Meeting of the

Priority Setting & Resource Allocation Committee

Jennifer Irwin & Eli Camhi LMSW, Co-Chairs

Friday, January 19, 2007 1:00–5:00 PM

GMHC, 119 W. 24th Street, New York, NY

Members Present: Eli Camhi LMSW (Co-Chair), Jennifer Irwin (Co-Chair), S.J. Avery, Felicia Carroll, Humberto Cruz, Linda Fraser, Steve Hemraj, JoAnn Hilger, Soraya Elcock (for Patrick McGovern), Peter Laqueur *(for B. Agins MD),* Hilda Mateo, Darryl Ng, Jan Carl Park, Tom Petro, Wesley Tashir-Rodriguez, Joshua Sippen, Edward Telzak, MD., Rev. Terry Troia,

OHAPCP/DOHMH Staff Present: Clarissa Silva, Rob Shiau, David Klotz

MHRA Staff Present: Rachel Miller, Gucci Kaloo, Allison Chi

I. Welcome/Introductions

Mr. Camhi and Ms. Irwin opened the meeting and introductions were made. The Committee accepted the Scenario Planning actions/decisions from the 1/12/07 minutes, but asked that the minutes be revised to reflect more of the discussion that took place. Ms. Silva reviewed the contents of the meeting packet.

II. FY 2007 Scenario Planning

A spreadsheet was presented with the new model for reductions developed by OHAPCP staff and Dr. Peter Messeri of CHAIN factoring in the carrying costs, targeted reductions (ADAP and Oral Health), EMA ranking score and a multiplier. The concept is a proportionate reduction based on the existing priority ranking of each category. Tri-county, administration and program support (which are unranked) are reduced by the

amount that the overall award is reduced and are thus taken out of the equation, which is only used for NYC program dollars. Two spreadsheets were presented – one that maintains the current 69%/31% split between core and non-core services, and one that moves the portfolio to a 75%/25% (which requires larger cuts in non-core services). After factoring in the Tri-county/admin/program support reduction, the 15% reduction scenario requires a $16.5M cut to NYC programs. This is the only amount within the purview of the Committee.

The Committee reviewed the use of various multipliers in the formula to see the resulting cut. Keeping the 69/31 core/non-core split, there would be an $11.4M cut to core services, and a $5.1M cut to non-core. After factoring the targeted reductions (all core), there would be an $8.3M cut to core services. Mr. Cruz pointed out that ADAP is accepting a disproportionate reduction. The Committee then reviewed a second spreadsheet that moves the portfolio to a 75%/25% core/non-core split. This would require a much larger cut to non-core than core services.

Committee members pointed out that some non-core services have higher ranking scores than some core services, that the current 69/31 split was just how the portfolio happened to fall out, that we still do not know how HRSA will define some core services, and that some services currently classified as non-core may be able to be classified as core in the future. If the formula is applied to the portfolio without regard to core/non-core (i.e., purely on the EMA's rankings), then there is only about $500,000 less of a reduction in non-core and $500,000 more in core.

The Committee discussed developing three possible scenarios: 1) if the EMA is not granted a waiver, in which case the portfolio would have to move to 75/25; 2) if the EMA is granted a waiver and the formula maintains the current 69/31 split; 3) if the EMA is granted a waiver and the formula is applied freely without regard to the historical core/non-core split.

The third scenario was moved, seconded and adopted. A discussion followed on the non-waiver scenario. It was decided to reclassify Case Management as a core service, as the IOC's redefinition of the category (to be implemented in the next re-RFP for FY 208) closely matches the NYSDOH definition of medical case management. This brings the portfolio very close to a 75/25 split. It was discussed reclassifying a portion of Food and Nutrition Services (FNS) to core services, as a portion of the category's service elements meets the definition of "medical nutritional therapy". Possible pitfalls of this approach were discussed (we do not know the proportion of FNS that is a core service; we do not know if we can classify just a portion of a category as core; there are large portions of core categories like Outpatient Medical Care that are non-core, which can cause problems in an audit). A motion was made, seconded and carried to adopt a non-waiver scenario where the Messeri formula is applied after Case Management and a portion of FNS is reclassified as core services.

III. Public Comments

R. Bannon reiterated the importance of "bricks and mortar" Housing TA in leveraging additional resources for creating housing for PLWHA.

Actions/Decisions

A motion was made and carried to accept 2 scenarios using the formula developed with Dr. Messeri. In the case of a waiver, the formula would be applied freely without regard to the historical core/non-core split. If there is no waiver, Case Management and a portion of Food & Nutrition Services will move to the core section, and then the Messeri formula will be applied.

Next Steps: Executive Committee and full Council review and approval of the above scenarios.