

2011 Funding Streams Overview for HIV/AIDS Services

Boston Ryan White Part A Eligible Metropolitan Area

Boston EMA Health Services Planning Council Support



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Table of Contents

List of Figures and Tables	iii
Acknowledgements	v
Acronyms	vi
Executive Summary	vii
Introduction	8
Overview of Boston EMA	8
Background	9
Objectives	9
Methodology	9
Limitations	9
Section I: Funding for HIV/AIDS Services in the Boston EMA	11
Overview of Three Main Funding Streams	11
Analysis of Boston EMA HIV Services Funding Streams	11
Funding By Core Medical and HIV Health-Related Support Services	13
Service Utilization & Demographics	20
Section II: Ryan White Funding Streams	24
Part A	24
Part B	26
Part C	27
Part D	27
Part F	28
Ryan White Funding Analysis	30
Ryan White Utilization	34
Section III: Other Federal Funding Streams	39
Centers for Medicare and Medicaid Services	39
US Department of Housing and Urban Development	41
Centers for Disease Control and Prevention	42
Substance Abuse and Mental Health Services Administration	43
Other Federal Funding Analysis	44
Other Federal Funding Utilization	47
Section IV: State Funding Streams	52
Massachusetts	52
New Hampshire	56
State Funding Analysis	57
State Funding Utilization	60
Section V: Conclusion	64
Section VI: Recommendations	65
Appendix	66

Figures

Figure 1	The Boston Part A Eligible Metropolitan Area (EMA)
Figure 2	Main Funding Sources in the Boston Part A EMA
Figure 3a	2010 Proportion of HIV/AIDS funding in the Boston EMA
Figure 3b	2011 Proportion of HIV/AIDS funding in the Boston EMA
Figure 4	Funding Stream Breakdown in the Boston EMA
Figure 5a	2010 Direct and Indirect Service Provision by All Streams
Figure 5b	2011 Direct and Indirect Service Provision by All Streams
Figure 6	Funding Streams Proportional Distribution for Core and Support Services
Figure 7	Proportional HIV/AIDS Funding for Each Service Category
Figure 8	Service Category Breakdown for All Funding Streams
Figure 8	Total HIV/AIDS Funding for Service Categories in the Boston EMA
Figure 10	Core Medical Services Distribution for All Streams
Figure 11	HIV Health-Related Support Services Distribution for All Streams
Figure 12	Boston EMA Utilization by Race
Figure 13	Boston EMA Utilization by Race for Each Funding Stream
Figure 14	Boston EMA Utilization by Ethnic Group
Figure 15	Boston EMA Utilization by Age Group
Figure 16	Proportion of Ryan White Streams in Total HIV-Related Funding
Figure 17	Historical Funding Pattern of Part A Funding in the Boston EMA
Figure 18	Ryan White Funding 2010 vs 2011 Comparison by Parts
Figure 19	Ryan White Core Medical and HIV Health-Related Support Services
Figure 20	Share of Core Service Categories Covered by Ryan White Parts
Figure 21	Share of Support Service Categories Covered by Ryan White Parts
Figure 22	Utilization of Ryan White by Part and Race
Figure 23	Utilization of Ryan White by Part and Ethnicity
Figure 24	Utilization of Ryan White by Part and Age
Figure 25	Utilization of Ryan White by Part and HIV Exposure
Figure 26	Proportion of Other Federal Streams in Total HIV-Related Funding
Figure 27	Other Federal Funds 2010 vs 2011
Figure 28	Other Federal Streams Core Medical and HIV Health-Related Support Services
Figure 29	Share of Core Service Categories Covered by Other Federal Streams
Figure 30	Share of Support Service Categories Covered by Other Federal Streams
Figure 31	Utilization of Other Federal Funds by Race
Figure 32	Utilization of Other Federal Funds by Ethnicity
Figure 33	Utilization of Other Federal Funds by Age
Figure 34	Utilization of Other Federal Funds by Exposure
Figure 35	Proportion of State Streams in Total HIV-Related Funding
Figure 36	States Funding 2010 vs 2011
Figure 37	State Streams Core Medical and HIV Health-Related Support Services
Figure 38	Share of Core Service Categories Covered by State Funding Streams
Figure 39	Share of Support Service Categories Covered by State Funding Streams
Figure 40	Utilization of State Streams by Race
Figure 41	Utilization of State Streams by Ethnicity
Figure 42	Utilization of State Streams by Age

Tables

Table I.A.1	Funding Streams in the Boston EMA
Table I.A.2	Core Medical Services
Table I.A.3	HIV Health-Related Support Services
Table I.A.4	HIV/AIDS Prevalence and Service Profile of the Boston EMA
Table II.A.1	Service Category Funding Levels for Ryan White Funding Streams
Table II.A.2	Utilization of Ryan White Funds by Demographic and HIV Exposure Group
Table III.A.1	Service Category Funding Levels for Other Federal Funding Streams
Table III.A.2	Utilization of Other Federal Funds by Demographic and Exposure Group
Table IV.A.1	Service Category Funding Levels for State Streams
Table IV.A.2	Utilization of State Funding Streams by Demographic and Exposure Group
Appendix 1	Service Category Funding Levels Across All Funding Streams
Appendix 2	Utilization of All Funding Streams by Demographic and Exposure Group
Appendix 3	AIDS Incidence, AIDS Prevalence and HIV Prevalence by Demographic Group and Exposure Category
Appendix 4	Part A Boston EMA Service Category Definitions

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AETC	AIDS Education Training Center
ASO	AIDS Service Organization
BPHC	Boston Public Health Commission
BSAS	Bureau of Substance Abuse Services (MA)
CARE	Comprehensive AIDS Resources Emergency Act
CBO	Community Based Organization
CDC	Centers for Disease Control & Prevention
CMS	Center for Medicare and Medicaid
EIS	Early Intervention Services
EMA	Eligible Metropolitan Area
FY	Fiscal Year
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HDAP/ADAP	HIV/AIDS Drug Assistance Program
HICP	Health Insurance Continuation Program
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for People with AIDS
HRSA	Health Service Resource Administration
HUD	Housing and Urban Development
IDU	Injection Drug User
MAI	Minority AIDS Initiative
MA	Massachusetts
MDPH	Massachusetts Department of Public Health
MEAD	Medicaid for Employed Adults with Disabilities
MSM	Men who have sex with men
NEAETC	New England AIDS Education Training Center
NH	New Hampshire
NIH	National Institute of Health
NHDHHS	New Hampshire Department of Health & Human Services
PCS	Planning Council Support
PLWH	People Living with HIV and AIDS
RFP	Request for Proposals
RWTMA	Ryan White Treatment Modernization Act
SAMHSA	Substance Abuse and Mental Health Services Administration
SHP	Supportive Housing Program
SPNS	Special Projects of National Significance
STD/STI	Sexually Transmitted Disease/Infection
TGA	Transitional Grant Area

Executive Summary

Every two years, an assessment of HIV/AIDS-related funding is conducted within the Boston Eligible Metropolitan Area (EMA). The Funding Streams analysis provides perspective on the 'big picture' of various HIV/AIDS funding sources available throughout the EMA. This report describes the types and amounts of public Federal, State and Local funds available for HIV-related services in the Boston EMA. Data for this assessment was collected using a survey completed by various HIV/AIDS payers and providers in the Boston EMA. The survey requested a description of available services and funding information on their most recent full fiscal year.

Section I of this report provides an overview of all the HIV/AIDS funding streams that are available in the Boston EMA. There was \$242,375,140 distributed in this region in the last fiscal year.

Section II of this report analysis Ryan White funding streams, including a breakdown of Parts A, B, C, D and F. For the period of time reviewed in this report, \$35,070,360 in Ryan White funding was available within the Boston EMA.

Section III of this report reviews Other Federal HIV-related funding sources, including the Centers for Medicare and Medicaid (CMS), the US Department of Housing and Urban Development (HUD), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Disease Control and Prevention (CDC). In the most recent fiscal year, there was \$115,832,371 in total funding available from these resources in the Boston EMA.

Section IV of this report reviews State funding sources for both Massachusetts (MA) and New Hampshire (NH). In this time period, there was \$91,472,409 in State funding available in the portions of MA and NH that are within the EMA.

The overall finding of this report details how a total of \$242,375,140 was allocated in 2011 to 29 types of core medical and HIV health-related support services available for PLWH in the Boston EMA. These funds stem from three main funding sources (i.e. Ryan White, State, Other Federal); the majority coming from "Other Federal" funding streams (48%, \$115,832,371), excluding Ryan White. State funding streams constitute the next largest share of funding available for HIV/AIDS services in the Boston EMA (38%, \$91,472,409). Ryan White funding streams make up only 14% (\$30,070,360) of the total HIV/AIDS funding available in the region.

When compared to 2010, there was an 11% increase (\$215,325,160), which was mainly due to an increase in funds from Medicaid (Other Federal and State). Consequently, there was a proportional increase in State (37% to 38%) and Other Federal funds (46% to 48%), and a decrease in Ryan White funds (17% to 14%) within the Boston EMA. Furthermore, because of the increase in Medicaid funds that were allocated mainly to core services; there was a slight (1%) increase in the proportion of funding for core services versus health-related support services (86%:14% in 2011 compared to 85% to 15% in 2010). Data shows that in 2011, the total allocation to core services in the Boston EMA was \$208,678,754; meanwhile, support services had a total allocation of \$33,696,386. In sum, as the payer of last resort, Ryan White continues to play a key role in the continuum of care, particularly for health-related support services, where its contribution largely accounts for 28% of services.

The information in the 2011 Funding Streams Report is used by members of the Ryan White Part A Planning Council to make funding decisions. This report identifies other resources available throughout the EMA and helps Planning Council members identify geographic and consumer service needs, while helping to maintain Part A service dollars as the payer of last resort (i.e., after all other available funding sources have been exhausted).

Introduction

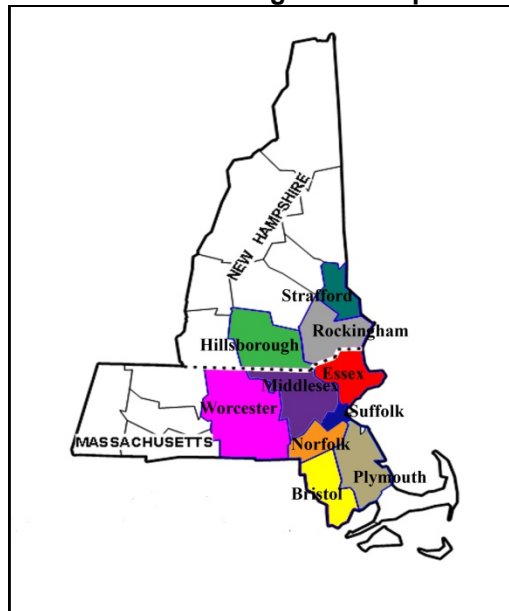
The 2011 Funding Streams Report provides an overview of the funding available to provide HIV/AIDS services within the Boston Eligible Metropolitan Area (EMA). The report also provides a resource inventory of all funded services and utilization by demographic characteristics for each of the examined funding streams. The conclusions and recommendations from this report are used by members of the Planning Council to set Part A service definitions and make funding decisions within the Planning Council cycle.

Overview of the Boston EMA

The Ryan White Treatment Extension Act (RWTEA) provides assistance to areas most impacted by the HIV/AIDS epidemic. Part A of the Ryan White Act Award funds EMAs that have reported at least 2,000 AIDS cases during the previous five years and have a total population of at least 500,000 people.

The Boston area has been an EMA since the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was first established in 1990. It covers 6,451 square miles and includes more than six million people in rural and urban areas. The Boston EMA consists of a ten county region: seven in Eastern and Central Massachusetts (Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk and Worcester) and three in Southern New Hampshire (Hillsborough, Rockingham and Strafford) (Figure 1). As of December 31, 2009, there were an estimated 15,536 individuals living with HIV/AIDS within the Boston EMA.

Figure 1: The Boston Part A Eligible Metropolitan Area (EMA)



Background

The goal of the Funding Streams Report is to provide information on the HIV service system in the Boston EMA, allowing the Planning Council to make informed decisions related to the definition and prioritization of Ryan White Part A service categories, and the Ryan White Part A funding allocations process. The Funding Streams Report is a complement of the Needs Assessment process. The *2011 Needs Assessment* can be downloaded on the Planning Council website: www.bostonplanningcouncil.org.

Objectives

The objectives of the Funding Streams Report are to:

- Provide basic information on HIV/AIDS service funding and the continuum of care;
- Ensure that Part A services remain the payer of last resort;
- Provide a summary of HIV services to facilitate the Boston EMA HIV Health Services Planning Council to make informed decisions related to Part A funding levels.

Methodology

This Funding Streams Report was conducted in two steps. First, Planning Council Support (PCS) developed a survey tool for regional HIV/AIDS service payers and providers to complete (Table V.A.5). A “service payer” is defined as an institution that does not provide services directly to the community, but contracts with other entities for this purpose; whereas a “service provider” provides services directly to the community.

The survey tool was distributed and collected information on:

- The amount of public funding received by the payer/provider to provide Part A fundable service categories for people living with HIV (PLWH);
- The amount of additional funding available for functions/services provided by the payer/provider that are not fundable by Part A; and
- Client demographics and service utilization data for each payer/provider’s funding stream.

Additionally, for multiple source recipients, the survey requested funding data to be stratified along major funding streams. Since fiscal years vary, funding data was requested for the most recent full fiscal year. Payers/providers reported on the funding amounts available for each of the 29 listed different core and support services in the survey for each of their funding streams (Table V.A.5).

Secondly, an analysis was conducted of the available funding streams for HIV/AIDS services in the Boston EMA. Fourteen funding streams were identified in the Boston EMA that fund 56 payers/providers.

Limitations

Funding Streams analysis helps provide input for important funding decisions, and serves as a catalogue for major regional HIV/AIDS service providers and their contribution to the regional continuum of HIV/AIDS care. There are limitations to conducting this type of broad funding analysis. The first is determining comparable fiscal years; there are several fiscal years funding HIV/AIDS services within the Boston EMA. The most valid analysis requires funding data to be provided in

comparable time periods. This report compares funding and utilization data across funding streams that have differing fiscal years due to varying needs and different established practices across streams. Planning Council Support (PCS) compensated for this by including data from the most recent fiscal year that fell between a two-year time period (July 1, 2009 through June 30, 2011). This wide time interval allowed for an overlap of fiscal years and a good approximation of funds available in the Boston EMA HIV services system. While this method provides a reasonably valid snapshot of the funding for HIV/AIDS services in the Boston region, the equivalent cannot be said about utilization data.

Along with fiscal information, PCS also collected utilization data in order to assess the service profile for each funding stream. Utilization data is collected independently by each payer/provider using different reporting formats and unique codes. Additionally, it is difficult to tell apart consumers who are using services from multiple payer/providers. Also, some payers/providers had different reporting demographics strata, which had been created based on service needs and populations served. Therefore, the data reported might include duplicate clients across multiple payers/providers. Moreover, time and staffing constraints did not allow for on-site HIV/AIDS surveying of service payers and providers while assembling this Funding Streams report. The survey tool developed by PCS to collect data for this report was delivered both electronically and by mail. Not all of the HIV/AIDS service payers and providers contacted responded to the data request survey, and not all agencies provided all the requested data. For funders and providers that PCS was unable to get stratified data, award totals for the last complete fiscal year were obtained from other sources, such as the HRSA website and Planning Council presentations.

A second limitation is that the survey data was self-reported by payers/providers thereby introducing some inconsistency to the funding streams analysis. Further, payers/providers have different data needs and techniques that may affect reporting. Also, information was collected only on public funding available for HIV services; private funding sources and insurance information are not included.

A third limitation is due to the reporting of Housing Opportunities for People with AIDS (HOPWA) funding. These grants are awarded to both individual agencies and municipalities. Due to a less than 100% response rate from HOPWA Grantees, there is some duplication of HOPWA funds in the *2011 Funding Streams Report*, which may lead to an over estimation of available HOPWA dollars in the Boston EMA in terms of total dollars. The percentage of HOPWA funds available in the Boston EMA should not be affected by this limitation.

To mitigate these limitations in the future, Planning Council Support staff will continue to follow up with each payer/provider that was asked to report data on an individual basis, and consistently collect data from each source for subsequent Funding Streams Reports.

Section I: Funding for HIV/AIDS Services in the Boston EMA

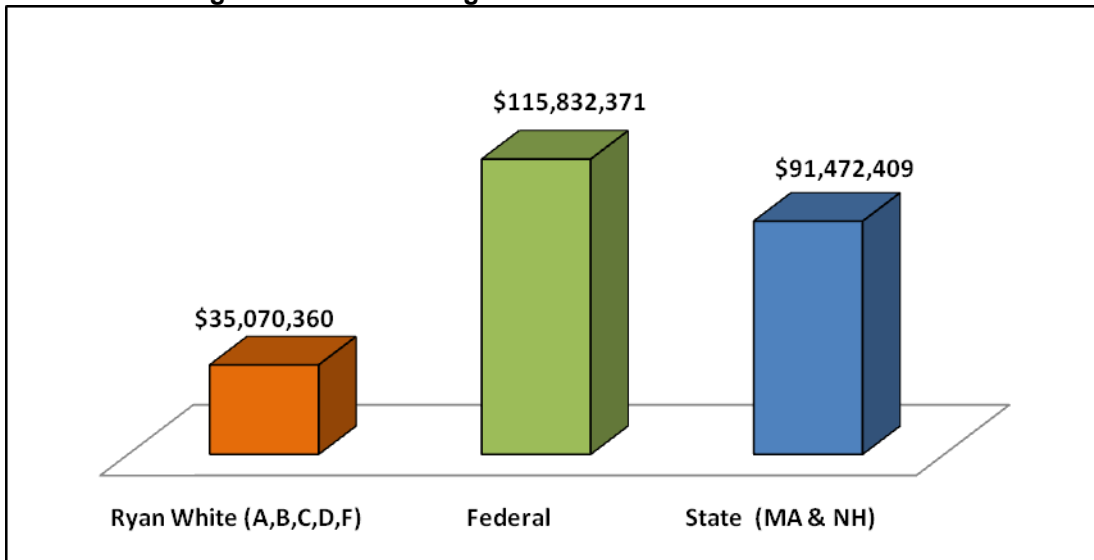
This section reviews all HIV/AIDS services funding in the Boston EMA. All funding for HIV/AIDS services are split between three major streams: 1) Ryan White, 2) Other Federal, and 3) States (MA and NH).

Overview of Three Main Funding Streams

This Funding Streams report splits the sources of funding operating within the Boston EMA into three groups: Ryan White Funds, Other Federal Funds, and State Funds. The proportion of each of these groups as a share of total HIV-related funding is shown below in Figure 2. However, further analysis of each of the major funding entities in the Boston EMA is provided in greater detail later in this report.

Within the three main funding sources for HIV/AIDS services (i.e. Other Federal, State, and Ryan White), 14 different funding streams were identified in the Boston EMA. These funding streams were contributing a total of \$242,375,140 in the last fiscal year to fund HIV/AIDS services in the Boston EMA. This is an 11% increase from 2010 (\$215,325,160).

Figure 2: Main Funding Sources in the Boston Part A EMA



Fifty-six regional HIV/AIDS service payers/providers for Ryan White, Other Federal, and State funding were identified within the Boston EMA. Each of the identified HIV/AIDS service payers/providers provide either a substantial amount of funding for services to PLWH, or provide direct services specifically for PLWH.

Analysis of Boston EMA HIV Services Funding Streams

The three main funding sources (Other Federal, State, and Ryan White) for HIV/AIDS services can be further subdivided into 14 funding streams. According to Figure 3, the majority of funding available for HIV/AIDS services in the Boston EMA comes from Other Federal funding streams (48%, \$115,832,371), excluding Ryan White. State funding streams constitute the next largest share of funding available for HIV/AIDS services in the Boston EMA (38%, \$91,472,409). Ryan White funding streams make up only 14% (\$30,070,360) of the total HIV/AIDS funding available in the region. When

compared to 2010, the proportion of Ryan White contribution in funding HIV/AIDS services in the Boston EMA is similar to 2011 (Figures 3a and 3b) there was a decrease in Ryan White and an increase in State and Other Federal funds.

Figure 3a: 2010 Proportion Main Funding Streams

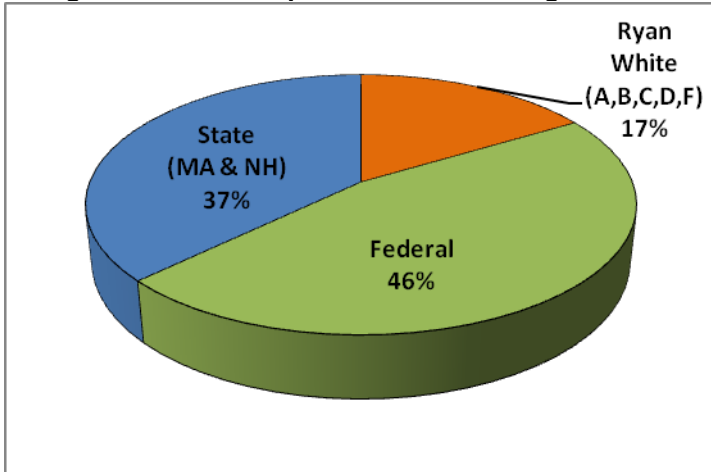
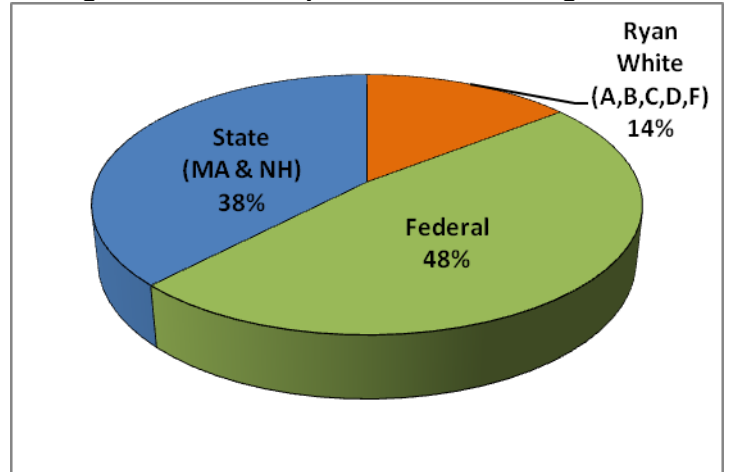


Figure 3b: 2011 Proportion Main Funding Streams



The breakdown of the total pot of funding available for the provision of HIV/AIDS services in the Boston EMA by each of the three main funding streams is shown in Figure 4 and Table I.A.1. Data was provided for 29 core medical and HIV health-related support services available for PLWH. Amongst all Ryan White payers/providers, Part B contributes \$14,820,326 in funding for HIV/AIDS services in the Boston EMA (6%). The MA Medicaid Line (27%) and MA State AIDS line (9%) accounts for the majority of State funding for HIV services (\$64,704,729 and \$21,618,456 respectively). Within Other Federal streams, Medicaid is the largest contributor to the continuum of care, giving \$105,405,221 (44% of the total HIV/AIDS funding available in the region).

Figure 4: 2011 Funding Stream Breakdown in the Boston EMA

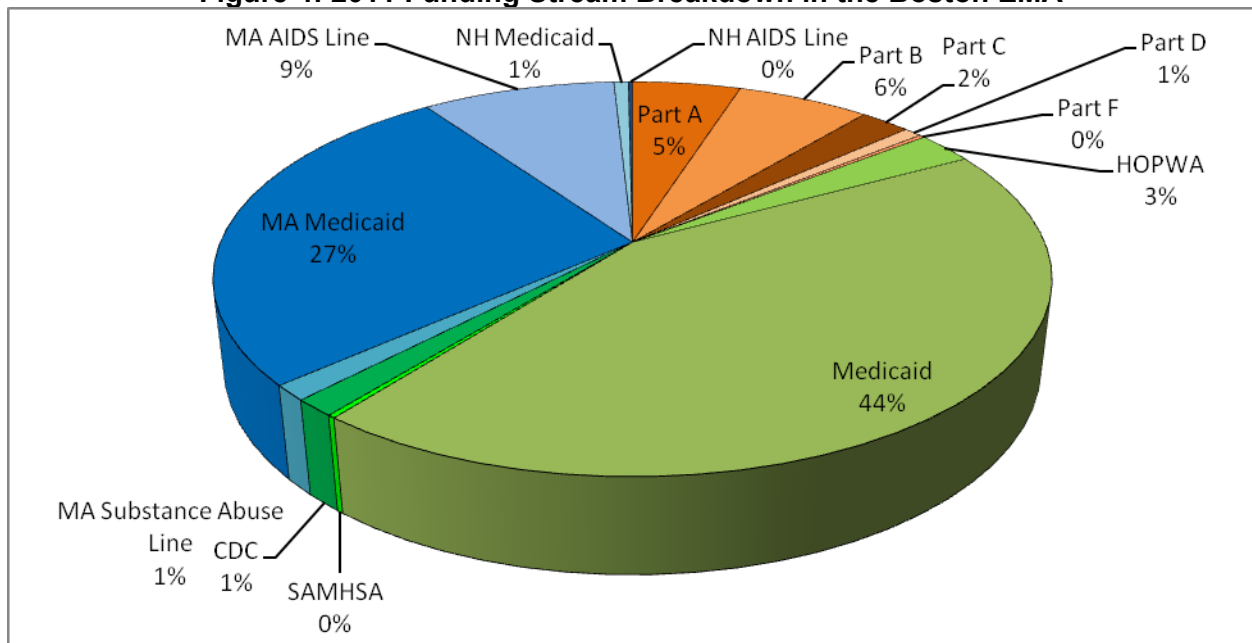


Table I.A.1: Funding Streams in the Boston EMA

Funding Source	Total Allocation
Ryan White Part A	\$12,082,745
Ryan White Part B	\$14,820,326
Ryan White Part C	\$5,596,181
Ryan White Part D	\$1,976,699
Ryan White Part F	\$594,409
Housing Opportunity for People with AIDS (HOPWA)	\$6,386,701
Federal Medicaid	\$105,405,221
Substance Abuse and Mental Health Services Administration (SAMHSA)	\$597,874
Centers for Disease Control & Prevention (CDC)	\$3,442,575
MA Substance Abuse Line	\$3,068,306
MA Medicaid	\$64,704,629
MA AIDS Line	\$21,618,456
NH Medicaid	\$1,619,366
NH AIDS Line	\$461,652
Total	\$242,375,140

Funding By Core Medical Services and HIV Health-Related Support Services

Payers/providers reported on the distribution of all HRSA fundable service categories for PLWH. Figure 5 illustrates the distribution of funds available within the Boston EMA for core medical services and HIV health-related support services. Across all funding streams, 86% of funding is allocated to core medical services, while only 14% of funding is allocated to HIV health-related support services, which accounts for a slight increase in core services when compared to the 2010 distribution. (Figures 5a and 5b).

Figure 5a: 2010 Breakdown of Funds for all HRSA Service Categories in the EMA

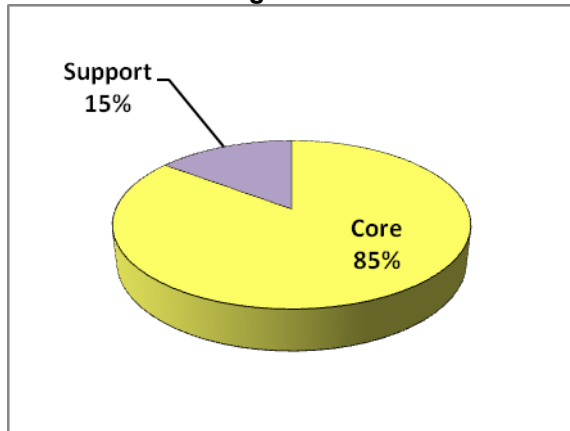
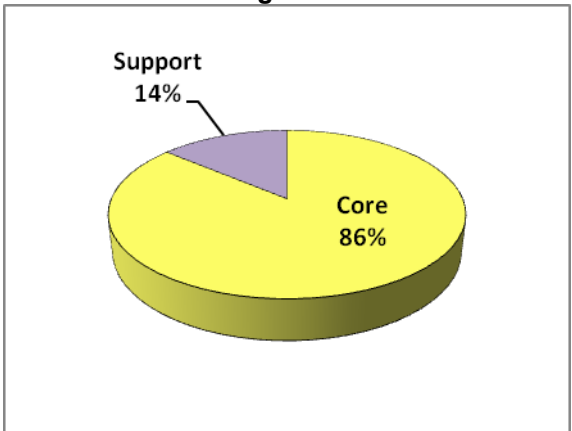


Figure 5b: 2011 Breakdown of Funds for all HRSA Service Categories in the EMA



The 75/25 clause of the Ryan White Act requires that 75% of direct services funding be devoted to providing core medical services. Only Parts A, B, and C are required to abide by this clause; no other funding stream has such a requirement. Ryan White Part A in the Boston EMA is the only area in the country to receive a waiver for this requirement.

Overall, State and Other Federal funding streams provide the greatest contribution to both core medical services and HIV health-related support services. Figure 6 illustrates the breakdown within the three major funding streams for each of the service types. Significant proportions of Other Federal (non-Ryan White) and State funding are allocated to core medical services (52% and 35% respectively). In 2011, the total allocation to core services in the Boston EMA was \$208,678,754. Meanwhile, the 2011 HIV health-related support services had a total allocation of \$33,696,386.

Figure 6: Funding for all HIV/AIDS Services in the EMA by Funding Stream

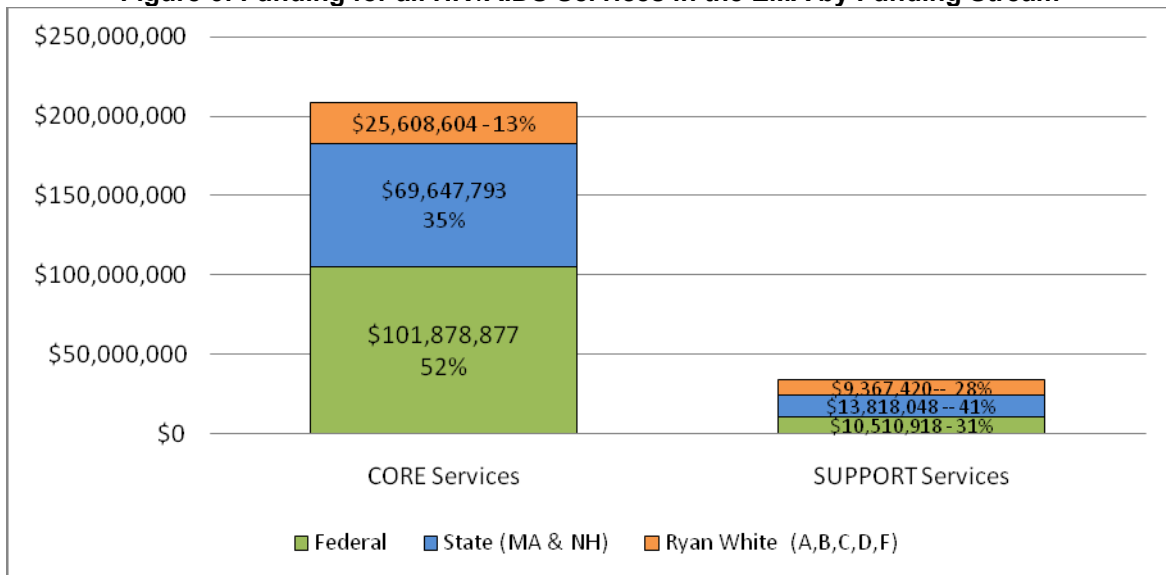
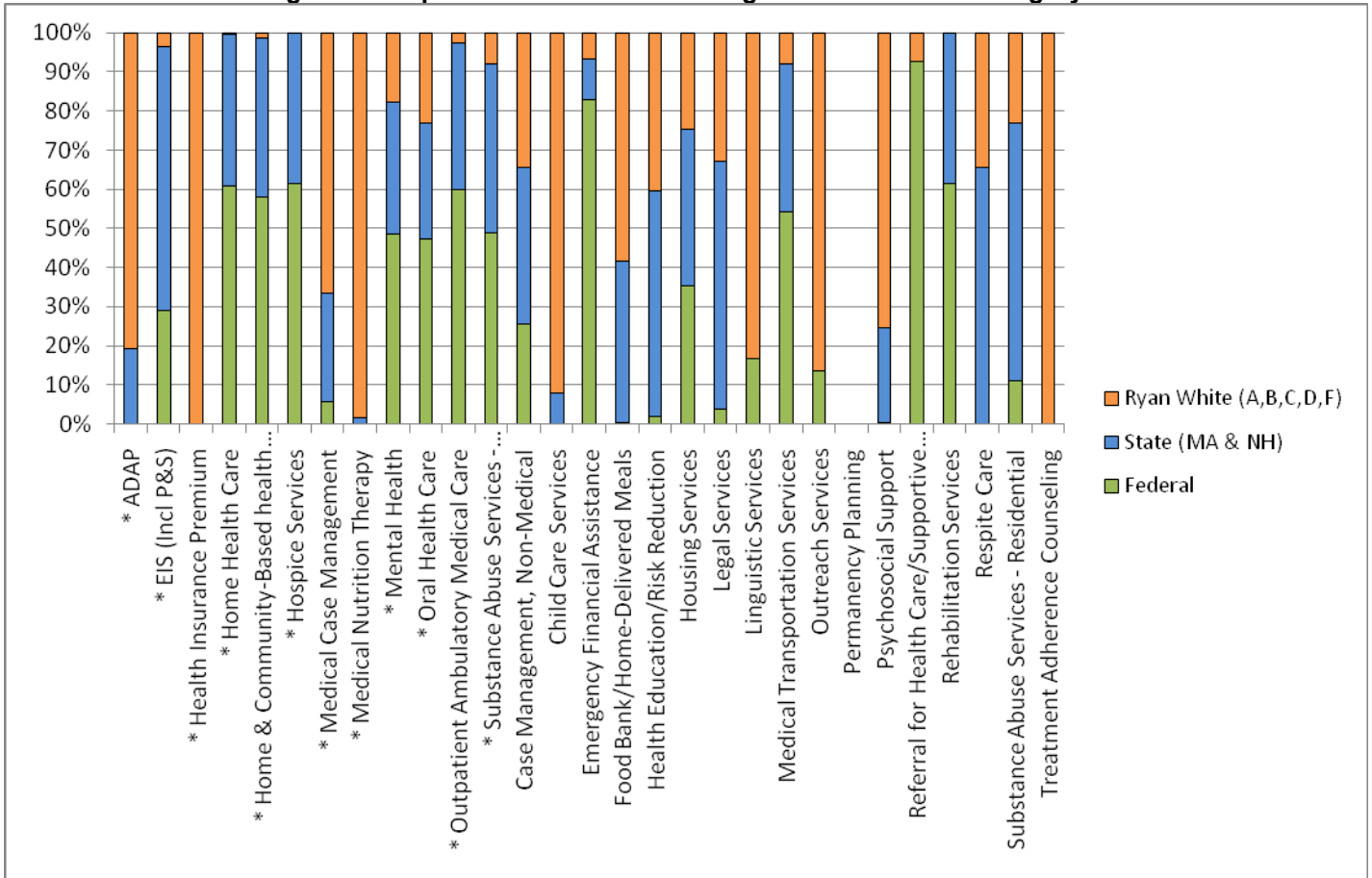


Figure 6 provides additional explanation on the breakdown of core and support services across the three main funding sources for HIV/AIDS services in the Boston EMA. Approximately 87% of core services are covered by Other Federal and State funding streams (\$105,321,452 and \$77,654,362, respectively). On the other hand, Ryan White covers 66% of Medical Case Management, a service that provides a critical link between PLWH and other much needed services. Within support services, Ryan White covers significant portions of Child Care Services, Food Bank/Home-Delivered Meals, Linguistic Services, Outreach Services, Psychosocial Support, and Treatment Adherence Counseling.

Figure 7: Proportional HIV/AIDS Funding for Each Service Category



When all funding streams are combined, 86% of funding provides core medical services particularly Outpatient/Ambulatory Medical Care (59%) and ADAP (6%) (Figures 8 and 9). HIV health-related support services receive 14% of all HIV/AIDS funding within the Boston EMA region and the main services are Housing Services (4%) and Medical Transportation (3%).

Figure 8: Service Category Breakdown for All Funding Streams

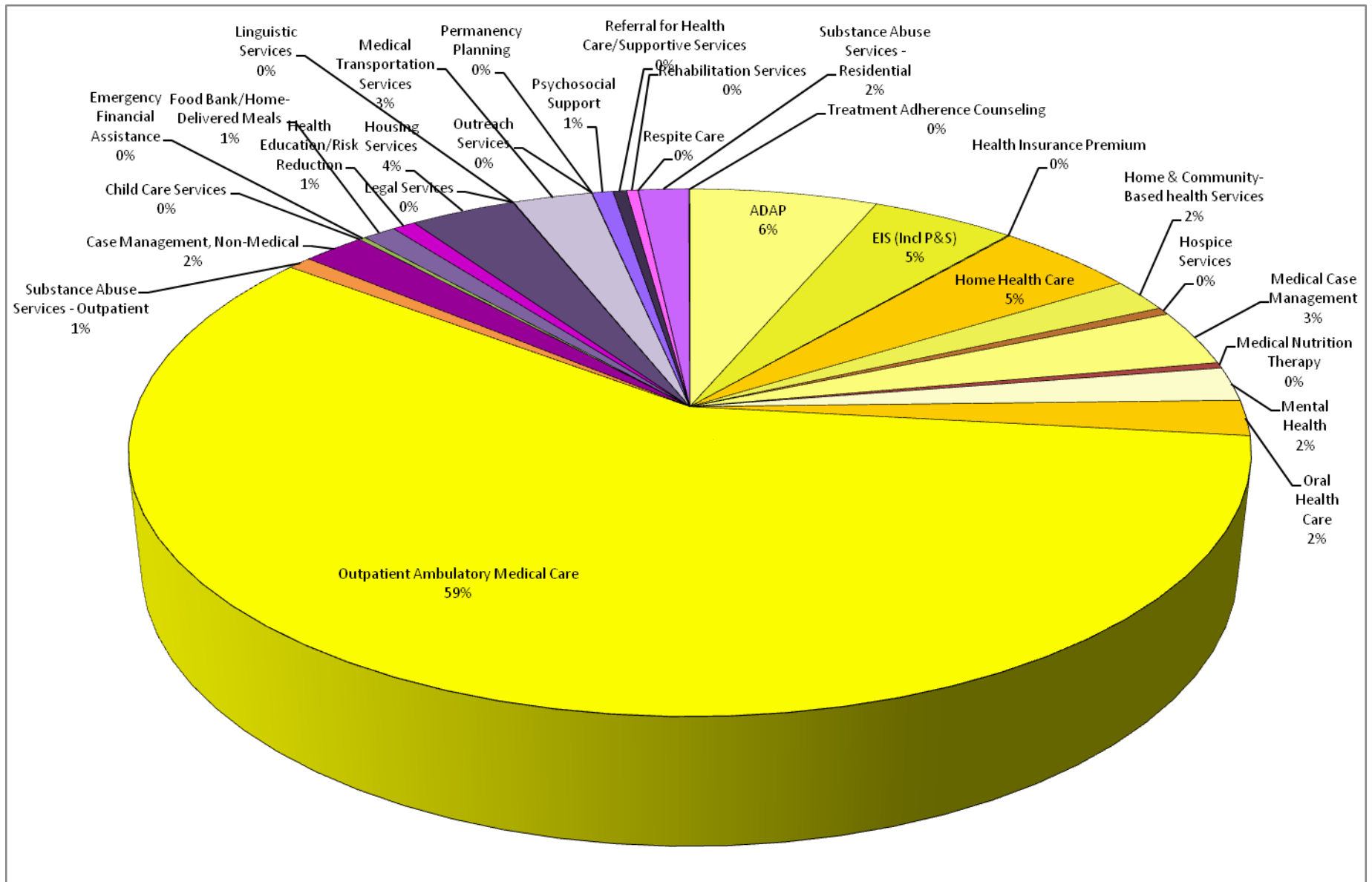
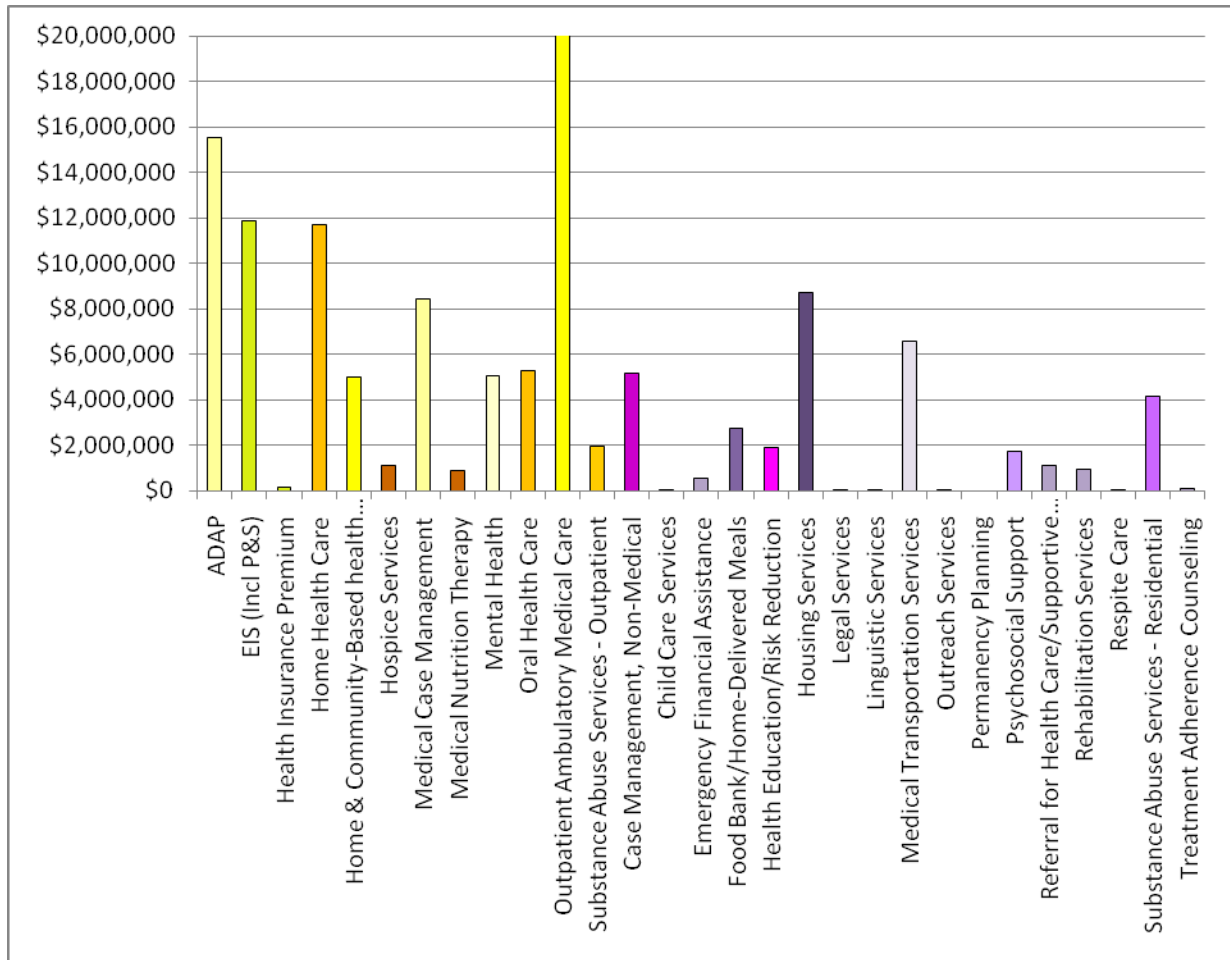


Figure 9: Total HIV/AIDS Funding for Service Categories in the Boston EMA



Core Medical Services

The largest proportions of the total funding collectively invested in core medical services were allocated to Outpatient/Ambulatory Medical Care (68%) and ADAP (7%) (Figure 10).

Figure 10: Core Medical Services Distribution for All Streams

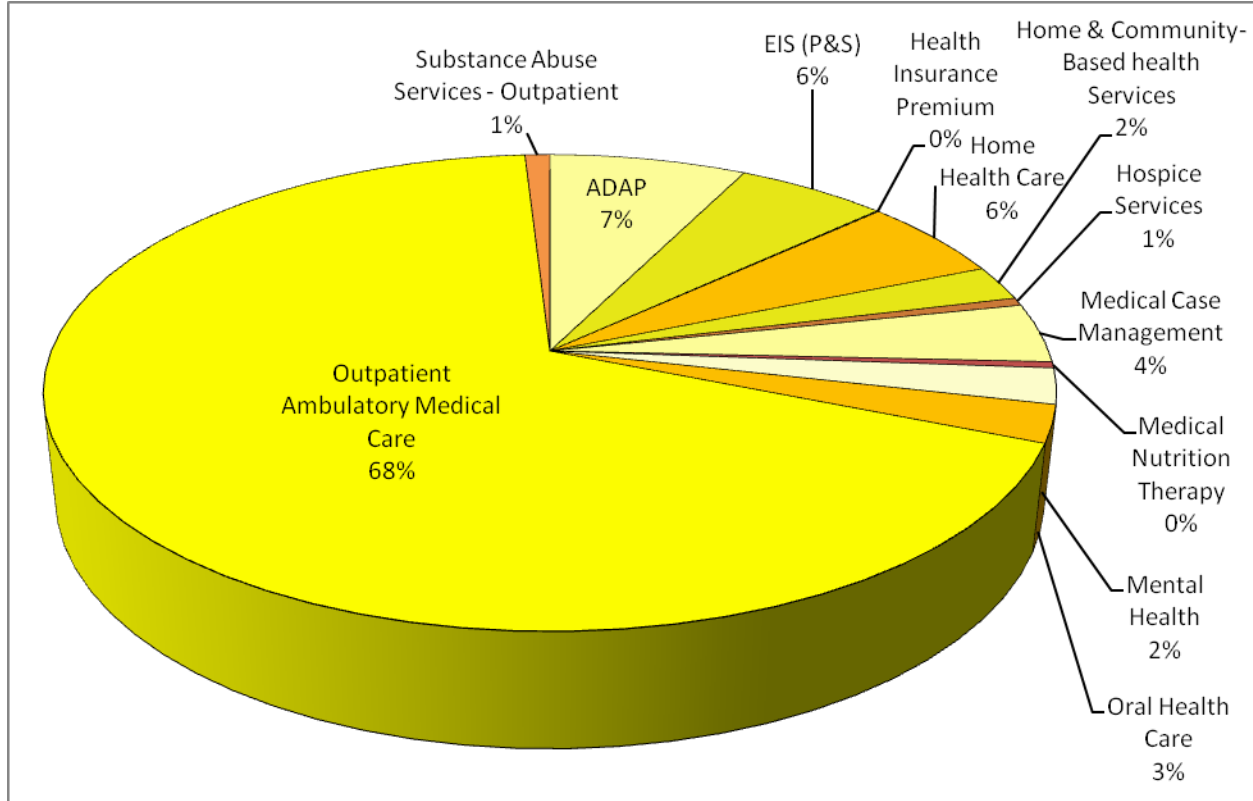


Table I.A.2 illustrates the funding available for Core Services in 2010 and 2011 data collection periods.

Table I.A.2 Core Medical Services

Service Categories	2010	2011
ADAP	\$15,873,915	\$15,530,981
EIS (Incl CTR)	\$6,257,327	\$11,861,493
Health Insurance Premium	\$129,056	\$136,972
Home Health Care	\$7,287,962	\$11,684,856
Home & Community-Based Health Services	\$2,989,031	\$4,968,469
Hospice Services	\$665,395	\$1,119,294
Medical Case Management	\$7,278,780	\$8,407,421
Medical Nutrition Therapy	\$912,736	\$868,307
Mental Health	\$3,548,232	\$5,062,195
Oral Health Care	\$3,870,035	\$5,265,255
Outpatient Ambulatory Medical Care	\$132,648,288	\$141,811,894
Substance Abuse Services - Outpatient	\$2,107,170	\$1,961,617
TOTAL	\$183,567,927	\$208,678,754

HIV Health-Related Support Services

Across all funding streams, Housing (26%) and Case Management, Non-medical (22%) received the largest proportion of funding for HIV health-related support services in the Boston EMA (Figure 11 and Table I.A.3).

Figure 11: HIV Health-Related Support Services Distribution for All Streams

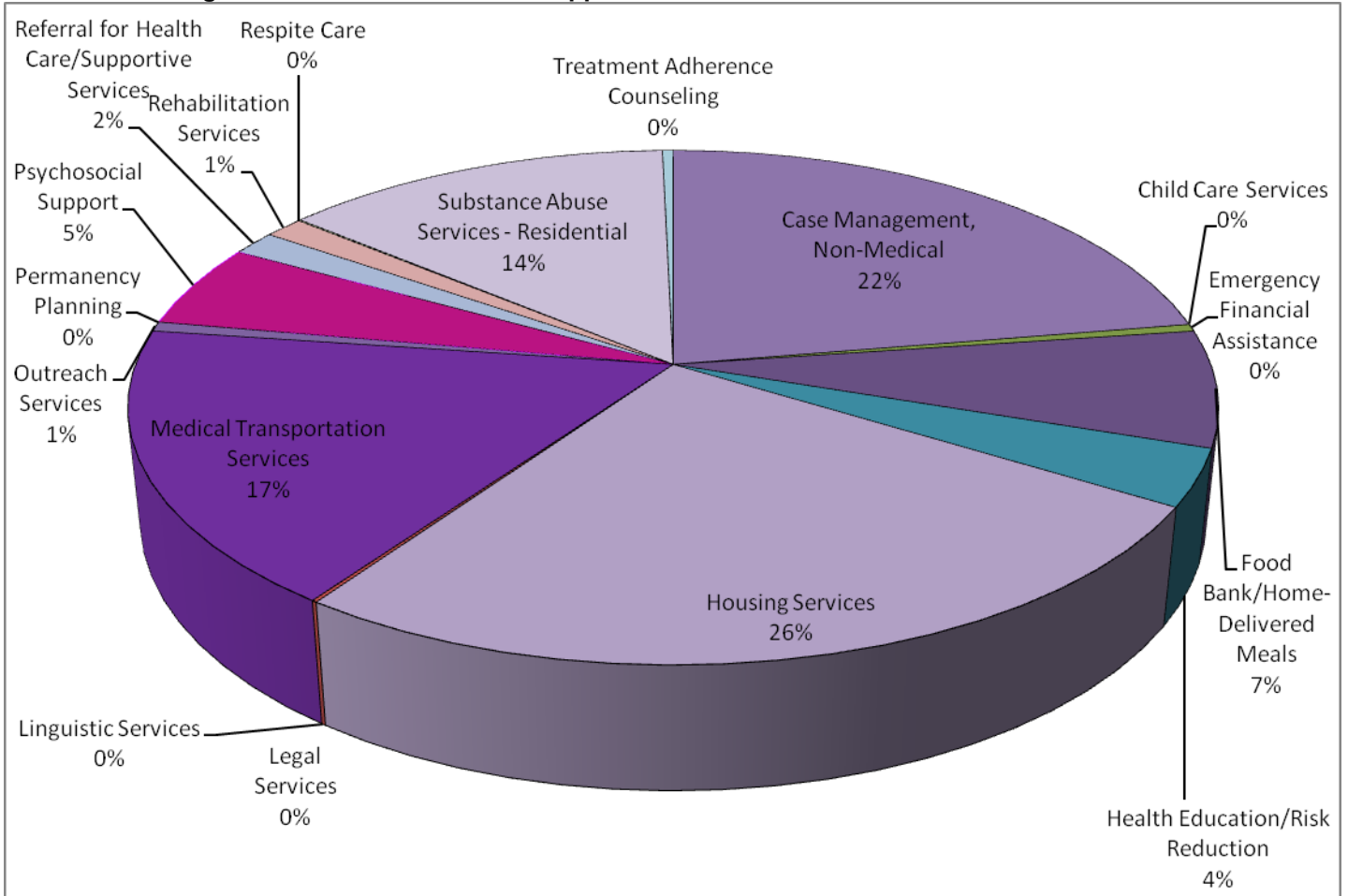


Table I.A.3 illustrates the funding available for health-related support services in 2010 and 2011 data collection periods.

Table I.A.3 HIV Health-Related Support Services

Service Categories	2010	2011
Case Management, Non-Medical	\$7,104,310	\$5,141,266
Child Care Services	\$336	\$200
Emergency Financial Assistance	\$143,940	\$523,206
Food Bank/Home-Delivered Meals	\$2,327,972	\$2,717,368
Health Education/Risk Reduction	\$1,137,042	\$1,909,352
Housing Services	\$8,245,823	\$8,689,635
Legal Services	\$655	\$25,387
Linguistic Services	\$40,302	\$53,618
Medical Transportation Services	\$5,510,591	\$6,550,467
Outreach Services	\$192,430	\$41,500
Permanency Planning	\$0	\$0
Psychosocial Support	\$1,678,687	\$1,726,162
Referral for Health Care/Supportive Services	\$492,738	\$1,106,109
Rehabilitation Services	\$429,473	\$948,641
Respite Care	\$23,650	\$25,277
Substance Abuse Services - Residential	\$4,310,802	\$4,161,750
Treatment Adherence Counseling	\$118,482	\$76,488
TOTAL	\$31,757,233	\$33,696,386

Utilization Demographics

In the Boston EMA, only those individuals with documentation of HIV/AIDS are eligible for services. Among those with HIV/AIDS in the Boston EMA, minorities are disproportionately represented. As of December 31, 2009, Whites make up the largest proportion of PLWH in the Boston EMA (Table I.A.4). Whites account for 47%, almost half of the prevalent cases, even though they comprise 80% of the Boston EMA population.

According to utilization data reported by all funding streams, 67% (58,936) of clients receiving services for PLWH are White (Figure 12). Even though Blacks account for 31% of PLWH, they comprise only 5% of the Boston EMA population and 14% (12,414) were reported as having accessed services funded for PLWH (Figure 15). Hispanics account for 21% of the prevalent cases in the Boston EMA, yet they comprise 8% of the Boston EMA population, and 14% (12,431) of recipients of HIV funded services.

Figure 12: Boston EMA Utilization by Race

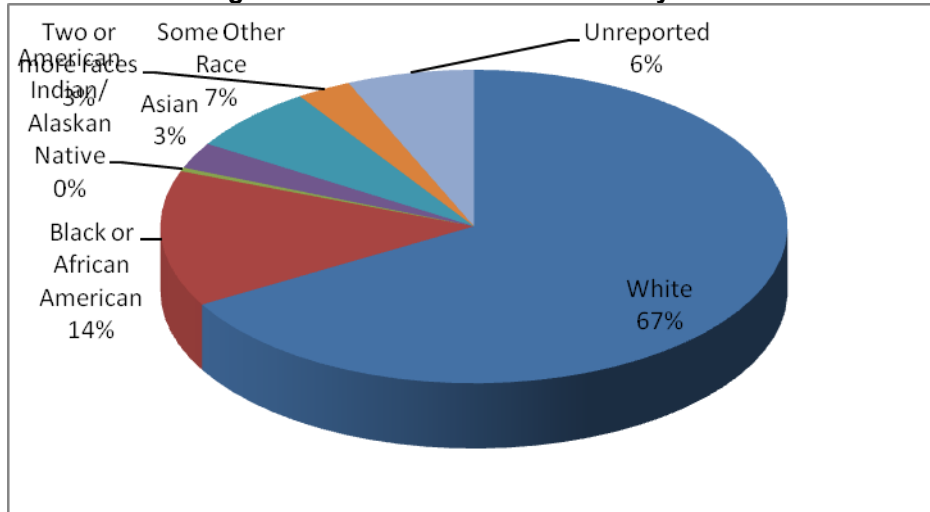


Table I.A.4: HIV/AIDS Prevalence and Service Profile of the Boston EMA

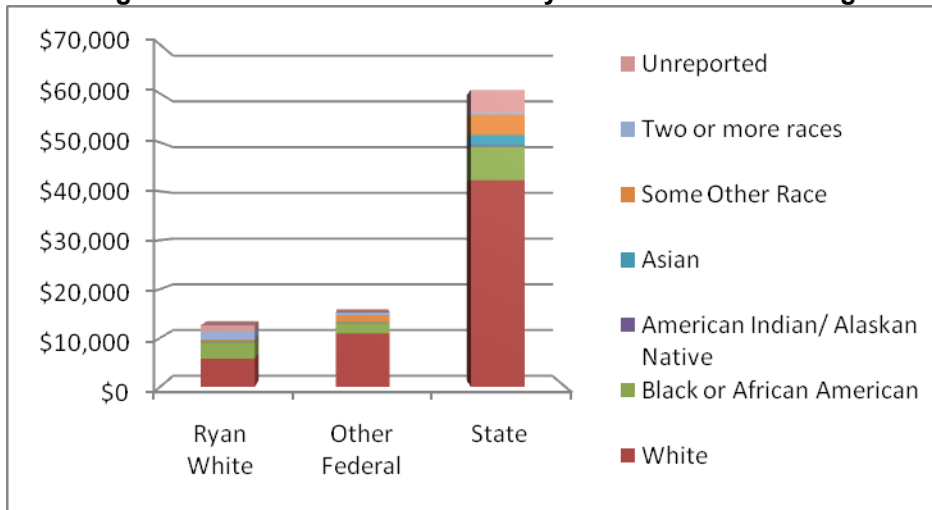
Race/Ethnicity	EMA*	HIV/AIDS Prevalence	Service Profile***
White	5,579,038	7,368	58,936
Black or African American	445,033	4,641	12,414
Hispanic**	528,880	3,213	12,431
American Indian/ Alaskan Native	19,349	24	342
Asian	316,038	246	2,392
Two or more races	83,847	N/A	2,496
Other/Unreported		44	11,801
	6,972,185	15,536	100,812

*2007 census estimates. Source: <http://quickfacts.census.gov/qfd/states/25000.html>

**Might be counted in other racial categories.

*** Includes duplicates/people accessing multiple services

Figure 13: Boston EMA Utilization by Race for Each Funding Stream



The majority of PLWH served with HIV/AIDS funds in the Boston EMA across all three main funding streams are White. Though this is reflective of the Boston EMA demographic profile (Figure 13), services provided through Ryan White cover a larger portion of racial/ethnic minorities. Due to varying methods of data collection, PCS was not able to collect separate racial demographics by ethnicity. However, overall in the Boston EMA, 86% of consumers of services for PLWH are non-Hispanic (Figure 14).

Figure 14: Boston EMA Utilization by Ethnic Group

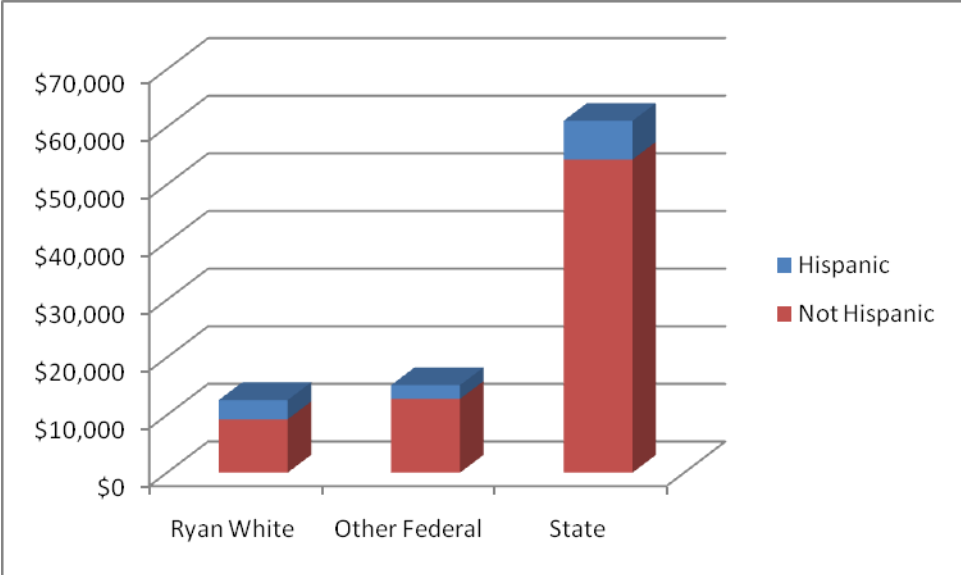
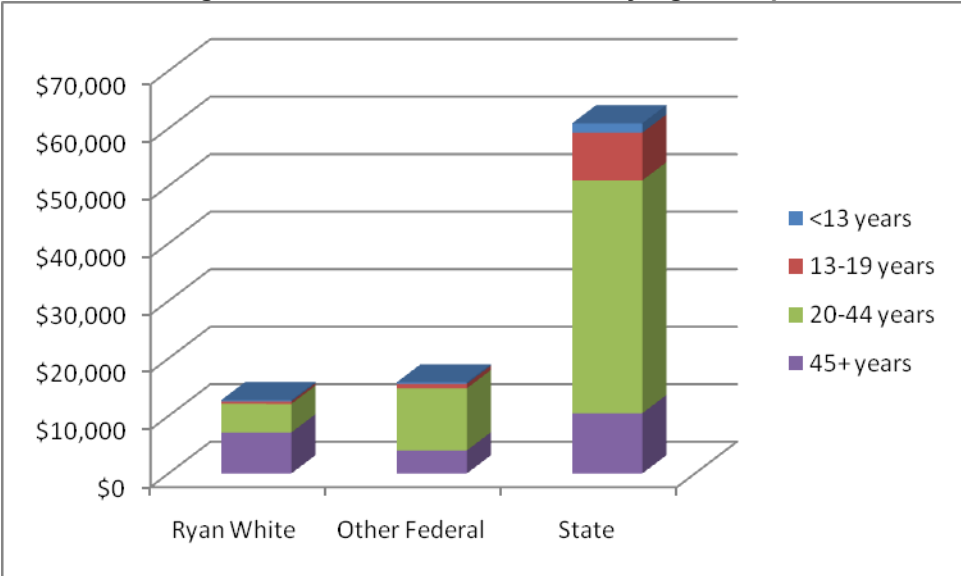


Figure 15 examines service utilization by age group. The majority of Ryan White funded services are used by PLWH over 45 years, while the majority of State and Other Federal funded services are used by PLWH aged 20-44.

Figure 15: Boston EMA Utilization by Age Group



Conclusion

The Boston EMA has a responsive and comprehensive continuum of care that includes both core medical and supportive services that promote health and enhance quality of life. In total \$242,375,140 in funding for the region provides services across the spectrum of public health needs. Other Federal, not including Ryan White, funding streams make up the greatest portion of dollars available for funding in the Boston EMA.

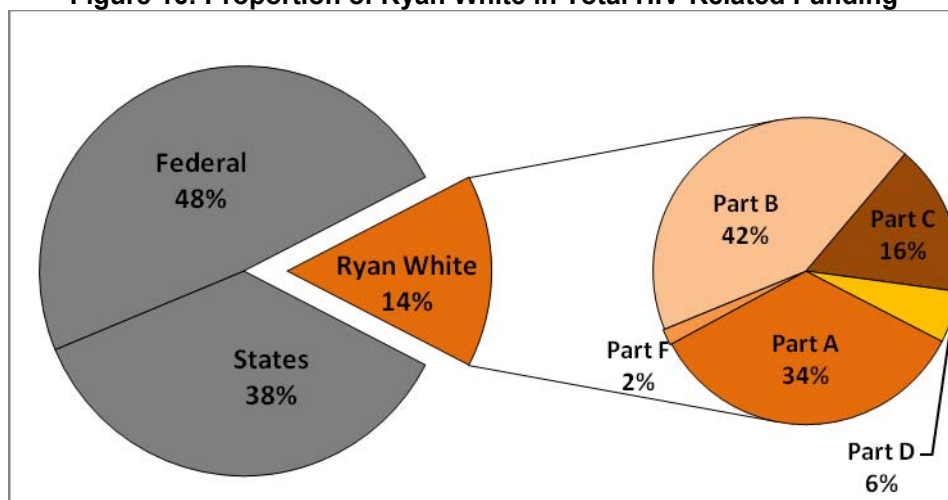
Outpatient/Ambulatory Medical Care and ADAP receive the most funding in the region. Medicaid serves as the largest payer. As payers of last resort, Ryan White streams help to provide necessary health-related support services such as Food Bank/Home-Delivered Meals, Case Management, Non-medical, and Psychosocial Support.

More information on the breakdown of Ryan White, Other Federal, and State funding streams can be found in the following three sections of this report.

Section II: Ryan White Funding

This section describes the total share of HIV-related funding that is associated with Ryan White funding streams in the Boston EMA: Part A, Part B, Part C, Part D and Part F (Dental, AIDS Education and Training Centers, and Special Projects of National Significance). Ryan White represents 14% of total funding for HIV/AIDS services in the Boston EMA (Figure 16).

Figure 16: Proportion of Ryan White in Total HIV-Related Funding



Introduction

The Ryan White Act was first enacted in August 1990 (formerly CARE Act), and has been amended and reauthorized four times since. Much has changed in the epidemiology and medical management of HIV/AIDS since the Ryan White Act was first enacted. Ryan White Act funding is Federal in origin and is administered by the Health Services Resource Administration (HRSA) across five parts. Part A is directed to metropolitan areas, Part B is directed to states, Part C is directed to community health centers for early intervention services, Part D is directed to community health centers for women and children, and Part F is directed to several institutions depending on subpart.

Ryan White Funding

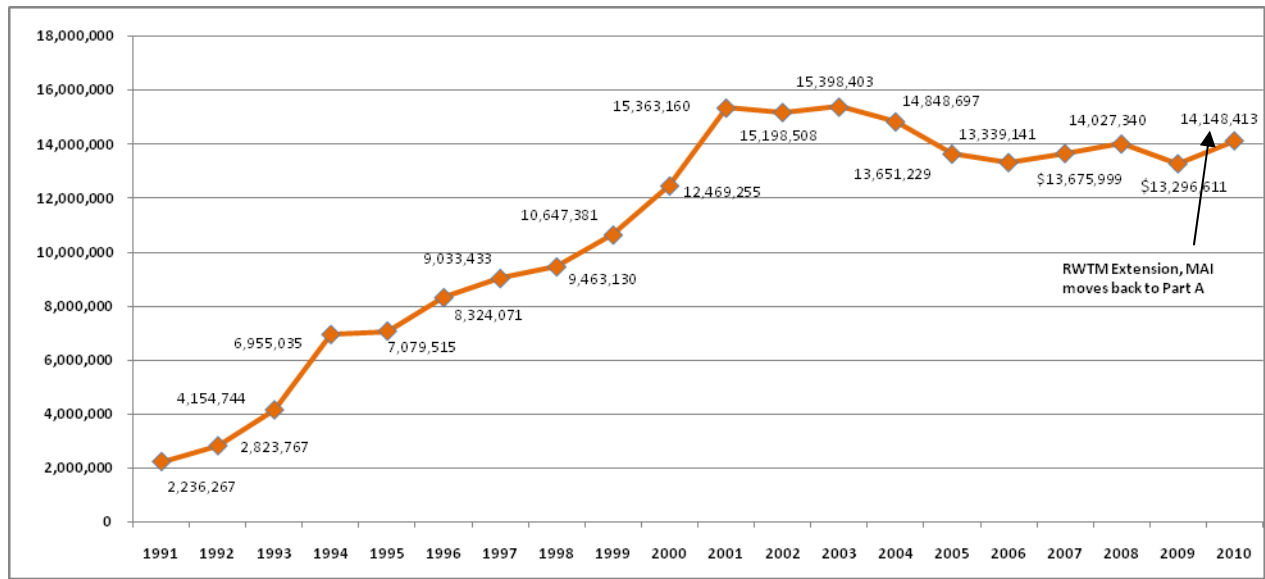
Part A

The Boston Public Health Commission (BPHC) HIV/AIDS Services Division receives Part A funding from HRSA. Planning Council Support is subcontracted by BPHC to support and provide administration to the Boston HIV Health Services Planning Council, the community planning group associated with Part A funds in the Boston EMA. Part A provides funding to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) most impacted by the HIV/AIDS epidemic. There are a total of 54 EMAs and TGAs eligible for this funding in the United States. Under Part A, cities receive formula awards based on the severity of the local epidemic, and supplemental awards based on an annual competitive grant.

Funding Level

The Boston EMA received \$12,082,745 in Ryan White Part A funding to provide direct services for FY10 (March 1, 2010 to February 28, 2011). As of March 2010, Minority AIDS Initiative (MAI) funding was no longer considered to be a separate funding stream, but included in Part A. The Minority AIDS Initiative provides funding for activities to evaluate and address the disproportionate impact of HIV/AIDS on racial and ethnic minorities. Of the \$12,082,745 in Part A funds, \$691,768 are appropriated for MAI Medical Case Management and Psychosocial Support programs. The funding for Part A is managed by BPHC, which distributes the funds throughout the community using a Request for Responses (RFR) process. Figure 17 demonstrates historical funding of Part A since its inception.

Figure 17: Historical Funding Pattern of Part A Funding in the Boston EMA



Resource Inventory

The City of Boston receives Part A funding to contract services throughout the EMA, which includes seven counties in Eastern and Central Massachusetts (Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, Worcester) and three counties in Southern New Hampshire (Hillsborough, Rockingham, Stafford). Part A service category definitions are located in the report Appendix (Appendix).

The Boston Public Health Commission distributes the Part A funding to agencies throughout the EMA using a RFR process. Part A funds are used to provide a range of community-based services to PLWH according to two general categories:

- **Core Services:** outpatient and ambulatory services including primary care, medications, medical case management, substance abuse and mental health treatment; and
- **HIV Health-Related Support Services:** services designed to maintain and enhance patients' primary medical care including nutritional, transportation, housing and legal services.

Boston EMA MAI funds support a combination of Medical Case Management and Psychosocial Support services to agencies throughout the region. The funds are distributed by BPHC to the community through a RFR process. State MAI funds support educational and outreach services to help communities of color improve their participation in their state's HDAP/ADAP.

In FY10, there were 96 programs based in 47 agencies. An entire list of the funded entities, a description of their services, and their funding level is available on the BPHC website (www.bphc.org/aids).

Utilization

Ryan White Part A services were provided to 6,366 unduplicated consumers in FY10. Thirty-seven percent of consumers served were White and 25% were Black. Approximately one third (33%) of consumers were Hispanic. The majority of consumers served with Part A funding were 20 years and older, with 38% in the 20-44 age group and 61% in the 45+ group. Heterosexual transmission was the most prevalent mode of HIV exposure (35%), but IDU and MSM were also significant modes of HIV exposure among Part A consumers (25% and 29%, respectively). Two percent of consumers' mode of infection was undetermined.

There is a potential for duplication of consumer counts within MAI utilization data. In total, MAI funding provided services to 536 PLWH in the Boston EMA in FY10. Approximately half of the PLWH served were women (264), with a small proportion composed of children (3) and youth (2). Thirty-seven percent of the consumers served with MAI funding in the Boston EMA were Black and 46% were Hispanic. Unlike other funding streams, MAI services target specifically minority populations.

Part B

Part B provides formula funding to states and territories to improve the quality, availability, and organization of health care and support services for PLWH. Under Part B, states receive awards that are determined by a formula, based on the severity of the state's HIV/AIDS epidemic. Other funds are specifically earmarked to support an HIV or AIDS Drug Assistance Program (HDAP/ADAP), which provide medications to low-income PLWH who have limited or no coverage from private insurance or Medicaid. In addition, HRSA awards supplemental funds to states that can demonstrate the existence of an emerging community, defined as a metropolitan area that has reported between 500 to 1,999 cumulative AIDS cases to the CDC for the most recent five years.

Funding Level

In the most recent complete fiscal year, MA received \$13,346,371 in Part B funding and NH received \$1,473,955 in Part B funding.

Resource Inventory

The Massachusetts Department of Public Health (MDPH) and New Hampshire Department of Health and Human Services (NHDHHS) receive Ryan White Part B funding in the Boston EMA. Each state receives funding for the entire state and services are distributed using an RFR process for:

- Home and community-based health care and support services;
- Continuum of health insurance coverage, through either a Health Insurance Continuation Program (HICP) or provision of medical benefits under a health insurance program including high risk pools;
- Pharmaceutical treatments through ADAP; and
- Direct health and HIV health-related support services.

Utilization

New Hampshire served 473 PLWH in the Boston EMA in their most recent complete fiscal year. The general population in New Hampshire is predominantly white. Sixty-eight percent of the consumers served with Part B funding in NH were White and 15.2% were Black; 12.9% were Hispanic and 16.9%

identified themselves as Two or More Races/Other Racial categories. Almost all of Part B services in NH (98.9%) were utilized by people 20 years and older, with 39.1% in the 20-44 and 59.8% in the 45+ group. Men who have sex with men is the most prevalent mode of HIV exposure among NH Part B consumers (47.8%) with Heterosexual following as the second most common mode of exposure (29.2% of consumers). Massachusetts was unable to provide unique Part B client utilization data. Therefore, Part B utilization numbers are included in the MA AIDS Line item utilization numbers under State funding streams.

Part C

Part C is allocated to community health centers in the EMA to provide early intervention services. Part C funds support comprehensive primary health care and other services for individuals who have been recently diagnosed with HIV.

Funding Level

Part C funding within the Boston EMA was \$5,596,181 in the most recently completed fiscal year. Fiscal years for Part C services in the Boston EMA vary typically occurring January to December and others occurring July to June. Several outliers had fiscal years that did not fall in either of these fiscal year groupings.

Resource Inventory

Part C services include:

- Risk-reduction counseling, partner involvement in risk reduction, education to prevent transmission, antibody testing, medical evaluation, and clinical care;
- Antiretroviral therapies, protection against opportunistic infections, ongoing medical, oral health, nutritional, psychosocial, and other care for PLWH;
- Case management to assure access to services, and continuity of care for PLWH; and
- Addressing "co-epidemics" that occur frequently in association with HIV infection, including tuberculosis and substance abuse.

Utilization

There is the potential for duplication of consumer counts within Part C utilization data. This is due to independent data collection by each Part C provider and a lack of communication among providers to unduplicate the consumers. In total, Part C funding provided services to 4,528 PLWH in the Boston EMA in the most recent fiscal year (again some consumers may be duplicates). The majority of the consumers served with Part C funding in the Boston EMA were White (63.9%), 26.4% were Black, and 19.7% were Hispanic. Similar to Part B, almost all of Part C services in the Boston EMA were utilized by people 20 years and older, with 42.8% in the 20-44 group and 55.5% in the 45+ group. Also similar to Part B, MSM is the most prevalent mode of HIV exposure among Part C consumers (46.0%), with Heterosexual following as the second most common mode of exposure (26.7). Of the 25 pediatric consumers receiving Part C funded services in the Boston EMA, 92% were exposed by their mother who was at risk for or already infected with HIV when the infant was born, and 8% were exposed by other means, such as hemophilia or blood transfusion.

Part D

Part D provides funding to agencies for comprehensive, community-based, and family-centered services to children, youth, and women living with HIV and their families. Part D systems of care also

enhance access to clinical research supported by the National Institutes of Health (NIH) and other organizations for their client populations.

Funding Level

There was \$1,976,699 in Part D funding in the Boston EMA in the most recent fiscal year. Fiscal years for Part D services in the Boston EMA vary with some occurring August to July, and others January to December. Several outliers had fiscal years that did not fall in either of these fiscal year groupings.

Resource Inventory

Part D program services provide a continuum of care for at risk populations which include:

- Primary and specialty medical care;
- Psychosocial services and logistical support; and
- Outreach and prevention

Utilization

There is also potential for duplication of consumer counts within Part D utilization data. In total Part D funding provided services to 972 PLWH in the Boston EMA in the most recent fiscal year. The majority of consumer served with Part D funding in the Boston EMA were Black (54%), 20.3% were White, and 26.1% of consumers were Hispanic. Unlike other funding streams, Part D services reach a higher proportion of minority populations.

A smaller portion of Part D clients belong to the 20 and over age group compared to other funding streams. Under 55% of Part D services in the Boston EMA were utilized by people 20 years and older, with 35.1% in the 20-44 group and 18.7% in the 45+ group. Consumers aged 13-19 years made up 28.9% of Part D clients. The most prevalent mode of HIV exposure among Part D consumers is Heterosexual transmission (57.7%), with MSM and IDU following as the second and third most common modes of exposure (16.2% and 16.1% of consumers, respectively).. Of the 388 pediatric consumers receiving Part D funded services in the Boston EMA, 100% were exposed by their mother who was at risk for or already infected with HIV when the infant was born.

Part F

Part F funding is divided into several subparts including: the Dental Program, Special Projects of National Significance (SPNS), and AIDS Education and Training Centers (AETC).

1) Dental Program

The Dental program assists accredited dental schools and post-doctoral dental programs with uncompensated costs incurred in providing oral health care treatment to PLWH. Costs are reimbursed to institutions as a proportion of their incurred costs compared to that of all institutions seeking reimbursement.

Funding Level

There was \$309,876 in Part F Dental Program funding in the Boston EMA in the most recent fiscal year. Most Part F Dental Program fiscal years run from July to June.

Resource Inventory

Three dental schools received reimbursement from the dental program through the Ryan White Act Part F in the Boston EMA in the most recent fiscal year. All of the programs were located within the City of Boston. There were no institutions located in NH or the remainder of the EMA.

Utilization

Part F Dental Program utilization data was only available for one program, which provided services to 412 PLWH in the Boston EMA in the most recent fiscal year. In this program, 51.5% of the consumers served were White, 34.0% were of Two or More/Other racial categories, and 9.0% were Hispanic. Similar to the other Ryan White parts, almost all of the Part F Dental Program clients were in the 20 and over age group, with 25.7% in the 20-44 group and 74% in the 45+ group. None of the Part F Dental Program recipients reported on HIV exposure risk factors, as they are not set up to report on their clients in this fashion.

2) Special Projects of National Significance (SPNS)

The SPNS program is intended to advance knowledge and skills in the delivery of health and support services to underserved PLWH. Special Projects of National Significance grants support the development of innovative models of service delivery and provide the mechanisms to assess and promote replication of effective models. The SPNS program is considered the research and development arm of the Ryan White Act. There are currently two programs (related to Medical Case Management, Housing, and electronic information systems) in the Boston EMA funded under a SPNS grant. A total of \$384,533 was allocated towards these two SPNS programs in the last fiscal year, of which \$284,533 was allocated towards direct services.

3) AIDS Education and Training Centers (AETC)

The AETC Program is a network of 15 regional centers and 75 associated sites, which conduct targeted, multi-disciplinary clinical education and training programs for health care providers. AIDS Education and Training Centers training and activities increase the number of health care providers who counsel, diagnose, treat and manage care for PLWH. The AETCs serve all 50 states, the Virgin Islands and Puerto Rico. Some AETCs have been funded to provide training on aspects of HIV prevention program design and implementation.

A total of \$1,210,000 was used within the Boston EMA in the most recent fiscal year. Each AETC regional center covers at least one Part A EMA, and collaboration between AETC and Part A is based on local needs. AIDS Education and Training Centers also collaborate with other Ryan White Act funded organizations, Area Health Education Centers (AHECs), community based HIV/AIDS organizations, medical and health professional schools, local hospitals, health departments, community and migrant health centers, medical societies and other professional organizations. The New England AETC (NEAETC) is located in Boston and serves Connecticut, Maine, Massachusetts, New Hampshire, Vermont, and Rhode Island. New England AIDS Education and Training Center subcontracts with local performance sites in each of the states in the region.

Ryan White Funding Analysis

For the most recent fiscal year, \$35,070,360 in Ryan White funding was distributed within the Boston EMA (Table II.A.1). The two largest Ryan White streams are Part B and Part A (\$14,820,326 and \$12,082,745, respectively), but these streams are intended to be used on a regional basis (Figure 18). Parts C, D and F, on the other hand, are directly awarded to health centers and AIDS Service Organizations (ASOs).

Figure 18: Ryan White Funding 2010 vs 2011 Comparison by Parts

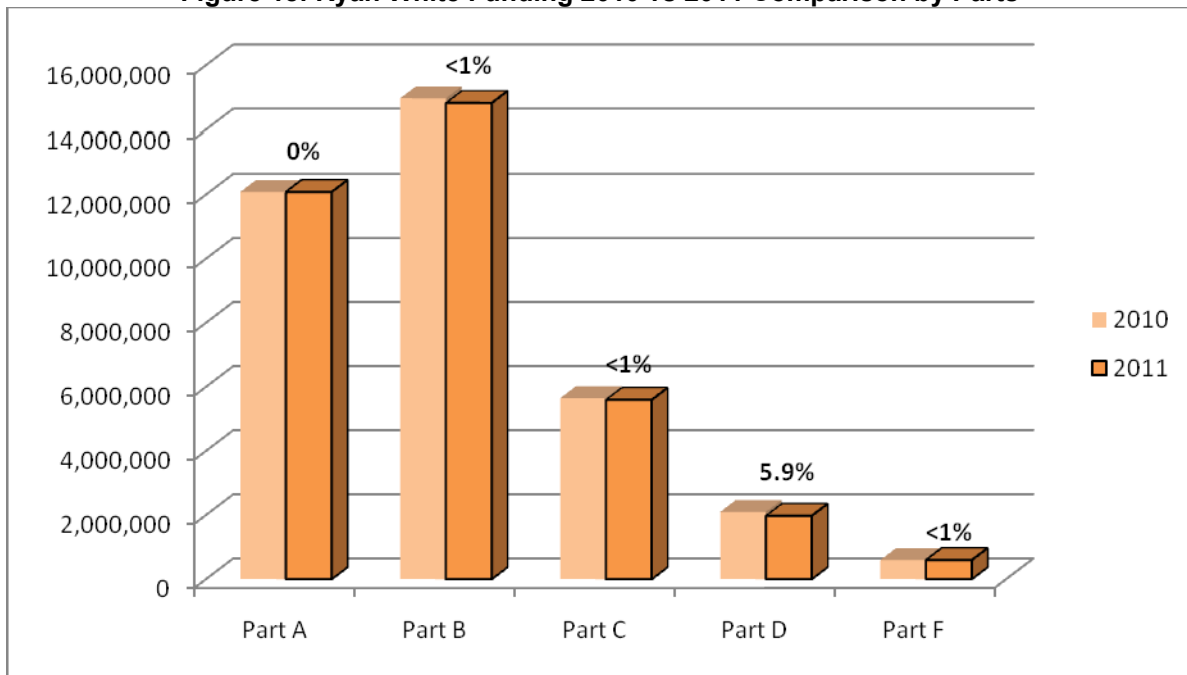


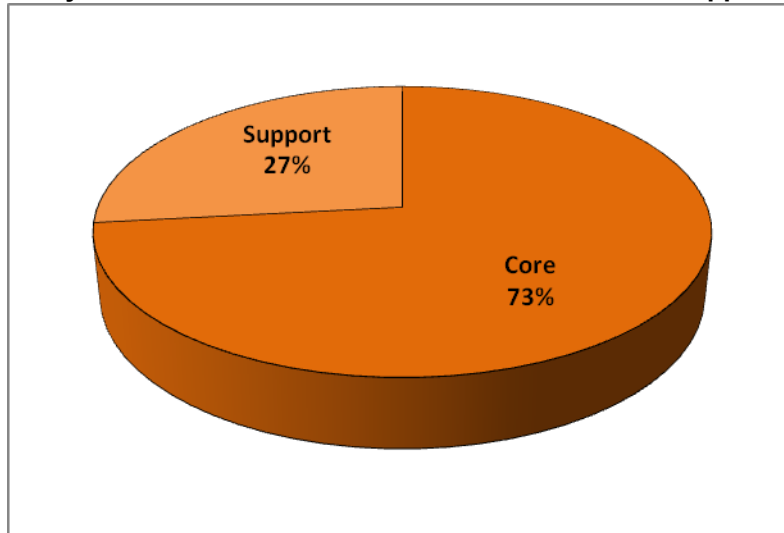
Table II.A.1. shows that ADAP, Medical Case Management, and Outpatient/Ambulatory Medical Care were the service categories that received the most funding of all Ryan White funding streams.

Table II.A.1: Service Category Funding Levels for Ryan White Funding Streams

Service Categories	Part A	Part B	Part C	Part D	Part F	Subtotal
Core Services						
ADAP/HDAP	\$1,888,389	\$10,666,860	\$0	\$0	\$0	\$12,555,249
Early Intervention Services	\$0	\$0	\$341,247	\$71,102	\$0	\$412,349
Health Insurance Premium & Cost Sharing Assistance	\$0	\$136,972	\$0	\$0	\$0	\$136,972
Home Health Care	\$0	\$47,364	\$0	\$0	\$0	\$47,364
Home and Community-based Health Services	\$0	\$32,671	\$41,117	\$0	\$0	\$73,788
Hospice Services	\$0	\$0	\$0	\$0	\$0	\$0
Medical Case Management	\$2,635,944	\$1,211,861	\$1,176,074	\$460,592	\$102,667	\$5,587,349
Medical Nutrition Therapy	\$714,821	\$9,135	\$129,126	\$0	\$0	\$853,082
Mental Health	\$283,278	\$50,057	\$502,897	\$64,183	\$0	\$900,415
Oral Health Care	\$685,684	\$13,273	\$211,424	\$0	\$309,876	\$1,220,257
Outpatient/Ambulatory Medical Care	\$153,681	\$64,041	\$2,856,779	\$686,242	\$0	\$3,760,743
Substance Abuse – Outpatient	\$80,033	\$17,466	\$58,084	\$0	\$0	\$155,583
Total Core Services	\$6,441,830	\$12,249,700	\$5,316,748	\$1,282,119	\$412,543	\$25,702,940
Support Services						
Case Management, Non-med	\$398,856	\$1,089,839	\$76,367	\$133,500	\$0	\$1,617,002
Child Care Services	\$0	\$8	\$0	\$325	\$0	\$331
Emergency Financial Assistance	\$0	\$27,973	\$0	\$9,819	\$0	\$42,678
Food Bank/Home-Delivered Meals	\$1,045,968	\$540,914	\$0	\$10,990	\$0	\$1,545,970
Health Education/Risk Reduction	\$0	\$576,217	\$43,166	\$110,602	\$0	\$684,984
Housing Services	\$1,964,981	\$0	\$0	\$0	\$181,866	\$2,146,847
Legal Services	\$0	\$8,370	\$0	\$0	\$0	\$132
Linguistic Services	\$0	\$0	\$44,729	\$0	\$0	\$40,302
Medical Transportation	\$367,237	\$98,112	\$11,550	\$50,913	\$0	\$523,188
Outreach Services	\$0	\$0	\$14,604	\$78,581	\$0	\$94,891
Permanency Planning	\$0	\$0	\$0	\$0	\$0	\$0
Psychosocial Support	\$895,594	\$220,520	\$9,517	\$214,117	\$0	\$1,317,091
Referral for Health Care/Supportive Services	\$0	\$0	\$49,997	\$31,668	\$0	\$57,665
Rehabilitation Services	\$0	\$0	\$0	\$0	\$0	\$0
Respite Care	\$0	\$8,673	\$0	\$0	\$0	\$7,896
Substance Abuse –Residential	\$968,279	\$0	\$0	\$0	\$0	\$968,279
Treatment Adherence Counseling	\$0	\$0	\$29,503	\$35,095	\$0	\$118,482
Total Support Services	\$5,640,915	\$2,570,626	\$279,433	\$675,610	\$181,866	\$9,165,738
Total of All Services	\$12,082,745	\$14,820,326	\$5,572,947	\$2,099,808	\$594,409	\$35,396,081

Among Ryan White funding streams, 73% of direct service funding was invested in core medical services and 27% was invested in HIV health-related support services (Figure 19). This is of particular importance, because these funding streams are subject to the HRSA requirement that at least 75% of direct service funding be invested in the core medical services.

Figure 19: Ryan White Core Medical and HIV Health-Related Support Services

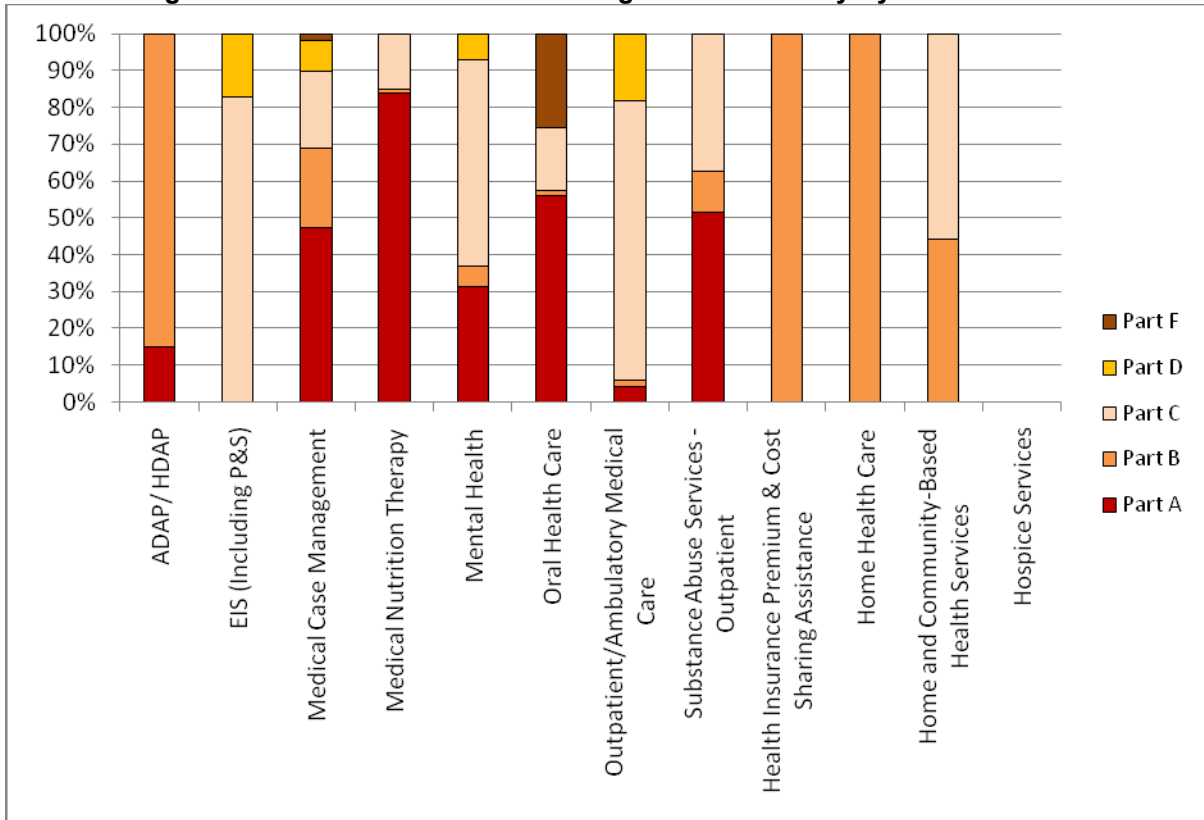


Each Ryan White funding part provides for a different service mix. Figures 20 and 21 show the proportional contribution of each Ryan White stream to the mix of core and support services in the Boston EMA. Among Ryan White funding streams, Part B makes the largest contribution to core medical services. This is due to the large amount of funding provided to the HDAP/ADAP programs as is seen in the ADAP service category.

For all funding streams except Part A, the majority of funding is invested in core medical services. As the ultimate payer of last resort in the Boston EMA, Part A funding is the most flexible in terms of its use for HIV health-related support services, as long as sufficient funding is available to ensure that PLWH can access core medical services. Since so many other funding streams are in operation in the Boston EMA, Part A funds can be used to fill HIV health-related support service gaps in the continuum of care if the Planning Council feels it is needed.

Part A funding for core services is most substantial for Medical Case Management, Medical Nutrition Therapy, Oral Health, and Substance Abuse Outpatient Services in comparison with other Ryan White streams. Part B funding is most substantial for ADAP, Home Health Care, and Health Insurance Premium and Cost Sharing Assistance in comparison with other Ryan White Streams. Part C funds the majority of Early Intervention Services, Home and Community-Based Health Services, Mental Health, and Outpatient/Ambulatory Medical Care in comparison with other Ryan White Streams in the Boston EMA. Part F funds make their most substantial contribution in Oral Health Care (Figure 20).

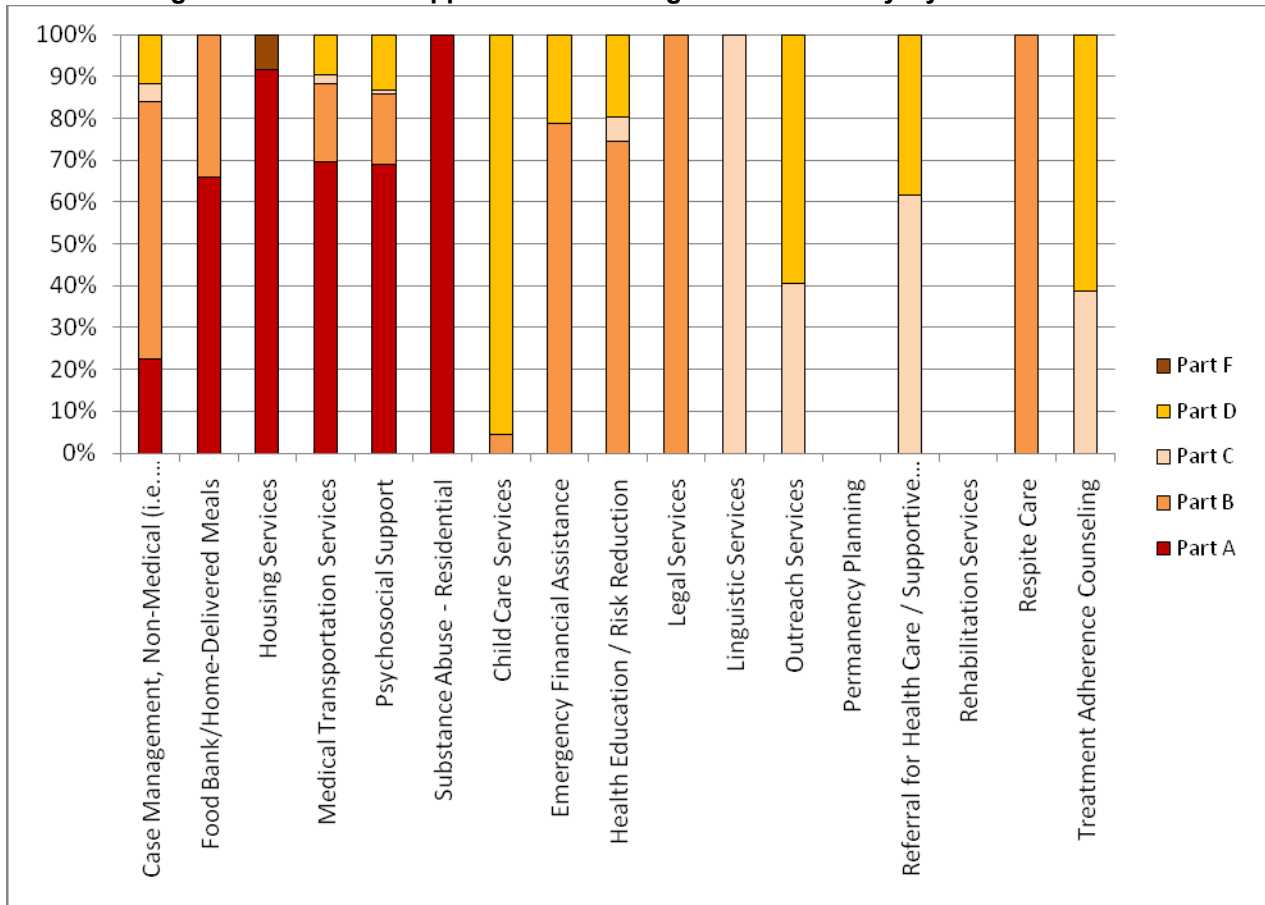
Figure 20: Share of Core Service Categories Covered by Ryan White Parts



NOTE: The bars on this graph represent the proportion of the total allocation for each service category. Some of these allocations are millions of dollars and some are thousands. See Table II.A.1 for the funding level of each individual service category and funding stream

Part A funding for support services is most substantial for Food Bank/Home-Delivered Meals, Housing, Medical Transportation, Psychosocial Support and Substance Abuse Residential in comparison with other Ryan White streams. Part B funding is most substantial for Case Management, Non-medical, Emergency Financial Assistance, Health Education/Risk Reduction, Legal Services, and Respite Care in comparison with other Ryan White Streams. Part C funds all of Linguistic Services, and the majority of Referral for Health Care/Supportive Services. Part D funds the majority of Child Care Services, Outreach Services, and Treatment Adherence Counseling. Part F funds make its most substantial contribution in Housing (Figure 21).

Figure 21: Share of Support Service Categories Covered by Ryan White Parts



Ryan White Utilization

Utilization data is difficult to capture. For the purpose of this report, each contacted provider was asked to provide utilization data on unduplicated consumers within their most recent fiscal year. For funding streams with single providers, there is unduplicated consumer utilization, but there is the potential for duplication in funding streams across multiple providers. The same caution carries over to all Ryan White streams, because when aggregated there will be duplication of client utilization data. There are additional cautions for this particular set of utilization figures: Part B utilization data only includes New Hampshire, because Massachusetts provided an aggregate of all clients served by money that is allocated by the Massachusetts Department of Public Health. Part F data does not include modes of HIV exposure, because none of the dental institutions collect this data. Finally, utilization data that did not have the racial component completed was grouped into the ‘Some Other Race’ category.

Table II.A.2: Utilization of Ryan White Funds by Demographic and HIV Exposure Groups

Group	Part A Funding		Part B Funding		Part C Funding		Part D Funding		Part F Funding		Ryan White Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Race												
White	2355	37.0%	321	67.9%	2689	63.9%	197	20.3%	212	51.5%	5774	46.0%
Black or African Am	1593	25.0%	72	15.2%	1110	26.4%	525	54.0%	58	14.1%	3358	26.8%
American Ind/Alaskan	10	0.2%	3	0.6%	11	0.3%	1	0.1%	1	0.2%	26	0.2%
Asian	59	0.9%	7	1.5%	98	2.3%	13	1.3%	1	0.2%	178	1.4%
Other	2	0.0%	1	0.2%	175	4.2%	195	20.1%	0	0.0%	373	3.0%
Two or more races	1204	18.9%	69	14.6%	124	2.9%	41	4.2%	140	34.0%	1578	12.6%
Unreported	1143	18.0%	0	0.0%	117	2.8%	0	0.0%	0	0.0%	1260	10.0%
Total	6366	100.0%	473	100.0%	4324	100.0%	972	100.0%	412	100.0%	12547	100.0%
Ethnicity												
Hispanic	2095	33.6%	61	12.9%	885	19.7%	254	26.1%	37	9.0%	3332	26.5%
Not Hispanic	4139	66.4%	412	87.1%	3612	80.3%	718	73.9%	375	91.0%	9256	73.5%
Total	6234	100.0%	473	100.0%	4497	100.0%	972	100.0%	412	100.0%	12588	100.0%
Age												
<13 years	49	0.8%	3	0.6%	7	0.2%	168	17.3%	0	0.0%	227	1.8%
13-19 years	70	1.1%	2	0.4%	72	1.6%	281	28.9%	1	0.2%	426	3.3%
20-44 years	2395	37.6%	185	39.1%	1937	42.8%	341	35.1%	106	25.7%	4964	38.9%
45+ years	3852	60.5%	283	59.8%	2512	55.5%	182	18.7%	305	74.0%	7134	55.9%
Total	6366	100.0%	473	100.0%	4528	100.0%	972	100.0%	412	100.0%	12751	100.0%
Adult/Adolescent HIV Exposure												
MSM	1869	30.1%	226	47.8%	1949	46.0%	88	16.2%	0	NA	4132	36.1%
IDUs	1566	25.2%	59	12.5%	726	17.1%	87	16.1%	0	NA	2438	21.3%
MSM and IDUs	210	3.4%	0	0.0%	66	1.6%	1	0.2%	0	NA	277	2.4%
Heterosexual	2214	35.7%	138	29.2%	1130	26.7%	313	57.7%	0	NA	3795	33.1%
Other/blood trans	204	3.3%	11	2.3%	38	0.9%	10	1.8%	0	NA	263	2.3%
Risk not reported	144	2.3%	39	8.2%	330	7.8%	43	7.9%	0	NA	556	4.9%
Total	6207	100.0%	473	100.0%	4239	100.0%	542	100.0%	0	NA	11461	100.0%
Pediatric HIV Exposure												
Mother at risk for HIV	159	100.0%	3	100.0%	23	92.0%	388	100.0%	0	0	573	99.7%
Other/blood trans	0	0.0%	0	0.0%	2	8.0%	0	0.0%	0	0	2	0.3%
Risk not reported	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0	0	0.0%
Total	159	100.0%	3	100.0%	25	100.0%	388	100.0%	0	0	575	100.0%

† Part B utilization includes only NH, MA utilization data is included in MA AIDS Line Item under State funding streams.

‡ Part F data was only provided by one program, and does not include modes of HIV exposure. None of the dental institutions collect this data

Table II.A.2 shows the utilization data for Ryan White funding streams during the period of time under study for this report. Part A provided HIV/AIDS services to the most PLWH in the Boston EMA during this period of time (6,336 PLWH) and Part C provided services to 4,324 PLWH. The following figures examine the demographic profile of each Ryan White funding stream in further detail.

Figure 22 examines utilization by racial group and Figure 23 examines utilization by ethnic group. The majority of PLWH served with Ryan White funds are White, except for services provided through Part D. Similarly, none of the Ryan White funding streams provides services to more than 35% PLWH who are Hispanic.

Figure 22: Utilization of Ryan White by Part and Race

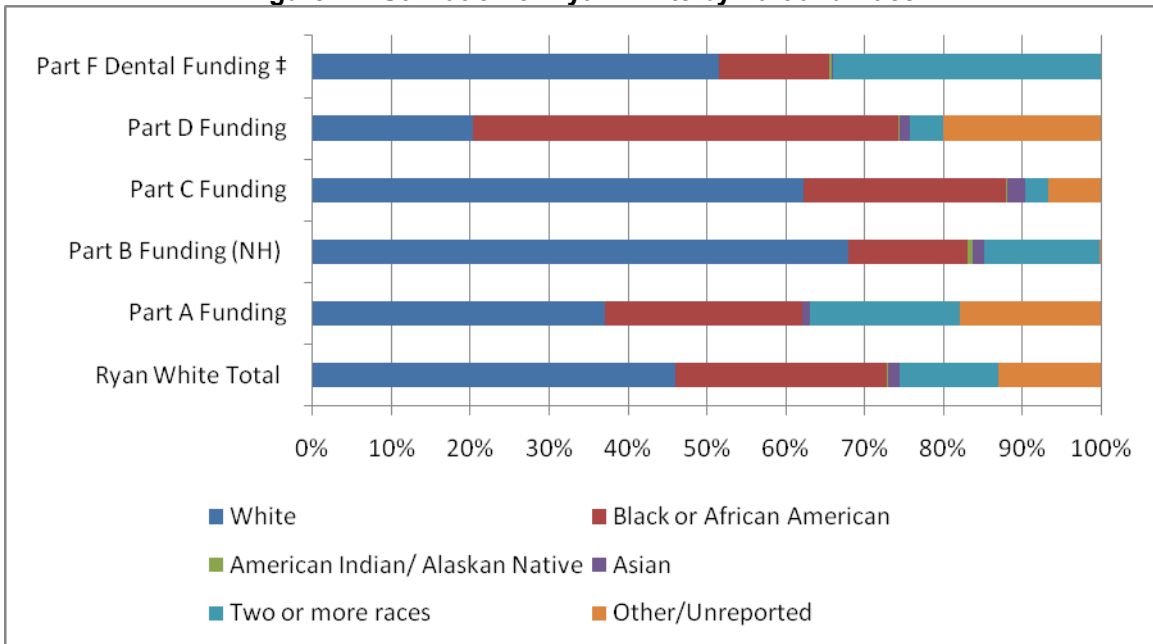


Figure 23: Utilization of Ryan White by Part and Ethnicity

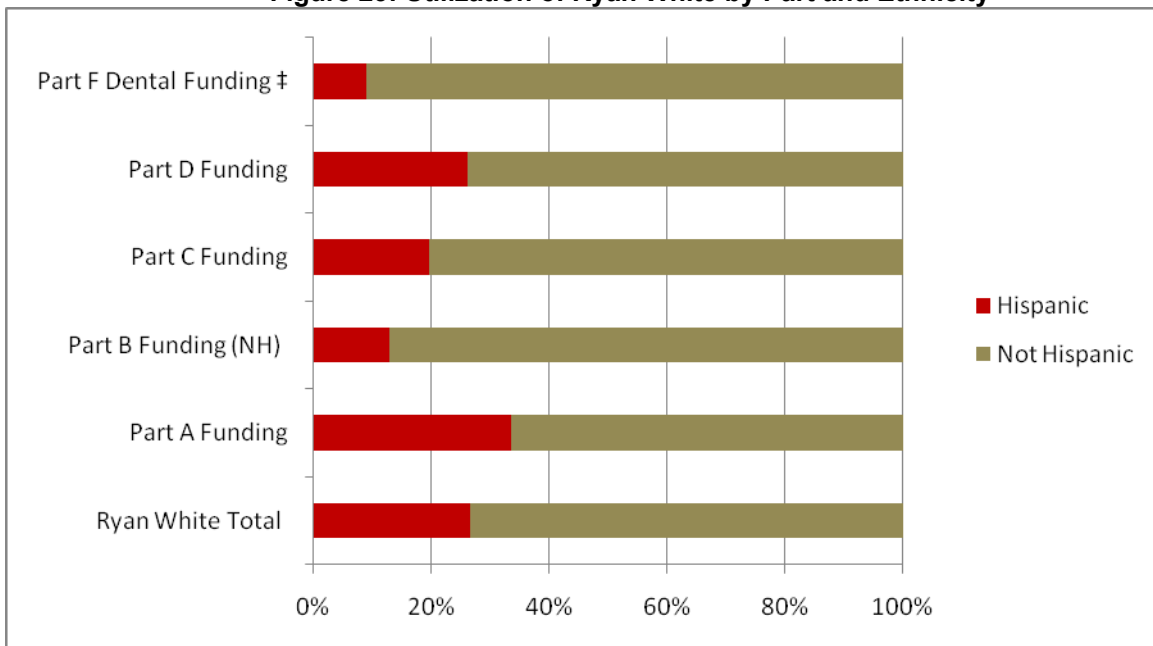


Figure 24 examines utilization by age group. The majority of PLWH served with Ryan White funds fall in the 20-44 and 45+ age groups. Again, the notable exception is Part D, which is discussed in further detail below.

Figure 24: Utilization of Ryan White by Part and Age

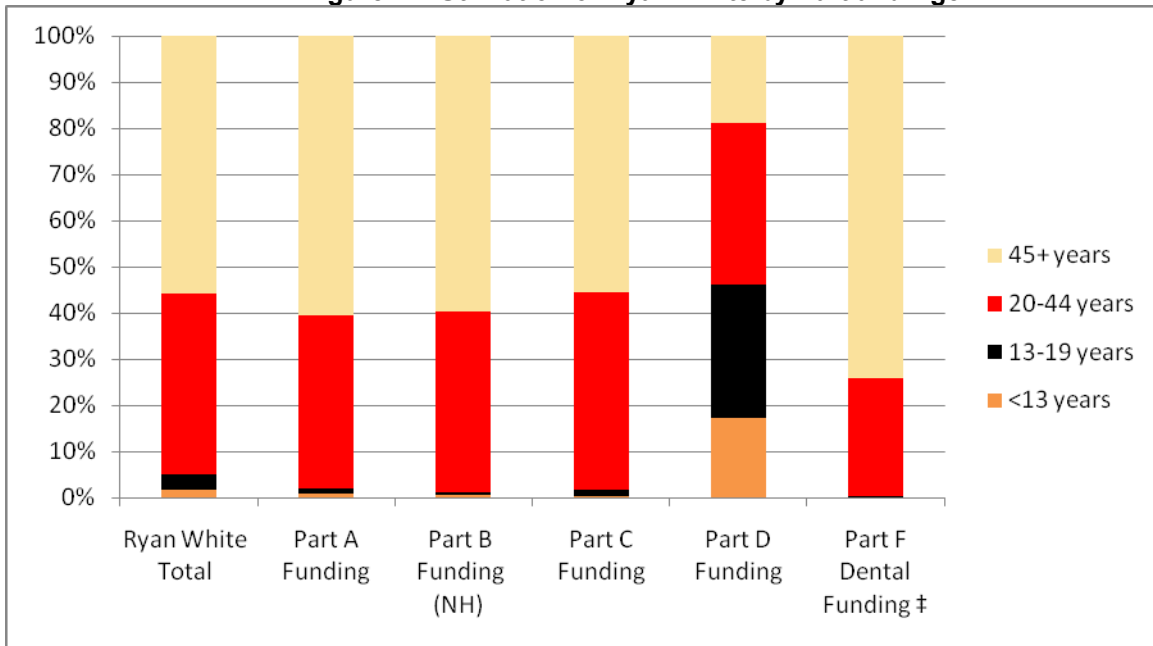
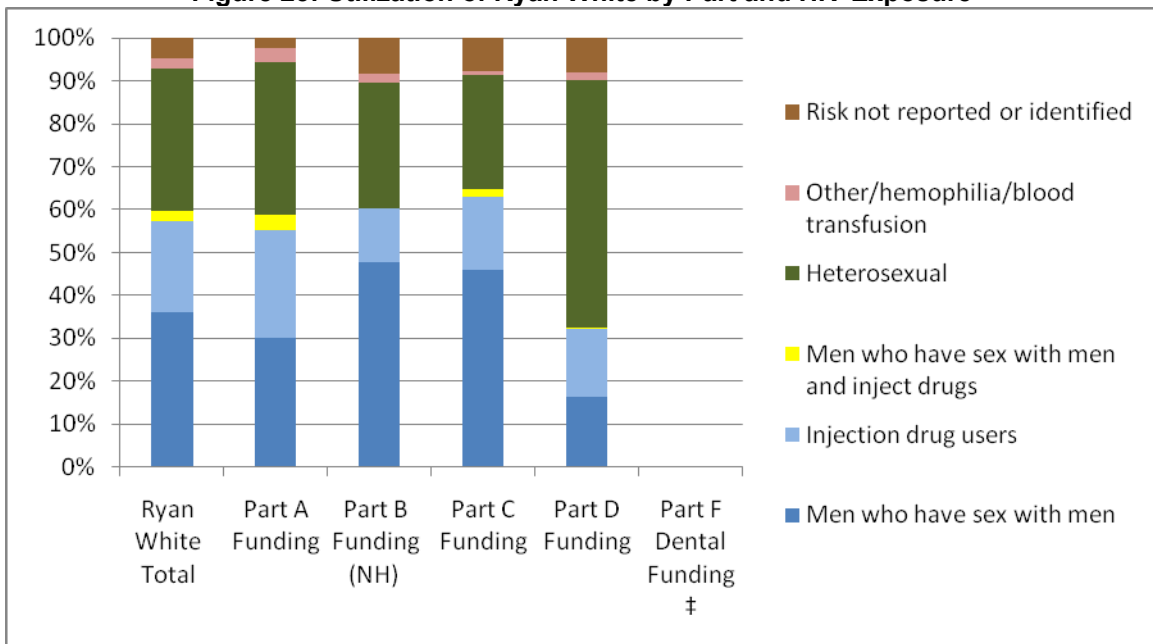


Figure 25 shows utilization by HIV exposure group. Part F is the only service category whose institutions do not collect this type of data. Men who have Sex with Men (MSM) and Heterosexual modes of exposure remain the predominant ways people become infected with HIV among Ryan White funding streams.

Figure 25: Utilization of Ryan White by Part and HIV Exposure



Conclusion

This section of the Funding Streams Report discussed Ryan White Parts A-F, which make up 14% of funding for HIV/AIDS services in the Boston EMA. Of the health centers and ASOs funded by Ryan White programs (Parts C, D and F Dental); the majority are located in the most densely populated region of the EMA, Suffolk County.

As a whole, Ryan White programs within the Boston EMA are in line with the core medical services requirement: 73% of total Ryan White funds are invested in core medical services. Only Parts A, B and C are required to abide by the 75/25 clause. Among Part A funded direct services, 53% are obligated to core medical services. For Parts B and C, 83% and 95% of direct service funding is invested in core medical services.

There is substantial overlap between programs in terms of PLWH served, and there is no reliable method of calculating what percentage of PLWH in the Boston EMA is accessing any Ryan White funding stream.

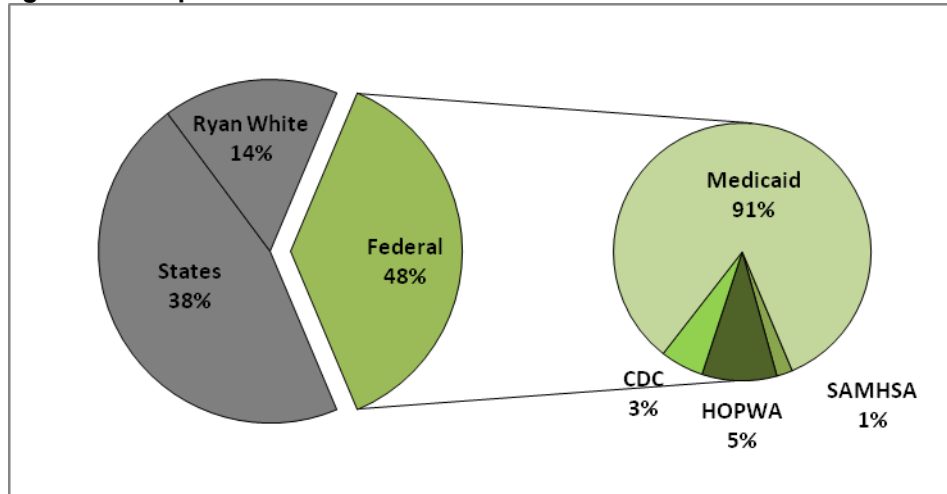
Ryan White funding has had an immense effect on its service areas. It is unique in its role as payer of last resort and has the ability to evolve with changes in the epidemic. This is especially true for Part A services which are overseen by the Planning Council. The Ryan White Planning Council prioritizes and allocates Federal funding through an in-depth community process. Looking specifically at the Ryan White service profile it is apparent that the dollars are reaching the populations most in need, as well as emerging communities.

Despite the fact that there is no way to extract a percentage of PLWH who are accessing only Ryan White funding streams, utilization information provides confirmation that through the balance of expenditure across Ryan White allocations the EMA is able to adapt to the changing needs of PLWH.

Section III: Other Federal Funding Streams

This section describes the share of total HIV-related funding that is associated with non-Ryan White funding streams: Centers for Medicare and Medicaid Services (CMS), United States Department of Housing and Urban Development (HUD), Centers for Disease Control and Prevention (CDC), and Substance Abuse and Mental Health Services Administration (SAMHSA). Other Federal funding represents 49% of total funding for HIV/AIDS services in the Boston EMA (Figure 26).

Figure 26: Proportion of Other Federal Streams in Total HIV-Related Funding



Introduction

Many medical and social services for PLWH are funded by federal sources that are not associated with the Ryan White Act. Some of these services are specifically designed to provide supports to PLWH, but most of these programs do not have this focus. Services that are not focused on HIV are targeted to the working poor and other disadvantaged groups with whom there is substantial overlap in the HIV+ community.

Other Federal Streams

Center for Medicare and Medicaid Services (CMS) - Medicaid

Medicaid is the federal health insurance program administered by the states where each state sets its own guidelines regarding eligibility and service provision. Each state receives a grant from the Federal government, which states supplement with their own funds. States are left to their own discretion in deciding the level of supplemental funding to add on top of the Federal Medicaid grant. For data collected for the 2011 Funding Streams Report, it was estimated that in Massachusetts 60% of MassHealth (the state Medicaid program) funding is Federal and the other 40% is State's contribution. In NH, the State Medicaid program contributes 49.5% and CMS contributes 50.5% of Medicaid funding. Massachusetts state officials developed and received federal approval for a waiver program in 2001 to expand MassHealth coverage to PLWH under 65 with incomes up to 200% of the FPL.

Eligibility for Medicaid in NH is more restrictive than in MA, requiring that individuals meet criteria for one of the NH eligibility categories, including financial requirements such as low-income and limited assets. In NH, a PLWH would be required to have a disability (AIDS diagnosis), and includes both an income limit of 72% FPL and an assets limit. Those with resources in excess of these limits may be eligible for the “In and Out Medical Assistance Program” that covers some medical expenses after an individual has spent down to the protected income level. In addition, Medicaid for Employed Adults with Disabilities (MEAD) has been available for disabled individuals who work. The income limit for this program is \$4,062 per month for an individual, with an assets limit of \$24,991. In addition to the eligibility requirements, the services covered by the NH Medicaid program are more restrictive than those covered in MA.

Funding Level

Medicaid funding is estimated using cost data for the most recent fiscal year. In the Boston EMA, Medicaid is the primary payer of health services for PLWH, accounting for over 50% of the total funding for Home and Community-Based Health Services, Hospice Services, Outpatient/Ambulatory Medical Care, Medical Transportation, and Rehabilitation Services.

Resource Inventory

In MA, the standard MassHealth benefits package covers comprehensive primary and inpatient health services, including primary care, ob/gyn, substance abuse, mental health, and transportation services. MassHealth enrolled consumers pay co-pays for medical services and prescription medications.

Similar to MA, the NH Medicaid program covers primary and inpatient health services, including primary care, ob/gyn care, mental health, and transportation services, but with coverage limits that may be restrictive to the needs of PLWH. The NH Medicaid program also includes drug benefits that have prescription limits and co-payments. Unlike MA, NH does not provide substance abuse services for Medicaid beneficiaries.

Utilization

Unique Federal Medicaid utilization data was not available. Both MA and NH reported both Federal and State Medicaid data together, and is included in the utilization data for MassHealth and NH Medicaid under the State funding streams.

Center for Medicare and Medicaid Services (CMS) - Medicare

Medicare is the federal health insurance program that is administered by the Federal government. Eligibility for Medicare is limited to those who are at least 65 years old or who are disabled (AIDS diagnosis). Some people are eligible for both Medicaid and Medicare and are thus considered dually-eligible. People who are dually-eligible typically receive the most support from their Medicaid funded programs, as Medicaid services are usually more comprehensive in scope than Medicare services. For these consumers, Medicare is considered the primary payer and Medicaid pays for what is leftover.

Medicare prescription drug coverage is available to everyone through Medicare Part D. Private insurance companies provide drug coverage for beneficiaries who enroll and pay premiums. Under Part D, members have a set prescription benefit plan that covers only certain medications, and co-payments range from \$0-\$5. Part D covers the cost of medications up to \$2,500 per member and then resumes coverage when the true out of pocket cost exceeds \$5,100. Once the Part D benefit has entered this doughnut hole threshold, ADAP funds assist in covering medication costs. In the case of HIV+ members, HDAP not only assists in covering Part D costs, but must also fill in the “medigap.”

Due to the recent federal health care reform, drug assistance given by ADAP now counts as “true out of pocket cost”. Prior to federal health care reform, ADAP assistance did not count towards “true out of pocket cost,” and Medicare did not resume coverage for people who receives assistance after reaching the threshold. For those who are not Medicare-eligible, MassHealth continues to provide coverage.

Due to the way the Medicare system is set up, there is no way to determine the amount of Medicare funding or utilization used by PLWH in the Boston EMA. In the future, it might be effective to contact CMS personnel and private insurers involved in the Medicare system as part of the *Funding Streams* and *Needs Assessment* process.

Housing Opportunities for Persons with AIDS (HOPWA)

The Housing Opportunities for Persons with AIDS (HOPWA) program was established by US Department of Housing and Urban Development (HUD) to address the specific needs of PLWH and their families. Grants are awarded by HOPWA to local communities, states, and non-profit organizations for projects that benefit low income PLWH and their families. HOPWA funds are awarded as grants from one of three programs:

- The HOPWA Formula Program uses a statutory method to allocate HOPWA funds to eligible States and cities on behalf of their metropolitan areas;
- The HOPWA Competitive Program is a national competition to select model projects or programs; and
- The HOPWA National Technical Assistance Funding awards are provided to strengthen the management, operation, and capacity of HOPWA grantees, project sponsors, and potential applicants of HOPWA funding.

HOPWA funding provides housing assistance and related supportive services as part of HUD’s Consolidated Planning initiative which works in partnership with communities and neighborhoods in managing Federal funds appropriated to HIV/AIDS programs. HOPWA grantees are encouraged to develop community-wide strategies and form partnerships with area non-profit organizations.

Two additional HUD programs provide services to PLWH in the Boston EMA. The Supportive Housing Program and the Shelter Plus Care Program are small, but important funding streams in the City of Boston. The Supportive Housing Program (SHP) provides funding for the development of transitional and permanent supportive housing and services that help homeless persons transition from homelessness to living as independently as possible. Some services are also funded to assist in achieving the goal of self-sufficiency. The Shelter Plus Care Program provides rental assistance for hard-to-serve homeless persons with disabilities in connection with supportive services funded from sources outside the program.

Funding Level

There was \$6,386,701 in HOPWA funding in the Boston EMA in the most recent fiscal year. Most HOPWA fiscal years run from July to June.

Resource Inventory

HOPWA funds are used for a wide range of housing, social services, program planning, and development costs. These include, but are not limited to, the acquisition, rehabilitation, or new construction of housing units; costs for facility operations; rental assistance; and short-term payments to prevent homelessness. HOPWA funds also may be used for health care and mental health services, chemical dependency treatment, nutritional services, case management, assistance with daily living,

and other supportive services. Many beneficiaries receive supportive services that are funded by HOPWA or other related public and private programs. Similar to Medicaid, states and cities may supplement funding provided by the HOPWA program with additional funding at their discretion.

Since FY 05, HOPWA funding has been decentralized so that it is broken up among many municipalities and agencies; and is no longer solely distributed by the City of Boston and the Commonwealth of MA. Boston EMA municipalities funded by HOPWA include: Boston (\$1,661,230), Lowell (\$466,829), Lynn (\$280,275), and Worcester (\$355,247). The City of Nashua, NH was awarded \$413,424 in HOPWA funding for the most recently completed fiscal year. A limitation of the *2011 Funding Streams* report is that there is potentially a slight over-estimate of HOPWA dollars in the Boston EMA. This is due to incomplete data from agencies and municipalities. It was impossible to discern what funding was allocated towards each agency in the municipality data. Also, one city did not submit data. This limitation is not thought to greatly affect the percentage of HOPWA dollars in the system.

Utilization

In total, HOPWA funding provided services to 3,931 PLWH in the Boston EMA in the most recent fiscal year. The majority of the consumers served with HOPWA funding in the Boston EMA were White (36.4%), 33.9% were Black, and 32.0% were Hispanic. As expected, most HOPWA services in the Boston EMA were utilized by people 20 years and older, with 51.3% in the 20-44 group and 37.0% in the 45+ group. Heterosexual contact is the most prevalent mode of HIV exposure among HOPWA consumers (43.6%), with MSM and IDU following as the second and third most common mode of exposure (23.2% and 22.0%). Of the 4 pediatric consumers receiving Part C funded services in the Boston EMA, all were exposed by their mother who was at risk for or already infected with HIV when the infant was born.

Centers for Disease Control and Prevention (CDC)

As a part of its overall public health mission, CDC provides leadership in helping control the HIV/AIDS epidemic by working with community, state, national, and international partners in surveillance, research, and prevention and evaluation activities. These activities are critically important, because CDC estimates that over 1.1 million Americans are living with HIV, and 1 in 5 of these people are unaware of their HIV infection.

In addition, the number of people living with HIV is increasing, as effective new drug therapies keep HIV-infected persons healthy longer and dramatically reduce the death rate. CDC's programs work to improve treatment, care, and support for PLWH and to build capacity and infrastructure to address the HIV/AIDS epidemic in the United States and around the world.

Funding Level

Both MA and NH received CDC funding for HIV/AIDS prevention. A total of \$3,442,575 was allocated towards prevention and screening programs in the last fiscal year. There are also five agencies operating within the Boston EMA that receive smaller grants directly from the CDC.

Resource Inventory

In NH, CDC money is used to fund HIV/AIDS prevention and education programs, as well as prevention and screening programs. In MA, CDC money also funds prevention and screening programs, as well as correctional programs, and training/capacity building.

Utilization

At this time, utilization information is only available for NH, as MA provided aggregate utilization data for all programs funded through the Office of HIV/AIDS at MDPH. In NH, CDC funds served 2,079 people with and at risk for HIV infection. Of those, 86.9% were White, 13.0% were Hispanic, 71.5% were between the age of 20-44, and the majority (59.9%) were exposed to HIV/AIDS through heterosexual contact.

Substance Abuse and Mental Health Services Administration (SAMHSA)

The Substance Abuse and Mental Health Services Administration provides comprehensive HIV prevention and treatment that includes a variety of complementary components to help drug-using populations increase their protective behaviors, and reduce their risks for HIV/AIDS and other blood-borne infections. HIV/AIDS related goals of SAMHSA programs include:

- To make an impact on curbing the nation's HIV/AIDS epidemic;
- To disseminate knowledge about the mental health aspects of HIV/AIDS and the ethical issues of providing services to people living with or affected by HIV/AIDS;
- To identify effective approaches for delivering mental health services to people living with HIV/AIDS and disseminate these findings to health care providers who serve the HIV/AIDS population; and
- To improve the health outcomes of people living with HIV/AIDS who also have a mental and substance use disorder.

Funding Level

Massachusetts received \$597,874 in HIV-specific SAMHSA funding in the most recent complete fiscal year. Within the Boston EMA, NH does not receive SAMHSA funding.

Resource Inventory

The HIV-specific SAMHSA funding is blended in with general Bureau of Substance Abuse (BSAS) funding in MA. The resources provided cover the full scope of BSAS services, which will be discussed in the next section.

Utilization

SAMHSA utilization in Massachusetts is an estimate due to the method BSAS utilizes to collect demographic data on its clients. In MA, 80.9% of people served by SAMHSA funds were White, 10.9% were Hispanic, and 74.3% were between the age of 20-44. Exposure data is not collected by SAMHSA.

Other Federal Funding Analysis

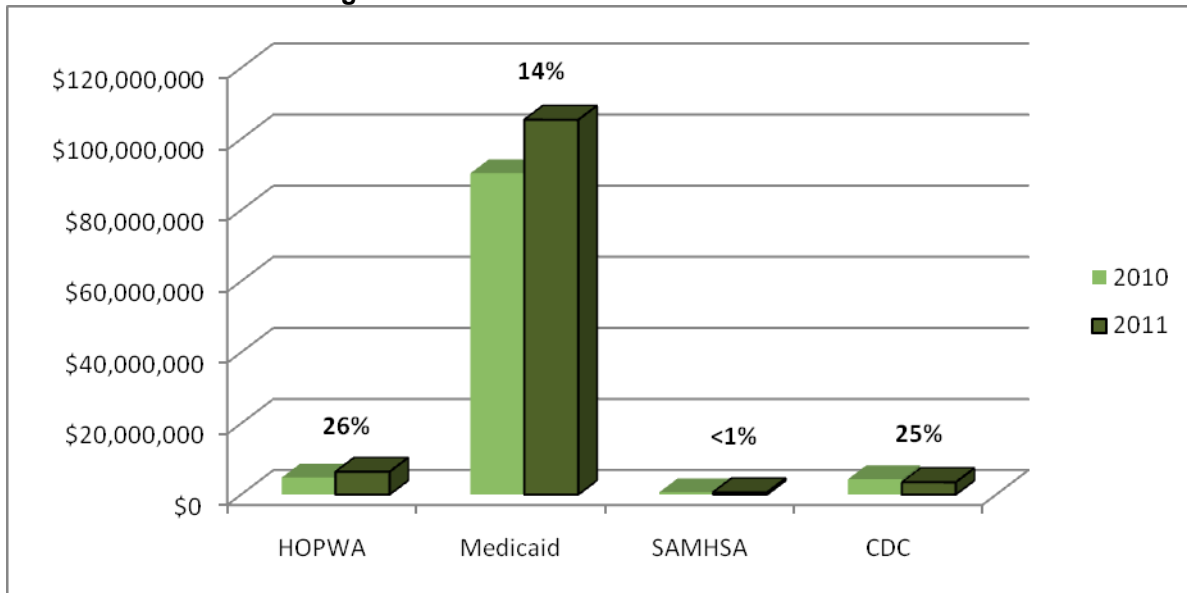
For the period of time reviewed in this report, \$115,832,371 in Other Federal funding was in operation within the Boston EMA. Each funding stream provides for a different service mix (Table III.A.1).

Table III.A.1: Service Category Funding Levels for Other Federal Funding Streams

Service Categories	HOPWA	Medicaid	SAMHSA	CDC	Subtotal
Core Services					
ADAP/HDAP	\$0	\$0	\$0	\$0	\$0
Early Intervention Services	\$0	\$0	\$0	\$3,442,575	\$3,442,575
Health Insurance Premium & Cost Sharing Assistance	\$0	\$0	\$0	\$0	\$0
Home Health Care	\$0	\$7,107,369	\$0	\$0	\$7,107,369
Home and Community-based Health Services	\$0	\$2,887,877	\$0	\$0	\$2,887,877
Hospice Services	\$0	\$689,373	\$0	\$0	\$689,373
Medical Case Management	\$453,702	\$28,642	\$0	\$0	\$482,344
Medical Nutrition Therapy	\$63	\$0	\$0	\$0	\$63
Mental Health	\$6,988	\$2,451,947	\$0	\$0	\$2,458,935
Oral Health Care	\$0	\$2,489,806	\$0	\$0	\$2,489,806
Outpatient/Ambulatory Medical Care	\$0	\$84,804,068	\$0	\$0	\$84,804,068
Substance Abuse – Outpatient	\$7,384	\$812,291	\$139,367	\$0	\$959,042
Total Core Services	\$468,137	\$101,271,373	\$139,367	\$3,442,575	\$105,321,452
Support Services					
Case Management, Non-med	\$1,306,448	\$0	\$0	\$0	\$1,306,448
Child Care Services	\$0	\$0	\$0	\$0	\$0
Emergency Financial Assistance	\$434,107	\$0	\$0	\$0	\$434,107
Food Bank/Home-Delivered Meals	\$13,581	\$0	\$0	\$0	\$13,581
Health Education/ Risk Reduction	\$33,687	\$0	\$0	\$0	\$33,687
Housing Services	\$3,074,776	\$0	\$0	\$0	\$3,074,776
Legal Services	\$992	\$0	\$0	\$0	\$992
Linguistic Services	\$8,889	\$0	\$0	\$0	\$8,889
Medical Transportation	\$10,883	\$3,549,579	\$0	\$0	\$3,560,462
Outreach Services	\$5,589	\$0	\$0	\$0	\$5,589
Permanency Planning	\$0	\$0	\$0	\$0	\$0
Psychosocial Support	\$4,500	\$0	\$0	\$0	\$4,500
Referral for Health Care/Supportive Services	\$1,025,112	\$0	\$0	\$0	\$1,025,112
Rehabilitation Services	\$0	\$584,268	\$0	\$0	\$584,268
Respite Care	\$0	\$0	\$0	\$0	\$0
Substance Abuse –Residential	\$0	\$0	\$458,507	\$0	\$458,507
Treatment Adherence Counseling	\$0	\$0	\$0	\$0	\$0
Total Support Services	\$5,918,564	\$4,133,847	\$458,507	\$0	\$10,510,918
Total of All Services	\$6,386,701	\$105,405,221	\$597,874	\$3,442,575	\$115,832,371

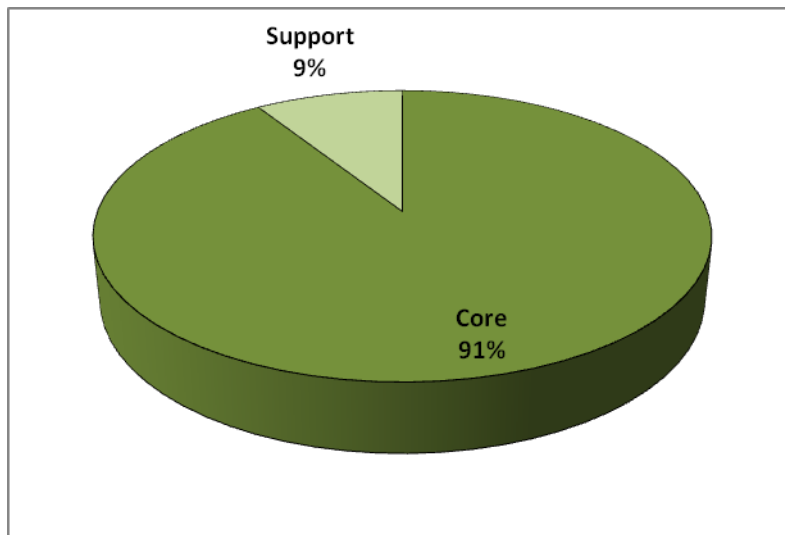
The two largest Other Federal funding streams are Medicaid and CDC (Figure 27).

Figure 27: Other Federal Funds 2010 vs 2011



Among Other Federal funding streams, 91% of direct service funding was invested in core medical services (Figure 28). Only Ryan White funding streams must abide by the 75/25 clause so this information is less vital for Other Federal streams. At the same time, this information speaks to the devotion regional providers have in prioritizing core medical services.

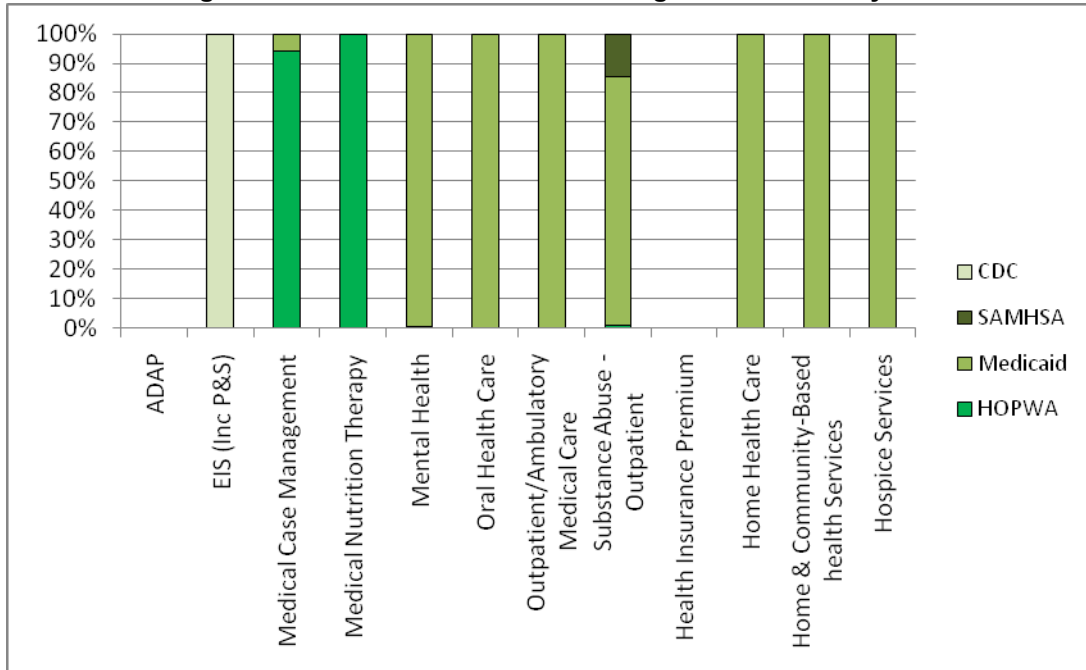
Figure 28: Other Federal Streams Core Medical and HIV Health-Related Support Services



Figures 29 and 30 show the core and support service category breakdown as a proportion of the whole pot of Other Federal funding available in the Boston EMA. Each service category is stratified by the Other Federal streams.

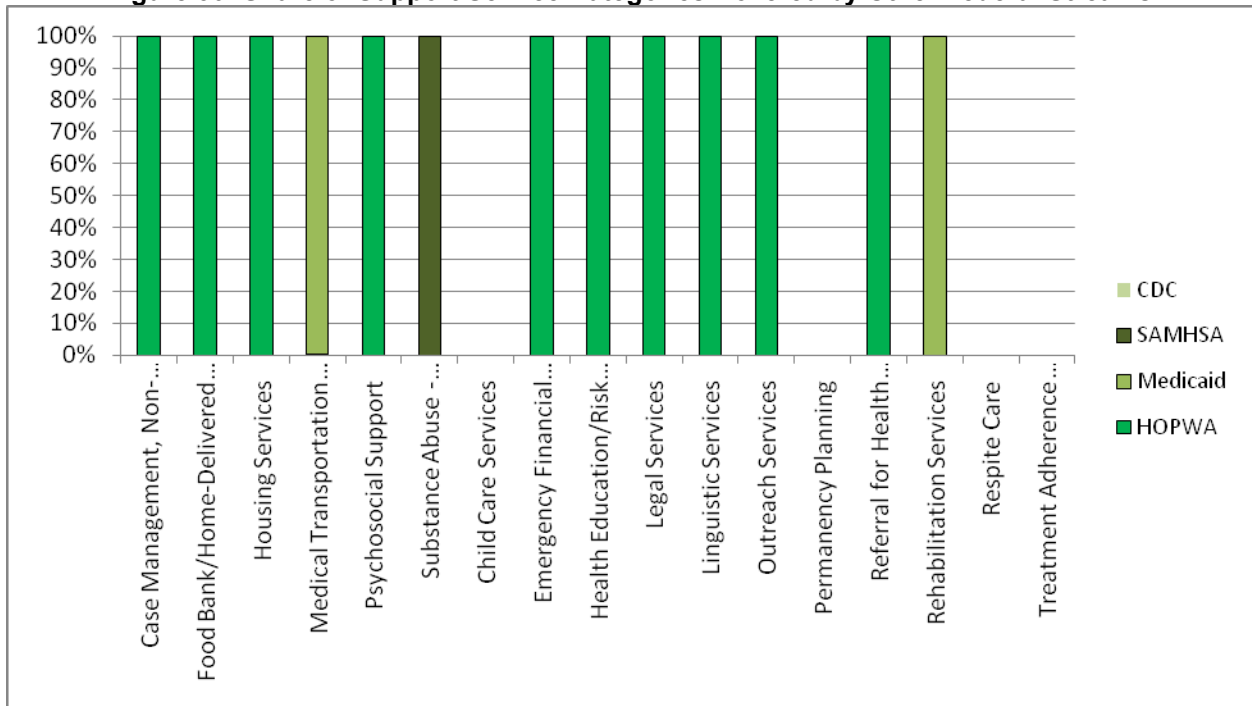
HOPWA funding is most substantial for Medical Case Management and Medical Nutrition Therapy in comparison with Other Federal streams. Medicaid provides the majority of the funding for all of the core services, except Medical Case Management and Medical Nutrition Therapy. The Other Federal funding streams do not contribute to ADAP, Early Intervention Services, or Health Insurance Premium and Cost Sharing Assistance (Figure 29).

Figure 29: Share of Core Service Categories Covered by Other Federal Streams



The most substantial amount of funding for Substance Abuse Services Residential in comparison with Other Federal streams is provided by SAMHSA. Medicaid provides all the funding for Medical Transportation, and Rehabilitation Services. All the funding for the remaining support service categories comes from HOPWA. The Other Federal funding streams do not contribute to Child Care Services, Permanency Planning, Respite Care, and Treatment Adherence Counseling. In addition, CDC does not provide any funding for support services (Figure 30).

Figure 30: Share of Support Service Categories Covered by Other Federal Streams



NOTE: The bars on this graph represent the proportion of the total allocation for each service category. Some of these allocations are millions of dollars and some are thousands. See Table III.A.1 for the funding level of each individual service category and funding stream.

Other Federal Funding Utilization

Utilization data is difficult to capture. For the purpose of this report, each contacted provider was asked to provide utilization data on unduplicated consumers within their most recent fiscal year. For funding streams with single providers, there is unduplicated consumer utilization, but there is the potential for duplication in funding streams across multiple providers. The same caution carries over to all Other Federal Funding streams, because when aggregated there will be duplication of client utilization data.

There are additional cautions for this particular set of utilization figures: CDC utilization data only includes NH. In addition, HOPWA data does not include modes of HIV exposure, because HOPWA providers do not collect this data. Finally, Medicaid utilization data is the combination of federal and state Medicaid funding and is included in the State funding utilization section of this report.

Table III.A.2 shows the utilization data for Other Federal funding streams.

Table III.A.2: Utilization of Other Federal Funds by Demographic and Exposure Group

Group	Medicaid §		HOPWA		CDC ∆		Other Fed Total	
	#	%	#	%	#	%	#	%
Race								
White	N/A	N/A	1,179	36.4%	1,806	86.9%	10,910	72.2%
Black or African American	N/A	N/A	1,096	33.9%	172	8.3%	2,140	14.2%
American Indian/Alaskan	N/A	N/A	22	0.7%	9	0.4%	75	0.5%
Asian	N/A	N/A	5	1.1%	34	1.6%	129	0.9%
Two or more races	N/A	N/A	335	10.4%	1	0.0%	430	2.8%
Other	N/A	N/A	569	17.6%	57	2.7%	1,428	9.4%
Total	N/A	N/A	3,235	100.0%	2,079	100.0%	15,112	100.0%
Ethnicity								
Hispanic	N/A	N/A	1,035	32.0%	270	13.0%	2,385	15.7%
Not Hispanic	N/A	N/A	2,200	68.0%	1,809	87.0%	12,801	84.3%
Total	N/A	N/A	3,235	100.0%	2,079	100.0%	15,186	100.0%
Age								
<13 years	N/A	N/A	229	5.8%	1	0.0%	250	1.6%
13-19 years	N/A	N/A	230	5.9%	158	7.6%	782	4.9%
20-44 years	N/A	N/A	2,018	51.3%	1,486	71.5%	10,807	68.2%
45+ years	N/A	N/A	1,454	37.0%	434	20.9%	4,006	25.3%
Total	N/A	N/A	3,931	100.0%	2,079	100.0%	15,845	100.0%
Adult/Adolescent HIV Exposure Categories								
MSM	N/A	N/A	368	23.2%	429	20.6%	797	21.8%
IDUs	N/A	N/A	348	22.0%	250	12.0%	598	16.3%
MSM and IDUs	N/A	N/A	11	0.7%	12	0.6%	23	0.6%
Heterosexual	N/A	N/A	691	43.6%	1,245	59.9%	1936	52.9%
Other /blood trans	N/A	N/A	31	2.0%	0	0.0%	31	0.8%
Risk not reported	N/A	N/A	135	8.5%	142	6.8%	277	7.6%
Total	N/A	N/A	1,584	100.0%	2078	100.0%	3662	100.0%
Pediatric HIV Exposure Categories								
Mother at risk for HIV	NA	NA	4	100.0%	0	0	4	100.0%
Other /blood trans	NA	NA	0	0.0%	0	0	0	0.0%
Risk not reported	NA	NA	0	0.0%	0	0	0	0.0%
Total	NA	NA	4	100.0%	0	0	4	100.0%

§ Medicaid utilization will be included in the State funding streams utilization data.

∆ CDC utilization only includes NH.

Figure 31 examines utilization by racial group and Figure 32 examines utilization by ethnic group. The majority of PLWH served with Other Federal funds are White, except for services provided through HOPWA. Similar to Ryan White funding, none of the Other Federal streams provides services to more than 35% PLWH who are Hispanic. CDC utilization by race is mostly white due to the lack of data on MA. New Hampshire is a relatively homogenous state with over 90% of the population being white.

Figure 31: Utilization of Other Federal Funds by Race

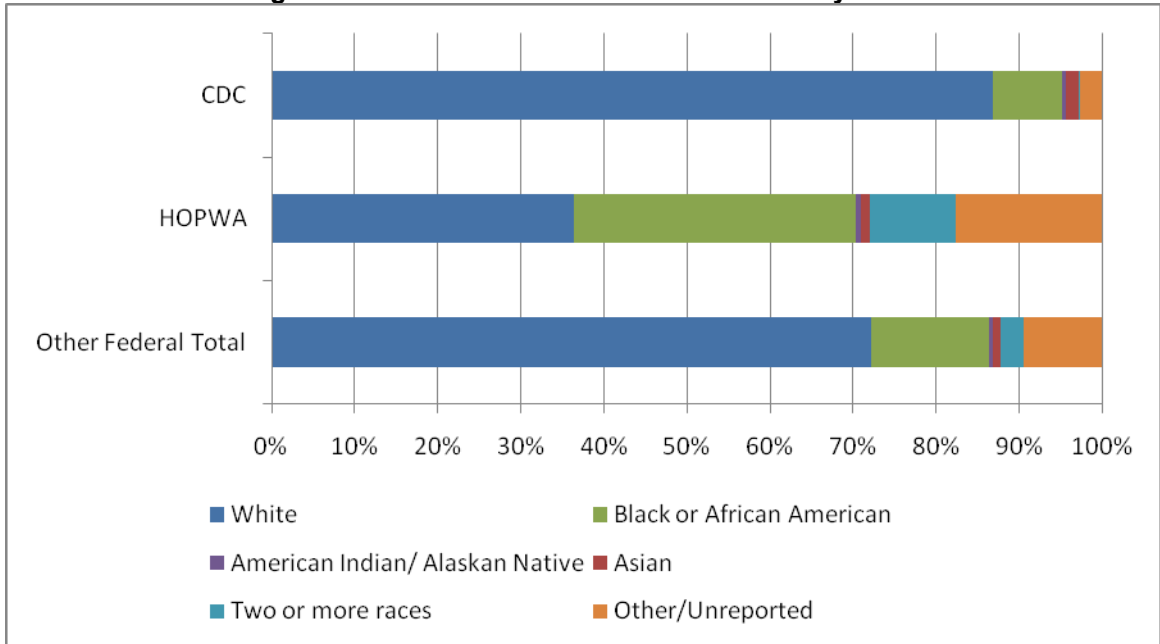


Figure 32: Utilization of Other Federal Funds by Ethnicity

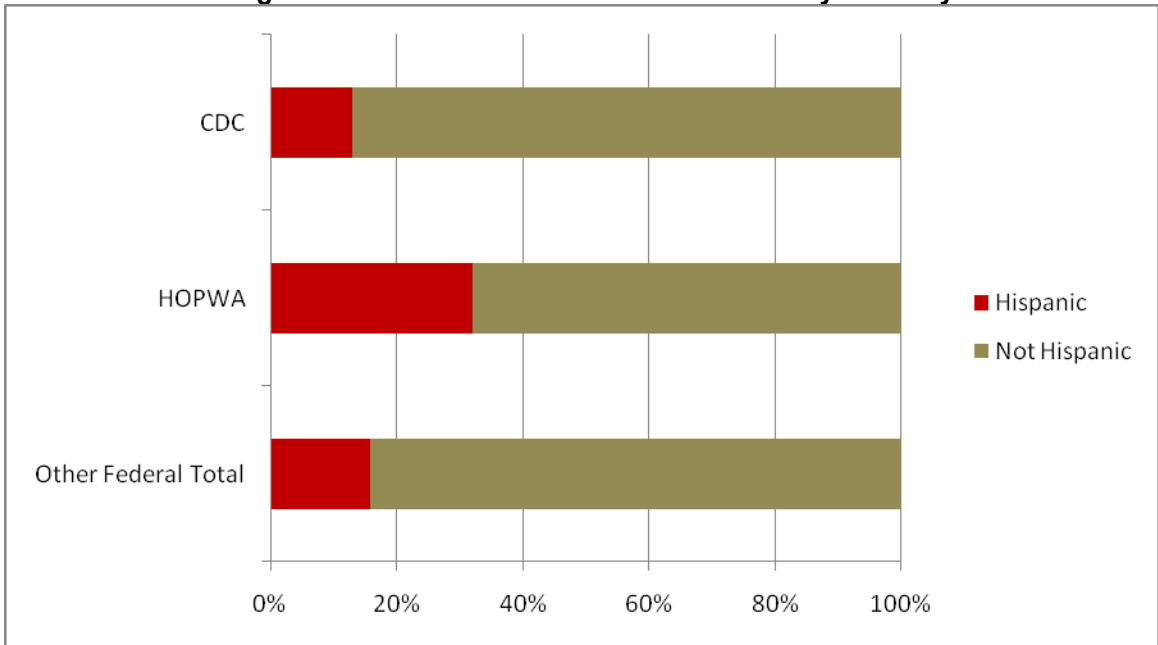


Figure 33 examines utilization by age group. The majority of PLWH served with Other Federal funds are in the 20-44 and 45+ age groups. Figure 34 shows utilization by HIV exposure group. MSM and IDU modes of exposure remain the significant modes of exposure to HIV among Other Federal funding streams.

Figure 33: Utilization of Other Federal Funds by Age

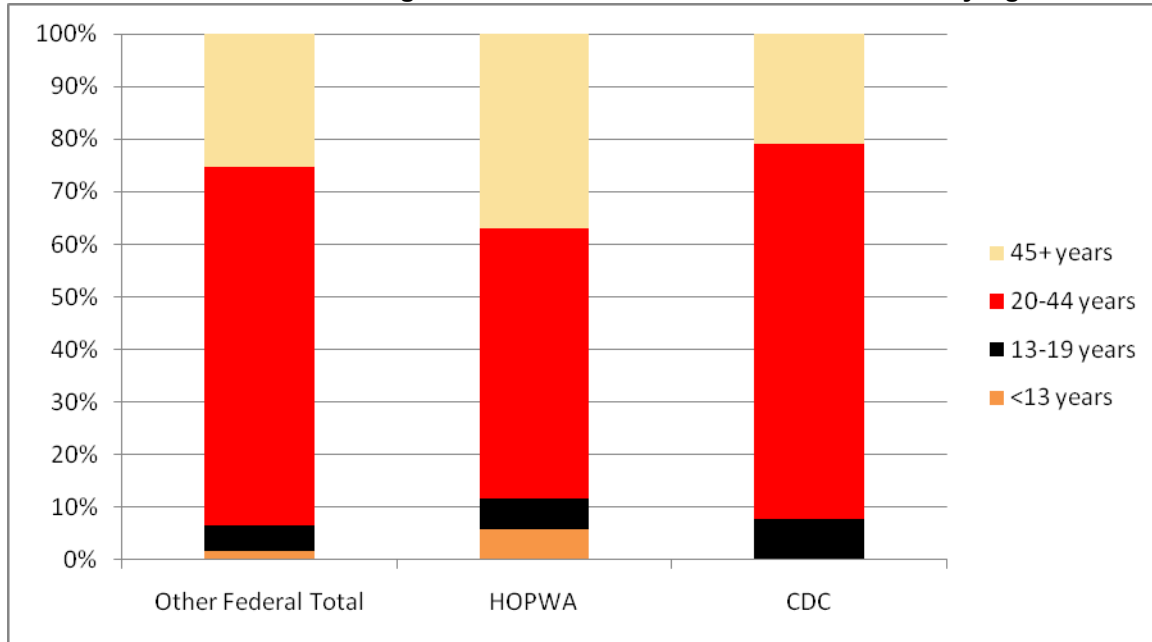
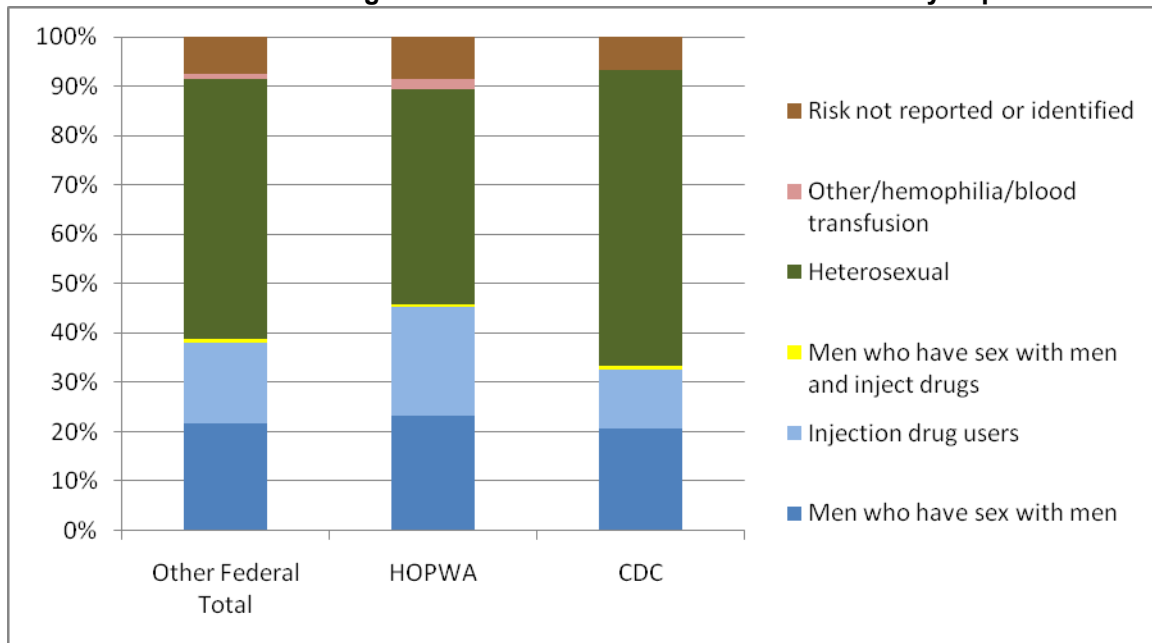


Figure 34: Utilization of Other Federal Funds by Exposure



Conclusion

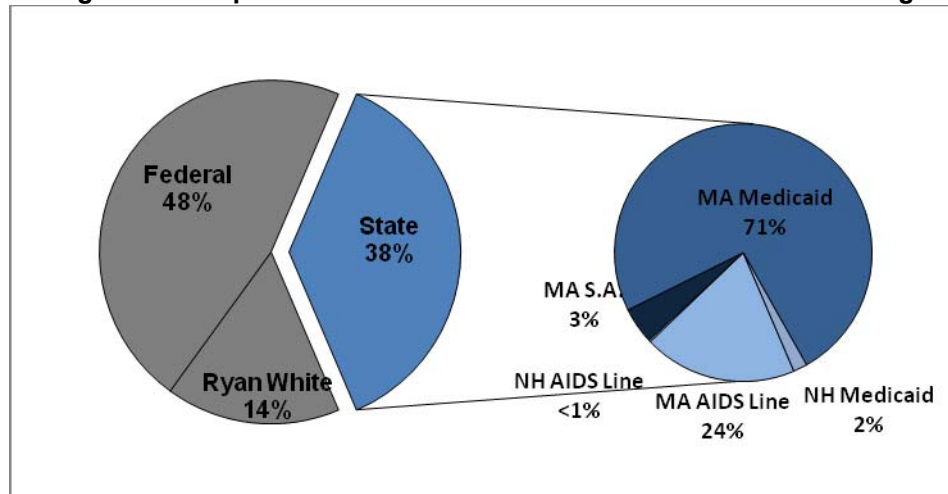
When reviewing the Other Federal funding it is important to recognize that these dollars are intended to support the larger health system within the EMA and may or may not be specifically earmarked for PLWH, unlike Ryan White dollars. However, Other Federal allocations are consistent with Ryan White in that utilization of Other Federal resources is reaching emerging and existing populations most in need, such as women, minorities and people age 20-44 and over 45.

Other Federal funding exemplifies how well supported the health care infrastructure is within our EMA, 91% of Other Federal money is allocated to core medical services. By providing stable core services, especially through Medicaid, Ryan White has the ability to adapt to the epidemic and fund many of the support services necessary to provide a holistic continuum of care throughout the EMA.

Section IV: State Funding Streams

This section explores funding streams provided through the Commonwealth of MA and the State of NH. State funding represents 38% of total funding for HIV/AIDS services in the Boston EMA (Figure 35).

Figure 35: Proportion of State Streams in Total HIV-Related Funding



Introduction

State funding sources are also important contributors to the continuum of HIV/AIDS services in the Boston EMA. Massachusetts and NH are close geographically, but differ substantially in terms of demographics and political culture.

State Funding Streams

Massachusetts AIDS Line Item

Massachusetts is able to provide a range of services throughout the state due to additional funding for HIV/AIDS services through the Department of Public Health (MDPH) AIDS budget line item. Statewide budget crisis in recent years have continued to affect services for PLWH in that the AIDS line item has sustained a number of cuts since 2002.

Funding Level

Massachusetts allocated \$21,658,456 to the AIDS Line Item for direct services in the last fiscal year.

Resource Inventory

The MA Office of HIV/AIDS (OHA) blends its many funding sources together to provide the most efficacious service mix to PLWH in the state. As such, services provided with this funding is similar to the scope of services provided with Ryan White Part B funding.

- ADAP/HDAP
- Early Intervention Services
- Home Health Care
- Home and Community-Based Health Services

- Medical Case Management
- Medical Nutrition Therapy
- Mental Health
- Case Management, Non-Medical
- Child Care
- Emergency Financial Assistance
- Food Bank/Home-Delivered Meals
- Health Education/Risk Reduction
- Housing Services
- Legal Services
- Medical Transportation Services
- Psychosocial Support
- Respite Care

Utilization

The state of Massachusetts provided utilization data as the number of Boston EMA clients served by OHA contracted agencies. This data includes clients served for both Ryan White Part B and MA AIDS Line Item funding. A total of 9,226 clients were served in the last fiscal year by the funding channeled through MDPH.

MassHealth Line Item

As mentioned in the previous section of this document, Medicaid is funded jointly by the Federal government and state governments. It is estimated that 60% of MassHealth funding is Federal and the other 40% is contributed by the State.

Funding Level

The state of MA contributed \$64,704,629 to the MassHealth program for direct services in the last fiscal year.

Resource Inventory

The standard MassHealth benefits package covers comprehensive primary and inpatient health services.

- Home Health Care
- Home and Community-Based Health Services
- Hospice Services
- Medical Case Management
- Mental Health
- Oral Health
- Outpatient/Ambulatory Medical Care
- Substance Abuse Services – Outpatient
- Medical Transportation Services
- Rehabilitation Services

Utilization

Utilization data for this funding stream is combined with Federal Medicaid utilization data. A total of 16,216 clients were served by Medicaid in the last fiscal year.

Massachusetts Bureau of Substance Abuse Services Line Item (BSAS)

Massachusetts provides funding for substance abuse services through the MDPH Substance Abuse Treatment line item. While HIV serostatus of clients is not collected, BSAS provides a range of HIV-related services to PLWH, injection drug users, pregnant women, homeless individuals, and individuals with chronic medical diagnoses are prioritized for admission to the services provided by BSAS programs.

Funding Level

Due to the fact that BSAS does not track whether or not clients are HIV+, it is estimated that 6.4% of the total BSAS funding is spent on PLWH. The Bureau of Substance Abuse Services reported in FY10 that \$51.8 million was available for substance abuse treatment services in the EMA (\$3,068,306 to PLWH per BSAS estimate).

Resource Inventory

A diverse continuum of services is in place to reduce risk of infection and engage high risk clients and PLWH in therapeutic interventions:

- Street outreach and harm reduction
- HIV counseling and testing education
- Temporary shelter
- Acute treatment services
- Ambulatory counseling and narcotic
- Residential rehabilitation treatment services and supportive housing
- Transitional support services
- Community-based case management

Utilization

It was estimated that 80.9% of consumers served by BSAS in FY10 were White, 8.9% were Black, and 10.9% of were Hispanic. The majority of consumers served with BSAS funding were 20 years and older with 74.3% in the 20-44 age group and 21.5% in the 45 and over group. BSAS prioritizes PLWH in the enrollment process, but says that no information on HIV status is collected. This paradox is the reason why BSAS is unable to provide information on HIV exposure risk.

Massachusetts Commonwealth Care & Commonwealth Choice

The MA Health Reform Law of 2006 extends access to medical insurance to all MA residents who are US citizens and qualified aliens. Increased access to medical insurance is likely to have direct and indirect impacts on Part A clients and utilization of Part A funded services.

Commonwealth Care is for uninsured citizens or qualified aliens aged nineteen years or older. Uninsured is defined as no MassHealth, no Medicare, no student health insurance, and no access in the last six months to employer sponsored insurance where the employer pays at least 33% of the individual's insurance premium. The program provides subsidized coverage by managed care organizations for the uninsured between 201% and 300% FPL (currently \$30,630). PLWH with income up to 200% remain eligible for MassHealth. All Commonwealth Care plans offer coverage to young adults two years after they lose their dependant status under federal tax law or to age 26, whichever comes first.

The managed care organizations offering plans through Commonwealth Care vary depending on geographic location, but each of the managed care organizations offer the four plan types described by the Health Insurance Connector Board. Plan Type I covers those with incomes up to 100% FPL (currently \$10,210). These plans have no premiums and MassHealth level co-pays. Plan Type I covers inpatient, outpatient, mental health, substance abuse, prescription drugs, vision and dental services. Plan Type II covers those with incomes between 101%-200% FPL (currently \$10,211-\$20,420). Type II plans have sliding scale premiums and the same benefits as Type I with the exception of dental services. Plan Types III and IV both cover those with incomes between 201% and 300% FPL (currently \$20,241-\$30,630). These plans have sliding scale premiums and the same benefits as Type I with the exception of dental services. Type III plans have lower premiums and higher co-pays, while Type IV plans have higher premiums and lower co-pays. The Uncompensated Care Pool (free care pool) continues to wrap around Commonwealth Care to help with cost sharing and any medically necessary, non-covered benefits.

Commonwealth Choice provides non-subsidized, 'affordable' plans available for purchase through the Connector Board by those over 300% FPL (currently \$30,630), including uninsured people living with HIV/AIDS. Each of the seven approved insurers offer five plans through the Connector Board with premiums, deductibles, and covered services varying by plan. Plans include one Premier Plan, two Value Plans, one Basic Plan and one Young Adult Plan.

Health Reform includes components requiring both employers and private individuals to participate. Employers with eleven full-time (or equivalent employees) must offer a Section 125 Plan, which allows employers to purchase insurance with pre-tax dollars. Such employers must also provide a reasonable level of coverage or pay a \$295 yearly assessment for each employee. Reasonable is defined as: employer covers 33% towards individual premiums (20% towards family premiums) or 25% of employees participate in the employer sponsored insurance program. A free-rider surcharge consisting of a percentage of costs of care for employees using significant amounts of free care is assessed when an employer does not offer Section 125 plans.

Individual responsibility stipulates that individuals must have insurance as long as affordable, minimal creditable coverage is available by December 31, 2007. Massachusetts tracks which individuals have insurance through information submitted by insurance companies. Individuals also receive a statement from the insurance company confirming their enrollment and providing individuals with the necessary information for their state tax returns. A waiver and appeals process is available for individuals unable to meet the requirements.

Funding Level

It is challenging to unravel the total cost of Health Reform due to the newness of the program and the changing rates of new enrollees into the system (estimates vary between some \$700 million and \$1.3 billion per year). The amount of funding that is realistically available to PLWH is even more challenging to discern. In the future, PCS will work with the Connector Board to estimate this figure.

Resource Inventory

Such coverage includes prescription drugs as a covered benefit, covers preventive physician visits prior to any deductible, caps any annual deductible at no more than \$2,000 for individuals and \$4,000 for families, caps an individual's out-of-pocket spending for hospital and physician services at \$5,000 for individuals and \$10,000 for families, disallows limitations on benefits per year or per sickness and disallows potentially deceptive benefits for only a certain amount of dollars toward a day in the hospital. Individuals who do not meet these requirements will face the loss of the personal state income tax exemption for tax year 2007 and will be assessed for 50% annualized cost toward lowest premium plan for tax year 2009 and beyond.

Utilization

Funding levels for private insurance markets are difficult to determine. In the future, PCS plans to contact Medicaid Managed Care Organizations and other large insurers to assess the effect of private insurance on the HIV/AIDS continuum of care in the Boston EMA.

Boston EMA Local Health Insurance Market

The Boston EMA is home to some of the most prestigious medical institutions in the world. Some PLWH have private medical insurance and are able to receive health services at one of the private hospitals or at a community health center. Of 6,366 unduplicated Part A clients in FY10, only 1,212 were enrolled in private insurance programs. This number has been increasing since the Massachusetts Health Reform Law was implemented and more Massachusetts citizens are enrolled in private health insurance programs.

Funding Level / Resource Inventory / Utilization

Funding levels for private insurance markets are difficult to determine, and were not collected for this report.

New Hampshire AIDS Line Item

In FY 05, NH provided state funds for HIV/AIDS services for the first time. Advocates and administrators in NH have been continuously working with the Governor and State House to increase the level of funding so that additional service categories can be funded within NH.

Funding Level

New Hampshire allocated \$461,652 to the AIDS Line Item for direct services in the last fiscal year.

Resource Inventory

Despite recent shortfalls in the state budget in the past few years, NH has been able to maintain some funding for services for PLWH.

- ADAP
- Mental Health
- Substance Abuse Services – Outpatient
- Case Management, Non-Medical
- Food Bank/Home-Delivered Meals
- Housing Services
- Medical Transportation Services

Utilization

Similar to Massachusetts, New Hampshire maximizes the effect of its funding by blending several streams together. The NHDHHS Division of Sexually Transmitted Diseases and HIV Prevention combines funding from the NH AIDS Line item and Ryan White Part B streams. As such, demographic utilization patterns of this funding reflects the same patterns seen in NH Ryan White Part B funded programs.

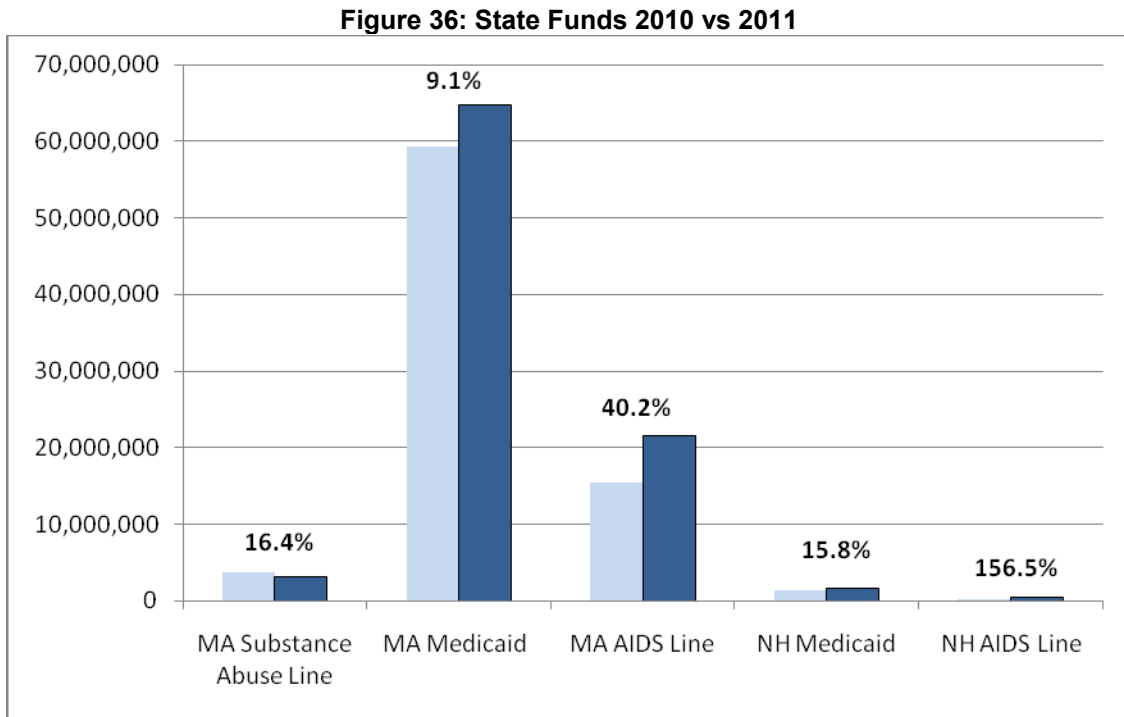
State Funding Analysis

For the period of time reviewed in this report, \$91,472,409 in State funding was in operation within the Boston EMA for PLWH (Table IV.A.1).

Table IV.A.1: Service Category Funding Levels for State Streams

Service Categories	MA Medicaid	MA S. Abuse	MA AIDS Line	NH Medicaid	NH AIDS Line	Subtotal
Core Services						
ADAP/HDAP	\$0	\$0	\$2,867,732	\$0	\$108,000	\$2,975,732
Early Intervention Services	\$0	\$0	\$8,006,569	\$0		\$8,006,569
Health Insurance Premium & Cost Sharing Assistance	\$0	\$0	\$0	\$0	\$0	\$0
Home Health Care	\$4,420,191	\$0	\$90,678	\$19,254	\$0	\$4,530,123
Home and Community-based Health Services	\$1,511,174	\$0	\$40,106	\$455,524	\$0	\$2,006,804
Hospice Services	\$429,921	\$0	\$0	\$0	\$0	\$429,921
Medical Case Management	\$17,863	\$0	\$2,320,076	\$0	\$0	\$2,337,939
Medical Nutrition Therapy	\$0	\$0	\$15,162	\$0	\$0	\$15,162
Mental Health	\$1,447,425	\$0	\$95,167	\$128,424	\$31,829	\$1,702,845
Oral Health Care	\$1,548,459	\$0	\$0	\$6,733	\$0	\$1,555,192
Outpatient/Ambulatory Medical Care	\$52,257,815	\$0	\$0	\$989,268	\$0	\$53,247,083
Substance Abuse – Outpatient	\$506,577	\$333,342	\$0	\$0	\$7,073	\$846,992
Total Core Services	\$62,139,424	\$333,342	\$13,435,490	\$1,599,204	\$146,902	\$77,654,362
Support Services						
Case Management, Non-med	\$0	\$0	\$1,968,440	\$0	\$91,949	\$2,060,389
Child Care Services	\$0	\$0	\$16	\$0	\$0	\$16
Emergency Financial Assistance	\$0	\$0	\$53,554	\$0	\$0	\$53,554
Food Bank/Home-Delivered Meals	\$0	\$0	\$1,035,565	\$0	\$81,340	\$1,116,905
Health Education/Risk Reduction	\$0	\$0	\$1,103,131	\$0	\$0	\$1,103,151
Housing Services	\$0	\$0	\$3,379,599	\$0	\$88,413	\$3,468,012
Legal Services	\$0	\$0	\$16,025	\$0	\$0	\$16,025
Linguistic Services	\$0	\$0	\$0	\$0	\$0	\$0
Medical Transportation	\$2,200,832	\$0	\$187,832	\$20,162	\$0	\$2,461,875
Outreach Services	\$0	\$0	\$0	\$0	\$0	\$0
Permanency Planning	\$0	\$0	\$0	\$0		\$0
Psychosocial Support	\$0	\$0	\$422,180	\$0	\$53,048	\$422,180
Referral for Health Care/Supportive Services	\$0	\$0	\$0	\$0	\$0	\$0
Rehabilitation Services	\$364,373	\$0	\$0	\$0	\$0	\$364,373
Respite Care	\$0	\$0	\$16,604	\$0	\$0	\$16,604
Substance Abuse –Residential	\$0	\$2,734,964	\$0	\$0	\$0	\$2,734,964
Treatment Adherence Counseling	\$0	\$0	\$0	\$0	\$0	\$0
Total Support Services	\$2,565,205	\$3,068,306	\$8,182,966	\$20,162	\$314,750	\$13,818,048
Total of All Services	\$64,704,629	\$3,668,723	\$21,618,456	\$1,619,366	\$461,652	\$91,472,409

The two largest State streams are the MA Medicaid Line Item and the MA AIDS Line Item (Figure 36).



Among State funding streams, 85% of direct service funding was invested in core medical services (Figure 37). Only Ryan White funding streams must abide by the 75/25 clause so this information is less vital for Other Federal streams. At the same time, this information speaks to the devotion regional providers have in prioritizing core medical services.

Figure 37: State Streams Core Medical and HIV Health-Related Support Services

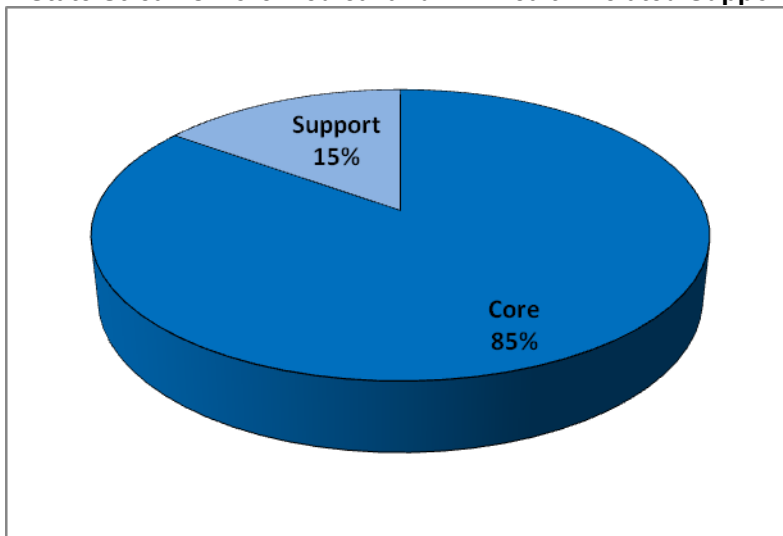


Figure 38 shows the core service category breakdown as a proportion of the whole pot of State funding available in the Boston EMA. Each service category is stratified by the State streams. The MA Medicaid Line Item and MA AIDS Line Item provide the majority of funding for many different service categories. Substance Abuse Outpatient Services is the only service category that receives a good portion of its funding from another source, the MA Substance Abuse Line Item. At this time, the NH AIDS Line Item is still small in comparison with the other State streams discussed, but has increased since 2010. No State funding is allocated towards Health Insurance Premium and Cost Sharing Assistance.

Figure 38: Share of Core Service Categories Covered by State Funding Streams

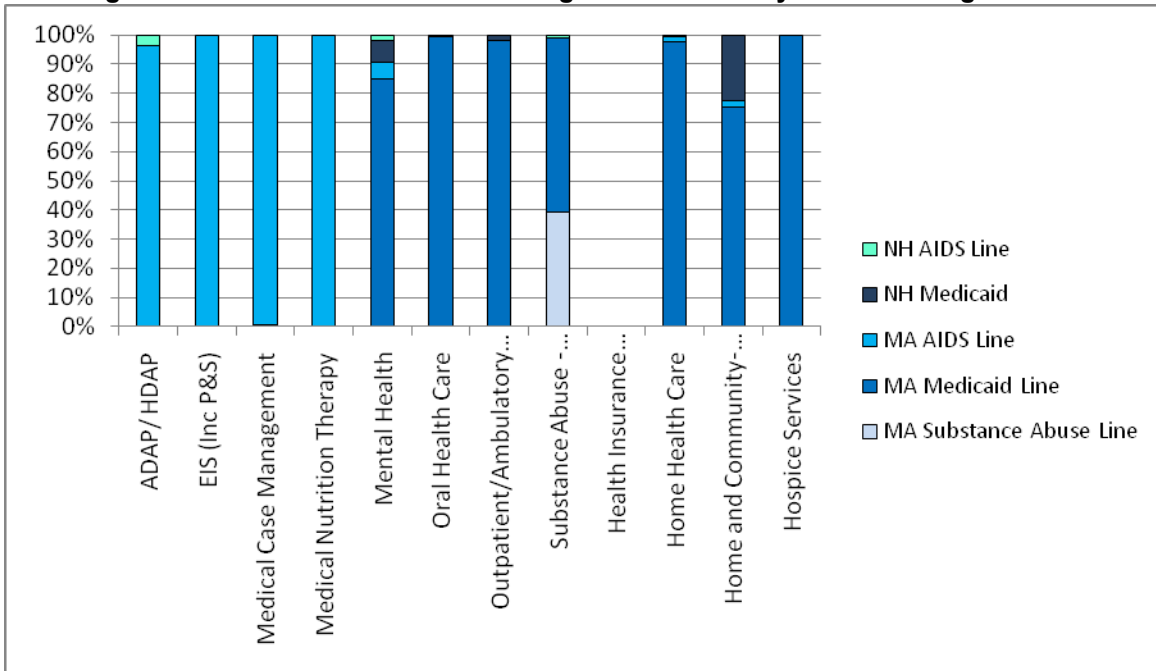
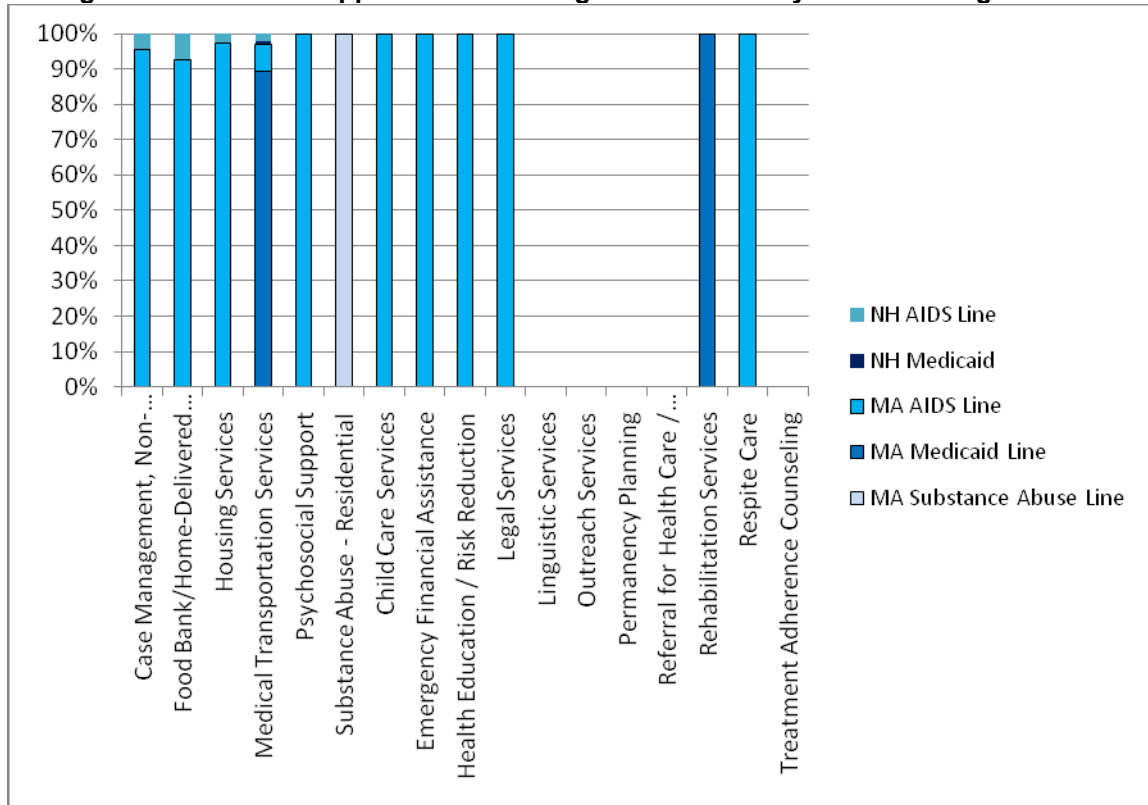


Figure 39 shows the support service category breakdown as a proportion of the whole pot of State funding available in the Boston EMA. Each service category is stratified by the State streams. Similar to the core services breakdown, the MA Medicaid Line Item and MA AIDS Line Item provide the majority of funding for many different service categories. Substance Abuse Residential Services is the only service category that receives the majority of its funding from another source, the MA Substance Abuse Line Item. No State funding was allocated towards Linguistic Services, Outreach Services, Permanency Planning, Referral for Health Care and Supportive Services, and Treatment Adherence Counseling.

Figure 39: Share of Support Service Categories Covered by State Funding Streams



State Utilization

For the purpose of this report, each contacted provider was asked to provide utilization data on unduplicated consumers within their most recent fiscal year. For funding streams with single providers, there is unduplicated consumer utilization, but there is the potential for duplication in funding streams across multiple providers. The same caution carries over to all State Funding streams, because when aggregated there will be duplication of client utilization data.

There are additional cautions for this particular set of utilization figures: MA AIDS Line Item utilization is included, but is an aggregate of utilization data for all services that are funded by MDPH (i.e. Part B and MA AIDS Line Item). Also, the MA Medicaid and NH Medicaid both include both state and federal utilization data. Finally, BSAS utilization data includes people that are not HIV+, because BSAS does not collect such information on their clients.

Table IV.A.2 shows the utilization data for State funding streams during the period of time under study for this report. The following figures examine the demographic profile of each Ryan White funding stream in further detail.

Table IV.A.2: Utilization of State Funding Streams by Demographic and Exposure Group

Group	MA Substance Abuse Line*		MA Medicaid**		MA AIDS Line***		NH Medicaid		State Total	
	#	%	#	%	#	%	#	%	#	%
Race										
White	35999	80.9%	6253	38.6%	4481	48.6%	369	83.9%	46733	66.8%
Black or African Am	3960	8.9%	2956	18.2%	2701	29.3%	64	14.5%	9617	13.7%
American Ind/Alaskan	198	0.4%	43	0.3%	38	0.4%	0	0.0%	279	0.4%
Asian	279	0.6%	1806	11.1%	114	1.2%	7	1.6%	2199	3.1%
Other	3645	8.2%	551	3.4%	1831	19.8%	0	0.0%	6027	8.6%
Two or more races	425	1.0%	63	0.4%	61	0.7%	0	0.0%	549	0.8%
Unreported	0	0.0%	4544	28.0%	0	0.0%	0	0.0%	4544	6.5%
Total	44506	100.0%	16216	100.0%	9226	100.0%	440	100.0%	69948	100.0%
Ethnicity										
Hispanic	4908	10.9%	1806	11.1%	2247	24.4%	71	16.1%	8961	12.7%
Not Hispanic	39939	89.1%	14410	88.9%	6979	75.6%	369	83.9%	61328	87.3%
Total	44847	100.0%	16216	100.0%	9226	100.0%	440	100.0%	70289	100.0%
Age										
<13 years	93	0.2%	1538	9.5%	24	0.3%	0	0.0%	1655	2.4%
13-19 years	1789	4.0%	6512	40.2%	39	0.4%	56	12.7%	8340	11.9%
20-44 years	33175	74.3%	7316	45.1%	3123	33.8%	190	43.2%	43614	62.2%
45+ years	9622	21.5%	850	5.2%	6040	65.5%	194	44.1%	16512	23.5%
Total	44679	100.0%	16216	100.0%	9226	100.0%	440	100.0%	70121	100.0%
Mode of Exposure										
MSM	N/A	N/A	N/A	N/A	2864	31.5%	N/A	N/A	2864	31.5%
IDUs	N/A	N/A	N/A	N/A	1846	20.3%	N/A	N/A	1846	20.3%
MSM and IDUs	N/A	N/A	N/A	N/A	101	1.1%	N/A	N/A	101	1.1%
Heterosexual	N/A	N/A	N/A	N/A	3259	35.8%	N/A	N/A	3259	35.8%
Other/blood trans	N/A	N/A	N/A	N/A	138	1.5%	N/A	N/A	138	1.5%
Risk not reported	N/A	N/A	N/A	N/A	893	9.8%	N/A	N/A	893	9.8%
Total	N/A	N/A	N/A	N/A	9101	100.0%	N/A	N/A	9101	100.0%
Pediatric Exposure Mode										
Mother at risk for HIV	N/A	N/A	N/A	N/A	125	100.0%	N/A	N/A	125	100.0%
Other/blood trans	N/A	N/A	N/A	N/A	0	0.0%	N/A	N/A	0	0.0%
Risk not reported	N/A	N/A	N/A	N/A	0	0.0%	N/A	N/A	0	0.0%
Total	N/A	N/A	N/A	N/A	125	100.0%	N/A	N/A	125	100.0%

*MA Substance Abuse Line data includes people who are not HIV+

**MA Medicaid data includes federal Medicaid for MA.

***MA AIDS Line includes MA Part B utilization data.

****NH did not provide utilization data for the NH AIDS Line.

Figure 40 examines utilization by racial group and Figure 41 examines utilization by ethnic group.

Figure 40: Utilization of State Streams by Race

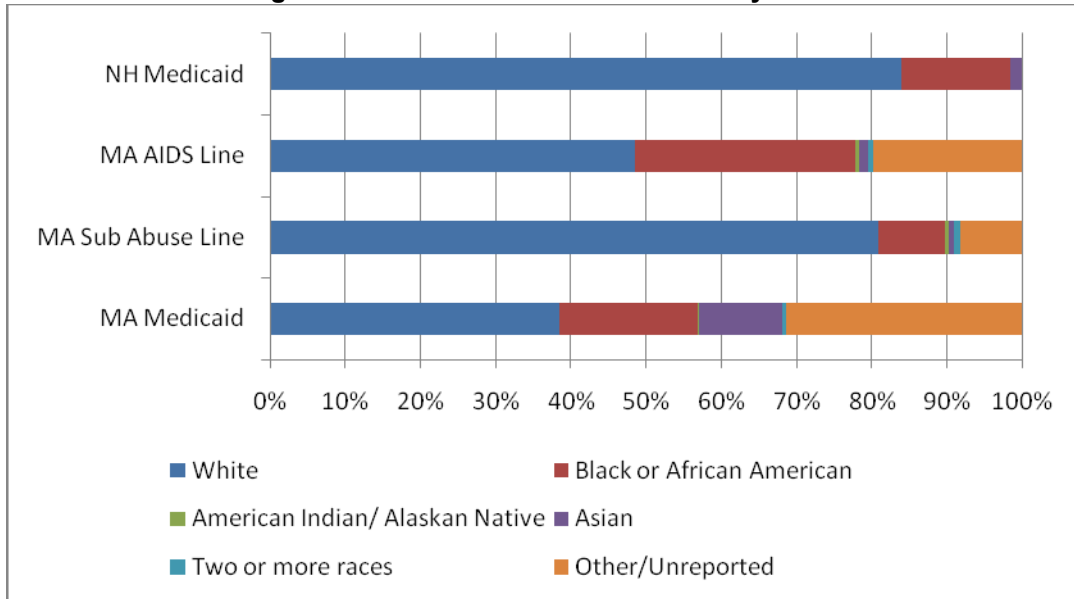


Figure 41: Utilization of State Streams by Ethnicity

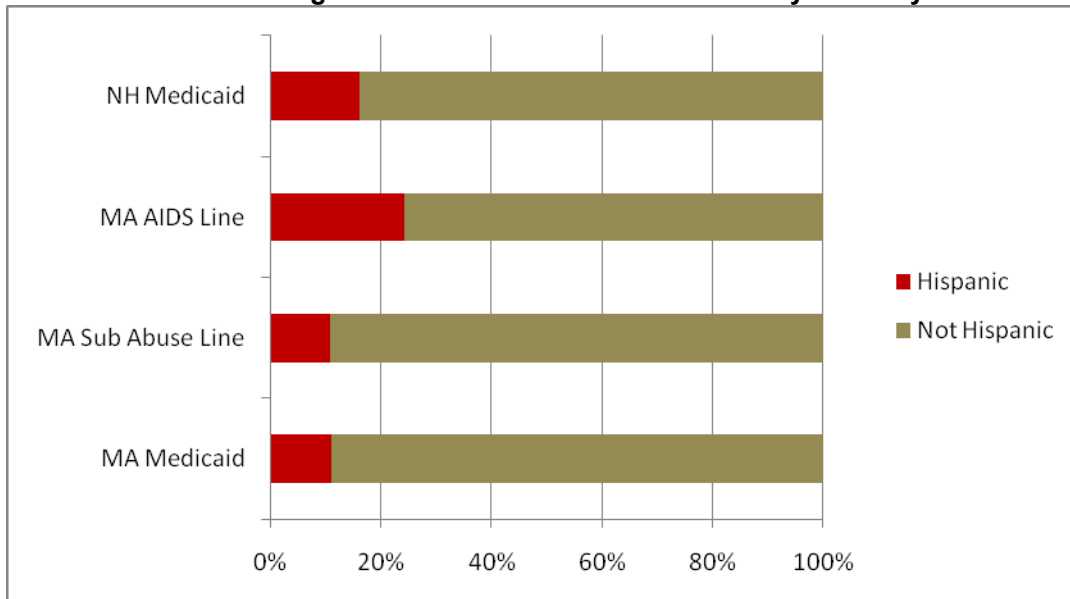
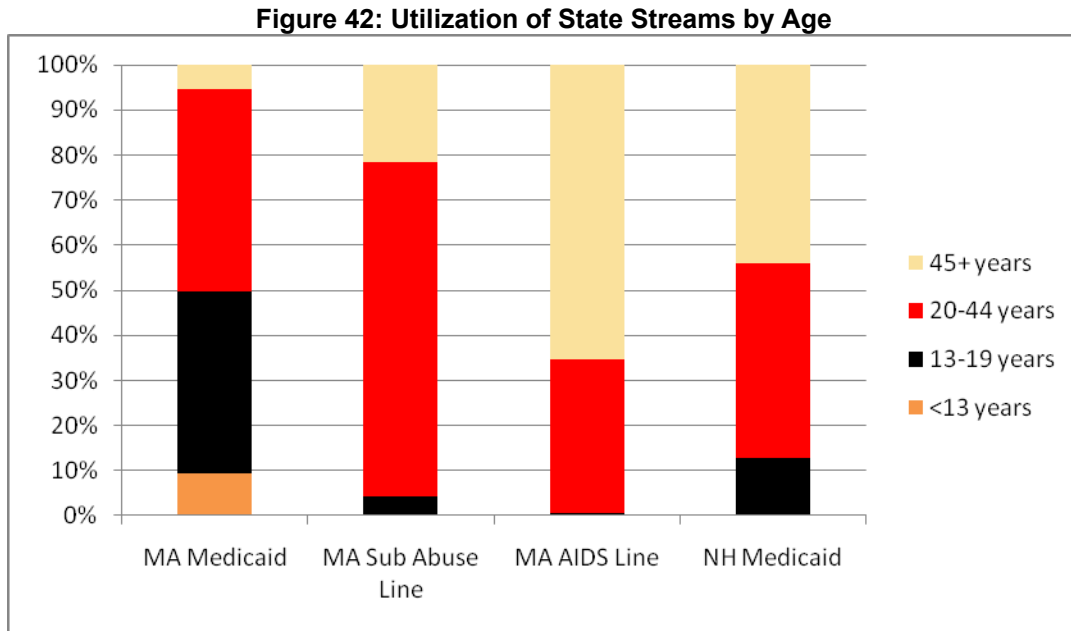


Figure 42 examines utilization by age group.



Conclusion

Although MA and NH are geographically close and both states have counties within the Boston EMA, the HIV/AIDS service needs of each state vary dramatically. Cumulatively, there is approximately \$91 million in State funding for MA and NH allocated to health and health-related services. Similar to Federal funding, not all money from the state is earmarked specifically for PLWH. However, the MA and NH AIDS line items are designated specifically for that purpose. Similar to Ryan White funding, the state AIDS line items are allocated to specific service categories where there is perceived need. However, MA allocates money to additional categories not covered by Ryan White or by other Federal funding, including: prevention and screening, capacity building, corrections, and service coordination.

The states' ability to fill the gaps in need by allocating money to service categories not covered by other sources of funding makes it an ideal portrayal of how the Boston EMA utilizes all of its resources to ensure that the needs of PLWH are attended to and guarantees that our EMA can maintain a stable continuum of care.

Section V: Conclusions

Conclusions

The epidemic within the Boston EMA continues to change. Many PLWH within the EMA are living longer, more productive lives, thus, the system must continue to adapt to the changing needs of the service area. It is the responsibility of all available funding streams to ensure that dollars are spent efficiently and with little duplication of efforts.

The Planning Council, as well as payers and providers have the task of maintaining equitable access to care, with the reality of finite resources. As the ultimate payer of last resort, the Boston EMA HIV Health Services Planning Council works to fill gaps left after other funding streams have been exhausted.

There is a total of \$242,375,140 within the Boston EMA allocated to direct health and health-related HIV services; Ryan White accounts for 14%, other Federal funding 48% and state funding is 38%. Although each of these funding streams impacts the service system differently, all have the same ultimate goal: to provide quality services for PLWH and increase the health of PLWH.

Section VI: Recommendations

Recommendations

Future Efforts

1. Visit survey respondents in person, as necessary, to ensure higher quality data collection.
2. Continue to expand the literature review to include additional funding sources that have not traditionally researched through this process.
3. Continue to expand the literature review to include new agencies and institutions that have not traditionally been assessed through this process.
4. Monitor and respond to programmatic changes in the Massachusetts Health Reform, the Medicaid waiver in Massachusetts and in expanding Medicaid eligibility to those who are HIV-positive.

Appendix

Appendix 1: Service Category Funding Levels Across All Funding Streams

Core Service Categories	Part A	Part B	Part C	Part D	Part F	Medicaid	HUD	SAMHS A	CDC	MA Sub Abuse Line	MA Medicaid Line	NH Medicaid Line	MA AIDS Line	NH AIDS Line	Total
ADAP/HDAP	\$1,888,389	\$10,666,860	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$2,867,732	\$108,000	\$15,530,981
EIS	\$0	\$0	\$341,247	\$71,102	\$0	\$0	\$0	\$0	\$3,442,575	\$0	\$0	\$0	\$8,006,569	\$0	\$11,861,493
Insurance Prem & Cost Share Asst	\$0	\$136,972	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$136,972
Home Health Care	\$0	\$47,364	\$0	\$0	\$0	\$7,107,369	\$0	\$0	\$0	\$0	\$4,420,191	\$19,254	\$90,678	\$0	\$11,684,856
Home/ Community Based Health	\$0	\$32,671	\$41,117	\$0	\$0	\$2,887,877	\$0	\$0	\$0	\$0	\$1,511,174	\$455,524	\$40,106	\$0	\$4,968,469
Hospice Services	\$0	\$0	\$0	\$0	\$0	\$689,373	\$0	\$0	\$0	\$0	\$429,921	\$0	\$0	\$0	\$1,119,294
Medical CM	\$2,635,944	\$1,211,861	\$1,176,074	\$460,592	\$102,667	\$28,642	\$453,702	\$0	\$0	\$0	\$17,863	\$0	\$2,320,076	\$0	\$8,407,421
Med Nutr Therapy	\$714,821	\$9,135	\$129,126	\$0	\$0	\$0	\$63	\$0	\$0	\$0	\$0	\$0	\$15,162	\$0	\$868,307
Mental Health	\$283,278	\$50,057	\$502,897	\$64,183	\$0	\$2,451,947	\$6,988	\$0	\$0	\$0	\$1,447,425	\$128,424	\$95,167	\$31,829	\$5,062,195
Oral Health Care	\$685,684	\$13,273	\$211,424	\$0	\$309,876	\$2,489,806	\$0	\$0	\$0	\$0	\$1,548,459	\$6,733	\$0	\$0	\$5,265,255
Outpatient/Amb Medical Care	\$153,681	\$64,041	\$2,856,779	\$686,242	\$0	\$84,804,068	\$0	\$0	\$0	\$0	\$52,257,815	\$989,268	\$0	\$0	\$141,811,894
Sub Abuse - Out	\$80,033	\$17,466	\$58,084	\$0	\$0	\$812,291	\$7,384	\$139,367	\$0	\$333,342	\$506,577	\$0	\$0	\$7,073	\$1,961,617
Subtotal Core Services	\$6,441,830	\$12,249,700	\$5,316,748	\$1,282,119	\$412,543	\$101,271,373	\$468,137	\$139,367	\$3,442,575	\$333,342	\$62,139,425	\$1,599,203	\$13,435,490	\$146,902	\$208,678,754
Support Service Categories	Part A	Part B	Part C	Part D	Part F	Medicaid	HUD	SAMHSA	CDC	MA Sub Abuse Line	MA Medicaid Line	NH Medicaid Line	MA AIDS Line	NH AIDS Line	Total
CM, Non-med	\$398,856	\$1,089,839	\$76,367	\$209,367	\$0	\$0	\$1,306,448	\$0	\$0	\$0	\$0	\$0	\$1,968,440	\$91,949	\$5,141,226
Child Care	\$0	\$8	\$0	\$176	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$16	\$0	\$200
Emergency Financial Asst.	\$0	\$27,973	\$0	\$7,572	\$0	\$0	\$434,107	\$0	\$0	\$0	\$0	\$0	\$53,554	\$0	\$523,206
Food Bank/Home-Delivered Meals	\$1,045,968	\$540,914	\$0	\$0	\$0	\$0	\$13,581	\$0	\$0	\$0	\$0	\$0	\$1,035,565	\$81,340	\$2,717,368
Health Ed/RR	\$0	\$576,217	\$43,166	\$153,131	\$0	\$0	\$33,687	\$0	\$0	\$0	\$0	\$0	\$1,103,151	\$0	\$1,909,352
Housing	\$1,964,981	\$0	\$0	\$0	\$181,866	\$0	\$3,074,776	\$0	\$0	\$0	\$0	\$0	\$3,379,599	\$88,413	\$8,689,635
Legal Services	\$0	\$8,370	\$0	\$0	\$0	\$0	\$992	\$0	\$0	\$0	\$0	\$0	\$16,025	\$0	\$25,387
Linguistic	\$0	\$0	\$44,729	\$0	\$0	\$0	\$8,889	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$53,618
Transportation	\$367,237	\$98,112	\$11,550	\$51,231	\$0	\$3,549,579	\$10,883	\$0	\$0	\$0	\$2,200,832	\$20,162	\$187,832	\$53,048	\$6,550,466
Outreach	\$0	\$0	\$14,604	\$21,307	\$0	\$0	\$5,589	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$41,500
Perm Planning	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Psychosocial Support	\$895,594	\$220,520	\$9,517	\$173,851	\$0	\$0	\$4,500	\$0	\$0	\$0	\$0	\$0	\$422,180	\$0	\$1,726,162
Referral for Services	\$0	\$0	\$49,997	\$31,000	\$0	\$0	\$1,025,112	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$1,106,109
Rehab Services	\$0	\$0	\$0	\$0	\$0	\$584,268	\$0	\$0	\$0	\$0	\$364,373	\$0	\$0	\$0	\$948,641
Respite Care	\$0	\$8,673	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$16,604	\$0	\$25,277
Sub Abuse – Res	\$968,279	\$0	\$0	\$0	\$0	\$0	\$0	\$458,507	\$0	\$2,734,964	\$0	\$0	\$0	\$0	\$4,161,750
Adherence Counseling	\$0	\$0	\$29,503	\$46,945	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$76,448
Subtotal Support Services	\$5,640,915	\$2,570,626	\$279,433	\$694,580	\$181,866	\$4,133,847	\$5,918,564	\$458,507	\$0	\$2,734,964	\$2,565,205	\$20,162	\$8,182,966	\$314,750	\$33,696,385
Total of All Services	\$12,082,745	\$14,820,326	\$5,596,181	\$1,976,699	\$594,409	\$105,405,220	\$6,386,701	\$597,874	\$3,442,575	\$3,068,306	\$64,704,630	\$1,619,365	\$21,618,456	\$461,652	\$242,375,139

Appendix 2: Utilization of All Funding Streams by Demographic and Exposure Group

Demographic Group/Exposure Category	Part A Funding		Part B (NH) □		Part C Funding		Part D Funding		Part F Dental Funding ‡		Medicaid §		HUD ¶		CDC ∆		MA AIDS Line ℓ		BSAS (MA Subs Abs) *		EMA Total		
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	
Race																							
White	2,593	42.6%	229	77.1%	2,622	64.2%	272	23.7%	1,061	65.0%	6,062	49.9%	629	56.0%	1,684	90.1%	0	NA	42,406	78.6%	57,558	69.9%	
Black or African Am	1,770	29.0%	38	12.8%	1,021	25.0%	639	55.7%	382	23.4%	2,635	21.7%	328	29.2%	141	7.5%	0	NA	5,165	9.6%	12,119	14.7%	
Am Indian/ Alaska Nat	107	1.8%	3	1.0%	5	0.1%	2	0.2%	1	0.1%	30	0.2%	4	0.4%	11	0.6%	0	NA	468	0.9%	631	0.8%	
Asian	44	0.7%	2	0.7%	52	1.3%	10	0.9%	3	0.2%	294	2.4%	5	0.4%	25	1.3%	0	NA	433	0.8%	868	1.1%	
Two or more races	1,498	24.6%	0	0.0%	31	0.8%	91	7.9%	160	9.8%	11	0.1%	90	8.0%	9	0.5%	0	NA	5,490	10.2%	7,380	9.0%	
Unreported	81	1.3%	25	8.4%	355	8.7%	134	11.7%	25	1.5%	3,115	25.6%	67	6.0%	0	0.0%	0	0.0%	3,802	4.6%			
Total	6,093	100.0%	297	100.0%	4,086	100.0%	1,148	100.0%	1,632	100.0%	12,147	100.0%	1,123	100.0%	1,870	100.0%	0	0.0%	53,962	100.0%	82,358	100.0%	
Ethnicity																							
Hispanic	1,823	29.9%	33	11.1%	854	20.1%	279	24.3%	361	22.1%	1,379	10.5%	271	23.8%	221	100.0%	0	NA	6,212	11.4%	11,433	14.0%	
Not Hispanic	3,497	57.4%	264	88.9%	3,383	79.4%	869	75.7%	1,271	77.9%	11,762	89.5%	867	76.2%	0	0.0%	0	NA	48,122	88.6%	70,035	86.0%	
Unreported	773	12.7%	0	0	22	0.5%	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
Total	6,093	87.3%	297	100.0%	4,259	99.5%	1,148	100.0%	1,632	100.0%	13,141	100.0%	1,138	100.0%	221	100.0%	0	0.0%	54,334	100.0%	81,468	100.0%	
Age																							
<13 years	70	1.1%	1	0.3%	11	0.3%	184	16.0%	0	0.0%	45	0.3%	2	0.2%	0	0	0	NA	196	0.4%	509	0.6%	
13-19 years	72	1.2%	3	1.0%	264	6.5%	311	27.1%	4	0.2%	1,394	10.3%	79	6.9%	0	0	0	NA	2768	5.1%	4,895	6.0%	
20-44 years	2,482	40.7%	136	45.8%	1,876	46.4%	419	36.5%	251	15.4%	6,082	45.0%	642	56.4%	0	0	0	NA	39,539	72.8%	51,427	62.5%	
45+ years	3,469	56.9%	157	52.9%	1,894	46.8%	234	20.4%	1,377	84.4%	6,005	44.4%	416	36.5%	0	0	0	NA	11,839	21.8%	25,391	30.9%	
Total	6,093	100.0%	297	100.0%	4,045	100.0%	1,148	100.0%	1,632	100.0%	13,526	100.0%	1,139	100.0%	0	0	0	NA	54,342	100.0%	82,222	100.0%	
Adult/Adolescent HIV Exposure Categories																							
MSM	1,607	22.8%	137	46.1%	1,659	38.6%	40	7.8%	0	NA	0	NA	95	16.5%	291	15.6%	0	NA	0	NA	3,829	26.2%	
IDUs	1,378	19.6%	33	11.1%	882	20.5%	62	12.1%	0	NA	0	NA	115	20.0%	185	9.9%	0	NA	0	NA	2,655	18.2%	
MSM & IDUs	0	0.0%	6	2.0%	54	1.3%	0	0.0%	0	NA	0	NA	23	4.0%	0	0.0%	0	NA	0	NA	83	0.6%	
Heterosexual	3,252	46.2%	111	37.4%	1,268	29.5%	357	69.9%	0	NA	0	NA	63	11.0%	709	37.9%	0	NA	0	NA	5,760	39.5%	
Other/blood trans	200	2.8%	5	1.7%	40	0.9%	12	2.3%	0	NA	0	NA	2	0.3%	0	0.0%	0	NA	0	NA	259	1.8%	
Risk not identified	598	8.5%	5	1.7%	399	9.3%	40	7.8%	0	NA	0	NA	277	48.2%	685	36.6%	0	NA	0	NA	2,004	13.7%	
Total	7,035	100.0%	297	100.0%	4,302	100.0%	511	100.0%	0	NA	0	NA	575	100.0%	1,870	100.0%	0	NA	0	NA	14,590	100.0%	
Pediatric HIV Exposure Categories																							
Mother at risk for HIV	0	0	0	0	16	100.0%	239	92.6%	0	0	NA	NA	2	100.0%	NA	NA	0	NA	NA	NA	255	93.1%	
Other /blood trans	0	0	0	0	0	0.0%	0	0.0%	0	0	NA	NA	0	0	NA	NA	0	NA	NA	NA	0	0.0%	
Risk not identified	0	0	0	0	0	0.0%	19	7.4%	0	0	NA	NA	0	0	NA	NA	0	NA	NA	NA	19	6.9%	
Total	0	0	0	0	16	100.0%	258	100.0%	0	0	NA	NA	2	100%	NA	NA	0	NA	NA	NA	274	100.0%	

Appendix 3: AIDS Incidence, AIDS Prevalence and HIV Prevalence by Demographic Group and Exposure Category

	AIDS INCIDENCE 1/1/08 - 12/31/09		AIDS PREVALENCE as of 12/31/09		HIV PREVALENCE as of 12/31/09		HIV/AIDS PREVALENCE as of 12/31/09	
	The number of <u>new</u> AIDS cases as reported to the CDC		The number of people living with AIDS		The number of people living with HIV (non-AIDS)		The number of people living with both AIDS and HIV (non-AIDS)	
Race/Ethnicity	#	%	#	%	#	%	#	%
White, not Hispanic	221	38%	4,091	46%	3,277	49%	7,368	47%
Black, not Hispanic	212	37%	2,690	31%	1,951	29%	4,641	30%
Hispanic	127	22%	1,870	21%	1,343	20%	3,213	21%
Asian/Pacific Islander	14	2%	139	2%	107	2%	246	2%
American Indian/Alaska Native	0	<1%	15	<1%	9	<1%	24	<1%
Not Specified ¹	3	<1%	8	<1%	36	<1%	44	<1%
Total	577	100%	8,813	100%	6,723	100%	15,536	100%
Gender								
Male	406	70%	6,322	72%	4,741	71%	11,063	71%
Female	171	30%	2,491	28%	1,982	29%	4,473	29%
Total	577	100%	8,813	100%	6,723	100%	15,536	100%
Age at Diagnosis (years)²								
<13 years	0	0%	12	<1%	41	<1%	53	<1%
13-19 years	10	2%	44	<1%	102	2%	146	<1%
20-44 years	302	52%	2,938	33%	3,172	47%	6,110	39%
45 + years	265	46%	5,819	66%	3,408	51%	9,227	59%
Total	577	100%	8,813	100%	6,723	100%	15,536	100%
Mode of Exposure								
Men who have sex with men (MSM)	198	34%	3,027	34%	2,855	42%	5,882	38%
Injection drug users (IDU)	75	13%	1,953	22%	1,023	15%	2,976	19%
MSM / IDU	14	2%	306	3%	203	3%	509	3%
Heterosexual Sex ³	213	37%	2,806	32%	1,965	29%	4,771	31%
Perinatal	3	<1%	122	1%	170	3%	292	2%
Other ⁴	0	0%	79	<1%	19	<1%	98	<1%
Risk not reported/identified	74	13%	520	6%	488	7%	1,008	6%
Total	577	100%	8,813	100%	6,723	100%	15,536	100%

¹Race was either not specified or unknown; includes multi-race (NH)

²Prevalent cases in the New Hampshire counties of the EMA are reported by age at diagnosis

³Includes presumed heterosexual, unknown risk of partner and primary risk categories have been denied

⁴Includes hemophilia and all other cases with identified modes of transmission not listed here (MDPH, NHDHHS).

Appendix 4: Part A Boston EMA Service Category Definitions

Service Category (IN ALPHABETICAL ORDER)	Definition
AIDS Drug Assistance Program (ADAP/HDAP)	A State-administered program authorized under Part B of the Ryan White Program that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.
Case Management, Medical	<p>A range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the client and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and review of utilization of services. This includes all types of case management, including face-to-face, telephone, and any other forms of communication.</p> <p>Boston EMA Addendum: <i>Services are to be offered in a variety of locations which may include one or more of the following venues: the agency or office setting, home visits, or other community-based settings.</i></p>
Case Management, Non-Medical	<p>Include advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments.</p> <p>Boston EMA Addendum: <i>Services offered under this category may include client advocacy, legal services, specialized assistance with benefits, and interpretation or other linguistic services.</i></p>
Early Intervention Services (EIS)	Include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, to diagnose the extent of immune deficiency, and to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and provision of therapeutic measures.
Food Bank/ Home-Delivered Meals	The provision of actual food or meals. It does not include finances to purchase food or meals, but may include vouchers to purchase food. The provision of essential household supplies, such as hygiene items and household cleaning supplies, also should be included in this item. The provision of food and/or nutritional supplements by a non-registered dietician should be included in this item as well.
Housing Services	Short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services, such as residential mental health services, foster care, or assisted living residential services.

Medical Nutrition Therapy	Is provided by a licensed registered dietitian outside of a primary care visit. The provision of food may be provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietitian. Nutritional services and nutritional supplements not provided by a licensed, registered dietitian shall be considered a support service. Food not provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietitian also shall be considered a support service.
Medical Transportation Services	Conveyance services provided, directly or through a voucher, to a client to enable him or her to access health care services.
Mental Health	Psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. They are conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.
Oral Health Care	Diagnostic, preventive, and therapeutic services provided by a dental health care professional licensed to provide health care in the State or jurisdiction, including general dental practitioners, dental specialists, and dental hygienists, as well as licensed and trained and dental assistants. Boston EMA Addendum: <i>Services funded by this category include education for, outreach to, and recruitment of dental providers.</i>
Outpatient/Ambulatory Medical Care	The provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse practitioner, or other health care professional who is certified in his or her jurisdiction to prescribe antiretroviral (ARV) therapy in an outpatient setting. These settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the PHS's guidelines. Such care must include access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination ARV therapies.
Psychosocial Support	Support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. They include nutrition counseling provided by a non-registered dietitian, but exclude the provision of nutritional supplements. Boston EMA Addendum: <i>Services funded under this category include peer support, where the person providing the psychosocial support is a person infected with HIV and of the client's self-identified community.</i>
Substance Abuse Services - Outpatient	Medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a physician or under the supervision of a physician, or by other qualified personnel.
Substance Abuse Services - Residential	Treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).



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