Seattle HIV/AIDS Planning Council

Monday, June 13, 2011 4:00 p.m.–6:30 p.m.
2100 Building: 2100 24th Avenue South

AGENDA

I. Welcome, Introductions and Announcements — 4:00
- Change in July meeting due to prioritization

II. Meeting Agenda *(2 min)*
- ➢ **Action**: Review and approve

III. Minutes: *(3 min)* — 🗁 *Attachment: white*
- ➢ **Action:** Review and approve

IV. Grantee Report (Jeff) — 4:05
- Part A Monitoring Standards and Medicaid and Insurance as payment in full

V. "Transitional Housing" Limits (Jeff) — 🗁 *Attachments: pink & green* — 4:45
- ➢ **Action:** Review new HRSA policy and policy recommended by the AIDS Housing Committee, and vote on whether this policy should be adopted by the Council.

VI. State EIP Check-In (Richard A.) — 🗁 *Attachment: buff* — 5:00
- State and Federal budget for 2011, and the impact on HIV programs

VII. Break — 5:30

VIII. Membership Committee Report (Oscar, Jake) — 5:45
- ➢ **Action:** Vote on new member candidate George Froehle

IX. How to Coordinate the Council's Plan with Other Fund Sources (James, Matt) — 6:00

X. Consumer Caucus Report (Chris, Joachim) — 6:15

XI. Adjourn — 6:30

Barrier-free location
Reasonable accommodation for persons with disabilities available upon advance request.

Seattle HIV/AIDS
Planning Council

Minutes ⌘ Monday, June 13, 2011
4:00pm - 6:30pm

2100 24th Avenue South Seattle, WA 98144

Council Members Present: *Richard Aleshire, Tim Blitch, Kenneth Burk, Sergio Cueva Flores, Shireesha Dhanireddy, Kate Elling, Matt Golden, Chris Haworth, Nykia Johnson, Jake Ketchum, Gerrie LaQuey, David Lee, Higinio Martinez, Jonas Nicotra, Christine Oyaro, Chris Porter, Richard Prasad, Tony Radovich, Michael Raitt, James Redel, Ed Wilhoite, Paul Williams*

Persons Nominated by the Council, but not appointed by the King County Executive: Jamie Johnson

Council Members Absent: *Amy Bennett (emeritus), Brian Flett, Oscar Grey, Joachim Hawn, Arthur Padilla, Jodie Pezzi, Germán Rodríguez*

Planning Council Staff Present: Jesse Chipps, Diane Ferrero, Courtney Speigner (minutes)

Public Health Staff Present: Linda Coomas, Julie Dombrowski, Becca Hutcheson, Jeff Natter, Joanne Stekler

Guests: George Froehle, Erick Seelbach

Italics denote Planning Council Membership.

I. Welcome, Introductions and Announcements

The group did a round of introductions and stated affiliations.

II. Meeting Agenda

There had been some interest in discussing the Medicaid 1115 waiver, and Richard will talk about this somewhat in his presentation.

☑ ***The agenda was approved as written by acclamation.***

III. May Meeting Minutes

Changes:

- Page 2, first bullet – state legislature to determine the state budget.
- Page 3, ninth bullet of third section – spelling should be George Froehle
- Page 4, first bullet of second section – spelling should be Richard A.

☑ ***The May minutes were approved as amended by acclamation.***

IV. Grantee Report

<Christine entered at 4:15pm>

Jeff presented on the Health Resources and Services Administration's (HRSA) new monitoring standards (presentation attached), and the following points were noted:

- Rent for programs was considered a direct expense in the past, if it was part of direct service (exam rooms, for example). In the new monitoring standards, rent must be considered an administrative expense with very few exceptions. The only allowable direct expense in rent is houses in which clients actually live and food pantries. This will affect agencies that have been billing rent as direct expense. Gerrie noted that HRSA moved to implement this in Part D in 2006, and their justification was that they were beginning to view Part D as no longer funding stand alone programs; Part D funding should go to programs with established budgets. Part D fought this and lost. Gerrie shared her opinion that more and more HRSA is considering Ryan White as funding for enhanced services and not willing to fund start-up or stand alone programs.
- All programs must now submit expense reports that track administrative expenses. Agencies already explain their administrative expenses in their proposals; this level of administrative detail is not useful, and takes a lot of additional time. Jeff noted that the National AIDS strategy calls for less administrative paperwork.
- Agencies must report program income at least annually. The HRSA project officer has said that programs should be charging client copays if funding is an issue. Jeff explained to the project officer that not having client copays is very valuable and helps people stay in care; many people living with HIV (PLWH) may not go to the doctor or substance use treatment visit if they have to pay a copay. They also recommend that agencies adopt sliding fee policies. Now, if agencies do not have a sliding fee policy, they must document this.
- HRSA now wants a six month client eligibility review for all programs. To bring in this information every six months is a lot to ask of consumers, especially for clients with mental health or substance abuse issues or homeless clients. It also places a great burden on case managers. Jeff is allowing case management programs to verify client eligibility for Ryan White, and other agencies may verify with case management. Eligibility includes: HIV positive status, proof of residence, financial eligibility (verify below 200% FPL) and insurance status. The project officer has said that the idea of this standard is to more quickly move clients off of Ryan White funding whose eligibility has changed.
- As part of client eligibility, insurance eligibility will have to be documented every six months. Case managers will be checking in with clients about every potential insurance coverage and will have to document a client is not Medicaid eligible in order to use Ryan White funds for any service that is covered by Medicaid. HRSA has said that Ryan White funds serve clients who are "uninsured" and under-insured," but have not defined "under-insured." They have said that Medicaid is payment in full. Jeff explained that Medicaid does not begin to cover the cost of many services.
- If a client is Medicaid eligible (including if they are in their spend-down, just recently eligible, etc.), Ryan White funding cannot be used to pay for any services that are eligible to be covered by Medicaid.

Jeff went over more details about use of Ryan White funding and Medicaid-eligible clients and the group discussed:

- Nykia explained that case managers in the jail try to get Medicaid turned on the day clients are released, but that is not always possible. She asked whether they would be eligible for Ryan White services. Jeff explained that because the client is technically Medicaid *eligible,* Ryan White funds could not be used to pay for services that could be covered by Medicaid.
- Higinio asked whether it may mean that some consumers on the Council would no longer be consumers of Ryan White services because they are Medicaid eligible. Jeff stated that they have not looked at this level yet, but it is possible.
- HRSA has stated Ryan White cannot be used to pay for uncompensated care. Jeff explained that the Seattle Transitional Grant Area (TGA) has used Ryan White funds to pay for services for which insurance or Medicaid does not pay the full cost. This has enabled agencies to avoid waiting lists. Even with using Ryan White funds for this, some agencies still have uncompensated care.
- Clients who are Medicaid eligible can only have services paid for by Ryan White which are not covered by Medicaid. Additionally, Ryan White can be used to pay for remaining visits, when

Medicaid only covers a certain number of visits. For example, if a client is prescribed 10 mental health sessions, and only five are covered by Medicaid, Ryan White can pay for the remaining five. However, if a visit encompasses five components, it's unclear whether Ryan White can be used to pay for components of the visit that are not covered by Medicaid, but it appears as though it cannot be.

- Kate asked what will be the impact on clients and agencies. Jeff stated that at some agencies, the remaining cost of a service not fully paid for by Medicaid will be write-off care. Those agencies at which a large proportion of clients are funded by Medicaid may not be able to spend out their awards. This could mean lay-offs of staff, reduced services, and/or wait lists.
- Medicaid will only allow one visit per day. If Medicaid is used to pay for a primary care appointment on a certain day, it could not cover a case management visit on the same day. Ryan White funds cannot be used to pay for the case management visit that day because a case management visit could be scheduled on another day and covered by Medicaid. The provider would be responsible for scheduling the visits on different days or covering the other visits as uncompensated care.
- The National Association of State and Territorial AIDS Directors (NASTAD) and the Care Coalition are fighting the monitoring standards. The issues around use of Ryan White funds for Medicaid eligible clients were a reminder from HRSA of a policy that they state has always been true. These issues are not part of the new monitoring standards and it may not be possible to challenge them.
- Matt asked who makes these decisions at HRSA. Jeff stated that the project officer is asking others at HRSA for opinions on interpreting the monitoring standards before replying to Jeff's questions, but Jeff does not know who the decision makers on this are at HRSA.
- Higinio asked whether some agencies will be more affected than others. Jeff answered yes, any agency that charges Medicaid for a significant number of their clients will be affected. Jesse noted that some agencies, for example Neighborcare, have clearly distinguished between Medicaid eligible clients and Ryan White eligible clients and will not be affected by this change.
- Jeff has confirmed that Ryan White funds can be used to cover non-emergency dental services for Medicaid eligible clients. Medicaid will only cover emergency dental services.
- Kenneth asked whether the Council could communicate with the Office of Management and Budget (OMB). Jeff explained that OMB is mostly involved with the fiscal management regulations, for example the rent issues. HRSA has said their regulations trump OMB regulations.
- Gerrie stated that when the administrative cost requirements were implemented for Part D, it was done seven months into the contract year and had to be applied retroactively.
- Jeff stated that other TGAs and Eligible Metropolitan Areas (EMAs) areas have higher financial eligibility requirements. The Council could consider raising the eligibility limit.
- Kate asked whether these new standards are related to reauthorization. Jeff stated this may be true. He noted that the OMB included $2.5 billion in savings from the Ryan White program in its estimates of cost savings from Healthcare reform.
- It was clarified that when Medicaid says they will provide one visit per day it means one visit per location, per day. Harborview would be considered one location. Becca asked whether this could change, especially with the emphasis on medical homes. Shireesha stated her understanding that a medical home is meant to refer to a Federally Qualified Health Center (FQHC), which Harborview is not.

V. "Transitional Housing" Limits

Jeff explained that HRSA had implemented a policy which stated that clients could have no more than 24 months in the entire lifetime of a client. People fought this policy, and HRSA eliminated it. Now, areas must come up with a plan to show they are not using the funds for permanent housing. The AIDS Housing Committee has created a system where after 24 months of transitional housing, the program must submit a waiver request and a copy of the client's housing plan. Jeff is then able to write a six month waiver and renew that for another six months. So far, it has been working well.

Reasons that people have needed a waiver have included people having difficulty getting permanent housing because of criminal history, immigration status, etc. Most clients are able to move into permanent housing within two years. After a total of three years, agencies can continue to provide services for the client using other funds but cannot use Ryan White funds.

MOTION: James moved to approve the waiver policy as written. Kate seconded.

Discussion: David asked whether this needs to be approved retroactively. Jeff has already implemented the waiver.

☑ ***The motion passed unanimously with the following members in favor:*** *Richard A., Tim, Kenneth, Sergio, Shireesha, Kate, Matt, Chris H., Nykia, Jake, Gerrie, David, Higinio, Jonas, Christine, Richard P., Tony, Michael, James, Ed, Paul*

<Chris P entered at 4:55pm>

Jesse suggested that the group switch agenda items to this order: Membership, break, EIP. The group agreed.

VI. Membership

Jake reported:

- The group is looking to recruit a prevention provider.
- Tony Radovich is completing his third term, and this is his last Council meeting. Tony has served on the Council for six years – the group thanked him for all his work on the Council. He will participate in the upcoming Prioritization and Allocation meeting and continue to participate in the Consumer Caucus.
- The committee will interview Pat Migliore and Arnell Alston at its next meeting. Anyone with feedback may approach Jake or Oscar.

Jake reported that the committee had interviewed George Froehle and would like to recommend him to the Council for nomination. He explained that although medical providers are well-represented on the Council, the committee felt that George brings a lot of expertise and access to recruiting other consumers. George introduced himself and explained he is a Physician Assistant at Dr. Shalit's Office. He has worked with the HIV Prevention Trials Unit at the University of Washington and Gay City and has been in the community in Seattle for 10 years.

MOTION: *Jake moved to nominate George Froehle for Planning Council membership. James seconded.*

Discussion: James noted that George's specific slot is healthcare planner.

☑ ***The motion passed unanimously with the following members in favor:*** *Richard A., Tim, Kenneth, Sergio, Shireesha, Kate, Matt, Chris H., Nykia, Jake, Gerrie, David, Higinio, Jonas, Christine, Chris P., Richard P., Tony, Michael, James, Ed, Paul*

BREAK 5:00 – 5:15pm

VII. State Early Intervention Program (EIP) Check-In

Jesse explained that the mailer only included pages one and three of the report. Page two was emailed, and hard copies were distributed at the meeting (full report attached). Richard A. presented the report and slides (also attached), and the group discussed the following items:

- Medical case management, Food and meals, Medical nutrition therapy, Substance abuse treatment - outpatient, and Medical transportation are the only services funded in the rest of the state outside of the TGA.

- For EIP clients in Group 1, EIP pays for everything except the client cost share.
- TrOOP stands for true out of pocket expense.
- The Center for Medicare and Medicaid Services (CMS) is allowing state programs to apply for a waiver, called an 1115 waiver, which would allow people to be eligible for Medicaid without a disability diagnosis (based on income alone). This will happen automatically in 2014 with healthcare reform, but the 1115 waiver would allow it to happen now.
- David asked why there has been an increase in the cost of insurance. Richard A. explained that there are 500 more clients on insurance, and there has been an increase in premiums.
- Kate asked whether rebates are estimated to remain the same. Richard A. explained that the amount for rebates listed under revenue is a conservative estimate. It was clarified that EIP receives the same amount of rebate for each drug whether they pay the full cost of a drug or only a small amount.
- Chris P. asked whether EIP was using a single lab, and Richard A. answered that EIP decided not to use a single lab because some offices use their own labs.
- Shireesha asked whether the EIP Steering Committee is leaning a certain direction on whether to start a waitlist. Richard A. stated the committee will revisit the issue at the August EIP meeting. The group needs to review more information, including the Part B award. Shireesha asked whether the 1115 Waiver may go through, and Richard A. answered this is still unknown.
- Tony asked whether the 1115 waiver would include the Alcohol Drug Addiction Treatment and Support Act (ADATSA) and General Assistance Unemployable (GAU). Richard A. answered no, because these are state programs that are not the core part of Medicaid.
- George asked a how insurance companies are chosen. Richard A. explained EIP works with Evergreen Health Insurance Program (EHIP). The best option is if the client is working and has insurance. The only other options are Washington State High-risk Insurance Pool (WSHIP) and the Pre-existing Condition Insurance Plan – Washington (PCIP-WA).
- Higinio asked whether EIP is considering eliminating coverage for all non anti-retroviral medications (ARV) and would this eliminate Group 2. Richard A. answered that it is something being considered but is not definite, and if implemented it would eliminate Group 2.
- Ed asked about the punitive period of one year to get back on insurance for someone who was in Group 1 but had not filled their ARV prescriptions. Richard A. explained that once insurance is lost with WSHIP it takes six months to get back on. Additionally, someone who has been on insurance for several months without filling their prescriptions has cost EIP a lot of money. EIP has been looking at individual cases and making exceptions based on unique situations.
- Matt asked about whether the proposed idea of basing eligibility on CD4 cell count below 300 refers to nader CD4. Richard A. answered this has not yet been determined.
- The slide regarding AIDS Drug Assistance Program (ADAP) counting toward TrOOP only refers to clients on Medicare Part D.
- Jesse asked how clients could be on both WSHIP and Medicare. Richard A. explained that Medicare is primary coverage, and WSHIP pays their copays.
- Tony stated that had heard a rumor that the 1115 waiver had already been approved. Richard A. stated that it was federally approved that states *could apply*, but that the Washington Medicaid program has not applied.

VIII. How to Coordinate the Council's Plan with Other fund Sources

Matt and James recently had a conference call with Maria Courogen (Department of Health - DOH) , David Kern (DOH), Richard Aleshire and Jeff Natter to discuss whether there is some way to coordinate the cuts to HIV funds throughout the state to diminish the potential impact. If the Washington State Department of Social and Health Services (DSHS) applies for and is granted the 1115 waiver, this would help the EIP issues. This group could address how cuts should happen if the waiver does not go through, and whether a decrement plan should be implemented. On the conference call they discussed including care and prevention in this coordination.

The group discussed:

- Jesse stated that there will not be a July Council meeting. There will be a four hour meeting of the Prioritization and Allocation Committee meeting. One of the biggest concerns is that the Council could make a plan to address the ADAP crisis, but then the waiver could come through and it would become moot. The Prioritization and Allocation Committee will need to address several issues, for example the changes to coverage of dental services and the use of Ryan White funds for Medicaid eligible clients, not just ADAP. Some things may still be unknown when the committee meets.
- James noted that if the Council makes cuts to entire service categories, and the waiver goes through, it would be very difficult or maybe impossible to reinstate those services.
- Matt noted the committee could create a plan but not yet enact it. He stated that everyone on the call did agree it is a good idea to coordinate. Even if the waiver goes through, this will not be the only crisis, so it is important to establish coordination now. Jesse noted that Part A does have a history of collaboration with Part B. It has been more complicated to coordinate with Part C, Part D and prevention funding because each has its own mechanism and criteria for decision making.
- Jesse reminded the group that the Prioritization and Allocation Committee meeting is an open public meeting (as are all Council meetings) and Council members who are not on the committee are welcome and encouraged to attend. The meeting is on Monday, July 11, 2:00 – 6:00pm at the 2100 Building. The Council will vote on the plan at the August meeting.
- Richard A. explained that the group discussed coordinating activities. On the care side, the planning groups include the Part A Planning Council, the EIP Steering Committee and a combined planning group for Parts B and D, which is in the process of forming now. The group decided that members from each of these groups should meet to coordinate with each other as well as meeting with the prevention planning group. Tony noted that apart from the Part A Planning Council, those planning groups are advisory, and the state could trump the decisions of that group.
- Each planning group could say no to the ideas of the coordination group, but Matt stated his opinion that it is unlikely that any of the groups will be completely dismissive of advice from the coordination group. At least the representatives from groups can meet and generate some ideas of how to coordinate – it is up to each group whether they agree with the ideas.

IX. Consumer Caucus Report

Chris H. reported the committee met on Wednesday, June 1, and discussed the following items:

- Syphilis is on the rise. The group was interested in getting demographic information on Syphilis cases to the Council.
- The committee will be meeting in a new location. The next meeting will be on July 6 at the Douglass-Truth Library. If this location does not work well, the group will plan to meet at the Chinook Building in the future. The group is committed to having one meeting per year in Everett.
- The group discussed the transitional housing waiver.
- Jesse presented on the most recent expenditure data.

The Council agreed they would be interested in getting more information on Syphilis. Kate stated she had heard that Syphilis is not reacting to medications, and Matt explained that this is not true and confirmed that Syphilis remains treatable.

☞ ***ACTION ITEM:*** Council members should send specific questions about Syphilis to Matt. Matt or Roxanne Piper-Kierani will present on the topic at a future meeting.

NEXT MEETING: Monday, August 8, 2011, 4:00 – 6:30pm at the ***2100 Building – 2100 24th Ave., Seattle 98144***