



Meeting of the
Priority Setting & Resource Allocation Committee

Jennifer Irwin & Eli Camhi, Co-Chairs

Thursday, July 5, 2007 3:00–5:30 PM

GMHC, 119 W. 24th Street, New York, NY

Members Present: Jennifer Irwin (Co-Chair), Eli Camhi (Co-Chair), SJ Avery, Felicia Carroll, JoAnn Hilger, Hilda Mateo, Patrick McGovern, Walter Okoroanyanwu, MD, Joanna Omi, Jan Carl Park, Tom Petro, Terry Troia

Members Absent: Bruce Agins, MD, Lloyd Bishop, Humberto Cruz, Linda Fraser, Steve Hemraj, Peter Laqueur, Darryl Ng, Joshua Sippen, Edward Telzak, MD

DOHMH Staff Present: David Klotz, Fabienne Laraque, MD, John Rojas, Nina Rothschild, Daniel Weglein, MD, Darryl Wong

MHRA Staff Present: Bettina Carroll, Rafael Frankenberg, Gucci Kaloo, Rachel Miller

Others Present: Terri Smith-Caronia, Marcus Cooke, Yves Gebhardt

Material Distributed: Agenda; minutes from June 7, 2007 PSRA Committee meeting; guidance from Integration of Care Committee on medical nutritional therapy, food bank/home delivered meals/congregate meals, and outpatient medical care; year 17 spending plan, prepared by MHRA; year 18 base application spending plan, prepared by MHRA; and the service category criteria analysis grid.

I. Introduction and Review of Minutes from June 7, 2007 PSRA Committee Meeting: Eli Camhi led the introductions, and Jennifer Irwin led the review of the minutes. SJ Avery called PSRA Committee members' attention to line 42 on page 1 of the minutes, in which the following statement appears: "We probably have a lot of clients who are eligible for Medicaid but are nevertheless receiving Title I resources." Committee members agreed to remove this line from the record. A request was also made to change line 23 of p. 2 of the minutes, in which Ms. Miller is quoted as stating that there was a little spike in underspending last year. Members of the PSRA Committee agreed to state instead that there was a little spike in underspending at the end of the third quarter, but this situation was resolved by the end of the year. The minutes were accepted with these two changes, with one abstention and no one opposed.

II. Review of Contents of Meeting Packet: Mr. Park reviewed the contents of the meeting packet, noting that the service category descriptions for medical nutrition therapy, food bank/home delivered meals/congregate meals (known as food and nutrition), and outpatient medical care were re-worded by the Integration of Care Committee to bring the New York EMA in line with HRSA's service category descriptions. He discussed the year 17 spending plan, noting that it takes into account the reduction in our award, and also stated that in the spending plan for 2008 we are asking for a restoration of money that was cut so that we can have a plan similar to the plan used in 2006. Mr. Park also discussed the service category criteria analysis grid, reminding Committee members that 75% of services need to be core medical services, and 25% can be non-core. He noted that the 24-hour drop-in center for HIV-positive Rikers Island releasees has been folded into Early Intervention Services, and EIS of this type is considered a core service.

III. Medical Nutrition Therapy: PSRA Committee members discussed this new core service category in preparation for ranking it in the grid. Mr. Park noted that the numbers for this category currently appearing in the grid are placeholders and will be removed after the category has been ranked. Within the column of the grid labeled "Payer of Last Resort," the other identified funding sources include the NYC Department for the Aging, HASA, NYS AIDS Institute (ADAP+), NYS Department of Health, NYS Office of Temporary and Disability Assistance, and Ryan White CARE Act Title III. PSRA Committee members engaged in extensive discussion of this category, noting that MNT includes direct professional service by a dietitian and does not refer to a dietitian serving in an advisory capacity; that the list of other sources of funding for this category, taken from the NYAM tool, does not provide information about the quality or capacity of those other sources; that these other sources (e.g., the Department of the Aging, which provides Meals on Wheels) may

provide some but not all of the services included within medical nutrition therapy; and that there are some payers in addition to Ryan White, but not a lot of payers. Committee members noted that they do not have as much information as they would like on this topic and will have to make a decision based on the limited information available. PSRA Committee members voted to rank the payer of last resort column for the medical nutrition therapy service category, giving it a score ranging from 0 (poor/no value) to 3 (high value). No Committee members gave it a score of 1, seven Committee members gave it a score of 2, and no Committee members gave it a score of 3. Providers of food and nutrition, who might have a conflict of interest, abstained from the vote. The final score for this column was 2.

PSRA Committee members also discussed the Access to Care/Maintenance in Care column of the grid for the Medical Nutrition Therapy category. Mr. Camhi asked whether a lack of medical nutrition therapy would inhibit a patient's ability to obtain primary medical care. A PLWHA may need a clinical referral from medical nutrition therapy to food and nutrition. Mr. Petro noted that the Committee is ranking medical nutrition therapy as though there are separate programs for this service and for food and nutrition, but in reality Committee members are really teasing out medical nutrition therapy to increase the percentage of services falling into the core medical services category. He also noted that food programs are a way to entice people into treatment and care. David Klotz commented that the Integration of Care Committee intended to include the provision of food as part of medical nutrition therapy when it discussed this service category. Ms. Troia stated that the medical nutrition therapy service category includes an element (food) that could be considered as core or as non-core; just because a service provider makes some food available doesn't automatically mean that the service provided is non-core. Dr. Laraque noted that her understanding of the HRSA guidelines is that the provision of supplements such as Ensure is allowed as part of medical nutrition therapy. Mr. Camhi commented that budgets are clearer if core services are outlined very specifically. Ms. Avery stated that access to care is not promoted by offering Ensure supplements but is promoted by offering food. Dr. Laraque stated that medical nutrition therapy does not include food, and that food should not be paid for in this category.

Rachel Miller introduced the question of operationalization into the discussion, asking whether medical nutrition therapy should be a stand-alone category without food or whether the RFP could be constructed so that CBOs can apply for both categories (MNT and FN) or none. Mr. Camhi proposed having a dietitian assess the availability of food. Mr. Petro reminded PSRA Committee members that they are using the grid to set priorities for Year 18 of the grant. Joanna Omi commented that medical nutrition therapy is theoretically essential to keeping people healthy but is actually necessary from a practical point of view. Regarding operationalization of these categories, Ms. Troia stated that offering one service category without the other would be challenging. Telling a client that he or she needs to do something without giving them the food with which to do it means losing the educational element. Ms. Omi clarified the option on the table, namely, bidding the service categories together but keeping them as separate categories for HRSA's sake. JoAnn Hilger noted that the PSRA Committee and the Planning Council could decide not to fund medical nutrition therapy, even though HRSA offers it as a core category. Ms. Avery noted that in reality, medical providers have not always been willing to offer food. Hilda Mateo commented that placing the two categories together means that the model has to change in order to teach the client how to use food. She works in a crisis center, where clients need food. Medical centers are not likely to provide food, and she doesn't want this lack of

provision of food to lead to loss of clients.

Mr. Petro commented that the PSRA Committee is reacting to the RW HATMA legislation in this conversation, rather than really examining what we want our programs to look like. He suggested that the Planning Council agree to pay for both medical nutrition therapy and for food and nutrition, rather than having a separate line item for the professional services of a dietitian. Even if the Council folds medical nutrition therapy into the larger service category of food and nutrition, the EMA is still within the 75/25 core/non-core split required by HRSA. If the PC eliminates medical nutrition therapy as a separate category, the EMA will go from a 77.8/22.2 split to a 77/23 split. PSRA Committee members voted not to fund medical nutrition therapy as a separate service category in 2008. Mr. Camhi summarized the conversation, stating that PSRA has reviewed the recommendations of IOC regarding MNT as a separate category and has declined to make the change. Mr. Petro underscored that this decision is not disrespectful to the IOC.

IV. Harm Reduction: PSRA Committee members noted that harm reduction has been designated a core service by HRSA, meaning that its score in the service category criteria analysis grid rose from 40.5 to 49.5.

V. Outpatient Medical Care: PSRA Committee members discussed the Outpatient Medical Care service category and examined a grid prepared by Dr. Daniel Weglein showing service utilization in 2003/4-2004/5. According to the grid, Outpatient Medical Care consists of five service categories: behavioral health, case management, treatment, adherence services, and health education. Behavioral health includes family counseling/alcohol and other drugs and family counseling/mental health. Follow-up encounters include some behavioral health and some case management. Percentages are presented in person-hours rather than in dollars because of limitations of the data. Ms. Troia stated that Outpatient Medical Care is an integrated service category. If the PC teases it out into these five subcategories, then clinics will apply within five different categories. Seeing data from this service category presented in this format is helpful, but Ms. Troia doesn't want to see this service category dismantled. Dr. Laraque stated that the goal of this analysis is to support integration. When the category is rebid, medical providers should apply to provide case management and outpatient medical services so that the patient has one case manager, not two. Mr. Petro questioned whether the category is a misnomer. Is it really outpatient medical care, or is it case management? Dr. Laraque supported cleaning up the category and pushing for comprehensive case management. Ms. Avery argued against dismantling the category, stating that there is a flaw when we micromanage case management at CBOs and give more latitude to case management conducted at medical centers. Ms. Omi asked whether the Planning Council should RFP chunks of money that applicants can pick from a list so that a service provider can build a menu including medical case management and some social services. We need to ensure one-stop shopping. Dr. Laraque commented that providers should show that they can provide comprehensive case management. The Planning Council should push them to integrate their services.

Ms. Avery commented that having HRSA's definitions of the components of service categories would be

helpful. The Integration of Care Committee is trying to bring the Planning Council's service descriptors more in line with HRSA's service descriptors. Mr. Camhi noted that the Planning Council could recommend to MHRA a menu-like approach. Dr. Laraque recommended taking money from outpatient medical care and providing it to already defined service categories in the portfolio. Ms. Omi noted that we don't want to reduce services for people without Medicaid, and we don't want to make the plan so complicated that it cannot be operationalized. Mr. Petro commented that case management is due to be re-RFP'd and that the PC might consider having two categories: medical case management and non-medical case management. Westchester is rebidding medical case management. Mr. Camhi mentioned the possibility of teasing out medical case management and psychosocial case management. Ms. Hilger asked whether all of the EMA's case management money should go to medical case management. Ms. Troia observed that the PC may lose the integrated portion of this category if we tinker with it too much. The IOC did not intend to tinker with case management.

Ms. Avery noted that the PC spent time looking at the units of service and at demand in the behavioral health area. Dr. Weglein's grid is informative, but the PSRA Committee should rethink some category descriptions. Should we consider core services in one group and non-core services as another group? Dr. Laraque advocated for integrating case management in outpatient medical care. Mr. Camhi reminded Committee members that the EMA wants to come up with a portfolio. We assume that a service category is a separate bid category. Ms. Troia reminded the group that the Commission on AIDS was examining how other jurisdictions deal with this situation and avoid duplication of services so that each person has one case manager. Ms. Mateo stated that medical case managers have access to some information to which CBO case managers do not. Mr. Petro asked Dr. Laraque whether someone can have two case managers – one for medical care and one for social services – and noted that Westchester is trying to force a relationship between an Article 28 facility and a CBO. Dr. Laraque's goal is for patients to receive most of their care at a medical agency. Ms. Omi stated that the PC should know more about how much duplication really exists within case management. We don't want duplication, but we also don't need to micromanage how care is provided. She would not support a model that is too rigid. The goal is just to make sure that a patient who needs a medical case manager has access to one.

The meeting was adjourned at 5:30 pm.