LOS ANGELES COUNTY
COMMISSION ON HIV

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

Tuesday, August 27, 2024
1:00pm – 4:00pm (PST)

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/r6b6c0837ec96fa0eab35f919f2350bd3

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.

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LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave., 14th Floor, Los Angeles CA 90020
MAIN: 213.738.2816 EML: hivcomm@lachiv.org WEBSITE: https://hiv.lacounty.gov

AGENDA FOR THE SPECIAL MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV

PLANNING, PRIORITIES, & ALLOCATIONS COMMITTEE

TUESDAY, AUGUST 27, 2024 | 1:00 PM – 4:00 PM

****PLEASE NOTE EXTENDED 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/register/r6b6c0837ec96fa0eab35f919f2350bd3
To Join by Telephone: 1-213-306-3065
Password: PLANNING Access Code: 2536 756 0897

Planning, Priorities, and Allocations Committee Members:			
Kevin Donnelly, Co-Chair	Felipe Gonzalez Co-Chair	Al Ballesteros, MBA	Lilieth Conolly
Rita Garcia (Alternate)	Michael Green, PhD	William King, MD, JD	Miguel Martinez, MPH, MSW
Matthew Muhonen (LOA)	Daryl Russell	Harold Glenn San Agustin, MD	Dee Saunders
LaShonda Spencer, MD	Lambert Talley (Alternate)	Jonathan Weedman	
QUORUM: 7			

AGENDA POSTED: August 22, 2024

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 1:15 PM – 1:22 PM
    a. HRSA Technical Assistance Site Visit Updates

b. Priority Setting and Resource Allocation (PSRA) Ground Rules for Discussion

8. Co-Chair Report 1:22 PM – 1:40 PM
   a. New Member Welcome – Dee Saunders
   b. National Ryan White Conference on HIV Care and Treatment Takeaways
   c. PY35 Service Rankings Review

9. Division of HIV and STD Programs (DHSP) Report 1:40 PM – 2:10 PM
   a. Ryan White Program Year 33 Expenditure Report

BREAK 2:10 PM – 2:20 PM

V. DISCUSSION ITEMS – PREPARATION FOR FY 2025 RWHAP PART A NOTICE OF FUNDING OPPORTUNITY 2:20 PM—3:55 PM

10. Review Paradigms and Operating Values
11. Review Utilization Reports
12. Approve Service Rankings and Allocations for Program Years (PY) 35-37 Ryan White Program Part A and Minority AIDS Initiative (MAI) Funds **MOTION #3**

VI. NEXT STEPS 3:55 PM – 3:57 PM

13. Task/Assignments Recap
14. Agenda Development for the Next Meeting
    a. Begin review of Committee/Caucus Directives

VII. ANNOUNCEMENTS 3:57 PM – 4:00 PM

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

VIII. ADJOURNMENT 4:00 PM

16. Adjournment for the meeting of August 27, 2024.

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 Service Rankings and Allocations for Program Years (PY) 35-37 Ryan White Program Part A and Minority AIDS Initiative (MAI) Funds, as presented or revised.

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 6.12.23)

☐ This meeting is a **Brown-Act meeting** and is being recorded.

- The conference room speakers are *extremely* sensitive and will pick up even the slightest of sounds, i.e., whispers. If you prefer that your private or side conversations, not be included in the meeting recording which, is accessible to the public, we respectfully request that you step outside of the room to engage in these conversations.
- 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. *For members of the public attending virtually, you may also submit your public comment via the Chat box. Should you wish to speak on the record, please use the "Raised Hand" feature or indicate your request in the Chat Box and staff will call upon and unmute you at the appropriate time. Public comment is limited to 2 minutes per person. Please note that all attendees are muted unless otherwise unmuted by staff.*

☐ 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, at all times, 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.

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-6748
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Approved by COH 6/8/23

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.)

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 8/14/24

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, & inked Referral…(CSV)
			STD Screening, Diagnosis, and Treatment
			Health Education/Risk Reduction (HERR)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation 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)
			Transportation Services
CIELO	**Mikhaela**	LAC & USC MCA Clinic	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	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated representative	No Ryan White or prevention contracts
FERGUSON	**Kerry**	ViiV Healthcare	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
FRAMES	**Arlene**	Unaffiliated representative	No Ryan White or prevention contracts
FRANKLIN*	**Arburtha**	Translatin@ Coalition	Vulnerable Populations (Trans)
GARCIA*	**Rita**	Translatin@ Coalition	Vulnerable Populations (Trans)
GERSH (SBP Member)	**Lauren**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			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
			Data to Care Services
GONZALEZ	**Felipe**	Unaffiliated representative	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated representative	No Ryan White or prevention contracts
GREEN	**Joseph**	Unaffiliated representative	No Ryan White or prevention contracts
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
KOCHEMS	**Lee**	Unaffiliated representative	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
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 Affiliation)	No Ryan White or prevention contracts
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
			Data to Care Services
MUHONEN	**Matthew**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			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
			Data to Care Services
OSORIO	**Ronnie**	Center For Health Justice (CHJ)	Transitional Case Management - Jails
			Promoting Healthcare Engagement Among Vulnerable Populations
PATEL	**Byron**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			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
RICHARDSON	**Dechelle**	AMAAD Institute	Community Engagement/EHE
ROBINSON	**Erica**	Health Matters Clinic	No Ryan White or prevention contracts
RUSSEL	**Daryl**	Unaffiliated representative	No Ryan White or prevention contracts
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
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation 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 Affiliation)	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES
July 16, 2024

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	Miguel Martinez, MPH, MSW	P
Felipe Gonzalez, Co-Chair	P	Matthew Muhonen	LOA
Al Ballesteros, MBA	A	Derek Murray	P
Lilieth Conolly	EA	Daryl Russell	P
Rita Garcia	A	Harold Glenn San Agustin, MD	P
Joseph Green	P	LaShonda Spencer, MD	P
Michael Green, PhD, MHSA	P	Lambert Talley	A
William King, MD, JD	P	Jonathan Weedman	EA
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Dawn McClendon, Lizette Martinez			
DHSP STAFF			
Pamela Ogata, Paulina Zamudio			

*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

Kevin Donnelly, Planning, Priorities and Allocations (PP&A) co-chair, called the meeting to order at approximately 1:05pm.

2. ROLL CALL & CONFLICT OF INTEREST STATEMENTS

K. Donnelly conducted roll call vote and committee members were reminded to state their conflicts.

ROLL CALL (PRESENT): J. Green, M. Green, W. King, M. Martinez, D. Murray, D. Russel, H. San Agustin, L. Spencer, K. Donnelly, F. Gonzalez

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.**

   R. Ybarra requested that the committee consider reallocating money for Program Year (PY) 34 towards Housing Services should there be a surplus in Part A or MAI funds.

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.**

   W. King requested that the committee discuss how to prioritize and fund HIV and STI prevention services at a future meeting to address recent comments about planning as an integrated body to focus on both HIV prevention and care.

IV. REPORTS

7. **Executive Director/Staff Report**

   a. **HRSA Dear Colleague Letter – Housing Security Deposit**

   - C. Barrit, Executive Director, reported that the Health Resources and Services Administration (HRSA) recently released a letter indicating that Ryan White Program (RWP) funds can be used towards rental security deposits. See meeting packet for details. She noted that a mechanism for ensuring security deposits directly go directly to the housing provider/landlord and returning the deposit back to the recipient (i.e., Division of HIV and STD Programs) or the subcontracted agenda when a tenant moves out must be in place. The security deposits cannot be sent directly or returned to a tenant.
   - DHSP staff, P. Zamudio, noted that this strategy can be used under Emergency Financial Assistance services as current Housing services under the RWP fund beds for the chronically ill and do not support general housing. She also noted that DHSP is in conversations with APLA, who manages the Emergency Financial Assistance program, on how this strategy can be implemented.

   b. **Priority Setting and Resource Allocation (PSRA) Refresher**

   - C. Barrit provided a brief refresher on the priority setting and resource allocation process. She briefly reviewed each step of the process and highlighted data summaries of previous utilization report presentations. See meeting packet for PSRA process summary and

utilization report summaries.

- It was noted that the Paradigms and Guiding Values are planning tools unique to the Commission on HIV and are not a requirement of HRSA.
- There was a reminder that Commissioners must complete the Priority Setting and Resource Allocation Training before the next PP&A Committee meeting in order to vote on allocations during the August meeting.

8. Co-Chair Report

a. Priority Setting and Resource Allocation Training Reminder

- F. Gonzalez reminded the group that they must complete the Priority Setting and Resource Allocation Training before the next PP&A Committee meeting in August to vote on allocations. Committee members who do not complete the training by August 26, 2024, will not be eligible to vote on recommended allocations for Program Year (PY) 35. The training can be found on the Events page of the Commission on HIV website. Once the training is complete, members must notify staff that they have completed the training. If staff is not notified, the training will be marked as incomplete.
- Commission staff will send a reminder to the committee with a link to the events page.

b. August 27, 2024 PP&A Committee Meeting

- F. Gonzalez reminded the group that the August PP&A Committee meeting was rescheduled from Tuesday, August 20th to Tuesday, August 27th to accommodate virtual attendance to the annual National Ryan White Conference on HIV Care and Treatment. The meeting will be held from 1pm-4pm at the Vermont Corridor.

9. Division of HIV and STD Programs (DHSP) Report

a. Ryan White Program Year 33 Expenditure Report

- P. Ogata reported that DHSP is still in the process of closing out the County fiscal year and that final numbers are not yet ready. DHSP will provide a final report in August.

b. Approval of Ryan White Program Year 34 Allocations MOTION #3

- P. Ogata provided a presentation on Program Year (PY) 34 potential allocation scenarios. Recommended allocations are based off PY33 Expenditures. See meeting packet for more details.
- P. Ogata reviewed important HRSA deadlines for the current PY34 and for the upcoming HRSA Part A 2025-2027 funding cycle; see meeting packet for more details.
- A review of RWP core and support services that are currently funded by Part A funds under DHSP was provided. It was noted that the Transitional Case Management (TCM) Services funded under Non-Medical Case Management Services is currently being restructured. It was noted that contracted providers for TCM-jails had trouble accessing inmates and that the new health director of the jail system wants the health department to provide services

as they have better access to health data. The new structure will consist of six DHSP staff who will go directly into the jails and will follow up with clients when released. Operating protocols and procedures are still under development.

- It was noted that total expenditures for PY33 exceeded the total award amount by approximately $3 million. Service categories that exceeded allocated amounts include Oral Health Services, Legal Services, Emergency Financial Assistance, Benefits Specialty (within Non-Medical Case Management Services) and Housing Services. DHSP was able to cover the overage via Net County Cost funds and other grants but noted these funds are not unlimited and may be needed to support other services in the future.
- The total RWP Part A and Minority AIDS Initiative (MAI) grant funds for PY34 available for direct services is approximately $41.3 million. DHSP projects that the PY 34 total RWP Part A and MAI direct services expenditures will exceed approximately $45 million. As a result, the Committee was tasked with reallocating funds to maintain RWP core and support services funded in LAC.
- DHSP staff met with PP&A and Commission on HIV co-chairs prior to the meeting to discuss potential reallocations. The proposed reallocations were presented to the committee for further discussion and deliberation. Discussion was had on the ramifications of reducing funding to categories and potential impact on services. It was noted that changes to allocations took into consideration other funding sources, consumer needs and maximizing funding to benefit all clients. See meeting packet for allocation changes for PY34.
- Some services were moved to other funding sources to maximize RWP PY34 grant funds. It was noted that just because services were removed from RWP funding does not indicate that services have stopped but, rather, are funded by other sources. These services include Partner Services (previously including under Early Intervention Services), Home Delivered Meals (previously under Nutritional Support Services), Linkage and Re-engagement Program (previously under Outreach Services), Language Services and Psychosocial Services.
- There was a concern that Emergency Financial Assistance (EFA) was no longer being offered. P. Zamudio, DHSP staff, clarified that applications are still being accepted but funding is being restricted to cover rent and will no longer support utilities or food bank cards as these services can be covered via other sources and services. Additionally, it was noted that the intent of EFA to keep people clients in their homes and that the change is to ensure clients can remain housed. Repeat applications will no longer be accepted. She noted that DHSP will need to work with contracted Benefits Specialty providers to ensure clients have knowledge and access to other programs that support rental assistance, utility assistance and food assistance. This information will be shared with HIV medical providers to share with their clients. It was noted that Benefits Specialty providers are not always accommodating to consumers that are not part of their client base which creates unnecessary challenges for consumers seeking Benefits Specialty services.
- M. Green provided a brief outline of items for consideration for establishing priorities and allocations for the next RWP Part A funding cycle; see meeting packet for details.
- After discussions, the Committee approved the Ryan White Program Year 34 Allocations;

see pages 34-36 of the meeting packet for PY34 Allocations. See table below for approved allocations.

	Services	YR 34 COH Part A %	YR 34 COH MAI %	YR 34 Re-Allocation	YR 34 Re-allocation Part A%	YR 34 Re-allocation MAI %
CORE	AOM/MSS	25.51%	0.00%	$6,500,000	17.11%	0.00%
	MCC/PSS	28.00%	0.00%	$10,316,352	27.15%	0.00%
	Oral Health	17.48%	0.00%	$7,900,000	20.79%	0.00%
	EIS (STD clinic)	0.00%	0.00%	$2,500,000	6.58%	0.00%
	Mental Health	4.07%	0.00%	$110,000	0.29%	0.00%
	Home Based Case Management	6.78%	0.00%	$2,470,000	6.50%	0.00%
SUPPORT	Transportation	2.17%	0.00%	$700,000	1.84%	0.00%
	Nutritional Support (food bank)	8.95%	0.00%	$2,200,000	5.79%	0.00%
	Professional Services (Legal)	1.00%	0.00%	$538,000	1.42%	0.00%
	Language	0.65%	0.00%	$ -	0.00%	0.00%
	Outreach (LRP)	0.00%	0.00%	$ -	0.00%	0.00%
	EFA	0.00%	0.00%	$2,400,000	6.32%	0.00%
	NMCM (TCM Jails) 6 medical case workers and 1 HPA I	0.00%	12.61%	$600,000	1.58%	0.00%
	NMCM (BSS)	2.44%	0.00%	$1,500,000	3.95%	0.00%
	Housing (H4H) housing only no EFA	0.00%	87.39%	$3,305,635	0.00%	100.00%
	Housing (RCFCI& TRCF Mental Health)	0.96%	0.00%	$344,000	0.91%	
	Psychosocial Services	1.00%	0.00%	$ -	0.00%	0.00%
	Childcare Services	0.95%	0.00%	$ -	0.00%	0.00%
	Total	**100%**	**100%**	**$41,303,987**	**100%**	**100%**

(✓Passed by majority; Roll Call: M. Green (A), W. King (Y), M. Martinez (Y), D. Russell (Y), G. San Agustin (Y), L. Spencer (Y), F. Gonzalez (Y), K. Donnelly (Y), J. Green (Y).)

V. DISCUSSION - PREPARATION FOR FY 2025 RWHAP PART A NOTICE OF FUNDING OPPORTUNITY

10. Review Paradigms and Operating Values

- The review of the Paradigms and Operating Values was postponed to the August meeting.

11. Review Utilization Reports

- The review of PY32 Utilization Reports was postponed to the August meeting. Committee members were reminded to review the utilization reports prior to the next meeting. The reports can be found on the Commission on HIV website under the Member Resources page.

12. Rank Ryan White Program Service Categories

- The Committee voted for FY 2025 RWP Service Category priorities via dot vote. Online participants were allowed to vote for their top 10 priorities via poll vote. Votes will be tallied and presented at the August PP&A meeting.

VI. NEXT STEPS

13. Task/Assignments Recap

a. Commission staff will compile votes from priority ranking activity and will review with the committee during the August meeting.
b. DHSP will share the PY33 Expenditure Report ahead of the August meeting to allow committee members time to review the document prior to the meeting.
c. Committee members will complete the Priority Setting and Resource Allocation training and will notify staff before August 26th.

14. Agenda Development for the Next Meeting

a. Program Year 33 Expenditures Report
b. Revisit Paradigms and Operating Values
c. Review Ryan White Service Ranking Votes
d. Allocate Funding to Ryan White Services
e. Approve FY 2025 (Program Year 35) Service Rankings and Allocations

VII. ANNOUNCEMENTS

15. Opportunity for Members of the Public and the Committee to Make Announcements

- *There were no announcements.*

VIII. ADJOURNMENT

16. Adjournment for the Meeting of July 16, 2024.

The meeting was adjourned by K. Donnelly at 3:50pm.

DRAFT

LOS ANGELES COUNTY
COMMISSION ON HIV

Steps in the Priority Setting and Resource Allocation Process
Ryan White Program Year – March 1 to February 28

1. Review core medical and support service categories, including HRSA service definitions

2. Review data/information from DHSP & COH Caucuses

3. Agree on how decisions will be made; what values will be used to drive the decision-making process

4. Rank services by priority
   Ranking DOES NOT equal level of allocation by percentage

5. Allocate funding sources to service categories by percentage
   Ryan White Program Part A and Minority AIDS Initiative (MAI)

6. Draft Directives: Provide instructions to DHSP on how best to meet the priorities
   Informed by COH Committees, Caucuses, Task Forces, data, PLWH & provider input

7. Reallocation of funds across service categories, as needed throughout funding cycle

LOS ANGELES COUNTY
COMMISSION ON HIV

Ryan White Program Service Categories

Core Medical Services

- AIDS Drug Assistance Program (ADAP) Treatments
- Local AIDS Pharmaceutical Assistance Program (LPAP)
- Early Intervention Services (EIS)
- Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
- Home and Community-Based Health Services (aka Home-based Case Management)
- Home Health Care
- Hospice Services
- Medical Case Management, including Treatment Adherence Services (aka Medical Care Coordination)
- Medical Nutrition Therapy
- Mental Health Services
- Oral Health Care
- Outpatient/Ambulatory Health Services
- Substance Abuse Outpatient Care

Supportive Services

- Childcare Services
- Emergency Financial Assistance
- Food Bank/Home Delivered Meals
- Health Education/Risk Reduction
- Housing
- Linguistic Services
- Medical Transportation
- Non-Medical Case Management Services
- Other Professional Services
  - Legal Services
  - Permanency Planning
- Outreach Services
- Permanency Planning
- Psychosocial Support
- Referral for Healthcare and Support Services
- Rehabilitation
- Respite Care
- Substance Abuse (Residential)

Click here for more information on allowable use of funds.

LOS ANGELES COUNTY
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Ryan White Program Parts

Program Part	Recipient	Funding Purpose
Part A and Minority AIDS Initiative Funds* **(Locally managed by DHSP)**	**Eligible Metropolitan Areas (EMAs) & Transitional Grant Areas (TGAs)**	• **Provide medical (core) and support services to cities/counties most severely affected by HIV** • **Minority AIDS Initiative – Help RWHAP recipients improve access to HIV care and health outcomes for minorities**
Part B	All 50 states, District of Columbia, Puerto Rico, U.S. Virgin Islands, and six U.S. territories; states distribute money to counties	• Improve the quality of and access to HIV health care and support in the U.S. • Provide medications to low-income people with HIV through AIDS Drug Assistance Program (ADAP)
Part C	Local community-based groups (e.g., FQHCs, clinics, CBOs, FBOs, etc.)	• Provide outpatient ambulatory health service s and support for people with HIV • Help for community-based groups to strengthen their capacity to deliver high-quality HIV care
Part D	Local community-based organizations	• Provide medical care for low-income women, infants, children and youth with HIV • Offer support services for people with HIV and their family members
Part F	• AETCs & SPNS • Dental Programs	• AIDS Education and Training Center (AETC) Program – Provide training and technical assistance to providers treating patients with or at risk for HIV • Special Projects of National Significance (SPNS) – Develop innovative models of HIV care and treatment to respond to RWHAP client needs • Dental Programs – Provide oral health care for people with HIV and education about HIV for dental care providers

** Indicates RWP Parts that are allocated by the Commission on HIV/Planning Council.*

LOS ANGELES COUNTY
COMMISSION ON HIV

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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.

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:** _____

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
PARADIGMS AND OPERATIONG VALUES
(Amended Draft - PP&A 04/20/2021)

PARADIGMS (Decision-Making)

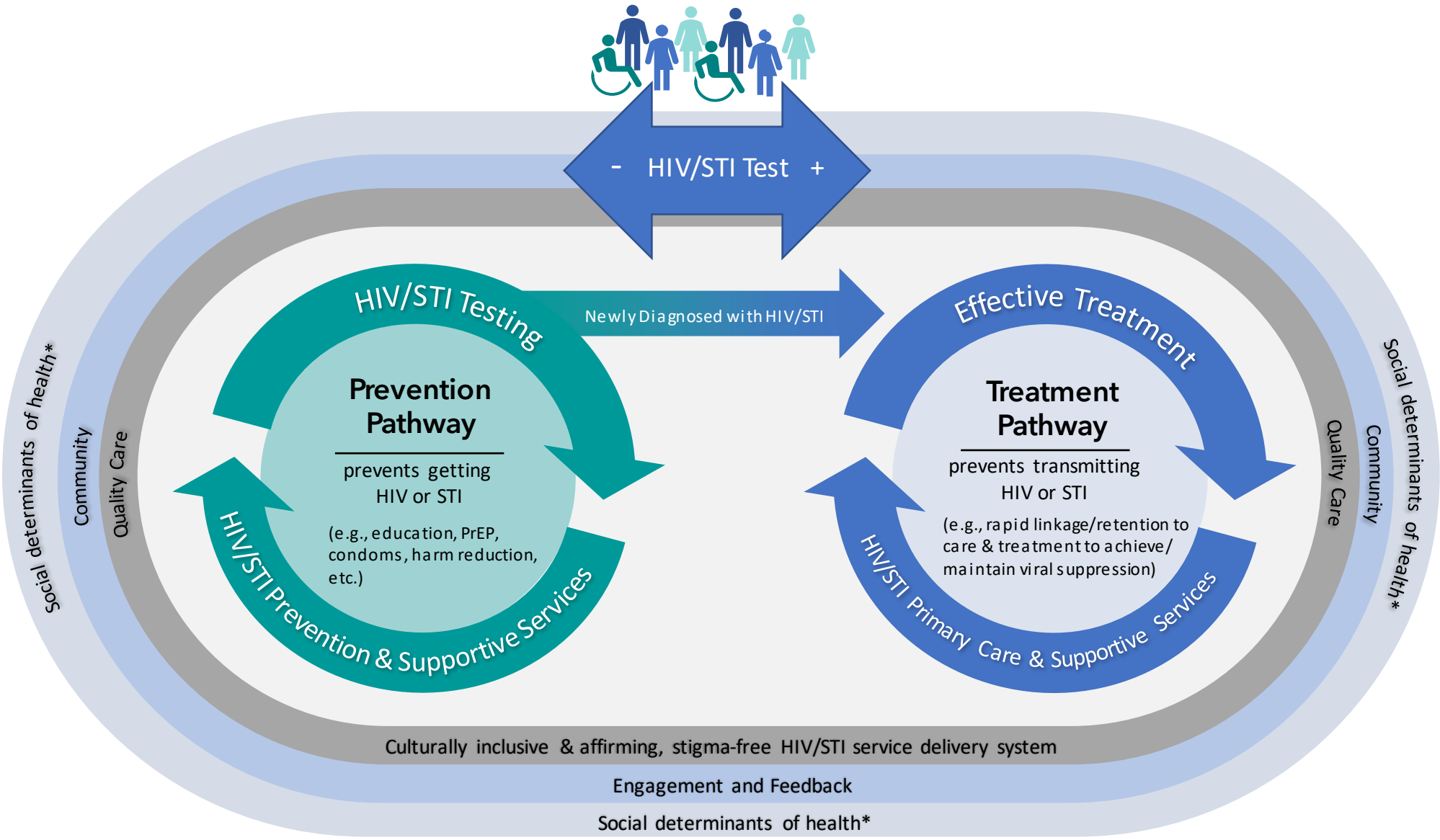
- Equity: Allocate resources in a manner that address avoidable or curable differences among groups of people, whether those groups are defined by ethnicity, socially, economically, demographically, or geographically. (1)
- ***Compassion: response to suffering of others that motivates a desire to help.*** (2)

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***. (3)

1 Based on the World Health Organization's (WHO) definition of equity.
2 Compassion moved to second position per April 20, 2021 committee meeting decision.
3 Wording change per April 20, 2021 committee meeting decision.

Status Neutral HIV and STI Service Delivery System



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.

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
RYAN WHITE PART A and MAI EXPENDITURES BY SERVICE CATEGORIES
GRANT PERIOD: MARCH 01, 2023 - FEBRUARY 29, 2024
YEAR 33 - SUMMARY REPORT

Priority #	Service Category	YR 33 PC Part A/MAI Allocation Percentages	Year 33 Part A/MAI Allocation in Dollars	Year 33 Part A/MAI Expenditures in Dollars	Variance between Expenditures and Allocations [5-4]	Year 33 Part A/MAI Expenditures Covered by Other Sources Dollars	YR 33 TOTAL EXPENDITURES	NOTES
	CORE SERVICES							
3	OUTPATIENT/AMBULATORY MEDICAL CARE (AOM)	17.10%	7,033,345	6,564,100	(469,245)	1,694,000	8,258,100	Not seeing a reduction even with MediCal expansion
13	ORAL HEALTH CARE	16.19%	6,658,823	7,188,786	529,963	616,496	7,805,282	
18	HOME AND COMMUNITY-BASED HEALTH SERVICES	6.24%	2,565,974	2,614,732	48,758	252,176	2,866,908	
6	MEDICAL CASE MANAGEMENT SERVICES (MCC)	22.27%	9,162,604	9,064,884	(97,720)	1,622,930	10,687,814	
7	MENTAL HEALTH SERVICES	3.14%	1,290,874	109,422	(1,181,452)	0	109,422	Challenge recruiting and retaining service providers
10	EARLY INTERVENTION SERVICES (EIS)	7.68%	3,160,652	3,014,301	(146,351)	251,465	3,265,766	
9	SUBSTANCE ABUSE OUTPATIENT	0.00%	-	0	-	0	0	
19	HOME HEALTH CARE	0.00%	-	0	-	0	0	
21	HEALTH INSURANCE PREMIUM/COST SHARING	0.00%	-	0	-	0	0	
23	MEDICAL NUTRITIONAL THERAPY	0.00%	-	0	-	0	0	
26	LOCAL PHARMACY ASSISTANCE	0.00%	-	0	-	0	0	
27	HOSPICE	0.00%	-	0	-	0	0	
	CORE SERVICES TOTAL	**72.62%**	**$29,872,272**	**$ 28,556,225**	**$ (1,316,047)**	**$ 4,437,067**	**$ 32,993,292**	

SUPPORTIVE SERVICES

14	CHILD CARE SERVICES	0.88%	360,299	0	(360,299)	0	0	Released RFP twice, no proposals received, no service providers
2	CASE MANAGEMENT SERVICES NON-MEDICAL (BSS/TCM)	3.26%	1,341,072	1,787,095	446,023	26,031	1,813,126	TCM expenditures were for contracted services.
22	LINGUISTIC SERVICES	0.60%	246,819	3,300	(243,519)	0	3,300	Very low utilization of service (written
11	MEDICAL TRANSPORTATION SERVICES	1.75%	721,770	603,552	(118,218)	33,599	637,151	
12	FOOD BANK/HOME-DELIVERED MEALS (NSS)	8.23%	3,386,812	3,381,611	(5,201)	500,853	3,882,464	
1	HOUSING SERVICES (TRCF/RCFCI) (THAS)	7.92%	3,256,752	4,007,396	750,644	4,433,206	8,440,602	
15	OTHER PROFESSIONAL SERVICES (LEGAL)	0.92%	379,213	537,627	158,414	0	537,627	
4	EMERGENCY FINANCIAL ASSISTANCE (EFA)	3.82%	1,569,808	2,614,115	1,044,307	0	2,614,115	
8	OUTREACH (LRP)	0.00%	-	473,413	473,413	449,631	923,044	
5	PSYCHOSOCIAL SUPPORT SERVICES	0.00%	-	0	-	0	0	
16	SUBSTANCE ABUSE RESIDENTIAL	0.00%	-	0	-	725,000	725,000	
17	HEALTH EDUCATION/RISK REDUCTION	0.00%	-	0	-	0	0	
20	REFERRAL	0.00%	-	0	-	0	0	
24	REHABILITATION	0.00%	-	0	-	0	0	
25	RESPITE CARE	0.00%	-	0	-	0	0	
	SUPPORTIVE SERVICES TOTAL	**27.38%**	**$ 11,262,545**	**##########**	**$2,145,564**	**$6,168,320**	**$19,576,429**	
	PART A AND MAI DIRECT SERVICES TOTAL	**100.00%**	**41,134,817**	**41,964,334**	**829,517**	**10,605,387**	**52,569,721**	

Other Funding Sources:
HRSA Part B
HRSA EHE
SAPC Non-Drug MediCal
County HIV Funds (NCC)

$5m was covered by Part B

LOS ANGELES COUNTY
COMMISSION ON HIV

Planning, Priorities and Allocations Committee
Service Category Rankings

PY[1] 35	PY 36	PY 37	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
1			Housing • Permanent Support Housing • Transitional Housing • Emergency Shelters • Transitional Residential Care Facilities (TRCF) • Residential Care Facilities for the Chronically Ill (RCFCI)	S	Housing
2			Emergency Financial Assistance	S	Emergency Financial Assistance
3			Mental Health • Mental Health Psychiatry • Mental Health Psychotherapy	C	Mental Health Services
4			Psychosocial Support	S	Psychosocial Support
5			Non-Medical Case Management • Linkage Case Management • Benefit Specialty • Benefits Navigation • Transitional Case Management • Housing Case Management	S	Non-Medical Case Management
6			Medical Care Coordination	C	Medical Case Management
7			Nutrition Support	S	Food Bank/Home Delivered Meals
8			Oral Health Services	C	Oral Health Care
9			AIDS Drug Assistance Program (ADAP) Treatments	C	AIDS Drug Assistance Program (ADAP) Treatments
10			Medical Transportation	S	Medical Transportation
11			Early Intervention Services	C	Early Intervention Services
12			Substance Abuse Outpatient	C	Substance Abuse Outpatient Care
13			Health Education/Risk Reduction	S	Health Education/Risk Reduction

PY[(1)] 35	PY 36	PY 37	Commission on HIV (COH) Service Categories	HRSA Core/ Support Service	Core and Support Services Defined by Health Resources and Services Administration (HRSA)
14			Outreach Services (Linkage and Re-engagement Program) • Engaged/Retained in Care	S	Outreach Services
15			Health Insurance Premium/Cost Sharing	C	Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
16			Home Health Care	C	Home Health Care
17			Home-Based Case Management	C	Home and Community-Based Health Services
18			Child Care Services	S	Child Care Services
19			Substance Abuse Residential	S	Substance Abuse Treatment Services (Residential)
20			Ambulatory Outpatient Medical Services	C	Outpatient/Ambulatory Health Services
21			Respite	S	Respite Care Respite Care
22			Local Pharmacy Assistance	C	Local AIDS Pharmaceutical Assistance Program (LPAP)
23			Legal Services and Permanency Planning	S	Other Professional Services (including Legal Services and Permanency Planning)
24			Referral	S	Referral for Health Care and Support Services
25			Rehabilitation	S	Rehabilitation
26			Medical Nutrition Therapy	C	Medical Nutrition Therapy
27			Language	S	Linguistic Services
28			Hospice Services	C	Hospice Services

Footnote:
1 – Service rankings approved by PP&A Committee on 7/16/2024

Los Angeles County Department of Public Health Division of HIV and STD Programs Proposed Revisions to FY 2023 (PY 33) Allocations

APPROVED BY COH 06.08.23

	Part A Award	MAI Award	Part A/MAI Totals
Total Award	**$ 42,984,882**	**$ 3,675,690**	**$ 46,660,572**
Admin Ceiling	$ 4,298,488	$ 367,569	**$ 4,666,057**
CQM	$ 859,698	$ -	**$ 859,698**
Direct Services	$ 37,826,696	$ 3,308,121	**$ 41,134,817**

		Allocations Approved by the Commission on HIV		Allocations Proposed by the Division of HIV and STD Programs						
	Service Category	**FY 2023 Approved Part A Allocations (approved 1/13/22)**	**FY 2023 Approved MAI Allocations (approved 1/13/22)**	**FY 2023 Part A Recommendation**	**RecommendedFY 2023 Part A %**	**FY 2023 MAI Recommendation**	**Recom-mended FY 2023 MAI %**	**Total FY 2023 Part A/MAI Recommended $**	**Recom-mended Total FY 2023 Part A/MAI %**	Notes
SERVICES (71.1%)	Outpatient/Ambulatory Medical Services	25.51%	0.00%	$ 7,033,345	18.59%	$ -	0.00%	**$ 7,033,345**	**17.10%**	Reduction in Part A allocation to account for addition of EIS, EFA and Outreach allocations and estimated YR 33 AOM expenditures.
	AIDS Drug Assistance Program (ADAP) Treatments	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	AIDS Pharmaceutical Assistance (local)	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Oral Health	17.60%	0.00%	$ 6,658,822	17.60%	$ -	0.00%	**$ 6,658,822**	**16.19%**	No change.
	Early Intervention Services	0.00%	0.00%	$ 3,160,651	8.36%	$ -	0.00%	**$ 3,160,651**	**7.68%**	Allocation includes Linkage and Reengagement Program and new DPH Clinic Health Services program. Funding will help support a status-neutral approach using Part A funds.
	Health Insurance Premium & Cost Sharing Assistance	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Home Health Care	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.

CORE	Home and Community Based Health Services	6.78%	0.00%	$ 2,565,974	6.78%	$ -	0.00%	**$ 2,565,974**	**6.24%**	No change.
	Hospice Services	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Mental Health Services	4.07%	0.00%	$ 1,290,874	3.41%	$ -	0.00%	**$ 1,290,874**	**3.14%**	Reduction in Part A allocation due to estimated YR 33 expenditures. Spanish Mental Health Telehealth and other mental health assesments will be supported using EHE funds.
	Medical Nutritional Therapy	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Medical Case Management (MCC)	28.88%	0.00%	$ 9,162,605	24.22%	$ -	0.00%	**$ 9,162,605**	**22.27%**	Reduction in Part A allocation by to account addition of EIS, Out reach and EFA allocations and estimated YR 33 MCC expenditures.
	Substance Abuse Services Outpatient	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
ES (28.9%)	Case Management (Non-Medical) Benefits Specialty	2.44%	0.00%	$ 923,917	2.44%	$ -	0.00%	**$ 923,917**	**2.25%**	No change.
	Case Management (Non-Medical) TCM - Jails	0.00%	12.61%	$ -	0.00%	$ 417,154	12.61%	**$ 417,154**	**1.01%**	No change.
	Child Care Services	0.95%	0.00%	$ 360,299	0.95%	$ -	0.00%	**$ 360,299**	**0.88%**	No change.
	Emergency Financial Assistance	0.00%	0.00%	$ 1,569,808	4.15%	$ -	0.00%	**$ 1,569,808**	**3.82%**	EFA allocation added. EFA was previously funded under HRSA EHE but now funded with Part A to ensure RWHAP target populations are reached with the program.
	Food Bank/Home-delivered Meals	8.95%	0.00%	$ 3,386,813	8.95%	$ -	0.00%	**$ 3,386,813**	**8.23%**	No change.
	Health Education/Risk Reduction	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Housing Services RCFCI	0.58%	0.00%	$ 220,719	0.58%	$ -	0.00%	**$ 220,719**	**0.54%**	No change.
	Housing Services TRCF	0.38%	0.00%	$ 145,065	0.38%	$ -	0.00%	**$ 145,065**	**0.35%**	No change.

Los Angeles County Department of Public Health Division of HIV and STD Programs Proposed Revisions to FY 2023 (PY 33) Allocations

SUPPORT SERVIC	Housing Services /Rental Subsidies with CM	0.00%	87.39%	$ -	0.00%	$ 2,890,967	87.39%	**$ 2,890,967**	**7.03%**	Permanent Supportive Housing/Rental Subsidies costs beyond allocation to be supported using MAI carryover or other funding sources.
	Legal Services	1.00%	0.00%	$ 379,213	1.00%	$ -	0.00%	**$ 379,213**	**0.92%**	No change.
	Linguistic Services	0.65%	0.00%	$ 246,819	0.65%	$ -	0.00%	**$ 246,819**	**0.60%**	No change.
	Medical Transportation	2.17%	0.00%	$ 721,771	1.91%	$ -	0.00%	**$ 721,771**	**1.75%**	Part A allocation reduced due to estimated YR 33 expenditures
	Outreach Services	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Psychosocial Support Services	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	New Buddy Program is supported using EHE funds.
	Referral	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Rehabilitation	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Respite Care	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Substance Abuse Residential	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Treatment Adherence Counseling	0.00%	0.00%	$ -	0.00%	$ -	0.00%	**$ -**	**0.00%**	No change.
	Overall Total			**$ 37,826,696**		**$ 3,308,121**		**$ 41,134,817**		
	Admin			**$ 4,298,488**		**$ 367,569**		**$ 4,666,057**		
	CQM			**$ 859,698**		**$ -**		**$ 859,698**		
				$ 42,984,882		**$ 3,675,690**		**$ 46,660,572**		

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
PARADIGMS AND OPERATIONG VALUES
(Amended Draft - PP&A 04/20/2021)

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. (1)
- ***Compassion: response to suffering of others that motivates a desire to help.*** (2)

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***. (3)

1 Based on the World Health Organization's (WHO) definition of equity.
2 Compassion moved to second position per April 20, 2021 committee meeting decision.
3 Wording change per April 20, 2021 committee meeting decision.

LOS ANGELES COUNTY COMMISSION ON HIV

Planning, Priorities and Allocations (PP&A) Committee

List of Paradigms and Operating Values for Priority and Allocation Setting Process

LOS ANGELES COUNTY COMMISSION ON HIV

TASKS

Questions to Consider When Selecting Paradigms and Operating Values

- Decisions are expected to address overall needs within the service area, not narrow advocacy concerns.
- Services must be culturally appropriate.
- Services should focus on the needs of low-income, underserved and disproportionately impacted populations.
- Equitable access to services should be provided across geographic areas and subpopulations.

LOS ANGELES COUNTY
COMMISSION ON HIV

Paradigms and Operating Values

Paradigms:

- Represents the ethical perspective from which decisions are made
- A lens through which the decision-making process is approached

Operating Values:

- Represents the codes of conduct
- Values applied to the decision-making process

LOS ANGELES COUNTY
COMMISSION ON HIV

Paradigms

Absolute Inclusion: No matter how meager the available resources, all community participants will receive a share.

Nuanced Inclusiveness: Guarantees complete participation but may entail differential distribution of resources.

Risk Equalization: Sharing risk across while engaging all participants in efforts to increase resources.

Equality: Equal portions to each or equal cuts

LOS ANGELES COUNTY COMMISSION ON HIV

Paradigms

Equity: Allocating levels of investments and commitment that meaningfully address the needs of populations disproportionately impacted by HIV/STIs and social determinants of health

Fairness: Similar cases treated in a similar fashion

Altruism: Volunteering to take a cut or go without

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

Chance: Fate decides through random choice; let the universe decide

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COMMISSION ON HIV

Paradigms

Coercion: Enforced decision by authority

Utilitarianism: Greatest good for the greatest number

Rights and Duties: Participation in the community recognizes reciprocal rights and duties

Retributive Justice: Making up for past inequities

Distributive Justice: Working toward general equality

Merit: Past or Current Contributions

Market: Ability or willingness to pay

LOS ANGELES COUNTY COMMISSION ON HIV

Paradigms

Fidelity: Recognizing and adhering to past commitments

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

LOS ANGELES COUNTY
COMMISSION ON HIV

Operating Values

Survival: Emphasis on maintaining the existence of the current system of care at all costs

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

Fidelity: Primary focus on commitments that bind providers and the clients for the duration of need

Beneficence: Assurances to do the most good in the process as possible

Advocacy: Addressing the asymmetrical power relationships of stake holders in the process

LOS ANGELES COUNTY COMMISSION ON HIV

Operating Values

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

Non-Maleficence: Making sure not to make the situation worse

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

Barriers: Primary focus on barriers and disparities of continuum of care

LOS ANGELES COUNTY COMMISSION ON HIV

Items for Consideration in Establishing Priorities and Allocations

- Based on data and evidence, what is the need of people with HIV in Los Angeles County?
- What barriers are preventing people from accessing the services and treatment they need?
- Looking at the expenditures, do you need to change (increases or decreases) the allocations? What data/evidence supports this?
- If increases in allocation are proposed, what decreases will be made? What data/evidence supports this?

Items for Consideration in Establishing Priorities and Allocations (cont.)

- Are there any changes to the way services are provided or where they are provided? What data/evidence supports the recommendations?
- What federal, state, local changes may occur that will impact available funding?
- What federal, state, local changes may occur that will impact service delivery?
- What federal, state, local changes may occur that will impact client needs?

SUMMARY OF FINDINGS

Service use and expenditures vary by service category and by priority populations. This variation may be influenced by the priority population size, underlying characteristics within each priority and priority population such as health status, income, housing status or neighborhood of residence, service need or service access and others. Main findings for service utilization are presented below in Table 5.

Table 5. Summary of Findings for RWP Service Utilization in LAC, Year 32

	RWP	AOM	MCC
Primary Populations Served	• Latinx and Black • Cisgender male • PLWH ≥ Age 50 • MSM	• Latinx • Cisgender male • PLWH aged 30-39 and ≥ Age 50 • MSM	• Latinx • Cisgender male • PLWH ≥ Age 50 • MSM
Utilization over time	• Decreased over time by 6% from Year 28 and 13% from Year 31 due to exit of DHS from RWP	• 35% lower number of RWP clients in Year 32 compared to Year 31 due to DHS exit from RWP	• 15% decrease in the number of MCC clients in Year 32 compared to Year 31, due to DHS exit from RWP
Telehealth	• Telehealth usage decreased to 25% compared to Year 31 (43%). The highest telehealth usage among: - Latinx - Non-binary and transgender clients - PWID - Unhoused	• 23% of AOM services provided via telehealth. The highest telehealth usage among: - Non-binary clients - Unhoused - PWID	• About 35% of MCC services were provided via telehealth in Year 32. The highest telehealth usage among: - Transgender people - Women of Color - Unhoused - PWID
HCC outcomes	• The lowest percentage of engagement in care was among unhoused people and Black MSM • The lowest percentage of RWP clients RiC was among youth aged 13-29, Black MSM and unhoused • The lowest percentage of VS was among unhoused	• AOM clients had higher engagement and RiC and VS compared to non-AOM clients	• MCC clients had lower engagement, RiC and VS compared to non-MCC clients
Service Units per Client	N/A (units vary)	**3 visits per client**	**13 hours per client**
Expenditures	$45.9 million: $42.1 million - Part A $3.8 million - MAI	**Total $5,884,932 (Part A)$1,692 per client**	**$8,918,584 (Part A), $752,548 (MAI)$1,375 per client**

Latinx MSM	• The largest populations receiving RWP services • About 25% of Latinx MSM received RWP services via telehealth • The 3rd highest percentage of engagement in HIV care • The 2nd highest percentage of VS • The highest percentage of Spanish-speakers • The highest percentage of uninsured	• Represented over a half of all AOM clients (56%) and accounted for about 60% percentage of services provided • Among priority populations average numbers of visits and expenditures were higher than respective average numbers for all AOM clients • The highest per client visits and expenditures among priority populations	• 37% MCC clients and accounted for the same percentage of services provided • Average number of visits and expenditures were slightly lower than respective average numbers for all MCC clients
Black MSM	• About 4% of all RWP clients in • About 25% received RWP services via telehealth • Over 2/3 were living ≤ FPL	• 8% of all AOM clients and accounted for about 6% percentage of services provided • Average number of visits and expenditures were lower than respective average numbers for all AOM clients • The lowest per client visits and expenditures among priority populations • Reasons for slightly low AOM service utilization are unclear but may reflect poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.	• 18% of all MCC clients and accounted for about 16% of services provided • Average number of visits and expenditures were lower than respective average numbers for all MCC clients • The lowest per client visits and expenditures among priority populations • Reasons for slightly low MCC service utilization are unclear but may reflect poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.
Youth 13-29 years old	• 12% of all RWP clients • A quarter of youth used RWP via telehealth • The 3rd highest percentage of uninsured among priority populations • The lowest percentage of RiC among priority populations	• 11% of all AOM clients but accounted for 9% of AOM services • Lower per client service units (visits) and expenditures than average for all AOM clients • Reasons for low AOM service utilization are unclear but may reflect	• 13% of all MCC clients and accounted for the same percentage of service hours provided • Lower per client service hours and expenditures than the average for all MCC clients

		poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.	• One of the lowest utilizers of MCC services as demonstrated by the percentage of total visits they received and average hours per client.
PLWD ≥ Age 50	• Over a third of all RWP clients • 22% received RWP services via telehealth • The 2nd highest percentage of engagement in care among priority populations • The highest percentage of RiC and VS among priority populations • The highest percentage of people living ≤ FPL and PWID • The 2nd highest percentage of uninsured, Spanish-speaking, and unhoused people	• 30% of all AOM clients and accounted for 29% of AOM services • One of the highest utilizers of AOM services as demonstrated by the percentage of total visit. • Moderately lower per client service units (visits) and expenditures than respective average for all AOM clients	• 34% of all MCC clients and accounted for 37% of services provided • One of the highest utilizers of MCC services as demonstrated by the percentage of total hours they received and average hours per client • Expenditures per client were above the average for all MCC clients
Women of Color	• 8% of RWP clients • About 20% received RWP services via telehealth • The highest percentage of engagement in HIV care among priority populations • The 2nd highest percentage of RiC among priority populations	• 8% of all AOM clients and accounted for 9% of services provided • The second highest utilizers of AOM services as demonstrated by the number of visits per client. • The second highest per client expenditures for AOM services among priority populations	• 6% of all MCC clients and accounted for 8% of services provided • The highest utilizers of MCC services as demonstrated by the number of hours per client • The 2nd highest per client expenditures for MCC services among priority populations
Transgender clients	• 4% of all RWP clients • 20% received RWP services via telehealth • The highest percentage of unhoused people • The 2nd highest percentage of people living ≤ FPL	• 2% of all AOM clients and accounted for the same percentage of services provided • Lower per client visits and expenditures than respective averages for all AOM clients	• 4% of MCC clients and accounted for 5% of services provided • Average number of service hours and expenditures were considerably higher than respective average numbers for all MCC clients

		• Reasons for slightly low AOM service utilization are unclear but may reflect poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.	
Unhoused in past 12m	• 18% of all RWP clients • About 22% received RWP services via telehealth • The highest percent of people living ≤ FPL and PWID	• 7% of clients receiving AOM service and 6% percentage of services provided • Average number of visits and expenditures were lower than respective average numbers for all AOM clients	• 18% of clients receiving MCC service and accounted for 24% percentage of services provided • Average number of visits and expenditures were considerably higher than respective average numbers for all MCC clients • High utilization of MCC services by unhoused people may be reflective of complexity of social and behavioral issues in this subpopulation.
PWID	• 5% of RWP clients • About 16% received RWP services via telehealth • The 2nd highest percentage of unhoused in past 12 m	• 2% of clients receiving AOM service and accounted for the same percentage of services provided • Average number of visits and expenditures were higher than respective average numbers for all AOM clients • The 2nd highest number of per client AOM visits among priority populations • The 3rd highest per client expenditures for AOM services among priority populations	• 5% of clients receiving MCC service and accounted for 7% of services provided • Average number of visits and expenditures were considerably higher than respective average numbers for all MCC clients • The highest number of per client hours of MCC service among priority populations • The highest per client expenditures for MCC services among priority populations

SUMMARY OF FINDINGS

Service use and expenditures vary by service category and by priority populations. This variation may be influenced by the priority population size, underlying characteristics within each priority and priority population such as health status, income, housing status or neighborhood of residence, service need or service access and others. The main findings are summarized in Table 5.

Table 5. Summary of Findings for RWP Service Utilization in LAC, Year 32

	RWP	Mental Health	Substance Abuse Residential
Clients Characteristics	• Latinx and Black race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH age 30-39 and ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH age 30-39 • MSM
Utilization over time	• Total number of clients decreased in Year 32 due to exit of DHS from RWP. • From Year 29-32, however, number of clients at remaining agencies was steady.	• Decrease in total clients due to DHS departure in Year 32 compared to Year 31 • Decrease in clients at remaining agencies possibly due to Medi-Cal expansion, provider shortages or other reason - further analysis needed	• Steady decrease in number of clients since Year 29
Telehealth	• Approximately 1 in 4 clients received a service via telehealth in Year 32 – a decrease from 46% in Year 30.	• Nearly half of MH clients continued to access services via telehealth in Year 32	• Not applicable
Service Units per Client	N/A (units vary)	• **Seven sessions per client**	**111 days per client**
Total Expenditures	$45.9 million	• **Total $216,060 (Part A)** • **$965 per client**	• **$656,363 (Part B)** • **$7,722 per client**
HCC outcomes	• Engagement in care was lowest among unhoused clients and Black MSM • RiC was lowest among youth aged 13-29, Black MSM and unhoused clients • VS was lowest among unhoused clients	• Engagement and retention in care were higher among MH clients compared to clients not accessing MH services but no difference in VS	• Engagement and retention in care and VS were higher among SAR clients compared to clients not accessing SAR

Ryan White Program Service Utilization Report, Contract Year 32 (March 1, 2022-February 28, 2023)

	RWP	Mental Health	Substance Abuse Residential
Latinx MSM	• Largest RWP population • About 25% of Latinx MSM received RWP services via telehealth • Largest percentage of uninsured clients	• Majority of MH clients (63%) and accounted for about 61% of services provided • Expenditure per clients were slightly lower than the average for all MH clients	• Represented 31% of clients and accounted for about 28% of services provided • The total days for SAR were the second highest among priority populations • Average number of days and expenditures per client were slightly lower than the average for all SAR clients
Black MSM	• About 4% of all RWP clients in • About 25% received RWP services via telehealth • Over 2/3 were living ≤ FPL	• Represented a small number and percent of MH clients and services provided • Average number of sessions and expenditures were lower than respective average numbers for all MH clients	• Represented small number and percent of SAR services provided • Average number of days and expenditures were lower than respective average numbers for all SAR clients •
Youth 13-29 years old	• 12% of all RWP clients • A quarter of youth used RWP via telehealth • The lowest percentage of RiC among priority populations	• 11% of all MH clients but accounted for 9% of MH services • Lower per client sessions and expenditures than average for all MH clients • Reasons for low MH service utilization are unclear but may reflect poor service engagement, low service access, ineffective service provision, stigma or other client-provider or system-level determinants.	• Represented small number and percent of SAR services provided • Highest per client service days and expenditures among priority populations • Highest utilizers of SAR services as demonstrated by the average days per client.
PLWD ≥ Age 50	• Over a third of all RWP clients • 22% received RWP services via telehealth • Second highest percentage of engagement in care among priority populations	• 68% received services via telehealth • 29% of all MH clients and accounted for 42% of MH services • Second highest utilizers of MH services as demonstrated by the percentage of total sessions as well	• 21% of all SAR clients and accounted for the same percentage of services provided • Number of service days provided and expenditures per client were slightly below the average for all SAR clients

	• The highest percentage of RiC and VS among priority populations • The highest percentage of people living ≤ FPL and PWID • Second highest percentage of uninsured, Spanish-speaking, and unhoused people	as sessions per client among priority populations • Second highest per client and overall expenditures among priority populations	
Women of Color	• 8% of RWP clients • About 20% received RWP services via telehealth • The highest percentage of engagement in HIV care among priority populations • Second highest percentage of RiC among priority populations	• Represented a small number and percent of MH clients and services provided • Lowest use of MH services as demonstrated by the number of sessions and expenditures per client among priority populations	• Represented small number and percent of SAR services provided • Lowest utilizers of SAR services as demonstrated by the number of sessions and expenditures per client among priority populations
Transgender clients	• 4% of all RWP clients • 20% received RWP services via telehealth • Highest percentage of unhoused people • Second highest percentage of people living ≤ FPL	• Represented a small number and percent of MH clients and services provided • Lower per client visits and expenditures than respective averages for all MH clients	• Represented small number and percent of SAR services provided • Average number of days and expenditures were considerably lower than respective average numbers for all SAR clients • Second lowest average of expenditures and days of SAR service per client among priority populations
Unhoused in past 12m	• 18% of all RWP clients • About 22% received RWP services via telehealth • The highest percent of people living ≤ FPL and PWID	• Second highest percent of MH clients who used services via telehealth (75%) • The highest average number of visits and expenditures among priority populations • High utilization of MH services by unhoused people may be reflective of complexity of social and behavioral needs in this subpopulation	• Half of SAR clients and accounted half of SAR days • High utilization of SAR services by unhoused people may be reflective of complexity of social and behavioral needs in this subpopulation.

PWID	• 5% of RWP clients • About 16% received RWP services via telehealth • Second highest percent of clients unhoused in past 12m	• Represented a small number and percent of MH clients and services provided • Lower per client sessions and expenditures than respective averages for all MH clients	• 18% of clients receiving SAR service and accounted for 19% of services provided • Average number of days and expenditures were considerably higher than respective average numbers for all SAR clients • High utilization of SAR services by PWID may reflect complex of social and behavioral needs in this subpopulation

SUMMARY OF FINDINGS

Service use and expenditures vary by service category and by priority populations. This variation may be influenced by the priority population size, underlying characteristics within each priority and priority population such as health status, income, housing status or neighborhood of residence, service need or service access and others. The main findings are summarized in Table 8.

Table 8. Summary of Findings for RWP Service Utilization in LAC, Year 32

	RWP	Oral Health Services	General Oral Care	Specialty Oral Care
Main client population served	• Latinx and Black race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM	• Latinx race/ethnicity • Cisgender male • PLWH ≥ age 50 • MSM
Utilization over time	• Total number of clients decreased in Year 32 due to AOM, MCC, and MH services stopping at DHS sites • However, number of clients at remaining agencies was steady	• Service provided only by non-DHS sites • Steep decrease in number of clients in Year 30 (due to COVID) Numbers of clients started to increase in the 2nd part of Year 30 and back to pre-pandemic numbers in Years 31 and 32	• Service provided only by non-DHS sites • Steep decrease in number of clients in Year 30 (due to COVID) Number of clients started to increase in the 2nd part of Year 30 and back to pre-pandemic numbers in Years 31 and 32.	• Service provided only by non-DHS sites • Steep decrease in number of clients in Year 30 (due to COVID) • Number of clients started to increase in the 2nd part of Year 30 and back to pre-pandemic numbers in Years 31 and 32
Service units per client	N/A (units vary)	• **Procedures**	• **Procedures**	• **Procedures**
Total expenditures	$45.9 million	• **$7,456,098 (Part A)** • **$1,746 per client**	• **$5,439,733 (part A)** • **$1,360 per client**	• **$2,016,365 (Part A)** • **$ 563 per client**
HCC outcomes	• HCC outcomes were higher among RWP clients compared to PLWH in LAC	HCC outcomes were higher among OH (including GOC and SOC) clients compared to clients not accessing those services		

Ryan White Program Service Utilization Report, Contract Year 32 (March 1, 2022-February 28, 2023)

	RWP	Oral Health Services	General Oral Care	Specialty Oral Care
Latinx MSM	• The second largest priority population in RWP (38%) • Largest percent of uninsured clients	• Second largest priority population (42%) and accounted for about 45% of services provided • Highest number of OH procedures per client • Highest expenditure per client	• Second largest priority population (43%) and accounted for 46% of GOC services provided • Highest number of GOC procedures per client • Highest expenditure per client	• Second largest priority population (43%) and accounted for 46% of SOC services provided • Highest number of SOC procedures per client • Highest expenditure per client
Black MSM	• About 15% of RWP clients • Over 2/3 living ≤ FPL	• Represented 11% of HS clients and only 9% of services provided • Lowest number of procedures per client • Lowest expenditures per client	• Represented 11% of HS clients and only 9% of GOC services provided • One of lowest number of GOC procedures per client • Lowest expenditures per client	• Represented 11% of HS clients and only 9% of SOC services provided • One of lowest number of SOC procedures per client • Lowest expenditures per client
Youth 13-29 years old	• 11% of RWP clients • The lowest percent of RiC among priority populations	• The second smallest population by number and percent of clients • The second lowest percent of procedures from the total and procedures per client	• The second smallest population by number and percent of GOC clients • One of lowest numbers of GOC procedures per client • The third lowest expenditures per client	• The second smallest population by number and percent of SOC clients • One of lowest numbers of SOC procedures per client • The third lowest expenditures per client
PLWD ≥ age 50	• 43% of RWP clients • The highest percent of RiC and VS and the second highest percent of engagement among priority populations • The highest percent of PWID • Second highest percent of unhoused in the contract year	• Highest utilizers of OH services across categories by percent of clients (~ 60%) and services provided (~ 60%) • Second highest expenditures per client	• Expenditures per client slightly higher than the average for all GOC clients.	• Expenditures per client lower than the average for all SOC clients.
Women of color	• 9% of RWP clients • The highest percent of engagement in care • The second highest percent of RiC among priority populations	• Represented 11% of OH clients and same percent of services provided • The third highest per client number of days and expenditures	• Represented 11% of GOC clients and 12% of services provided • The second highest per client number of procedures and expenditures	• Represented 11% of SOC clients and 12% of services provided • The second highest per client number of SOC procedures and expenditures

Ryan White Program Service Utilization Report, Contract Year 32 (March 1, 2022-February 28, 2023)

	RWP	Oral Health Services	General Oral Care	Specialty Oral Care
Transgender clients	• 3% of all RWP clients • Highest percent of clients unhoused in the contract period • Second largest percent of people living ≤ FPL	• Represented the smallest number and percent of OH clients (2%) and services provided (2%)		
		• Per client expenditure much lower than overall average and the third lowest among priority populations	• Per client expenditure slightly higher than overall average for GOC clients	• Per client procedures slightly higher than average for all SOC clients • Per client expenditures lower than overall average for SOC clients
Unhoused in the contract year	• 12% of all RWP clients • Largest percent of clients living ≤ FPL and PWID	Similar utilization of OH services across categories by clients who were unhoused in the contract year: • Represented 5% percent of clients and 4% of OH services provided		
		• Lowest per client expenditures among priority populations	• The second lowest per client expenditures among priority populations	• The second lowest per client expenditures among priority populations
PWID	• 4% of RWP clients • Second highest percent of clients unhoused in the contract year	Similar utilization of OH services across categories of clients who are PWID: • Represented 4% percent of OH clients and 4% services provided		
		• Slightly lower number of OH procedures per client than the average for all OH clients	• Slightly lower expenditures per client than the average for all GOC clients	• Per client procedures slightly higher than average for all SOC clients • Lower expenditures per client than the average for all SOC clients

Home-Based Case Management at-a-Glance

Goal	• To facilitate optimal health outcomes for functionally impaired PLWDH through home and/or community-based care, advocacy, liaison, and collaboration
Objectives	• Provide client-centered CM and social work, home health, and home care activities • Improve the health status of clients • Increase a client's sense of empowerment, self-advocacy and medical self management
Population	• Uninsured or underinsured PLWDH living ≤500% of FPL with documentation of impaired functional status
Staffing	• Registered Nurse Case Manager (licensed RN) • Social Work Case Manager (Master's degree in accredited program) • Attendant Care or Homemaker (through licensed subcontractor)

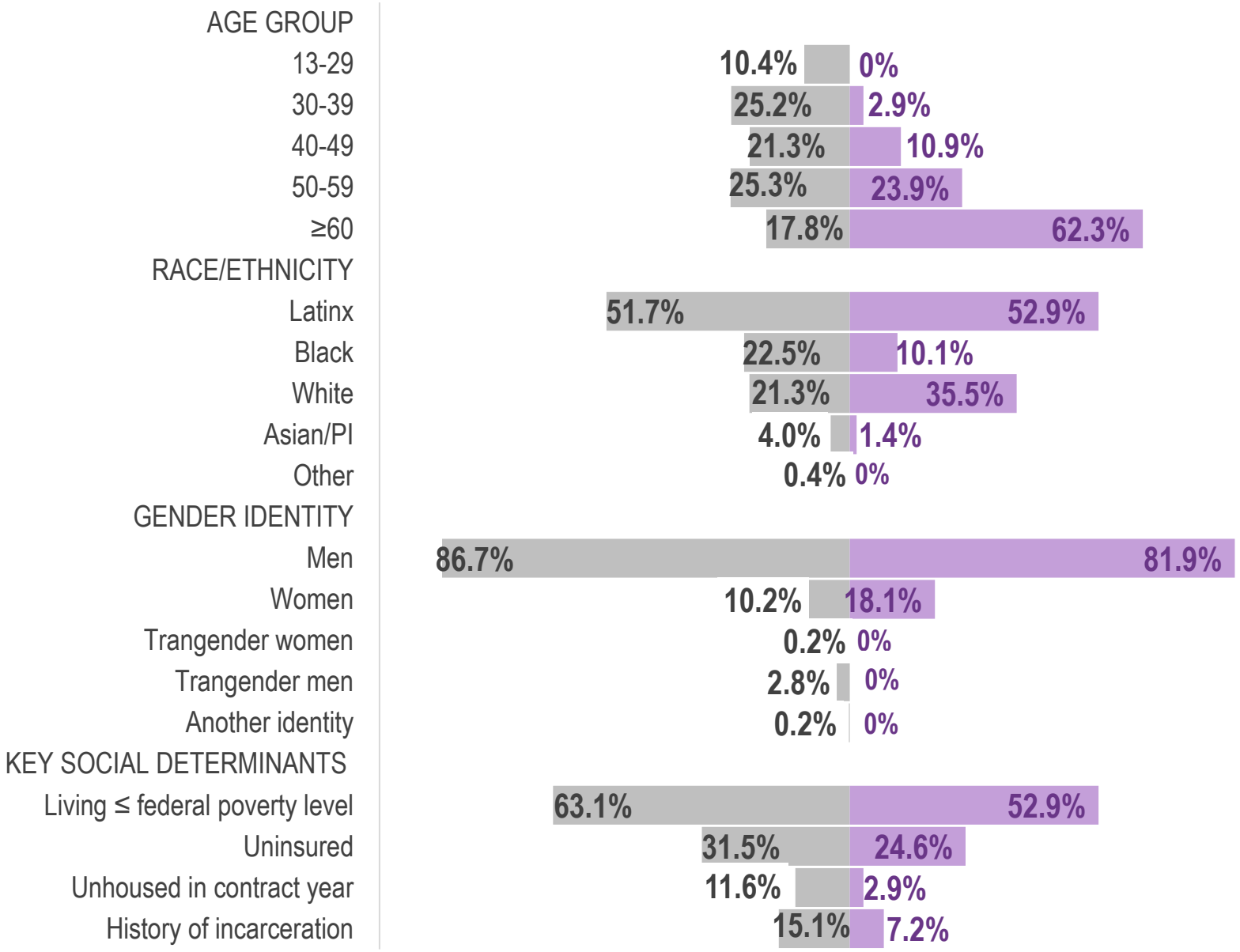
Funding Source and Annual Expenditures, Year 32

- Funding source: Part A

- Contract end: June 2024 – requires Board approval to extend

- Five agencies funded to deliver home-based services
  – Clinic average of 28 clients per year (ranging from 6 to 61 clients)

- Total estimated expenditures: $2,758,499
  – Expenditures per client: $19,989



Fewer than 1% of RWP clients accessed HBCM.

Most HBCM clients were ≥ age 60, Latinx and men in Year 32.

Compared to Ryan White clients overall, a larger percent of HBCM clients were older and women.

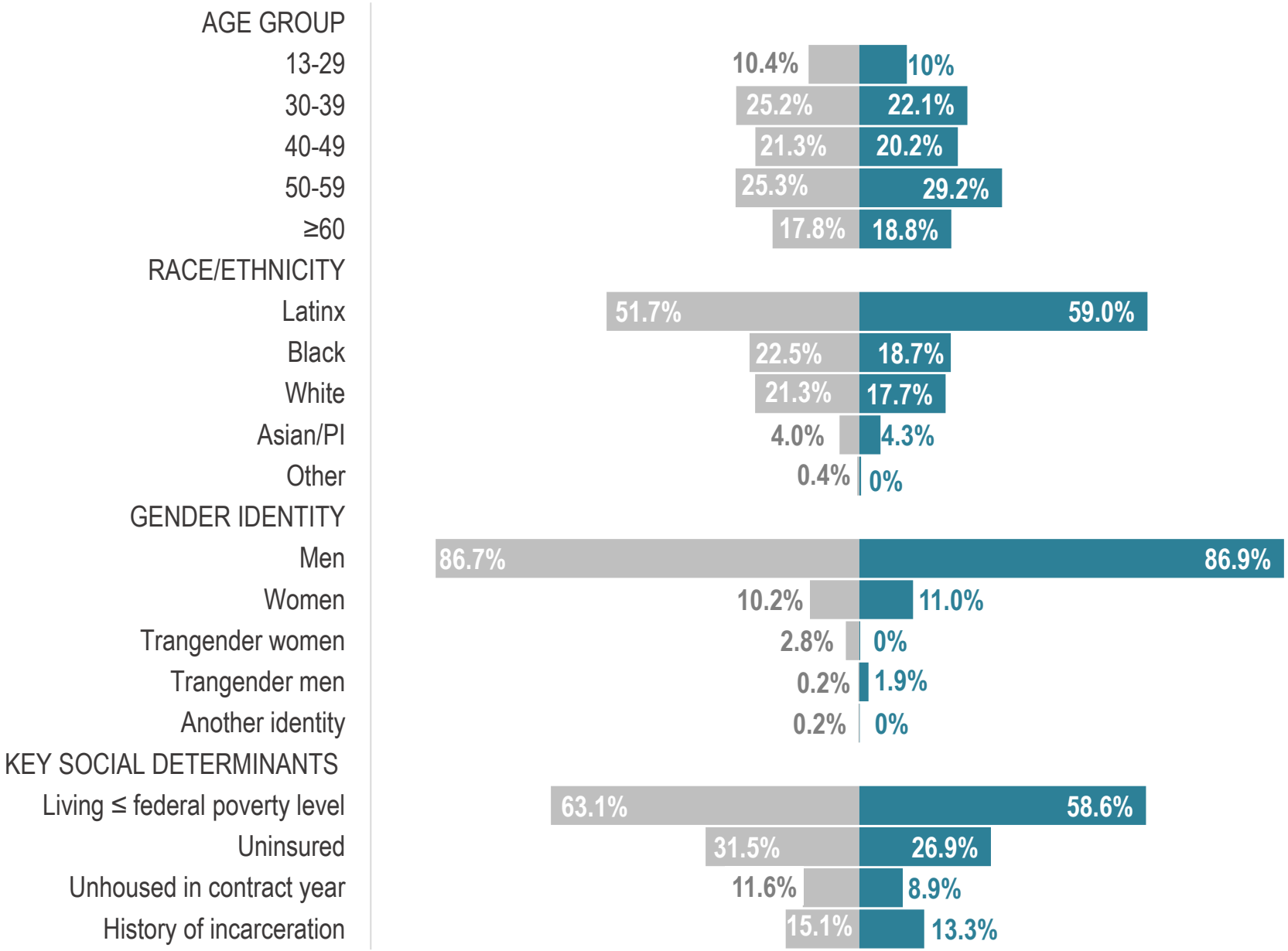
Ryan White Program Utilization Report, Mar. 2022-Feb. 2023, LAC

Benefits Specialty Services at-a-Glance

Goal	• To address gaps in access to public benefits and programs outside of the Ryan White Program (RWP) services network among clients in LAC.
Objectives	• Assist PLWDH with entry in and movement through service systems outside RWP • Educate clients about public and private benefits • Ensure clients are receiving the benefits and entitlements for which they are eligible.
Population	• Uninsured or underinsured PWLDH with income ≤ 500% FPL
Staffing	• Certified benefits specialists (completed within 6 months of hire)

BSS Funding and Expenditures, Year 32

- Funding source: Part A
- Contract end: February 2024 with authority to extend 12 months
- Agencies funded: 11 agencies
  - Clinic average of 302 clients per year (range 40-1,702 clients)
- Total estimated expenditures: $1,413,243
  - Estimated expenditure per client: $345

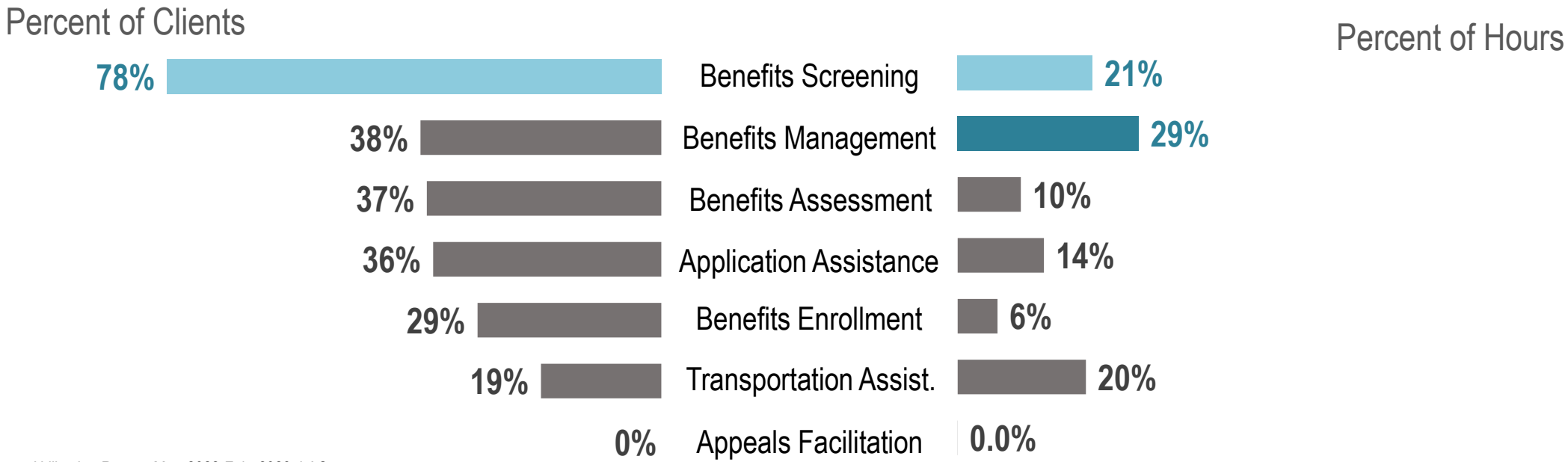


Most **BSS clients** were ≥ age 50, Latinx and men in Year 32.

Compared to Ryan White clients, a smaller percent of **BSS clients** were living ≤ FPL and uninsured.

Ryan White Program Utilization Report, Mar. 2022-Feb. 2023, LAC

- 20,139 service hours were provided to 4,099 clients resulting in **5 hours per client** in Year 32.
- Most clients received **Benefits Screening** however it only accounted for 21% of hours.
- **Benefits Management** made up the largest percent of hours provided.
- Fewer than 5 clients received Appeals Facilitation.



Ryan White Program Utilization Report, Mar. 2022-Feb. 2023, LAC

Transitional Case Management at-a-Glance

Goal	• To improve HIV health outcomes among justice-involved PLWH by supporting post-release linkage and engagement in HIV care
Objectives	• Identify and address barriers to care • Assist with health and social service systems navigation • Provide health education and risk reduction counseling • Refer and link to culturally competent HIV medical providers • Support reentry through community or jail-based resources
Population	• PLWDH incarcerated at Twin Towers, Men's Central Jail or the Century Regional Detention facility
Staffing	• Nurse • Case Manager
Funding	• Minority AIDS Initiative (MAI)

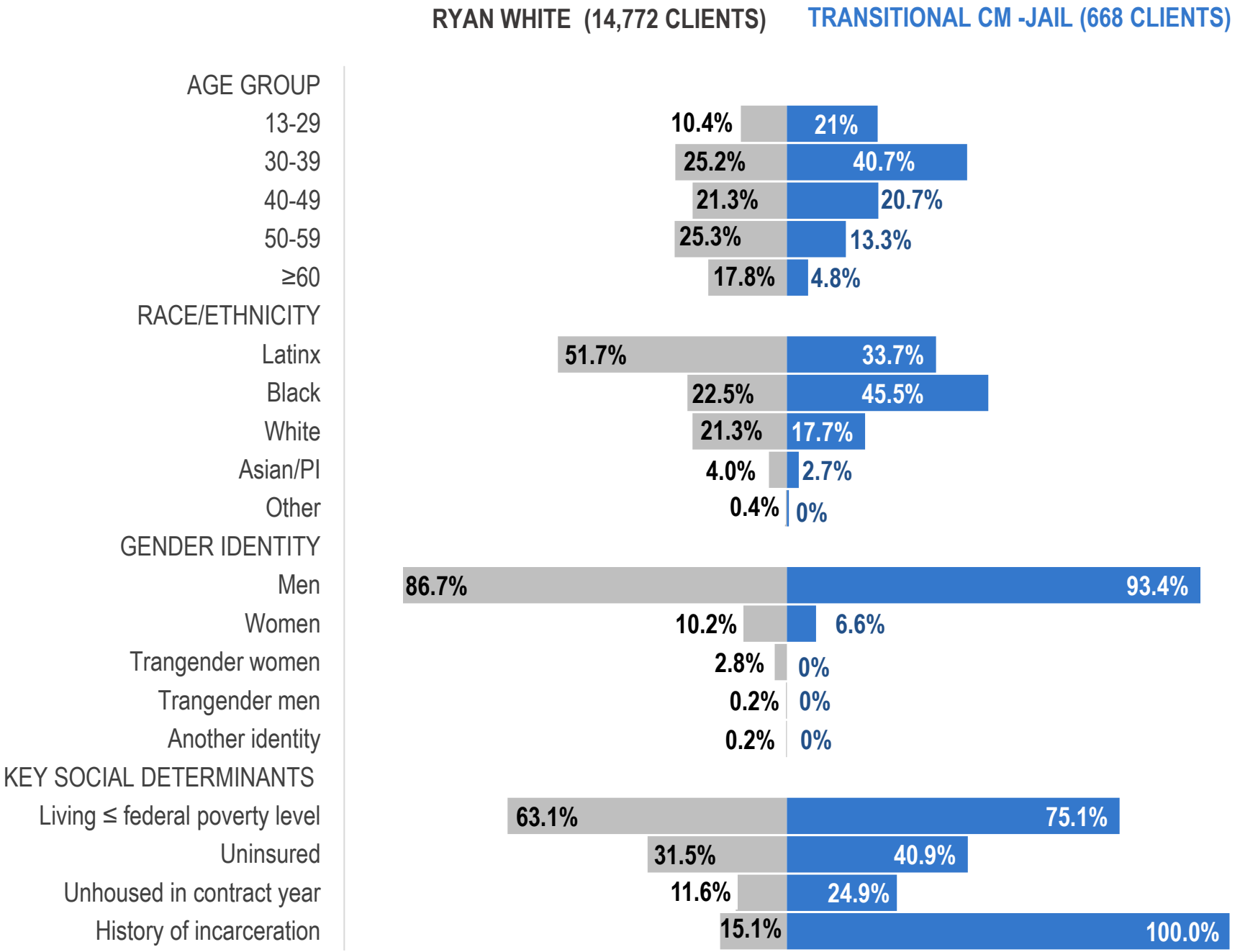
TCM -Jails Funding and Expenditures, Year 32

- Funding source: Minority AIDS Initiative (MAI)

- Contract period: Sunset September 2023
  - Services to be transferred the Office of Diversion and Re-entry at DHS

- Agencies funded: 5 agencies
  - Clinic average of 174 clients per year (range 16-260 clients)

- Total estimated expenditures: $523,926
  - Expenditure per client: $784



Most TCM clients were age 30-39, Black, and men in Year 32.

Compared to Ryan White clients overall, a larger percent of TCM clients were living ≤ FPL, uninsured and recently unhoused.

Ryan White Program Utilization Report, Mar. 2022-Feb. 2023, LAC

Linkage and Re-engagement Program (LRP) Description

- LRP is based at DHSP within Direct Community Services

- LRP is a referral-based service and data to care program that focuses on persons who have diagnosed HIV and are not in care (NiC).

Primary Goal (2016):
LRP's overarching goal is to improve the health outcomes of HIV-positive clients by linking and re-engaging them into HIV medical care with the ultimate goal of viral suppression.

Program Enhancement (2020):
LRP prioritizes pregnant/postpartum clients to reduce the risk of perinatal transmission by ensuring a safe delivery.

Target Populations for LRP Services and Client Criteria

- LRP prioritizes persons who are highly impacted and may have multiple and complex needs, including persons not touching systems of care, and often having significant life challenges

- Criteria: Persons who have diagnosed HIV and reside in LAC
  - 2016: Any person who has been out of care for > 12 months
  - 2020: Any person who is currently pregnant or recently delivered a baby and needs additional support

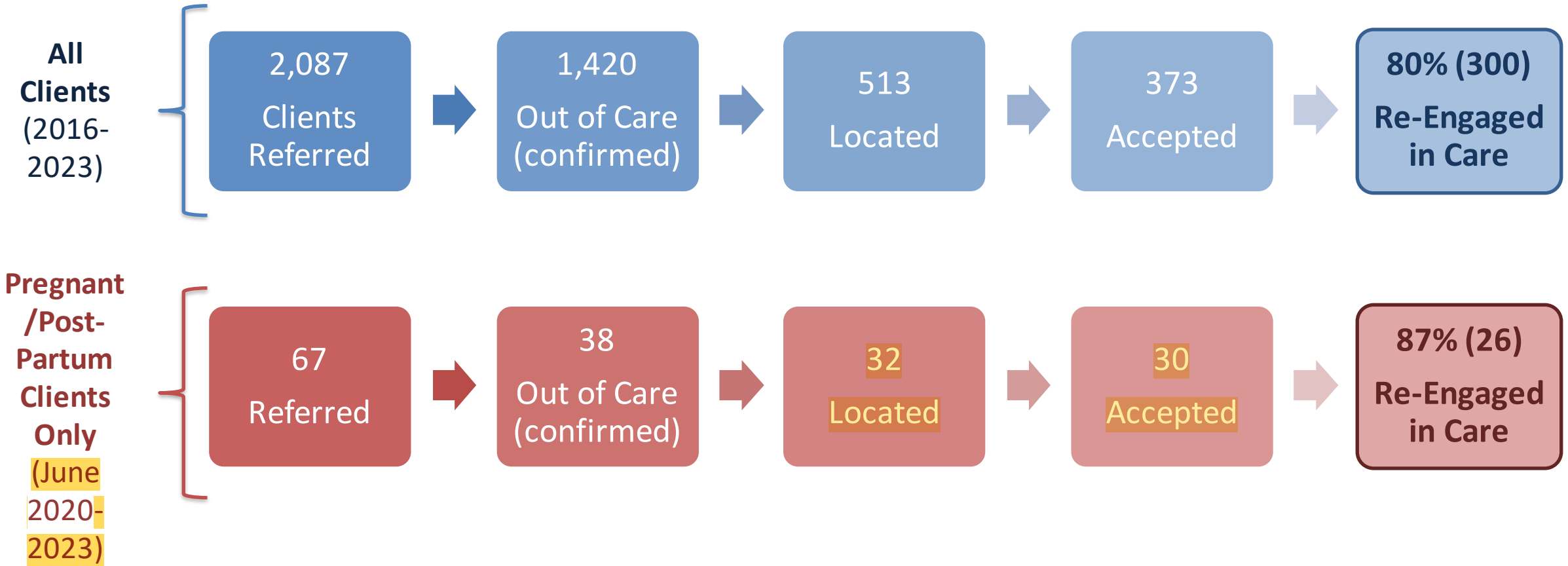
LRP Team

- Staffing model currently includes:
  - 2 clinical social workers to address immediate mental health needs and ongoing support throughout the intervention
  - 5 experienced health navigators
- DHSP-based physicians provide oversight and consultation to LRP team
- LRP team collaborates closely with the DHSP Perinatal Surveillance Coordinator

LRP's Impact on Systems and Services

- Timely communication and notification between DHSP and community partners (HIV clinics, hospitals, delivery sites, labs) to leverage client engagement
- Streamlined clinic appointments for LRP clients
  - Reduced, eliminated barriers to entering care
  - Improved processing of insurance verification
- Use of surveillance information to monitor viral load among all reported pregnant clients
- Increase HIV/Syphilis screening among hospitals of pregnant clients and knowledge of treatment protocols for patient and baby
- Improve HIV Cluster Detection and Response follow-up for LRP clients
- Coordination across DCS units to address cases of co-infection with syphilis to reduce congenital syphilis diagnosis

Overview of LRP Processes and Outcomes by Population of Focus



Los Angeles County 2022 -2026 Integrated HIV Prevention and Care Plan: Needs Assessment Data

PLANNING, PRIORITIES, AND ALLOCATIONS COMMITTEE

JULY 16, 2024

LOS ANGELES COUNTY
COMMISSION ON HIV

Barriers to Services

Top 5 Barriers to Accessing HIV Testing

	Providers	Community
1	Lack of culturally appropriate services	Substance Use
2	Substance Use	Lack of accurate information about testing
3	Mental Health	They don't believe they're at risk
4	They don't believe they're at risk	Mental Health
5	Lack of accurate information about testing	Lack of culturally appropriate services

Additional identified barriers: lack of awareness of free services, lack of awareness of testing locations and hours, fear of finding out they're infected, isolation, stigma/internalized homophobia, PTSD

Barriers to Services

Top 5 Barriers to Accessing PrEP

	Providers	Community
1	Mental Health	Concern they won't be able to pay for PrEP
2	Substance Use	Substance Use
3	Lack of culturally appropriate services	Lack of accurate information about PrEP
4	Lack of stable housing	Mental Health
5	Lack of accurate information about PrEP	Trauma

Additional identified barriers: discomfort taking medication when not sick, thinking PrEP is for other people because of lack of authentic advertising, inability to store medication due to being unhoused

Barriers to Services

Top 5 Barriers to Linkage to Care

	Providers	Community
1	Substance Use	Substance Use
2	Lack of accurate information about LTC	Mental Health
3	Lack of culturally appropriate services	Concern that they won't be able to pay for HIV care
4	Lack of stable housing	Lack of accurate information about LTC
5	Trauma	Lack of stable housing

Additional identified barriers: lack of HIV+ peers to talk to, need a warm hand-off to services without having to wait, stigma, transportation, unfriendly and insensitive waiting rooms, fear of people thinking they're gay, unwilling to access care due to bad experiences with providers in the past, discomfort in clinic's physical space, concern over administrative hurdles

Barriers to Services

Top 5 Barriers to Remaining Engaged in Care

	Providers	Community
1	Substance Use	Substance Use
2	Mental Health	They don't feel sick
3	Trauma	Mental Health
4	Lack of stable housing	Lack of stable housing
5	Lack of accurate information about HIV care	Trauma

Additional identified barriers: lack of appointment time options, don't want to take medication or go to doctor's office, lack of peer support and treatment advocates, lack of respect in waiting areas/reception for drug users and homeless, stigma, transportation, medical mistrust, lack of childcare, need for peer advocates

Key Priorities Identified

- Integration and streamlining of services
- Address the mental health needs of PLWH and at-risk for HIV
- Address SUD, especially meth use disorder
- Address the needs and gaps in the HIV workforce
- Clear marketing and messaging about services and risks to reach priority populations
- Need to increase health literacy

myMedi-Cal

How to Get the Health Care You Need

CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Table of Contents

DHCS On Social Media

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DHCS.CA

California Department of Health Care Services

DHCS_CA

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."

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.

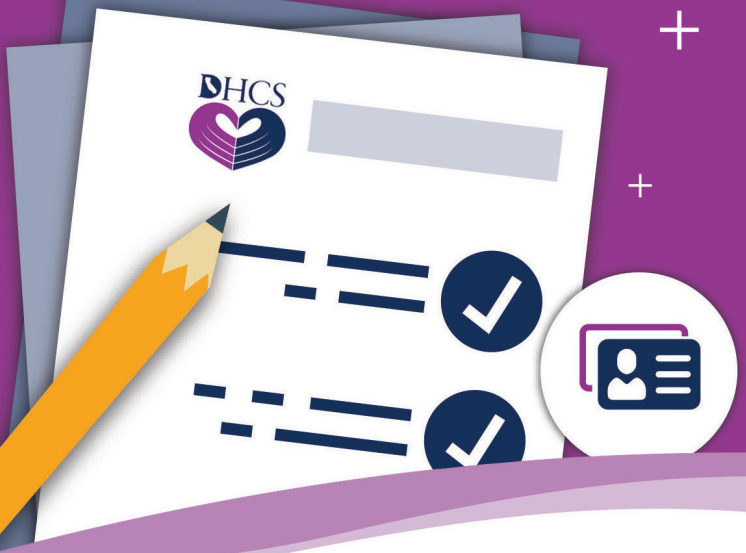
To file a claim, you must call or write to:

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.



Updating & Renewing My Medi-Cal

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។ ទូរសព្ទទៅកាន់ការិយាល័យខោនធីក្នុងមូលដ្ឋានរបស់អ្នកសម្រាប់បញ្ហាទាក់ទងនឹងសិទ្ធិទទួលបានសេវា 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. ໂທຫາຫ້ອງການເຂດໃນທ້ອງຖິ່ນຂອງທ່ານເພື່ອສອບຖາມກ່ຽວກັບເງື່ອນໄຂໃນການມີສິດໄດ້ຮັບ ຫຼື ມີຄຳຖາມອື່ນໆ. (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 ਕਾਉਂਟੀ ਦਫਤਰ 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)

California Department of
Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

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HRSA RWP Services in LAC in YR 34

CORE	SUPPORT
Outpatient/Ambulatory Health Services	Housing
Medical Case Management (including treatment adherence services)	Non-Medical Case Management Services
Mental Health Services	Medical Transportation
Oral Health Care	Food Bank/Home Delivered Meals
Home and Community Based Health Services	Child Care Services
Early Intervention Services	Other Professional Services
	Emergency Financial Assistance
	Linguistic Services
	Outreach

YR 34 Part A: Re-Allocation Services

	Services	YR 34 COH Part A %	YR 34 COH MAI %	YR 34 Re-Allocation	YR 34 Re-allocation Part A%	YR 34 Re-allocation MAI %
CORE	AOM/MSS	25.51%	0.00%	$6,500,000	17.11%	0.00%
	MCC/PSS	28.00%	0.00%	$10,316,352	27.15%	0.00%
	Oral Health	17.48%	0.00%	$7,900,000	20.79%	0.00%
	EIS (STD clinic)	0.00%	0.00%	$2,500,000	6.58%	0.00%
	Mental Health	4.07%	0.00%	$110,000	0.29%	0.00%
	Home Based Case Management	6.78%	0.00%	$2,470,000	6.50%	0.00%
SUPPORT	Transportation	2.17%	0.00%	$700,000	1.84%	0.00%
	Nutritional Support (food bank)	8.95%	0.00%	$2,200,000	5.79%	0.00%
	Professional Services (Legal)	1.00%	0.00%	$538,000	1.42%	0.00%
	Language	0.65%	0.00%	$ -	0.00%	0.00%
	Outreach (LRP)	0.00%	0.00%	$ -	0.00%	0.00%
	EFA	0.00%	0.00%	$2,400,000	6.32%	0.00%
	NMCM (TCM Jails) 6 medical case workers and 1 HPA I	0.00%	12.61%	$600,000	1.58%	0.00%
	NMCM (BSS)	2.44%	0.00%	$1,500,000	3.95%	0.00%
	Housing (H4H) housing only no EFA	0.00%	87.39%	$3,305,635	0.00%	100.00%
	Housing (RCFCI& TRCF Mental Health)	0.96%	0.00%	$344,000	0.91%	
	Psychosocial Services	1.00%	0.00%	$ -	0.00%	0.00%
	Childcare Services	0.95%	0.00%	$ -	0.00%	0.00%
	Total	**100%**	**100%**	**$41,303,987**	**100%**	**100%**

Approved by Planning, Priorities, and Allocations Committee on 7.16.24
Approved by the full-body Commission on HIV on 8.8.24

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

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

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

Purpose of PCN

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

Background

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

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

HRSA HAB has developed program policies that incorporate both HHS regulations

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

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

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

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

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

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

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

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

Eligible Individuals:

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

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

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

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

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

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

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

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

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

Other unallowable costs include:

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

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

Service Category Descriptions and Program Guidance

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

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

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

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

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

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

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

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

RWHAP Core Medical Services

AIDS Drug Assistance Program Treatments

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

AIDS Pharmaceutical Assistance

Early Intervention Services (EIS)

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

Home and Community-Based Health Services

Home Health Care

Hospice

Medical Case Management, including Treatment Adherence Services

Medical Nutrition Therapy

Mental Health Services

Oral Health Care

Outpatient/Ambulatory Health Services

Substance Abuse Outpatient Care

RWHAP Support Services

Child Care Services

Emergency Financial Assistance

Food Bank/Home Delivered Meals

Health Education/Risk Reduction

Housing

Legal Services

Linguistic Services

Medical Transportation

Non-Medical Case Management Services

Other Professional Services

Outreach Services

Permanency Planning

Psychosocial Support Services

Referral for Health Care and Support Services

Rehabilitation Services

Respite Care

Substance Abuse Services (residential)

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

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

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

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

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

Appendix

RWHAP Legislation: Core Medical Services

AIDS Drug Assistance Program Treatments

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

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

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

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

See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance

AIDS Pharmaceutical Assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

Early Intervention Services (EIS)

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

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

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

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

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

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

Description:

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

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

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

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

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

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

when determined to be cost effective.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Key activities include:

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

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

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

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

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

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

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

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

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

See also Food-Bank/Home Delivered Meals

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

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

See also Psychosocial Support Services

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

Program Guidance:
None at this time.

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

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

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

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

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

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

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

See also Early Intervention Services

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

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

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

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

guidance.

See also Substance Abuse Services (residential)

RWHAP Legislation: Support Services

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

Allowable use of funds include:

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

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

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

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

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

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

Food Bank/Home Delivered Meals
Description:

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

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

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

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

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

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

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

See also Early Intervention Services

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

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

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

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

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

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

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

Legal Services
See Other Professional Services

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

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

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

Program Guidance:
Medical transportation may be provided through:

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

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

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

Unallowable costs include:

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

Non-Medical Case Management Services

Description:

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

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

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

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

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

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

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

See 45 CFR § 75.459

Outreach Services

Description:

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

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

Outreach Services must:

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

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

Program Guidance:

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

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

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

See also Early Intervention Services

Permanency Planning
See Other Professional Services

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

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

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

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

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

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

See also Respite Care Services

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

Program Guidance:

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

vocational therapy.

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

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

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

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

See also Early Intervention Services

Respite Care
Description:

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

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

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

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

See also Psychosocial Support Services

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

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

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

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

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