Meeting of the

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Wednesday, May 9, 2012
DOHMH, 2 Gotham, Long Island City, Room 20-38
3:05 – 5:05 pm

M I N U T E S

Members Present: Marya Gilborn (Co-chair), Allan Vergara (Co-chair), Victor Benadava, Felicia Carroll, Nancy Cataldi, Sharen Duke, JoAnn Hilger (for Graham Harriman), Peter Laqueur, Amanda Lugg, Hilda Mateo, Tracy Douglas Neil, Jan Carl Park, Tom Petro, Dena Rakower, Leonardo Vicente III

Members Absent: Robert Cordero, Joan Edwards, Deb Marcano, Dorella Walters

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

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

Mr. Vergara and *Ms. Gilborn* opened the meeting followed by introductions and a moment of silence. The minutes of the April 11, 2012 meeting were approved with no change.

Agenda Item #2: Core Services Waiver

Ms. Gilborn provided some background for the continuing discussion on whether or not the EMA should apply for a waiver of the minimum 75% core services requirement. There has been much discussion at Council and committee meetings about likelihood of future challenges to operating within the 75/25 core/non-core limits due to various changes in the environment which will unfold gradually over the next three years, the impact of which is difficult to predict. We anticipate that the changing environment will impact demand for Part A-funded core services during the FY 2013 and 14 years, but we do not expect to have enough information to make major changes to the preliminary FY 2013 spending plan by the time we have to submit the grant application. With all this in mind, key staff from the Council, DOHMH and Public Health Solutions convened and came up with a possible solution that involves making a minor and appropriate shift in classification from core to non-core to the categories in which we fund two programs. This would justify applying for a waiver without making any changes to current programs funded and would give us flexibility to complete a final spending plan after the award is known and more data is available about actual carrying costs, and to reprogram funds during the year per our reprogramming plan without having to worry about maintaining the minimum 75% core services component. This proposal was discussed prior to this meeting with the PSRA chairs and with the Council's Community Co-chair.

Mr. Klotz presented the proposal for the PSRA to recommend the pursuit of a core services waiver with the FY 2013 application. The major uncertainties in this planning process are due to the implementation of Health Homes, the Affordable Care Act, Medicaid expansion, and HRSA monitoring standards will affect several major core service categories.

- Early Intervention Services (EIS): Implementation requirements for Medicaid certification of testing programs is unknown pending HRSA's response to request for an exemption for targeted testing at CBOs.
- Medical Case Management (MCM): There is an inability to estimate how many Part A Care Coordination clients will move to Health Homes (Phase I) in FY 2013. New Transitional Care Coordination programs may also be affected by Health Homes.
- Harm Reduction (HRR): The timeline for implementation of and impact from changes to Medicaid reimbursement policies will not be known until at least 2013.
- Mental Health (MSV): All programs will be Medicaid certified in 2013 or 2014, which will likely reduce Part A expenditures.

These uncertainties mean that we may not have enough information to change allocations for these core services categories until later in 2013 or 2014. We will not know the answers in time for the application spending plan. We may have more information to complete the final, post-award spending plan in March 2013. We have also requested information on possible penalties if the EMA does not have a waiver and the proportion of spending on core services falls below 75% during the year should we have significant under-spending in core services during the year,. A core services waiver will allow us to plan without consideration of the core/non-core percentage of the application spending plan, the final spending plan, and our final expenditure report to HRSA.

Since the waiver must reflect the application spending plan and PC planning process for FY 2013, the proposal is to reclassify certain core services as non-core services, in accordance with the HRSA service definitions provided in the revised HRSA Part A Program Monitoring Standards:

- Transitional Support for Incarcerated Inmates (PRS): Currently classified as part of MCM, this service mostly provides discharge planning and should accurately be classified as non-medical Case Management (a non-core service). $4,262,511
- Positive Life Program: Currently classified as part of EIS, it does not provide all elements of HRSA-defined EIS, and should be accurately classified as Health Education and Risk Reduction (a non-core service). $557,008

Reclassification would not take funds from any existing services. A spending plan with these categories reclassified as non-core, and with ADAP fully funded, would give us a spending plan that is 72.34% core/27.66% non-core (assuming all other allocations remain at current levels). A waiver will allow us to explore multiple options for the application spending plan to allocate dollars based on known carrying costs and to request additional grant funds for new services based on need. A waiver will allow us the flexibility to develop a final (post-award) spending plan in March with more information on actual MCM, EIS and HRR costs.

A waiver also gives the Council and its committees the flexibility to do longer-range planning for 2014 when even more information is known (including new Medicaid eligibility criteria when ACA is fully implemented) and expands the possibilities for planning, including possibly developing new service priorities and models.

The highlights of the ensuing discussion were as follows:

- Concerns were expressed about the Positive Life program. It was explained that, at this point, this proposal is to only re-classify it as a non-core service. HRSA service definitions have changed with the new monitoring standards, but the local services are not changing.
- Reclassifying these categories does not change the service model or allocation. Changes to service models or allocations can be done later in the planning process and is not related to whether or not they are classified as core or non-core services.
- A reading of the HRSA definition of Health Education closely matches the actual work of the Positive Life program.
- Having a waiver, but then going back over the 75% core services minimum in a final spending plan or during the course of the year through reprogramming would not entail any penalty, but *not* having a waiver and falling below the 75% core minimum is not allowed.
- The revised program definitions in the new HRSA monitoring standards show that PRS, which provides linkage to care for people leaving Riker's Island, fits the definition of non-core case management. Unlike MCM, PSR does not follow clients through their treatment or provide services such as treatment adherence support or patient navigation. PRS often enrolls clients in MCM programs upon discharge for that kind of on-going support.
- Our HRSA project officer has informed us that the EMA has been setting higher standards for the waiver process than HRSA. The EMA has been successfully submitting a WICY waiver for many years, which tells HRSA that the EMA has a robust enough Medicaid program that we do not have to set aside specific allocations for services for women, children, infants and youth.
- The importance of reclassifying these programs as non-core services is to give us an application spending plan that justifies a waiver, thus enabling us to approve a final spending plan when the award is known without considering the core services requirement. This is vital because there is the likelihood that allocations for several core services categories will be reduced.

A motion was made, seconded and approved to reclassify PRS and Positive Life as non-core services and to authorize the grantee to pursue a core services waiver in the grant application.

Agenda Item #3: FY 2013 Ranking Tool

Ms. Gilborn introduced the continuation of the discussion of the criteria factor weights of the ranking tool. At the previous PSRA meeting, this was linked to the concern that a change would

cause the spending plan to fall below the 75% core services limit if there were a cut in the award. PSRA can now consider revising the weights based solely on their relative importance in the ranking process. The Committee reviewed the previously discussed versions of the criteria weights and was encouraged to systematically discuss the relative importance of each one.

Highlights of the ensuing discussion were as follows:

- It was noted that this is not a discussion of the scoring of the service categories within each criterion.
- The original version of the ranking tool was developed over many hours with a great deal of deliberation, but the weights were revised several years ago with much less discussion and are relatively arbitrary.
- There was a question of why Payer of Last Resort is a criterion at all, since all Ryan White funds must be payer of last resort. Also, all programs are required to provide access to/maintenance in care.
- Even though RW funds are all payer of last resort, the service category score may vary depending on variables such as capacity, which justifies the need for this criterion. Some service categories fulfill the POLR criterion to a greater extent than others.
- Does applying for a waiver necessarily mean that Core Services should be given less weight? Does eliminating the Core Services criterion send a message that the EMA does not agree with the value placed on core medical services in the legislation (i.e., for some people, food programs are a core service)?
- The Committee should review the documents from the original creation of the ranking tool for additional guidance.

A motion was made, seconded and approved to redistribute the 10% weight of the Core Services criterion to the Emerging Gaps/Needs Criterion (giving that criterion a weight of 25%).

The next steps in the planning process are the annual ranking and allocation plans for the application. This will require additional and longer meetings in June and possibly July. A list of planning tasks will be distributed to the Committee, along with the HRSA definitions for all service categories.

There being no further business, the meeting was adjourned.