MIAMI-DADE HIV/AIDS PARTNERSHIP

New Member Orientation

Part I: Ryan White Program Legislation and Rules

Revised February 2022

Our Vision is to eliminate disparities and improve health outcomes for all people living with or at risk for HIV/AIDS.

Sections of this presentation have been adapted from the Target HIV-Planning CHATT

New Member Orientation Objectives

Part I: Introduce Ryan White Program legislation and rules.

Part II: Introduce the Partnership's functions, goals, missions and committees, review Partnership members' responsibilities, essential processes of the Partnership, and introduce terms, concepts, and governing documents.

Part III: Familiarize new Partnership members with some HIV/AIDS data elements and how to use them.

Note: The Partnership is the official Ryan White HIV/AIDS Planning Council

RYAN WHITE LEGISLATION

WHAT EVERY PLANNING COUNCIL MEMBER SHOULD KNOW

Ryan White Treatment Extension Act

- Largest Federal government program *specifically designed* to provide services for people living with HIV/AIDS – $2.5 billion in funding in FY 2020 including new funding for Ending the Epidemic,
- Third largest Federal program serving people living with HIV/AIDS – after Medicaid and Medicare
- Enacted as the Ryan White Comprehensive AIDS Resources Emergency Act in 1990
- Amended in 1996, 2000, 2006, 2009 – no longer an "emergency" act; currently the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Services Act
- Provides grants awarded to the chief elected official of the city or county, who designates a lead agency to administer the funds.

Revised Purpose of Ryan White Legislation

- No longer "emergency relief" for overburdened health care systems.
- Now "Revise and extend the program for providing life-saving care for those with HIV/AIDS."
- "Address the unmet care and treatment needs of persons living with HIV/AIDS by funding primary health care and support services that enhance access to and retention in care."

Five Parts to Ryan White Program

- Part A
- Part B
- Part C
- Part D
- Part F

Ryan White Programs: Part A

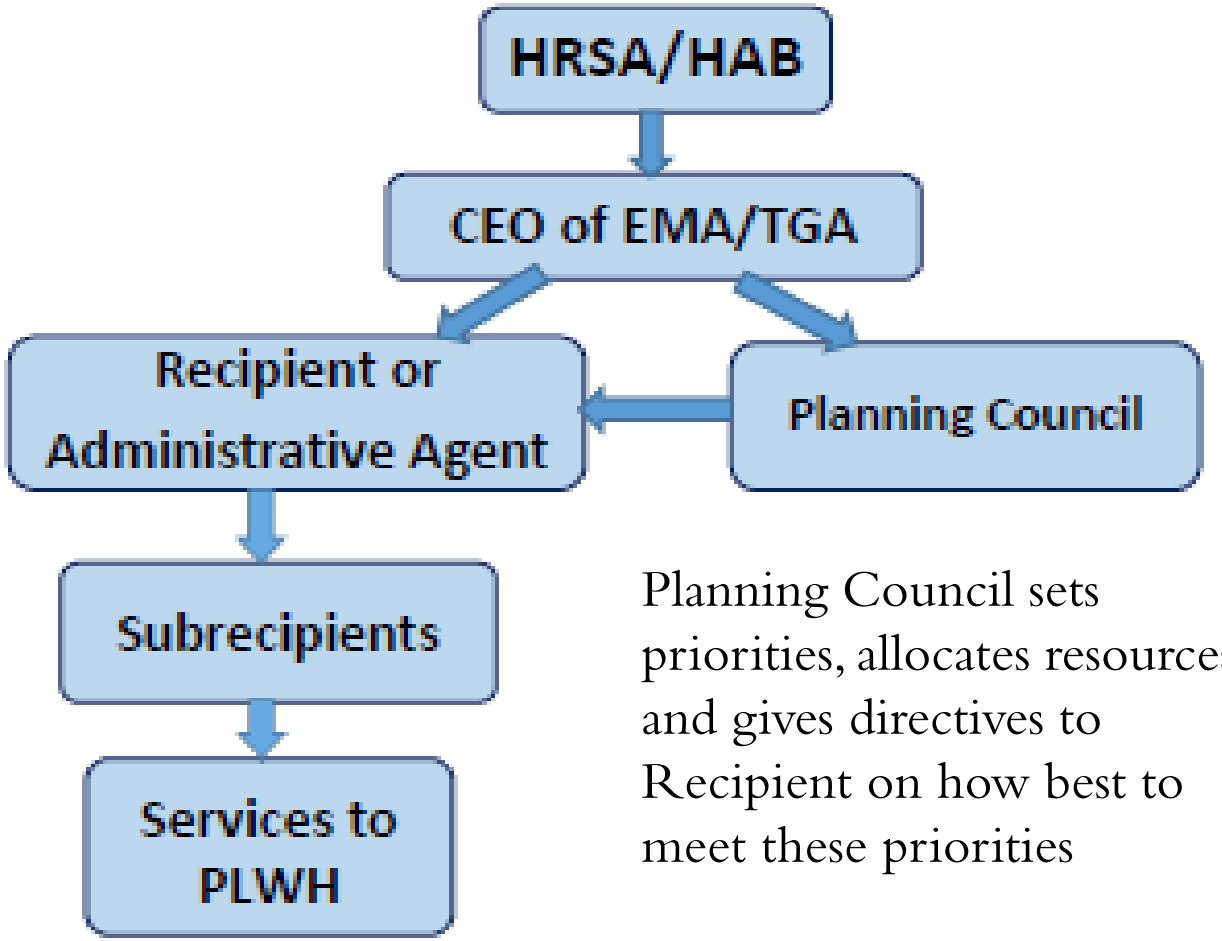
- Funding for 52 **E**ligible **M**etropolitan **A**reas (EMAs) and **T**ransitional **G**rant **A**reas (TGAs) that are severely and disproportionately affected by the HIV epidemic:
  - 24 EMAs

    At least 2,000 cases in the most recent five years and have a population of at least 50,000

    Each EMA must have a planning council which sets HIV-related service priorities and allocates Part A funds.
  - 28 TGAs

    Reported 1,000-1,999 AIDS cases reported in the most recent five years and a population of a least 50,000
  - Two part funding: base formula and supplemental award
  - Approximately $655.9 million was appropriated to Part A in FY 2020.
- Administered by the Division of Metropolitan HIV/AIDS Programs (DMHAP), a division of the Health Resources and Services Administration (HRSA).

Flow of RWHAP Part A Decision Making and Funds



Planning Council sets priorities, allocates resources, and gives directives to Recipient on how best to meet these priorities

Ryan White Programs: Part B

- Grants to all 50 States, DC, Puerto Rico, territories and jurisdictions:
  - Base Award
  - Supplemental Award (competitive)
  - AIDS Drug Assistance Program (ADAP)
  - Supplemental ADAP Award
  - Grants to Emerging Communities (500-999 new cases in past 5 years)
- Administered by the Division of State HIV/AIDS Programs (DSHAP) a division of the Health Resources and Services Administration (HRSA).

Parts C and D

- Part C (four grantees locally)
  - Funding to local community-based organizations, community health centers, health departments, and hospitals to support comprehensive primary health care and support services in an outpatient setting.
  - Planning grants and capacity development grants to more effectively deliver HIV care and services.
- **Part D** Family-centered HIV primary medical and support services for women, infants, children, and youth living with HIV and their affected family members.

Part F Minority AIDS Initiative (MAI)

- Congress authorized MAI in 1999 to improve access to HIV care and health outcomes for disproportionately affected minority populations.
- Allowable uses of MAI funds vary by Ryan White Program Part.
- Ryan White HIV/AIDS Program (RWHAP) Part As receive MAI formula grants to use for core medical and related support services designed to improve access and reduce disparities in health outcomes.
- Funding formula is based on the number of racial and ethnic minority individuals with HIV/AIDS in the jurisdiction.

Part F Dental Services

- **Part F** Dental Reimbursement Programs and Community Based Dental Partnership.
- Administered by the Division of Community HIV/AIDS Programs (DCHAP) a division of the Health Resources and Services Administration (HRSA).

Other Part F Programs

- **Special Projects of National Significance (SPNS)** Supports the development of innovative models of care and effective delivery systems for HIV care, and the dissemination of successful models.
- **HIV/AIDS Education and Training Centers (AETCs)** Supports a network of regional centers that conduct targeted, multidisciplinary education and training programs for health care providers serving people with HIV.
- Administered by the Office of HIV/AIDS Training and Capacity Development (OHATCD).

FACTORS IMPORTANT TO PLANNING COUNCILS/BODIES

Medical Model

Major focus on core medical services (medical model)

- 75% of funds must be spent on core medical services.
- Support services must contribute to positive clinical outcomes.
- Refinements to service categories and definitions in 2016 (PCN #16-02).

Eligible Core Medical Services: Parts A and B

1. AIDS Drug Assistance Program (ADAP) Treatments
2. Local AIDS Pharmaceutical Assistance Program (LPAP)
3. Early Intervention Services (EIS)
4. Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
5. Home and Community-Based Health Services
6. Home Health Care
7. Hospice Services
8. Medical Case Management, including Treatment Adherence Services
9. Medical Nutrition Therapy
10. Mental Health Services
11. Oral Health Care
12. Outpatient/Ambulatory Health Services
13. Substance Abuse Outpatient Care

Support Services

- **Must be**
  - ≤25% of total service expenditures;
  - Approved by the Secretary of HHS; and
  - Needed to achieve medical outcomes.
- **Medical outcomes**
  - Outcomes affecting the *HIV-related clinical status* of an individual with HIV/AIDS.

Allowable Support Services: Parts A and B

1. Child Care Services
2. Emergency Financial Assistance
3. Food Bank/Home Delivered Meals
4. Health Education/Risk Reduction
5. Housing
6. Linguistic Services
7. Medical Transportation
8. Non-Medical Case Management Services
9. Other Professional Services, e.g., Legal Services and Permanency Planning
10. Outreach Services
11. Psychosocial Support Services
12. Referral for Health Care and Support Services
13. Rehabilitation Services
14. Respite Care
15. Substance Abuse Services (residential)

Limits on Non-Service Funding

- Focus
  - Maximize funding for direct services.
- 10% Administrative Cap
  - For administrative costs, including Planning Council(Miami-Dade HIV/AIDS Partnership) support costs.

Factors Affecting HIV/AIDS Services Nationally

1. Because of available and emerging therapies, people with HIV/AIDS are living long and productive lives.
2. Changes in the larger health care system and financing affect HIV services.
3. Policy and funding increasingly are determined by clinical outcomes.
4. National policies effect local programs, National HIV Strategy (NHAS) and Ending the Epidemic (EHE)

Focus on National HIV/AIDS Strategy (NHAS) Goals and HIV Care Continuum

NHAS 2022 Goals

1. Reducing new HIV cases.
2. Increasing access to care and improving health outcomes for people with HIV.
3. Reducing HIV-related disparities and health inequities.
4. Achieving a more coordinated national response to the HIV epidemic.

Ending the HIV Epidemic: A Plan for America

The U.S. Department of Health and Human Services (HHS) has launched Ending the HIV Epidemic: A Plan for America. The cross-agency initiative leverages critical scientific advances in HIV prevention, diagnosis, treatment, and outbreak response by coordinating the highly successful programs, resources, and infrastructure of many HHS agencies and offices.

GOAL:

reaching 75% reduction in new HIV infections by 2025 and at least 90% reduction by 2030.

HHS will work with each community to establish local teams on the ground to tailor and implement strategies to:

- **Diagnose** all people with HIV as early as possible after infection.
- **Treat** HIV infection rapidly and effectively to achieve sustained viral suppression.
- **Prevent** new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).
- **Respond** quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

The Initiative is focusing resources on areas where HIV transmission occurs most frequently.

Geographical Selection:

Data on burden of HIV in the US show areas where HIV transmission occurs more frequently. More than 50% of new HIV diagnoses* occurred in only 48 counties, Washington, D.C., and San Juan, Puerto Rico. In addition, 7 states have a substantial rural burden – with over 15 cases and 30% or more of their diagnoses in rural areas.

*2016-2017 data

Ending the HIV Epidemic

www.HIV.gov

ROLES AND RESPONSIBILITIES OF PLANNING COUNCILS

AN OVERVIEW

Roles and Responsibilities

Roles/Duties of the CEO, Recipient, and Planning Council

ROLE/DUTY	RESPONSIBILITY		
	CEO	Recipient	Planning Council
Establishment of Planning Council/ Planning Body	✓		
Appointment of Planning Council/ Planning Body Members	✓		
Needs Assessment		✓	✓
Integrated/Comprehensive Planning		✓	✓
Priority Setting			✓
Resource Allocations			✓
Directives			✓
Procurement of Services		✓	
Contract Monitoring		✓	
Coordination of Services		✓	✓
Evaluation of Services: Performance, Outcomes, and Cost-Effectiveness		✓	*Optional*
Development of Service Standards		✓	✓
Clinical Quality Management		✓	*Contributes but not responsible*
Assessment of the Efficiency of the Administrative Mechanism			✓
Planning Council Operations and Support		✓	✓

Recipient and Planning Council Roles and Responsibilities

- Recipient and Planning Council
  - Two independent entities, both with legislative authority and roles
  - Recipient: "The County" Miami-Dade County Office of Management and Budget (OMB)
  - Planning Council: Miami-Dade HIV/AIDS Partnership
- Some roles belong to one entity alone and some are shared.
- Effectiveness requires clear understanding of the roles and responsibilities of each entity, *plus:*
  - Communications, information sharing, and collaboration between the Recipient, Planning Council, and Planning Council support (PCS) staff
  - Ongoing consumer and community involvement

Planning Council Formation and Membership

- Planning Council (Partnership) established by Chief Elected Official (CEO).
  - Mayor appoints all members
- Membership must meet legislated requirements:
  - Representation (legislatively required categories)
  - 33% unaffiliated consumers of Ryan White HIV/AIDS Program (RWHAP) Part A services
  - Reflectiveness (of the epidemic in the EMA/TGA)
- Must use an open nominations process
- Recipient (The County) has no role in membership selection
- Bylaws may call for a Recipient representative on the Council
- The Planning Council (Partnership) may not be chaired solely by an employee of the Recipient (The County)

Needs Assessment

- Planning Council (Partnership) has primary responsibility.
- Recipient (The County) provides support – data, procurement if a consultant is needed, and staff assistance.
- Need active community involvement – especially people with HIV and service providers.
- Need multi-year plan for assessing needs of people with HIV, in and out of care.
- Findings go in user-friendly formats as input to decision-making, especially priority setting and resource allocation.
- Data driven process.

Expectations: Needs Assessment

- Process to determine:
  - What services are needed?
  - What services are being provided?
  - What service gaps exist?
- Reviews services and expenditures overall *and* for identified target populations (in and out of care).
- Includes obtaining input of people with HIV on service needs and gaps.

Components of Needs Assessment

1. **Epi profile**
   - HIV and AIDS cases and trends
2. **A resource inventory**
   - Existing services
3. **Profile of provider capacity and capability**
   - Availability, accessibility and appropriateness overall and of specific populations
4. **Estimate and assessment of unmet need**
   - People with HIV who know their status but are not in care and people with HIV who do not know their status
5. **Estimates and assessments of people living with HIV who are unaware of their status**
   - People with HIV who have not been diagnosed
6. **Assessment of service needs gaps**
   - Information about service needs of people with HIV and barriers to getting services

Priority Setting

- Planning Council (Partnership) responsibility.
- Determining what service categories are most important for people with HIV in the EMA (Miami-Dade County) – unrelated to who provides the funding for these services.
- Recipient (The County) provides service utilization data and advice.
- The Partnership must establish a sound, fair process for priority setting and ensure that decisions are data based.
- Important to prioritize needed service categories even if there may not be enough money to fund all categories.

Directives

- Planning Council (Partnership) role.
- Providing guidance to the Recipient (The County) on how best to meet the priorities and other factors to consider in procurement.
- Often specify use or non-use of a particular service model, or address geographic access to services, language issues, or specific target populations.
- Must not have the effect of limiting open procurement by making only 1-2 providers eligible.
- Planning Council needs to be aware of cost implications.
- Recipient must follow Planning Council directives in procurement and contracting (but cannot always guarantee full success).

Resource Allocation

- Planning Council (Partnership) responsibility.
- Process of deciding how much funding to allocate to each priority service category or sub-category:
  - No **less** than 75% of service dollars must go to core services (unless program has a waiver); and
  - No **more** than 25% to support services needed for achieving medical outcomes.
- Recipient (The County) provides data and advice, but has no decision-making role
- Need a fair, data-based process that controls conflict of interest.
- Consider other funding streams, cost per client, plans for bringing people into care – *so some highly ranked service categories may receive little or no funding.*

Reallocation

- Planning Council (Partnership) role – must approve any reallocation of funds among service categories.
- Reallocation usually means moving funds:
  - From underspent providers to those *in the same service category* spending at a higher level (Recipient decision); or
  - From underspent service categories to *different service categories* spending at a higher level or with additional need (Planning Council must approve).
- Recipient (The County) provides expenditure data by service category to Planning Council, usually monthly, and requests permission for reallocations as needed.
- Some Recipients do regular "sweeps" or request reallocation permission at set times each year – *rapid reallocations process ia very important to avoid unobligated funds and ensure funds are used to address priority service needs.*

Priority Setting and Resource Allocations (PSRA)

The most important legislative responsibility of Planning Councils – ***PSRA should involve all members***

- Priority Setting
  - Deciding what service categories are most important for people with HIV in the Eligible Metropolitan Area (EMA), locally, Miami-Dade County
- Resource Allocations
  - Deciding how much RWHAP Part A funding to provide for each service priority (best done in both dollars and percent) – including separate allocation of RWHAP Part A and RWHAP Minority AIDS Initiative funds.
- Directives to the Recipient
  - How to best to meet these priorities, e.g., what service models for what populations in what geographic areas.
- Reallocation of Funds
  - Completed throughout the program year to ensure all funds are expended on needed services.

Unobligated Funds

- If an EMA (Miami-Dade County) or TGA has more than 5% of its formula grant unspent at the end of the program year (as determined when Financial Status Report is submitted):
  - Amount over 5% is deducted from the grant awarded the following fiscal year.
  - EMA/TGA cannot compete for supplemental funds in the next application cycle.
  - Recipient can apply for carryover, and funds must be used the next year.

Integrated Planning

- Legislation requires RWHAP Part A and Part B Programs prepare comprehensive plans that set goals and objectives and guide the work of the Program.
- All Parts are expected to participate in the Statewide Coordinated Statement of Need (SCSN) process.
- In 2016, RWHAP Part A and Part B Recipients prepared ***integrated plans*** based on a combined guidance from CDC and HRSA to submit 5-year Integrated HIV Prevention and Care Plans, including the Statewide Coordinated Statement of Need (SCSN).
- Plans for 2017-2021 were submitted in September 2016 and are now being implemented.

Integrated Planning, Cont.

- Combined guidance designed to help reach the goals of the National HIV/AIDS Strategy (NHAS) and improve performance along the HIV Care Continuum (HCC)/Treatment Cascade.
- Programs are expected to regularly review Plan progress and refine objectives and strategies as needed.
- The Comprehensive Plan should be a living document that guides the annual planning cycle.
- Collaborative implementation and monitoring of the plan between prevention and care (and between RWHAP Part A and Part B) encouraged.

Coordination of Services

- Shared responsibility of Planning Council (Partnership) and the Recipient (The County).
- Focus on ensuring that RWHAP Part A funds fill gaps, do not duplicate other services, and make Ryan White the payer of last resort.
- Involves coordination in planning, funding, and service delivery.
- Partnership reviews other funding streams as input to resource allocation.
- Recipient ensures that providers have linkage agreements and use other funding where possible, for example, helping clients apply for entitlements like Medicaid.

Contract Monitoring

- Recipient (The County) role.
- No Planning Council (Partnership) involvement, except that standards of care (approved by Planning Council) are typically included in contracts and therefore a basis for monitoring.
- Involves site visits/document review for monitoring of:
  - Program quality and quantity of services; and
  - Finances/fiscal management, including expenditure patterns and adherence to Health Services Resources Administration-HIV/AIDS Bureau (HRSA/HAB) and municipal regulations in use of funds.
- Aggregate findings (by service category or across categories) shared with the Planning Council as input to decision-making.

Clinical Quality Management (CQM)

- Recipient (The County) plays primary role.
- Involves ensuring that:
  - Services meet clinical guidelines and local standards of care;
  - Supportive services are linked to positive medical outcomes; and
  - Demographic, clinical, and utilization data are used to understand and address the local epidemic.
- Recipient requires providers to develop CQM plans, monitors providers based on quality standards, and recommends improvements.
- Council establishes standards of care for use in CQM.
- Recipient reports to Planning Council on CQM findings by service category or across categories for use in decision-making.

Cost-Effectiveness and Outcomes Evaluation

- Planning Council (Partnership) has the option of assessing the effectiveness of services offered – usually best done in coordination with CQM.
- Recipient (The County) monitors performance, clinical outcomes, and cost effectiveness of services as part of CQM.
- Major focus on HIV Care Continuum.
- Findings used by Recipient in selecting and monitoring providers.
- Findings used by Planning Council in priority setting, resource allocation, and development of directives on service models.

Assessment of the Efficiency of the Administrative Mechanism

- Planning Council (Partnership) responsibility
- Legislation requires Planning Councils to "assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area."
- Should be done annually.
- Involves assessing how efficiently the Recipient (The County) does procurement, disburses funds, supports the Planning Council's planning process, and adheres to Planning Council priorities and allocations.
- Written report goes to Recipient; Recipient then indicates what action it will take to address any identified problem or areas for improvement.

Questions?

Thank you for your time!

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