Meeting of the

# PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, February 4, 2013
Cicatelli Assoc., 505 Eighth Avenue, 19th Floor
3:10– 5:05 pm

## M I N U T E S

**Members Present**: Marya Gilborn (Co-Chair), Victor Benadava, Felicia Carroll, Nancy Cataldi, Robert Cordero, Graham Harriman, Peter Laqueur, Julie Lehane (for Tom Petro), Hilda Mateo, Tracy Douglas Neil, Dena Rakower, Allan Vergara, Leonardo Vicente III, Dorella Walters

**Members Absent:** Sharen Duke, Joan Edwards, Amanda Lugg, Deb Marcano, Jan Carl Park, Sam Rivera

**Other Planning Council Members Present:** Randall Bruce, Jerome Payne

**Staff Present**: David Klotz, Anna Thomas, Amber Casey, Rafael Molina (DOHMH); Rachel Miller, Gucci Kaloo, Bettina Carroll (Public Health Solutions);

**Guests Present:** Christine Rivera (NYSDOH); Theresa Galvin (Village Nursing Home); Andresa Person (VNSNY); Mary Poupon (St. Mary's Hospital); Fiona Larkin (HHC)

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

*Ms. Gilborn* opened the meeting followed by introductions. *Mr. Harriman* led a moment of silence in memory of JoAnn Hilger, who passed away on February 1st. JoAnn devoted her life to helping PLWHA. As Ryan White Part A grant administrator for 20 years, she made an immeasurable contribution to the EMA's system of HIV/AIDS care.

The revised draft minutes of the January 14, 2013 meeting were approved with no change.

## Agenda Item #2: NYS ADAP Program

*Ms. Rivera* gave an overview of the HIV Uninsured Care Programs (ADAP, etc.). The mission of the programs is to provide access to care for all New York residents living with AIDS or HIV. Active enrollment in ADAP is currently just under 20,000 after steadily increasing over many years. ADAP clients are about 80% male and over 80% people of color. The number of people with incomes at enrollment over $10,000 has increased in recent years, likely due to the economic downturn. The CD4 count at enrollment has dramatically increased due to the introduction of "test and treat" guidelines, which means that people are accessing medications earlier in their infection. Use of Primary Care services has steadily increased to about 10,000 clients, but the number of users of the Insurance Continuation Program (APIC) has increased dramatically to currently over 4500. 79% of the program

funds are used for medication (of that amount 90% are for ARVs), 12% for APIC, 7.2% for ADAP Plus, 1.4% for operations, and 0.3% for Home Care. 72.4% of enrollees Statewide are in NYC, and 77.7% of expenditures are on NYC clients.

In 2010, NY ADAP received no findings during a targeted payer of last resort audit of 10 large ADAP's by the federal Office of the Inspector General (OIG). OIG also validated program activities to meet the HRSA requirements for twice annual recertification. As a result of those findings, ADAP focused operational assets on coordinating benefits (e.g., moving clients onto other payers such as Medicaid) to maximize resources in response to the potential for cost containment actions. For 2012-13, the program expects to save about $132M through rebates from drug manufacturers, billing insurance and other areas, allowing the program to serve an additional 6,919 enrollees. 50% of program income comes from such recoveries, 34.7% from Part B, 9.8% from the State, and 5.4% from Part A.

About 30% of enrollees move to Medicaid every year. Regarding projections for the future, there is not expected to be a mass exodus to other payers, even with Medicaid expansion and insurance exchanges. Those moving to Medicaid are generally not the heaviest users of the program. Those left on ADAP will be a core of people without other options. In 2014, there will likely be an increase in people able to obtain purchased insurance through APIC, and wrap-arounds will remain an important component of the program.

The HIV Home Care Program provides coverage for home care services to chronically medically dependent individuals as ordered by their physician. The program covers reimbursement for skilled nursing, home health aide services, intravenous therapy administration, medications and supplies and durable medical equipment. There is a $30,000 lifetime cap on covered home care services.
To reduce expenses and expedite service provision, a process called Medicaid Spend down Direct billing was established for Medicaid enrolled home care agencies to bill the program directly for services provided to participants with a Medicaid Spend down. Participants with a spend down who require home care services can have a spend down direct enrolled home care provider collect the monthly spend down amount from the HIV Uninsured Care Programs as long as the cost of the monthly services exceed the monthly spend down amount. In 2012, the Uninsured Care Program spent about $171K for 186 clients on Home Care in NYC, mostly for Medicaid spend-down.

In response to questions from the Committee, *Ms. Rivera* stated that Part B is likely to be cut due to sequestration and hold harmless provisions. The cut in the Part B award could be as high as 10%. Also, there is no State budget yet. For FY 2013, the State has accepted the upfront reduction to be restored through reprogramming. A bigger worry is reauthorization in 2014. Should the Uninsured Care Programs take a large cut, there is a tiered cost containment plan that includes reducing the formulary but maintaining ARV coverage. Severe cuts could result in other changes to services and enrollment. Ms. Rivera will keep the PSRA and Council informed of any potential severe cuts.

## Agenda Item #3: Home Care

*Ms. Gilborn* reminded the Committee that eliminating the lowest ranked service category (Home Care) was discussed as a possibility in the event of a large cut to the award. PSRA asked for more information on that service category. *Ms. Thomas* presented on the category, a summary of which follows:

- The HRSA service category definition for Home Care is services provided in the patient's home by licensed health care workers such as nurses. The NY EMA definition is comprehensive coordinated home-based healthcare, support and service coordination that addresses the full range of client needs (e.g., psychosocial support, respite, child care, assistance with activities of daily living). Some of the NY-defined services are excluded under the HRSA definition.

- The NY EMA ranks Home Care 12th out of 12 priorities, with funding level at $1.5M (about 1.6% of the portfolio). Of other large EMAs, only Washington, DC funds Home Care (ranked 24 of 29 categories).
- Of the 406 active clients (as of February 2012), 65% have CDC-defined AIDS, 57% are over the age of 50, 38% live in Manhattan, 23% each on Brooklyn and the Bronx, 55% are female, 54% are black, 31% Hispanic, 52% women of color.
- Services provided be the four contracted agencies (in various combinations) include: intake and assessment, custodial visits (in-home personal care, cleaning, etc.), supportive counseling, nutritional counseling, psych evaluations and visits, pantry bags, and follow-up visits.
- Units of service are not distributed evenly across the clients in each service grouping, but there are higher numbers of hours of mental health counseling and units of custodial visits than other services. The largest proportion of clients receives nutritional and supportive counseling.
- Other providers of Home Care include HASA, ADAP, RW Part C, various City agencies (e.g., Aging, ACS), Medicaid and Medicare.
- Many of the services provided in the NY EMA programs are provided in other Part A categories, esp. Food & Nutrition, Supportive Counseling, and Mental Health.
- The services currently provided could be reclassified under the HRSA core service category of "Home and Community-based Health Services"

Representatives from the four funded Part A programs spoke about their programs. Highlights are:

HHC (F. Larkin): Services include licensed clinical social workers (LCSW) to provide coordinated care and registered dieticians to provide nutritional counseling. This is the only home-based professional services for HIV+ people. There is also follow-up to insure primary care status measures. A severe cut to or loss of the program would result in gaps in treatment, which could lead to emergency room admissions. ADAP home care has a $30,000 lifetime cap, unlike Part A. Most clients are referred after inpatient admissions. Duration of enrollment is anywhere from 2 months to 5 years depending on the patient. Many have ambulatory or psychiatric problems.

St. Mary's Hospital (M. Poupon): Services include mental health and psychiatric care in the home for patients who can not or will not come to the clinic for services. There is a focus on young adults and adolescents who were perinatally infected.

Visiting Nurse Service of NY (A. Person): VNS has a family support team with an LCSW that deals with the most challenging cases. Services includes custodial (homemaking, child care if the patients are too ill to do those themselves), and other direct services in the home. 90% of the patients are women of color. Without these services, they would be at risk of losing traditional home care. Also, Medicaid will not pay for home-based counseling. This is a "safety net for the safety net", for cases that have not been successful in other programs and models and is a gateway to other services.

Village Care of NY (T. Galvin): Services include home care intake/assessment, AOD and nutritional counseling, pantry bags, and follow-up. Home care was hit hard by Medicaid redesign, making Ryan White more needed than ever to fill gaps. PLWHA are maxed out of Medicaid home care after 120 days and shifted to Managed Long-term Care (MLTC), which is inadequate. There is no substitute for having services provided at someone's bedside or kitchen table. Our services help keep clients in the continuum of care, and without these services, they will be lost to care. We get referrals from Care Coordination programs. CC requires a big commitment from clients, some of whom are not ready for it. Home care clients are lower threshold and include a lot more mental health care.

PSRA members will consider the information presented next week in the continuation of scenario planning for FY 2013.

## Agenda Item #4: Public Comment

*M. Gold*: Without Ryan White home care services, I would not be alive; they have provided me with excellent care. Medicaid forces people into LTMC, which does not meet my needs, such as not providing skilled services and daily wound care. There are still many people who are seriously ill from AIDS and need these services.

*J. Payne*: I agree with the previous comments, adding that some people who do not necessarily meet the medical criteria for "homebound" may need these services.

*Ms. Galvin* invited PSRA members to spend a day at her agency to see how necessary her program is to its clients.

There being no further business, the meeting was adjourned.