Meeting of the

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, March 10, 2016
AIDS Service Center of NYC, 64 W. 35th St., 3rd Floor
3:10 – 4:40pm

M I N U T E S

Members Present: Sharen Duke (Co-Chair), Matthew Baney (Co-Chair), Randall Bruce, Joan Edwards (by phone), Graham Harriman, Jan Hudis, Jesus Maldonado (by phone), L. Freddy Molano, M.D., Jan Carl Park

Members Absent: Victor Ayala, Matthew Lesieur, Amanda Lugg, Claire Simon

Other PC Members Present: Billy Fields

Staff Present: David Klotz, Nasra Aidarus (DOHMH); Christine Nollen, Bettina Carroll, Gucci Kaloo (Public Health Solutions)

Agenda Item #1: Welcome/Introductions/Minutes

Ms. Duke and *Mr. Baney* opened the meeting, followed by introductions and a moment of silence. The minutes of the February 8, 2016 meetings were approved with no changes.

Agenda Item #2: Review of Service Categories: Home & Community-Based Services, Mental Health

Ms. Aidarus presented the data on Home & Community-Based Services (HOM). The Ryan White Part A HOM program is defined as: skilled health services furnished in the home of an HIV-infected individual, based on a written plan of care prepared by a case management team that includes appropriate health care professionals. It provides comprehensive, coordinated home-based services include psychosocial support as well as respite for caregivers, childcare during appointments and hospitalizations, and assistance with activities of daily living and household chores. Current contracts, last rebid in 1997, are cost-based. Spending has fluctuated over the past 5 years but has never exceeded 100% of the overall category allocation. Spending was only at 90% in the most recent reported year (FY 2014), mainly due to one contractor severely under-performing because of difficulty meeting payer of last resort requirements. That contractor was put on conditional status.

The Medicaid Redesign Team has set forth a goal of "Care Management for All". This has led to a change from a fee-for-service delivery system to a system where clients requiring >120 days of community based long term care must transition to Managed Long Term Care (MLTC) programs. The state is also has ADAP Home Care and is considering an "MLTC Plus" initiative to enhance care coordination. With a doctor's letter of support, clients can receive expedited enrollment (down from six weeks to seven days) to a MLTC plan (run by agencies such as Visiting Nurses Service and HHC).

The NYC Department of Aging offers home care services for clients over 60 years of age. These services are offered through contracts with case management agencies. They also offer a Long Term Home Health Care program and a Expanded In-Home Service for Elderly program. HASA offers home visits, home care and homemaking services for HIV symptomatic clients. The ADAP Home Care Program provides coverage for home care services to chronically medically dependent individuals such as: skilled nursing, home health aide services, medication, supplies, and medical equipment when ordered by a physician.

A summary of points raised in the ensuing discussion include:

- The template (service directive) for this category, created in 1996 when the entire Part A portfolio was re-bid, is for a medical-based home health care service. As the need for this kind of service declined and the service evolved into the current range of services, the Council re-classified the service as Home and Community-based Services.
- Re-bid of HOM was held off for this year because the grantee wanted to see what the Council would decide concerning this category. Several years ago, the PSRA considered eliminating the category, but backed down after impassioned pleas from a small number of consumers and providers.
- The bulk of service types are delivered under other categories (home-based psychiatric services in Mental Health, food delivery in Food & Nutrition).
- The one service type where it is unclear whether or not they are covered in another category is custodial visits. In FY 2014, there were 26 clients in two programs who received this service. While this service is provided by other payers, the clients in these programs would not be Medicaid eligible due to payer of last resort requirements.
- As there is already an infrastructure for these services (including the State's program and the new Part A MH RFP), it would be more cost effective to expand existing services to accommodate the clients served in this category. Transitioning clients to performance-based programs will also give the grantee a better sense of how must it costs to provide these services.
- Eliminating the category would free up funds for emerging needs, including those identified in the recent Needs Assessment Community Briefing (hepatitis C, housing).
- The Council may want to consider the needs of a possibly growing cohort of elderly and frail long-term survivors who will require custodial in-home assistance with daily living as they age.

The grantee and master contractor will drill down for more data on the 26 clients who receive custodial visits and bring that data to next month's meeting.

Ms. Aidarus presented the data on Mental Health Services (MH). The Ryan White Part A MH Program offers comprehensive mental health programs in health centers and community-based organizations that are co-located with HIV primary care services or have established linkages with HIV primary care providers. Services may also be provided in the home, as necessary, to meet a client's needs. The MH portfolio is currently out for rebid with new contracts to start in mid-2016. These programs will include in-home services (which are not Medicaid reimbursable). Also, the service model has been re-tooled by IOC to focus heavily on other non-Medicaid reimbursable services, such as MH readiness and accompaniment.

Mental Health has consistently underspent and the portfolio of contracts has been right-sized over the past several years. Spending performance has fluctuated over the past 5 years but has never exceeded 100% of the overall category allocation.

NYC DOHMH offers outpatient and psychiatric services as part of their Community Health Centers regardless of ability to pay or immigration status. NYC HHC offers emergency psychiatric services, treatment for mental illness and support for clients recovering from substance use. The NYS Office of Mental Health offers the PACT (Program for Assertive Community Treatment) program that provides

psychiatric and general health care, supportive therapy, and resources to help client manage symptoms of their illness. This funding also covers anti-psychotic and anti-depressant medications. The NYS AI offers similar services as well as specialized services for women, children and adolescents. ADAP Plus through NYS AI covers MH treatment in the context of HIV primary care. An eligibility requirement for mental health programs is to be Article 28 or 31 certified so they can bill allowable services to Medicaid.

A result of healthcare reform has been the large push to integrate behavioral and primary healthcare services. This aim has been reflected as the Affordable Care Act (ACA) established Health Homes, Medicaid expansion, as well as through incentives in the Delivery System Reform Incentive Program (DSRIP). Additionally, Health and Recovery Plans (HARPs) began enrolling clients in plans in October 2015.

Agenda Item #3: Reprogramming Enhancement Cap

Ms. Duke explained that the Finance Committee has asked PSRA to revisit the 15% cap on enhancements to programs through reprogramming. These enhancements are one-time within the fiscal year and do not change the allocations in the spending plan. Currently, any enhancements over the 15% cap needs to be brought to the Council for approval, and as timing is critical (PHS generally needs 4-5 weeks to complete the closeout process and prepare final spending reports), this is usually not possible. Historically, only two categories have performed above 15% of their original allocation: Legal and Supportive Counseling (SCF). As SCF is being re-bid this year, it will not likely over-perform in the current year. A 20% cap would still maintain the Council's checks and balances on the service category amounts.

Mr. Kaloo described the process for doing enhancements (first within the service category, then between categories, while keeping a balance across the portfolio). He noted that as the formula award trends downward, the grantee and master contractor can use the greater flexibility to keep under-spending rate as low as possible.

A motion was made and seconded to raise the cap on enhancements in the reprogramming plan to 20%. As there was no longer a quorum, the motion was tabled until the April meeting, when a draft reprogramming plan will be presented.

The next meeting will take place on Monday, April 11, 2016, 3-5pm at ASCNYC.

There being no further business, the meeting was adjourned.