HIV Health & Human Services
PLANNING COUNCIL OF NEW YORK
A Mayoral Council established by the Ryan White C.A.R.E. Act of 1990

Meeting of the

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, January 13, 2014
AIDS Service Center of NYC, 41 E. 11th Street, 5th Floor
3:10 – 5:00 pm

MINUTES

Members Present: Sharen Duke (Co-Chair), Randall Bruce, Felicia Carroll, Robert Cordero, Joan Edwards, Graham Harriman, Jan Hudis, Peter Laqueur, L. Freddy Molano, M.D., Jan Carl Park, Tom Petro, Daniel Pichinson, Allan Vergara, Leonardo Vicente III

Other Council Members Present: Billy Fields, David Martin

Members Absent: Matthew Baney, Nancy Cataldi, Deb Marcano, Amanda Lugg, Tracy Douglas Neil Sam Rivera

Staff Present: David Klotz, Darryl Wong, Rafael Molina, Anna Thomas (DOHMH); Rachel Miller, Gucci Kaloo (Public Health Solutions); Christine Rivera (NYSDOH – by phone)

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

Ms. Duke opened the meeting followed by introductions. *Mr. Klotz* reviewed the meeting packet, including a synopsis of the services provided within each category. The draft minutes of the December 9, 2013 meeting were approved with no changes. *Mr. Klotz* recapped the discussion at that meeting.

Agenda Item #2: FY 2014 Spending Scenario Planning

ADAP

Mr. Park and *Mr. Harriman* gave a brief update on the national budget picture. After discussions with Steve Young from HRSA, the loss from the end of Hold Harmless (HH) funding is expected to be somewhat ameliorated because all HH funding nationally will go into the pool of Part A supplemental funding. Also, the recent Congressional budget agreement will mean smaller sequestration effects. Thus, an 8% reduction scenario is prudent planning.

Mr. Klotz reviewed the targeted cut to ADAP discussed at the previous meeting. *Ms. Duke* explained that the Committee asked that ADAP Director Christine Rivera call in to answer questions and affirm that a $2.76M reduction in the EMA's contribution will not adversely affect the ADAP programs and their clients.

Ms. Rivera explained that she prefers, for planning purposes, to know at the beginning of the year what the Part A contribution will be, with no additional reductions in the course of the year. The State does not

yet know what its Part B federal allocation will be yet, but she prefers to plan on a stable funding stream from Part A. The total uninsured care pools are funded at around $380M (for medications, primary care and insurance continuation), serving about 26,000 clients. Ninety percent of that goes towards medications (and 80% of that portion for ARVs). With full implementation of the Affordable Care Act, overall expenses are expected to remain stable or possibly decline slightly. A bigger concern is for FY 2015-16, when manufacturer rebates from makers of ARVs will be re-negotiated nationally. In the meanwhile, ADAP, as always, maximizes resources by enrolling clients in Medicaid and other forms of insurance as soon as possible and remains a gap-filling safety net.

In response to a question from Mr. Harriman, *Ms. Rivera* affirmed that ADAP can still accept reprogramming funds that come late in the fiscal year.

A motion was made, seconded and approved unanimously to implement in a reduction scenario a $2,768,244 targeted reduction to ADAP with no promise to restore it in the course of the year, leaving an ADAP/ADAP+ allocation of $15,584,781 for FY 2014, with no further proportionate reduction.

Early Intervention Services (EIS)

Mr. Harriman reviewed how the grantee would implement a $3M reduction to EIS, as recommended by PSRA and the Council in the FY 2014 application spending plan. In FY2013, grantees were required to submit a prior approval request to their HRSA Project Officers justifying the use of EIS program funds on HIV testing. While HRSA ultimately approved the New York EMA's request, they expressed concern that the EMA had overcommitted funds to HIV testing. Specifically, they stated that they believe the city may be oversaturated with testing programs considering the low-positivity rate in both targeted and routine testing programs. CDC officials shared similar perceptions during the Prevention site visit. In addition to recommendations from our federal partners, the implementation of the Affordable Care Act should expand public access to HIV testing opportunities either through primary health care services via private insurance or Medicaid. With the reasonable assumption of a reduction in future awards and the payer of last resort requirement, the Grantee and Planning Council must take these additional resources into consideration. To this end, grantee staff analyzed positivity rates and linkage to care rates for service contracts and compared them to national and local standards. A summary of the entire portfolio of Part A HIV Testing contracts shows a number of contracts that are consistently underperforming in terms of both confirmatory testing (e.g., 0.51% compared to the 1% performance expectations) and linkage to care rates. In some cases, there were programs that did not link anyone to care over the review period of nearly two years. A $3 million dollar reduction would focus resources on agencies that have a proven track record of identifying new positives and linking them to medical care.

Mr. Cordero expressed the opinion that the cuts to EIS need to be even greater than the proposed $3M, given the large number of contracts, the large non-Part A resources for testing, the new state testing law and other factors. A valuable part of the EIS program, such as those doing outreach to homeless youth or providing linkage services to those who know their status but have fallen out of care, needs to be kept. More information is needed to make an informed decision.

This recommendation engendered a lively discussion, which is summarized below:

- EIS is composed of multiple service models and target populations and includes both testing and linkage to care, and so it is difficult to isolate the cost per client.
- The most successful programs have been more focused on identifying those unaware of their status in high prevalence populations, and those that link people to care who have fallen out of care.

- Even with routine testing in medical settings payable through Medicaid and insurance, there are still people marginal to the system (e.g., people who do not make hospital visits, undocumented immigrants) that Part A is needed for.
- The Committee needs to consider, regardless of the amount of the award, whether it is good public health policy to reduce the EIS allocation and target it more narrowly. PSRA approved a reduction in EIS for FY 2014 even in the event of an increase to the award, and in a cut scenario, it needs to decide if this is the first item to be cut in the portfolio. Also, if the cut in the award is less than the targeted reduction to EIS, PSRA will have to consider where to reallocate funds.
- The EMA is required to have an EIIHA (early identification of individuals with HIV/AIDS) strategy, and 33% of the supplemental grant application is based on this. It will be difficult to make the case for supplemental dollars if all Part A EIS programs are eliminated.
- A $3M cut to EIS leaves programs that provide linkage to care and that come closer to the expected 1% positivity rate for testing.
- The EMA can make the case that programs are being right-sized, but we need to drill down to find out what models have higher positivity rates. The DOHMH Director of HIV Testing, Dr. Ben Tsoi, can provide additional data for both Part A and CDC-funded programs.
- Another strategy is to set the bar even higher than that proposed by the grantee for positivity rates and eliminate programs that fall beneath that.
- A high proportion of those found to be positive are young. In addition to performance, the grantee would consider target populations and geographical targets when considering a cut.
- PSRA should re-examine the payer of last resort data for EIS programs.
- Tri-county eliminated their EIS programs because they had a virtual 0% positivity rate. They had to strike a balance in using limited resources finding people who are unaware of their status and serving those who are already known to have HIV/AIDS.

The Committee agreed to continue the discussion at the next meeting with the additional information discussed and with Dr. Tsoi present to answer questions raised in this discussion.

Agenda Item #3: Recommendation to the Grantee on Implementing Reductions

The Committee reviewed a draft letter from the Council to the grantee supporting the grantee in eliminating low performing contracts when making contract-level cuts going forward.

A motion was made, seconded and approved unanimously to forward the letter as presented to the Executive Committee.

The next meeting will take place on Monday, February 3rd, 2-5pm at ASCNYC.

There being no further business, the meeting was adjourned.