Meeting of the

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, February 10, 2017
ASCNYC, 64 W. 35th Street, 3rd Floor
3:15 – 4:30pm

M I N U T E S

Members Present: Matthew Baney (Co-chair), Sharen Duke (Co-chair), Randall Bruce, Amber Casey (for Graham Harriman), Jan Hudis, Jesus Maldonado

Members Absent: Victor Ayala, Joan Edwards, Daphne Hazel, Steve Hemraj, Matthew Lesieur, Amanda Lugg, L. Freddy Molano, M.D., Jan Carl Park, Claire Simon

Other Planning Council Members Present: Billy Fields

Staff Present: David Klotz, Ashley Azor (NYC DOHMH); Bettina Carroll, Gucci Kaloo (by phone) (Public Health Solutions); Julie Lehane, PhD (Westchester Department of Health)

Agenda Item #1: Welcome/Introductions/Minutes

Mr. Baney and *Ms. Duke* opened the meeting, followed by introductions and a moment of silence. The minutes of the December 12, 2016 meeting were approved with no changes.

Agenda Item #2: FY 2017 Scenario Planning

It was explained that the EMA is facing a probable 1-2% reduction in the formula award, as in the last few years, due to the declining national proportion of PLWHA in the EMA (a testament to the relative success of New York in preventing new cases). This may be partially offset by an increase in the supplemental award. A draft scenario was shown with a strict application of a proportionate reduction across all categories based on the ranking scores approved by the PSRA and Council for the FY 2017 application spending plan. The reduction is offset by the $572K that was allocated for close-out of the eliminated Home and Community-based Services category. Some of those funds were needed for restoring an upfront reduction to ADAP, so the saving are closer to $300K.

Ms. Casey described savings from changes to the carrying costs of programs. There is an expected savings of $53K in MCM, $53K in Legal Services (due to applicants of the RFP not requesting the maximum available), and $75K in Health Education & Risk Reduction (due to savings from the move of the programs to community-based providers). This totals an additional $181K in savings. This is a smaller amount than previous years, as the EMA has been doing targeted cuts for years and there is not much room for more. In the event of a 1-2% cut, the remainder of the deficit can possibly be made up through reductions to ADAP and application of the proportionate reductions based on ranking score.

When considering for possible large cuts in future years, the DOHMH Research and Evaluation Unit (REU) is developing measures to see which services are targeting those most in need (e.g., for MCM, people who are not virally suppressed), and which are having the biggest impact on health. There will also be data on where there are overlapping services, so that clients can be transitioned. These measures will help the PSRA and the Council consider further data-driven and strategic targeted reductions in anticipation of possible major cuts in FY 2018 and beyond.

There was a discussion on the possibility of reducing the allocation to ADAP. PSRA will invite ADAP Director Christine Rivera to the March meeting to present on ADAP. Specific questions that the PSRA would want from Ms. Rivera include: projections in Part B funding, trends in ADAP utilization, projected additional costs from adding the hep C DAAs to the formulary, data on the proportion on the budget spent on medication versus insurance support and primary care (all Part A funds pay for medications, 97% of which are ARVs), cost containment plans, and the effect of the elimination of 340B pricing being taken off the table for now.

Ms. Casey will bring data on the threshold that the ADAP allocation would have to reach to trigger lowering the administrative rate for other contractors from 21% to 10%, which may result in losing contractors who cannot afford to run programs at that rate.

The following is a summary of the ensuing discussion:

- The partial award for FY 2017 will allow for five months of funding for programs. If the past few years are any indication, the full award will not come until early summer at the earliest. A Council-approved scenario plan will allow to grantee and Public Health Solutions to immediately fully execute contracts as soon as the full award comes in.
- PSRA should keep in mind that we planned for systems changes that never materialized (DSRIP, Health Homes).
- As more people achieve stability (including viral load suppression), we should consider graduating people from programs so that they can enroll people who have not reached that stage.
- There needs to be qualitative information ("the story") from providers and consumers, in addition to the data that will be provided by REU.
- The strict implementation of the formula reductions were meant in order to avoid horse trading and impassioned pleas. PSRA would need to be mindful of this when discussing larger targeted cuts in future years.
- IOC is looking at the MCM/Care Coordination model, which could mean a shift in eligibility or emphasis, which will help PSRA look at the highest funded category for FY 2018. The program has had excellent outcomes, but is the only category for which that kind of outcome data is available. Additional information on those with stable viral load suppression who return to work would be helpful.

The next meeting is set for March 20th. There being no further business, the meeting was adjourned.