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

Meeting Agenda

Committee: Priority Setting & Resource Allocation

Date/Time: Wednesday, November 20, 2013; 12:30 p.m. **Location:** BRHPC

Part A Co-Chair: Carla Taylor-Bennett **Part B Co-Chair:** Vacant

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

2. Approvals: 11/20/13 Agenda and 10/16/13 Meeting Minutes

3. Standard Committee Items:

a. Update on ad Hoc Local Pharmacy Advisory Committee: Review and approve LPAC recommendations for Ryan White Part A formulary revisions (Handout A)

4.Unfinished Business:

5.Meeting Activities

Work Plan Objectives	Today's Meeting Goals
1. Assessment of the Administrative Mechanism (3.1) 2. MAI Case Management Analysis 3. Review ACA Impact on Allocations (1.9)	1. Assessment of the administrative mechanism to ensure compliance. 2. Review PowerPoint presentation from the previous PSRA meeting and continue discussion on analysis of MAI Case Management (utilization and outcomes) (Handout B) 3. Continue review and discussion of allocations to ensure that allocations meet clients' needs transitioning into ACA (Handout C)

6. Grantee Reports:

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

8. Agenda Items/Tasks For Next Meeting: (January 15, 2014 at 12:30 p.m. **Venue:** BRHPC**)**

Agenda Items/Work Plan Item	Information requested/Action To Be Taken
Review Expenditures Reallocations (2.1, 2.2)	Monitor expenditure vs. allocation and recommend strategies to address identified issues. Recommend reallocations to ensure sufficient core funding is distributed appropriately.

9. Announcements:

10. Adjournment:

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Meeting Minutes

Committee: Priority Setting & Resource Allocation

Date/Time: Wednesday, October 16, 12:30 p.m. **Location:** BRHPC

Part A Co-Chair: Carla Taylor Bennett **Part B Co-Chair:** Vacant

ATTENDANCE						
#	**Members**		**Present**	**Absent**		**Guests**
1	Taylor-Bennett, C.	Part A Co-Chair	X			Majcher, B.
2	Gammell, B.			X		
3	Grant, C.		X			
4	Hayes, M.		X			
5	Katz, H. B.		X			
6	Reed, Y.		X			
7	Schickowski, K.		X			**Grantee Staff**
8	Siclari, R		X			Jones, L. (Part A)
9	Wynn, J		X			Mercer, A. (Part B)
10	Proulx, D.		X			Copa , R. (Part A)
11	DeSantis, M.		X			Degraffenreidt, S. (Part A)
						HIVPC Support Staff
						Crawford, T.
						Rosiere, M.
						Solomon, R.
						McEachrane, T.
	Quorum = 7		10			

1. CALL TO ORDER:

The Part A Co-Chair called the meeting to order at 12:40 p.m.
The Part A Co-Chair welcomed all present. 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.
Chairs, committee members, guests, grantee staff and support staff self-introductions were made.

2. Moment of Silence

Members observed the passing of the Chair's mother-in-law who was also a Ryan White client.

3. APPROVALS:

Motion #1	To approve today's meeting agenda		
Amendment	Grantee Report moved to Item 5		
Proposed by:	Reed, Y.	**Seconded:**	Katz, H.B.
Action:	Passed Unanimously		

Motion #2	To approve meeting minutes of 9/18/13		
Proposed by:	Reed, Y.	**Seconded by:**	Katz, H.B.
Action:	Passed Unanimously		

4. UNFINISHED BUSINESS: None

5. Grantee Reports:

a) Part B

The written Part B Grantee report was provided detailing expenditures up to August 2013.
Non-Medical Case Management conducted 732 eligibility interviews in August. Medication co-payment served 202 clients. There were 194 clients served in August for Medication Co-Payment and8 clients served for Mail Orders. Medical Transportation for August 2013: A total of 80 (10 ride) and 707 (31 day) passes distributed.

The Grantee brought forth the motion from Joint Planning regarding a sweep of $300,000 from Medication co-pay to Residential Substance Abuse (RSA). $200,000 was requested in addition to the current $100,000 placeholder previously approved by the Committee during the Allocations. The following motion was made:

Motion #4	To recommended moving a total of $300,000 ($200,000 additional to $100,000 placeholder) from Medical Co-pay to Residential Substance Abuse.
Proposed by:	Siclari, R.
Seconded by:	Grant, C.
Action:	Passed Unanimously

The Grantee stated that there was a transition of people moving ADAP and that the RSA category was determined to be eligible for funding without having a Request for Proposal (RFP). This is the first substance abuse-related residential service to be provided by Part B within the community. The service covers 7 days of detox and 30 days of housing. Clients will be linked to Part A follow-up support services. The program will provide services to a total 50 clients.

One member inquired about housing funding for PLWHA in Broward County. The Department of Children and Families provides housing services as well through a Substance Abuse and Mental Health Services Administration (SAMSA) program.

One member inquired about the increase in medication co-payment expenditures from July to August while the number of clients served has decreased. The Grantee stated that insurance changes, additional medications, deductible increases or any number of reasons may cause medication co-payments increase from month to month regardless of the number of clients served.

6. MEETING ACTIVITIES / NEW BUSINESS

a. Review Policies and Procedures

Members reviewed the Policies and Procedures. In lieu of ACA implementation, the Committee reviewed references to "Super Core" to determine if it was still aligned with the current PSRA process. The following motion was made:

Motion #5	To approve the Policies and Procedures with the removal of references to "Super Core"
Proposed by:	Reed, Y.
Seconded by:	Katz, H.B.
Action:	Passed Unanimously

Members reviewed the language regarding funding increases. The Chair clarified that priority will still be given to core services and then support services if a funding increase is to occur.

Members discussed the effects of funding shortages in lieu of the ACA. Members determined that there are still too many unknowns to determine ACA effects on funding. The Committee will meet in January to determine final allocations to service categories. The members will also review ACA impact on allocations at the November Committee meeting.

b. Review ACA Impact on Allocations

FY 14/15 ALLOCATIONS: PART A

Rank	Service	FY 13 Allocation	Factors to Consider	Recomended FY14 Allocation	
#		$	*Client increase from expanded testing offset by Exchange enrollment	%	$
1	Medical	$5,706,496	Expanded testing will link more clients to care. No Medicaid expansion & long transition to ACA health exchanges means full funding needed for FY14-15. Expect 3% Medicare reimbursement increase ($171,195).	15%	$6,546,809
2	Pharmacy	$509,576	Expanded testing will link more clients to care. Decreased PAP access. Long transition to exchanges means full funding needed	55%	$787,665
3	Medical Case Mgt [Disease Mgt (DM]	$0	DM constitutes a change in the MCM category. This ensures the EMA's current MCM services provide appropriate DM to help improve client medical outcomes. This clinically based case management will only be operated by a licensed practitioner at a medical provider site. Based on FY12 VL analysis, DM could have benefited 812 clients. 30% of FY 12 MCM clients were new; based on growth rate, FY14 estimate is 1,056.	100%	$546,650
4	Health Insurance Continuation (HICP)	$0	HICP for approximately half of RW clients transitioning to ACA exchange & needing premium & out-of-pocket assistance despite subsidies. Estimated cost $3,779 (100-250% FPL) & $6,953(250-400%) New and existing clients to this service category (800 clients maximum will enroll, but not all clients will access this service category immediately)	100%	$2,329,002
5	Oral Health	$2,623,653	Part F funding uncertain. Low Medicaid coverage. Difficult to access.	19%	$3,132,354
6	Mental Health	$336,987	Expanded testing = more clients. No Medicaid expansion & long transition to exchange means full funding needed.	10%	$369,387
7	Substance Abuse	$342,889	Expanded testing will link more clients to care. No Medicaid expansion & long transition to ACAinsurance exchange.	3%	$354,827
	Core	$9,519,601		$14,066,694	
1	CIED	$467,513	Enrolling clients into Exchange may result in longer encounter time.	20%	$562,244
	Non-Medical Case Mgt (NMCM)	$0	This service category will encompass comprehensive case management, which is an addition to the NMCM category. Along with CIED, NMCM is a supportive service to ensure health outcomes through referral and linkage.	100%	$1,016,769
2	Food Bank	$642,846	No other significant funders. Increase from 12 boxes/3vouchers (15 units) to 24 total units. Eligibility to be reviewed. Allocation split 90% for Food Bank and 10% for Food Vouchers; food vouchers to be allocated $100,000.	85%	$1,189,473
3	Legal	$131,426	No other funding identified. SSI appeals process.	16%	$152,466
4	Outreach	$58,768	No other funders. Expanded testing = client increase	-12%	$52,004
	Support	$1,300,553		$2,972,956	
	TOTAL	$10,820,154		$17,039,650	

FY 14/15 ALLOCATIONS: MAI

FY 14 Rank	Service	FY 13 Allocation	Factors to Consider	Recommended FY 14 Allocation
#		$		
	Utilize FY13/14 allocation plus % increase			
1	Medical	$100,000	Expanded testing will link more clients to care. ACA Impact	$105,000
2	Medical Case Mgt	$176,644		$185,476
3	Mental Health	$128,418		$134,839
4	Substance Abuse	$400,000		$420,000
	Core	$805,062		$845,315
1	Eligibility	$290,957	Uncertainty of insurance exchange plans will make eligibility determinations more time-consuming and difficult.	$320,053
	Support	$290,957		$320,053
	TOTAL	$1,096,019		$1,165,368

Members reviewed FY14/15 Allocations for Part A. The Committee previously added Medical Case Management as a service to ensure that clients receive support specific to HIV/AIDS. Members also previously reviewed non-medical case management and specified that it should be provided by a clinician within a clinical setting. With the exception of Substance Abuse, the Committee utilized the regular process to determine appropriate allocations and see how they increase over time. HICP also received additional funding to cover client premiums and deductibles as needed.

One member inquired about HRSA review of allocations. In the Ryan White Part A Grant Application the Grantee requested $20 million. The member expressed concern about delayed funding and anticipating much less from HRSA. The Grantee stated that allocations are determined based on flat funding first. In January, the Committee will be factoring in client enrollment into Marketplace which may shift funding to cover insurance premiums and other service categories. The current allocations are a starting point for January's final allocation process. The Chair stated that there isn't enough information for the Committee to further allocate funds ahead of January.

One member inquired if service categories could be tracked by month or by quarter to get a better idea in January of how many clients have enrolled and if there will be any savings. The Grantee stated that there is not a list for tracking due to the complexities of data collection from multiple sources. Clients can pick a plan but will not have coverage until they pay their first premium which makes expenditures difficult to anticipate. The Chair stated that client transition into the Marketplace may also take longer than anticipated.

Members discussed clients who voluntarily refuse Marketplace and receive a penalty. It was noted that they should not receive Ryan White services if they voluntarily refuse the Individual Mandate. HRSA strongly recommends that clients enroll in Marketplace but has no official mandated requirement. For many clients, paying premiums will be a large shift from previous agreements for coverage.

One member inquired about the incentive for clients who are currently enrolled in Ryan White to enter into Marketplace. The incentives are more so for ADAP and it encourages clients to enroll into Marketplace. There will be a statewide meeting November 4, 2013 where a group vote will take place determining the actions to be taken by ADAP in response to the ACA. According to the Grantee, HICP should complement ADAP not supplement due to budgeting. Changes to funding sources due to changes with ADAP remain unknown. As a result, Part A will encourage clients to enroll in Marketplace, but will not endorse specific plans until verified information is provided by the state. In accordance with HRSA policies, RW remains the payer of last resort for clients.

Members discussed client enrollment. The Grantee stated that enrollment is a separate process from ensuring that clients maintain their insurance.

Regarding undocumented clients, they will continue to be served by RW. According to data, 15% clients are eligible to enroll Marketplace while 85% will be ineligible and maintain RW services as they currently stand. $2.7 million would be saved if everyone who is eligible to be enrolled into Marketplace plans. High utilizers of services may not enroll to Marketplace while healthier clients are anticipated to enroll. The Committee will request more concrete data come January to determine final allocations.

One member mentioned HICP allocations may decrease due to better plan coverage than expected of Marketplace plans. RW is only allowed to reimburse for Silver Marketplace plans. Members discussed the importance of customer service to maintain clients in the future.

c. MAI Case Management Analysis *(Presentation on file)*

Representatives from the Grantee office presented the data on the MAI Case Management Model. The presentation included: Scope of Services; utilization; demographics; MAI Medical Case Management Client Flow Chart; challenges; and recommendations. MAI CM is based on the Anti-Retroviral Treatment and Access to Services (ARTAS) Model. The program is peer-based but is currently funded under the Medical Case Management (MCM) service category. In March, non-medical case management (NMCM) and medical case management (MCM) will become more distinct, separate categories.

The program began in September 2012 under FY12-13 with a 6 month contract amount of $176,000. The FY 13-14 contract amount is $131,000 due to sweeps. A total of 176 clients have been served thus far with 134 being male, 41 female and 1 transgendered client.

A flowchart of the program process was explained. It is unknown how many clients have completed the six sessions (face to face with the case manager) within the 90 day period. Many clients appear to be having difficulty completing the sessions. Throughout the process, the initial case manager maintains contact with the MAI case manager with the goal of linking the client back to their initial plan of care.

Challenges of the program were discussed. The program is an intensive but short term and thus far, there is only one contracted provider billing for services. It was noted that the clients who do complete the program are successfully linked back to care.

d. Assessment of the Administrative Mechanism

This item was deferred to the next meeting.

7. **Public Comment:** None

8. Agenda Items/Tasks For Next Meeting: (November 20, 2013 at 12:30 p.m. **Venue:** BRHPC)

Agenda Items/Work Plan Item	Information requested/Action To Be Taken
1. Assessment of the Administrative Mechanism (3.1) 2. MAI Case Management Analysis 3. Review ACA Impact n Allocations (1.9)	1. Assessment of the administrative mechanism to ensure compliance. 2. Review PowerPoint presentation from the previous PSRA meeting and continue discussion on analysis of MAI Case Management (utilization and outcomes) (Handout A) 3. Continue review and discussion of allocations to ensure that allocations meet clients' needs transitioning in to ACA (Handout B)

Members discussed work plan items for the November meeting. It was recommended that the Committee meet in November in order to cancel the December meeting.

9. Announcements:

10. Adjournment: Meeting adjourned 3:07 p.m.

Priority Setting and Resource Allocation Committee
Attendance CY 2013

Member	1/16/13	2/20/13-CX	3/20/13	4/17/2013 CX	5/15/13 CX	6/12/13	7/10/13	7/17/13	8/21/13-cx	9/18/13	10/16/13	Notes
Bennett-Taylor, C., **Part A Chair**	1		1	1		1	1	1		1	1	
Schickowski, K.	1		1	1		1	1	1		1	1	
Gammell, B.	A		1	1		1	1	1		1	A	
Grant, C.	1		1	1		A	1	1		1	1	
Hayes, M.	1		1	1		1	A	A		1	1	
Katz, H. B.	1		1	1		1	1	1		1	1	
Reed, Y.	1		1	1		E	1	1		E	1	
Siclari, R.	1		E	A		E	A	1		E	1	
DeSantis, M.	*Appointed 3/25/13*			A		1	1	1		1	1	
Proulx, D.	*Appointed 1/24/13*		1	1		1	1	1		1	1	
Wynn, J.	1		1	1		1	1	1		1	1	
Quorum=7	Yes		Yes	Yes		Yes	Yes	Yes		Yes	Yes	

LPAC Meeting Summary to PSRA Committee

Medical Network Recommendations for Formulary Additions and Deletions

The Committee began reviewing the Medical QI Network's recommendations for additions to the Formulary. The recommendations were: ***Add -*** *Elavil (Amitriptyline), Remeron (Mirtazapine), Qvar (Beclomethasone), Prevnar 13, Gardasil, and Zostavax;* ***Remove –*** *Azmacort (Triamcinolone).*

Elavil (Amitriptyline)

Recommendation: Members reviewed the Medical Network recommendation to move Elavil from Tier 3 to Tier 1 of the formulary. *The Medical Network's justification to add Elavil is to provide a second affordable option for the treatment of neuropathy (common among clients) when Gabapentin (Neurontin) does not work. Elavil can also be prescribed for sleep disorders and depression*.

Estimated Cost: The Florida Department of Health Broward County (FLDOH-BC) ran a report to quantify Elavil utilization when Elavil was on the ADAP formulary in 2009. Members noted that 17,641 tablets were prescribed, most prescriptions in a 60 tab quantity, with an average of 300-600 prescriptions in the year. The most common prescribed strength was 25mg-50mg. There was a discussion on the projected cost for Elavil; Members estimated the cost to be approximately $2,000 and noted that the estimated cost is low.

Zithromax (Azithromycin) and Diflucan (Fluconazole)

Members reviewed the Medical Network's previous recommendation to move Zithromax and Diflucan from Tier 2 to Tier 1 of the formulary. Members noted the Medical Network's new recommendation to ***not*** move Zithromax and Diflucan with the understanding that both medications are available through the AIDS Drug Assistance Program (ADAP) and by emergency provision through the Ryan White Part A program office; both medications to remain on Tier 2 of the formulary.

Remeron (Mirtazapine)

The Committee reviewed the Medical Network recommendation to add Remeron to Tier 1 of the formulary.

Recommendation: *The Medical Network's justification to add Remeron (indicated for the treatment of major depressive disorder) to the Formulary is to provide another indication not available in other options.* Members noted that Remeron was initially removed from the formulary due to the availability of a Patient Assistance Program (PAP).

Estimated Cost: The Committee reviewed the cost utilization when Remeron was on the formulary for FY 10-11 and noted the cost to be $100.41; Members were reminded that Remeron is available as a generic. There was a discussion about the specificity of Remeron; Members agreed that Remeron is unlikely to be overused.

Qvar (Beclomethasone)

Recommendation: Members reviewed the Medical Network recommendation to add Qvar (*inhalation Aerosol used in the ongoing treatment of asthma*) to Tier 1 of the formulary instead of Azmacort (Trimcinolone) which has been discontinued.

Estimated Cost: The Committee noted the cost utilization for FY 12-13 to be $7,261.87. FLDOH-BC informed the Committee that they have been dispensing Qvar to replace Azmacort.

Prevnar 13 (Pneumococcal Vaccine)

Members reviewed the Medical Network recommendation to add Prevnar 13 to Tier 1 of the formulary.

Recommendation: *The Medical Network's justification to add Prevnar 13 is to ensure that clients are immunized properly. The Network stated it is futile to administer Pneumovax 23 without Prevnar 13. Members emphasized they are required to comply with medical standards of care but are prohibited from doing so fully when the medically indicated medication/vaccine is not made available for them. The Network cannot continue to provide inappropriate therapy while being held to unattainable medical standards.*

Estimated Cost: Members noted the cost estimate based on two possible scenarios suggested by the Medical Network: 1) 20% of the 3,500 Part A clients (about 1,300) would be eligible for the vaccine and 2) 50% of the 165 vaccinated in FY 12-13 with Pneumovax 23 would be eligible. The Committee also noted the FLDOH-BC cost of the vaccine to be $130 and

reviewed Prevnar 13 PAP Criteria: For individuals 50 and over. Potential impact based on PAP criteria: 3,419 clients were served in Part A OAMC between 3.1.13-10.31.13. Of those, 59% are below age 49, 33% are between 49-58, and 8% are age 59 and above.

FLDOH-BC ran utilization data for Pneumovax 23 to estimate number of clients ineligible for Prevnar 13 based on the criteria for clients receiving multiple Pneumovax 23 vaccines. The report included 8 years of data (January 2005-Ocotober 2013) and identified 14 clients who received Pneumovax 23 more than once. Members discussed the similarities between administering Pneumovax 23 and Prevnar 13 and noted possible client barriers adhering to vaccine guidelines (e.g. transportation to transport the vaccine to their personal care physician and ability to keep the vaccine refrigerated). The Committee suggested physicians purchase the vaccine in advance to reduce client barriers.

Gardasil (HPV Vaccine) and Zostavax (Herpes Zoster Vaccine)

The Committee reviewed the Medical Network recommendation to add Gardasil to Tier 1 of the formulary.

Recommendation: *The Medical Network's justification for Gardasil noted the vaccine was effective. The Florida/Caribbean AIDS Educations Training Center (F/C AETC) recommendations include age parameters while other recommendations are broader indicating the need to vaccinate all Persons Living with HIV and AIDS (PLWHA) against HPV. The Network asked to consider the rates of HPV among men and women, the rates of cervical cancer, and the low rates of cervical screening. The vaccine may serve as a preventative measure which is generally more cost effective than treatment. The Medical Network's justification for Zostavax is adding the vaccine would not create a large impact financially as anyone with a CD4 under 200 would not be applicable. It was noted that the guidelines for individuals without HIV call for excluding those who are age 60 and over, and those who are immunocompromised.* Members reviewed the Merck PAP Criteria: 19 years old or older; no health insurance or cannot afford the vaccines; maximum FPL 400%; reside in the U.S.; U.S. citizenship not required.

The Committee expressed concern over the lack of conclusive data with both Gardasil and Zoster vaccines. Members reviewed the F/C AETC CareLink Newsletter and noted a rating system of *BIII* for the HPV vaccine, indicating: Moderate recommendation for the statement from an expert opinion. It was also noted that the HIV CareLink Newsletter is a snapshot of the opportunistic infections (OIs) guidelines established by the Center for Disease Control (CDC) and are not specifically recommendations. One member expressed concern over the contraindications of using live vaccines such as Zostavax in HIV positive patients. There was a discussion about the need to add Gardasil and Zostavax to the formulary considering there are PAPs available. It was suggested to not continue to rely on PAPs as they may be dissipating in the near future causing this conversation to occur again.

Decision Pending: The Committee agreed to schedule a meeting with Dr. Beal to hear more insight on the F/C AETC recommendations; Staff to contact Dr. Beal to schedule an appointment.

Tier 3 Updates

Members agreed to **remove** Hydrea (Hydroxyurea) from the Formulary (*indicated for sickle cell anemia and cancer*). There are no cost implications.

Hyperglycemia medications: Diabeta (Glyburide), Glucophage (Metformin) and Glucotrol (Glipizide) were moved from Tier 3 to Tier 1 in June 1, 2012; they remained on Tier 3 accidentally. Members agreed to **remove** the Hyperglycemia medications from Tier 3. There are no cost implications.

The Committee reviewed the Flu Medication category on Tier 3. It was noted that Relenza (Zanamivir) is underutilized; prescriptions are generally written for Tamiflu. Relenza is an orally inhaled capsule that can cause bronchospasms in adults and asthmatics. Members discusssed adding Tamiflu to the formulary. One member suggested estimating the cost utilization before recommending that Tamiflu be added. The Committee noted the average retail for Tamiflu $118.99. FLDOH-BC noted that in the case of a flu pandemic the state will make Tamiflu available. Members agreed to remove Relenza (Zanamivir) and deferred adding Tamiflu to the formulary.

The Committee reviewed the Anticonvulsant category on Tier 3. It was suggested to move Levetiracetam (Keppra) from Tier 3 to Tier 1 of the formulary. It was noted that Keppra is the anticonvulsant with the least drug interactions with the protease inhibitors. Most HIV clients that have seizures are given Keppra; Phenytoin (Dilantin) and other anticonvulsants decrease levels of protease inhibitors. Members noted that the FY 12-13 utilization for Keppra identified one client. The

LPAC Meeting Summary to PSRA Committee

Committee agreed to keep Keppra on Tier 3 of the formulary.
Medication Reclassification
Per a Provider's request, the Committee reviewed the Other/Miscellaneous category of Tier 1 to reclassify the medications. Members recommended adding another subcategory under CNS, Anxiety, Psych, Neuro, and Autonomic entitled Anti-inflammatory. It was suggested to place the new subcategory after Analgesic. The following medications to be moved to the Anti-inflammatory category: Dexamethasone (Decadron), Methyprednisolone (Medrol dosepak) and Prednisone (Deltasone). Members reclassified Celebrex (Celecoxib) as an Analgesic.
Members reviewed Tier 2 of the formulary to update the tier to be more reflective of the current ADAP formulary. Members added Tivicay (Dolutegravir) to the Protease Inhibitors (PIs). The Committee suggested adding another category entitled Multiclass. The following medications to be added to the Multiclass category: Atripla (Efavirenz, Emtricitabine, Tenofovir), Complera (Emtricitabine, Rilpivirine, Tenofovir) and Stribild (Elvitegravir, Cobicistat, Tenofovir, Emtricitabine). Members also added Edurant (Rilpivirine) to the Nonnucleosides (NNRTIs).

LPAC Motions			
Motion #1	**To move Elavil (Amitriptyline) from Tier 3 to Tier 1 of the formulary**		
Proposed by:	Sherman, E.	**Seconded by:**	Ehren, M.
Justification	Accept Medical Network recommendation		
Action:	Passed Unanimously		
Motion #2	**To add Remeron (Mirtazapine) to Tier 1 of the formulary**		
Proposed by:	Sherman, E.	**Seconded by:**	Leverence, S.
Justification	Accept Medical Network recommendation		
Action:	Passed Unanimously		
Motion #3	**To remove Azmacort (Trimcinolone) and add Qvar (Beclomethasone) to Tier 1 of the formulary**		
Proposed by:	Sherman, E.	**Seconded by:**	Ehren, M.
Justification	Azmacort has been discontinued and Qvar is the most cost effective replacement		
Action:	Passed Unanimously		
Motion #4	**To add Prevnar 13 to Tier 1 of the formulary**		
Proposed by:	Sherman, E.	**Seconded by:**	Leverence, S.
Justification	CDC and F/C AETC recommendation for standard of care; Accept Medical Network recommendation.		
Action:	Passed Unanimously		
Motion #5	**To defer decision regarding Gardasil and Zostavax pending a conversation with Dr. Jeffrey Beal, FC/AETC Medical Director, to hear more insight on F/C AETC recommendations.**		
Proposed by:	Leverance, S.	**Seconded by:**	Sherman, E.
Justification	Both lack strong recommendation from CDC with insufficient evidence demonstrating efficacy and safety in HIV patients; PAP available.		
Action:	Passed Unanimously		
Motion #6	**To remove Hydrea (Hydroxyurea) from Tier 3 of the formulary**		
Proposed by:	Ehren, M.	**Seconded by:**	Sherman, E.
Justification	No utilization in FY 12-13		
Action:	Passed Unanimously		
Motion #7	**To remove Relenza (Zanamivir) from Tier 3 of the formulary**		
Proposed by:	Ehren, M.	**Seconded by:**	Leverence, S.
Justification	No utilization in FY 12-13		
Action:	Passed Unanimously		

HANDOUT B

MAI
Medical Case Management

Presented by:
Rafael Copa, Administrative Manager I
Shaundelyn DeGraffenreidt, QA Coordinator

INTRODUCTION
MAI MEDICAL CASE MANAGEMENT

- THIS PRESENTATION PROVIDES AN OVERVIEW OF THE RYAN WHITE PART A MAI MEDICAL CASE MANAGEMENT PROGRAM

- THE PRESENTATION IS DIVIDED INTO:
  - SCOPE OF SERVICES
  - SERV ICE UTILIZATION
  - CLIENT FLOW CHART
  - CHALLENGES
  - RECOMMENDATIONS

SCOPE OF SERVICES

- MAI Medical Case Management services supports the ability for Clients to remain adherent to medical care.
- MAI Medical Case Management services has a central role of providing treatment adherence counseling that supports adherence to complex HIV/AIDS treatments and retention in medical care.
- MAI Medical Case Management services shall be based on a Strengths-Based social work counseling approach that emphasizes people's self-determination and strengths. (ARTAS program)
- Services are provided by peers

SCOPE OF SERVICES

To be eligible for MAI MCM services:

- Currently enrolled in Ryan White Part A Medical Case Management program
- Missed a minimum of one scheduled Outpatient/Ambulatory medical services appointment in the last six months and;
- Be considered at risk for falling out of medical care.

Services must be conducted:

- Within a 90-day period
- Utilizing a maximum of six individual face-to-face client sessions that do not exceed 120 minutes per session
- MAI MCM must also conduct a 3-month and 6 month follow up assessments following case closures

SERVICE UTILIZATION

MAI Case Management	FY 2012-13 (Sept - Feb)	FY 2013-14 (Mar - Aug)
Contract Amount	$176,644	$131,644
Expenditures	$23,544	$25,474
Units of Service	3,138	3,362

SERVICE UTILIZATION

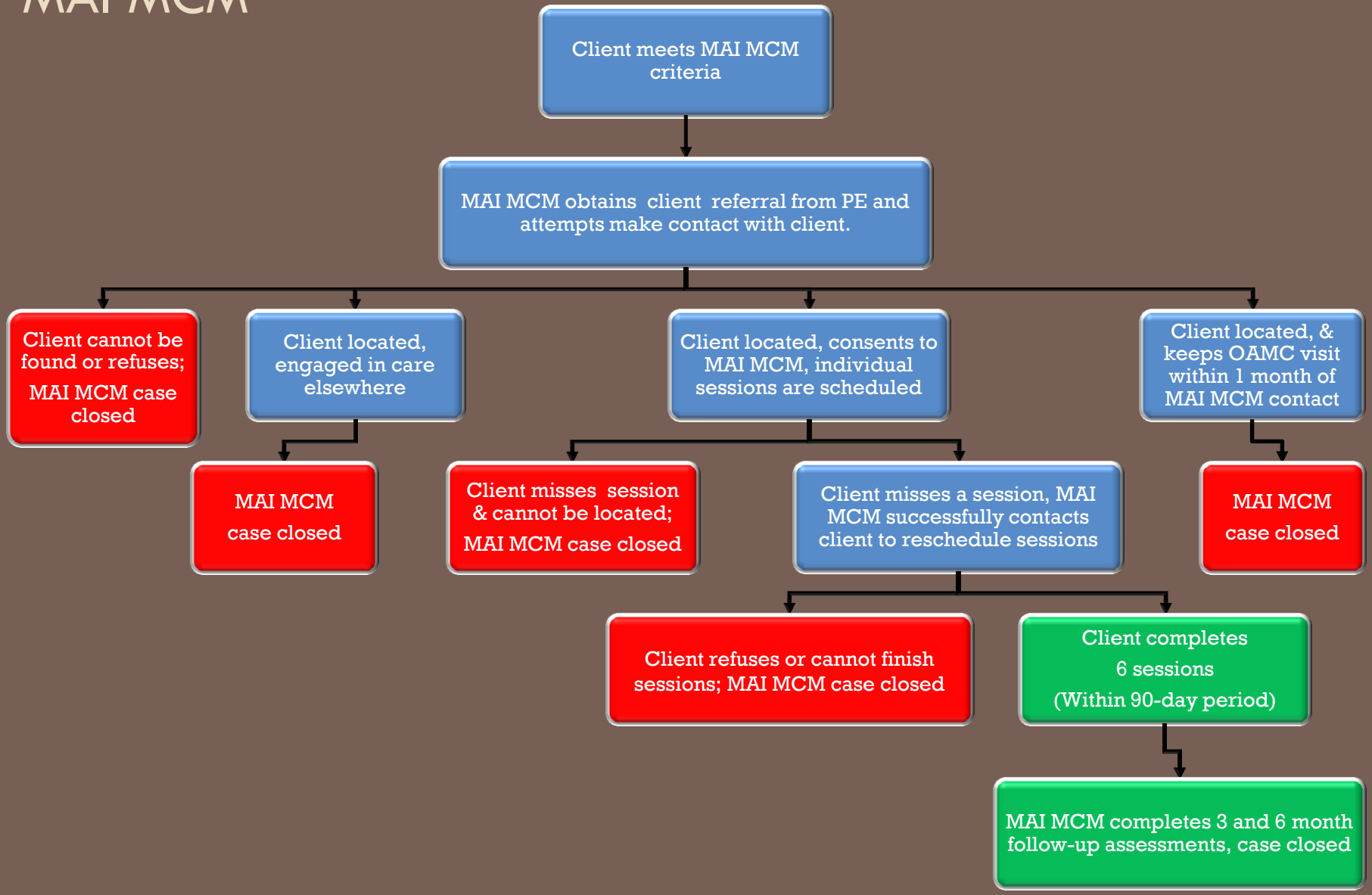
Clients Served (Sept. 2012 – Aug. 2013)	# Clients
Male	134
Female	41
Transgender	1
Total Clients	176

SERVICE UTILIZATION

Race (Sept. 2012 – Aug. 2013)	# Clients
Black	115
White	59
More Than Once Race	2

Ethnicity (Sept. 2012 – Aug. 2013)	# Clients
Haitian	8
Hispanic	63
Non-Hispanic	113

Client Flow Chart
MAI MCM



CHALLENGES

- Most challenging clients to retain into care
- Only one contracted provider currently billing for services
- Strictly a peer-driven model
- Based on ARTAS Model (Intensive Short-term – 90 day program)

RECOMMENDATIONS

- Revise the Model to include other service personnel
- Revise the Model to include a component for clients who need long – term, strengths-based interventions
- Service Category should be restricted to Ryan White Part A Outpatient/Ambulatory Medical Care providers

QUESTIONS AND ANSWERS

HANDOUT C

FY 14/15 ALLOCATIONS: PART A

Rank	Service	FY 13 Allocation	Factors to Consider	Recomended FY14 Allocation	
#		$	*Client increase from expanded testing offset by Exchange enrollment	%	$
1	Medical	$5,706,496	Expanded testing will link more clients to care. No Medicaid expansion & long transition to ACA health exchanges means full funding needed for FY14-15. Expect 3% Medicare reimbursement increase ($171,195).	15%	$6,546,809
2	Pharmacy	$509,576	Expanded testing will link more clients to care. Decreased PAP access. Long transition to exchanges means full funding needed	55%	$787,665
3	Medical Case Mgt [Disease Mgt (DM]	$0	DM constitutes a change in the MCM category. This ensures the EMA's current MCM services provide appropriate DM to help improve client medical outcomes. This clinically based case management will only be operated by a licensed practitioner at a medical provider site. Based on FY12 VL analysis, DM could have benefited 812 clients. 30% of FY 12 MCM clients were new; based on growth rate, FY14 estimate is 1,056.	100%	$546,650
4	Health Insurance Continuation (HICP)	$0	HICP for approximately half of RW clients transitioning to ACA exchange & needing premium & out-of-pocket assistance despite subsidies. Estimated cost $3,779 (100-250% FPL) & $6,953(250-400%) New and existing clients to this service category (800 clients maximum will enroll, but not all clients will access this service category immediately)	100%	$2,329,002
5	Oral Health	$2,623,653	Part F funding uncertain. Low Medicaid coverage. Difficult to access.	19%	$3,132,354
6	Mental Health	$336,987	Expanded testing = more clients. No Medicaid expansion & long transition to exchange means full funding needed.	10%	$369,387
7	Substance Abuse	$342,889	Expanded testing will link more clients to care. No Medicaid expansion & long transition to ACAinsurance exchange.	3%	$354,827
	Core	$9,519,601		$14,066,694	
1	CIED	$467,513	Enrolling clients into Exchange may result in longer encounter time.	20%	$562,244
	Non-Medical Case Mgt (NMCM)	$0	This service category will encompass comprehensive case management, which is an addition to the NMCM category. Along with CIED, NMCM is a supportive service to ensure health outcomes through referral and linkage.	100%	$1,016,769
2	Food Bank	$642,846	No other significant funders. Increase from 12 boxes/3vouchers (15 units) to 24 total units. Eligibility to be reviewed. Allocation split 90% for Food Bank and 10% for Food Vouchers; food vouchers to be allocated $100,000.	85%	$1,189,473
3	Legal	$131,426	No other funding identified. SSI appeals process.	16%	$152,466
4	Outreach	$58,768	No other funders. Expanded testing = client increase	-12%	$52,004
	Support	$1,300,553		$2,972,956	
	TOTAL	$10,820,154		$17,039,650	

FY 14/15 ALLOCATIONS: MAI

FY 14 Rank	Service	FY 13 Allocation	Factors to Consider	Recommended FY 14 Allocation
#		$		
	Utilize FY13/14 allocation plus % increase			
1	Medical	$100,000	Expanded testing will link more clients to care. ACA Impact	**$105,000**
2	Medical Case Mgt	$176,644		**$185,476**
3	Mental Health	$128,418		**$134,839**
4	Substance Abuse	$400,000		**$420,000**
	Core	**$805,062**		**$845,315**
1	Eligibility	$290,957	Uncertainty of insurance exchange plans will make eligibility determinations more time-consuming and difficult.	**$320,053**
	Support	**$290,957**		**$320,053**
	TOTAL	$1,096,019		$1,165,368

2013-14 Work Plan Calendar for Priority Setting & Resource Allocation Committee

	March	April	May	June	July	Aug
PSRA	1 Review Grant Award 2 Set PSRA timeline 3 ID PSRA data	1 Review Grant App stats (Unmet need, epi, co-morbidities, etc) 2 PCIP report	1 Scorecards 2 Review JPC/JCCR recommendations	1 FY14 Priorities rankings 2 Review scope services, eligib. 3 Client Survey results	1 FY14 Allocations	X

	Sep	Oct	Nov	Dec	Jan	Feb
PSRA	1 Affordable Care Act Impact 2 FY13 Sweeps 3 Review Policies & Procedures	Training on Assessment of Admin Mechanism	1 Develop HIVPC self-assess survey 2 Conduct Assessment of Admin Mechanism	Affordable Care Act Impact	FY13 Sweeps	1 Update Work Plan, P&P 2 Annual Evaluation

FY 2013-2014 Broward County HIV Health Services Planning Council **Priority Setting & Resource Allocation Committee** Work Plan

Objective 1. Priority Setting and Resource Allocations	Responsible	Outcome	Start	Due	Progress
1.1 Approve PSRA timeline and identify data to be used	PSRA, Staff	PSRA process	3/13	3/13	Complete
1.2 Review PCIP recommendations and determine next steps	PSRA (Data: Staff)	Ensure services meet needs	4/13	6/13	Restructured
1.3 Review Grant Data (Epi, unmet need, imp plan, co-morbidities, EIIHA, survey)	PSRA, JPC, Staff	Better informed PSRA	4/13	4/13	Complete
1.4 Review updated Scorecards format	PSRA (Data: Staff)	Data for PSRA	5/13	6/13	Complete
1.5 Review recommendations from Joint Planning Committee, JCCR	PSRA (Data: Staff)	Input based on data	5/13	6/13	Complete
1.6 Review scope of services and eligibility for each service category	PSRA (Data: Staff)	Data for PSRA	6/13	6/13	Complete
1.7 Review Client Survey results	PSRA (Data: Staff)	Input from clients on PSRA	6/13	6/13	Complete
1.8 Rank Part A & MAI Priorities	PSRA	Priorities for services	6/13	6/13	Complete
1.9 Allocate funds by service category (Part A & MAI) a. Ensure resources target underserved populations hit hard by epidemic b. Discuss funding to expand services by adding more providers	PSRA <u>Data:</u> PC Staff Grantee Staff	Funds allocated per HRSA requirements; Resources targeted	7/13	7/13	Complete
1.9 Review and discuss impact of Affordable Care Act on allocations	PSRA, staff, grantee	Ensure allocations meet needs	9/13	12/13	In process
Objective 2. Execute Implementation Plan					
2.1 Monitor Expenditure vs. Allocation. Recommend strategies to address shortfalls	PSRA	Appropriate service funding	9/13 & 1/14		Complete
2.2 Recommend reallocations ("Sweeps") to ensure sufficient core funding and distributed fairly to other categories	Data: Grantee, Staff	Appropriate service funding			Complete
Objective 3. Assess the Administrative Mechanism					
3.1 Assessment of Administrative Mechanism Training	PSRA	Ensure compliance efficiency	10/13	10/13	Pending
3.2 Plan PC Self-Assessment (related to Assessment of Admin Mechanism)	Data: Grantee and	Improved administration	11/13	11/13	Pending
3.3 Conduct Assessment of Administrative Mechanism	PC Staff		11/13	11/13	Pending
Objective 4. Review And Revise Committee Work Plan, Policies And Procedures					
4.1 Review and update Work Plan, Policies & Procedures	PSRA, Staff,	Updated Plans	8/13, 2/14	2/14	Complete
4.2 Annual Evaluation: Assess the past year and recommend improvements	Grantee	Improved process	2/14	2/14	
Objective 5: Review PSRA Proposals to Meet the Goals of the National HIV/AIDS Strategy					
5.1 Study possible new services PSRA identified to address goals of NHAS a. Funding for peers to address issues of retention in care b. Integrated model including prevention for positives, medical care and outreach for discordant couples c. Develop plan to reduce wait times at clinics d. Develop plan to streamline eligibility and intake, through more locations e. Develop with QM Committee strategy to increase retention in care f. Develop with QM strategy to refocus MAI funding	PSRA, Grantee, Staff	Ensure services meet needs of clients	9/13	9/13	Complete

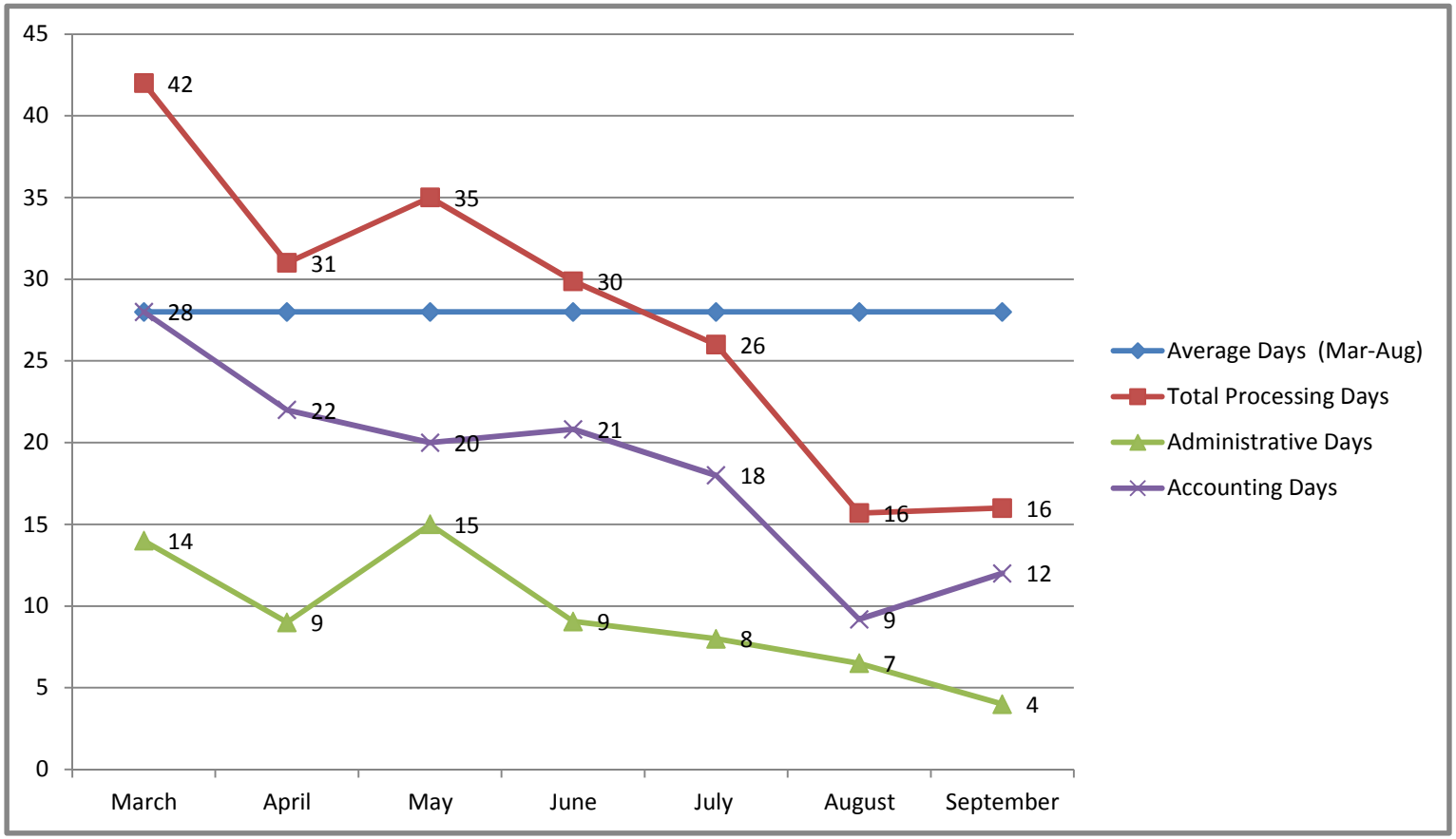
Ryan White Part A
Administrative Invoice Processing Summary

	FY13-14			MARCH'13			APRIL'13			MAY'13			JUNE'13			JULY'13			AUGUST'13			SEPTEMBER'13		
	DAYS STAMPED TO PAID	ADMIN PROCESSING	ACCOUNTING PROCESSING	DAYS STAMPED TO PAID	ADMIN PROCESSING	ACCOUNTING PROCESSING	DAYS STAMPED TO PAID	ADMIN PROCESSING	ACCOUNTING PROCESSING	DAYS STAMPED TO PAID	ADMIN PROCESSING	ACCOUNTING PROCESSING	DAYS STAMPED TO PAID	ADMIN PROCESSING	ACCOUNTING PROCESSING	DAYS STAMPED TO PAID	ADMIN PROCESSING	ACCOUNTING PROCESSING	DAYS STAMPED TO PAID	ADMIN PROCESSING	ACCOUNTING PROCESSING	DAYS STAMPED TO PAID	ADMIN PROCESSING	ACCOUNTING PROCESSING
MONTHLY AVERAGE	28	9	18	42	14	28	31	9	22	35	15	20	30	9	21	26	8	18	16	7	9	16	4	12
OAM	28	9	18	47	16	31	30	9	22	35	16	19	30	9	21	25	7	18	15	5	10	12	4	9
OAM MAI	41	14	27										41	14	27									
APA	25	8	17	47	14	34	30	12	18	33	14	19	30	9	21	24	7	17	13	5	8	19	4	15
OHS	26	9	17	27	3	24	28	3	25	35	12	23	35	15	21	31	15	17	16	6	10	11	2	10
MCM	26	9	17	41	16	24	28	9	20	32	17	15	25	7	18	26	8	18	16	7	9	14	2	12
MCM MAI	21	7	14	26	7	19	19	6	14	45	20	25	35	8	27	34	11	23	18	9	9	29	7	22
MHS	30	10	21	46	14	32	35	9	27	35	12	23	33	10	24	29	11	19	17	6	10	17	5	12
MHS MAI	24	8	16	26	6	20	19	6	14	38	16	22	28	8	20	9	3	6	15	12	3	13	1	12
SAS	29	9	19	46	20	27	37	10	27	32	13	19	31	9	22	27	6	21	16	5	11	13	4	9
SAS MAI	32	10	22	53	21	32	40	14	26	39	8	31	25	8	17	29	7	22	18	9	9	20	1	19
Food Bank	31	11	20	42	10	32	52	22	30	33	19	14	26	8	18	29	7	22	18	7	11	17	6	11
Food Voucher	28	7	21	42	10	32	42	14	28	47	14	33	30	3	27	14	6	8	11	4	7	12	1	11
CIED	32	10	22	45	14	31	31	5	26	49	19	30	35	8	27	29	7	22	18	9	9	14	6	8
CIED MAI	30	8	22	46	14	32	31	5	26	42	12	30	35	11	24	29	7	22	15	4	11	14	6	8
OUTREACH	18	6	13	51	19	32	11	3	8	11	3	8	11	3	8	11	3	8				14	3	11
LAS	34	12	22	52	20	32	38	14	24	43	19	24	28	11	17	29	4	25	18	7	11	29	7	22
CQA	31	12	19	41	23	18	36	8	28	33	12	21	42	15	27	29	7	22	18	9	9	18	7	11
PCS	30	10	20	45	14	31	36	8	28	33	12	21	32	12	20	29	7	22	18	9	9	18	7	11
NAS																								

OAM = Out Patient Ambulatory
APA = Pharmaceutical Assistance
OHS = Oral Health
MCM = Medical Case Management
MHS = Mental Health
SAS = Substance Abuse
LAS = Legal Aid
CQA = Clinical Quality Assurance
PCS = Planning Council
NAS = Needs Assessment

Monthly Invoice Tracking

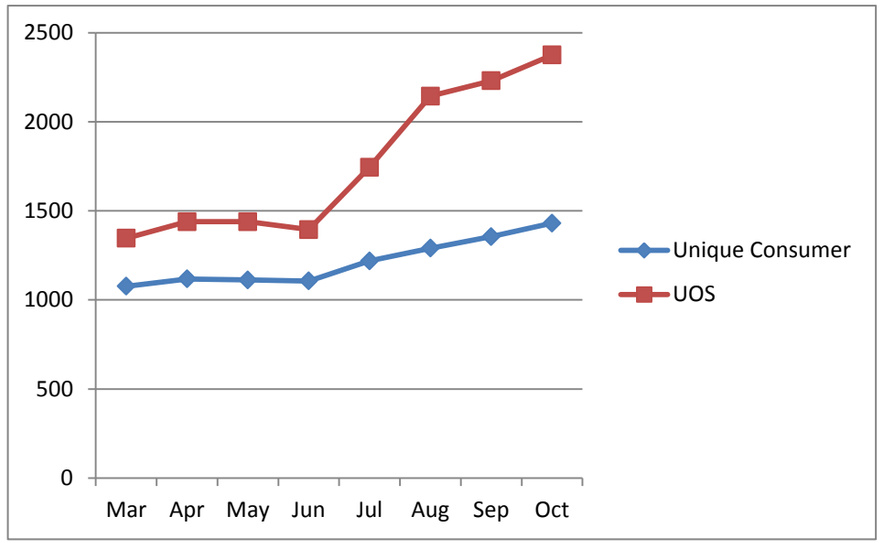
March 2013 - September 2013

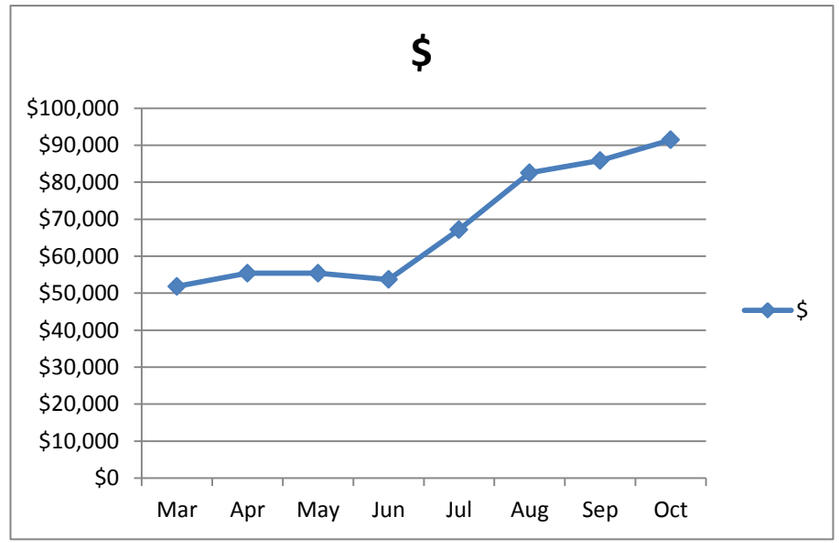


Food Bank/Voucher Utilization
March 2013 - October 2013
(7 Months)

Month	Unique Consumer	UOS	Boxes Per Consumer	$
Mar	1077	1346	1.2	$51,821
Apr	1118	1439	1.3	$55,402
May	1112	1439	1.3	$55,402
Jun	1106	1395	1.3	$53,708
Jul	1219	1745	1.4	$67,183
Aug	1290	2144	1.7	$82,544
Sep	1355	2230	1.6	$85,855
* Oct	1431	2375	1.7	$91,438
		Total Utilization		**$543,351**

Food Bank Balance	$51,708
Food Bank BULK Balance	$591,572
Total	**$643,279**

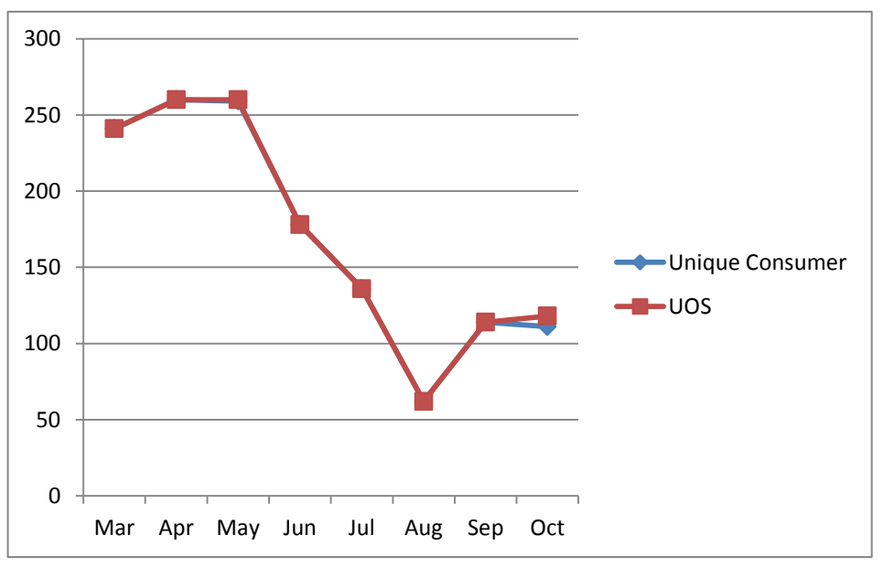


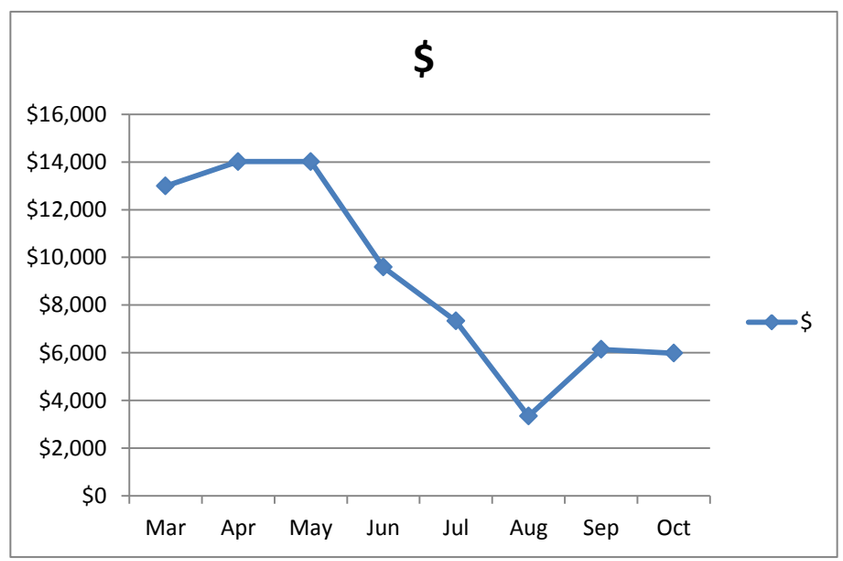


* Estimated, invoice in process.

Month	Unique Consumer	UOS	Vouchers Per Consumer	$
Mar	241	241	1.0	$12,990
Apr	260	260	1.0	$14,014
May	259	260	1.0	$14,014
Jun	178	178	1.0	$9,594
Jul	136	136	1.0	$7,330
Aug	62	62	1.0	$3,342
Sep	114	114	1.0	$6,145
Oct	111	118	1.1	$5,983
		Total Utilization		**$73,412**

Food Voucher Balance	$45,665
Food Voucher BULK Balance	$100,910
Total	**$146,575**



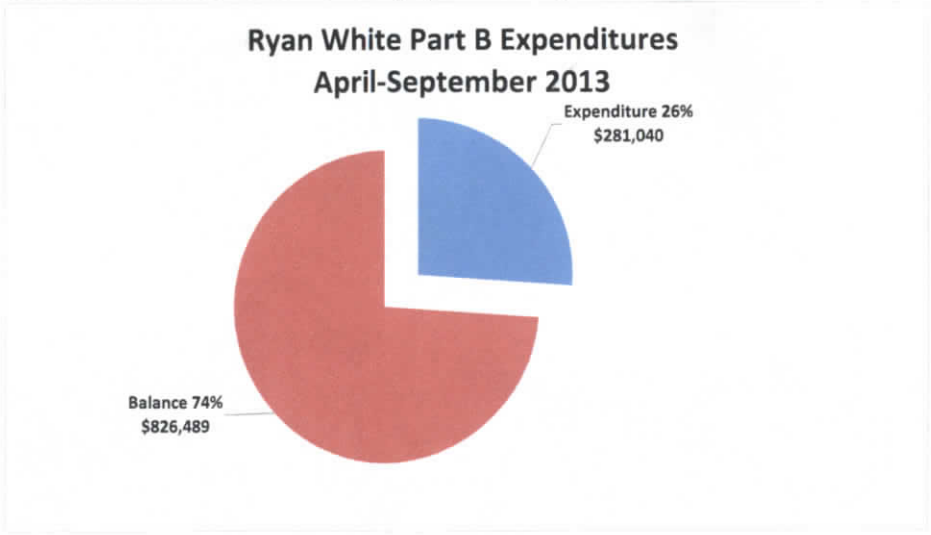


11/19/2013

Ryan White Part B
Expenditure Report
September 2013

Service Category	Part B 2013-14 Allocated	Part B 2013-14 (September/ Encumbered)	Part B 2013-14 Monthly Average Left	Part B 2013-14 (YTD Spent/ Encumbered)	Part B 2013-14 (% Encumbered)	Part B 2013-14 (% Left)	Part B 2013-14 (Balance)
Home Delivered Meals	$ 2,479	$ 420	$ 413	$ 420	17%	83%	$ 2,059
Medication Co Pay	$ 310,000	$ 15,576	$ 29,812	$ 131,127	42%	58%	$ 178,873
Case Management (non-med)	$ 228,287	$ 18,486	$ 21,507	$ 99,248	43%	57%	$ 129,039
Residential Substance Abuse	$ 300,000	$ -	$ 50,000	$ -	0%	100%	$ 300,000
Medical Transportation	$ 150,971	$ -	$ 25,162	$ -	0%	100%	$ 150,971
Administration	$ 110,192	$ 7,195	$ 9,991	$ 50,245	46%	54%	$ 59,947
TOTALS	**$ 1,101,929**	**$ 41,677**	**$ 136,885**	**$ 281,040**	**26%**	**74%**	**$ 820,889**
					74%		

Home Delivered Meals 1
Non-Medical Case Management conducted 725 eligibility interviews in Sept.
Medication Co Payment served 181 clients in September.
174 Clients served in September Medication Co Payment
7 Clients served in Sept. Mail Order
Medical Transportation 413 (31 day) and 12 (10 ride) were distributed in September.
Residential Substance Abuse - new category added to begin in November

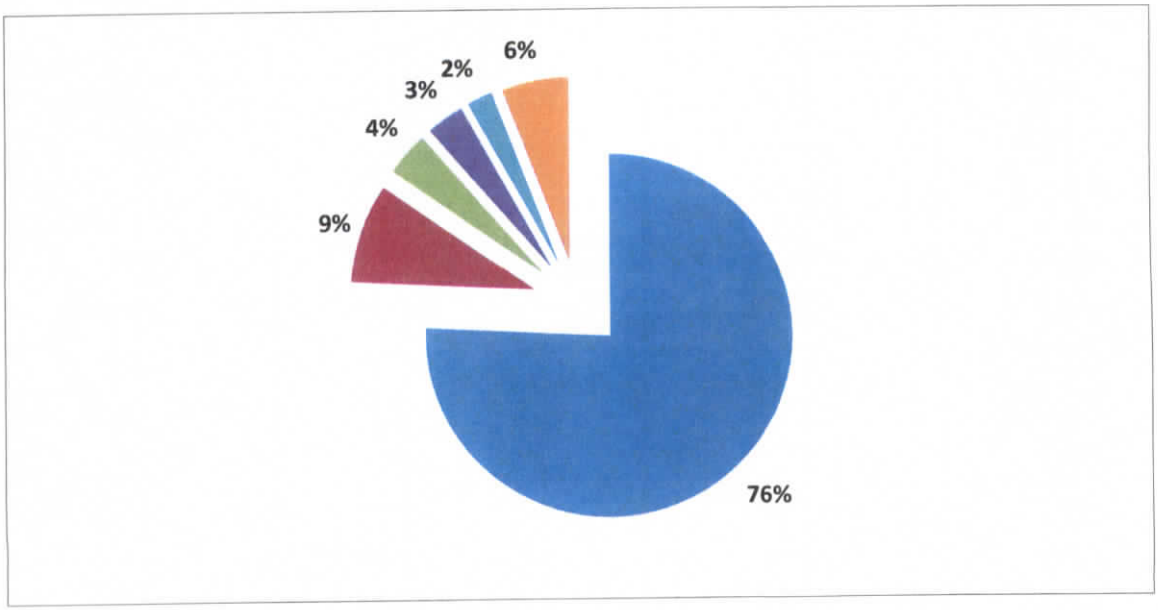


ADAP REPORT BROWARD
October 1 - 28 2013 Revised (10-30-13)

Clients Enrolled	3755
Clients Served*	2676
No Show FLHC	27%
No Show Paul Hughes	25%
Clients in ADAP w Ins Waiver	
Medicare D*	271
AICP Transition*	178
No Brand Coverage	6
No Presc. Coverage	32
Prescription cap	7
Discount Plan	4
Unafford Co-Pay/Deductibles*	85
Pre Existing Condition	3

% ADAP Clients by Viral Load

%	Viral Load
76%	0-75
9%	76-500
4%	501-5000
3%	5001-30000
2%	30001-55000
6%	55001



REVISED Eligibility Requirements for Part B Bus Passes effective 11/1/2013

Ryan White Part B Medical Transportation – Bus Passes – 31 day only

- HIV+
- Broward County Resident
- **Proof of Income increased to 400% FPL (Single household $44,680)**
- Must have current RW Part A & Part B Eligibility Certification
- Must have no other form of reliable transportation
- Client cannot receive a bus pass if they have Medicaid

Authorized staff at agencies responsible for distribution of bus passes must continue to verify client's Part A & B eligibility and if the client has scheduled appointments for core services medical, dental, mental health, substance abuse, ADAP/pharmacy, case management to justify need for a bus pass.

Bonnie Majcher must have the name of authorized staff and alternate who will be picking up the passes.

DOH staff to verify Part B Eligibility:

- Ann Mercer 954-467-4700 ext 5650
- Bonnie Majcher 954-467-4700 ext 5658
- Michael Worley 954-467-4700 ext 5630
- Charles Mayas 954-467-4700 ext 5669

Ryan White Part B 2nd FY 13/14 Re-Allocations November 2013

Core Services	FY 13/14 Initial Approved Allocation	Sweep Out	Sweep In	Revised Allocation	Revised % of Award based on Sweep	Current Balance as of 10/31/13	% Spent based on initial Allocation	Amount Expended as of 10/31/13
Medication Co Payment	$ 310,000							
Core Total 28%	$ 310,000				28.13%	$ 166,389	46%	$ 143,611
Support Services								
Residential Sub. Abuse	$ 300,000					$ 300,000	0	$ -
Home Delivered Meals	$ 2,479					$ 2,059	17%	$ 420
Medical Transportation	$ 150,971	$ (16,641)		$ 134,330	12.19%	$ 100,656	33%	$ 50,315
Non Med.Case Manag.	$ 228,287		$16,641	$ 244,928	22.23%	$ 87,606	62%	$ 140,681
Support Total 62%	$ 681,737					$ 490,321		
Administration 10%	$ 110,192					$ 51,317	53%	$ 58,875
Total Funding	**$ 1,101,929**					$ 708,024	**36%**	$ 393,902