HIV HEALTH & HUMAN SERVICES PLANNING COUNCIL OF NEW YORK
A Mayoral Council established by the Ryan White C.A.R.E. Act of 1990

Meeting of the

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, July 29, 2013
Cicatelli Assoc., 505 Eighth Avenue, 20th Floor
9:40 am– 5:00 pm

M I N U T E S

Members Present: Marya Gilborn (Co-Chair), Randall Bruce, Felicia Carroll, Nancy Cataldi, Sharen Duke, Joan Edwards, Graham Harriman, Peter Laqueur, Amanda Lugg, Deb Marcano, Hilda Mateo, Jan Carl Park, Tom Petro, Dena Rakower, Allan Vergara, Dorella Walters

Members Absent: Robert Cordero, Tracy Douglas Neil, Sam Rivera, Leonardo Vicente III

Other PC Members Present: Charles Shorter, Lisa Zullig

Staff Present: David Klotz, Darryl Wong, Nina Rothschild, Rafael Molina, Anna Thomas (DOHMH); Christine Rivera (NYSDOH, by phone); Bettina Carroll (Public Health Solutions)

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

Ms. Gilborn opened the meeting followed by introductions. *Mr. Shorter* led the moment of silence. The draft minutes of the July 15, 2013 meeting were approved no corrections.

Agenda Item #2: New Service Directives

Mr. Shorter presented the three new service directives developed by the Integration of Care Committee (IOC) this year and approved by the Executive Committee (EC) on July 25, 2013:

Health Education and Risk Reduction (HERR)

The Council was asked to create a HERR service directive (new service category) to accommodate The Positive Life Workshop (TPLW) previously categorized as part of Medical Case Management (MCM). TPLW is a health education program for PLWH focusing on engagement in care, adherence, goal setting, identification of barriers, social support building, and risk reduction. The grantee proposed a TPLW-focused HERR service directive that would allow the health education training to be provided by CBOs. Agencies would apply to provide TPLW with DOHMH staff providing technical assistance (TA) and capacity building.

The new HERR service directive allows agencies to select from a menu of evidence-based health education programs inclusive of TPLW. Program requirements are:

- Grounded in theory and scientifically evaluated,

- Increase understanding of impact of behavior on health,
- Encourage behavioral change to improve health and decrease transmission,
- Encourage timely entry into care, adherence, maintenance, and VL suppression,
- Encourage use of curriculum emphasizing health self-management,
- Provide info and access to services within agency and in larger health/social support service system,
- Utilize trained peers.

Client eligibility is PLWHA, especially those who: do not have suppressed viral load, do not consistently utilize or remain in treatment and care, are seeking assistance with self-management, or are returning to care after an absence. Agency eligibility is: CBOs, clinics and hospitals with bilateral linkages with programs with expertise in medical care, Early Intervention Services, mental health, food and nutrition, substance use, medical case management, and psychosocial support. Any individual agency does not have to serve all 5 boroughs, but funded agencies should be accessible to clients from all boroughs and be able to provide services in languages spoken by target pops.

Non-Medical Case Management (nMCM)

The Council was asked to create an nMCM service directive (new service category) to accommodate the existing Rikers Island Initiative and create an opportunity for service expansion. Ryan White Part A funding has supported non-medical case management for incarcerated PLWH on Rikers Island for many years. CBOs participate in the Rikers Island Transitional Health Care Consortium and provide: post-release assistance with benefits and entitlements/restoration of Medicaid and ADAP; financial counseling; treatment education/risk reduction; linkage to other RW-funded services. The new directive calls for continuation of this program (Part A), and community-based, non-incarcerated nMCM (Part B). Both Parts will provide:

- Assistance with accessing services including medical care, health home care management, managed care behavioral health services, existing and future insurance exchanges or new models arising from ACA and Medicaid redesign,
- Promote strategies for improving health of PLWHA,
- Facilitate access to continuum of care including medical and support services.

Client eligibility is: HIV+ inmates in NYC, PLWH newly released from NYS correctional facilities to NYC, and HIV+ individuals who meet baseline eligibility criteria for services and are not receiving duplicative services elsewhere. Active substance use does not preclude client eligibility. Agency eligibility is: CBOs, clinics, hospitals and government agencies; for Part A of the service directive must have experience in working with incarcerated populations; must have experience with individuals who are out of care, sporadically in care, or in need of self-management support; must house or establish bilateral linkages with programs with expertise in medical care, EIS, mental health, food and nutrition, AOD, MCM, supportive counseling and family stabilization, housing, Medicaid, Medicare, and NYS Health Insurance Exchange Systems; staff must have cultural sensitivity training; agencies must be accessible to and able to serve clients from throughout the 5 boroughs; must be able to provide services in languages spoken by pops served.

Supportive Counseling and Family Stabilization Services (SCF)

This service category needed to be reviewed and updated because it is non Medicaid billable and presents a growth opportunity. This is a high performing service category, and agencies do well on reporting on Primary Care Status Measures. Allowable services include: individual, family and group counseling; support groups; crisis intervention; peer and non-peer led interventions; drop-in activities; grief and bereavement counseling; pastoral care; transitional services to stabilize families following a death; and

relationship-building activities, education, training, and skills-building activities, medical and social support services. This is very similar to the current service model, with the main difference the inclusion of pastoral care.

Client eligibility is all individual and family units in which one or more persons are HIV+ are eligible. The client and/or family members need not have a DSM V diagnosis, and active substance use does not preclude eligibility. Agency eligibility is CBOs, clinics, and hospitals experienced with HIV+ individuals and experienced reaching out to and engaging individuals who are out of care or sporadically in care or in need of self-management support. Agencies must house or establish linkages with programs providing medical and social support services and staff must be culturally sensitive and provide services in languages spoken by pops served.

A summary of the ensuing discussion follows:

- nMCM is a low threshold (for entry) and low intensity service, allowing for more flexibility.
- nMCM fills a gap for clients who do not need or want the more intensive MCM services and would round out the services provided by MCM, as well as provide educational services.
- There are currently about 3,400 MCM clients. It is anticipated that as Health Homes are more fully implemented, the demand for MCM will decrease, but the demand for nMCM will increase. As of this year, with MCM programs having been "right sized", they are on target to spend their maximum reimbursable amount (MRA).
- MCM is high cost because of the intensity of the service provided. The program has proven effective at keeping clients in care in their viral load suppressed, but need has been seen for additional case management that nMCM would provide (e.g., connection to public benefits).
- Part B of nMCM used to be provided by Part A funds, but when the system changed to MCM many clients were lost who only needed a small array of services, like linkage to public benefits.
- MCM clients are assessed for Health Homes and COBRA eligibility. Only 4% of MCM clients were in COBRA programs. Reports from Health Homes show that they are not providing the intensive services most MCM clients need. Also, Health Homes also serve HIV-negative people.
- In the FY 2013 grant application, there was an analysis of the effect of the implementation of the Affordable Care Act (ACA) on MCM enrollment, and only 7% were found to be expected to be eligible for health insurance exchanges.
- The cost for nMCM is estimated to be $1,200 for 1,000 clients, based on the cost of providing services in the SCF category, which are the most analogous.
- There were 2,400 discharge plans completed in 2013 under the current program. Reductions in seropositivity among inmates discussed at the previous meeting referred to testing within State prisons.

There was a discussion of allocations for this category in the FY 2014 application spending plan, and whether this should be a request for new funding, or reallocated from an existing category, such as Early Intervention Services (EIS), where there are high testing rates, but low outcomes for finding HIV-positives and linking them to care. This discussion was continued in the section below on the FY 2014 application spending plan.

Agenda Item #3: FY 2014 Application Spending Plan

Ms. Rivera gave an update on the state of the Uninsured Care Pools - ADAP, ADAP+, APIC (insurance continuation). ADAP serves tens of thousands in an efficient, comprehensive system. Many clients use it as a transitional service before moving onto Medicaid (ADAP also helps with spend-down). NYSDOH is far along in its planning for the impact of the ACA, and only about 1,000 clients are expected to move

into expanded Medicaid. About 3,000 will be covered through insurance exchanges, but most will need to remain in the program for insurance and cost-sharing assistance. In 2015, funds spent on insurance premiums are expected to decrease, but the cost of drugs is expected to rise. The State took a $12M cut in Part B funding and the reserve has been eaten up. Open enrolment periods will allow client to enroll in ACA authorized federal pre-existing conditions plans, and ADAP expects to cover the new $1,000 deductibles. For Part A funds, ADAP+ is a priority, as federal funds are dedicated to APIC. There are many blips in the ACA system leaving many clients to rely on ADAP. In the ADAP formulary, 70% of the budget is spent on ARVs. With ADAP's cost-containment plan, whole categories of drugs will disappear, including psychotropics, which could have unintended consequences for the use of ARVs.

The PSRA discussed strategy for developing an FY 2014 application spending plan. *Mr. Harriman* reviewed the increases that were requested in previous years. For FY2013, the PC asked for an additional $3.01M (including $2.76M to fully fund ADAP). For FY 2012, the request was $3.5m more than the FY 2011 award. In FY 2011, the request was $3.27M more than the FY 2010 award [Note: the actual award increased by over $13M in FY 2010.]

Any additional funding requests will only come out of the pool of supplemental funding. That pool may increase if "Hold Harmless" expires, but would be offset by a larger increase in formula funds with no Hold Harmless protection. In addition, sequestration is expected to continue for another year.

The board ideas discussed by PSRA for changes in the allocations were:

1. Asking for additional funds to fund the newly revised/expended service directives (HERR, nMCM, SCF).
2. Asking for the full amount of ADAP funding (restoring the cut and/or adding $2.76M).
3. Reduce allocation to EIS by between $1.9M and $3.9M and reallocate those funds.
4. Eliminating Home and Community-based Services (HOM) and reallocating its $1.1M.
5. Requesting a restoration of a percentage of the FY 2013 cuts to all categories.

A summary of the ensuing discussion follows:

- It is unknown how the requested amount will affect the application reviewers.
- The amount should be based on need.
- The portfolio needs to adjust to the new reality of reduced funding.
- PSRA should remain optimistic and not accept continued reduced funding as the "new normal".
- The grantee is unable to report yet the effect on service delivery to clients of the FY 2013 cut, but contractors will have reduced service targets. Also, it will be impossible to know the number of clients who would never been seen in the first place because of loss of program capacity.
- One contract in the HERR category is estimated to cost about $250,000. Ideally, there should be 4 across the City for adequate coverage, meaning an increase in the current allocation for this category by about $600K.
- If new funds are requested, it should be with the understanding that newly created programs would only be implemented if funding was available.
- Based on the analogous program models, $1.26M would be required to serve 1,000 nMCM clients. This does not include fringe and OTPS costs, which would bring to total to about $2M.
- The nMCM service directive should explicitly state that the service is "low threshold" for entry and "low intensity" for service. Caseloads in nMCM should be estimated at about 30 clients per staff.
- The services in the HOM category are mostly available in other Part A programs. One unique service is at-home assistance with child care (which is available in other non-Part A programs).

- HOM clients are already mostly connected with other Ryan White services. An aging HIV population might be an indication of potential growth in need for this service.
- The cut in services has meant carrying the same number of contracts with a much smaller infrastructure, making the portfolio more difficult to manage.
- EIS programs are spending well because they are conducting HIV tests, but the rate of finding HIV-positives is extremely low for many programs (meaning little or no linkage to care). DOHMH has provided extensive TA to EIS programs with no improvement in their ability to find HIV-positives. Cutting the lowest performing contracts could mean $1.9M for reallocation. The next lowest group of performing contractors would mean $3.9M for reallocation.
- There is a multitude of testing resources. Also, new State law mandating that emergency departments and other providers offer the test will make it more accessible.
- EIS funds should be concentrated on finding HIV-positives in the groups with the largest prevalence rates and linking them to care.
- The HERR service directive is broad and flexible and should explicitly state that it allows contractors to choose their own intervention, as long as it is evidence-based (which can include the Positive Life Workshop model or others listed in the directive, but does not need to).

The PSRA will re-review these options when considering the allocations for the FY 2014 application spending plan. There was a consensus that there should be changes in the allocations that show the EMA responding to the changing environment. There was also a general consensus that the request for an increase should fall somewhere in the middle of a small increase and the complete restoration of the cut, although *Mr. Bruce* argued for a request to ask for the full restoration of the reduction FY 2012 grant.

Agenda Item #4: FY 2014 Priority Setting Tool and Service Category Ranking

The PSRA began its ranking exercise with the Payer of Last Resort (POLR) criterion. There was a consensus to consider the two parts of nMCM as separate lines in the spending plan, pending the final approval of the directive by the full Council. nMCM/General ("Part B") will be scored from scratch as a new category.

There was a discussion on conflicts of interest (COI) rules. The Council Bylaws were consulted. The broadest reading of the COI guidelines would preclude providers with any Part A contracts from voting on ranking because of the indirect effect of a change in ranking on all categories in the portfolio. There was a consensus to follow past practice that COI restrictions should only apply to direct allocation decisions. A summary of the ensuing discussion on ranking follows:

- There was a question of how POLR should be considered, i.e., should a high score be assigned if the service is payer of last resort for the clients enrolled in Part A programs, or should overall availability of similar services in the system be factored in.
- Ranking scores should be considered in comparison with scores for all categories, in order to make them more meaningful.
- *Ms. Walters* presented documents from the New York Coalition of HIV/AIDS Nutrition Services supporting maintaining the high ranking of FNS for its role in promoting medical care, as well as the continuing food insecurity experienced by many PLWHA.
- The addition of mental health advocates/navigators gives the Mental Health category additional non-Medicaid reimbursable services. There was little under-spending in Mental Health last year. When this service is re-RFPed, it will be clear that it is only for non-billable services.
- Medicaid expansion to cover harm reduction services has been delayed and is not expected to be implemented this coming year.
- The POLR tool and scorecards were consulted for various service categories.

- While all Part A programs are required to promote access to and maintenance in primary care, top scores for the ATC/MIC criterion should only be assigned for services whose primary focus is ATC/MIC and that provide a direct access to medical care (e.g., testing, treatment, making doctors appointments, accompaniment, etc.).
- Services that help reduce barriers to care (e.g., Housing, MH) should be scored the second highest ranking (5).
- Harm Reduction and Mental Health services are analogous in how they promote ATC/MIC.
- Legal Services are the one category where programs do not report full primary care status measures.

The following motions were made, seconded and approved concerning the POLR scores:

1. **Reaffirm the scores for ADAP, ADAP+, FNS, nMCM (Rikers/Releasees), MCM, Housing, Mental Health, Harm Reduction, Supportive Counseling, Legal Services, SCF, HERR and HOM.**
2. **Assign a score of 5 for nMCM(General).**
3. **Reduce the score for EIS from 5 to 3.**

The following motions were made, seconded and approved concerning the ATC/MIC scores:

1. **Reaffirm the scores for ADAP, ADAP+, nMCM/Rikers, MCM, EIS, HERR and HOM.**
2. **Assign a score of 5 for nMCM/General.**
3. **Reduce the score for FNS, Housing, Mental Health, Harm Reduction and SCF from 8 to 5.**
4. **Reduce the score for Legal Services from 5 to 3.**

The next meeting will be held on Monday, August 5th, 1-5pm to complete the FY 2014 ranking tool and application spending plan.

The Committee recognized the incredible contributions of Ms. Gilborn and Ms. Rakower, whose terms end in August and will be on vacation for the final meeting. The Committee thanked them for their five years of dedication and service to the PSRA and Council. The Committee acknowledged Ms. Gilborn's extraordinary service as co-chair, particularly her availability to consumers to help them understand and participate in the planning process.

There being no further business, the meeting was adjourned.