary and prior written authorization must be obtained by the provider.

***Assumption:*** One visit will occur on one date of service. All labs, x-rays, procedures, screens, etc. tied to the initial office visit will be treated as part of one visit.



**Economic Impact:**  
**PAST, PRESENT, FUTURE**

<b>Past Benefits Coverage (Prior to October 1, 2008)</b>	<b>Present Benefits Coverage (Oct 1, 2008-Sept 30, 2009)</b>	<b>Future Benefits Coverage (Beginning Fall 2009)</b>
<ul style="list-style-type: none"> <li>-Open Access to Care</li> <li>-No Visit Limits</li> <li>-Few Service Limits</li> <li>-No Management of Care</li> <li>-No Review of Utilization</li> <li>-No Quality Improvement/ Quality Assurance/Quality Management</li> <li>-Large Increase in # of Plan Members Enrolled in Short Time (Untrained Eligibility Workers/Temporaries)</li> <li>-No active monitoring of contracts/invoices</li> </ul> <p style="text-align: center;"><b>SKYROCKETING COSTS</b></p>	<ul style="list-style-type: none"> <li>-Immediate discontinuation of approvals for services that are not medically necessary.</li> <li>-No authorization limit for Primary Care Physicians. The authorization limit for Specialists is based on medical necessity (1, 2, or 3 visit limits)</li> <li>-Review of every service by a nurse. Planning for future Utilization Review &amp; Quality Management &amp; Case Management with Medical Director begins.</li> <li>-Medical Director begins review of current utilization data and contracts and provides recommendations regarding Utilization Review, Quality Management, and Case Management strategies</li> <li>-Review of Characteristics of Providers Giving Care and their level of Quality as defined by national standards - Utilization Review and Pharmacy &amp; Therapeutics Committees defining quality standards</li> <li>-Review of current contract requirements; implementation of policies and procedures plan-wide; development of Member and Provider Manuals; drafting future contract standards.</li> </ul> <p style="text-align: center;"><b>MANAGING COSTS based on # of services/members</b></p>	<ul style="list-style-type: none"> <li>-Gatekeeper Model</li> <li>-Reasonable, Structured Service Limitations</li> <li>-Balanced Management of Care</li> <li>-Methodical Utilization Review Activities/Strategy</li> <li>-Quality Improvement/Quality Assurance/Quality Management Strategy enforced by the Plan's Medical Management Section and Standards Adopted in Provider Contracts</li> <li>-All Member Services associates will be trained on how to perform a review of a potential member's assets prior to signing the person up for the plan, all new policy and the Member Contract for Care will be explained in English and Spanish and presented in a New Member Instructional Video (other information will include education regarding health, wellness, chronic disease, appropriate ER utilization).</li> <li>-In the future, there will be 3 people devoted to overseeing daily contracts monitoring efforts for all contracts of the plan. Additionally, the Administration Services Branch will be required to oversee fiscal services, which provides separation of duties in payment of invoices.</li> </ul> <p style="text-align: center;"><b>BALANCING COSTS based on member need &amp; taxpayer mandate</b></p>

**ECONOMIC IMPACT: Plan Design**

# PHP Budget FY 2009/2010

- Assumptions Built into Future Budget:
- The loss of \$12,191,226 is returned to the County
- The Plan begins the year in good standing with a positive fund balance
- Essential building blocks of the plan are approved and implemented

# PHP Budget FY 2009/2010

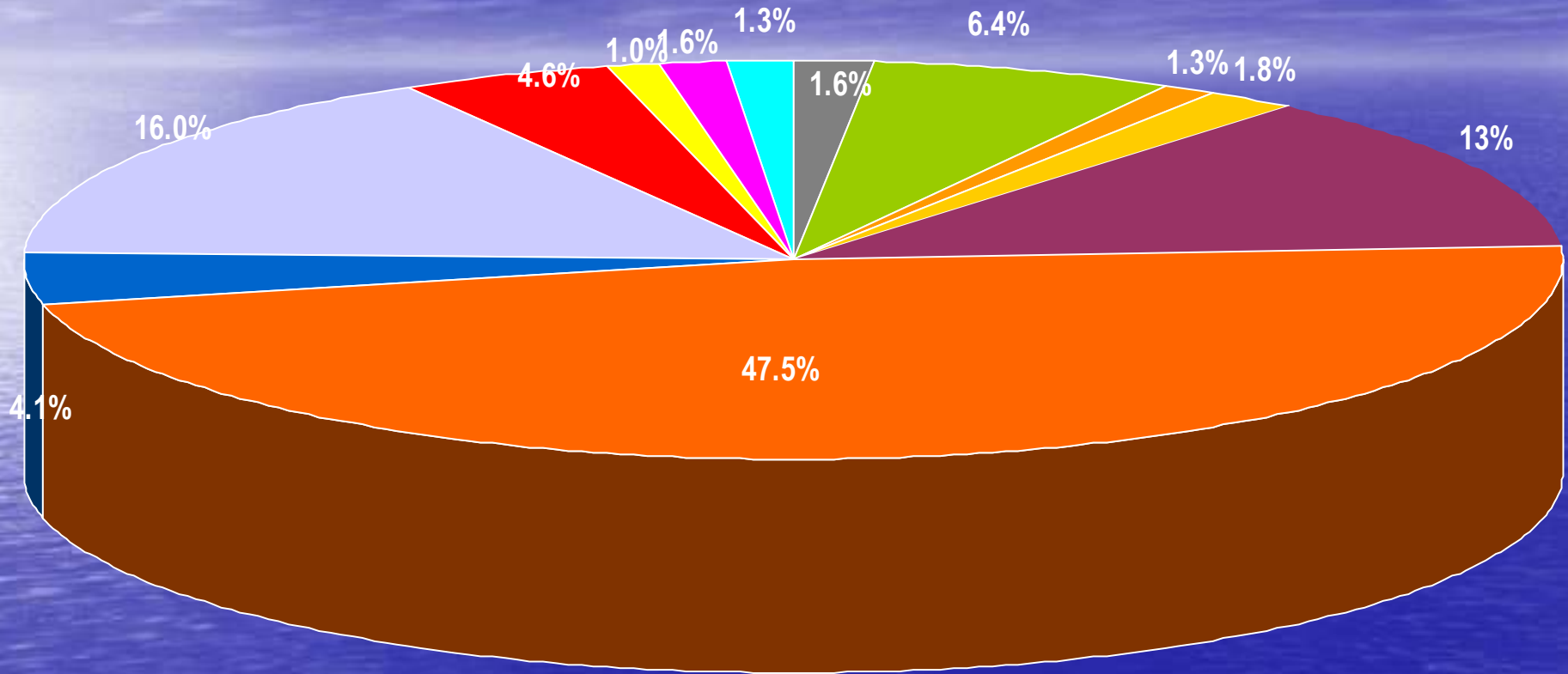
- The health plan will increase services slowly in a balanced, stable environment as the plan infrastructure is finalized
- Operational integrity and fiscal stability maintained
- Slow growth monthly figure of 3,000 members
  - These members could vary from month to month
  - Multiple members throughout the year will be served
  - The total number of people possible to be served = 36,000
  - The likely number of people to be served = 7,000 to 10,000
- “Future Plan Services Expansion” so that the plan can add members

14491 Fund Polk HealthCare Plan	<b>FY08/09 Projected Actual</b>	<b>FY09/10 Recommended Budget</b>	<b>FY09/10 Projected Actual</b>	<b>FY10/11 Recommended Budget</b>	<b>FY10/11 Projected Actual</b>
Beginning Fund Balance	\$(5,191,225)	\$6,281,999	\$6,281,999	\$7,241,334	\$7,241,334
½ cent sales tax revenue	\$30,426,548	\$28,905,221	\$30,426,548	\$29,772,377	\$31,339,344
Other Revenues	\$ 523,467	\$562,820	\$562,820	\$572,413	\$ 572,413
<b>Total Revenue Available</b>	<b>\$25,758,790</b>	<b>\$35,750,040</b>	<b>\$37,271,367</b>	<b>\$37,568,124</b>	<b>\$39,153,091</b>
Expenditures:					
Polk HealthCare Plan	\$5,408,609	\$16,992,000	\$16,992,000	\$18,653,455	\$18,653,455
Polk Co. Health Department	\$341,000	\$361,000	\$361,000	\$371,830	\$371,830
Low Income Pool (LIP) Grant	\$289,900	\$289,900	\$289,900	\$289,900	\$289,900
CJMHS A Grant	\$275,833	\$275,833	\$275,833	\$275,833	\$275,833
Primary Care Clinics	\$964,000	\$1,478,000	\$1,478,000	\$1,522,340	\$1,522,340
Lakeland Volunteers (LVIM)	\$264,000	\$264,000	\$264,000	\$271,920	\$271,920
The Haley Center	\$73,405	\$73,405	\$73,405	\$75,607	\$75,607
We Care	\$93,468	\$93,468	\$93,468	\$96,272	\$96,272
Healthy Start	\$25,000	\$25,000	\$25,000	\$25,750	\$25,750
Mandated Services (MH/SA/HCRA)	\$1,604,301	\$1,633,124	\$1,633,124	\$1,682,118	\$1,682,118
CHS Operating Expenses	\$611,609	\$569,382	\$569,382	\$613,868	\$613,868
Salaries and Benefits (Personnel)	\$2,240,491	\$2,272,744	\$2,272,744	\$2,285,120	\$2,285,120
Indirect Costs	0	\$636,839	\$636,839	\$636,839	\$636,839
Software (Capital Outlay)	0	\$450,000	\$450,000	\$300,000	\$300,000
HCAP	\$110,175	-	-	-	-
Reserve (6%)/Contingencies (10%)	0	\$5,720,006	0	\$6,013,779	0
Loan Repayment/Interest	\$7,175,000	-	-	-	-
Future Plan Services Expansion/Clinics	0	\$4,615,338	\$4,615,338	\$4,471,492	\$4,471,492
<b>Total Expenditures</b>	<b>\$19,476,791</b>	<b>\$ 35,750,040</b>	<b>\$30,030,033</b>	<b>\$37,568,124</b>	<b>\$31,572,344</b>
Ending Fund Balance	\$6,281,999	\$0	\$7,241,334	\$0	\$7,580,747
<b>Total Expended/FundBalance</b>	<b>\$25,758,790</b>	<b>\$ 35,750,040</b>	<b>\$37,271,367</b>	<b>\$37,568,124</b>	<b>\$ 39,153,091</b>

# Polk HealthCare Plan

## 14491 Fund

### FY09/10 Proposed Budget



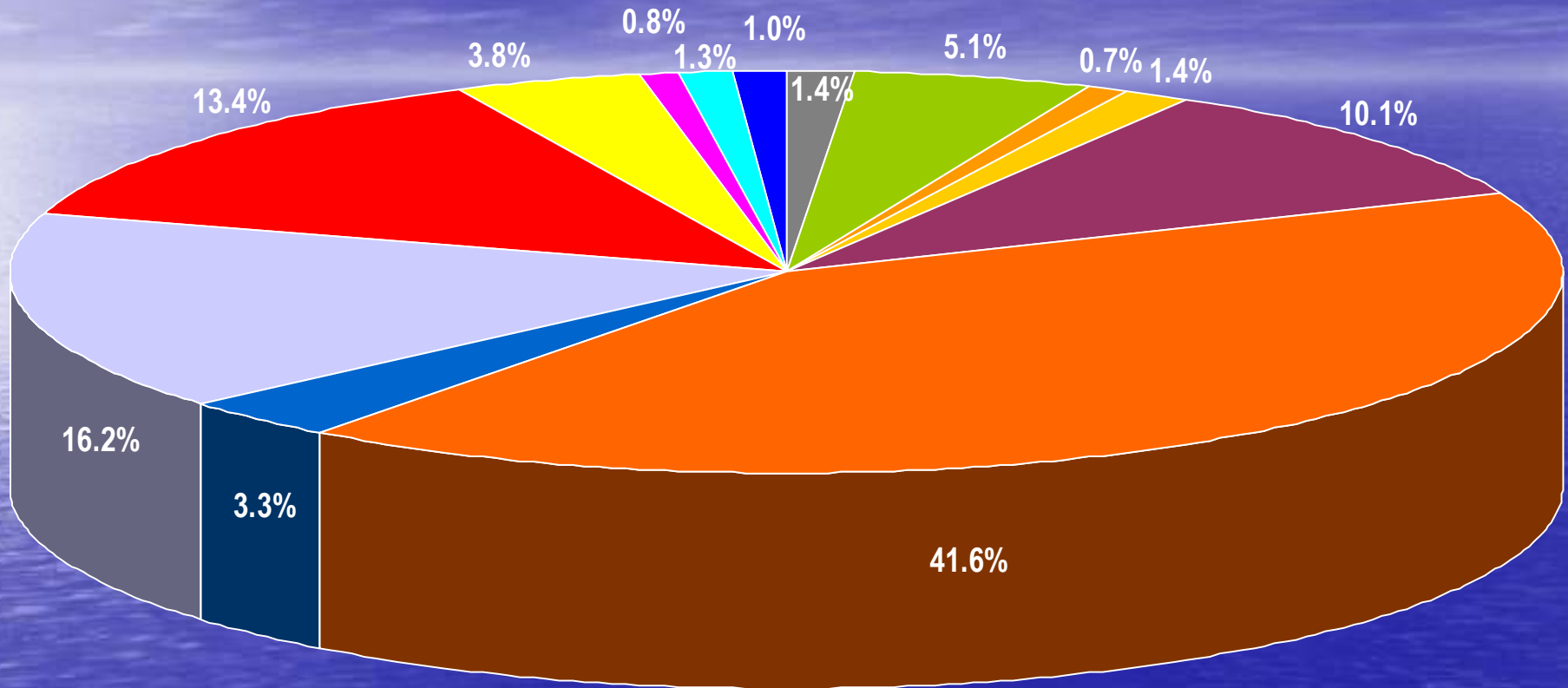
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|---|--|
| ■ Operating Expenses, \$569,382                       | ■ Salaries/Benefits (Personnel), \$2,272,744 |
| ■ Software (Capital Outlay), \$450,000                | ■ Indirect Costs, \$636,839                  |
| ■ Future Plan Services Expansion/Clinics, \$4,615,338 | ■ Polk HealthCare Plan, \$16,992,000         |
| ■ Primary Care Clinics, \$1,478,000                   | ■ Fund Reserve/Contingencies, \$5,720,006    |
| ■ Mandated Services, \$1,633,124                      | ■ Polk Co. Health Department, \$361,000      |
| ■ LIP/CJMHA Grants, \$565,733                         | ■ Community Partners, \$455,873              |

**Total Polk HealthCare Plan: \$35,750,040**

# Polk HealthCare Plan

## 14491 Fund

### FY10/11 Proposed Budget



Operating Expenses, \$613,868	Salaries/Benefits (Personnel), \$2,285,120
Software (Capital Outlay), \$300,000	Indirect Costs, \$636,839
Future Plan Services Expansion/Clinics, \$4,515,854	Polk HealthCare Plan, \$18,653,455
CFHC Lakeland/WH Clinics, \$1,478,000	Beg'g Fund Balance, \$7,241,334
Fund Reserve/Contingencies, \$6,013,779	Mandated Services, \$1,682,118
Polk Co. Health Department, \$371,830	LIP/CJMHA Grants, \$565,733
Community Partners, \$469,527	

**Total Polk HealthCare Plan: \$37,568,124**

# Final Approval for Projects

Medical Management Criteria Software –Milliman Care Guidelines

✓ COC Approved Unanimously on April 17, 2009

Claims Coding Software – McKesson ClaimCheck

✓ COC Approved Unanimously on April 17, 2009

Balanced plan benefits design/packages

✓ Approved by Utilization Review Committee - May/June 2009

Efficiency in operations/management of resources

Health Plan Financial Analyst

✓ Approved by COC on April 17, 2009

Overall Budget Approval

# Questions?

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