

Polk HealthCare Plan

Citizens Oversight Committee

FY 2009/2010 Budget Presentation:
Transformation, Vision, & Implementation



*Neil Combee Bldg.
Boardroom
August 21, 2009*



*Presented by:
Jan Howell, J.D.
Polk HealthCare Plan*



Highlights of Presentation

- ▶ History, Transformation, Vision, Early Successes
- ▶ Essential Building Blocks of the Plan
- ▶ Proposed FY 2009/2010 Budget
- ▶ Request for Approvals

Essential Building Blocks of Plan

▶ **BUILDING BLOCKS PREVIOUSLY APPROVED:**

- *Automated Claims Processing System – MCO*
- *Medical Director*
- *Development of comprehensive medical management strategy*
- *Medical Management Criteria Software – Milliman Care Guidelines*
- *Claims Coding Software – McKesson ClaimCheck*
- *Efficiency in operations & resource management*

▶ **PRESENTATION REVIEW/APPROVAL REQUESTS:**

- Acceptance of balanced plan benefits design/packages first presented to COC in January 2009

History, Early Successes & Transformation: August 2008 – January 2009

- ▶ 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.
- ▶ 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.

Communication/Operational/Financial Successes – Spring 2009

- ▶ 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
- ▶ 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

Polk HealthCare Plan Mission & Vision

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.

Crux of Healthcare Issues: Unique Role of Polk HealthCare Plan

- ▶ The synergy discovered where the incentives of providers, members, and taxpayers meet
- ▶ When the financially invested engage in cooperative goal-setting recognizing the need for improved member health outcomes
 - It's less expensive to pay for true health care that works than it is to ignore health care needs.
 - "Do the right thing!!!"
 - The question now is---how do we separate out roles and responsibilities? What incentives exist, and who should bear the weight of making decisions and bearing cost?
 - Is it the member, who has the most direct decision making capability and can choose whether to have apple wedges or french fries?

Moving beyond Member Education to Member Investment

- ▶ Hallmarks of Industry
 - Member Education
 - Medical Case Management
 - Complex Medical Case Management for Members w Co-morbidities

- ▶ Movement to Member Investment with Clear Incentives
 - **EXAMPLES OF EMPLOYER-DRIVEN INCENTIVES (Carrot approach)**
 - Flexible Medical Spending Accounts, Employer-Sponsored Gym Memberships
 - Employer Has an Onsite Gym (and provides flexible break time to accommodate exercise)
 - Employer Has an Onsite Cafeteria and markets Healthy Cafeteria Choices, removes unhealthy
 - **EXAMPLES OF MEDICAID INCENTIVES (Carrot approach)**
 - For a certain number of healthy behaviors, members get free goods or services (gym memberships)
 - **EXAMPLES OF POLK HEALTHCARE PLAN INCENTIVES (Carrot & Stick Approach)**
 - Each member will be responsible for signing a Member Contract for Care (Includes Member Rights of Care, Member Responsibilities, and Basic Eligibility Considerations)
 - Stick approach - Elimination from plan membership for Fraud, Waste, Abuse, Repeated Non-Compliance with Provider Direction
 - Importance of Provider Collaboration to Incentivize Members – Fresh Approaches – More Direct Impact – Knowledge regarding what works with different members
 - Potentially move to point where PHP implements a program like Employer Health Plan

Achieving Improved Member Health Outcomes

- ▶ How can we achieve improved member health outcomes?
 - Now that everyone's at the table, both the financially invested and the members, we have a better overview of how the current system is adverse to creating member incentives.
 - Member Contract for Care – Members need to agree to be active, involved, and proactive in their health care. They have the most control and make the most direct decisions that will ultimately affect health outcomes.
 - Member Education – Part of ensuring the best ultimate effect through wise member decision making assumes that members are educated regarding their care. Where they are not, it is the community around them who must become active to educate them regarding their decisions and the power they have to have good health. Otherwise, local emergency rooms will always be overrun with an increasing amount of uncompensated care individuals.
 - Various Mediums for Member Education – Health Expos, Personal Appointments, Mobile Unit, Initial Enrollment Visit, PGTV. At the Polk Health Care Plan, when a member becomes enrolled there will be a video in English and Spanish that provides them with education regarding their enrollment in the Plan, their rights and responsibilities, when it is appropriate to utilize the Emergency Room, and some basic wellness education regarding diabetes.

Comparison/Contrast: Plan Design

<u>CURRENT SERVICE PROVISION</u>	<u>FUTURE PLAN DESIGN</u>
Covered/Excluded Services	Covered/Excluded Services
-Rich for indigent plan	-Based on Previous Services Provided -Difficult Balance due to Chronically Ill
Member Copays	Member Copays
-\$5 copay for office visit -Copay amount could prohibit access to primary care -May prevent members from seeking needed care (more expensive later-ER) -Copay amount could be prohibitive for chronically ill	-General Rule - \$5 copay for office visit -Exception - \$1 copay for primary care office visit -Will encourage appropriate use of care in right setting -Exception - \$3 copay for chronic illnesses (office visit)
Service Limits	Service Limits
-Costs skyrocketed in FY 2008 due to lack of service limits, which provide some control of utilization	-Still generous; Mirrors usual insurance plan -Prevent fraud, waste & abuse -Assists in ensuring quality of care -Assists with Return on Value

Economic Impact:
PAST, PRESENT, FUTURE

Past Benefits Coverage (Prior to October 1, 2008)	Present Benefits Coverage (Oct 1, 2008-Sept 30, 2009)	Future Benefits Coverage (Beginning Fall 2009)
<ul style="list-style-type: none"> -Open Access to Care -No Visit Limits -Few Service Limits -No Management of Care -No Review of Utilization -No Quality Improvement/ Quality Assurance/Quality Management -Large Increase in # of Plan Members Enrolled in Short Time (Untrained Eligibility Workers/Temporaries) -No active monitoring of contracts/invoices <p style="text-align: center;">SKYROCKETING COSTS</p>	<ul style="list-style-type: none"> -Immediate discontinuation of approvals for services that are not medically necessary. -No authorization limit for Primary Care Physicians. The authorization limit for Specialists is based on medical necessity (1, 2, or 3 visit limits) -Review of every service by a nurse. Planning for future Utilization Review & Quality Management & Case Management with Medical Director begins. -Medical Director begins review of current utilization data and contracts and provides recommendations regarding Utilization Review, Quality Management, and Case Management strategies -Review of Characteristics of Providers Giving Care and their level of Quality as defined by national standards - Utilization Review and Pharmacy & Therapeutics Committees defining quality standards -Review of current contract requirements; implementation of policies and procedures plan-wide; development of Member and Provider Manuals; drafting future contract standards. <p style="text-align: center;">MANAGING COSTS based on # of services/members</p>	<ul style="list-style-type: none"> -Gatekeeper Model -Reasonable, Structured Service Limitations -Balanced Management of Care -Methodical Utilization Review Activities/Strategy -Quality Improvement/Quality Assurance/Quality Management Strategy enforced by the Plan's Medical Management Section and Standards Adopted in Provider Contracts -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). -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. <p style="text-align: center;">BALANCING COSTS based on member need & taxpayer mandate</p>

ECONOMIC IMPACT: Plan Design

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

COVERED/EXCLUDED SERVICES

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

DISCLAIMER: The benefits plan design may be revised periodically. The latest version will be posted to the Polk HealthCare Plan Website.

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
Endocrinology Services	\$5.00 copay	\$3.00 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
Infectious Disease 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
Optometry Services	\$5.00 copay	\$5.00 copay
Orthopedic Services	\$5.00 copay	\$5.00 copay
Plastic Surgery (Non-Cosmetic)	\$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, Rx, Dental, Pain, Preventive

Covered Services	Costsharing/Copays	
	ESSENTIAL CARE CHOICES	CHRONIC CARE CHOICES
Primary Care Services	\$1.00 copay	\$1.00 copay
Prescription Drugs	\$1.00 copay for generic \$5.00 copay for brand	\$0 copay for generic \$3.00 copay for brand
Preventive Screening Services		
Pain Management Services	\$10.00 copay	\$10.00 copay
Dental Services	\$10.00 copay	\$10.00 copay

Copays: Chronic Illness

Covered Services	Costsharing/Copays	
	ESSENTIAL CARE CHOICES	CHRONIC CARE CHOICES
Cardiology Services	\$5.00 copay	\$3.00 copay
Cardiothoracic Surgery	\$5.00 copay	\$3.00 copay
Hematology/Oncology 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
Physical Therapy/Occupational Therapy/Speech Therapy	\$5.00 copay	\$3.00 copay
Podiatry Services	\$5.00 copay	\$3.00 copay
Pulmonology Services	\$5.00 copay	\$3.00 copay

Copays: Diagnostic, Hospital, Lab, Transportation

Covered Services	Costsharing/Copays	
	ESSENTIAL CARE CHOICES	CHRONIC CARE CHOICES
Diagnostic Services		
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
Nuclear Medicine Studies	\$5.00 copay per Nuclear Study	\$5.00 copay per Nuclear Study
PET Scan	\$20.00 copay per PET Scan	\$20.00 copay per PET Scan
Ultrasound	\$5.00 per Ultrasound	\$5.00 per Ultrasound
X-rays	\$3.00 per X-ray	\$3.00 per X-ray
Durable Medical Equipment		
Hospital Services		
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 - Emergency Room	\$25.00 per visit unless admission	\$25.00 per visit unless admission
Laboratory Services	\$5.00 copay	\$3.00 copay
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

SERVICE/VISIT LIMITATIONS

	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
Dental Services					1 visit annually (if dental contract cap has not been reached)
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	
Nuclear Medicine Studies		3 Nuclear Medicine Studies per year		3 Nuclear Medicine Studies 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 (Post-Surgical Back Brace; Knee Immobilizer; Short Wrist Splint; Air Cast Splint for Ankle; Cam Walker Boot)					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 Services	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
Hematology/Oncology Services	2 visits	4 visits	6 visits	9 visits	Chemotherapy & Radiation Therapy are not covered

	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)	
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 and up to 48 hours 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
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

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	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)	
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		All drugs provided via plan CVS Caremark formulary		All drugs provided via plan CVS Caremark formulary	Formulary Drugs Only
Preventive Screening Services					
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 and 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.

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 Plan

▶ **BUILDING BLOCKS PREVIOUSLY APPROVED:**

- *Automated Claims Processing System – MCO*
- *Medical Director*
- *Development of comprehensive medical management strategy*
- *Medical Management Criteria Software – Milliman Care Guidelines*
- *Claims Coding Software – McKesson ClaimCheck*
- *Efficiency in operations & resource management*

▶ **PRESENTATION REVIEW/APPROVAL REQUESTS:**

- Acceptance of balanced plan benefits design/packages first presented to COC in January 2009

PHP Budget FY 2009/2010

Assumptions

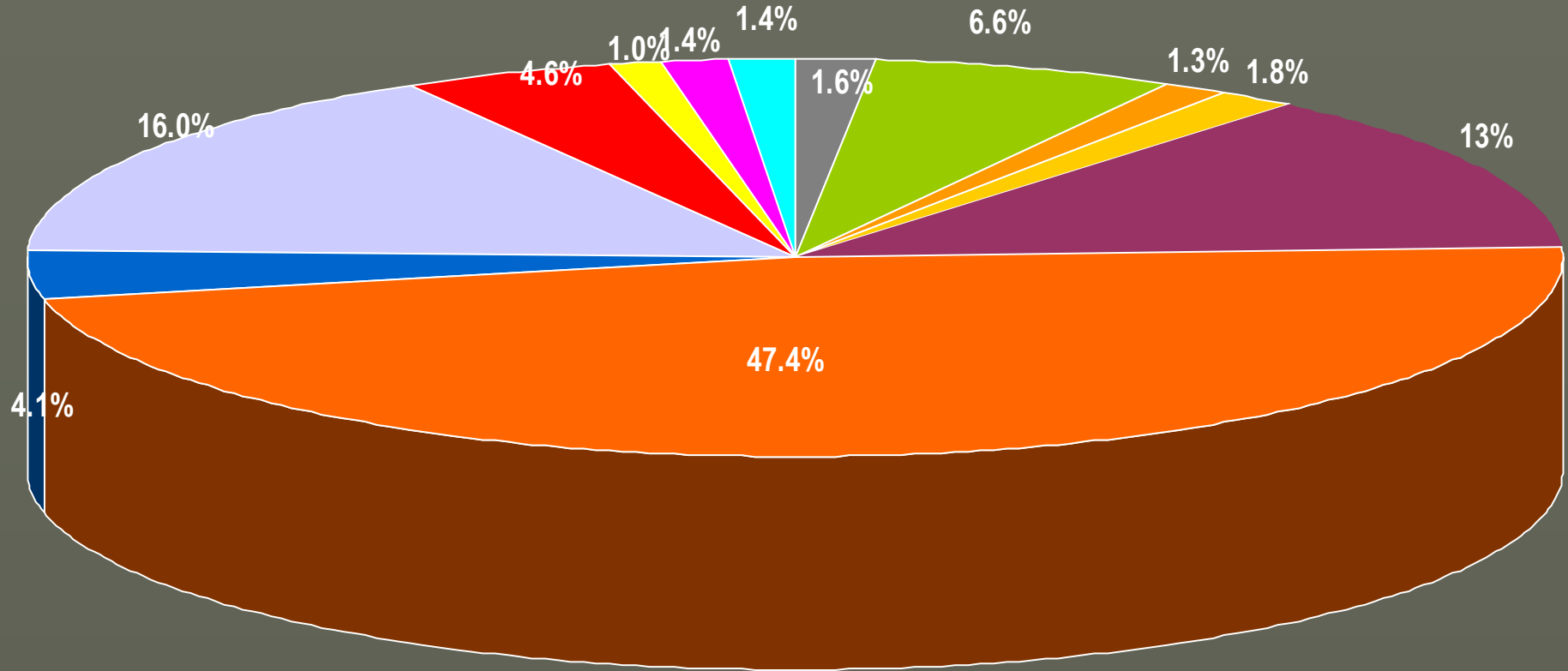
- Beginning Reserve of approximately \$6.46 million (as loan of \$7 mil is repaid and loss of negative \$5.191 mil fund balance eliminated)
- The health plan will increase services slowly in a balanced, stable environment as the plan infrastructure is finalized
- Operational integrity and fiscal stability maintained
- New Benefits Design/Benefits Packages are approved/implemented
- Restructuring of internal resources for efficiency in management
- Slow growth monthly figure of 3,000 members
- Provision for "Future Plan Services Expansion"

14491 Fund Polk HealthCare Plan	FY08/09 Projected Actual	FY09/10 Recommended Budget	FY09/10 Projected Actual	FY10/11 Recommended Budget	FY10/11 Projected Actual
Beginning Fund Balance	\$(5,191,226)	\$6,469,005	\$6,469,005	\$7,230,876	\$7,230,876
½ cent sales tax revenue	\$30,226,654	\$28,715,321	\$30,226,654	\$29,576,781	\$31,133,454
Other Revenues	\$ 910,368	\$562,820	\$562,820	\$572,413	\$ 572,413
Total Revenue Available	\$25,945,796	\$35,747,146	\$37,258,479	\$37,380,070	\$38,936,743
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	\$210,000	\$210,000	\$210,000	\$210,000
CJMHSAs 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	\$79,860	\$79,860	\$82,256	\$82,256
We Care	\$93,468	\$94,968	\$94,968	\$97,817	\$97,817
Healthy Start	\$25,000	\$25,000	\$25,000	\$25,750	\$25,750
Traviss Career Center	\$0	\$50,000	\$50,000	\$51,500	\$51,500
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	\$2,362,669	\$2,362,669	\$2,413,570	\$2,413,570
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	\$5,719,543	0	\$5,980,811	0
Loan Repayment/Interest	\$7,175,000	-	-	-	-
Future Plan Services Expansion/Clinics	0	\$4,544,928	\$4,544,928	\$4,190,163	\$4,190,163
Total Expenditures	\$19,476,791	\$ 35,747,146	\$30,027,603	\$37,380,070	\$31,399,259
Ending Fund Balance	\$6,469,005	\$0	\$7,230,876	\$0	\$7,537,484
Total Expended/FundBalance	\$25,945,796	\$ 35,747,146	\$37,258,479	\$37,380,070	\$ 38,936,743

Polk HealthCare Plan

14491 Fund

FY09/10 Proposed Budget



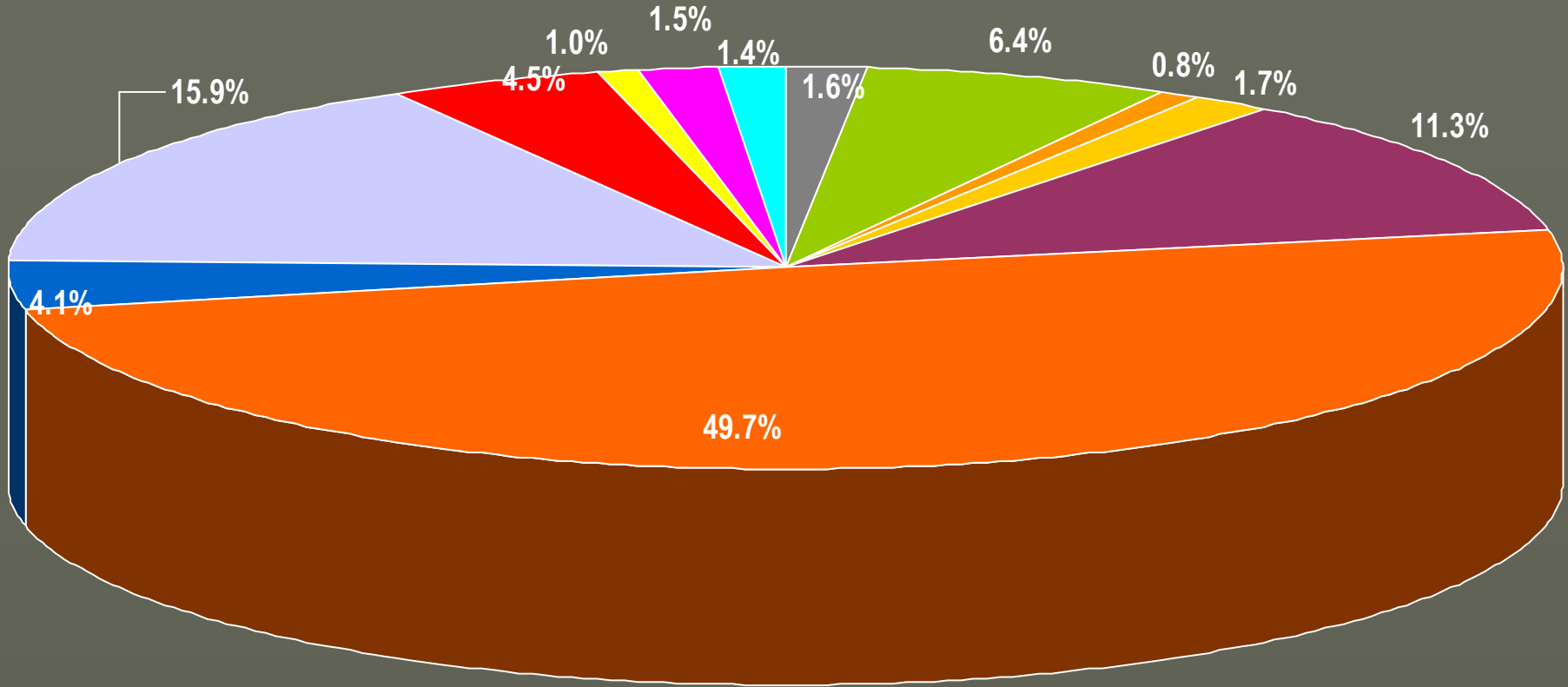
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| □ Operating Expenses, \$569,382 | □ Salaries/Benefits (Personnel), \$2,362,669 |
| □ Software (Capital Outlay), \$450,000 | □ Indirect Costs, \$636,839 |
| □ Future Plan Services Expansion/Clinics, \$4,544,928 | □ Polk HealthCare Plan, \$16,992,000 |
| □ Primary Care Clinics, \$1,478,000 | □ Fund Reserve/Contingencies, \$5,719,543 |
| □ Mandated Services, \$1,633,124 | □ Polk Co. Health Department, \$361,000 |
| □ LIP/CJMHA Grants, \$485,833 | □ Community Partners, \$513,828 |

Total Polk HealthCare Plan: \$35,747,146

Polk HealthCare Plan

14491 Fund

FY10/11 Proposed Budget



Operating Expenses, \$613,868	Salaries/Benefits (Personnel), \$2,413,570
Software (Capital Outlay), \$300,000	Indirect Costs, \$636,839
Future Plan Services Expansion/Clinics, \$4,190,163	Polk HealthCare Plan, \$18,653,455
CFHC Lakeland/WH Clinics, \$1,522,340	Fund Reserve/Contingencies, \$5,980,811
Mandated Services, \$1,682,118	Polk Co. Health Department, \$371,830
LIP/CJMHTSA Grants, \$485,833	Community Partners, \$529,243

Total Polk HealthCare Plan: \$37,380,070

Final Approval for Projects

- Approval of Balanced benefits design/packages
 - ✓ Approved by Utilization Review Committee - May/June 2009

- Approval of Budget with incorporated assumptions

Questions?

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June Executive Summary Report

Demographic Summary For Medical	Prior Month	Current Month	Difference	Prior Plan Year	Plan Year to Date
Number of Polk HealthCare Plan Members	1,125	2,332	107.3%	19,031	3,618
Percent Male Members	36.5%	36.4%	-0.1%	38.1%	36.7%
Percent Female Members	63.5%	63.6%	0.1%	61.9%	63.3%
Average Age Range of Members	Ages 46-50	Ages 46-50	0.0%	Ages 40-45	Ages 46-50
Key Financial Statistics					
Total Rx Paid Amount	\$89,962	\$91,739	1.98%	\$10,444,083	\$1,150,414
Total Medical Paid Amount	\$271,523	\$309,368	13.9%	\$41,255,659	\$6,619,091
Total Per Member Per Month/Plan Year	\$321	\$172	-46.5%	\$2,717	\$2,147
Key Medical Utilization Statistics					
Total Unique Medical Claimants	705	738	4.5%	17,210	5,345
Inpatient Hospital Claims/1,000 Members per Month	21.3	12.9	-39.7%	21.5	25.9
Days of Care/1,000 Members per Month	61.3	56.2	-8.4%	162.7	109.6
Average Length of Stay	2.9	4.4	51.9%	7.6	3.9
Physician Claims/1,000 Members per Month	927.1	526.6	-43.2%	1,359.1	1,405.5
ER Claims/1,000 Members	48.0	16.7	-65.2%	60.8	52.4

Primary Care = 40% of Total Physician Claims Paid
 Primary Care = 654 Claims (\$81.92 Avg Per Claim)

Specialty Care=60% of Total Physician Claims Paid
 Specialty Care=574 Claims (\$141.30 Avg Per Claim)

**** Provider Type Not a Hospital or Physician (ARNP, ASC, CRNA, Certified Surgical Technician, Dental, DME, Medical, Optical Supplies, Other, Pathology, PT, PA, Radiology, RN, Registered Nurse First Assistant, Shelter, Sleep Center, Therapy)**

Revenue	\$23,315,629	
(Expenditures)	\$8,305,337	
Balance	\$15,010,292	
Loan to be Paid	\$ 12,191,226	
Claims Liability	\$638,000 as of June 2009	

Demographic Summary For Medical	DEFINITIONS/EXPLANATIONS
Number of Polk HealthCare Plan Members	Most health plans define their entire business by the number of members they serve annually or monthly. For others in healthcare, this generally serves as the comparison mark for profit margin, operational hurdles, etc. In Florida, there are many small managed care organizations due to Florida Medicaid awarding contracts to lots of managed care companies and third party administrators.
Percent Male Members	Generally men cost less than women in the healthcare arena. (Men may have chronic disease conditions but are generally more healthy.)
Percent Female Members	Women cost more in our health plan due to ob/gyn needs, as well as their vulnerability to the prevalent chronic disease conditions, such as diabetes, COPD (chronic Obstructive pulmonary disorder), asthma, CAD (coronary artery disease), CHF (congestive heart failure).
Average Age Range of Members	The older populations can be some of the most expensive to care for. In our population, many of our members need care even before their later years due to a heavy prevalence of chronic disease states.
Key Financial Statistics	
Total Rx Paid Amount	This figure represents the total amount the Polk HealthCare Plan paid out to Caremark CVS for pharmacy services during the month.
Total Medical Paid Amount	This figure represents the total amount the Polk HealthCare Plan paid out to physicians and hospitals for medical services during the month.
Total Per Member Per Month/Plan Year	This figure represents the total amount that the Polk HealthCare Plan paid out in average for each member for the month or the plan year. If you add the "Total Rx Paid Amount" and the "Total Medical Paid Amount", then divide it by the "Number of Polk HealthCare Plan Members", you will calculate the "Total Per Member Per Month" or "Total Member Per Plan Year".
Key Medical Utilization Statistics	
Total Unique Medical Claimants	This figure represents the total number of different people who had a claim for the month, whether it was approved or denied. The significance in this figure is that the health plan may have some members who did not receive services or have a claim, which would lower our costs and our Total Per
Inpatient Hospital Claims/1,000 Members per Month	Many health plans use this formula to track how much their members are using the inpatient hospital services. It is a key figure due to the fact that inpatient hospital services are generally the most expensive that a member can receive. It is preferable for the health plan to have services performed in a medical doctor's office or a surgical center or another type of outpatient setting because it is cheaper.
Days of Care/1,000 Members per Month	This is another way to monitor how expensive your members are with regard to the number of days that they require an inpatient hospital stay.
Average Length of Stay	The "Average Length of Stay" is another way to gauge what is normal in your particular community, locale, and in that particular hospital.
Physician Claims/1,000 Members per Month	This figure is a way to measure how much your members use physicians' services and how many of your members are using them. The ratio can show you that a small number of members are using all the services or that many members are using only a few services, or that there is a balanced ratio, which
ER Claims/1,000 Members	The "ER Claims/1,000 Members" is another way to gauge what is normal in your particular community, locale, and in that particular hospital. This could be particularly relevant if the hospitals in your areas have the busiest Emergency Departments in your region.
Primary Care = 35% of Total Physician Claims Paid	These figures regarding primary care will give us a way to gauge how much of the care provided is for primary care. It also demonstrates that primary care is generally less expensive if that is the care that is needed. If it is not the care needed, and specialty care is necessary, then it could be a quality of care issue not to have the appropriate specialty care available for coordination of care and continuity of care. This is one item we need to educate our community about so that everyone knows that there is a place for specialty care.
Primary Care = 783 Claims (\$81.84 Avg Per Claim)	The number of claims is not the same as the number of visits but is a good indicator of how much primary care is used in comparison to specialty care.
Specialty Care=65% of Total Physician Claims Paid	These figures regarding specialty care will give us a way to gauge how much of the care provided by Polk HealthCare Plan is specialty physician care. There may be a real need for specialty care. Also, there may be a fallacy of relying on the way our information is presented here. We rely on the providers to tell us what their specialty is. If they designate something other than primary care but still provide some basic primary care in the context of their specialty, we may not be "giving enough credit" to those physicians and be counting them solely as specialty physicians, when in fact they could be providing both primary and specialty care. It is really impossible to say that a specialist cannot or should not treat for something that a primary could treat for when the person also has a major issue and it wouldn't make sense to break these out. <i>In short, the claims system captures this information by specialty only, so what is actually occurring in practice, that a pulmonologist is also a primary care doctor 60% of the time---he just listed</i>
Specialty Care=758 Claims (\$158.54 Avg Per Claim)	The number of claims is not the same as the number of visits but is a good indicator of how much specialty care is used in comparison to primary care.
** Provider Type Not a Hospital or Physician (ARNP, ASC, CRNA, Certified Surgical Technician, Dental, DME, Medical, Optical Supplies, Other, Pathology, PT, PA, Radiology, RN, Registered Nurse First Assistant, Shelter, Sleep Center, Therapy)	
Revenue \$12,902,029	
(Expenditures) \$ 3,950,692	
Balance \$ 8,951,337	
Loan to be Paid \$ 12,191,226	This is the amount that the Polk HealthCare Plan borrowed from the County out of the General Fund last year.
Claims Liability \$ 799,000	This is the amount that remains to be paid back before FY 2009 ends.