LOS ANGELES COUNTY
COMMISSION ON HIV

PLANNING, PRIORITIES & ALLOCATIONS COMMITTEE **SPECIAL** MEETING

Thursday, May 1, 2025
1:00pm – 3:30pm (PST)
Note Extending Meeting Time

510 S. Vermont Avenue, 9th Floor, LA 90020
Validated Parking @ 523 Shatto Place, LA 90020
As a building security protocol, attendees entering the building must notify parking attendant and/or security personnel that they are attending a Commission on HIV meeting.

Agenda and meeting materials will be posted on our website at https://hiv.lacounty.gov/planning-priorities-and-allocations-committee

Register Here to Join Virtually

https://lacountyboardofsupervisors.webex.com/weblink/register/rf773c13ab5ea
e763f881e1ccc7ccde77

Public Comments

You may provide public comment in person, or alternatively, you may provide written public comment by:
- Emailing hivcomm@lachiv.org
- Submitting electronically at https://www.surveymonkey.com/r/PUBLIC_COMMENTS

* Please indicate your name, the corresponding agenda item, and whether you would like to state your public comment during the meeting. All public comments will be made part of the official record.

Accommodations

Requests for a translator, reasonable modification, or accommodation from individuals with disabilities, consistent with the Americans with Disabilities Act, are available free of charge with at least 72 hours' notice before the meeting date by contacting the Commission office at hivcomm@lachiv.org or 213.738.2816.

Scan QR code to download an electronic copy of the meeting packet. Hard copies of materials will not be available in alignment with the County's green initiative to recycle and reduce waste. If meeting packet is not yet available, check back prior to meeting; meeting packet subject to change. Agendas will be posted 72 hours prior to meeting per Brown Act.

together.

WE CAN END HIV IN OUR COMMUNITIES ONCE & FOR ALL

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For application assistance, call (213) 738-2816 or email hivcomm@lachiv.org

AGENDA FOR THE **SPECIAL MEETING** OF THE
LOS ANGELES COUNTY COMMISSION ON HIV
PLANNING, PRIORITIES, &
ALLOCATIONS COMMITTEE

THURSDAY, MAY 1, 2025 | 1:00 PM – 3:30 PM
NOTE EXTENDED MEETING TIME

510 S. Vermont Ave
Terrace Level Conference Room, Los Angeles, CA 90020

Validated Parking: 523 Shatto Place, Los Angeles 90020

MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
https://lacountyboardofsupervisors.webex.com/weblink/registe
r/rf773c13ab5eae763f881e1ccc7ccde77

To Join by Telephone: 1-213-306-3065
Password: PLANNING   Access Code: 2534 828 4606

Planning, Priorities, and Allocations Committee Members:			
Kevin Donnelly, Co-Chair Carlos Vega-Matos *(Alternate)*	Daryl Russell Co-Chair	Al Ballesteros, MBA	Lilieth Conolly (LOA) Gerald Green *(Alternate)*
Felipe Gonzalez Rita Garcia *(Alternate)*	Michael Green, PhD	William King, MD, JD	Rob Lester *(Committee-only)*
Miguel Martinez, MPH, MSW *(Committee-only)*	Ismael Salamanca	Harold Glenn San Agustin, MD	Dee Saunders
LaShonda Spencer, MD	Lambert Talley *(Alternate)*		
QUORUM: 8			

AGENDA POSTED: April 28, 2025

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment,

you may join the virtual meeting via your smart device and post your Public Comment in the Chat box - or- email your Public Comment to mailto:hivcomm@lachiv.org -or- submit your Public Comment electronically here. All Public Comments will be made part of the official record.

ATTENTION: Any person who seeks support or endorsement from the Commission on any official action may be subject to the provisions of Los Angeles County Code, Chapter 2.160 relating to lobbyists. Violation of the lobbyist ordinance may result in a fine and other penalties. For information, call (213) 974-1093.

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 72 hours' notice before the meeting date. To arrange for these services, please contact the Commission Office at (213) 738-2816 or via email at HIVComm@lachiv.org.

Los servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con Oficina de la Comisión al (213) 738-2816 (teléfono), o por correo electrónico a HIVComm@lachiv.org, por lo menos setenta y dos horas antes de la junta.

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located at 510 S. Vermont Ave. 14th Floor, Los Angeles, CA 90020. Validated parking is available at 523 Shatto Place, Los Angeles 90020. *Hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste.*

I. ADMINISTRATIVE MATTERS

1.	Call to Order & Meeting Guidelines/Reminders		1:00 PM – 1:03 PM
2.	Roll Call & Conflict of Interest Statements		1:03 PM – 1:05 PM
3.	Approval of Agenda	**MOTION #1**	1:05 PM – 1:07 PM
4.	Approval of Meeting Minutes	**MOTION #2**	1:07 PM – 1:10 PM

II. PUBLIC COMMENT   1:10 PM – 1:15 PM

5. Opportunity for members of the public to address the Committee of items of interest that are within the jurisdiction of the Committee. For those who wish to provide public comment may do so in person, electronically by clicking here, or by emailing hivcomm@lachiv.org.

III. COMMITTEE NEW BUSINESS ITEMS

6. Opportunity for Committee members to recommend new business items for the full body or a committee level discussion on non-agendized matters not posted on the agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting, or matters requiring immediate action because of an emergency situation, or where the need to take action arose subsequent to the posting of the agenda.

IV. REPORTS

7. Executive Director/Staff Report   1:16 PM—1:23PM
    a. Operational and Commission Updates

8. Co-chair Report   1:24 PM—1:30 PM
    a. May 20, 2025 Planning, Priorities, and Allocations Committee Meeting

9. Division on HIV and STD Programs (DHSP) Report   1:31 PM—2:15 PM
    a. Ryan White Program Year 33 (PY33) Utilization Report - Support Services

- B R E A K -   2:16 PM—2:20 PM

V. DISCUSSION   2:21 PM—3:25 PM

10. Contingency Planning
    MOTION #3 - Approve the Ryan White Program Year 35 Allocation Contingency Plan (Scenario #3)

VI. NEXT STEPS   3:25 PM – 3:27 PM

11. Task/Assignments Recap
12. Agenda Development for the Next Meeting

VII. ANNOUNCEMENTS   3:28 PM – 3:30 PM

13. Opportunity for members of the public and the committee to make announcements.

VIII. ADJOURNMENT   3:30 PM

14. Adjournment for the meeting of May 1, 2025.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order, as presented or revised.
MOTION #2	Approve the Planning, Priorities and Allocations Committee minutes, as presented or revised.
MOTION #3	Approve the Ryan White Program Year 35 Allocation Contingency Plan (Scenario #3) and grant the Division of HIV and STD Programs (DHSP) the authority to adjust allocations by up to ten percent (10%) per service category, as needed —without returning to the full Commission for additional approval.

LOS ANGELES COUNTY
COMMISSION ON HIV

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS
(Updated 7.15.24)

☐ This meeting is a **Brown-Act meeting** and is being recorded.
- Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
- Your voice is important and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

☐ The **meeting packet** can be found on the Commission's website at https://hiv.lacounty.gov/meetings/ or accessed via the QR code provided. Hard copies of materials will not be provided in compliance with the County's green initiative to recycle and reduce waste.

☐ Please comply with the **Commission's Code of Conduct** located in the meeting packet.

☐ **Public Comment** for members of the public can be submitted in person, electronically @ https://www.surveymonkey.com/r/public_comments or via email at hivcomm@lachiv.org. *Please indicate your name, the corresponding agenda item, and whether you would like to state your public comment during the meeting; if so, staff will call upon you appropriately. Public comments are limited to two minutes per agenda item. All public comments will be made part of the official record.*

☐ For individuals joining in person, to mitigate any potential streaming interference for those joining virtually, we respectfully ask that you **not simultaneously log into the virtual option of this meeting via WebEx.**

☐ Committee members invoking **AB 2449 for "Just Cause" or "Emergency Circumstances**" must communicate their intentions to staff and/or co-chairs no later than the start of the meeting. Members requesting to join pursuant to AB 2449 must have their audio and video on for the entire duration of the meeting and disclose whether there is a person over the age of 18 in the room in order to be counted toward quorum and have voting privileges. For members joining virtually due to "Emergency Circumstances", a vote will be conducted by the Committee/COH for approval.

☐ Members will be required to explicitly state their agency's **Ryan White Program Part A and/or CDC prevention conflicts of interest** on the record (versus referring to list in the packet). A list of conflicts can be found in the meeting packet and are recorded on the back of members' name plates, courtesy of staff.

If you experience challenges in logging into the virtual meeting, please refer to the WebEx tutorial HERE or contact Commission staff at hivcomm@lachiv.org.

CODE OF CONDUCT

The Commission on HIV welcomes commissioners, guests, and the public into a space where people of all opinions and backgrounds are able to contribute. In this space, we challenge ourselves to be self-reflective and committed to an ongoing understanding of each other and the complex intersectionality of the lives we live. We create a safe environment where we celebrate differences while striving for consensus in the fights against our common enemies: HIV and STDs. We build trust in each other by having honest, respectful, and productive conversations. As a result, the Commission has adopted and is consistently committed to implementing the following guidelines for Commission, committee, and associated meetings.

All participants and stakeholders should adhere to the following:

1) **We approach all our interactions with compassion, respect, and transparency.**
2) **We respect others' time by starting and ending meetings on time, being punctual, and staying present.**
3) **We listen with intent, avoid interrupting others, and elevate each other's voices.**
4) **We encourage all to bring forth ideas for discussion, community planning, and consensus.**
5) **We focus on the issue, not the person raising the issue.**
6) **Be flexible, open-minded, and solution-focused.**
7) **We give and accept respectful and constructive feedback.**
8) **We keep all issues on the table (no "hidden agendas"), avoid monopolizing discussions and minimize side conversations.**
9) **We have no place in our deliberations for racist, sexist, homophobic, transphobic, and other discriminatory statements, and "-isms" including misogyny, ableism, and ageism.**
10) **We give ourselves permission to learn from our mistakes.**

In response to violation of the Code of Conduct which results in meeting disruption, Include provisions of SB 1100 which states in part, ". . . authorize the presiding member of the legislative body conducting a meeting or their designee to remove, or cause the removal of, an individual for disrupting the meeting . . . . Removal to be preceded by a warning to the individual by the presiding member of the legislative body or their designee that the individual's behavior is disrupting the meeting and that the individual's failure to cease their behavior may result in their removal." Complaints related to internal Commission matters such as alleged violation of the Code of Conduct or other disputes among members are addressed and resolved in adherence to Policy/Procedure #08.3302." (Commission Bylaws, Article VII, Section 4.)

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 4/21/25

In accordance with the Ryan White Program (RWP), conflict of interest is defined as any financial interest in, board membership, current or past employment, or contractual agreement with an organization, partnership, or any other entity, whether public or private, that receives funds from the Ryan White Part A program. These provisions also extend to direct ascendants and descendants, siblings, spouses, and domestic partners of Commission members and non-Commission Committee-only members. Based on the RWP legislation, HRSA guidance, and Commission policy, it is mandatory for Commission members to state all conflicts of interest regarding their RWP Part A/B and/or CDC HIV prevention-funded service contracts prior to discussions involving priority-setting, allocation, and other fiscal matters related to the local HIV continuum. Furthermore, Commission members must recuse themselves from voting on any specific RWP Part A service category(ies) for which their organization hold contracts.*An asterisk next to member's name denotes affiliation with a County subcontracted agency listed on the addendum.*

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALE-FERLITO	Dahlia	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
ALVAREZ	Miguel	No Affiliation	No Ryan White or prevention contracts
ARRINGTON	Jayda	Unaffiliated representative	No Ryan White or prevention contracts
BALLESTEROS	Al	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & Linked Referral…(CSV)
			STD Screening, Diagnosis, and Treatment
			High Impact HIV Prevention
			Mental Health
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
			Data to Care Services
BURTON	Alasdair	No Affiliation	No Ryan White or prevention contracts
CAMPBELL	Danielle	T.H.E. Clinic, Inc.	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Biomedical HIV Prevention
			Transportation Services
CIELO	Mikhaela	Los Angeles General Hospital	Biomedical HIV Prevention
CONOLLY	Lilieth	No Affiliation	No Ryan White or prevention contracts
CUEVAS	Sandra	Pacific AIDS Education and Training - Los Angeles	No Ryan White or prevention contracts
CUMMINGS	Mary	Bartz-Altadonna Community Health Center	Community Engagement/EHE

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
DAVIES	Erika	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DAVIS (PPC Member)	OM	No Affiliation	No Ryan White or prevention contracts
DOLAN (SBP Member)	Caitlyn	Men's Health Foundation	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Data to Care Services
DONNELLY	Kevin	Unaffiliated representative	No Ryan White or prevention contracts
FERGUSON	Kerry	ViiV Healthcare	No Ryan White or prevention contracts
FINLEY	Jet	Unaffiliated representative	No Ryan White or prevention contracts
FRAMES	Arlene	Unaffiliated representative	No Ryan White or prevention contracts
FRANKLIN*	Arburtha	Translatin@ Coalition	Vulnerable Populations (Trans)
GARCIA	Rita	No Affiliation	No Ryan White or prevention contracts
GERSH (SBP Member)	Lauren	APLA Health & Wellness	High Impact HIV Prevention
			Benefits Specialty
			Nutrition Support
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Residential Care Facility - Chronically Ill
			Intensive Case Management
GONZALEZ	Felipe	Unaffiliated representative	No Ryan White or Prevention Contracts
GORDON	Bridget	Unaffiliated representative	No Ryan White or prevention contracts
GREEN	Gerald	Minority AIDS Project	Benefits Specialty
GREEN	Joseph	Unaffiliated representative	No Ryan White or prevention contracts
			Ambulatory Outpatient Medical (AOM)

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GUTIERREZ	Joaquin	Connect To Protect LA/CHLA	HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
HALFMAN	Karl	California Department of Public Health, Office of AIDS	Part B Grantee
HARDY	David	LAC-USC Rand Schrader Clinic	No Ryan White or prevention contracts
HERRERA	Ismael "Ish"	Unaffiliated representative	No Ryan White or prevention contracts
JONES	Terrance	Unaffiliated representative	No Ryan White or prevention contracts
KOCHEMS	Lee	Unaffiliated representative	No Ryan White or prevention contracts
KING	William	W. King Health Care Group	No Ryan White or prevention contracts
LESTER (PP&A Member)	Rob	Men's Health Foundation	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Data to Care Services
MARTINEZ (PP&A Member)	Miguel	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
			Promoting Healthcare Engagement Among Vulnerable Populations
MARTINEZ-REAL	Leonardo	Unaffiliated representative	No Ryan White or prevention contracts
MAULTSBY	Leon	Charles R. Drew University	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MENDOZA	Vilma	Unaffiliated representative	No Ryan White or prevention contracts
MINTLINE (SBP Member)	Mark	Western University of Health Sciences	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MOLETTE	Andre	Men's Health Foundation	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Oral Healthcare Services
NASH	Paul	University of Southern California	Biomedical HIV Prevention
			Community Engagement/EHE
			Oral Healthcare Services
NELSON	Katja	APLA Health & Wellness	High Impact HIV Prevention
			Benefits Specialty
			Nutrition Support
			Sexual Health Express Clinics (SHEx-C)
			Data to Care Services
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Residential Care Facility - Chronically Ill
			Case Management

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
PATEL	Byron	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			High Impact HIV Prevention
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
PERÉZ	Mario	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
RAINES	Aaron	No Affiliation	No Ryan White or prevention contracts
RICHARDSON	Dechelle	No Affiliation	No Ryan White or prevention contracts
ROBINSON	Erica	Health Matters Clinic	No Ryan White or prevention contracts
RUSSEL	Daryl	Unaffiliated representative	No Ryan White or prevention contracts
SALAMANCA	Ismael	City of Long Beach	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			HIV Testing & Sexual Networks
SAMONE-LORECA	Sabel	Minority AIDS Project	Benefits Specialty
SATTAH	Martin	Rand Schrader Clinic LA County Department of Health Services	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	Harold	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			High Impact HIV Prevention
			Mental Health
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
			Data to Care Services
SAUNDERS	Dee	City of West Hollywood	No Ryan White or prevention contracts
SPENCER	LaShonda	Oasis Clinic (Charles R. Drew University/Drew CARES)	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
STALTER	Kevin	Unaffiliated representative	No Ryan White or prevention contracts
TALLEY	Lambert	Grace Center for Health & Healing	No Ryan White or prevention contracts
VALERO	Justin	No Affiliation	No Ryan White or prevention contracts
VEGA-MATOS	Carlos	Men's Health Foundation	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Data to Care Services
WEEDMAN	Jonathan	ViaCare Community Health	Biomedical HIV Prevention
YBARRA	Russell	Capitol Drugs	No Ryan White or prevention contracts

Commission member presence at meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges. Members of the public may confirm their attendance by contacting Commission staff. Approved meeting minutes are available on the Commission's website and may be corrected up to one year after approval. Meeting recordings are available upon request.

PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A)
COMMITTEE MEETING MINUTES
April 15, 2025

COMMITTEE MEMBERS			
P = Present	P* = Present as member of the public; does not meet AB 2449 requirements	A = Absent	EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	Rob Lester	A
Daryl Russell, Co-Chair	P	Miguel Martinez, MPH, MSW	P
Al Ballesteros, MBA	A	Ismael Salamanca	P
Lilieth Conolly	LOA	Harold Glenn San Agustin, MD	P
Rita Garcia	A	Dee Saunders	P
Felipe Gonzalez	P	LaShonda Spencer, MD	P
Gerald Green	P	Lambert Talley	EA
Michael Green, PhD, MHSA	P	Carlos Vega-Matos	A
William King, MD, JD	P	Jonathan Weedman	P
COMMISSION STAFF AND CONSULTANTS			
Dawn McClendon, Jose Garibay, Lizette Martinez			
DHSP STAFF			
Sona Oksuzyan, Janet Cuanas, Paulina Zamudio, Victor Scott, Pamela Ogata, Anahit Nersisyan			

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.
*Members of the public may confirm their attendance by contacting Commission staff at hivcomm@lachiv.org.
*Meeting minutes may be corrected up to one year from the date of approval.

Meeting agenda and materials can be found on the Commission's website. Click HERE.

I. ADMINISTRATIVE MATTERS
1. CALL TO ORDER AND MEETING GUIDELINES/REMINDERS
Darrell Russell, Planning, Priorities and Allocations (PP&A) co-chair, called the meeting to order at approximately 1:00pm.

2. ROLL CALL & CONFLICT OF INTEREST STATEMENTS
D, McClendon conducted roll call and committee members were reminded to state their conflicts.

ROLL CALL (PRESENT): R. Garcia, F. Gonzalez, M. Green, W. King, M. Martinez, I. Salamanca, H. San Agustin, D. Saunders, L. Spencer, J. Weedman, D. Russell, K. Donnelly, J. Green

3. **Approval of Agenda**
   MOTION #1: Approve the Agenda Order **(✓Passed by Consensus)**

4. **Approval of Meeting Minutes**
   MOTION #2: Approval of Meeting Minutes **(✓Passed by Consensus)**

II. PUBLIC COMMENT

5. **Opportunity for members of the public to address the Committee on items of interest that is within the jurisdiction of the Committee.**

   See Public Comment Addendum for public comments.

III. COMMITTEE NEW BUSINESS

6. **Opportunity for Committee members to recommend new business items for the full body or a committee-level discussion on non-agendized matters not posted on the agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting, or matters requiring immediate action because of an emergency situation, or where the need to take action arose subsequent to the posting of the agenda.**

   There was no committee new business.

IV. REPORTS

7. **Executive Director/Staff Report**
   - L. Martinez, Commission staff, reminded the committee to review the report from the recent workgroups that were held on the restructuring of the Commission on HIV (COH). The report can be found in the April COH meeting packet (beginning on page 165). A formal report out of the findings and recommendations will be provided at the May 8, 2025 COH meeting.

8. **Co-chair Report**
   a. Priority Setting and Resource Allocation Process Mandatory Training – April 23, 2025
      - K. Donnelly, PP&A co-chair, reminded committee members of the upcoming mandatory training Priority Setting and Resource Allocation Process. The training will be held virtually on April 23, 2025 from 12pm-1pm and is also open to the public. See training flyer for registration information.
   b. HRSA Ryan White Program 2030 Letter | Exploring Strategies for Reaching Out of Care PLWH
      - K. Donnelly called attention to the Ryan White Program 2030 (RWP 2030) Dear Colleague letter that was released by the Health Resources and Services Administration (HRSA) in Dec 2024 outlining a goal of continuing to provide high-quality to care for those receiving services through the RWP while also prioritizing efforts to reach people with HIV who are out of care and not virally suppressed. Committee members were encouraged to review the document.

K. Donnelly noted that the committee will be reviewing and discussing potential strategies to address reaching people with HIV who are out of care and not virally suppressed in future discussions. See meeting packet (page 19) for dear colleague letter.

9. **Division of HIV and STD Programs Report**

    a. Ryan White Program Year 33 (PY33) 34 Utilization Report – Core Services

    - DHSP staff, S. Oksuzyan and J. Cuanas, provided a Program Year 33 (PY33) Utilization Report on funded Ryan White Program services to the committee. The report focused on Core Services. See meeting packet for more details.

    - The utilization report showed that the most utilized core services were Medical Care Coordination (MCC), followed by Oral Health and Ambulatory/Outpatient Medical (AOM) services. Home-based case management services saw a decline in clients and utilization from PY 29 to PY 33. In PY 33, expenditures for oral health and home-based case management services increased, while mental health expenditures decreased.

    - Although representing only 1% of RWP clients, home-based case management had the highest expenditure per client at approximately $23,891 per client with a total of 120 clients. The lowest expenditures per client was for mental health services at $725 per clients with a total of 151 clients.

    - Core service utilization among priority populations was relative to their size – the larger the population the higher the utilization. The lowest utilization of core services was among transgender people, people who inject drugs (PWID), and youth aged 13-29 years representing the smallest priority populations.

    - M. Martinez noted that home-based case management services showed a large number of people that are covered by insurance and asked what services were covered under RWP that were not covered by their insurance. P. Zamudio responded that insurance was billed first and RWP services were used to cover services after their insurance coverage for the service had been exhausted.

    - S. Oksuzyan added that when reporting on insurance coverage, the report can only show if a person was insured at any point during the reporting period - PY 33 (March 1, 2023 to Feb 29, 2024). It cannot show if a person was insured at the time they received a particular service.

    - C. Thompson, a member of the public, offered some clarity on how dental services are billed. He noted that Medi-Cal is billed first but the standard of care is higher for the RWP so if additional services are needed that are not covered under Medi-Cal they are billed to RWP. He added that home-based case management services operate similarly in that RWP will cover costs after Medi-Cal limits have been reached or for those who do not qualify for services under Medi-Cal but meet eligibility requirements under RWP.

    - M. Martinez asked what services are covered under RWP that are not covered under Denti-Cal. M Perez, member of the public, offered an example that Denti-Cal will only pay for one dental cleaning per year and RWP will pay for two cleanings a year.

V. **DISCUSSION ITEMS**

10. Contingency Planning

- K. Donnelly opened the discussion around contingency planning by providing a brief overview of a proposed 20% reduction scenario. In the interest of fairness and preservation of as many programs/services possible an overall 13% reduction across all funded services and the elimination of the lowest funded services – Transitional Case Management Jails and Mental Health- was introduced.

- M. Green noted that DHSP requested that the committee deliberate a scenario based on a 20% reduction as it will be the most helpful scenario for DHSP. He added that DHSP received a verbal notification from HRSA that another partial notice of award is forthcoming. There is still no indication what the total award amount will be.

- M. Martinez raised concern in doing across the board reductions. He noted that in their March meeting, the committee wanted to ensure certain categories to maintain funding at current allocations. He asked that the committee take another look at allocations. He urged the committee to start by focusing on what services they don't want to cut first then looking at services that can be cut.

- J. Green asked if DHSP would use Net County Cost (NCC) funds to cover costs in service categories that the committee may choose to reduce allocations for. M. Green reminded the committee that NCC funds are used to fill gaps where needed. L. Spencer asked if available NCC funds will remain stable. M. Green noted he is has not heard that it will not remain stable and that it is a legislative requirement to maintain the same level of effort and assumes that DHSP will continue to receive NCC funds. K. Nelson, member of the public, added that $19 million was earmarked for DHSP based on the proposed County budget.

- T. Goddard, member of the public, asked if the Department of Health Services (DHS) can take on approximately 200 units within their Housing for Health portfolio to free up funds for other services. M. Green noted that looking for other resources is an excellent strategy and that DHSP has been in discussions with DHS about absorbing RWP clients into their system. He added that DHS does not have the capacity to absorb all RWP residential clients at once but rather, it would need to be a gradual migration over time and that DHS is also looking at a budget deficit.

- G. San Agustin recommended additional reductions to oral health services by restricting or limiting some specialty dentistry services.

- C. Vega-Matos, attending as a member of the public, noted that agencies are currently expending at the current approved allocation. He noted cuts at the agency level will be deeper than 13% and the agency will have to absorb the difference in costs. M. Green noted that the longer the delay in adjusting allocations the longer the delay in changing contracts and it will seem like a deeper cut at the agency level. C. Vega-Matos recommended looking at services that are unique to ensure they remain funded.

- L. Spencer asked if mental health services could be transferred to the Department of Mental Health (DMH). P. Zamudio commented that DMH was previously funded for mental health services but no longer receive funding. She noted there is no capacity to provide bilingual services, which is needed. She added that mental health has a low utilization and low allocation because it is a fee for service model (paid by the clients that you serve).

- M. Martinez noted that Patient Support Services (PSS) is not included in the service categories listed and needs to be included to have a complete picture of allocations along with an estimate of investment amounts to give the committee a target number for allocation. P. Zamudio noted that PSS is a new service, within the Non-Medical Case Management Service Category, that was created by DHSP for PY35 that is included in new contracts that started on March 1, 2025. PSS was added to provide additional support beyond Medical Care Coordination (MCC) services such as housing specialists, mental health, and peer support for agencies that do not have a contract for Benefits Specialty Services.

- G. San Agustin recommended additional reductions to Home-based Case Management Services noting the high cost per client and a small number of clients. He noted some of the services can potentially be integrated into other service categories. W. King noted that home-based case management services are often for those with the highest need and that should be taken into consideration when allocating funding.

- M. Green noted that if there is a uniform cut across the board, current approved allocations do not change. Additionally, he noted that if a funded category receives zero funding through the reduction exercise, contracts will be ended. Leaving some funding in a category leaves infrastructure to get money back into those services quickly if additional funding becomes available at a later date.

- The committee decided to review and allocate each service category rather than a uniform cut across all categories. M. Martinez reminded the group to consider alternative payor sources and/or programs that can cover the same services when considering allocations.

- The committee did not complete the reallocation at a 20% reduction scenario and will hold an emergency meeting on May 1, 2025 to continue its deliberations.

VI. **NEXT STEPS**
   11. Task/Assignments Recap
   a. Committee will continue its contingency planning at a special meeting on May 1 ahead of the full Commission on HIV May meeting.
   b. Commission staff will revise contingency plan spreadsheet and prepare the document for further edits.

   12. Agenda Development for the Next Meeting
   a. Continue twenty percent reduction contingency planning.
   b. Review PY33 Support Services Utilization Report.

VII. <u>ANNOUNCEMENTS</u>

13. Opportunity for Members of the Public and the Committee to Make Announcements
There were no announcements.

VIII. <u>ADJOURNMENT</u>

14. Adjournment for the Meeting of April 15, 2025.
The meeting was adjourned by K. Donnelly at 4:05pm.

DRAFT

PUBLIC COMMENTS FOR THE
APRIL 15, 2025 PLANNING, PRIORITIES, AND ALLOCATIONS
COMMITTEE MEETING
All public comments received become a part of the official record.

Member of the Public	Comment(s)
Robert Boller	Hello, my name is Robert Boller and I'm the Director of Government Partnerships for Project Angel Food and I'm here to speak on behalf of nutrition support. Thank you for allowing me to make this public comment and I also want to say thank you to the commissioners, the members of the PPA, and for the county commissioner for the Commission on Aging for volunteering and working hard on behalf of your community. I've been with Project Angel Food for almost 30 years now. Thirty years ago, I was delivering meals to people living with HIV, later I was dispatch manager, and then in 2007 I became Director of Programs. After the Director of Programs, I oversaw the Ryan White Program. I've been the one who's been doing the budgets and the invoices and helping with the audits and all those amazing things, but I also see what happens, so we'll just talk about that today. First of all, just a little bit about in 2007 when I have the director, we were making a $150,000 from the Ryan White grant and I was at these meetings because things were tight. That was about $0.79 a meal, which was about 16 % of the cost of the meal. And we had the fund rate for the rest. So, it's very important that we came here to try to increase that. And we did over the last ten years that grant has begun growing, and now we are getting about $5 a meal which is $1.3 million and that's about 50 % of the cost of the meal because the cost of the meal has gone up. We're still fundraising for that other 50 %. And I just want to bring that because who are we serving? Our HIV population started in three groups. There are the people come to us for the first time who are newly infected, maybe going to a crisis coming out of the hospital. That's kind of our usual client in time already. See also Attachment A.

Ethan Kuritz	Good afternoon. My name is Ethan Kuritz, and I am a supervising attorney at the Inner City Law Center. I am here to urge this commission to include continued funding for crucial legal services in this contingency plan. In our current landscape, executive orders in Washington attack the ability of all lawyers to represent clients it doesn't like, like immigrant children. And these executive orders attack the basic rights of vulnerable members of the LGBT community with HIV and AIDS to have access to vital legal health. The program at stake, the one that you're considering today, provides the only dedicated funding for legal aid for people with HIV and AIDS in LA County. Historically, our clients have challenges to stable housing and other necessities. If the legal service program is eliminated, we don't know where our clients will turn for help. Now they currently turn to us when they face eviction, they confront the loss of government benefits on which they rely for basic sustenance or healthcare. They have fines, citations, or warrants that impede their ability to access housing and jobs. One in seven of our clients are homeless. We urge you to preserve access for this population and continue finding legal services in a contingency plan.
Adam Yakira	Hello everyone, my name is Adam Yakira and I'm the Directing Attorney that oversees the HIV Law Project (HLP) Program at Inner City Law Center which handles the Ryan White funding. We provide legal services to everyone in Los Angeles County with HIV or AIDS. We provide a wide range of services, including housing, record clearing, creation defense, income maintenance, credit counseling. The Ryan White Program lets us provide these services, which have been shown to keep people housed. One hundred percent of our patrons have some sort of successful outcome. Whether we secure some sort of soft landing for them where we keep them in their home. It's been shown that people who are living with HIV or AIDS that are unhoused and living on the streets have a myriad of help problems that are associated with that. Also, a lot of these other programs benefit from having legal services around. I know there's discussion about emergency rental assistance that, without having a lawyer at the helm, case

	managers don't really know that they should be paying any money, whether the landlord deserved that money. We get requests all the time from case managers who are making payments and don't know when the landlord should be receiving that money. There's needs to be a legal lens, I think, that even oversee a lot of these other things that honestly would be missing without this kind of funding. I think you can touch on this, there's NO other funding source that's identified for this. Even with LAHSA, the HIV program has much more forgiving requirement because it requires an HIV diagnosis. These people are individuals who will not be able to be treated under LAHSA because LAHSA has much more stringent requirements. This is really the only funding source that would be able to provide these kinds of services. We would love to have the previous funding level, but we do realize tough decisions have to be made. We would be able to also potentially deal with the services on reduced budget, even up to 50% and that obviously will impact our ability to provide services, but we would still be able to. Thank you.
Bridget Tweddell	Hi, Bridget Tweddell, from Project New Hope. Thanks for the intro. We've been super busy that's why we couldn't make it to a lot of the meetings, so I just wanted to let you know, but we're happy to be here now. Representing an agency that has RCFCIs and TRCFs. These are housing opportunities for people that are in between a boarding care and a skilled nursing facility specifically for RCFCIs. If you shut all the beds down and you decide not to fund those any further, there's NO place for these people to go. We also would like to ask you that you direct our funders to work with us early enough so that we can evict people in plenty of time so that they can seek services with Inner City Law Center to help them out. We have to give 60-day notice to our tenants or residents, per law, because we're licensed by the state of California, so we can't just close down overnight. We are in the second month into the new funding year have NO idea whether or not we're going to get paid. This is going to shut our agency down. If you

	guys decide that you're only going to fund those agencies that give us the most bang for your buck, you might want to look at what it is being done in the smaller agencies that have less people but give a lot more intensive care - housing, support services, all at a whole array of stuff to people that will not have access to once these houses are cut. And once these houses are cut, there will be NO more available to them. Thank you.
Jeffrey Bailey	Good afternoon, everyone. My name is Jeffrey, and I am the Director of Access Services at APLA Health. I would like to speak in support of food and nutrition care continuums in LA County for which DHSP, under Ryan White funding, has constructed considerable infrastructure regardless of the agency that's funded. There is a considerable infrastructure around nutrition support. If that is defunded that infrastructure goes away. But let's say in two months, but we found money, we can fund you again and it will be too late. That infrastructure is gone. The delivery trucks, the warehouses, the staff that are all associated with that will go away. As you probably know, the majority of the individuals who come for food and support services, based on your reports regardless of the agency, are adults living with HIV. They are individuals who have relied upon these services for most of their life. They are not working. They're relying on public assistance and, therefore, if this service goes away, a very critical basic life need can also go away. I really think we should consider funding food first in the first necessity for an individual. As you build on particular scenarios, just remember if this goes away but comes back later, that infrastructure is gone. Thank you.
Craig Thompson	Craig Thompson also from APLA Health. Thank you. I want to talk a little bit about oral health for a moment. We're a large oral health provider as are a number of other folks. I want to encourage folks not to do is to not look at funding the entire category or not funding the entire category. I think there could be a plan to prioritize general dentistry over specialty dentistry and the category could still live on and provide a pretty robust dental service.

		We've had an abundance of money towards dental the last number of years. That's not going to continue, we know that's true, but I want to encourage folks to not take an all or nothing approach and on half od that money we could reconstruct a perfectly adequate dental program that would support the Medi-Cal program that already exists – dental Medi-Cal. I want to encourage that. The other thing, in speaking about food and nutrition, I want to just encourage folks to think about this the way the clients think about it. It's a basic support like EFA. Either they get free food, or they get a rental check or the get an emergency check every now and then. Clients see food as something that they have to pay for in the same way they see rental support. I would encourage you, as you are thinking about these things, to think about it from the client's perspective. It's really a matter of receiving that check twice a year or that support whether it comes through free food or whether it comes through an EGFA grant. What they really need is that help, say twice a year. I would just encourage you to think about those basic needs services together. Thank you.
	Katja Nelson	Hello, Katja Nelson, third district representative, Public Policy Co-chair and Commissioner. I understand that we are looking at a 25% reduction scenario and 50% reduction scenario today. Given a 25% reduction scenario, I wonder if we can look at scenarios where we just sort of do a 25% cut across all the categories and see what that looks like in terms of still supporting all the categories and support what every has said here. Once that category is gone, if we eliminate it, it would be really hard to build it back in when the landscape changes. If we do need to cut further, like at 50% level in the future, I think that is something where we do need to revisit conversations around things like screening for Medi-Cal and how that frees up money among categories. I think we need to consider things like the needs among demographics. A lot of folks access the services are 55 and up and we want to make sure that some of those key categories that support those folks remain funded and don't disappear.

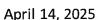| Scott Blackburn	ICMS Home Health
	• **Impact**- ICMS Home Health services provide home-based case management, attendant care, and home-based psychotherapy to HIV+ clients who are experiencing multiple medical co-morbidities, psychosocial stressors, poor social support, and challenges completing activities of daily living. ICMS services help to guard against homelessness and institutionalization of some of our most needy and fragile clients, by supporting them sufficiently in their homes, and ensuring ongoing linkage to HIV and specialty medical care. ICMS recipients are not eligible for In-Home Supportive Services through Medi-Cal, nor are they eligible for the Medi-Cal Waiver Home Health program. • **Scalability**- ICMS Home Health services at APLA Health can be scaled up or down using a variety of cost-cutting measures, for instance- prioritizing the most crucial home-based services to offer clients, and discontinuing others. APLA Health believes ICMS Home Health services could continue to be impactful at 75% or even 50% its current funding levels, if necessary. **Comparable Services (time permitting)** Currently, all enrolled ICMS clients at APLA Health are covered by Medicare only, Medi-Medi with a share of cost, and a few who access private plan coverage through a pension or other means. None of those patients are eligible for Medi-Cal Waiver Home Health services nor are they eligible for In-Home Supportive Services, a Medi-Cal benefit. Put simply, there are no comparable services available to ICMS Home Health recipients.

PROJECT
ANGEL
FOOD

April 14, 2025

Delivered Via Email and By Hand

Planning, Priorities, and Allocations Committee
Los Angeles County Commission on HIV
510 South Vermont Avenue, 14th Floor
Los Angeles, CA 90020

Re: **Project Angel Food is a Critical and High-Impact Ryan White Service**

To the Planning, Priorities, and Allocations Committee:

For decades, Project Angel Food has provided thousands of people in Los Angeles County who are living with HIV/AIDS crucial nutritional healthcare through our home-delivered medically tailored meals and through individualized education from our staff registered dietitians.

We are writing to underscore the importance and value of this work – and to urge that it continues to receive robust support from the County under Ryan White.

Background

Project Angel Food was borne out of the HIV/AIDS epidemic. We were founded in 1989 in a church basement in West Hollywood. We were an all-volunteer organization, and the caring, compassionate "angels" made and took meals to people who were suffering because it gave those first clients comfort and hope.

In 1995, Project Angel Food began our partnership with the LA County Dept of Public Health in an effort to reach more people with HIV, improve their nutrition, and increase adherence to medical regimens. With the Ryan White Program, OAPP - the DPH office at that time - wrote plans of care that required nutrition support agencies be overseen by Registered Dietitians and that our meals complimented medical treatments and dietary requirements of the many different conditions that people with AIDS were enduring. This helped our clients become healthier and eased side effects and symptoms of HIV/AIDS.

Indeed, several agencies around the country were formed with a similar genesis and history, such as God's Love We Deliver in New York, Project Open Hand in San Francisco, and Food & Friends in Washington, D.C. Our work alongside these sister agencies became the

source of the concept of "medically tailored meals" (MTM). Now, the idea that meals that are based on evidence, in dietary guidelines, help foster and improve health is firmly founded in scientific literature and in policy.

Now, we are one of a handful of accredited MTM providers in the Country, and we were a founding member of both the national Food Is Medicine Coalition and the California Food Is Medicine Coalition.

I personally have witnessed much of this history. I joined Project Angel Food in 1997 as a driver. At that time, we were only serving people with HIV/AIDS, and I saw firsthand how much we matter among this population. I delivered meals to people with HIV/AIDS and saw their faces light up when the meals arrived. Then, I saw them stabilize and often improve over time.

Since 2007, I have been in senior leadership at Project Angel Food and remained the point person for our contract with the County under Ryan White. Underneath the reports and contracts and audits and financial breakdowns, I know that there are stories and lives of people with a complex, lifelong condition and of those people who depend on us. Caring for people with HIV/AIDS has been a part of our history since day one; the community knows us for that legacy and work; and it will always be a core part of our mission.

The Value and Impact of Project Angel Food's Work Under Ryan White

Last year, Project Angel Food delivered over 270,000 meals to nearly 500 people living with HIV/AIDS under Ryan White. Each of those clients also received – at onboarding, on recertification and on request – individual nutrition counseling from our staff of registered dietitians.

Those services were secured by Ryan White funding of more than $1 million last year (and now that same amount is currently scheduled for this year). That is a small fraction of the total funding allocated through Ryan White in Los Angeles County -- on the order of one to two percent. That funding is crucial to Project Angel Food, representing six percent of our annual budget.

But make no mistake: Even with this funding, Project Angel Food provides services to this population at a steep discount. The County covers meals at a rate of about $5 per meal under Ryan White. Meanwhile, our cost per meal is about double that. Of course, Project Angel Food has to make up the funding gap elsewhere, and that comes largely from our generous private donors.

The County's investment, subsidized almost 1-1 by Project Angel Food, has a huge return. Our services keep our clients out of the hospital and save costs on the healthcare system elsewhere, including the County's facilities.

Many of our HIV clients live with co-morbidities such as diabetes and heart disease, making them high-risk patients. An article just published in April 2025's issue of the *Health Affairs* journal stated that on a nationwide basis, MTMs for high-risk patients could save $32.1 billion in healthcare costs and prevent 3.5 million hospitalizations annually. Titled "Estimated Impact of Medically Tailored Meals on Healthcare Use and Expenditures in 50 U.S. States," that study by the Friedman School of Nutrition Science and Policy at Tufts University, gives a glimpse to the impact of the investment by Los Angeles County in nutrition healthcare under Ryan White. With the cost to Ryan White of $2,000 to $4,000 per client per year for one or two meals daily, one can be sure that avoiding just a single hospital visit more than pays for itself.

Meanwhile, we know that our services remain critical to our clients' health. In our annual survey, 86 percent of the hundreds of respondents agree or strongly agree that receiving regular, healthy meals helps them with their medication adherence. Perhaps most importantly, a stunning 95 percent say that our meals improve their health. Almost universally, they confirm that the meals help them maintain weight, improve their mood, reduce their stress, and increase their energy.

We know that our services are still necessary. We still see applications from, and enroll, people with full-blown AIDS. We know that home-delivered services help older, longer-term survivors; they in particular may feel lasting stigma around their condition and have complex emotional landscapes, and we provide connection and care. We know that most of our clients are people from vulnerable or underserved communities. About two-thirds of our clients are people of color; more than half live in central, south or east Los Angeles. About 85 percent are over 50 years old.

Most of our clients – and by definition those eligible for Ryan White -- do not have significant financial resources and low or very low income. Many of them face a choice between rent or food or other critical expenses. Indeed, about 85 percent of our annual survey respondents say that we are their primary source of food. Almost 100 percent say our meals help them financially.

Perhaps for these reasons, the community relies on Project Angel Food and knows our HIV/AIDS services are foundational to who we are. Our partner organizations, such as Being Alive and APLA, advocate with us routinely on behalf of specific clients and call us for additional support in the midst of crises.

Finally, we know our meals help. Apart from all the economic and outcome data and studies, we see the stories of positive change. In 2021, upon referral by Kaiser, we enrolled a 69-year-old, Black man living with HIV and residing in Gardena. After a year of eating our meals, he was feeling better. He was so moved by the impact of our organization that he reached out and asked if he could help. He joined our packing and delivery staff on a part-time basis and

was soon helping us prepare the meals and get them to people in need, paying it forward to others in need.

Conclusion

We recognize that the Planning, Priorities, and Allocations Committee and the HIV Commission itself face difficult decisions in the current political environment. We respect that prioritizing among competing needs is challenging when previously reliable funding is being cut or unclear. That said, Project Angel Food also believes that the long-standing support of the County for nutritional healthcare under Ryan White is crucial to preserve and maintain. It is a wise investment that seeds economic returns far beyond the allocation itself. And it is a critical way to maintain and improve the health of some of people with HIV/AIDS who are most at risk.

We appreciate your consideration, and we are grateful for your work and efforts during this very challenging time.

Please let me know if you have any questions.

Very truly yours,

Robert Boller
Senior Director, Program Logistics & Government Partnerships

Cc: Richard Ayoub, Project Angel Food CEO
       Benjamin R. Martin, JD, Project Angel Food Director of Programs & Strategy

Los Angeles County Commission on HIV

REVISED 2025 TRAINING SCHEDULE
SUBJECT TO CHANGE

- ➢ All training topics listed below are mandatory for Commissioners and Alternates.
- ➢ All trainings are open to the public.
- ➢ Click on the training topic to register.
- ➢ Certificates of Completion will be provided.
- ➢ All trainings are virtual via Webex.
- ➢ For questions or assistance, contact: hivcomm@lachiv.org

[Commission on HIV Overview](#)	February 26, 2025 @ 12pm to 1:00pm
[Ryan White Care Act Legislative Overview and Membership Structure and Responsibilities](#)	~~March 26, 2025~~ @ 12pm to 1:00pm April 2, 2025
[Priority Setting and Resource Allocations Process](#)	April 23, 2025 @ 12pm to 1:00pm
[Service Standards Development](#)	May 21, 2025 @ 12pm to 1:00pm
[Policy Priorities and Legislative Docket Development Process](#)	June 25, 2025 @ 12pm to 1:00pm
[Bylaws Review](#)	July 23, 2025 @ 12pm to 1:00pm

PLANNING, PRIORITIES
AND ALLOCATIONS
(PP&A)COMMITTEE
MEETING
MAY 1, 2025

WHAT WE'VE LEARNED AND KNOW

1. We are in unprecedented times and are having to make very difficult and painful decisions.

2. While we know, your personal experiences and hopes inform your individual viewpoints, today's exercise is one wherein each of you is being asked, as a member of this important body/team, to help determine a scenario of 20% reduction in RW funding on behalf of folx who look to you for access to care.

DRIVING QUESTION

Based on the data we have, what might COH/PP&A do to serve the greatest number of people possible in 2025 across LA County with under a 20% funding reduction for HIV services?

CLARIFYING QUESTIONS

1. Your service is a gift to LA County and is appreciated by many many people. Thank you!

2. We will want your input on the critical question, so please weigh in. You are the folx in these shoes now!

DISCUSSION

1. This decision is one driven by data which you received and were presented today. Your vote matters!

2. We are not asking that you give up your hopes for what the COH wants to achieve in LA County.

3. In fact, the overall funding allocation process is dynamic and is subject to shift and change. There may be better news down the line, and we may receive more and/or the full funding for RWP. You will continue to wrestle with this issue in the next few foreseeable months.

POLICY/ PROCEDURE:	NO. 09.5203	Priority Setting and Resource Allocations (PSRA) Framework and Process
		APPROVED 7.11.24

SUBJECT: The Commission's Priority Setting and Resource Allocations (PSRA) framework, process and specifics.

PURPOSE: To outline the Commission's service prioritization and resource allocations process, as mandated by the Ryan White Treatment Modernization Act (Ryan White) and Los Angeles County Charter Code 3.29.

BACKGROUND:

- Service prioritization and resource allocations are two of the Part A planning councils' chief responsibilities, detailed specifically in Ryan White legislation and confirmed in County Charter Code.

- In accordance with Health Resources and Services Administration (HRSA) guidance, the Commission sets service priorities based on consumer need and determines allocations from priorities and other factors such as service capacity, other sources of funding, service utilization and cost-effectiveness.

- As defined in its ordinance, the Commission establishes priorities and allocations of Ryan White Part A and B and CDC prevention funding in percentage and/or dollar amounts to various services; review the grantee's allocation and expenditure of these funds by service category or type of activity for consistency with the Commission's established priorities, allocations and Comprehensive HIV plan, without the review of individual contracts; provide and monitor directives to the grantee on how to best meet the need and other factors that further instruct service delivery planning and implementation; and provide assurances to the Board of Supervisors and HRSA verifying that service category allocations and expenditures are consistent with the Commission's established priorities, allocations and comprehensive HIV plan.

POLICY:

- This policy outlines the Priority Setting and Resource Allocation (PSRA) process used to

- prioritize services and allocate resources—in accordance with governing Ryan White and County code legislation—encompassing the specific partners, responsibilities, steps, tasks, and timelines associated with the process.

- The PSRA process is led by the Commission's Planning, Priorities and Allocations (PP&A) Committee. The Division of HIV and STD Programs (DHSP) provides critical information; consumer input is collected through the Comprehensive HIV Plan and other assessments; and provider input is collected through focus forums, surveys, and Commission participation.

- The policy details the expectations and timing of stakeholder involvement in the multi-year Ryan White Part A funding cycle determined by the HRSA Ryan White HIV/AIDS Program (RWP). The process allows for ongoing stakeholder input at several key junctures. Multi-year allocations are intended to conclude prior to the submission of the RWP Part A application. Allocations are reviewed annually to ensure alignment with and responsiveness to community needs and funding requirements.

A. **Priorities and allocations are data based**. Decisions are based on the data, not on personal preferences. Commissioners should avoid presenting anecdotal information or personal experiences during the decision making, focusing on needs assessments, and cost/service utilization data rather than a single person's experience.

B. **Conflicts of interest are stated and followed.** Commission members must state areas of conflict according to the approved Conflict of Interest Policy at the beginning of meetings. As stated in the RWHAP Part A Manual, X. Ch 8. Conflict of Interest, p. 147, Conflict of Interest can be defined as an actual or perceived interest by the member in an action that results or has the appearance of resulting in a personal, organizational, or professional gain. The definition may cover both the member and a close relative, such as a spouse, domestic partner, sibling, parent, or child. This actual or perceived bias in the decision-making process is based on the dual role played by a planning council member who is affiliated with other organizations as an employee, a board member, a member, a consultant, or in some other capacity. Any funded RWHAP Part A provider must declare all funded service categories (e.g., areas of conflict of interest) at the beginning of the meeting(s). They can participate in discussions, answer questions directed by other members, and can vote on priorities and allocations presented as a slate.

C. The data provide the basis for changes in **priorities or allocations from the previous year**. The data indicate changes in service needs/gaps and availability based on information from the various data sources.

D. **Needs of specific populations and geographic areas** are an integral part of the discussion in the data presentations and the decision making. They may also lead to recommendations to the Recipient on how best to meet the priorities.

E. **Final vote** on the complete priorities and allocations will be presented by the Planning, Priorities and Allocations Committee Co-Chairs to the full planning council for a roll-call vote. Commissioners must complete the required annual Priority Setting and Resource Allocation training prior to voting. Commissioners must notify staff once training is complete and a record of the completed training will be kept on file by Commission staff. Commissioners who have not completed the training are not eligible to vote. *Planning, Priorities and Allocations Committee-only members must also complete the annual Priority Setting and Resource Allocation training. Training materials can be found on the Commission website at: https://hiv.lacounty.gov/events-training/.

F. **Paradigms and operating values** are selected and used by the PP&A Committee to help guide their decision-making in setting service priorities and resource allocations. The PP&A Committee reviews the paradigms and operating values selected and approved from the previous year as the foundation for current year PSRA process or reallocations. (Attachment 1)

G. **The Commission's Status Neutral HIV and STI Delivery System framework** is used by the PP&A Committee to ensure that service priorities and resources allocations emphasizes high-quality care to engage and retain people in services regardless of if the services are for HIV treatment or prevention. This approach continually addresses the healthcare and social service needs of all people affected by HIV so that they can achieve and maintain optimal health and well-being. (Attachment 2)

H. Decisions should help to ensure **parity in access to care**, for all Ryan White-eligible HIV/AIDS population groups and for PLWH/A regardless of where they live in the County.

I. Discussions and decisions should have a major focus on **improving performance on the HIV Care Continuum/Treatment Cascade,** focusing on areas of concern – such as linkage to care or retention in care. Reducing unmet need (the number of people who know they are HIV-positive but are not in care) requires deciding how many "new" or "lost to care" clients should be identified, estimating the mix of services they will need from RWHAP Part A, and allocating funds sufficient to meet those needs. Where a choice needs to be made between providing a wider range of services to more individuals and getting additional people into care, the Planning Council will give priority to getting more people key services (among them primary care and medications).

J. The Commission members will keep in mind current goals, objectives, and priorities from its **Comprehensive HIV Plan (CHP)** to be sure they receive appropriate attention in decision making.

Policy 09.5203 **:** Priority Setting and Resource Allocations (PSRA) Framework and Process
Last Revised: *June 18, 2024; (Approved: July 11, 2024)*

PROCEDURE(S):

1. The priority setting process should consider services needed to provide and/or support a continuum of care, regardless of how these services are being funded and the extent of unmet demand for these services. Funding availability and unmet needs associated with these service priorities are considered during the resource allocation process.

2. The list of HRSA fundable service categories (core and support) and the definitions of these services will be presented by the Commission staff.

3. The list of HIV prevention categories from the most recently approved Prevention Service Standards will be presented by the Commission staff.

4. DHSP compiles service utilization reports (including, but not limited to, clients served, priority populations, expenditures per client), anticipated service delivery goals/objectives, expenditures reports, surveillance reports, prevention data (including, but not limited to, counseling and testing and PrEP and PEP utilization), and programmatic and fiscal challenges and opportunities for service improvements.

5. The PP&A Committee will consult with all Caucuses prior to the start of the annual priority setting and resource allocation process to:
    a) Gather opinions from consumers on which services should be prioritized and how resources should be allocated;
    b) go over the main points from the latest Ryan White Program Service Utilization Reports and HIV prevention data provided by DHSP;
    c) Look at the most recent financial reports on HIV prevention and care from DHSP;
    d) Examine the main goals, objectives, and measures from important documents like the Comprehensive HIV Plan and Ending the HIV Epidemic Plan:

6. The PP&A Committee formally organizes focus groups at various provider stakeholder meetings or conducts provider surveys as needed to inform the PSRA process.

7. During July-August, the PP&A Committee deliberates and prioritizes services categories in rank order (highest need is #1 priority). The principal data and information used for priority-setting are the Comprehensive HIV Plan, relevant needs assessment, the HIV epidemiology report, fiscal and programmatic reports, and service utilization reports.
    a) The PP&A Committee only ranks service priorities once—regardless of funding scenario—as they indicate the services most needed regardless of changes in the funding picture or in which different resources available.
    b) The PP&A Committee compiles and/or reviews the data and feedback it has collected from DHSP, community listening sessions and/or surveys and reviews it in June, prior to service prioritization.

8. During July-August after the service categories have been ranked and prioritized, the PP&A Committee determines resource allocations for services:
   a) Allocations can be made by actual amounts or percentages based on specific expenditure proposals, although percentages allow more flexibility to respond to variances in the funding awards.
   b) Allocations may change in each of the selected funding scenarios.
   c) It is strongly encouraged that stakeholders who suggest funding allocations for specific service categories also present accompanying recommendations to advise how the continuum of care will accommodate those suggested modifications to funding levels.
   d) Additional streams of funding are identified in each service category, with amounts locally dedicated for HIV services where the information is available.
   e) The PP&A Committee, in collaboration with DHSP, compiles a resource inventory for allocation-setting, and uses it to help determine capacity and other resources when allocating funds.

9. The PP&A Committee recommends and secures approval for service priorities and funding allocations at the August or September Commission meeting, prior to the RWP Part A grant application submission deadline and/or annual report and program terms report.

10. When a reallocation of funds is necessary, adequate data to support the movement of funds between service categories will be presented, considered, and fully documented in the minutes of the meeting during which the reallocation of funds is approved. Proposed re-allocations must be submitted to the Commission for approval. All changes in allocations must be accompanied with a written justification detailing the reasons for the modifications. Reallocations should occur in June or July with a presentation of recommendations and memorandum from DHSP explaining the reasons for the reallocations. In alignment with County policy, the Commission grants authority to DHSP to make adjustments of 10% greater or lesser than the approved allocations amount, as expenditure categories dictate, without returning to the Commission for approval.

11. During the month (30 days) following the approval of resource allocations by Commission, the PP&A Committee will consider appeals regarding its PSRA process. Appeals must be presented to the PP&A Committee at its monthly meeting immediately following the Commission meeting in which the allocations were adopted. The following two types of appeals will be considered:
    a) new factual information that may have led to different decisions if the information had been available during the PSRA process, and/or
    b) questions or complaints about decision-making that did not conform to the process as outlined.

12. In September-November, the PP&A Committee compiles information and suggestions made throughout the PSRA process to further elaborate on its priority and allocation decisions by developing "directives."

a) These "directives" are framed as "guidance", "recommendations", and/or "expectations" and are intended to detail "how best to meet the need" or as "other factors to be considered" to be forwarded to DHSP the Commission and/or its various committees, and/or other stakeholders, as appropriate.

b) The guidance, recommendations and expectations further define minimum quality of care standards, implementation practices and/or mechanisms to respond to specific operational or system needs.

c) Once completed and approved by the PP&A Committee, the directives are forwarded to the Executive Committee and the Commission for approval.

d) The approved directives are transmitted to DHSP for consideration and implementation if deemed to be feasible by DHSP. DHSP will review the directives and provide a written response to the PP&A Committee which recommendations are feasible with a timeline for implementation.

e) DHSP shall provide periodic updates at PP&A Committee meetings.

13. In addition to its other business, the PP&A Committee devotes the intervening months between each year's PSRA process to further study identified service categories, populations and/or related planning issues, and implements committee activities accordingly to compile the necessary data.

**NOTED AND
APPROVED:** _____

**EFFECTIVE
DATE:** _____

Original Approval: May 1, 2011   *Revision(s): July 11, 2024*

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
PARADIGMS AND OPERATING VALUES
(Approved - PP&A 11/19/2024)
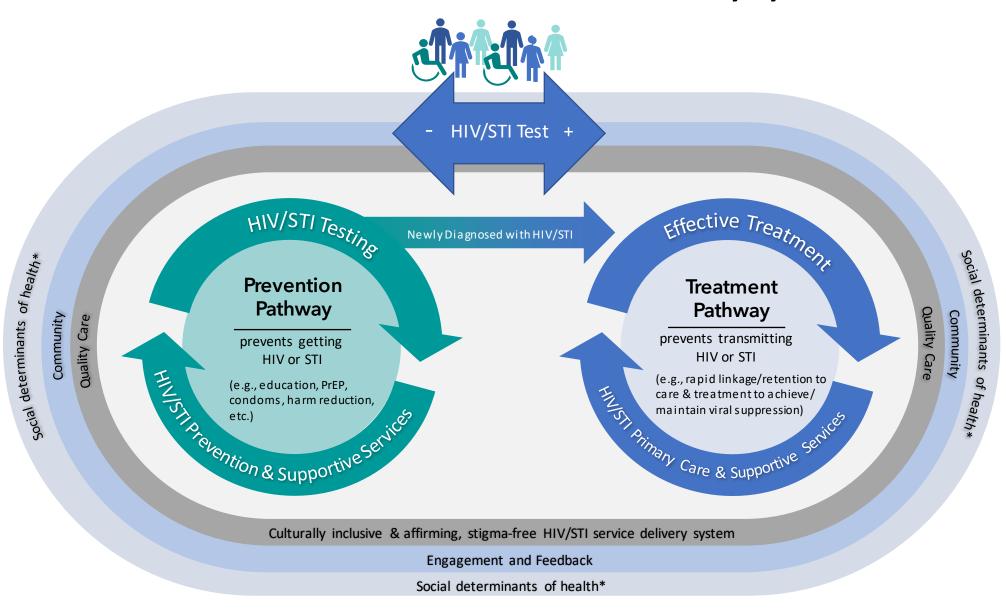
PARADIGMS (Decision-Making)

- **Equity:** Allocate resources in a manner that address avoidable or curable differences among groups of people, whether those groups are defined by ethnicity, socially, economically, demographically, or geographically.

- **Compassion:** Response to suffering of others that motivates a desire to help.

- **Restorative Justice**: correction of past inequities[1].

OPERATING VALUES

- **Efficiency**: Accomplishing the desired operational outcomes with the least use of resources.

- **Quality**: The highest level of competence in the decision-making process.

- **Advocacy**: Addressing the asymmetrical power relationships of stakeholders in the process.

- **Representation**: Ensuring that all relevant stakeholders/constituencies are adequately represented in the decision-making process.

- **Humility**: Acknowledging that we do not know everything and willingness to listen carefully to others.

- **Access**: Assuring access to the process for all stakeholders and/or constituencies.

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1. *Restorative justice seeks to examine the harmful impact of a crime and then determines what can be done to repair that harm while holding the person who caused it accountable for his or her actions. Accountability for the offender means accepting responsibility and acting to repair the harm done.*

Status Neutral HIV and STI Service Delivery System

- **HIV/STI Test** +

HIV/STI Testing

Newly Diagnosed with HIV/STI

Effective Treatment

Prevention Pathway
_____
prevents getting HIV or STI

(e.g., education, PrEP, condoms, harm reduction, etc.)

HIV/STI Prevention & Supportive Services

Treatment Pathway
_____
prevents transmitting HIV or STI

(e.g., rapid linkage/retention to care & treatment to achieve/maintain viral suppression)

HIV/STI Primary Care & Supportive Services

Social determinants of health*
Community
Quality Care

Social determinants of health*
Quality Care
Community

Culturally inclusive & affirming, stigma-free HIV/STI service delivery system

Engagement and Feedback

Social determinants of health*

LOS ANGELES COUNTY **COMMISSION ON HIV**

Revised 10/18/23

* Social determinants of health include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

See Healthy People 2030 for more details on the social determinants of health.

S:\Committee - Planning, Priorities & Allocations\Prevention Planning Workgroup\LAC_Status_Neutral_Framework

Ryan White Program Utilization Summary Year 33: Support Services (March 1, 2023-February 2024)

Sona Oksuzyan, Supervising Epidemiologist

Janet Cuanas, Research Analyst III

Monitoring and Evaluation Unit

Division of HIV and STD Programs

May 1, 2025

RWP Support Services
(Year 33: Mar 1, 2023-Feb 29, 2024)
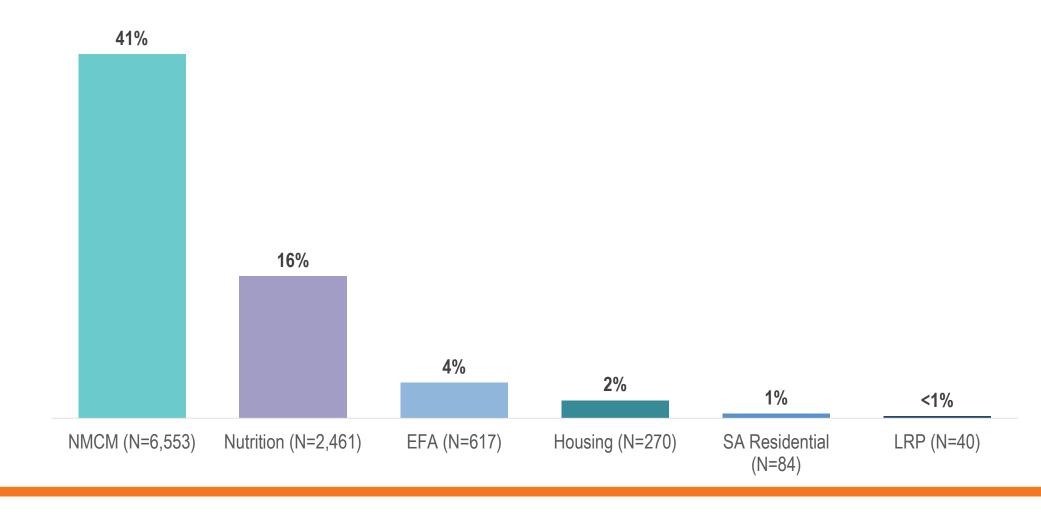
- Emergency Financial Assistance (EFA)

- Housing

- Non-Medical Case Management (NMCM)

- Nutrition

- Substance Abuse (SA) Residential

- Linkage & Re-engagement Program (LRP)

County of Los Angeles
Public Health

Emergency Financial Assistance (EFA)

Provides limited one-time or short-term payments to assist RWP clients with an urgent need for rent, utilities and/or food. Annual cap was $5,000. Clients may apply at APLA and DHS.

- A total of **617 unique clients** received EFA services, an increase from Year 31 at 275 and Year 32 at 378.

- EFA clients represented **4% of RWP clients**

COUNTY OF LOS ANGELES
Public Health

Utilization of EFA clients, Year 33

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
EFA	617	Dollars	2,058,506	3,336	$2,614,115	$4,237
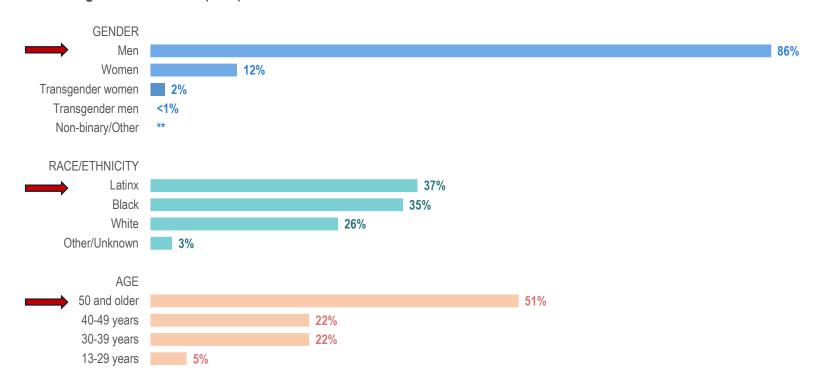
Funding Source:

- *Part A - $2,614,115*

Men, Latinx, and RWP clients aged 50 and older comprised the majority of EFA clients.
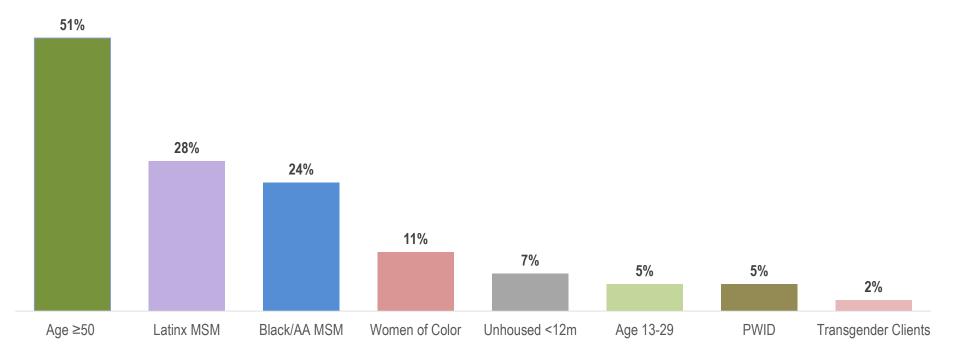
In Year 33 the largest percent of EFA clients identified as men (86%), or were Latinx (37%), or were aged 50 and older (51%).

GENDER
- Men — 86%
- Women — 12%
- Transgender women — 2%
- Transgender men — <1%
- Non-binary/Other — **

RACE/ETHNICITY
- Latinx — 37%
- Black — 35%
- White — 26%
- Other/Unknown — 3%

AGE
- 50 and older — 51%
- 40-49 years — 22%
- 30-39 years — 22%
- 13-29 years — 5%

EFA services are reaching clients in LAC priority populations*, Year 33

- Over half of EFA clients were people **aged 50 and older**
- Over a quarter were **Latinx MSM**
- Slightly less than a quarter were **Black/AA MSM**

Bar chart values:
- Age ≥50: 51%
- Latinx MSM: 28%
- Black/AA MSM: 24%
- Women of Color: 11%
- Unhoused <12m: 7%
- Age 13-29: 5%
- PWID: 5%
- Transgender Clients: 2%
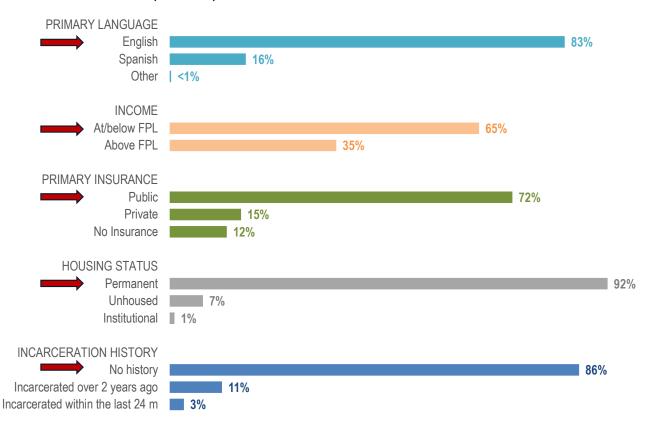
*Priority population groups are not mutually exclusive, they overlap.

Most EFA clients were English speakers, most were living ≤ FPL, most had private insurance, most were permanently housed, and most had no incarceration history.

EFA Client Health Determinants, Year 33, N=617

PRIMARY LANGUAGE
- English — 83%
- Spanish — 16%
- Other — <1%

INCOME
- At/below FPL — 65%
- Above FPL — 35%

PRIMARY INSURANCE
- Public — 72%
- Private — 15%
- No Insurance — 12%

HOUSING STATUS
- Permanent — 92%
- Unhoused — 7%
- Institutional — 1%

INCARCERATION HISTORY
- No history — 86%
- Incarcerated over 2 years ago — 11%
- Incarcerated within the last 24 m — 3%

HIV Care Continuum in EFA clients, Year 33 (N=617)

- Engagement, retention in care, and viral load suppression percentages were higher for EFA clients compared to RWP clients overall, Year 33.

- EFA clients did not meet the EHE target of 95% for viral suppression. However, they met the local target of 95% for engagement in care.

Legend: ■ EFA   ■ RWP clients

	EFA	RWP clients
Engaged in HIV Care	98%	95%
Retained in HIV Care	83%	75%
Suppressed Viral Load	90%	85%

— 95% Target

Data source: HIV Casewatch as of 5/2/2024

Housing

Provides temporary or permanent housing with supportive services for RWP clients. Sites: APLA, DHS, Project New Hope and Salvation Army Alegria

A total of **270 unique clients** received Housing services, an increase from Year 31 at 237 and Year 32 at 241.

- *Permanent Supportive Housing* - **173** clients
- *Residential Care Facilities for the Chronically Ill* – **70** clients
- *Transitional Residential Care* – **32** clients

Housing clients represented **2% of RWP clients** in Year 33.

County of Los Angeles
Public Health

Utilization of Housing clients, Year 33

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
Housing	**270**	**Days**	**68,921**	**255**	**$8,354,482**	**$30,943**
Permanent Supportive Housing (H4H)	173	Days	47,664	276	$3,841,288	$22,204
Residential Care Facilities for the Chronically Ill	70	Days	14,866	212	$3,668,495	$52,407
Transitional Residential Care Facilities	32	Days	6,391	200	$844,699	$26,397
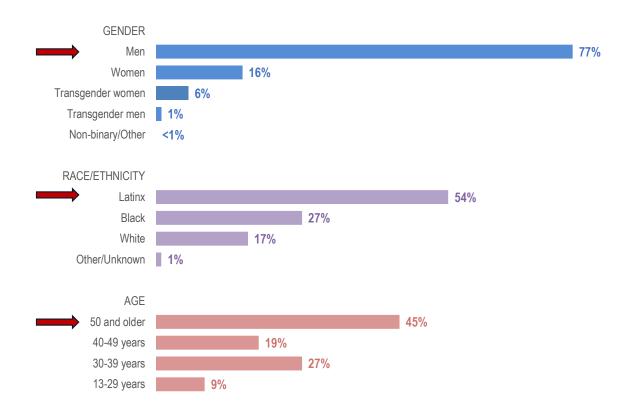
Funding Source:

- *Part A - $336,381*
- *MAI - $3,671,015*
- *Part B – $4,153,100*
- *HIV NCC - $193,986*

Most Housing clients identified as men, most were Latinx, and most aged 50 and older
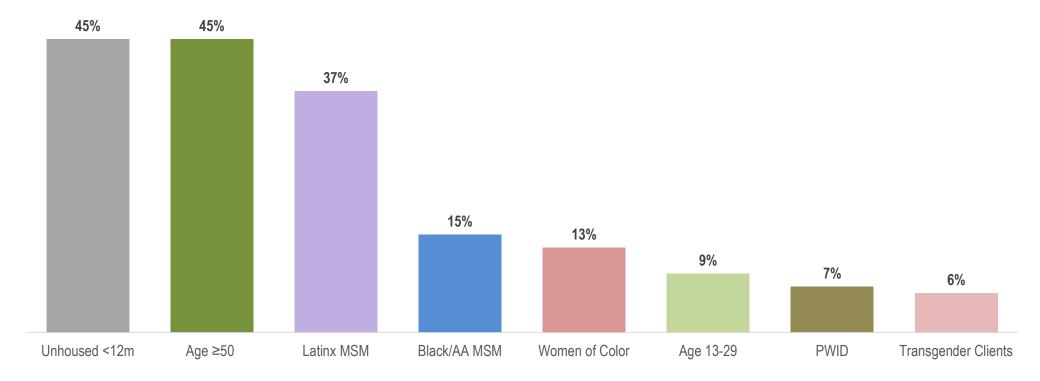
Housing Client Demographics, Year 33, N=270

GENDER

- Men — **77%**
- Women — **16%**
- Transgender women — **6%**
- Transgender men — **1%**
- Non-binary/Other — **<1%**

RACE/ETHNICITY

- Latinx — **54%**
- Black — **27%**
- White — **17%**
- Other/Unknown — **1%**

AGE

- 50 and older — **45%**
- 40-49 years — **19%**
- 30-39 years — **27%**
- 13-29 years — **9%**

LAC Priority Populations Accessing Housing Services*, Year 33

- About 45% of Housing clients were unhoused at some point during Year 33
- RWP clients **aged 50 and older** represented 45% of Housing clients, followed by **Latinx MSM** clients

Unhoused <12m	Age ≥50	Latinx MSM	Black/AA MSM	Women of Color	Age 13-29	PWID	Transgender Clients
45%	45%	37%	15%	13%	9%	7%	6%
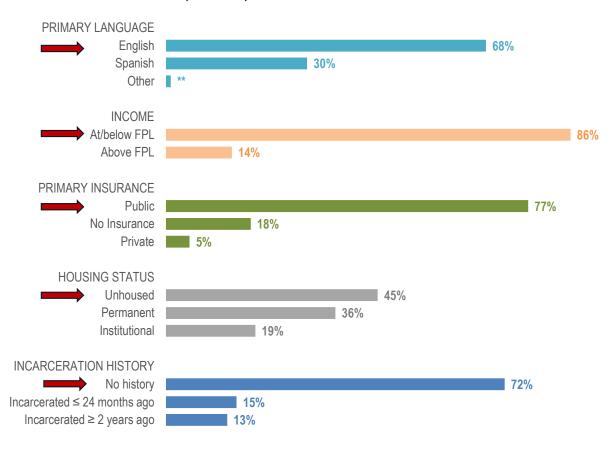
*Priority population groups are not mutually exclusive, they overlap.

Most of Housing clients were English-speakers, most living ≤ FPL, most had public insurance, most were unhoused, most had no history of incarceration.
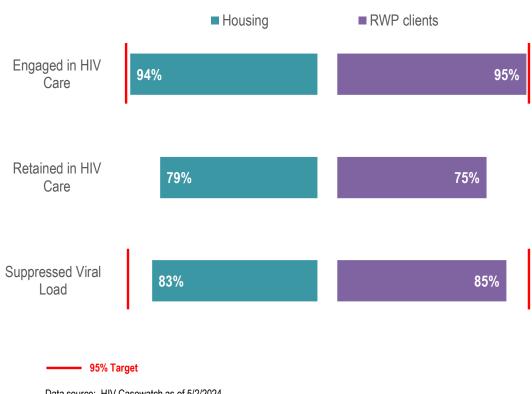
Housing Client Health Determinants, Year 33, N=270

PRIMARY LANGUAGE
- English — 68%
- Spanish — 30%
- Other — **

INCOME
- At/below FPL — 86%
- Above FPL — 14%

PRIMARY INSURANCE
- Public — 77%
- No Insurance — 18%
- Private — 5%

HOUSING STATUS
- Unhoused — 45%
- Permanent — 36%
- Institutional — 19%

INCARCERATION HISTORY
- No history — 72%
- Incarcerated ≤ 24 months ago — 15%
- Incarcerated ≥ 2 years ago — 13%

HIV Care Continuum in Housing clients, Year 33 (n=270)

- Engagement and viral load suppression percentages were lower for Housing clients compared to RWP clients overall, Year 33. Retention was higher among housing clients than RWP clients overall.

- Housing clients did not meet the EHE targets.

	Housing	RWP clients
Engaged in HIV Care	94%	95%
Retained in HIV Care	79%	75%
Suppressed Viral Load	83%	85%

— 95% Target

Data source: HIV Casewatch as of 5/2/2024

Non-Medical Case Management (NMCM)

Provides coordination, guidance and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services, and assists eligible clients to obtain access to other public and private programs. Available at 12 contracted sites.

A total of **6,553 unique clients** received **NMCM** services, an increase from Year 31 at 5,146 and Year 32 at 4,712.

- *Benefit Specialty* services were provided to **6,121** clients.

- *Transitional Case Management (TCM)* services were provided to **472** clients.

NMCM clients represented **41% of RWP clients.**

County of Los Angeles
Public Health

Utilization of NMCM clients, Year 33

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
NMCM	**6,553**	**26,290**	**Hours**	**4**	**$1,813,126**	**$277**
Benefit Specialty	6,121	24,364	Hours	4	$1,491,010	$244
Transitional Case Management	472	1,926	Hours	4	$332,116	$704

Funding Source:
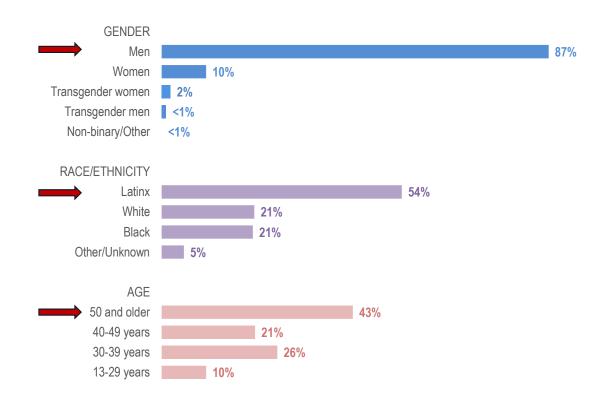
- *Part A - $1,464,979*

- *MAI - $322,116*

- *HIV NCC - $26,031*

Most of NMCM clients were men, most were Latinx, and most were aged 50 and older

NMCM Client Demographics, Year 33, N=6,553

GENDER
- Men — 87%
- Women — 10%
- Transgender women — 2%
- Transgender men — <1%
- Non-binary/Other — <1%

RACE/ETHNICITY
- Latinx — 54%
- White — 21%
- Black — 21%
- Other/Unknown — 5%

AGE
- 50 and older — 43%
- 40-49 years — 21%
- 30-39 years — 26%
- 13-29 years — 10%
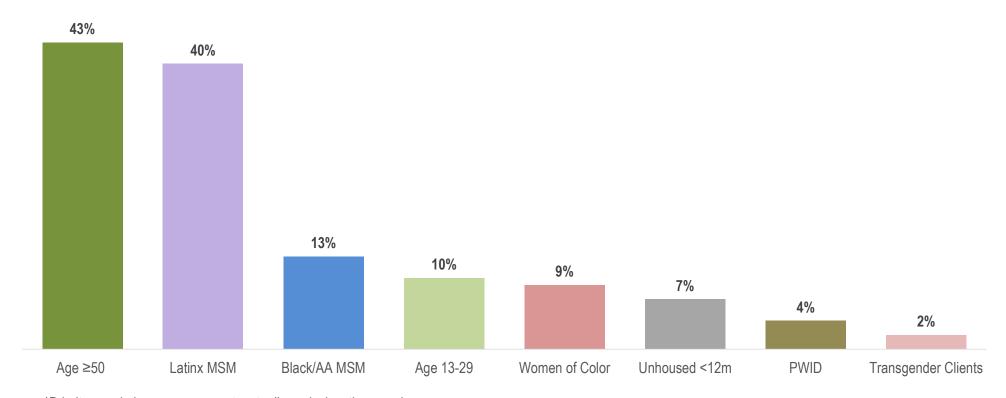
LAC Priority Populations Accessing the NMCM Services*, Year 33

- Clients **age ≥ 50** represented the largest percentage of NMCM clients
- **Latinx MSM** clients were the next highest priority population served by NMCM

Age ≥50	Latinx MSM	Black/AA MSM	Age 13-29	Women of Color	Unhoused <12m	PWID	Transgender Clients
43%	40%	13%	10%	9%	7%	4%	2%
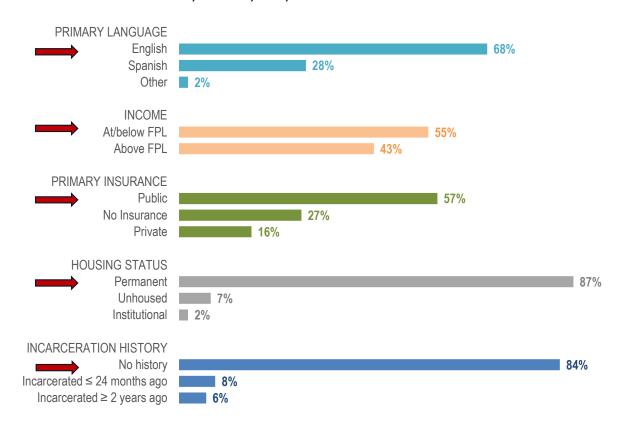
*Priority population groups are not mutually exclusive, they overlap.

Most of NMCM clients were English-speakers, most were living ≤ FPL, most had public insurance, most were permanently housed, and most had no history of incarceration.
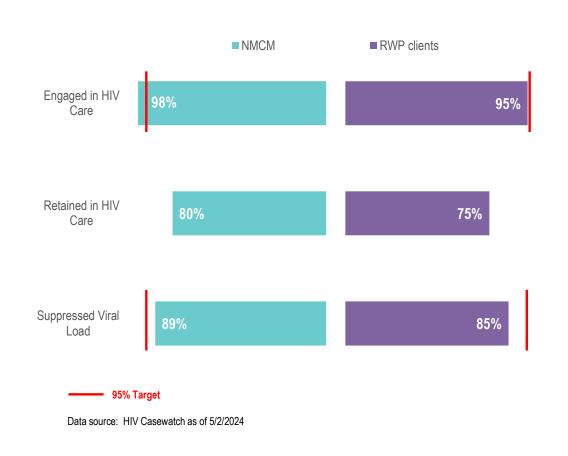
NMCM Client Health Determinants, Year 33, N=6,533

HIV Care Continuum in NMCM clients, Year 33 (n=6,553)

- Engagement, retention, and viral load suppression percentages were higher for NMCM clients compared to RWP clients overall, Year 33.

- NMCM clients did not meet the EHE target of 95% for viral suppression. However, they met the local target of 95% for engagement in care.

Data source: HIV Casewatch as of 5/2/2024

Nutrition Services (NS)

Provides food to RWP clients, improving and sustaining nutrition, food security and quality of life from APLA, Bienestar, and Project Angel Food sites.

A total of **2,461 unique clients** received **Nutrition** services, an increase from Year 31 at 1,971 and Year 32 at 2,117.

- *Delivered Meals* – **453** clients
- *Food Bank* – **2,133** clients

Nutrition service clients represented **16% of RWP clients.**

COUNTY OF LOS ANGELES
Public Health

Utilization of Nutrition Service clients, Year 33

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
Nutrition Services	**2,461**	**Various**	**497,107**	**202**	**$3,882,464**	**$1,578**
Delivered Meals	453	*Meals*	295,021	651	*$1,337,818*	*$2,953*
Food Bank	2,133	*Bags of groceries*	202,086	95	*$2,544,646*	*$1,193*
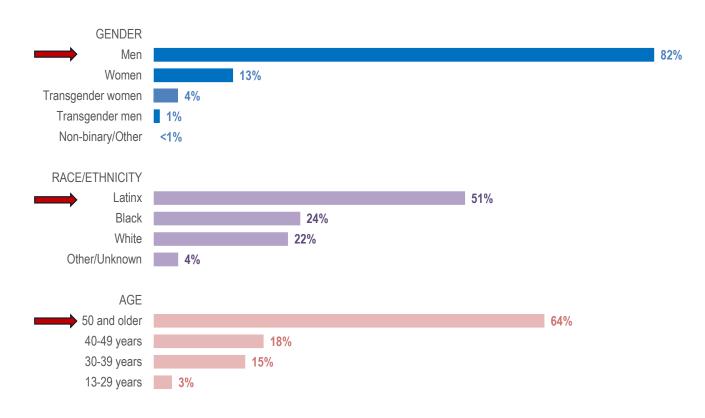
Funding Source:

- *Part A - $3,381,611*

- *HIV NCC - $500,853*

Most of Nutrition Service clients were men, most were Latinx and most were aged 50 and older.

Nutrition Client Demographics, Year 33, N=2,461

GENDER
- Men: 82%
- Women: 13%
- Transgender women: 4%
- Transgender men: 1%
- Non-binary/Other: <1%

RACE/ETHNICITY
- Latinx: 51%
- Black: 24%
- White: 22%
- Other/Unknown: 4%

AGE
- 50 and older: 64%
- 40-49 years: 18%
- 30-39 years: 15%
- 13-29 years: 3%
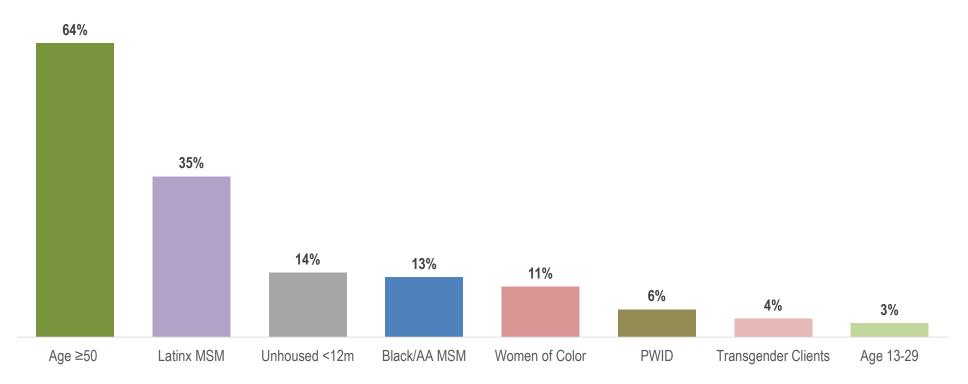
LAC Priority Populations Accessing Nutrition Services*, Year 33

- Clients **age ≥ 50** represented the majority of NS clients (including subservices)
- Latinx MSM clients were the next highest served by NS (including subservices)

Category	Percentage
Age ≥50	64%
Latinx MSM	35%
Unhoused <12m	14%
Black/AA MSM	13%
Women of Color	11%
PWID	6%
Transgender Clients	4%
Age 13-29	3%
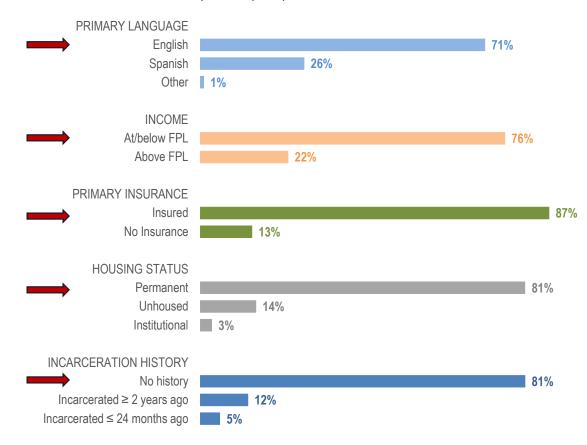
*Priority population groups are not mutually exclusive, they overlap.

Most of Nutrition clients were English-speakers, most lived ≤ FPL, most had public insurance, most were permanently housed, most had no history of incarceration.

Nutrition Client Health Determinants, Year 33, N=2,461

PRIMARY LANGUAGE
- English — 71%
- Spanish — 26%
- Other — 1%

INCOME
- At/below FPL — 76%
- Above FPL — 22%

PRIMARY INSURANCE
- Insured — 87%
- No Insurance — 13%

HOUSING STATUS
- Permanent — 81%
- Unhoused — 14%
- Institutional — 3%

INCARCERATION HISTORY
- No history — 81%
- Incarcerated ≥ 2 years ago — 12%
- Incarcerated ≤ 24 months ago — 5%

COUNTY OF LOS ANGELES
Public Health

HIV Care Continuum in Nutrition Service clients, Year 33 (N=2,461)

- Engagement and viral load suppression percentages were similar for NS clients compared to RWP clients overall, Year 33.

- Retention in care was higher among NS clients than RWP clients overall in Year 33.

- NS clients met the local target for engagement in care.

Legend: ■ Nutrition ■ RWP clients

	Nutrition	RWP clients
Engaged in HIV Care	95%	95%
Retained in HIV Care	81%	75%
Suppressed Viral Load	84%	85%

—— 95% Target

Data source: HIV Casewatch as of 5/2/2024

Substance Use Residential (SUR) Services

Provides outpatient services for the treatment of drug or alcohol use disorders at Tarzana Treatment Center.

A total of **84 unique clients** received **SUR** services, a slight decline from Year 31 at 90 and Year 32 at 85.

SA Residential service clients represented **<1% of RWP clients.**

COUNTY OF LOS ANGELES
Public Health

Utilization of SU Residential clients, Year 33

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
SUR	84	Days	12,333	147	$725,000	$8,631
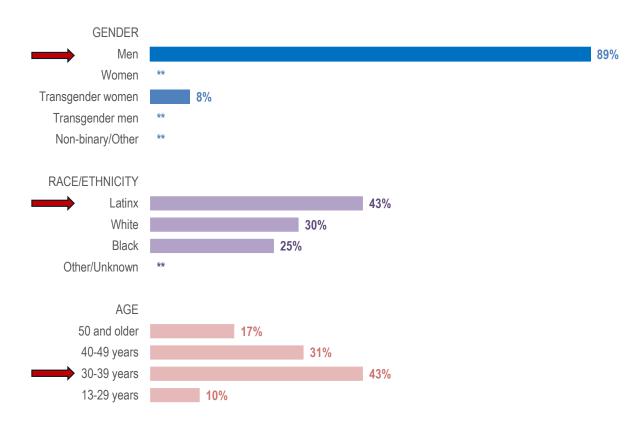
Funding Source:

- *Part B - $670,000*

- *SAPC Non-DMC - $55,000*

Most of SU Residential clients were men, most were Latinx, and most were ages 39 years old and below

SU Residential Client Demographics, Year 33, N=84

GENDER

- Men → 89%
- Women **
- Transgender women 8%
- Transgender men **
- Non-binary/Other **

RACE/ETHNICITY

- Latinx → 43%
- White 30%
- Black 25%
- Other/Unknown **

AGE

- 50 and older 17%
- 40-49 years 31%
- 30-39 years → 43%
- 13-29 years 10%
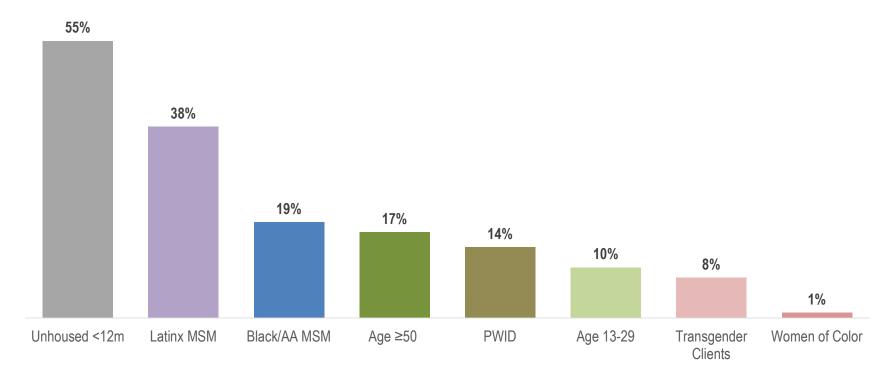
LAC Priority Populations Accessing SU Residential Services*, Year 33

- Recently unhoused clients represented the majority of SUR clients
- Latinx MSM were the next highest served by SUR service followed by Black MSM

55% — Unhoused <12m
38% — Latinx MSM
19% — Black/AA MSM
17% — Age ≥50
14% — PWID
10% — Age 13-29
8% — Transgender Clients
1% — Women of Color
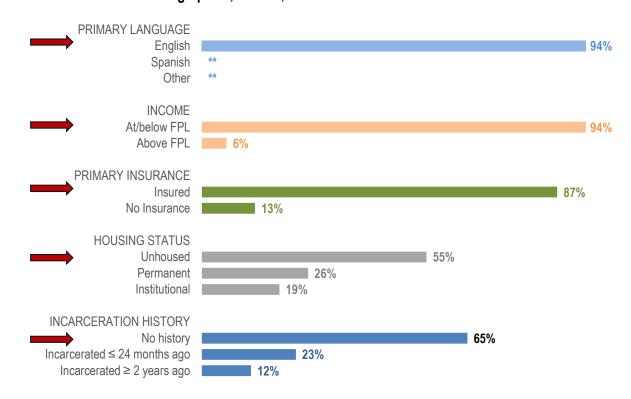
*Priority population groups are not mutually exclusive, they overlap.

Most of SU Residential clients were English-speakers, most were living ≤ FPL, most were insured, most were unhoused, most had no history of incarceration.

SU Residential Client Demographics, Year 33, N=84

PRIMARY LANGUAGE
- English — 94%
- Spanish — **
- Other — **

INCOME
- At/below FPL — 94%
- Above FPL — 6%

PRIMARY INSURANCE
- Insured — 87%
- No Insurance — 13%

HOUSING STATUS
- Unhoused — 55%
- Permanent — 26%
- Institutional — 19%

INCARCERATION HISTORY
- No history — 65%
- Incarcerated ≤ 24 months ago — 23%
- Incarcerated ≥ 2 years ago — 12%

HIV Care Continuum in SU Residential clients, Year 33 (n=84)

- Engagement, retention, and viral load suppression percentages were higher for SUR clients compared to RWP clients overall, Year 33.

- SUR clients did not meet the EHE target of 95% for viral suppression. However, they met the local target of 95% for engagement in care.

Legend: ■ SUR ■ RWP clients

	SUR	RWP clients
Engaged in HIV Care	98%	95%
Retained in HIV Care	81%	75%
Suppressed Viral Load	92%	85%

— 95% Target

Data source: HIV Casewatch as of 5/2/2024

Linkage-Reengagement Program (LRP)

Assists people newly diagnosed or identified as living with HIV who are lost or returning to treatment engage in medical and psychosocial services. Provided by DHSP health navigators.

A total of **40 unique clients** received **LRP** services, a slight decline from Year 32 at 46.

LRP service clients represented **<1% of RWP clients.**

COUNTY OF LOS ANGELES
Public Health

Utilization of LRP clients, Year 33

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
LRP	40	Hours	804	20	$923,044	$23,076
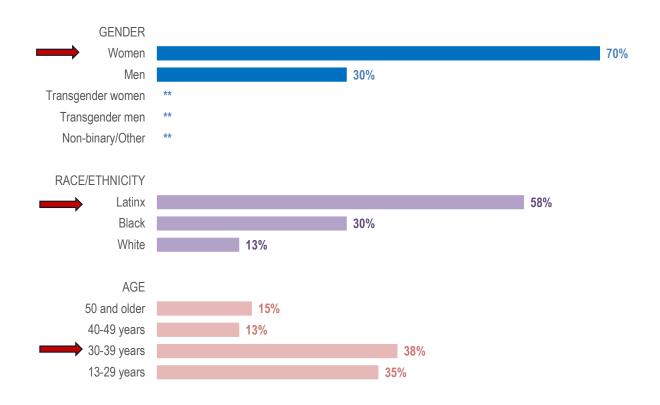
Funding Source:

- *Part A- $473,413*

- *HRSA EHE- $449,631*

Most LRP clients were women, most were Latinx, most were ages 39 years and below
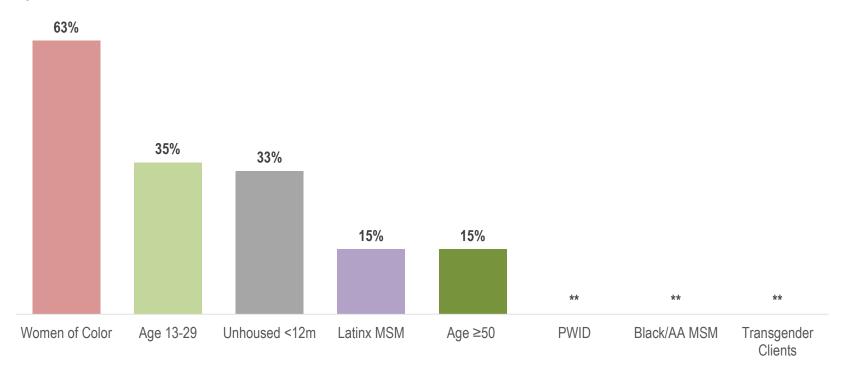
LRP Client Demographics, Year 33, N=40

GENDER

Women — 70%
Men — 30%
Transgender women — **
Transgender men — **
Non-binary/Other — **

RACE/ETHNICITY

Latinx — 58%
Black — 30%
White — 13%

AGE

50 and older — 15%
40-49 years — 13%
30-39 years — 38%
13-29 years — 35%

- Women of color represented the majority of LRP clients
- LRP clients aged 13-29 and recently unhoused were the next highest priority populations served by LRP service
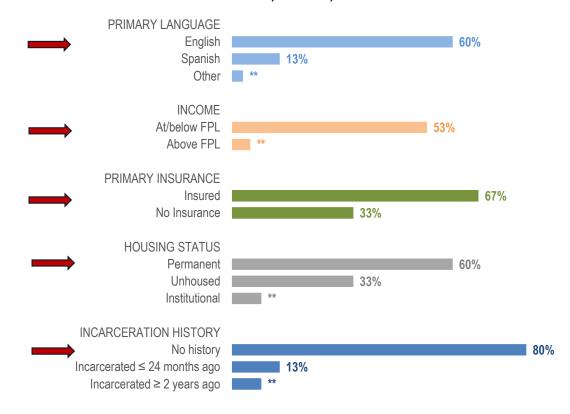
*Priority population groups are not mutually exclusive, they overlap.

Most of LRP clients were English-speakers, most were living ≤ FPL, most were insured, most were permanently housed, and most had no history of incarceration.
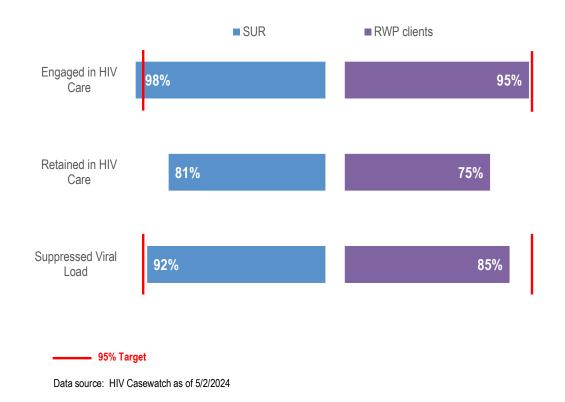
LRP Client Health Determinants, Year 33, N=40

PRIMARY LANGUAGE
- English — 60%
- Spanish — 13%
- Other — **

INCOME
- At/below FPL — 53%
- Above FPL — **

PRIMARY INSURANCE
- Insured — 67%
- No Insurance — 33%

HOUSING STATUS
- Permanent — 60%
- Unhoused — 33%
- Institutional — **

INCARCERATION HISTORY
- No history — 80%
- Incarcerated ≤ 24 months ago — 13%
- Incarcerated ≥ 2 years ago — **
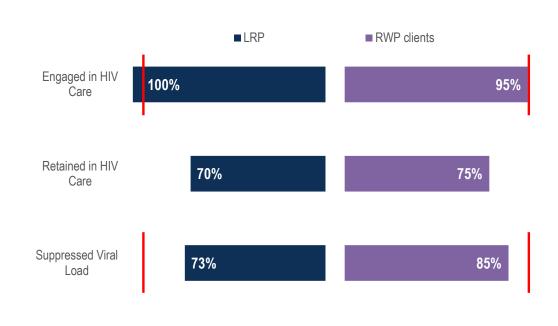
HIV Care Continuum in LRP clients, Year 33 (n=40)

- Engagement in care was higher for LRP clients compared to RWP clients overall, Year 33.

- Retention in care and viral load suppression percentages were considerably lower for LRP clients compared to RWP clients overall.

- LRP clients did not meet the EHE target of 95% for viral suppression. However, they met the local target of 95% for engagement in care.

Data source: HIV Casewatch as of 5/2/2024
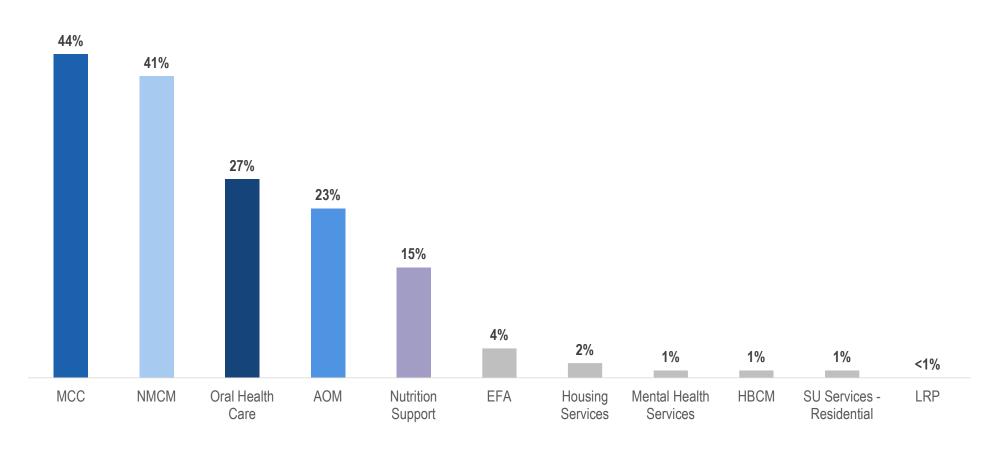
Top 5 RWP Services Utilized

The top five services utilized the most by RWP clients in Year 33 were MCC program, followed by NMCM, Oral Health, AOM and Nutrition.
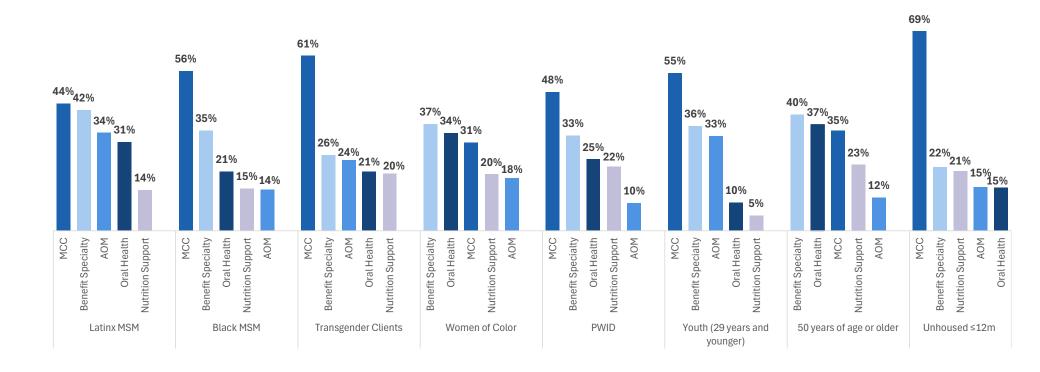
Utilization of RWP services in Year 33

Top 5 RWP Services Used by Priority Populations, Year 33

Top five RWP service utilized by LAC priority populations in Year 33 were MCC, Benefit Specialty, Oral Health, AOM and Nutrition Support.

Latinx MSM
- MCC: 44%
- Benefit Specialty: 42%
- AOM: 34%
- Oral Health: 31%
- Nutrition Support: 14%

Black MSM
- MCC: 56%
- Benefit Specialty: 35%
- Oral Health: 21%
- Nutrition Support: 15%
- AOM: 14%

Transgender Clients
- MCC: 61%
- Benefit Specialty: 26%
- AOM: 24%
- Oral Health: 21%
- Nutrition Support: 20%

Women of Color
- Benefit Specialty: 37%
- Oral Health: 34%
- MCC: 31%
- Nutrition Support: 20%
- AOM: 18%

PWID
- MCC: 48%
- Benefit Specialty: 33%
- Oral Health: 25%
- Nutrition Support: 22%
- AOM: 10%

Youth (29 years and younger)
- MCC: 55%
- Benefit Specialty: 36%
- AOM: 33%
- Oral Health: 10%
- Nutrition Support: 5%

50 years of age or older
- Benefit Specialty: 40%
- Oral Health: 37%
- MCC: 35%
- Nutrition Support: 23%
- AOM: 12%

Unhoused ≤12m
- MCC: 69%
- Benefit Specialty: 22%
- Nutrition Support: 21%
- AOM: 15%
- Oral Health: 15%

Expenditures for Support RWP Services
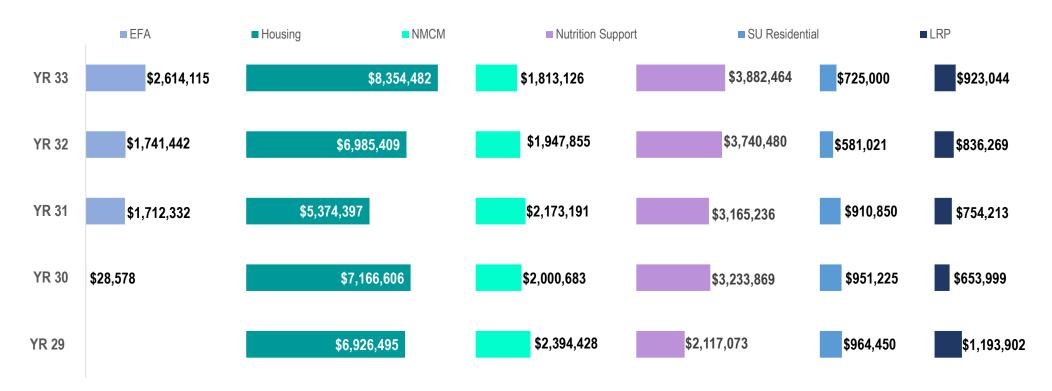
EFA	$2,614,115
Housing	$8,354,482
NMCM	$1,813,126
Nutrition Support	$3,882,464
SA Residential	$725,000
LRP	$923,044

County of Los Angeles Public Health

Expenditures by Support Service Category, Years 29-33

SUR and NMCM services expenditures decreased since Year 29; NMCM funding was the lowest in Year 33.
Expenditures for EFA, Housing,and Nutrition services gradually increased over five years since Year 29.

	EFA	Housing	NMCM	Nutrition Support	SU Residential	LRP
YR 33	$2,614,115	$8,354,482	$1,813,126	$3,882,464	$725,000	$923,044
YR 32	$1,741,442	$6,985,409	$1,947,855	$3,740,480	$581,021	$836,269
YR 31	$1,712,332	$5,374,397	$2,173,191	$3,165,236	$910,850	$754,213
YR 30	$28,578	$7,166,606	$2,000,683	$3,233,869	$951,225	$653,999
YR 29		$6,926,495	$2,394,428	$2,117,073	$964,450	$1,193,902

County of Los Angeles
Public Health

Expenditures per Client for Support RWP Services, Year 33

- The **highest expenditures** per client were spent **for Housing**, followed by **LRP** services.

- The **lowest expenditures** per client were spent for **NMCM**, followed by **Nutrition** services.

Service Category	Number of clients	% of RWP clients	Expenditures	% of expenditures	Expenditures per client
Housing	270	2%	$8,354,482	18%	*$30,943*
LRP	40	1%	$923,044	2%	*$23,076*
SU Residential	84	1%	$725,000	2%	*$8,631*
EFA	617	4%	$2,614,115	6%	*$4,237*
Nutrition Support	2,461	16%	$3,882,464	8%	*$1,578*
NMCM	6,553	41%	$1,813,126	4%	*$277*

Early Intervention Services	$3,014,301
Legal	$1,337,818
Transportation	$637,151
Language services	$3,300

Key Takeaways – Support RWP Services

- Out of Support services, **NMCM** services were utilized by the highest number of RWP, although the expenditures for **NMCM** decreased over the past five years and expenditures per client were the lowest of all support services. Most clients utilized **Benefit Specialty** within NMCM.

- LRP services were utilized by the least number of RWP clients, although its utilization slightly increased in the past four years. LRP services were focused mostly on pregnant females and females of reproductive age.

- Utilization of **EFA, Housing, NMCM**, and **Nutrition** services consistently increased over four years starting from Year 30

- Utilization of **SU Residential** decreased over the course of the past five years

Key Takeaways – Priority Populations

- The RWP is reaching and serving LAC priority populations:

  o Top 5 RWP services utilized were **MCC, NMCM, Oral Health, AOM and Nutrition Support.**

- While poverty impacts all of the LAC priority populations, they are differentially impacted by SDOH

- Service utilization among LAC priority population was consistent relative to their size for **EFA, NMCM, and Nutrition support services:**

  o **Latinx MSM and people aged ≥ 50 and older were the highest utilizers**

  o **Lowest utilization was among Transgender people, PWID and youth aged 13-29.**

- Service utilization among LAC priority population was consistent with the type of service:

  o **People unhoused <12m were the highest utilizers of Housing and SU Residential services**

  o **Women of color and youth aged 13-29 were the highest utilizers of LRP services**

Key Takeaways - Expenditures

- SUR and NMCM services expenditures **decreased** since Year 29

- Expenditures for EFA, Housing, and Nutrition Support services gradually **increased** over five years since Year 29.

- **The highest expenditures per client** were spent for Housing, followed by LRP services. These services were utilized by (one of) the lowest number of RWP clients receiving Support Services.

- **The lowest expenditures per client** were for NMCM services, although it served the highest number of RWP clients receiving Support Services.

Next Steps

- Examine detailed utilization of RWP services within each LAC priority populations

- Examine RWP services by priority population over time

Questions/Discussion

Thank you!

- Acknowledgements
  - Monitoring and Evaluation – Wendy Garland, Siri Chirumamilla
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  - PDR – Victor Scott, Michael Green
  - CCS – Paulina Zamudio and the RWP program managers
  - RWP agencies and providers
  - RWP clients

Allocation Deliberation Grounding Guide

1. **Lead with Data, Not Emotion**
   Decisions must be rooted in facts, not feelings. While personal experiences and passion drive our commitment, our charge is to prioritize strategies backed by data, not anecdotes or impassioned pleas.

2. **Remove the Hat - Represent the Whole**
   Whether you're a provider, consumer, advocate, or policymaker-step into the space as a representative of the entire community. Focus on the greatest need and widest impact, especially given limited resources.

3. **Fight the Issue, Not Each Other**
   We are not each other's opponents-the real challenge is the funding gap. Let's direct our energy toward problem-solving and collective decision-making, not personal tensions or positional debates.

Ryan White Program Year (PY) 35 Service Rankings and Allocations Table (Approved by COH on 9/26/24)

Service Type	Service Ranking	Service Category	FY 2025 (PY 35) [1]	
			Part A %	MAI %
Core	6	Medical Case Management (Medical Care Coordination)	29.00%	0.00%
Core	8	Oral Health	21.30%	0.00%
Core	20	Outpatient/Ambulatory Medical Health Services (Ambulatory Outpatient Medical)	17.11%	0.00%
Core	11	Early Intervention Services (Testing Services)	0.00%	0.00%
Core	17	Home and Community-Based Health Services	6.50%	0.00%
Support	2	Emergency Financial Assistance	8.00%	0.00%
Support	7	Nutrition Support (Food Bank/Home-delivered Meals)	7.79%	0.00%
Support	5	Non-Medical Case Management		
		Patient Support Services	0.00%	0.00%
		Benefits Specialty Services	3.95%	0.00%
		Transitional Case Management - Jails	1.58%	0.00%
Support	10	Medical Transportation	1.84%	0.00%
Support	23	Legal Services	2.00%	0.00%
Support	1	Housing		
		Housing Services RCFCI/TRCF (Home-Based Case Management)	0.91%	0.00%
		Housing for Health	0.00%	100.00%
Core	3	Mental Health Services	0.02%	0.00%
Core	9	AIDS Drug Assistance Program (ADAP) Treatments	0.00%	0.00%
Core	22	Local AIDS Pharmaceutical Assistance Program (LPAP)	0.00%	0.00%
Core	15	Health Insurance Premium & Cost Sharing Assistance	0.00%	0.00%
Core	16	Home Health Care	0.00%	0.00%
Core	28	Hospice Services	0.00%	0.00%
Core	26	Medical Nutritional Therapy	0.00%	0.00%
Core	12	Substance Abuse Services Outpatient	0.00%	0.00%
Support	18	Child Care Services	0.00%	0.00%
Support	13	Health Education/Risk Reduction	0.00%	0.00%
Support	27	Linguistic Services (Language Services)	0.00%	0.00%
Support	14	Outreach Services (LRP)	0.00%	0.00%
Support	4	Psychosocial Support Services	0.00%	0.00%
Support	24	Referral	0.00%	0.00%
Support	25	Rehabilitation	0.00%	0.00%
Support	21	Respite Care	0.00%	0.00%
Support	19	Substance Abuse Residential	0.00%	0.00%
		Overall Total	**100.00%**	**100.00%**

Footnotes:

(1) Approved by PP&A Committee on 9/17/24; approved by Exec. Committee on 9/26/24: Exe. approved due to lack of quorum @ COH meeting on 9/12/24

Ryan White Program Year (PY) 35 Service Rankings and Allocations - Scenario #3

(20% reduction) Part A ($30,398,680) and Minority AIDS Initiative (MAI) ($2,644,286) = $33,043,000 [1]

Service Type	Service Ranking	Service Category	Approved FY 2025 (PY 35) [2]				20% Reduction Proposed Allocations [3]			
			Part A %	MAI %	Part A funding by allocation %	MAI funding by allocation %	Part A %	MAI %	Part A funding by allocation %	MAI funding by allocation %
Core	6	Medical Case Management (Medical Care Coordination)	29.00%	0.00%	$ 11,019,522	$ -	26.00%	0.00%	$ 7,903,657	$ -
Core	8	Oral Health	21.30%	0.00%	$ 8,093,649	$ -	19.00%	0.00%	$ 5,775,749	$ -
Core	20	Outpatient/Ambulatory Medical Health Services (Ambulatory Outpatient Medical)	17.11%	0.00%	$ 6,501,518	$ -	17.11%	0.00%	$ 5,201,214	$ -
Core	11	Early Intervention Services (Testing Services)	0.00%	0.00%	$ -	$ -	0.00%	0.00%	$ -	$ -
Core	17	Home and Community-Based Health Services (Home-Based Case Management)	6.50%	0.00%	$ 2,469,893	$ -	6.50%	0.00%	$ 1,975,914	$ -
Support	2	Emergency Financial Assistance	8.00%	0.00%	$ 3,039,868	$ -	7.00%	0.00%	$ 2,127,908	$ -
Support	7	Nutrition Support (Food Bank/Home-delivered Meals)	7.79%	0.00%	$ 2,960,072	$ -	7.79%	0.00%	$ 2,368,057	$ -
Support	5	Non-Medical Case Management								
		Patient Support Services [4]	0.00%	0.00%	$ -	$ -	5.00%	0.00%	$ 1,519,934	$ -
		Benefits Specialty Services	3.95%	0.00%	$ 1,500,935	$ -	3.95%	0.00%	$ 1,200,748	$ -
		Transitional Case Management - Jails	1.58%	0.00%	$ 600,374	$ -	0.00%	0.00%	$ -	$ -
Support	10	Medical Transportation	1.84%	0.00%	$ 699,170	$ -	1.84%	0.00%	$ 559,336	$ -
Support	23	Legal Services	2.00%	0.00%	$ 759,967	$ -	2.00%	0.00%	$ 607,974	$ -
Support	1	Housing								
		Housing Services RCFCI/TRCF	0.91%	0.00%	$ 345,785	$ -	0.91%	0.00%	$ 276,628	$ -
		Housing for Health	0.00%	100.00%	$ -	$ 3,305,358.00	0.00%	100.00%	$ -	$ 2,644,286.00
Core	3	Mental Health Services	0.02%	0.00%	$ 7,600	$ -	0.02%	0.00%	$ 6,080	$ -
		Overall Total	**100.00%**	**100.00%**	**$ 37,998,351**	**$ 3,305,358**	**97.12%**	**100.00%**	**$ 30,398,680**	**$ 2,644,286**

Footnotes:

(1) Twenty percent reduction based grant amount available for Part A and Minority AIDS Initiative (MAI) direct service totals reported in the March 18, 2025 DHSP Expenditure Report.

(2) PY35 Approved Allocations - Approved by COH on 9/26/24

(3) PP&A Committee has not completed it's reallocations and will continue deliberations at the next PP&A meeting on May 1, 2025. MAI allocations not yet reviewed.

(4) $5,412,988 total for Patient Support Services in pending DHSP award amounts

Division on HIV and STD Programs Program year 34 (PY34) Expenditure Report - Part A Expenditures

Priority #	Service Category	YR 34 Allocation Percentages	Year 34 Commission Allocations	YTD Actual	Full Year Estimate	Estimated Year 34 Expenditure Percentages	Variance Full Year Estimate vs. COH Allocations
			[1]	[2]	[3]	[4]	[1-3]
	CORE SERVICES						
3	OUTPATIENT/AMBULATORY MEDICAL CARE	17.11%	6,500,000	$ 4,543,129	$ 6,860,111	18.05%	$ (360,111)
13	ORAL HEALTH CARE	20.79%	7,900,000	6,068,278	8,751,232	23.03%	$ (851,232)
18	HOME AND COMMUNITY-BASED HEALTH SERVICES	6.50%	2,470,000	2,093,866	2,345,241	6.17%	$ 124,759
6	MEDICAL CASE MANAGEMENT SERVICES (MCC)	27.15%	10,316,352	9,754,986	11,660,438	30.69%	$ (1,344,086)
7	MENTAL HEALTH SERVICES	0.29%	110,000	81,352	85,420	0.22%	$ 24,580
23	MEDICAL NUTRITION THERAPY	0.00%	-	-	-	0.00%	$ -
10	EARLY INTERVENTION SERVICES (PH STD Clinic)	6.58%	2,500,000	1,947,287	2,332,127	6.14%	$ 167,873
	CORE SERVICES TOTAL	78.41%	$ 29,796,352	$ 24,488,898	$ 32,034,569	84.31%	$ (2,238,217)
	SUPPORTIVE SERVICES						
14	CHILD CARE SERVICES	0.00%	-	-	-	0.00%	$ -
2	CASE MANAGEMENT SERVICES NON-MEDICAL (BSS)	3.95%	1,500,000	1,322,942	1,517,835	3.99%	$ (17,835)
22	LINGUISTIC SERVICES	0.00%	-	664	664	0.00%	$ (664)
11	MEDICAL TRANSPORTATION SERVICES	1.63%	620,000	617,243	715,013	1.88%	$ (95,013)
12	FOOD BANK (NSS)[2]	5.79%	2,200,000	2,473,565	2,783,905	7.33%	$ (583,905)
1	HOUSING SERVICES (TRCF/RCFCI) (THAS)	0.91%	344,000	557,738	571,410	1.50%	$ (227,410)
15	LEGAL SERVICES	1.42%	538,000	962,220	1,049,695	2.76%	$ (511,695)
4	EMERGENCY FINANCIAL ASSISTANCE (EFA)[3]	6.32%	2,400,000	1,539,288	1,539,288	4.05%	$ 860,712
2	NMCM (TCM Jails) 6 medical case workers and 1 HPA I	1.58%	600,000	6,680	26,720	0.07%	$ 573,280
8	OUTREACH SERVICES (LRP)	0.00%	-	-	-	0.00%	$ -
	SUPPORTIVE SERVICES TOTAL	21.59%	8,202,000	7,480,340	8,204,530	21.59%	(2,530)
	DIRECT SERVICES TOTAL	100.00%	37,998,351	28,083,483	40,239,099	105.90%	(2,240,748)
	QUALITY MANAGEMENT	0.00%	500,001	911,161	1,251,836	2.93%	$ (751,835)
	ADMINISTRATIVE SERVICES (includes Planning Council/A	10.00%	4,277,594	7,410,098	4,277,594	10.00%	$ -
	QM & ADMIN TOTAL	10.00%	4,777,595	8,321,259	5,529,430	12.93%	(751,835)
	PART A GRAND TOTAL	110.00%	42,775,946	40,290,497	45,768,529	118.82%	(2,992,583)

Notes:
(1) Allocation based on priorities set by HIV Commission. Actual YR 34 grant award is **$42,775,946**

(2) Home-delivered Meals for Year 34 funded through HRSA EHE

(3) EFA expenditures shown represent March 1, 2024 - May 31, 2024. Additional funding for Emergency Rental Assistance through HRSA EHE

Division on HIV and STD Programs Program year 34 (PY34) Expenditure Report - Minority AIDS Initiative (MAI) Expenditures

Priority #	Service Category	YR 34 Allocation Percentages	Year 34 Commission Allocations	YTD Actual	Full Year Estimate	Estimated Year 34 Expenditure Percentages	Variance Full Year Estimate vs. COH Allocations
			[1]	[2]	[3]	[4]	[1-3]
	CORE SERVICES						
3	OUTPATIENT/AMBULATORY MEDICAL CARE	0.00%	-	$ -	$ -	0.00%	$ -
13	ORAL HEALTH CARE	0.00%	-	-	-	0.00%	$ -
18	HOME AND COMMUNITY-BASED HEALTH SERVICES	0.00%	-	-	-	0.00%	$ -
6	MEDICAL CASE MANAGEMENT SERVICES (MCC)	0.00%	-	-	-	0.00%	$ -
7	MENTAL HEALTH SERVICES	0.00%	-	-	-	0.00%	$ -
23	MEDICAL NUTRITION THERAPY	0.00%	-	-	-	0.00%	$ -
10	EARLY INTERVENTION SERVICES (PH STD Clinic)	0.00%	-	-	-	0.00%	$ -
					-		
	CORE SERVICES TOTAL	**0.00%**	**$ -**	**$ -**	**$ -**	**0.00%**	**$ -**
	SUPPORTIVE SERVICES						
14	CHILD CARE SERVICES	0.00%	-	-	-	0.00%	$ -
2	CASE MANAGEMENT SERVICES NON-MEDICAL (BSS)	0.00%	-	-	-	0.00%	$ -
22	LINGUISTIC SERVICES	0.00%	-	-	-	0.00%	$ -
11	MEDICAL TRANSPORTATION SERVICES	0.00%	-	-	-	0.00%	$ -
12	FOOD BANK (NSS)	0.00%	-	-	-	0.00%	$ -
1	HOUSING SERVICES (Transitional Housing)	100.00%	3,305,358	4,031,415	5,375,220	162.62%	$ (2,069,862)
15	LEGAL SERVICES	0.00%	-	-	-	0.00%	$ -
4	EMERGENCY FINANCIAL ASSISTANCE (EFA)	0.00%	-	-	-	0.00%	$ -
2	NMCM (TCM Jails) 6 medical case workers and 1 HPA I	0.00%	-	-	-	0.00%	$ -
8	OUTREACH SERVICES (LRP)	0.00%	-	-	-	0.00%	$ -
	SUPPORTIVE SERVICES TOTAL	**100.00%**	**3,305,358**	**4,031,415**	**5,375,220**	**162.62%**	**(2,069,862)**
	DIRECT SERVICES TOTAL	**100.00%**	**3,305,358**	**4,031,415**	**5,375,220**	**162.62%**	**(2,069,862)**
	ADMINISTRATIVE SERVICES	10.00%	367,569	416,179	367,292	10.00%	$ 277
	MAI ADMIN TOTAL	**10.00%**	**367,569**	**416,179**	**367,292**	**10.00%**	**277**
	PART A GRAND TOTAL	**110.00%**	**3,672,927**	**4,447,594**	**5,742,512**	**172.62%**	**(2,069,585)**

Notes:

(1) Allocation based on priorities set by HIV Commission. Actual YR 34 grant award is **$3,672,927**

Division on HIV and STD Programs Program year 34 (PY34) Expenditure Report - Part B Expenditures

Priority #	Service Category	YTD Actual	Full Year Estimate
	CORE SERVICES		
3	OUTPATIENT/AMBULATORY MEDICAL CARE	$ -	$ -
13	ORAL HEALTH CARE	-	-
18	HOME AND COMMUNITY-BASED HEALTH SERVICES	-	-
6	MEDICAL CASE MANAGEMENT SERVICES (MCC)	-	-
7	MENTAL HEALTH SERVICES	-	-
23	MEDICAL NUTRITION THERAPY	-	-
10	EARLY INTERVENTION SERVICES (PH STD Clinic)	-	-
			-
	CORE SERVICES TOTAL	$ -	$ -
	SUPPORTIVE SERVICES		
14	CHILD CARE SERVICES	-	-
2	CASE MANAGEMENT SERVICES NON-MEDICAL (BSS)	-	-
22	LINGUISTIC SERVICES	-	-
11	MEDICAL TRANSPORTATION SERVICES	-	-
12	FOOD BANK (NSS)	-	-
1	HOUSING SERVICES (Substance Use Transitional Housing)	812,475	891,175
1	HOUSING SERVICES (RCFCI/TRCF)	4,027,286	4,396,698
15	LEGAL SERVICES	-	-
4	EMERGENCY FINANCIAL ASSISTANCE (EFA)	-	-
2	NMCM (TCM Jails) 6 medical case workers and 1 HPA I	-	-
8	OUTREACH SERVICES (LRP)	-	-
	SUPPORTIVE SERVICES TOTAL	4,839,761	5,287,873
	DIRECT SERVICES TOTAL	4,839,761	5,287,873
	ADMINISTRATIVE SERVICES	419,997	576,134
	Part B ADMIN TOTAL	419,997	576,134
	PART B GRAND TOTAL	5,259,758	5,864,007

Division on HIV and STD Programs Program year 34 (PY34) Expenditure Report - HRSA Ending the HIV Epidemic (EHE) Expenditures

Service Category	YTD Actual	Full Year Estimate
	[2]	[3]
STREET MEDICINE PROGRAM	$ 2,388,566	$ 2,388,566
MENTAL HEALTH SERVICES (Spanish Telehealth Mental Health)	269,143	269,143
EARLY INTERVENTION SERVICES (Partner Services, HIV Rapid Tests)	1,703,447	1,703,447
EHE INNOVATION AWARDS	1,656,394	1,656,394
EHE MINI GRANTS	110,365	110,365
EHE PRIORITY POPULATIONS	3,189,074	3,189,074
MEDICAL TRANSPORTATION SERVICES	17,678	17,678
HOME DELIVERED MEALS (NSS)	1,241,912	1,241,912
FOOD BANK GIFT CARDS	1,417,344	1,417,344
EMERGENCY RENTAL ASSISTANCE	1,228,161	1,228,161
FLEX (Guaranteed Gift Cards)	3,659,160	3,659,160
DARE2Care (Data-to-Care)	727,393	875,241
RAPID AND READY (Linkage-to-Care)	324,924	324,924
OUTREACH SERVICES (LRP)	836,247	836,247
DIRECT SERVICES TOTAL	**18,769,808**	**18,917,656**
e2LA DATA SYSTEM	564,323	564,323
THIRD-PARTY ADMINISTRATOR (EHE Services)	2,475,915	2,475,915
RYAN WHITE SERVICES MEDIA CAMPAIGN	1,334,546	1,334,546
OTHER COSTS	**4,374,784**	**4,374,784**
ADMINISTRATIVE/PLANNING 7 EVALUATION SERVICES	1,835,430	1,835,430
HRSA EHE ADMIN/PLANNING & EVAL TOTAL	**1,835,430**	**1,835,430**
HRSA EHE GRAND TOTAL	**24,980,022**	**25,127,870**

ASSESSMENT OF FULL YEAR ESTIMATE COMPARED TO GRANT AMOUNT AVAILABLE FOR DIRECT SERVICES

Grant	Grant Amount Available for Direct Services	Year End Estimate for Direct Services	Variance
Part A	$37,998,351	$40,239,099	$2,240,748
MAI	$3,305,358	$5,375,220	$2,069,862
Part B	$5,287,873	$5,287,873	$0
HRSA EHE*	$16,244,557	$23,144,592	$6,900,035
Total	$62,836,139	$74,046,784	$11,210,645

*includes FY 2020 - 2023 carryover of $9,536,247 and FY 2024 available services funding of $6,708,310.

Ryan White Program Utilization Summary, Year 33 (March 1, 2023-February 29, 2024)

Sona Oksuzyan, Supervising Epidemiologist

Janet Cuanas, Research Analyst III

Monitoring and Evaluation Unit

Division of HIV and STD Programs

March 13, 2025

Overview

- **Background**

- **Methods**

- **Results**

- **Key Takeaways**

- **Next Steps**

- **Questions/Discussion**

Background

- Ryan White Program (RWP) Funding

- RWP Report Updates

- RWP Service Categories

RWP Funding and Report Updates

Ryan White Program (RWP) Annual Funding to DHSP

- Source: Health Resources and Services Administration HIV/AIDS Bureau (HRSA-HAB)

Commission on HIV (COH) RWP DHSP Report

- Utilization Report informs service planning and resource allocation activities

RWP Utilization Report Updates

- Separate reports for core and support service categories to better inform activities
- The report is restructured to track utilization across the priority populations identified in the Los Angeles County (LAC) Ending the HIV Epidemic (EHE) Strategic Plan and the LAC Integrated Comprehensive HIV Plan
- **While not identified as a priority population in the above plans, persons experiencing homelessness (unhoused people) are included in the utilization report**

PRIORITY POPULATIONS

Latinx Men Who Have Sex with Men (MSM)

Black MSM

Cisgender Women of Color

Transgender Persons

Youth (29 years and younger)

PLWH Age ≥ 50

Persons Who Inject Drugs (PWID)

Unhoused RWP Clients

RWP Service Categories

Core Service Categories

- Ambulatory Outpatient Medical (AOM)

- Medical Care Coordination (MCC)

- Oral Health
  - General Oral Health
  - Specialty Oral Health

- Home-Based Care Management (HBCM)

- Mental Health

Support Service Categories

- Emergency Financial Assistance (EFA)

- Housing Services
  - Housing Services (RCFCI)
  - Housing Services (TRCF)
  - Permanent Supportive Housing (H4H)

- Non-Medical Case Management (NMCM):
  - Benefits Specialty
  - Transitional Incarceration

- Nutritional Services
  - Food Bank
  - Delivered Meals

- Substance Abuse Services Residential

- Outreach (LRP)

Methods

- RWP Report Framework

- Evaluation Framework

RWP Report Framework

Year 33: March 1, 2023-February 29, 2024

Data Sources
- HIV Casewatch: Client characteristics and service use
- HIV Surveillance: Viral load, CD4 and genotype tests
- DHSP Expenditure Reports

Utilization Indicators
- Total service units = **Number of services units** paid for by DHSP (includes hours, visits, procedures, days, and sessions)
- Total Expenditures = **Total dollar amount** paid by DHSP
- Service units per client = Total number of service units / number of clients
- Expenditures per client = Total dollar amount / number of clients

Outcomes
- Engagement in care
- Retention in care
- Viral suppression

Evaluation Framework

Demographics of RWP Clients
- Number of unique clients
- Type of clients who receive services
- Social determinants of health of clients
- RWP priority populations

RWP Service Utilization
- Types of services utilized
- How was the service utilized
- How much of the service did clients receive?
- Gaps or differences in how clients received services

Local and Federal HIV Target Progress
- Engagement in care, retention in care, and viral suppression in RWP clients and LAC overall
- Disparities in outcomes among priority populations
- Client outcomes within specific service categories

Results: Year 33

- Service Utilization
- RWP Client Demographics
- RWP Priority Populations
- HIV Care Continuum Outcomes

County of Los Angeles
Public Health
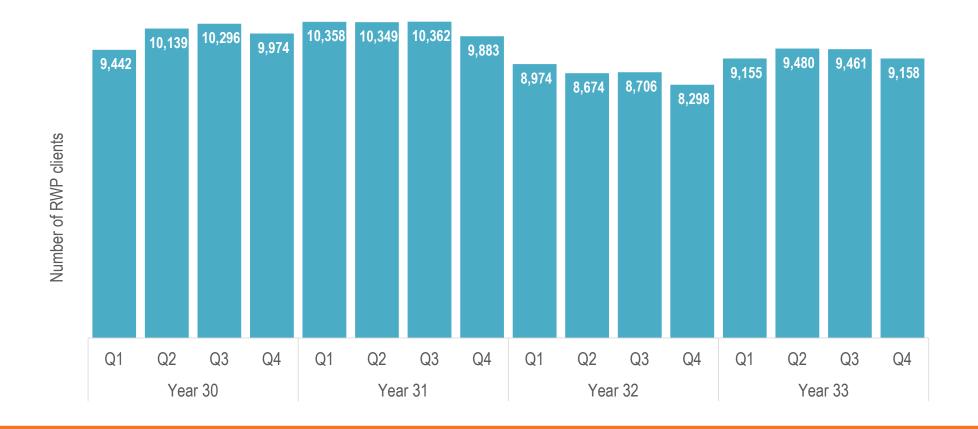
Utilization remains consistent among contracted providers over the past four years.
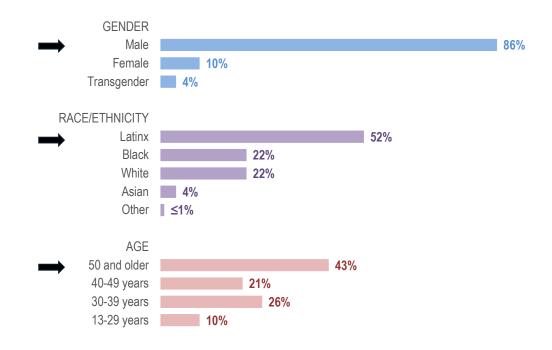
Quarterly RWP Utilization at Funded Agencies, Years 30-33

	Year 30				Year 31				Year 32				Year 33			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of RWP clients	9,442	10,139	10,296	9,974	10,358	10,349	10,362	9,883	8,974	8,674	8,706	8,298	9,155	9,480	9,461	9,158

In Year 33 most RWP clients identified as male, over half were Latinx, and three out of five were under aged 50.

RWP Client Demographics, Year 33 (N=15,882)

GENDER
- ➡ Male — 86%
- Female — 10%
- Transgender — 4%

RACE/ETHNICITY
- ➡ Latinx — 52%
- Black — 22%
- White — 22%
- Asian — 4%
- Other — ≤1%

AGE
- ➡ 50 and older — 43%
- 40-49 years — 21%
- 30-39 years — 26%
- 13-29 years — 10%
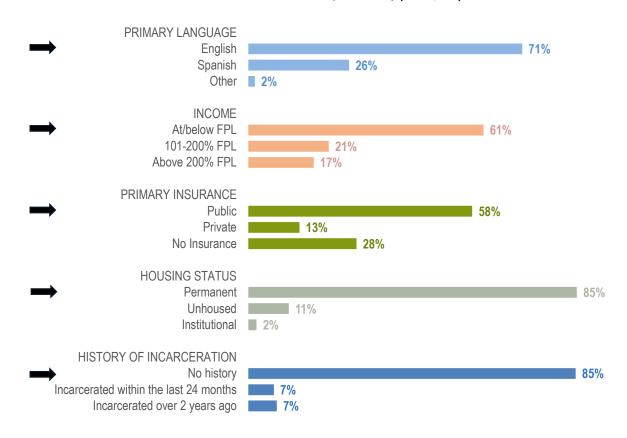
Most RWP clients were English-speakers, lived ≤ FPL, had public health insurance, had permanent housing status and no history of incarceration.
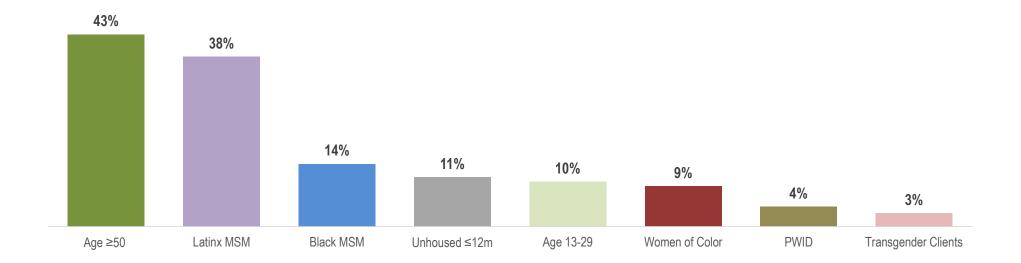
RWP Client Social Determinants of Health, Year 33, (N=15,882)

PRIMARY LANGUAGE
- English — 71%
- Spanish — 26%
- Other — 2%

INCOME
- At/below FPL — 61%
- 101-200% FPL — 21%
- Above 200% FPL — 17%

PRIMARY INSURANCE
- Public — 58%
- Private — 13%
- No Insurance — 28%

HOUSING STATUS
- Permanent — 85%
- Unhoused — 11%
- Institutional — 2%

HISTORY OF INCARCERATION
- No history — 85%
- Incarcerated within the last 24 months — 7%
- Incarcerated over 2 years ago — 7%

RWP is reaching clients in LAC priority populations, Year 33

The majority of clients (43%) were **50 years of age or older,** followed by **Latinx MSM.***

43%	38%	14%	11%	10%	9%	4%	3%
Age ≥50	Latinx MSM	Black MSM	Unhoused ≤12m	Age 13-29	Women of Color	PWID	Transgender Clients

*Priority population groups are not mutually exclusive, they overlap.

Comparison of LAC Priority Populations[a] for RWP Utilization, Year 33

Population (% of row population)	Trans-identified Clients[b]	Latinx MSM[c]	Black MSM[c]	Women of Color	Age 13-29	Age ≥ 50	PWID	Unhoused ≤12m
Trans-identified Clients[b]	**535 (3% of RWP)**	253 47%	88 16%	-	89 17%	161 30%	12 2%	120 22%
Latinx MSM[c]	253 4%	**6,055 (38% of RWP)**	-	-	658 11%	2,303 38%	152 3%	520 9%
Black MSM[c]	88 4%	-	**2,255 (14% of RWP)**	-	292 13%	731 32%	62 3%	327 15%
Women of Color	-	-	-	**1,436 (9% of RWP)**	105 7%	765 53%	37 3%	140 10%
Age 13-29	89 6%	658 43%	292 19%	105 7%	**1,539 (10% of RWP)**	-	36 2%	243 16%
Age ≥ 50	161 2%	2,303 34%	731 11%	765 11%	-	**6,872 (43% of RWP)**	351 5%	450 7%
PWID	12 2%	152 23%	62 9%	37 6%	36 5%	351 53%	**660 (4% of RWP)**	146 22%
Unhoused ≤12m	120 7%	520 31%	327 20%	140 8%	243 15%	450 27%	146 9%	**1,668 (11% of RWP)**

Data source: HIV Casewatch as of 5/2/2024, HIV Surveillance data as of 5/8/2024
[a]Populations not mutually exclusive
[b]Includes 497 transgender women and 38 transgender men
[c]MSM defined by primary HIV risk category
[d]Reported as unhoused within the 12 months reporting period.
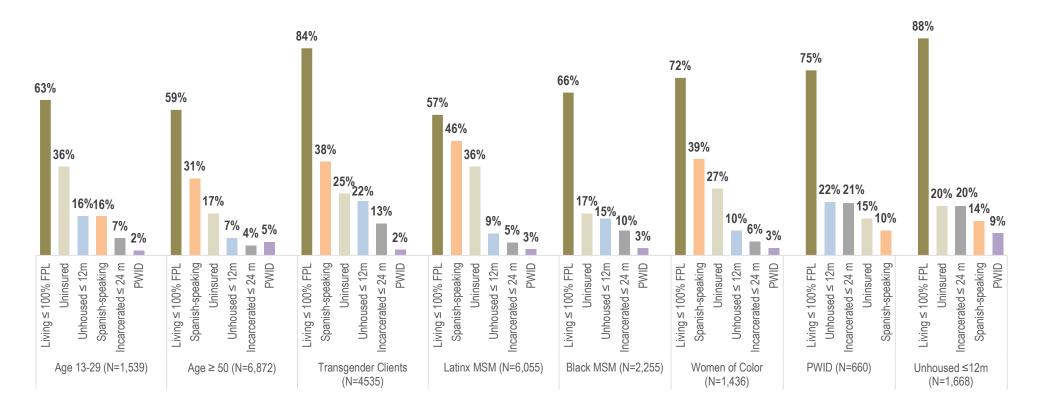
Poverty and having no insurance impacted the highest percent of clients across priority populations, however the other SDOH impacted each population differently.

Social Determinants among LAC Priority Populations, Year 33

Utilization of RWP Services by LAC Priority Populations[a], Year 33
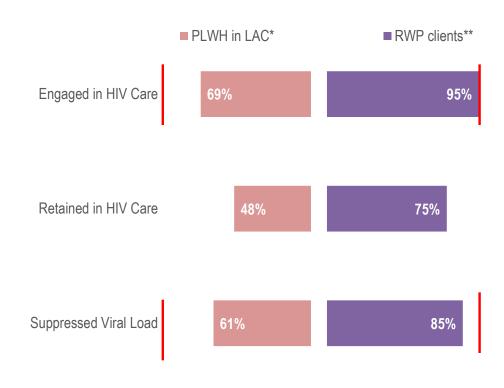
Service Category	Age 12-29	Age ≥ 50	Transgender Clients	Women of Color	Latinx MSM	Black MSM	PWID	Unhoused ≤12m
SUD Residential (n=84)	10%	17%	8%	1%	38%	19%	14%	55%
HBCM (n=120)	-	87%	-	13%	20%	8%	4%	2%
MH Services (n=151)	13%	17%	5%	7%	58%	11%	-	7%
Housing Services (n=270)	9%	45%	6%	13%	37%	15%	7%	45%
EFA (n=617)	5%	51%	2%	11%	28%	24%	5%	7%
Nutrition Support (n=2,461)	3%	64%	4%	11%	35%	13%	6%	14%
AOM (n=3,604)	13%	21%	3%	7%	54%	8%	2%	6%
Oral Health (n=4,332)	3%	58%	3%	11%	43%	11%	4%	6%
NMCM (n=6,553)	10%	43%	2%	9%	40%	13%	4%	7%
MCC (n=6,942)	12%	34%	5%	6%	39%	18%	5%	17%

- Engagement[a], retention in care[b] and viral load suppression[c] percentages were higher for RWP clients compared to PLWH in LAC, Year 33.

- RWP overall did not meet the EHE target of 95% for viral suppression or local targets for engagement and retention in care (95%).

Chart legend: ■ PLWH in LAC*   ■ RWP clients**

	PLWH in LAC*	RWP clients**
Engaged in HIV Care	69%	95%
Retained in HIV Care	48%	75%
Suppressed Viral Load	61%	85%

— 95% Target

[a]**Engagement in Care** defined as 1 ≥ viral load, CD4 or genotype test reported in the 12-month period based on HIV laboratory data as of 5/8/2024

[b]**Retention in care** defined as 2 ≥ viral load, CD4 or genotype test reported >30 days apart in the 12-month period based on HIV laboratory data as of 5/8/2024

[c]**Viral suppression** defined as most recent viral load test <200 copies/mL in the 12-month period based on HIV laboratory data as of 5/8/2024

* Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022. http://publichealth.lacounty.gov/dhsp/Reports/HIV/Annual_HIV_Surveillance_Report_2022_LAC_Final.pdf

** Data source: HIV Casewatch as of 5/2/2024

- RWP clients **aged 50 and older had the highest engagement, retention in care and viral suppression**.

- RWP clients **experiencing homelessness had the lowest engagement and retention in care and viral suppression.**

- RWP clients **aged 50 and older, Latinx MSM and Women of color met the target of 95% for engagement in care.**

- None of other LAC priority populations met the EHE or local targets for HCC outcomes.

Priority Population	No.	% of RWHAP Population	Engaged in Care	Retained in Care	Virally Suppressed
50 years of age or older	6,872	43%	**96%**	**81%**	**89%**
Latinx MSMc	5,790	36%	**96%**	77%	87%
Women of color	1,663	10%	**95%**	76%	85%
Transgender Personsb	535	3%	95%	76%	79%
Youth (29 years and younger)	1,539	10%	94%	64%	79%
Black MSMc	2,105	13%	94%	68%	79%
Persons Who Inject Drugs (PWID)	660	4%	93%	74%	82%
People experiencing homelessness	1,668	11%	**91%**	**64%**	**72%**

[a]Limited to membership in two priority populations; a client could be in more than two priority populations as population definitions are not mutually exclusive
[b]Includes 497 transgender women and 38 transgender men
[c]MSM defined as PLWH who reported male sex at birth, sex with men as primary HIV risk category and non-White race/ethnicity

Viral Suppression among RWP and by Service Category, Year 33 (N=15,882)

- Among RWP clients, **85% were virally suppressed**

- **Neither** the RWP overall **nor any** of the service categories **met the EHE viral suppression target of 95%**

RWP Core Services	Viral Load Suppression
Oral Health Care	93%
Mental Health Services	90%
Outpatient/Ambulatory Medical Care	89%
Home and Community-Based Case Management	84%
Medical Case Management	79%
RWP Support Services	
Substance Abuse Services Residential	92%
Emergency Financial Assistance (EFA)	90%
NMCM Benefits Specialty	90%
Housing Services (RCFCI)	88%
Food Bank	85%
Delivered Meals	85%
Housing Services (TRCF)	83%
Permanent Supportive Housing (H4H)	83%
NMCM Transitional Jail	78%
Outreach	73%

95% EHE target

Expenditures

- Expenditures by Funding Source

- Expenditures by Service Category

- Expenditures per Client
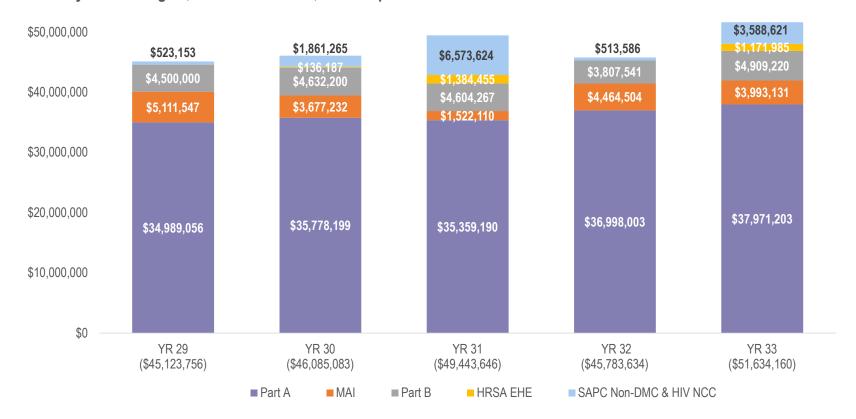
RWP Expenditures by Source of Funding, Years 29-33
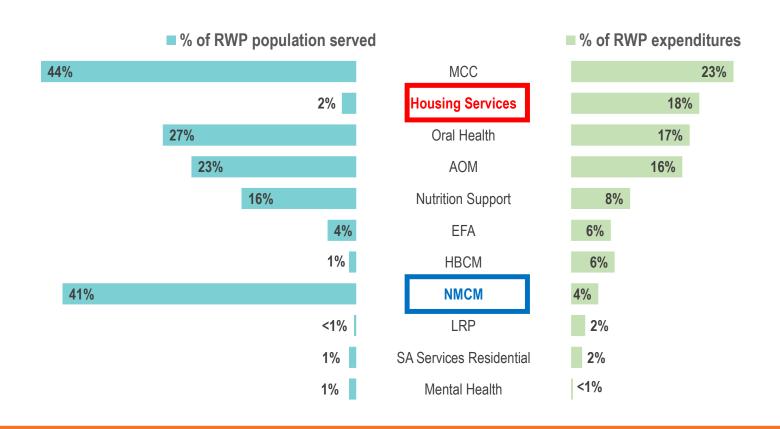
Total expenditures increased: Part A expenditures gradually increased, MAI expenditures varied due to carryover strategies, Part B was stable, other expenditures varied.

	Part A	MAI	Part B	HRSA EHE	SAPC Non-DMC & HIV NCC
YR 29 ($45,123,756)	$34,989,056	$5,111,547	$4,500,000		$523,153
YR 30 ($46,085,083)	$35,778,199	$3,677,232	$4,632,200	$136,187	$1,861,265
YR 31 ($49,443,646)	$35,359,190	$1,522,110	$4,604,267	$1,384,455	$6,573,624
YR 32 ($45,783,634)	$36,998,003	$4,464,504	$3,807,541		$513,586
YR 33 ($51,634,160)	$37,971,203	$3,993,131	$4,909,220	$1,171,985	$3,588,621

The costliest RWP service category compared to the percent of RWP population served was **Housing;** the least costly service was **NMCM.**

RWP Population Served vs Total Expenditures, Year 33

	% of RWP population served		% of RWP expenditures
MCC	44%		23%
Housing Services	2%		18%
Oral Health	27%		17%
AOM	23%		16%
Nutrition Support	16%		8%
EFA	4%		6%
HBCM	1%		6%
NMCM	41%		4%
LRP	<1%		2%
SA Services Residential	1%		2%
Mental Health	1%		<1%

RWP Service Category Expenditures, Year 33

- **The highest expenditures per client** were spent **for Housing Services**, followed by HBCM and LRP.
- **The lowest expenditures per client** were spent for **NMCM, Mental Health and MCC.**

Service Category	Number of clients	Expenditures YR 33	Expenditures per client YR 33
Housing Services	270	$8,440,602	***$31,261***
Home-Based Case Management	120	$2,866,908	*$23,891*
Linkage Re-Engagement Program	40	$923,044	*$23,076*
Substance Abuse Services Residential - Transitional	84	$725,000	*$8,631*
Emergency Financial Assistance	617	$2,614,115	*$4,237*
Medical Outpatient	3,604	$7,322,339	*$2,032*
Oral Health	4,332	$7,805,282	*$1,802*
Nutrition Support	2,461	$3,882,464	*$1,578*
Medical Care Coordination	6,942	$10,688,014	*$1,540*
Mental Health	151	$109,422	*$725*
Non-Medical Case Management	6,553	$1,787,095	***$273***

- **Utilization of RWP services remains consistent** across community-based agencies

- Most of RWP clients are **male, Latinx, aged 50 and older, English-speakers, living at or below FPL, with public health insurance, with permanent housing and without incarceration history**

- The RWP is **reaching and serving LAC priority populations**

- Service utilization among LAC priority populations is consistent relative to their size with the **highest among RWP clients aged 50 and older, Latinx MSM and Black MSM.**

- While poverty impacts all of the LAC priority populations, they are **differentially impacted by SDOH**:

  o The majority of RWP clients from each priority population lived at or below FPL.

  o High percentage of priority populations were Spanish-speakers and uninsured.

  o Recent incarceration (≤24m), drug use and unstable housing were more prevalent among RWP clients aged 13-29, unhoused and PWID.

Key Takeaways - Expenditures

- **Part A expenditures gradually increased, MAI expenditures varied, and Part B was stable over 5 years.** The percentage of expenditures from other sources increased over the years.

- Although **Housing served one of the lowest percentage of RWP clients**, it had the highest expenditures per client.

- Although **NMCM and MCC served the largest percentage of RWP clients, per client expenditures for NMCM and MCC were the lowest.**

- Present to SMT and COH on two major service clusters
  - o Core Services (AOM, MCC, Oral Health, HBCM, Mental Health)
  - o Support Services (EFA, Housing, NMCM, Nutrition Support, LRP, Substance Use Residential)

- Examine detailed utilization of RWP services within each LAC priority populations

- Examine RWP by priority population over time

Questions/Discussion

Thank you!

- **Acknowledgements**

  - Monitoring and Evaluation – Wendy Garland, Siri Chirumamilla

  - PDR – Victor Scott, Michael Green

  - Surveillance – Virginia Hu, Kathleen Poortinga

  - CCS – Paulina Zamudio and the RWP program managers

  - RWP agencies and providers

  - RWP clients

Ryan White Program Utilization Summary, Year 33: Core Services (March 1, 2023-February 2024)

Sona Oksuzyan, Supervising Epidemiologist
Janet Cuanas, Research Analyst III
Monitoring and Evaluation Unit
Division of HIV and STD Programs

April 15, 2025
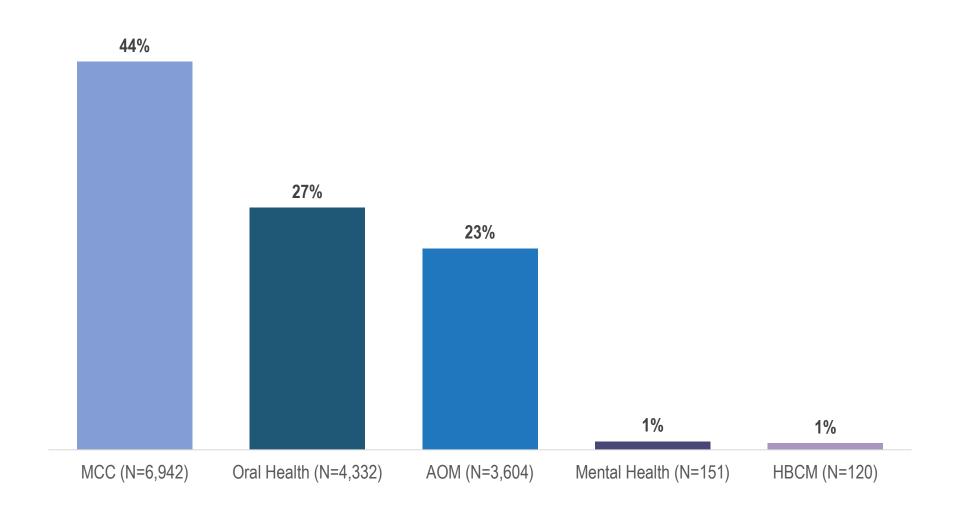
RWP Core Services

- Ambulatory Medical Outpatient (AOM)

- Medical Care Coordination (MCC)

- Oral Health

- Home-Based Care Management (HBCM)

- Mental Health

COUNTY OF LOS ANGELES
Public Health

MCC, Oral Health, and AOM were the most highly used core services in Year 33.

Ambulatory Medical Outpatient (AOM)

Provides primary medical care, HIV medication management, laboratory testing, counseling, nutrition education, case management, support groups, and access to specialized HIV treatment options at 18 contracted sites.

- A total of **3,604 unique clients** received AOM services (Year 32 at 3,478, Year 31 at 5,351)

- AOM clients represented almost a quarter (**23%) of RWP clients**

COUNTY OF LOS ANGELES
Public Health

Utilization of AOM clients, Year 33

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
AOM	**3,604**	**Visits**	**9,733**	**3**	**$7,479,143**	**$2,075**
Medical Outpatient	3,604	Visits	9,733	3	$4,510,048	$1,251
Supplemental AOM Procedures	3,211	Procedures	64,156	20	$2,526,186	$787
Medical Subspecialty*					$442,909	

Funding Source:
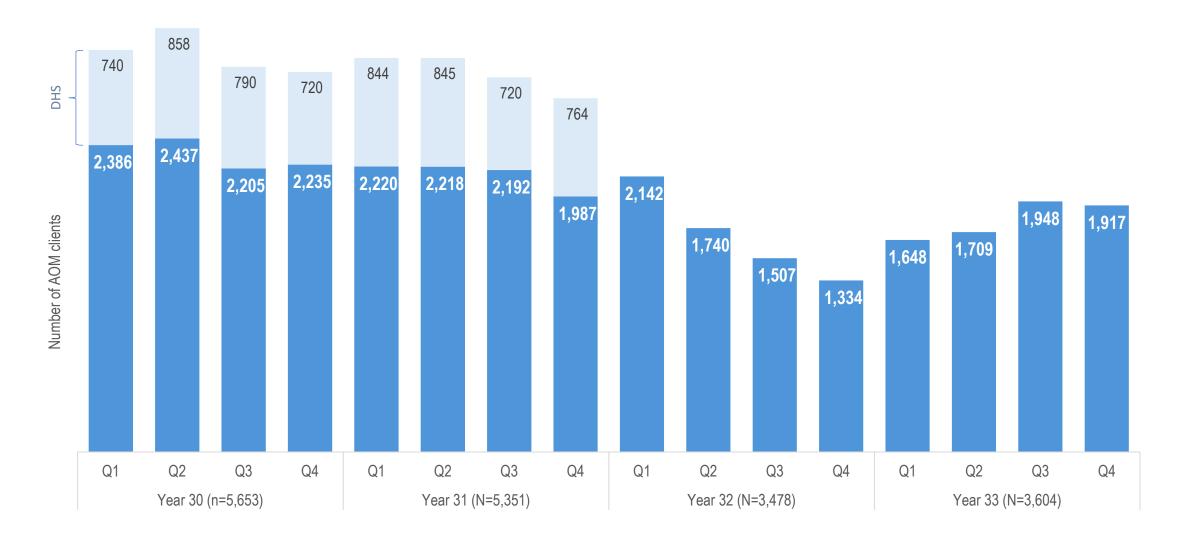
- *Part A - $6,564,101*

- *HIV NCC - $915,042*

*No data in CaseWatch

AOM utilization decreased over three years (Medi-Cal expansion) with the lowest in Year 32 but went slightly up in Year 33.
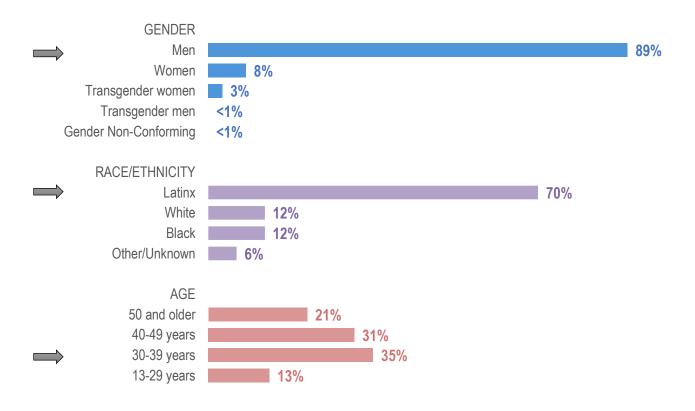
Quarterly AOM Utilization at Department of Health Services (DHS) and non-DHS Agencies, Years 30-33

DHS

Number of AOM clients

	Q1	Q2	Q3	Q4
DHS (Year 30)	740	858	790	720
non-DHS (Year 30)	2,386	2,437	2,205	2,235

Year 30 (n=5,653)

	Q1	Q2	Q3	Q4
DHS (Year 31)	844	845	720	764
non-DHS (Year 31)	2,220	2,218	2,192	1,987

Year 31 (N=5,351)

	Q1	Q2	Q3	Q4
non-DHS (Year 32)	2,142	1,740	1,507	1,334

Year 32 (N=3,478)

	Q1	Q2	Q3	Q4
non-DHS (Year 33)	1,648	1,709	1,948	1,917

Year 33 (N=3,604)

AOM Demographics
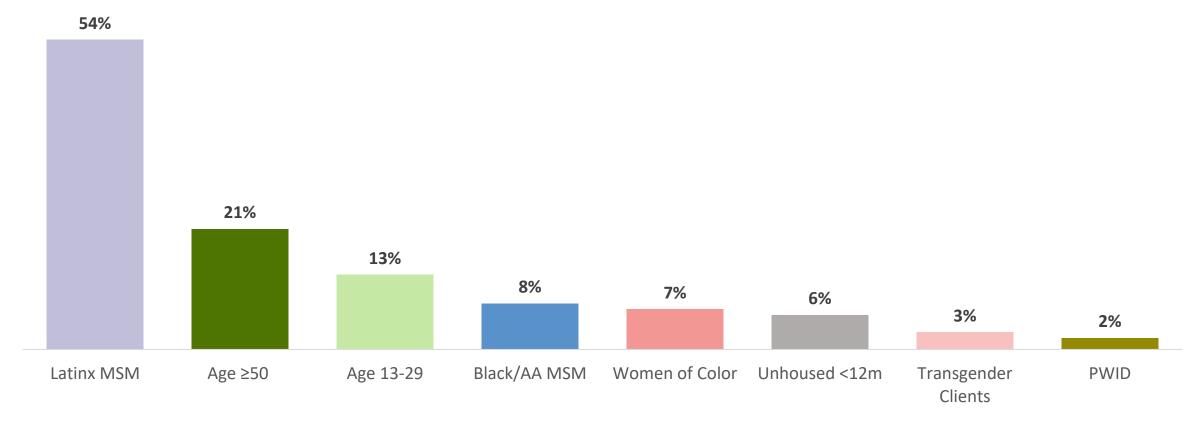
AOM Client Demographics, Year 33 (N=3,604)

GENDER
- Men — 89%
- Women — 8%
- Transgender women — 3%
- Transgender men — <1%
- Gender Non-Conforming — <1%

RACE/ETHNICITY
- Latinx — 70%
- White — 12%
- Black — 12%
- Other/Unknown — 6%

AGE
- 50 and older — 21%
- 40-49 years — 31%
- 30-39 years — 35%
- 13-29 years — 13%
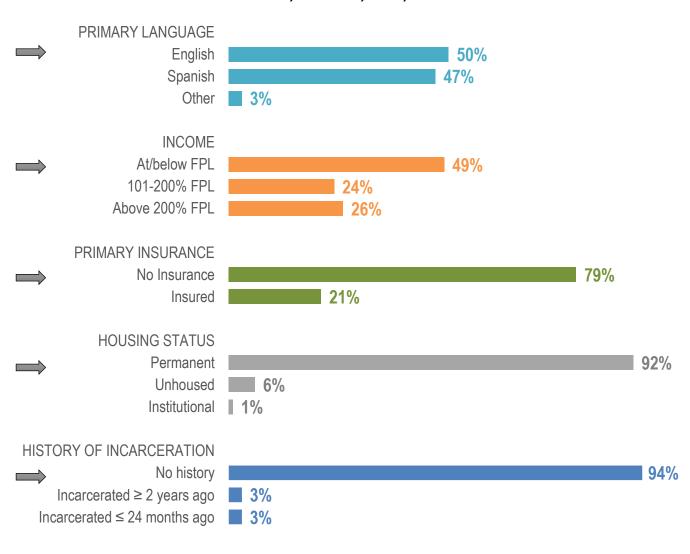
Half of AOM clients spoke English; half lived ≤ FPL; most had no insurance; most were permanently housed; most had no history of incarceration.

AOM Client Health Determinants, Year 33, N=3,604

PRIMARY LANGUAGE
- English — 50%
- Spanish — 47%
- Other — 3%

INCOME
- At/below FPL — 49%
- 101-200% FPL — 24%
- Above 200% FPL — 26%

PRIMARY INSURANCE
- No Insurance — 79%
- Insured — 21%

HOUSING STATUS
- Permanent — 92%
- Unhoused — 6%
- Institutional — 1%

HISTORY OF INCARCERATION
- No history — 94%
- Incarcerated ≥ 2 years ago — 3%
- Incarcerated ≤ 24 months ago — 3%
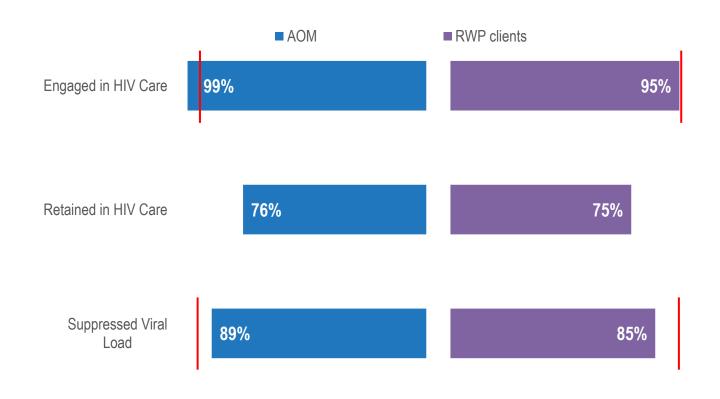
HIV Care Continuum in AOM clients, Year 33 (N=3,604)

- Engagement, retention in care, and viral load suppression percentages were higher for AOM clients compared to RWP clients overall, Year 33.

- AOM clients did not meet the EHE target of 95% for viral suppression. However, they met the local target of 95% for engagement in care.

■ AOM   ■ RWP clients

Engaged in HIV Care   99%   95%

Retained in HIV Care   76%   75%

Suppressed Viral Load   89%   85%

—— 95% Target

Data source: HIV Casewatch as of 5/2/2024

Medical Care Coordination (MCC)

An integrated service model to respond to patients' unmet medical and non-medical needs through coordinated case management activities to support continuous engagement in care and adherence to ART offered at 18 contracted sites.

A total of **6,942 unique clients** received MCC services, which is a decline from Year 31 at 8,244 and Year 32 at 7,036.

MCC clients represented **44% of RWP clients** in Year 33.

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
MCC	6,942	Hours	97,771	14	$10,687,814	$1,540
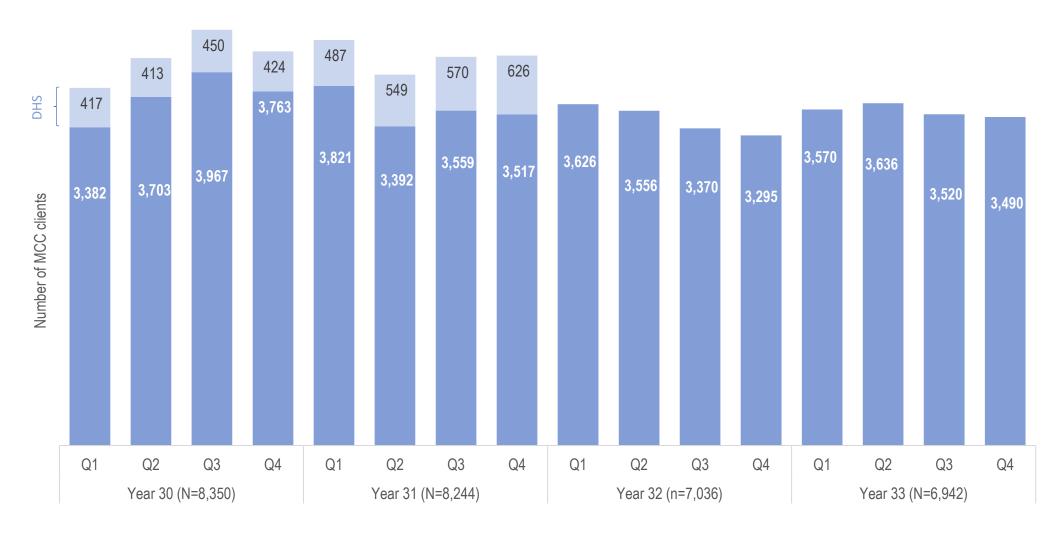
Funding Source:

- *Part A - $9,064,884*

- *HRSA EHE - $722,354*

- *HIV NCC - $900,576*

Number of clients declined over the four years from Year 30 to Year 33. However, MCC utilization continued to be stable over four years.
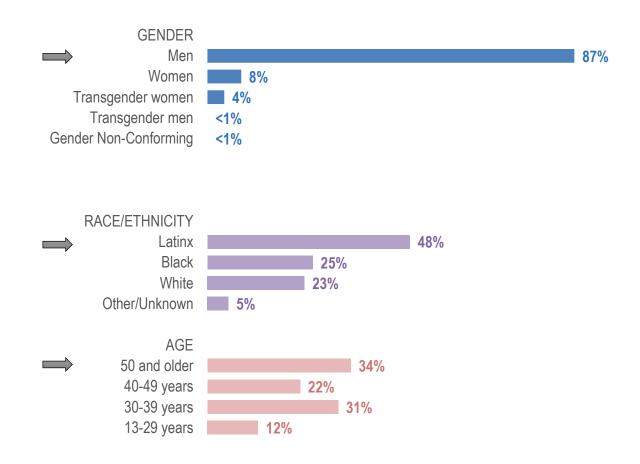
Quarterly MCC Utilization at DHS and non-DHS Agencies, Years 30-33
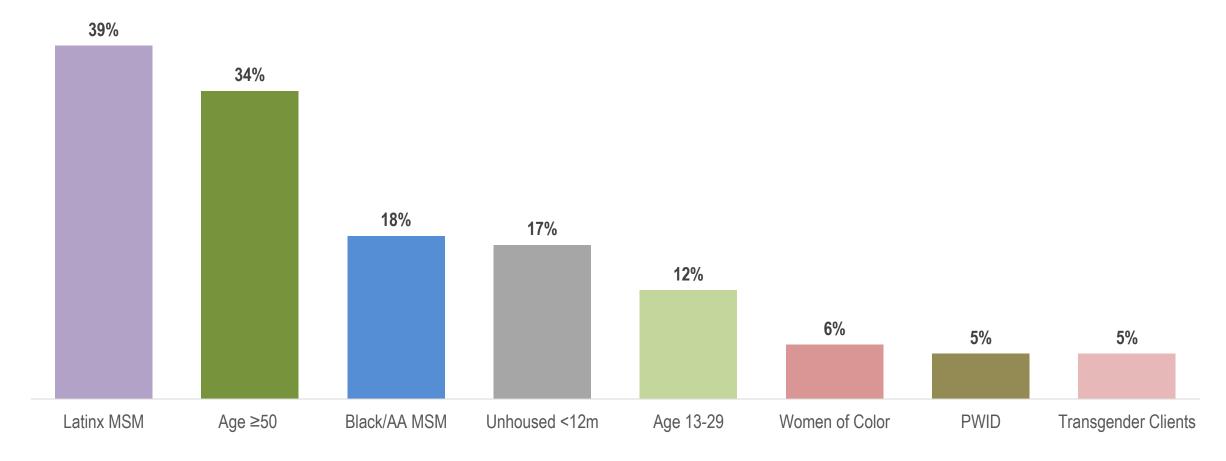
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
DHS	417	413	450	424	487	549	570	626								
non-DHS	3,382	3,703	3,967	3,763	3,821	3,392	3,559	3,517	3,626	3,556	3,370	3,295	3,570	3,636	3,520	3,490

Year 30 (N=8,350)   Year 31 (N=8,244)   Year 32 (n=7,036)   Year 33 (N=6,942)

Number of MCC clients

MCC Client Demographics

MCC Client Demographics, Year 33 (N=6,942)

GENDER
- Men — 87%
- Women — 8%
- Transgender women — 4%
- Transgender men — <1%
- Gender Non-Conforming — <1%

RACE/ETHNICITY
- Latinx — 48%
- Black — 25%
- White — 23%
- Other/Unknown — 5%

AGE
- 50 and older — 34%
- 40-49 years — 22%
- 30-39 years — 31%
- 13-29 years — 12%
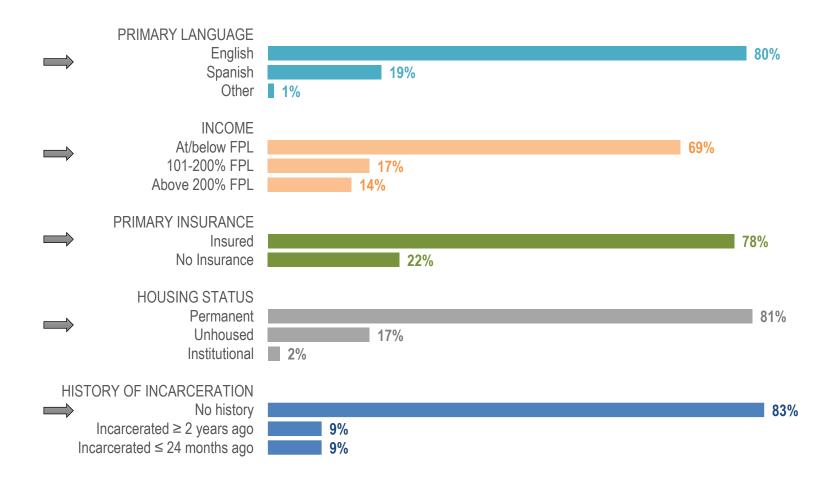
Most of MCC clients spoke English; most lived ≤ FPL; most were insured; most were permanently housed; most had no history of incarceration.

MCC Client Health Determinants, Year 33, N=6,942

PRIMARY LANGUAGE
- English — 80%
- Spanish — 19%
- Other — 1%

INCOME
- At/below FPL — 69%
- 101-200% FPL — 17%
- Above 200% FPL — 14%

PRIMARY INSURANCE
- Insured — 78%
- No Insurance — 22%

HOUSING STATUS
- Permanent — 81%
- Unhoused — 17%
- Institutional — 2%

HISTORY OF INCARCERATION
- No history — 83%
- Incarcerated ≥ 2 years ago — 9%
- Incarcerated ≤ 24 months ago — 9%

- Engagement, retention, and viral load suppression percentages were lower for MCC clients compared to RWP clients overall, Year 33.

- MCC clients did not meet the EHE targets.

	MCC	RWP clients
Engaged in HIV Care	92%	95%
Retained in HIV Care	67%	75%
Suppressed Viral Load	79%	85%

— 95% Target

Data source: HIV Casewatch as of 5/2/2024

Oral Health Care (OH)

Provides routine, comprehensive oral health care, including prevention, treatment, counseling, and education at 12 contracted sites.

A total of **4,332 unique clients** received **Oral Health Care** services, which is a steady increase from Year 31 at 4,145 and Year 32 at 4,270.

- *General Oral Health* services were provided to **4,064** clients.
- *Specialty Oral Health* services were provided to **999** clients.

Oral Health Care clients represented **27% of RWP clients.**

COUNTY OF LOS ANGELES
Public Health

Utilization of Oral Health clients, Year 33

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
Oral Health	**4,332**	**Procedures**	**47,235**	**11**	**$7,805,232**	**$1,802**
General	4,064	Procedures	42,309	10	$5,752,477	$1415 $136 per procedure
Specialty	999	Procedures	4,926	5	$2,052,755	$2,055 $417 per procedure
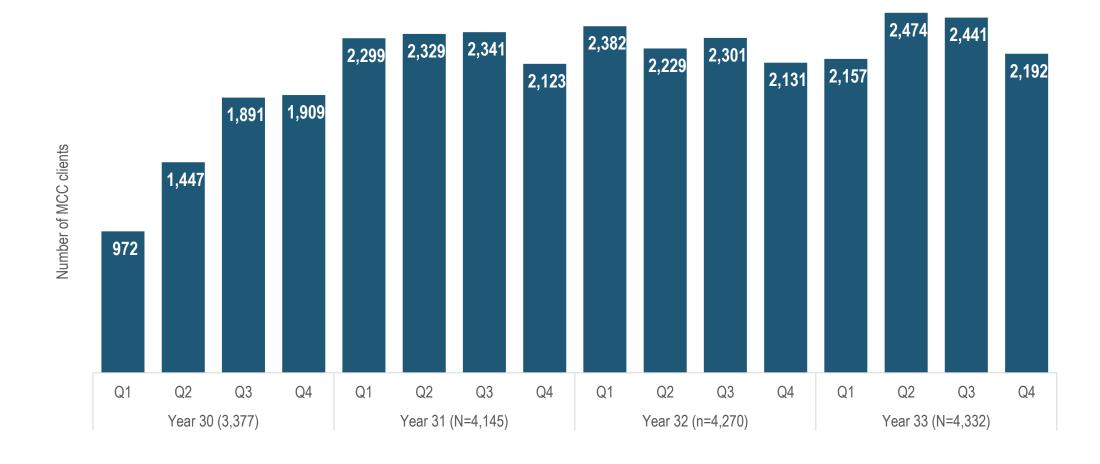
Funding Source:

- *Part A - $7,188,736*

- *HIV NCC - $616,496*

After a drop in the number of Oral Health Care clients due to COVID-19 pandemic, utilization of OHC services gradually increased, reaching the highest numbers in Year 33, Q2 and Q3 in particular.
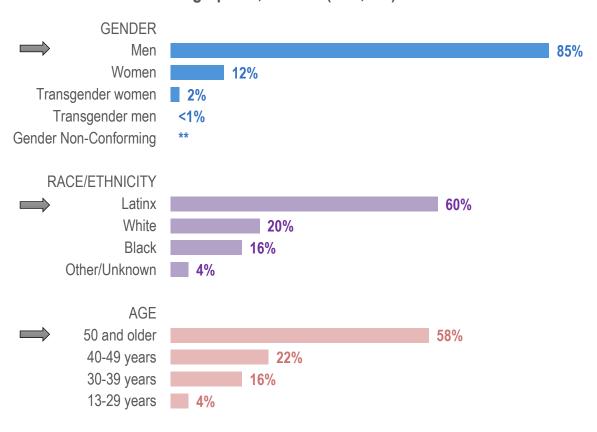
Quarterly Oral Health Care Utilization, Years 30-33

Oral Health Care Client Demographics

Oral Health Client Demographics, Year 33 (N=4,332)

GENDER
- Men — 85%
- Women — 12%
- Transgender women — 2%
- Transgender men — <1%
- Gender Non-Conforming — **

RACE/ETHNICITY
- Latinx — 60%
- White — 20%
- Black — 16%
- Other/Unknown — 4%

AGE
- 50 and older — 58%
- 40-49 years — 22%
- 30-39 years — 16%
- 13-29 years — 4%
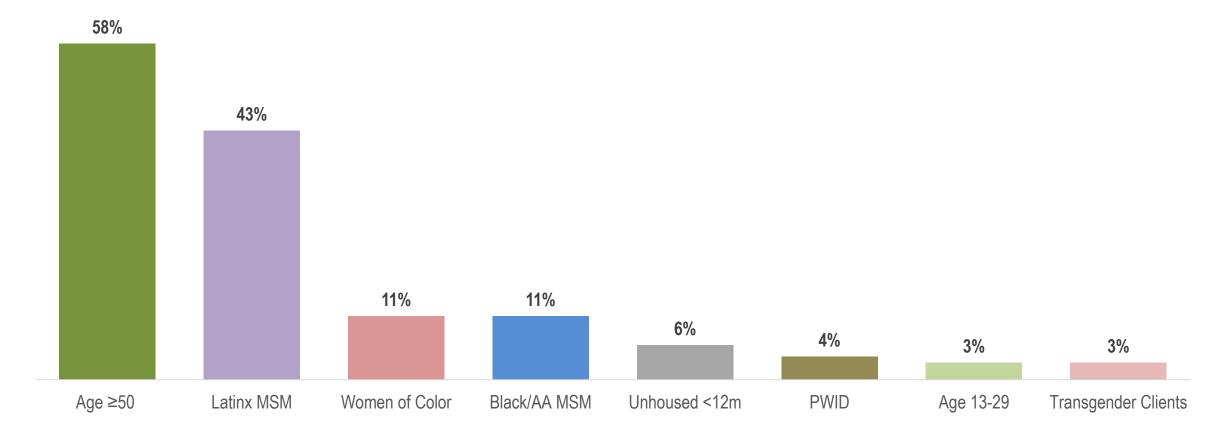
LAC Priority Populations Accessing the Oral Health Services*, Year 33
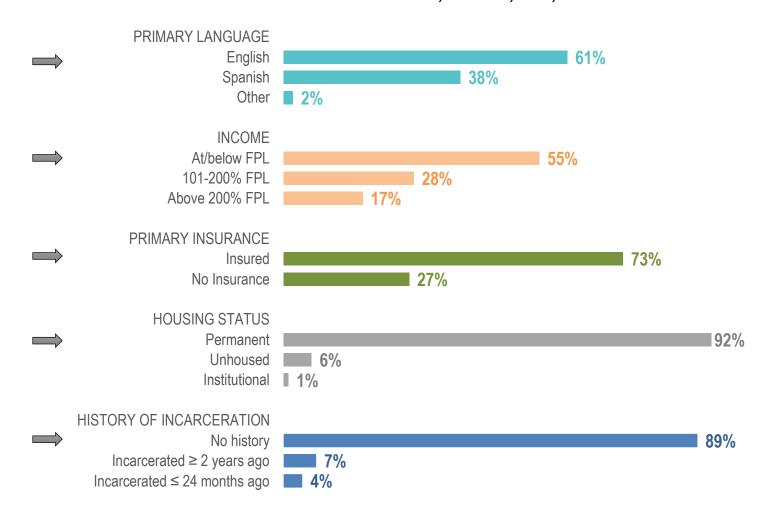
- **Clients aged ≥ 50** represented the largest percentage of Oral Health clients
- **Latinx MSM clients** were the next highest served by Oral Health
- Percentages for General and Specialty Oral Care look similar

Age ≥50	Latinx MSM	Women of Color	Black/AA MSM	Unhoused <12m	PWID	Age 13-29	Transgender Clients
58%	43%	11%	11%	6%	4%	3%	3%

*Priority population groups are not mutually exclusive, they overlap.

Most Oral Health Care clients were English-speakers; most lived ≤ FPL, most were insured; most were permanently housed; most had no history of incarceration.

Oral Health Care Client Health Determinants, Year 33, N=4,332

PRIMARY LANGUAGE
- English — 61%
- Spanish — 38%
- Other — 2%

INCOME
- At/below FPL — 55%
- 101-200% FPL — 28%
- Above 200% FPL — 17%

PRIMARY INSURANCE
- Insured — 73%
- No Insurance — 27%

HOUSING STATUS
- Permanent — 92%
- Unhoused — 6%
- Institutional — 1%

HISTORY OF INCARCERATION
- No history — 89%
- Incarcerated ≥ 2 years ago — 7%
- Incarcerated ≤ 24 months ago — 4%

HIV Care Continuum in Oral Health clients, Year 33, N=4,332

- Engagement, retention, and viral load suppression percentages were higher for Oral Health clients compared to RWP clients overall, Year 33.

- Oral Health clients did not meet the EHE target of 95% for viral suppression. However, they met the local target of 95% for engagement in care.

Oral Health | RWP clients

	Oral Health	RWP clients
Engaged in HIV Care	98%	95%
Retained in HIV Care	89%	75%
Suppressed Viral Load	93%	85%

—— 95% Target

Data source: HIV Casewatch as of 5/2/2024

Home-Based Case Management (HBCM)

Provides client-centered case management and social work activities, focusing on care for PLWH who are functionally impaired and require intensive home and/or community-based care offered at 5 contracted sites.

A total of **120 unique clients** received **HBCM** services, a decline from Year 31 at 151 and Year 32 at 138.

- Attendant Care – 9 clients
- Case Management – 120 clients
- Equipment – 4 clients
- Homemaker services – 69 clients
- Nutrition services – 34 clients
- Psychotherapy – 36 clients

HBCM clients represented **<1% of RWP clients.**

COUNTY OF LOS ANGELES
Public Health

Utilization of HBCM clients, Year 33

- Homemaker subservice had the highest total units served and the highest units per client
- Case management had the highest total and per client expenditures

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
HBCM	**120**	**Various**	**43,840**	**365**	**$2,866,908**	**$23,891**
Attendant Care	9	*Hours*	3,305	367	*$92,976*	*$10,331*
Case Management	120	*Hours*	6,925	58	*$1,620,056*	*$13,500*
Durable Medical Equipment	4	*Medical Equipment*	7	2	*$546*	*$137*
Homemaker	69	*Hours*	25,871	375	*$813,621*	*$11,792*
Nutrition	34	*Nutritional Supplements*	6,811	200	*$9,451*	*$278*
Psychotherapy CM	36	*Hours*	920	26	*$97,251*	*$2,701*
Administrative costs*	120				*$233,007*	*$1,942*

Funding Source:
- *Part A - $2,614,732*
- *HIV NCC - $252,176*
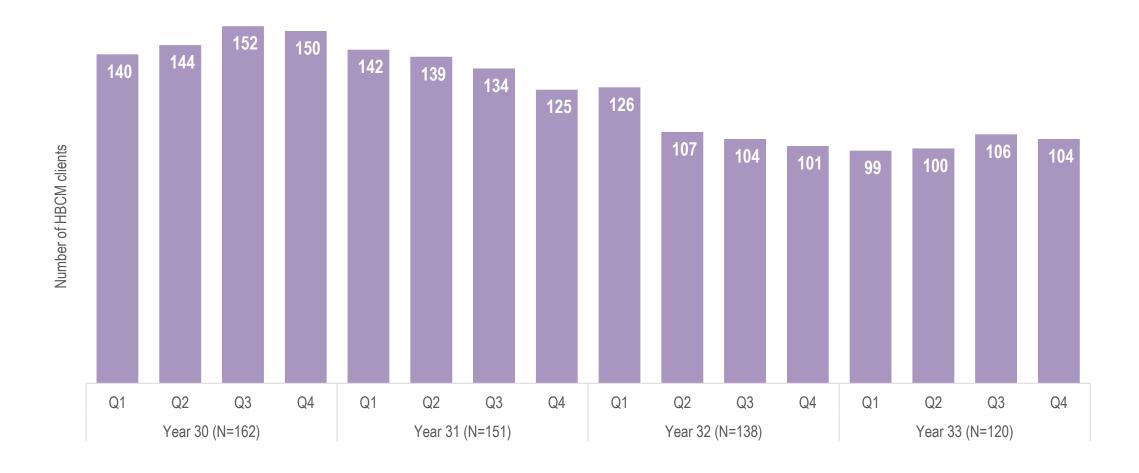
* No information in CaseWatch; we distributed Administrative costs to all HBCM clients
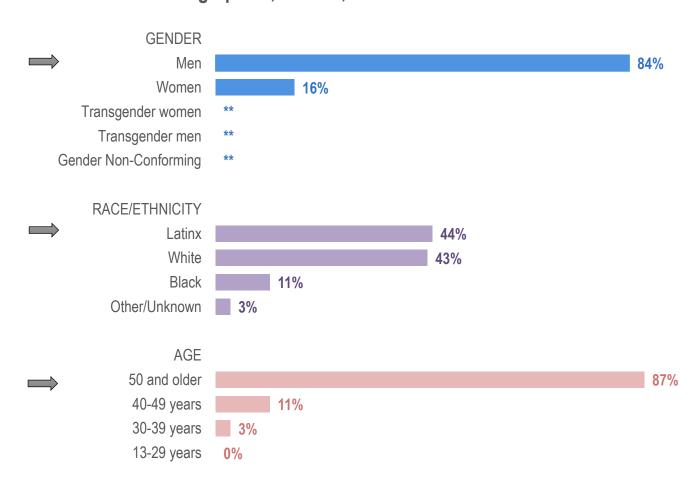
HBCM Client Demographics

HBCM Client Demographics, Year 33, N=120

GENDER
- Men — 84%
- Women — 16%
- Transgender women — **
- Transgender men — **
- Gender Non-Conforming — **

RACE/ETHNICITY
- Latinx — 44%
- White — 43%
- Black — 11%
- Other/Unknown — 3%

AGE
- 50 and older — 87%
- 40-49 years — 11%
- 30-39 years — 3%
- 13-29 years — 0%
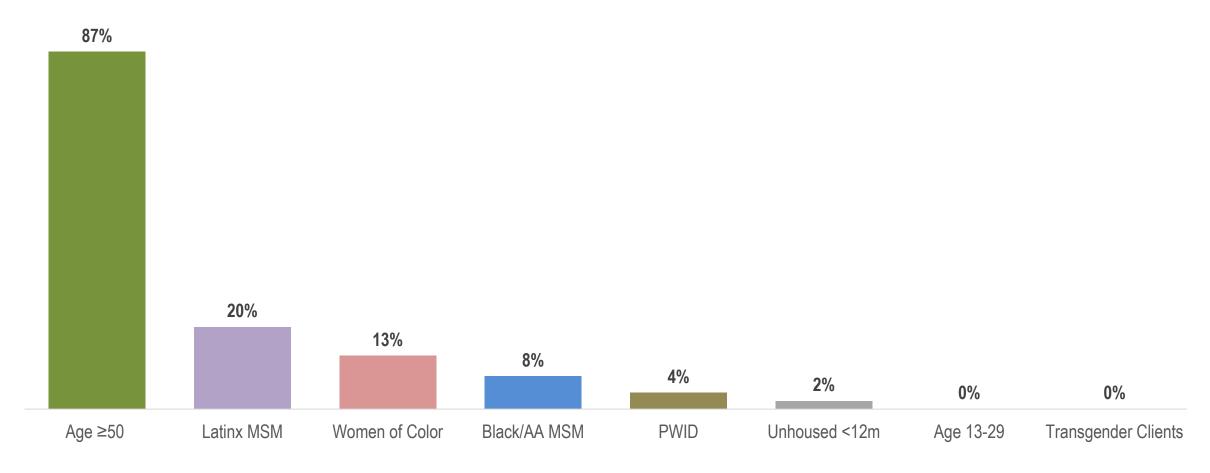
LAC Priority Populations Accessing HBCM Services*, Year 33
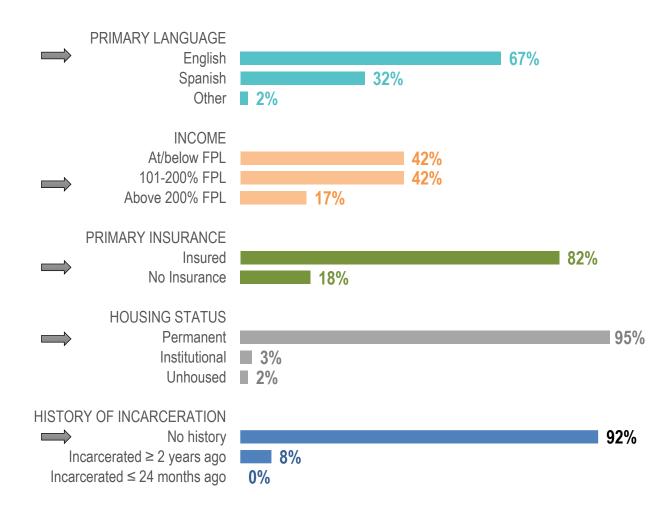
- **Clients age ≥ 50** represented the majority of HBCM clients
- **Latinx MSM clients** were the next highest served by HBCM

Age ≥50	Latinx MSM	Women of Color	Black/AA MSM	PWID	Unhoused <12m	Age 13-29	Transgender Clients
87%	20%	13%	8%	4%	2%	0%	0%

*Priority population groups are not mutually exclusive, they overlap.

Most HBCM Client were English-speakers; most lived above FPL; most were insured; most had permanent housing; most had no history of incarceration.

HBCM Client Health Determinants, Year 33, N=120

PRIMARY LANGUAGE
- English — 67%
- Spanish — 32%
- Other — 2%

INCOME
- At/below FPL — 42%
- 101-200% FPL — 42%
- Above 200% FPL — 17%

PRIMARY INSURANCE
- Insured — 82%
- No Insurance — 18%

HOUSING STATUS
- Permanent — 95%
- Institutional — 3%
- Unhoused — 2%

HISTORY OF INCARCERATION
- No history — 92%
- Incarcerated ≥ 2 years ago — 8%
- Incarcerated ≤ 24 months ago — 0%

HIV Care Continuum in HBCM clients, Year 33 (N=120)

- Engagement and viral load suppression percentages were lower for HBCM clients compared to RWP clients overall, Year 33.

- Retention in care was higher among HBCM clients than RWP clients overall in Year 33.

- HBCM clients did not meet the EHE targets for any of the HCC measures.

■ HBCM   ■ RWP clients

Engaged in HIV Care: HBCM 93% | RWP clients 95%

Retained in HIV Care: HBCM 81% | RWP clients 75%

Suppressed Viral Load: HBCM 84% | RWP clients 85%

— **95% Target**

Data source: HIV Casewatch as of 5/2/2024

Mental Health (MH) Services

Provides mental health (MH) assessment, treatment planning and provision at 7 contracted sites.

A total of **151 unique clients** received **Mental Health** services, a decline from Year 31 at 331 and Year 32 at 224 .

MH service clients represented **<1% of RWP clients.**

Service Category	Unique Clients Served	Service Unit(s)	Total Service Units	Units Per Client	Expenditures	Expenditures per client
Mental Health	151	Sessions	766	5	$109,422	$725

Funding Source:

- *Part A - $109,422*

Utilization of MH services decreased over 4 years, reaching the lowest in Year 33.
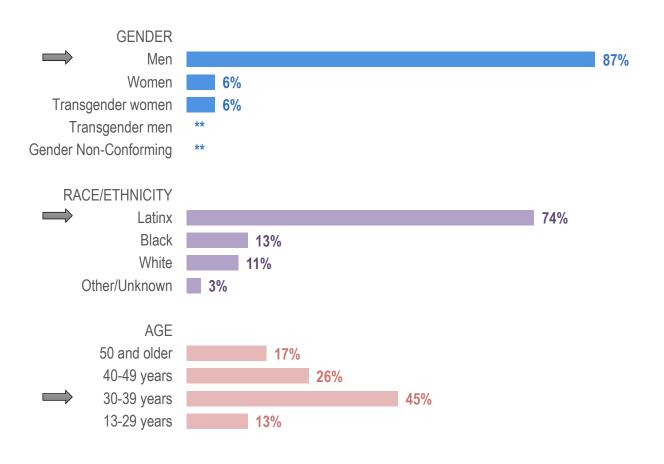
Quarterly MH Serices Utilization at DHS and non-DHS Agencies, Year 30-33
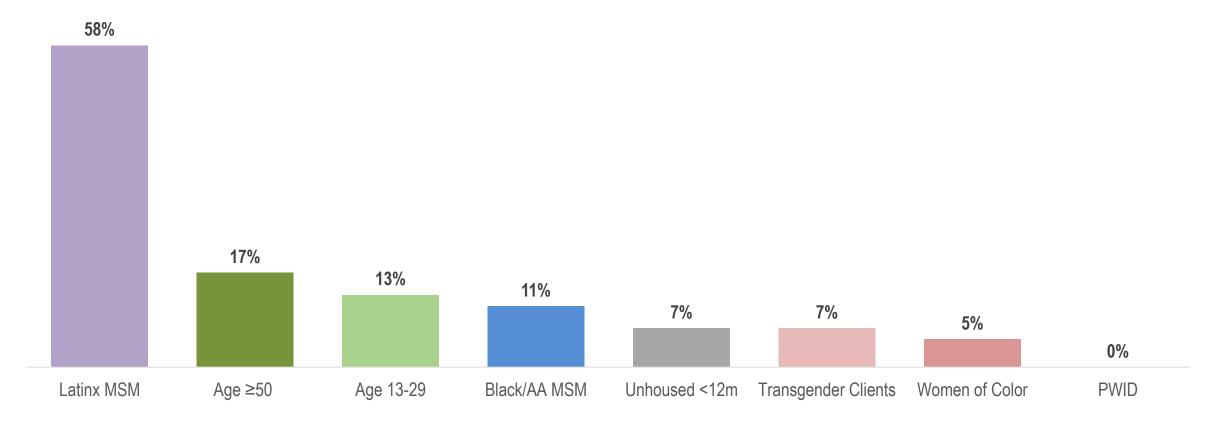
DHS

Number of Mental Health clients

	Q1	Q2	Q3	Q4
Year 30 (N=312)	126 / 17	151 / 20	148 / 18	131 / 17
Year 31 (N=331)	142 / 18	162 / 19	155 / 15	116 / 17
Year 32 (N=224)	127	96	98	67
Year 33 (N=151)	69	63	63	49

Mental Health Client Demographics

Mental Health Client Demographics, Year 33, N=151
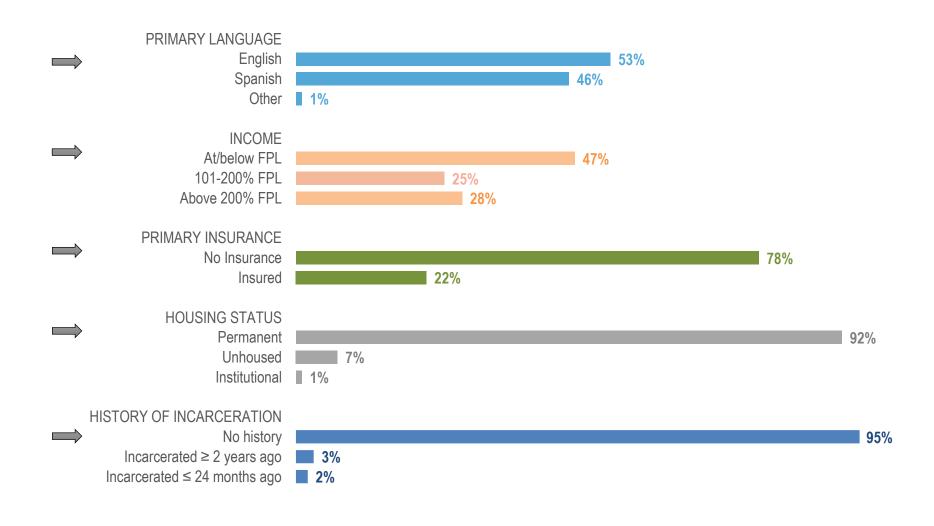
GENDER
- Men — 87%
- Women — 6%
- Transgender women — 6%
- Transgender men — **
- Gender Non-Conforming — **

RACE/ETHNICITY
- Latinx — 74%
- Black — 13%
- White — 11%
- Other/Unknown — 3%

AGE
- 50 and older — 17%
- 40-49 years — 26%
- 30-39 years — 45%
- 13-29 years — 13%

Most Mental Health clients were English speakers; most lived above FPL; most were uninsured; most were permanently housed; most had no history of incarceration.

Mental Health Client Health Determinants, Year 33, N=151

PRIMARY LANGUAGE
- English — 53%
- Spanish — 46%
- Other — 1%

INCOME
- At/below FPL — 47%
- 101-200% FPL — 25%
- Above 200% FPL — 28%

PRIMARY INSURANCE
- No Insurance — 78%
- Insured — 22%

HOUSING STATUS
- Permanent — 92%
- Unhoused — 7%
- Institutional — 1%

HISTORY OF INCARCERATION
- No history — 95%
- Incarcerated ≥ 2 years ago — 3%
- Incarcerated ≤ 24 months ago — 2%

HIV Care Continuum in Mental Health clients, Year 33 (N=151)

- Engagement, retention, and viral load suppression percentages were higher for Mental Health clients compared to RWP clients overall, Year 33.

- Mental Health clients did not meet the EHE target of 95% for viral suppression. However, they met the local target of 95% for engagement in care.

Mental Health   RWP clients

Engaged in HIV Care — Mental Health 98% / RWP clients 95%

Retained in HIV Care — Mental Health 83% / RWP clients 75%

Suppressed Viral Load — Mental Health 90% / RWP clients 85%

— 95% Target

Data source: HIV Casewatch as of 5/2/2024

Expenditures for Core RWP Services
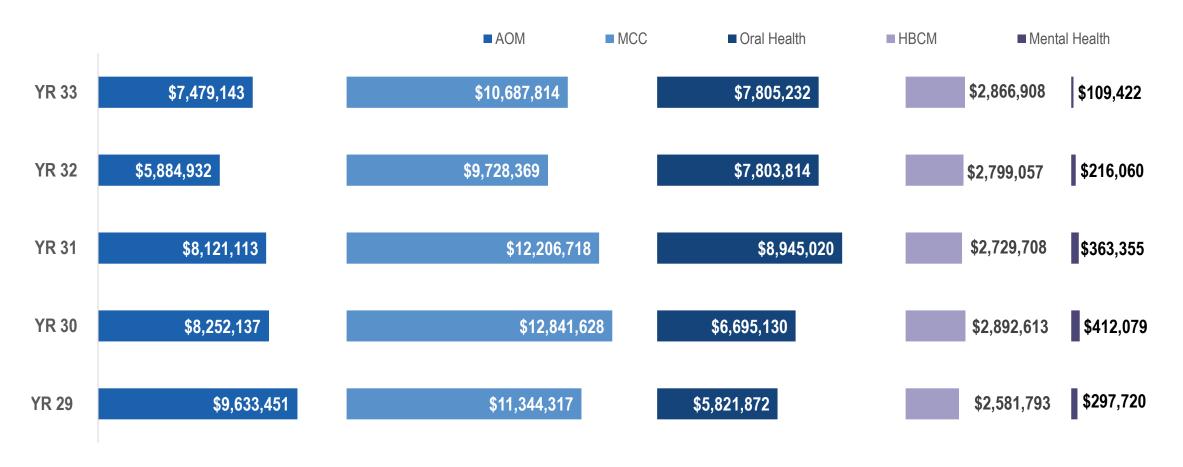
AOM	*$7,479,143*
MCC	*$10,687,814*
Oral Health	*$7,805,232*
HBCM	*$2,866,908*
Mental Health	*$109,422*

Expenditures by Core Service Category, Years 29-33

AOM, MCC and Mental Health services expenditures generally decreased since Year 29; MH funding was the lowest in Year 33. Expenditures for Oral Health Care services and HBCM gradually increased over five years since Year 29.

	AOM	MCC	Oral Health	HBCM	Mental Health
YR 33	$7,479,143	$10,687,814	$7,805,232	$2,866,908	$109,422
YR 32	$5,884,932	$9,728,369	$7,803,814	$2,799,057	$216,060
YR 31	$8,121,113	$12,206,718	$8,945,020	$2,729,708	$363,355
YR 30	$8,252,137	$12,841,628	$6,695,130	$2,892,613	$412,079
YR 29	$9,633,451	$11,344,317	$5,821,872	$2,581,793	$297,720

Expenditures per Client for Support RWP Services, Year 33

- The **highest expenditures** per client were spent **for Housing**, followed by **LRP** services.

- The **lowest expenditures** per client were spent for **NMCM**, followed by **Nutrition** services.

Service Category	Number of clients	% of RWP clients	Expenditures	% of expenditures	Expenditures per client
MCC	6,942	44%	$10,687,814	21%	$1,540
Oral Health	4,332	27%	$7,805,232	15%	$1,802
AOM	3,604	23%	$7,479,143	14%	$2,075
HBCM	120	1%	$2,866,908	6%	$23,891
Mental Health	151	1%	$109,422	<1%	$725

Key Takeaways

- **MCC** services were utilized by **the highest number of RWP clients in Year 33.** The number of clients dropped in Year 32 due to departure of DHS agencies from RWP. However, **MCC remains the most consistently utilized service** across years.

- Utilization of **HBCM and Mental Health decreased** over the course of the past three years starting from Year 31. **HBCM** services were utilized by **the lowest number of RWP clients**. Mental Health utilization decrease is likely due to lack of MH providers within RWP.

- Utilization of **AOM decreased** over the course of the past three years starting from Year 31; however, it increased slightly in Year 33. Decrease in Year 32 was largely due to departure of DHS agencies from RWP and partially due to expansion of Medi-Cal.

- Utilization of **Oral Health Care services increased** in the past three years after a drop in Year 30 due to COVID-19 pandemic.

- **The RWP is reaching and serving LAC priority populations**

- **The top five RWP services utilized by priority populations** were **MCC**, **Oral Health**, **AOM**, **Benefit Specialty** and **Nutrition Support**.

- **Core services utilization among LAC priority population was consistent relative to their size (larger population − higher utilization):**

  - **Latinx MSM and people aged ≥ 50 and older** were the **highest utilizers** of RWP Core services

    - RWP client aged 50 and older were the highest utilizers of Oral Health and HBCM services

    - Latinx MSM were the highest utilizers of AOM, MCC and MH services

  - **Lowest utilization** of RWP Core services was among **transgender people**, **PWID and youth aged 13-29**, the smallest priority populations.

Key Takeaways - Expenditures

- **AOM**, **MCC and Mental Health** services expenditures **decreased** since Year 29

- Expenditures for **Oral Health Care services and for HBCM gradually increased** since Year 29 along with the number of clients served.

- **HBCM** had the **highest expenditures per client, followed by AOM** likely due to decreased number of clients but some increase in expenditures in the Year 33.

- **Mental Health** had the **lowest expenditures per client, followed by MCC** likely due to significant decrease in the number of clients served by MH services and some decrease in the number of MCC clients along with decreased expenditures.

- Present to SMT and COH on the second of two major service clusters
  - Support Services (EFA, Housing, NMCM, Nutrition Support, LRP, Substance Use Residential)

- Examine detailed utilization of RWP services within each LAC priority populations

- Examine RWP by priority population over time

Questions/Discussion

Thank you!

- Acknowledgements
  - Monitoring and Evaluation – Wendy Garland, Siri Chirumamilla
  - Surveillance – Virginia Hu, Kathleen Poortinga
  - PDR – Victor Scott, Michael Green
  - CCS – Paulina Zamudio and the RWP program managers
  - RWP agencies and providers
  - RWP clients

*my*Medi-Cal

How to Get the Health Care You Need

CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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Health Coverage in California

"My Medi-Cal: How to Get the Health Care You Need" tells Californians how to apply for Medi-Cal for no-cost or low-cost health insurance. You will learn what you must do to qualify. This guide also tells you how to use your Medi-Cal benefits. It tells you when to report changes. You should keep this guide and use it when you have questions about Medi-Cal.

California offers two ways to get health coverage. They are "Medi-Cal" and "Covered California." Both programs use the same application.

What Is Medi-Cal?

Medi-Cal is California's version of the Federal Medicaid program. Medi-Cal offers no-cost and low-cost health coverage to eligible people who live in California.

The Department of Health Care Services (DHCS) oversees the Medi-Cal program.

Your local county office manages most Medi-Cal cases for DHCS. You can reach your local county office online at *www.benefitscal.com*. You can also call your local county office.

> **To get the phone number for your local county office, go to:**
> *http://dhcs.ca.gov/mymedi-cal*
>
> **or call 1-800-541-5555**
> **(TTY 1-800-430-7077)**

The local county offices use many facts to determine what type of help you can get from Medi-Cal. They include:

- How much money you make
- Your age
- The age of any children on your application
- Whether you are pregnant, blind or disabled
- Whether you receive Medicare

Did you know?

It is possible for members of the same family to qualify for both Medi-Cal and Covered California. This is because the Medi-Cal eligibility rules are different for children and adults.

For example, coverage for a household of two parents and a child could look like this:

Parents—eligible for a Covered California health plan and receive tax credits and cost sharing to reduce their costs

Child—eligible for no-cost or low-cost Medi-Cal

Most people who apply for Medi-Cal can find out if they qualify based on their income. For some types of Medi-Cal, people may also need to give information about their assets and property. To learn more, see the Medi-Cal Program Comparison on page 5.

What Is Covered California?

Covered California is the State's health insurance marketplace. You can compare health plans from brand-name insurance companies or shop for a plan. If your income is too high for Medi-Cal, you may qualify to purchase health insurance through Covered California.

Covered California offers "premium assistance." It helps lower the cost of health care for individuals and families who enroll in a Covered California health plan and meet income rules. To qualify for premium assistance, your income must be under the Covered California program income limits.

Did you know?

If you qualify for Supplemental Security Income (SSI), you automatically qualify for SSI-linked Medi-Cal.

Your local county office can help with some SSI Medi-Cal related problems. They will tell you if you need to contact a Social Security office to solve the problem.

Covered California has four levels of coverage to choose from: Bronze, Silver, Gold, and Platinum. The benefits within each level are the same no matter which insurance company you choose. Your income and other facts will decide what program you qualify for.

To learn more about Covered California, go to **www.coveredca.com** or call **1-800-300-1506 (TTY 1-888-889-4500)**.

What Are the Requirements to Get Medi-Cal?

To qualify for Medi-Cal, you must live in the state of California and meet certain rules. You must give income and tax filing status information for everyone who is in your family and is on your tax return. You also may need to give information about your property.

You do not have to file taxes to qualify for Medi-Cal. For questions about tax filing, talk to the Internal Revenue Service (IRS) or a tax professional.

All individuals who apply for Medi-Cal must give their Social Security Number (SSN) if they have one. Every person who asks for Medi-Cal must give information about his or her immigration status. Immigration status given as part of the Medi-Cal application is confidential. The United States Citizenship and Immigration Services cannot use it for immigration enforcement unless you are committing fraud.

Adults age 19 or older may qualify for limited Medi-Cal benefits even if they do not have a Social Security Number (SSN) or cannot prove their immigration status. These benefits cover emergency, pregnancy-related and long-term care services.

You can apply for Medi-Cal for your child even if you do not qualify for full coverage.

In California, immigration status does not affect Medi-Cal benefits for children under age 19. Children may qualify for full Medi-Cal benefits, regardless of immigration status.

To learn more about Medi-Cal program rules, read the Medi-Cal Program Comparison on the next page.

Medi-Cal Program Comparison

MAGI VS. Non-MAGI

The Modified Adjusted Gross Income (MAGI) Medi-Cal method uses Federal tax rules to decide if you qualify based on how you file your taxes and your countable income.

Non-MAGI Medi-Cal includes many special programs. Persons who do not qualify for MAGI Medi-Cal may qualify for Non-MAGI Medi-Cal.

Who is eligible:

- Children under 19 years old
- Parents and caretakers of minor children
- Adults 19 through 64 years old
- Pregnant individuals

- Adult aged 65 years or older
- Child under 21
- Pregnant individual
- Parent/Caretaker Relative of an age-eligible child
- Adult or child in a long-term care facility
- Person who gets Medicare
- Blind or have a disability

Property rules:

No property limits.

- Must report and give proof of property such as vehicles, bank accounts, or rental homes
- Limits to the amount of property in the household

For both MAGI and Non-MAGI:

- The local county office will check your application information. You may need to give more proof.
- You must live in California.
- U.S. citizens or lawfully-present applicants must provide their SSN.
- You must apply for any income that you might qualify for such as unemployment benefits and State Disability Insurance.
- You must comply with medical support enforcement* which will:
  - Establish paternity for a child or children born outside of marriage.
  - Get medical support for a child or children with an absent parent.

  If you think you have a good reason not to follow this rule, call your local county office.

How Do I Apply?

You can apply for Medi-Cal at any time of the year by mail, phone, fax, or email. You can also apply online or in person.

You can only apply for Covered California coverage on certain dates. To learn when you can apply, go to **www.coveredca.com** or call **1-800-300-1506 (TTY 1-888-889-4500)**.

✉ Apply by mail:

You can apply for Medi-Cal and Covered California with the Single Streamlined Application. You can get the application in English and other languages at: **http://dhcs.ca.gov/mymedi-cal**. Send completed applications to your local county office.

> **Find your local county office address at:**
> **http://dhcs.ca.gov/mymedi-cal**

> **You can also send applications to:**
> *Covered California*
> *P.O. Box 989725*
> *West Sacramento, CA 95798-9725*

📞 Apply by phone, fax, or email:

Call your local county office. You can find the phone number on the web at **http://dhcs.ca.gov/mymedi-cal** or call Covered California at **1-800-300-1506**.

🖥 Apply online at:

> **www.benefitscal.com**

OR

> **www.coveredca.com**

👥 In person:

Find your local county office at **http://dhcs.ca.gov/mymedi-cal**. You can get help applying.

You can also find a Covered California Certified Enrollment Counselor or Insurance Agent at **www.CoveredCA.com/get-help/local/**.

How Long Will it Take for My Application to Be Processed?

It may take up to 45 days to process your Medi-Cal application. If you apply for Medi-Cal based on disability, it may take up to 90 days. Your local county office or Covered California will send you an eligibility decision letter. The letter is called a "Notice of Action." If you do not get a letter within the 45 or 90 days, you may ask for a "State Fair Hearing." You may also ask for a hearing if you disagree with the decision. To learn more, read "Appeal and hearing rights" on page 19.

How Do I Use My Medi-Cal Benefits?

Medi-Cal covers most medically necessary care. This includes doctor and dentist appointments, prescription drugs, vision care, family planning, mental health care, and drug or alcohol treatment. Medi-Cal also covers transportation to these services. Read more in "Covered Benefits" on page 12.

Once you are approved, you can use your Medi-Cal benefits right away. New beneficiaries approved for Medi-Cal get a Medi-Cal Benefits Identification Card (BIC). Your health care and dental providers need your BIC to provide services and to bill Medi-Cal. New beneficiaries and those asking for replacement cards get the new BIC design showing the California poppy. Both BIC designs shown here are valid:

Please contact your local county office if:

- You did not get your BIC
- Your BIC is lost
- Your BIC has wrong information
- Your BIC is stolen

Once you are sent a new BIC, you cannot use your old BIC.

You can get the phone number for your local county office at:

http://dhcs.ca.gov/mymedi-cal

or call:

1-800-541-5555 (TTY 1-800-430-7077)

How Do I See a Doctor?

Most people who are in Medi-Cal see a doctor through a Medi-Cal managed care plan. The plans are like the health plans people have with private insurance. Read more about managed care plans starting on the next page.

It may take a few weeks to assign your Medi-Cal managed care plan. When you first sign up for Medi-Cal, or if you have special situations, you may need to see the doctor through "Fee-for-Service Medi-Cal."

State of California
Benefits Identification Card

STATE OF CALIFORNIA
BENEFITS IDENTIFICATION CARD

ID No. 01234567A95052
JOHN Q RECIPIENT
M 05 20 1991 **Issue Date** 02 21 05

What Is Fee-for-Service Medi-Cal?

Fee-for-Service is a way Medi-Cal pays doctors and other care providers. When you first sign up for Medi-Cal, you will get your benefits through Fee-for-Service Medi-Cal until you are enrolled in a managed care health plan.

Before you get medical or dental services, ask if the provider accepts Medi-Cal Fee-for-Service payments. The provider has a right to refuse to take Medi-Cal patients. If you do not tell the provider you have Medi-Cal, you may have to pay for the medical or dental service yourself.

How Are Medical or Dental Expenses Paid on Fee-for-Service Coverage?

Your provider uses your BIC to make sure you have Medi-Cal. Your provider will know if Medi-Cal will pay for a medical or dental treatment. Sometimes you may have to pay a "co-payment" for a treatment. You may have to pay $1 each time you get a medical or dental service or prescribed medicine. You may have to pay $5 if you go to a hospital emergency room when you do not need an emergency service. Those beneficiaries enrolled in a managed care plan do not have to pay co-payments.

There are some services Medi-Cal must approve before you may get them. See page 9 for more information.

How Do I Get Medical or Dental Services When I Have to Pay a Share of Cost (SOC)?

Some Non-MAGI Medi-Cal programs require you to pay a SOC. The Notice of Action you get after your Medi-Cal approval will tell you if you have a SOC. It will also tell the amount of the SOC. Your SOC is the amount you must pay or promise to pay to the provider for health or dental care before Medi-Cal starts to pay.

The SOC amount resets each month. You only need to pay your SOC in months when you get health and/or dental care services. The SOC amount is owed to the health or dental care provider. It is not owed to Medi-Cal or the State. Providers may allow you to pay for the services later instead of all at once. In some counties, if you have a SOC you cannot enroll in a managed care plan.

If you pay for health care services from someone who does not accept Medi-Cal, you may count those payments toward your SOC. You must take the receipts from those health care expenses to your local county office. They will credit that amount to your SOC.

You may be able to lower a future month's SOC if you have unpaid medical bills. Ask your local county office to see if your bills qualify.

What Is Medi-Cal Managed Care?

Medi-Cal Managed Care is an organized system to help you get high-quality care and stay healthy.

> ❝ **Medi-Cal Managed Care health plans help you find doctors, pharmacies and health education programs.** ❞

Most people must enroll in a managed care plan, unless you meet certain criteria or qualify for an exemption. Your health plan options depend on the county you live in. If your county has multiple health plans, you will need to choose the one that fits your and your family's needs.

Every Medi-Cal managed care plan within each county has the same services. You can get the directory of managed care plans at *http://dhcs.ca.gov/mymedi-cal*. You can choose a doctor who works with your plan to be your primary care physician. Or your plan can pick a primary care doctor on your behalf. You may choose any Medi-Cal

family planning provider of your choice, including one outside of your plan. Contact your managed care plan to learn more.

Managed care health plans also offer:

- Care coordination
- Referrals to specialists
- 24-hour nurse advice telephone services
- Customer service centers

Medi-Cal must approve some services before you may get them. The provider will know when you need prior approval. Most doctors' services and most clinic visits are not limited. They do not need approval. Talk with your doctor about your treatment plan and appointments.

How Do I Enroll in a Medi-Cal Managed Care Plan?

If you are in a county with more than one plan option, you must choose a health plan within 30 days of Medi-Cal approval. You will get an information packet in the mail. It will tell you the health plan(s) available in your county. The packet will also tell you how to enroll in the managed care plan you choose. If you do not choose a plan within 30 days of getting your Medi-Cal approval, the State will choose a plan for you.

Please wait for your health plan information packet in the mail.

> **If your county only has one health plan, the county chooses the plan for you.**

If you live in **San Benito County**, there is only one health plan. You may enroll in this health plan. Or you may choose to stay in Fee-for-Service Medi-Cal.

If your county has more than one health plan, you will need to choose the one that fits your and your family's needs.

> **To see what plans are in your county, go to**
> **https://www.healthcareoptions.dhcs.ca.gov/**

How Do I Disenroll, Ask for an Exemption from Mandatory Enrollment, or Change My Medi-Cal Managed Care Plan?

Most Medi-Cal beneficiaries must enroll in a Medi-Cal managed care plan. If you enrolled in a health care plan **by choice**, you may disenroll at any time. To disenroll, call Health Care Options at **1-800-430-4263.**

When your county has more than one plan, you can call Health Care Options if you want to change your managed care health plan.

If you are getting treatment now from a Fee-for-Service Medi-Cal provider, you may qualify for a temporary exemption from mandatory enrollment in a Medi-Cal managed care plan. The Fee-for-Service provider cannot be part of a Medi-Cal managed care plan in your county. The provider must be treating you for a complex condition that could get worse if you have to change providers.

Ask your provider if he or she is part of a Medi-Cal managed care plan in your county. If your provider is not part of a Medi-Cal managed care plan in your county, have your provider fill out a form with you to ask for an exemption from enrolling in a Medi-Cal managed care plan.

Your provider will need to sign the form, attach required proof, and mail or fax the form to Health Care Options. They will review it and decide whether you qualify for a temporary exemption from enrollment in a Medi-Cal managed care plan. You can find the form and instructions at **_http://dhcs.ca.gov/mymedi-cal_**.

If you have questions, call **1-800-430-4263.**

What if I Have Other Health Insurance?

Even if you have other health coverage such as health insurance from your work, you may still qualify for Medi-Cal. If you qualify, Medi-Cal will cover allowable costs not paid by your primary insurance. Under federal

law, Medi-Cal beneficiaries' private health insurance must be billed first before billing Medi-Cal.

Medi-Cal beneficiaries are required by federal and state law to report private health insurance. To report or change private health insurance, go to *http://dhcs.ca.gov/mymedi-cal* or call **1-800-541-5555 (TTY 1-800-430-7077)**. Outside of California, call **1-916-636-1980.**

You also must report it to your local county office and your health care provider. If you fail to report any private health insurance coverage that you have, you are committing a misdemeanor crime.

Can I Get Medi-Cal Services When I Am Not in California?

When you travel outside California, take your BIC or proof that you are enrolled in a Medi-Cal health care plan. Medi-Cal can help in some cases, such as an emergency due to accident, injury or severe illness. Except for emergencies, your managed care plan must approve any out-of-state medical services before you get the service. If the provider will not accept Medicaid, you will have to pay medical costs for services you get outside of California. Remember: there may be many providers involved in emergency care. For example, the doctor you see may accept Medicaid but the x-ray department may not. Work with your managed care plan to limit what you have to pay. The provider should first make sure you qualify by calling **1-916-636-1960.**

If you live near the California state line and get medical service in the other state, some of these rules do not apply. To learn more, contact your Medi-Cal managed care plan.

> " **You will not get Medi-Cal if you move out of California. You may apply for Medicaid in the state you move to.** "

If you are moving to a new county in California, you also need to tell the county you live in or the county you are moving to. This is to make sure you keep

getting Medi-Cal benefits. You should tell your local county office within 10 days of moving to a new county.

What Should I Do if I Can't Get an Appointment or Other Care I Need?

The Medi-Cal Managed Care Office of the Ombudsman helps solve problems from a neutral standpoint. They make sure you get all necessary required covered services.

The Office of the Ombudsman:

- Helps solve problems between Medi-Cal managed care members and managed care plans without taking sides
- Helps solve problems between Medi-Cal beneficiaries and county mental health plans without taking sides
- Investigates member complaints about managed care plans and county mental health plans
- Helps members with urgent enrollment and disenrollment problems
- Helps Medi-Cal beneficiaries access Medi-Cal specialty mental health services
- Offers information and referrals
- Identifies ways to make the Medi-Cal managed care program more effective
- Educates members on how to navigate the Medi-Cal managed care and specialty mental health system

To learn more about the Office of the Ombudsman, you can call:

1-888-452-8609

or go to:

http://dhcs.ca.gov/mymedi-cal

How Does Medi-Cal Work if I also Have Medicare?

Many people who are 65 or older or who have disabilities qualify for both Medi-Cal and Medicare. If you qualify for both programs, you will get most of your medical services and prescription drugs through Medicare. Medi-Cal provides long-term services and supports such as nursing home care and home and community-based services.

> ❝ **Medi-Cal covers some benefits that Medicare does not cover.** ❞

Medi-Cal may also pay your Medicare premiums.

What Is the Medicare Premium Payment Buy-In Program?

The Medicare Premium Payment Program, also called Medicare Buy-In, allows Medi-Cal to pay Medicare Part A (Hospital Insurance) and/or Part B (Medical Insurance) premiums for Medi-Cal members and others who qualify for certain Medi-Cal programs.

What Is the Medicare Savings Program (MSP)?

Medicare Savings Programs may pay Medicare Part A and Medicare Part B deductibles, co-insurance and co-payments if you meet certain conditions. When you apply for Medi-Cal, your county will evaluate you for this program. Some people who do not qualify for full-scope Medi-Cal benefits may still qualify for MSP.

If I Use a Medicare Provider, Will I Have to Pay Medicare Co-Insurance?

No. If eligible to MSP you will not have to pay any co-insurance or deductibles. If you get a bill from your Medicare provider, contact your Medi-Cal managed care plan or call **1-800-MEDICARE.**

If I Have Medicare, Do I Have to Use Doctors and Other Providers Who Take Medi-Cal?

No. You can use any Medicare provider, even if that provider doesn't take Medi-Cal or isn't part of your Medi-Cal managed care plan. Some Medicare providers may not accept you as a patient.

Did you know?

Medi-Cal provides breastfeeding education as part of Maternity and Newborn Care.

You are eligible for routine eye exams once every 24 months.

To learn more about what's offered, visit: *http://dhcs.ca.gov/mymedi-cal*

Medi-Cal Covered Benefits

Medi-Cal offers a full set of benefits called Essential Health Benefits. To find out if a service is covered, ask your doctor or health plan. Essential Health Benefits include:

- Outpatient services, such as a checkup at a doctor's office
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health services
- Substance use disorder services, such as treatment for drug or alcohol addiction
- Prescription drugs
- Laboratory services, such as blood tests
- Programs such as physical therapy (called rehabilitative and habilitative services) and medical supplies and devices such as wheelchairs and oxygen tanks
- Preventive and wellness services
- Chronic disease management
- Children's (pediatric) services, including oral and vision care
- In-home care and other long-term services and supports

Substance Use Disorder Program

Medi-Cal offers inpatient and outpatient settings for drug or alcohol abuse treatment. This is also called substance use disorder treatment. The setting depends on the types of treatment you need. Services include:

- Outpatient Drug Free Treatment (group and/or individual counseling)
- Intensive Outpatient Treatment (group counseling services provided at least three hours per day, three days per week)
- Residential Treatment (rehabilitation services provided while living on the premises)
- Narcotic Replacement Therapy (such as methadone)

Some counties offer more treatment and recovery services. Tell your doctors about your condition so they can refer you to the right treatment. You may also refer yourself to your nearest local treatment agency. Or call the Substance Use Disorder non-emergency treatment referral line at **1-800-879-2772.**

Medi-Cal Dental Program

Dental health is an important part of overall health. The Medi-Cal Dental Program covers many services to keep your teeth healthy. You can get dental benefits as soon as you are approved for Medi-Cal.

You can see the dental benefits and other resources at *http://dhcs.ca.gov/mymedi-cal*. Or, you can call **1-800-322-6384 (TTY 1-800-735-2922)** Monday through Friday between 8:00 a.m. and 5:00 p.m.

How Do I Get Medi-Cal Dental Services?

The Medi-Cal Dental Program gives service in two ways. One is Fee-for-Service Dental and you can get it throughout California. Fee-for-Service Dental is the same as Fee-for-Service Medi-Cal. Before you get dental services, you must show your BIC to the dental provider and make sure the provider takes Fee-for-Service Dental.

The other way Medi-Cal gives dental services is through Dental Managed Care (DMC). DMC is only offered in Los Angeles County and Sacramento County. DMC plans cover the same dental services as Fee-for-Service Dental. DHCS uses three managed care plans in Sacramento County. DHCS also contracts with three prepaid health plans in Los Angeles County. These plans provide dental services to Medi-Cal beneficiaries.

If you live in Sacramento County, you must enroll in DMC. In some cases, you may qualify for an exemption from enrolling in DMC.

To learn more, go to Health Care Options at *http://dhcs.ca.gov/mymedi-cal*.

In Los Angeles County, you can stay in Fee-for-Service Dental or you can choose the DMC program. To choose or change your dental plan, call Health Care Options.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

If you or your child are under 21 years old, Medi-Cal covers preventive services, such as regular health check-ups and screenings. Regular checkups and screenings look for any problems with your medical, dental, vision, hearing, and mental health, and any substance use disorders. You can also get vaccinations to keep you healthy. Medi-Cal covers screening services any time there is a need for them, even if it is not during your regular check-up. All of these services are at no cost to you.

Checkups and screenings are important to help your health care provider identify problems early. When a problem is found during a check-up or screening, Medi-Cal covers the services needed to fix or improve any physical or mental health condition or illness. You can get the diagnostic and treatment services your doctor, other health care provider, dentist, county Child Health and Disability Prevention program (CHDP), or county mental or behavioral health provider says you need to get better. EPSDT covers these services at no cost to you.

Your provider will also tell you when to come back for the next health check-up, screening, or medical appointment. If you have questions about scheduling a medical visit or how to get help with transportation to the medical visit, Medi-Cal can help. Call your Medi-Cal Managed Care Health Plan (MCP). If you are not in a MCP, you can call your doctor or other provider or visit *http://dhcs.ca.gov/mymedi-cal* for transportation assistance.

For more information about EPSDT you may call **1-800-541-5555**, go to *http://dhcs.ca.gov/mymedi-cal*, contact your county CHDP Program, or your MCP. To learn more about EPSDT Specialty Mental Health or Substance Use Disorder services, contact your county mental or behavioral health department.

Transportation Services

Medi-Cal can help with rides to medical, mental health, substance use, or dental appointments when those appointments are covered by Medi-Cal. The rides can be either nonmedical transportation (NMT) or non-emergency medical transportation (NEMT). You can also use NMT if you need to pick up prescriptions or medical supplies or equipment.

If you can travel by car, bus, train, or taxi, but do not have a ride to your appointment, NMT can be arranged.

If you are enrolled in a health plan, call your Member Services for information on how to get NMT services.

If you have Fee-for-Service, you can do the following:

- Call your county Medi-Cal office to see if they can help you get an NMT ride.
- To set up a ride, you should first call your Fee-for-Service medical provider and ask about a transportation provider in your area. Or, you can call one of the approved NMT providers in your area listed at *http://dhcs.ca.gov/mymedi-cal*.

If you need a special, medical vehicle to get to your appointment, let your health care provider know. If you are in a health plan, you can also contact your plan to set up your transportation. If you are in Fee-for-Service, call your health care provider. The plan or provider can order NEMT such as a wheelchair van, a litter van, an ambulance, or air transport.

Be sure to ask for a ride as soon as you can before an appointment. If you have frequent appointments, your health care provider or health plan can request transportation to cover future appointments.

Go to *http://dhcs.ca.gov/mymedi-cal* for more information about rides arranged by approved NMT providers.

Specialty Mental Health Services

If you have mental illness or emotional needs that your regular doctor cannot treat, specialty mental health services are available. A Mental Health Plan (MHP) provides specialty mental health services. Each county has an MHP.

Specialty mental health services may include, but are not limited to, individual and group therapy, medication services, crisis services, case management, residential and hospital services, and specialized services to help children and youth.

To find out more about specialty mental health services, or to get these services, call your county MHP. Your MHP will determine if you qualify for specialty mental health services. You can get the MHP's telephone number from the Office of the Ombudsman at **1-888-452-8609** or go to *http://dhcs.ca.gov/mymedi-cal*.

Other Health Programs & Services

California offers other programs for your medical needs. You can apply for some through the same local county office that handles Medi-Cal.

From Your Local County Office

You can ask for the programs below from the same local county office where you apply for Medi-Cal. You can get the phone number for your county at *http://dhcs.ca.gov/mymedi-cal* or call **1-800-541-5555 (TTY 1-800-430-7077)**.

Former Foster Youth

If you were in foster care on your 18th birthday or later, you may qualify for free Medi-Cal. Coverage may last until your 26th birthday. Income does not matter. You do not need to fill out a full Medi-Cal application or give income or tax information when you apply. For coverage right away, contact your local county office.

Confidential Medical Services

You can apply for confidential services if you are under age 21. To qualify, you must be:

- Unmarried and living with your parents, or
- Your parent must be financially responsible for you, such as college students

You do not need parental consent to apply for or get coverage. Services include family planning and pregnancy care, and treatment for drug or alcohol abuse, sexually transmitted diseases, sexual assault, and mental health.

250% Working Disabled Program

The Working Disabled Program gives Medi-Cal to adults with disabilities who have higher income than most Medi-Cal recipients. If you have earned disability income through Social Security or your former job, you may qualify. The program requires a low monthly premium, ranging from $20 to $250 depending on your income. To qualify, you must:

- Meet the Social Security definition of disability, have gotten disability income, and now be earning some money through work
- Meet program income rules for earned and unearned income
- Meet other program rules

Medi-Cal Access Program (MCAP)

MCAP gives low-cost comprehensive health insurance coverage to pregnant individuals. MCAP has no copayments or deductibles for its covered services. The total cost for MCAP is 1.5% of your Modified Adjusted Gross Income. For example, if your income is $50,000 per year, your cost would be $750 for coverage. You can pay all at once or in monthly installments over 12 months. If you are pregnant and in Covered California coverage, you may be able to switch to MCAP. Babies born to individuals enrolled in MCAP qualify for the Medi-Cal Access Infant Program or for Medi-Cal. To qualify for MCAP, you must be:

- A California resident
- Not enrolled in no-cost Medi-Cal or Medicare Part A and Part B at time of application

- Not covered by any other health insurance plan
- Within the program income guidelines

To learn more about MCAP, go to *http://dhcs.ca.gov/mymedi-cal* or call **1-800-433-2611**.

In-Home Supportive Services (IHSS) Program

IHSS helps pay for services so you can remain safely in your own home. If you qualify for Medi-Cal, you may also qualify for IHSS. If you do not qualify for Medi-Cal, you may still qualify for IHSS if you meet other eligibility criteria. If you have Medi-Cal with no SOC, it will pay for all your IHSS services. If you have Medi-Cal with a SOC, you must meet your Medi-Cal SOC before any IHSS services are paid. To qualify, you must be at least **one** of the following:

- Age 65 and older
- Blind
- Disabled (including disabled children)
- Have a chronic, disabling condition that causes functional impairment expected to last at least 12 consecutive months or expected to result in death within 12 months

IHSS can authorize services such as:

- Domestic services such as washing kitchen counters or cleaning the bathroom
- Preparation of meals
- Laundry
- Shopping for food
- Personal care services
- Accompaniment to medical appointments
- Protective supervision for people who are mentally ill or mentally impaired and cannot remain safely in their home without supervision
- Paramedical services

To learn more, go to *http://www.cdss.ca.gov/In-Home-Supportive-Services*.

Other State Health Services

The programs below have a different application process from Medi-Cal's. You can apply or learn more about the program using the contact information listed.

Breast and Cervical Cancer Treatment Program

The Breast and Cervical Cancer Treatment Program gives cancer treatment and related services to low-income California residents who qualify. They must be screened and/or enrolled by the Cancer Detection Program, Every Woman Counts, or by the Family Planning, Access, Care and Treatment programs. To qualify, you must have income under the limit and need treatment for breast or cervical cancer. To learn more, call **1-800-824-0088** or email *BCCTP@dhcs.ca.gov*.

Home and Community-Based Services

Medi-Cal allows certain eligible seniors and persons with disabilities to get treatment at home or in a community setting instead of in a nursing home or other institution. Home and Community-Based Services include but are not limited to case management (supports and service coordination), adult day health services, habilitation (day and residential), homemaker, home health aide, nutritional services, nursing services, personal care, and respite care. You must qualify for full-scope Medi-Cal and meet all program rules. To learn more, call DHCS, Integrated Systems of Care Division at **1-916-552-9105**.

California Children's Services (CCS) Program

The CCS program gives diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 who have CCS-eligible medical conditions. CCS-eligible medical conditions are those that are physically disabling or require medical, surgical or

rehabilitative services. Services authorized by the CCS program to treat a Medi-Cal enrolled child's CCS-eligible medical condition are not services that most health plan's cover. The Medi-Cal health plan still provides primary care and preventive health services not related to the CCS-eligible medical condition.

To apply for CCS, contact your local county CCS office. To learn more, go to ***http://dhcs.ca.gov/mymedi-cal*** or call **1-916-552-9105**.

Genetically Handicapped Person's Program (GHPP)

GHPP gives medical and administrative case management and pays for medically-necessary services for persons who live in California, are over age 21, and have GHPP-eligible medical conditions. GHPP-eligible conditions are inherited conditions like hemophilia, cystic fibrosis, Phenylketonuria, and sickle cell disease that have major health effects. GHPP uses a system of Special Care Centers (SCCs). SCCs give comprehensive, coordinated health care to clients with specific eligible conditions. If the service is not in the health plan's covered benefits, GHPP authorizes yearly SCC evaluations for Medi-Cal enrolled adults with a GHPP-eligible medical condition.

To apply for GHPP, complete an application. Fax it to **1-800-440-5318**. To learn more, call **1-916-552-9105** or go to ***http://dhcs.ca.gov/mymedi-cal***.

Retroactive Medi-Cal

If you have unpaid medical or dental bills when you apply for Medi-Cal, you can ask for retroactive Medi-Cal. Retroactive Medi-Cal may help pay medical or dental bills in any of the three months before the application date.

For example, if you applied for Medi-Cal in April, you may be able to get help with bills for medical or dental services you got in January, February and March.

To get retroactive Medi-Cal you must:

- **Qualify for Medi-Cal in the month you got the medical services**
- **Have received medical or dental services that Medi-Cal covers**
- **Ask for it within one year of the month in which you received the covered services**
- **You must contact your local county office to request retroactive Medi-Cal**

For example, if you were treated for a broken arm in January 2017 and applied for Medi-Cal in April 2017, you would have to request retroactive Medi-Cal by no later than January 2018 to pay the medical bills.
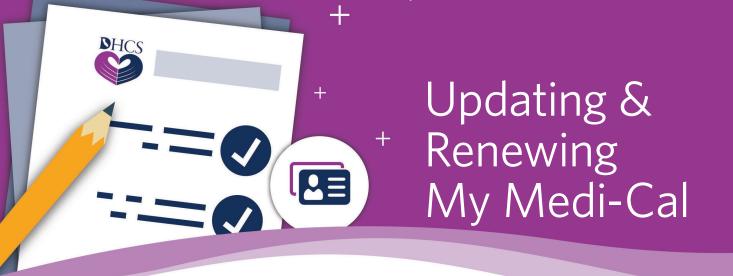
If you already paid for medical or dental service you got during the three months of the retroactive period, Medi-Cal may also help you get paid back. You must submit your claim within one year of the date of service, or within 90 days after approval of your Medi-Cal eligibility, whichever is longer.

To file a claim, you must call or write to:

**Department of Health Care Services
Beneficiary Services
P.O. Box 138008
Sacramento, CA 95813-8008
1-916-403-2007 (TTY 1-916-635-6491)**

For Medical, Mental Health, Substance Use Disorder, and In-Home Support Services Claims

**Medi-Cal Dental Beneficiary Services
P.O. Box 526026
Sacramento, CA 95852-6026
1-916-403-2007 (TTY 1-916-635-6491)**

For Dental Claims.

You must report any household changes within 10 days to your local county office. You can report changes in person, online, by phone, email or fax. Changes can affect your Medi-Cal eligibility.

You must report if you:

- Get married or divorced
- Have a child, adopt or place a child for adoption
- Have a change in income or property (if applicable)
- Get any other health coverage including through a job or a program such as Medicare
- Move, or have a change in who is living in your home
- Have a change in disability status
- Have a change in tax filing status, including change in tax dependents
- Have a change in citizenship or immigration status
- Are incarcerated (jail, prison, etc.) or released from incarceration
- Have a change in American Indian or Alaska Native status or change your tribal status
- Change your name, date of birth or SSN
- Have any other changes that may affect your income or household size

What if I Move to Another County in California?

If you move to another California county, you can have your Medi-Cal case moved to the new county. This is called an Inter-County Transfer (ICT). You must report your change of address to either county within 10 days from the change. You can report your change of address online, in person, by phone, email, or fax. Your managed care plan coverage in your old county will end on the last day of the month. You will need to enroll in a managed care plan in your new county.

When you leave the county temporarily, your Medi-Cal will not transfer. This includes a child going to college or when you take care of a sick relative. Contact your local county office to report the household member's temporary address change to a new county. The local county office will update the address so the household member can enroll in a health plan in the new county.

How Do I Renew My Medi-Cal Coverage?

To keep your Medi-Cal benefits, you must renew at least once a year. If your local county office cannot renew your Medi-Cal coverage using electronic sources, they will send you a renewal form. You will need to give information that is new or has changed. You will also need to give your most current information. You can return your information online, in person, or by phone or other electronic means if available in your county. If you mail or return your renewal form in person, it must be signed.

If you do not give the needed information by the due date, your Medi-Cal benefits will end. Your local county office will send you a Notice of Action in the mail. You have 90 days to give your local county office all the missing information without having to re-apply. If you give the missing information within 90 days and still qualify for Medi-Cal, your local county office will reinstate your Medi-Cal with no gaps in coverage.

Rights & Responsibilities

When you apply for Medi-Cal, you will get a list of your rights and responsibilities. This includes the requirement to report changes in address or income, or if someone is pregnant or gave birth. You can call your local county office or find the most up-to-date list of your rights and responsibilities online at:

http://dhcs.ca.gov/mymedi-cal

Appeal and Hearing Rights

Health Care Services and Benefits

You have the right to ask for an appeal if you disagree with the denial of a health care service or benefit.

If you are in a Medi-Cal managed care plan and you get a Notice of Action letter telling you that a health care service or benefit is denied, you have the right to ask for an appeal.

You must file an appeal with your plan within 60 days of the date on the Notice of Action. After you file your appeal, the plan will send you a decision within 30 days. If you do not get a decision within 30 days or are not happy with the plan's decision, you can then ask for a State Fair Hearing. A judge will review your case. **You must first file an appeal with your plan before you can ask for a State Fair Hearing.** You must ask for a State Fair Hearing within 120 days of the date of the plan's written appeal decision.

If you are in Fee-for-Service Medi-Cal and you get a Notice of Action letter telling you that a health service

or benefit has been denied, you have the right to ask for a State Fair Hearing right away. You must ask for a State Fair Hearing within 90 days of the date on the Notice of Action.

You also have the right to ask for a State Fair Hearing if you disagree with what is happening with your Medi-Cal application or eligibility. This can be when:

- You do not agree with a county or State action on your Medi-Cal application
- The county does not give you a decision about your Medi-Cal application within 45 or 90 days
- Your Medi-Cal eligibility or Share of Cost changes

Eligibility Decisions

If you get a Notice of Action letter telling you about an eligibility decision that you disagree with, you can talk to your county eligibility worker and/or ask for a State Fair Hearing. If you cannot solve your disagreement through the county, you must request a State Fair Hearing within 90 days of the date on the Notice of Action. You can ask for a State Fair Hearing by contacting your local county office. You can also call or write to:

California Department of Social Services
Public Inquiry and Response
PO Box 944243, M.S. 9-17-37
Sacramento, CA 94244-2430
1-800-743-8525, (TTY 1-800-952-8349)

You can also file a hearing request online at:

http://www.cdss.ca.gov/

If you believe you have been unlawfully discriminated against on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can make a complaint to the DHCS Office of Civil Rights.

You can learn how to make a discrimination complaint in "Federally Required Notice Informing Individuals About Nondiscrimination and Accessibility Requirements" on page 21.

About State Fair Hearings

The State will tell you it got your hearing request. You will get a notice of the time, date and place of your hearing. A hearing representative will review your case and try to resolve your issue. If the county/State offers you an agreement to solve your issue, you will get it in writing.

You can give permission in writing for a friend, family member or advocate to help you at the hearing. If you cannot fully solve your issue with the county or State, you or your representative must attend the State Fair Hearing. Your hearing can be in person or by phone. A judge who does not work for the county or Medi-Cal program will hear your case.

You have the right to free language help. List your language on your hearing request. Or tell the hearing representative you would like a free interpreter. You cannot use family or friends to interpret for you at the hearing.

> **If you have a disability and need reasonable accommodations to fully take part in the Fair Hearing process, you may call 1-800-743-8525 (TTY 1-800-952-8349). You can also send an email to SHDCSU@DSS.ca.gov.**

To get help with your hearing, you can ask for a legal aid referral. You may get free legal help at your local legal aid or welfare rights office.

Third Party Liability

If you suffer an injury, you may use your Medi-Cal to get medical services. If you file an insurance claim or sue someone for damages because of your injury, you must notify the Medi-Cal Personal Injury (PI) program within 30 days of filing your claim or action. You must tell both your local county office and the PI program.

To notify the Medi-Cal PI program, please complete the "Personal Injury Notification (New Case)" form. You can find it on the website below. If you do not have internet access, please ask your attorney or insurance company representative to notify the Medi-Cal PI program on your behalf. You can find notification and update forms at: **http://dhcs.ca.gov/mymedi-cal**.

If you hire a lawyer to represent you for your claim or lawsuit, your lawyer is responsible for notifying the Medi-Cal PI program and giving a letter of authorization. This authorization allows Medi-Cal staff to contact your lawyer and discuss your personal injury case. Medi-Cal does not provide representation or attorney referrals. Staff can offer information that can help the lawyer through the process.

Estate Recovery

The Medi-Cal program must seek repayment from the estates of certain Medi-Cal members who have died. Repayment is limited to payments made, including managed care premiums, for nursing facility services, home and community based services, and related hospital and prescription drug services when the beneficiary:

- Was an inpatient in a nursing facility, or

- Received home and community based services on or after his or her 55th birthday

If a deceased member does not leave an estate subject to probate or owns nothing when they die, nothing will be owed.

> **To learn more, go to *http://dhcs.ca.gov/er***
> **or call 1-916-650-0590**

Medi-Cal Fraud

Beneficiary responsibilities

A beneficiary must always present proof of Medi-Cal coverage to providers before getting services. If you are getting treatment from more than one doctor or dentist, you should tell each doctor or dentist about the other doctor or dentist providing your care.

It is your responsibility not to abuse or improperly use your Medi-Cal benefits. It is a **crime** to:

- Let other people use your Medi-Cal benefits

- Get drugs through false statements to a provider

- Sell or lend your BIC to any person or give your BIC to anyone other than your service providers as required under Medi-Cal guidelines

Misuse of BIC/Medi-Cal benefits is a crime. It could result in negative actions to your case or criminal prosecution. If you suspect Medi-Cal fraud, waste or abuse, make a confidential report by calling **1-800-822-6222**.

Federally Required Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

DHCS complies with applicable federal and state civil rights laws. DHCS does not unlawfully discriminate on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic

information, marital status, gender, gender identity or sexual orientation. DHCS does not unlawfully exclude people or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. DHCS:

- Provides free aids and services to people with disabilities to communicate effectively with DHCS, such as:
  - Qualified sign language interpreters
  - Written information in other formats such as large print, audio, accessible electronic formats and other formats
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the Office of Civil Rights, at **1-916-440-7370, (Ext. 711, California State Relay)** or email ***CivilRights@dhcs.ca.gov***.

If you believe DHCS has failed to provide these services or you have been discriminated against in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation, you can file a grievance at:

> **Office of Civil Rights**
> **PO Box 997413, MS 0009**
> **Sacramento, CA 95899-7413**
> **1-916-440-7370, (Ext. 711, CA State Relay)**
> **Email: *CivilRights@dhcs.ca.gov***

If you need help filing a grievance, the Office of Civil Rights can help you. Complaint forms are available at:

> ***http://www.dhcs.ca.gov/Pages/Language_Access.aspx***

Important Resources

ONLINE

Main Medi-Cal Site:
http://dhcs.ca.gov/mymedi-cal

Get the myMedi-Cal smartphone app to help you learn more about coverage, find local help, and more!

PHONE NUMBERS

Medi-Cal Members & Providers:
1-800-541-5555

Medi-Cal Managed Care:
1-800-430-4263
(TTY 1-800-430-7077)

Office of the Ombudsman:
1-888-452-8609

State Fair Hearing:
1-800-743-8525
(TTY 1-800-952-8349)

Covered California:
1-800-300-1506

Medi-Cal Dental Program:
1-800-322-6384

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. You can file electronically through the Office for Civil Rights Complaint Portal at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or you can file by mail or phone at:

> **U.S. Department of Health and Human Services**
> **200 Independence Avenue, SW**
> **Room 509F, HHH Building**
> **Washington, D.C. 20201**
> **1-800-368-1019, TTY 1-800-537-7697**

You can get a complaint form at:

> *http://www.hhs.gov/ocr/office/file/index.html*

This document meets Section 508 accessibility standards. This publication can also be made available in Braille, large print, and other electronic formats in response to a reasonable accommodation request made by a qualified individual with a disability. To ask for a copy of this publication in another format, call the Medi-Cal Eligibility Division at **1-916-552-9200 (TTY 1-800-735-2929)** or email *MCED@dhcs.ca.gov*.

Language Assistance

Attention: If you speak English, you can call 1-800-541-5555 (TDD 1-800-430-7077) for free help in your language. Call your local county office for eligibility issues or questions. (English)

تنبيه: إذا كنت تتحدث العربية، فيمكنك الاتصال برقم 1-800-541-5555 (TDD 1-800-430-7077) للمساعدة المجانية بلغتك. اتصل بمكتب المقاطعة المحلي للمشكلات أو الأسئلة المتعلقة بالتأهل. (Arabic)

Ուշադրություն: Եթե Դուք հայերեն եք խոսում, կարող եք զանգահարել 1-800-541-5555 (TDD 1-800-430-7077) և անվճար օգնություն ստանալ Ձեր լեզվով: Իրավասության հետ կապված խնդիրների կամ հարցերի դեպքում զանգահարեք Ձեր շրջանային գրասենյակ: (Armenian)

សម្គាល់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ អ្នកអាចទូរសព្ទទៅលេខ 1-800-541-5555 (TDD 1-800-430-7077) សម្រាប់ជំនួយដោយឥតគិតថ្លៃ ជាភាសារបស់អ្នក។ ទូរសព្ទទៅការិយាល័យខោនធីក្នុងតំបន់ លដ្ឋានរបស់អ្នកសម្រាប់បញ្ហាត្រាក់ងនឹងសិទ្ធិទទួលបានសេវា ឬក្នុងករណីមានសំណួរណាមួយ។ (Cambodian)

注意： 如果您使用中文，請撥打1-800-541-5555 (TDD 1-800-430-7077) 免費獲得以您所用語言提供的協助。關於資格的爭議或問題請致電您所在縣的辦事處。 (Chinese)

توجه: اگر به زبان فارسی صحبت می کنید، می توانید برای دریافت کمک رایگان به زبان خود با شماره 1-800-541-5555 (TDD 1-800-430-7077) تماس بگیرید. برای مسائل مربوط به صلاحیت یا سؤالات، با دفتر محلی شهرستان خود تماس بگیرید. (Farsi)

ध्यान दें: यदि आप हिंदी भाषी हैं, तो आप अपनी भाषा में निःशुल्क सहायता के लिए 1-800-541-5555 (TDD 1-800-430-7077) पर कॉल कर सकते हैं। योग्यता संबंधी समस्याओं या प्रश्नों के लिए अपने स्थानीय काउंटी कार्यालय को कॉल करें। (Hindi)

Lus Ceeb Toom: Yog tias koj hais lus Hmoob, koj tuaj yeem hu rau tus xov tooj 1-800-541-5555 (TDD 1-800-430-7077) kom tau kev pab koj dawb ua koj hom lus. Hu rau lub chaw lis dej num hauv koj lub nroog txog cov teeb meem kev tsim nyog tau txais kev pab los yog cov lus nug. (Hmong)

注意: ご希望により、1-800-541-5555 (TDD 1-800-430-7077) へお電話いただければ日本語で対応いたします。有資格問題または質問などは、地域の代理店までお電話ください。 (Japanese)

주의: 한국어를 말하면, 1-800-541-5555 (TDD 1-800-430-7077) 번으로 무료로 도움을 받으실 수 있습니다. 적격 문제 또는 질문은 해당 지역 카운티 사무소에 문의하십시오. (Korean)

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດໂທຫາເບີ 1-800-541-5555 (TDD 1-800-430-7077) ເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອຟຣີໃນພາສາຂອງທ່ານ. ໂທຫາຫ້ອງການເຂດໃນທ້ອງຖິ່ນຂອງທ່ານເພື່ອສອບຖາມກ່ຽວກັບບັນຫາໄພໃນການມີສິດໄດ້ຮັບ ຫຼື ມີຄຳຖາມອັນໃດໆ. (Laotian)

Waac-mbungh: Se gorngv meih gongv mien waac nor, maaiv zuqc cuotv nyaanh gunv korh waac mingh taux 1-800-541-5555 (TDD 1-800-430-7077) yiem wuov maaih mienh tengx faan waac bun meih hiuv duv. Gunv korh waac taux meih nyei kaau dih nyei mienh, Se gorngv meih oix hiuv taux, meih maaih fai maaiv maaih ndaam-dorng leiz puix duqv ziqv nyei buanc. (Mien)

ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਸੀਂ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫ਼ਤ ਸਹਾਇਤਾ ਪਾਉਣ ਲਈ 1-800-541-5555 (TDD 1-800-430-7077) 'ਤੇ ਕਾਲ ਕਰ ਸਕਦੇ ਹੋ। ਪਾਤਰਤਾ ਸੰਬੰਧੀ ਵਿਵਾਦਾਂ ਜਾਂ ਸਵਾਲਾਂ ਦੇ ਲਈ ਆਪਣੇ ਸਥਾਨਕ ਕਾਊਂਟੀ ਦਫ਼ਤਰ ਨੂੰ ਕਾਲ ਕਰੋ। (Punjabi)

Внимание: Если Вы говорите по-русски, Вы можете позвонить по номеру 1-800-541-5555 (TDD 1-800-430-7077), чтобы получить бесплатную помощь на Вашем языке. Позвоните в Ваш местный окружной офис по вопросам или проблемам, связанным с соответствием требованиям. (Russian)

Atención: Si usted habla español puede llamar al 1-800-541-5555 (TDD 1-800-430-7077) para obtener ayuda gratuita en su idioma. Llame a la oficina local de su condado si tiene algún problema o alguna pregunta sobre elegibilidad. (Spanish)

Atensiyon: Kung nagsasalita ka ng Tagalog, maaari kang tumawag sa 1-800-541-5555 (TDD 1-800-430-7077) para sa libreng tulong sa wika mo. Tawagan ang lokal mong tanggapan sa county para sa mga isyu sa pagiging nararapat o mga tanong. (Tagalog)

โปรดทราบ: หากท่านพูดภาษาไทย ท่านสามารถโทรศัพท์ไปที่เบอร์ 1-800-541-5555 (TDD 1-800-430-7077) เพื่อรับความช่วยเหลือในภาษาของท่านโดยไม่เสียค่าใช้จ่าย กรุณาโทรศัพท์หาสำนักงานประจำท้องถิ่นของท่านเพื่อสอบถามเกี่ยวกับสิทธิ์ของท่าน (Thai)

Увага: Якщо ви розмовляєте українською, ви можете зателефонувати за номером 1-800-541-5555 (TDD 1-800-430-7077), щоб отримати безкоштовну допомогу Вашою мовою. З питань стосовно права на пільги та іншої інформації, телефонуйте до вашого місцевого окружного офісу. (Ukrainian)

Lưu ý: Nếu quý vị nói tiếng Việt, quý vị có thể gọi 1-800-541-5555 (TDD 1-800-430-7077) để được trợ giúp miễn phí bằng ngôn ngữ của mình. Hãy gọi văn phòng quận địa phương của quý vị nếu có các vấn đề hoặc thắc mắc về tính đủ điều kiện. (Vietnamese)

CHCF Fact Sheet

CalAIM Explained: Overview of New Programs and Key Changes

California Advancing and Innovating Medi-Cal — more commonly known as CalAIM — is a far-reaching, multiyear plan to transform California's Medi-Cal program and enable it to work more seamlessly with other social services. Led by the California Department of Health Care Services (DHCS), the goal of CalAIM is to improve outcomes for the millions of Californians covered by Medi-Cal, including those with the most complex needs. Pending federal approval, CalAIM would add new programs and make important reforms to many existing programs, bringing in significant federal matching dollars in addition to the $782 million allocated from the general fund in the 2021–22 budget and more in future budget years. This explainer provides an overview of all the changes proposed.

Who CalAIM Will Help

CalAIM's broad reach is intended to help all Medi-Cal enrollees through a focus on population health and greater emphasis on prevention and overall wellness. In addition, there are several specific reforms to improve care for people with the most complex needs. In general, this group includes:

- ➤ People with significant behavioral health needs, including people with mental illness, serious emotional disturbance, or substance use disorder
- ➤ Seniors and people living with disabilities
- ➤ People experiencing homelessness who also have complex physical or behavioral health needs
- ➤ People transitioning from jail or prison back to the community who also have complex physical or behavioral health needs
- ➤ Children with complex medical conditions, such as cancer, epilepsy, or congenital heart disease
- ➤ Children and youth in foster care

For examples of how CalAIM will impact the lives of Medi-Cal enrollees, see *CalAIM Explained: A Five-Year Plan to Improve Medi-Cal*.[1]

New Programs

Under CalAIM, DHCS would create several new Medi-Cal programs to improve care for populations with complex health needs. These build on the Whole Person Care Pilots[2] and Health Homes Program,[3] which are ending in 2021.

- ➤ **Enhanced Care Management (ECM).** Today, Medi-Cal is highly fragmented, with some enrollees needing to access care paid for by six or more delivery systems, which can make it difficult for people to navigate across providers and services. For example, a person living with agoraphobia who is unable to leave their home but needs dental care, medical care, and mental health care would need to seek authorization for home-based care from three organizations. In response, a new ECM benefit would provide a high-touch care coordinator for Medi-Cal managed care enrollees with multiple complex needs. If successfully implemented, this benefit would ensure that enrollees with complex needs are identified and engaged by someone who understands their goals, develops a plan in partnership with them and their providers, and actively connects them with the clinical and nonclinical services and resources that help them meet those goals. DHCS has designated a dozen specific populations of focus[4] (PDF) for the ECM benefit, and managed care plans can add to that list at their discretion.

- ➤ **Community Supports (or "In Lieu of Services").** Medi-Cal's coverage may be comprehensive when it comes to health care services like doctor's visits, hospital or nursing home stays, or medications and equipment. There are, however, situations where traditional health care services on their own are not enough to support well-being. For example, a person experiencing homelessness who is diagnosed with cancer may not be able to tolerate chemotherapy if they don't have a safe place to stay, rest, and recover from treatment. Traditionally, Medi-Cal has not covered that safe place

to recuperate, instead only covering a nursing home or hospital, which is more than what is needed. In response, DHCS is proposing to give managed care plans the option to substitute new clinical and non-clinical services for traditionally covered services like care in a nursing home or hospital. This would give plans the financial flexibility to meet the needs of members in new, more patient-focused ways. These services, selected based on evidence that they can improve outcomes, are also intended to prevent or limit the kinds of health complications that require more expensive interventions.

DHCS has given plans the option of providing the following community supports[5] (PDF):

Housing supports
➤ Housing transition navigation services (e.g., assistance applying for and finding housing, signing a lease, securing resources for setup, utilities, moving in)

➤ Housing deposits

➤ Housing tenancy and sustaining services (e.g., early intervention around behaviors that might jeopardize housing, dispute resolution with landlords and neighbors, recertification support)

Short-term recovery supports
➤ Short-term, posthospitalization housing

➤ Recuperative care[6] (medical respite)

➤ Respite services for caregivers (such as those caring for people with dementia or children with disabilities) who need short-term relief

➤ Sobering centers[7]

Independent living supports
➤ Day habilitation programs (e.g., training on independent living skills like cooking, cleaning, and shopping)

➤ Nursing facility transition/diversion to assisted living facilities, such as residential care facilities for the elderly and adult residential facilities

➤ Community transition services / nursing facility transition to a home

➤ Personal care and homemaker services

➤ Environmental accessibility adaptations (home modifications)

➤ Medically tailored meals / medically supportive food

➤ Asthma remediation

➤ **Prerelease/in-reach care for people who are incarcerated.** People who are incarcerated are much more likely to be living with chronic illness and/or behavioral health conditions — like mental illness and substance use disorder — compared to people who are not incarcerated. Federal law prohibits Medi-Cal coverage for people while they are incarcerated. Instead, the jail or prison health service delivers and finances most care in facilities. However, people transitioning from incarceration face increased risk of adverse health events, including death. Research shows former prisoners are 129 times more likely than the general public to die of a drug-involved overdose in the two weeks after release,[8] and are also at higher risk for suicide after release.[9] As part of CalAIM, DHCS is seeking federal authority to expand coverage for key Medi-Cal services in the 90 days prior to release from jail or prison to ensure adequate planning for a smooth transition. Services while incarcerated include care management / care coordination, physical and behavioral health consultation services, and medication-assisted treatment for addiction. Following release, DHCS proposes to provide a 30-day supply of medication as well as durable medical equipment needed post-release, such as a walker or a glucometer. In addition, DHCS would mandate that counties implement a prerelease application process by January 1, 2023. The hope is that by enrolling people in Medi-Cal nearing their release and providing some targeted services early, CalAIM can help ease transition back to the community and prevent physical health and behavioral health complications, including the risk of post-release homelessness.

➤ **Providing Access and Transforming Health (PATH).** To successfully implement CalAIM, many providers will need to increase capacity and capabilities up front. For example, many of the providers that serve CalAIM's populations of focus have never contracted

with managed care plans. In fact, many have never interacted with the Medi-Cal program. Some parts of California may not even have enough providers, and those that do may need to train their workforce in delivering care and services in a coordinated way. The data sharing needed to support that coordination will also require investment in technical infrastructure. To address those needs, DHCS is seeking federal support for infrastructure improvements and technical assistance for community-based providers and correctional facilities. This PATH initiative would be able to cover assistance with contracting and payment processes, workforce development, and staff training. It would cover investments in delivery system infrastructure, such as certified electronic health record technology, care management document systems, closed-loop referral, billing systems and services, and onboarding and enhancements to health information exchange capabilities. PATH would also provide resources for county sheriff departments and state prisons to help with the design and launch of prerelease services. These services include IT services and infrastructure to enable jails and prisons to more easily enroll people in Medi-Cal and to begin coverage and care before they are released.

▶ **Population health management.** While many of CalAIM's reforms are focused on those with the most complex needs, getting to equitable outcomes requires identifying and addressing issues before they become bigger problems. With that in mind, DHCS has proposed requiring managed care plans to develop a comprehensive population health management program. Plans would need to prioritize prevention and wellness in the following ways: assessing member risk consistently and equitably, ensuring effective care coordination to safeguard members during transitions across settings and systems, and ensuring that plans provide services to address social risk factors (e.g., housing, nutrition) and to meet needs outside the managed care delivery system (e.g., behavioral and oral health). DHCS has also recognized that with data housed in many different places, it can be difficult to proactively identify who needs what services. In response, the agency proposes developing a new technology platform to expand access to medical, behavioral, and social service data — both

at the individual member level and for aggregate use by plans.

Key Changes to Existing Programs

CalAIM also proposes other key changes to Medi-Cal, including the following:

▶ **Behavioral health reforms.** The Medi-Cal behavioral health system today is divided three ways, with substance use services and specialty mental health services administered by counties, often across different departments or agencies, and non-specialty mental health services for people with mild to moderate illness administered by managed care plans. These divisions, and the different rules for payment and documentation surrounding them, make it difficult for patients to find the care they need, and for providers to respond in a patient-centered way. While maintaining the fundamental structure of behavioral health services in Medi-Cal, DHCS proposes reforms to ensure that patients can get treatment wherever they seek care — even before they receive a formal diagnosis — and to clarify the division of responsibility for mental health services between managed care plans and county mental health plans. It would also introduce a reimbursement system for behavioral health services based on the type of care provided, rather than the cost of the care, similar to reimbursement in the physical health system. DHCS also proposes streamlining clinical documentation requirements for specialty mental health and substance use disorder treatment services, with the goal of reducing administrative burden and supporting clinicians to focus more on patient care. Finally, CalAIM would help facilitate the integration of specialty mental health and substance use services at the county level into one behavioral health managed care program and proposes a new benefit — known as contingency management — for people with stimulant use disorder.

▶ **Aligned incentives and integrated care for seniors and people with disabilities.** Fragmentation of care and services is particularly acute for seniors and people with disabilities.[10] Medicare plays a significant role in paying for health care services for these populations. At the same time, they also receive important services, like nursing home care and personal care attendants,

that are paid for by Medi-Cal and are typically carved out of managed care. Under CalAIM, DHCS proposes reforms and incentives to make it easier for managed care plans to help seniors and people with disabilities stay in their homes and communities rather than move to nursing homes. It would also require plans to provide aligned Medicare and Medi-Cal plans for people eligible for both programs,[11] thereby supporting better integration and coordination of services. These reforms would build on lessons learned from the Coordinated Care Initiative.[12]

▶ **Standardized and enhanced requirements for managed care.** California has many different models of managed care today, each with a unique set of benefits and covered populations. In addition, there is variation in what plans do around population health management, data sharing, and voluntary accreditation. DHCS proposes a new requirement for managed care plans to proactively reach out to their members based on their needs, share data with other organizations and agencies providing care, and become accredited by the National Committee for Quality Assurance.[13] At the same time, DHCS would also introduce an aligned set of benefits and populations for all managed care plans to standardize their offerings and enable regional rate-setting.

▶ **More flexible payment for public hospitals that care for the uninsured.** Since 2015, public hospitals have been paid differently for care they provide to the uninsured, moving away from a system that focused on acute and emergency care to one focused on preventive care, including primary care and behavioral health. CalAIM would make the Global Payment Program a stronger tool for addressing health inequities by allowing participating public hospitals to be reimbursed for providing additional nontraditional services that address social determinants of health and improve population health outcomes and health equity. If these reforms are successfully implemented, uninsured patients would receive more preventive care, outreach, and care management services and be less likely to have complications that require an emergency room or hospital visit.

▶ **Enhanced oversight of county eligibility and enrollment processes.** Today, California delegates many functions of Medi-Cal to counties, including the determination of eligibility for Medi-Cal. There is variation in the degree to which counties successfully fulfill state and federal requirements for these functions. Under CalAIM, DHCS would do more to ensure that county eligibility and enrollment processes are compliant with federal and state regulations. The department plans to convene a workgroup to improve the collection of enrollee contact and demographic information in Medi-Cal and other public assistance programs.

▶ **Enhanced oversight of county California Children's Services programs.** The California Children's Services program is the primary way that Medi-Cal provides case management services and diagnostic and treatment services — as well as physical and occupational therapy services — to children and youth with eligible medical conditions, like cerebral palsy and diabetes. This program is administered by California's 58 counties. Through CalAIM, the state will enhance its oversight of counties to ensure they comply with applicable state and federal requirements.

▶ **Model of care for foster youth.** CalAIM would also develop a strategy for a fully integrated model of care for foster youth. DHCS has convened a workgroup[14] to determine short- and long-term policy recommendations for coordinating and improving care for this population.

Timeline for Implementation of CalAIM

DHCS maintains a calendar[15] (PDF) with updated time frames for when different reforms will go live. That should be the primary reference for those seeking more information about the timing of specific CalAIM programs.

This is the second in a series of explainers on CalAIM. The first, *CalAIM Explained: A Five-Year Plan to Transform Medi-Cal*, provides a basic overview of the initiative. Additional publications and resources from CHCF can be found in the CalAIM Collection. Additionally, the Department of Health Care Services has information on CalAIM on its website.

About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

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DHCS