Emerging Issues and Special Projects within Ryan White HIV//AIDS Program Part A

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HIV/AIDS Bureau (HAB)
Health Resources and Services Administration (HRSA)

Health Resources and Services Administration (HRSA) Overview

- Supports more than 90 programs that provide health care to people who are geographically isolated, economically or medically vulnerable through grants and cooperative agreements to more than 3,000 awardees, including community and faith-based organizations, colleges and universities, hospitals, state, local, and tribal governments, and private entities

- Every year, HRSA programs serve tens of millions of people, including people living with HIV/AIDS, pregnant women, mothers and their families, and those otherwise unable to access quality health care

HIV/AIDS Bureau Vision and Mission

Vision

Optimal HIV/AIDS care and treatment for all.

Mission

Provide leadership and resources to assure access to and retention in high quality, integrated care, and treatment services for vulnerable people living with HIV/AIDS and their families.

Ryan White HIV/AIDS Program (RWHAP)

- Provides comprehensive system of HIV primary medical care, medications, and essential support services for low-income people living with HIV
  - More than half of people living with diagnosed HIV in the United States – more than 550,000 people – receive care through the Ryan White HIV/AIDS Program (RWHAP)
- Funds grants to states, cities/counties, and local community based organizations
  - Recipients determine service delivery and funding priorities based on local needs and planning process
- Payor of last resort statutory provision: RWHAP funds may not be used for services if another state or federal payer is available
- 84.9% of Ryan White HIV/AIDS Program clients were virally suppressed in 2016, exceeding national average of 59.8%

Source: HRSA. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2016; CDC. HIV Surveillance Supplemental Report 2016;21(No. 4)

HRSA Ryan White & Global HIV/AIDS Programs

Overarching Program Purpose – RWHAP Part A

- Intended to support comprehensive, community-based, outpatient HIV/AIDS care **systems** for delivering life-saving care and treatment to persons living with HIV disease (PLWH) in metropolitan areas with the greatest number of HIV/AIDS cases.

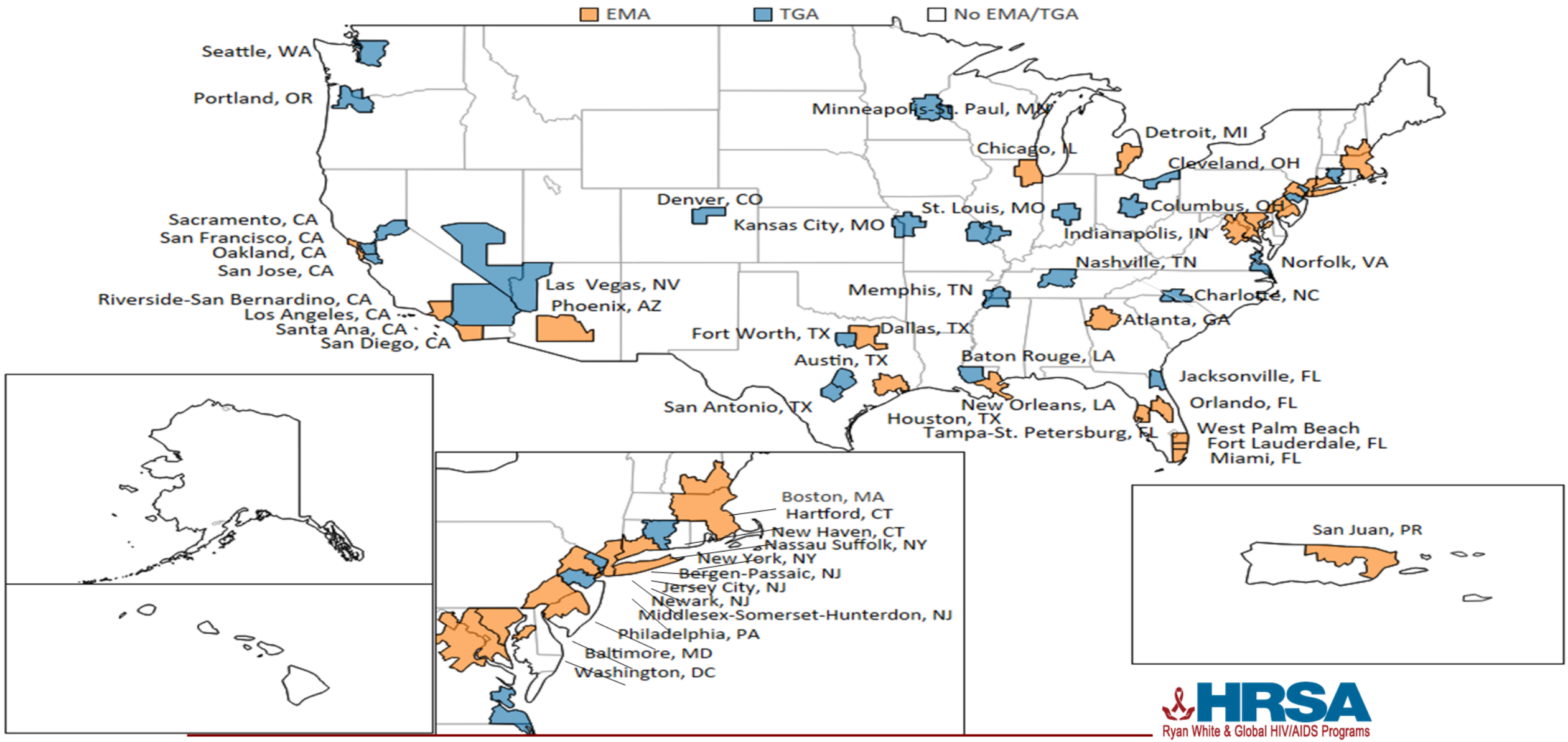
Ryan White HIV/AIDS Program - Part A

- Provides emergency assistance to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are most severely impacted by the HIV/AIDS epidemic
  - EMAs have at least 50,000 inhabitants and ≥2,000 reported AIDS cases in the past 5 years
  - TGAs have at least 50,000 inhabitants and 1000 - 1999 reported AIDS cases in the past 5 years or prior status as an EMA
  - Award made to Chief Elected Official
  - Funding allocations determined by Planning Council
  - Use established boundaries of Metropolitan Statistical Areas to generate HIV/AIDS case counts

Ryan White HIV/AIDS Program - Part A Grants

- RWHAP Part A grants to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) include formula and supplemental components as well as Minority AIDS Initiative (MAI) funds, which support services targeting minority populations
  - **Formula grants (2/3)**are based on living HIV/AIDS cases (as reported by CDC) in the EMA or TGA as of December 31 in the most recent calendar year for which data are available
  - **Supplemental grants (1/3)** are awarded competitively on the basis of demonstrated need and other selective criteria
  - **MAI** funding is awarded by formula according to the distribution of living HIV/AIDS cases among racial and ethnic minorities

RWHAP Part A Emergency Metropolitan Areas (EMA) & Transitional Grant Areas (TGAs)



HRSA
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Current EMAs (N=24)

- Atlanta, GA
- Baltimore, MD
- Boston, MA
- Chicago, IL
- Dallas, TX
- Detroit, MI
- Ft. Lauderdale, FL
- Houston, TX
- Los Angeles, CA
- Miami, FL
- Nassau-Suffolk, NY
- New Haven, CT
- New Orleans, LA
- New York, NY
- Newark, NJ
- Orlando, FL
- Philadelphia, PA
- Phoenix, AZ
- San Diego, CA
- San Francisco, CA
- San Juan, PR
- Tampa-St. Petersburg, FL
- Washington, DC
- West Palm Beach, FL

Current TGAs (N=28)

- Austin, TX
- Baton Rouge, LA
- Bergen-Passaic, NJ
- Charlotte-Gastonia, NC-SC
- Cleveland, OH
- Columbus, OH
- Denver, CO
- Ft. Worth, TX
- Hartford, CT
- Indianapolis, IN
- Jacksonville, FL
- Jersey City, NJ
- Kansas City, MO
- Las Vegas, NV
- Memphis, TN
- Middlesex-Somerset-Hunterdon, NJ
- Minneapolis-St. Paul, MN
- Nashville, TN
- Norfolk, VA
- Oakland, CA
- Orange County, CA
- Portland, OR
- Riverside-San Bernardino, CA
- Sacramento, CA
- Saint Louis, MO
- San Antonio, TX
- San Jose, CA
- Seattle, WA

Key Facts about RWHAP - Part A

- RWHAP services are not an entitlement
- RWHAP is the payer of last resort
- Intent is to provide a continuum of care with equitable access throughout the service area
- Key role for consumers of RWHAP Part A services – through Planning Council and other types of involvement

Components/Entities in RWHAP Part A Structure

- Chief Elected Official – Official recipient of RWHAP Part A funds (mayor, county executive, chair county board of supervisors, freeholder, judge, etc.)
- Recipient – administrative agent for RWHAP Part A funds
- Administrative or fiduciary agent – retained by the CEO and/or recipient to assist in fulfilling administrative activities
- Planning Council/Planning Body (Baton Rouge & Charlotte) – establishes plans and priorities for the area
- Subrecipients – core medical and support service providers

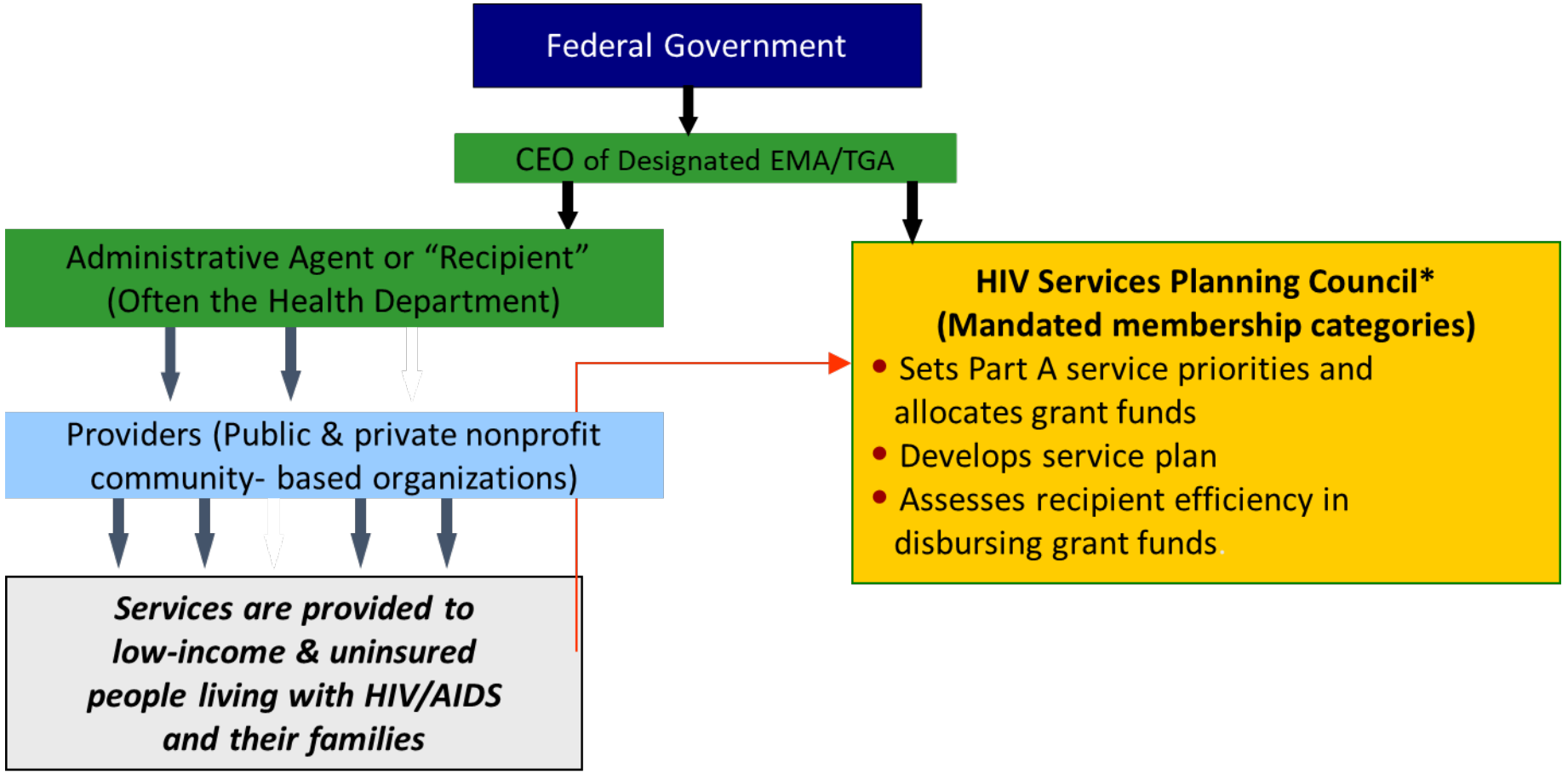
HRSA'S Expectations of RWHAP Part A EMAs/TGAs

- Proper stewardship of grant funds
- Program and fiscal monitoring of sub-recipients – National Monitoring Standards
- Adherence to reporting requirements
- Compliance to legislation
- Appropriate membership of Planning Council
- Planning for integration of HIV prevention and care – population health

HRSA HAB's Comprehensive Site Visits (CSV)

- Once every four years for each RWHAP Part A jurisdiction
- 52/52 completed to date since 2012
- Phase II began in FY 2017
- Components/Modules
  - Site Visit Desk Reference
  - Administrative/Program
  - Fiscal
  - CQM
  - Sub-recipient
- CSVs → SV Report → TA & Corrective Action Plan
  - Example: CQM budgets often include admin costs for QA or data

Flow of RWHAP Part A Funds and Decision Making



RWHAP Part A Recipient and Planning Council Roles & Responsibilities

- Recipient and Planning Council = two independent entities, both with legislative authority and roles
- Some roles belong to one entity and some are shared
- HRSA/HAB recommends separation of duties to avoid confusion of roles
- Effectiveness requires communications, information sharing, and collaboration between the recipient, Planning Council, and Planning Council support staff – and ongoing consumer and community involvement
- Memorandum of Understanding –codifies relationship

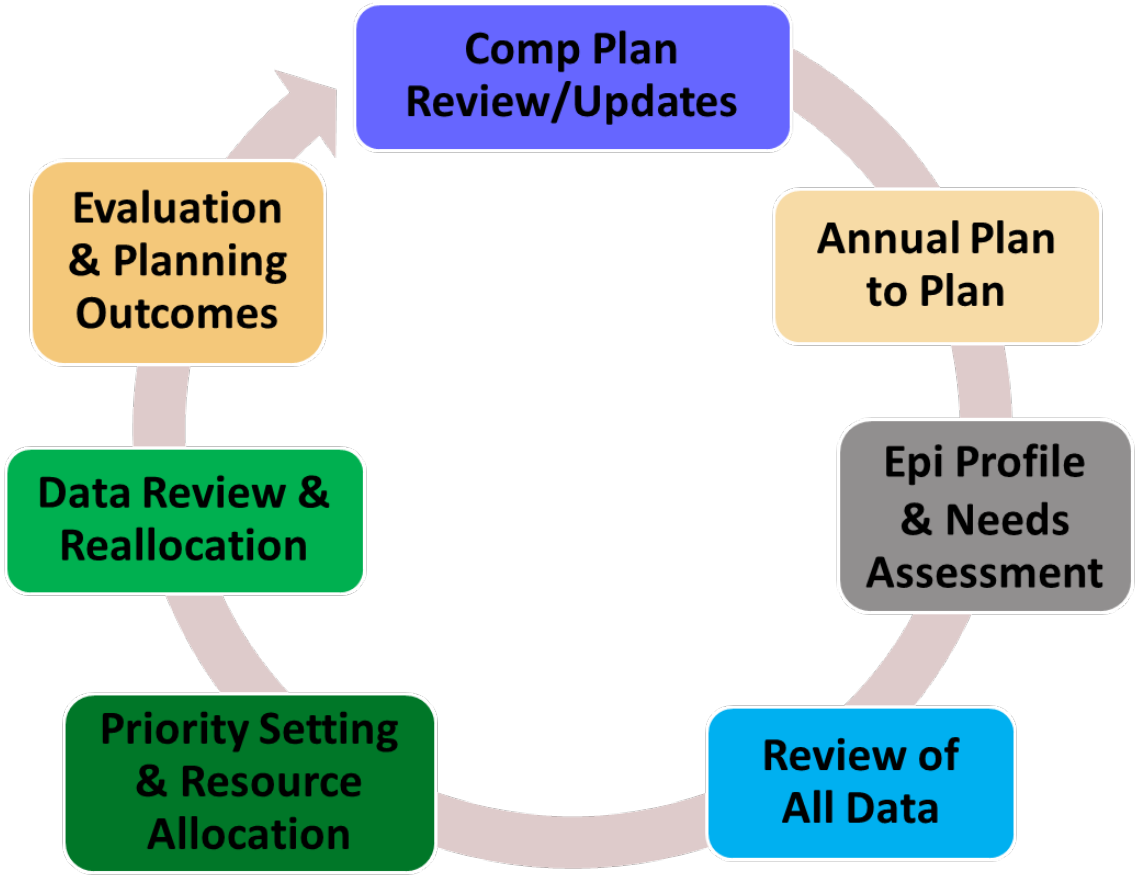
Planning Council Membership

- Reflectiveness – of local epidemic
- Open nominations and conflict-of-interest provisions
- Representation – 13 required categories of various providers, government officials, PLWH
- 33% of Council membership are to be unaligned PLWH
- Technical Assistance Resource - RWHAP Part A Planning Council and Transitional Grant Area (TGA) Planning Body Cooperative Agreement

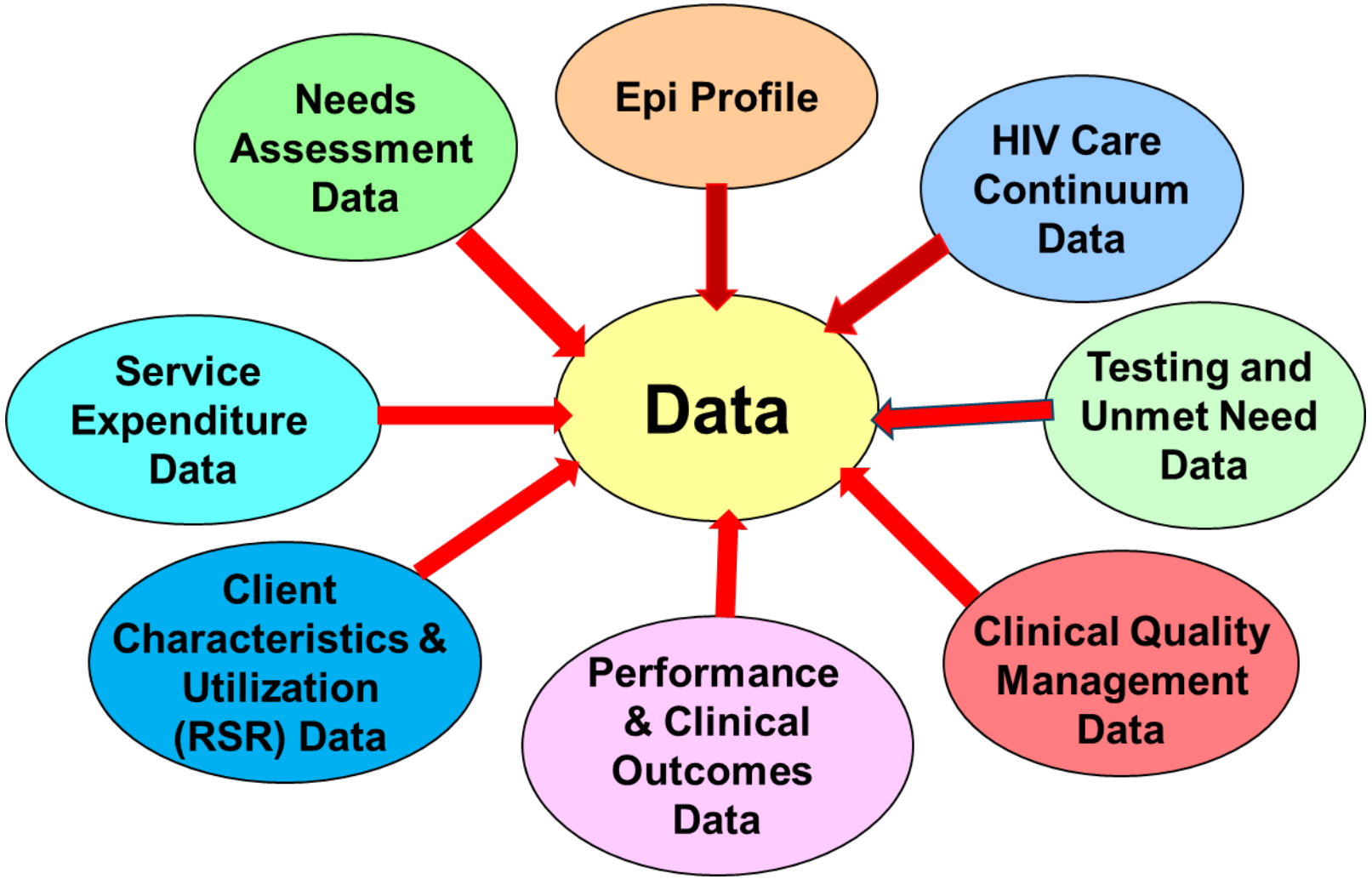
RWHAP Part A Recipient and Planning Council Roles & Responsibilities

Role/Task	CEO/ Recipient	Planning Council
Planning Council Formation/Membership	✓ (CEO)	
Needs Assessment	✓	✓
Comprehensive Planning	✓	✓
Priority Setting		✓
Directives		✓
Resource Allocation		✓
Coordination of Services	✓	✓
Procurement	✓	
Contract Monitoring	✓	
Clinical Quality Management	✓	✓
Cost- Effectiveness and Outcomes Evaluation	✓	✓(option)
Assessment of the Administrative Mechanism		✓

RWHAP Part A Recipient and Planning Council Annual Planning Cycle

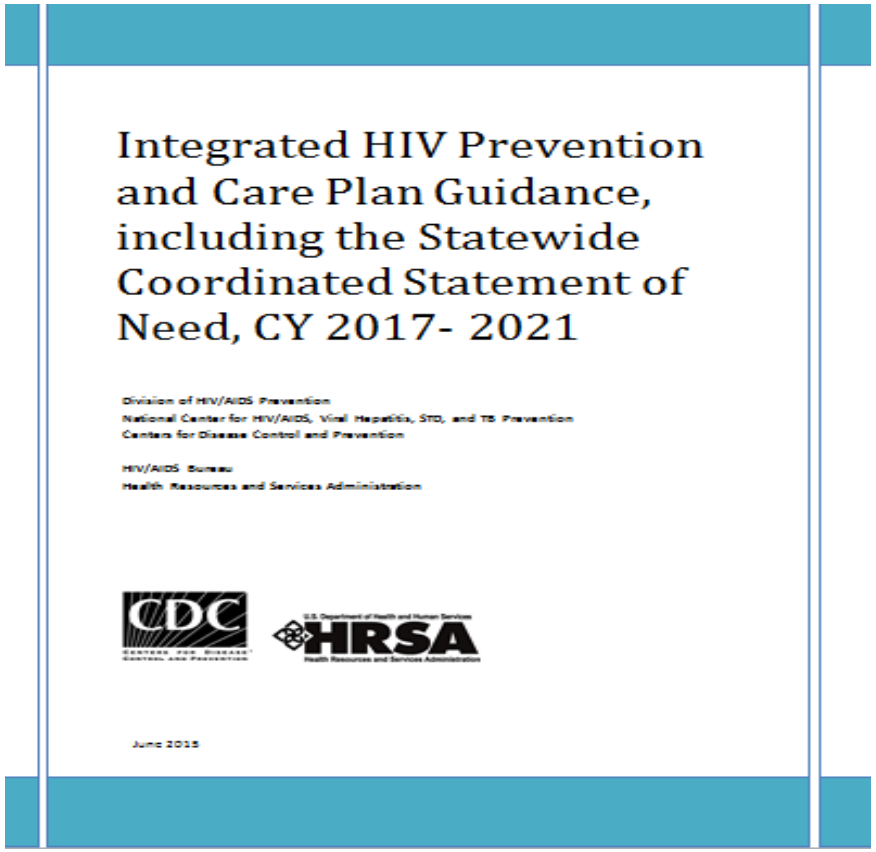


Data Needs for RWHAP Part A Planning

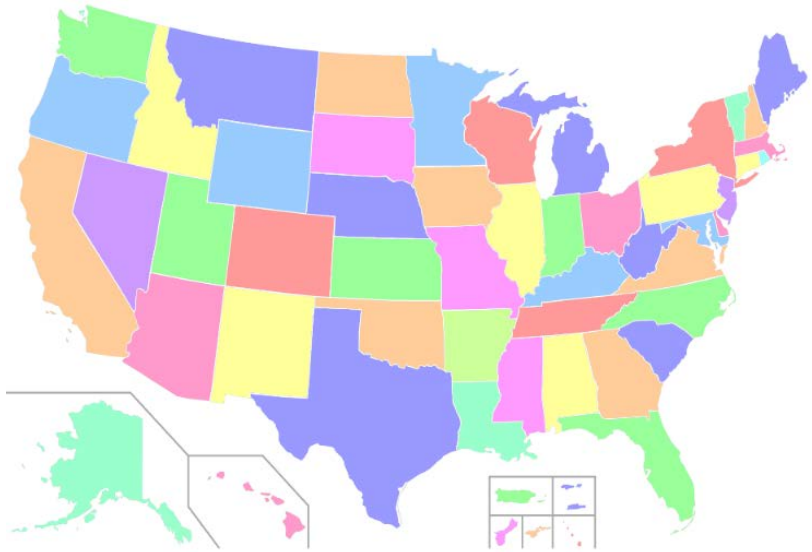


Comprehensive Planning

- Integrated HIV Prevention and Care Plan GUIDANCE, Including the Statewide Coordinated Statement of Need, CY 2017- 2021
- FY 2016 National TA Cooperative Agreement to assist RWHAP Part A and B recipients



Integrated HIV Prevention and Care Plan/SCSN Submission



Received 80 Integrated HIV Prevention and Care Plans, including the Statewide Coordinated Statements of Need:

- Total RWHAP Part B – 37 that includes prevention and care
- Total RWHAP Part A – 21 that includes prevention and care
- Total Integrated Plans – 22 RWHAP Part A/Part B Plans that includes prevention and care

Conducted joint reviews of the CY 2017-2021 Integrated HIV Prevention and Care Plans, including the Statewide Coordinated Statements of Need, in March 2017.

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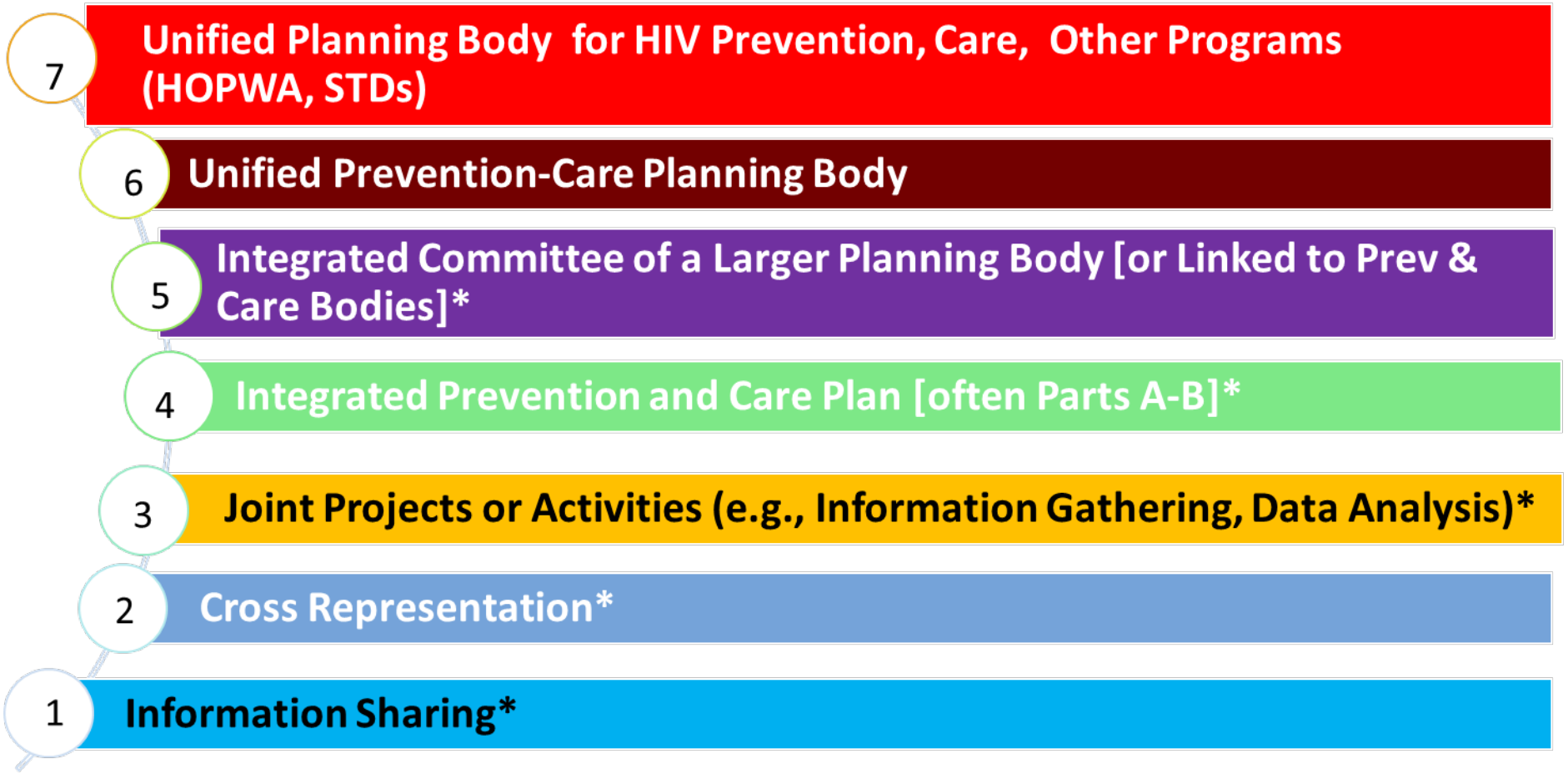
HIV Prevention-Care Model of Cooperation



* Also Cross-part Cooperation

Source: Integrated HIV Prevention-Care Planning Activities, EGM Consulting for HRSA/HAB through the Ryan White Technical Assistance Contract, 2014.

Legislative Context: Facts and Factors & Major Themes for RWHAP Part A

- RWHAP uses a medical model
- Increased focus on getting people into primary medical care and keeping them in care
- Limits on non-service costs
- Focus on ensuring all funds are used -- “use or lose” Part A funding (historically ~ 0.8% unexpended rate)
- Public health approach focusing on a “system of care” for all PLWH in the jurisdiction.

Medical Model

- **Major focus on core medical services (medical model)**
  - **75% of service funds must be spent on core medical services**
  - **Up to 25% of service funds may be spent on support services** that contribute to positive clinical outcomes

RWHAP Core Medical Services

1. Outpatient and ambulatory health services
2-3. Medications: AIDS Drug Assistance Program (ADAP) and Local Pharmaceutical Assistance Programs (LPAP)
4. Oral health care
5. Early intervention services (EIS)
6. Substance abuse services – outpatient
7. Mental health services
8. Medical case management including treatment adherence
9. Health insurance premium & cost sharing assistance
10. Home health care
11. Home & community-based health services
12. Medical nutrition therapy
13. Hospice services

RWHAP Support Services

1. Child Care Services
2. Emergency Financial Assistance
3. Food Bank/Home Delivered Meals
4. Health Education/Risk Reduction
5. Housing
6. Legal Services
7. Linguistic Services
8. Medical Transportation
9. Non-Medical Case Management
10. Other Professional Services
11. Outreach Services
12. Permanency Planning
13. Psychosocial Support Services
14. Referral for Health Care and Support Services
15. Rehabilitation Services
16. Respite Care
17. Substance Abuse Services (residential)

Support Services

- **Must be:**
  - ≤25% of total service expenditures
  - Approved by the Secretary of HHS
  - Needed to achieve medical outcomes
- **Medical outcomes** = outcomes affecting the *HIV-related clinical status* of an individual with HIV/AIDS
- **Support Services** are intended to contribute to positive medical outcomes

What is the Core Medical Services Requirement?

Under Title XXVI of the Public Health Service Act, recipients receiving Ryan White HIV/AIDS Program Part A, B, and/or C funds are required to spend at least 75% of grant funds on Core Medical Services:

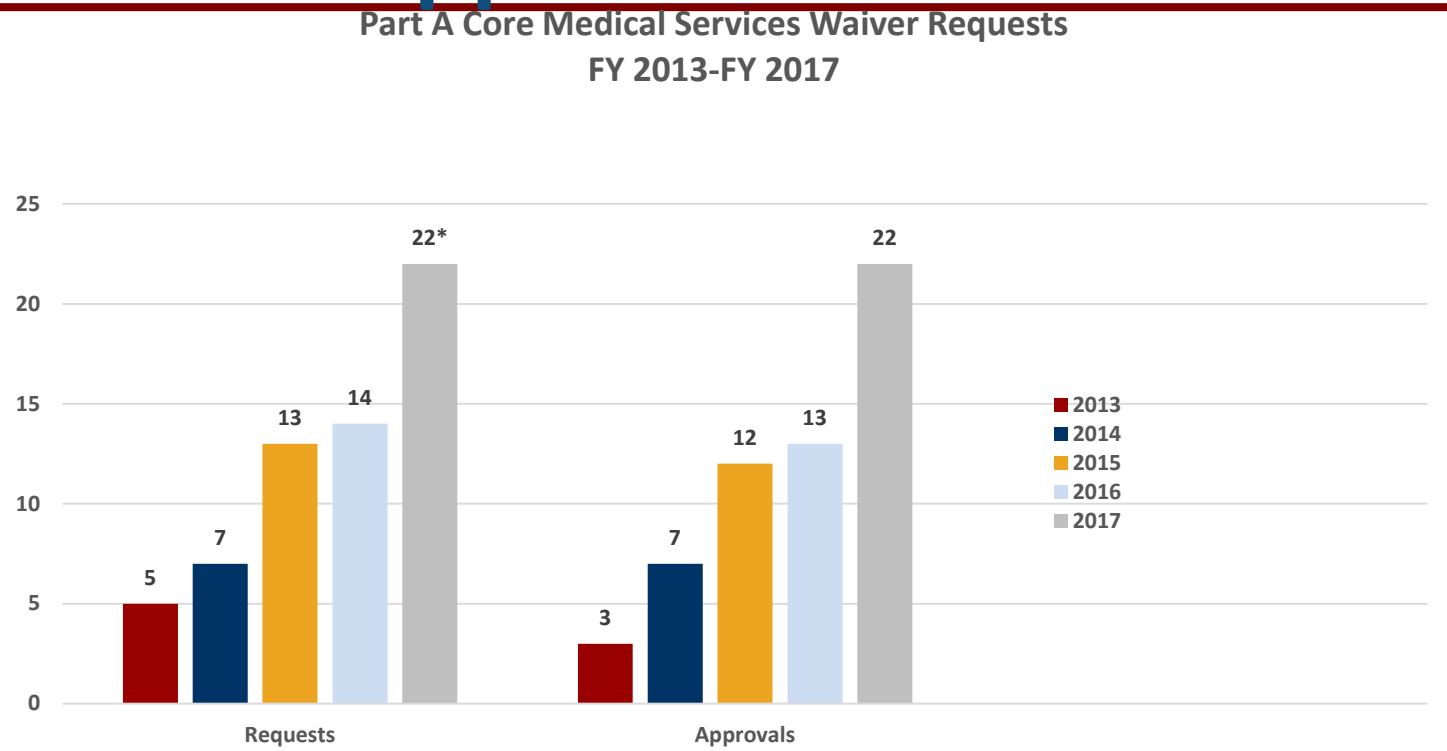
- Section 2604(c) – Part A
- Section 2612(b) – Part B
- Section 2651(c) – Part C

How Does a Recipient Qualify for a Core Medical Services Waiver?

The Public Health Service Act grants HRSA authority to waive the Core Medical Services requirement if:

- The recipient is funded by Ryan White HIV/AIDS Program Parts A, B, or C
- There are no ADAP waiting lists in the applicant's state
- Core Medical Services are available to all eligible individuals in the applicant's state, jurisdiction or service area

RWHAP Part A Core Medical Services Waiver Requests and Approvals 2013-2017



	2013	2014	2015	2016	2017
Requests	5	7	13	14	22
Approvals	3	7	12	13	22

** For FY 2018, multiple requests are already approved or pending approval.*

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Limits on Non-Service Funding

- **Focus:** Maximize funding for direct services
- **2006 legislation has a 10% administrative cap inclusive of planning, evaluation and Planning Council support**
- **Another 5% (or $3.0 million, whichever is less) for Clinical Quality Management**
  - Assess quality of care and clinical outcomes

”Use or Lose” Formula Funding

- Penalty for unobligated & unliquidated funds
- If more than 5% of formula funds are unspent at the end of the year ineligible for supplemental funding.

  Note: MAI is not counted toward the Unobligated Balance (UOB)

- Unobligated formula balance is used to off set future grant award

Addressing the HIV Care Continuum in Southern Metropolitan Areas

- Purpose - to support a single organization that will serve as the Coordination and Technical Assistance Center (CTAC) to provide technical assistance and capacity building/service delivery resources to four Part A jurisdictions located in southern metropolitan areas serving targeted minority populations to improve outcomes along the HIV care continuum.

Jurisdictional Public Health Approach to HCV Diagnosis/Treatment of Co-infected Individuals

- Purpose - Increase jurisdiction-level capacity to provide comprehensive care and treatment for hepatitis C among HIV/HCV co-infected people; Increase numbers of HIV/HCV co-infected people who are diagnosed with hepatitis C, treated, and cured

People of Color Living with HIV Leadership and Training

- PLWH leadership and planning support training that will enable PLWH to participate on planning bodies, on care teams, in organizations, board of directors, etc.

Care Continuum Learning Collaborative (CCLC) - Domains

- Data Access and Coordination
- Using Data to Inform the Need for, and Selection of Evidenced-based/informed Approaches
- Identifying and Implementing Targeted Evidenced-based/informed Interventions
- Linkage to Care
- Changing Healthcare Landscape
- Phase II – Data to Care & Pay for Performance

CCLC Examples of Objectives Achieved

- New Peer to Peer retention program implemented
- Data to Care program developed and launched
- Non-RWHAP providers trained on HIV/AIDS care standards to expand system-level capacity
- New integrated RWHAP Part A data system launched
- Existing retention in care processes enhanced
- Quality Management Plan revised to include youth-specific interventions
- 'Barriers to care' tracking tool developed and piloted
- Data sharing agreements completed and lab data imported into centralized system

RWHAP Part A Planning Council and TGA Planning Body Technical Assistance (TA) Cooperative Agreement

Areas of focus:

- Increasing direct communications and engagement with Planning Council/Body support staff
- Clarifying legislative expectations and ensuring that Planning Councils/Bodies work in partnership with RWHAP Part A recipients while maintaining their status as separate entities, maximizing areas of collaboration and maintaining healthy, sustainable relationships.
- Updating training materials to support ongoing orientation and training for Planning Council/Body members
- Providing operational models and best practices of Planning Councils/Bodies and Program Support
- Providing effective training that leads to the retention of Planning Council/Body members
- Updating governing by-laws & MOUs
- Revising and improving Planning Council/Body committee structures

Data Driven Methodology for the Allocation of RWHAP Part A Supplemental Funds

- Assistant Secretary for Planning and Evaluation Technical Expert Panel
  - Reviewed existing approach and related metrics
  - Explored options for new data driven methodology
  - Proposed future exploration of domains including need, geography, data quality, and performance (quality bonus payment)

- Funded "Feasibility Study" contract
  - Assessed availability, quality, and potential utility of framework data sources
  - Developed a potential methodology to distribute the Part A supplemental funds based on a new framework of need and performance with identified data sources
  - Built a SAS model with Excel front end to test various thresholds and scenarios to inform final approach

RWHAP Part A Supplemental –Data Driven Methodology Data Variables

- Need: Diagnosed, not suppressed
  - Address at time of diagnosis
  - Current address
- Data Quality
  - 95% labs reported to CDC
  - Completeness on insurance status or viral load (RSR)
- Performance
  - VL suppression – threshold and improvement (RSR)
  - VL suppression – subpopulations
- Geographic Adjustment
  - High % of uninsured adults
  - High cost by Medicare Wage Index

RWHAP Part A Supplemental – Data Driven Methodology Development Next Steps

- Next Phase of "Feasibility Study" contract
  - Finalize limited set of data inputs/sources and determine thresholds and weights
  - Establish "guardrails" to prevent significant fluctuations in funding that may negatively impact continuity of HIV service provision
  - Run various and focused scenarios with pros/cons

Unmet Need Consultation

Methodology Consultation

- On November 14, 2017 - technical expert panel (TEP) consultation meeting on the topic of unmet need, consisting of representation from RWHAP Part A and Part B recipients, as well as national HIV partners, researchers and clinicians.
- Purpose of the meeting:
  - explore the utility of past and potential unmet need frameworks;
  - develop agreement on terms and definitions;
  - refine methods, data elements, and models for assessing jurisdictional unmet need;
  - determine the availability of easy to use formulas to estimate the overall number of individuals not in care; and
  - assess flexibility to meet State and local needs and capabilities
- Findings from the consultation meeting will be used to inform a new contract on a revised unmet need estimation methodology

Getting to Zero by Addressing the Hardest to Reach Populations in Ryan White HIV/AIDS Program Part A Jurisdictions

Ending the Epidemic – Getting There

- Funding/Resources
- Policy
- Leadership
- Community Engagement
- Leverage – Build on Existing Infrastructure
- Innovation

Summary of Current/Relevant RWHAP Part A Issues

Leading the RWHAP Part A program to translate our vision of zero new HIV infections into a reality; 73% of living cases in RWHAP Part A jurisdictions

- Changing leadership & resources;
- Core medical service waivers;
- Integration of prevention & care;
- Use of fiduciary agents;
- PC/PB requirements & recipient relationship;
- Sub-recipient monitoring;
- Clinical quality management;
- Challenges to local procurement processes;
- Audit resolution.

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Contact Information

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