Meeting of the
POLICY COMMITTEE
Sharen Duke, Chair

March 18, 2013
AIDS Service Center of NYC
41 East 11th Street, 5th Floor
3:00 pm – 5:00 pm

Members Present: Kareem Clemons, Sharen Duke, Adrian Guzman, Graham Harriman, Jan Hudis, Jan Carl Park, Kimberleigh Smith, Lyndel Urbano

Members Absent: Yves Gebhardt, Sandy Guillaume, Matthew Lesieur, Lorna Littner, Esther Lok, Paul Meissner, Gloria Searson, Dorella Walters

NYC DOHMH Staff Present: Merline Jean-Casimir, Ralph Molina, Nina Rothschild, DrPH, Anna Thomas

Others Present: Randall Bruce, Jennifer Celio, Marissa Darcy, Elizabeth Lovinger, Mallory Lowenstein, Stephen Sukumaran, Laura Wellder

Material Distributed:

- Agenda
- Minutes from the February 14, 2013 Meeting
- Presentation on the Impact of Sequestration on PLWHA
- Presentation on Ryan White Part A Policy Issues and the Portfolio
- Spreadsheet on EMA HRSA Service Categories for Policy Review
- Policy Committee List of Open and Closed Items
- Planning Council Calendar for March 2013

Welcome/Introductions/Review of the Meeting Packet/Review of the Minutes/Moment of Silence: Committee Chair Sharen Duke welcomed everyone. Meeting participants introduced themselves. Nina Rothschild reviewed the contents of the meeting packet. The minutes from the February meeting of the Policy Committee were accepted for posting on the Planning Council website at nyhiv.org. Participants observed a moment of silence.

Policy Issues: Sharen Duke stated that service should drive policy. The Ryan White portfolio will have to shift because of the implementation of the Affordable Care Act and because of the payer of last resort rule – Ryan White cannot pay for a service for which another payer exists. Ms. Duke wants the Policy Committee to take a look at the portfolio, see what Ryan White programs are allowed to offer by HRSA, and see whether there are ways in which we should shift the definitions of programs. We can cast a wide net. Although this Committee does not develop service models, we can make recommendations to the Integration of Care Committee.

The Impact of Sequestration on PLWHA: Sequestration is being implemented because Congress and the President are unable to agree on a budget deal. Ideally, we shouldn't approach people's lives with across the board cuts. The possibility exists that politicians will be able to reach a deal to mitigate the effects of sequestration. Although Ryan White programs are scheduled to be cut by 5%, the cut to the NY EMA may be smaller. States that have not completely implemented names-based reporting and are not fully in compliance with HRSA's requirements to shift from code-based reporting to name-based reporting may be hit more heavily. Nina Rothschild delivered a presentation on the impact of sequestration on PLWHA. The presentation is posted on the Planning Council website.

Policy Issues and the New York Eligible Metropolitan Area Portfolio: Anna Thomas of the Care and Treatment Program noted several big issues affecting our portfolio, including the Affordable Care Act (ACA), NYS Medicaid Redesign (especially health homes), and the HRSA monitoring standards. Starting in 2014, PLWHA who earn less than 138% of the federal poverty level will be covered by Medicaid; insurance carriers cannot refuse to provide insurance to PLWHA and cannot have cost caps; insurance companies will not be able to exclude patients based on pre-exiting conditions; and the health insurance exchanges, where patients can shop for insurance coverage, will open. Currently, New York State spends $2.8 billion Medicaid dollars on PLWHA. Fifty-six percent of PLWHAs in the NY EMA are Medicaid recipients.

Medicaid reform may affect a number of service categories, including oral health, medical case management, harm reduction, recovery readiness and relapse prevention, home care, early intervention services, and mental health. Behavioral health homes are supposed to offer a medical case management-type service, but how this will play out is not yet clear – the list of offered services is quite short. High cost patients are being identified for health homes, but we are nowhere near the statewide targeted enrollment of 44,000 into health homes. We don't yet know – once someone becomes more stable, will they remain in a health home? The probable answer is yes, although there needs to be a case mix. We need to inform ourselves about

what the current array of services is, who the other payers are, and where the gaps are. We should also know whether there are other services that have not been included but may be beneficial to add. Mr. Harriman noted that NY State was issuing guidance about health homes and then reissuing the guidance.

We need to make sure that Ryan White continues to be the payer of last resort (PLR). Mr. Park noted that the NY Academy of Medicine took a long time to identify all possible payers of services to ensure that we are indeed following the PLR rule. The flow chart in Ms. Thomas's presentation should help providers to develop a sense of what their future might look like going forward.

Mr. Park asked whether the grantee has done an assessment of patients who are currently enrolled in medical case management and asked how many of them will have their services directly affected by the implementation of health homes. The roll-out of health homes is very slow, and all the data is not yet in. Acuity of need is being assigned by Medicaid based on an algorithm that is known to no one. Some people, moreover, are being rated by Medicaid as low acuity because they are going to their appointments – but without the support of care coordination, they might not be attending regularly. Seeing how all of this plays out will take a while.

Randall Bruce asked about what PLWHAs should expect in the next few months. Ms. Duke stated that this system is not yet a system and that we want to make sure that the Ryan White portfolio is sustainable in the context of change. Some services that Ryan White provides such as directly observed therapy, or DOT, are not provided by NY State. Ms. Duke noted that there are quantifiable data about positive health outcomes associated with directly observed therapy (DOT). Mr. Park commented that DOT is extremely expensive and that the State may have decided that it is not cost-effective. As we start to deconstruct the service categories, we need to be careful about what we are trying to save – for example, if other payers say that DOT is not cost-effective, we should look at that information.

Health homes are based on a chronic disease model and are not HIV-specific. How do we support people in this time of transition? Ms. Duke noted that this is a journey. We are doing research, looking at what is going on within a community and outside of it and making recommendations. Mr. Bruce noted that this is very confusing and is a way of losing PLWHAs in the system. Mr. Harriman mentioned the importance of maintaining a level of calmness and stability. We can come up with conclusions and then make recommendations for other committees. Mr. Harriman reminded the group that he is talking about system-level changes, not just changes in Ryan White. Mr. Park reminded the group that different committees own different tasks, but the ownership is not absolute – they can assist each other.

Public Comment: No members of the public commented.

Adjournment: The meeting was adjourned.