The Ryan White HIV Drug Assistance Program:
A Vital Part of Ohio’s Public Health Infrastructure

By Jon Honeck, Ph.D., Fellow & Director, Public Policy & Advocacy
Tara Dolansky, M.P.A., Public Policy & Planning Assistant
The Center for Community Solutions

Highlights
The Ohio Department of Health (ODH) and the federal government jointly fund Part B of the Ryan White Program to help low-income individuals receive care for HIV/AIDS. ODH contracts with nonprofit organizations to provide case management and referral services to HIV+ individuals. The core medical service offered through Ryan White Part B is access to antiretroviral drugs paid by the Ohio HIV Drug Assistance Program (OHDAP).

- Over 16,000 Ohioans are diagnosed as living with HIV/AIDS and it is likely that there are an additional 5,000 or more who are undiagnosed. Over 1,500 new cases are diagnosed each year.

- State General Revenue Fund (GRF) dollars in the ODH budget for Part B of the Ryan White program ($5.8 million per year) are lower than they were a decade ago and are only about half of what is needed to meet federal spending requirements. The state relies on a “paper match” of AIDS-related spending from agencies other than ODH to meet federal match requirements. Paper match dollars are not available to fund Ryan White services. ODH is partially compensating by more aggressively seeking rebates from pharmaceutical manufacturers.

- ODH program managers instituted a waiting list for OHDAP in July, 2010, due to a financial crisis. The list grew to nearly 500 individuals by the end of the fiscal year. ODH revised its policies at the beginning of the new fiscal year, however, and had effectively cleared the waiting list by the end of September, 2011. ODH intends to stabilize OHDAP monthly enrollment at about 3,700 individuals during FY 2012, a level that the department believes is financially sustainable in the short-term, but not necessarily for FY 2013.
The temporary suspension of the waiting list in FY 2012 is made possible in part by high turnover on the program. When the waiting list was in place, 55 percent of individuals on the waiting list had previously been on the program. Each month approximately 591 clients re-enrolled, but another 96 individuals who were expected to re-enroll, did not. ODH is working with case managers, providers, and advocates to improve the re-enrollment process.

The current inadequate funding path contributes to a growing public health crisis. State investment in this program is a vital part of Ohio’s public health infrastructure, and it should be given top priority in the budget process.

Overview
There were 16,400 people diagnosed as living with HIV/AIDS in the state of Ohio as of December, 2009. An additional 5,000 or more Ohioans may be living with HIV/AIDS but are undiagnosed. Some of these individuals have access to private health insurance, but many do not, and must access publicly funded benefits. Nationally, Medicaid is the primary means of health care coverage for individuals with advanced AIDS because they can qualify on the basis of a permanent disability. Childless adults who are HIV+, however, do not qualify for Medicaid on that basis alone. For these individuals, the Ryan White HIV/AIDS program, a federal program that is administered by the Ohio Department of Health (ODH), provides limited health insurance coverage.

The Ohio HIV Drug Assistance Program (OHDAP) is the largest part of the Ryan White Part B program. OHDAP coverage provides access to anti-retroviral medications and some medical services. OHDAP can act as the primary insurer or provide secondary coverage by paying premiums or co-pays required under other private or public plans.

States are required to match 50 percent of federal funds with their own resources for Ryan White Part B. Even though the number of Ohioans living with HIV/AIDS increases every year, state General Revenue Fund (GRF) resources have not kept pace. The state has resorted to using a “paper match” to meet part of its obligation. The paper match counts funds spent by other agencies for HIV/AIDS-related services, but these funds do not actually support the Ryan White program.

Problems with Ryan White program funding are occurring even as important advances in HIV/AIDS treatment and prevention can significantly lower the rate of disease transmission and death. With proper investments in this vital program and related public health interventions, Ohio can make major strides in slowing the spread of HIV and keeping people with HIV/AIDS healthy, employed, and contributing to the community. The current inadequate funding path, however, contributes to a growing public health crisis. This report explains the major challenges facing the OHDAP program and its evolution over the last year.
The Ryan White HIV/AIDS Program
The Ryan White HIV/AIDS Program was established through the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 as a payor of last resort for HIV/AIDS patients seeking care, medication, and support services for their disease. The program covers treatment costs, medical case management, and co-pays and insurance premiums for uninsured or underinsured low-income individuals. The federal authorizing legislation has been amended and reauthorized four times since 1990. The most recent reauthorization (Ryan White HIV/AIDS Treatment Extension Act of 2009) lasts through federal fiscal year 2013. The Ryan White program is administered by the Health Resources and Services Administration (HRSA) within the U.S. Department of Health and Human Services. Funds for this program are distributed to cities, states, providers, and community-based organizations.

The program provides grants to Ohio in multiple categories, as shown in Table 1. Parts A and B comprise the vast majority of spending. In federal fiscal year 2011, Part A will receive $4.4 million in federal support, and Part B will receive $25.1 million.4

Table 1: Federal Grant Categories5

<table>
<thead>
<tr>
<th>Part A – Transitional Grant Area</th>
<th>Six Counties in Greater Cleveland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part B – Base and AIDS Drug Assistance Program Earmark</td>
<td>Statewide program administered by Ohio Department of Health</td>
</tr>
<tr>
<td>Part C – Early Intervention Services, Planning and Capacity Development Grants</td>
<td>Grants given directly to service providers for early intervention and ambulatory care</td>
</tr>
<tr>
<td>Part D- Services for Women, Infants, Youth and Families</td>
<td>Grants given directly to service providers for primary outpatient and ambulatory care</td>
</tr>
</tbody>
</table>

Source: HRSA, HIV/AIDS Programs

Seventy-five percent or more of the grants must be spent on core medical services (this requirement applies to Parts A through C). Core medical services include outpatient and ambulatory care, provision of HIV/AIDS medications, mental health services, hospice care, home- and community-based health services, oral health, early intervention services, nutrition services, outpatient substance abuse treatment, and medical case management. Twenty-five percent or less of the funds are spent on support services that must link to medical outcomes. Under federal law, support services can include linguistic services, transportation, respite care for caregivers, referrals, inpatient substance abuse treatment, and other case management. In Ohio, the Part B program no longer provides any non-medical services such as housing or transportation. Limited oral health services are being restored after being suspended in FY 2011.

Part A of the Ryan White program provides grants to Eligible Metropolitan Areas and Transitional Grant Areas (EMAs/TGAs). These are areas that have a population disproportionately affected by HIV/AIDS. To qualify for an EMA designation, “an area must have reported at least 2,000 AIDS cases in the most recent 5 years and have a population of at
least 50,000” and to qualify for TGA designation “an area must have reported 1,000 to 1,999 new AIDS cases in the most recent 5 years and have a population of at least 50,000.” The only region in Ohio that qualifies for Part A is the Cleveland Regional TGA, covering Ashtabula, Cuyahoga, Geauga, Lake, Lorain, and Medina counties. Cuyahoga County is the grantee that administers Part A funds in the Cleveland Regional TGA under the guidance of a Ryan White Part A Planning Council. Additionally, the AIDS Funding Collaborative (AFC), which is housed at The Center for Community Solutions, provides a mechanism for coordinating public and private funding efforts in Greater Cleveland.

Part C of the Ryan White program makes grants directly to providers for services. These grants are generally designated to ambulatory medical clinics to provide early intervention services and ambulatory care. Part C also provides planning grants to more effectively provide and deliver care for HIV/AIDS. An additional component of Part C is a capacity development fund that helps grantees “to develop, strengthen, and expand” access to quality care for people in underserved or rural communities and communities of color with or at risk of getting HIV/AIDS.

The largest portion of the Ryan White program, the Part B program, provides grants to states that include the base grant, the AIDS Drug Assistance Program (ADAP) award, ADAP supplemental grants, grants to states for Emerging Communities, and a Minority AIDS Initiative Award. The amount provided to a state is based on the number of people living with HIV and AIDS in the state. The Ohio Department of Health (ODH) administers the Part B program for Ohio. Case management occurs through 12 grantee organizations, and includes treatment adherence as well as referrals to relevant providers. The Part B formula is weighted to reflect the presence of the Cleveland TGA, but it is important to note that the ADAP program is available statewide.

The AIDS Drug Assistance Program is the core component of the Part B program, called the Ohio HIV Drug Assistance Program (OHDAP) in Ohio. Federal funds are specifically designated for ADAPs. ADAPs provide medication for the treatment of HIV/AIDS to qualifying individuals. ADAP funds can also be used to purchase health insurance through existing private coverage, including COBRA for individuals who are laid off, to provide co-pays through Medicare or Medicaid, and for programs that promote adherence and access to drug treatment plans. A client can receive more than one of these services at the same time.

**Public Sector Support for the Ryan White Program**

If a state reports having more than 1 percent of the total AIDS cases in the U.S. for the past two years, then the state must provide matching funds based on a formula outlined in the enacting legislation. Currently, Ohio must match every $2 of federal funds with $1 of state funds. The maintenance of effort (MOE) requires that the state contribute at least the same amount of state funds for HIV/AIDS-related activities as in the previous fiscal year. The state makes up the maintenance of effort with GRF dollars, as well as in-kind or prevention service funds from
other state agencies that provide some type of diagnosis or medical care related to HIV/AIDS. These funds are also referred to as a “paper match.” The Ohio Department of Rehabilitation and Corrections provides most of the state’s paper match. Paper match funds are not real dollars for the Part B program to use for program costs.

State spending for the Ryan White program peaked in state FY 2002 at $9.4 million and had declined to $5.4 million in FY 2011, representing a decline of over 40 percent (Figure 1). FY 2012-2013 appropriations are $5.8 million each year. Over the last decade, as ODH GRF funding has declined, the state has reported growing amounts of paper match to the federal government. Except for FY 2008, the paper match has exceeded GRF funding in recent years.

The federal government has provided between $21 million and $24 million per year to Ohio for Ryan White Part B. Just over $25 million will be disbursed in federal fiscal year 2011. A large increase above previous levels occurred in federal fiscal year 2007 due to the reauthorization of the Ryan White program in 2006, which changed the funding formula. Enhanced federal funding was made available to states that implemented (or already used) a name-based reporting system for HIV/AIDS cases rather than an estimate. Ohio had already implemented the name-based reporting system, hence the increased federal funding in 2007.

Figure 1. Public Sector Funding Streams for Ryan White Part B*

![Diagram showing public sector funding streams for Ryan White Part B from 2006 to 2010.]

Sources: HRSA Grantees 2000-2010, Ohio LSC Redbooks; Cleveland TGA information request.
* Federal funds are disbursed on a program year basis (April-March) which does not coincide with the state fiscal year of July – June.
According to federal requirements, there must be an identifiable line item in the state budget dedicated to HIV/AIDS prevention and treatment to meet maintenance of effort. The line item can include dedicated funds for ADAP, HIV treatment for inmates, HIV prevention, or the state share of Medicaid costs for HIV+ individuals, among other items. As discussed in its budget submission, ODH uses many of these items to meet the maintenance of effort. Despite the requirement that an identifiable line item for these items must exist in the state budget if they are to be used for maintenance of effort, there is only one identifiable line item in ODH’s budget entitled AIDS Prevention and Treatment. Other agencies that provide an HIV-related service have to report after-the-fact.

Crisis in the Ohio HIV Drug Assistance Program
The number of individuals living with HIV/AIDS grew from 7,504 in 1999 to 16,405 in 2009, a rise of 119 percent (Figure 2). Over 1,500 new cases were diagnosed in both 2008 and 2009. OHDAP client enrollment followed suit, rising from 2,071 in 2000 to nearly 4,700 in 2009 (Figure 3). This dramatic increase in caseloads was caused not only by the increased number of individuals living with HIV/AIDS, but rising unemployment and the consequent loss of health insurance coverage from the recession. Treatment costs also increased, including clinical trends toward more expensive drug therapies. Still, in June, 2010, OHDAP average monthly costs per client were 21 percent lower than the national average. These same pressures produced a crisis nationally and forced other states to make changes to their programs.

Figure 2. Number of Ohioans Living with HIV/AIDS Increases

Source: ODH HIV/AIDS Surveillance Program
Data in calendar years.
ODH was forced to make changes to OHDAP in July, 2010, because of a projected multi-million-dollar shortfall in the program’s budget.\textsuperscript{19} Program cuts included reducing income qualifications for OHDAP from 500 percent of the federal poverty level (FPL) to 300 percent, limiting the types of drugs available through the program, and establishing a waiting list.

These changes immediately resulted in 257 people becoming ineligible for services. Additionally, the recertification process was changed to match HRSA guidance to place more emphasis on six-month recertification, rather than with a complete recertification every 12 months.

Although much of the public attention has focused on the waiting list, reductions in other Part B services and to the drug formulary were also important. Drugs removed from the formulary include treatments for cardiac problems, diabetes, acid reflux, and diarrhea. Non-medical services that were eliminated include assistance for transportation, utilities, housing, and non-emergency dental services.\textsuperscript{20} Some of these changes are being reconsidered or reversed in FY 2012, as discussed below.

While HIV/AIDS patients may be able to piece together these kinds of assistance from other social service programs and free clinics, many of those programs also received cuts in their state and federal funding. In all, these cuts made successfully living with HIV/AIDS that much harder.

In September, 2010, then-Governor Ted Strickland designated $12.8 million in enhanced federal Medicaid matching funds to OHDAP. These funds were used to cover the program’s budget gap for current enrollees until the end of fiscal year 2011, but did not eliminate the waiting list.\textsuperscript{21}
One piece of the budget shortfall was $3.9 million in back payments that ODH owed to CVS Caremark, the pharmacy that provides HIV/AIDS medication for the OHDAP program.\textsuperscript{22}

The OHDAP program year runs from April to March. The decline in the number of clients in the most recent OHDAP program year ending April, 2011, is shown in Table 2. The number of unduplicated client enrollments fell by 14 percent, or 592 individuals. Even larger shifts occurred in the specific types of financial assistance that clients accessed (clients can be enrolled in more than one program). ODH made a determined effort to help clients access less expensive forms of payment, especially Medicare Part D. OHDAP payments can now be included in “True out of pocket payments” for Medicare Part D, which means clients move more quickly through the unreimbursed segment of expenses (the “doughnut hole”) in Part D plans, thereby lowering OHDAP cost-sharing. The change has led to $1.6 million in savings in the current program year.\textsuperscript{23}

On a percentage basis, the largest declines occurred in the more expensive COBRA Premium, Health Insurance Premium Program (HIPP) and HIPP co-pays, and the core OHDAP program in which the state pays required formulary costs with no assistance. Enrollment in the less expensive Medicare Part D premiums and co-pay programs were much more stable in comparison.

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<thead>
<tr>
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<tbody>
<tr>
<td>OHDAP Prime (Full pay)</td>
<td>2,345</td>
<td>1,326</td>
<td>-43%</td>
</tr>
<tr>
<td>HIPP Premium (private insurance)</td>
<td>312</td>
<td>261</td>
<td>-16%</td>
</tr>
<tr>
<td>COBRA Premium</td>
<td>176</td>
<td>48</td>
<td>-73%</td>
</tr>
<tr>
<td>Medicare Part D Premium</td>
<td>346</td>
<td>360</td>
<td>4%</td>
</tr>
<tr>
<td>Medicaid Monthly Spend down</td>
<td>139</td>
<td>121</td>
<td>-13%</td>
</tr>
<tr>
<td>HIPP Co-pays</td>
<td>1,289</td>
<td>688</td>
<td>-47%</td>
</tr>
<tr>
<td>Medicare Part D Co-pays</td>
<td>1,331</td>
<td>1,235</td>
<td>-7%</td>
</tr>
<tr>
<td>Medicaid Co-pays</td>
<td>308</td>
<td>294</td>
<td>-5%</td>
</tr>
<tr>
<td>Unduplicated Clients in all OHDAP Programs</td>
<td>4,272</td>
<td>3,680</td>
<td>-14%</td>
</tr>
</tbody>
</table>

Source: ODH Quarterly Data Report to OHDAP Advisory Committee.
Note: Clients can access more than one program segment.

Over the course of the program year from April, 2010, to March, 2011, policy changes and reduced costs for certain generic drugs lowered quarterly program costs from $5.6 million to $4.7 million.
In addition to reducing costs, ODH began a more aggressive pursuit of drug rebates. Ohio had not made extensive use of rebates before, although other state programs rely on them extensively. Drug rebates are 29 percent of total ADAP expenditures nationally, now exceeding the aggregate national level of state support for the program. By September, 2011, OHDAP had $7.8 million in rebates on hand (including rebates from previous program years).

The emergence of a waiting list for the first time in the history of the Ohio program was a major topic of concern for the AIDS advocacy community. Over the course of FY 2011, the list grew by an average of 14 persons each week. Periodically, ODH was able to enroll a significant number of individuals, only to see the list grow again. In January, 2011, some individuals living in the Cleveland TGA were temporarily served through Part A funding. In April, 2011, ODH was able to reduce the waiting list by 165 individuals because of $1.2 million in special federal funding from HRSA. Wait list numbers peaked at nearly 500 individuals in the first week of July, 2011, before ODH changed its policies (Figure 4).

![Figure 4. Number of Persons on the OHDAP Waiting List](image)

According to AIDS advocates, most wait-listed individuals were able to establish access to antiviral medications through patient assistance plans offered by pharmaceutical companies, but had to seek help from free clinics and other community resources for other health care needs. Disenrollment from the program could lead to problems adhering to a consistent treatment regimen, causing a greater risk of drug resistant viruses and increased risk of transmission.

With continued uncertainty, ODH continues to consider alternative methods of managing the waiting list, especially the use of medical criteria. In June, 2011, ODH proposed new administrative rules that would have allowed the director to establish medical criteria for program enrollment based on national standards. After some advocates expressed concern
that the rules did not spell out the specific criteria, ODH withdrew them before they were finalized.\textsuperscript{26} New rules were submitted to the Joint Committee on Agency Rule Review in early October that contained specific criteria that would prioritize pregnant and post-partum women and individuals with low values for T-cells expressing CD4.\textsuperscript{27}

**FY 2012 OHDAP Program Changes**

Better understanding of turnover, lowered costs, and improved revenues led ODH to re-evaluate the program and make changes in FY 2012. The department conducted a survey of wait-listed individuals during the spring of 2011. This survey revealed the full extent of the turnover affecting clients in the program. An astonishing 55 percent of wait-listed individuals had been on the program before. Each month, approximately 591 clients re-enrolled, but another 96 individuals who were expected to re-enroll, did not.\textsuperscript{28} This implies a turnover rate of 14 percent each month. A few clients died, but most either moved or failed to complete their recertification forms in a timely fashion despite a 30-day grace period. The recertification process has become more burdensome because of HRSA’s interpretation of regulations that require a more stringent income eligibility check every six months rather than the former practice of once per year.\textsuperscript{29} ODH is working with advocates and case management organizations to address the issue.

Program costs continued to decline at the beginning of FY 2012, even with increased enrollment. As of May, 2011, monthly program costs were about $1.5 million, with an implied annual cost of $18.1 million. By August, monthly costs had declined to $1.3 million, with an implied annual cost of $15.5 million. In contrast, annual costs had exceeded $20 million before the crisis during the summer of 2010 (at a higher enrollment level).\textsuperscript{30}

The level of turnover and cost reductions reached a point in July, 2011, that ODH allowed 254 wait-listed individuals to enroll in the program. They were enrolled on a “first-come, first-served” basis, consistent with previous practice. Subsequent enrollments of wait-listed clients in August and September led to the effective suspension of the waiting list by late September, with the exception of a handful of individuals who could not be located. ODH is now regularly reviewing applications to enroll individuals up to the point at which their aggregate anticipated cost equals the total cost of the individuals who left the program.

Many of the individuals enrolled from the waiting list during the summer of 2011 had no insurance coverage and needed full-pay, OHDAP prime assistance (Table 3). Interestingly, the largest recent increase in any program segment was in the less expensive private insurance co-pays. The differential in average monthly costs between full ODHAP coverage and HIPP co-pays is over three to one ($594.15 vs. $177.84). The average monthly cost for Medicare Part D co-pays, the second largest program segment, is $72.33.\textsuperscript{31}
Table 3. Changes in Monthly OHDAP Enrollment Patterns from May to August, 2011

<table>
<thead>
<tr>
<th>OHDAP Program Segment</th>
<th>Clients May 2011</th>
<th>Clients August 2011</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>OHDAP Prime</td>
<td>1384</td>
<td>1588</td>
<td>14.7%</td>
</tr>
<tr>
<td>HIPP Premium (private insurance)</td>
<td>194</td>
<td>195</td>
<td>0.5%</td>
</tr>
<tr>
<td>COBRA Premium</td>
<td>63</td>
<td>57</td>
<td>-9.5%</td>
</tr>
<tr>
<td>Medicare Part D Premium</td>
<td>364</td>
<td>357</td>
<td>-1.9%</td>
</tr>
<tr>
<td>Medicaid Monthly Spenddown</td>
<td>101</td>
<td>99</td>
<td>-2.0%</td>
</tr>
<tr>
<td>HIPP Co-pays</td>
<td>194</td>
<td>626</td>
<td>222.7%</td>
</tr>
<tr>
<td>Medicare Part D Co-pays</td>
<td>1196</td>
<td>1227</td>
<td>2.6%</td>
</tr>
<tr>
<td>Medicaid Co-pays</td>
<td>403</td>
<td>383</td>
<td>-5.0%</td>
</tr>
<tr>
<td>Unduplicated Clients in all OHDAP</td>
<td>3546</td>
<td>3771</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

Source: ODH data provided to OHDAP Advisory Board.
Note: Clients can enroll in more than one program.

ODH believes that program enrollments can be sustained at about 3,700 slots in FY 2012. Improved finances also help, including some enhanced Medicaid payments that were carried over into the current program year. As noted above, the program is pursuing rebates more aggressively, and expects annual income from this source to average between $2 million and $3 million. The federal fiscal year 2011 award for Part B will total just over $25 million, and the federal government will also provide $1.2 million in emergency relief to Ohio. Improved financial stability has allowed the program to restore dental services with a $2,500 per client cap. ODH is also asking OHDAP advisory committees for recommendations about restoring medications to the formulary that had been authorized before July, 2010. It is likely that some will be restored.

It is not clear that ODH can maintain stable program enrollment and services through FY 2013 given the uncertainty of federal funding.

The Ryan White Program in the FY 2012 – 2013 State Budget
Along with all other state agencies, ODH submitted a budget request to the Strickland administration at the end of calendar year 2010 for the FY 2012-2013 biennium. At the time of submission, there were 303 people on the OHDAP waiting list. ODH requested $8,546,326 per year in the GRF line item (440-444) for AIDS Prevention and Treatment. This amount was about $3 million per year above FY 2010-2011 funding levels.
Governor John Kasich’s budget, presented in March, 2011, allocated $5,542,314 for each year in the biennium (remaining flat from 2011). In May, 2011, the Ohio House of Representatives passed its version of the budget and added $300,000 per year to the executive level of funding for AIDS Prevention and Treatment, bringing the annual total to $5,842,315. In Senate testimony, Dr. Ted Wymyslo, ODH director, stated that an additional $5.5 million were needed to maintain current operational levels, but an additional $16.7 million were needed over the biennium to enroll all other individuals who would become eligible.34 (The director did not mention turnover rates, but the estimate appears to apply to the total number of individuals theoretically eligible.)

The Senate passed its version of the budget on June 8, 2011, and kept the $300,000 per year increase added by the House, but did not add any additional funding to the AIDS Prevention and Treatment line item.35 No other changes were made to line item 444 in the final budget passed by the legislature and signed by the governor, meaning that it will be funded with $5.8 million per year in GRF dollars.36

With a potential crisis looming on the horizon for SFY 2013, ODH was told by the Ohio Office of Budget and Management that the program would be reassessed during a mid-biennium review. ODH has indicated that it will make the case to increase FY 2013 funding to $10 million.

The Affordable Care Act (federal health care reform) becomes effective in January, 2014, and may ease pressures on the program. According to the National Alliance of State and Territorial AIDS Directors (NASTAD), the new law will help Ryan White programs across the country financially in the following ways, some of which Ohio has implemented already:

- expanding Medicaid eligibility in 2014 will allow some individuals to move off of the program;
- establishing a health insurance exchange will expand insurance coverage, allowing the program to pay for premiums or co-pays rather than full formulary costs. Ohio already pays premiums in the high-risk insurance pool, but subsidies in the exchange will lower costs;
- modifying Medicare Part D will allow ADAP spending to count toward “True Out of Pocket Expenditures” (TrOOP) and will eventually close the “doughnut hole” (this occurs in Ohio already); and,
- improving pricing transparency and rebate amounts for drug purchases will lower costs.37

With health care reform under attack at the state and national levels, it may be too soon to count on all of these changes surviving intact.
Conclusion

The number of people diagnosed with HIV in Ohio continues to grow each year, increasing the need for the Ryan White program. State funding has not kept pace with demand. Although advocates welcomed the small funding increase in the program for the FY 2012-2013 budget when many other social service programs were cut, OHDAP program managers have been left to make difficult policy decisions over the last 18 months. Relying on a “paper match” from other state agencies allows the state to continue to achieve its maintenance of effort requirements but erodes state support for the program.

The Ohio Department of Health has been able to temporarily suspend the OHDAP waiting list for now, but only at a reduced level of enrollment compared to the first half of 2010, and with an unacceptably high turnover rate among clients. ODH is working with case managers, providers, and advocates to develop new procedures, but additional resources are needed as well. It is preferable from a public health standpoint to keep individuals currently on the program enrolled rather than risk a lapse in adherence to treatment protocols.

Keeping OHDAP enrollment stable at about 3,700 clients means that over time the program will serve a declining share of the population living with HIV/AIDS. It is expected that an additional 1,500 people will be diagnosed with HIV/AIDS each year.

Significant strides have been made in HIV/AIDS treatments. Better drug therapies have allowed patients to live longer and have made it possible to lower their viral loads and make it much less likely that they will transmit HIV to others. State investment in this program is a vital part of Ohio’s public health infrastructure, and it should be given top priority in the budget process.

2Public health experts estimate that 20 percent of the individuals living with HIV/AIDS are undiagnosed. Steve Sternberg and Jack Gillum, “Many with HIV don’t know they have it,” USA Today, June 8, 2011. www.USATODAY.com Citing Centers for Disease Control and Prevention.
5Ohio also receives federal funding in Part F of the Ryan White program for Special Projects of National Significance and the Dental Reimbursement Program. Special Projects of National Significance are grants to advance knowledge and skills in providing care for underserved populations of HIV diagnosed. The Dental Reimbursement Program provides funds to accredited dental education programs to help defray the costs of providing oral health care to people with HIV. Source: HRSA, HIV/AIDS Program and HRSA, Find Grantees
6About the Ryan White HIV/AIDS Program: Grants to Emerging Metropolitan and Transitional Grant Areas, HRSA.
7The AFC is a partnership of eight private and public funders (e.g. foundations, United Way, City of Cleveland, Cuyahoga County, ADAMHS Board) that strengthens the community’s response to HIV/AIDS by providing coordination, leadership, and funding in Greater Cleveland. The AFC uses a variety of strategies to target resources to fill gaps, including responsive grants, targeted grants, smaller discretionary grants, and AFC-led initiatives such as large-scale evaluation projects, research, and community capacity building efforts. Examples of recently funded projects include an innovative prevention program for males involved in buying or selling sex (e.g. prostitution), a
capacity building project to integrate HIV testing into the Cuyahoga County Board of Health’s clinic that helped position this clinic to open a federally-funded family planning clinic with true opt-out HIV testing, and an effort to routinize HIV testing at MetroHealth Medical Center utilizing electronic medical records that resulted in a decrease in the number of people who had never been tested. In addition to funding programs, the AFC is involved in a number of community planning bodies, including the Ryan White Part A Planning Council for the Ryan White Part A grant that the Greater Cleveland area receives from the federal government. The AFC also is involved with advocacy at the national and state level via national summits and testimony in the Ohio legislature. The AFC joined in the successful lobbying of former Governor Ted Strickland to provide the OHDAP with an additional $12.8 million in federal funds to cover the budget shortfall in SFY2011.

8 HRSA, About the Ryan White HIV/AIDS Program.
9 NASTAD Ryan White Program Part B Matching Requirements Fact Sheet.
10 Ohio Department of Health Operating Budget Request for Fiscal Years 2012-2013.
11 Information request from the Cleveland TGA to ODH, 7-12-2010.
13 NASTAD Ryan White Program Part B Maintenance of Effort (MOE) Fact Sheet.
14 Ohio LSC Redbook, Department of Health, April 2011.
17 OHDAP’s monthly per client cost was $748, while the national average was $949. NASTAD, National ADAP Monitoring Project Annual Report: Module 2, Table 6, “ADAP Average Monthly Cost Per Client, June 2010.” p. 74
19 The cause of the shortfall has not been completely explained. The ODH budget request indicated that the program did not spend 98 percent of its funds per federal requirements, and was penalized $2.4 million in federal funds. Rising caseloads and falling months behind on payments to CVS for pharmacy services also contributed.
23 Discussion at OHDAP Advisory Board meeting, 9-8-2011.
25 Proposed Ohio Administrative Code section 3701-44-03, withdrawn from consideration 6-27-2011, to be refiled with the Joint Committee on Agency Review.
27 Register of Ohio, Refiled proposed administrative rules 3701-44-01 et seq., Sep. 22, 2011
28 ODH “Waiting List Management Plan” (Draft) distributed to the OHDAP Advisory Committee Meeting, June 30, 2011, and subsequent presentation and discussion.
29 Ibid.
31 Based on August, 2011 program information provided to the OHDAP Advisory Board, Sep. 8, 2011.
33 ODH has applied for $400,000 from a federal Part B Supplemental grant, and expects $200,000 to be transferred from Part A.
34 Testimony of Dr. Ted Wymyslo, Director, Ohio Department of Health, before the Ohio Senate Finance Committee, May 10, 2011, p. 5
35 LSC Budget in Detail, HB 153, As Passed by the Senate.
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