

Policy Committee
2007-2008 Policy Committee Year-End Report
June 2008

Drafted for the
Boston Part A EMA
HIV/AIDS Health Services
Planning Council

Produced by



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*The Policy Committee of the Boston EMA HIV Health Services Planning Council presents
its 2007-2008 Year End Report*

Committee Charge

The Policy Committee is one of the Council’s standing committees. The Council’s bylaws state the charge to the committee in 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

Barry Sandberg, Chair
Maria Orsini, Vice-Chair
Neil Cronin
Paul Keating
Alison Kirchgasser
Susan Oleksiw
Florence Saintiche

Staff

Michael Hager, PCS
Steph Sharp, PCS
Leela Strong, PCS
Eric Thai, BPHC

Committee Meetings

Thursday, November 15, 2007	3:00pm- 5:00pm	Boston Public Library
Thursday, January 17, 2008	3:30pm- 5:00pm	Boston Public Library
Thursday, February 21, 2008	3:30pm- 5:00pm	Boston Public Library
Thursday, March 20, 2008	3:30pm- 5:00pm	Boston Public Library
Thursday, April 17, 2008	3:30pm- 5:00pm	Boston Public Library
Thursday, May 15, 2008	3:30pm- 5:00pm	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 Policy Committee issues. Each issue was followed by a particular committee member.

1. Reauthorization of the Ryan White Act.....*Barry Sandberg*
2. Massachusetts Health Law Reform Implementation*Neil Cronin*
3. Names-Based HIV Case Reporting *Paul Keating*
4. CDC Counseling and Testing Guidelines*Susan Oleksiw and Maria Orsini*
5. New Hampshire Updates*Alison Kirchgasser*
6. Policy Committee Liaison with Consumer Committee ..*Florence Saintiche and Maria Orsini*

Progress on Recommendations from the 2006-2007 Policy Committee

The 2006-2007 Policy Committee made several recommendations to the incoming committee members. They included continuing to track the issues surrounding Health Law Reform, MAI and supplemental funding issues, names-based reporting, and the response to the CDC Counseling and Testing Guidelines. An additional recommendation was made to divide Policy Committee roles and responsibilities among committee members which the current committee With the exception of following MAI and supplemental funding issues, the Committee rigorously followed these suggestions and their findings are described in this report. Had there been any, MAI and supplemental funding issues would have been tracked by Barry Sandberg as part of his of his report on the impact of changes in Ryan White legislation.

Reauthorization of the Ryan White Act

Policy Committee Chair Barry Sandberg led research and discussion on the impacts of the Ryan White HIV/AIDS Treatment Modernization Act (RWTMA) on the Boston EMA. The legislation has been in place since December 19, 2006 and will continue until its sunset on October 30, 2009. Some of the changes, particularly the requirement that 75% of Part A funds be used for Core Medical Services the committee paid particular attention to this issue and presented their findings to the full Council at the April 24, 2008 meeting. Below is a detailed history of the issue and a summary of their findings.

When RWTMA replaced the CARE Act in 2006, one of the changes in legislation impacting the EMA is the Core Medical Services Requirement, which requires that a minimum of 75% of Part A funds be used for Core Medical Services. These services include:

- Outpatient and ambulatory health services
- ADAP
- AIDS pharmaceutical assistance
- Oral health care
- Early intervention services
- Health insurance premiums and cost sharing assistance for low-income individuals
- Home health care
- Medical nutrition therapy
- Hospice services
- Home and community-based health services
- Mental health services
- Substance abuse outpatient care
- Medical case management, including treatment adherence services.

The Planning Council process sets priorities and allocates funds based on the needs of people living with HIV and AIDS in the region. For FY08, the balance of services within the EMA was 53% core and 47% support. Since this balance falls outside the 75/25 requirement, it was necessary for the Grantee to request a waiver from the Core Medical Services requirement so that they could follow the Council's allocation decisions.

The Policy Committee monitored the impact that the waiver process had on the EMA by looking at the impact on the Grantee's office, the way in which the Council set priorities and made

allocations, and the affects the process had on the service delivery system. The Committee concluded that the Planning Council process was an effective method for making allocations based on the need of PLWH in the community. Should their recommendations fall outside the 75/25 requirement then the Grantee who is legally bound to follow the direction of the Council, must submit apply for a waiver from this requirement. Maria Orsini presented the Policy Committee findings to the full Council at the April 24, 2008 meeting.

Changes to the Waiver Process

The process of applying for a waiver has changed since the legislation was put into place in late 2006. Initially, there was no process for waiver requests, and for FY 2007 HRSA required Grantee's to submit:

- Certification from the Part B grantee (MDPH) that there are no current or anticipated ADAP services waiting lists.
- Certification that core medical services within Part A, B, and C are available within 30 days for identified and eligible consumers in the EMA.
- Evidence that a public process was conducted to seek public input on availability of core medical services.
- Evidence that receipt of the waiver is consistent with the grantee's "Description of Priority Setting and Resource Allocation Processes" (4.b.) and "Unmet Need Estimate and Assessment" (1.g.) sections of the Part A application.
- Grantee must include funds awarded under MAI. Requests that do not include MAI funds will not be considered.

Under this process, the Grantee received a waiver for FY 2007. For FY 2008 additional requirements were released, but due to the timing of the federal application deadline and uncertainty regarding details surrounding the waiver, waivers for FY 2008 were granted based upon the same requirements as FY 2007. For the upcoming fiscal year, FY 2009, details have been clarified and the Grantee plans on submitting a waiver request with the following information which is required in addition to the Part A application:

- Evidence that all of the core medical services listed in the status, are available to all individuals with HIV/AIDS in the service area within 30 days,
- HIV/AIDS care and treatment services inventories including funding sources,
- HIV/AIDS met and unmet needs assessments,
- HIV/AIDS client/patient service utilization data,
- Planning Council core medical services priority setting and funding allocations documents,
- Letters from Medicaid and other state and local HIV/AIDS entitlement and benefits programs including private insurers,
- Information must show specific verifiable evidence that all listed core medical services are available and are utilized to meet the needs of persons with HIV/AIDS without further infusion of Ryan White HIV/AIDS program dollars,
- Such documentation must also describe which specific core medical services are available, from whom, and through what funding source,
- Also must describe the local/state underlying issues that influences the Grantee's decision to request a waiver and how the submitted documentation supports the assertion that such services are available and accessible to all individuals with HIV/AIDS identified and eligible under Title XXVI in the service area,

- How the approval of a waiver will impact the grantee's ability to address unmet need for HIV/AIDS services and perform outreach to HIV-positive individuals not currently in care,
- And the consistency of the waiver request with the grantee's grant application, including proposed service priorities and funding allocations.

A summary of the waiver requirements for 2009 was presented during the April 24, 2008 presentation to Planning Council.

Massachusetts Health Reform Law of 2006

Massachusetts Senate and House of Representatives passed a landmark healthcare reform bill that will dramatically increase access to healthcare for the state's uninsured. On April 4, 2006, Chapter 58 of the Acts of 2006 was passed by the legislature. Neil Cronin monitored how the laws affect access to care and how this legislation may fill gaps currently filled by Ryan White dollars.

On the second anniversary of health reform over 340,000 residents had gained healthcare coverage. Part of the success of the program may have been an extension of the penalty date which moved from December 31, 2007 to January 1, 2008. This change effectively gave individuals another month to request coverage without penalty.

Also during this term, a new affordability schedule was released which increased premiums for some clients. The Policy Committee noted that this change - in particular, the shifted costs onto patients in Plan Type III - will directly affect HDAP funds. The Committee will continue to monitor this issue in the coming year and will advise the Council should there be significant impacts on HDAP funding.

Names-Based HIV Case Reporting in Massachusetts

On January 1, 2007 the Massachusetts Department of Public Health changed the reporting system for HIV cases from code-based to names-based. The change was made because the CDC stated that a standardized system was necessary and that confidential names-based reporting was the only way to achieve highly accurate and reliable reporting. While some disagreed with the CDC's rationale, the change was ultimately made because named-based reporting was tied to Ryan White funds and both the state and the EMA risked losing millions if they did not comply with the CDC recommendation.

Since New Hampshire has always used a named-based HIV reporting system Paul Keating monitored only Massachusetts' compliance with the CDC recommendations. Paul worked with Kevin Cranston, HIV/AIDS Bureau Director of the Massachusetts Department of Public Health to monitor the state's progress. At the end of the term, Massachusetts achieved only 50% names ascertainment - in part because of the work burdens on high-volume providers to re-report HIV cases with names to the state, and in part due to delayed implementation of name-based reporting at local health care facilities where they struggle with whether to obtain consent from patients before reporting their HIV status by name.

CDC Counseling and Testing Guidelines

The Centers for Disease Control in 2001 updated their HIV Counseling, Testing, and Referral (CTR) Standards and Guidelines. Among other changes, the guidelines recommended routine screening for HIV without written consent. This contradicts state law and has been one of the many barriers in implementing the new guidelines. Policy Committee members Susan Oleksiw and Maria Orsini led research and discussion on the new CDC Counseling and Testing Guidelines. They found that recommendations from the CDC explicitly urge states to adopt “opt out” screening, meaning the elimination of distinct written consent for testing which is inconsistent with state law (MGL Chapter 111 Section 70F). Over the course of the term, the Massachusetts Department of Public Health convened a task force of physicians, other care providers, HIV+ consumers, legal and policy advocates, and governmental officials to examine their response to the guidelines. At the close of the term, it has met twice, and was reviewing a proposed protocol for routine screening for HIV in medical settings that is consistent with MGL C. 111 s. 70F. Although there have been some attempts from providers to change state law, thus far the language of the law remains unchanged. Additionally, an amendment introduced in January of 2007 to change the language of C.111 S. 70F (H 2276) is still in Committee and did not progress this term.

At the national level, many states are struggling to make the necessary changes to follow the CDC’s recommendations. The AETC released an updated Compendium of State HIV Testing Laws to show how the laws changed since the CDC’s recommendations were put in place.

New Hampshire Updates – NH Medicaid HIV/AIDS Waiver Status

Background

Medicaid is a public health insurance program for low-income individuals that is jointly administered and funded by the federal government and the states. The federal government sets the minimum standards for eligibility and services covered by Medicaid but states can ask the federal government to “waive” certain requirements to allow the state to cover individuals normally not eligible and/or provide services that fall outside the range of mandatory and optional services allowed under federal law.

In general, people with HIV/AIDS can only qualify for Medicaid once they have an AIDS diagnosis and have been determined to be disabled. Some states have requested waivers to allow them to cover HIV positive individuals through their Medicaid programs, on the grounds that improved health outcomes and potential savings might result from getting people who are HIV positive into care before their disease progresses to AIDS.

Currently there are only three states with waivers to expand Medicaid coverage to people with HIV prior to an AIDS diagnosis and disability determination. In 2000, the state of Maine was granted a waiver to cover individuals with HIV with income up to 250% of the federal poverty level (FPL). In 2001, the District of Columbia was granted a waiver to cover individuals with HIV (we believe with income up to 100% FPL) and in 2001 Massachusetts began implementing a waiver to cover individuals with HIV with income up to 200% FPL.

New Hampshire HIV/AIDS Medicaid Waiver Legislation

Current eligibility for people with HIV/AIDS to qualify for NH Medicaid is limited to those with AIDS who have been determined to be disabled and who have income of less than 75% of the Federal Poverty Level.

In 2007 the New Hampshire legislature passed Chapter 282 of the Laws of 2007 which requires the New Hampshire Department of Health and Human Services (DHHS) to develop and present a design concept and cost estimates for a five year Medicaid HIV/AIDS waiver to the legislature for approval prior to submitting it to the federal Centers for Medicare and Medicaid Services (CMS). As noted in the legislation, the purpose of this waiver is to “support the extension of Medicaid-allowable HIV/AIDS services” by modifying the eligibility requirements to allow more individuals with HIV/AIDS to qualify for Medicaid in New Hampshire.

Waiver Proposal Status

DHHS has met with a number of challenges in developing the waiver proposal.

- *Federal environment* – No new HIV/AIDS waivers have been approved since 2001. DHHS has had some initial conversations with CMS that indicate that approval of such a waiver is currently uncertain at best and that the waiver negotiation process would be extremely challenging. Given this challenge, NH will likely wait until a new federal administration is in place before submitting a waiver proposal.
- *Budget Neutrality* - One requirement of any such waiver is that it be “budget neutral”. This means that the costs to the federal government of the total population covered once the waiver is in place must not be more than the federal government would have paid in the absence of a waiver. This neutrality can be achieved by considering the savings that could result from getting people into care earlier, preventing more expensive treatments that would be needed later if people did not qualify for Medicaid until they are already disabled. Proving budget neutrality is extremely difficult and has prevented several additional states from obtaining approval for HIV waivers. It will be challenging for DHHS to provide a calculation to show neutrality over the five years of the waiver.
- *State Budget Constraints* – While the federal government pays for 50% of the costs of the NH Medicaid program, the state needs to have the funds available to pay for the remaining 50%. An initial estimate of the numbers who would qualify for NH Medicaid under a waiver is 275, which would result in an increase in Medicaid spending of \$3 million, or \$1.5 million in state funds. Given the challenging current fiscal environment, the DHHS is not supporting any requests that will increase Medicaid expenditures. The likelihood of including this program in the DHHS budget for Fiscal Years 2010-2011 is uncertain.

In light of these concerns and challenges, DHHS continues to work on a waiver proposal as required by the legislation. The waiver proposal design work includes developing a preliminary program outline and cost estimates and conducting extensive stakeholder outreach. DHHS’s current goal is to present a preliminary waiver design and cost estimate to the legislature by January 2009. DHHS will only submit the waiver proposal to CMS if it is approved by the legislature and does not require additional funds.

Policy Committee Liaison with Consumer Committee

Policy Committee member Florence Saintiche worked with the Consumer Committee Chair and PCS to provide timely updates on pressing policy developments to the Consumer Committee. Policy Committee member Maria Orsini delivered leadership training to members of the Consumer Committee.

Meeting with Connie Gardner of Senator Kennedy's Office

Senator Kennedy's Office held meetings with providers and consumers to discuss the Ryan White Act and plans for reauthorization. Consumer members from the Planning Council as well as Michael Goldrosen from the Grantee's office were present.

Recommendation to Resource & Allocation Committee

The Policy Committee presented information on the Core Medical Services Requirement and an update on the waiver process to the full Council at the April 24, 2008 meeting. Their conclusion was that the current Planning Council and Resource and Allocations processes are sufficient for the allocation of resources within the EMA. If the outcome of these processes yield a distribution outside of the 75/25 requirement, then the Policy Committee recommends the Grantee's office apply for a waiver.

Recommendations to the 2007-2008 Policy Committee

1. Continue to follow the 2009 sunset of the Ryan White Act.
2. Continue monitoring the 75/25 waiver process and its impacts on the Council.
3. Continue to monitor the implementation of the names-based HIV reporting system and its effects on providers and the community.
4. Continue to follow the implementation of Health Reform.
5. Continue to track progress of the New Hampshire Medicaid HIV waiver.
6. Follow the New Hampshire state budget and track funding of the AIDS line item.
7. Continue to track changes to CDC recommendations to HIV counseling and testing in Massachusetts.