Broward County Title I Ryan White CARE Act Fiscal Impact Assessment:
Final Report

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B. EXECUTIVE SUMMARY

In this assessment, quantitative and qualitative research techniques were used to evaluate the impact of reduced or flattened federal, State, or local funding on HIV care in Broward County. Since the assessment was initiated, the HIV public financing system in Broward County has experienced a decrease in federal, State, and local funding. In the past, policymakers in Broward County have used a "mutually exclusive service category" approach to assign the financial responsibility of specific services to individual funders. Recent cuts in federal HIV housing funds and flattening of Title II funds have left some services particularly vulnerable, including housing assistance, the Florida AIDS Drug Assistance Program (ADAP), and the AIDS Insurance Continuation Program AICP)- with waiting lists for services being considered or implemented. Reductions in benefits of the Florida Medicaid Project AIDS Care (PAC) have reduced the scope of covered services for Broward County residents. Additional impending changes to ADAP, PAC, and AICP funds and coverage are also likely to shift additional financial burden to Title I funded programs.

HIV care providers in Broward County are heavily reliant on a small set of funders to support their services. Community-based, racial/ethnic minority agencies are particularly heavily reliant on Title I funds. While some of these agencies can bill health insurers for some of the services they provide, they have not been aggressive in seeking reimbursement.

While Broward County's economy has experienced an expansion in the past few years, County general revenue and hospital district tax support for HIV community-based care has been reduced. The Title I maintenance of effort requirement has not been enforced by the federal government, despite a drop in local, County, and State contributions to the Title I maintenance of effort. To account for a drop in the maintenance of effort contributions by various funders, inpatient uncompensated charges have been used in the maintenance of effort submission.

Extensive interviews of HIV care providers in Broward County were conducted to determine if greater efficiencies and other systemic changes might be adopted to optimize future HIV funding. Substantial barriers to efficiency were identified. There is duplication in HIV planning efforts that result in a focus on "Title-specific" service delivery rather than on planning and coordinating services in the HIV care system as a whole. The system is highly bureaucratic, paper-driven, and coordinated with multiple meetings that distract from client care.

Case managers are the gatekeepers for the system and responsible for distribution of referrals for most enabling services. As a result, case managers report that they do not have the time to

undertake casework or eligibility determination. High rates of turnover among case managers have resulted in gaps in service and long waits for services. HIV medical care and community-based case management services are poorly coordinated and are operated in parallel systems with little communication. The rates of referral to other systems of care, such as mental health and drug treatment, are low as case managers are not sufficiently familiar with those systems to advocate on behalf of their clients.

Periodic eligibility determination is critical to ensuring that Broward County residents living with HIV become enrolled in the programs to which they are eligible. Eligibility determination is focused on intake, however, with clients not referred to benefit programs on a timely basis following entry into care. As a result, clients continue to rely on CARE Act funded clinical and ancillary services. Opportunities for third party insurance coverage are forgone.

The Broward County HIV care system has not focused on vocational training, education, or reentry into the workforce, despite the high rate of unemployed HIV-infected individuals who are not disabled. Supportive services required to assist reentry, such as mental health services and drug treatment, have not been incorporated as a long-range strategy in client care plans. As a result, HIV-infected clients are heavily reliant on Title I and other federal funds for basic subsistence, including food and housing.

In this report, we suggest ways to resolve the major areas of inefficiency identified above. Changes in policies, procedures, and practices are outlined with roles and responsibilities identified. We also suggest ways in which other resources can be used to support HIV care. Detailed recommendations are made regarding the design and implementation of an effective eligibility determination system that can rapidly identify maximum benefits for which clients are legally entitled. Strategies for maximizing third party insurance revenue are also provided, with technical assistance and training outlined to meet the needs of Title I subgrantees. Mechanisms for adhering to federal payer of last resort requirements are also discussed. Realistic recommendations are outlined for gaining support from other funders.

To make the most of Title I funds, results of evidence-based studies are presented to assist policymakers to understand the demonstrated cost-benefit and outcomes associated with the types of services supported by Title I. Some of the services funded by Title I in Broward County have been found in other communities or in national studies to provide a significant benefit and improve clinical and other outcomes. Some services, however, have not been demonstrated to have a positive impact.

Benchmark data are provided so that the allocation of funds in Broward County can be compared to that of Title I Eligible Metropolitan Areas (EMAs) throughout the US. Benchmark data are also provided for Miami/Dade and West Palm Beach. The Broward County EMA did not allocate Title I funds for health insurance between FY 1999 to FY 2002, compared to 16 EMAs that did. Given the high number of uninsured Broward County residents living with HIV expanded funding might be considered. The Broward County EMA also did not allocate Title I funds for housing or housing assistance between FY 1999 to FY 2002, compared to 33 EMAs that funded housing. Given the recent reduction in the federal HIV housing award in Broward County, funding of housing services might be considered to sustain the current level of services. The Broward County EMA ranks relatively low among EMAs in the proportion of funds allocated to transportation; 34th out of 48 EMAs. Given the persistent identification by HIV care providers regarding the need for additional transportation services, additional funding might be considered by the Planning Council.

C. INTRODUCTION: THE SHIFTING LANDSCAPE OF HIV CARE FINANCING

In the past decade, many States and municipalities experienced substantial increases in tax revenue. With increased resources allocated to health and social services, State governments, municipalities, and care providers made a significant contribution to HIV care. States expanded Medicaid eligibility, added coverage for HIV targeted case management and support services, initiated home and community-based waiver programs, purchased health insurance premiums, underwrote HIV programs, expanded coverage and funds for ADAPs, and enhanced fee-for-service and capitated insurance payments. Additionally, some States have underwritten health insurance pools, AICPs and supported pharmacy programs for medically indigent populations. County and city governments have also made significant financial contributions to HIV care.

The healthy US economy also resulted in the availability of jobs for many individuals that had problems in the past gaining and sustaining employment. Medium and large employers reaped the benefit of economic growth. Employers offered reasonably priced comprehensive insurance benefits to recruit and retain employees. HIV-infected employees were commonly able to purchase employer-supported insurance coverage at reasonable prices.

With the recent downturn in the US economy, State and municipal governments have experienced unplanned, precipitous drops in tax revenue. At the same time, the Federal government has increasingly shifted financial responsibility to the States in the form of unfunded mandates, such as homeland security and smallpox vaccination. State and municipal policymakers must now operate programs with less revenue, often with public health programs competing for funds with other basic government functions.

The attention of policymakers and the public has shifted away from domestic HIV funding to international funding. During the past several years, the growth in federal funds to the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act has stalled. For the first time this year, some Title I EMAs experienced decreased funding. Title II ADAPs and AICPs also report sharp increases in expenditures, with some States instituting waiting lists and other cost-saving measures.

The decreased rate of HIV federal domestic funds comes at a time when the number of individuals entering HIV care is increasing due to newly diagnosed HIV infections and introduction of rapid HIV testing methods. Moreover, individuals entering care tend to be relatively advanced in the spectrum of HIV disease, tend to have other chronic diseases including mental illness and chemical dependency, and have complex unmet psychosocial needs.

HIV care programs report a significant decline in institutional revenue available to support HIV care and underwrite their administrative costs. Many of the parent corporations in which many HIV programs operate are experiencing reduced third party insurance revenue and other government support. A growing number of patients are loosing employer-sponsored health insurance and coverage by State insurance and prescription benefit pools. As a result, the rate of uninsured US residents has climbed precipitously in the past several years. Meanwhile, since September 11, 2001, health and social support agencies such as HIV programs, are experiencing significant decreases in corporate and individual donations. As a result, HIV programs no longer have the level of institutional or charitable support that they once relied upon.

D. AIM AND OBJECTIVES OF THE ASSESSMENT

To address the challenges presented by a rapidly changing HIV financing environment, the Broward Regional Health Planning Council (BRHPC) commissioned Positive Outcomes, Inc. (POI) to assess the effectiveness of Title I funding in supporting the HIV care system in Broward County. The objectives of the assessment are:

- Assess the impact of reduced or flattened federal, State, or local funding on the HIV care system;
- Evaluate the impact of changes in HIV funding on the maintenance of effort of the Title I grantee, the Broward County Human Services Department (BCHSD);
- Determine if greater efficiencies and other systemic changes might be adopted to optimize future HIV funding;
- Identify other resources that might be drawn upon to support HIV services;
- Synthesize evidence-based studies regarding the impact of Title I funds on consumers and care providers for use by stakeholders to make informed allocation decisions; and
- Provide benchmark data regarding the distribution of Title I funds among service categories allocated by similar Title I EMAs.

E. OVERVIEW OF THE ASSESSMENT METHODS

Several methods were used by POI to conduct the assessment:

- POI staff reviewed BRHPC and Title I grant applications, sponsored studies, reports, budgets, planning documents, and funding allocation data to ensure a comprehensive understanding of the HIV delivery and financing system in Broward County. These environmental factors must be considered in the assessment.
- Relevant County, State, and federal documents were also reviewed to ensure a comprehensive understanding of trends likely to impact future HIV financing in Broward County. Federal HIV policymakers were interviewed regarding the likely future of HIV financing. Their guidance was sought regarding priority setting, coordination of funding streams, and statutory requirements regarding maintenance of effort and payer of last resort. State HIV and Medicaid policymakers were interviewed regarding likely changes in HIV financing and delivery, priority setting, and coordination of funding streams.
- POI staff assessed the availability of funds from other service systems that might be used to support HIV providers or that could accept referrals of Broward County residents living with HIV. Program staff from publicly funded mental health, alcohol, and drug treatment programs in Broward County were interviewed to evaluate the likelihood that these systems of care and financing might be tapped to expand the diversity of funding for Broward County residents living with HIV and expand access to these services in the future. Similarly, representatives of feeding programs in the County were interviewed regarding their current and future funding and their ability to absorb additional referrals of Broward County residents living with HIV.

- The status of corporate and other charitable funding was evaluated in Broward County. Broward County philanthropic foundations were identified and key staff interviewed to evaluate the current and future funding levels available to support HIV programs.
- To assess the barriers to enrollment in Medicaid, Social Security Administration (SSA) staff in Broward County was asked to generate denial rate data for HIV-infected applicants to the Supplemental Security Income (SSI) program. Similarly, trends in enrollment in the Florida PAC Medicaid home and community-based waiver by Broward County residents and associated expenditures were requested from the Florida Agency for Health Care Administration (AHCA).
- BCHSD Title I grant application submissions for federal fiscal years (FY) 1999 to FY 2003 were reviewed. Documentation regarding the nature and scope of the BCHSD's maintenance of effort was abstracted and analyzed. BCHSD grants management staff and the Broward County Title I Planning Council chairperson were interviewed regarding priority setting, procurement processes, third party reimbursement, use of other non-CARE Act funds, and other policies and procedures. Title I grantees in the Miami/Dade and West Palm Beach Title I EMAs were also interviewed to identify factors related to differences in Title I priority setting and funding in the three EMAs.
- Data maintained by HAB regarding the distribution of direct service funds by service category for each Title I EMA were analyzed to rank the Broward County Title I EMAs' proportionate distribution relative to other EMAs. Data from FY 1999, 2000, 2001, and 2002 were studied. Similarly a sub-analysis was conducted specifically of Title I direct services funds by service category for Broward County, Miami/Dade, and West Palm Beach EMAs.
- The CARE Act Data Reports (CADRs) for calendar year (CY) 2002 were reviewed to gain a better understanding of the organizational environment in which Title I-funded HIV programs operate. CADR data were also summarized regarding the nature of the HIV services provided, the volume of services delivered, the sources of funds that support the HIV programs, and the number and characteristics of the clients served by the HIV programs.
- BCHSD Title I budget submissions from subgrantees were analyzed to assess the impact of Title I and Minority AIDS Initiative (MAI) funds on personnel, HIV programs, institutions, and the HIV care system in Broward County. Additional supplemental budgetary information regarding the various sources of their support was requested from Title I subgrantees.
- Extensive on-site interviews were conducted of Title I subgrantees in Broward County. Information was gathered regarding their payer mix, efforts made to obtain funds from sources other than the CARE Act, services that should be billed to third party payers, eligibility determination and billing processes, and the extent to which HIV care providers coordinate and collaborate. Subgrantee staff was also asked to provide feedback regarding ways the HIV care and financing system in Broward County could be improved. Similar on-site and telephone interviews were conducted with Title II, III, IV, and Dental Reimbursement Program (DRP) grantees and sub-grantees in Broward County. A structured interview instrument was adapted from earlier POI studies and used to guide the on-site interviews. Table 1 summarizes the content of the interview guide.
- A comprehensive literature review was conducted to identify evidence-based studies regarding the types of services funded by Title I in Broward County. The published results of studies were sought regarding HIV medical care, HIV pharmaceuticals, case management,

nutrition services, alcohol and drug treatment, mental health services, complementary therapy, and ancillary HIV services. POI staff reviewed cost-benefit or cost-effectiveness studies regarding these types of services. Peer-reviewed articles published in US journals between CY 2000 and 2003 were examined.

Throughout the course of the project, POI staff worked closely with the BCHSD and the BRHPC to identify key informants, gather needed information, and address challenges presented by gaps in information.

Table 1. Components of the Site Visit Guide

- Agency organizational characteristics
- HIV model used (e.g., HIV-focused, one stop shopping, multidisciplinary team, etc.)
- Services provided on-site or at satellites
- Size of staff and their credentials
- Hospital privileges of physicians
- Care coordination methods used and barriers (internal and external)
- Ways in which care coordination can be enhanced
- Intake, registration, and appointment scheduling
- Eligibility determination process
- Capacity to serve current and future clients
- Revenue sources
- Third party insurers, payment mechanisms, managed care contracts
- Use of sliding fee scale and collection of insurance co-payments and deductibles
- Accounting and billing systems
- Uncompensated care
- Efforts to diversify funding and barriers
- Status of charitable donations
- Unfunded services they would like to provide
- Physical layout of the program
- Likely impact of decreased Title I funding

F. IMPACT OF CHANGES IN HIV FUNDING

Reduction or flattening of HIV funding is likely to have variable impact on Broward County agencies engaged in HIV care. These agencies vary in their reliance upon CARE Act, Medicaid, other State, County, and other sources of funding. They also differ in the extent to which they provide inpatient services, a service category not generally supported by CARE Act funds. They also vary due to whether the services they provide are covered by Medicaid or other third party insurers.

POI staff conducted interviews with key Federal, State, and County officials to identify changes likely to occur in funding for the HIV care system in Broward County. Funding data gathered by the BRHPC were analyzed to determine the sources of funds supporting HIV care in Broward County and the relative impact that changes in those funding streams would have. The assessment of the impact of changes in funding levels on individual Broward County HIV programs was not feasible. Most programs were unable to provide POI with data documenting the sources and amounts of their funding. CADR data regarding sources of third party insurance were found to be inaccurate for some Title I subgrantees because they were unable to generate payer mix data prior to the HAB reporting deadline. POI also could not assess the per capita impact of changes in HIV funding because no reliable client or beneficiary counts were available for Title I or other funding streams. Alternatively, POI assessed the impact of loss or flattening of Title I funds on employees of Title I subgrantees.

1. Funding Streams Supporting HIV Care in Broward County

In FY 2002, an estimated $139.6 million dollars in public funds were expended to support HIV inpatient, pharmaceutical, and community-based care in Broward County. While other sources of funds, including commercial insurance payments, also support HIV care, the amount of funds they expend for Broward County residents is unclear. While Title I and MAI funds support critical HIV services, they represent only about 10.6% of total public HIV services funds in Broward County. Other CARE Act programs contribute 16.5% of total HIV care dollars, the Housing Opportunities for Persons With AIDS (HOPWA) Program administered by the US Housing and Urban Development Program (HUD) contributes 5.0%, other federal programs such as the federally-funded Medicaid Program contribute 44.3%, State general revenue and other State funds contribute 14.7%, and Broward County and other local governments contribute 8.9%.

Since payer mix data are not available for individual Broward HIV care providers, it is not possible to measure the direct impact of funding changes on those agencies. The contribution of public payers to individual HIV service categories can generally be assessed. Tables 16 and 18 in the Appendix show that funds for home/community-based services are funded by a mix of Title I and MAI funds (20.2%), other CARE Act funds (17.1%), HOPWA (39.8%), other federal funds (5.0%), State general revenue and other State funds (16.4%), and Broward County and other local funds (1.5%). In contrast, 85.5% of HIV ambulatory care services are funded by other federal funds, 8.8% by Title I, 1.6% by other CARE Act programs, 3.7% by State general revenue and other State funds, and 0.4% by Broward County and other local funds. Reflecting the allocation of Title II ADAP funds, 85.5% of pharmaceutical costs are supported by other CARE Act programs, 13.7% by Title I, and 0.5% by State general revenue. About two-thirds (62.2%) of other outpatient/community-based health services are funded by Title I and MAI

funds, 13.8% by other CARE Act programs, 5.2% by other federal funds, and 18.8% by State general revenue.

Inpatient care is not generally an allowable expense for CARE Act programs. About one-third (39.0%) of inpatient costs were supported by other federal funds, 34.1% by State general revenue, and 27% by other local funds (i.e., the North and South Broward Hospital Districts).

It should be noted that additional HIV-related service costs are not included in Tables 16 and 17. Medicaid costs reported above are associated with inpatient admissions only. Other Medicaid costs, including pharmaceuticals, diagnostic testing, and ancillary costs are not reflected in the data. Similarly, other Broward County costs are associated with inpatient admissions to North or South Broward Hospital District facilities. Outpatient department costs for these hospital districts are not included in the tables.

Responsibility for supporting some service categories reflects an agreement by Broward County CARE Act funders to support "mutually exclusive service categories."[1] The total amount of funds for food bank, support groups, day/respite care, and complementary therapies are supported by Title I in Broward County. In contrast, Title II funds 100.0% of funds allocated to home-delivered meals, bus passes, buddy/companion services, legal/permanency planning, client advocacy, medication co-payments, and home health care. The Broward County HOPWA Program supports 100.0% of rental vouchers, project-based rental assistance, substance abuse housing, and housing referral/placement. During periods in which HIV funds were abundant, this funding approach helped to achieve administrative simplification for both grantees and subgrantees. In periods of decreasing funds, however, service categories with single sources of support are particularly vulnerable if those funding streams experience flat or reduced funding.

A mix of payers funds other service categories. Case management is funded by a mix of Title I (48.7%), other CARE Act funds (38.4%), other federal funds (6.6%), and State general revenue (6.3%). Nutritional services are funded by Title I and MAI funds (71.0%) and State general revenue (28.9%). Transportation services are funded by Title I (94.0%) and Title II (6.0%) funds. Health education/risk reduction (HERR) services are funded by Title I (21.5%), Title IV (6.1%), other federal funds (26.3%), and State general revenue (46.1%). Outreach services are funded by Title I and MAI funds (61.6%), Title III (1.4%), and State revenue (37.0%). Reflecting the coverage of ambulatory/outpatient medical services by Medicaid, other federal funds support 85.6% of medical services, while Title I and MAI funds support 8.8%, State general revenue supports 3.7%, and Broward County funds support 0.4%.

2. Anticipated Changes In Programs Supporting HIV Care in Broward County

Given the lack of diversity of funders supporting many HIV service categories, recent or future changes in the funding levels, coverage, or eligibility criteria are likely to have a significant impact on the HIV financing system in Broward County.

a. CARE Act Funding

As of June 2003, Congress was considering cuts to CARE Act programs. While it is unclear if cut will be made to all titles and programs of the CARE Act, it is likely that some titles will receive at least flat funding, if not reductions in awards. The Congressional deliberations should

be watched carefully so that CARE Act grantees and subgrantees can prepare contingency plans for reductions in effort. Moreover, CARE Act grantees should be prepared to fully document the need for additional supplemental funds from Title I.

b. Title I

Broward County HIV care providers are heavily reliant on Title I funds and less so on other titles of the CARE Act. Among the fifteen Broward County Title I subgrantee agencies funded in FY 2003, 53.3% received only Title I funds, 33.3% received Titles I and Titles II funds, 6.7% received Title I and Title III funds, and 6.7% received Titles I, II, and III.

The federal Title I Program received a slight increase in total funds ($2.3 million) for FY 2003 compared to total Title I funds in FY 2002. As shown in Table 2, the federal Title I Program received a slight (0.97%) increase in formula funds, a decrease (0.97%) in supplemental funds, and a 4.10% increase in MAI funds. In turn, the BCHSD received a slight reduction (1.19%) in FY 2003 Title I funds compared to FY 2002 levels. While BCHSD received a 0.41% increase in Title I formula funds, they experienced a 1.89% reduction in Title I supplemental funds and a 7.94% reduction in MAI funds.

Table 2. Change in Title I Funds, US and Broward County Eligible Metropolitan Area, FY 2002 and 2003

Year		Formula	Supplemental	MAI	Total
2002	**US**	$305,561,130	$249,894,870	$41,800,000	$597,256,000
2003	**US**	$308,523,566	$247,474,434	$43,515,000	$599,513,000
Percent Change		0.97%	-0.97%	4.10%	0.38%
2002	**Broward County EMA**	7,360,837	6,425,858	1,086,150	14,872,845
2003	**Broward County EMA**	7,390,932	6,304,723	999,869	14,695,524
Percent Change		0.41%	-1.89%	-7.94%	-1.19%

To account for the recent cut in Title I funds, BCHSD has apportioned a reduction in funds across all subgrantee awards. The impact of the cuts is likely to be felt the greatest, however, on agencies with a relatively low level of institutional support, inability to bill third party payers for their services, and less diversified payer mix. A reduction in funds came at a time when Title I subgrantees report that Title I funds are insufficient to support increased demand for services and growing administrative costs that are not covered in the Title I administrative cap rate. Title I subgrantees also report that the Title I unit-based payment levels, which are tied to Medicaid payment rates, are significantly lower than the cost of care. Case management rates paid by Title I, for example, are now lower that those rates recently set for the PAC Program. Inadequacy of funding has led one Title I subgrantee in the past year to withdraw from participation. Several other agencies interviewed by POI reported that they are assessing whether they can continue to

participate in the program if funds are reduced further or if uncompensated administrative costs continue to rise.

c. Title II

The Florida Title II Program received only a slight increase of funds in FY 2003. A State Title II official reports that funds will be required in FY 2003 from Title I grantees to support the Florida ADAP.[2] Until the current fiscal year, the Florida ADAP was adequately supported through a combination of Title II funds, State general revenue, and manufacturer rebates. The Florida ADAP is likely to experience shortfalls in FY 2003. ADAP is experiencing growth in the number of enrollees, the period of enrollment in ADAP is growing for many ADAP clients, the average number of covered drugs that they receive is increasing, and the per capita cost of medications is rising.[3] State officials expressed hope that the Broward County EMA would contribute to the ADAP budget to ensure that reduction in benefits, narrowing of eligibility criteria, or other cost-cutting measures will not be necessary.

The Florida AICP purchases insurance premiums and makes co-payments for clients that are receiving insurance continuation benefits under the Congressional Omnibus Reconciliation Act (COBRA). Due to Florida State legislation, the AICP cannot enroll clients that do not have health insurance covered through COBRA. In other states, such as California, Maryland, Minnesota, and New York, the AICPs have been demonstrated to be extremely cost effective. They also have ensured much broader coverage than would be available through contracted CARE Act services. In some states, Medicaid programs have funded AICPs to shift the cost of HIV care to commercial insurers at relatively low premium costs to Medicaid. Additionally, commercial insurance plans generally compensate HIV clinics and other care providers at much higher rates than supported by the CARE Act or Medicaid. As a result, HIV clinics and other health care providers are able to cover the costs of their HIV care.

Florida AICP staff has identified a pressing need for additional funds from EMAs to support the program at current levels.[4] While the AICP received a slight increase in Title II funds for CY 2003, those funds are not sufficient to maintain current enrollment levels and accept new clients. In February 2003, the AICP staff contacted Title I grantees to notify them of the need for Title I support. Funds for AICP enrollment are distributed on a proportion basis to reflect HIV/AIDS epidemiologic data by county. A county-specific waiting list may be instituted by mid-FY 2003 to ensure that existing clients' premiums can be covered through the rest of the fiscal year. AICP staff report that it is unlikely that individuals on county waiting lists will be able to sustain their COBRA premium payments for more that one to two months due to their recent disability and loss of income. If their premium payments lapse they will be ineligible at a later date to reinstate their COBRA benefits with AICP funds. These individuals are likely to seek uncompensated clinical services through Title I and II funded clinics, enroll in ADAP, and be reliant on CARE Act supported services.

As of June 2003, AICP staff received a commitment from all Florida Title I EMAs except for Broward County for Title I funds to be allocated to the State AICP budget. AICP staff plans to meet with Broward County Planning Council representatives to present their request for Title I support.

d. MAI

MAI funds represent a significant source of revenue for some Broward County HIV care providers. MAI funds also underwrite a significant portion of services provided to Broward County HIV infected racial/ethnic minority populations. MAI funded must be appropriated on an annual basis and are not statutorily authorized, as the CARE Act is. In appropriating MAI funds, Congress envisioned these funds as being developmental rather than forming the basis for long-term support to specific subgrantees. In each year of its funding, the MAI has required significant advocacy to ensure its continued funding. It is important for BCHSD to develop contingency planning if MAI funds are not appropriated in the future so that no break in service occurs, particularly purchasing pharmaceuticals for enrolled clients.

e. HOPWA

The Broward County HOPWA Program received an unanticipated 22% cut in FY 2003 funds.[5] Since there were carry-over funds from the FY 2001 budget, there had been expansion of the program in the FY 2002. As a result, the reduction in funded services are actually greater than the 22% cut. HOPWA staff has identified a contingency plan that would shift some clients to the Ft. Lauderdale Housing Authority. Funds for housing vouchers are likely to be the service most impacted by reduction in HOPWA funds. A waiting list has been instituted, with a ceiling on the number of individuals allowed on the list. At least one CBO relies heavily on HOPWA funds and a cut to their budget may result in closure of some housing units.

f. State General Revenue and Other Funds

In FY 2002, almost $3 million in State revenue and $17.5 million in other State funds were allocated to Broward County HIV programs. State general revenue and other State funds support Broward County HIV case management, nutritional services, HERR, outreach and referral, AICP, direct emergency financial assistance, and children and family services. As of early June 2003, State HIV Program staff report that it is unclear if their State general revenue funds will be decreased by the State legislature.[2]

g. Medicaid

The Florida Medicaid Program underwrites a high proportion of HIV-related inpatient, ambulatory care, and medication costs in Broward County. While the Florida Medicaid Program has a significant role in funding HIV care, the Florida Medicaid fee-for-service payment rates are relatively low and have not been adjusted recently to account for rapidly growing medical care inflation. The relative contribution by Medicaid assistance categories is unknown, but likely to be predominantly driven by SSI, the medically needy program, TANF, and PAC. Timely enrollment and expenditure data for Broward County were not available at the time this assessment was conducted.

Last year, the Florida State legislature significantly cut PAC funding, resulting in decreased revenue for participating care providers. It is unclear how much revenue has been lost in Broward County due to changes in the PAC funding. According to PAC staff, only one Broward County agency is enrolled as a PAC provider.[6] Another agency was enrolled but discontinued participation in the program. It is unclear why other Broward County agencies are not enrolled

and if their lack of participation may be an indication that Broward County residents living with HIV are not being assessed for PAC eligibility.

Changes in PAC coverage are to be implemented as of July 1, 2003.[6] An acuity system will be implemented to determine the number of services that will be covered by the PAC. Enrollees in PAC with lower acuity levels will experience a reduction in the number of covered benefits that they can receive. HAB's payer of last resort policies will allow a CARE Act program to fund the additional services needed by the client but not covered by PAC. It is unclear, however, if sufficient funds are available in the budgets of Broward County Title I subgrantees or other CARE Act programs to cover these additional services. It is also uncertain how services will be coordinated between PAC case managers, community-based case managers, clinicians, and Positive Healthcare staff.

The Florida Medically Needy Program's fate is unclear. The State legislature considered did not adopt a proposal to eliminate the program during the 2003 general session. It is uncertain, however, how long the program will be maintained. If the Medically Needy Program is eliminated in the future, Broward County beneficiaries of the program are likely to seek care from Title I-funded providers.

It is unclear what impact the reduction in PAC and medically needy benefits will have in future years on the State's match or maintenance of effort requirement. If the maintenance of effort levels dropped below the State's required funding level, for example, the Title II award could be decreased proportionately to the drop in funds in the State's maintenance of effort contribution. As a result, the amount of Title II funds allocated to Broward County would decrease.

Another change on the horizon for the Florida Medicaid Program is the implementation of a voluntary HIV capitation program for several Florida counties, including Broward County. ACHA is rapidly developing the eligibility criteria and covered benefits package for the program. The program is likely to offer enhanced Medicaid payment levels that may make it appealing to HIV clinical, case management, and ancillary care providers. Broward County HIV clinics and other care providers generally are not experienced in negotiating capitated or fee-for-service contracts with managed care plans. As a result, it is unclear if the providers will directly benefit from the enhanced rates. Significant training and technical assistance (TA) will be required by Broward County HIV programs to ensure that they are ready to fully participate in the program when it is implemented.

h. Social Security Administration

The Social Security Administration (SSA) is responsible for administering the SSI Program. Medical determinations are conducted on a contractual basis by State agencies. As a result of inconsistent application of SSA disability criteria, States tend to vary in their rates of accepted claims for HIV-related disability. Broward County HIV providers report significant difficulty in getting clients enrolled. As a result, the rate of rejected HIV disability claims is reported to be high. Data regarding the rate of denied claims for Broward County HIV-related claims are not available from the SSA. Some providers have been informed erroneously that a client may apply for SSI only once per year. The SSI application process is reported to be slow and the level of documentation is significant, without compensation from CARE Act or other funders. SSA staff report that SSI applications often do not sufficiently document the applicant's disability.[7]

SSA is now accepting comments regarding the current national standards for SSI eligibility for applicants with HIV-related disability and several other conditions. It is unclear what the result of this comment period will be. HIV disability advocates have voiced concern that SSI beneficiaries may be required to be re-determined to document their continued disability and inability to be gainfully employed. This re-determination process may result in SSI beneficiaries losing their Medicaid benefits, as well as disability income payments. Loss of SSI benefits is likely to significant impact the State ADAP program, as well as Title I and II funded providers.

i. Medicare

It is unclear how many Broward residents living with HIV are now enrolled in Medicare. Actuaries from the Centers for Medicare and Medicaid Services (CMS) report that the number of HIV-infected Medicare beneficiaries is likely to continue to grow slightly over the next five years. Since Medicare does not cover pharmaceuticals, Medicare beneficiaries living with HIV tend to rely on the Title I drug assistance program and the State ADAP for pharmaceuticals. Due to the high levels of indigent HIV-infected individuals in Broward County, it is unlikely that many Medicare beneficiaries are likely to afford Part B coverage for ambulatory and community-based services. These individuals may be dually enrolled in Medicaid and Medicare.

j. Broward County Revenue

Broward County has enjoyed sustained growth in the period between April 1996 and April 2003, according to an analysis conducted by POI staff. Table 3 shows that growth occurred in incomes (4.3%), employment (1.9%), employment production (11.3%), proprietorships (3.7%), and building permits (16.0%). The health care sector also grew during this period, with employment in health care growing by 9.7% and wages in health care increasing by 10.6%. Not all segments of the Broward County population enjoyed the benefits of the grow in Broward County's economy, however, with the unemployment rate growing by 6.4% and the unemployment insurance rate growing by 9.9%.

Compared to other Title I EMAs, Broward County has experienced a relatively expansive economy. In an analysis conducted by Dr. Wendy Warcholik, Economic Consultant to POI, Broward County had the ninth highest growth index score among 42 EMAs studied.

Table 3. Average Annual Growth in Broward County Florida, April 1996 to April 2003

Income Growth	Employment	Unemployment Rate	Unemployment Insurance	Employment-Healthcare
4.3%	**1.9%**	**6.4%**	**9.9%**	**9.7%**
Wage- Healthcare	Employment Production	Wage Production	Proprietorships	Building Permits
10.6%	**11.3%**	**0.5%**	**3.7%**	**16.0%**

Source: Adapted for a project funded by the HIV/AIDS Bureau and conducted by Dr. Wendy Warcholik, POI.

While growth in Broward County's economy has been strong and sustained, population growth has resulted in the need for County revenues to support infrastructure such as new schools. At

the same time, Broward County must support unfunded mandates such as increased outlays to underwrite costs related to law enforcement and bioterrorism surveillance.

County revenue is used to support some HIV programs. County staff reports that it is unclear if the County's budget will be cut and what the impact will be on HIV services. A cut in County funds may result in a decrease in Title I maintenance of effort funding. It is unclear what impact this will have on ongoing Title I funding.

j. Hospital District Tax Revenue

It is unclear to what extent Broward County's economic growth has impacted the North and South Broward Hospital Districts' tax revenue base. Both hospital districts have strict eligibility criteria and uninsured individuals are billed. At the same time, health care wages in Broward County have increased by 10.6%, with salaries for nurses and other key personnel increasing rapidly. Capital costs are also likely to rise as hospital district buildings age and require increased upkeep. At least one HIV care program has been notified by hospital district managers that there may be a significant drop or an elimination of funds to support community-based step down care. A cut in hospital district funds would result in a decrease in Title I maintenance of effort funding. It is unclear what impact this cut will have on ongoing Title I funding.

3. Impact of Cuts in HIV Funding on Workers in the HIV Delivery System

Reductions in Title I and/or MAI funds are likely to disproportionately impact HIV care workers and administrative staff, as personnel costs make up the vast majority of most subgrantee's budgets. To assess the number of personnel currently supported by Title I and the MAI, POI staff reviewed the final FY 2002 Title I and MAI subgrantee budgets.[8] POI evaluated the amount budgeted for salaries and fringe benefits for direct care and administrative/indirect personnel. Funds budgeted for consultant fees and contractual employees were also included in the analysis of direct care personnel costs. These line items were used by subgrantees to pay for specialty consultations and to employee contractual physicians on a part-time basis.

It should be noted that Title I budget materials submitted by subgrantees to BCHSD were of highly variable accuracy and clarity. The quality of the budgetary information appears to be unrelated to the size of the subgrantee's institution or sophistication of their accounting and finance staff. As a result of the conflicting and incomplete information provided by subgrantees, caution should be used in interpreting the findings presented in this section.

As shown in Table 4, direct care salaries represented $5.6 million in Title I and MAI funds in FY 2002. Among Title I personnel costs, 81.6% were associated with direct care salaries, 13.3% with direct care fringe benefits, 4.2% with administrative personnel salaries, and 1.0% with administrative personnel fringe benefits. Among MAI personnel costs, 59.0% were associated with direct care salaries, 14.1% with direct care fringe benefits, 20.8% with administrative personnel salaries, and 6.2% with administrative personnel fringe benefits.

Table 4. Title I and MAI-Funded Direct Care and Administrative / Indirect Personnel, Contractual Employee, and Medical Consultant Charges, FY 2002					
	Direct Care		Administrative / Indirect		
Funding Source	Salaries	Fringe Benefits	Salaries	Fringe Benefits	Total
Title I	$3,814,168	$620,195	$195,285	$45,534	$4,675,181
MAI	$545,390	$129,938	$192,015	$57,377	$924,720
Total	$4,359,558	$750,133	$387,299	$102,911	$5,599,901
Source: Broward County Human Services Department FY 2002 Line Item Budget Form					

Changes in future levels of Title I funding are likely to disproportionately impact racial/ethnic minority agencies. As shown in Table 5, 54.1% of Title I personnel funds were awarded to agencies with predominantly racial/ethnic minority staff and 1.7% of funds were awarded to agencies with predominantly racial/ethnic minority boards but not staff. An additional 15.5% of Title I personnel funds were awarded to agencies with a tradition of serving racial/ethnic minority populations, but that do not meet the minority provider criteria. Almost two-thirds (61.7%) of MAI personnel funds were awarded to agencies with predominantly racial/ethnic minority staff.

Table 5. Title I and MAI-Funded Direct Care and Administrative / Indirect Personnel, Contractual Employee, and Medical Consultant Charges, FY 2002, By Minority Provider Status			
Funding Source	Minority Provider Status	Total	Percent
Title I	Minority Board Only	$78,764	1.7%
	Minority Staff Only	$2,530,860	54.1%
	Traditional Provider	$1,340,713	28.7%
	Other	$724,844	15.5%
	Total	$4,675,181	100.0%
MAI	Minority Staff Only	$570,601	61.7%
	Traditional Provider	$354,119	38.3%
	Total	$924,720	100.0%
Total	Minority Board Only	$78,764	1.4%
	Minority Staff Only	$3,101,461	55.4%
	Traditional Provider	$1,694,832	30.3%
	Other	$724,844	12.9%
	Total	$5,599,901	100.0%
Source: Broward County Human Services Department FY 2002 Line Item Budget Form and CARE Act Data Reports (CADR), CY 2002			

HIV community-based organizations (CBOs) tend to have less institutional support to draw upon during times of economic downturn or to support administrative costs. Moreover, CBOs tend to have fewer vacancies in other parts of their organization to shift personnel that can no longer be supported with grant or other funding sources. In Broward County, 51.0% percent of Title I personnel funds were allocated to CBOs, compared to 61.7% of MAI funds.

Almost one-half (41.2%) of Title I personnel funds were allocated to the medical service category, 25.6% to case management services, 9.5% to dental services, and the balance of funds to other service categories. In contrast, 38.3% of MAI personnel funds were allocated to pharmaceutical services, 28.6% to outreach, 16.1% to substance abuse treatment, 11.4% to medical services, and 5.6% to mental health services.

Table 6. Title I and MAI-Funded Direct Care and Administrative / Indirect Personnel, Contractual Employee, and Medical Consultant Charges, FY 2002, By Provider Type

Funding Source	Provider Type	Sum	Percent
Title I	CBO	$2,384,006	51.0%
	Health Department	$1,296,922	27.7%
	Hospital clinic	$994,254	21.3%
	Total	$4,675,181	100.0%
MAI	CBO	$570,601	61.7%
	Health Department	$354,119	38.3%
	Total	$924,720	100.0%
Total	CBO	$2,954,606	52.8%
	Health Department	$1,651,041	29.5%
	Hospital clinic	$994,254	17.8%
	Total	$5,599,901	100.0%

Source: Broward County Human Services Department FY 2002 Line Item Budget Form and CARE Act Data Reports (CADR), CY 2002

Title I personnel funds were highly concentrated among a small number of subgrantees, with three subgrantees accounting for 63.5% of total Title I personnel costs. These subgrantees include: Broward County Health Department (BCHD) (27.7%), Community Healthcare Center 1 (21.2%), and North Broward Hospital District (14.6%). In contrast, about three-quarters (72.7%) of MAI personnel funds were allocated to two subgrantees: BCHD (38.3%) and Broward House (34.4%).

POI planned to compute the number of workers or estimate the number of full-time equivalent (FTE) personnel funded by Title I and MAI. Subgrantees did not consistently use BCHD budget forms. Frequently the subcontractors also misinterpreted the full-time equivalent item in the BCHD budget form and submitted incorrect information. Due to erroneous information, POI was unable to accurately conduct this component of the analysis.

POI also planned to assess the potential impact of reduced or flattened funding on various types of personnel including licensed professionals, paraprofessionals, and support staff. Due to the inconsistent use of job titles, it was difficult to accurately aggregate similar personnel into categories. For example, some employees were given different titles based on their assignment to different service category budgets. An employee might be defined as a supervisor in one budget, a direct service worker in another budget, and an administrator in another budget.

4. Impact of Cuts in HIV Funding on Broward County Hospitals

Inpatient rates in most EMAs have decreased significantly with the advent of highly active antiretroviral therapy (HAART), laboratory testing, and improved access to experienced HIV primary physicians. Reductions in support for HIV care systems through the CARE Act, Medicaid, and other programs are likely to result in decreased access to HIV therapeutics and primary care services. To establish baseline trends in inpatient admissions in Broward County, admissions data from hospitals in the county were sought. Unfortunately, admission trend data are not available at this time. Alternatively, cross-sectional inpatient admission data from 2000 were obtained from BRHPC.

POI assessed the potential impact of reduced access to HIV ambulatory care and pharmaceutical coverage on inpatient admissions to hospitals in Broward County. To simplify the analysis, data from hospitals owned and operated by the same corporations were aggregated. For example, North Broward Hospital District owns several hospitals which had HIV-related inpatient admissions in 2000. Hospital ownership data were obtained from the Florida Hospital Association website. The results of the analysis are shown in Table 9.

If inpatient hospital admissions increase due to reduced HIV ambulatory care and pharmaceutical coverage, North Broward Hospital District facilities are likely to experience the greatest increase in uncompensated inpatient admissions. In 2000, for example, North Broward Hospital District had 74.2% of HIV-related inpatient admissions and 73.4% of patient days (the sum of the lengths of stay of individual patients). North Broward Hospital District also experienced 79.9% of total charges, 78.4% of self-pay patients, 82.8% of Medicaid charges, and 81.7% of uncompensated HIV-related charges. In contrast, the hospital with the second highest number of HIV-related admissions, South Broward Hospital District, had only 11.8% of HIV-related admissions.

Clearly, many factors may work to reduce the marginal impact on inpatient admissions resulting from reduced funds for HIV ambulatory and pharmaceutical services. Insufficient data are currently available, however, to model the likely impact of the various forces that might be in play as support for HIV ambulatory and pharmaceutical funds is reduced. It is also unclear how rapidly changes might be made and in what combination over time. What is clear, however, is that the most likely impact of changes in support for HIV ambulatory and pharmaceutical services will be on the North Broward Hospital District.

Table 7. Title I and MAI-Funded Direct Care and Administrative / Indirect Personnel, Contractual Employee, and Medical Consultant Charges, FY 2002, By Ownership Type			
Funding Source	**Service Category**	**Total**	**Percent**
Title I	Medical	$1,925,368	41.2%
	Case Management	$1,198,084	25.6%
	Dental and Dental Supplement	$443,559	9.5%
	Mental Health	$231,117	4.9%
	Transportation	$205,615	4.4%
	Complementary Therapies	$205,286	4.4%
	Substance Abuse Treatment	$106,463	2.3%
	Nutritional Services	$105,915	2.3%
	Health Education and Risk Reduction (HERR)	$82,917	1.8%
	Outreach	$80,635	1.7%
	Food Bank	$45,230	1.0%
	Support Groups	$38,706	0.8%
	Day / Respite Care Children	$6,286	0.1%
	Total	$4,675,181	100.0%
MAI	Pharmaceutical	$354,119	38.3%
	Outreach	$264,368	28.6%
	Substance Abuse Treatment	$149,206	16.1%
	Medical	$105,585	11.4%
	Mental Health	$51,442	5.6%
	Total	$924,720	100.0%
Total	Medical	$2,030,953	36.3%
	Case Management	$1,198,084	21.4%
	Dental and Dental Supplement	$443,559	7.9%
	Pharmaceutical	$354,119	6.3%
	Outreach	$345,003	6.2%
	Mental Health	$282,559	5.0%
	Substance Abuse Treatment	$255,669	4.6%
	Transportation	$205,615	3.7%
	Complementary Therapies	$205,286	3.7%
	Nutritional Services	$105,915	1.9%
	HERR	$82,917	1.5%
	Food Bank	$45,230	0.8%
	Support Groups	$38,706	0.7%
	Day / Respite Care Children	$6,286	0.1%
	Total	$5,599,901	100.0%
Source: Broward County Human Services Department FY 2002 Line Item Budget Form and CARE Act Data Reports (CADR), CY 2002			

Table 8. Title I and MAI-Funded Direct Care and Administrative / Indirect Personnel, Contractual Employee, and Medical Consultant Charges, FY 2002, By Agency			
Funding Source	**Agency**	**Total Personnel Costs**	**Percent**
Title I	Broward County Health Department (BCHD)	$1,296,922	27.7%
	Community Healthcare Center One*	$991,188	21.2%
	North Broward Hospital District	$684,000	14.6%
	Wansiki Foundation**	$414,590	8.9%
	Broward House	$396,574	8.5%
	South Broward Hospital District	$310,254	6.6%
	Community AIDS Resource	$160,136	3.4%
	Minority Development and Empowerment, Inc. (MDEI)	$132,465	2.8%
	Trinities Ministries	$123,720	2.6%
	Christ Crusaders	$42,777	0.9%
	Parents Information and Recreation Center (PIRC)	$41,272	0.9%
	Wellness Center of South Florida	$37,505	0.8%
	Hispanic Unity***	$37,492	0.8%
	Family Center, Inc***.	$6,286	0.1%
	Total	$4,675,181	100%
MAI	BCHD	$354,119	38.3%
	Broward House	$318,528	34.4%
	Community Healthcare Center 1*	$142,802	15.4%
	MDEI	$109,271	11.8%
	Total	$924,720	100%
Total	BCHD	$1,651,041	29.5%
	Community Health Care Center 1*	$1,133,990	20.3%
	Broward House	$715,101	12.8%
	North Broward Hospital District	$684,000	12.2%
	Wansiki Foundation**	$414,590	7.4%
	South Broward Hospital District	$310,254	5.5%
	MDEI	$241,736	4.3%
	Community AIDS Resource	$160,136	2.9%
	Trinities Ministries	$123,720	2.2%
	Christ Crusaders	$42,777	0.8%
	PIRC	$41,272	0.7%
	Wellness Center of South Florida	$37,505	0.7%
	Hispanic Unity***	$37,492	0.7%
	Family Center, Inc.***	$6,286	0.1%
	Total	$5,599,901	100%
Source: Broward County Human Services Department FY 2002 Line Item Budget Form and CARE Act Data Reports (CADR), CY 2002 * Now doing business as AIDS Project Florida, ** no longer in operation, *** no longer Title I subgrantee			

Table 9. Total Inpatient Hospital Utilization and Charges Associated With HIV / AIDS Admissions to Broward County Hospitals, CY 2000							
INPATIENT MEASURES	**North Broward Hospital District**	**South Broward Hospital District***	**Tenet Health System**	**HCA East Florida Division**	**Kindred Healthcare**	**Catholic Health Services**	**Total**
INPATIENT UTILIZATION							
Total number of unduplicated patients	1,489	279	153	199	6	2	2,128
% unduplicated patients admitted for HIV/AIDS care	70.0%	13.1%	7.2%	9.4%	0.3%	0.1%	100.0%
Total number of admissions	2,357	375	167	270	6	3	3,178
% Broward County HIV / AIDS admissions	74.2%	11.8%	5.3%	8.5%	0.2%	0.1%	100.0%
Total number of inpatient days	17,666	3438	1065	1653	132	98	24,052
% Broward County HIV / AIDS inpatient days	73.4%	14.3%	4.4%	6.9%	0.5%	0.4%	100.0%
INPATIENT CHARGES							
Total Medicaid charges	$24,942,860	$2,695,685	$1,144,658	$1,296,567	$9,973	$27,251	$30,116,993
% Medicaid charges	82.8%	9.0%	3.8%	4.3%	0.0%	0.1%	100.0%
Total Medicare charges	$14,769,092	$1,988,278	$1,296,200	$509,725	$484,842		$19,048,137
% Medicare charges	77.5%	10.4%	6.8%	2.7%	2.5%	0.0%	100.0%
Total third party (insurance, HMO, PPO, etc.) charges	$19,881,311	$2,998,302	$1,555,394	$950,244	$0	$4,843	$25,390,094
% third-party charges	78.3%	11.8%	6.1%	3.7%	0.0%	0.0%	100.0%
Total other / self-pay charges (I.e., indigent, welfare)	$13,038,312	$2,964,679	$186,380	$438,382	$0		$16,627,753
% Broward County HIV/AIDS other / self-pay charges	78.4%	17.8%	1.1%	2.6%	0.0%	0.0%	100.0%
Total charges	$72,631,575	$10,646,943	$4,182,632	$3,195,418	$494,815	$33,215	$91,184,597
% Broward County HIV / AIDS inpatient charges	79.7%	11.7%	4.6%	3.5%	0.5%	0.0%	100.0%
Estimated unreimbursed charges	$55,563,258	$8,090,657	$2,887,498	$1,490,086	$1,536	$3,252	$68,036,287
% of total Broward County unreimbursed charges	81.7%	11.9%	4.2%	2.2%	0.0%	0.0%	100.0%

Source: Personal Communication, Terri Sudden, Broward Regional Health Planning Council, 2003. Florida Hospital Association Hospital Directory, http://www.fha.org/hospdir.html
* South Broward Hospital District does business as Memorial Health Care System

5. Impact of Cuts in HIV Funding on the Maintenance of Effort of the Title I Grantee

States and EMAs are required by the CARE Act to maintain a level of HIV expenditures for services at an amount that is equal to the levels of such expenditures for the preceding year. The purpose of the maintenance of effort requirement is to ensure that States, local governments and educational institutions will not shift the costs of HIV care to the federal government. As illustrated in Table 10, the maintenance of effort provision under Title I, II, III and DRP of the CARE Act states that the Secretary "shall not make a grant under this subsection if doing so would result in a reduction of State funding allocated for such purposes." Thus, Federal funding can be decreased but not directly due to a reduction in other Federal funds, including reduction in CARE Act funds received by Title I, Title II, or AETC grantees.

Table 10. Ryan White CARE Act Maintenance of Effort Fiscal Requirement, By Title and Part F

Fiscal Requirement	Title I	Title II	Title III	Title IV	Part F, Dental Reimbursement Program
Maintenance of Effort	◆	◆	◆		◆

Source: Ryan White CARE Act

The external and institutional environments have left many CARE Act grantees struggling with diminished governmental, institutional, and charitable resources to meet the fiscal requirements of the CARE Act, including matching fund and maintenance of effort. The benchmarks by which CARE Act grantees' maintenance of effort rates are currently set reflect the budgetary environment of several years ago rather than the more recent contraction of government, institutional, and community resources. Moreover, Federal, State, and municipal government programs are increasingly vying for position as the payer of last resort for HIV and other indigent medical care. State and local tax dollars for HIV care may be difficult to sustain in future years.

These recent developments are likely to result in:

- Significant challenges among CARE Act grantees in meeting the CARE Act's maintenance of effort and matching fund requirements.
- Narrowing of eligibility and covered benefits by other payers that will result in increased efforts to use CARE Act funds as the "first payer" for a growing number of grantees serving persons eligible for Medicaid or other third party insurance benefits.
- A willingness by grantees to have their CARE Act awards so that local funds can be redistributed for other funding requirements.

With the approaching FY 2005 reauthorization of the CARE Act, HAB may reconsider the maintenance of effort requirement. Alternative approaches that might be taken include eliminating the requirement for Title I and other grantees. Elimination of the requirement would likely lead to significant reductions in local and other non-federal funds allocated by EMAs for HIV services. Large portions of the HIV services infrastructure would be de-funded as a result. Alternatively, the maintenance of effort requirement might be retained, with a waiver process offered as relief to EMAs that are unable to sustain their level of HIV funding. Once again, it is

likely that many EMAs would submit a waiver and funding for HIV services would be significantly reduced. In the third scenario, the maintenance of effort requirement would be retained and HAB would be likely to be stricter in enforcing the requirement.

Title I applications from the BCHSD to HAB were analyzed by POI. Between FY 1998 and FY 2001, the Broward County Title I EMA maintenance of effort initially decreased significantly between FY 1998 and FY 1999 (15.7%) and then began to rise again between FY 1999 and FY 2000 (2.1%) and between FY 2000 and FY 2001 (3.7%). Significant decreases in Medicaid expenditures (26.7%) were experienced early in this period and would not be likely to trigger concern on the part of HAB regarding the BCHSD's maintenance of effort because Medicaid expenditures were driven by unanticipated declines in Medicaid utilization- probably resulting from decreased inpatient admissions as the benefits of HAART were experienced by Medicaid beneficiaries.

Other decreases in the sources of funding making up the maintenance of effort are less likely to be outside the control of Broward County policy makers. For example, outpatient expenses associated with North Broward Hospital District decreased by 46.2% between FY 1998 and FY 1999, 54.5% between FY 1999 and FY 2000, and 20.4% between FY 2000 and FY 2001. This was the period in which Title III funding was awarded to the North Broward Hospital District. It might appear that the Hospital District supplanted their funds with Title III funds, although it is unclear in the materials submitted to HAB. Also notable in the maintenance of effort submission is the decrease by 10.3% between FY 1999 and FY 2000 and by 77.3% in funding of the Broward House adult living facility by North Broward Hospital District between FY 2000 and 2001.

To compensate for reductions in other maintenance of effort inputs, BCHSD have identified an increase in North Broward Hospital District and South Broward Hospital District inpatient expenditures and a small amount of new funds by the Broward County Family Success Administration. Increased expenses associated with inpatient admissions reflect likely treatment failure and poor access to clinical interventions. Use of these funds to demonstrate maintenance of effort does not appear to reflect Congress's intent that local communities support community-based HIV services. It is also noted that no State or Broward County tax funds currently are used as part of the maintenance of effort budgetary inputs.

Table 11. Broward County Title I Eligible Metropolitan Area Maintenance of Effort Submissions, FY 1998 to FY 2001 and Percent Change							
Governmental Unit	**Total Funds Expended**				**Percent Change**		
	FY 1998	**FY 1999**	**FY 2000**	**FY 2001**	**FY 1998 to 1999**	**FY 1999 to 2000**	**FY 2000 to 2001**
FL Department of Health Broward County Local Tax Funds	$387,496	$415,679	$485,000	$485,000	6.8%	14.3%	0.0%
FL Department of Health Broward County State Revenue	$1,888,316	$1,888,316	$1,888,136	$1,888,136	0.0%	0.0%	0.0%
North Broward Hospital District Outpatient Services	$2,486,000	$1,700,000	$1,100,000	$913,489	-46.2%	-54.5%	-20.4%
North Broward Hospital District Inpatient Services	$16,724,452	$16,672,395	$16,672,395	$18,993,401	-0.3%	0.0%	12.2%
South Broward Hospital District Inpatient Services	$7,323,900	$8,157,352	$10,174,546	$11,485,454	10.2%	19.8%	11.4%
Florida Agency for Health Care Administration (Medicaid)	$55,462,843	$43,786,746	$43,990,765	$43,786,746	-26.7%	0.5%	-0.5%
Broward County Board of County Commissioners	$104,719	$0	$0	$0	0.0%	0.0%	0.0%
Broward House-Broward County, Adult Living Facility	$758,040	$989,426	$897,074	$506,085	23.4%	-10.3%	-77.3%
Broward County Family Success Administration	$0	$0	$0	$56,000	0.0%	0.0%	100.0%
Total	$85,135,766	$73,609,914	$75,207,916	$78,114,311	-15.7%	2.1%	3.7%
Source: Applications to the HRSA HIV / AIDS Bureau for Title I Funds, Broward County Human Services Department							

F. ACHIEVING GREATER EFFICIENCIES AND OTHER SYSTEMIC CHANGES TO OPTIMIZE FUTURE HIV FUNDING

1. Efficiencies and Other Systemic Changes Needed to Optimize Future HIV Funding

Throughout the US, HIV care and delivery systems are reengineering their systems to achieve greater efficiency and maximize available funding. HIV care providers recognize that while significant resources are dedicated to community-based needs assessment, there often is little opportunity for providers to directly collaborate in a forum that focuses on patients and not on planning and paperwork. Reduced funding to support the HIV care system is a driving force in striving to achieve greater efficiency. Enhanced efficiency in the HIV care system can be achieved by:

- Identifying the resources available to provide HIV care and blending funding streams;
- Clearly defining the roles and responsibilities of agencies and personnel devoted to HIV care;
- Adopting new types of workers that can provide targeted, high quality care at a lower price;
- Reducing unnecessary processes required to enter persons living with HIV into care, retain them in care, and ensure that they access needed services in and outside of the HIV care system; and
- Adopting technology that will help to reduce staff time in clerical activities.

The Broward County EMA has substantial opportunity to achieve greater efficiency in planning and provision of HIV care. Some of the elements that will compel HIV care providers to strive for improved efficiency are in place:

- Decreased Title I funding will necessitate a revisiting of earlier priorities and policies;
- The rapidly increasing number of persons living with HIV in the EMA requires that providers do more with the same or less funds;
- Well trained and experienced HIV medical providers;
- A well developed array of social support providers;
- Planned implementation of a client-based information system for Title I subgrantees;
- For PAC beneficiaries, the method by which their care is paid and organized is changing, with the expense of some services likely to be shifted to Title I; and
- Impending implementation of a Medicaid HIV/AIDS managed care program that may result in a shift of clients to another parallel care system that may not support HIV-experienced providers, including the ones funded by Title I.

2. Barriers to Efficiency in Providing HIV Care In Broward County and Possible Resolutions

In this section, the results of interviews of HIV grantees, subgrantees, and direct care providers are summarized. Barriers to efficiency in providing HIV care in Broward County are identified and recommendations for possible resolution of those barriers are made.

a. Efficient and Effective HIV Care Planning

Barriers: Several planning groups are charged with coordination and planning for various components of the HIV care system. Multiple planning bodies result in duplicated effort. There are a large number of meetings that tend to focus on "Title-specific" activities rather than on the HIV care and financing system as a whole. HIV care providers report that it is difficult to fully participate in these planning efforts, as their direct service obligations demand much of their time. Some providers report that due to unit-based cost reimbursement, they cannot afford their staff to attend planning meetings.

Resolutions: The HIV planning groups might consolidate into one body, with a broader focus to ensure that multi-title issues are addressed. Needs assessments, priority setting, and other required activities can be addressed collaboratively. Unit-based reimbursement by Title I should be expanded to include participating in meetings that focus on care coordination.

Barriers: No group is convened to address problems with the HIV care system and collaborate to identify solutions. Instead, management staff participates in network meetings with a set agenda that focuses primarily on grant requirements. Providers have little opportunity to communicate outside these network meetings. Front line staff rarely has the time to participate in these groups, nor do they learn from their supervisors what went on. Cross-agency communication is reported to be minimal among front line staff. Subgrantees tend to identify themselves as Title I or Title II providers rather than participants in a broader HIV care system.

Resolutions: A separate group of clinical and psychosocial providers might be established to identify problems with the HIV care system and ways that they can collaborate to address those problems. While BRHPC staff might staff the meetings, the group would set the agenda. Models for such HIV provider integrated networks exist in other communities and training and TA is available from HAB. Reimbursement for the time spent by front line staff in coordination meetings must be addressed to ensure that they participate and their agencies are compensated.

b. HIV System Bureaucracy

Barriers: The HIV care and financing system in Broward County is highly bureaucratic, paper-driven, and coordinated through multiple meetings. Contracts are so complex, for example, that it is difficult to determine changes in requirements each year. At the same time, Title I subgrantees have received less than the 10% in administrative funds to support their Title I activities. Subgrantees must seek institutional support to fund these activities, with small and mid-size CBOs unable to adequately support their HIV programs.

Resolutions: A task force should be formed representing BCHSD, BRHPC, and subgrantees to review required forms, committees, reporting, contracts, and other Title I requirements. The group would review HAB and County policies to determine what information is required to sustain the grant. The task force would identify ways that requirements can be reduced.

c. Geographic Distribution of Medical and Dental Services

Barriers: HIV medical and dental providers tend to be concentrated in a relatively small geographic area of Broward County. Travel time and lack of transportation are reported by HIV care providers to be a barrier to access to care.

Resolutions: Additional clinical points of entry should be identified at community health centers and publicly funded dental programs. Co-located medical and dental services might be established in Broward County communities based on their physical proximity to areas with relatively high HIV seroprevalence rates, based on HIV epidemiological data.

d. Care Coordination

Barriers: Most HIV care providers interviewed by POI reported that HIV care is poorly coordinated and that clients may have multiple providers. In the absence of an effective care coordination system, Broward County residents living with HIV may be treated by multiple clinics and served by care providers. Resources are inefficiently used to care for the same individual in multiple sites.

Resolutions: Full implementation of PCIS may address these problems. In the meanwhile, HIV care providers should set policies and procedures regarding specified service areas, assignment of new clients, targeting clients to other providers with exceptional expertise, and negotiating case transfers. Some EMAs have addressed this issue, to some extent, through centralized intake.

e. Eligibility Determination

Barriers: Periodic eligibility determination is critical to ensure that CARE Act funds are used as the payer of last resort. Eligibility determinations are not conducted, however, on a periodic basis. Case managers are reported to not be adequately trained in benefits coordination. Currently, case managers are undertaking this role, in addition to their many other job requirements. Experienced eligibility determination workers from Department of Children and Families (DCF) and SSA are not integrated into the HIV system. As a result, a high rate of denials of benefits occurs.

Resolutions: Eligibility workers funded by Title I, SSA, and DCF might be out-stationed at HIV clinics, case management agencies, pantries, and other locations where large numbers of HIV infected individuals congregate. DCF might employ the eligibility workers to allow for placement at multiple sites during the month to maximize their time and expertise. Eligibility workers would receive ongoing training to ensure that they are familiar with changes in eligibility policies and requirements.

f. Third Party Reimbursement

Barriers: HIV policymakers and HIV care providers do not appear to understand nor adopt HAB's requirements regarding payer of last resort, billing, accrual of third party revenue to the HIV program, and adoption of a sliding fee scale. Community-based providers, in particular, have inadequate third party billing systems in place and inadequately trained billing clerks. It is unclear if PCIS will resolve some of these problems.

Resolutions: HAB policies regarding payer of last resort, billing, and related policies should be distributed to Title I subgrantees. County policies should be reviewed to ensure that they are consistent with HAB's. Subgrantees should modify their policies to be consistent with HAB and county requirements. TA and staff training needs should be assessed and addressed through a request for TA from HAB-funded TA contractors. Small and mid-size agencies should be encouraged to consider billing companies that can assign on-site employees.

g. Health Insurance Coverage

Barriers: Broward County has a large number of uninsured Broward County residents living with HIV who are heavily reliant on the CARE Act for basic services. While Title II has purchased health insurance premiums for some clients, there is significant unmet need in the County. Title I does not fund health insurance premiums because Title II has agreed to support this activity.

Resolutions: Other EMAs and States have found that the purchase of premiums is a cost-effective strategy to ensure broad health care coverage that goes well beyond services covered by the CARE Act. Commercial payers also tend to pay providers at rates that are greater than those of Medicaid. Titles I and II should consider increasing the number of premiums purchased and to over come barriers, such as legal residency, that prohibit participation by some Broward County residents living with HIV.

h. Training and Employment for Broward County Residents Living With HIV

Barriers: Many Broward County residents living with HIV are unemployed and not disabled, based on SSA criteria. Large portions of these Broward County residents living with HIV are ineligible for health insurance benefits. There appears to be little or no emphasis on entry or re-entry to work in the Broward County HIV care system. The federal Ticket to Work program and other vocational training initiatives have not been implemented by the State of Florida. Case managers do not appear to emphasize employment among their clients, nor is job counseling funded by the various Titles.

Resolutions: There are a growing number of program models that assist Broward County residents living with HIV to enter or reenter employment. These models should be considered for adoption in Broward County. Since disability is not a factor for many clients, case managers and other care providers should encourage employment. In the case of chronically mentally ill or addicted clients, those problems should be addressed, with the goal being gainful employment and economic self-sufficiency.

i. Case Management

Barriers: The Broward County HIV care system is driven by a case management services broker or gatekeeper model. To access many of the services funded by Title I, Broward County residents living with HIV must have an assessment and be assigned a case manager. Therefore, some case managers must focus on distributing resources rather than on helping clients to address their needs and navigate the HIV care system.

Resolutions: Case managers should be assigned tasks that maximize their training and experience. A trained paraprofessional or clerical employee could distribute resources. Case managers should conduct initial client assessments when Broward County residents living with HIV enter care. Clients should be able to decline ongoing case management until they identify the need for that service. The case manager should check in with the client on no less than a quarterly basis to identify any emerging problems.

Barriers: The method used to fund case managers provides incentives to agencies to retain clients that do not need assistance and to recruit the clients of other agencies. Since payment is based on process and productivity rather than high quality care, case managers have little time to seek

training, meet in case conferences, or participate in network meetings. The reimbursement rate currently used is based on a PAC waiver rate that PAC no longer uses because it does not adequately compensate case management agencies.

Resolutions: The reimbursement, training, credentialing, professional and practice standards, and supervision of case managers must be reviewed. Results of recent studies conducted regarding HIV case management services in Broward County should be pooled. The results of this review should help guide development of a new system of case management services and financing. Front line case managers, as well as supervisors, must be a part of the planning effort. Other successful models are operating elsewhere in Florida and throughout the US. Peer TA is available through HRSA to assist in this effort.

Barriers: Community-based case managers and clinicians in Broward County report that there is little coordination in development and implementation of clinical and psychosocial care plans. It is reported that case managers are poorly trained about the clinical aspects of HIV. Commonly, case managers do not have access to the medical chart, do not participate in case conferences, and are also unfamiliar with the roles that they might play in facilitating the clinical care plan.

Resolutions: In redefining the scope and nature of HIV case management in Broward County, meaningful ways to collaborate with medical providers should be identified. Out-stationing of case managers at clinics is undertaken successfully in many EMAs, particularly when their roles and responsibilities are well defined. Basic HIV training is needed and might be coordinated with the local AETC performance site.

j. Transportation

Barriers: HIV care providers tend to be concentrated in several areas in Broward County, with less access in the southern part of the County. HIV care providers report that transportation is a barrier to accessing HIV services and a serious impediment to keeping medical appointments. Public transportation routes are poorly distributed and result in long waits and numerous connections between home and HIV care providers. The proportion of Title I funds allocated for transportation is relatively small compared to other EMAs. Funds that are allocated to transportation are used to fund van services. This service model is relatively capital intensive and is associated with comparably high salaries for drivers. For example, one Title I subgrantee pays van drivers and case managers approximately the same annual salaries.

Resolutions: Additional resources are required to support transportation. Subgrantees funded for van transportation should investigate whether they can be paid as a Medicaid transportation provider. Donations from van companies should also be sought to reduce the costs of purchasing additional vans. An assessment should be done to determine if a South Broward provider should be funded to provide services in the southern part of the county. Alternatively, other transportation models might be considered, including a taxi voucher system in which volume discounts might be negotiated.

k. Behavioral Health Services

Barriers: Mental illness and addictions are common among Broward County residents living with HIV. Although some agencies have been successful in gaining rapid access to behavioral

services through the County, other agencies have not. Although coordination appears to take place at the County level, system-wide coordination appears to be inadequate at the service delivery system level. Other strategies, such as fast-tracking Broward County residents living with HIV into treatment, have not been adopted.

Resolutions: Since mental illness and substance abuse treatment are major barriers to achieving adherence to HIV treatment, barriers to behavioral services should be identified and eliminated. A task force, for example, might be convened to systematically identify barriers and propose how those barriers might be eliminated. The task force might develop recommendations for improved coordination of HIV and behavioral health funding.

l. Pantry, Home Delivered Meals, and Nutrition Services

Barriers: Pantry and home delivered meals have grown to be a significant portion of Title I funding. Although pantry programs meet an essential need, clients appear to be enrolled indefinitely in those programs, are inadequately counseled regarding ways to become self-sufficient, or are not referred to behavioral health care that might address underlying problems that contribute to lack of self-sufficiency. At the same time, nutritional counseling is not sufficiently funded and is poorly coordinated with medical providers.

Resolutions: Significant efficiency can be achieved through a co-located service model that provides pantry services along with nutritional assessment, vocational counseling, eligibility determination, behavioral health, and medical triage. Policies should be developed by BCHSD, in collaboration with pantry managers and nutritionists to identify ways that pantry funds might be reduced through caps on service, triaging of clients, and referrals to other pantry programs.

Barriers: Despite the importance of nutritional services to ensure the health of Broward County residents living with HIV and their clinical outcomes, nutritional services are poorly integrated into HIV clinical settings and pantry programs. Only a small number of Broward County residents living with HIV disease have at least one nutrition assessment per year. Coordination of the medical care plan with the findings of the nutritional assessment is uncommon. In turn, community-based nutritional providers do not routinely communicate with medical providers regarding the nutritional problems of their patients.

Resolutions: Additional funds should be allocated so that Broward County residents living with HIV can receive at least one nutritional assessment per year. That assessment should address not only their dietetic requirements, but also economic and environmental issues that impact on achieving sound nutritional status. Policies and procedures should be instituted to ensure that nutritional providers routinely communicate the findings of their assessments with medical and pantry service providers. Co-location of nutritionists in the medical settings where the majority of clients are located should be considered to maximize their availability to clients and ensure communication with medical providers.

G. OTHER RESOURCES TO SUPPORT HIV SERVICES

There is a substantial effort being made by Federal discretionary programs to shift costs to other payers. At the same time, many employers are reducing or eliminating health insurance benefits. Public and commercial health insurers are increasingly shifting their costs to employers and patients. Federal programs are increasingly shifting costs to local and State governments through reduced funding and unfunded mandates. It is in this environment that other resources to support HIV services are being sought.

1. Implementing an Effective Eligibility Determination System

Tax supported systems, such as hospital districts, are shifting costs to patients through strict eligibility determination processes. Costs may be shifted due to unfunded Federal mandates, narrowing of eligibility criteria, or decreased Federal funds. To be successful at shifting costs to other sectors, the Broward HIV care system must develop an eligibility determination and advocacy system that aggressively advocates on behalf of residents to gain enrollment into programs to which they are legally entitled.

Title I subgrantees and other HIV care providers in Broward County reported that eligibility determination processes are very weak. As discussed in an earlier section, it is important that a new approach be taken to the systematic and periodic assessment of eligibility for health insurance benefits, disability benefits, enrollment in entitlement and discretionary programs, and other benefits for which the client is legally entitled. The design features of a reengineered eligibility determination system are described below:

- A centralized eligibility determination unit could be established to provide a single point of determination for eligibility for Title I and other programs. Eligibility determination workers could be out-stationed at key points of entry into HIV care. They would be supervised, however, by trained and experienced personnel to ensure quality control and oversight.
- Emphasis would be placed on eligibility determination at entry into HIV care and be conducted at least every six months following intake. Triggers for re-determinations would be identified and routinely screened, including hospital admission, loss of employment due to disability, and loss of employer-based health insurance due to withdrawal of employer contributions.
- The roles and responsibilities of case managers and medical personnel should be brokered by the Title I grantee as part of Title I quality management processes. Role definition would help to ensure that these personnel actively support the eligibility determination system by identifying triggers for eligibility determination and preparing medical documentation required for applications.
- Funding by Title I of a new service category, eligibility determination worker or benefits counselor, which would assume the determination activities previously assigned to case managers. Trained and experienced determination workers might be funded at the Florida DCF to ensure on-site advocacy for the various programs operated by that agency. Title I funds might be supplemented or substituted with State or federal administrative match dollars to reduce the cost of the system for Title I.

- Eligibility determination software, such as that in use at North Broward Hospital District, might be adapted to assist eligibility determination workers to systematically and accurately screen for eligibility. Such software should be modified to produce pre-printed forms that minimize the amount of information that a client must record on application forms.
- Eligibility workers would assist clients to identify and retain important documentation that would substantiate their eligibility for various programs.
- A strong referral system including legal aid services should be established to rapidly investigate rejected claims for benefits and to advocate on behalf of clients at administrative hearings.
- The unique challenges experienced by new immigrants must be taken into consideration by a reengineered HIV eligibility determination system. Many Broward County HIV providers reported to POI that it is particularly challenging to identify programs in which undocumented residents are eligible to enroll. Moreover, many new immigrants, regardless of the legal status in the US, are reluctant to enroll in assistance programs. They often are concerned that they will be deemed ineligible for permanent residency status or citizenship. Well-informed, culturally appropriate approaches should be developed to effectively work with new immigrants to identify programs that can assist them.
- Structural barriers to rapid enrollment of disabled Broward County residents living with HIV should be eliminated by provision of training by HIV clinical experts for State medical examiners engaged in SSI determinations. Alternatively, SSA staff should periodically provide training to medical providers responsible for preparation of the medical documentation required for an SSI claim. To ensure their attendance at the training, the local performance site of the AETC could arrange for continuing education credits.

2. Maximizing Third Party Insurance Revenue

It is likely that additional funds can be obtained by Broward County Title I subgrantees through enforcement of the payer of last resort requirement by the Title I grantee. The payer of last resort requirement was introduced in the 1990 authorization of the CARE Act and is applicable to Titles I, II, III, and IV of the Act. Under the requirement, CARE Act grant funds cannot be used to "make payments for any item or service if payment has been made, or can reasonably be expected to be made, with respect to that item or service under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or by an entity that provides prepaid health care."

Table 12. Ryan White CARE Act Payer of Last Resort Fiscal Requirement, By Title and Part F

Fiscal Requirement	Title I	Title II	Title III	Title IV	Part F, Dental Reimbursement Program
Payer of Last Resort	◆	◆	◆	◆	◆

Source: Ryan White CARE Act

POI staff identified considerable confusion regarding HAB payer of last result requirements among CARE Act grantees and subgrantees in Broward County during onsite interviews. Some policymakers and providers were under the impression that the HAB payer of last resort requirement is optional and only relates to agencies with existing billing systems or that are likely to receive significant amounts of third party payments. Most Title I subgrantees were also not well informed regarding which services are covered by Medicaid and other third party payers. They are also often unaware of how to become a Medicaid provider or whether they can retain grant income from Medicaid in their HIV program budgets.

POI provided TA during site visits to ensure that Broward Title I EMA grantee, Planning Council, and subgrantee staff is well informed about HAB's payer of last report policies. We have also summarized HAB's payer of last resort policies below.

As shown in Table 12, all CARE Act grantees except DRPs are required to adhere to HAB's payer of last resort policies. In December of 2002, Dr. Deborah Parham, HAB Administrator, issued guidance to all grantees and subgrantees to clarify HAB's policies.[9] In part, that guidance states that if a CARE Act grantee, sub-grantee, or contractor provides a service that is eligible for third party reimbursement, they must have a system to bill and collect from third parties. CARE Act grantees, sub-grantees, and contractors must become a Medicaid provider if they provide a service covered by Medicaid. As a result, it is important that CARE Act care providers be aware of what the Florida Medicaid Program covers for its various enrolled populations and programs.

HAB requires that potential sources of third party reimbursement revenue be sought for each client and they must be referred for eligibility determination. CARE Act grantees, sub-grantees, and contractors must set up billing systems for services covered by third party reimbursement and they must bill all available sources of third party reimbursement, regardless of the expected payment level. Providers are encouraged to negotiate the best reimbursement rates possible. While Medicaid eligibility determination is pending, a provider may use grant dollars but they must bill retroactively (i.e., pay and chase) when their patient or client becomes enrolled in Medicaid.

HAB does not support the reduction of a grant award to their contractors due to increased third party reimbursement revenue. HAB prefers that providers use the money to expand and/or enhance HIV services. Additionally, parent organizations (e.g., hospitals or county health departments that operate HIV clinics) must report the amount of the reimbursements to the HIV unit and return or credit these funds to the HIV unit. The funds must be used to pay for HIV/AIDS services to the eligible population.

If a provider does not meet Medicaid credential requirements *and* they provide Medicaid covered services they must make staffing changes or other changes necessary to become a Medicaid provider. If a provider does not charge for the covered service or seek third party reimbursement, there is a waiver provision. CARE Act capacity development funds can be used to help providers to become a Medicaid provider. The Title I Planning Council must allocate capacity development funds, however, for this purpose.

Substantial improvement in the ability of Broward County Title I subgrantees to obtain Medicaid and other third party income. These improvements are outlined below:

- BCHSD should require the enrollment by Title I subgrantees as Medicaid providers in the fee-for-service program. Participation in PAC should also be required for case management agencies. Training should be arranged with ACHA to regarding the types of services covered, limits placed by Medicaid on the number of services that may be paid in a defined period, and requirements for becoming a Medicaid provider. Barriers to provider enrollment should be identified and rapidly addressed. Services funded by Title I should be systematically reviewed to identify discrete and overlapping services covered by Medicaid and subgrantees should be informed about BCHSD's policies regarding which units of service should be billed to Medicaid or another payer before Title I funds can be used.
- BCHSD should arrange for TA for providers so that they can rapidly access their payer mix data to identify potential sources of enhanced third party revenue.
- BCHSD should require that Title I subgrantees systematically review the services that they provide to ensure that all billable services are charged to third party payers.
- BCHSD should encouraging medical providers to contract with an independent billing company to review previously submitted claims to ensure that they were coded optimally. If claims were "under-coded" they should be resubmitted for payment. In other communities, this strategy has identified significant levels of revenue that would have otherwise been forgone.
- BCHSD should require that, as a condition of receipt of Title I funds, grant income obtained through Medicaid and other third party payers be returned by institutions to the HIV programs. This requirement should be enforced not only in large health systems but AIDS service organizations that currently use third party revenue to support general administrative overhead or other programs not funded by Title I.
- BCHSD should arrange for TA to be provided to Title I subgrantees regarding unit cost development, establishment and maintenance of billing systems, and proper application of evaluation and management (E & M) codes.
- BCHSD should encourage subgrantees with small amounts of billable services to outsource claims coding and submission to experienced, training billing agencies with a proven track record in accurate and efficient claims processing and with personnel and billing software needed for accurate and timely claims submission.
- Title I subgrantees should consider expanding their participation in capitated payment arrangements, including commercial and Medicaid systems. To prepare for participation in managed care systems, BCHSD should arrange for training regarding the basics of managed care, roles and responsibilities of managed care network providers, negotiating capitated and fee-for-service contracts, and other aspects of managed care.

3. Pharmaceutical Coverage

Pharmaceuticals and pharmacy dispensing costs represent a large portion of HIV expenditures in Broward County, reflecting the importance of antiretroviral therapy and other medications in treating HIV and related conditions. Federal appropriations for Title II and ADAP earmark funds have not kept pace with demand for ADAP coverage and expenditures. As a result, across the US, ADAPs are reporting that they must invoke waiting lists, narrow enrollment criteria, and take other cost control measures.[10]

Significant shortfalls in funding and cost shifting are likely to occur in the near future in Florida. This is a result of an increase in the number of newly identified HIV infected Florida residents, new HIV-related therapeutics are approved by the US Food and Drug Administration (FDA), and the per capita cost of ADAP clients continues to rise.[11] The Florida ADAP plans to narrow ADAP eligibility criteria in July 2003. In Broward County, this is likely to result in increased demand for pharmaceutical coverage by Title I.

Several cost containment efforts might be considered by the BCHSD to constrain pharmaceutical costs. The State of Florida, in conjunction with several other State ADAPs, has negotiated significantly lower prices with some major HIV pharmaceutical manufacturers. BCHSD should investigate whether the prices negotiated by the State can also be used to purchase medications using Title I funds. The BCHSD contracts with the BCHD to purchase and dispense medications. Since BCHD is operated by the State of Florida, it would seem appropriate under the manufacturer pricing agreement to apply the lower prices. This alternative pricing arrangement should be investigated by the BCHSD.

Several other cost containment strategies might also be adopted by BCHSD on a short and long term basis to constrain pharmaceutical costs, contingent upon the future availability of Title I and II funds for medication. In the short term, the formulary currently used to purchase medications with Title I funds should be reviewed to identify medications that are expensive and likely to be abused or sold by clients. Prior authorizations might be implemented that would require a physician to document the need for the medication prior to a prescription being filled. Alternatively, medications likely to be abused or sold by clients might be removed from the formulary. Title I funds might also be used to purchase of AICP premiums for eligible individuals with pharmaceutical coverage.

A large portion of Title I funds for pharmaceutical services is used to pay BCHD personnel salaries and related costs. While this approach offers important benefits such as patient medication education and adherence counseling, it is an expensive strategy for the distribution of HIV medications. BCHSD should continue to reduce the cost of dispensing medication by contracting with additional retail pharmacy chains that are able to use their purchasing power to reduce prices currently paid by BCHD. Contracting with retail chains also provides expanded geographic access to clients. This approach should be considered particularly if Title I cannot benefit from the State of Florida's pricing agreement. A cost-benefit analysis might be conducted by BRHPC to assess the relative benefits of the centralized versus decentralized dispensing model prior to implementing additional contracts with retail pharmacy chains. As part of the assessment, a determination should be made regarding the extent to which BCHD pharmacists actually provide patient education and adherence services.

In the long term, the income criteria for enrollment in pharmaceutical coverage might be set at a lower level. The clinical criteria for enrollment might be adjusted to include only those clients who have moderate or low CD4 counts. The formulary might also be reduced to include only HIV and OI medications. In making decisions regarding adjusting eligibility criteria and the formulary, it will be important to address the ethical and clinical impact of any policy being considered. A medical ethicist, HIV clinical experts, and consumers should participate in an advisory role to BCHSD staff.

4. Other Sources of HIV Care Funding

Several other strategies can be taken by BCHSD and their Title I subgrantees to identify and expand other sources of HIV care funding. These strategies are outlined below.

a. Commercial Health Insurers

CARE Act funds should be optimized through an increased commitment by Titles I and II to purchase health insurance premiums through the AICP. The cost of the premium is likely to be significantly lower than the funds now used to purchase care through contracts with health and ancillary care subgrantees. The benefit package purchased through AICP would be broader than that available through Title I or Title II. State legislative authority is needed, however, to expand AICP eligibility for individuals that are not eligible for COBRA benefits.

b. State and Federal Employment and Vocational Rehabilitation Funds

Currently, there appears to be little systemic effort in Broward County to assist Broward County residents living with HIV to receive training or retraining. Implementation of a "return to work" program could result in an increased number of employed Broward residents living with HIV who would be eligible for employer-based insurance or increased income to provide out-of-pocket payments. There is a large group of Broward County residents living with HIV who are not employed and not eligible for the Florida medically indigent program or other Medicaid assistance categories. This approach would benefit them in particular. Through the federal Ticket to Work Program, Medicaid beneficiaries would not lose their income and health insurance coverage. The State of Florida would have to apply to participate in the Ticket to Work program.

c. County/State Substance Abuse and Mental Health System

Broward County HIV providers report variable success in obtaining access to treatment for their clients. A triage system within the County's substance abuse and mental health system could be established to fast track Broward County residents living with HIV into care. More clinical training is needed, however, by the substance abuse and mental health system regarding HIV to ensure high quality of care. Due to the State's budgetary problems, there is likely to be a decrease in State support for these systems in the short-term.

d. HRSA Bureau of Primary Health Care (BPHC) Funds

Federally Qualified Health Centers (FQHCs) in Broward County could be encouraged to participate in the HIV delivery system. Clinical collaborations could be established between FQHCs and HIV clinics to ensure high quality care and access to HIV specialists. Community-based HIV clinics should consider applying for the FQHC designation, as several are likely to be eligible but have not pursued designation. Gaining FQHC status has significant financial benefits for clinics including enhanced Medicaid fee-for-service payments, availability of grant funds, and provision of ongoing TA.

e. Food Stamps and Women, Infants, and Children (WIC) Programs

Under HAB's payer of last resort requirement, if a client is eligible for Food Stamps or WIC, they should apply for and use that benefit before CARE Act funds are used. A joint effort should

be made by the BCHSD and pantry programs to arrange for Food Stamp and WIC eligibility determination workers to be out-posted to pantry programs for rapid eligibility determination. Since the benefits provided by the Food Stamp and WIC programs are narrow, CARE Act and other funds will be needed to meet the demand for pantry services that exceed benefits covered by Food Stamps and WIC.

f. Federal and Other Grant Funds

Federal and other grant funds for service demonstrations projects are not being sought by many Broward County HIV care providers to supplement their revenue. Multi-agency joint applications should be sought to strengthen their proposals. Development assistance might be provided by one of the hospital districts or the BRHPC to prepare joint applications for funding.

g. Foundations

Broward County HIV care providers tend to focus their efforts at fund raising on local charitable foundations. Currently, local charitable foundations report that they have reduced funds available for grant making. Although this is also the case for foundations throughout the US, many national foundations have grants available that could benefit Broward County HIV care providers.

h. Community Pantry Funds

Community pantry providers and planning groups report that their funds have diminished significantly and that there are insufficient funds to add additional clients. Some community pantry programs have waiting lists. It is unlikely that a shift of clients from Title I funded meal programs to other community pantry programs is a feasible solution to meeting the need for food among indigent Broward County residents living with HIV.

i. Community Fund Raising

HIV care providers report that their efforts at community fund raising are yielding significantly less funds than in the past. Personal and corporate charitable donations have dropped significantly. Traditional approaches to fund raising are yielding ever diminishing returns in donations.

j. Faith-Based Programs

Faith-based HIV providers report that it has been difficult to gain the financial support of church congregations in Broward County. Additional, coordinated efforts should be made to educate the church congregations of Broward County about the HIV epidemic in the County and the need for their support. Church congregations may be the source of volunteers and some limited funds for HIV care. Faith-based Title I subgrantees should also be strongly encouraged by the BCHSD to seek federal faith-based funds. Federal appropriations for faith-based programs have been significantly increased for the upcoming federal fiscal year.

k. State and Local Corrections Systems

HIV care providers report that HIV-infected releasees need pre-release planning and case management. Matching funds might be sought from the State and local correction systems to support a pre-release case management system.

l. CDC Prevention and Counseling and Testing

Several Title I grantees report that they provide unfunded HIV primary and secondary prevention, as well as counseling and testing. These agencies should seek County and State prevention and counseling and testing funds.

m. Patients / Clients

Since 1990, the CARE Act has required that all agencies receiving CARE Act funds for direct services should have a mechanism to request payment from patients or patients. Broward County hospital-based outpatient HIV programs tend to have and use a sliding fee scale. It is commonly the policy of their institution and mechanisms have been set up to collect, bank, and account for out-of-pocket payments. In contrast, Broward County community-based Title I subgrantees report that they tend not to have or use a sliding fee scale to request out-of-pocket payments from clients or patients. Some agencies also report that they do not routinely collect co-payments or deductibles.

Some Title I subgrantees report that they do not have sufficient security in place to store cash during the day, have no courier to transport cash to the bank, do not have staff to collect funds, and their staff feel uncomfortable asking clients for cash. Although the revenue to be gained may be marginal, particularly if resources are required to allow cash handling, they should be collected according to HAB policies.

H. MAKING THE MOST OF TITLE I FUNDS: EVIDENCE-BASED STUDIES REGARDING THE IMPACT OF SERVICES FUNDED BY TITLE I

It is important for the Planning Council and BCHSD to take a combination of factors into consideration in setting priorities for future HIV services. HAB requirements for expenditure of Title I funds must be considered. Additionally, demonstrated community-based need and feedback from HIV care consumers are important factors in making allocation decisions. Environmental issues, such as the availability of third party insurance and Title II funds, must also be weighed. Additionally, evidence regarding the impact of services on clinical outcomes and their cost-effectiveness and cost-benefit are also important to consider.

POI was asked to supplement information provided to Planning Council members with a summary of scientific studies that address the types of services commonly purchased with Title I funds. The published results of studies were sought regarding HIV medical care, HIV pharmaceuticals, case management, nutrition services, alcohol and drug treatment, mental health services, dental care, complementary therapy, and ancillary HIV services. POI staff reviewed cost-benefit or cost-effectiveness studies regarding these types of services, as well as outcomes studies. Peer-reviewed articles were examined that summarize the findings of studies conducted in the US and that were published in US journals between CY 2000 and CY 2003.

1. HIV Ambulatory Medical Care, Diagnostic Testing, and Therapeutics

The FY 2003 Title I Grant Application Guidance identifies primary medical care services that are consistent with Public Health Service (PHS) guidelines as an important part of the HIV comprehensive continuum of care.[12] Primary medical services are defined by HAB as including primary medical care, diagnostic tests, and therapeutics including combination antiretroviral therapies and other drug therapies such as those used in prophylaxis and treatment of opportunistic infections (OIs).

In 1996, National Institutes of Health (NIH) and the Henry J. Kaiser Family Foundation convened the Panel on Clinical Practices for Treatment of HIV Infection. The purpose of the panel was to develop guidelines for the clinical management of HIV-infected adults and adolescents.[13] Since that time, the guidelines have been periodically updated to reflect advances in HIV therapeutics and knowledge regarding the effectiveness of HIV treatment. Several sets of guidelines have been developed for children and adults, as well as for the clinical management of HIV-related conditions such as OIs. The guidelines form the basis for HIV treatment in the US and are used as the basis of quality assurance assessment by HAB.

The PHS guidelines summarize an extensive body of scientific evidence that documents that the provision of HIV primary and specialty service, in conjunction with combination antiretroviral therapeutics and diagnostic testing, results in reduction of HIV-related illness, decreased mortality, and improved quality of life.

Several published studies also demonstrate the cost-effectiveness of antiretroviral therapy. Early intervention with antiretrovirals has been demonstrated to be more cost-effective than delayed treatment.[14, 15, 16, 17] The cost-benefit of prophylaxis for OIs has also been demonstrated.[18, 19] The cost-effectiveness of use of genotypic resistance testing in HIV clinical decision-making has also been demonstrated.[20]

2. Case Management

Studies conducted nationally and in Florida and New York among large populations of HIV-infected Medicaid beneficiaries demonstrate that the case management model used in that system is associated with improved outcomes. Results of a study conducted among Florida Medicaid beneficiaries has the most relevance to the decision making of Planning Council members.[21] PAC beneficiaries receiving case management were compared to beneficiaries with AIDS enrolled in the Florida Medicaid fee-for-service program. As illustrated in Table 13, beneficiaries with AIDS in the Medicaid fee-for-service program have 510% higher inpatient costs than PAC beneficiaries, with other costs also significantly higher.

Table 13. Relative Impact of Participation in Florida's Medicaid Fee-For-Service (FFS) Program by Beneficiaries With AIDS Relative to Beneficiaries Enrolled in the Florida Medicaid Home and Community Waiver for Persons with AIDS

Impact Measure	Relative Difference Between FFS Versus Waiver Enrollees
Inpatient costs	510% higher
Outpatient cost	83% higher
Average monthly costs, excluding drugs	73% higher
Total monthly costs	42% higher
Total costs, excluding drugs	136% higher

Source: Mitchell, JM, Anderson, KH. Effects of Case Management and New Drugs on Medicaid AIDS Spending. *Health Affairs*, July/August 2000, 19, 233-243.

In New York, use of case management by persons living with HIV was associated with more frequent linkages to referred services than their counterparts not in case management.[22] Case managed clients were more likely than others to be rapidly linked to medical and legal services.

A national probability sample of HIV care also found that clients receiving case management had less unmet need for income assistance, health insurance, home health care, or emotional counseling than HIV-infected individuals that did not received case management.[23] Case managed clients also were more likely to use combination antiretroviral therapy than other HIV-infected study participants. There was no significant difference between case managed clients and their counterparts in the use of ambulatory care or emergency department visits.

It should be noted, however, that the case management model that is commonly used in Broward County is likely to vary significantly from those used in New York and by PAC case managers. As a result, the evaluation findings may not be generalizable to case managers in Broward County. Other studies evaluating HIV case management have not demonstrated positive benefits when compared to other service models, such as brief contact or information and referral.[24]

3. Substance Abuse and Mental Health Services

Several studies suggest that HIV-infected addicts enrolled in drug treatment programs achieve improved clinical outcomes and adherence to medication regimens.[25, 26] Similarly, HIV-infected individuals with persistent and severe mental illness, as well as individuals with less severe mental illness, have better clinical outcomes and adherence to medication regimens if they are in

treatment. It is important to routinely screen patients for mental illness, including depression and anxiety.

4. Nutrition Services

It is the position of the American Dietetic Association and Dieticians of Canada that nutritional assessment, therapy, and nutrition-related education should be integrated into routine HIV care.[27, 28] There is a dearth of studies, however, that have evaluated the use of nutrition services in HIV care and their associated benefits.

5. Complementary Therapies

While use of complementary or alternative therapies are reported to be common among persons living with HIV, few randomized clinical trials have been conducted that demonstrate the efficacy of such therapies on improved clinical outcomes or other measures.[29, 30, 31, 32, 33] Studies among persons living with HIV to assess the efficacy of complementary medicine tend to use small sample sizes, have short observational periods, do not use randomization to assign patients to various treatment approaches including no treatment, and experience high rates of exit from the study prior to the end of the observation period.[34] While these studies focus on the physiologic benefit associated with complementary therapy, the psychological benefit to persons living with HIV is not well documented.[35, 36]

5. Dental Care

Persons living with HIV have been found to have high rates of unmet need for dental care.[37, 38] In a recent article, the benefit of regular oral health care by primary care dentists for persons living with HIV was demonstrated by the Minnesota Access to Dental Care Program.[39]

6. Other HIV Ancillary Services

Several studies have documented the use and benefit of an array of ancillary services among persons living with HIV. In California, ancillary service use by CARE Act clients was associated with receipt of and retention in primary medical care.[40] Provision of ancillary services to HIV-infected Medicaid beneficiaries in eastern North Carolina also demonstrated the benefit of transportation, housing, substance abuse services, and legal services.[41] Similar results were found among a group of patients receiving HIV care at community-based clinic in Boston and a cohort in New York City.[42, 43]

I. BENCHMARK DATA REGARDING THE DISTRIBUTION OF TITLE I FUNDS BY TITLE I EMAS.

1. HAB Policies Regarding Allocation of Title I Funds

The CARE Act gives Title I grantees and Planning Councils substantial discretion in the allocation of funds among service categories. The Title I grantee and Planning Council, however, must demonstrate a strong link between the results of a community-based needs assessment and the distribution of funds by service category. Since the CARE Act is considered by HAB to be the payer of last resort, Title I funds should only be allocated for services not paid for by another mechanism. Title I EMAs vary significantly in the nature and scope of their HIV epidemics and HIV care delivery system. Title I EMAs also vary considerably in the rate of health insurance coverage among their residents, covered benefits package, and provider payment levels. Public entitlement programs vary considerably from state to state. Due to this high level of variability, Title I EMAs have allocated their funds in different proportions to the allowable services categories.

2. Comparison of Broward and Other EMA Allocations by Service Category

The Broward Title I allocation was ranked for each service category by the proportion of total direct service dollars allocated. The proportionate distribution of funds by service category for all other EMAs was compared to the Broward County EMA. The proportionate allocation of funds by service category for the West Palm Beach and Miami/Dade EMAs were also compared to the Broward County EMA. Trends analysis was conducted for FY 00, 01, and 02 to identify shifts of priorities for the Broward County and other EMAs. The proportionate distribution of subgrantees' HIV program budget by source of funds also was studied.

The Broward County EMA did not allocate Title I funds for health insurance between FY 1999 to FY 2002 since the Florida Title II Program supported that service category. Other EMAs find that purchasing of health insurance is a cost-effective mechanism to expand coverage and cost-shift. A total of 16 EMAs funded health insurance in FY 2002. Given the high number of uninsured Broward County residents living with HIV, expanded funding might be considered to purchase insurance premiums.

The Broward County EMA also did not allocate Title I funds for housing or housing assistance between FY 1999 to FY 2002. Other EMAs supplemented HOPWA funds with Title I funds; 33 EMAs funded housing in FY 2002 and 21 EMAs funded housing services in FY 2002. Given the recent reduction in the HOPWA award to Broward County, funding of housing services might be considered to sustain the current level of services.

The Broward County EMA ranks relatively low among EMAs in the proportion of funds allocated to transportation; 34th out of 48 EMAs. Given the persistent identification by HIV care providers regarding the need for additional transportation services, additional funding might be considered by the Planning Council.

The Broward County EMA ranks relatively high among EMAs in the proportion of funds allocated to:

- Ambulatory medical care, eighth out of 51 EMAs in FY 2002;
- Local drug assistance, fourth out of 36 EMAs;
- Nutrition services, ninth out of 24 EMAs; and
- Food bank and home delivered meal, twelfth out of 44 EMAs.

3. Differences in the Distribution of Funds by Broward, Miami/Dade, and West Palm Beach Title I EMAs

The distribution of funds by service category was compared for the Broward, Miami/Dade, and West Palm Beach EMA. The three EMAs operate in similar health care markets, have similar HIV epidemics, and have the same Medicaid eligibility and coverage. The Broward County EMA allocated the highest proportion of Title I funds to health services and the lowest proportion to case management and support services. The West Palm Beach EMA allocated the lowest proportion of Title I funds to health services and the highest proportion to case management and support services. Miami/Dade ranked second in proportionate allocation for health care, case management, and support services.

Table 14. Ranking of the Title I Percentage Allocation of Direct Service Funds For Broward County EMA Compared to Other Title I EMAs						
Service Categories	**FY 2000**		**FY 2001**		**FY 2002**	
	Broward Rank*	**# of EMAs Allocating Funds****	**Broward Rank***	**# of EMAs Allocating Funds****	**Broward Rank***	**# of EMAs Allocating Funds****
Health Care Services						
Ambulatory/Outpatient Medical Care	13	51	15	51	8	51
Local Title I Drug Assistance or Medications Program	6	38	4	37	4	36
Dental Care	23	48	23	48	20	46
Provision of Health Insurance	-	11	-	12	-	16
Mental Health Therapy / Counseling Services	39	50	41	51	38	51
Nutritional Services	5	14	10	18	9	24
Substance Abuse Services: Outpatient	10	46	15	47	18	44
Treatment Adherence / Compliance	13	17	15	22	-	25
Case Management	36	51	35	50	39	51
Support Services Subtotal						
Child Care Services	-	-	-	-	20	21
Day / Respite Care	32	38	36	38	-	25
Food Bank / Home Delivered Meals / Nutritional Supplements	12	44	12	43	12	44
Health Education / Risk Reduction	-	20	18	22	12	19
Housing Assistance	-	28	-	37	-	33
Housing-Related Services	-	20	-	15	-	21
Outreach / Referral to Primary Care and Related Services	14	36	19	36	-	-
Outreach Services	-	-	-	-	19	38
Psychosocial Support Services	-	-	-	-	21	23
Referral to Health Care / Supportive Services	-	-	5	12	-	6
Transportation	27	46	37	49	34	48
Other Support Services	23	42	-	41	23	35

Source: HRSA HIV/AIDS Bureau, http://hab.hrsa.gov/reports/data2b.htm.
* A dash, "-", indicates no funds allocated to this line item by the Title I EMA
** Number of Title I EMAs grantees allocating funds to this service category
Note: Rankings are from highest to lowest. Rank #1 indicates the highest percentage of funds allocated to a line item and rank # 51 indicates the lowest percentage of funds allocated to a line item.

Table 15. Ranking of the Title I Percentage Allocation of Direct Service Funds For Broward County, Miami/Dade, and West Palm Beach EMAs						
	Health Care Services		Case Management		Support Services	
EMA	%	Rank	%	Rank	%	Rank
Ft. Lauderdale	71.2%	1	10.9%	3	17.9%	3
Miami	61.3%	2	17.2%	2	21.5%	2
W Palm Beach	45.3%	3	24.6%	1	30.2%	1

APPENDIX

Table 16. Estimated Distribution of HIV Service Funds By Total Funds, Source, and Service Category, FY 2002-2003							
Service Category	**Title I & MAI**	**Other CARE ACT***	**HOPWA**	**Other Fed**	**State Gen Rev & Other State Funds**	**Broward County & Other Local**	**TOTAL**
Case Management	$1,476,818	$1,163,835		$201,019	$191,736	$0	$3,033,408
Food Bank	$956,777	$0			$0	$0	$956,777
Home Delivered Meals	$0	$125,000			$0	$0	$125,000
Nutritional Services	$128,904	$0			$52,398	$0	$181,302
Transportation	$282,690	$18,000			$0	$0	$300,690
Bus Passes	$0	$200,000			$0	$0	$200,000
Support Groups	$50,000	$0			$0	$0	$50,000
Day/Respite Care	$20,000	$0			$0	$0	$20,000
Buddy/Companion	$0	$126,939			$0	$0	$126,939
Legal/Permanency Planning	$0	$119,251			$0	$0	$119,251
Client Advocacy	$0	$157,870			$0	$0	$157,870
Health Education/Risk Reduction	$101,584	$28,994		$124,326	$218,259	$0	$473,163
Outreach/Referral	$415,898	$9,320			$250,000	$0	$675,218
Prevention/Counseling/Testing	$0	$78,411		$516,924	$0	$175,713	$771,048
Insurance Continuation	$0	$881,910			$135,000	$0	$1,016,910
Project-Based Rental Assistance	$0	$0	$1,156,386		$0	$0	$1,156,386
Rental Vouchers	$0	$0	$3,500,000		$0	$0	$3,500,000
ACLF Placement	$0	$0	$845,000		$0	$82,109	$927,109
Substance Abuse Housing	$0	$0	$682,883		$0	$0	$682,883
Direct Emergency Financial Assistance	$0	$0	$501,931		$10,000	$0	$511,931
Housing Referral/Placement	$0	$0	$65,000		$0	$0	$65,000
Children/Family Services	$0	$0			$1,924,117	$0	$1,924,117
Total Home/Community Based	$3,432,671	$2,909,530	$6,751,200	$842,269	$2,781,510	$257,822	$16,975,002
Medication Co-Payments	$0	$91,000			$0	$0	$91,000
Ambulatory/Outpatient Medical	$4,532,950	$722,390		$43,789,746	$1,893,771	$214,500	$51,153,357
Total Ambulatory	$4,532,950	$813,390	$0	$43,789,746	$1,893,771	$214,500	$51,244,357
Pharmaceuticals	$3,002,725	$18,762,302			$103,000	$0	$21,868,027

Table 16. Estimated Distribution of HIV Service Funds By Total Funds, Source, and Service Category, FY 2002-2003							
Service Category	**Title I & MAI**	**Other CARE ACT***	**HOPWA**	**Other Fed**	**State Gen Rev & Other State Funds**	**Broward County & Other Local**	**TOTAL**
Oral Health	$674,760	$115,082			$216,479	$0	$1,006,321
Substance Abuse Treatment	$387,838	$39,381		$95,692	$51,799	$0	$574,710
Mental Health Therapy/Counseling	$317,101	$79,444		$40,819	$222,914	$0	$660,278
Complementary Therapies	$248,302	$0				$0	$248,302
Home Health Care	$0	$128,613			$0	$0	$128,613
Total Other Outpatient/Community-based	$1,628,001	$362,520	$0	$136,511	$491,192	$0	$2,618,224
Inpatient Medical Services	$0	$0	$0	$17,060,700	$14,910,828	$11,815,218	$43,786,746
Total Grant Administrative/Program/Council Support	$2,276,498	$199,402	$208,800	$88,160	$322,185	$75,333	$3,170,378
TOTAL	$14,872,845	$23,047,144	$6,960,000	$61,917,386	$20,502,487	$12,362,873	$139,662,734
Source: Broward Regional Health Planning Council							

Table 17. Estimated Distribution of HIV Service Funds By Percent of Total Funds, Source, and Service Category, FY 2002-2003							
Service Category	**Title I & MAI**	**Other CARE ACT**	**HOPWA**	**Other Fed**	**State Gen Rev & Other State Funds**	**Broward County & Other Local**	**TOTAL**
Case Management	48.7%	38.4%	0.0%	6.6%	6.3%	0.0%	100.0%
Food Bank	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Home Delivered Meals	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Nutritional Services	71.1%	0.0%	0.0%	0.0%	28.9%	0.0%	100.0%
Transportation	94.0%	6.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Bus Passes	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Support Groups	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Day/Respite Care	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Buddy/Companion	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Legal/Permanency Planning	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Client Advocacy	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Health Education/Risk Reduction	21.5%	6.1%	0.0%	26.3%	46.1%	0.0%	100.0%
Outreach/Referral	61.6%	1.4%	0.0%	0.0%	37.0%	0.0%	100.0%
Prevention/Counseling/Testing	0.0%	10.2%	0.0%	67.0%	0.0%	22.8%	100.0%
Insurance Continuation	0.0%	86.7%	0.0%	0.0%	13.3%	0.0%	100.0%
Project-Based Rental Assistance	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%
Rental Vouchers	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%
ACLF Placement	0.0%	0.0%	91.1%	0.0%	0.0%	8.9%	100.0%
Substance Abuse Housing	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%
Direct Emergency Financial Assistance	0.0%	0.0%	98.0%	0.0%	2.0%	0.0%	100.0%
Housing Referral/Placement	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%
Children/Family Services	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	100.0%
Total Home/Community Based	20.2%	17.1%	39.8%	5.0%	16.4%	1.5%	100.0%
Medication Co-Payments	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Ambulatory/Outpatient Medical	8.9%	1.4%	0.0%	85.6%	3.7%	0.4%	100.0%
Total Ambulatory	8.8%	1.6%	0.0%	85.5%	3.7%	0.4%	100.0%
Pharmaceuticals	13.7%	85.8%	0.0%	0.0%	0.5%	0.0%	100.0%

Table 17. Estimated Distribution of HIV Service Funds By Percent of Total Funds, Source, and Service Category, FY 2002-2003							
Service Category	**Title I & MAI**	**Other CARE ACT**	**HOPWA**	**Other Fed**	**State Gen Rev & Other State Funds**	**Broward County & Other Local**	**TOTAL**
Oral Health	67.1%	11.4%	0.0%	0.0%	21.5%	0.0%	100.0%
Substance Abuse Treatment	67.5%	6.9%	0.0%	16.7%	9.0%	0.0%	100.0%
Mental Health Therapy/Counseling	48.0%	12.0%	0.0%	6.2%	33.8%	0.0%	100.0%
Complementary Therapies	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Home Health Care	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Total Other Outpatient/Community-based	62.2%	13.8%	0.0%	5.2%	18.8%	0.0%	100.0%
Inpatient Medical Services	0.0%	0.0%	0.0%	39.0%	34.1%	27.0%	100.0%
Total Grant Administrative/Program/Council Support	71.8%	6.3%	6.6%	2.8%	10.2%	2.4%	100.0%
TOTAL	10.6%	16.5%	5.0%	44.3%	14.7%	8.9%	100.0%
Source: Broward Regional Health Planning Council							

Individuals Interviewed and Contributing Information to the Assessment

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Norma Wagner
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Shirley Watkins-Blythe
Bill Wilde
Joey Wynn
Joe Zajac
Melissa Zafonte-Sanders

Citations And Notes

[1] Personal communication, William Green, April 2003.

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[3] Trends in Florida ADAP enrollment, coverage, and expenditures conducted by POI using ADAP HIV/AIDS Bureau, ADAP At-A-Glance, 2000-2002. HAB: Rockville MD.

[4] Personal communication, Nicole Montgomery, June 2003.

[5] Personal Communication, Michael McWiggins, April 2003.

[6] Personal communication, Sheila Mani, May 2003.

[7] Personal communication, Robert Tomasullo, June 2003.

[8] Budget information was provided to POI by Rita Volpitta, Substance Abuse and Health Services Division, Broward County Human Services Department.

[9] The letter from Dr. Parham and the accompanying questions and answers document can be found in the HIV/AIDS Frequently Asked Billing Questions section at: http://www.hrsa.gov/third party reimbursement/tech-assistance.htm.

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