HIV HEALTH & HUMAN SERVICES PLANNING COUNCIL OF NEW YORK
A Mayoral Council established by the Ryan White C.A.R.E. Act of 1990

Meeting of the

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, April 8, 2013
Cicatelli Assoc., 505 Eighth Avenue, 20th Floor
3:10– 5:00 pm

MINUTES

Members Present: Marya Gilborn (Co-Chair), Sam Rivera (Co-chair), Victor Benadava, Felicia Carroll, Sharen Duke, Graham Harriman, Peter Laqueur, Amanda Lugg, Hilda Mateo, Jan Carl Park, Tom Petro, Dena Rakower, Allan Vergara, Leonardo Vicente III, Dorella Walters

Other Council Members Present: Randall Bruce

Members Absent: Nancy Cataldi, Robert Cordero, Joan Edwards, Deb Marcano, Tracy Douglas Neil

Staff Present: David Klotz, Darryl Wong, Amber Casey, Rafael Molina (DOHMH); Rachel Miller, Bettina Carroll (Public Health Solutions)

Agenda Item #1: Welcome/Introductions/Moment of Silence/Minutes

Ms. Gilborn and *Mr. Rivera* opened the meeting followed by introductions. *Mr. Benadava* led the moment of silence. The draft minutes of the February 11, 2013 meeting were approved with no change.

Agenda Item #2: FY 2013 Reprogramming Plan

Ms. Gilborn introduced the discussion by explaining that every year the PSRA and Council approve a plan for the use of funds that become available in the course of the grant year through take-downs, contract terminations, etc. The FY 2012 plan was presented, which first restored funding cut from ADAP at the beginning of the year, followed by allowing the grantee to shift funds between categories to enhance over-performing contracts while not exceeding 15% of a category's original allocation without Council approval. In FY 2012, consideration was also given to maintaining the 75% minimum core services requirement. A summary of the discussion follows:

- The anticipated amount for restoration to ADAP is $2,768,244, but the exact amount will be known when the final award comes in.
- For FY 2013, should the core services waiver be approved (as is likely), the grantee would have the flexibility to make enhancements without regard to the core services percentage. The core/non-core percentages in the application spending plan are not binding amounts; once a waiver is granted the EMA has the flexibility to adjust the plan according to its needs.
- The 15% cap on a category's enhancement already ties the reprogramming plan to the original spending plan.

- There was some question about the HRSA monitoring standards regarding when an EMA must notify HRSA about changes to the allocations (e.g., more than $250,000). The grantee will get clarification on that.
- The changes made within the Mental Health category was within a category and was not a shift between categories. It was done through changes in maximum reimbursable amounts (MRAs) and adding service elements to a category.
- Changes in a service model are related to the work of the IOC. Reporting of spending to the Finance Committee is done by service category, not by service element within a category.
- The Council and grantee need to collaborate on strategic thinking about services and responding to the changing environment.

There was a consensus to wait to consider the reprogramming plan until later in the year when more information is known about the HRSA monitoring standards and the waiver application.

Agenda Item #3: FY 2014 Priority Setting Strategy Session

The Committee discussed the data needs for the upcoming annual service category ranking and allocation process. *Mr. Harriman* described an update of the Payer of Last Resort (POLR) tool, which was last revised in 2009. The tool lists other payers of Part A-funded services that serve PLWHA in NYC and includes information on funder, services provided, client eligibility and program capacity. The revision, which is being undertaken by a team led by consultant Jessica Wahlstrom, will update the data and expand the tool to include anticipated changes to services as a result of health care reform and references to make future updates easier. The tool will also get information on payers of other Part A-allowable services that are not currently funded (e.g., oral health, insurance premium assistance) so that the tool can be useful beyond the PSRA's ranking needs.

The timeline for completion of the update is be the June 10th PSRA meeting, but the grantee will concentrate on updating the currently funded categories first so that the Committee can use it in the upcoming ranking exercise.

There was discussion on the expected new service directives that IOC is developing (Health Education and Risk Reduction, Non-medical Case Management and Supportive Counseling). PSRA's ranking for the FY 2014 application will be based on the revised directives, which would be presented to PSRA with information on the data that supports the need for those revised services.

The Committee discussed the cost of programs, noting that the Committee has not traditionally done zero-based budgeting in order to maintain stability in programs. When a new service need is identified (e.g., nMCM outside of Riker's Island), the Committee needs a methodology for determining the cost of the program and the number of programs needed. A program cost is based on an estimate of the typical staff time that will be required to provide the service. The grantee and Public Health Solutions develop unit costs, which can be adjusted based on actual costs when a program is running. A newly created allocation can be put into the application spending plan as a request to HRSA that reflects the EMA's needs.

Mr. Wong reported on upcoming listening sessions that will provide updated data for assessing the consumer priority criterion in the ranking tool. The sessions, which will be conducted by a consultant and held in each borough (plus one in Spanish), will use the treatment cascade as a framework for questions. The cascade shows the number of people who fall out of optimal care at each point in the treatment cycle, from testing to suppressed viral load. A report with qualitative data will be available for PSRA in June, with a more detailed report later.

It was noted that CHAIN also provides consumer priority data through its extensive cohort. There was a consensus for CHAIN to provide updated information to PSRA on consumers' identified services and unmet need for those services. The Medical Monitoring Project may also provide similar data.

There was a discussion on the service category scorecards, which have been updated since the past ranking exercise. In addition, two more service categories will have even more updated scorecards soon. Committee members expressed the need for some additional narrative highlights attached to the cards to give a more rounded picture of the service (e.g., clients were not placed in housing in HPA programs).

Other data needs were discussed, including information on Outpatient Bridge Medical Services, which had its last remaining provider decline its contract. There will be no change to the Home and Community-based Services category (reclassified from Home Care) for FY 2014, but IOC will likely address it for the following year.

There being no further business, the meeting was adjourned.