CONSUMERS COMMITTEE

Wednesday, October 19, 2011, 1-3:00PM

NYCDOHMH, Gotham Center, 42-09 28th Street, Room 22-12, Long Island City, NY

Planning Council Members Present: Victor Benadava (Co-Chair), Gregory Cruz (Co-Chair), Randall Bruce**,** Felicia Carroll, Kareem Clemmons, Gerald DeYounge, Munying Hunt, Pastor Jerome Payne

Planning Council Members Absent: Victor Alvarez, John Eddie, Steve Hemraj, Deborah Marcano, Hilda Mateo

Community Members Present: Manuel Ducret III**,** Billy Fields, Yves Gebhardt, Delores Henley, Rev. Keith Scott Holder, Joey Lopez, Mallory Lowenstein, Jesus Maldonado, David Martin, Glen Phillip, Russel Stephen, Jacqueline Williams

Staff: DOHMH: JoAnn Hilger, Rafael Molina, Jan Park, Darryl Wong

Guest: Kelly Piersanti

MEETING MATERIALS DISTRIBUTED:

- Meeting Agenda/Planning Council Ground Rules of Respectful Engagement;
- September 21, 2011 Draft Meeting Minutes;
- HRSA/HAB Monitoring Standards FAQs, April 2011;
- HRSA/HAB Universal Monitoring Standards Par A & B;
- HRSA/HAB Program Monitoring Standards, Part A;
- HRSA/HAB Fiscal Monitoring Standards, Part A;
- Questions on Tactic to Prevent HIV, NY Times, October 10, 2011;
- Medicaid & HIV: A National Analysis, October 2011, Kaiser Family Foundation;
- Positive Voice, National Association of People with AIDS, Vol 2, Issue 14,10/10/11;
- ADAP Watch List, NASTAD, October 14, 2011;
- October 2011 HIV Planning Council Calendar

INTRODUCTIONS:

Gregory Cruz & Victor Benadava, Committee Co-Chairs opened the meeting, followed by Committee member introductions. Pastor Payne led the moment of silence and reviewed the Rules of Respectful Engagement. Mr. Cruz reviewed the meeting agenda and Darryl Wong reviewed meeting materials. The minutes of the October 2011 meeting were reviewed and approved.

PUBLIC COMMENT:

Myron Gold, Committee member, has been ill and would appreciate hearing from community members.

PLANNING COUNCIL, FEDERAL/STATE & CITY HIV/AIDS POLICY UPDATES:

Jan Park provided an update on Federal, State and City policy issues affecting funding for HIV/AIDS services for PLWHAs, underscoring the current environment of fiscal constraints and the resultant need for continued advocacy at all levels. Although Ryan White/HRSA funding does not allow for political/fiscal advocacy using Part A funds, individuals were encouraged to organize within their respective networks and communities in support of continued and enhanced funding.

PRESENTATION I: HRSA PART A MONITORING STANDARDS

JoAnn Hilger, Director of Ryan White CARE Services, presented an overview of the HRSA Monitoring Standards for Part A & Part B grantees, which include universal standards, program monitoring standards and fiscal monitoring standards. The monitoring standards became effective on April 1, 2011.
The components that will have a major impact on all Ryan White programs include the requirement that agencies must be certified to bill Medicaid for potentially billable service, clients will be subject to

DRAFT

income eligibility standards starting March 1, 2012, clients will be required to provide evidence of EMA residency for eligibility starting March 1, 2012 and subcontractor rent and utilities will no longer be include in program costs, but rather, as administrative costs and will be phased in from 2011-12 (some contractors have already adjusted their budgets to reflect this change).

The Medicaid certification requirement will ensure that every subcontractor must participate in Medicaid and be certified to receive Medicaid payments in order to receive Part A funds in the Mental Health, Early Intervention, Home Care, Substance Use and Outpatient Medical Care service categories. Bridge Care programs would be exempt from this requirement because services are provided Off-site, All other service categories will be phased in except Harm Reduction programs beginning in 2012.

With respect to income eligibility requirements, all new and continuing Ryan White Part A clients in the NY EMA must meet the income eligibility requirement beginning March 1, 2012, with the exception of Early Intervention Services, whose clients are exempt from this requirement. Because EIS services aim to 1) reduce barriers to testing, 2) increase the number of individuals who are aware of their HIV status 3) promote early entry into HIV care and 4) provide an essential linkage to care for newly diagnosed individuals, those programs will not ask clients about their income qualifications. The EMA will use 435% of the Federal Poverty Level (FPL) for maximum household income (currently at $47,371 per household, the same amount as used by the ADAP program to determine eligibility). In order to reduce the paperwork burden on clients receiving services at multiple agencies, primary income documentation may be maintained by the referring provider.

Preferred documentation includes the NYSDOH Uninsured Care (ADAP) card or Medicaid card. Other accepted documents, for unemployed clients without ADAP or Medicaid cards, would include unemployment, Social Security or pension checks, while acceptable documents for employed clients could include recent copies of the most current two consecutive pay stubs. If paystubs are not available, a notarized letter from the employer showing the gross pay for the most current two (2) consecutive pay stubs is acceptable. If the notarized letter is unavailable, the client may submit a notarized statement reporting monthly or annual income. Of nearly 19,000 HIV+ clients enrolled in non-EIS Ryan White contracts, approximately 80% of clients report income at or below the Federal Poverty Level of $10,980 for an individual and nearly 95% of clients qualify for the $47,371 ADAP income requirement.

With respect to residency requirements, effective March 1, 2012, all new and continuing Ryan White Part A clients in the NY EMA must provide documentation of residency in the EMA. Those exempt from this requirement include incarcerated individuals who receive services in jails/prisons located in the EMA and those who avail themselves of HIV testing in mobile units (unless the client tests positive, in which case documentation would be required for continued services). As in income requirements, for those clients who are referred to other Ryan White Part A services, documentation of primary residence may be maintained by the referring provider.

Preferred documentation includes: a government issued ID card, NYS driver's license, any local (City or County) government benefits card or letter with client name, an insurance benefit card with name and address, a residential lease, a tenancy agreement for individuals who do not have a lease, a NYS voter registration card or any US immigration document with the current address. Other acceptable documents would include a bank statement with name and address, any bill that includes the name and address, e.g., utility, phone, mobile phone, cable, internet, hospital, clinic or credit card bills or a pharmacy receipt with name and address. Committee members concerns included documentation for undocumented immigrants, especially those who are homeless, those living in NYCHA or Section 8 public housing, the shift of infrastructural costs from program to administrative costs, the number of Part A contractors who are not currently Medicaid certified, performance-based contract monitoring vs. cost-reimbursement monitoring, the number of clients from neighboring counties and/or states. Ms. Hilger re-iterated that there is continued dialog with HRSA regarding the implementation of these standards. It is envisioned that operationalization will require a period of approximately two years. Committee members were referred to the HAB/HRSA website for the specific monitoring standards.

PRESENTATION II: UPDATE ON COMMUNITY ADVISORY BOARD (CAB) PROJECT

Ms.Kelly Pieranti, Graduate Intern, presented an update on the project, noting that of the 88 CABs approached for participation, 57 agencies have completed agency CAB leader surveys with a total of 148 members surveys, from which a data analysis could be drawn. The following are highlights of the presentation:

- The most frequently cited barriers to client participation on CABs were consumers' lack of interest, lack of incentives/compensation for participation, lack of funding for consumer board activities and family and health issues;
- With respect to CAB functioning/coordination, there was a high degree of concurrence with statements measuring CAB productivity, organization , written plans & schedules, availability of fellow consumers to assist each other and self and mutual/shared understanding of th CAB's goals for improving client services;
- With respect to conflict management, there was a high degree of agreement with statements that measured the value of discussions in resolving conflicts and the degree of personal commitment to work through problems; there was a significant difference in opinion regarding mutual satisfaction with a joint decision and the role played by the CAB leader in resolving an issue. There was strong agreement in reaction to statements indicating that disagreements are dealt with directly and not left to fester and that it is rare for the agency CAB leader to have to resolve disputes between members or for problems to be referred to someone higher up. There was strong agreement that all points of view are considered when a problem needs resolution;
- Regarding team effectiveness, there was strong agreement that all members contributed based on their experience and expertise, that the CAB does well in meeting client needs, responding well to client emergencies, that the CAB has a high ability to almost always meets client needs and that overall, the CAB functions very well together;
- With respect to team meeting communication, members indicated agreement that CAB members feel free to speak their minds during meetings, that there exists a lot of respect between CAB members for each other and different points of view, that members are not generally defensive and react well to differing points of view and that meetings offer a safe places to discuss ideas and concerns. Across the board, however, CAB members felt that meetijngs are sometimes very tense;
- Finally, with respect to team leadership, there was agreement that meetings are not dominated by a small number of individuals, that the facilitator does not dominate the discussion and the consumers are held accounted for actions they agree to undertake and that the facilitator creates a comfortable atmosphers, fostering communication and reinforcing members' input.
- There is agreement that there is clarity around shared accountability, focused discussion and ease of reaching consensus.

As agency recruitment continues through enhanced community outreach, more agency responses are needed and a more complete analysis, comparing cohorts of agency CAB leaders and CAB community members is envisioned. It was also noted that while the preliminary results indicate a high degree of functionality, the best practices related to such successes can be codified into recommendations guiding the recruitment, engagement and input/feedback processes of successful CAB initiatives.

BOROUGH UPDATES ON HIV NETWORKING ACTIVITIES

[Inaudible due to lapses in recording]

PUBLIC COMMENT

There was no public comment.

ADJOURNMENT:

There being no further business, the meeting was adjourned at 3:00PM.