



Meeting of the
PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, March 9, 2015
AIDS Service Center of NYC, 65 W. 35th St., 3rd Floor
3:10 – 5:00 pm

MINUTES

Members Present: Sharen Duke (Co-Chair), Matthew Baney (Co-Chair), Victor Ayala, Randall Bruce, Joan Edwards, Graham Harriman, Jan Hudis, L. Freddy Molano, M.D., Jan Carl Park, Tom Petro

Other Planning Council Members Present: Altirik Harper

Members Absent: Steve Hemraj, Harry Jackson, Matthew Lesieur, Amanda Lugg, Jesus Maldonado, Lazara Paz-Gonzalez, Daniel Pichinson, Sam Rivera, Lyndel Urbano

Staff Present: David Klotz, Anna Thomas, M. Bari Khan (DOHMH); Bettina Carroll, Lauren Feldman-Hay (Public Health Solutions)

Guest Present: Christine Rivera (*NYSDOH*)

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

Ms. Duke and *Mr. Baney* opened the meeting, followed by introductions. *Mr. Park* led a moment of silence. The draft minutes of the January 12, 2015 meeting were approved with no changes.

Agenda Item #2: ADAP Update

Ms. Rivera gave an update on the uninsured care programs (ADAP, ADAP Plus, Insurance Continuation and Home Care). The ADAP program has added a fifth component using State funds to pay for PrEP. Highlights of the presentation are:

- Active enrollment statewide at the end of February 2015 was 19,302 (down from a high of 20,500 in Nov. 2012). There are about 26,000 active users per year in NY State. 2014 saw the lowest number of new enrollees (2,783) since 1989. In 2014 there were 13,247 active enrollees.
- Home Care use has shrunk considerably over the years, while insurance continuation use has grown markedly.
- New York City enrollees comprise 72.6% of the State's enrollment and 78.1% of expenditures.
- The average CD4 count of ADAP enrollees has increased, with a growing percentage >500 or >200. They now make up about 80% of ADAP enrollees. This is partially likely due to the change in clinical guidelines to treat early).

- A high proportion of ADAP enrollees move onto Medicaid, and there is a growing number who are insured. Many are in a transition period (e.g., eligible for insurance, but missed the open enrollment period).
- The first year of the ACA left many confused and some falling through the cracks in the exchange plans (e.g., some plans required a change in primary care provider). As challenges with insurance coverage decrease, a growing number will be successfully insured.
- The overwhelming majority (81%) of the program budget pays for ADAP (medications). The Part A contribution is a big part of the ADAP+ (primary care) program, but relatively a small share of the ADAP portion.
- Of active enrollees, 96.5% had at least one doctor visit and lab test, 92% were in continuous care (two or more visits/labs 90 days apart), and 88% had an undetectable viral load. There was speculation among some committee members that this high number is due partially to the population being more compliant (“pill takers”).

There was a lengthy discussion of hepatitis C medications. The number of hep C co-infected ADAP clients is not known (it could range from 14% to 50%), but Ms. Rivera estimated that the cost of providing the new hep C medications to all eligible ADAP enrollees would total over \$6M per year, which is \$30K/month for the course of treatment (after the discount negotiated with the drug companies). This makes it unfeasible to be recommended for addition to the ADAP formulary at this time. It is currently easier for clients to get into the companies’ patient assistance programs (which enroll the undocumented). For higher income individuals whose insurance plans do not cover the new medications, ADAP and Medicaid are not available, and the co-pays for patient assistance programs can be prohibitive. *Mr. Park* reported that NYC DOHMH has received some new City funding for new hep C initiatives. National advocacy for a federal Ryan White-type hep C program is needed, or other strategies (such as pursuing generics in foreign countries). Fewer than 200 ADAP enrollees are currently using the older hep C treatment, possibly because many are waiting for access to the new, less debilitating treatment.

Mr. Baney raised the issue of clients at Designated AIDS Centers (DACs) who face service disruptions after enrolling in a State insurance exchange. *Ms. Rivera* said that ADAP works to coordinate benefits and minimize interruptions.

Agenda Item #3: Service Category Report Cards

Ms. Feldman-Hay presented the revised 2011-13 Service Category Report Cards. The Scorecards use data collected through eSHARE, the DOHMH Research & Evaluation Unit, and Public Health Solutions’ fiscal data. It is easier to get unique client counts with eSHARE and to cross reference with the DOHMH registry. Also, incentives for fee-for-service contracts keep service data clean. In FY 2013, the NYC portion of the EMA spent \$85.2M for programs and served over 72,000 clients (54,000 of those for testing services and about 17,000 HIV+ clients). Over 850,000 units of service were provided (a large proportion of which was in Food & Nutrition Services). Changes in the new version of the Scorecards include: combined Base/MAI cards for Housing Placement, which receives funding from both funding streams; splitting MAI housing into separate cards for transitional and housing placement; changing the homeless definition to include the unstably housed. One artifact of the change in data collection from AIRS to eSHARE is that Rikers Island program participants are entered as homeless.

The new Scorecards reflect the huge 14.75% cut in the grant award for FY 2013. Service projections were decreased for all categories, but in some cases programs did not reduce their units of service as much as the projections. For some categories (e.g., FNS), this is because they received enhancements for over-performing during the year. Other programs might have either found other resources to provide services, or

asked their staffs to perform more. DOHMH did a survey on the effects of the cut, which was presented to the Council.

Ms. Feldman-Hay reviewed the data on a sample Scorecard (for Supportive Counseling), which includes spending data, units of service, primary care status measures (PCSM), unduplicated client counts and client demographics by age, gender, race/ethnicity and special populations. A summary of the discussion follows:

- The Scorecards are used by the PSRA in planning as a data point for considering ranking scores, particularly for the Access to Care/Maintenance in Care and Emerging Needs/Gaps criteria.
- While collecting PCSM data is useful (and helps providers improve their efforts to encourage connection to primary care), it is hard to say that a specific category is the factor that leads to improved PCSM outcomes, except for Care Coordination. Data on the proportion of clients who are virally suppressed would help.
- As PSRA is focused on resource allocation, the Scorecards do not present the “story” of how the service categories provide services and improve quality of life and health outcomes. This story is presented more fully to IOC, and is available in reports such as the grant application and progress reports.
- The number of Transgender clients is captured under Clients by Gender tables and should not be lumped in with MSM clients (this conflates gender identity and sexual orientation).
- Data on undocumented individuals is not collected and thus not available.
- Other EMAs have been extremely impressed with the Scorecards and are looking to emulate them.

At the next meeting, PSRA should begin looking at the service categories that IOC is revising (EIS/Linkage to Care, Legal). Cross collaboration would help, particularly as IOC figures out the price tag for the revised service directives.

There being no further business, the meeting was adjourned.