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SUBJECT: RYAN WHITE PROGRAM SPENDING

Dear Co-Chairs:

This is to update the Los Angele County Commission on HIV (Commission) on important information relating to the federal Health Resources and Services Administration's (HRSA) Ryan White Program (RWP) grant administered by the Department of Public Health and its Division of HIV and STD Programs (DHSP).

BACKGROUND:
With the early implementation of health care reform in California through the Section 1115 Medicaid waiver beginning in July 2013, and with the subsequent and full expansion of Medicaid as part of the statewide implementation of the Affordable Care Act (ACA), the RWP-funded system of care has seen a dramatic decrease in the number of Ryan White-eligible patients who access medical care and some support services throughout Los Angeles (County). This decrease was long expected and in many ways signals the success of Medicaid expansion and ACA implementation statewide. Locally, demand for Ambulatory Outpatient Medical (AOM) services has experienced a significant decrease, and there has also been a drop in service demand for mental health, substance abuse, and oral health services, all of which are supported in part by Medicaid expansion-related programs. The decline was steepest in the past Ryan White Program year (March 1, 2014-February 28, 2015), and is on pace seven months into the current program year (March 1, 2015-February 29, 2016) to continue declining, though DHSP expects some degree of stabilization. This decreased demand for services has also resulted in fewer RWP-related expenditures.

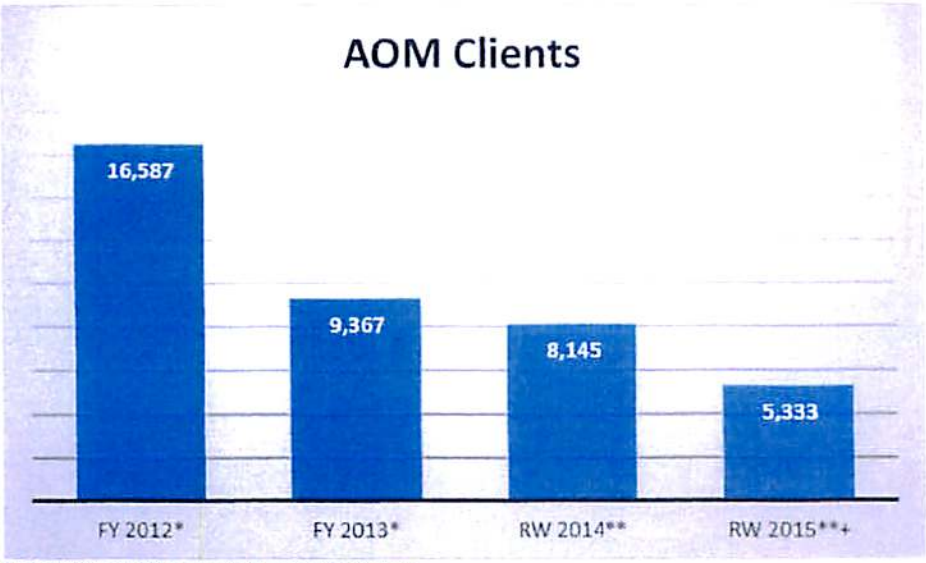
Among the factors contributing to reduced service demand:

1. Reduction in the average number of patient visits (likely in large part due to continuously-improving HIV medications that allow adherent patients to remain healthier, with suppressed viral loads and fewer side effects and therefore less need for higher numbers of annual medical visits;
2. Increase in the number of patients who receive primary care through new payers; while these patients remain eligible to access wrap-around RWP-funded services, most are no longer doing so;

3. A Board of Supervisors-approved shift from an AOM cost reimbursement contracting structure to a more streamlined fee-for-service based contracting structure that is consistent with most public and private health plan payment methodologies and that has eliminated opportunities for double billing;
4. Improved eligibility screening and identification of correct payer for clients;
5. Stringent requirements by HRSA to screen patients for other potential payer sources, including doing so every six months as opposed to the historical practice of doing so annually;
6. Improved coordination of spending between RWP Part A and RWP Part C and/or D-funded agencies and Federally-Qualified Health Centers (FQHCs) that results in those awards being maximized before Part A funding is leveraged; the result has been improved fiscal oversight to ensure that those agencies' RWP Part A budgets are not billed for a service that has already been paid for by RWP Part C or D;
7. Inability for some funded Department of Health Services (DHS) clinics to bill for services it has provided to RWP-eligible clients, including ongoing implementation issues with DHS' ORCHID system;
8. Inability for some contracted community-based providers to maximize their current budgets;
9. Inability for current community-based provider of Medical Subspecialty Services to maximize its budget for the last two contract periods;
10. Lack of flexibility by HRSA to allow for a broader range of services allowable under the RWP including prevention services to HIV-negative but high at-risk individuals, owing to the fact that the program has not had a full authorization since 2006 and is currently no longer authorized by Congress (although Congress continues to appropriate against the existing statute);
    - For example, biomedical interventions such as Post-exposure Prophylaxis (PEP) and Pre-exposure Prophylaxis (PrEP) were in the research phase during the last full authorization of the RWP. Thus, given that the current statute prohibits services for individuals who are not HIV positive, DHSP cannot spend RWP funding on these critical new HIV prevention tools.
11. Statutory limits on the use of HIV surveillance data in outreach and reengagement activities, resulting in the necessity for DPH to perform such activities itself instead of procuring services from community-based providers. This problem is exacerbated by the continuing significant barriers for DPH-DHSP to hire staff to perform the outreach work; and
12. Partial restoration of the adult Denti-Cal program in California resulting in some oral health programs and procedures being covered by Denti-Cal and therefore no longer billable to the RWP, creating significant savings in the Oral Health service category.

As a result, and despite the strong efforts of both DHSP and the Commission in its planning role, DHSP is experiencing challenges with maximizing its Part A and B grants this program year. Los Angeles County is not alone in its experience. DHSP understands that other RWP Part A jurisdictions in states with broad Medicaid expansion efforts have not been able to fully maximize their Ryan White grants. This is also true with Part B jurisdictions (States).

RYAN WHITE PROGRAM-ELIGIBLE AOM PATIENT POPULATION



* For 2012 and 2013, data is for those fiscal years.
**For 2014, data is for the RWP program year.
\+ For 2015, data is for first seven months of the RWP program year

PLANNING AND PROGRAM RESPONSE

While DHSP and the Commission have been progressive in implementing and expanding HRSA allowable service categories other than AOM (e.g., Medical Care Coordination, Benefits Specialty), numerous policy and financing hurdles remain. In fact, with decreased service demand and with a finite amount of HRSA-approved service categories, and with statutorily-required payer-of-last-resort limitations, DHSP is increasingly challenged to maximize all the available Ryan White dollars without offering new or redesigned services.

DHSP continues to have robust planning discussions with the Commission and its Planning, Priorities, and Allocations Committee (PP&A) in order to explore all possible options. Over the past number of years, and more recently with Medicaid expansion and ACA implementation, the Commission has re-programmed RWP resources to support a range of service categories to meet the needs of local RWP consumers as well as to ensure that dollars are utilized to the fullest extent possible. A large part of the challenge stems from the fact that AOM by its nature is the most expensive category; the significant reduction in demand for AOM services means that an increasingly greater amount of funding must not only be reprogrammed but, ultimately, must be utilized by a decreasing amount of patients.

PLANS TO MITIGATE IMPACT

Since DHSP's initial report to the Commission's PP&A Committee, one important fiscal decision is already being implemented that will impact 2015 grant expenditures. DHSP is shifting a number of NCC-supported contracts into the RWP (these include Oral Health and Home Based Case Management). **Doing so will mean that DHSP is able to fully maximize its Year 25 Part A and its Year 24 rollover MAI resources.** DHSP projects a reduction in expenditures of approximately $2 million for its Part B grant, however. These funds will be re-programmed by the State Office of AIDS in order to help address HIV care and treatment needs for Californians living with HIV.

DHSP and the Commission are currently conducting the Los Angeles Comprehensive HIV Needs Assessment (LACHNA) in order to identify areas of unmet need among people living with HIV/AIDS (PLWHA) in the County. The findings from LACHNA will be used to refine HIV and STD investments beginning in mid-2016.

Local programmatic expansion is currently under way for the provision of housing services that have historically been supported by the federally-supported Housing Opportunities for People with AIDS (HOPWA) program managed by the City of Los Angeles. This expansion is necessary in order for HOPWA to divert resources to the development of new housing facilities. This expansion will increase RWP expenditures by an estimated $2 million annually beginning in early 2016, and the combined planning efforts between DHSP and the HOPWA program will result in increased housing inventory for eligible PLWHA.

DHSP has recently released a comprehensive solicitation for prevention, care, and treatment services targeting a) young African-American and Latino MSM and b) transgender women that will rely partially on RWP funds. The solicitation should result in new contracts for services at an annual investment of nearly $5 million, with programs starting in late 2016.

Also in development are solicitations to redesign and expand mental health services, oral health services, and medical subspecialty services. All of these services can be supported with RWP funds, pending allocation by the Commission. Services through these service categories could start as early as January 2017.

Finally, DHSP will implement the Linkage and Reengagement Program (LRP) in January 2016, which combines robust outreach efforts with comprehensive linkage-to-care strategies to locate and engage both PLWHA who are undiagnosed and PLWHA who are not optimally engaged in medical care for their HIV. This program has full support from the Commission and strives to dramatically reduce the number of PLWHA who are not virally suppressed. Services delivered by the LRP will be supported by RWP funds.

I look forward to discussing this update with the Commission's Executive and PP&A Committees on November 30, 2015. Please see Attachment A for DHSP's responses to the Commission's related email of November 19, 2015, which I will also address at the November 30 meeting.

Respectfully submitted,

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MJP:kb
R:/Executive Office/Letters 2015/RWP Spending

Enclosures

c: Cynthia A Harding
Dr. Jeffrey Gunzenhauser
Each Health Deputy

ATTACHMENT A

Commission email of November 19, 2015:

To address concerns related to Ryan White Part A, B and MAI underspending, at its meeting on November 17, 2015, the Planning, Priorities and Allocations (PP&A) Committee requested that DHSP provide a report at the November 30, 2015 Executive Committee meeting identifying, describing and/or explaining:

1. **Part A, B and MAI areas of underspending;**
2. **Contributing factors to underspending;**
3. **DHSP's activities in progress to address underspending; and**
4. **Feasibility of expending funds rather than returning them to the state**

➡ **These are addressed in DHSP's letter to the Commission.**

Additionally, as a means to mitigate the amount of underspending, the PP&A Committee has requested that DHSP provide a response to the following suggestions:

1. **Allow Federally Qualified Health Centers (FQHC) to bill the Ryan White Program (RWP) for same-day visits not compensated by Medicaid. Currently, state Medicaid regulations do not allow for multiple billing of services administered same-day, such as medical and mental health or dental and mental health services. As it now stands, when an HIV+ patient receives more than one service on the same day, the FQHC provider can only submit billing for *one* of the services rendered. This practice creates a barrier to integrated HIV care because multiple visits on different days reduces the chances of the patient returning for services and reduces the FQHC's incentive to provide more than one service on the same day because there is no compensation;**

➡ **Within the FQHC reimbursement guidelines, multiple client visits to the same medical provider in a single day cannot be billed separately to Medicaid/Medi-Cal. Further, under the RWP, HRSA considers the single payment to that medical provider for services provided in a single day to be payment in full. FQHCs with different reimbursement issues should contact DHSP individually for discussions about options for reimbursement of services for RWP-eligible clients and services.**

2. **Remove the limitation on the number of mental health sessions as long as the standard of medical necessity is met. This change would align DHSP mental health services with Medi-Cal and Medicare service provisions and/or standards of practice;**

For DHSP-funded mental health services, there is a cap of 12 mental health visits annually. However, there is a clear process for obtaining a waiver to allow more than 12 visits, and DHSP does not have a history of denying many of these waiver requests.

3. Review Requests for Proposals (RFPs) including sole sources to streamline processes and minimize delays;

See memo for DHSP plans for service procurement in 2016. DHSP has recently successfully advocated for increased human resources to expedite new solicitations to reduce the delay in County solicitation processes.

4. Augment budgets using projected savings in Part A Outpatient/Ambulatory Medical Care service category. The increase in funding would support safety-net care teams specializing in HIV medicine and would also provide wrap-around care, panel management, engagement and retention or re-engagement services. Additionally, increase in funding would finance efforts to identify populations for re-engagement and refer them to the safety-net system through DHSP's outreach and engagement services;

It would be not be prudent to add resources to the existing AOM contracts when agencies cannot currently spend what is already allocated. Further, the robust FFS rate and the presence of MCC teams combined are designed to do exactly what is described in this recommendation.

5. Review Medical Care Coordination (MCC) staffing patterns by assessing census sizes in relation to acuity and eligibility levels to determine the appropriate number of patients to staff ratio as it relates to full-time and /or part-time MCC teams. Explore other staff tied to MCC teams to allow for greater flexibility and size. Augment funding for MCC services as appropriate based on findings;

DHSP is currently examining existing MCC protocols to assess whether or not there are opportunities for increased flexibility and/or modified staffing patterns.

6. Augment funding for Benefit Specialty contracts. This will allow for enhanced counseling services to PLWHA in and out of the RWP;

This assumes that benefits specialty teams are already operating at capacity; DHSP's most recent service utilization data suggest that this is not the case.

7. **Provide additional services at non-RWP medical homes;**

DHSP is currently assessing the feasibility for implementing this idea. Inasmuch as it could potentially be deployed using under the non-medical case management rubric, the Commission would need to allocate funds under this service category (as it historically had for a number of years).

8. **Review delegated authority limits and increasing the current 10% limit in PY 26;**

This is a County-wide contracting practice promulgated by the Board, the CEO, and County Counsel. DHSP is sometimes able to request a higher amount of delegated authority if it can be justified. Nonetheless, if current contracts are not being maximized, adding more delegated authority will not address the underlying issue(s) that result in underspending.

9. **Review Ambulatory Outpatient Medical (AOM) rates. Implement a one-time infrastructure building for AOM teams to include activities not covered by MCC such as appointment follow-up and increasing Residential Services; and**

Additional clarification is needed.

10. **Consider retroactive adjustments to administrative cap, e.g., allow rent to be charged to another line item**

The revised budget instructions that DHSP released to providers on October 15, 2015, which are based on HRSA's new policy regarding allowable shifting of administrative costs to program costs, has already addressed this issue.

Lastly, in an effort to reduce the amount of underspending, in your report please address:

1. **What strategies can be implemented now?**
2. **What strategies can be implemented by 3/1/2016?**
3. **What long-term strategies can be implemented?**

These are addressed in DHSP's letter to the Commission.