DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2009

Health Resources and Services Administration

Justification of Estimates for Appropriations Committees

Ryan White HIV/AIDS Treatment Modernization Act of 2006

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$2,112,795,000	$2,141,792,000	$2,142,912,000	+$1,120,000
PHS Act (SPNS)	25,000,000	25,000,000	25,000,000	---
Total	$2,137,795,000	$2,166,792,000	$2,167,912,000	+$1,120,000
FTE	28	30	30	---

**The amounts include funding for Special Projects of National Significance (SPNS) funded from Department PHS Act evaluation set-asides in FY 2008 and proposed for FY 2009.*

Authorizing Legislation: Title XXVI of the Public Health Service Act, as amended.

FY 2009 Authorization…….....…$2,289,300,000

Allocation Method……. Competitive and Formula Grants, Cooperative Agreements and Contracts

Summary of Request

The purpose of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program) is to address the unmet care and treatment needs of persons living with HIV/AIDS who are uninsured or underinsured and therefore unable to pay for HIV/AIDS health care and vital health-related supportive services. Ryan White HIV/AIDS Program funding pays for core primary health care and support services that enhance access to and retention in care and fills gaps in care not covered by other resources or payers. The Program serves more than half a million low-income people with HIV/AIDS in the U.S. each year. Thirty-three percent of those served by the Ryan White HIV/AIDS Program are uninsured and 56 percent are underinsured. Ryan White HIV/AIDS Program services are intended to reduce the use of more costly emergency services and inpatient care, increase access to care for underserved populations, and improve the quality of life for those infected or affected by the epidemic.

The Ryan White Comprehensive AIDS Resources Emergency Act was first enacted in August 1990. It was amended and reauthorized for five years in May 1996 and for an additional five years in October 2000. The Program was reauthorized again in December 2006 for three years as the Ryan White HIV/AIDS Treatment Modernization Act of 2006.

The Ryan White HIV/AIDS Program demonstrates a comprehensive and aggressive approach in how government has targeted dollars toward the development of an effective service delivery system. By funding and partnering with community based, non-profit, local and State programs, the Ryan White HIV/AIDS Program provides primary medical care and support services; healthcare provider training; and technical assistance to help funded programs address implementing the new law and emerging HIV care need.

The HIV/AIDS Bureau requests $2.17 billion for the Ryan White HIV/AIDS Program. The program's structure and distinct components serve very specific purposes. The FY 2009 Program specific funding request and structure of each component follow.

- $619 million for Part A which will provide grants for 22 eligible metropolitan areas (EMAs) and 34 transitional grant areas (TGAs) disproportionately affected by HIV/AIDS to fund a variety of medical and support services;
- $1.2 billion for Part B which will provide grants to 59 States and Territories to improve the quality, availability, and organization of HIV/AIDS health care and support services. This includes $815 million to provide access to FDA approved HIV-related medications through the AIDS Drug Assistance Program (ADAP) which is the nation's prescription drug safety-net for people living with HIV/AIDS, serving primarily low-income people who have limited or no access to needed medications;
- $199 million for Part C which will provide 357 grants directly to service providers (i.e. Federally-qualified health centers, family planning clinics, rural health clinics, Indian Health Service facilities; community-based organizations, and nonprofit faith-based organizations) to support outpatient HIV early intervention services and ambulatory care. It will also provide 15 capacity building grants;
- $74 million for Part D which will provide 93 grants to community based and non-profit private and public organizations to support family-centered comprehensive care to HIV-infected women, infants, children and youth and support to their affected family members. It also will provide 16 Adolescent Program grants.
- Part F: Including:
    - $29 million for AIDS Education and Training Center (AETC) grants to organizations to support education and training of health care providers through 11 Regional Centers, 130 Local Performance Sites and 4 National Centers; and
    - $13 million for HIV/AIDS Dental Reimbursement Program, a retrospective payment system providing reimbursement to dental schools, hospitals with postdoctoral dental education programs, and community colleges with dental hygiene programs for uncompensated costs incurred in providing oral health treatment to patients with HIV disease; and for Community-based Dental Partnership Grants to provide support to dental providers for increased access to oral health care services for HIV-positive individuals while providing education and clinical training for dental care providers, especially those located in community based settings.
- $25 million for Special Projects of National Significance (SPNS) funded from the Department PHS Act evaluation set-asides.

The HIV/AIDS Bureau has continued to demonstrate outstanding performance by improving access to health care, improving health outcomes, improving quality of health care, and promoting efficiency. The Ryan White Program uses various strategies to achieve its performance goals, including targeting resources to high-risk areas, working to assure patient adherence and compliance, directing outreach and prevention education

and testing to populations at disproportionate risk for HIV infection, tailoring services to populations known to have delayed care-seeking behaviors (e.g., varying hours, care offered in various sites, linguistically and culturally appropriate service provision), and collaborating with other programs and providers for referrals to Ryan White service providers.

Improving Access to Health Care: The Ryan White HIV/AIDS Program works to improve access to health care by addressing the disparities in access, treatment, and care for racial/ethnic minorities and women disproportionately impacted by HIV/AIDS. The Ryan White HIV/AIDS Program provides HIV/AIDS care and treatment services to a significantly higher proportion of racial/ethnic minorities and women than their representation among AIDS cases as reported by CDC. The proportion of Ryan White clients who were racial/ethnic minorities in 2005 was 72%, compared to the 64.1% of CDC-reported AIDS cases. In 2006, 72% of the Ryan White HIV/AIDS Program clients were racial/ethnic minorities. (The CDC AIDS data for comparison are not available at the time of this writing.)

In 2005, 33% of persons served by the Ryan White HIV/AIDS Program were women, compared to 24% of CDC reported AIDS cases. The proportion of women served by the Ryan White HIV/AIDS Program in 2006 was 33%. (CDCs AIDS data used for comparison are not available at the time of this writing.)

Improving Health Outcomes: In 2006, the AIDS Drug Assistance Program (ADAP) served 157,988 clients through State ADAPs. This can not be compared with the FY 2006 target because the actual performance is based on the revised measure using annual data and the target is based on the former measure utilizing monthly Program data. The number of ADAP clients served through State ADAPs annually in 2006 was 10,801 persons above the 2005 results. About one in four HIV positive people in care in the U.S. receive their medications through State ADAPs.

CDC estimates that 1.039 to 1.185 million people in the United States are living with HIV/AIDS, of whom an estimated 25 percent are unaware of their serostatus. In 2005, the number of persons who learned their serostatus from Ryan White HIV/AIDS Programs was 572,397, exceeding the target by 7,757 persons. These efforts demonstrate that the Ryan White HIV/AIDS Program has made important strides in reaching people living with HIV/AIDS in the United States who do not know their serostatus.

Mother-to-child transmission in the U.S. has decreased dramatically, since its peak in 1992, due to the use of anti-retroviral therapy which significantly reduces the risk of transmission from the mother to her baby. In 2005, 85.3% of HIV-positive pregnant women in Ryan White HIV/AIDS Programs received anti-retroviral medications.

Improving the Quality of Health Care: A major focus of the Ryan White HIV/AIDS Program is to improve the quality of care that its clients receive. Legislative requirements found in the Ryan White HIV/AIDS Treatment Modernization Act of 2006 direct grantees to develop, implement, and monitor clinical quality management

programs to ensure that service providers adhere to established HIV clinical practices and quality improvement strategy; and that demographic, clinical, and health care utilization information is used to monitor trends in the spectrum of HIV-related illnesses and the local epidemic. Building on earlier program efforts, by 2006, 88.6% of Ryan White HIV/AIDS Program-funded primary medical care providers had implemented a quality management program, exceeding the target by 18.6 percentage points.

CD4 cell measurement, a key test used to assess the functioning of the immune system, helps guide decisions about when to start HIV treatment and monitors effectiveness of HIV treatment. Viral load tests measure the amount of HIV in the blood and are used along with CD4 cell counts to decide when to start HIV treatment and to monitor response to therapy. In 2006, the Ryan White HIV/AIDS Program provided CD4 count testing to 84.9% of new clients and viral load testing to 82.5% of these new clients. This exceeded the target for CD4 tests by 4.9 percentage points and exceeded the target of new clients receiving viral load testing by 7.5 percentage points.

Promoting Efficiency: State ADAPs use a variety of strategies to contain costs and these result in a more effective use of funding, enabling ADAPs to serve more people. Cost-containment measures used by ADAPs include: using drug purchasing strategies like seeking cost recovery through drug rebates and third party billing; and direct negotiation of pharmaceutical pricing. ADAPs' savings strategies on medications resulted in a savings of $76 million in 2002, $92.5 million in 2003, and $143.5 million is 2004. In 2005, the ADAP program had cost-savings on medications of $275 million, exceeding the target by $128.7 million.

Program Assessment Rating Tool: An Office of Management and Budget (OMB) Program Assessment Rating Tool (PART) reassessment of the Ryan White HIV/AIDS Program was conducted in 2007 and the Program received the highest possible rating of Effective. The review found that the program has had a positive impact, has strong and effective collaborations with similar programs, and has demonstrated improved management and oversight of the use of Federal funds. The Program is undertaking actions that include: 1) Implementing the 2006 reauthorization of the Ryan White HIV/AIDS Program and assuring that new provisions are being fulfilled appropriately, and 2) Working toward client-level data reporting by Ryan White HIV/AIDS Program beginning in 2009 to obtain accurate counts of those served with Ryan White HIV/AIDS Program funds. (See www.ExpectMore.gov for more information).

***Funding History**

FY 1999	$ 1,435,851,000
FY 2000	$ 1,619,235,000
FY 2001	$ 1,832,609,000
FY 2002	$ 1,927,239,000
FY 2003	$ 2,017,966,000
FY 2004	$ 2,044,861,000
FY 2005	$ 2,073,296,000
FY 2006	$ 2,061,275,000
FY 2007	$ 2,137,795,000
FY 2008	$ 2,166,792,000

* Includes SPNS

Budget Request

The FY 2009 Request of $2,167,912,000 is an increase of $1,120,000 over the FY 2008 Enacted level. This funding will continue to support over 2,300 providers that help half a million individuals living with HIV/AIDS obtain access to life-sustaining care and supportive services. The Part A request includes a decrease of $7,725,000. The FY 2009 Request also includes an increase of $14,239,000 to support current Part B program activities and includes an increase of $6,046,000 to AIDS Drug Assistance Program that provides life-saving medications for an additional 148 people living with HIV over the FY 2008 target. The Part C FY 2009 Request is $198,754,000 and the Part D FY 2009 Request is $73,690,000. Both the Part C and the Part D Request are the same as the FY 2008 Enacted level. The Part F AIDS Education and Training Centers FY 2009 Request of $28,700,000 is $5,394,000 less than the FY 2008 Enacted level. This will decrease the AETC Program's level of services including training and technical assistance to HIV/AIDS health care providers. The Part F Dental Service FY 2009 Request of $12,857,000 is equal to FY 2008 Enacted level.

In FY 2009, the Program will continue its central goal of increasing access to care for underserved populations, and improving the quality of life for those infected or affected by the epidemic. Some ongoing challenges faced in meeting performance targets include the following: many persons are unaware of their serostatus, persons who know they are infected may be reluctant to seek HIV/AIDS care, and persons may be unaware of the availability of Ryan White HIV/AIDS Program services. To the extent possible, the Program targets resources to address these challenges.

The Program will continue to appropriately target racial/ethnic minorities and women because these groups are disproportionately impacted by HIV/AIDS. For African Americans and other blacks, HIV/AIDS is a leading cause of death. With regard to women, data from the 2005 census show that together, black and Hispanic women represent 24% of all US women. However, women in these 2 groups accounted for 82% of the estimated total of AIDS diagnoses for women. The FY 2009 targets for the proportion of racial/ethnic minorities and women served in Ryan White HIV/AIDS – funded programs are 5 percentage points above CDC data.

In FY 2009, the Program will aim to reach the following additional performance targets. The number of clients served by ADAPs is predicted to be 158,887 clients. The FY 2009 target for persons who learn their serostatus from Ryan White HIV/AIDS programs is 572,397. The FY 2009 target for the percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive anti-retroviral medication is 89.3%.

The budget request will also support the Program's ongoing efforts to improve the quality of health care. The FY 2009 target for the percentage of Ryan White HIV/AIDS Program-funded primary care providers that will have implemented a quality management program is 95.7%. The FY 2009 targets for new HIV infected clients who are tested for CD4 is 87.2% and for viral load is 83.3%.

In FY 2009, the Ryan White HIV/AIDS Program will continue to coordinate and collaborate with related Federal, State, local entities as well as national AIDS organizations in order to further leverage and promote efforts to address the unmet care and treatment needs of persons living with HIV/AIDS who are uninsured or underinsured. The Program's work in collaboration with others has been a key to its success. Federal partners include the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Center for Medicaid and Medicare Service, (CMS), Indian Health Service (IHS), the Department of Housing and Urban Development (HUD), the National Institutes of Health (NIH), the Department of Veteran's Affairs (DVA), and the Department of Justice (DOJ).

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long-Term Objective: Expand the Capacity of the Health Care Safety Net										
16.1	Number of racial/ethnic minorities and the number of women served by Ryan White HIV/AIDS-funded programs. (Baseline – 2005)		412,000/ 195,000							2014: 422,300/ 199,875
16.I.A.1	Proportion of racial/ethnic minorities in Ryan White HIV/AIDS-funded programs served. (exceeding their representation in national AIDS prevalence data reported by the CDC)	DNA[a]	72%	5 percentage points above CDC data[b]	72%	5 percentage points above CDC data	Oct-08	5 percentage points above CDC data	5 percentage points above CDC data	NA[c]

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long-Term Objective: Expand the Capacity of the Health Care Safety Net										
16.I.A.2	Proportion of women in Ryan White HIV/AIDS funded-programs served. (exceeding their representation in national AIDS prevalence data reported by the CDC)	33%	33%	5 percentage points above CDC data[b]	33%	5 percentage points above CDC data	Oct-08	5 percentage points above CDC data	5 percentage points above CDC data	NA[c]
Long-Term Objective: Expand the Availability of Health Care, Particularly to Underserved, Vulnerable, and Special Needs Populations										
16.2	Reduce deaths of persons due to HIV infection. (Baseline – 2003: 4.7 per 100,000)									2014: 3.1 per 100,000

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
				Target / Est.	Actual	Target/ Est.	Actual			
Long-Term Objective: Expand the Availability of Health Care, Particularly to Underserved, Vulnerable, and Special Needs Populations										
16.II.A.1.	Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually.	DNA[a]	147,187	131,808[d]	157,988	143,339[d]	Jan-09	158,739[d]	158,887	NA[c]
16.II.A.2.	Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs.	553,569	572,397	583,845	Feb-08	572,397[e]	Feb-09	572,397[e]	572,397	NA[c]
16.II.A.3.	Percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive Anti-Retroviral Medications.	DNA[a]	85.3%	86.3%	Feb-08	87.3%	Feb-09	88.3%	89.3%	NA[c]

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target / Est.
				Target / Est.	Actual	Target / Est.	Actual			
Long-Term Objective: Promote Effectiveness of Health Care Systems										
16.3	Ryan White HIV/AIDS Program-funded HIV primary medical care providers will have implemented a quality management program and will meet two "core" standards included in the October 10, 2006 "Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents. (Baseline – 2005)		63.7%							2014: 90% [f]
16.III.A.1.	Percentage of Ryan White HIV/AIDS Program-funded primary medical care providers that will have implemented a quality management program.	DNA[a]	85.7%	70%	88.6%	90.7%[e]	Aug-08	93.2%[e]	95.7%	NA[c]
16.III.A.2.	Proportion of new Ryan White HIV/AIDS Program HIV-infected clients who are tested for CD4 count and viral load.	DNA[a]	CD4 - 83.2% Viral Load – 79.3%	CD4- 80% Viral Load – 75%	CD4-84.9% Viral Load- 82.5%	CD4- 85.2% Viral Load- 81.3%[e]	Aug-08	CD4- 86.2% Viral Load – 82.3%[e]	CD4- 87.2% Viral Load – 83.3%	NA[c]
Efficiency Measure										
16.E.	Amount of savings by State ADAPs' participation in cost-savings strategies on medications.[g]	$143.5M	$275M	2 percent over FY 05	Apr-08	1 percent over FY 06[e]	Apr-09	1 percent over FY 07[e]	1 percent over FY 08	NA[c]
	Appropriated Amount ($ Million)	$2,044.9	$2,073.3		$2,061.3		$2,137.8	$2,166.8	$2,167.9	

Notes:

[a] DNA = Data not available. Due to the aggregate nature of the CADR data and the way the race/ethnicity questions were phrased, the proportion of racial/ethnic minorities served by the Ryan White HIV/AIDS Program can not be calculated for 2002-2004.

[b] CDC's data for comparison is not available as of this writing.

[c] NA = Not applicable.

[d] The FY 2006 target is based on number of persons served at least one quarter of the year, rather than number of persons served annually. The FY 2007 and FY 2008 targets differ from those shown in the FY 2008 Congressional Justification to reflect actual funding levels.

[e] The FY 2007 and FY 2008 targets differ from those shown in the FY 2008 Congressional Justification because targets were reset in the FY 2007 PART reassessment.

[f] This target was established during the PART reassessment, and therefore differs from the previously reported target.

[g] Cost-saving strategies are defined as rebates, third party reimbursements, and direct negotiations with pharmaceutical companies.

Ryan White HIV/AIDS Program, Part A Emergency Relief Grants

	FY 2007 Enacted	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$603,993,000	$627,149,000	$619,424,000	-$7,725,000

Authorizing Legislation: Title XXVI, Sections 2601-2610 of the Public Health Service Act, as amended.

FY 2009 Authorization…….……$649,500,000

Allocation Method……..…. Competitive and Formula Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Part A of the Ryan White HIV/AIDS Program prioritizes primary medical care, access to anti-retroviral therapies, and medical case management as the areas of greatest need for persons with HIV disease. Part A funds may be used to provide a continuum of care for people living with HIV disease who are primarily low income, underserved, uninsured and underinsured. The grants fund systems of care to provide 13 core medical services and other additional support services for individuals with HIV/AIDS in 22 Eligible Metropolitan Areas (EMAs), which are jurisdictions with over 2,000 living AIDS cases over the last five years and 34 transitional grant areas (TGAs) (jurisdictions with between 1,000 and 2,000 living AIDS cases over the last five years). Two-thirds of the funds available are awarded according to a formula based on the number of living cases of HIV/AIDS in the EMAs and TGAs. The statute also includes a hold harmless provision which limits a potential loss in EMA's formula award to a specific percentage of the amount of the award in the previous year. The remaining funds, less any hold harmless amounts, are awarded as discretionary supplemental grants based on the demonstration of additional need by the EMAs and TGAs and as competitive Minority AIDS Initiative grants.

More than 70 percent of all people living with HIV/AIDS in the U.S. reside in a metropolitan area served by Part A. Part A serves an estimated 300,000 people living with HIV/AIDS each year. Seventy-five percent of Part A clients are people of color and 30 percent are women. In 2004 Part A provided 3.11 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) and 3.18 million visits were provided in 2005. In FY 2006, 2.47 million visits were provided by 51 Part A grantees. This number is 440,000 below the 2006 target. The decrease in visits for FY 2005 and FY 2006 is may be a result of the decline in Ryan White HIV/AIDS Program resources available for funding service provision, which resulted in fewer PART A providers and clients, and the impact of healthcare inflation.

Cervical Intraepithelial Neoplasia (CIN) refers to cellular changes in the cervix, thought to be precursors of cervical cancer that can be detected with PAP screening. Researchers

conclude that HIV+ women are three times as likely as HIV negative women to have CIN. Part A has continued to increase the proportion of women that receive PAP screening. In 2005, 38% of women received PAP screening and in 2004 35.8% of women received such screening. In FY 2006, the Part A program provided 40.8% of women served with PAP screening. This fell short of the target by 6.6 percentage points.

Latent TB is much more likely to become active TB in someone who is HIV infected. This is because HIV weakens the immune system, allowing TB to flourish. The CDC recommends HIV-infected persons get tested for TB, with a TB Skin Test (TST). The Part A program provided TB skin tests to 28% of clients in 2004, and 54% of client in 2005. In FY 2006, the Part A program provided 52.5% of clients with TB skin tests. This exceeded the target by 18.5 percentage points.

Program Assessment Rating Tool: Part A was included in the combined PART reassessment conducted in 2007 for the Ryan White HIV/AIDS Program. The Program received an Effective rating. See Summary of Request for more details.

External Evaluation: Part A is regularly evaluated by independent entities, such as Office of the Inspector General and Government Accountability Office. In the past year an OIG Audit was conducted entitled "Review of the Management of Unobligated Funds Provided by Part A of the Ryan White Comprehensive AIDS Resources Emergency Act" (A-02-03-02006) (Final Report - February 2007). The findings of these Audits indicated that HRSA did not always comply with Departmental policy that limit the carryover of unobligated grant balances to the next budget year only. These funds were originally awarded to provide services during a specific budget year but were carried over for use in subsequent budget periods. Departmental policy guidance issued after the audit period now permits the carryover of unobligated grant funds into either of the next two budget periods. HAB has taken appropriate steps and follows current Departmental policy regarding the approval of carryover requests from Part A grantees.

The GAO conducted an evaluation in the past year entitled "Impact of Legislative Funding Proposal on Urban Areas" (GAO-08-137R) (Final Report - October 2007). The Legislative Funding Proposal found that prior to the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (enacted December 19, 2006), the Part A funding amounts were evenly split between formula and supplemental grants. The new legislation changed the distribution such that two-thirds of Part A funds are distributed as formula grants and one-third as supplemental grants. The findings showed how the proposed hold-harmless provision from H.R. 3043 would impact funding for urban areas under the proposed funding levels.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 1999	$ 505,039,000
FY 2000	$ 546,392,000
FY 2001	$ 604,169,000
FY 2002	$ 619,381,000
FY 2003	$ 618,693,000
FY 2004	$ 615,023,000
FY 2005	$ 610,094,000
FY 2006	$ 603,576,000
FY 2007	$ 603,993,000
FY 2008	$ 627,149,000

Excludes comparable amounts for SPNS

Budget Request

The FY 2009 Request of $619,424,000 is $7,725,000 below the FY 2008 Enacted level but does support authorized program activities and services in the 22 Eligible Metropolitan Areas and 34 Transition Grant Areas.

The FY 2009 target for the number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) to the level that approximates inclusion of new clients is set at 2.44 million visits. The proportion of women that receive PAP screening has a FY 2009 target 45.9% (baseline plus 1.5%). The FY 2009 target for the proportion of clients that receive TB skin test will be to sustain the FY 2008 result. Part A funding will also contribute to achieving the FY 2009 targets for the Ryan White Program's over-arching performance measures, including proportion of racial/ethnic minorities and women served, persons tested for CD4 count and viral load, and providers implementing a quality management program. (See Summary of Request for targets and for strategies and challenges.)

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long – Term Objective: Promote Effectiveness of Health Care Services									
17.III.A.1.	Proportion of women that receive PAP screening.	35.8%	38%	Baseline plus 1.5%	40.8%	Baseline plus 1.5%	Oct-08	Baseline plus 1.5%	Baseline plus 1.5%
17.III.A.2.	Proportion of clients that receive TB skin tests.	28%	54%	1.5% over FY 05	52.5%	Sustain FY 06	Oct-08	Sustain FY 07	Sustain FY 08

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Enacted	FY 2009 Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual		
Long – Term Objective: Expand the Capacity of the Health Care Safety Net									
17.I.A.1.	Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) to a level that approximates inclusion of new clients.	3.11 M	3.18 M	2.91 M	2.47 M	2.91 M	Jan-09	2.47 M[a]	2.44 M
	EMAs	51	51		51				
	EMAs and Transitional areas						56	56	56
	Appropriated Amount ($ Million)	$615.023	$610.094		$603.576		$603.993	$627.149	$619.424

Notes:
[a] This FY 2008 target was changed from that shown in the FY 2008 Congressional Justification to be consistent with recent performance.

FY 2007 Ryan White HIV/AIDS Treatment Modernization Act of 2006
Part A - Formula & Supplemental Grants

EMAs	Formula	Supplemental	Total
Atlanta, GA	$ 12,223,780	$ 3,850,505	$ 16,074,285
Baltimore, MD	13,101,233	5,186,790	18,288,023
Boston, MA	9,091,554	3,769,583	12,861,137
Chicago, IL	16,477,405	6,888,727	23,366,132
Dallas, TX	9,137,396	3,640,608	12,778,004
Detroit, MI	5,648,743	2,073,152	7,721,895
Ft. Lauderdale, FL	9,444,098	3,727,245	13,171,343
Houston, TX	12,780,890	5,120,182	17,901,072
Los Angeles, CA	23,182,654	9,552,345	32,734,999
Miami, FL	16,014,327	6,481,882	22,496,209
New Orleans, LA	4,944,054	1,770,338	6,714,392
New York, NY	74,867,223	25,998,357	100,865,580
Newark, NJ	9,089,812	3,552,687	12,642,499
Orlando, FL	5,503,524	1,980,246	7,483,770
Philadelphia, PA	14,920,594	5,037,001	19,957,595
Phoenix, AZ	4,970,250	1,811,234	6,781,484

EMAs	Formula	Supplemental	Total
San Diego, CA	6,769,231	2,912,131	9,681,362
San Francisco, CA	14,672,553	4,134,300	18,806,853
San Juan, PR	9,415,282	2,553,297	11,968,579
Tampa-St. Petersburg, FL	6,330,047	2,345,441	8,675,488
Washington, DC	18,759,719	6,895,292	25,655,011
West Palm Beach, FL	5,769,416	1,949,450	7,718,866
	$303,113,785	**$111,230,793**	**$414,344,578**

TGAs	Formula	Supplemental	Total
Austin, TX	$ 2,311,513	$ 1,073,557	$ 3,385,070
Bergen-Passaic, NJ	2,480,997	1,101,476	3,582,473
Caguas, PR	690,977	269,503	960,480
Cleveland, OH	2,606,155	1,060,413	3,666,568
Denver, CO	4,860,304	1,925,546	6,785,850
Dutchess County, NY	719,007	339,616	1,058,623
Ft. Worth, TX	2,298,475	940,508	3,238,983
Hartford, CT	2,003,833	913,750	2,917,583
Jacksonville, FL	3,078,757	1,414,071	4,492,828
Jersey City, NJ	2,831,049	1,286,939	4,117,988
Kansas City, MO	2,524,021	1,013,510	3,537,531
Las Vegas, NV	3,251,501	1,193,110	4,444,611
Middlesex-Somerset-Hunterdon, NJ	1,599,025	701,085	2,300,110
Minneapolis-St. Paul, MN	2,963,378	1,240,032	4,203,410
Nassau-Suffolk, NY	3,130,907	1,358,744	4,489,651
New Haven, CT	3,278,228	1,501,862	4,780,090
Norfolk, VA	3,390,349	1,284,883	4,675,232
Oakland, CA	3,781,868	1,663,113	5,444,981
Orange County, CA	3,328,279	1,345,454	4,673,733
Ponce, PR	1,101,000	445,740	1,546,740
Portland, OR	2,120,010	957,919	3,077,929
Riverside-San Bernardino, CA	4,389,913	2,074,448	6,464,361
Sacramento, CA	1,472,863	689,474	2,162,337
St. Louis, MO	3,471,180	1,424,275	4,895,455
San Antonio, TX	2,441,234	949,837	3,391,071
San Jose, CA	1,596,809	604,404	2,201,213
Santa Rosa, CA	725,352	265,582	990,934

TGAs	Formula	Supplemental	Total
Seattle, WA	4,051,676	1,667,482	5,719,158
Vineland-Millville-Bridgeton, NJ	518,884	196,470	715,354
Baton Rouge, LA	2,179,184	831,337	3,010,521
Charlotte-Gastonia, NC-SC	2,854,516	974,327	3,828,843
Indianapolis, IN	2,277,616	763,694	3,041,310
Memphis, TN	3,585,906	1,432,797	5,018,703
Nashville, TN	2,541,621	938,981	3,480,602
	$86,456,387	**$35,843,939**	**$122,300,326**

Ryan White HIV/AIDS Program, Part B HIV Care Grants to States

	FY 2007 Enacted	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$1,195,500,000	$1,195,248,000	$1,209,487,000	+$14,239,000
State	$ 405,954,000	$ 386,748,000	$ 394,941,000	+$ 8,193,000
ADAP	$ 789,546,000	$ 808,500,000	$ 814,546,000	+$ 6,046,000

Authorizing Legislation: Title XXVI, Sections 2611-2631 of the Public Health Service Act, as amended.

FY 2009 Authorization……..……$1,285,200,000

Allocation Method……. Competitive and Formula Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Part B of the Ryan White HIV/AIDS 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. 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 are metropolitan areas that do not qualify as EMAs or TGAs but have 500-999 cumulative reported AIDS cases over the last five years and apply for supplemental funding through a grant application. The AIDS Drug Assistance Programs (ADAPs) provides 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.

The Part B programs have been successful in helping to ensure that people living with HIV/AIDS can get the care and services they need to stay healthy longer. The number of visits for health-related services demonstrates the effectiveness of the Part B program in delivering primary care and related services for individuals infected with HIV/AIDS by increasing the availability and accessibility of care. Part B programs provided 2.28 million visits in 2004 and 2.34 million visits in 2005. In FY 2006, Part B provided 1.88 million visits. The actual performance for FY 2006 exceeded the target by 320,000 visits. This however was a decrease from FY 2005. This is most likely a result of the decline in Program resources available for funding service provision, which resulted in fewer providers and clients, and the impact of healthcare inflation. ADAP served 147,187 clients in 2005. In FY 2006, 157,988 clients were served annually through State ADAPs exceeding the target. Sixty-five percent of those served by ADAPS are people of color. Nationally, more than 78 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.

Program Assessment Rating Tool: Part B was included in the combined PART reassessment conducted in 2007 for the Ryan White HIV/AIDS Program. The Program received an Effective rating. See Summary of Request for more details.

External Evaluation: The Part B program is regularly evaluated by independent agencies, such as OIG and GAO. In the past year an OIG Audit was conducted entitled "Review of the Management of Unobligated Funds Provided by Part B of the Ryan White Comprehensive AIDS Resources Emergency Act" (A-06-04-00060) (Final Report - May 2007). The findings of these Audits indicate that HRSA did not always comply with Departmental policy that limit the carryover of unobligated grant balances to the next budget year only. These funds were originally awarded to provide services during a specific budget year were instead carried over for use in subsequent budget periods. Departmental policy guidance issued after the audit period now permits the carryover of unobligated grant funds into either of the next two budget periods. HAB has taken appropriate steps and follows current Departmental policy regarding the approval of carryover requests from Part B (Title II) grantees. Additionally, the Part B program examines the reasons for some States' large unobligated balances and monitors compliance to obligate 75 percent of grant award with in 120 days.

A GAO evaluation conducted in the past year was entitled "Oversight of Drug Pricing in Federal Programs" (GAO-07-481T) (Final Report - February 2007). The Legislative Funding Proposal found that prior to the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (enacted December 19, 2006), the Part A funding amounts were evenly split between formula and supplemental grants. The new legislation changes the distribution whereas; two-thirds of Part A funds will be distributed as formula grants and one-third as supplemental grants. The finding showed how the proposed hold-harmless provision from H.R. 3043 would impact funding for urban areas under the proposed funding levels. The Oversight of Drug Pricing in Federal Programs provided

information related to the oversight of prescription drug pricing practices, especially 340B drug pricing programs which provide discounted drug prices to some State ADAPs. HRSAs Healthcare Systems Bureau, Office of Pharmacy Affairs administers the 340B Program which GAO found lacks transparency in 340B prices, lacks oversight, and provides overpayments to drug manufactures.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount	ADAP-Non-Add
FY 1999	$ 737,765,000	($461,000,000)
FY 2000	$ 823,838,000	($528,000,000)
FY 2001	$ 910,969,000	($589,000,000)
FY 2002	$ 977,240,000	($639,000,000)
FY 2003	$1,053,393,000	($714,326,000)
FY 2004	$1,085,900,000	($748,872,000)
FY 2005	$1,121,836,000	($787,521,000)
FY 2006	$1,119,744,000	($789,005,000)
FY 2007	$1,195,500,000	($789,546,000)
FY 2008	$1,195,248,000	($808,500,000)

Excludes comparable amounts for SPNS

Budget Request

The FY 2009 Request of $1,209,487,000 is an increase of $14,239,000 over the FY 2008 Enacted level. The request supports current program activities and includes an increase to provide life-saving medications to people living with HIV. Of this amount $394,941,000 which is $8,193,000 above the FY 2008 Enacted level will be used for base formula HIV grants for the provision of services in the fifty States, the District of Columbia, Puerto Rico, the Virgin Islands and six Pacific jurisdictions. This request also includes $814,546,000 for State ADAP which is $6,046,000 above the FY 2008 Enacted level.

HRSA has developed a model for estimating the marginal cost of serving ADAP clients. The model takes into account many of the factors affecting purchasing power, such as increases in cost of HIV/AIDS drugs; the legislative requirement that all State ADAPs maintain a minimum drug formulary, including new drug classes; and the impact of Medicare Part D, rebates, and insurance coverage. The FY 2009 ADAP Request of $814,546,000 will support providing ADAP services to 158,887 persons. This represents an increase of 148 individuals over the estimated number that might be served at the FY 2008 level. The marginal cost model corroborates the Program's projected target for number of ADAP clients is by 2009. Part B funding will also contribute to achieving the FY 2009 targets for the Ryan White Program's over-arching performance measures, including proportion of racial/ethnic minorities and women served, number of ADAP

clients, persons tested for CD4 count and viral load, and providers implementing a quality management program. (See Summary of Request for targets and for strategies and challenges.)

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Enacted	FY 2009 Target/ Est.
				Target / Est.	Actual	Target/ Est.	Actual		
Long – Term Objective: Expand the Capacity of the Health Care Safety Net									
18.I.A.1.	Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) to a level that approximates inclusion of new clients.	2.28M	2.34M	1.56M	1.88M	1.56M	Jan-09	2.14 M[a]	2.28 M
	Grantees Funded	59	59		59		59	59	59
	Part B Emerging Communities	29	28		26		19	19	TBD[b]
	Appropriated Amount ($ Million)	$1,085.9	$1,121.8		$1,119.7		$1,195.5	$1,195.2	$1,209.5

Notes:
[a.] This FY 2008 target was changed from that shown in the FY 2008 Congressional Justification to be consistent with recent performance.
[b.] Emerging Communities are metropolitan areas that do not yet qualify as EMAs or TGAs but have 500 - 999 cumulative AIDS cases over the last five years. The number of Part B Emerging Communities for 2009 is determined by the reported AIDS cases from 1/2003 - 12/2007. The Program expects to receive the 2007 AIDS case data from CDC that is required for this calculation around the Summer or Fall of 2008.

State Table

FY 2009 Ryan White HIV/AIDS Treatment Modernization Act
Part B CARE Grants

State/Territory	FY 2007 Total*	FY 2008** Estimate	FY 2009*** Estimate	Difference +/- 2008
Alabama	$ 19,791,847			
Alaska	1,129,894			
Arizona	13,543,748			
Arkansas	7,901,902			
California	122,936,034			
Colorado	13,396,954			
Connecticut	15,044,081			
Delaware	5,270,515			
District of Columbia	18,834,754			
Florida	117,413,102			

State/Territory	FY 2007 Total*	FY 2008** Estimate	FY 2009*** Estimate	Difference +/- 2008
Georgia	40,350,086			
Hawaii	3,237,348			
Idaho	1,105,364			
Illinois	36,392,873			
Indiana	12,996,706			
Iowa	2,874,145			
Kansas	3,434,675			
Kentucky	7,608,908			
Louisiana	21,542,485			
Maine	1,399,166			
Maryland	35,050,493			
Massachusetts	19,567,006			
Michigan	16,950,334			
Minnesota	7,088,148			
Mississippi	13,997,861			
Missouri	13,786,156			
Montana	866,238			
Nebraska	2,381,505			
Nevada	8,010,232			
New Hampshire	1,502,980			
New Jersey	45,995,066			
New Mexico	4,065,724			
New York	169,488,721			
North Carolina	34,000,911			
North Dakota	343,556			
Ohio	23,352,802			
Oklahoma	9,110,963			
Oregon	6,709,281			
Pennsylvania	38,649,989			
Rhode Island	3,348,666			
South Carolina	29,068,516			
South Dakota	805,924			
Tennessee	18,374,749			
Texas	89,342,110			
Utah	4,275,389			
Vermont	902,212			
Virginia	28,922,603			
Washington	11,757,722			
West Virginia	2,457,104			

State/Territory	FY 2007 Total*	FY 2008** Estimate	FY 2009*** Estimate	Difference +/- 2008
Wisconsin	9,475,779			
Wyoming	680,188			
Subtotal	**1,116,533,515**			
Guam	291,084			
American Samoa	51,979			
Marshall Islands	52,968			
N. Marianas	53,958			
F. States Micronesia	57,447			
Republic Of Palau	50,000			
Puerto Rico	32,563,575			
Virgin Islands	1,272,874			
Subtotal	**34,393,885**			
Total States/Territories	**$1,150,927,400**			
Technical Assistance				
Other Adjustments*****	41,000,176			
Subtotal Adjustments	41,000,176			
Total	**$ 1,191,927,576**	**1,195,248,000**	**1,209,487,000**	

*Total includes AIDS Drug Assistance Program (ADAP) and Base Formula awards, and Competitive ADAP Supplemental and Minority AIDS Initiative (MAI) award amounts

**Fiscal Year 2008 grant amounts pending award calculations in March 2008

***Fiscal Year 2009 grant amounts pending award calculations in March 2009

****Total State Grants include or would include amounts for AIDS Drug Assistance Programs as follows:
FY 2007 $789,546,000 (excludes 5% setaside for severe need supplemental)
FY 2008 $808,500,000 (excludes 5% setaside for severe need supplemental)
FY 2009 $814,546,000 (excludes 5% setaside for severe need supplemental)

*****Includes amount for technical assistance to Ryan White Program grantees and program evaluation

Ryan White HIV/AIDS Program, Part C Early Intervention Services

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$193,721,000	$198,754,000	$198,754,000	---
FTE	28	30	30	---

Authorizing Legislation: Title XXVI, Sections 2651-2667 of the Public Health Service Act, as amended.

FY 2009 Authorization……..……$235,100,000

Allocation Method……. Competitive Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Part C of the Ryan White Program provides direct grants to over 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 frontier communities. Part C programs target the most vulnerable communities, including people of color, women, and low-income populations. The program also funds capacity building grants to help organizations strengthen their ability to deliver care to people living with HIV/AIDS. Seventy-one percent of those served are people of color and 30 percent are female. In addition, Part C providers are central to the nation's HIV testing initiatives, providing HIV counseling and testing to more than 500,000 people each year.

The 2004 results showed 212,471 persons were served by the Early Intervention Services program. In 2005, the Part C program provided primary care services under Early Intervention Services (EIS) to 216,591 clients, exceeding the target by 37 percent and representing an increase of 2% in new clients served compared to FY 2004.

Program Assessment Rating Tool: Part C was included in the combined PART reassessment conducted in 2007 for the Ryan White HIV/AIDS Program. The Program received a rating of Effective. See Summary of Request for more details.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 1999	$ 94,270,000
FY 2000	$138,372,000
FY 2001	$185,879,000
FY 2002	$185,879,000
FY 2003	$198,374,000
FY 2004	$197,170,000
FY 2005	$195,578,000
FY 2006	$193,488,000
FY 2007	$193,721,000
FY 2008	$198,754,000

Excludes comparable amounts for SPNS

Budget Request

The FY 2009 Request of $198,754,000 is equal to the FY 2008 Enacted level. At this level, the program will continue to fund existing Part C (EIS) Programs and will sustain primary health care and social support services to people living with HIV and AIDS at 357 EIS grantee sites in 49 States, D.C., Puerto Rico and the U.S. Virgin Islands.

The FY 2009 target for the number of people receiving primary care services under Early Intervention Services programs is 216,591. Part C funding will also contribute to achieving the FY 2009 targets for the Ryan White Program's over-arching performance measures including, proportion of racial/ethnic minorities and women served, persons learning of their serostatus from Ryan White programs, persons tested for CD4 count and viral load, and providers implementing a quality management program. (See Summary of Request for targets and for strategies and challenges.)

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Enacted	FY 2009 Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual		
Long – Term Objective: Expand the Availability of Health Care, Particularly to Underserved, Vulnerable, and Special Needs Populations									
19.II.A.1	Number of people receiving primary care services under Early Intervention Services programs.	212,471	216,591	158,346[a]	Mar-08	158,346[a]	Mar-09	216,591[a]	216,591
	EIS Grants	363	363		361		357	357	357
	Capacity Building Grants	12	12		12		8	8	15
	Appropriated Amount ($ Million)	$197.170	$195.578		$193.488		$193.721	$198.754	$198.754

Notes:

[a] The FY 2006 and FY 2007 targets were set prior to the availability of FY 2004 and FY 2005 results. The FY 2008 target was changed from that shown in the FY 2008 Congressional Justification to be consistent with recent performance.

Ryan White HIV/AIDS Program, Part D Women, Infants, Children and Youth

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$71,794,000	$73,690,000	$73,690,000	---

Authorizing Legislation: Title XXVI, Section 2671 of the Public Health Service Act, as amended.

FY 2009 Authorization……..……$71,800,000

Allocation Method…….……. Competitive Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

The Part D program focuses on providing coordinated access to primary medical care and support services for HIV-infected women, infants, children, and youth which are culturally competent and family-centered. It also funds other services, like case management and childcare that help clients get the care they need. Currently, there are Part D programs in 34 states, the District of Columbia, Puerto Rico, and the Virgin Islands. In 2006, Part D provided services to 84,950 clients, 71 percent of whom were HIV infected. Of the clients with known race, the majority (86 percent) were members of racial minority groups. Sixty-nine percent of all clients with known gender served were females.

Eligible organizations are public or private nonprofit entities that provide or arrange for primary care for HIV-positive women, infants, children, and youth. Organizations include State and local governments, their agencies, and Indian Tribes or tribal organizations. Faith-based and community-based organizations are eligible to apply. Part D programs started in 1988 as the Pediatric AIDS Demonstration Projects. The 13 original projects served infected infants and children, infected pregnant women and their families. The projects provided supportive care to families to help infected children receive medical care. In 1994 Congress funded these projects under Part D of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (formerly known as the Ryan White Comprehensive AIDS Resource Emergency Act).

Part D served 52,306 female clients in 2005 and 48,800 female clients in 2004. In FY 2006, Part D provided 49,701 females with comprehensive services, including appropriate services before and during pregnancy, to reduce perinatal transmission. This number exceeds the FY 2006 target by 16,929 clients.

Program Assessment Rating Tool: Part D was included in the combined PART reassessment conducted in 2007 for the Ryan White HIV/AIDS Program. The Program received an Effective rating. See Summary of Request for more details.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 1999	$45,985,000
FY 2000	$50,990,000
FY 2001	$64,995,000
FY 2002	$70,964,000
FY 2003	$73,551,000
FY 2004	$73,108,000
FY 2005	$72,519,000
FY 2006	$71,744,000
FY 2007	$71,794,000
FY 2008	$73,690,000

Excludes comparable amounts for SPNS

Budget Request

The FY 2009 Request of $73,690,000 is equal to the FY 2008 Enacted level. The request will help to sustain primary health care and social support services available to over 60,000 women, infants, children and youth living with HIV and AIDS and their affected families at programs in 34 States, D.C., Puerto Rico and Virgin Islands.

The FY 2009 target for the number of female clients provided comprehensive services through Part D, including appropriate services before or during pregnancy, to reduce perinatal transmission, is 52,306. Part D funding will also contribute to achieving the FY 2009 targets for the Ryan White Program's over-arching performance measures including, proportion of racial/ethnic minorities and women served, HIV-positive women who receive anti-retroviral medications, persons tested for CD4 count and viral load, and providers implementing a quality management program. (See Summary of Request for targets and for strategies and challenges.)

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Enacted	FY 2009 Target/ Est.
				Target / Est.	Actual	Target / Est.	Actual		
Long – Term Objective: Expand the Availability of Health Care, Particularly to Underserved, Vulnerable, and Special Needs Populations									
20.II.A.1	Numbers of female clients[a] provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission.[a]	48,800	52,306	32,772	49,701	32,772	Jan-09	52,306[b]	52,306

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Enacted	FY 2009 Target/ Est.
				Target / Est.	Actual	Target / Est.	Actual		
Long – Term Objective: Expand the Availability of Health Care, Particularly to Underserved, Vulnerable, and Special Needs Populations									
	Grants	91	89		91		89	91	89
	Adolescent Programs Grants	17	16		16		16	16	16
	Appropriated Amount ($ Million)	$73.108	$72.519		$71.744		$71.794	$73.690	$73.690

Notes:

[a] Female clients counted are age 13 and above.
[b] This FY 2008 target was changed from that shown in the FY 2008 Congressional Justification to be consistent with recent performance.

Ryan White HIV/AIDS Program, Part F: AIDS Education and Training Programs

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$34,701,000	$34,094,000	$28,700,000	-$5,394,000

Authorizing Legislation: Title XXVI, Section 2692(a) of the Public Health Service Act, as amended.

FY 2009 Authorization…….……$34,700,000

Allocation Method……. Competitive Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

The AETCs—a network of 11 regional centers with more than 130 local performance sites and four national centers—offer specialized clinical education and consultation on HIV/AIDS transmission, treatment, and prevention to front-line healthcare providers, including physicians, nurses, physician assistants, dentists and pharmacists. The clinical management of HIV/AIDS, particularly the use of highly-active antiretroviral therapy (HAART) is the central focus of training. The AETCs target training to providers who serve minority populations, the homeless, rural communities, incarcerated persons, federally qualified community and migrant health centers, and Ryan White HIV/AIDS Program sites. AETC trained providers are more competent with regard to HIV issues and more willing to treat persons living with HIV than other primary care providers. The AETCs provide education in a variety of formats including skills building workshops, hands-on preceptorships and mini-residencies, on-site training and technical assistance. Clinical faculty also provides timely clinical consultation in person, or via the telephone or internet. Based in leading academic centers across the country, the AETCs use nationally recognized faculty and HIV researchers in the development, implementation, and evaluation of the education and training offered. The AETC program has provided an estimated 800,000 training interaction/sessions to HIV/AIDS providers, including more than 64,000 persons trained between July 1, 2006 and June 30, 2007.

The AETC program provided training interventions to 44% racial/ethnic minorities in 2004. In FY 2005, the proportion of racial/ethnic minority health care providers participating in the AETC training interventions programs was 43% which met the target.

Program Assessment Rating Tool: The AETC program was included in the combined PART reassessment conducted in 2007 for the Ryan White HIV/AIDS Program. The Program received an Effective rating. See Summary of Request for more details.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 1999	$19,994,000
FY 2000	$26,644,000
FY 2001	$31,598,000
FY 2002	$35,282,000
FY 2003	$35,550,000
FY 2004	$35,335,000
FY 2005	$35,051,000
FY 2006	$34,646,000
FY 2007	$34,701,000
FY 2008	$34,094,000

Budget Request

The FY 2009 Request of $28,700,000 is $5,394,000 less than the FY 2008 Enacted level. This level will decrease the AETC Program's level of services for health care providers. The AETCs are an important part of the Ryan White HIV/AIDS Program and play a vital role in ensuring the highest quality of care among providers. HRSA will continue to prioritize for the AETCs interactive training that demonstrates effectiveness to change provider behavior. This request will help meet the program's performance goal to, "Maintain the proportion of racial/ethnic minority health care providers participating in the AETC intervention programs". The FY 2009 target for the proportion of racial/ethnic minority health care providers participating in AETC training interventions is set at 43%.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.
				Target / Est.	Actual	Target / Est.	Actual		
Long – Term Objective: Increase Collaborative Efforts to Improve the Capacity and Efficiency of the Public Health and Health Care Systems									
21.V.B.1	Proportion of racial/ethnic minority health care providers participating in AETC training intervention programs.	44%	43%	43%	Mar-08	43%	Mar-09	43%	43%

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Enacted	FY 2009 Target/ Est.
				Target / Est.	Actual	Target / Est.	Actual		
Long – Term Objective: Increase Collaborative Efforts to Improve the Capacity and Efficiency of the Public Health and Health Care Systems									
	Regional Centers	11	11		11		11	11	11
	Local Performance Sites	130	130		130		130	130	130
	National Centers	4	4		4		4	4	4
	Appropriated Amount ($ Million)	$35.335	$35.051		$34.646		$34.701	$34.094	$28.700

Ryan White HIV/AIDS Program, Part F: Dental Reimbursement Program

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$13,086,000	$12,857,000	$12,857,000	---

Authorizing Legislation: Title XXVI, Section 2692 (b) of the Public Health Service Act, as amended.

FY 2009 Authorization……$13,000,000

Allocation Method……..…. Competitive Grants

Program Description and Accomplishments

The HIV/AIDS Dental Reimbursement Program provides access to oral health care for people living with HIV/AIDS by reimbursing dental education programs for the nonreimbursed costs they incur providing such care. By offsetting the costs of non-reimbursed HIV care in dental education institutions, the Dental Reimbursement Program improves access to oral health care for people living with HIV and trains dental and dental hygiene students and dental residents to provide oral health care services to people living with HIV. The care provided through the program includes a full range of diagnostic, preventive, and treatment services, including oral surgery, as well as oral health education and health promotion. The Community-Based Dental Partnership Program supports collaborations between dental education programs and community-based partners to deliver oral health services in community settings while training students and residents enrolled in accredited dental educations programs. Dental schools, post-doctoral dental education programs, and dental hygiene education programs accredited by the Commission on Dental Accreditation that have documented non-reimbursed costs for providing oral health care to people living with HIV are eligible to apply for reimbursement. Funds are then distributed to eligible organizations taking into account the number of people served and the cost of providing care.

In FY 2006, the Dental Reimbursement Program awards met 42.3% of the total non-reimbursed costs reported by 68 participating institutions in support of oral health care. These institutions reported providing care to 34,394 HIV-positive individuals, for whom no other funded source was available. This number exceeded the goal by 7,894 individuals or 29.8%. This represents a 10.8% increase from FY 2005 for persons whom a portion/percentage of their unreimbursed oral health costs was reimbursed. The Community Dental Partnership Program funded 12 partnership grants to collaborate and coordinate between the dental education programs and the community-based partners in the delivery of oral health services. Community-Based Dental Partnership grants are intended for a period of up to three years. In FY 2005, the demographic characteristics of patients who were cared for by institutions participating in the DRP were: 33.3% women, 61.6% minority. Therefore, the DRP served a higher proportion of women than the representation of women among all AIDS cases in the nation, as reported by CDC. CDC

reports 24% of AIDS cases in 2005 were among women and 64.1% of AIDS cases were among racial/ethnic minorities.

Program Assessment Rating Tool: The Dental Reimbursement Program was included in the combined PART reassessment conducted in 2007 for the Ryan White HIV/AIDS Program. The Program received an Effective rating. See Summary of Request for more details.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 1999	$ 7,798,000
FY 2000	$ 7,999,000
FY 2001	$ 9,999,000
FY 2002	$13,493,000
FY 2003	$13,405,000
FY 2004	$13,325,000
FY 2005	$13,218,000
FY 2006	$13,077,000
FY 2007	$13,086,000
FY 2008	$12,857,000

Budget Request

The FY 2009 Request of $12,857,000 is equal to the FY 2008 Enacted level. These funds will continue to support the reimbursement of applicant institutions, outreach to people with HIV/AIDS who need dental care, and continued efforts to improve service coordination among reimbursement recipients and other community-based health service providers. Currently, the Dental Reimbursement Program reimburses approximately 42 percent of the costs associated with the more than 34,000 people with oral health needs served by accredited dental schools and other graduate dental education programs.
The FY 2009 target for the number of persons for whom a portion/percentage of their unreimbursed oral health costs will be reimbursed is 34,394.

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Enacted	FY 2009 Target/ Est.
				Target / Est.	Actual	Target / Est.	Actual		
Long – Term Objective: Promote Access to Health Insurance and Maximize Use of Available Reimbursements for Health Care Services									
22.I.D.1.	Number of persons for whom a portion/ percentage of their unreimbursed oral health cost were reimbursed.	30,598	31,050	26,500	34,394	30,600	Apr-08	34,394[a]	34,394
	Community-Based Dental Partnership Programs	12	12		12		12	12	12
	Appropriated Amount ($ Million)	$13.325	$13.218		$13.077		$13.086	$12.857	$12.857

Notes:

[a] This FY 2008 target was changed from that shown in the FY 2008 Congressional Justification to be consistent with recent performance.