Ensuring Ryan White HIV/AIDS Program Funding Aligns with Needs

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The AIDS Institute
How Can Funding Align More 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

- Change Law through Reauthorization Process
  - 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

• 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
- Not all states apply
- Not all states eligible due to unobligated funds
Part B Supplemental Awards: 2014

• 27 states applied for and received funding in 2014
  • AL did not apply nor did other states in need
• Highest awards:
  • NY: $12.2 million or 27 percent of the total
  • FL: $7.6 million or 17 percent of the total
  • TX: $3.5 million or 8 percent of the total
• Question grant award criteria
  • Community letters to HRSA
  • Is the funding going to where it is needed?
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
- After grant score, HRSA runs through formula
  - Why? Not in the law
  - Opportunity to reexamine current practices
Part B Supplemental Awards: 2016

• AL, AR, NH, MA, WA, Northern Mariana Islands & American Samoa not eligible in 2016
• Concerted effort to encourage states to apply
• Available funding: $167 million
  • Cap award at $30 million
  • How was that number developed?
• Awards will be announced in September
• Opportunities for further review
  • Funding pool may continue to grow
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
  • HRSA must 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

• Both will be recompeted
  • Opportunity to review distribution of funding
ADAP Supplemental

• 5% set-aside for states demonstrating “severe need”
• $41.3 million to 16 states in 2015
  • In 2014 it was to 26 states
  • Highest Awards in 2015
    • TX: $18.2 million
    • GA: $9.5 million
• 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
    • Prescribed in law
ADAP Emergency Relief Funds

• Pool of money set aside for ADAP through appropriations
• $75 million to 17 states in 2015
• 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:
  • GA: $10.3 million
  • VA: $10.2 million
  • PR: $9.6 million
• Not included in Ryan White Program law; can be changed through appropriations or incorporated into law
The Future

• If we are going to meet the goals of the National HIV/AIDS Strategy 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/AIDS community seem to support status quo
• Need leadership for change
  • Next Administration?
• Continue to encourage HRSA to examine current practices and look towards improvements
• Impact of 340B funding
• Change eventually needs to occur
  • If we don’t come up with proposals, decisions will be made for us
Thank you!

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