

**SECTION BY SECTION DESCRIPTION OF
“RYAN WHITE CARE ACT AMENDMENTS OF 2009” DISCUSSION DRAFT**

Section 1: Short Title; References

This section would establish “Ryan White CARE Act Amendments of 2009” as the title.

Section 2: Reauthorization of HIV Health Care Services Program

Current Law:

The table below compares fiscal year 2009 authorization amounts to fiscal year 2009 appropriation amounts and the 2010 House Budget request.

Table 1. Federal Funding for the Ryan White Program
(\$ in millions)

Ryan White Program Parts	FY2009 Authorization	FY2009 Appropriations	FY2010 House Passed
Part A	\$650	\$663.1	\$679.1
Part B	\$1,285	\$1,223.8	\$1,253.8
Part C	\$235	\$201.9	\$206.8
Part D	\$72	\$76.8	\$78.7
Part F: AECTs	\$35	\$34.4	\$35.2
Part F: Dental	\$13	\$13.4	\$13.8
Part F: SPNS	\$30	\$25	\$25
Total	\$2,320	\$2,238	\$2,292

Proposal:

The discussion draft would authorize “such sums as are necessary” for Parts A through D. It would authorize “such sums” for Demonstration and Training Grants under Part F including HIV/AIDS Communities, Schools and Centers and the Minority AIDS Initiative.

The discussion draft would eliminate the sunset provision. After three years, the authorization will expire, but Congress will have the opportunity to revisit the program as is the practice with most programs.

Section 3: Extended Exemption Period for Names-Based Reporting

Current Law:

Under current law, the amount of funding that metropolitan areas and states receive is based on formulas that reflect the number of people infected with HIV, as well as those already diagnosed with AIDS. Most states initially collected surveillance data on HIV under a code-based system, which excluded any identifying information for individuals. In the late 1990s, CDC recommended that all States switch to a name-based system, which decreases duplication and creates a more accurate count. Some states have been collecting name-based data for longer periods, but others had to change state laws and regulations to change their systems.

Today, every state collects name-based HIV data to some degree, which is reported to CDC on an annual basis. However, because state systems evolved at different rates, there is substantial variation in the maturity of their name-based HIV reporting systems and the extent to which they fully reflect the current epidemic in each state. Eight states, including California, Hawaii, Illinois, Maryland, Massachusetts, Oregon, Rhode Island, and Vermont, and the District of Columbia, do not yet have fully mature names-based HIV surveillance systems.

Under the 2006 reauthorization, states are allowed to continue to submit code-based HIV data directly to HRSA, but they receive a 5% penalty to account for potential duplication. States reporting code-based data are also subject to a 5% cap on increases in case count. Once the Secretary of the U.S. Department of Health and Human Services (HHS), after consulting with the state's chief official, certifies that the state's name-based data is accurate and reliable, the state switches to exclusive name-based reporting.

Proposal:

The discussion draft would maintain these provisions for states and jurisdictions with maturing names-based HIV case data. Jurisdictions that report code-based data to HRSA will continue to incur a 5- percent penalty against their count of living cases of HIV and will still be subject to a 5% cap on increases in the HIV case count.

Section 4: Extension of Transitional Grant Area Status

Current Law:

The 2006 reauthorization divided Part A funding into two separate categories— Emerging Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). EMAs are defined as areas with at least 50,000 people and at least 2,000 AIDS cases reported in the prior five years. TGAs are jurisdictions with at least 1,000 but fewer than 2,000 cumulative AIDS cases during the prior five calendar years.

An EMA retains its status until it (a) fails for 3 years to have at least 2,000 cases of AIDS during the most recent 5 calendar years and (b) fails for 3 years to have 3,000 or more living cases of AIDS as of December 31 of the most recent calendar year.

A TGA retains its status until it (a) fails for 3 years to have at least 1,000 but fewer than 2,000 cases of AIDS during the most recent 5 calendar years and (b) fails for 3 years to have 1,500 or more living cases of AIDS as of December 31 of the most recent calendar year. HRSA has identified 6 TGAs that potentially will lose their eligibility in fiscal year 2011 based on decreasing numbers of AIDS cases: Santa Rosa, California; Vineland-Millville-Bridgeton, New Jersey; Ponce, Puerto Rico; Caguas, Puerto Rico, Middlesex-Somerset-Hunterdon, New Jersey; and Dutchess County, New York.

While EMA and TGA eligibility are based on AIDS cases alone, the actual award amounts they receive are based on both HIV prevalence and AIDS cases.

Proposal:

The discussion draft would extend TGA status for three years to all TGAs that received an award in fiscal year 2009. By 2012, there will be a more detailed national picture of both HIV and AIDS surveillance nationwide. Until that time, this proposal would maintain service stability for existing TGAs. As under current law, TGA funding will be awarded on the basis of HIV and AIDS counts, so jurisdictions with fewer cases will get less funding.

Section 5: Hold Harmless

Current Law:

Under Parts A and B, metropolitan areas and states receive both formula funding and supplemental funding. Formula funding, as described above, is distributed based on HIV and AIDS cases in the area.

Under Part A, two-thirds of funds are distributed based on a formula and one-third of funds are supplemental. Supplemental funding is awarded on a competitive basis.

Under Part B, the proportion of funds that are supplemental can vary annually. The Part B supplemental pool comes from one-third of money appropriated above the fiscal year 2006 amount; from cancelled and returned unobligated funding; and from grant funds taken out of awards for grantees as a penalty for unobligated balances.

Large shifts in funding from one year to the next can be destabilizing and lead to weakened systems of care for Ryan White patients. Under current law, a “hold harmless” provision protects both Eligible Metropolitan Areas and states from large decreases in formula funding. Formula awards for a jurisdiction’s grant in fiscal year 2007 could not be less than 95% of funding for fiscal year 2006, and funding for fiscal years 2008 and 2009 should be no less than 100% of fiscal year 2007.

Proposal:

The discussion draft would repeat the hold harmless pattern established in the last reauthorization. Formula grants for fiscal year 2010 would be no less than 95% of funding for fiscal year 2009, and funding for fiscal years 2011 and 2012 should be no less than 100% of fiscal year 2010.

After the last reauthorization, the Health Resources and Services Administration’s (HRSA) application of a formula change resulted in significant losses for a number of jurisdictions. For each of the last two years and in the fiscal year 2010 Labor-HHS appropriations bill, annual appropriations bills have mitigated these problematic cuts through a stop-loss provision. The provision includes additional funding specifically to address the losses faced by those jurisdictions, rather than taking money from the other areas. In fiscal year 2009, 3 EMAs and 10 TGAs received stop-loss funding.

The discussion draft would prevent the need for repeated legislative action by including the fiscal year 2009 stop-loss funding in the hold-harmless baseline for fiscal year 2010. This reflects the purpose of the hold-harmless provisions, which is to provide stability in funding and prevent precipitous drops in services. Because some of the jurisdictions that received stop-loss funding in fiscal year 2009 are TGAs, the discussion draft extends hold harmless protection to all TGAs.

Sections 6 and 7: AIDS Drug Assistance Program (ADAP) Rebate Funds and Treatment of Unobligated Funds

Current Law:

Current law contains several provisions related to the requirement that Part A and Part B grantees obligate funds by the end of the grant year.¹

- Formula and ADAP Base funding: If a Part A or Part B grantee has any unobligated dollars remaining at the end of the grant year, it can request a waiver to carryover the funding. If the waiver is not granted or if the funds still are not spent by the end of the carryover year, the funds return to the Secretary and become available for supplemental grants.

If a Part A or Part B grantee reports an unobligated balance that is 2% or more of the total award, certain penalties apply, whether or not the jurisdiction receives a carryover waiver. For formula funds, future formula funding will be reduced by the amount of the unobligated balance, beginning in the year following the report. In addition, the jurisdiction will not be eligible for supplemental funding in the year following the report.

- Supplemental funding: If a Part A or Part B grantee has unobligated supplemental funding at the end of the grant year, the funds are cancelled and returned to the Secretary for redistribution.

Because of multiple factors including statewide budget problems and hiring freezes, it has been difficult for all Part A and Part B grantees to obligate 98% of their funds by the end of the year. Nine states experienced a reduction in their fiscal year 2009 grants due to unobligated balances in fiscal year 2007.

The unobligated balances requirement intersects with the treatment of ADAP rebate dollars. Currently, many states purchase ADAP drugs directly from the manufacturer and receive substantial rebates in return. These rebates must be put back into the program and, as a general requirement, states must spend rebate dollars before grant dollars. However, the amount and timing of rebate dollars is unpredictable. For example, a state may receive a significant rebate late in the award year. Since rebates must be spent before program funds, the state could therefore end the year with more than 2% unobligated program funds.

¹ HRSA Policy Notice 7-9, Policy Notice - Notice 07-09 - The Unobligated Balances Provision (online at <http://hab.hrsa.gov/law/0709.htm>).

Proposal:

The discussion draft would clarify that rebate dollars may not be required to be obligated by the end of the year if such requirement would result in a penalty for unobligated funding. It would provide flexibility to states so they are not penalized for unobligated balances related to rebate timing. It also would require Part B grantees to report the activities for which the drug rebates are used and to certify that the rebate funds will be put back into the Part B program with preference given to ADAP services.

The discussion draft would retain the requirement that unobligated funds be returned unless a waiver is granted to carry over formula or ADAP funds. It would eliminate the penalty that reduces future grant amounts. It would retain the penalty that renders grantees ineligible for supplemental grants in the following fiscal year, but would raise the threshold for the unobligated balance so this penalty is triggered at 5% rather than 2%.

Section 8: Application to Primary Care Services

Current Law:

Part D of Ryan White provides grants to entities serving women, infants, children, and youths living with HIV/AIDS. Programs provide for outpatient medical care and offer case management, referrals, and other services to enable participation in the program, including services designed to recruit and retain youth with HIV.

Under current statute, Part D grantees are required to provide medical care to clients, either directly or by contract. Since the last reauthorizations, Part D grantees have been instructed by HRSA to include medical expenses in their program budget. However, Part D clients are often able to access other forms of health coverage, usually SCHIP and Medicaid. In addition, some Part D clients provide care for their clients not through contracts but rather through memoranda of understanding.

Proposal:

The discussion draft would maintain the overall responsibilities and requirements for Part D grantees. It would clarify that Part D should be the payer of last resort and specify memoranda of understanding as vehicles for Part D providers to ensure access to primary care.

Section 9: GAO Report

Current Law:

The 2006 reauthorization required the Government Accountability Office (GAO) to submit a report every two years on barriers to HIV program integration, particularly for racial and ethnic minorities, and on activities under the Minority AIDS Initiative; including

recommendations for enhancing care and prevention services. As directed, GAO submitted one report during the last reauthorization period².

Proposal:

The discussion draft would instruct GAO to periodically report on activities carried out under the Minority AIDS Initiative, in consultation with the Committees of jurisdiction.

Section 10: Severity of Need Index and Client-Level Data

Current Law:

Current law instructs HRSA to develop a Severity of Need Index (SONI) for Ryan White grantees. HRSA has worked on this index, but since the national data set does not yet include uniform HIV reporting and Congress has not yet explored the potential impact of the SONI, there is general consensus that the SONI should not yet be implemented. Current law is silent on implementation of the SONI.

Current law also provides funding for grants in Parts A through D to help grantees develop client-level data systems.

Proposal:

The discussion draft would retain the Client-Level Data grants. It would clarify that neither the SONI nor the Client-Level data should be used to adjust funds under Parts A or B during this authorization period.

²Government Accountability Office, Implementation of New Minority AIDS Provisions, (Report No.GAO-09-315) (online at <http://www.gao.gov/new.items/d09315.pdf>).