COMMUNITIES ADVOCATING EMERGENCY AIDS RELIEF
CAEAR COALITION

December 19, 2008

Ms. Melody Barnes
Co-Director of Agency Review
Obama-Biden Transition Project
Washington, DC 20270

Dear Ms. Barnes:

Congratulations on your appointment as Director-designate of the Domestic Policy Council. As you continue your transition responsibilities and move into your White House position, CAEAR Coalition is eager to work with you to address the significant health care needs of people living with HIV/AIDS (PLWHA), especially as they relate to reform of the nation's health care system and the Ryan White HIV/AIDS Program.

CAEAR Coalition's members include Ryan White Program Part A, Part B, Part C, Part D and Part F consumers, grantees, and providers. The combination of municipal administrators, community-based providers and consumers of HIV care and support services provides CAEAR Coalition with unique and invaluable programmatic insight and policy expertise.

The Ryan White Program is central to the nation's response to domestic HIV/AIDS, having contributed to the decline in the number of AIDS cases and deaths due to HIV/AIDS—as we have seen firsthand and as confirmed by an OMB assessment of the program (see Attachment A). The Ryan White Program is also essential to addressing disparities in access to HIV treatment and care, serving women and racial and ethnic minorities in significantly higher proportions than their representation among reported AIDS cases. The OMB assessment found the Ryan White program to be one of the nation's most effective government programs, in spite of years of flat or reduced funding and rising caseloads.

As we look to develop and implement significant changes to the health care system, the Ryan White Program must be maintained and strengthened in the interim. We must ensure that the program can continue to meet the needs of the more than 500,000 low-income, uninsured and underinsured people it serves each year. We urge your support for a simple three-year extension of the Ryan White HIV/AIDS Treatment Modernization Act to prevent this program from terminating at the end of Fiscal Year 2009. We also ask the administration to take action quickly to address two key administrative issues, which are outlined in further detail in the attached documents (see Attachments B and C).

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As you look to developing the FY 2010 budget, please stand with us in support of funding increases for the Ryan White Program. We must begin to address the significant and still growing gap between demand for services and funding (see Attachment D).

Moving forward, the needs of PLWHA and the lessons learned over the 27 years of the nation's response to the epidemic must be central to conversations about health care reform. The current state of the crisis demands it. An estimated 1,106,400 adults and adolescents were living with HIV infection in the United States at the end of 2006 and 56,000 new infections are occurring every year. Over half of the people who know they are infected are not receiving adequate care and treatment, and an estimated 21 percent of those infected are unaware of their infection.

These numbers cut across a broad swath of demographic and socioeconomic factors with an especially devastating impact on racial and ethnic minorities and men who have sex with men (MSM). African Americans account for 50% of new AIDS diagnoses and Latinos account for 19% of new diagnoses, though they account for only approximately 12% and 15% of the U.S. population, respectively. Latina and African American women account for 77% of new HIV infections among females while the rate of AIDS diagnoses for black women was nearly 23 times the rate for white women. The rate of AIDS diagnoses for black men was eight times the rate for white men. MSM made up more than two-thirds (68%) of all men living with HIV in 2005, even though only about 5% to 7% of men in the U.S. reported having sex with other men. In a 2005 study of five large U.S. cities, 46% of African American MSM were HIV-positive.

In addition to these sobering statistics, the on-going challenges of preventing new infections and helping all those living with HIV learn their status and access care need to be part of the health care reform process from the very beginning. We are eager to be a part of those conversations.

We have attached additional information and resources on the HIV/AIDS epidemic in the U.S. and the critical role of the Ryan White Program. These documents include an overview of recent statistics, recent and requested Ryan White Program funding levels, overviews of Ryan White Program services, and information on CAEAR Coalition(see Attachments E–I).

We would greatly appreciate the opportunity to meet with you during the transition or soon thereafter to discuss these issues. Our office can be reached at 202-789-3565.

Sincerely,

Christopher Brown
Chair, Board of Directors

cc: Phil Schiliro, Director of Congressional Relations
Michael Strautmanis, Director of Public Liaison and Intergovernmental Affairs
Parag Mehta, Deputy Director of Public Liaison and Intergovernmental Affairs
Bill Corr, Lead, Department of Health and Human Services Review Team
Nicole Lurie, Lead, Department of Health and Human Services Review Team
C. Earl Fox, Member, Department of Health and Human Services Review Team

Attachment A

OMB: The Ryan White HIV/AIDS Program Works

*The White House Office of Management and Budget's assessment of the Ryan White Program found it to be in the **top 1% of all federal programs** in the area of "Program Results and Accountability."*

In its 2007 Program Assessment Rating Tool (PART), OMB gave the Ryan White Program its highest possible rating of "effective"—a distinction shared by only 18% of all programs rated. According to OMB, effective programs "set ambitious goals, achieve results, are well-managed and improve efficiency."

Ryan White Program PART Assessment Scores	
Purpose & Design	100%
Strategic Planning	86%
Program Management	91%
Program Results/Accountability	100%

Half of the OMB ranking is based on the category of "program results and accountability." Out of the 1,016 federal programs rated—98 percent of all federal programs—**the Ryan White Program was one of seven that received a score of 100% in "Program Results and Accountability."**

OMB's Summary Assessment of the Ryan White Program

♦**The program has had a positive impact. It has contributed to the decline in the number of AIDS cases and deaths due to HIV/AIDS.** From 1999 to 2003 deaths due to HIV/AIDS went from 5.3 to 4.7 per 100,000. A cause of the decrease is increased use of antiretroviral medications. In 2000 the program's AIDS Drug Assistance Program (ADAP) served 128,078 clients. In 2005 ADAP served 143,339 clients.

♦**The program has exhibited strong and effective collaborations with similar programs.** The program collaborates with Federal, State and local partners, as well as with private and non-profit HIV/AIDS care, treatment and advocacy groups. By working with this wide range of partners, persons infected with and affected by HIV/AIDS receive coordinated comprehensive care and support services.

♦**The program has demonstrated improved management and oversight of the use of Federal funds.** The previous PART review and other assessments indicated deficiencies in the oversight of grantees' use of Ryan White funds. The program has taken corrective action by expanding grantee technical assistance and monitoring grantee financial accountability and performance.

Attachment B

Department of Health and Human Services
Health Resources and Services Administration

Issue: **If a jurisdiction funded by Part A of the Ryan White HIV/AIDS Program moves between the Part's two tiers (EMA and TGA), the jurisdiction's funds should follow it into the new tier so that the two funding streams reflect the shifting caseloads.**

Explanation: Part A of the Ryan White Program funds HIV/AIDS services in the metropolitan areas hardest hit by HIV/AIDS. The Ryan White HIV/AIDS Treatment Modernization Act, signed into law in December 2006, created two separate tiers of funded jurisdictions: Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs).The two tiers are based on caseloads and there are several key differences between the two.

In authorizing $604 million for Part A in FY 2007, Congress set specific funding amounts for EMAs ($458,310,000) and TGAs ($145,690,000) based explicitly on the number of jurisdictions that would fall into those tiers under the criteria in the legislation. For the subsequent years, Congress gave the Secretary the authority to determine the amounts reserved for EMAs and TGAs and required that if a jurisdiction moved between tiers due to a change in its caseload, then its funds must move with it.

After enactment and prior to the allocation of FY 2007 funds, HRSA determined which jurisdictions fell into which tier based on its interpretation of the legislation and reflecting Congressional intent. One of the TGAs was Nassau-Suffolk, NY. The counties of Nassau and Suffolk believed they should be an EMA based on their interpretation of the legislation, and sued in federal court. The court agreed with the counties and, as the result of the decision in *Nassau v. Leavitt (United States Court of Appeals for the Second Circuit, Docket No. 07-0825-cv)*, Nassau-Suffolk will become an EMA in FY 2009. It is our understanding that New Haven, CT, also governed by the Second Circuit and meeting the same standard applied by the court as Nassau-Suffolk, will likely also be reclassified as an EMA. The fate of four other TGAs that meet this standard, but are outside the Second Circuit, is unclear.

Requested Action: We request the Department move the funds of any transitioning jurisdiction into its new Part A tier. The realignment of funding to follow shifts in the EMA and TGA tiers is within HRSA's authority and reflects Congressional intent as outlined in *SEC. 2610. Authorization of Appropriations. (c) Transfer of Certain Amounts; Change in Status as Eligible Area or Transitional Area.*

Maintaining the balance between the EMA and TGA funding streams by moving the funds of transitioning jurisdictions is essential to sustaining systems of care and preventing the draconian cuts in services that would result from an increase in the number of EMAs without a commensurate increase in funding. To act otherwise in the face of multiple jurisdictions moving into the EMA tier would severely impact access to HIV care and services for the more than 230,000 people living with AIDS in existing EMAs and more than 16,000 living in the affected TGAs.

Attachment C

Department of Health and Human Services
Health Resource and Services Administration

Issue: **Lift the policy that establishes a cumulative, 24-month lifetime service cap per household for short-term and emergency housing assistance through the Ryan White HIV/AIDS Program.**

Explanation: The Ryan White HIV/AIDS Treatment Modernization Act funds support services "that are needed for individuals with HIV/AIDS to achieve their medical outcomes." Research demonstrates that housing is crucial to accessing and maintaining HIV/AIDS care and adhering to treatment and homelessness is a significant barrier for individuals attempting to adhere to HIV/AIDS care and treatment. While the law gives the Secretary authority to approve those services, the law does not require nor does it indicate the need for any time limits on services.

HRSA HIV/AIDS Bureau (HAB) Policy Notice 99-02 Amendment #1, Federal Register, February 26, 2008 (Vol. 73, No. 38) p. 10260, which took effect March 27, 2008, directs grantees on the use of Ryan White HIV/AIDS Program funds for short-term and emergency housing assistance for people living with HIV/AIDS (PLWHA) and limits the duration of short-term and emergency housing assistance to a lifetime cumulative period of 24 months per household.

The limits imposed by this policy adversely affect those the program was designed to serve. HIV disease is cyclical and episodic in nature, and it is crucial to support people living with HIV disease once they initiate treatment, so they are better able to adhere to a complex drug regimens.

There is a lack of affordable housing in many of the areas most severely impacted by HIV/AIDS, and the Ryan White transitional housing assistance serves as a safety net, providing PLWHA with the stability needed to adhere to treatment. This adherence helps to maintain the health benefits of treatment and to ensure PLWHA do not develop drug-resistant strains of HIV, limiting their future treatment options. Imposing limits would lock individuals out of essential housing services and create the risk that once stable patients will begin to skip treatment.

Requested Action: Withdraw Policy Notice 99-02 Amendment #1 by the Administrator of the Health Resources and Services Administration and eliminate the cumulative 24-month lifetime service cap per household on housing assistance. Such action would not undermine the requirement that Ryan White grantees and community-based providers develop a written transitional housing plan, in coordination with other programs, to identify permanent housing, maintain access to quality care, and support long-term housing needs. Part of the policy notice which may remain necessary to "clarify and update certain nomenclature found in the original housing policy 99-02", but excluding the 24-month cap could be reissued.

COMMUNITIES ADVOCATING EMERGENCY AIDS RELIEF
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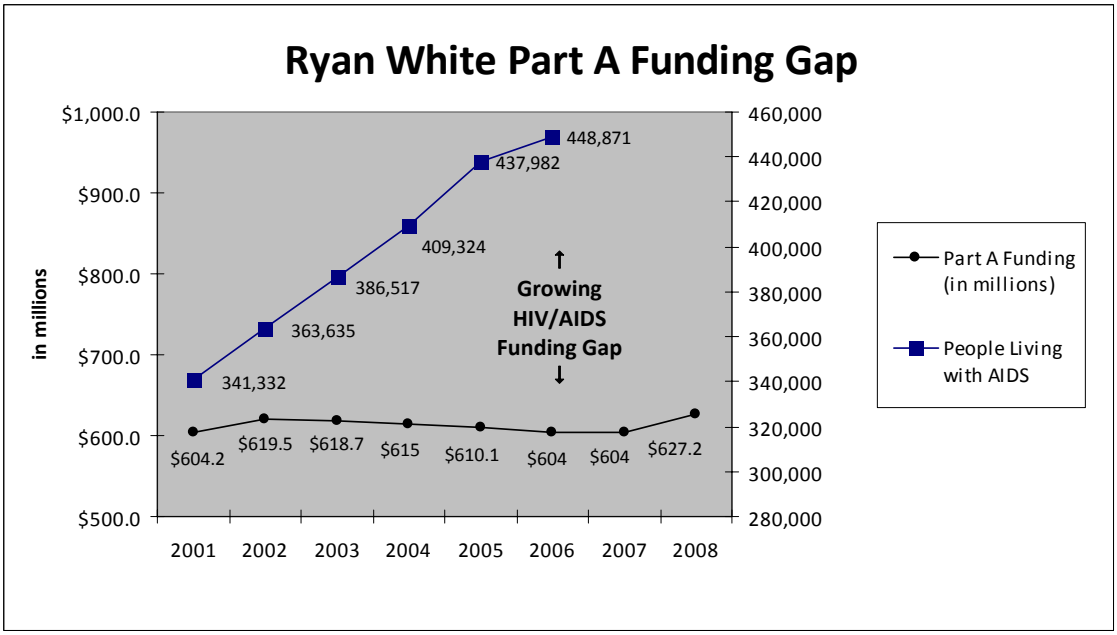
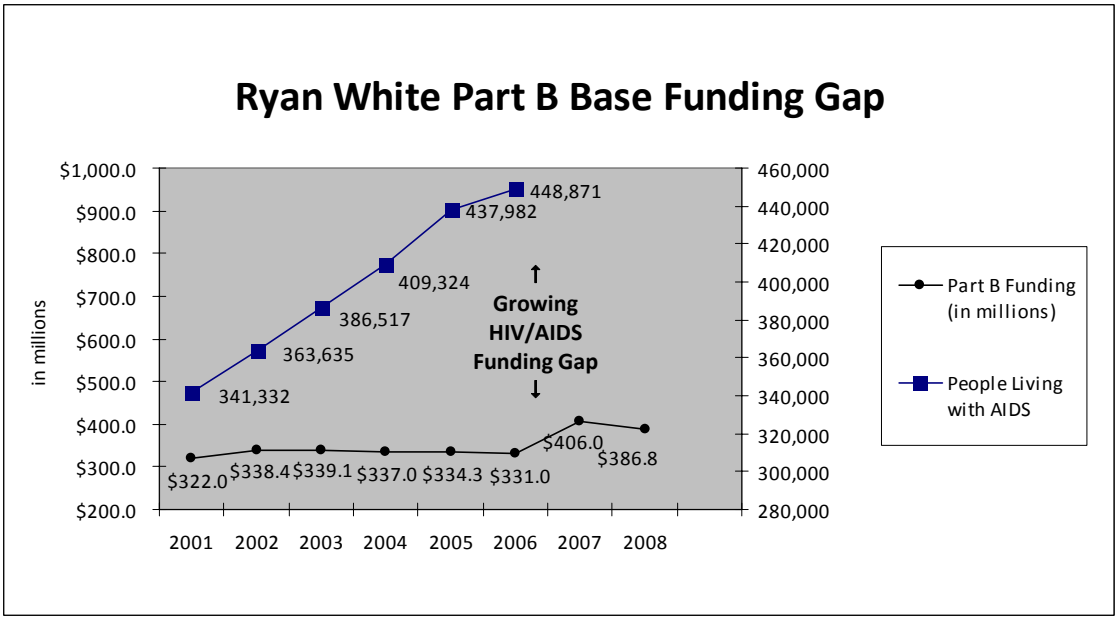
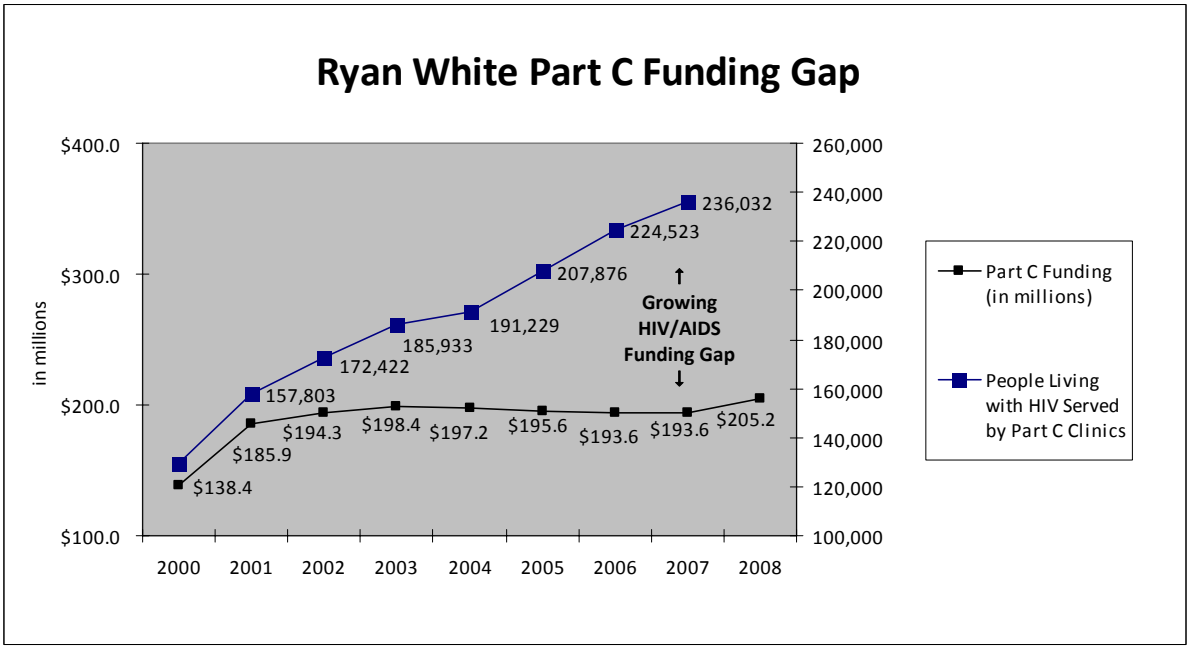
Attachment D

Growing HIV/AIDS Funding Gaps, 2001–2008







Attachment E

The Ryan White HIV/AIDS Program: Key to America's Response to the Domestic HIV/AIDS Crisis

➢Services from Coast to Coast in Communities Large and Small

The Ryan White Program provides lifesaving medical care and support services to more than half a million low-income people living with HIV/AIDS each year. Services are provided in urban and rural communities in all 50 states and the territories. The program is a model for the efficient delivery of services that respond to local needs and reduce the use of more costly emergency services and inpatient facilities. Key to that success has been the flexibility the Ryan White Program provides to states and localities to tailor program services to fill gaps in their networks of care.

➢Multi-Part Structure Directs Services Where They Are Most Needed

The Ryan White Program's multi-part structure was designed to efficiently distribute resources where they are needed most. Part A directs funds to the hardest-hit municipalities, while Part C has been used to improve access to care in rural and urban communities in great need. Part D provides access to specialized care for women, children and families, while Part F supports oral health care and specialized training for health care providers through the AIDS Education and Training Centers. The Minority AIDS Initiative provides resources across the program to enhance access for racial and ethnic minorities.

➢Adapting to Evolving Treatment Options

The Ryan White Program has evolved along with the HIV epidemic. Originally a source of care for those at the end of life, it now supports the comprehensive medical care and enhancing support services necessary for the complex treatment of HIV/AIDS with highly active antiretroviral therapy (HAART). Care and treatment offered through Ryan White-funded providers and the Part B AIDS Drug Assistance Programs help people living with HIV/AIDS determine and access the most appropriate drug regimens.

One in four people living with HIV in the U.S. receives their HIV medications through Ryan White Program-funded AIDS Drug Assistance Programs (ADAP).
Source: U.S. Department of Health and Human Services, Fiscal Year 2009, Justification of Estimates for Appropriations Committees, Health Resources and Services Administration.

➢Medical Care and Support Services Make Treatment with Anti-HIV Medications Possible

The administration of drugs does not by itself result in successful treatment; additional medical and support services are also essential. To that end, the Ryan White program provides a medical care and other services to support the management of and adherence to complex drug regimens. The selection and initiation of an antiretroviral regimen are critical elements of successful HIV treatment. The programs supported by the Ryan White Program provide the infrastructure in which people living with HIV/AIDS can take an anti-HIV/AIDS drug regimen under proper ongoing medical supervision, including costly

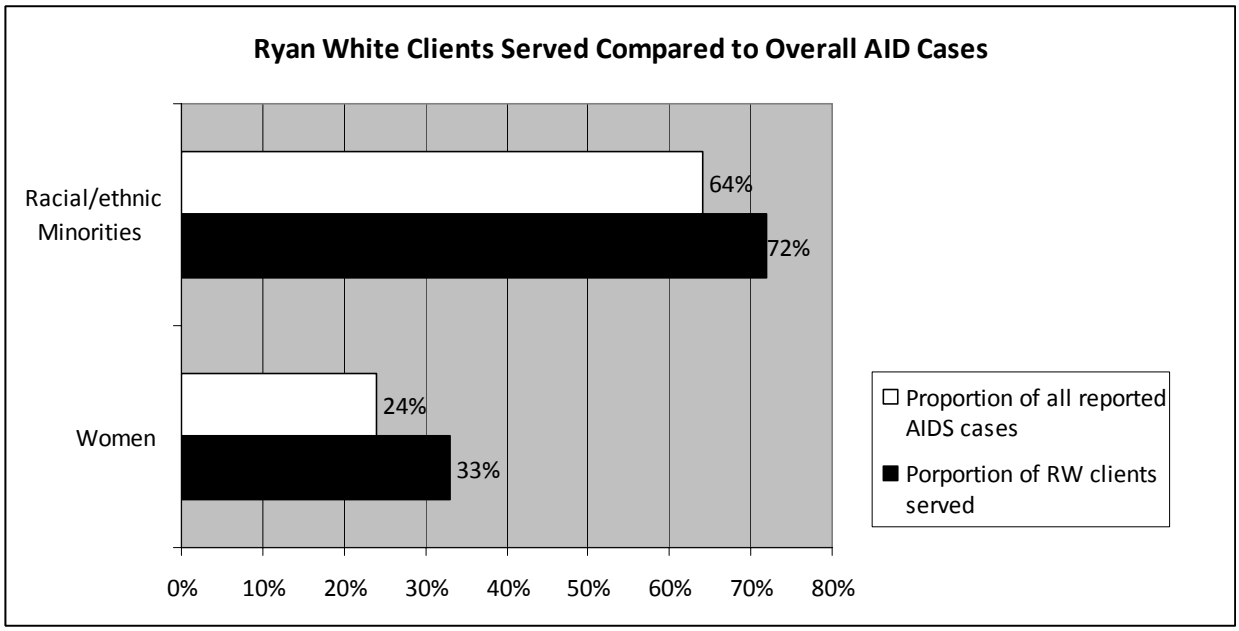
By 2006, 88.6% of Ryan White Program-funded primary medical care providers had implemented a quality management program.
Source: U.S. Department of Health and Human Services, Fiscal Year 2009, Justification of Estimates for Appropriations Committees, Health Resources and Services Administration.

laboratory testing. Without the experience and expertise of these medical professionals—many of them trained through the Ryan White Program—the powerful drugs used to manage HIV/AIDS could easily be misused or insufficiently managed and result in serious consequences such as viral resistance, complications, including increased risk of heart disease, high cholesterol, anemia, diabetes, kidney and pancreatic and liver dysfunction; and treatment failure.

Competing needs, such as food, nutrition services, and housing, and barriers to care, such as lack of transportation or childcare, limit access to HIV health care services. One study found that more than one-third of people living with HIV in the health care system postponed or went without care during a six-month period because of competing needs and barriers. These barriers were also associated with significantly greater odds for never receiving antiretroviral treatment. Others went without food, housing, and clothes in order to pay for their care.[1] While the majority of Ryan Program funds support HIV treatment, a portion also provide key support services, such as food and transportation, as well as case management services to link people living with HIV/AIDS to medical care and support services.

➢Addressing Disparities in Access to Care

The Ryan White Program provides HIV/AIDS care and treatment services to a significantly higher proportion of racial/ethnic minorities and women than their representation among reported AIDS cases.



Source: U.S. Department of Health and Human Services, Fiscal Year 2009, Justification of Estimates for Appropriations Committees, Health Resources and Services Administration.

Footnote

[1.] Cunningham WE, Andersen RM, Katz MH, et al. The impact of competing subsistence needs and barriers on access to medical care for persons with human immunodeficiency virus receiving care in the United States. *Medical Care.* 1999;37(12):1270-1281.

Attachment F

HIV/AIDS Epidemic Remains a Public Health Emergency in the U.S.

➢More People than Ever are Living with HIV and AIDS

- More than 1.1 million Americans living with HIV and AIDS.[1]

- 448,871 people living with AIDS in the 50 states, DC and dependent areas.[2]

➢Almost Half of All People with HIV Who Need Anti-HIV Therapies Are Not Receiving Them

- 45% of HIV-infected people in the U.S. for whom antiretroviral therapy would likely be recommended are not receiving it.[3]

➢HIV/AIDS in the U.S. Increasingly Affects Communities of Color, as Well as Economically-Depressed and Other Underserved Communities

- African Americans account for 50% of new AIDS diagnoses and Latinos account for 19% of new diagnoses, though they account for approximately 12% and 15% of the U.S. population, respectively.[4]

- Latina and African American women account for 77% of new infections among females in the U.S.[5,6] The rate of AIDS diagnoses for black women was nearly 23 times the rate for white women. The rate of AIDS diagnoses for black men was eight times the rate for white men. [7]

➢Men who Have Sex with Men (MSM), Especially MSM of Color, Still Bear Large Brunt of Epidemic

- MSM made up more than two thirds (68%) of all men living with HIV in 2005, even though only about 5% to 7% of men in the United States reported having sex with other men.[8]

- A 2005 study of five large U.S. cities found that 46% of African American MSM were HIV-positive.[9]

➢CDC Initiative Aims to Bring Thousands of New HIV+ Patients into Care

According to CDC Director Dr. Julie Gerberding, CDC's "Advancing HIV Prevention" initiative aims "to open up the door to [HIV] testing so that people can learn their status and get the appropriate treatment and prevention services that they deserve and need." Many of the estimated 200,000 people living with HIV in the U.S. who are unaware of their HIV status that are diagnosed under the new CDC initiative will turn to health care providers funded through the Ryan White Program for their HIV-related care.

➢Public Programs are Key to Health Care Access

20% of the people living with HIV who receive HIV-related care are uninsured and 68%to 83% either rely on public-sector insurance programs or are uninsured.[10]

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[1] Kaiser Family Foundation, The HIV/AIDS Epidemic in the United States; October 2008.
[2] CDC, HIV/AIDS Surveillance Report, Vol. 18, Cases of HIV Infection and AIDS in the United States and Dependent Areas, 2006
[3] Teshale EH, et al., "Estimated Number of HIV-infected Persons Eligible for and Receiving HIV Antiretroviral Therapy, 2003—United States,", *12th Conference on Retroviruses and Opportunistic Infections* ,Abstract #167; 2005.
[4] Kaiser Family Foundation, The HIV/AIDS Epidemic in the United States; October 2008.
[5] Kaiser Family Foundation, Black Americans and HIV/AIDS; October 2008.
[6] Kaiser Family Foundation, Latinos and HIV/AIDS; October 2008.
[7] CDC, HIV/AIDS Among African Americans; August 2008.
[8,9] CDC, HIV/AID and Men Who Have Sex with Men; http://www.cdc.gov/hiv/topics/msm/index.htm, June 28, 2007.
[10] Kaiser Family Foundation, Financing HIV/AIDS Care, A Quilt with Many Holes; May 2004.

Attachment G

COMMUNITIES ADVOCATING EMERGENCY AIDS RELIEF

CAEAR COALITION

Ryan White Program Appropriations: FY2009 Request

Program	President's FY 2008 Request	CAEAR Coalition FY 2008 Request	FY 2008 Omnibus	President's FY 2009 Request	CAEAR Coalition FY 2009 Request	House Labor/HHS Subcommittee Mark-up	Senate Labor/HHS Subcommittee Mark-up
Part A	$604.0m (+0)	$840.4m (+$236.4m)	$627.2m (+$23.2m)	$619.4 (-$7.7m)	**$840.4m (+$213.2m)**	**$670.0m (+42.8m)**	**$619.4m (-$7.7m)**
Part B Base	$400.98m (-$5.02m)		$400.9m (-$5.1)	$409.1m (+$8.2m)	**$496.2m (+$95.3m)**	**$415.4m (+$14.5m)**	**$409.1m (+$8.2m)**
Part B ADAP	$814.5m (+$25.4m)	$1,022m (+$232.9m)	$794.4m (+$5.3m)	$800.4m (+$6.0m)	**$929.0m (+134.6m)**	**$822.7m (+28.3m)**	**$800.4m (+$6m)**
Part C	$199.82 (+$6.32m)	$281.3m (+$87.8m)	$198.8m (+$5.25m)	$198.8m (+0)	**$299.3m (+$100.5m)**	**$205.0m (+6.2m)**	**$198.8m (+0)**
Part D	$71.8m (+0)		$73.7m (+$1.9m)	$73.7m (+0)	$80.7m (+7.0m)	$80.0m (+6.3m)	$73.7m (+0)
Part F AETC	$28.7m (-$6m)	$50.0m (+$15.3m)	$34.1m (-$.6)	$28.7m (-$5.4m)	**$50.0m (+$15.9m)**	**$34.7m (+.6m)**	**$34.1m (+0)**
Part F Dental Reimb.	$13.1m (+0)		$12.9m (-.23)	$12.9m (+0)	$19.0m (+6.1)	$14.0m (+1.1m)	$12.9m (+0)

Attachment H

Ryan White Program Overview

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was first enacted in 1990 and has been reauthorized there times—first in 1996, then in 2000, and most recently in 2006. Now referred to as the Ryan White HIV/AIDS Treatment Modernization Act of 2006, the program is divided into different components, each of which is designed to address a specific aspect of the HIV/AIDS epidemic.

Part A (formerly Title I)

Provides emergency relief through funding for health care and support services to 56 U.S. eligible metropolitan areas (EMAs) and transitional grant areas (TGAs) disproportionately affected by HIV/AIDS.

Part B (formerly Title II)

Assists states and territories in improving the quality, availability, and organization of health care and support services for individuals and families with HIV disease, and provides access to pharmaceuticals through the AIDS Drug Assistance Program (ADAP).

Part C (formerly Title III)

Provides support directly to community-based providers for early intervention and primary care services for people living with HIV/AIDS.

Part D (formerly Title IV)

Enhances access to comprehensive care and research of potential clinical benefits for children, youth, women, and their families with or at risk for HIV.

Part F: Special Projects of National Significance (SPNS)

Supports the development of innovative HIV/AIDS service delivery models that have potential for replication in other areas.

Part F: HIV/AIDS Education and Training Centers

Supports training for health care providers to identify, counsel, diagnose, treat, and manage individuals with HIV infection and to help prevent high-risk behaviors that lead to infection.

Part F: Dental Reimbursement Program

Provides support to dental schools, postdoctoral dental education programs, and dental hygiene programs for non-reimbursed care provided to persons with HIV/AIDS.

Part F: Minority AIDS Initiative

Provides funding across several federal agencies and programs to strengthen organizational capacity and expand HIV-related services in minority communities. The Ryan White component in the most recent reauthorization.

Ryan White Program Part A

Supporting Medical Care and Support Services in Communities Hardest Hit by HIV/AIDS

The Ryan White Program

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was first enacted in 1990 and has been reauthorized there times—first in 1996, then in 2000, and most recently in 2006. Now referred to as the Ryan White HIV/AIDS Treatment Modernization Act of 2006, the program is divided into different components, each of which is designed to address a specific aspect of the HIV/AIDS epidemic.

"The CARE Act supports a system of care. It extends way beyond the prescription—it extends to a total commitment to providing comprehensive care that addresses many patient needs in order to achieve optimal outcomes."

— Marla J. Gold, M.D., Professor and Dean, Drexel University School of Public Health in testimony before the House Labor/HHS Appropriations Subcommittee.

Part A Basics

Part A of the Ryan White Program funds health care and support services for uninsured and underinsured persons living with HIV and AIDS in 56 U.S. urban areas most adversely affected by the HIV/AIDS epidemic. Part A servers an estimated 200,000 people living with HIV/AIDS each year, providing nearly three million health-care-related visits. Approximately two-thirds of Part A clients are people of color and 30 percent are women. More than 70 percent of people with HIV/AIDS live in a metropolitan area served by Part A.

There are two types of Part A entities: eligible metropolitan area (EMA) jurisdictions with over 2,000 living AIDS cases over the last five years, and transitional grant area (TGA) jurisdictions with between 1,000 and 2,000 living AIDS cases over the last five years. Support for EMAs and TGAs is structured the same way, but there are a few key differences in the provisions that apply to these entities.

A Continuum of Care

Communities use Part A funds to provide outpatient health services, including medical and dental care, laboratory testing, and support services such as child care, legal aid, housing, and residential substance abuse treatment.

Funded jurisdictions have used Part A funds to build community-based care systems that include desperately needed services for those living with HIV/AIDS, such as mental health treatment, drug adherence programs, clinical case management, substance abuse treatment, nutrition services, housing and transportation assistance, home care, and emergency assistance. The guiding philosophy behind this integrated, comprehensive system of care is that people living with HIV/AIDS can best manage their illness and reap the benefits of HIV treatments when the full set of care and related needs are met. The legislation mandates that each Part A jurisdiction spend a minimum of 75% of funds on core medical services.

Core Services Mandate

The Ryan White Program requires that 2/3 of spending for Part A services be used on the following core medical services:

- Outpatient/ ambulatory health services;
- ADAP treatments;
- AIDS pharmaceutical assistance;
- Oral health care;
- Early intervention services;
- Health Insurance premium & cost sharing assistance;
- Home health care;
- Home and community-based health services;
- Hospice services;
- Mental health services;
- Medical nutrition therapy;
- Medical case management; and
- Outpatient substance abuse services



Responding to Local Needs

Realizing that each community has different service needs and gaps in care, Congress structured Part A of the Ryan White Program so that local communities play a central role in determining how funds should be used to meet the needs of people living with HIV/AIDS in their areas.

The Ryan White HIV/AIDS Treatment Modernization Act requires the use of a planning council in each EMA and for TGAs that were EMAs under previous versions of the legislation. Planning council membership must be reflective of the local epidemic and is comprised of local public health officials, communitybased service providers, people living with HIV/AIDS, community leaders, and others; at least one-third of planning council membership must be consumers of Ryan White Program services. The planning councils develop needs assessments and funding priorities for use of Part A funds within parameters set by the authorizing statute. The establishment of planning councils is optional in newly-designated TGA jurisdictions.

Distribution of Part A Funds

The HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA) distributes Part A funds to the chief executive of the lead city or county in each jurisdiction. The grantee then distributes funds to local service providers based on the priorities developed by the planning council or other community input.

There are 56 Part A jurisdictions in 24 states, Puerto Rico, and the District of Columbia that receive Part A funding. In order to qualify as a Part A entity, a jurisdiction must have at least 1,000 cumulative AIDS cases reported during the past five years. There are 21 EMAs and 35 TGAs. Part A funding includes formula and supplemental components, as well as Minority AIDS Initiative (MAI) funds targeted for services to minority populations. Formula grants are based on the estimated number of living cases of HIV and AIDS. HRSA awards supplemental and MAI grants competitively based on demonstration of severe need and other criteria. Formula, supplemental, and MAI awards are currently announced and disbursed on a staggered schedule.

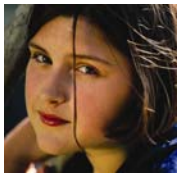
56 Part A Jurisdictions

(Italics indicate EMA jurisdictions)

- *Atlanta, GA*
- Austin, TX
- *Baltimore, MD*
- Baton Rouge, LA
- Bergen-Passaic, NJ
- *Boston, MA and NH*
- Caguas, PR
- Charlotte, NC
- *Chicago, IL*
- Cleveland, OH
- *Dallas, TX*
- Denver, CO
- *Detroit, MI*
- Dutchess County, NY
- *Ft. Lauderdale, FL*
- Ft.Worth, TX
- Hartford, CT
- *Houston, TX*
- Indianapolis, IN
- Jacksonville, FL
- Jersey City, NJ
- Kansas City, MO
- *Las Vegas, NV*
- Los Angeles, CA
- Memphis, TN
- *Miami, FL*
- Middlesex-Somerset-Hunterdon, NJ
- Minneapolis-St. Paul, MN
- Nashville, TN
- Nassau-Suffolk, NY
- New Haven, CT
- *New Orleans, LA*
- *New York, NY*
- *Newark, NJ*
- Norfolk, VA
- Oakland, CA
- Orange County, CA
- *Orlando, FL*
- *Philadelphia, PA*
- *Phoenix, AZ*
- Ponce, PR
- Portland, OR
- Riverside-San Bernardino, CA
- Sacramento, CA
- San Antonio, TX
- *San Diego, CA*
- *San Francisco, CA*
- San Jose, CA
- San Juan, PR
- Santa Rosa/Petaluma, CA
- Seattle,WA
- St. Louis, MO
- *Tampa-St. Petersburg, FL*
- Vineland-Millville-Bridgeton, NJ
- *Washington, DC - MD and VA*
- *West Palm Beach, FL*





COMMUNITIES ADVOCATING EMERGENCY AIDS RELIEF
CAEAR COALITION

Ryan White Program: Part B/AIDS Drug Assistance Program (ADAP)

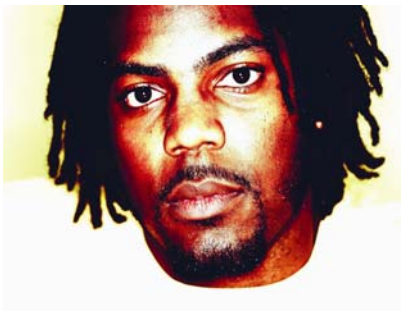
Providing Outpatient Care and Support Services at the State Level and Access to HIV Medications for Those in Greatest Need

The Ryan White Program

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was first enacted in 1990 and has been reauthorized three times—first in 1996, then in 2000, and most recently in 2006. Now referred to as the Ryan White HIV/AIDS Treatment Modernization Act of 2006, the program is divided into different components, each of which is designed to address a specific aspect of the HIV/AIDS epidemic.

Part B Basics

Part B of the Ryan White Program provides grants to all 50 states, the District of Columbia, Puerto Rico and the U.S. territories to provide services for people living with HIV/AIDS, including outpatient medical care, oral health care, home- and community-based services, continuation of health insurance coverage, prescription drugs, HIV care consortia, and supportive services. Part B includes the AIDS Drug Assistance Program (ADAP), which supports the provision of HIV medications and related services. Seventy-five percent of Part B funds must be used to support core medical services.



Funding Mechanisms

Part B funds are distributed through base and supplemental grants, ADAP and ADAP supplemental grants, and Emerging Communities (ECs) grants**.** The base awards are distributed by a formula based on a state or territory's living HIV/AIDS cases weighted for cases outside of Part A-funded jurisdictions. Supplemental awards are available to states with demonstrated need. Congress designates a portion of the Part B award to support ADAP.The majority of ADAP funds are also distributed by a formula based on living HIV/AIDS cases, though 5% of the funds are set aside for states with severe need. A state's combined Part B base award and ADAP allocation cannot decrease by more than five percent per year.

Most states provide some services directly, while others work through subcontracts with Part B HIV Care Consortia. A consortium is an association of public and nonprofit health care and support service providers and community-based organizations that plans, develops, and delivers services for people living with HIV/AIDS. Emerging communities—metropolitan areas that do not yet qualify as EMAs or TGAs but have 500-999 cumulative reported AIDS cases over the last five years— apply for supplemental funding through a grant application.

ADAP Basics

The AIDS Drug Assistance Programs (ADAPs) are a component of Part B. ADAPs provide FDA-approved prescription medications for people with HIV/AIDS with limited or no prescription drug coverage. ADAP funds also may be used to purchase health insurance for eligible clients or to pay for services that enhance access, adherence, and monitoring of drug treatments. In June 2006, ADAPs had more than 141,000 enrollees, representing approximately one-quarter of those with HIV/AIDS who are receiving care in the U.S. Sixty-one percent of those served by ADAPS are people of color. Nationally, more than 80 percent of ADAP clients have incomes at 200 percent or less of the federal poverty level (FPL). Individual ADAPs operate in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, Commonwealth of the Northern Mariana Islands, and the Republic of the Marshall Islands.

Funding Mechanism

Congress "earmarks" a portion of its annual Ryan White Program Part B appropriation for ADAPs. Although the ADAP "earmark" is by far the fastest growing component of Ryan White appropriations, current funding levels do not match the increasing need. ADAPs also receive money from their respective states, other Ryan White components in the state/territory, and cost-savings strategies, such as participation in the 340B Drug Discount program.

Formularies and Distribution Vary By Program

The ADAP in each state or territory also determines which medications will be included in its formulary and how those drugs will be distributed. The majority of ADAPs cover all FDA-approved antiretrovirals, but 19 do not. Only four ADAPs provide all 29 drugs highly recommended for prevention and treatment of HIV-related opportunistic infections, while 37 provide 15 or more. Many states and territories provide medications through a pharmacy reimbursement model, while others use pharmacies located within public health clinics or purchase drugs and mail them directly to clients.

Eligibility

The ADAP in each state or territory determines the eligibility criteria for its participants. All ADAPs require that individuals document their HIV status. Income eligibility ranges from 100 percent to 500 percent of the Federal Poverty Level (FPL). Fifteen states have income eligibility at 200 percent or less of the FPL.

Waiting Lists and Other Cost Containment Measures Hamper Access

As of March 2007, four ADAPS had waiting lists totaling 571 individuals. Nine ADAPs, including one with a waiting list, had other cost containment measures in effect: reduced formularies (2); eligibility restrictions (3); capped enrollment (2) and cost sharing (1). An additional three ADAPs anticipate instituting new cost containment measures in FY 2008.






Attachment H

COMMUNITIES ADVOCATING EMERGENCY AIDS RELIEF
CAEAR COALITION

Ryan White Program Part C

Providing Health Care to People Living with HIV/AIDS in Underserved Communities

The Ryan White Program

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was first enacted in 1990 and has been reauthorized three times—first in 1996, then in 2000, and most recently in 2006. Now referred to as the Ryan White HIV/AIDS Treatment Modernization Act of 2006, the program is divided into different components, each of which is designed to address a specific aspect of the HIV/AIDS epidemic.

Part C Basics

Part C of the Ryan White Program provides direct grants to 357 community-based primary health clinics and public health providers in 49 states, Puerto Rico, the District of Columbia, and the US Virgin Islands.

Part C is the primary means for targeting HIV medical services to underserved and uninsured people living with HIV/AIDS in the nation's rural and urban communities. Part C programs target the most vulnerable communities, including people of color, women, and low-income populations. The program also funds capacity building and planning grants to help organizations strengthen their ability to deliver care to people living with HIV/AIDS. In 2007, Part C funded services reached more than 236,032 people with HIV/AIDS. Sixty-one percent of those served are people of color and 30 percent are female. In addition, Part C clinics are central to the nation's HIV testing initiatives, providing HIV counseling and testing to more than 500,000 people each year.

*Most new patients at Part C-funded clinics are classified as moderately to severely ill and require extensive and costly medical services. Forty-two percent have no health insurance and 72 percent have incomes at or below the federal poverty level.**

* Source: HRSA, Ryan White CARE Act Title III 2001 Data Report

Medical Care for the Underserved

Part C clinics provide a range of health care services designed to help people with HIV learn their HIV status and then access appropriate medical care and services in a community health center/clinic. Seventy-five percent of Title III grants must be spent on core medical services. Specific medical and support services provided by Title III clinics include:

- Medical assessment and on-going medical care;
- Laboratory testing related to antiretroviral therapies;
- Antiretroviral therapies and adherence support;
- Prevention and treatment of HIV-related opportunistic infections;
- Mental health services;
- Outpatient substance abuse treatment;
- Oral health care;
- Care for co-morbidities, including tuberculosis and Hepatitis B and C;
- Medical case management to ensure access to services and continuity of care;
- Nutritional and psychological services;
- Risk-reduction counseling to prevent HIV transmission; and
- HIV counseling and testing.

Planning and Capacity Building Grants

Planning and capacity building grants are critical tools for communities to explore the financial and program implications of starting or expanding primary health services. Planning grants are limited to one year and provide organizations with resources to plan for the provision of new, high quality comprehensive HIV primary health care services in rural or urban underserved areas and communities of color. Intended for a fixed period of one to three years, capacity building grants support efforts to strengthen organizational infrastructure and enhance capacity to develop, improve or expand high quality HIV primary health care services.

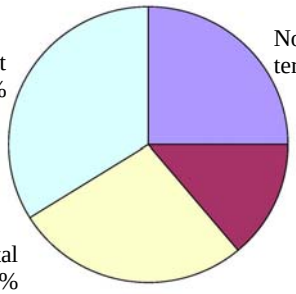
Part C is the primary method for delivering HIV care to rural areas. Approximately half of Part C providers serve rural communities. Frequently, Part C providers are the only means by which many persons receive HIV testing and care.

Funding Mechanism

The HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA) distributes Part C funds directly to service providers through competitive grants in three categories: early intervention services, planning, and capacity building. In FY 2007, $193.5 million was appropriated for the program. The following types of organizations are eligible for Part C grants:

- Community Health Centers, Migrant Health Centers, and Health Care for the Homeless sites funded under Section 330 of the Public Health Service (PHS) Act;
- Family planning grantees (other than states) funded under Section 1001 of the PHS Act;
- Comprehensive Hemophilia Diagnostic and Treatment Centers;
- Federally qualified health centers funded under Section 1905(1)(2)(b) of the Social Security Act;
- City and county health departments providing primary care;
- Out-patient primary care programs at community hospitals and medical centers; and
- Current public or private not-for-profit providers of comprehensive primary care for populations at risk for HIV.

Part C EIS Grantees, 2004



**Source: HRSA, Part C (Title III) 2004 EIS Fact Sheet*

A United Voice for the Ryan White Program

COMMUNITIES ADVOCATING EMERGENCY AIDS RELIEF
CAEAR
COALITION

CAEAR Coalition is a national membership organization which advocates for federal appropriations, legislation, policy and regulations to meet the care, treatment, support service and prevention needs of people living with HIV/AIDS and the organizations that serve them. CAEAR Coalition's proactive national leadership is focused on the Ryan White legislation as a central part of the nation's response to HIV/AIDS.

MEMBERS

California
- AIDS Project East Bay, Oakland
- Alameda County Office of AIDS
- Black Coalition on AIDS, San Francisco
- Catholic Charities CYO, San Francisco
- Desert AIDS Project, Palm Springs
- HIV/AIDS Provider Network, San Francisco
- L.A. Gay & Lesbian Center
- Riverside County Health Services Agency
- San Francisco AIDS Foundation
- San Francisco Department of Public Health
- San Francisco Part A Planning Council
- Tenderloin Health, San Francisco
- Women Responding to Life-Threatening Diseases (WORLD), Oakland

Connecticut
- HealthCare Connection, Inc., Stamford
- Connecticut AIDS Resource Coalition, Hartford

Florida
- Care Resource, Miami
- Miami Beach Community Health Center
- Miami-Dade County

Georgia
- AID Atlanta
- AID Gwinnett, Duluth
- Atlanta Part A Grantee's Office
- Atlanta Part A Planning Council
- Grady Infectious Disease Program, Atlanta

Illinois
- AIDS Foundation of Chicago
- Chicago Department of Public Health, Division of STD/HIV/AIDS
- Chicago EMA Part A Planning Council
- Heartland Health Outreach, Chicago
- The CORE Center, Chicago

Maryland
- Chase Brexton Health Services, Baltimore
- InterGroup Services, Inc., Baltimore

Massachusetts
- Boston Public Health Commission
- Fenway Community Health Center, Boston

Minnesota
- Hennepin County / Minneapolis/St. Paul TGA

New Jersey
- Bergen/Passaic Part A Planning Council
- City of Newark

New York
- AIDS Service Center NYC, New York
- Brooklyn AIDS Task Force
- Community Healthcare Network, New York
- Harlem United Community AIDS Center
- New York AIDS Coalition, New York
- NYC Department of Health & Mental Hygiene
- Project Hospitality, Staten Island
- Village Care of New York

Pennsylvania
- Action AIDS, Philadelphia
- Mazzoni Center, Philadelphia
- Philadelphia Department of Public Health
- Philadelphia Office of HIV Planning

National
- National Association of AETCs
- National Association of People with AIDS
- Project Inform, San Francisco
- Ryan White Foundation

Affiliate
- Bristol-Myers Squibb
- Tibotec Therapeutics
- Virco Lab, Inc.