

Health Care Study Committee

Final Report

October 5, 2005

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SPECIAL TRIBUTE

DR. FREDERICK A. REDDY

This report is dedicated to the memory of Dr. Frederick A. Reddy, a member of the Health Care Study Committee until his death on July 27, 2005. Dr. Reddy was a member of the Hillsborough County Health Care Advisory Board from 1996 to 2004. Representing the Hillsborough County Medical Association, he chaired the Advisory Board's Medical Committee.

Dr. Reddy was respected by the members of the Study Committee and staff. Our admiration was not just for his technical knowledge and intelligence but even more for his sincere concern for people and his desire to work with people to find solutions.

Dr. Reddy will be remembered for his willingness to assist staff and other members of the Advisory Board and for his strong advocacy on behalf of quality health care for all patients regardless of income. He will be missed.

ACKNOWLEDGEMENTS

Many individuals graciously contributed their time and energy to the development of this report. We would like to acknowledge and thank all of them for their contributions.

- Members of the Study Committee who generously gave of their time to attend meetings, hear presentations, review materials, and to provide the leadership in developing recommendations.

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- Sub-committees members who shared their knowledge of the existing program and ideas to help build a better program in the future.

Core Services - Phyllis Busansky, Chair(Study Committee) Edi Erb, Vice Chair (Study Committee), Charles Bottoms (Tampa Community Health Centers), Dr. Patrick Cimino (St. Joseph's Hospital), Dr. Steve Freedman (Study Committee), Dr. Hernan Leon (Study Committee), Jana Manecchi (Tampa General Hospital), Brantz Roszel / Dr. Dennis Penzell (Suncoast Community Health Center)

Innovations and Best Practices - Dr. John Curran, Chair (Study Committee), Mary Ellen Gillette, Vice Chair (Study Committee), Phyllis Busansky (Study Committee), Joe Chillura (Study Committee), Dr. Jim Davison (Study Committee), Sherry Dorsey (St. Joseph's Hospital), Steve Fleming (Suncoast Community Health Center), Edward Kucher (Tampa Community Health Centers), Trevor Price (Tampa General Hospital)

Combined Management, Administration, Compensation, Reimbursement and Incentives (There were separate subcommittees for Management / Administration and Compensation / Reimbursement until June 10, 2005.) Jim Waters, Chair (Study Committee), Dr. Steve Freedman, Vice-Chair (Study Committee), John Barger (Humana Inc.), Charles Bottoms (Tampa Community Health Centers), Phyllis Busansky (Study Committee), Patrick Cosgrove (Hillsborough County Informational & Technology Services), Sherry Dorsey (St. Joseph's Hospital), Anthony Escobio (Tampa General Hospital), Steve Fleming (Suncoast Community Health Center), Dr. Richard Goldberger (Orthopedic Surgeon), George Hammond (Suncoast Community Health Center), Edward Kucher (Tampa Community Health Centers), Dr. Hernan Leon (Study

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Dave Rogoff (Director of Health and Social Services), Jack Kroll (Director of Health and Financial Services); Vicki Adelson (Administrator of Program Services); Kristen Phillips Gopman (Health and Social Services Intern), and others as needed.

GLOSSARY OF TERMS

340B Pricing: Federal drug pricing program providing access to reduced price prescription drugs to over 12,000 health care facilities certified by the U.S. Department of Health and Human Services (HHS) as "covered entities". These clinics, centers and hospitals in turn serve more than 10 million people in all 50 states, plus commonwealths and territories.

Ad Valorem Taxes: A tax that is computed as a percentage of the value of specific property.

Chronic Disease: An illness of long duration that progresses slowly; a condition that is constant and recurring over a long period of time and not an single acute episodic condition.

Claims Adjudication: To review medical claims and determine appropriate amounts to pay for services consistent with applicable contract provisions,

Centers for Medicare & Medicaid Services (CMS): The federal agency that runs the Medicare program. In addition, CMS works with the States to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high quality health care.

Diagnosis Related Group (DRG): A classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual. Medicare is the major payor that utilizes this form of reimbursement, although Medicare also allows "outliers," which provide additional fees, sometimes exceptionally high, to be paid per pre-set criteria.

Disproportionate Share Hospitals (DSH): A hospital with a disproportionately large share of low-income patients. Under Medicaid, States augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

Federally Qualified Health Centers (FQHCs): A facility located in a medically underserved area that provides low-income people preventive primary medical care under the general supervision of a physician.

Formulary: The list of drugs that are covered by a plan. "Non-formulary" medications and injectibles are drugs that are not covered by a plan.

Health Care Responsibility Act (HCRA): The Act places the ultimate financial obligation for an indigent patient's out-of-county emergency care on the county in which the indigent patient resides.

Health Insurance Portability & Accountability Act (HIPAA): A Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Other provisions include the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative *code sets* should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information.

Inpatient/Ancillary: Professional services by a hospital. These may include x-ray, drug, laboratory, or other services.

Medicaid: A joint federal and state program that helps with medical costs for some people with low incomes and limited resources.

Medicaid Match: States have some discretion in deciding how their Medicaid program is structured. In 20 states, including Florida, the state requires local governments to contribute to this match.

Medical Crisis Intervention (MCI): Program for Hillsborough County citizens with income between 100% and 150% of the federal poverty level and no other coverage. Co-payments are required based on income. MCI cases are approved for those conditions, which are expensive to treat either because of the severity or the chronicity of the medical condition.

Radiology: The branch of medicine that deals with the use of radioactive substances in diagnosis and treatment of disease especially the use of x-rays.

Ryan White: This department, Health & Social Services administers the Ryan White CARE Act funds for the local area, according to the directions of a community-based Care Council. Funds are awarded through a competitive process to providers serving persons living with HIV/AIDS and their families in an eight-county area, including Hillsborough, Pinellas, Pasco, Hernando, Manatee, Polk, Hardee and Highlands.

Sales Tax Trust Fund: Refers to State of Florida Health Care Sales Surtax Trust Fund. Money raised through the ½ cent sales tax for indigent health care is deposited into this account.

Social Security Disability Insurance (SSDI): Federal cash benefit that may be available if a person is disabled.

Third Party Administrator (TPA): A business entity that performs claims administration and related business functions for a self-insured entity. A contract is signed with a TPA to administer parts of health coverage, which does not share in the potential risk of loss as does an insurance company.

Uncompensated Care: Health care that is not paid for either out of pocket by the uninsured themselves or by a private or public insurance source.

Upper Payment Limit (UPL): Provides additional assistance to hospitals with uncompensated care costs. UPL allows states to enhance Medicaid payments to health care providers as long as the payments do not exceed what Medicare would have paid for the same service. States use intergovernmental transfers to provide the state's contribution to these UPL payments.

BACKGROUND

INTRODUCTION AND OVERVIEW

Hillsborough HealthCare¹ provides a comprehensive managed care plan for low-income, uninsured residents of Hillsborough County that do not otherwise qualify for health care coverage. The plan was developed in response to a decision by the Hillsborough Board of County Commissioners (BOCC) to find a way to provide more cost-effective and accessible care for these people. Based on the belief that communities can control indigent health care costs by investing in a managed care model of service delivery that emphasizes prevention and early intervention, the plan's major goals are to:

- Improve access to primary health care.
- Assure the quality of health care.
- Improve integration of medical, mental health, substance abuse, and social services.
- Increase the level of prevention and early intervention.
- Reduce per patient expenditures.

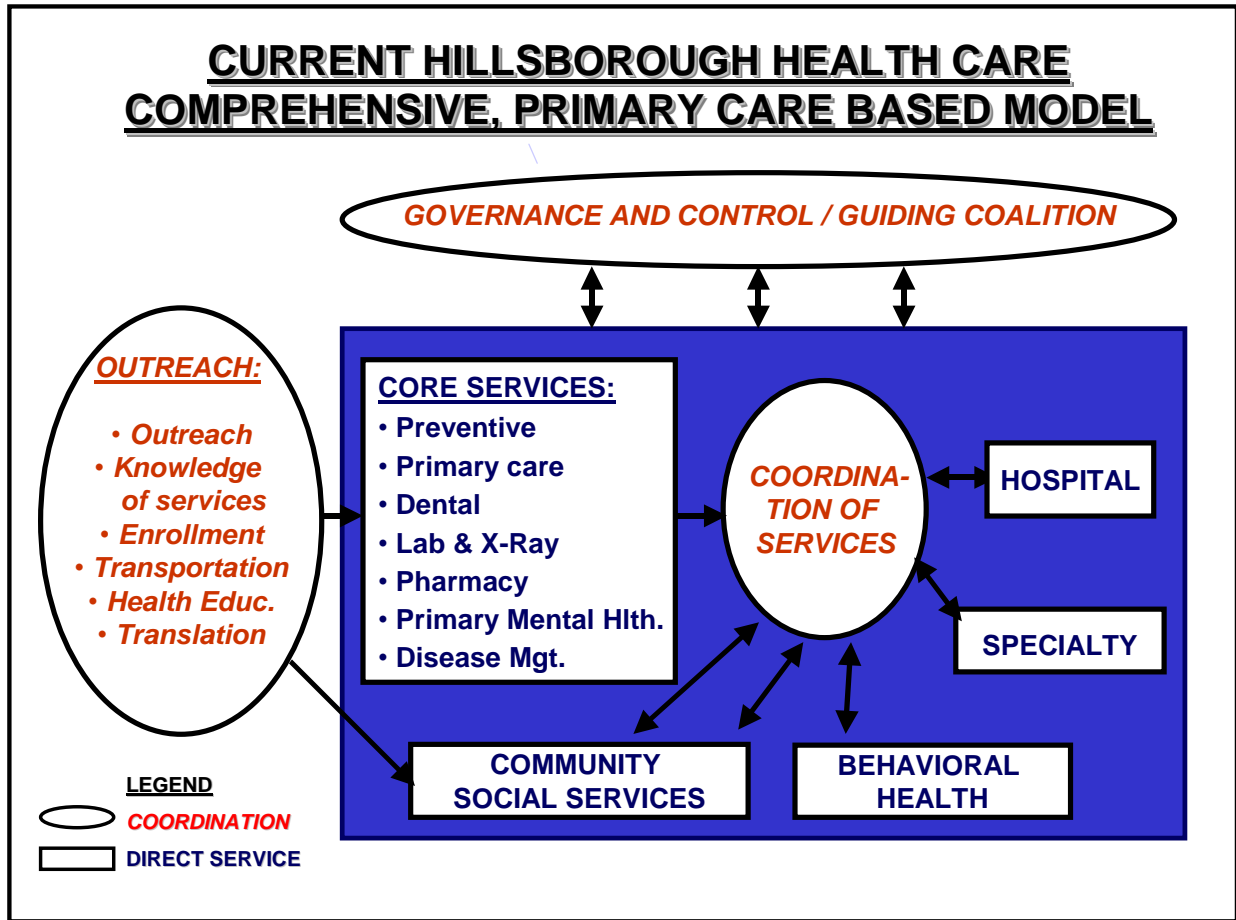
Funding for Hillsborough HealthCare is obtained primarily from a one-half cent sales tax that was passed by the BOCC on September 21, 1991, as authorized by subsections to Florida's statute 212.055. The BOCC establishes policy for the managed care plan with the advice of a community-based Health Care Advisory Board (HCAB). The County's Department of Health and Social Services (HSS) is responsible to the BOCC for administering the plan.

The total amount of money collected through the ½ cent sales tax is deposited into the Sales Tax Trust Fund. This money is used to pay for Hillsborough HealthCare, the managed care plan. In addition, it has been used to fund Hillsborough County's required local Medicaid match and a \$3.5 million subsidy for Level I trauma centers.

Historically, Hillsborough HealthCare has delivered health services through four geographically-based service networks made up of primary care physicians, specialists, and hospitals. The County contracted with the provider networks, which were paid to furnish services consistent with patients' treatment plans. Each network oversaw the provision of all services within its geographical area. As the "gatekeeper" to the service network, the primary care physician was responsible for authorizing referrals to specialists and inpatient facilities. The County conducted outreach and determined eligibility for the plan.

¹ When Hillsborough enacted its managed care plan for indigent health care, the State enabling legislation referred to the program as the Hillsborough County Health Care Plan (HCHCP). Over time, while legal documents continue to refer to this name, the program is also called the Hillsborough HealthCare. Both terms and the abbreviation, HCHCP, are used in this document to refer to the managed care plan.

A graphic depicting the concept of the comprehensive network is displayed below.



Hillsborough HealthCare has had a significant impact on indigent health care in Hillsborough County. The managed care plan has resulted in the development of a community-based primary health care service delivery system for the indigent in a county where one previously did not exist and has directed uninsured low-income residents away from higher cost hospital-based settings for care, thus reducing the rate of growth in projected health care expenditures.

HISTORY OF THE MANAGED CARE PLAN

In 1990, as the result of fiscal problems, consideration was given to the possibility of privatizing Tampa General Hospital — an action strongly opposed by the community. The BOCC passed a motion declaring its support for maintaining Tampa General as a public hospital and its commitment to finding better solutions for financing indigent health care, a reason given by Tampa General Hospital for its fiscal problems.

The BOCC appointed a committee to look into the problem of financing indigent health care. The committee recommended that additional funds be raised for this purpose by increasing the county's sales tax. The BOCC directed staff to work with the Hillsborough delegation to seek authorization to levy a one-third cent sales tax for this purpose. Despite the efforts of the delegation and staff, such legislation was not passed.

On May 2, 1990 the BOCC created the Hillsborough County Health Care Advisory Board (Advisory Board) to study health care cost control and access to needed services, and to assist with the development of recommendations that could serve as the basis for a sound health care plan. The Advisory Board was charged with developing a "model plan" for BOCC approval before the beginning of the 1991 legislative session.

On November 21, 1990, the Advisory Board presented a plan to the BOCC describing its vision: a managed care system designed to provide prevention and early intervention services with effective cost controls. Services would be delivered through a network of neighborhood-based primary care centers that would improve access to health care for indigents and reduce inappropriate emergency room use and hospital admissions.

The BOCC endorsed the Advisory Board's plan and directed staff to work with the Advisory Board and the community to persuade the state legislature to authorize the County to levy a limited, local option sales tax to support indigent health care. Countless hours were spent discussing indigent health care with community groups representing every constituency in the county. Finally, in 1991, with the community's support, the State legislature passed Chapter 212.055, which contained sub-sections that authorized the County to pass a one-half cent sales tax to fund the model plan.

The BOCC directed the Advisory Board and County staff to develop more detailed plans. Four community-based committees were established for this purpose. The committees developed a plan that divided the county into four service zones. Each zone housed a neighborhood health center with a full array of primary health care services and a pharmacy.

In the proposed plan, primary care physicians at the neighborhood health centers would act as gatekeepers to secondary, tertiary, and ancillary services. Outpatient, inpatient, and emergency treatment would be available from participating hospitals and outpatient clinics. Ancillary services would include home health care, dental services, vision care, hospice, durable medical equipment, medical supplies, etc.

Eligibility was based on having an income at or below 150% of the federal poverty guidelines, with the County serving as the payer of last resort. A uniform data collection system would facilitate information-sharing. The plan concluded with a discussion of quality assurance. Included were recommendations for ongoing, bi-annual, and annual peer monitoring, self-assessment, and independent reviews of the financial and medical aspects of the program.

When the plan was presented to the BOCC, a number of questions remained and, as a result, a plan addendum was brought to the BOCC on September 21, 1991 with more details. Staff advised the BOCC that the County would reach a state-imposed ten mill cap on property taxes by the 1992-93 fiscal years if indigent health care costs were not reduced or another source of funding identified for these expenditures. Without an increase in the ten mill cap, the County would have to cut other services funded with property taxes in order to maintain its support of indigent health care.

In addition, staff reminded the BOCC that, according to state law, counties levying a sales tax for indigent health care were required to continue to fund these services with property taxes at the same level as they had during the fiscal year prior to passing the sales tax. The County could save \$42 million over the next seven years if the BOCC acted before the 1990-91 fiscal year began.

With these facts in mind and a plan in hand, the BOCC unanimously authorized the collection of a one-half cent sales tax for the next seven years to implement the new indigent health care program as described in the planning documents. However, because commissioners were concerned about the impact of the proposed eligibility requirements, they directed staff to establish eligibility criteria for the plan based on an income at or below 100% of the federal poverty guidelines.

CHARGE OF HEALTH CARE STUDY COMMITTEE

On February 2, 2005 HSS staff presented a report to the BOCC that projected a deficit of \$6 million in the FY 2005-06 budget of the health care program if changes were not made. The major reasons for this deficit were unexpected increases in user volume and close to a 20% increase in the required local Medicaid match over multiple years. To prevent the deficit, the report recommended several short-term cost-saving measures involving catastrophic, dental, vision, and pharmacy services. In addition, the report recommended that the HCAB develop a plan to assure the program's long-term viability.

After considerable deliberation, the BOCC accepted the report's short-term cost-saving recommendations and on March 2, 2005 established the Health Care Study Committee (Study Committee) to re-evaluate the structure of managed care plan. The BOCC asked the Study Committee to recommend changes that would result in the best service for the residents of Hillsborough County and protect the long-term financial viability of the plan. The BOCC charged the Study Committee with:

- Looking at many other models.
- Getting the best product possible while being true to the original vision and the budget available.
- Examining the delivery of care in the current plan to see what works and what new ideas could be added.
- Preparing a report that shares ideas and defines the changes and their impact.
- Conducting the planning in a pro-active, as opposed to a reactive, manner.

The Study Committee was asked to complete its report by the end of the summer in 2005, with the understanding that the committee's report would be reviewed by the HCAB and then forwarded to the BOCC with the HCAB's comments.

PROCESS USED BY STUDY COMMITTEE

The Study Committee held its first meeting on March 29, 2005. At this meeting, the committee reviewed its charge. The County Attorney provided an orientation to Florida's Sunshine Law (Section 286.011, Florida Statutes) and the importance of committee members not having a conflict of interest (e.g. financial interest in the committee's outcome) was discussed. As required by BOCC policy, committee members were asked to sign an anti-lobbying disclosure form.

At this meeting, the Study Committee was given an Orientation Manual with information about Hillsborough HealthCare – its history, structure, and benefits. After HSS staff discussed the challenges and pressures that the program faced, the committee reviewed the mission statement of Hillsborough HealthCare and, to provide a framework for its deliberations, decided to update the plan's mission statement.

On April 15, the Study Committee formed three sub-committees to explore the issues that the committee believed were the most critical in terms of the ability of Hillsborough HealthCare to fulfill its mission: Core Services; Management and Administration; Compensation and Incentives. In addition, the committee established a fourth sub-committee, Innovations and Best Practices, to brainstorm creative, new ideas that might be "outside the box."

The Study Committee finalized the membership of the sub-committees at its April 29 meeting. Included on each were current and prospective providers. Members of the Study Committee chaired and vice-chaired the sub-committees, each of which was furnished a list of questions to answer by the middle of July. It was understood that, while these groups would make recommendations to the Study Committee, only the Study Committee would be able to make recommendations to the BOCC.

The Study Committee continued to meet while the sub-committees were working, providing a forum for the sub-committees to report back to and also to address issues raised in sub-committee meetings. The Study Committee held fifteen meetings between March 29 and September 9, which included a videoconference with Dr. David Cutler (Harvard University) on the subject of pay for performance as well as presentations by managed care providers and the four existing health care networks on the services that they provide. During the period, the committee also heard presentations from and examined information about models of health care plan implemented in other Florida counties (see Appendix).

The sub-committees held a total of 30 meetings from April 22 until July 21. The Management and Administration Sub-Committee merged with the Compensation and

Incentives Sub-Committee on June 10, when the chair of the former departed. On July 22, the sub-committees presented their reports and recommendations to the Study Committee. The recommendations of the sub-committees (see Appendix) were accepted, with the exception of certain items that were “red-flagged” for further discussion (see Appendix).

From July 22 to September 9, the Study Committee reviewed materials, debated issues, formulated recommendations above those in the sub-committee reports, and developed this report. (See Appendix for list of motions made.) In addition, the committee worked with staff to calculate the “Return on Community Investment (see Appendix). The HCAB, provided with updates throughout the process, met on September 15 to completed its review of the final report. The Study Committee held a final meeting on September 23 to prepare for its October 5 presentation to the BOCC.

The Study Committee and its sub-committees held a total of 45 meetings between March 29 and September 23. All meetings were posted as required by Florida law. Minutes and tapes of the meetings were made available to public for review. In addition, the Study Committee established a website where meetings were noticed, minutes were posted, and materials distributed to the committee and sub-committees were made available to the public. Every meeting of the Study Committee and its sub-committees ended with the opportunity for public comment. Additionally, non-members were encouraged to contribute to the discussion during sub-committee meetings.

MISSION AND GOALS

EXISTING MISSIONS AND GOALS

In 1993, the Health Care Advisory Board approved the following mission for Hillsborough HealthCare:

To assure, within available resources, the provision of quality health care to the County's eligible medically poor residents who lack other coverage.

This will be accomplished by:

- *Promoting access to health care providers within the County,*
- *Giving special emphasis to prevention, early intervention and health education,*
- *Promoting coordination among appropriate social service agencies, and*
- *Encouraging the efficient use of available resources.*

Later, in 1997, the HCAB approved a mission change that reflected a more generic role that went beyond Hillsborough HealthCare. This revised mission was:

To improve the health of eligible residents by providing quality health services at reasonable cost and in a manner which contributes to the overall health of the community.

Then, in 2002, the HCAB, as part of financial planning, took on goals that emphasized the following concepts:

- *Restore Hillsborough HealthCare to its original mission / purpose.*
- *Demonstrate fiscal responsibility by operating within budget.*
- *Provide high quality care for greatest number of people.*
- *Simplify plan to improve quality of the experience for the clients, providers, staff, HCAB, and the community.*
- *Reaffirm commitment to enhance / improve partnerships.*
- *Re-establish appropriate reserve balance in Trust Fund.*

RECOMMENDED MISSION AND GOALS

In readdressing the mission of Hillsborough HealthCare, the Study Committee chose to emphasize, consistent with the revisions made to the plan's mission statement in 2002, that Hillsborough HealthCare must return to its original mission and pursue a plan for fiscal viability that accentuates stabilization of the reserve fund and operating within budget. In addition to some wording changes, new concepts added to the mission emphasize the importance of individuals being responsible for their own health, the

continued development of information technology, and that reimbursement to providers and incentives to users of services must support achievement of the plan's goals.

Therefore, the Study Committee recommends the following mission:

To assure within available resources, the delivery of quality health care for the County's eligible medically poor residents who lack other coverage.

This mission will be accomplished by achieving the following goals:

- ***Promoting efficient and effective access to health care services within the County.***
- ***Giving special emphasis to health education, prevention, early intervention, and disease and case management with measurable outcomes.***
- ***Promoting coordination among appropriate health and social service agencies.***
- ***Motivating and educating program participants to be responsible for their health.***
- ***Establishing information technology systems that support effective program management and the delivery of quality health care services.***
- ***Structuring reimbursement and other incentives to support achieving the above goals.***

The recommendations developed for restructuring the managed care plan must reflect this mission.

ANALYSIS

TARGET POPULATION

Number of Hillsborough Uninsured

Hillsborough HealthCare, the managed care plan, serves uninsured residents of Hillsborough County living at or below 100% of the federal poverty level. The Florida KidCare program provides health care coverage for children under 19 years of age who live in households that are at or below 200% of the federal poverty level, while Medicare provides health care coverage for uninsured persons who are 65 years of age or over. For this reason, the managed care plan specifically targets low-income uninsured persons between 19 and 64 years old.

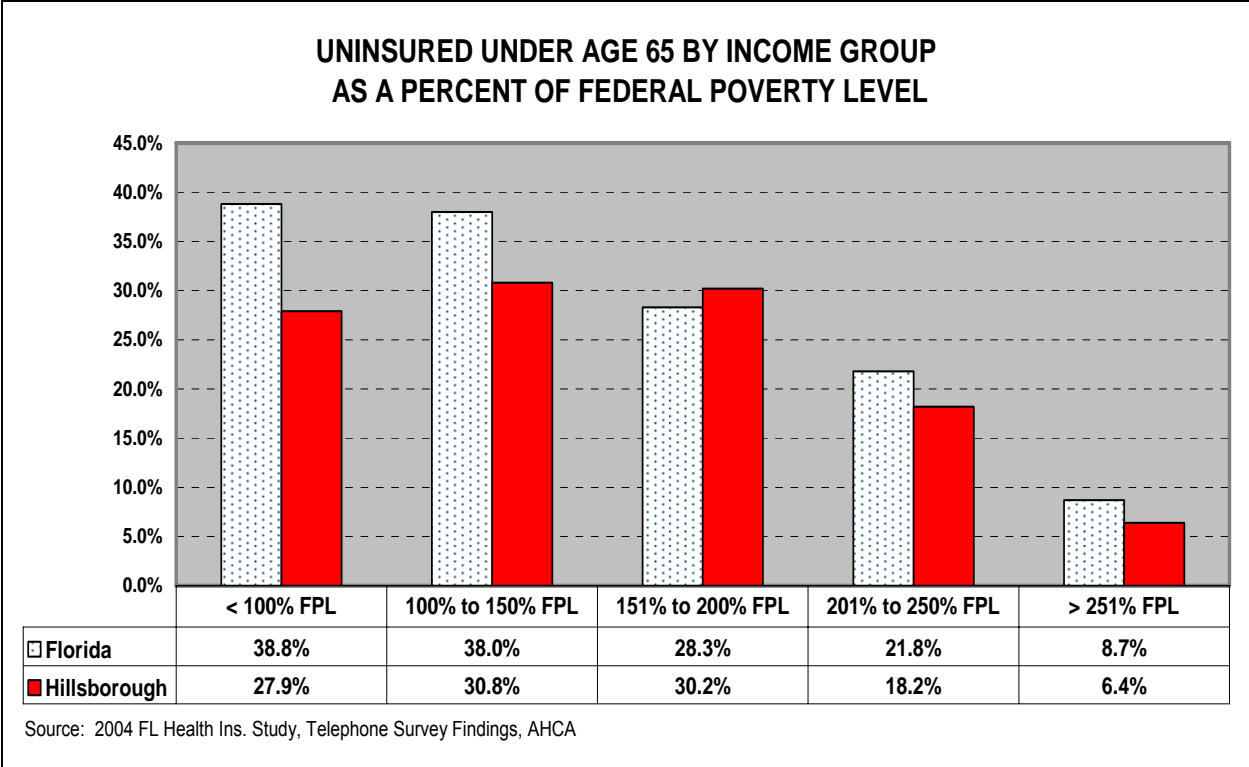
The chart below presents estimates for the number of Hillsborough non-elderly uninsured by income group using data from the Agency for Health Care Administration (AHCA) 2004 Florida Health Insurance Study and the 2003 U.S. Census Bureau's American Household Survey.

ESTIMATE OF HILLSBOROUGH UNINSURED BY INCOME GROUP AS A PERCENT OF FEDERAL POVERTY LEVEL					
INCOME AS A % OF FEDERAL POVERTY LEVEL	POPULATION		UNINSURED		
	ALL AGES	< 65 YRS.	% OF < 65 YRS.	POP.	% OF ALL UNINSURED
<100% FPL	144,071	128,903	27.9%	35,964	27.4%
100% to 150% FPL	102,997	75,276	30.8%	23,185	17.7%
151% to 200% FPL	93,769	80,882	30.2%	24,426	18.6%
>200% FPL	706,567	644,654	7.4%	47,515	36.2%
TOTAL	1,047,404	929,715	14.1%	131,090	100.0%

Data Sources: 2004 Florida Health Insurance Study (AHCA) and 2003 U.S. Census Bureau

As shown in the chart, approximately 14% of Hillsborough residents below 65 years of age are uninsured. By applying this percentage to 2003 census data, it is estimated that there are 131,000 Hillsborough residents under 65 years of age are uninsured. Approximately 60,000 or less than half (45%) of the 131,000 persons have income below 150% of federal poverty level. Almost 36,000 or over one-quarter (27%) of the non-elderly uninsured persons have income below 100 % of the federal poverty level.

In the chart below, the percentage of uninsured Hillsborough residents is compared to the percentage of uninsured Florida residents by income.



As illustrated in the chart, at low-income levels, the percentage of uninsured Hillsborough County residents is less than the percentage of uninsured Florida residents.

- For people with income less than 100% of the federal poverty level: Hillsborough 27.9% vs. Florida 38.8%
- For people with income between 100% and 150% of the federal poverty level: Hillsborough 30.8% vs. Florida 38.0%

Ethnicity of Hillsborough Uninsured

The ethnic mix of the estimated number of uninsured persons is only available for all income groups. The chart on the following page presents estimates about the ethnic distribution of uninsured residents of Hillsborough County. This ethnic grouping utilizes definitions and titles used by the U.S. Census Bureau as clustered by AHCA in its survey, which is the only way that the data are available. (The ethnic clusters are White Non-Hispanic, Hispanics, Blacks, and Other. Examples of groups in the Other category are Native Americans and Asians.)

The percentage of White Non-Hispanics without insurance (11.9%) is significantly lower than all other ethnic groups (17.5% for Hispanics, 16.5% for Blacks, and 24.3% for Other). In aggregate, slightly more than half of the 131,000 Hillsborough uninsured are from ethnic groups other than Non-White Hispanic.

While specific data are not available, the large uninsured number for the Other category likely reflects numbers from the Asian ethnic group, particularly Southeast Asia.

**HILLSBOROUGH COUNTY UNINSURED UNDER AGE 65
BY RACE/ETHNIC GROUP**

RACE/ETHNIC GROUP	UNINSURED		
	PERCENTAGE		EST. POP.
	OF GROUP	OF TOTAL	
White Non- Hispanic	11.9%	48.3%	63,380
Hispanic	17.5%	25.6%	33,507
Black	16.5%	19.2%	25,182
Other	24.3%	6.9%	9,020
TOTAL	14.1%	100.0%	131,090

Sources: U.S. Census' 2003 American Community Survey, AHCA's 2004 FL Health Ins. Study.
Ethnic group titles and description are those of U.S. Census Bureau.

The chart below shows the ethnicity of Hillsborough HealthCare Program enrollees. As shown in the chart, together Hispanics and Blacks comprise 54% of the managed care plan's enrollees as compared to only 45% of the estimated uninsured.

**HEALTH CARE PROGRAM ENROLLEES, FY 2004
RACE / ETHNIC GROUP**

RACE / ETHNIC GROUP	% OF ENROLLEES
White	44.4%
Hispanic	27.4%
Black	25.6%
Other	2.6%

Source: County Records

Population Below Poverty Reached by Hillsborough HealthCare

The 2004 Hillsborough uninsured rate for individuals less than 65 years old living at or below 100% of federal poverty level is 28% in comparison to 38% for the State on the whole. The chart below applies these rates to 2003 census data for to develop estimates of the number of non-elderly uninsured persons living at or below 100% of federal poverty level in Hillsborough County. There is a 14,000 person difference in the two estimates, which is comparable to the enrollment in the managed care plan.

COMPARISON OF BELOW POVERTY UNINSURED FOR HILLSBOROUGH UTILIZING COUNTY RATE AND STATE RATE

CALCULATION	HILLSBOROUGH % UNINSURED	FLORIDA % UNINSURED
Hillsborough Population <100% FPL and < 65 yrs. old	128,903	
X % of Population Uninsured	27.9%	38.8%
= Population Uninsured	35,964	50,014
DIFFERENCE	-14,050	

Sources: U.S. Census' 2003 American Community Survey, AHCA's 2004 FL Health Ins. Study.

A total of 21,977 of the persons enrolled in Hillsborough Healthcare during 2004 were living at or below the federal poverty level. The AHCA survey includes the managed care plan's members in the insured category. An estimate of the percentage of the eligible population below 100% of federal poverty level can be determined by dividing enrollees during the year by the sum of the survey's uninsured below 100% (35,964 people) plus the annual number of non-elderly living in poverty served by the plan (21,977). Therefore, as detailed in the chart below, it is conservatively estimated that the managed care plan reaches 38 % of the non-elderly uninsured living below poverty.

**ESTIMATED PERCENT OF UNDER AGE 65
HILLSBOROUGH UNINSURED POPULATION LIVING IN POVERTY
COVERED BY HILLSBOROUGH HEALTHCARE PROGRAM**

FOR COUNTY POPULATION <65 YRS. OLD LIVING IN POVERTY (*):		
a.	Hillsborough Population	128,903
b.	% Uninsured of Hillsborough Pop.in Group	X 27.9%
c.	Total Number Uninsured	35,964
d.	Total 2004 HealthCare Enrollees	+ 21,977
e.	Total Potential Enrollment	57,941
f.	% of Potential Enrollment Enrolled in HealthCare Program	37.9%

SOURCES / NOTES:

- (*) Definition of Living in Poverty: People at or below 100% of Fed. Poverty Level.
- 2003 Census Bureau.
 - 2004 FL Health Ins. Study (AHCA) which considered Hillsborough HealthCare, Medicaid, Medicare, and other Govt. health program enrollees as insured.
 - = a. X b.
 - Hillsborough HealthCare Enrollment data. Since the AHCA survey asks if an individual was covered in the last year, the annual total is an appropriate statistic for this calculation.
 - = c. + d.
 - = d. / e.

Health Issues Related to Ethnic and Social Disparities

The three major chronic disease entities believed to benefit from disease management are diabetes, pulmonary diseases (such as asthma), and cardiovascular diseases (such as hypertension). Overall, minority and low-income populations are more likely than others to have and to die from these diseases. Obesity and smoking are a common thread among these diseases.

Utilizing September 2002 to January 2003 survey data from the Florida Department of Health, the Hillsborough incidence rate of these three chronic diseases and the percentage of adult smokers can be compared by income groups and by ethnic groups. The lower-income residents of Hillsborough had higher prevalence of all of these indicators than the higher income groups.

The ethnic data only splits out White, Black, and Hispanic. For these ethnic groups, there are differences in incidence rates:

- Asthma - Hispanics have a much higher incident rate than Whites and Blacks.
- Diabetes - Blacks have a much higher incident rate than Whites and Hispanics.
- Hypertension – A much higher incident rate for Blacks. Hispanics have the lowest incident rate.
- A higher percentage of Whites smoke than do Blacks or Hispanics.

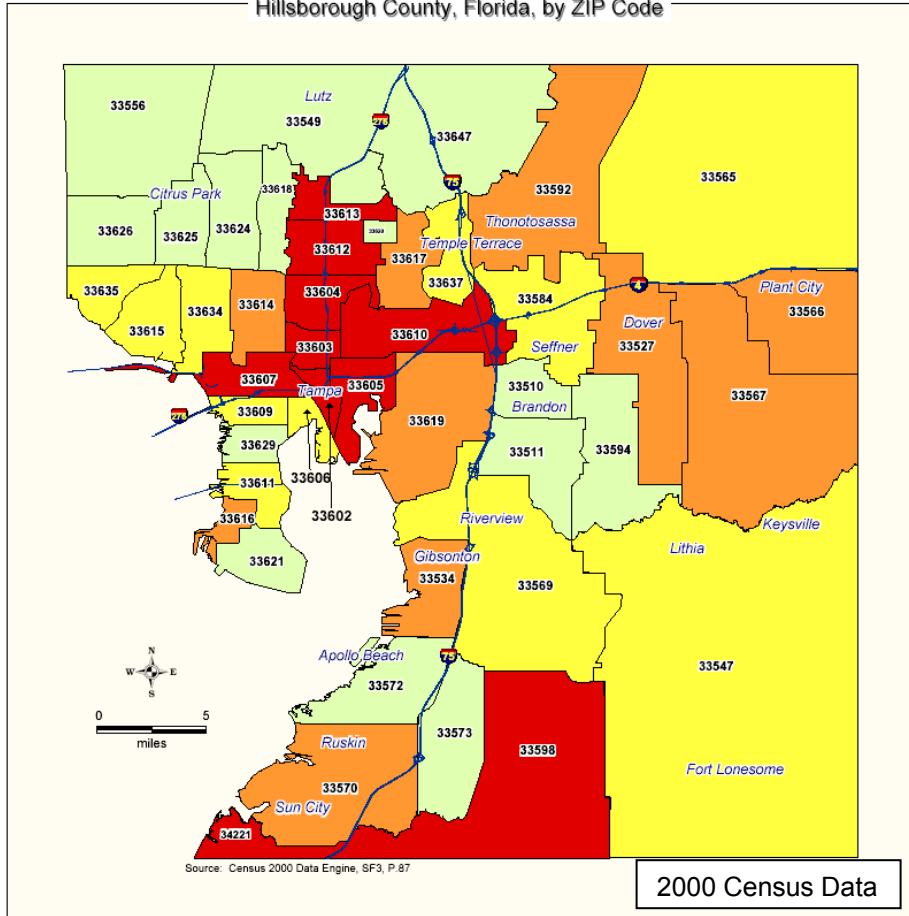
SELECTED PREVALENCE RATES FOR HILLSBOROUGH RESIDENTS BY RACE / ETHNIC GROUP			
INDICATOR	RACE / ETHNIC GROUP		
	WHITE	BLACK	HISPANIC
Ever Had Asthma	6.3%	8.6%	20.6%
Person Told by Professional That He/She Has:			
Diabetes	5.3%	12.1%	6.3%
Hypertension	24.5%	36.2%	18.1%
Currently Smokes	24.0%	21.6%	21.4%
SELECTED PREVALENCE RATES FOR HILLSBOROUGH RESIDENTS BY ANNUAL INCOME			
INDICATOR	ANNUAL INCOME		
	< \$25K	\$25K - \$50K	>\$50K
Ever Had Asthma	15.6%	9.1%	6.4%
Person Told by Professional That He/She Has:			
Diabetes	9.3%	5.9%	5.0%
Hypertension	35.2%	23.7%	20.7%
Currently Smokes	29.5%	19.4%	20.4%
Source: 2002 County Behavioral Risk Factor Surveillance System (BRFSS) Study, Florida Dept. of Health			

Geographical Distribution of Target Population

As shown in the map on the following page, in absolute numbers, the County's population living in poverty are concentrated in the central city and along the I-275 corridor.

Percent of Population in Poverty

Hillsborough County, Florida, by ZIP Code



Percent of Individuals At or Below Poverty Level by ZIP Code in Hillsborough County, Florida

- 21.5% to 42.4% in poverty (10)
- 12.5% to 21.4% in poverty (10)
- 7.8% to 12.4% in poverty (11)
- 0% to 7.7% in poverty (15)

(Numbers in parentheses indicate number of ZIP Codes falling within this range)

Note: In Hillsborough County, Florida, 12.5% of the total population is below the federal poverty threshold.

- ZIP Code Boundary
- Interstate Highway

FINANCIAL DATA AND TRENDS

Expenditures

In 1996, after the balance in the Sales Tax Trust Fund rose to over \$150 million, policy and management decisions were made to reduce the sales tax rate from ½ cent to ¼ cent and to eliminate a \$26.8 million contribution to the Sales Tax Trust Fund from the County's general fund. At the same time, policy and management decisions were made to increase the use of sales tax funds for expenditures not directly related to the managed care plan. Between 1997 and 2001, expenditures from the Sales Tax Trust Fund rose at the same time that sales tax revenues went down, primarily due to increased non-plan costs. After the balance in the Sales Tax Trust Fund went down to \$16 million, a policy and management decision was made to increase the sales tax from ¼ cent back to ½ cent.

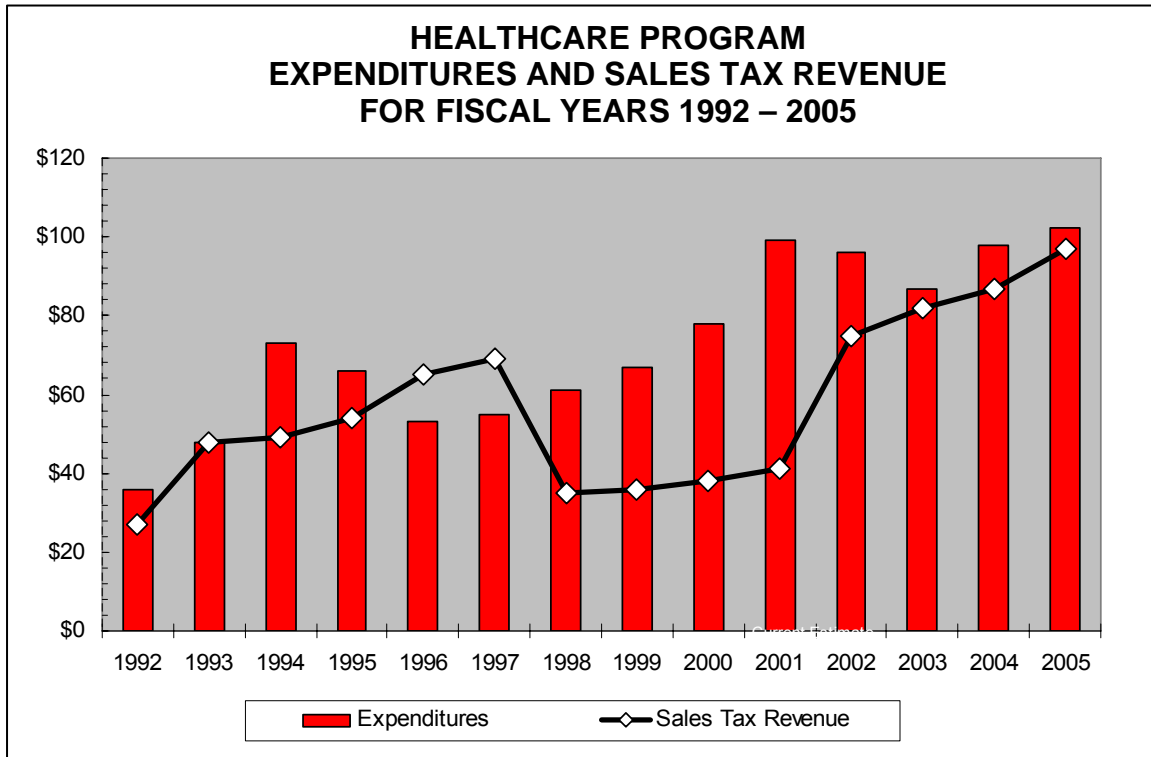
This year, after several years of between 18% and 20% annual increases, a 16% increase is expected in the Medicaid match. Overall, the Medicaid match has increased by 63% in the past five years causing concern, therefore, over how the Medicaid match should be funded in the future. In addition, the source of funds for paying the Medicaid match was complicated by an attorney general's opinion to Polk County that the Medicaid match could not be paid for out of sales tax under the same enabling legislation as Hillsborough's program. As a result, Hillsborough has requested an opinion from the attorney general specifically for its program.

In 2002, the BOOC approved both short- and long-term financial strategies developed by administration and the HCAB to address deficiencies noted in a consultant's operational review of the health care program. The following year, in 2003, the State passed legislation that eliminated "sunsetting" of the managed care plan with the requirement that the plan be audited bi-annually. In 2003, as part of budget process, the BOCC approved adding \$5 million in FY 2004 and \$6.9 million in FY 2005 from the general fund into the Sales Tax Trust Fund to address increased enrollment and increases in the required local Medicaid match.

In 2004, the consultant's operational report indicated considerable improvement over the January 2002 report. The same year, the BOCC approved a \$6.9 million amendment to FY 2004 budget to cover costs due to increased County share of Medicaid (\$2.95 million), increased medical expenditures due primarily to unbudgeted increase in members (\$3.95 million), and decreased sales tax collection from State's previous estimate (\$1.0 million). In early 2005, HSS staff presented a report to the BOCC projecting a deficit of \$6 million in the health care program's FY 2005 budget. Subsequently, the BOCC approved several short-term cost-saving measures involving the managed care plan's catastrophic, dental, vision, and pharmacy services, which the BOCC approved.

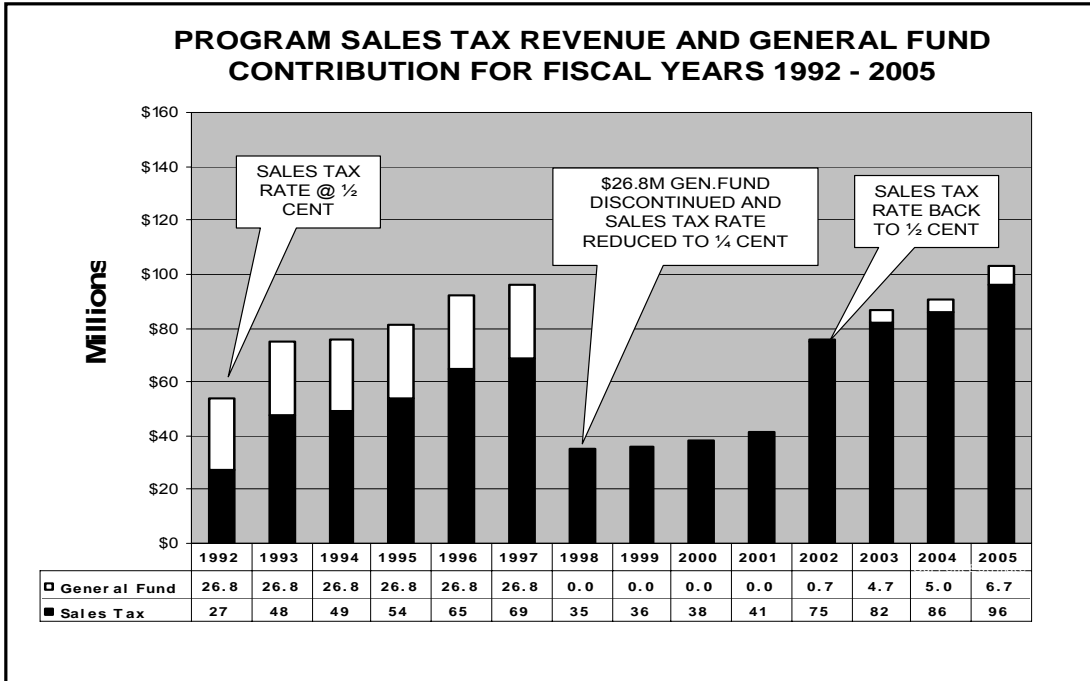
As shown in the chart below, with the exception of the years between 1998 and 2001, expenditures for the Hillsborough HealthCare Program and sales tax revenue

increased at approximately the same rate. Annually, revenue and expenditure increases averaged from 5% to 6% with the exception of 1998-2001, when the sales tax rate was reduced from ½ cent to ¼ cent. Additionally, the general fund contribution to the health care program decreased significantly over these years.



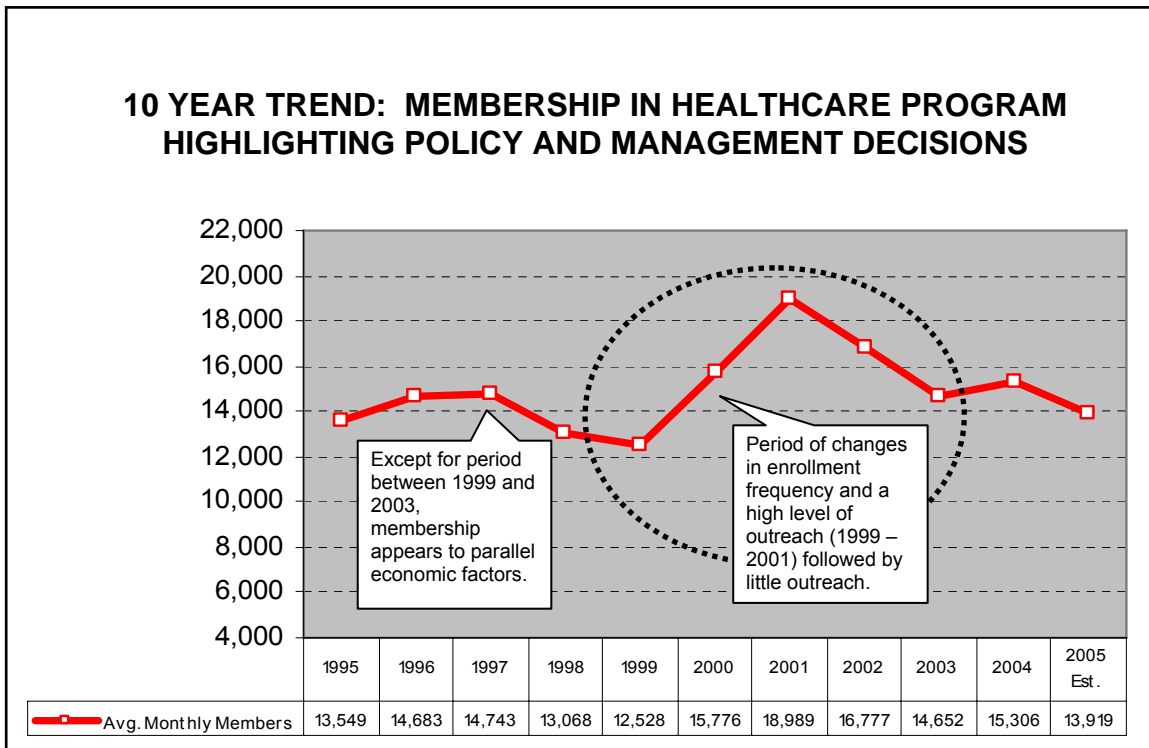
The chart on the next page shows sales tax revenue and general fund contributions to the health care program from 1992 to 2005.² As shown in the chart, for the first years of the program (1992-1997), there was a general fund contribution to the program of \$26.8 million annually. In FY 1998, the general fund contribution was discontinued. Between 1998 and 2002, sales tax revenue declined due to a recession and decisions were made to increase the funding of non-plan services with sales tax dollars. This reduced the balance in the Sales Tax Trust Fund to \$16 million, resulting in the need to reinstitute a general fund contribution to the program beginning in FY 2003. Since that year, the general fund contribution has remained at a low level, with the \$6.7 million budgeted in FY 2005 being the largest contribution requested.

² Sales tax for FY 2005 is estimated.



Membership

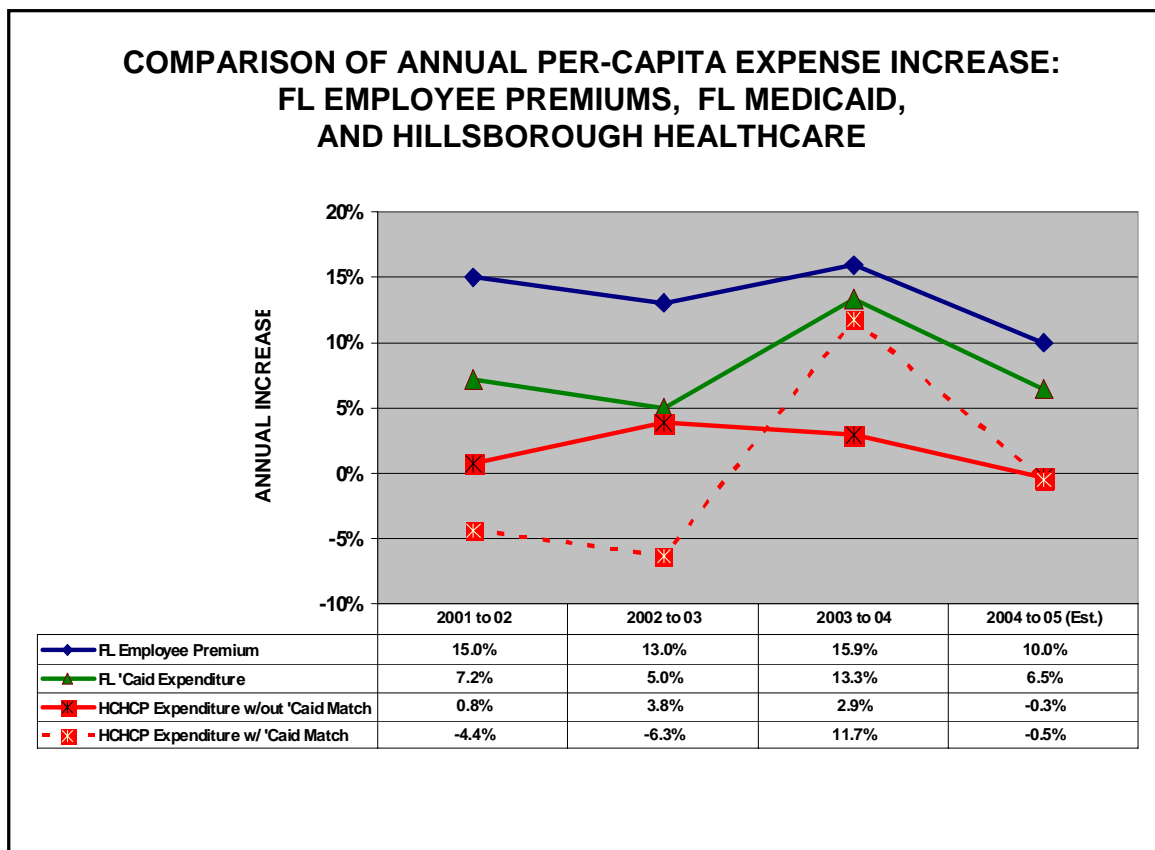
The chart below shows that, with the exception of the years between 1999 and 2003, there are parallels between membership levels and the percentage of uninsured.



Changes in the frequency of enrollment and outreach appear to affect membership in the plan. Between 1999 and 2003, policy and management decisions appear to be the main drivers of membership levels. Although membership decreased between 2001 and 2003, high users of services remained in the plan and, as a result, per member per month costs did not go down and, in fact, increased by 17.9% in 2002 and 11.1% in 2003.

Growth of Plan Expenditures Compared to Employer Coverage Growth

As shown in the chart below, the per capita growth in expenditures for the Hillsborough HealthCare program compares quite favorably to the per capita growth of Florida employee premiums (the combination of employer and employee contributions). The health care program per capita growth also compares favorably to the Medicaid growth.



The chart on the following page shows the financial impact of the recommendations made in this report as well as a timeframe for when these impacts are expected to occur.

SUMMARY OF FINANCIAL IMPACT OF RECOMMENDATIONS AND TIMEFRAME

CATEGORY AND RECOMMENDED ACTION	ANNUAL IMPACT WHEN FULLY IMPLEMENTED (IN \$ MILLIONS)	TIME FRAME	NOTE
<u>A. IN PROCESS OR NEAR TERM COST ELIMINATION ACTIONS:</u>			
1. Discontinue prescription coverage for Medicare Members	\$5.0	10/1/2006	(a)
2. Discontinue paying hospital facility charges for "retros"	\$3.2	6/1/2005	
3. Phase out of Medical Crisis Intervention Program	\$11.0	9/30/2006	(b)
4. Continue \$1 co-pay for prescriptions for members <100%FPL	\$0.4	10/1/2004	
5. Reduce program administrative costs / soc. sves.case mgt.	\$1.5	9/30/2007	
6. Decrease in General Fund Contribution (FY05 to FY06)	(\$3.2)	10/1/2005	
7. <u>Less: budget reduction/efficiency for Medicare</u>	<u>(\$3.8)</u>	10/1/2005	(a)
Total to fund transition to all members at of below 100%FPL	\$14.2		
<u>B. FUNDING POLICY DECISIONS:</u>			
1. Continue sales tax at 1/2 cent; discontinue general fund support.	None if Budget Change	10/1/2005	(c)
2. Medicaid match should not exceed 4 year rolling average or 10% of gross sales tax whichever is less for FY06 and FY07	\$3.7	10/1/2005	
3. Promote passage of legislation to eliminate Medicaid Match.	\$13.0	9/30/2006	(d)
4. Restore membership of 3 time felons	TBD	Ongoing	
5. Continue support for Level I trauma center.	TBD	Ongoing	(e)
<u>C. STRUCTURE CHANGES:</u>			
1. Desirable to provide core services from a single collaborative but may be done through more than one contract	TBD	10/1/2006	
2. Have a single contract to manage specialty services	TBD	10/1/2006	
3. Have multiple contracts for inpatient/ancillary services	TBD	10/1/2006	
4. Provide as many as possible overlay services from a single contract.	TBD	10/1/2006	
5. Implement pay for performance reimbursement for providers	TBD	10/1/2006	
6. Establish block ER payments to be budget neutral.	\$0.0	10/1/2006	
7. Develop incentives to foster adoption of interoperable health information technology	TBD	Ongoing	
8. Establish a program of system navigators	TBD	10/1/2006	
<u>D. OTHER RECOMMENDATIONS:</u>			
1. Facilitate creation of affordable health care for people >100%	TBD	9/30/2007	
2. Negative impact of a single contract with an insurance company for all services (Loss of upper payment limit and other State and Federal dollars).	(\$30.0+)	10/1/2006	(f)
3. Require primary care providers to participate in PAP programs	\$0.5	10/1/2006	

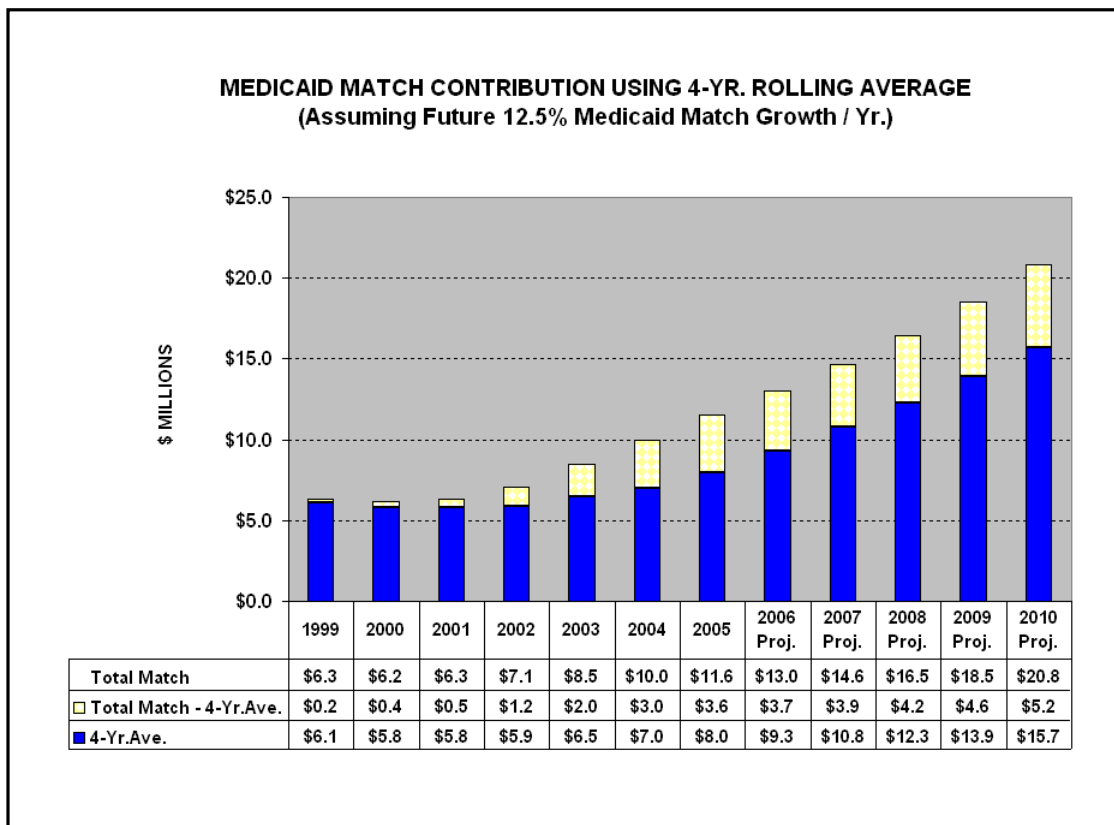
NOTES:

- (a) Medicare drug program starts 1/1/2006, therefore first full year of impact is FY07. FY06 is 9 months' impact (\$3.75M).
 - (b) Total is \$14.5M however \$3.5M is overlap with Medicare drugs or Retros. Therefore, \$11.0M entry is unduplicated.
 - (c) FY 06 and FY 07 budgets already have \$3.75M per year expense reduction. Budget reflects reduced expenses through less use of sales tax. To reduce another \$3.5 M is duplication unless there is a budget amendment to use full sales tax.
 - (d) If full local match requirement is removed and there is no other offsetting payment (such as jail health).
 - (e) Impact depends upon whether funding level remains at current \$3.5M.
 - (f) Includes both the loss of providers' direct upper payment limit match (\$6.7M) and other related leveraging (over \$23 M).
- TBD = To be determined.

RECOMMENDATIONS

SOURCE OF FUNDING

- Continue the sales tax at ½ cent solely for the purpose of providing a continuing revenue source for Hillsborough HealthCare, which should be self-sustaining and able to survive on revenues from the sales tax alone and not require any ad valorem taxes.
- The BOCC and Hillsborough County's legislative delegation should work together to pass legislation that will remove the requirement that Florida counties contribute a local match in order to participate in Medicaid.
- The Medicaid match contribution from the sales tax should not exceed the lesser of the four-year rolling average of expenditures for this purpose or 10% of the total gross sales tax revenue attributed to this program.
 - As shown below, based upon projections, the following would be the Medicaid match contribution from the plan in the next two years.



- **Pending underwriter's review, a minimum of \$3.5 million should be provided from the sales tax for trauma care based on service and accountability measures to be developed by staff.**

INCOME ELIGIBILITY AND TARGET POPULATION

- **Target people living at or below 100% of the federal poverty level who do not have access to health insurance from other sources or from government subsidized health programs, such as Medicaid or Medicare.**
 - Historically, Hillsborough HealthCare provided pharmaceutical, dental, and vision coverage for Medicare-eligible individuals, both elderly and disabled, with incomes at or below 100% of the federal poverty level. (Note: routine dental and vision coverage has been curtailed for all persons enrolled in the health care program.) Because Medicare will begin to provide pharmaceutical coverage in 2006, this coverage will be eliminated from the managed care program. HSS staff will continue to help individuals on Medicare to obtain pharmaceutical coverage through that program.
 - There will be an increased emphasis on health education, prevention, early intervention, and disease and case management with measurable outcomes.
 - Coverage for people living in poverty will further focus on the management of chronic diseases, specifically diabetes, cardiovascular problems, and pulmonary problems such as asthma. Close to two-thirds of the managed care expenditures are for individuals with one or more of these three diseases. This increased emphasis will lead to the early identification of uninsured persons living in poverty with chronic diseases that can be enrolled in the Hillsborough HealthCare Program and provided with disease management.
- **Evaluate the feasibility of facilitating the creation of a program(s) that provides affordable health care for low-income individuals living above 100% of the federal poverty level.**
 - In the longer run, there will be an evaluation of the financial feasibility of facilitating the creation of programs that provide affordable health care for low-income individuals living above 100% of the federal poverty level.
 - County action would be the facilitation of the creation of these programs in the private sector and, could if financially feasible, include government partial payments.
 - Options for affordable health coverage programs include but are not limited to HealthFlex type programs and cost-sharing programs.

“THREE STRIKES” PROVISION

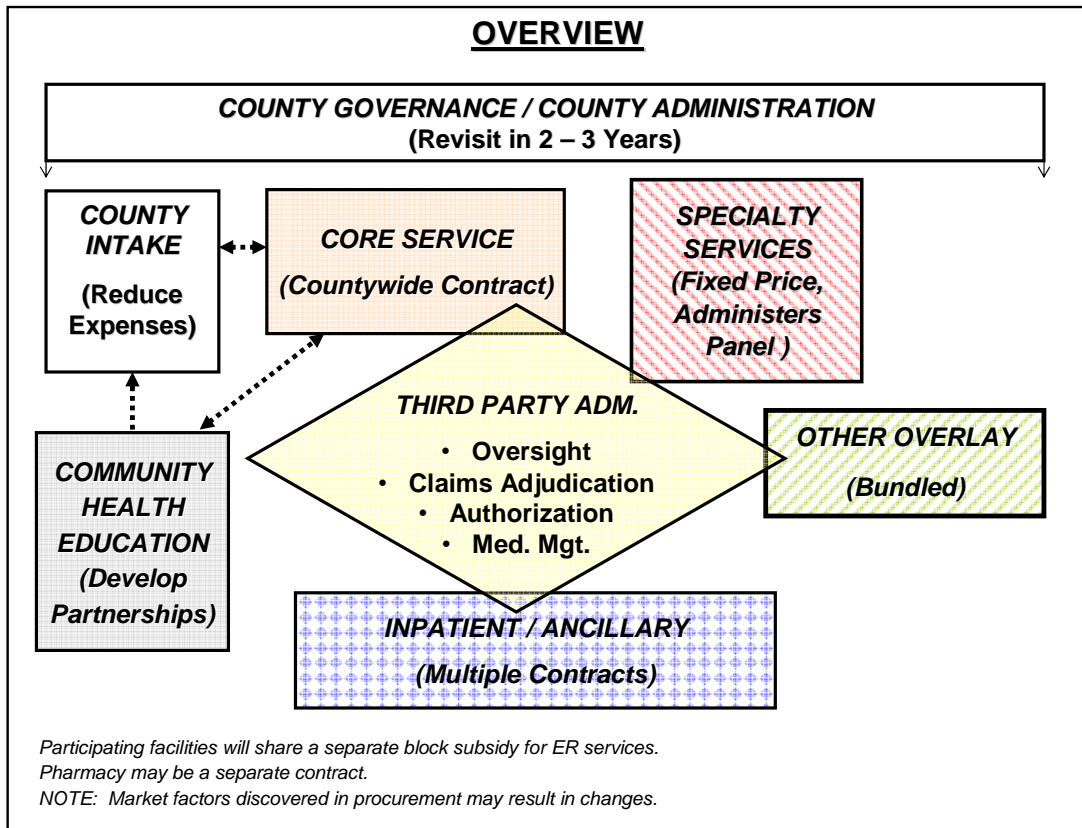
- **Reinstate the membership of three-time felons in the managed care plan after completion of all court-imposed sanctions, with the understanding that commission of a fourth felony after being reinstated will take them off the plan irrevocably.**

PROGRAM GOVERNANCE AND ADMINISTRATION

- **The current governance structure and control should be maintained for a period of two to three years in order to stabilize the program and reduce administrative costs through implementation of the proposed recommendations.**
 - This recommendation maintains the governance structure and administration of Hillsborough Healthcare for an additional two to three years so that the plan can stabilize and continue to reduce administrative costs, which were less than 8% in FY 2004. During this period of time, the BOCC will continue to establish policy for the managed care plan with the advice of the HCAB and its sub-committees. In addition, HSS will continue to staff the HCAB, monitor contracts, and implement the proposed recommendations, including streamlining program administration and reducing duplication of County and provider administrative costs. At the end of this period, the issue of governance and administration will be revisited to determine whether the plan has stabilized and administrative costs have decreased.

STRUCTURE OF THE PROGRAM

- **Transition Hillsborough HealthCare from being based upon multiple comprehensive networks to contracting for bundled components of services that best take advantage of the market strengths of providers.**
 - This recommendation provides overall direction for re-structuring the managed care plan, which is depicted in the chart below. Virtually all contracts will be re-procured during the one to two years after BOCC approval of this plan. The actual procurement and contracting for services may result in minor adjustments to the model.



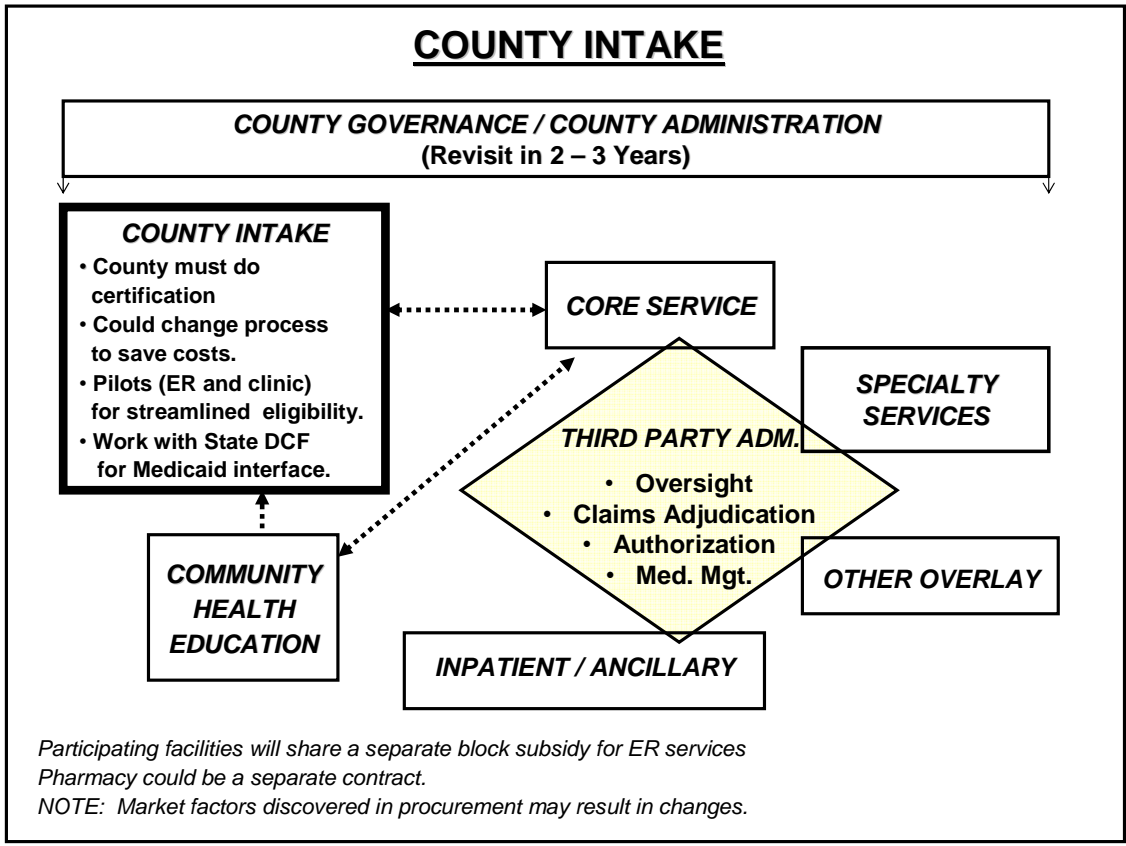
- Minor adjustments to the model may need to be made in response to market factors during the procurement process, including whether there is interest in proposing the packages as described. Additional information will be obtained during procurement and as new ideas are tested.
- During the contract procurement process, the County will use its' contracted / underwriter / actuary to assist in developing positions for price negotiation that will keep contracts within budget and responsive to proposals, and to develop new positions in response to market realities that are identified.
- The option of a single contract with an insurance company for all services was considered. The major drawback to such an option is that federal rules and regulations require that the matching of health care program's payment of Upper Payment Limit funds to qualified disproportionate share hospitals (DSH) and federally qualified health centers (FQHCs) must be accomplished through inter-government transfers (IGT). . Another potential drawback of a single insurance company provider arrangement would be the jeopardizing of favorable inpatient rates.
 - The Upper Payment Limit (UPL) program allows facilities that have a high level of service provided to patients covered by government-subsidized

programs to receive additional state and federal reimbursement. The UPL program has stringent requirements for how the payments are made. Federal rules require the County to send dollars to be matched directly to the state, which then pays the qualified hospitals and FQHCs directly. Payments through an intermediary, such as an insurance company, cannot be included. The impact of a loss of UPL payments is great. Last year, by using health care program dollars as part of the UPL payment, eligible Hillsborough hospitals (Tampa General Hospital and St. Joseph's) and FQHCs (Suncoast and Tampa Community Health Centers) directly received an additional \$6.7 million.

- Currently, Hillsborough HealthCare's inpatient reimbursement is 60% of the inpatient Medicare Case Rate with no outlier payments, acknowledged by hospital providers to be one of their lowest contracted rates. This low rate is offered because the hospitals know that they can use the reimbursement for state and federal match, and there is still a discount because they believe it is their obligation to the community.

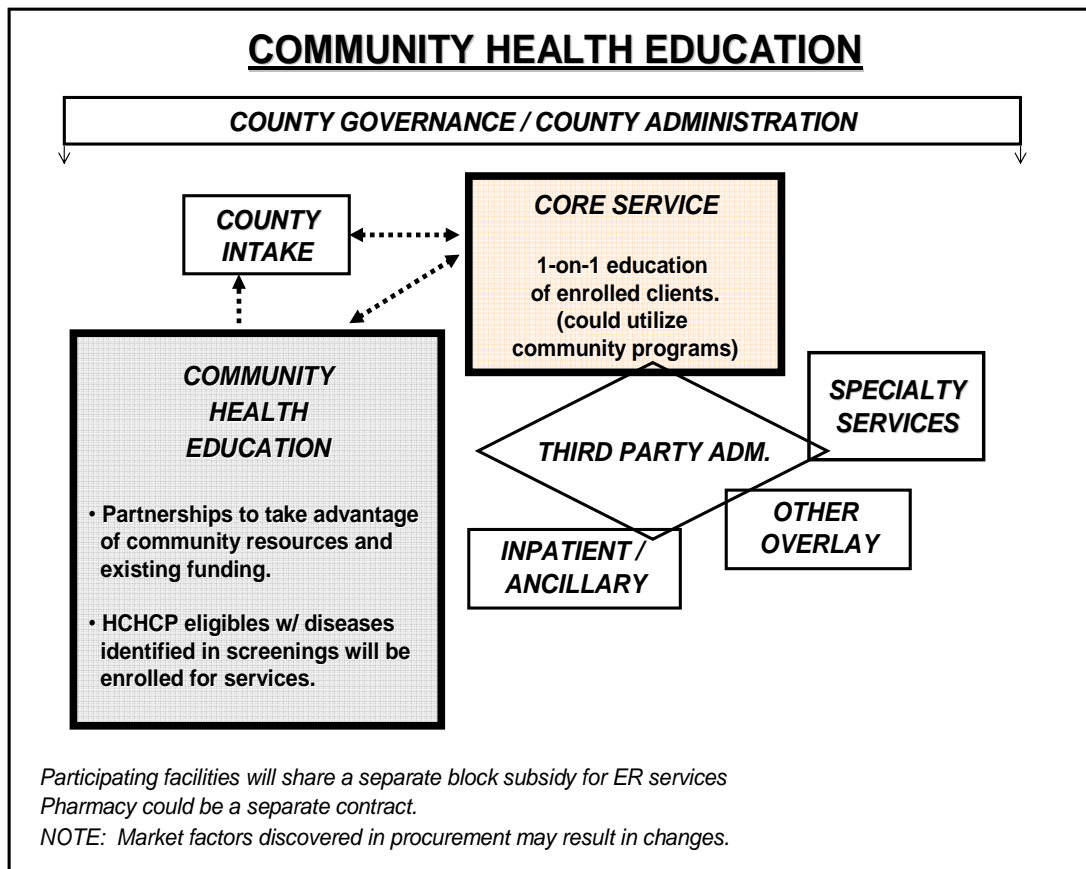
COMPONENTS

Intake and Eligibility Determination



- **The intake and eligibility determination process should be reengineered to require less time and to be more convenient for health care providers and patients.**
 - The intake and eligibility determination process should be re-designed so that it requires less time and is more convenient for health care providers and patients. Increased use should be made of electronic processing, including the monitoring of income. As a first step, pilot projects could be developed at a hospital and a primary clinic site to test allowing health care provider staff to transmit intake packets electronically to HSS intake workers to certify eligibility and to issue membership cards for the managed care plan within 24 hours via U.S. mail.
 - With the exception of members on a fixed income, whose eligibility is reviewed once every twelve months, the eligibility of all other members is reviewed every three months as approved by the BOCC. The 3-month re-enrollment was proposed by HSS and the HCAB at a time when the monthly enrollment in Hillsborough HealthCare exceeded 19,000 and was implemented as part of an overall plan to control enrollment increases. Eligibility interviews are made face-to-face with members and take an average of one hour. Currently, mail-in re-enrollments for members generally are not done. The length of enrollments for members not on fixed income should be increased from three months to six months with a mail-in reenrollment procedure at the six-month interval.
 - Initial assessment of the proposed re-design of the intake and eligibility determination process indicates that the above actions would result in a reduction of expenditures of close to \$1,000,000 annually after changes are fully implemented. This would include a reduction of 12 to 15 FTEs, which would be implemented over the next two years. HSS expects to realize the reduction of eligibility staff through attrition. There are eight people scheduled to complete the drop program during this time frame. In addition, where possible, vacancies will not be filled. (This does not include program administration cost reductions.)
- **HSS' cost allocation plan should be re-assessed after the intake and eligibility determination process is reengineered.**
 - Historically, the allocation of administrative costs is done by an outside consultant every few years. The allocation of administrative costs was last reviewed by Tribrook in 2002. Since changes in the intake and eligibility determination process will likely result in an amount smaller than the current 65% being allocated for payment from the Sales Tax Trust Funds. HSS' cost allocation plan should be re-assessed after the changes are implemented.

- Community Health Education

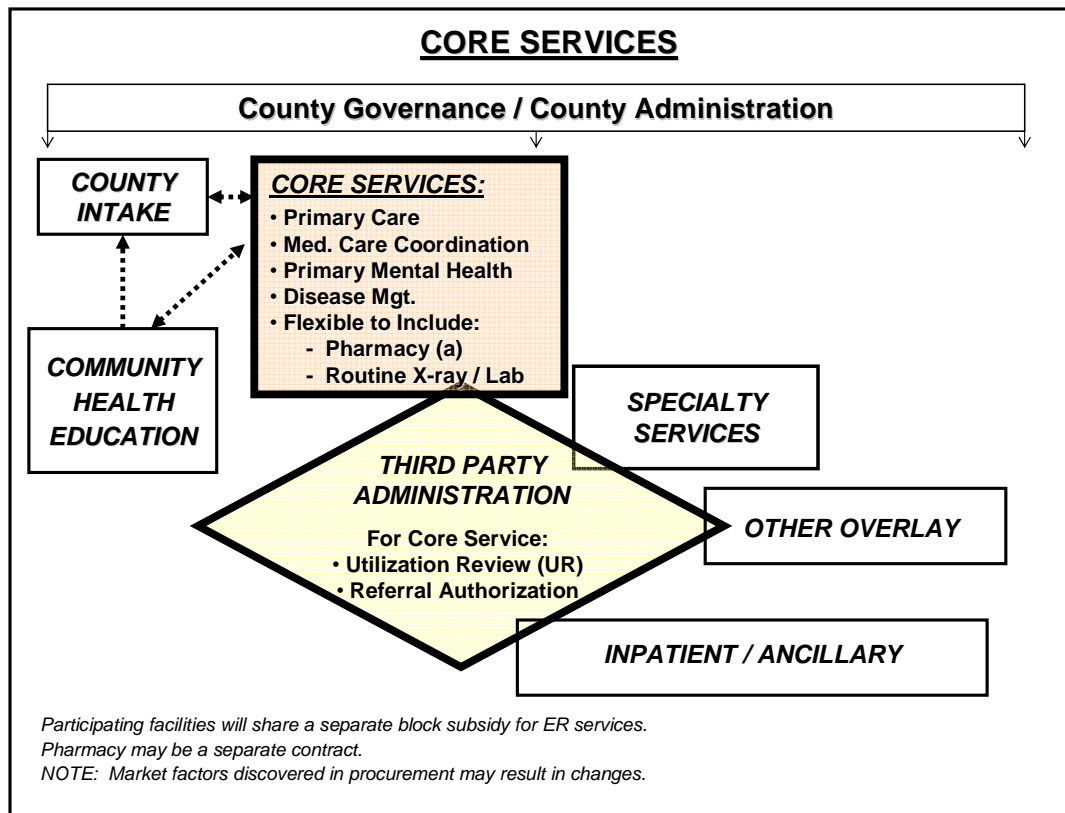


- Sales tax dollars should be budgeted to pay for health education provided to members of the managed care plan.
- Sales tax dollars also should be budgeted for community screenings, which in turn should be used to identify uninsured persons who are eligible for enrollment in the managed care plan.
- Health education and community screening programs and services should be developed through community partnerships, with priority being placed on the targeting of geographical areas that have a high number of persons eligible for the managed care plan.
- Funds for health education and screening should be included in the contract(s) for Core Services.
 - Community education is different from individual client education, although both are encompassed by the term “health education,” which refers to programs

designed to help the community know about health risks and how to reduce these risks. Health education targets both healthy and ill people through primary, secondary, and tertiary prevention activities, including nutrition, smoking cessation, exercise, and weight loss classes. Sales tax dollars should be used for health education provided to members of the managed care plan. In addition, sales tax dollars should be budgeted for community screenings, which in turn can be used to identify uninsured persons who are eligible for enrollment in the plan. Further, these programs and services should be developed through community partnerships with the Hillsborough County Department of Health and other organizations, with priority being placed on the targeting of geographical areas with a high number of persons eligible for the managed care plan.

- Funds for Health Education and Screening should be included in the contract for Core Services. These funds could be dispersed by the Core Services Provider through a single subcontract or through multiple subcontracts. The subcontract(s) should be designed to coordinate with and utilize community resources, such as the Department of Health’s Steps to a Healthier Hillsborough and other organizations, whenever possible. Funds set aside in the Core Services contract for Health Education and Screening should not include Care or Medical Management, which should be budgeted separately. (See Core Services, below.)

Core Services



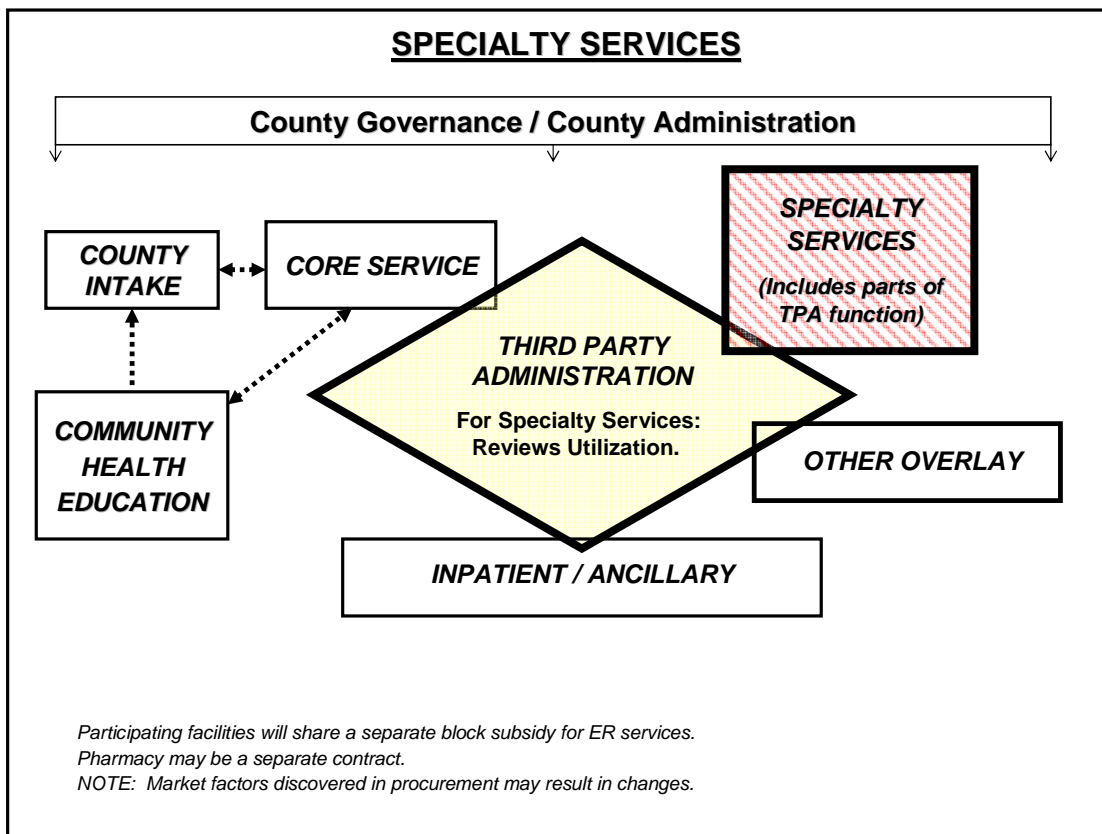
- **The core services should include primary care, medical care coordination, primary mental health (principally the management of mental health medication), and disease management.**
- **Although technically not a disease, smoking cessation should also be offered as a core service and handled with a disease management approach toward behavior change.**
 - Since some primary care clinics offer routine x-ray and lab services on-site, which is more convenient for patients, there should be flexibility in the contract for core services to allow for coverage of these services. In addition, as discussed elsewhere in this report, some providers may be able to offer additional value through their access to special pharmacy rates.
 - As in the past, primary mental health services – medication and medication management -- should continue to be a core service. Staff has been working collaboratively with the Florida Department of Children and Families and service providers to find cost-effective ways of providing mental health treatment to Hillsborough HealthCare members. In addition, effort should be made to reduce pharmacy costs for mental health related medications and the savings should be used to be pay for grant-writing services and/or as match (leverage) for grant applications designed to provide mental health services.
 - It is desirable to have Core Services provided by a single collaborative. It may be appropriate to meet this expectation and address market realities through more than one contract. The determination will need to be made through a process of negotiation of procurement that gives the best value to the citizens of Hillsborough County.
- **A new disease management program should be created; the program should begin slowly as a pilot project with one disease, possibly diabetes, and expand to include other diseases as the program shows its value.**
 - A review of FY 2003-04 adjudicated claims³ for asthma, cardio-vascular disease (hypertension, dyslipidemia, coronary artery disease), and diabetes showed that 45% of Hillsborough HealthCare patients had at least one of these chronic diseases, which accounted for \$32,725,271 or 63% of the medical claims paid that year excluding pharmacy costs. It is believed that a disease management program targeting asthma, cardio-vascular disease, and/or diabetes will prove cost-effective over time, especially if the program is designed to foster “personal responsibility”. Therefore, it is recommended that the disease management

³ Adjudicated claims do not include pharmacy costs.

program begin slowly as a pilot project with one disease, possibly diabetes, and expand to include other diseases as the program shows its value.

- Funds for Health Education, Screening, Preventive Care, and Disease Management including Smoking Cessation should be included in the single contract for Core Services. As discussed under Community Education, the funds could be dispersed by the Core Services Provider, either through a single subcontract or through multiple subcontracts. The subcontract(s) should be designed to coordinate with and utilize community resources, such as the Department of Health’s Steps to a Healthier Hillsborough and other organizations, whenever possible. Funds set aside for these services should not include Care or Medical Management, which should be budgeted separately.

Specialty Services



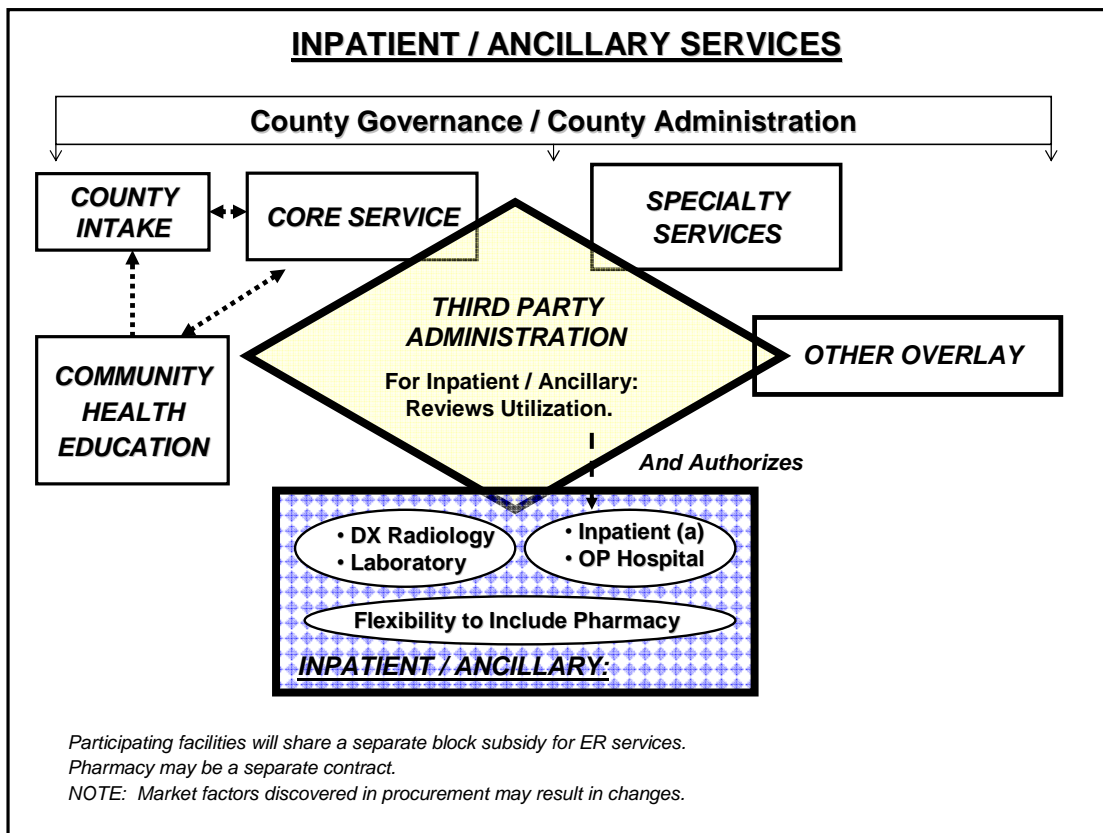
There should be a single contract to manage a countywide specialty physician and provider panel for referrals.

- There is a link between specialists on the panel and inpatient / ancillary contracts in that the patients of specialists need to be admitted to hospitals when necessary. There are different ways that this can be handled, such as requiring that all panel members having admitting privileges to at least one participating

hospital, a “hospitalist” type of arrangement (a physician admits with other specialists as consultants), or a combination of the above. The details will be determined during procurement.

- To control costs, referrals could be handled through third party administrator authorization or fixed reimbursements with the latter having the advantage of reducing the administrative costs of referral authorization. However, there is still a need for a mechanism that also controls for over-referral of services by the core provider as a means of reducing their costs.

Inpatient / Ancillary Services

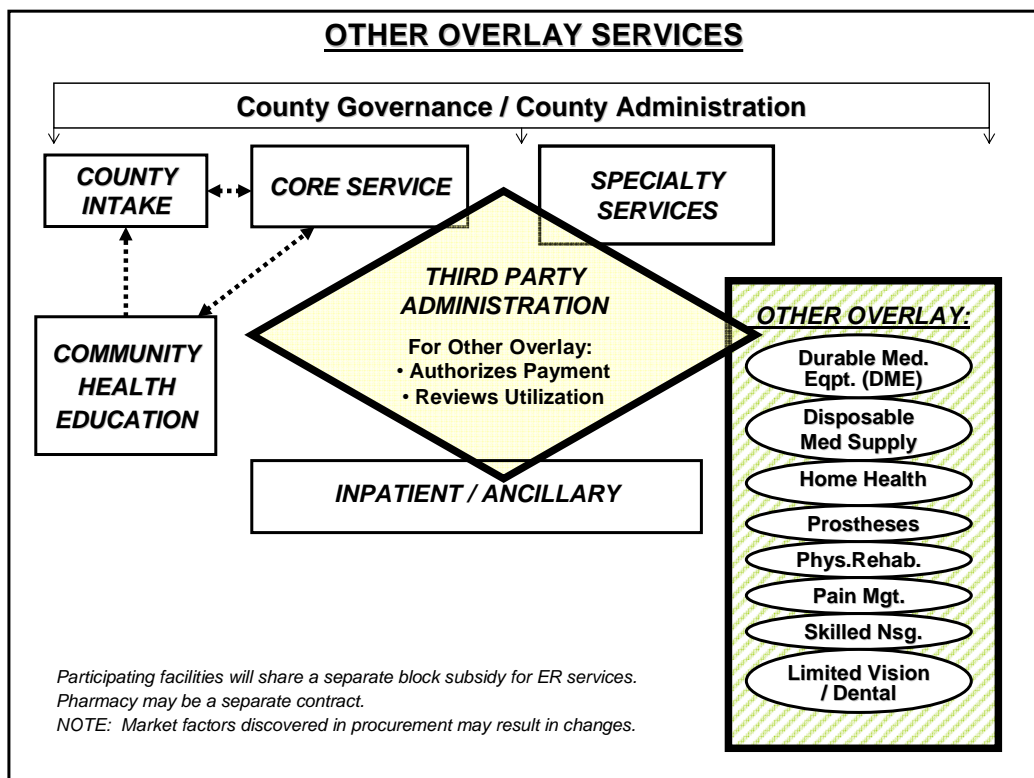


- **Contracts for inpatient / ancillary services should include inpatient hospital services, outpatient hospital services (such as same day surgery), and key ancillary services such as radiology and laboratory, although flexibility will be needed to potentially address pharmacy services (see Pharmacy Strategy).**
 - The third party administrator would be responsible for authorization of inpatient and outpatient services provided in the hospital setting (such as same day surgery). However, physicians should be able to order most radiology and laboratory services without pre-authorization. This should not preclude after the

fact utilization review of the ordering of radiology and laboratory services by physicians.

- A schedule for reimbursement of services will be developed with the County’s underwriter. Hospitals willing to accept this schedule and other contractual conditions would be able to participate. Current preference would be to continue to utilize case-based (per stay) reimbursement for inpatient stay with no outliers based on a Medicare schedule rather than paying on a per day basis. This type of payment has allowed lower administrative costs of utilization review.
- **Only hospitals that have a contract should be able to participate in the block grant program for emergency services (see Reimbursement Strategies).**
 - Only hospitals with a contract for inpatient/ancillary services will be able to participate in the block subsidy for emergency services. This practice, adopted from Pinellas County’s health care program, fixes emergency room costs at a pre-set level. (See Specialty Services.)

Other Overlay Services



- **“Overlay” services (e.g., durable medical equipment, disposable medical supplies, home health services, prostheses, physical rehabilitation, pain management, skilled nursing, and limited vision and dental) should be**

provided separately from other contracts and ideally through a single contract.

- As many “overlay” services as possible should be provided by a single contract. However, there are certain of these services that might be better clustered with other contracts (for example, physical rehabilitation with hospital services). In addition, some of the services such as limited vision and limited dental might be its own contract. There should be approval prior to the provision of these services (pre-authorization) as well as a limitation on the number of encounters (or other volume measures) that will be provided.

REIMBURSEMENT STRATEGIES AND FINANCIAL INCENTIVES

Reimbursement Strategies

- **The reimbursement structure for providers should be linked to outcomes.**
 - “Pay for performance” is the concept of linking health care provider reimbursement to outcomes. Pay for performance is a recent focus of the health care industry on the whole. In addition, Medicare and Medicaid are looking at specific applications of the concept. Hillsborough HealthCare should develop and implement its pay for performance methodology over the next few years, which will allow the plan to develop improved information systems for measuring outcomes and to build upon the lessons learned by other providers.
 - The pay for performance concept is based on the belief that increased emphasis on performance through financial rewards will motivate all contractors, not just the best performer. Contractors that do not improve will see their increases disappear, certainly a good first-step message before contract termination.
 - On the next page is an example of how a pay for performance system might evolve over time. In this example, a contract would be negotiated in Year 1 with a guaranteed base pay and a 10% incentive opportunity tied to the accomplishment of objectives. This example assumes that there would be a 3% per year increase in the total payment opportunity. However, the increase would be entirely in the incentive opportunity with no change in the base pay. In this example, the pay for performance incentive would increase from 10% of the total reimbursement opportunity in Year 1 to close to 24% in Year 5.

**EXAMPLE OF APPLICATION OF
PAY FOR PERFORMANCE METHODOLOGY
3% ANNUAL INCREASE IN TOTAL OPPORTUNITY FOR PAY
PLACED ENTIRELY IN INCENTIVE**

CALCULATION	YEAR				
	1	2	3	4	5
<u>Pay Opportunity</u>					
Base Pay	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
Incentive Opportunity	<u>\$100</u>	<u>\$133</u>	<u>\$167</u>	<u>\$202</u>	<u>\$238</u>
Total Pay Opportunity	\$1,100	\$1,133	\$1,167	\$1,202	\$1,238
Effective Percentages:					
Annual Incentive Opportunity Change	NA	33.0%	25.6%	21.0%	17.9%
Incentive Opportunity as % of Total Pay Opportunity	10.0%	13.3%	16.7%	20.2%	23.8%

Scenario for Example:

This is example, percentages are hypothetical. Example shows how a payment for services that is \$1,000 in the first year would increase under an assumption that base pay stays the same and incentive payments change under the following assumptions:

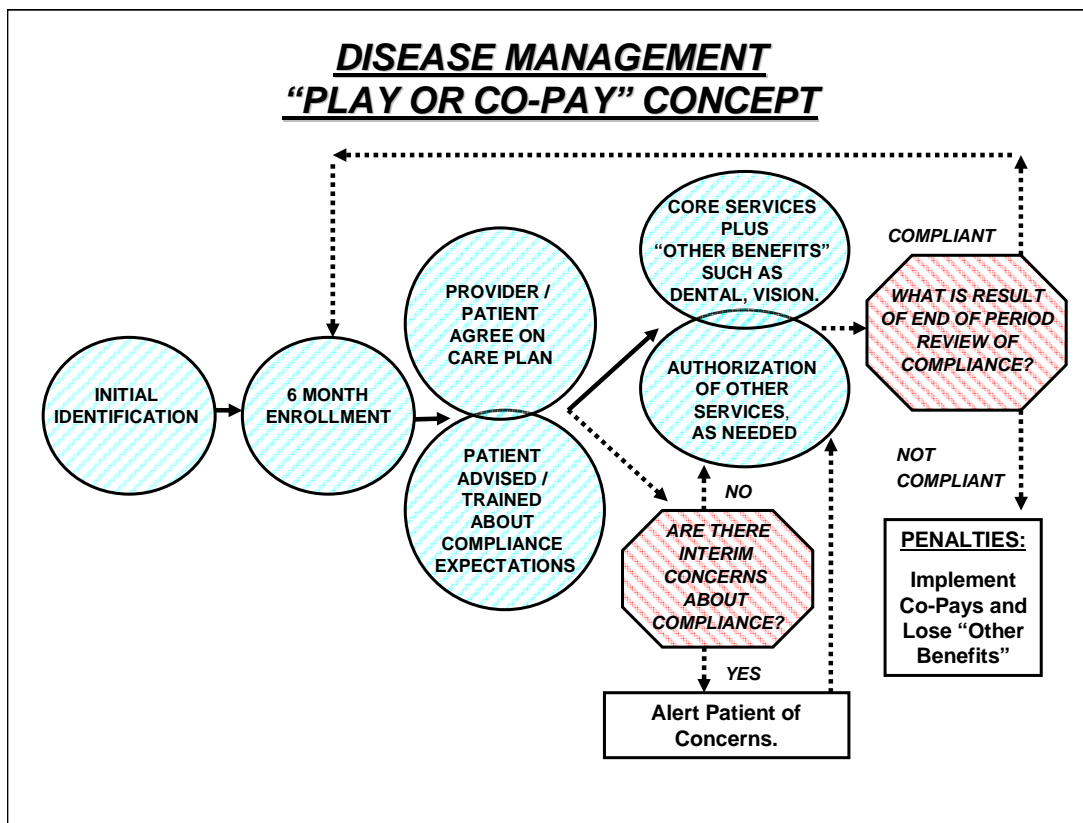
First Year Percentage of Opportunity for Pay for Performance: 10.0%
Annual Increase in Total Opportunity 3.0%

Financial Incentives

- **Patients should be motivated to take responsibility for their own health through the provision of rewards and, when necessary, the application of penalties.**
 - A concept called “Play or Co-Pay” was developed to support increased participation in self-management of one’s own disease. The development of a disease management program provides the opportunity to test the efficacy of the concept, which uses incentives as a means of motivating patients to take responsibility for their own health.
 - The figure on the next page shows how this “Play or Co-Pay” concept might work. Patients with a chronic disease targeted by the disease management

program (e.g., diabetes) would be given to opportunity to enroll in the disease management program. Enrollment in the program would entitle them to certain disease-linked benefits for which they would not otherwise be eligible (e.g., vision and dental coverage) if they comply with their treatment plans. If participants did not comply with their treatment plans, a co-pay would be required to maintain the enhanced benefits and/or the person would be disenrolled, either from the disease management program or from Hillsborough HealthCare.

- While it is suggested that this “Play or Co-Pay” concept first be piloted on one disease entity such as diabetes, the concept could then be expanded to other chronic diseases that can be managed, such as certain cardiovascular and pulmonary diseases.
- In addition, the “Play or Co-Pay” concept could be applied to other situations where behavioral change is desired. For example, Hillsborough HealthCare will be paying for smoking cessation and will be looking at applying the “Play or Co-Pay” concept to compliance. Another example might be to use the “Play or Co-Pay” concept to encourage frequent users of emergency room services to go to their primary care physicians.



- **The current method for reimbursing emergency room expenses of participating hospitals should be replaced by a “block grant” for hospitals restricted to participating in the managed care plan.**
 - A “block grant” or flat rate should be paid to hospitals participating in the managed care plan for emergency room services. This practice, borrowed from Pinellas County, would fix emergency room payments at a pre-set level. Over time, this could have the positive effect of diverting plan members away from the higher cost emergency rooms back into the primary care setting.
 - Only hospitals that are inpatient/ancillary providers can participate in the distribution of the emergency room block grant.
 - The specific formula for the distribution will be determined.

PHARMACY STRATEGY

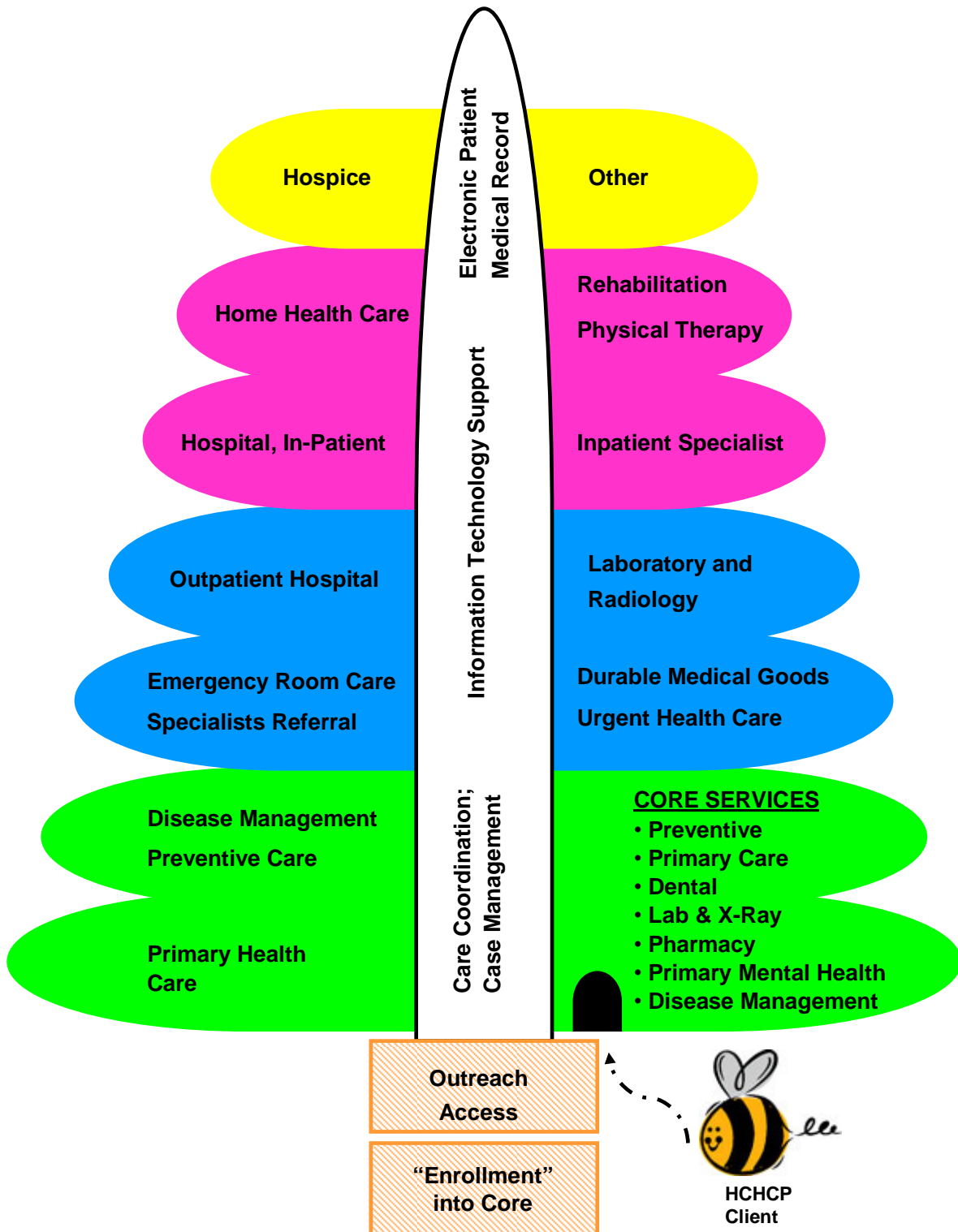
- **Primary care providers should be required to participate in patient assistance or “free drug” programs (PAP) as a contract condition, although consideration may be given to reimbursing providers from the savings achieved from the PAP.**
- **There should continue to be a strict drug formulary that is weighted toward lower cost drugs.**
- **There should be continued contracting of a pharmacy advisor in order to reduce or eliminate potential over-utilization and potential illegal distribution of medications by patients.**
- **The \$1 co-pay on generic and brand drugs should be continued in an effort to help members assume some responsibility for their personal health.**
 - Many private and public sector programs are experiencing double digit increases in pharmacy costs, whereas Hillsborough HealthCare experienced growth of only 3.7% in per member per month pharmacy costs from FY 2003 to FY 2004. For FY 2005, Hillsborough HealthCare per member per month costs for pharmacy are up less than 1% and overall pharmacy expenditures are expected to be about \$2 million under budget at year-end.
 - While pharmacy remains the single largest line item of HealthCare Program expenditures; staff working with providers, the pharmacy benefits manager and our independent pharmacy advisors have implemented a number of actions to contain pharmacy costs. For instance:
 - Minimal co-pays of \$1 were established for members at the poverty level.

- More substantial tiered co-pays of \$6 and \$10 were established for members above poverty level.
 - Formulary emphasizes generic drugs; currently 64% of drugs dispensed are generic.
 - Department staff has negotiated favorable discounts on drugs and low dispensing fees.
 - A pill splitting practice has been implemented for select drugs.
 - A patient assistance program has been instituted to obtain free drugs from manufacturers.
 - Limits have been placed on the number of controlled prescriptions allowed per month.
 - A \$10 cap per over the counter item has been established.
- Hillsborough HealthCare contracts with one of the largest pharmacy benefits managers in the country. This allows a small program to share in manufacturer rebate programs along with large health care programs with many thousands of covered lives. Currently, Hillsborough HealthCare receives about \$1 million in rebates annually.
 - The specific pharmacy strategy is a function of how the Core Services and other contracts are let. For example, while 340B pricing is the lowest available in the industry, it is accessed only through specific types of facilities that may not end up being the providers of services. However, negotiating lower costs for core services could offset the additional cost for the pharmacy contract.
 - Hillsborough HealthCare should continue its current strategy to control pharmaceutical costs through a multi-faceted approach. The possibility of purchasing pharmaceuticals directly should be abandoned; it was explored and found not to be cost-effective. Purchasing pharmaceuticals from Mexico or Canada was considered briefly as well but is illegal in Florida.
 - Regarding inappropriate and excessive drug utilization by Hillsborough HealthCare members, it should be noted that Clinical Pharmacology Services, the plan's independent pharmacy advisor, is required by contract to review and evaluate the drug utilization pattern of HealthCare members in order to reduce or eliminate potential over-utilization and potential illegal distribution of medications by patients. In this regard, Clinical Pharmacology has a policy of denying requests from members who claim to have lost their controlled drugs and are seeking an early refill.

INFORMATION SYSTEMS

- **Incentives should be developed to foster the adoption of an interoperable health information technology infrastructure by all providers contracting with Hillsborough HealthCare.**
- **The HCAB should establish a committee to provide oversight for the development of a comprehensive, interoperable, online information technology infrastructure that facilitates management of the managed care plan.**
- **The development of an electronic health record, an essential building block of any health information technology infrastructure, should be referred to the HCAB for further study and consideration as well.**
 - A comprehensive, on-line information technology infrastructure is essential to the efficient and effective management of the managed care plan. The on-going effort to develop a reliable and easy-to-use data warehouse for the plan is applauded. However, much more needs to be done to improve the plan's data management systems. Having good data is the "back bone" of many enhancements recommended in this report. Successful implementation of these recommendations depends to some extent on the efficient management of data.
 - The "beehive" structure on the next page shows why a comprehensive, on-line information system is essential for efficient and effective program management. The beehive represents an active ecosystem with interconnected parts. The virtual bee is like the patient, who should enter at the bottom of the beehive (and not the middle or the top) so that he can receive primary and preventive care. The core of the beehive is where information flows. Electronic health records, information technology support, and care coordination/case management supports the system with these elements flowing both up and down the model.
 - The flow of information is essential to allow the primary care elements to receive patient information from the hospitals. This flow of information will prevent errors and decrease costs associated with ordering duplicate tests, which is essential for reducing mortality and morbidity. The model shows the importance of the patient remaining at the primary care level. The money that is available for the managed care plan should be focused on the items in the bottom of the beehive. Core services are the primary focus of the plan and available money should flow from the bottom to the top of the beehive. This model directly relates to both information systems and care coordination/system navigation.

HILLSBOROUGH COUNTY HEALTHCARE PROGRAM



CARE COORDINATION / SYSTEM NAVIGATION

- **Over the next two years, staff should assess the cost-effectiveness of using paid and/or unpaid navigators to provide resource and care coordination for non-compliant members of the plan; increase their access to needed health and social services; follow-up to ensure appropriate linkage to these services; and coordinate their medical care, disease management, and social services.**
- **Assuming the cost-effectiveness of paid and /or unpaid navigators, it is recommended that during this two-year period staff review the budget to determine how to best fund a program using this model.**
 - As discussed earlier, a review was conducted of FY 2003-04 adjudicated claims for asthma, cardio-vascular disease, and diabetes. The review revealed that a total of 8,630 or 45% of the plan's 19,070 patients with clinic or hospital benefits had at least one of these chronic diseases and that, excluding pharmacy costs, these diseases accounted for expenditures of \$32,725,271 or 63% of the medical claims paid that year. These figures suggest that the managed care plan can do a better job of managing the care of its chronically ill residents, both to improve the quality of care received and to slow the growth of health care costs.
 - Elsewhere in this report, it was recommended that Hillsborough HealthCare expand its existing disease management program. The goal is to develop a program that is centered in primary care but is coordinated with and utilizes community resources, such as the education and prevention services provided by the Hillsborough County Department of Health's STEPS to a Healthier Hillsborough project and other organizations. Assuming the availability of community resources as well as the ability of Hillsborough HealthCare primary care providers to monitor clinical symptoms, compliance with treatment plans, and treatment outcomes, there still will be a need to more closely manage the cases of patients having difficulty following-through with treatment recommendations. It is believed that these patients would benefit from a treatment plan tailored to their unique circumstances as well as support in realizing the goals of their plan.
 - Several models used by different communities to enhance access, follow-up, and coordination were examined, including programs that utilize paid and unpaid "navigators" to provide resource and care coordination for uninsured, working poor families. Time did not permit the selection of a specific model to use, which is the reason for this recommendation for assessing the cost-effectiveness of this approach, possibly through the development of a pilot project.

FINANCIAL AND BUSINESS PLAN

SHORT TERM STRATEGIES

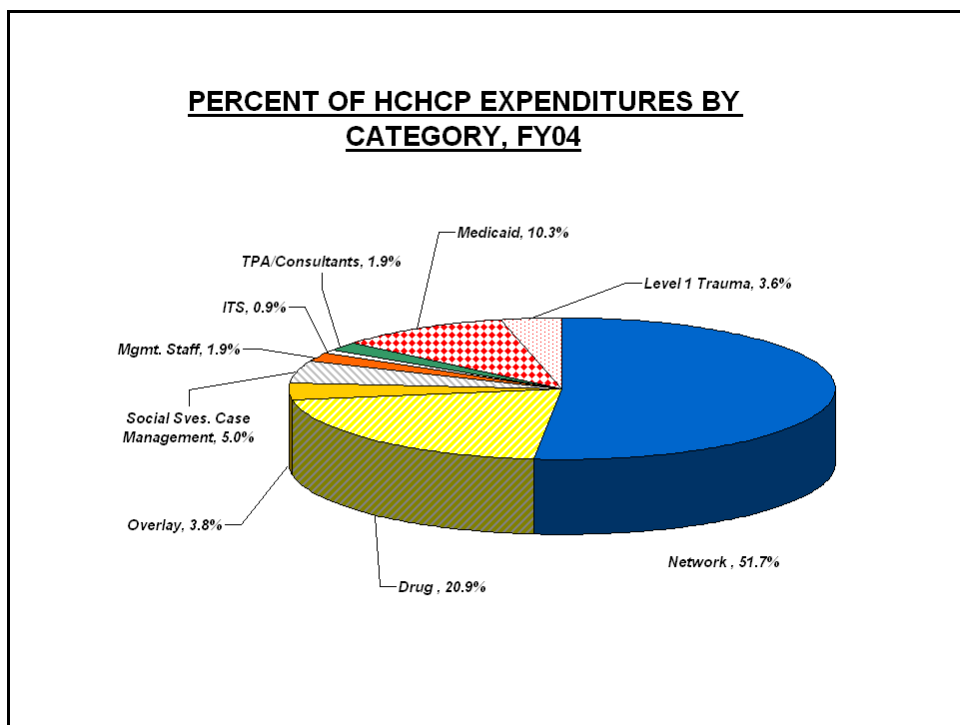
In order to assure the ongoing financial viability of the Hillsborough HealthCare Program, the program will, beginning with BOCC approval of the recommendations in this report, implement the following short-term actions on a phased basis over the next two years:

- Return to Hillsborough HealthCare's basic mission of targeting the need of individuals who live in poverty (e.g., at or below 100% of federal poverty level) and who do not have access to affordable insurance coverage or other government-subsidized health coverage. The transitioning of the existing plan to better match this mission will include the following:
 - Coverage for people living in poverty will focus on the disease management of diabetes, cardiovascular problems, and pulmonary problems such as asthma. Close to two-thirds of Hillsborough HealthCare expenditures are for individuals with one or more of these three diseases entities.
 - Target the early identification of people living in poverty who have chronic diseases and provide them with disease management programs as part of their overall medical care.
 - The shift in emphasis to people living in poverty with certain disease states is not a new, more costly program; instead, it is a restructuring of the existing program to better serve a core component of the target population - the most needy individuals living in poverty.
- The shift in focus to people living in poverty who are enrolled in disease management programs can be done within budget and with existing revenues by:
 - Phasing out the existing Medical Crisis Invention (MCI) program over the next two years. Since February 2005, no new members have been enrolled in the MCI program. The MCI program, also called the "Catastrophic Program", covers individuals whose income is between 101% and 150% of the federal poverty level, have selected chronic diseases, and have health expenses that result in their net income being below federal poverty level. In FY 2004, \$14.5 million was spent on medical care and pharmaceuticals for members of the MCI program.
 - In January 2006, discontinue pharmaceutical coverage for Medicare recipients. The federal government will begin providing pharmaceutical coverage to these individuals in 2006. In FY 2004, about \$5 million was spent on pharmaceuticals for Medicare recipients. The \$5 million expenditure for Medicare recipients was split relatively equally between the MCI program and the regular program. The

elimination of Medicare members from Hillsborough HealthCare beginning in January 2006 was recognized as a cost efficiency of the plan and the FY 2006-2007 budget has been reduced accordingly.

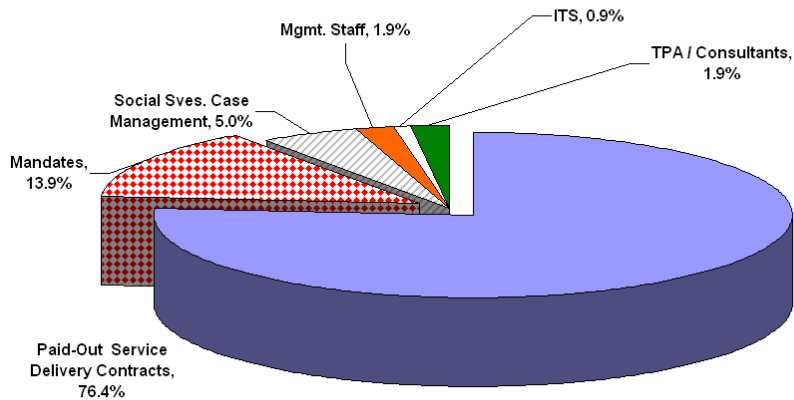
- On June 1, 2005 the Hillsborough HealthCare stopped paying hospital facility charges for members retroactively enrolled in the plan. It is recommended that a permanent ban be placed on paying hospital facility charges for members retroactively enrolled in the plan. In FY 2004, the hospital facility charges for “retros” amounted to \$3.2 million.
- On October 1, 2004, Hillsborough HealthCare instituted a \$1 co-pay on generic and brand drugs for people under 100% of federal poverty in an effort to help these individuals take some personal responsibility for their health care. It is recommended that the \$1 co-pay remain in place. This modest co-pay saves the program about \$400,000 annually.
- During FY 2005, Hillsborough HealthCare implemented, through the award of a competitive contract, a patient assistance program that permits its members to gain access to some drug manufacturers’ free drug programs. One future business strategy for the primary care contract or contracts may be to require primary care providers to participate in the patient assistance program as a condition of the contract award. Consideration may be given to some form of reimbursement to the providers to be paid from the savings achieved from the patient assistance program.
- The specific pharmacy strategy is a function of how the Core Services and other contracts are let. For example, while 340B pricing is the lowest available in the industry, it is accessed only through specific types of facilities that may not end up being the providers of services. However, negotiating lower costs for core services could offset the additional cost for the pharmacy contract.
- Another business strategy will be to provide block funding to participating hospitals for emergency room care. This practice, adopted from the Pinellas health care program, fixes emergency room costs at a pre-set level and could, over time, have the positive effect of diverting members away from the higher cost emergency rooms into the primary care setting.
- Over the next two years, institute additional changes that will result in annual administrative and case management cost savings of at least \$1.5 million. In FY 2005, administrative staff and case management costs are projected to be \$436,000 under budget as a result of cost saving measures already implemented. With the streamlining of the eligibility determination process and possible additional savings in third party administrator costs, we expect to reach the \$1.5 million savings target over the next two years.

- “Overhead” expenditures for Hillsborough HealthCare are relatively low. In FY 2004, according to the Florida Hospital Association’s HMO Indicators Report, the median administrative expense ratio was 10.9%. (The administrative expense ratio is defined as administrative expenses divided by total expenses.) In FY 2004, the “overhead” expenditures (TPA/consultants, ITS, and management staff) for the managed care plan represented 4.7% of total plan expenditures. (In this example Hillsborough HealthCare case management expenses of 5% were **not** included.)
- The following chart shows a breakout of each of the major program and “overhead” costs for Hillsborough HealthCare in FY 2004:



- The FY 2005 estimated health care expenditures (network, pharmacy, and overlay) of \$73 million supported an average monthly membership of about 13,900 members. It is believed that the plan will be able to serve at least 15,000 persons after the recommendations in this report are fully implemented.
- An important part of the recommended restructuring of the managed care plan is the contracting out of services. The chart on the next page shows contract services in FY 2004 compared to the administrative, case management, and ITS salary and related costs:

**PERCENT OF FY04 EXPENDITURES FOR
CONTRACTED VS. IN-HOUSE SERVICES AND MANDATED
PAYMENTS**



- Market forces will determine if the new contracts resulting from the recommendations in this report will prove to be more cost-effective and deliver the same or higher quality of services as prior contracts. Some of the strategies that will be employed to meet cost and quality objectives will be the bundling of “like” services, focusing efforts on disease management programs, and implementing “Play or Co-pay” strategies for members and pay for performance strategies for providers.
 - Also, to help achieve the cost and quality objectives, staff will work closely with the County’s underwriter to develop purchasing strategies that will be at least budget-neutral. This practice was successfully employed during the last round of network hospital contracts, when participating hospitals acknowledged that Hillsborough HealthCare has the lowest inpatient rates of any health care plan.
 - While staff will start work on developing new contracts as soon as the BOCC approves the recommendations in this report, the complex health care procurement process will likely take at least a year and up to two years to fully implement. In the meantime, staff has taken action to have the BOCC approve 12-month extensions in the current provider contracts while the new contract process is taking place.

LONG-TERM STRATEGIES

In October 2002, the BOCC approved a long-term financial for Hillsborough HealthCare that over time would bring expenditures in line with available revenues and, with some contribution from the general fund, build up the Sales Tax Trust Fund reserve balance to target levels. This plan has served as financial guide for the plan since 2002.

- It is recommended that the BOCC adopt an updated financial plan for Hillsborough HealthCare that reflects current revenue estimates, projected expenditure budgets, including Medicaid match and Trauma Center special funding, and an actuarial-determined target balance for the Sales Tax Trust Fund.
 - The updated plan will have the same basic overall goal as the original financial plan that required Hillsborough HealthCare to live within available revenues. The major changes in the updated financial plan are: (1) increasing revenues, (2) smaller increases in expenditures, and (3) less reliance on the general fund to build reserves. In fact, beginning in FY 2008, the plan would not require any contribution from the general fund. Increasing revenues and expenditure restraints would be adequate to build and preserve the reserve balance.
 - This approach also will give the BOCC and staff the flexibility to increase the expenditure budget through the budget amendment process to serve more people living in poverty. The financial plan shows projected revenues exceeding expenditure budgets by \$7 - \$8 million annually. Some of the excess revenue could be appropriated as a part of the budget process and used to provide benefits to more eligible people living in poverty. This strategy should still permit adequate funds to be maintained in the Sales Tax Trust Fund reserve.
 - The chart of the following page shows the original 2002 plan (shaded) and the updated 2005 plan (not shaded).
- Over the next year, further develop plans for long-term business strategies that will position the managed care plan to better serve the needs of the indigent population. These strategies include:
 - Continued development of better information technology systems for the managed care plan, such as (1) HIPAA-compliant electronic data interchanges with providers for claims processing, (2) the purchase of specialized software capable of performing health care industry standard analysis and outcome measurement of the quality of health care services, (3) evaluate Medicare and Medicaid plans for implementing electronic medical records and adapting the systems developed by these large entities to the managed care plan.
 - As staff completes the purchasing process for the new contracts and assess the overall financial picture with regard to health care program, they will evaluate, with the assistance of an underwriter, options for facilitating enrollment of

individuals living at 101% to 200% of the federal poverty level in affordable health coverage programs. The facilitation of these programs does not necessarily imply funding by the County.

- o Further consider coordination with activities that are part of state and federal Medicaid programs, such as Health Flex programs and Medicare initiatives.

**CURRENT BUDGET PLAN
MAINTAINS GENERAL FUND CONTRIBUTION
AS AN OFFSET TO MEDICAID MATCH
FOR THE HEALTH CARE PROGRAM
COMPARISON OF 2002 BOCC-APPROVED FINANCIAL PLAN
WITH 2005 UPDATED FINANCIAL PLAN – CURRENT**

	In Millions							
	Original Plan FY05 <u>Estimate</u>	Updated Plan FY05 <u>Estimate</u>	Original Plan FY06 <u>Estimate</u>	Updated Plan FY06 <u>Estimate</u>	Original Plan FY07 <u>Estimate</u>	Updated Plan FY 07 <u>Estimate</u>	Original Plan FY 08 <u>Estimate</u>	Updated Plan FY 08 <u>Estimate</u>
Sales tax, interest on trust fund, Medicaid recoveries, and pharmacy rebates	\$94.8	\$103.2	\$100.4	\$106.2	\$106.5	\$110.7	\$112.8	\$115.6
Trust Fund Expenditure Budget (1)	\$93.8	\$99.5	\$99.4	\$99.3	\$105.0	\$102.0	\$111.3	\$108.1
General Fund Contribution (2)	\$3.8	\$6.7	\$3.5	\$3.5	\$3.3	\$3.3	\$3.0	\$0.0
Projected Trust Fund Balance	\$18.9	\$25.2	\$23.3	\$32.1	\$28.1	\$40.8	\$32.6	\$48.3
Target Trust Fund Balance at 9/30 33% of Prior Year Expenditures (3) Targets to be verified by actuary	\$28.9	\$29.3	\$30.3	\$32.3	\$30.9	\$32.9	\$32.8	\$32.8

Notes:

(1) Excludes \$4.7M "wash" transaction from expenditure budget and general fund contribution in FY05 for Medicaid match and inmate health care.

(2) Excludes general fund contribution for FY08 and increases expenditure budget by the original planned amount of the contribution for FY08 of \$3 million.

(3) The 33% of prior completed year expenditure target for the trust fund was set by staff. The plan is to have this target set by an independent actuarial review.

- The updated plan reflects the BOCC approved budget for FY06/07 for the HealthCare Program. The work study committee has made two recommendations that, if adopted, will impact the updated financial plan and are somewhat offsetting:

- The \$3.5M and \$3.25M general fund contributions currently approved for FY06 and FY07 respectively would be withdrawn if the Study Committee's recommendation that there will be no general fund contribution to the managed care plan is adopted.
- The general fund would make a contribution of \$3.7M and \$3.9M in FY06 and FY07 respectively for Medicaid match if the work study committee's recommended 4 year rolling average methodology for capping the Trust Funds payment of the Medicaid match is adopted.
- Continue to utilize sales tax and general fund health care expenditures for leveraging private and public sector dollars such as:
 - STEPS to a Healthier Hillsborough is funded through a cooperative agreement with the U.S. Department of Health and Human Services. The purpose of the grant is to reduce the burden of diabetes, heart disease, obesity, and asthma by addressing three related risk factors ----- physical inactivity, poor nutrition, and tobacco use. A Leadership Team assists with the grant's implementation. The team reports to Partnership for a Healthy Hillsborough, a coalition of public and private organizations, associations, agencies and individuals established to reduce chronic diseases and the associated risk factors.

Federal support for the project, about to complete its first year of funding, is \$7 million over five years. While the lead agency is the Hillsborough County Health Department, other partners include Hillsborough County, Hillsborough County School District, YMCA, American Heart Association, Community Health Advocacy Partnership (CHAP), University of South Florida College of Public Health, Tampa Black Nurses Association, American Lung Association, Asthma and Allergy Foundation of America, and St. Joseph's Hospital.

The target area for the STEPS grant consists of 16 zip codes in the City of Tampa and Temple Terrace with the county's poorest residents. It is logical for Hillsborough HealthCare to build upon this investment and to use the project along with sales tax dollars to leverage other funds for this population. This would include expanding compatible programs into other areas of the county with concentrations of managed care members.

- Mental Health Certification: In FY 2005-2005, the County will provide \$9.3 million for community-based mental health and substance abuse treatment of adults. Almost half (43%) of these dollars are from the Sales Tax Trust Fund; the remainder are from the general fund. About \$1.8 million is being used to leverage State mental health and substance abuse dollars – at the rate of one County dollar to every three State dollars. Consideration should be given to re-programming some of the remaining funds so that they can be used for grants-writing and/or for matching (leverage) to bring down other monies.

For example, AHCA was authorized recently to amend the Medicaid State Plan to include community-based outpatient detoxification services, community based substance abuse intervention services and comprehensive support services for substance abuse. Payment for these services is contingent upon the local matching funds being provided by participating counties. For every forty-one cents of public funds a County commits to Medicaid enrollees for these three services, the federal government will provide a fifty-nine cent match.

BENEFITS AND RETURN TO THE COMMUNITY

This section summarizes the findings of a measurement of the benefits and return on the community's investment in Hillsborough HealthCare. The full report, which includes results and how the benefits were calculated, is in the appendix to this report. In order to quantify the financial impact of Hillsborough HealthCare on the community, a return on the community's investment (ROCI) model was used. The benefits categories to be considered are:

- Decreased direct health care costs.
- Decreased indirect costs and increased indirect benefits.
- Improved influx of funds into the community.
- Improved quality of life, which includes the value of being able to work.

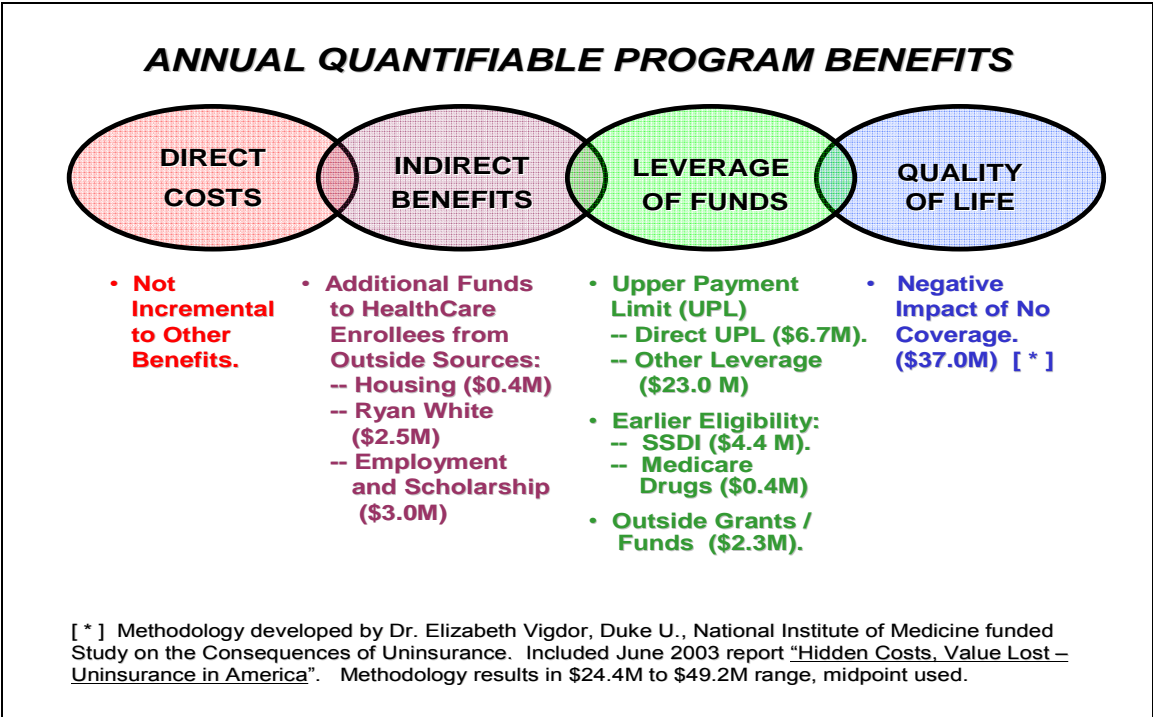
As seen in the graphics below, the major financial impact on the community is the improvement of quality of life. In addition, there is a significant benefit from the ability to improve the influx of funds into the community, not just for health care, but also for additional support to individuals who made their initial contact with the County to obtain health services (e.g., indirect benefits).

As also seen in the graphics below, the difference between the \$84.5 million expenditure for the managed care part of the health care program in FY2004 (excludes the Medicaid Match and Trauma Center subsidy) and the projected quantifiable benefits of \$79.7 million is \$4.8 million. This difference is acceptable given the overall objective of maintaining a strong health care safety net and that there are several benefits that could not be measured. For a complete description of the calculation, see the Appendix.

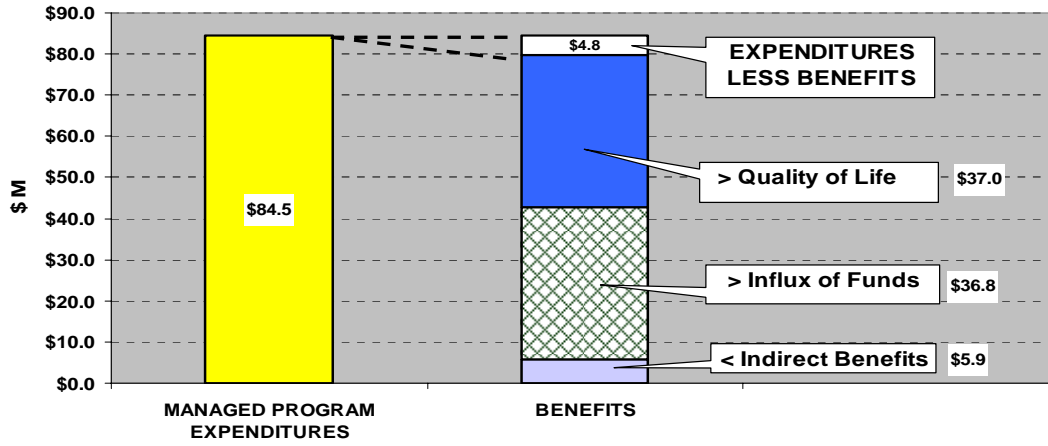
The benefits that were not measurable at this point include:

- Value of a Stabilized Health Care Safety Net -- It is difficult to quantify the financial impact of the strengthening of hospitals and providers and the stabilizing of the County's health care industry by reducing unpaid bills. The hospitals report the value of uncompensated care and there is an ongoing debate over what is the actual amount. However, it is reasonable to state that there is a value to the government helping stabilize the health care market. The strength of the health care market is a safety net important for the entire population, not just the uninsured. Health care is a needed service and a major employer.

- Values to future generations -- For example, mental and physical health and welfare of children is negatively impacted by being raised by non-healthy parents.
- The already negative impact of financial risk and uncertainty therefore stress as a consequence of being uninsured is proportionately greater for low-income people. Uninsured individuals pay more of their income for health care. Uninsured individuals pay 35% of their income for health care compared to 20% for individuals with coverage. For low-income people, this is a significant burden.
- Poor health has created inequities between income groups and between ethnic groups. The inequities are barriers to success or even advancement.



**COMPARISON OF HILLSBOROUGH HEALTH CARE PROGRAM
MANAGED PROGRAM EXPENDITURES AND BENEFITS, FY 04
(Excludes Medicaid Match and TGH Subsidy)**



Appendix A

Sub-Committee Recommendations

Combined Management, Administration, Reimbursement Subcommittee

Innovations & Best Practices Subcommittee

Core Services Subcommittee

**COMBINED MANAGEMENT, ADMINISTRATION,
COMPENSATION/REIMBURSEMENT AND INCENTIVES SUBCOMMITTEE
SUMMARY OF RECOMMENDATIONS AND OUTSTANDING ISSUES**

“Play or Co-Pay” Concept for Disease Management

The subcommittee passed a motion unanimously to support the “Play or Co-Pay” concept for disease management emphasizing personal responsibility. (See Attachment for outline of concept).

Continue Development of Data Systems to Manage the Program

The subcommittee pointed out the critical need for better data management systems and endorsed the on-going efforts to develop a reliable and easy to use data warehouse for the HealthCare Program. Having good data is the “back bone” of many of the enhancements the various subcommittees are recommending e.g. disease management and pay for performance systems.

Phase Out Current Medical Crisis Intervention (MCI) Program by the End of 2006

The subcommittee passed a motion unanimously that by the end of 2006 the county will have developed an alternative for current MCI enrollees. In addition, the current suspension on enrolling new members in the MCI Program will be made permanent. This motion may delay the cost saving measures for eligibility determination of social services staff realignment since staff will be needed to work with the affected enrollees to help them find other coverage. If no alternative plan is developed by staff working with the Health Care Advisory Board, MCI enrollees will be dropped at the end of 2006.

Use Industry Standard Measures/Ratios for Showing the Program’s Administrative Costs

The subcommittee passed a motion unanimously to have the major providers work with Department staff to develop industry standard measures/ratios for showing the HealthCare Program’s administrative costs. This process will allow for better “apples to apples” comparisons of the Program’s administrative costs with private sector HMOs.

Preserve Maximum UPL Funding and Other Federal Matching Funding

The subcommittee passed a motion unanimously that any restructuring of the HealthCare Program would preserve maximum level of UPL funding and other Federal matching programs. Based on a presentation by Tony Carvalho, President, Florida Teaching Hospital Council, the subcommittee was informed that any organizational structure that interrupts the direct flow of funds from the Federal/State government to providers would jeopardize UPL funding for the HealthCare Program providers.

Claims Processing and Payment

The subcommittee passed a motion unanimously to support the streamlining of the claims processing and payment system. The extent of streamlining of the claims processing system will be dependent to some extent on both the providers and Third Party Administrator (TPA) having electronic claims capability. This capability may have to be a contractual requirement of providers and the TPA for the restructured Program. Whether the streamlined system will require specialist claims to be submitted through a network will need to be addressed. Staff will continue to work with the Clerk of the Circuit Court and providers on improving the claim payment process.

Pay for Performance

The subcommittee voted unanimously for the HealthCare Program to shift to a pay for performance basis over the next few years at all levels. Staff, providers, and the Health Care Advisory Board will need to address the specific pay for performance concepts possibly following the CMS models under development. Staff expects the concept would involve establishing a base line year with future (beyond the baseline year) reimbursement growth tied to reaching incentive goals.

ER Block Payments

The subcommittee voted 6-5 on the recommendation that the HealthCare Program would make block payments for emergency room services to participating doctors and hospitals based upon an allocation percentage among participating hospitals to be determined and agreed upon by staff and providers. Voting for: Ms. Busansky, Dr. Reddy, Dr. Davison, Mr. Waters, Dr. Freedman, and Mr. Fleming. Voting against: Ms. Dorsey, Ms. Mayer, Dr. Leon, Ms. Sharpless and Mr. Escobio. Abstaining votes: Mr. Kucher and Mr. Hammond.

Streamlining and Restructuring Eligibility Determination

The subcommittee endorsed on-going staff efforts to streamline the eligibility process. A key to this process will be to extend the current eligibility period from 3 months to 6 months or one year, thus reducing the expense of repeated eligibility screenings by staff social workers. In addition, the process will be reengineered to better take advantage of information systems and better linkage with existing data bases (such as Medicaid). Staff will continue to work with the Department of Children and Families (DCF) and the Benefit Bank to develop linkage.

The subcommittee unanimously recommended a provider based pilot program to screen for eligibility. A secondary determination for more expensive specialist or hospital costs could be done by county or 3rd party. This recommendation was referred to staff to discuss with the Health Care Advisory Board Management Committee to figure out the details on implementing the pilot project.

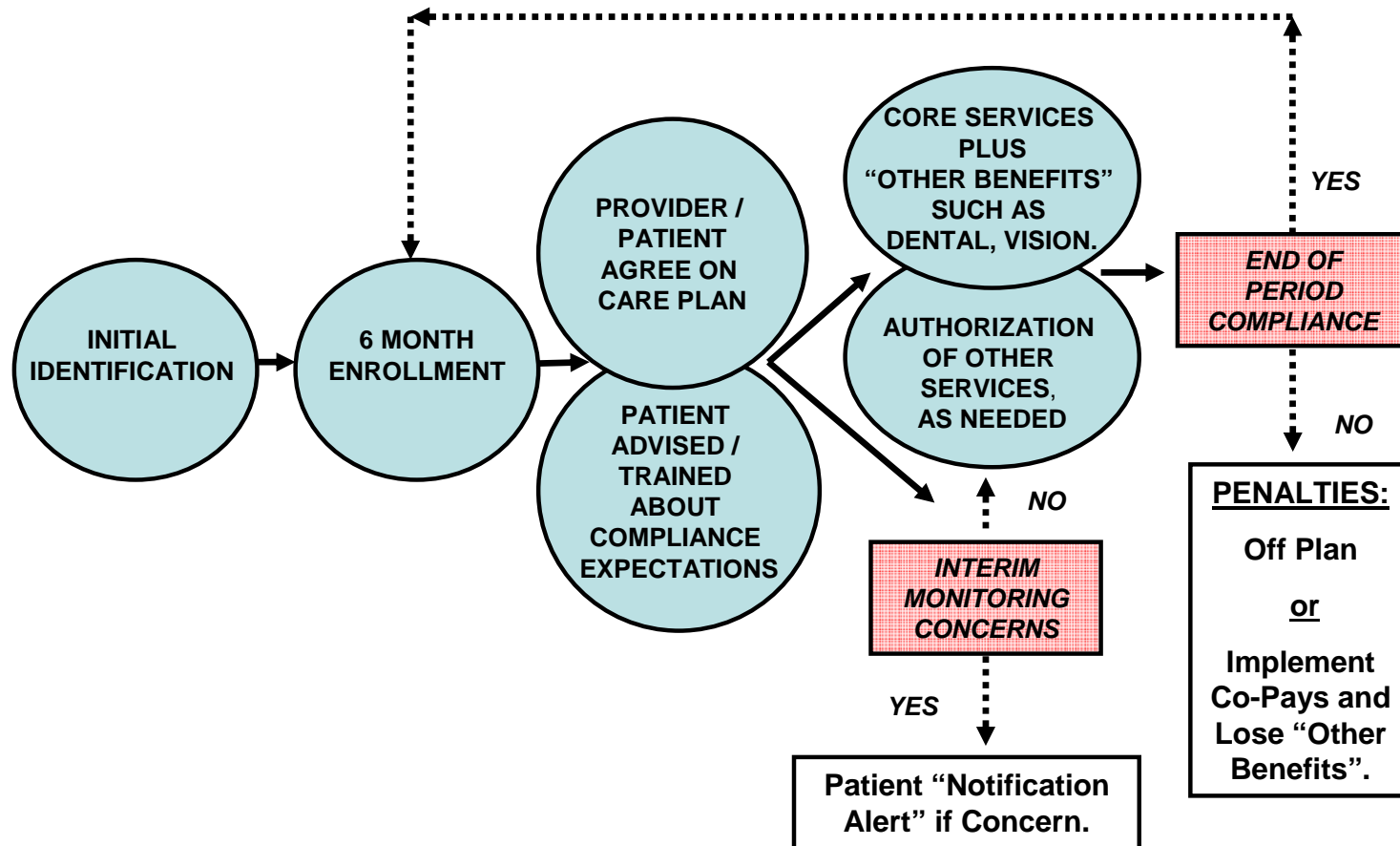
Electronic Health Record – Longer Term Development

The subcommittee passed a motion unanimously that an electronic health record is essential to health care and it should be further evaluated by staff and the Health Care Advisory Board. The subcommittee further recommended that the Program review models being developed by large organizations such as Medicare and adopt one of these models for the Program rather than creating an entirely new model.

Use of Financial Resources for the HealthCare Program

The subcommittee unanimously recommended that the full Study Group assess what expenses are paid for out of the Trust Fund to ensure that the revenues are used solely to support the Hillsborough HealthCare program.

DISEASE MANAGEMENT “PLAY OR CO-PAY” CONCEPT



**INNOVATIONS AND BEST PRACTICES COMMITTEE
RECOMMENDATIONS AND OUTSTANDING ISSUES
SUMMARY**

RECOMMENDATIONS

1. Incentives should be developed to foster the adoption of interoperable health IT by all providers contracting with Hillsborough HealthCare.
2. Implementation of an electronic health record system should be referred to the Management Committee of the Health Care Advisory Committee for further study and consideration.
3. Disease management should be considered a core service.
4. A disease management program should be phased-in one disease at a time.
5. The disease management program should include components to:
 - Educate patients about their disease and how they can better manage it.
 - Actively monitor patients' clinical symptoms and treatment plans, following evidence-based guidelines.
 - Coordinate care for the disease among all providers including physicians, hospitals, laboratories, and pharmacies.
 - Provide feedback on individual patients to physicians about patients' follow-through and status between office visits.
6. The disease management program should include both process and outcome measurement and evaluation.
7. An information technology system should be developed to support the disease management program.
8. Eligibility for Hillsborough HealthCare services should be restored if the excluded person is not convicted of another felony for a period of three years.
9. Over the next few years, Hillsborough HealthCare should shift to a pay for performance basis at all levels of the program; ways should be explored to implement this policy without escalating costs after a disease management program is put into place.

OUTSTANDING ISSUES

1. What are the ways to best leverage our investment?

**CORE SERVICES COMMITTEE
RECOMMENDATIONS AND OUTSTANDING ISSUES
SUMMARY**

RECOMMENDATIONS

1. The first priority should be to make certain that all eligible persons living in poverty between 18 and 65 years of age are served.
2. After all eligible persons are served, Hillsborough HealthCare membership could be extended to uninsured persons between 18 and 65 years of age with incomes above the Federal poverty level; before the program is extended to persons with incomes over the Federal poverty level, a business plan should be developed to serve this population with estimated costs and projections showing who could be served based on the amount of funds that are available.
3. Hillsborough HealthCare members should have open access to all core services with no co-pays.
4. The core services guaranteed to all Hillsborough HealthCare members should be:
 - Health Education, Screening, and Preventive Care
 - Primary Care Clinic/Office Visits (Routine, Acute, and Chronic Conditions)
 - Care Coordination/Medical Case Management
 - Disease Management including Smoking Cessation
 - Primary Mental Health (Medication and Medication Management)
5. With respect to mental illness, Hillsborough HealthCare should:
 - Continue to pay medication and medication management for members
 - Work collaboratively with DCF and the providers to find cost-effective ways of providing mental health treatment for members
 - Reduce pharmacy costs for mental health related medications and use the savings for grant-writing and/or as match (leverage) for grant applications.
6. Referrals from primary care physicians should be required for all services that are not defined as core services.
7. The following referral services should require prior authorization from an independent third party:
 - Outpatient/Hospital (Same Day Surgery)
 - Specialist Referrals (Includes Hospice Referrals)

- Vision (Limited and Enhanced for Disease Management Participants)
 - Dental (Limited and Enhanced for Disease Management Participants)
 - Hospital Inpatient
 - Home Health
 - Pain Management
 - Durable Medical Equipment (Includes Prostheses)
 - Skilled Nursing
 - Physical Rehabilitation (Inpatient and Outpatient)
8. The following services should be excluded from coverage if they are not already excluded:
 - Transplantation (Except Corneal)
 - Voluntary Abortions
 - Cosmetic Surgery
 - Retroactive Payment for ER Visits and Resultant Admissions of Persons Eligible For But Not in HCHCP “Retros”)
 9. Primary care/core services should be separated from specialty care.
 10. Sales tax dollars should be budgeted both for Health Education, Screening, and Preventive Care, and for Disease Management including Smoking Cessation.
 11. Evidence-based programs and services be developed and/or utilized for Health Education, Screening, and Preventive Care and for Disease Management including Smoking Cessation.
 12. Efforts should be made to coordinate with and utilize community resources, such as DOH (STEPS) and other organizations, whenever possible for Health Education, Screening, and Preventive Care, and for Disease Management including Smoking Cessation.
 13. Health Education, Screening, and Preventive Care and Disease Management including Smoking Cessation programs and services should be used to identify unserved eligibles for enrollment in Hillsborough HealthCare, particularly those who could benefit from disease management.
 14. Geographical areas with a high penetration of eligible populations be targeted for Health Education, Screening, and Preventive Care and for Disease Management including Smoking Cessation
 15. A “carrots and sticks” approach should be developed for disease management involving the use of benefits such as enhanced dental and vision coverage as carrots and co-pays or disenrollment as sticks.

OUTSTANDING ISSUES

1. Should staff explore, possibly through a pilot project, the use of clinical and/or volunteer navigators to 1) increase access to health and social services; 2) follow-up to ensure appropriate linkage; and (3) coordinate medical care and disease management.
2. What are the best strategies for reaching unserved eligible persons?
3. Are the networks as currently structured still relevant?
4. Do one or more contracts for primary care/core services make more sense?
5. Should separate contracts be used for referral services?
6. Or, would separate contracts for referral services, particularly the high cost services requiring prior authorization, prove more cost-effective?

Appendix B
Study Committee Motions
Red Flag Items

Hillsborough County Health Care Study Committee Motions

Topic Program Structure/Management

Motion Dr. Freedman made a motion that there shall be one contract for all core services countywide, i.e., issue one request for proposals (RFP) for a single comprehensive contract. Process and outcome standards, quality measures and information sharing requirements shall be built into the RFP and any resulting contract. Formal community provider collaboratives will be eligible to respond to the RFP along with corporate entities. The motion was seconded by Ms. Gillette and passed unanimously (Ms. Busansky absent).

Date August 5, 2005

Topic: Specialty Services

Motion: Dr. Curran made a motion to have an RFP for TPA for specialty services and medical management with fixed price and promotes competition and innovation. Includes requirement to develop and implement disease management program coordinated with Core Services contract. The motion was seconded and passed the committee unanimously (Ms. Erb absent)

Date: August 10, 2005

Topic: Inpatient/Ancillary

Motion: Dr. Curran made a motion to consider inpatient, multiple contracts for outpatient hospital, diagnostic, radiology, possibly pharmacy, and diagnostic lab services. The motion was seconded and passed the committee unanimously (Ms. Erb and Mr. Waters absent)

Date: August 10, 2005

Topic: Inpatient/Ancillary

Motion: Dr. Curran made a motion to have group contracting for DME, Home Health, Prosthetics, Pain Management, Skilled Nursing, Limited Dental/Vision, Physical Rehab. similar but not more expensive than similar services provided to county employees. The motion was seconded and passed the committee unanimously (Ms. Erb and Mr. Waters absent)

Date: August 10, 2005

Topic: ER Block Payment

Motion: Dr. Curran made a motion to support the ER block payment distributed between hospitals that participate in program. That total should initially be set with future increases limited. This is not intended to be a cost saving measure, but rather an attempt to provide incentives for seeing individuals in non-emergency settings. The total amount and process for dividing between facilities need to be determined. Retros will not be paid. The motion was seconded and passed the committee unanimously (Ms. Erb and Mr. Waters absent)

Date: August 10, 2005

Topic: Governance Structure

Motion: Dr. Curran made a motion to maintain current governance structure and control for a period of 2-3 years in order to stabilize the program and try to reduce administrative costs with proposed recommendations. The motion was seconded and passed the committee unanimously (Ms. Erb and Mr. Waters absent)

Date: August 10, 2005

Topic: Disease Management

Motion: Dr. Davison made a motion to adopt the disease management Play or Co-pay concept leaving it up to staff to implement on which disease, the motion passed unanimously (Dr. Freedman & Dr. Curran absent).

Date: August 12, 2005

Topic: Smoking Cessation

Motion: Dr. Davison made a motion that core services will include a smoking cessation program for smokers as a covered service, the motion passed unanimously (Dr. Freedman, Dr. Leon & Dr. Curran absent).

Date: August 12, 2005

Topic: Program Funding

Motion: Dr. Davison made a motion that the program be self sustaining and survive on revenues from sales tax and not require any ad valorem taxes (The motion passed unanimously).

Date: August 19, 2005

Topic: Sales Tax

Motion: Dr. Curran made a motion that sales tax be continued at ½ cent solely for this purpose as a continuing revenue source (The motion passed unanimously, Dr. Freedman absent).

Date: August 19, 2005

Topic: Medicaid Match

Motion: Dr. Curran made a motion that the Medicaid Match contribution not exceed 10 year rolling average for this plan (The motion passed unanimously, Dr. Freedman absent).

Date: August 19, 2005

Topic: Medicaid Match

Motion: Ms. Gillette made a motion for the BOCC to have discussion with legislative delegation concerning the Medicaid Match (The motion passed unanimously, Dr. Freedman absent).

Date: August 19, 2005

Topic: Trauma Care

Motion: Dr. Curran made a motion pending the underwriter's review to provide a minimum of \$3.5 million for trauma care based on service and accountability measures to be developed by staff (The motion passed unanimously).

Date: August 19, 2005

Topic: Clinical & Volunteer Navigators

Motion: Dr. Curran made a motion to support the Clinical & Volunteer Navigators recommended staff motion (The motion passed unanimously). Over the next two years staff assess the cost-effectiveness of using clinical and/or volunteer navigators to provide resource and care coordination for non-compliant members of Hillsborough Health Care: increase access to health and social services; (b) follow-up to ensure that appropriate linkage to health and social services; and (3) coordinate medical care, disease management, and social services. Further, assuming the cost-effectiveness of clinical and/or volunteer navigators, it is recommended that during this two-year period staff review the budget to determine how to best fund a program using clinical and/or volunteer navigators for these purposes.

Date: August 19, 2005

Topic: Smoking Cessation

Motion: Ms. Erb made a motion for staff to evaluate a smoking cessation play or co-pay component with incentives & penalties and report back to BOCC & HCAB with time frame. (The motion passed with a majority, Commissioner Sharpe voted against this motion) Dr. Curran made a motion to reconsider because of Sharpe's concern (The motion to reconsider passed unanimously).

CORRECTED MOTION: Dr. Curran made a motion to implement and evaluate a smoking cessation program within scope of benefits for core services; failure to demonstrate satisfactory compliance and progress would require substantial co-payment after a period of time to be determined (The motion passed unanimously).

Date: August 19, 2005

Topic: Co-pays

Motion: Dr. Freedman made a motion to continue the current member co-pays for 100% FPL and under (The motion passed unanimously).

Date: August 19, 2005

Topic: 3 Strikes

Motion: Commissioner Sharpe made a motion to table the 3 strikes discussion until the County Attorney provides legal opinion (The motion passed unanimously).

Date: August 19, 2005

Topic: Information Technology

Motion: Dr. Freedman made a motion to move the development of a comprehensive, interoperable, on-line information technology infrastructure that permits assessment of the efficient and effective management of the HCHCP. In order to facilitate implementation, the HCAB will establish a committee to maintain oversight of the development (The motion passed unanimously).

Date: August 19, 2005

Topic: Outreach

Motion: Commissioner Sharpe made a motion not to add any additional employees for outreach and to coordinate with the current county Communications office (The motion passed unanimously).

Date: August 19, 2005

Topic: Program Structure

Motion: Ms. Erb made a motion to open up the single contract for Core Services recommendation for reconsideration. (The motion passed, Dr. Freedman voted against the motion and Dr. Leon was absent). Ms. Busansky will submit concerns in writing to staff to be shared with group.

Date: August 19, 2005

Topic: Medicaid Match

Motion: Dr. Curran made a motion that the Medicaid Match contribution from sales tax should not exceed the lesser of the 4 year rolling average of expenditures for this purpose or 10% of sales tax revenue attributed to this program. (The motion passed, Commissioner Sharpe voted against the motion).

Date: September 9, 2005

Topic: Program Structure

Motion: Dr. Curran made a motion that it is desirable to have Core Services provided by a single collaborative. It may be appropriate to meet this expectation and address market realities through more than one contract. The determination will need to be made through a process of negotiation of procurement at the best value for the citizens of Hillsborough County (The motion passed unanimously), to replace Dr. Freedman's August 5th motion for one contact for Core Services).

Date: September 9, 2005

Topic: 3 Strikes

Motion: Dr. Curran made a motion for reinstatement after completion of all court ordered sanctions, committing 4th strike would take them off plan after they are reinstated. (The motion was passed unanimously).

Date: September 9, 2005

HIGHEST PRIORITY FOR INITIAL DISCUSSION “Red Flag” Items:

- Program structure and management including:
 - Nature of contracts.
 - Management of program.
 - Number of providers.
 - Prior authorization of specialists.
 - ER block payment (including history of ER payments)
 - Impact of Upper Payment Limit (UPL) and other matching opportunities on the decision (and the general discussion of how the structure could impact matching funding.)
 - Governance Structure.
- What expenses should be included in the use of the Trust Fund including addressing:
 - Local Medicaid Match Requirement
 - TGH trauma subsidy
 - Other program expenses.
- Estimate of financial impact of actions including:
 - Dollar Savings: Problems/Opportunities/Solutions.
 - Return on Community Investments (ROCI).
 - Impact of cost shifting to providers.(NOTE: Staff is preparing a report to address the above.)

FOR LATER DISCUSSION:

- Overall Pharmacy Strategy
 - Tracking
 - Reduce Costs
 - Overall Nature of Contract
- Navigators/Clinical Case Management & Social Services.
- Three Strikes Policy.
- Smoking Cessation.
- Play or Co-pay.
- Outreach and community awareness.
- Clarification/Agreement ITS Recommendation (Added by HSS Staff):
 - Data Warehouse and Evolution to Better Data Access
 - Electronic Medical Record
 - Electronic Claims Management

STAFF WILL PROVIDE WRITTEN RESPONSE THEN STUDY GROUP CAN DETERMINE IF FURTHER DISCUSSION IS NEEDED:

- Hormone Therapy.
- Medicaid Recovery (in total and for Specialists).
- **BOCC PRESENTATION**
- Format.
- Participants.

Appendix C
Comparison to Other Counties

At the June 1, 2005, BOCC meeting, HSS staff was asked: How does the Hillsborough HealthCare Program costs compare to the costs of other counties? In a report dated July 21, 2005, the following response was given:

Comparison of the Ratio of Tax Supported Health Care Costs to the Non-Elderly Population Living in Poverty

An evaluation of costs for per capita health care for a County should acknowledge that there is a need for a higher investment in Counties with a larger number of people in need. Therefore, to make this comparison, we will look at relative need by using a ratio of health care expenses to the size of the population that is non-elderly and living in poverty. While it is true that expenses are not just for this target population, this is the population that results in the needs for local subsidies.

As illustrated in Exhibit 1, Hillsborough's expenditure ratio is lower than Broward, Miami-Dade and Palm Beach. Hillsborough's expenditure ratio is higher than Duval and Pinellas.

EXHIBIT 1.

Ratio of Tax Subsidy for Health per Non-Elderly Person Living in Poverty for Selected Florida Urban Counties

Calculation	Hillsborough	Pinellas	Duval	Broward	Miami-Dade	Palm Beach
County's Tax Subsidy for Health (in \$M)	\$98.0 M	\$45.6 M	\$38.0 M	\$203.0 M	\$345.0 M	\$104.8 M
/ Population < 65 Yrs. Old Living in Poverty	128,903	83,701	101,859	171,964	348,869	101,767
Ratio of Tax Subsidy for Health per Non-Elderly Person Living in Poverty	\$760	\$545	\$373	\$1,180	\$989	\$1,030

Additional Detail by County:

When comparing Hillsborough County government's expenditures to other Florida counties, it is important for consistency to do the following:

- Include all tax subsidies for health care. While the vast majority of Hillsborough County's local tax support for health care is from the HealthCare Program trust fund, other Florida counties use multiple sources. In addition, some counties have different benefits for different eligible groups (referred to as tiered programs) with funding from multiple sources.
 - **Broward's tax subsidies for health were over \$200M in 2004.** There are two hospital taxing districts in Broward (North Broward Hospital District and South Broward Hospital District). In 2004, North Broward collected \$174M and South Broward collected \$16M. In addition, the Broward County government allocated \$13M for their health care program. (Source: Florida Hospital Association, South Broward Hospital District).
 - **Miami-Dade's tax subsidies for health are over \$300M.** Miami-Dade's tax subsidies are accounted under the County's Public Health Trust (PHT). Tax contribution to the PHT is projected to total \$290M in FY 04 - 05 which includes proceeds from a dedicated % cent sales tax for health care (projected by Miami-Dade to be \$171 M in FY 04-05) and general fund support (budgeted at \$119M in FY 04-05). The proposed FY 05 - 06, budget increases this contribution to a total of over \$307 M. In addition, there are other tax supports to Jackson Memorial (such as capital subsidies currently planned at **\$55M** and a proposed \$25M subsidy to reformat their liability coverage.) Therefore, conservatively, including the capital subsidies, Miami-Dade has \$345 M in tax subsidies for health in FY 04-05. Miami-Dade does pay for their Medicaid match out of the PHT. (Source: Miami-Dade County Manager's Budget Presentation, June 2005)
 - **Palm Beach's Health Care District collected \$116.8M in 2005 of which over \$104M would be allocated to adult programs.** The Palm Beach Health Care District has a multi-tiered system and includes programs for adults and children. A proportionate allocation of tax dollars to programs not funded through other sources results in over \$104 M of the tax dollars being for adult programs. One of the District's programs is the Coordinated Care Program (\$58.8 M budgeted in 2005). The District's commitment to adult health care includes more than this program. For example, \$34.5 M is earmarked for trauma.

Palm Beach County also benefits from a significant private sector philanthropy contribution to health care. For example, Palm Beach is

the home of the Quantum Foundation whose mission is to support social services for Palm Beach County. It provided over \$7 M in grants within Palm Beach County in 2004. In addition, the MacArthur Foundation, although based in Chicago, has Palm Beach as major target for grants because Palm Beach is the home of the MacArthur family. (Source: Florida Hospital Association, Palm Beach Health Care District financial report, Quantum Foundation Annual Report)

o **The calculation of Jacksonville / Duval's health subsidies is more complicated.**

While the direct subsidies for health were budgeted to be \$28 M in FY 05 (a combination of a \$23.7 M subsidy to Shands - Jacksonville and \$3 M for JaxCare), the subsidy has varied significantly by year, mostly a function of the financial bail outs of Shands - Jacksonville (formerly University - Jacksonville). In FY 2000, the bail out was close to \$70 M. The subsidy to Shands - Jacksonville also includes State subsidies. In addition, Jacksonville / Duval's Medicaid match (estimated at over \$10M) should be added to be consistent with Hillsborough. (SOURCE: City of Jacksonville Budget Proposal, Shands - Jacksonville).

■ **Since Hillsborough's program is often compared to Pinellas, a more detailed comparison is given below:**

- o **As further detailed in the attached chart, Pinellas FY 06 requested budget for its health care programs is close to \$46 compared to our proposed \$98M (See Exhibit 2 at the end of this section for detailed analysis).**

While the Pinellas managed care program (whose third party administrator is Well Care) has a proposed budget of \$14.7M, this does not reflect all its tax supported expenditures for health care. To make its costs consistent with Hillsborough, the following are key adjustment:

- Pinellas has additional add-ons to the managed care program (such as pharmacy, dental, and general medical) that raise their medical program budget to \$24M.
- Pinellas has block grant subsidies for hospitals, emergency services, and primary care that are an additional \$6.3M.
- In Hillsborough, the program management costs of the Program are allocated to its budget. In Pinellas, it is not, so using Hillsborough's allocation method, it is estimated that Pinellas' management allocation would be over \$5M..
- Pinellas' Medicaid match and Health Care Responsibility Act (HCRA) mandates are budgeted at \$10.3M.

(SOURCE: Pinellas Human Services)

- o **Hillsborough has 1.5 times as many non-elderly people living in poverty than does Pinellas.**

When looking at the expenditure per capita, the amount of people in poverty for whom only the County can give health care support should be considered not the total population. The populations below 65 years old who live in poverty are an indicator of the primary objective for local programs. For example, while Hillsborough and Pinellas Counties are close in size of the total population, Hillsborough number of non-elderly people living in poverty (128,900 in the 2003 US Census estimate) is over 1.5 times as many as Pinellas (83,700 people).

- o **Pinellas County's managed care program has less than 3,000 people enrolled at any one point in time. Hillsborough's program has close to 5 times the enrollment.**

The Pinellas' Board of County Commissioners have acknowledged that they need additional funding for health care for its low-income population and are looking at ways to increase funding. (See attached article).

EXHIBIT 2.

COMPARABLE COSTS FOR HEALTH CARE PROGRAMS HILLSBOROUGH AND PINELLAS COUNTIES FY 06 BUDGET REQUEST (IN \$ MILLIONS)

CATEGORY OF COST	HILLSBOROUGH	PINELLAS
Medical Care - Managed Care Program/UPL	\$ 71.76	\$ 23.86
Block Grant-Type Payments to Medical Facilities		
Hillsborough - Trauma Care Payment to TGH	\$ 3.50	
Pinellas - Uncompensated Care Payment - Hospitals		\$ 4.15
Pinellas - Uncompensated Care Payment - ERs		\$ 0.62
Pinellas - Primary Care - Increased Access		\$ 1.53
Subtotal - All Medical Care	\$ 75.26	\$ 30.16
Program Delivery/Case Management/Administration		
Program Delivery/Case Mgmt.	\$ 5.94	
Administration	\$ 4.30	
Subtotal -Prog.Delivery/Case Mgmt./ Admin (1)	\$ 10.24	\$ 5.13
State Mandated Programs		
Medicaid Match	\$ 13.69	\$ 10.20
Health Care Responsibility Act (HCRA)	\$ 0.10	\$ 0.10
Subtotal - Mandated Programs (2)	\$ 13.79	\$ 10.30
Total HealthCare Program (Comparable Costs)	\$ 99.29	\$ 45.59

Notes: Assumes Hillsborough's 65.1 % cost allocation factor of these costs for Pinellas. At the present time, Pinellas does not allocate these costs to the Health Care Program. The allocation is made to enable a cost comparison.

(1) Medicaid match and HCRA costs are not allocated by Pinellas to HealthCare Program. The allocation is made to enable a cost comparison.

An evaluation of costs for per capita indigent health care for a county should acknowledge there is a need for a higher investment in counties with a larger number of people in need. The following exhibit shows the tax subsidy for health care per non-elderly person living in poverty in various Florida counties:

	Hillsborough	Pinellas	Duval	Broward	Miami-Dade	Palm Beach
Tax Subsidy	\$760	\$545	\$373	\$1.180	\$989	\$1,030

The Hillsborough HealthCare Program is often compared to Pinellas program even though there are some major differences in the two programs that make comparisons difficult. For example:

1. The Pinellas managed care program has less than 3,000 people enrolled at any one time whereas Hillsborough has historically had about 15,000 people enrolled at any one time.
2. Hillsborough has 1.5 times as many non-elderly people living in poverty than does Pinellas.
3. Major costs such as the Medicaid match and staff oversight costs are not included in the Pinellas program, but are included in the cost of the Hillsborough program.

One issue both programs are facing is rising health care costs. Pinellas reportedly has had to take \$3.3 million from county reserves to fund a projected FY 05 budget shortfall due to rising costs and increased demand for health care services. In FY 04, the Hillsborough program had to withdraw \$6 million from reserves to meet an increase in enrollment and the rising cost of health care. Actions have been taken by Hillsborough staff to prevent a repeat of the FY 04 experience in FY 05.

Appendix D
Return on Community Investment

MEASUREMENT OF THE RETURN ON THE COMMUNITY'S INVESTMENT IN THE HILLSBOROUGH HEALTHCARE PROGRAM

This document provides an estimate of the return on the community's investment (ROCI) resulting from the Hillsborough HealthCare Program⁴.

The benefits categories to be considered are:

- Decreased direct health care costs.
- Decreased indirect costs and increased indirect benefits.
- Improved influx of funds into the community.
- Improved quality of life.

The rest of this section describe how these factors could be measured and applies these measurements to the Hillsborough HealthCare Program.

Direct Cost Measurements:

Typically, a financial impact of a health care program for the indigent population is to reduce the total cost of care for the target population.

However, later in this analysis, we will quantify the financial impact of individuals being covered who would not otherwise be covered. Therefore, including the direct cost savings in this analysis would be redundant.

Indirect Benefits:

There are several factors to measuring indirect costs, such as the savings of centralizing functions, the impact of centralized negotiation of benefits and expenses, and the cost benefits to related functions (e.g. the improvement in physical health reduces the costs to the mental health and judicial systems, sayings in non-health care needs of the individuals.) At this point, since we could not specifically quantify this benefit, it is not included in the analysis.

In addition, a holistic approach to social services includes obtaining non-county funded assistance for an individual initially came to the County for health care assistance.

⁴ This analysis utilizes a methodology developed by Dave Rogoff during a three year period from 2000 and 2003. The work was supported with grant money from the Health Resource Services Administration (HRSA) as well as state and federal grants to analyze existing programs and programs being developed. This ROCI framework was applied to over thirty communities and counties. In addition to reports for individual sites, a monograph was written and published in July 2003. It is available electronically at: http://www.cjaonline.net/Documents/ROCI_by_DavidRogoff.pdf.

Therefore, the value of non-health care, non-County funded support for individuals who first came to obtain HealthCare Program benefits is included as an indirect benefit.

❖ Social and Health Services from Non-County Fund Sources (\$5.9 M):

In the last year, the holistic review of the needs of individuals who initially came for the health care program resulted in additional measurable funding of:

- Housing assistance (\$0.4 M)
- Ryan White funding for HIV / AIDS (\$2.5M)
- Employment placement and tuition assistance to help individuals obtain and retain employment (\$3.0 M)

In addition, there is added value to mental health funding for HealthCare clients but it is difficult to specifically quantify, so it was not included in the analysis.

Improving Inflow of Funds and Leveraging Funds:

Improved inflow of funds is a measurement of dollars brought into or retained in the community as the result of the *intervention*. As relevant to an individual *intervention*, this measurement could include the value of:

- The value of funding brought into the community.
- Grants acquired.
- Increased reimbursement.
- In-kind contributions and volunteers.
- Health care services retained in the community.

Hillsborough HealthCare Application of Influx of Funds Measurements:

There are several ways that HealthCare Program expenditures are leveraged to obtain additional outside funding. These categories include:

- State and federal funding under the Upper Payment Limit (UPL) program and other similar matching programs for health care expenditures.
- Assisting individuals in obtaining earlier access to external funding.
- Obtaining public and private sector grants utilizing the infrastructure of the HealthCare Program.

The program to acquire free drugs on behalf of our HealthCare clients has just begun to experience benefits. Therefore, these annual benefits have not been measured and are not included in this analysis.

❖ **State and federal funding under the Upper Payment Limit (UPL) program and other similar matching programs for health care expenditures (\$6.7 M per year) as well as other leverage matching (\$23.0 M).**

There is a program called the Upper Payment Limit (UPL) program that allows federal and state matching of Hillsborough HealthCare Program payments to eligible hospitals and federally qualified health centers that are program providers (Tampa General Hospital, St. Joseph’s Hospital, Tampa Community Health Centers, and Suncoast Health Centers). Last year, these providers received a total of \$6.7M of State and Federal match that are direct match to Hillsborough HealthCare Program payments. In addition, providers can use the UPL payments to increase their Medicaid reimbursement rate which resulted in over \$23 M additional payments for Hillsborough eligible hospitals.

❖ **Helping Hillsborough residents obtain earlier eligibility for federal Programs including Social Security Disability Income (SSDI) (\$4.4 M per year) and Medicare Pharmacy (\$0.4 M).**

The Hillsborough HealthCare Program has helped enrollees who are legitimately disabled to become eligible for federal Social Security Disability Income (SSDI) on an average of 6 months earlier than without the program. We have averaged 675 individuals becoming SSDI eligible per year over the last six years ranging from 605 in FY04 to 776 in FY02. The financial value of the earlier eligibility is increased SSDI payments (at \$590 per person per month) and the cost avoidance value of less months that the HealthCare Program pays for medical coverage for these individuals (assumed to be plan average of \$500). The resulting value is \$4.4 M per year.

CALCULATION OF ANNUAL VALUE OF EARLIER SSDI DETERMINATION FOR HEALTH CARE PROGRAM CLIENTS

Number of People Enrolled in SSDI through Plan (a)	675
X <u>Average Months Earlier that SSDI is Granted from Feds</u>	<u>6</u>
People Months	4050
X Value of Additional Federal Funds per Month	\$1,090
[Sum of \$590 SSI Payment per Month Plus \$500 Average HealthCare Cost / Month (c)]	
TOTAL VALUE OF ADDITIONAL FEDERAL FUNDS PER YEAR	\$4,414,500

In addition, starting in 2006, the Hillsborough HealthCare Program will no longer pay for prescription drugs for Medicare eligible individuals. However, we will assist them in getting enrolled in the government approved drug programs. We project that we will assist individuals in getting enrolled two months. Based upon an average of \$X per person per month and Y individuals, this results in an estimate of \$400,000 value.

❖ **Obtaining public and private sector grants utilizing the infrastructure of the HealthCare Program (\$2.3 M per year).**

A successful delivery system such as the Hillsborough HealthCare Program in partnership with its providers and other organizations can obtain additional grants.

EXAMPLES OF SPECIFIC APPLICATION OF QUALITY OF LIFE MEASUREMENTS:

By applying factors from national studies on the financial impact of uninsurance to Hillsborough County, we can estimate the economic value to individuals of having access to health coverage and being healthy.

But in addition to the absolute negative economic value of uninsurance, there are inequities in who is impacted. The negative value of uninsurance is a higher percentage of the income of poor people. In addition, these negative factors create barriers to improvement in people's quality of life and data shows that these barriers are more significant for low-income groups, particularly low-income non-white ethnic groups.

These factors are further described below.

Cost of Uninsurance and Poor Health:

❖ **Kaiser Commission on Medicaid and the Uninsured and Governor Bush's Task Force on Access to Affordable Health Insurance:**

The June 2003 report of the Kaiser Commission on Medicaid and the Uninsured, The Cost of Not Covering the Uninsured, presented key findings on the financial impact of being uninsured. The February 2004 final report of Florida Governor Bush's Task Force on Access to Affordable Health Insurance (Co-Chaired by Lt. Governor Toni Jennings and Chief Financial Officer Tom Gallagher) cited the following specific findings from the Kaiser Commission's report (Pg. 20 of Governor's Task Force Report):

- The uninsured receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care and have higher mortality rates.

- A conservative estimate based on the full range of studies is that a reduction in mortality of 5 -15% could be expected if the uninsured were to gain continuous health coverage.
- Better health would improve annual earnings by about 10-30% and would increase educational attainment.
 - For the Hillsborough HealthCare Program, of the approximate 15,000 annualized covered lives last year, 60% were employed or seeking employment. ***To be conservative, using the Florida minimum wage level of \$6.15 per hour and 2080 hours per year, if these individuals die not have health coverage and therefore their health became poorer, there would be lost earnings of \$11.3M to \$34M.***
 - This is conservative because it does not include an economic stimulator factor. That is, the impact of additional wage dollars also includes economic stimulation and tax dollars.
- On the average, the uninsured receive about half as much care as people who are insured all year. In 2001, an uninsured person received approximately half the care of an insured person. In dollar value, uninsured for the full year used \$1,253 per person per year in medical care compared to \$2,484 per insured person per year.
- Total uncompensated care (...nationwide) provided in 2001 was estimated to be \$35 billion. The primary source of funding for uncompensated care is government which spent an estimated \$30.6 billion for care of the uninsured, two thirds of which is federal.

❖ **National Institute of Medicine (NIM) Committee on the Consequences of Uninsurance:**

The National Institute of Medicine charged a multi-year study on the Consequences of Uninsurance. There were multiple reports from this Committee on the Consequences of Uninsurance including the June 2003 report "Hidden Costs, Value Lost – Uninsurance in America". The June 2003 report included the results of an extensive study on the economic impact of uninsurance, conducted by Dr. Elizabeth Richardson Vigdor, an economist from Duke University, for the Committee.

A key finding from Dr. Vigdor's study was: "Economic value of the healthier and longer life that an uninsured child or adult foregoes because he or she lacks health insurance ranges between \$1,645 and \$3,280 for each additional year spent without coverage (p. 3 of Executive Summary)"

❖ **Estimated Impact of Hillsborough HealthCare Program on Quality of Life:**

Since the Hillsborough HealthCare Program has met the needs of a sicker population, it is reasonable to assume the value of the lost coverage would be in the upper half of the calculated impacts using the Vigdor model (\$2,463 to \$3,280).

Applying the upper half of the range from the Vigdor range to the Hillsborough HealthCare Program, with approximately 15,000 annualized covered lives, results in a lost value of \$36.9 M to \$49.2 M if these individuals lost their coverage.

This is still a very conservative calculation of impact on quality of life because it does not include the following factors:

Values to future generations.

For example, the mental and physical health and welfare of children is negatively impacted by being raised by parents who are not healthy.

The already negative impact of financial risk and uncertainty therefore stress as a consequence of being uninsured is proportionately greater for low-income individuals.

Uninsured individuals pay more of their income for health care. For low-income people, this is a significant burden. Uninsured individuals pay 35 percent of their income for health care compared to 20 percent for individuals with coverage.

This statistic was initially presented in the May 2003 NIM report and later confirmed in a May 2004 report from The Kaiser Commission on Medicaid and the Uninsured entitled The Cost of Care for the Uninsured: What Do We Spend, Who Pays and What Would Full Coverage Add to Medical Spending?

This number can be confirmed by the following analysis. The typical working family has between \$5000 and \$6000 per year spent on their behalf for health coverage. This includes the employer's contribution to the family's health care premium, the family's contribution to the premium, and the family's co-pays and deductibles. Our own County employees' coverage falls in this range. The average family size in Hillsborough is over 3 people.

As shown in below, for a family of 3 living at poverty level, a \$5000 to \$6000 annual expenditure is 31% to 37% of their income.

There are many social issues and values that affect an analysis of impact. Poor health has created inequities between income groups and between ethnic groups. The inequities are barriers to success or even advancement.

**HEALTH CARE PAYMENTS AS PERCENTAGE OF UNINSURED FAMILY WAGES
FOR FAMILIES AT FEB. 2003 FEDERAL POVERTY LEVEL**

Family Size	100% FPL	% OF WAGE FOR SELECTED ANNUAL HEALTH EXPENDITURES				
		\$4,000	\$4,500	\$5,000	\$5,500	\$6,000
1	\$9,570	42%	47%	52%	57%	63%
2	\$12,830	31%	35%	39%	43%	47%
3	\$16,090	25%	28%	31%	34%	37%
4	\$19,350	21%	23%	26%	28%	31%
5	\$22,610	18%	20%	22%	24%	27%
6	\$25,870	15%	17%	19%	21%	23%
7	\$29,130	14%	15%	17%	19%	21%
8	\$32,390	12%	14%	15%	17%	19%

The average Hillsborough family size is slightly over 3 and typical health coverage costs \$5500 to \$6000 per year for a family (includes combination of personal and employer premium and co-pays / deductibles). Therefore, the average uninsured family in Hillsborough would be paying about 1/3 of wages for health care.

Value of a Stabilized Health Care Safety Net:

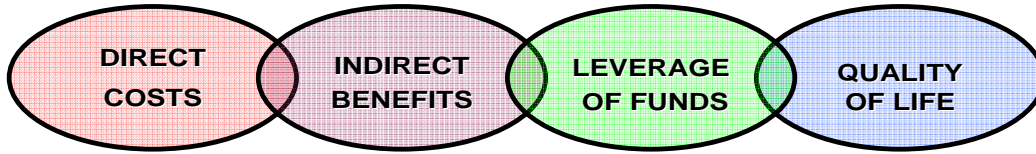
It is hard to quantify the financial impact of the strengthening of hospitals and provides and the stabilizing of the County's health care industry by reducing unpaid bills. The hospitals report the value of uncompensated care and there is an ongoing debate over what is the actual amount.

However, it is reasonable to state that there is a value to the government helping stabilize the health care market. The strength of the health care market is important for the entire population, not just the uninsured. Health care is a service that people need and a major employer of County residents.

SUMMARY OF IMPACT:

As also seen in the graphics below, the difference between the \$84.5M expenditure for the managed care part of the Hillsborough HealthCare Program in FY2004 (excludes the Medicaid Match and Trauma Center subsidy) and the projected quantifiable benefit of \$79.7M is \$4.8M. This difference is acceptable given the overall objective of maintaining a strong health care safety net and that there are several benefits that could not be measured.

ANNUAL QUANTIFIABLE PROGRAM BENEFITS



- **Not Incremental to Other Benefits.**
- **Additional Funds to HealthCare Enrollees from Outside Sources:**
 - Housing (\$0.4M)
 - Ryan White (\$2.5M)
 - Employment and Scholarship (\$3.0M)
- **Upper Payment Limit (UPL)**
 - Direct UPL (\$6.7M).
 - Other Leverage (\$23.0 M)
 - **Earlier Eligibility:**
 - SSDI (\$4.4 M).
 - Medicare Drugs (\$0.4M)
 - **Outside Grants / Funds (\$2.3M).**
- **Negative Impact of No Coverage. (\$37.0M) [*]**

[*] Methodology developed by Dr. Elizabeth Vigdor, Duke U., National Institute of Medicine funded Study on the Consequences of Uninsurance. Included June 2003 report "Hidden Costs, Value Lost – Uninsurance in America". Methodology results in \$24.4M to \$49.2M range, midpoint used.

COMPARISON OF HILLSBOROUGH HEALTH CARE PROGRAM MANAGED PROGRAM EXPENDITURES AND BENEFITS, FY 04 (Excludes Medicaid Match and TGH Subsidy)

