

Sample Approaches for Resource Allocations

Approach 1

Divide priorities into tiers of services and other activities, as follows:

- First-tier categories that are considered “core” or “essential” services, including the most important core services and the most important support services.
- Second-tier priorities that should be funded if funds permit.
- Third-tier categories that should not receive funding this year, unless the program receives a funding increase.

Start by using Approach #1 (the flat funding scenario). First allocate the funds needed to ensure continuation of first-tier services for the same number of clients as the current year, if continued funding is needed. Once these “essential” services have received needed funding, allocate a specified proportion of additional expected funds (e.g., 60 percent) to second-tier service categories, deciding on amounts per category based on number of clients to be served and costs per client. Divide funds among categories based on your priorities and needs assessment results. Use the remaining funds to expand funding for first-tier categories towards the estimated total need. When you use the second increased funding scenario, first increase first-tier service categories to fill identified service gaps, then allocate funds to the second-tier services using the same allocations procedure as before. See how much money is left, and decide which, if any, of the third-tier categories to fund. When you use the third (decreased funding) scenario, consider which second-tier categories you may want to zero-fund in order to maintain essential services.

Approach 2

Using the first (flat funding) approach, decide which services are most important — perhaps your first 5-7 categories), and begin by allocating full needed funding to those categories. Determine how much funding remains, and allocate it to other prioritized services based on the number of people you need to serve in each service category and the cost per client per year. Under this scenario, you will provide most of your funding to the service categories you define as “essential,” and therefore will fund fewer service categories. Under the increased funding scenario, you will add service categories to the funding list. Under the decreased funding scenario, you will eliminate additional categories.

Approach 3

Continue to fund at the same level those services with high priority rankings, or those identified in the continuum of care as essential to life or essential to providing access to care. Cut other services by a specified percent (e.g., 21 percent). Use the pool of funds created by the cuts to fund new priorities or unmet components of high-priority service categories (e.g., substance abuse treatment services for women, medical case management services for Spanish-speaking PLWHA, ambulatory medical care in an outlying county). If the funding level is higher than expected, a set percentage of increased funds might go to new services, high-priority existing

services, and lower-priority existing services. If the funding level is lower, a set percentage in cuts might be applied across all services, or smaller cuts to high priority services.

Approach 4

Divide services into tiers as in Scenario #1. Continue to fund existing services in first and second tier, but decrease funding levels for second-tier services. Base these reductions on a careful review to identify services that are lower in priority, level of unmet need or service gap, and/or availability of other resources. Make sufficient cuts to generate a pool of \$X dollars to allocate to new service priorities and to increase allocations to specific high-priority services that have high levels of unmet need and low availability of other resources.

In any scenario or approach, the highest-priority services within the EMA/TGA are not always the services that receive the largest allocations. The highest-priority services may cost less than other services and/or other Ryan White or non-Ryan White resources may be available to fund them. A Ryan White Part A program might, for example, identify ADAP as its number two service priority, but allocate little or no Ryan White Part A funding to the service category because sufficient funds are available through the State's Ryan White Part A program. With the expected expansion of Medicaid in some states and establishment of health insurance exchanges in all states as of 2014, planning bodies may find that they will need to allocate less funding for outpatient/ambulatory medical care, ADAP, and other service categories covered through these programs. Similarly, a service category that is relatively lower priority but is not funded through other available grant funding streams or included in Medicaid or private health insurance might be allocated a larger proportion of Ryan White funds. See also the chapter on Planning Council Operations in this manual.

This approach to priority setting and resource allocation has the advantage that it applies regardless of changes in other funding streams. For example, if severe cuts were to occur in other funding for outpatient primary health care, the planning body would reallocate some of its resources. Similarly, if the demand for medications grew beyond the Part B State ADAP's capacity to meet it, a planning body might choose to allocate additional funds for ADAP rather than other services.

Resource allocations are best made at a full planning body meeting. As with priority setting, it is helpful for a committee to present data on service needs and costs and make recommendations for service categories in particular need of increases, as well as categories where funds were underspent the prior year. The committee may make recommendations about resource allocations, and may ask the grantee to provide recommendations as well. Often, the committee and grantee provide their input, and the full planning body uses the three funding-level scenarios to do the allocations at an open meeting. Principles, criteria, needs and resource data, and the selected scenarios and approach should be presented and discussed at the beginning of the meeting. The full planning body reviews the information provided and recommendations made, and then does the final allocations using the agreed-upon process. It is important that the planning body discuss allocations choices and underlying data, based on the criteria and the needs and resource information. The planning body either reaches consensus on the resource allocations, or adopts them through a formal vote. Usually, votes are done for all groups of

service categories – such as all core services or all support services – but individual votes may also be taken for a single service category.

Staff document the resource allocation process and decisions along with the priority setting process and results (See Step 1 for a sample format for documentation). Once this process is completed, these priority setting and resource allocation decisions are reported to the community. The planning body publicizes its decisions through its own meetings and often through public hearings or meetings in several locations. Since the allocations are likely to be refined after the Ryan White Part A award is made and the precise funding level is known, some Ryan White Part A programs wait to present their allocations until after they have been finalized.

9. Provide decisions to the grantee for use in the application and procurement.

The planning body must provide the grantee or administrative agent with the results of the priority setting and resource allocation process, both to include in the Ryan White Part A application and as a basis for the selection of providers (the procurement process). The planning body's priorities and accompanying directives on how best to meet the priorities will reflect specific population groups, geographic areas, and service delivery mechanisms. As noted previously, the grantee handles procurement. The planning council must not be involved in the selection of providers.

10. Identify areas of uncertainty and needed improvement.

Once the entire process has been completed for the year, the committee and the full planning body should review the experience and identify ways to improve the process in future years. A designated group should:

- Obtain written or oral feedback from the responsible committee and the full planning body.
- Identify missing or incomplete information that affected decision making, with emphasis on recent legislative requirements, policies, or guidelines.
- Review the decision-making process for weaknesses or problems and seek solutions, with special attention to any aspects of the process that might make the planning body vulnerable to a grievance.
- Review how conflict of interest was managed, and whether additional efforts are required.
- Make recommendations and plans for improvement, then assign responsibility for follow up to be sure they are carried out in the following year's PSRA process.

11. Reallocate funds across service categories as needed.

Allocations happen before the annual Ryan White Part A application is submitted. Reallocation occurs after funds have been awarded, often at several times during the program year.

The Planning Council almost always needs to do some. The first occurs when the EMA/TGA gets its Notice of Grant Award from HRSA/HAB. Usually the amount will not be precisely what

was requested. Often, the Planning Council will need to make some adjustments to its allocations to fit the actual funding received, using the appropriate funding scenario.

Additional reallocation is generally needed during the program year. Under the 2009 Ryan White legislation, the EMA/TGA will lose future funding if it does not spend at least 95% of its formula grant. This means that the grantee must very carefully monitor provider expenditures. If it becomes clear that one provider cannot spend all the funds, the grantee has the authority to reallocate funds within the service category. But if more funds are needed in a different service category, the grantee must come back to the planning body and get its approval for reallocating funds to a different category. The grantee will often provide recommendations, but the planning body should review them and available cost and utilization data and then vote on reallocations.

Because of the need to ensure that all funds are spent, the planning body needs a *rapid reallocation process* to use in the last several months of the program year, to help the grantee ensure that funds are fully spent. This may mean calling special committee or full planning body meetings on short notice. Sometimes the planning body has a policy that allows the grantee to reallocate up to a specified percentage of total service dollars (e.g., 3% or 5%) without its prior approval during the last 3-4 months of the program year. Sometimes there is prior agreement about how funds may be moved if they become available, so the grantee can act quickly once it knows how much money needs to be reallocated. This process must be worked out between the grantee and planning council.

XI. Ch 5. Comprehensive Plan

Introduction

Planning is central to the Ryan White HIV/AIDS Program's focus on local and State decision making in developing HIV/AIDS care systems. Each grant year, Ryan White Part A planning councils establish service and resource-allocation priorities and implementation plans to address them. Comprehensive HIV services planning goes beyond this annual process and provides a road map for developing and improving a comprehensive and responsive system of care over time. It provides an opportunity for the planning council to step back from short-term tasks to review the current system of care and envision an "ideal" system of care, then develop a three-year plan for working towards it, based on a Guidance provided by HRSA/HAB. It does so by reviewing epidemiologic, needs assessment, and client utilization data; data on individuals who know their status but are not in care and HIV-positive individuals unaware of their status; existing resources to meet those needs; and barriers to care; and consulting with the community to obtain their perspectives about the system of care. Additional useful information to review includes performance measure and evaluation data (including data on cost effectiveness and outcome effectiveness of services) and contract monitoring data.

This information is used to set out long-term goals, objectives, and strategies for delivering services and improving the system of care. The plan reflects the community's vision and values about how best to deliver HIV/AIDS care, particularly in light of increasing numbers of PLWHA entering care, more PLWHA needing care over many years due to improved treatments, and limited resources.