**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, April 9, 2026 - 9:30 AM**

**Click Here to Join Priority Setting and Resource Allocation Committee Meeting**
Meeting ID: 251 437 066 890 59
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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. **ACTION ITEM:** Review of Agenda for April 9, 2026

IV. **ACTION ITEM:** Approval of Minutes from March 5, 2026 **(Handout A)**

V. Standard Committee Items:

None.

VI. Public Comment

VII. Old Business: None.

VIII. New Business

- **a. Action Item (Motion & Vote):** Overview of System of Care and Quality Management Recommendations; *SOC Chair & QMC Chair (15 Minutes)* **(Handout B)**

  *Motion #1: On behalf of the SOC Committee, B. Fortune-Evans moved to approve the payment of premiums for Affordable Care Act plans using Health Insurance Continuation Program (HICP) funds. The motion was seconded by M. Patterson and passed unanimously.*

  *Motion #2: On behalf of the SOC Committee, B. Fortune-Evans moved to set approve Federal Poverty Level (FPL) range at 100–250% for assistance with premium payments. The motion was seconded by M. Patterson. The committee had a brief discussion and approved with one nay from T. Pietrogallo.*

- **b. Action Item (Motion & Vote):** Health Insurance Continuation Premium Caps; *PSRA Chair (30 Minutes)*

IX. Public Comment

X. Recipient Report

XI. **Next Meeting Date:** April 16, 2026, 9:30AM to 12:30PM. Location: **Microsoft Teams and BRHPC**

Agenda Items for Next Meeting:

a. **Presentation:** PSRA Overview; *PCS Staff (30 minutes)*
b. **Review:** PSRA Timeline; *PCS Staff (5 minutes)*
c. **Discussion:** How Best to Meet the Need and Give Direction to System of Care Committee *(15 minutes)*
d. **Discussion:** Discussion Around Preparing for an ADAP Waiting List *(15 minutes)*

XII. 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.

# April 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 |
|---|---|---|---|---|---|---|
| | | | Oral Health Network Meeting (CQM) 3:00 PM - 4:15 PM 1 | System of Care Meeting (SOC) / Quality Management (QMC) Joint Meeting 9:30AM - 11:30AM 2 | 3 | 4 |
| 5 |   6 | Community Empowerment Committee (CEC) 3:00PM - 5:00PM 7<br>Behavioral Health Network Meeting (CQM) 2:00 PM - 3:15 PM | 8 | PSRA Committee Meeting 9:30AM - 11:00AM 9<br>Executive Committee Meeting 11:00AM - 12:00PM<br>HIV Planning Council Meeting 12:30PM to 1:30PM |   10 | 11 |
| 12 | 13 | 14 | Quality Network Meeting (CQM) 9:00 AM - 12:00 PM 15 | PSRA Committee Meeting 9:30AM - 11:30AM 16<br>Executive Committee Meeting 12:45PM - 2:45PM | 17 | 18 |
| 19 | Membership/Council Development Committee Meeting (MCDC) 9:30AM - 11:30AM 20 | Integrated Planning Work Group 1:00PM - 3:00PM 21 | 22 | HIV Planning Council Meeting 9:30AM to 11:30AM 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | | GET CARE BROWARD TREAT HIV \| BEAT HIV RYAN WHITE \| PART A |

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**.

# April 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<br><br>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<br><br>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<br><br>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**
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AN ADVISORY BOARD OF THE BROWARD COUNTY BOARD OF COUNTY COMMISSIONERS
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(954) 561-9681 • FAX (954) 561-9685

# Priority Setting and Resource Allocation Committee

**Thursday, March 5, 2026 – 9:30 AM**
**Meeting at Broward Regional Health Planning Council and via Microsoft Teams**

## DRAFT MINUTES

**PSRA Members Present**: B. Barnes, B. Mester, V. Biggs, L. Robertson, R. Jimenez, J. Rodriguez, M. Schweizer, A. Machado, S. Tinsley, J. Castillo, S. Hafley, J. Rogers, K. Schickowski, M. Patterson, L. Jones
**PSRA Members Absent**: Y. Barrientos
**Recipient Part A Staff Present:** G. James, T. Thompson, B. Spaulding, W. Cius, J. Roy, C. Evans
**Recipient Part B Staff Present:** No Representatives
**PCS/CQM Present:** G. Berkeley Martinez, M. Rosiere, M. Lacroix, S. Isidore, D. Liao
**Guests Present:** J. Hidalgo, F. D'Amore, J. Shirley

Call to Order

The PSRA Chair called the meeting to order at **9:46 AM.**

1. Welcome from the Chair & Public Record Requirements

   The PSRA Chair welcomed all attendees 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.

   There were no public comments.

3. Action Item: Review of Agenda for March 5, 2026

   MOTION #1: On behalf of PSRA, M. Schweizer moved to approve the agenda for the March 5, 2026, Priority Setting and Resource Allocation Committee meeting, with updates to review New Business before Old Business and to include a review of the PSRA Work Plan. L. Jones seconded the motion. The motion was unanimously approved.

4. Action Item: Approval of Minutes of February 19, 2026

   MOTION #2: B. Mester, on behalf of PSRA, made a motion to approve the February 19, 2026, Priority Setting and Resource Allocation Committee minutes. The motion was seconded by M. Schweizer and passed unanimously.

5. Standard Committee Items
   None.
6. New Business *(Approved During Meeting Agenda Approvals)*
   a. Review: PSRA Workplan FY2026-2027

      B. Barnes noted that after discussion with the Part A Office, the committee will make allocation decisions for the new Ryan White fiscal year and will need to closely monitor spending across service categories. Currently, PSRA conducts two sweeps, with the Part A Office conducting an internal sweep in January when expenditures are 2% or less. B. Barnes proposed adding a third PSRA sweep to enable the committee to monitor spending more closely and adjust earlier if needed. The proposal is to add a third reallocation/sweep in May while maintaining the November sweep. B. Barnes requested a motion to amend the work plan to include an additional sweep.

      MOTION #3: On behalf of PSRA, M. Schweizer moved to amend the PSRA Work Plan to add Sweeps in May. A friendly amendment by M. Schweizer revised the date to June, with PSRA conducting Sweeps in June, August, and November. J. Castillo seconded the motion. The committee held a brief discussion, and the motion passed unanimously.

      *Discussion: L. Jones questioned whether two months of expenditure data would be sufficient to assess spending trends, given typical delays at the start of the fiscal year. T. Thompson noted that while only two months of current data would be available, comparisons with March–April billing from the prior year could help establish trends and support preliminary forecasting. G. James stated that delays should be reduced this year since contracts are already in place. B. Mester and J. Rodriguez expressed concern that recent policy changes and delayed implementation dates may limit the usefulness of early data for trend analysis.*

7. Old Business
   a. **Discussion:** AIDS Drug Assistance Program (ADAP) Program Update; *Part A and Part B (5 Minutes)*

      **Part A Update:** J. Roy, Part A Representative, reported that a resolution urging the State of Florida to reinstate the previous priority eligibility criteria and benefits under the AIDS Drug Assistance Program (ADAP) has been drafted with assistance from Attorney Ron Honick and Intergovernmental Affairs. The draft draws on resolutions previously developed in Miami and Palm Beach. Intergovernmental Affairs is collaborating with Commissioner Rogers to sponsor the item.

      J. Roy added that the resolution may be shared with the Executive Committee before the March 19 meeting to allow time for review and input. Additionally, W. Cius has compiled a summary of provider feedback on the effects of the ADAP changes and is available to present the findings.

      **Part B Update:** J. Rodriguez, Part B Representative, reported that ADAP system updates reflecting the new eligibility criteria have been implemented. Clients under 130% of the

federal poverty level who were not participating in the Insurance Payment Assistance Program have been suspended in the system. Clients currently receiving payment assistance remain active and have been issued cards to cover copays and deductibles, provided they continue paying their premiums. A special enrollment period is available through April 15 for clients seeking to obtain insurance.

J. Rodriguez also noted delays in updating insurance termination records in manufacturer databases, resulting in some patients being denied assistance. To prevent treatment interruptions, emergency medications are being dispensed locally through the DOH pharmacy. Following the update, the committee held a discussion.

M. Schweizer raised concerns about potential billing issues if insurance cancellations are not immediately reflected in system databases. M. Rosiere explained that most clients enrolled in the ADAP insurance program remain active through the end of the month and should maintain access to services during that period. Providers typically verify insurance status in real time before delivering services, reducing the likelihood of unexpected patient billing. J. Rodriguez added that pharmacies are required to verify claim status before dispensing medications.

G. James asked about changes to the ADAP formulary and Part B Emergency Financial Assistance (EFA) eligibility limits. J. Rodriguez reported that Biktarvy is the only ARV removed from the formulary and that Descovy may require prior authorization in the future. He also confirmed that Part B EFA eligibility extends up to 400% of the federal poverty level.

V. Biggs requested clarification regarding copay cards, and J. Rodriguez confirmed that previously issued cards remain active. B. Barnes inquired about possible changes to income documentation requirements, and J. Rodriguez noted that no official guidance has been released yet. Additional information is expected following an upcoming statewide call.

b. **Review:** Overview of New Federal Poverty Levels; *PSRA Chair (5 Minutes)*

B. Barnes opened the agenda item for questions or discussion regarding the previously approved changes to federal poverty level (FPL) eligibility. J. Rodriguez clarified that shared eligibility between Ryan White Part A and Part B will no longer be accepted, and that Part A providers will no longer be able to rely on Part B Notices of Eligibility (NOEs).

Members asked about potential impacts on eligibility processes and documentation requirements. J. Rodriguez explained that Part B eligibility timelines are not expected to change significantly and that recent documentation already in the system may be used when appropriate; however, updated income verification may still be required. He emphasized that eligibility would continue to follow the standard certification period and that staff would work to minimize unnecessary barriers for clients.

The committee also discussed coordination between Part A and Part B, including concerns about client transitions and Test-and-Treat linkage to care. J. Rodriguez stated that the linkage process will remain largely unchanged, though uninsured clients above 130% FPL may need to rely on patient assistance programs (PAPs) rather than ADAP. He noted that information on affected clients has been shared with Part A to support follow-up and help ensure continuity of care.

c. **Discussion:** 2026-2027 Allocations by Service Category; *PSRA Chair* (*1 Hour)*

G. James gave an overview of last year's allocations, noting that final numbers will not be available until after April 15, when providers submit updates. G. James clarified that the handout reflects allocations, not expenses, and represents Part A Office recommendations. PSRA may adjust allocations as needed, similar to sweeps with multiple opportunities throughout the year to move funds. The columns show last year's beginning allocations, post-sweep allocations, differences, proposed FY 26-27 allocations, and related comparisons. Carryover funds contributed to higher totals in some categories.

B. Mester noted the increase in pharmaceutical assistance and primary care and questioned the large decrease in non-medical case management. G. James explained that the allocations are a starting point, with cost-saving measures and multiple opportunities for reallocation during the year based on utilization.

L. Jones requested clarification on one-time anomalies affecting allocations. G. James noted that the late start to contract issuance last year influenced sweep outcomes, favoring core services. The current allocations reflect lessons learned and aim to maintain essential wrap-around services without creating waiting lists. B. Barnes emphasized ongoing uncertainty stemming from pending lawsuits and ADAP changes but noted that current reallocations aim to maximize resources and maintain service standards. He outlined the voting process, conflict of interest forms, and funding caps of $13,096,633 for Part A and $1,026,070 for MAI.

Part A Core Medical Services

**a.** MOTION #4: M. Schwiezer, on behalf of PSRA, motioned to allocate $5,746,053.00 to Integrated Primary Care and Behavioral Health Services (Ambulatory). After a brief discussion, L. Robertson seconded the motion, which passed with three objections (J. Rodriguez, B. Mester, J. Castillo).

*Discussion: B. Mester proposed reducing the $449,000 increase to Integrated Primary Care and reallocating $200,000 to non-medical case management, arguing it would help balance service funding. S. Tinsley supported a smaller increase now, noting that outpatient services would still grow and that adjustments could be made later during sweeps without dramatically reducing non-medical case management. J. Rodriguez emphasized the importance of maintaining clarity in staffing and budgeting, explaining that the $5.7 million allocation should cover returning clients who rely on Ryan White for primary care, and that adjustments could be made later if needed. After the discussion, the motion was approved.*

**b.** MOTION #5: V. Biggs, on behalf of PSRA, made a motion to allocate $550,000.00 to AIDS Pharmaceutical Assistance. The motion was seconded by M. Schweizer and passed with four abstentions (L. Jones, S. Hafley, M. Patterson, L. Robertson).

**c.** MOTION #6: V. Biggs, on behalf of PSRA, made a motion to allocate $2,404,053.00 to Oral Health (Routine). The motion was seconded by L. Robertson, followed by a brief committee discussion, and passed with three objections (B. Mester, J. Rodriguez, and J. Castillo).

*Discussion: B. Mester suggested reallocating the $459,000 increase to other service categories rather than concentrating it in one area, noting that it could be capped or*

*otherwise limited. G. James added that some specialty services are being reduced. The discussion focused on balancing funding across categories*.

**d.** MOTION #7: V. Biggs, on behalf of PSRA, made a motion to allocate $346,964.00 to Oral Health (Specialty). The motion was seconded by M. Patterson and passed with one objection (J. Rodriguez).

**e.** MOTION #8: V. Biggs, on behalf of PSRA, made a motion to allocate $820,081.00 to Medical Case Management. The motion was seconded by J. Castillo, followed by a brief committee discussion, and passed with one objection (S. Hafley).

*Discussion: B. Mester expressed concern that the $17,000 reduction to medical case management was too small and suggested reallocating funds to other service categories facing larger reductions. J. Castillo agreed and noted that further review in upcoming discussions could identify additional adjustments. T. Thompson explained that limited reductions were intentional because clients potentially entering the system due to FPL changes may initially require medical case management, and planning was based on a worst-case scenario. J. Roy added that providers will be encouraged to transition clients who have been virally suppressed for more than two years to other appropriate services. Members also noted that maintaining funding for medical case management is important to prevent clients from being lost in the system while monitoring potential future ADAP funding changes.*

**f.** MOTION #9 (withdrawn): L. Jones, on behalf of PSRA, made a motion to allocate $1.2 million to Non-Medical Case Management. The motion was seconded by B. Mester and followed by a brief committee discussion. After the discussion, L. Jones withdrew the motion.

*Discussion: B. Mester cautioned that large increases or decreases in funding could affect provider staffing, emphasizing the need for gradual adjustments to avoid the loss of essential services and case management capacity. V. Biggs noted that providers bill by service units and would not experience immediate funding changes, expressing confidence in the Part A Office's annual recommendations. G. James added that increasing funding in one category would require reductions in others, as several service categories had already been approved. L. Jones raised concerns about potential workforce reductions and the need for adequate resources to support clients who rely heavily on case management services. J. Roy explained that Ending the HIV Epidemic (EHE) funding adjustments would be made after allocation decisions, leading to L. Jones' withdrawal of the motion following the discussion.*

**g.** MOTION #10: V. Biggs, on behalf of PSRA, made a motion to allocate $130,000.00 to Mental Health-Trauma Informed. The motion was seconded by J. Castillo and passed with three abstentions (R. Jimenez, M. Patterson, L. Robertson).

**h.** MOTION #11: V. Biggs, on behalf of PSRA, made a motion to allocate $650,000.00 to Health Insurance Premium and Cost Sharing Assistance. The motion was seconded by S. Tinsley, followed by a brief committee discussion, and passed with one objection (J. Rodriguez).

*Discussion: G. James noted that Health Insurance Premium and Cost Sharing Assistance is a service category that will require close monitoring due to variations in insurance plans among clients. J. Rodriguez added that further discussion with PSRA and the Council may be needed, particularly during special enrollment periods, as supporting premium payments for more cost-effective insurance plans could help keep clients from relying on ambulatory primary healthcare services.*

**i.** MOTION #12: V. Biggs, on behalf of PSRA, made a motion to allocate $250,000.00 to Medical Nutrition Therapy. The motion was seconded by L. Jones and passed with one objection (J. Rodriguez) and two abstentions (J. Castillo, B. Barnes).

**j.** MOTION #13: V. Biggs, on behalf of PSRA, made a motion to allocate $150,000.00 to Substance Abuse-Outpatient. The motion was seconded by J. Castillo and passed with two abstentions (M. Patterson, L. Robertson).

### Part A Support Services

**a.** MOTION #14: V. Biggs, on behalf of PSRA, made a motion to allocate $349,378.00 to Non-Medical Case-Management (Centralized Intake and Eligibility Determination). The motion was seconded by L. Robertson and passed unanimously.

**b.** MOTION #15: V. Biggs, on behalf of PSRA, made a motion to allocate $820,081.00 to Non-Medical Case-Management (Case Management). The motion was seconded by S. Tinsley and passed with one objection (J. Castillo).

**c.** MOTION #16: V. Biggs, on behalf of PSRA, made a motion to allocate $600,000.00 to Food Services (Food Bank). The motion was seconded by B. Mester and passed with four abstentions (J. Castillo, B. Barnes, L. Robertson, M. Patterson).

**d.** MOTION #17: V. Biggs, on behalf of PSRA, made a motion to allocate $35,000.00 to Food Services (Food Voucher). The motion was seconded by L. Jones and passed with two abstentions (J. Castillo, B. Barnes).

**e.** MOTION #18: V. Biggs, on behalf of PSRA, made a motion to allocate $129,151.00 to Legal Assistance. The motion was seconded by L. Robertson and passed with one abstention (K. Schickowski).

**f.** MOTION #19: V. Biggs, on behalf of PSRA, made a motion to allocate $115,872.00 to Emergency Financial Assistance. The motion was seconded by S. Tinsley and passed with four abstentions (L. Jones, S. Hafley, M. Patterson, L. Robertson) and one objection (J. Rodriguez).

**k.** MOTION #20: V. Biggs, on behalf of PSRA, made a motion to allocate a total of $13,096,633.00 in Part A funds. The motion was seconded by S. Tinsley, followed by a brief committee discussion, and passed unanimously.

*Discussion: V. Biggs emphasized that while PSRA is responsible for allocating funds, other committees, such as System of Care and Quality Management, play a key role in ensuring clients move effectively through the system of care. He noted the importance of those committees addressing service delivery processes and implementing tools such as service delivery models and MOUs. Members acknowledged the need for continued coordination to support client navigation and system effectiveness.*

### MAI Core Services

a. MOTION #21: L. Jones, on behalf of PSRA, made a motion to allocate $50,000.00 to MAI Ambulatory. The motion was seconded by V. Biggs and passed with two abstentions (B. Barnes, J. Castillo).

b. MOTION #22: V. Biggs, on behalf of PSRA, made a motion to allocate $65,000.00 to MAI Mental Health. The motion was seconded by L. Jones and passed with two abstentions (M. Patterson, L. Robertson)

c. MOTION #23: V. Biggs, on behalf of PSRA, made a motion to allocate $300,000.00 to MAI Substance-Abuse Outpatient. The motion was seconded by L. Jones and passed with two abstentions (M. Patterson, L. Robertson)

MAI Support Services

a. MOTION #24: V. Biggs, on behalf of PSRA, made a motion to allocate $187,004.00 to MAI Non-Medical Case Management (Case Management). The motion was seconded by S. Tinsley and passed with three abstentions (R. Jimenez, M. Patterson, L. Robertson)

b. MOTION #25: V. Biggs, on behalf of PSRA, made a motion to allocate $424,066.00 to MAI Non-Medical Case Management (Centralized Intake Eligibility Determination). The motion was seconded by S. Tinsley and passed with three abstentions (R. Jimenez, M. Patterson, L. Robertson)

c. MOTION #26: V. Biggs, on behalf of PSRA, made a motion to allocate a total of $14,122,703.00 in Part A and MAI funds. The motion was seconded by L. Robertson and passed unanimously.

d. **Discussion:** PSRA Preliminary Report; *Recipient Office & PSRA Committee (15 Minutes)*

B. Barnes proposed adding a brief data update at the beginning of each meeting, following the Part A report, to be provided by T. Thompson as a 10 to 15-minute overview. T. Thompson explained that the proposed monthly report would be a brief, high-level overview to help the committee monitor trends without requiring an extensive presentation. Potential elements include monthly burn rate comparisons by service category between fiscal years, unduplicated client counts, and expenditure trends to estimate how quickly funds are being utilized. B. Mester supported the concept but noted that comparisons for the current month may be challenging due to last year's contract delays affecting early data. T. Thompson clarified that the analysis will be based on the service date rather than the payment date, allowing service data from prior months to be captured for comparison.

M. Schweizer requested the inclusion of the cost per client to support provider planning. T. Thompson agreed it could be included but noted that cost per client reflects client engagement with services rather than differences in provider payment and may fluctuate significantly month to month, making it more meaningful when reviewed over a longer period, such as a quarter. S. Tinsley asked whether service caps could be implemented through this process, and T. Thompson responded that caps are determined by the

recipient and noted that related discussions are already underway. V. Biggs asked whether an average number of service units per client could be determined. T. Thompson stated this may be feasible for some service categories, such as case management, but less applicable for services like outpatient care, where client needs vary widely.

L. Jones emphasized the importance of considering social determinants and the varying needs of clients when analyzing utilization and cost data. T. Thompson noted that acuity may be assessed using case management assessments and diagnostic codes to better understand comorbidities and client complexity. He also shared an HRSA best practice indicating that spending disparities among clients below 150% of the federal poverty level (FPL) should be monitored and reported to the Planning Council as an informational metric. M. Schweizer expressed interest in reviewing this metric over time. J. Roy asked about another scorecard being explored, and T. Thompson briefly described a preliminary internal provider grading system that would evaluate providers on factors such as SDM compliance, fiscal and contractual compliance, invoicing timeliness, and utilization. He noted the system is still in development and may be used to support provider improvement efforts and identify where additional assistance or monitoring may be needed.

e. **Discussion:** HICP Scope of Service; Regarding Making Changes to Allow Insurance to be Covered Under HICP; *PSRA Chair (15 Minutes)*

B. Barnes explained that under the current scope of service and allowable units for the Health Insurance Continuation Program (HICP), premiums are not covered. Given recent changes, he suggested the committee consider whether this service delivery model (SDM) should be reviewed. He noted that the appropriate committee to evaluate potential changes would be the Quality Management Committee (QMC) and asked whether the committee wished to submit a request for QMC to explore the issue.

S. Tinsley asked whether the discussion was focused on paying premiums for clients enrolled in new, more affordable plans or for those remaining in plans that require significant assistance. B. Barnes clarified that the request would simply be to have QMC review the possibility and hold a more detailed discussion, rather than conduct an in-depth analysis, during the current meeting. M. Schweizer stated that financial feasibility should be considered before forwarding the request, emphasizing the need to determine whether sufficient funding exists to support such changes.

MOTION #27: M. Patteson, on behalf of PSRA, made a motion requesting that the Quality Management Committee review the Health Insurance Continuation Program (HICP) scope of service and Service Delivery Model (SDM) to determine whether it continues to meet the needs of the Ryan White Part A system. The motion was seconded by S. Tinsley. Following the discussion, the motion passed unanimously.

> *Discussion: M. Schweizer noted that while client choice is important, funding limitations require setting reasonable boundaries on the types of plans that can be supported. B. Barnes stated that PSRA's role would be to determine spending limits. B. Mester added that before making changes to the Service Delivery Model (SDM), the committee would need to determine what level of support is financially feasible, noting that funding sources such as ADAP and Ryan White currently cover different portions of care. G. James explained that some clients moved to more affordable non-Marketplace plans during the recent ADAP challenges and asked whether co-pays and deductibles for those plans should be covered. J. Rodriguez clarified that previously, Ryan White Part A covered*

*co-pays and deductibles for ADAP-approved Marketplace plans and suggested exploring whether the SDM could be amended to provide assistance to* clients enrolled in other ACA plans. He noted that this could potentially result in cost savings while maintaining client coverage. B. Mester cautioned that many of these plans may have high deductibles and limited coverage, which could increase overall costs. J. Rodriguez recommended that the issue be referred to the QMC for further evaluation of cost-effectiveness and potential service caps before any SDM changes are considered.

f. **Discussion:** Wrap Up and Next Steps; *PSRA Chair (15 Minutes)*

B. Barnes noted that the LPAP Committee will need to meet soon to address the issue. Any recommendations from the committee must first be approved by this committee and then by the full Planning Council. Members emphasized the importance of the committee meeting within the next 20–30 days so that any proposed changes can be approved by April and implemented by May 1. It was noted that delaying changes for two months could result in higher costs or other program impacts, making timely action necessary.

The next meeting remains scheduled for the committee's regular time on March 19. It was suggested that the matter be discussed during the coordination meeting, and members were invited to join virtually if they wished. The time will remain open in case an urgent meeting is needed before then. If no additional meeting is required, the next in-person meeting will take place on April 16.

8. Discussion Items: None.
9. Public Comment: None.
10. Recipient Report: None
11. Data Request(s)
12. Next Meeting: March 19, 2026, 9:30 AM to 1:30 PM. Location: Microsoft Teams and BRHPC
13. Agenda Items for Next Meeting
    a. Workshop: Prepare for the agenda for the April 16, 2026, meeting. Review PSRA workplan and timeline.
14. Announcements:
    - The Ujima Men's Collective is participating in this year's AIDS Walk and will be hosting a lip sync battle tonight at Hunters at 7:00 PM. Members are encouraged to attend and support the team so they can compete for the prize being offered tonight. If you are available, please come out and show your support.

There being no further business, the meeting was adjourned at **12:14PM.**

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 | 5 | | | | | | | | | | |
| 1 | Barnes, B., Chair | X | X | X | X | | | | | | | | | | |
| 2 | Mester, B. | X | X | X | X | | | | | | | | | | |
| 3 | Robertson, L. | X | X | X | X | | | | | | | | | | |
| 4 | Rodriguez, J. | X | X | X | X | | | | | | | | | | |
| 5 | Biggs, V. | X | X | X | X | | | | | | | | | | |
| 6 | Jimenez, R. | X | X | A | X | | | | | | | | | | |
| 7 | Schwiezer, M. | X | X | X | X | | | | | | | | | | |
| 8 | Machado, A. | X | A | E | X | | | | | | | | | | |
| 9 | Tinsley, S. | X | X | X | X | | | | | | | | | | |
| 10 | Castllo, J. | X | X | X | X | | | | | | | | | | |
| 11 | Barrientos, Yahaira | X | X | X | A | | | | | | | | | | |
| 12 | Hafley, Shalisa | X | X | X | X | | | | | | | | | | |
| 13 | Rogers, Jonathan | A | A | X | X | | | | | | | | | | |
| 14 | Schickowski, Kara | A | X | X | X | | | | | | | | | | |
| 15 | Patterson, M. | X | X | X | X | | | | | | | | | | |
| 16 | L. Jones | | | | X | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | Fortune-Evans, B. | X | X | X | | | | | | | | | | | |
| | **Quorum = 9** | 14 | 14 | 14 | 15 | | | | | | | | | | |

| 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 – March 5, 2026, Minutes prepared by PCS Staff*

***Motions from Joint Meeting of the SOC and QMC – April 2, 2026***

**Motion #1:** On behalf of the SOC Committee, B. Fortune-Evans moved to approve the payment of premiums for Affordable Care Act plans using Health Insurance Continuation Program (HICP) funds. The motion was seconded by M. Patterson and passed unanimously.

**Motion #2:** On behalf of the SOC Committee, B. Fortune-Evans moved to set approve Federal Poverty Level (FPL) range at 100–250% for assistance with premium payments. The motion was seconded by M. Patterson. The committee had a brief discussion and approved with one nay from T. Pietrogallo.

***Summary of Motions***

*The committees voted to recommend the following actions to the PSRA Committee:*

1. **Expansion of HICP Services**
   Expand the Health Insurance Continuation Program (HICP) to include assistance with health insurance premium payments for clients with incomes between **100% and 250% of the Federal Poverty Level (FPL)**.

2. ***Proposed Language Revisions to the HICP Service Delivery Model (SDM), March 2025***

   a. Under **Program Requirements**, add the following language (page 6 of 23):

      HICP may pay insurance premiums for clients who qualify for and are receiving an advanced tax credit. To be eligible for premium assistance, clients must also comply with federal tax return filing requirements.

   b. Make the following deletions throughout the SDM document:
      i. Remove all references to the **“ADAP Premium Assistance Program.”**

# 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.