



Meeting of the

EXECUTIVE COMMITTEE

February 15, 2007

2:45 – 4:10 PM

Friends House, 130 E. 25th Street

MINUTES

Members Present: J. C. Park, MPA (Governmental Co-chair), S. Hemraj (Community Co-chair), E. Camhi, S. Elcock (for P. McGovern), I. Gamble-Cobb, J. Grimaldi, MD, J. Hilger, J. Irwin, H. Mateo, D. Ng, T. Petro, T. Troia

Staff Present: *OAPCP:* D. Klotz, N. Rothschild, D. Wong; *DOHMH:* D. Weglein; *MHRA:* R. Miller, G. Kaloo, B. Carroll, P. Jensen

Agenda Item #1: Welcome/Introductions/Minutes

Mr. Park opened the meeting.

Ms. Elcock introduced the moment of silence.

Mr. Park reviewed the meeting agenda packet.

The minutes of the July 20, 2006 EC meeting were approved with no changes.

Agenda Item #2: Public Comment, Part I

L. Hayden: I appreciate the difficult position the EC is in this year, but I am concerned with the possibility of delaying all new contracts. It is not necessarily true that new contractors will not be affected. Since our award notice, our agency has begun planning, identified staff, planned to shift existing staff, and are now facing possible layoffs. Also, there will be gaps in high ranking priorities, such as harm reduction. The EC should move forward by funding the top ranked categories, and capping contracts in lower ranking categories to the first seven months of the year. That would respect the Council's extensive priority ranking process.

Agenda Item #3: FY 2007 Spending Plan

Mr. Park: We share the concerns raised in the public comment, but we are facing a unique set of funding challenges. We built our FY 2007 spending scenario around a potential reduction up to \$18M. Since then, we learned that the MAI grant will be delayed until August, and last week we discussed the services and communities those programs target. We also participated in a conference call with HRSA on Tuesday, which confirmed that we must meet the 75% core medical services requirement for FY 2007. Our spreadsheet shows us at 76%, but we are hedging our bets a bit because we classified Case Management to core services. We got no sense from the conference call that that would be a problem, but we do not know for sure. We were also informed that MAI funding will begin around August 1st and is not retroactive, but that we can continue to fund direct services. Treatment Adherence can no longer be a stand-alone service category, but can be part of another category, such as "Medical Case Management".

Program support also can not be a separate category, but is part of the 10% grantee administration, which affects the TA for Housing Providers category.

Ms. Hilger: HRSA also informed us that non-core services must be linked to health outcomes, but we were uncertain what that meant, or if it is different than current policy, which requires that we show that those services improve access to medical care. They used the example of Transportation, which now must only be used for transport to a medical provider. Many Title I cities had questions, and Doug Morgan of HRSA was responding to questions off the cuff and may have to fact check some of his answers. We have asked HRSA for clarity on these policies in writing as soon as possible.

Mr. Ng: The Integration of Care Committee (IOC) should meet regarding Case Management. We have moved it to core, but should proactively work to tweak it to meet possible new definitions of core services.

Dr. Grimaldi: IOC did that last year, and we have talked about doing that with Transportation and Food & Nutrition, but I think we need more guidance from HRSA.

Mr. Park (in response to a question from Ms. Gamble-Cobb): The formula and supplemental awards will come together in FY 2008, but we do not know if MAI will always be on different funding cycle.

Mr. Park: Last week, the EC voted to remove the Oral Health category from the portfolio, given the numerous new programs funded through other funding streams in the EMA. We also had a discussion on the MAI programs, where our options include closing them out and waiting until the award in August (which will not likely be same amount as this year), or considering MAI as part of the continuum of services with base-funded programs. We looked at the cost to maintain current MAI contracts for five months and how to pay for them, and estimated it to be about \$900,000/month. We discussed with the AIDS Institute having them take the \$4M cut to ADAP in the beginning of the year and using the funds to help carry the MAI programs. This action, as well as starting up new contracts late, will enable us to maintain the entire portfolio with formula award, while offsetting a possible reduction in supplemental and MAI.

Mr. Camhi: MAI programs are all in higher ranked categories. An issue is do we operate as if there will be no reduction and spend at the current level, and if we get a big cut in supplemental and MAI, it will mean having to make even deeper cuts in the middle of contract year. We have to do something to reduce the portfolio early on.

Ms. Hilger: We are considering base and MAI as one equal pot of money for services. We could lose up to \$24M in the worst case scenario. Given that there is no MAI funding until August, and that we can lower ADAP by \$4M at the beginning of the year and delay new contracts, then everything gets prorated, and when the supplemental award comes in, we will have a better understanding of the percentage cuts to the award and can implement the formula-based proportionate cuts. We also will have significant under-spending from FY 2006. We will have to stage new contracts – some will start, some will be delayed. It is an awkward year and will impact contractors, but we have no choice. We want to have the flexibility to fund as many contracts as possible with as little risk as possible, balancing multiple factors.

Mr. Camhi: So we have to give general parameters on cuts, but the grantee will make prorated cuts based on the knowledge of award.

Ms. Hilger (in response to a question from Mr. Ng): We have already taken out from ADAP what we would restore from carry-over. The \$4M is a cut to their base award.

Mr. Park (in response to a question from Ms. Elcock): Percentage cuts are to all categories, as base and MAI are combined into one integrated portfolio.

Ms. Miller: In a worst case scenario, the cuts we implement at beginning of year would be applied to the full year. If the reduction is less, we can fund at higher levels.

Mr. Ng: We will do proportionate cut based on rank. Do we implement that in March or after the supplemental comes in? If the reduction is less, would there be a risk of higher under-spending?

Ms. Hilger: Proportionate cuts would take effect after the supplemental award is received, but we would delay new contracts and a take reduction to ADAP at the beginning of the year to mitigate risk, which will provide a cushion. The majority of cuts would be implemented after the supplemental award.

Ms. Miller: There are a large number of new contracts this year and the majority will proceed March 1st, but there is some built in under-spending we can count on.

Mr. Petro: In Tri-county, are funding all direct services at the current carrying cost with the understanding that we may not have full funding after August and some categories may be taken down later in the year. We will look at targeted cuts to have a minimal reduction in services.

Ms. Hilger (in response to a question from Mr. Hemraj): If a category could not be funded due to a new HRSA policy, it would free up the funds allocated to that category.

Mr. Camhi: So, the spreadsheet presented today shows us carrying the whole portfolio, and I suggest that we validate and approve this, as it matches our priorities.

A motion was made and seconded to approve the proportionate cut spreadsheet.

Ms. Hilger: We can no longer have a program support category, and I want to ask the EC what we should do. I propose a friendly amendment to eliminate the TA for Housing category.

Mr. Ng: I want to modify the friendly amendment that we move that item to administration and ask the grantee to evaluate the feasibility of continuing it.

Mr. Camhi: The modified friendly amendment is accepted. This would be a targeted reduction applied before a proportionate cut.

Ms. Miller: It looks like HRSA would not allow TA for Housing subsumed in another category, as we can with Treatment Adherence, which can be part of Medical Case Management or Outpatient Medical Care.

Mr. Camhi: I restate the motion: that we accept the formula for proportionate cuts after the eliminating of TA for Housing, which we ask the grantee to consider continuing as program support under the 10% administrative cap. The grantee will have flexibility, with a \$4M up-front cut to ADAP and the delaying of new contracts to buy time until we know supplemental the award. [The motion carried unanimously.]

Mr. Ng: I move that the EC send a letter to the HOPWA administrator that the TA for Housing program has been historically valuable, that we would have continued funding it with Title I if we were allowed, and we recommend that they look at the HOPWA portfolio and use carry-over or other funds to continue funding for this program. [The motion was seconded and carried unanimously.]

Mr. Park: We have discussed this with the HOPWA administrator, and while the budget is set for the year, a door was left open to the possibility.

Ms. Hilger: The EC may want to recommend where to move the Treatment Adherence category.

Mr. Park: We left it on the spreadsheet as a stand alone category. If the EC moves it to Case Management or Outpatient Medical Care, it would affect the priority rank of that category.

Mr. Petro: That is not necessarily an issue, as we would fund it as intended. The question is only one of classification.

Mr. Klotz: Doug Morgan said on the conference call that Treatment Adherence can be part of “Medical Case Management”, which is listed in the Ryan White Act as a core service, but we already have “Case Management” as a stand-alone core category.

Mr. Miller: We have always had more categories than HRSA, and it is a matter of reporting to HRSA. We can keep it in our spending plan as a separate category.

Mr. Ng: I move to keep Treatment Adherence as is for our planning purposes, but give the grantee the flexibility to place it in an appropriate category for reporting to HRSA. [The motion was seconded.]

Mr. Camhi: This is part of next year's priority setting process, but for this year, working with IOC, we will tweak all services to fit in with the appropriate HRSA category.

Mr. Ng restated motion, which carried unanimously.

Mr. Hemraj: It will be crucial to maintain flexibility, since we have to have minimal under-spending. We should discuss a mechanism to give the grantee the flexibility to shift funds between categories to keep under-spending low, as we have in previous years.

Mr. Park: This will move forward to the Planning Council next week, but we will have to monitor it regularly as we learn more from HRSA.

Agenda Item #4: PC Timeline

Mr. Klotz: In the meeting packet is a timeline of activities for the Council and its committees prepared by Clarissa Silva. This will be adjusted as necessary (e.g., IOC will consider MAI eligibility requirements after HRSA issues its MAI guidance).

Agenda Item #5: Public Comment, Part II

M. Ducret: We should let the federal government know that it is wrong to cut funding when we are trying to bring more people into care.

Mr. Park: We are engaged in advocacy efforts around these issues through our government and community partners.

Ms. Moon: We are preparing a letter to US HHS on the problem of the delay in MAI funding, which we will get to the Council members tomorrow.

Mr. Ng: We are working with our Congressional delegation – especially Congressional Black Caucus, NYAC is organizing a community sign-on letter, and we are visiting Washington, DC next week.

Ms. Miller: Advocacy should stress the problem of notifying us of these changes so late and the problems it causes.

Mr. Park: I want to acknowledge everyone's hard work. There is a big impact across the country from these policies. We will do what we can collectively to maintain services in the community.

Ms. Hilger: Implementation of the proposed HRSA housing policy is being delayed until September 1st.

There being no further business, the meeting was adjourned.

Minutes approved by the Executive Committee on March 13, 2007.