# 2023

# MIAMI-DADE HIV/AIDS PARTNERSHIP NEEDS ASSESSMENT

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CORAL GABLES, FL 33134
WWW.AIDSNET.ORG

JULY 13, 2023 VERSION

The annual Priority Setting and Resource Allocation needs assessment process is a series of Care and Treatment Committee meetings. The results of the meetings are included in this book.

# Disclaimer

Prepared by Behavioral Science Research Corporation for the Miami-Dade County Office of Management and Budget-Grants Coordination and the Miami Dade HIV/AIDS Partnership. This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H89HA00005, CFDA #93.914 – HIV Emergency Relief Project Grants, as part of a Fiscal Year 2023 award totaling $27,558,848 as of March 29, 2023, with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS or the U.S. Government.

# TABLE OF CONTENTS

# TABLE OF CONTENTS

# SCHEDULE OF MEETINGS

## NEEDS ASSESSMENT TOPICS

**MAY 4, 2023** **10AM-NOON**

PLANNING COUNCIL RESPONSIBILITIES FOR NEEDS ASSESSMENT

2022 CLIENT SATISFACTION SURVEY RESULTS AND STIGMA STUDY

**JUNE 8, 2023** **10 AM-1PM**

SETTING PRIORITIES AND ALLOCATION RESOURCES PROCESS

2020-2021 EPI PROFILE SUMMARY
2022 EIIHA
2022 RYAN WHITE DEMOGRAPHICS
2022 RYAN WHITE HIV CARE CONTINUUM

**JULY 13, 2023** **10 AM-1 PM**

2022 RYAN WHITE UTILIZATION
2022 CO-OCCURING CONDITIONS
OTHER FUNDING AND DASHBOARD CARDS
NEXT STEPS

**AUGUST 17, 2023** **10 AM-1 PM**

UNMET NEED/SERVICE GAPS AND PROJECTION
SERVICE CATEGORIES
COMMUNITY INPUT AND TOWN HALL RESULTS
SUMMARY TO DATE AND NEXT STEPS
SPECIAL DIRECTIVES
PRIORITY SETTING
RESOURCE ALLOCATIONS

**SEPTEMBER 14, 2023** **10 AM-NOON**

AS NEEDED

# HOUSEKEEPING AND RULES

# SECTION 1

MIAMI-DADE
HIV/AIDS PARTNERSHIP

# Meeting Housekeeping

Updated April 17, 2023

*Miami-Dade County Main Library Version*

# Disclaimer & Code of Conduct

- Audio of this meeting is being recorded and will become part of the public record.
- Members serve the interest of the Miami-Dade HIV/AIDS community as a whole.
- Members do not serve private or personal interests, and shall endeavor to treat all persons, issues and business in a fair and equitable manner.
- Members shall refrain from side-bar conversations in accordance with Florida Government in the Sunshine laws.

# Language Matters!

In today's world, there are many words that can be stigmatizing. Here are a few suggestions for better communication.


Remember **People First** Language . . .
***People*** with HIV, ***People*** with substance use disorders, ***People*** who are homeless, etc.

Please don't say **RISKS** . . . Instead, say **REASONS.**
Please don't say, **INFECTED with HIV** . . . Instead, say **ACQUIRED HIV, DIAGNOSED with HIV,** or **CONTRACTED HIV.**

Please **do not** use these terms . . .

**Dirty . . . Clean . . . Full-blown AIDS . . . Victim . . .**

# General Housekeeping

- You must sign in to be counted as present.
- Place cell phones on mute or vibrate - *If you must take a call, please excuse yourself from the meeting.*
- Have your Cultural Center Parking Garage ticket validated at the Library front desk for a reduced parking rate.
- Eligible committee members should see staff for a voucher at the end of the meeting

# Meeting Participation

- Raise your hand if you need clarification about any terminology or acronyms used throughout the meeting.
- Raise your hand to be recognized by the Chair or added to the queue.
- Discussion should be limited to the current Agenda topic or motion.
- Speakers should not repeat points previously addressed.
- Any attendee may be permitted to address the board as time allows and at the discretion of the Chair.

# Resources

- Behavioral Science Research Corp. (BSR) staff are the Resource Persons for this meeting.
- See staff after the meeting if you are interested in membership or if you have a question that wasn't covered during the meeting.
- Today's presentation and supporting documents are online at aidsnet.org/meeting-documents/.

# MIAMI-DADE HIV/AIDS PARTNERSHIP

# 2023 NEEDS ASSESSMENT

# PROCESS FOR SETTING PRIORITIES AND ALLOCATING RESOURCES

The annual Priority Setting and Resource Allocation (PSRA) needs assessment process is a series of monthly Care and Treatment Committee meetings scheduled from June to August. If business items are not completed by the final meeting, the September 2023, meeting will serve to complete them. The results of the needs assessment process including priorities and allocations will be included in Ryan White Program updates report to HRSA due in the Fall. Representatives of the affected community, community stakeholders, and service providers are urged to attend and participate.

## STEP 1. TRAINING ON RESPONSIBILITIES

The committee will be trained in the responsibilities regarding the needs assessment and how to use data.

## STEP 2. PROCESS REVIEW

The committee will discuss and agree on the foundation of the process, including:

- Procedures for community input at meetings; and
- Review and, if necessary, revise established principles for setting priorities and allocations (e.g., priority on the poorest, priority on the sickest, etc.).

The committee's decisions at any meeting during this process will be made available to all participants at subsequent meetings through minutes of the meetings which will be posted online.

## STEP 3. COMMUNITY INPUT

The Committee may receive input in four ways:

1) Written or phone comments from members of the affected community will be accepted and provided to the committee during their last meeting.
2) Committee members and non-members in attendance will be encouraged to participate in discussion and consensus-building by offering relevant information and stating their opinions. This input will be given during discussions of service categories, either during the general discussion before a motion is made, or during the discussion of the motion. We will use a queue to ensure orderly discussion. A Partnership Staff Support person may serve as a parliamentarian to ensure that the scheduled business is completed and that all parties are heard from, as time permits.
3) Results of the client satisfaction and stigma survey.
4) Results of a virtual community town-hall.

## STEP 4. DATA REVIEW

Staff Support will provide an overview of HIV/AIDS epidemiology, Ryan White Program client demographics and service utilization, cost of services, unmet need and other data for Miami-Dade County ahead of the meetings, posting the information on the www.aidsnet,org web site, and will provide summaries at the time of the meeting when these data are discussed. Information will include, as available:

- A comparative profile of the 2020 vs 2021 HIV/AIDS Epidemiology for Miami-Dade County;
- The number of clients and demographic composition of clients receiving services under the Ryan White Program in FY 2022 (March 1, 2022 – February 28, 2023);
- Current cost and funding allocations for existing Ryan White Program services;
- FY 2022 cost and funding allocations for services;
- Other funding streams that cover the same services as the Ryan White Program and the number of HIV-positive recipients;
- HIV Care Continuum data;
- Estimates of unmet need; and
- Other issues relating to specific services.

Procedures for examining services will include:

- Review of information pertaining to definition, cost and utilization of specific services at each meeting when services are discussed.
- Discussion and questions by committee members and others present to clarify and elicit additional information.

***The committee will not make motions or take actions related to service priorities and funding allocations until after Step 4 has been completed.***

## STEP 5. SERVICE CATEGORIES

The committee will review and use needs assessment data as a basis for selecting service categories to be funded for the coming fiscal year. Currently funded service categories and demonstrated need will be reviewed to:

- Eliminate service categories for which no need is identified, focusing attention on the cost of the services and the impact that removing the services may have on the health of the affected community; and
- Identify and introduce new core and/or support service categories and seek to establish the basis of funding for these services, as needed.

Establishment of new categories must be based on data that demonstrate the extent of need and the lack of other funding sources or services to supply the area of need. ***Persons seeking to introduce new services are responsible for providing data on need and potential utilization: it will not be sufficient to assert that a particular service is needed without providing concrete data on the magnitude of that need among persons living with HIV/AIDS and the absence of***

***non-Ryan White funding to support service provision for that need.*** Responsibility for providing data in support of proposed new services rests with the proposer. The committee will vote on the proposed new service(s) following presentation and review of the pertinent data.

## STEP 6. PRIORITY RANKING

The Committee will review needs assessment data once more. The Committee will follow the below process for establishing priority rankings of service categories.

- Members will complete a survey ranking services in order of importance prior to the final meeting;
- Guests will complete a survey ranking services in order of importance prior to the final meeting;
- Staff will tally the surveys and post the compiled services ranking of committee members and guests at the last meeting;
- The committee and others present will review this ranking, and based on discussion, make adjustments if necessary;
- The committee will come to a consensus on the final rank order of priorities and will adopt them by formal motion.

## STEP 7. DIRECTIVES

After full consideration of relevant data reviewed during the needs assessment process, the committee may direct the Recipient to address unmet (or under-delivered) service priorities and to address other issues defined during the process. These may, among other things, address access issues to services for special populations or special geographic areas.

## STEP 8. ALLOCATION OF FUNDS

The Committee will use the service priorities, established principles, and needs assessment data to allocate funds for Fiscal Year 2024 (March 1, 2024-February 28, 2025), generating a flat funding budget using the current grant award and a prospective resource allocation budget using the grant ceiling total.

**Care and Treatment Committee members who work for subrecipients ("providers") currently funded by the Ryan White Program may vote on funding recommendations affecting a service category in which their employers provide services under Ryan White, as long as the member's employer is not the sole subrecipient ("provider") in that service category. Members who are "conflicted" in this way must declare their conflicted status during the meeting prior to discussion and vote of the service category. The conflicted member will then leave the meeting and he or she will be contacted by staff to rejoin the meeting once the conflicted vote is concluded. They will be emailed Form 8B which will be completed and returned to staff within 48 hours after the conclusion of the meeting. Copies of completed Form 8Bs will be included with the minutes of the meeting.**

## STEP 9. DETERMINATION OF FINAL PRIORITIES AND ALLOCATIONS

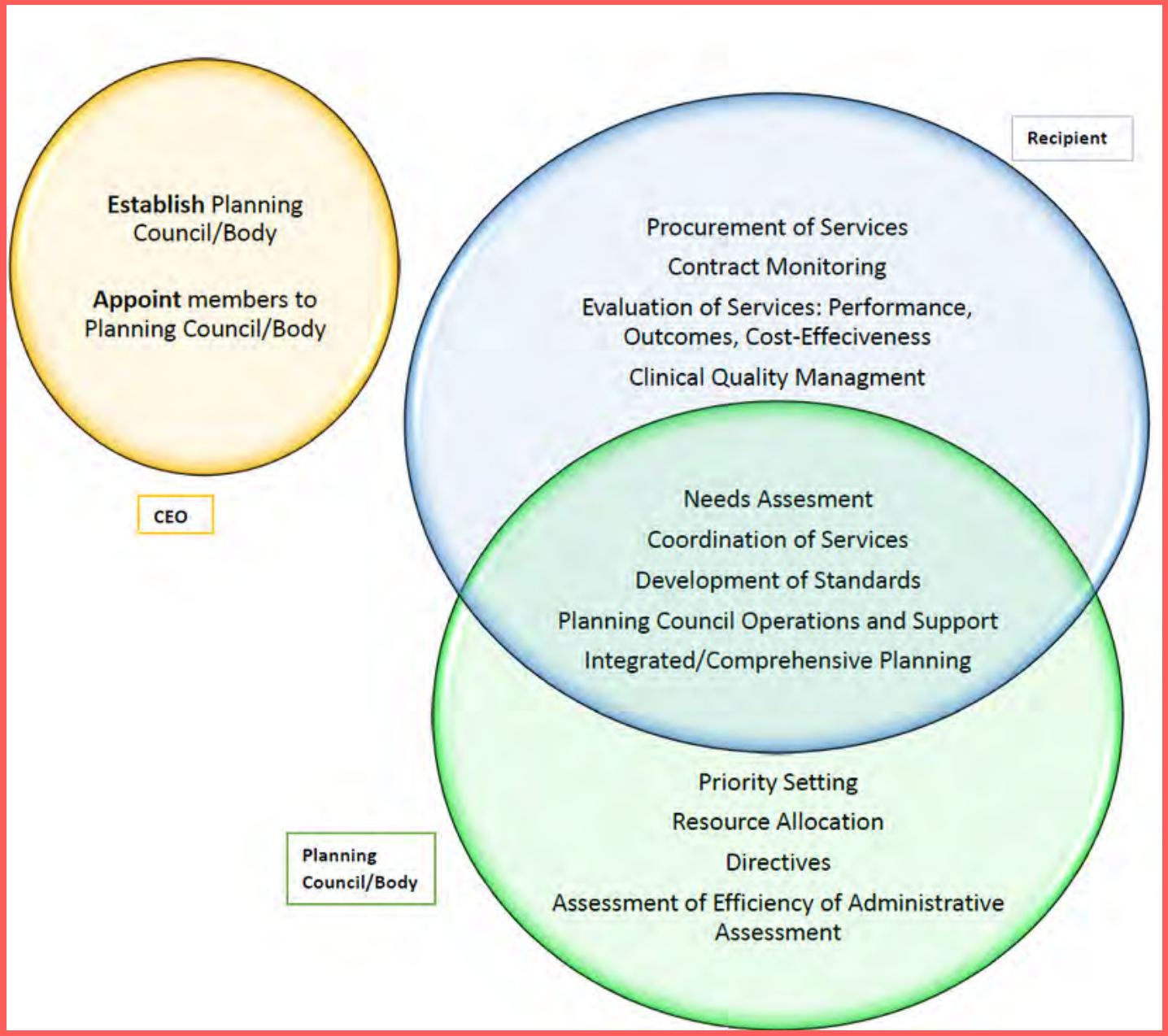
The final priorities and allocations for Fiscal Year 2024 (March 1, 2024-February 28, 2025), as determined by the Care and Treatment Committee, will be presented to the full Partnership for approval.

# NEEDS ASSESSMENT PREPARATION

# SECTION 2

# PLANNING COUNCIL RESPONSIBILITIES AND NEEDS ASSESSMENT

PRESENTED MAY 4, 2023




In Miami-Dade County, the CEO is the Mayor and the Recipient is the Office of Management and Budget-Grants Coordination.

PLANNING COUNCIL

# LEGISLATIVE RESPONSIBILITY

For the population of individuals living with HIV in the Miami-Dade County eligible metropolitan area (EMA):

Determine their **size** and **demographics** and **needs** particularly for those who know their HIV status and are **not receiving HIV-related serv**ices; and address **disparities in access and services** among affected subpopulations and historically underserved communities.

# HRSA EXPECTIONS

The planning council's (**Miami-Dade HIV/AIDS Partnership**) decisions about service priorities, service models, population emphases, and directives for the Recipient will be **data-based**.

Data used for decision making will include:

- Needs assessment and community input
- Service cost and utilization data
- System-wide (not subrecipient-specific) Quality Management data

The planning council will be trained and comfortable in reviewing, assessing, and using data.

# COMPONENTS OF A RYAN WHITE NEEDS ASSESSMENT

1. **Epidemiological profile** of HIV and AIDS cases and trends in Miami-Dade County.

2. A **resource inventory** of existing services.

3. A **profile of provider capacity** and capability -availability, accessibility and appropriateness overall and for 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. **Estimate and assessment of people with HIV** who are unaware of their status.

6. **Assessment of service need gaps,** information about service needs of people with HIV and barriers to getting services.

# DATA COLLECTION FOR THIS YEAR

Surveillance (from Florida Department of Health in Miami-Dade)

Ryan White Program demographic and utilization data (from the Provide Enterprise Miami system), as available

Input from persons with HIV

and

Other funding information.

# NEEDS ASSESMENT DATES 2023*

10:00 a.m. to 1:00 p.m.

June 1, 2023

July 13, 2023

August 3, 2023

*September 7, 2023 (if needed)

# STEPS FOR 2023 NEEDS ASSESSMENT

- Training on responsibilities and data elements
- Additional training materials posted online
- Agreement on process
- Data elements provided
- Directives developed
- Priorities set
- Allocations determined

# DEVELOPING DIRECTIVES

Provide guidance to the Recipient on desired ways to respond to identified service needs, priorities, and/or shortfalls.

Often specify use or non-use of a particular service model, or address geographic access to services, language issues, or specific populations.
[9]

*May* have cost implications.

Usually only a small number are developed.

Must be followed by Recipient in procurement, contracting, or other service planning.

# PRIORITY SETTING

Determining what service categories are most important for people living with HIV in Miami-Dade County and place them in priority order.

Priorities are **not** tied to funding or to service providers.

Planning council must establish a sound, fair process for priority setting and ensure that decisions are data-based and control conflict of interest.

Take into account data such as utilization, epidemiological, and unmet needs.

Priorities tend to change only a little from year to year.

# Core Medical Services

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

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)

# RESOURCE ALLOCATION

Process of deciding how much money to allocate to each service category.

Resource allocation is **not** tied to p**riorities**; some lower-ranked service categories may receive disproportionate funding because they are expensive to provide.

Other funding streams, cost per client data and anticipated numbers of new clients coming into care should be considered in decision making.

# RESOURCE ALLOCATIONS (CONTINUTED)

## Core Services

HRSA requires **no less** than **75% of funds** be allocated to core services .

## Support Services

HRSA requires support services to be **no more** than **25%** of funds.

Funded support services need to be linked to positive medical outcomes/affecting the HIV-related clinical status of an individual with HIV/AIDS.

# CONFLICT OF INTEREST

Process should be fair, data-based, and free of conflicts of interest.

*If a member is the sole provider in a service category and funds are being allocated, the conflicted member must recuse him/herself from voting. The member will follow a formal disclosure process, complete form 8B, and will step outside of the room both during discussion of and voting on the conflicted item. He/she may return to the meeting once the discussion and voting are concluded.*

# BUDGET DEVELOPMENT OPTIONS

A) Flat

and

B) Increase (up to allowable threshold)

*can include or not:*

C) Decrease (determine %)

# Types of Charts (bars, lines, pies, tables) for Data


# EPI DATA

Number of people living with a disease.

# EPIDEMIOLOGIC PROFILE

Describes the HIV Epidemic in the  Miami-Dade service area

Focuses on the social and demographic groups  and behaviors most affected by or that can transmit HIV.

Data are provided by the Florida Department of Health

Estimates the number and characteristics of persons with HIV who know their status but are not in care (unmet need) and those unaware of their status.

# TERM-INCIDENCE

## INCIDENCE

The number of **new** cases of a disease in a population during a defined period of time – such as the number of new HIV cases in Miami-Dade County as of December 31 of the reference year .

## INCIDENCE RATE

The frequency of **new** cases of a disease that occur per unit of population during a defined period of time – such as the rate of new HIV cases per 100,000 in Miami-Dade County as of December 31 of the reference year .

# TERM-PREVALENCE

## PREVALENCE

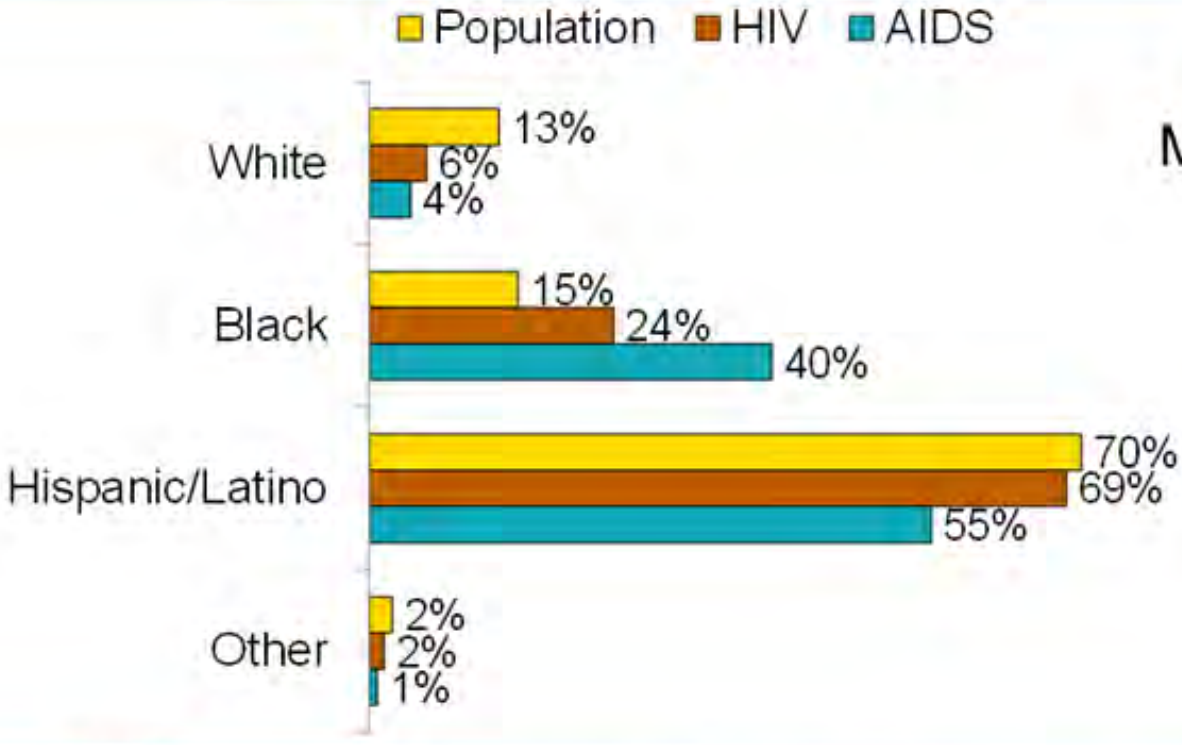
The **total** number of people in a defined population with a specific disease or condition at a given time – such as the total number of people diagnosed with HIV in Miami-Dade County as of December 31 of the reference year.

## PREVALENCE RATE

The **total or cumulative** number of cases of a disease per unit of population as of a defined date – such as the rate of HIV cases per 100,000 population diagnosed in Miami-Dade County as of December 31 of the reference year.

# EPI DATA SAMPLE
# USING A BAR GRAPH

## Adult HIV and AIDS Diagnoses and Population by Race or Ethnicity, 2021, Miami-Dade County




Miami-Dade County Adult Population Estimate
N=2,444,510

HIV
N=1204

AIDS
N=388

Florida HEALTH

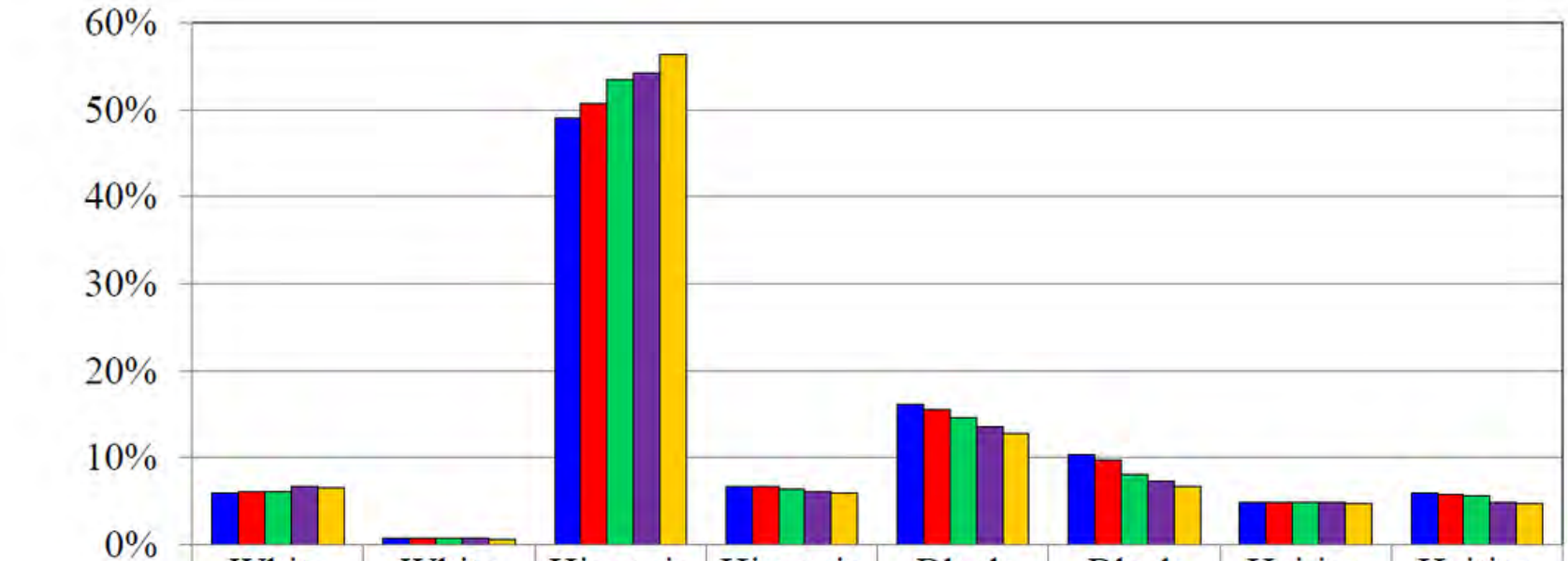
Rounding may cause percentages to total more or less than 100.

# DEMOGRAPHICS

Statistical data relating to the population and particular groups within it.

# DEMOGRAPHICS DATA SAMPLE USING A BAR GRAPH

Race/Ethnicity of Clients in Care, by Gender Ryan White Program, FY 2017 - FY 2021




| | White Male | White Female | Hispanic Male | Hispanic Female | Black Male | Black Female | Haitian Male | Haitian Female |
|---|---|---|---|---|---|---|---|---|
| FY 2017 | 6% | 1% | 49% | 7% | 16% | 10% | 5% | 6% |
| FY 2018 | 6% | 1% | 51% | 7% | 16% | 10% | 5% | 6% |
| FY 2019 | 6% | 1% | 54% | 6% | 15% | 8% | 5% | 6% |
| FY 2020 | 7% | 1% | 54% | 6% | 14% | 7% | 5% | 5% |
| FY 2021 | 7% | 1% | 56% | 6% | 13% | 7% | 5% | 5% |

# SERVICE UTILIZATION

A measure of expenditures and units of service across service categories.

# UTILIZATION DATA SAMPLE USING A TABLE

## Total Clients by Service Category

| SERVICE CATEGORIES | FY 2017 | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|---|
| Medical Case Management, inc. Treatment Adherence (includes Peer Support) | 8,656 | 8,496 | 8,116 | 7,378 | 7,842 |
| Outpatient/Ambulatory Health Services | 5,021 | 5,447 | 5,317 | 4,281 | 4,422 |
| Oral Health Care | 3,500 | 3,381 | 3,170 | 1,711 | 2,237 |
| Health Insurance Premium & Cost Sharing Assist | 1,415 | 1,307 | 1,335 | 1,125 | 1,255 |
| Food Bank | 709 | 701 | 715 | 735 | 712 |
| Medical Transportation Services | 733 | 638 | 720 | 94 | 645 |
| AIDS Pharmaceutical Assistance (Local) | 1,162 | 697 | 605 | 185 | 183 |
| Mental Health Services | 349 | 327 | 274 | 95 | 121 |
| Outreach Services | 965 | 624 | 472 | 130 | 116 |
| Substance Abuse Services (Residential) | 214 | 169 | 95 | 70 | 66 |
| Other Professional Services - Legal Services | 100 | 76 | 66 | 48 | 44 |
| Substance Abuse Services Outpatient | 120 | 115 | 55 | 0 | 17 |
| Emergency Financial Assistance | N/A | N/A | N/A | N/A | N/A |

# UTILIZATION DATA SAMPLE USING TEXT

## Outpatient/Ambulatory Health Services

- Forty one percent of direct service expenditures were spent on O/AHS– over $7.7 million – similar to last fiscal year though less than FY 2018 and FY 2019.
- Nearly 53% of all clients (4,422 clients) used O/AHS which is similar to last fiscal year.
- Top six most used services are:

1. Office Outpatient Visit 25 Minutes, 24%
2. Office Outpatient Visit 15 Minutes, 15%
3. Office Outpatient Visit 10 Minutes, 3%
4. Blood Collection, 3%
5. IADNA HIV-1 Quant & Reverse Transcription, 3%
6. IADNA Chlamydia Trachomatis Amplified Probe TQ, 3%

# DASHBOARD CARDS

Tool to visualize utilization and other funding data.

# DASHBOARD CARD DATA SAMPLE USING TABLES

2022 Needs Assessment Dashboard Cards
Ryan White Program

**Core Service: AIDS Pharmaceutical Assistance**

| FY 2022: March 1, 2022-February 28, 2023 | | | | |
|---|---|---|---|---|
| | FY 2022 Ranking | FY 2022 Direct Services Totals | FY 2022 Total as % | RFP Allocation |
| Total | | | | |
| Part A | 4 | $84,492 | 0.39% | $88,255 |

| Ranking, Allocation, and Expenditure History | | |
|---|---|---|
| Fiscal Year | Expenditure | Expense as % |
| FY 2017 | $23,425,356 | 1.9% |
| FY 2018 | $21,934,627 | 0.4% |
| FY 2019 | $23,019,718 | 0.3% |
| FY 2020 | $17,660,128 | 0.3% |
| FY 2021 | $19,018,258 | 0.2% |

| Fiscal Year | Part A Ranking | Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|---|
| FY 2017 | 4 | $449,500.00 | $425,218.67 | 94.60% |
| FY 2018 | 4 | $137,000.00 | $81,547.78 | 59.52% |
| FY 2019 | 4 | $87,000.00 | $52,697.84 | 60.57% |
| FY 2020 | 3 | $66,007.00 | $5,993.21 | 9.08% |
| FY 2021 | 9 | $83,595.00 | $4,379.02 | 5.24% |

| Fiscal Year | MAI Ranking | MAI Final Allocation | MAI Final Expenditure | % Spent |
|---|---|---|---|---|
| FY 2017 | 3 | $17,000.00 | $15,983.13 | 94.02% |
| FY 2018 | 3 | $100,000.00 | $4,661.97 | 4.66% |
| FY 2019 | 7 | $100,000.00 | $5,145.45 | 5.15% |
| FY 2020 | NA | NA | NA | NA |
| FY 2021 | NA | NA | NA | NA |

**Service Program**

**Limitations:** **400% FPL**

| Fiscal Year | RW Clients | Clients Served | % | Expenditure | Avg Per Client |
|---|---|---|---|---|---|
| FY 2017 | 9,883 | 1,162 | 11.8% | $441,202 | $379.69 |
| FY 2018 | 9,578 | 697 | 7.3% | $86,210 | $123.69 |
| FY 2019 | 9,031 | 605 | 6.7% | $57,843 | $95.61 |
| FY 2020 | 8,127 | 185 | 2.3% | $5,993 | $32.40 |
| FY 2021 | 8,420 | 183 | 2.2% | $4,379 | $23.93 |

# OTHER FUNDING DATA (DASHBOARD CARD) SAMPLE USING CHART

**Other Funding Streams: AIDS Pharmaceutical Assistance (Prescription Drugs)**

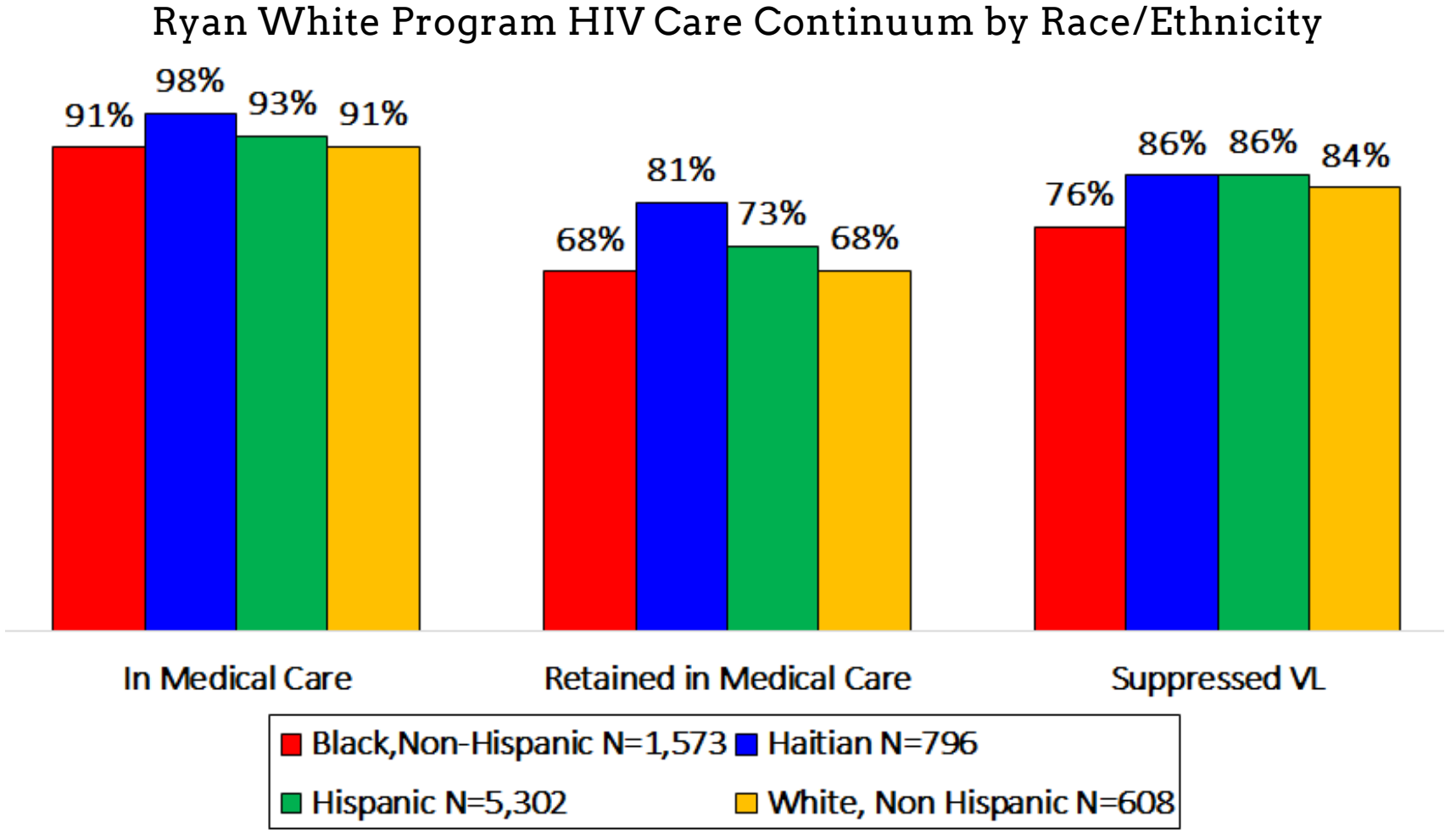
| Other Funding Streams 2021 | | | | |
|---|---|---|---|---|
| | **Funder** | **Expended** | **Number of Clients** | **Cost per Client** |
| 1 | ADAP | $32,843,354.00 | 4,596 | $7,146.07 |
| 2 | General Revenue | $442,771.88 | 408 | $1,085.23 |
| 3 | Medicaid | $104,595,615.00 | 5,213 | $20,064.38 |
| 4 | Part C | $32,874.33 | N/A | N/A |

| Other Funding Streams 2022 | | | | |
|---|---|---|---|---|
| | **Funder** | **Expended** | **Number of Clients** | **Cost per Client** |
| 1 | ADAP | $28,342,383.90 | 4,587 | $6,178.85 |
| 2 | General Revenue | $262,520.31 | 547 | $479.93 |
| 3 | Medicaid | $109,082,427.54 | 5,435 | $20,070.36 |
| 4 | Part C | $25,492.00 | N/A | N/A |

# CARE CONTINUUM

Model that outlines the steps/stages that people with HIV go through whose goal is viral suppression.

# HIV CARE CONTINUUM
# DATA SAMPLE
# BAR GRAPH



# How do we connect the data?

Priorites

Allocations

Directives

Address identified service needs or underserved groups

Per client cost=estimate allocation

# SERVICE UTILIZATION AND CONTINUOUS QUALITY IMPROVEMENT DATA USAGE

## In setting service priorities

What service categories have fully used all funding, which had waiting lists, which had unused resources, which needed more funding?

## In allocating resources

How can we use cost per client data to determine funding allocations for anticipated new clients?

## In preparing directives to the Recipient

What access to care issues have been identified and how can these be addressed?

# Think 3 D!

# Data, Driven, Decisions!

Use data to make informed decisions to improve the service delivery system for people living with HIV in Miami-Dade.

# THANK YOU!

BEHAVIORAL SCIENCE RESEARCH

MIAMI-DADE HIV/AIDS PARTNERSHIP

MIAMI-DADE COUNTY

WWW.AIDSNET.ORG

# 2023 Needs Assessment Preparation

Slides in this presentation provided by Planning CHATT . Some local data have been added to provide context.

# Understanding the Legislation

## Authorizing the Ryan White HIV/AIDS Program (RWHAP)

**Module 1 (revised)**

# Topics

- History and Evolution of the Ryan White HIV/AIDS Program (RWHAP) Legislation
- Overview of RWHAP Parts
- Understanding Part A

# History and Evolution of RWHAP Legislation

# RWHAP Legislation

- Largest Federal government program specifically designed to provide services for people with HIV – $2.5 billion in funding in FY 2020 including new funding for Ending the Epidemic
- Third largest Federal program serving people with HIV – after Medicaid and Medicare
- First enacted as the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990
- Current legislation is the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act)
- Provides grants awarded to the chief elected officials of the city or county, who designates a lead agency to administer the funds.

# Purpose of RWHAP Legislation

- Began as “emergency relief” for overburdened healthcare systems at a time when effective medications were not available
- **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 with HIV by funding primary health care and support services that enhance access to and retention in care”

# Importance of RWHAP: Scope

- More than 1.2 million people in the U.S. age 13 years and older are living with HIV as of 2018.
- About 1 in 7 (nationally) do not know their status
- More than half of million people are receiving at least one medical, health, or related support service through the Ryan White Program provider in 2018, with many clients receiving multiple types of services.

# Importance of RWHAP: Client Need

- RWHAP serves people with HIV who are low-income and do not have insurance that covers their HIV care and medications – over 60% have incomes below the federal poverty line
- RWHAP is the payer of last resort – funds may not be used to pay for items or services that are eligible for coverage by other federal or state programs or private health insurance
- RWHAP is not an “entitlement” program: it must operate using the funds appropriated annually by Congress and awarded to recipients

# Importance of RWHAP: Outcomes

- Nationwide, more than 80% of RWHAP clients in 2016 were retained in care – they had at least two outpatient ambulatory health services (OAHS) visits during the year, at least 90 days apart.
  - In Miami-Dade, 75% retained in Ryan White Care in FY 2019
- Nationwide, about 85% of clients receiving outpatient OAHS through RWHAP achieved viral suppression in 2016
  - Up from 69.5% in 2010
  - In Miami-Dade, 86% of OAHS clients virally suppressed in FY 2019 2019

# Factors Affecting HIV Services

- The epidemic continues, especially among traditionally underserved and hard-to-reach populations – but new diagnoses have been declining since 2008
- Because of effective therapies, people with HIV can live nearly normal life spans if they begin treatment early and stay in care
- Treatment is prevention – viral suppression prevents HIV transmission
- Changes in health care system and financing have affected how RWHAP funds are used at the state and local levels

# Tools for Ending the Epidemic

- National goals to end the epidemic, first developed through the National HIV/AIDS Strategy (NHAS)
- The HIV care continuum, which helps track the estimated number of people living with HIV, percent diagnosed, and percent who are linked to care, retained in care, and achieve viral suppression
- Performance measures developed by HRSA/HAB to assess quality of care and clinical outcomes of RWHAP-funded services
- Ending the Epidemic: A Plan for America

# National Goals to End the Epidemic

## 2020 Goals:

- Reduce new HIV infections
- Increase access to care and improve health outcomes for people with HIV
- Reduce HIV-related disparities and health inequities
- Achieve a more coordinated national response to the HIV epidemic

# Performance Measures Portfolio

- Established in 2013
- Focus on critical areas of HIV care and treatment, including processes (like development of treatment plans) and outcomes (like viral suppression rates)
- Alignment with milestones along the HIV care continuum
- Can be used by individual providers or at a system of care level – by all RWHAP-funded providers in a service area

# Overview of RWHAP Parts

# The Ryan White HIV/AIDS Program

- Provides a comprehensive system of care for people with HIV
- Most funds support primary medical care and other medical-related and support services
- Provides ongoing access to HIV medications
- Small amount of funds used for technical assistance, clinical training, and development of innovative models of care

# The Ryan White HIV/AIDS Program (cont.)

- Includes five Parts: A, B, C, D, and F
- Administered by the HIV/AIDS Bureau (HAB), within the Health Resources and Services Administration (HRSA)
- RWHAP Parts designed to work together to ensure a comprehensive system of care in urban, suburban, and rural communities throughout the U.S.

# RWHAP Part A

- Funding for areas hardest hit by the HIV epidemic
- Funding for two categories of metropolitan areas:
  - **Eligible Metropolitan Areas** (EMAs), with at least 2,000 new cases of AIDS reported in the past 5 years and at least 3,000 people living with HIV
  - **Transitional Grant Areas** (TGAs), with 1,000 – 1,999 new cases of AIDS reported in the past 5 years and at least 1,500 people living with HIV
- Funds are used to develop or enhance access to a comprehensive system of high quality community-based care for low-income people with HIV

# RWHAP Part B

- Funding to all 50 States, DC, Puerto Rico, U.S. territories and jurisdictions to improve the quality, availability, and organization of HIV health care and support services
- Provides funds for medical and support services
- Includes the AIDS Drug Assistance Program (ADAP), which provides access to HIV-related medications, through direct purchase and purchase of health insurance
- Also provides funds to emerging communities with a growing epidemic, reporting 500-999 new cases in the past 5 years

# RWHAP Part C

- Funding to support “early intervention services”: comprehensive primary health care and support services for PLWH in an outpatient setting
- Competitive grants to local community-based organizations, community health centers, health departments, and hospitals
- Priority on services in rural areas and for traditionally underserved populations
- Capacity development grants provided to help public and nonprofit entities deliver HIV services more effectively

# RWHAP Part D

- Funding to support family-centered HIV primary medical and support services for women, infants, children, and youth living with HIV
- Competitive grants to local public and private health care entities, including hospitals, and public agencies
- Includes services designed to engage youth with HIV and retain them in care
- Recipients must coordinate with HIV education and prevention programs designed to reduce the risk of HIV infection among youth

# RWHAP Part F: Dental Services

**Two types of dental programs:**

- Dental Reimbursement Programs run by dental schools and other dental programs
- Community Based Dental Partnership Program, to provide dental services for PLWH while providing education and clinical training for dental care providers

# RWHAP Part F: Minority AIDS Initiative (MAI)

- Funds used to improve access to HIV care and health outcomes for disproportionately affected racial and ethnic minorities
- Part A programs apply for MAI funds as part of the annual application and receive funds on a formula basis
- Formula is based on the number of racial and ethnic minority individuals with HIV/AIDS in the jurisdiction

# RWHAP Part F: Special Project of National Significance (SPNS)

- Supports the development of innovative models of care to better serve people with HIV, and to address emerging client needs
- Competitive funding
- Projects include a strong evaluation component
- Promising models are disseminated

# RWHAP Part F: AIDS Education and Training Centers (AETCs)

- Supports a network of 8 regional centers that provide targeted, multidisciplinary education and training programs for health care providers serving PLWH
- Intended to increase the number of providers prepared and motivated to counsel, diagnose, treat, and medically manage PLWH
- AETC's National Clinician Consultation Center responds to questions from clinicians

# Importance of Collaboration Across RWHAP Parts

- Representatives of all RWHAP Parts as members of Part A planning councils/planning bodies (PC/PBs).
  - In Miami-Dade, this is the Miami-Dade County HIV/AIDS Partnership
- Collaboration in development of the HRSA/CDC Integrated HIV Prevention and Care Plans, submitted by RWHAP Parts A & B
- Coordination in targeting and use of resources

# Coordination of Care Across Parts

## A single RWHAP client living in an EMA or TGA might:

- Receive medications through RWHAP Part B ADAP
- Get oral health care from a RWHAP Part F-funded dental program or Part A-funded Oral Health Care subrecipients
- Obtain other services funded through RWHAP Part A, Part C, and/or Part D
- Participate in a RWHAP Part F demonstration SPNS project

# Understanding Part A

# Ryan White HIV/AIDS Programs: Part A

- Funding for Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are severely & disproportionately affected by the HIV epidemic
- In 2018, 24 EMAs and 28 TGAs
- Service areas can include a single county or a multi-county area
- 11 programs have service areas that cross state boundaries

# RWHAP Part A

- **Funds go to the Chief Elected Official (CEO)** of "the city or urban county that administers the public health agency that provides outpatient and ambulatory services to the greatest number of individuals with AIDS" [§2602(a)(1)]
- Recipient must establish an **Intergovernmental Agreement (IGA)** with any jurisdiction with at least 10% of the total number of reported cases of AIDS to establish a mechanism for allocating resources to address their service needs [§2602(a)(2)]

# RWHAP Part A (cont. 1)

**Legislative requirement for extensive community planning,** including participation of consumers of RWHAP Part A services

- EMAs required to have *planning councils that decide how program funds will be used*
- TGAs strongly encouraged by HRSA/HAB to maintain planning councils
- TGAs that choose not to have planning councils encouraged to have planning bodies with roles, responsibilities and membership that are as much like planning councils as possible

# RWHAP Part A (cont. 2)

**RWHAP Part A programs receive both "formula" and "supplemental" funding:**

- Part A formula funding is based on the number of living cases of HIV and AIDS in the EMA or TGA
- Minority AIDS Initiative (MAI) formula funding is based on the number of minorities living with HIV and AIDS
- Supplemental funding is competitive, based on demonstration of additional need in the annual application

# Services Fundable under RWHAP Part A

- **Core medical services** identified in legislation as being essential (no less than 75%)
  *Outpatient/Ambulatory Health Services, Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals, Oral Health Care, Mental Health Services, AIDS Pharmaceutical Assistance, Substance Abuse Outpatient Care, Medical Case Management, including Treatment Adherence Services, Early Intervention Services, Home Health Care, Home and Community-Based Health Services, Hospice Services and Medical Nutrition Therapy*

# Services Fundable (cont. 2)

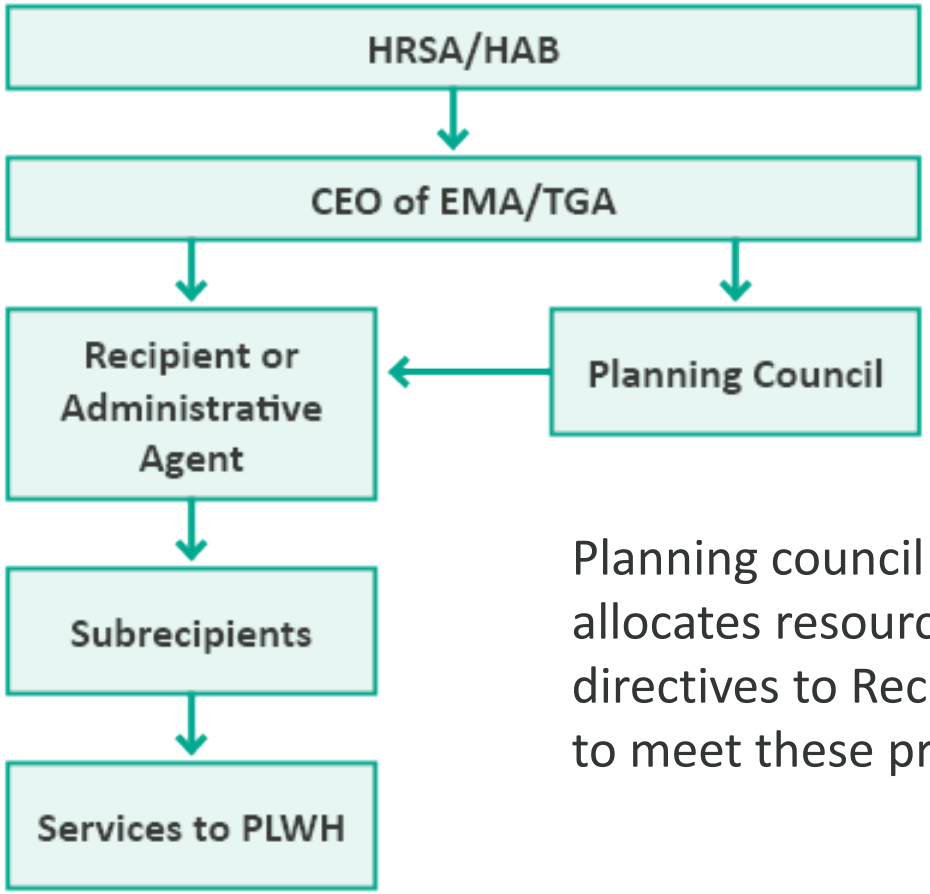
- **Support services** needed so that people with HIV can reach their medical outcomes (no more than 25% of total funding)
  *Emergency Financial Assistance, Food Bank/Home-Delivered Meals, Other Professional Services (Legal Services and Permanency Planning), Medical Transportation, Outreach Services, Substance Abuse Services (residential), Non-Medical Case Management, Child Care Services, Health Education/Risk Reduction, Housing, Linguistic Services, Psychosocial Support Services, Rehabilitation Services and Respite Care*

- HRSA/HAB provides service definitions and descriptions
  *Refinements to service categories and definitions in 2016 and 2018 [Policy Clarification Notice (PCN) #16-02]*

# Collaboration between Recipient and Planning Council/Planning Body

- Recipient (Miami-Dade County) receives and administers funds and is responsible for contracting with providers (subrecipients) who provide care and treatment
- Planning council/planning body (the Partnership) decides how best to use available funds to help support a community-based system of care for people with HIV
- Recipient and Partnership work closely together, sharing responsibility for tasks like needs assessment and integrated/comprehensive planning

# Flow of RWHAP Part A Decision Making & Funds




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

# EPIDEMIOLOGICAL "EPI" DATA

# SECTION 3

# HIV Epidemiology In Miami-Dade County, 2021

## DEPARTMENT OF HEALTH

Kira Villamizar

HIV/AIDS Program Coordinator

Florida Department of Health

Data as of 6/30/2022

# Acronyms

- **HIV:** Human Immunodeficiency Virus
- **AIDS:** Acquired Immune Deficiency Syndrome
- **IDU:** Injection Drug Use
- **MMSC:** Male-to-Male Sexual Contact
- **MSM:** Men Who Have Sex with Men

# Acronyms, continued

- **PWH**: Persons with HIV
- **PWID**: Persons Who Inject Drugs
- **STI**: Sexually Transmitted Infection
- **VL**: Viral Load

# Technical Notes

- Data for 2020 and 2021 should be interpreted with caution due to the impact of COVID-19 on HIV testing, care-related services, and case surveillance activities in state and local jurisdictions.

- Unless otherwise noted, all data in this presentation are as of 6/30/2022.

# Technical Notes, continued

- Each year, the HIV data for the previous calendar year and all prior years back to 1979 are finalized and frozen for reporting purposes on June 30. The frozen data are used in all data reports until the following June 30, when the continuously deduplicated HIV/AIDS data set will be finalized and frozen again.

- Unless otherwise noted, population-related data (such as rates) are provided by FLHealthCHARTS as of 6/30/2022.

# Technical Notes, continued

- HIV-Related deaths represent persons with an HIV diagnosis in the CDC's electronic HIV/AIDS Reporting System (eHARS) who resided in Florida at death and whose underlying cause of death was HIV, regardless of whether their HIV status was reported in Florida.

- STI data are derived from the Surveillance Tools and Reporting System (STARS) and provided by the STD Prevention and Control Section as of 7/01/2022.

# Technical Notes, continued

- HIV diagnoses by year represent persons whose HIV was diagnosed in that year, regardless of AIDS status at time of diagnosis.

- AIDS and HIV diagnoses by year are not mutually exclusive and cannot be added together.

# Technical Notes, continued

- HIV prevalence data represent PWH living in Florida through the end of the calendar year, regardless of where they were diagnosed.

- For diagnosis data over time, sub-geographical area data exclude Florida Department of Corrections (FDC) and Federal Correctional Institution (FCI) diagnoses. For prevalence data, area and county data include FDC and FCI data.

# Technical Notes, continued

- Adult diagnoses represent people ages 13 years and older; pediatric diagnoses represent people under the age of 13 years.
  - For data by year of diagnosis, age is by age at diagnosis.
  - For prevalence data, age is by current age at the end of the most recent calendar year, regardless of age at diagnosis.

# Technical Notes, continued

- Unless noted, White and Black people are non-Hispanic/Latino, and Other (which may be omitted in some graphs due to small numbers) represents American Indian/Alaska Native, Asian/Pacific Islander, or multi-racial.

- Transgender people include:
  - Transgender women (assigned male at birth).
  - Transgender men (assigned female at birth).

# Definitions of Mode of Exposure Categories

- **MMSC:** Male-to-male sexual contact; these data exclude transgender persons.
- **IDU:** Injection drug use.
- **MMSC/IDU:** Male-to-male sexual contact and injection drug use; these data exclude transgender persons.
- **Transgender Sexual Contact:** Sexual contact resulting in a transgender person acquiring HIV.

# Definitions of Mode of Exposure Categories, continued

- **Heterosexual:** Heterosexual contact with person(s) who received an HIV diagnosis or had a known HIV risk; these data exclude transgender persons.

- **Other Risk**: Includes recipients of clotting factor for hemophilia or other coagulation disorders, recipients of HIV-infected blood or blood components other than clotting factor or of HIV-infected tissue, perinatal and other pediatric risks, or other confirmed risks.

# Florida's Four Key Components Plan To Eliminate HIV Transmission and Reduce HIV-Related Deaths

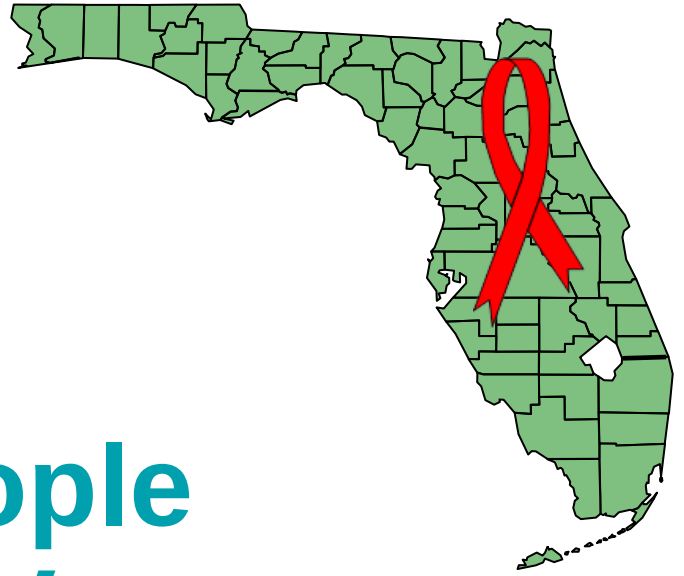
- Implement routine HIV and STI screening in health care settings and priority testing in non-health care settings.

- Provide rapid access to treatment and ensure retention in care (Test and Treat).

# Florida's Four Key Components Plan To Eliminate HIV Transmission and Reduce HIV-Related Deaths, Continued

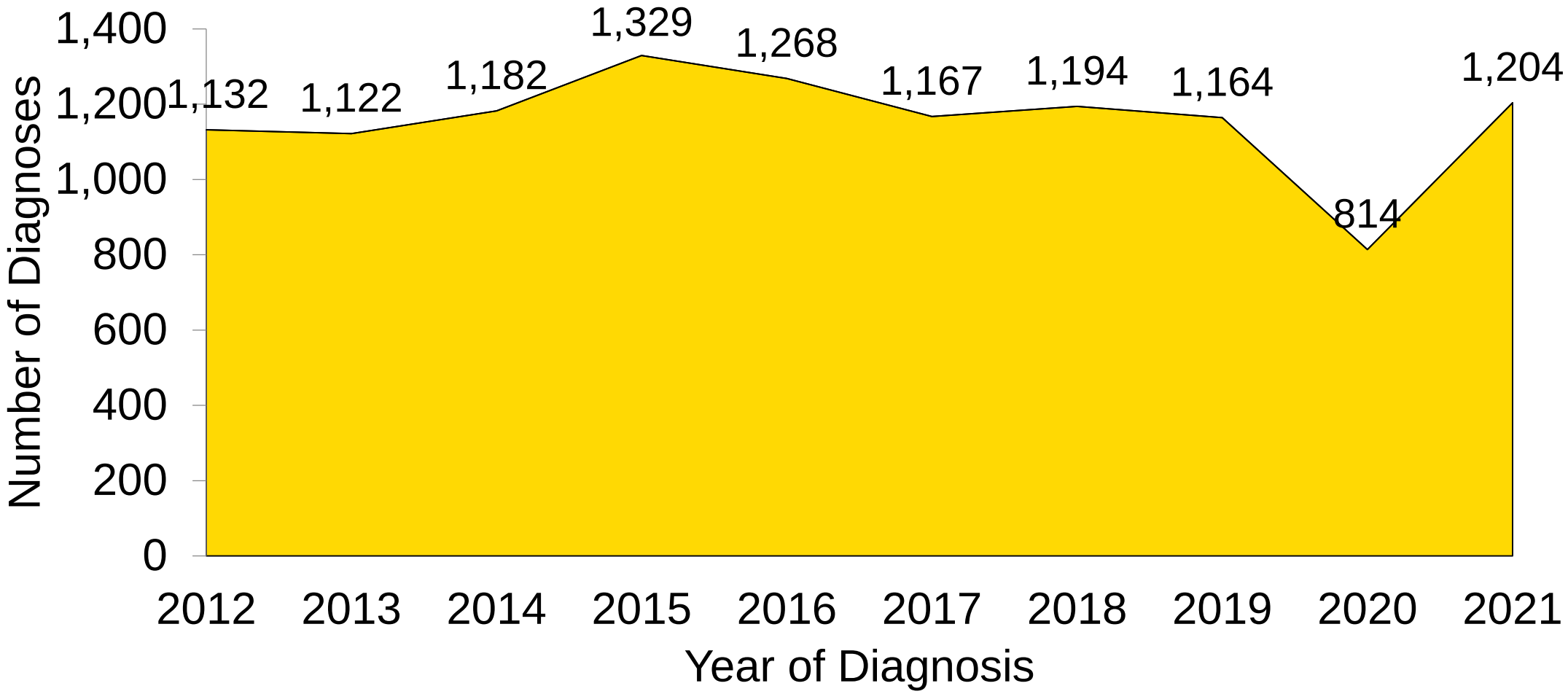
- Improve and promote access to antiretroviral PrEP and nPEP.

- Increase HIV awareness and community response through outreach, engagement, and messaging.

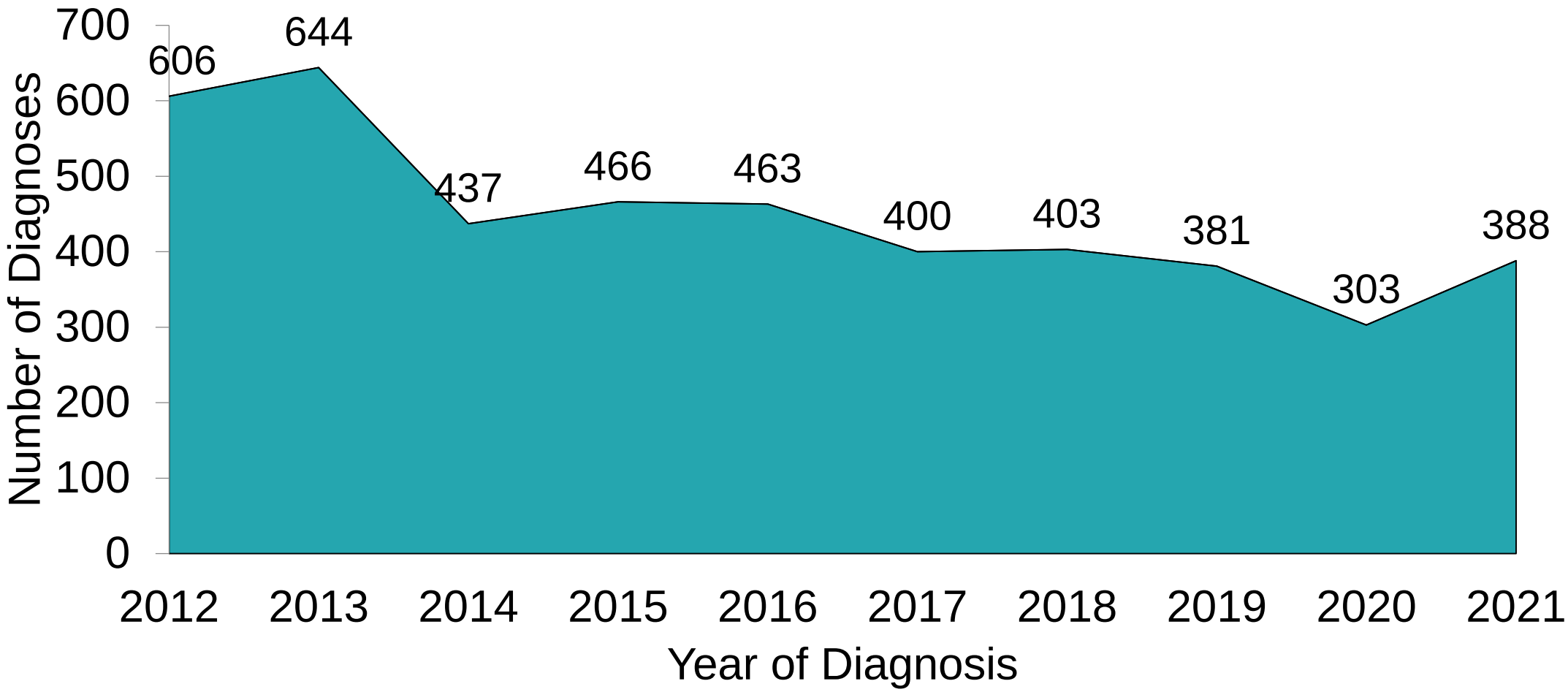


# Demographics of People Diagnosed with HIV

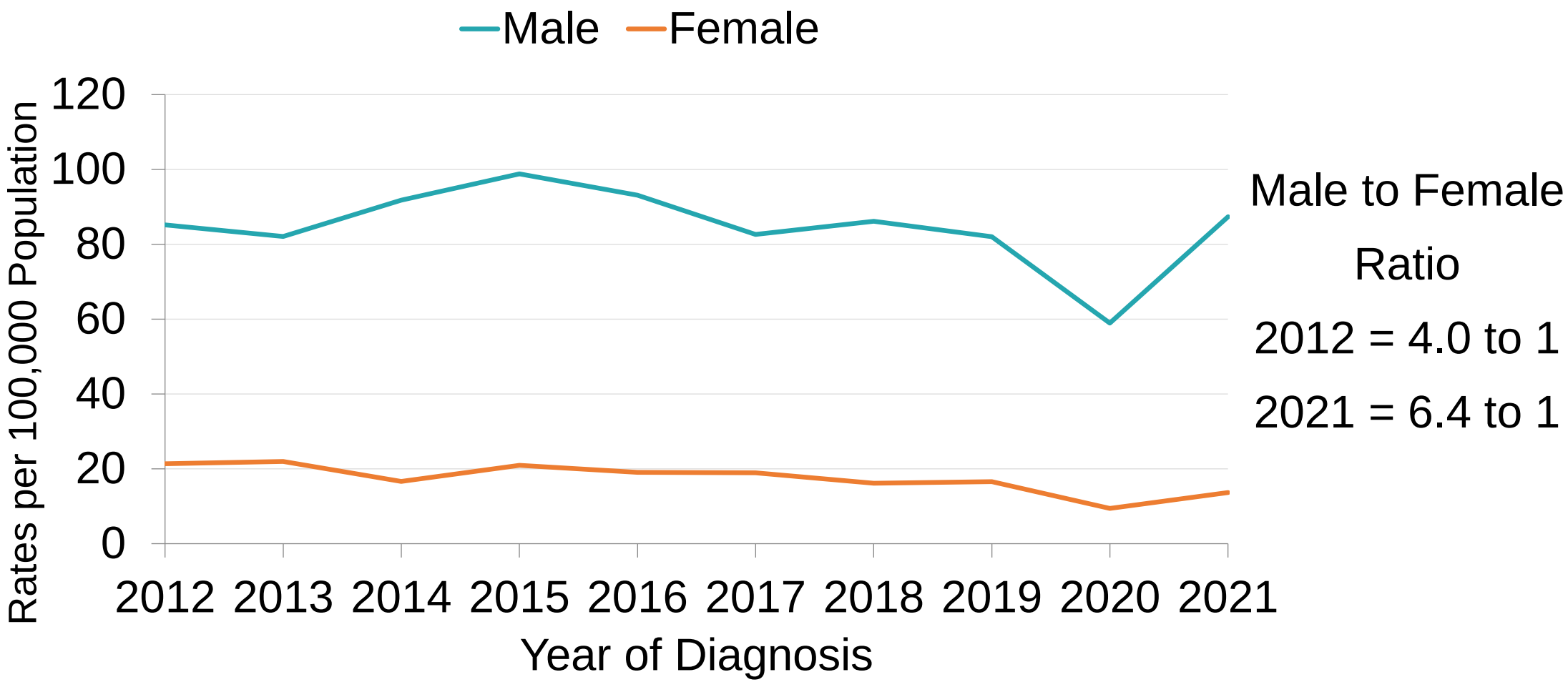
# Diagnoses of HIV, 2012–2021, Miami-Dade County



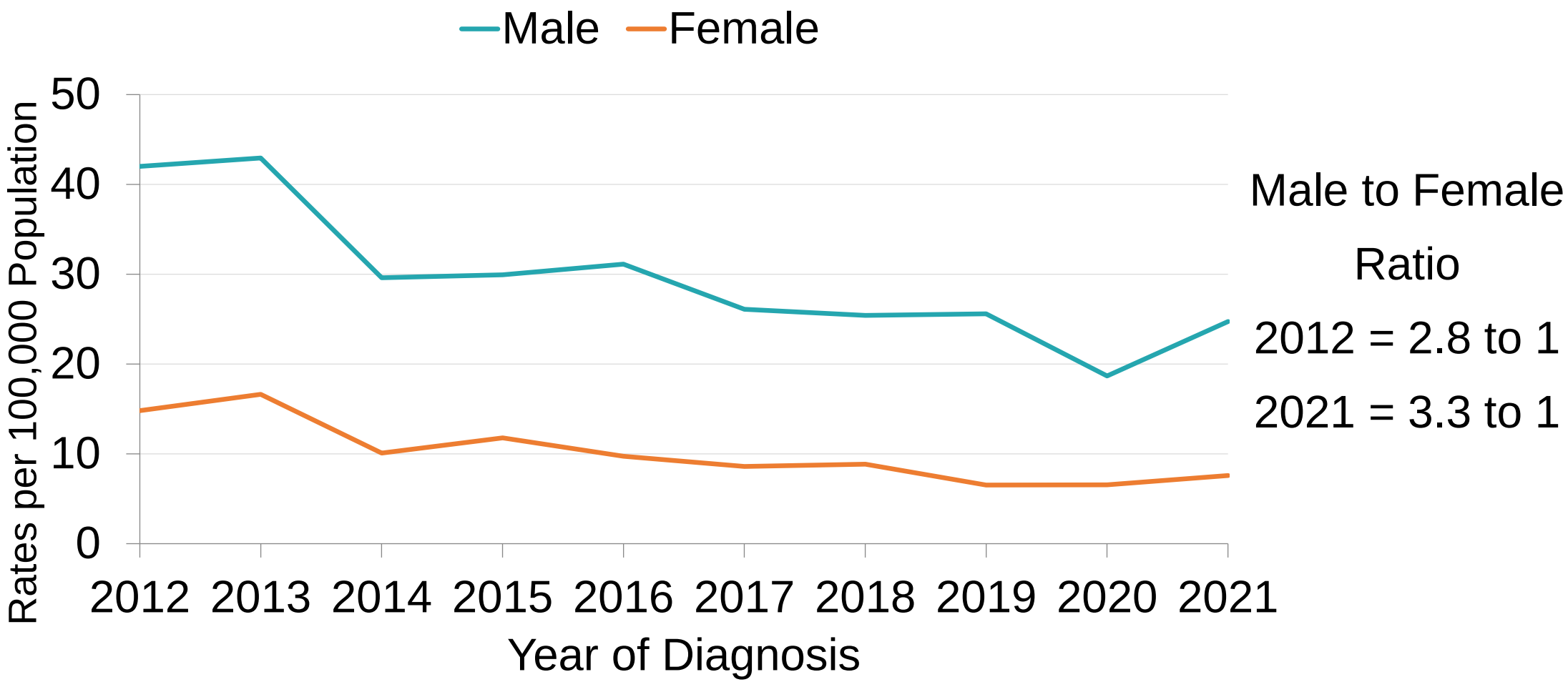
# Diagnoses of AIDS, 2012–2021, Miami-Dade County



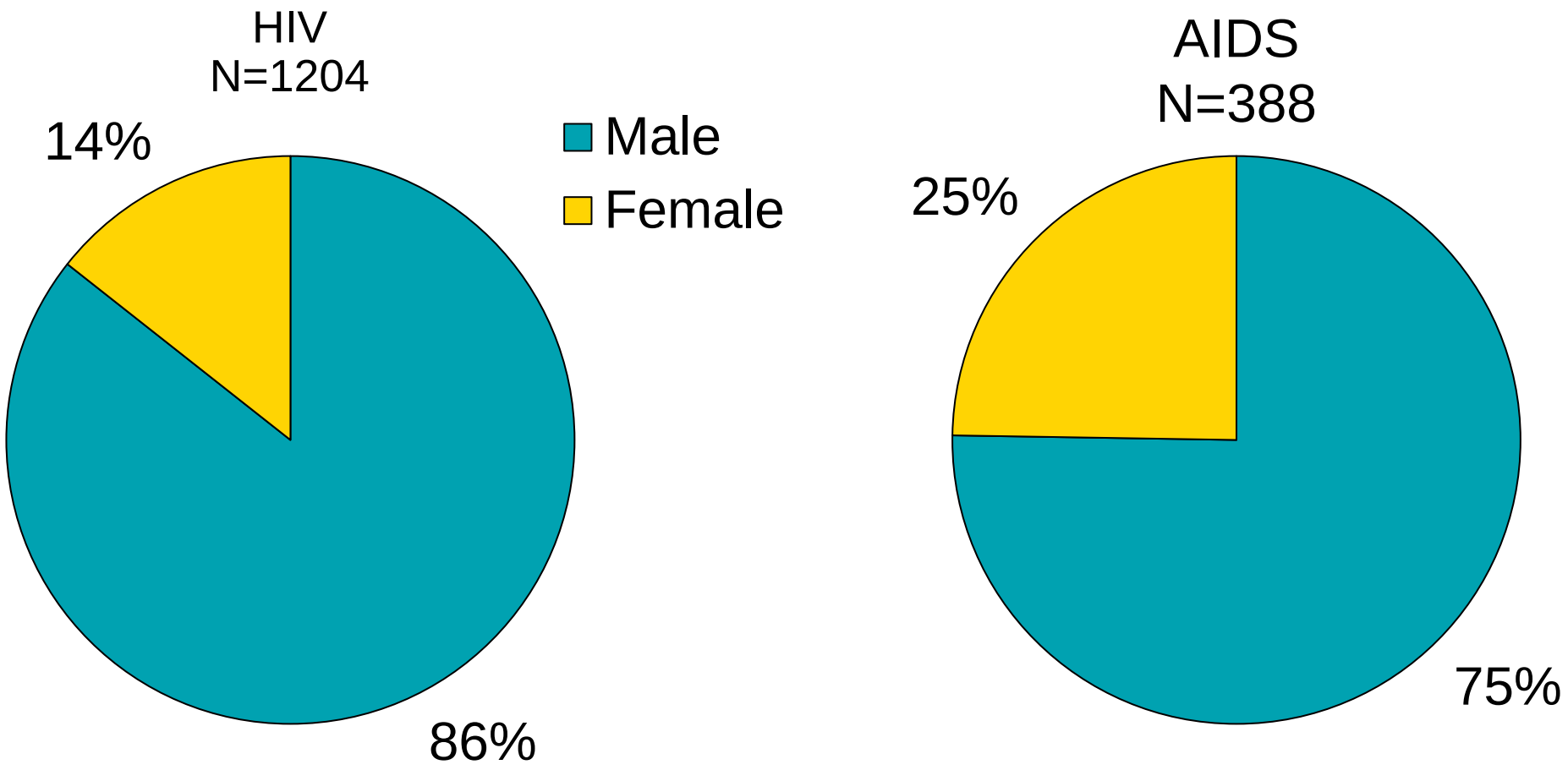
# Adult HIV Diagnosis Rates by Sex at Birth, 2012–2021, Miami-Dade County



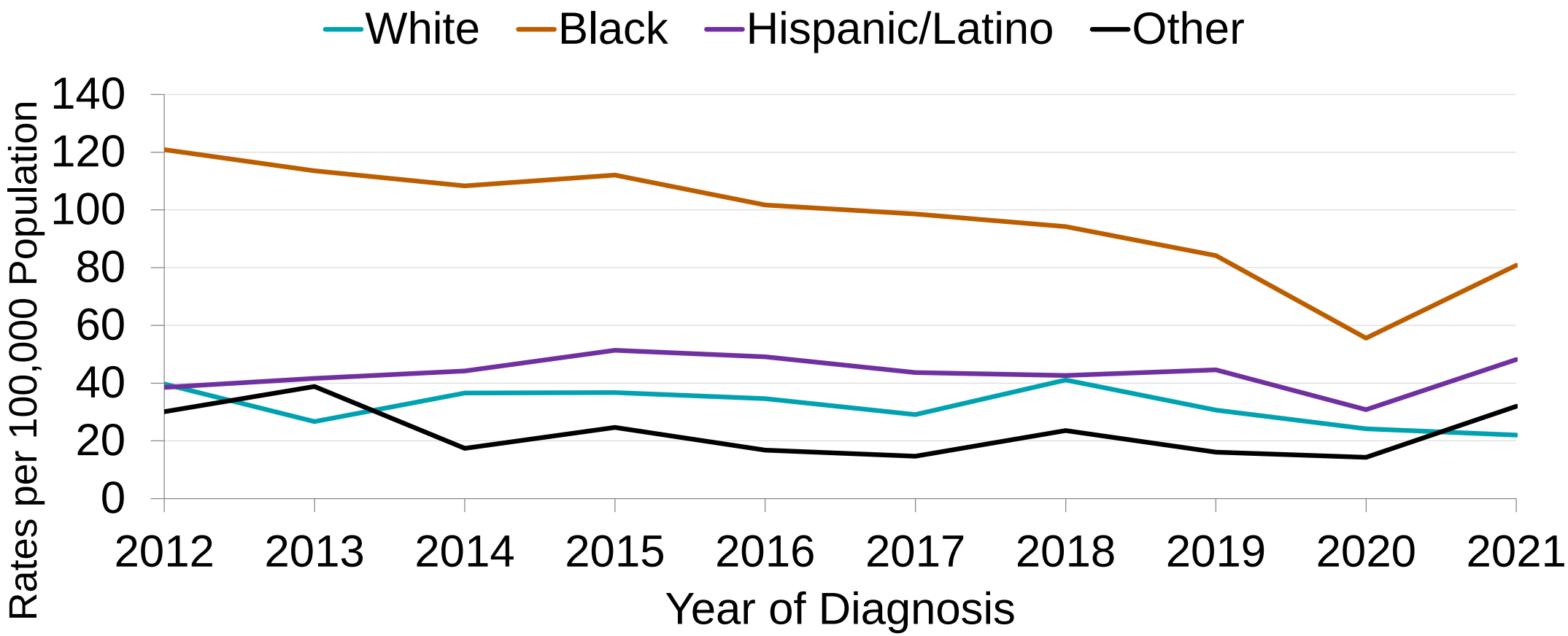
# Adult AIDS Diagnosis Rates by Sex at Birth, 2012–2021, Miami-Dade County



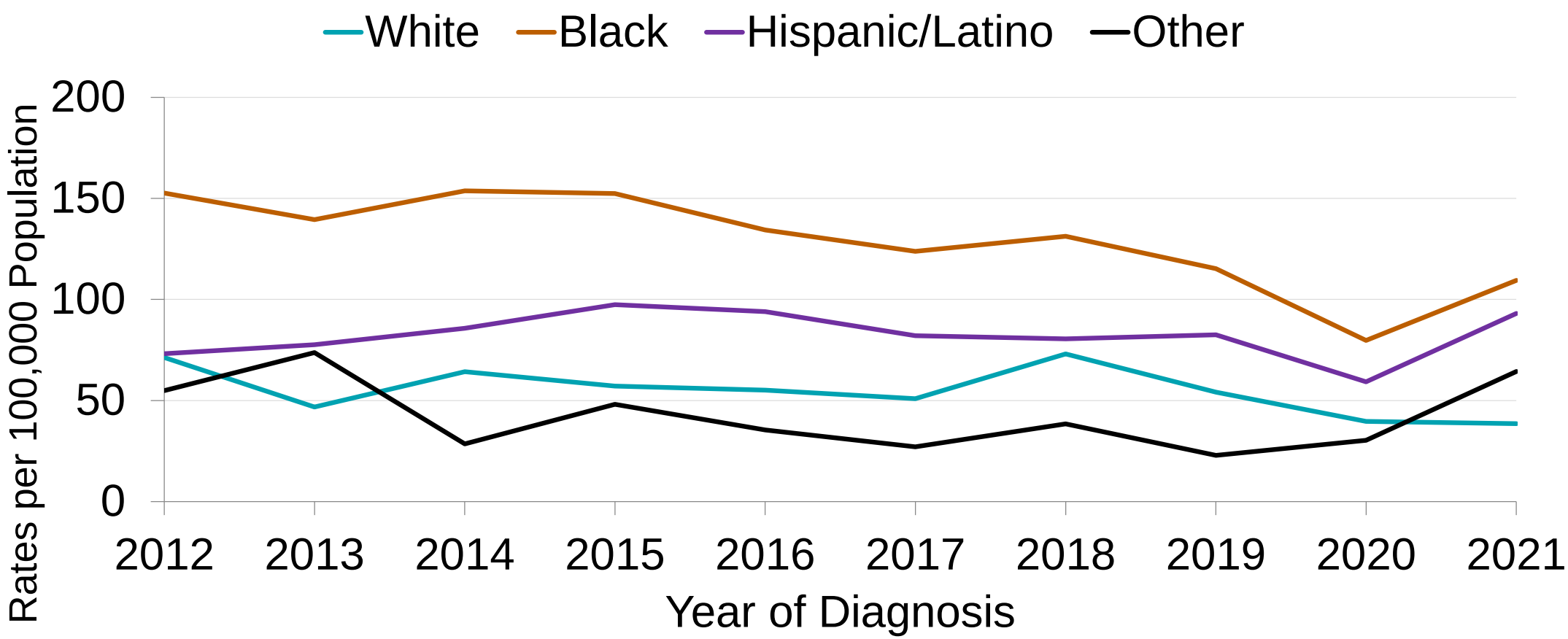
# Adult HIV and AIDS Diagnoses
# By Sex at Birth, 2021, Miami-Dade County



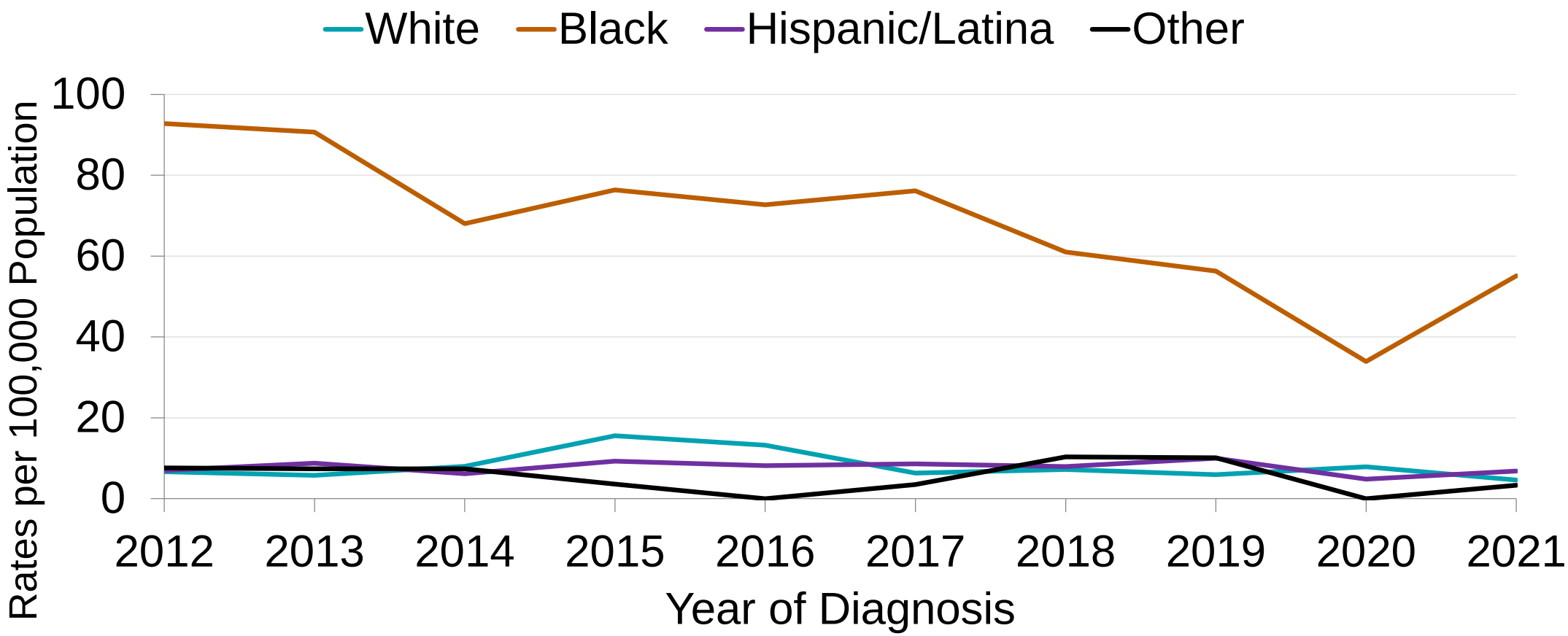
# Adult HIV Diagnosis Rates
# By Race or Ethnicity, 2012–2021, Miami-Dade County



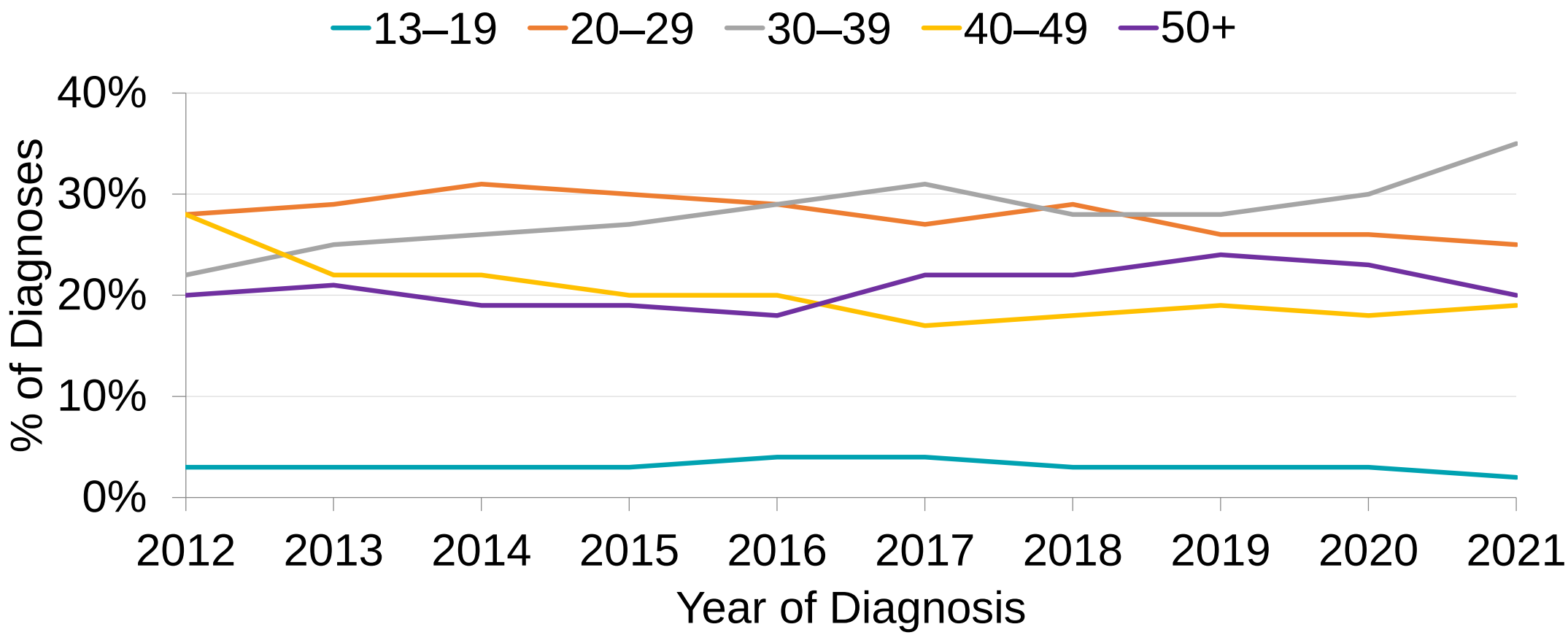
# Adult Male HIV Diagnosis Rates By Race or Ethnicity, 2012–2021, Miami-Dade County



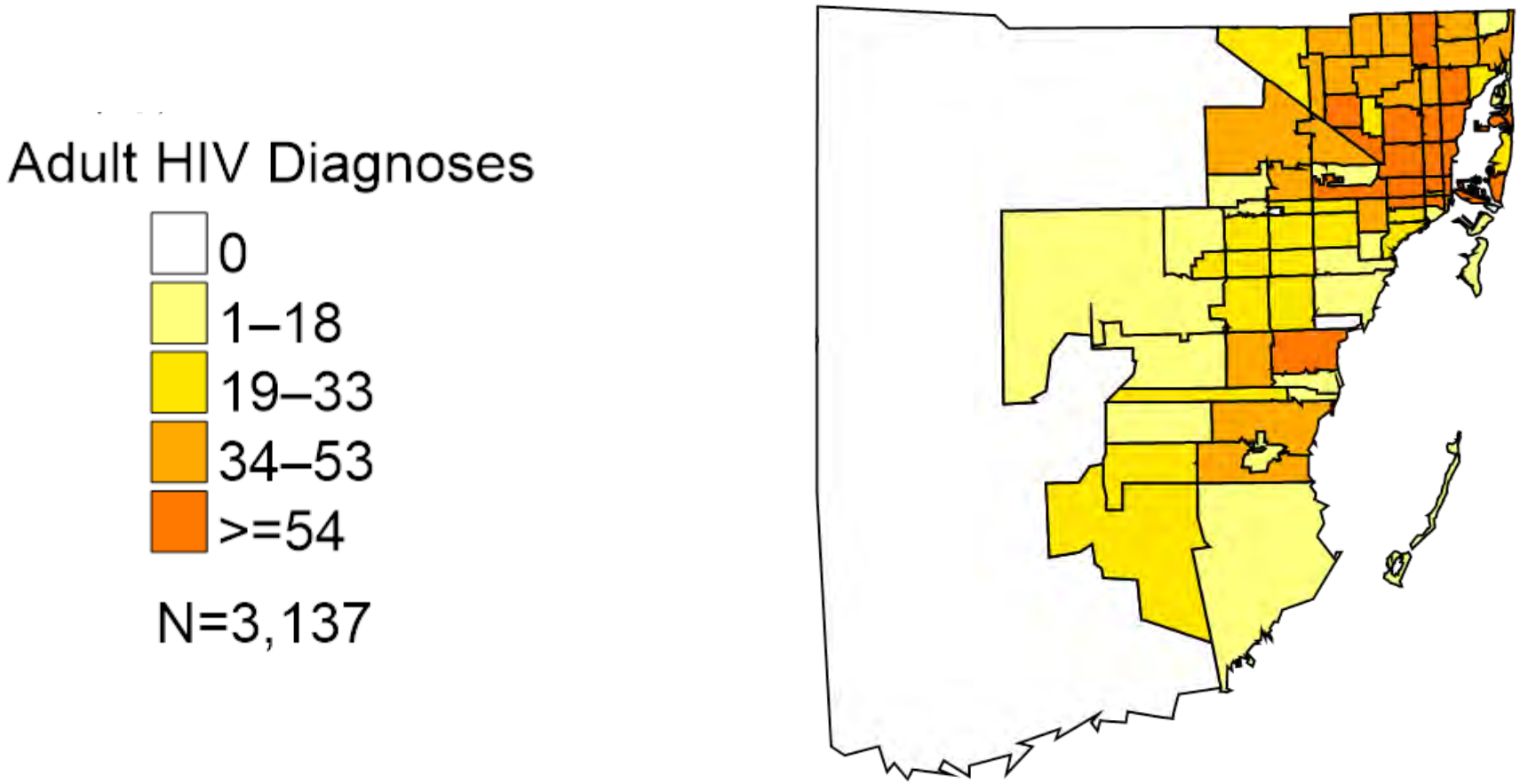
# Adult Female HIV Diagnosis Rates By Race or Ethnicity, 2012–2021, Miami-Dade County



# Adult HIV Diagnoses by Age At Diagnosis, 2012–2021, Miami-Dade County

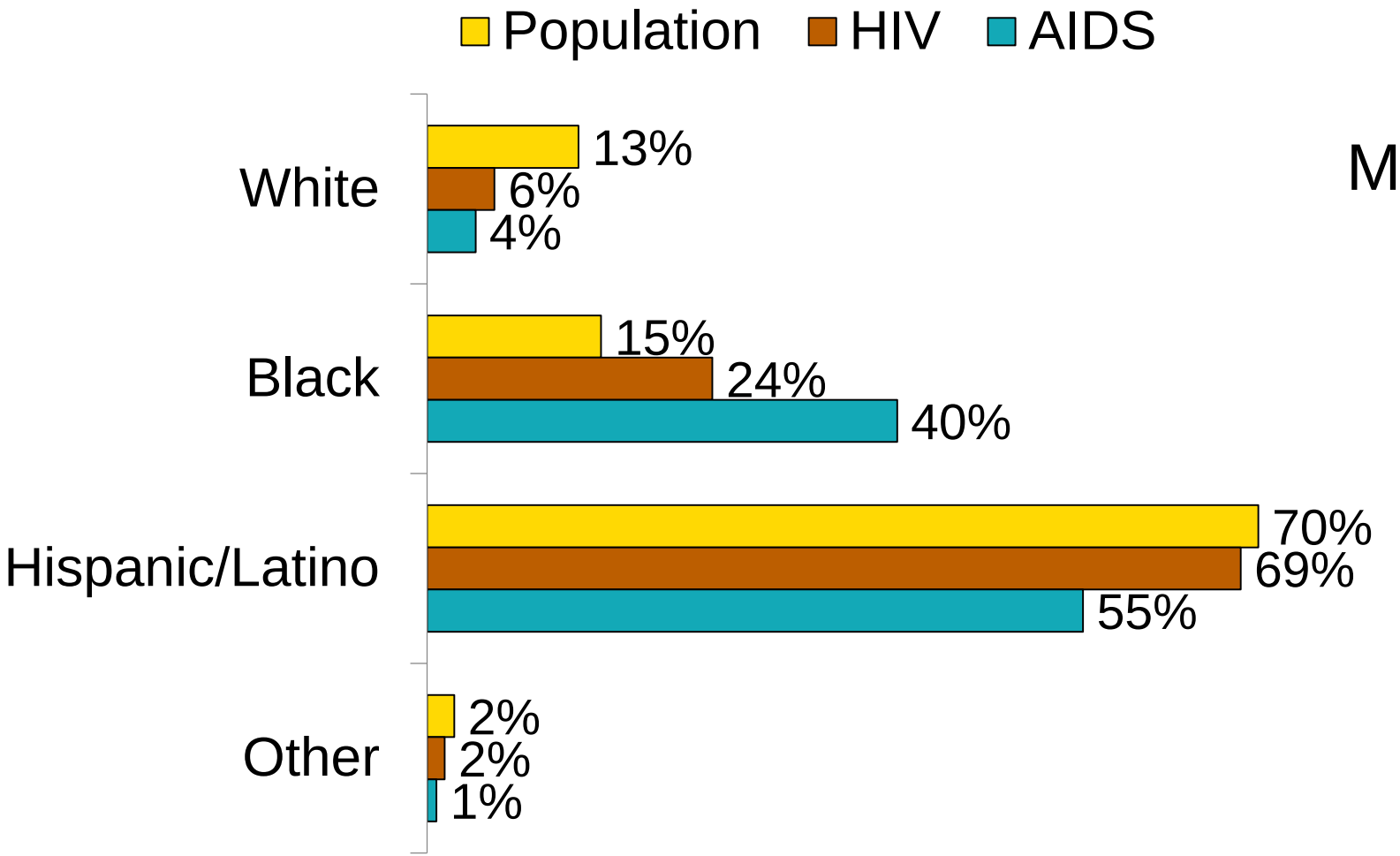


# Adult HIV Diagnoses by ZIP Code of Residence At Diagnosis, 2019–2021, Miami-Dade County




County map boundaries include agricultural and/or conservation areas, which may not be populated.

# Adult HIV and AIDS Diagnoses and Population by Race or Ethnicity, 2021, Miami-Dade County



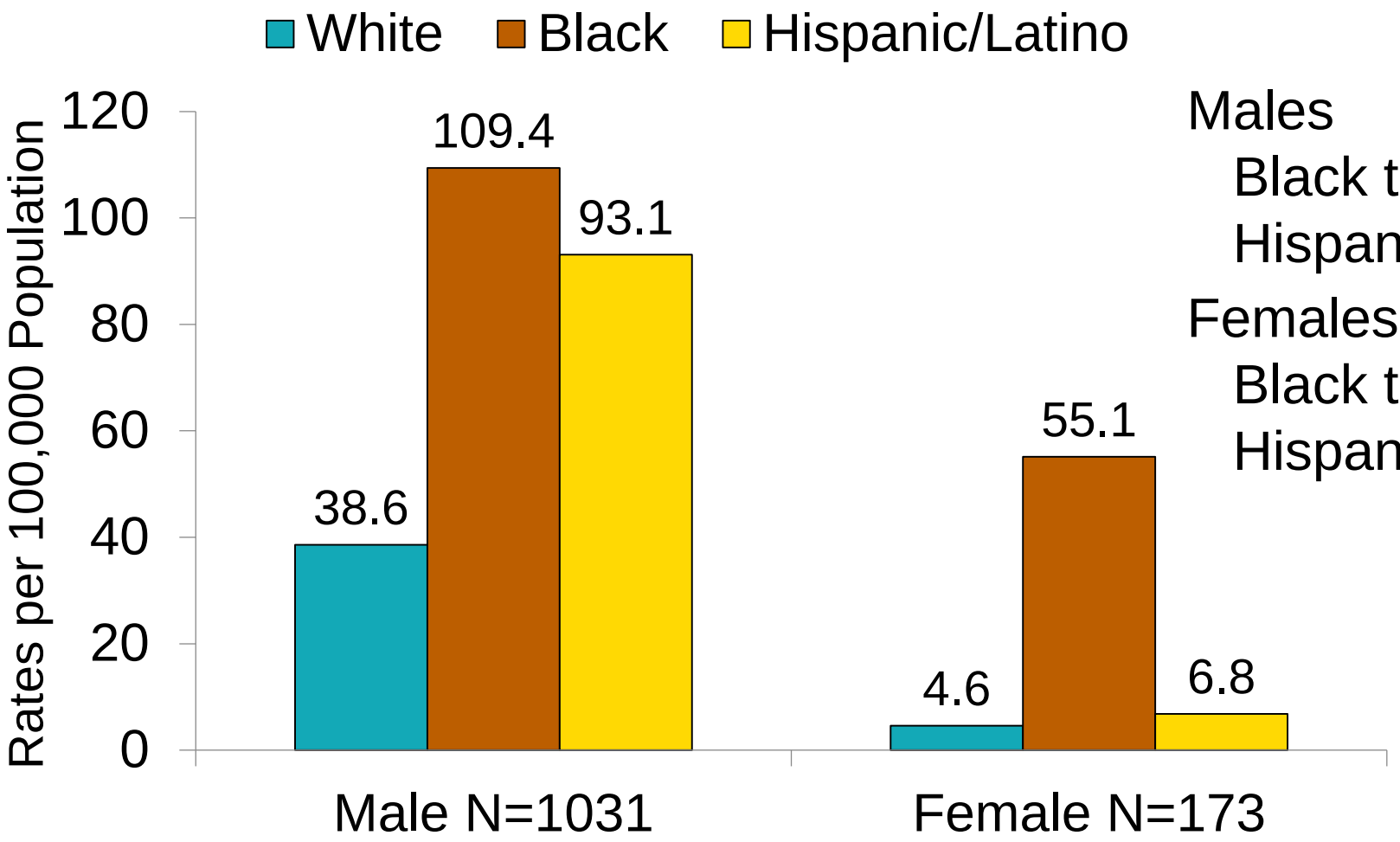

Miami-Dade County Adult Population Estimate
N=2,444,510

HIV
N=1204

AIDS
N=388

Rounding may cause percentages to total more or less than 100.

# Adult HIV Diagnosis Rates by Sex And Race or Ethnicity, 2021, Miami-Dade County




Rate Ratios

Males

Black to White: 2.8 to 1

Hispanic/Latino to White: 2.4 to 1

Females

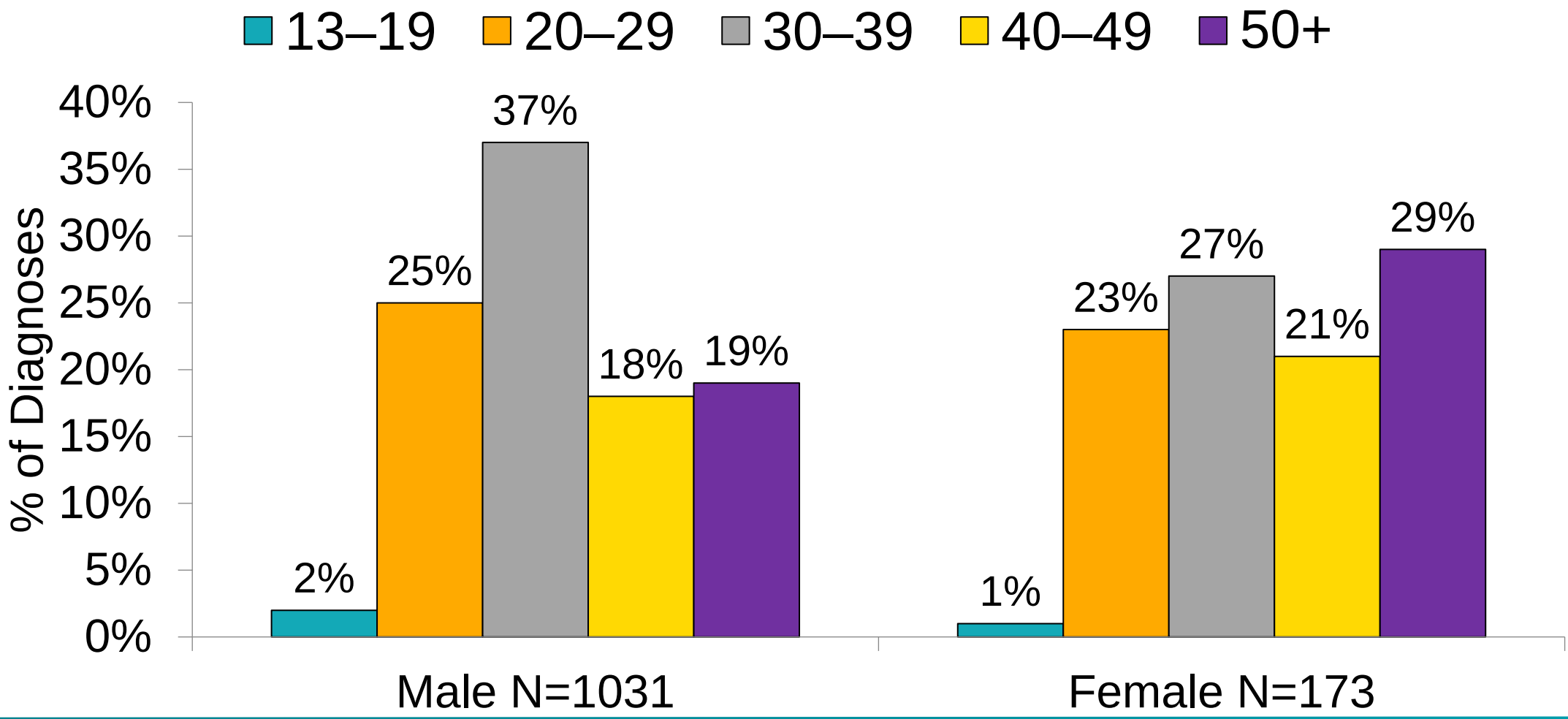
Black to White: 12.0 to 1

Hispanic/Latina to White: 1.5 to 1

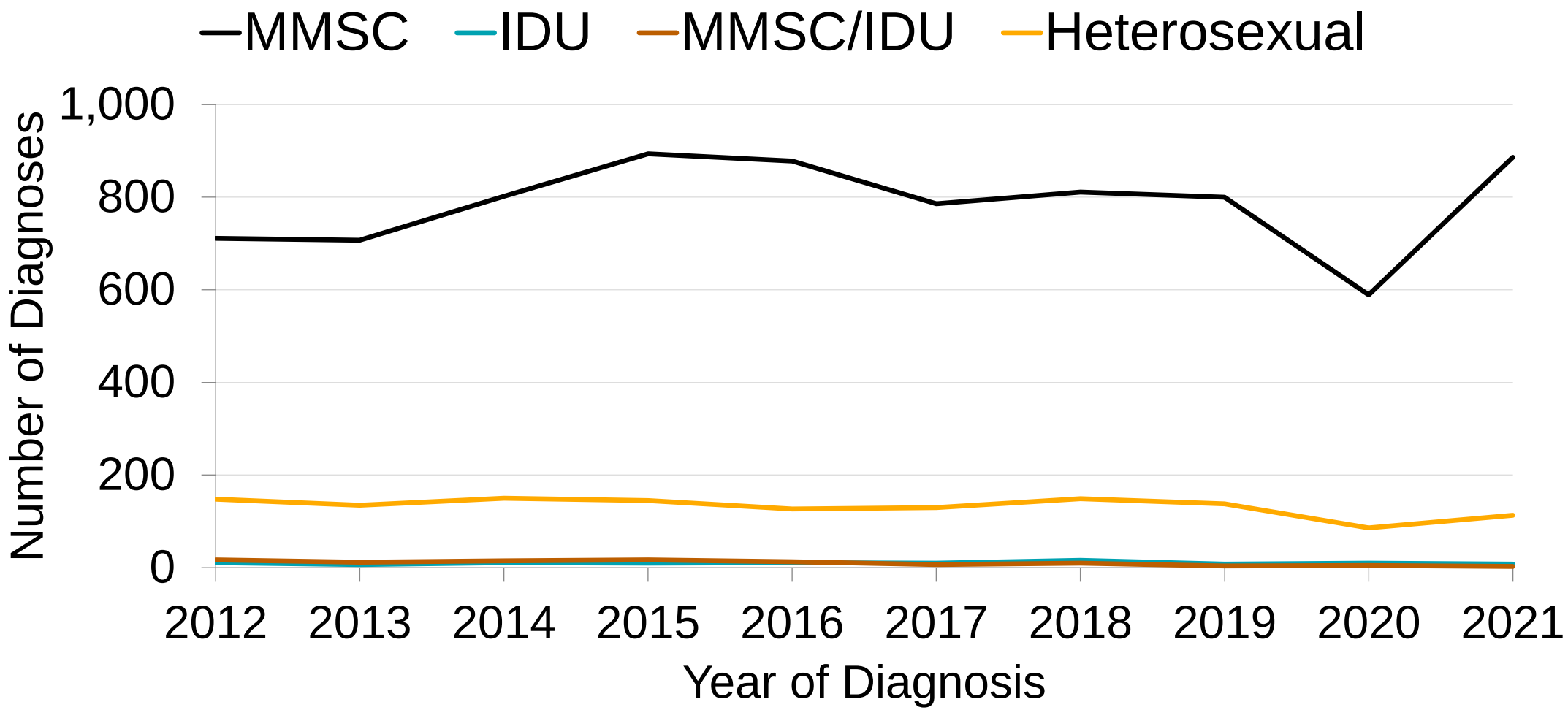


Rounding may cause percentages to total more or less than 100.

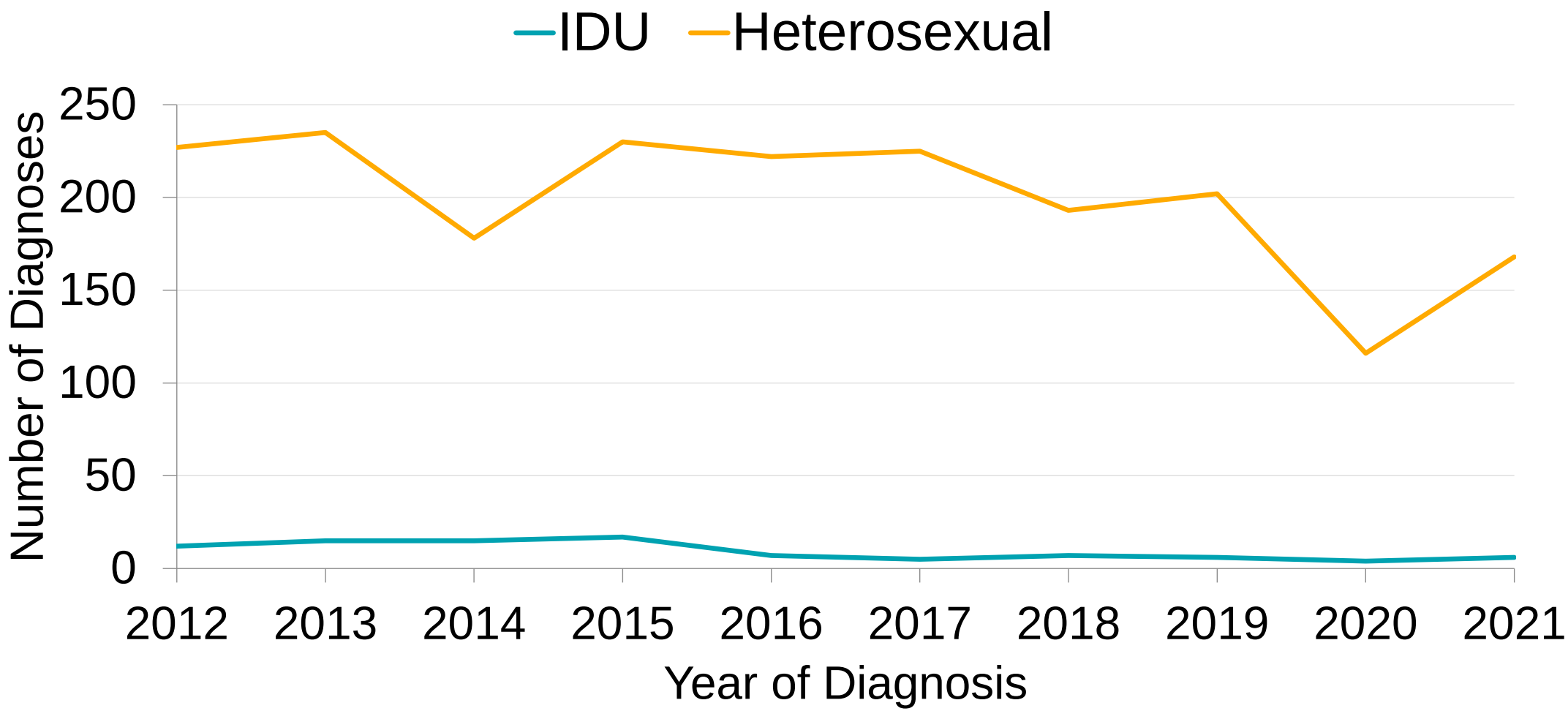
# Adult HIV Diagnoses By Sex and Age at Diagnosis, 2021, Miami-Dade County

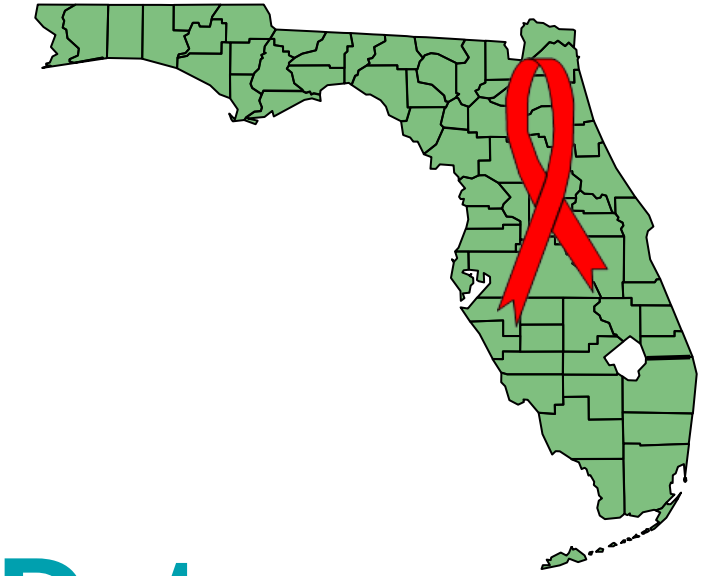


# Adult Male HIV Diagnoses by Mode of Exposure, 2012–2021, Miami-Dade County



# Adult Female HIV Diagnoses by Mode of Exposure, 2012–2021, Miami-Dade County



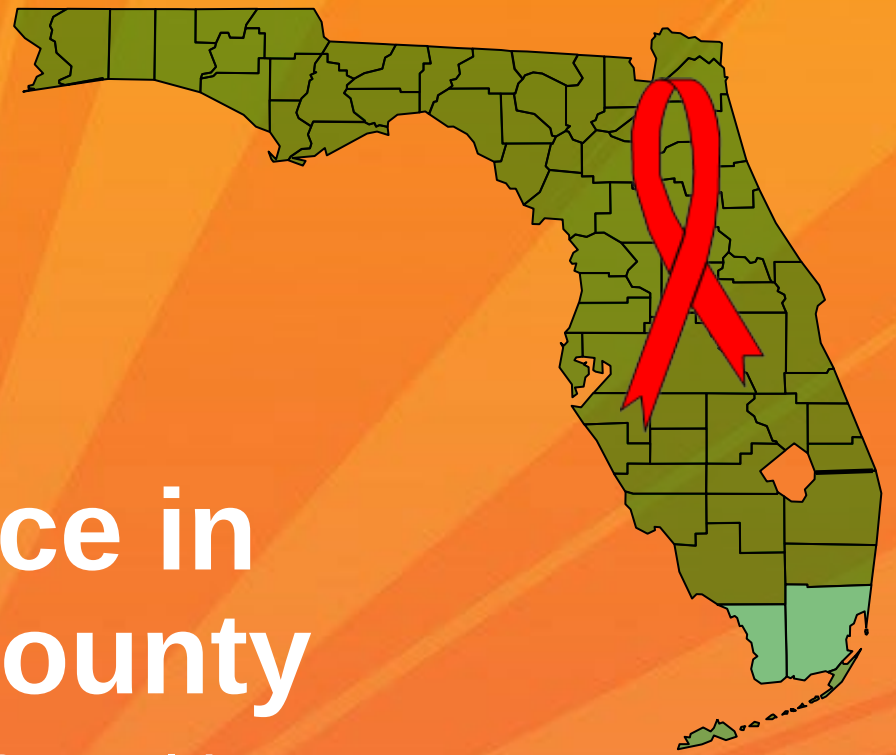


# HIV Co-morbidity Data

# PWH with a Co-occurring Diagnosis of an STI by Type and Year of STI Report, 2017–2021, Miami-Dade County

| Year of STI Report | HIV/ Early Syphilis[1] | HIV/ Chlamydia | HIV/ Gonorrhea |
|---|---|---|---|
| **2017** | 724 | 611 | 595 |
| **2018** | 928 | 803 | 806 |
| **2019** | 1,000 | 955 | 1,034 |
| **2020** | 1,096 | 837 | 953 |
| **2021** | 1,248 | 1,202 | 1,188 |
| **Percentage Change** | 72% | 97% | 100% |

[1]Primary, secondary and early non-primary, non-secondary syphilis.

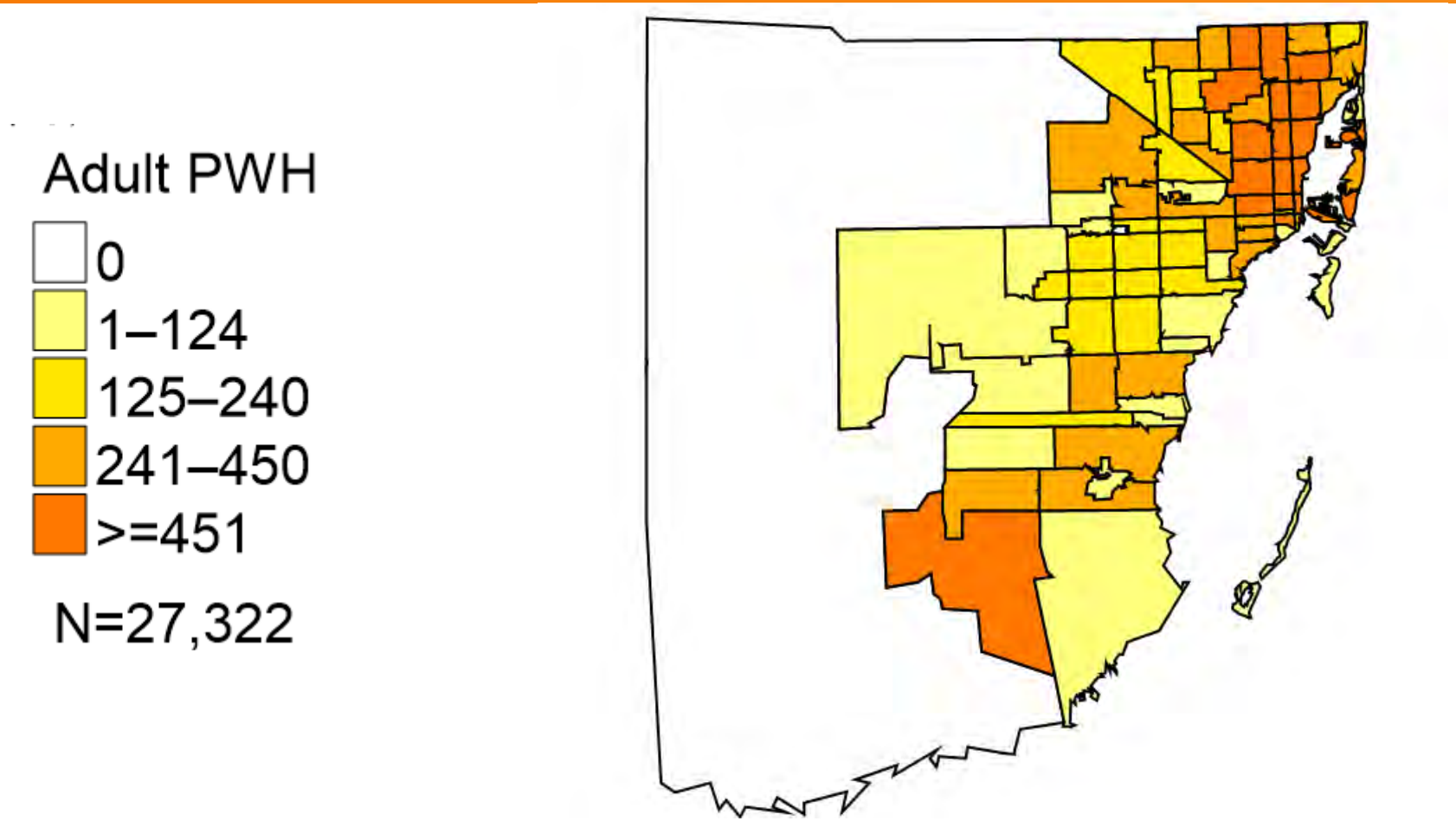


# HIV Prevalence in Miami-Dade County

Florida Department of Health

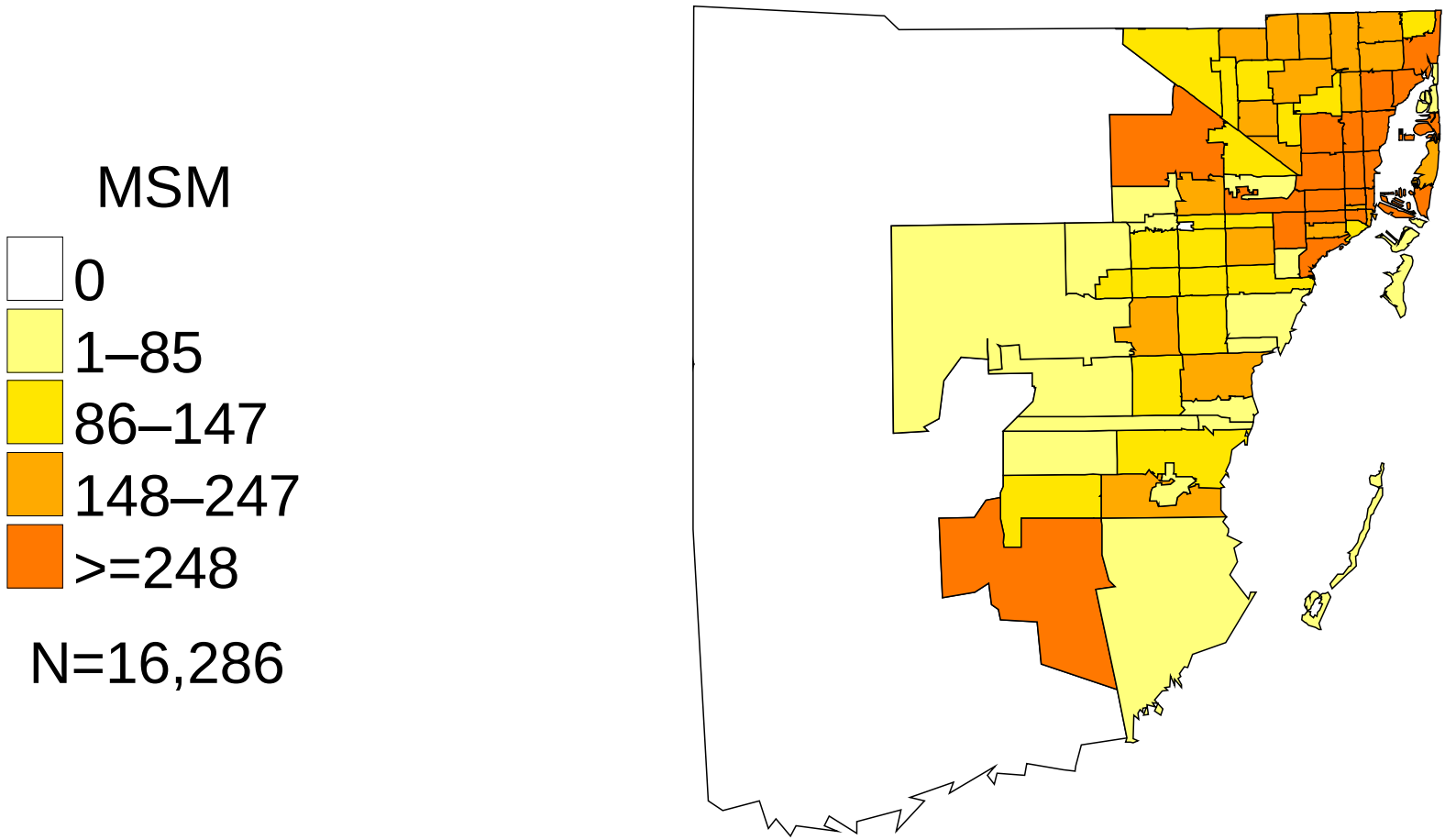
Florida HEALTH

# Adult PWH by ZIP Code of Residence,[1] 2021
# Living in Miami-Dade County




[1]Excludes homeless persons and persons with unknown ZIP codes.

# MSM[1] with HIV by ZIP Code of Residence,[2] 2021 Living in Miami-Dade County




[1]Data includes MSM/PWID and excludes transgender persons.
[2]Excludes homeless persons and persons with unknown ZIP codes.

# PWID[1] with HIV by ZIP Code of Residence,[2] 2021
# Living in Miami-Dade County

PWID

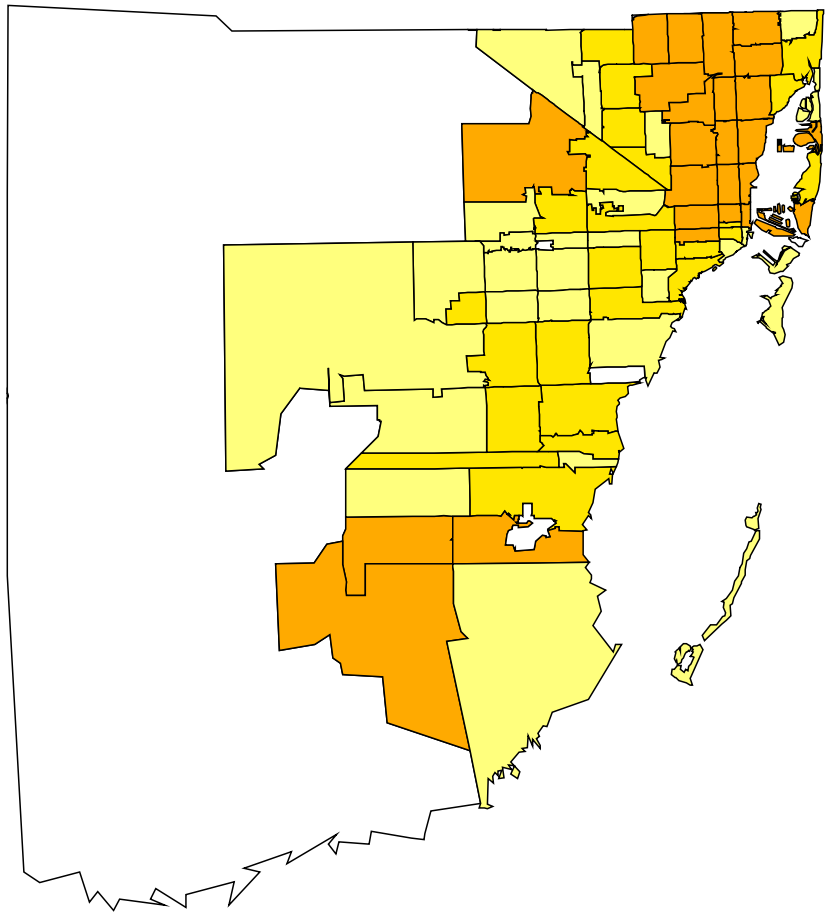
0

1–7

8–25

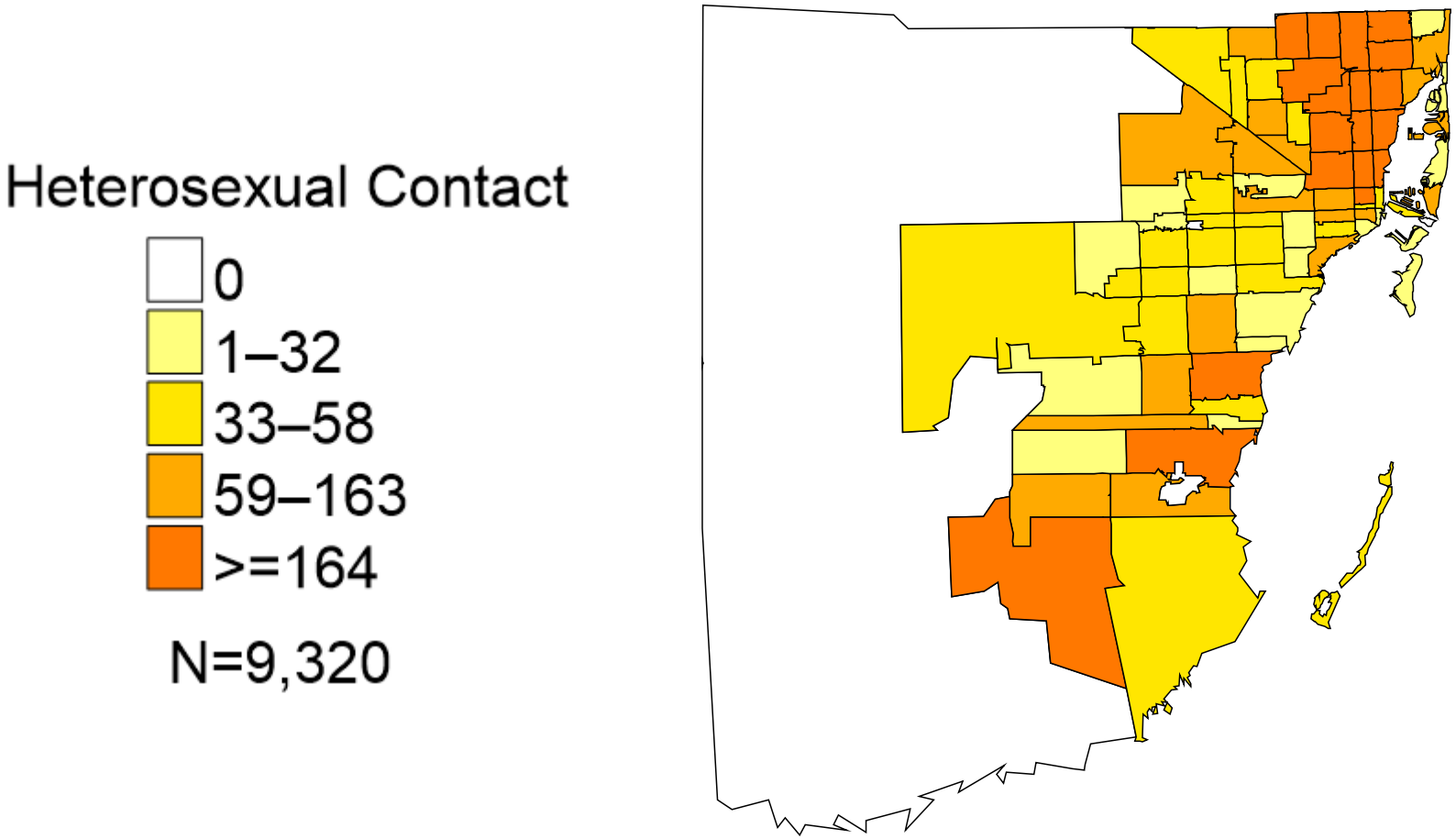
>=26

N=1,929



[1]Data includes MSM/PWID.
[2]Excludes homeless persons and persons with unknown ZIP codes.

# Persons with Heterosexual Contact with HIV by ZIP Code of Residence,[1] 2021, Living in Miami-Dade County



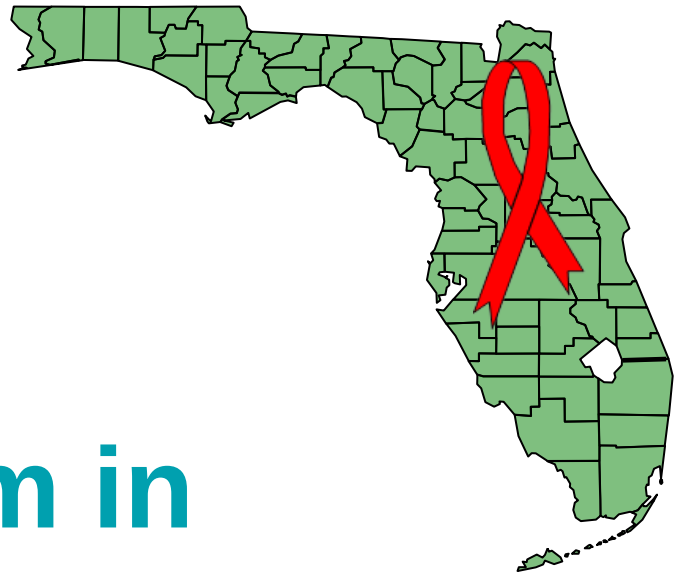

[1]Excludes homeless persons and persons with unknown ZIP codes.

# Adults with HIV, 2021, Living in Miami-Dade County

| | | Male # | % | Female # | % | Total # | % |
|---|---|---|---|---|---|---|---|
| Race/ Ethnicity | White | 2,481 | 11.7% | 275 | 4.2% | 2,756 | 9.9% |
| | Black | 6,453 | 30.4% | 4,443 | 67.9% | 10,896 | 39.2% |
| | Hispanic/Latino | 12,016 | 56.6% | 1,745 | 26.7% | 13,761 | 49.6% |
| | Other | 267 | 1.3% | 82 | 1.3% | 349 | 1.3% |
| Age Group | 13-19 | 36 | 0.2% | 15 | 0.2% | 51 | 0.2% |
| | 20-29 | 1,414 | 6.7% | 325 | 5.0% | 1,739 | 6.3% |
| | 30-39 | 3,811 | 18.0% | 880 | 13.4% | 4,691 | 16.9% |
| | 40-49 | 3,995 | 18.8% | 1,338 | 20.4% | 5,333 | 19.2% |
| | 50+ | 11,961 | 56.4% | 3,987 | 60.9% | 15,948 | 57.4% |
| Mode of Exposure | MMSC | 15,870 | 74.8% | 0 | 0.0% | 15,870 | 57.2% |
| | IDU | 811 | 3.8% | 532 | 8.1% | 1,343 | 4.8% |
| | MMSC/IDU | 637 | 3.0% | 0 | 0.0% | 637 | 2.3% |
| | Heterosexual Contact | 3,663 | 17.3% | 5,838 | 89.2% | 9,501 | 34.2% |
| | Transgender Sexual Contact | 96 | 0.5% | 3 | 0.0% | 99 | 0.4% |
| | Other risk | 141 | 0.7% | 172 | 2.6% | 313 | 1.1% |

Florida HEALTH

Rounding may cause percentages to total more or less than 100.



# HIV Care Continuum in Miami-Dade County

# HIV Care Continuum Definitions

- **PWH:** Persons with HIV living in Florida at the end of 2021.
- **In Care:** PWH with at least one documented VL or CD4 lab, medical visit, or prescription from 1/1/2021 through 3/31/2022.
- **Retained in Care:** PWH with two or more documented VL or CD4 labs, medical visits or prescriptions at least three months apart from 1/1/2021 through 6/30/2022.

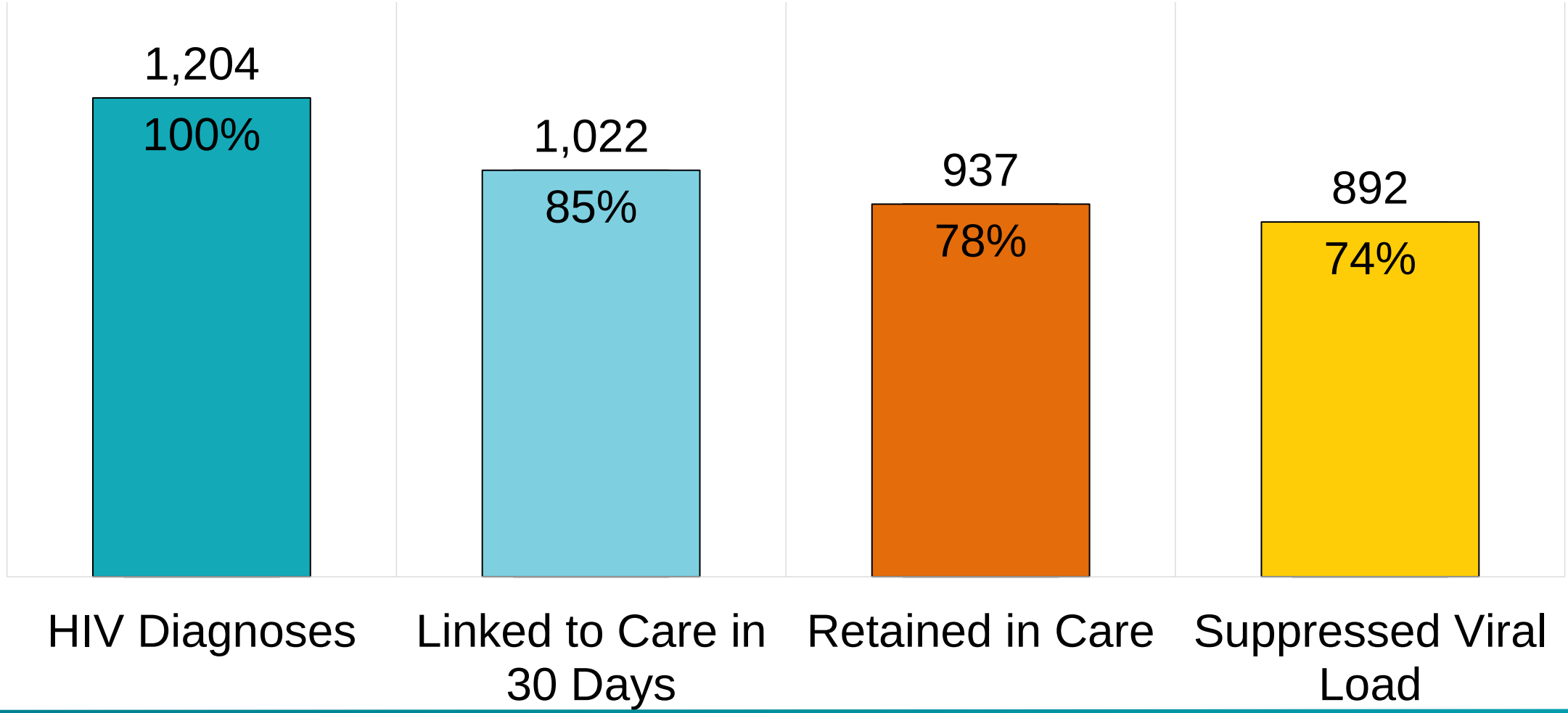
# HIV Care Continuum Definitions, continued

- **Suppressed Viral Load**: PWH with a suppressed VL (<200 copies/mL) on their last VL lab from 1/1/2020 through 3/31/2022.

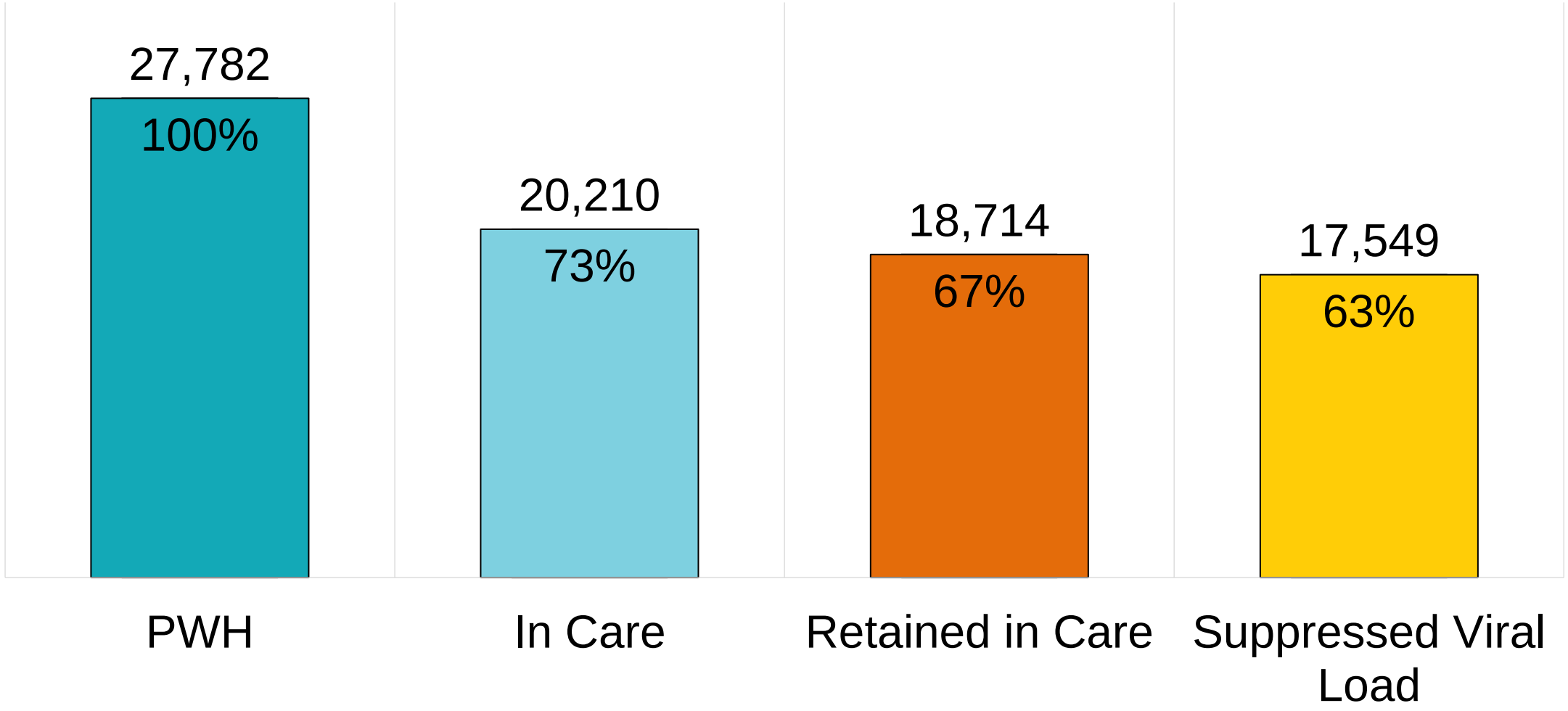
- **Not in Care:** PWH with no documented VL or CD4 lab, medical visit or prescription from 1/1/2021 through 3/31/2022.

- **Linked to Care**: PWH with at least one documented VL or CD4 lab, medical visit, or prescription following their first HIV diagnosis date.

# Persons Who Received an HIV Diagnosis Along the HIV Care Continuum in 2021, Miami-Dade County



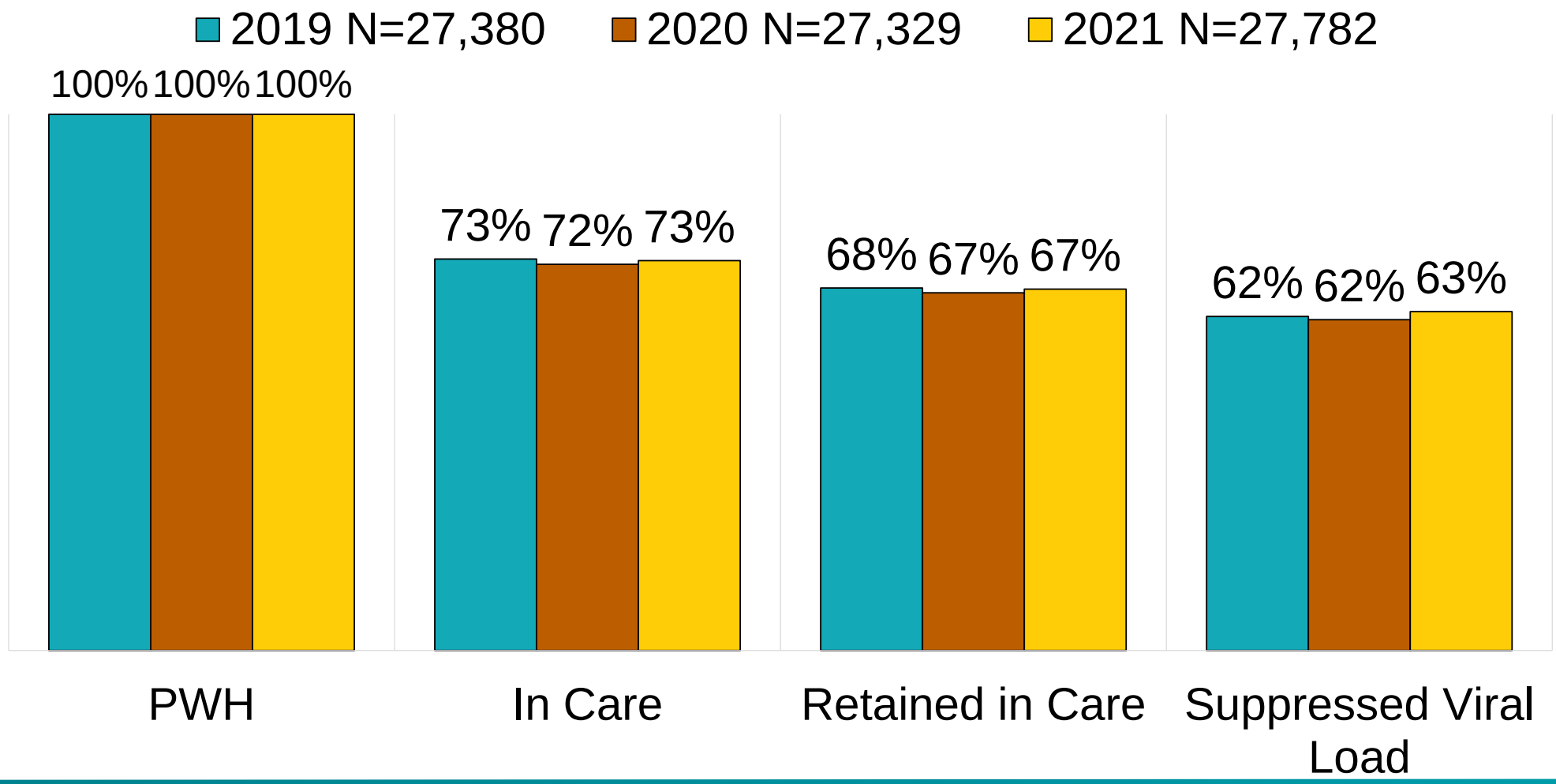
# PWH Along the HIV Care Continuum in 2021, Living in Miami-Dade County



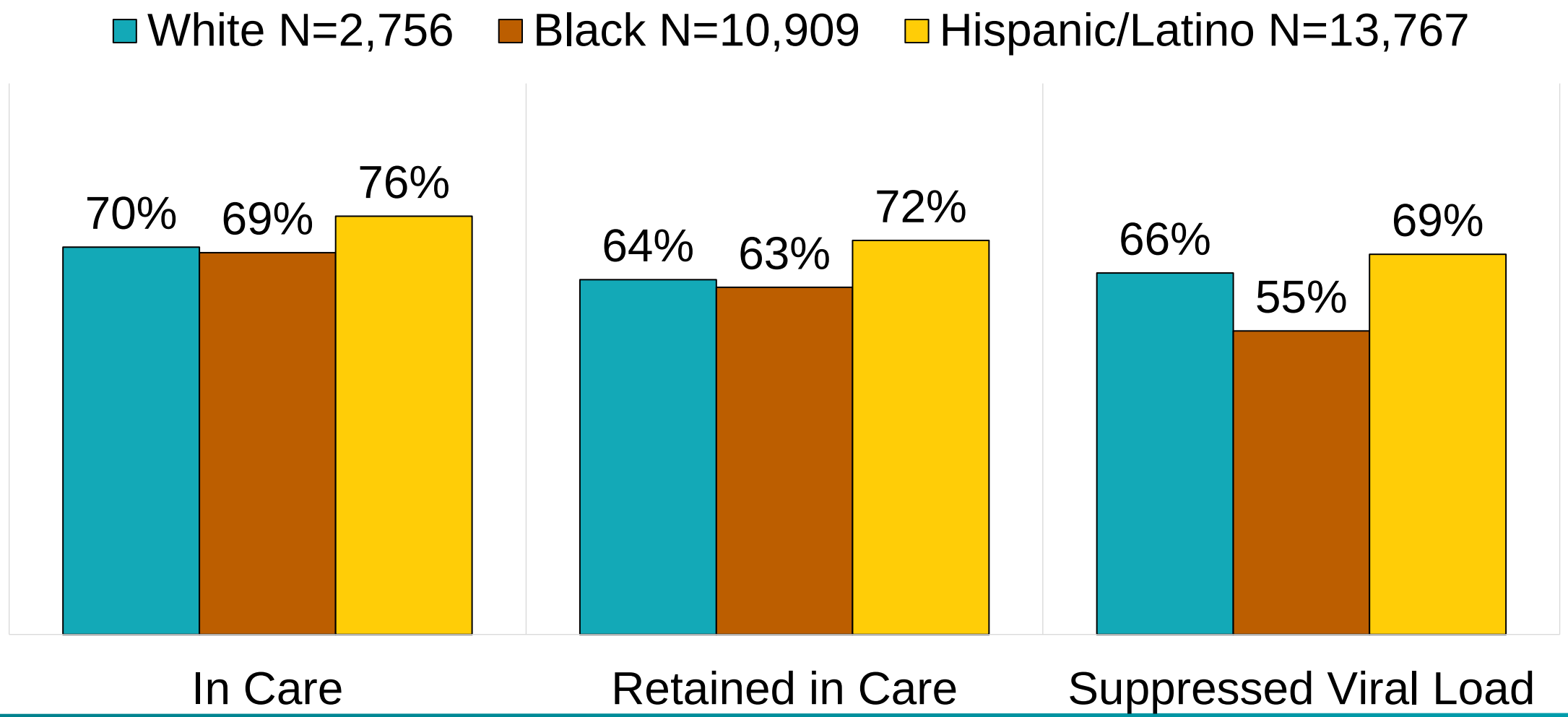

Florida HEALTH

Note: 89% of persons retained in care had a suppressed viral load.

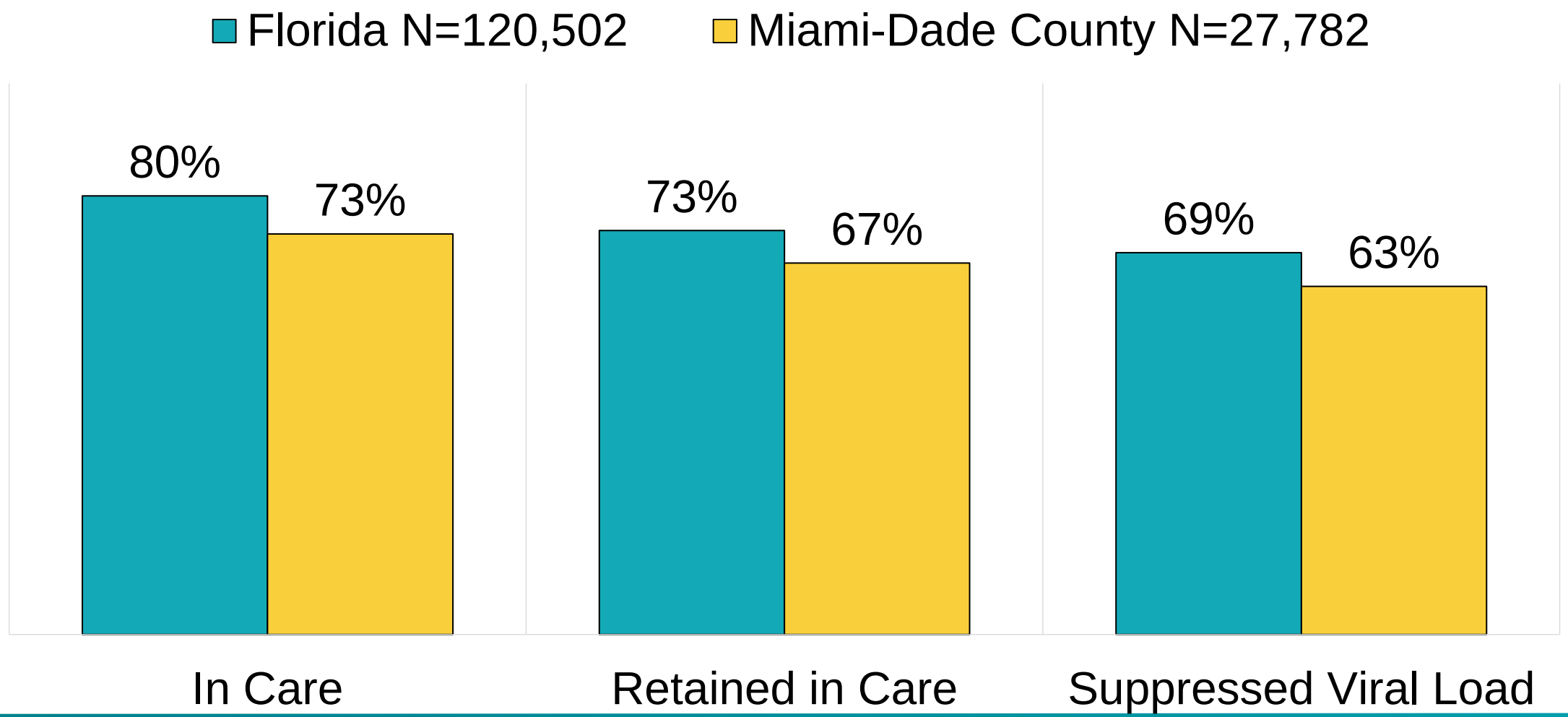
# PWH Along the HIV Care Continuum, 2019–2021
# Living in Miami-Dade County



# PWH by Race or Ethnicity Along the HIV Care Continuum In 2021, Living in Miami-Dade County



# PWH Along the HIV Care Continuum in 2021 Living in Florida Compared to Miami-Dade County

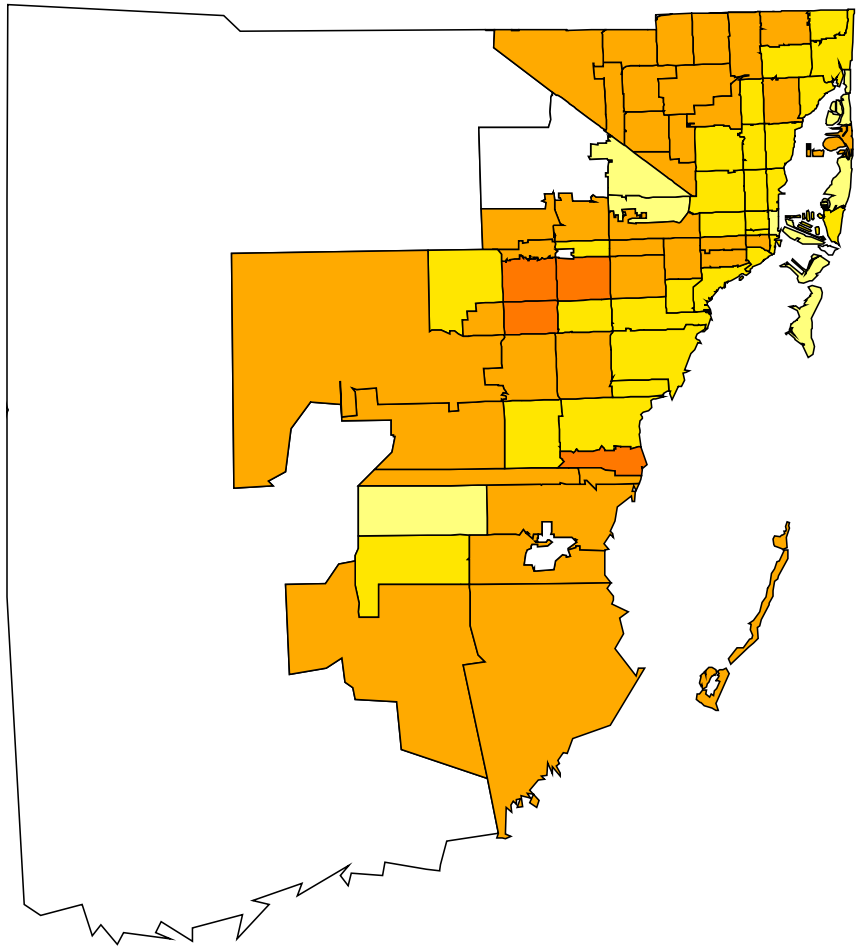


# Percentage of PWH Who Were Retained in Care by ZIP Code of Residence[1] in 2021, Living in Miami-Dade County

Retained in Care

- <50%
- 50%–59%
- 60%–69%
- 70%–79%
- 80%–100%

Overall 68%



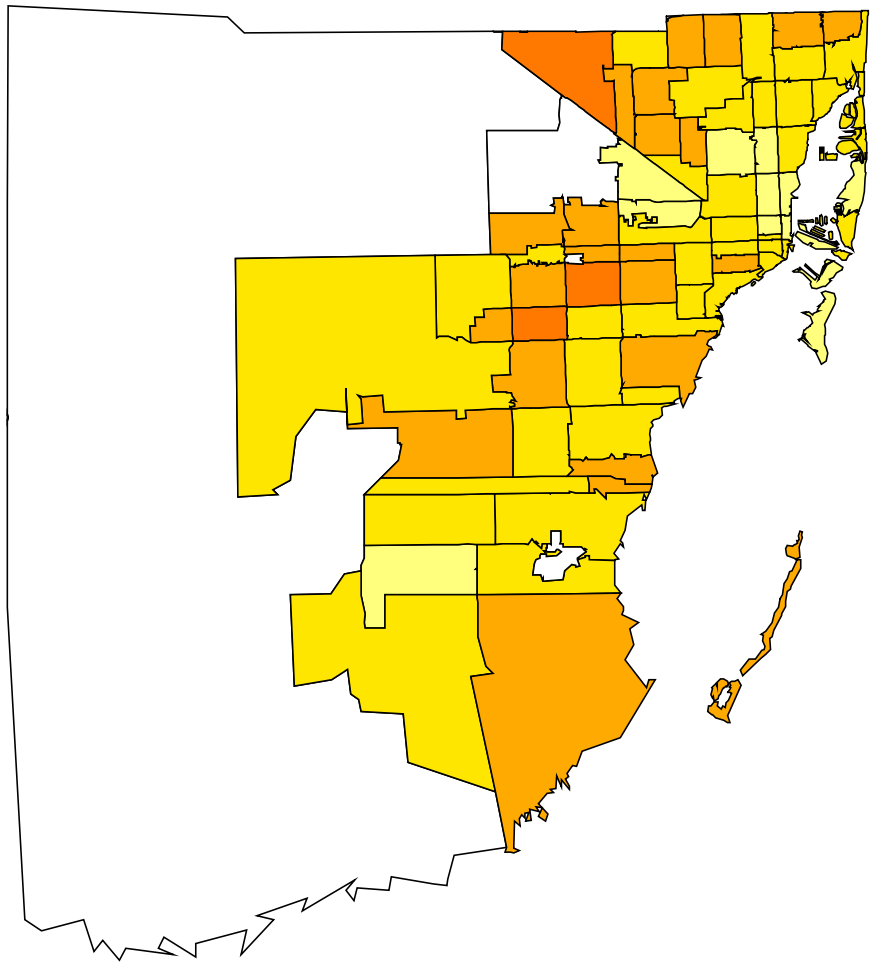
[1]Excludes data from homeless persons and persons with unknown ZIP codes.

# Percentage of PWH Who Had a Suppressed VL by ZIP Code of Residence,[1] 2021, Living in Miami-Dade County

Suppressed VL

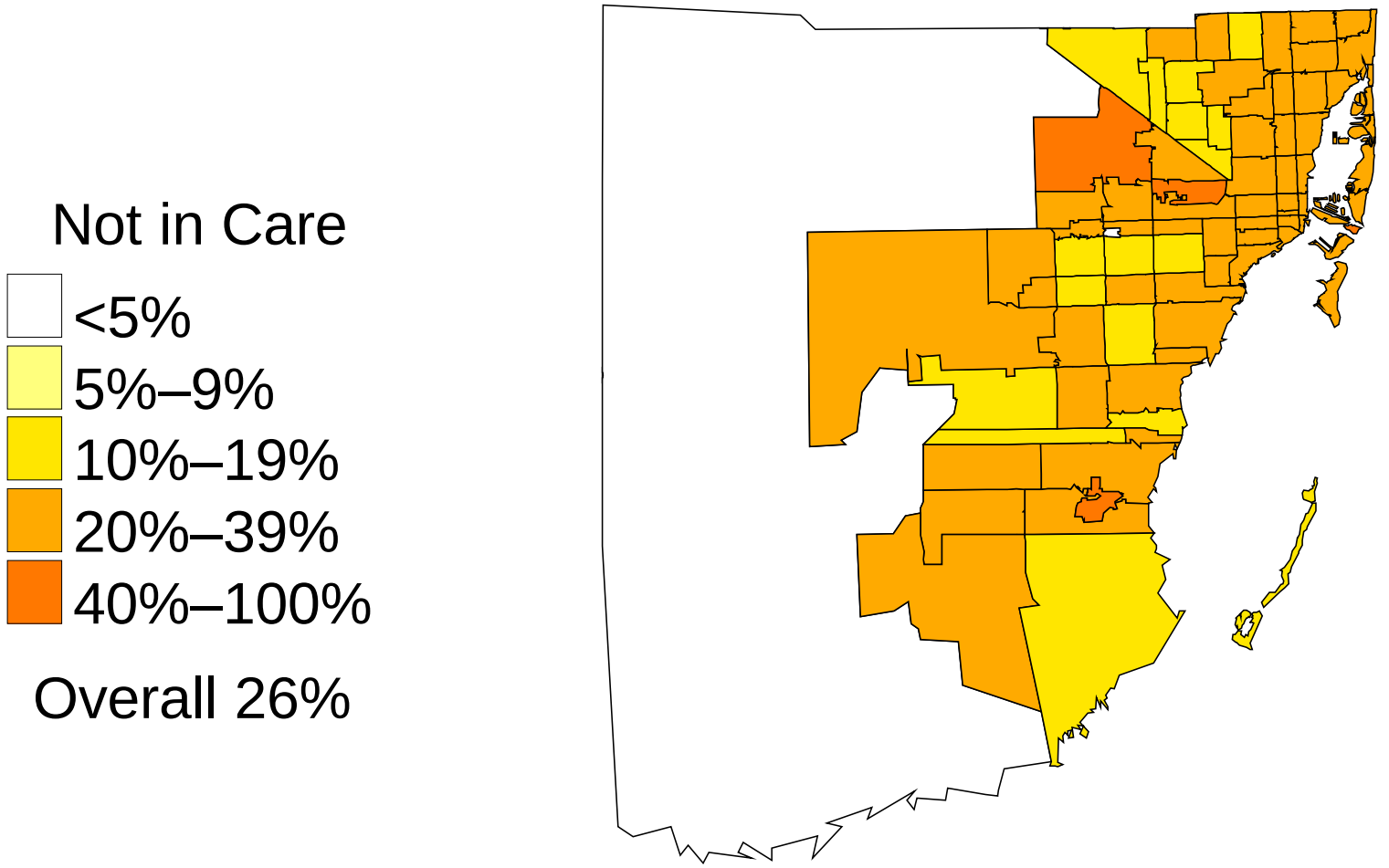
- <50%
- 50%–59%
- 60%–69%
- 70%–79%
- 80%–100%

Overall 64%

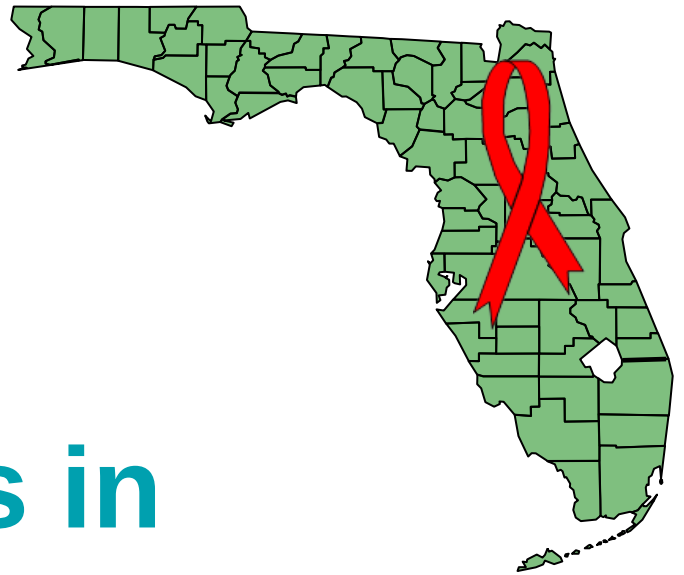


[1]Excludes data from homeless persons and persons with unknown ZIP codes.

# Percentage of PWH Who Were Not in Care by ZIP Code of Residence[1] in 2021, Living in Miami-Dade County

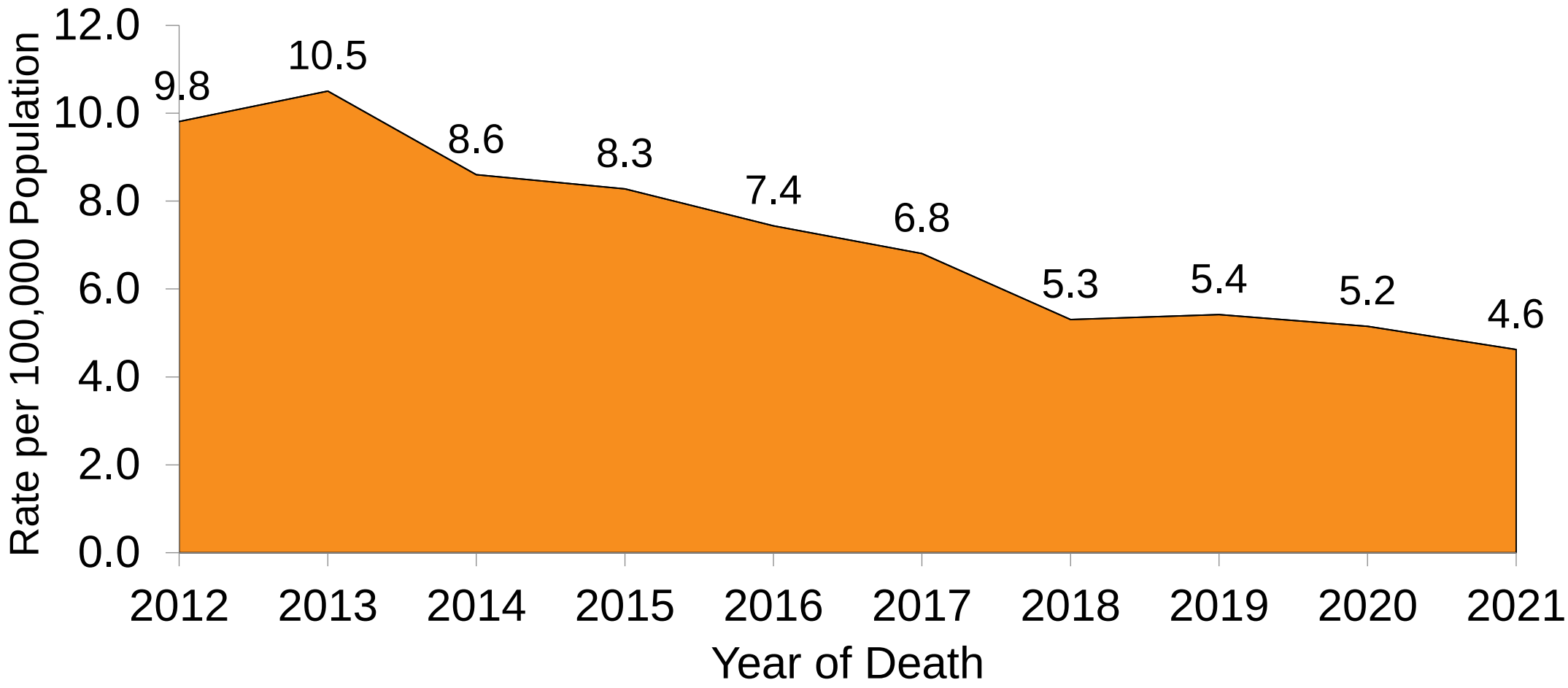


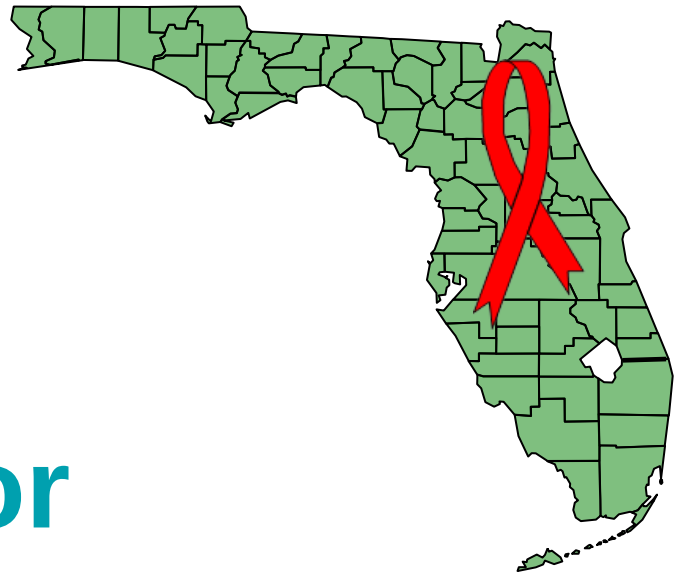

[1]Excludes data from homeless persons and persons with unknown ZIP codes.



# HIV-Related Deaths in Miami-Dade County

# Rate of HIV-Related Deaths
# 2012–2021, Miami-Dade County





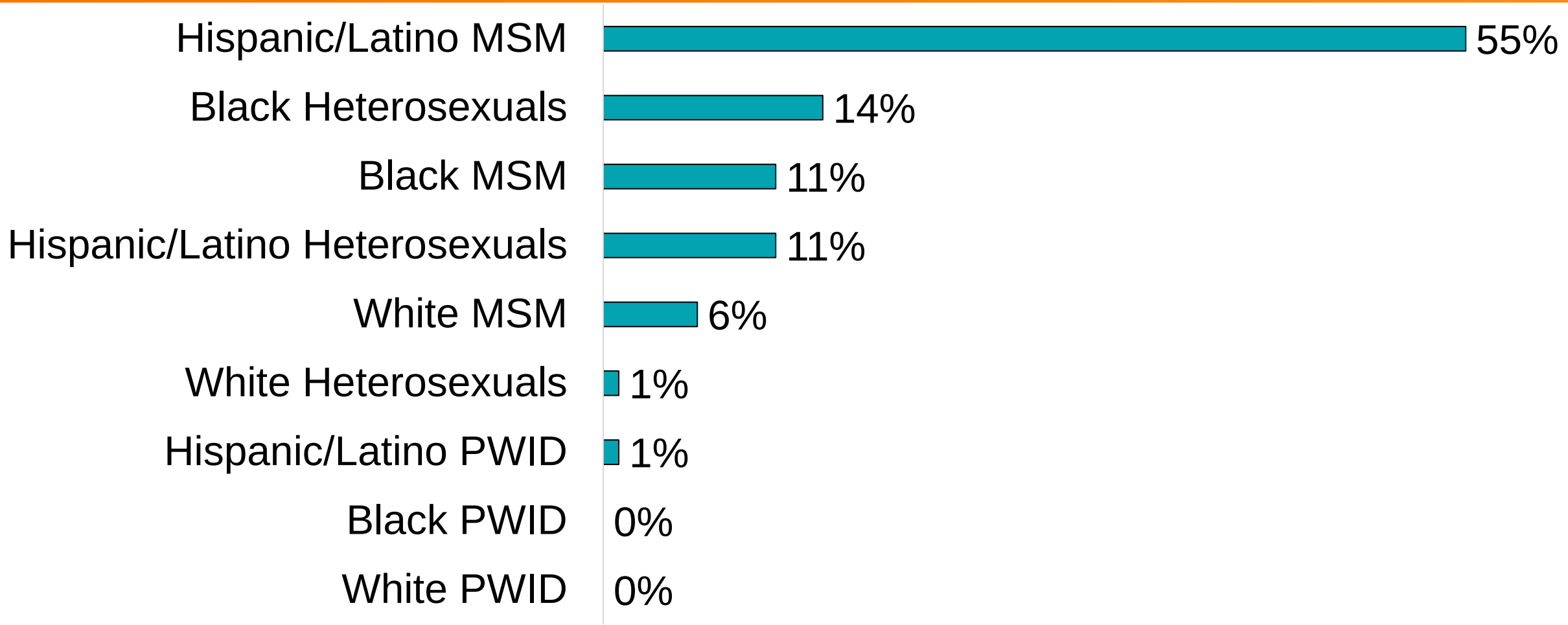
# HIV Prevention for Miami-Dade County

# Priority Populations for Primary HIV Prevention

- These data were calculated from HIV diagnoses 2019–2021 and represent the proportion of each race or mode of exposure group to the total diagnoses.

- These data are used to identify and prioritize testing, PrEP and other HIV prevention services to those at greatest risk for acquiring HIV in Florida.

# Priority Populations for Primary HIV Prevention in 2021, Miami-Dade County



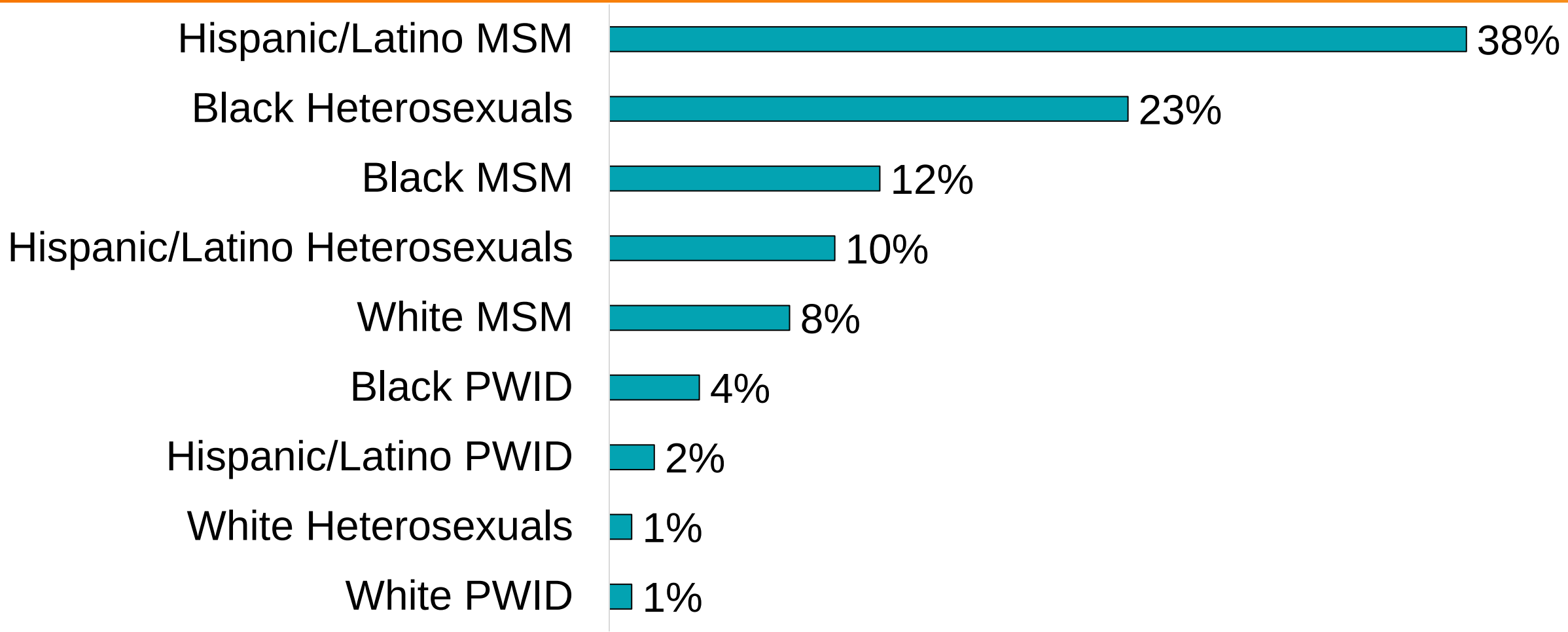

MSM=MMSC and MMSC/IDU diagnoses, and PWID=IDU and MMSC/IDU diagnoses; thus, the data are not mutually exclusive. Data is for HIV diagnoses 2019–2021. Rounding may cause percentages to total more or less than 100.

# Priority Populations for Prevention for PWH

- These data were calculated from PWH living in Florida at year-end 2021 and represent the proportion of each race or mode of exposure group to the total PWH.

- These data are used to prevent further transmission of HIV for those already diagnosed with HIV by providing linkage to care and other services to improve health outcomes and viral suppression to those who need it.

# Priority Prevention Populations for PWH
# In 2021, Living in Miami-Dade County




MSM=MMSC and MMSC/IDU diagnoses, and PWID=IDU and MMSC/IDU diagnoses; thus, the data are not mutually exclusive.
Rounding may cause percentages to total more or less than 100.

## HIV Testing

Everyone between the ages of 13 and 64 should get tested for HIV at least once. Persons at increased risk for HIV should get tested at least annually. Visit knowyourhivstatus.com for testing options in your area or to order a free at-home testing kit.

Florida law (section 384.31, Florida Statutes) requires all pregnant women to be tested for HIV and other STIs at their initial prenatal care visit, again at 28–32 weeks and at labor and delivery if their HIV status is unknown.

## PrEP

PrEP medication, taken as directed, can reduce the risk of acquiring HIV through sexual contact by over 90% and through injection drug use by 70%. Condoms are still important during sex to prevent other STIs and unwanted pregnancy. STIs are increasing in Florida and can increase HIV risk. To find a PrEP provider who can help you decide if PrEP is right for you, visit preplocator.org.

## Antiretroviral Therapy (ART)

For PWH, starting ART as soon as possible improves health outcomes and quality of life by reducing viral load and the risk of disease progression. People living with HIV who take antiretroviral medication as prescribed and achieve and maintain an undetectable viral load cannot transmit HIV to their sexual partners. ART is recommended for all PWH, regardless of how long they have had HIV or how well they feel. To find a care provider or to learn more about the resources available to PWH, visit floridaaids.org.

## Florida HIV/AIDS Hotline

1-800-352-2437 English
1-800-545-7432 Spanish
1-800-243-7101 Haitian Creole
1-888-503-7118 Hearing/Speech Impaired
211bigbend.org/flhivaidshotline
Text ‘FLHIV’ or ‘flhiv’ to 898211

For more information, email
DiseaseControl@flhealth.gov

# Some Useful Links

Department of Health HIV/AIDS Section
floridaaids.org

CDC HIV Surveillance Reports (State and Metro Data)
cdc.gov/hiv/library/reports/hiv-surveillance.html

CDC's Morbidity and Mortality Weekly Report
(Special Articles on Diseases, including HIV)
cdc.gov/mmwr

U.S. Census Data (Available by State and County)
census.gov

# Florida HIV/AIDS Surveillance Data
# Miami-Dade County Contact

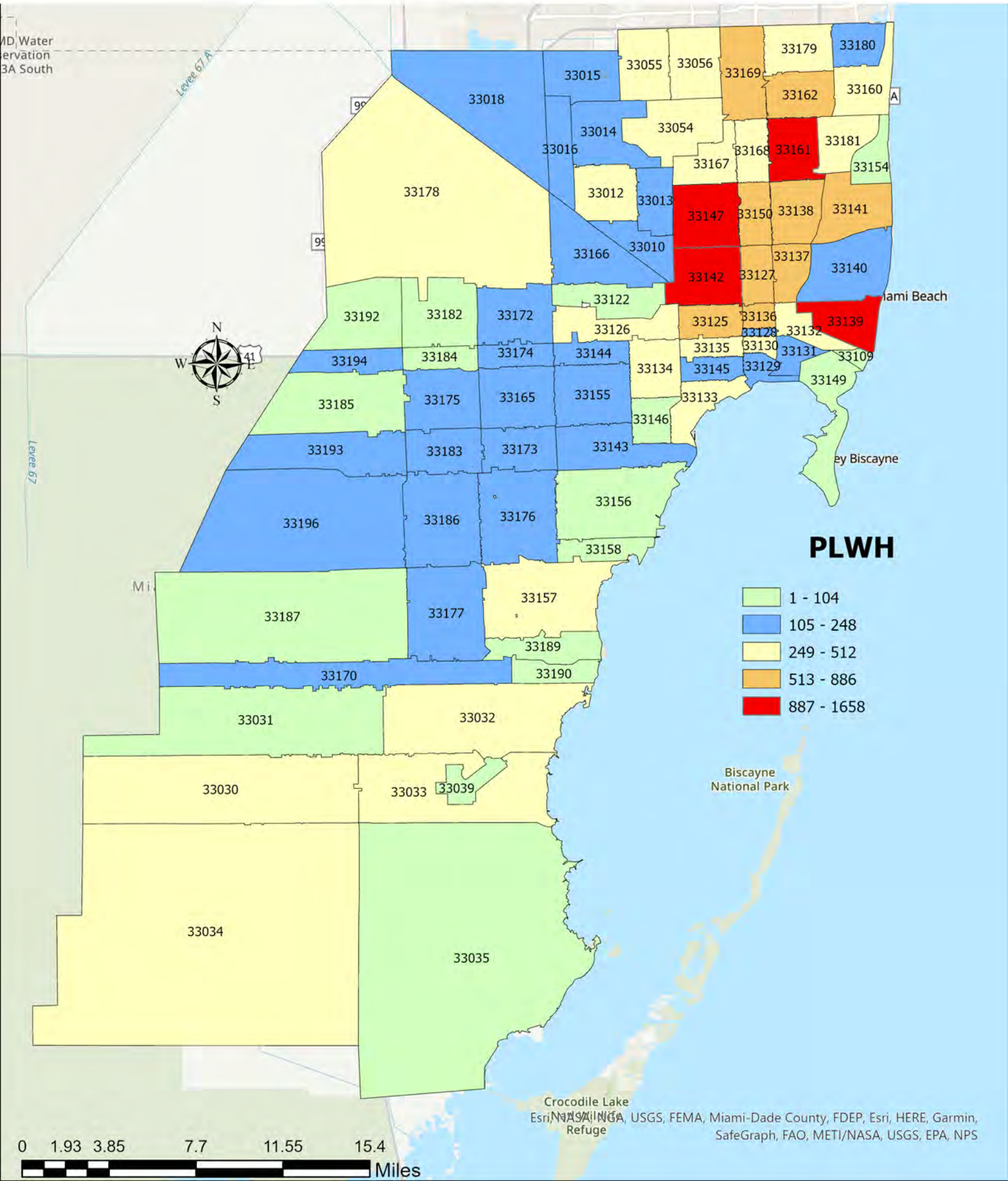
**Anthoni Llau**
Florida Department of Health in
Miami-Dade County
Phone: 305-470-6984
Email: Anthoni.Llau@flhealth.gov

HIV/AIDS surveillance data are frozen on June 30 for the previous calendar year. These are the same data used for FLHealth CHARTS and all grant-related data.
flhealthcharts.com/charts/CommunicableDiseases/default.aspx

# Department of Health

## Thank you!

# Persons Living With HIV (PLWH)
# By Zip Code of Residence
# Miami-Dade County, 2021



# SUMMARY OF HIV EPIDEMIOLOGY PROFILE DATA 2020-2021

PRESENTED JUNE 8, 2023

2023 NEEDS ASSESSMENT

# DISCLAIMER

Most slides used in this presentation were generated using the Epi Data provided by the Florida Department of Health as of June 30, 2022.

DEFINITION

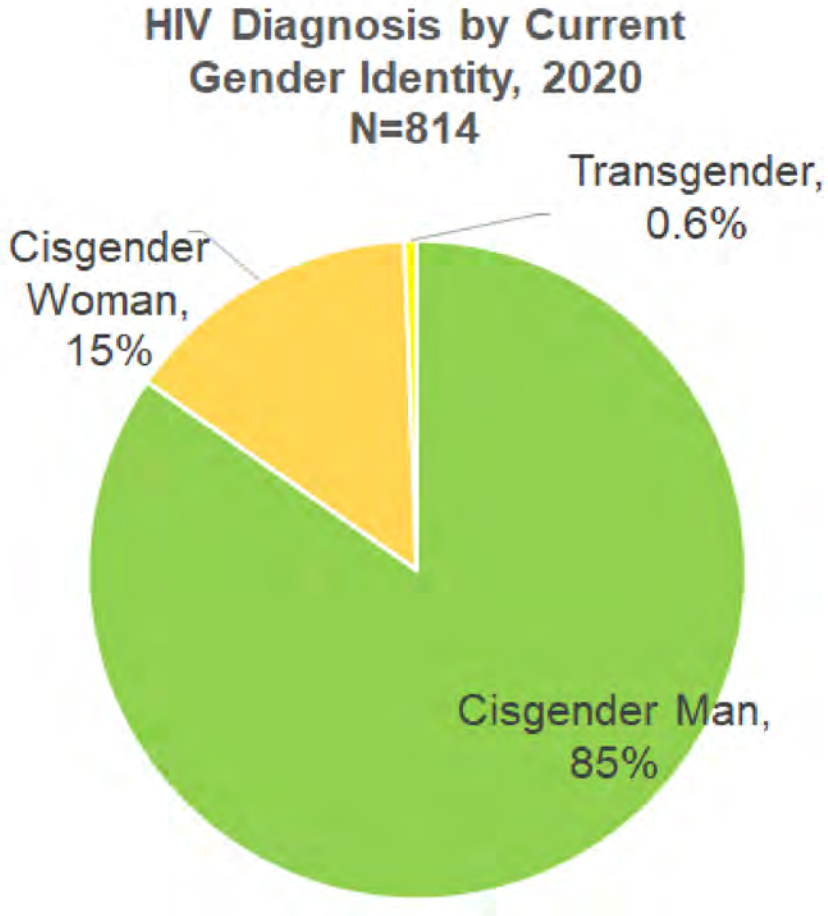
# INCIDENCE

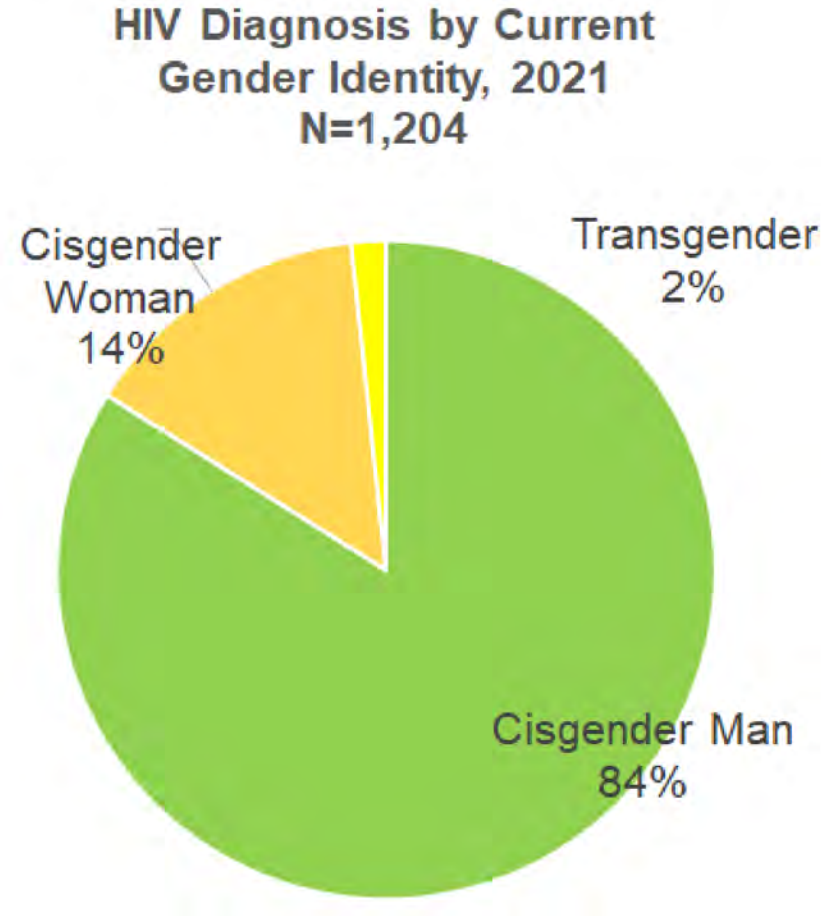
Number of new cases of a disease in a population during a defined period of time – such as the number of new HIV cases in Miami-Dade County

# HIV/AIDS INCIDENCE SNAPSHOT IN MIAMI-DADE FOR 2021

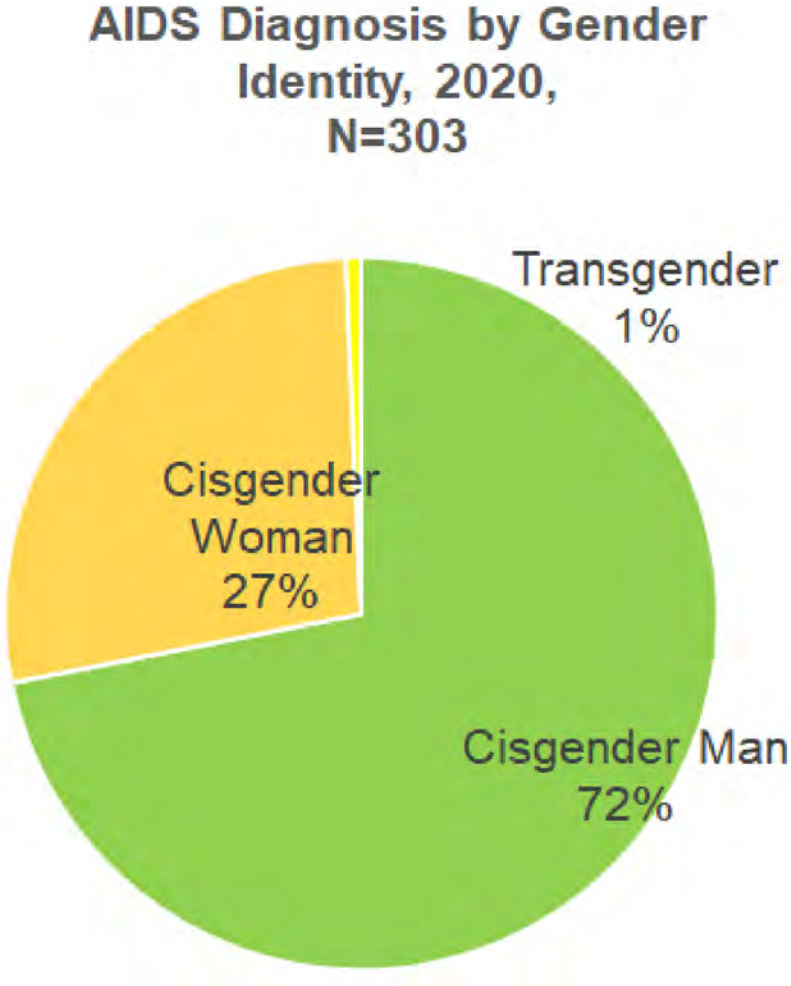
- HIV cases increased 48% in 2021 from 2020
- AIDS cases increased 28% in 2021 from 2020
- Men made up 84% of new diagnosis, among these the primary exposure was from male-to-male sexual contact.
- Transgender cases have increased significantly from 2017 to 2021
- Gonorrhea cases (co-infected with HIV) have increased by 100% since 2017.
- Chlamydia cases (co-infected with HIV) have increased by 97% since 2017.
- Early syphilis cases (co-infected with HIV) have increased by 72% since 2017.

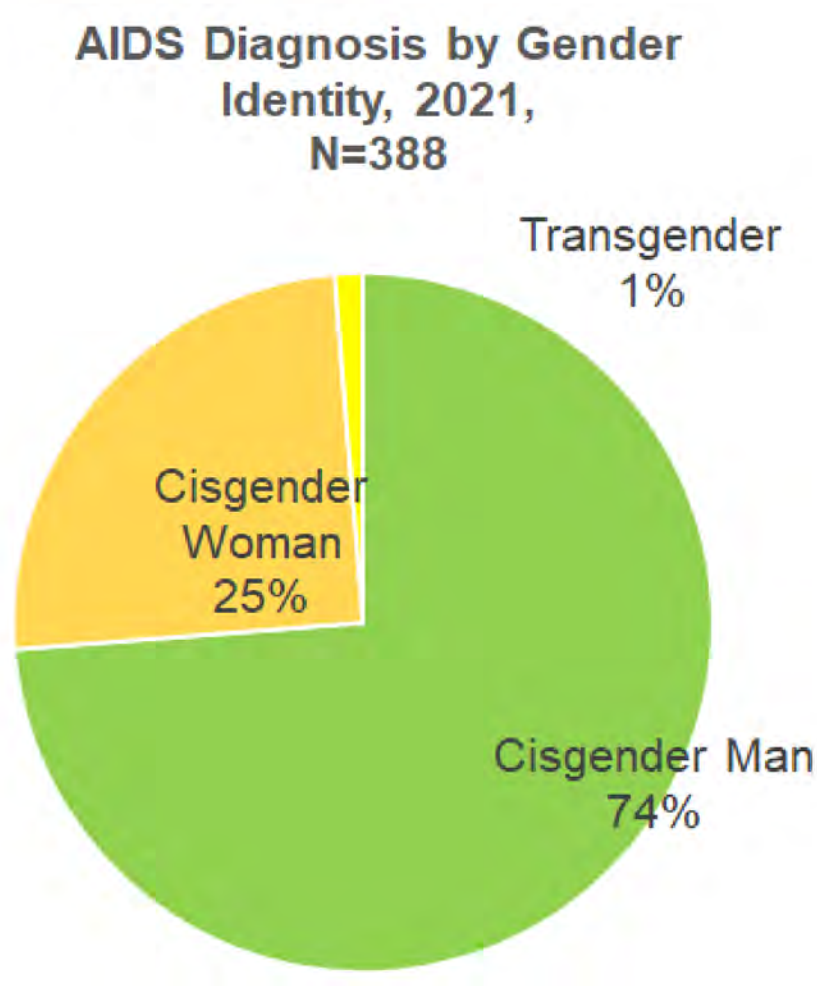
# HIV DIAGNOSIS BY GENDER IDENTITY 2020 AND 2021



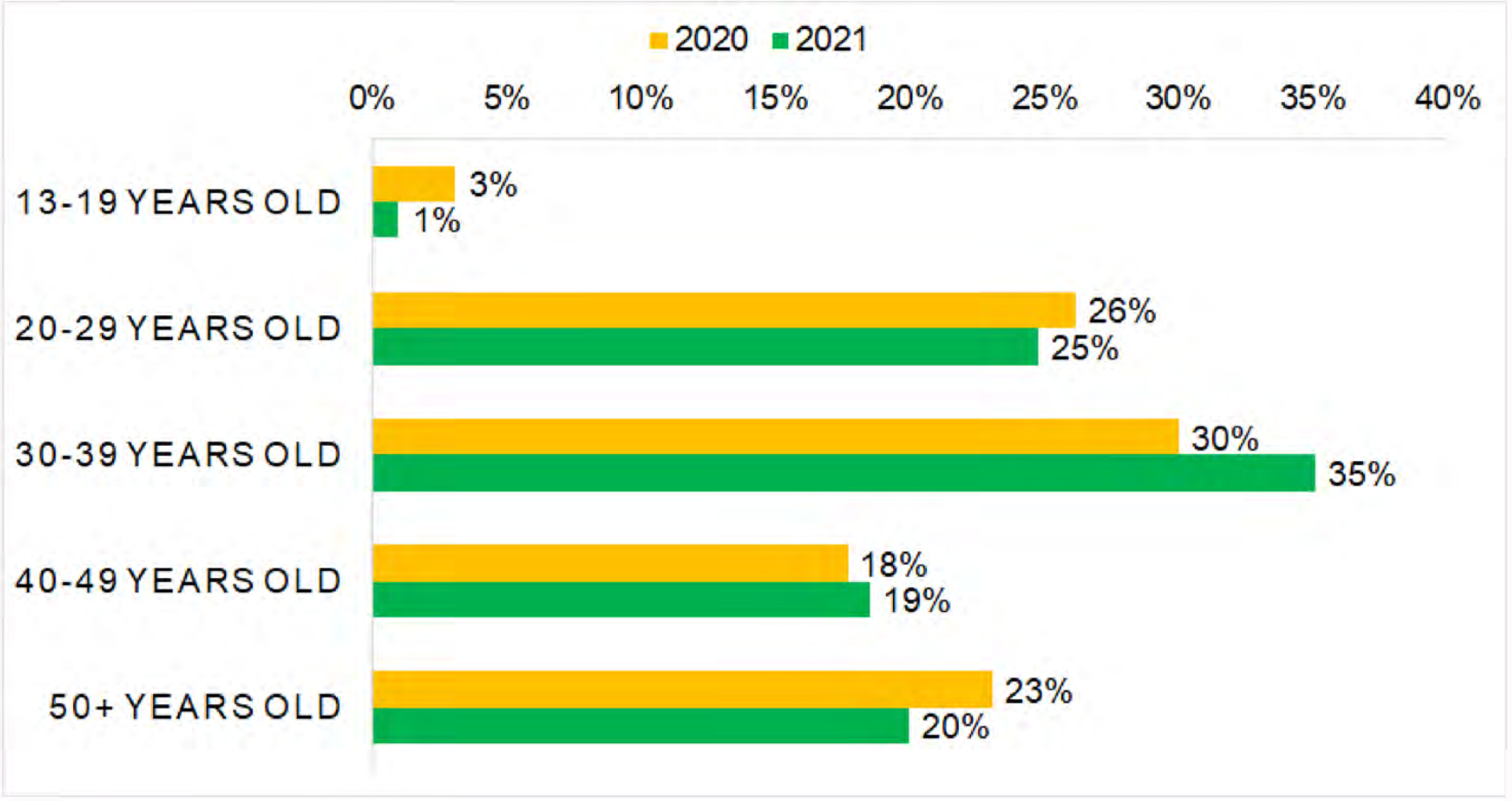



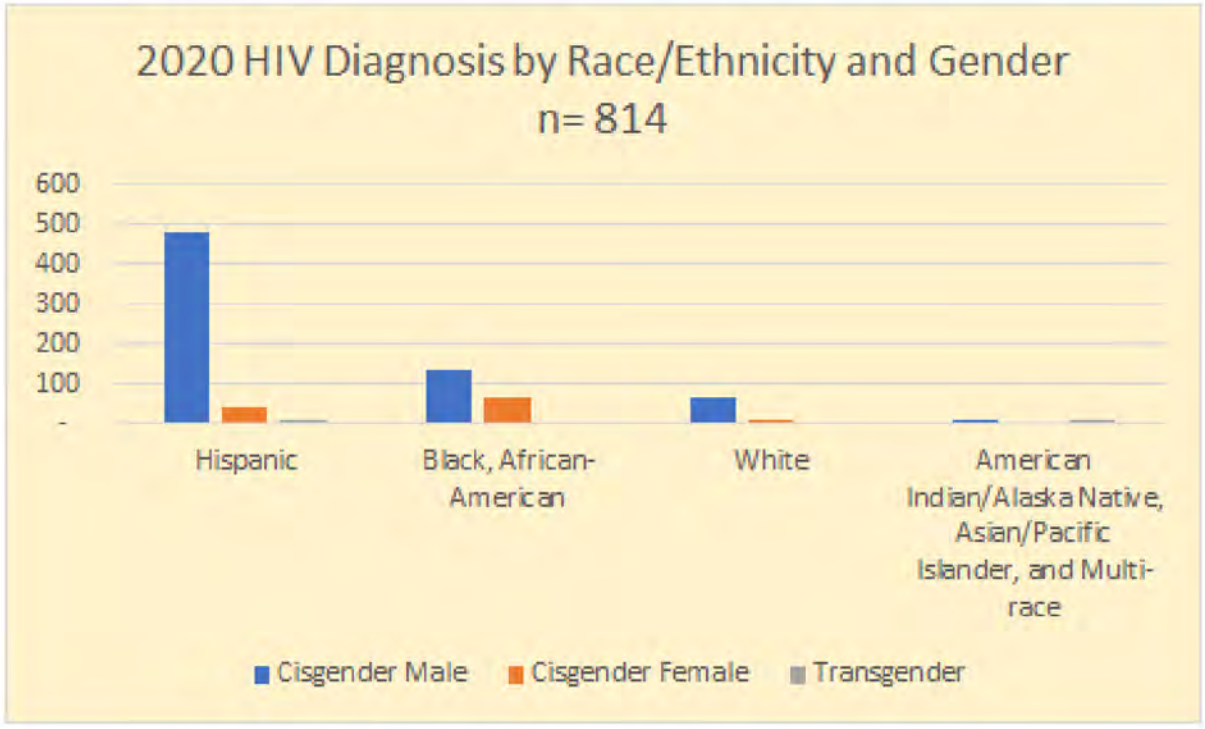
# AIDS DIAGNOSIS BY GENDER IDENTITY 2020 AND 2021

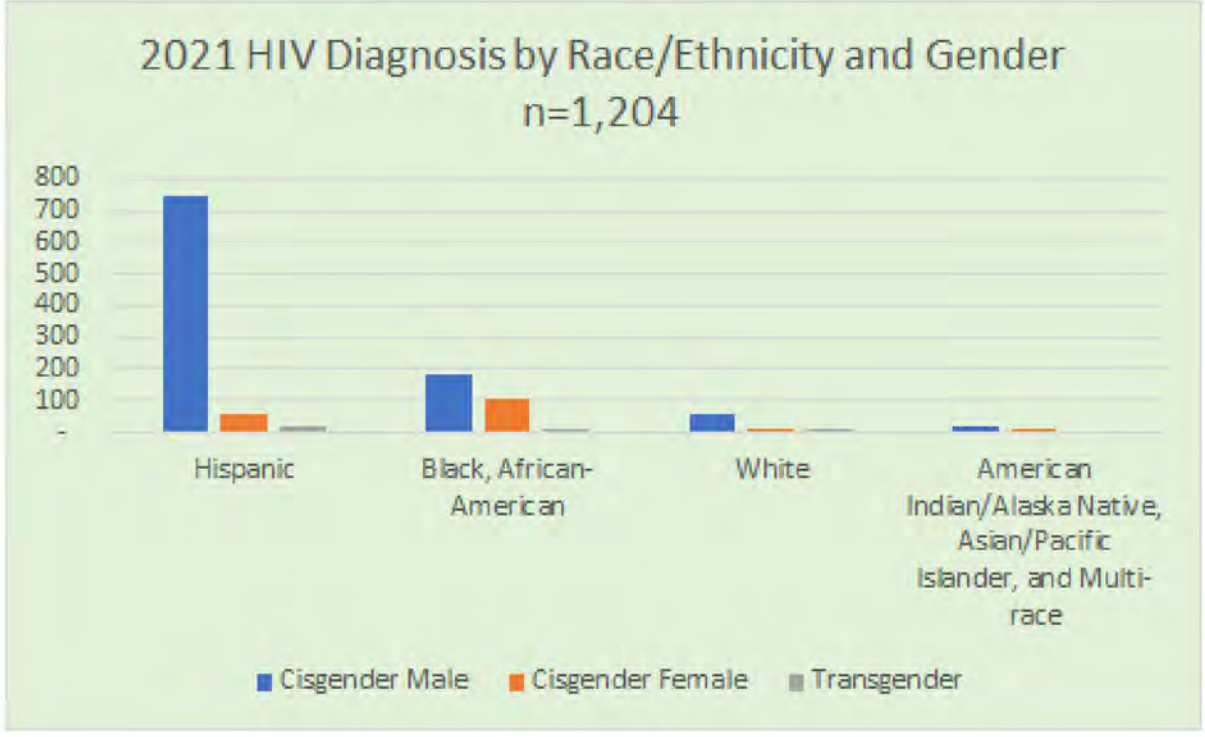


# ADULT HIV BY AGE AT DIAGNOSIS COMPARISON 2020 AND 2021






# HIV DIAGNOSIS BY RACE/ETHNICITY AND GENDER IDENTITY 2020 AND 2021

# HIV and Co-Occurring Conditions

# CO-OCCURRING CONDITIONS: HEPATITIS B, HEPATITIS C, AND TUBERCULOSIS WITH HIV, 2021

| Co-occurring Condition with HIV | 2019 | 2020 | 2021 | % change 2019 - 2021 |
|---|---|---|---|---|
| Hepatitis B | 44 | 56 | 56 | 27% |
| Hepatitis C | 61 | 82 | 138 | 126% |
| Tuberculosis | 15 | 7 | 12 | -20% |

## HIV WITH CO-OCCURRING DIAGNOSIS OF AN STI BY YEAR OF STI REPORT, 2017-2021

| Year of STI Report | HIV/ Early Syphilis[1] | HIV/ Chlamydia | HIV/ Gonorrhea |
|---|---|---|---|
| **2017** | 724 | 611 | 595 |
| **2018** | 928 | 803 | 806 |
| **2019** | 1,000 | 955 | 1,034 |
| **2020** | 1,096 | 837 | 953 |
| **2021** | 1,248 | 1,202 | 1,188 |
| **Percentage Change 2017-2021** | 72% | 97% | 100% |

[1]Primary, secondary and early non-primary, non-secondary syphilis.

DEFINITION

# PREVALENCE

Total number of people in a population who have a disease or health condition at a specific period of time, usually expressed as a percentage of the population – such as the total number of people diagnosed with HIV in Miami-Dade County (EMA) as of December 31 of the reference year.

# HIV/AIDS PREVALENCE SNAPSHOT IN MIAMI-DADE FOR 2021

- 2021 (27,782) had a 2% increase over the 2020 (27,329) prevalence figure
- Hispanics comprise 50% of those living with HIV
- Hispanics have increased 10% from 2017-2021
- HIV transgender prevalence has increased
- The largest age group of those living with HIV are 50+ years old (57%)
- The largest exposure group is male to male sexual contact (MMSC) (57%)

# PEOPLE WITH HIV 2020 AND 2021 IN MIAMI-DADE COUNTY

| Demographic Group / Exposure Category | 2020 | 2021 |
|---|---|---|
| *Race/Ethnicity* | n=27,329 | n=27,782 |
| White | 10% | 10% |
| Black | 40% | 40% |
| Hispanic | 49% | 50% |
| Asian/Pacific Islander | <1% | <1% |
| American Indian/Alaska Native | <1% | <1% |
| Multi-race | 1% | 1% |
| **Total** | 100% | 100% |
| *Current Gender ID* | | |
| Cisgender Man | 75% | 76% |
| Cisgender Woman | 24% | 24% |
| Transgender Man | <1% | <1% |
| Transgender Woman | <1% | <1% |
| **Total** | 100% | 100% |
| *Age* | | |
| Age 0-12 | <1% | <1% |
| Age 13-19 | <1% | <1% |
| Age 20-29 | 7% | 6% |
| Age 30-39 | 16% | 17% |
| Age 40-49 | 20% | 19% |
| Age 50-59 | 30% | 29% |
| Age 60+ | 27% | 28% |
| **Total** | 100% | 100% |
| *Cisgender Man Adult/Adolescent 13+ years old Transmission* | | |
| MSM | 74% | 75% |
| IDU | 4% | 4% |
| MSM/IDU | 3% | 3% |
| Heterosexual | 18% | 17% |
| Other risk | 1% | 1% |
| **Total Males** | **100%** | **100%** |
| *Cisgender Woman Adult/Adolescent 13+ years old* | | |
| IDU | 8% | 8% |
| Heterosexual | 89% | 89% |
| Risk not diagnosed/Other | 3% | 3% |
| **Total Females** | **100%** | **100%** |
| *Transgender Adult/Adolescent 13+ years old Transmission* | | |
| IDU | 6% | 6% |
| Sexual contact | 94% | 94% |
| Other | 0% | 0% |
| **Total Transgender** | **100%** | **100%** |
| *Pediatric Exposure Category (ages 0-12)* | | |
| Perinatal Exp | 96% | 100% |
| Non-Perinatal Exp | 4% | 0% |
| **Total Peds** | **100%** | **100%** |

# TRANSGENDER TRANSMISSION, 2017-2021

## HIV Incidence

| | Total | Transgender | Transgenders as % of Total |
|---|---|---|---|
| 2017 | 1,167 | 1 | 0.1% |
| 2018 | 1,194 | 8 | 0.7% |
| 2019 | 1,164 | 5 | 0.4% |
| 2020 | 814 | 5 | 0.6% |
| 2021 | 1,204 | 21 | 1.7% |

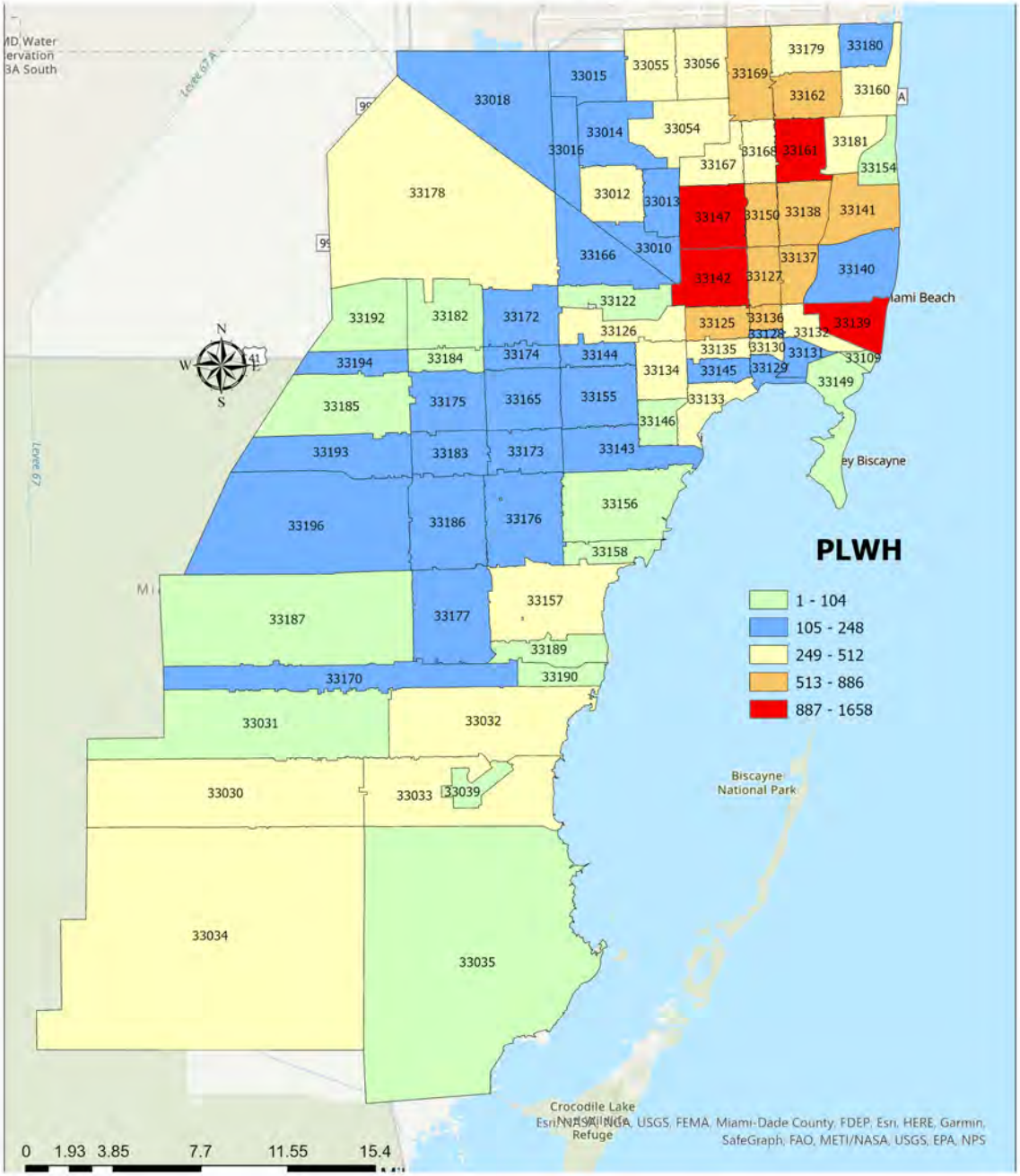
## HIV Prevalence

| | Total | Transgender | Transgenders as % of Total |
|---|---|---|---|
| 2017 | 27,307 | 81 | 0.3% |
| 2018 | 27,389 | 81 | 0.3% |
| 2019 | 27,380 | 85 | 0.3% |
| 2020 | 27,329 | 87 | 0.3% |
| 2021 | 27,782 | 105 | 0.4% |

# PERSONS WITH HIV, IDU TRANSMISSION, 2020-2021

| | 2020 N=27,329 | | 2021 N=27,782 | |
|---|---|---|---|---|
| Cisgender Man | 800 | 2.9% | 805 | 2.9% |
| Cisgender Woman | 551 | 2% | 532 | 1.9% |
| Transgender | 5 | .01% | 6 | .02% |

**Persons Living With HIV (PLWH)**
**By Zip Code of Residence**
**Miami-Dade County, 2021**




# 2021
# Map of Prevalence

# THANK YOU!

Behavioral Science Research

Miami-Dade HIV/AIDS Partners

Miami-Dade County

WWW.AIDSNET.ORG

# EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS (EIIHA)

## TRENDS IN HIV+ DIAGNOSIS AND LINKAGE TO CARE CALENDAR YEARS (CY) 2021 AND 2022

Presented June 8, 2023

2023 NEEDS ASSESSMENT

# SUMMARY

Data are derived from the Florida Department of Health.

Miami-Dade accounted for **22%** of State of Florida publicly funded test events in **CY 2022**.

In **CY 2022**, an additional **14%** more test events were held (**48,115** vs **54,857**). Black females accounted for **14%** of these tests. Black Male-to-Male Sexual Contact (MMSC) accounted for **2**%. Hispanic/Latinx MMSC accounted for **13**%.

The **54,857** tests yielded **277** newly-diagnosed HIV+ persons (1% of the total tests), of which **208 (75%)** were linked to care, up from the **69%** were linked to care in **CY 2021**. These tests yielded **777** previously diagnosed, of which **532 (68%)** were re-linked to care in **CY 2022**.

Hispanic/Latinx MMSC showed a marked increase in linkage to care in 2021 vs 2022, from **83%** to **97%** for newly diagnosed and **95%** to **97%** in previously-diagnosed.

# FDOH EIIHA DATA
# HIV TEST EVENTS, MIAMI-DADE,
# NEWLY-DIAGNOSED, CY 2021 AND CY 2022

| | All | Black Female | Black MMSC | Hispanic/Latinx MMSC |
|---|---|---|---|---|
| Total publicly funded test events in Miami, 2021 | 48,115 | 7,655 | 914 | 6,636 |
| Total publicly funded test events in Miami, 2022 | 54,857 | 7,894 | 1,202 | 6,890 |
| | | | | |
| Newly-diagnosed HIV+ test event, 2021 | 452 | 41 | 31 | 110 |
| Newly-diagnosed HIV+ test event, 2022 | 277 | 28 | 47 | 122 |
| | | | | |
| New positives linked to care, 2021 | 314 (69%) | 39 (95%) | 31 (100%) | 91 (83%) |
| New positives linked to care, 2022 | 208 (75%) | 28 (100%) | 47 (100%) | 118 (97%) |

# FDOH EIIHA DATA
# HIV TEST EVENTS, MIAMI-DADE,
# PREVIOUSLY-DIAGNOSED, CY 2021 AND CY 2022

| | All | Black Female | Black MMSC | Hispanic /Latinx MMSC |
|---|---|---|---|---|
| Previously-diagnosed with new HIV+ test results, 2021 | 484 | 25 | 31 | 186 |
| Previously-diagnosed with new HIV+ test results, 2022 | 777 | 33 | 38 | 267 |
| | | | | |
| Previously-diagnosed HIV+ linked to care, 2021 | 367 | 22 (88%) | 30 (97%) | 176 (95%) |
| Previously-diagnosed HIV+ linked to care, 2022 | 532 | 32 (97%) | 37 (97%) | 259 (97%) |

# THANK YOU!

Behaviora Science Research

MIAMI-DADE HIV/AIDS PARTNERSHIP

MIAMI-DADE COUNTY

# RYAN WHITE PROGRAM HIV CARE CONTINUUM FISCAL YEAR 2022 (3/1/2022-2/28/2023)

Presented June 8, 2023

2023 NEEDS ASSESSMENT

# HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) HIV CARE CONTINUUM

# RYAN WHITE PROGRAM HIV CARE CONTINUUM DEFINITIONS

**RWP Client** = Ryan White Program clients who received at least **one** Ryan White Part A or MAI-funded service in the fiscal year (FY 2022: 03/01/2022–02/28/2023).

**Linked to Care** = Newly-diagnosed persons with HIV, who were linked to HIV medical care anywhere in Miami-Dade County. Data from Florida Department of Health (FDOH) **Early Identification of Individuals with HIV/AIDS (EIIHA), CY 2022**.

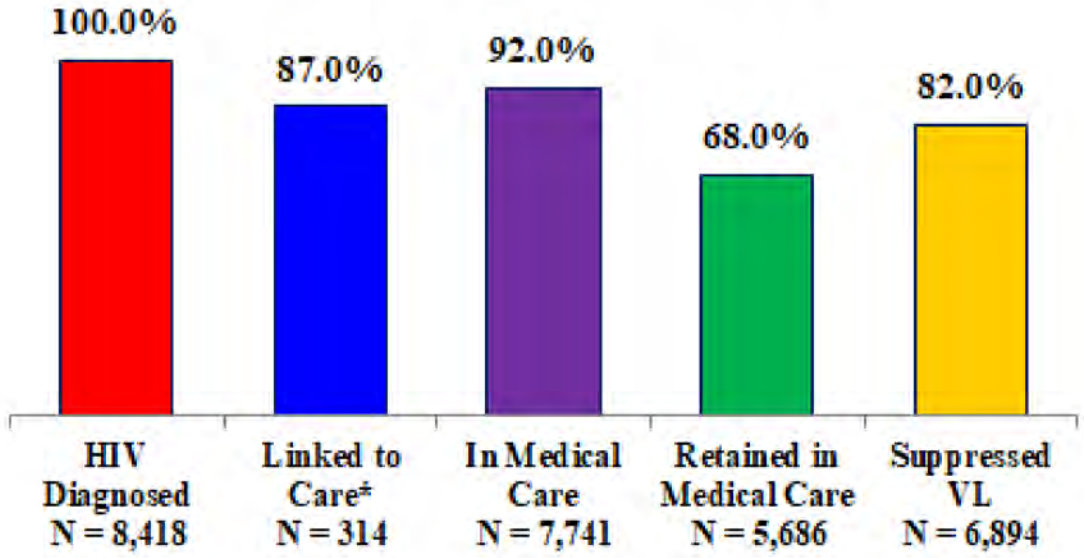
**In Medical Care** = **Active** Ryan White Program clients receiving **one or more medical visit**s with any Ryan White Program provider with prescribing privileges, Viral Load test, or medical visit copay, **during the 12-month** reporting period (FY 2022).

**Retained In Medical Care** = **Active** Ryan White Program clients receiving **two or more billed** medical visits with a Ryan White Program provider, or Viral Load test, or medical visit copay, at **least 90 days apart**, during the **12-month** reporting period (FY 2022).

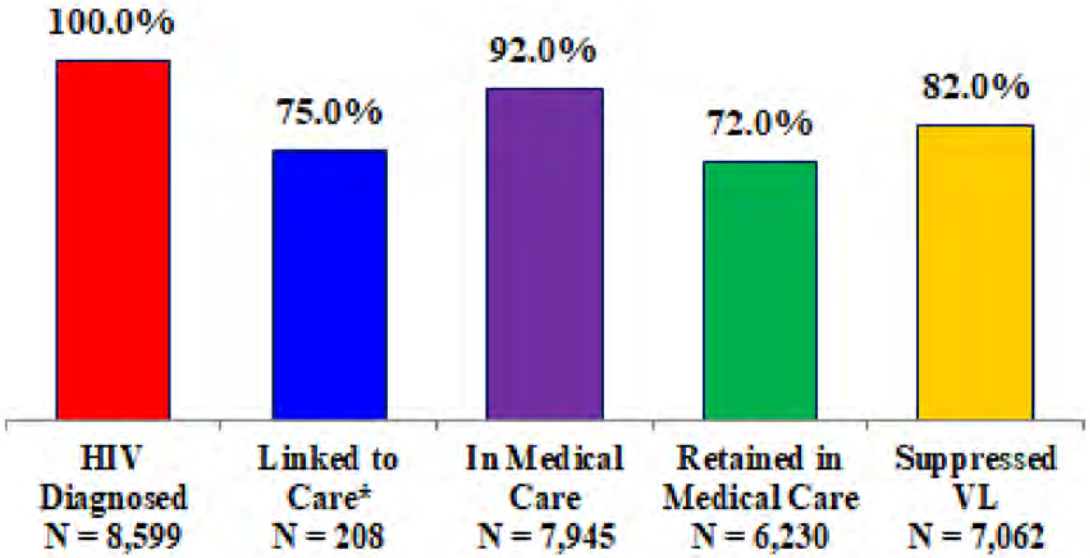
**Suppressed VL** = Active Ryan White Program clients with a documented **suppressed Viral Load (<200 copies /mL)** in the **most recently** reported lab test.

# RYAN WHITE PROGRAM HIV CARE CONTINUUM
## FY 2021 VS FY 2022

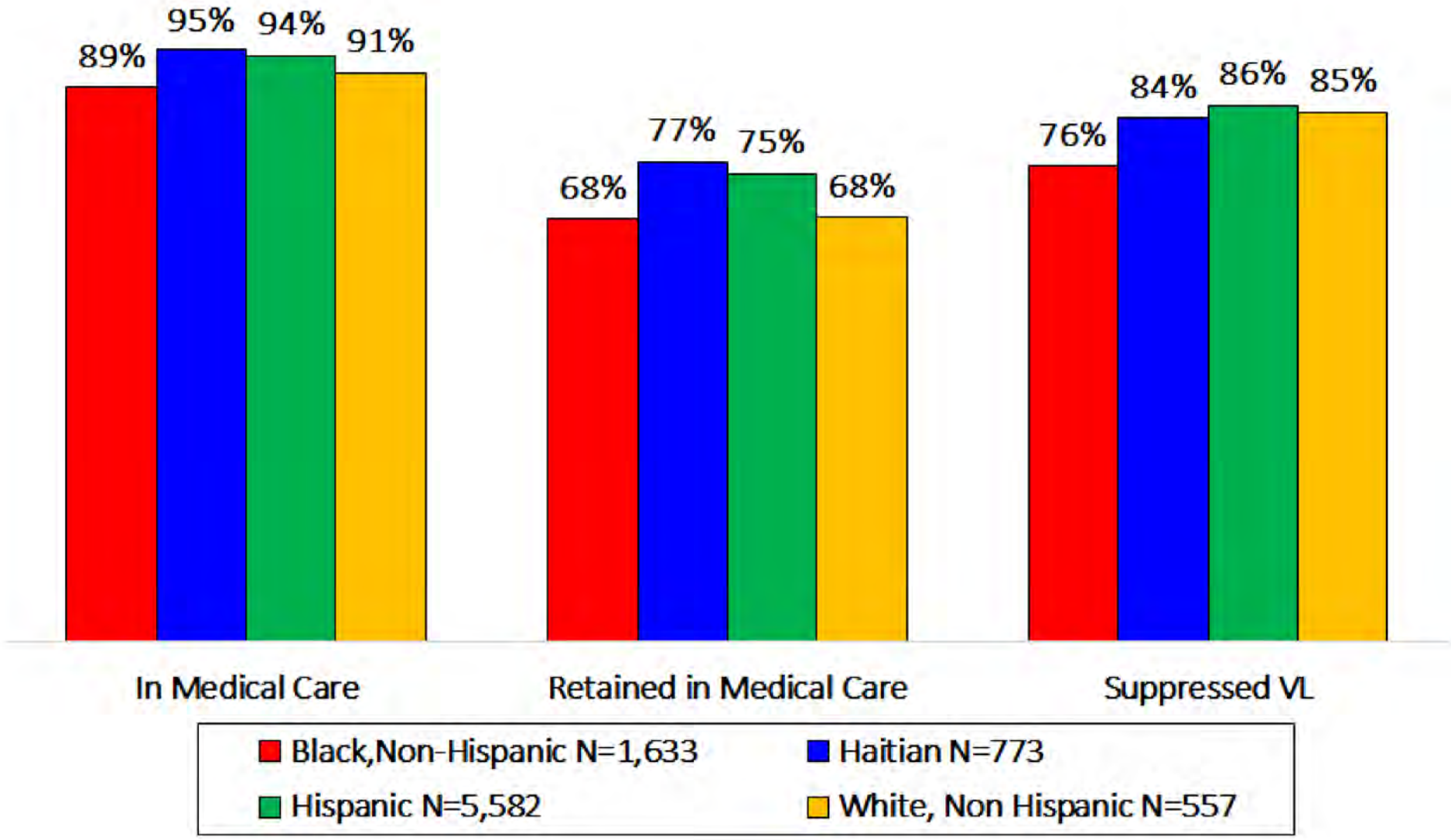
2021



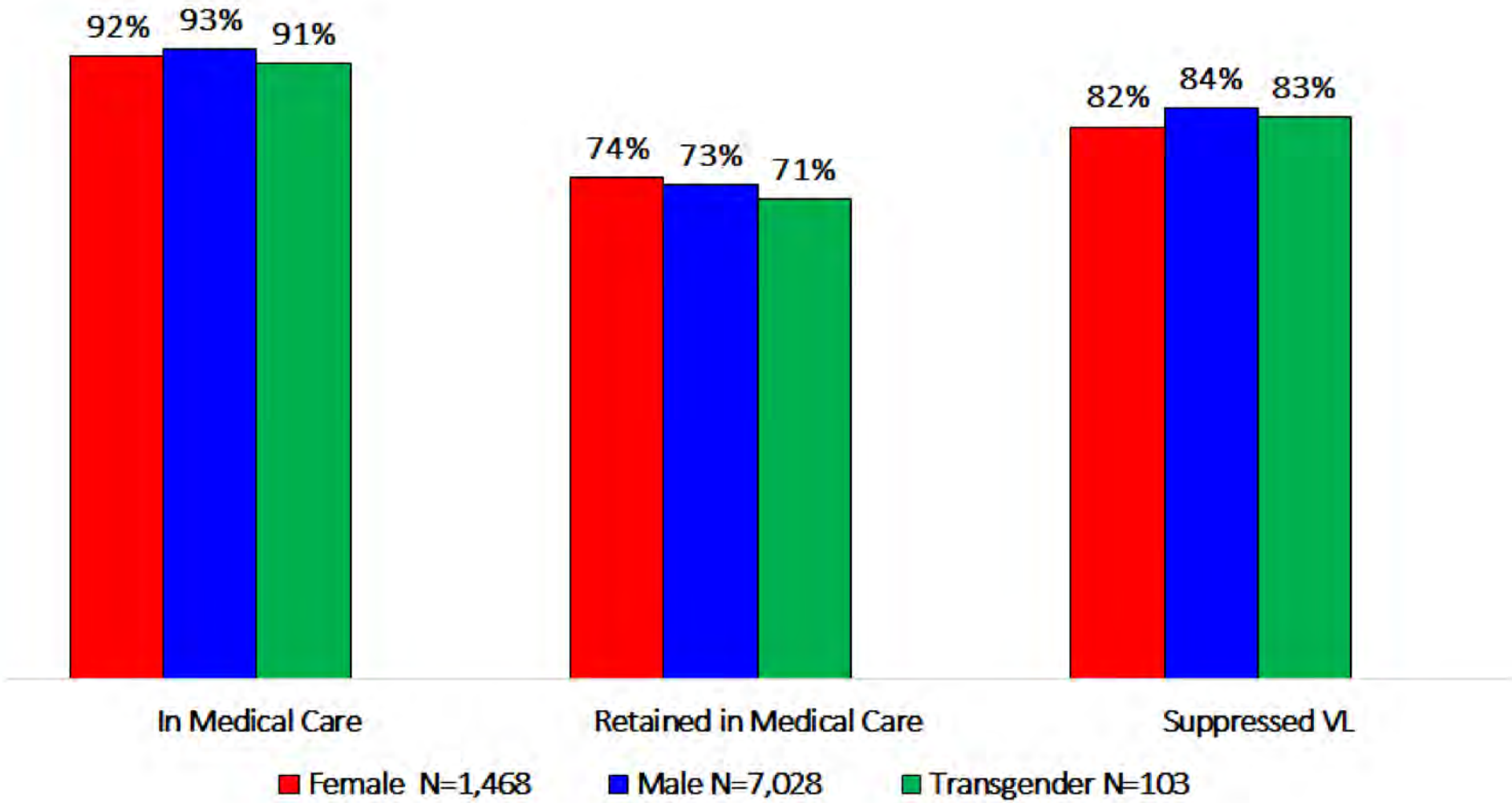

2022



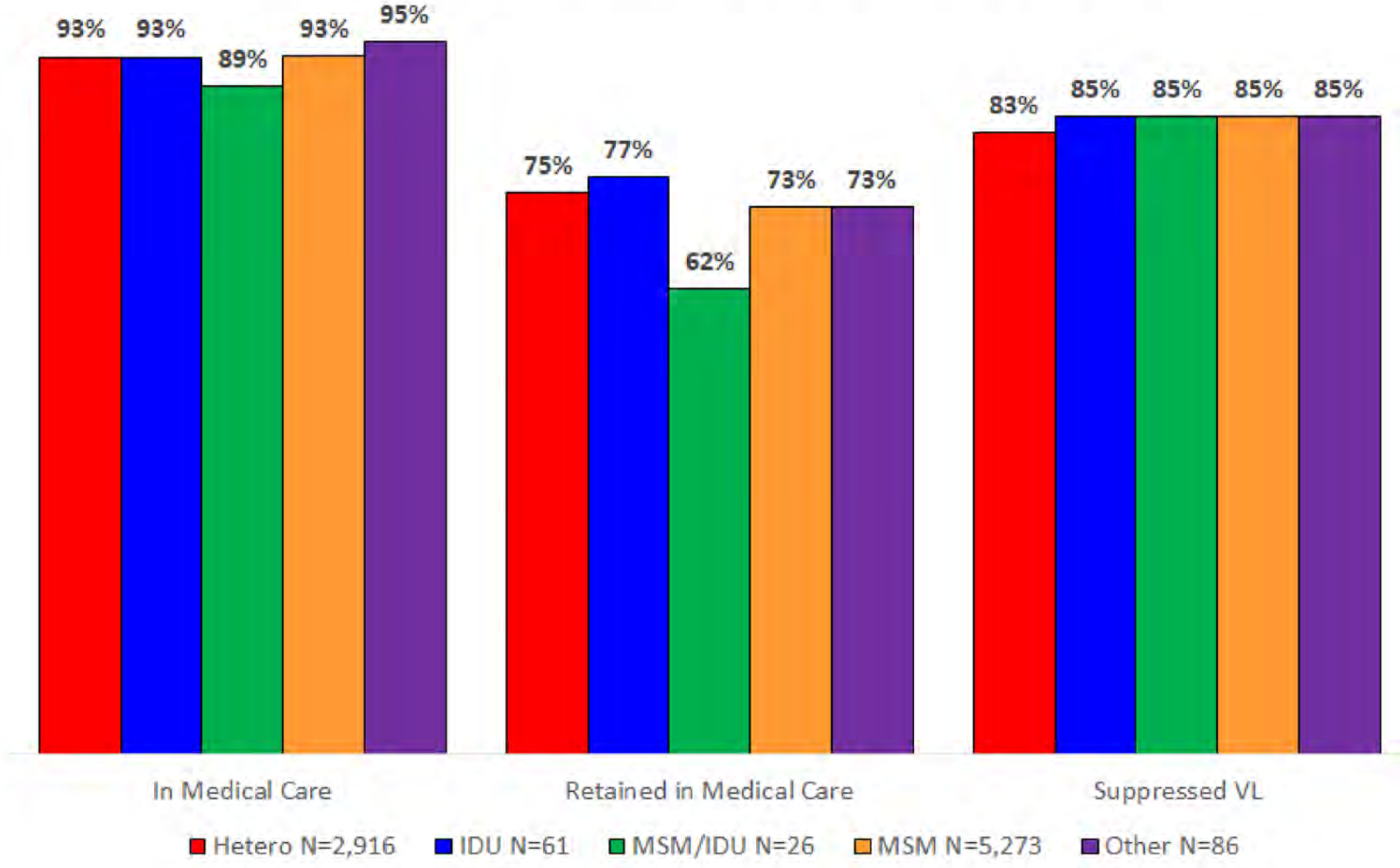
# RYAN WHITE PROGRAM HIV CARE CONTINUUM BY RACE/ETHNICITY, FY 2022



# RYAN WHITE PROGRAM HIV CARE CONTINUUM
# PERCENT BY GENDER, FY 2022



# RYAN WHITE PROGRAM HIV CARE CONTINUUM BY INITIAL EXPOSURE, FY 2022



# THANK YOU!

BEHAVIORA SCIENCE RESEARCH

MIAMI-DADE HIV/AIDS PARTNERSHIP

MIAMI-DADE COUNTY

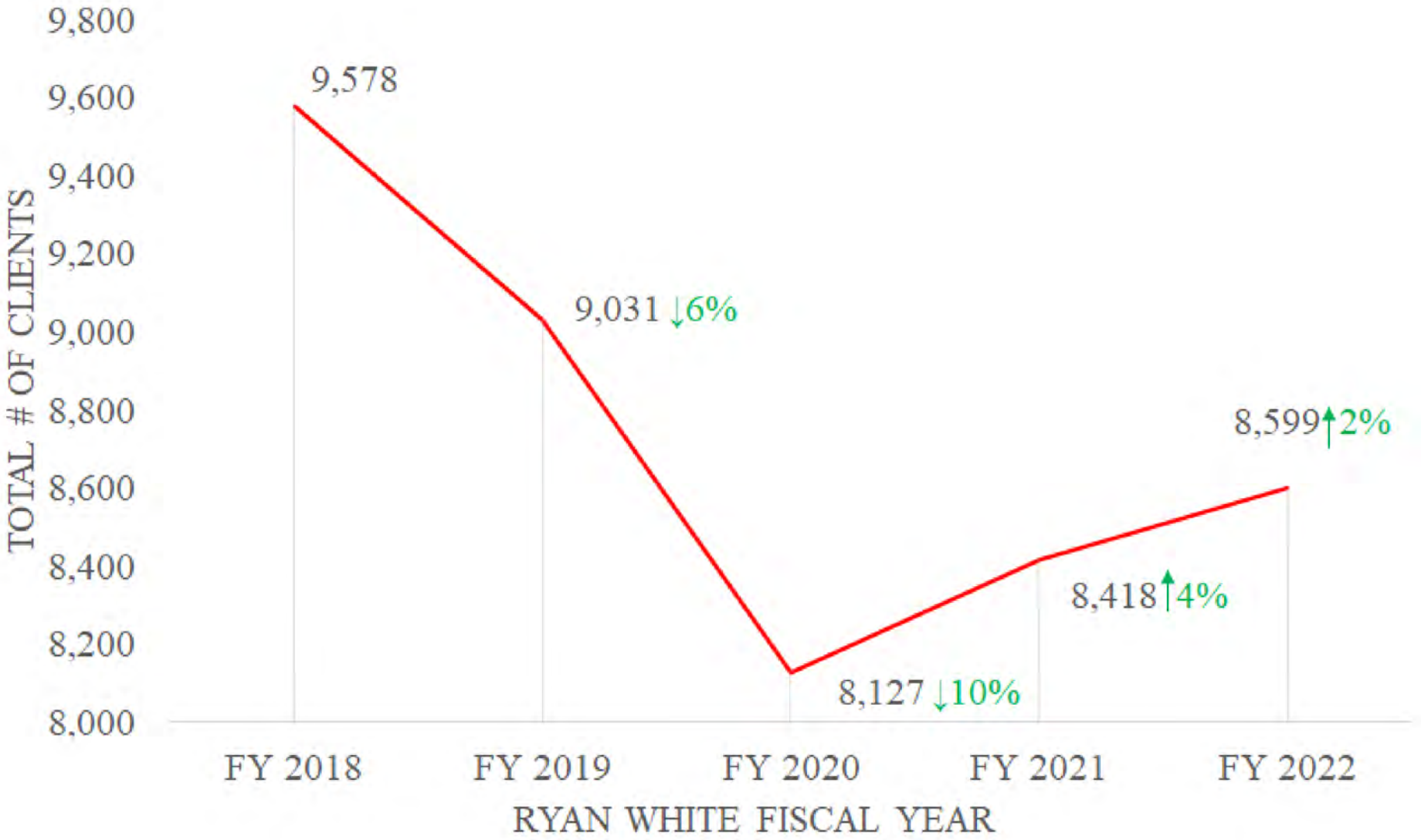
# SERVICE DEMOGRAPHICS

# SECTION 4

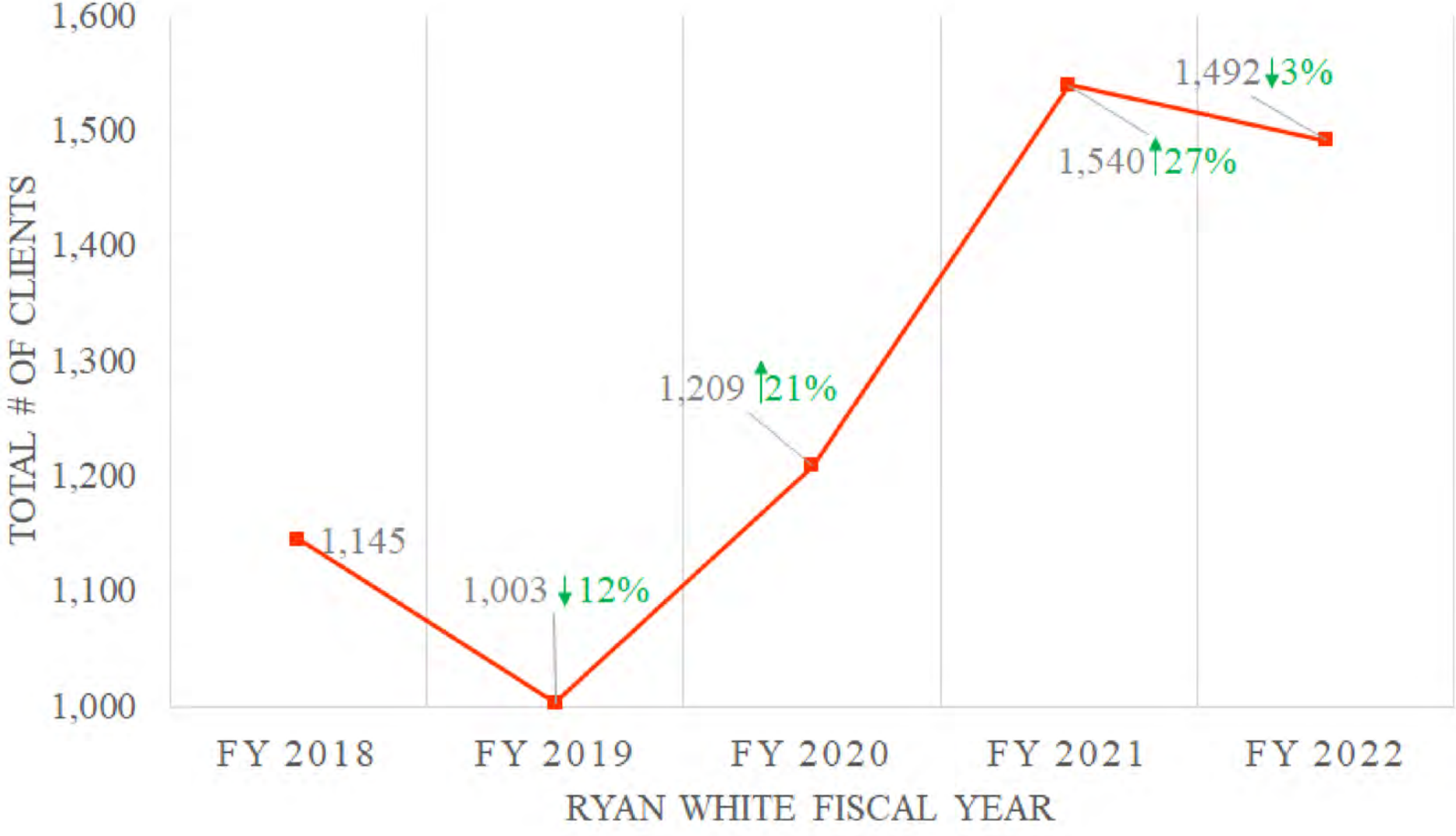
# RYAN WHITE PROGRAM DEMOGRAPHIC DATA FY 2022 (3/1/22-2/28/22)

Presented June 8, 2023

# TOTAL NUMBER OF CLIENTS SERVED
# RYAN WHITE PROGRAM
# FY 2018-2022

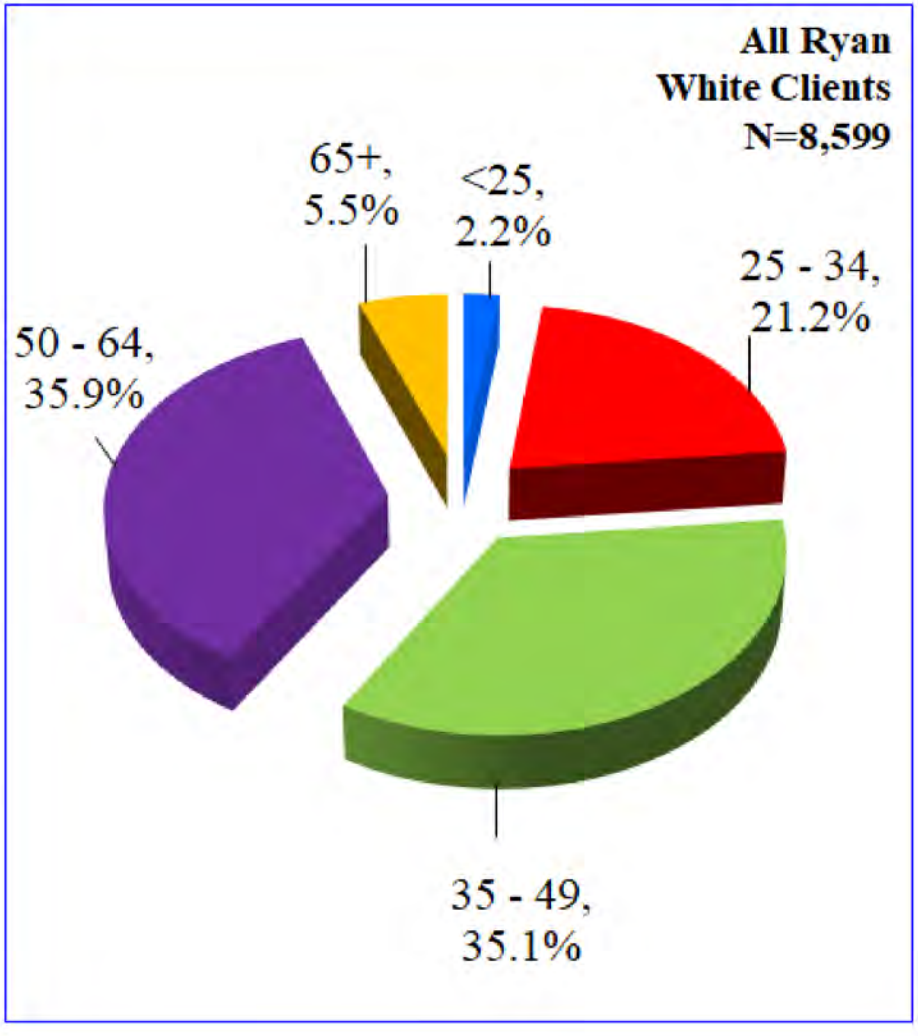


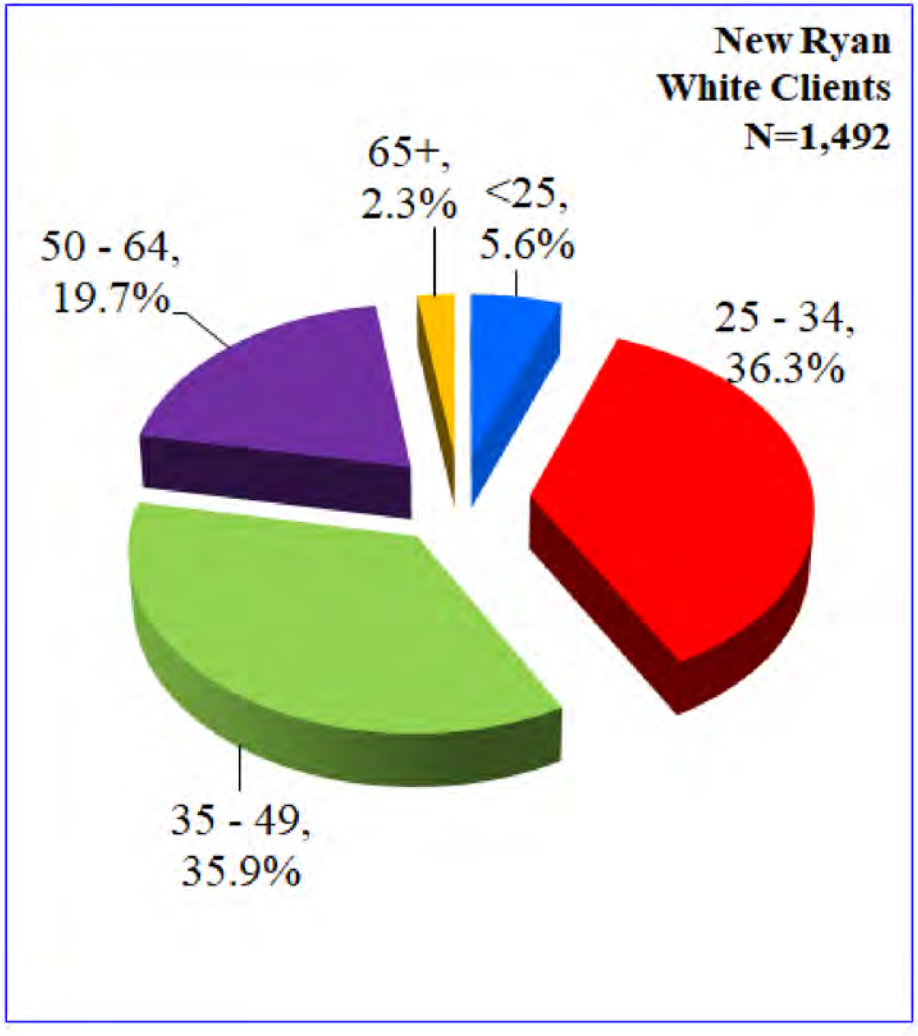
# NUMBER OF NEW CLIENTS SERVED
# RYAN WHITE PROGRAM
# FY 2018-2022



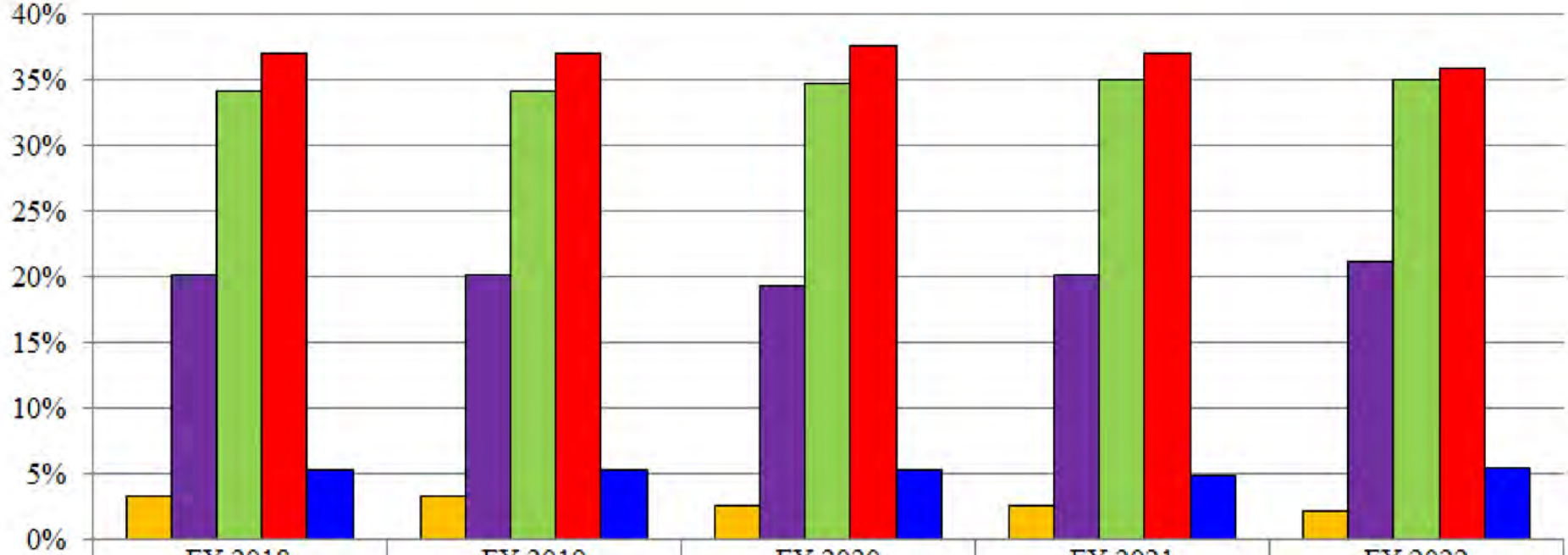
# AGE

# AGE OF NEW AND TOTAL CLIENTS IN CARE
# RYAN WHITE PROGRAM, FY 2022



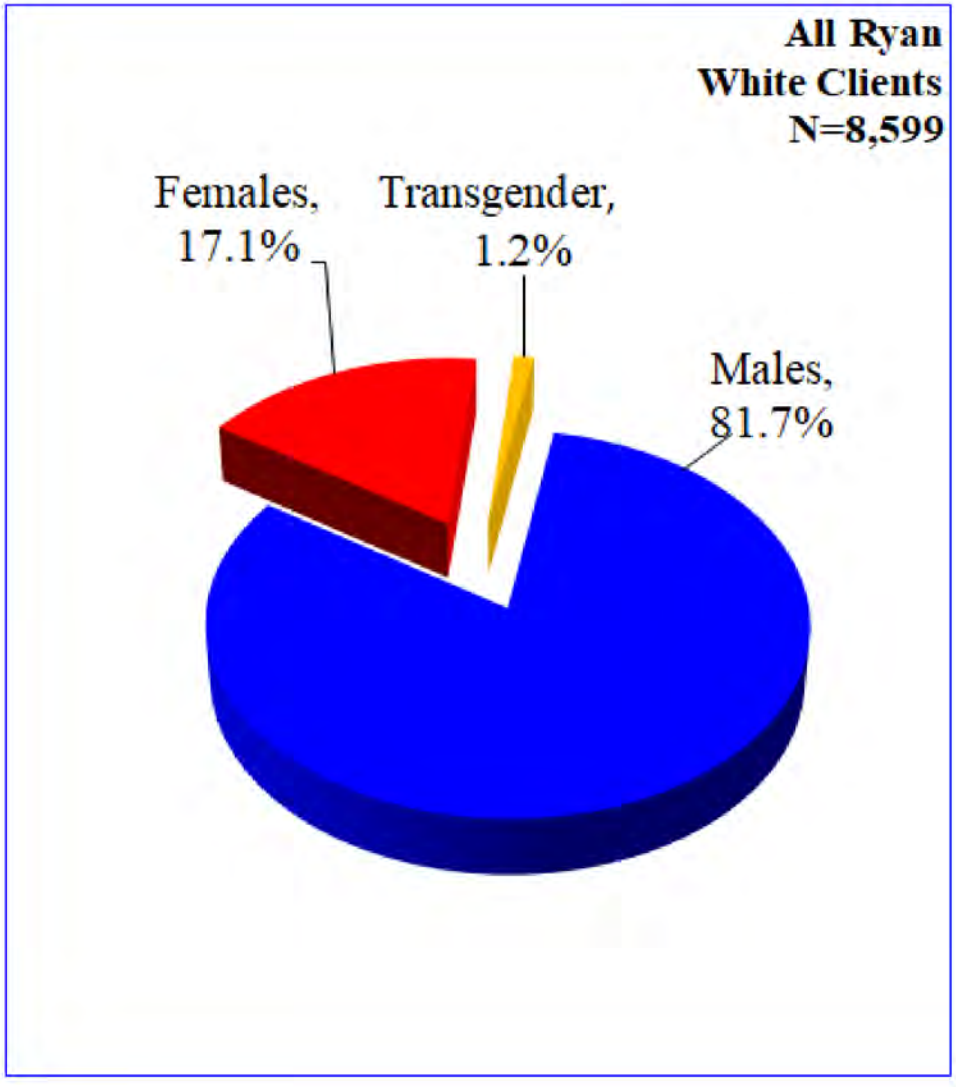
# CLIENTS BY AGE GROUP
# RYAN WHITE PROGRAM, FY 2018-2022

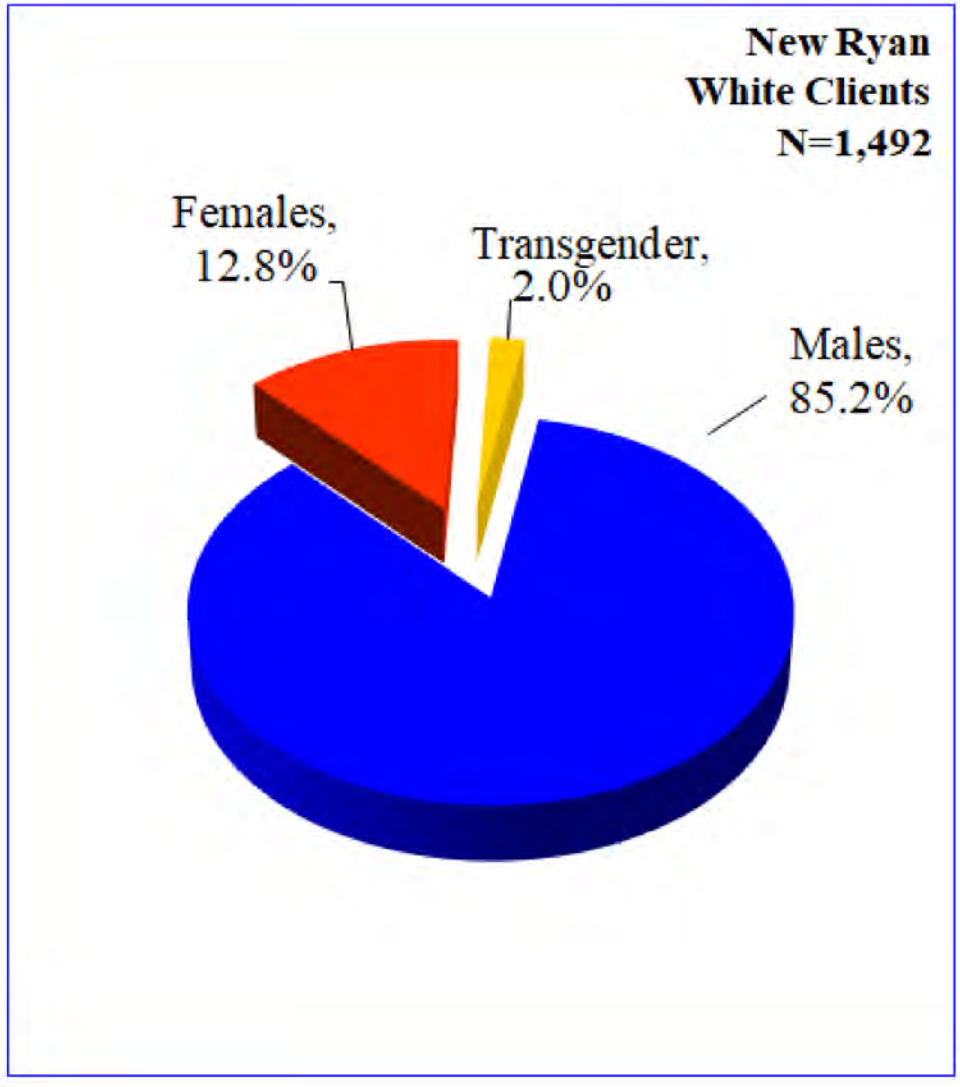



| | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|
| <25 | 3% | 3% | 3% | 3% | 2% |
| 25 - 34 | 20% | 20% | 19% | 20% | 21% |
| 35 - 49 | 34% | 34% | 35% | 35% | 35% |
| 50 - 64 | 37% | 37% | 38% | 37% | 36% |
| 65+ | 5% | 5% | 5% | 5% | 6% |

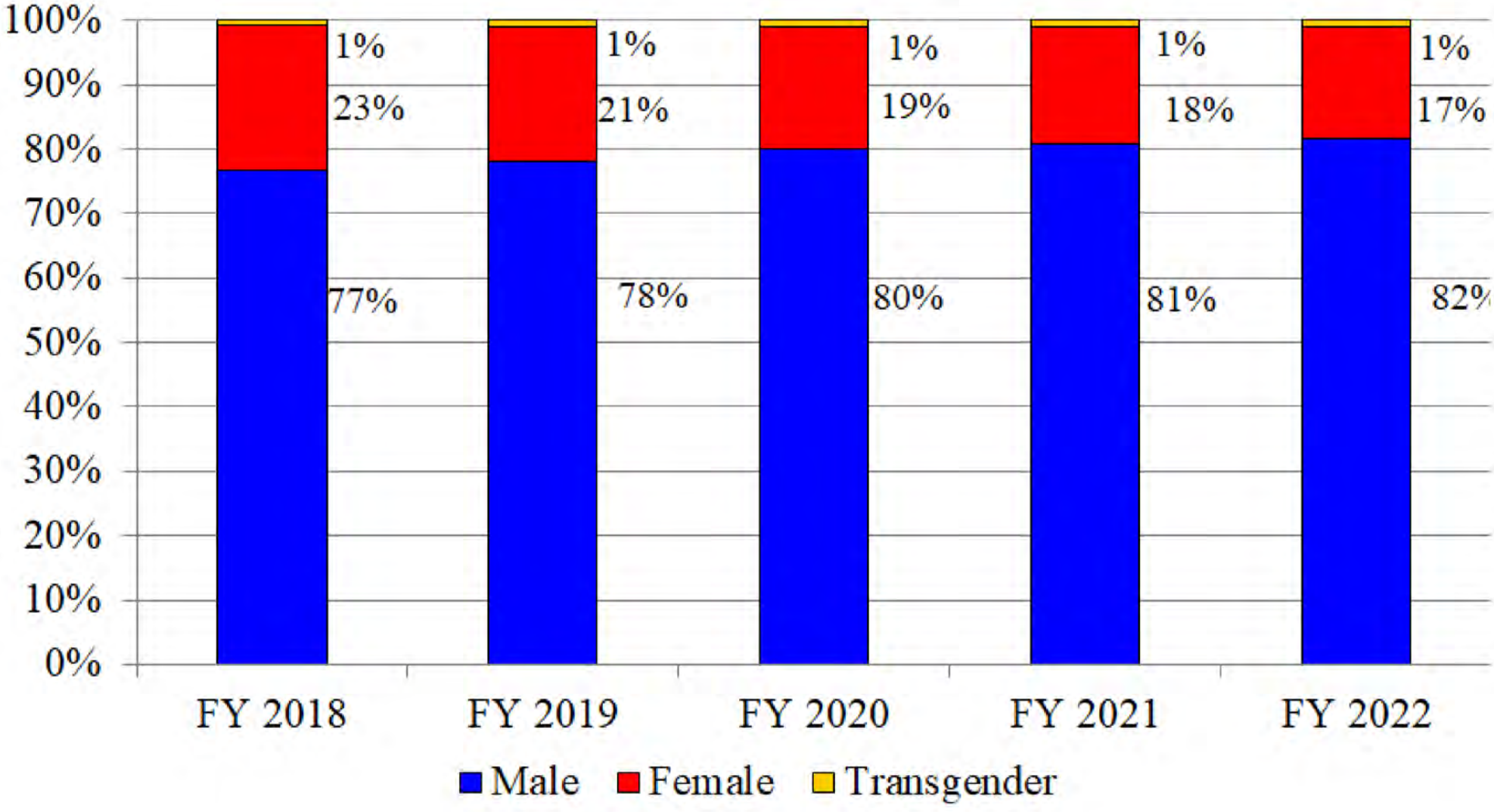
# GENDER

# GENDER OF NEW AND TOTAL CLIENTS IN CARE
# RYAN WHITE PROGRAM, FY 2022



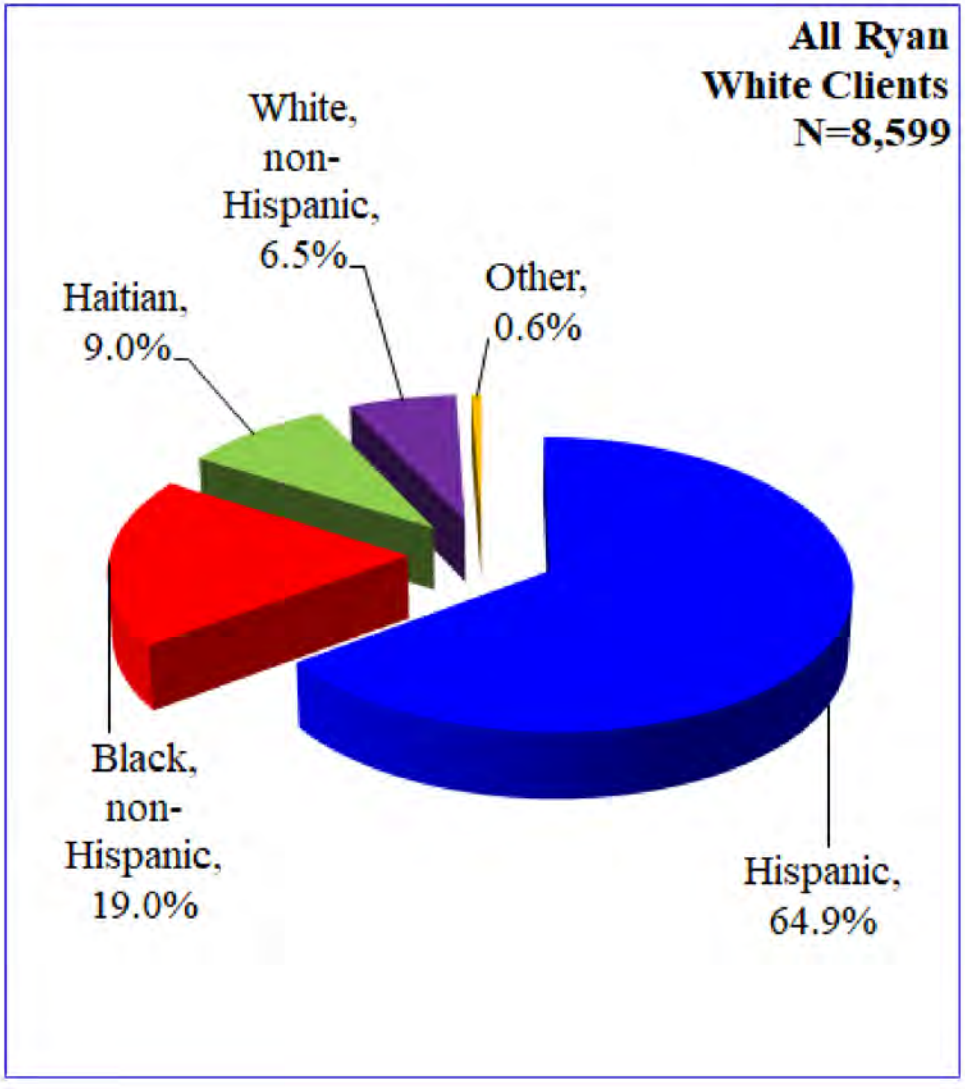



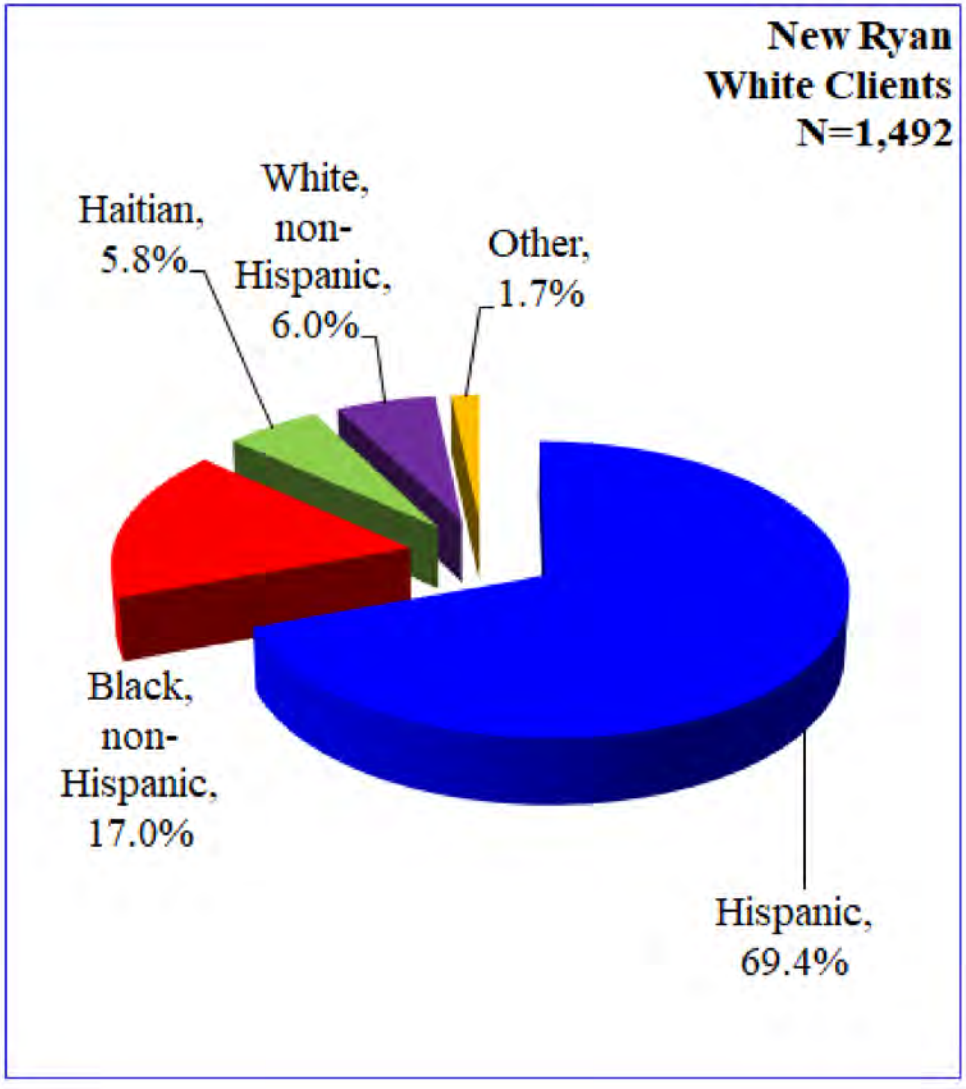
## GENDER OF CLIENTS IN CARE
## RYAN WHITE PROGRAM, FY 2018-2022



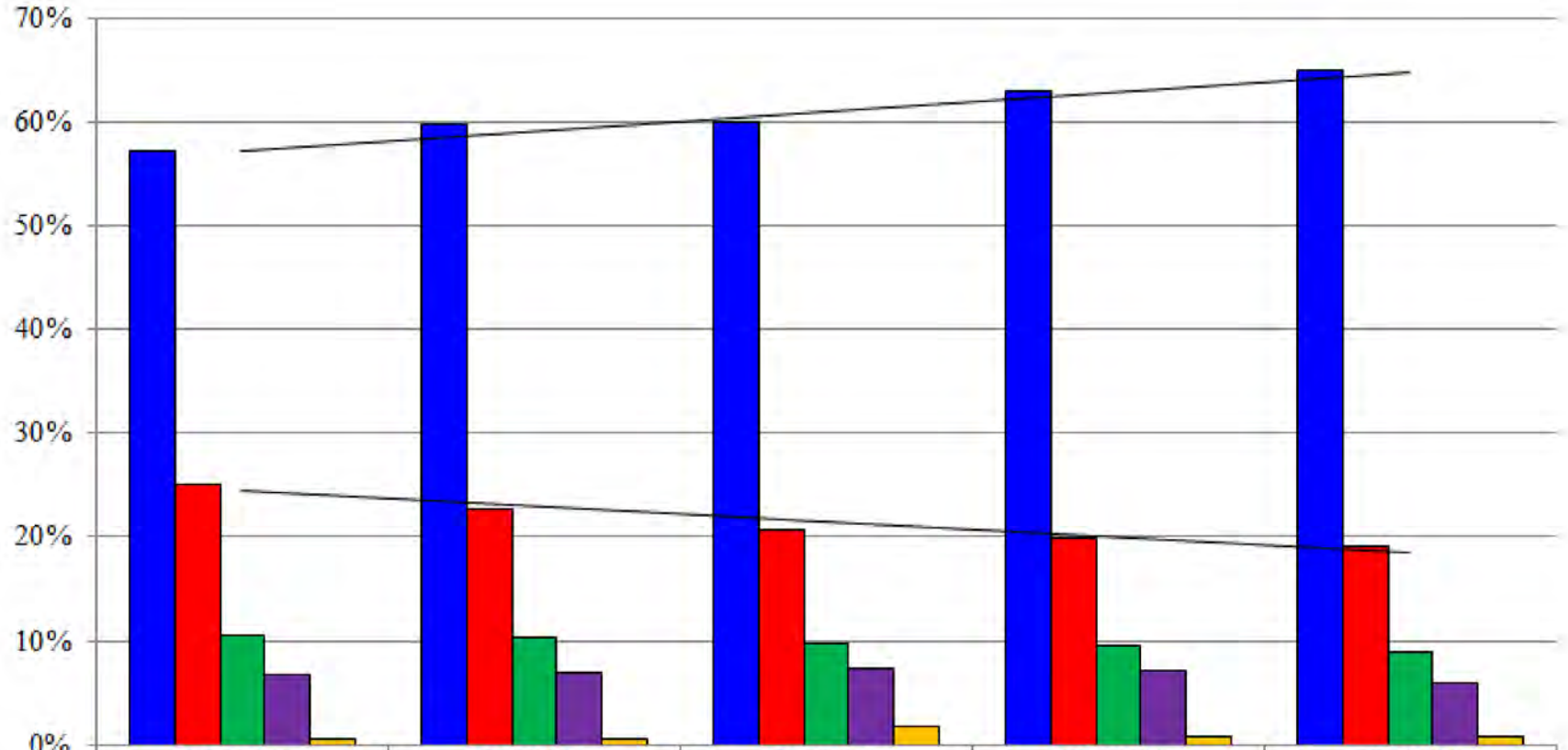
# RACE/ETHNICITY

# RACE/ETHNICITY OF NEW AND TOTAL CLIENTS IN CARE
# RYAN WHITE PROGRAM, FY 2022



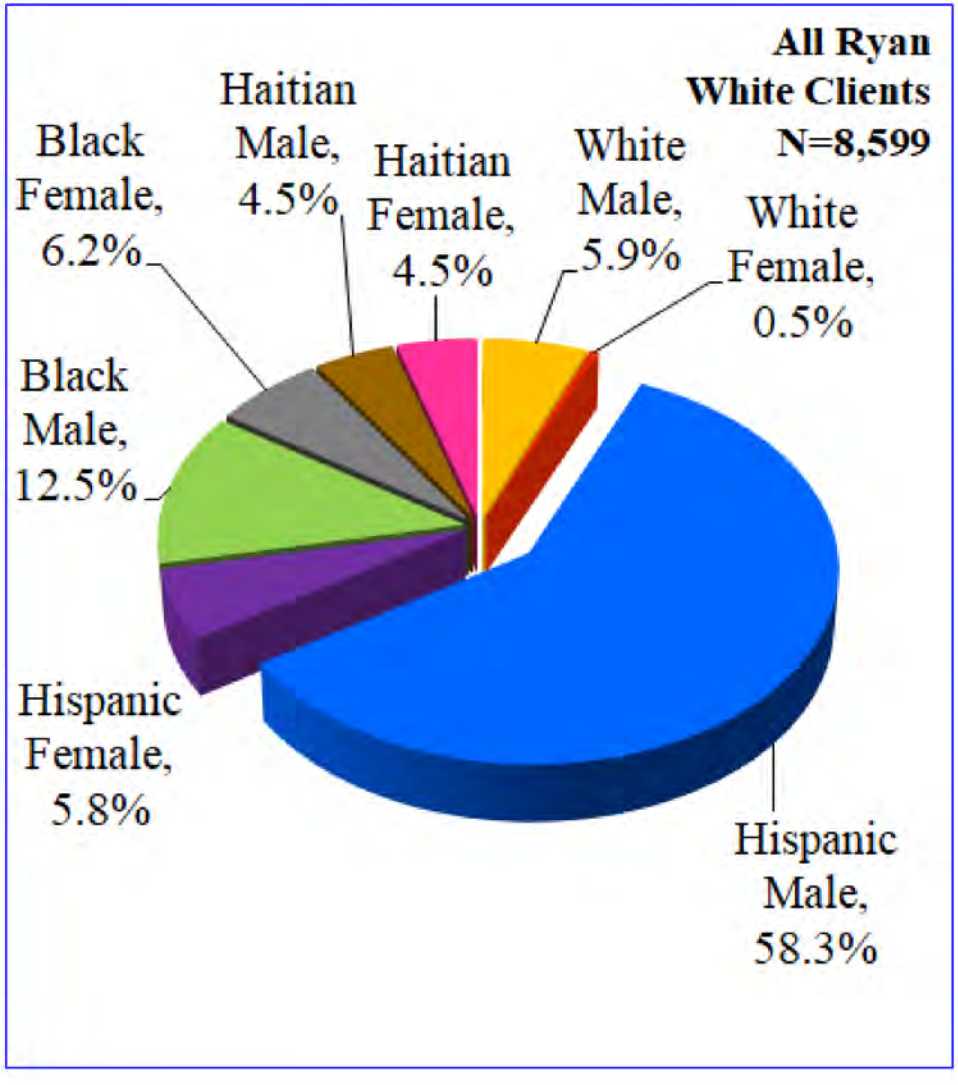
# RACE/ETHNICITY OF CLIENTS IN CARE
# RYAN WHITE PROGRAM, FY 2018-2022

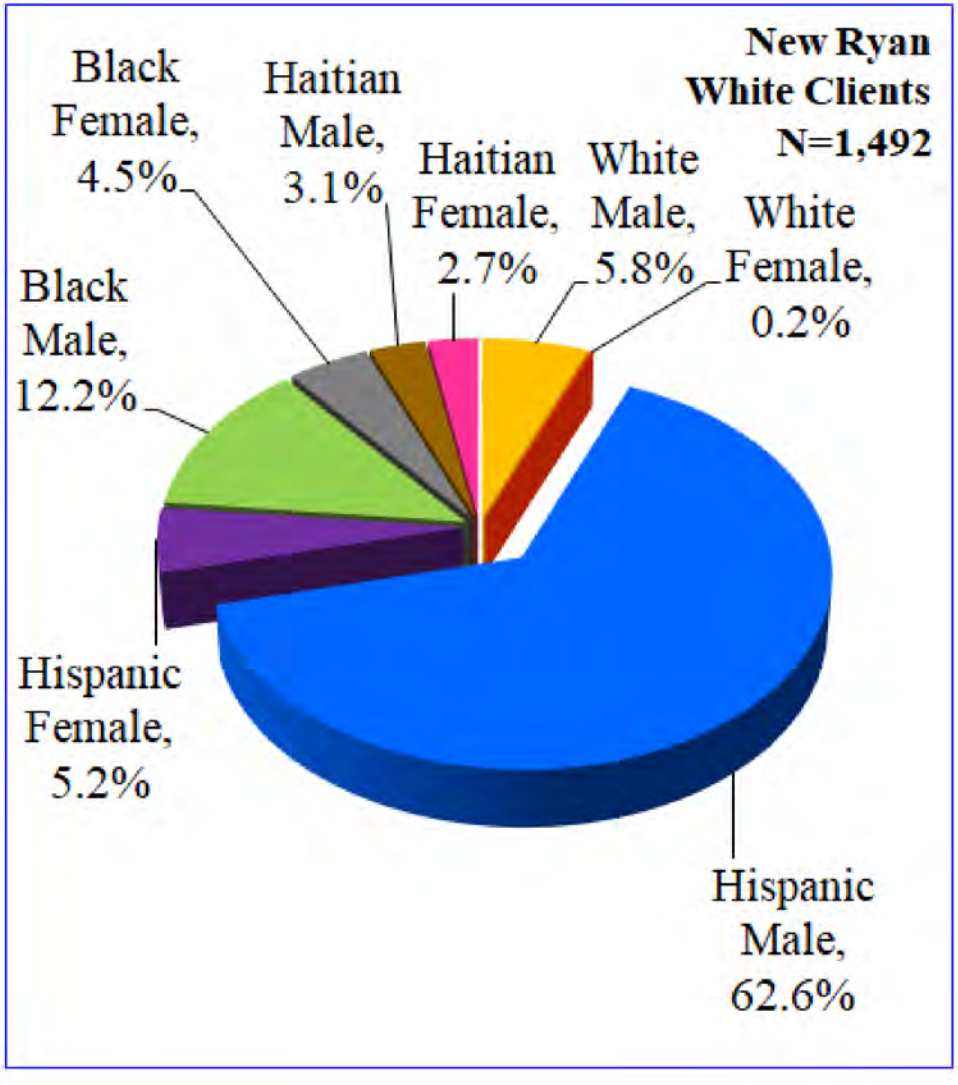



| | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|
| Hispanic | 57% | 60% | 60% | 63% | 65% |
| Black, non-Hispanic | 25% | 23% | 21% | 20% | 19% |
| Haitian | 11% | 10% | 10% | 10% | 9% |
| White, non-Hispanic | 7% | 7% | 7% | 7% | 6% |
| Other | 1% | 1% | 2% | 1% | 1% |

# RACE/ETHNICITY AND GENDER

# RACE/ETHNICITY BY GENDER OF NEW AND TOTAL CLIENTS IN CARE RYAN WHITE PROGRAM, FY 2022



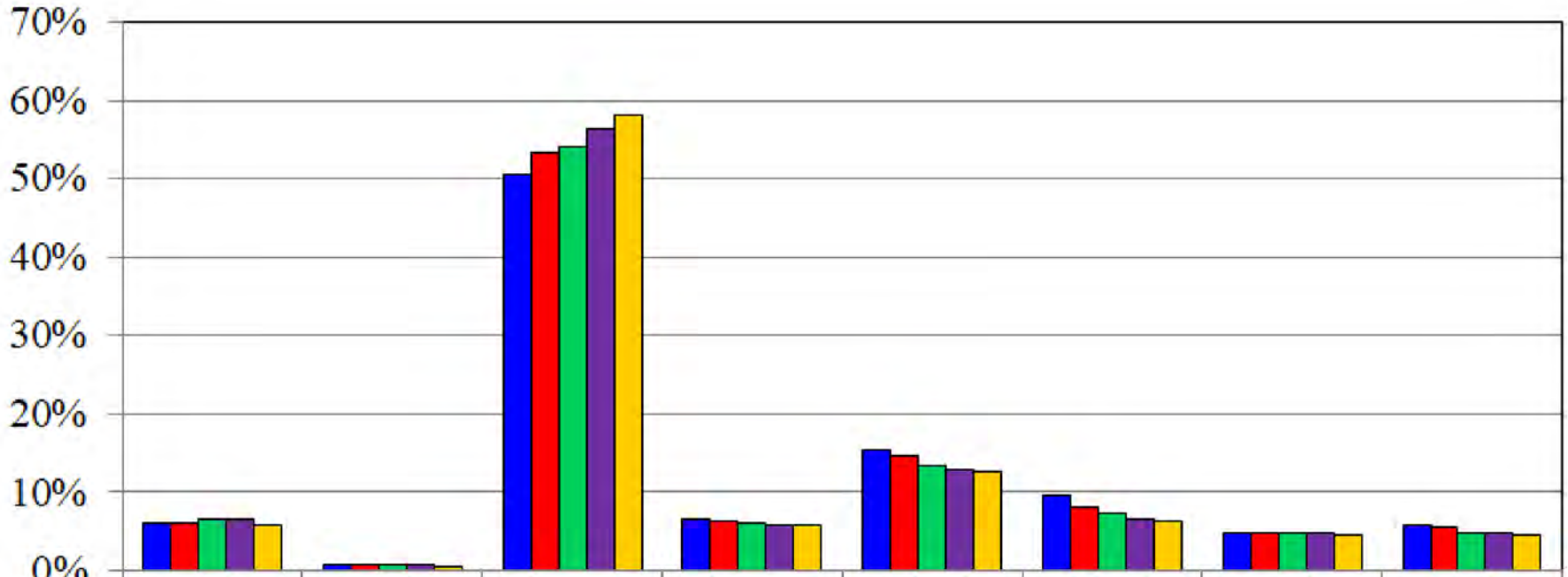



# RACE/ETHNICITY OF TRANSGENDER CLIENTS RYAN WHITE PROGRAM, FY 2022

| Established N=8,599 | Black/African American | Haitian | Hispanic | White |
|---|---|---|---|---|
| Transgender MtF | 26 | 1 | 71 | 4 |
| Transgender FtM | 0 | 0 | 1 | 0 |
| Total | 26 | 1 | 72 | 4 |

| New N=1,492 | Black/African American | Haitian | Hispanic | White |
|---|---|---|---|---|
| Transgender MtF | 4 | 0 | 25 | 1 |
| Transgender FtM | 0 | 0 | 0 | 0 |
| Total | 4 | 0 | 25 | 1 |

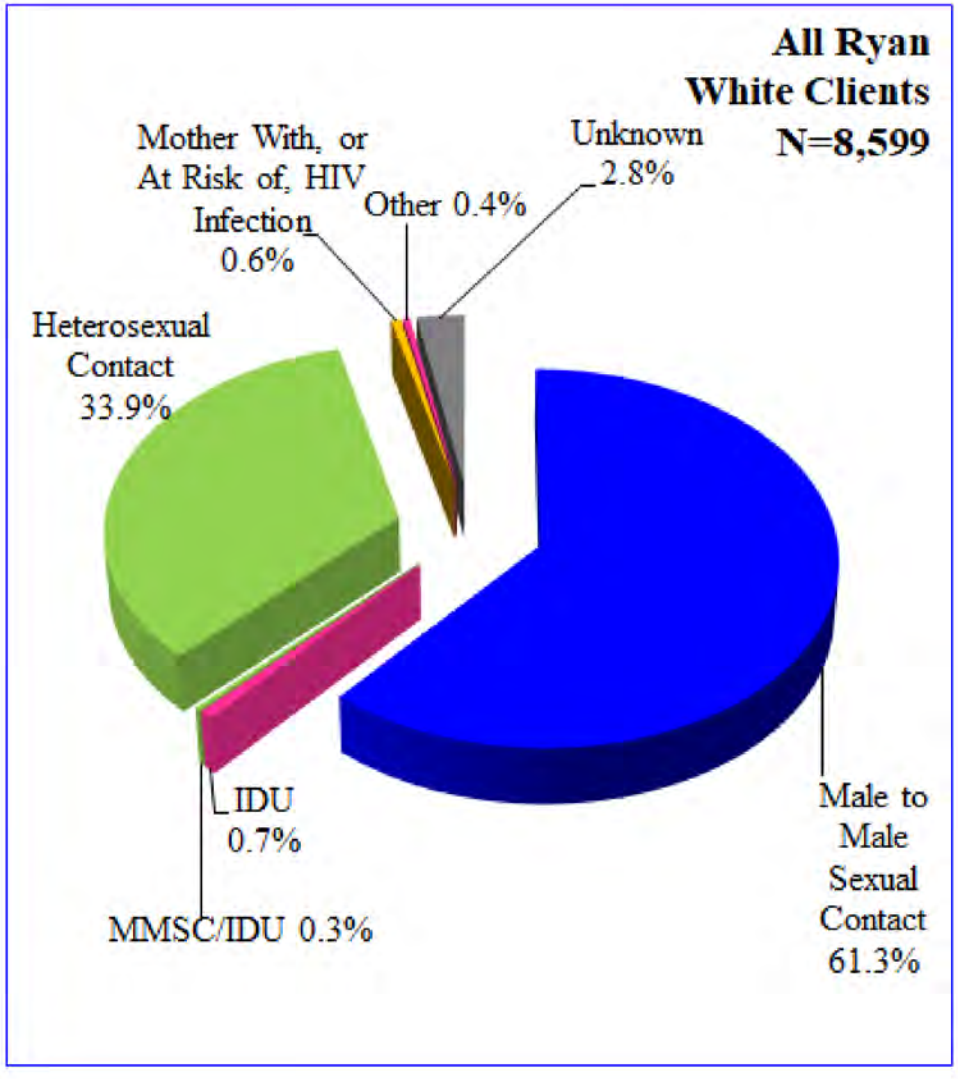
# RACE/ETHNICITY OF CLIENTS IN CARE, BY GENDER
# RYAN WHITE PROGRAM, FY 2018-2022

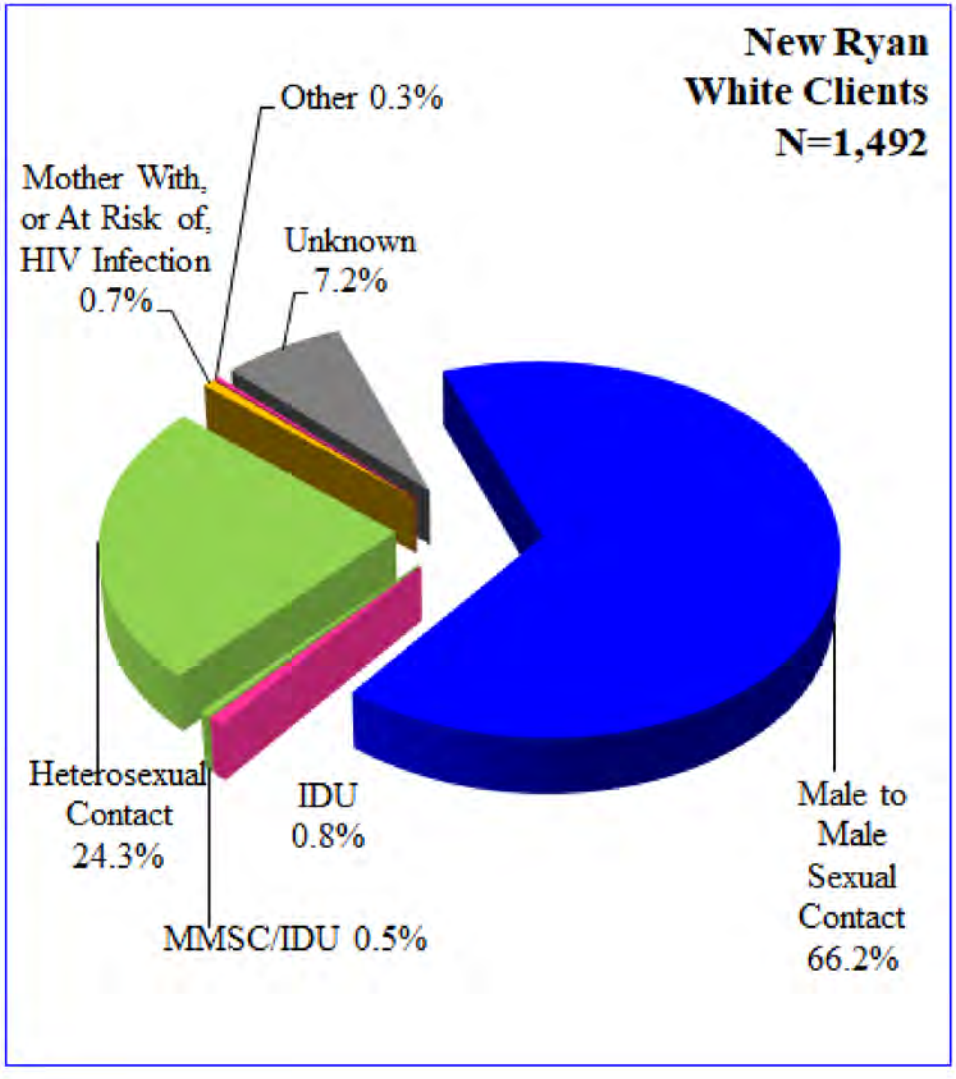



| | White Male | White Female | Hispanic Male | Hispanic Female | Black Male | Black Female | Haitian Male | Haitian Female |
|---|---|---|---|---|---|---|---|---|
| FY 2018 | 6% | 1% | 51% | 7% | 16% | 10% | 5% | 6% |
| FY 2019 | 6% | 1% | 54% | 6% | 15% | 8% | 5% | 6% |
| FY 2020 | 7% | 1% | 54% | 6% | 14% | 7% | 5% | 5% |
| FY 2021 | 7% | 1% | 56% | 6% | 13% | 7% | 5% | 5% |
| FY 2022 | 6% | 1% | 58% | 6% | 13% | 6% | 5% | 5% |

# PRIMARY MODE OF EXPOSURE

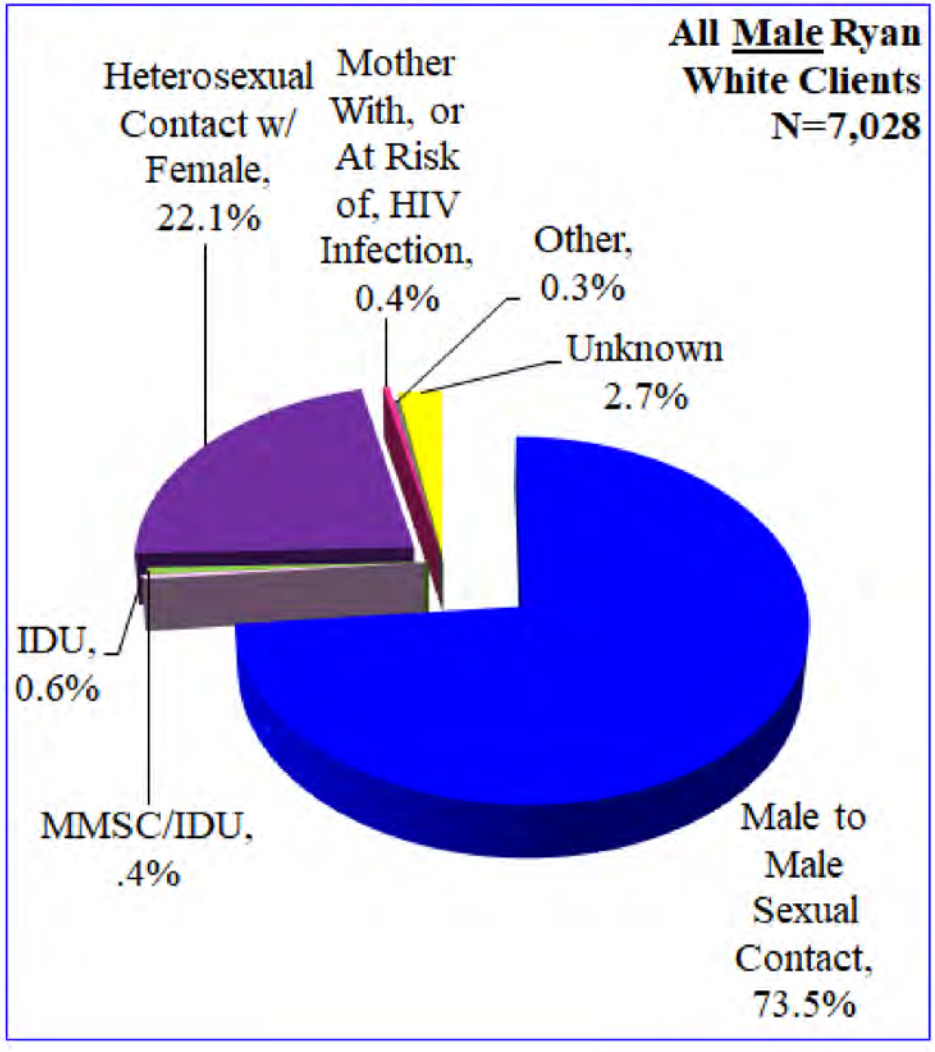
# PRIMARY MODE OF EXPOSURE OF NEW AND TOTAL CLIENTS IN CARE RYAN WHITE PROGRAM, FY 2022

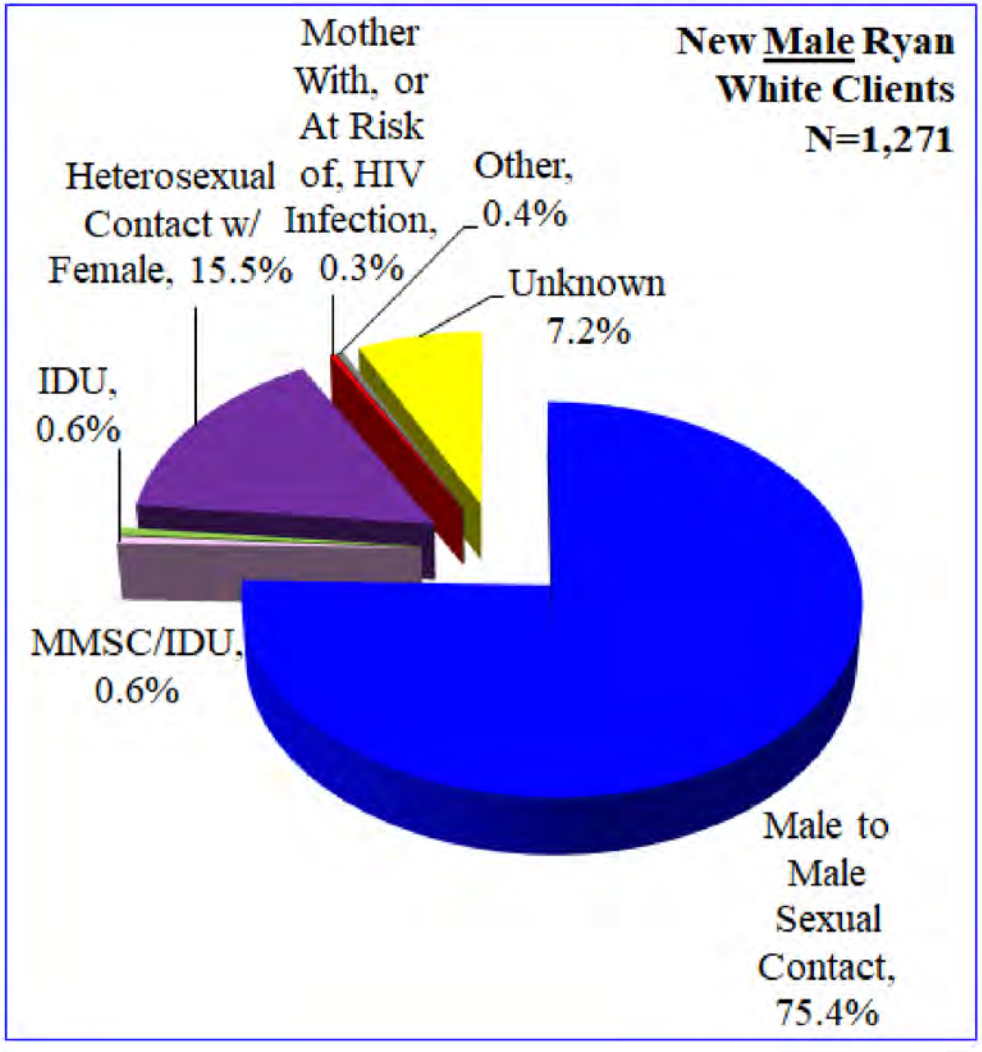


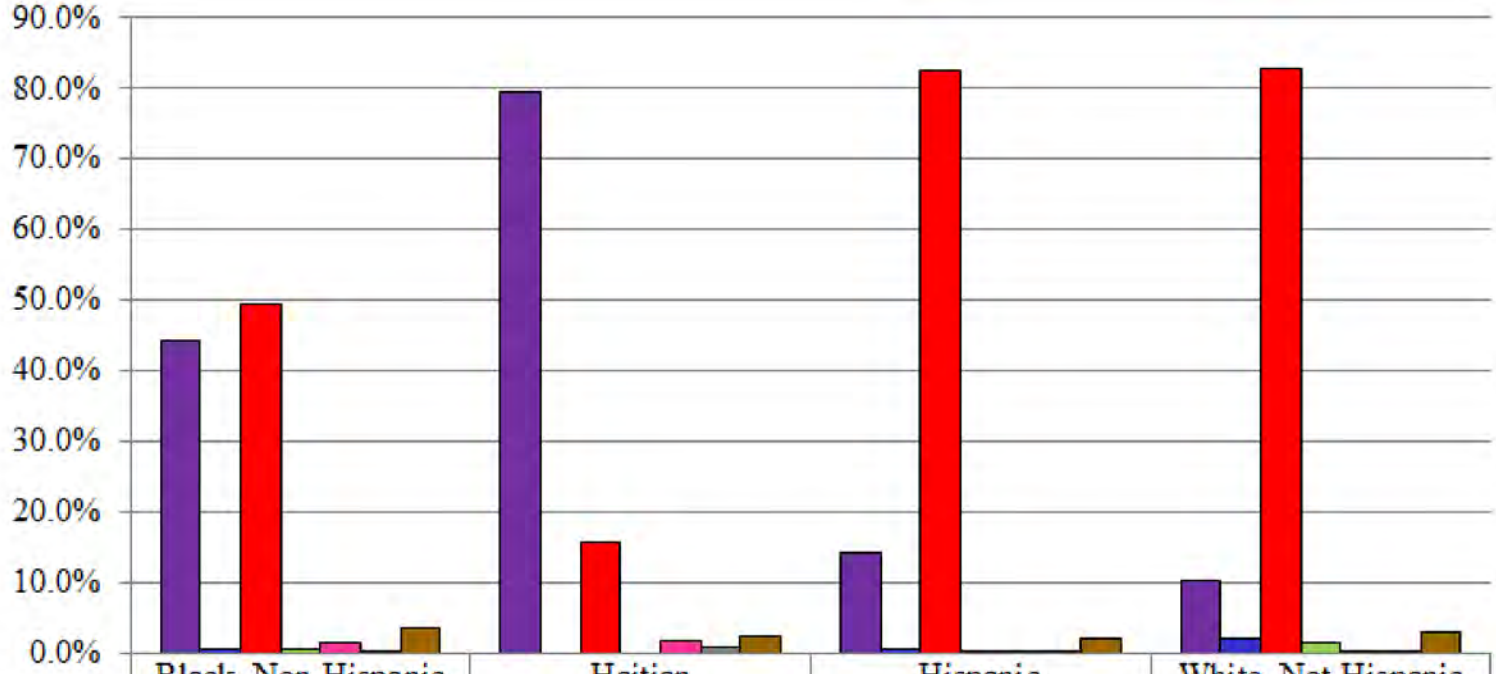
# MALE PRIMARY EXPOSURE MODES

# PRIMARY MODE OF EXPOSURE NEW AND TOTAL MALES IN CARE RYAN WHITE PROGRAM, FY 2022



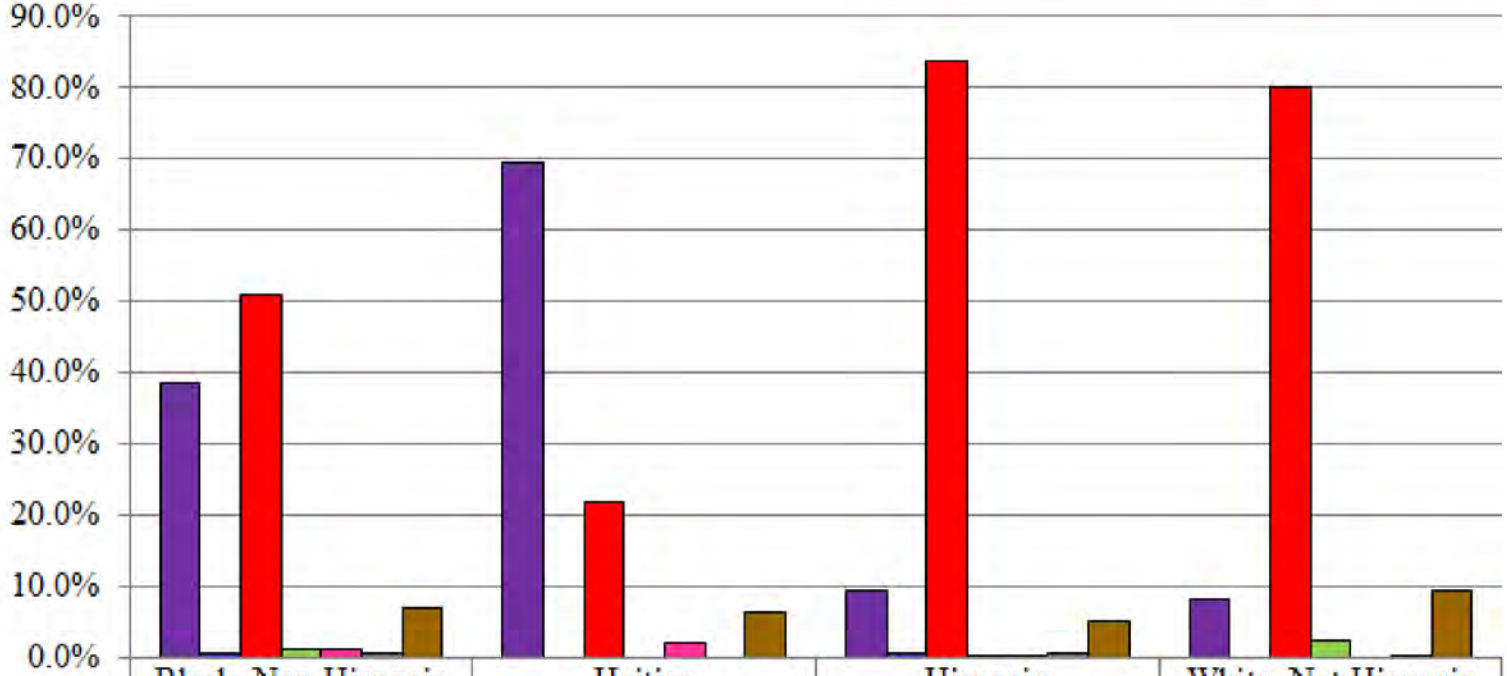



# PRIMARY MODE OF EXPOSURE BY RACE/ETHNICITY MALES IN CARE RYAN WHITE PROGRAM, FY 2022




| | Black, Non-Hispanic | Haitian | Hispanic | White, Not-Hispanic |
|---|---|---|---|---|
| Heterosexual | 44.2% | 79.5% | 14.2% | 10.2% |
| Injection Drug Use | 0.7% | 0.0% | 0.5% | 2.2% |
| Male to Male Sexual Contact | 49.3% | 15.8% | 82.4% | 82.9% |
| Male to Male Sexual Contact/IDU | 0.7% | 0.0% | 0.2% | 1.4% |
| Mother | 1.5% | 1.8% | 0.1% | 0.2% |
| Other | 0.1% | 0.9% | 0.4% | 0.2% |
| Unknown | 3.5% | 2.3% | 2.2% | 2.9% |

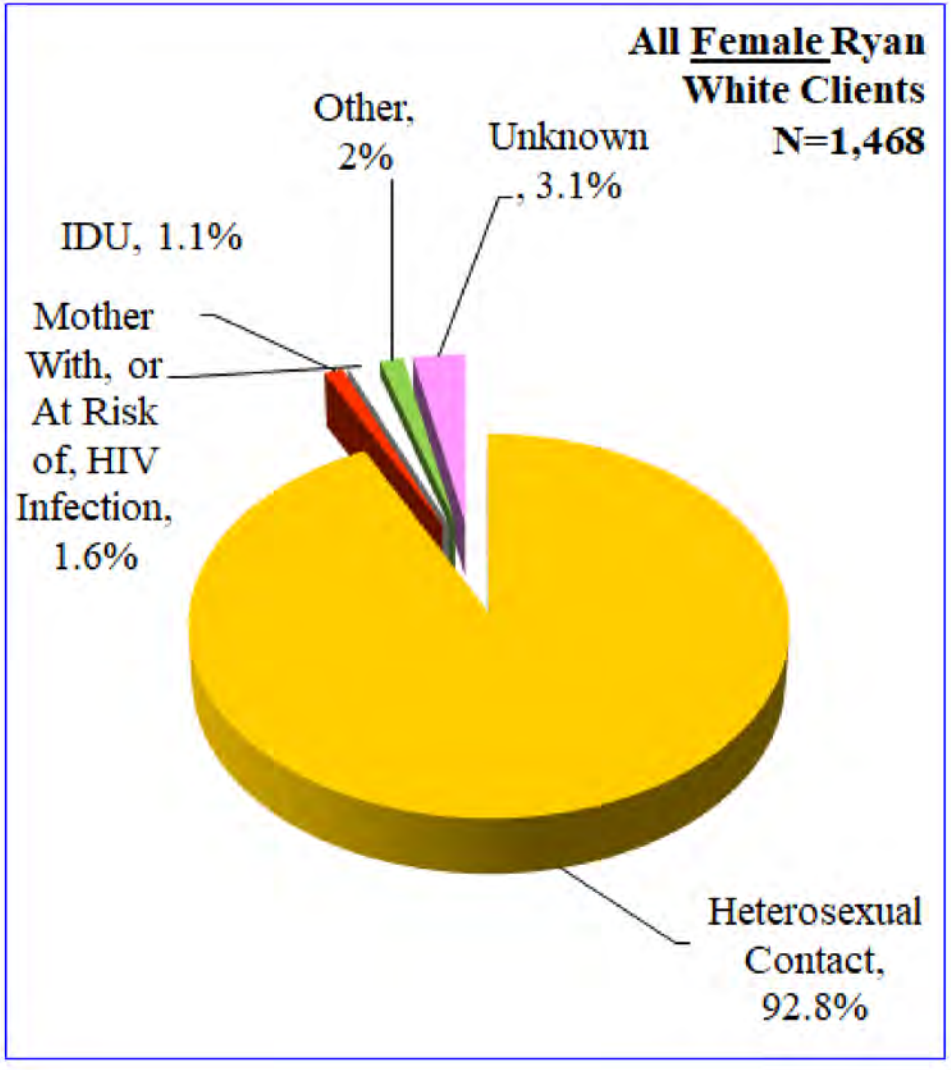
# PRIMARY MODE OF EXPOSURE BY RACE/ETHNICITY MALE NEW TO CARE RYAN WHITE PROGRAM, FY 2022

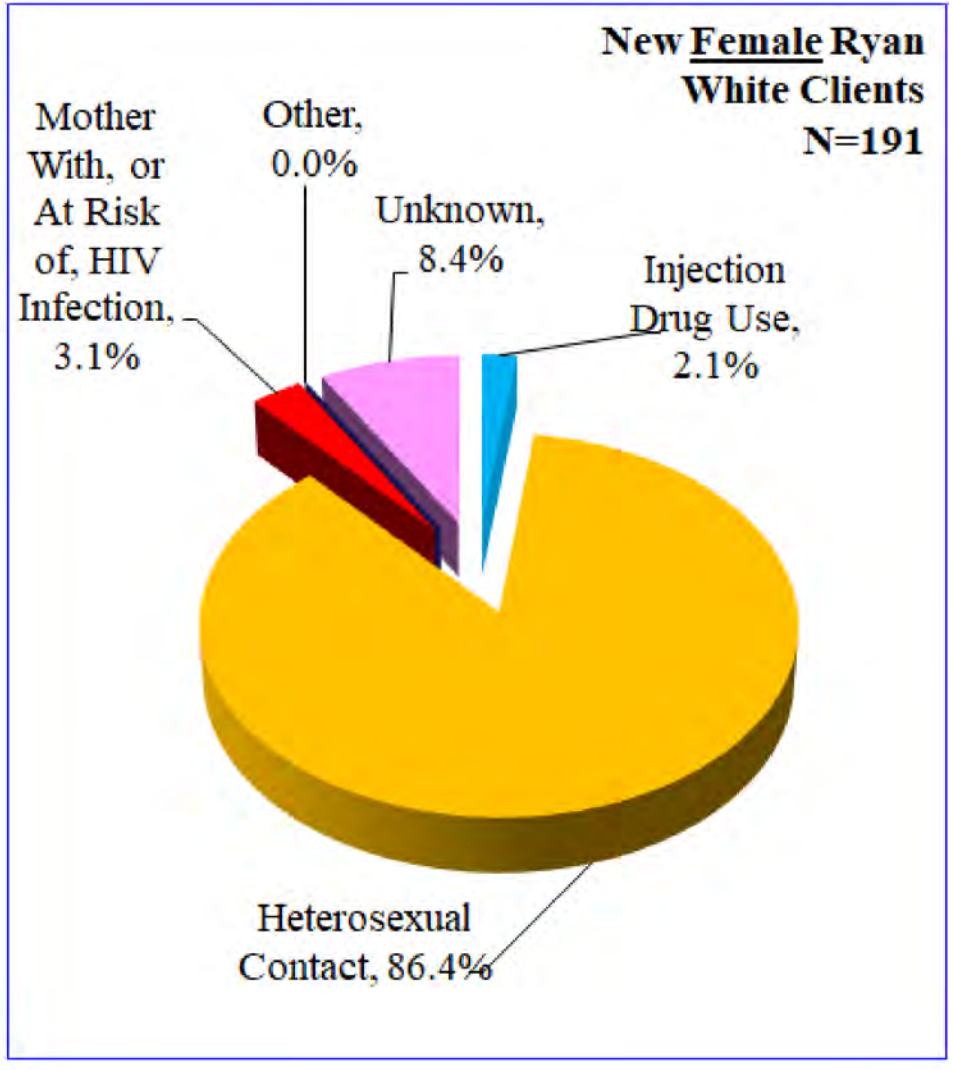



| | Black, Non-Hispanic | Haitian | Hispanic | White, Not-Hispanic |
|---|---|---|---|---|
| Heterosexual | 38.5% | 69.6% | 9.4% | 8.1% |
| Injection Drug Use | 0.5% | 0.0% | 0.7% | 0.0% |
| Male to Male Sexual Contact | 51.1% | 21.7% | 83.6% | 80.2% |
| Male to Male Sexual Contact/IDU | 1.1% | 0.0% | 0.3% | 2.3% |
| Mother | 1.1% | 2.2% | 0.1% | 0.0% |
| Other | 0.6% | 0.0% | 0.7% | 0.1% |
| Unknown | 7.1% | 6.5% | 5.2% | 9.3% |

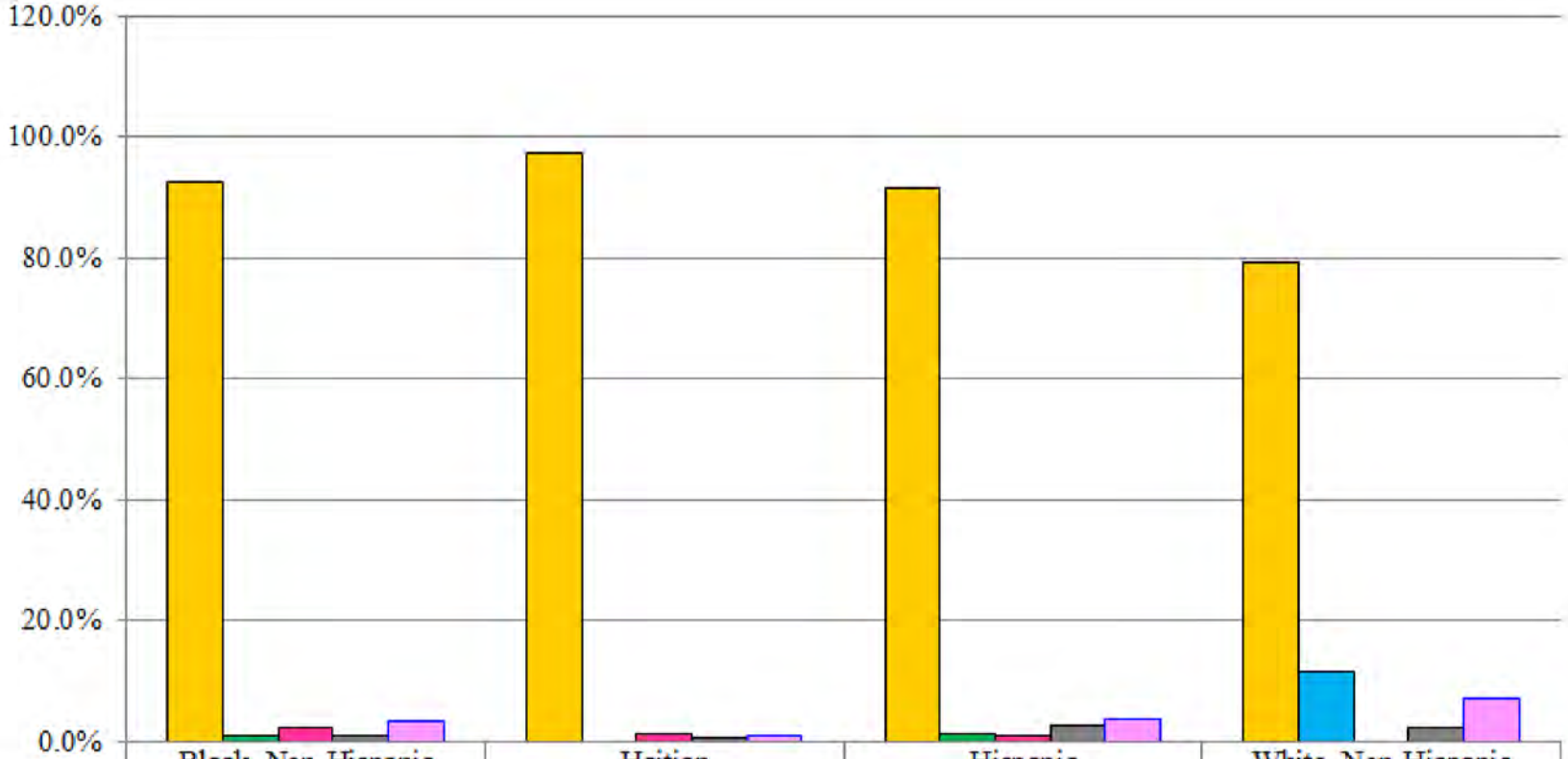
# FEMALE PRIMARY EXPOSURE MODES

# PRIMARY MODE OF EXPOSURE NEW AND TOTAL FEMALES IN CARE RYAN WHITE PROGRAM, FY 2022



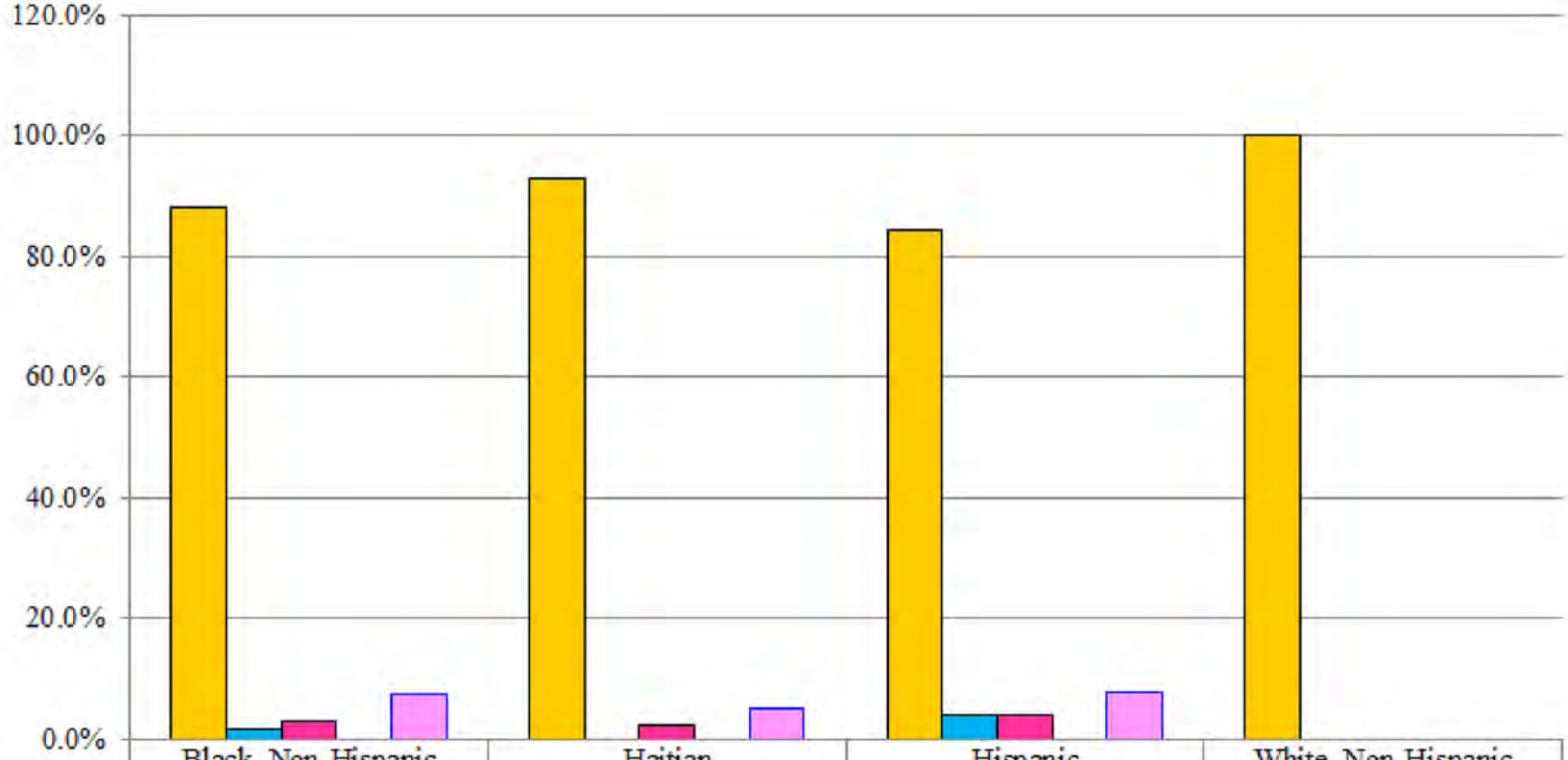



# PRIMARY MODE OF EXPOSURE BY RACE/ETHNICITY FEMALES IN CARE RYAN WHITE PROGRAM, FY 2022




| | Black, Non-Hispanic | Haitian | Hispanic | White, Non-Hispanic |
|---|---|---|---|---|
| Heterosexual | 92.5% | 97.2% | 91.4% | 79.1% |
| Injection Drug Use | 0.8% | 0.0% | 1.4% | 11.6% |
| Mother with or at risk | 2.4% | 1.3% | 1.0% | 0.0% |
| Other | 0.9% | 0.7% | 2.6% | 2.3% |
| Unknown | 3.4% | 0.8% | 3.6% | 7.0% |

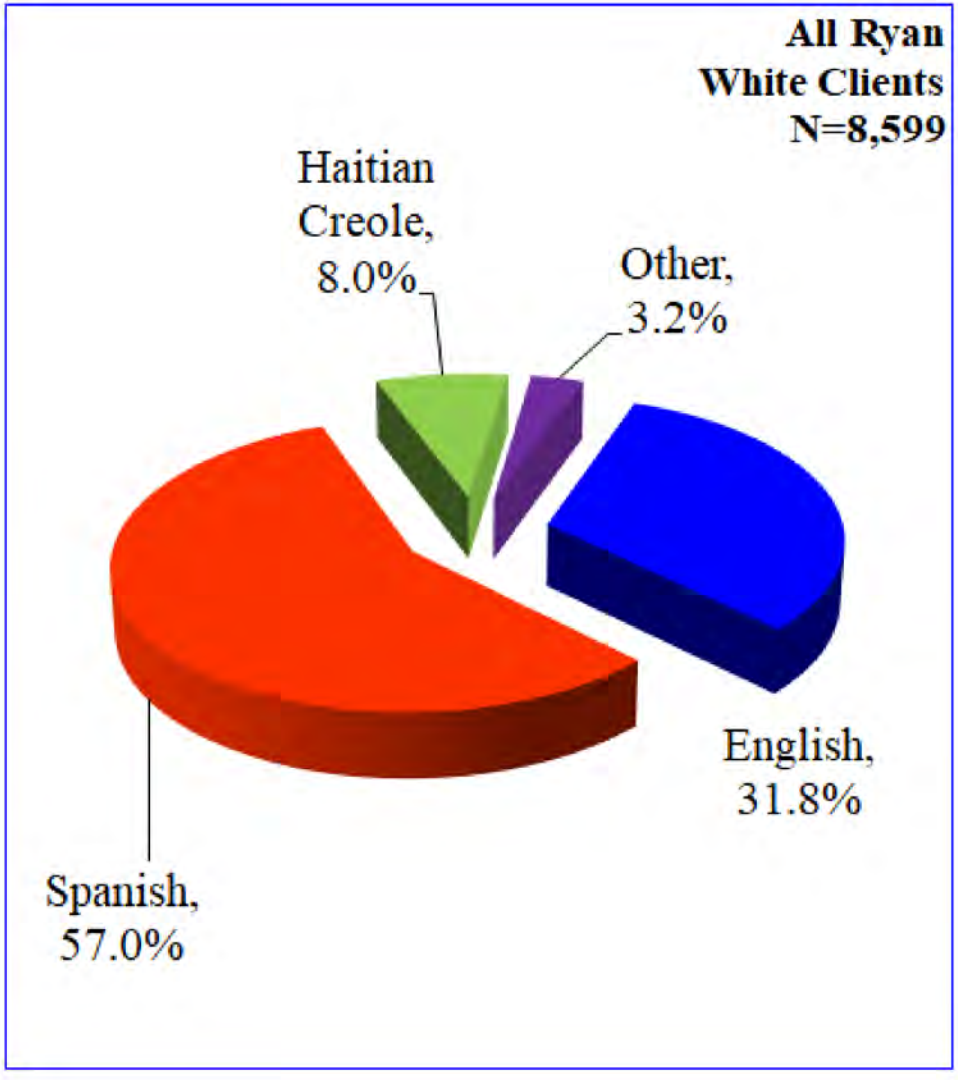
# PRIMARY MODE OF EXPOSURE BY RACE/ETHNICITY FEMALE NEW TO CARE RYAN WHITE PROGRAM, FY 2022

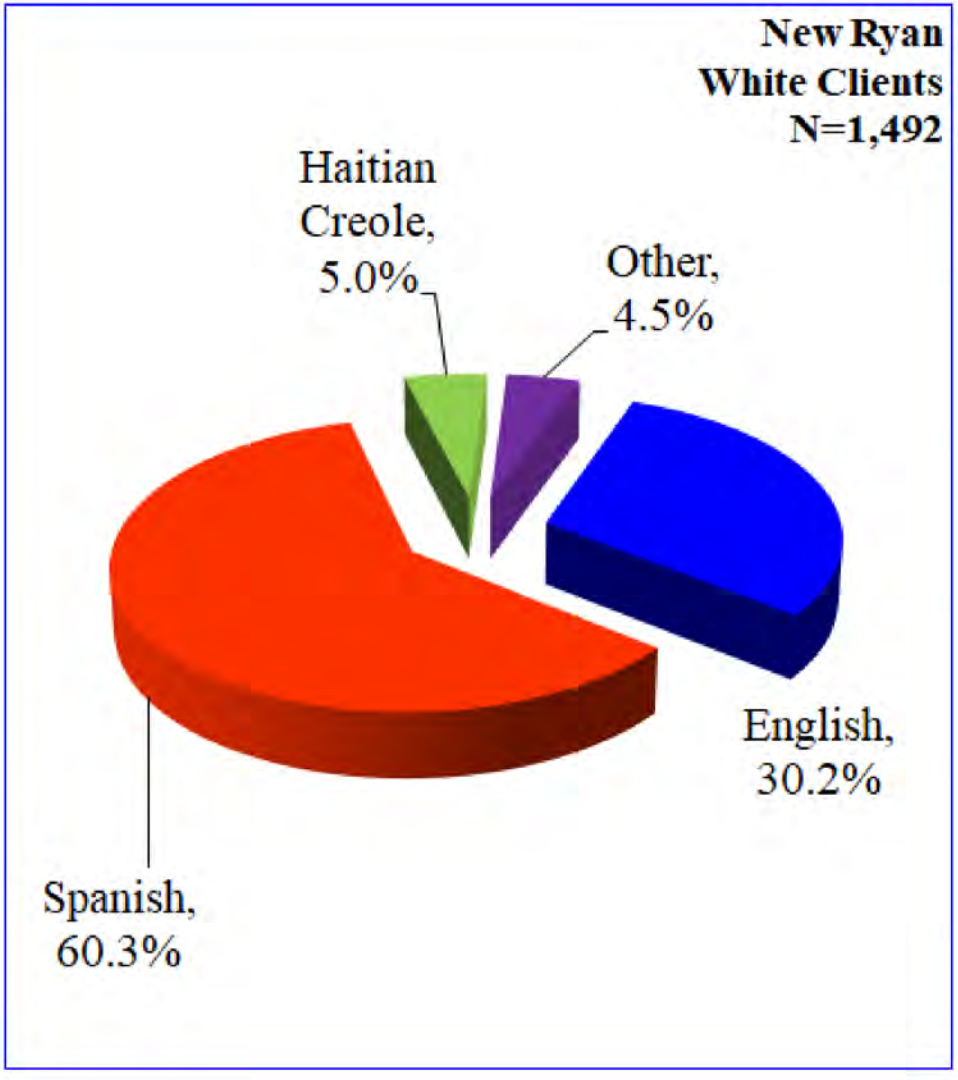



| | Black, Non-Hispanic | Haitian | Hispanic | White, Non-Hispanic |
|---|---|---|---|---|
| Heterosexual | 88.1% | 92.7% | 84.4% | 100.0% |
| Injection Drug Use | 1.5% | 0.0% | 3.9% | 0.0% |
| Mother with or at risk | 3.0% | 2.4% | 3.9% | 0.0% |
| Other | 0.0% | 0.0% | 0.0% | 0.0% |
| Unknown | 7.5% | 4.9% | 7.8% | 0.0% |

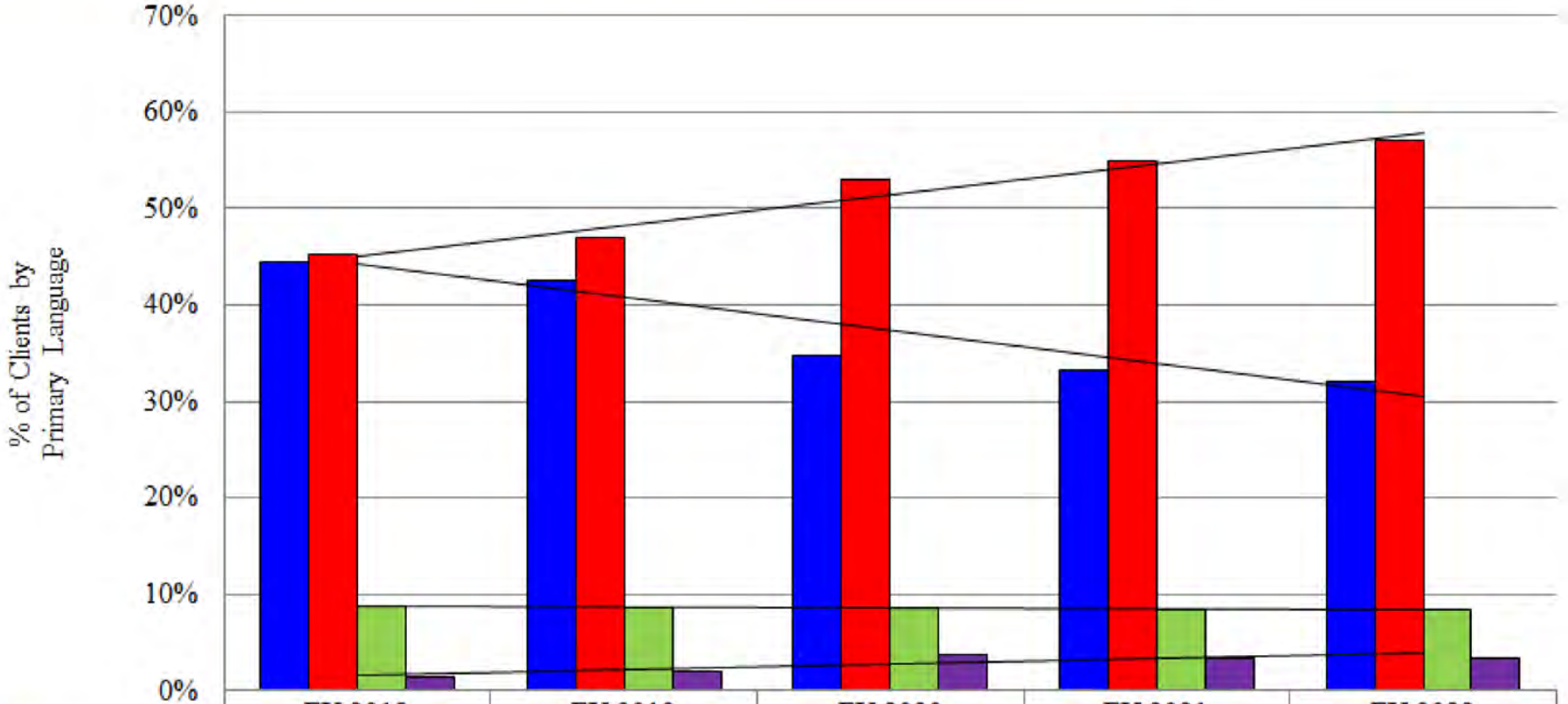
# PRIMARY LANGUAGE

# PRIMARY LANGUAGE OF NEW AND TOTAL CLIENTS IN CARE
# RYAN WHITE PROGRAM, FY 2022



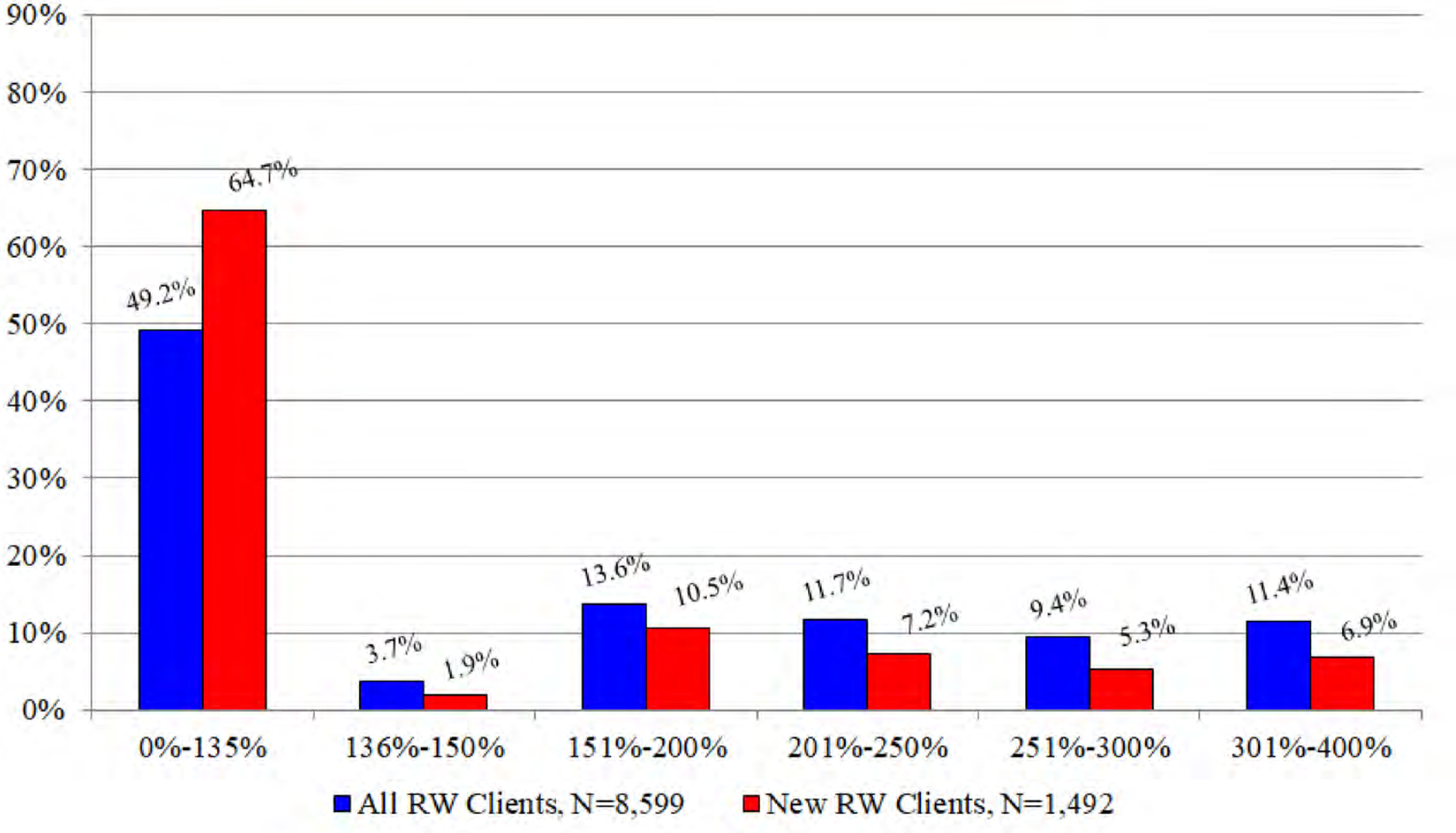
# PRIMARY LANGUAGE OF CLIENTS IN CARE
# RYAN WHITE PROGRAM, FY 2018-2022



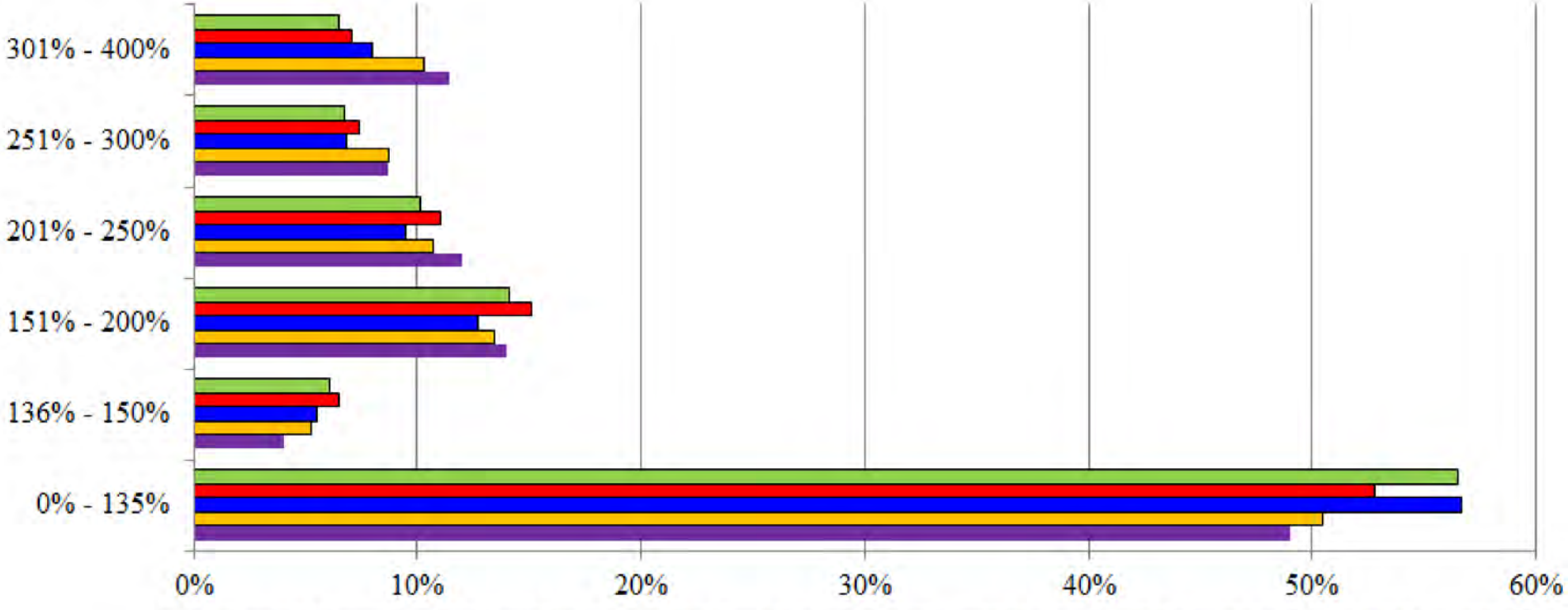

| | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|
| English | 45% | 43% | 35% | 33% | 32% |
| Spanish | 45% | 47% | 53% | 55% | 57% |
| Haitian Creole | 9% | 9% | 9% | 8% | 8% |
| Other | 1% | 2% | 4% | 3% | 3% |

# INCOME LEVEL

# INCOME LEVEL OF NEW AND TOTAL CLIENTS IN CARE RYAN WHITE PROGRAM, FY 2022



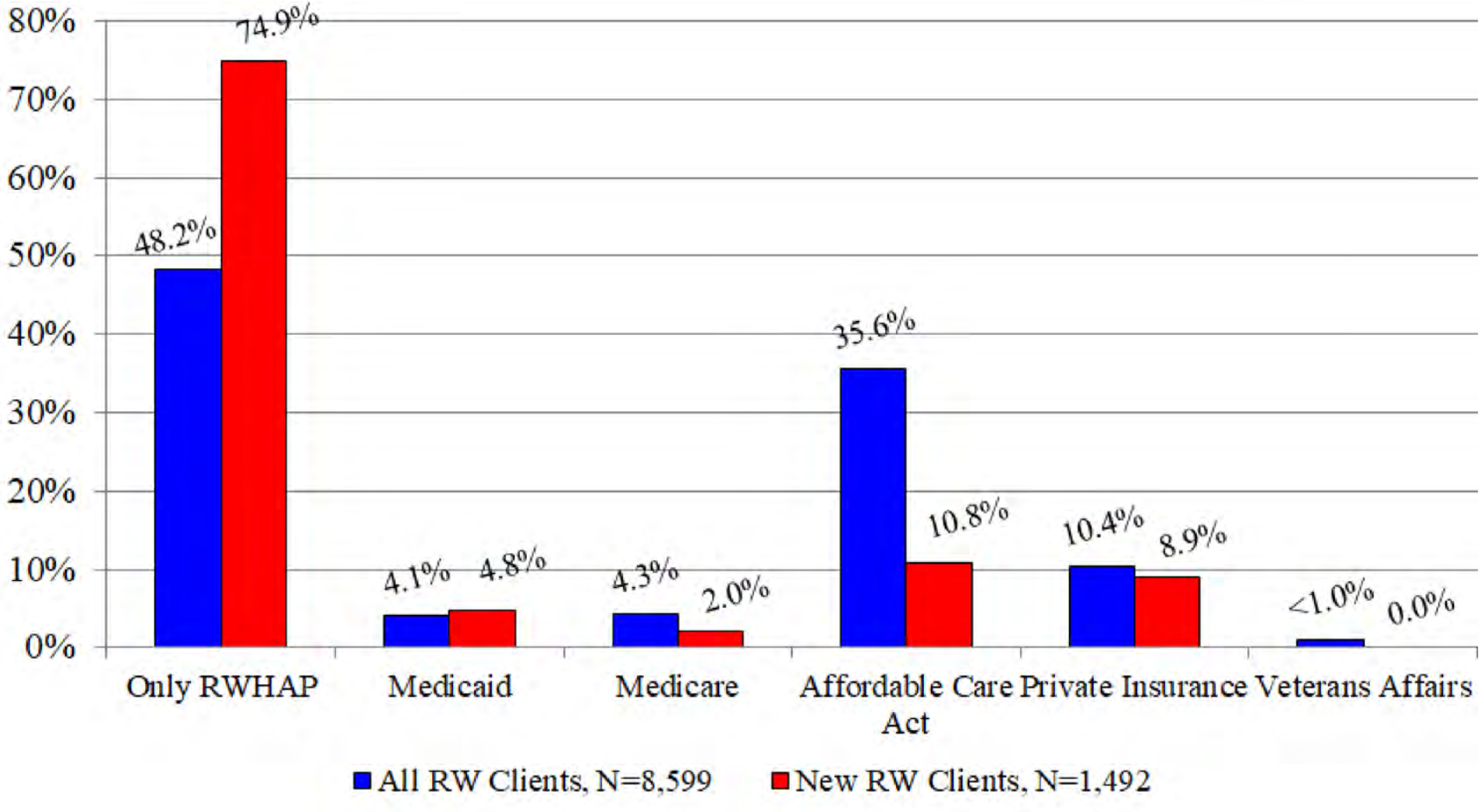
# INCOME LEVEL OF CLIENTS IN CARE
# RYAN WHITE PROGRAM, FY 2018-2022



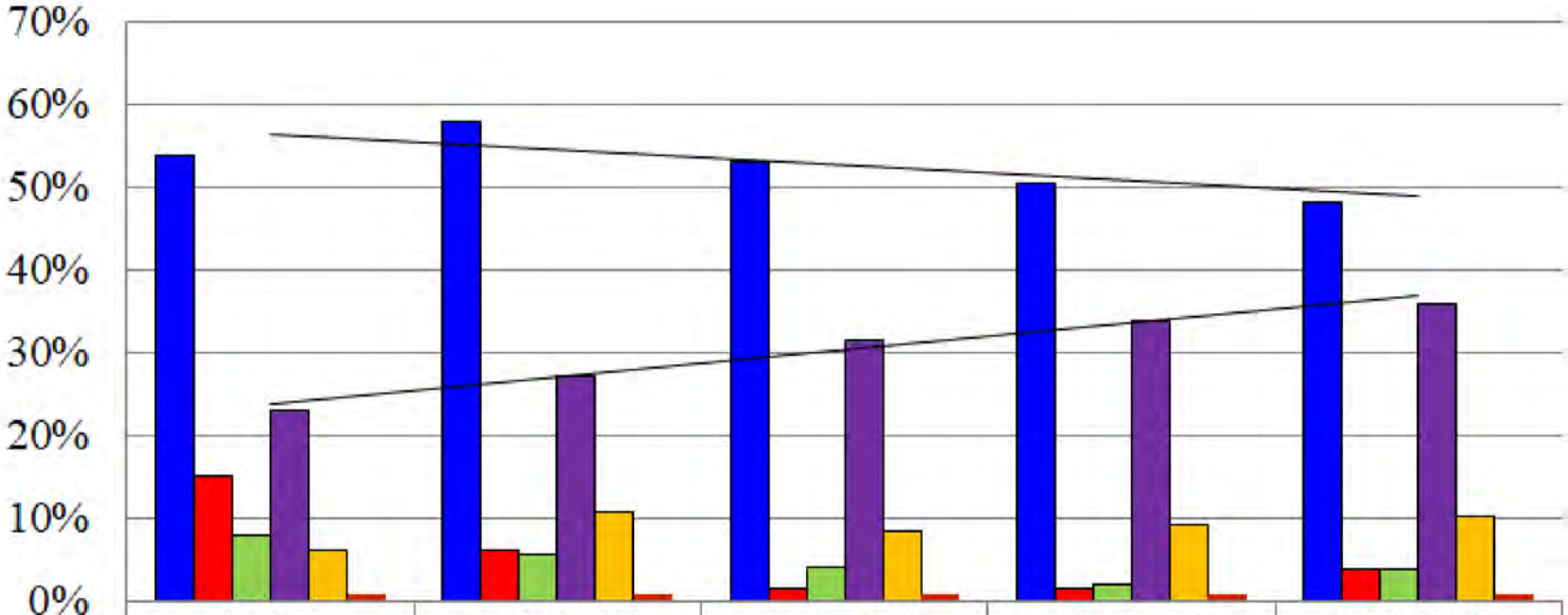

| | 0% - 135% | 136% - 150% | 151% - 200% | 201% - 250% | 251% - 300% | 301% - 400% |
|---|---|---|---|---|---|---|
| FY 2018 | 57% | 6% | 14% | 10% | 7% | 7% |
| FY 2019 | 53% | 7% | 15% | 11% | 7% | 7% |
| FY 2020 | 57% | 6% | 13% | 10% | 7% | 8% |
| FY 2021 | 51% | 5% | 13% | 11% | 9% | 10% |
| FY 2022 | 49% | 4% | 14% | 12% | 9% | 11% |

# INSURANCE COVERAGE

# INSURANCE COVERAGE OF NEW AND TOTAL CLIENTS IN CARE RYAN WHITE PROGRAM, FY 2022



# INSURANCE COVERAGE OF CLIENTS IN CARE
# RYAN WHITE PROGRAM, FY 2018-2022




| | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|
| Only RWHAP | 54% | 58% | 53% | 51% | 48% |
| Medicaid | 15% | 6% | 2% | 2% | 4% |
| Medicare | 8% | 6% | 4% | 2% | 4% |
| ACA | 23% | 27% | 32% | 34% | 36% |
| Private Ins | 6% | 11% | 9% | 9% | 10% |
| VA | 1% | 1% | 1% | 1% | 1% |

# THANK YOU!

BEHAVIORA SCIENCE RESEARCH

MIAMI-DADE HIV/AIDS PARTNERSHIP

MIAMI-DADE COUNTY

# SERVICE UTILIZATION

# SECTION 5

# RYAN WHITE PROGRAM SERVICE UTILIZATION DATA FY 2022 (3/1/2022-2/28/23)

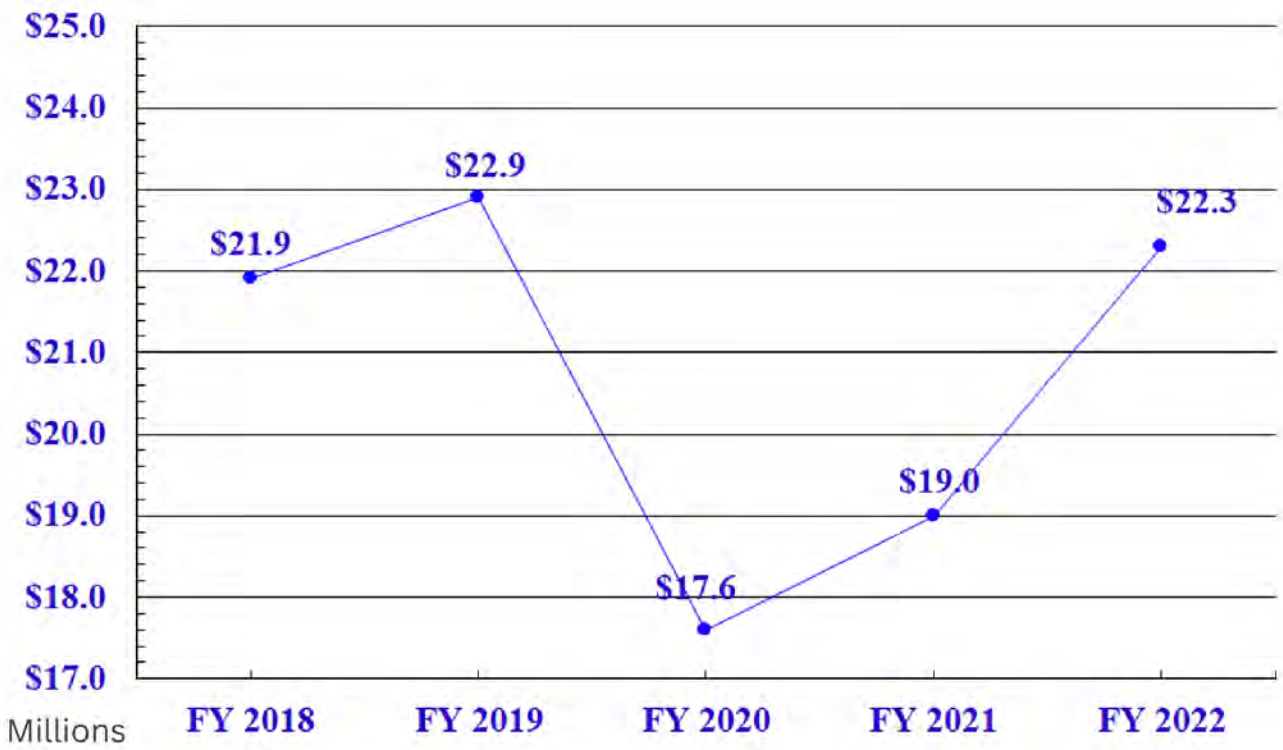
July 13, 2023 version

# SUMMARY

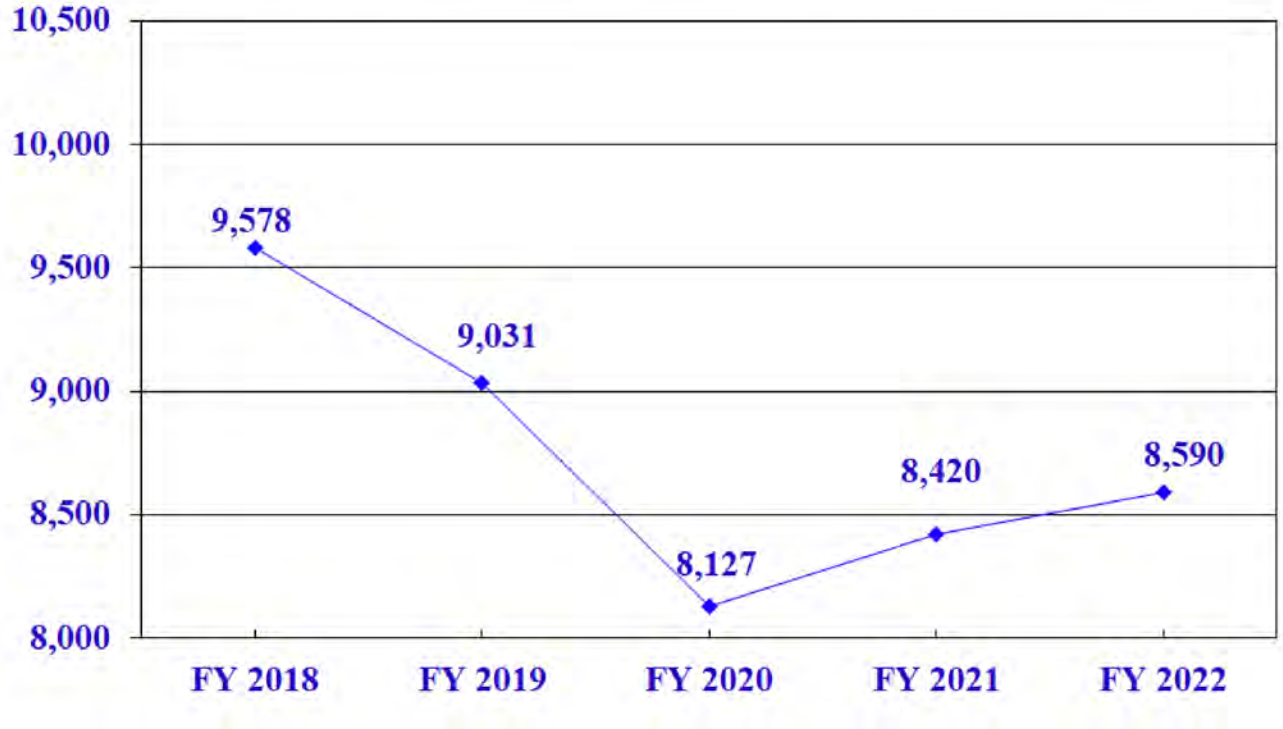
## *TOTALS AND GRAPHS*

# Ryan White Program Services Expenditures and Clients Served

| | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|
| **Total Expenditures** | $21,934,627 | $22,984,845 | $17,660,128 | $19,018,258 | $22,372,898 |
| **Total Unduplicated Clients** | 9,578 | 9,031 | 8,127 | 8,420 | 8,590 |
| **Average Cost/Client** | $2,290 | $2,545 | $2,173 | $2,258 | $2,604 |

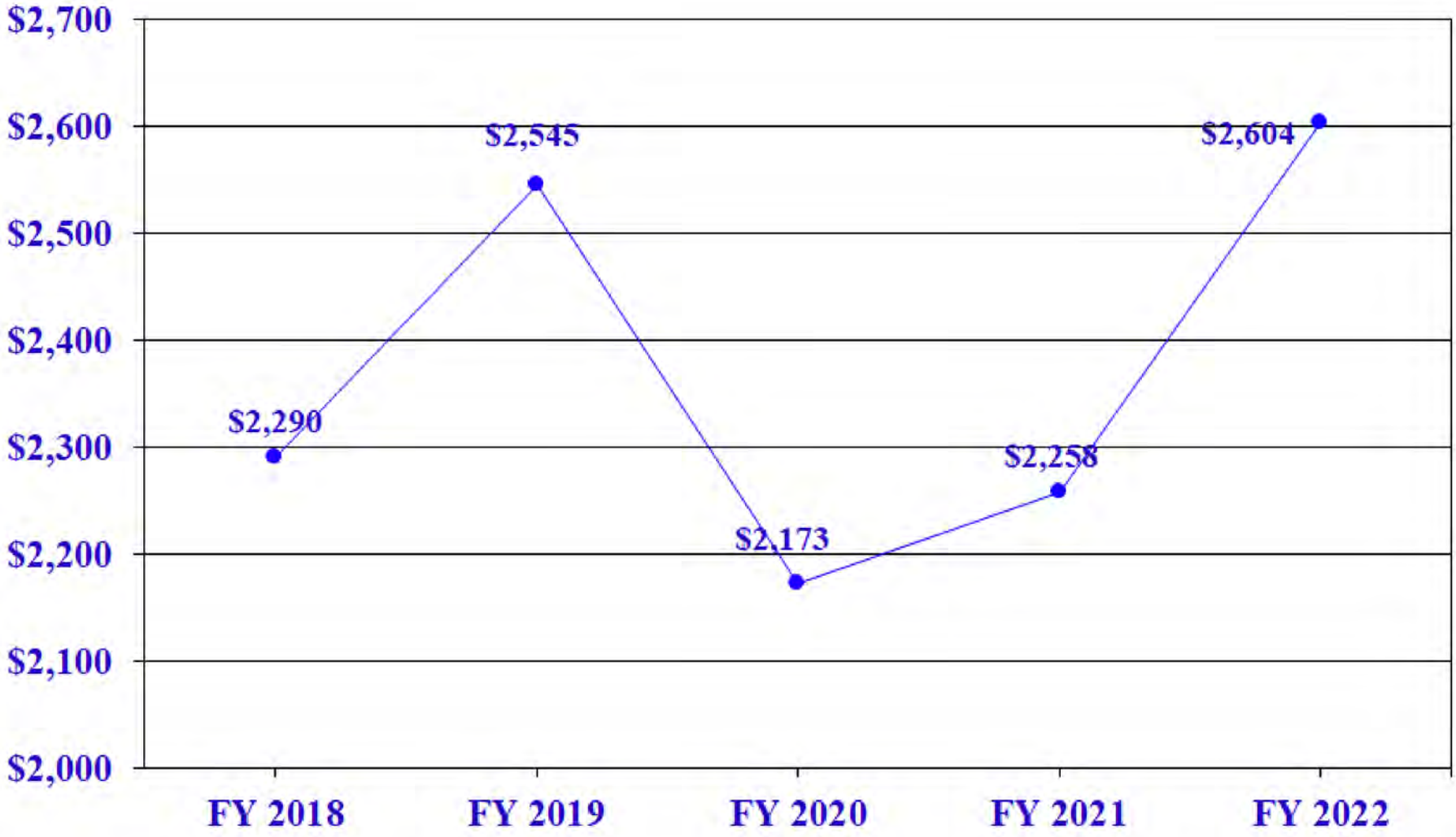



**Total Expenditures Between FY 2018 and FY 2022**




**Total Number of Unduplicated Clients Between FY 2018 and FY 2022**

# Average Cost Per Client Between FY 2018 and FY 2022



# TABLES

## RYAN WHITE PROGRAM (RWP) CLIENTS AND EXPENDITURES SORTS

# RWP Clients Served

## Sorted Alphabetically

| SERVICE CATEGORIES | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|
| RWP TOTAL | 9,578 | 9,031 | 8,127 | 8,411 | 8,590 |
| AIDS Pharmaceutical Assistance (Local) | 697 | 605 | 185 | 183 | 157 |
| Emergency Financial Assistance | N/A | N/A | N/A | N/A | N/A |
| Food Bank | 701 | 715 | 735 | 712 | 1,130 |
| Health Insurance Premium & Cost Sharing Assist | 1,307 | 1,335 | 1,125 | 1,255 | 1,440 |
| Medical Case Management, inc. Treatment Adherence (includes Peer Support) | 8,496 | 8,116 | 7,378 | 7,842 | 8,085 |
| Medical Transportation Services | 638 | 720 | 94 | 645 | 743 |
| Mental Health Services | 327 | 274 | 95 | 121 | 107 |
| Oral Health Care | 3,381 | 3,170 | 1,711 | 2,237 | 2,577 |
| Other Professional Services - Legal Services | 76 | 66 | 48 | 44 | 103 |
| Outpatient/Ambulatory Health Services | 5,447 | 5,317 | 4,281 | 4,422 | 4,540 |
| Outreach Services | 624 | 472 | 130 | 116 | 158 |
| Substance Abuse Services Outpatient | 115 | 55 | 0 | 17 | 22 |
| Substance Abuse Services (Residential) | 169 | 95 | 70 | 66 | 72 |

# RWP Clients Served

## Sorted by Highest Usage

| SERVICE CATEGORIES | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|
| Medical Case Management, inc. Treatment Adherence (includes Peer Support) | 8,496 | 8,116 | 7,378 | 7,842 | 8,085 |
| Outpatient/Ambulatory Health Services | 5,447 | 5,317 | 4,281 | 4,422 | 4,540 |
| Oral Health Care | 3,381 | 3,170 | 1,711 | 2,237 | 2,577 |
| Health Insurance Premium & Cost Sharing Assist | 1,307 | 1,335 | 1,125 | 1,255 | 1,440 |
| Food Bank | 701 | 715 | 735 | 712 | 1,130 |
| Medical Transportation Services | 638 | 720 | 94 | 645 | 743 |
| Outreach Services | 624 | 472 | 130 | 116 | 158 |
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| Mental Health Services | 327 | 274 | 95 | 121 | 107 |
| Other Professional Services - Legal Services | 76 | 66 | 48 | 44 | 103 |
| Substance Abuse Services (Residential) | 169 | 95 | 70 | 66 | 72 |
| Substance Abuse Services Outpatient | 115 | 55 | 0 | 17 | 22 |
| Emergency Financial Assistance | N/A | N/A | N/A | N/A | N/A |

# RWP Expenditure

## Sorted Alphabetically

| SERVICE CATEGORIES | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|
| **CORE SERVICES** | | | | | |
| AIDS Pharmaceutical Assistance (Local) | $86,210 | $57,843 | $5,993 | $4,379 | $3,954 |
| Health Insurance Premium & Cost Sharing Assistance | $502,536 | $372,895 | $289,193 | $298,950 | $297,152 |
| Medical Case Management, inc. Treatment Adherence (includes Peer Support) | $5,308,840 | $5,776,806 | $5,283,942 | $5,744,512 | $6,031,337 |
| Mental Health Services | $133,790 | $135,505 | $90,019 | $60,239 | $64,577 |
| Oral Health Care | $2,841,838 | $3,547,495 | $1,645,879 | $2,533,062 | $3,273,644 |
| Outpatient/Ambulatory Health Services | $9,112,521 | $9,391,615 | $7,397,592 | $7,729,584 | $8,724,251 |
| Substance Abuse Services Outpatient | $55,390 | $23,970 | $23,556 | $1,356 | $4,971 |
| **SUPPORT SERVICES** | | | | | |
| Emergency Financial Assistance | N/A | N/A | N/A | N/A | N/A |
| Food Bank | $1,451,528 | $1,851,369 | $1,303,702 | $1,338,778 | $2,540,864 |
| Medical Transportation | $139,855 | $140,937 | $5,642 | $100,956 | $159,552 |
| Other Professional Services - Legal Services | $140,599 | $115,976 | $146,336 | $97,371 | $67,581 |
| Outreach Services | $307,380 | $332,602 | $148,155 | $140,761 | $151,423 |
| Substance Abuse Services (Residential) | $1,854,140 | $1,237,830 | $1,320,120 | $968,310 | $1,053,590 |

# RWP Expenditures

## Sorted by Highest Cost

| SERVICES CATEGORIES | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|---|---|
| **CORE SERVICES** | | | | | |
| Outpatient/Ambulatory Health Services | $9,112,521 | $9,391,615 | $7,397,592 | $7,729,584 | $8,724,251 |
| Medical Case Management, inc. Treatment Adherence (includes Peer Support) | $5,308,840 | $5,776,806 | $5,283,942 | $5,744,512 | $6,031,337 |
| Oral Health Care | $2,841,838 | $3,547,495 | $1,645,879 | $2,533,062 | $3,273,644 |
| Health Insurance Premium & Cost Sharing Assistance | $502,536 | $372,895 | $289,193 | $298,950 | $297,152 |
| Mental Health Services | $133,790 | $135,505 | $90,019 | $60,239 | $64,577 |
| AIDS Pharmaceutical Assistance (Local) | $86,210 | $57,843 | $5,993 | $4,379 | $3,954 |
| Substance Abuse Services Outpatient | $55,390 | $23,970 | $23,556 | $1,356 | $4,971 |
| **SUPPORT SERVICES** | | | | | |
| Food Bank | $1,451,528 | $1,851,369 | $1,303,702 | $1,338,778 | $2,540,864 |
| Substance Abuse Services (Residential) | $1,854,140 | $1,237,830 | $1,320,120 | $968,310 | $1,053,590 |
| Outreach Services | $307,380 | $332,602 | $148,155 | $140,761 | $151,423 |
| Medical Transportation | $139,855 | $140,937 | $5,642 | $100,956 | $159,552 |
| Other Professional Services - Legal Services | $140,599 | $115,976 | $146,336 | $97,371 | $67,581 |
| Emergency Financial Assistance | N/A | N/A | N/A | N/A | N/A |

# SERVICE UTILIZATION

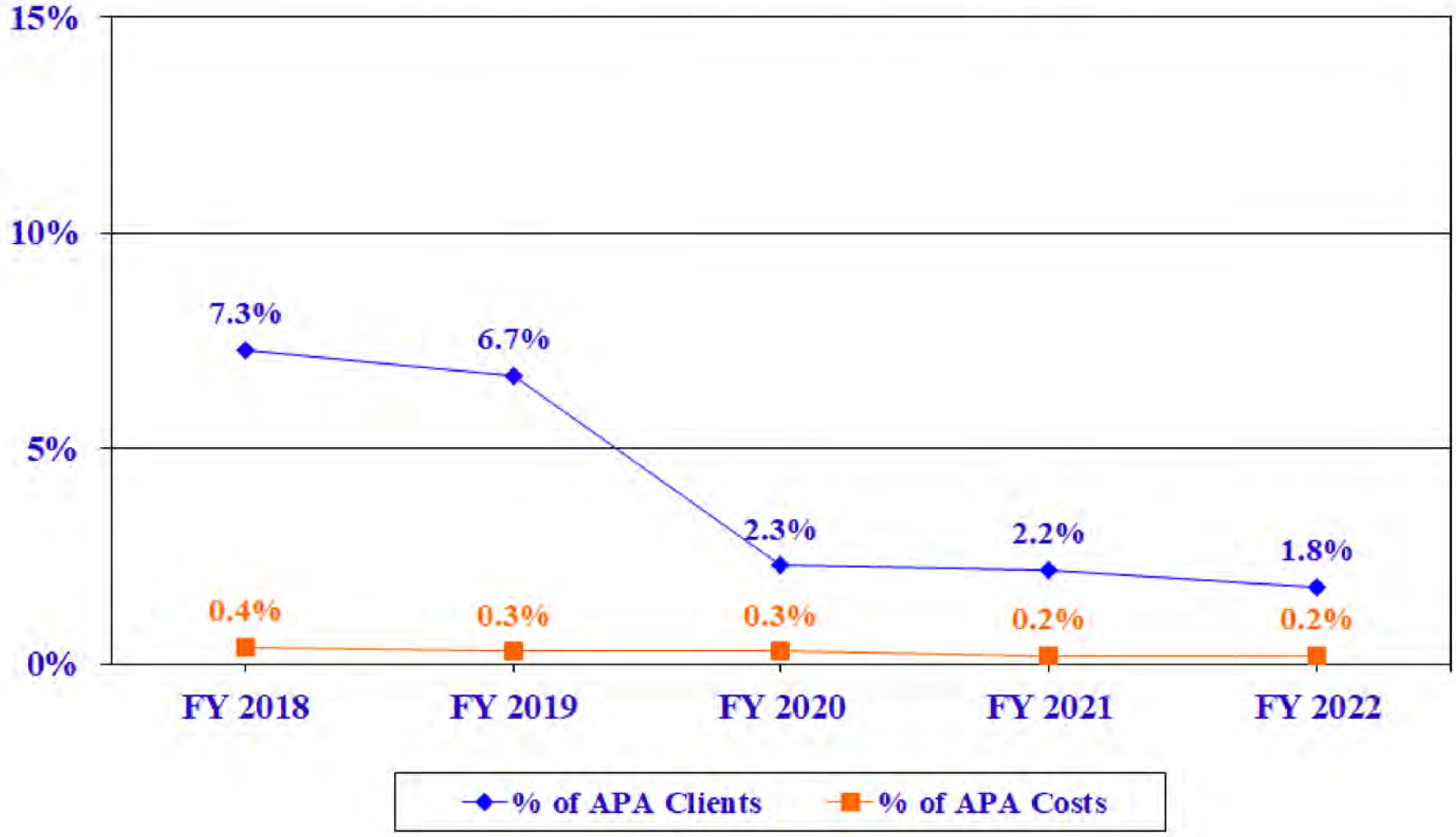
## SORTED ALPHABETICALLY

# AIDS PHARMACEUTICAL ASSISTANCE

# AIDS Pharmaceutical Assistance (APA)-the local pharmaceutical assistance program

- Since the expansion of the AIDS Drug Assistance Program (ADAP) formulary to include non-antiretroviral medications in 2017 and the continued expansion of the ADAP formulary, the utilization of the Ryan White Program AIDS Pharmaceutical Assistance program continues to be reduced.
- 156 clients received pharmaceuticals from Part A in FY 2022, the lowest usage in the last five years.
- Expenditures decreased to $3,954 (~10% less than FY 2021).
- Top medications dispensed:
  - Antibiotics, 45%
  - Psychiatric, 30%
  - Topicals, 15%
  - Colonoscopy Prep, 4%

# Percent of Clients Served and Percent Spent on AIDS Pharmaceutical Assistance (APA)



# AIDS Pharmaceutical Assistance (APA) by Gender and Ethnicity

| Gender and Ethnicity | % of Active Clients in Each Group Receiving APA | Percent of All RWP Clients in Each Group |
|---|---|---|
| Hispanic Male | 2.4% | 58.6% |
| Hispanic Female | 1.8% | 5.9% |
| Black Male | 1.4% | 12.6% |
| Black Female | 0.6% | 6.2% |
| Haitian Male | 0.3% | 4.5% |
| Haitian Female | 0.5% | 4.5% |
| White Male | 0.8% | 6.0% |
| White Female | 0.0% | 0.5% |
| Transgender | 1.9% | 1.2% |
| Total RWP | 1.9% | 100% |

# Emergency Financial Assistance

*No billing data were provided for this fiscal year.*

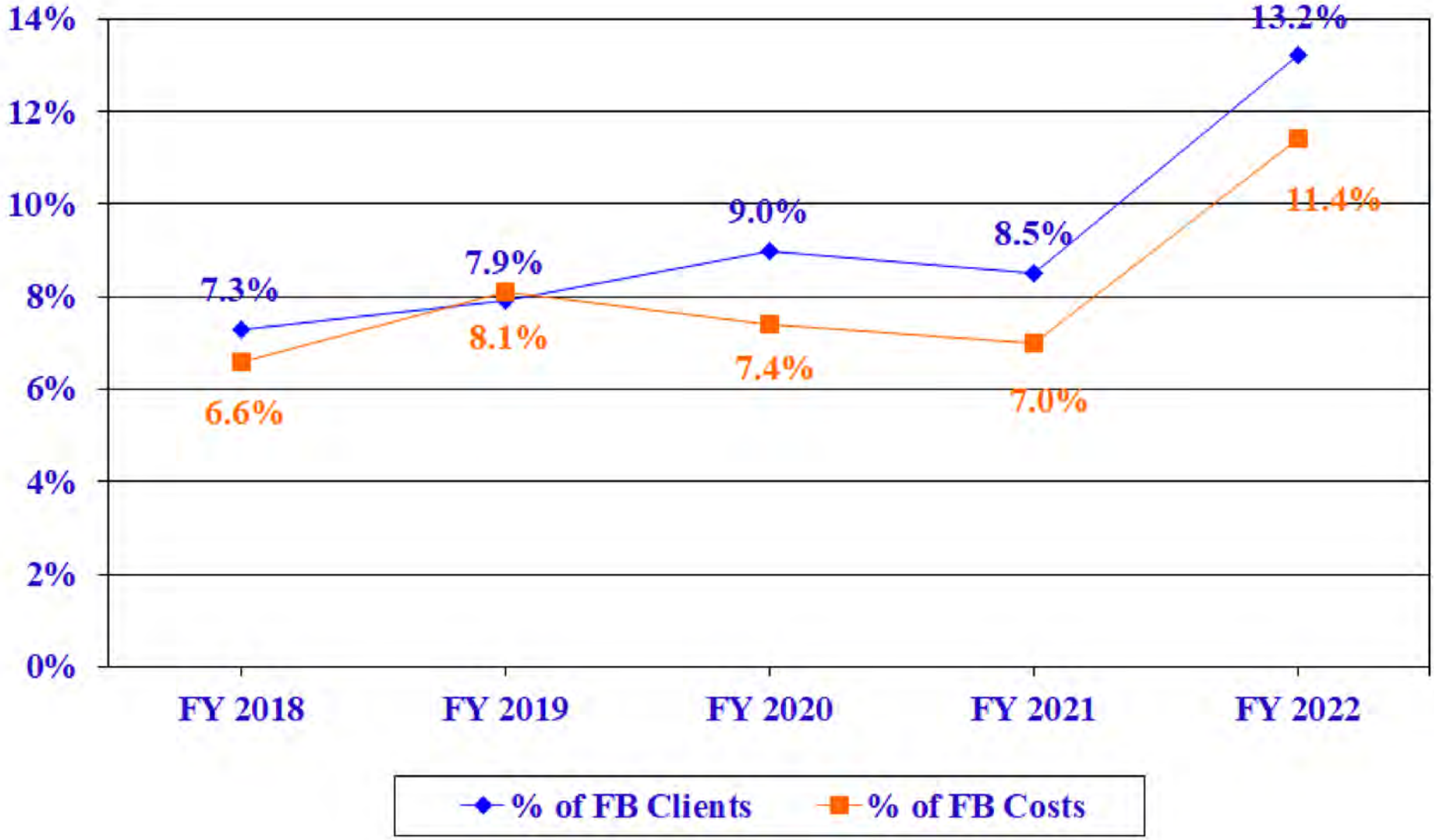
# FOOD BANK

# Food Bank (FB)

The dollars spent on the service has increased 90%, from $1.3 million in FY 2021 to over $2.5 million in FY 2022.

A total of 1,130 clients used the service in FY 2022, a 59% increase from FY 2021.

# Percent of Clients Served and Percent Spent on Food Bank (FB)



# Food Bank (FB) by Gender and Ethnicity

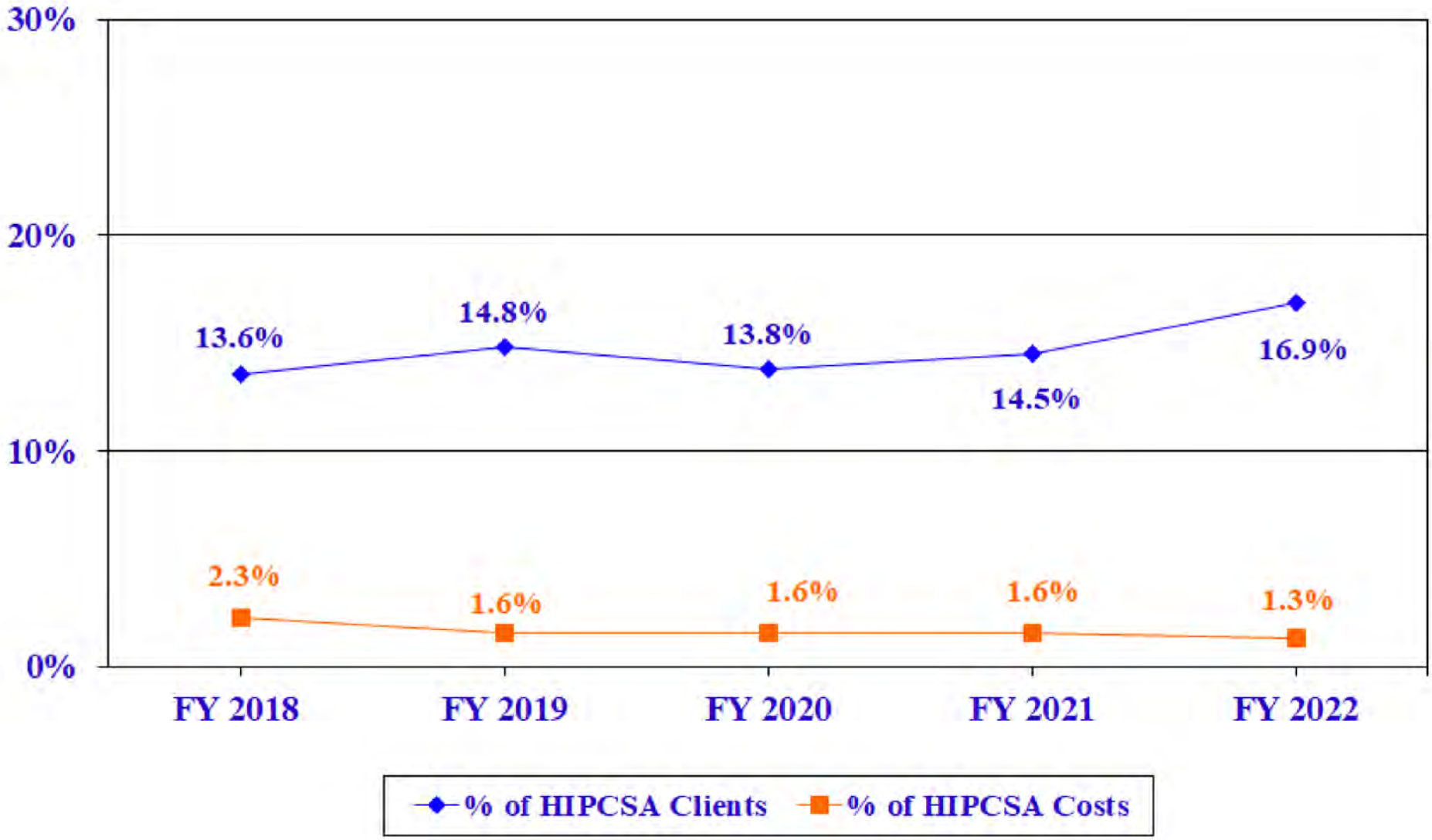
| Gender and Ethnicity | % of Active Clients in Each Group Receiving Food Bank Services | Percent of All RWP Clients in Each Group |
|---|---|---|
| Hispanic Male | 14.8% | 58.6% |
| Hispanic Female | 13.8% | 5.9% |
| Black Male | 10.5% | 12.6% |
| Black Female | 15.4% | 6.2% |
| Haitian Male | 6.5% | 4.5% |
| Haitian Female | 9.8% | 4.5% |
| White Male | 8.0% | 6.0% |
| White Female | 2.3% | 0.5% |
| Transgender | 17.5% | 1.2% |
| Total RWP | 13.2% | 100% |

# HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE FOR LOW-INCOME INDIVIDUALS

# Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals (HIPCSA)

- In 2018-19, AIDS Drug Assistance Program (ADAP) began assuming responsibility for Ryan White Program client's Affordable Care Act (ACA) marketplace insurance premium payments. This resulted in a drastic drop in the dollars spent in this service category. The Ryan White Program now covers wrap around services for ACA clients. This downward trend continued in FY 2022, with spending declining to $297,152.
- The number of Ryan White Program clients served remained relatively stable at over 1,000 (1,454) over the last five years. This was because the program continued to cover co-payments and deductibles for medication, office visits and lab/diagnostic tests.
- The most used service were ACA related co-payments, 78% of all services.

# Percent of Clients Served and Percent Spent on Health Insurance (HIPCSA)



# Health Insurance (HIPCSA) by Gender and Ethnicity

| Gender and Ethnicity | % of Active Clients in Each Group Receiving HIPCSA | Percent of All RWP Clients in Each Group |
|---|---|---|
| Hispanic Male | 20.6% | 58.6% |
| Hispanic Female | 13.4% | 5.9% |
| Black Male | 7.4% | 12.6% |
| Black Female | 9.4% | 6.2% |
| Haitian Male | 7.0% | 4.5% |
| Haitian Female | 12.9% | 4.5% |
| White Male | 23.5% | 6.0% |
| White Female | 4.7% | 0.5% |
| Transgender | 8.7% | 1.2% |
| Total RWP | 16.8% | 100% |

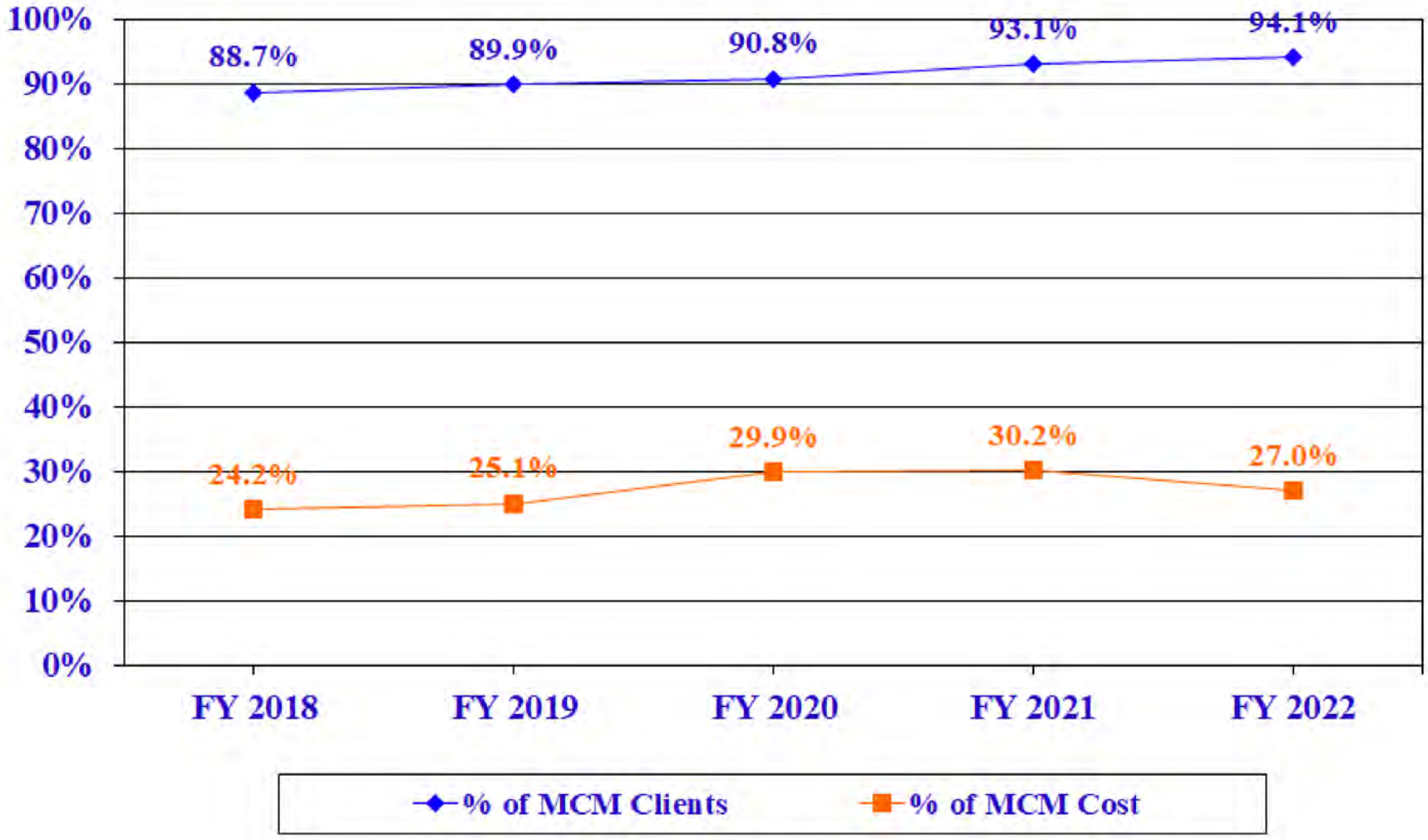
# MEDICAL CASE MANAGMENT INCLUDING TREATMENT ADHERENCE SERVICES [INCLUDES PEER EDUCATION AND SUPPORT NETWORK]

# Medical Case Management (MCM) Including Treatment Adherence Services [includes Peer Support Network Services (PESN)]

- Of the 8,590 clients in RWP care in FY 2022, 94% received MCM services in FY 2022. This represents a 2% increase over the number served in FY 2021.
- In FY 2022, 27% of all direct services expenditures (~$6 million) were spent on MCM.
- The most frequently billed services:

| MCM | | PESN | |
|---|---|---|---|
| 28% | Documentation | 38% | Documentation |
| 21% | Plan of Care | 10% | Collateral |
| 19% | Adherence | 19% | Telephone Encounter |
| 15% | Telephone | 22% | Adherence |
| 5% | ACA Consult | 10% | Face to Face Encounter |

# Percent of Clients Served and Percent Spent on Medical Case Management (MCM)



# Medical Case Management (MCM) by Gender and Ethnicity

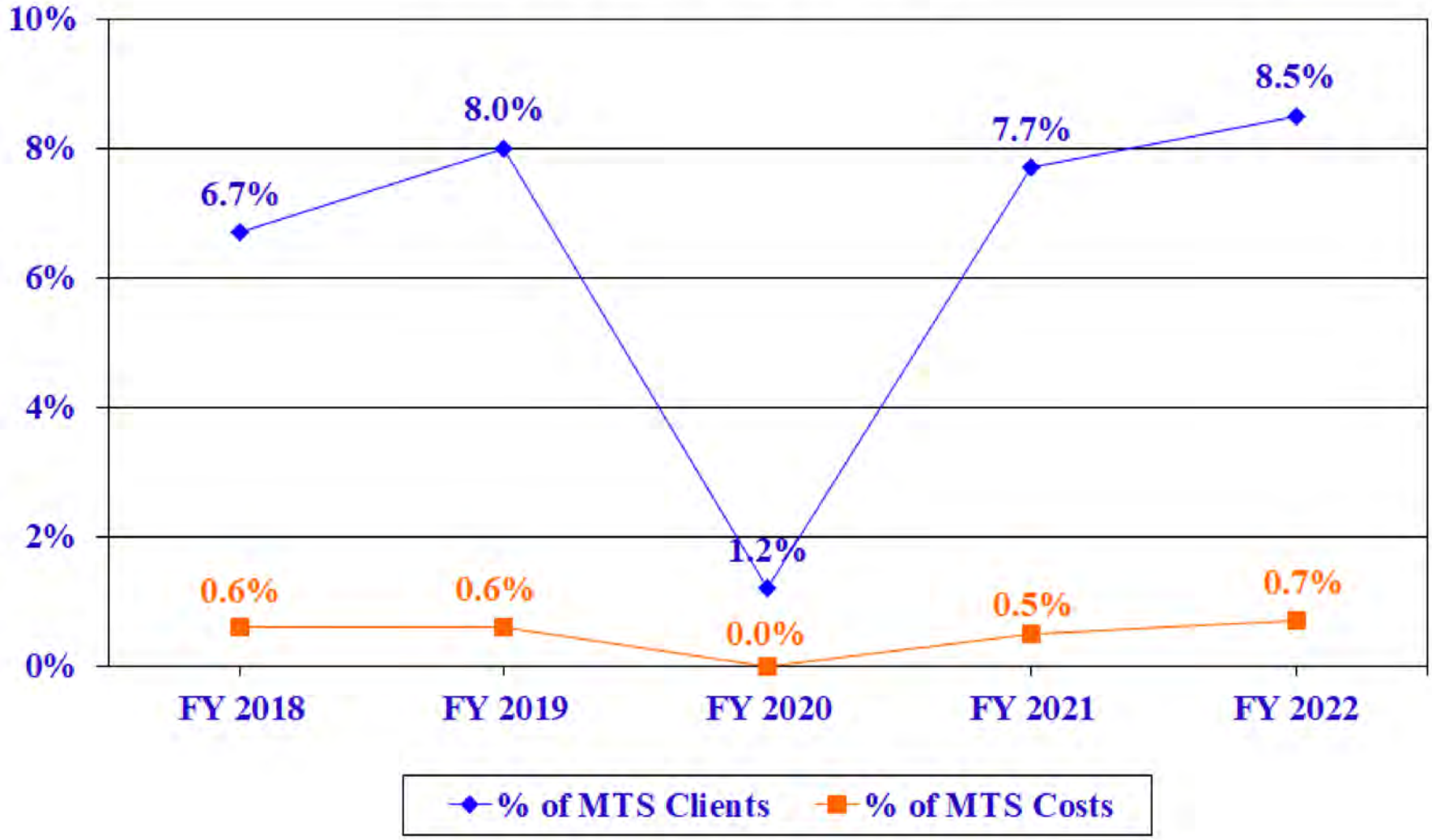
| Gender and Ethnicity | % of Active Clients in Each Ethnic/Gender Group Receiving MCM | Percent of All RWP Clients in Each Group |
|---|---|---|
| Hispanic Male | 95.2% | 58.6% |
| Hispanic Female | 92.4% | 5.9% |
| Black Male | 91.3% | 12.6% |
| Black Female | 87.6% | 6.2% |
| Haitian Male | 96.1% | 4.5% |
| Haitian Female | 94.8% | 4.5% |
| White Male | 95.5% | 6.0% |
| White Female | 90.7% | 0.5% |
| Transgender | 93.2% | 1.2% |
| Total RWP | 94.1% | 100% |

# MEDICAL TRANSPORTATION SERVICES

# Medical Transportation Services (MTS)

- Utilization of Ryan White Program dollars for this service category has been increasing since FY 2021. FY 2022 expenditures are 56% higher than FY 2021 and are the highest in five years.
- EASY monthly pass accounted for 23% of the service, and ride shares (Uber/Lyft) accounted for 73%.

# Percent of Clients Served and Percent Spent on Medical Transportation Services (MTS)



# Medical Transportation Services (MTS) by Gender and Ethnicity

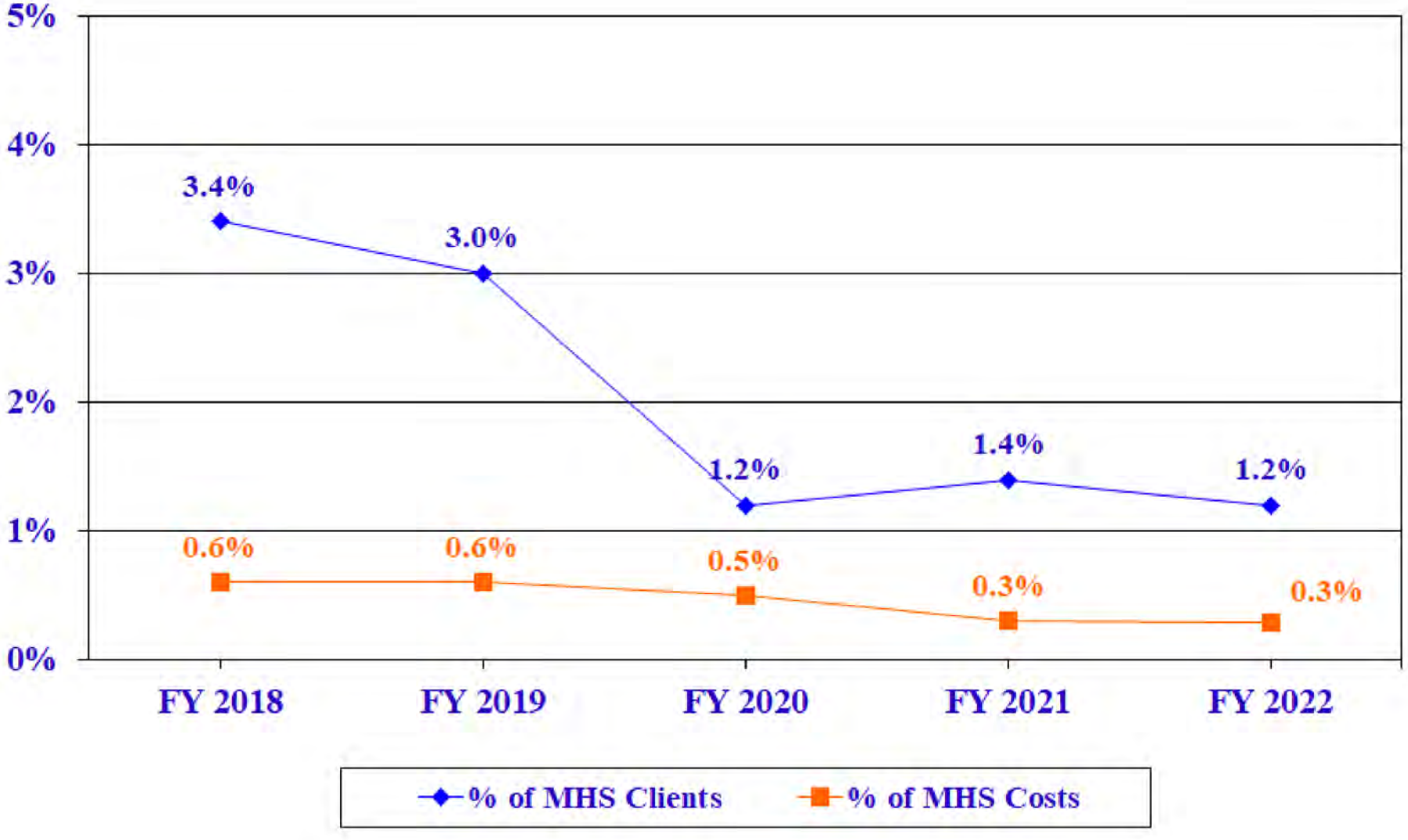
| Gender and Ethnicity | % of Active Clients in Each Group Receiving Medical Transport | Percent of All RWP Clients in Each Group |
|---|---|---|
| Hispanic Male | 8.8% | 58.6% |
| Hispanic Female | 9.8% | 5.9% |
| Black Male | 9.1% | 12.6% |
| Black Female | 7.3% | 6.2% |
| Haitian Male | 7.5% | 4.5% |
| Haitian Female | 9.6% | 4.5% |
| White Male | 6.7% | 6.0% |
| White Female | 4.7% | 0.5% |
| Transgender | 10.7% | 1.2% |
| Total RWP | 8.7% | 100% |

# MENTAL HEALTH SERVICES

# Mental Health Services (MHS)

- The number of clients receiving MHS continued its decline since FY 2016.
  - 101 MHS clients were served in FY 2022, a 69% decline from FY 2018 (327 clients)
- MHS expenditures as a percentage of all RWP expenditures slightly dropped to 0.3% (lowest levels in over 5 years).
- Service provided breakdown:
  - Tele-Mental Health Individual Level II – 54%
  - Mental Health Individual Level II – 36%
  - Tele-Mental Health Individual Level I – 7%
  - Mental Health Individual Level I– 3%

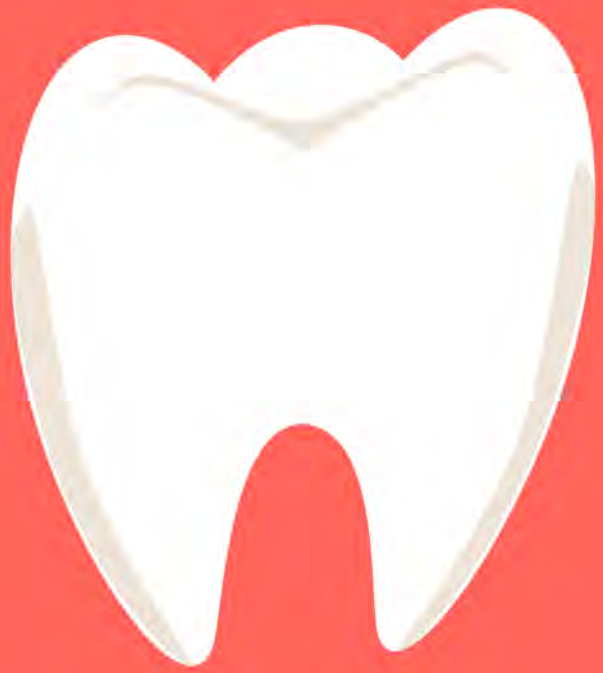
# Percent of Clients Served and Percent Spent on Mental Health Services (MHS)



# Mental Health Services (MHS) by Gender and Ethnicity

| Gender and Ethnicity | % of Active Clients in Each Group Receiving Mental Health Serv. | Percent of All RWP Clients in Each Group |
|---|---|---|
| Hispanic Male | 1.2% | 58.6% |
| Hispanic Female | 1.6% | 5.9% |
| Black Male | 1.4% | 12.6% |
| Black Female | 1.7% | 6.2% |
| Haitian Male | 1.0% | 4.5% |
| Haitian Female | 0.5% | 4.5% |
| White Male | 1.0% | 6.0% |
| White Female | 2.3% | 0.5% |
| Transgender | 1.0% | 1.2% |
| Total RWP | 1.2% | 100% |

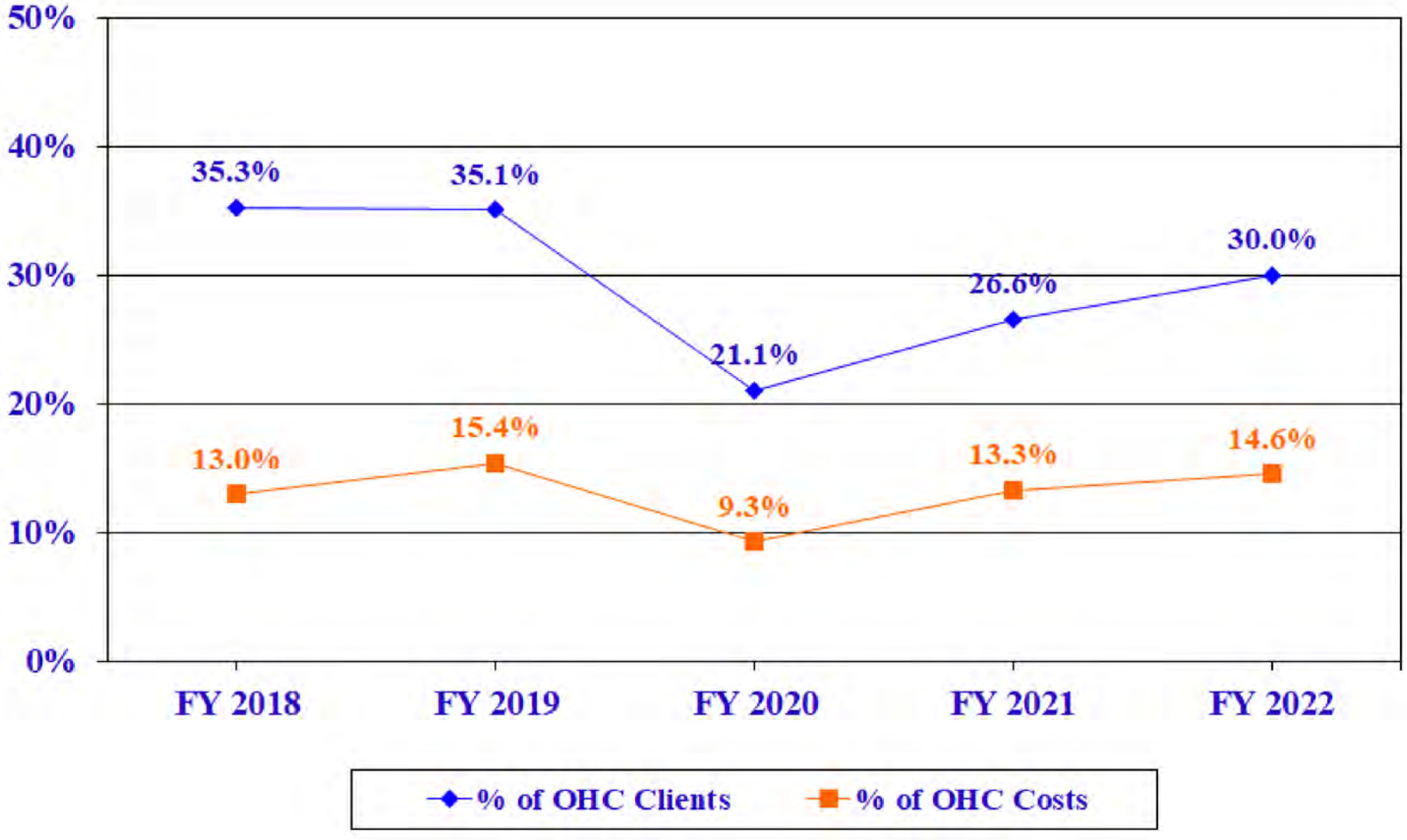
# ORAL HEALTH CARE



# Oral Health Care (OHC)

- Utilization of OHC services dropped dramatically in FY 2020, but has been steadily climbing. FY 2022 expenditures are a 29% increase from FY 2021 and mark the highest expenditure in last five years.
- Expenditures rose to over $3.2 million, which accounted for ~15% of all Ryan White Program expenditures and 30% of all clients in Ryan White.
- Top dental services used were:
  - Panoramic Film, 7%
  - Prophylaxis – Adult Age 12+, 6%
  - Periodontal Scaling and Root Planing – Four or More Per Quadrant, 6%
  - Resin-Based Composite – One Surface, Posterior, 6%
  - Oral Hygiene Instructions, 6%

# Percent of Clients Served and Percent Spent on Oral Health Care (OHC)



# Oral Health Care (OHC) by Gender and Ethnicity

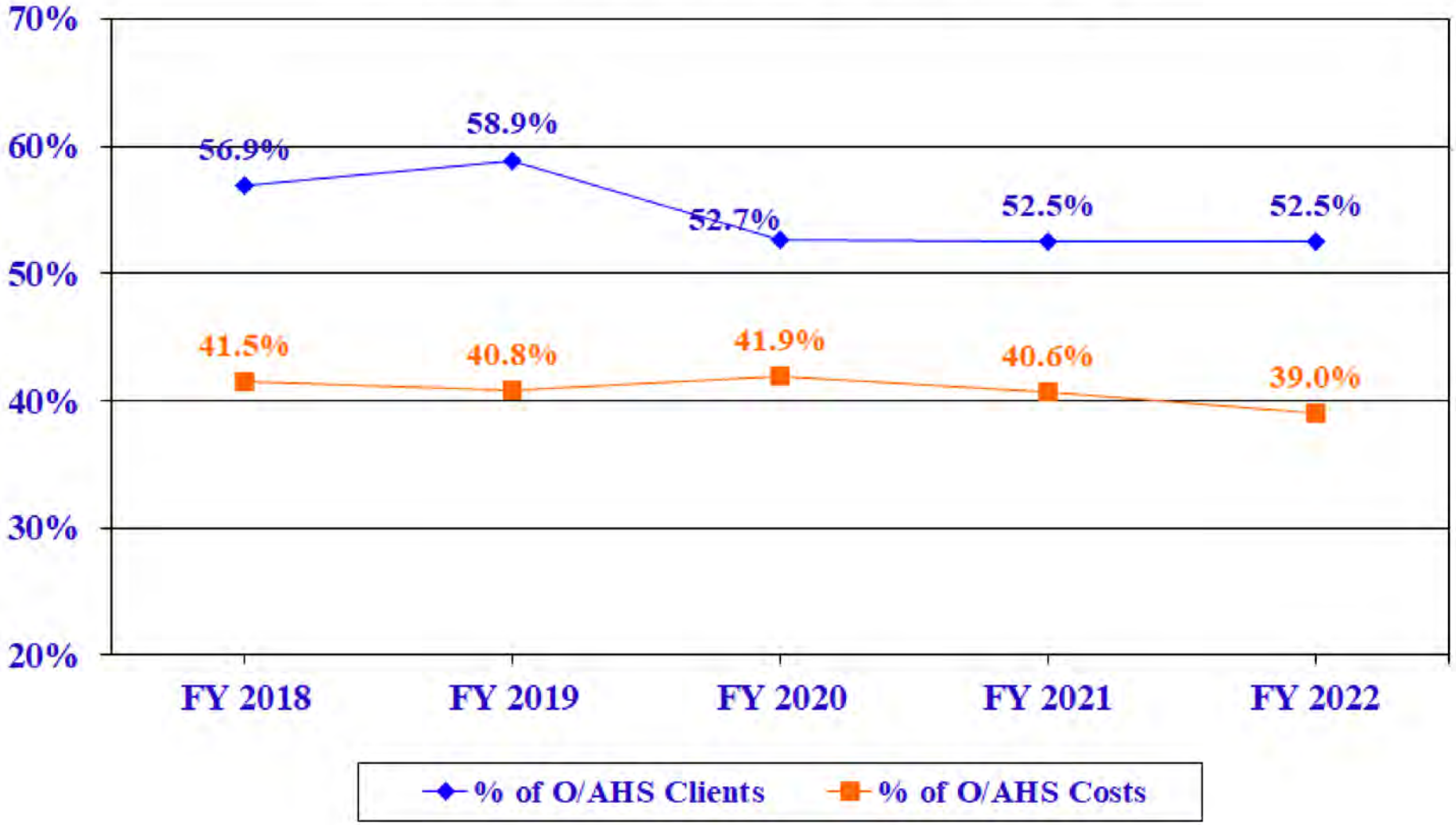
| Gender and Ethnicity | % of Active Clients in Each Ethnic/Gender Group Receiving OHC | Percent of All RWP Clients in Each Group |
|---|---|---|
| Hispanic Male | 32.8% | 58.6% |
| Hispanic Female | 33.8% | 5.9% |
| Black Male | 22.7% | 12.6% |
| Black Female | 25.4% | 6.2% |
| Haitian Male | 25.7% | 4.5% |
| Haitian Female | 23.8% | 4.5% |
| White Male | 30.0% | 6.0% |
| White Female | 27.9% | 0.5% |
| Transgender | 23.3% | 1.2% |
| Total RWP | 30.1% | 100% |

# OUTPATIENT AMBULATORY HEALTH CARE

# Outpatient Ambulatory Health Services (O/AHS)

- Thirty-nine percent of direct service expenditures were spent on O/AHS – over $8.7 million – 12.8 % more than FY 2021 but still less than FY YR 2018 and FY 2019.
- Nearly 53% of all clients (4,506 clients) used O/AHS which is similar to last fiscal year.
- Top six most used services are:
  - Office Outpatient Visit 25 Minutes, 6%
  - Chlamydia Trachomatis Amplified Probe TQ, 6%
  - Neisseria Gonorrhoeae Amplified Probe TQ, 5%
  - HIV-1 Quant & Reverse Transcription, 5%
  - Comprehensive Metabolic Panel, 5%
  - Syphilis Test Non-Treponemal Antibody Qual, 4%

# Percent of Clients Served and Percent Spent on Outpatient Ambulatory Health Care (O/AHS)



# Outpatient Ambulatory Health Service (O/AHS) by Gender and Ethnicity

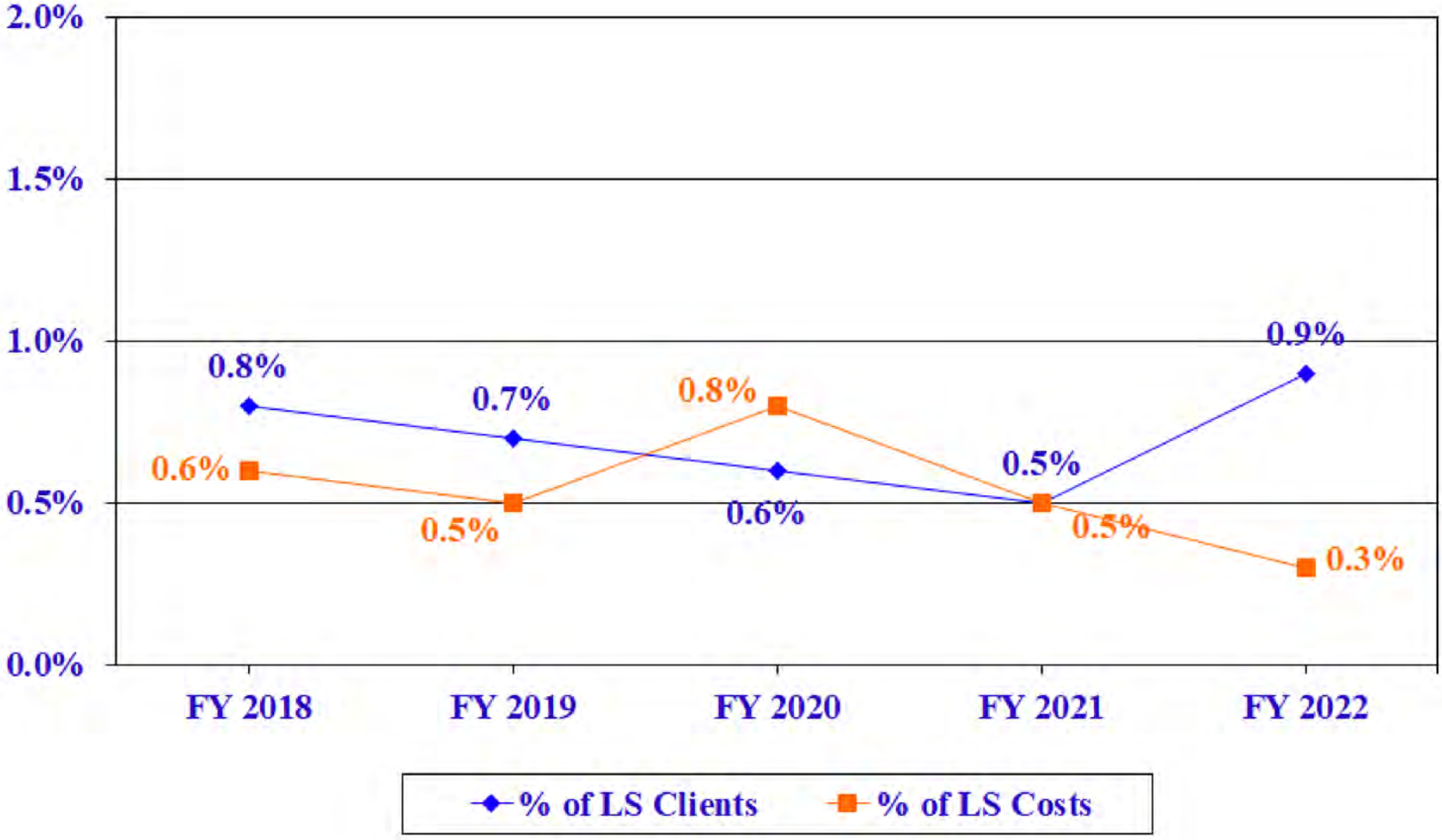
| Gender and Ethnicity | % of Active Clients in Each Ethnic/Gender Group Receiving O/AHS | Percent of All RWP Clients in Each Group |
|---|---|---|
| Hispanic Male | 51.9% | 58.6% |
| Hispanic Female | 62.0% | 5.9% |
| Black Male | 59.2% | 12.6% |
| Black Female | 43.3% | 6.2% |
| Haitian Male | 53.5% | 4.5% |
| Haitian Female | 50.4% | 4.5% |
| White Male | 45.9% | 6.0% |
| White Female | 46.5% | 0.5% |
| Transgender | 75.7% | 1.2% |
| Total RWP | 52.8% | 100% |

# OTHER PROFESSIONAL SERVICES-PERMANENCY PLANNING AND LEGAL SERVICES

# Other Professional Services-Permanency Planning and Legal Services (LS)

- The number of clients utilizing legal services has risen in FY 2022 (78), a 77% increase from FY 2021 (44).
- The total expenditures are the lowest in the past five years $67,581 (30.5% decrease) from FY 2021.
- The service is most used to access government benefits, 94%.

# Percent of Clients Served and Percent Spent on Other Professional-Legal Services (LS)



# Other Professional-Legal Services (LS) by Gender and Ethnicity

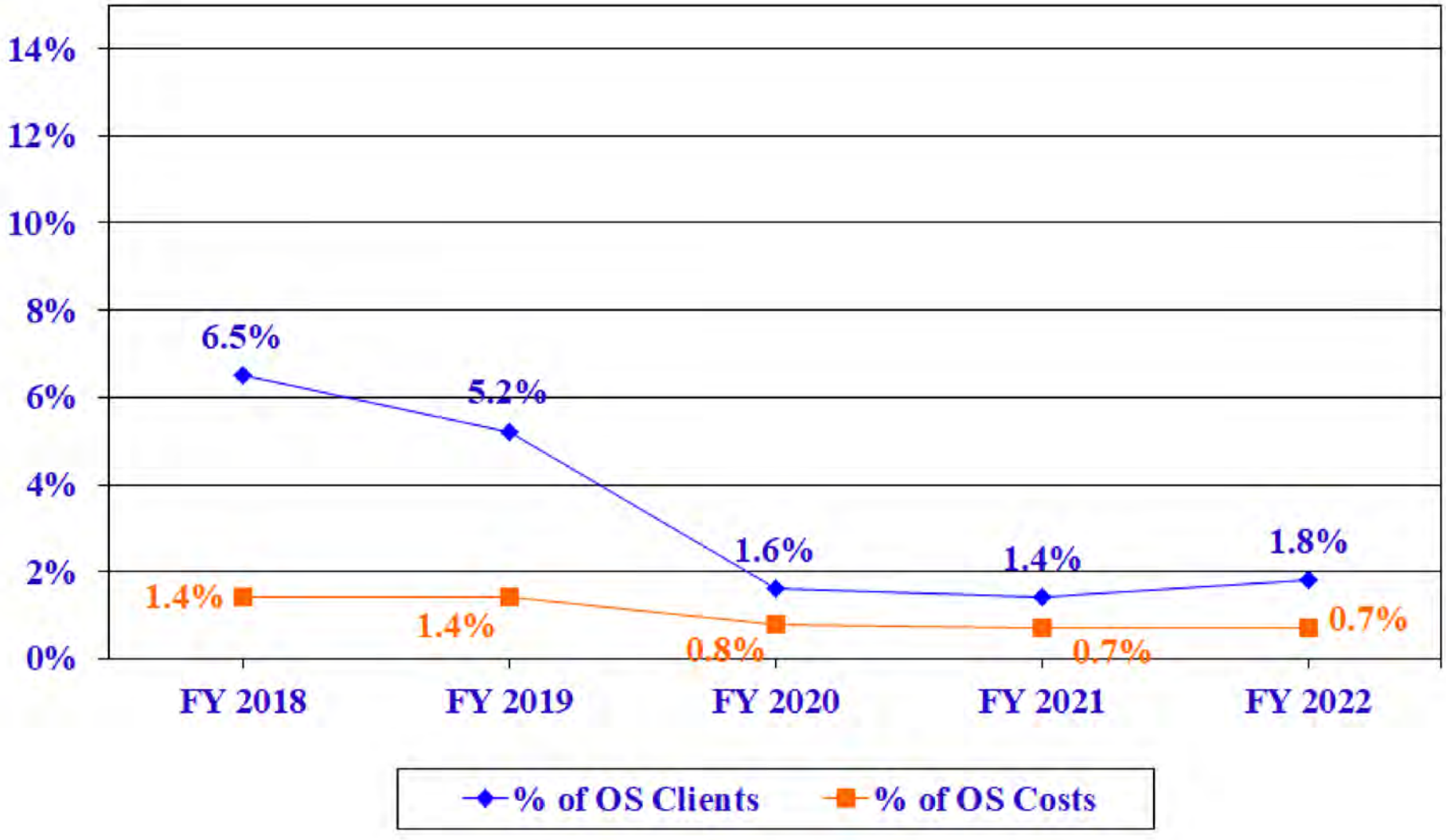
| Gender and Ethnicity | % of Active Clients in Each Group Receiving Other Prof. Services | Percent of All RWP Clients in Each Group |
|---|---|---|
| Hispanic Male | 1.1% | 58.6% |
| Hispanic Female | 0.6% | 5.9% |
| Black Male | 1.9% | 12.6% |
| Black Female | 0.9% | 6.2% |
| Haitian Male | 0.8% | 4.5% |
| Haitian Female | 0.3% | 4.5% |
| White Male | 1.6% | 6.0% |
| White Female | 2.3% | 0.5% |
| Transgender | 6.8% | 1.2% |
| Total RWP | 1.2% | 100% |

# OUTREACH

# Outreach Services (OS)

- The number of clients reached by outreach continues to be less than 200 clients (155), with FY 2022 serving 33.6% more than FY 2021 (116). This is a 75 % decline from the 624 clients served in FY 2018.
- The service billed mostly documentation encounters, 40%, followed by telephone encounters, 32%.

# Percent of Clients Served and Percent Spent on Outreach Services (OS)



# Outreach Services (OS) by Gender and Ethnicity

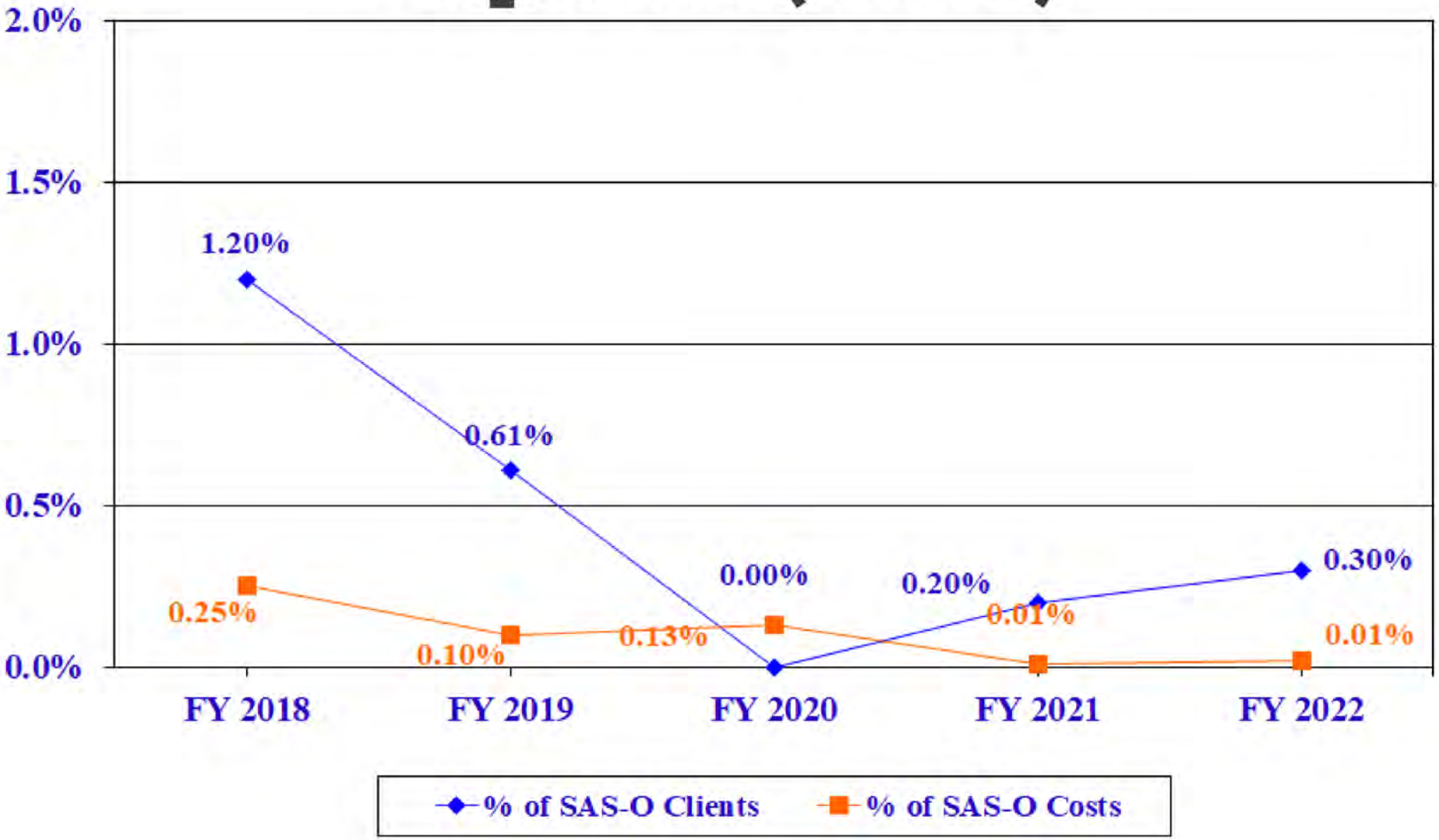
| Gender and Ethnicity | % of Active Clients in Each Group Receiving Outreach Services | Percent of All RWP Clients in Each Group |
|---|---|---|
| Hispanic Male | 1.6% | 58.6% |
| Hispanic Female | 1.8% | 5.9% |
| Black Male | 2.5% | 12.6% |
| Black Female | 1.7% | 6.2% |
| Haitian Male | 0.8% | 4.5% |
| Haitian Female | 2.3% | 4.5% |
| White Male | 1.6% | 6.0% |
| White Female | 4.7% | 0.5% |
| Transgender | 3.9% | 1.2% |
| Total RWP | 1.8% | 100% |

# SUBSTANCE ABUSE SERVICES-OUTPATIENT

# Substance Abuse Services-Outpatient (SAS-O)

- Utilization of this service continues to decline with continued low expenditures ($4,401) and number of clients (22) in FY 2022.
- From FY 2018, expenditures have decreased 92% and clients served have decreased 80.8%.

# Percent of Clients Served and Percent Spent on Substance Abuse Services-Oupatient (SAS-O)



# Substance Abuse Services-Outpatient (SAS-O) by Gender and Ethnicity

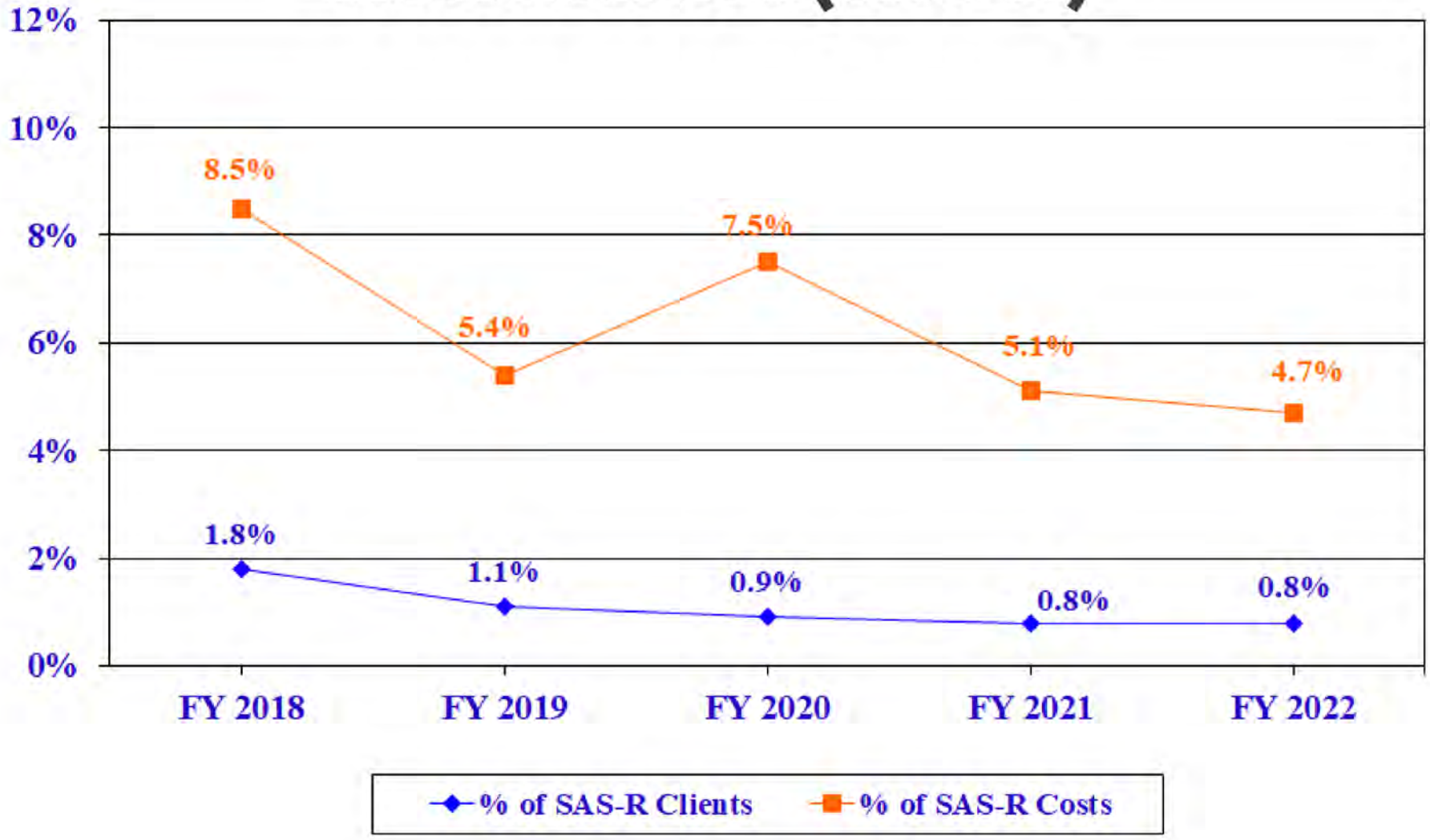
| Gender and Ethnicity | % of Active Clients in Each Group Receiving SAS (Outpatient) | Percent of All RWP Clients in Each Group |
|---|---|---|
| Hispanic Male | 0.3% | 58.6% |
| Hispanic Female | 0.0% | 5.9% |
| Black Male | 0.1% | 12.6% |
| Black Female | 0.0% | 6.2% |
| Haitian Male | 0.0% | 4.5% |
| Haitian Female | 0.0% | 4.5% |
| White Male | 0.6% | 6.0% |
| White Female | 0.0% | 0.5% |
| Transgender | 0.0% | 1.2% |
| Total RWP | 0.3% | 100% |

# SUBSTANCE ABUSE SERVICES-RESIDENTIAL

# Substance Abuse Services -Residential (SAS-R)

- The number of clients receiving SAS-R continues to steadily decline since FY 2017, dropping 57% between FY 2018 (169 clients) and FY 2022 (72 clients).
- The dollars spent in FY 2022 are a little over $1 million, 8.8% increase from FY 2021.

# Percent of Clients Served and Percent Spent on Substance Abuse Services-Residential (SAS-R)



# Sustance Abuse Services -Residential (SAS-R) by Gender and Ethnicity

| Gender and Ethnicity | % of Active Clients in Each Group Receiving SAS (Residential) | Percent of All RWP Clients in Each Group |
|---|---|---|
| Hispanic Male | 0.5% | 58.6% |
| Hispanic Female | 0.4% | 5.9% |
| Black Male | 2.3% | 12.6% |
| Black Female | 1.1% | 6.2% |
| Haitian Male | 0.8% | 4.5% |
| Haitian Female | 0.0% | 4.5% |
| White Male | 1.4% | 6.0% |
| White Female | 0.0% | 0.5% |
| Transgender | 2.9% | 1.2% |
| Total RWP | 0.8% | 100% |

# THANK YOU!

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MIAMI-DADE HIV/AIDS PARTNERSHIP

MIAMI-DADE COUNTY

# THANK YOU!

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MIAMI-DADE HIV/AIDS PARTNERSHIP

MIAMI-DADE COUNTY

# OTHER FUNDING AND SERVICES

# SECTION 6

# OTHER HIV-SPECIFIC FUNDING SOURCES

Presented July 13, 2023

DEFINITION

# HOWS AND WHYS?

Every year, BSR disseminates a survey to explore the different funding sources that support care to persons with HIV in Miami-Dade County.

These sources include Ryan White Program Parts B, C, and D; other providers who have additional resources directed toward people with HIV; and the Medicaid program.

The survey quantifies the number of HIV+ clients provided specific services during the recently completed fiscal year, as well as the expenditures for these services.

The data used for this analysis are derived from this survey. Please note clients maybe duplicated across funding sources and services provided.

# REPRESENTED BY FIVE RYAN WHITE PROGRAM PARTS (A-F):

- **Part A** Core and support services provided through the Eligible Metropolitan Area (EMA)
- **Part B** Services provided through states/territories and AIDS Drug Assistance Program (ADAP)
- **Part C** Community-Based Early Intervention Services
- **Part D** Women, Infants, Children, and Youth (WICY)
- **Part F** Dental Programs, AIDS Education and Training Centers (AETC), Special Projects of National Significance (SPNS) projects

# HOW DATA IS PRESENTED?

The summary table is one double-sided page and list the services, totals expended and age/gender of clients. The age/gender categories are derived from the breakdown of the women, infants, children and youth report data. See slide that follows for reference.

These data are also included at the bottom of the dashboard cards, and are sorted by service categories.

# MEDICAID

The following two slides and two tables included in your materials provide details on the Medicaid program's total number of HIV/AIDS clients served, including expenditures, and demographics.

Demographics include race/ethnicity, gender, and age.

Due to changes in Medicaid reporting, a new label of "other" is being used for categories with items less than 15.

Data from the Medicaid program is also included at the bottom of the dashboard cards.

# MEDICAID HIV/AIDS CLIENTS
# FY 2019-20 THROUGH FY 2021-22

**Total Medicaid HIV/AIDS Clients**

| | FY 2019-2020 | | | | | | FY 2020-2021 | | | | | | FY 2021-2022 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Male | % | Female | % | Total | % | Male | % | Female | % | Total | % | Male | % | Female | % | Total | % |
| Black/African American | 1,581 | 36.98% | 2,067 | 59.04% | 3,648 | 46.87% | 1,666 | 36.38% | 2,163 | 56.65% | 3,829 | 45.55% | 1,778 | 38.83% | 2,405 | 62.99% | 4,183 | 44.30% |
| Hispanic | 1,478 | 34.57% | 645 | 18.42% | 2,123 | 27.28% | 1,520 | 33.20% | 769 | 20.14% | 2,289 | 27.23% | 1,793 | 39.16% | 959 | 25.12% | 2,752 | 29.14% |
| Not Determined | 870 | 20.35% | 600 | 17.14% | 1,470 | 18.89% | 1,044 | 22.80% | 662 | 17.34% | 1,706 | 20.29% | 1,125 | 24.57% | 718 | 18.81% | 1,843 | 19.52% |
| Other | 50 | 1.17% | 51 | 1.46% | 101 | 1.30% | 53 | 1.16% | 67 | 1.75% | 120 | 1.43% | 99 | 2.16% | 84 | 2.20% | 183 | 1.94% |
| Other (*less than 15 count) | | 0.00% | | 0.00% | 7 | 0.09% | | 0.00% | | 0.00% | 10 | 0.12% | | 0.00% | | 0.00% | 11 | 0.12% |
| White | 296 | 6.92% | 138 | 3.94% | 434 | 5.58% | 296 | 6.46% | 157 | 4.11% | 453 | 5.39% | 309 | 6.75% | 162 | 4.24% | 471 | 4.99% |
| TOTAL | 4,275 | 54.93% | 3,501 | 44.98% | 7,783 | 100.00% | 4,579 | 54.47% | 3,818 | 45.41% | 8,407 | 100.00% | 5,104 | 54.05% | 4,328 | 45.83% | 9,443 | 100.00% |

**Medicaid HIV/AIDS Clients 18-64 years older**

| | FY 2019-2020 | | | | | | FY 2020-2021 | | | | | | FY 2021-2022 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Male | % | Female | % | Total | % | Male | % | Female | % | Total | % | Male | % | Female | % | Total | % |
| Black/African American | 1,464 | 35.79% | 1,951 | 59.09% | 3,415 | 46.15% | 1,542 | 35.21% | 2,044 | 56.57% | 3,586 | 44.81% | 1,644 | 37.54% | 2,269 | 62.80% | 3,913 | 43.44% |
| Hispanic | 1,449 | 35.43% | 603 | 18.26% | 2,052 | 27.73% | 1,486 | 33.93% | 725 | 20.07% | 2,211 | 27.63% | 1,755 | 40.08% | 913 | 25.27% | 2,668 | 29.62% |
| Not Determined | 841 | 20.56% | 577 | 17.47% | 1,418 | 19.16% | 1,015 | 23.18% | 637 | 17.63% | 1,652 | 20.64% | 1,097 | 25.05% | 695 | 19.24% | 1,792 | 19.90% |
| Other | 46 | 1.12% | 42 | 1.27% | 88 | 1.19% | 46 | 1.05% | 56 | 1.55% | 102 | 1.27% | 93 | 2.12% | 72 | 1.99% | 165 | 1.83% |
| Other * (counts less than 15) | | 0.00% | | 0.00% | 7 | 0.09% | | 0.00% | | 0.00% | 10 | 0.12% | | 0.00% | | 0.00% | 11 | 0.12% |
| White | 290 | 7.09% | 129 | 3.91% | 419 | 5.66% | 290 | 6.62% | 151 | 4.18% | 441 | 5.51% | 303 | 6.92% | 155 | 4.29% | 458 | 5.08% |
| TOTAL | 4,090 | 55.28% | 3,302 | 44.63% | 7,399 | 100.00% | 4,379 | 54.72% | 3,613 | 45.15% | 8,002 | 100.00% | 4,892 | 54.31% | 4,104 | 45.56% | 9,007 | 100.00% |

**Medicaid HIV/AIDS Clients less than 18 year old**

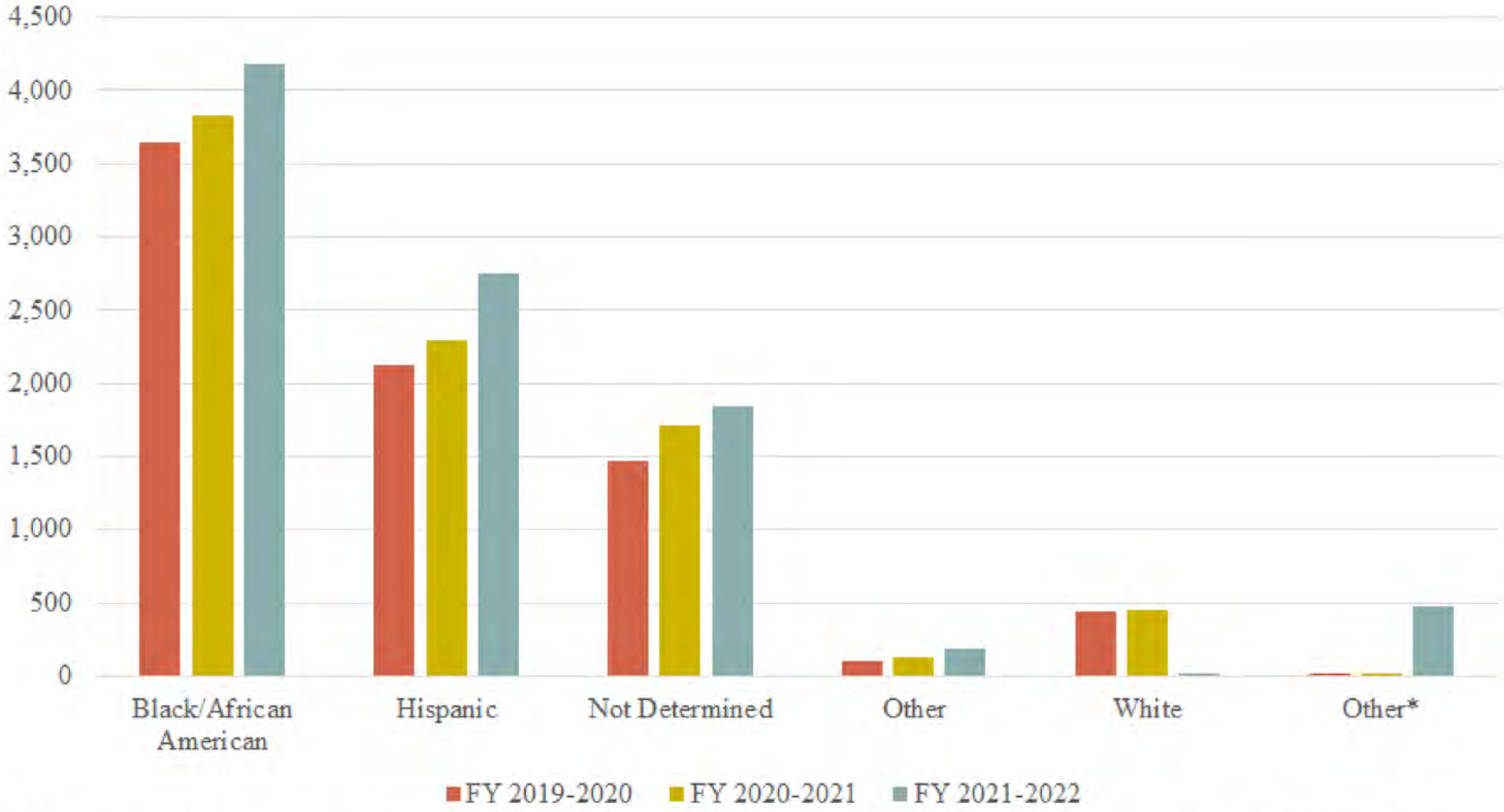
| | FY 2019-2020 | | | | | | FY 2020-2021 | | | | | | FY 2021-2022 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Male | % | Female | % | Total | % | Male | % | Female | % | Total | % | Male | % | Female | % | Total | % |
| Black/African American | 117 | 66.86% | 116 | 70.30% | 233 | 60.68% | 124 | 66.31% | 119 | 59.80% | 243 | 60.00% | 134 | 71.66% | 136 | 68.34% | 270 | 61.93% |
| Hispanic | 29 | 16.57% | 42 | 25.45% | 71 | 18.49% | 34 | 18.18% | 44 | 22.11% | 78 | 19.26% | 38 | 20.32% | 46 | 23.12% | 84 | 19.27% |
| Not Determined | 29 | 16.57% | 23 | 13.94% | 52 | 13.54% | 29 | 15.51% | 25 | 12.56% | 54 | 13.33% | 28 | 14.97% | 23 | 11.56% | 51 | 11.70% |
| Other | | 0.00% | | 0.00% | 0 | 0.00% | | 0.00% | 11 | 5.53% | 11 | 2.72% | | 0.00% | | 0.00% | | 0.00% |
| Other (*less than 15 count) | | 0.00% | | 0.00% | 28 | 7.29% | | 0.00% | | 0.00% | 19 | 4.69% | | 0.00% | | 0.00% | 31 | 7.11% |
| White | | 0.00% | | 0.00% | 0 | 0.00% | | 0.00% | | 0.00% | | 0.00% | | 0.00% | | 0.00% | | 0.00% |
| TOTAL | 175 | 45.57% | 181 | 47.14% | 384 | 100.00% | 187 | 46.17% | 199 | 49.14% | 405 | 100.00% | 200 | 45.87% | 205 | 47.02% | 436 | 100.00% |

| | | | |
|---|---|---|---|
| TOTAL MEDICAID CLIENTS | 7,783 | 8,407 | 9,443 |

# MEDICAID HIV/AIDS CLIENTS BY GENDER
# FY 2019-20 THROUGH FY 2021-22


Note: There are slightly more men (54.05%) in the Medicaid program.

# MEDICAID HIV/AIDS CLIENTS BY DEMOGRAPHICS FY 2019-20 THROUGH FY 2021-22




Note: The program serves more Black/African Americans (44.30%) than any other race.

# MEDICAID DATA

Miami-Dade Medicaid Expenditures
FY 2021-2022

| Bucket | Service | Recipients | Amount |
|---|---|---|---|
| 01 | HOSPITAL INPATIENT SERV | 1,096 | $12,661,882.55 |
| 02 | HOSPITAL INSURANCE BENE | 340 | $599,172.66 |
| 03 | HOSPITAL OUTPATIENT SER | 3,537 | $4,720,221.59 |
| 04 | HOSPITAL OUTPATIENT XOV | 1,100 | $609,971.01 |
| 05 | SKILLED NURSING XOVER | | |
| 06 | SKILLED NURSING CARE | 118 | $4,694,361.55 |
| 07 | INTERMEDIATE CARE | 43 | $1,994,082.48 |
| 08 | GENERAL CARE | | |
| 12 | PHYSICIAN SERVICES | 5,255 | $6,599,060.75 |
| 13 | PHYSICIAN XOVER | 1,310 | $182,648.95 |
| 14 | PRESCRIBED MEDICINE | 6,121 | $112,742,679.80 |
| 15 | OTHER LAB AND X-RAY | 3,559 | $1,053,525.27 |
| 16 | LAB AND X-RAY XOVER | 604 | $8,392.52 |
| 17 | TRANSPORTATION | 2,368 | $1,533,593.04 |
| 18 | TRANSPORTATION XOVER | 249 | $43,736.48 |
| 19 | FAMILY PLANNING SERVICE | 42 | $7,018.43 |
| 20 | HOME HEALTH SERVICES | 1,342 | $2,859,519.86 |
| 21 | HOME HEALTH XOVER | 323 | $83,504.04 |
| 22 | EPSDT SCREENING | 228 | $19,520.19 |
| 24 | CHILD VISUAL SERVICES | 32 | $3,126.44 |
| 25 | CHILD HEARING SERVICES | | |
| 27 | ADULT VISUAL SERVICES | 302 | $28,998.32 |
| 28 | ADULT HEARING SERVICES | | |
| 29 | CASE MANAGEMENT-CMS | 150 | $274,382.33 |
| 31 | NURSE PRACTITIONER SERV | 123 | $29,645.36 |
| 32 | OTHER XOVER PRACTITIONE | 390 | $9,741.46 |
| 33 | HOSPICE | 52 | $679,384.03 |
| 34 | COMMUNITY MENTAL HLTH S | 1,773 | $3,065,692.86 |
| 35 | HCB-AGING | 444 | $1,107,031.62 |
| 36 | HCB-DEVELOPMENTAL SERVI | 96 | $2,760,157.56 |
| 37 | HCB-AIDS | 339 | $610,109.77 |
| 39 | PREPAID HEALTH PLAN | 10,674 | $234,419,460.75 |
| 40 | RURAL HEALTH CLINICS | | |
| 42 | PERSONAL CARE SERVICES | | |
| 43 | PRIVATE DUTY NURSING SE | 19 | $578,693.17 |
| 44 | PHYSICAL THERAPY SERVIC | 174 | $145,879.91 |
| 45 | SPEECH THERAPY SERVICES | | |
| 46 | OCCUPATIONAL THERAPY SE | 19 | $39,396.52 |
| 49 | FEDERALLY QUALIFIED CEN | 883 | $123,302.16 |
| 53 | CLINIC SERVICES | 183 | $18,027.74 |
| 56 | CASE MANAGEMENT-ADULT M | 265 | $421,267.20 |

# MEDICAID HIV/AIDS EXPENSES AND CLIENTS FY 2019-20 THROUGH FY 2021-22

| | FY 2019-20 | FY 2020-21 | FY 2021-22 |
|---|---|---|---|
| Expenses | $328,303,705 | $379,527,639.90 | $422,582,947.28 |
| Clients Served | 7,783 | 8,407 | 9,443 |
| Average annual cost per client | $42,182.15 | $45,144.24 | $44,750.92 |

Relative to FY 2020-2021, FY 2021-22 shows an increase in the number of clients served (+12%) and total expenditures (+10.19%),

# INCREASES IN MEDICAID EXPENDITURES FY 2021-22

Due to increased:

medication usage
insurance usage
transportation

# THANK YOU!

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MIAMI-DADE COUNTY

# 2023 (WICY) Needs Assessment Funding and Clients Served Survey

| | Totals | | | Infants (0-23 months old) | | Children (2 -12 years old) | | Youth (13-24 years old) | | Adult Females (25+ years old) | | Adult Males (25+ years old) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Services** | **Amount $ Expended** | **# of clients** | **Funding Source** | **Amount $ Expended on Infants (0-23 months old)** | **# of Infants (0-23 months old)** | **Amount $ Expended on Children (2-12 years old)** | **# of Children (2-12 years old)** | **Amount $ Expended on Youth (13-24 years old)** | **# of Youth (13-24 years old)** | **Amount $ Expended on Adult Females (25+ years old)** | **# of Adult Females (25+ years old)** | **Amount $ Expended on Adult Males (25+ years old)** | **# of Adult Males (25+ years old)** |
| **Early Intervention Services (EIS)** | $376,629 | 5,042 | Part C | | | | | $10,839.70 | 40 | $128,876.07 | 460 | $236,913.50 | 1,003 |
| **Emergency Financial Assistance** | $147,358 | 67 | General Revenue | | | | | $22,466.08 | 9 | $21,149.11 | 10 | $103,743.24 | 48 |
| | $520,191 | 359 | Part B | | | | | $39,100.85 | 19 | $66,080.91 | 101 | $415,009.55 | 239 |
| **Food Bank** | $37,786 | 192 | Other | | | | | $0.00 | 0 | $7,675.22 | 39 | $30,110.48 | 153 |
| | $6,124 | 260 | Part D | $761.17 | 30 | $304.47 | 12 | $1,466.35 | 59 | $3,591.53 | 159 | | |
| **Health Education** | $357,706 | 2,566 | Part C | | | | | $8,712.62 | 59 | $113,632.01 | 869 | $235,360.96 | 1,638 |
| | $23,982 | 214 | Part D | $6,523.12 | 65 | $1,103.91 | 11 | $9,992.14 | 96 | $6,362.86 | 42 | | |
| **Health Insurance Premium and Cost-Sharing Assistance for Low Income Individuals** | $35,912,608 | 3,231 | ADAP-Pt B | $0.00 | 0 | $5,666.94 | 1 | $233,450.70 | 21 | $5,369,366.10 | 483 | $30,304,124.19 | 2,726 |
| **Home and Community-Based Health Services** | $245 | 1 | General Revenue | | | | | | | | | $245.00 | 1 |
| **Home Health Care** | $44,102 | 12 | General Revenue | | | | | $3,045.00 | 1 | $11,110.00 | 3 | $29,946.50 | 8 |
| **Housing (TBRA, STRMU, and Project)** | $10,421,280 | 912 | HOPWA | | | | | | | | | | |
| **Linguistic Services** | $7,098 | 105 | Part D | $2,966.74 | 32 | $370.84 | 4 | $475.12 | 6 | $3,284.86 | 63 | | |
| **Linkage Specialist** | $1,023 | 9 | Part C | | | | | $113.66 | 1 | $909.32 | 8 | $0.00 | 0 |
| **Medical Case Management, including Treatment Adherence** | $1,470,920 | 1,773 | General Revenue | | | | | $42,310.72 | 51 | $406,514.76 | 490 | $1,022,094.24 | 1,232 |
| | $0 | 377 | Other | | | | | $0.00 | 5 | $0.00 | 56 | $0.00 | 316 |
| | $88,579 | 579 | Part B | | | | | $2,898.00 | 13 | $20,389.50 | 144 | $65,291.25 | 422 |
| | $67,122 | 64 | Part C | | | | | $162.50 | 1 | $5,850.00 | 36 | $4,387.50 | 27 |
| | $139,275 | 286 | Part D | $18,845.22 | 29 | $9,097.69 | 14 | $71,395.09 | 118 | $39,936.62 | 125 | | |
| **Medical Nutrition Therapy** | $8,999 | 41 | General Revenue | | | | | | | $2,179.22 | 9 | $6,819.43 | 32 |
| | $0 | 36 | Other | | | | | $0.00 | 0 | $0.00 | 11 | $0.00 | 25 |
| | $60,746 | N/A | Part C | | | | | | | | | | |
| **Medical Transportation** | $68,815 | 298 | General Revenue | | | | | $562.50 | 4 | $22,519.55 | 99 | $45,733.05 | 195 |
| | $11,974 | 39 | Part C | | | | | $921.08 | 3 | $5,219.44 | 17 | $5,833.49 | 19 |
| | $7,797 | 277 | Part D | $1,127.36 | 40 | $394.58 | 14 | $2,620.38 | 93 | $3,654.33 | 130 | | |
| **Mental Health Services** | $82,088 | 180 | General Revenue | | | | | $1,927.05 | 5 | $26,609.48 | 45 | $53,551.53 | 130 |
| | $729,367 | 134 | Other | | | | | $5,443.04 | 1 | $103,417.77 | 19 | $620,506.61 | 114 |
| | $13,894 | 118 | Part B | | | | | $422.50 | 2 | $1,950.00 | 13 | $11,521.25 | 103 |
| | $183,643 | 445 | Part C | | | | | $3,375.69 | 5 | $87,499.24 | 167 | $87,746.95 | 273 |
| | $107,996 | 138 | Part D | $0.00 | 0 | $17,507.23 | 16 | $81,962.34 | 79 | $8,526.09 | 43 | | |

# 2023 (WICY) Needs Assessment Funding and Clients Served Survey

| | Totals | | | Infants (0-23 months old) | | Children (2 -12 years old) | | Youth (13-24 years old) | | Adult Females (25+ years old) | | Adult Males (25+ years old) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Services** | **Amount $ Expended** | **# of clients** | **Funding Source** | **Amount $ Expended on Infants (0-23 months old)** | **# of Infants (0-23 months old)** | **Amount $ Expended on Children (2-12 years old)** | **# of Children (2-12 years old)** | **Amount $ Expended on Youth (13-24 years old)** | **# of Youth (13-24 years old)** | **Amount $ Expended on Adult Females (25+ years old)** | **# of Adult Females (25+ years old)** | **Amount $ Expended on Adult Males (25+ years old)** | **# of Adult Males (25+ years old)** |
| **Non-Medical Case Management Services** | $547,953 | 2,371 | General Revenue | | | | | $15,021.92 | 65 | $135,659.51 | 587 | $397,272.06 | 1,719 |
| | $147,961 | 283 | Part B | | | | | $11,502.27 | 22 | $22,481.71 | 43 | $113,977.05 | 218 |
| | $120,593 | 327 | Part C | | | | | $5,800.27 | 13 | $20,484.46 | 70 | $94,307.81 | 244 |
| | $71,955 | 356 | Part D | $27,868.37 | 65 | $1,286.23 | 3 | $29,744.81 | 83 | $13,055.25 | 205 | | |
| **Non-Medical Case Management Services (Housing Specialist)** | $1,606,455 | 820 | HOPWA | | | | | | | | | | |
| **Oral Health Care** | $263,157 | 149 | Other | | | | | $3,532.30 | 2 | $61,815.31 | 35 | $197,808.98 | 112 |
| | $209,902 | 398 | Part C | | | | | $878.00 | 3 | $21,667.00 | 74 | $93,988.00 | 321 |
| **Outpatient/Ambulatory Health Services** | $1,131,997 | 1,861 | General Revenue | | | | | $18,592.48 | 49 | $366,326.34 | 492 | $747,078.39 | 1,320 |
| | $1,389,789 | 2,152 | Other | | | | | $14,207.88 | 22 | $167,911.25 | 260 | $1,207,669.39 | 1,870 |
| | $1,029,407 | 4,058 | Part C | | | | | $18,682.20 | 85 | $278,232.14 | 1317 | $524,994.70 | 2,656 |
| | $766,471 | 708 | Part D | $136,387.86 | 101 | $21,606.00 | 16 | $159,828.53 | 123 | $448,648.92 | 468 | | |
| **Outreach Services** | $41,469 | 1,229 | Part C | | | | | $1,012.00 | 30 | $11,169.00 | 331 | $29,288.00 | 868 |
| | $40,090 | 381 | Part D | $0.00 | 0 | $0.00 | 0 | $38,556.09 | 356 | $1,533.81 | 25 | | |
| **Prescription Drugs (AIDS Pharmaceutical Assistance)** | $26,005,586 | 4,589 | ADAP-Pt B | $5,666.94 | 1 | $0.00 | 0 | $719,701.34 | 127 | $4,692,226.03 | 828 | $20,587,991.75 | 3,633 |
| | $351,172 | 446 | General Revenue | | | | | $9,145.89 | 6 | $149,766.77 | 130 | $192,259.03 | 310 |
| | $30,873 | N/A | Part C | | | | | | | | | | |
| **Psychosocial Support** | $53,204 | 152 | Part D | $15,845.16 | 46 | $2,411.22 | 7 | $26,941.43 | 78 | $8,005.83 | 21 | | |
| **Referral for Health Care and Supportive Services** | $359,344 | 575 | General Revenue | | | | | $9,374.19 | 15 | $68,119.08 | 109 | $281,850.51 | 451 |
| | $0 | 1,351 | Other | | | | | $0.00 | 8 | $0.00 | 193 | $0.00 | 1,150 |
| **Risk reduction** | $48,001 | 689 | Part D | $6,523.12 | 65 | $1,103.91 | 11 | $10,191.73 | 110 | $30,181.74 | 503 | | |
| **Specialty patient navigation** | $54,553 | 452 | Part C | | | | | $482.77 | 4 | $54,069.76 | 448 | $0.00 | 0 |
| **Substance Abuse Outpatient Care** | $0 | 18 | Other | | | | | $0.00 | 0 | $0.00 | 1 | $0.00 | 17 |
| | $3,467 | 12 | Part C | | | | | $0.00 | 0 | $1,733.28 | 6 | $1,733.28 | 6 |
| **Substance Abuse Services (residential)** | $462,172 | 43 | General Revenue | | | | | | | $336,654.50 | 16 | $125,517.00 | 27 |

Medicaid HIV/AIDS Demographic Information
FY 2019-2022

**Total Medicaid HIV/AIDS Clients**

| | FY 2019-2020 | | | | | | FY 2020-2021 | | | | | | FY 2021-2022 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Male | % | Female | % | Total | % | Male | % | Female | % | Total | % | Male | % | Female | % | Total | % |
| Black/African American | 1,581 | 36.98% | 2,067 | 59.04% | 3,648 | 46.87% | 1,666 | 36.38% | 2,163 | 56.65% | 3,829 | 45.55% | 1,778 | 38.83% | 2,405 | 62.99% | 4,183 | 44.30% |
| Hispanic | 1,478 | 34.57% | 645 | 18.42% | 2,123 | 27.28% | 1,520 | 33.20% | 769 | 20.14% | 2,289 | 27.23% | 1,793 | 39.16% | 959 | 25.12% | 2,752 | 29.14% |
| Not Determined | 870 | 20.35% | 600 | 17.14% | 1,470 | 18.89% | 1,044 | 22.80% | 662 | 17.34% | 1,706 | 20.29% | 1,125 | 24.57% | 718 | 18.81% | 1,843 | 19.52% |
| Other | 50 | 1.17% | 51 | 1.46% | 101 | 1.30% | 53 | 1.16% | 67 | 1.75% | 120 | 1.43% | 99 | 2.16% | 84 | 2.20% | 183 | 1.94% |
| Other (*less than 15 count) | | 0.00% | | 0.00% | 7 | 0.09% | | 0.00% | | 0.00% | 10 | 0.12% | | 0.00% | | 0.00% | 11 | 0.12% |
| White | 296 | 6.92% | 138 | 3.94% | 434 | 5.58% | 296 | 6.46% | 157 | 4.11% | 453 | 5.39% | 309 | 6.75% | 162 | 4.24% | 471 | 4.99% |
| TOTAL | 4,275 | 54.93% | 3,501 | 44.98% | 7,783 | 100.00% | 4,579 | 54.47% | 3,818 | 45.41% | 8,407 | 100.00% | 5,104 | 54.05% | 4,328 | 45.83% | 9,443 | 100.00% |

**Medicaid HIV/AIDS Clients 18-64 years older**

| | FY 2019-2020 | | | | | | FY 2020-2021 | | | | | | FY 2021-2022 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Male | % | Female | % | Total | % | Male | % | Female | % | Total | % | Male | % | Female | % | Total | % |
| Black/African American | 1,464 | 35.79% | 1,951 | 59.09% | 3,415 | 46.15% | 1,542 | 35.21% | 2,044 | 56.57% | 3,586 | 44.81% | 1,644 | 37.54% | 2,269 | 62.80% | 3,913 | 43.44% |
| Hispanic | 1,449 | 35.43% | 603 | 18.26% | 2,052 | 27.73% | 1,486 | 33.93% | 725 | 20.07% | 2,211 | 27.63% | 1,755 | 40.08% | 913 | 25.27% | 2,668 | 29.62% |
| Not Determined | 841 | 20.56% | 577 | 17.47% | 1,418 | 19.16% | 1,015 | 23.18% | 637 | 17.63% | 1,652 | 20.64% | 1,097 | 25.05% | 695 | 19.24% | 1,792 | 19.90% |
| Other | 46 | 1.12% | 42 | 1.27% | 88 | 1.19% | 46 | 1.05% | 56 | 1.55% | 102 | 1.27% | 93 | 2.12% | 72 | 1.99% | 165 | 1.83% |
| Other * (counts less than 15) | | 0.00% | | 0.00% | 7 | 0.09% | | 0.00% | | 0.00% | 10 | 0.12% | | 0.00% | | 0.00% | 11 | 0.12% |
| White | 290 | 7.09% | 129 | 3.91% | 419 | 5.66% | 290 | 6.62% | 151 | 4.18% | 441 | 5.51% | 303 | 6.92% | 155 | 4.29% | 458 | 5.08% |
| TOTAL | 4,090 | 55.28% | 3,302 | 44.63% | 7,399 | 100.00% | 4,379 | 54.72% | 3,613 | 45.15% | 8,002 | 100.00% | 4,892 | 54.31% | 4,104 | 45.56% | 9,007 | 100.00% |

**Medicaid HIV/AIDS Clients less than 18 year old**

| | FY 2019-2020 | | | | | | FY 2020-2021 | | | | | | FY 2021-2022 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Male | % | Female | % | Total | % | Male | % | Female | % | Total | % | Male | % | Female | % | Total | % |
| Black/African American | 117 | 66.86% | 116 | 70.30% | 233 | 60.68% | 124 | 66.31% | 119 | 59.80% | 243 | 60.00% | 134 | 71.66% | 136 | 68.34% | 270 | 61.93% |
| Hispanic | 29 | 16.57% | 42 | 25.45% | 71 | 18.49% | 34 | 18.18% | 44 | 22.11% | 78 | 19.26% | 38 | 20.32% | 46 | 23.12% | 84 | 19.27% |
| Not Determined | 29 | 16.57% | 23 | 13.94% | 52 | 13.54% | 29 | 15.51% | 25 | 12.56% | 54 | 13.33% | 28 | 14.97% | 23 | 11.56% | 51 | 11.70% |
| Other | | 0.00% | | 0.00% | 0 | 0.00% | | 0.00% | 11 | 5.53% | 11 | 2.72% | | 0.00% | | 0.00% | | 0.00% |
| Other (*less than 15 count) | | 0.00% | | 0.00% | 28 | 7.29% | | 0.00% | | 0.00% | 19 | 4.69% | | 0.00% | | 0.00% | 31 | 7.11% |
| White | | 0.00% | | 0.00% | 0 | 0.00% | | 0.00% | | 0.00% | | 0.00% | | 0.00% | | 0.00% | | 0.00% |
| TOTAL | 175 | 45.57% | 181 | 47.14% | 384 | 100.00% | 187 | 46.17% | 199 | 49.14% | 405 | 100.00% | 200 | 45.87% | 205 | 47.02% | 436 | 100.00% |

| | | | |
|---|---|---|---|
| TOTAL MEDICAID CLIENTS | **7,783** | **8,407** | **9,443** |

Miami-Dade Medicaid Expenditures
FY 2021-2022

| Bucket | Service | Recipients | Amount |
|---|---|---|---|
| 01 | HOSPITAL INPATIENT SERV | 1,096 | $12,661,882.55 |
| 02 | HOSPITAL INSURANCE BENE | 340 | $599,172.66 |
| 03 | HOSPITAL OUTPATIENT SER | 3,537 | $4,720,221.59 |
| 04 | HOSPITAL OUTPATIENT XOV | 1,100 | $609,971.01 |
| 06 | SKILLED NURSING CARE | 118 | $4,694,361.55 |
| 07 | INTERMEDIATE CARE | 43 | $1,994,082.48 |
| 12 | PHYSICIAN SERVICES | 5,255 | $6,599,060.75 |
| 13 | PHYSICIAN XOVER | 1,310 | $182,648.95 |
| 14 | PRESCRIBED MEDICINE | 6,121 | $112,742,679.80 |
| 15 | OTHER LAB AND X-RAY | 3,559 | $1,053,525.27 |
| 16 | LAB AND X-RAY XOVER | 604 | $8,392.52 |
| 17 | TRANSPORTATION | 2,368 | $1,533,593.04 |
| 18 | TRANSPORTATION XOVER | 249 | $43,736.48 |
| 19 | FAMILY PLANNING SERVICE | 42 | $7,018.43 |
| 20 | HOME HEALTH SERVICES | 1,342 | $2,859,519.86 |
| 21 | HOME HEALTH XOVER | 323 | $83,504.04 |
| 22 | EPSDT SCREENING | 228 | $19,520.19 |
| 24 | CHILD VISUAL SERVICES | 32 | $3,126.44 |
| 27 | ADULT VISUAL SERVICES | 302 | $28,998.32 |
| 29 | CASE MANAGEMENT-CMS | 150 | $274,382.33 |
| 31 | NURSE PRACTITIONER SERV | 123 | $29,645.36 |
| 32 | OTHER XOVER PRACTITIONE | 390 | $9,741.46 |
| 33 | HOSPICE | 52 | $679,384.03 |
| 34 | COMMUNITY MENTAL HLTH S | 1,773 | $3,065,692.86 |
| 35 | HCB-AGING | 444 | $1,107,031.62 |
| 36 | HCB-DEVELOPMENTAL SERVI | 96 | $2,760,157.56 |
| 37 | HCB-AIDS | 339 | $610,109.77 |
| 39 | PREPAID HEALTH PLAN | 10,674 | $234,419,460.75 |
| 43 | PRIVATE DUTY NURSING SE | 19 | $578,693.17 |
| 44 | PHYSICAL THERAPY SERVIC | 174 | $145,879.91 |
| 46 | OCCUPATIONAL THERAPY SE | 19 | $39,396.52 |
| 49 | FEDERALLY QUALIFIED CEN | 883 | $123,302.16 |
| 53 | CLINIC SERVICES | 183 | $18,027.74 |
| 56 | CASE MANAGEMENT-ADULT M | 265 | $421,267.20 |
| 59 | TSFC-COMMUNITY MENTAL H | 132 | $129,517.42 |
| 62 | PHYSICIAN ASSISTANT SER | 691 | $56,525.20 |
| 64 | SCHOOL BASED SERVICES | 18 | $3,329.94 |
| 65 | DIALYSIS CENTER | 61 | $932,475.88 |
| 67 | BRAIN & SPINAL CORD INJU | 80 | $430,256.98 |
| 71 | ASSISTIVE CARE SERVICES | 120 | $450,457.55 |
| 72 | HEALTHY START WAIVER | 79 | $26,301.00 |
| 79 | ALZHEIMERS WAIVER | 31 | $6,677.30 |
| 81 | ADULT DAY CARE | 21 | $136,075.75 |
| 94 | PREPAID LTC | 767 | $22,125,077.23 |
| 95 | APPLIED BEHAVIORAL ANALYSIS | 30 | $693,747.19 |
| 99 | UNKNOWN | 19 | $612.25 |
| | OTHER | 204 | $2,864,705.22 |
| | **Total:** | | **$422,582,947.28** |

# DASHBOARD CARDS

# SECTION 7

# TOOLS FOR NEEDS ASSESSMENT: 2023 GUIDE TO DASHBOARD CARDS

July 13, 2023 version

# The Why?

The need assessment process must be data-driven.

During the needs assessment, a lot of data are presented regarding specific service categories. By the time we get to the prioritization and allocation discussions, it can be very confusing.

The dashboard cards provide information by service category, summarize a lot of the information presented, provide information on other funders, and is intended to facilitate your decision-making process.

## CORE SERVICE: AIDS PHARMACEUTICAL ASSISTANCE

**Ranking, Allocation, and Direct Services Expenditure History**

| Fiscal Year | Final Expenditure | Category Expense as % |
|---|---|---|
| FY 2018 | $21,934,627.17 | 0.39% |
| FY 2019 | $22,984,844.87 | 0.25% |
| FY 2020 | $17,660,128.37 | 0.03% |
| FY 2021 | $19,018,258.46 | 0.02% |
| FY 2022 | $22,372,897.85 | 0.02% |

| Trend |
|---|
| Expenses and Clients |
|  |

| Fiscal Year | Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|
| FY 2018 | $257,000.00 | $86,209.75 | 36.38% |
| FY 2019 | $187,000.00 | $57,843.29 | 30.93% |
| FY 2020 | $66,007.00 | $5,993.21 | 9.08% |
| FY 2021 | $83,595.00 | $4,379.02 | 5.24% |
| FY 2022 | $84,492.00 | $3,954.10 | 4.68% |

| Fiscal Year | | Part A Final Allocation | Part A Final | % Spent |
|---|---|---|---|---|
| FY 2018 | 4 | $137,000.00 | $81,547.76 | 59.52% |
| FY 2019 | 4 | $87,000.00 | $52,697.84 | 60.57% |
| FY 2020 | 3 | $66,007.00 | $5,993.21 | 9.08% |
| FY 2021 | 9 | $83,595.00 | $4,379.02 | 5.24% |
| FY 2022 | 4 | $84,492.00 | $3,954.10 | 4.68% |

| Fiscal Year | | MAI Final Allocation | MAI Final | % Spent |
|---|---|---|---|---|
| FY 2018 | 3 | $100,000.00 | $4,661.97 | 4.66% |
| FY 2019 | 7 | $100,000.00 | $5,145.45 | 5.15% |
| FY 2020 | N/A | N/A | N/A | N/A |
| FY 2021 | N/A | N/A | N/A | N/A |
| FY 2022 | N/A | N/A | N/A | N/A |

**Service Program**

**Limitations:** **400% FPL**

| Fiscal Year | RW Clients | Clients Served | Served as % RW Clients | Expenditure | Avg Per Client |
|---|---|---|---|---|---|
| FY 2018 | 9,578 | 697 | 7.3% | $86,210.00 | $123.69 |
| FY 2019 | 9,031 | 605 | 6.7% | $57,843.29 | $95.61 |
| FY 2020 | 8,127 | 185 | 2.3% | $5,993.21 | $32.40 |
| FY 2021 | 8,420 | 183 | 2.2% | $4,379.02 | $23.93 |
| FY 2022 | 8,590 | 156 | 1.8% | $3,954.10 | $25.35 |

**Other Funding Streams 2022**

| | Funder | Expended | Number of Clients | Cost per Client |
|---|---|---|---|---|
| 1 | ADAP | $28,342,384 | 4,587 | $6,179 |
| 2 | General Revenue | $262,520 | 547 | $480 |
| 3 | Medicaid | $109,082,428 | 5,435 | $20,070 |
| 4 | Part C | $25,492 | N/A | N/A |

**Other Funding Streams 2023**

| | Funder | Expended | Number of Clients | Cost per Client |
|---|---|---|---|---|
| 1 | ADAP | $26,005,586 | 4,589 | $5,667 |
| 2 | General Revenue | $351,172 | 446 | $787 |
| 3 | Medicaid | $112,742,680 | 6,121 | $18,419 |
| 4 | Part C | $30,873 | N/A | N/A |

Notes:
Expenditures continue on a downward trend because most clients access the ADAP program for this service.

# Ryan White Dashboard Cards

We will break down each item located on the cards and explain the data points. We will start at the top of the form and move down.

The data in this presentation are for illustration only.

This top section indicates if a service is a **core** or **support** service. The **fiscal year** year range is **FY 2018** (3/1/2018-2/28/2019) to **FY 2022** (3/1/22-2/28/23). The table details the **final expenditure** for the all direct services for the Ryan White Program. The **Category Expense as %** indicates what percent the reference service category expenditures is in relation to the entire fiscal year expenditure.

**NEW**: A trend box with an arrow or circle (no activity) is on the right side. Green trending up, yellow is trending down, and red has no activity.

## CORE SERVICE: AIDS PHARMACEUTICAL ASSISTANCE

**Ranking, Allocation, and Direct Services Expenditure History**

| Fiscal Year | Final Expenditure | Category Expense as % |
|---|---|---|
| FY 2018 | $21,934,627.17 | 0.39% |
| FY 2019 | $22,984,844.87 | 0.25% |
| FY 2020 | $17,660,128.37 | 0.03% |
| FY 2021 | $19,018,258.46 | 0.02% |
| FY 2022 | $22,372,897.85 | 0.02% |

This table provides historical information for the last five years. The **top** table is for both **Part A and MAI data**, where applicable. **Part A data** is on the **second** table and the **third** table is for **MAI data**. Each individual table lists the fiscal year (**Fiscal Year**), the priority ranking (**Ranking**), final allocation (**Final Allocation**), final expenditure (**Final Expenditure**), and percent spent (**% Spent**) which indicates the percent of the allocation the expenditure represents for that year. If the service is no longer applicable, this will be designated with **N/A**.

| Fiscal Year | Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|
| FY 2018 | $237,000.00 | $86,209.75 | 36.38% |
| FY 2019 | $187,000.00 | $57,843.29 | 30.93% |
| FY 2020 | $66,007.00 | $5,993.21 | 9.08% |
| FY 2021 | $83,595.00 | $4,379.02 | 5.24% |
| FY 2022 | $84,492.00 | $3,954.10 | 4.68% |

| Fiscal Year | | Part A Final Allocation | Part A Final | % Spent |
|---|---|---|---|---|
| FY 2018 | 4 | $137,000.00 | $81,547.76 | 59.52% |
| FY 2019 | 4 | $87,000.00 | $52,697.84 | 60.57% |
| FY 2020 | 3 | $237,000.00 | $86,209.75 | 36.38% |
| FY 2021 | 9 | $83,595.00 | $4,379.02 | 5.24% |
| FY 2022 | 4 | $84,492.00 | $3,954.10 | 4.68% |

| Fiscal Year | | MAI Final Allocation | MAI Final | % Spent |
|---|---|---|---|---|
| FY 2018 | 3 | $100,000.00 | $4,661.97 | 4.66% |
| FY 2019 | 7 | $100,000.00 | $5,145.45 | 5.15% |
| FY 2020 | N/A | N/A | N/A | N/A |
| FY 2021 | N/A | N/A | N/A | N/A |
| FY 2022 | N/A | N/A | N/A | N/A |

Service Program information provides the **limitations** for each service category, most often the federal poverty **(FPL)** or usage limits.

The table that follows provides historical data for five years back, including the total number of clients (**RW Clients**), number of clients served by the service category (**Clients Served**), what percent of clients this represent (**Served as % RW Clients**), the total expenditures for the service category (**Expenditure**), and the average cost per client (**Avg Per Client**).

**Service Program**

**Limitations:** **400% FPL**

| Fiscal Year | RW Clients | Clients Served | Served as % RW Clients | Expenditure | Avg Per Client |
|---|---|---|---|---|---|
| **FY 2018** | 9,578 | 697 | 7.3% | $86,210.00 | $123.69 |
| **FY 2019** | 9,031 | 605 | 6.7% | $57,843.29 | $95.61 |
| **FY 2020** | 8,127 | 185 | 2.3% | $5,993.21 | $32.40 |
| **FY 2021** | 8,420 | 183 | 2.2% | $4,379.02 | $23.93 |
| **FY 2022** | 8,590 | 156 | 1.8% | $3,954.10 | $25.35 |

The final table on the form indicates information on the **other funding streams**. This year information for 2022 and 2023 are included. It list the funding source (**Funder**), the amount spend by the funder (**Expended**), number of clients serviced (**Number of Clients**), and the average cost per client (**Cost per Client**).

The numbers on the left-hand side only indicate the number of funding sources that responded. The final data element are notes (**Notes**)which indicate things that are important to take note of regarding the service category.

**Other Funding Streams 2022**

| | Funder | Expended | Number of Clients | Cost per Client |
|---|---|---|---|---|
| 1 | ADAP | $28,342,384 | 4,587 | $6,179 |
| 2 | General Revenue | $262,520 | 547 | $480 |
| 3 | Medicaid | $109,082,428 | 5,435 | $20,070 |
| 4 | Part C | $25,492 | N/A | N/A |

**Other Funding Streams 2023**

| | Funder | Expended | Number of Clients | Cost per Client |
|---|---|---|---|---|
| 1 | ADAP | $26,005,586 | 4,589 | $5,667 |
| 2 | General Revenue | $351,172 | 446 | $787 |
| 3 | Medicaid | $112,742,680 | 6,121 | $18,419 |
| 4 | Part C | $30,873 | N/A | N/A |

Notes:

Expenditures continue on a downward trend because most clients access the ADAP program for this service.

# How can the Dashboard help?

Different data points can be used to allocate funds, assess if other funding streams pay for the service, or to estimate needs.

For example, if **500** clients are expected to access the AIDS Pharmaceutical service category, at a yearly cost of **$25**. Accordingly, the service category estimated allocation would be **$12,500**.

For example, if the estimated number of Ryan White clients that will be served next year is **9,020**, with a yearly cost of **$2,605** per client, the program would spend **$23,497,100**.

# THANK YOU!

BEHAVIORA SCIENCE RESEARCH

MIAMI-DADE HIV/AIDS PARTNERSHIP

MIAMI-DADE COUNTY

# CORE SERVICE: AIDS PHARMACEUTICAL ASSISTANCE

**Ranking, Allocation, and Direct Services Expenditure History**

| Fiscal Year | Final Expenditure | Category Expense as % |
|---|---|---|
| **FY 2018** | $21,934,627.17 | 0.39% |
| **FY 2019** | $22,984,844.87 | 0.25% |
| **FY 2020** | $17,660,128.37 | 0.03% |
| **FY 2021** | $19,018,258.46 | 0.02% |
| **FY 2022** | $22,372,897.85 | 0.02% |

| Trend |
|---|
| Expenses and Clients  |

| Fiscal Year | Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|
| **FY 2018** | $237,000.00 | $86,209.75 | 36.38% |
| **FY 2019** | $187,000.00 | $57,843.29 | 30.93% |
| **FY 2020** | $66,007.00 | $5,993.21 | 9.08% |
| **FY 2021** | $83,595.00 | $4,379.02 | 5.24% |
| **FY 2022** | $84,492.00 | $3,954.10 | 4.68% |

| Fiscal Year | | Part A Final Allocation | Part A Final | % Spent |
|---|---|---|---|---|
| **FY 2018** | 4 | $137,000.00 | $81,547.76 | 59.52% |
| **FY 2019** | 4 | $87,000.00 | $52,697.84 | 60.57% |
| **FY 2020** | 3 | $66,007.00 | $5,993.21 | 9.08% |
| **FY 2021** | 9 | $83,595.00 | $4,379.02 | 5.24% |
| **FY 2022** | 4 | $84,492.00 | $3,954.10 | 4.68% |

| Fiscal Year | | MAI Final Allocation | MAI Final | % Spent |
|---|---|---|---|---|
| **FY 2018** | 3 | $100,000.00 | $4,661.97 | 4.66% |
| **FY 2019** | 7 | $100,000.00 | $5,145.45 | 5.15% |
| **FY 2020** | N/A | N/A | N/A | N/A |
| **FY 2021** | N/A | N/A | N/A | N/A |
| **FY 2022** | N/A | N/A | N/A | N/A |

**Service Program**

**Limitations:** **400% FPL**

| Fiscal Year | RW Clients | Clients Served | Served as % RW Clients | Expenditure | Avg Per Client |
|---|---|---|---|---|---|
| **FY 2018** | 9,578 | 697 | 7.3% | $86,210.00 | $123.69 |
| **FY 2019** | 9,031 | 605 | 6.7% | $57,843.29 | $95.61 |
| **FY 2020** | 8,127 | 185 | 2.3% | $5,993.21 | $32.40 |
| **FY 2021** | 8,420 | 183 | 2.2% | $4,379.02 | $23.93 |
| **FY 2022** | 8,590 | 156 | 1.8% | $3,954.10 | $25.35 |

**Other Funding Streams 2022**

| | Funder | Expended | Number of Clients | Cost per Client |
|---|---|---|---|---|
| 1 | ADAP | $28,342,384 | 4,587 | $6,179 |
| 2 | General Revenue | $262,520 | 547 | $480 |
| 3 | Medicaid | $109,082,428 | 5,435 | $20,070 |
| 4 | Part C | $25,492 | N/A | N/A |

**Other Funding Streams 2023**

| | Funder | Expended | Number of Clients | Cost per Client |
|---|---|---|---|---|
| 1 | ADAP | $26,005,586 | 4,589 | $5,667 |
| 2 | General Revenue | $351,172 | 446 | $787 |
| 3 | Medicaid | $112,742,680 | 6,121 | $18,419 |
| 4 | Part C | $30,873 | N/A | N/A |

Notes:
Expenditures continue on a downward trend because most clients access the ADAP program for this service.

## SUPPORT SERVICE: EMERGENCY FINANCIAL ASSISTANCE

**Ranking, Allocation, and Direct Services Expenditure History**

| Fiscal Year | Final Expenditure | Category Expense as % |
|---|---|---|
| **FY 2018** | $21,934,627.17 | 0.0% |
| **FY 2019** | $22,984,844.87 | 0.0% |
| **FY 2020** | $17,660,128.37 | 0.0% |
| **FY 2021** | $19,018,258.46 | 0.0% |
| **FY 2022** | $22,372,897.85 | 0.0% |

| Trend |
|---|
| Expenses and Clients |

| Fiscal Year | Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|
| **FY 2018** | N/A | N/A | N/A |
| **FY 2019** | N/A | N/A | N/A |
| **FY 2020** | N/A | N/A | N/A |
| **FY 2021** | N/A | N/A | N/A |
| **FY 2022** | N/A | N/A | N/A |

| Fiscal Year | | Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|---|
| **FY 2018** | N/A | N/A | N/A | N/A |
| **FY 2019** | 12 | N/A | N/A | N/A |
| **FY 2020** | 12 | N/A | N/A | N/A |
| **FY 2021** | 12 | N/A | N/A | N/A |
| **FY 2022** | 11 | N/A | N/A | N/A |

| Fiscal Year | | MAI Final Allocation | Expenditure | % Spent |
|---|---|---|---|---|
| **FY 2018** | N/A | N/A | N/A | N/A |
| **FY 2019** | 6 | N/A | N/A | N/A |
| **FY 2020** | 7 | N/A | N/A | N/A |
| **FY 2021** | 7 | N/A | N/A | N/A |
| **FY 2022** | 7 | N/A | N/A | N/A |

**Service Program**

**Limitations: 400% FPL; limited to prescriptions drugs if TTRA funds are depleted**

| Fiscal Year | RW Clients | Clients Served | Served as % RW Clients | Expenditure | Avg Per Client |
|---|---|---|---|---|---|
| **FY 2018** | 9,578 | NA | NA | NA | NA |
| **FY 2019** | 9,031 | NA | NA | NA | NA |
| **FY 2020** | 8,127 | NA | NA | NA | NA |
| **FY 2021** | 8,420 | NA | NA | NA | NA |
| **FY 2022** | 8,590 | NA | NA | NA | NA |

**Other Funding Streams 2022**

| | Funder | Expended | Number of Clients | Cost Per Client |
|---|---|---|---|---|
| 1 | General Revenue | $112,883 | $57 | $1,980 |
| 2 | Part B | $593,090 | $244 | $2,431 |

**Other Funding Streams 2023**

| | Funder | Expended | Number of Clients | Cost Per Client |
|---|---|---|---|---|
| 1 | General Revenue | $147,358 | $67 | $2,199 |
| 2 | Part B | $520,191 | $359 | $1,449 |

Notes:

No expenditures have been made in this category since Test and Treat Rapid Access (TTRA) funds have not been exhausted by the Department of Health.

# SUPPORT SERVICE: FOOD BANK

**Ranking, Allocation, and Direct Services Expenditure History**

| Fiscal Year | Final Expenditure | Category Expense as % |
|---|---|---|
| **FY 2018** | $21,934,627.17 | 6.6% |
| **FY 2019** | $22,984,844.87 | 8.1% |
| **FY 2020** | $17,660,128.37 | 7.4% |
| **FY 2021** | $19,018,258.46 | 7.0% |
| **FY 2022** | $22,372,897.85 | 11.4% |

| Trend |
|---|
| Expenses and Clients  |

| Fiscal Year | Ranking | Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|---|
| **FY 2018** | 9 | $1,451,588.00 | $1,451,528.00 | 100.00% |
| **FY 2019** | 7 | $1,851,588.00 | $1,851,369.00 | 99.99% |
| **FY 2020** | 8 | $1,303,799.00 | $1,303,702.40 | 99.99% |
| **FY 2021** | 5 | $1,385,995.00 | $1,338,778.40 | 96.59% |
| **FY 2022** | 8 | $2,660,108.00 | $2,540,864.00 | 95.52% |

**Service Program**

**Limitations:** **400% FPL**

| Fiscal Year | RW Clients | Clients Served | Served as % RW Clients | Expenditure | Avg Per Client |
|---|---|---|---|---|---|
| **FY 2018** | 9,578 | 701 | 7.3% | $1,451,528.00 | $2,070.65 |
| **FY 2019** | 9,031 | 715 | 7.9% | $1,851,369.00 | $2,589.33 |
| **FY 2020** | 8,127 | 735 | 9.0% | $1,303,702.40 | $1,773.74 |
| **FY 2021** | 8,420 | 712 | 8.5% | $1,338,778.40 | $1,880.31 |
| **FY 2022** | 8,590 | 1,130 | 13.2% | $2,540,864.00 | $2,248.55 |

**Other Funding Streams 2022**

| | Funder | Expended | Number of Clients | Cost per Client |
|---|---|---|---|---|
| 1 | Other | $46,987 | 387 | $121 |
| 2 | Part D | $13,331 | 313 | $43 |

**Other Funding Streams 2023**

| | Funder | Expended | Number of Clients | Cost per Client |
|---|---|---|---|---|
| 1 | Other | $37,786 | 192 | $197 |
| 2 | Part D | $6,124 | 260 | $24 |

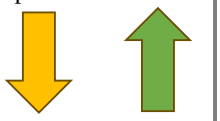
Notes:

Expenditures and clients are the highest in the five year period. With the current financial burdens, expenditures are likely to continue to increase.

# CORE SERVICE: HEALTH INSURANCE

**Ranking, Allocation, and Direct Services Expenditure History**

| Fiscal Year | Final Expenditure | Category Expense as % |
|---|---|---|
| **FY 2018** | $21,934,627.17 | 2.3% |
| **FY 2019** | $22,984,844.87 | 1.6% |
| **FY 2020** | $17,660,128.37 | 1.6% |
| **FY 2021** | $19,018,258.46 | 1.6% |
| **FY 2022** | $22,372,897.85 | 1.3% |

| Trend |
|---|
| Expenses and Clients  |

| Fiscal Year | Ranking | Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|---|
| **FY 2018** | 3 | $787,974.00 | $502,536.41 | 63.78% |
| **FY 2019** | 5 | $372,974.00 | $372,895.13 | 99.98% |
| **FY 2020** | 5 | $459,450.00 | $289,193.00 | 62.94% |
| **FY 2021** | 6 | $442,447.00 | $298,950.41 | 67.57% |
| **FY 2021** | 6 | $595,700.00 | $297,151.61 | 49.88% |

**Service Program**

**Limitations:** **400% FPL**

| Fiscal Year | RW Clients | Clients Served | Served as % RW Clients | Expenditure | Avg Per Client |
|---|---|---|---|---|---|
| **FY 2018** | 9,578 | 1,307 | 13.6% | $502,536.00 | $384.50 |
| **FY 2019** | 9,031 | 1,335 | 14.8% | $372,895.13 | $279.32 |
| **FY 2020** | 8,127 | 1,125 | 13.8% | $289,193.00 | $257.06 |
| **FY 2021** | 8,420 | 1,225 | 14.5% | $298,950.10 | $244.04 |
| **FY 2022** | 8,590 | 1,454 | 16.9% | $297,151.61 | $204.37 |

**Other Funding Streams 2022**

| | Funder | Expended | Number of Clients | Cost Per Client |
|---|---|---|---|---|
| 1 | ADAP | $29,915,353 | 3,144 | $9,515 |
| 2 | Medicaid | $192,843,127 | 9,506 | $20,286 |

**Other Funding Streams 2023**

| | Funder | Expended | Number of Clients | Cost Per Client |
|---|---|---|---|---|
| 1 | ADAP | $35,912,608 | 3,231 | $11,115 |
| 2 | Medicaid | $234,419,461 | 10,674 | $21,962 |

Notes:

With the ADAP program paying for ADAP eligible clients, cost are on a downward trend since only wraparound services are being paid.

## CORE SERVICE: MEDICAL CASE MANAGEMENT

**Ranking, Allocation, and Direct Services Expenditure History**

| Fiscal Year | Final Expenditure | Category Expense as % |
|---|---|---|
| **FY 2018** | $21,934,627.17 | 24.2% |
| **FY 2019** | $22,984,844.87 | 25.1% |
| **FY 2020** | $17,660,128.37 | 29.9% |
| **FY 2021** | $19,018,258.46 | 30.2% |
| **FY 2022** | $22,372,897.85 | 27.0% |

| Trend |
|---|
| Expenses and Clients  |

| Fiscal Year | Total Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|
| **FY 2018** | $5,709,857.00 | $5,308,840.20 | 92.98% |
| **FY 2019** | $5,952,739.00 | $5,776,805.90 | 97.04% |
| **FY 2020** | $6,901,831.00 | $5,283,941.69 | 76.56% |
| **FY 2021** | $6,825,797.00 | $5,744,512.45 | 84.16% |
| **FY 2022** | $7,130,657.00 | $6,031,337.35 | 84.58% |

| Fiscal Year | | Part A Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|---|
| **FY 2018** | 2 | $4,929,857.00 | $4,683,761.00 | 95.01% |
| **FY 2019** | 1 | $5,172,739.00 | $5,131,667.10 | 99.21% |
| **FY 2020** | 1 | $5,745,493.00 | $4,932,874.00 | 85.86% |
| **FY 2021** | 1 | $5,921,877.00 | $5,094,347.45 | 86.03% |
| **FY 2022** | 1 | $6,226,737.00 | $5,415,024.15 | 86.96% |

| Fiscal Year | | MAI Final Allocation | Expenditure | % Spent |
|---|---|---|---|---|
| **FY 2018** | 2 | $780,000.00 | $625,079.20 | 80.14% |
| **FY 2019** | 1 | $780,000.00 | $645,138.80 | 82.71% |
| **FY 2020** | 1 | $1,156,338.00 | $351,067.69 | 30.36% |
| **FY 2021** | 1 | $903,920.00 | $650,165.00 | 71.93% |
| **FY 2022** | 1 | $903,920.00 | $616,313.20 | 68.18% |

**Service Program**

**Limitations:** **400% FPL**

| Fiscal Year | RW Clients | Clients Served | Served as % RW Clients | Expenditure | Avg Per Client |
|---|---|---|---|---|---|
| **FY 2018** | 9,578 | 8,496 | 88.7% | $5,308,840.00 | $624.86 |
| **FY 2019** | 9,031 | 8,116 | 89.9% | $5,776,805.90 | $711.78 |
| **FY 2020** | 8,127 | 7,378 | 90.8% | $5,283,941.69 | $716.18 |
| **FY 2021** | 8,420 | 7,842 | 93.1% | $5,744,512.00 | $732.53 |
| **FY 2022** | 8,590 | 8,085 | 94.1% | $6,031,337.35 | $745.99 |

**Other Funding Streams 2022**

| | Funder | Expended | Number of Clients | Cost Per Client |
|---|---|---|---|---|
| 1 | General Revenue | $1,527,951 | 1,897 | $805 |
| 2 | Medicaid | $876,330 | 348 | $2,518 |
| 3 | Part B | $122,567 | 297 | $413 |
| 4 | Part C | $170,453 | 793 | $215 |
| 5 | Part D | $174,501 | 879 | $199 |

**Other Funding Streams 2023**

| | Funder | Expended | Number of Clients | Cost Per Client |
|---|---|---|---|---|
| 1 | General Revenue | $1,470,920 | 1,773 | $830 |
| 2 | Medicaid | $695,650 | 415 | $1,676 |
| 3 | Part B | $88,579 | 579 | $153 |
| 4 | Part C | $67,121 | 64 | $1,049 |
| 5 | Part D | $139,275 | 286 | $487 |

Notes:

Clients and expenditures are up; expenditures highest of five years and clients are almost at pre-pandemic levels. Utilization may change with clients only required to access the service every 366 days.

# SUPPORT SERVICE: MEDICAL TRANSPORTATION

**Ranking, Allocation, and Direct Services Expenditure History**

| Fiscal Year | Final Expenditure | Category Expense as % |
|---|---|---|
| **FY 2018** | $21,934,627.17 | 0.6% |
| **FY 2019** | $22,984,844.87 | 0.6% |
| **FY 2020** | $17,660,128.37 | 0.0% |
| **FY 2021** | $19,018,258.46 | 0.5% |
| **FY 2022** | $22,372,897.85 | 0.7% |

| Trend |
|---|
| Expenses and Clients  |

| Fiscal Year | Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|
| **FY 2018** | $168,832.00 | $139,854.83 | 82.84% |
| **FY 2019** | $151,873.00 | $140,937.32 | 92.80% |
| **FY 2020** | $158,277.00 | $5,641.90 | 3.56% |
| **FY 2021** | $158,316.00 | $100,955.62 | 63.77% |
| **FY 2022** | $217,540.00 | $159,552.49 | 73.34% |

| Fiscal Year | | Part A Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|---|
| **FY 2018** | 7 | $168,832.00 | $139,854.63 | 82.84% |
| **FY 2019** | 10 | $151,873.00 | $140,937.32 | 92.80% |
| **FY 2020** | 10 | $150,649.00 | $5,641.90 | 3.75% |
| **FY 2021** | 10 | $150,688.00 | $98,584.06 | 65.42% |
| **FY 2022** | 10 | $209,912.00 | $153,904.90 | 73.32% |

| Fiscal Year | | MAI Final Allocation | MAI Final | % Spent |
|---|---|---|---|---|
| **FY 2018** | N/A | N/A | N/A | N/A |
| **FY 2019** | N/A | N/A | N/A | N/A |
| **FY 2020** | 4 | $7,628.00 | $0.00 | 0.00% |
| **FY 2021** | 4 | $7,628.00 | $2,371.56 | 31.09% |
| **FY 2022** | 4 | $7,628.00 | $5,647.59 | 74.04% |

**Service Program**

**Limitations: 400% FPL; passes are monthly**

| Fiscal Year | RW Clients | Clients Served | Served as % RW Clients | Expenditure | Avg Per Client |
|---|---|---|---|---|---|
| **FY 2018** | 9,578 | 638 | 6.7% | $139,855.00 | $219.21 |
| **FY 2019** | 9,031 | 720 | 8.0% | $140,937.32 | $195.75 |
| **FY 2020** | 8,127 | 94 | 1.2% | $5,641.90 | $60.02 |
| **FY 2021** | 8,420 | 645 | 7.7% | $100,955.62 | $156.52 |
| **FY 2022** | 8,590 | 727 | 8.5% | $159,552.49 | $219.47 |

**Other Funding Streams 2022**

| | Funder | Expended | Number of Clients | Cost Per Client |
|---|---|---|---|---|
| 1 | General Revenue | $2,189 | 32 | $68 |
| 2 | Medicaid | $1,355,658 | 2,466 | $550 |
| 3 | Part C | $800 | 36 | $22 |
| 4 | Part D | $7,095 | 320 | $22 |

**Other Funding Streams 2023**

| | Funder | Expended | Number of Clients | Cost Per Client |
|---|---|---|---|---|
| 1 | General Revenue | $68,815 | 298 | $231 |
| 2 | Medicaid | $1,577,330 | 2,617 | $603 |
| 3 | Part C | $11,974 | 39 | $307 |
| 4 | Part D | $7,797 | 277 | $28 |

Notes:
Clients and expenditures have increased and are highest in five years.

## CORE SERVICE: MENTAL HEATLH

**Ranking, Allocation, and Direct Services Expenditure History**

| Fiscal Year | Final Expenditure | Category Expense as % |
|---|---|---|
| **FY 2018** | $21,934,627.17 | 0.61% |
| **FY 2019** | $22,984,844.87 | 0.59% |
| **FY 2020** | $17,660,128.37 | 0.51% |
| **FY 2021** | $19,018,258.46 | 0.32% |
| **FY 2022** | $22,372,897.85 | 0.29% |

| Trend |
|---|
| Expenses and Clients  |

| Fiscal Year | Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|
| **FY 2018** | $225,190.00 | $133,790.00 | 59.41% |
| **FY 2019** | $172,190.00 | $135,505.00 | 78.70% |
| **FY 2020** | $142,217.00 | $90,019.31 | 63.30% |
| **FY 2021** | $169,464.00 | $60,238.75 | 35.55% |
| **FY 2022** | $161,654.00 | $64,577.50 | 39.95% |

| Fiscal Year | | Part A Final Allocation | Part A Final Expenditure | % Spent |
|---|---|---|---|---|
| **FY 2018** | 6 | $225,190.00 | $133,790.00 | 59.41% |
| **FY 2019** | 6 | $172,190.00 | $135,505.00 | 78.70% |
| **FY 2020** | 4 | $123,257.00 | $82,435.31 | 66.88% |
| **FY 2021** | 3 | $150,504.00 | $56,566.25 | 37.58% |
| **FY 2022** | 3 | $142,694.00 | $63,570.00 | 44.55% |

| Fiscal Year | | MAI Final Allocation | MAI Final Expenditure | % Spent |
|---|---|---|---|---|
| **FY 2018** | N/A | N/A | N/A | N/A |
| **FY 2019** | NA | N/A | N/A | N/A |
| **FY 2020** | 3 | $18,960.00 | $7,584.00 | 40.00% |
| **FY 2021** | 3 | $18,960.00 | $3,672.50 | 19.37% |
| **FY 2022** | 3 | $18,960.00 | $1,007.50 | 5.31% |

**Service Program**

**Limitations:** **400% FPL**

| Fiscal Year | RW Clients | Clients Served | Served as % RW Clients | Expenditure | Avg Per Client |
|---|---|---|---|---|---|
| **FY 2018** | 9,578 | 327 | 3.4% | $133,790.00 | $409.14 |
| **FY 2019** | 9,031 | 274 | 3.0% | $135,505.00 | $494.54 |
| **FY 2020** | 8,127 | 95 | 1.2% | $90,019.31 | $947.57 |
| **FY 2021** | 8,420 | 121 | 1.4% | $60,238.75 | $497.84 |
| **FY 2022** | 8,590 | 101 | 1.2% | $64,577.50 | $639.38 |

**Other Funding Streams 2022**

| | Funder | Expended | Number of Clients | Cost Per Client |
|---|---|---|---|---|
| 1 | General Revenue | $62,818 | 188 | $334 |
| 2 | Medicaid | $6,111,638 | 2,405 | $2,541 |
| 3 | Other | $612,554 | 141 | $4,344 |
| 4 | Part B | $22,054 | 171 | $129 |
| 5 | Part C | $138,517 | 457 | $303 |
| 6 | Part D | $174,713 | 280 | $624 |

**Other Funding Streams 2023**

| | Funder | Expended | Number of Clients | Cost Per Client |
|---|---|---|---|---|
| 1 | General Revenue | $82,088 | 180 | $456 |
| 2 | Medicaid | $3,195,210 | 1,905 | $1,677 |
| 3 | Other | $729,367 | 134 | $5,443 |
| 4 | Part B | $13,894 | 118 | $118 |
| 5 | Part C | $183,643 | 445 | $413 |
| 6 | Part D | $107,996 | 138 | $783 |

Notes:
Clients continue to decline and expenditues are still below pre-pandemic levels.

# CORE SERVICE: ORAL HEALTH CARE

**Ranking, Allocation, and Direct Services Expenditure History**

| Fiscal Year | Final Expenditure | Category Expense as % |
|---|---|---|
| **FY 2018** | $21,934,627.17 | 13.0% |
| **FY 2019** | $22,984,844.87 | 15.4% |
| **FY 2020** | $17,660,128.37 | 9.3% |
| **FY 2021** | $19,018,258.46 | 13.3% |
| **FY 2022** | $22,372,897.85 | 14.6% |

| Trend |
|---|
| Expenses and Clients  |

| Fiscal Year | Ranking | Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|---|
| **FY 2018** | 5 | $3,009,423.00 | $2,841,838.00 | 94.43% |
| **FY 2019** | 2 | $3,666,830.00 | $3,547,495.00 | 96.75% |
| **FY 2020** | 6 | $2,888,975.00 | $1,645,878.57 | 56.97% |
| **FY 2021** | 4 | $3,108,975.00 | $2,533,061.80 | 81.48% |
| **FY 2022** | 5 | $3,864,445.00 | $3,273,644.50 | 84.71% |

**Service Program**

**Limitations: 400% FPL**

| Fiscal Year | RW Clients | Clients Served | Served as % RW Clients | Expenditure | Avg Per Client |
|---|---|---|---|---|---|
| **FY 2018** | 9,578 | 3,381 | 35.3% | $2,841,838.00 | $840.53 |
| **FY 2019** | 9,031 | 3,170 | 35.1% | $3,547,495.00 | $1,119.08 |
| **FY 2020** | 8,127 | 1,711 | 21.1% | $1,645,878.57 | $961.94 |
| **FY 2021** | 8,420 | 2,237 | 26.6% | $2,533,061.80 | $1,132.35 |
| **FY 2022** | 8,590 | 2,575 | 30.0% | $3,273,644.50 | $1,271.32 |

**Other Funding Streams 2022**

| | Funder | Expended | Number of Clients | Cost Per Client |
|---|---|---|---|---|
| 1 | Part C | $158,813 | 399 | $398 |

**Other Funding Streams 2023**

| | Funder | Expended | Number of Clients | Cost Per Client |
|---|---|---|---|---|
| 1 | Other | $263,157 | 149 | $1,766 |
| 2 | Part C | $209,902 | 398 | $527 |

Notes:

Expenditures have increased and client levels are above pre-pandemic levels. Additions to oral healthcare formulary and removal of annual cap increase expenditures.

# SUPPORT SERVICE: OTHER PROFESSIONAL SERVICES-LEGAL

**Ranking, Allocation, and Direct Services Expenditure History**

| Fiscal Year | Final Expenditure | Category Expense as % |
|---|---|---|
| **FY 2018** | $21,934,627.17 | 0.6% |
| **FY 2019** | $22,984,844.87 | 0.5% |
| **FY 2020** | $17,660,128.37 | 0.8% |
| **FY 2021** | $19,018,258.46 | 0.5% |
| **FY 2022** | $22,372,897.85 | 0.3% |

| Trend |
|---|
| Expenses and Clients  |

| Fiscal Year | Ranking | Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|---|
| **FY 2018** | 12 | $194,000.00 | $140,599.00 | 72.47% |
| **FY 2019** | 13 | $189,000.00 | $115,976.42 | 61.36% |
| **FY 2020** | 13 | $154,449.00 | $146,335.50 | 94.75% |
| **FY 2021** | 13 | $154,449.00 | $97,371.00 | 63.04% |
| **FY 2022** | 13 | $154,449.00 | $67,581.00 | 43.76% |

**Service Program**

**Limitations:** **400 % FPL**

| Fiscal Year | RW Clients | Clients Served | Served as % RW Clients | Expenditure | Avg Per Client |
|---|---|---|---|---|---|
| **FY 2018** | 9,578 | 76 | 0.8% | $140,599.00 | $1,849.99 |
| **FY 2019** | 9,031 | 66 | 0.7% | $115,976.00 | $1,757.21 |
| **FY 2020** | 8,127 | 48 | 0.6% | $146,336.00 | $3,048.67 |
| **FY 2021** | 8,420 | 44 | 0.5% | $97,371.00 | $2,212.98 |
| **FY 2022** | 8,590 | 78 | 0.9% | $67,581.00 | $866.42 |

Notes:

Lowest expenditure in last five years but highest number of clients.

## CORE SERVICE: OUTPATIENT/AMBULATORY HEALTH SERVICES

**Ranking, Allocation, and Direct Services Expenditure History**

| Fiscal Year | Final Expenditure | Category Expense as % |
|---|---|---|
| **FY 2018** | $21,934,627.17 | 41.5% |
| **FY 2019** | $22,984,844.87 | 40.9% |
| **FY 2020** | $17,660,128.37 | 41.9% |
| **FY 2021** | $19,018,258.46 | 40.6% |
| **FY 2022** | $22,372,897.85 | 39.0% |

| Trend |
|---|
| Expenses and Clients  |

| Fiscal Year | Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|
| **FY 2018** | $9,224,722.00 | $9,112,521.26 | 98.78% |
| **FY 2019** | $9,916,009.00 | $9,391,615.42 | 94.71% |
| **FY 2020** | $10,153,862.00 | $7,397,591.74 | 72.85% |
| **FY 2021** | $10,010,471.00 | $7,729,583.99 | 77.21% |
| **FY 2022** | $10,652,424.00 | $8,724,251.44 | 81.90% |

| Fiscal Year | | Part A Final Allocation | Expenditure | % Spent |
|---|---|---|---|---|
| **FY 2018** | 1 | $8,138,920.00 | $8,040,509.80 | 98.79% |
| **FY 2019** | 3 | $8,848,373.00 | $8,438,714.13 | 95.37% |
| **FY 2020** | 2 | $8,661,870.00 | $6,911,704.73 | 79.79% |
| **FY 2021** | 2 | $8,647,718.00 | $7,268,815.93 | 84.05% |
| **FY 2022** | 2 | $9,295,763.00 | $8,063,884.64 | 86.75% |

| Fiscal Year | | MAI Final Allocation | MAI Final Expenditure | % Spent |
|---|---|---|---|---|
| **FY 2018** | 1 | $1,085,802.00 | $1,072,011.46 | 98.73% |
| **FY 2019** | 3 | $1,067,636.00 | $952,901.29 | 89.25% |
| **FY 2020** | 2 | $1,491,992.00 | $485,887.01 | 32.57% |
| **FY 2021** | 2 | $1,362,753.00 | $460,768.06 | 33.81% |
| **FY 2022** | 2 | $1,356,661.00 | $660,366.80 | 48.68% |

**Service Program**

**Limitations:** **400% FPL**

| Fiscal Year | RW Clients | Clients Served | Served as % RW Clients | Expenditure | Avg Per Client |
|---|---|---|---|---|---|
| **FY 2018** | 9,578 | 5,447 | 56.9% | $9,112,521.00 | $1,672.94 |
| **FY 2019** | 9,031 | 5,317 | 58.9% | $9,391,615.42 | $1,766.34 |
| **FY 2020** | 8,127 | 4,281 | 52.7% | $7,397,591.74 | $1,728.01 |
| **FY 2021** | 8,420 | 4,422 | 52.5% | $7,729,583.99 | $1,747.98 |
| **FY 2022** | 8,590 | 4,506 | 52.5% | $8,724,251.44 | $1,936.14 |

**Other Funding Streams 2022**

| | Funder | Expended | Number of Clients | Cost per client |
|---|---|---|---|---|
| 1 | General Revenue | $1,492,544 | 1,702 | $877 |
| 2 | Medicaid | $12,917,775 | 15,438 | $837 |
| 3 | Other | $733,179 | 2,049 | $358 |
| 4 | Part C | $1,056,071 | 3,119 | $339 |
| 5 | Part D | $809,464 | 871 | $929 |

**Other Funding Streams 2023**

| | Funder | Expended | Number of Clients | Cost per client |
|---|---|---|---|---|
| 1 | General Revenue | $1,131,997 | 1,861 | $608 |
| 2 | Medicaid | $13,411,062 | 17,635 | $760 |
| 3 | Other | $1,389,789 | 2,152 | $646 |
| 4 | Part C | $1,029,407 | 4,058 | $254 |
| 5 | Part D | $766,471 | 708 | $1,083 |

Notes:
Increased expenditures and clients closer to FY 2019 figures. Highest avgerage cost per client in last five years.

# SUPPORT SERVICE: OUTREACH SERVICES

**Ranking, Allocation, and Direct Services Expenditure History**

| Fiscal Year | Final Expenditure | Category Expense as % |
|---|---|---|
| **FY 2018** | $21,934,627.17 | 1.4% |
| **FY 2019** | $22,984,844.87 | 1.4% |
| **FY 2020** | $17,660,128.37 | 0.8% |
| **FY 2021** | $19,018,258.46 | 0.7% |
| **FY 2022** | $22,372,897.85 | 0.7% |

| Trend |
|---|
| Expenses and Clients |

| Fiscal Year | Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|
| **FY 2018** | $410,003.00 | $307,379.72 | 74.97% |
| **FY 2019** | $401,643.00 | $332,602.39 | 82.81% |
| **FY 2020** | $304,512.00 | $148,154.86 | 48.65% |
| **FY 2021** | $212,096.00 | $140,761.02 | 66.37% |
| **FY 2022** | $217,902.00 | $151,422.86 | 69.49% |

| Fiscal Year | | Part A Final Allocation | Part A Final Expenditure | % Spent |
|---|---|---|---|---|
| **FY 2018** | 10 | $290,003.00 | $221,434.56 | 76.36% |
| **FY 2019** | 9 | $281,643.00 | $236,599.58 | 84.01% |
| **FY 2020** | 11 | $264,696.00 | $118,293.86 | 44.69% |
| **FY 2021** | 11 | $172,280.00 | $104,263.02 | 60.52% |
| **FY 2022** | 12 | $178,086.00 | $114,924.86 | 64.53% |

| Fiscal Year | | MAI Final Allocation | MAI Final Expenditure | % Spent |
|---|---|---|---|---|
| **FY 2018** | 4 | $120,000.00 | $85,945.16 | 71.62% |
| **FY 2019** | 2 | $120,000.00 | $96,002.81 | 80.00% |
| **FY 2020** | 5 | $39,816.00 | $29,861.00 | 75.00% |
| **FY 2021** | 5 | $39,816.00 | $36,498.00 | 91.67% |
| **FY 2022** | 6 | $39,816.00 | $36,498.00 | 91.67% |

**Service Program**

**Limitations:** **NA**

| Fiscal Year | RW Clients | Clients Served | Served as % RW Clients | Expenditure | Avg Per Client |
|---|---|---|---|---|---|
| **FY 2018** | 9,578 | 624 | 6.5% | $307,380.00 | $492.60 |
| **FY 2019** | 9,031 | 472 | 5.2% | $332,602.39 | $704.67 |
| **FY 2020** | 8,127 | 130 | 1.6% | $148,154.86 | $1,139.65 |
| **FY 2021** | 8,420 | 116 | 1.4% | $140,761.02 | $1,213.46 |
| **FY 2022** | 8,590 | 155 | 1.8% | $151,422.86 | $976.92 |

**Other Funding Streams 2022**

| | Funder | Expended | Number of Clients | Cost per client |
|---|---|---|---|---|
| 1 | Part C | $126,192 | 1,335 | $95 |
| 2 | Part D | $27,725 | 351 | $79 |

**Other Funding Streams 2023**

| | Funder | Expended | Number of Clients | Cost per client |
|---|---|---|---|---|
| 1 | Part C | $41,469 | 1,229 | $34 |
| 2 | Part D | $40,090 | 381 | $105 |

Notes:

Expenditures been dropping since FY 2020, with small increase in FY 2022. Client are slightly up.

# CORE SERVICE: SUBSTANCE ABUSE OUTPATIENT

**Ranking, Allocation, and Direct Services Expenditure History**

| Fiscal Year | Final Expenditure | Category Expense as % |
|---|---|---|
| **FY 2018** | $21,934,627.17 | 0.25% |
| **FY 2019** | $22,984,844.87 | 0.10% |
| **FY 2020** | $17,660,128.37 | 0.13% |
| **FY 2021** | $19,018,258.46 | 0.01% |
| **FY 2022** | $22,372,897.85 | 0.02% |

| Trend |
|---|
| Expenses and Clients  |

| Fiscal Year | Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|
| **FY 2018** | $106,000.00 | $55,390.00 | 52.25% |
| **FY 2019** | $37,166.00 | $23,970.00 | 64.49% |
| **FY 2020** | $52,186.00 | $23,556.19 | 45.14% |
| **FY 2021** | $52,186.00 | $1,356.00 | 2.60% |
| **FY 2022** | $53,526.00 | $4,971.00 | 9.29% |

| Fiscal Year | | Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|---|
| **FY 2018** | 8 | $106,000.00 | $55,390.00 | 52.25% |
| **FY 2019** | 8 | $37,166.00 | $23,970.00 | 64.49% |
| **FY 2020** | 7 | $44,128.00 | $19,527.19 | 44.25% |
| **FY 2021** | 7 | $44,128.00 | $1,146.00 | 2.60% |
| **FY 2022** | 9 | $45,468.00 | $4,401.00 | 9.68% |

| Fiscal Year | | MAI Final Allocation | MAI Final Expenditure | % Spent |
|---|---|---|---|---|
| **FY 2018** | N/A | N/A | N/A | N/A |
| **FY 2019** | N/A | N/A | N/A | N/A |
| **FY 2020** | 4 | $8,058.00 | $4,029.00 | 50.00% |
| **FY 2021** | 4 | $8,058.00 | $210.00 | 2.61% |
| **FY 2022** | 4 | $8,058.00 | $570.00 | 7.07% |

**Service Program**

**Limitations:** **400% FPL**

| Fiscal Year | RW Clients | Clients Served | Served as % RW Clients | Expenditure | Avg Per Client |
|---|---|---|---|---|---|
| **FY 2018** | 9,578 | 115 | 1.2% | $55,390.00 | $481.65 |
| **FY 2019** | 9,031 | 55 | 0.6% | $23,970.00 | $435.82 |
| **FY 2020** | 8,127 | N/A | 0.0% | $23,556.19 | N/A |
| **FY 2021** | 8,420 | 17 | 0.2% | $1,356.00 | $79.76 |
| **FY 2022** | 8,590 | 22 | 0.3% | $4,971.00 | $225.95 |

**Other Funding Streams 2022**

| | Funder | Expended | Number of Clients | Cost Per Client |
|---|---|---|---|---|
| 1 | Part C | $12,528 | 13 | $964 |

**Other Funding Streams 2023**

| | Funder | Expended | Number of Clients | Cost Per Client |
|---|---|---|---|---|
| 1 | Part C | $3,467 | 12 | $289 |

Notes:

Expenditures have steadily declined with FY 2021 having the lowest expenditure in over 5 years.

# SUPPORT SERVICE: SUBSTANCE ABUSE RESIDENTIAL

**Ranking, Allocation, and Direct Services Expenditure History**

| Fiscal Year | Final Expenditure | Category Expense as % |
|---|---|---|
| **FY 2018** | $21,934,627.17 | 8.5% |
| **FY 2019** | $22,984,844.87 | 5.4% |
| **FY 2020** | $17,660,128.37 | 7.5% |
| **FY 2021** | $19,018,258.46 | 5.1% |
| **FY 2022** | $22,372,897.85 | 4.7% |

| Trend |
|---|
| Expenses and Clients  |

| Fiscal Year | Final Allocation | Final Expenditure | % Spent |
|---|---|---|---|
| **FY 2018** | $2,065,200.00 | $1,854,140.00 | 89.78% |
| **FY 2019** | $1,398,180.00 | $1,237,830.00 | 88.53% |
| **FY 2020** | $1,773,744.00 | $1,320,120.00 | 74.43% |
| **FY 2021** | $1,289,469.00 | $968,310.00 | 75.09% |
| **FY 2022** | $1,538,406.00 | $1,053,590.00 | 68.49% |

| Fiscal Year | | Part A Final Allocation | Part A Final | % Spent |
|---|---|---|---|---|
| **FY 2018** | 11 | $1,828,000.00 | $1,617,080.00 | 88.46% |
| **FY 2019** | 11 | $895,280.00 | $805,560.00 | 89.98% |
| **FY 2020** | 9 | $1,773,744.00 | $1,320,120.00 | 74.43% |
| **FY 2021** | 8 | $1,289,469.00 | $968,310.00 | 75.09% |
| **FY 2022** | 7 | $1,538,406.00 | $1,053,590.00 | 68.49% |

| Fiscal Year | | MAI Final Allocation | MAI Final Expenditure | % Spent |
|---|---|---|---|---|
| **FY 2018** | 5 | $237,200.00 | $237,060.00 | 99.94% |
| **FY 2019** | 8 | $502,900.00 | $432,270.00 | 85.96% |
| **FY 2020** | N/A | N/A | N/A | N/A |
| **FY 2021** | N/A | N/A | N/A | N/A |
| **FY 2022** | N/A | N/A | N/A | N/A |

**Service Program**

**Limitations: 400% FPL: 180 day within 12-month period max**

| Fiscal Year | RW Clients | Clients Served | Served as % RW Clients | Expenditure | Avg Per Client |
|---|---|---|---|---|---|
| **FY 2018** | 9,578 | 169 | 1.8% | $1,854,140.00 | $10,971.24 |
| **FY 2019** | 9,031 | 95 | 1.1% | $1,237,830.00 | $13,029.79 |
| **FY 2020** | 8,127 | 70 | 0.9% | $1,320,120.00 | $18,858.86 |
| **FY 2021** | 8,420 | 66 | 0.8% | $968,310.00 | $14,671.36 |
| **FY 2022** | 8,590 | 72 | 0.8% | $1,053,590.00 | $14,633.19 |

**Other Funding Streams 2022**

| | Funder | Expended | Number of Clients | Cost Per Client |
|---|---|---|---|---|
| 1 | General Revenue | $166,098 | 18 | $9,228 |

**Other Funding Streams 2023**

| | Funder | Expended | Number of Clients | Cost Per Client |
|---|---|---|---|---|
| 1 | General Revenue | $462,172 | 43 | $10,748 |

Notes:

Expenditures have been on downward trend as have clients. Slight increase in both clients and expenditures in FY 22 vs FY

# UNMET NEED

# SECTION 8

# Ryan White Program
# 2022 Client Satisfaction Survey
## Summary of Findings

aidsnet.org

Presented on
May 4, 2023

Prepared by
Behavioral Science Research Corporation

BEHAVIORAL SCIENCE RESEARCH

MIAMI-DADE HIV/AIDS PARTNERSHIP

MIAMI-DADE COUNTY

# 2022 Ryan White Program Client Satisfaction Survey

- FY 2022 was the 14th consecutive Ryan White Client Satisfaction Survey (CSS) administered by Behavioral Science Research (BSR). This survey has been conducted annually since 2008.
- Provides BSR and the Miami-Dade County RWP with an annual opportunity to take the pulse of program clients.
- 589 client interviews were completed, focusing on Medical Case Management (MCM), Outpatient Ambulatory Health Services (OAHS) and Oral Health Care (OHC) service categories.
- Survey data collection was conducted between September and October 2022.

# Survey Methodology

- Clients were interviewed by telephone to avoid COVID-19 contact issues.
  - The clients were quota-sampled by MCM Subrecipient site, based on the number of clients currently being seen at each site. A total of 589 MCM clients were interviewed, of whom 311 also qualified for OHC surveys. A representative sample of clients with ACA insurance was sampled from each service site.
    - 23 RWP MCM sites were sampled.
    - 220 clients had ACA insurance.
  - Clients must have been in MCM care at the site for at least 6 months.
  - Clients were recruited by MCMs from a list of clients receiving MCM services. These clients gave consent for BSR to conduct the interview before BSR could contact them.
- As an incentive to participate, clients were given a $30 Walmart “e-gift” card, by text, email, or sent by US mail.

# Service Utilization among Client Satisfaction Survey Respondents, FY 2020-2022

| SERVICE CATEGORY | 2020 | | 2021 | | 2022 | |
|---|---|---|---|---|---|---|
| | # Served | % of Total | # Served | % of Total | # Served | % of Total |
| Medical Case Management | 325 | 100% | N/A | N/A | 589 | 100% |
| Outpatient Ambulatory Health Services | 315 | 97% | 517 | 100% | 553 | 94% |
| Oral Health Care | 133 | 42% | 201 | 39% | 311 | 53% |

# Summary of Client Satisfaction Survey Respondent Characteristics (1)

| Ethnicity (2% other) | |
|---|---|
| Hispanic | 59% |
| Black non-Hispanic | 23% |
| Haitian | 11% |
| White non-Hispanic | 5% |

| Age | |
|---|---|
| Under 35 years | 18% |
| 35-49 years | 29% |
| 50-64 years | 48% |
| 65 years and above | 5% |

| Preferred Language | |
|---|---|
| English | 42% |
| Spanish | 48% |
| Haitian Creole | 10% |

| Gender | |
|---|---|
| Males | 78% |
| Females | 21% |
| Transgender | 1% |

# Summary of Client Satisfaction Survey Respondent Characteristics (2)

| Year of HIV/AIDS Diagnosis (5% don't remember) | |
|---|---|
| Before 1995 | 11% |
| 1995 – 2004 | 23% |
| 2005-2014 | 30% |
| 2015 – present | 31% |

| First Treated in Miami-Dade County (5% don't know) | |
|---|---|
| Before 1995 | 4% |
| 1995-2004 | 18% |
| 2005-2014 | 27% |
| 2015 – present | 46% |

| Employment Status | |
|---|---|
| Working full time | 41% |
| Working part time | 20% |
| Sporadic, episodic | 11% |
| Not working | 28% |

| Education | |
|---|---|
| Less than High School | 3% |
| High School, Trade School | 45% |
| AA or Post-HS certificate | 19% |
| College or post-grad | 33% |

# Summary of Client Satisfaction Survey Respondent Characteristics (3)

| Sexual Orientation (1% refused to answer) | |
|---|---|
| Heterosexual | 35% |
| Gay/Lesbian | 53% |
| Bisexual/Pansexual | 10% |
| Other | 1% |

| Mode of Acquisition (10% don't know) | |
|---|---|
| Male-Male Sexual Contact (MMSC) | 56% |
| Male heterosexual contact | 11% |
| Female heterosexual contact | 15% |
| Male IDU | 3% |
| Female IDU | <1% |
| Some other way | 4% |

| Tele-Health Use for MCM | |
|---|---|
| All visits in person | 59% |
| Most in person, some tele-health | 14% |
| Half in person, half tele-health | 13% |
| Most or all visits tele-health | 14% |

| Reported Problems | |
|---|---|
| Signing up for Ryan White Program services? | 3% |
| Language barriers in services? | 2% |

# Summary of Client Satisfaction Survey
# ACA Usage by 220 Clients

| MCM gave full instructions on how to use GAP card? (2% don't remember) | |
|---|---|
| Yes | 92% |
| No | 6% |

| Was GAP card used at PCP? (1% don't remember) | |
|---|---|
| GAP Card was used (n = 184) | 84% |
| GAP Card was not used | 15% |

| Of 184 clients who used the GAP Card, were there problems using it? | |
|---|---|
| Yes (n-41) | 22% |
| No | 78% |

| Of 41 clients with problems, was problem resolved so client did not pay out of pocket? (2% don't remember) | |
|---|---|
| Yes | 37% |
| No | 61% |

# Percent "Very Satisfied" with Specific Personnel FY 2020-2022

| SERVICE CATEGORY | 2020 | 2021 | 2022 |
|---|---|---|---|
| | % Very Satisfied | % Very Satisfied | % Very Satisfied |
| Medical Case Manager | 81% | N/A | 80% |
| Physician (MD, DO), APRN, PA | 72% | 76% | 80% |
| Dentist | 56% | 56% | 58% |
| Oral hygienist | 55% | 66% | 62% |

# Adherence Counseling at Medical Case Management (MCM)/Primary Medical Provider (PMP) Visits

| When the client visits their MCM/PMP, how frequently does the provider… | For MCMs | For PMPs |
|---|---|---|
| Discuss the importance of client making all appointments? (% at every visit) | 76% | 85% |
| *Information is clear and easy to understand* | 81% | 82% |
| Discuss the importance of the client taking all required medications? (% at every visit) | 74% | 89% |
| *Information is clear and easy to understand* | 81% | 81% |
| Discuss the importance of getting/keeping VLs undetectable? (% at every visit) | 71% | 88% |
| *Information is clear and easy to understand* | 79% | 81% |

# Percent "Very Satisfied" with Lagtime to New/Next Appointment 2020-2022

| SERVICE CATEGORY | 2020 | 2021 | 2022 |
|---|---|---|---|
| | % Very Satisfied | % Very Satisfied | % Very Satisfied |
| Medical Case Management | 58% | N/A | 65% |
| Outpatient Ambulatory Health Services | 51% | 46% | 51% |
| Oral Health Care | 37% | 23% | 26% |

# Percent "Very Satisfied" with the Amount of Time it Takes to Get a Phone Call Returned 2020-2022

| SERVICE CATEGORY | 2020 | 2021 | 2022 |
|---|---|---|---|
| | % Very Satisfied | % Very Satisfied | % Very Satisfied |
| Medical Case Management | 55% | N/A | 65% |
| Outpatient Ambulatory Health Services | 36% | 28% | 38% |

# Percent "Very Easy" to Make New/Next Appointments for Care

| SERVICE CATEGORY | 2021 | 2022 |
|---|---|---|
| | % Very Easy | % Very Easy |
| Medical Case Management | N/A | 64% |
| Outpatient Ambulatory Health Services | 46% | 52% |
| Oral Health Care | 26% | 32% |

Note: 9% reported problems keeping appointments with their OAHS providers. Of those who had problems, the most frequently mentioned reason (27%) was that they had conflicts with their work schedules.

# Major Client Satisfaction Survey (CSS) findings to keep in mind …

- Black/African Americans and persons 50-64 years old were slightly over-represented in the CSS sample when compared to the RWP as a whole (based on Needs Assessment demographic data, 2022).

- Over half the MCM client base is working full-time (41%) or part-time (20%), potentially complicating access to RWP services.
  - However, only 9% reported problems keeping their medical appointments. Of these, only 27% reported that work conflicts were the main obstacle.

- Preferred survey language was English for 42% of the respondents, Spanish for 48%, and Haitian Creole for 10%.
  - Only 2% reported difficulty communicating with agency staff in preferred language.

# More Client Satisfaction Survey (CSS) findings …

- "Ease of making an appointment" is easiest for MCM (64%), over OAHS (52%) and OHC (32%).
  - "Very easy" ratings for OAHS and OHC clients are higher than 2021.

- "Appointment satisfaction" and "contact satisfaction" levels in 2022 are higher for MCM than OAHS and OHC.
  - 64% of MCM clients are "very satisfied" with lagtime to getting a "new or next" appointment (vs. 52% for OAHS, 32% for OHC).
    - MCM client satisfaction with appointment lagtime in 2022 is much higher than the 58% reported in 2020.
  - Satisfaction with the time it takes to get a phone call returned is higher for MCM clients (65% very satisfied) than for OAHS (38%).
    - MCM client satisfaction with returned phone calls in 2022 is much higher than the 55% reported in 2020.

# Reported Feelings of (Non)Discrimination Within the Ryan White Program

| Discrimination at Medical Provider's Office (2021 CSS) or MCM's Office (2022 CSS) | MCM (% no) | PMP (% no) |
|---|---|---|
| Did _____ say or do anything to make you feel uncomfortable or discriminated against? | 98% | 99% |
| Were you ever treated unfairly at your _____ office because of your race/ethnicity? | 99% | 99% |
| *…because of your country of origin?* | 99% | 99% |
| *…because of your sexual orientation?* | 99% | 99% |
| *…because of your HIV infection?* | 99% | 99% |
| *…because of your gender?* | 99% | 99% |
| Did anyone at your _____ office do or say anything to make you feel uncomfortable or discriminated against? | 96% | 97% |

# Ryan White Program Testimonials from Qualitative Stigma Study

- “It was a situation that made me cry (acquiring HIV)… they hugged me and told me not to cry… those are beautiful things that made me stay (in the program) and feel at perfect ease.”
- "Never ever did I feel that there was someone who had… a type of discrimination or had said a word that hurt me ... on the contrary, everyone received me with great affection and gave me great encouragement.”
- “(Other providers outside the RWP) don’t inspire confidence. They discriminate against me because of my appearance… (The personnel in the RWP) treat me really well. I don’t have any complaints about them.”
- “I cannot say anything negative (about the care within the program)… They always welcome me, if I have an urgency to see the doctor and I did not have appointment, they let me in.”
- “I am eternally grateful for Ryan White… The care I receive is wonderful, it’s familial, very beautiful, very empathetic. I am very grateful to God and to Ryan White.”

# "Experienced Stigma" Scores by Priority Populations

| Total and Component Abbreviated Stigma Scale Scores by Race/Ethnicity/Gender Client Group | | | | | |
|---|---|---|---|---|---|
| Priority Population | Total Stigma Score | Disclosure Concerns | Negative Self Image | Personalized Stigma | Public Attitudes |
| BAA Male Hetero | 27.0 | 8.5 | 5.5 | 5.7 | 7.3 |
| BAA MSM | 28.3 | 8.6 | 5.6 | 6.0 | 8.0 |
| BAA Female | 28.8 | 8.7 | 6.1 | 6.1 | 7.8 |
| Haitian Male | 28.7 | 9.5 | 6.5 | 5.8 | 7.0 |
| Haitian Female | 30.1 | 10.2 | 6.2 | 6.0 | 7.8 |
| Hispanic Male Hetero | 29.7 | 9.0 | 6.3 | 6.7 | 7.6 |
| Hispanic MSM | 27.8 | 8.6 | 5.9 | 6.0 | 7.3 |
| Hispanic Female | 29.6 | 8.7 | 6.4 | 6.6 | 8.0 |
| White Male | 24.1 | 7.3 | 5.1 | 5.0 | 6.8 |
| White Female | 27.0 | 8.0 | 4.5 | 6.5 | 8.0 |
| Other | 25.3 | 7.9 | 4.9 | 5.4 | 7.1 |
| **All Respondents** | **28.0** | **8.7** | **5.9** | **6.0** | **7.4** |

* Highlighted cells indicate deviation ≥0.5 points above the average for that section.
**Midpoint for Total Stigma Score is 30.0. Midpoint for each stigma component is 7.5.

# "Experienced Stigma" Scores by Age of Clients

| Total and Component Abbreviated Stigma Scale Scores by Age of Clients | | | | | |
|---|---|---|---|---|---|
| Age Categories | Total Stigma Score | Disclosure Concerns | Negative Self-Image | Personalized Stigma | Public Attitudes |
| 18-24 (n=10) | 28.4 | 9.4 | 5.6 | 5.2 | 8.2 |
| 25-34 (n=90) | 28.2 | 8.6 | 5.9 | 5.9 | 7.7 |
| 35-44 (n=105) | 28.6 | 8.6 | 6.0 | 6.2 | 7.8 |
| 45-54 (n=138) | 27.2 | 8.4 | 5.7 | 6.0 | 7.1 |
| 55-64 (n=181) | 28.3 | 8.8 | 6.0 | 6.0 | 7.4 |
| 65+ (n=26) | 27.3 | 8.8 | 5.7 | 5.7 | 7.1 |
| **All Respondents** | **28.0** | **8.7** | **5.9** | **6.0** | **7.4** |

*Highlighted cells indicate deviation ≥0.5 points above the average for that section.
**Midpoint for Total Score is 30.0. Midpoint for each stigma component is 7.5.

# Thank you for your attention.

# Any questions?

# HRSA SERVICE CATEGORIES

# USING MAI FUNDS

# SECTION 9

# *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds*

*Policy Clarification Notice (PCN)* #16-02 (Revised 10/22/18)
*Replaces Policy #10-02*

**Scope of Coverage:** Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, and D, and Part F where funding supports direct care and treatment services.

## Purpose of PCN

This policy clarification notice (PCN) replaces the HRSA HIV/AIDS Bureau (HAB) PCN 10-02: Eligible Individuals & Allowable Uses of Funds. This PCN defines and provides program guidance for each of the Core Medical and Support Services named in statute and defines individuals who are eligible to receive these HRSA RWHAP services.

## Background

The Office of Management and Budget (OMB) has consolidated, in 2 CFR Part 200, the uniform grants administrative requirements, cost principles, and audit requirements for all organization types (state and local governments, non-profit and educational institutions, and hospitals) receiving federal awards. These requirements, known as the "Uniform Guidance," are applicable to recipients and subrecipients of federal funds. The OMB Uniform Guidance has been codified by the Department of Health and Human Services (HHS) in 45 CFR Part 75—Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards. HRSA RWHAP grant and cooperative agreement recipients and subrecipients should be thoroughly familiar with 45 CFR Part 75. Recipients are required to monitor the activities of its subrecipient to ensure the subaward is used for authorized purposes in compliance with applicable statute, regulations, policies, program requirements and the terms and conditions of the award (see 45 CFR §§ 75.351-352).

45 CFR Part 75, Subpart E—Cost Principles must be used in determining allowable costs that may be charged to a HRSA RWHAP award. Costs must be necessary and reasonable to carry out approved project activities, allocable to the funded project, and allowable under the Cost Principles, or otherwise authorized by the RWHAP statute. The treatment of costs must be consistent with recipient or subrecipient policies and procedures that apply uniformly to both federally-financed and other non-federally funded activities.

HRSA HAB has developed program policies that incorporate both HHS regulations

and program specific requirements set forth in the RWHAP statute. Recipients, planning bodies, and others are advised that independent auditors, auditors from the HHS' Office of the Inspector General, and auditors from the U.S. Government Accountability Office may assess and publicly report the extent to which an HRSA RWHAP award is being administered in a manner consistent with statute, regulation and program policies, such as these, and compliant with legislative and programmatic policies. Recipients can expect fiscal and programmatic oversight through HRSA monitoring and review of budgets, work plans, and subrecipient agreements. HRSA HAB is able to provide technical assistance to recipients and planning bodies, where assistance with compliance is needed.

Recipients are reminded that it is their responsibility to be fully cognizant of limitations on uses of funds as outlined in statute, 45 CFR Part 75, the HHS Grants Policy Statement, and applicable HRSA HAB PCNs. In the case of services being supported in violation of statute, regulation or programmatic policy, the use of RWHAP funds for such costs must be ceased immediately and recipients may be required to return already-spent funds to the Federal Government. Recipients who unknowingly continue such support are also liable for such expenditures.

## Further Guidance on Eligible Individuals and Allowable Uses of Ryan White HIV/AIDS Program Funds

The RWHAP statute, codified at title XXVI of the Public Health Service Act, stipulates that "funds received...will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made under...an insurance policy, or under any Federal or State health benefits program" and other specified payment sources.[1] At the individual client-level, this means recipients must assure that funded subrecipients make reasonable efforts to secure non-RWHAP funds whenever possible for services to eligible clients. In support of this intent, it is an appropriate use of HRSA RWHAP funds to provide case management (medical or non-medical) or other services that, as a central function, ensure that eligibility for other funding sources is vigorously and consistently pursued (e.g., Medicaid, Children's Health Insurance Program (CHIP), Medicare, or State-funded HIV programs, and/or private sector funding, including private insurance).

In every instance, HRSA HAB expects that services supported with HRSA RWHAP funds will (1) fall within the legislatively-defined range of services, (2) as appropriate, within Part A, have been identified as a local priority by the HIV Health Services Planning Council/Body, and (3) in the case of allocation decisions made by a Part B State/Territory or by a local or regional consortium, meet documented needs and contribute to the establishment of a continuum of care.

HRSA RWHAP funds are intended to support only the HIV-related needs of

[1] *See* sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.

eligible individuals. Recipients and subrecipients must be able to make an explicit connection between any service supported with HRSA RWHAP funds and the intended client's HIV care and treatment, or care-giving relationship to a person living with HIV (PLWH).

**Eligible Individuals:**

The principal intent of the RWHAP statute is to provide services to PLWH, including those whose illness has progressed to the point of clinically defined AIDS. When setting and implementing priorities for the allocation of funds, recipients, Part A Planning Councils, community planning bodies, and Part B funded consortia may optionally define eligibility for certain services more precisely, but they may NOT broaden the definition of who is eligible for services. HRSA HAB expects all HRSA RWHAP recipients to establish and monitor procedures to ensure that all funded providers verify and document client eligibility.

Affected individuals (people not identified with HIV) may be eligible for HRSA RWHAP services in limited situations, but these services for affected individuals must always benefit PLWH. Funds awarded under the HRSA RWHAP may be used for services to individuals affected by HIV only in the circumstances described below:

a. The primary purpose of the service is to enable the affected individual to participate in the care of a PLWH. Examples include caregiver training for in-home medical or support service; psychosocial support services, such as caregiver support groups; and/or respite care services that assist affected individuals with the stresses of providing daily care for a PLWH.

b. The service directly enables a PLWH to receive needed medical or support services by removing an identified barrier to care. Examples include payment of a HRSA RWHAP client's portion of a family health insurance policy premium to ensure continuity of insurance coverage that client, or childcare for the client's children while they receive HIV-related medical care or support services.

c. The service promotes family stability for coping with the unique challenges posed by HIV. Examples include psychosocial support services, including mental health services funded by RWHAP Part D only, that focus on equipping affected family members, and caregivers to manage the stress and loss associated with HIV.

d. Services to affected individuals that meet these criteria may not continue subsequent to the death of the family member who was living with HIV.

Unallowable Costs:
HRSA RWHAP funds may not be used to make cash payments to intended clients of HRSA RWHAP-funded services. This prohibition includes cash incentives and

cash intended as payment for HRSA RWHAP core medical and support services. Where direct provision of the service is not possible or effective, store gift cards,[2] vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used.

HRSA RWHAP recipients are advised to administer voucher and store gift card programs in a manner which assures that vouchers and store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and store gift cards.[3]

Other unallowable costs include:

- Clothing
- Employment and Employment-Readiness Services, except in limited, specified instances (e.g., Non-Medical Case Management Services or Rehabilitation Services)
- Funeral and Burial Expenses
- Property Taxes
- Pre-Exposure Prophylaxis (PrEP)
- non-occupational Post-Exposure Prophylaxis (nPEP)
- Materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual
- International travel
- The purchase or improvement of land
- The purchase, construction, or permanent improvement of any building or other facility

Allowable Costs:
The following service categories are allowable uses of HRSA RWHAP funds. The HRSA RWHAP recipient, along with respective planning bodies, will make the final decision regarding the specific services to be funded under their grant or cooperative agreement. As with all other allowable costs, HRSA RWHAP recipients are responsible for applicable accounting and reporting on the use of HRSA RWHAP funds.

## Service Category Descriptions and Program Guidance

The following provides both a description of covered service categories and program guidance for HRSA RWHAP Part recipient implementation. These service category descriptions apply to the entire HRSA RWHAP. However, for some services, the

[2] Store gift cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the HRSA RWHAP are allowable as incentives for eligible program participants.
[3] General-use prepaid cards are considered “cash equivalent” and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.

HRSA RWHAP Parts (i.e., A, B, C, and D) must determine what is feasible and justifiable with limited resources. There is no expectation that a HRSA RWHAP Part recipient would provide all services, but recipients and planning bodies are expected to coordinate service delivery across Parts to ensure that the entire jurisdiction/service area has access to services based on needs assessment.

The following core medical and support service categories are important to assist in the diagnosis of HIV infection, linkage to and entry into care for PLWH, retention in care, and the provision of HIV care and treatment. HRSA RWHAP recipients are encouraged to consider all methods or means by which they can provide services, including use of technology (e.g., telehealth). To be an allowable cost under the HRSA RWHAP, all services must:

- Relate to HIV diagnosis, care and support,
- Adhere to established HIV clinical practice standards consistent with U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV[4] and other related or pertinent clinical guidelines, and
- Comply with state and local regulations, and provided by licensed or authorized providers, as applicable.

Recipients are required to work toward the development and adoption of service standards for all HRSA RWHAP-funded services to ensure consistent quality care is provided to all HRSA RWHAP-eligible clients. Service standards establish the minimal level of service or care that a HRSA RWHAP funded agency or provider may offer within a state, territory or jurisdiction. Service standards related to HRSA RWHAP Core Medical Services must be consistent with U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as other pertinent clinical and professional standards. Service standards related to HRSA RWHAP Support Services may be developed using evidence-based or evidence-informed best practices, the most recent HRSA RWHAP Parts A and B National Monitoring Standards, and guidelines developed by the state and local government.

HRSA RWHAP recipients should also be familiar with implementation guidance HRSA HAB provides in program manuals, monitoring standards, and other recipient resources.

HRSA RWHAP clients must meet income and other eligibility criteria as established by HRSA RWHAP Part A, B, C, or D recipients.

## RWHAP Core Medical Services

AIDS Drug Assistance Program Treatments

[4] https://aidsinfo.nih.gov/guidelines

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

Substance Abuse Outpatient Care

### RWHAP Support Services

Child Care Services

Emergency Financial Assistance

Food Bank/Home Delivered Meals

Health Education/Risk Reduction

Housing

Legal Services

Linguistic Services

Medical Transportation

Non-Medical Case Management Services

Other Professional Services

Outreach Services

Permanency Planning

Psychosocial Support Services

Referral for Health Care and Support Services

Rehabilitation Services

Respite Care

Substance Abuse Services (residential)

**Effective Date**
This PCN is effective for HRSA RWHAP Parts A, B, C, D, and F awards issued on or after October 1, 2016. This includes competing continuations, new awards, and non- competing continuations.

**Summary of Changes**
**August 18, 2016** –Updated *Housing Service* category by removing the prohibition on HRSA RWHAP Part C recipients to use HRSA RWHAP funds for this service.

**December 12, 2016** – 1) Updated *Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals* service category by including standalone dental insurance as an allowable cost; 2) Updated *Substance Abuse Services (residential)* service category by removing the prohibition on HRSA RWHAP Parts C and D recipients to use HRSA RWHAP funds for this service; 3) Updated *Medical Transportation* service category by providing clarification on provider transportation; 4) Updated *AIDS Drug Assistance Program Treatments* service category by adding additional program guidance; and 5) Reorganized the service categories alphabetically and provided hyperlinks in the Appendix.

**October, 22, 2018** – updated to provide additional clarifications in the following service categories:

Core Medical Services: *AIDS Drug Assistance Program Treatments; AIDS Pharmaceutical Assistance; Health Insurance Premium and Cost Sharing Assistance for Low-income People Living with HIV; and Outpatient/Ambulatory Health Services*
Support Services: *Emergency Financial Assistance; Housing; Non-Medical Case Management; Outreach; and Rehabilitation Services*.

# Appendix

## *RWHAP Legislation: Core Medical Services*

### AIDS Drug Assistance Program Treatments

*Description:*
The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under RWHAP Part B to provide U.S. Food and Drug Administration (FDA)-approved medications to low-income clients living with HIV who have no coverage or limited health care coverage. HRSA RWHAP ADAP formularies must include at least one FDA-approved medicine in each drug class of core antiretroviral medicines from the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV.[5] HRSA RWHAP ADAPs can also provide access to medications by using program funds to purchase health care coverage and through medication cost sharing for eligible clients. HRSA RWHAP ADAPs must assess and compare the aggregate cost of paying for the health care coverage versus paying for the full cost of medications to ensure that purchasing health care coverage is cost effective in the aggregate. HRSA RWHAP ADAPs may use a limited amount of program funds for activities that enhance access to, adherence to, and monitoring of antiretroviral therapy with prior approval.

*Program Guidance:*
HRSA RWHAP Parts A, C and D recipients may contribute RWHAP funds to the RWHAP Part B ADAP for the purchase of medication and/or health care coverage and medication cost sharing for ADAP-eligible clients.

*See* PCN 07-03: The Use of Ryan White HIV/AIDS Program, Part B AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence, and Monitoring Services

*See* PCN 18-01: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance

*See also* AIDS Pharmaceutical Assistance and Emergency Financial Assistance

### AIDS Pharmaceutical Assistance

*Description:*
AIDS Pharmaceutical Assistance may be provided through one of two programs, based on HRSA RWHAP Part funding.

1. A Local Pharmaceutical Assistance Program (LPAP) is operated by a HRSA RWHAP Part A or B (non-ADAP) recipient or subrecipient as a supplemental means of providing ongoing medication assistance when an HRSA RWHAP ADAP

[5] https://aidsinfo.nih.gov/guidelines

has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

HRSA RWHAP Parts A or B recipients using the LPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- Uniform benefits for all enrolled clients throughout the service area
- A recordkeeping system for distributed medications
- An LPAP advisory board
- A drug formulary that is
    - Approved by the local advisory committee/board, and
    - Consists of HIV-related medications not otherwise available to the clients due to the elements mentioned above
- A drug distribution system
- A client enrollment and eligibility determination process that includes screening for HRSA RWHAP ADAP and LPAP eligibility with rescreening at minimum of every six months
- Coordination with the state's HRSA RWHAP Part B ADAP
    - A statement of need should specify restrictions of the state HRSA RWHAP ADAP and the need for the LPAP
- Implementation in accordance with requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

2. A Community Pharmaceutical Assistance Program (CPAP) is provided by a HRSA RWHAP Part C or D recipient for the provision of ongoing medication assistance to eligible clients <u>in the absence of any other resources</u>.

HRSA RWHAP Parts C or D recipients using CPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- A financial eligibility criteria and determination process for this specific service category
- A drug formulary consisting of HIV-related medications not otherwise available to the clients
- Implementation in accordance with the requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

*Program Guidance:*
For LPAPs: HRSA RWHAP Part A or Part B (non-ADAP) funds may be used to support an LPAP. HRSA RWHAP ADAP funds may not be used for LPAP support. LPAP funds are not to be used for emergency or short-term financial assistance. The Emergency Financial Assistance service category may assist with short-term assistance for medications.

For CPAPs: HRSA RWHAP Part C or D funds may be used to support a CPAP to routinely refill medications. HRSA RWHAP Part C or D recipients should use the Outpatient/Ambulatory Health Services or Emergency Financial Assistance service

categories for non-routine, short-term medication assistance.

*See also* AIDS Drug Assistance Program Treatments, Emergency Financial Assistance, and Outpatient/Ambulatory Health Services

**Early Intervention Services (EIS)**

*Description:*
The RWHAP legislation defines EIS for Parts A, B, and C. See § 2651(e) of the Public Health Service Act.

*Program Guidance:*
The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. HRSA RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

- HRSA RWHAP Parts A and B EIS services must include the following four components:
    - Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be living with HIV
        - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
        - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
    - Referral services to improve HIV care and treatment services at key points of entry
    - Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
    - Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

- HRSA RWHAP Part C EIS services must include the following four components:
    - Counseling individuals with respect to HIV
    - High risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency)
        - Recipients must coordinate these testing services under HRSA RWHAP Part C EIS with other HIV prevention and testing programs to avoid duplication of efforts
        - The HIV testing services supported by HRSA RWHAP Part C EIS funds cannot supplant testing efforts covered by other sources
    - Referral and linkage to care of PLWH to Outpatient/Ambulatory Health

Services, Medical Case Management, Substance Abuse Care, and other services as part of a comprehensive care system including a system for tracking and monitoring referrals
- Other clinical and diagnostic services related to HIV diagnosis

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

*Description:*

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client.

To use HRSA RWHAP funds for health insurance premium assistance (not standalone dental insurance assistance), an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- Clients obtain health care coverage that at a minimum, includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient/ambulatory health services; and
- The cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services (HRSA RWHAP Part A, HRSA RWHAP Part B, HRSA RWHAP Part C, and HRSA RWHAP Part D).

To use HRSA RWHAP funds for standalone dental insurance premium assistance, an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirement:

- HRSA RWHAP Part recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only

when determined to be cost effective.

*Program Guidance:*
Traditionally, HRSA RWHAP Parts A and B recipients have supported paying for health insurance premiums and cost sharing assistance. If a HRSA RWHAP Part C or Part D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective.

HRSA RWHAP Parts A, B, C, and D recipients may consider providing their health insurance premiums and cost sharing resource allocation to their state HRSA RWHAP ADAP, particularly where the ADAP has the infrastructure to verify health care coverage status and process payments for public or private health care coverage premiums and medication cost sharing.

*See* PCN 14-01: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act

*See* PCN 18-01: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance

**Home and Community-Based Health Services**
*Description:*
Home and Community-Based Health Services are provided to an eligible client in an integrated setting appropriate to that client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services and personal care services in the home

*Program Guidance:*
Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.

**Home Health Care**
*Description:*
Home Health Care is the provision of services in the home that are appropriate to an eligible client's needs and are performed by licensed professionals. Activities provided under Home Health Care must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care

- Routine diagnostics testing administered in the home
- Other medical therapies

*Program Guidance:*
The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

**Hospice Services**
*Description:*
Hospice Services are end-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are:

- Mental health counseling
- Nursing care
- Palliative therapeutics
- Physician services
- Room and board

*Program Guidance:*
Hospice Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes.

To meet the need for Hospice Services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the recipient. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective state Medicaid programs.

**Medical Case Management, including Treatment Adherence Services**
*Description:*
Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan

- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented activities above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

*Program Guidance:*
Activities provided under the Medical Case Management service category have as their objective improving health care outcomes whereas those provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

**Medical Nutrition Therapy**
*Description:*
Medical Nutrition Therapy includes:
- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

These activities can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

*Program Guidance:*
All activities performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Activities not provided by a

registered/licensed dietician should be considered Psychosocial Support Services under the HRSA RWHAP.

*See also* Food-Bank/Home Delivered Meals

**Mental Health Services**
*Description:*
Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

*Program Guidance:*
Mental Health Services are allowable only for PLWH who are eligible to receive HRSA RWHAP services.

*See also* Psychosocial Support Services

**Oral Health Care**
*Description:*
Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

*Program Guidance:*
None at this time.

**Outpatient/Ambulatory Health Services**
*Description:*
Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include: clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits.

Allowable activities include:
- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy

- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

*Program Guidance:*
Treatment adherence activities provided during an Outpatient/Ambulatory Health Service visit are considered Outpatient/Ambulatory Health Services, whereas treatment adherence activities provided during a Medical Case Management visit are considered Medical Case Management services.

Non-HIV related visits to urgent care facilities are not allowable costs within the Outpatient/Ambulatory Health Services Category.

Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

*See* PCN 13-04: Clarifications Regarding Clients Eligible for Private Insurance and Coverage of Services by Ryan White HIV/AIDS Program

*See also* Early Intervention Services

**Substance Abuse Outpatient Care**
*Description:*
Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient Care service category include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Outpatient drug-free treatment and counseling
    - Medication assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention

*Program Guidance:*
Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the HRSA RWHAP, it is included in a documented plan.

Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HAB-specific

guidance.

*See also* Substance Abuse Services (residential)

*RWHAP Legislation: Support Services*

**Child Care Services**
*Description:*
The HRSA RWHAP supports intermittent Child Care Services for the children living in the household of PLWH who are HRSA RWHAP-eligible clients for the purpose of enabling those clients to attend medical visits, related appointments, and/or HRSA RWHAP-related meetings, groups, or training sessions.

Allowable use of funds include:

- A licensed or registered child care provider to deliver intermittent care
- Informal child care provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

*Program Guidance:*
The use of funds under this service category should be limited and carefully monitored. Direct cash payments to clients are not permitted.

Such arrangements may also raise liability issues for the funding source which should be carefully weighed in the decision process.

**Emergency Financial Assistance**
*Description:*
Emergency Financial Assistance provides limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program.

*Program Guidance:*
Emergency Financial Assistance funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the Emergency Financial Assistance category. Direct cash payments to clients are not permitted.

Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

**Food Bank/Home Delivered Meals**
*Description:*

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

*Program Guidance:*
Unallowable costs include household appliances, pet foods, and other non-essential products.

*See* Medical Nutrition Therapy. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the HRSA RWHAP.

**Health Education/Risk Reduction**
*Description:*
Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

*Program Guidance:*
Health Education/Risk Reduction services cannot be delivered anonymously.

*See also* Early Intervention Services

**Housing**
*Description:*
Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search,

placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

*Program Guidance:*
HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits,[6] although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards.

Housing, as described here, replaces PCN 11-01.

**Legal Services**
*See* Other Professional Services

**Linguistic Services**
*Description:*
Linguistic Services include interpretation and translation activities, both oral and written, to eligible clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of HRSA RWHAP-eligible services.

*Program Guidance:*
Linguistic Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

**Medical Transportation**
*Description:*
Medical Transportation is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services.

*Program Guidance:*
Medical transportation may be provided through:

[6] See sections 2604(i), 2612(f), 2651(b), and 2671(a) of the Public Health Service Act.

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher or token systems

Costs for transportation for medical providers to provide care should be categorized under the service category for the service being provided.

Unallowable costs include:

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees.

**Non-Medical Case Management Services**

*Description:*

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan

- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

*Program Guidance:*
NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

**Other Professional Services**
*Description:*
Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include:

- Legal services provided to and/or on behalf of the HRSA RWHAP-eligible PLWH and involving legal matters related to or arising from their HIV disease, including:
    - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
    - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the HRSA RWHAP
    - Preparation of:
        - Healthcare power of attorney
        - Durable powers of attorney
        - Living wills
- Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
    - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
    - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.

*Program Guidance:*
Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

*See* 45 CFR § 75.459

**Outreach Services**

*Description:*

The Outreach Services category has as its principal purpose identifying PLWH who either do not know their HIV status, or who know their status but are not currently in care. As such, Outreach Services provide the following activities: 1) identification of people who do not know their HIV status and/or 2) linkage or re-engagement of PLWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options.

Because Outreach Services are often provided to people who do not know their HIV status, some activities within this service category will likely reach people who are HIV negative. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Outreach Services must:

1) use data to target populations and places that have a high probability of reaching PLWH who
    a. have never been tested and are undiagnosed,
    b. have been tested, diagnosed as HIV positive, but have not received their test results, or
    c. have been tested, know their HIV positive status, but are not in medical care;
2) be conducted at times and in places where there is a high probability that PLWH will be identified; and
3) be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort.

Outreach Services may be provided through community and public awareness activities (e.g., posters, flyers, billboards, social media, TV or radio announcements) that meet the requirements above and include explicit and clear links to and information about available HRSA RWHAP services. Ultimately, HIV-negative people may receive Outreach Services and should be referred to risk reduction activities. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

*Program Guidance:*

Outreach Services provided to an individual or in small group settings cannot be delivered anonymously, as some information is needed to facilitate any necessary follow-up and care.

Outreach Services must not include outreach activities that exclusively promote HIV prevention education. Recipients and subrecipients may use Outreach Services funds for HIV testing when HRSA RWHAP resources are available and where the testing would not supplant other existing funding.

Outreach Services, as described here, replaces PCN 12-01.

*See also* Early Intervention Services

**Permanency Planning**
*See* Other Professional Services

**Psychosocial Support Services**
*Description:*
Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services may include:

- Bereavement counseling
- Caregiver/respite support (HRSA RWHAP Part D)
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (*see* Medical Nutrition Therapy Services)
- Pastoral care/counseling services

*Program Guidance:*
Funds under this service category may not be used to provide nutritional supplements (*See* Food Bank/Home Delivered Meals).

HRSA RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

HRSA RWHAP Funds may not be used for social/recreational activities or to pay for a client's gym membership.

For HRSA RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be reported as Psychosocial Support Services; this is generally only a permissible expense under HRSA RWHAP Part D.

*See also* Respite Care Services

**Rehabilitation Services**
*Description:*
Rehabilitation Services provide HIV-related therapies intended to improve or maintain a client's quality of life and optimal capacity for self-care on an outpatient basis, and in accordance with an individualized plan of HIV care.

*Program Guidance:*

Allowable activities under this category include physical, occupational, speech, and

vocational therapy.

Rehabilitation services provided as part of inpatient hospital services, nursing homes, and other long-term care facilities are not allowable.

**Referral for Health Care and Support Services**
*Description:*
Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. Activities provided under this service category may include referrals to assist HRSA RWHAP-eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

*Program Guidance:*
Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

*See also* Early Intervention Services

**Respite Care**
*Description:*

Respite Care is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HRSA RWHAP-eligible client to relieve the primary caregiver responsible for their day-to-day care.

*Program Guidance:*
Recreational and social activities are allowable program activities as part of a Respite Care provided in a licensed or certified provider setting including drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities.

Funds may be used to support informal, home-based Respite Care, but liability issues should be included in the consideration of this expenditure. Direct cash payments to clients are not permitted.

Funds may not be used for off premise social/recreational activities or to pay for a client's gym membership.

*See also* Psychosocial Support Services

**Substance Abuse Services (residential)**
*Description:*
Substance Abuse Services (residential) activities are those provided for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. Activities provided under the Substance Abuse Services (residential) service category include:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

*Program Guidance:*
Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the HRSA RWHAP.

Acupuncture therapy may be an allowable cost under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the HRSA RWHAP.

HRSA RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.

# HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP) Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds

## Frequently Asked Questions

**HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP)**

**Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds**

**Frequently Asked Questions**

**GENERAL:**

1. Are practitioners who provide RWHAP services required to have a professional license?

   When licensure/certification is required by state and/or local regulations, providers must be appropriately licensed and in compliance with those regulations.

2. Do subrecipients have to adhere to the service category descriptions?

   Yes, subrecipients must adhere to the service category descriptions. RWHAP recipients must ensure that subrecipients adhere to the service categories descriptions when developing contracts or memorandums of understanding and through their monitoring processes and procedures.

**CORE MEDICAL SERVICES:**

3. Which service categories can be used to purchase medications?

   Purchasing of medications can be done through many service categories. To determine the appropriate category, review the program guidance under: AIDS Drug Assistance Program (ADAP) Treatments, Outpatient Ambulatory Health Services (OAHS), Emergency Financial Assistance (EFA), AIDS Pharmaceutical Assistance (i.e., Local Pharmaceutical Assistance Program (LPAP), Community Pharmaceutical Assistance), Substance Abuse Outpatient Care, Substance Abuse Services (residential), and/or Hospice Services.

4. During a medical care visit, there are immediate needs by the client to obtain a medication. Can a provider dispense this medication as part of that medical care visit and have the service categorized under Outpatient Ambulatory Health Services or EFA?

   RWHAP recipients should not make the dispensing of medications a standard practice. When this does occur, on a rare occasion, the recipient should document such service under EFA. If EFA is not available (due to lack of contract or processes in place), the service can be documented under OAHS if the medication is dispensed as part of a medical visit and there is an immediate and urgent medical need.

5. As a direct medical care provider funded by Part C, which category should be used to capture the dispensing of medication?

   Depending on the model of care, a direct provider of care could provide services under three different categories: AIDS Pharmaceutical Assistance (Community Pharmaceutical

Assistance), OAHS (prescription and management of prescription therapy), or EFA. Availability of pharmaceutical resources will influence which category is used.

6. Under OAHS, does prescription and management of medication include dispensing?

   When the medications are not funded by any other source (such as ADAP or LPAP as part of AIDS Pharmaceutical Assistance), OAHS is an option if resources are available until such time that the client can be enrolled in other programs to pay for medications. The dispensing of medication should be in the context of a medical visit. This should be on a short term basis until recipients enroll clients in ADAP, AIDS Pharmaceutical Assistance or EFA.

7. What is the difference between a local pharmaceutical assistance program for indigent populations that is run and funded by a state or local government and the AIDS Pharmaceutical Assistance/LPAP service category described by HRSA/HAB?

   HAB's use of the term LPAP is intended to differentiate this service from the state ADAP. It is a supplemental means of providing medication assistance for people living with HIV (PLWH) where there are various limits on the state ADAP; it is created and supported by the RWHAP recipient, although, in some instances, the RWHAP-supported LPAP may also receive state or local funding. HAB recognizes that many governments fund and provide, with their own generated resources, more general pharmaceutical assistance to a wide range of indigent populations within their jurisdiction, some of which are called local pharmaceutical assistance programs. To the extent that such programs are available to PLWH, they should be utilized, but the term "LPAP" under RWHAP does not constitute a reference to such programs.

8. Can I provide targeted HIV testing and referral services under Early Intervention Services (EIS)?

   Yes, in conjunction with the other required components of EIS. RWHAP Parts A and B EIS must include the following four components: targeted HIV testing, referral services, access and linkage to HIV care and treatment services, and health education/risk reduction related to HIV diagnosis. Part C EIS services must include the following four components: counseling individuals with respect to HIV, high risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency), referral and linkage to care of HIV-infected clients, and other clinical and diagnostic services related to HIV diagnosis.

9. I am a Part C recipient. Can I use the Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals service category?

   Traditionally, RWHAP Parts A and B funding support health insurance premiums and cost-

sharing assistance. If a RWHAP Part C or D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective. Equitable is a systematic approach that is fair.

10. How are medical case management and non-medical case management services different?

    Medical Case Management (MCM) services help clients improve health care outcomes. MCM providers should be able to analyze the care that a client receives to ensure that the client is obtaining the services necessary to improve his/her health outcomes. Non-Medical Case Management (NMCM) services provide guidance and assistance to clients to help them to access needed services (medical, social, community, legal, financial, and other needed services), but may not analyze the services to enhance their care toward improving their health outcomes.

    Both MCM and NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans.

    Both service categories include several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient.

11. How do I know which service category should be used for treatment adherence?

    Treatment adherence services are provided conjointly with many service categories such as OAHS, MCM, or ADAP. As such, recipients may choose to record treatment adherence within the service category during which the adherence service was given. In addition, if treatment adherence services are provided as a stand-alone activity, it can be reported under Health Education/Risk Reduction.

12. Who are authorized to provide Home Health Care services to RWHAP clients?

    Home health care services must be prescribed by a licensed medical provider and can be performed by licensed medical professionals, such as physicians, mid-level providers, nurses, and certified medical assistants. This does not include non-licensed, in-home care providers.

**SUPPORT SERVICES:**

13. If there is another professional service that clients need, can I include it under other professional services?

Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include: legal services, permanency planning, and income tax preparation services. Recipients should work with their project officer to discuss other allowable professional services that may fall within this category.

14. Can I include vocational therapy under the rehabilitation services category?

    Yes, this is an allowable activity, but a recipient should establish policies regarding the use of this service, and ensure it is cost effective.

15. How do recipients define the length of life expectancy an individual must have in order to receive hospice care?

    Recipients have the flexibility to define life expectancy, but must establish that criterion and implement it consistently.

16. Can a RWHAP recipient support intermittent child care services for the children living in the house of HIV-infected clients?

    Recipients may use funds to cover child care services for HIV-infected clients to enable their attendance at medical visits, related appointments, and/or RWHAP and HIV-related meetings, groups, or training sessions. Direct cash payments to clients are not permitted. Funds used for this service should be limited and carefully monitored.

17. Should EFA funds that are used for allowable services (food, housing, transportation, etc.) be accounted under the corresponding service category or the specific category of EFA?

    The funds should be counted under EFA regardless of how the funds were used.

18. Is transitional housing an allowable service under the RWHAP?

    Yes. Recipients and local decision making planning bodies are strongly encouraged to institute duration limits to provide transitional and emergency housing services. HAB recommends that recipients consider using the U.S. Department of Housing and Urban Development's definition of transitional housing as 24 months.

19. Can linguistic services be used to pay for translating printed materials such as ADAP application?

    Yes, this activity would facilitate discussion between the provider and client regarding their service needs through a language that is understood.

**HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP)**

**Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds**

**Housing Services Frequently Asked Questions**

1. What service category should be used if the housing service is a one-time payment for a utility bill? Is a housing assessment required for this one-time payment?

   The housing service category covers transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment that extends beyond a one-time service. If a RWHAP recipient makes a one-time payment for a client's utility or housing bill, this should be categorized as emergency financial assistance. A housing assessment and individualized housing plan would not be required for a one-time housing payment provided under emergency financial assistance.

2. A client comes in to receive services and it is determined that their housing needs extend beyond a one-time payment. If the client's housing needs were previously assessed, would that client need an additional assessment?

   If a RWHAP client's housing needs extend beyond a one-time payment, and there is a need for additional housing services, this service should be categorized as housing. Clients receiving housing services must have their housing needs assessed annually and an individualized written housing plan developed to determine if there is a need for new or additional housing services.

3. Can RWHAP funds be used for rental deposits?

   No, RWHAP funds may not be used for rental deposits. Because rental deposits are typically returned to clients as cash, this would violate the prohibition on providing cash payments to clients. In some instances, deposits may be retained as payment (e.g., damage to the property). As such costs would additionally be unallowable, recipients cannot pay for a rental deposit using federal funds, program income generated from federal funds, or pharmaceutical rebates generated from federal funds.

**HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP)**

**Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds**

**Standalone Dental Insurance Frequently Asked Questions**

1. Can recipients offer both standalone dental insurance premiums and/or cost sharing assistance under the service category Health Insurance Premiums and Cost Sharing Assistance **and** RWHAP Oral Health Care services in their program?

   Recipients and subrecipients are able to provide both service categories within their programs as long as the standalone dental insurance premium and/or cost sharing assistance and Oral Health Care services are provided in compliance with the requirements for each described in *PCN #16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds*.

2. Can recipients/subrecipients use RWHAP funds to pay for oral health care services that exceed annual expenditure caps established by standalone dental insurance plans?

   RWHAP recipients and subrecipients are in the best position to understand the unique needs of their client populations, determine which costs are cost-effective to pay, and ensure availability of the resources equitably for eligible clients. It is up to the recipient and subrecipient to identify which costs they will cover related to standalone dental insurance, which can include: premiums, deductibles, co-payments, and/or costs above the cap. The recipient or subrecipient must have policies and procedures in place to ensure these services are available to all eligible RWHAP clients.

3. Can ADAP funds or pharmaceutical rebates be used to purchase standalone dental insurance premiums and/or cost sharing assistance?

   ADAP funds cannot be used to purchase standalone dental insurance premiums and cost sharing assistance because standalone dental insurance does not cover the cost of medications necessary in treatment for people living with HIV. See *PCN #13-05 Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost Sharing Assistance for Private Health Insurance* for requirements for ADAPs to pay for Health Insurance Premiums and Cost Sharing Assistance for Individuals.

   However, as *PCN #15-04 Utilization and Reporting of Pharmaceutical Rebates* explains, "the RWHAP legislation requires that rebates collected on ADAP medication purchases be applied to the RWHAP Part B Program with a priority, but not a requirement, that the rebates be placed back into ADAP. These rebates must be used for the statutorily permitted purposes under the RWHAP Part B Program which are limited to core medical services including ADAP, support services, clinical quality management, and administrative expenses (including planning and evaluation) as part of a comprehensive system of care for low-income individuals living with

HIV." Pharmaceutical rebates earned by the RWHAP Part B Program may be used to pay for standalone dental insurance premiums and/or cost sharing assistance.

4. When does the addition of standalone dental insurance to the Health Insurance Premiums and Cost Sharing Assistance for Low-Income Individuals service category take effect?

   PCN #16-02 is in effect for all awards made on or after October 1, 2016, including competing continuations, noncompeting continuations, supplements, and new awards.

# Minority AIDS Initiative (MAI)

# USING MAI FUNDS EFFECTIVELY: TAILORING SERVICES FOR LOCALLY IDENTIFIED SUBPOPULATIONS

This resource explains the history and goals of the Minority AIDS Initiative (MAI), describes allowable uses of MAI funds, offers sound practices for planning councils allocating MAI funds, identifies challenges, and gives examples of how planning councils have used MAI funds to support responsive, tailored services.

## Resource Overview

**Goals/Purpose of MAI funding**
The Ryan White HIV/AIDS Program's (RWHAP) Minority AIDS Initiative (MAI) provides additional funding under RWHAP Parts A, B, C, D, and F to improve access to HIV care and health outcomes for racial and ethnic minority populations disproportionately affected by HIV. Under RWHAP Part A, MAI formula grants are used to fund core medical and support services that will improve access and reduce disparities in health outcomes for minority populations in metropolitan areas hardest hit by HIV/AIDS.

**Populations of focus for MAI-funded services**
RWHAP Part A jurisdictions are expected to identify specific minority subpopulations to focus on as they work to strengthen the local HIV service system. Planning councils use local data to identify population-based differences in linkage to care, retention in care, and viral suppression, as well as barriers to access for different groups. In identifying populations of focus, planning councils may go beyond race and ethnicity (e.g., all African Americans or all Latinos) to consider additional characteristics that affect service needs, such as gender/gender identity, sexual orientation, and age.

**Types of services that can be supported with MAI funds**
RWHAP Part A MAI funds should be used to support "population-tailored services" – specially designed, culturally responsive medical or support services that will improve treatment access and outcomes for the jurisdiction's particular minority subpopulations of focus. In addition, services supported with MAI funding should employ innovative approaches or interventions that address the unique needs of the different subpopulations of focus.

**Separate allocation process for MAI funds**
In priority setting and resource allocation (PSRA), planning councils are expected to separately allocate RWHAP Part A and MAI funds, and to report separately on priorities, allocations, expenditures, and number of clients served. A separate allocation process helps to ensure that MAI funds are used to implement tailored services or new service models that will improve access and treatment outcomes for the jurisdiction's identified subpopulations of focus.

# Using MAI Funds Effectively: Tailoring Services for Locally Identified Subpopulations

## Introduction

The Minority AIDS Initiative (MAI) provides funding through agencies within the Department of Health and Human Services (HHS) to reduce disparities in HIV access, treatment, care, and outcomes for racial and ethnic minorities. Under Part A of the Ryan White HIV/AIDS Program (RWHAP), the HIV/AIDS Bureau expects MAI funds to be used to support culturally-responsive core medical and related support services designed to address the unique barriers and challenges faced by disproportionately impacted racial and ethnic minority subpopulations as identified by each jurisdiction. It is not sufficient for MAI funds to be used to pay for services to racial and ethnic minorities. These services should be "population-tailored" so that they contribute to positive treatment outcomes, including increased levels of sustained viral suppression among subpopulations of focus.

This resource summarizes the history and purpose of MAI and then focuses on use of MAI funds under RWHAP Part A. It explains the continuing need for MAI, describes expectations for use of MAI funds, provides examples of MAI projects, identifies challenges, and describes the MAI-related roles of RWHAP Part A planning councils/planning bodies (PC/PBs). It is designed to help PC/PBs ensure that such funds improve HIV treatment outcomes and reduce HIV-related health disparities for racial and ethnic minorities.

## History

In March of 1998, the Centers for Disease Control and Prevention (CDC) brought together a group of African American community leaders and service providers for a briefing that presented new surveillance data showing the extremely high and disproportionate rates of HIV infection among African Americans. The data led the leaders to declare a "state of emergency" in the African American community regarding HIV. They called upon the federal government to declare a public health state of emergency. Both the Congressional Black Caucus (CBC) and the President's Advisory Council on HIV/AIDS (PACHA) endorsed this action. In October 1998, President Bill Clinton described HIV as a "severe and ongoing health care crisis" in racial and ethnic minority communities and announced a new initiative to address it. Initially known as the CBC Initiative, it received FY 1999 funding of about $165 million, including newly appropriated and reprogrammed funds. The name later became the Minority AIDS Initiative (MAI) to reflect a broader focus on racial and ethnic minority communities, including African Americans, Alaska Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders.[1]

Congressional intent for use of MAI funds was specified in FY 2002:

> These funds are for activities that are designed to address the trends of the HIV/AIDS epidemic in communities of color based on the most recent estimated living AIDS cases, HIV infections and AIDS mortality among ethnic and racial minorities as reported by the Centers for Disease Control and Prevention.[2]

MAI implementation is decentralized, with funds going to various parts of the Department of Health and Human Services (HHS), including the Health Resources and Services Administration (HRSA), CDC, Substance Abuse and Mental Health Services Administration (SAMHSA), and the Office of the Secretary. By FY 2004, MAI funds totaled about $400 million and were supporting over 50 separate projects in prevention, care and treatment, and research. Total MAI funding across the four agencies totaled about $416 million in FY 2011.

The MAI program within the RWHAP was codified in Section 2693 of the 2006 reauthorization: "to evaluate and address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities."[3] The 2009 reauthorization called for synchronization of the schedules for MAI and the applications for each Part. MAI is a component of Part F, with funds allocated to each grant recipient on a formula basis. To receive an MAI grant, an entity must have received a grant under the relevant RWHAP Part. In FY 2021, MAI funding under Part A totaled almost $51.7 million.

Strategies and uses of MAI funds have changed over the years. For example, MAI was restructured in 2010, with the release of the National HIV/AIDS Strategy (NHAS). The intent remains unchanged: to reduce HIV-related disparities and improve outcomes for disproportionately impacted racial and ethnic minorities.

**Allowable Uses of MAI Funds under RWHAP**

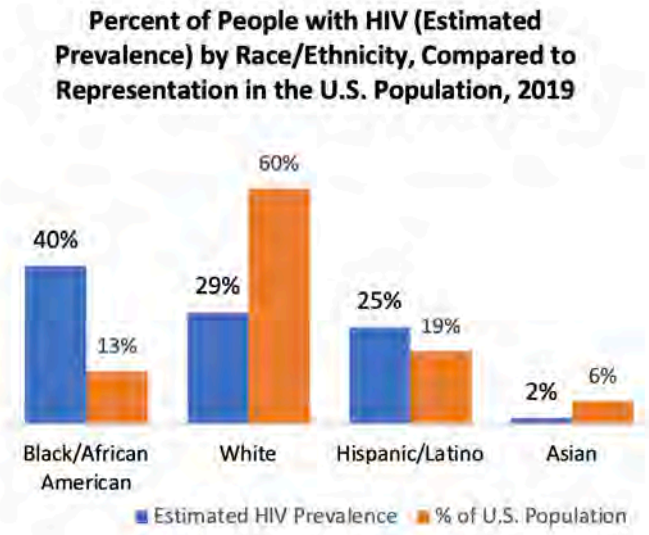
Several HHS agencies receive MAI funding, and each agency and each RWHAP Part uses funds differently. Use of funds under each RWHAP Part is summarized below. Expectations for other agencies are provided in Attachment A and may help PC/PBs in developing resource inventories covering other funding streams.

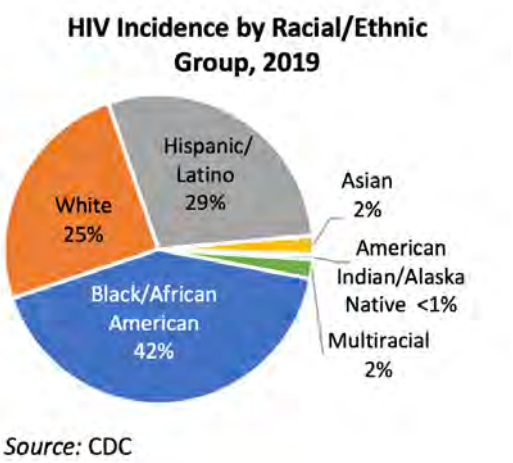
MAI funding under RWHAP is legislatively authorized, and the HIV/AIDS Bureau has specified allowable uses by Part: [4]

- **Part A:** for "core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas hardest hit by HIV/AIDS."
- **Part B:** to "fund outreach and education services designed to increase minority access to needed HIV/AIDS medications," including the AIDS Drug Assistance Program (ADAP). Part B recipients receive MAI funding only if they choose to request it and provide the required narrative in their application.
- **Part C:** for "the provision of culturally and linguistically appropriate care for racial and ethnic minority populations."
- **Part D:** for "eliminating racial and ethnic disparities in the delivery of comprehensive, culturally and linguistically appropriate HIV/AIDS care services for women, infants, children, and youth."
- **Part F:** for "increasing the training capacity of AIDS Education and Training Centers to expand the number of health care professionals with treatment expertise and knowledge about the most appropriate standards of HIV-related treatments and medical care for racial and ethnic minority adults, adolescents, and children with HIV."

## Continuing Need

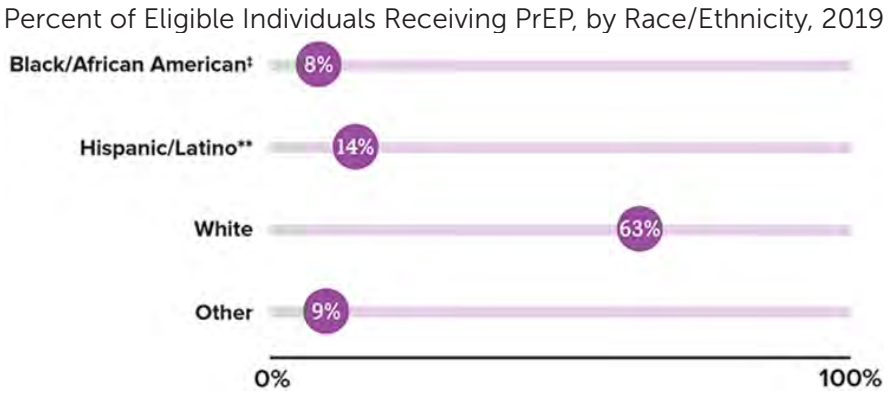
CDC data show that HIV-related racial and ethnic disparities remain – in new diagnoses, access to care including medications, viral suppression, and deaths. Three-fourths of new HIV diagnoses in the U.S. in 2018 and in 2019 were among racial and ethnic minorities. African Americans and Latinos together accounted for more than 70% -- 42% were African American and 29% Latino.[5]




In 2019, rates of HIV infection were 8.1 times as high among African Americans, 3.6 times as high among Hispanics/Latinos, and 1.9 times as high among American Indians/Alaska Natives as among White non-Hispanics.[6]

Contributing to the rate of new infections, racial and ethnic minorities are less likely than White Americans to use Pre-Exposure Prophylaxis (PrEP). As the figure below shows, while nearly two-thirds of eligible White Americans receive PrEP, the proportion is under 15% for racial and ethnic minorities.[7]




New HIV infections declined by 8% overall between 2015 and 2019, but there was no decline among African Americans. They are still less likely than White Americans to be virally suppressed within six months of diagnosis or to have sustained viral suppression. Death rates are falling for all groups but remain highest among African Americans, who accounted for 43% of HIV-related deaths in 2019.[8]

## MAI under RWHAP Part A

### Applications and Funding

The amount of MAI funding awarded each RWHAP Part A jurisdiction is calculated annually based on "the number of people with HIV and AIDS who are minorities in a jurisdiction"[9] and their proportion of all minorities with HIV in Part A service areas. In the FY 2022 RWHAP Part A Notice of Funding Opportunity (NOFO), MAI allocations by jurisdiction ranged from about $150,000 to $8.6 million. Jurisdictions are expected to separately allocate RWHAP Part A and Part A MAI funds, and to report separately on priorities, allocations, expenditures, and number of unduplicated clients served with MAI funds.

Applicants prepare an MAI narrative as part of the RWHAP Part A application. Focusing on identified "minority subpopulations of focus" (groups that are "disproportionately affected by HIV, as a result of specific needs"), applicants describe "how MAI services will be implemented to address the needs" of each identified subpopulation of focus, and how the planned MAI services "may prevent new HIV infections, improve health outcomes, and decrease health disparities and inequities" among those subpopulations.[10]

### HIV/AIDS Bureau Expectations

All RWHAP Part A funds serve racial and ethnic minority subpopulations, who are a majority of RWHAP clients – 73.6% in 2020.[11] Part A MAI funds should support "population-tailored services" – specially designed, culturally appropriate services that improve treatment access and outcomes for the jurisdiction's particular minority populations of focus. As stated in the FY 2022 RWHAP Part A NOFO:

> "MAI funds must be used to deliver ***services designed to address the unique barriers and challenges faced by hard-to-reach, disproportionately impacted individuals*** within the EMA/TGA"(Eligible Metropolitan Area/Transitional Grant Area) [Emphasis added] [p 21]

> "MAI services must be consistent with the epidemiologic data and the identified need, and be ***culturally appropriate***. Furthermore, effective MAI service provision should ***employ the use of population-tailored, innovative approaches or interventions*** by specifically addressing the unique needs of MAI subpopulations most disproportionately impacted by HIV. Similar to the other components of RWHAP Part A, the goal of the MAI is ***viral suppression*** among ***identified minority subpopulations***. [Emphasis added] [p 23]

RWHAP Part A jurisdictions are expected to identify specific minority subpopulations to focus on. They can design MAI services for both broadly and narrowly defined subpopulations. Recent RWHAP Part A NOFOs have asked applicants to identify three subpopulations of focus in the Demonstrated Need section, and these are typically, though not always, the populations of focus for MAI. One large EMA simply notes "Blacks and Hispanics." Another has identified the following subpopulations: MSM of color aged 18-29, MSM of color aged 30 and older, and transgender women of color. Following are some other examples of groups identified for MAI services: African immigrants, Asian Americans, recently diagnosed Latinos, Black women of childbearing age, transgender Latinas, African American women living in outlying counties, immigrants who have dropped out of care, and African American men over age 55. The choices typically reflect the local epidemic, needs assessment findings, HIV care continuum data, and client outcomes data.

### Inappropriate Use of MAI Funds under RWHAP Part A

Some Part A jurisdictions have used Part A MAI funds to support any core medical-related and support services delivered to people with HIV who are racial or ethnic minorities. For example, one TGA described how it used to put funds into service categories based on overall need, and direct providers to charge racial and ethnic minority clients receiving those services to MAI instead of regular Part A. This approach is not considered acceptable, since it does not involve designing or refining services to meet subpopulation needs.

### Examples of MAI Activities in RWHAP Part A EMAs/TGAs

Following are examples of strategies and activities supported with RWHAP Part A MAI funds. Many involve use of peers – people from similar backgrounds to the individuals they serve, often people with HIV who have direct lived experience with the local system of HIV care – and/or other provider staff of the same racial/ethnic background as the subpopulations of focus.

- ***Tailored Early Intervention Services (EIS).*** MAI funds have been used to implement a variety of EIS models. For example:
  - One jurisdiction hired personnel from its subpopulations of focus to work with testing sites, linking individuals with a new HIV diagnosis to care and providing support for the first 3-6 months following linkage. They help ensure that these individuals feel fully connected to their medical provider and know how to request other services when needed.
  - Another used peers to locate people with HIV who had been diagnosed at least six months before but were not in care, and linked or re-linked them to services, accompanying them to the first few medical, case management, and other HIV-related appointments.

- ***Specialized case management.*** Jurisdictions have tailored case management models and strategies for specific racial and ethnic subpopulations. Some examples:
  - A TGA initiated strength-based Case Management for African American women.
  - Several jurisdictions added peers as "case management assistants" who provide navigation and treatment adherence services for clients who need extra support either long- or short-term.
  - Another jurisdiction assigned bilingual non-medical case managers to Spanish-dominant Latinos, with a focus on helping clients obtain the full range of needed services, apply for entitlements or other financial assistance, and identify non-RWHAP services to address other aspects of their lives that affect treatment outcomes, such as job training and placement.
- ***Culturally competent navigation services.*** Navigators, often linked to case managers and matched to subpopulations of focus in race/ethnicity, gender/gender identity, sexual orientation, and/or age, support linkage to care, retention and treatment adherence, and re-engagement in care. Services are intensive but time limited.

- ***Clusters of coordinated services.*** Sometimes MAI funds support a group of linked and coordinated services for the same group of clients. For example, one jurisdiction has used MAI funds to support a cluster of linked and coordinated core medical-related and support services designed to meet the needs of Latino and African immigrants.

MAI funds support a combination of outpatient ambulatory health services, medical case management, mental health services, medical transportation, outreach services, psychosocial support services, and linguistic services that support interpreters where providers are unable to hire bilingual staff.

- ***Services to address social determinants.*** MAI funds can be used for support services that address various social determinants of health and contribute to HIV-related disparities. For example, one jurisdiction's needs assessment highlighted racially-based disparities in housing and access to non-medical services, from childcare to nutritional support. To respond, it allocated MAI funds to housing and to non-medical case management, to help clients access needed services beyond HIV care.

**PC/PB MAI-related Roles**

Part A planning councils/planning bodies (PC/PBs) have many roles related to MAI. For example:

- ***Needs assessment:*** Epidemiologic and HIV care continuum data can identify population-based differences in linkage to care, retention in care, adherence to treatments, and viral suppression. Surveys, focus groups, or special needs assessment studies can collect and analyze data about service barriers by race and ethnicity, and identify disproportionately affected subpopulations. This can be a multi-step process, as described in the box.

**Using Needs Assessment in MAI Planning**

*Step 1:* Survey people with HIV, asking about their experience with services and barriers to care, and collecting demographic data; if possible, use trained peers to maximize response rates and obtain frank responses.

*Step 2:* Analyze findings by race/ethnicity and identify racial and ethnic populations with the greatest barriers to care.

*Step 3:* Do additional analyses of the same survey data by subpopulations defined by multiple characteristics, including race/ethnicity, age, gender, sexual orientation, and/or other locally-defined factors – for example, African American MSM under 30; limited-English-proficient Latinx immigrants; recently incarcerated African American men; African American women experiencing homelessness. Determine which subpopulations appear to face the greatest barriers and HIV-related disparities.

*Step 4:* The following year, do specialized needs assessment – e.g., focus groups, analysis of service utilization data, review of Clinical Quality Management data -- that looks at these identified subpopulations, to better understand barriers they face and strategies that can help overcome them.

*Step 5:* Use this information to inform MAI priority setting and resource allocation.

- ***Integrated planning:*** Integrated HIV prevention and care planning provides an opportunity to document the need for improving viral suppression or other service outcomes for particular racial/ethnic subpopulations, and to lay out objectives and tasks for refining services to address those subpopulation-specific needs.

- ***Care strategies:*** The PC/PB can work with the recipient to identify or refine service strategies or develop innovative service models to help overcome barriers to care and improve treatment outcomes for identified racial/ethnic subpopulations.

- ***Priority setting and resource allocation (PSRA):*** PC/PBs are responsible for setting service priorities and allocating resources, including MAI funds, to prioritized service categories. The expectation is for separately allocating Part A and Part A MAI funds to serve subpopulations of focus and implement tailored services or new service models that the data indicate are most needed to improve their treatment outcomes.

- ***Directives:*** As a part of PSRA, PC/PBs can provide directives to the recipient on how best to meet each priority. Once a new service model or strategy is identified or developed, a directive may call for testing it with a specific subpopulation. The recipient then uses the directive in contracting for services. The box below provides an example of such a process.

**Using Allocations and Directives to Improve Subpopulation Treatment Outcomes**

Available data show that Latinas with HIV in your jurisdiction have high rates of viral suppression when retained in care but are less likely than other subpopulations to be linked to care promptly after diagnosis and much more likely to drop out of care in the first few months after linkage. A special study including focus groups found that this subpopulation includes many recent immigrants with limited English proficiency and identified two key problems: (1) current EIS staff do not speak Spanish; and (2) none of the current medical providers focus on women, and the only one with Spanish-speaking medical personnel is overbooked and has not been accepting new patients for almost two years. The PC/PB and recipient agree on the need for tailored services and cost out some options. The PC/PB allocates MAI funds to EIS, OAHS, and Language Services, and adopts two directives. One calls for a coordinated pilot project including a Latina-focused, peer-based EIS project to link newly diagnosed and out-of-care Latinas to care and provide support for up to six months and support more Spanish-speaking medical personnel. The second requires all medical providers without bilingual staff to use trained interpreter/navigators. The recipient uses the model, allocations, and directives in putting out a Request for Proposals (RFP) to implement the new model. The recipient also redesigns Language Services under MAI to involve trained interpreter/navigators. Careful monitoring and evaluation of linkage, retention in care, and viral suppression data are planned, as well as a Spanish-language client satisfaction study for Latinas.

## Challenges in Using MAI Funds Effectively

PC/PBs have identified a number of challenges in developing and implementing MAI projects that can demonstrate success. They include the following:

- ***Amount of MAI funding.*** MAI funding for Part A jurisdictions for FY 2021 ranged from about $146,000 to $8.6 million. The median amount was about $554,000, but seven

jurisdictions received less than $300,000, and nine others less than $400,000. Smaller allocations make it harder for PC/PBs to support potentially effective strategies for multiple minority subpopulations. Some smaller jurisdictions may need to focus on one or two disproportionately impacted subpopulations.

- ***Demonstrating increased viral suppression.*** Jurisdictions are expected to demonstrate that MAI funds are contributing to improved health outcomes, with a focus on viral suppression. This can be challenging with some strategies. For example, an MAI EIS project that focuses on getting people into care – and hands them off to case managers after the first few medical visits – may find it hard to demonstrate increased viral suppression for the clients served by that initiative. It may, however, be able to demonstrate that clients from that subpopulation have high rates of viral suppression if they are retained in care, and to show that their model increases retention in care.

- ***Lack of PC/PB familiarity with MAI expectations.*** Jurisdictions, including their PC/PBs, vary in their knowledge of the history and development of MAI and its intended use to help address HIV-related disparities. They may need a better understanding of HIV/AIDS Bureau expectations and assistance in establishing processes to meet these expectations through a combination of priority setting, resource allocation, directives, and service design.

- ***Knowledge and experience in designing tailored projects.*** Some jurisdictions have been providing subpopulation-tailored services for many years. Others have far less experience in designing services for specific groups – or may need to focus on a different subpopulation due to changing epidemiologic trends. Review of completed Special Projects of National Significance (SPNS) initiatives can help increase PC/PB familiarity with models and strategies that have been effective with specific subpopulations.

- ***Staffing.*** Racial and ethnic minority staff play an extremely important role in providing culturally and linguistically appropriate services. Some PC/PBs have used directives to encourage hiring of staff from disproportionately impacted subpopulations, but providers may find that a variety of factors – such as limits on salaries and benefits combined with challenging jobs – make it hard to compete successfully for minority social workers, mental health counselors, and other professional staff. Providers in one TGA said that young professionals often stay only a year or two, then use their experience to move on to higher-paid, less-demanding positions.

- ***Providers.*** In the early days of MAI, a key focus was providing capacity-building services to enable minority-focused providers with strong program skills but limited federal funding experience to compete for MAI funds and meet federal subrecipient management requirements. This has become less common. Many jurisdictions have been funding the same group of providers for a long time. PC/PBs can use directives to encourage efforts to broaden the provider network, and recipients can encourage new applicants. However, the number of minority-focused providers varies considerably by jurisdiction. EHE funding has encouraged community health center engagement, and some jurisdictions have used EHE funds to support additional providers and try new approaches.

## Sound Practices for PC/PBs in Using MAI Funds

- ***Understand MAI purposes and HIV/AIDS Bureau expectations.*** This requires including MAI in new member orientation and/or as a topic for a mini-training session during a PC/PB meeting. The appropriate PC/PB committee should receive and review any new guidance or clarifications provided to the recipient, including findings from a comprehensive site visit or changes in the Notice of Funding Opportunity NOFO) instructions for preparing the MAI narrative in the Part A application. Many PC/PBs provide refresher sessions at the beginning of the PSRA process; MAI should be a part of such discussions.

- ***Regularly collect, receive, and review MAI-relevant data.*** This includes analyzing and reviewing available epi, client utilization, outcomes, and needs assessment data (usually provided by the recipient) by race and ethnicity, with special attention to HIV care continuum data for Part A clients. The PC/PB should work with the recipient to identify subpopulations that have lower rates of viral suppression, as well as longer delays between testing and linkage to care, lower retention rates or less frequent doctor visits, and lower rates of adherence to medications, using a combination of quantitative and qualitative data.

- ***Participate in discussions about the jurisdiction's subpopulations of focus.*** The needs assessment section of the Part A application typically asks each EMA or TGA to identify three disproportionately affected subpopulations of focus, based on local data. In identifying these subpopulations, it is usually best to go beyond race and ethnicity (e.g., all African Americans or all Latinos) to consider additional characteristics that affect service needs, such as gender/gender identity, sexual orientation, and age. Local data may indicate that other characteristics may also be important. For example, the jurisdiction may have a large subpopulation of people with HIV who are immigrants that speak primarily a language other than English (like Spanish) or come from a particular country (like Haiti). In a jurisdiction that includes urban, suburban, and rural areas, place of residence within the EMA or TGA may be important. A jurisdiction may identify subpopulations based on multiple characteristics, like young African American MSM aged 13-34, transgender Latinas, Haitian immigrants with limited English proficiency, recently incarcerated African American men, or Latinas living in the outlying counties.

- ***Engage people from your subpopulations of focus in developing service models.*** In addition to PC/PB members, input to design of MAI service strategies can be obtained through "roundtables" that focus on particular subpopulations, task forces or work groups, and community listening sessions. For example, one PC/PB obtained specific service model recommendations from an African American Task Force of people with lived experience. Another held listening sessions with disproportionately impacted subpopulations (e.g., Latino immigrants and aging/older African American adults with HIV) as a basis for service design or redesign.

- ***Have a process in place to guide the allocation of MAI funds.*** MAI allocations should be done separately from other Part A allocations, and with some different considerations. Since non-MAI Part A funds already support many people of color with HIV, MAI funds can be focused on a limited number of service categories that require special strategies

to better serve a specific subpopulation. Often the appropriate PC/PB committee (e.g., Care Strategy) works closely with the recipient to ensure the availability of information needed to make such decisions. For example, the PC/PB's process may call for identifying service categories that need to be tailored to better serve identified subpopulations. This may require allocations to more than one service category (for example, EIS and medical case management to improve linkage and retention, or non-medical case management and housing to address homelessness and food insecurity); development of directives; and consultation with the recipient to estimate the cost for implementing a new or refined service model. Having a clearly defined process helps ensure an efficient, data-driven process.

- ***Ask for and review progress and outcomes data on MAI services.*** MAI requires evaluation of outcomes. Regular – perhaps twice annual – review and discussion of such data enable the PC/PB to consider what service categories and strategies should continue to receive support and whether refinements or new models are needed.

- ***Maintain ongoing collaboration with the recipient.*** The PC/PB and recipient share responsibility for establishing and maintaining a comprehensive, culturally appropriate system of care and for the many tasks to accomplish that. For example, the PC/PB is responsible for PSRA including directives; the recipient contracts for services. Year-round cooperation on MAI-related tasks – e.g., sharing of epi and client data, discussion of service needs and barriers for specific subpopulations, review of Quality Management findings, agreement on strategies to refine and improve viral suppression -- is necessary for maintaining a system of care that meets the needs of all people with HIV, including disproportionately impacted racial and ethnic minorities.

## Putting It All Together: A Comprehensive Scenario

The scenario that follows describes a process that can be used by a PC/PB for identifying a subpopulation in need of MAI funds, learning more about their needs and service barriers, and working with the recipient to design, implement, and evaluate an appropriate strategy or service model.

### Tailoring Services to Improve Subpopulation Treatment Outcomes

Two years ago, an analysis of HIV care continuum data by subpopulation showed that young African American MSM aged 13-29 in your jurisdiction had the lowest rate of viral suppression among identified subgroups. Overall, 67% of people diagnosed with HIV had achieved viral suppression, compared with 57% of young African American men. To better understand the situation, the PC/PB and recipient analyzed RWHAP Part A client data on viral suppression and found that overall viral suppression among clients was much higher at 88%, but the rate for African American MSM aged 13-29 was 79%. Further analysis of service utilization and Clinical Quality Management (CQM) data found that members of this subpopulation were also less likely to see a medical provider regularly or to adhere to prescribed medications. Young African American MSM were noted as a subpopulation of

focus in the Part A application that year.
Last year, your PC/PB did a survey of people with HIV as part of its needs assessment and analyzed the data by race/ethnicity, risk factor, gender, and age. The survey explored barriers to care and found that young African American MSM were especially likely to report unstable housing, incomes below the poverty level, frequent periods of unemployment, and lack of health insurance.

A special study as part of the needs assessment this past winter, including focus groups with young African American MSM and with key informants (several of them peers) who work with this subpopulation, confirmed these findings and identified some issues with the local system of care. They included the following: few African American medical personnel or case managers, some provider facilities where these clients didn't feel comfortable due to their age and race, and not enough use of peers with similar life experiences. Those living outside the central city found it especially difficult to access culturally appropriate care, with the only medical provider facility nearby described as "not welcoming." Getting into town to another provider was challenging given the distance and the lack of evening and weekend hours. Many clients were unaware that they could receive transportation assistance for medical appointments.

Based on the available data, the PC/PB asked the Care Strategy Committee to work with the recipient to identify service strategies to improve retention in care and viral suppression in this subpopulation, develop a directive if needed, and provide advice on resource allocations.

The Committee held a roundtable with people from the focus subpopulation and several provider staff to discuss how to address the identified barriers, and also explored approaches used in other jurisdictions for improving treatment adherence and viral suppression. They identified an EMA and a TGA that reported improved outcomes through a combination of tailored medical services from providers that have African American and relatively young staff, along with the use of peer navigators/case management assistants who help ensure that new clients are aware of available medical and support services and assist them for about six months by providing information, referrals, and adherence counseling. The Committee and recipient studied and refined the model and estimated the cost of implementation. The Committee drafted a directive calling for testing the model by at least one medical provider that would either provide case management directly or work with a medical case management provider able to use peer navigator assistants.

To support the model, the PC/PB allocated MAI funds to OAHS and medical case management and approved the directive. The recipient used the model, allocations, and directive in putting out a Request for Proposals (RFP), and eventually selected two providers to implement the model, one in the central city, the other in an outlying county. Careful monitoring and evaluation of service utilization, retention in care, viral suppression, and client satisfaction were arranged.

## Attachment A:
## Uses of Minority AIDS Initiative Funds by Agencies Other than the HRSA HIV/AIDS Bureau

***SAMHSA:*** MAI funds are used for activities including:

- Service Integration to "help reduce the co-occurring epidemics of HIV, Hepatitis, and mental health disorders through accessible, evidence-based, culturally appropriate mental and co-occurring disorder treatment that is integrated with HIV primary care and prevention services" and focuses on racial and ethnic minorities living with or at risk for HIV and/or hepatitis.[12]
- Substance Use Disorder Treatment to "increase engagement in care for racial and ethnic underrepresented individuals with substance use disorders (SUD) and/or co-occurring substance use and mental disorders (COD) who are at risk for, or are living with, HIV/AIDS and receive HIV/AIDS services/treatment."[13]

***CDC:*** MAI funds support various prevention activities tailored to specific racial and ethnic groups, and for the Minority HIV/AIDS Research Initiative (MARI), which helps to build capacity for HIV epidemiologic and prevention research among mostly African American and Hispanic/Latino communities and investigators.[14]

***Office of the Secretary:*** Managed by the Office of Infectious Disease Policy (OIDP) as what is now the Minority HIV/AIDS Fund, resources are used to improve "prevention, care, and treatment for racial and ethnic minorities across federal programs through innovation, systems change, and strategic partnerships and collaboration,"[15] and to "reduce HIV-related disparities among racial/ethnic minority populations."[16] Funds are distributed to up to 10 other HHS agencies, which award the grants. Projects are aligned with National HIV/AIDS Strategy (NHAS) priorities, including cross-agency collaboration. Some Minority HIV/AIDS Fund resources help support Ending the HIV Epidemic (EHE).

***Other HHS agencies:*** Some MAI funds from the Minority HIV/AIDS Fund are provided to other HHS agencies.

# References


[1] Regina Aragon and Jennifer Kates, "The Minority AIDS Initiative," Policy Brief, Kaiser Family Foundation, June 2004; https://www.kff.org/racial-equity-and-health-policy/issue-brief/policy-brief-minority-aids-initiative/

[2] FY 2002 Labor and Health and Human Services, and Education appropriations report language for the MAI; quoted in Aragon and Kates, *Ibid.*

[3] Section 2693(b)(2)(A) of the Public Health Service Act.

[4] HRSA Ryan White HIV/AIDS Program, About the Program, Program Parts & Initiatives, Part F: Minority AIDS Initiative, at https://ryanwhite.hrsa.gov/about/parts-and-initiatives/part-f-minority-aids-initiative.

[5] CDC, "HIV in the United States by Race/Ethnicity: HIV Diagnoses," 2019 data, https://www.cdc.gov/hiv/group/racialethnic/other-races/diagnoses.html.

[6] HIV.gov, What Is the Impact of HIV on Racial and Ethnic Minorities in the U.S.?" 2019 data, accessed from website October 2022, https://www.hiv.gov/hiv-basics/overview/data-and-trends/impact-on-racial-and-ethnic-minorities.

[7] CDC, "HIV In the United States by Race/Ethnicity: PrEP Coverage," accessed from website October 2022, https://www.cdc.gov/hiv/group/racialethnic/other-races/prep-coverage.html.

[8] KFF, "The HIV/AIDS Epidemic in the United States: The Basics," https://www.kff.org/hivaids/fact-sheet/the-hivaids-epidemic-in-the-united-states-the-basics, based on data from Centers for Disease Control and Prevention, *HIV Surveillance Report, 2019*; vol.32, May 2021; http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html.

[9] Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program Notice of Funding Opportunity, Fiscal Year 2022, p 8; see https://www.hrsa.gov/grants/find-funding/HRSA-22-018.

[10] *Ibid,* p 24.

[11] HRSA, "Clients Served by the Ryan White HIV/AIDS Program 2020: Overview 2020," released December 2021; https://ryanwhite.hrsa.gov/data/reports.

[12] See, for example, SAMHSA Notice of Funding Opportunity No. SM-22-005, Minority AIDS Initiative – Service Integration, announced February 24, 2022; https://www.samhsa.gov/grants/grant-announcements/sm-22-005.

[13] See, for example, SAMHSA Notice of Funding Opportunity No. TI-22-004, Minority AIDS Initiative: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS, announced February 28, 2022; https://www.samhsa.gov/grants/grant-announcements/ti-22-004.

[14] "What CDC is Doing," CDC website; https://www.cdc.gov/hiv/group/racialethnic/other-races/cdc-efforts.html.

[15] "Minority HIV/AIDS Fund Activities," HIV.gov; https://www.hiv.gov/federal-response/smaif/current-activities.

[16] Ronald O. Valdiserri and Timothy P. Harrison, "The Evolution of the Secretary's Minority AIDS Initiative Fund: The US Department of Health and Human Services Responds to the National HIV/AIDS Strategy," *Public Health Report: 2018 Nov-Dec: 133*(2 Suppl): 3S-5S; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6262522/

# PRIORITIES, ALLOCATIONS, AND BUDGETS

# SECTION 10

Ryan White Program (Part A/MAI)
Last Four Year's (FY 2020-2024) Priority Ranking

Ryan White Program Part A Priorities, sorted by FY 2023-2024

| Services | FY 2020-2021 | FY 2021-2022 | FY 2022-2023 | FY 2023-24 |
|---|---|---|---|---|
| AIDS Drug Assistance Program (ADAP) Treatment [C] | | | | 1 |
| Medical Case Management, including Treatment Adherence Services[C] | 1 | 1 | 1 | 2 |
| AIDS Pharmaceutical Assistance (Prescription Drugs) [C] | 3 | 9 | 4 | 3 |
| Emergency Financial Assistance [S] | 12 | 12 | 11 | 4 |
| Outpatient/Ambulatory Health Services [C] | 2 | 2 | 2 | 5 |
| Oral Health Care [C] | 6 | 4 | 5 | 6 |
| Food Bank/Home-Delivered Meals (Food Bank) [S] | 8 | 5 | 8 | 7 |
| Health Insurance Premium And Cost-Sharing Assistance for Low-Income Individuals [C] | 5 | 6 | 6 | 8 |
| Mental Health Services [C] | 4 | 3 | 3 | 9 |
| Substance Abuse Services (residential) [S] | 9 | 8 | 7 | 10 |
| Housing Services [C] | | | | 11 |
| Substance Abuse Outpatient Care [C] | 7 | 7 | 9 | 12 |
| Medical Transportation (Transportation Vouchers) [S] | 10 | 10 | 10 | 13 |
| Outreach Services[S] | 11 | 11 | 12 | 14 |
| Other Professional Services (Legal Assistance/Permanency Planning) [S] | 13 | 13 | 13 | 15 |
| Early Intervention Services [C] | | | | 16 |
| Home Health Care [C] | | | | 17 |
| Medical Nutrition Therapy [C] | | | | 18 |
| Home and Community Based Health Care [C] | | | | 19 |
| Psychosocial Support [S] | | | | 20 |
| Hospice Services [C] | | | | 21 |
| Non-Medical Case Management [S] | | | | 22 |
| Child Care Services [S] | | | | 23 |
| Rehabilitation Services [S] | | | | 24 |
| Health Education/Risk Reduction [S] | | | | 25 |
| Referral for Health Care and Support Services [S] | | | | 26 |
| Linguistic Services [S] | | | | 27 |
| Respite Care [S] | | | | 28 |

C=core services S=support services

Ryan White Program (Part A/MAI)
Last Four Year's (FY 2020-2024) Priority Ranking

Ryan White Program MAI Priorities, sorted by FY 2023-2024

| Services | FY 2020-2021 | FY 2021-2022 | FY 2022-2023 | FY 2023-24 |
|---|---|---|---|---|
| Medical Case Management, including Treatment Adherence Services[C] | 1 | 1 | 1 | 1 |
| AIDS Drug Assistance Program (ADAP) Treatment [C] | | | | 2 |
| AIDS Pharmaceutical Assistance (Prescription Drugs) [C] | | | | 3 |
| Mental Health Services [C] | 3 | 3 | 3 | 4 |
| Outpatient/Ambulatory Health Services [C] | 2 | 2 | 2 | 5 |
| Emergency Financial Assistance [S] | 7 | 7 | 7 | 6 |
| Oral Health Care [C] | | | | 7 |
| Substance Abuse Outpatient Care [C] | 4 | 4 | 4 | 8 |
| Medical Transportation | 6 | 6 | 5 | 9 |
| Outreach Services [S] | 5 | 5 | 6 | 10 |
| Substance Abuse Services (residential) [S] | | | | 11 |
| Food Bank/Home-Delivered Meals [S] | | | | 12 |
| Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals [C] | | | | 13 |
| Housing Services [C] | | | | 14 |
| Health Education/Risk Reduction [S] | | | | 15 |
| Home and Community Based Health Care [C] | | | | 16 |
| Medical Nutrition Therapy [C] | | | | 17 |
| Non-Medical Case Management [S] | | | | 18 |
| Psychosocial Support [S] | | | | 19 |
| Home Health Care [C] | | | | 20 |
| Early Intervention Services [C] | | | | 21 |
| Referral for Health Care and Support Services [S] | | | | 22 |
| Child Care Services [S] | | | | 23 |
| Rehabilitation Services [S] | | | | 24 |
| Hospice Services [C] | | | | 25 |
| Other Professional Services (Legal Assistance and Permanency Planning) [S] | | | | 26 |
| Linguistic Services [S] | | | | 27 |
| Respite Care [S] | | | | 28 |

C=core services S=support services

## RYAN WHITE PART A GRANT AWARD (Grant #: BURW3201)

## EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE YR32

## FORMULA, SUPPLEMENTAL AND MAI FUNDING

## Per Resolution #S: R-1162-21, R-246-20, R-247-20 & R-817-19

| Project #: BURW3201 | AWARD AMOUNTS | ACTIVITIES | FY 2022 Award |
|---|---|---|---|
| Grant Award Amount Formula | 16,141,380.00 | FORMULA | W/out C/O |
| Grant Award Amount Supplemental | 4,121,835.00 | SUPPLEMENTAL | Form + Supp |
| Grant Award Amount FY'20 Supplemental | 4,268,879.00 | PY_SUPPLEMENTAL | $24,532,094 |
| Carryover Award FY'21 Formula | 4,076,477.00 | CARRYOVER | |
| Grant Award Amount MAI | 1,089,480.00 | MAI | MAI |
| Grant Award Amount FY'20 MAI | 1,623,771.00 | PY_MAI | 2,713,251 |
| Carryover Award FY'21 MAI | 1,212,670.00 | MAI_CARRYOVER | |
| **Total Award** | **$ 32,534,492.00** | | |

### CONTRACT ALLOCATIONS/ FORMULA, SUPPLEMENTAL & CARRYOVER

**DIRECT SERVICES:**

| Core Medical Services | Allocations | Carryover Allocations | | Account |
|---|---|---|---|---|
| AIDS Pharmaceutical Assistance | 84,492.00 | | | 5606970000 |
| Health Insurance Services | 335,776.00 | 259,924.00 | 595,700 | 5606920000 |
| Medical Case Management | 6,730,657.00 | 400,000.00 | 7,130,657 | 5606870000 |
| Mental Health Therapy/Counseling | 70,197.00 | 91,457.00 | 161,654 | 5606860000 |
| Oral Health Care | 2,864,445.00 | 1,000,000.00 | 3,864,445 | 5606900000 |
| Outpatient/Ambulatory Health Svcs | 10,052,424.00 | 600,000.00 | 10,652,424 | 5606610000 |
| Substance Abuse - Outpatient | 36,157.00 | 17,369.00 | 53,526 | 5606910000 |
| CORE Services Totals: | | 22,542,898.00 | | |

| Support Services | Allocations | Carryover Allocations | | Account |
|---|---|---|---|---|
| Emergency Financial Assistance | 9,853.00 | | | 5606940000 |
| Food Bank | 1,660,108.00 | 1,000,000.00 | 2,660,108 | 5606980000 |
| Medical Transportation | 217,540.00 | | | 5606460000 |
| Other Professional Services | 154,449.00 | | | 5606890000 |
| Outreach Services | 217,902.00 | | | 5606950000 |
| Substance Abuse - Residential | 1,338,406.00 | 200,000.00 | 1,538,406 | 5606930000 |
| SUPPORT Services Totals: | | 4,798,258.00 | | |

| | | | |
|---|---|---|---|
| **DIRECT SERVICES TOTAL:** | | **$ 27,341,156.00** | |
| Total Core Allocation | 20,174,148.00 | | |
| Target at least 80% core service allocation | 19,017,924.80 | | |
| **Current Difference (Short) / Over** | **$ 1,156,223.20** | | |
| **Recipient Admin. (GC, GTL, BSR Staff)** | **$ 2,724,534.00** | | 5606710000 |
| **Quality Management** | **$ 748,405.00** | | 5606880000 |
| **(+) Unobligated Funds / (-) Over Obligated:** | | | |
| Unobligated Funds (Formula, Supp & MAI) | $ - | | |
| Unobligated Funds (Carry Over) | $ 1,720,397.00 | 5,193,336.00 | 32,534,492.00 |

| | | |
|---|---|---|
| **Core medical % against Total Direct Service Allocation (Not including C/O):** | | |
| Cannot be under 75% | **84.86%** | **Within Limit** |
| **Quality Management % of Total Award (Not including C/O):** | | |
| Cannot be over 5% | **2.75%** | **Within Limit** |
| **OMB-GC Administrative % of Total Award (Cannot include C/O):** | | |
| Cannot be over 10% | **10.00%** | **Within Limit** |

### CURRENT CONTRACT EXPENDITURES

**DIRECT SERVICES:**

| Account | Core Medical Services | Expenditures | Carryover Expenditures | |
|---|---|---|---|---|
| 5606970000 | AIDS Pharmaceutical Assistance | 3,954.10 | | |
| 5606920000 | Health Insurance Services | 297,151.61 | 0.00 | 297,151.61 |
| 5606870000 | Medical Case Management | 6,031,337.35 | 0.00 | 6,031,337.35 |
| 5606860000 | Mental Health Therapy/Counseling | 52,244.50 | 12,333.00 | 64,577.50 |
| 5606900000 | Oral Health Care | 2,864,445.00 | 409,199.50 | 3,273,644.50 |
| 5606610000 | Outpatient/Ambulatory Health Svcs | 8,724,251.44 | 0.00 | 8,724,251.44 |
| 5606910000 | Substance Abuse - Outpatient | 4,971.00 | 0.00 | 4,971.00 |
| | CORE Services Totals: | 18,399,887.50 | | |

| Account | Support Services | Expenditures | Carryover Expenditures | |
|---|---|---|---|---|
| 5606940000 | Emergency Financial Assistance | 0.00 | | |
| 5606980000 | Food Bank | 1,540,864.00 | 1,000,000.00 | 2,540,864.00 |
| 5606460000 | Medical Transportation | 159,552.49 | | |
| 5606890000 | Other Professional Services | 67,581.00 | | |
| 5606950000 | Outreach Services | 151,422.86 | | |
| 5606930000 | Substance Abuse - Residential | 1,053,590.00 | 0.00 | 1,053,590.00 |
| | SUPPORT Services Totals | 3,973,010.35 | | |

| | | | |
|---|---|---|---|
| **TOTAL EXPENDITURES DIRECT SVCS & % :** | | **$ 22,372,897.85** | **81.83%** |
| **Formula Expenditure %** | **95.52%** | | |
| | **Part A** | **MAI** | |
| **Available Funds Carryover** | **$722,594.00** | **$1,074,294.00** | $1,796,888.00 |
| **Recipient Administration** | **2,149,629.91** | | |
| **Quality Management** | **727,374.00** | | 2,877,003.91 |
| **Grant Unexpended Balance** | **FY 2022 Award** | **Carryover** | |
| | **3,416,975.74** | **3,867,614.50** | 7,284,590.24 |
| **Total Grant Expenditures & %** | | **$ 25,249,901.76** | **77.61%** |

| | | |
|---|---|---|
| **Core medical % against Total Direct Service Expenditures (Not including C/O):** | | |
| Cannot be under 75% | **85.81%** | **Within Limit** |
| **Quality Management % of Total Award (Not including C/O):** | | |
| Cannot be over 5% | **2.67%** | **Within Limit** |
| **OMB-GC Administrative % of Total Award (Cannot include C/O):** | | |
| Cannot be over 10% | **7.89%** | **Within Limit** |

## RYAN WHITE PART A GRANT AWARD (Grant #: BURW3201)

## EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE YR32

## FORMULA AND SUPPLEMENTAL FUNDING

## Per Resolution #S: R-1162-21, R-246-20, R-247-20 & R-817-19

| Project #: BURW3201 | AWARD AMOUNTS | ACTIVITIES | |
|---|---|---|---|
| Grant Award Amount Formula | 16,141,380.00 | FORMULA | |
| Grant Award Amount Supplemental | 4,121,835.00 | SUPPLEMENTAL | FY 2022 Award |
| Grant Award Amount FY'20 Supplemental | 4,268,879.00 | PY_SUPPLEMENTAL | $24,532,094 |
| Carryover Award FY'21 Formula | 4,076,477.00 | CARRYOVER | |
| **Total Award** | **$ 28,608,571.00** | | |

### CONTRACT ALLOCATIONS/ FORMULA, SUPPLEMENTAL & CARRYOVER

**DIRECT SERVICES:**

| Priority Order | Core Medical Services | Allocations | Carryover Allocations | | Account | Core Medical Services | Expenditures | Carryover Expenditures | |
|---|---|---|---|---|---|---|---|---|---|
| 4 | AIDS Pharmaceutical Assistance | 84,492.00 | | | 5606970000 | AIDS Pharmaceutical Assistance | 3,954.10 | | |
| 6 | Health Insurance Services | 335,776.00 | 259,924.00 | 595,700 | 5606920000 | Health Insurance Services | 297,151.61 | 0.00 | 297,151.61 |
| 1 | Medical Case Management | 5,826,737.00 | 400,000.00 | 6,226,737 | 5606870000 | Medical Case Management | 5,415,024.15 | 0.00 | 5,415,024.15 |
| 3 | Mental Health Therapy/Counseling | 51,237.00 | 91,457.00 | 142,694 | 5606860000 | Mental Health Therapy/Counseling | 51,237.00 | 12,333.00 | 63,570.00 |
| 5 | Oral Health Care | 2,864,445.00 | 1,000,000.00 | 3,864,445 | 5606900000 | Oral Health Care | 2,864,445.00 | 409,199.50 | 3,273,644.50 |
| 2 | Outpatient/Ambulatory Health Svcs | 8,695,763.00 | 600,000.00 | 9,295,763 | 5606610000 | Outpatient/Ambulatory Health Svcs | 8,063,884.64 | 0.00 | 8,063,884.64 |
| 9 | Substance Abuse - Outpatient | 28,099.00 | 17,369.00 | 45,468 | 5606910000 | Substance Abuse - Outpatient | 4,401.00 | 0.00 | 4,401.00 |
| | | CORE Services Totals: | 20,255,299.00 | | | | CORE Services Totals: | 17,121,630.00 | |
| | **Support Services** | **Allocations** | **Carryover Allocations** | | **Account** | **Support Services** | **Expenditures** | **Carryover Expenditures** | |
| 11 | Emergency Financial Assistance | 9,853.00 | | | 5606940000 | Emergency Financial Assistance | 0.00 | | |
| 8 | Food Bank | 1,660,108.00 | 1,000,000.00 | 2,660,108 | 5606980000 | Food Bank | 1,540,864.00 | 1,000,000.00 | 2,540,864.00 |
| 10 | Medical Transportation | 209,912.00 | | | 5606460000 | Medical Transportation | 153,904.90 | | |
| 13 | Other Professional Services | 154,449.00 | | | 5606890000 | Other Professional Services | 67,581.00 | | |
| 12 | Outreach Services | 178,086.00 | | | 5606950000 | Outreach Services | 114,924.86 | | |
| 7 | Substance Abuse - Residential | 1,338,406.00 | 200,000.00 | 1,538,406 | 5606930000 | Substance Abuse - Residential | 1,053,590.00 | 0.00 | 1,053,590.00 |
| | | SUPPORT Services Totals: | 4,750,814.00 | | | | SUPPORT Services Totals | 3,930,864.76 | |
| | **DIRECT SERVICES TOTAL:** | | **$ 25,006,113.00** | | | **TOTAL EXPENDITURES DIRECT SVCS & % :** | | **$ 21,052,494.76** | **84.19%** |
| | Total Core Allocation | 17,886,549.00 | | | | | | | |
| | Target at least 80% core service allocation | 17,149,890.40 | | | | | | | |
| | **Current Difference (Short) / Over** | **$ 736,658.60** | | | | **Formula Expenditure %** | **95.52%** | | |
| | **Recipient Admin. (GC, GTL, BSR Staff)** | **$ 2,453,209.00** | | | 5606710000 | **Recipient Administration** | **1,937,959.51** | | |
| | **Quality Management** | **$ 641,522.00** | | | 5606880000 | **Quality Management** | **620,491.00** | | 2,558,450.51 |
| | **(+) Unobligated Funds / (-) Over Obligated:** | | | | | | | | |
| | Unobligated Funds (Formula & Supp) | $ - | | | | **Grant Unexpended Balance** | **FY 2022 Award** | **Carryover** | |
| | Unobligated Funds (Carry Over) | **$ 507,727.00** | 3,602,458.00 | 28,608,571.00 | | | **2,342,681.23** | **2,654,944.50** | 4,997,625.73 |
| | | | | | | **Total Grant Expenditures & %** | | **$ 23,610,945.27** | **82.53%** |

| | | |
|---|---|---|
| **Core medical % against Total Direct Service Allocation (Not including C/O):** | | |
| Cannot be under 75% | **83.44%** | **Within Limit** |
| **Quality Management % of Total Award (Not including C/O):** | | |
| Cannot be over 5% | **2.62%** | **Within Limit** |
| **OMB-GC Administrative % of Total Award (Cannot include C/O):** | | |
| Cannot be over 10% | **10.00%** | **Within Limit** |

| | | |
|---|---|---|
| **Core medical % against Total Direct Service Expenditures (Not including C/O):** | | |
| Cannot be under 75% | **81.57%** | **Within Limit** |
| **Quality Management % of Total Award (Not including C/O):** | | |
| Cannot be over 5% | **2.53%** | **Within Limit** |
| **OMB-GC Administrative % of Total Award (Cannot include C/O):** | | |
| Cannot be over 10% | **7.90%** | **Within Limit** |

## RYAN WHITE PART A GRANT AWARD (Grant#: BURW3201)
## EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE YR32
## MINORITY AIDS INITIATIVE (MAI) FUNDING
## Per Resolution #S: R-1162-21, R-246-20, R-247-20 & R-817-19

| PROJECT #: BURW3201 | AWARD AMOUNTS | ACTIVITIES | |
|---|---|---|---|
| david | 1,089,480.00 | MAI | FY 2022 Award |
| Grant Award Amount FY'20 MAI | 1,623,771.00 | PY_MAI | 2,713,251.00 |
| Carryover Award FY'21 MAI | 1,212,670.00 | MAI_CARRYOVER | |
| **Total Award** | **$ 3,925,921.00** | | |

| Priority Order | CONTRACT ALLOCATIONS | | | | Account | CURRENT CONTRACT EXPENDITURES | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **DIRECT SERVICES:** | | | | | **DIRECT SERVICES:** | | | |
| | **Core Medical Services** | **Allocations** | | | | **Core Medical Services** | **Expenditures** | **Carryover Expenditures** | |
| | AIDS Pharmaceutical Assistance | | | | 5606970000 | AIDS Pharmaceutical Assistance | | | |
| | Health Insurance Services | | | | 5606920000 | Health Insurance Services | | | |
| 1 | Medical Case Management | 903,920.00 | | | 5606870000 | Medical Case Management | 616,313.20 | | |
| 3 | Mental Health Therapy/Counseling | 18,960.00 | | | 5606860000 | Mental Health Therapy/Counseling | 1,007.50 | | |
| | Oral Health Care | | | | 5606900000 | Oral Health Care | | | |
| 2 | Outpatient/Ambulatory Health Svcs | 1,356,661.00 | | | 5606610000 | Outpatient/Ambulatory Health Svcs | 660,366.80 | | |
| 4 | Substance Abuse - Outpatient | 8,058.00 | 2,287,599.00 | | 5606910000 | Substance Abuse - Outpatient | 570.00 | | 1,278,257.50 |
| | **Support Services** | **Allocations** | | | **Account** | **Support Services** | **Expenditures** | **Carryover Expenditures** | |
| 7 | Emergency Financial Assistance | 0.00 | | | 5606940000 | Emergency Financial Assistance | 0.00 | | |
| | Food Bank | | | | 5606980000 | Food Bank | | | |
| 5 | Medical Transportation | 7,628.00 | | | 5606460000 | Medical Transportation | 5,647.59 | | |
| | Other Professional Services | | | | 5606890000 | Other Professional Services | | | |
| 6 | Outreach Services | 39,816.00 | | | 5606950000 | Outreach Services | 36,498.00 | | |
| | Substance Abuse - Residential | | 47,444.00 | | 5606930000 | Substance Abuse - Residential | | | 42,145.59 |
| | **DIRECT SERVICES TOTAL:** | | **$ 2,335,043.00** | | | **TOTAL EXPENDITURES DIRECT SVCS & %:** | | **$ 1,320,403.09** | **56.55%** |
| | Total Core Allocation | 2,287,599.00 | | | | | | | |
| | Target at least 80% core service allocation | 1,868,034.40 | | | | | | | |
| | **Current Difference (Short) / Over** | **$ 419,564.60** | | | | | | | |
| | **Recipient Admin. (OMB-GC)** | **$ 271,325.00** | | | 5606710000 | **Recipient Administration** | **211,670.40** | | |
| | | | | 3,925,921.00 | | | | | |
| | **Quality Management** | **$ 106,883.00** | | | 5606880000 | **Quality Management** | **106,883.00** | | 318,553.40 |
| | **(+) Unobligated Funds / (-) Over Obligated:** | | | | | **Grant Unexpended Balance** | **FY 2022 Award** | **Carryover** | |
| | Unobligated Funds (MAI) | **$ -** | 378,208.00 | 2,713,251.00 | | | **1,074,294.51** | **1,212,670.00** | 2,286,964.51 |
| | Unobligated Funds (Carry Over) | **$ 1,212,670.00** | | | | **Total Grant Expenditures & % (Including C/O):** | | **$ 1,638,956.49** | **41.75%** |

| | | |
|---|---|---|
| **Core medical % against Total Direct Service Allocation (Not including C/O):** | | |
| Cannot be under 75% | **97.97%** | **Within Limit** |
| **Quality Management % of Total Award (Not including C/O):** | | |
| Cannot be over 5% | **3.94%** | **Within Limit** |
| **OMB-GC Administrative % of Total Award (Cannot include C/O):** | | |
| Cannot be over 10% | **10.00%** | **Within Limit** |

| | | |
|---|---|---|
| **Core medical % against Total Direct Service Expenditures (Not including C/O):** | | |
| Cannot be under 75% | **96.81%** | **Within Limit** |
| **Quality Management % of Total Award (Not including C/O):** | | |
| Cannot be over 5% | **3.94%** | **Within Limit** |
| **OMB-GC Administrative % of Total Award (Cannot include C/O):** | | |
| Cannot be over 10% | **7.80%** | **Within Limit** |

# ADDITIONAL MATERIALS

# SECTION 11

**2023 HHS FEDERAL POVERTY GUIDELINES**
**Annual Income Ranges (Gross Household Income)**
*(approximate calculations)*

***(Effective March 1, 2023 through February 29, 2024 for Ryan White Part A & MAI Services in Miami-Dade County, FL)***

| Family Size | A 100-135% | B 136-150% | C 151-200% | D 201-250% | E 251-300% | F 301-400% | G ≥401% |
|---|---|---|---|---|---|---|---|
| 1 | < or equal to $14,580 - $19,828 | $19,829 - $22,015 | $22,016 - $29,305 | $29,306 - $36,595 | $36,596 - $43,885 | $43,886 - $58,465 | $58,466 + |
| 2 | < or equal to $19,720 - $26,818 | $26,819 - $29,776 | $29,777 - $39,636 | $39,637 - $49,496 | $49,497 - $59,356 | $59,357 - $79,076 | $79,077 + |
| 3 | < or equal to $24,860 - $33,809 | $33,810 - $37,538 | $37,539 - $49,968 | $49,969 - $62,398 | $62,399 - $74,828 | $74,829 - $99,688 | $99,689 + |
| 4 | < or equal to $30,000 - $40,799 | $40,800 - $45,299 | $45,300 - $60,299 | $60,300 - $75,299 | $75,300 - $90,299 | $90,300 - $120,299 | $120,300 + |
| 5 | < or equal to $35,140 - $47,789 | $47,790 - $53,060 | $53,061 - $70,630 | $70,631 - $88,200 | $88,201 - $105,770 | $105,771 - $140,910 | $140,911 + |
| 6 | < or equal to $40,280 - $54,780 | $54,781 - $60,822 | $60,823 - $80,962 | $80,963 - $101,102 | $101,103 - $121,242 | $121,243 - $161,522 | $161,523 + |
| 7 | < or equal to $45,420 - $61,770 | $61,771 - $68,583 | $68,584 - $91,293 | $91,294 - $114,003 | $114,004 - $136,713 | $136,714 - $182,133 | $182,134 + |
| 8 | < or equal to $50,560 - $68,761 | $68,762 - $76,345 | $76,346 - $101,625 | $101,626 - $126,905 | $126,906 - $152,185 | $152,186 - $202,745 | $202,746 + |
| +1 | $5,140 | $7,710 | $10,280 | $12,850 | $15,420 | $20,560 | $20,611 + |

***SOURCE:*** HHS Poverty Guidelines for 2023. *https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines (Based on the table titled, "2023 Poverty Guidelines for the 48 Contiguous States and the District of Columbia")*

***IMPORTANT NOTES:***

1) Using the table above as a guide for families/households with more than eight (8) members, add $5,140 for EACH additional family/household member.

2) The Miami-Dade County Ryan White Program Provide® Enterprise Miami data management system will be programmed according to these guidelines, effective March 1, 2023 through February 29, 2024.

3) Income eligibility for the following Ryan White Part A and Minority AIDS Initiative (MAI) Program-funded services in Miami-Dade County is limited to program-eligible clients who have a gross household income at or below 400% of the Federal Poverty Level (FPL). The 400% FPL income limit applies to all locally-funded Ryan White Part A and MAI Program service categories.

4) **Please be advised that this document is simply an internal reference tool and the rounding calculations may be slightly off.** Percentage calculations in the table above are rounded to avoid gaps between whole number dollar amounts. The first number for each household size in column A is exact per the 2023 HHS Poverty Guidelines, as are the calculations in the Provide® Enterprise Miami data management system.

# REMINDERS AND NEXT STEPS

July 13, 2023 version

# MATERIALS ONLINE-BOOK

Needs Assessment book is posted online-review **all** items!


2121 PONCE DE LEON BLVD, STE. 240
CORAL GABLES, FL 33134
WWW.AIDSNET.ORG

JULY 13, 2023 VERSION

# MATERIALS ONLINE-LINK

www.aidsnet.org/partners/annual-needs-assessment/

# REMAINING TOPICS

- Co-occurring Conditions
- Unmet Need/Gaps and Projections
- Community Input/Town Hall Results
- Service Categories
- Summary
- Directives
- Priorities
- Allocations

## REMAINING DATES

August 17, 2023

10 a.m. to 1 p.m.

September 14, 2023

10 a.m. to 1 p.m.

# THANK YOU!

BEHAVIORA SCIENCE RESEARCH

MIAMI-DADE HIV/AIDS PARTNERSHIP

MIAMI-DADE COUNTY

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# AGENDA AND MINUTES

# SECTION 12

MIAMI-DADE HIV/AIDS PARTNERSHIP

# Care and Treatment
# Thursday, May 4, 2023

10:00 a.m. – 12:00 p.m.

Miami-Dade County Main Library
101 West Flagler Street, Auditorium
Miami, FL 33130

## AGENDA

| | | |
|---|---|---|
| I. | Call to Order | Dr. Diego Shmuels |
| II. | Introductions | All |
| III. | Meeting Housekeeping and Rules | Marlen Meizoso |
| IV. | Floor Open to the Public | Dr. Diego Shmuels |
| V. | Review/Approve Agenda | All |
| VI. | Review/Approve Minutes of March 2, 2023 | All |
| VII. | Reports | |
| | • Grantee reports (Part A, Part B, and ADAP) | All |
| | • Vacancy | Marlen Meizoso |
| | • Medical Care Subcommittee Report | Marlen Meizoso |
| VIII. | Standing Business | |
| | • Vice-Chair Election | All |
| | • FCPN Representative | All |
| | • Outreach Service Description | All |
| IX. | New Business | |
| | • Planning Council Responsibilities and Needs Assessment | Marlen Meizoso |
| | • 2022 Client Satisfaction Survey Results | Robert Ladner |
| X. | Open Discussion and Announcements | All |
| XI. | Next Meeting: **June 1, 2023** at Main Library- **Auditorium** | Dr. Diego Shmuels |
| XII. | Adjournment | Dr. Diego Shmuels |

Meeting documents available at: http://aidsnet.org/meeting-documents/#docsct

***Please turn off or mute cellular devices – Thank you***

**For more information, regarding the Miami-Dade HIV/AIDS Partnership's Care and Treatment Committee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com**

**Care and Treatment Committee Meeting**
**Miami-Dade Public Library, Auditorium**
**101 West Flagler, Miami, FL 33130**
**March 2, 2023**

| # | Committee Members | Present | Absent |
|---|---|---|---|
| 1 | Alcala, Etelvina | X | |
| 2 | Downs, Frederick | | X |
| 3 | Grant, Gena | | X |
| 4 | Henriquez, Maria | X | |
| 5 | Iadarola, Dennis | X | |
| 6 | Kubilus, Barbara | X | |
| 7 | Mills, Vanessa | X | |
| 8 | Roelans, Ryan | X | |
| 9 | Siclari, Rick | | X |
| 10 | Shmuels, Diego | X | |
| 11 | Trepka, Mary Jo | X | |
| 12 | Wall, Dan | | X |
| **Quorum: 5** | | | |

| Guests | |
|---|---|
| Mester, Brad | |
| Poblete, Karen | |
| Valle-Schwenk, Carla | |
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| | |
| **Staff** | |
| Robert Ladner | Marlen Meizoso |

Note that all documents referenced in these minutes were accessible to members and the public prior to (and during) the meeting, at www.aidsnet.org/meeting-documents.

## I. Call to Order — *Dr. Diego Shmuels*

Dr. Diego Shmuels, the Chair, called the meeting to order at 10:15 a.m.

## II. Meeting Housekeeping and Rules — *Dr. Diego Shmuels*

Dr. Shmuels reviewed the Housekeeping and Rules presentation (copy on file), which reviewed the environmental reminders, parking, and meeting decorum for all participants.

## III. Introductions — *Dr. Diego Shmuels*

Members and guests introduced themselves around the room.

## IV. Floor Open to the Public — *Dr. Diego Shmuels*

Dr. Shmuels read the following:

*Pursuant to Florida Sunshine Law, I want to provide the public with a reasonable opportunity to be heard on any items on our agenda today. If there is anyone who wishes to be heard, I invite you to*

*speak now. Each person will be given three minutes to speak. Please begin by stating your name and address for the record before you talk about your concerns.*

*BSR has a dedicated line for statements to be read into the record. No statements were received.*

There were no comments, so the floor was closed.

**V. Review/Approve Agenda** *All*

The committee reviewed the agenda and made to motion approved it as presented.

**Motion to accept the agenda, as presented.**
**Moved: Vanessa Mills Seconded: Barbara Kubilus Motion: Passed**

**VI. Special Presentation: HIV Epidemiology in Miami-Dade County, 2021** *Dr. Anthoni Llau*

Dr. Anthoni Llau from the Department of Health presented "HIV Epidemiology in Miami-Dade County, 2021" which provided information on the HIV and AIDS cases, co-morbidity data, HIV care continuum, deaths, and prevention populations (copy on file). For 2021 (as of June 30, 2022) there were 1,204 HIV cases, 388 AIDS cases, and 27,782 living with HIV. Black people (African Americans and Haitians) are disproportionately affected within the epidemic.

**VII. Review/Approve Minutes of January 12, 2023** *All*

The committee reviewed the minutes of January 12, 2023, and accepted them as presented.

**Motion to accept the minutes from January 12, 2023, as presented.**
**Moved: Vanessa Mills Seconded: Dennis Iadarola Motion: Passed**

**VIII. Reports**

- *Part A* *Carla Valle-Schwenk for Dan Wall*

Carla Valle-Schwenk reviewed the January Recipient report on expenditures, which provided data on Part A/MAI reimbursements through March 1, 2023 (copy on file). Thus far, the program has served 8,472 unduplicated clients. An enhanced Service Utilization report is now being used with a definitions list on the last page. The expenditures have important items highlighted and reflect service though January 2023. Since its inception, TTRA has served over 3,369 clients. Amendments were executed prior to the close of February 28, 2023. All reports are up to date. The Ryan White Program Services Report (RSR) had an internal deadline of the end of February, and submissions are being reviewed. Monitoring site visits for Part A, MAI, and EHE subrecipients were conducted prior to the end of the fiscal year. Some findings from the site visits include missing documentation, insufficient documentation to support time and effort, and missing updates to policy and procedures. The final award notice has not been received but a partial notice of award ($4,723,294) was received in January 2023. The County is working on a new Ending the Epidemic (EHE) RFP. Programing

enhancements have been made to Provide Enterprises for EHE subrecipients. Technical assistance continues to be provided by HRSA's provider on the Housing First Model to be included in the upcoming EHE RFP. The FCPN statewide Needs Assessment survey deadline has been extended until the end of March. Thus far, Miami-Dade has only provided 304 of the 2,700 surveys requested. Ms. Valle-Schwenk encouraged persons present to share the survey information with clients, and if a client could not complete the survey through the FCPN survey portal, they client could fill out a paper copy and BSR would input the data into the portal. The Medication Access Committee continues to meet. The Florida Part A and B recipients met for a coordination meeting February 27-28 to review statewide data to care initiatives, standardized self-attestation form, and standardized notice of eligibility.

- *Part B* *Marlen Meizoso*

Marlen Meizoso reviewed the December 2022 (copy on file) report. Over $1.6 million has been allocated but only $63,343.93 has been spent on 93 clients.

- *.ADAP* *Marlen Meizoso*

Mrs. Meizoso reviewed the January 2023 (copy on file) report, including data on enrollments, pharmacy and insurance expenditures, program updates and current pharmacy listings.

- *General Revenue* *Marlen Meizoso*

Mrs. Meizoso reviewed the General Revenue report for December 2022 (copy on file) which indicated 760 clients were served and $476,316.30 was expended for the month.

- *Vacancies* *Marlen Meizoso*

Mrs. Meizoso reviewed the February 22, 2023, vacancy report (copy on file) which indicated there are eleven vacancies for members of the affected community on the Partnership. There are 12 members on the Care and Treatment Committee, with four vacancies for members of the affected community since Travis Neff has resigned. Staff urged members to share vacancy information with clients and staff and to invite clients to trainings and meetings.

- *Medical Care Subcommittee Report* *Marlen Meizoso*

The Medical Care Subcommittee (MCSC):

- Met on January 27 and February 24, 2023.
- Heard updates from the Ryan White Program and the ADAP Program.
- Re-elected Dr. Robert Goubeaux (chair) and James Dougherty (vice-chair).
- Welcomed a new member, Cristhian Ysea, to the Subcommittee.

The Subcommittee had previously reviewed the Oral Health Service standards and suggested additional language. The Subcommittee reviewed the item again and maintained the motion to accept the revisions.

**1. Motion to accept the changes to the Oral Health Services Standards, as discussed.** *(Attachment 1).*
**Moved: Ryan Roelans** **Second: Maria Henriquez** **Motion: Passed**

The Subcommittee concluded its review and updates to the Primary Medical Care Standards.

*2.* **Motion to approve the Minimum Primary Care Standards, as presented.** *(Attachment 2)*
**Moved: Dennis Iadarola** **Second: Ryan Roelans** **Motion: Passed**

The Subcommittee reviewed the Mental Health and Substance Abuse service description. Some revisions are being worked on, but the Subcommittee approved the revisions to the Substance Abuse service description. Revisions are in track changes.

3. **Motion to approve the Substance Abuse service description, as presented.** *(Attachment 3)*
**Moved: Barbara Kubilus** **Second: Etelvina Alcala** **Motion: Passed**

The Subcommittee began review of the medications approved on the ADAP formulary. The first 44 were reviewed for pricing, other options or payor sources, medication interactions, and if the medications were either lifesaving or cost effective. The Subcommittee recommended all but nine medications which have been shaded in grey on the attachment. Two medications were restricted to tablets only.

**4. Motion to add all the medications included in the December 2022 ADAP formulary additions to the Ryan White Prescription Drug Formulary Items #1-44 sheet to the Ryan White Formulary with the restriction on #18 levonorgestrel and #22 clonidine to tablets only but excluding the following nine items: #2 diclofenac, #3 nepafenac, #10 rifapentine, #20 bempedoic acid, #24 olmesartan, #28 olmesartan/hydrochlorothiazide, #36 ezetimibe/rosuvastatin, #39 evolocumab, and #40 alirocumab.** *(Attachment 4)*
**Moved: Barbara Kubilus** **Second: Etelvina Alcala** **Motion: Passed**

The Subcommittee requested data on utilization of four letters of medical necessity: the data showed very low utilization, and the Subcommittee voted to discontinue usage of the four letters to reduce paperwork.

**5. Motion to discontinue the Letters of Medical Necessity for 1) Roxicodone and Percocet, 2) Neupogen, 3) Procrit or Epogen, and 4) the (lab test) for the Highly Sensitive Tropism Assay required to prescribe Maraviroc.**
**Moved: Barbara Kubilus** **Second: Ryan Roelans** **Motion: Passed**

The Subcommittee continued work on revisions to the Allowable Conditions listing, including formatting and additions.

The next Subcommittee meeting was scheduled for March 24, 2023, but not take place because of a lack of quorum.

## IX. Standing Business *All*

- *2023 Officer Elections* *All*

Dr Shmuels indicated that a memo announcing eligible candidates for vice-chair was included in the meeting materials and posted online (copy on file) indicating the four qualified candidates for the position: Dr. Mary Jo Trepka, Vanessa Mills, Ryan Roelans, and Barbara Kubilus. The only interested member was Ms. Kubilus, whom the committee voted into the vice-chair position.

**Motion to elect Barbara Kubilus as vice-chair of the Care and Treatment Committee.**
**Moved: Dr. Mary Jo Trepka Seconded: Etelvina Alcala Motion: Passed**

- *Service Descriptions: Outreach* *All*

Staff distributed copies of the Outreach service description, which was updated for content and reviewed by CQM staff and an outreach worker. Updated language was included along with suggestions. There was a suggestion to strike a section on one-time referrals, but the Committee indicated instead that additional language should be included to have outreach workers connect a client to a medical case management site. Staff will provide some language, but the Committee also wanted the item to reviewed again.

**Motion to send the Outreach service description back to staff and relevant parties to review.**
**Moved: Barbara Kubilus Second: Dennis Iadarola Motion: Passed**

## X. New Business

*No new business.*

## XI. Announcements *All*

Meeting announcements should be forwarded to Staff for distribution through the aidsnet.org website and weekly Community Notices.

Mrs. Meizoso indicated that annual source of income forms were located in member packets. She reviewed how to complete the forms. All forms must be completed before July 1, 2023, to comply with local and state rules. Penalties for non-completion include fees and removal from the committee.

A new candidate for the FCPN will be needed with Mr. Neff's resignation. Staff will contact FCPN for application materials and a memo will be sent out with requirements so that a vote can be made at the next meeting.

## XII. Next Meeting *Dr. Diego Shmuels*

The next meeting is scheduled for Thursday, April 6, 2023, at the Miami-Dade County Main Library Auditorium, 101 West Flagler Street, Miami, FL 33130, from 10:00 a.m. to 12:00 p.m.

## XIII. Adjournment *Dr. Diego Shmuels*

With business concluded, Dr. Shmuels thanked the members for participating in today's meeting and adjourned the meeting at 11:45 a.m.

MIAMI-DADE HIV/AIDS PARTNERSHIP

# Care and Treatment
# Thursday, June 8, 2023

10:00 a.m. – 1:00 p.m.

Miami-Dade County Main Library
101 West Flagler Street, Auditorium
Miami, FL 33130

## AGENDA

| | | |
|---|---|---|
| I. | Call to Order | Dr. Diego Shmuels |
| II. | Introductions | All |
| III. | Meeting Housekeeping and Rules | Dr. Mary Jo Trepka |
| IV. | Floor Open to the Public | Dr. Mary Jo Trepka |
| V. | Review/Approve Agenda | All |
| VI. | Review/Approve Minutes of May 4, 2023 | All |
| VII. | Reports | |
| | • Grantee reports (Part A, B, ADAP, and General Revenue) | Recipients |
| | • Vacancies | Marlen Meizoso |
| | • Report to Committees (reference only) | All |
| VIII. | Standing Business | |
| | • None | All |
| IX. | New Business | |
| | • Setting Priorities and Allocating Resource Process (**Section 1**) | All |
| | • Summary of HIV Epi Profile Data, 2020-2021 (**Section 3**) | Marlen Meizoso |
| | • 2022 EIIHA data (**Section 3**) | Dr. Robert Ladner |
| | • 2022 Ryan White Program HIV Care Continuum (**Section 3**) | Dr. Robert Ladner |
| | • 2022 Ryan White Demographics (**Section 4**) | Dr. Robert Ladner |
| X. | Open Discussion and Announcements | All |
| XI. | Next Meeting: **July 13, 2023** at Main Library- **Auditorium** | Dr. Mary Jo Trepka |
| XII. | Adjournment | Dr. Diego Shmuels |

Meeting documents available at: http://aidsnet.org/meeting-documents/#docsct

***Please turn off or mute cellular devices – Thank you***

**For more information, regarding the Miami-Dade HIV/AIDS Partnership's Care and Treatment Committee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com**

**Care and Treatment Committee Meeting**
**Miami-Dade Public Library, Community Room**
**101 West Flagler, Miami, FL 33130**
**May 4, 2023**

| # | Committee Members | Present | Absent |
|---|---|---|---|
| 1 | Alcala, Etelvina | X | |
| 2 | Downs, Frederick | | X |
| 3 | Grant, Gena | | X |
| 4 | Henriquez, Maria | X | |
| 5 | Iadarola, Dennis | | X |
| 6 | Mills, Vanessa | | X |
| 7 | Roelans, Ryan | | X |
| 8 | Siclari, Rick | | X |
| 9 | Shmuels, Diego | X | |
| 10 | Trepka, Mary Jo | X | |
| 11 | Wall, Dan | X | |
| **Quorum: 5** | | | |

| **Guests** | |
|---|---|
| Jose Camino | |
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| | |
| **Staff** | |
| Robert Ladner | Marlen Meizoso |

All documents referenced in these minutes were accessible to members and the public prior to (and during) the meeting, at www.aidsnet.org/meeting-documents.

## I. Call to Order *Dr. Diego Shmuels*

Dr. Diego Shmuels, the Chair, called the meeting to order at 10:27 a.m.

## II. Introductions *Dr. Diego Shmuels*

Members and guests introduced themselves around the room.

## III. Meeting Housekeeping and Rules *Dr. Diego Shmuels*

Dr. Shmuels reviewed the Housekeeping and Rules presentation (copy on file), which reviewed the environmental reminders, parking, and meeting decorum for all participants.

## IV. Floor Open to the Public *Dr. Diego Shmuels*

Dr. Shmuels read the following:

*Pursuant to Florida Sunshine Law, I want to provide the public with a reasonable opportunity to be heard on any items on our agenda today. If there is anyone who wishes to be heard, I invite you to*

*speak now. Each person will be given three minutes to speak. Please begin by stating your name and address for the record before you talk about your concerns.*

*BSR has a dedicated line for statements to be read into the record. No statements were received.*

There were no comments, so the floor was closed.

**V. Review/Approve Agenda** *All*

The committee reviewed the agenda and made a motion to approve it as presented.

**Motion to accept the agenda, as presented.**
**Moved: Dr. Mary Jo Trepka Seconded: Dan Wall Motion: Passed**

**VI. Review/Approve Minutes of March 2, 2023** *All*

The committee reviewed the minutes of March 2, 2023, and accepted them as presented.

**Motion to accept the minutes from March 2, 2023, as presented.**
**Moved: Dr. Mary Jo Trepka Seconded: Dan Wall Motion: Passed**

**VII. Reports**

- *Part A* *Dan Wall*

Dan Wall reviewed the February Recipient report on expenditures, which provided data on Part A/MAI reimbursements as of May 3, 2023 (copy on file). As of the time of the report, the Part A/MAI program has served 8,584 unduplicated clients. Final figures are being worked on and the report to-date is posted online indicated 80% expenditures under Part A and 40% under MAI. Since its inception, TTRA has served over 3,496 clients with over 75% being virally suppressed. Annual Ryan White reports are in process and are due to HRSA at the end of May. The final award notice for this fiscal year has been received, totaling $27,558,848. Reallocation/sweeps will need to be done in June. The EHE RFP will be released next week and includes four components: HealthTec, Quick Connect, Housing Stability Support, and Mobil Go-Team. HRSA is scheduling an EHE site visit July 12-14, 2023. Jimmy Llaque is the interim care director at the Florida Department of Health in Tallahassee with the transfer of the former director to another department.

- *Part B* *Marlen Meizoso*

Marlen Meizoso reviewed the January and February 2022 (copy on file) report. In the month of January, 119 clients were served for $76,852.38 and in February, 122 clients were served for $75,587.32. A question was asked regarding why the housing line item was not expended. Staff will follow up with the Part B representative.

- *.ADAP* *Marlen Meizoso*

Mrs. Meizoso reviewed the April 2023 (copy on file) report as of May 1, 2023, including data on enrollments, pharmacy and insurance expenditures, program updates, medication additions, and current pharmacy listings. A Committee member indicated that there have been challenges for clients using Magellan to access medications. Staff will inquire from the ADAP representative if other providers have been having problems with access.

- *Vacancies* *Marlen Meizoso*

Mrs. Meizoso reviewed the April 2023 vacancy report (copy on file) which indicated there are eleven vacancies for members of the affected community on the Partnership. Barbara Kubilus has resigned, so there are eleven members on the Care and Treatment Committee and five vacancies including seats for members of the affected community. Staff urged members to share vacancy information with clients and invite them to upcoming training and meetings.

- *Medical Care Subcommittee Report* *Marlen Meizoso*

Mrs. Meizoso reviewed the Medical Care Subcommittee report.

The Medical Care Subcommittee (MCSC):

Met on April 28, 2023 and heard updates from the Ryan White Program and the ADAP Program.

Reviewed and approved a request to add two codes, D5284- D5284-Removal unilateral partial denture and D3221-Pulpal debridement to the Oral Health Care formulary since the codes would be beneficial to clients.

**1. Motion to add D5284-Removal unilateral partial denture and D3221-Pulpal debridement to the Ryan White Oral Health Care formulary.**
**Moved: Dr. Mary Jo Trepka Seconded: Dan Wall Motion: Passed**

After numerous revisions, the Subcommittee approved the revised Allowable Conditions as presented.

**2. Motion to approve the revised Allowable Conditions list as presented. (*Attachment 1)***
**Moved: Dan Wall Seconded: Dr. Mary Jo Trepka Motion: Passed**

After numerous revisions, the Subcommittee approved the Mental Health service description. Additional language was added to clarify certain issues and allow for certain mental health services provided by licensed mental health professionals to be reimbursed under the outpatient/ambulatory health services description. References highlighted in yellow will need to be updated (see attachment).

**3. Motion to accept the Mental Health service description as discussed (*and presented*). [*Attachment 2*]**
**Moved: Dan Wall Seconded: Maria Henriquez Motion: Passed**

Along with the edits to the Mental Health service description, the Subcommittee requested language in the Outpatient/Ambulatory Health Services be amended to include the language included in the mental health service description regarding mental health services provided by select licensed mental health professionals.

**4. Motion to amend the Outpatient/Ambulatory Health service description to include the following language "Additional mental health services may be provided under Outpatient/Ambulatory Health Services when delivered by a licensed psychiatrist or other doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner or physician assistant."**
**Moved: Dan Wall Seconded: Dr. Mary Jo Trepka Motion: Passed**

Continued review of the medications approved on the ADAP formulary for items #45-75 for pricing, other options or payor sources, medication interactions, and if the medications were either lifesaving or cost effective. The Subcommittee recommended all the medications be added except for #72-75, which are not allowed because they are over-the-counter products. Comments and restrictions are listed on the form.

**5. Motion to add medications #45-71 included in the December 2022 ADAP formulary additions to the Ryan White Prescription Drug Formulary Items sheet to the Ryan White Formulary with comments and restrictions, as indicated. (*Attachment 3*)**
**Moved: Dan Wall Seconded: Dr. Mary Jo Trepka Motion: Passed**

The ADAP program also recently added five new medications to the ADAP Formulary. The Subcommittee discussed these additions and decided to also add them to the Ryan White Prescription Drug Formulary.

**6. Motion to add betamethasone/clotrimazole, ciprofloxacin/dexamethasone, dextromethorphan/promethazine, fluticasone/salmeterol, and budesonide to the Ryan White prescription drug formulary.**
**Moved: Dan Wall Seconded: Etelvina Alcala Motion: Passed**

The next subcommittee meeting is scheduled for May 26, 2023.

## VIII. Standing Business

- *Vice-Chair Elections* *All*

Dr. Shmuels indicated that with the resignation of Ms. Kubilus an election for vice-chair was needed. A memo announcing eligible candidates for vice-chair was included in the meeting materials, emailed ahead of the meeting, and posted online (copy on file) indicating the qualified candidates for the position: Dr. Mary Jo Trepka, Vanessa Mills, and Ryan Roelans. The only interested member was Dr. Trepka, whom the committee voted into the vice-chair position.

**Motion to elect Dr. Mary Jo Trepka as vice-chair of the Care and Treatment Committee.**
**Moved: Dan Wall Seconded: Etelvina Alcala Motion: Passed**

- *Florida Comprehensive Planning Network (FCPN) Representative* *All*

Dr. Shmuels reported that the prior area 11A representative, Travis Neff, resigned earlier this year, creating a vacancy. A memo announcing the vacancy was emailed to members, was posted online, and is located in member meeting packets on the reverse of the prior memo. There are five members who qualify but only Dr. Mary Jo Trepka has expressed interest in the position. The Committee made a motion to recommend Dr. Trepka as the area 11A FCPN planning care representative.

**Motion to recommend Dr. Mary Jo Trepka as the area 11A Patient Care representative to the Florida Comprehensive Planning Network.**
**Moved: Dan Wall** **Seconded: Etelvina Alcala** **Motion: Passed**

- *Service Descriptions: Outreach* *All*

At the last meeting, the Committee reviewed the comments, updates, and changes recommended to the Outreach service description. Clarifying language was requested under the section "one-time referral." The Committee reviewed the language and made a motion to accept the revisions to the outreach service description.

**Motion to approve the Outreach service description as presented.**
**Moved: Dan Wall** **Second: Dr. Mary Jo Trepka** **Motion: Passed**

## IX. New Business

- *Planning Council Responsibility and Needs Assessment* *Marlen Meizoso*

Mrs. Meizoso, with the assistance of the Committee, reviewed the Planning Council Responsibilities and Needs Assessment presentation which serves as the foundation of the work that the Committee will engage in over the next few months (copy on file). The committee's responsibilities and the requirement to use data throughout the process for priority setting, resource allocations, and in establishing directives were reviewed. The diverse types of data types that will be presented throughout the process were also reviewed as well as to apply data to decision making.

- *2022 Client Satisfaction Results* *Dr. Robert Ladner*

Dr. Ladner reviewed the 2022 Client Satisfaction Survey results (copy on file). For the 2022 survey, 589 quota sampled client interviews were completed via phone. The full sample were medical case management clients, 311 qualified for the oral health survey, and 220 clients had Affordable Care Act (ACA) insurance. Seventy percent (Spanish 59% and Creole 11%) spoke a language other than English so it important for providers to have multilingual staff at provider sites. Fifty-three percent were 50-years old and older. Overall, 61% of those sampled worked either full-time (41%) or part-time (26%) so their biggest obstacle to care was work conflicts for appointments. For those clients with ACA plans, 15% did not use the GAP card. Service satisfaction has improved in outpatient ambulatory health services but continues to be low for oral health. An additional component of the 2022 survey was a qualitative stigma section. Overall, although stigma is felt by a number of client

groups in a number of dimensions, particularly among younger clients, instances of discriminatory or stigmatizing behavior among subrecipients are extremely rare.

**X. Open Discussion and Announcements** *All*

Open discussion is a new item on the agenda to encourage members of the community to speak up or out about issues they wish to share. Members indicated they had no issues to raise.

**XI. Next Meeting** *Dr. Diego Shmuels*

The next meeting is scheduled for Thursday, June 1, 2023, at the Miami-Dade County Main Library Auditorium, 101 West Flagler Street, Miami, FL 33130, from 10:00 a.m. to 1:00 p.m.

**XII. Adjournment** *Dr. Diego Shmuels*

With business concluded, Dr. Shmuels thanked the members for participating in today's meeting and adjourned the meeting at 11:57 a.m.

MIAMI-DADE HIV/AIDS PARTNERSHIP

# Care and Treatment
# Thursday, July 13, 2023

10:00 a.m. – 1:00 p.m.

Miami-Dade County Main Library
101 West Flagler Street, Auditorium
Miami, FL 33130

**AGENDA**

| | | |
|---|---|---|
| I. | Call to Order | Dr. Diego Shmuels |
| II. | Meeting Housekeeping and Rules | Dr. Mary Jo Trepka |
| III. | Introductions | All |
| IV. | Floor Open to the Public | Dr. Mary Jo Trepka |
| V. | Review/Approve Agenda | All |
| VI. | Review/Approve Minutes of June 8, 2023 | All |
| VII. | Reports | |
| | • Grantee reports (Part A, B, ADAP, and General Revenue) | Recipients |
| | • Vacancy | Marlen Meizoso |
| VIII. | Standing Business | |
| | • none | All |
| IX. | New Business | |
| | • YR 2023 Sweeps 2 Reallocation | All |
| | • YR 2022 Carryover | All |
| | • 2022 Ryan White Utilization **(Section 5)** | Dr. Robert Ladner |
| | • Other Funding **(Section 6)** | Marlen Meizoso |
| | • Dashboard Guide and Cards (**Section** 7) | Marlen Meizoso |
| | • Reminders and Next Steps **(Section 11)** | Marlen Meizoso |
| X. | Announcements and Open Discussion | All |
| XI. | Next Meeting: **August 17, 2023** at Main Library- **Auditorium** | Dr. Mary Jo Trepka |
| XII. | Adjournment | Dr. Diego Shmuels |

***Please turn off or mute cellular devices – Thank you***

**For more information, regarding the Miami-Dade HIV/AIDS Partnership's Care and Treatment Committee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com**

**Care and Treatment Committee Meeting**
**Miami-Dade Public Library, Auditorium**
**101 West Flagler, Miami, FL 33130**
**June 8, 2023**

| # | Committee Members | Present | Absent |
|---|---|---|---|
| 1 | Alcala, Etelvina | X | |
| 2 | Downs, Frederick | | X |
| 3 | Grant, Gena | X | |
| 4 | Henriquez, Maria | X | |
| 5 | Iadarola, Dennis | | X |
| 6 | Mills, Vanessa | | X |
| 7 | Roelans, Ryan | | X |
| 8 | Siclari, Rick | | X |
| 9 | Shmuels, Diego | | X |
| 10 | Trepka, Mary Jo | X | |
| 11 | Wall, Dan | X | |
| **Quorum: 5** | | | |

| Guests | |
|---|---|
| Brad Mester | |
| Karen Poblete | |
| Javier Romero | |
| Carla Valle-Schwenk | |
| Jennifer William | |
| | |
| | |
| | |
| | |
| | |
| **Staff** | |
| Robert Ladner | Marlen Meizoso |

All documents referenced in these minutes were accessible to members and the public prior to (and during) the meeting, at www.aidsnet.org/meeting-documents.

## I. Call to Order *Dr. Mary Jo Trepka*

Dr. Mary Jo Trepka, the Vice-Chair, called the meeting to order at 10:14 a.m. in the absence of the Chair.

## II. Introductions *Dr. Mary Jo Trepka*

Members and guests introduced themselves around the room.

## III. Meeting Housekeeping and Rules *Dr. Mary Jo Trepka*

Dr. Trepka reviewed the Housekeeping and Rules presentation (copy on file), which reviewed the environmental reminders, parking, and meeting decorum for all participants.

## IV. Floor Open to the Public *Dr. Mary Jo Trepka*

Dr. Trepka read the following:

*Pursuant to Florida Sunshine Law, I want to provide the public with a reasonable opportunity to be heard on any items on our agenda today. If there is anyone who wishes to be heard, I invite you to*

*speak now. Each person will be given three minutes to speak. Please begin by stating your name and address for the record before you talk about your concerns.*

*BSR has a dedicated line for statements to be read into the record. No statements were received.*

There were no comments, so the floor was closed.

**V. Review/Approve Agenda** *All*

The committee reviewed the agenda and made a motion to approve it as presented.

**Motion to accept the agenda, as presented.**
**Moved: Dennis Iadarola** **Seconded: Dan Wall** **Motion: Passed**

**VI. Review/Approve Minutes of May 4, 2023**
*All*

The committee reviewed the minutes of May 4, 2023, and accepted them as presented.

**Motion to accept the minutes from May 4, 2023, as presented.**
**Moved: Dan Wall** **Seconded: Dennis Iadarola** **Motion: Passed**

**VII. Reports**

- *Part A/Minority AIDS Initiative (MAI)* *Dan Wall*

Dan Wall reviewed the End of Fiscal Year Recipient report on expenditures, which provided data on Part A/MAI reimbursements as of June 1, 2023. The Part A/MAI program served 8,590 unduplicated clients (8,526 under Part A and 1,351 under MAI). The current client count is 5,968. The full expenditure report is posted online and indicates expenditures of over $22 million in direct services. The first Sweeps were done in June at the Partnership to meet Health Resources and Services Administration (HRSA) deadlines. Carryover and Sweeps #2 will need to be conducted in July. The full grant award for the current year was received and totaled $27,558,848. All reports have been submitted. Test and Treat/Rapid Access has served 3,558 to-date with 2,700 (76%) being virally suppressed. The Ending the HIV Epidemic (EHE) Request for Proposals (RFP) has been released and is due by 2:00 p.m. on June 28, 2023. Four components are funded under the EHE RFP: HealthTec, Quick Connect, Housing Stability Support, and Mobile GO Team. HRSA has rescheduled the EHE site visit to August 8-10, 2023.

- *Part B* *Marlen Meizoso*

Marlen Meizoso reviewed the Final 2022-2023 Part B report. For the fiscal year ending March 2023, 1,337 clients were served at an expense of $1,679,849.

- *.ADAP* *Javier Romero*

Dr. Javier Romero reviewed the May 2023 report as of June 5,2023, including data on enrollments, pharmacy and insurance expenditures, program updates, medication additions, and current pharmacy listings. There have been few former-Medicaid clients accessing the program. CHI is now a pharmacy under Magellan and has two sites for prescription drug access. As of February 1, Care Resource is no longer participating with Magellan. Clients must be open in ADAP in order to participate in Magellan. There may be issues with clients going to multiple sites (Florida Department of Health and Magellan pharmacy). Tracking of compliance with program rules is done through reported pharmacy pickups. A brief email will be provided by Dr. Romero with ADAP reminders to be forwarded to the County to share with medical case managers.

- *General Revenue* *Marlen Meizoso*

Mrs. Meizoso reviewed the March 2023 General Revenue report. In the month of March, 2,025 clients were served for $554,844.82 in expenditures. Year-to-date expenditure totals $3,781,261.54.

- *Vacancies* *Marlen Meizoso*

Mrs. Meizoso reviewed the May 2023 vacancy report which indicated there are eleven vacancies for members of the affected community on the Partnership. Current vacancies on the Care and Treatment Committee total five including seats for members of the affected community. Staff urged members to share vacancy information with clients or invite them to upcoming training and meetings.

- *Report to Committees (reference only)* *All*

A copy of the report to committees is posted online. The report details the actions taken at the last Partnership meeting. Any questions can be directed to staff.

## VIII. Standing Business

- *None*

## IX. New Business

- *Setting Priorities and Allocating Resource Process* *Marlen Meizoso*

Mrs. Meizoso presented the Process for Setting Priorities and Allocating Resources document which indicated the step-by-step guide the Committee would be following. The Committee voted to adopt the process.

**Motion to adopt the Process for Setting Priorities and Allocating Resources, as presented.**
**Moved: Dan Wall** **Seconded: Gena Grant** **Motion: Passed**

- *Summary of HIV Epidemiological (Epi) Profile Data, 2020-2021* *Marlen Meizoso*

Mrs. Meizoso reviewed the Summary of HIV Epi Profile Data, 2020-2021. The full epi profile was presented by the Florida Department of Health in Miami-Dade County (FDOH-MDC) in March. Today's presentation provided highlights of incidence and prevalence from 2020 to 2021. HIV and AIDS cases have increased. Overall, prevalence has increased 2%. Male-to-male sexual contact (MMSC) continues to be the primary vector for new cases. Cases among transgenders have been increasing significantly from 2017 to 2021. Cases of co-occurring HIV with sexually transmitted diseases (STDs) have also been increasing significantly. Awareness of STDs should be shared with medical case managers. In the Integrated Plan, Men who have sex with men (MSM) with STDs is a special group of interest which will be tracked on the Clinical Quality Management Committee report card.

- *2022 Early Identification of Individuals with HIV/AIDS (EIIHA) Data* *Dr. Robert Ladner*

Dr. Robert Ladner reviewed the 2022 EIIHAdata for calendar year 2022. This data presents an overview of testing events funded by the FDOH-MDC. There were 22% more tests conducted in calendar year 2022. Testing data for black females, black MMSC, and Hispanic/Latinx MMSC were reviewed. Comparing 2021 to 2022 linked to care rates for newly diagnosed and previously diagnosed improved.

- *2022 Ryan White Program (RWP) HIV Care Continuum* *Dr. Robert Ladner*

Dr. Ladner reviewed the 2022 Ryan White HIV Care Continuum. Comparing 2021 to 2022, there have been improvements in retained in care figures from 68% to 72%. Comparing race/ethnicity, black/non-Hispanics have the lowest suppressed viral load rates. Comparing gender, suppressed viral load rates are similar for females, males, and transgender persons. Comparing by exposure category, rates are similar for viral suppression rates.

- *2022 Ryan White Program (RWP) Demographics* *Dr. Robert Ladner*

Dr. Ladner reviewed the 2022 RWP Demographics Data . In fiscal year 2022, there was a 2% increase in overall clients from 8,418 to 8,599. Clients over 50 years of age make up over 40% of all RWP clients.. More men are served (81.7%) than women (17.1%). Hispanics account for the largest ethnic group (64.9%). Of the transgender clients in the program, the majority are Hispanic. Primary language of choice for clients is Spanish (57%) and English (31.8%); this trend has been steadily growing since fiscal year 2018. New clients entering the system are poorer (under 135% FPL) compared to established clients. There has been a steady increase in the number of clients with Affordable Care Act insurance from FY 2018 (23%) to FY 2022 (36%).

## X. Open Discussion and Announcements *All*

Open discussion is a novel item on the agenda to encourage members of the community to speak up or out about issues they wish to share. A member indicated that testing everyone is important since this knowledge may have been helpful to get care early. They had an acquaintance who was recently

diagnosed positive in their 60s and recently passed away. While the acquaintance had other health factors which may or may not have contributed to their demise, it is important to focus on overall health. Clients who have HIV under control still need to go to the doctor to address other co-occurring conditions, e.g., diabetes, hypertension, mental health issues. HIV positive clients age 'faster' so it important to do preventive testing and care early.

**XI. Next Meeting** *Dr. Mary Jo Trepka*

The next meeting is scheduled for Thursday, July 13, 2023, at the Miami-Dade County Main Library Auditorium, 101 West Flagler Street, Miami, FL 33130, from 10:00 a.m. to 1:00 p.m.

**XII. Adjournment** *Dr. Mary Jo Trepka*

With business concluded, Dr. Trepka thanked the members for participating in today's meeting and requested a motion to adjourn.

**Motion to adjourn.**
**Moved: Dan Wall** **Moved: Etelvina Alcala** **Motion: Passed**

The Vice Chair adjourned the meeting at 12:50 p.m.