2007 Priority Setting and Resource Allocation Guidance for HIV Care Services

Background

Priority setting and resource allocations (P&As) processes for Part B entities are not specifically addressed in the Treatment Modernization Act. In Texas, contracted Administrative Agencies set service priorities in a defined geographic planning area and allocate resources for Part B funds by HIV Service Delivery Area (HSDA). Administrative Agencies are also responsible for setting service priorities, determining how best to meet those service priorities in a manner responsive to identified need, and allocating resources to implement the service priorities. In order to foster community participation Administrative Agencies are required by the Texas Department of State Health Services (DSHS) to have a community input plan that provides a mechanism for community input and participation in the priority setting and resource allocation process. Each Administrative Agency is encouraged to develop a community input plan that is flexible and promotes a diversity of ideas. The plan must be based on community capacity and how people want to participate. The plan must also include multiple avenues for community input for affected parties, consumers, providers, other planning groups, and other allied providers.

Priority Setting and Resource Allocations depend on and impacts most tasks required in the planning process. P&As should not be viewed as the end product of the planning process but as a component of the whole; dependent on, supportive of, and to some degree, influencing the various other tasks and products of care services planning.

This Department of State Health Services (DSHS) Priority Setting and Resource Allocation Guidance for HIV Care Services is based upon guidance from the Health Resources and Services Administration (HRSA) and community stakeholders, with the goal of creating processes that are objective, systematic and data-driven. It does not contain prescriptive methods for determining service priorities or resource allocations. Rather, it contains guiding principles and requirements to follow when making initial service priority and allocation decisions, establishing funding thresholds and for reallocating and/or redistributing funds during the contract year. Administrative Agents (AA) are encouraged to develop methods for making P&A decisions that fit the needs of their plan area.

Priority Setting and Resource Allocation

DSHS recognizes that P&A processes may vary and acknowledges the value of allowing regions to develop processes that are best suited to and reflect the needs of local populations. While it is not the intent of DSHS to prescribe strict processes for completing P&As, it is the expectation that any P&A process be base upon a common set of guiding principles.

Guiding Principles for Using Data in the Priority Setting and Resource Allocation Process

Priority setting and resource allocations must be data driven. If the P&A process is being conducted in an HSDA containing an EMA/TGA, the AA is required to cooperate with that EMA/TGA Part A Planning Council in developing the Part B and State Services priorities and allocations. The priorities and allocations developed with Part A are considered by DSHS to be recommendations, may not be changed by the AA and must be submitted for approval to DSHS. Any Part A defined service category which differs from the DSHS Taxonomy and is allocated funding under Part B or States Services must be approved by DSHS planning staff prior to implementation. The following is a suggested list of the data sources that should be used in the P&A process.

- Epidemiologic data on HIV/AIDS cases in the plan area
- Documented needs of HIV-infected communities from needs assessment results
- The most recent Statewide Coordinated Statement of Need
- Documented HIV care service utilization data
- Current and/or historical service priorities and resource allocations/reallocations
- Continuum of Care
- Provider survey data
- Identified gaps in available data

There must be a logical connection between the data used to make decisions and the goals and objectives of the Comprehensive Plan.

- Service priority and resource allocation decisions must be based on clearly stated and consistently applied criteria.
- They must be responsive to emerging trends in the HSDA, balancing ongoing needs with emerging needs.
- They must support the goals and objectives in the Comprehensive Plan.
- Service priorities and resource allocations must address overall needs within the HSDA, not narrow advocacy concerns
- Decisions must meet established HRSA and DSHS guidelines for care (where available) and demonstrate quality and effectiveness as determined by Administrative Agency

Selected service categories must comply with the DSHS Taxonomy of service categories eligible for Part B funding. Please refer to the DSHS website at http://www.tdh.state.tx.us/hivstd/taxonomy/default.htm for the most recent glossary.

Thresholds and Contingency Planning

As of the release of this document, HRSA has a definition of core services, and DSHS requires that Administrative Agencies fund these services to meet established minimum thresholds. Also, the Ryan White HIV/AIDS Treatment Modernization Act of 2006 requires that 75% of Part B funds be allocated to the core medical services. While 25% of the remaining Part B funds may be spent on support services, the AA must justify how funding these support services support client access to and/or maintenance in medical care.
The core services are:

- Outpatient Ambulatory Health Services
- AIDS Drug Assistance Program Treatments
- AIDS Pharmaceutical Assistance
- Oral Health Care
- Early Intervention Services
- Health Insurance
- Home Health Care
- Medical Nutrition Therapy
- Hospice
- Home and Community Based Health Services
- Mental Health Services
- Substance Abuse Outpatient Care
- Medical Case Management

AAs are also required to provide documentation that these core medical service categories are adequately funded in each HSDA. To that end, the AA must calculate minimum dollar amounts (Minimum Funding Thresholds) needed to adequately provide these service categories. The Allocations process must ensure that these thresholds are met either through Part B and State Services funds, from other funding streams (ex. Parts A, C & D) or a combination of funding sources. When developing funding thresholds, the AA should consider the following:

- Not all Core Services need to be funded using Part B funds.
- In areas where service priorities and resource allocations are developed with Part A EMA/TGA, the Part B AAs and Planning Councils should make every effort to appropriately share funding proportions for core and non-core services.
- If Part B funds are not allocated to a core service, AAs must describe how the minimum thresholds for the service will be funded.
- AAs should review thresholds at a specified point, such as six-months and adjust as needed.
- The Ryan White HIV/AIDS Treatment Modernization Act of 2006 is the funder of last resort
- Part B funds will not be able to meet all identified needs
- All available funding sources should be considered when allocating funds
- The AA should consider data on HOPWA allocations, expenditures and utilization data when allocating funds to Part B and State Services housing and housing related service categories.

- Information on HOPWA funding caps, eligibility requirements and/or services restrictions set by the AA must be considered.
- Non-core services may be funded after the minimum funding thresholds and the 75% requirement have been met for the twelve core medical services AND the AA can show how funding these support services support client access to and/or maintenance in medical care.

DSHS does not prescribe a specific formula to establish minimum funding thresholds. To establish the minimum funding threshold, the AA may:

- Use expenditure and utilization data from the previous contract year to provide a baseline from which to make decisions.
- Use an average of two or more years' worth of expenditure and utilization data to identify possible trends and account for unanticipated expenses and client needs.
- Use data on reallocations by service category in the previous contract year to identify any trends or over/under-allocation of funds.
- Incorporate current needs assessment data to estimate the need for each service category.
- Conduct key informant interviews with service providers to capture emerging trends of issues.

The AA is required to use minimum funding threshold information in constructing a contingency plan should there be an unexpected shortfall in funds awarded to a HSDA. The contingency plan should detail how funds will be reallocated to ensure that the minimum funding threshold for each category is met to guarantee the continuation of services.

Reallocation and Redistribution

If in the course of the contract year, if it becomes apparent that funds in a particular service category's allocation will not be expended, the AA may redistribute or reallocate those remaining funds. Redistribution is defined as moving money in the same category to a different provider. In other words, the amount of money dedicated to the service category doesn't change, but it may be transferred to a another provider. To do this there must be more than one provider for the service in the HSDA. Reallocation is defined as moving money from one service category to another service category and can be moved within the same agency, to other agencies within the HSDA and across HSDAs to meet critical services.

The following principles should be considered when making reallocation/redistribution decisions. For further clarification see the DSHS Policy Number HIV/STD 241.006 Reallocation of HIV Client Services Funds:

- AA's should examine services expenditures by category on at least a quarterly basis.
- In accordance with the DSHS policy, the AA is to first explore redistribution of funds within the service category to other providers in the HSDA.
- If redistribution is not appropriate, the AA should consider reallocating the funds across all HSDAs in the service area to meet critical service needs.
- Reallocation will not affect the set point used for hold harmless calculations in DSHS's funding formula.

- Reallocations are not considered permanent changes to the expected allocation for HSDAs in that administrative service area.
- Reallocations cannot be made to increase the administrative budget of the AA.
- High priority critical service needs are not necessarily limited to the core services. High priority critical services can include ancillary services that have a strong relation to enrolling and maintaining clients in medical care.
- Reallocations should be made only to service categories where there is a high priority need, and there is an anticipated shortfall or lower than desired initial allocation.
- If there is no need or capacity within the HSDA to use the funds within the service category, the AA should consider using the funds to address gaps in meeting high priority critical service needs across all HSDAs in the planning area.
- AAs should consider using reallocated/redistributed funds for critical services across the entire plan area to prevent funds from being used for lower priority services while other HSDAs may be experiencing shortages for a critical service.

Community Input on Service Priority and Resource Allocation Decisions

Administrative Agencies are required to have an approved Community Input Plan for gathering stakeholders comments and feedback on the P&A decisions. While DSHS does not have set requirements for this plan, the following principles must be considered when soliciting stakeholder input into the P&A process:

- The process for getting community input and participation should be diverse and flexible
- It must be based on community capacity and how people want to participate.
- AAs must consider what meaningful community participation and input looks like in their area.
- AAs must create multiple avenues for community input: affected parties, consumers, providers, other planning groups, and other allied providers.
- Community Input does NOT preclude meetings, formal hearings, web blogs, etc.
- The AA should consider multiple avenues for consumers to participate.
- Public hearings on the completed comprehensive plan are required but not sufficient because they only happen after a decision is made.

Approval of Service Priorities & Resource Allocations

The AA is required to submit all initial service priority and resource allocation decisions and justifications to DSHS planning staff for review and approval before the start of a new contract year using Table 1.

- AAs may make requests to move money across HSDAs before final allocations are approved and each request will be reviewed and approved by DSHS on a case-by-case basis.
- Final service priority and resource allocations must have been presented to the community for input and recommendations before being submitted to DSHS
- If resources have not been allocated to a core service, the AA must submit justifications for not funding the service.
- Funding for ancillary services that exceeds funding for a core service must be justified

- The minimum funding thresholds established by the AA for each of the twelve core medical service categories, or documentation and verification on alternative funding sources used to meet funding requirements, must be submitted along with Table 1

Approval of Reallocation and Redistribution of Funds

AAs will be required to send reallocations and redistribution requests to the DSHS planning staff for review and approval prior to implementation. Reallocation/redistributions do not need to go through the community input process. Requests should be submitted using the following procedures:

- Reallocation and redistribution of funds must comply with the 75/25 HRSA requirement.
- Requests should be submitted to the appropriate Field Operations Consultant and DSHS Planner for approval via email using Attachment A.
- All requests must include a detailed justification for the reallocation and/or redistribution
- DSHS will respond with an approval, disapproval, or request for additional information within 3 working days.
- Within 30 days of the effective date of the reallocation, the AA should submit an amended Table 1-B for each HSDA affected by the funds transfer and modified budgets and subcontractor data sheets as appropriate.

DSHS has no set timeframe for when annual service priority and resource allocation decisions must be submitted for approval. These timelines are set by each Administrative Agency to meet their contractual and/or Part A requirements. Also, this guidance is not intended to address all issues associated with the P&A process, nor is it intended to supplant Part A requirements. For questions regarding this guidance please contact your assigned DSHS planner.

Attachment A: Administrative Agency Reallocation Request Form

Administrative Agency:			
Date:	**Contact:**	**Phone:**	**Email:**
From HIV Service Delivery Area (HSDA):			
Funding Source: ☐ Ryan White ☐ State Services		**Funding Year:**	
DSHS Approval: ☐ Approved ☐ Not Approved		**Approval Date:**	

Service Category	Priority	Current Allocation	Expenditures as of _____	Requested Reduction	New Requested Allocation
Total Reallocation					

To HIV Service Delivery Area (HSDA):

Service Category	Priority	Current Allocation	Expenditures as of _____	Requested Increase	New Requested Allocation
Total Reallocation					

Reallocation/Redistribution Justifications

Please provide a justification for the reallocation/redistribution request.

If the requested reallocation/redistribution is not for a core service, how will this change in funding facilitate enrolling and keeping people in medical care?

Please provide a revised performance measure based on the requested reallocation/redistribution (must, at a minimum, include the current and proposed number of unduplicated clients and number of units). If the performance measure does not change, why not?

Are there any additional comments or justifications you'd like to provide?