Policy Committee
2006-2007 Policy Committee Year-End Report
May 10, 2007

Drafted for the
Boston Part A (Title I) EMA
HIV Health Services
Planning Council

Produced by

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The Policy Committee of the Boston EMA HIV Health Services Planning Council presents its 2006-2007 Year-End Report

Committee Charge

The Policy Committee is one of the Planning Council's standing committees. The Planning Council's bylaws state the charge to the committee at Section 6.4.5:

"The Policy Committee shall analyze local and federal policy and legislative issues, and advise the Council on how these issues may impact the Boston EMA, recommend response strategies, and coordinate such response activities."

Committee Membership

Members	***Staff***
Barry Sandberg, Chair	Michael Hager, PCS
Emerson Miller, Vice-Chair	Jonathan Leite, PCS
Alison Kirchgasser	Leela Strong, PCS
Susan Oleksiw	Stacey Martin, BPHC
Lester Payne	

Committee Meetings

Thursday, October 19, 2006	2pm-4pm	Boston AIDS Consortium
Thursday, November 16, 2006	3pm-5pm	Boston Public Library
Thursday, January 18, 2007	3pm-5pm	Boston Public Library
Thursday, March 15, 2007	3pm-5pm	Boston Public Library
Thursday, April 19, 2007	3pm-5pm	Boston Public Library

Work of the Committee

Policy Committee structured its work around several concerns that influence the lives of people living with HIV locally and nationally. Some of these issues were studied per the recommendation of last year's Policy Committee. Others were added due to their relevance to the Policy Committee charge. Each issue was followed by a particular committee member.

1. Reauthorization of the Ryan White Act..*Barry Sandberg*
2. Massachusetts Health Reform Law Implementation ....*Alison Kirchgasser*
3. HIV Case Reporting... *Emerson Miller*
4. Revised CDC Counseling and Testing Recommendations................................. *Susan Oleksiw*
5. Policy Committee Liaison with Consumer Committee ....*Lester Payne*

Reauthorization of the Ryan White Act

Policy Committee Chair Barry Sandberg led research and discussion on Ryan White Reauthorization. Policy Committee tracked proposed reauthorization bills until the Ryan White HIV/AIDS Treatment Modernization Act (RWTMA) was signed into law on December 19, 2006. Once Ryan White was reauthorized through the RWTMA, the Policy Committee began evaluating the legislation and its implementation to determine the direct consequences for the Part A (Title I) Boston EMA. The RWTMA will sunset on September 30, 2009 (a three-year authorization).

Recommendations from the 2005-2006 Planning Council Term

1) *Recommended that the current Policy Committee revisit the question of equity and access to resources:*
   a) *in the context of substantive changes emerging from the reauthorization of the CARE Act*
   b) *in the context of the geographically equitable distribution of funds*
      - ✓ a. this is a moot point, as the boundaries of the EMA remained stable
      - ✓ b. lengthy conversations were held at the Planning Council level, which have informed New Hampshire's use of Part A (Title I) funds
2. *Recommended that the current Policy Committee follow up on any new issues arising from the new Ryan White Act of 2006 in order to keep the Planning Council informed about how these issues affect the Boston EMA*
   - ✓ The remainder of this section handles this recommendation

Ryan White Reauthorization Key Dates

- ✓ September 30, 2005 - Ryan White CARE Act expires
- ✓ December 19, 2006 - Ryan White HIV/AIDS Treatment Modernization Act of 2006 is signed into law
- ✓ February 12, 2007 – Grantee sends expected award amounts to providers
- ✓ February 15, 2007 – FY 2007 Appropriations are signed into law (for October 2006 – September 2007)
- ✓ March 1, 2007 –Grantee issues local provider award letters
- ✓ March 5, 2007 – HRSA issues Part A (Title I) FY 2007 Formula awards
- ✓ April 18, 2007 – Grantee receives waiver to the 75/25 Clause
- ✓ *May, 2007 – Grantee receives Supplemental Award?*
- ✓ *August, 2007 – Grantee receives and allocates MAI Award?*

Award Eligibility

- ✓ Eligible Metropolitan Areas (EMA) have a population greater than 50,000 and more than 2,000 cumulative AIDS cases over the last five years
- ✓ Transitional Grant Areas (TGA) have a population greater than 50,000 and between 1,000 and 2,000 cumulative AIDS cases over the last five years

HIV Case Reporting

Living HIV cases are counted in addition to AIDS cases for funding considerations. Living HIV cases reported to the CDC using an approved names-based HIV reporting system are preferable, but states lacking mature names-based HIV reporting systems may count 95% of the living HIV cases reported to HRSA.

Award Structure Changes

- *Formula*
  - ✓ The formula portion of the award consumes 66% of the total award
  - ✓ The formula is based on living HIV cases (see above) and cumulative AIDS cases over the last 5 years

- *Supplemental*
  - ✓ The supplemental award was delayed in FY 2007 because HRSA had to review the competitive grants that arrived late from the five new TGAs. This issue will not arise in future fiscal years

- *MAI*
  - ✓ The Minority AIDS Initiative (MAI) has been moved to Part F, but the funds are still available for Part A (Title I) jurisdictions through a separate competitive grant writing process
  - ✓ MAI projects will be awarded on three-year grant cycles (the Grantee will submit non-competitive continuation proposals to HRSA for FY 2008 and FY 2009)
  - ✓ MAI will now be awarded and monitored separately from the rest of Part A. MAI will operate on a separate fiscal year from the rest of Part A (August 1 – July 31)
  - ✓ The Grantee will need to procure MAI services immediately upon receiving its MAI award from HRSA in late summer

- *Carryover*
  - ✓ Grantees are expected to expend 98% of their formula award
    - The remaining 2% is available for carryover by request to HRSA
  - ✓ Grantees are expected to expend 100% of their supplemental award

- *Hold Harmless*
  - ✓ For FY 2007, hold harmless will be factored as 95% of the FY 2006 formula award (corrected for the increase in the formula award's proportion of the total award)
  - ✓ For FY 2008 and FY 2009, hold harmless will be factored as 100% of the FY 2007 formula award
  - ✓ TGAs are not eligible for hold harmless

75/25 Clause and Waiver

RWTMA stipulates that 75% of funding must be allocated to core medical services. The remaining 25% of funding may be used on HRSA-approved support services. While there was no time for HRSA to institute a formal waiver process to the 75/25 Clause in FY 2007, they are approving one-time waivers on an ad-hoc basis. The Boston Part A (Title I) EMA has been approved for a 75/25 Clause waiver for FY 2007.

Planning Councils

Planning Councils are required for all previously funded EMAs/TGAs, but are optional for the five newly funded TGAs.

Massachusetts Health Reform Law of 2006

Policy Committee member Alison Kirchgasser led research and discussion on the Massachusetts Health Reform Law of 2006 and its implementation. Health reform extends access to medical insurance to all Massachusetts residents who are United States citizens and qualified aliens. Increased access to medical insurance will undoubtedly have direct and indirect impacts on Part A (Title I) clients and utilization of Part A (Title I) funded services.

Health Reform Law Key Dates

- ✓ April 4, 2006 – Massachusetts Health Reform Law of 2006 is signed into law
- ✓ October 1, 2006 – Enrollment in Commonwealth Care begins
- ✓ March 8, 2007 – Seven health organizations are given the Connector Board's seal of approval for provision of health plans as part of health reform
- ✓ March 20, 2007 – *Draft Minimum Creditable Coverage Regulations are released by Connector Board*
- ✓ April 12, 2007 – *Draft Affordability Regulations are released by Connector Board*
- ✓ May 1, 2007 – Enrollment in Commonwealth Choice begins
- ✓ *December 31, 2007 –All Massachusetts residents must have health insurance as long as affordable coverage is available to them*

Health Reform Law Implementation

1. *Commonwealth Care*
   - ✓ Must be 19 or older, citizen or qualified alien, uninsured (no MassHealth, no Medicare, no student health insurance, no access in the last six months to employer sponsored insurance where employer pays at least 33% of individual premium)
   - ✓ Subsidized access to managed care organizations for uninsured up to 300% Federal Poverty Level (FPL). Those eligible include uninsured people living with HIV with income between 201% and 300% FPL (**people living with HIV with income up to 200% remain eligible for MassHealth**). All plans must offer coverage to young adults two years after they lose their dependant status under federal tax law or to age 26, whichever comes first
     - Managed Care Organizations (depends on geographic location)
       - Boston Medical Center HealthNet Plan
       - Fallon Community Health Plan
       - Neighborhood Health Plan
       - Network Health
     - Plan Type I
       - Up to 100% FPL
       - No premiums, MassHealth level co-pays
       - Inpatient, outpatient, mental health, substance abuse, prescription drugs, vision, dental
     - Plan Type II
       - 101%-200% FPL
       - Sliding scale premiums
       - Benefits same as Type I, but no dental

- Plan Type III
  - 201%-300% FPL
  - Sliding scale premiums
  - Lower premium, higher co-pays
  - Benefits same as Type I, but no dental
- Plan Type IV
  - 201%-300% FPL
  - Sliding scale premiums
  - Higher premium, lower co-pays
  - Benefits same as Type I, but no dental

✓ Enrollment just under 70,000 as of April 19, 2007
- 140,000 total individuals estimated to be eligible

✓ Uncompensated Care Pool (free care pool) will wrap around Commonwealth Care to help with cost sharing and any medically necessary, non-covered benefits until at least October, 2007

2. *Commonwealth Choice*

✓ Non-subsidized, 'affordable' plans available for purchase through the Connector Board by those over 300% FPL, including uninsured people living with HIV/AIDS, including small employers

✓ Enrollment begins May 1, 2007 and becomes effective July 1, 2007

✓ Each of the seven approved organizations will offer five plans through the Connector Board. Premiums, deductibles, and covered services will vary by plan
- One Premier Plan
- Two Value Plans
- One Basic Plan
- One Young Adult Plan

3. *Employer Responsibility for Employers with 11 Full-time or Equivalent Employees*

✓ Must offer a Section 125 Plan, which allows employers to purchase insurance with pre-tax dollars

✓ Must provide reasonable level of coverage or pay $295 yearly assessment for each employee. Reasonable is defined as:
- Employer covers 33% towards individual, 20% towards family premiums
- OR 25% of employees participate in employer sponsored insurance

✓ Free-rider surcharge
- A percentage of costs of care for employees using significant amounts of free care when employer does not offer Section 125 plans

4. *Individual Responsibility*

✓ December 31, 2007, individuals must have insurance as long as affordable, minimal creditable coverage is available

✓ Massachusetts will track which individuals have insurance through insurers. Individuals will receive a statement from their health insurer confirming their enrollment and individuals will need to include the information for their coverage on their state tax returns. The Division of Insurance and the Department of Revenue will share information on who is insured.

- ✓ Minimal Creditable Coverage as described in draft regulations released by the Connector Board on March 20, 2007
  - o Individuals must have a plan with minimal creditable coverage by January 1, 2009 (the delay is to provide an opportunity to switch plans during employers' open enrollment)
  - o Includes prescription drugs as a covered benefit
  - o Covers preventive physician visits prior to any deductible
  - o Caps any annual deductible at no more than $2,000 for individuals and $4,000 for families
  - o Caps an individual's out-of-pocket spending for hospital and physician services at $5,000 for individuals and $10,000 for families
  - o Disallows limitations on benefits per year or per sickness
  - o Disallows potentially deceptive benefits for only a certain amount of dollars toward a day in the hospital
- ✓ Affordability Standard as described in draft regulations released by the Connector Board on April 12, 2007

Income Range	**Maximum Affordable Monthly Premium**
$30,631 - $35,000	$150
$35,001 - $40,000	$200
$40,001 - $50,000	$300
Over $50,000	All insurance deemed affordable unless granted a waiver

- ✓ Penalties
  - o 2008 (for tax year 2007): loss of the personal state income tax exemption
  - o 2009 and beyond: assessed for 50% annualized cost of lowest premium plan
- ✓ Waiver and Appeals Process is included in the draft Affordability Regulations

5. *Outreach and Communications*
   - ✓ Outreach
     - o Connector Board to send postcards to all taxpayers and letters to all employers in May, 2007
     - o Organizations like Health Care For All are helping with outreach
   - ✓ Enrollment
     - o 877-MA-ENROLL
     - o www.macommonwealthcare.org
     - o www.gethealthcoverage.net

Health Reform Law Impacts on Boston Part A (Title I) EMA Services

1. *HDAP/CHII Wrap Around*
   - ✓ How will HDAP/CHII treat the new insurance programs in its application?
   - ✓ Will HDAP/CHII benefits wrap-around the cost-sharing elements of the new insurance programs (premiums, deductibles, co-pays)?

2. *HIPAA Issues*
   - ✓ Is it within HIPAA guidelines for the state to track who has insurance?
   - ✓ How will the Division of Health Care Finance and Policy invoke the free-rider surcharge and inform employers that certain employees over-access Uncompensated Care Pool funds?

3. *Undocumented People Living With HIV*
    - ✓ The Uncompensated Care Pool will remain available for undocumented non-citizens living with HIV. Ryan White dollars will also continue to be available to these groups

4. *Other short-term impacts*
    - ✓ The new programs will potentially be confusing for people living with HIV. The Part A (Title I) service system faced a similar question regarding the implementation of Medicare Part D. Experience shows that additional outreach and enrollment efforts by providers will make the transition smoother for people living with HIV.

5. *Other long-term impacts*
    - ✓ If Health Reform is successful, Part A (Title I) spending and utilization on core services will decrease.
    - ✓ If necessary for future 75/25 Clause waivers, will dollars for 'core services' be routed to New Hampshire?
    - ✓ What happens to the service care system if the new insurance programs prove to be financially unsustainable and the Health Reform Law is revoked?

6. *On-going unknowns (developed November 16, 2006)*
    - ✓ How extensive will the drug formularies be for the approved plans?
    - ✓ Will provider networks have the capacity to handle the increased caseload for the newly insured?
    - ✓ How will part-time students be handled? How will out-of-state students be handled?
    - ✓ What specialty care services are covered by the new insurance programs?

HIV Case Reporting

The third recommendation made last year by Policy Committee was that they continue tracking the implementation of names-based HIV case reporting. Policy Committee Vice-Chair Emerson Miller led research and discussion on the transition to a names-based HIV reporting system.

In July 2005 the US Centers for Disease Control (CDC) sent letters to governors of states still using code-based HIV reporting systems. The letter indicated the possibility of losing federal funds if names-based HIV reporting was not implemented. Massachusetts Department of Public Health (MDPH) Commissioner Paul Cote announced that the state intended to implement names-based HIV reporting January 1, 2007.

There has been controversy in the implementation process of the new names-based HIV reporting system regarding Massachusetts General Laws Chapter 111, §70F. It is the assertion of MDPH that the new reporting system is in harmony with 111, §70F. Representatives from diverging opinions were invited to a Policy Committee meeting to discuss these issues. At the April 19, 2007 meeting, AIDS Action Committee (AAC) expressed its belief that the new names-based HIV reporting system and 111, §70F are not in harmony. Legislation supported by AAC has been filed that would amend 111, §70F.

New Hampshire has always used a names-based HIV reporting system so this issue does not affect them. ***See the appendix at the end of this report for notes on Massachusetts and New Hampshire HIV testing and the proposed amendment to 111 §70F.***

Revised CDC Counseling and Testing Recommendations

Policy Committee member Susan Oleksiw led research and discussion on the Revised CDC Counseling and Testing Recommendations.

The CDC now recommends routine voluntary screening of HIV as a normal part of medical practice, similar to screening for other treatable conditions.

1. *Target Populations*
   - ✓ All persons aged 13-64
   - ✓ All those initiating treatment for tuberculosis (TB)
   - ✓ All those seeking treatment for STDs (during each visit for a new complaint)
   - ✓ Those at high risk should be tested at least annually
   - ✓ Results of HIV tests should be provided in the same way as other diagnostic results
   - ✓ Prevention counseling should not be required as part of HIV screening in healthcare settings

2. *Patient Consent*
   - ✓ Consent for HIV screening is incorporated into patients' general consent for all medical care
   - ✓ Patients should be informed orally or in writing:
     - o That HIV testing will take place
     - o That patient can opt out of HIV testing
   - ✓ Patient may decline testing- this is noted in the patient's medical record

3. *Pregnant Women*
   - ✓ All pregnant women should be screened for HIV
   - ✓ Include HIV testing as part of routine prenatal tests
   - ✓ Testing must be voluntary and free from coercion
   - ✓ Patient should receive oral or written information about HIV, interventions to prevent mother to child transmission, meanings of test results, etc.
   - ✓ HIV tests are treated like any other diagnostic test- no additional oral or written consent forms are provided
   - ✓ If HIV test is declined, this decision is documented in the patient's medical record
   - ✓ Any woman with undocumented HIV status at the time of labor will be screened with a rapid HIV test (with the option for the mother to opt-out)
   - ✓ Any woman with undocumented HIV status after delivery will be screened with a rapid HIV test (with the option for the mother to opt-out)

4. *Adolescents*
   - ✓ Healthcare providers should try to respect an adolescent's request for privacy about HIV testing. Providers should engage all adolescents about HIV screening and encourage those who are sexually active to be tested
   - ✓ Information about HIV should be part of an adolescent's primary care

Policy Committee Liaison with Consumer Committee

Policy Committee member Lester Payne worked with the Consumer Committee Chair and PCS to provide timely updates on pressing policy developments to the Consumer Committee. Consumer Committee conversation and questions related to these policy issues were then taken back to Policy Committee for answers and to provide a consumer-centered compass to Policy Committee research.

Recommendation to Resource & Allocation Committee

Policy Committee requested the Resources and Allocations Committee review issues related to Massachusetts Health Reform and CDC Counseling and Testing Guidelines when developing the FY 2008 Funding Scenarios. The implications of these issues are larger than the Policy Committee has been able to identify this term. The Executive Committee was consulted for guidance in making this recommendation.

Through this recommendation Policy Committee intended for Resource & Allocations Committee to consider the new insurance programs' effects on Part A (Title I) consumers and on Part A (Title I) spending. Similarly, the new CDC Counseling and Testing Guidelines have applications that touch on Massachusetts General Law Chapter 111 §70F and on the potential to bring many new consumers into the Part A (Title I) continuum of care. Both of these issues have enormous potential impacts for Part A (Title I) services, as Health Reform will limit the amount of funding needed for services provided through the reforms and the new consumers identified via CDC Counseling and Testing Guidelines will stretch supportive service dollars more thinly.

Recommendations to the 2007-2008 Policy Committee

1. Continue to follow-up on the unanswered Health Reform Law implementation questions.

2. Continue to track MAI and supplemental funding issues, including missions, timelines, and program implementation.

3. Continue to track issues related to names-based HIV reporting systems and the Revised CDC Counseling and Testing Recommendations and their perceived dissonance with Massachusetts General Laws Chapter 111 §70F.

4. Track the medical response to the Revised CDC Counseling and Testing Recommendations with an emphasis on provider consequences.

5. Spilt up Policy Committee roles, goals, and responsibilities among the committee members similar to this year.

Appendix

Notes on Massachusetts HIV Testing

Overview

A physician or other healthcare provider must have informed, written consent to:

- ✓ Test for HIV;
- ✓ Reveal to a third party that someone was tested; and
- ✓ Disclose the results of an HIV test.

Written informed consent means a specific release for an HIV test, for disclosure of test results, and purpose for which HIV test/status information is requested.

Minors (under age 18)

Minor can give consent to medical or dental care providers in certain situations, including if he or she reasonably believes he or she has come into contact with any disease considered dangerous by MDPH, including HIV.

Confidentiality

No clear legal grounds allow a provider to breach HIV status confidentiality

Excerpt from April 19, 2007 Policy Committee Handout, Susan Oleksiw

Notes on New Hampshire HIV Testing

Overview

- ✓ No healthcare practitioner, including employees of a blood bank may administer HIV tests without HIV-specific consent from individuals to be tested.
- ✓ Prior to administering an HIV test, providers must inform patients about the medical interpretation of positive and negative HIV test results and New Hampshire law about confidentiality of those results.
- ✓ New Hampshire law mandates appropriate counseling for individual testing for HIV upon notification of HIV test results.
- ✓ Written consent for HIV testing is not required.

Exceptions to Rule of Voluntary Informed Consent and Confidentiality

- ✓ All those convicted of sexual assault crimes are tested for HIV. Test results are given to the person convicted and to victim/witness assistance, which can disclose the test results to the victim and advocates
- ✓ Those in correctional facilities or hospitals where HIV test results are necessary for placement of individuals; HIV test results are disclosed administratively and to other officials as needed
- ✓ Those who cannot give voluntary informed consent during a medical emergency, to protect the health of the patient

Adolescents

Any minor over the age of 14 can be tested and treated for HIV without parental consent. Providers may disclose HIV testing and treatment to parents of children aged 14-18, but are not obligated to do so

Testing by Insurers

Insurer must obtain an individual's written consent on a form provided by the New Hampshire Department of Health and Human Services. Positive HIV results are given only to person tested. Records must be kept confidential.

Occupational Exposure

No provision for involuntary HIV testing for healthcare workers in event of exposure.

Confidentiality

Identities of people tested for HIV may not be disclosed except to:

- ✓ Individual being tested
- ✓ Parent of legal guardian of children younger than 18
- ✓ Physician ordering the test or his or her representative

Written consent is required to disclose HIV testing history and HIV test results. Consent must be HIV-specific and provide reasons for the request to disclose.

Excerpt from April 19, 2007 Policy Committee Handout, Susan Oleksiw

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AN ACT RELATIVE TO HEALTH PRIVACY

MASS. PUBLIC HEALTH PRIVACY ACT H.2276

SECTION 4: Amendment to Chapter 111, sec. 70F

Informed consent under Chapter 111, § 70F must include information that (a) the presence of the HIV or HTLV-III antibody or antigen is reportable to the public health agency, (b) a description of the purposes for which the individual's protected health information will be used by the agency, and (c) a description of the security measures used to protect the security of the information.

Excerpt from H.2276 Section by Section Summary