INTEGRATION OF CARE COMMITTEE

NYU McSilver Institute
41 East 11th Street in Room 741
June 22, 2016, 9:40am-12:00pm

M I N U T E S

Members Present: Christopher Joseph (Co-Chair) , Lisa Zullig (Co-Chair), Peter Campanelli, PsyD, Amber Casey (for Graham Harriman), Michael Ealy, Dorothy Farley, Zach Hennessey, Peter Laqueur, Julie Lehane, PhD, Jan Carl Park, Bobby Rallakis, John Schoepp, Claire Simon

Members Absent: Christopher Cunningham, Joan Edwards, Janet Goldberg, Deborah Greene, Terry Hamilton, Gina Quattrochi, David Price, Brenda Starks-Ross

Staff Present: David Klotz, Nasra Aidarus (NYC DOHMH), Linda Hakim (WCDOH)

Public Health Solutions Staff Present: Bettina Carroll

Other Planning Council Members Present: Randall Bruce, Billy Fields

Agenda Item #1: Welcome/Introductions/Moment of Silence/Minutes

Mr. Joseph and *Ms. Zullig* opened the meeting followed by introductions. *Mr. Joseph* led the moment of silence. The minutes from the meeting on April 20th were accepted with no changes. The meeting packet was reviewed.

Agenda Item #2: Needs Assessment Committee Recommendations

Mr. Park presented the recommendations developed by the Needs Assessment Committee (NAC) derived from the February Half Day Community Briefing: 1) Establish a Local Pharmaceutical Assistance Program (LPAP) to expand access to Hepatitis C direct acting antiviral medications for Ryan White Part A eligible HIV/HCV co-infected clients; 2) Increase Short-Term Rental Assistance programs for Ryan White Part A eligible clients living in the Tri-County Region; 3) Amend RW Part A service directives to require that providers be trained in the impact of financial hardship, including unemployment and inadequate access to benefits, in order to link clients to financial counseling and employment and educational services.

Details were provided on the background of the recommendations:

1) LPAP:

- As of Dec. 2014 there were approximately 11,049 HIV/HCV co-infected individuals living in NYC, of whom 3,977 were Ryan White Part A clients
- Less than five years ago, drug manufacturers flooded the market with new drugs that cure the hepatitis C virus
- As of Dec. 2015, 19 State ADAP programs have added at least one curative DAA treatment to their formularies. New York State ADAP has not.
- Although HCV is curable and preventable, the number of Americans dying as a result of HCV reached an all-time high in 2014
- Between 2000 and 2011, in New York City, 5,475 adults co-infected with HCV/HIV died.
- Among 706 NYC CHAIN participants interviewed between Nov. 2009 and Dec. 2015, 38% (n=207) tested positive of HCV (note: the CHAIN cohort is older than the overall HIV-positive population; the surveillance data suggests the total percentage of co-infected between 10-20%).

2) Tri-County Housing:

- Participants with housing needs in the Tri-County region are more likely to be doubled up or be street or shelter homeless than to be in temporary/transitional housing programs
- Among Tri-County CHAIN participants interviewed in 2008-2012 (n=1,000) 34% were in need of rental assistance and did not receive it
- In 2013 there were 4,182 PLWHA in the Tri-County region. Using this as a base, CHAIN researchers estimate the 965 PLWHA residing in the Tri-County region currently need rental assistance but are not receiving any.
- Receipt of housing assistance to secure and maintain stable and adequate housing improves retention in HIV care, adherent ART use, and health outcomes.

3) Employment/Education

- Consumers are considering returning to work or school without losing benefits (HASA, SSDI/SSI, Medicaid/Medicare).
- They may be eligible for return-to-work or no-cost/low-cost educational programs for people with disabilities that will not affect benefits.

Ms. Zullig and *Mr. Joseph* recommended addressing the 2nd and 3rd recommendations first, as they will require less time to discuss. There was a discussion on the appropriate body to address Tri-County Housing. The Tri-County Steering Committee (TCSC) sets priorities and allocations for that region. The NAC recommendation does not call for a change to the service directive. A change in allocation would be addressed by TCSC and PSRA. The recommendation calls for increasing short-term rental assistance, which is currently covered in the TC service directive. If the TCSC decides to recommend a change to the directive, that would come back to IOC.

A motion was made, seconded and approved to refer the Tri-County Housing recommendation to the TCSC.

The IOC members addressed the Employment/Education recommendation. The following is a summary of the discussion:

- Benefits and entitlement counseling are already a part of many programs, either as direct services or through referrals. The recommendation may be addressed through the grantee adding the referral type to specifically include employment and education.
- DOHMH has a CDC grant to work with the National Working Positive Coalition to develop training for providers to assist clients with employment.
- The Ryan White legislation still explicitly prohibits providing vocational therapy (e.g., resume writing, interview skills), but counseling about and referrals to that service are allowable.
- There are two tiers to implementation: training Part A providers to offer counseling, and establishing linkages for referrals.
- Medical Case Management (MCM), non-MCM and EIS programs (which cover over 60% of Part A clients) already provide navigation to this service. Other programs can make referrals and linkages.
- All Part A providers should have basic knowledge of employment/education and entitlements/benefits, but only those actually navigating people through the system can be expected to know all the constantly changing nuances of the system. Training all providers to be experts will take years, but a baseline level of knowledge is possible.
- There are already many workforce development programs, although not all have HIV-specific programs.
- The master directive includes language to allow for referrals and linkages for all unmet social service needs. IOC decided not to list every possible service (e.g., Legal, Psychosocial Support, etc.) in order to be a blanket for all services without limiting it to the ones listed.
- The Council can just direct the grantee to implement the current master directive to include employment/education services as part of the referral package.

Ms. Casey proposed that the grantee develop an implementation plan in the fall, and IOC can provide input on how to implement the NAC recommendations in the contract renewal process.

A motion was made, seconded and approved to have the grantee develop an implementation plan to require Part A providers to have enhanced training on benefits and entitlements in order to broaden access for clients to employment and educational programs.

Mr. Park reviewed the following background documents related to hepatitis C and LPAPs:

1) CHAIN report of hepatitis C prevalence in the CHAIN cohort (higher than the overall HIV population).
2) Presentation from DOHMH given at the Half Day Community Briefing on HIV/HCV coinfection. The presentation shows that there are 115,184 people with HIV in NYC (as

of Dec. 2014). Of the 23,676 who are Ryan White clients, 17% (3,977) are HCV infected. About 9% of those are uninsured.

3) Presentation from the NYSDOH to the NYS HIV Advisory Body on hepatitis C that gives a picture of HCV statewide.
4) Presentation from HRSA on LPAPs. About 29 EMAs have LPAPs.
5) HRSA monitoring standards on LPAPs, including implementation rules.
6) NASTAD data on pharmaceutical companies' patient assistance programs (PAPs). It is a long process to qualify for a PAP and they have varying eligibility (e.g., income can be 500% of federal poverty level). Out of pocket expenses can range widely. Many pharmacies and agencies provide help with these. *Ms. Casey* added that PAPs do not count towards payer of last resort requirements for an LPAP, so a client would not have to be denied assistance from a PAP to use an LPAP, only be denied insurance coverage. *Mr. Hennessey* added that PAPs often require perfect adherence. NASTAD representatives should be asked to join this discussion.
7) NASTAD document on ADAPs and drug price negotiations, including the 340B rebate (a federal program that allows ADAPs to access discounts negotiated by Medicaid). Thinking about the future, there may be other new drugs (e.g., HIV gene therapy) that are that an LPAP can assist with in the time before ADAP adds them to their formulary.
8) Transcript of NYS ADAP Director Christine Rivera's presentation to PSRA. *Ms. Zullig* pointed out that Ms. Rivera said that she is "cautiously optimistic" about ADAP's adding DAAs to the formulary, but cannot say exactly when, and she does not recommend the EMA to establishing an LPAP. She said that if the EMA did, she could administer it as a pharmacy benefits management company. Also, if the Council took funds from its ADAP allocation to use for an LPAP (the State currently uses no administrative fees), it would impact the entire Part A portfolio. Because ADAP does not currently take an administrative fee, other Part A contractors are allowed to use 12% for administration. This would be reduced to 10%, which may be too high a burden for some contractors. There are other states that have negotiated lower prices for DAAs, including California (with conditions). We do not know the politics of the NYS negotiations. We should ask other programs how they are covering these drugs.

The following is a summary of the additional ensuing discussion points:

- Administrators of other cities' LPAPs need to be invited to call in and describe their programs.

- *Ms. Casey* noted that details of how an LPAP is implemented are through the grantee and an advisory committee that it must set up: setting the formulary, eligibility and cost containment plans for waiting lists, as well as the administrative mechanism (e.g., procurement - a pharmacy benefits manager would be needed). She explained that the IOC and Council are only responsible for establishing the need for an LPAP and developing a directive (which can be simple) and allocating the funds.

- It was noted that if the Council wants to create an LPAP, it must go into the grant application. If the intention is to have it created in FY 2017, it must go into the FY 2017

grant application, which is due in September, which means the Council must sign off on a complete plan by the end of this planning cycle.

- We do not know from surveillance data is what number of co-infected are uninsured/ADAP only. Eligibility must be even across jurisdiction and not limited to Ryan White clients. Mathematical modeling would be needed to get a handle on the numbers who would be expected to be served. All numbers will be estimates.

- At the PSRA meeting, members said that they are willing to explore an LPAP, but needed data on need and cost, etc. There was also concern about the effect on the administrative rate for all Part A programs. The PSRA committee may decide not to allocate funding, in an environment of shrinking funding, but more discussion is needed. PSRA will also look at the implications for the entire Part A service system. Part A contributes 4% of the ADAP budget, but it is not known what will happen if that amount is reduced (either to ADAP or the rest of the Part A portfolio, which will have their administrative amounts reduced, which could result in contractors leaving the system).

- LPAPs have strict rules on how they operate and the mechanism for how medications are disbursed is up to the grantee. There are also HRSA rules for who serves on the advisory board, but the grantee establishes it (some jurisdictions use a Council committee).

- We cannot earmark funds for ADAP to use for DAAs, since they have universal access requirements across the entire State.

- Adding drugs to the ADAP formulary (which is done by its own advisory board) depends on cost and need. NYS is a huge market and is negotiating with pharmaceutical companies to lower costs to make sure the formulary sustainable and accessible. The Fair Pricing Coalition (including ADAP and Medicaid directors) is involved in these negotiations. Most drugs have both wholesale and 340B prices, but the DAAs do not have 340B prices yet. The hope is that they will reduce prices through negotiations (with a 340B price or some other discount).

Staff will work with the chairs to set a schedule for upcoming meetings.

There being no further business, the meeting was adjourned.