Meeting of the

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, July 21, 2014
AIDS Service Center of NYC, 85 University Pl., 5th Floor
2:15 – 5:00 pm

M I N U T E S

Members Present: Sharen Duke (Co-Chair), Matthew Baney, Randall Bruce, Joan Edwards, Graham Harriman, Jan Hudis, Deb Marcano, L. Freddy Molano, M.D., Jan Carl Park, Julie Lehane (for Tom Petro), Allan Vergara

Other Planning Council Members Present: Billy Fields, David Martin

Members Absent: Felicia Carroll, Nancy Cataldi, Robert Cordero, Amanda Lugg, Peter Laqueur, Daniel Pichinson, Sam Rivera, Leonardo Vicente III

Staff Present: David Klotz, Nina Rothschild, John Rojas, Anna Thomas (DOHMH); Bettina Carroll, Gucci Kaloo (Public Health Solutions); Christine Rivera (NYSDOH, by phone)

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

Ms. Duke opened the meeting. The draft minutes of the July 9, 2014 meeting were approved with no changes.

Agenda Item #2: ADAP Update

Ms. Rivera gave an update on the ADAP program, answering some specific questions from PSRA members. In response to a question from Mr. Baney, Ms. Rivera stated that, for almost all ADAP clients who have another form of coverage, ADAP is secondary. There were some snafus with pharmacies at the beginning of the exchanges, but those have been smoothed out. She said that any further problems with Designated AIDS Centers should be brought to her off line. In response to a question from Mr. Park, Ms. Rivera reported that the AIDS Institute is working on a local and national level to resolve issues with mail order pharmacies. Also, Gilead has not been as responsive as a national coalition would like on lowering the price of new hepatitis C medication, but has patient assistance and co-pay help programs.

Regarding ADAP needs for the next year, Ms. Rivera stated that, while they are still doing an analysis of the implementation of ACA health insurance exchanges, there have been no substantial savings yet to ADAP from that or from expanded Medicaid. Weekly and monthly enrollment have stayed stable, and about half of the ADAP clients projected to transition to expanded Medicaid have done so (1200 out of 2000 eligible). This may change, but for FY 2015, the Part A contribution to ADAP should remain stable.

The Committee discussed asking Ms. Rivera to query DACs to assess whether there have been breaks in services or medication due to client enrolment in State health insurance exchanges.

A motion was made, seconded and approved unanimously to maintain the FY 2014 carrying cost for ADAP into FY 2015 with no upfront reduction.

Agenda Item #3: FY 2013 Carry-over Plan

Mr. Klotz presented the FY 2013 carry-over plan, based on the preliminary carry-over request approved by PSRA and the Council in December 2013. $615,731 in base carry-over and $5,669 in MAI will mostly go to ADAP. As presented by Dr. Lehane, this includes the Tri-county (TC) portion of the Base carry-over, of which $10,903 goes to Housing and $35,312 goes to Medical Transportation in the TC region.

A motion was made, seconded and approved unanimously to approve the carry-over request as presented.

Agenda Item #4: Home and Community-based Services Directive

Dr. Rothschild presented the new service directive for Home and Community-based Health Services (HOM), approved by the Integration of Care Committee (IOC) after a lengthy process. The goals of the service are: provide comprehensive, coordinated home and community based healthcare, support and service coordination that addresses the full range of needs of PLWH and facilitates continued engagement in medical and psychosocial care and treatment and aims to enhance the quality of life; and reduce the number and length of hospitalizations and nursing home placements of PLWH. Objectives are: increase proportion of newly diagnosed individuals who enter primary care within 3 months of diagnosis; increase retention in HIV care and treatment; increase proportion of clients with optimal level of ART adherence; increase viral suppression; improve immunological health; decrease reliance on acute care; reduce socio-demographic differences in delayed diagnosis of HIV; reduce socio-demographic differences in prompt linkage to HIV care after diagnosis; reduce socio-demographic differences in retention in primary medical care; and reduce socio-demographic differences in viral suppression.

Required components of the service are: HIV treatment education; assistance with medication adherence; client engagement activities to schedule program appointments, coordinate services, and maintain connection to primary care; advocacy services to assist with navigation of home care resources and address any grievances that may arise regarding home care, regardless of payer; outreach for re-engagement to monitor scheduled appointments and follow-up on a client's missed appointments; psychiatric evaluation and visits; individual and family supportive counseling; substance use counseling; homemaking/chore services (includes child care); home health and personal care services/assistance with activities of daily living; skilled nursing services; home intravenous and aerosolized drug therapy; provision of durable medical equipment; physical therapy; occupational therapy; speech therapy; independent living skills; nutritional counseling and emergency food provision; and respite for caregivers, childcare during appointments and hospitalizations (the agency determines how to provide this, e.g., a babysitter or use of a child care facility). An optional component is use of a multidisciplinary team, including peer-delivered services, as some clients may initially consider home-based services an intrusion and a peer can facilitate willingness to accept services.

Client eligibility is: individual and family units with one or more HIV+ persons; active substance use does not preclude eligibility for and maintenance in services; household income less than 435% of FPL; client lives within NY EMA; and (unique to this category) clients with physical, behavioral, psychosocial, or sensory impairments limiting them from presenting to an office location. Some clients may be able to leave home, but require the assistance, for example, from a home health aide.

Agency eligibility is: organizations must have experience serving HIV+ individuals and experience reaching out to and engaging individuals who are out of care or sporadically in care, transitioning from institutional care, or in need of self-management support; agencies must be co-located or have linkages with programs providing medical and psychosocial support services, Medicaid, Medicare, NYS Health Insurance Exchange Systems, and Health Homes; must have the capacity to bill Medicaid for Medicaid-billable home based

services or be in a contractual relationship with an agency that can bill Medicaid; must ensure that staff have HIV knowledge, training and cultural sensitivity and must be able to provide services in languages of populations served; and must have the capacity to provide services to clients with physical, behavioral, psychosocial, or sensory impairments limiting them from presenting to an office location. Although any individual agency does not have to serve clients from all five boroughs, funded agencies should be accessible to clients from throughout the New York EMA.

Differences with the existing model are: the new directive allows funded agencies to offer advocacy services to assist with navigating the home care system and address objections/ complaints regarding home care, irrespective of payer; allows funded agencies to include peers as part of a multidisciplinary team for providing services; addresses the issues of clients with sensory impairments; and requires co-location or linkages with programs providing NYS Health Insurance Exchange Systems and Health Homes.

IOC Committee has recommended that funding for this category for next year remain the same as for current year. Mr. Park pointed out that, while the number of unduplicated clients has decreased substantially (from 592 in FY 2010 to 325 in FY 2012), for those who need it, it is a vital service not available through other payers. Also, the need could grow as the HIV population ages. This directive refines the model and recommends that is continue for several years in order to reassess the need. *Mr. Harriman* explained that the current programs are cost-based, which is why spending has continued at the current level, despite the lower number of clients. When the category is re-bid, new contracts will be performance-based so that the allocation may change if the number of clients or units of service continue to decrease.

A motion was made, seconded and approved to support the revised service directive and maintain the FY 2014 carrying cost into FY 2015 as the category's allocation.

Agenda Item #5: HOPWA Update

Mr. Rojas reported that in FY 2014, the HOPWA award to the NY grant area, which funds permanent supportive housing, was reduced by about $5M in service dollars (from $53.1M the previous year). This was due to the US Dept. of Housing and Urban Development (HUD) revising the definition of AIDS to exclude people whose CD4 count has risen above 200 after having previously fallen below. Also, the grant area, which already included the Tri-county region) was expanded to include several counties in New Jersey. NYC's HOPWA dollars are split between HASA housing and individual sub-contractors. DOHMH is negotiating with the Office of Management and Budget (OMB) about where the cuts will go, as a loss of HASA funds would be made up through City Tax Levy dollars. DOHMH expects that the City may lose up to 350 units of permanent supportive housing this year, with another cut possible in FY 2015, on top of the general housing affordability crisis in NYC. Clients who lose their HOPWA-funded housing will not end up on the street or a shelter, but will transition to temporary and emergency housing, which while not optimal, is time-limited. Also, many HOPWA clients are not HASA-eligible. Fifty units of housing costs about $1M. Also, Mr. Rojas reported that DOHMH research is showing that housing is the most effective service in keeping people in care (93% of clients in permanent housing are virally suppressed).

There was a general consensus in the Committee to ask for additional housing dollars in the FY 2015 RW Part A application.

Agenda Item #6: Ranking Scores: MH, SCF, HOM

The Committee voted unanimously (with abstentions for those with conflicts of interest) to re-affirm the previous year's ranking scores for the following categories: ADAP, ADAP+, Non-medical Case Management (both parts), Medical Case Management, Food and Nutrition, Harm Reduction, Mental Health, Legal Services, Health Education and Risk Reduction, and Early Intervention.

Concerning Housing, even with the reduction in HOPWA, the committee decided that the Payer of Last Resort (POLR) score should remain the same, as a 5 reflects the availability of some other payers. The analysis of the effect of housing on viral suppression was justification for increasing the ATC/MIC score from 5 to 8. **A motion was made, seconded and approved to score Housing as follows: 5 (POLR), 8 (ATC/MIC), 8 (Consumer Priority) and 5 (Gaps/Needs).**

Concerning Supportive Counseling and Family Stabilization Services (SCF), there was a consensus in the Committee that the lack of Medicaid reimbursement for this service justified the increase of the POLR score from 5 to 8. **A motion was made, seconded and approved to increase the POLR score to 8 and reaffirm the previous year's ranking for the other criteria.**

There was a consensus in the Committee that the fact that, for Part A HOM clients, there are no other payers, justifies raising the POLR score from 1 to 5. **A motion was made, seconded and approved to rank HOM as 5 for POLR and reaffirm the previous year's ranking for the other criteria.**

Agenda Item #7: FY 2015 Application Spending Plan

The Committee discussed the FY 2015 spending request for the Part A grant application. The following is a summary of the discussion:

- For FY 2014, PSRA asked for a total increase of about 8%, including fully funding ADAP (an additional $2.76M) and a 5% increase (weighted using the ranking scores) for all categories. This was in addition to specific amounts for new categories (nMCM, HERR).
- DOHMH is conducting a survey on the impact of reductions that will be ready for the following planning cycle.
- ADAP does not need additional funds, as per Ms. Rivera, but should be considered for any across-the-board increase.
- Some of the HOPWA cut should be made up in the new funding request, especially since there will be no additional request for ADAP.
- Housing should be included in the across-the-board increase on top of any targeted addition.
- For the application, any increases can be framed as based on need and utilization.
- The Tri-county spending request asks for an additional $86,000. When backed into an overall spending plan with an 8% increase, this results in the percentage of funds for TC decreasing.

The Committee reached a consensus to ask for $3M additional for Housing, and an across-the-board weighted increase of 8% for all categories. Dr. Lehane will consult with the Tri-county Steering Committee about increasing their request to keep their share of the award close to 4.71%.

There being no further business, the meeting was adjourned.