Meeting of the
PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, March 9, 2020
Cicatelli Associates, 505 Eighth Ave., NYC
3:10 – 5:00pm

M I N U T E S

Members Present: Jeff Natt (Co-chair), Dorella Walters (Co-chair), Randall Bruce, Paul Carr, Broni Cockrell, Graham Harriman, David Klotz, Matthew Lesieur, Carmelo Cruz Reyes, Michael Rifkin, Leo Ruiz, John Schoepp, Claire Simon, Terry Troia (by phone), Rob Walker

Members Absent: Joan Edwards, Steve Hemraj, Oscar Lopez, Jesus Maldonado, Barry Zingman, MD

Staff Present: Faisal Abdelqader, Scott Spiegler *(NYC DOHMH)*; Gucci Kaloo *(Public Health Solutions)*

Agenda Item #1: Welcome/Introductions/Minutes

Mr. Natt and *Ms. Walters* opened the meeting, followed by introductions and a moment of silence. The minutes of the January 13, 2020 meeting were approved with one change to reflect accurate attendance.

Mr. Klotz reported that NYC DOHMH is not yet recommending that in-person meetings be suspended in response to the COVID-19 ("coronavirus") outbreak. When feasible, some meetings may be done by conference call (including the March 19th Executive Committee), and a call-in option is always available, but otherwise, attendees should just take standard precautions (frequent hand washing, etc.), and chairs will be spaced out as much as possible.

Agenda Item #2: FY 2020 Reprogramming Plan

Mr. Klotz presented the draft FY 2020 reprogramming plan, which PSRA approves near the beginning of every fiscal year so that the Recipient (Grantee) can maximize spending in the course of the year. As in previous years, the plan gives the Recipient the flexibility to enhance over-performing contracts by moving funds between service categories up to 20% of the original spending plan allocation. This is done after the Recipient and Public Health Solutions (PHS) enhances over-performing programs from funds taken down from programs within the same service category to the maximum extent possible. Enhancements are one-time and must be used by the end of the fiscal year, and usually come late in the year. Initial enhancements to Tri-County and NYC programs from take-downs of programs in their respective regions, and after initial enhancements are made, to put remaining reprogramming money into one EMA-wide pot. ADAP is eligible for enhancement after all other service categories have been considered and has no cap. A summary of the discussion follows:

- The cap on the increase to a service category allocation used to be 15% and the Council raised it because enhancements were hitting the cap. Also, in recent years, the Council has increased the baseline allocations of service categories that were consistently over-performing (e.g., Food & Nutrition), and so there has not been the need to give such large

enhancements to those categories, and Public Health Solutions (PHS) has not bumped up against the 20% cap.

- Enhancements are done after close-out, which means that DOHMH and PHS has exact data, rather than projecting "potential" over-performance. Also, as enhancements are done at close-out, programs that over-perform must pay for any services above their contract amounts from other sources of revenue without a guarantee that they will be reimbursed through reprogramming.
- Most programs are fee-for-service contracts, which means that PHS tracks actual performance through eShare. Also, PHS contract managers monitor programs' spending and performance to ensure that services are performed as reported.

***Mr. Bruce* made a motion, which was seconded, to approve the FY 2020 reprogramming plan as presented. *Mr. Harriman* made a friendly amendment, which was accepted, to strike the words "or show potential to perform above" from the first sentence. The motion as amended was adopted unanimously.**

Agenda Item #3: FY 2021 Application Planning: Non-Medical Case Management/General Population

Mr. Klotz prefaced the discussion by reiterating that noting that the PSRA has agreed on the need to revisit all service category allocations in the light of continued expected reductions to the grant award, the need to fund new initiatives (e.g., oral health services, emergency financial assistance), and the diminishing availability of the ADAP allocation to achieve this. It was also pointed out that the service directive for Non-medical Case Management (nMCM) contains the service models for two distinct categories: nMCM for the incarcerated/recently released (which has specific services for that population), and nMCM for the general population, which focuses on connecting those not in a correctional setting to services and benefits. They are listed separately on the spending plan with separate allocations. This meeting focuses only on the latter category, Non-Medical Case Management/General Population (NMG).

Mr. Spiegler and *Mr. Abdelqader* presented on NMG, including the new service category Fact Sheet. The HRSA definition was described, including key activities and program guidance. The locally defined service (as per the Council's directive) was explained: 1) advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services; 2) Low-threshold intervention; 3) Support for individuals living with HIV who do not need intensive, on-going assistance managing their care and treatment but who still require help identifying and accessing available resources. The total allocation is $1,570,199. Contracts were last rebid in 2014 and there are four providers with a range of $291K-$322K. the four contractors all have other Ryan White Part A (RWPA) contracts. For example, Program 1 (located in Queens) also has Food & Nutrition, Housing Placement, Supportive Counseling, Harm Reduction, Mental Health and Legal Services. All RWPA programs provide case management services. As the eligibility requirements are virtually identical for all services, it would be easy to enroll NMG clients in another program where they can get the same services.

The Fact Sheet shows that spending decreased in NMG in 2017 and 2018 (e.g., in 2018, programs spent $1,263,369 of the original allocation of $1,570,199, an under-performance rate of nearly 20%). The number of unduplicated clients units of services has fluctuated some but stayed relatively stable. The number of service units (not unduplicated, as the same client can access multiple service types) follow the same pattern, with an uptick for client assistance, and a decrease for outreach for reengagement. The percentage of clients from priority populations (Black or Latino MSM, Older PLWH, Transgender women, Women of color, Young MSM) closely mirrored their representation in the EMA. The percentage of older PLWH is increasing slightly. Other client demographics (borough of residence, risk factor, age, race/ethnicity, gender) were described.

Payer of Last Resort considerations include that individuals who are Medicaid/Medicare eligible may receive HIV treatment, mental health, and case management services (including medical transportation, general and medical case management, ADAP, etc.). Under the Affordable Care Act, individuals with private insurance are able to access HIV testing/treatment, and outpatient substance use services. Services provided under NMG are also offered to those without insurance coverage, including transportation, case management, and substance use screenings/referrals, through the NYS AIDS Institute. HASA, Medicaid Health Homes, Special Needs Plans, and Ryan White Part B, RWPA Care Coordination and Supportive Counseling all provide similar case management services.

System-level considerations include that there are no large systems level considerations for NMG at the moment, however, with expanding Medicaid coverage offering more services to those covered, NMG services should continue to be monitored to ensure the utilization of NMG as wrap-around services. Plus, there is duplication of service types across the RWPA portfolio (e.g., accompaniment is done in Harm Reduction, Mental Health, Medical Case Management, Psychosocial Support, and Early Intervention). Definitions of the service types were provided.

In summary, given that NMG services are duplicated in other RWPA programs, and that there are other funded case management services (Medicaid, Health Homes, Parts C & D, etc.), the PSRA needs to think about where the model fits in the Council's funding priorities. With the prospect of continued decreases in the RWPA grant award and upcoming new priorities, should the Council use this service allocation to offset future reductions and/or for additional funding to higher priority or new service categories? Also, what is the planning process for making this decision? PSRA's purview, as per the Council Bylaws, is to make recommendations on allocations, including whether or not to fund an existing category or at what level. The last time a service category was eliminated (Transitional Care Coordination), it had been brought to the PSRA initially and the committee voted that the category should be discontinued and the funds reallocated to Housing. That decision was kicked back to the Needs Assessment Committee, and the process ended up taking multiple years before coming back to the PSRA, where the original recommendation was adopted. Given the time constraints (an application spending plan must be completed by the July meeting), the need to streamline services in order to respond to the changing epidemic and funding scenario, and the role of the PSRA, there was discussion about the necessity to have multiple committees review the PSRA's recommendation. It was noted that any PSRA recommendations still go through two more layers of review – by the Executive Committee and full Council.

A summary of the discussion follows:

- Staffing or programs is decided by the contractors, but is generally a mix of case managers and patient navigators. Some programs may use some peer workers.
- Just because a program is located in a specific borough does not mean that their clients are all from that area. Some people migrate to services outside their area of residence for privacy.
- On Staten Island, this program serves many undocumented PWLH who are not eligible for Medicaid or Medicare and often require a lot of patient navigation. There are Part C and D programs on SI that can also serve this population.
- DOHMH does not collect data on immigration status, but can look at Medicaid eligibility, with the number of those ineligible as a proxy for the undocumented.
- When a program is discontinued, there are ways to ensure a "warm handoff", i.e., ensuring that a client is enrolled in a new program and has a seamless continuity of services. This has been done many times, most recently with TCC clients.
- Some people may only want case management services and not the core services in other categories. For example, an NMG client may not want or need or to want to enroll in need Harm Reduction

program to get connected to benefits (and enrolment in Harm Reduction could be stigmatizing to a client).

There was a consensus that it is PSRA's role to review the allocations. Given the timing of the planning cycle and the need to review multiple fact sheets, there may be a need to have 3-hour meetings as well as a possible extra meeting in May or June. Some fact sheets will not require extensive review, as there is relative stability in the programs (e.g., Legal). Service categories that will require a more extensive review include Mental Health (where the Needs Assessment Committee may have recommendations), Harm Reduction (where the payer of last resort landscape is changing), and Medical Case Management, as it is by far the largest allocation. The following additional data points will be presented at the April meeting for PSRA to conclude discussion on NMG:

- How many NMG clients are dually enrolled in Medicaid/Medicare?
- What specific services within a service type are the most utilized and will they be easily accessible to current clients if the program is reduced or eliminated?
- What specific service types are not reimbursable by Medicaid/Medicare?
- List of Part C and D programs by geographic distribution
- How does the "warm handoff" work?

The data will be presented at the April meeting for a continuation, and hopefully a conclusion to the discussion.

There being no further business, the meeting was adjourned.