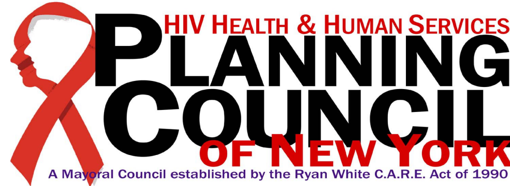

Meeting of the

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, March 10, 2014
AIDS Service Center of NYC, 41 E. 11th Street, 5th Floor
3:20 – 5:00 pm

MINUTES

Members Present: Sharen Duke, Sam Rivera (Co-Chairs), Matthew Baney, Randall Bruce, Robert Cordero, Joan Edwards, Graham Harriman, Jan Hudis, Amanda Lugg, L. Freddy Molano, M.D., Tom Petro, Allan Vergara, Leonardo Vicente III

Other Council Members Present: Billy Fields, David Martin

Members Absent: Nancy Cataldi, Felicia Carroll, Peter Laqueur, Deb Marcano, Jan Carl Park, Daniel Pichinson

Staff Present: David Klotz, Darryl Wong, Anna Thomas, Benjamin Tsoi, MD (DOHMH); Rachel Miller, Bettina Carroll (Public Health Solutions)

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

Ms. Duke and *Mr. Rivera* opened the meeting followed by introductions. *Mr. Klotz* reviewed the meeting packet. The draft minutes of the February 12, 2014 meeting were approved with no changes.

Agenda Item #2: FY 2014 Spending Scenario Planning (Continued)

Early Intervention Services (EIS)

Dr. Tsoi presented additional data on EIS services, based on the discussion at the previous meeting. Reimbursed activities paid for in EIS are: rapid tests; confirmatory tests; linkage to care (with higher rates paid for linkage within 90 days, and lowest rates for navigation activities); and re-engagement to care for those previously diagnosed and fallen out of care. Reimbursement rates are lower for routine testing (as performed in hospitals and clinics), as opposed to testing through social network strategies. Outreach to Homeless Youth (OHY) programs are reimbursed for additional, non-testing activities (e.g., case finding, readiness counseling). In response to a question, Dr. Tsoi noted that DOHMH does not track those who may have tested positive in the past and are retested due to a 9-month lag in reporting to the HIV registry. Reimbursement for EIS is primarily performance-based, with agencies paid higher rates for achieving timely linkage. Only about $400K of the service category allocation was unspent last year.

Non-testing services (e.g., health promotion, accompaniment, referrals) account for 9% of EIS spending. Of testing services, 23% is directly for testing and 67% for additional testing-related activities (e.g., case

finding, readiness counseling). Estimated FY 2013 over-performance for all EIS contracts for rapid tests, confirmatory tests and treatment linkage was $544K, mostly for rapid tests.

Dr. Tsoi provided data on where re-engagement occurs throughout the EIS portfolio (both in testing programs, as well as FSU, OHY, etc.). A total of 256 clients were re-engaged in care in FY 2012, 45% of them in programs that fell below the threshold for positivity rates in their testing component.

Ms. Duke provided a summary table of the data presented the previous meeting, showing that $4,689,755 of the $7.394M of the EIS allocation for testing was spent on under-performing contracts.

Below is a summary of the ensuing discussion:

- As more programs are expected to perform routine testing, the positivity rate will decrease. Differences in positivity rates may depend on the targeted population or neighborhood (e.g., a clinic targeting MSM will have higher positivity rates).
- Ryan White funds should not be subsidizing hospitals to do routine testing. Incentives to develop systems to ramp up testing were acceptable, but with the new testing law, PSRA should reconsider the use of funds.
- As payer of last resort funds, RW only pays for tests for people who are otherwise not covered (e.g., undocumented immigrants).
- The testing law is an unfunded mandate and does not mandate linkage activities.
- Unfunded mandates/providing unreimbursed services are part of the reason that some hospitals have closed.
- Non-testing activities in OHY should be carved out of any cuts.
- FSU is unique because DOHMH is the only entity that has lawful access to the HIV registry to identify people unconnected to care.
- Re/engagement in care is an obligation that all providers should do. There is no need for additional funds to pay for it.
- Under the law, hospitals have supposed to have had routine testing since 2010, but are still not up to standards.
- Unfunded mandates should be paid for. Re/engagement goes above and beyond testing, costs money, can be expensive (especially if a client has to be tracked down), and is not a realistic activity for most hospitals to do.

Mr. Cordero moved that the PSRA cut $4,689,755 (under any funding scenario) from the EIS allocation that now pays for under-performing testing contracts, annualized going forward and pro-rated for this year (FY 2014), given the need to do contract close-outs and pay for services already provided since the beginning of the fiscal year. The grantee should also provide additional analysis to get more data on the category to determine if it is doing what is intended, including case finding and re/engagement. The motion was seconded. The following is a summary of the ensuing discussion:

EIS data is the best we have in the portfolio (along with MCM), and thus gives a skewed view. Once funds are taken away from the category, it is gone for good. There are already discussions about refocusing EIS only on the linkage piece of the treatment cascade, and funds are needed for those activities. If the whole category is gutted the EMA will lose the capacity to do these activities. Output for those getting reimbursed for those activities is already fairly small. PSRA should consider the effect of such a large cut on the grant application, where 33% of the score is based on the EMA's plan to identify and link unknown positives to care.
The HRSA project officer indicated in a call with the Executive Committee that cutting EIS will not hurt the EMA's application score. It takes courage to make this decision, but there is a clearly articulated

rationale for this cut. The $3M cut proposed in the application spending plan was reallocated to new service categories that the IOC and Council approved. Given the timeline for an RFP for those services, this proposal has no plan for reallocating the funds. If the cut to the award is lower than expected or if there is flat funding, PSRA can decide to park the funds in ADAP while deciding how to reallocate it after a final award is known.

A friendly amendment was offered to reduce the cut to $4M to allow for more flexibility. The friendly amendment was rejected.

There was a discussion on the conflicts of interest guidelines. A provider who stands to gain financially from a decision must recuse themselves from a vote, but it is unclear if a provider must recuse themselves from a decision that negatively affects their agency. There was a consensus to allow the vote with all participating, and to clarify the guidelines with the parliamentarian at the EC meeting.

A vote was taken and the motion carried 8Y, 5N.

Home and Community-based Services (HOM)

Ms. Duke distributed a table summarizing the data presented at the previous meeting, which shows the average monthly cost per client at $300, a not unreasonable amount.

There was a consensus to keep the current allocation amount (subject to any proportionate reduction) in order to allow IOC to revise the service category guidance to reduce redundancy in the service model.

There being no further business, the meeting was adjourned.