Fort Lauderdale / Broward County EMA
Broward County HIV Health Services Planning Council
An Advisory Board of the Broward County Board of County Commissioners
200 Oakwood Lane, Suite 100, Hollywood, FL, 33020 - Tel: 954-561-9681 / Fax: 954-561-9685

JOINT PRIORITIES COMMITTEE
Meeting Agenda
Wednesday, December 19, 2012 at 12:30 p.m.

Carla Taylor-Bennett, *Part A Co-Chair* **Lisa Agate, *Part B Co-Chair***

1. **CALL TO ORDER**
2. **WELCOME AND INTRODUCTIONS**
   a. Review Meeting Ground Rules, Sunshine and Public Comment Requirements
   b. Committee Member and Guest Introductions
   c. Moment of Silence
3. **APPROVALS**
   a. Meeting Agenda 12/19/12
   b. Add item 5 d to the agenda, at the request of the Joint Planning Committee
   c. Meeting Minutes 11/19/12
4. **UNFINISHED BUSINESS**
   a) Update on ad Hoc PCIP Subcommittee
5. **NEW BUSINESS**
   a) Assessment of the Administrative Mechanism
   ACTION ITEM: The committee is scheduled in December to conduct the Assessment of Administrative Mechanism. Part A Grantee will give a presentation.
   b) Nominate Dionne Proulx to be a member of Joint Priorities
   c) Presentation on the Affordable Care Act and Ryan White (HANDOUT A)
   INFORMATION ITEM: Presentation by Joey Wynn.
   d) Viral Load Report as Eligibility Requirement
   ACTION ITEM: The Joint Planning Committee recommended that Joint Priorities consider a proposal to require that newly diagnosed and new Part A clients submit a viral load report and CD4 count to become eligible for Part A services. The goal is to collect data to develop an estimate of Community Viral Load.
6. **GRANTEE REPORTS**
   a. Part A
   b. Part B and ADAP (HANDOUT B)
7. **PUBLIC COMMENT**
8. **AGENDA ITEMS FOR NEXT MEETING:** January 16, 2013 at 12:30 p.m. **VENUE:** BRHPC
9. **ADJOURNMENT**

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JOINT PRIORITIES COMMITTEE
November 19, 2012 at 12:30 p.m.
200 Oakwood Lane, Suite 100, Hollywood, FL, 33020
MEETING MINUTES

ATTENDANCE						
#	**Members**		**Present**	**Absent**		**Guests**
1	Taylor-Bennett, C.	Part A Co-Chair	**X**			Green, D.
2	Agate, L.	Part B Co-Chair	**X**			Proulx, D.
3	Ferrer, M.		**X**			
4	Gammell, B.		**X**			
5	Grant, C.		**X**			**Grantee Staff**
6	Hayes, M.			**E**		Jones, L. (Part A)
7	Jackson, R.			**X**		Degraffenreidt, S. (Part A)
8	Katz, H. B.		**X**			
9	Reed, Y.			**X**		
10	Schickowski, K.		**X**			**HIVPC Support Staff**
11	Siclari, R		**X**			Rosiere, M.
12	Starkey , J.			**X**		Eshel, A.
13	Wynn, J		**X**			Crawford, T.
		Quorum = 8	**9**	**4**		LaMendola, B

1. CALL TO ORDER (*Please sign-in)*

The Part A Co-Chair called the meeting to order at 12:45 p.m.

2. WELCOME, INTRODUCTIONS & MOMENT OF SILENCE

The Part A Co-Chair welcomed everyone. Attendees were notified of information regarding the Government in the Sunshine Law and meeting reporting requirements, which includes the recording of minutes. Attendees were advised that the meeting ground rules are present, for reference. In addition, attendees were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed. Member, staff and guest introductions were made. A moment of silence was observed.

3. APPROVALS

a. Approval of Today's Agenda

Motion #1:	To Approve the 11/19/12 Meeting Agenda
Proposed by:	Joey Wynn
Seconded by:	Claudette Grant
Action:	Passed Unanimously

b. Approval of 10/17/12 Meeting Minutes

Motion #2:	To Approve the 10/17/12 Meeting Minutes
Proposed by:	H. Bradley Katz
Seconded by:	Joey Wynn
Action:	Passed Unanimously

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4. UNFINISHED BUSINESS

a. **Meeting the Goals of the National HIV/AIDS Strategy (HANDOUT A)**

The Committee discussed the list of actions being developed to meet the goals of the National HIV/AIDS Strategy (NHAS), which are (i) reduce the number of people who become infected with HIV, (ii) increase access to care and improve health outcomes for PLWHA, and (iii) reduce HIV-related health disparities. A PowerPoint presentation regarding the In + Care Campaign as well as videos by AIDSVu and National Quality Center were shown to the Committee. The In + Care Campaign Retention Measures include: (i) gap measure (ii) medical visit frequency (iii) patients newly enrolled in medical care and (iv) viral load suppression. The various barriers that clients face while trying to obtain access to care were discussed. As a result, the Committee recognized the need to create a system of care that clients can navigate more easily.

A Committee member mentioned that the system needs more quality improvement functions in order to avoid or minimize the inefficiencies that result in missed appointments. It was suggested that this is also analyzed through demographics to see which group is experiencing the most missed visits. The members also discussed various factors that would strengthen clients' retention in care. The Joint Priorities Committee agreed to have one of the members show a PowerPoint presentation on health care reform at the next committee meeting.

The Grantee suggested that the Joint Priorities Committee partner with the Quality Management Committee in order to review outcomes and indicators to see why individuals have fallen out of care and see what the barriers are as well as how to address and improve them. The members discussed the need for all committees to work collectively to accomplish these goals. The Committee agreed to include an overall assessment of the impact of the Affordable Healthcare Act in the work plan. The Committee identified that it can advance the NHAS goal of improving health outcomes by finding ways to retain patients in care, and working with QM to reduce patients falling out of care. The Committee also agreed that it would look for a project potentially funded by Minority AIDS Initiative as an action to reduce disparities.

The members discussed the need for newly diagnosed consumers to be more aware of the HIV/AIDS resources that are available in the community. Staff presented the HIV/AIDS resource directory that is located on the BRHPC website: http://www.brhpc.org/files/Resource%20Directory.pdf. It was noted that it is only a draft version due to the continuous change in contact information. The resource directory was also printed and disseminated to the Committee members for review. The Committee suggested having something simplified in order for consumers to use as a point of reference. The Committee identified a need for more outreach in the community and via social media, and urged the Joint Client/Community Relations Committee to take the lead.

b. **Update on Pre-Existing Condition Insurance Plan Subcommittee**

The Committee discussed that the ad Hoc PCIP Subcommittee met on Thursday, November 15, 2012 and began making recommendations for preliminary data and identified which data they would need to review. The Subcommittee reviewed uninsured data for Broward as well as Monroe County and will begin to do cost comparison analysis to determine a PCIP plan. The next meeting is December 12, 2012 at 12:30 p.m. in order to review the previously requested data. The Joint Priorities Committee will review the subcommittee's information in March 2013.

c. **Review Initial Data from Part A on Viral Load and Demographics (HANDOUT B)**

The Committee reviewed the data from Part A on viral load, which was broken down by demographics. It was noted that the data was preliminary and the handout was for informational purposes only.

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5. NEW BUSINESS

The Committee recommended Doretta Green to become a member of Joint Priorities. The interested party introduced herself and explained why she would like to be a part of Joint Priorities. The recommendation will be addressed at the next HIV Planning Council meeting.

Motion #3	To recommend Doretta Green to be a Part A member of the Joint Priorities Committee
Proposed by:	Joey Wynn
Seconded by:	H. Bradley Katz
Action:	Passed unanimously

6. GRANTEE REPORTS

a. Part A

The Grantee is holding a World AIDS Day event on Wednesday, December 5, 2012 at 11:30am at Esplanade Park. Phill Wilson, Founder and Executive Director of Black AIDS Institute, will be the keynote speaker. There will be a PWA forum held afterward at 2:00 p.m. at the main library. It was announced that there are multiple copies of the palm cards, advertising the World AIDS Day events.

b. Part B

The Part B Grantee report was provided detailing expenditures up to September 30, 2012.
Non-Medical Case Management conducted 697 eligibility interviews in September. Medication co-payment served 255 clients of which 5 were new to the program. There were 246 clients served in September for Medication Co-Payment and 9 clients served for Mail Orders. Cost avoidance for Medication Co-Payment program for September is $33,642.63. Total cost savings April – September 2012 is approximately $107,177. Home Delivered Meals served zero (0) clients. Medical Transportation for September 2012:
Part B Bus Passes: There were 366 (31 day) and 189 (10 ride) distributed in September.
Part A Bus Passes: There were 0 (31 day) and 266 (10 ride) distributed in September.
The bus passes distributed represent a partial number as not every agency picks up bus passes each month.

c. ADAP Update

The ADAP report through October 25, 2012 was provided: The total ADAP "open" enrollment was 2,815 with 774 total ADAP clients being served in the last 30 days. The ADAP Waitlist enrolled 52 clients and the total ADAP/Medicare Part D Enrollment was 176. There were 774 appointments of which 242 (31%) were missed. *Clients Served* is defined as having at least one "pickup" in the period. The category definitions are as follows:
Category A Clients Served = 8 (CD4 < 200 cells/mm3 and/or CD4% < 14%: A diagnosis of AIDS and/or diagnosis of active opportunistic infection and/or diagnosis of HIV-associated nephropathy.)
Category B Clients Served = **7** (CD4 cell count between 201-350 cells/ mm3: Persons currently on ARV therapy, persons previously on ARV therapy but therapy was interrupted and treatment naïve clients)
Category C Clients Served = 37 (Treatment naïve clients with CD4 cell count > 350 cells/mm3)
Category D Clients Served = **0** (Unknown/Other)

Clients are removed from the Wait List by medical category in the order of earliest enrollment. This serves as a reminder that clients MUST recertify every 6 months or they will lose their position on the Wait List.

7. PUBLIC COMMENT

There was no public comment.

8. AGENDA ITEMS FOR NEXT MEETING: December 19, 2012 at 12:30 p.m. /Venue: BRHPC

- Presentation on Healthcare Reform
- Standing Agenda Items

9. ADJOURNMENT

Without objection, the meeting was adjourned at 3:23 p.m.

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JOINT PRIORITIES COMMITTEE - ATTENDANCE CY 2012

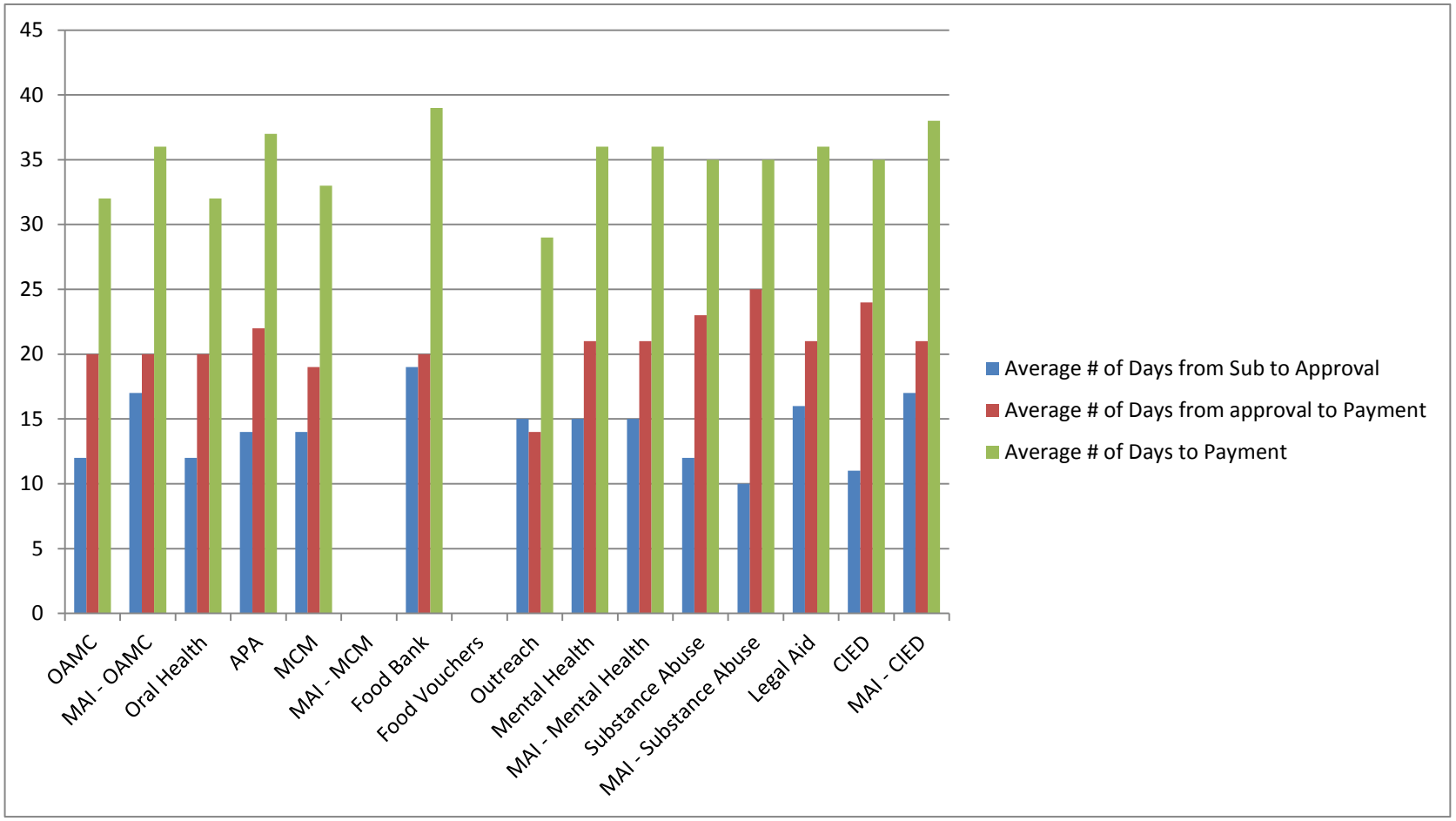
#	Members	Jan	Feb	Mar	Apr	May	Jun 13	Jun 20	Jul	Aug	Sep	Oct	Nov	Dec
1	Taylor-Bennett, C	P	P	P	P	P	P	P	P	P		P	P	
2	Agate, L.	*Interim Chair as of 6/21*					P	P	P	**A**		P	P	
3	Ferrer, M.	P	P	P	P	P	P	P	P	P		P	P	
4	Gammell, B.	P	P	P	P	P	P	P	P	P		P	P	
5	Grant, C.	P	P	P	P	P	P	P	P	P		P	P	
6	Hayes, M.	P	P	P	P	P	**A**	P	P	P		P	**E**	
7	Katz, H. B.	P	**E**	P	P	P	P	**E**	**E**	P		P	P	
8	Jackson, Rev. R.	*Appointed 6/20*							**A**	P		**A**	**A**	
10	Reed, Y.	P	P	P	P	P	P	P	P	P		P	**A**	
11	Schickowski, K.	*Appointed at August meeting*										P	P	
12	Siclari, R	P	P	P	P	E	P	P	P	**A**		P	P	
	Starkey , J.	**E**	P	P	**A**	P	**A**	**A**	**E**	P		**E**	**A**	
13	Wynn, J	P	**A**	**E**	**A**	P	P	P	P	P		P	P	
Quorum = 8		**15**	**11**	**13**	**13**	**12**	**11**	**10**	**10**	**10**		**11**	**9**	

VISION: To ensure the delivery of high quality comprehensive HIV/AIDS services to low income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care

MISSION: We direct and coordinate an effective response to the HIV epidemic in Broward County to ensure high quality, comprehensive care that positively impacts the health of individuals at all stages of illness. In so doing, we: Foster the substantive involvement of the HIV affected communities in assuring consumer satisfaction, identifying priority needs, and planning a responsive system of care
Support local control of planning and service delivery, and build partnerships among service providers, community organizations, and federal, state, and municipal governments
Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment

BROWARD COUNTY HIV HEALTH SERVICES PLANNING COUNCIL
ADMINISTRATIVE MECHANISM REVIEW
FIRST QUARTER(MARCH 2012 - MAY 2012)

Service Category	Approved $ Allocation	Average # of Days from Sub to Approval	$ Amt Monthly Invoice Paid	Average # of Days from approval to Payment	Average # of Days to Payment
OAMC	$6,348,597	12	$1,261,455.52	20	32
MAI - OAMC	$100,000	17	$49,981.37	20	36
Oral Health	$2,623,653	12	$618,803.01	20	32
APA	$453,141	14	$104,872.20	22	37
MCM	$1,145,110	14	$259,701.37	19	33
MAI - MCM	$176,644	0	$0.00	0	0
Food Bank	$68,103	19	$41,079.50	20	39
Food Vouchers	$87,787	0	$0.00	0	0
Outreach	$67,000	15	$33,374.87	14	29
Mental Health	$336,987	15	$98,270.11	21	36
MAI - Mental Health	$95,368	15	$12,274.88	21	36
Substance Abuse	$357,889	12	$96,394.09	23	35
MAI - Substance Abuse	$400,624	10	$50,008.77	25	35
Legal Aid	$124,426	16	$37,075.50	21	36
CIED	$475,513	11	$56,232.00	24	35
MAI - CIED	$290,957	17	$120,238.80	21	38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Substance Abuse
MAI - Substance Abuse
Legal Aid
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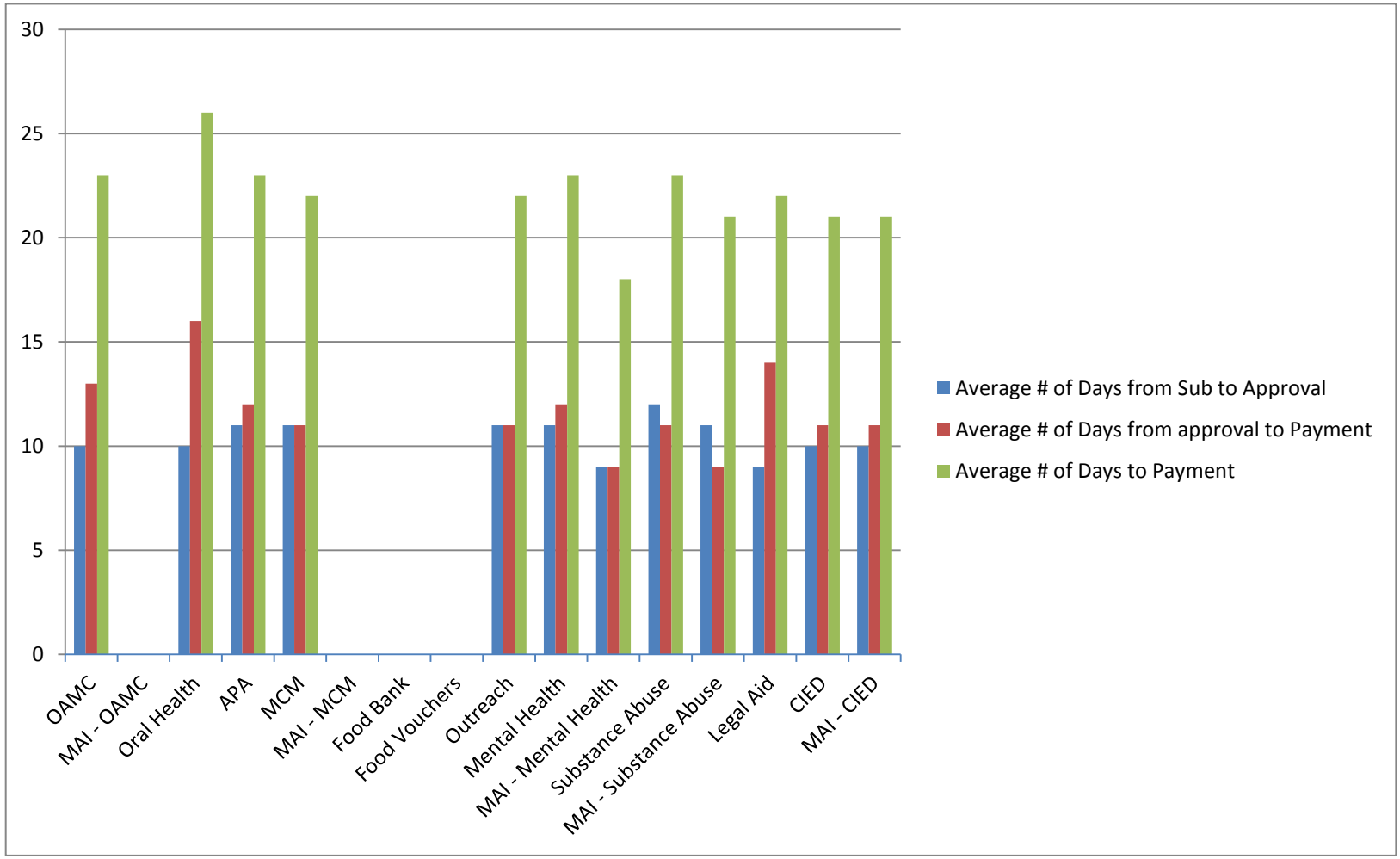
MAI - CIED
Average # of Days from Sub to Approval
Average # of Days from approval to Payment
Average # of Days to Payment

BROWARD COUNTY HIV HEALTH SERVICES PLANNING COUNCIL
ADMINISTRATIVE MECHANISM REVIEW
SECOND QUARTER (JUNE - AUGUST 2012)

Service Category	Approved $ Allocation	Average # of Days from Sub to Approval	$ Amt Monthly Invoice Paid	Average # of Days from approval to Payment	Average # of Days to Payment
OAMC	$6,348,597	10	$1,393,784.29	13	23
MAI - OAMC	$100,000	0	$0.00	0	0
Oral Health	$2,623,653	10	$419,009.76	16	26
APA	$453,141	11	$102,278.51	12	23
MCM	$1,145,110	11	$273,525.29	11	22
MAI - MCM	$176,644	0	$0.00	0	0
Food Bank	$68,103	0	$0.00	0	0
Food Vouchers	$87,787	0	$0.00	0	0
Outreach	$67,000	11	$2,588.25	11	22
Mental Health	$336,987	11	$93,386.89	12	23
MAI - Mental Health	$95,368	9	$15,334.99	9	18
Substance Abuse	$357,889	12	$45,843.92	11	23
MAI - Substance Abuse	$400,624	11	$90,012.08	9	21
Legal Aid	$124,426	9	$38,684.25	14	22
CIED	$475,513	10	$63,703.20	11	21
MAI - CIED	$290,957	10	$119,336.80	11	21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Substance Abuse
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Legal Aid
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Average # of Days from Sub to Approval
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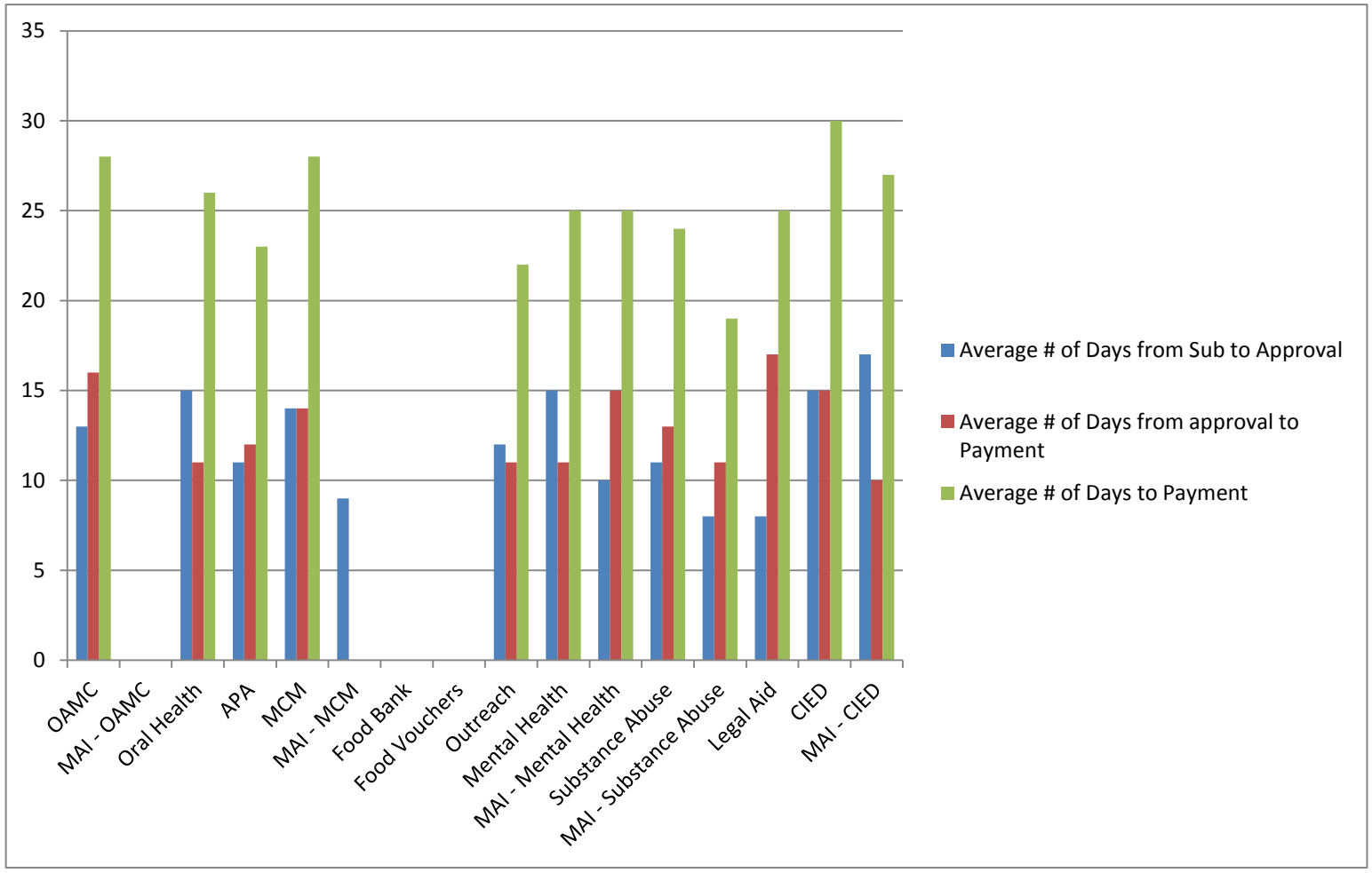
BROWARD COUNTY HIV HEALTH SERVICES PLANNING COUNCIL
ADMINISTRATIVE MECHANISM REVIEW
THIRD QUARTER(SEPTEMBER & OCTOBER 2012)

Service Category	Approved $ Allocation	Average # of Days from Sub to Approval	$ Amt Monthly Invoice Paid	Average # of Days from approval to Payment	Average # of Days to Payment
OAMC	$6,348,597	13	$925,681.88	16	28
MAI - OAMC	$100,000	0	$0.00	0	0
Oral Health	$2,623,653	15	$194,688.69	11	26
APA	$453,141	11	$86,220.66	12	23
MCM	$1,145,110	14	$173,060.62	14	28
MAI - MCM	$176,644	9	$0.00	0	0
Food Bank	$68,103	0	$0.00	0	0
Food Vouchers	$87,787	0	$0.00	0	0
Outreach	$67,000	12	$5,479.23	11	22
Mental Health	$336,987	15	$39,545.06	11	25
MAI - Mental Health	$95,368	10	$17,938.36	15	25
Substance Abuse	$357,889	11	$15,125.11	13	24
MAI - Substance Abuse	$400,624	8	$90,655.97	11	19
Legal Aid	$124,426	8	$20,196.00	17	25
CIED	$475,513	15	$69,458.40	15	30
MAI - CIED	$290,957	17	$8,043.20	10	27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Outreach
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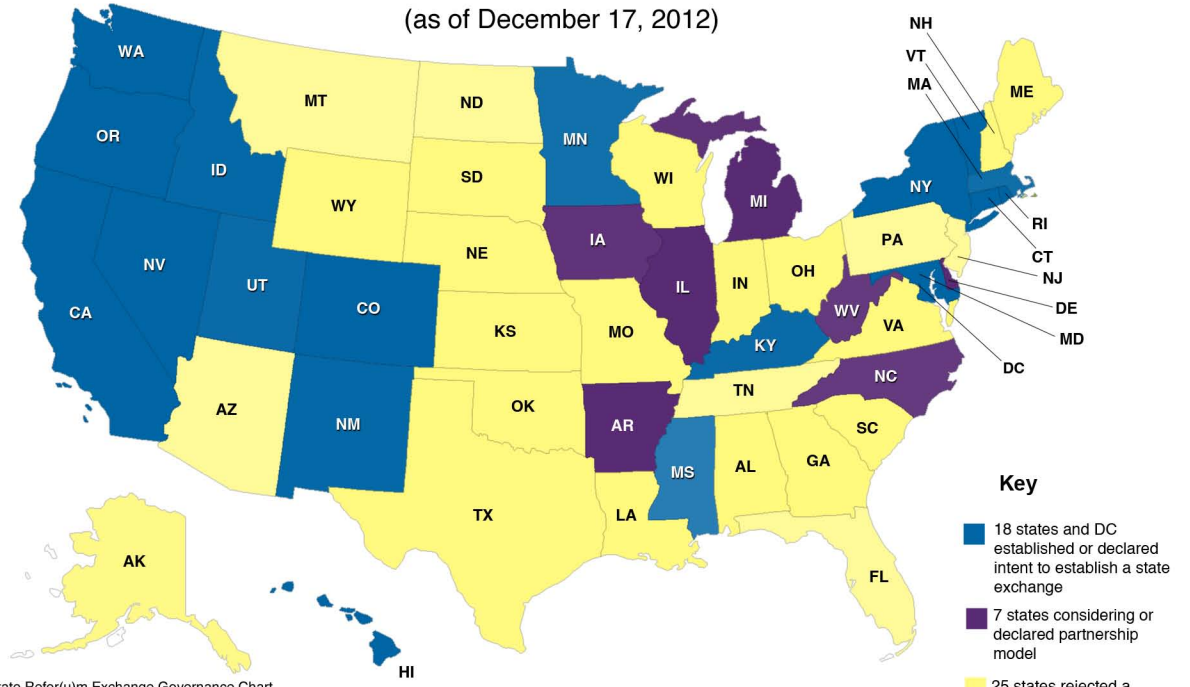
MAI - Mental Health
Substance Abuse
MAI - Substance Abuse
Legal Aid
CIED
MAI - CIED
Average # of Days from Sub to Approval
Average # of Days from approval to Payment
Average # of Days to Payment

State, Partnership, or Federal Health Insurance Exchange?
Where States Stand So Far
(as of December 17, 2012)



Sources: State Refor(u)m Exchange Governance Chart
http://statereforum.org/exchange-governance-chart

State Refor(u)m Exchange Blueprint Chart
http://www.statereforum.org/exchange-blueprint-chart

State Refor(u)m Exchange Policy Decisions Chart
http://statereforum.org/exchange-policy-decisions-chart

statereforum

HANDOUT A

Healthcare Reform Implementation: Moving Forward and Managing Change

Joey Wynn,
Co Chair – Florida HIV AIDS Advocacy Network
November 14th, 2012
PCPG meeting / Tampa, Florida

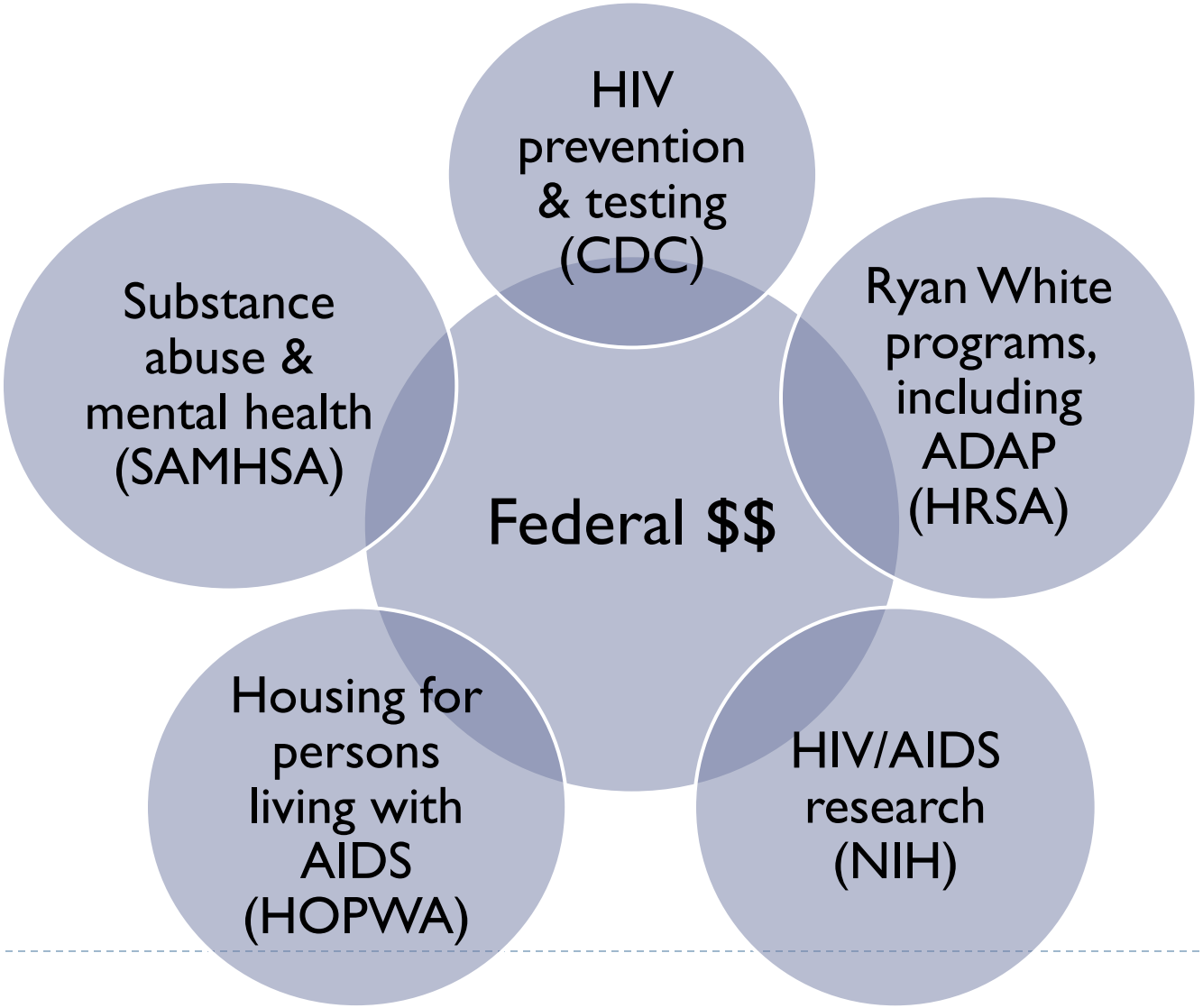
ACA Implementation: Moving Forward

Federal AIDS Policy Partnership
September 13, 2012

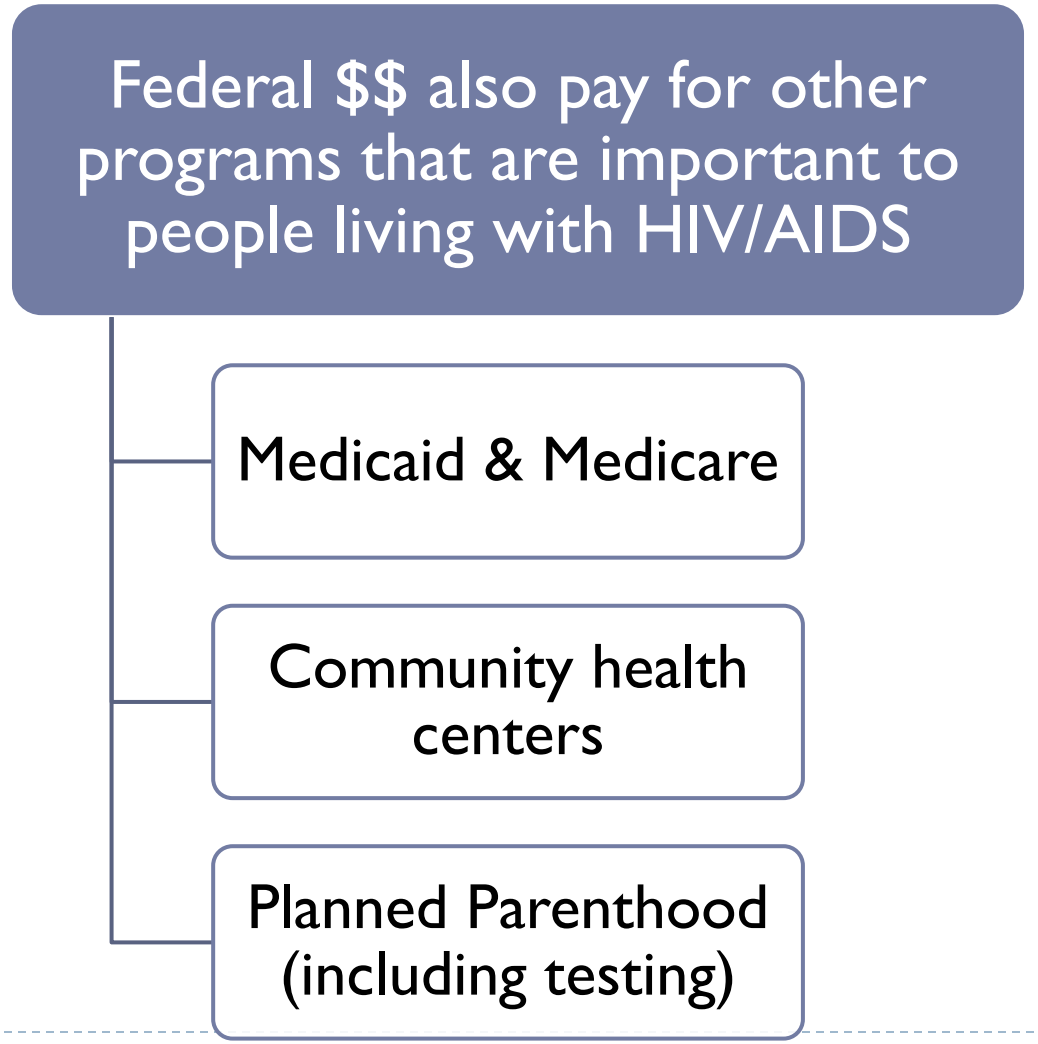
HIV Health Care Access Working Group

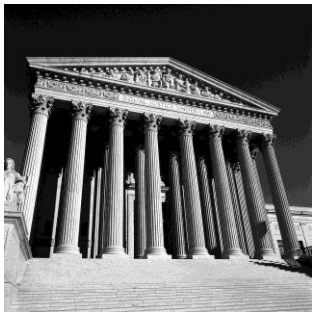
Slideshow created by Andrea Weddle – HIV Medicine Association

Background:
Budget decisions affect HIV/AIDS programs



Background:
Budget decisions also affect other services



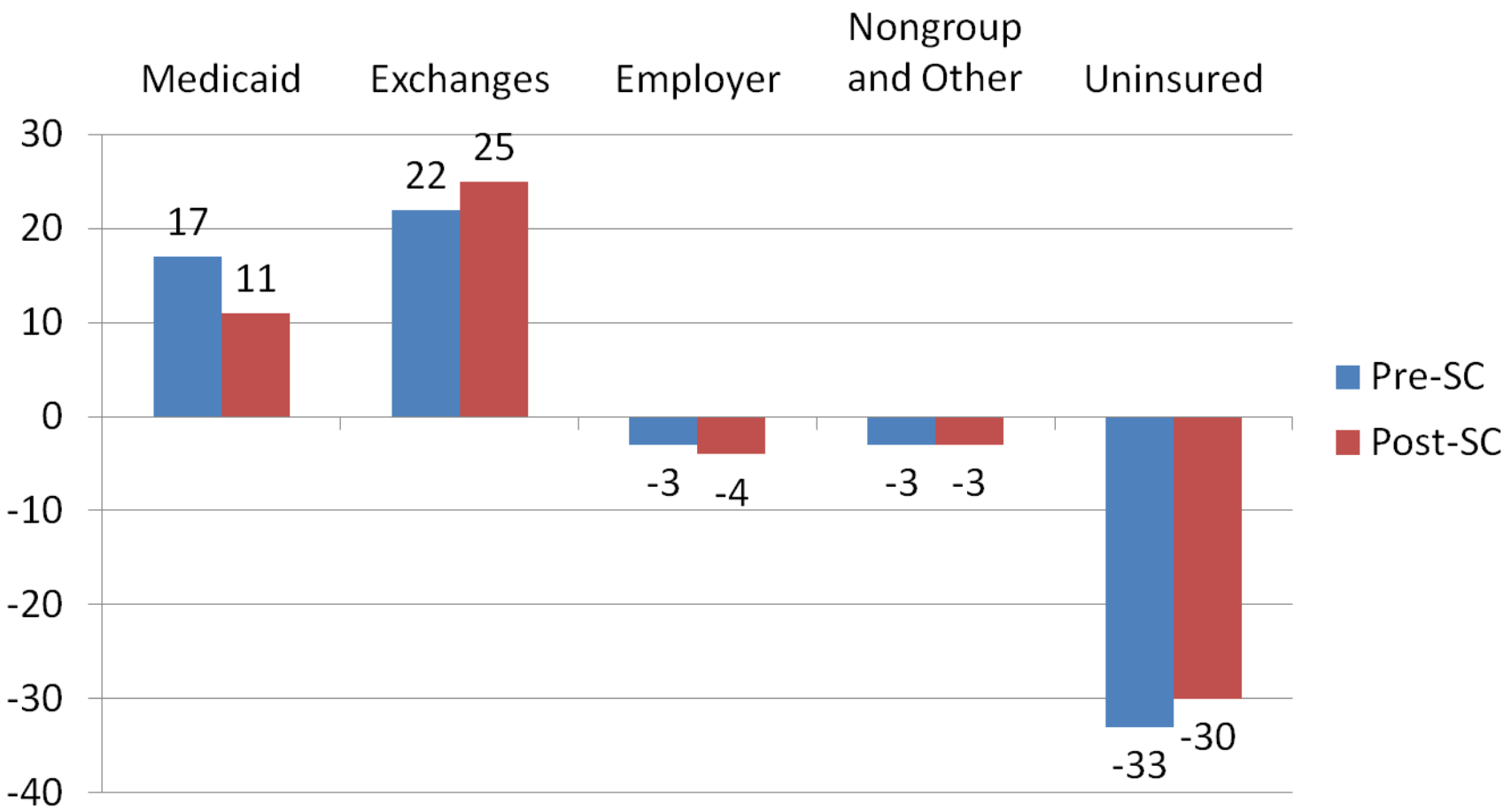


The Supreme Court Decision: In Brief

- Upheld requirement to purchase insurance ("individual mandate")
  - Exchanges, new insurer rules, etc. move forward
- Found Medicaid expansion "coercive"
  - States can opt out of the Medicaid expansion without risking all of their federal Medicaid $
- Left other provisions in intact - applies only to authority to enforce Medicaid expansion

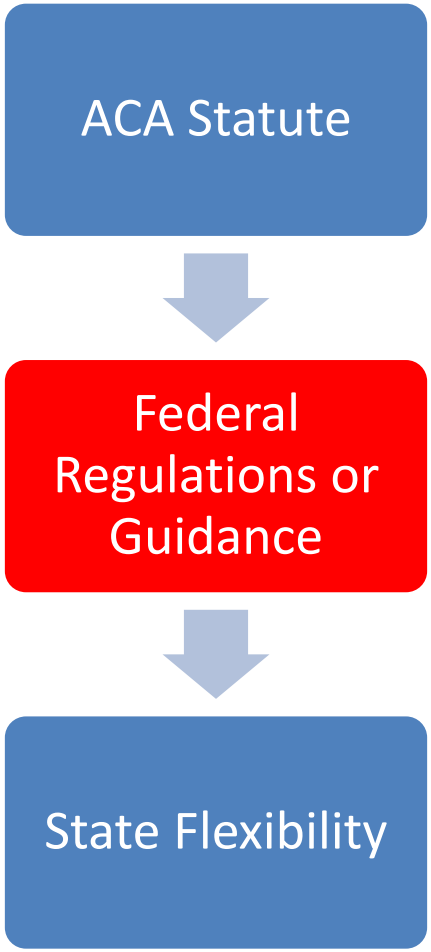
The Impact of the Decision: Estimated Coverage in 2022

In Millions



Source: Congressional Budget Office. Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision. July 2012.

ACA Implementation Looks Different In Every State



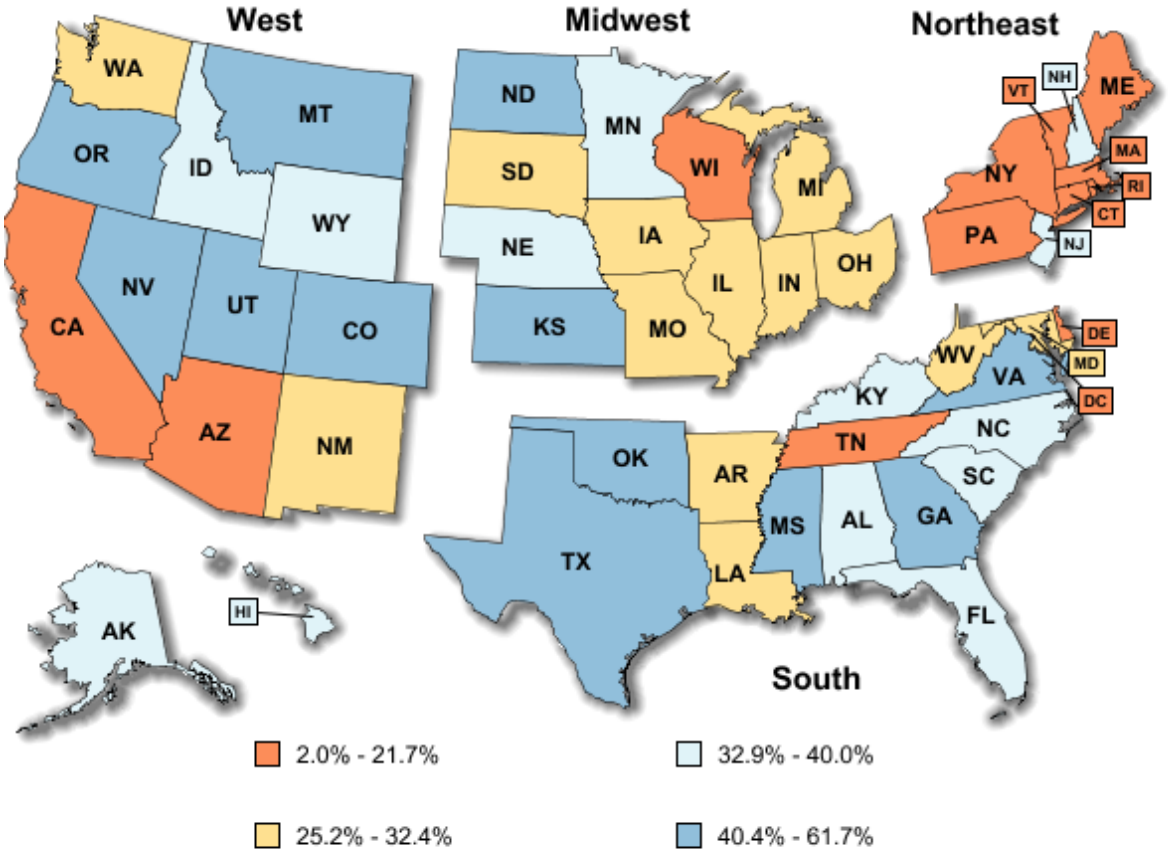
Burning Issues

- Medicaid Expansion, to be or not to be, that is the Question. (In Florida anyway)
- Essential Health Benefits, Who will be creating them for us? How do we get involved?
- State Exchanges, Many details impact us Directly

Medicaid Expansion Update

- CBO lowered enrollment estimate by 6 million
- No deadline for states to opt in
- 100% federal match applies 2014 to 2016
- States required to maintain eligibility for enhanced rates (“MOE requirement”)
- States may push for partial expansion
- Many states waited …until after the elections

Medicaid Expansion: Estimated Increase in Enrollment by State



Medicaid Expansion to 133% of Federal Poverty Level (FPL): Increase in Enrollment and Spending Relative to Baseline: Enrollment in 2019

THE HENRY J. KAISER FAMILY FOUNDATION statehealthfacts.org
Your source for state health data

Making the Expansion Work: Medicaid Primary Care Rate Increase in 2013 & 2014

- Internists, family medicine and pediatricians and NPs/PAs they supervise eligible for enhanced rates for primary care services

- No minimum billing requirement

- Specialists trained in IM, FM, and Pediatrics including infectious diseases, eligible

Essential Health Benefits
What We Know

- States selecting from 10 benchmark options to set the standard for their EHB
- State benchmark selection were due Sept 30th
- Largest small group plan in the state is the default
  - Generally lowest cost option, more service limits, etc.
- Regulations delayed until how long after elections?

Ryan White Core Services vs. EHB

Ryan White Core Services

- ✓ **Ambulatory and outpatient care**
- ✓ **AIDS pharmaceutical assistance**
- ✓ **Mental health services**
- ✓ **Substance abuse outpatient care**
- **Home health care**
- **Medical nutrition therapy**
- **Hospice services**
- **Home and community-based health services**
- **Medical case management, including treatment adherence services**
- Oral health care (not standard)

ACA "Essential Health Benefits"*

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management, and
- Pediatric services, including oral and vision care

Low Bar Set for Drug Coverage

- Plans only required to cover one drug per drug class or category (per 12/16 guidance)

- Urging stronger protections at the federal level
  - Adopt Medicare Part D classes of clinical concern (AKA – 6 protected classes)
  - Ensure coverage meets the HHS HIV treatment guidelines (www.aidsinfo.gov)

Federal comment period on state selections this fall

State-based Exchanges – Key Dates and Options

- State blueprints due mid-November
  - http://cciio.cms.gov/resources/files/hie-blueprint-081312.pdf
- HHS approve (or conditionally approve) by 1/1/2013 for 2014
- States may establish in 2015 and beyond
  - Grants continue through 2014
- If no state plan – exchange will be "federally facilitated" –http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf

The Role of the Exchanges: Federal Rules

- Certify “qualified health plans”
- Educate consumers
  - Must establish call center, website, navigators (at least one nonprofit group), premium calculator
- Conduct or contract eligibility and enrollment
  - Streamlined “no wrong door” application process
- Set standards for provider networks
  - Required to contract with “sufficient number and geographic distribution of essential community providers”
  - Ryan White providers identified as essential

New Preventive Services Benefits – Effective in New Plans August 2012

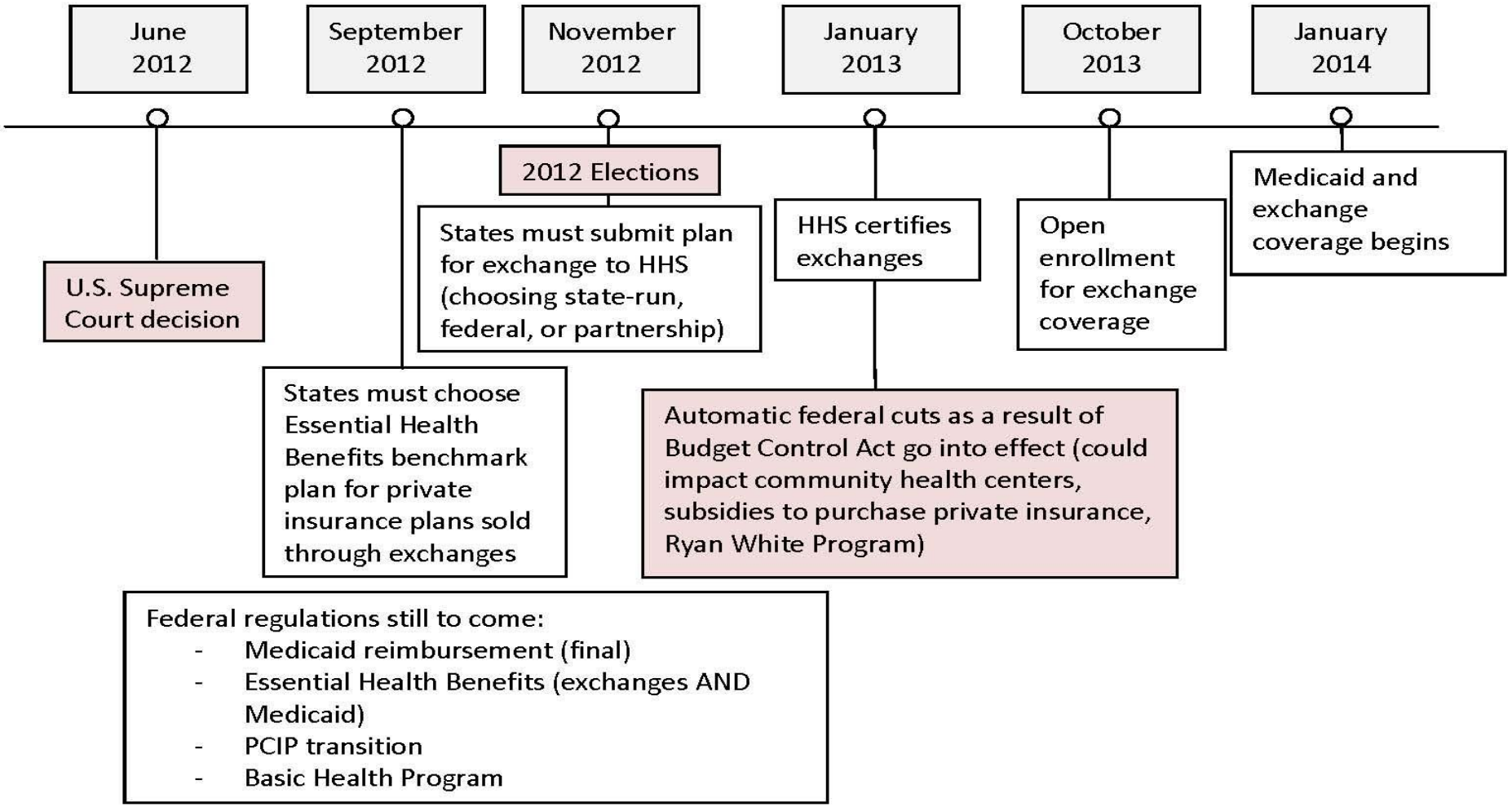
- HIV screening and counseling
- Well-woman visits
- Screening for gestational diabetes
- HPV testing for women 30 years and older
- STI counseling
- FDA-approved contraception methods and counseling
- Breastfeeding support, supplies, and counseling
- Domestic violence screening and counseling

These next slides were created by:

Amy Killelea, National Alliance of State & Territorial AIDS Directors

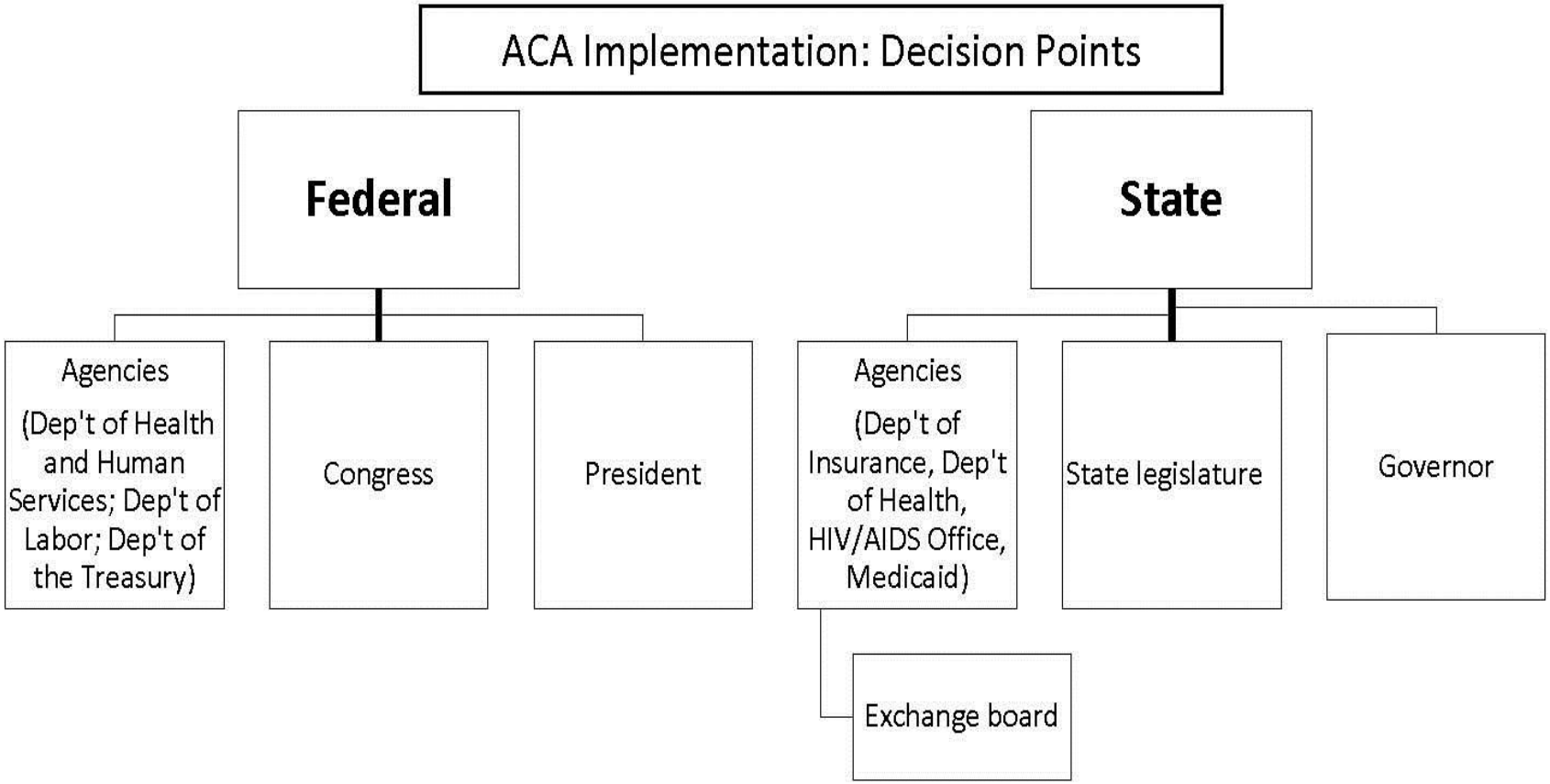
STATE UPDATE

Timeline



Source: Treatment Access Expansion Project, May 2012

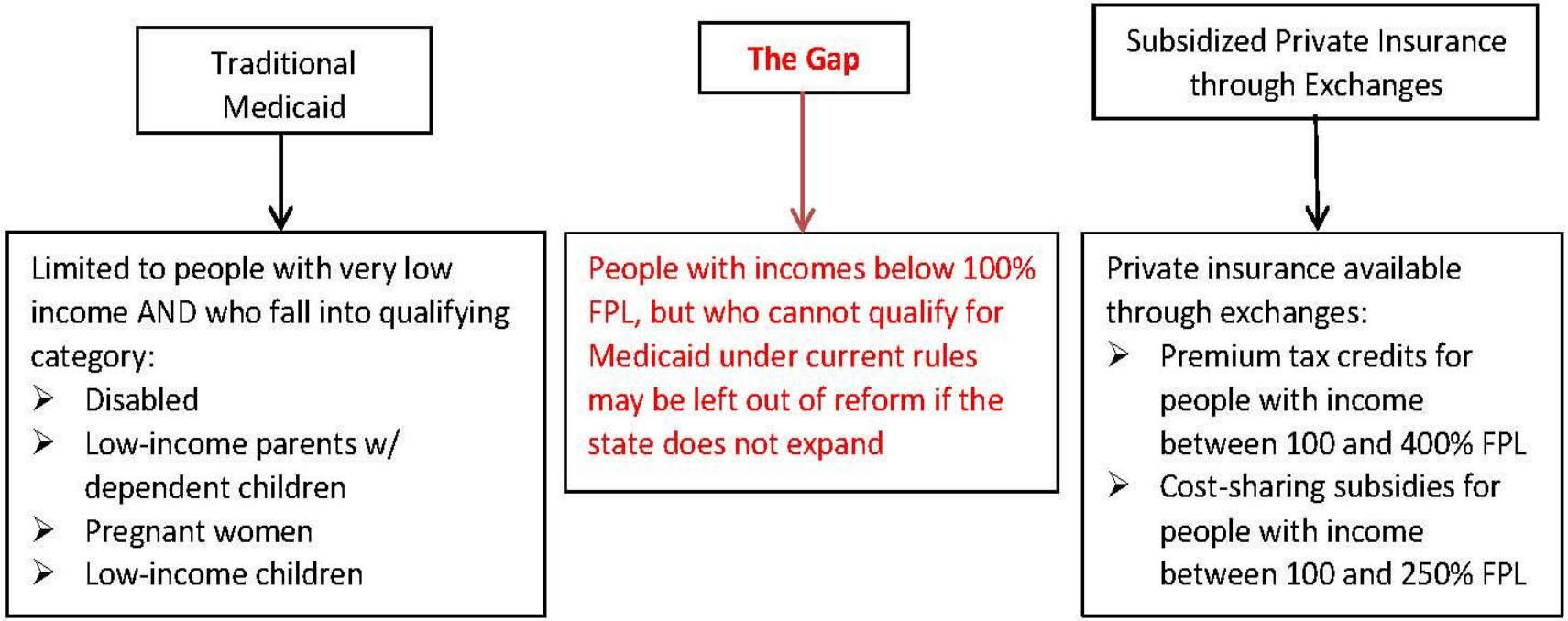
PPACA Implementation Decision Points



Source: Treatment Access Expansion Project, May 2012

Medicaid Expansion: Planning in the Midst of Uncertainty (in Florida)

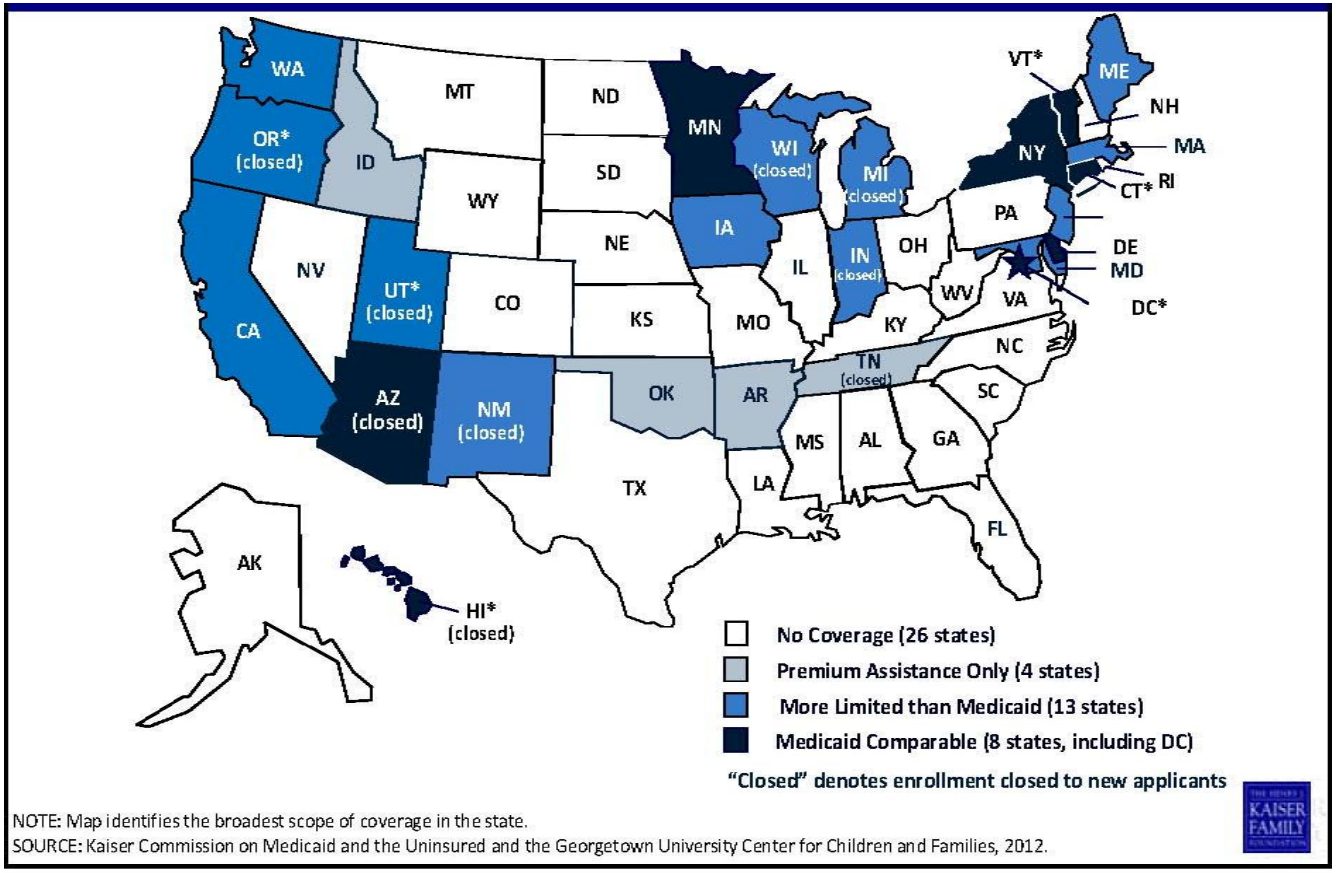
- What happens in a state that does not comply with expansion?



- Greater role for Ryan White Program and ADAP
- Greater dependence on subsidies to purchase private insurance

States with the Greatest Gaps in Coverage if They Do Not Comply with Medicaid Expansion

Medicaid Coverage of Low-Income Adults, January 2012



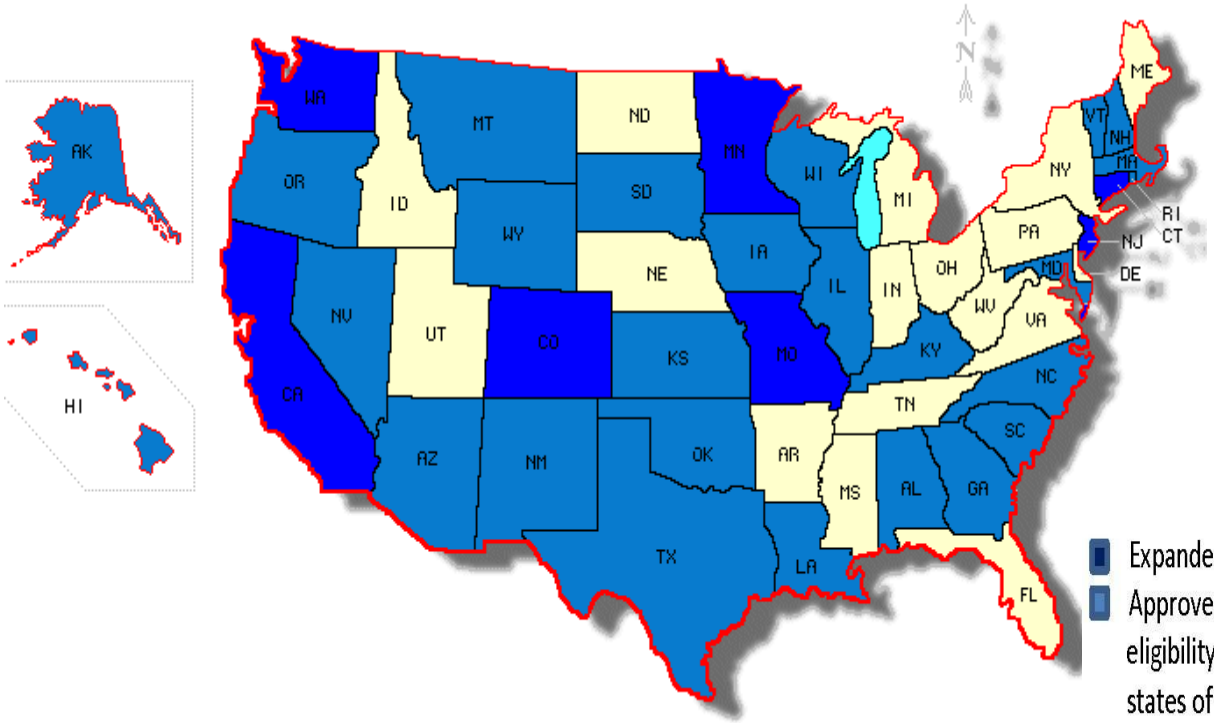
NOTE: Map identifies the broadest scope of coverage in the state.
SOURCE: Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

Most States are Still Weighing Options with Regard to Medicaid Expansion and Weighing Costs/Benefits

- There are still plenty of reasons a state will continue with expansion:
  - Federal government pays 100% of expansion costs for 2014-2016 and gradually reduced to 90% in 2020 and beyond
  - Other reforms (e.g., DSH payment reductions) make it difficult not to expand because of the increased pressure on hospitals without increased revenue from insured patients
  - Uptake may be slow, but states have generally come around to Medicaid and CHIP expansions

Medicaid Reforms Still Happening in States

State Medicaid Reform Implementation Activities

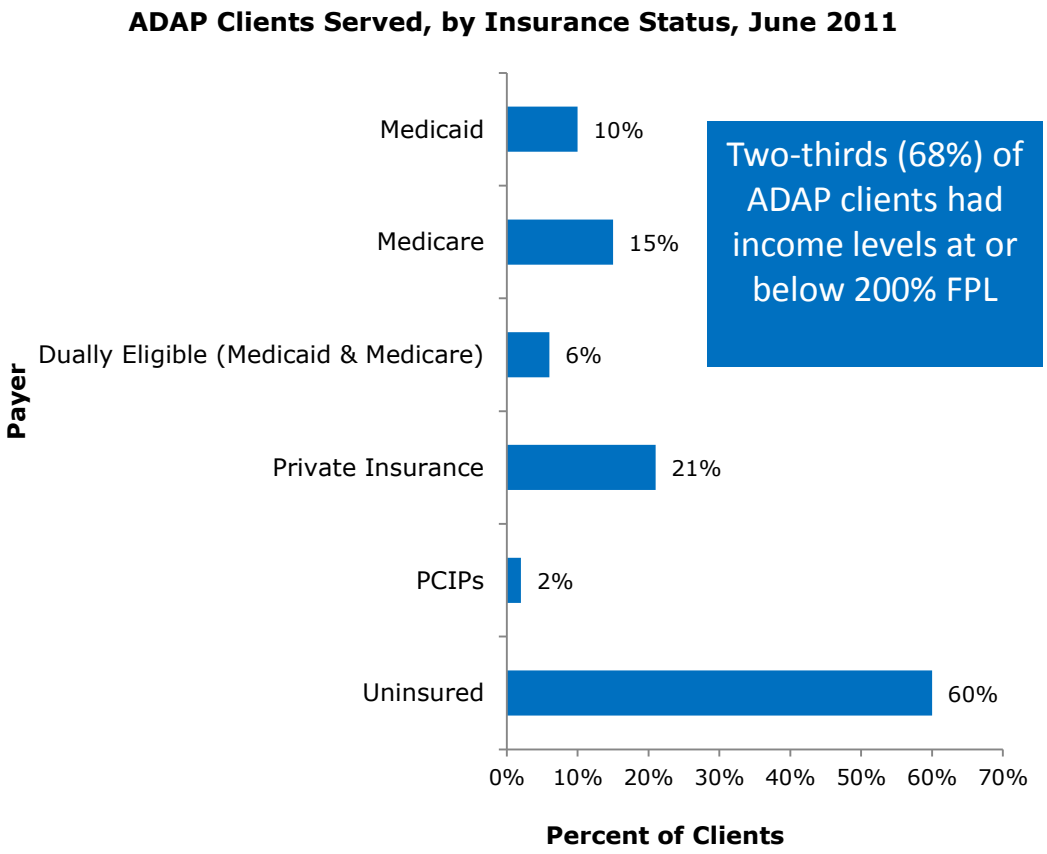


Map created using data from Kaiser Family Foundation

- Expanded Medicaid early under ACA option (7 states and DC)
- Approved or submitted plan to update Medicaid eligibility systems (28 states and DC and includes early expansion states of DC, MN, and NJ)
- Opted not to expand early and have not yet updated Medicaid eligibility systems (17 states)

Predicting Client Migration

- Identifying clients who will be affected
  - Eligible for Medicaid
  - Eligible for subsidized private insurance
  - Those left out of reform (undocumented immigrants ineligible for public or private insurance expansion and legal immigrants within 5 year ban still ineligible for Medicaid)



Moving Forward: Planning for Role of Ryan White Program Services

Ryan White will not be going away anytime soon, but will look completely different for most areas:

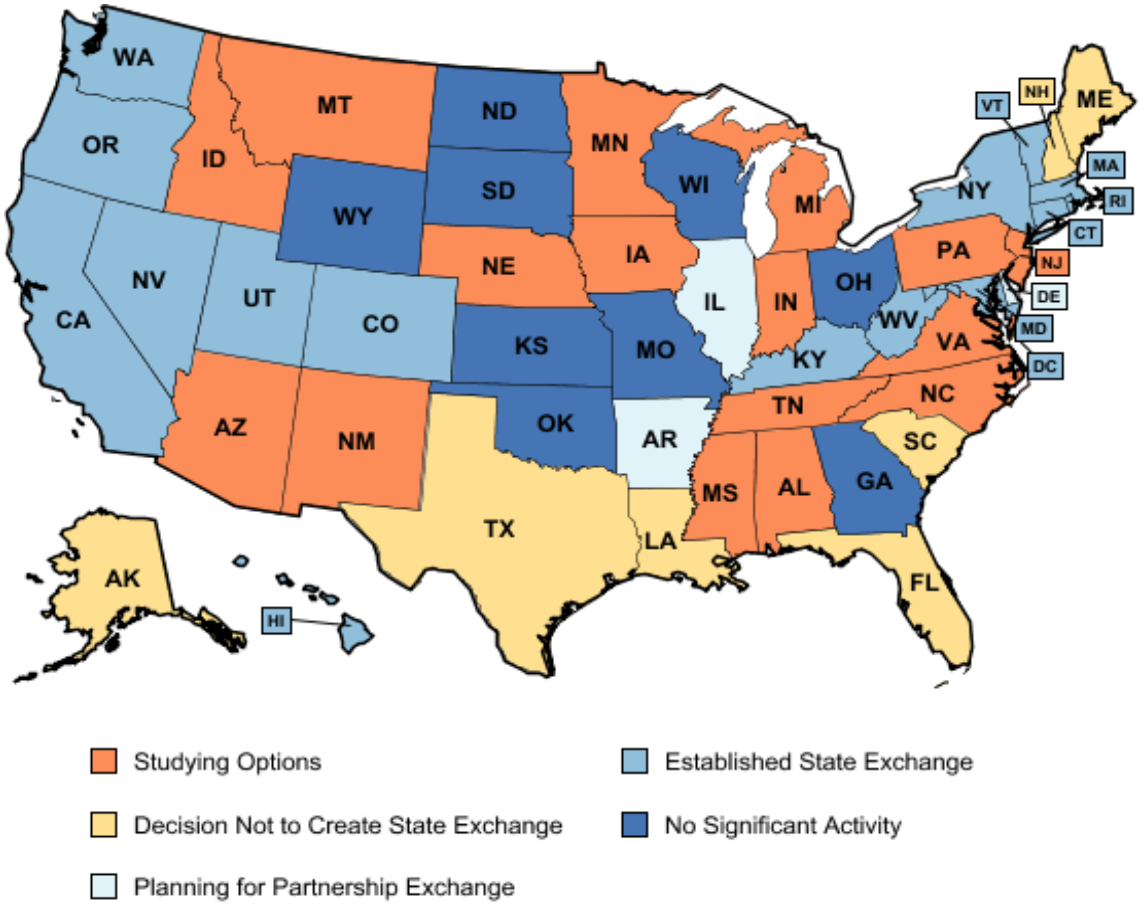
ADAP COVERAGE TO INCLUDE:

INSURANCE PREMIUM SUPPORT
MEDICATION CO PAYS
"STATE EXCHANGE & PRIVATE INSURANCE" DEDUCTIBLES
PHARMACY SERVICES (PROBABLY IN A VERY LIMITED CAPACITY)

PART A & B (AND MAYBE C & D)

DENTAL SERVICES
CASE MANAGEMENT (OF SOME TYPE)
PEER NAVIGATION / ELIGIBILITY / ENROLLMENT STAFF
EPISODIC CARE
COVERAGE FOR UNDOCUMENTED (AT LEAST FOR NOW)
"LINKAGE TO CARE CATEGORIES" SUCH AS TRANSPORTATION, HEALTH LITERACY, FOOD, DAYCARE ETC….) NEED TO REBRAND FROM SUPPORTIVE DEFINITION

Exchange Activity: Where the States Are



State Action Toward Creating Health Insurance Exchanges, as of August 1, 2012: Status of State Action

THE HENRY J. KAISER FAMILY FOUNDATION
statehealthfacts.org
Your source for state health data

Exchange Planning: Getting to the Table

- Challenges in engaging in exchange process:
  - Finding the decision makers
  - VERY fast timeline
    - EHB benchmark must be chosen by September; blue print deadline is November
  - HIV is small piece of larger planning issues
- Successful strategies for involvement:
  - State HIV/AIDS Ryan White all parts meetings as venue to engage Medicaid and others on health reform (KY, MN, TX)
  - Coalitions with other stakeholders

Essential Health Benefits: Will the Private Insurance Benchmark Plan Cover Necessary Care and Treatment?

- Ongoing concerns:
  - Federal prescription drug requirements are weak (plans must cover only one drug in each class) and confusion among states
    - CA interpreting one drug per class language as standard rather than floor
    - NY and MA interpreting one drug per class language as floor
  - Service limits and utilization management techniques may continue

Essential Health Benefits: Will the Private Insurance Benchmark Plan Cover Necessary Care and Treatment?

Kentucky ANTHEM BCBS Prescription Drug Formulary

Tier 1 ➢ $10 co-pay	Tier 2 ➢ $25 co-pay	Tier 3 ➢ $45 co-pay	Tier 4 ➢ 25% Co-insurance
Didadnosine	Ziagen	Combivir	Fuzeon
Lamivudine	Trizivir	Zerit	
Lamivudine /Zidovudine	Emtriva	Viramune	
Stavudine	Truvada		
Zidovudine	Epivir		
Nevirapine	Viread		
	Agenerase		
	Reyataz		
	Lexiva		
	Crixivan		
	Kaletra		
	Viracept		
	Norvir		
	Invirase		
	Edurant		
	Rescriptor		
	Sustiva		
	Atripla		
	Complera		
	Retrovir		

Not on formulary:
Epzicom
Darunavir/Prezista
Aptivus
Etravirine (Intelence)
Maraviroc (Selzentry)
Raltegravir (Isentress)

Moving Forward: Planning for the role of Ryan White Program Services

- Identifying gaps in covered services and affordability
  - E.g., insurance assistance, supportive services, dental services

Exhibit 1. Premium Tax Credits and Cost-Sharing Protections Under the Affordable Care Act, 2012

Federal poverty level	Income	Premium contribution as a share of income	Out-of-pocket limits	Actuarial value: silver plan
<133%	S: <$14,856 F: <$30,657	2% (or Medicaid)	S: $2,017 F: $4,034	94%
133%–149%	S: $14,856 – <$16,755 F: $30,657 – <$34,575	3.0%–4.0%		94%
150%–199%	S: $16,755 – <$22,340 F: $34,575 – <$46,100	4.0%–6.3%		87%
200%–249%	S: $22,340 – <$27,925 F: $46,100 – <$57,625	6.3%–8.05%	S: $3,025 F: $6,050	73%
250%–299%	S: $27,925 – <$33,510 F: $57,625 – <$69,150	8.05%–9.5%		70%
300%–399%	S: $33,510 – <$44,680 F: $69,150 – <$92,200	9.5%	S: $4,033 F: $8,066	70%
400%+	S: $44,680+ F: $92,200+	—	S: $6,050 F: $12,100	—

Source: Commonwealth Fund, 2012

Ongoing State Implementation Issues

- Outreach and enrollment programs
  - Patient Navigator program design
    - Eligibility criteria for state contracts must include those with disease specific expertise
    - Training must include range of health and social services programs (e.g. Ryan White Program)
    - Program should utilize subcontracts to smaller CBOs with expertise in reaching vulnerable populations
  - Coordination of ADAP/Ryan White Program application and eligibility determination with new systems
    - E.g., Data sharing with Medicaid, Dep't of Insurance, and others
- Provider network adequacy standards
- Payer of last resort compliance
- Infrastructure to serve an insured population

Resources

- HIV Health Reform, http://www.hivhealthreform.org
- State Refor(u)m, http://www.statereforum.org
- CBPP--*State Policy Decisions in Exchange Implementation* - http://www.cbpp.org/files/state-policy-decisions-in-exchange-implementation-SBE.pdf
- KFF--*State Activity Toward Creating Exchanges* -- http://statehealthfacts.kff.org/comparemaptable.jsp?ind=962&cat=17
- Medicaid Expansion Advocacy Resources
  - National Health Law Program
  - Families USA
  - Treatment Access Expansion Project
- National Alliance of State & Territorial AIDS Directors, http://www.nastad.org
- HIV Medicine Association, http://hivma.org

Ryan White Part B
Expenditure Report

HANDOUT B

Service Category	Part B 2012-2013 Allocated	Part B 2012-2013 October / Encumbered	Part B 2012-2013 Monthly Average Left August	Part B 2012-2013 YTD Spent/ Encumbered	Part B 2012-2013 % Encumbered	Part B 2012-2013 (% Left)	Part B 2012-2013 (Balance)
Home Delivered Meals	$2,479	$0	$391	$525	21.2%	78.8%	$ 1,954
Medication Co-Pay	$610,000	$22,666	$86,692	$176,541	28.9%	71.1%	$ 433,459
Case Management (non-medical)	$228,287	$19,576	$23,276	$111,908	49.0%	51.0%	$ 116,379
Medical Transportation	$150,971	$0	$20,212	$49,909	33.1%	66.9%	$ 101,062
Administration	$110,192	$12,287	$9,334	$63,521	57.6%	42.4%	$ 46,671
TOTALS	**$1,101,929**	**$54,529**	$139,905	$402,404	36.5%	63.5%	$ 699,525
					63.5%		

Home Delivered Meals Served 0 client

Medication Co Payment served 212 clients in which 9 were new to the program.
205 Clients served in October Medication Co Payment.
7 Clients served in October Mail Order
Cost Avoidance for Medication Co-Payment Program for October is $32,940.31
Savings as a result of using co-pay cards April- October is approximately $ 129,565

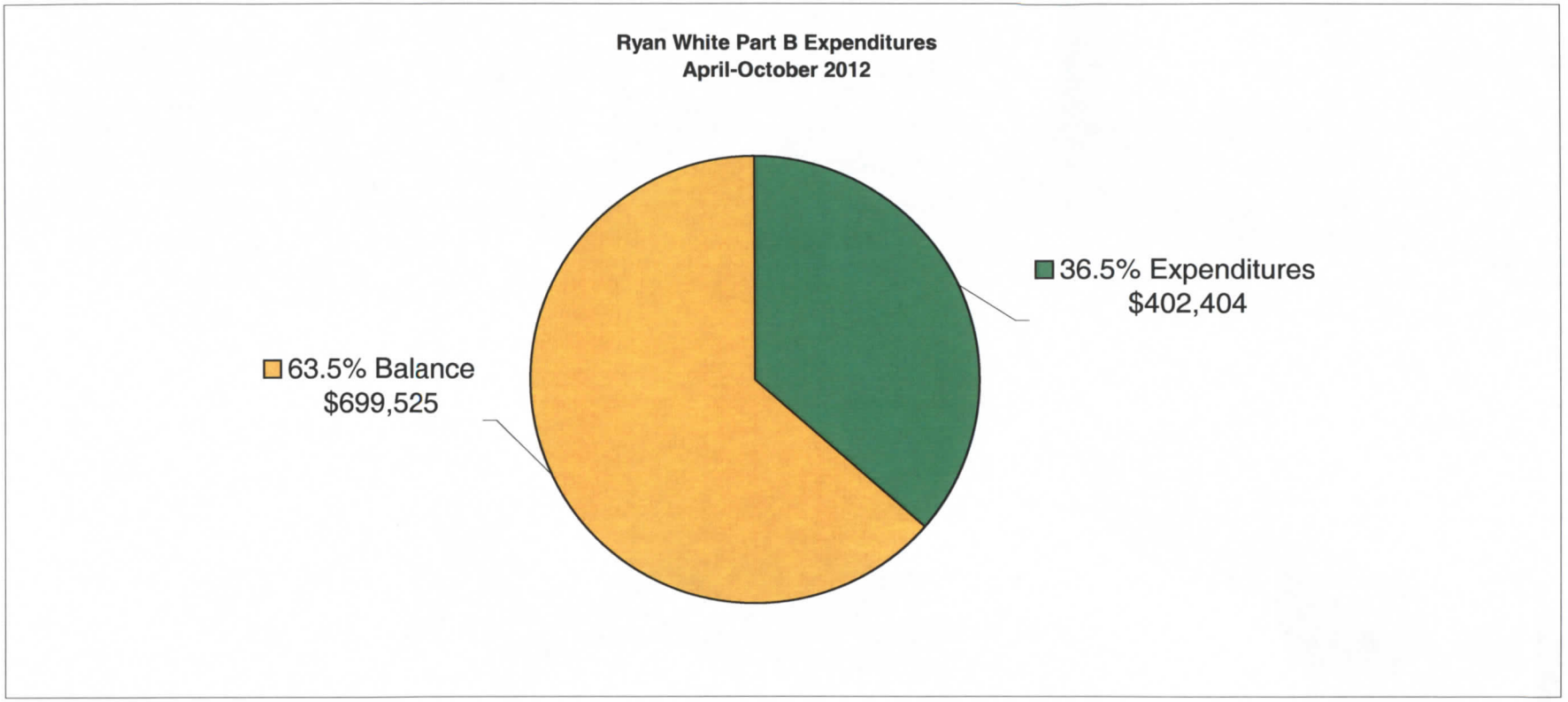
Non-Medical Case Management conducted 868 eligibility interviews in October.

Medical Transportation Part B Bus Passes: 228 (31 day) and 94 (10 ride) were issued to agencies in October.
Medical Transportation Part A Bus Passes: 0 (31 day) and 148 (10 ride) were distributed to agencies in October
The passes distributed are a partial number as not every agency pickups each month.

This report reflects all invoices received and paid as of 10/31/2012

HANDOUT B

Ryan White Part B
Expenditure Report



Report for Fiscal Year April 2012 thru March 2013

HANDOUT B

Broward County Health Department ADAP Report as of 11/26/12

Total ADAP "Open" Enrollment		2,885
Total ADAP Clients Served in Last 30 Days*		1,858
Total ADAP Waitlist Enrollment**		39
	Category A	4
	Category B	10
	Category C	25
Total ADAP/Medicare Part D Enrollment		176
Number of Appointments in October		761
Number of Missed Appointment in October		272
Percentage of October Appointments Missed		36%

*"Clients Served" defined as having at least one "pickup" in the period.

** Category Definitions:
CATEGORY A
Diagnosis of AIDS and/or CD4 < 200 cells/mm3 and/or CD4% < 14%
Diagnosis of active opportunistic infection
Diagnosis of HIV-associated nephropathy (HIVAN)

CATEGORY B
Persons who are currently on ARV therapy
Persons who were previously on ARV therapy but therapy was interrupted
Treatment naïve clients with CD4 cell count between 201-350 cells/ mm3

CATEGORY C
Treatment naïve clients with CD4 cell count > 350 cells/mm3

CATEGORY D
Unknown/Other

Clients are removed from the Wait List **by medical category** in the order they were placed on it. This serves as a reminder to people that if they are on the wait list they MUST recertify at 6 months or they will loose their position on the Wait List.