

Outline of Policy Proposal for the Reauthorization of the Ryan White CARE Act

May 9, 2006

Overall goals

- Maintain the current structure of the Ryan White program.
- Respond to the current changes with the HIV epidemic, without creating drastic reductions in funding which would harm the current HIV care infrastructure.

Title 1 – Locality funding

Tier 1:

*Eligibility = 2000 living AIDS cases (not ELCs) reported in the last 5 years

*Distribution = 2/3 formula, 1/3 supplemental

*Hold harmless would only be eligible to grantees in FY07 and would apply for 3 years at the following percentages: 90, 85, and 80. FY06 is the base year.

*Modify the supplemental pool so that it appropriately targets demonstrated need in an area.

*Planning councils would be mandatory.

Tier 2:

*Eligibility = 1000 -1999 living AIDS cases (not ELCs) reported in the last 5 years, except that for FY07, EMAs that do not fall into tier 1 are added to this category.

*Distribution = 2/3 formula, 1/3 supplemental

*Supplemental would be directed as per Tier 1.

*No hold harmless.

*Planning council would be voluntary. If the chief elected official opts not to have a planning council, then the official must demonstrate that he/she consulted with individuals with HIV in formulating the overall plan for spending the funding.

Tier 3

*Eligibility = 500-999 living AIDS cases (not ELCs) reported in the last 5 years

*Funding = \$5 M

*Distribution = all formula

*No hold harmless.

*Planning council would be voluntary. If the chief elected official opts not to have a planning council, then the official must demonstrate that he/she consulted with individuals with HIV in formulating the overall plan for spending the funding.

All Tiers

*Remove any population requirement but still require that it be a metropolitan area (with a population of 50,000).

*Switch to HIV and AIDS counts in the distribution of the formula amounts in FY07 BUT with an appropriate transition for the HIV count.

*Transition will involve a 4 year (FY07 – FY10) proxy allowed for HIV cases IF the State has decided to switch to HIV reporting by September 30, 2006 (as deemed appropriate by CDC) and their data system was not yet mature (as determined by the CDC). Actual proxy estimate = 0.9 times the number of AIDS cases. However, in applying the proxy, a grantee can only be awarded 10% over the previous year award.

*Living AIDS cases as part of the count (not ELCs)

*Eligibility would be maintained until a grantee went below the eligibility threshold for three consecutive years at which time they would move down to the appropriate tier or become dependent on the State for funding. New eligibility would be determined on an annual basis. Although authorization levels would only focus on FY07, it would be the intent of the authorizers that the money for that grantee would move with that grantee to the various tiers.

*Cap of administrative costs = 10%, along with a clarification that planning council activities are included within administrative costs.

*Boundaries for metropolitan areas would be as per current law, as were in effect in 1994.

*Clarify that the provisions related to the percentage of funding for women, infants, children and youth (including the waiver) are tied to the number of people with HIV (not AIDS).

Title 2

Title 2 base

*New supplemental grant pool would be 1/3 of any additional funds over FY06 levels.

*Supplemental grants would have the same "demonstrated need" factors as Title 1 supplemental.

*Increase in the total Title 2 base funding would be at least \$30 M over FY06.

*Proposal for Double-counting/80-20

Distribution for FY07-FY11

*0.75 – all of the HIV and AIDS cases in the State

*0.20 – all of the HIV and AIDS cases outside of Tier 1 and Tier 2

*0.05 – all of the HIV and AIDS cases for States not receiving any Tier 1 or Tier 2 funds

Movement to client level data and severity of need index (SONI)

In FY10, if the Secretary states that a new SONI is ready, double-counting/75-20-5 is eliminated and the new SONI is in effect. If it is not ready in FY10, then the double-counting/75-20-5 stays into effect until the Secretary states that it is ready.

(Note: SONI is implied as a factor that is multiplied times the total number of HIV and AIDS cases in the State to provide different weights of those cases, based on a variety of different factors.)

*Require annual reports from HRSA about their progress toward obtaining client level data and developing SONI. HRSA will also report whether it could make a deadline earlier than FY10. Staff to request quarterly briefings on status.

ADAP

*Remains in Title 2.

*Required Minimum drug list based on (1) classes of drugs and (2) PHS Guidelines for ARVs.

*Secretary may waive the match for severe need supplemental, as long as the state provided all of its match for the rest of Title 2.

*Increase ADAP supplemental flexibility by not tying the eligibility to what was available on January 1, 2000.

Overall Title 2

*Overall Title 2 (includes Title 2 base and the ADAP) hold harmless would only be eligible to grantees in FY07 and would apply for 3 years at the following percentages: 90, 85, and 80. FY06 is the base year.

*Switch to HIV and AIDS counts in the distribution of the formula amounts in FY07 BUT with an appropriate transition for the HIV count.

*Transition will involve a 4 year (FY07 – FY10) proxy allowed for HIV cases IF the State has decided to switch to HIV reporting (as deemed appropriate by CDC) and their data system was not yet mature (as determined by the CDC). Actual proxy estimate = 0.9 times the number of AIDS cases. However, in applying the proxy, a grantee can only be awarded 10% over the previous year award.

*Living AIDS cases as part of the count (not ELCs).

*The State shall specify a lead agency. That lead agency will receive all notices for grant awards, continue to develop the statewide coordinated statement of need, receive the audits from other grantees within the State, outline key outcome measures, and perform other duties as determined by the Secretary.

*Clarify that the provisions related to the percentage of funding for women, infants, children and youth (including the waiver) are tied to the number of people with HIV (not AIDS).

*Clarify services under section 2614 must involve the coordination of services for hepatitis B and C coinfection.

*Note: Emerging communities are no longer necessary, given Tier 2 and 3 in Title 1.

Title 3

*Clarify that only funds provided under Ryan White would need to follow the counseling and testing guidelines within Ryan White.

*State that the counseling provided before testing must include measures for the prevention of and exposure to hepatitis B and C, information related to the accuracy and reliability of tests for hepatitis B and C, and the potential for developing hepatitis-related liver disease and its impact on HIV disease if one is diagnosed with chronic hepatitis B or C.

*State that for post-test counseling, there must be additional information regarding their potential to spread hepatitis B or C.

*For counseling provided under Ryan White, individuals must be given information on the transmission and prevention of hepatitis B and C and the location of entities that provide hepatitis B vaccinations to individuals who are infected with HIV/AIDS.

*Clarify that a health facility operated by or pursuant to a contract with the Indian Health Service or a rural health clinic is eligible as a direct grantee.

*Specify that grantees under this Title serve underserved populations.

*In determining the preference for awarding grants, adding a preference for examining the number and rate of increase of those co-infected with hepatitis B or C.

*Require all grantees to provide documentation to the Secretary regarding the process used to obtain community input into the design and implementation of activities related to the grant.

Title 4

*Clarify that a health facility operated by or pursuant to a contract with the Indian Health Service is eligible as a direct grantee .

*Clarify that the current focus of the Title IV activities is on family-centered care (not research), while still maintaining a strong link with the research community.

*Cap administrative expenses to 10% (as it is for all other Titles), while providing a definition of administrative expenses for Title 4.

*Define family-centered care (as per other parts of Ryan White) and youth (ages 13-24).

Provisions Applicable to Titles 1-4

*Every grantee would be required to submit an audit to their State (or in the case of a State to HHS) every other year. Such audits will be posted on the HRSA website.

*75% of the Federal funds must be spent on core medical services. The rest of the funding could be spent on support services. The Secretary may grant a waiver of the 75% requirement if the grantee can demonstrate that, in the service area of the grantee, there is no ADAP waiting list and everyone with HIV is receiving the core medical services.

*Clarify in the payer of last resort provisions that Native Americans can receive services from any Ryan White grantee and may not be denied such services because of they are Native Americans.

*For the planning councils or other advisory bodies related to planning, Native Americans shall be represented, as appropriate.

*As part of the grant application, a grantee under Titles 1-4 will need to provide a narrative about how the activities are coordinated with the State and other grantees within that state and specify how the expenditures under the grant will improve overall outcomes (as outlined by the State) or through additional outcome measures.

Part E

*Delete the current provisions regarding emergency medical personnel (that has never been funded).

*Insert the authority of the Secretary to waive requirements of the Ryan White program to improve the health and safety of those receiving care under this Title and the general public during a public health emergency, subject to the requirements of that emergency declaration. Such waiver can only involve the transfer of up to 5% of the funds from the Title 1 and 2 supplementals (not ADAP supplemental) in any given fiscal year.

Part F

SPNS

*Recraft the SPNS program so that it focuses on (1) development of health information technology systems to support client level data, as it relates to the severity of need index, and (2) responding to emerging needs of populations served by Ryan White.

AETCs

*Clarify that training can include issues relevant to hepatitis B and C.

Dental care

*Clarify that all dentists can apply for unreimbursed dental care expense offsets, including those tied to dental schools.

*Maintain the current connection between dental and dental hygienist schools and community-based dentists as part of the community-based dental projects.