2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT
Allocating and Optimizing Program Funds to Better Address the Epidemic and Improve the HIV Care Continuum
Ensuring Ryan White HIV/AIDS Program Funding Follows the Epidemic

Carl Schmid, Stephanie Hengst

The AIDS Institute
Learning Objectives

• Examine current Ryan White Program funding methodologies and award distribution by state and case count to determine if the funding is following the epidemic

• Discuss potential administrative and legislative changes that could be made to the Ryan White Program distribution methodologies to better target high-impacted and resource poor areas while maintaining current funding needs
Why This Matters

• Ryan White Program provides some type of services to more than 551,000 people living with HIV
• People in Ryan White Program have a higher viral suppression rate
• The ACA, including Medicaid expansion, is not sufficient
  • Payer of last resort and wraps around other programs
  • Medicaid expansion, other coverage and resources vary by state
• Concerted effort to End AIDS in the US
  • Jurisdictions need resources to achieve goals
  • Level needed not the same everywhere
Current Funding Framework

• Formula awards to cities and states based on case counts
• Competitive grants based on demonstrated need
• Other competitive grants:
  • Minority AIDS Initiative
  • ADAP Emergency Relief,
  • Special Programs of National Significance
  • Other programs
Funding & The Epidemic

• National HIV/AIDS Strategy calls for federal funding to follow the epidemic and be distributed to areas most in need
• 2016 data shows that the epidemic disproportionately impacted the southern US:
  • Southern states accounted for more than half of all new HIV diagnosis and 46% of all people living with HIV, despite making up 38% of national population
  • Prevalence rates of people living with diagnosed HIV:
    • overall in the U.S.: 303.5 per 100,000 people
    • by region: 417.8 (Northeast) 359.3 (South) 248.6 (West) 170.6 (Midwest)
An Analysis of Current Ryan White Program Funding

Stephanie Hengst

The AIDS Institute
Purpose

• Examine where current Ryan White Program funding is distributed to determine if it is following the epidemic

• Inform and motivate a discussion about how Ryan White Program funding is being distributed and how it can be better allocated in the future to achieve greater viral suppression across the country
Methodology

Examined FY 2017 funding awards
  • By program Part
  • Per HIV/AIDS case count
  • Nationwide by states
    • Excluded 6 jurisdictions with low case counts:
      • Guam, Palau, American Samoa, Northern Mariana Islands, Federated States of Micronesia, & Marshall Islands
Methodology

Analyzed funding in the following ways:

1. Per case above/below median for Parts A&B (including ADAP)
2. Per case above/below median for Part B ADAP
3. Total Part B & ADAP Supplementals
4. Total Part C & total Part D
5. Per case above/below median for Parts A-D (including ADAP)
6. Per case above/below median for Parts A-D (including ADAP) multiplied by total number of cases
Methodology

Ranked states 3 ways:

1. A-D including ADAP funding per case
2. A-D including ADAP funding per case multiplied by total cases
3. A & B including ADAP funding per case

Medicaid Expansion noted

Data Limitation:

• Do not have data breaking down Part A awards and Part B Emerging Community awards distributed to multiple states
• Credited such awards to only one state; so some state funding amounts shown are higher than actually received while others are lower than actual
Parts A & B including ADAP
(Above the Median)

Median Funding per Case: $1,818
Parts A & B including ADAP (Below the Median)

Median Funding per Case: $1,818
Part B ADAP (Above/Below the Median)

Median Funding per Case: $813

*States that received median funding per case not shown*
Part B & ADAP Supplementals

*Excludes states that did not receive Part B Supplemental or ADAP Supplemental
Parts A - D
(Above the Median)

Median Funding per Case: $2,278
Parts A - D
(Below the Median)

Median Funding per Case: $2,278
Parts A - D Multiplied by Total Cases
(Above the Median)

Median Funding per Case: $2,278
Parts A - D Multiplied by Total Cases
(Below the Median)

Median Funding per Case: $2,278
## Rankings

<table>
<thead>
<tr>
<th>State</th>
<th>A-D including ADAP per Case</th>
<th>A-D including ADAP per Case Total Cases</th>
<th>A&amp;B including ADAP per Case</th>
<th>Medicaid Expansion</th>
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</table>
State Funding Rankings
Total Parts A-D Funding, Above/Below the Median, Multiplied by Total Cases
Observations

• Part B & ADAP Supplemental awards push states above median
• Important to consider all Part A, B, C and D funding together
• Looking at funding above/below the median multiplied by case count shows the magnitude of funding differentials

Examples:
• Montana’s A-D funding per case was $6,090 above median but $2.6 m in total when multiplied by the number of cases
• New York’s A-D funding per case was only $158 above median but $20.9 m in total
• If states received funding equitably per case, Florida would gain the most ($28.5m)
How Can Funding be Better Aligned with the Need

Carl Schmid
The AIDS Institute
Mechanisms that Align Funding with Needs

- Non-Formula Funding
  - Under Current Law
    - Parts A & B Supplemental Funding
    - Parts C & D
  - Requires changes in law
    - ADAP Supplemental & Emergency Relief Funding
How Can Funding Align More with Needs?

• Change Law
  • Distribute Funding based on different factors
    • Case Counts and other factors:
      • Death Rate
      • Viral Suppression Rate
      • Number of Clients using Ryan White Program
      • Insurance Coverage
      • Cost of care
      • Poverty Rate

• Examine the Part Structure
• Change proportion of Supplemental Funding and Factors for Distribution
Non-Formula Funding Opportunities

• The AIDS Institute prioritizing opportunities under current law
• Part A Supplemental
  • HRSA examining improvements, but need legislative changes
  • In the meantime, any opportunities?
    • Current law of basing on need and testing and linkage to care is not working as intended
    • Every grant application scores well
Non-Formula Funding Opportunities

• Part B (Non-ADAP) Supplemental
  • Distributed Based on Need
    • Factors Include (Similar to Part A Supplemental):
      • Prevalence
      • Increasing case numbers, including those in emerging populations
      • Cost and complexity of delivering care
      • Uninsured rates
      • Other access limitations
      • Impact of homelessness, co-morbidities and justice involvement
      • Impact of reductions in base awards
Part B Supplemental

- Due to end of hold harmless available funding has grown
  - 2013: $15.4 million
  - 2014: $44.6 million

- Due to unobligated Part B funds (including ADAP) funding has grown even more
  - 2015: $61.4 million
  - 2016: $167 million
  - 2017: $177 million
  - 2018: $170 million

- Not all states apply
- Not all states eligible due to unobligated funds
Part B Supplemental Awards: 2015

- DC, MA, MD, Micronesia & Virgin Islands not eligible in 2015
- 18 states applied for and received funding
  - including 3 that did not receive funding in the previous year (AL, MS, and NE)
- 12 states did not receive funding in 2015 but did in 2014
  - (CO, CT, DE, IL, IN, IA, LA, MI, ND, SD, VA, in addition to MA, which was ineligible)
- Highest awards:
  - NY: $23.8 million or 39 percent of the total
  - CA: $10 million or 16 percent of the total
Part B Supplemental Awards: 2016

- AL, AR, NH, MA, WA, Northern Mariana Islands & American Samoa not eligible
- 20 states applied and all received funding
- Available funding: $167 million; Total awarded: $105 million
- Highest Awards:
  - NY: $29.2m
  - CA: $16.7m
  - PR: $14.3m
  - IA: $6.9m
  - MS: $5.9m
  - DC: $6m
Part B Supplemental Awards: 2017

• OH, MA, the Marshall Islands, and American Samoa were not eligible
• 21 States, Puerto Rico, US Virgin Islands, and Mariana Islands applied
• $218 million available; $177.8 million awarded
• Highest awards:
  • NY: $35m
  • CA: $35m
  • IN: $26.4m
• Other Recipients: AL, AK, GA, ID, IA, ME, MN, MS, MO, MT, NE,NV, NJ, NC, RI, TX, UT, WI, Puerto Rico, Mariana Islands, US Virgin Islands
Part B Supplemental Awards: 2018

- DC, OH, OR, Marshall Islands, and Palau not eligible
- 24 States, Puerto Rico, US Virgin Islands, and Mariana Islands applied
- $170 million available; $165.4 million awarded
  - $40.2m carried over from previous year
  - $35m award cap
- Highest awards:
  - NY: $26m; CA: $24m; FL: $21m; PR: $14m; AL: $12m; SC: $12m
- Other Recipients: AK, GA, ID, IN, IA, ME, MA, MS, MN, MO, MT, NE, NJ, NC, ND, RI, TX, UT, WI, US Virgin Islands, Marianna Islands
Part B Supplement: Questions to Consider

- After grant score, HRSA runs through formula
  - Why? Not in the law
  - Opportunity to reexamine current practices
- Why aren’t all states applying?
- Cap award at $35 million
  - How was that number developed?
- Opportunities for further review
Part C & D Awards

- **Part C Grants**
  - Direct grants to clinics for services to underserved populations
    - Preference for grantees in areas with increased HIV/AIDS burden
  - To be considered in determining awards:
    - Balance in allocations between rural and urban areas
    - Supporting early intervention in rural areas
    - Underserved areas

- **Part D Grants**
  - Direct grants to providers for family-centered health care and supportive services for women, infants, children and youth
  - HRSA has broad discretion in directing Part D funds
Recent HRSA changes include new geographic service areas and “right sizing” funding based on clients served

- **70% of Funding**
  - **Base Funding**: minimum baseline amount per service area augmented by number of clients served

- **30% of Funding**
  - **Demographics**: a service area’s proportion of populations disproportionately impacted by the HIV epidemic with significant disparities in health outcomes and uninsured populations
  - **Presence of RWHAP Part A**: Part C service areas outside of Part A jurisdictions receive additional funding
ADAP Supplemental

- 5% of ADAP Base award set-aside for states demonstrating “severe need”
- $42.6 million to 9 states in 2017
  - $41.3m to 15 states in 2015
- Highest Awards in 2017
  - TX: $21.4m
  - GA: $8.9m
- Severe need determined based on one of following:
  - Client population <200% federal poverty level
  - Formulary limitations affecting availability of core ARTs
  - Waiting lists, enrollment caps, expenditure caps
  - Unanticipated increase in eligible individuals
ADAP Emergency Relief Funds

- Pool of money set aside for ADAP through appropriations
- $54 million to 9 states in 2018
- Awards made to eliminate or prevent ADAP waiting lists, and to fund cost-cutting or cost-saving activities
- Funded activities include steps to enroll ADAP clients in insurance plans, as cost-saving measures.
- Highest Awards:
  - CA: $11m; PR: $11m; VA: $11m; TN: $9m
- Not included in Ryan White Program law; can be changed through appropriations or incorporated into law
President Trump Budget

• “The Administration looks forward to working with Congress to reauthorize the RWHAP to ensure that Federal funds are allocated to address the changing landscape of HIV across the United States”

• Proposes statutory changes to Parts A & B funding methodologies
  • No specifics provided
  • Allows for a data driven distribution to ensure funds are allocated to populations experiencing high or increasing rates of infections
  • Reduces burden on recipients and allows for better targeting of resources
President Trump Budget

• Increase HHS’s ability to effectively focus resources for HIV care, treatment, and support needs in funded cities and states based on need, geography, data quality, and performance.

• Proposed changes to Ryan White Program authorization
  • To simplify, modernize, and standardized requirements and definitions consistent across the Program Parts
  • Reduces burden on organizations when receiving funding from multiple Parts
The Future

• If we are going to meet the goals of the National HIV/AIDS Strategy & End AIDS need to examine Ryan White Program funding distribution
• Analysis of funding demonstrates current funding is not distributed equitably or on need
• Environment has changed, mostly due to ACA
  • Some disparities have increased
• Difficult to increase overall appropriations
  • Need to look at distributing funding in different ways
  • No one wants to loose funding
The Future

• Most in HIV community seem to support status quo
• Consequences of Legislative Changes
  • Potential Opportunities?
• Continue to encourage HRSA to examine current practices and look towards improvements
• Impact of 340B funding and rebates in general
  • Generic drugs do not provide large rebates
• Change eventually needs to occur
  • If we don’t come up with proposals, decisions will be made for us
Ryan White Program Funding: A Regional Perspective

Carolyn McAllaster
Colin W. Brown Clinical Professor of Law
Director, Southern HIV/AIDS Strategy Initiative (SASI)
Duke University School of Law
"The South now experiences the greatest burden of HIV infection, illness, and deaths of any U.S. region, and lags far behind in providing quality HIV prevention and care to its citizens."

– Centers for Disease Control and Prevention
HIV Diagnoses - 2016

Percentage of New HIV Diagnoses by Region in 2016

- South: 51%
- Northeast: 16%
- Midwest: 13%
- West: 20%
New HIV Diagnoses: 
9 of 10 top MSAs are in the Deep South

Top Ten MSAs for Highest Rates of New HIV Diagnoses year end 2015

1. Miami, FL
2. New Orleans, LA
3. Baton Rouge, LA
4. Atlanta, GA
5. Orlando, FL
6. Jackson, MS
7. Memphis, TN
8. Jacksonville, FL
9. Las Vegas, NV
10. Houston, TX

Source: CDC. Diagnoses of HIV Infection in the United States and Dependent Areas, 2016.
New AIDS Diagnoses:
9 of 10 top MSAs are in the Deep South

Top Ten MSAs for Highest Rates of New AIDS Diagnoses
year end 2015

1. Baton Rouge, LA
2. Jackson, MS
3. Miami, FL
4. New Orleans, LA
5. Jacksonville, FL
6. Columbia, SC
7. Atlanta, GA
8. Baltimore, MD
9. Orlando, FL
10. Memphis, TN

Source: CDC. Diagnoses of HIV Infection in the United States and Dependent Areas, 2016.
RURAL AREAS:

23% of new HIV diagnoses in the South are in suburban and rural areas – *more than any other region*. This poses unique challenges.
# Ryan White Part B Supplemental Funding 2018 in the South: Overview

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<tr>
<th>Part B Grantees</th>
<th>FY 18 Final Part B Supplemental Awards</th>
<th>Change from FY 2017</th>
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<td>District of Columbia</td>
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<td><strong>Percent of Total – South</strong></td>
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<td>California</td>
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<td>New York</td>
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<td><strong>TOTAL – CA and NY</strong></td>
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<td><strong>Percent of Total (CA)</strong></td>
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<td><strong>Percent of Total (NY)</strong></td>
<td><strong>16%</strong></td>
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</tr>
</tbody>
</table>
Ryan White Part B Supplemental Funding Distribution: 2016

US % of People Living with HIV--2016

FY 2016 Ryan White Part B Supp. Funding Distribution
Ryan White Part B Supplemental Funding Distribution: 2017

US % of People Living with HIV--2016

- All other States 29%
- CA 13%
- NY 14%
- South 44%

FY 2017 Ryan White Part B Supp. Funding Distribution

- All other States, 49%
- South, 12%
- CA 20%
- NY 19%
Thank you!

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NATIONAL 2018 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT
Utilization of 340B Income to Improve the HIV Care Continuum

Michael Ridinger RN, MBA- Administrative Director
Becky McDermott MSW, LCSW- Senior Social Worker

UPMC HIV/AIDS Program, Pittsburgh, PA
2018 UPMC HIV/AIDS Program Overview

**Ryan White (RW) Grant Numbers**
- Part C: H76HA25775
- Part D: H12HA26266
- Part F: H97HA27434

**Program Milestones**
- 1994: Awarded RW Part C Grant
- 2001: Awarded RW Part D Grant
- 2003: Conemaugh Medical Center Site established (Johnstown, PA)
- 2014: Awarded “Special Project of National Significance” Part F (McKeesport, PA)
Overview

Current Patient Volume
1842

Current VL Suppression Rate
91.0%

Geographic Locations
Pittsburgh AIDS Center for Treatment
Magee-Women’s Hospital of UPMC
Children’s Hospital of Pittsburgh of UPMC
UPMC Latterman Family Health Center
Conemaugh Memorial Medical Center
UPMC HIV/AIDS Program: Goals

1. Provide a broad range of high quality health care services to a diverse population of persons living with HIV through a collaborative, multidisciplinary, on-site model
2. Build sustainable programs that address basic human needs to facilitate care compliance
3. Provide access to investigational therapies for HIV infection
4. Increase the knowledge and self-management skills of consumers
5. Provide education to health professionals and develop HIV workforce capacity
6. Incorporate continuous quality improvement into clinical operations
7. Contain costs of patient care and operational expenses
Clinical Services- One Stop Shop

- HIV Primary Care & Treatment of Co-Infections
- Medical Case Management
- Social Work
- Pharmacy
- Physical Therapy
- Pain Management
- Mental & Behavioral Health
- Dietician
- Addiction Therapy
- OB/GYN Care
- Anal Dysplasia Care
- Peer Advocacy
Basic Human Needs- 340B Impact

• Food Assistance
  • - Supplemental Nutrition
  • - Food Bank

• Hygiene Closet

• Parking & Transportation

• Mental & Behavioral Health Support
  • - Positions
  • - Tools
Adjunct Programs - 340B Impact

- Oral Health Care
- Vision Services
- Peer Support Groups
- HIV Fellowship Program
- Pain Management
- Addiction Therapy- Collaboration
- Linkage to Care
- Caps On Charges
Program Development- 340B Indirect Impact

- Uber Health
- Translation Technology
- Telemedicine - HIV
340B Program Challenges

- 2016 Program Changes- Program Spend
- Conflicting Legislation- RW Guidelines vs. Office of Inspector General
- Finance Perspective
- 340B Site Designation
- Pharmaceutical Influence
- Prevention vs. Treatment
- Political Implications
Questions
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