

Reducing HIV-Related Disparities through the HRSA Designations for Medically Underserved Areas and Populations

October 2010

The Affordable Care Act required HRSA to convene a negotiated rulemaking committee to re-evaluate the criteria used to determine medically underserved areas and population designations (MUP/MUA, HPSA). The review offers an opportunity to better target federal resources to alleviate the HIV-related disparities that still exist across the U.S.¹ In recognition of the relevance to people with HIV, HRSA appointed Ryan White medical provider Kathleen Clanon, MD to the Committee. The review of the criteria is critical to HIV care given that:

- Federally funded safety-net programs are the only source of care for many people with HIV disease.
- There is a growing gulf between demand for HIV care and HIV care system capacity.
- A burgeoning HIV medical workforce crisis is likely to fuel HIV-related disparities if left unabated.

The Ryan White program was created in 1990 to respond to the urgent need to provide access to care to the marginalized populations disproportionately affected by HIV disease, an infectious and at the time fatal condition.

Special Attention to HIV Is Warranted

HIV drug therapies and expert HIV care now provide people with HIV the opportunity to live near normal life spans, but too many in the U.S. are diagnosed late and die prematurely due to the irreversible damage already done to their immune system. More than 55,000 new cases of HIV disease occur annually, and the number of people living with HIV in the U.S. has surpassed 1 million.¹ At least 20 percent of people with HIV in the U.S. are unaware that they are infected, and nearly one-third of people with HIV progress to AIDS within one year of being diagnosed – despite an average latency period of 10 years.^{2 3}

HIV disease is a chronic condition that requires reliable and continuous access to providers with expertise in complex primary and HIV specialty care. Patients managed by experienced HIV medical providers are more likely to be prescribed HIV treatment appropriately and to receive more cost effective care.^{4 5} Many people with HIV disease also are dually or triply diagnosed with mental illness, addiction disorders and hepatitis B or C and frequently lack access to treatment for these conditions.^{6 7 8}

HIV disease disproportionately affects minorities and low-income individuals, and a majority of individuals affected are uninsured or rely on Medicaid coverage. The latest demographic data available from HRSA on individuals receiving Ryan White services offer an important snapshot of people with HIV in care. Forty-seven percent of Ryan White patients are black or African American; 27% are white and 22% are Hispanic or Latino. Nearly 70% live below the federal poverty line with 88% living below 200% of the federal poverty line, and at least 14% do not have permanent housing. Thirty-four percent of patients were on Medicaid, 30 percent were uninsured, 13 percent were on Medicare and only 12 percent had private insurance coverage.⁹

Significant disparities in access to care and outcomes for people with HIV disease exist. In 2006, the Institute of Medicine estimated that as many as 50% of people diagnosed with HIV disease lacked a reliable source for HIV treatment.

Research from the AHRQ and HRSA-funded HIV Research Network has documented the challenges that minorities and other underserved populations face in accessing HIV care from longer travel and wait times for medical care to being less likely to be prescribed HIV treatment appropriately even when in care.^{10 11} Greater survival loss among these populations also has been documented.¹²

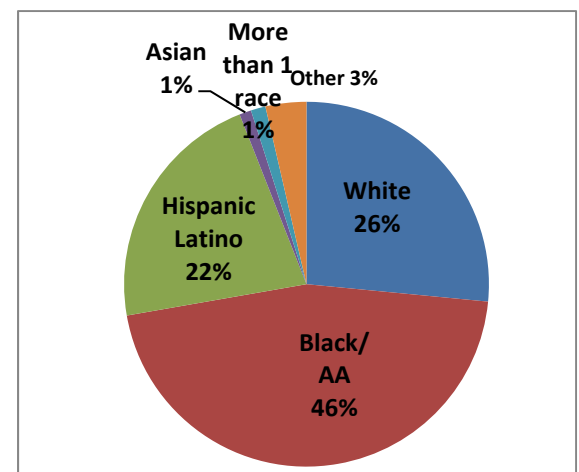


Figure 1 Ryan White Clients by Race/Ethnicity 2008

¹ The MUP/MUA and HPSA designations are used to allocate or prioritize funding for 39 programs, including National Health Service Corps sites, boosted payments under Medicare and Federally Qualified Health Center resources. See www.bhpr.hrsa.gov/shortage.

Like mental illness, HIV disease carries with it stigma that impedes diagnosis and access to medical care. Groups such as Lambda Legal routinely challenge in the courts HIV-related stigma and discrimination affecting employment, housing and access to health care.¹³ As an example of the prevalence of stigma, a study conducted in Los Angeles evaluating health care provider stigma found that 56% of skilled nursing facilities and 47% of obstetricians refused to treat patients with HIV disease.¹⁴

Workforce Shortages and Stigma Leave Few Options for People with HIV in Rural Areas: Mr. CJ is a 43 year old accountant working in a border community in the Southwest. He was diagnosed with HIV several years prior to being hospitalized for meningitis. He had not been in care for HIV as there was no HIV identified physician in his community and he had been told by a physician in another state shortly after his diagnosis that his immune status was good and he did not need medications "at that time." Mr. CJ now travels four hours every three months to have his HIV treatment managed by an experienced HIV physician in an urban area.

Now is the Time to Act

In July 2010, President Obama released the first ever comprehensive strategy for addressing HIV disease in the U.S. that will inform a coordinated federal response to HIV disease that aims to reduce HIV incidence; improve access to care and health outcomes for people with HIV disease and reduce HIV-related disparities. The Strategy acknowledges our success in developing effective treatment and care models for managing HIV but also our shortcomings in providing everyone with HIV in the U.S. the chance to fully benefit from these successes.¹⁵ Our health system's failures have contributed to a growing HIV epidemic that if not reversed will result in HIV prevalence increasing by 24% to 38% over the next decade.¹⁶

Recommendations

The following should be considered to improve the targeting of federal resources using the MUP and HPSA designations:

- Develop separate criteria to identify medically underserved areas and health professions shortage areas for HIV disease as was done for mental health.
- Designate Ryan White-funded medical programs, such as Part C programs, automatically as HPSA sites.
- Incorporate HIV prevalence data into the HPSA and MUP/MUA score or a combined score if one is developed.

¹ Hall HI, S. R. Estimation of HIV Incidence in the United States. *Journal of the American Medical Association*. 2008;520-9.

² Centers for Disease Control and Prevention (CDC). HIV in the United States. July 2010. Online at www.cdc.gov/hiv/resources/factsheets/us.htm.

³ CDC. (2010). *HIV Surveillance Report, 2008*. Available at www.cdc.gov/hiv/surveillance/resources/reports/2008report/cover.htm.

⁴ Wilson IB, Landon BE, Ding L, et al. A National Study of the Relationship of Care Site HIV Specialization to Early Adoption of Highly Active Antiretroviral Therapy. *Med Care*. 2005 Jan;43(1):12-20.

⁵ Bozzette SA, Joyce G, McCaffrey DF, et al. Expenditures for the Care of Patients with HIV. *N Engl J Med* 2001;344(11):817-823.

⁶ Fleming CA, Christiansen D, Nunes D, Heeren T, Thornton D, Horsburgh CR, Jr, et al. Health-related quality of life of patients with HIV disease: Impact of hepatitis C coinfection. *Clin Infect Dis*. 2004 Feb 15;38(4):572-8.

⁷ Gaynes BN, Pence BW, Eron JJ, Jr, Miller WC. Prevalence and comorbidity of psychiatric diagnoses based on reference standard in an HIV+ patient population. *Psychosom Med*. 2008 May;70(4):505-11.

⁸ Korthuis PT, Zephyrin LC, Fleishman JA, Saha S, Josephs JS, McGrath MM, et al. Health-related quality of life in HIV-infected patients: The role of substance use. *AIDS Patient Care STDS*. 2008 Nov;22(11):859-67.

⁹ U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. *Going the Distance: The Ryan White HIV/AIDS Program: 20 Years of Leadership, A Legacy of Care*. August 2010.

¹⁰ Gebo KA, Fleishman JA, Conviser R, et al. Racial and Gender Disparities in Receipt of Highly Active Antiretroviral Therapy Persist in a Multistate Sample of HIV Patients in 2001. *J Acquir Immune Defic Syndr*. 2005;38(1):96-103.

¹¹ Korthuis PT, Saha S, Fleishman JA, et al. Impact of Patient Race on Patient Experiences of Access and Communication in HIV Care. *J Gen Intern Med*. 2008. 23(12):2046-52.

¹² Losina E, Shackman BR, Sadownik SN, et al. Racial and Sex Disparities in Life Expectancy Losses among HIV-Infected Persons in the United States: Impact of Risk Behavior, Late Initiation, and Early Discontinuation of Antiretroviral Therapy. *Clin Infect Dis*. 2009 Nov 15;49:1570-8.

¹³ Lambda Legal. *The State of HIV Stigma and Discrimination in 2007: An Evidence Based Report*. Available online at: www.lambdalegal.org/our-work/publications/general/2007-hiv-stigma-discrimination.html.

¹⁴ Sears B and Ho D. *HIV Discrimination in Health Care Services in Los Angeles County: The Results of Three Testing Studies*. The Williams Institute, UCLA Law School. December 2006.

¹⁵ Office of National AIDS Policy. *National HIV/AIDS Strategy*. July 2010. Online at www.whitehouse.gov/administration/eop/onap/nhas.

¹⁶ Hall HI, Green TA, Wolitski RJ, et al. Estimated Future HIV Prevalence, Incidence, and Potential Infections Averted in the United States, A Multiple Scenario Analysis. *J Acquir Immune Defic Syndr*. 2010. Jul 14.