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BEFORE THE

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COMMITTEE ON ENERGY AND COMMERCE

U.S. HOUSE OF REPRESENTATIVES

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Mr. Chairman, Members of the Committee, thank you for the opportunity to appear before you today to discuss reauthorization of the Ryan White HIV/AIDS Program administered by the Health Resources and Services Administration within the Department of Health and Human Services.

Introduction

Let me start by expressing the Administration's strong support for continuation of the Ryan White Program and its reauthorization. I am eager to work with you and appreciate your support in this effort. The Program was first enacted in 1990 and reauthorized in 1996, 2000, and 2006. Ryan White provides critical medical care and support services to uninsured, underinsured, and low-income people living with HIV/AIDS who have no other source of care. Through HRSA's HIV/AIDS Bureau, grants are awarded to cities, States, and local community-based organizations for the purpose of providing primary medical care and support services to individuals living with HIV/AIDS. Since its inception, the Ryan White Program has been providing HIV/AIDS related services to a growing number of HIV/AIDS infected individuals. This year, approximately 529,000 individuals receive Ryan White services. The Program consists of Parts A, B, C, D, and F, which are differentiated by the types of services rendered and/or the entities receiving funding.

Part A of the Program provides emergency assistance to eligible metropolitan areas (EMAs) and transitional grant areas (TGAs) that meet a certain threshold of reported AIDS cases. Part A grants are comprised of formula and supplemental grants. Funding allocations for formula grants are based on the number of living HIV/AIDS cases reported in that particular jurisdiction. Supplemental grants are awarded

competitively to areas that demonstrate the need for additional funding to combat the HIV/AIDS epidemic. Part A grantees must expend 75 percent of their formula award on providing core medical services and may expend the remaining 25 percent on support services, unless the grantee requests and receives a waiver allowing more than 25 percent to be spent on support services. Examples of core medical services include AIDS medications, outpatient and ambulatory services, early intervention services, substance abuse treatment services, and mental health services. Support services include services linked to medical outcomes, such as respite care, outreach, and medical transportation. Support services provided by Ryan White often play a significant role in retaining clients in treatment.

Part B of the Program awards funds to States and territories for provision of core medical services and support services, with the same requirement as Part A to spend at least 75 percent of the formula award on core services and up to 25 percent on supportive services. Funding under Part B includes formula and supplemental grants, AIDS Drug Assistance Program (ADAP) formula grants, ADAP supplemental grants, and grants for emerging communities based on the number of living HIV/AIDS cases. ADAP serves as a critical resource because its funds are used to provide access to life-saving medications. Similar to Part A, Part B supplemental grants are awarded competitively based on demonstrated need.

Part C of the Program awards funds to public and private organizations for the purpose of providing early intervention services (*i.e.*, diagnostic tests and medical case management), core medical services, support services, clinical quality management costs, and administrative costs. Grantees are required to expend a minimum of 75 percent of

funds toward core medical services, and may expend 25 percent toward support services. In addition, Part C grantees may be eligible for capacity development grants to help strengthen organizational infrastructure and enhance services for rural and underserved areas.

Part D funds are awarded to private and public entities with a focus on services for women, infants, children, youth, and families. Grantees provide family-centered care involving outpatient or ambulatory care. Services include primary and specialty medical care, treatment, support services, and logistical support and coordination.

Part F grants include funding for AIDS Education & Training Centers (AETCs), the Dental Reimbursement Program, the Community-Based Dental Partnership Program, Minority AIDS Initiative (MAI), and Special Projects of National Significance (SPNS). In accordance with the 2006 reauthorization statute, MAI grants are awarded competitively and provide funding to evaluate and address the disproportionate impact of HIV/AIDS on racial and ethnic minorities. The AETC Program supports a network of 11 regional centers that conduct targeted, multi-disciplinary education and training programs for health care providers treating individuals with HIV/AIDS.

Reauthorization of the Ryan White HIV/AIDS Program

I would like to reiterate the Administration's strong support for reauthorization of the Ryan White HIV/AIDS Program so we can continue to serve the over half million individuals living with HIV/AIDS who rely on us for life-saving, life extending treatment. With this in mind, I would like to talk broadly about the Administration's vision for reauthorizing the Program.

HRSA recommends a four-year reauthorization to: 1) minimize disruption of funding and services for grantees and clients; and 2) permit time for implementation of health care reform policies and programs to examine the impact on Ryan White. The Administration would also support a three-year reauthorization, consistent with the draft House bill.

In addition, HRSA supports the option proposed in the Energy and Commerce draft language to eliminate the repeal language that was part of the last reauthorization.

Presently, Parts A and B grantees are subject to three different penalties if they have unused funds remaining by the end of the grant year. First, grantees must return any unspent supplemental funds to HRSA at the end of the grant year. Grantees may request a waiver for any formula funds unused by the end of the grant year in order to carryover those funds to the subsequent grant year. However, if a waiver is not granted, then grantees must return the unused amount to HRSA. Second, grantees with remaining unobligated formula funds will receive a reduction in their subsequent grant award in the amount of the unobligated balance from the previous grant award, regardless of their eligibility for a waiver. Third, grantees with more than 2 percent of unobligated formula funds at the end of the grant year can not apply for supplemental funds for the subsequent grant year, regardless of their eligibility to carryover those funds.

HRSA encourages amending these penalties for Parts A and B grantees because of the financial and administrative burden it places on grantees. The risk of being penalized forces grantees to focus on spending funds down to the two percent threshold as opposed to spending the funds more judiciously and efficiently. Potential causes of unobligated balances for grantees include hiring freezes and expenditure limits imposed

by jurisdictions, natural disasters that disrupt grantees' ability to continue services, post-audit findings resulting in funds being returned to the grantee, and unanticipated increases in funds in the form of rebates for medications. For example, an Arizona grantee's correction of an accounting error associated with ADAP funds resulted in the grantee having unobligated funds above the two percent threshold at the end of their grant year. As a result, the grantee was financially penalized. It is important that grantees not be penalized when they inadvertently and unintentionally have unused funds. Such penalties can interfere with grantees' capacity to provide HIV/AIDS care to their clients.

HRSA suggests eliminating the penalty which requires a decrease in a grantee's subsequent grant award by an amount equal to the unobligated balance amount remaining from the previous year's award. The elimination of this provision helps to ensure that grantees will have sufficient funds so they will not have to interrupt service to individuals living with HIV/AIDS. In addition, HRSA recommends raising the threshold from two to five percent for the penalty preventing grantees from receiving supplemental funds for unobligated formula funds. A grantee's failure to expend their entire award during a fiscal year does not necessarily equate to a lack of need for HIV/AIDS services for infected individuals living in those areas.

HRSA also suggests offsetting future year awards for grantees with unobligated balances as opposed to cancellation of the amount, as required under current law. Utilization of the term "cancel" in the current law triggers a lengthy and intricate process and increases the amount of time required before redistribution of these funds can be made to other grantees. Allowing the grantees to retain unobligated balances for the subsequent award year, while offsetting their future award by an amount equivalent to the

unobligated balance, will permit the grantee to continue using funds for services while still being penalized. The change from a de-obligation to an offset would retain the intent of the law while simplifying penalty administration and expediting the redistribution of funds to other grantees to provide HIV/AIDS care.

The current distinction between EMAs and TGAs prevents funding from following the epidemic. Under the current statute, 75 percent of Part A funding is allocated to EMAs and the remaining 25 percent is distributed to TGAs. Although EMAs have a higher disease burden as compared with TGAs, the TGAs receive more funding per client.

HRSA supports eliminating this distinction between EMAs and TGAs under Part A. HRSA proposes designating Part A grantees as EMAs when those grantees have greater than or equal to 1,000 cases of AIDS during the most recent period of five calendar years for which such data are available. By eliminating the EMA/TGA distinction, the appropriation for Part A could be distributed proportionally across all highly impacted jurisdictions based on the number of living HIV/AIDS cases. This suggestion is supported by Energy and Commerce's draft legislation, which implements hold harmless provisions for TGAs. Hold harmless provisions already apply to EMAs, so implementation of hold harmless provisions for TGAs eliminates any major distinctions between the two.

Moreover, for the TGAs that are at risk of losing TGA status in future fiscal years, HRSA supports efforts to maintain Part A award levels so that important HIV/AIDS services in those jurisdictions are not interrupted. This recommendation is reflected in the Energy and Commerce draft legislation. Six TGAs are at risk of losing

their status under Part A in fiscal year 2011 due to their inability to meet the definition of a TGA based on AIDS case counts. Loss of eligibility for these areas could potentially result in destabilization of HIV care delivery systems, significant reductions in essential services, and neighboring jurisdictions being burdened with an influx of new or displaced patients from former TGAs. HRSA is eager to work with you in resolving this issue.

We are over a quarter century into the HIV/AIDS epidemic. As our first wave of HIV experts nears retirement, we need to train a new cadre of HIV health professionals to replace them and also need to meet the difficult clinical challenges that are emerging in a world where HIV infection, with treatment, is managed as a chronic condition. The AETC Program, as currently authorized, does not allow for stipends or scholarship payments for long-term training for individuals, nor does it allow HRSA to issue grant awards or contracts for this purpose. To remedy this, the Department supports adding legislative language that would permit long-term training for selected participants in the AETC Program. HRSA suggests implementing a program that provides training of sufficient duration to ensure that new health professionals are appropriately trained to provide HIV care and are strategically placed in areas with high need of HIV medical care.

You may recall a significant change in the 2006 reauthorization that required Parts A and B formula grant awards to be based on the number of living HIV/AIDS reported cases as opposed to only AIDS cases. This legislative change also mandated States to report living HIV case counts from name-based reporting systems, with an exception for States that had code-based HIV surveillance systems but established a plan to transition to name-based surveillance systems. Name-based reporting States are

required to submit their case counts to CDC; code-based States are mandated to submit their data to HRSA. Most States have transitioned to name-based systems for reporting living HIV cases. However, some States are still transitioning due to the complexity of modifying public health surveillance and reporting systems. Each name-based reporting system matures at a different rate and it is difficult to ascertain when each system will meet CDC's operational standards. Some States require a lengthier transition time to adopt name-based reporting of HIV cases due to various reasons, such as patient privacy issues or changes in State legislation.

HRSA proposes to permit additional time for code-based reporting States to transition to name-based reporting systems for living HIV/AIDS case counts upon which funding is based. Under current law, the exception for code-based reporting will expire at the end of fiscal year 2009 and, as of fiscal year 2010, all jurisdictions must report name-based data, regardless of maturity of their data systems. Nine jurisdictions are still in the process of converting to name-based reporting systems. Name-based reporting is critically important for the full implementation of the statute because it provides the most reliable and accurate data for the distribution of formula funding. Without an extension, these code-based reporting States will be unable to receive funding after fiscal year 2009, which will disrupt services to persons with HIV/AIDS in those areas. The cancellation of funds to States needing more time to transition to name-based reporting would also hinder HRSA's ability to allow funds follow the epidemic.

The Obama Administration is committed to working with Congress to reauthorize the Ryan White Program and ensure that critical services continue beyond September 30,

2009. I would be pleased to answer any questions you might have concerning the reauthorization of Ryan White HIV/AIDS Program.