

Seattle HIV/AIDS Planning Council

Monday, December 12, 2011 4:00 p.m.–6:30 p.m.
2100 Building: 2100 24th Avenue South

AGENDA

- I. **Welcome, Introductions and Announcements** 4:00
- II. **Meeting Agenda (2 min)**
➤ **Action:** Review and approve
- III. **Minutes: (3 min)** *Attachment: white*
➤ **Action:** Review and approve
- IV. **Approve Preliminary Unobligated Balance Request (Jeff)** *Attachment: buff* 4:10
• New HRSA Requirement: The Council must write a letter confirming that the Grantee's preliminary carryover request conforms with the Council's 2012 plan.
➤ **Action:** Vote on letter, due January 3rd.
- V. **Should 2012 Allocation Process be Re-opened? (James)** *Attachment: pink* 4:30
➤ **Action 1:** Vote on whether to re-open the 2012 allocation process
• If the vote is *approved*, the allocation will be sent to the Prioritization and Allocation Committee to create a plan to be brought to the Council in January.
• If the vote is *not approved*, then the following items need to be addressed by the Council today:
➤ **Action 2:** (If Action 1 is voted down). Vote on whether to approve the Parity Principles, but oppose the Parity Calculations for 2012 on the basis that the Council will not be allocating 27.3% to the Early Intervention Program.
➤ **Action 3:** (If Action 1 is voted down). Vote on whether it was the Council's intention that any program providing Medical nutrition therapy with Part A dollars would have a food and meal program as part of its services.
- VI. **Break** 5:00
- VII. **Provider Panel: What Agencies are Doing to Prepare for the ACA** 5:15
- VIII. **Adjourn** 6:30

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Questions? Call: 206-296-4527***

Seattle HIV/AIDS Planning Council

Minutes ☉ Monday, December 12, 2011
4:00pm - 6:30pm

2100 24th Avenue South Seattle, WA 98144

Council Members Present: *Richard Aleshire, Arnell Alston, Kate Elling, George Froehle, Matt Golden, Joachim Hawn, Chris Haworth, Nykia Johnson, Jake Ketchum, David Lee, Higinio Martinez, Pat Migliore, Jonas Nicotra, Chris Porter, Richard Prasad, James Redel, Germán Rodríguez*

Persons Nominated by the Council, but not appointed by the King County Executive present:
Randy Russell

Council Members Absent: *Tim Blich, Kenneth Burk, Shireesha Dhanireddy, Oscar Grey (emeritus), Jodie Pezzi, Ed Wilhoite, Paul Williams*

Planning Council Staff Present: Elizabeth Barash, Jesse Chipps, Courtney Speigner (minutes)

Public Health Staff Present: Linda Coomas, Jeff Natter

Guests: Amber Casey (Department of Health – DOH), Robb Crowe, Robert Harrington (Harborview Madison Clinic) Jennifer Hinson (Lifelong AIDS Alliance), Jennifer Magnani (University of Washington – Harborview Madison Clinic), Ann McGettigan (Seattle Counseling Service), Linda McVeigh, Jenn Morton (Planning Council Intern), Tony Radovich (Rosehedge/Multifaith), Glenn Reed, Erick Seelbach (Health and Human Services – HHS), James Ward (Rosehedge/Multifaith),

Italics denote Planning Council Membership.

I. Welcome, Introductions and Announcements

The group did a round of introductions and stated affiliations.

Jeff announced that the HIV section of the HIV/STD program has moved. The new address is: 401 5th Ave., Ste 1100-E, Seattle 98104.

Nykia announced that Megan Conden, Jail Health Services, would be on leave as of Friday, December 16.

II. Meeting Agenda

Jesse asked whether people feel there has been enough time to review the Snohomish Island Committee (SIC) plan in order to vote on it today. David Lee asked that a committee member summarize it. The group agreed by acclamation to add it to the agenda, after “Approve Preliminary Unobligated Balance Request.”

The agenda was approved as amended by acclamation.

III. November Meeting Minutes

The November minutes were approved as written by acclamation.

IV. Approve Preliminary Unobligated Balance Request

Jeff explained that the program is allowed to request carryover from one year to the next from the Health Resources and Services Administration (HRSA). The program always tries to spend out the award, but there are usually some funds that need to be carried over. HRSA requires that 100% of the supplemental funds and 95% of the formula be spent out. HRSA now requires that programs submit an estimate of unobligated funds and how they will be allocated by January 3. For the last five years, Part A has allocated them to the AIDS Drug Assistance Program (ADAP). Jesse read the draft letter (buff – attached) which states the funds will be allocated to ADAP.

MOTION: Kate moved to approve the letter. Joachim seconded.

Discussion: Nykia asked how much the carryover is typically. Jeff explained that last year it was \$146,000 (less than 1% of the full award, and about 2.7% of the formula award). There will be some additional unexpected carry over because the Quality Manager position will be unpaid for several months. He estimated between \$150,000 and \$170,000.

<Randy entered at 4:10pm>

The motion passed with the following vote:

- In favor – 12 – Matt, Joachim, Germán, Higinio, James, Kate, Chris H., Nykia, George, Arnell, David, Richard P.
- Opposed – 0
- Abstaining – 1 – Richard A.

V. SIC 2012 Allocation Plan

Joachim noted that the group was very cooperative. Hard copies of the plan were distributed at the meeting (attached), and Jesse explained some of the major differences:

- Funding to Medical case management was decreased by \$60,000, mainly because of the cost per client.

<Pat entered at 4:20pm>

- The group funded Oral health care at \$70,200. This was due to the anticipated loss of the state Early Intervention Program (EIP) dental program. (The group knew it could not fill the entire dental gap.)
- Funds to Mental health services were decreased due to lower anticipated expenses for 2011.
- Medical transportation was funded at \$2,000 as a part of Medical case management. Jesse clarified that the funding for Medical case management is \$439,230, plus an *additional* \$2,000 for Medical transportation.
- Food bank/home-delivered meals (hereafter referred to as Food and meals) was cut significantly. The remaining funds are focused on emergency grocery vouchers and Ensure supplements.

<Chris P. entered at 4:22pm>

The group also created a decrement plan of \$100,000 to be used if the Council decides to allocate additional funds to ADAP. These are major cuts. SIC recommended that the Council not reopen the 2012 allocations because of the severity of the cut that would be required if 27.3% were allocated to ADAP.

The group discussed the plan:

- Matt asked why Medical transportation was eliminated completely in the decrement and not Oral health care. He asked how many people can be supported by \$20,000 in Oral health care (in the decrement plan). James explained that in the decrement plan, Oral health care funds are only to be used for preventative care. He added the group felt it was important to keep some funds because this is the only anticipated funding available for people living with HIV (PLWH). Jesse added that the group's assumption was that even in a decrement situation,

some of the Medical case management funds would be used toward transportation needs, but the plan would eliminate the funds specifically set aside for Medical transportation. Germán stated that those on Medicaid would qualify for transportation dollars, and Jesse explained that these funds provide gas vouchers for people to travel cross-county for services.

- George noted that the \$4,255 left in Mental health services in the decrement plan seemed like very little and wondered whether it was worth funding it at all in the decrement plan. James explained that it is a high priority. Jesse explained that the funding amounts in Snohomish and Island Counties are much lower because there are fewer PLWH in those counties. Higinio added that some of these dollars fund group sessions which cover more people for less money.
- Jeff noted that in the King County plan, the committee created a caveat that Medical case management must address Medical transportation. The group may want to consider this caveat for the entire Transitional Grant Area (TGA) when it plans for 2013.
- Kate asked what the justification was for eliminating Food and meals in the decrement, especially when food banks are overwhelmed. James explained that in Snohomish and Island Counties this category is currently funded as supplements, household supplies and food vouchers. The group felt after some input from a representative from that agency at the meeting, that the need for household supplies was less. Funds had to be cut from somewhere, and this was the lowest priority. Joachim noted that the group also considered whether there were other sources for this service. Jesse added that the SIC stressed they did not feel the Council should re-open allocations and its intent was that the \$100,000 decrement plan would not have to be put into place.

<Jake entered at 4:30pm>

MOTION: James moved to approve the SIC 2012 allocation plan. Joachim seconded.

Discussion:

- James stated that the SIC's biggest concern was the decrement plan which would seriously cut funding in Snohomish and Island Counties as well as be a significant hit to Medical case management, which is the key to accessing services.
- George stated that it is unclear what kind of effect these plans would have on people. He stated it would be helpful to have data such as number of people served, etc. Jesse explained that this is the reason why there is a prioritization committee – they consider a large amount of data, including number of people served, cost per client, performance data etc. She explained that Council members are really voting on the process by which the committee made its decision. The planning process for the entire TGA for 2013 will begin next year and will be open to all Council members. Matt stated his view that the full Planning Council needs to review more data to fully assess the outcome when voting, and not just the process.

☑ The motion passed with the following vote:

- In favor – 14 – Richard A., Matt, Joachim, Germán, Higinio, James, Kate, Chris H., Nykia, Pat, George, Arnell, David, Richard P.
- Opposed – 0
- Abstaining – 2 – Chris P., Jake

VI. Should 2012 Allocation Process be Re-opened?

Jesse explained that the Executive Committee decided that if the Planning Council decides to reopen allocations, the decision will need to go to the Prioritization Committee. The group discussed whether to reopen allocations:

- Randy asked Richard A. to explain the request. Richard A. stated that the parity workgroup met recently, and at that meeting he announced that the state would contribute 27.3% of the Part B funds to ADAP. He explained that the state is not asking for the same amount from Part A. They did not request a specific figure at the meeting. He added that the program was originally expecting a \$26 million shortfall (for the biennium); at this point it is down to a \$10 million shortfall. If Part A were to put the same percentage as Part B it would be \$1.3 million. Currently, Part A has allocated \$690,000, which is 12.3%. Jeff clarified this is an estimated guess, based on carryover, the Minority AIDS Initiative (MAI) award, and the Part A award, but this is true of any category's allocations.
- Randy asked whether there is an estimate of when a waiting list would begin without additional funds from Part A. He noted that having an ADAP waitlist does not mean there would not be drugs available for PLWH; it would mean people would have to go on patient assistance. Richard A. explained that the Early Intervention Program (EIP) Steering Committee made a list of action items, and creating a waitlist is at the end of the list. Before implementing a waitlist, the program would take every other drug off formulary, eliminate Group 3, eliminate Group 2, and many other steps before starting a waitlist. The legislature has decided not to take action on reducing programs, so the program must wait to see what the final budget will be. If they cut \$3.9 million (which is the governor's recommendation), that would be severe.
- Jesse clarified that the question is whether the Council feels satisfied with its plan or whether it wants to reopen the discussion, partly in light of the ADAP crisis. The Council cannot tell the Prioritization Committee to increase the allocation to ADAP, but it may ask the committee to consider it.
- Matt stated that the committee may want to consider increasing the allocation to Outpatient/ambulatory medical care; it is possible that paying for health insurance is not the most cost effective method, although it was noted that that is currently how medications are paid for.
- Chris P. asked whether it would be possible to reopen allocations at a later date if the group does not decide to do so today. Jesse explained the Council may do this at any time. However, once the grant year has begun – March 1, 2012 – it becomes more difficult because funds will already be awarded to, contracted with and spent by programs. For example, in 2011 Part A did not know its award until half way through the grant year and then had to make more severe cuts because half of the awards were already spent. At this time, federal awards are not known (for Part A or Part B), and it is also not known what the legislature will decide. Richard noted that if the state does not get a cut from the legislature, and there is an increase in the Part B award, the program may get by without additional help.

<Jonas entered at 4:45pm>

- Richard A. read the rest of the items to implement before creating a waitlist (determined by the EIP Steering Committee): stop paying copays, contract with a single lab, contract with a single pharmacy, limit CD4 and viral load counts, and lower financial eligibility.
- Randy stated that the contribution to ADAP from Part A varies across the country. He stated that in Florida, having a waitlist has been difficult because some PLWH have had to wait a long time to get their medications, but that is with a very large waitlist. With a smaller list, like a couple of hundred, it is more straightforward. Most of the drug companies have morphed into one entry point for patient assistance. He stated that the Council should not try to put additional funds into ADAP, even if it means moving toward a waitlist; it creates more chaos to dismantle the system. There were several dittos.
- James Ward asked if any more information will be known before March 1. Jeff stated that it is unlikely that the Council will know all of these numbers by March 1, 2012.

MOTION: David moved to not reopen reallocation at this time. Kate seconded.

Discussion:

- Matt asked if the group has a decrement plan for 2012, and Jesse answered this has not yet been created. The Executive Committee will discuss when to create this and will likely decide to wait until there is more information. Matt noted that the downside of waiting longer is that cuts must be deeper if they are created after the contract year begins. Jesse clarified that the purpose of a decrement plan is if the Part A award is less than the amount for which the prioritization committee planned, not for moving money to different services. Additionally the plan is typically created before the contract year begins.
- Richard A. stated that clients in Group 1 who are not picking up their anti-retroviral medications (ARVs) are moved to Group 2 (EIP does not cover insurance for this group). In the first quarter, there were 47 people moved from Group 1 to Group 2, which saved about \$500,000. The program is currently assessing the second and third quarters; they expect about 70 clients to move to Group 2, which should save approximately \$700,000. Additionally, there are several clients currently getting medications from patient assistance because they are not eligible for EIP for one year.
- Nykia stated she thought the Council already created a decrement plan for 2012, but Jesse clarified that the Council created a decrement plan for 2011 and a allocation plan for 2012 (but not a decrement plan for 2012).
- Joachim asked why clients are being moved from Group 1 to Group 2 and how they are being contacted. Richard A. explained that the program checks to see who is picking up medications from the pharmacy. Those who had not were asked to show proof of picking up ARVs for two months out of a four month period. EIP has sent multiple letters and emailed case managers of those who may be moved to Group 2.
- Chris P. stated his view that to not reopen allocations and consider adjusting the allocation to ADAP is to ignore obvious signs. Already, providers have received notice that Medicare will decrease payments; there have been many indicators that the federal government is giving less.
- Randy suggested that the Council create a decrement plan because it may be needed if the award is less or Part A decides to allocate more funds to ADAP in the future. He suggested that the group not reopen allocations at this point but create a decrement plan soon. Jesse explained that a decrement plan is generally created in January or February.

Friendly Amendment: Chris P. suggested that the motion be revised to say that the Council is choosing not to reopen the allocation process at this time but will create a decrement plan by February. David and Kate accepted.

Further discussion: Matt asked how much of the year would be spent by the time the decrement plan is created, and Jesse answered that no funds will have been spent because the contract year begins on March 1.

☑ The motion passed with the following vote:

- In favor – 16 – Matt, Joachim, Germán, Higinio, James, Jonas, Kate, Chris H., Jake, Nykia, Pat, Arnell, David, Richard P., Chris P., George
- Opposed – 0
- Abstaining – 1 – Richard A.

Medical Nutrition Therapy (MNT)

Jeff explained that at the last meeting, the Council moved the Food and meals funds under MNT. This moved funds from a support service to a core service. It did not decrease amount of food going to clients in any way, but made the food program a part of MNT service. Now that food is included under MNT, he needs the Council to determine whether it wants to limit funding to only MNT programs

which provide food as a part of their program or continue to fund programs that are stand-alone without food. The group discussed:

- James stated his interpretation that the Council intended for MNT programs to include food. Kate agreed.
- Joachim stated that there was a reason that the prioritization committee defunded this category in 2011 and asked what will guarantee that the same issues do not continue. Jeff noted that the MNT program is much closer to meeting benchmarks for 2011 and have been able to show clinical outcomes. He stated it would be difficult for the Council to justify funding Food and meals as a separate category with no clinical outcomes.
- Linda clarified there is currently one contracted MNT program that also provides food, and one that does not. Of the total 2012 allocation to MNT, \$65,000 is reserved specifically for MNT services, and \$345,000 for food. The Council needs to determine whether that \$65,000 can only be for a program that also provides food or be stand-alone.
- Kate asked whether having a caveat could limit the number of agencies that will apply. Jeff answered he does not know, but it will affect the currently funded programs.
- Chris P. asked whether clinical outcomes are too difficult to track in stand-alone food programs. Jeff answered they have tried for many years to show clinical outcomes associated with Food and meals, but without success. Jesse clarified the group already made the decision to move Food and meals under MNT at the last meeting, and it would take a two thirds vote to reopen that discussion.

MOTION: Kate moved that the MNT funds be open to any MNT program (with no caveat that MNT programs must provide food. James seconded.

Discussion:

- Matt asked Jeff what the implication of this would be. Jeff stated that \$64,000 is probably only enough to support one staff person in one program. The current funding is barely enough for less than .5 full-time equivalent (FTE) in two programs.
- Jesse clarified that if a member votes no, they are voting to fund only MNT programs that are connected to food and meals program.
- Jennifer Hinson stated that funding for MNT was already radically cut, and last year, it was cut in half. With the addition of administering a clinical approach with a food program, those funds will not go far.
- Nykia clarified that making the funds only available to MNT programs which contain a food component would really mean funding only one program.
- George stated that having an MNT program and nutritional discussion without access to food does not make sense. He stated that the only MNT programs with a food component should be funded. Nykia stated that she had seen many clients benefit from seeing nutritionists at Madison Clinic (which does not have a food component), especially clients who are diabetic. They go to discuss their diet, but they do not necessarily need to be connected to a food program.
- Jesse clarified there will not be an RFP process. The motion is to allow funds to go to both currently funded MNT programs. If the motion fails, funds can only be awarded to the MNT program that currently provides food.

✓ The motion passed with the following vote:

- In favor – 15 – Matt, Richard A., Germán, Higinio, James, Jonas, Kate, Chris H., Jake, Nykia, Pat, Arnell, David, Richard P., Chris P.
- Opposed – 1 – George
- Abstaining – 1 – Joachim

The funds will be divided between the two current contracts.

BREAK: 5:20 – 5:25pm

VI. Provider Panel: How Agencies are Preparing for the ACA

Jesse asked each member on the panel to begin by talking about what their agency is doing to prepare for the implementation of the Affordable Care Act (ACA).

- *Linda McVeigh (Country Doctor)* stated that Country Doctor has been a Federally Qualified Health Center (FQHC) since the legislation went into effect. Country Doctor is currently trying to grow. When Massachusetts implemented a similar Healthcare Reform (HCR) plan, FQHCs were immediately slammed with six month waitlists because those without access to primary care suddenly had access. Country Doctor's Carolyn Downs Clinic did receive some stimulus money to make additions. There will be competition for primary care providers. Places like Swedish are already hiring primary care providers in anticipation of the changes. Country Doctor is working hard in workforce development. Baby boomers are aging into needing more access to healthcare. Additionally medical providers are beginning to retire; Country Doctor has had four recent retirements – they have been able to replace these people because they work with residents from Swedish Hospital. They are working to get certification as a patient medical home in 2013. They have adopted electronic health records (EHR), which already helps with disease management. They are also partnering with the Community Health Plan of Washington to participate in the exchange and have more insured patients. In December 2010, 54% of Country Doctor's clients were uninsured, which has grown to 67% now. With ACA, they anticipate that more than half of their clients will be insured.
- *Randy Russell (Lifelong AIDS Alliance)* noted that Congress is considering reestablishing a ban on federal funds for needle exchange. He also stated that it is now up the states to decide for themselves what the reimbursement would be for essential health benefits. Seventeen million people will be participating in the insurance exchange, and the rest will be included in the Medicaid expansion. He explained the Medicaid expansion allows states to approach how to administer Medicaid (by organization, or by third party), the range of services covered (possibility of housing advocacy, for example), and what the reimbursement rate is. He explained different aspects Lifelong is focused on:
 - *Policy and Advocacy* – Lifelong just signed a new director of policy and advocacy with a tremendous focus on health home designation. He noted that the Healthcare Authority (HCA) has only five people working on HCR and there are no plans for listening sessions; they are making decisions without community input. He asked that more people join the Washington HIV/AIDS Community Advocacy Network (WHACAN) to advocate about these issues.
 - *Collaboration* – Lifelong is currently “dating” different medical providers to see which would be the best fit for collaboration. Lifelong can contribute space for the clinic. Current possible partners include University of Washington and community health centers. He stated there is benefit for consumers to have medical services co-located with other services.
 - *Housing* – Lifelong is looking to add to these programs.
 - *Chicken soup* – Lifelong would like to expand this program.
 - He also noted that Lifelong is paying a lot of money in rent right now, and are looking into this right now.
- *Ann McGettigan (Seattle Counseling Service – SCS)* explained that SCS is Lesbian, Gay, Bisexual and Transgender (LGBT) organization and a licensed mental health and chemical dependency treatment agency. They provide a combination of mental health, harm reduction and abstinence-based programs. SCS sees about 1,750 people per year. They receive Ryan White funds for a substance abuse treatment program and HIV prevention funding for Project Neon. They are a Medicaid and Medicare provider (although have not been paid by Medicare for some time). SCS is experiencing some anxiety about HCR. Ann stated she does not have confidence in the state's ability to administer the Medicaid program. SCS is hopeful that the

number of people who will become eligible to access services will increase. They currently have many clients on a sliding fee scale. SCS has worked hard to provide culturally competent care, including for PLWH. She expressed concern that with the implementation of ACA, some of the smaller organizations will be lost, and with them culturally competent care will be lost. SCS is partnering with WHACAN. They have also reconstituted the Cross-Cultural Alliance, which is a small group of providers committed to culturally competent care including organizations who provide services LGBT, African American, Asian/Pacific Islander, and Latino communities. She also expressed concern about federal, state, and county budget issues and that human service safety net providers will be lost in the shuffle.

- *Jennifer Magnani (Madison Clinic)* is the case management supervisor at Madison Clinic. Madison Clinic is one of the largest medical providers for PLWH, with over 2,100 clients receiving primary care. Under ACA, there is no recognition that there are specific primary care needs for PLWH. Madison Clinic sees value in continuing care specific to PLWH. In the current legislation, it appears that people will be directed to medical homes and FQHCs. Madison Clinic does not have the designation as a medical home or FQHC that would allow it to maximize funding. Madison Clinic serves the mission population that they would need to serve as a medical home. They are currently looking at how to approach becoming a FQHC or getting medical home designation. She added that about 40% of case management time is spent working on funding issues and hopes that this will decrease with ACA so that case managers may focus on other work, such as getting people into treatment.
- *Richard Aleshire. (EIP)* explained that EIP is primarily working with the National Alliance of State and Territorial AIDS Directors (NASTAD). They have had a few meetings on the ACA. Their goal is to make sure that in 2014, PLWH have access to the services they need. They are working to get the message to Congress to reauthorize the Ryan White Care Act in 2013. They have been assured that Ryan White is fully supported, but this may not be true when Congress is trying to figure out how to pay for ACA. NASTAD's message is that Ryan White must be reauthorized past 2014 because we do not know what will happen with ACA. NASTAD is working to come up with the least amount of items that PLWH need for the essential benefits list. They have suggested that instead of eliminating Ryan White, it should be used as the model for working with people with other diseases. Additionally, Ryan White is needed for people who will not be covered by ACA, but they are not sure how to deliver that message. EIP is trying to prepare clients to transition to ACA. Eighty-six percent of EIP clients now have insurance. About half of the EIP clients are at 133% of FPL or below and will be on Medicaid. Currently, no one is working on the 1115 waiver; EIP is waiting for decisions from the legislature before revisiting the 1115 waiver with HCA. If the waiver could be implemented in 2013, it would give one year to help PLWH transition.
- Randy noted that there is a difference between the current Medicaid and what Medicaid will be like in 2014. On January 1, 2014, the federal government will pay 100% of the cost of Medicaid for new enrollees, with no state match required (the current match rate from the state of Washington is 50%). This 100% coverage would last three years. In Washington, about 500,000 people will become eligible for Medicaid. There will be two pools. Those who qualify before 2014 will be on the current package; those who become eligible in 2014 will get the newly defined package. Jesse added that if the government will reimburse at a higher rate in 2014, HCA cannot dump those who were enrolled pre-2014 and reenroll them.
- Richard A. explained that in Part B, services have been cut to only Medical case management. They are working with NASTAD to see if case managers may be retained as "patient navigators" under ACA.

Chris P. asked the panel to speak about if and how they used the Electronic Health Record (EHR) incentive.

- Linda stated that Country Doctor used it to close the gap left by the state reductions (otherwise they would have had to reduce staff). The EHR system also better meets needs in a medical home, for example with electronic prescribing. Germán asked whether that is a closed system,

and Linda responded that it is, but she hopes that under ACA there will be funds available to have systems work with each other.

- Jennifer answered that Madison Clinic has had EHR for some time. She did not know if they received any funds for this.
- Ann stated that SCS is too small to have qualified for this. They are interested in moving to an EHR system because audits are very difficult with hand-written records.

David asked what keeps Madison from becoming an FQHC.

- Jennifer M. explained that there are certain requirements for being an FQHC. They must have a governing board that is 50% consumers, which is very difficult as an academic center. Madison Clinic is part of the whole entity of the University of Washington. Additionally, FQHCs already exist in the area. She wondered whether the federal government would expect that the current FQHCs take on Madison Clinic's 2100 clients, and Linda noted that they would not have that large of capacity.
- Randy noted that many cities are dealing with an academic institution with an HIV clinic inside of it, and there are a lot of people in the chain between the medical clinic and leader of the academic institution. He noted that HIV did a service to exploring the health home model. New York has already decided that any chronic condition is lumped into a health home. Jennifer M. noted that under that system, Madison Clinic would not exist.
- Jesse asked what the barrier to Madison Clinic becoming a medical home is, and Jennifer M. answered that Madison Clinic may be able to more easily meet these criteria.

Jesse asked each provider to address how their agency is helping to transition clients.

- Linda stated that under ACA, Country Doctor clients will have different reimbursement, but they will not have to change where they are getting care. They have eligibility specialists on staff to help people with the insurance exchanges. Most Country Doctor patients will move onto Medicaid. They will have access to specialty care; specialists will have to take Medicaid, unless they plan to become a boutique healthcare provider (and some will).
- Richard A. stated that Medicaid rates will go to Medicare rates in 2014. Health homes can negotiate rates.
- Ann stated that SCS has not drilled down to preparing clients; they are still trying to manage the current benefits systems. She stated she imagines they will see an increase in the number of clients served through Medicaid and moving people off of sliding scale fee and will continue to serve those who won't meet Medicaid eligibility.
- Randy stated that Lifelong has begun conversations with consumer groups. Their approach is not to wait to talk with clients until Lifelong has ACA figured out, but to create space to have those conversations as it is happening. He announced that on March 8, 2012 there is a public listening and planning session around HCR. It is possible that the future Medicaid will require higher copays, and people who have not had copays will now have them. It may require job training for PLWH who have not been employed recently.
- Jennifer M. stated that Madison Clinic clients are expressing anxiety; staff are trying to reassure them but do not have clear answers.

The group continued to ask questions and discuss:

- David Lee noted that patient navigators could be a variety of people, such as registered nurses or social workers. Randy noted that as a state, Washington may get a say in this. Ann noted that patient navigators could be a peer model rather than professional workers. Jesse stated she had heard in a national meeting that patient navigators may be insurance agents.

<Bob Harrington entered at 6:20pm>

- Matt stated that the issue with Harborview goes beyond HIV. Harborview has many primary care clinics.

- Germán asked what a medical home is. Linda explained that it is a center that provides medical care as well as other services in one place (such as interpretation, transportation, behavioral health, etc.) The patient is seen as a partner with a health care provider.
- Bob Harrington (Madison Clinic) stated his concern that if Ryan White is eliminated, Madison Clinic will not receive enough reimbursement to continue providing services – Medicaid and Medicare reimbursement will be less, and they are already insufficient. Madison Clinic may not be able to provide primary care, and only be a consultative practice, simply to manage HIV. This would be an affront to everything Madison Clinic has worked for. They have applied to the state to become a medical home because they do provide a complete medical care model.
- Kate asked whether those on Medicaid now will have new out of pocket expenses. Linda explained that the benefit package will drive the expenses. She noted the concern that providers will be left to cover this. Country Doctor would provide services even if clients cannot cover copays. Randy stated that there may have to be changes to state revenue, which the legislature is now considering. They are already reducing reimbursement for Medicare. If they are covering so many more people and we can't afford it now, we won't be able to cover it later, unless there is an increase to state revenue. Randy suggested it may be smarter to move to a self pay model and job training.
- Kate asked whether in 2014 there will be community health centers in rural areas. Linda explained that there are currently 26 community health centers in the state, with 109 sites, so there is already a pretty wide coverage of rural and urban areas.
- Providers made suggestions on what the Council can address in its Comprehensive Plan. Linda suggested advocating for more revenue from the state. Randy stated the Council must not only think about Part A but consider every source. Ann agreed that advocacy is critical. The Council can have an effective voice as a TGA. Jennifer M. stated the Council should advocate on the national level for the continuation of Ryan White funds.

Jesse asked the group whether they think Ryan White will continue to exist:

- Bob stated he thought it would exist but believes ADAP will be eliminated. He stated his hope that funds for primary care and case management will continue, as well as other services. He noted that it is reassuring that President Obama put an additional \$50,000,000 into Part C.
- Linda stated that there are too many people not covered under ACA to eliminate Ryan White: undocumented immigrants will not qualify, immigrants must be in the United States legally for five years before qualifying, and many homeless folks will not be able to submit necessary paperwork, etc.
- Randy noted that this iteration of Ryan White does not sunset. Congress can choose to continue to appropriate funds to it. He stated that he is not sure whether we should fight for reauthorization because we do not know what we want yet, but we should fight for appropriation.
- Jennifer M. noted that in the states that have implemented 1115 waivers, there has been a huge increase in demand on mental health and chemical dependency services, so there is definitely a need for Ryan White to continue to fund these.
- Germán asked whether someone who moves to another state will have to restart the process of qualifying for Medicaid. Linda explained that there are different models. There are migrant streams with cooperative agreements between states, and this should happen nationally. Jesse noted that the floor of coverage may be different in different states, and Ann stated it already is different.

The group thanked the providers for participating in the panel. The meeting adjourned.

NEXT MEETING: Monday, January 9, 2011, 4:00 – 6:30 at the **2100 Building – 2100 24th Ave. S, Seattle 98144**