NASTAD

RYAN WHITE HIV/AIDS PROGRAM

Uses of ADAP Rebate and Program Income Funds

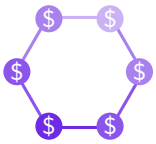
June 2025

Recipients of state and territorial Ryan White HIV/AIDS Program (RWHAP) Part B funding are well positioned to be leaders in addressing the myriad barriers that keep people with HIV from receiving rapid and effective treatment to achieve viral suppression – and ultimately end the HIV epidemic in the U.S.
In addition to maximizing federal funds, AIDS Drug Assistance Program (ADAP)-generated pharmaceutical rebates and program income have allowed many RWHAP Part B recipients to strengthen their systems and expand services to meet the dynamic needs of their RWHAP clients. For example, through leveraging rebates and program income, recipients have been able to enhance the allowable services they fund to help achieve higher viral suppression rates, address barriers, and strengthen their workforce to meet the complex needs of the health care environment serving individuals with HIV.

The federal requirements for the tracking, monitoring, and expenditure of program income and pharmaceutical rebates directly generated from a federal award can be found in the RWHAP legislation, the Code of Federal Regulations, and HRSA HAB policy clarification notices (especially PCNs 15-03, "Clarifications Regarding the Ryan White HIV/AIDS Program and Program Income" and 15-04, "Utilization and Reporting of Pharmaceutical Rebates"). This document compiles ideas and mechanisms that states have employed to assist RWHAP Part B and ADAP staff in deciding how their programs can effectively use funds accrued through ADAP rebates and program income to further the goals of the program. The first section of this document highlights fundamental principles underpinning the development and design of program budgets that maximize rebates and program income expenditures. The remainder of this document addresses innovative strategies states and territories employ to enhance their care systems for people with HIV, focusing on health data systems and technology, improving access, lowering barriers to care, expanding service provisions, and optimizing auxiliary service opportunities.

FUNDAMENTAL PRINCIPLES FOR PROGRAMS TO MAXIMIZE REBATE AND PROGRAM INCOME FUNDS

For RWHAP Part B ADAPs, rebates and program income funds directly generated by federal funds must be utilized for RWHAP Part B allowable costs, prioritizing ADAP. Rebates and program income generated by ADAP can be used to support any RWHAP Part B core medical and support service categories, as well as clinical quality management (CQM), administrative, and planning and evaluation expenditures (see also HAB PCN 16-02, "Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds," and 45 CFR 75 Subpart E – Cost Principles). All RWHAP Part Bs are encouraged to evaluate that they are maximizing the impact of rebates and program income to meet the needs of people with HIV in their jurisdiction. In doing so, they should examine the list of ideas provided in this document and assess whether these could be replicated to enhance and expand the range, quality, and effectiveness of services offered through ADAP and other allowable service categories. However, before exploring real-world examples from states and territories, program staff must understand some guiding principles for rebate and program income expenditures.



Strategically Managing Multiple Funding Streams

States and territories have found that having multiple funding streams for programs creates new opportunities for implementing innovative processes to achieve national strategic goals, including the EHE goal of reducing new HIV infections. While managing multiple funding streams can be complicated – each with unique rules, budgeting cycles, and reporting requirements – most RWHAP Part B recipients recognize the advantages of leveraging funding sources beyond their federal funding. Additional funding streams include ADAP Emergency Relief Funding, Part B Supplemental, other federal funding, state funding, drug rebates, and program income.

Maximizing Quality Core Medical and Support Services

RWHAP Part B recipient staff are strongly encouraged to explore their program's administration and operations to ensure the care system supports clients in reaching the highest attainable standard of health possible. Achieving optimal health outcomes requires examining avenues through which health systems deliver services while addressing obstacles that often disrupt access to quality services. Improving access to services particularly among people and communities disproportionately impacted by HIV is essential to achieving this goal. Addressing client needs with ADAP-generated rebates and program income is one way to address health disparities and maximize health outcomes.

Involving Community Partners

RWHAP Part B recipients are required to have a planning process to determine how to use all available RWHAP Part B resources to provide a comprehensive system of high-quality HIV care and treatment. This includes developing and submitting a Statewide Coordinated Statement of Need (SCSN) and a comprehensive plan. States and territories should strive to integrate multiple RWHAP provider voices in the design, development, and implementation of RWHAP service delivery. Several states have accomplished this by developing an extensive request for proposal (RFP) noting the allowable scope of work and asking subrecipients to submit a proposal and budget for all the work they would like to do within their funded programs. This has allowed funded agencies and other partners to bring forward new projects to address the needs they are experiencing in working with their clients, creating a more robust set of services overall. Instead of trying to work with subrecipients toward the end of the fiscal year to spend funds quickly, this process should begin early in (or in advance of) a new funding period.

Planning and Monitoring

Recipients and subrecipients should proactively project the number of rebates and program income they anticipate receiving. HRSA expects rebate and program income projected funds to be incorporated into the recipient's planning for services based on the comprehensive HIV care and treatment needs of the recipient's jurisdiction. This should be done to effectively determine the allocation and utilization of RWHAP funds during the current period of performance.

Maximizing the Flexibility of Rebate Funds and Program Income

Since rebate and program income funds are not subject to the RWHAP statutory caps (e.g., 10% administrative cost cap; spending at least 75 percent of the award on core medical services (after reserving amounts for administration, planning and evaluation, and clinical quality management)), it provides RWHAP Part Bs opportunities to consider funding programs or initiatives that would otherwise exceed one of the caps. Many RWHAP Part Bs utilize rebates and program income to bridge gaps in services and address staff capacity issues through creative partnerships that would exceed the administrative caps outlined in the RWHAP legislation and HRSA policy clarification notices. As programs maximize the flexibility that rebates and program income allow, program administrators must always consider the long-term sustainability of using rebates and program income to fund new delivery and staffing systems and prioritize the latest initiatives in their budget forecasting for future years.

EXPANDING THE INNOVATIVE USE OF REBATES AND PROGRAM INCOME TO MEET PROGRAM GOALS

Below is a menu of innovative and allowable initiatives and best practices RWHAP Part Bs have implemented to maximize rebates and program income to expand programming along the HIV care continuum. The menu items below are organized into four categories:

1. **Improving Health Department Data Platforms,**
2. **Enhancing Awareness of and Access to Services,**
3. **Expanding Core Medical and Support Service Offerings, and**
4. **Reimagining Auxiliary Services**

1. Improving Health Department Data Platforms

Data Platforms:
Rebate funds can be used to develop, purchase, or upgrade data systems for use in the RWHAP, including electronic lab reporting, CAREWare, home-grown data systems, online application systems, and pharmacy reporting systems. This section will illustrate how RWHAP recipients have maximized and reimagined their information technology infrastructure in ways that expanded access, monitoring, reporting, and overall quality enhancements for their service delivery systems.

REAL-WORLD EXAMPLE(S)
One jurisdiction is implementing an electronic content management (ECM) system to include data collection and workflow for care coordination, needs assessment, performance management, and client and population-level reporting. Implementing the ECM system allows a more streamlined approach to paperwork and workflow associated with client services and ADAP. In addition, it gives the health department access to client-level data previously not readily accessible in paper forms, which streamlines site visit monitoring and federal and state reporting requirements.

REAL-WORLD EXAMPLE(S)
Several ADAPs have used rebate dollars to develop and launch a cloud-based application portal to streamline its eligibility process and ensure the full implementation of PCN 21-02, "Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program". One program had previously been verifying paper applications and documents submitted by fax or mail, which was labor-intensive, time-consuming, and subject to human error. Using ADAP rebates, the program implemented a cloud-based application portal with an integrated eligibility determination process, effectively reducing administrative burden and increasing client satisfaction.

Data Staffing Capacity:
Several RWHAP Part Bs have hired data managers or consultants to assist with designing, developing, and implementing their data systems.

REAL-WORLD EXAMPLE(S):
States and territories have leveraged outside contractors to provide data system design, implementation, and management when hiring internal data managers is challenging for a health department. Some ADAPs have utilized rebates and program income to support staff position(s), such as a data manager or analyst with specialized skills to work with the health department to ensure their data systems remain relevant in an ever-changing market. ADAPs have also used rebates to fund data analysts to assist with pulling reports, interpreting trends, and ensuring that data collected is used for program enhancements and changes, especially if these specialized skill sets are outside the department's current staffing structure.

Data-to-Care/Re-Engagement:
Most states have implemented data-to-care strategies to inform the design of re-engagement programs and initiatives. Rebate and program income funds can be used to provide adequate staffing, ensuring that those most in need of services remain in or are re-engaged in care.

Encryption Software:
Several RWHAP Part Bs have expanded and updated their encryption software to maximize the ability to securely send and receive client medical and personal documents, eliminating the need for faxing and postal mail.

Enhanced Call Center Technology:
Several RWHAP Part Bs utilized rebates and program income to purchase enhanced centralized calling services that better allow them to manage client helplines and measure the quality of these critical frontline services more efficiently. These newer centralized helpline telephone systems also enable the deployment of texting services, telephone campaigns, and massive outreach efforts during key open enrollment periods, eligibility confirmation notifications, and medication adherence interventions.

Medication Therapy Monitoring:
One ADAP implemented a standardized medicine therapy monitoring (MTM) initiative with their pharmacy benefit manager (PBM) and contracted pharmacies to engage participants experiencing medication adherence challenges, as evidenced by detected viral load levels. MTM programs have proven successful when their pharmacists collaborate with a patient's prescribing providers to address pill fatigue, medication side effects, and overall adherence challenges.

Telehealth Expansion:
Many RWHAP Part Bs have strategically launched and secured telehealth options to address the needs of rural areas, metropolitan areas where safety is an issue, homebound participants with HIV. The "HRSA HAB EHE Qualitative Summary of Progress" available via the HRSA website includes examples from EHE programs of ways to incorporate telehealth expansion that are also allowable under the RHWAP.

2. Enhancing Awareness of and Access to Services

Many RWHAP Part Bs utilize rebates and program income to enhance allowable services outlined in PCN 16-02. In addition, programs explore new and innovative approaches to ensure services reach the largest group of individuals with HIV in their jurisdictions. The following examples provide recommendations and best practices shared by RWHAP Part B-funded states and territories, which include ADAPs.

Raising Awareness of RWHAP Part B and ADAP Services:
Although RWHAP rebates and program income cannot be used for broad-based public announcements or outreach activities that exclusively promote HIV prevention education, RWHAP recipients can promote their programs in a targeted manner through awareness activities that address people with HIV lost to care. These awareness activities contain HIV information with explicit and clear links to health care services that assist in optimizing health outcomes. Rebate and program income funds can be used for public service announcements to promote RWHAP services available to potential participants and announcements of other related initiatives such as anti-stigma campaigns, enrollment fairs, and targeted treatment and care involvement campaigns for people and communities disproportionately impacted by HIV.

REAL-WORLD EXAMPLE(S): One state developed a **three-pronged promotion effort** for those already diagnosed with HIV from disproportionately impacted communities using both a newspaper and digital approach to 1) reduce overall stigma, 2) increase case-finding, and 3) encourage retention in care.

To reach Medicaid recipients with HIV and their providers, one state **developed informational materials** modeled after a successful HPV vaccine campaign. Materials were distributed to Medicaid recipients with HIV and their providers to inform them of comprehensive services that the RWHAP Part B and ADAP can provide when unavailable through state Medicaid.

Increasing Federal Poverty Levels (FPL):
Some RWHAP Part Bs have used rebates and program income to increase their income cap (FPL) to reach a wider group of people with HIV who would benefit significantly from the comprehensive services provided through the RWHAP, including ADAP.

Addressing HIV-Related Needs:
The national HIV goals are to prevent new HIV infections, improve HIV-related health outcomes of people with HIV, and achieve integrated, coordinated efforts that address the HIV epidemic among all partners and collaborators. Rebate and program income funds provide an opportunity to be creative and innovative to address these issues. States may need to 'think outside the box' to develop appropriate regional responses.

Collaboration with Justice Systems:
Rebates and program income can fund innovative ways to offer appropriate service delivery to justice-involved individuals, such as those assigned to county jails and work release programs.

REAL-WORLD EXAMPLE(S):
One state developed a program to address challenges ADAP recipients face when in county jails on a short-term basis (i.e., <180 days). Since county jails are not legally responsible for providing medical care or medications, the ADAP covered the cost of drugs for ADAP-eligible clients housed in those facilities, ensuring their consistent access to ART.

Another state developed a medical case management program to work with individuals recently released from state and local correctional facilities. These Correctional Case Managers were trained to deal with release mandates and movement controls placed on individuals by their parole officers.

Another state worked with its correctional facility to develop community engagement fairs that brought local community providers together for one day to orientate parolees to medical and social services in their area. HIV, hepatitis C, and drug testing occurred at the fairs, and linkage to treatment was provided for those who tested positive.

3. Expanding Core and Support Service Offerings

This section will illustrate how states and territories have created new initiatives to meet the needs and capacity challenges of the RWHAP Part Bs, including ADAPs. In addition, this section will show how programs may help assist clients along the HIV care continuum and describe innovative ways states could consider meeting the needs of people with HIV within some of the HRSA-defined Core Medical and Support Service categories. When addressing core and support service categories, the allowable service areas will not be listed in alphabetical order but in the order of highest utilization.

CORE MEDICAL SERVICES

- AIDS Drug Assistance Program treatments
- AIDS pharmaceutical assistance
- Early intervention services (EIS)
- Health insurance premium and cost-sharing assistance for low-income individuals
- Home and community-based health services
- Home healthcare
- Hospice
- Medical case management, including treatment adherence services
- Medical nutrition therapy
- Mental health services
- Oral health care
- Outpatient/ambulatory health services
- Substance abuse outpatient care

[1]Whetten, K., Reif S., Whetten R., Murphy-McMillan, L.K., (June 2008). Trauma, mental health, distrust, and stigma among HIV positive persons: implications for effective care. Psychosomatic Medicine, 70(5), 531-8.

AIDS Drug Assistance Program Treatments:
RWHAP Part Bs can use rebates and program income to improve access to ADAP services and to expand the treatment available through ADAPs, which support the goals of the EHE initiative. For example, ADAPs can use their formularies to ensure that all individuals have access to the highest-quality medications required to manage their health needs.[2]

REAL-WORLD EXAMPLE(S):
Several ADAPs are exploring strategic and systematic approaches to expand their formularies through the additions of allowable drug classes. For example, RWHAP Part B recipients can address many aging-related conditions commonly experienced by people with HIV through ADAP formulary coverage of medications that treat aging-related comorbid conditions, including Alzheimer's disease, cardiac, metabolic, neuropathy, and pulmonary medications.

Several states have explored medication delivery options to enhance and support their dispensing efforts, such as Pharmacy Benefit Managers (PBM), Insurance Benefit Managers (IBM), and Medical Benefit Managers (MBM). NASTAD's HCORe microsite has examples of requests for proposals (RFPs) that states have developed to secure benefit managers, which are available to RWHAP Part Bs. If you need access to HCORe, please email HCA@NASTAD.org for assistance.

As addressed earlier, some ADAPs are working with county and local jail systems and early work release programs to explore pathways to assist with medication assistance for people with HIV. This may include funding specialized case managers or medical benefit coordinators who are trained and able to enter local and state correctional facilities to link people with HIV to needed services.

ADAPs continue to explore avenues to develop and deploy rapid start programs for those newly diagnosed or those re-engaging in care. Rebate and program income funds can be used to assist with designing and building data systems for rapid start programs that can enroll clients and dispense, track, and bill for antiretroviral medications. It is important to remember that each rapid start program should include a process for billing a funding source outside of the ADAP in the case that a rapid start participant fails the eligibility and enrollment requirements for the state ADAP.

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals:
The Health Insurance Premium and Cost Sharing Assistance (HIPCSA) service category supports clients' ability to maintain continuity of health insurance, including paying for insurance premiums and cost-sharing (e.g., deductibles, copayments, or coinsurance) associated with comprehensive HIV care. RWHAP recipients and subrecipients can use HIPCSA to cover premium and cost-sharing assistance that cannot be provided by the state or territorial ADAP, including copayments or coinsurance associated with services covered under an insurance plan's medical benefit.

REAL-WORLD EXAMPLE(S):
A state uses rebate funds to cover client copayments for weekly mental health counseling sessions for RWHAP Part B clients.

Medical Case Management:
Case management is one of the most effective tools available to address the complex needs of people with HIV. It can help improve quality of life, satisfaction with care, and link individuals to community-based services. Case management also helps to reduce the cost of care by decreasing hospitalizations due to HIV-related medical conditions. It is effective in assisting clients in addressing housing, substance use, mental health, and medication adherence services. Rebates and program income can address critical challenges in case management programs, including high caseloads of high-acuity clients, clinical supervision support, and competitive salaries.

REAL-WORLD EXAMPLE(S):
Reducing client-to-case manager ratios can help a jurisdiction free up case managers' time to manage an appropriate number of clients more effectively. To this end, rebates and program income can add more case managers to a system that has high client-to-case manager ratios. One state increased funding to RWHAP Part B program subrecipient contracts, enabling them to achieve a 45:1 client-to-case manager ratio, which cut caseloads in half in several cases.

HIV case managers are often low-paying, entry-level positions with relatively few opportunities for advancement. Consequently, the turnover of these positions is often a significant problem. One state has worked with subrecipient human resources departments with moderate success in increasing salaries for case managers at subrecipient agencies.

[2]Essien UR, et al. JAMA. 2021;326(18):1793-1794

While intensive case management is an effective method to assist clients who have the most difficulty staying in care, high demand and low resources have seen intensive case management services reduced or eliminated in many jurisdictions. One state has added funding from rebates to allow for the continuation of this more intensive form of case management. States also have invested in clinical case manager supervisors to strengthen case managers' capacity to support clients with comorbid conditions that can complicate sustained engagement with health care providers.

Mental Health Services:
People with HIV in the U.S. experience markedly higher rates of mental health conditions compared to the general population. Studies have shown that the prevalence of disorders like depression and anxiety is significantly elevated among this population. For example, a U.S.-based study found that 36% of people with HIV had major depression and 15.8% had generalized anxiety disorder, compared to 7.1% and 3.1%, respectively, in the general population.[3] Rebate and program income funds can be used to provide mental health services to people with HIV by hiring or contracting with licensed mental health professionals.

REAL-WORLD EXAMPLE(S):
One state has used rebate funding to increase the time a Licensed Independent Social Worker (LISW) provides therapy in an HIV clinic.

An RWHAP Part B program subrecipient proactively searched for a local licensed therapist willing to specialize in issues common to people with HIV. Once identified, the subrecipient set up a subcontract with the therapist and refers clients to the therapist.

The Behavioral Health Consultant (BHC) model is being implemented in one state that hired a dedicated BHC at each clinic receiving RHWAP funds.

Oral Health Care:
People with HIV experience a higher burden of oral diseases compared to the general population.[4] These conditions can range from common issues like cavities and gum disease to more specific HIV-associated manifestations. For instance, studies have indicated a higher prevalence of periodontal disease and certain oral lesions, such as oral candidiasis (thrush) and hairy leukoplakia, among people with HIV, particularly those with compromised immune systems. While the advent of antiretroviral therapy has decreased the occurrence of some opportunistic oral infections, people with HIV still face significant oral health challenges. Consequently, people with HIV should receive regular oral health care. Many barriers to oral health care exist, including a need for dentists trained or willing to see people with HIV and a lack of dental insurance. States can use rebate funds to pay for a dentist's time and supplies to increase oral health care access for people with HIV. In addition, states can also consider buying dental insurance within the parameters of HRSA HAB's policy for insurance purchasing.

REAL-WORLD EXAMPLE(S):
One state recently provided part of the salary for a dentist to expand dental services in its impoverished geographical areas. This state also purchases dental insurance for clients through the Health Insurance Premium and Cost Sharing Assistance category.

Another state has used rebate funds to expand its dental assistance program to cover additional dental care services, including dentures, crowns, and implants. The state excluded coverage for braces, whitening, or veneers and established an annual cap on dental services of $10,000 per client.

Outpatient and Ambulatory Health Services:
Workforce shortages, especially for direct-care medical providers, are common and projected to worsen in the next few years, with additional HIV specialists retiring. Rebate funds can cover hiring medical providers, including recruitment, training, salary, and fringe benefits. States should work with other RWHAP Parts in their jurisdictions to determine the need for additional HIV providers.

REAL-WORLD EXAMPLE(S):
One RWHAP Part B reached out to the state's four RWHAP Part C grant recipients to see if there was a need for assistance with funding direct medical providers. The RWHAP Part C recipients responded with a need for assistance in hiring medical providers responsive to patients served in the area. Rebate dollars were used as an administrative cost to build out a hiring framework that was sensitive to the needs and gaps in HIV medical care.

[3]Remien RH, Stirratt MJ, Nguyen N, Robbins RN, Pala AN, Mellins CA. Mental health and HIV/AIDS: the need for an integrated response. AIDS. 2019 Jul 15;33(9):1411-1420.

[4]Patel R, Gallagher JE. Healthy ageing and oral health: priority, policy and public health. BDJ Open. 2024 Oct 9;10(1):79. doi: 10.1038/s41405-024-00262-z. PMID: 39379352; PMCID: PMC11461822.

Substance Use Disorder Services:
The Substance Abuse and Mental Health Services Administration indicates that 66% of people with HIV have used illicit drugs, 16.5% have a history of intravenous drug use, and 24% report receiving treatment for substance use disorders.[5] Substance use issues can interfere with adherence to medical appointments and medication regimens. Rebate and program income funds can be used to support residential and outpatient substance use disorder treatment for people with HIV (as defined in PCN 16-02), including hiring an HIV and Substance Use Disorder Coordinator.

REAL-WORLD EXAMPLE(S):
Due to past funding restraints, several states reported being often unable to fund substance use disorder treatment. The allocation of rebate dollars allowed these states to remove restrictions and caps that were barriers to allowable substance use disorder services in both residential and outpatient treatment facilities.

One state utilized rebate funds to hire an HIV and Substance Use Disorder coordinator to increase HIV case-finding in substance use disorder facilities (both in and out-patient), to increase substance use screening in HIV care settings, and to provide capacity building and technical assistance to both entities.

Early Intervention Services (EIS):
The EIS service category includes four components: 1) targeted HIV testing and counseling, 2) referral services, 3) access and linkage to care, and 4) outreach services and health education/risk reduction related to HIV diagnosis. Rebates and program income can be used to fund EIS services to better meet the needs of people with HIV and those at high risk of acquiring infection. RWHAP Part Bs must remember RWHAP funds can only be used if all four components are available to clients, regardless of how these EIS service components are funded.

REAL-WORLD EXAMPLE(S):
One state with ten CDC-funded testing sites experienced funding cuts that resulted in no more than .25 FTE available at each location, limiting the amount of HIV testing services available. Rebate funds were used to add 1 FTE to each site to ensure people with HIV were identified in the jurisdiction and linked to care.

Disease Intervention Specialists (DIS) are one of the most effective resources for linking newly HIV-positive individuals into care and re-engaging clients lost to care. One state used rebates to fund DIS Retention Specialists whose primary responsibility was reaching out and connecting with RWHAP clients who were lost to care. The specialists provided direct assistance to reconnect clients with their medical provider or case manager and helped identify the structural barriers that contributed to client disengagement from HIV care.

Medical Nutrition Therapy:
Proper nutrition can help keep people with HIV healthy. Using rebate or program income funds to provide people with HIV access to specialized nutritional assistance is a simple yet powerful way to improve health outcomes, medication adherence (including nutritional support required for medications that must be taken with food), and viral suppression.

REAL-WORLD EXAMPLE(S):
In one RWHAP-funded agency, approximately 40% of clients experience co-morbidities such as diabetes, obesity, hypertension, and chronic obstructive pulmonary disease (COPD). Currently, the program does not have enough RWHAP funding to cover the costs associated with medical nutrition services for clients who could benefit from nutritional support and education. Rebate funds are being used to provide medical nutrition services to clients with referrals for these services from HIV providers. The programs also offer client education and have increased the capacity of staff to address nutritional aspects of care. In addition, using rebate funds, a nutritionist oversees food pantry orders to ensure the best dietary options are available.

SUPPORT SERVICES

- Childcare Services
- Emergency Financial Assistance
- Food Bank/Home-Delivered Meals
- Health Education/Risk Reduction
- Housing
- Legal Services
- Linguistics Services (interpretation and translation)
- Medical Transportation
- Non-Medical Case Management Services
- Other Professional Services
- Outreach Services
- Psychosocial Support Services
- Referral for Health Care and Supportive Services
- Rehabilitation Services
- Respite Care
- Substance Abuse Services (Residential)

[5]SAMHSA, The Case for Behavioral Health Screening in HIV Care Settings, available at https://store.samhsa.gov/sites/default/files/sma16-4999.pdf

Emergency Financial Assistance:
Historically, emergency financial assistance has been heavily used because of its flexibility in providing clients with critical resources in times of need. Rebates and program income can expand the resources available to meet these needs. These emergency funds can provide temporary relief in allowable areas to help clients stabilize themselves and have a higher likelihood of staying retained in care. Please note that the RWHAP legislation prohibits providing cash payments to clients.

REAL-WORLD EXAMPLE(S):
One state used rebate funds to establish an emergency heating fund for its clients. The program offered clients with incomes below 350% FPL up to $500 in one-time assistance in addition to their standard allowance of up to $750 a year in housing/food assistance.

Health Education/Risk Reduction:
Though access to comprehensive health care has improved for people with HIV navigating benefits has become increasingly difficult. Rebate and program income funds can be used to assist clients in bolstering their health and health insurance literacy. Several states have used this funding to add specialized benefits experts to current staffing.

REAL-WORLD EXAMPLE(S):
Rebate funds are used to hire temporary employees during open enrollment to assist clients with registration into health insurance plans. Current RWHAP Part B staff serve as supervisors for these positions.

A largely rural state with several small to medium-sized population centers used rebate funds to hire permanent, full-time "Field Benefits Specialists" to serve as regional and statewide experts on benefits. Working with case managers, these employees take the lead on all benefits enrollment issues throughout the year, including during open enrollment.

Housing:
Housing is considered one of the most critical components for staying engaged in care. Many states find that their Housing Opportunities for People with AIDS (HOPWA) funds are insufficient to ensure consistent and stable housing for all RWHAP clients with housing needs, and rebate and program income funds are used to provide RWHAP-allowable housing services to expand what's available through HOPWA.

REAL-WORLD EXAMPLE(S): One state uses rebate funds to considerably expand housing assistance in its jurisdiction. This initiative addresses gaps such as those cited above and has been one of that jurisdiction's most heavily utilized expansions. The initiative offers permanent, affordable housing as quickly as possible for those experiencing housing vulnerabilities. Then, it provides the supportive services and connections to the community-based support needed for clients to maintain stable housing.

Another Part B program used rebate funds to launch two transitional housing programs for underserved focus populations with complex and intersecting needs. These programs integrate the treatment of HIV with housing and provide many direct support services, as well as educational and vocational training.

Linguistics Services (Interpretation and Translation):
To improve outreach and to better meet client needs, interpreter services, including in-person translation, document review, and document translation, can be paid for using rebate or program income funds.

REAL-WORLD EXAMPLE(S): Instead of relying on a "language line" to allow a nurse care manager to conduct intakes and assessments with clients who need interpretation services. Using an interpreter has allowed them to provide interpretation services for their HIV program, pharmacy, and other services for clients with HIV.

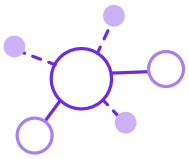
Medical Transportation: Medical Transportation is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services.

REAL-WORLD EXAMPLE: **Transportation Alternative Options:** Many RWHAP Part Bs have used rebates and program income to pay for alternative transportation when public transportation is unavailable in areas of the state that have limitations (e.g., geographical rural areas; gang related challenges with public transportation; unpredictable or unreliable public transit incidents that are well documented, etc.).

Outreach Services: Outreach services can fund programs whose principal purpose is identifying those who know their status but are not in care (i.e., case finding). This service description is prescriptive; however, it can create frameworks for innovative program designs for an approach or intervention, as shown below.

REAL-WORLD EXAMPLE(S): One state developed a unique initiative to address an HIV epidemic that is distributed throughout a large, predominantly rural, geographic area. Eight Rural Outreach Liaisons (ROLs) were hired and located strategically throughout the state. The liaisons were tasked with building relationships with health systems, hospitals, community health centers, private providers, mental health professionals, county mental health agencies, substance abuse agencies, and community-based corrections in their region. The main goal is to institute targeted outreach to find undiagnosed cases of HIV and link those persons into care. In addition, the ROLs educate those agencies listed above to ensure issues unique to people with HIV are understood. This way, professionals in other fields can help keep people with HIV adhere to their medications and medical appointments.

In one jurisdiction, rebate funds were allocated to a community health center to purchase and equip a mobile medical van to provide mobile outreach and services. Mobile outreach services can improve access to HIV treatment, supportive services, education, and prevention for clients who may be unable to visit traditional clinic locations. In addition to the direct provision of HIV care and support services, Early Intervention Services (EIS) – including engagement and re-engagement outreach, targeted HIV testing, referral services, and linkage/re-linkage to RWHAP services – were funded and provided via the mobile outreach unit with disproportionately impacted populations in non-traditional venues like rural areas, homeless camps, local parks, as well as community events.



4. Program Capacity Building

Rebate and program income funds present an opportunity to examine innovative ways to expand services and create new partnerships that leverage the talents and expertise of other service providers in the delivery of allowable services under the RWHAP. Program capacity building services must be allowable as a RWHAP administrative cost or fit within a RWHAP service category. The following are examples of program capacity building services that can help RWHAP Part Bs and ADAPs maximize their impact.

AIDS Education and Training Centers (AETC):
The RWHAP Part F AIDS Education and Training Center (AETC) program supports a network of leading HIV experts who provide locally based, tailored education, clinical consultation, and technical assistance to health personnel, faculty, and health care organizations to integrate state-of-the-science comprehensive care for people with or affected by HIV. The AETC network includes two national centers, the National Clinician Consultation Center (NCCC) and the National Coordination Resource Center (NCRC), the online National HIV Curriculum (NHC), eight regional centers comprised of more than 130 regional partners (local sites), and two Integration of the NHC into Health Professions Training programs. Together, this network serves all states, DC, Puerto Rico, the U.S. Virgin Islands, and the Associated Pacific Jurisdictions.

AETCs' training and capacity development ability can be broad and far-reaching. States should consider increasing their partnerships with their AETCs, including the possibility of using rebates or program income to fund certain AETC activities that are outside the scope of the AETC funding. For example, AETCs can be tasked with providing additional workforce training or asked to tackle a specific issue, such as low utilization of hepatitis C curative treatments among individuals co-infected with HCV and HIV.

REAL-WORLD EXAMPLE(S): One recipient developed an interagency agreement with its AETC to help them develop consistent policies and procedures for case management services and to incorporate these into a customized training for RWHAP staff.

Program Staffing: Rebate and program income funds can be expended to increase staffing at both recipient and subrecipient programs to extend the reach and scope of their programs. The program's staffing needs can vary yearly and change depending on programmatic initiatives and goals.

REAL-WORLD EXAMPLE(S): In addition to the examples in other sections above, the following are positions that states have funded through rebates or program income:

- RWHAP Part B and ADAP Client Services Coordinator
- Quality Improvement Coordinator
- ADAP Enrollment and Benefits Specialist
- Re-engagement Specialist
- Peer Navigators
- Data Manager and Data Analytic Specialists
- Epidemiologists
- Pharmacist for formulary management
- Special Projects Coordinator
- HIV Surveillance Coordinator

One RWHAP Part B subrecipient, who also is an RWHAP Part C grant recipient, was allocated rebate funds through their RWHAP Part B sub-award to fund an additional 1.5 FTE in administrators/managers to coordinate across the RWHAP Part B and C program components.

Cellphone Equipment and Data Minutes: RWHAP Part B has used rebate or program income funds to support the purchase of cell phones and data minutes for clients who would benefit from a cell phone to access telehealth medical services. This was especially critical during the COVID-19 pandemic. This service is also deployed so that unstably housed participants can connect with their case manager and service delivery system.

Consultants: Rebate or program income funds can be used to hire consultants to work on projects that are beyond the capacity or expertise of existing staff, such as performing an overall systems assessment, assessing RWHAP Part B and ADAP policy and procedures, and developing a needs assessment or other planning activity. States have used various types of entities as consultants, including individual consultants, small firms, and universities or colleges.

REAL-WORLD EXAMPLE(S): States have hired consultants to assist them in developing the state's Integrated Plan. States should ensure that program leaders and staff stay intimately involved in the design and process while utilizing the assistance of an expert.

One state hired a consultant to provide targeted technical assistance for subrecipients on leadership development, team building, and reporting services. The consultant and program staff worked together to ensure activities aligned with overall goals for the state.

One low-incidence state hired a part-time consultant to analyze the best ways to re-engage individuals lost to care. The consultant researched approaches used by other jurisdictions and developed a unique system for that state. The consultant then spent time with the state and its stakeholders as the new re-engagement plan was adopted by the program.

Consultants can also be used to support financial forecasting activities critical to the fiscal sustainability of ADAPs and the services they provide. One state used its rebate funds to hire a financial consultant to help ensure the program receives all allowable rebates on medication dispenses for full-pay medication and ADAP-funded insurance program clients.

Membership Dues: Rebate or program income funds can be used to pay organizational membership dues that support activities consistent with RWHAP services.

REAL-WORLD EXAMPLE(S): States frequently use rebate funds to pay membership dues to national organizations that provide professional development, capacity building, and technical assistance, including professional organizations (i.e., National Association of Social Workers, American Bar Association, American Public Health Association) and national organizations (i.e., NASTAD, National Coalition of STD Directors).

Travel: Rebates or program income can fund in-state and out-of-state travel for site visits, peer learning, meetings, training, and conferences.

REAL-WORLD EXAMPLE(S): One state convened a two-day leadership planning meeting for its three largest subrecipients to address issues such as the changing health care landscape, staff turnover, hiring challenges, and a change in focus with 'treatment as prevention.' The meeting also covered 'big picture' strategy building, and program design. The initiative was so successful that the leaders prioritized additional meetings quarterly.

States frequently use rebate funds to travel to and participate in national meetings, including the HRSA HAB Administrative Reverse Site Visit, HRSA HAB National Ryan White Conference, and other HIV-related professional development opportunities to support the RWHAP.

Needs Assessments: Rebate or program income funds can support the development and implementation of client, provider, and community needs assessments and efforts to implement changes identified from the needs assessment.

REAL-WORLD EXAMPLE(S): Several states have hired firms to implement a consumer needs assessment. These firms assisted with developing, implementing, analyzing, and reporting feedback received from participants who responded to the survey.

Alterations and Renovations: Minor alterations and renovations (A&R) are allowable under the RWHAP, with a threshold for minor A&R of less than $150,000 or 25% of the total project budget. Minor A&R is work that changes the interior arrangements or other physical characteristics of an existing facility or installed equipment to be used more effectively for its designated purpose or adapted to an alternative use to meet a programmatic requirement. A&R may include work referred to as improvements, conversion, rehabilitation, remodeling, or modernization but is distinguished from construction and large-scale permanent improvements. Minor A&R does not build out (i.e., expand the footprint) or up (i.e., add a story).

REAL-WORLD EXAMPLE(S): A state used rebate funds to make minor A&R to an existing RWHAP Part B- and Part C-funded dental clinic. Not only did the A&R-associated conversions yield additional clinical space, but rebate funds were used to purchase dental chairs, X-ray equipment, and supplies.

Micro-grants: Another innovative strategy to address issues surrounding HIV currently in practice is providing "micro-grants" that allow jurisdictions to put forth an issue or problem in a request for proposals (RFP) to solicit locally generated and innovative ideas. The process results in local solutions to access and other barriers, fostering experimentation and essential relationship building. Some states have been surprised by the success of the out-of-the-box solutions this approach generates.

This publication was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement #U69HA26846 as part of an award totaling $500,000 with zero percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.