



# LOS ANGELES COUNTY COMMISSION ON HIV

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## JOINT PUBLIC POLICY (JPP) COMMITTEE MEETING MINUTES

August 22, 2012



The JPP Committee acts in accordance with the role of the Commission on HIV, as dictated by Los Angeles County Code 3.29.090. Consistent with Commission Bylaws Article VI, Section 2, no Ryan White resources are used to support JPP Committee activities.

MEMBERS PRESENT	MEMBERS ABSENT	PUBLIC	PUBLIC, CONT.	COMM STAFF/ CONSULTANTS
Aaron Fox, <i>Co-Chair</i>	Sergio Aviña	James Chud	Bradley Land	Jane Nachazel
Stephen Simon, <i>Co-Chair</i>	Kathy Watt	Whitney Engeran-Cordova	William Paja	Craig Vincent-Jones
Kyle Baker		Christina Ghaly	Ricky Rosales	
Cheryl Barrit		Joseph Green	LaShonda Spencer	
Joseph Cadden		Kevin Heslin	Donna Stidham	<b>DHSP STAFF</b>
Lee Kochems		Miki Jackson	Jithin Veer	Carlos Vega-Matos
Elizabeth Mendia		David Kelly		
Jason Wise		Luke Klipp		

### CONTENTS OF COMMITTEE PACKET

- 1) **Agenda:** Joint Public Policy (JPP) Committee Agenda, 8/22/2012
- 2) **Proposal:** DSRIP Category 5 HIV Transition Projects, 7/19/2012
- 3) **Letter:** HIV/AIDS Bureau Response to California Office of AIDS Questions on LIHP Eligible Clients, California ADAP Rebate Usage and California Medicaid Share of Cost, 6/5/2012

1. **CALL TO ORDER:** Mr. Fox called the meeting to order at 1:10 pm.
2. **APPROVAL OF AGENDA:**  
**MOTION #1:** Approve the Agenda Order (**Passed by Consensus**).
3. **APPROVAL OF MEETING MINUTES:**  
**MOTION #2:** Approve Joint Public Policy (JPP) Committee Meeting Minutes (**Postponed**).
4. **PUBLIC COMMENT, NON-AGENDIZED:** Mr. Klipp reported Assemblyman Anthony Portantino will host his 6<sup>th</sup> Annual HIV/AIDS Summit on 9/12/2012, 9:00 am to 12:30 pm. The Summit is of special interest to those in the San Gabriel Valley area and will include a panel on the changing face of HIV prevention. Call the Assemblyman's office to RSVP.
5. **COMMITTEE COMMENT, NON-AGENDIZED:** There were no comments.
6. **CO-CHAIRS' REPORT:** There was no report.
7. **DSRIP CATEGORY 5 HIV TRANSITION PROJECTS:**
  - Dr. Ghaly, Deputy Director, Department of Health Services (DHS), noted that the new Category 5 of the 1115 Waiver was motivated by the migration of Low Income Health Program (LIHP)-eligible Ryan White (RW) patients. The transition moves costs for both medical care and medications to DHS. Estimated future unreimbursable costs are \$40 million per year.
  - There were multiple discussions on how to mitigate costs from the start of the LIHP migration on 7/1/2012 and continuing through 12/31/2013. Clients will migrate into Medi-Cal under an automated LIHP transition process starting in 2014.

- An Intergovernmental Transfer (IGT) was the other primary option, but the Centers for Medicare and Medicaid Services (CMS) rejected it partly due to issues elsewhere in California. The DSRIP option has been approved and details are being finalized.
- The Waiver includes a \$3.3 billion reimbursement incentive pool across California over five years. The previously existing four categories include areas such as infrastructure development, IT and data collection tools. None are HIV-specific.
- Category 5 is HIV-specific. Category 5a: Infrastructure and Program Design, includes seven potential projects of which Designated Public Hospital systems (DPHs) may select three. Milestones must be achieved to collect reimbursement.
- Category 5b: Clinical and Operational Outcomes, requires data on six Health Resources and Services Administration/ HIV/AIDS Bureau (HRSA/HAB) HIV Core Clinical Performance Measures for those enrolled in the LIHP. DPHs may choose four additional metrics from three groupings with at least one from each group. Metric baseline performance must be reported within the first six months. Reimbursement incentives will be based on achieving performance targets.
- DHS is seeking stakeholder input on any concerns with its proposed choices. Category 5b reflects basic metrics so it is anticipated most questions will revolve around Category 5a. DHS is leaning towards selection of Projects 1, 2 and 6.
- Project 1 focuses on enrolling HIV+ patients into medical homes with HIV expertise. Patients are already using these providers to a large extent, but may not have an established relationship, continuity of care, may not be tracked over time and may not be able to identify the provider. Skills vary by clinic and are hard to track due to six different IT systems.
- DHS already has a focus on medical homes and has enrolled 290,000 patients not known to have HIV into medical homes to date. These are at LAC+USC, Harbor-UCLA and Olive View Hospitals as well as clinics in the care network. Rancho Los Amigos Hospital will be the medical home for those with specialized conditions such as traumatic brain injuries.
- Project 2, implementing a Disease Management Registry module suitable for managing patients with HIV, complements Project 1. DHS historically used Chronic Resource Management (CRM), but it requires physicians to enter a particular patient's medical record number to access such information as laboratory results or the need for a mammogram. DHS is transitioning to the publicly available Eye-2-Eye Track, a top CMR nationally, capable of such searches. It is being implemented in clinics with attention to ensure it is properly configured to manage HIV, including appropriate metrics.
- Project 6 will launch an electronic consultation system between HIV primary care medical homes and specialty care providers. This will replace the current referral system and act as a consultation system. The primary care physician will request a referral for the specialist to review electronically. The specialist might recommend trying a medication prior to a referral appointment or might request more information for the appointment, such as additional laboratory reports. Such consultation eliminates unnecessary appointments and ensures all relevant data is available for needed appointments.
- A San Francisco study reported that specialists do not know the reason for a referral patient's appointment 60% of the time and from 40% to 70% of such appointments are either unnecessary or should have been referred to a different specialist.
- eConsult went live in July 2012 beginning with the top five specialties: dermatology, neurology, obstetrics, ophthalmology and cardiology. The next three to be rolled out are: podiatry, rheumatology and nephrology. Key top specialties for HIV are among these, such as neurology, but gastro-intestinal (GI) and colorectal surgery have not been rolled out. There are no plans yet to add the latter, but efforts have begun to add GI, although it is an especially complex specialty that will take longer to develop.
- Mr. Fox noted RW providers already strive to provide medical homes so was unsure how Project 1 would enhance existing services. Dr. Ghaly replied these activities only apply to the DHS medical system—where infrastructure and staffing, such as for nurses and medical case workers, vary across sites. There is also limited central ability to monitor and manage care from a Medi-Cal managed care perspective to ensure providers are accountable for patient care.
- Mr. Engeran-Cordova asked how activities would enhance HIV coordinated care overall. Dr. Ghaly felt Project 6 most directly improves coordination. Initial eConsult roll-out focuses on DHS sites, but implementation in all 151 DHS community partners is planned over time. Mr. Vega-Matos added there are two parts of CHAIN. The Healthy Way LA (HWLA) piece will phase out by 12/31/2014 and most likely merge into the DHS system. The RW portion is still being analyzed.
- Mr. Vincent-Jones asked about the process for selecting the priorities. Dr. Ghaly said input was received from all chief executive officers, and all HIV clinic medical directors and administrators. It is not feasible to do Project 3, build clinical decision support tools to allow for more effective management of patients with HIV, prior to Project 2 as IT would not be in place to facilitate it in time.
- Project 4, develop retention programs for patients with HIV who inconsistently access care, was seriously considered as an alternative to Project 6 since it also complements Projects 1 and 2. eConsult was chosen as a higher priority, but with the knowledge that much Project 4 work will also be incorporated in Project 1 and through Medical Care Coordination (MCC).

- Project 5, enhance data sharing between DPHs and County Departments of Public Health to allow for systematic monitoring of quality of care, disease progression, and patient and population level health outcomes, was not feasible considering the poor state of County data and the time and resources available to address it under this Waiver.
- Project 7, ensure access to RW wrap-around services for new LIHP enrollees, was not chosen in lieu of prioritizing ambulatory care. Mr. Vega-Matos noted RW is addressing wrap-around services through MCC including Linkage To Care, adherence and retention components. MCC will be available to all PLWH in medical homes regardless of payer source.
- Mr. Vincent-Jones noted, whether consciously or not, many DHS decisions appear to take RW system abilities into account. He recommended DHS coordinate with DHSP and the Commission to allocate resources across systems.
- Dr. Ghaly added a key driver in choices was to incentivize new programs such as eConsult to improve HIV referrals.
- Mr. Land suggested bridging to RW medical providers outside the DHS system. Dr. Ghaly noted DHS is not doing Project 5, but Eye-2-Eye will improve data sharing among DHS sites as well as DHSP sites as it is interactive with Case Watch. Mr. Vega-Matos added DHSP is working with providers to ensure their Case Watch maps interact well with other sources and is developing a central data exchange. It is not possible at this time to develop interactions with other systems, such as Kaiser.
- Ms. Barrit noted the short timeframe for three major projects. She asked about roll-out, staffing and TA, e.g., on MCC. Mr. Vega-Matos said the MCC staffing pattern was developed. Many non-DHS medical homes have various MCC components. DHSP will help structure those per the Standards of Care and provide training or help develop MCC, if needed. DHS medical homes lack case management, so staffing patterns for them are being developed in an organic process.
- Dr. Ghaly added all projects must be rolled out concurrently due to the timeline. Reports are due each six months.
- Mr. Klipp understood the County sought to mitigate the estimated \$40 million cost of migrating patients from RW to LIHP with Waiver Category 5 and identified underutilized funds to do so. But the new programs also have substantial costs. He asked about their support. Dr. Ghaly said the district had no extra funds. These funds are available under budget neutrality. The County is cutting costs and improving productivity to fund care for the estimated 5,000 RW patients migrating to LIHP.
- Mr. Fox asked if Category 5 indicated DHS clinics were not as good as RW clinics. Dr. Ghaly replied this is a statewide project that does not imply poor County care, but will improve its quality and cost effectiveness.
- Mr. Vincent-Jones asked how projects will be sustained once this funding ends. Dr. Ghaly noted Projects 2 and 6 are essentially one-time costs with minimal follow-up. Project 1 is more expensive and ongoing. Long-term sustainability and cost effectiveness are being considered in medical home team design, e.g., using lower level items as appropriate such as more Certified Nursing Assistants and fewer Registered Nurses. eConsult will also improve cost effectiveness.
- Mr. Vincent-Jones noted the Los Angeles Coordinated Needs Assessment (LACHNA) underscored the disconnect between primary medical care and oral health and need for the latter. The Commission has been increasingly funding for oral health substantially, which has, in turn, resulted in a much larger share of patients enrolled in oral health care. Since the LIHP will not cover oral health care, he encouraged DHS to be attentive to referring eligible LIHP patients into RW-funded oral health care. Dr. Ghaly said oral health is part of wrap-around services that would fall under Project 7, but she will ensure attention to referrals. Mr. Vega-Matos added the MCC team will work to ensure connections.
- Mr. Klipp asked about Category 5b selections. Dr. Ghaley said selections had not been made, but key considerations are reliable availability of data and usefulness in supporting improvement. The baseline must be established by December 2012 and then an improvement target must be established. Mr. Fox suggested selecting "oral exam" from Group 2.
- The proposed 5a and 5b plan must be submitted in early September for 30-60 day review by the state and then by CMS.
- Mr. Vincent-Jones encouraged DHS to call on the Commission should it need support, e.g., with the Board, as DHSP does.
- ➡ Mr. Vincent-Jones will request a presentation on eConsult, which is being funded by LA Care.
- ➡ Plan future discussion with DHSP on Case Watch versus Affinity.
- ➡ Dr. Ghaly will present on the Category 5 plan at the Commission meeting once it has been approved.

#### 8. LIHP ENROLLMENT/IMPLEMENTATION:

- Mr. Land felt last week's discussion with the State Office of AIDS (OA) on cost-sharing for Medi-Medi patients was concerning. OA noted HRSA's response on co-payments and said it was unable to prove funding of last resort for continued use of RW funds for such co-payments. He urged the County request a waiver such as that obtained by Massachusetts to use RW funds for co-payments for another federal program.
- OA-HIPP pays insurance premiums and ADAP co-payments for medications not on insurance formularies. HRSA has decided, per payer of last resort that those eligible for LIHP must migrate to it rather than access OA-HIPP or ADAP. Mr. Land felt the decision would also apply to the 250% Return To Work Program, under which Medicare Part B is paid by the state.
- Mr. Vega-Matos said RW funds can still be used for private insurance premiums, but not for public ones such as Medi-Medi.

- He also recommended a “Health Care Reform” rather than “LIHP” heading for such discussions since “LIHP” confuses people about unrelated issues such as the Medi-Cal Fee-For-Service move to managed care and OA-HIPP benefit changes.
- ➡ Add co-payment issues to JPP agenda on regular basis and include related 6/5/2012 HRSA letter in packet.
- ➡ Mssrs. Fox, Land and Juan Rivera represent the Commission on the state’s stakeholder call and will raise the co-payment issue there as well. The next call was scheduled for 8/24/2012.

**9. ROUTINE HIV SCREENING/TESTING:**

- Mr. Fox reported the planned call on this state legislation was cancelled, but noted the United States Preventive Services Task Force (USPSTF) appears to be moving from recommending HIV testing for gay men, women and those at high risk to universal testing. USPSTF is an independent body with support from the Agency for Healthcare Research and Quality, HHS.
- ➡ Mr. Fox will provide an update at the next JPP meeting.

**10. RYAN WHITE REAUTHORIZATION PRINCIPLES:**

- Mr. Fox reported HRSA has received numerous comments to date. These have spanned the spectrum from replacing the Ryan White Act entirely to maintaining its current form. Mr. Baker added that, disturbingly, most comments supported the status quo and were primarily from people who might be familiar with health care reform legislation but not consequences on the ground. Few comments supported needed reforms. He felt Commission comments were the most nuanced.
- Mr. Vega-Matos said some states may opt out of the expanded Medicaid program under the Affordable Care Act (ACA). Their decisions will strongly affect the RW role in those states and make forging a consensus on RW harder.
- Mr. Vincent-Jones is preparing a summary of the Commission’s Principles document, but has not yet completed it.
- ➡ Mr. Baker is gathering all the comments and will provide them with a grid for the next JPP meeting.

**11. FY 2012 LEGISLATIVE DOCKET:** Governor Brown has called a 12/3/2012 special session of the legislature to pass stalled legislation needed to implement the ACA. Amendments are possible. Tax measures may also be considered in the session.

**12. COMMUNITY COLLABORATIONS:**

**A. CA Center for HIV/AIDS Policy Research:**

- Mr. Fox said Governor Brown vetoed set-aside funding for the Center when he signed the budget. Funds were absorbed into the University of California budget. The LA Gay and Lesbian Center (LAGLC), AIDS Project Los Angeles (APLA) and the University of California Los Angeles are Center partners. Current grant funds end March 2013.
- Routine HIV testing is a key priority coinciding with national, state and local action. There have been conversations with Mssrs. Vincent-Jones, Mario Pérez and Baker, Los Angeles County; representatives of an Orange County pilot project; and review of New York’s legislation. Research assumes movement towards routine testing and seeks to identify the best approach for California. The Executive Committee approved work which will start the next week. No IRB is needed.
- Mr. Klipp added meetings in Northern and Southern California in the next few months will identify statewide issues.
- Mr. Vincent-Jones asked about undocumented research progress. Mr. Klipp replied Kevin Farrell and Arlene Liebowitz were negotiating with DHSP. Mr. Baker said he followed-up after the last meeting. No one had pushed the subject since Dr. Jennifer Sayles left, but Mike Janson said he was ready for the researchers’ data requests once received.

**13. WORK PLAN REVIEW:** This item was postponed.

**14. ANNOUNCEMENTS:** There were no announcements.

**15. ADJOURNMENT:** The meeting adjourned at 3:15 pm.