Meeting of the

EXECUTIVE COMMITTEE

February 8, 2007
2:45 – 4:10 PM
Friends House, 130 E. 25th Street

M I N U T E S

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

Staff Present: OAPCP: D. Klotz, C. Silva, D. Wong; DOHMH: A. Karpati, MD, D. Weiglein; MHRA: J. Vedino, R. Miller, G. Kaloo, B. Carroll, P. Jensen

Agenda Item #1: Welcome/Introductions/Minutes

Mr. Park opened the meeting.

Mr. Hemraj introduced the moment of silence.

Mr. Park reviewed the meeting packet.

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

Agenda Item #2: FY 2007 Spending Plan

Mr. Park: There was supposed to be a HRSA Title I conference call on Tuesday, where we expected to learn more about Ryan White HATMA implementation, but it has been postponed to next Tuesday.

Ms. Hilger: There has only been informal communication from HRSA or from our advocates, such as CAEAR Coalition. We have expressed our concerns to HRSA that we are in an awkward position to plan for a fiscal year that starts in two weeks. We have been told that there will be no waiver process in 2007, and that we have to implement the 75% core services requirement this year. It is not clear when we have to submit a budget, which we usually do after the full award is received, which would be later in the spring. The award will come in three stages: the formula will arrive around March 1st. The supplemental award will arrive after the 5 new EMAs complete their applications. HRSA is still working on the application guidance, and we do not expect the process to be completed until around May or June. Finally, the Minority AIDS Initiative (MAI) award will be through a competitive application process on a separate budget year beginning August 1st. Thus, as of March 1st, there is no MAI money, which last year was about $11M. We have no criteria yet for the kind of services or eligible providers that can be funded though MAI. We also do not know the level of detail of definition of core services (i.e,. can we classify part of service category as core and part non-core), and we will have to be able to justify any classification as core services.

Ms. Hilger (in response to a question from Mr. Camhi): Most EMAs can receive MAI funds, and we currently get far more than even the next largest recipient.

Mr. Camhi: The Priority Setting & Resource Allocation Committee (PSRA) met over several months and developed, with assistance from CHAIN, a formula to make weighted cuts based on priority rank. We also obtained a commitment from the AIDS Institute to reduce the amount allocated to ADAP, and we voted to eliminate the Oral Health category, as there are many new awards for that service under Ryan White Part F. After the full award comes in, we would apply the formula. This was unanimously accepted by PSRA and put forward to the EC. However, given what we just found out about the award, this no longer applies.

Mr. Park: Every year, we develop scenarios in anticipation of a possible reduction in the award so that we are ready to implement the spending plan when award comes in, but due to changes in the law and HRSA policy, we must make adjustments. We feel secure that base formula funding will be fine, but we expect a big loss in our supplemental award, and now we have learned that there will be no MAI funds for at least 5 months. We have been in contact with CAEAR and other EMAs to learn about what other jurisdictions are doing to cope with this problem. Various approaches have been discussed, such as carrying the MAI contracts with base funding, as well as closing out MAI programs, as we do not know if we will get any MAI funds or what they can be used for. We internally developed scenario plans to see what the funding picture would look like if everything the same, and if there are reductions in various parts of the award. HRSA has made clear to us that there is no waiver from the 75% core services requirement for 2007. We will speak to our representatives in Washington, DC about the unfair burden this causes, and we are working behind the scenes with HRSA and our advocates on this issue. However, we still need to plan based on the information we have today.

Dr. Karpati: The goal of the scenarios presented today is to illustrate the impact of possible cuts to various parts of the portfolio. The first scenario shows the portfolio with no cuts to the award. The next shows a slight shortfall with the reduction in Oral Health and a small offset in administrative costs. The next scenario shows a worst case scenario of a total loss of MAI funding (in 6 program categories). The spreadsheet shows what percentage cuts to those categories the MAI cut represents (e.g., Treatment Adherence = 52%). The true worst case scenario is a loss of about $28M (a 15% base cut, plus the loss of MAI funds). The spreadsheet shows the PSRA-approved formula cut to the remainder of the portfolio after the loss of MAI funds. After the loss of MAI funds, the portfolio's status quo already meets the 75% requirement (with Case Management classified as a core service).

Ms. Hilger (in response to a question from Dr. Grimaldi): We wanted the EC to understand that no MAI funds are likely to be available from March 1st through August 1st, which will have a real impact on programs.

Mr. Park: If we receive our MAI grant in August, it is not retroactive to March 1st. It will also probably be much less than it is now, even prorated over the course of a year, as new EMAs are competing for MAI funds. We have to decide whether or not to let MAI programs end, or support them with base funds until the MAI grant is announced.

Dr. Karpati: The PSRA-approved proportionate cut is based on each category's rank score, as developed by the PSRA. For example, Mental Health, with a score close to that of ADAP (the highest possible rank), is only cut a small amount, but Home Care, with half of ADAP's score, is cut twice as much. Another spreadsheet shows the MAI cut simply added into the total base cut, i.e., applying the PSRA formula the same way the base cut is distributed.

Ms. Miller (in response to a question from Mr. Petro): Of MAI categories, Outpatient Medical Care (OMC) and Early Intervention Services (EIS) are new programs due to start March 1st; the others are continuing programs. Some of the contractors with new awards are for "brand new" programs, and other new awards may be for agencies that have programs in the same category from before the category was re-bid, and so they function as an on-going program with existing staff and clients ("continuing new").

Mr. Ng: Thinking about operationalizing this, in one scenario, we can freeze MAI programs until August, and then find out how much is available and start them back up as much as possible. In the other scenario, we float all programs, and will have to apply the unknown MAI amount to all contracts.

Ms. Hilger: The grantee is still thinking about how to operationalize this. Base-funded OMC and EIS programs are also starting up. With flexibility of funding, we will be better able to meet the goal of getting programs into the communities with highest need. Also, with a partial award in August, we will have to think in terms of a two-year plan. It is better to think of how to best use the funding that we have, so that we can get services out onto the street, rather than having to scramble in August.

Dr. Grimaldi: It is hard to justify cutting all MAI programs just because HRSA is arbitrarily distributing funds on a different time table.

Dr. Karpati: Even base supplemental funds are going to be late, and that is where we will take the biggest cut, and so we will still not know about the entire portfolio on March 1st.

Mr. Camhi: We know that we will get a fixed amount on March 1 (base formula). Could we commit to six-month contracts based on an initial award and not commit beyond that until we know rest of award? It is hard to exercise judgment on the total portfolio without knowing the total award. We can apply cuts as the awards come in, but it will be more severe, as we will have spent six months of formula funds for the whole portfolio.

Ms. Miller: As a practical matter, we have mechanisms to allow us to be flexible; contracts always depend on the availability of funds. Also, we do not know about eligibility for MAI funds yet. Our current MAI programs might not be eligible in the future.

Mr. Camhi: We also do not know if our core designated categories will be allowed as core by HRSA.

Ms. Verdino: In the best case scenario, with no cut to MAI, we are still losing at least $5M of MAI funds, because they starting in August. If we float the whole portfolio, we will still have to cut $5M at the end of the year.

Mr. Clanton: I agree with Ms. Verdino. If we have to cut $5M at the end of the year, we will do severe damage to programs.

Mr. Petro: There are upsides and downsides to floating the full portfolio. The upside is that there is no interruption in services. The downside is that there is no way to plan for funding, and we may find that in the 7th month of the fiscal year that we have no money for the portfolio for the rest of the fiscal year.

Dr. Karpati: That is the dilemma we face. We could begin by delaying brand new contracts, as this would not disrupt continuity of services.

Mr. Ng: I think that we need to start adjusting for loss of five months of MAI funds by delaying brand new contracts.

Ms. Miller (in response to a question from Ms. Gamble-Cobb): There are about $9M to $10M in brand new programs across the portfolio, only a relatively small amount in MAI.

Mr. Camhi: We could take half of the $18M cut scenario, plus a $5M cut in MAI as a targeted reduction, then making staged decisions as the supplemental and MAI awards come in.

Mr. Camhi (in response to a question from Dr. Grimaldi): This is not a recap of the discussion in PSRA on a targeted versus an across-the-board cut. This applies the weighted PSRA formula after an early targeted reduction, which we can boost after the award comes in if it is higher that we expected.

Ms. Hilger: If we impose a 15% cut now, we risk not being able to spend the award should we get a larger amount when the supplemental and MAI come in.

Ms. Miller: EC members should be aware that a cut to a service category could mean a reduction in the number of contracts, and not an across-the-board cut to all contracts in that category. If we make cuts up front and get a fuller award later, we would be cutting programs unnecessarily.

Mr. Ng: I propose that we freeze "brand new" programs and use those funds to give the grantee flexibility to float the rest of the portfolio until we know the full award amount.

Ms. Hilger: We have a lot of new contracts this year, and so expect a lot of under-spending, which could be to our advantage in this scenario.

Mr. Camhi: Is there any downside to taking the targeted ADAP reduction early?

Mr. Park: The AIDS Institute is not here, and we would need their response.

Ms. Verdino: We can use our carry-over as bridge, but we don't receive it until the late fall (which is why we usually use it to restore ADAP funding).

Mr. Park: We have scheduled an EC for next week. Before then, we need to answer: the dollar amount of all "brand new" and "new continuing" contracts, if the ADAP targeted cuts can be done in advance of knowledge of award, and if we can restore that amount if we do not get cut. We will try to get this information to the EC in advance of the meeting.

Mr. Camhi: I want to commend the EC for being sensitive to Title I consumers, given our challenges.

Agenda Item #3: Public Comment

T. Smith-Caronia: In terms of MAI, we do not know if funding will run for an entire year, and so decisions should not be premised on a full year of funding. We also do not know if MAI funds will fall under the 2% under-spending requirement.

M. Ducret: Our project in Washington Heights is working to get people tested and into care. We should bring to HRSA's attention that more people are coming into care and there is less money for services.

Mr. Hemraj: I want to congratulate everyone for working together in such a difficult environment.

Ms. Hilger: We have one more item of business: we need to agree on the elimination of the Oral Health category so that we can send out notices and close out the contracts.

A motion was made, seconded and approved unanimously to eliminate the Oral Health category.

There being no further business, the meeting was adjourned.

Minutes approved by the Executive Committee February 15, 2007