Priority Setting and Resource Allocation

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Training Objectives

Following the training, participants will be able to:

PSRA Importance and Context:

1. Explain the 4 components of PSRA as specified in the RWHAP legislation
2. Identify at least 5 HRSA/HAB expectations for the PSRA process

Priority Setting, Resource Allocation, and Directives:

3. Describe suggested steps in priority setting
4. Describe suggested steps in resource allocation

Training Objectives (cont.)

Implementing PSRA:

6. Describe how CARE Council can manage conflict of interest (COI) in PSRA
7. Explain the role of the recipient in PSRA

Reallocation:

9. Explain the importance of reallocation
10. List 5 steps in managing the reallocation process

PSRA Importance and Context

Legislative Language on PSRA

DUTIES

The CARE Council shall:

> ***"establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a grantee should consider in allocating funds under a grant"***

§2602(b)(4)(C)

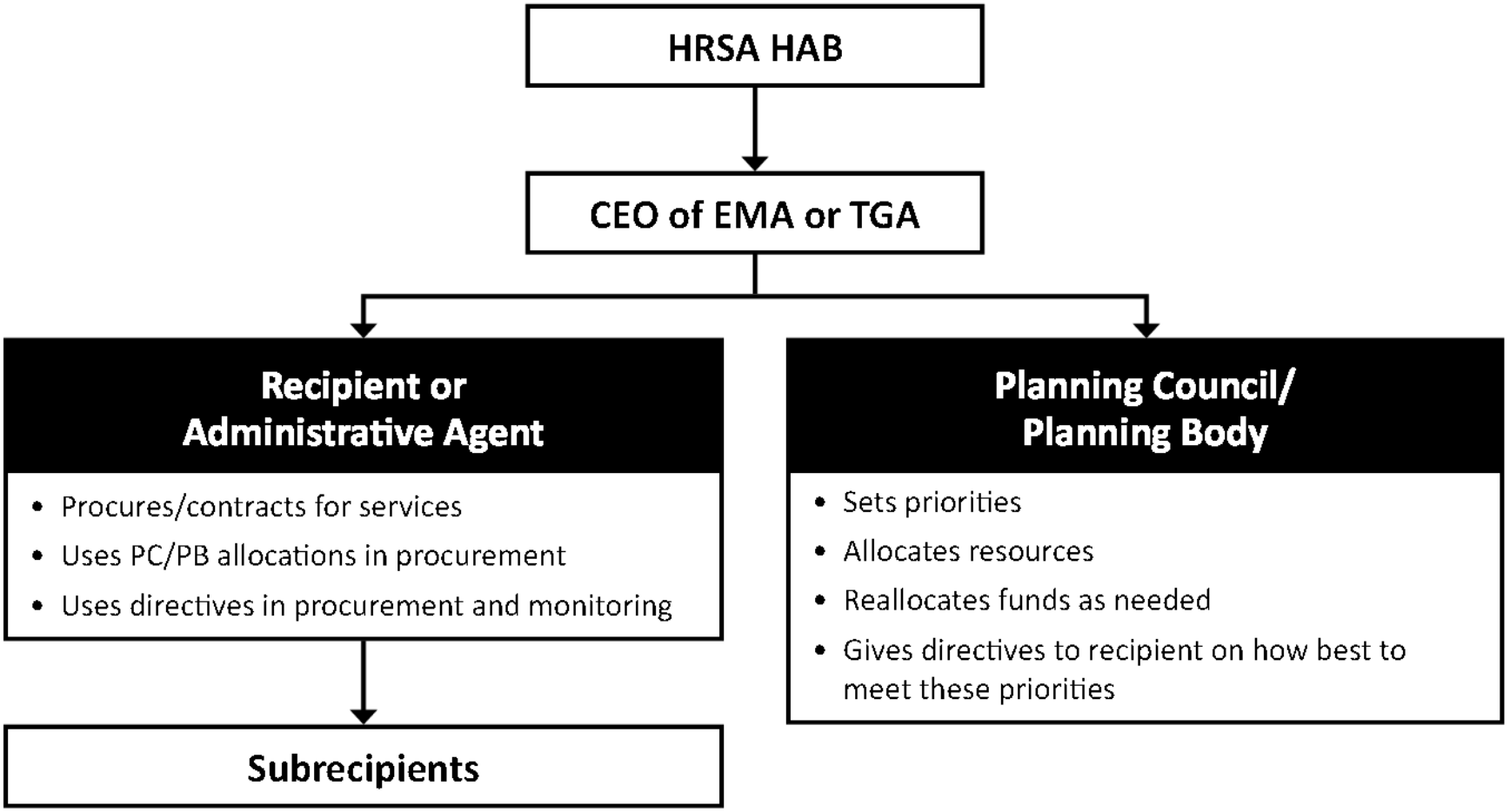
PSRA: CARE Council Responsibility

- **CARE Council** is *the decision maker* about the use of RWHAP Part A program funds – at least 85% of the total grant award
  - Recipient must manage procurement so that funds are spent on services in the amounts determined by the CARE Council
  - Funds can be moved among service categories only with CARE Council approval
- **CARE Council** sets priorities and *recommends* allocations and directives to the recipient

HRSA/HAB Expectations for PSRA

- The entire CARE Council participates actively in decisions about priority setting and resource allocation
- Decisions are made based on data, not anecdotal information or “impassioned pleas”
- Meetings are open, but practices regarding public comment vary, and only CARE Council members vote
- Conflict of interest is managed
- Both the actual process and results of PRSA are documented in writing

PSRA: The PC/PB's Most Important Role



Components of PSRA

1. Priority setting
2. Resource allocation
3. Reallocation (as needed during the program year)
4. Development of directives – *"how best to meet each priority"*

…all based on needs assessment and recipient data, obtained and analyzed throughout the year

Priority Setting

The process of deciding which HIV/AIDS services are the most important in providing a comprehensive system of care for all PLWH in the EMA

HRSA/HAB Expectations for Priority Setting

- Priority is based on the importance of services to diverse PWH living in the EMA– which services should be a part of the comprehensive system of quality care
- Decisions on priorities should not consider sources or amounts of funding for these services
  - Even if the CARE Council cannot fund all prioritized services, additional resources could become available – or other funding for an important service might be lost
  - A CARE Council should never allocate funds to a service category that is not prioritized

Sound Practices in Priority Setting

- Set priorities after the annual Data Presentation
- Prioritize each of the 28 service categories that is important to PWH in your EMA– exclude only services that are not needed
- Begin with current year's priorities and revise from there – some EMAs do a full "reprioritization" every 3-4 years and a review and updating in between

Directives

Directives are the CARE Council's guidance to the recipient on "how best to meet each such priority and additional factors" to consider in procurement.

Develop Directives Before Resource Allocation

Directives can be developed year-round but are best completed and adopted prior to resource allocation because they often have fiscal implications:

- The cost of implementing a directive needs to be included in the allocation for the affected service category
- Adding funds to one category may require reducing funds for other categories – best done as part of the allocation process

Directives: Purposes and Examples 1

1. **Ensuring availability of services in all parts of the EMA or in a particular county or area**

   Examples:

   - PLWH located in all three regions of the EMA must be able to obtain outpatient ambulatory health services (HIV-related medical care) within their region or less than 5 miles outside it
   - Mental health services must be available in Outlying County A

Directives: Purposes and Examples 2

2. **Ensuring services appropriate for specific target populations**

   Examples:

   - Core medical service providers must have bilingual Spanish-English staff in positions with direct client contact, including clinical staff
   - Each service provider in the EMA must be qualified to provide culturally appropriate services to young MSM of color

Directives: Purposes and Examples 3

3. **Overcoming barriers that reduce access to care**

   Examples:

   - Every funded outpatient ambulatory health services (OAHS) provider and medical case management provider must offer services at least one evening each week or one weekend day each month
   - Transportation must be made available to PLWH who are unwilling to obtain care in their own communities due to fear of exposure and stigma, and who require such assistance so they can access care in another location within the EMA

Directives: Purposes and Examples 4

4. **Calling for the testing or broader use of a particular service model**

   Examples:

   - At least one medical provider will receive funds to test a Rapid Response linkage to care model, designed to ensure that newly diagnosed PLWH clients have their first medical visit within 72 hours after receiving a positive test result
   - All medical case management providers will ensure that at least one case manager completes recipient-approved geriatric training on a refined case management model for older PLWH

HRSA/HAB Expectations – Directives Should:

- **Address a documented need,** often using data/analyses based on information from:
  - **Needs assessment** – service gaps or problems identified by consumers or providers
  - **HIV care continuum** – disparities in linkage to care, retention, and/or viral suppression among specific PLWH populations
  - **Service utilization** – disparities in use of particular service categories by different PLWH populations
  - **Clinical Quality Management** – changes in service models that improve patient care, health outcomes, and patient satisfaction

HRSA/HAB Expectations (cont.) – Directives Should:

- **Be explored and developed as needed throughout the year** – often with the involvement of several committees, such as the following:
  - Needs Assessment and Planning
  - Care Strategy/System of Care
  - Consumer/Community Access
  - Priority Setting and Resource Allocation
- **Be presented in relation to the PSRA process**, since they often have financial & procurement implications
- **Be approved by the full** CARE Council**,** along with or separate from resource allocations

HRSA/HAB Expectations – Directives Must Not:

- **Have the effect of limiting open procurement by making only 1-2 providers eligible**

  Examples:

  - **OK:** Mental health services must be provided by clinicians that can demonstrate expertise in serving people living with HIV
  - **Not OK:** Mental health services must be provided by organizations with prior RWHAP experience

In Developing Directives, CARE Council should:

- **Work with the recipient to explore cost implications**

  Example:

  To improve retention of employed PWH, the CARE Council wants to require OAHS and medical case management providers to have evening or weekend hours

  - **Cost implications:** Adding evening or weekend hours adds costs for staff and for keeping the facility open longer
  - **Funding implications:** Implementing this directive will require adding funds to OAHS and medical case management or serving fewer people in these service categories

After a Directive is Approved

- Recipient must follow directives in procurement and contracting but cannot always guarantee full success

  Example:

  - Recipient puts out a request for proposals but receives no qualified responses

- Recipient should be asked to provide updates on implementation of directives
- CARE Council and recipient should work together to assess the results and value of the directive

Resource Allocation

The process of deciding how much RWHAP Part A funding to provide for each prioritized service priority

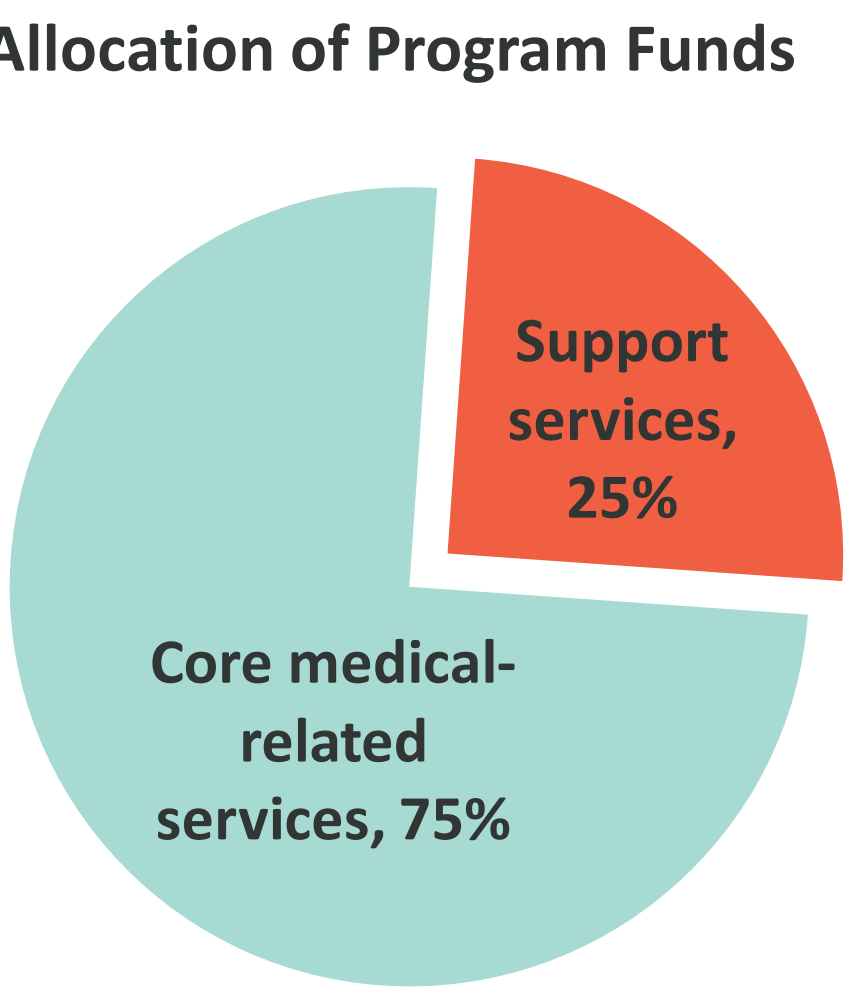
HRSA/HAB Expectations for Resource Allocation

- Funds may be allocated only to prioritized service categories
- Recipient provides data and advice, but the CARE Council is the decision maker
- Must use a fair, data-based process that manages conflict of interest
- Process must be documented in writing and followed consistently – otherwise affected parties may file a grievance against the CARE Council

HRSA/HAB Expectations for Resource Allocation (cont.)

- A committee may do the initial work, but:
  - The entire CARE Council should participate in the data presentation
  - Allocation recommendations from a committee must be reviewed, actively discussed, and approved by the entire CARE Council
  - Only CARE Council members may vote on allocations
- At least 75% of program funds must be allocated to core medical-related services, unless the EMA obtains a waiver from HRSA/HAB

Allocation and Use of Part A Funds [Without a Waiver]



Core Medical-Related Services

- ADAP
- Local Pharm Assistance Program
- Early Intervention Services
- Health Insur Premium and
- Cost-Sharing Assistance
- Home & Community-based Health Services
- Home Health Care
- Hospice
- Medical Case Management
- Med Nutrition Therapy
- Mental Health Services
- Oral Health Care
- Outpat/Ambulatory Health Services
- Substance Abuse Outpatient Care

Support Services

- Child Care Services
- Emergency Financial Assistance
- Food Bank/Home-Deliv Meals
- Health Educ/Risk Reduction
- Housing
- Linguistic Services
- Medical Transportation
- Non-Med Case Management
- Other Professional Services
- Outreach Services
- Psychosocial Support Services
- Referral for Healthcare &
- Support Services
- Rehabilitation Services
- Respite Care
- Substance Abuse Servs (Resid)

Approaching Resource Allocation

- Process must be data based, and should consider:
  - Number and characteristics of clients in each service category last year and demand in current year
  - PWH needs assessment data on service needs and gaps
  - Cost per client for each service category
  - Funds provided through other funding streams
  - Plans for bringing additional PLWH into care

Approaching Resource Allocation

- Some highly ranked service categories may receive little or no funding because:
  - Needed funds are provided by other funding sources – for example, RWHAP Part B may meet need for HIV-related medications through ADAP
  - Some services are needed by a small subset of PLWH – for example, linguistic services
  - Some services involve relatively low costs – for example, child care
- Allocations are included in the annual application for RWHAP Part A funding

Models for Implementing PSRA

- Factors to Consider
- Committee-based Models
- Full CARE Council-based Models

Managing Conflict of Interest in PSRA

- Process must manage conflict of interest (COI)
- A provider member that receives or is seeking funds under RWHAP Part A should have limited participation in discussion and should not vote on motions involving service categories where there is a COI
  - Exception: generally OK to vote on the full slate of services
- Subrecipients can provide input to the process during town halls or a provider forum
- Sound practice is not to allow a subrecipient to initiate discussion during PSRA decision making sessions
- Content questions about a service category should go to staff rather than funded providers

Managing Anecdotes & Impassioned Pleas

- PLWH, providers, and other community members should have an opportunity to present their perspectives prior to PSRA
- New information should not be presented during decision-making meetings when there is no way to check it
- Training on using data for decision making should help CARE Council members understand when to serve as advocates and when to act as planners on behalf of all PLWH in the jurisdiction – PSRA requires planners who make decisions based on the best available data

Roles of the Recipient in PSRA

- Provides considerable data for PSRA
- Often asked to provide and present suggestions or factors to consider in making allocations
- Provides pre-meeting input on the costs of implementing proposed directives
- Has several staff present throughout the process to provide data and answer questions
- Serves as a source of information about the system of care – so these questions are not addressed by subrecipients with conflicts of interest
- Does not vote or try to influence decision making

Committee-based Model: PSRA Committee

- The PSRA Committee:
  - Should be as diverse as possible, representative of the populations in the jurisdiction's HIV/AIDS epidemiology
  - Must not be provider-driven due to COI issues – with providers not voting on most decisions, decisions might be made by very few CARE Council members
  - Should focus on use of most recent available data
  - Develops recommendations with a clear rationale

Committee-based Model: Full CARE Council

- Full CARE Council receives, reviews, discusses, and either modifies or approves committee recommendations
- The CARE Council should:
  - Schedule an in-depth presentation and review of recommendations
  - Review data and ask questions
  - Make needed revisions or send recommendations back to committee for further work
  - Approve recommendations based on data-based, informed review

Reallocation

Moving funds from a prioritized service category following initial allocation, to reflect actual funding received and ensure that all funds are expended on needed services

Timing of Reallocation

1. After a partial or final grant award is received, since total or final amount received is usually higher or lower than the amount requested
   - Reallocation can be calculated based on percent of funding provided to each service category in the allocation scenario, then approved by the CARE Council
   - CARE Council may choose to refine allocations based on award amount
2. During the program year, when some service categories are underspent and others have greater demand

RWHAP Legislation Provides Penalties for "Unobligated" Funds

- If an EMA has more than 5% of its formula award unspent at the end of the program year:
  - Amount over 5% is deducted from the amount awarded the following fiscal year
  - EMA cannot compete for supplemental funds in the next application cycle – it receives only formula funds
    - Means if funds left unobligated in FY 2020, no supplemental funding and a deduction from formula funds in FY 2022
  - Jurisdiction can request use of funds as "carryover" for the following year but approval is not assured

Reallocation Prevents "Unobligated" Funds

- Many factors can contribute to underspending:
  - Reduced demand for services
  - Long-term staff vacancies
  - Natural disasters or sustained bad weather that prevents clients from accessing services
  - Damage to facilities that prevent or reduce ability to provide services
  - Management issues
- *Timely reallocation moves funds that could otherwise go unused – so they are spent on needed services

Two Types of Reallocation

1. Moving funds from underspent providers to those *in the same service category* who are spending at a higher level

   [Decision is made by the recipient]

2. Moving funds from underspent service categories to *different service categories* that:
   - Are spending at a higher level
   - Need additional funds to meet the need for services

   [CARE Council must approve, recipient can recommend]

HRSA/HAB Expectations for Reallocation

- *CARE Council must approve reallocation* of funds across service categories as part of its legislative responsibility for the "allocation of funds"
- Reallocation should happen as soon as it is clear that funds will not be fully spent
  - Recipient must revise subrecipient contracts to move funds
  - Subrecipient needs time to spend additional funds
- CARE Council should have a reallocation process, including a special "rapid reallocation" process for use late in the program year

Sum Up

- PSRA is the most important responsibility of the CARE Council
- CARE Council is the decision maker about priorities, allocations by service category, and directives
- The entire CARE Council must be actively involved in PSRA and must approve priorities, allocations, and directives
- There is no one “right” way to do PSRA, but there are sound practices and approaches to consider
- Decisions should be based on the best available data