

# 2009 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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- Fenway Community Health Center
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- Latino Health Institute
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## Acronyms

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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

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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 funders and providers in the Boston EMA. The surveys 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 \$289,434,650 distributed in this region in the last fiscal year.

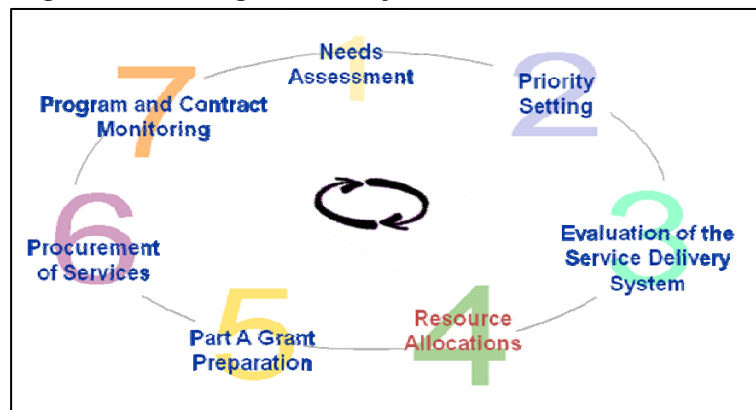
Section II of this report analysis Ryan White funding streams, including a breakdown of Parts A, B, C, D and F. For the period of time reviewed in this report, \$47,863,454 in Ryan White funding was available within the Boston EMA.

Section III of this report reviews other Federal HIV-related funding sources, including the Centers for Medicare and Medicaid, the US Department of Housing and Urban Development (HUD), the Substance Abuse (BSAS) and Mental Health Services Administration (SAMHSA), and the Centers for Disease Control and Prevention (CDC). In the most recent fiscal year, there was \$107,967,084 in total funding available from these resources in the Boston EMA included in the Boston EMA.

Section IV of this report reviews State funding sources for both Massachusetts and New Hampshire. In this time period, there was \$133,606,121 in State funding available in portions of Massachusetts and New Hampshire.

The information in the 2009 Funding Streams Report is used by members of the Ryan White Part A Planning Council to make funding decisions in step 4 of the Planning Council cycle (Figure 1). 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).

**Figure 1: Planning Council Cycle**



## Introduction

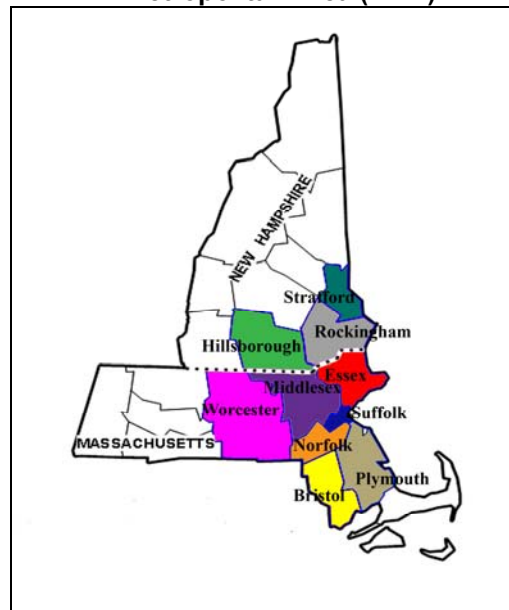
*The 2009 Funding Streams Report is intended to provide an overview of the funding available to provide HIV/AIDS services within the Boston Eligible Metropolitan Area (EMA). The report also provides a resource inventory of all funded services and utilization by demographic characteristics for each of 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 Modernization Act (RWTMA) 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 2 shows the boundaries of this region and the service area for Ryan White Part A funding. As of December 31, 2007, there were an estimated 14,420 individuals living with HIV/AIDS within the Boston EMA.

**Figure 2: 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 *2009 Needs Assessment* can be downloaded on the Planning Council website: [www.bostonplanningcouncil.org](http://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).

*An "HIV/AIDS 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 an "HIV/AIDS 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 25 listed different direct and indirect services in the survey for each of their funding streams (Table V.A.5).

Planning Council definitions for Boston Ryan White Part A EMA fundable service categories were used to describe 15 HIV/AIDS service categories (Table V.A.5). Data on ten additional service categories was captured to provide funding information on indirect services. These ten

additional services were selected for reporting because of their importance in the continuum of care for PLWH, even though they are not Part A services.

Secondly, an analysis was conducted of the available funding streams for HIV/AIDS services in the Boston EMA. Fourteen funding streams were indentified in the Boston EMA that fund 34 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, 2007 through June 30, 2009). 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. The funding streams survey response rate from payers/providers was 81%. For funders and providers that PCS was unable to get stratified data, award totals for the last complete fiscal year were obtained from the HRSA website.

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.

To mitigate these limitations in the future, specific surveys will be crafted to request data from each HIV/AIDS service payer/provider in a format that more closely follows their own data

collection practices. On site data collection is another option that could improve the quality of collected data. In addition, PCS will continue to encourage all HIV/AIDS service payers and providers to create universal standards for data collection which would allow cross referencing of data. PCS will also follow up with each payer/provider that reported data and consistently collect data from each source for subsequent Funding Streams Reports.

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

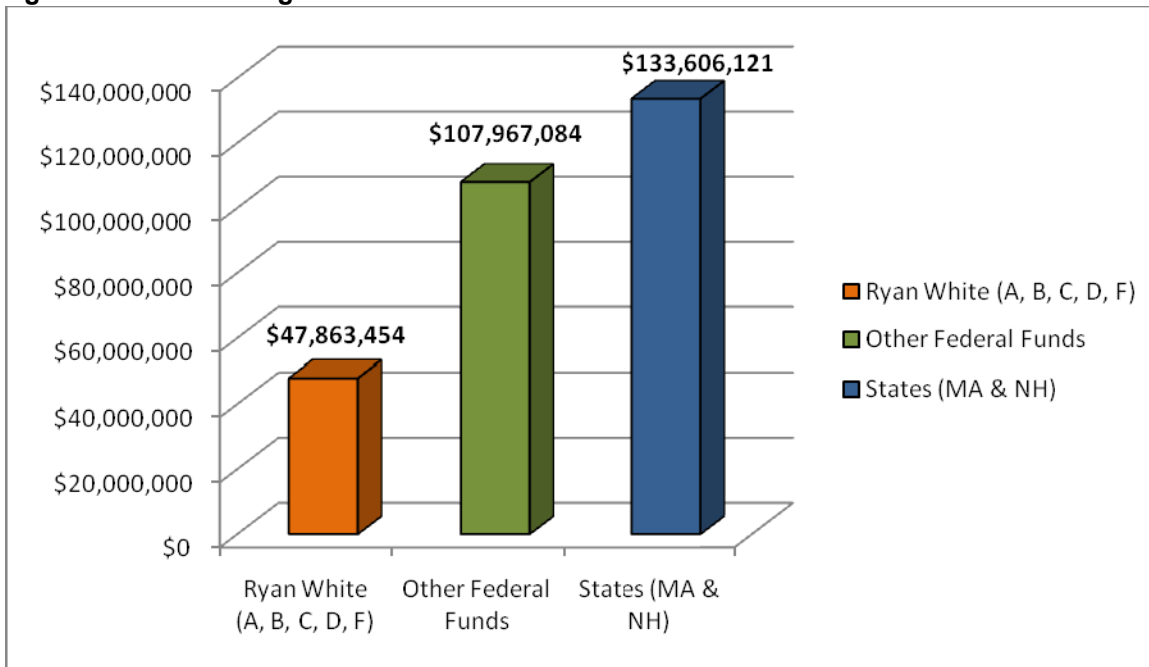
*This section reviews all HIV/AIDS services funding in the Boston EMA. All funding for HIV/AIDS services are split between three major streams: 1) Ryan White, 2) Other Federal, and 3) States (MA and NH).*

### 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 3. However, further analysis of each of the major funding entities in the Boston EMA including a comparative analysis between 2008 and 2009, is provided in greater detail later in this report.

Within the three main funding sources for HIV/AIDS Services (i.e. Federal, State, and Ryan White), PCS identified 14 different funding streams, operating in the Boston EMA (Figure 3). These funding streams were contributing at total of \$289,434,650 in the last fiscal year, to fund HIV/AIDS services in the Boston EMA. This is a 10% increase from 2008 (\$264,071,973).

**Figure 3: Main Funding Sources in the Boston Part A EMA**

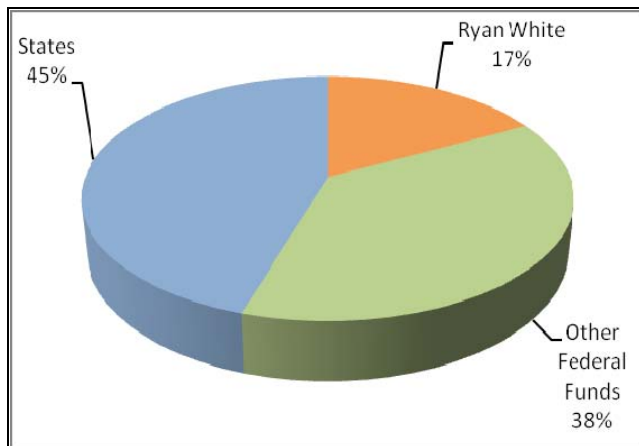


PCS also identified 34 regional HIV/AIDS service payers/providers that operate within the Boston EMA using these funding streams. Each of the HIV/AIDS service payers/providers provided either a substantial amount of funding/services to PLWH or provided direct services specifically for PLWH.

## Analysis of Boston EMA HIV Services Funding Streams

The three main funding sources (Federal, State, and Ryan White) for HIV/AIDS services are further subdivided into 14 funding streams in the Boston EMA. According to Figure 4b, the majority of funding available for HIV/AIDS services in the Boston EMA comes from State (MA and NH) funding streams (46%, \$133,606,121). Other Federal funding streams, other than Ryan White, make up the next largest share of funding available for HIV/AIDS services in the Boston EMA (38%, \$107,967,084). Ryan White funding streams make up only 16% (\$47,863,454) of the total HIV/AIDS funding available in the region. When compared to 2008, the proportion of Ryan White contribution in funding HIV/AIDS services in the Boston EMA is almost identical to 2009 (Figures 4a and 4b), although there was a decrease in Ryan White funds and an increase in State funds.

**Figure 4a: 2008 Proportion of HIV/AIDS funding in the Boston EMA**



**Figure 4b: 2009 Proportion of HIV/AIDS funding in the Boston EMA**

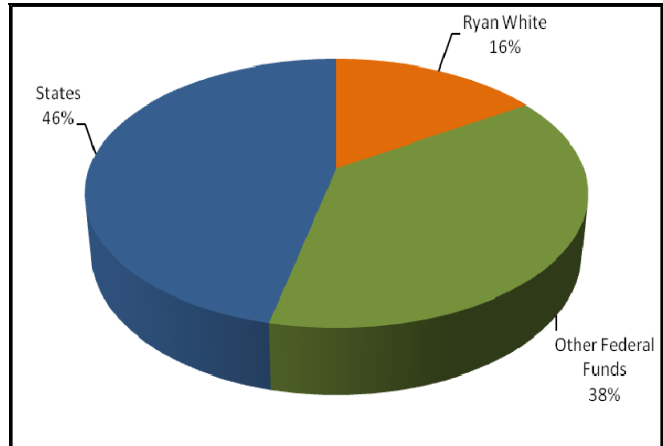
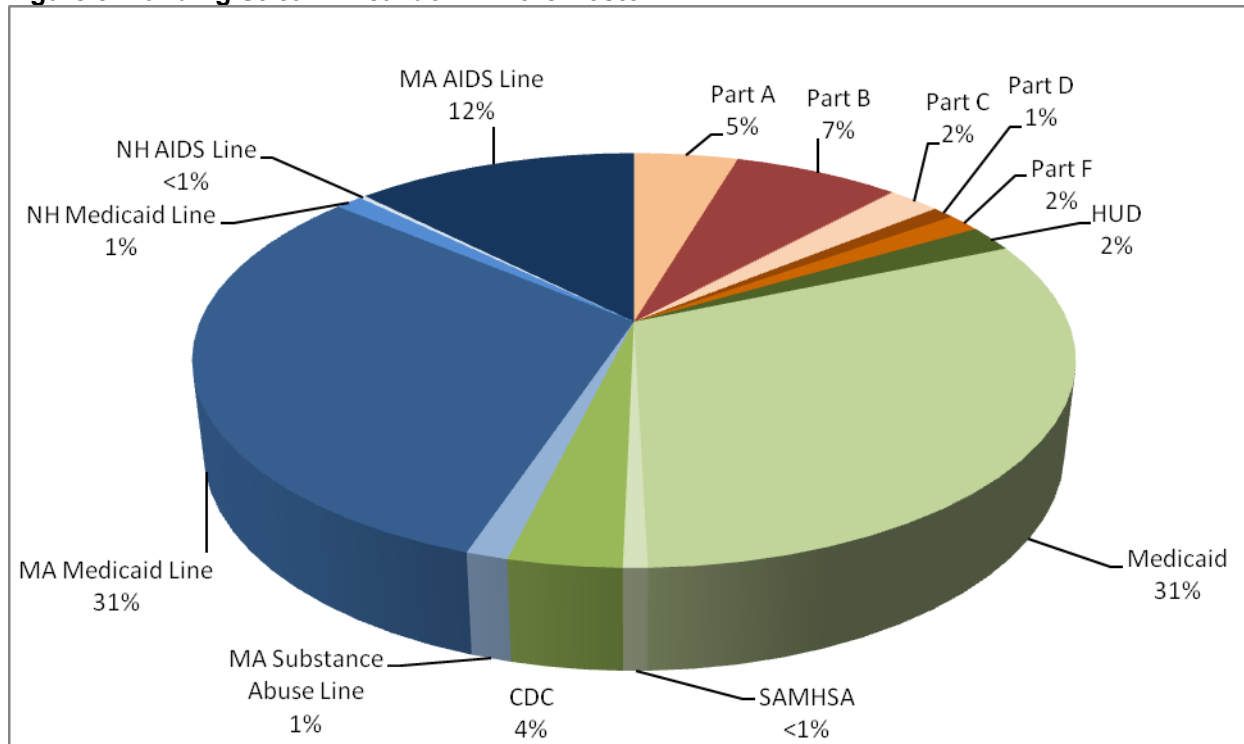


Figure 5 and Table I.A.1 show the breakdown of each of the three main funding streams' share of the total pot of funding available for the provision of HIV/AIDS services in the Boston EMA. Data was provided for 25 Core Medical and HIV Health-Related Support services available for PLWH. Amongst all Ryan White payers/providers, Part B contributes \$21,068,347 in funding for HIV/AIDS services in the Boston EMA (7%). MA Medicaid Line (31%) and MA State's AIDS line (14%) accounts for majority of the State funding for HIV services (\$89,735,360 and \$35,901,632 respectively). Within Other Federal streams, Medicaid is the largest contributor to the continuum of care (32% of the total HIV/AIDS funding available in the region).

**Figure 5: Funding Stream Breakdown in the Boston EMA**



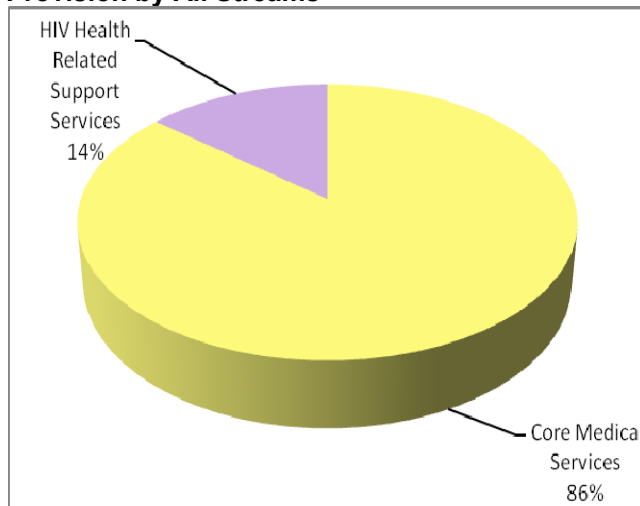
**Table I.A.1: Funding Streams in the Boston EMA**

<b>Funding Source</b>	<b>Total Allocation</b>
Part A	\$13,184,240
Part B	\$21,068,347
Part C	\$6,646,349
Part D	\$2,788,812
Part F	\$4,175,679
Housing and Urban Development (HUD)	\$5,907,732
Federal Medicaid	\$89,735,361
Substance Abuse and Mental Health Services Administration (SAMHSA)	\$2,179,905
Centers for Disease Control & Prevention (CDC)	\$10,144,086
MA Substance Abuse	\$3,747,653
MA Medicaid	\$89,735,360
NH Medicaid	\$3,469,467
MA AIDS Line	\$35,901,632
NH AIDS Line	\$750,000
<b>Total</b>	<b>\$289,434,650</b>

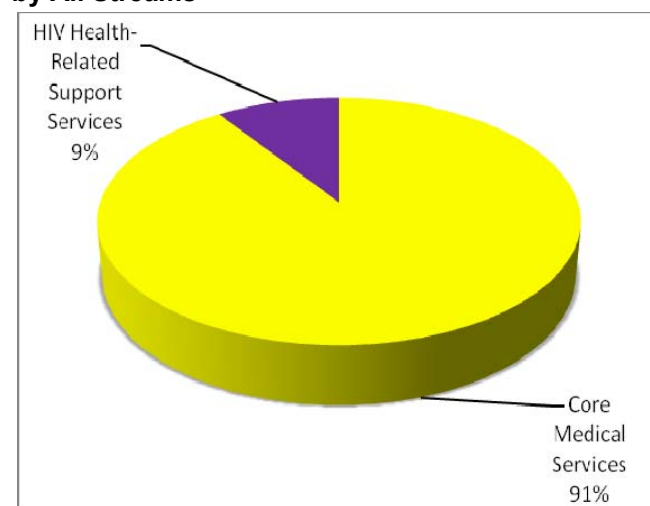
## Funding By Core Medical Services and HIV Health-Related Support Services

Payers/providers also reported on the distribution of their funds by Part A fundable service categories for PLWH. Figure 6a and 6b illustrate the distribution of funds available within the Boston EMA for Core Medical Services and HIV Health-Related Support Services. Across all funding streams, 91% of funding is allocated to Core Medical Services, while only 9% of funding is allocated to HIV Health-Related Support Services. This is slightly different from the 2008 distribution, which allocated more funds to HIV Health-Related Support Services (14% compared to 9%) (Figures 6a and 6b).

**Figure 6a: 2008 Direct and Indirect Service Provision by All Streams**



**Figure 6b: 2009 Direct and Indirect Service Provision by All Streams**



*The 75/25 clause of the Ryan White Act of 2006 requires that 75% of direct services funding be devoted to providing Core Medical Services. No other funding stream has such a requirement. According to the Ryan White Act of 2006, only Parts A, B and C are required to abide by the 75/25 clause. However, Part A received a waiver for this requirement during the period under review.*

Overall, State and Other Federal funding streams provide the greatest contribution to both Core Medical Services and Non-Core Medical Services. Figure 7 illustrates the breakdown within the three major funding streams for each of the service types. Significant proportions of State and Other Federal (non-Ryan White) funding are allocated to Core Medical Services (45% and 43% respectively). In 2009, the total allocation to Core services in the Boston EMA was \$210,756,411 which is \$12,079,466 more compared to \$198,676,945 in 2008. Meanwhile, the 2009 HIV Health-Related Support Services had a total allocation of \$22,383,042 which is \$4,042,702 more compared to the 2008 allocation level of \$18,340,340.

**Figure 7: 2009 Funding Streams Proportional Distribution for Core and Support Services**

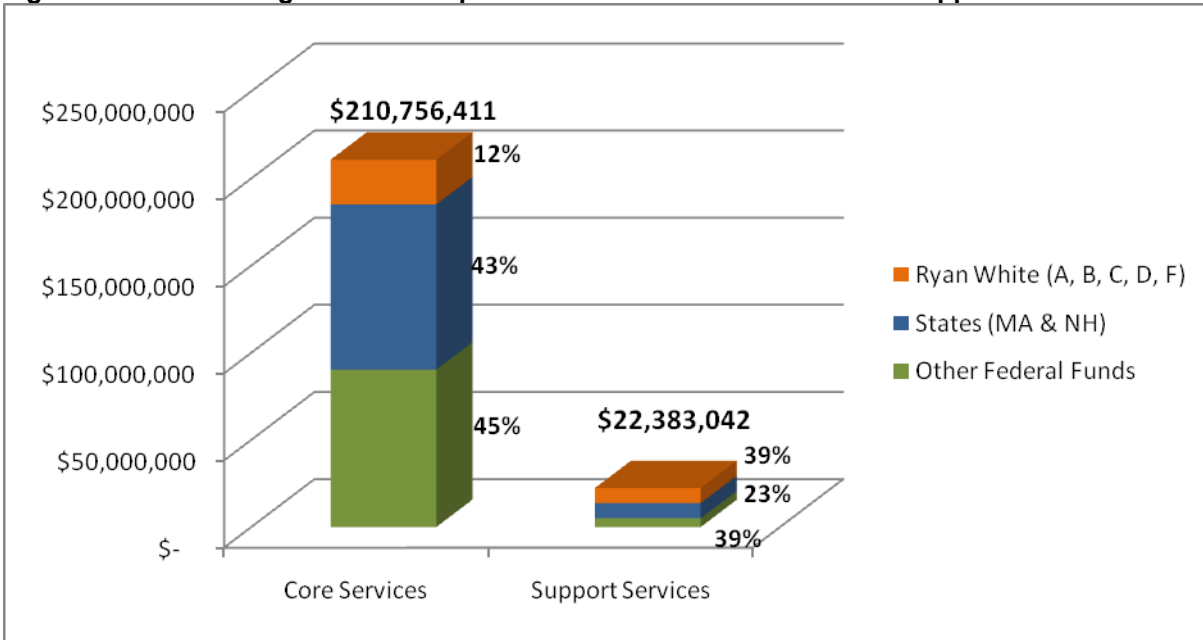
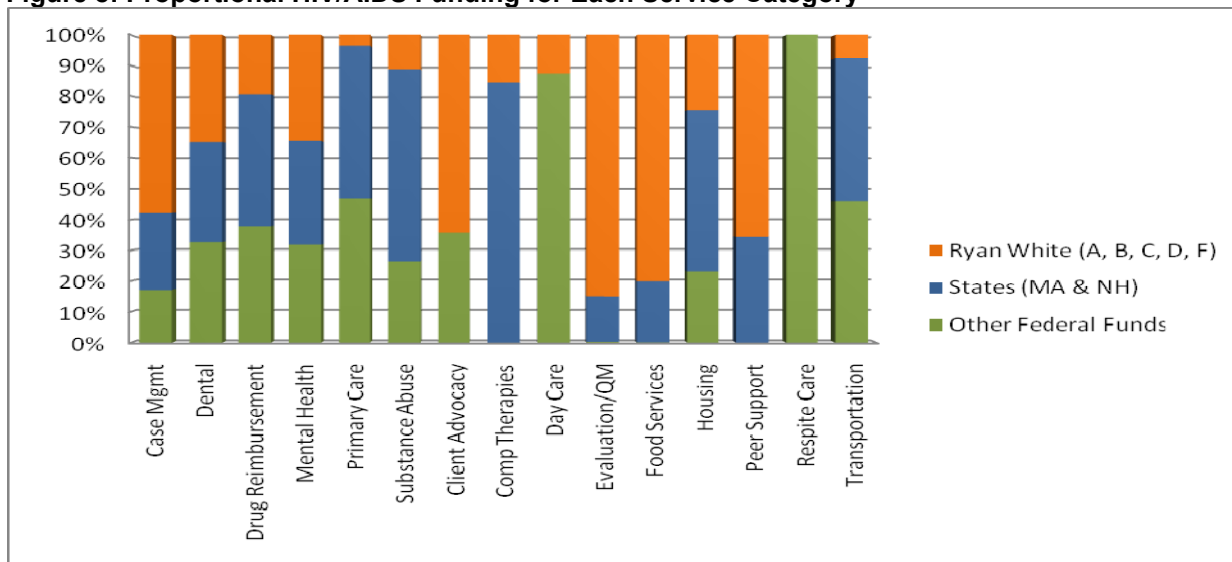


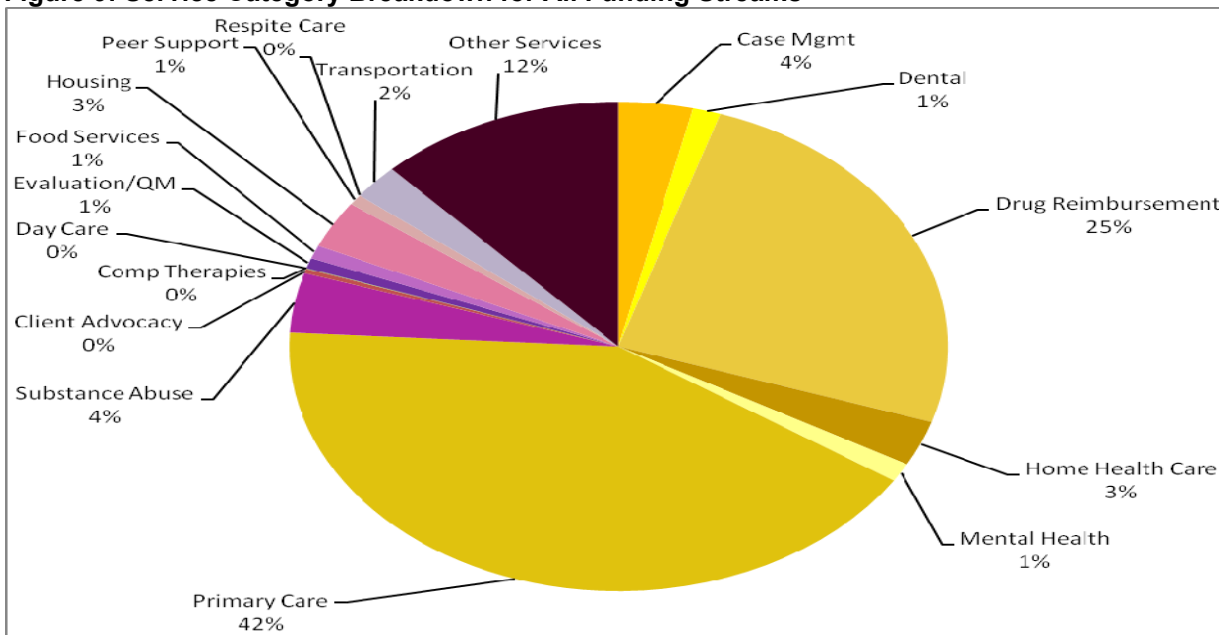
Figure 8 provides additional explanation on the breakdown of Core and Health-Related Support Services across the three main funding sources for HIV/AIDS services in the Boston EMA. States and Other Federal funding streams cover Part A services that fall within the domain of Core Medical Services (Figure 8). Almost 90% of Core Medical Services are covered by these funding streams (\$94,789,500 and \$90,347,791, respectively). Meanwhile, Ryan White covers almost 60% of Case Management, a service that provides a critical link between PLWH and other much needed services. Within HIV Health-Related Support Services, Ryan White covers significant portions of Client Advocacy, Evaluation/Quality Management, Food Services, and Peer Support.

**Figure 8: Proportional HIV/AIDS Funding for Each Service Category**

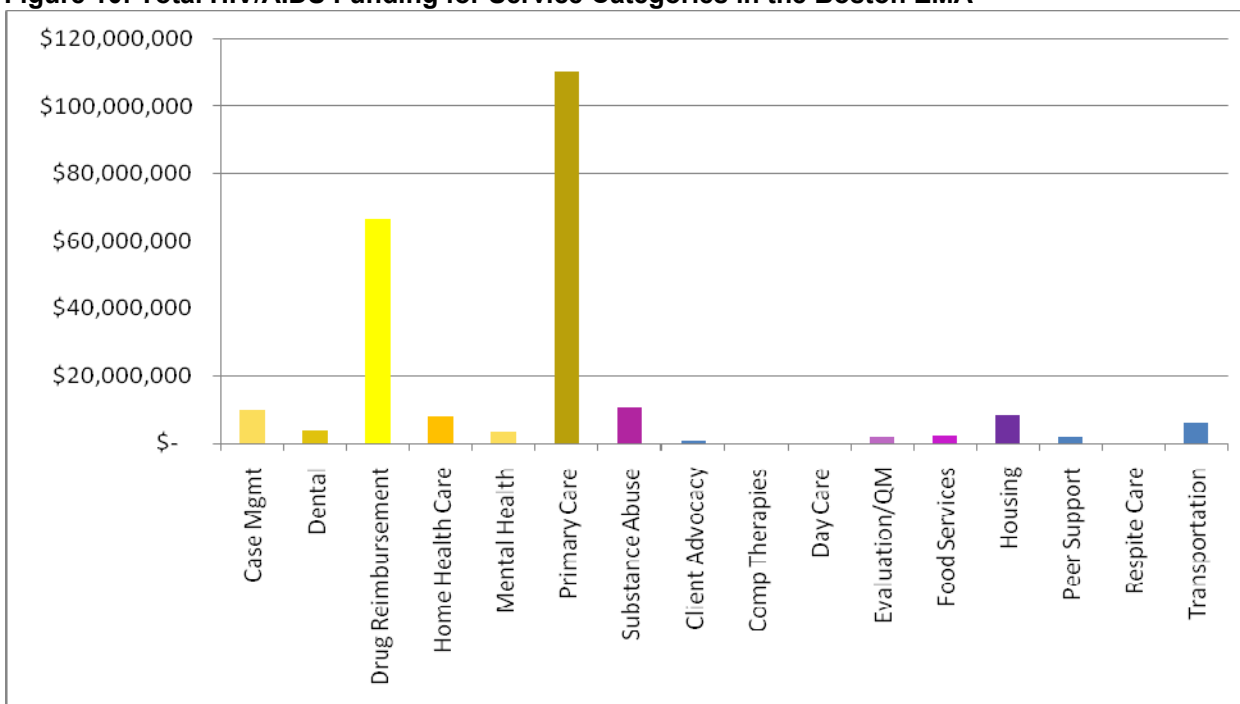


When all funding streams are combined, 91% of funding provides Core Medical Services particularly Primary Care (42%) and Drug Reimbursement (25%) (Figures 9 and 10). HIV Health-Related Support Services receives 9% of all HIV/AIDS funding within the Boston EMA region and the main services are Housing (3%) and Transportation (2%). 12% of the total funds for HIV services in the EMA is allocated for “other services” that were not listed on the survey, and these included services for continued education, journal subscriptions, travel reimbursement for staff, and supplies

**Figure 9: Service Category Breakdown for All Funding Streams**



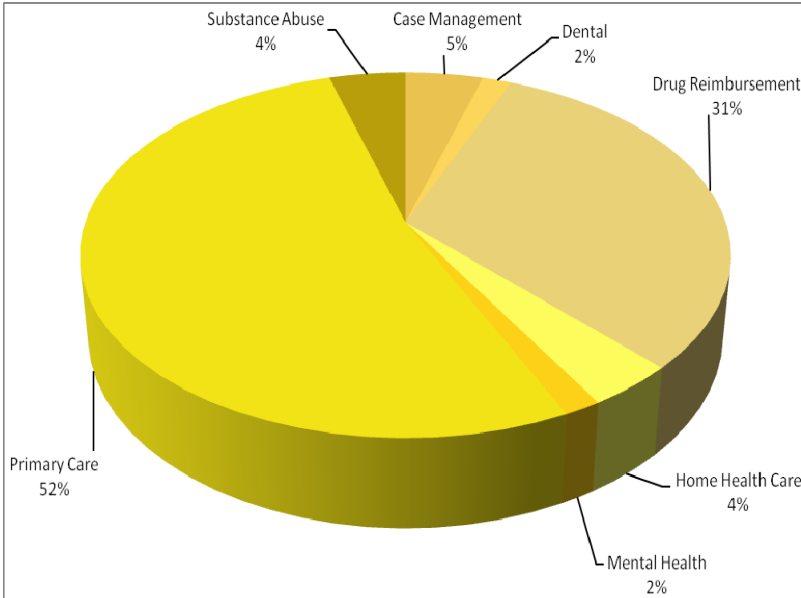
**Figure 10: Total HIV/AIDS Funding for Service Categories in the Boston EMA**



## Core Medical Services

The largest proportions of the total funding collectively invested in Core Medical Services were allocated to Primary Care (52%) and Drug Reimbursement (31%) (Figure 11).

**Figure 11: Core Medical Services Distribution for All Streams**

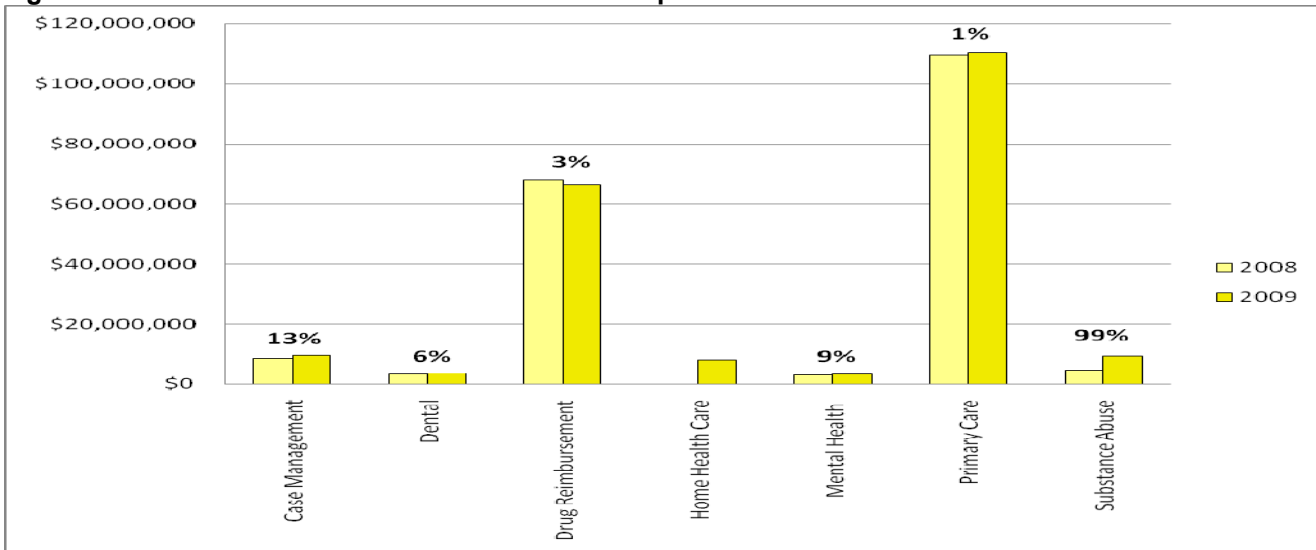


**Table I.A.2 Core Medical Services**

Service Categories	2008	2009
Case Management	\$8,526,126	\$9,644,339
Dental	\$3,407,566	\$3,621,522
Drug Reimbursement	\$68,038,845	\$66,277,052
Home Health Care	NA	\$7,982,982
Mental Health	\$3,020,331	\$3,290,499
Primary Care	\$109,625,660	\$110,442,776
Substance Abuse	\$4,781,194	\$9,497,241
	<b>\$197,399,722</b>	<b>\$210,756,411</b>

Comparing 2009 funding for Core Medical Services to funds available in 2008, there was a 3% decrease (\$1,761,793) in Drug Reimbursement funding. Substance Abuse had an increase from \$4,781,194 in 2008 to \$9,497,241 in 2009, due to an increase from Other Federal funding (Table 1.A.2 and Figure 12). In 2008, the Part A Grantee was required to split the services covered under Substance Abuse. In this report, \$993,375 of Substance Abuse Residential allocated for Residential services funding was placed in HIV Health-Related Support Services. Additionally, some payers/providers that reported in 2008 did not provide data for the 2009.

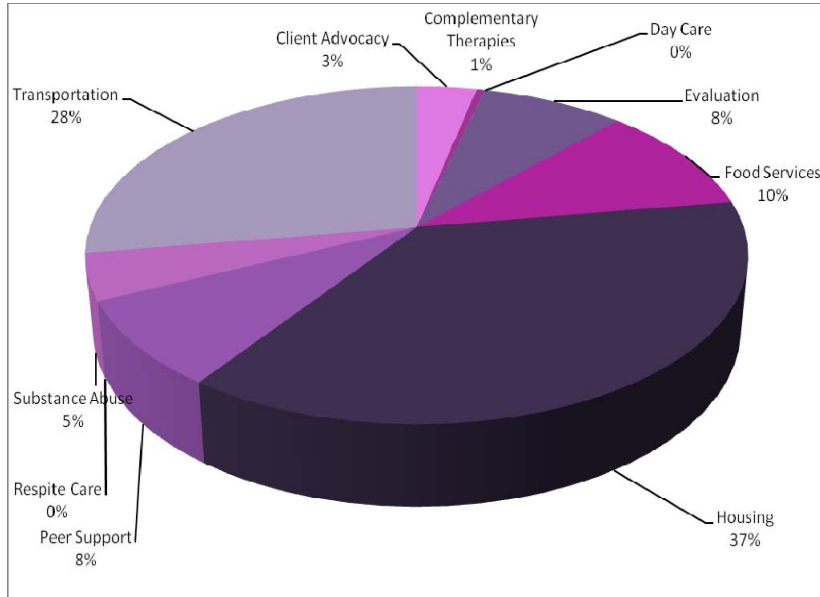
**Figure 12: Core Medical Services 2008 vs 2009 Comparison for All Streams**



## HIV Health-Related Support Services

Across all funding streams, Housing (37%) and Transportation (28%) received the largest proportion of funding for HIV Health-Related Support Services in the Boston EMA (Figure 13 and Table I.A.3).

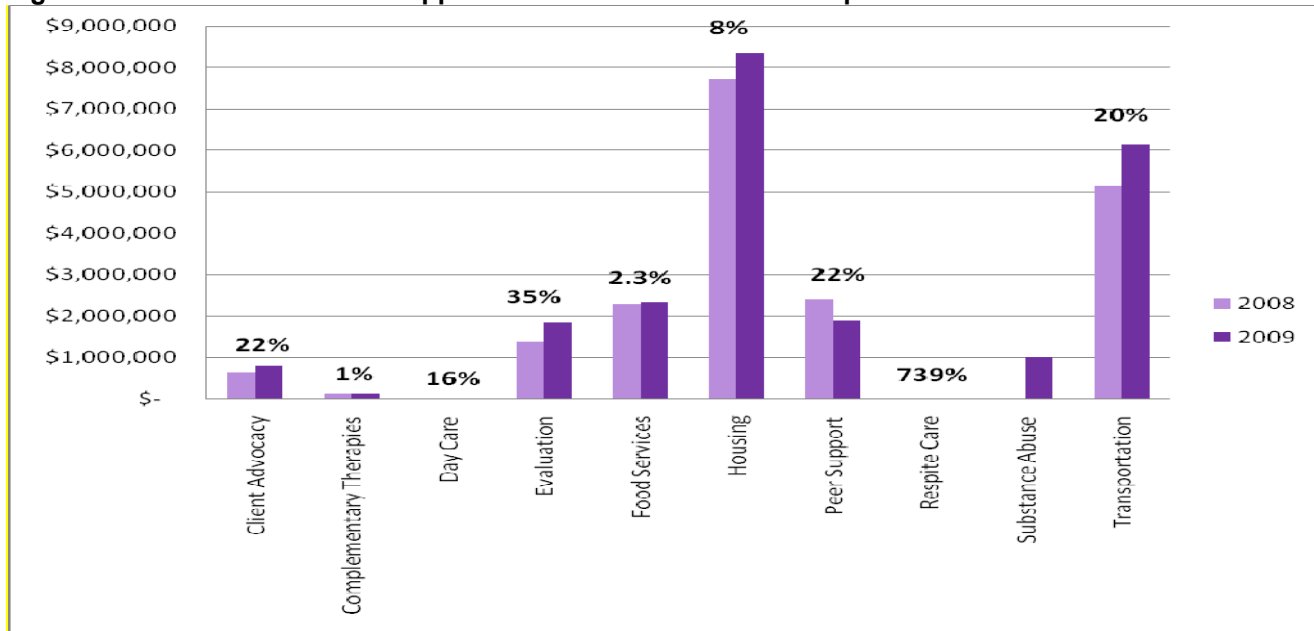
**Figure 13: HIV Health-Related Support Services Distribution for All Streams**



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

Service Categories	2008	2009
Client Advocacy	\$626,938	\$766,836
Complementary Therapies	\$107,530	\$108,411
Day Care	\$2,956	\$3,434
Evaluation	\$1,356,878	\$1,828,071
Food Services	\$2,274,367	\$2,327,405
Housing	\$7,705,120	\$8,342,225
Peer Support	\$2,398,754	\$1,864,548
Respite Care	\$250	\$2,082
Substance Abuse		\$993,375
Transportation	\$5,144,770	\$6,146,655
	<b>\$19,617,563</b>	<b>\$22,383,042</b>

**Figure 14: HIV Health-Related Support Services 2008 vs 2009 Comparison for All Streams**



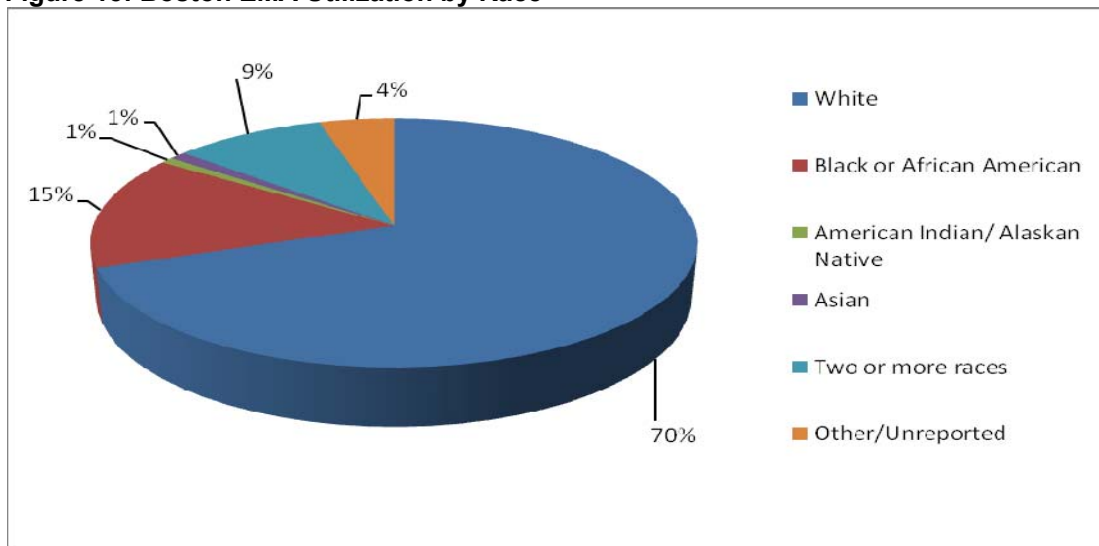
Although, overall, there was a 14% increase in HIV Health-Related Support Service, comparing 2008 to 2009, there were large increases in Client Advocacy (22%), Evaluation/Quality Management (35%), and Transportation (22%) services (Figure 14).

## 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, 2007, Whites make up the largest proportion of PLWH in the Boston EMA (Table I.A.4). Whites account for 48%, almost half of the prevalent cases, even though they comprise 83% of the Boston EMA population.

According to utilization data reported by all funding streams, 70% (55,536) of clients receiving services for PLWH are White (Figure 15). Even though Blacks account for 30% of PLWH, they comprise only 5% of the Boston EMA population and 15% (11,799) were reported as having accessed services funded for PLWH (Figure 15). Hispanics account for 20% of the prevalent cases in the Boston EMA, yet they comprise 6% of the Boston EMA population, and 14% (11,091) of recipients of HIV funded services.

**Figure 15: Boston EMA Utilization by Race**



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

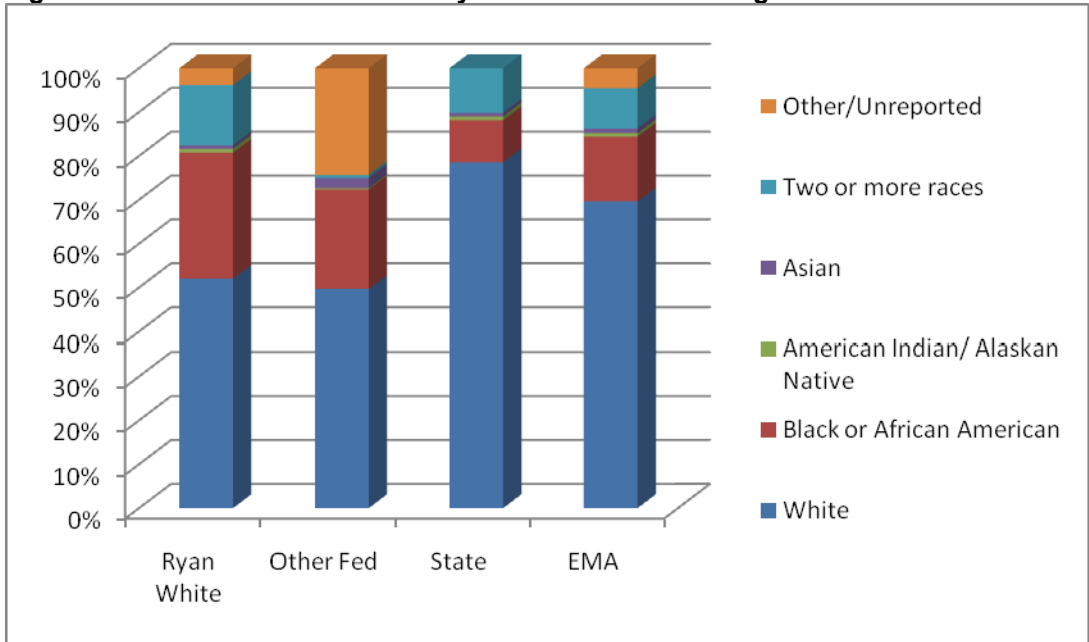
Race/Ethnicity	EMA*	HIV/AIDS Prevalence	Service Profile***
White	5,579,038	6,873	55,536
Black or African American	445,033	4,277	11,799
Hispanic**	528,880	2,972	11,091
American Indian/ Alaskan Native	19,349	25	619
Asian	316,038	210	834
Two or more races	83,847	N/A	7,357
Other/Unreported		63	3,631
	<b>6,972,185</b>	<b>14,420</b>	<b>90,867</b>

\*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 16: 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 16), services provided through Ryan White cover a larger portion of racial/ethnic minorities (Figures 16 and 17). Due to varying methods of data collection, PCS was not able to collect separate racial demographics by ethnicity. However, overall in the Boston EMA, 90% of consumers of services for PLWH are non-Hispanic (Figure 17). Ryan White funded programs serve more Hispanics compared to other funding streams in the Boston EMA.

**Figure 17: Boston EMA Utilization by Ethnic Group**

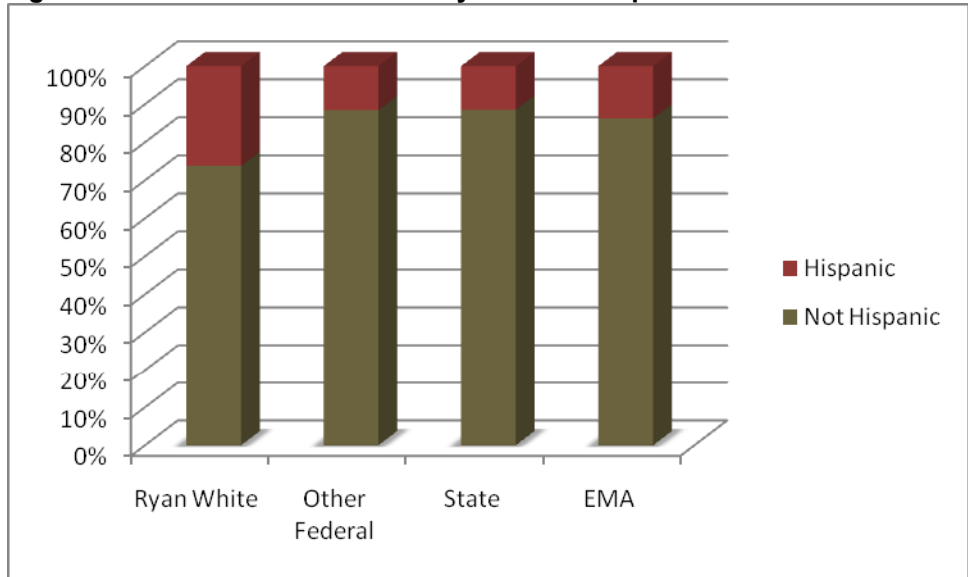
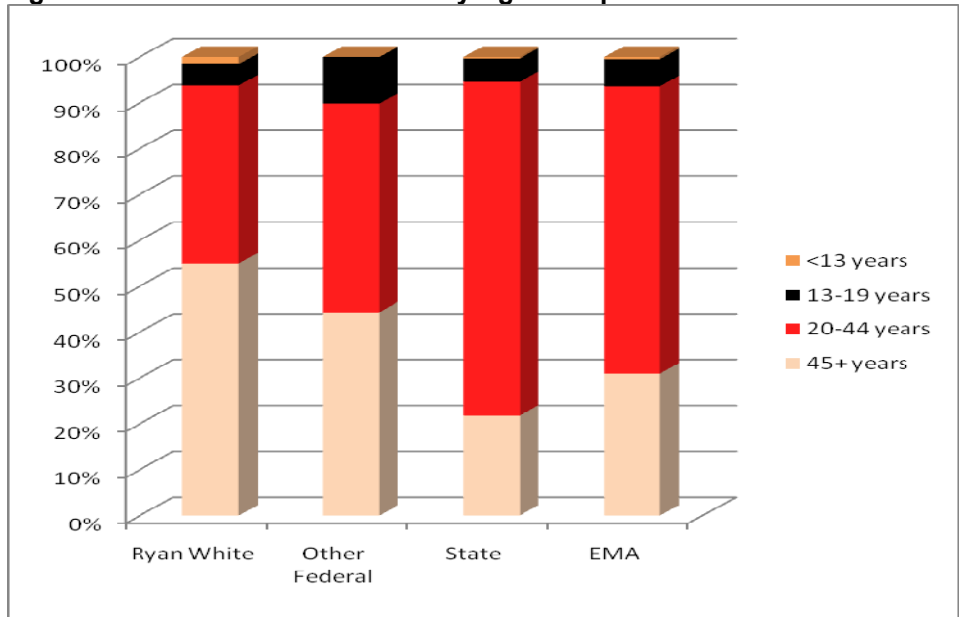


Figure 18 examines service utilization by age group. The majority of Ryan White funded services are used by PLWH over 45 years, while the majority of State and Other Federal funded services are used by PLWH aged 20-44.

**Figure 18: Boston EMA Utilization by Age Group**



**Conclusion**

The Boston EMA has a responsive and comprehensive continuum of care that includes both Primary Medical Care and supportive services that promote health and enhance quality of life. In total \$289,434,650 in funding for the region provides services across the spectrum of public health needs. State funding streams make up the greatest portion of dollars available for funding in the Boston EMA.

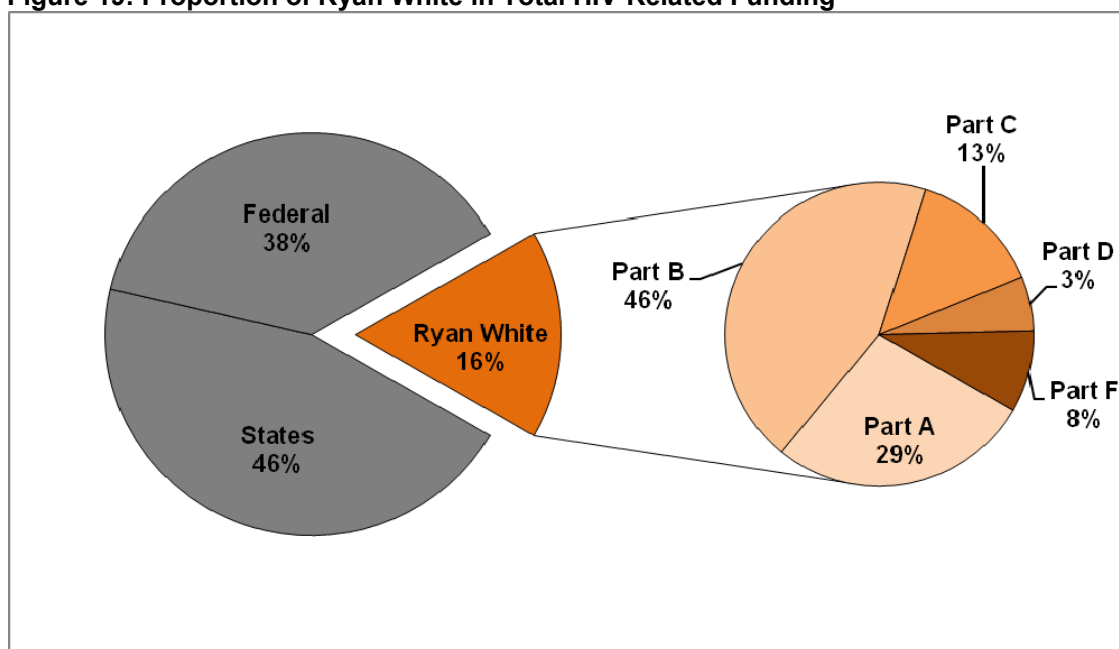
Primary Medical Care and Drug Reimbursement receive the most funding in the region. MassHealth, the Massachusetts Medicaid program, serves as the largest payer. As payers of last resort, Ryan White streams help to provide necessary Health-Related Support Services such as Food services, Client Advocacy, and Peer 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 share of total 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, Special Projects of National Significance and the Minority AIDS Initiative). Ryan White represents 16% of total funding for HIV/AIDS services in the Boston EMA (Figure 19).*

**Figure 19: Proportion of Ryan White in Total HIV-Related Funding**



### Introduction

The Ryan White Act was first enacted in August 1990 (formerly CARE Act). Much has changed in the epidemiology and medical management of HIV/AIDS since the Ryan White Act was first enacted. It was amended and reauthorized for five years in May 1996, reauthorized again for an additional five years in October 2000, and reauthorized once more for three years in December 2006. Ryan White Act funding is Federal in origin and is administered by Health Services Resource Administration (HRSA) across its 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

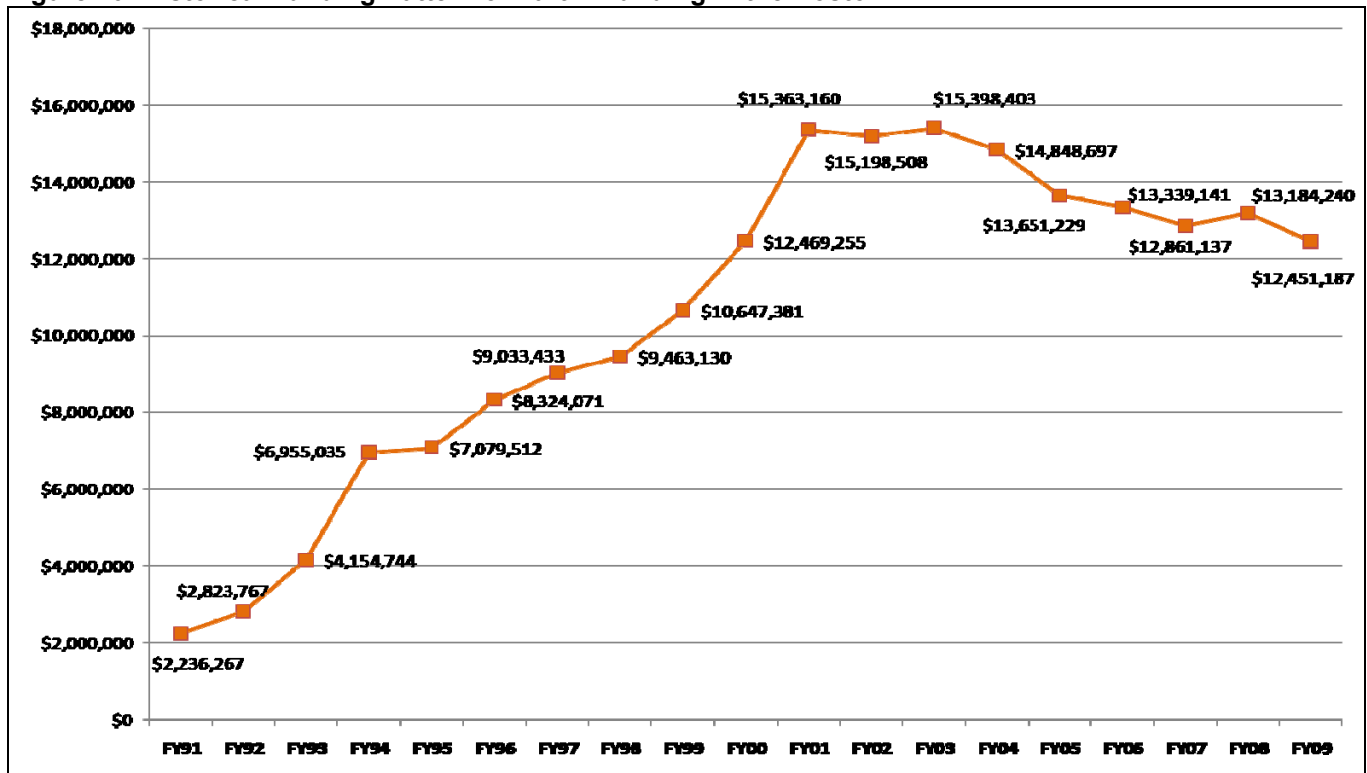
The Boston Public Health Commission (BPHC) HIV/AIDS Services Division receives funding from the HRSA. PCS, which produced this report, is subcontracted by BPHC to support and provide administration to the Boston HIV Health Services Planning Council, the community planning group associated with Part A 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 56 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 \$12,451,187 in Ryan White Part A funding for FY 2009 (March 1, 2009 to February 28, 2010). The funding is managed by BPHC, which distributes the funds throughout the community using a Request for Proposals process. Figure 20 demonstrates historical funding of Part A since its inception.

*FY 2009 funding levels are now available for Ryan White Part A services, but this data was not used since FY 2009 falls outside of the period of time under review in this report. Moreover, there is no utilization data to accompany the FY 2009 funding data.*

**Figure 20: Historical Funding Pattern of Part A Funding in the Boston EMA**



### *Resource Inventory*

The City of Boston receives Part A funding for 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) and Part A services are contracted throughout the entire EMA. Part A definitions for services were used to complete this report and are located in the report Appendix (Appendix).

BPHC receives funding from HRSA for the entire EMA and the services are then distributed throughout the territory using a Request for Proposals (RFP) process. Part A funds are used to provide a range of community-based services to PLWH according to two general categories:

- *Direct 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.*

In FY 2009 there were 93 programs based in 50 agencies. An entire list of the funded entities, a description of their services and their funding level is available on the Boston Public Health Commission website ([http://www.bphc.org/bphc/pdfs/aids\\_agencydesc.pdf](http://www.bphc.org/bphc/pdfs/aids_agencydesc.pdf)).

### *Utilization*

Ryan White Part A services were provided to 6,191 unduplicated consumers in FY 2008. 35.9% of consumers served were White and 27.7% were Black. Approximately a third (32.3%) of consumers were Hispanic. The majority of consumers served with Part A funding were 20 years and older, with 42.7% in the 20-44 age group and 54.9% in the 45+ group. Heterosexual transmission was the most prevalent mode of HIV exposure (30.2%), but IDU and MSM were also significant modes of HIV exposure among Part A consumers (25.8% and 22.7%, respectively). 12.1% of consumers' mode of infection was undetermined.

### *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 base 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 provides 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, Massachusetts received \$19,567,006 in Part B funding and New Hampshire received \$1,501,341 in Part B funding. FY 2009 funding levels are now available for Ryan White Part B services, but this data was not available at the time of drafting this report. Moreover, the FY 2009 utilization data is not yet available.

### *Resource Inventory*

The Massachusetts Department of Public Health and New Hampshire Department of Health and Human Services receive Ryan White Part B funding in the Boston EMA. Each state receives funding for the entire state and the services are then distributed throughout the territory, including the Boston EMA using an RFP 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 the ADAP Program; and
- Direct health and HIV Health-Related Support Services.

### *Utilization*

New Hampshire served 297 PLWH in the Boston EMA in their most recent complete fiscal year. The general population in New Hampshire is predominantly white. 77.1% of the consumers served with Part B funding in NH were White and only 12.8% were Black. 11.1% of consumers were Hispanic and 8.4% identified themselves as Two or More Races/Other Racial categories. 98.7% of Part B services in NH were utilized by people 20 years and older, with 45.8% in the 20-44 and 52.9% in the 45+ group. MSM is the most prevalent mode of HIV exposure among NH Part B consumers (46.1%) with Heterosexual and IDU following as the second and third most common modes of exposure (37.4% and 11.1% of consumers respectively). 1.7% of NH Part B consumers had an unidentified exposure category. Massachusetts was unable to provide Part B utilization data for this report.

### Part C

Part C is allocated to community health centers in the EMA for Early Intervention Services (EIS). 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 \$6,646,349 in the most recently completed fiscal year. Fiscal years for Part C services in the Boston EMA vary typically occurring January 1, 2008 to December 31, 2009 and others occurring July 1, 2008 to June 30, 2009. 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;
- 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 4,086 PLWH in the Boston EMA in the most recent fiscal year (again some consumers may be duplicates). 64.2% of the consumers served with Part C funding in the Boston EMA were White and only 25% were Black. 20.1% of consumers were Hispanic and 9.5% self-identified as members of Two or More/Other racial categories. Over 93.2% of Part C services in the Boston EMA were utilized by people 20 years and older, with 46.4% in the 20-44 group and 46.8% in the 45+ group. MSM is the most prevalent mode of HIV exposure among Part C consumers (38.6%), with Heterosexual and IDU following as the second and third most common modes of exposure (29.5% and 20.5% of consumers respectively). 9.3% of Part C consumers had an unreported exposure risk category. Of the 16 pediatric consumers receiving Part C 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 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 \$2,788,812 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 1, 2008 to July 31, 2009, and others occurring January 1, 2008 to December 31, 2008. 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 1148 PLWH in the Boston EMA in the most recent fiscal year. 55.7% of the consumers served with Part D funding in the Boston EMA were Black and only 23.7% were White. 24.3% of consumers were Hispanic and 19.6% were

members of Two or More/Other racial categories. 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 60% of Part D services in the Boston EMA were utilized by people 20 years and older, with 36.5% in the 20-44 group and 20.4% in the 45+ group. Consumers aged 13-19 years make up 27.1% of Part D clients. The most prevalent mode of HIV exposure among Part D consumers is Heterosexual transmission (69.9%), with IDU and MSM following as the second and third most common modes of exposure (12.7% and 7.8% of consumers, respectively). 6.6% of Part D consumers had an unreported exposure risk category. Of the 258 pediatric consumers receiving Part D funded services in the Boston EMA, 92.6% were exposed by their mother who was at risk for or already infected with HIV when the infant was born, and 7.4% had an unreported risk.

### Part F

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

#### *1) Minority AIDS Initiative (MAI)*

Part F MAI provides funding for activities to evaluate and address the disproportionate impact of HIV/AIDS on racial and ethnic minorities. Before the most recent authorization of the Ryan White Act, MAI funding was bundled as a carve-out of awards to the various parts of the Ryan White system to address disparities in access, treatment, care, and health outcomes. The new Ryan White HIV/AIDS Treatment Modernization Act of 2006 moved MAI funding under its own subpart within Part F. Recipients of Part A and B funding compete for the additional MAI funding. MAI funding for Parts C, D and Part F AIDS Education and Training Center programs continue to be awarded at the same time as recipient providers receive their other Ryan White funds.

#### *Funding Level*

The Boston Public Health Commission received \$843,100 in Part F MAI funding to distribute throughout the Boston EMA in FY 2008.

#### *Resource Inventory*

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

#### *Utilization*

There is also potential for duplication of consumer counts within MAI utilization data. In total, MAI funding provided services to 404 PLWH in the Boston EMA in the most recent fiscal year. Majority of the PLWH served were women (238), with a small proportion

composed of children (3) and youth (8). 44% of the consumers served with MAI funding in the Boston EMA were Black and 56% were Hispanic. Unlike other funding streams, MAI services target specifically minority populations.

## *2) 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 \$438,644 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 1, 2007 to June 30, 2008.

### *Resource Inventory*

Agencies 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 New Hampshire or the remainder of the EMA.

### *Utilization*

Part F Dental Program utilization data is not unduplicated by consumer. In total Part F Dental Program funding provided services to 1,632 PLWH in the Boston EMA in the most recent fiscal year. 65% of the consumers served with Part F Dental Program funding in the Boston EMA were White and only 23.4% were Black. 22.1% of consumers were Hispanic and 11.3% were of Two or More/Other racial categories 99.8% of Part F Dental Program clients were in the 20 and over age group, with 15.4% in the 20-44 group and 84.4% 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.

## *3) 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. SPNS 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 is currently only one program in Massachusetts funded under a SPNS grant.

## *4) 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. AETC 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.

Each AETC regional center covers at least one Part A EMA, and collaboration between AETC and Part A is based on local needs. AETCs 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. NEAETC subcontracts with local performance sites in each of the states in the region.

### Ryan White Funding Analysis

For the most recent fiscal year, \$47,863,454 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 (\$21,068,374 and \$13,184,240, respectively), but these streams are intended to be used on a regional basis (Figure 21). Parts C, D and F, on the other hand, are directly awarded to health centers and AIDS Service Organizations (ASOs).

**Figure 21: Ryan White Funding 2008 vs 2009 Comparison by Parts**

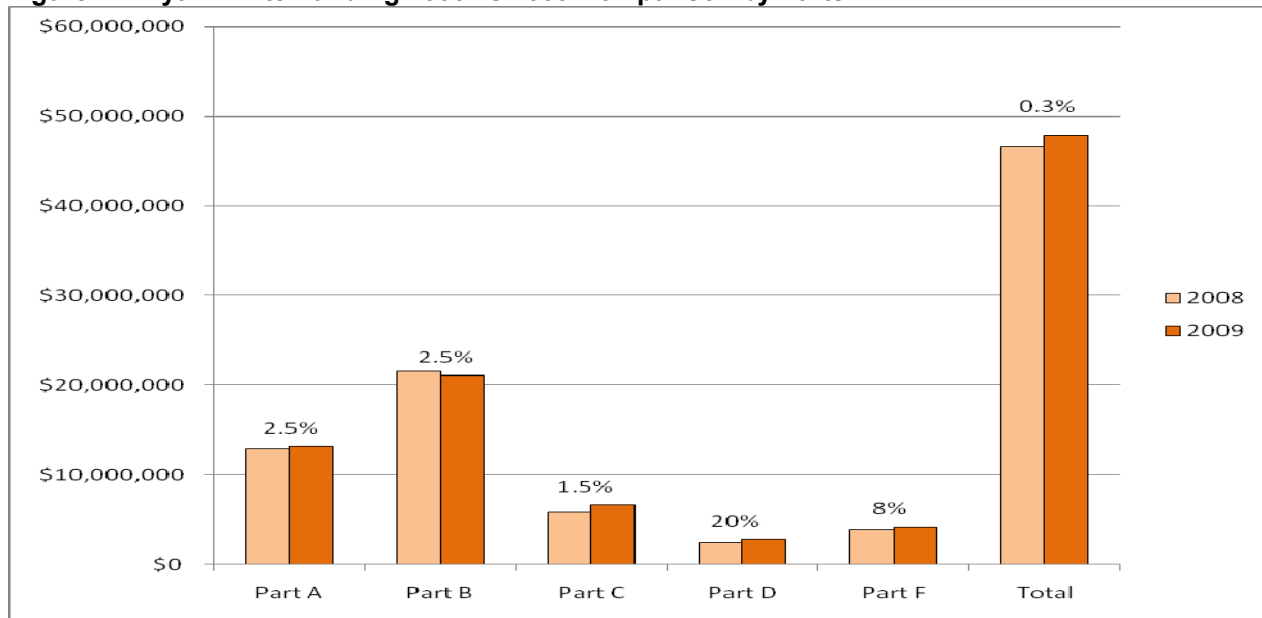


Table II.A.1 shows that Drug Reimbursement, Case Management and Primary Medical Care were the service categories that received the most funding as a percentage of all Ryan White streams (37%, 17% and 12%, respectively).

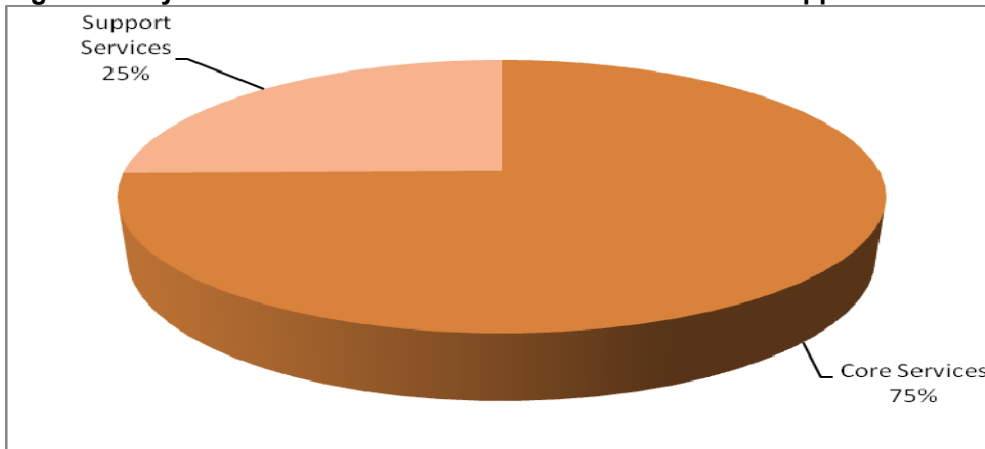
**Table II.A.1: Service Category Funding Levels for Ryan White Funding Streams**

Part A Svc Categories	Part A	Part B	Part C	Part D	Part F	Subtotal
Case Management	\$2,281,285	\$1,898,890	\$598,588	\$806,932	\$0	\$5,585,695
Client Advocacy	\$445,332	\$0	\$0	\$47,467	\$0	\$492,799
Complementary Therapies	\$0	\$0	\$16,890	\$0	\$0	\$16,890
Day Care	\$0	\$0	\$0	\$0	\$0	\$0
Dental	\$657,458	\$18,267	\$141,985	\$0	\$438,644	\$1,256,354
Drug Reimbursement	\$1,402,639	\$11,522,463	\$15,000	\$0	\$0	\$12,940,102
Evaluation/QM	\$417,160	\$368,238	\$169,241	\$5,052	\$550,000	\$1,551,435
Food Services	\$1,769,927	\$52,997	\$10,464	\$28,697	\$0	\$1,862,085
Home Health Care	\$0	\$428,796	\$0	\$0	\$0	\$428,796
Housing	\$2,039,043	\$0	\$0	\$0	\$1,737	\$2,040,780
Mental Health	\$427,196	\$74,255	\$513,729	\$115,395	\$0	\$1,130,575
Peer Support	\$735,521	\$456,511	\$2,500	\$29,282	\$0	\$1,223,814
Primary Care	\$216,787	\$74,478	\$3,373,161	\$420,292	\$0	\$4,084,718
Respite Care	\$0	\$0	\$0	\$0	\$0	\$0
Substance Abuse	\$1,099,338	\$25,434	\$61,135	\$174	\$0	\$1,186,081
Transportation	\$374,140	\$23,789	\$18,242	\$58,578	\$0	\$474,749
<b>Subtotal Part A Svc Cat</b>	<b>\$11,865,826</b>	<b>\$14,944,098</b>	<b>\$4,917,344</b>	<b>\$1,557,812</b>	<b>\$990,381</b>	<b>\$34,275,481</b>
Additional Services	Part A	Part B	Part C	Part D	Part F	Subtotal
Admin/Program Support	\$939,683	\$119,136	\$545,938	\$94,373	\$264,783	\$1,963,913
Capacity Building/TA	\$0	\$32,000	\$3,968	\$59,207	0	\$95,175
Counseling & Testing	\$0	\$0	\$147,336	\$19,050	\$0	\$166,386
Education/Risk Reduction	\$0	\$0	\$91,265	\$20,100	\$0	\$111,365
Emergency Financial Assist	\$0	\$47,831	\$18,000	\$0	\$0	\$65,831
Insurance Continuation	\$0	\$150,842	\$45,697	\$0	\$0	\$196,539
Outreach	\$0	\$0	\$58,193	\$47,600	\$0	\$105,793
Prevention/Education	\$0	\$0	\$19,715	\$0	\$0	\$19,715
Other	\$0	\$627,851	\$190,250	\$0	\$0	\$818,101
Unreported	\$0	\$0	\$0	\$0	\$0	\$0
<b>Subtotal of Additional Svcs</b>	<b>\$939,683</b>	<b>\$977,660</b>	<b>\$1,120,362</b>	<b>\$240,330</b>	<b>\$264,783</b>	<b>\$3,542,818</b>
<b>Total of All Svcs</b>	<b>\$13,184,240</b>	<b>\$15,921,778</b>	<b>\$6,037,706</b>	<b>\$1,798,142</b>	<b>\$1,255,164</b>	<b>\$38,197,030</b>

Note: Not all agencies within the above four Funding Streams provided a stratified analysis of allocated funds. PCS obtained total awards for agencies that did not provide a survey from the HRSA website. Therefore the sum in the above table is less than what was actually collected.

Among Ryan White funding streams, 75% of direct service funding was invested in Core Medical Services and 25% was invested in HIV Health-Related Support Services (Figure 22). 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 22: Ryan White Core Medical and HIV Health-Related Support Services**

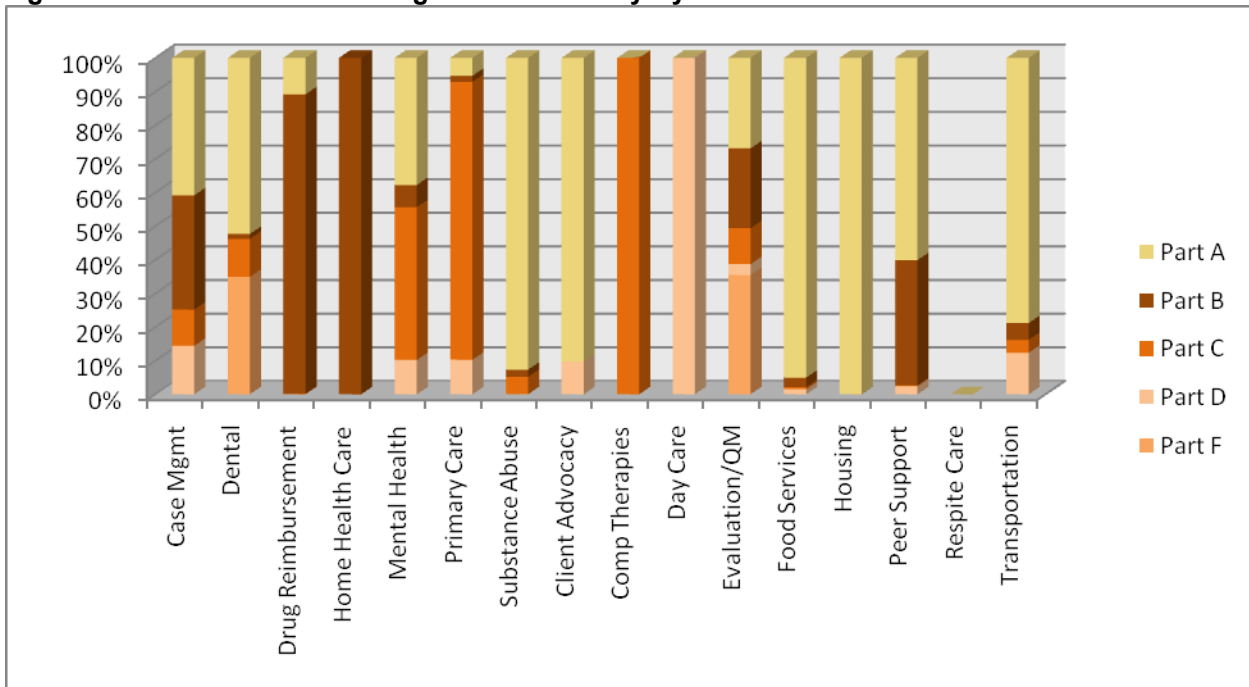


However, each funding stream provides for a different service mix. Figure 23 shows the proportional contribution of each Ryan White stream to the mix of Core and HIV Health-Related Support Services. Among Ryan White funding streams, Part B makes the largest contribution to Core Medical Services, but this is due to the large amount of funding provided to ADAP as is seen in the Drug Reimbursement 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 if 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.

Figure 23 shows that Part A funding is most substantial for Client Advocacy, Case Management, Food and Meals Services, Housing, Substance Abuse Services and Transportation in comparison with other Ryan White streams. Part B funding is most substantial for Drug Reimbursement in comparison with other Ryan White Streams. Part C funds all of Complementary Therapies in the Boston EMA, and a substantial amount of Mental Health Services and Primary Medical Care in comparison with other Ryan White Streams. Part F funds make their most substantial contribution in Dental Services in comparison with other Ryan White streams.

**Figure 23: Share of 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

## 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 did not provide utilization data. 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	
	#	%	#	%	#	%	#	%	#	%	#	%
<b>Race</b>												
White	2,593	42.6%	229	77.1%	2,622	64.2%	272	23.7%	1,061	65.0%	6,777	51.1%
Black or African Am	1,770	29.0%	38	12.8%	1,021	25.0%	639	55.7%	382	23.4%	3,850	29.0%
American Ind/Alaskan	107	1.8%	3	1.0%	5	0.1%	2	0.2%	1	0.1%	118	0.9%
Asian	44	0.7%	2	0.7%	52	1.3%	10	0.9%	3	0.2%	111	0.8%
Two or more races	1,498	24.6%	0	0.0%	31	0.8%	91	7.9%	160	9.8%	1,780	13.4%
Other	81	1.3%	25	8.4%	355	8.7%	134	11.7%	25	1.5%	620	4.7%
<b>Total</b>	<b>6,093</b>	<b>100.0%</b>	<b>297</b>	<b>100.0%</b>	<b>4,086</b>	<b>100.0%</b>	<b>1,148</b>	<b>100.0%</b>	<b>1,632</b>	<b>100.0%</b>	<b>13,256</b>	<b>100.0%</b>
<b>Ethnicity</b>												
Hispanic	1,823	29.9%	33	11.1%	854	20.1%	279	24.3%	361	22.1%	3,350	26.5%
Not Hispanic	3,497	57.4%	264	88.9%	3,383	79.4%	869	75.7%	1,271	77.9%	9,284	73.5%
Unknown/Unreported	773	12.7%			22	0.5%	0		0			
<b>Total</b>	<b>6,093</b>	<b>87.3%</b>	<b>297</b>	<b>100.0%</b>	<b>4,259</b>	<b>99.5%</b>	<b>1,148</b>	<b>100.0%</b>	<b>1,632</b>	<b>100.0%</b>	<b>12,634</b>	<b>100.0%</b>
<b>Age</b>												
<13 years	70	1.1%	1	0.3%	11	0.3%	184	16.0%	0	0.0%	266	2.0%
13-19 years	72	1.2%	3	1.0%	264	6.5%	311	27.1%	4	0.2%	654	4.9%
20-44 years	2,482	40.7%	136	45.8%	1,876	46.4%	419	36.5%	251	15.4%	5,164	39.1%
45+ years	3,469	56.9%	157	52.9%	1,894	46.8%	234	20.4%	1,377	84.4%	7,131	54.0%
<b>Total</b>	<b>6,093</b>	<b>100.0%</b>	<b>297</b>	<b>100.0%</b>	<b>4,045</b>	<b>100.0%</b>	<b>1,148</b>	<b>100.0%</b>	<b>1,632</b>	<b>100.0%</b>	<b>13,215</b>	<b>100.0%</b>
<b>Adult/Adolescent HIV Exposure</b>												
MSM	1,607	22.8%	137	46.1%	1,659	38.6%	40	7.8%	0	NA	3,443	28.3%
IDUs	1,378	19.6%	33	11.1%	882	20.5%	62	12.1%	0	NA	2,355	19.4%
MSM and IDUs	0	0.0%	6	2.0%	54	1.3%	0	0.0%	0	NA	60	0.5%
Heterosexual	3,252	46.2%	111	37.4%	1,268	29.5%	357	69.9%	0	NA	4,988	41.1%
Other/blood trans	200	2.8%	5	1.7%	40	0.9%	12	2.3%	0	NA	257	2.1%
Risk not reported	598	8.5%	5	1.7%	399	9.3%	40	7.8%	0	NA	1,042	8.6%
<b>Total</b>	<b>7,035</b>	<b>100.0%</b>	<b>297</b>	<b>100.0%</b>	<b>4,302</b>	<b>100.0%</b>	<b>511</b>	<b>100.0%</b>	<b>0</b>	<b>NA</b>	<b>12,145</b>	<b>100.0%</b>
<b>Pediatric HIV Exposure</b>												
Mother at risk for HIV	0	0	0	0	16	100.0%	239	92.6%	0	0	255	93.1%
Other/blood trans	0	0	0	0	0	0.0%	0	0.0%	0	0	0	0.0%
Risk not reported	0	0	0	0	0	0.0%	19	7.4%	0	0	19	6.9%
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>	<b>100.0%</b>	<b>258</b>	<b>100.0%</b>	<b>0</b>	<b>0</b>	<b>274</b>	<b>100.0%</b>

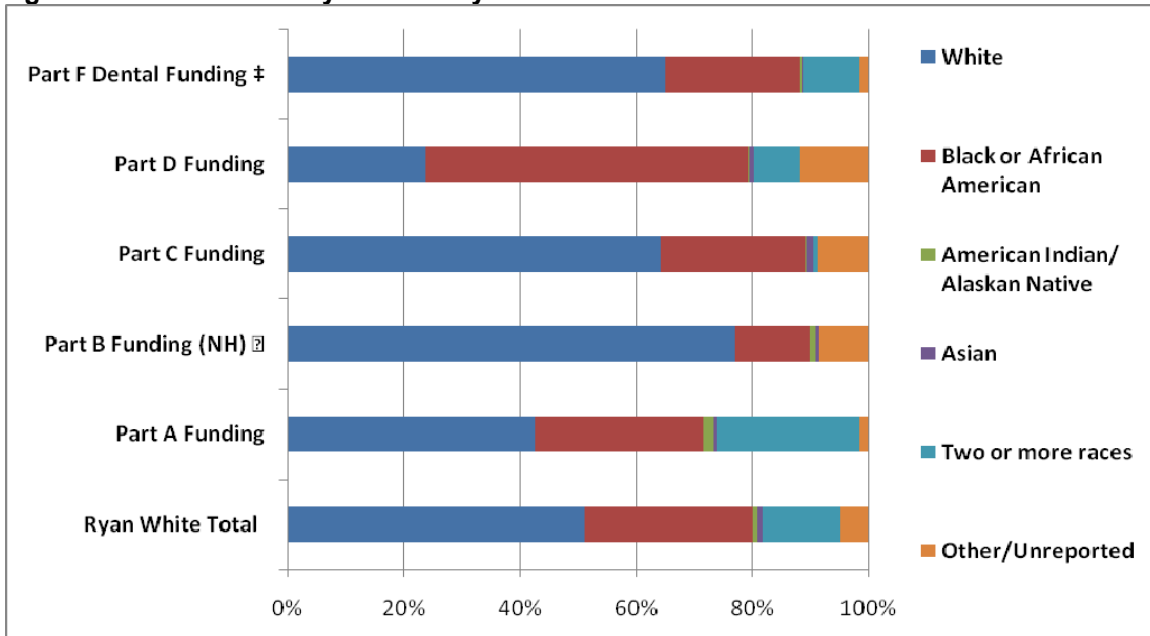
† Part B utilization includes only NH, because MA did not provide utilization data for this report.

‡ Part F data 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 (6,093 PLWH) and Part C provided services to 4,086 PLWH. The following figures examine the demographic profile of each Ryan White funding stream in further detail.

Figure 24 examines utilization by racial group and Figure 25 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 30% PLWH who are Hispanic.

**Figure 24: Utilization of Ryan White by Part and Race**



**Figure 25: Utilization of Ryan White by Part and Ethnicity**

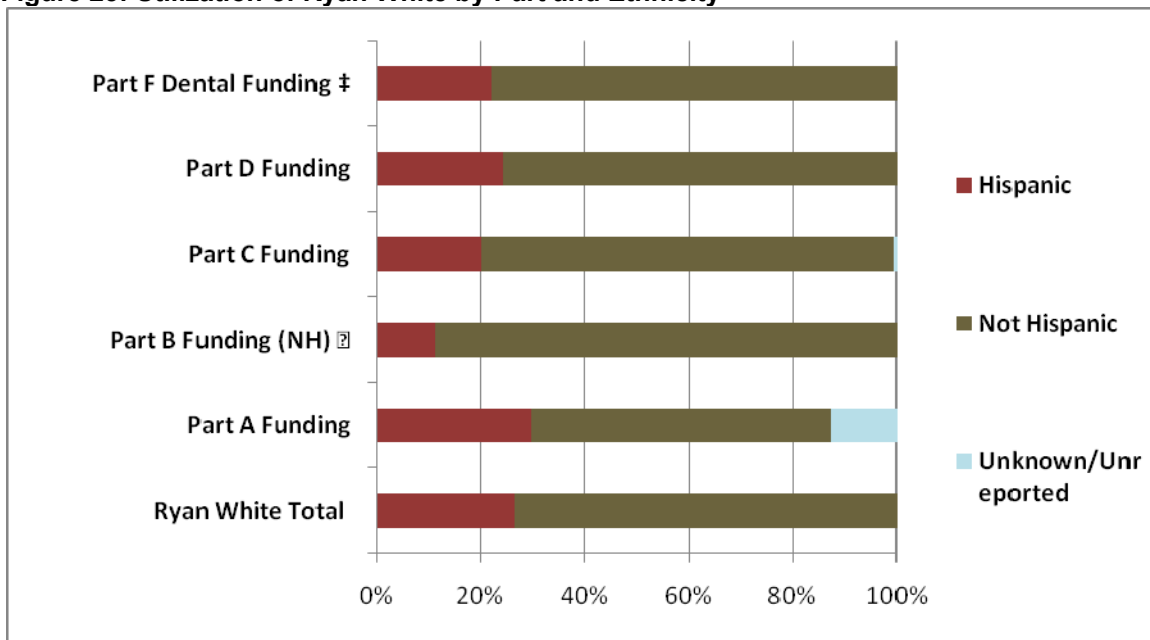


Figure 26 examines utilization by age group. The majority of PLWH served with Ryan White funds fall in the 20-44 and 45+ age groups. Again, the notable exception is Part D, which is discussed in further detail below.

**Figure 26: Utilization of Ryan White by Part and Age**

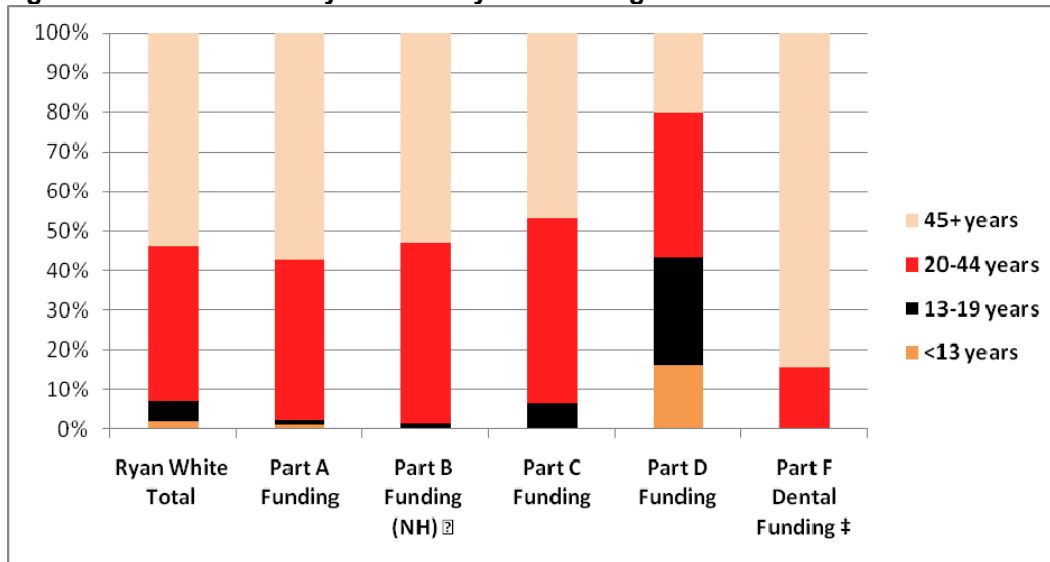
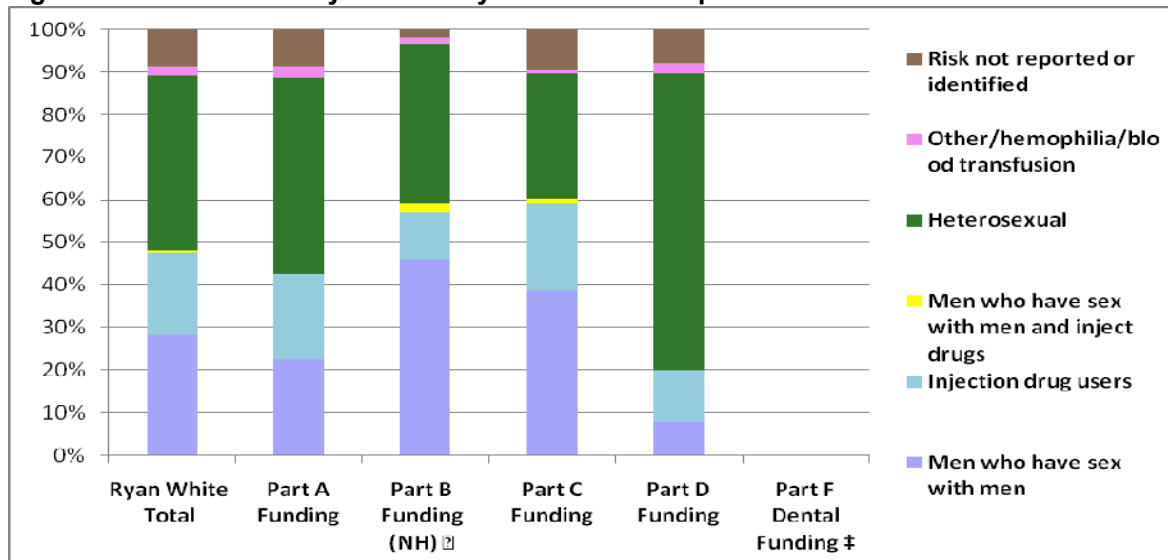


Figure 27 shows utilization by HIV exposure group. Part F is the only service category whose institutions do not collect this type of data. Men who have Sex with Men (MSM) and Heterosexual modes of exposure remain the predominant ways people become infected with HIV among Ryan White funding streams.

**Figure 27: Utilization of Ryan White by Part and HIV Exposure**



## Conclusion

This section of the Funding Streams Report discussed Parts A-F, which make up 25% of funding for HIV/AIDS services in the Boston EMA that are related to the Ryan White Act. 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: 91% 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, 54% are obligated to Core Medical Services. For Parts B and C, 93.8% and 95.6% 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.

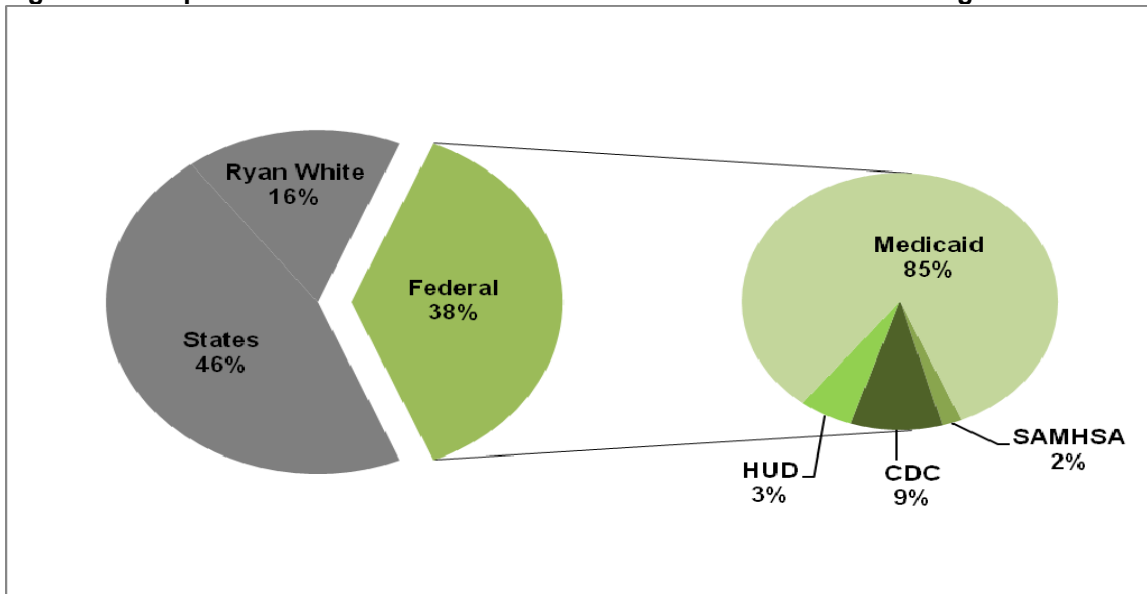
Ryan White funding has had an immense effect on its service areas. It is unique in its role as payer of last resort and has the ability to evolve with changes in the epidemic. This is especially true for Part A services which are overseen by the Planning Council. The Ryan White Planning Council prioritizes 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 (see Figures 23-26 and Table II.A.2).

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: State 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 38% of total funding for HIV/AIDS services in the Boston EMA (Figure 28).

**Figure 28: 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-positive 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. Massachusetts contributes a substantial amount of funding beyond the federal contribution (for our purposes, it is estimated that 50% of MassHealth

funding is Federal and the other 50% is State's contribution). In New Hampshire, the government does not exceed its minimum required contribution and the state does not have a special name for its Medicaid program.

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. New Hampshire state officials are working with the Federal government to create an HIV waiver program similar to that found in Massachusetts.

In New Hampshire, eligibility for Medicaid is more restrictive, requiring disability (AIDS diagnosis), and includes both an income limit of 75% FPL and an assets limit of \$2,500. 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 450% FPL per month for an individual, with an assets limit of \$21,947. 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 (July 1, 2007 to June 30, 2008). In the Boston EMA, Medicaid is the primary payer of health services for PLWH. 46.7% of the primary care funds for PLWH in the EMA (\$51,651,729) and 37.8% of the drug reimbursement funds for PLWH in the EMA (\$25,078,538) are provided through Medicaid. Medicaid also accounts for 31.7% (\$1,041,787) of the Mental Health funds for PLWH in the EMA and provides about 45.7% of the total funding available for Transportation services (\$2,810,297) for PLWH in the EMA.

#### *Resource Inventory*

In Massachusetts, 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.

Like Massachusetts, the New Hampshire 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. Similar to Massachusetts, the New Hampshire Medicaid program also includes drug benefits that have prescription limits and co-payments. Unlike Massachusetts, New Hampshire does not provide substance abuse services for Medicaid beneficiaries.

#### *Utilization*

In 2006, approximately 12,147 PLWH were enrolled into MassHealth using the Massachusetts HIV waiver. Between MassHealth and New Hampshire Medicaid, of PLWH consumers 49.9% are White, 21.7% are Black, and 10.5% are Hispanic. 45% are in the 20-44 age group and 44.4% are in the 45+ age group.

### 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 (the member has paid \$2,600). ADAP/HDAP funds assist in covering medication costs once the Part D benefit has entered this *doughnut hole* threshold. In the case of HIV+ members, HIV Drug Assistance Program (HDAP) not only assist in covering Part D costs, but must also fill in the “medigap.” Drug assistance does not count as “out of pocket,” so Medicare does not resume coverage for people who receive assistance after reaching the threshold. For those who are not Medicare-eligible, MassHealth continues to provide coverage. However, for people who are dually-eligible continue to receive their prescription drug benefits through their Medicaid program.

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, PCS intends on contacting CMS personnel and the private insurers involved in the Medicare system as part of the Funding Streams and Needs Assessment process.

### US Department of Housing and Urban Development (HUD)

The Housing Opportunities for Persons With AIDS (HOPWA) Program was established by HUD to address the specific needs of PLWH and their families. HOPWA awards grants to local communities, states, and nonprofit 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 that 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 nonprofit 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 \$3,839,665 in HUD/HOPWA funding in the Boston EMA in the most recent fiscal year. Most HUD/HOPWA fiscal years ran from July 1, 2007 to June 30, 2008.

#### *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 2005, HOPWA funding has been decentralized so that it is broken up among many municipalities and is no longer solely distributed by the City of Boston and the Commonwealth of Massachusetts to other areas. EMA municipalities funded by HOPWA include: Boston (\$1,486,992), Lowell (\$650,090), Lynn (\$326,000), and Worcester (\$368,000). In addition, Massachusetts received a State award (\$201,335).

#### *Utilization*

Tracking HOPWA utilization was challenging in that the City of Boston (the largest recipient of funding) was unable to provide utilization data aside from the number of PLWH they served in one year. Due to this issue, there are no significant findings that can be drawn from HUD/HOPWA utilization in this report and caution should be taken in interpreting the presented utilization data.

### 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 one million Americans are living with HIV, and 24% to 27% 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 Massachusetts (\$8,546,274) and New Hampshire (\$659,099) receive CDC funding for HIV/AIDS prevention. There are likely smaller CDC grants operating within the Boston EMA that fund CBOs and ASOs directly, but PCS did not have the resources to identify them all for the purpose of this report. A more extensive search of CDC funded community programs will be conducted in the future.

#### *Resource Inventory*

Information on the kinds of services provided with CDC funding was only provided by New Hampshire. In New Hampshire, CDC funding supports counseling and testing sites in addition to programs that provide education and risk reduction counseling in the Boston EMA. Limited funding is also used to provide bar outreach and to create Comprehensive Plans. In the future, PCS will assess CDC funding and utilization face-to-face to ameliorate this data quality issue.

#### *Utilization*

At this time, utilization information is only available for New Hampshire, as Massachusetts was unable to provide data due to technical difficulties. In New Hampshire, CDC funds serve more than 1,870 people with and at risk for HIV infection. 90.1% of the people served are White, 7.5% are Black and 11.8% are Hispanic.

### Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA provides comprehensive HIV prevention and treatment that include a variety of complementary components to help drug-using populations increase their protective behaviors and reduce their risks for HIV/AIDS as well as other blood-borne infections, such as Hepatitis C Virus (HCV), and other STDs. 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 receives a SAMHSA grant for HIV/AIDS prevention, but New Hampshire does not. Massachusetts received \$2,179,905 in HIV-specific SAMHSA funding in the most recent complete fiscal year.

#### *Resource Inventory*

The HIV-specific SAMHSA funding is blended in with general Bureau of Substance Abuse funding in Massachusetts that received an additional \$3,747,653 from the State for HIV-specific services. 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. The utilization table does not have a SAMHSA column, because the data is included with the Massachusetts State Substance Abuse Line column.

## Other Federal Funding Analysis

For the period of time reviewed in this report, \$189,494,628 in Other Federal funding was in operation within the Boston EMA (Table III.A.1). The two largest Other Federal streams are Medicaid and CDC (\$97,053,798 and \$5,754,190, respectively). SAMHSA and CDC funding are likely inadequately captured due to the way data was collected for this report (only MDPH and NHDHHS were contacted for this information, but many ASOs and CBOs also receive this funding independently).

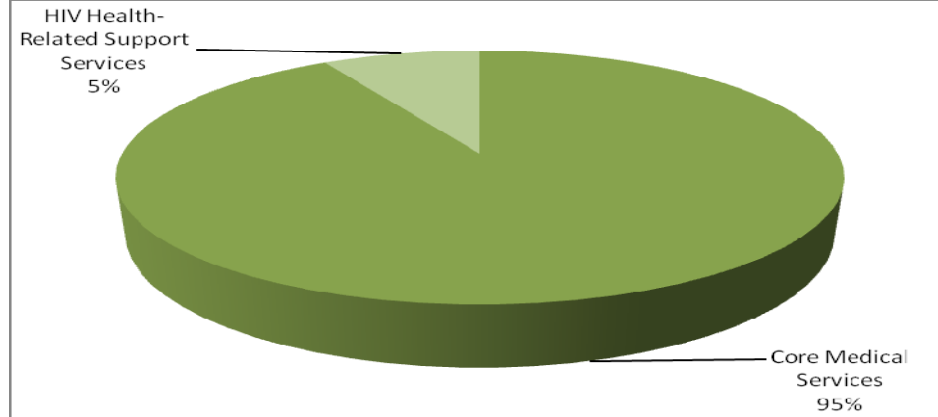
**Table III.A.1: Service Category Funding Levels for Other Federal Funding Streams**

<b>Part A Svc Categories</b>	<b>Medicaid</b>	<b>HUD</b>	<b>SAMHSA</b>	<b>CDC</b>	<b>Subtotal</b>
Case Management	\$53,452	\$1,604,242	\$0	\$0	\$1,657,694
Client Advocacy	\$0	\$274,037	\$0	\$0	\$274,037
Complementary Therapies	\$0	\$0	\$0	\$0	\$0
Day Care	\$0	\$3,000	\$0	\$0	\$3,000
Dental	\$1,182,584	\$0	\$0	\$0	\$1,182,584
Drug Reimbursement	\$25,078,538	\$0	\$0	\$0	\$25,078,538
Evaluation/QM	\$0	\$6,448	\$0	\$0	\$6,448
Food Services	\$0	\$4,000	\$0	\$0	\$4,000
Home Health Care	\$6,952,174	\$0	\$0	\$0	\$6,952,174
Housing	\$0	\$1,932,113	\$0	\$0	\$1,932,113
Mental Health	\$1,041,787	\$4,844	\$0	\$0	\$1,046,631
Peer Support	\$0	\$0	\$0	\$0	\$0
Primary Care	\$51,651,729	\$0	\$0	\$0	\$51,651,729
Respite Care	\$0	\$2,082	\$0	\$0	\$2,082
Substance Abuse	\$598,536	\$0	\$2,179,905	\$0	\$2,778,441
Transportation	\$2,810,297	\$8,899	\$0	\$0	\$2,819,196
<b>Subtotal Part A Svc Cat</b>	<b>\$89,369,097</b>	<b>\$3,839,665</b>	<b>\$2,179,905</b>	<b>\$0</b>	<b>\$95,388,667</b>
<b>Additional Services</b>					
<b>Additional Services</b>	<b>Medicaid</b>	<b>HUD</b>	<b>SAMHSA</b>	<b>CDC</b>	<b>Subtotal</b>
Admin/Program Support	\$0	\$128,162	\$0	\$0	\$128,162
Capacity Building/TA	\$0	\$215,000	\$0	\$0	\$215,000
Counseling & Testing	\$0	\$0	\$0	\$1,942,088	\$1,942,088
Education/Risk Reduction	\$0	\$0	\$0	\$331,438	\$331,438
Emergency Financial Assist	\$0	\$0	\$0	\$0	\$0
Insurance Continuation	\$0	\$0	\$0	\$0	\$0
Outreach	\$0	\$0	\$0	\$0	\$0
Prevention/Education	\$0	\$0	\$0	\$2,078,705	\$2,078,705
Other	\$7,684,701	\$30,251	\$0	\$1,401,959	\$9,116,911
Unreported	\$0	\$0	\$0	\$0	\$0
<b>Subtotal of Additional Svcs</b>	<b>\$7,684,701</b>	<b>\$373,413</b>	<b>\$0</b>	<b>\$5,754,190</b>	<b>\$13,812,304</b>
<b>Total of All Svcs</b>	<b>\$97,053,798</b>	<b>\$4,213,078</b>	<b>\$2,179,905</b>	<b>\$5,754,190</b>	<b>\$109,200,971</b>

**Note:** Not all agencies within the above four Funding Streams provided a stratified analysis of allocated funds. PCS obtained total awards for agencies that did not provide a survey from the HRSA website. Therefore the sum in the above table is less than what was actually collected.

Among Other Federal funding streams, 95% of direct service funding was invested in Core Medical Services (Figure 29). 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 29: Other Federal Streams Core Medical and HIV Health-Related Support Services**



Each funding stream provides for a different service mix. Figure 30 compares the contributions of each Other Federal stream from 2008 versus 2009. Among Other Federal funding streams, Medicaid made the largest contribution in both 2008 and 2009.

**Figure 30: Other Federal Funds 2008 vs 2009**

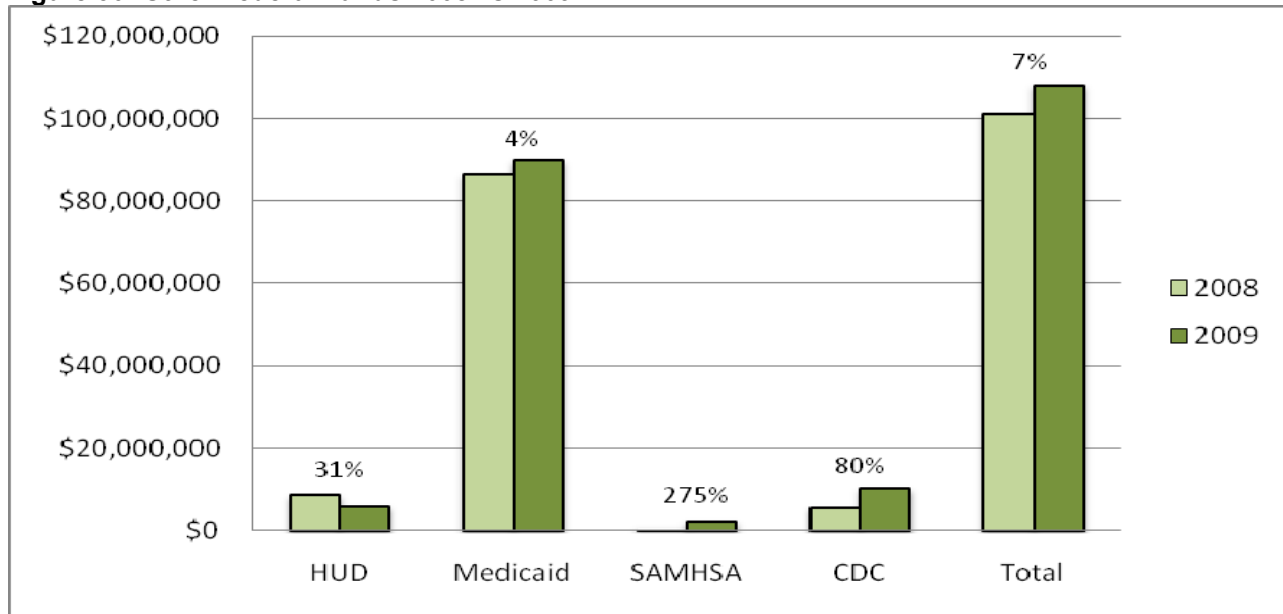
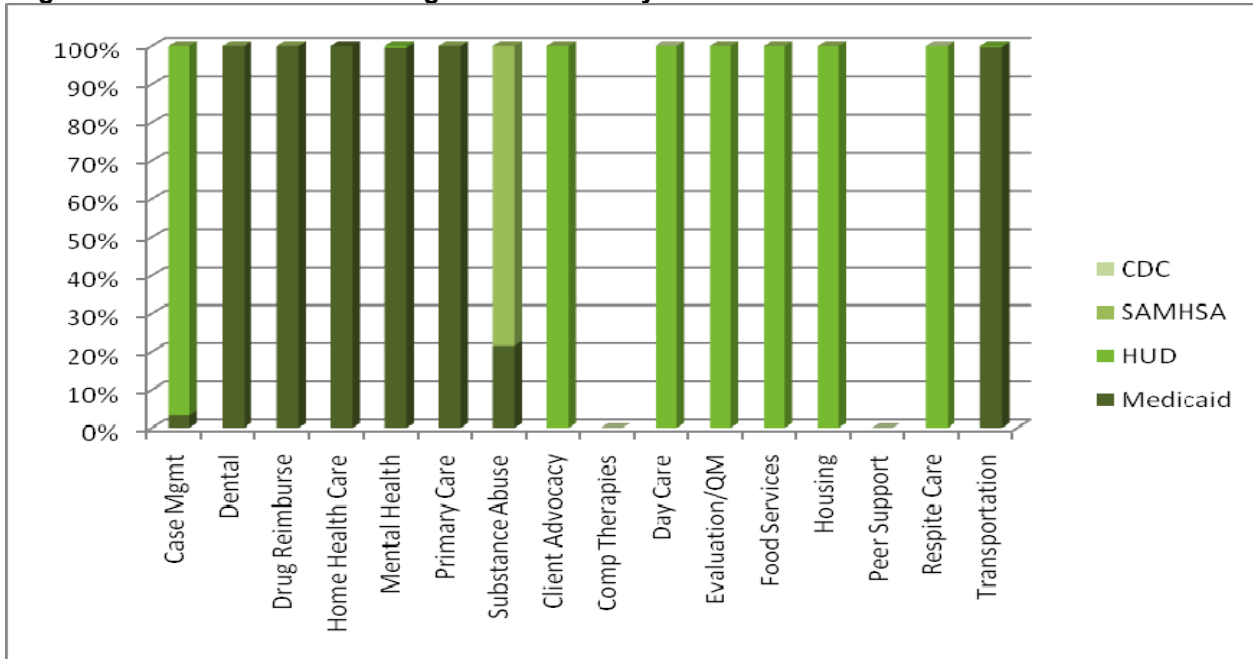


Figure 31 shows the service category breakdown as a proportion of the whole pot of Other Federal funding available in the Boston EMA and each service category stratified by the Other Federal streams.

Figure 31 shows that HUD funding is most substantial for Case Management, Client Advocacy, Day Care, Evaluation and Quality Management, Food Services, Housing, and Respite Care in comparison with Other Federal streams. Medicaid funding is most substantial for Dental Services, Drug Reimbursement, Mental Health, Primary Medical Care and Transportation in comparison with Other Federal Streams.

**Figure 31: Share of 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.  
**NOTE:** There was no Other Federal Funding Stream that funded Client Advocacy, Complementary Therapies or Respite Care.

### 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 New Hampshire, because Massachusetts did not provide any utilization data. HUD utilization was minimally provided by Boston Department of Neighborhood Development (only the number of clients seen was provided), which biases HUD data since this agency is the largest HUD provider in the Boston EMA. In addition, HUD data does not include modes of HIV exposure, because HUD providers do not collect this data. Finally, Medicaid utilization data is the combination of Medicaid funding and MassHealth Line Item funding due to the inability to separate each stream’s contribution to the utilization figure.

Table III.A.2 shows the utilization data for Other Federal funding streams. Medicaid provided HIV/AIDS services to the most PLWH in the Boston EMA during this period of time (13,526 consumers) and CDC in New Hampshire provided services to 1,870 PLWH. The following figures examine the demographic profile of each Ryan White funding stream in further detail.

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

Group	Medicaid §		HUD ♣		CDC △		Other Fed Total	
	#	%	#	%	#	%	#	%
<b>Race</b>								
White	6,062	49.9%	629	56.0%	1,684	90.1%	8,375	55.3%
Black or African American	2,635	21.7%	328	29.2%	141	7.5%	3,104	20.5%
American Indian/Alaskan	30	0.2%	4	0.4%	11	0.6%	45	0.3%
Asian	294	2.4%	5	0.4%	25	1.3%	324	2.1%
Two or more races	11	0.1%	90	8.0%	9	0.5%	110	0.7%
Other	3,115	25.6%	67	6.0%	0	0.0%	3,182	21.0%
<b>Total</b>	<b>12,147</b>	<b>100.0%</b>	<b>1,123</b>	<b>100.0%</b>	<b>1,870</b>	<b>100.0%</b>	<b>15,140</b>	<b>100.0%</b>
<b>Ethnicity</b>								
Hispanic	1,379	10.5%	271	23.8%	221	100.0%	1,871	12.9%
Not Hispanic	11,762	89.5%	867	76.2%	0	0.0%	12,629	87.1%
Unknown/Unreported	0	0%	0	0%	0	0%	0	0%
<b>Total</b>	<b>13,141</b>	<b>100.0%</b>	<b>1,138</b>	<b>100.0%</b>	<b>221</b>	<b>100.0%</b>	<b>14,500</b>	<b>100.0%</b>
<b>Age</b>								
<13 years	45	0.3%	2	0.2%	0	0	47	0.3%
13-19 years	1,394	10.3%	79	6.9%	0	0	1,473	10.0%
20-44 years	6,082	45.0%	642	56.4%	0	0	6,724	45.9%
45+ years	6,005	44.4%	416	36.5%	0	0	6,421	43.8%
<b>Total</b>	<b>13,526</b>	<b>100.0%</b>	<b>1,139</b>	<b>100.0%</b>	<b>0</b>	<b>0</b>	<b>14,665</b>	<b>100.0%</b>
<b>Adult/Adolescent HIV Exposure Categories</b>								
MSM	0	NA	95	16.5%	291	15.6%	386	15.8%
IDUs	0	NA	115	20.0%	185	9.9%	300	12.3%
MSM and IDUs	0	NA	23	4.0%	0	0.0%	23	0.9%
Heterosexual	0	NA	63	11.0%	709	37.9%	772	31.6%
Other /blood trans	0	NA	2	0.3%	0	0.0%	2	0.1%
Risk not reported	0	NA	277	48.2%	685	36.6%	962	39.3%
<b>Total</b>	<b>0</b>	<b>0.0%</b>	<b>575</b>	<b>100.0%</b>	<b>1,870</b>	<b>100.0%</b>	<b>2,445</b>	<b>100.0%</b>
<b>Pediatric HIV Exposure Categories</b>								
Mother at risk for HIV	NA	NA	2	100.0%	NA	NA	NA	NA
Other /blood trans	NA	NA	0	0	NA	NA	NA	NA
Risk not reported	NA	NA	0	0	NA	NA	NA	NA
<b>Total</b>	<b>NA</b>	<b>NA</b>	<b>2</b>	<b>100%</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>

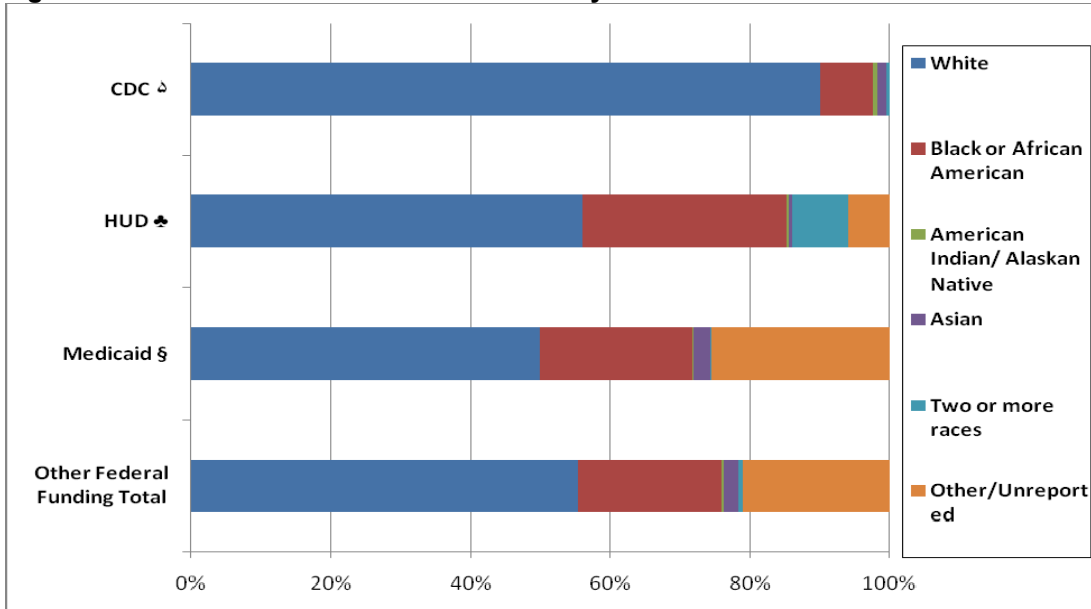
§ Medicaid utilization includes Medicaid and MassHealth Line Item Funding Streams. In addition, neither MA nor NH Medicaid programs collect HIV exposure data.

♣ HUD utilization was minimally provided by Boston Department of Neighborhood Development (all grouped in 'Some Other Race'). In addition, the majority of HUD funded providers do not collect HIV exposure data.

△ CDC utilization only includes NH, because MA did not provide any utilization data for this report.

Figure 32 examines utilization by racial group and Figure 33 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 30% PLWH who are Hispanic. CDC utilization by race is mostly white due to the lack of data on Massachusetts. New Hampshire is a relatively homogenous state with over 95% of the population being white. HUD utilization by race shows the lack of specific data from Boston Department of Neighborhood Development as previously described.

**Figure 32: Utilization of Other Federal Funds by Race**



**Figure 33: Utilization of Other Federal Funds by Ethnicity**

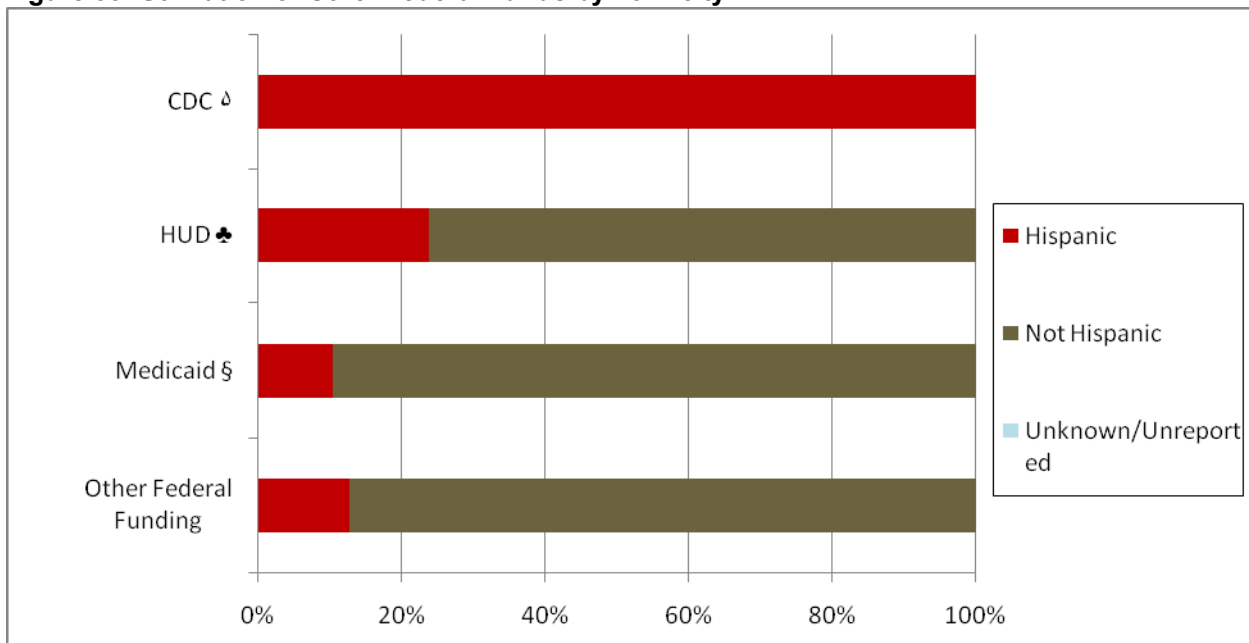
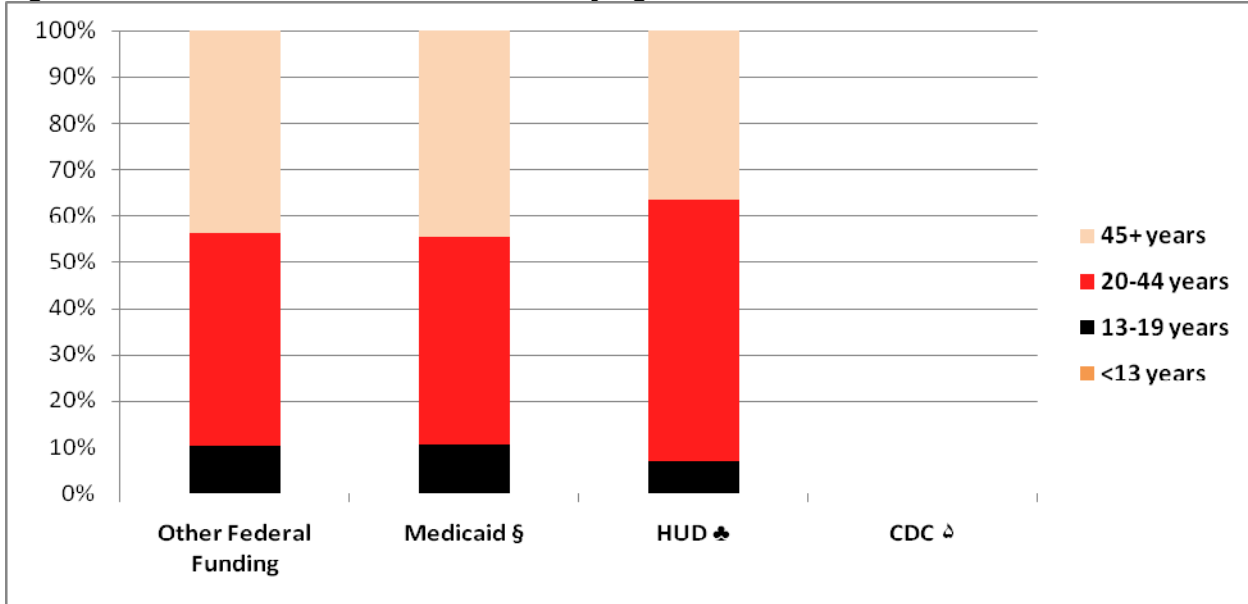
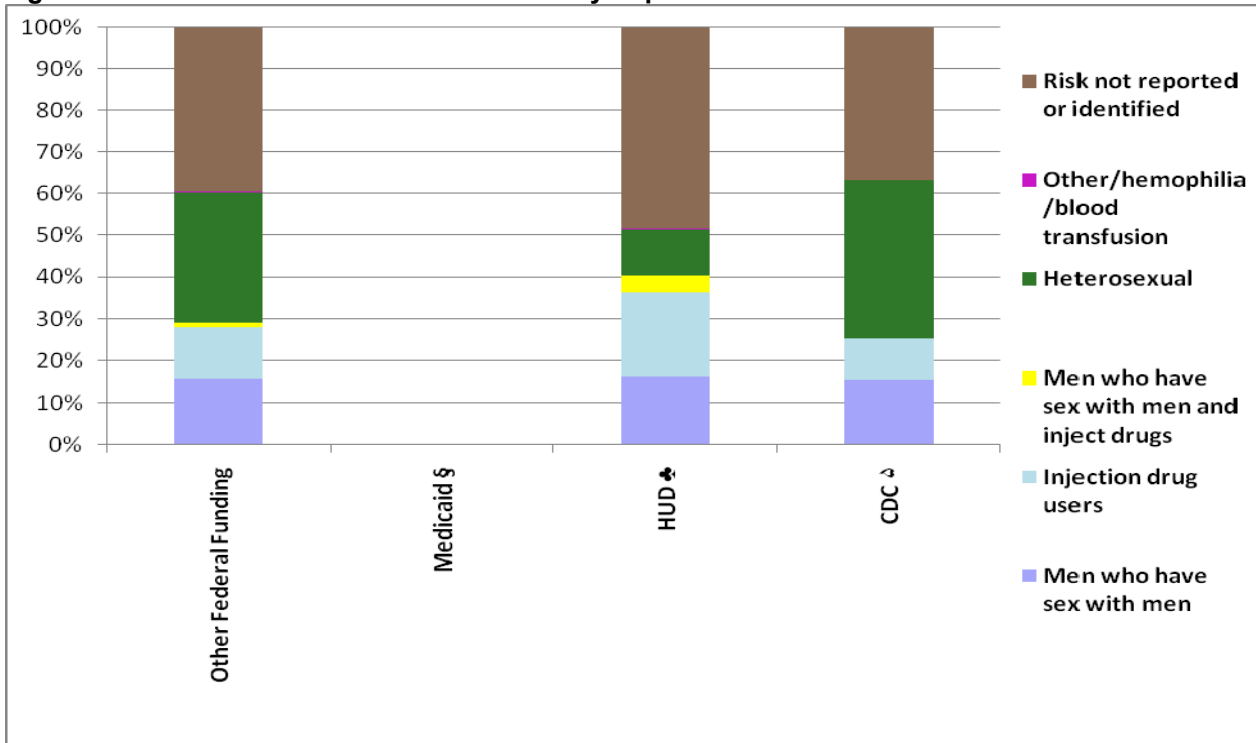


Figure 34 examines utilization by age group. The majority of PLWH served with Other Federal funds are in the 20-44 and 45+ age groups. Figure 35 shows utilization by HIV exposure group. Medicaid is blank, because this data is not collected. MSM and IDU modes of exposure remain the significant modes of exposure to HIV among Other Federal funding streams.

**Figure 34: Utilization of Other Federal Funds by Age**



**Figure 35: Utilization of Other Federal Funds by Exposure**



## **Conclusion**

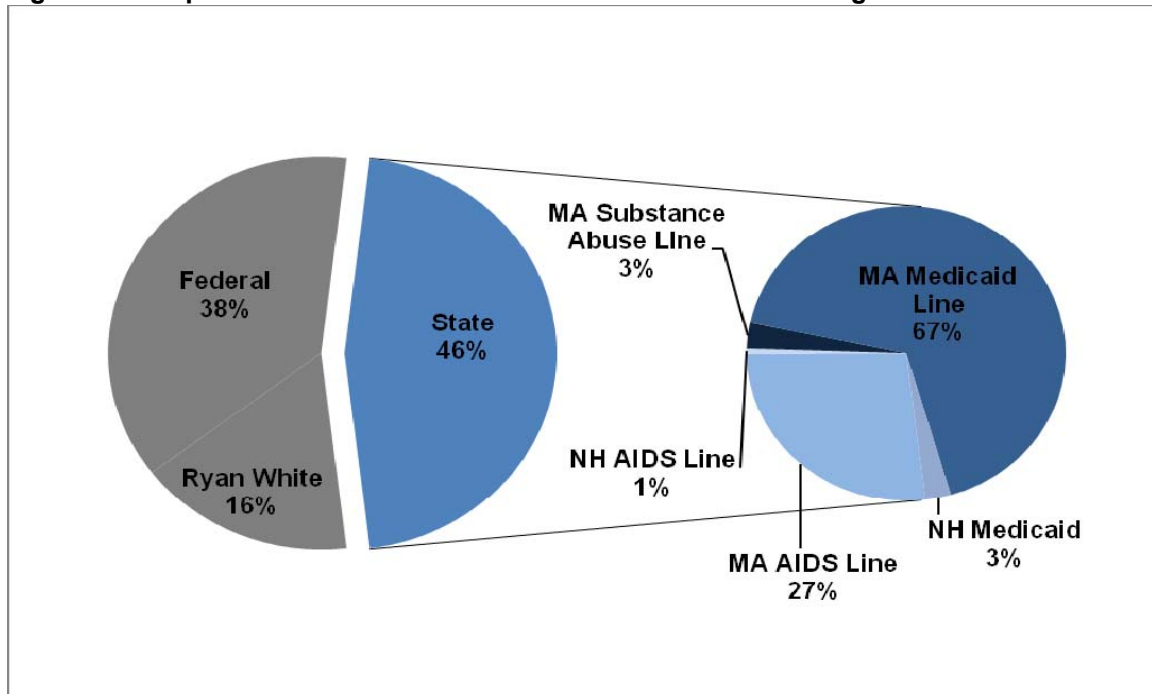
When reviewing the other Federal funding it is important to recognize that these dollars are intended to support the larger health system within the EMA and may or may not be specifically earmarked for PLWH, unlike Ryan White dollars. However, other Federal allocations are consistent with Ryan White 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 healthcare infrastructure is within our EMA, 95% 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 Massachusetts and the State of New Hampshire. Other Federal funding represents 45% of total funding for HIV/AIDS services in the Boston EMA (Figure 36).

**Figure 36: 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 New Hampshire are close geographically, but differ substantially in terms of demographics and political culture. While MA has typically been acknowledged to be a liberal Democratic state, NH is more conservative and Libertarian in comparison. Massachusetts contributes to its Medicaid program substantially and has a generous line item for substance abuse services. A specific AIDS line item has bolstered supportive services in MA for many years, but is a recent addition to the funding streams operating in NH.

### State Funding Streams

#### Massachusetts AIDS Line Item

Massachusetts provides additional funding for HIV/AIDS services through the *Department of Public Health* (DPH) AIDS budget line item. The 2002 statewide budget crisis continues to affect services to PLWH in that the total funding for HIV/AIDS services has never been fully restored, but the DPH AIDS line item provides a range of services throughout the state.

### *Funding Level*

Massachusetts allocated \$36,648,951 to the AIDS Line Item in its budget in FY 2007.

### *Resource Inventory*

The Massachusetts Department of Public Health Office of HIV/AIDS 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.

- HIV Prevention and Education
- Primary Care services
- HIV Counseling and Testing
- Supportive Housing services
- HIV Drug Assistance Program (HDAP)
- Client Support Services
- HIV services in correctional facilities
- Transportation
- Case Management
- Food Services
- Mental Health services
- Respite and Day Care
- Complementary/holistic therapies
- Dental Care
- Home Health Care
- Emergency Financial Assistance

### *Utilization*

At this time, utilization information is not available for Massachusetts, as the state was unable to provide data due to technical difficulties. In the future, PCS will assess MA AIDS Line Item funding and utilization face-to-face to ameliorate this data quality issue.

### *Massachusetts MassHealth Line Item*

As mentioned in the previous section of this document, Medicaid is funded jointly by the Federal government and state governments. Massachusetts contributes a substantial amount of funding beyond the federal contribution (for our purposes, it is estimated that 50% of MassHealth funding is Federal and the other 50% is local in origin).

### *Funding Level*

The state of Massachusetts contributed \$82,889,003 to the MassHealth program in FY 2007.

### *Resource Inventory*

The standard MassHealth benefits package covers comprehensive primary and inpatient health services, including primary care, ob/gyn, substance abuse, mental health, and transportation services.

### *Utilization*

Since the purpose of this funding is to augment the Medicaid funding provided by the Federal government, utilization data for this funding stream is included in the Medicaid column of the utilization table.

### *Massachusetts Bureau of Substance Abuse Services Line Item (BSAS)*

Massachusetts provides funding for substance abuse services through the DPH 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*

For many years BSAS has estimated that 2.6% of their funding specifically serves PLWH. BSAS reported in FY 2005 that \$72.9 million was available for substance abuse treatment services in the EMA (\$1,895,284 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*

In the last section, it was explained that SAMHSA dollars are wrapped into the Bureau of Substance Abuse Services continuum of care. BSAS estimates that its services were provided to 1,208 unduplicated consumers in FY 2007. 76.3% of consumers served were White and 10.6% were Black. 12.1% of consumers were Hispanic and 10.9% were identified as members of Some Other Race. The majority of consumers served with BSAS funding were 20 years and older with 71.8% in the 20-44 age group and 22.4% 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. This is also the reason why BSAS needs to estimate the number of PLWH it serves (BSAS estimates that 2.6% of its funding is utilized by PLWH and that 2.6% of its utilization goes to PLWH).

## 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 take 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.

#### *New Hampshire AIDS Line Item*

In FY 2005, NH provided state funds for HIV/AIDS services for the first time. Advocates and administrators in NH are 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*

The New Hampshire state budget is biannual.

In 2008, total ADAP funding in NH was 1,545,435 and clients within the Boston EMA received \$150,842 in premiums. NH ADAP program has discontinued paying Medigap premiums.

### *Resource Inventory*

The state of New Hampshire provides AIDS Drug Assistance (ADAP), Insurance Continuation, Primary Medical Care, Case Management, Substance Abuse Services, Oral Health Services, Home and Community Based Care Services, and Mental Health Services.

### *Utilization*

Similar to Massachusetts, New Hampshire maximizes the effect of its funding by blending several streams together. The New Hampshire Department of Health and Human Services 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.

### *Boston EMA Local Health Insurance Market*

The Boston EMA is home to some of the most prestigious medical institutions in the world. Many 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 6,253 unduplicated Part A clients in FY 2006, only 654 were enrolled in private insurance programs. Since Ryan White funded services are intended to be the payer of last resort, it is logical that only 10% of the PLWH receiving Ryan White Part A services are enrolled in private insurance programs. This number is expected to increase rapidly as the Massachusetts Health Reform Law is 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. 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.

## State Funding Analysis

For the period of time reviewed in this report, \$118,516,040 in State funding was in operation within the Boston EMA (Table IV.A.1). The two largest State streams are the MA MassHealth Line Item and the MA AIDS Line Item (\$82,416,923 and \$30,171,559 respectively).

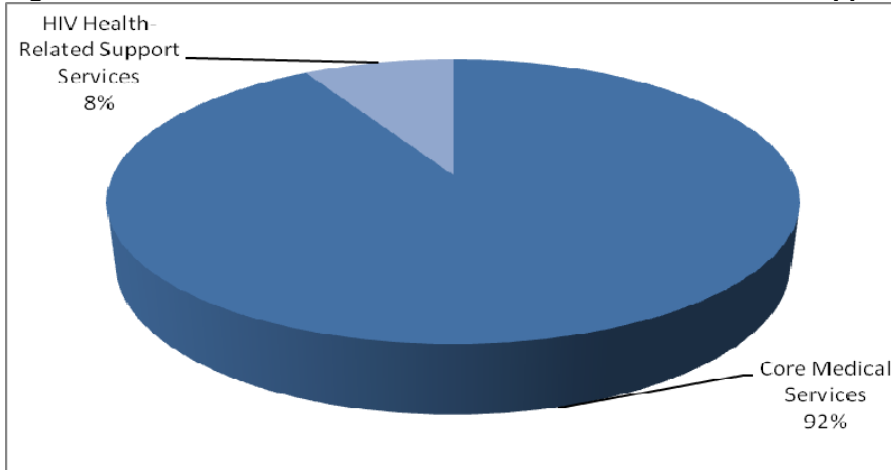
**Table IV.A.1: Service Category Funding Levels for State Streams**

Part A Svc Categories	MA Subs Abuse Line	MA MassHealth Line	MA AIDS Line	NH AIDS Line	Subtotal
Case Management	\$0	\$53,452	\$2,347,498	\$0	\$2,400,950
Client Advocacy	\$0	\$0	\$0	\$0	\$0
Complementary Therapies	\$0	\$0	\$91,521	\$0	\$91,521
Day Care	\$0	\$0	\$0	\$0	\$0
Dental	\$0	\$1,182,584	\$0	\$0	\$1,182,584
Drug Reimbursement	\$0	\$25,078,538	\$3,179,700	\$0	\$28,258,238
Evaluation/QM	\$0	\$0	\$270,188	\$0	\$270,188
Food Services	\$0	\$0	\$461,320	\$0	\$461,320
Home Health Care	\$0	\$0	\$602,012	\$0	\$602,012
Housing	\$0	\$0	\$4,369,332	\$0	\$4,369,332
Mental Health	\$0	\$1,041,788	\$71,505	\$0	\$1,113,293
Peer Support	\$0	\$0	\$640,734	\$0	\$640,734
Primary Care	\$0	\$51,651,729	\$3,054,600	\$0	\$54,706,329
Respite Care	\$0	\$0	\$0	\$0	\$0
Substance Abuse	\$5,927,558	\$598,536	\$0	\$0	\$6,526,094
Transportation	\$0	\$2,810,296	\$42,414	\$0	\$2,852,710
<b>Subtotal Part A Svc Cat</b>	<b>\$5,927,558</b>	<b>\$82,416,923</b>	<b>\$15,130,824</b>	<b>\$0</b>	<b>\$103,474,305</b>
Additional Services	MA Subs Abuse Line	MA MassHealth Line	MA AIDS Line	NH AIDS Line	Subtotal
Admin/Program Support	\$0	\$0	\$0	\$0	\$0
Capacity Building/TA	\$0	\$0	\$0	\$0	\$0
Counseling & Testing	\$0	\$0	\$2,886,090	\$0	\$2,886,090
Education/Risk Reduction	\$0	\$0	\$0	\$0	\$0
Emergency Financial Assist	\$0	\$0	\$48,226	\$0	\$48,226
Insurance Continuation	\$0	\$0	\$0	\$0	\$0
Outreach	\$0	\$0	\$0	\$0	\$0
Prevention/Education	\$0	\$0	\$9,240,705	\$0	\$9,240,705
Other	\$0	\$0	\$2,865,714	\$0	\$2,865,714
Unreported	\$0	\$0	\$0	\$0	\$0
<b>Subtotal of Additional Svcs</b>	<b>\$0</b>	<b>\$0</b>	<b>\$15,040,735</b>	<b>\$0</b>	<b>\$15,040,735</b>
<b>Total of All Svcs</b>	<b>\$5,927,558</b>	<b>\$82,416,923</b>	<b>\$30,171,559</b>	<b>\$0</b>	<b>\$118,516,040</b>

**Note:** Not all agencies within the above four Funding Streams provided a stratified analysis of allocated funds. PCS obtained total awards for agencies that did not provide a survey from the HRSA website. Therefore the sum in the above table is less than what was actually collected.

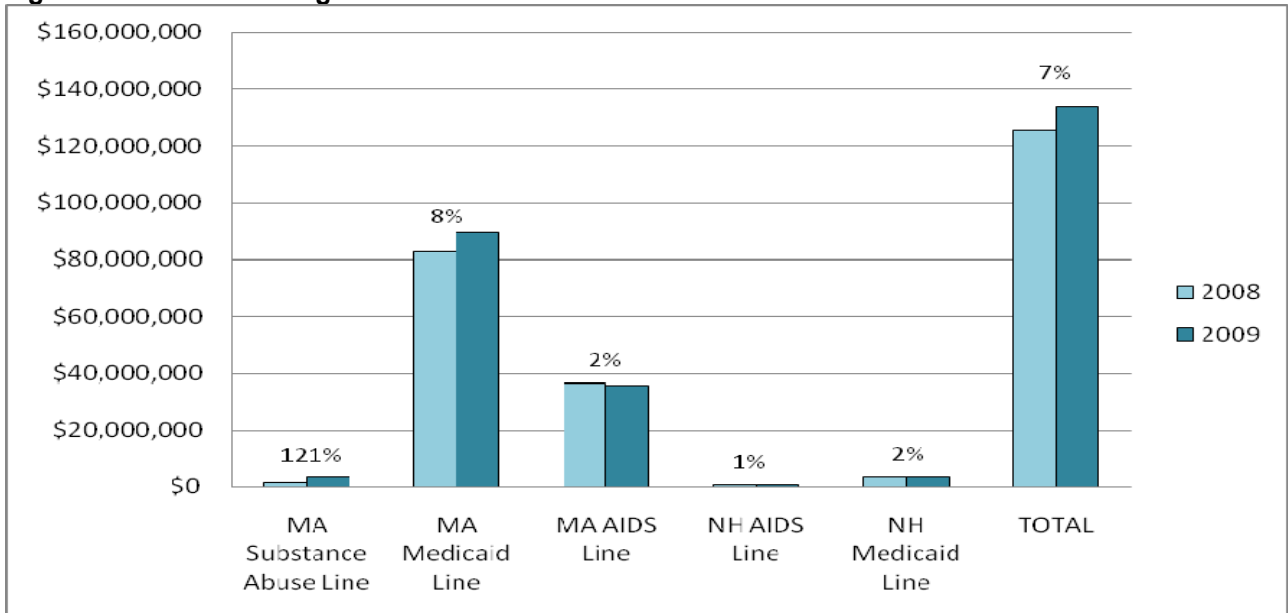
Among State funding streams, 92% of direct service funding was invested in Core Medical Services (Figure 37). Only Ryan White funding streams must abide by the 75/25 clause so this information is less vital for Other Federal streams. At the same time, this information speaks to the devotion regional providers have in prioritizing Core Medical Services.

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



Each funding stream provides for a different service mix. Figure 38 compares the contributions of each State stream from 2008 versus 2009. Among State funding streams, the MA MassHealth Line makes the largest contribution. MA AIDS Line Item and MA MassHealth Line funding provide a substantial share of funding among the State streams.

**Figure 38: States Funding 2008 vs 2009**

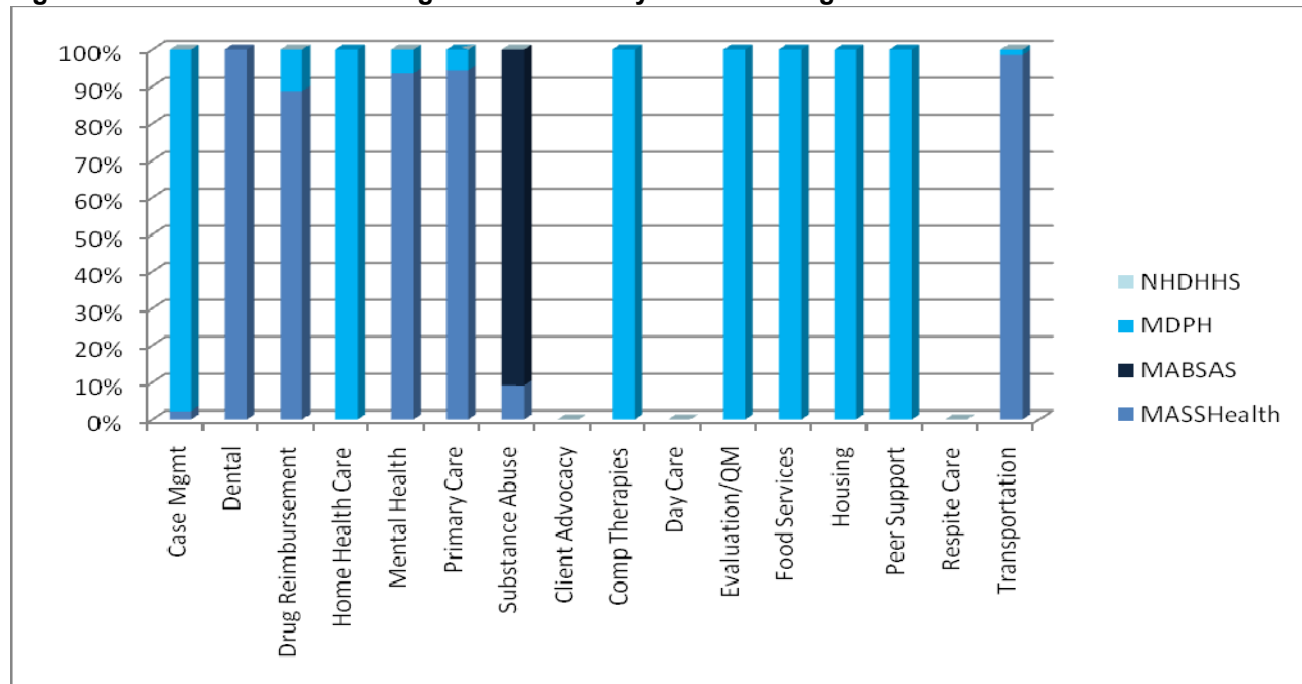


**NOTE:** The bars on this graph represent the proportion of the total allocation for each service category. Some of these allocations are millions of dollars and some are thousands. See Table IV.A.1 for the funding level of each individual service category and funding stream

Figure 39 shows the service category breakdown as a proportion of the whole pot of State funding available in the Boston EMA and each service category stratified by the State streams.

Figure 39 also shows that MA MassHealth Line Item and MA AIDS Line Item provide the majority of funding for many different service categories. Substance Abuse Services is the only service category that receives the majority 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.

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



**NOTE:** There was no State funding stream that funded Client Advocacy or Day Care.

## 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 absent, because Massachusetts did not provide utilization data for this report. In addition, BSAS utilization includes the Massachusetts Substance Abuse Line Item and SAMHSA funding due to the way funding sources are blended by BSAS and distributed throughout the state. Finally, the MassHealth Line Item is not included here, because it was included with the Medicaid data under Other Federal funding streams.

Table IV.A.2 shows the utilization data for State funding streams during the period of time under study for this report. BSAS provided HIV/AIDS services to the most PLWH in the Boston EMA during this period of time (54,342 PLWH). 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**

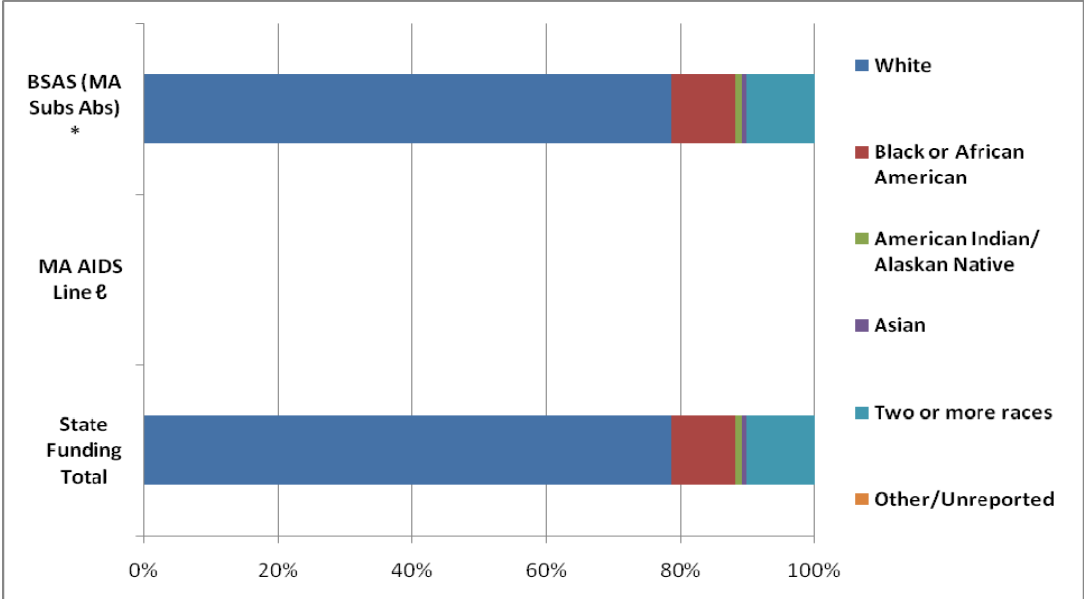
Demographic Group/Exposure Category	MA AIDS Line ℓ		BSAS (MA Subs Abs) *		State Total	
	#	%	#	%	#	%
<b>Race</b>						
White	0	NA	42,406	78.6%	42,406	78.6%
Black or African Am	0	NA	5,165	9.6%	5,165	9.6%
American Indian/ Alaska Native	0	NA	468	0.9%	468	0.9%
Asian	0	NA	433	0.8%	433	0.8%
Two or more races	0	NA	5,490	10.2%	5,490	10.2%
Other	0	NA	0	0.0%	0	0.0%
<b>Total</b>	<b>0</b>	<b>NA</b>	<b>53,962</b>	<b>100.0%</b>	<b>53,962</b>	<b>100.0%</b>
<b>Ethnicity</b>						
Hispanic	0	NA	6,212	11.4%	6,212	11.4%
Not Hispanic	0	NA	48,122	88.6%	48,122	88.6%
Unknown/Unreported	0	NA	0	0%	0	0%
<b>Total</b>	<b>0</b>	<b>NA</b>	<b>54,334</b>	<b>100.0%</b>	<b>54,334</b>	<b>100.0%</b>
<b>Age</b>						
<13 years	0	NA	196	0.4%	196	0.4%
13-19 years	0	NA	2,768	5.1%	2,768	5.1%
20-44 years	0	NA	39,539	72.8%	39,539	72.8%
45+ years	0	NA	11,839	21.8%	11,839	21.8%
<b>Total</b>	<b>0</b>	<b>NA</b>	<b>54,342</b>	<b>100.0%</b>	<b>54,342</b>	<b>100.0%</b>
<b>Adult/Adolescent HIV Exposure</b>						
MSM	0	NA	0	NA	NA	NA
IDUs	0	NA	0	NA	NA	NA
MSM and IDUs	0	NA	0	NA	NA	NA
Heterosexual	0	NA	0	NA	NA	NA
Other /blood trans	0	NA	0	NA	NA	NA
Risk not reported	0	NA	0	NA	NA	NA
<b>Total</b>	<b>0</b>	<b>NA</b>	<b>0</b>	<b>NA</b>	<b>0</b>	<b>NA</b>
<b>Pediatric HIV Exposure</b>						
Mother at risk for HIV	0	NA	NA	NA	NA	NA
Other /blood trans	0	NA	NA	NA	NA	NA
Risk not reported	0	NA	NA	NA	NA	NA
<b>Total</b>	<b>0</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>

ℓ MA AIDS Line utilization is absent, because MA did not provide utilization data for this report.

\* BSAS utilization includes the MA Substance Abuse Line, HUD and SAMHSA funding.

Figure 40 examines utilization by racial group and Figure 41 examines utilization by ethnic group. The majority of the PLWH served by BSAS are White. Very few Hispanics receive services through BSAS (11.4%).

**Figure 40: Utilization of State Streams by Race**



**Figure 41: Utilization of State Streams by Ethnicity**

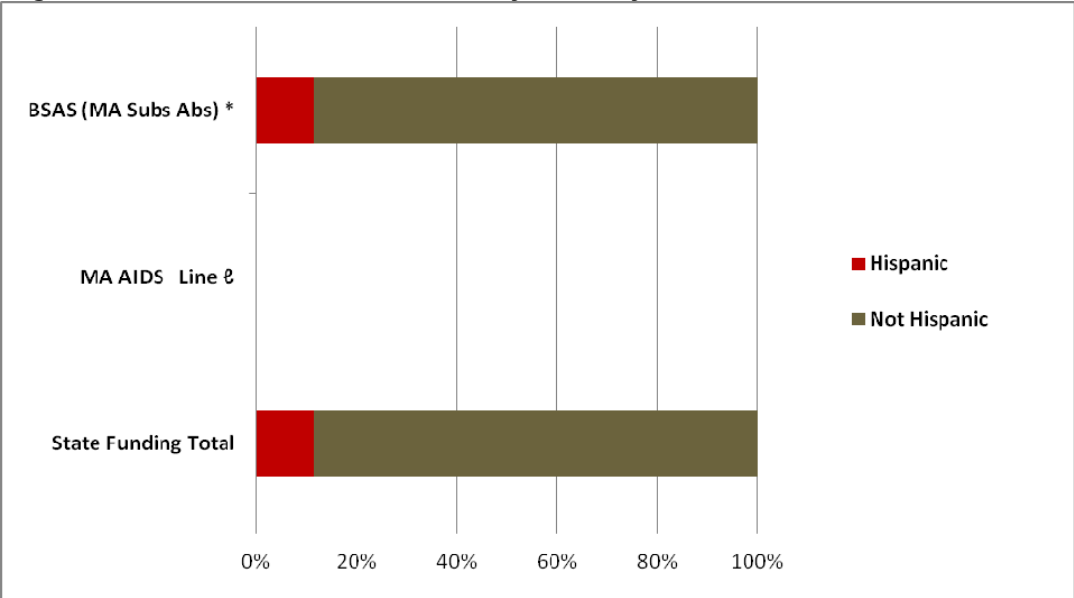
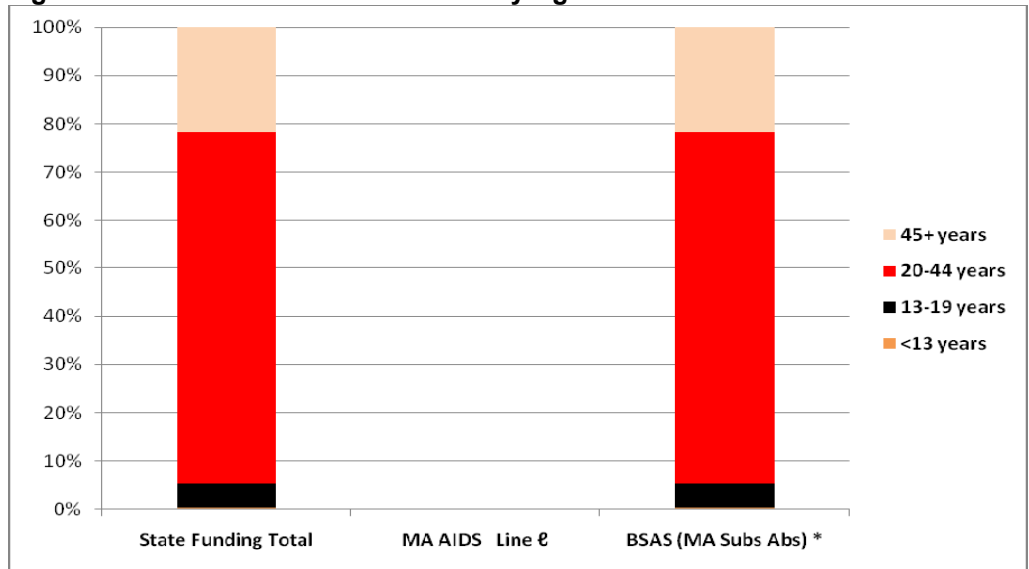


Figure 42 examines utilization by age group. The majority of PLWH served with State dollars belong to the 20-44 age group.

**Figure 42: Utilization of State Streams by Age**



## Conclusion

Although Massachusetts and New Hampshire 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 over 110 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, the state allocates money to additional categories not covered by the Ryan White or by other Federal funding, including; capacity building, counseling and testing, emergency family assistance, insurance continuation, home healthcare, as well as, prevention and education.

The state's 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 \$289,434,650 dollars within the EMA allocated to direct health and health-related HIV services; Ryan White accounts for 16%, other Federal funding 38% and state funding is 46%. 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. Develop a survey tool that is customizable by funding stream.
2. Visit survey respondents in person to ensure higher quality data collection.
3. Expand the literature review to include additional funding sources that have not traditionally researched through this process.
4. Expand the literature review to include new agencies and institutions that have not traditionally been assessed through this process.
5. 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.
6. Modify the survey tool to reflect accurate HRSA definitions of Service Categories.

# Appendix

**Table V.A.1: Service Category Funding Levels Across All Funding Streams**

Part A Service Categories	Part A	Part B	Part C	Part D	Part F	Medicaid	HUD	SAMHSA	CDC	MA Subs Ab Line	MA Medicaid Line	MA AIDS Line	NH AIDS Line	Total
Case Management	\$2,281,285	\$1,898,890	\$598,588	\$806,932	\$0	\$53,452	\$1,604,242	\$0	\$0	\$0	\$53,452	\$2,347,498	\$0	\$9,644,339
Client Advocacy	\$445,332	\$0	\$0	\$47,467	\$0	\$0	\$274,037	\$0	\$0	\$0	\$0	\$0	\$0	\$766,836
Comp Therapies	\$0	\$0	\$16,890	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$91,521	\$0	\$108,411
Day Care	\$0	\$0	\$0	\$0	\$0	\$0	\$3,000	\$0	\$0	\$0	\$0	\$0	\$0	\$3,000
Dental	\$657,458	\$18,267	\$141,985	\$0	\$438,644	\$1,182,584	\$0	\$0	\$0	\$0	\$1,182,584	\$0	\$0	\$3,621,522
Drug Reimbursement	\$1,402,639	\$11,522,463	\$15,000	\$0	\$0	\$25,078,538	\$0	\$0	\$0	\$0	\$25,078,538	\$3,179,700	\$0	\$66,276,878
Evaluation/QM	\$417,160	\$368,238	\$169,241	\$5,052	\$550,000	\$0	\$6,448	\$0	\$0	\$0	\$0	\$270,188	\$0	\$1,828,071
Food Services	\$1,769,927	\$52,997	\$10,464	\$28,697	\$0	\$0	\$4,000	\$0	\$0	\$0	\$0	\$461,320	\$0	\$2,327,405
Housing	\$2,039,043	\$0	\$0	\$0	\$1,737	\$0	\$1,932,113	\$0	\$0	\$0	\$0	\$4,369,332	\$0	\$8,342,225
Mental Health	\$427,196	\$74,255	\$513,729	\$115,395	\$0	\$1,041,787	\$4,844	\$0	\$0	\$0	\$1,041,788	\$71,505	\$0	\$3,290,499
Peer Support	\$735,521	\$456,511	\$2,500	\$29,282	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$640,734	\$0	\$1,864,548
Primary Care	\$216,787	\$74,478	\$3,373,161	\$420,292	\$0	\$51,651,729	\$0	\$0	\$0	\$0	\$51,651,729	\$3,054,600	\$0	\$110,442,776
Respite Care	\$0	\$0	\$0	\$0	\$0	\$0	\$2,082	\$0	\$0	\$0	\$0	\$0	\$0	\$2,082
Substance Abuse	\$1,099,338	\$25,434	\$61,135	\$174	\$0	\$598,536	\$0	\$2,179,905	\$0	\$5,927,558	\$598,536	\$0	\$0	\$11,589,954
Transportation	\$374,140	\$23,789	\$18,242	\$58,578	\$0	\$2,810,297	\$8,899	\$0	\$0	\$0	\$2,810,296	\$42,414	\$0	\$6,146,655
<b>Subtotal Part A Services</b>	<b>\$11,865,826</b>	<b>\$14,515,322</b>	<b>\$4,917,344</b>	<b>\$1,557,812</b>	<b>\$990,381</b>	<b>\$82,416,923</b>	<b>\$3,839,665</b>	<b>\$2,179,905</b>	<b>\$0</b>	<b>\$5,927,558</b>	<b>\$82,416,923</b>	<b>\$14,528,812</b>	<b>\$0</b>	<b>\$226,255,201</b>
<b>Additional Services</b>	<b>Part A</b>	<b>Part B</b>	<b>Part C</b>	<b>Part D</b>	<b>Part F</b>	<b>Medicaid</b>	<b>HUD</b>	<b>SAMHSA</b>	<b>CDC</b>	<b>MA Subs Ab Line</b>	<b>MA Medicaid Line</b>	<b>MA AIDS Line</b>	<b>NH AIDS Line</b>	<b>Total</b>
Admin/Program Support	\$939,683	\$119,136	\$545,938	\$94,373	\$264,783	\$0	\$128,162	\$0	\$0	\$0	\$0	\$0	\$0	\$2,092,075
Capacity Building/TA	\$0	\$32,000	\$3,968	\$59,207	0	\$0	\$215,000	\$0	\$0	\$0	\$0	\$0	\$0	\$310,175
Counseling & Testing	\$0	\$0	\$147,336	\$19,050	\$0	\$0	\$0	\$0	\$1,942,088	\$0	\$0	\$2,886,090	\$0	\$4,994,564
Education/Risk Red	\$0	\$0	\$91,265	\$20,100	\$0	\$0	\$0	\$0	\$331,438	\$0	\$0	\$0	\$0	\$442,803
Emergency Family Assistance	\$0	\$47,831	\$18,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$48,226	\$0	\$114,057
Home Health Care	\$0	\$428,796	\$0	\$0	\$0	\$6,952,174	\$0	\$0	\$0	\$0	\$0	\$602,012	\$0	\$7,982,982
Insurance Continuation	\$0	\$150,842	\$45,697	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$196,539
Outreach	\$0	\$0	\$58,193	\$47,600	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$105,793
Prevention/Education	\$0	\$0	\$19,715	\$0	\$0	\$0	\$0	\$0	\$2,078,705	\$0	\$0	\$9,240,705	\$0	\$11,339,125
Other	\$0	\$627,851	\$190,250	\$0	\$0	\$7,684,701	\$30,251	\$0	\$1,401,959	\$0	\$0	\$2,865,714	\$0	\$9,935,012
Unreported	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>Subtotal Add'l Svcs</b>	<b>\$939,683</b>	<b>\$1,406,456</b>	<b>\$1,120,362</b>	<b>\$240,330</b>	<b>\$264,783</b>	<b>\$14,636,875</b>	<b>\$373,413</b>	<b>\$0</b>	<b>\$5,754,190</b>	<b>\$0</b>	<b>\$82,416,923</b>	<b>\$15,642,747</b>	<b>\$0</b>	<b>\$37,513,125</b>
<b>Total of All Services</b>	<b>\$13,184,240</b>	<b>\$15,921,778</b>	<b>\$6,037,706</b>	<b>\$1,798,142</b>	<b>\$1,255,164</b>	<b>\$97,053,798</b>	<b>\$4,213,078</b>	<b>\$2,179,905</b>	<b>\$5,754,190</b>	<b>\$5,927,558</b>	<b>\$97,053,798</b>	<b>\$30,171,559</b>	<b>\$0</b>	<b>\$263,768,326</b>

Note: Not all agencies within the above four Funding Streams provided a stratified analysis of allocated funds. PCS obtained total awards for agencies that did not provide a survey. Therefore the sum in the above table is less than what was actually collected.

**Table V.A.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	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
<b>Race</b>																						
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	NA	0	0.0%	3,802	4.6%
<b>Total</b>	<b>6,093</b>	<b>100.0%</b>	<b>297</b>	<b>100.0%</b>	<b>4,086</b>	<b>100.0%</b>	<b>1,148</b>	<b>100.0%</b>	<b>1,632</b>	<b>100.0%</b>	<b>12,147</b>	<b>100.0%</b>	<b>1,123</b>	<b>100.0%</b>	<b>1,870</b>	<b>100.0%</b>	<b>0</b>	<b>0.0%</b>	<b>53,962</b>	<b>100.0%</b>	<b>82,358</b>	<b>100.0%</b>
<b>Ethnicity</b>																						
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	0	0.0%
<b>Total</b>	<b>6,093</b>	<b>87.3%</b>	<b>297</b>	<b>100.0%</b>	<b>4,259</b>	<b>99.5%</b>	<b>1,148</b>	<b>100.0%</b>	<b>1,632</b>	<b>100.0%</b>	<b>13,141</b>	<b>100.0%</b>	<b>1,138</b>	<b>100.0%</b>	<b>221</b>	<b>100.0%</b>	<b>0</b>	<b>0.0%</b>	<b>54,334</b>	<b>100.0%</b>	<b>81,468</b>	<b>100.0%</b>
<b>Age</b>																						
<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%
<b>Total</b>	<b>6,093</b>	<b>100.0%</b>	<b>297</b>	<b>100.0%</b>	<b>4,045</b>	<b>100.0%</b>	<b>1,148</b>	<b>100.0%</b>	<b>1,632</b>	<b>100.0%</b>	<b>13,526</b>	<b>100.0%</b>	<b>1,139</b>	<b>100.0%</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>NA</b>	<b>54,342</b>	<b>100.0%</b>	<b>82,222</b>	<b>100.0%</b>
<b>Adult/Adolescent HIV Exposure Categories</b>																						
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%
<b>Total</b>	<b>7,035</b>	<b>100.0%</b>	<b>297</b>	<b>100.0%</b>	<b>4,302</b>	<b>100.0%</b>	<b>511</b>	<b>100.0%</b>	<b>0</b>	<b>NA</b>	<b>0</b>	<b>NA</b>	<b>575</b>	<b>100.0%</b>	<b>1,870</b>	<b>100.0%</b>	<b>0</b>	<b>NA</b>	<b>0</b>	<b>NA</b>	<b>14,590</b>	<b>100.0%</b>
<b>Pediatric HIV Exposure Categories</b>																						
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%
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>	<b>100.0%</b>	<b>258</b>	<b>100.0%</b>	<b>0</b>	<b>0</b>	<b>NA</b>	<b>NA</b>	<b>2</b>	<b>100%</b>	<b>NA</b>	<b>NA</b>	<b>0</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>274</b>	<b>100.0%</b>

**Table V.A.3: AIDS Incidence, AIDS Prevalence and HIV Prevalence by Demographic Group and Exposure Category**

Demographic Group/Exposure Category	AIDS INCIDENCE: 01/01/05 TO 12/31/06 <i>The number of new AIDS cases as reported to the CDC</i>		AIDS PREVALENCE: AS OF 12/31/06 <i>The number of people living with AIDS</i>		HIV PREVALENCE: AS OF 12/31/06 <i>The number of people living with HIV (non-AIDS)</i>		HIV/AIDS PREVALENCE: AS OF 12/31/06 <i>The number of people living with HIV (non-AIDS) and AIDS</i>	
	#	% of Total	#	% of Total	#	% of Total	#	% of Total
<b>Race/Ethnicity</b>								
White, not Hispanic	356	41.1%	3630	47.2%	3039	49.7%	6669	48.3%
Black, not Hispanic	290	33.5%	2336	30.4%	1699	27.8%	4035	29.2%
Hispanic	200	23.1%	1598	20.8%	1202	19.7%	2800	20.3%
Asian/Pacific Islander	1	0.1%	114	1.5%	86	1.4%	200	1.5%
American Indian/Alaska Nat	0	0.0%	7	0.1%	10	0.2%	17	0.1%
Not Specified <sup>1</sup>	19	2.29%	13	0.2%	76	1.2%	89	0.6%
<b>Total</b>	866	100.0%	7698	100.0%	6112	100.0%	13810	100.0%
<b>Gender</b>								
Male	620	71.5%	5549	72.1%	4262	69.7%	9811	71.0%
Female	246	28.4%	2149	27.9%	1850	30.3%	3999	29.0%
<b>Total</b>	866	100.0%	7698	100.0%	6112	100.0%	13810	100.0%
<b>Age at Diagnosis (years)<sup>2</sup></b>								
<13 years	1	0.1%	20	0.3%	54	0.9%	74	0.5%
13-19 years	10	1.2%	56	0.7%	96	1.6%	152	1.1%
20-44 years	542	62.6%	3304	42.9%	3389	55.5%	6693	48.5%
45 + years	313	36.1%	4318	56.1%	2573	42.1%	6891	49.9%
<b>Total</b>	866	100.0%	7698	100.0%	6112	100.0%	13810	100.0%
<b>Mode of Exposure, Adult</b>								
Men who have sex with men (MSM)	263	30.6%	2509	33.0%	2498	41.9%	5007	36.9%
Injection drug users (IDU)	163	19.0%	1923	25.3%	1094	18.4%	3017	22.3%
MSM/IDU	22	2.6%	259	3.4%	172	2.9%	431	3.2%
Heterosexual Sex <sup>3</sup>	308	35.8%	2333	30.7%	1720	28.9%	4053	29.9%
Other <sup>4</sup>	0	0.0%	95	1.3%	24	0.4%	119	0.9%
Risk not reported/identified	104	12.1%	480	6.3%	454	7.6%	934	6.9%
<b>Total</b>	860	100.0%	7599	100.0%	5962	100.0%	13561	100.0%
<b>Mode of Exposure, Child</b>								
Hemophilia	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Mother with/at risk HIV+	6	100.0%	99	100.0%	150	100.0%	249	100.0%
Receipt of blood transfusion	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Risk not reported/identified	0	0.0%	0	0.0%	0	0.0%	0	0.0%
<b>Total</b>	6	100.0%	99	100.0%	150	100.0%	249	100.0%

<sup>1</sup>Includes multi-race (NH)

<sup>2</sup>Prevalent cases in the Massachusetts counties of the EMA are reported by current age

<sup>3</sup>Includes presumed heterosexual, unknown risk of partner and primary risk categories have been denied

<sup>4</sup>Includes hemophilia and cases with identified modes of transmission other than those listed above (SOURCE: MDPH and NHD)

**Table V.A.4: Part A Boston EMA Service Category Definitions**

## **SERVICE CATEGORY DEFINITIONS**

**AS APPROVED BY THE BOSTON EMA RYAN WHITE PART A HIV HEALTH SERVICES PLANNING COUNCIL, MAY 2008.**

<b>Service category (IN ALPHABETICAL ORDER)</b>	<b>Definition</b>
Case Management	Services funded under this category are client centered services that link with primary medical care and health-related support services in a manner that ensures timely, coordinated access to appropriate levels of care. Client centered services support a clients ability in maximizing their self-sufficiency and independence. Key activities include: information and referral; assessment of the client's needs and personal support systems; development of a comprehensive individualized service care plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; periodic reevaluation and adoption of the plan.
Client Advocacy	Services funded under this category provide short-term "specialized" assistance to clients throughout the process of accessing and obtaining financial and legal services that include, but which are not limited to: healthcare benefits, immigration, social security and disability benefits.
Complementary Therapies	Services funded under this category include, but are not limited to: acupuncture; chiropractic treatment; and, other holistic modalities. The purpose of this category is to provide services that enhance adherence to care, such as symptom management.
Dental	Services funded under this category are recruitment of dentists and preventive diagnostic and therapeutic services rendered by dentists, dental hygienists and other dental practitioners
Drug Reimbursement	The service funded under this category is the provision of medically prescribed pharmaceuticals used in the prevention, management and treatment of HIV disease.
Food Services	The service funded under this category is the provision of calorically and nutritionally appropriate prepared food, which may include, but is not limited to: prepared meals; congregate meals; home-delivered food; food banks; nutritional supplements; and, the provision of nutritional counseling under the supervision of a registered dietician.
Housing	Services funded under this category include the provision of short-term and/or emergency rental assistance, the provision of housing support in a group home or scattered-site setting, and emergency housing-related expenses such as utilities. These services also include assessment, search, placement, and advocacy services provided by those who possess an extensive knowledge of local, State, and Federal housing programs and how they can be accessed.
Mental Health	Services funded under this category are psychological and psychiatric treatment, counseling and case consultation services provided by professional therapists (licensed or authorized within the state).
Peer Support	Services funded under this category provide assistance to clients where the person(s) providing the service is a person infected with HIV and of the client's self-identified community and provide services to a full spectrum of individuals infected by HIV. Such services include the provision of culturally competent psychosocial support; assistance in obtaining a range of services and entitlement that will meet the needs of the client and are provided by licensed or non-licensed, para-professional individuals.
Primary Care	Services funded under this category provide routine, non-emergency, non-inpatient medical care, case consultation, patient education, and OB/Gyn services.
Substance Abuse	Services funded under this category may include: pretreatment program of recovery readiness; harm reduction; mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse; drug-free treatment and counseling; neuro-psychiatric pharmaceuticals; relapse prevention in an outpatient or residential health service setting; and activities targeting persons with HIV disease so that they can be enrolled or retained in care/ treatment services.
Transportation	Services provide taxi vouchers, public transportation, coordination of volunteer transportation, and agency-sponsored vans to transport clients to vital medical and social service appointments.

Table V.A.5: Part A Boston EMA Funding Streams Survey

Part A

Please fill out and return to:	
<b>Boston Public Health Commission</b> <b>Planning Council Support</b> 1010 Massachusetts Avenue, 2nd Floor Boston, MA 02218	<b>W: 617.534.4559</b> <b>F: 617.534.5756</b> <b>E: lkozek@bphc.org</b> <a href="http://www.bostonplanningcouncil.org">www.bostonplanningcouncil.org</a>

## HIV-Related Care and Services Funding Stream Form

**1. Contact Information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Phone: \_\_\_\_\_

FAX: \_\_\_\_\_

E-mail: \_\_\_\_\_

**2. Funding for HIV-Related Treatment, Care, and Services**

The fiscal year reported began on: \_\_\_\_\_

The fiscal year reported ended on: \_\_\_\_\_

Funding Stream	Award
<b>Total</b>	\$0

This information is requested by the Boston Public Health Commission Planning Council Support, on behalf of the Ryan White Part A HIV Health Services Planning Council to help meet the legislative requirements of the Ryan White HIV/AIDS Treatment Modernization Act for allocating Part A funds.



If you have any questions, please contact Laura Kozek at (617) 534-4559 or lkozek@bphc.org.

**Table 1: Part A Service Category Breakdown**

Include funding for care and treatment services listed below. Briefly describe each service to provide a basis for comparison among grantors/grantees. Funding for services beyond these 15 categories may be catalogued in the next table.

<b>Part A Service Category</b>	<b>Amount of Funds only used within the Boston EMA</b>	<b>Description of Service</b>
Case Management		
Client Advocacy		
Complementary Therapies		
Day Care		
Dental		
Drug Reimbursement		
Evaluation		
Food Services		
Housing		
Mental Health		
Peer Support		
Primary Care		
Respite Care		
Substance Abuse		
Transportation		
<b>Total</b>	<b>\$0</b>	

This information is being requested by the Boston Public Health Commission Planning Council Support, on behalf of the Ryan White Part A HIV Health Services Planning Council. If you have any questions, please contact Laura Kozek at (617) 534-4559 or lkozek@bphc.org.

**Table 2: Other HIV/AIDS Services**

Please include funding for care and treatment services listed below. If your agency provides services not listed please include them in the rows marked "other." Briefly describe the service to provide a basis for comparison among grantors/grantees.

Additional Services	Amount of Funds only used within the Boston EMA	Description of Service
Administrative/ Program Support		
Adoption/Foster Care		
Buddy/ Companion Programs		
Capacity Building/ Technical Assistance		
Counseling and Testing		
Education/Risk Reduction		
Emergency Financial Assistance		
Home Health Care		
Insurance Continuation		
Outreach		
Prevention/Education		
Other: _____		
Other: _____		
Other: _____		
Other: _____		
Total	\$0	

This information is being requested by the Boston Public Health Commission Planning Council Support, on behalf of the Ryan White Part A HIV Health Services Planning Council. If you have any questions, please contact Laura Kozek at (617) 534-4559 or lkozek@bphc.org.

**Table 3: Client Utilization Data**

Demographic Group/Exposure Category	Number of EMA Clients Served with Funding	
	#	%
<b>Race</b>		
White		
Black or African American		
American Indian/ Alaskan Native		
Asian		
Some other race		
Two or more races		
<b>Total</b>		
<b>Ethnicity</b>		
Hispanic		
Not Hispanic		
<b>Total</b>		
<b>Age</b>		
<13 years		
13-19 years		
20-44 years		
45+ years		
<b>Total</b>		
<b>Adult/Adolescent AIDS Exposure Categories</b>		
Men who have sex with men		
Injection drug users		
Men who have sex with men and inject drugs		
Heterosexual		
Other/hemophilia/blood transfusion		
Risk not reported or identified		
<b>Total</b>		
<b>Pediatric AIDS Exposure Categories</b>		
Mother with/at risk for HIV Infection		
Other/hemophilia/blood transfusion		
Risk not reported or identified		
<b>Total</b>		

This information is being requested by the Boston Public Health Commission Planning Council Support, on behalf of the Ryan White Part A HIV Health Services Planning Council. If you have any questions, please contact Laura Kozek at (617) 534-4559 or lkozek@bphc.org.