# LOS ANGELES COUNTY COMMISSION ON HIV

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Approved 1/21/2014

## PLANNING, PRIORITIES & ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES

December 17, 2013

| P&P MEMBERS PRESENT | P&P MEMBERS ABSENT | PUBLIC | COMM STAFF/ CONSULTANTS |
|---|---|---|---|
| Al Ballesteros, MBA, *Co-Chair* | Marc McMillin/Mark Davis, DDS | Brian Beneat | Glenda Pinney |
| Bradley Land, *Co-Chair* | Juan Rivera/Rev. Alejandro Escoto, MA | Kevin Donnelly | Craig Vincent-Jones |
| Michelle Enfield | | Miguel Fernandez | |
| Lynnea Garbutt | | Aaron Fox | |
| Anthony Gutierrez, MA | | Rob Lester | **DHSP STAFF** |
| Sharon Holloway | | Joseph Green | Dave Young |
| Abad Lopez | | David Kelly | |
| LaShonda Spencer, MD | | Ismael Morales | |
| Monique Tula | | Scott Singer | |
| Carlos Vega-Matos, MPA | | Jason Wise | |

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3) **Policy/Procedure**: #09.1007: Community Member Appointments, *Approved 7/14/2011*
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5) **Memorandum**: Fiscal Year 2014 Ryan White Parts A/B and MAI Allocations, *6/13/2013 (revised 7/13/2013)*
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7) **PowerPoint**: Non-Medical Case Management Provider Meeting, *10/16/2013*
8) **PowerPoint**: Priority and Critical Populations 2009-2013, *12/17/2013*
9) **PowerPoint**: The Los Angeles County HIV Prevention Plan 2009-2013, *7/17/2007*

1. **CALL TO ORDER**: Mr. Land called the meeting to order at 1:30 pm.

2. **APPROVAL OF AGENDA**:
   **MOTION #1**: Approve the Agenda Order **(*Passed by Consensus*)**.

3. **APPROVAL OF MEETING MINUTES**:
   **MOTION #2**: Approve the meeting minutes, as presented, from Priorities and Planning (P&P) and/or Planning, Priorities and Allocations (PP&A) Committee meetings **(*Postponed*)**.

4. **PUBLIC COMMENT, NON-AGENDIZED OR FOLLOW-UP**: There were no comments.

5. **COMMISSION COMMENT, NON-AGENDIZED OR FOLLOW-UP**: There were no comments.

6. **CO-CHAIRS' REPORT**:
   A. **Community Membership**:
   - Mr. Land noted community members can augment expertise. Each committee decides if they would like to community members appointed to the committee.
   - Mr. Vincent-Jones added they are unique as voting members appointed directly to the committee, but are not Commissioners. Board appointment ensures accountability, and bestows voting privileges on them. Committees which choose to include them must identify selection criteria and member responsibilities. Previously, on the former Commission, the Standards of Care (SOC) and Joint Public Policy (JPP) Committee had Community Members; the Operations and Priorities and Planning (P&P) Committees did not.
   - In most cases, Community Member applications are invited by the respective committees. The nominations are reviewed by the Operations Committee to ensure they are consistent with the committee's stated criteria and must be approved by the Commission before being forwarded to the Board for appointment.
   - Mr. Fox noted the P&P Committee had chosen not to have community members previously. While they can add expertise, the most likely candidates would be providers, and that would present a number of additional conflicts. Mr. Vincent-Jones noted that HRSA is very concerned about undue provider influence, particularly in the priority- and allocation-setting process.
   - Mr. Kelly noted he had served on the P&P Committee for two years previously on the former Commission. He asked the Committee to support his request for a secondary assignment to PP&A.
   - Mr. Vincent-Jones noted that secondary assignments were not the same as Community Member appointments. He reported that the Co-Chairs had postponed secondary assignments for full members until the committees of their primary assignments had had a chance to gel. Alternates, however, could request secondary assignments, if they desired, because the secondary assignments often give them a voice and voting privileges independent of their Alternate assignments.

   **MOTION #2A (*Enfield/Tula*)**: Moved not to include Board-appointed voting community members on PP&A **(*Passed by Consensus*)**.

7. **FY 2013 FINANCIAL EXPENDITURES REPORTS**:
   - Mr. Young estimated full expenditure of the FY 2013 Ryan White Part A grant award at this point. There could be some adjustments depending on the number of clients who transition off of Ryan White in the final months of the grant year.
   - The State changed its Part B/Single Allocation Model (SAM) Care grant year to coincide with HRSA's Part B fiscal year, 4/1/2013-3/31/2014. April through October expenditure data was used with estimates through 3/31/2014. Provider contracts are unchanged. The allocation increased by $300,000 which will be reflected on next month's reports.
   - There are three Minority AIDS Initiative (MAI) service categories: Oral Health Care (also funded by Parts A/B); Case Management, Medical (Part A); and Transitional Case Management (Part B). Expenditure of the full MAI grant is projected, but there could be adjustments based on utilization and the other funding sources.
   - The Summary reflects other contracted Net County Cost (NCC) and State funds with a column for CDC funding, when available. The NCC total is $5,294,246 with $4,565,968 for residential services. NCC is used to fund transitional case management in the jails since Federal law bars use of Ryan White funds in state or federal corrections facilities (those facilities are responsible for the inmates' medical and health care, and, so, there is no use for Ryan White funds, as last resort) and also funds psychotherapy, medical nutrition therapy, legal and language services. The State funds ADAP and a $200,192 pass-through for the Center for Substance Abuse Treatment contracts.
   - Mr. Vega-Matos noted the total for contracted services from Parts A/B, MAI, NCC and the State is $45,786,900. That does not include some special project grants such as from the Substance Abuse and Mental Health Services Administration (SAMHSA) or the HOPWA CHISS grant to the Commission. DHSP seeks to maximize all various funding streams to ensure all available funds are used locally and not returned to the funding source.
   - Nearly $18 million is contracted for Ambulatory Outpatient Medical (AOM), which includes some ancillary services such as ADAP enrollment and imaging at medical clinics, pharmacy, approximately $2.5 million for the Therapeutic Monitoring Program and $1.5 million in medical specialty services.
   - Over $8 million is contracted for Medical Care Coordination (MCC), with $5,664,969 of that amount expended to date for core medical services. With full MCC implementation, remaining stand-alone (not affiliated with a medical site) non-medical case management contracts are transitioning to Linkage to Care (LTC), with funding anticipated to decline to $1.4 million in the next year.

- Mr. Kelly asked about presentation of the financial reports to the Commission. Mr. Vincent-Jones replied the Commission receives reports in the monthly meeting packet. There is usually a presentation on them quarterly, but a Summary Revisions Workgroup is working on revising the schedules to include prevention and STD funding. He felt it more useful to wait for the revised reports.

**8. DIVISION OF HIV/STD PROGRAMS (DHSP) REPORT**:

**A. Net County Cost (NCC) Expenditures**: There was no additional discussion.

**B. Minority AIDS Initiative (MAI) Funding:** There was no additional discussion.

**C. Medical Outpatient/Specialty:** There was no additional discussion.

**D. Service Category Presentation: Transitioning Non-Medical Case Management to Linkage to Care**:

- Mr. Vega-Matos said the presentation was provided 10/16/2013 to the current, contracted non-medical case management providers (unaffiliated with a medical site). The presentation introduced linkage to HIV care rates in the County, the current case management response, and the future of such services.
- Data on the 2011 County HIV Care Continuum was derived from HIV surveillance and the Medical Monitoring Project (MMP). There are an estimated 59,500 PLWH in the County including the CDC estimate of 18.1% unaware of their status. Of those, these are: diagnosed, 82%; linked to care at 3 months, 66%; 6 months, 69%; 12 months, 71%; retained in care with at least two Viral Loads (VLs) at least 3 months apart, 47%; with at least one VL in last 12 months, 56%; prescribed ART, 41%; virally suppressed, 45%. Linkage, retention and VL suppression are significantly higher in the Ryan White system than they are in more general healthcare or the County's other systems locally.
- National HIV/AIDS Strategy (NHAS) goals are to: reduce new infections 25% by 2015; improve health outcomes andincrease access to care by increasing linkage to care of the newly diagnosed from 65% to 85%; and reduce HIV-related health disparities by improving access to prevention and care for all Americans and increasing the proportion of persons with undetectable VLs.
- Historically, there has been approximately $2.6 million contracted in Non-Medical Case Management (NMCM) services. Slightly less than half of the providers offered services in a medical clinic with the rest stand-alone social service providers not directly associated with a medical clinic. The case managers/case workers facilitate a client's access to, maintenance in and adherence to primary HIV-specific care, as well as services that address barriers to care, such as mental health, addiction treatment and other support services.
- Medical Care Coordination (MCC) services were launched in late 2012 and are now fully implemented at all contracted agencies as of the past couple of months. MCC is an integrated clinic-based approach combining medical and psychosocial functions to focus on adherence to HIV care and treatment with interventions conducted by teams of nurse case managers, Masters-level social workers, bachelor-level case workers, and other clinical or service staff who are helping the patients, in spite of who is father is. Most providers were able to establish MCC in the first three or four months with a few finally staffing up to do so more recently.
- DHSP realized it needed to assess NMCM so MCC teams could prepare to serve clients who were part of a medical home and to determine the status of other clients whether with a non-Ryan White-funded provider or not in care. Changes in the health care system also means it will be necessary to have some providers focus on linking people to HIV care whether through Ryan White or another provider, based on their insurance status. Ryan White can continue to cover needed services for patients with other medical care so long as the service is not covered by their insurance, and will continue to be the primary of provider of a large part of the patient population who is ineligible for services covered by the Affordable Care Act (ACA).
- Mr. Singer said Casewatch used to document eligibility. MCC does that now, but it is slower and more documentation is needed despite no additional funding. Mr. Vega-Matos said contracts include eligibility determination. Approximately 3,000 of the 18,000 patients in the local Ryan White-funded system currently received non-medical case management services. The 15,000 or so patients who previously (before LIHP enrollment and Medi-Cal Expansion) relied on the Ryan White system medical outpatient services, reimbursed through the newly instituted Fee-For-Service (FFS) system, get eligibility determinations, but the determinations may not be uploaded to Casewatch as quickly as desired.
- DHSP is working to streamline the process so documents can be scanned onto Casewatch. That will allow providers to download documents such as for residency, income and HIV diagnosis, and add any needed for home-based services.
- Regarding certification, HRSA has been pressuring California to implement six-month ADAP recertification for the past two years; but agreed to its postponement last year during the patient migration to Healthy Way LA (HWLA). DHSP is

expecting that it will have to be implemented during the first quarter of FY 2014. Mr. Vega-Matos added providers have a responsibility to educate consumers so they understand the process.

- In January 2013, nine or ten NMCM providers had 749 active clients with 500 already linked to AOM with MCC services. By August 2013, there were 418 with 333 linked to AOM with MCC services. Just 331 (44%) transitioned to medical homes. Some agencies increased their caseloads during this period, either through recruiting new clients or improved reporting. Mr. Singer noted his provider had not had Casewatch access for a time and was only able to update patient status when it finally became available.
- Mr. Vega-Matos noted there are four acuity levels for MCC based on an assessment. "Self-managed" is the lowest, but in the past has been over-used by providers who might see such clients once or twice a year even when clients were not taking their medications and might be experiencing other social determinants impacting their health, such as mental health or substance abuse issues. The assessment is designed to ensure each individual receives needed services at the level they need. Both the insurance screening tool and the assessment tool are on the DHSP website.
- Options for NCMC going forward were: continue with limited progress, duplicative services, and a limited number of clients linked; sunset NCMC service category and procure more streamlined, time-limited approach; or redesign the service with a focused approach to Linkage to Care (LTC) and evaluate impact. The last option was chosen.
- The refined NCMC LTC model uses a strengths-based approach with brief interventions to assist clients in accessing HIV health care and to address barriers to care. Refined NCMC activities include: outreach and brief interventions for assessment, identifying client's readiness to enter HIV care, risk reduction, follow-up, and graduated disengagement.
- Outreach goes beyond street-based or client-level intervention to include collaborative activities, such as developing relationships with agencies that can identify and refer out-of-care clients, e.g., HIV testing and health education/risk reduction programs, primary health care centers/clinics, and as supported by MOU with three or more partners. It also includes educating service delivery partners about NMCM-based LTC services availability and benefits.
- Brief intervention sessions help patients identify and break-down barriers to care, addressed in up to five sessions over 90 days. Sessions conduct a strengths-based assessment, develop a service plan, motivate clients to access HIV medical care, monitor client progress towards linkage, and provide graduated disengagement.
- Attributes for NCMC LTC case managers/workers are: previous case management experience, experience providing services to PLWH, Masters of Social Work or equivalent, harm reduction skills, motivational interviewing skills, flexibility to meet client needs, and strong customer service skills, with both clients and referring professionals.
- Performance measures are: linkage to HIV care within six months, 85%; NMCM assessment completed within 30 days, 100%; disengagement from NMCM after five or fewer face-to-face brief interventions within 90 days; percentage of clients with identified risk behaviors who received risk reduction interventions in the measurement period, 100%.
- DHSP is implementing an evaluation plan to describe and monitor fidelity to the refined NCMC protocol including: staff training and supervision; outreach collaboration with HIV care providers; service delivery, activities and plans, assessments, client contacts, brief interventions and referrals; total annual program costs and average cost per client.
- This information will also be used to inform the RFP. DHSP is now negotiating contract terms with providers. Contracts will not be renewed for providers who decline to participate in the new protocol as a LTC provider with an LTC program, but all seem amenable to date.

**E. Oral Health Services**:

- Mr. Vega-Matos noted significant progress in ongoing oral health expansion. The start of the Phase II expansion had been delayed, so DHSP chose to delay Phase III until Phase II had been fully implemented, and remaining patient need for oral health services could be assessed, especially given that Denti-Cal-reimbursed services will be re-introduced in mid-2014.
- DHSP has also received the first report from its HRSA Technical Assistance (TA) oral health consultant. The report reflects the number of visits per year per client and procedures per visit. It indicates that existing providers have not yet met capacity, and can expand further without additional infrastructure/capacity costs to the system.
- Issues such as how and how well current providers maximize resources, and consistency between the services and the current standards of care (e.g., regarding linkage to care) will be addressed in the TA report to be provided shortly to the Commission and the Oral Health Advisory Committee for review and discussion.
- Mr. Vega-Matos recommended that the current 2014 funding level be maintained, without additional funds for a Phase III expansion, while DHSP staff and oral health providers have a chance to continue increasing internal capacity, operational efficiency, and oral health patient census volume. He indicated that he felt the final FY 2013 funding level

for oral health care (without Phase III expansion augmentation) should be sufficient for anticipated expenditures in FY 2014.

**F**. **Medical Care Coordination (MCC)**:

- Mr. Vega-Matos said that MCC—when fully implemented, functioning and at full capacity—is expected to cost approximately $8.9 million annually. Ryan White is the payer of last resort; however, some patients migrating to other systems of medical care will not have access to comparable MCC services, and will be eligible for Ryan White MCC. MCC differs from and is more extensive than the certified Medi-Cal and/or patient-centered medical homes, so MCC will be the primary coordinator of care and collaboration for any patient/client receiving services in the local HIV continuum.
- DHSP is tracking measures of service delivery, outcomes, progress and ongoing implementation efficiencies and challenges. DHSP will also track MCC effectiveness, including health outcomes, by continuous by using CD4s and VLs from HIV surveillance data.

**G.** Be**nefits Support**:

- Mr. Vega-Matos reported that approximately $850,000 is contracted for Benefits Specialty contracts annually—which constitutes a significant proportion of the Benefits Support funding—to ensure clients receive are eligible for, able to be enrolled in, and can assess all services for which they are entitled.
- Much of the rest of the allocation is absorbed by and additional (beyond the level of State funding) ADAP enrollment costs. A fraction of the funds were allocated with other recent FY 2013 allocation modifications for the contracted legal services firm to provide legal defense or representation in complex public benefits appeals/litigation.
- Additionally, the work requires expertise in other, non-Ryan White private and public benefits programs available through other resources, and linking patients and clients into care, e.g., Covered California.
- The remainder of Benefits Support funds health insurance premiums and cost-sharing. The State plans to assume funding insurance premiums and medication co-pays (OA-HIPP will require all Covered California applicants to enroll in ADAP, which will cover co-pays as needed for those who have them), but there are local and State concerns how effectively they will be able to manage the work.
- According to OA staff, they would prefer to hire a third party administrator for the program, but State procurement rules prohibit it. To date, OA will not be covering deductibles, co-pays or other cost-shares in the program's first year, but the State may agree to cover those expenses in FY 2014-2015.
- In the meantime, the local system is the only possible alternative that might assume those costs. While a number of possible arrangements were discussed with OA staff, the Commission and DHSP have not yet found a solution that does not involve a sole source purchase order for a third-party vendor (this option unlikely), or entail augmenting a contract for an existing provider which would delay procurement and potentially prompt calls of favoritism or conflict-of-interest (this option also unlikely).

**H**. **Home Health Care**:

- Mr. Vega-Matos reported contracts are approximately $3 million for Home-based Care, which is complemented by other funding streams, e.g., Medi-Cal Waiver enrollees are eligible for services up to a cap of $13,000, after which Ryan White funds can be used. Mr. Singer indicated that Medi-Cal Waiver is reviewing rates. Current rates will be in effect until 12/31/2016.
- The State provided approximately $1 million in funding until approximately three years ago. DHSP has not reviewed the service since them, but there are plans to evaluate the effectiveness of the service and whether fee-for-service would be a suitable reimbursement scheme for these services.

**I.** **Housing Supportive Services and HOPWA**:

- Mr. Vega-Matos reported that under this service category, there are contracts for Residential Care Facilities for the Chronically Ill (RCFCI) and Transitional Residential Care Facilities, which are both combined housing and wrap-around support service programs.
- As noted earlier, a number of the RCFCI clients should more appropriately be considered hospice or skilled nursing clients, but there is no contracted hospice/skilled nursing facility in which to house them. The costs of care for these clients should be more appropriately paid out of the hospice/skilled nursing allocation, or that allocation should be moved to the housing supportive services category.
- HOPWA funds supportive services such as housing case management. DHSP is working with HOPWA to better streamline and coordinate services, and to avoid duplicative efforts by the HOPWA and Ryan White systems.

**J. Mental Health Services**:

- Approximately $1 million is allocated and contracted annually to psychiatry, with another $2 million for psychotherapy services. DHSP is working on an RFP based on the revised Mental Health Standards of Care that combines the two services for a seamless continuum of mental health services that includes medication and therapy. Fee-for-service, rather than cost allocations, reimbursements are also being considered for this service category.
- DHSP is discussing application of the mental health standards with the Department of Mental Health (DMH). The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) is the recently updated manual used by mental health professionals to diagnose conditions and assess the severity of mental health impairment. DHSP and DMH are also discussing how Ryan White patients with co-morbid mental health conditions who have been transferred to Medi-Cal will be covered under Medicaid Expansion, and, if appropriate, how they will be enrolled in the DMH's three-tier classification system [Tier 1 (acute and persistently mentally ill, severely impacts daily functioning); Tier 2 (mood and personality disorders, anxiety, depression, etc.); Tier 3 (psychiatric consultation only)]. DMH will reimburse for Tier 1 and 3 services, and new occurrences of Tier 2 disorders. Most Ryan White patients with mental health conditions fall in the Tier 2 classification, but many were not eligible for DMH coverage given their conditions were pre-existing.
- Mr. Land stressed it was important for stakeholders to understand not only HIV, but the system of care so patients can achieve optimal outcomes. Mr. Vega-Matos responded that DHSP works proactively to understand client needs and identify the best ways for clients to engage the system. DMH is also expanding its provider network and DHSP has encouraged Ryan White providers to join so HIV consumers migrating to other systems can retain the same providers.
- Mr. Singer noted many Ryan White providers are unfamiliar with other systems, but do want to provide continuity of care. They do not have a problem meeting quality standards, but need to familiarize themselves with the alternate systems' expectations and learn how to help their clients navigate system entry.
- Mr. Ballesteros suggested hosting a provider forum to help providers engage as mental health contractors and teach them how to facilitate patients' entry into mental health care. Mr. Vega-Matos noted some providers are already established and experienced with the system, and, as a result, are able to more smoothly navigate the contracting process.
- ➲ Confirm foregoing information in preparation for FY 2014 allocation modifications, and resume discussion at next PP&A Committee meeting, with additional information as available, to conclude deliberations and finalize FY 2014 allocation modification decisions.

**9. FY 2014 PRIORITY- AND ALLOCATION-SETTING (P-AND-A)—MODIFICATIONS TO FY 2014 ALLOCATIONS**: Committee members and members of the public declared their conflicts of interest.

- Mr. Land said modifications are needed in anticipation of projected funding cuts. Mr. Vega-Matos said that across-the-board percentage reductions could be the solution, but cutting all categories equally presents a greater problem for service categories with already small allocations. Reducing already small allocations further can make render it impossible to effectively continue the service.
- It is important to evaluate changes in other funding streams, e.g., DHSP is discussing the expansion of mental health services reimbursed by DMH for patients migrating to Medi-Cal managed care. DHSP is also discussing how best to maximize services in coordination with HOPWA, e.g., they fund housing specialists, housing case management and some mental health services. The goal is to leverage and optimize all services as well as possible.
- Mr. Land asked if there were discussions in Washington, DC about adjusting the requirement to allocate 75% of Ryan White funds to core medical services with support services capped at 25%. Mr. Vincent-Jones said the 75% core medical service threshold was statutory and could not be changed administratively, although HRSA has relaxed the requirements of requesting a waiver for the core medical threshold. The first question, he said, was how to structure allocations without a definitive reduction amount from the sequester, as of yet. Depending on how deep the cuts, the 75%/25% may not end up being a significant concern.

**MOTION #3**: Approve modifications to FY 2014 allocations, as detailed (***Postponed***).

**A. Forecasting ACA Impact and Other Factors**: Mr. Vega-Matos said DHSP has been monitoring medical services for particular populations as they migrate into managed care. The goal for MCC is to ensure PLWH maximize the systems of care now available to them. There will be ongoing monitoring to ensure the best response to this massive system change.

**B. Contingency Funding Scenarios**:

- Mr. Vincent-Jones said creating scenarios leads to multiple sets of allocations. In the past, when the Committee has chosen an increase and a decrease scenario, the Committee might determine allocations for flat funding; and then revise it for more funding, or significantly less funding. When the Committee has relied on contingency scenarios due to changes in the award amount, it has reassembled after the award announcement, reviewed the appropriate contingency scenario allocations, and made adjustments to them, as necessary. Having the contingency scenarios done in advance has been extremely useful and has expedited the process substantially. He added that the Committee has rarely made across-the-board cuts, but has preferred to modify select service categories.
- Mr. Singer agreed they could be useful, but more funding is unlikely. He suggested a more general discussion on, for example, whether to keep whole some service categories and zero out others, whether cuts should be more evenly spread, or whether there might be funding in other systems of care. Determining a basic direction would be helpful.
- Mr. Vincent-Jones said another option would be to create just two scenarios for flat-funding and significant cuts. He noted the Commission has been creative in developing scenarios to meet the need and urged thinking outside the box.
- Mr. Vega-Matos noted cutting across-the-board can make maintenance of some smaller service categories untenable. Instead, he recommended protecting core service categories and making any cuts from those remaining.
- Mr. Singer urged Commission leadership and the Public Policy Committee to emphasize that jurisdiction cuts will directly undermine necessary services for PLWH and petition the State for relief from its budget surplus. Mr. Vincent-Jones said the Public Policy Committee has advocated for restoring funding since 2009 without success. However, he noted, this would be the first year since then that the State would have a surplus—so there might be a different response.
- Ms. Tula noted prevention had not been discussed and asked for funding information comparable to that for care. Mr. Vincent-Jones said material was being developed, and the Committee was preparing to discuss how to proceed with priority- and allocation-setting for prevention. Mr. Vega-Matos added there will be STD responsibilities as well.
- Mr. Vincent-Jones said PP&A was advancing into FY 2014 allocation revisions because the former Commission's P&P Committee completed the FY 2014 allocations in May, but did not feel the data nor the information was sufficient and defined the initial allocations as only preliminary—committing to reconvene the Committee following unification for a better assessment of service utilization, migration and cost expenditure patterns. The Committee is behind schedule for final determination of the FY 2014 allocations; if the allocations are not updated by the January meeting it will be necessary to call a special meeting(s) until it can generate allocation recommendations to the Commission, which must approve final allocations in time for DHSP to modify contracts prior to the start of FY 2014.
- The FY 2015 priority- and allocation-setting process (P-and-A process) will be the first one that the new PP&A Committee will shape and complete from scratch. As the first P-and-A process since the Commission's and PPC's unification, the PP&A Committee must determine how it will prioritize and allocate HIV care, prevention—and possibly STD—resources, services and interventions in an integrated manner. He expressed hope that they could start the discussion and deliberations of how to modify the traditional P-and-A process so that it can cover a broader spectrum of services, interventions and approaches, as well as disease conditions, than what it had initially been designed.
- Mr. Vincent-Jones said that re-formatting the process is the Committee's next responsibility, after completing the FY 2014 P-and-A Allocation modifications. He expressed hope that they could start it with Sophia Rumanes or another designated party from DHSP presenting an overview of the local HIV prevention strategy, service delivery, and financing requirements and options.
- Mr. Singer suggested DHSP might provide recommendations, but Mr. Vincent-Jones said PP&A should evaluate their choices first by considering the breadth of information provided. Mr. Vega-Matos added the challenge going forward is that the ACA will expand coverage, but it may not be in the manner to which we are accustomed, so it must be assessed over time. He noted Covered California has navigators, but they often will not be experienced in interacting with PLWH.
- Mr. Ballesteros suggested funding other potential cuts by reducing medical outpatient and psychiatry by half since they are covered by ACA. Mr. Vincent-Jones urged developing parameters, such as scenarios, before determining allocations. He suggested a five-hour January meeting with a tentative second meeting to complete allocations.

➲ Two PP&A Committee meetings scheduled for January 21 and 28, 2014, both 12:00 – 5:00 pm, with lunch provided. The first priority is completing the FY 2014 allocation modifications. If completed in the first meeting, it will be the Committee's decision to keep the second January meeting date and begin addressing the FY 2015 P-and-A Process, or to cancel the meeting, and begin the FY 2015 discussion at the regularly scheduled February meeting.

**C**. **Resource Allocations**: Mr. Land urged all to read the Los Angeles County HIV Prevention Plan, 2009-2013. A PowerPoint was in the packet and the Plan is on the DHSP website.

**10. FY 2015 PRIORITY- AND ALLOCATION-SETTING (P-AND-A)**: This item was postponed.

**11. COMPREHENSIVE HIV PLAN**: This item was postponed.

**12. FY 2014 WORK PLAN**:

**A. Committee Work Priorities**: There was no discussion.

**B**. **Scheduling and Timeline(s)**:

- Expand 1/27/2014 meeting to 12:00 noon to 5:00 pm with a second meeting 1/28/2013 if needed to complete modification of FY 2014 allocations.

**C**. **Community Engagement Plan**: There was no discussion.

**13. NEXT STEPS**: This item was postponed.

**14. ANNOUNCEMENTS**: There were no announcements.

**14. ADJOURNMENT**: The meeting adjourned at 4:00 pm.