NEW HAVEN / FAIRFIELD COUNTIES
RYAN WHITE PLANNING COUNCIL

*Joanne Montgomery, Mitchell Namias & Anthony Santella, Co-Chairs*

**Planning Council Resource Allocation Meeting Minutes**

**Meeting Date:** Friday, September 11, 2026
**Start Time:** 9:09am
**End Time:** 1:25pm
**Location:** Burroughs Community Center & Zoom Videoconference
**Presiding Chairs:** Joanne Montgomery
**Recorder:** Sara Seaburg

**(1.0) Moment of Silence**

Joanne called the meeting to order at 9:09 a.m. A moment of silence was observed in recognition of September 11th and all who have been affected by HIV/AIDS.

**(2.0) Welcome and Introduction**

Joanne welcomed everyone and requested that all Planning Council members and guests introduced themselves, where they live in the EMA, their conflicts and their Planning Council leadership role, if applicable.

**(3.0) Co-Chair Announcements**

Joanne reminded attendees of the importance of declaring conflicts because the meeting involved funding decisions and resource allocation discussions. Support staff confirmed that annual conflict of interest forms had been completed and filed.

**(4.0) GY2027Resource Allocation Training and Overview**

Joanne presented a training on the resource allocation process. She explained that priority setting and resource allocation are related but separate activities. While priority setting determines the relative importance of service categories based on needs assessment findings, epidemiologic data, and service utilization trends, resource allocation determines how available Ryan White Part A funds are distributed across approved service categories. Attendees were reminded that a highly ranked service category does not automatically receive the largest funding amount because other funding sources may already support those services. Examples included AIDS Drug Assistance Program services and housing services, which remain high priorities even when Ryan White Part A funding is limited because other programs partially address those needs.

Attendees reviewed the resource allocation methodology, including use of historical expenditures, current allocations, unduplicated client counts, cost-per-client calculations, regional funding formulas, service utilization data, and federal funding limitations. They were reminded that decisions must be based on documented data rather than anticipated future changes, such as potential Medicaid eligibility losses. The training also emphasized HRSA requirements for documenting funding rationales and maintaining evidence supporting all allocation decisions. Attendees discussed the need to reconcile results with the Non-Competing Continuation (NCC) funding ceiling and ensure compliance with HRSA's 75% core service requirement and 25% support service limitation.



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COLLABORATIVE RESEARCH

*Joanne Montgomery, Mitchell Namias & Anthony Santella, Co-Chairs*

**GY27 Funding Overview**

*Medical Case Management (MCM)*
Attendees reviewed Medical Case Management expenditures, allocations, unduplicated client counts, and cost-per-client calculations for all five regions. The FY25 expenditure data showed over $1.3 million invested in MCM services across the EMA. Discussion focused on maintaining service stability during the third year of the current funding cycle and minimizing disruptions to existing service systems. The average cost-per-client methodology was reviewed, with attendees examining regional cost variations and discussing how the weighted average was calculated. There was agreement that MCM remains the foundation of the Ryan White service system because it supports linkage to care, retention in care, treatment adherence, and access to support services. Attendees noted that while costs have increased over time due to salary and operational expenses, the overall allocation percentage for MCM remained relatively stable. The committee ultimately maintained the established methodology, recognizing the importance of preserving continuity of care and avoiding significant funding shifts during a continuation year.

*Minority AIDS Initiative (MAI) Intensive Medical Case Management*
Attendees reviewed the MAI allocation directive and discussed the historical rationale for distributing MAI funds equally across all five regions. It was noted that the MAI funding pool is relatively small and dividing funding according to regional utilization would result in amounts too small to meaningfully support staffing or service delivery. Because of this, the Planning Council's standing directive requiring a 20% distribution to each region remained. Attendees agreed that maintaining equal regional distribution maximizes the impact of MAI resources and ensures all regions have dedicated intensive medical case management support for disproportionately impacted populations.

*Oral Health Care Services*
The oral health discussion focused heavily on Region 1 utilization data. Attendees noted that Region 1 experienced a provider transition and had to rebuild its oral health program, resulting in significantly lower utilization numbers than expected. Several attendees expressed concern that relying solely on current utilization data would unfairly penalize a newly established program still in a startup phase. Discussion included the cost of maintaining dental professionals and the challenge of supporting oral health programs with limited funding. Attendees acknowledged that oral health remains an important component of HIV care and discussed concerns that reductions could affect access to preventive and restorative dental services. The committee later revisited this category and approved additional funding support (+$21,000) above the original calculated amount because attendees felt the utilization data did not fully reflect actual need due to the startup circumstances.

*Outpatient Ambulatory Health Services (OAHS)*
Discussion focused on the number of uninsured and uninsurable clients served across regions and the unique situation in Region 4. Because Region 4 does not receive Part C funding, attendees discussed the need to continue using a different methodology that accounts for its greater reliance on Part A-supported outpatient medical care. Considerable discussion occurred regarding how uninsured client counts are calculated, whether counts are fully capturing actual need, and whether fluctuations may reflect changing insurance enrollment rather than true decreases in medical need. Attendees



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ultimately chose to preserve service stability through a level-funding approach rather than implementing significant shifts that could negatively affect medical access. Multiple participants emphasized that outpatient medical care remains one of the core services directly linked to viral suppression outcomes.

*Mental Health Services*
Attendees reviewed regional mental health service utilization trends and funding allocations. Data demonstrated shifting utilization patterns among regions, resulting in moderate funding increases and decreases. Discussion centered on the growing need for mental health services among people living with HIV and the critical role that behavioral health plays in treatment adherence, housing stability, and overall quality of life. Several attendees noted that mental health needs continue to increase across the EMA as clients face economic instability, housing insecurity, substance use issues, and social isolation. Although the allocation methodology resulted in minor regional changes, attendees generally agreed that mental health remains a priority service area and supported maintaining a strong funding commitment.

*Substance Abuse Services - Outpatient*
Attendees reviewed outpatient substance use treatment funding, regional client counts, and average cost-per-client calculations. Discussion focused on maintaining consistency with prior-year methodologies while ensuring sufficient support for substance use treatment services. Participants noted that outpatient treatment often prevents more costly interventions by keeping clients connected to recovery services before issues escalate to residential treatment needs. Funding changes generated by utilization data were relatively small, and the committee supported the projected allocation model without major adjustments.

*Health Insurance Premium Cost Sharing Assistance (HIPCSA)*
Discussion regarding HIPCSA focused on its role as a payer-of-last-resort service. Attendees reviewed utilization patterns and noted that in many cases clients obtain health insurance coverage through Medicaid, Marketplace plans, or other sources before HIPCSA funding becomes necessary. Representatives from Region 1 explained that utilization trends accurately reflected actual demand and that funding is frequently reallocated when anticipated enrollment does not occur. Discussions highlighted that lower utilization should not necessarily be viewed negatively since successful enrollment into other insurance options often reduces reliance on Ryan White-funded premium assistance.

*Emergency Financial Assistance (EFA)*
Attendees discussed EFA as one of the most flexible support service categories available within the Ryan White system. Funding supports emergency needs that threaten a client's ability to remain engaged in care, including utility assistance, temporary financial crises, and urgent needs impacting treatment adherence. Several attendees emphasized that EFA often serves as an intervention that prevents larger crises such as homelessness or disengagement from medical care. The funding calculations produced moderate regional changes, but attendees generally agreed that EFA remains a critical support service within the continuum of care.



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*Medical Transportation Services*

Medical Transportation generated extensive discussion because several regions experienced funding reductions under the allocation formula. Attendees raised concerns that transportation barriers continue to increase as clients lose access to other transportation resources and face rising costs associated with travel to appointments. Multiple participants highlighted the challenge created when reduced funding limits service availability, resulting in lower utilization and even lower allocations in future years. Discussion included the possibility of exploring gas cards, transportation vouchers, rideshare models, and alternative transportation approaches during future planning cycles. Ultimately, attendees favored restoring transportation funding to prior levels because transportation remains essential for ensuring access to medical appointments and supportive services.

*Food Bank/Home Delivered Meals*

Attendees noted substantial differences among regional food assistance models. Some regions provide food cards to a large number of clients at lower amounts, while others provide larger food benefits to fewer clients. Participants repeatedly emphasized that unduplicated client counts do not adequately capture the real impact of food services because client benefits vary significantly by region. Food insecurity was repeatedly cited as a major concern affecting adherence to medications and overall health outcomes. Attendees discussed the lack of a standardized food assistance model throughout the EMA and questioned whether future directives should establish more consistent food benefit levels. Because food emerged as a major area of need throughout discussions, additional funding (+$70,000) was ultimately directed to this category during final allocation reconciliation.

*Housing Services*

Housing discussions focused on increasing housing instability and the distinction between Ryan White housing assistance and broader housing subsidy programs. Attendees reviewed fair market rent calculations and discussed how housing funds are used differently across regions. Some providers utilize a portion of funding for housing coordinators and housing navigation services, while others primarily provide first month's rent, last month's rent, or arrearage assistance. A significant part of the discussion centered on the recent loss of housing resources in some areas, particularly concerns surrounding HOPWA funding reductions affecting clients in Waterbury. Attendees acknowledged rising housing costs throughout the EMA and agreed that housing stability remains closely tied to treatment retention and health outcomes. Concerns were also raised regarding allocation methods that may unintentionally suppress future funding when lower funding levels reduce the number of clients served. Additional resources (increased to 115% of 2026 FMV)were eventually directed toward housing during final allocation adjustments.

*Substance Abuse Services - Residential/Inpatient*

Attendees reviewed historical data showing a substantial decline in bed days, from nearly 2,800 bed days in previous years to approximately 864 bed days in FY25. Discussion focused on structural changes in service delivery, the reduction of available treatment capacity, changes in contracting approaches, and the impact of Connecticut's Substance Use Disorder waiver process. Participants raised concerns that fewer beds were available within the service system, leading to lower utilization despite continued demand for treatment.



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At the same time, attendees recognized that residential treatment remains an essential service for clients experiencing severe substance use disorders. Debate centered on whether funding should remain level despite lower utilization or whether allocations should reflect observed decreases in bed days. Some attendees argued that maintaining prior funding levels could not be justified when bed-day utilization had dramatically declined. Others emphasized that reducing funding could further limit already constrained treatment capacity. After extensive discussion, attendees reached consensus to reduce the allocation by approximately one-third while documenting concerns about treatment capacity and identifying this category for future review. Participants specifically requested follow-up discussions regarding contracting structures, regional access, service capacity, and future directives to ensure equitable residential treatment access across the EMA.

**Final Reconciliation and Allocation Adjustments**

Once all service categories were reviewed, the committee examined the cumulative funding picture. Initial calculations revealed unallocated funds and prompted discussions regarding where additional dollars should be placed. Members considered support service priorities, data limitations, current utilization patterns, and changing community needs. Additional resources were ultimately directed toward Food Bank/Home Delivered Meals, Oral Health Services, Housing Services, and other identified priorities following committee discussion and consensus-building. Throughout the process, members carefully monitored the required 75% core/25% support service distribution and ensured compliance with HRSA requirements. Final calculations resulted in an allocation structure that closely matched available funding while maintaining compliance with all funding restrictions.

A roll call vote was taken for each service category's funding rationale with conflicted Planning Council members abstaining.

Chris Cole made a motion to accept the allocation of 5.23% for Outpatient Ambulatory Health Services and Rich Radocchia seconded it:
**For: (11)** Burdick, Cole, Datcher, Davis, Johns, McNair, McNeil, , Montgomery, Namias, Radocchia, Santella
**Against: (0)**
**Abstain: (3)** Pennacchia, Stewart, Walton

Anthony Santella made a motion to accept the allocation of 31.22% for Medical Case Management and Chris Cole seconded it:
**For: (9)** Burdick, Datcher, Davis, Johns, McNair, McNeil, Namias, Santella
**Against: (0)**
**Abstain: (5)** Cole, Montgomery, Pennacchia, Radocchia, Stewart, Walton

Chris Cole made a motion to accept the allocation of 5.25% for Food Bank/Home Delivered Meals and Anthony Santella seconded it:
**For: (9)** Burdick, Datcher, Davis, Johns, McNair, McNeil, Namias, Santella
**Against: (0)**
**Abstain: (5)** Cole, Montgomery, Pennacchia, Radocchia, Stewart, Walton



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Chris Cole made a motion to accept the allocation of 15.87% for Mental Health and Anthony Santella seconded it:
**For: (9)** Burdick, Datcher, Davis, Johns, McNair, McNeil, Namias, Santella
**Against: (0)**
**Abstain: (5)** Cole, Montgomery, Pennacchia, Radocchia, Stewart, Walton

Anthony Santella made a motion to accept the allocation of 4.37% for Emergency Financial Assistance and Chris Cole seconded it:
**For: (9)** Burdick, Datcher, Davis, Johns, McNair, McNeil, Namias, Santella
**Against: (0)**
**Abstain: (5)** Cole, Montgomery, Pennacchia, Radocchia, Stewart, Walton

Anthony Santella made a motion to accept the allocation of 6.84% for Housing Services and Rich Radocchia seconded it:
**For: (10)** Burdick, Cole, Datcher, Davis, Johns, McNair, McNeil, Namias, Radocchia, Santella
**Against: (0)**
**Abstain: (4)** Montgomery, Pennacchia, Stewart, Walton

Anthony Santella made a motion to accept the allocation of 3.43% for Oral Health Services and Chris Cole seconded it:
**For: (9)** Burdick, Datcher, Davis, Johns, McNair, McNeil, , Montgomery, Namias, Santella
**Against: (2)** Cole, Radocchia
**Abstain: (3)** Pennacchia, Stewart, Walton

Anthony Santella made a motion to accept the allocation of 1.70% for Medical Transportation and Chris Cole seconded it:
**For: (9)** Burdick, Datcher, Davis, Johns, McNair, McNeil, Namias, Santella
**Against: (0)**
**Abstain: (5)** Cole, Montgomery, Pennacchia, Radocchia, Stewart, Walton

Chris Cole made a motion to accept the allocation of .85% for Health Insurance Premium and Cost Sharing Assistance and Anthony Santella seconded it:
**For: (11)** Burdick, Datcher, Davis, Johns, McNair, McNeil, Montgomery, Namias, Santella
**Against: (0)**
**Abstain: (3)** Cole, Montgomery, Pennacchia, Radocchia, Stewart, Walton

Anthony Santella made a motion to accept the allocation of 17.40% for Substance Abuse Services Outpatient and Chris Cole seconded it:
**For: (9)** Burdick, Datcher, Davis, Johns, McNair, McNeil, Namias, Santella
**Against: (0)**
**Abstain: (5)** Cole, Montgomery, Pennacchia, Radocchia, Stewart, Walton

Chris Cole made a motion to accept the allocation of 7.84% for Substance Abuse Services Residential and Gloria McNeil seconded it:



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**For: (14)** Burdick, Cole, Datcher, Davis, Johns, McNair, McNeil, , Montgomery, Namias, Pennacchia, Radocchia, Santella, Stewart, Walton
**Against: (0)**
**Abstain: (0)**

Chris Cole made a motion to extend the meeting 10 minutes and Joanne Montgomery seconded it.
**For: (14)** Burdick, Cole, Datcher, Davis, Johns, McNair, McNeil, , Montgomery, Namias, Pennacchia, Radocchia, Santella, Stewart, Walton
**Against: (0)**
**Abstain: (0)**

Chris Cole made a motion to extend the meeting 10 minutes and Mitchell Namias seconded it.
**For: (14)** Burdick, Cole, Datcher, Davis, Johns, McNair, McNeil, , Montgomery, Namias, Pennacchia, Radocchia, Santella, Stewart, Walton
**Against: (0)**
**Abstain: (0)**

| 2026 FINAL AWARD (SERVICES) Formula + Supplemental | | $ 4,366,817 | 2026 FINAL MAI | $ 351,254 | 2026 TOTAL AWARD SERVICES ONLY | $ 4,718,071 |
|---|---|---|---|---|---|---|
| 2027 NCC Ceiling Formula + Supplemental (SERVICES ONLY) | | $ 4,459,250 | 2027 NCC MAI | $ 358,689 | 2027 TOTAL NCC Ceiling | $ 4,817,939 |
| Service Category | 2026 Allocated | 2026 % of Allocation | 2026 MAI Allocated | FY27 Formula/Supplemental Grant Request--$$ | FY27 Formula/Supplemental Grant Request--%% | FY27 MAI Grant Request |
| Outpatient/Ambulatory Health Services | $ 228,384 | 5.2300% | | $ 228,384 | 5.1216% | |
| Food Bank/Home Delivered Meals | $ 229,256 | 5.2500% | | $ 320,294 | 7.1827% | |
| Medical Case Management | $ 1,363,321 | 31.2200% | $ 351,255 | $ 1,365,612 | 30.6243% | $ 351,255 |
| Oral Health Care | $ 149,782 | 3.4300% | | $ 170,024 | 3.8128% | |
| Housing Services | $ 298,692 | 6.8400% | | $ 352,621 | 7.9076% | |
| Mental Health Services | $ 693,012 | 15.8700% | | $ 712,215 | 15.9716% | |
| Substance Abuse Services-Outpatient | $ 759,826 | 17.4000% | | $ 769,350 | 17.2529% | |
| Medical Transportation | $ 74,236 | 1.7000% | | $ 74,236 | 1.6648% | |
| Emergency Financial Assistance | $ 190,831 | 4.3700% | | $ 190,012 | 4.2611% | |
| Health Insurance Premium/Cost Sharing | $ 37,118 | 0.8500% | | $ 39,420 | 0.8840% | |
| Substance Abuse Services-Inpatient | $ 342,359 | 7.8400% | | $ 237,082 | 5.3166% | |
| *TOTAL ALLOCATION* | $ 4,366,817 | 100% | $ 351,255 | $ 4,459,250 | 100.00% | $ 351,255 |

| FY 2027 | | |
|---|---|---|
| | $4,718,072 | 100% |
| CORE SEVICES | $3,582,698 | 75.9356% |
| SUPPORT SERVICES | $1,135,374 | 24.0644% |

| FY 2027 | | |
|---|---|---|
| 2027 Total Request | $ 4,810,504 | 100% |
| Core Services | $ 3,636,260 | 75.5900% |
| Support Services | $ 1,174,245 | 24.4100% |
| Formula + Supplemental N | $ 4,459,250 | SERVICES |
| MAI - MAX | $ 358,689 | SERVICES |
| | $ 4,817,939 | |
| Formula + Supplemental | $ 5,246,176 | (+15% Admin) |
| MAI | $ 421,987 | (+15% Admin) |
| Total | $ 5,668,163 | |



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Before adjournment, members discussed the need for a future PSRA/QISPA debrief to examine recurring concerns identified during the allocation process, including food assistance methodology, transportation formulas, housing allocation methods, oral health utilization trends, and residential treatment funding. Members also agreed that future discussions should examine the availability of other funding resources throughout the EMA and consider more equitable approaches to measuring service need across regions.

**(6.0) Announcements**
None

**(7.0) Adjournment -** The meeting adjourned at 1:20pm

| | Council Member | Jan | Feb | Mar | April | May | June | PSRA Day 1 | PSRA Day2 | Sept | Oct | Nov |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. | Maria Bigby | X | X | X | A | A | A | A | A | | | |
| 2. | Jeremie Burdick | X | X | X | X | X | X | X | X | | | |
| 3. | *Chris Cole PC Co-Chair* | X | X | X | X | A | X | X | X | | | |
| 4. | Brian Datcher | A | X | X | X | X | X | X | X | | | |
| 5. | Libra Davis | X | X | X | X | X | X | X | X | | | |
| 6. | Kasima Jeter | X | X | X | X | X | A | X | A | | | |
| 7. | Christopher Johns | A | A | A | A | A | X | X | X | | | |
| 8. | Gloria McNeil | X | X | X | A | X | A | A | X | | | |
| 9. | LaTonya McNair | X | X | X | A | X | X | X | X | | | |
| 10. | **Joanne Montgomery, Co-Chair** | X | A | X | X | X | X | X | X | | | |
| 11. | **Mitchell Namias, Co-Chair** | A | X | A | X | X | X | X | X | | | |
| 12. | Ruth Pennacchia | A | X | X | X | X | X | X | X | | | |
| 13. | Richard Radocchia | A | X | X | X | X | A | X | X | | | |
| 14. | **Anthony Santella, Co-Chair** | X | X | X | X | X | X | X | X | | | |
| 15. | *Roberta Stewart PC Co-Chair* | X | X | X | X | X | X | X | X | | | |
| 16. | Keith Taylor | - | - | - | - | - | X | X | A | | | |
| 17. | Sophie Walton | X | A | X | X | X | X | A | X | | | |
| | Ryan White Office | X | X | X | X | X | X | X | X | | | |
| | Planning Council Staff | X | X | X | X | X | X | X | X | | | |
| | % of Council present: | 67% | 78% | 83% | 72% | 78% | 76% | 82% | 82% | | | |

Guests: Jennifer Degraca, Jackson Monarca, Jen Loschiavo, Nida Butt, Nitza Agosto, Jamelia Beckford, Jean Brown, Nick Boshnack, Chloe Johnson, Sofia Swaby, Migdalia Garcia, Merceditas Villanueva, Michael Virata, Christine Bianchi



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