Meeting of the

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, August 10, 2015
AIDS Service Center of NYC, 64 W. 35th St., 3rd Floor
3:10 – 4:30 pm

M I N U T E S

Members Present: Sharen Duke (Co-Chair), Matthew Baney (Co-chair), Randall Bruce, Amber Casey (for Graham Harriman), Jan Hudis (by phone), Amanda Lugg, Claire Simon, Jan Carl Park, Tom Petro

Other Planning Council Members Present: Billy Fields

Members Absent: Victor Ayala, Joan Edwards, Steve Hemraj, Matthew Lesieur, Jesus Maldonado, L. Freddy Molano, M.D., Lyndel Urbano

Staff Present: David Klotz, Nina Rothschild (DOHMH); Bettina Carroll, Gucci Kaloo (Public Health Solutions)

Agenda Item #1: Welcome/Introductions/Re-thinking the PSRA Methodology

Ms. Duke and *Mr. Baney* opened the meeting, followed by introductions. The chairs reviewed the HIV treatment cascade for NYC overlaid with Part A service categories as a framework for a new way to analyze service categories and allocations. Only Early Intervention Services (EIS) overlaps with the first segments of the cascade (estimated HIV-infected, ever HIV-diagnosed). Most services, especially Medical Case Management (MCM) overlap with the segment where the most drop-off occurs (from ever linked to care to retained in care), which is an indication that the PSRA's priorities are generally in line with the cascade. The Committee also reviewed the cascade for the population of people receiving Part A services, which shows Part A clients doing better at all initial stages, but a slightly lower percentage of those who have started ARV who are virally suppressed, which is an indication of the fact that Part A services are reaching the clients with the greatest barriers to viral load suppression and getting them linked to care.

The following is a summary of the discussion:

- Most RW programs try to stabilize people and graduate them out of programs once they are virally suppressed, and to enroll new clients. A few programs continue to serve clients (e.g., Food and Nutrition) because they do not address the underlying inequities (e.g., poverty), even as they help clients overcome barriers to care and viral suppression. The grantee can do an analysis of who stays enrolled in which programs.
- PSRA should look at services that are not funded that may impact viral suppression and determine if the continuum and funding amounts are satisfactory. Adjustments in funding as well as quality of services, with an emphasis on viral suppression should be made.

- Medical Case Management (MCM) viral suppression rates are very high (albeit at high cost). The grantee has a new focus on determining viral suppression rates of all service categories. All wrap around services (e.g., FNS, Housing) contribute to viral suppression.
- While we know the outcome effectiveness of MCM, not all clients need or want such intensive services or such a restrictive protocol.
- PSRA should look at ways to "stretch out" MCM services to give a client only what they require ("MCM Lite"), enabling to program to serve more clients with the same allocation.
- Consumers need to be surveyed to determine needs (the CHAIN cohort is not representative enough, particularly among younger PLWHA).
- The grantee should include questions in their client satisfaction surveys to assess barriers to viral suppression (although this will miss the unconnected to care, some data on which is available through CHAIN).
- It is difficult to ascribe viral suppression to one service (e.g., MCM), as many clients receive multiple services (e.g., mental health, housing) that contribute to retention in care.
- Non-Medical Case Management is a new service and it will take some time to determine if it can fill the need for a "MCM Lite"
- Changes in allocations require a place to park funds. Over-performing programs can be useful for that, but over-performing categories (e.g., Legal) are not necessarily the ones that are contributing to viral suppression.
- Given the national funding picture, the EMA will probably continue to lose money. Instead of chipping away at all service categories, it may be wise to eliminate an entire category. All options should be on the table, including consideration of the EMA's ADAP contribution.
- The totally uninsured population is decreasing. Payer of last resort requirements should be kept in mind to focus Part A services on what is not reimbursable (e.g., individuals not eligible for insurance, second visits).
- As a baseline, PSRA should consider viral load suppression data by service category. Data from clinical providers will be public. For agencies with multiple contracts it will be difficult to isolate which service is contributing most to viral suppression. For non-clinical programs, some data from eShare reporting on primary care status measures will be needed.
- PSRA needs to keep in mind that Part A funds are a drop in the bucket of HIV-related care expenditures, especially the billions spent through Medicaid. The Committee should focus on how to use the portfolio to fill niche gaps in care or support the entire system of care (including through revision of service directives).

For next steps, the Committee will review specific recommendations from the Needs Assessment on service gaps. There will be a need to assess Medicaid changes and to plan for the impact of DSRIP (preliminary, given the unknowns and long-range timeline for roll out). There was a consensus that a consultant should be hired to complete a report (similar to the Manatt report on Medicaid changes) that can guide the Committee.

The next meeting will take place on Monday, September 21, 2015, 3-5pm.

There being no further business, the meeting was adjourned.