Ryan White Part A Planning Council (RWPC) of the Philadelphia EMA
Comprehensive Planning & Needs Assessment Committees
Meeting Minutes
Thursday, January 19, 2017
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA

Present: Katelyn Baron, Keith Carter, David Gana, Ann Ricksecker, Adam Thompson, Lorrita Wellington, Tessa Fox, Pam Gorman, Gerry Keys, Nicole Miller, Leroy Way, Mark Coleman, Joseph Roderick

Excused: Peter Houle, Cheryl Dennis, Karen Coleman, Lupe Diaz

Absent: Deanne Wingate

Guests: James Breinig, Sebastian Branca, Casey Johnson

Staff: Mari Ross-Russell, Nicole Johns, Briana Morgan, Antonio Boone, Jennifer Hayes

Call to Order/Introductions: A. Thompson called the meeting to order at 2:05p.m. Those present then introduced themselves.

Approval of Agenda: A. Thompson presented the agenda for approval. **Motion**: K. Carter moved, D. Gana seconded to approve the agenda. **Motion passed**: All in favor.

Approval of Minutes *(December 15, 2016)*: A. Thompson presented the minutes for approval. **Motion**: K. Carter moved, D. Gana seconded to approve the December 15, 2016 minutes. **Motion passed**: All in favor.

Report of Staff: M. Ross-Russell reported that RWPC members were now required to complete a tax certification form. She said that J. Hayes sent an email out to planning body members with instructions for filling out the form. She explained that members of executive boards needed to prove that they did not owe any back taxes, as of Mayor Nutter's administration. She noted that there was a computer set up in the office, and staff could help members fill in the form after the meeting.

B. Morgan stated that the PA HIV Planning Group was changing their composition. She noted that 24/28 of HPG members' terms had expired in November 2016. She said the current membership proposal for the body would include, as voting members, 4 consumers, 4 representatives from Ryan White Part B organizations, 3 representatives from Part C, 1 from Part D, 3 testing or prevention providers, and 2 subrecipients or subgrantees. She stated that non-voting members included 1 member from the PA Department of Health (DOH), 1 from Part A, 1 for Part F, and 4 human service providers. B. Morgan said the PA HPG was accepting applications for new members. A. Thompson stated that it seemed the new plan for the state HPG would not represent the state population. K. Carter asked if the RWPC could voice their thoughts on the new plan.

M. Ross-Russell noted that the CDC required inclusiveness, parity, and representation on HPGs. She said the Philadelphia Part A EMA was required to coordinate with the state for their integrated prevention and care plan.

A. Thompson noted that the National HIV/AIDS Strategy (NHAS) emphasized coordination between states and local bodies. A. Ricksecker noted that the CPC had been discussing health insurance premium/cost-sharing assistance, which would possibly require working together with the state. She asked how the CPC and RWPC would communicate with the HPG within the bounds of the new structure.

A. Thompson asked if the Part A representatives would be providers or those who lived in the Part A jurisdiction. B. Morgan said the proposal noted that Part A was expected to have a single representative, likely from the recipient (AACO). A. Ricksecker asked who the two Part B subrecipients were. B. Morgan noted that there were 7 Part B subrecipients. She said that 2 of these would be included as voting members in the HPG.

K. Carter asked if this proposal was new or if it had already existed. B. Morgan replied that it was new. A. Thompson said the new requirements were a barrier to participation.

P. Gorman asked what rationale was given for the distribution of voting members in the new plan. B. Morgan noted that there were new guidelines for advisory boards in the state DOH. She added that they wanted to make the group smaller, and AACO was a sufficient representative for Part A because of their collaborative working relationship. P. Gorman asked if AACO was an administrator for Part B as well as Part A. B. Morgan agreed, and added that AACO would be considered Part A for these purposes.

In response to A. Ricksecker's earlier comments, A. Thompson asked if the group would like to draft a feedback letter about the proposal. A. Thompson volunteered to make a draft of the letter.

Motion: A. Ricksecker moved, K. Carter seconded that A. Thompson draft a letter on behalf of the CPC to the state DOH to inquire about Part B collaboration on health insurance premium/cost-sharing assistance. **Motion passed**: All in favor.

N. Johns reported that the OHP has distributed 2365 copies of the consumer survey, of which 269 paper copies had been returned. She stated that about 30 online surveys had also been completed. She noted that several Spanish language surveys had been returned, along with many from NJ. She stated that 145 surveys were received by the office yesterday. She asked the group to continue distributing flyers to their clients and in other locations in the community. She stated that the office may be able to report on preliminary results in February. She noted that transportation was the most frequently mentioned barrier to services thus far.

Report of Chair: K. Baron asked if there had been any nominations for another co-chair of the CPC. N. Johns stated that the group had decided A. Thompson would be the sole co-chair at the last meeting. No further nominations were made.

Discussion Item:
Health Insurance Premium/Cost-Sharing Assistance

N. Johns said that R. McKenna of the Health Resources and Services Administration (HRSA) regional field office would be coming to the meeting around 3:00. A. Thompson noted Comprehensive Planning Committee had discussed speaking with him about collaborating with the state on a health insurance premium/cost-sharing assistance plan. A. Ricksecker asked if R. McKenna was present at the last PA HPG meeting. B. Morgan said that he had not attended the January meeting, but was present in November.

M. Ross-Russell stated that she had told R. McKenna the group planned to discuss health insurance premium/cost-sharing assistance and how it was carried out in other areas. N. Johns said that, if the service category was going to be funded only through Ryan White Part A, the current allocation would not be sufficient to support the program (as discussed at the previous meeting). She noted that the group would have to discuss this with the Finance Committee. She stated that up to 10 times this amount would be required to run a health insurance premium/cost-sharing assistance program.

N. Johns said that there was a need for health insurance premium/cost-sharing assistance for 630 people in the EMA, as noted by AACO representatives at previous meetings. She noted that it was unknown what would happen to the Affordable Care Act (ACA) and Medicaid in the future, given the upcoming shift to a new presidential administration. She passed around a map of ADAP Part B programs that currently purchase qualified health plans for clients. She noted that NJ was designated incorrectly on the map, as they recently implemented a health insurance premium/cost-sharing assistance program. She noted that Texas and Idaho didn't cover any health insurance premium/cost-sharing program under Ryan White, while PA was one of the three states that offer co-pay assistance but not premium assistance. She noted that in most of the country, Ryan White assistance was available for premiums and copays.

N. Johns noted that one of the group's activities for 2017 was to determine the most efficient, cost-effective, and feasible mechanism to provide health insurance cost-sharing assistance (see attached sheet, pg. 67, 2.2.3). A. Ricksecker asked what the EMA would do if the state was not prepared to support the program. A. Thompson said that the group would get feedback from R. McKenna and the state, in response to their letter. He asked if the Finance Committee would discuss their allocation for health insurance premium/cost-sharing assistance. M. Ross-Russell responded that it was currently unknown what the Ryan White award would be for FY 2017-18. She noted that the committee would need to discuss with the Finance Committee the possibility of the category getting cut if the grant amount was decreased in the future. She reiterated that approximately $1.8 million would be required to fully support the premium assistance and cost-sharing program.

A. Thompson noted that it was important to figure out what each service category paid for before any funding was removed. He stated that sudden changes to funding could be harmful to clinics. M. Ross-Russell said that there were only a few service categories with sufficient funds to come up with $1.8 million, outpatient ambulatory care and pharmaceutical assistance, because of the amount of funding in those categories. She noted that medical case management received several million dollars, however the RWPC may need to add more funding to it to support the additional needs and barriers due to potential changes in health policy. K. Carter asked if money could be allocated to the health insurance premium/cost-sharing assistance program from underspending. M. Ross-Russell stated that underspending tended to range from $200,000-500,000, which was not enough to support the program. She

added that underspending totals varied from year to year and the program would need to be sustainable.

P. Gorman reiterated that upcoming political changes could majorly change the costs and operations of health insurance programs. She noted that it took a great deal of time, energy, and resources to set up health insurance premium/cost-sharing assistance programs. She said her hospital-based institution took about 6 months to implement their procedures to use the NJ HIPCSA program. A. Thompson stated that some NJ institutions had given the money for the programs back because they were too difficult to implement.

A. Thompson suggested informing the Finance Committee that there were insufficient funds to support health insurance premium/cost-sharing assistance, according to the current allocation. He said the Comprehensive Planning Committee should start by drafting their letter to the state and see what kind of response they got.

M. Ross-Russell reminded the group that they'd discussed the difficulties in paying copays through HIPCSA because of the need to track costs across the system (due to Ryan White percentage caps based on income). Because of this information, the group had decided funding copays wasn't feasible, and it may be easier to fund premiums and deductibles. A. Thompson said he'd suggested piloting a program covering only a certain population of clients.

M. Ross-Russell said that there had been a program in the city in the past specifically for people who were uninsured and newly diagnosed with HIV. She stated that it was set up to cover services like the first three doctor visits. She said that implementing this kind of service under health insurance premium/cost-sharing assistance still would involve tracking fees to monitor the Ryan White cap for out-of-pocket costs. She noted that some providers may have trouble tracking these fees in specific populations.

A. Ricksecker asked how the program M. Ross-Russell mentioned had been implemented in the past. M. Ross-Russell said it had fallen under the category of primary medical care. She said it paid for initial labs, doctors' visits, and return visits. She stated that it required collaboration between medical providers and case managers. A. Ricksecker noted that these kinds of programs facilitated linkage to care. She asked if it could still be supported under ambulatory/outpatient medical care.

Returning to HIPCSA specifically, M. Ross-Russell stated that historically the PA HIV Division did not have the capacity to issue direct payment to insurers. Furthermore, because changes to the Ryan White program in response to the ACA, HRSA's HIV/AIDS Bureau requires review of tax returns to reconcile federal subsidies for premium and cost-sharing assistance.

A. Thompson asked R. McKenna if any other EMA in the country provided HIPCSA using Part A funding. R. McKenna responded that he had not been able to identify any. He said that PA was one of few states that was not providing a health insurance premium/cost-sharing assistance program.

R. McKenna stated that each Part B jurisdiction in the state carried out their health insurance premium/cost-sharing assistance programs differently. He noted that some reimbursed providers by check. He said providers initially paid for the services and then billed for them. He noted that the providers and jurisdictions supporting the service in PA already had the money in their budget from Part B, and they decided to provide the service to clients. N. Johns said that these Part B subrecipients typically identified clients with a need, provided the assistance, then provided documentation to get reimbursed.

A. Ricksecker asked what the source of funding was for the programs R. McKenna was describing. He replied that funding for the programs was from Part B. A. Ricksecker asked if PA ADAP dollars were available to fund these programs. R. McKenna said that PA ADAP staff were exploring supporting HIPCSA programs.

M. Ross-Russell asked if a jurisdiction could use multiple funding sources to fund health insurance premium/cost-sharing assistance. R. McKenna said that funding HIPCSA in other areas within PA had not reduced funding for existing categories. He reiterated that the inability within state infrastructure to cut a check and reconciliation of tax credits were two barriers to program administration.

R. McKenna said that HRSA did not dictate a process for funding HIPCSA. He stated that the rule was that there needed to be a mechanism in place for health insurance premium/cost-sharing assistance for the service to be funded, but it was not specific what that mechanism was. A. Thompson said that administration of the program could be handled by a pre-existing third-party entity, which may ease the reconciliation of tax credits.

R. McKenna asked if the group was considering paying for only health insurance premium assistance. M. Ross-Russell replied that they were initially planning to pay for only cost-sharing assistance. However, AACO had given them more information about the difficulty of administering a cost-sharing assistance program. She noted that AACO representatives had said supporting a health insurance premium assistance program would cost $1.8 million. She said the group had discussed piloting a program that targeted only a certain population and speaking with the Finance Committee about the feasibility of funding it. She added that they also planned to ask the state for assistance.

R. McKenna said that there was a lot of work involved in determining what insurance plans would be paid for using health insurance premium assistance programs. He stated that states had determined which insurance plans would be more efficient to cover than paying directly for healthcare. He said that, if the dollar amount available was very limited, than some organizations used their health insurance premiums, deductibles, and copays category only for patients in short-duration, limited time emergency situations. He said that these programs were run in similar fashions to larger scale health insurance premium assistance programs. S. Branca asked if providers determined eligibility and applied for reimbursement. R. McKenna said they did.

K. Carter said that paying for deductibles in the case of financial hardship would ensure continuity of care. A. Thompson stated his organization had decided not to participate in the program because of the need to track costs for each client. He stated that the administrative burden may not be worth the amount of service that was being provided. He noted that the allocation of $160,000 could serve 50 people if it was paying for silver plan deductibles. P.

Gorman stated that organizations with electronic billing systems had an easier time tracking costs than others did. However, it was difficult at a provider level regardless. A. Thompson said that a rationed, limited service not available to everyone did not sustain care.

A. Ricksecker stated that the group now knew that at least one Part B region in PA was doing this kind of program. R. McKenna stated that he'd like to know what the demand was for the service. He said the Jewish Healthcare Foundation of Pittsburgh had found that there wasn't much of a demand for the service there. A. Thompson said the need wasn't as dire in a state with Medicaid expansion, like PA. A. Ricksecker reiterated that there were 630 people with a need for the service in Philadelphia. She stated that only a small percentage would begin using the service initially.

N. Johns stated that the consumer survey included questions about whether or not insurance was a barrier to care. She stated that it did not seem to be a commonly cited need in the surveys she'd seen so far.

N. Johns stated that the Comprehensive Planning Committee would begin their priority setting process in March. She said discussions of health insurance premium/cost-sharing assistance would be important in determining priorities.

R. McKenna asked if HRSA could convene a meeting inviting the state and HRSA to discuss how health insurance premium/cost-sharing assistance could be implemented. The group agreed to this proposition by general consensus.

S. Branca noted that ambulatory outpatient care and medical case management services may be cut in Part B rather than Part A if the funding for the HIPCSA program came from core services rather than ADAP. A. Thompson asserted that the funding for this sort of program should come out of ADAP and not other Part B programs.

- **Discuss Goals and Objectives**

N. Johns said the goals and objectives were included in the handouts. She said that items marked with asterisks were placed in a timeframe through the end of 2017. She stated that some of the items that were underway were not necessarily being implemented by the RWPC. She added that the Comprehensive Planning Committee would continue discussing many of these items in the future.

Old Business: None.

New Business: None.

Next Steps: A. Thompson said he'd draft the letter by early next week and send it out to the group for review.

Announcements: None.

Motion: D. Gana moved, P. Gorman seconded to adjourn the meeting at 3:58p.m. **Motion passed**: All in favor.

Respectfully submitted by,

Jennifer Hayes, Staff

Handouts distributed at the meeting:

- Meeting Agenda
- December 15, 2016 Meeting Minutes
- Health Insurance Premium and Cost-Sharing Assistance Program: Considerations
- ADAP/Part B Programs Currently Purchasing Qualified Health Plans (QHPs) for Clients (September 2015)
- Section II: Integrated HIV Prevention and Care Plan (Goals and Objectives)
- OHP Calendar