

Meeting of the

**HIV Health and Human Services Planning Council of New York**

SEIU/Local 1199, 310 West 43<sup>rd</sup> Street

April 15, 2004

2:25-5:00pm

**MINUTES**

**Members Present:** F. Oldham, Jr. (Governmental Co-chair), P. Avitabile (for E. del Campo), M. Bacon, R. Bonilla, G. Brown, MD, K. Butler, F. Carroll (for R. Abadia), R. Cassar (for T. Troia), C. Craig, B. L. Curry, C. Dzubilo, I. Feldman, L. Fraser, R. Gonzalez, A. Gutkovich (for D. Marder, MD), M. Hamilton (for P. Stabile), S. Halperin, CSW, E. Handelsman, MD, J. Hilger (for M. Hill, PhD), R. Joyner, H. Mateo, P. McGovern, H. Melore, D. Ng, J. Pedraza, T. Petro, A. Raiola, M. Reynolds, N. Rodriguez (for D. DeLeon), E. Santiago, D. Woodard

**Members Absent:** S. Abramowitz, PhD, A. Ali, M. Barnes, L. Bishop, F. Carbone, R. Chavez, B. Chu, MD, C. Cobb, H. Cruz, S. Hemraj (Finance Officer), N. Nagy (Community Co-chair), A. Paige-Bowman, J. Pressley, M. Wainberg, MD, B. Watts

**Staff Present:** OAPC: R. Cordero, D. Klotz, S. Dwyer, I. Gonzalez; DOHMH: S. Forlenza, MD, MPH; MHRA: J. Verdino, G. Weinberg, P. Jensen, R. Miller; NYSDOH: L. Cross

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**Agenda Item #1: Introductions/Announcements/Minutes**

*Mr. Oldham* opened the meeting, followed by introductions.

*Ms. Curry:* I ask that everyone remember those who were recently lost, some of who were over 50, a population that needs more research.

*Mr. Oldham:* I am pleased to introduce Ingrid Gonzalez, our new program coordinator for Social Services and Mental Health. She comes with much experience as former coordinator of the Central Harlem HIV CARE Network. All workgroup chairs really need to attend tomorrow's Data Day. Also, please read the 2004 Community Forum Report that is in your packet.

*Mr. Joyner* read the rules of respectful engagement.

*Mr. Oldham:* The last few weeks have been very difficult for the AIDS community, and is reminiscent of the earlier days of the epidemic. I invite Terri Smith-Caronia to lead the moment of silence.

*Ms. Smith-Caronia:* Thank you to everyone who showed their respect to Keith Cylar, Joe Bostic and Joe Capestany. In their honor, rather than a traditional moment of silence, I ask that everyone remember that silence equals death and chant "Act-up, fight back, fight AIDS".

*Mr. Cordero* reviewed the meeting packet, noting that the meeting calendar is on the web site and will be more interactive.

The minutes of the March 18, 2004 meeting were approved with no changes.

*Mr. Oldham (in response to a question from Ms. Melore):* We will put the audit report in the parking lot.

**Agenda Item #2: Public Comment**

*V. Mooney:* In 2005 I will row from West Africa to New York for AIDS awareness. I invite people to contribute and have names of loved ones inscribed on the boat.

*M. Gold:* It has been a difficult few weeks. Keith Cylar and Joe Bostic were in their 40s. Other less well-known PLWH are dying. Many of my peers from when I became a client of Minority Task Force on AIDS ten years ago have passed. People in their 30s and 40s are dying of heart disease and cancer, and this must be related to HIV and medications. We need more research and a cure.

*C. Henderson:* Too many young people are dying. At Citiwide Harm Reduction, we have clients who have no resources. The Planning Council should look into finding funds to help pay for a decent, dignified burial for poor PLWH.

*L. Holley:* People with disabilities are entitled to half fare on public transportation, but Access-a-ride, which is public transportation for people with disabilities does not accept half fares, thus riders must pay \$2/trip, which is not fair. The Mayor needs to tell the MTA to change this.

### **Agenda Item #3: PWA Advisory Group Report**

*Ms. Carroll:* The PWA Summit was held on April 10<sup>th</sup>. It was a big success, with team building and conflict management sessions in small groups.

*Ms. Melore:* The next AG meeting is this Saturday at the LBGT Center.

### **Agenda Item #4: ADAP Presentation**

*Mr. Cross:* The mission of the New York State (NYS) HIV Uninsured Care Programs (“ADAP pools”) is to provide access to care for all New York residents with HIV. It is one piece of the health care funding for HIV, has inclusive eligibility criteria (New York State residency) and a comprehensive formulary (over 450 drugs), and is user and provider friendly. Services include drug reimbursement, outpatient primary care, home care and insurance continuation. With the decline in AIDS deaths and growth in number of living AIDS cases, enrolment has steadily increased, with the proportion of women enrollees rising. Government and community are partnering on drug pricing. We use our buying power to buy drugs at a deeply discounted price. To answer questions raised by Mr. Halperin, Canadian retail drug prices are higher than our prices. New York’s ADAP has doubled its buying power since 1998 and with other ADAPs have clout with pharmaceutical companies. With the recent steep increase in the price of Norvir, our expenses jumped, but we will get the entire Norvir price hike back as an increased rebate.

Drug reimbursement and primary care usage has increased, but home care usage is dropped substantially. Our expenditures have increased dramatically, but federal support has not kept pace, thus we have instituted a seven-tiered cost containment plan using principles developed by our advisory body, starting with doing the least clinical harm. We have only implemented the first tier and even restored some of those cuts. With State and Title I contributions, we have regained financial stability and continued to expand the formulary (all anti-retroviral drugs are covered, including Fuzeon). We project future growth in enrolment and costs, but do not know the effects of changes in Medicare and Medicaid, reauthorization, and other factors.

*Mr. Halperin:* I thank you and Mr. Cruz for being so responsive to my questions.

*Mr. Cross (in response to questions from Mr. Halperin):* Last year, we got agreements with the drug companies for discounts for 1 to 1.5 years. We are re-entering into negotiations and want to annualize this. The savings was \$65M out of \$850M (gross payments, before rebates) spent with these companies.

The State spent \$184M on drugs in calendar year 1993. The NYC share of that is 73.6%; Tri-county is 4.2%. NYS contributed \$56M to the entire program. Contributions from Title I EMAs are spent only in those EMAs, but the State contribution is spent in the entire state.

*Mr. Halperin:* This year there will be higher accruals due to late starting contracts, thus more available for ADAP in reprogramming. I am concerned that when the State makes decisions about its contribution, that they will reduce theirs if they know that Title I will be contributing more.

*Mr. Cross:* ADAP is only requesting restoration of the Title I contribution to its original amount. The State amount is appropriated in 2-3 year cycles, and is up for renewal again in mid 2005. We show the legislature a flat funding scenario for Title I and a minimal federal increase, along with higher costs, which is why the State contribution keeps going up.

*Mr. Pedraza:* NYS ADAP is one of the best in the US, and I am especially proud of it because it serves immigrants.

*Mr. Cross (in response to questions from Mr. Pedraza):* Other states have waiting lists because of restrictive Medicaid programs and ADAPs that do not have an adequate level of state commitment. As of last month, there are 1,269 people on ADAP waiting lists nationally, and this number will likely go up. We combined our buying power with the California, Texas and Florida ADAPs, but smaller states benefited too.

*Mr. Cordero:* All titles have put in their requests for FY 2005 appropriations, and the ADAP request is two different asks (\$217M and \$319). Where does NYS stand? Also, there are potentially harmful amendments being proposed for reauthorization, e.g. collapsing Titles I and II to create block grant to states, which NYS opposes, and mandatory contribution from Title I programs to ADAP, which we do, but not all EMAs.

*Mr. Cross:* The lower request (\$217M) is more realistic. ADAPs need about \$100M per year, but only got \$35M this year. We need a \$100M emergency appropriation now, plus another \$100M increase in the regular appropriation. NYS put out proposals to counter some from Southern states. NASTAD (representing Title II) is trying to resolve this. Southern and rural states point out some inequities in funding, e.g. states with Title I EMAs get more CARE Act dollars per person than states without them. Title I funding has helped keep us solvent, and some solution has to be found for equitable funding, and we want to influence what that is.

*Mr. Cross (in response to a question from Mr. Oldham):* We are a long way from having a waiting list, even with fluctuations in Title I funding. Other measures would be taken before that.

*Ms. Verdino:* To clarify, we do not anticipate the amount available for ADAP being any larger than usual, as under-spending is not great because of very high spending rates by providers.

*Mr. Cross (in response to a question from Ms. Verdino):* The federal amount is a weighted AIDS case formula, similar to the Title I formula. The reason NYS is not in dire straits is because of Medicaid, Title Is and the State contribution. The enrollment count is unduplicated – each person is counted once. More people are using more services.

*Mr. Cross (in response to a question from Mr. Hamilton):* There is a maintenance of effort requirement for HIV dollars spent overall but not specific to ADAP.

*Mr. Ng:* The Planning Council needs to acknowledge the very efficient administration of the ADAP program. With a small staff, they cover a high range of services. Also, I hear only compliments about how consumer friendly the processes for enrolment and getting services are.

*Mr. Cross (in response to questions from Mr. Joyner):* We do not pay for administration of Fuzeon because of the cost. If someone needs home care, we can pay for injections in that setting, or if clients get the first injection of the day in a medical setting. We need a better drug. We are looking closely at how Medicare will relate to ADAP. If we are designated a State Pharmaceutical Assistance Program, Medicare will have to coordinate with us. We do not pay for mammograms specifically, but we pay for clinic visits, so if done in that context, we will pay for it, but not at an enhanced rate.

*Dr. Brown:* There are resources for free mammograms, although they can take some patience to find.

*Mr. Cross, Mr. Avitabile and Mr. Feldman (in response to a question from Ms. Curry):* If someone meets the ADAP criteria and has partial insurance, we would look at the relative share to income. ADAP cannot pay for inpatient care. Medicaid, Medicare and ADAP have no co-payments for inpatient care.

## **Agenda Item #5: Committee and Workgroup Reports**

*Mr. Klotz:* The Finance Committee met on April 7<sup>th</sup> and reviewed current un-reconciled spending provided by Ms. Miller of HIV CARE Services. The Committee will review the FY 2003 close-out report at its June meeting and will report back to the full Planning Council. The Committee is also responsible for assessing the administrative mechanism, as approved by the Executive Committee (EC).

*Mr. Dwyer:* The By-laws Task Force will present its draft new Planning Council by-laws to the EC in June. We will roll it out for comment, and the goal is to have the full Council vote on it at the July meeting.

*Mr. Cordero:* The Planning and Evaluation Committee (P&E) has set the timeline for priority setting and resource allocation. We have been on schedule with everything this planning year so far. We need to ensure that we stick to this schedule. We have built in a little more time for workgroups to complete their work.

*Mr. Halperin:* All priorities need to be prioritized at June 25<sup>th</sup> meeting. We may need an extra meeting.

*Mr. Cordero:* We can combine the EC and P&E on July 1<sup>st</sup> to do both prioritization and allocations. This will allow us to have an EC meeting on July 9<sup>th</sup> if we do not finish. The Final vote by the full Planning Council will be on July 15<sup>th</sup>, but we can meet again on July 29<sup>th</sup> if we are not finished.

*Mr. Halperin:* It is too ambitious to roll out the new by-laws in June and vote in July. It needs more time for consideration.

*Mr. Oldham:* Ms. Nagy and I always said it might require additional meetings.

*Mr. Halperin:* The RSVP list for tomorrow's Data Day is only about 30, which is low. This could mean that people are tired. What really matters is how data is applied. We will see this in the results of the planning process.

*Mr. Ng:* Commissioner Frieden came to the last Housing Workgroup meeting to discuss HOPWA-related issues. The Workgroup is happy about the restoration of HOPWA funding for outreach in SROs. We also had a presentation by Pagnoni and Associates on evaluation of MAI housing programs. We also discussed reprogramming and are looking at whether ideas are operational.

*Dr. Brown:* The Health Workgroup is meeting twice per month, reviewing our portfolio with a standardized format. We have had good turnouts. We are also looking at reprogramming.

*Mr. Santiago:* AOD is reassessing its templates, looking to consolidate several similar templates. We also looked at the criteria for reprogramming.

*Mr. Klotz:* The Mental Health and Social Services Workgroups are continuing their template reviews and will also consider reprogramming ideas at their upcoming meetings.

## **Agenda Item #6: FY 2004 Reprogramming**

*Mr. Cordero:* Unspent funds come from three different sources: 1) carry-over from FY 2003 (available late fall/early winter, must be approved by HRSA); 2) under-spending from FY 2004 (funds from one-time reductions of contracts and late starting contracts, must be spent by end of fiscal year); and 3) uncommitted FY 2004 funds (from permanent reductions if contracts). The Planning Council is being prudent by developing a plan now that will maximize spending.

The criteria for reprogramming initiatives are: 1) identify one-time, non-recurring initiatives; 2) develop ongoing initiatives that reflect the FY 2004 priorities; 3) implementation must not require a full solicitation; 4) funds may not be used for capital construction or other expenses prohibited by federal rules; 5) funding must be spent by February 28, 2005; 6) existing service categories should be enhanced if needs are identified; 7) carryover funds may not be used for Planning & Evaluation initiatives, but uncommitted and under-spending can be used to fund one-time P&E initiatives. Workgroups will develop proposals for consideration by a joint P&E/EC meeting on May 13<sup>th</sup>. Final

Planning Council approval is at the May 20<sup>th</sup> meeting. This is a different process than last year, when there were perceived conflicts of interests. Initiatives need to be tied to identified needs. Plus, two priorities have already been agreed upon by the Planning Council as part of the FY 2004 spending plan: ADAP and P&E initiatives (cost-effectiveness, mapping, client level data pilot, staffing analysis, special population studies).

*Ms. Verdino: (in response to a question from Mr. Halperin):* There are 14 new contracts starting this year. Those awarded through the Year 13 RFP have an August 1<sup>st</sup> start date, and the others start September 1<sup>st</sup>. New contracts normally have under-spending. We did an analysis of past new contracts, and this year we will do negotiations based on real time costs (e.g. some will not likely have full staffing until as late as December). That will mean more funds available to implement the reprogramming plan, thus less carry-over at the end of the year. Workgroups should be careful not to raise expectations. The first \$5.3M in under-spending is committed to ADAP, and so if there is \$3M in FY 2003 carry-over, then the next \$2.3M in FY 2004 under-spending goes to ADAP. We will need more than \$5.3M in total under-spending to fund any other initiative. We could consider the list for future years' reprogramming. Under-spending is so low because we cut everyone 3%, plus did take-downs in response to last year's cut. Thus, providers really tried to maximizing spending in FY 2003.

*Mr. Oldham:* We can lose the increase in the supplemental award, which is why it is so important to implement this process.

*Ms. Hilger:* We have to show HRSA that we have committed all funds by the end of July, even if they are not spent, and so we do not have that much time.

#### **Action/Follow-up Items (Timeline/responsible parties)**

- Complete reprogramming plan according to timeline (May 20/workgroups, P&E, EC, full Council)

#### **Agenda Item #7: Grantee and Tri-county Reports**

*Ms. Hilger:* We are working on FY 2003 close-out. We have not yet received the draft audit report from the federal Office of the Inspector General and do not expect it until late spring or summer.

*Ms. Verdino (in response to a question from Mr. Halperin):* The American Red Cross subsidized the Title I transportation program, plus there was some State funding that ended. Thus, with the transfer of the program to Project Hospitality (PH), there is a reduction in hours, clients have to call for pick-up earlier, and there are fewer vans. PH will also be prioritizing trips by need (e.g. medical appointments have higher priority). A letter went out to all service providers that make referrals with guidelines and rules. We will get a copy to Mr. Cordero for distribution.

*Mr. Petro:* In the packet is a map of the Tri-county region to help members understand the geography of the region, with areas of high prevalence and location of service sites. Southern Westchester County has the bulk of AIDS cases and services in the region.

*Mr. Petro (in response to a question from Dr. Brown):* It takes 45 minutes to an hour for people from Putnam County to get primary care due to the loss of their one HIV specialist. They go south to lower Westchester, Peekskill (further upstate) and east to Danbury, Connecticut.

#### **Action/Follow-up Items (Timeline/responsible parties)**

- Distribute new transportation program guidelines to the Council (ASAP/Ms. Verdino, Mr. Cordero)

#### **Agenda Item #8: Public Comment, Part II**

*R. Jones:* Accountability is needed for all the funds spent. We have to make sure that they are used in the way intended. People do not know what services are available. We have to offer services before people get too sick. Peer outreach is effective. Also, agencies need to post their grievance procedures. I will continue to come to these meetings with more PLWH to speak out.

*Ms. Curry:* PLWH should talk to Ms. Verdino about any problem with a Title I provider. Thank you for coming and telling us what you need.

There being no further business, the meeting was adjourned.

#### **Parking Lot**

- Office of Inspector General audit report

Minutes approved by the HIV Planning Council on May 20, 2004

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Frank J. Oldham, Jr.  
Governmental Co-chair