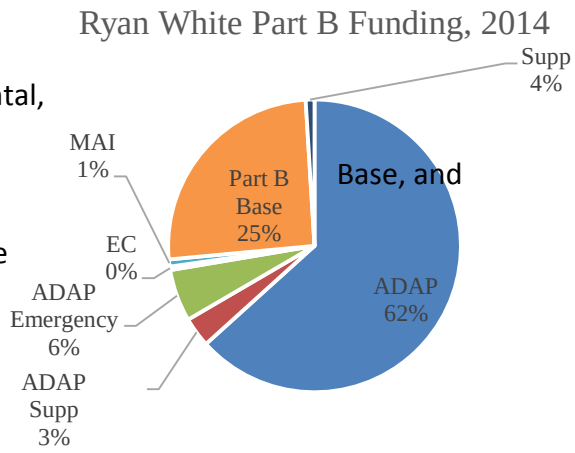
February 2015 **SASI CALL TO ACTION**

Introduction: The nine-state Deep South region targeted by the Southern HIV/AIDS Strategy Initiative (SASI)[1] is one region in need of increased Ryan White Part B Supplemental funding to help address the significant HIV/AIDS burden and high death rates experienced by this region.

Ryan White Part B Overview: Part B allocates funding to all 50 states, DC, Puerto Rico, and other US jurisdictions to fight HIV, whereas Part A allocates funding to metropolitan areas.

- Part B is comprised of multiple components: AIDS Drug Assistance Program (ADAP), ADAP Supplemental, ADAP Emergency Funding, Emerging Communities (EC) Grants, Minority AIDS Initiative (MAI), Part B Part B Part B Supplemental.
- Part B Supplemental is particularly important to the South and other areas that have serious epidemics but fewer metropolitan areas that receive Part A.



Ryan White Part B Supplemental: Ryan White Part B Supplemental funds are required to be distributed based on "demonstrated need" among eligible states.[2] "Demonstrated need" is a 10-factor test[3] including factor 9 which is "[t]he relevant factors that limit access to health care,

[1] AL, FL, GA, LA, MS, NC, SC, TN, TX.
[2] 42 U.S.C. § 300ff-29a.
[3] The full 10-factor test for "demonstrated need," paraphrased from the statute and HRSA's Part B Webinar, is:
(1) The "unmet need" for HIV-related services, as determined through a community input process. "Unmet ~~ne~~ need" refers specifically to unmet need for primary health care among people who know their HIV status but are not receiving HIV-related primary health care (Ryan White Part B Program Manual, pg. 150).
(2) An increasing need for HIV/AIDS-related services, including relative rates of increase in the number of cases of HIV/AIDS.
(3) The relative rates of increase within new or emerging subpopulations.
(4) The current prevalence of HIV/AIDS.
(5) Relevant factors related to the cost and complexity of delivering health care to individuals with HIV/AIDS in an area.
(6) The impact of co-morbid factors, including co-occurring conditions.
(7) The prevalence of homelessness.
(8) The prevalence of individuals who were released from federal, state or local prisons during the preceding three years, and had HIV/AIDS on the date of their release.

including geographic variation, adequacy of health insurance coverage and language barriers." Part B and Part B Supplemental are funded and distributed according to criteria described below.

	Distributed according to:	**2014 funding:**[4]
Part B Base	a formula based 75% on the state's proportion of living HIV/AIDS cases, with the remaining 25% to partially adjust for HIV/AIDS cases outside Part A funded areas (42 U.S.C. § 300ff–28(a)(2)(A)-(B))	$313.7 million
Part B Supplemental is funded with 1/3rd of the excess above 2006 appropriations for non-ADAP Part B funds (§ 300ff-31b(b)(2))	grants based on "**demonstrated need**" among eligible states, with priority to states with a **decline in funding** due to Part B formula changes (§ 300ff–29a(a)-(c))	$44.5 million

In 2014 and previously, HRSA conducted a competitive grant process for Ryan White Part B non-ADAP Supplemental Funding. Grant proposals are scored by an Objective Review Committee (ORC). Awards are then made based on a formula using the ORC score and the number of living HIV/AIDS cases in the state.

Significant HIV Burden faced by Targeted Deep South States: SASI's research team, in collaboration with authors from the Centers for Disease Control, recently published new research about the HIV burden and outcomes in nine Deep South states, including death rates[5] and 5-year survival[6] among persons living with HIV and AIDS in the targeted states region.[7] **Researchers found that HIV positive people in the targeted states are dying at faster rates than in any other region of the country.** Twenty-seven percent of persons diagnosed with AIDS in the 9-state region had died within 5 years of diagnosis. In Louisiana, one-third of persons diagnosed with AIDS and 19% of those diagnosed with HIV had died within 5 years.

The death rate among persons living with HIV was higher in the targeted states than in any other US region, even after adjusting for age, sex, transmission category, and area population

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(9) The relevant factors that limit access to health care including geographic variation, adequacy of health insurance coverage, and language barriers.
(10) The impact of a decline in the amount received in formula funding on services available to all individuals with HIV/AIDS identified and eligible under the title.
Note: Part A Supplemental uses the same test for demonstrated need (§ 300ff–13(b)(2)(A)).
[4] http://www.hrsa.gov/about/news/2014tables/ryanwhite/partb.html
[5] *See* Appendix 2.
[6] *See* Appendix 3.
[7] *HIV Diagnoses, Prevalence and Outcomes in Nine Southern States,* Reif, Pence, Hall, Hu, Whetten & Wilson, Journal of Community Health, 19 Dec. 2014, DOI: 10.1007/s10900-014-9979-7, www.southernaidsstrategy.org.

size. Living outside a large urban area at diagnosis significantly predicted greater death rates among persons living with HIV in the 9-state region, suggesting "..a disconnect between diagnosis and maintenance of HIV care in this region…"[8]

In 2011, 38% of those diagnosed with HIV in the United States lived in the 9-state Deep South region. This region also has the highest number of persons living with HIV of any region in the US. More people diagnosed in this region are black/African American, female and aged 13-24 than in other US regions, and a higher percentage reported heterosexual contact as the transmission category.[9] Living in the rural and suburban areas of the Deep South at the time of diagnosis significantly predicted higher death rates among persons living with HIV in the Deep South region when compared to urban residence. The Deep South Region also has high rates of uninsured compared to the US average.[10]

Identifying effective prevention and care services to address common barriers to care such as geographic access and pervasive stigma is critical to improving HIV outcomes in the Deep South region.

Impact of State Decisions on Medicaid Expansion[11]: In 2015, adequacy of insurance will become more important than ever to people living with HIV.

- *In states that expand Medicaid*, whole new classes of people with HIV will gain coverage, allowing use of Ryan White dollars for other services that identify people with HIV, keep them in care, enable them to live healthy, productive lives, and prevent transmission of HIV.
- *In states that do not expand Medicaid*, some of the lowest-income people with HIV will be left out, risking even higher death rates and lower survival rates for HIV positive persons.

Call to Action: If we are to achieve the goals of the National HIV/AIDS Strategy, federal and state public health officials and policy makers must focus attention and resources on this 9-state region where HIV diagnosis rates are highest, uninsured rates are highest, and more people are living and dying with HIV. SASI's research findings give us a deeper understanding of the dire consequences that having an HIV diagnosis in the Deep South has for too many. Without appropriate care, HIV is still deadly. Increasing Part B funds, placing special emphasis on factors that limit access to health care, and studying the current utilization of funds can help provide needed services for people with HIV in a post-health-reform world.

[8] *Id.*
[9] *Id.*
[10] http://kff.org/other/state-indicator/total-population/
[11] *See* Appendix 3

SASI calls on:

1. HRSA to re-examine how Ryan White Part B Supplemental funding is being allocated to ensure that funds are given to states where the need is greatest in order to improve health outcomes..
2. HRSA to take into account when distributing Ryan White Part B Supplemental funds the demonstrated need as evidenced by high HIV incidence and prevalence, high uninsured rates, high death rates and low 5-year survival rates among persons living with HIV in the targeted Southern region.

Appendix 1: Survival for more than 60 months after a diagnosis of AIDS or a diagnosis of HIV infection, adults and adolescents (Aged 13 years or over) diagnosed in 2003-2004 in selected Southern States and other United States Regions.[12]

Percent of those diagnosed with HIV who died within 5 years of diagnosis	
United States	14%
Targeted States Region[13]	15%
Individual Targeted States (in order of severity)	
Louisiana	19%
Mississippi	17%
South Carolina	16%
Florida	15%
North Carolina	15%
Tennessee	15%
Alabama	14%
Georgia	14%
Texas	13%

Percent of those diagnosed with AIDS who died within 5 years of diagnosis	
United States	23%
Targeted States Region[14]	27%
Individual Targeted States (in order of severity)	
Louisiana	33%
Mississippi	32%
Alabama	31%
Florida	28%
Tennessee	28%
South Carolina	27%
North Carolina	26%
Georgia	25%
Texas	24%

[12] Data taken from Table 3, *HIV Diagnoses, Prevalence and Outcomes in Nine Southern States,* Reif, Pence, Hall, Hu, Whetten & Wilson, Journal of Community Health, 19 Dec. 2014, DOI: 10.1007/s10900-014-9979-7, www.southernaidsstrategy.org.

[13] AL, FL, GA, LA, MS, NC, SC, TN, TX.

[14] AL, FL, GA, LA, MS, NC, SC, TN, TX.

Appendix 2: Death rate among persons living with HIV, unadjusted and adjusted by United States region and by specific characteristics within selected Southern States, 2010[15]

	Unadjusted rate Rate of deaths 2010 (among 1,000 PLWH and new diagnoses during 2010)	Adjusted rate[16] Rate of deaths 2010 (among 1,000 PLWH and new diagnoses during 2010)
United States	24.0	
Region of residence		
Northeast	24.7	22.3
Midwest	20.7	22.5
South	26.7	28.0
Targeted states[17]	27.3	29.0
West	18.8	21.2
State of residence	(in order of severity)	
Louisiana	34.5	
Alabama	30.7	
South Carolina	29.6	
Florida	29.1	
Mississippi	28.6	
Georgia	28.4	
North Carolina	25.6	
Tennessee	25.0	
Texas	22.2	

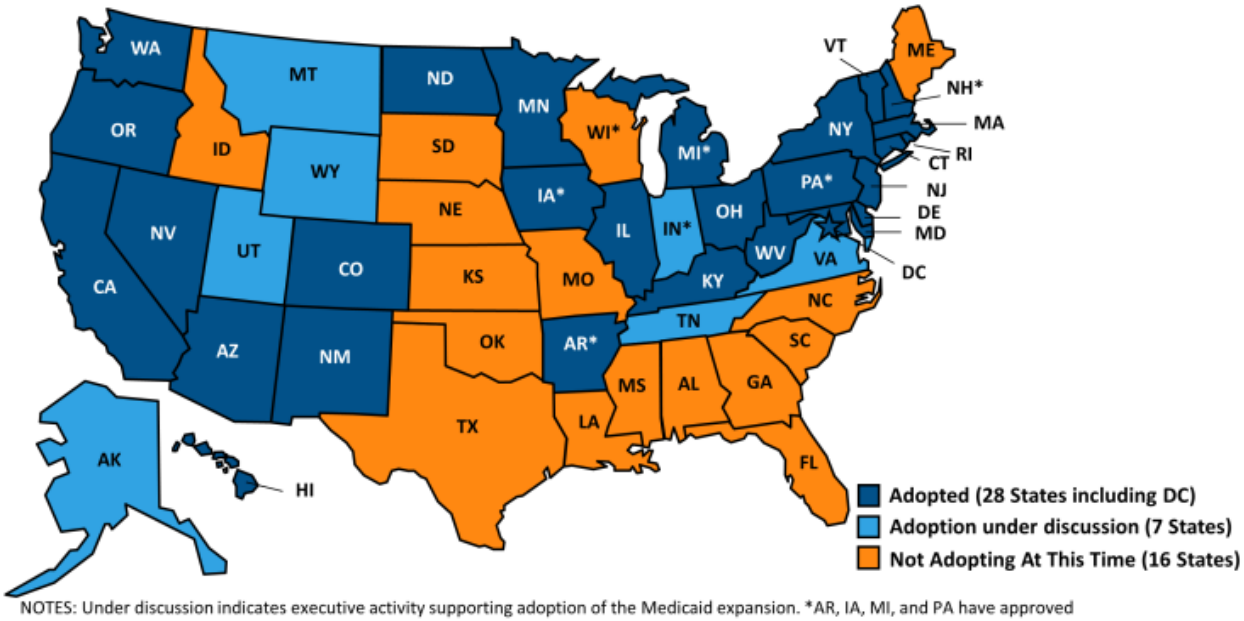
[15] Data taken from Table 4, *HIV Diagnoses, Prevalence and Outcomes in Nine Southern States,* Reif, Pence, Hall, Hu, Whetten & Wilson, Journal of Community Health, 19 Dec. 2014, DOI: 10.1007/s10900-014-9979-7, www.southernaidsstrategy.org.

[16] Adjusted for age, race/ethnicity, sex, transmission category, residence at diagnosis.

[17] AL, FL, GA, LA, MS, NC, SC, TN, TX.

Appendix 3: Where States stand on Medicaid Expansion

Current Status of State Medicaid Expansion Decisions



NOTES: Under discussion indicates executive activity supporting adoption of the Medicaid expansion. *AR, IA, MI, and PA have approved Section 1115 waivers; IN has a pending waiver to implement the expansion. The PA waiver is set to go into effect on January 1, 2015, but the newly-elected governor may opt for a state plan amendment. NH has submitted a waiver to continue their expansion via premium assistance. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated December 17, 2014.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

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