2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

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Allocating and Optimizing Program Funds to Better Address the Epidemic and Improve the HIV Care Continuum

NATIONAL 2018 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

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

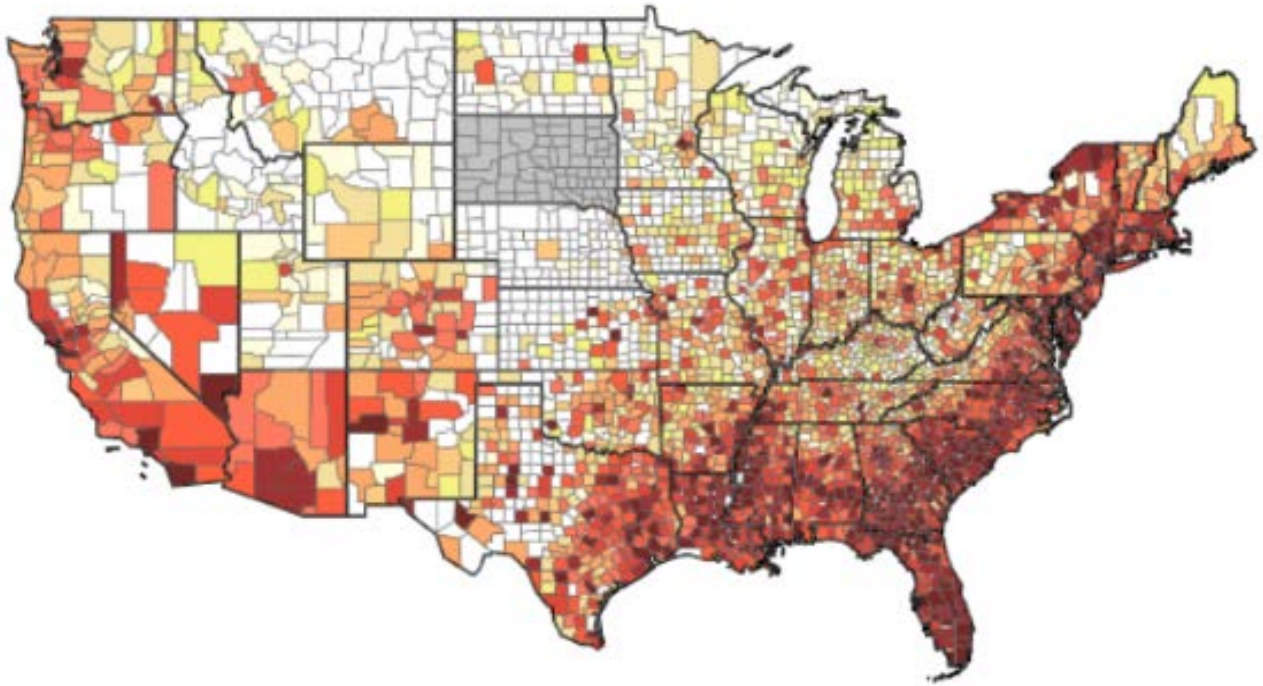
- Ryan White Program provides some type of services to more than 551,000 people living with HIV
- People in Ryan White Program have a higher viral suppression rate
- The ACA, including Medicaid expansion, is not sufficient
  - Payer of last resort and wraps around other programs
  - Medicaid expansion, 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)

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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:

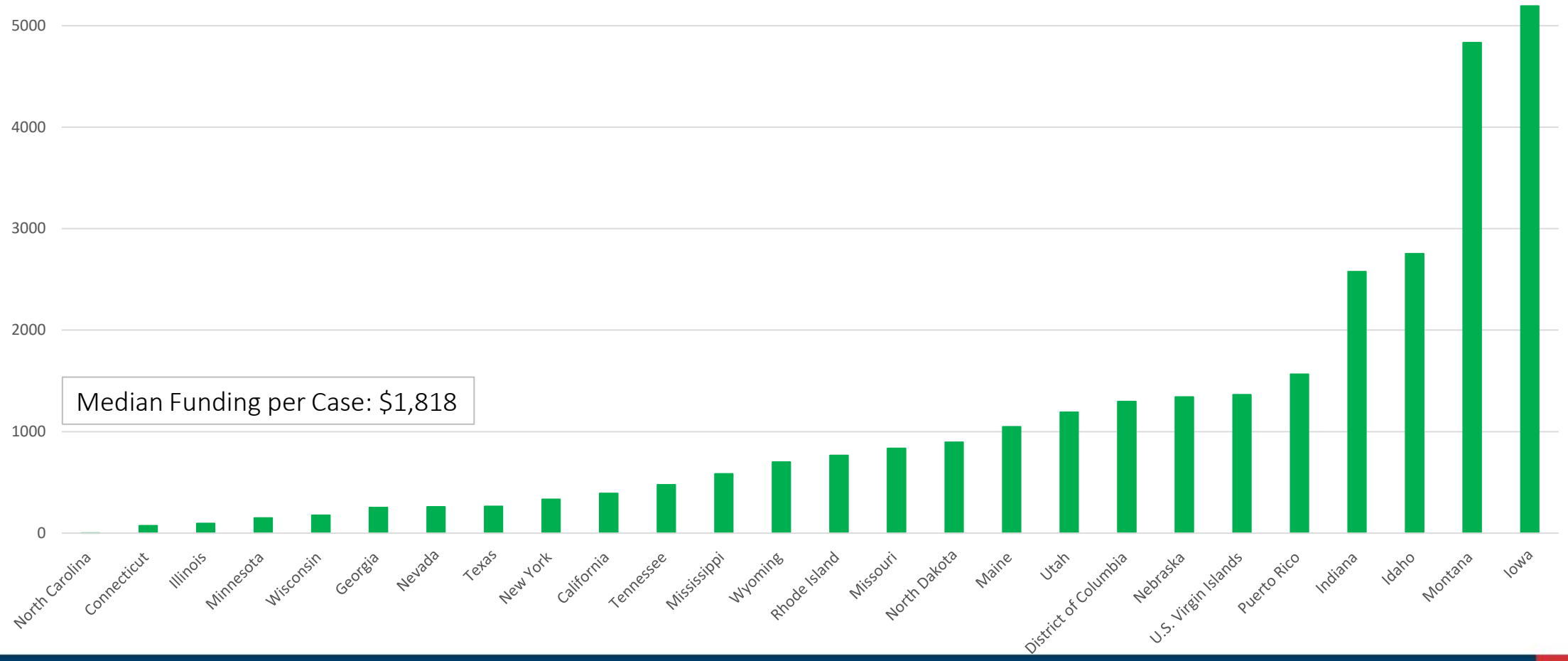
1. A-D including ADAP funding per case
2. A-D including ADAP funding per case multiplied by total cases
3. A & B including ADAP funding per case

Medicaid Expansion noted

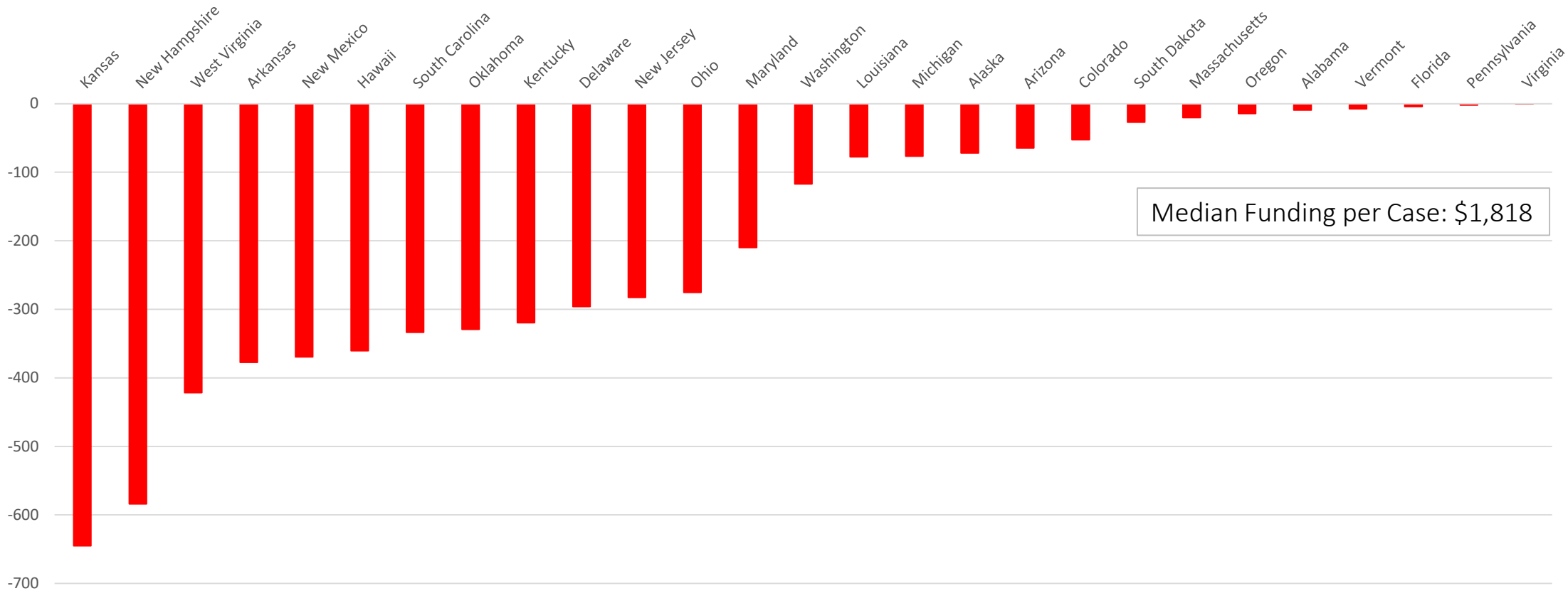
Data Limitation:

- 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

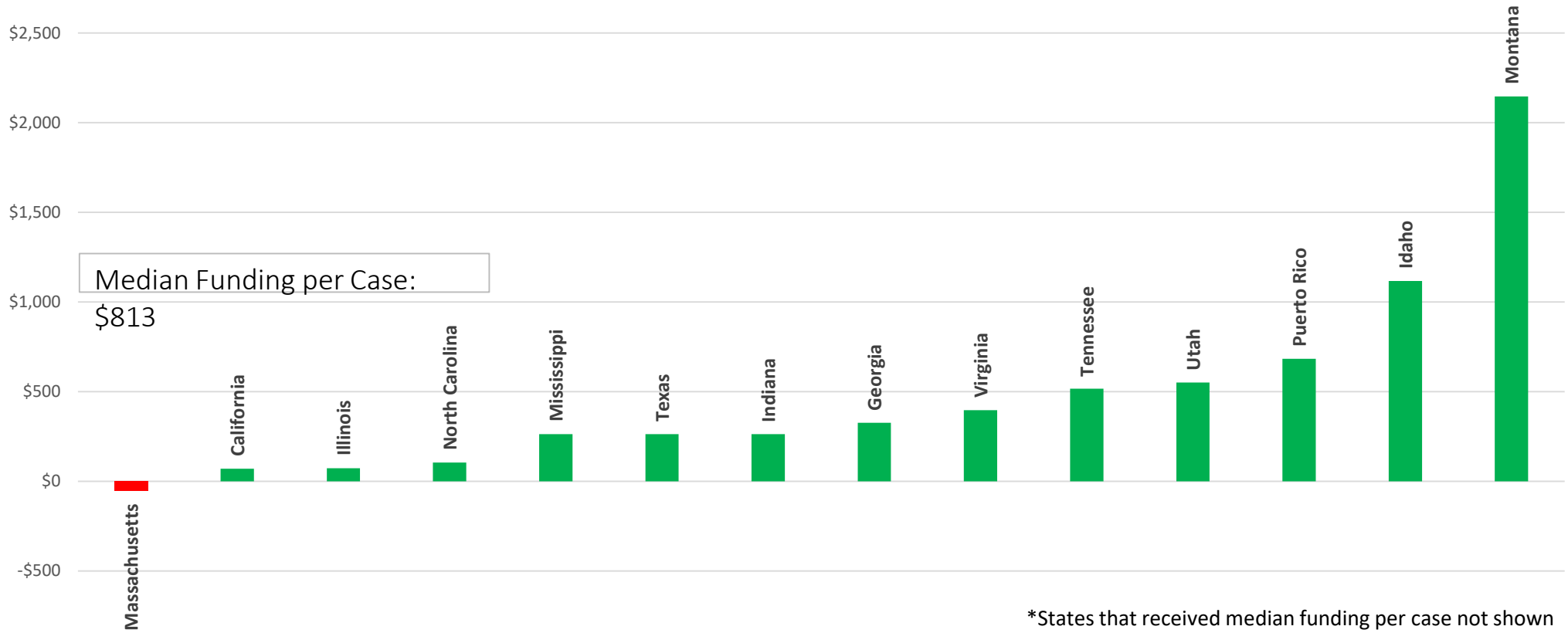
Parts A & B including ADAP
(Above the Median)



Parts A & B including ADAP
(Below the Median)

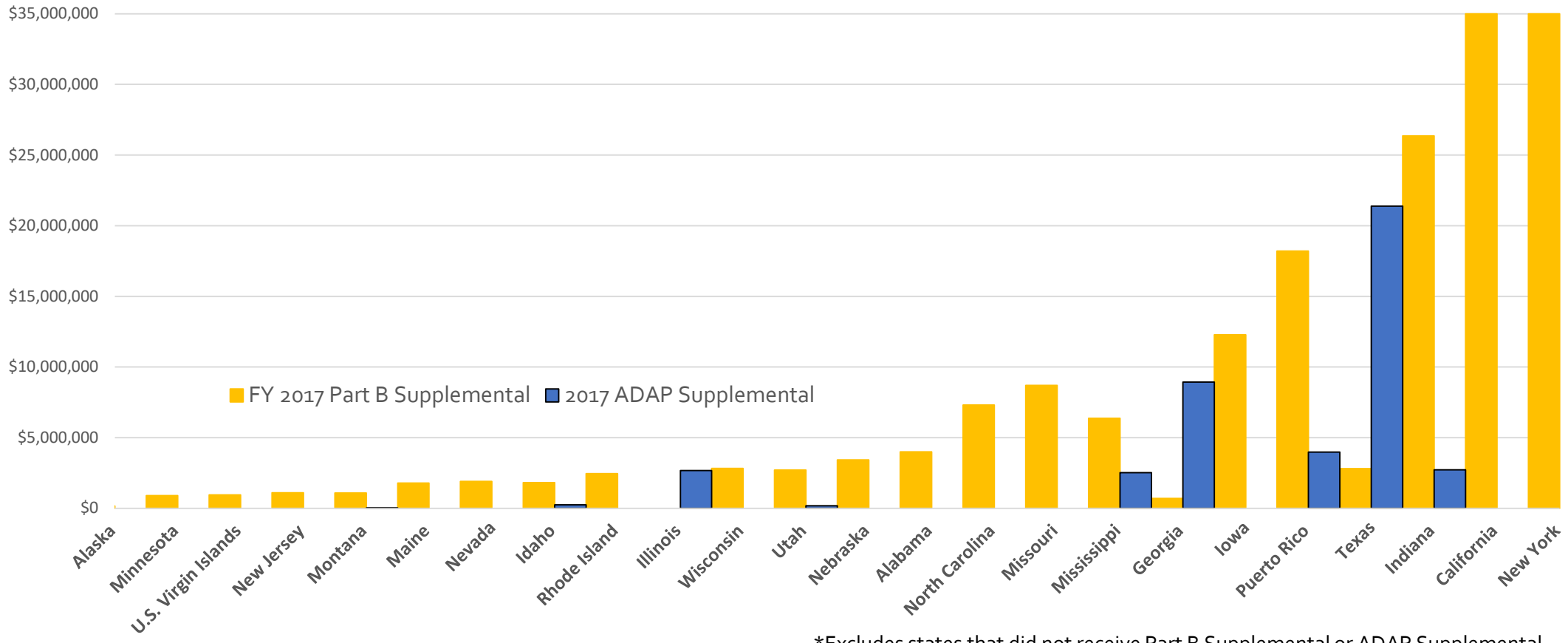


Part B ADAP
(Above/Below the Median)



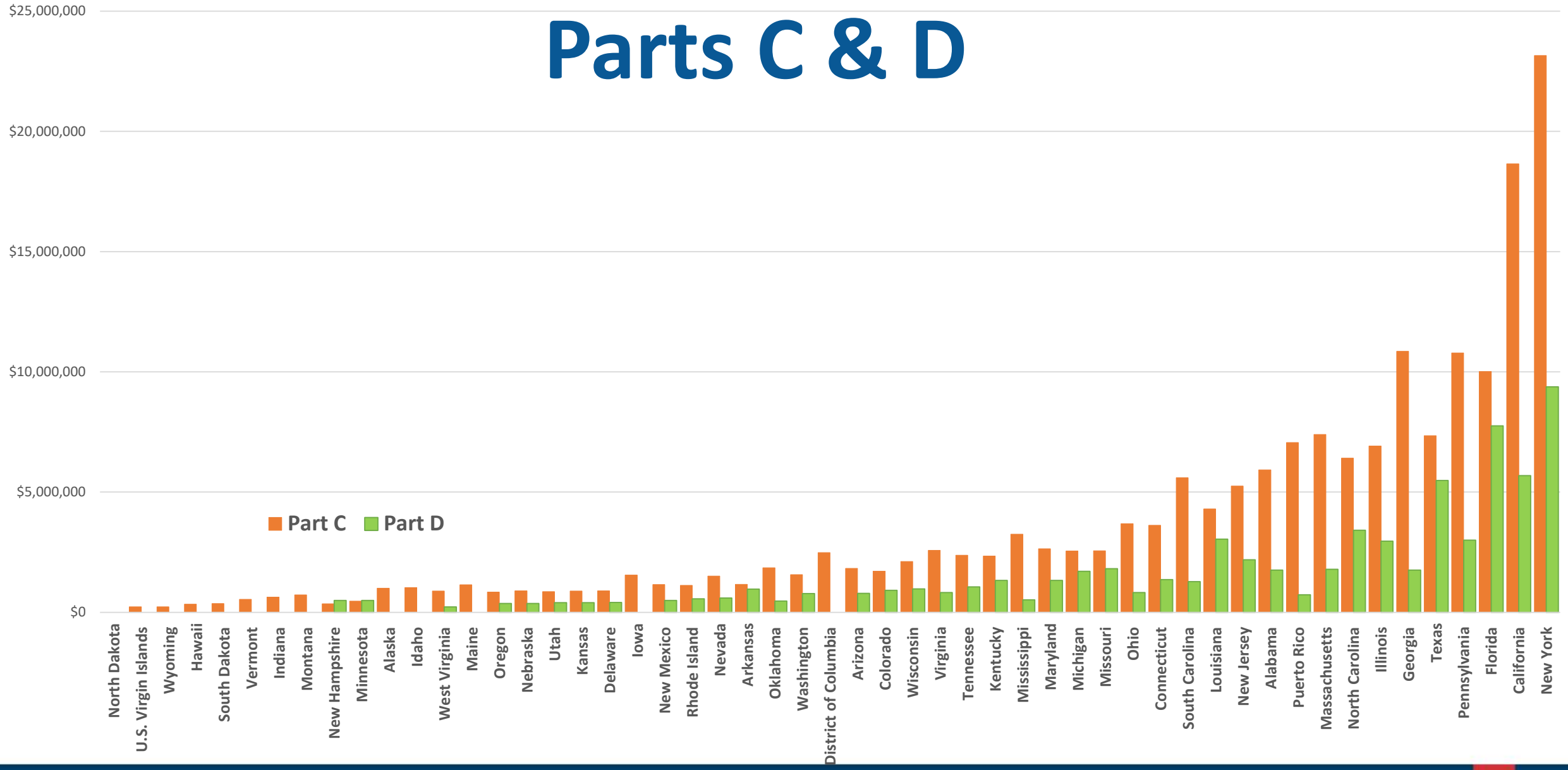
*States that received median funding per case not shown

Part B & ADAP Supplementals

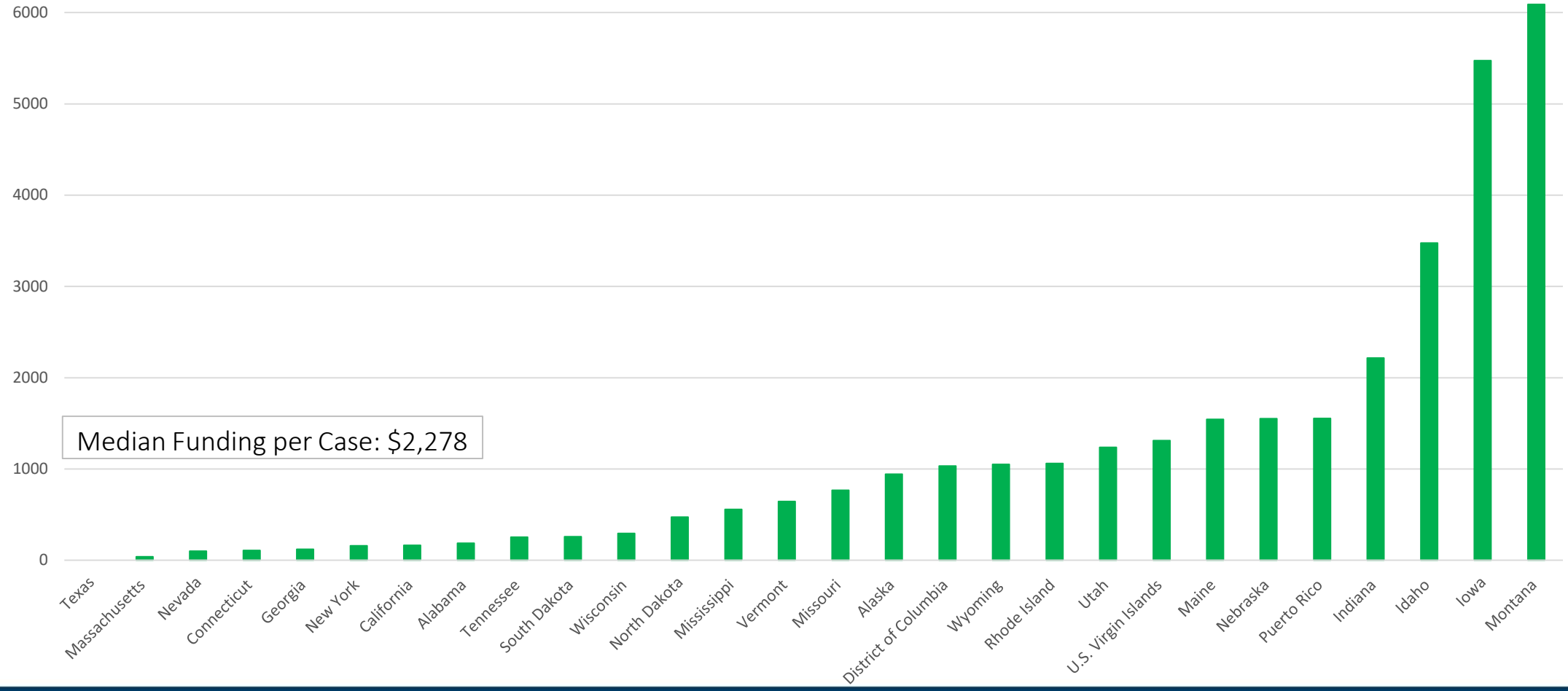


*Excludes states that did not receive Part B Supplemental or ADAP Supplemental

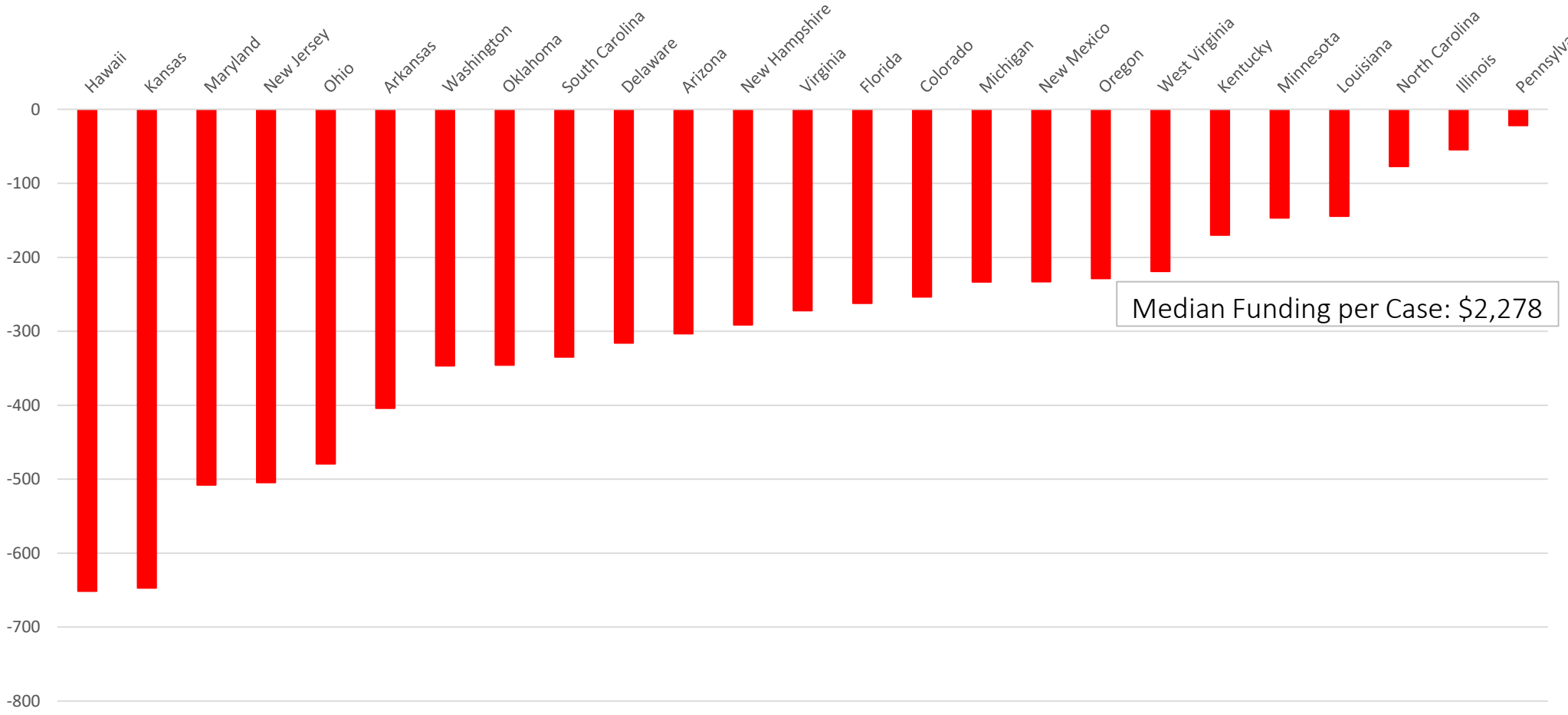
Parts C & D


$25,000,000
$20,000,000
$15,000,000
$10,000,000
$5,000,000
$0
Part C
Part D
North Dakota
U.S. Virgin Islands
Wyoming
Hawaii
South Dakota
Vermont
Indiana
Montana
New Hampshire
Minnesota
Alaska
Idaho
West Virginia
Maine
Oregon
Nebraska
Utah
Kansas
Delaware
Iowa
New Mexico
Rhode Island
Nevada
Arkansas
Oklahoma
Washington
District of Columbia
Arizona
Colorado
Wisconsin
Virginia
Tennessee
Kentucky
Mississippi
Maryland
Michigan
Missouri
Ohio
Connecticut
South Carolina
Louisiana
New Jersey
Alabama
Puerto Rico
Massachusetts
North Carolina
Illinois
Georgia
Texas
Pennsylvania
Florida
California
New York

Parts A - D
(Above the Median)

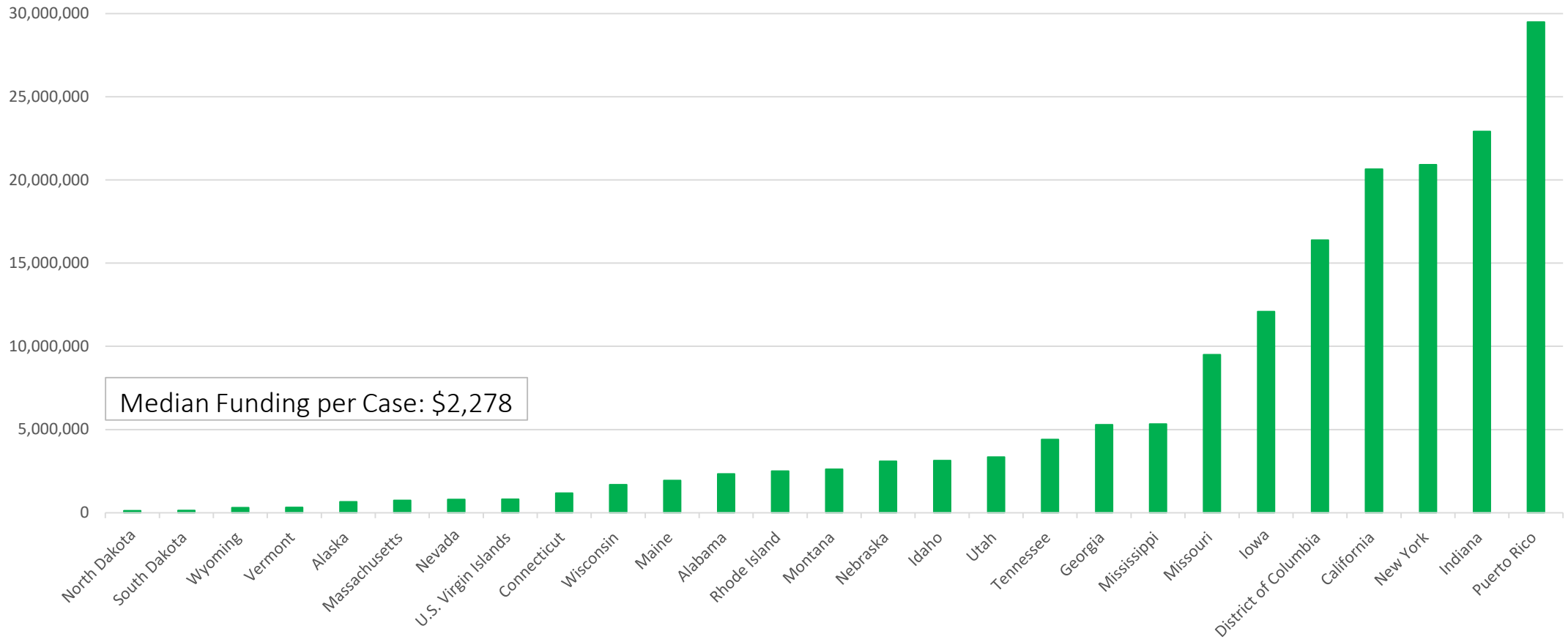


Parts A - D
(Below the Median)

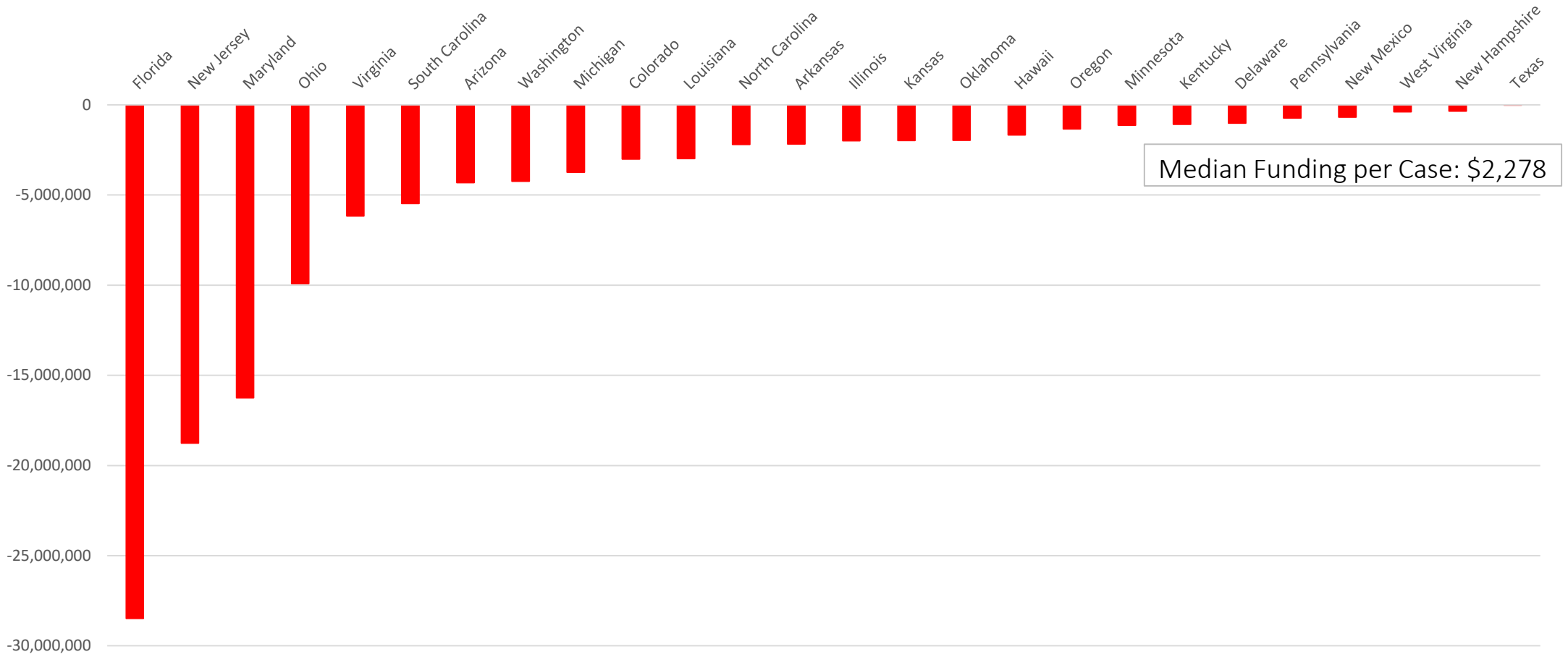


Parts A - D Multiplied by Total Cases

(Above the Median)



Parts A - D Multiplied by Total Cases
(Below the Median)



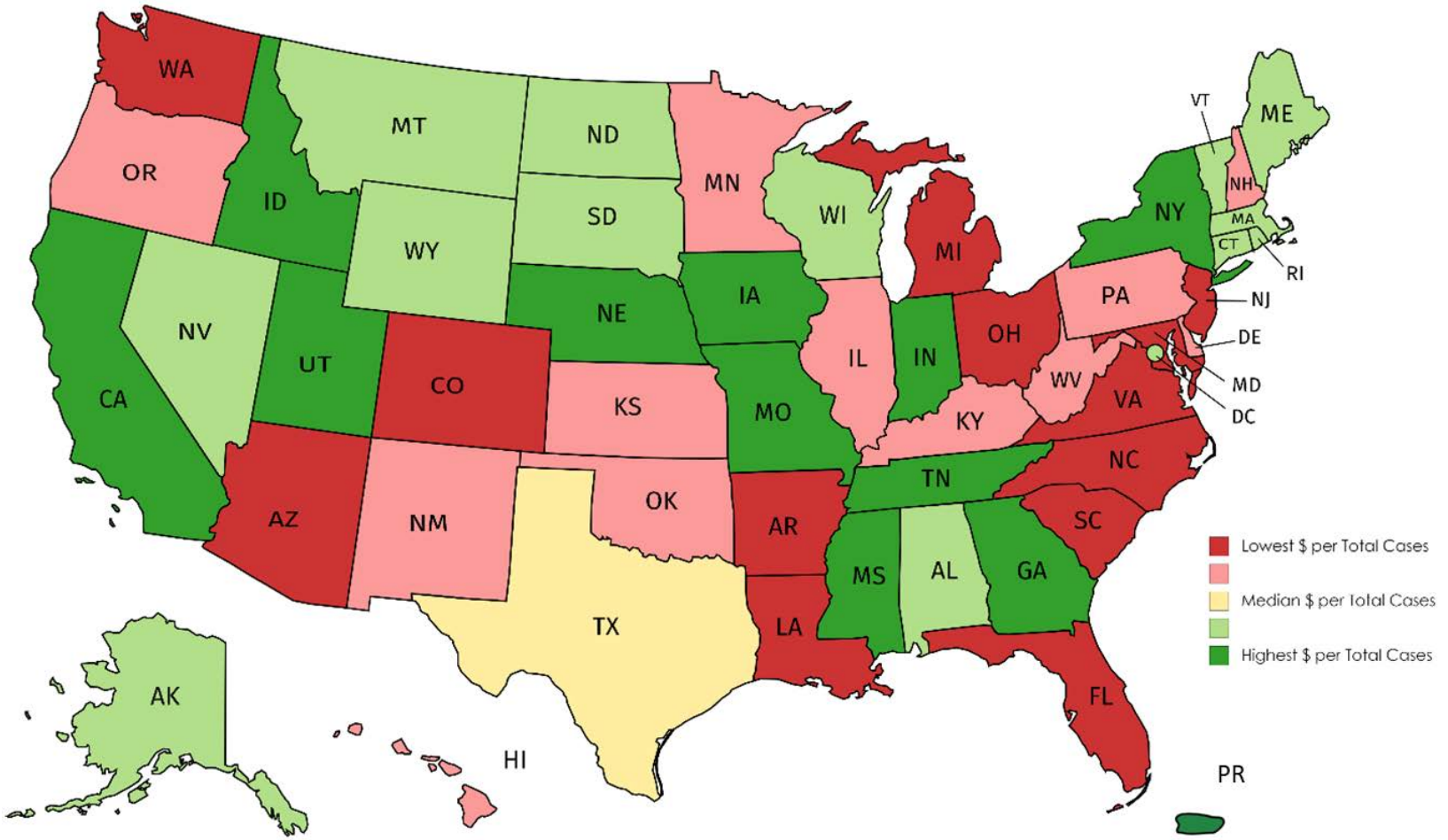
Rankings

State	A-D including ADAP per Case	A-D including ADAP per Case x Total Cases	A&B including ADAP per Case	Medicaid Expansion
Montana	1	14	2	
Iowa	2	6	1	
Idaho	3	12	3	No
Indiana - -	4	2	4	
Puerto Rico	5	1	5	
Nebraska	6	13	7	No
Maine	7	17	10	No
U.S. Virgin Islands	8	20	6	
Utah	9	11	9	No
Rhode Island +	10	15	13	
Wyoming	11	25	14	No
District of Columbia +	12	5	8	
Alaska	13	23	37	
Missouri ++	14	7	12	No
Vermont	15	24	30	
Mississippi -	16	8	15	No
North Dakota	17	27	11	
Wisconsin -	18	18	22	No
South Dakota	19	26	34	No
Tennessee +	20	10	16	No
Alabama	21	16	31	No
California	22	4	17	
New York	23	3	18	
Georgia +	24	9	21	No
Connecticut	25	19	25	
Nevada +	26	21	20	
Massachusetts + -	27	22	33	

State	A-D including ADAP per Case	A-D including ADAP per Case x Total Cases	A&B including ADAP per Case	Medicaid Expansion
Texas	28	28	19	No
Pennsylvania + -	29	32	28	
Illinois -	30	40	24	
North Carolina +	31	42	26	
Louisiana	32	43	39	
Minnesota +	33	35	23	
Kentucky - +	34	34	45	
West Virginia -	35	30	51	
Oregon +	36	36	32	
New Mexico	37	31	49	
Michigan	38	45	38	
Colorado	39	44	35	
Florida	40	53	29	No
Virginia -	41	49	27	
New Hampshire -	42	29	52	
Arizona -	43	47	36	
Delaware +	44	33	44	
South Carolina - -	45	48	47	No
Oklahoma	46	38	46	No
Washington -	47	46	40	
Arkansas -	48	41	50	
Ohio +	49	50	42	
New Jersey - -	50	52	43	
Maryland - -	51	51	41	
Kansas -	52	39	53	No
Hawaii	53	37	48	

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)

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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 consider 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

Part C Funding Changes

- 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

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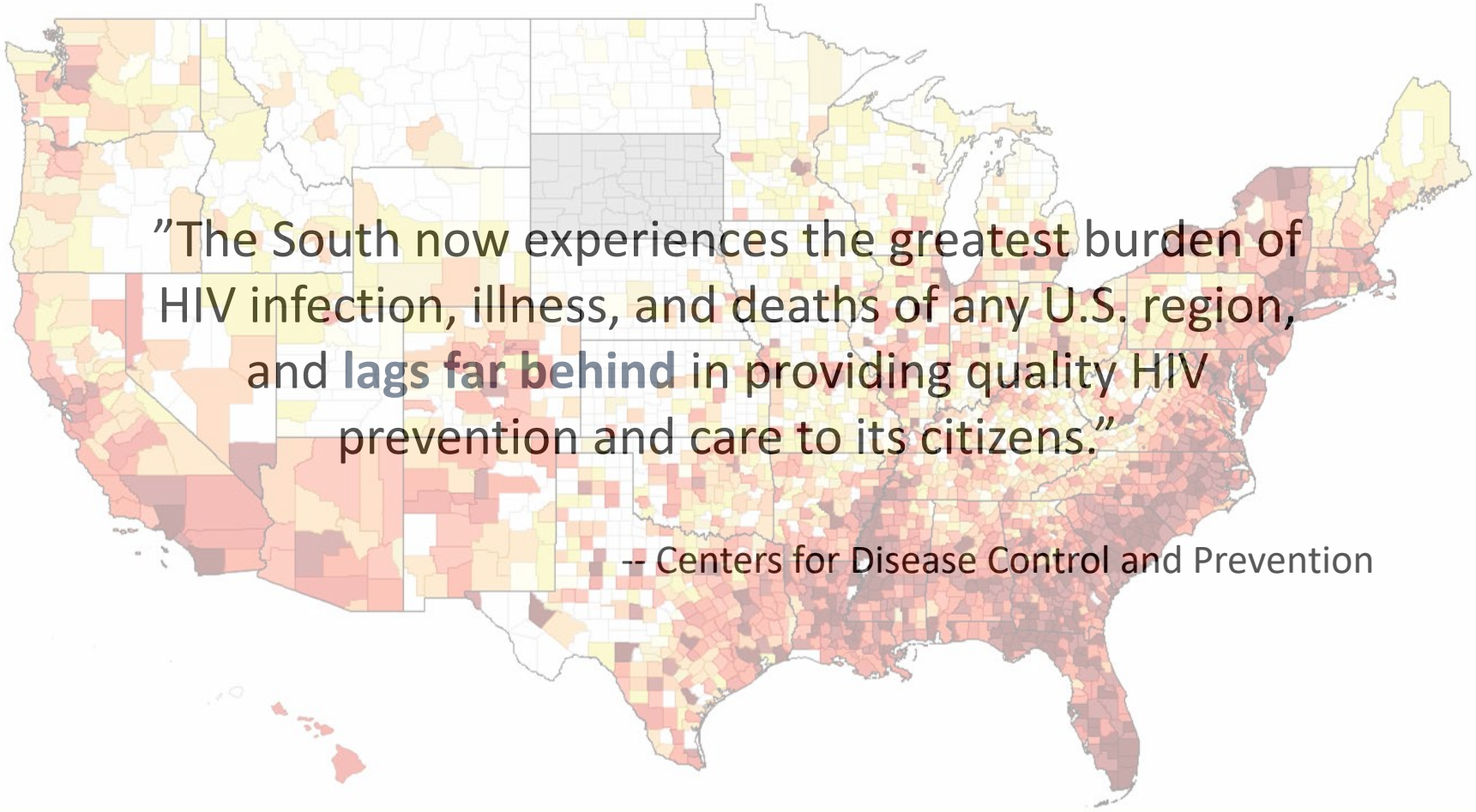
Ryan White Program Funding: A Regional Perspective

Carolyn McAllaster

Colin W. Brown Clinical Professor of Law
Director, Southern HIV/AIDS Strategy Initiative (SASI)
Duke University School of Law

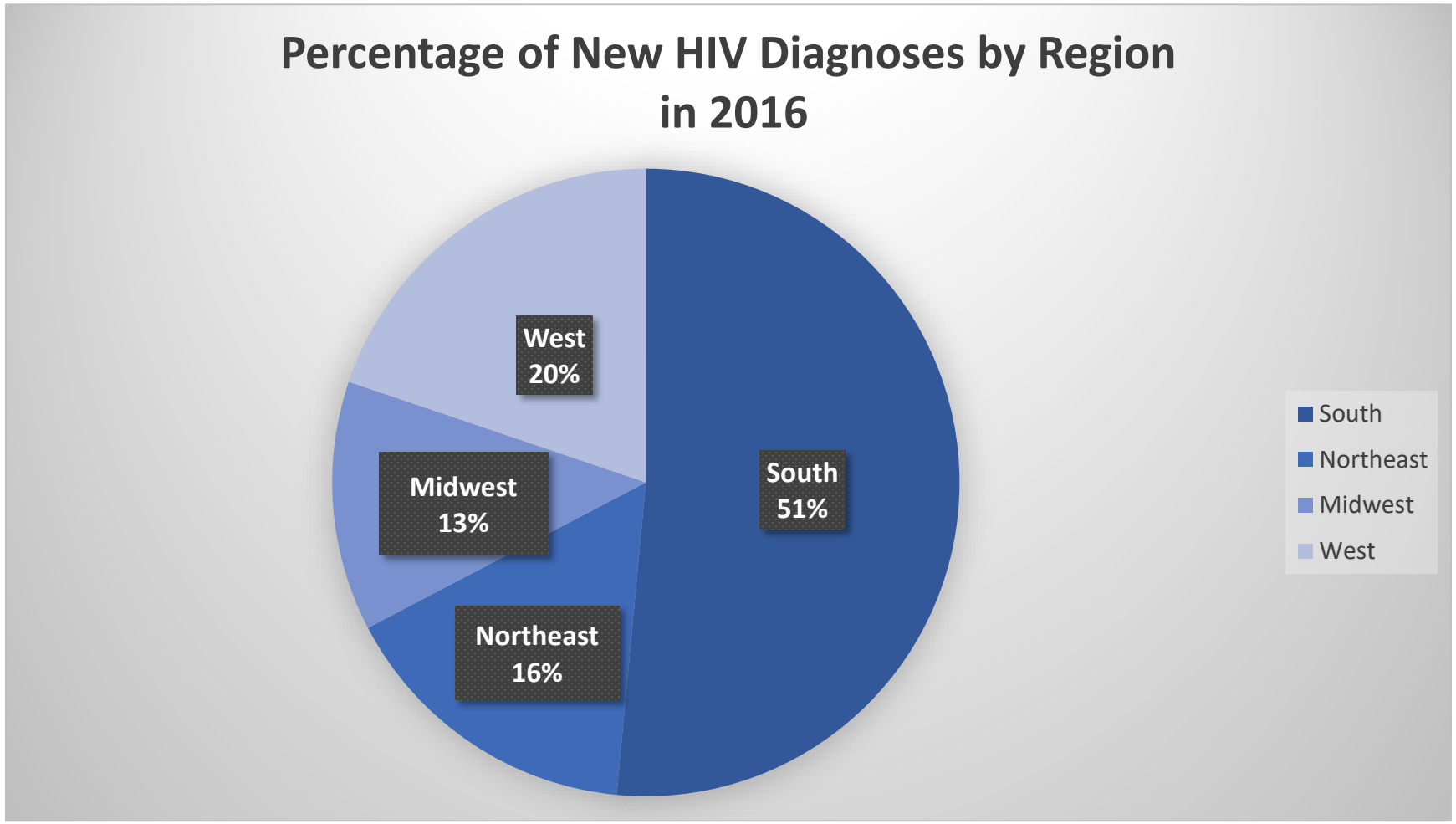
A Region in Crisis



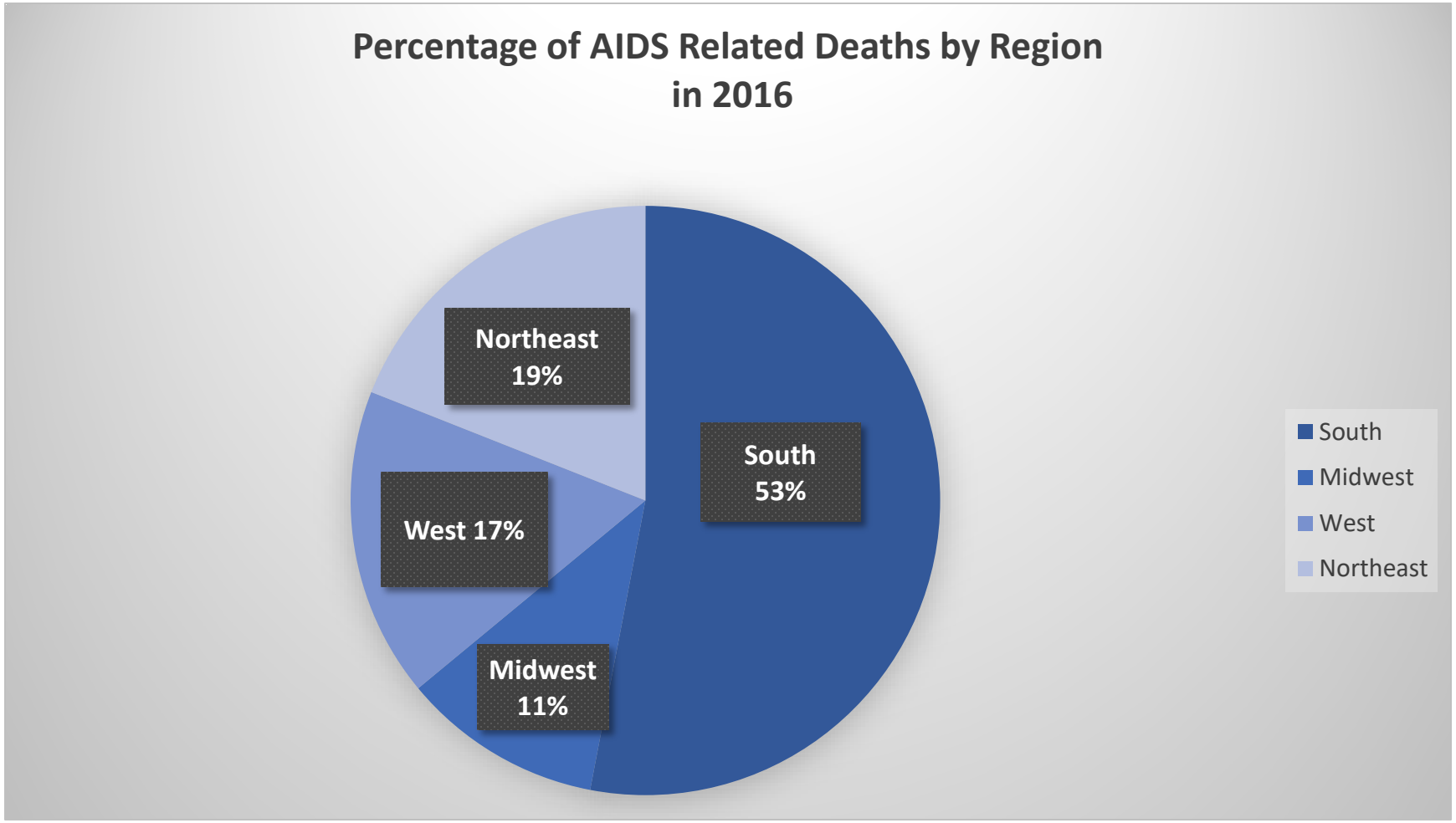
”The South now experiences the greatest burden of HIV infection, illness, and deaths of any U.S. region, and **lags far behind** in providing quality HIV prevention and care to its citizens.”

-- Centers for Disease Control and Prevention

HIV Diagnoses - 2016



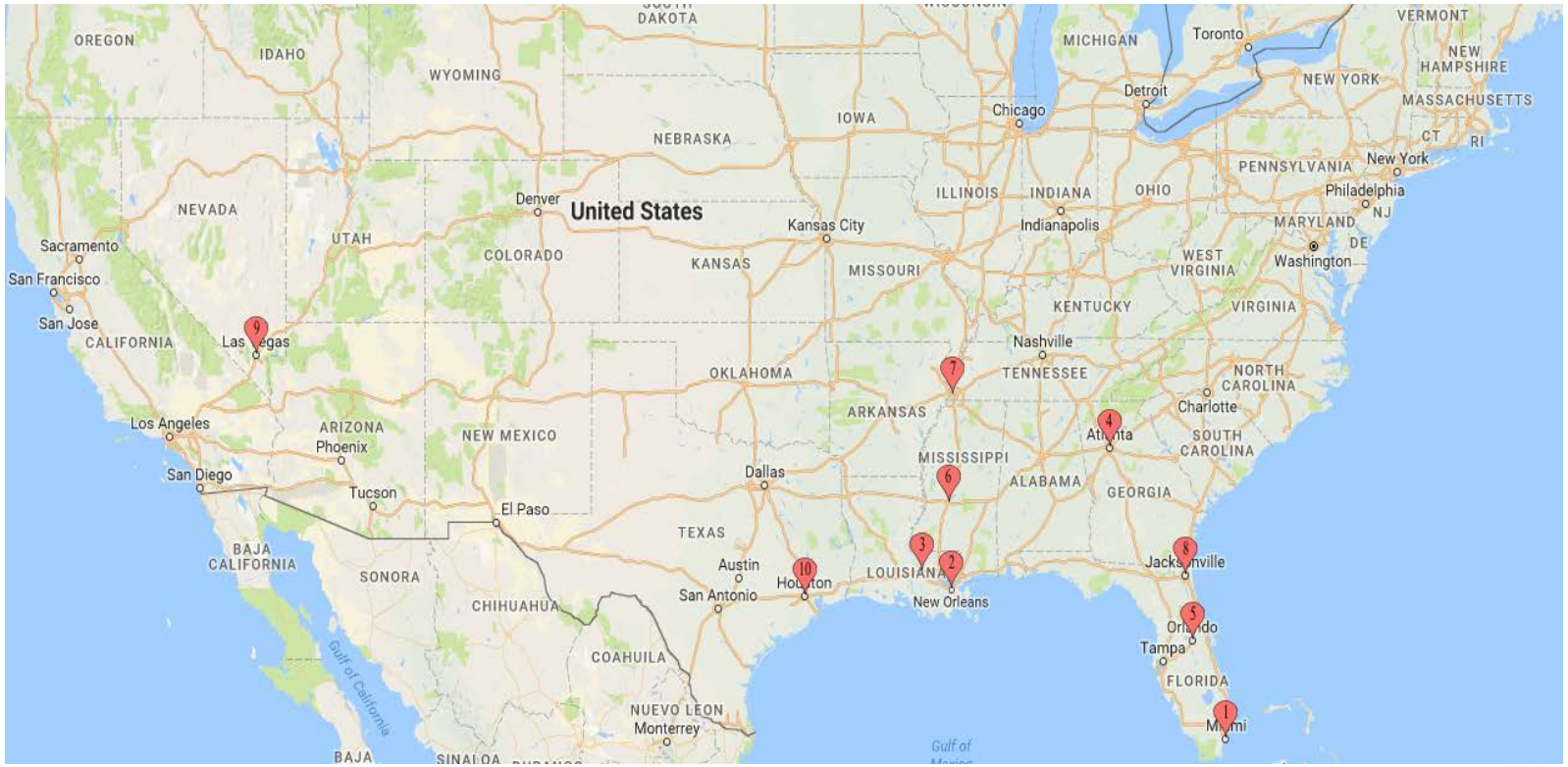
AIDS Related Deaths - 2016



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

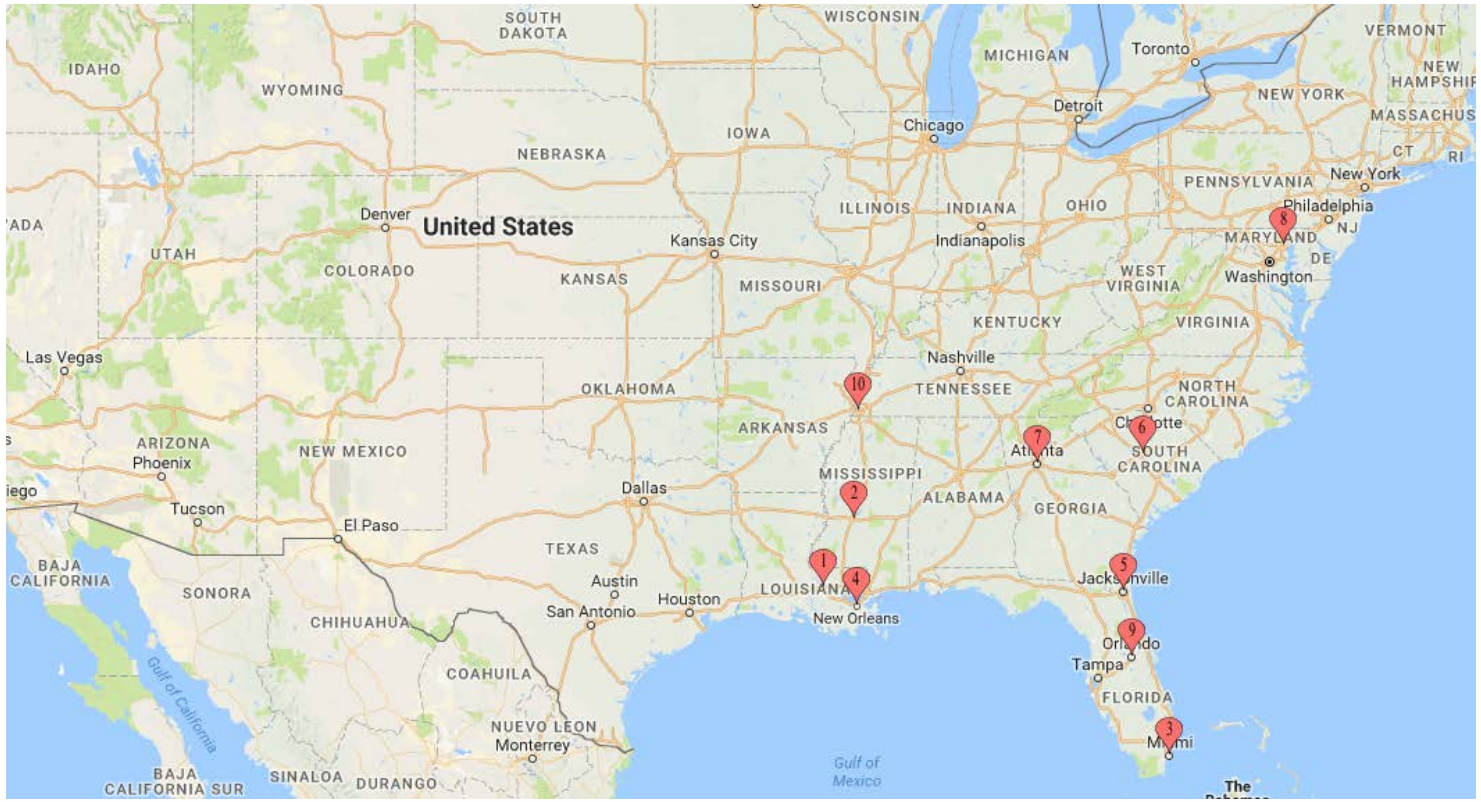


Source: CDC. Diagnoses of HIV Infection in the United States and Dependent Areas, 2016.

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:

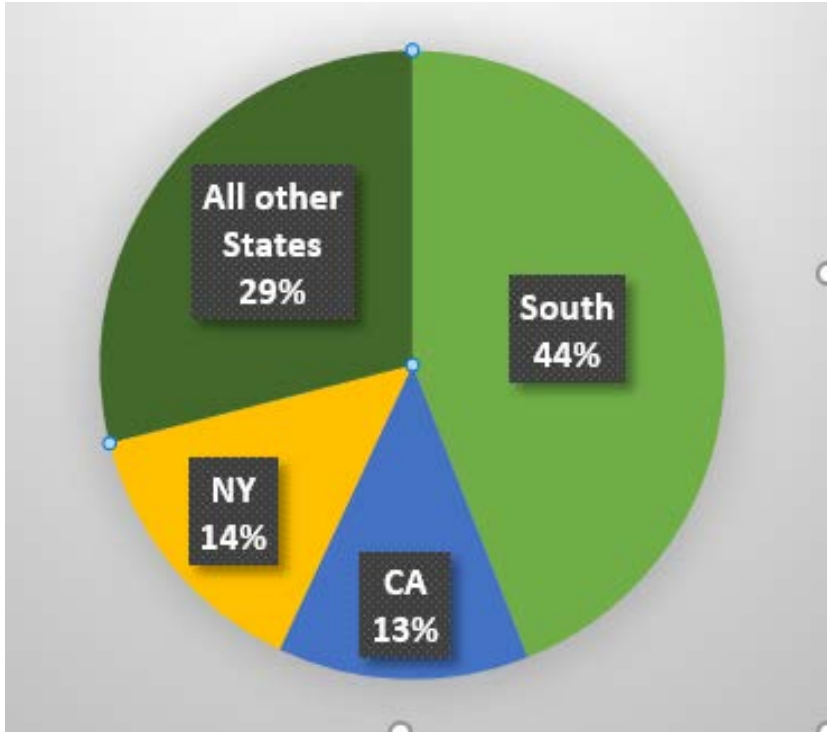
23% of new **HIV diagnoses** in the South are in **suburban and rural areas** – ***more than any other region.*** This poses unique challenges.

Ryan White Part B Supplemental Funding 2018 in the South: Overview

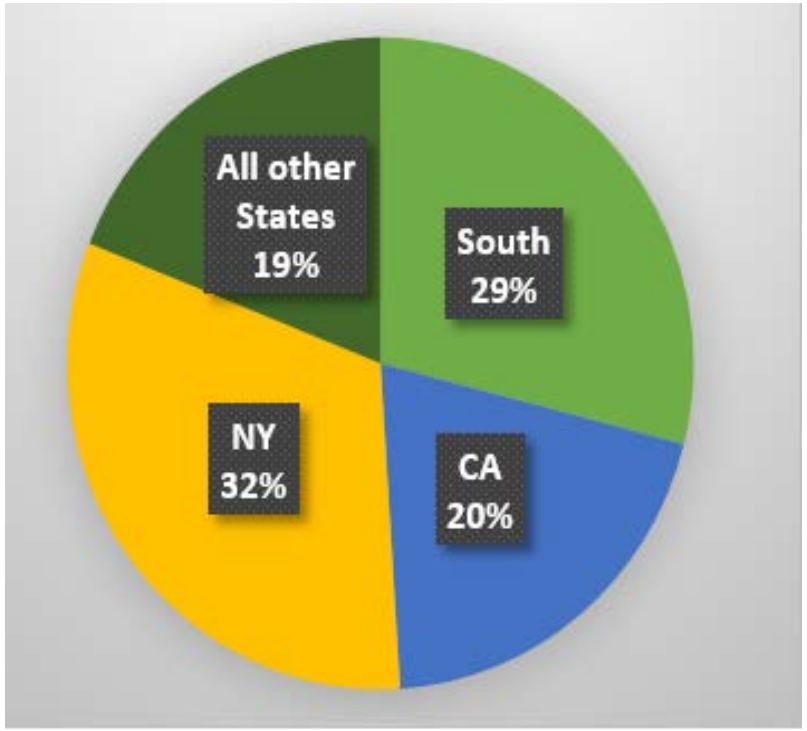
Part B Grantees	FY 18 Final Part B Supplemental Awards	Change from FY 2017
Alabama	$ 12,335,911	$ 8,335,911
Arkansas	0	0
Delaware	0	0
District of Columbia	Not Eligible in 2018	0
Florida	$ 20,900,239	$ 20,900,239
Georgia	$ 2,060,818	$ 1,360,818
Kentucky	0	0
Louisiana	0	0
Maryland	0	0
Mississippi	$ 3,510,443	$ (2,864,557)
North Carolina	$ 2,612,392	$ (4,687,608)
Oklahoma	0	0
South Carolina	$ 12,038,386	$ 12,038,386
Tennessee	0	0
Texas	$ 1,884,208	$ (915,792)
Virginia	0	0
West Virginia	0	0
TOTAL – South	$ 55,342,397	$ 34,167,397
Percent of Total – South	**33%**	
California	$ 23,765,871	$ (11,234,129)
New York	$ 26,333,142	$ (8,666,858)
TOTAL – CA and NY	$ 45,586,122	$ (19,900,987)
Percent of Total (CA)	**14%**	
Percent of Total (NY)	**16%**	

Ryan White Part B Supplemental Funding Distribution: 2016

US % of People Living with HIV--2016

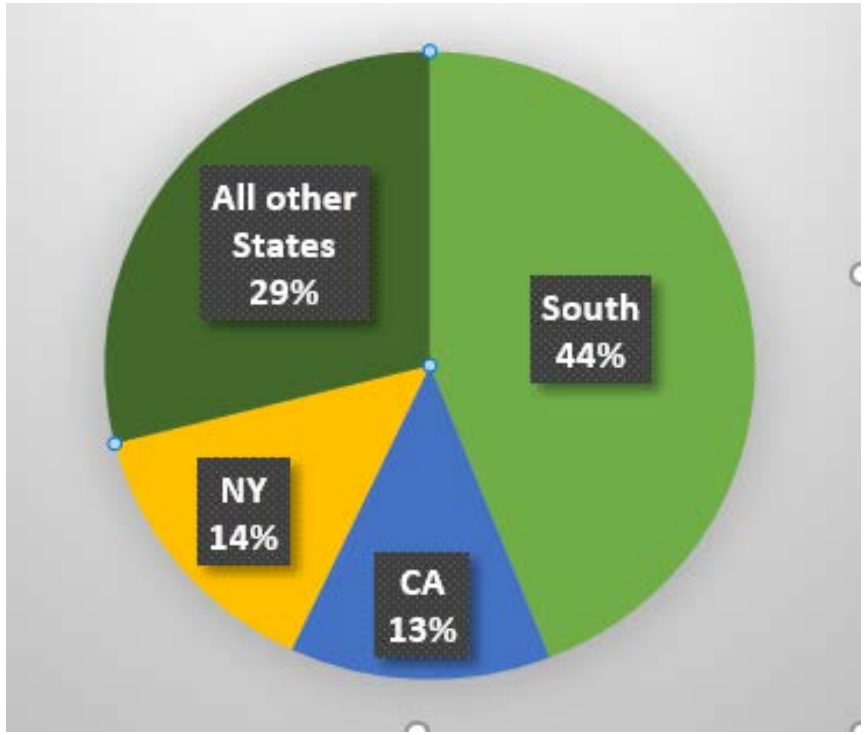


FY 2016 Ryan White Part B Supp. Funding Distribution

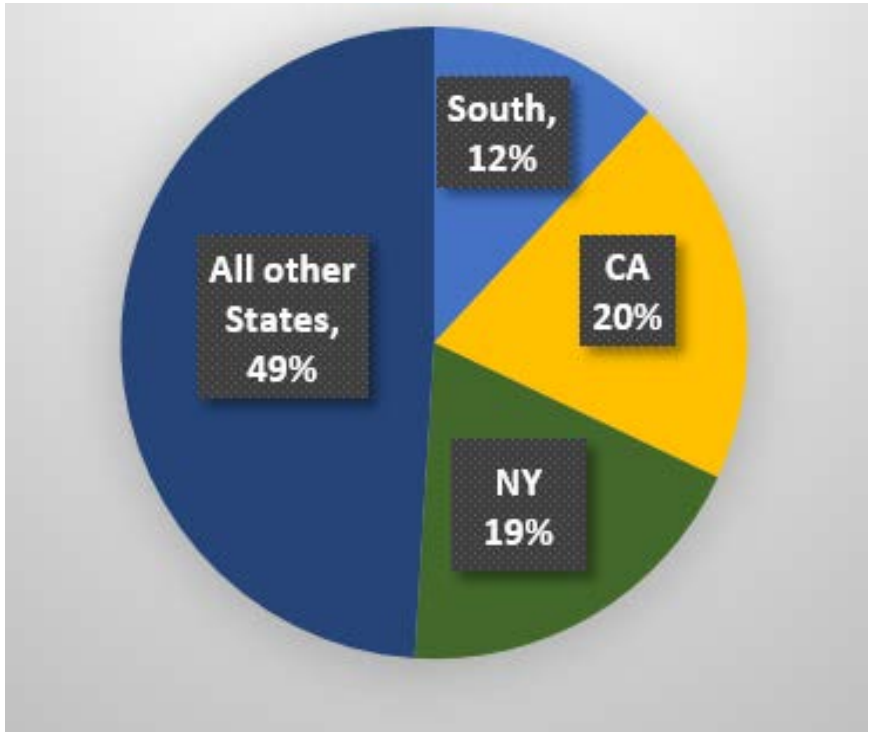


Ryan White Part B Supplemental Funding Distribution: 2017

US % of People Living with HIV--2016

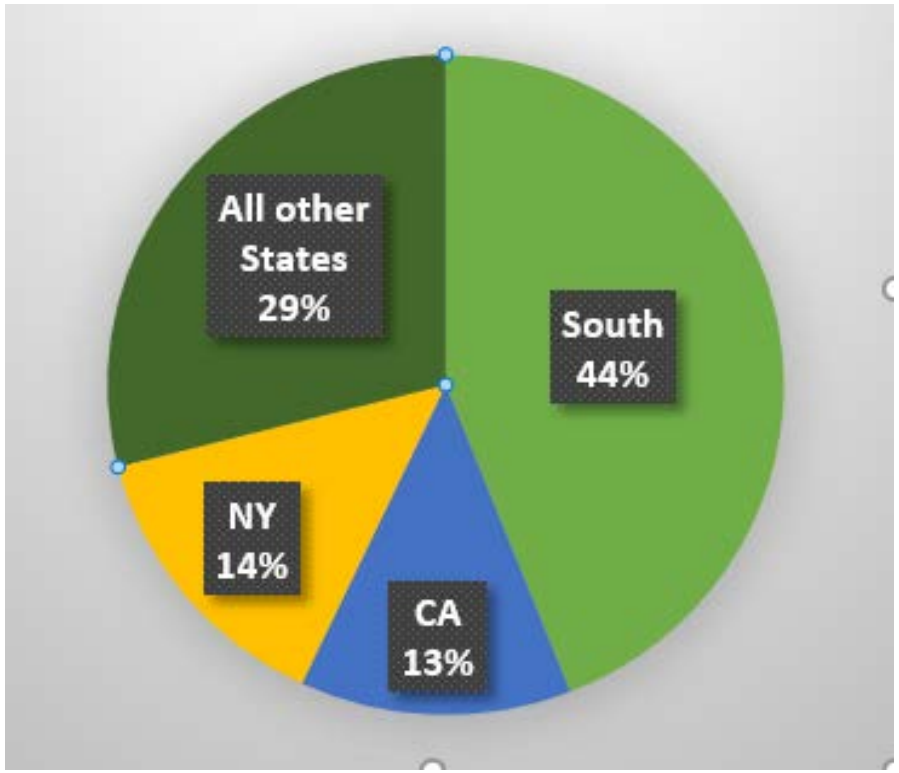


FY 2017 Ryan White Part B Supp. Funding Distribution

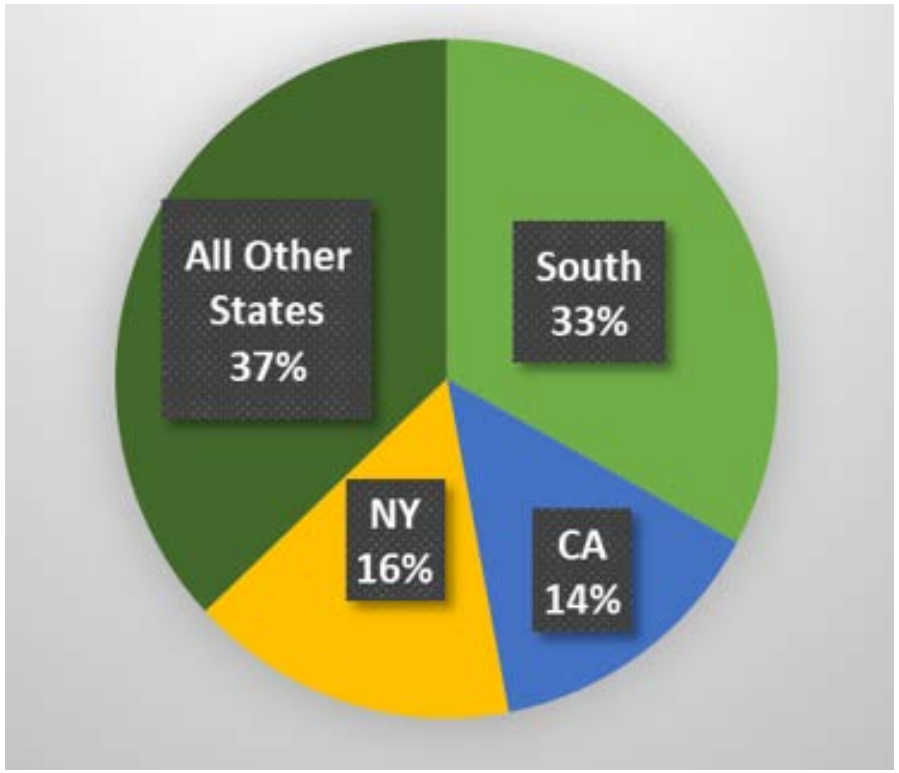


Ryan White Part B Supplemental Funding Distribution: 2018

US % of People Living with HIV--2016



FY 2018 Ryan White Part B Supp. Funding Distribution



Thank you!

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Presentation available online at:
https://bit.ly/2CwoPiI

The AIDS Institute complete funding analysis available at:
https://bit.ly/2N1GNP2

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2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

2018 NATIONAL 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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