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 / www.BRHPC.org

Committee Meeting Agenda: Joint Priorities

Date/Time: Wednesday, April 17, 2013, 12:30 p.m. Location: BRHPC

Part A Co-Chair: Carla Taylor Bennett Part B Co-Chair: Lisa Agate

1. Call To Order: Welcome, Ground Rules, Sunshine, Introductions, Moment of Silence, & Public Comment

2. Approvals: 4/17/13 Agenda and 3/20/13 Meeting Minutes

3. Standard Committee Items: None

4. Unfinished Business

a. Update on ad Hoc PCIP Subcommittee (Information Item): Acting Subcommittee Chair and Co-Chairs will give an update on progress. Consider appointing a subcommittee chair.

5. Meeting Activities/New Business

Work Plan Objective #: 1.3	Today's Meeting Goals
Needs Assessment Step 1: 1. Ensure ACA Alignment	1. Discuss strategy to develop an action plan to ensure PSRA process is coordinated with and adapts to changes that will occur with Affordable Care Act (ACA) implementation.
2. Review Severe Need Data	2. Review data and document how these data sets will be utilized in the PSRA process.

6. Grantee Reports

7. Public Comment (Please sign up on the Public Comment Sheet)

8. Agenda Items/Tasks For Next Meeting (May 15, 2013 at 12:30 p.m. Venue: BRHPC)

Agenda Items/Work Plan Item #	Responsible	Information requested/Action To Be Taken
1. Review Updated Scorecard Format (WP Item 1.4)	Staff	1. Review update scorecard format and make recommendations
2. Review JPC recommendations	JPC, Staff	2. Joint Planning Committee (JPC) PSRA recommendations

9. Announcements

10. Adjournment

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JOINT PRIORITIES COMMITTEE
March 20, 2013 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**			DeSantis, M
2	Agate, L.	Part B Co-Chair	**X**			Dyer, L.
3	Ferrer, M.		**X**			Ettinger, R.
4	Gammell, B.		**X**			
5	Grant, C.		**X**			**Grantee Staff**
6	Hayes, M.		**X**			Jones, L. (Part A)
7	Katz, H. B.		**X**			Majcher, B. (Part B)
8	Reed, Y.		**X**			Copa , R. (Part A)
9	Schickowski, K.		**X**			
10	Siclari, R			**X**		**HIVPC Support Staff**
11	Wynn, J		**X**			Eshel, A.
12	Green, D.		**X**			Crawford, T.
13	Proulx, D.		**X**			LaMendola, B
	Quorum = 8		**12**	**1**		Solomon, R.

1. CALL TO ORDER (*Please sign-in)*
The Part A Co-Chair called the meeting to order at 12:44 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 3/20/13 Meeting Agenda
Proposed by:	Katz, H.B.
Seconded by:	Green, D
Amendment	Move the Grantee portion of the meeting to 4a.
Action:	Passed Unanimously

b. Approval of 1/16/13 Meeting Minutes

Motion #2:	To Approve the 1/16/13 Meeting Minutes
Proposed by:	Katz, H.B
Seconded by:	Gammell, B.
Action:	Passed Unanimously

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4. UNFINISHED BUSINESS

a. **Update on ad Hoc Pre-Existing Condition Insurance Plan Subcommittee**

The Committee discussed the future goals of the ad Hoc PCIP Subcommittee. The next Subcommittee meeting date is April 9. The original proposal for PCIP was to evaluate the effectiveness of purchasing pre-existing insurance plans for Part A clients. The anticipated expansion of Medicaid in Florida and the closure of the federally run PCIP plan for the rest of 2013 have changed the original mission. A potential focus for PCIP is determining how to cover the gaps in services clients will experience next year in Medicaid, private insurance and Ryan White Part A (e.g. mental health, substance abuse and under-served populations).

Members requested that a breakdown of service utilization by FPL for total clients using services be provided. There was a discussion on determining gaps for Part A overlap once the Affordable Care Act (ACA) takes effect (such as co-pay assistance). Insurance plan coverage relative to Part A coverage must also be compared.

The Committee charged PCIP with these main tasks: evaluate the data by FPL; identify potential gaps in coverage/service faced by clients entering insurance exchanges through ACA as well as in Medicaid; identify services that may need Part A funding, and establish a baseline of services to solidify where we are now. The Committee requested that PCIP data directives be completed within 90 days. The Committee will evaluate PCIP findings in June.

5. NEW BUSINESS

a. **Appoint HOPWA Representative to Joint Priorities**

HOPWA Representative confirmed his commitment to Joint Priorities Committee and provided background information. The following motion was made:

Motion # 3	To appoint HOPWA Representative Mario DeSantis to Joint Priorities Committee
Proposed by:	Wynn, J.
Seconded by:	Reed, Y.
Action:	Passed Unanimously

b. **Review PSRA Timeline/Data Items for FY 14-15**

The Committee agreed to gather data directives in preparation for Priority Setting Resource Allocation (PSRA). Staff was asked to bring scorecards to May meeting. The Grantee noted that scorecards will change to include more Quality Management data and National HIV/AIDS Strategy (NHAS) guidelines. Priority ranking by service category is scheduled for June. Meetings are expected to be long. Priorities will conduct a PSRA primer at the May meeting of the Joint Client/Community Relations (JCCR) Committee, so the members can recommend rankings. It was suggested that July 10, 2013 be added as a meeting date for setting allocations, and that the July 17 meeting be kept on the calendar in case a grant update is needed. It will be cancelled if not needed.

Changes to Timeline: (i) add PCIP recommendations to data directives; (ii) add AIDS Insurance Continuation Program cost/benefit analysis report, if available.

Motion # 4	To use previous years data if updated data not available for decision making
Proposed by:	Gammell, B.
Seconded by:	Grant, C.
Action:	Passed with one opposition

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c. **Review Committee Meeting dates for 2013**
The Committee approved meeting dates for 2013. Staff will send outlook calendar invitations for the year.

d. **Member Recommendation**
A member offered an impromptu motion. The Part A Co-Chair requested tabling this item until the August 2013 meeting.

Motion # 5	To appoint Leroy Dryer to Joint Priorities Committee
Proposed by:	Katz, B.
Seconded by:	Grant, C.
Action:	Motion withdrawn

6. GRANTEE REPORTS

a. **Part A**
The Grantee introduced the new Administrative Manager, Rafael Copa.
The Grantee discussed the intended sweep to ADAP, which did not occur. The Grantee made a bulk purchase to food bank, food vouchers and pharmacy.
HRSA sent a letter indicating that all formula funds would be reduced by 5%, but it was unclear if the cut applied to just formula funds or total funding. A deduction in formula would affect $550,000 and a deduction in total funding would be $770,000. The reduction is not projected to seriously impact the EMA due to bulk purchases and carry over from FY 2012/13. If projected cuts exceed anticipated values, service delivery models will be reevaluated. It was also noted that there have been leadership changes at HRSA.

b. **Part B and ADAP (HANDOUT B)**
The written Part B Grantee report was provided detailing expenditures up to January 31, 2013.
Non-Medical Case Management conducted 835 eligibility interviews in January. Medication co-payment served 250 clients of which 15 were new to the program. There were 242 clients served in December for Medication Co-Payment and 8 clients served for Mail Orders. Cost avoidance for Medication Co-Payment program for January is $45,122.86. Total cost savings April – January 2013 is approximately $105,042. Home Delivered Meals served zero (0) clients. Medical Transportation for January 2013: A total of 128 (10 ride) and 175 (31 day) passes were distributed. There are approximately 400 Part A passes left.

7. PUBLIC COMMENT
None.

8. AGENDA ITEMS FOR NEXT MEETING: April 17, 2013 at 12:30 p.m /Venue: BRHPC
- Standing Agenda Items

9. ADJOURNMENT
Without objection, the meeting was adjourned at 2:18 p.m.

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JOINT PRIORITIES COMMITTEE - ATTENDANCE CY 2013

#	Members	Jan	Feb	Mar
1	Taylor-Bennett, C	P		P
2	Agate, L.	P		P
3	Ferrer, M.	A		P
4	Gammell, B.	A		P
5	Grant, C.	P		P
6	Hayes, M.	P		P
7	Katz, H. B.	P		P
8	Reed, Y.	P		P
9	Schickowski, K.	P		P
10	Siclari, R	P		A
11	Green, D.	P		P
12	Wynn, J	P		P
13	Proulx, D.			P
Quorum = 8		**10**		**12**

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

Planning for the Potential Impact of the Affordable Care Act on the Ryan White Program

April 17, 2013

HRSA Expectations For Ryan White Part A Planning Councils

- Part A Comprehensive Plan Guidance
  - Ensure coordination with and adaptation to changes that will occur with Affordable Care Act (ACA) implementation

Ryan White Program Reauthorization and the Affordable Care Act

Deborah Parham Hopson
Assistant Surgeon General
Associate Administrator, HAB, HRSA, HHS

ACA Provisions with Impact on Ryan White

Immediate Impact on RW - ADAP

- PCIP plans <1/2 of States using ADAP for PCIP (2,393 clients)
- ADAP counts toward true-out-of-pocket Medicare
- ADAP can cover Medicare Part D "donut hole"
- States calculating cost savings

Long-Term Impact on RW

- Optional Medicaid expansion to 133% FPL
- Subsidies via health insurance exchanges for 133-400% FPL
- Insurance reforms that ban health insurance rescissions and eliminate lifetime and annual caps

Future of Ryan White Program

- The implementation of the ACA does not eliminate the need for the Ryan White program
- Gaps in coverage will remain, both in terms of Medicaid and private insurance
- This will be the case for coverage of oral health and substance abuse treatment services and support services that link clients to care

Fort Lauderdale/Broward EMA

FY 2014/15 PSRA Challenges

FY 2014/15 PSRA Challenges

- Current PSRA process documents needs, sets priorities and allocates funding for FY 2014/15 (3/1/14 – 2/28/15)
- Difficult to project what EMA's service needs will be in 2014
- Insurance Exchange coverage becomes effective 1/1/14 and will have already been in effect for 2 months at start of FY 14/15
- However, planning for ACA impact is difficult given that the State has not finalized decisions regarding Insurance Exchange or Medicaid Expansion
- Even with full ACA implementation may be a long transition phase with overlapping needs
- Identification of specific service gaps for reallocating Part A and Part B funding from direct medical care to premium support and services not covered by Medicaid or private insurance

ad-Hoc PCIP Subcommittee Directives and Data

Priorities Directives to ad-Hoc PCIP

- Original focus: Evaluate Part A purchasing pre-existing insurance plans
- Closure of new enrollments in federal PCIP plan changed original focus
- Potential new focus: determining potential gaps for Medicaid, insurance and Part A
- Members requested a breakdown of service utilization by FPL
- There was discussion on determining gaps for Part A overlap once the ACA takes effect (such as co-pay assistance). Insurance coverage relative to Part A coverage must also be compared.
- PCIP Committee's main tasks:
  - Evaluate Part A utilization data by FPL
  - Identify potential service gaps that could be filled by Part A funding due to:
    - Potential Medicaid expansion
    - Implementation of insurance exchanges
  - Identify services that may need Part A funding
  - Establish a baseline of services to solidify where we are now
- Priorities Committee requested PCIP data directives be completed w/in 90 days
- PCIP findings to be evaluated in June

Service Expenditures by FPL FY12-13 (*Partial Year Data*)

Services included:
Pharmacy, OAMC, CIED, Food Bank, SA, Outreach, OHC, MH, Legal, MCM

FPL	Clients	Units	Amount
0-138%	5,368	263,399	$8,242,675
139-300%	1,593	64,164	$2,256,685
301-400%	69	2,314	$75,607
>/=400%	10	86	$1,187
Total	**7,040**	**329,963**	**$10,576,154**

*FY12/13 Part A Expenditures by FPL:

Medical, Pharmacy, Mental Health & Substance Abuse

FPL	Clients	Units	Amount
0-138%	2,873	123,829	$4,864,677
139-300%	912	32,988	$1,242,385
301-400%	42	1,401	$54,763
Total*	**3,827**	**158,218**	**$6,161,825**

*Partial Year Data

2014 Subsidies for Buying Health Coverage in Insurance Exchanges

- Subsidy for Monthly Premiums
  - 4 categories of health plans offered by State Insurance Exchanges {Bronze (covers 60% of an average person's cost; Silver (70%); Gold (80%); Platinum (90%)}
  - Subsidy based on family income and cost of second-lowest Silver plan in the state. Consumers pay a % of their income toward the premium.

FPL	% Paid for Premium
100%-133%	2%
133%-150%	3%-4%
150%-200%	4%-6.3%
200%-250%	6.3%-8.05%
250%-300%	8.05%-9.5%
300%-400%	9.5%

2014 Subsidies for Buying Health Coverage in Insurance Exchanges

- Subsidy for Out of Pocket Expenses
  - Applies to the cost of deductibles, co-payments, and co-insurance

FPL	% Paid for Premium
100%-150%	6%
150%-200%	13%
200%-250%	27%

*State Health Reform Impact Modeling Project: **Florida***

Center For Health Law And Policy Innovation Of Harvard Law School And The Treatment Access Expansion Project

January 2013

Medicaid Expansion (Optional)

- Patient Protection and ACA directs states to extend Medicaid eligibility to all individuals < 133% FPL
- Offers a 100% federal matching rate for these newly eligible individuals (those not otherwise Medicaid eligible before the new law)
- Currently Florida does NOT expand Medicaid
- However, it is still being debated

Medicaid Expansion Limitations

- Many Ryan White eligible services are NOT available under Florida's current Medicaid program
- Limitations on Medicaid recipients' pharmacy benefits
- May pose challenges for individuals in need of multiple branded prescriptions
- PLWHA likely to exceed the maximum allowable number of monthly branded prescriptions covered
- Although newly eligible beneficiaries must have access to any drug with a therapeutic advantage over another, utilization-review tactics such as prior authorization may impede access to comprehensive care

Challenges With Respect To FL's Default Benchmark Plan, To Be Used To Define EHB For Exchange Insurance Plans

- Many RW **services not available** under benchmark plan
- **Cost-sharing requirements** may prohibit low-income PLWHA transitioning from Ryan White from accessing certain services available under private insurance plans on the exchange
- The benchmark's formulary is comprehensive, **cost-sharing requirements** are likely to restrict low-income PLWHA access to the multitude of **prescription drugs** they require for **comprehensive antiretroviral therapy** (ART)
- ADAP will continue to be essential to fill both coverage and affordability gaps

Factors Essential To Implementing ACA To Reduce Florida's HIV Burden

- Adopting the Medicaid expansion, pursuant to the ACA, Florida must **extend Medicaid eligibility to individuals < 133% FPL** to slow transmission and make treatment accessible to thousands of individuals who currently lack care
- Ensure Ryan White and ADAP services are available where Medicaid or private insurance coverage or affordability gaps exist:
  - Transportation
  - Non-medical case management
  - Food
  - Nutrition
  - Copays

Estimate Of Current Ryan White ADAP Clients Eligible For Medicaid Or Insurance Credits In 2014

- Many PLWHA are expected to become eligible for Medicaid, a BHP, or subsidies in 2014, provided that FL fully implements the law
- Estimated 23% of FL's RW clients in 2010 were between 101-200% FPL, making them potentially eligible for either Medicaid or a BHP in 2014
- Estimated 51% of FL ADAP clients will be eligible for Medicaid expansion
- 28% are estimated to be eligible for private insurance subsidies
- FL's ADAP clients who will be newly eligible for Medicaid = 51%, considerably higher than national proportion of newly eligible (29%)
- Primarily because FL ADAP mostly serves individuals <133% FPL (62% of FL ADAP clients were <133% FPL in 2011), 100% of whom were uninsured
- % of FL's ADAP clients expected to qualify for private insurance subsidies (29%), higher than the national proportion (15%), likely because FL's ADAP serves a substantial number of individuals with income above 133% FPL (approximately 38% in 2011)

Florida's ADAP served 14,305 individuals in 2010. Of those, we estimate that 5,435.90 (38%) ADAP clients have incomes above 133% FPL. We also estimate that there were 1,067.34 insured ADAP clients with incomes below 133% FPL. Approximately 5.42% of the state population was composed of undocumented immigrants in 2008 (amounting to approximately 480.57 ADAP clients with incomes below 133% FPL).

Thus, the calculation for Florida is:

	14,305	ADAP clients being served in fiscal year 2010
–	**5,435.90**	ADAP clients with incomes above 133% FPL
–	**1,067.34**	insured ADAP clients with incomes below 133% FPL
–	**480.57**	undocumented immigrants with incomes below 133% FPL in June 2011
=	**7,321**	ADAP clients who will be newly eligible for Medicaid in 2014; or 51.2% of ADAP clients served in fiscal year 2010

Comparing Services Provided By Ryan White, ADAP, Medicaid, and Exchange

- Since a significant number of HIV+ individuals in Florida who are currently served by the Ryan White program or ADAP are likely to be eligible for Medicaid or subsidized private insurance in 2014, it is important to assess the outcome of transitioning from the former programs to Medicaid or onto the exchange
- Assessment compares and contrasts services and treatments that the Ryan White program, ADAP, Medicaid, and FL's health insurance exchange currently or will provide to HIV+ Floridians

Comparing Ryan White, Medicaid, And Benchmark Plan For The FL Exchange

- Ryan White funds both core medical and support services for PLWHA
- Both medical and ancillary services are critical to maintaining health of low-income PLWHA who may not have access to many necessities that affect access to HIV treatment and care (e.g. transportation, child care, nutrition)
- Medicaid and FL's benchmark plan, which will determine essential health benefits (EHB) for private insurance sold on the state's exchange, do not cover ancillary services (although they cover a broader range of medical)
- Accounting for gaps between Ryan White and Medicaid or private insurance sold on the exchange will be critical in transitioning Ryan White beneficiaries onto Medicaid and private insurance, while ensuring that their health status does not deteriorate (e.g. due to lack of proper nutrition, access to transportation to a health clinic, or stable housing that supports treatment adherence)

Table 1. Ryan White Versus Medicaid and the Benchmark Plan: Covered Services

Benefits applying only to beneficiaries under 21 years of age are not assessed in this report.

Covered Service	Ryan White[38]	Medicaid[39]	BlueCross BlueShield BlueOptions[40,41]
Home Health Care	X	X (PA)	X (PA; excludes cooking, housekeeping, meal preparation)
Outpatient Mental Health	X	X (PA)	X
Inpatient Mental Health			X
Outpatient Substance Abuse Treatment	X	X	X
Inpatient Substance Abuse Treatment			X
Medical Case Management	X	X	
Community-based Care	X	X	
Ambulatory/Outpatient Care	X	X	X
Oral Health Care	X		
Early Intervention Clinic	X	X	
Intermediate Care Facilities for the Mentally Retarded		X (15 days per hospital stay; 45 days per year)	
Ambulance		X	X
Family Planning		X (PA; familial dysautonomia diagnosis required)	
Durable Medical Equipment		X	X
Hospital Services		X	X
Lab and X-ray Services		X	X
Eyeglasses Related to Accident, Surgery, or Medical Condition		X	
Nursing Facility		X	X
Midwife/NP services		X	
Private Duty Nursing		X	
Physician Services		X	X
Nonmedical Case Management Services	X		
Child Care	X		
Emergency Financial Assistance	X		
Food Bank/Home Delivered Meals	X		
Housing Services	X		
Health Education/Risk Reduction	X		
Legal Services	X		
Linguistic Services	X		
Nonemergency Medical Transportation	X	X	
Outreach Services	X	X	
Psychosocial Support	X		
Referral Agencies	X		
Treatment Adherence Counseling	X		
Chiropractor		X	X
Podiatry		X	
Hospice		X	X
Respiratory Therapy		X	
PT, OT, and Speech Therapy		X	
Orthotics and Prosthetics		X	

OT = occupational therapy; PA = prior authorization; PT = physical therapy.

Challenges

- Ryan White offers PLWHA a number of ancillary services that Medicaid and FL's benchmark plan do not cover, and will not be required EHB components
- FL's benchmark plan is subdivided into plans with varying cost-sharing schedules
  - Primary care copays up to $75 per visit
  - Specialists copays up to $100
  - Given the frequency with which HIV+ individuals must see physicians, including specialists, this cost sharing may be prohibitive
  - Ryan White will remain a critical payer of last resort in this scenario

Assessing the Potential Impact of the Affordable Care Act (ACA) on the Ryan White HIV/AIDS Program (RWHAP)

HIV/AIDS Bureau, HRSA
11/27/12

Health Insurance Exchanges

- Creation of affordable insurance exchanges:
  - 100 to 400% FPL (if ineligible for Medicaid) can receive assistance to purchase private insurance
  - November deadline to submit plans for state-based exchanges
  - Exchanges open for enrollment in October 2013
  - Coverage starts in January 2014
- Exchanges will provide new source of coverage for PLWHA
  - Might face more cost-sharing requirements (e.g., for drugs)
  - Some needed services might not be covered
- Need to improve exchange navigation and streamline enrollment for PLWHA

Health Insurance Exchanges

- ACA citizenship requirements:
  - Undocumented immigrants and "lawfully present" immigrants within 5 years of residency barred from receipt of federal benefits
  - Under ACA, lawfully present immigrants
    - Still barred from Medicaid for first five years
    - Can purchase insurance in Exchanges
    - Can qualify for private insurance tax credits and cost sharing reductions
- PLWHA who do not meet eligibility requirements will still need services from RWHAP
  - Other groups are also likely to require RWHAP services

Insurance Benefits

- Basic Health Plan:
  - State plan option for 133 - 200% FPL
    - Otherwise eligible for premium tax subsidies
    - Benefits must be at least as generous as state's EHBs
- Potential BHP benefits:
  - Lower costs for those who cannot afford other qualified health plans
  - Prevent churning between Medicaid and private insurance for PLWHA with income fluctuations in this range

Benefit Reform Recommendations

- Comprehensive EHBs that meets complex health care needs of PLWHA
- Continuity of access to ART medications
- Identification of state-specific service gaps for reallocating Part A and Part B funding from direct medical care to premium support and services not covered by Medicaid or private insurance

Private Health Insurance Subsidies

- Citizens and lawfully present residents (with incomes from 100-400% FPL if otherwise ineligible for Medicaid) are eligible for advance tax credits
  - Cost-sharing reductions available for 100-250% FPL
  - Will cover copayments, deductibles, and co-insurance
  - Available to low-income people with high out-of-pocket costs
- Not clear what assistance, if any, will be available to PLWHA with incomes <100% FPL in non-Medicaid expansion states

Cost Reform Recommendations

- Allocate RWHAP funds to cover cost-sharing
- Educate RWHAP community about tax credits, cost-sharing reductions and out-of-pocket expense limits

Houston EMA

ACA Experiences

Houston EMA

- RW-eligible PLWHA will likely need more assistance with premiums, co-insurance and co-payments
- RW Health Insurance Assistance allocation may need increase to meet the needs of Exchange-eligible PLWHA
- Increased need for wrap-around services
  - Linkage to care, system navigation, case management
  - Dental, medications & other services not fully covered under expanded Medicaid or insurance policies available via the Insurance Exchange

Houston EMA Experiences: Benefits

- Essential Health Benefit (EHB) remains work in progress
- EMA has "bundled" RW-funded Primary Care, Medications, Medical Case Management and Service Linkage (non-medical CM) into a single local category
- Will assist Planning Council, Grantee and Providers in quickly retooling RW-funded services to best wrap-around EHB to ensure access to and retention in care
- Local Pharmacy Assistance Program (LPAP) may be able to wrap-around expanded benefits as with ADAP
- Ongoing training for CMs, patient navigators & eligibility workers on new benefits available to PLWHA

Houston EMA Experience: Payments

- Fee-for-Service reimbursement model
- Aligns with enhanced Medicaid rates (FQHC rate)
- Includes HIV specialists and Sub-specialty providers
- Local continuum of care includes most wrap-around services needed by PLWHA including:
  - Medical & Non-medical case management*
  - HIV and HIV-related medications*
  - Oral Health
  - Mental Health and Substance Abuse Treatment
  - Medical Nutritional Assessment & Therapy*
    - *bundled with Primary Care services – 1 Stop Shopping