Meeting of the

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, April 18, 2016
Cicatelli Associates, 505 Eighth Avenue, 20th Floor
3:10 – 4:55pm

M I N U T E S

Members Present: Matthew Baney (Co-Chair), Victor Ayala (by phone), Randall Bruce, Graham Harriman, Daphne Hazel, Steve Hemraj (by phone), Jan Hudis, Matthew Lesieur, L. Freddy Molano, M.D., Jan Carl Park, Claire Simon

Members Absent: Sharen Duke, Joan Edwards, Amanda Lugg, Jesus Maldonado

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

Agenda Item #1: Welcome/Introductions/Minutes

Mr. Baney opened the meeting, followed by introductions and a moment of silence. The minutes of the March 10, 2016 meetings were approved with no changes.

Agenda Item #2: FY 2016 Reprogramming Plan

Mr. Baney presented a revised FY 2016 reprogramming plan with the new 20% cap on enhancements, as approved by PSRA at the March 10th meeting. All other aspects of the plan remain the same: The grantee would have the latitude to shift funds between service categories in order to enhance contracts that are performing above or show potential to perform above the maximum reimbursable amount. No service category will be enhanced by more than 20% of its original allocation in the spending plan, unless the Council approves an increase above 20%. ADAP will be included as a category for enhancement after all other service categories have been considered for enhancement. ADAP will not be subject to the 20% cap on enhancements.

There were questions about how DOHMH and Public Health Solutions make enhancements (first keeping funds within the service category, then applying percentage increases across categories as eligible). It was noted that contractors who over-perform are not guaranteed enhancements and thus do not budget beyond the amounts in their contracts.

A motion was made, seconded and approved unanimously to accept the reprogramming plan as presented.

Agenda Item #3: Update: Home & Community-Based Services/Custodial Visits

Ms. Aidarus, as a follow up to the previous meeting, reported that of the 23 clients who receive custodial visits under the HOM programs, 21 are insured (18 through Medicaid). She presented a comparison of

HOM custodial visits (home assistance with activities of daily living, escort to medical appointments and essential services, homemaker services to provide chore services to provide support to the family), and Medicaid Long Term Managed Care (personal care – help with bathing, dressing and grocery shopping, and other services, home delivered meals, personal emergency response, transportation to medical appointments). In addition, ADAP Home Care is available for the uninsured.

In the ensuing discussion, the following points were raised:

- There is no requirement for skilled nursing in the personal care services through LCMT.
- There is a policy to transition any clients of Part A programs that end so that there is no interruption in service, and this must be documented.
- There is a 20-day median stay in HOM programs.
- Enrollment in LCMT is being handled through a vendor called Maximus, who is required to have an assessment of a client within 7 days.

Mr. Baney noted that any formal decision on funding for HOM will be made later in the planning cycle when PSRA develops the FY 2017 application spending plan.

Agenda Item #4: Medical Case Management

Ms. Aidarus presented the data on Medical Case Management (MCM), which is divided into two distinct programs: Care Coordination (CC), and Transitional Care Coordination (TCC). The Ryan White Part A CC program provides Medical Case Management services according to the Care Coordination Program Manual, including treatment adherence support, health promotion, care navigation and home visits. CC consistently underspent in its early years, but the portfolio of contracts has been right-sized over the past several years. Spending performance has fluctuated over the past 5 years and only exceeded 100% of the overall category allocation in Year 23 which was the year we received a large reduction to the RW awards.

The ACA created an optional Medicaid State Plan benefit so states could establish Health Homes. In NYS, Health Homes coordinate care for persons who have chronic conditions. This integrates coordination for primary, acute, behavioral health and long-term services intended to treat the whole person. Eligibility requirements for MCM programs are specifically HIV treatment adherence related which is not the case for Health Homes. An average of the clients and service units for each service topic from FY 2011 to Feb 2016 was presented. Total number of (unduplicated) clients in FY 2015 was 8,606. Number of units of service was 1.7 million.

NYS AIDS Institute offers a family-centered case management for women and their families. This includes services such as housing placement, child care, linkages, mental health services, legal services and crisis intervention. The NYS Department of Health offers several case management programs (e.g., SNPS Case Management, Hospital-based case management, etc.). The NYS Office of Mental Retardation & Development Disabilities offers comprehensive case management and service coordination for those eligible.

Ms. Aidarus presented the data on TCC, which provides stabilizing case management for homeless and unstably housed individuals. Spending performance has really been good over the past 4 year; mostly over performance. 2011 was the first year of TCC contracts and the category underspent. Category over performed in Year 23 -109%. The category was increased by 9%, the full amount of the over performance. Category over performed in Year 24 -114.98%. The category was increased by just below the 15% cap.

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eligibility requirements for MCM programs are specifically HIV treatment adherence related which is not the case for Health Homes.

An average of the clients and service units for each service topic from FY 2011 to Feb 2016 was presented (3,590 unduplicated clients in FY 2015, 17,667 units of service). The NYS Office of Mental Retardation & Development Disabilities offers comprehensive case management and service coordination for those eligible.

The following were points raised in the ensuing discussion:

- The population served by MCM is different that Health Homes. MCM has specific medical criteria in additional treatment adherence support. MCM also has limitations on the number of clients. Health Homes' model is very general and not specific to the population served in MCM, thus there is little overlap between clients.
- It is difficult to break out the State's client in NYC to see who pays for each individual's services and where they are delivered.
- DOHMH is increasing its capacity to match MCM data with Medicaid data to get clearer patterns of utilization.
- MCM offers an impressive constellation of services using a rigorous protocol.
- Outcomes data have been presented to the Council previously, but an update at the next PSRA meeting is warranted, along with a cross-map with other programs.
- Data in e-Share on viral load and CD4 for MCM can be matched very directly to the services provided, unlike for most other service categories.
- Average cost per client cannot be inferred from the number of clients and number of service units, as there is great variation between the types and number of services that clients receive, depending on the intensity of services they require.

Agenda Item #5: Data Questions for ADAP

Mr. Baney explained that ADAP Director Christine Rivera will present at the next meeting, and asked for a discussion on any data points that PSRA would like her to address, in addition to her usual presentation on service utilization and trends.

Points raised by the Committee included:

- The number of people enrolled in each of the ADAP component parts and the amounts paid for in different parts of the program (ADAP, ADAP+, Home Care, Insurance Continuation)
- Ways to help people co-infected with HCV, including assistance in enrolment in patient assistance programs
- Paying for HCV testing (including rapid tests)
- The effect of ACA eligibility on ADAP (including the number of people who have gained insurance through an exchange and had to return to ADAP due to inability to pay premiums and co-pays)
- Information on ADAP's outreach component (esp. regarding insurance premium and co-pay assistance)

It was noted that a PrEP program that is housed in ADAP does not use Ryan White funds.

The next meeting will take place on Monday, May 9, 2016, 3-5pm at ASCNYC.

There being no further business, the meeting was adjourned.