Paterson-Passaic County-Bergen County HIV Health Services Planning Council

Priority Setting Fiscal Year 2016
Report to the Grantee

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Bergen-Passaic Transitional Grant Area
Jose "joey" Torres, Chief Elected Official and Mayor, City of Paterson
Department of Human Services, Ryan White Grants Division
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PATERSON-PASSAIC COUNTY – BERGEN COUNTY
HIV HEALTH SERVICES PLANNING COUNCIL

PRIORITY SETTING FY 2016
REPORT TO THE GRANTEE

I. INTRODUCTION, PARTICIPATION, ROLES AND RESPONSIBILITIES

Each year, the Planning Council engages in a comprehensive review of the priority ranking and resource allocations process. To prepare for FY 2016 deliberations, the Planning Council moved to strengthen the ability of Planning Council members to make informed decisions. Specifically, relevant data were provided both in summary and detail formats to reflect defined criteria and to enhance Planning Council's understanding of service need and use. Additionally, Planning Council members were offered technical assistance to enhance their understanding of the priority setting process and the use of data for decision-making. Finally, steps were taken to (1) assure absence of conflict of interest by Planning Council members, (2) avoid opportunities for impassioned plea, and (3) assume sole responsibility by the Planning Council for reviewing all data, establishing policy, priorities and allocations. As a result, a thorough and unbiased priority setting process was successfully implemented again for FY 2016.

The tasks of the Planning Council are articulated by the Planning Council in the approved Priority Setting Process, contained below.

To remove potential conflict of interest by aligned members of the Planning Council, each service category under consideration was voted separately, and members aligned with that service category were required to declare their status and not permitted to vote. Council members were permitted to offer their views and experiences during discussions to highlight the data. However, comments considered personal or self-serving in nature were not allowed.

The Planning & Development Committee accepted responsibility for assuring a smooth and effective priority setting process on behalf of the Planning Council by establishing and maintaining a year-round detailed month-by-month timeline for completing the required tasks of priority setting, resource allocations and directives. The Committee reviewed the priority setting timeline at each of its monthly meetings and then intensified its efforts in June through September of 2015. The committee's work included review of data and materials that would be brought to the Planning Council for review, guidance on procedural matters and formulating recommendations for consideration by the Council.

The Planning Council requested technical assistance from HRSA to help improve the Council's process, particularly with regard to data presentation. Although the request was answered, consultants were unable to provide relevant recommendations.

A Planning Council task force was created to review data related materials and to recommend how these materials could be simplified and made more user friendly. The task force, consisting mostly of consumer members, worked with the Planning & Development Committee and the planning consultant to develop summary worksheets aimed at facilitating comprehension and decision making. The process was successful.

Persons living with HIV/AIDS (PLWHA) and other community members participated in the priority setting and resource allocation process at multiple levels. Four new Planning Council members, including two PLWHA, received a full-day orientation on April 28, 2015. A second orientation with five new members including two PLWA was held on August 31, 2015. Both orientations included training on the priority setting and resource allocation process. Additionally, on June 30, 2015, Planning Council members and alternates with an interest in improving their understanding of the data and the process were invited to a special technical assistance program. Participants used the environmental assessment, needs assessment presentation and data work book to discuss factors relating to priorities and allocations. They also reviewed the voting process that would be used. The orientation helped PLWHA lay a strong foundation for the complete process. Twelve Planning Council members, seven of whom were consumers, participated. Finally, members of the public, many also PLWHA, were invited to the Council's priority setting and resource allocations meetings and allowed to participate in discussions prior to the voting.

The Planning Council formally began priority setting deliberations on July 7, 2015 with the environmental assessment, data review and priority ranking. Resource allocations on August 4, 2015, and directives to the grantee were discussed and voted on September 1, 2015. Information and vital issues were discussed with motions and recommendations made from the floor. The overall process was successful and resulted in carefully considered priorities, allocations, and directives firmly grounded in the use of data for decision making. This report describes the process as well as the decisions of the Planning Council.

II. DATA

As part of the priority setting process and prior to the voting deliberations, the Planning Council received an environmental assessment of the status of HIV/AIDS in the Bergen-Passaic TGA with reference to state and national priorities. Under the guidance of the Planning & Development Committee, a complete data set in the form of a Priority Setting Data Work Book was assembled for the Planning Council with elements addressing the various criteria and variables considered crucial to decision making. The FY 2016 Priority Setting Data Work Book was intended to assist members of the Paterson-Passaic County – Bergen County HIV Health Services Planning Council as they determined priorities, allocations and directives. Data tables contained information requested by the Planning Council, supplemented by information and recommendations from the 2012-2013 Comprehensive Needs Assessment and 2015 Update, and earlier special population studies describing specific characteristics of the population as well as service needs, access and barriers.

The Data Work Book was organized into four parts: (1) an introduction and summary tables; (2) profiles for each funded service category pertaining to priority ranking; (3) profiles for each service category pertaining to resource allocations, and (4) recommendations from the 2012-2013 Comprehensive Needs Assessment and 2015 Update, and previous special population studies. Part I described how to use the work books and provided major summary tables from Parts II and III. Part II looked at each service category in the RWHAP Part A program that was funded in the previous fiscal year and likely to be funded again in FY 2016. Data tables provided information from the Needs Assessment, the Gaps Analysis and other related studies. Part III again looked at each service category in the RWHAP Part A program that was funded in FY 2015 and chosen for funding in FY 2016. The Work Book provided information about how the funds were utilized in the previous fiscal year and availability of other sources of public funds, apart from Part A, to support the needs of PLWHA. Part IV was intended as a reference tool containing current and past recommendations from needs assessments and special population studies.

To further facilitate their review, two summary tables were developed by the special Data Task Force of the Planning Council. These tables succinctly summarized data related to the criteria identified by the Council. The summaries allowed for easy comparisons across service categories as well as succinct tables on service need, utilization and funding.

III. THE PROCESS

The complete priority setting process is explained, as follows.

PROCESS COMPONENTS

1. Review of priority setting process
2. Review of priority setting criteria
3. Review of service category definitions
4. Environmental assessment to include the HIV Care Continuum, National HIV/AIDS Strategy, HRSA priorities, and status of the epidemic
5. Data reviews
6. Priority ranking (what services are needed)
7. Identification of which categories would be prioritized
8. Resource allocations (how dollars are to be spent)
9. Contingency scenarios (what if there is a significant increase or drop in funding)
10. Directives to the grantee
11. Report to the grantee
12. Process evaluation

PRIORITY RANKING CRITERIA

Priority Ranking defines the *importance* of each service category in maintaining engagement or providing access to HIV medical care. Priority Ranking does *not* relate to how much the service is used in Part A/MAI.

FY 2016 criteria, stated in priority order:

1. **In-Care PLWHAs (In-Care** means the individual is getting medical care for HIV): The service addresses their needs and maintains them in medical care, as indicated by:[1]
    - "Do you use this service?" from the needs assessment survey;
    - "If you do not use this service, do you need it?" from the needs assessment survey results;
    - Other available information from various sources.

2. **Out-of-Care PLWHA** (**Out of Care** means the individual is not getting medical care for HIV) **and Unaware** (**Unaware** means the individual is HIV-positive but does not know his or her status)**:** The service addresses their needs, as indicated by:
    - "If you do not use this service, do you need it?" from the needs assessment survey;
    - Other available information from various sources.

3. **Access:** The service addresses access issues ("ability to get the services you need") that get in the way of getting medical care, as indicated by:
    - "What keeps you from getting the service?" from the needs assessment survey;
    - Providers' capacity to increase access and remove barriers for needed services;
    - Comparison of provider locations to the epi-centers;
    - Other available information.

The priority ranking model uses the criteria identified above. Every HRSA approved service category is given a score from one to five points.

Voting is for each service category individually. Aligned members of the Planning Council may not vote on the service category to which they are aligned.

[1] A person is in care if he/she receives an HIV-related medical visit, a CD4 test or viral load test within the past six months.

PRIORITY RANKING SCORING TOOL

1 = Not Important		5 = Very Important
In-Care PLWHA		
Need: For PLWHA who are engaged in HIV primary medical care (in care), the service does NOT significantly contribute to maintenance in care.	**THIS SERVICE IS IMPORANT TO MEET IN-CARE AND NOT-IN-CARE NEED AND ACCESS TO SERVICES**	*Need:* For PLWHA who are engaged in HIV primary medical care (in care), the service significantly contributes to maintenance in care.
Unmet Need: The service has NOT been identified by PLWHA who are engaged in HIV primary medical care as an unmet need.		*Unmet Need:* The service has been identified by PLWHA who are engaged in HIV primary medical care as an unmet need.
Gaps in Services: The service is NOT identified in the gaps analysis as significant to the network of services that enhance access to HIV primary medical care.		*Gaps in Services:* The service is identified in the gaps analysis as significant to the network of services that enhance access to HIV primary medical care.

Scoring Range:

1 = Not important
2 = Somewhat important
3 = Moderately important
4 = Important
5 = Very important

Planning Council members vote by assigning a score of 1 to 5 for each service category. Scores are averaged and then sorted from high to low to determine priority ranking. All HRSA defined service categories are ranked.

When all service categories are ranked and approved by the Planning Council, each will be reviewed to determine whether to fund the service in FY 2016. The Planning Council will decide by a Yes/No vote for each service category.

Public comment is allowed during discussion of each service category. Voting is for each service category individually. Aligned members of the Planning Council may not vote on the service category to which they are aligned. Aligned members are officers, board members, employees, consultants, regularly scheduled volunteers[2] or anyone who may benefit financially from decisions made.

[2] Regularly scheduled volunteers who can vote will be determined on a case-by-case basis.

RESOURCE ALLOCATION CRITERIA

Resource allocation defines the way Ryan White funds will be distributed to specific service categories. The resource allocations criteria help to determine the level of funding for services that support engagement and retention in medical care.

FY 2016 criteria, stated in priority order:

1. *Utilization* of services provided by Ryan White Part A or MAI, as indicated by:
   - Percent of funds spent for the service category (provided by the Ryan White grantee);
   - Cost per client to render the service (provided by the Ryan White grantee);
2. *Capacity* for providers to render services, as indicated by:
   - Percent of expected clients versus actual clients served in the Part A system (provided by the Ryan White grantee);
3. *Availability of other sources of funds* that may be used to serve PLWHAs, as indicated by:
   - How much in other public funds are available to serve PLWHA.

The resource allocation model uses the criteria identified above, each of which is given a score from one to five points.

RESOURCE ALLOCATION CRITERIA
SCORING TOOL

1 = Needs Less $		**5 = Needs More $**
Utilization: This service is NOT well utilized by PLWHA to maintain engagement in HIV primary medical care.	**SERVICE UTILIZATION**	*Utilization:* This service is very well utilized by PLWHA to maintain engagement in HIV primary medical care.
Capacity: Existing providers are able to provide enough services for PLWHA.	**SERVICE CAPACITY**	*Capacity:* Existing providers are NOT able to provide enough services for PLWHA.
Funding Resources: Adequate funding sources are available to provide the same or a similar service.	**OTHER SOURCES OF FUNDS**	*Funding Resources:* There are FEW (or NO) adequate funding sources that provide the same or a similar service.

Scoring Range:

1 = 20% less dollars
2 = 10% less dollars
3 = No change
4 = 10% more dollars
5 = 20% more dollars

For each service category, Planning Council members apply the resource allocation criteria by assigning a score of 1 to 5 to each of the three criteria. Scores are aggregated for each service category.

A decision model (or calculation) is constructed to determine the new allocations. The model assigns dollars to each service category and then adjusts each service category after the voting, as follows.

1. Allocations begin with an assumption of stable funding, i.e. no increase or decrease from fiscal year 2015.
2. A baseline, expressed in dollars allocated to each service category, establishes funding at one hundred percent of the prior year.
3. Each category is scored for utilization, capacity and other sources of available funds.
4. The scores are weighted and dollars adjusted for each service category. *The total of all service categories may be different from the baseline.*

Score	Weight	Meaning
1	0.80	Weight assigns 20% less dollars
2	0.90	Weight assigns 10% less dollars
3	1.00	Weight assigns no change in dollars
4	1.10	Weight assigns 10% more dollars
5	1.20	Weight assigns 20% more dollars

5. The difference is then allocated through deliberations by the Planning Council. Some service categories may receive more funds and some less, depending on the consensus of the Council.
6. When deliberations are completed, allocations are then converted into *percentages*.

The Planning Council is given responsibility for reviewing data pertaining to service utilization, capacity and other sources of funds

Public comment is allowed during discussion of each service category. Voting is for each service category individually. Aligned members of the Planning Council may not vote on the service category to which they are aligned.

CONTINGENCY SCENARIOS

Contingency scenarios define how the Planning Council will act if the grant award differs significantly from the prior year. The Planning Council determines a course of action based on discussion and consensus.

The process is as follows. FY 2015 contingency scenarios are reviewed by the Planning Council for their appropriateness in FY 2016. Current scenarios serve as the basis for the discussion process:

Example: In the event that FY 2016 funding levels significantly change from the prior fiscal year, the Planning Council determined the following course of action.

Scenario 1: If funding is up to 20% (+/-) of the FY 2015 award, the Grantee will distribute funds proportionately in accordance with percentages established by the Planning Council.

Scenario 2: If funding is increased or decreased by more than 20%, the Planning Council will convene to revise the previously established allocations.

DIRECTIVES

A directive advises the Grantee on the best use of funds. It goes beyond resource allocation and takes into consideration changes in the environment that could have an effect on services for PLWHA. The Planning Council reviews the most recent information and recommendations from:

- Comprehensive HIV Health Services Plan
- Outcomes and Satisfaction Surveys
- Quality Measures
- Unit Cost and Cost per Case
- Needs Assessments, Special Population Studies, Epi-Profiles, Environmental Assessments, CARS data, etc.
- Statewide Coordinated Statement of Need (as available)

Directives may be offered as motions by members of the Planning Council or any of its committees. Discussion and voting occurs at the Planning Council by all members. Aligned members may not vote on behalf of the service category to which they are aligned.

REPORT TO THE GRANTEE

Results of the Council's priority setting decisions, as reflected in the meeting minutes, are compiled into a report to the grantee. The Planning & Development Committee reviews the drafts and forwards the final draft for further review to the Steering Committee. The report is forwarded to the Council for ratification. The Planning Council may edit the report for accuracy prior to final adoption.

PROCESS EVALUATION

A formal evaluation of the priority setting process is conducted in two phases: (1) an evaluation following each Planning Council meeting in which priority setting is an agenda item, and (2) a final evaluation of the entire process.

The first phase utilizes a survey instrument that each Planning Council member completes at the end of each meeting. The Steering Committee reviews the results and forwards them to Planning & Development Committee for discussion.

The second phase is completed by the Planning Council and includes (1) a review of the FY 2016 Priority Setting calendar for completed tasks during the fiscal year and (2) review of the Planning Council's survey responses following the completion of the entire process. Results are forwarded to Steering Committee by the Planning & Development Committee for further review along with recommendations for the next fiscal year. The Planning Council receives a report at its January 2016 meeting and determines appropriate improvements to be implemented for FY 2017.

IV. RESULTS

SERVICE CATEGORIES

The Planning Council reviewed 31 allowable service categories to determine which would be included in the FY 2016 plan. First, the Council reviewed each definition along with related need and access data. Members then voted on the importance of each HRSA-defined category. Results are shown in Table 1.

Table 1
RWHAP Prioritized Service Rankings FY 2016

Service Category	Rank	
	Part A	**MAI**
a. Ambulatory/Outpatient Medical Care	**1**	**1**
b. AIDS Drug Assistance Program (ADAP)	**6**	**13**
c. AIDS Local Pharmaceutical Assistance (local)	**7**	**14**
d. Oral Health Care	**2**	**5**
e. Early Intervention Services	**8**	**6**
f. Health Insurance Premium & Cost Sharing Assistance	**18**	**20**
g. Home Health Care	**16**	**23**
h. Home and Community-based Health Services	**22**	**21**
i. Hospice Services	**19**	**27**
j. Mental Health Therapy and Counseling	**3**	**2**

Service Category	Rank	
k. Medical Nutrition Therapy	**24**	**19**
l. Medical Case Management	**4**	**4**
m. Substance Abuse Services Outpatient	**15**	**18**
n. Case Management - Non-medical	**5**	**3**
o. Child Care Services	**27**	**26**
p. Pediatric Development Assessment and Early Intervention Services	**N/A**	**N/A**
q. Emergency Financial Assistance	**12**	**8**
r. Food Bank/Home Delivered Meals	**23**	**17**
s. Health Education/Risk Reduction	**21**	**22**
t. Housing Services	**10**	**7**
u. Legal Services/Permanency Planning	**17**	**15**
v. Linguistic Services	**28**	**28**
w. Medical Transportation Services	**11**	**9**
x. Outreach Services	**9**	**10**
y. Permanency Planning	**N/A**	**N/A**
z. Psychosocial Support Services	**13**	**11**
aa. Referral for Health Care/Supportive Services	**20**	**12**
bb. Rehabilitation Services	**26**	**24**
cc. Respite Care	**29**	**29**
dd. Substance Abuse Services - Residential	**25**	**25**
ee. Treatment Adherence Counseling	**14**	**16**

The results of the priority ranking decisions reflect some changes from FY 2015, most often in response to the Affordable Care Act (ACA), needs arising from the changing insurance environment and improvements in substance abuse treatment. In keeping with its historic importance, Ambulatory/Outpatient Medical Care was assigned the highest priority. Oral Health Care (ranked #2), Mental Health Therapy (ranked #3) and Medical Case Management (ranked #4) were also given high priority as they were in FY 2015. Other core services considered important included AIDS Drug Assistance (ADAP and local ranked #6 and #6)) and Early Intervention Services (ranked #8). Importance ranking for Substance Abuse Counseling (ranked #15) was reduced in response to low priority placed on substance abuse treatment needs by consumers. This was a significant change from prior years where substance abuse treatment for

a community with persistent substance abuse issues was clearly recognized. The Planning Council's decision reflected trends toward lower HIV transmission rates by injecting drugs and declines in drug dependency among PLWHA. Support services with the highest priority ranking were Non-Medical Case Management (ranked #5) and Outreach (ranked #9). See Table 1 for other ranking decisions.

Priorities for MAI funded services differed somewhat from those in Part A. Non-medical Case Management (ranked #3) received highest priority behind Ambulatory/Outpatient Medical Care (ranked #1) and Mental Health Therapy (ranked #2). Support services, in general, received higher importance rankings, reflecting the needs of low income PLWH, many of whom are minorities. Housing Services (ranked #7), Emergency Financial Assistance (ranked #8) and Medical Transportation Services (ranked #9) were among the most important services identified by the Planning Council. Outreach (ranked #10) also reflected needs of minority populations at risk for HIV infection.

Part Two of the priority ranking process involved decisions about which services would be funded in FY 2016. The Planning Council again reviewed need and access data as well as HRSA's HIV Continuum of Care (HCC) memorandum advising Planning Councils to link funded service categories with those that supported the HCC.

All service categories approved in FY 2015 were again approved in FY 2016 with modest changes. Outreach/Health Education and Risk Reduction were separated, and Health Education and Risk Reduction would no longer be funded under Part A but would continue to be funded as an MAI service category in FY 2016. Emergency Financial Assistance was not funded because other service categories with capacity were seen as available. See Table 2.

Table 2
FY 2016 Funded Service Categories

FY 2016 Rank	Service Categories
	Part A Core Services
1	Ambulatory/Outpatient Medical Care
2	Oral Health Care
3	Mental Health Therapy and Counseling
4	Medical Case Management/Treatment Adherence
8	Early Intervention Services
15	Substance Abuse Services Outpatient
18	Health Insurance Premium & Cost Sharing Assistance

FY 2016 Rank	Service Categories
	Part A Support Services
5	Case Management - Non-medical/Non-medical incl. Treatment Adherence Counseling
9	Outreach Services/Health Ed. And Risk Reduction
10	Housing Services
11	Medical Transportation Services
13	Psychosocial Support Services
23	Food Bank/Home Delivered Meals
17	Legal Services/Permanency Planning
	MAI
3	Non-Medical Case Management
10	Outreach Services/ Health Education/Risk Reduction
18	Substance Abuse Services/Outpatient
22	Health Education/Risk Reduction

Funding decisions reflect the strong preference by the Planning Council to maintain the network of Part A and MAI providers with stable funding. Decisions also considered implications service needs implied by the HIV Care Continuum as recommended by HRSA in its memorandum of June 11, 2015. The Planning Council will fund eight of the twelve service categories identified by HRSA for Part A funding. The remaining four are available either from Part B funds (AIDS Pharmaceutical Assistance), government insurance programs (Home and Community-based Health Services, Home Health Care) or other Part A programs (Treatment Adherence Counseling).

In FY 2016, the Planning Council decided not to fund Emergency Financial Assistance (EFA), largely because it would be available as part of other funded service categories. The FY 2015 directive for EFA specified that funds could only be used to bridge temporary pharmaceutical needs resulting from insurance coverage gaps. Although the need for EFA should be met, in recognition of the fluid nature of new coverage plans, the Council directed the Grantee to monitor client needs and to return with a recommendation should EFA funding become necessary.

HRSA approved service categories that will not be funded FY 2016 along with rationales for excluding these service categories were based on their availability through other programs in the TGA, either within or outside of RWHAP, and are summarized in Table 3.

Table 3
Services Not Funded in FY 2016

Service Category	Rationale
Core Services	
AIDS Drug Assistance Program (ADAP)	Available through NJ-DHSTS Part B.
AIDS Local Pharmaceutical Assistance	Funding from ADAP considered adequate.
Home Health Care	Alternative programs available in the TGA, Medicare and Medicaid
Home and Community-based Health Services	Available through home health programs and Medicaid
Hospice Services	Alternative programs available through Medicare and Medicaid
Medical Nutrition Therapy	Provided with outpatient medical care
Support Services	
Child Care Services	Alternative programs available; low importance ranking
Developmental Services for HIV-positive Children	Program available through Part C/D
Pediatric Developmental Assessment Services	Program available through Part C/D
Emergency Financial Assistance	Assistance available through other Part A programs; future need will be monitored
Linguistic Services	Bi-lingual staff are required for all Part A programs as part of performance standards; other technology is available although future need will be monitored
Referral for health care/supportive services	Provided with Medical and Non-medical Case Management
Rehabilitation Services	Alternative programs available, Medicare and Medicaid
Respite Care	Alternative programs available
Substance Abuse - Residential	Covered under most insurance programs; cost prohibitive for RWHAP
Treatment Adherence Counseling	Provided with Ambulatory/Outpatient Medical Care and Medical Case Management

RESOURCE ALLOCATIONS

The RWHAP Part A and MAI resource allocations decisions for FY 2016 were adopted by the Planning Council on September 1, 2015. Allocations are shown in Table 4 below. Resource allocations reflect local needs for PLWHA as well as national priorities established by the National AIDS Strategy, HRSA directives and the ACA. The FY 2016 allocations comply with the legislative requirement to provide a minimum of 75% of Part A and MAI combined funds for core services. Rationales for the Planning Council's decisions are described beginning page 17.

Table 4
FY 2015 and FY 2016 Resource Allocations
RWHAP Part A and MAI Direct Services

Service Category	FY 2015 Allocation In Percent Part A and MAI Combined	FY 2016 Allocation in Percent Part A and MAI Combined
CORE		
Ambulatory/Outpatient Medical Care	14.72%	11.84%
Oral Health Care	17.96%	16.99%
Mental Health Therapy and Counseling	9.22%	5.04%
Medical Case Management	16.37%	16.15%
Early Intervention Services	2.25%	5.16%
Substance Abuse Services Outpatient	7.30%	11.34%
Health Insurance Premium & Cost Sharing Assistance	2.57%	3.09%
Total Part A Core	70.39%	69.61%
Substance Abuse Services Outpatient - MAI	4.62%	5.39%
Total Part A + MAI Core	75.01%	75.00%
SUPPORT		
Case Management - Non-medical	10.74%	10.90%
Outreach Services*	2.52%	2.50%
Housing Services	0.26%	0.20%
Medical Transportation Services	4.02%	3.53%
Emergency Financial Assistance	0.29%	0.00%
Psychosocial Support Services	0.45%	0.50%
Legal Services/Permanency Planning	0.82%	0.91%
Food Bank/Home Delivered Meals	2.01%	1.93%
Total Part A Support	21.11%	20.47%

Service Category	FY 2015 Allocation In Percent Part A and MAI Combined	FY 2016 Allocation in Percent Part A and MAI Combined
MAI		
Case Management - Non-medical	2.34%	2.72%
Outreach Services	1.42%	1.39%
Substance Abuse (See above)		
Health Education/Risk Reduction	0.12%	0.42%
Total Part A + MAI Support	24.99%	25.00%
Grand Total RWHAP	100.00%	100.0%

The FY 2016 results reflect the consensus of the Planning Council to approve:

- Increases for three core and two support services in Part A;
- Decreases for four core and five support services in Part A;
- An increase for three core services in MAI; and
- A decrease for one support service in MAI.

The most important changes reflect the impact of the Affordable Care Act (ACA) and availability of new insurance options. Reductions in Ambulatory/Outpatient Medical Care and Mental Health Therapy were justified by availability of other funds from the Medicaid Expansion Program in New Jersey and new insurance options. Second, in response to potential gaps the insurance coverages, funds for Health Insurance Premium & Cost Sharing were increased. Early Intervention Services (EIS) was increased to support efforts for HIV testing in the TGA.

Core and Support services, while changing slightly, remained relatively stable. Health Education/Risk Reduction (HERR) was increased with MAI to balance declines in Outreach Services which, together, respond to heightened emphasis on prevention and HIV testing. See Table 5.

Table 5
Changes in Resource Allocations
FY 2016

Increased	No Change or Not Funded	Decreased
Part A Core Services		
Early Intervention Services (from 2.25% to 5.16%)	AIDS Drug Assistance Program (ADAP)/AIDS Pharmaceutical Assistance (local)/Home & Community-based Health Services - not funded	Ambulatory/Outpatient Medical Care (from 14.72% to 11.84%)
Substance Abuse Treatment (from 7.30% to 11.34%)		Oral Health Care (from 17.96% to 16.99%)
Health Insurance Premium & Cost Sharing Assistance (from 2.57% to 3.09%)		Mental Health Counseling (from 9.22% to 5.04%)
		Medical Case Management (from 16.37% to16.15 %)
Part A Support Services		
Psychosocial Support Services (from 0.45% to 0.50%)	Emergency Financial Assistance – not funded from 0.29%	Non-Medical Case Management (from 10.74% to 10.09%)
Legal Services/Permanency Planning (from 0.82% to 0.91%)		Outreach Services (from 2.52% to 2.50%)
		Housing Services (from 0.26% to 0.20%)
		Medical Transportation Services (from 4.02% to 3.53%)
		Food Bank/Home Delivered Meals (from to 2.01% to 1.93%)
MAI		
Non-Medical Case Management (from 2.34% to 2.72%)		Outreach Services (from 1.42% to 1.39%)
Substance Abuse Treatment (from 4.62% to 5.39%)		
Health Education/Risk Reduction (from 0.12% to 0.42%)		

At the conclusion of the voting process, it was clear to the Planning Council that results would be able to support the 75/25 requirement with some minor adjustments. To accommodate their decision to comply with the requirement rather than authorize a waiver application, adjustments in core/support percentages were identified and approved through a series of motions from the floor. The changes in percentages were not significant, and the monetary impact would be manageable as MAI represents a small portion of the total RWHAP award.

Each service category is discussed further as follows, in the order they were ranked.

Core Services

Ambulatory/Outpatient Medical Care is the first priority of RWHAP Part A Program and will receive 11.84% of RWHAP funding, a reduction from 14.72% in FY 2015. As Medicaid expansion rolls out in New Jersey, more patients have transitioned from RWHAP to Medicaid coverage; therefore, the Part A allocation could be reduced without loss of services.

Funds will be used to (1) meet ongoing need, as indicated by current utilization data; (2) respond to anticipated volume increases from outreach and early intervention efforts; (3) address the rising costs of providing medical care and lab tests; and (4) meet the medical needs of aging PLWHA.

Oral Health Care will decline from 17.96% in FY 2015 to 16.99% in FY 2016. This decision despite continued demand for this service and consumers' response to the 2013-2014 Consumer Survey is justified as Medicaid coverage increases. Further, as the ACA does not address oral health care, demand for this service is expected to remain consistent. Patients with private insurance may not be covered; thus, their needs may be met only through RWHAP.

Mental Health Therapy and Counseling will be decreased from 9.22% in FY 2014 to 5.04% FY 2016. The Council recognizes the need for mental health services to respond to emotional problems arising from co-morbidities, longer life expectancies and added stress of living with HIV/AIDS. Information from the 2009 focus groups and the 2013 out-of-care interviews indicated a need for "emotional supports" that can be provided through mental health counseling/therapy. Mental health treatment helps to engage the newly diagnosed and to maintain adherence to medical regimens. Nevertheless, expanded Medicaid coverage in FY 2016 are expected to reduce the financial burdens of the Part A program, thereby justifying a reduced allocation.

Medical Case Management will be reduced slightly from 16.37% in FY 2015 to 16.15% in FY 2016. The Council's decision is based on the ongoing emphasis on engagement and retention into care and the critical role of the medical case manager in meeting the goals of the FY 2016 Plan. Case managers will be called upon to assist RWHAP recipients with the transition to other insurance plans made available by the ACA. A newly identified emphasis on health literacy in FY 2016 will further case management responsibilities.

Early Intervention Services will be increased substantially from 2.25% in FY 2015 to 5.16% in FY 2016. This service category responds to President Obama's National AIDS Strategy and HRSA's initiative to address engagement and linkage of newly diagnosed PLWHA. Programs are being developed and/or expanded in FY 2016 to support the HIV Continuum of Care, particularly testing, referral and engagement in medical care.

Substance Abuse Treatment will increase from 7.30% in FY 2015 to 11.34% in FY 2016 for Part A. This increase recognizes consistently high need for substance abuse treatment in this TGA, particularly among persons of color. MAI allocations will increase from 4.62% in FY 2015 to 5.39% in FY 2016. MAI funds will be targeted to African-American and Hispanic PLWHA.

Health Insurance Premium & Cost Sharing Assistance will increase from 0.99% in FY 2015 to 2.57% in FY 2016. As a newly funded service, future utilization is expected to increase. Persons experiencing changes in insurance coverage are likely to see changes in co-pays and deductibles as well. Therefore, the Planning Council decided to increase this allocation and to monitor utilization going forward.

Support Services

Non-Medical Case Management will decline slightly from 10.74% in FY 2015 to 10.09% in FY 2016. Non-medical case managers will play an important role of assisting PLWHA in meeting new requirements of the ACA. In recognition of this, the Planning Council allocated 2.72% in MAI funds to non-medical case management targeted to African-Americans and Hispanic PLWH in addition to 10.09% of Part A funds.

Outreach Services/Health Education and Risk Reduction will decrease slightly from 2.52% in FY 2015 to 2.50% in FY 2016. This small decreased will be balanced by an increase in Health Education/Risk Reduction, a closely related service category. In addition, 1.39% of MAI funds will be allocated to this service category to support efforts to increase testing for individuals at risk for HIV. MAI funds for this service category will be targeted to African-American and Hispanic PLWHA.

Housing Services will decrease slightly from 0.26% in FY 2015 to 0.20% in FY 2016. HOPWA is the principal source of housing assistance, and it has proven effective as an alternative funding stream. As a result, the need for Part A funds is relatively small. However, as a stable housing situation is critical to retention in medical care, the Council believes that a small allocation is justified in the short-term for services not available from HOPWA.

Medical Transportation Services will be reduced slightly from 4.02% in FY 2014 to 3.53% in FY 2016. The centralized transportation system now in place emphasizes van service as the preferred modality. Bus passes and vouchers, while proven not as effective, will continue to be offered. Medicaid provides transportation assistance, thereby justifying the slightly lower allocation of Part A funds.

Emergency Financial Assistance will not be funded in FY 2016. In FY 2015, the Planning Council provided a small allocation to cover emergency pharmaceutical coverage. As this services will be provided through Health Insurance Premium & Cost Sharing Assistance, the Planning Council did not feel additional funding for EFA was justified. However, the Planning Council asked the Grantee to monitor service needs for other EFA components and report if situations change in FY 2016.

Psychosocial Support Services will increase slightly from 0.45% in FY 2015 to 0.50% in FY 2016. This service is considered necessary to maintain the effective support groups not available elsewhere in the TGA as well as support groups recommended in the FY 2016 EIIHA Plan.

Legal Services/Permanency Planning will increase slightly from 0.82% in FY 2015 to 0.91% FY 2016. This decision to fund this service was made in light of continued demand and the need to support PLWHA who are experiencing significant legal barriers to obtaining long term benefits.

Food Bank/Home Delivered Meals will be reduced slightly from 2.01% in FY 2015 to 1.93% FY 2016. This decision recognizes the ongoing need for food and dwindling community resources in the TGA. However, as HOPWA funds are available for food, a small decreased was justified.

MAI

Non-Medical Case Management will be increased from 2.34% of RWHAP funds in FY 2015 to 2.72% in FY 2016. As Medical Case Management will receive reduced support in FY 2016, this increase was made to balance the 75/25 requirement of core and support services. MAI funds for non-medical case management will be targeted to African-American and Hispanic PLWH .

Substance Abuse Treatment will increase from 4.62% of RWHAP funds in FY 2015 to 5.39% in FY 2016. This decision was made to support the 75/25 requirement for core services. MAI funds will be targeted to African-American and Hispanic PLWHA.

Outreach Services will decline slightly from 1.42% of RHWAP funds in FY 2015 to 1.39% in FY 2016. This decision was made in light of increased funding for Health Education and Risk Reduction (HERR) in FY 2016. Both Outreach and HERR are closely aligned, and funding is expected to complement both service categories. This service category will be targeted to African-American and Hispanic PLWH.

Health Education and Risk Reduction (HERR). HERR will be increased from 0.12% to 0.42% of RWHAP funds in FY 2016. This allocation is expected to balance slight reductions in Outreach, a closely related service category.

V. DIRECTIVES TO THE GRANTEE

Specific recommendations were provided to the Grantee for all service categories combined and for each individually. Directives focused on funding practices as well as steps to support the National AIDS Strategy, HRSA priorities, the ACA, the Comprehensive HIV Health Services Plan, the EIIHA Plan, the Quality Management Plan and administrative mechanism requirements.

FY 2016 DIRECTIVES TO THE GRANTEE

GLOBAL DIRECTIVES

1. Continue to correlate Part A services with requirements of the Affordable Care Act. Identify, monitor and track insurance access issues. Develop strategies to address emerging gaps in services that may result from implementation of the Act. Provide feedback on how providers are negotiating services to match the Affordable Care Act and identify emerging gaps.
2. Continue to direct sub-grantees to require new enrollees in Part A and MAI services to complete the needs assessment consumer survey, and tie this requirement to billing.
3. Work with the Planning Council to prioritize and establish/update all approved standards of care, and develop a policy and procedures manual beginning with medical and non-medical case management, primary medical care and substance abuse treatment. Work with the Planning Council to post on its website all approved standards of care with effective date of implementation within one month of adoption.
4. The Grantee shall provide a semi-annual written or oral report on progress with implementation of the Comprehensive HIV Health Services Plan, the EIIHA Plan and the Quality Management Plan as pertains to Grantee's responsibilities. This report shall be undertaken in concert with quarterly progress reviews by the Planning & Development Committee, included in the annual report to the Planning Council, discussed at scheduled grantee meetings, and available to Steering Committee in advance of the Administrative Mechanism Review.
5. The Grantee shall submit a Semi-annual Report on January and July to the Steering Committee, the Planning & Development Committee and the Planning Council on the effectiveness and compliance of the Planning Council's directives. This narrative report shall provide specific documented evidence of compliance with each of the bulleted directives. This report shall be incorporated into the Council's Priority Setting Process as well as the Administrative Mechanism Review.
6. Conduct two provider and two consumer meetings per year to foster communication between the grantee's office and the Planning Council.
7. Continue to encourage sub-grantees to offer Health Insurance Premium & Cost Sharing in coordination with the core services.
8. Establish goals to support the HIV Care Continuum in the Bergen-Passaic TGA, moving toward achievement of sustainable viral suppression. The Grantee will disseminate information on progress made in concert with the Quality Management Team and Planning Council sponsored collaboratives. Work in partnership with the Planning Council to utilize the HIV Care Continuum for planning purposes.
9. Help implement the Planning Council's health literacy plan when approved by the Planning Council.

SERVICE CATEGORY DIRECTIVES

Core Services	
Early Intervention Services	• Continue to encourage EIS sub-grantees to work with Patient Navigator Programs to achieve linkage to care within 24 hours or next business day following preliminary positive test result. • When necessary, EIS providers should access facilities that have the capacity to offer services in a language the consumer understands.
Health Insurance Premium & Cost Sharing	• Provide technical assistance for all sub-grantees who provide this service. • Develop standards for HIP&CS with the Planning Council.
Medical Case Management	• Determine the need for evaluating the primary case management system as directed in the Comprehensive Plan (Goal II, Objective 4).
Support Services	
Outreach	• Continue to direct funding for outreach services within the EIIHA target populations and communities. • Continue to coordinate quarterly meetings to facilitate outreach to the EIIHA target populations. • Address contract monitoring deficiencies as related to bi-lingual outreach personnel.
Health Education and Risk Reduction	• Continue to direct funding for health education and risk reduction within the EIIHA target populations and communities. • Continue to coordinate quarterly meetings to facilitate HERR to the EIIHA target populations.
Housing Services	• Continue to provide housing assistance only to those persons who are not eligible for HOPWA assistance and/or when HOPWA funds are not available.
Medical Transportation Services	• Encourage sub-grantees to dedicate up to 5% of the total medical transportation funds for needed off-hour services.
Emergency Financial Assistance	• Monitor gaps in services that appear to come under EFA, and advise the Planning Council on future needs for priority setting decisions.

VI. CONTINGENCY SCENARIOS

In the event that FY 2016 funding levels significantly change from the prior fiscal year, the Planning Council determined the following course of action.

Scenario 1: If funding is up to 20% (+/-) of the FY 2013 award, the Grantee will distribute funds proportionately in accordance with percentages established by the Planning Council.

Scenario 2: If funding is increased or decreased by more than 20%, the Planning Council will convene to revise the previously established allocations.

EXHIBIT A
Abbreviations Used in This Report

ACA	Affordable Care Act
ACCAP	AIDS Community Care Alternatives Program
ADAP	AIDS Drug Assistance Program
CARS	Client Acuity Rating System
EIIHA	Early Identification of Individuals with HIV/AIDs
EIS	Early Intervention Services
FY	Fiscal Year
HERR	Health Education and Risk Reduction
HIP&CS	Health Insurance Premium and Cost Sharing
HIV	Human Immunodeficiency Virus
HOPWA	Housing for People with AIDS
HRSA	U.S. Department of Health & Human Services, Health Resources & Services Administration
MAI	Minority AIDS Initiative
MSM	Men who have sex with men
PLWHA	Persons Living with HIV/AIDS
RWHAP	Ryan White HIV/AIDS Program
SCSN	Statewide Coordinated Statement of Need
TGA	Transitional Grant Area

EXHIBIT B
Priority Ranking Worksheet

Part A		
This service rates the importance of maintaining engagement or providing access to HIV medical care.		
Core Services	**Score**	**FY 2016 Rank 1**
Ambulatory/Outpatient Medical Care	0.89	1
Oral Health Care	0.65	2
Mental Health Therapy and Counseling	0.64	3
Medical Case Management	0.62	4
Case Management - Non-medical	0.57	1
AIDS Drug Assistance Program (ADAP)	0.53	5
Early Intervention Services	0.50	7
AIDS Local Pharmaceutical Assistance (local)	0.50	6
Outreach Services	0.50	3
Housing Services	0.50	2
Medical Transportation Services	0.47	5
Emergency Financial Assistance	0.47	4
Psychosocial Support Services	0.41	6
Treatment Adherence Counseling	0.40	7
Substance Abuse Services Outpatient	0.38	8
Legal Services/Permanency Planning	0.35	8
Home Health Care	0.35	9
Health Insurance Premium & Cost Sharing Assistance	0.32	10
Referral for Health Care/Supportive Services	0.30	9
Hospice Services	0.30	11
Health Education/Risk Reduction	0.29	10
Home and Community-based Health Services	0.25	12
Food Bank/Home Delivered Meals	0.22	11
Medical Nutrition Therapy	0.21	13
Substance Abuse Services - Residential	0.21	12
Rehabilitation Services	0.20	14
Child Care Services	0.20	13
Linguistic Services	0.15	15
Respite Care	0.05	16
~~Pediatric Development Assessment and Early Intervention Services~~	0.00	17
~~Permanency Planning~~	0.00	18

MAI		
This service rates the importance of maintaining engagement or providing access to HIV medical care.		
Core Services	**Score**	**Rank 1**
Ambulatory/Outpatient Medical Care	0.89	1
Mental Health Therapy and Counseling	0.71	2
Case Management - Non-medical	0.71	1
Medical Case Management	0.62	3
Oral Health Care	0.61	4
Early Intervention Services	0.50	5
Housing Services	0.50	2
Medical Transportation Services	0.47	4
Emergency Financial Assistance	0.47	3
Outreach Services	0.43	5
Psychosocial Support Services	0.41	6
Referral for Health Care/Supportive Services	0.40	7
AIDS Local Pharmaceutical Assistance (local)	0.39	7
AIDS Drug Assistance Program (ADAP)	0.39	6
Legal Services/Permanency Planning	0.35	8
Treatment Adherence Counseling	0.35	9
Food Bank/Home Delivered Meals	0.32	10
Substance Abuse Services Outpatient	0.31	8
Medical Nutrition Therapy	0.28	9
Health Insurance Premium & Cost Sharing Assistance	0.26	10
Home and Community-based Health Services	0.25	11
Health Education/Risk Reduction	0.24	11
Home Health Care	0.20	12
Rehabilitation Services	0.16	12
Substance Abuse Services - Residential	0.16	13
Child Care Services	0.15	14
Hospice Services	0.10	13
Respite Care	0.10	16
Linguistic Services	0.10	15
~~Pediatric Development Assessment and Early Intervention Services~~	0.00	
~~Permanency Planning~~	0.00	

EXHIBIT C
Resource Allocation Worksheet

Service Category	FY 2015 Allocation In Percent Part A and MAI Combined	FY 2016 Allocation In Percent Part A and MAI Combined	FY 2016 Proposed Adjustments	Proposed FY 2016 Allocation in Percent Part A and MAI Combined
CORE				
Ambulatory/Outpatient Medical Care	14.72%	11.84%		11.84%
Oral Health Care	17.96%	16.99%		16.99%
Mental Health Therapy and Counseling	9.22%	5.04%		5.04%
Medical Case Management	16.37%	16.15%		16.15%
Early Intervention Services	2.25%	2.19%	+2.97%	5.16%
Substance Abuse Services Outpatient	7.30%	11.34%		11.34%
Health Insurance Premium & Cost Sharing Assistance	2.57%	2.77%	+0.32%	3.09%
Total Part A Core	70.39%	66.32%		69.61%
Substance Abuse Services Outpatient - MAI	4.62%	5.39%		5.39%
Total Part A + MAI Core	75.01%	71.71%		75.00%
SUPPORT				
Case Management - Non-medical	10.74%	11.96%	-1.06%	10.90%
Outreach Services*	2.52%	4.32%	-1.82%	2.50%
Housing Services	0.26%	0.29%	-0.09%	0.20%
Medical Transportation Services	4.02%	3.53%		3.53%
Emergency Financial Assistance	0.29%	0.32%	-0.32%	0.00%
Psychosocial Support Services	0.45%	0.50%		0.50%
Legal Services/Permanency Planning	0.82%	0.91%		0.91%
Food Bank/Home Delivered Meals	2.01%	1.93%		1.93%
Total Part A Support	21.11%	23.76%		20.47%
MAI				
Case Management - Non-medical	2.34%	2.72%		2.72%
Outreach Services	1.42%	1.39%		1.39%
Substance Abuse (See above)				
Health Education/Risk Reduction	0.12%	0.42%		0.42%
Total Part A + MAI Support	24.99%	28.29%		25.00%
Grand Total RWHAP	100.00%	100.00%		100.0%