



Planning for Change RWTMA 2006

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1



Overview

- Changes to the law will require decisions to be made
- We are at the cusp of something new. What is it and what does it look like?

2



More Overview

- Historical changes in Ryan White CARE Act and medical care
- Provisions of RWTMA 2006
- Where are we now
- Discussion

3



1981 to mid 1990s

- Pre CARE Act limited funding, RWJF "AIDS Health Services Program" 1986
- AZT approved 1987, ACT-UP
- RWCA Signed 1990
- HOPWA 1991
- CARE Act 1990 - 1995 bought a lot of medical care, ancillary focused on palliative, permanency planning
- ASOs starting up and growing, becoming more prevalent

4



Mid 1990s to early 2000s

- ART/HAART becoming available 1995 - first protease inhibitor
- 1996 first NNRTI and first test for VL approved
- First reauthorization of RWCA in 1996, added AETC, WICY, ADAP
- 1997 - deaths decline 40% from previous year largely to HAART
- Palliative and end of life services loose focus and funding, other ancillary more important (food and transportation)

5



mid 90s - early 2000s cont'd.

- Second reauthorization in 2000
- Many advancements in medical technology and medications
- Funding increases primarily geared toward ADAP, modest (if that) increases in base and supplemental awards (non-ADAP)
- Medical inflation greater than general index
- 16% of GDP spent on medical care in general

6



Mid 2000s to present

- Last FY cycle, TX RWII base reduced
- DSHS and AAs absorbed cuts in T II
- RW II required to spend 75% in core 6
- Cost of medical care increasing, number of clients increasing, funds decreasing, resulting in reduced amounts available for ancillary

7



Core 6 Services

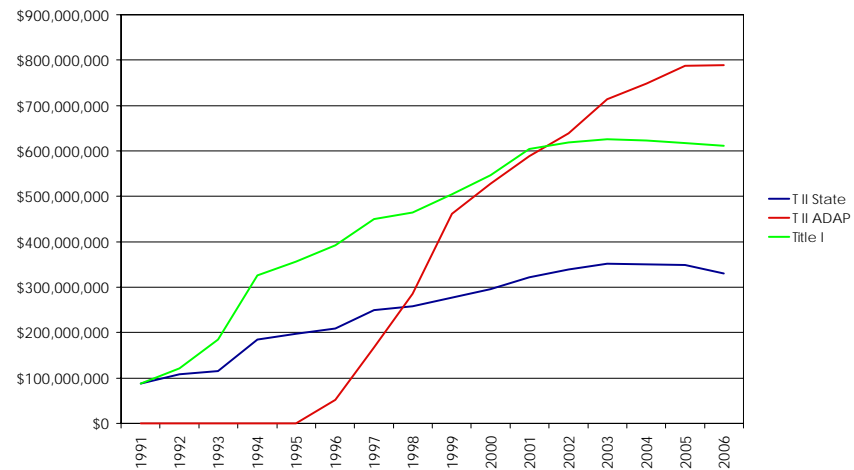
- Ambulatory / Outpatient Medical Care
- Drug Reimbursement
- Case Management
- Oral Health Care
- Substance Abuse Treatment
- Mental Health Services

8

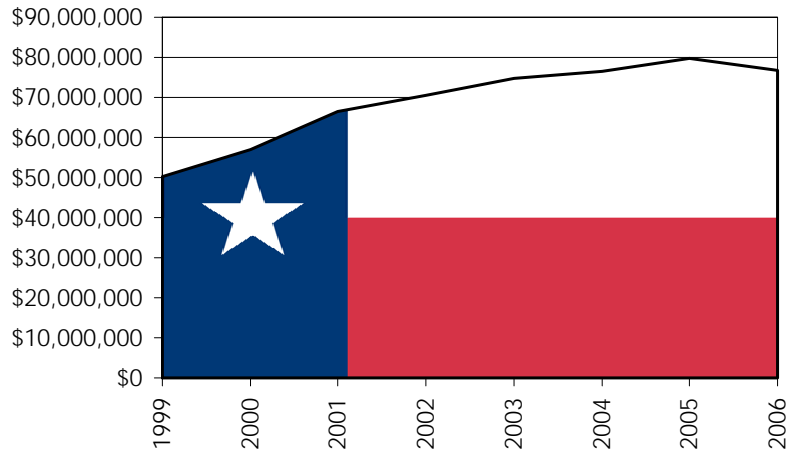
Mid 2000s to present cont'd.

- Planners' response to adjust for reductions - thresholds: guided tough decisions
- Incorporated contingency plans

U.S. T I, II, and ADAP

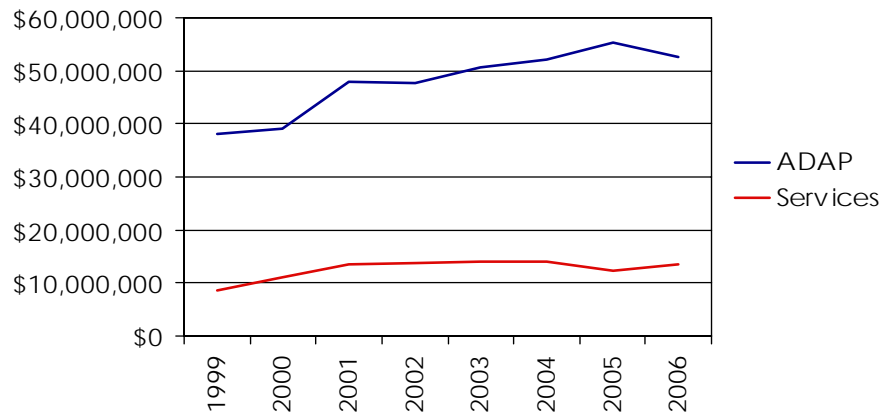


Texas T II overall



11

TX T II and ADAP



12



RWTMA 2006

- RWCA expired September 2005
- Reauthorization was technically not necessary
- Provisions of RWTMA 2006
 - 75% core medical RW I & II
 - MCM only type of CM under core medical
 - Waiver if certain conditions met

13



Core Medical Services

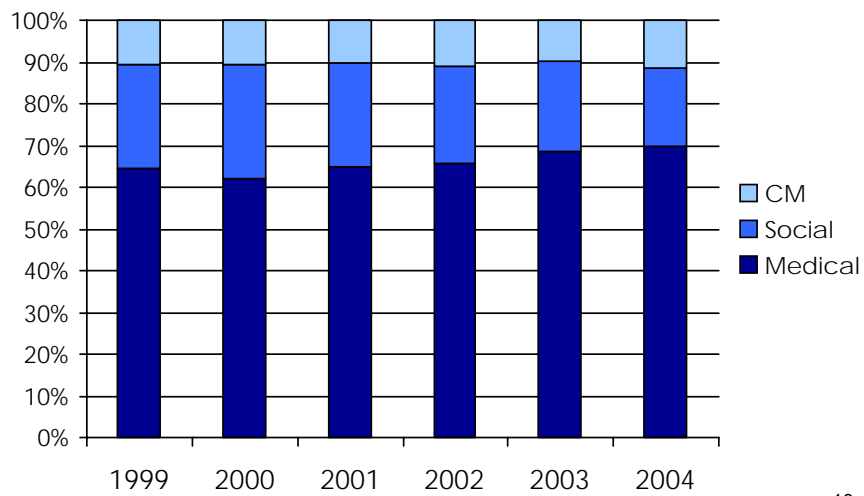
- AOMC
- ADAP & Drug Reimbursement
- Oral Health
- EIS (as described in bill)
- Health Insurance continuation
- Home Health
- Medical Nutrition Therapy
- Hospice
- Home and community based health services (as defined in bill)
- Mental Health
- Substance abuse treatment (outpatient)
- Medical Case Management, including treatment adherence

HR.6143

14

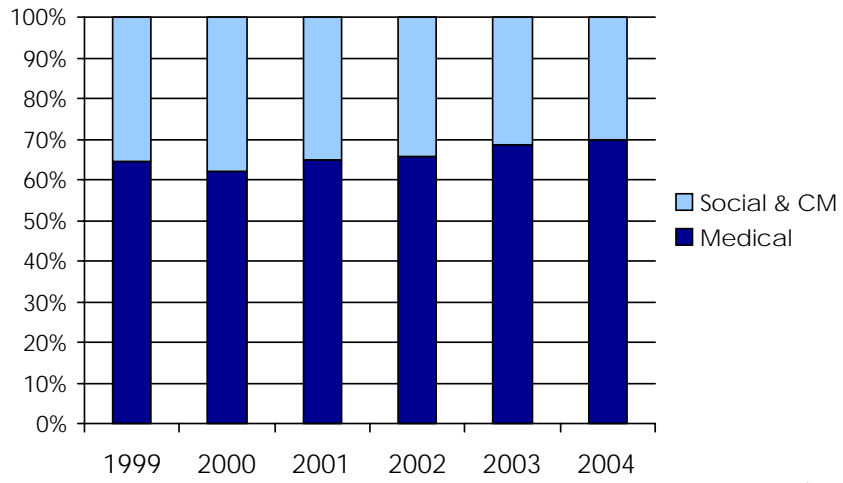
How do we fare now that
75% of funds must be spent in
core medical services?

TX T I



HRSA - All TX EMAs combined

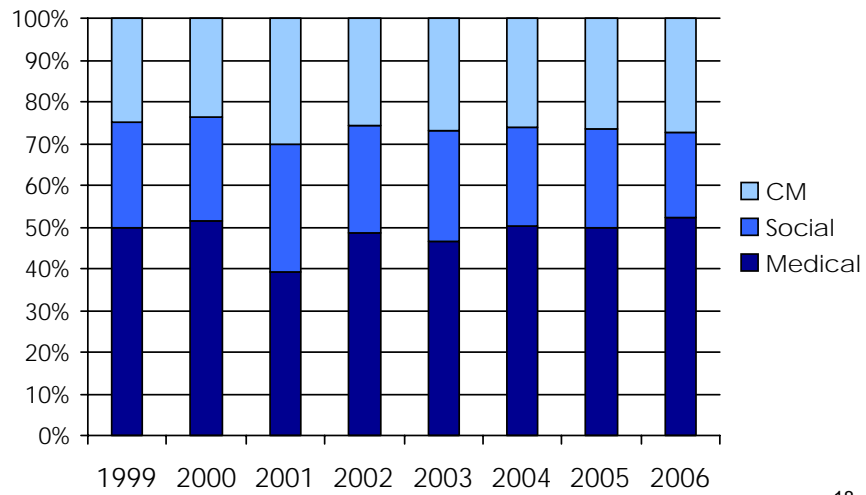
TX T I cont'd.



HRSA - All TX EMAs combined

17

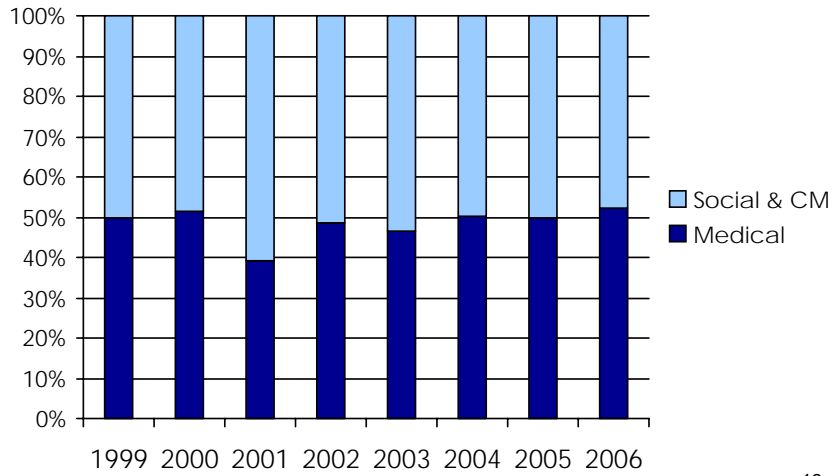
TX T II



HRSA

18

TX T II cont'd.

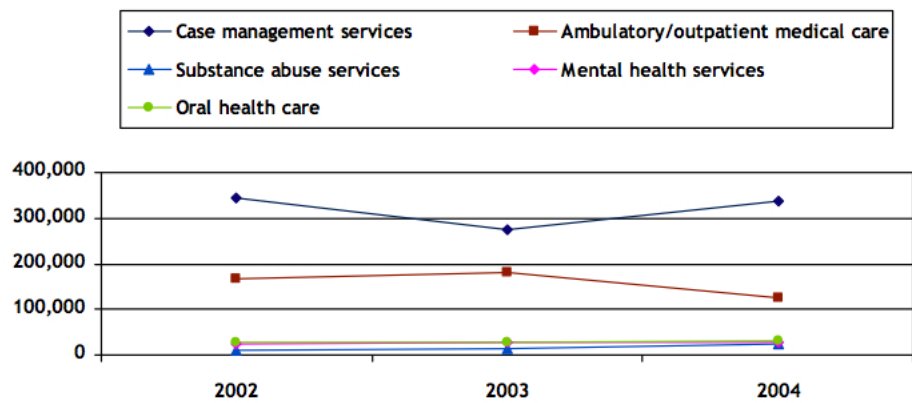


HRSA

19

Care System Built on CM

NUMBER OF VISITS FOR KEY SERVICES⁵



HRSA: State Profile - Ryan White CARE Act - Texas 2006 ed.

20



Care system cont'd.

Number of Service Agencies / Organizations
by Services Provided

| | |
|--------------------------------------|----|
| Case Management | 80 |
| Transportation | 53 |
| Ambulatory / Outpatient Medical Care | 52 |
| Food Bank / Home Delivered Meals | 46 |
| Mental Health Services | 44 |
| Housing Services | 41 |
| Client Advocacy | 36 |
| Oral Health | 35 |

HRSA: State Profile - Ryan White CARE Act - Texas 2006 ed.

21



What do we know?

- The CARE Act has always been about medical care
- It has responded to change in the health care and medical environment
- Generally speaking, we have been able to adjust and handle comparatively small changes
- We know what the goal is with this reauthorization
- We know we have a system based on Case Management, primarily social CM
- Ancillary or social services are being squeezed by medical services and case management

22



CENTRAL TEXAS HIV PLANNING

Threat Down

- 75% Core Medical
- No Social CM in core medical
- A system, particularly in suburban and rural areas, built on SCM
- We have a way to go before meeting the 75% requirement

24

Precipice

- We have been able to maintain
- We are on the edge of something new
- Two choices
 - Try to maintain
 - Change

25

Planning for the future

- Planners are taking these changes into consideration
- Examining all aspects of our care delivery models
 - Do some pieces need tweaks while others need major change?

26

Recap

- Changes to the CARE Act that got us here
- The legislation and its changes
- Where we are now with our care systems
- Questions for the future

27

Discussion

- Can we still make incremental changes or do they need to be larger in scale?
- What role does vertical integration play?
- From a consumer/client perspective, what changes could be made to maintain or enhance the delivery model?
- Is dramatic change imminent or inevitable?
- What if RWTMA 2006 was not an issue, should there be a change?

28



Additional Resources

- <http://hiv.bvcog.org>
- <http://www.nap.edu>
 - Measuring What Matters: Allocation, Planning, and Quality Assessment for the Ryan White CARE ACT
 - Public Financing and Delivery of HIV/AIDS Care: Securing the Legacy of Ryan White
- <http://www.gao.gov>
 - GAO-05-841T "Ryan White CARE Act - Factors that Impact HIV and AIDS Funding and Client Coverage" 6.23.05
 - GAO-06-332 "HIV/AIDS: Changes Needed to Improve the Distribution of Ryan White CARE Act and Housing Funds" 2.28.06
 - GAO-06-646 "Ryan White CARE Act: Improved Oversight Needed to Ensure ADAPs Obtain Best Prices for Drugs" 04.26.06
 - GAO-06-703T "Ryan White CARE Act: Changes Needed to Improve the Distribution of Funding" 4.27.06
- <http://thomas.loc.gov>
 - House Report 109-695
 - HR.6143
 - S.2823
- <http://hab.hrsa.gov>