Meeting of the

FINANCE COMMITTEE

Wednesday, April 10, 2013, 3:00-5:00PM
DOHMH, 2 Gotham Center, Long Island City, NY

M I N U T E S

Members Present: Robert Cordero (Chair), Marya Gilborn, Graham Harriman, David Martin, Jan Carl Park, Dan Pinchinson, Rob Shiau, Dorella Walters
Staff Present: *NYCDOHMH*: David Klotz, Merline Jean-Casimir Amber Casey; *Public Health Solutions:* Rachel Miller, Gucci Kaloo, Peter Chea; WCDOH: Tom Petro

I. Welcome/Introductions

Mr. Cordero opened the meeting, followed by introductions. The minutes of the December 4, 2012 meeting were approved with no change. Mr. Cordero reported that the five-year analysis of trends in spending will be presented at the June 13th meeting so that it can include FY 2012 data. *Mr. Park* asked that future meetings be recorded.

II. Planning Council Support Budget

Ms. Jean-Casimir presented the FY 2012 closeout report for the Planning Council support budget. With modifications made during the year, $839,663 was spent of the $866,191 budgeted. *Mr. Klotz* reviewed the draft FY 2013 budget, which more closely reflects actual expenditures in FY 2012, with some adjustments. The proposed budget is $863,618. Some highlights of the budget include:

- Elimination of the local travel line, as staff uses their own unlimited MetroCards.
- Elimination of the Out-of-town travel line, as there will be no HRSA conference in 2013.
- Elimination of the $5,000 one-time consultant expense to complete the online training.
- One-time $5,000 increase to the consultant line for the PC website to create a feature that will allow people to complete PC and committee applications online at any time.
- $10,000 increase in audio-visual.
- Reduction in space rental to reflect actual usage.
- Increase in nutritional snacks to reflect actual usage.

The Committee agreed that, pending the final award notification, the total amount should be kept at the same level as FY 2012, with the $2,573 difference added to the participant travel line.

Adjustments can be brought directly to the Executive Committee. *Mr. Cordero* noted that the PC budget is 0.7% of the grant award, which is a very good "bang for the buck".

III. FY 2012 Base and MAI 3rd Quarter Reports

Mr. Kaloo gave an overview of the FY 2012 Base and MAI third quarter commitment and expenditure reports. Overall, spending is close to target (25% unspent at the end of the 3rd quarter). The base award was 31% unspent (compared to 29% at this point in FY 2011). The MAI award is 42% unspent, but this number is skewed upwards because the State had not yet reported any of its ADAP Plus spending; full spending of ADAP Plus occurred in the 4th quarter. If the ADAP Plus expenditures were pro-rated for the 9 –months period represented by the 3rd Quarter, actual MAI under-spending would be 33%.

Overall, 51 contracts were taken down (generally one-time) by $4.4M. $2.36M of that was reprogrammed to enhance over-performing contracts and the balance was used to restore the upfront reduction to the ADAP program. Also, ADAP received additional enhancements that exceed the spending plan allocation, which will be covered by additional take-downs after contract closeouts are processed. For FY 2012, enhancements were provided to contracts in January 2013 compared with the prior two years when enhancements were provided at closeout. Providing the enhancements earlier this year allowed more time for contractors to plan (e.g., making one-time purchases, continuing to perform at increased levels) and reduced the risk and uncertainty of not being reimbursed for services provided above the established targets and contract amount.

Mr. Kaloo explained that the total enhancement amount for FY 2012 closely matched the total enhancement amounts provided during the previous years' closeout and we therefore project fewer contract enhancements for the FY 2012 closeout.

Mr. Chea provided other highlights of the base report:

- Reported spending for ADAP Plus is below target due to a lag in the State's reporting.
- $2.1M shown as uncommitted under Care Coordination is a net amount which included enhancements to several over-performing contracts and takedown to others that underperformed.
- Higher than average under-spending in Transitional Care Coordination, Harm Reduction and Early Intervention was due to enhancements to contracts in these categories that had not yet been spent during the 3rd Qtr but will be reported in the 4th quarter/Final Report.
- $295,000 was uncommitted in Emergency Rental Assistance due to client recruitment difficulties. *Mr. Harriman* explained that due to HRSA program rules, they can not pay for security deposits (clients are referred to the HOPWA Sustainable Living Fund). Also, clients who become HASA eligible are moved to that program. The program is also finding that new income eligibility verification procedures have found client incomes to be higher than anticipated and the program's share of the rent therefore becomes lower. This service model does not allow case management services to be provided to client. As a result, clients that referred out who need case management for housing readiness (e.g.,

training is daily living skills) and other wrap-around services are sometimes lost to the program. Finally, the service is limited to the AIDS-diagnosed or HIV-symptomatic, as per the Council's service directive.

- $275,149 was uncommitted in Housing Placement Assistance due to severe underperformance of one of the four contracts in this category which was taken down by 2/3 of its contract amount. Two other contracts over-performed in this category.
- $200,833 was uncommitted in Outreach to Youth (and the category unspent by 44%), due to issues with the service model. For FY 2013, the programs will concentrate more on outreach and engagement rather than services to those who test positive, as the number of those identified HIV-positive was relatively low. *Mr. Cordero* stated that this points to the need for the Council to continually review service models that have problems.
- Outpatient Medical ("Bridge") Care is 100% unspent due to the last remaining provider in this category voluntarily giving up its contract. This is discussed in greater detail below.

Mr. Petro explained that the Tri-county under-spending is overstated due to the fact that payments lag by two months, i.e., are not made until two months after the quarter's end, so 3rd quarter liquidated expenses more accurately reflect spending as of the 2nd quarter. Also, in Tri-county, in order for unspent funds to be re-allocated to programs, contract amendments need to go through a county board which happens too late in the year, and as Tri-county has no reprogramming plan, a portion of the Tri-county unspent funds will be returned to NYC to be reprogrammed. Also this year, several contracts did not submit their audits which resulted in payments being held to their organizations, but those expenditures are expected to be made by the end of the year.

Highlights of the MAI report are:

- There was $561,885 overcommitted in ADAP Plus. Spending for this program was not reported during the 3rd Qtr; full spending of ADAP Plus occurred in the 4th quarter. $244,038 was uncommitted in Care Coordination due to 3 contract takedowns (which were offset by 2 contract enhancements).
- Tri-county reported 43% unspent as of the 3rd quarter.

In response to a question from *Mr. Martin, Ms. Miller* explained that contractors with severe under-spending are required to develop a plan and timeline for improvement. In addition, providers in some categories are given technical assistance from DOHMH staff. If there is no improvement in performance, contracts can be subject to permanent take-downs, or in extreme cases, terminations.

Mr. Harriman reported that for the current year (FY 2013), MCM contracts were analyzed for permanent reductions to their contract amounts. There are several over-performing MCM contract that could be permanently enhanced by the available funds from the permanent reductions, but these enhancement will not be made until the full award is known.

Also, EIS programs are required to report program income as part of their closeout. All Ryan White programs must facilitate enrollment in applicable insurance programs (Medicaid,

Medicare, etc.) for all uninsured clients. Once the client is approved for insurance, the program must disenroll the client from the RW program, but during the period in which the client is still uninsured, Ryan White can pay (even if the program can subsequently bill insurance retroactively). The reimbursement received from the back-billing of third party insurers for services provided to Ryan White clients at the time they were uninsured is considered "program income" by HRSA. Program income may be used to expand program services or to cover allowable costs not paid for by contract income (such as administrative costs not covered by the administrative cap in the underlying RW contract).

In response to a previous request from the Finance Committee, *Mr. Harriman* reported on the factors that led to the discontinuation of all contracts under the Outpatient Bridge Medical Care (OBMC) category, which was designed to provide medical care in SROs, a particularly marginalized population. The service was an optional program element for Care Coordination and Transitional Care Coordination applicants. Information was gleaned from a conference call with 6 OBMC providers. The most important points about the challenges of this service model were:

- Identification of medical personnel willing to work in the field,
- Volume of HRSA-required documentation (incl. STD tests, pap smears, etc.) was a barrier to engagement for a wary population,
- Identification of appropriate patients in SROs and mobile units (documented HIV-positive status) due to potential HIPAA violations,
- Low client volume, attributed to the significant number of missed appointments, had a big impact on program and agency finances,
- Patients that attend one clinic visit are considered "linked" and disallowed from receiving further PBMC services, thus no follow-up is conducted by the OBMC team and patients feel abandoned.

Mr. Cordero said that this is something for the Council to examine regarding all service models that may not meet expectations. *Ms. Miller* noted that the HRSA regulations and monitoring standards for this category may work at cross-purposes to the goal of reaching these difficult clients. The origin of the service goes back many years to the old Health Work Group, and when it was re-bid was linked to MCM in order to open it up to additional populations, but providers were required to have experience with SRO residents.

Mr. Klotz pointed out the 2012 assessment of the administrative mechanism, saying that the spreadsheet will be revised for this year at the June 13th meeting.

There being no further business, the meeting was adjourned.