Quick Reference Handout 5.5: Resource Allocation

Introduction

Resource allocation is a component of Priority Setting and Resource Allocation, the most important legislative responsibility of a PC/PB. Planning councils are the decision makers in resource allocation, while planning bodies make recommendations to the recipient. Resource allocation is the process used by planning councils/planning bodies (PC/PBs) to decide how much Ryan White HIV/AIDS Program (RWHAP) Part A funding to provide for each prioritized service category. Funds may be allocated only to core medical and support service categories that are approved for funding under RWHAP Part A;[1] all of these services should be included in the PC/PB's list of service priorities, with rankings based on their importance for people with HIV in the Eligible Metropolitan Area (EMA) or Transitional Grant Area (TGA). Not all prioritized services are funded.

The Health Resources and Services Administration's HIV/AIDS Bureau (HRSA HAB) expects the PC/PB to use a fair, data-based resource allocation process to decide how much funding will be provided the following program year to the PC/PB's prioritized services. The process must manage conflict of interest and it must be documented in writing and followed consistently. Because these are decisions about funding, not following the approved process or not managing conflict of interest may lead an affected party (such as persons with HIV or a service provider) to file a grievance against the PC/PB. A grievance is a complaint or dispute about a funding-related decision that involves a formal request for resolution.

Other HRSA HAB expectations:

- The recipient provides data to inform resource allocation and may offer advice, but the recipient does not vote;[2] the planning council is the decision maker.
- Either the PC/PB or a committee may do the initial work of resource allocation, but the entire PC/PB should participate in the final decision-making. If a committee recommends resource allocations, these recommendations must be reviewed, actively discussed, and approved by the entire PC/PB.
- Only PC/PB members appointed by the Chief Elected Official (CEO) may vote on allocations. Resource allocation meetings are open to the public, but they do not vote.
- At least 75% of program funds must be allocated to core medical services, and no more than 25% to support services, unless the EMA/TGA obtains a waiver from HRSA HAB. This is a legislative requirement.

RWHAP Part A-Fundable Service Categories

Core Medical Services (13)

AIDS Drug Assistance Program (ADAP) Treatments

AIDS Pharmaceutical Assistance

Early Intervention Services (EIS)

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Home and Community-Based Health Services

Home Health Care

Hospice

Medical Case Management, including Treatment Adherence Services

Medical Nutrition Therapy

Mental Health Services

Oral Health Care

Outpatient/Ambulatory Health Services (OAHS)

Substance Abuse Outpatient Care

RWHAP Support Services (15)

Child Care Services

Emergency Financial Assistance (EFA)

Food Bank/Home Delivered Meals

Health Education/Risk Reduction

Housing

Linguistic Services

Medical Transportation

Non-Medical Case Management Services

Other Professional Services (e.g., Legal Services, Permanency Planning, Income Tax Preparation Services)

Outreach Services

Psychosocial Support Services

Referral for Health Care and Support Services

Rehabilitation Services

Respite Care

Substance Abuse Services (residential)

Sound Practices

Sound practices to help your PC/PB meet HRSA HAB expectations and make appropriate resource allocation decisions include the following:

- **Effective timing:** Do resource allocations as soon as possible after the other phases of PSRA: the annual data presentation, priority setting, and approval of directives, while the data are still “top of mind” for members. Some PC/PBs do everything over a 1-2 day period. Others do the work over several weeks.
- **Consider funding level uncertainty:** Make allocations with the understanding that they must be made before the EMA/TGA knows how much money it will receive. Using three different funding scenarios – one assuming flat funding and the others assuming a 5% increase or a 5% decrease – will help in quickly adjusting allocations once funding is received.

- **Separate process for MAI funds:** Allocate funds for Part A Minority AIDS Initiative (MAI) funds separately from other Part A funds. MAI funds are awarded using a formula based on the number of racial and ethnic minority individuals with HIV in the EMA or TGA, and they must be used not only to serve these subpopulations but specifically to improve their access to HIV care and their health outcomes.
- **Data-based resource allocation decisions:** All members should attend the data presentation that informs both priority setting and resource allocation. Many PC/PBs do not allow members to vote on resource allocations unless they attend the data presentation or watch/listen to a recording of it, since it is the key source of up-to-date information about service needs and utilization. PC/PBs should ensure that the resource allocation process is data-based and considers at least the following:
  - The number and characteristics of clients served in each funded service category during the past year and the demand observed so far in the current year.
  - The level of service utilization by service category, overall and for major subpopulations.
  - Needs assessment data on service needs and gaps, provided by RWHAP Part A clients and other people with lived experience.
  - The cost per client for each service category during the most recent completed program year.
  - Funds provided for particular services through other funding streams, including other RWHAP Parts, Medicaid, other federal agencies, and state and local resources.
  - Plans for bringing additional people into care, the estimated number of new clients, and the RWHAP Part A services they are expected to need.
- **Consider the PC/PB's priority rankings of service categories:** Carefully consider your prioritized list of service categories when allocating resources. However, recognize that some highly ranked service categories may receive little or no funding because:
  - Other funding streams are providing most or all the needed funds – for example, RWHAP Part B may meet the need for HIV-related medications through the AIDS Drug Assistance Program (ADAP).
  - Some services may be very important for a small percentage of your EMA/TGA's clients – for example, linguistic services.
  - Some services involve relatively low costs – for example, child care.

Typical Steps in Resource Allocation

There is no one correct way to do resource allocation, but many PC/PBs use steps like the following, which meet HRSA HAB expectations and reflect sound practices.

1. **Obtain agreement from the full PC/PB on principles, criteria, and the decision-making process/methods for allocating funds.** Be sure that your PC/PB's process is documented in writing, and that all members understand it.

2. **Review financial and utilization data,** including:
   - Final allocations for the current program year.
   - Final expenditures vs. allocations for each funded service category in the most recently complete program year.
   - Number of clients served during the prior program year and costs per client or per unit of service for each service category.
   - Decide whether to use the last program year's final allocations or your current year allocations as a starting point.
3. **Review and approve directives,** so that their costs can be considered in the allocation process. For example, if the PC/PB approves a directive that calls for providers of certain medical services to add evening or weekend hours, the added costs for staff and for keeping the facility open longer will need to be estimated and added to the allocation for those service categories to avoid a reduction in number of clients served. This may also mean less funds available for lower-priority services.
4. **Make allocations by service category,** based on projected number of clients and costs per client:
   - Project on a screen both current and proposed allocations for each service category during the process, so members can see and review their progress. Include both actual dollars and percent of expected total funding for the scenario being considered.
   - Keep separate track of total allocations for core medical-related services and support services allocations because of the 75%-25% requirement.
   - Vote separately on allocations for each service category or group of related categories as you go through the process.
   - Be sure the allocations consider the cost of new and ongoing directives.

   Throughout the process:
   - Be sure members with conflicts of interest declare their conflicts and refrain from voting or trying to influence the votes of other members.
   - Focus on making decisions based on the best available data, not on individual "impassioned pleas."
5. **Review and vote on the total allocation for "flat" funding.** Record the votes for and against and the abstentions for each service category. Repeat this process for two other possible funding scenarios, e.g., a 5% increase in funding, and a 5% decrease.
6. **Follow a similar process (steps 1-5) to allocate MAI funds.** Be sure members understand what specific strategies are recommended to improve access to care and improve service outcomes for racial and ethnic minority subpopulations in the EMA or TGA.[3]
7. **Document the discussion and decisions,** including reasons for any changes in funding and for amounts allocated and how conflict of interests was addressed in discussion and voting. If the process was done by a committee, the full PC/PB will need to understand the rationale behind the committee's recommendations. In addition, documentation is useful in case of a grievance, since it can show how the PC/PB followed its approved process and managed conflict of interest.

8. **Schedule a review of the process within a month after implementation** to:
    - Identify any data gaps or process issues that need improvement for next year.
    - Work with the recipient on data or other issues.
    - Be sure process changes are presented and approved before next year's PSRA process begins.
9. **Be prepared to revise allocations once the EMA/TGA receives its notice of award from HRSA HAB**. If the amount received is substantially higher or lower than "flat" funding, the PC/PB's staring point may be one of the other funding scenarios.

End Notes

[1]PCN #16-02, "Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds," was issued in 2016 and revised on October 22, 2018; it is available online at https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf. The service category definitions in #16-02 are summarized in Quick Reference Handout 5.1: Quick Guide to RWHAP Part A-Fundable Service Categories.

[2]According to a RWHAP Part A Recipient Letter from the Director of the Division of Metropolitan HIV/AIDS Programs (DMHAP), "A recipient representative, whose position is funded with RWHAP Part A funds, provides in-kind services, or has significant involvement in the RWHAP Part A grant, shall not occupy a seat in the PC/PB, nor have a vote in the deliberations of the PC/PB"; see https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/planning-council-planning-body-requirements-expectations.pdf.

[3]See Planning CHATT resources: Using MAI Funds Effectively: Tailoring Services for Locally Identified Subpopulations