FORT LAUDERDALE/BROWARD EMA
BROWARD HIV HEALTH SERVICES PLANNING COUNCIL
A BOARD OF THE BROWARD COUNTY BOARD OF COUNTY COMMISSIONERS
200 OAKWOOD LANE, SUITE 100, HOLLYWOOD, FL 33020
(954) 561-9681 • FAX (954) 561-9685

Priority Setting & Resource Allocation Committee Special Meeting Agenda

Thursday, March 5, 2026 - 9:30 AM

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Meeting ID: 262 344 748 849
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Chair: Brad Barnes • Vice Chair: Dr. Mark Schweizer

This meeting is audio and video recorded.

Quorum for this meeting is 9

ORDER OF BUSINESS

I. Call to Order

II. Welcome from the Chair:
- **a.** Meeting Ground Rules
- **b.** Statement of Sunshine
- **c.** Introductions & Abstentions
- **d.** Moment of Silence

III. Public Comment

IV. **ACTION ITEM:** Review of Agenda for March 5, 2026

V. **ACTION ITEM:** Approval of Minutes from February 19, 2026 **(Handout A)**

VI. Standard Committee Items:

None.

VII. Old Business
- **a. Discussion:** AIDS Drug Assistance Program (ADAP) Program Update; *Part A and Part B (5 Minutes)*
- **b. Review:** Overview of New Federal Poverty Levels; *PSRA Chair* **(Reflected in the Minutes; Handout A)** *(5 Minutes)*
- **c. Discussion:** 2026-2027 Allocations by Service Category; *PSRA Chair* **(Handout B)** (*1 Hour)*
- **d. Discussion:** PSRA Preliminary Report; *Recipient Office & PSRA Committee (15 Minutes)*
- **e. Discussion:** HICP Scope of Service; Regarding Making Changes to Allow Insurance to be Covered Under HICP; *PSRA Chair (15 Minutes)*
- **f. Discussion:** Wrap Up and Next Steps; *PSRA Chair (15 Minutes)*

VIII. Discussion Items: None.

IX. New Business: None.

X. Public Comment

XI. Recipient Report

a. Status of ADAP Resolution

XII. **Next Meeting Date:** March 19, 2026, 9:30AM to 12:30PM. Location: **Microsoft Teams and BRHPC**

a. Agenda Items for Next Meeting:

i. **Detailed Review:** *Ryan White Part A Office: Overall FY24-25 Allocations Expenditure/Utilization Report – by service category: Recipient Representative*

XIII. Announcements

XIV. Adjournment

For a detailed discussion on any of the above items, please refer to the minutes available at:
HIV Planning Council Website

Please complete your meeting evaluation.

Three Guiding Principles of the Broward County HIV Health Services Planning Council
• Linkage to Care • Retention in Care • Viral Load Suppression •

Vision: To ensure the delivery of high-quality, comprehensive HIV/AIDS services to low-income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care.

Mission: We direct and coordinate an effective response to the HIV epidemic in Broward County to ensure high-quality, comprehensive care that positively impacts the health of individuals at all stages of illness. In so doing, we: (1) Foster the substantive involvement of the HIV-affected communities in assuring consumer satisfaction, identifying priority needs, and planning a responsive system of care, (2) Support local control of planning and service delivery, and build partnerships among service providers, community organizations, and federal, state, and municipal governments, (3) Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment.

March 2026

Broward HIV Health Services Planning Council Calendar

All events listed on this calendar are free and open to the public. Meeting dates and times are subject to change. Please contact support staff at **hivpc@brhpc.org** or **(954) 561-9681 ext. 1244/1343**. Visit **HIV Health Service Planning Council** for updates.

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
1	2	3 Community Empowerment Committee (CEC) 3:00PM - 5:00PM	4	5 PSRA Committee Meeting 9:30AM - 11:30PM	6	7
8	9	10	11	12	13	14
15	16 Quality Management Committee Meeting (QMC) 12:30PM - 2:30PM	17 	18	19 PSRA Committee Meeting 9:30AM - 11:30PM Executive Committee Meeting 12:45PM - 2:45PM	20	21
22	23	24	25	26 HIV Planning Council Meeting 9:30AM to 11:30AM	27	28  Fort Lauderdale Beach Park 8:00AM to 1:00PM
29	30	31				

Broward Regional Health Planning Council (BRHPC):
200 Oakwood Lane, Suite #100, Hollywood, FL 33020
Links are active and lead to meetings or Awareness Day Information. **Information is subject to change.**

Meetings in **RED** are canceled. Meetings in **BLUE** are for the HIV Planning Council Committees. Meetings in **GREEN** are for the Provider Network. Holidays and meetings outside of the HIV Planning Council are in **BLACK**.

March 2026

Broward HIV Health Services Planning Council Calendar

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TODOS ESTAN BIENVENIDOS!	ALL ARE WELCOME!	BON VINI!
A menos que se anote de forma diferente en el calendario, todas las reuniones se realizarán en: Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020 Para confirmar información acerca de la reunión de Consejo de Planeación HIV, o confirmar la reserva de servicios especiales tales como: Traducción Inglés a Español o a Criollo (Haitiano), servicios para discapacitados en visión o audición, por favor llame con 48 horas de antelación para que puedan hacerse los arreglos necesarios.	Unless otherwise noted on the calendar, all meetings are held at: Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020 To confirm HIV Planning Council meeting information, or reserve special needs services such as Translation from English to Spanish or Creole, or are hearing or visually impaired, please call 48 hours in advance so that arrangements can be made for you.	Sòf si yo ta ekri yon lòt bagay nan almanak-la, tout rankont-yo ap fét: Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020 Pou konfime enfòmasyon ou resevwa sou rankont Konsèy Planifikasyon HIV-a, oswa pou rezève sèvis pou bezwen Espesyal tankou: Tradiksyon angle an panyòl oswa kreyol; oswa, si ou gen pwoblèm wè oswa tande, rele 48 tè alavans pou yo ka fè aranjman pou ou.

HIVPC Committee Descriptions

HIV Health Services Planning Council (HIVPC): Continuously monitors, evaluates, and improves the quality of HIV care for Ryan White Part A and MAI-funded patients.

Executive Committee (EXEC): Oversees the HIV Integrated Prevention and Care Plan, work of HIVPC committees, recommendations, and grievance resolution. Sets HIVPC agendas, manages conflicts of interes, and review attendance.

Priority Setting and Resource Allocation Committee (PSRA): Recommends priorities and allocates Ryan White Part A funds based on data review. Develops, monitors, and refines eligibility, service definitions, and strategies to meet community needs.

Quality Management Committee (QMC): Ensures high-quality HIV care by developing outcomes and indicators. Oversees standards of care, evaluates programs, assesses client satisfaction, and training.

Membership/Council Development Committee (MCDC): Recruits and screens applicants to ensure the Council meets demographic requirements. Provides recommendations, orientation, training for new members.

Community Empowerment Committee (CEC): Engages in community outreach to Ryan White Part A consumers to inform them about opportunities to participate in the HIV Planning Council and provide input.

System of Care Committee (SOC): Evaluates the system of care and the impact of policies on people living with HIV in Broward County. Plans and coordinates care across diverse groups to improve access and reduce disparities.

Handout A

FORT LAUDERDALE/BROWARD EMA
BROWARD HIV HEALTH SERVICES PLANNING COUNCIL
AN ADVISORY BOARD OF THE BROWARD COUNTY BOARD OF COUNTY COMMISSIONERS
200 OAKWOOD LANE, SUITE 100, HOLLYWOOD, FL 33020
(954) 561-9681 • FAX (954) 561-9685

Priority Setting and Resource Allocation Committee

Thursday, February 19, 2026 – 9:30AM
Meeting at Broward Regional Health Planning Council and via Microsoft Teams

DRAFT MINUTES

PSRA Members Present: B. Barnes, B. Fortune-Evans, B. Mester, V. Biggs, L. Robertson, J. Rodriguez, M. Schwiezer. S. Tinsley, S. Hafley, J. Castillo, Y. Barrientos, K. Schickowski, M. Patterson, J. Rogers
PSRA Members Absent: A. Machado (excused), R. Jimenez
Recipient Part A Staff Present: G. James, T. Thompson, B. Spaulding, R. Pena, B. Baker, W. Cius, J. Roy, T. Currie, G. Moxey, R. Honick
Recipient Part B Staff Present: S. Cook
PCS/CQM Present: G. Berkeley-Martinez, M. Rosiere, M. Lacroix, S. Isidore, D. Liao, D. Cestaro-Seifer, J. Beal
Guests Present: N. Burell, M. DiMaria, G. Verger, F. D'Amore, J. Hidalgo, L. Jones, A. Perry, J. Dresseno, T. Smith, D. Steele, C. Archibald, N. Graham, H. Singh, R. Goubeaux, J. Ritter, R. Campbell, R. Labissiere, J. Alexandre, J. Sesay, S. Santiago, J. Starkey, J. Charlot, F. Esterlien, K. Giglioli, A. Diaz, J. Deleo, J. Welsh, T. Benjamin, L. Athouriste, J. Saboe-Rodriguez, K. Fitzpatrick, A. Jenks, S. Vickers

Call to Order

The PSRA Chair called the meeting to order at **9:34 AM.**

1. Welcome from the Chair & Public Record Requirements

   The PSRA Chair welcomed all meeting attendees that were present. Attendees were notified that the PSRA meeting is based on Florida's "Government-in-the-Sunshine Law and meeting reporting requirements, including the recording of minutes. In addition, it was stated that the acknowledgment of HIV status is not required but is subject to public record if it is disclosed. Introductions were made by the PSRA Chair, committee members, Recipient staff, PCS staff, CQM Staff, and guests by roll call, and a moment of silence was observed.

2. Public Comment

   The Public Comment portion of the meeting is intended to give the public a chance to express opinions about items on the meeting agenda or to raise other matters pertaining to HIV/AIDS and services in Broward County.

N. Burrell emphasized the importance of maintaining mental health and substance abuse services alongside ADAP support, warning that removing these services could negatively impact clients' medication adherence, housing stability, and overall well-being.
T. Smith, while recognizing the financial challenges, emphasized that maintaining integrated, comprehensive services is essential for clients' overall health, warning that cutting these services would reverse progress in HIV care.
F. D'Amore, a consumer who would be personally impacted by a loss of services, attested to the critical importance of mental health support. She recommended a cap on services rather than eliminating them, ensuring continued access while addressing financial constraints.

3. Action Item: Review of Agenda for February 19, 2026

   MOTION #1: On behalf of PSRA, V. Biggs moved to approve the agenda for the February 19, 2026, Priority Setting and Resource Allocation Committee meeting. B. Mester seconded the motion, which was unanimously approved.

4. Action Item: Approval of Minutes from February 12, 2026

   MOTION #2: M. Schweizer, on behalf of PSRA, made a motion to approve February 12, 2026. Priority Setting and Resource Allocation Committee minutes. The motion was seconded by V. Biggs, and passed unanimously.

5. Standard Committee Items
   None.

6. Old Business
   a. Discussion: AIDS Drug Assistance Program (ADAP) Program Update
      J. Roy, Administrator, reported that the Recipient Office scheduled one-on-one meetings with medical providers to understand their capacity and how they can manage changes impacting clients, including ADAP changes and insurance coverage options. She noted the concern of clients migrating in and out of Broward County in response to the ADAP changes.

      The Recipient Office has received technical assistance from the National Alliance of State and Territorial AIDS Directors (NASTAD). They are planning future capacity-building support and the effects of becoming a 340B network. W. Cius informed the committee that technical assistance from NASTAD and Georgetown University is available to all recipients and subrecipients within the system of care, and they may contact the Recipient Office to access these resources.

      J. Rodriguez reported no changes from FDOH.

   b. Data Request: Funding Scenario Analysis; Recipient Office
      T. Thompson presented updated data for each funding scenario, incorporating revised client counts and cost estimates based on the invoices that had been submitted up to that point. He explained that scenario examples are not recommendations and can be adjusted based on council input during the discussion period. Despite a slight increase in the number of clients above the 250% FPL threshold, the cost per client remains roughly the same. Tim stated that regardless of today's vote, the recipient office will meet next week

to review provider spending and make internal decisions on cost-saving measures.

In **Scenario 1**, the FPL for all services remains the same (<=400%) and service categories are reduced to seven. In **Scenario 2**, the FPL for all services is reduced to <=250% and service categories are reduced to seven. In **Scenario 3,** the FPL for all services is reduced to <=300% and all service categories are kept with service restrictions. In **Scenario 4**, everything remains unchanged. T. Thompson covered the estimated savings and the number of affected clients for each scenario. He emphasized that Scenario 4 is the most unrealistic and unsustainable course of action.

T. Thompson noted that cutting service categories yields limited savings, with costs primarily driven by control mechanisms within service categories and management of low-FPL clients. He highlighted outpatient/ambulatory care and oral health as the system's largest expenditures and emphasized that careful management is more effective than elimination. Leveraging control measures and monitoring low-income clients are the most effective strategies for cost containment.

B. Barnes noted that the dollar amounts of each FPL are listed in Handout B3.
The committee discussed the data requests and the answers provided in Handout B4.

V. Biggs asked which clients, currently disqualified for ADAP, could qualify for PAPs offered by the providers? How many would qualify, and how many would still be disqualified? T. Thompson stated that there was not enough time to compile a document after speaking with the providers. W. Cius explained that providers do not offer specific pre-set plans but instead conduct a cost analysis to determine which options are most suitable and affordable for each client. V. Biggs disagreed, noting that the providers do in fact have established programs. J. Roy added that these questions are currently being addressed and that discussions have not yet been taken.

V. Biggs also asked if Miami-Dade County and Palm Beach County have officially voted and updated their appeals yet and, if so, whether Broward County would mirror those changes. place with all providers. J. Roy confirmed that Mami-Dade voted to change their FPLs. G. James confirmed that Palm Beach does not intend to lower their FPLs.

B. Mester asked about the cost for the Broward EMA to provide non-ARVs to 374 individuals, and J. Rodriguez responded that it would total $1.4 million if the ADAP formulary remains unchanged. B. Mester also questioned whether outreach to 340B pharmacies had occurred, noting that ARVs are sold for over $2,500 and suggesting those funds could be better used to cover clients. He emphasized the need for stronger engagement with pharmacies to explore coverage options.

T. Thompson stated that beginning in March, tracking will be implemented to monitor the number of clients identified as new in order to assess the influx of clients.

M. Patterson asked whether an analysis had been conducted on how much hospital districts contribute toward covering clients. J. Roy responded that outreach to hospital districts has not yet occurred and added that the Recipient Office is receptive to the 340B

plan.

M. Schweizer emphasized that while some clients may be negatively affected, the priority is to minimize harm and maximize client benefit. He stated that reducing services would have serious mental and physical consequences and stressed the importance of understanding how many clients would be impacted under the FPL scenarios. He recommended implementing caps rather than eliminating service categories. He also noted that clients should take personal responsibility, including enrolling in employer-sponsored health insurance when available.

J. Beal asked whether exceptions could be granted under a reduced FPL for individuals with extenuating circumstances or service needs beyond established caps and suggested assessing the capacity of 340B providers to absorb clients losing insurance, even if it requires changing primary care providers. J. Roy stated this is being addressed in screening, though providers require individuals to be established patients. T. Thompson noted eligibility overrides are possible but limited.

B. Barnes invited the committee to draft a fifth option. J. Rodriguez responded that many will lose insurance under any FPL level and proposed 400% FPL eligibility for non-ARVs and medical care to preserve access to treatment, with remaining funds allocated by service category and individual needs under applicable caps. After discussion, the committee drafted a fifth scenario.

Scenario Five: Have everyone covered 0-400% FPL, for Outpatient Medical and LPAP with the remaining funds allocated to other service categories based on utilization and need/ranking (ex. NMCM, CIED).

V. Biggs expressed concern about the amount of clients remaining in the 0-50% federal poverty level bracket for multiple years and recommended a deeper analysis to address barriers to moving out of the system of care.

M. Patterson and J. Rodriguez noted that after ARVs were removed from the formulary, clients would need funding for other prescriptions, especially mental health medications, and discussed the expected influx of clients needing assistance. M. Schweizer noted that prescribing mental health medications without accompanying care or oversight would be ineffective.

B. Mester suggested placing caps on CIED and combining Scenario 3 and Scenario 5. G. James noted that CIED primarily handles eligibility determination and serves as the first point of contact for clients, making it more efficient than case management. V. Biggs added that CIED’s budget has already been reduced and should be reassessed.

J. Beal stated that Scenario 5 is the most compassionate and provides the best service to the community by keeping clients on medication and in care but warned that allocating remaining funds would significantly increase the Recipient Office’s administrative burden and could lead to increased client relocation from other areas.

B. Barnes reminded committee members that a vote to eliminate service categories

requires disclosure of conflicts of interest. The committee implemented a roll call for vote following a ten-minute break.

B. Barnes invited consumers to share their thoughts on the matter.

S. Tinsley shared that, as a client unable to work, cutting services would be harmful. She noted that these programs are intended to help clients move toward self-sustainability and make room for new clients, not serve as long-term support.

J. Hidalgo suggested that the first eligibility step should require clients to be Broward residents for a specified period. This approach is permitted by HRSA and accounts for clients who relocate to Broward to access services.

B. Barnes invited the committee members to propose motions “in principle” and to stack motions if necessary.

M. Schweizer proposed a motion on principle to adopt Scenario 3, which was seconded by J. Castillo. B. Mester proposed a friendly amendment to add the caveats of Scenario 5. M. Schweizer expressed concern that this might conflict with aspects of Scenario 3.

B. Mester proposed a motion to adopt a hybrid of Scenario 3 and Scenario 5, which was seconded by J. Rodriguez.

V. Biggs proposed a motion to adopt Scenario 1 while adding caps to services and including the caveats of Scenario 5. No one seconded the motion, and it died on the floor.

J. Castillo and M. Schweizer stated that caps are needed on every service category. G. James and T. Thompson reiterated that the Recipient Office would implement cost-containment methods.

B. Fortune-Evans noted that Scenario 3 and Scenario 5 have different FPL thresholds and questioned how they could be combined. B. Barnes clarified that the motion is “in principle,” and that additional motions tailored to each service category would follow. G. James noted that Integrated Primary Care and Behavioral Health does not provide the same level of care as specialized substance use programs, and some individuals may require a higher level of treatment.

MOTION #3 (Repealed): M. Schweizer, on behalf of PSRA, made a motion to adopt Scenario 3 – FPL for all service categories <=300% and all service categories kept with service restrictions. The motion was seconded by J. Castillo and passed with nine votes in favor and four votes against.

V. Biggs called a point of order that the secondary motion must be passed before the primary motion. The meeting was paused until County Attorney R. Honick could join the call and provide legal counsel. R. Honick counseled that the secondary motion must indeed precede the primary motion and advised the committee to repeal the motion they had just passed.

MOTION #4: V. Biggs, on behalf of PSRA, made a motion to repeal the previous motion. The motion was seconded by S. Tinsley, and passed unanimously.

A motion was presented to adopt a combination of Scenario 3 and Scenario 5. The motion was proposed by B. Mester and seconded by J. Rodriguez. The vote resulted in a tie, with seven votes in favor and seven votes against.

B. Mester called a point of order, noting that members with conflicts of interest related to OAHS and LPAP should abstain from voting. Atty, R. Honick confirmed that conflicts of interest are relevant given the amount of funds represented. The committee discussed how to revise the motion.

MOTION #5: B. Mester, on behalf of PSRA, made a motion to set FPL for all service categories less than or equal to 300% (<=) FPL, except Outpatient Medical, AIDS Pharmaceutical (LPAP) and Centralized Intake and Eligibility Determination (CIED) which would be less than or equal to 400% of FPL. Upon review by the Recipient Office, all service categories will be assigned restrictions and caps. The motion was seconded by J. Rodriguez and passed with six in favor, four against, and four abstentions (B. Fortune-Evans, L. Robertson, S. Hafley, M. Patterson).

B. Mester proposed a motion to conduct allocations and FPL eligibility determination at the same time service category by service category. The motion was not seconded and died on the floor.

MOTION #6: V. Biggs, on behalf of PSRA, made a motion to set AIDS Pharmaceutical Assistance eligibility at 400% of the FPL. The motion was seconded by J. Rodriguez and passed with seven in favor, two against, and four abstentions (B. Fortune-Evans, L. Robertson, S. Hafley, M. Patterson).

MOTION #7: V. Biggs, on behalf of PSRA, made a motion to set Integrated Primary Care and Behavioral Health eligibility at 400% of the FPL. The motion was seconded by J. Rodriguez and passed with twelve in favor and one against.

MOTION #8: V. Biggs, on behalf of PSRA, made a motion to set Medical Case Management eligibility at 300% of the FPL. The motion was seconded by B. Mester and passed unanimously.

MOTION #9: M. Schweizer, on behalf of PSRA, made a motion to set Mental Health Services eligibility at 300% of the FPL. The motion was seconded by J. Castillo and passed with ten in favor, one against, and two abstentions (L. Robertson, M. Patterson).

MOTION #10: M. Schweizer, on behalf of PSRA, made a motion to set Substance Abuse Treatment eligibility at 300% of the FPL. The motion was seconded by J. Castillo and passed with ten in favor, one against, and two abstentions (L. Robertson, M. Patterson).

MOTION #11: M. Schweizer, on behalf of PSRA, made a motion to set Insurance Support Services (Health Insurance Continuation Program) eligibility at 300% of the FPL, including ADAP approved plans. The motion was seconded by J. Rodriguez and passed with eleven in favor and two against.

MOTION #12: M. Patterson, on behalf of PSRA, made a motion to set Medical Nutrition Therapy eligibility at 300% of the FPL. The motion was seconded by M. Schweizer and passed with ten in favor, one against, and two abstentions (B. Mester, J. Castillo).

MOTION #13: M. Patterson, on behalf of PSRA, made a motion to set Oral Health Services eligibility at 300% of the FPL. The motion was seconded by J. Castillo and passed unanimously.

MOTION #14: V. Biggs, on behalf of PSRA, made a motion to set Centralized Intake and Eligibility Determination eligibility at 400% of the FPL. The motion was seconded by M. Patterson and passed with twelve in favor and one against.

MOTION #15: M. Patterson, on behalf of PSRA, made a motion to set Non-Medical Case Management eligibility at 300% of the FPL. The motion was seconded by J. Rodriguez and passed with twelve in favor and one against.

M. Schweizer made a motion to set Emergency Financial Assistance eligibility at 250% of the FPL. The motion received no second and therefore died on the floor.

MOTION #16: M. Schweizer, on behalf of PSRA, made a motion to set Emergency Financial Assistance eligibility at 300% of the FPL. The motion was seconded by J. Castillo and passed with six in favor, three against, and four abstentions (B. Fortune-Evans, L. Robertson, S. Hafley, M. Patterson).

The committee did not make changes to Food Bank eligibility FPL.

MOTION #17: V. Biggs, on behalf of PSRA, made a motion to set Legal Services eligibility at 300% of the FPL. The motion was seconded by J. Rodriguez and passed with twelve in favor, none against, and one abstention (K. Schickowski).

MOTION #18: V. Biggs, on behalf of PSRA, made a motion to set the proposed FPL changes to go into effect on April 1, 2026. A friendly amendment by M. Patterson revised the effective date to April 15, 2026. The motion was seconded by J. Rodriguez and passed unanimously.

The committee discussed ensuring that new clients are documented residents of Broward County before accessing Ryan White Part A services. Concerns were raised about clients moving from other areas which could increase intake in Broward and put a strain on the system of care.

Atty, R. Honick explained that Broward County already has a residency requirement for incoming clients. Clients must be residents of Broward County and this includes individuals who move from another county and establish residency in Broward. If individuals choose to relocate from other areas the program is obligated to serve them once they establish residency. B. Fortune-Evans and Y. Barrientos expressed concern that strict residency requirements could create barriers for unhoused clients and newly diagnosed patients relocating from other states who need immediate access to care.

c. Review: Options and Recommendations from Part A Office
   Refer to Item B - *Data Request: Funding Scenario Analysis*
d. Discussion: Alternative Options for Response to ADAP Crisis
   Refer to Item B - *Data Request: Funding Scenario Analysis*
e. Discussion: Select Two Options for ADAP Crisis
   Refer to Item B - *Data Request: Funding Scenario Analysis*
f. Discussion: Motion to Address the ADAP Crisis to Forward to Planning Council with Justification
   Refer to Item B - *Data Request: Funding Scenario Analysis*

7. Discussion Items: None.
8. New Business: None
9. Public Comment: None.
10. Recipient Report: None
11. Data Request(s)
    Atty. R. Honick and Dr. J. Hidalgo to assist with language addressing migration.
12. Next Meeting: March 5, 2026, 9:30AM to 1:30PM. Location: Microsoft Teams and BRHPC
13. Agenda Items for Next Meeting
    a. To Be Determined
14. Announcements: None.

There being no further business, the meeting was adjourned at **1:05 PM**

PSRA Attendance for CY 2026

Count	Meeting Month	Jan	Feb	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
	Meeting Date	15	12	19											
1	Barnes, B., Chair	X	X	X											
2	Fortune-Evans, B.	X	X	X											
3	Mester, B.	X	X	X											
4	Robertson, L.	X	X	X											
5	Rodriguez, J.	X	X	X											
6	Biggs, V.	X	X	X											
7	Jimenez, R.	X	X	A											
8	Schwiezer, M.	X	X	X											
9	Machado, A.	X	A	E											
10	Tinsley, S.	X	X	X											
11	Castllo, J.	X	X	X											
12	Barrientos, Yahaira	X	X	X											
13	Hafley, Shalisa	X	X	X											
14	Rogers, Jonathan	A	A	X											
15	Schickowski, Kara	A	X	X											
16	Patterson, M.	X	X	X											
	Quorum = 9	14	14	14											

Legend:	
X - present	N - newly appointed
A - absent	Z - resigned
E - excused	C - canceled
NQA - no quorum absent	W - warning letter
NQX - no quorum present	Z - resigned
CX - canceled due to quorum	R - removal letter

Priority Setting and Resource Allocation Committee Meeting Minutes – February 19, 2026, Minutes prepared by PCS Staff

Handout B

	Service Category		Ending Amount FY25/26	Proposed FY 26/27	Change	Note
Core Medical Services	Ambulatory- Integrated Primary Care and Behavioral Health Services (7)		5,537,990	$5,746,053.00	$208,063.00	There was Admin money that was moved into the service categories at the end of the year. However, we wanted our recommendations to relfect utilizing where we ended off at and made adjustments historically based upon Sweeps and anticipation of service utilization.
	AIDS Pharmaceutical Assistance (3)		4,652	$550,000.00	$545,348.00	
	Oral Health Care	Routine (4)	2,404,053	$2,404,053.00	$0.00	
		Specialty (1)	346,964	$346,964.00	$0.00	
	Medical Case Management	Disease Case Management (9)	900,478	$820,081.00	-$80,397.00	
	Mental Health- Trauma-Informed (4)		124,000	$130,000.00	$6,000.00	
	Health Insurance Premium & Cost Sharing Assistance		619,465	$650,000.00	$30,535.00	
	Medical Nutrition Therapy (1)		250,000	$250,000.00	$0.00	
	Substance Abuse-Outpatient (1)		185,684	$150,000.00	-$35,684.00	
Support Services	Non-Medical Case Management	Centralized Intake and Eligibility Determination (1)	416,454	$349,378.00	-$67,076.00	
	Non-Medical Case Management	Case Management (10)	1,433,684	$820,081.00	-$613,603.00	
	Food Services	Food Bank (2)	620,000	$600,000.00	-$20,000.00	
		Food Voucher (3)	33,186	$35,000.00	$1,814.00	
	Legal Assistance (1)		129,151	$129,151.00	$0.00	
	Emergency Financial Assistance (3)		194,872	$115,872.00	-$79,000.00	
	Total Part A Funds		**13,200,633**	$13,096,633.00		
	*** Some of the providers have not billed for month of JAN 2025**					
	Service Category		**Contract/ Allotted Amount**	**Proposed FY 26/27**	**Change**	
Core Medical Services	MAI Ambulatory (1)		1,000	$50,000.00	$49,000.00	
	MAI Mental Health (1)		82,469	$65,000.00	-$17,469.00	
	MAI Substance Abuse-Outpatient (1)		461,318	$300,000.00	-$161,318.00	
Support Services	MAI Non-Medical Case Management	Case Management (4)	274,967	$187,004.00	-$87,963.00	
	MAI Non-Medical Case Management	Centralized Intake and Eligibility Determination (1)	541,431	$424,066.00	-$117,365.00	
	Total MAI Funds		**1,361,185**	$1,026,070.00		
	*** Some of the providers have not billed for month of JAN 2025**					
	*** Carryover amount of $254,837 included in calculations.**					
	Total Part A and MAI Funding		**14,561,818**	$ 14,122,703.00		

HIV HEALTH SERVICES PLANNING COUNCIL MEETING GROUND RULES

1. The Council, its members, and the public recognize and respect the committee process adopted by this Council. The Council, its members, and the public recognize that full discussion and analysis of issues occurs at the committee level rather than at Council meetings.

2. Before a member can make a motion or speak in debate, the member must be recognized by the Chair as having the exclusive right to be heard at that time.

3. All speakers are expected to address the Council in a respectful manner to respect time limits, to speak briefly and to the point, and to stay on agenda. All other persons in attendance should not interrupt the speaker who is recognized by the Chair as having the floor.

4. If the member who made the motion claims the floor and has not already spoken on the question, that member is entitled to be recognized in preference to other members.

5. No person is entitled to the floor a second time in debate on the same item as long as any other person who desires the floor has not spoken on the item.

6. Speakers should restrict comments and debate to the pending question or motion. Speakers must address their remarks to the Chair and maintain a courteous tone. The Chair may impose time limits on debate or discussion to ensure efficient conduct of Council business.

7. Members should not name service providers and/or persons during any discussion unless the service provider or person is identified in the subject of the motion or agenda item. Specific concerns regarding service providers should be directed towards the Grantee, outside of the meeting.

8. Members of the public may only address the Council upon recognition by the Chair. They are subject to the same rules of conduct expected of Council members.

9. No alcohol or drug use (unless prescribed by a licensed physician), is permitted at Council meetings, grantee or support staff offices.

10. No abusive language, threats of violence, or possession of weapons are permitted in Council meetings, grantee or staff offices.

11. Repeated violation of these meeting rules may result in no further recognition of the offending member or attendee by the Chair at that meeting. Any serious breach of conduct which disrupts the Council's meeting may subject the offender to removal from the meeting, administrative or legal process.

Revised 7/24/14

CONSEJO DE PLANEACIÓN DE SERVICIOS DE SALUD VIH
REGLAS BÁSICAS DE LA REUNIÓN

1. Los miembros deberán aceptar y respetar el proceso de comité adoptado por este Consejo. Las discusiones y el análisis en pleno de los temas tendrán lugar a nivel de comité y no en las reuniones plenarias del Consejo.

2. Antes de que un miembro pueda iniciar una moción o de que una persona pueda hablar en un debate, el Presidente de la reunión deberá reconocer que él o ella tienen el derecho exclusivo de hablar en ese momento dado.

3. Se espera que todos los ponentes se dirijan al Consejo de una manera respetuosa, que no se interrumpa al ponente con derecho al habla en el momento, que cuando se hable se haga de forma clara y concisa, y que se mantenga la agenda.

4. Si el miembro que inicia una moción no ha hablado todavía y reclama su derecho a hablar sobre un asunto, él/ella tendrán el derecho a que con preferencia se les reconozca.

5. Nadie tendrá derecho a reclamar el habla por una segunda vez, en un debate sobre el mismo tema, cuando otra persona que no ha hablado todavía, desea hacerlo.

6. Los debates deben ceñirse a los asuntos o mociones que estén pendientes. Al hablar, los ponentes deben referirse al Presidente, y mantener un tono cortés.

7. Los miembros del público solo podrán dirigirse al Consejo cuando hayan sido reconocidos por el Presidente de la reunión. Estarán sujetos a las mismas reglas de conducta que se esperan de los miembros del Consejo. Se establecerán límites de tiempo según sea necesario para garantizar que los asuntos del Consejo cursen de manera eficiente.

8. Miembros del público sólo podrán dirigir el Consejo a partir del reconocimiento por el Presidente. Están sujetos a las mismas reglas de conducta que se espera de los miembros del Consejo.

9. No estará permitido el uso de bebidas alcohólicas o de drogas en las reuniones del Consejo y tampoco en las oficinas del personal de soporte y donatarios.

10. No está permitido el uso de lenguaje abusivo, amenazas de violencia y posesión de armas en las reuniones del Consejo ni en las oficinas del personal de soporte y donatarios.

11. La repetida violación de estas reglas básicas dará como resultado que el Presidente de la reunión deje de reconocer al derecho a participación del ofensor o miembro de la audiencia. Cualquier violación de conducta grave, que perturbe la reunión de Consejo, terminará en la remoción del ofensor, de la reunión.

Revised 7/24/14

KONSÈY PLANIFIKASYON SÈVIS SANTE POU HIV RÈGLEMAN RANKONT-YO

1. Manm-yo dwe rekonèt epi respekte pwosesis komite-a ke Konsèy-la adopte. Diskisyon ak analiz total pwoblèm-yo fèt nan nivo komite-a; li pa fèt pandan rankont tout Konsèy-la.

2. Anvan yon manm ka fè yon pwopozisyon oswa nenpòt ki moun gen dwa pale pandan yon deba, fòk Prezidan Komite-a bali dwa esklizif pou fè moun tande-li nan moman sa-a.

3. Yo atann-yo aske tout moun k'ap pale ak Konsèy-la fè-li avèk respè, pou pèsonn pa koupe moun ke Konsèy-la bay dwa pale lapawòl, pou moun k'ap pale-a respekte kantite tan yo ba-li pou pale-a, pou li di sa l'ap di-a rapidman epi avèk presizyon, epi pou li respekte ajanda-a.

4. Si manm ki fè pwopozisyon-an mande pou li pale epi si li poko pale sou keksyon-an deja, li gen priyorite sou lòt manm-yo.

5. Pèsonn moun pa gen dwa pran lapawòl de fwa sou yon menm sijè si gen lòt moun ki poko pale epi ki vle esprime tèt-yo.

6. Deba-a dwe rete sou keksyon oswa pwopozisyon k'ap fèt-la. Moun k'ap pale-a dwe adrese sa l'ap di-a bay Prezidan Komite-a epi pale sou yon ton ki make ak respè.

7. Manm piblik-la dwe pale ak Konsèy-la sèlman si Prezidan Konsèy-la bay-yo lapawòl. Yo dwe respektè menm règleman kondwit avèk manm Konsèy-yo. Lè sa nesesè pou zafè Konsèy-la byen mache, yo gen dwa bay-yo yon limit tan pou yo pale.

8. Manm nan piblik la sèlman pou adrese a konsèy sou rekonèsans sou chèz la. Yo ka tonbe anba menm lòd de kondwit ki te espere nan manm konsèy yo.

9. Itilizasyon alkòl ak dwòg (sòf si se yon doktè lisansye ki preskri-li), entèdi nan rankont Konsèy-la oswa nan biwo estaf sipò-a oswa Resevè-a.

10. Vye langaj, menas vyolans, oswa posesyon zam entèdi nan rankont Konsèy-la oswa nan biwo estaf-la oswa Resevè-a.

11. Vyolasyon repete règleman rankont-yo ap lakòz yon manm oswa lòt moun k'ap asiste rankont-lan pa kapab patisipe ankò. Nenpòt ki move kondwit serye ki twouble rankont-la ap lakòz yo mete moun-nan deyò.

Acronym List

ACA: The Patient Protection and Affordable Care Act

ADAP: AIDS Drugs Assistance Program

Administration HUD: U.S Department of Housing and Urban Development

IW: Integrated Workgroup

AETC: AIDS Education and Training Center

AHF: AIDS Health Care Foundation

AIDS: Acquired Immuno-Deficiency Syndrome

ART: Antiretroviral Therapy

ARV: Antiretrovirals

BARC: Broward Addiction Recovery Center

BCFHC: Broward Community and Family Health Centers

BH: Behavioral Health

BRHPC: Broward Regional Health Planning Council, Inc.

CBO: Community-Based Organization

CDC: Centers for Disease Control and Prevention

CDTC: Children's Diagnostic and Treatment Center

CEC: Community Empowerment Committee

CIED: Client Intake and Eligibility Determination

CLD: Client Level Data

CQI: Continuous Quality Improvement

CQM: Clinical Quality Management

CTS: Counseling and Testing Site

eHARS: Electronic HIV/AIDS Reporting System

EIIHA: Early Intervention of Individuals Living with HIV/AIDS

EFA: Emergency Financial Assistance

EMA: Eligible Metropolitan Area

FDOH: Florida Department of Health

FPL: Federal Poverty Level

FQHC: Federally Qualified Health Center

HAB: HIV/AIDS Bureau

HHS: U.S. Department of Health and Human Services

HICP: Health Insurance Continuation Program

HIV: Human Immunodeficiency Virus

HIV HSSS: HIV Human Services Software System

HIVPC: Broward County HIV Health Services Planning Council

HOPWA: Housing Opportunities for People with AIDS

HRSA: Health Resources Services Administration

IDU: Intravenous Drug User

JLP: Jail Linkage Program

LPAP: Local AIDS Pharmaceutical Assistance Program

MAI: Minority AIDS Initiative

MCDC: Membership/Council Development Committee

MCM: Medical Case Management

MH: Mental Health

MNT: Medical Nutrition Therapy

MOU: Memorandum of Understanding

NBHD: North Broward Hospital District (Broward Health)

NGA: Notice of Grant Award

NHAS: National HIV/AIDS Strategy

NMCM: Non-Medical Case Management

NOFO: Notice of Funding Opportunity

nPEP: Non-Occupational Post Exposure Prophylaxis

NSU: Nova Southeastern University

nPEP: Non-occupational Post-Exposure Prophylaxis

OAHS: Outpatient Ambulatory Health Services

OHC: Oral Health Care

PCN: Policy Clarification Notic

PE: Provide Enterprise

PLWH: People Living with HIV

PLWHA: People Living with HIV/AIDS

PrEP: Pre-Exposure Prophylaxis

PRISM: Patient Reporting Investigating Surveillance System

PROACT: Participate, Retain, Observe, Adhere, Communicate and Teamwork is DOH- Broward's treatment adherence program.

PSRA: Priority Setting & Resource Allocations

QI: Quality Improvement

QIP: Quality Improvement Project

QM: Quality Management

QMC: Quality Management Committee

RSR: Ryan White Services Report

RWHAP: Ryan White HIV/AIDS Program

RWPA: Ryan White Part A

SBHD: South Broward Hospital District (Memorial Healthcare System)

SCHIP: State Children's Health Insurance Program

SDM: Service Delivery Model

SOC: System of Care

SPNS: Special Projects of National Significance

STD/STI: Sexually Transmitted Diseases or Infection

TA: Technical Assistance

TB: Tuberculosis

TGA: Transitional Grant Area

VA: United States Department of Veteran Affairs

VL: Viral Load

VLS: Viral Load Suppression

WICY: Women, Infants, Children, and Youth

Frequently Used Terms

Recipient: Government department designated to administer Ryan White Part A funds and monitor contracts.

Planning Council Support (PCS) Staff/'Staff': Provides professional staff support, meeting coordination, and information to the HIVPC, its standing and ad-Hoc Committees, Chair, and Recipient.

Clinical Quality Management (CQM) Support Staff: Provides professional support, meeting coordination, and technical assistance to assist the Recipient through analysis of performance measures and other data with the implementation of activities designed to improve patient care, health outcomes, and patient satisfaction throughout the system of care.

Provider/Sub-Recipient: Agencies contracted to provide HIV Core and Support services to consumers.

Consumer/Client/Patient: A person who is an eligible recipient of services under the Ryan White Act.