Meeting of the

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, May 9, 2016
ASCNYC, 64 W. 35th Street, 3rd Floor
3:05 – 5:00pm

M I N U T E S

Members Present: Matthew Baney (Co-chair), Sharen Duke (Co-chair), Victor Ayala, Randall Bruce, Joan Edwards, Graham Harriman, Daphne Hazel, Steve Hemraj (by phone), Jan Hudis, Jesus Maldonado, L. Freddy Molano, M.D., Jan Carl Park, Claire Simon

Members Absent: Matthew Lesieur, Amanda Lugg

Other Planning Council Members Present: Billy Fields, John Schoepp, Lisa Zullig

Staff Present: David Klotz, Darryl Wong, Amber Casey, Stephanie Chamberlain, Mary Irvine, PhD, Jennifer Carmona (DOHMH); Christine Nollen, Gucci Kaloo (Public Health Solutions); Christine Rivera (NYSDOH)

Agenda Item #1: Welcome/Introductions/Minutes

Mr. Baney opened the meeting, followed by introductions and a moment of silence. The minutes of the April 18, 2016 meeting were approved with no changes. *Mr. Klotz* noted that there will be two meetings in June (6/6 and 6/13) and one more in July (7/11) in order to complete the planning cycle and develop a spending plan for the FY 2017 grant application.

Agenda Item #2: ADAP Update

Ms. Rivera presented on the NYS HIV Uninsured Care Programs: ADAP (medications), ADAP+ (primary care), Home Care, APIC (insurance continuation), and PrEP Assistance Program (the newest element, solely funded out of State dollars, as Ryan White funds cannot be used for prevention). Part A funds only go towards ADAP and ADAP+. For PrEP AP, there is $1M is allocated (at about $1,500/client) and $80,000 spent for 453 enrollees (after over 50 promotional presentations). Currently only lab testing and primary care visits are covered, not the Truvada prescriptions. It will be around a year and a half before it is fully scaled up. Enrollees are mostly uninsured and are younger (mostly under 35) than other ADAP clients (mostly over 50). NYSDOH is looking at why more Blacks are not enrolled.

Since 2014, there was a slight drop of 1,000-1,500 in active ADAP enrollment (virtually all enrollees in ADAP+ and APIC are also enrolled in ADAP, so this can act as a proxy for the entire program) due to access to the essential health plan for people under 200% of federal poverty level. There is little utilization of Home Care (which provides clinical services, and personal care services only if clinically ordered) – mostly for spend down so they can be enrolled in Medicaid. There was a slight downtick in primary care utilization and expenditures, likely due to increases in insurance coverage (also possibly due to less frequent usage due to successful viral suppression). There was a slight decrease in 2014 in APIC

enrollment, but growth is expected through a myriad of coverage (private insurance, exchange plans, COBRA, etc.). As long as coverage is cost effective as providers participate, APIC will pay for premiums).

Most enrollees in all programs continue to be male and people of color. There was a slight increase in client with mid-range CD4 counts. The vast majority of clients and expenditures are in NYC. Terminations in enrollment are usually due to death, lost to follow-up, moved out of state, or moved onto Medicaid. In previous years, 25% of enrollees moved quickly onto Medicaid. With ACA plans and Medicaid expansion, in 2014-15 there was a smaller group passing through. As it takes time to get insurance and get comfortable using a plan, ADAP still has group of people in transition, moving through to an exchange plan using navigator. There will always be a core group of people ineligible for any other coverage.

77% of all program funds are used for ADAP (which has a huge formulary - 500+ drugs). 93% of drug expenditures are for ARVs. The largest source of funds is from recoveries (back billing insurance and rebates from drug companies). Part A dollars (~$15M) fund only 4.3% of all programs (down from a peak of 25%), and the State contributes 10%. NYSDOH is doing a match with State surveillance data to gather CD4 and viral load statistics and ADAP is doing very well with VL suppression , especially with people who are continuously active in program (it is harder to tell with the significant number of people who cycle in and out of program).

The program conducts many outreach and education activities, receives over 100,000 calls/year on the hotline, did 100 presentations (not including PrEP forums), and hundreds of other presentations. Over 1,000 people enrolled through those activities.

NYSDOH is asking the Council to leave the Part A allocation the same. The possibility of Ryan White reauthorization is a big threat, as it could move vast resources to the south. The program is currently able to get full a rebate on co-payment claims, which has helped to keep the budget solid and prevent waiting lists, but changes to regulations could means dramatic cuts in 2018. There is a significant increase in Part B supplemental funding due to Part B carry-over. NYS received $23M this year, and next near could get $30M. Concerning direct acting agents (DAA) for hepatitis C, once one manufacturer comes to table, NYSDOH can negotiate coverage for all DAAs. The program is also adding a full time patient navigator for patient assistance programs for HCV treatment. Ms. Rivera is cautiously optimistic that DAAs will be added to the formulary. Other states are not seeing large utilization of DAAs.

Ms. Rivera advised the EMA to wait to set up a local pharmaceutical assistance program (LPAP). A second tier access system in NYS that provides the same access as ADAP would be expensive to run, and she is optimistic that the formulary will expand. ADAP is already providing all the clinical services for HCV/HIV co-infected people. It would be more cost effective for Part B to cover DAAs, as they have access to discounts. Also, clients would have consistent access to the same pharmacy.

Ms. Duke noted the challenges of flat funding for Part A and the inability to fund new initiatives. Ms. Rivera, in response to a question from Mr. Baney, stated that if the EMA earmarked Part A funds for ADAP to pay for DAAs, there would be a cost similar to a pharmacy administration expense (if Health Research Inc. approved that arrangement). *Mr. Harriman* pointed out that ADAP does not use any Part A administrative funds, which allows other Part A providers to use 12% for administration. Reducing the ADAP allocation would mean lowering the administration cap for all other programs to 10%. Also, ADAP/ADAP+ are the top two ranked service categories, and the Council should think about how a reduction would be discussed in the grant application. *Ms. Rivera* added that while there is some small reduction in enrollment, it is important to have resources, especially for primary care, for which there is not much Part B funding. Also, in response to a question from Mr. Ayala, she stated that it is always better for a client to have Medicaid, as it pays for comprehensive medical coverage, including all non-HIV health

care needs. In response to a question from Mr. Maldonado, she replied that ADAP does not fund transportation, but has contractors that assist people to apply for programs that provide transportation.

The Committee thanked Ms. Rivera for her presentation.

Agenda Item #3: Care Coordination Outcomes Data

Ms. Chamberlain presented data on the CHORDS study, a research partnership between DOHMH and the CUNY School of Public Health to measure outcomes of the Medical Case Management Care Coordination Program (CCP) program. She briefly reviewed the CCP goals, model and population, and showed the geographic distribution of programs. The aim of the CHORDS is to assess short and long-term CCP effectiveness by comparing care engagement and VL suppression among CCP participants with those of similar PLWH in HIV care who do not receive the CCP intervention by matching CCP programmatic data (eShare) with NYC HIV Registry data (laboratory VL and CD4 tests, HIV diagnostic events). Of the 7,058 CCP living clients enrolled on or before March 31, 2013, 5,941 who were previously diagnosed on enrollment and were looked at as the study population. Statistical measures were: Engagement in Care (EiC): ≥2 CD4 or VL tests ≥90 days apart, with ≥1 in each half of 12-month period; and Viral Load Suppression (VLS): VL≤200 copies/mL on most recent test in second half of 12-month period. The study measured estimated post- vs. pre- CCP enrollment relative risks (RR) for EiC and VLS. RR is defined as how much better off people were as a client in a CCP compared to PLWHA who are not enrolled in a CCP.

The study also looked at the following psychosocial barriers and the reduction of those barriers: 1) unstable housing (homelessness or residence in temporary/transitional housing); 2) lower mental health functioning (Mental Component Summary score ≤37.0 on the functional MH assessment); and 3) recent hard drug use (self-report of using heroin, cocaine, methamphetamines, or prescription drugs to get high in the past 3 months). 52% of CCP enrollees had at least one barrier. In response to questions from PSRA members, it was explained that alcohol was not included due to the difficulty of measuring the amounts used.

Key results of the study included:

- An increase among those previously diagnosed who are engaged in care from 70% to 91% 12 months post-CCP enrollment.
- An increase among those previously diagnosed who are virally suppressed from 30% to 54% 12 months post-CCP enrollment.
- The longer clients were enrolled, the better their outcomes.
- Improvements in the RR for EiC and VLS of CCP clients for those with any psychosocial barrier post-enrollment.
- Barrier reductions post-baseline (15% unstable housing, 48% MH, 36% hard drug use).
- In a comparison with the control group of similar PLWHA from the surveillance registry, it was found that at 12 months follow-up, CCP clients had far greater improvements in EiC (84% vs. 49%) and VLS (88% vs. 51%).

Conclusions from the data are: 1) Significant EiC/VLS increases occurred in all subgroups examined, including those with key barriers to HIV care and treatment adherence; 2) findings suggest a link between support to reduce psychosocial barriers and greater improvement on 12-month EiC/VLS outcomes; 3) CCP shows promise for increasing health/survival opportunities among those at highest risk for suboptimal HIV health outcomes; 4) In short-term (12-mo.) comparisons of CCP clients' post-enrollment EiC and VLS to the EiC and VLS achieved among other, similar PLWH, the CCP demonstrates effectiveness at increasing EiC and VLS overall, and evidence of CCP effectiveness over usual care suggests the public health value of intervention scale-up, focusing on PLWH with the greatest need, lowest engagement in care.

Ms. Chamberlain also noted that the study will continue, including identifying individual and CCP site-level determinants of care engagement and VL suppression up to 36 months following CCP enrollment; and assessing the cost-effectiveness of the CCP relative to usual care outside the CCP, considering downstream cost-savings and individual and public health benefits due to improved VL suppression and HIV infections averted

In the ensuing discussion, the following points were raised:

- More detailed analysis is needed to determine which CCP elements (e.g., patient navigation, treatment education, etc.) have the greatest effect on client outcomes.
- More analysis is needed to determine how length of enrollment and intensity of services (i.e., tracks) affects outcomes.
- When looking at clients with multiple psychosocial barriers, those who received CC were even more likely to improve EiC and VLS the longer they were enrolled in CCP.
- Human resources-related and qualitative data from providers will be helpful (e.g., effect of turnover of navigators).
- It is difficult to control for clients who are enrolled in other programs, but the study is looking at similar people, and so it is fair to say that CCP contributes to improved outcomes. Eventually, the study will be able to control for enrollment in other Ryan White programs.

The next two meetings will take place on Monday, June 6th and 13th, 2016, 3-5pm at ASCNYC.

There being no further business, the meeting was adjourned.