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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

OCT - 1 1993

FROM: Acting Director, National AIDS Program Office

TO: Acting Administrator, HRSA

SUBJECT: Review of 1994 Ryan White Title I CARE Act Application Guidance

As requested, we have reviewed the proposed Application Guidance materials and offer the following observations:

1. The burden is placed on the applicant to present responsive material which will be the only material to be evaluated by the reviewer. As a result of this approach, the reviewers are being asked to review the application in a historical performance vacuum. The guidance HRSA provides does not allow for an unbiased presentation or inclusion of a factual history of an applicant's (i.e., those applicants currently funded) capabilities or problems based on monitored grant performance. While it is unquestionably important that applications be **OBJECTIVELY** reviewed, factual indicators of past performance will help to place the application in context, suggest the appropriateness of proposed future directions, and allow the reviewer to make realistic assessments. We, therefore, recommend that factual indicators of past performance be made available to reviewers and review committees.

2. The HRSA guidance requires the applicant to address unique aspects of the epidemic and local needs. The guidance does not sufficiently address or account for the complexity of problems and issues within an eligible metropolitan area (EMA). As a result of the manner selected to structure the objective review process, variation among EMAs is not considered. Not properly considering complexity could place EMAs with multiple, coincident epidemics in several populations at a significant scoring disadvantage. Thus, we recommend that the consideration of complexity be given a high priority in the narrative scoring.

3. Potential disagreements resulting from funding decisions might be avoided by carefully and systematically describing the pre- and post-objective review funding processes to all applicants as an integral part of this package. Therefore, funding statement should include such items as:

   - amount of funds available to current grantees vs. new applicants;

- maximum amount of funds that each EMA is eligible for based on a percentage of the formula component (this allows the applicant to prepare a realistic budget and application, not one based upon an artificial expectation);

- summary statement of the distribution of funds from applicants which did not receive their maximum allocation.

4. A complete, stepwise discussion of the calculations involved in converting raw points scores from review committees into dollars of funding is essential. The discussion should begin with the steps taken to standardize scores from multiple review committees, how the effect of scoring tendencies from these separate committees and other factors are taken into account in the final awards.

5. We suggest that a re-examination be conducted of the statistical and mathematical processes used to determine the specific amount of funding commensurate with a particular applicant's adjusted score. The purpose of the examination should be to develop a replacement method for this current procedure which is more direct and more likely to be understood by a non-mathematician.

   In the event that the program chooses to continue with the current mathematical process, then we suggest that the package contain a disclosure of the stepwise calculations and why the high degree of complexity is necessary. Once again, we strongly recommend that the discussion be crafted in a manner that a lay person can understand.

6. We recommend that a carefully thought-out "what if" set of possible funds award combinations be conducted by the Bureau. For example, policy-makers should examine the likely results of the effects of various size EMAs receiving little or no funds as a result of disqualification or low scores under the competitive procedure. The analysis should encompass the requested narrative texts and the distribution of points within the review scheme laid out in the guidance. The results of this policy analysis will assure that blocks of points are appropriately dispersed to guarantee that EMAs are competing on the basis of the application narrative and not subject to an unintended effect of how points are spread within the rating criteria.

We appreciate the opportunity to review and comment on this package. Should you have questions regarding this, please call me at (202) 690-6248.

Arthur J. Lawrence, Ph.D.

cc: Dr. Lee
Dr. Boufford
Ms. Gebbie
Mr. Itteilag
Mr. Rickard

CARE Act Coalition
Reauthorization Recommendations
June 15, 1994

The national organizations that constitute the coalition are: Title I--Cities Advocating Emergency AIDS Relief (CAEAR); Title II--National Alliance of Sate and Territorial AIDS Directors (NASTAD); Title III(b)--National Ryan White Title III(B) Coalition; and Title IV--AIDS Policy Center for Children, Youth and Families. A summary of consensus recommendations for reauthorization of the CARE Act follows.

Joint Consensus Document

- These national organizations agree that the Ryan White CARE Act should be reauthorized in 1994 -- before the end of the 103rd Congress - in order to be securely in place for Fiscal Year 1996 budget planning by the Administration and the Congress.

- CARE Act funds no longer necessary for some health care services as a result of health care reform should be reinvested in CARE Act programs.

- The four-title coalition supports increased participation of those who are both infected and affected by HIV disease.

- The coalition supports the retention of the distinct structure and intent of each of the four titles of the CARE Act.

- The coalition supports additional guidelines by HRSA to foster improved management of the CARE Act grants, while opposing the development of regulations - which may be less flexible than internal agency guidelines.

- The coalition supports peer technical assistance regarding issues such as inclusion of communities of color, women, persons living with HIV/AIDS and process and product evaluations.

- The coalition supports limiting expenditures of administrative funds in order to maximize the funds available for delivery of care services.

- The HRSA should mandate to develop guidance, in concert with affected parties, regarding the establishment of title-specific grievance procedures to address allegations of egregious violations of the spirit or the letter of the Act.

- Coordination Among Titles of the Ryan White CARE Act to include:
  - amending Title II to require that each state or territorial health department annually convene at least one meeting of representatives from each of the Titles and Special Projects of National Significance, to develop a statewide coordinated statement of need (SCSN) for delivery of services to people living

with HIV/AIDS under the Ryan White CARE Act.

- amending Title I, II, III(B), IV and SPNS to require participation in this process.
- providing that an individual Title I, II, III(B), IV and SPNS grantee may apply for funding without appendix and without penalty, when approved by HRSA, if other title representatives within their state or territory fail to participate in the coordination process, or fail to submit evidence of compliance with SCSN. HRSA should provide technical assistance on the process for development of the SCSN.
- requiring HRSA to award new Title I, III(B), IV and SPNS grants to applicants which may not have participated in the development of the SCSN, by considering the consistency of the competitive grant application with the SCSN conducted within the same state or territory.
- providing that needs assessment produced pursuant to any title of the CARE Act shall be utilized in producing the SCSN, and that whatever possible, efforts will not be duplicated.
- making the overall SCSN dependent upon increasing the administrative cap under Title II on creating a new Title V for the SPNS program.

- The SPNS need to be maintained and enhanced in reauthorization by the creation of a new Title V of the Act to authorize SPNS.

- The 15% set-aside for infants, children, youth, women, and families should be maintained. In states where infants, children, youth, and women comprise greater than ten percent of that states total AIDS caseload over the preceding two years, not less than fifteen percent of that state's total Title II funds will be used for these groups. In those states in which the population of infants, children, youth, and women are diagnosed with AIDS is less than ten percent of total AIDS cases, this requirement shall not apply.

- Title I should be amended to state that a representative of the Title IV grantee(s), where they exist, or a representative of pediatric, youth, and women service organizations operating in the area to be served are required to be represented on the planning council.

- Title II shall be amended to include pediatric, youth, and women service providers and consumers to participate in the planning and needs assessment process.

Prepared by:TFox/MSchroeder:ONAP:690-5560:6/15/94:RWCOAL.615

Authorization Levels 1996		
	HRSA	Coalition
Title I	$500 Million	$500 Million
Title II	$300 Million	$500 Million
Title III	$125 Million	$200 Million
Title IV	$75 Million	$100 Million
Authorization Levels 1997-2000		
Title I	SSAN	SSAN
Title II	SSAN	SSAN
Title III	SSAN	SSAN
Title IV	SSAN	SSAN

Ryan White Care Act FY 1996 Legislative Proposals		
HRSA AIDS Advisory Committee (HAAC) Recommendations	HRSA Recommendations	CARE Act Coalition Recommendations
PROPOSED BY HAAC:		
Base funding formula on people living with HIV/AIDS, not cumulative cases, using currently available data and proxies (such as incidence of TB, drug abuse prevalence, proportion of women, poverty data and proportion of residents with insurance). If a multi-year mean of incidence is used, it should be a 3-4 year mean	No legislative change proposed. See section I-C, Issue #4C.	CAEAR--recommends altering the formula for Title I grants to increase weight of cumulative caseload and decrease weight of cumulative incidence. From current 3:1 ratio to 4:1. NASTAD--recommends enhancing resource allocation through Title II.
Transfer the AIDS Education and Training Centers program (AETC) into the CARE Act as a separate Title	Agree. See Section I-A, HRSA legislative proposal #14A	No Position Stated (NPS)
Transfer the HIV/AIDS Dental Reimbursement Program into the CARE Act as a separate line item	Agree. See Section I-A, HRSA legislative proposal #15A	NPS
Expand the mission of Title IV to: 1) serve children and families, including child-bearing and child-rearing women, and 2) support the development of systems for children and families that incorporate research and care	Agree. See Section I-A, HRSA legislative proposal #13A	AIDS Policy Center (Title IV) recommends several comprehensive changes to broaden purpose and impact of Title IV.

Increase administrative cap to 10% across all Titles. Raise the matching requirement for high incidence States (Title II) by an equivalent 5%; require 5% match for Title I	Partially agree. See Section I-A, HRSA legislative proposal #12A (increase cap for Title III(b) only) Also see Section I-C, Issue #1C	CAEAR (Title I)--recommends retaining 5% cap for administrative purposes, however, funds for evaluation purposes be prioritized by planning councils. NASTAD (Title II)--recommends 5-10% cap for administrative and 5-10% for planning and evaluation, but not more than 15% of overall Title II award. Title III(b) Coalition--recommends 10% for administrative activities.
Maintain 15% set-aside for women, children and adolescents, but allow States flexibility in determining when a 15% set-aside is inappropriate. Require a waiver from HRSA, documenting need to reduce set-aside, to exercise this option	No legislative change proposed. See Section I-C, Issue #2C	CONSENSUS--Not less than 15% set-aside for women, children and adolescents, if the total AIDS caseload within the state, over the preceding two years for women, children, and adolescents is greater than 10%. If less than 10%, this requirement shall not apply.
Allow States flexibility in determining set-aside for consortia	No legislative change proposed. See Section I-C, Issue #3C	NASTAD--recommends no change in requirement for 50% consortia set-aside for states reporting 1% or more of total number of AIDS cases.
Hold State and local governments responsible for matching fund requirements	Agree. This is HRSA's current administrative and monitoring policy	NASTAD--recommends no change in matching fund requirement.
Reassert emergency nature of CARE Act	Agree. See Section I-A, HRSA legislative proposal #lA	CAEAR--Agree.
Maintain Ryan White as a categorical program to ensure that services to PWAs are not reduced under health care reform	Agree. No action necessary	CONSENSUS--CARE Act funds no longer necessary for some health care services as a result of health care reform should be reinvested in CARE Act programs.

Increase minimum Title II allocation to $250,000 for all States	Agree. See Section I-A, HRSA legislative proposal #8A	NASTAD--recommends for grantees with 20 or more AIDS cases receive formula allocation or $250,000, whichever is higher. For grantees receiving $100,000 in FY95, with less than 20 cases will be held harmless in FY96 and subsequent years.
Base Title II allocations on needs assessment and coordinated, comprehensive multi-year regional plan	Agree in principle (except for multi-year regional plan). See Section I-A, HRSA legislative proposal #9A	CONSENSUS--improve coordination mechanism the four Titles: 1. amend Titles to require annual meeting of CARE Act representatives to develop a statewide coordinated statement of need (SCSN). 2. waiver of SCSN requirement through HRSA.
Develop grievance and mediation process, for implementation across Title, with procedures to be determined by HRSA and grantees	Agree. HRSA encourages grantees to develop local grievance processes and procedures. HRSA is currently providing technical assistance to grantees on this issue	CONSENSUS--recommends HRSA be mandated to develop guidance regarding the establishment of Title-specific grievance procedures.
Acknowledging the uniqueness of each Title and Congressional mandate, compatible data collection program and reporting systems across Titles based on the principle of coordination, which may require legislative changes for Title III(b)	Agree. All HRSA HIV programs currently ask for aggregate data, and data elements are being made compatible. See Section I-B, Issue #1B.	NPS
Mandate increased emphasis on patient care, across Title	Agree. See Section I-A, HRSA legislative proposals #10A and #11A.	NPS
Define the following terms: a) "clinical case management" as a core component of primary care; and, b) "administrative costs"	Agree. Issue previously discussed with grantees. No legislative change proposed. b) Agree. In development with grantees	NPS

Require representation of Title IV agencies on councils and consortia. In jurisdictions without Title IV grants, Title V agencies (Social Security Act) should represent Title IV programs	Agree (except consortia). See Section I-A, HRSA legislative proposal #2A	AIDS Policy Center (Title IV)--Agree (except consortia)
Create a line item for planning grants for newly eligible Title I cities	Agree. See Section I-A, legislative proposal #3A	NPS
Mandate linkages and administrative coordination between CDC-funded counseling and testing programs and HRSA-funded early intervention and CARE programs to ensure follow-up care	No legislation proposed. This will be handled with CDC as part of HRSA's administrative policy	NPS
Require representation of administrative agencies on planning councils	Agree. See legislative proposal #2A	CAEAR--supports a balanced authority between the administration and planning councils through a Co-Chair structure of leadership. A position on representation of administration on planning council is not stated.
	PROPOSED BY HRSA:	
NPS	Maintenance of effort for Title I - maintain at each prior year's level, instead of the level prior to the first Part A award (same as for Title II)	NPS
NPS	For Titles I, II, and III(b) allocation of funds to private for-profit entities	NPS
Admin. recommendation to authorize a multi-year funding cycle across Titles, with a uniform funding and application process.	Single application and award process for Title I	NPS
NPS	Eliminate the 0.0025 cumulative rate factor eligibility criteria for Title I.	NPS

		PROPOSED BY CARE ACT COALITION:
Admin. recommendation to develop mechanisms and guidelines to support PWA participation on consortia and planning councils.	Agree. See legislative proposal #2A (minimum 25% membership for people with HIV).	CONSENSUS--a standard for representation of infected and affected communities should be established. CAEAR--believes 20-50% of planning council should be people living with HIV/AIDS.
Agree. Admin. recommendation #1	Agree. This is HRSA's current administrative policy.	CONSENSUS--supports retention of the distinct structure and intent of each of the four CARE Act Titles
NPS	NPS	**CONSENSUS--reauthorization of the CARE Act before the end of the 103rd Congress**
NPS	NPS	CONSENSUS--create a new Title V for the Special Projects of National Significance.

Prepared by:TFox/MSchroeder:ONAP:690-5560:6/15/94:RWCTable.615

Summary

Part A (Title I)

1A. Reauthorization

- 1996 - $500 million; 1997-2000 - SSAN (proposal combined with Part B)

2A. Membership on HIV Health Services Planning Councils

- minimum of 25 percent membership for people with HIV
- add an official representative of the grantees' administering body (such as the health department or Mayor's office), Part D (or MCH Title V where there is no Part D program), AETCs, Housing Opportunities for People with AIDS program, Medicaid, substance abuse, dental, CDC prevention planning body. Require that membership from State government be from the Part B program

3A. HIV Health Care Services Planning Grants (transition grants)

- $75,000 one-time grants to CDC-certified EMAs

4A. Maintenance of effort

- maintain at each prior year's level, instead of the level prior to the first Part A award (same as Part B)

5A. Allocation of funds to private for-profit entities (includes Parts A,B,C-II)

- for-profit subcontractors eligible for funding

6A. Single Application/Single Award

- streamline the process

7A. Eligibility Criteria

- eliminate the 0.0025 cumulative rate factor eligibility criteria

Part B (Title II)

1A) Reauthorization (see combined proposal #1A)

- 1996 - $300 million; 1997-2000 - SSAN

5A) Allocation of Funds to private for-profit entities (See combined proposal #5A)

- For-profit subcontractors eligible for funding

8A. Minimum Allotment to States/Waiver for Administrative Expenses

- increase from $100,000 to $250,000 minimum
- waiver to raise administrative cap to allow one FTE for low incidence States

9A. State-Level Assessment of HIV-Related Needs and Resources

- require States to base their comprehensive plan on a process that follows a State-level assessment of the health care and support services needs of PWHIV and a consideration of all HIV-related resources in the State

Part C, Subpart II (Title III-b)

10A. Reauthorization

- 1996 - $125 million; 1997-2000 - SSAN
- establish 50 percent minimum expenditures for primary care
- specify a range of primary care services to be provided
- specify services to be provided *directly* by grantee

11A. Planning and Development Grants

- $50,000 grants to assist non-providers of primary care to develop primary care delivery systems (would expand number of sites for early intervention services)

12A. Administrative Expenses

- increase administrative expenditures cap to 10 percent

5A) Allocation of funds to private for-profit entities (See combined proposal #5A)

- for-profit subcontractors eligible for funding

Part D (Title IV)

13A. Reauthorization

- 1996 - $75 million; 1997-2000 - SSAN
- comprehensive changes to broaden purpose and impact
- establish initial planning and implementation grants
- authority to use funds for training and TA
- authority to fund resource centers

14A. HIV/AIDS Education and Training Centers Program - Reauthorization

- 1996 - $30 million; 1997-2000 - SSAN
- move authority from Title VII to Title XXVI
- add language to include:
  - — training of Title XXVI/other community providers
  - — training of allied health/mental health workers

15A. HIV/AIDS Dental Reimbursement Program - Reauthorization

- 1996 - $12 million; 1997-2000 - SSAN
- move authority from Title VII to Title XXVI
- add grants to CHC/MHCs and other non-profit community-based entities

Ryan White CARE Act FY 96 Administrative Recommendations		
HRSA AIDS Advisory Committee (HAAC)	**HRSA Response**	**CARE Act Coalition**
Retain current Title structure. HRSA should determine appropriate administrative placement of Titles for optimal program administration	Agree. This is HRSA's current administrative policy	NPS (No position stated).
HRSA should work with grantees to develop administrative guidance to encourage limitation of Title III(B) funds for counseling and testing services	Agree. See Section I-A, HRSA legislative proposal #10A	NPS
Mandate development of multi-year plans by councils, consortia and appropriate government agencies to enable applicants for all Title and programs to base their proposals on coordinated needs assessments within a shared framework. Encourage and permit administrative agencies to make planning grants available across Title	Partially agree. See Section I-A, HRSA legislative proposals #3A, 9A, 13A	NPS
Clearly define roles, responsibilities and authority of planning councils, consortia, grantees, administrative agencies and State/local governments	Agree. HRSA is currently developing policy in these areas in collaboration with grantees	CAEAR-- Supports balanced authority between the grantees and planning councils
Expand and ensure coordination: 1) across Title, program and services; and 2) between councils and consortia; EMAs and States	Agree. See Section I-A, HRSA legislative proposals #2A, 9A, 14A, 15A; and Section I-B, administrative Issues #IB, 2B, 3B, 5B	NPS

Maintain and increase HRSA's involvement in facilitation, coordination and problem solving with administrative agencies and grantees. Clarify HRSA's role in providing technical assistance (TA), monitoring and problem solving	Agree. This is part of HRSA's ongoing monitoring and technical assistance activities	NPS
Develop procedures for grievance and mediation for Title I and II; clearly define roles of HRSA and outside groups. Planning councils should designate ombudsman to process complaints from grantees and patients. Issues not resolvable at local/state level should be resolved by a mediation/ arbitration process to be developed by HRSA	Agree. These issues are currently being handled through technical assistance and administrative policy	NPS
Develop clear guidelines to manage conflict of interest	Agree. HRSA has developed and issued a technical assistance document related to this issue	NPS
Develop Procedures for rapid re-allocation of funds	Agree. This is HRSA's current administrative policy	NPS
Authorize a multi-year funding cycle across Title, with a uniform funding and application process	Partially agree. See Section I-A, HRSA legislative proposal #6A; and Section I-B, administrative Issue #6B	NPS
Require all grantees to develop and implement functional quality assurance (QA) and evaluation programs to monitor their services (including subcontractors), effective October 1997. Administrative agencies should use administrative funds to monitor grantees' QA and evaluation programs	Agree in principle. A technical assistance contract is in place to assist grantees with quality assurance	NPS

Develop basic definition and operational guidelines for "case management services" (including medical and social service models); define the following terms: "community-based organization" "consumers" and "representative," "maintenance of effort," "matching requirements" and "statewide planning"	Agree in principle. This is part of HRSA's ongoing monitoring and technical assistance	NPS
HRSA should work with administrative agencies to develop procedures for monitoring grantees (and subcontractors) relative to standards of care, adopted by relevant professional associations and institutions, adopted/adhered to within their area or region. HRSA should provide TA to assist local communities in meeting acceptable standards of care	Agree in principle. HRSA currently distributes national HIV care guidelines and PHS treatment recommendations. Deciding among and enforcing adherence to multiple professional practice guidelines is not practical	NPS
a) Designate Ryan White providers and consortia as "essential service providers" during 5-year reauthorization period. b) Designate communities with a high incidence of HIV/AIDS as health professional shortage areas	a) Agree. Ryan White providers are included as "essential service providers" in the Administration's Health Security Act. If health care reform legislation designates essential community providers Ryan White funded providers should be so designated b) No legislative change proposed	NPS
Increase coordination and linkages between HRSA and HUD officials implementing the AIDS Housing Opportunities Act (HOPWA) to facilitate coordination between planning councils and HUD	Agree. See Section I-A, HRSA legislative proposal #2A	NPS

Request Assistant Secretary for Health to submit annual reports to Congress on steps to ensure coordination of HIV prevention and services. Include coordination of planning and funding policies, data reporting @ms and research -in all Federal agencies	No legislation proposed. Can be requested under current authority	NPS
Conduct an external review of the reauthorized CARE Act, mid-cycle (1997-1998)	The need for an external review should be re--evaluated after reauthorization	NPS
HRSA should more closely integrate medical and dental care at the program administration level	Agree. See Section I-A, HRSA legislative proposals #2A, 9A, 10A, 14A, 15A	NPS
Permit people with HIV/AIDS to access services within their geographic region, regardless of specific residence. Ensure access and interpreting services for all people with HIV/AIDS	Agree in principle. There are many practical ramifications of this recommendation that would need to be discussed with grantees. HRSA is currently working to develop administrative guidance	NPS
Expand access to services for adolescents. Ensure inclusion of adolescent needs in planning and needs assessment, and age appropriate programs that link prevention and care	Agree. See Section I-A, legislative proposal #13A	NPS
Expand initiative to develop mechanism for incorporating results of successful SPNS models into Ryan White programs	Agree. This is HRSA's current administrative policy	NPS
Establish technical assistance as a priority for program development and grantee support. Ensure flexibility in determining the form it will take and the amount of funding available	Agree. HRSA has a contract in place to provide peer technical assistance on program issues	Consensus-- Coalition supports the development of peer-based technical assistance across all Titles.

a) Develop a data collection and reporting system based on the principle of coordination, across Title and agencies. b) Simplify and coordinate applications, funding cycles and needs assessments, across Titles	Agree in principle. a) All HIV programs currently ask for aggregate data, and data elements are being made compatible. b) See Section I-A, HRS.A legislative proposals #6A, 9A; and Section I-B, issue #6B	NPS
Ensure that all grantees are informed that only aggregate data are required. Work with grantees to resolve data collection problems	Agree. This is HRSA's current administrative policy	NPS
Evaluation should incorporate a range of behavioral research skills and methodologies	Agree in principle. This is HRSA's current administrative policy, and part of HRSA's ongoing evaluation efforts	NPS
Develop a range of mechanisms to support PWA participation on councils and consortia and ensure that all entities are clearly informed about implementation	Agree. See Section I-A, HRSA legislative proposal #2A; and Section I-B, administrative Issue #2B	NPS
Develop clear guidelines for representation of affected populations on councils and consortia, including definition of roles and responsibilities, selection and participation. Provide TA to councils and consortia that have difficulty ensuring adequate representation. Require grant applications for Title I and R to contain assurances of adequate consumer representation on councils and consortia	Agree in principle. See Section I-A, HRSA legislative proposal #2A; and Section I-B, administrative Issues #2B, 3B	NPS
Require training and orientation for new council and consortia members (particularly PWAS) to enable them to participate more effectively	Agree in principle. HRSA's current policy more effective@ encourages this. Also, this is part of HRSA's ongoing technical assistance and development plan	NPS

Mandate membership of providers with clinical care and public health expertise on councils and consortia, relevant to the local epidemic	Agree. This is HRSA's current administrative policy	NPS
Include Title III(b) grantees on councils and consortia	Agree (except consortia). See Section I-A, HRSA legislative proposal #2A	NPS
Develop mechanisms to keep community informed of reauthorization process	Agree. This is HRSA's current administrative policy	NPS
Maintain Title II priority on drug reimbursement, insurance continuation, home-based care and consortia, but allow funding for other key services as identified through comprehensive plan	Agree. This is HRSA's current administrative policy	NPS
Work with grantees to develop guidelines for use of funds to support council responsibilities (e.g., a portion of Title I funds should be set aside for planning, needs assessments, etc.)	Agree. It is current HRSA policy that a small portion of Title I program funds may be used to support HIV services planning council activities	NPS
Ensure that funds are used to meet specific, unmet service needs, as identified in the comprehensive plan, for infrastructure and capacity building for undeserved communities	Agree. This is HRSA's current administrative and monitoring policy	NPS
Permit rapid re-allocation of funds (when providers are unable to deliver services or excess funds are available). HRSA should work with grantees to develop guidelines for re-allocation compatible with local procedures	Agree. Current HRSA administrative policy encourages grantees to re-allocate funds as appropriate	NPS

Extend Ryan White eligibility to include Urban Indian Health Programs (UIHP) and non-UIHP community organizations serving Native American PWAs	No legislative change proposed. Administrative guidance to grantees will clarify that these entities are eligible to apply for funds from all Ryan White CARE Act programs	NPS

Prepared by:TFox/MSchroeder:ONAP:690-5560:6/15/94:Admin

Issues To Be Resolved Administratively
Summary

Issue 1B: Coordination, planning, and joint allocation decisions

- HRSA will, in collaboration with constituents, develop and issue policy guidance related to improving coordination and planning. The policy will focus on mechanisms to maximize access to a continuum of care for all populations, improve the quality and responsiveness of HIV-related health care and support services, and maintain people with HIV infection in systems of community-based care.
- All Titles will have developed and will implement compatible (not identical) data systems for aggregate reporting of data regarding clients and services.

Issue 2B: Membership and functioning of consortia

- HRSA will, in collaboration with the National Association of State and Territorial AIDS Directors (NASTAD) and leaders of consortia throughout the country, develop and issue policy guidance to Title II grantees directing that appointment of persons with HIV/AIDS is required before a consortium can certify that it is "representative of populations and subpopulations reflecting the local incidence of HIV."
- Technical assistance and policy guidance documents will be developed regarding operations and functioning of consortia.

Issue 3B: Title I planning council structure, organization, and functioning

- Administrative guidance is being developed in consultation with grantees to ensure that alternative representation be provided in the case of excused member absences, e.g., for people with HIV disease who are ill, and for training of new members. Planning council membership will be expected to be representative of the entire community of the EMA.
- Planning councils and EMA administrative agencies will be expected to develop working agreements that establish plans to involve consumers in planning and evaluation activities, establish a grievance process, address training needs, etc.

Issue 4B: Non-service, non-administrative costs

- HRSA will, in consultation with grantees, planning councils, and care consortia representatives, issue policy guidance regarding planning, technical assistance, evaluation and staffing functions of planning councils and HIV care consortia as a priority for their geographic area, to assist them in meeting their mandated responsibilities.

Issue 5B: Multi-jurisdictional EMAs

- HRSA expects that every Title I EMA, its planning council, and administrative agency will initiate steps in FY 1994 to ensure that the development of a comprehensive plan for the organization and delivery of health services include the entire geographic area of the EMA.

Issue 6B: Distribution of Title I supplemental funds

- To decrease burden on grantees of developing a complete supplemental application each year, policy will be developed in collaboration with grantees to award supplemental funds for a multi-year period with non-competing continuation funding decisions to be made programmatically based on criteria developed with extensive input from all Title I grantees.

Section I-B
Issues To Be Resolved Administratively

The HRSA administrative actions presented in this section reflect a careful review of concerns raised by HRSA staff in meetings with constituency groups, the recommendations of the HRSA AIDS Advisory Committee, and 3-1/2 years' experience in administering the Ryan White CARE Act programs.

Issue 1B: Coordination, planning, and joint allocation decisions

Discussion: Coordinated planning and optimal use of resources available from all Titles of the Ryan White CARE Act are critical to improve services to clients and families with HIV disease. To improve coordination and funding decisions, the following issues need policy and administrative clarification: needs assessments, strategic planning, priority setting, coordinated service delivery, and data collection.

HRSA is submitting a legislative proposal (see legislative proposal #9A) as well as this administrative action aimed at improving coordination and joint planning because of the importance of this issue. The issuance of policy guidance will permit a strong focus on improving coordination immediately, while a legislative proposal could not be enacted until FY 1996.

Administrative Action: HRSA will, in collaboration with constituents, develop and issue policy guidance related to improving coordination and planning. The policy will focus on mechanisms to maximize access to a continuum of care for all populations, improve the quality and responsiveness of HIV-related health care and support services, and maintain people with HIV infection in systems of community-based care. Policies will be developed based on broad input already received from all HRSA grantees, national organizations, providers, and people living with HIV, and will include (1) joint local and State needs assessments and planning based on a full consideration of all existing resources and funding streams, and (2) accountability for the process by which decision-making and prioritization occur. Additional issues include the need to coordinate with the community planning bodies for HIV prevention programs at the State and local levels and coordination with Title III(b), Title IV, the AIDS Education and Training Centers program, and other Federal programs, e.g., Substance Abuse and Mental Health Services Administration (SAMHSA) and CDC. Programmatic requirements that address joint planning, needs assessment, decision-making, and an expectation of cross-CARE Act review and comment on applications will enhance coordination at the service delivery level. All Titles will have developed and will implement compatible (not identical) data systems for aggregate reporting of data regarding clients and services. Since different Titles have different populations to serve and involve different legislatively mandated activities, e.g., early intervention, pharmaceutical reimbursement, support services, and medical services, reporting cannot be identical. Data and reporting requirements will, in consultation with grantees, be changed if necessary to ensure compatibility with the Health Security Act or any other enacted health care reform legislation.

Issue 2B: Membership and functioning of consortia

Discussion: Title II of the CARE Act defines HIV care consortium as "an association of one or more public, and one or more nonprofit private, health care and support service providers and community-based organizations operating within areas determined by the State to be most affected by HIV disease." Membership or representation on the HIV care consortium is a requirement for service providers that receive funding through the consortium. The consortium may also include service providers that do not receive Title II funding, and representatives of business, educational, and religious communities. All HIV care consortia are expected to include people with HIV infection in their memberships. Their legislated responsibilities are to (1) assess and plan for the service needs of populations and subpopulations with HIV disease, (2) promote the coordination and integration of community resources, (3) ensure continuity of services through effective case management, and (4) periodically evaluate the consortium's effectiveness in responding to service needs and providing cost-effective alternatives to hospitalization.

The legislation offers no further clarification regarding the membership of consortia and its functioning, and experience to date indicates wide variance in the extent to

which affected populations are represented by persons living with HIV disease and in the organization and functioning of consortia.

Administrative Action: HRSA's Division of HIV Services will, in collaboration with the National Association of State and Territorial AIDS Directors (NASTAD) and leaders of consortia throughout the country, develop and issue policy guidance to Title II grantees directing that appointment of persons with HIV/AIDS is required before a consortium can certify that it is "representative of populations and subpopulations reflecting the local incidence of HIV." Policy guidance will further direct grantees to ensure that consortia membership reflects the demographics of the epidemic within the area and the various populations affected by HIV in the community, and that strategies should be developed to ensure input from affected communities. Policy will also address operations and functioning of consortia, including strategies for the management of conflict of interest.

Issue 3B: Title I planning council structure, organization, and functioning

Discussion: The CARE Act requires that "to be eligible for assistance under this part, the chief elected official...shall establish or designate an HIV Health Services Planning Council..." that is representative of the agencies and organizations engaged in the provision of care to those affected by HIV/AIDS, State and local government, other community leaders, and persons affected by HIV/AIDS, including individuals with HIV disease. In the House/Senate Conference Report, while there was acknowledgement of the authority vested in the CEO to appoint such a council, there was commitment and reference to the fact that these councils were not to be advisory in nature or intent. Planning councils were expected to be given full authority and discretion in executing their roles and responsibilities.

Administrative Action: While the issue of representation of consumers and other key HIV/AIDS programs' representatives on the planning councils is proposed to be dealt with through a legislative change, administrative approaches are necessary for resolution of several other issues. Administrative guidance is being developed in consultation with grantees to ensure that alternative representation be provided in the case of excused member absences, e.g., for people with HIV disease who are ill, and for training of new members. Planning council membership will be expected to be representative of the entire community of the EMA. Procedures will need to be established between the CEO and planning council to fill vacancies, add members, reappoint members, and deal with a transition to a new CEO. In terms of ongoing duties and responsibilities, planning councils and EMA administrative agencies will be expected to develop working agreements that establish plans to involve consumers in planning and evaluation activities, establish a grievance process, address the training needs of planning council members, and involve the planning council in decisions regarding reallocation of unexpended funds and monitoring the quantity and quality of the performance of service providers. Planning councils will need to develop bylaws that at a minimum address inclusiveness of membership, managing conflict of interest (especially in terms of service provider representation on the planning councils), timeframes for filling vacancies, reimbursement for HIV-positive and low-income members, and identification of which constituency groups individual members represent.

Issue 4B: Non-service, non-administrative costs

Discussion: Program experience to date indicates that adequate funds must be allocated by grantees to ensure effective performance by planning councils and consortia (for planning staff, removal of barriers to participation by persons with HIV/AIDS and/or of low-income, etc.) and the best use of direct service dollars. Grantees have experienced difficulty in making such allocations because they may be misconstrued by potential service recipients as "administrative" expenses that take funds away from direct services.

Administrative Action: HRSA's Division of HIV Services will, in consultation with grantees, planning councils, and care consortia representatives, issue policy guidance for grantees that planning councils and HIV care consortia should identify certain planning, technical assistance, evaluation, and staffing functions as a priority for their geographic area, to assist them in meeting their mandated

responsibilities (including payment for staff, eliminating barriers for participation, as well as system enhancements and accountability mechanisms such as needs assessments). Such guidance would define current authority and specifically indicate that such decisions are both permissible *and expected* and should *not* be counted toward legislatively-mandated caps on administrative expenses.

Issue 5B: Multi-jurisdictional EMAs

Discussion: Although the Ryan White CARE Act is specific about eligibility requirements for Title I funding, it does not specifically identify which local jurisdictions comprise a Title I EMA. It uses as a reference the CDC AIDS Surveillance Report, which publishes its AIDS data by metropolitan statistical areas (MSAs). The Office of Management and Budget (OMB) has recently enacted changes in certain MSAs, based primarily on Bureau of the Census data on patterns of commuting for employment. In many cases, these areas include new suburban and outlying counties contiguous with the major urban center. These newly designated MSAs transcend traditional public health, HIV service delivery, and even State systems and borders, and present difficult challenges to currently funded EMAs and their planning councils in developing a comprehensive plan for the organization and delivery of health services in the entire geographic area.

Administrative Action: HRSA's Division of HIV Services expects that every Title I EMA, its planning council, and administrative agency will initiate steps in FY 1994 to ensure that the development of a comprehensive plan for the organization and delivery of health services includes the entire geographic area of the EMA. FY 1994 will serve as a phase-in period that will likely progress differently in various Title I EMAs.

Specifically, EMAs will be expected to include plans for: consideration of planning council membership that is representative of the entire EMA and all local jurisdictions, or establishment of subcommittees or sub-councils that have a formal relationship with and role in planning council responsibilities (such sub-council planning processes for distinct political subdivisions should be specifically identified and agreed upon via intergovernmental agreements); implementation of an area-wide needs assessment process; and establishment of priorities that consider service delivery issues and funding availability throughout the EMA. Thus, a single planning council will retain statutory responsibility for mandated planning council functions at the same time that policy guidelines encourage a locally flexible planning process.

HRSA understands that the level of involvement of local jurisdictions will vary by EMA. However, this administrative solution affords all local jurisdictions the opportunity to engage in discussions and planning/priority-setting processes that lead to a rational approach for dealing with the service needs of people with HIV in the entire EMA.

Issue 6B: Distribution of Title I supplemental funds

Discussion: Grantees have provided considerable input regarding the burden of developing a competitive grant proposal each year for supplemental grant awards under Title I. In the absence of program experience in the first years of CARE Act implementation, the Division of HIV Services made funding decisions regarding the supplemental award based on a process that began with the appropriation and based the awards to each EMA on the congressionally determined formula amount, adjusted up or down based on results of an external review and minimal staff input regarding performance. Now that HRSA has sufficient program experience, it can enact policy and administrative changes that will allocate supplemental funds to areas most able to quickly and effectively utilize these funds to provide services to diverse populations in the coming year. These changes will be consistent with the statutory intent that supplemental funds be provided to those EMAs that have a demonstrated need for, and ability to use, funds in the next year in addition to funds available through their formula awards.

Administrative Action: To decrease the burden on grantees of developing a complete supplemental application each year, policy will be developed in collaboration with grantees to award supplemental funds for a multi-year period with non-competing continuation funding decisions to be made programmatically based on criteria developed with extensive input from all Title I grantees. In addition to performance in the prior year and

service delivery plans for the coming year, emphasis will be placed on the applicant's ability to demonstrate both the unmet need and the ability to expend funds to meet those needs in the budget period of the supplemental grant award. This change will strengthen the ability to achieve the congressional intent that supplemental funds be awarded to areas that demonstrate both unmet need and the ability to use funds in an expeditious and cost-effective manner.

Provisions for addressing in future years an application that is disapproved or funded at a low level during the first year of a competitive application cycle will be developed with grantees. For example, a predetermined portion of funds each year could be used for augmenting awards of "unsuccessful" or disapproved applicants from prior years if they have demonstrated program improvements.

Funds for newly eligible EMAs will be awarded in a manner similar to that done previously. Half of the funds will be based on formula and the supplemental award will be based on a competitive application. The total amount awarded to all new EMAs as a group in their supplemental awards will be the total of their combined formula amounts.

Issues Considered For Which No Or Partial Changes Have Been Made
Summary

Issue 1C: Raise the cap on administrative expenses from 5 percent to 10 percent for Titles I, II, and III(b). Require a 5 percent match for administrative expenses above 5 percent for Title I and high incidence Title II States

- Legislative proposal to raise the administrative cap for Title III(b) only. These grantees are not-for-profit community-based organizations that do not have supplementary resources to adequately perform Ryan White functions.
- The 5 percent administrative cap does not pose the same (as Title III(b)) hardship for Titles I and II grantees because they have other resources they can use to supplement this activity.

Issue 2C: Delete or allow flexibility in the Title II requirement that 15 percent of the funds be used to provide health care and support services to infants, children, women, and families with HIV disease

- No change is made. It is less disruptive to keep the requirement as it is currently mandated. The demography of HIV has changed; a higher proportion of AIDS cases in recent years are infants, women, and children. Special emphasis in funding for services for these populations needs to be continued.

Issue 3C: Delete or allow flexibility in the 50 percent requirement for Title II consortia

- No change is made. Substantial progress has already been made in creating local, regional, and statewide consortia and improving planning and delivery of care by these consortia. Reducing funding for them at this stage would be highly disruptive of service delivery.

Issue 4C: Change the funding formula for Title I

- No change is made. Any change to the Title I formula, without related increases in the appropriations, would negatively impact Newark, Jersey City, New York City, and San Francisco.

Issue 5C: Mandate a single appropriation with percentages for each Title

- No change is made. The Administration should have the ability to propose an emphasis on one or more programs (Parts or Titles) as appropriate, and the appropriations process should have the discretion to award funds as changed needs and conditions arise. HRSA will emphasize funding increases for all Ryan White Titles through the appropriations process.

Issue 6C: Authorize funding for SPNS as a separate authority, with a set-aside from all Ryan White Titles

- No change is made. A separate authority for SPNS with a set-aside from all Titles would prevent the appropriations process from directing resources appropriately when changes in the epidemic or standards of care occur.
- The program is working well now and is administered to address issues of recipients of funds for all Ryan White Titles.

Issue 7C: Eliminate the current Title structure and replace it with a single appropriation to the States with a pass-through to Title I cities and/or other currently funded grantees

- No change is made. Current Ryan White programs have different purposes and different recipients of funds. Such a change would create a cumbersome, disruptive application and funding process.
- The current structure has facilitated locally-based responses to the epidemic and has permitted the expedited use of funds in areas of greatest need.
- Constituent groups for all Ryan White programs have endorsed the current organization and funding structure.

Issue 8C: Change the funding formula for Title II to one which requires a portion of the State grant to be awarded on the basis of a current formula calculation and a supplemental portion to be awarded on the basis of demonstrated need, a concept similar to Title I

- No change is made. Such a change would disrupt care for unsuccessful applicants unless a hold-harmless provision were instituted in a year of substantial budget increase.

Section I-C

Issues Considered For Which No Or Partial Changes Have Been Made

Some legislative and administrative issues were debated by the HRSA internal workgroup and changes were proposed by the HAAC or constituents for which HRSA either did not make changes or made partial changes. A great deal of thought and analysis was given to these issues before arriving at these conclusions. Some of the options considered for change, while based on a real concern, would be too disruptive to the programs and would, in the judgment of HRSA, negatively impact client services. Some might even require undoing progress already made in communities before there could be additional positive results.

Issue 1C: Raise the cap on administrative expenses from 5 percent to 10 percent for Titles I, II and III(b) programs. Require a 5 percent match for administrative expenses above 5 percent for Title I and high incidence Title II States

Discussion: Current legislation requires that only 5 percent of Ryan White grant funds be used for administrative expenses. The administration of these programs is complex and adequate accountability for use of these funds requires needs assessment, planning, technical assistance, contracting, contract monitoring, data collection, and program oversight and evaluation. Grantees have almost uniformly felt that they could improve technical assistance, program planning, and provider contract oversight if additional staff could be hired to perform these functions. In many cities and States this would require use of more than 5 percent of the grant award. Many localities do not have a full-time staff person to administer the Ryan White programs. This complex program requires more staff time and expertise than the 5 percent cap permits. Many people living with HIV and many providers of care strongly feel the funds should continue to be used mostly for direct delivery of services and oppose increases in administrative expenses.

Options: A legislative proposal is submitted to raise the administrative cap for Title III(b) only (see legislative proposal #12A). The Title III(b) grantees are not-for-profit community-based organizations that do not have supplementary resources to adequately perform the Ryan White related administrative functions within the current 5 percent administrative cap. While Title I and high incidence Title II grantees could effectively use an increase in the administrative cap, the 5 percent cap does not pose the same hardship for them as it does for Title III(b) providers because the States and cities have other resources they can use to supplement this activity. The option to increase the cap and require cities and States to match the 5 percent increase was strongly considered. Raising the cap to allow for at least one full-time staff person to administer the program in each State has strong support from many constituents. However, in the face of continued concern about resources for services, no change was made in the current legislative language for Titles I and II.

Issue 2C: Delete or allow flexibility in the Title II requirement that 15 percent of the funds be used to provide health care and support services to infants, children, women, and families with HIV disease

Discussion: States have been creative and responsible in trying to meet the 15 percent legislative mandate and in serving these population groups. However, because of geographic differences in the demographics of the epidemic, meeting the 15 percent requirement has not been possible in some areas. Certain States, especially those that have low HIV prevalence and those that receive minimum allotments under Title II, have few women and children with HIV disease. They can only meet the 15 percent requirement by providing services to families, which may restrict them in their ability to meet the primary needs of people with HIV disease.

Options: One of the options considered was to permit States in which women, infants, and children represent less than 15 percent of reported AIDS cases (or reported HIV cases if the State has HIV reporting) to provide services to these populations consistent with the local (State) epidemiology. Another option would be for States with less than 15 percent of the population of people with HIV/AIDS in these categories to show that the care needs of women, infants, and children are being met and, with HRSA approval, to use leftover funds for other purposes. It is recognized that the level of funding that needs to be devoted to these populations varies from State to State. On

balance, however, it is felt to be less disruptive to keep the requirement as it is currently mandated. The demography of HIV has changed; in 1993, 17 percent of AIDS cases nationally are infants, children (less than 13 years of age), and women. To emphasize and ensure planning for optimal care of these groups, special emphasis in funding for services needs to be continued.

Issue 3C: Delete or allow flexibility in the 50 percent requirement for Title II consortia

Discussion: High incidence States are required to use 50 percent of their Title II award for HIV care consortia. The amount of funds remaining is often insufficient to adequately address the needs of many people with HIV through pharmaceuticals, home and community-based care, and health insurance continuation.

Options: One option considered was to discontinue the 50 percent requirement and allow the allocation for consortia to be determined at the State level. This would be in keeping with a central tenet of the Ryan White CARE Act to emphasize local control and autonomy. Another option was to require formation of consortia in all States without a designated percentage of funds to be used for this activity. The option to retain the 50 percent requirement for consortia was taken because substantial progress has already been made in creating local, regional, and statewide consortia and improving planning and delivery of care by these consortia. Reducing funding for them at this stage would be highly disruptive of service delivery.

Issue 4C: Change the funding formula for Title I

Discussion: The Title I formula award to eligible metropolitan areas (EMAs) is based on an amount related to the number of cumulative cases of AIDS and an amount related to per capita cumulative incidence. The Title II formula award to States is based on the number of AIDS cases for the two most recent years adjusted by average per capita income. Both EMAs and States are developing systems of care and providing health care and support services to people living with HIV disease. The formula for Title I gives heavy weight to cases reported many years ago and many of those individuals are deceased. The formula for Title II is a better surrogate for care of those people with HIV who are most ill and most in need of care than is the Title I formula if one were starting at the beginning of the legislation. However, in 1995 when the systems of care in many EMAs have been under development for 5 years and because sufficient resources are not available from all sources for comprehensive care for all people with HIV, it would be disruptive to existing care systems to alter the Title I formula and convert to the Title II formula at this time (as shown in Tables in Part III of this report). Major disruptions in care would occur in Newark, Jersey City, New York City, and San Francisco. If this were to be attempted it could only be done over a 2-3 year period in which at least one of the years included a substantial increase in appropriations to ensure at least level funding for service providers currently funded. Major funding shifts which might result in cutting people currently served from their present care system could be medically unethical.

Options: The options considered included: (1) using the current Title II formula for both Title I and Title II; (2) using the current Title II formula for both Title I and Title II, but changing the case reporting period to 3 years to account for people living longer and to reflect a truer picture of those receiving services; (3) increasing the weight given to per capita cumulative incidence since that factor is a more adequate surrogate measure that reflects the impact of HIV disease against the availability of local resources; and (4) no change. HRSA did not propose changes to the formula because of the reasons stated in the discussion. Any change to the Title I formula, without related increases in the appropriations (which are unpredictable), would negatively impact Newark, Jersey City, New York City, and San Francisco.

Issue 5C: Mandate a single appropriation with percentages for each Title

Discussion: The current Ryan White program organizational structure mandates four Titles, each with a separate appropriations authority. Appropriations requests for each of the Titles are initially coordinated at the HRSA level to ensure that funding needs are considered in conjunction with all Titles. The actual appropriations, however, do not proportionately increase funding for all

Titles. This has the effect of reducing or eliminating the opportunities for funding new primary care and training programs in areas in which the epidemic has recently reached.

Options: The options considered were to maintain separate Titles but mandate one annual appropriation for all of Ryan White with a percentage formula for allocation among Titles, or to make no change. Having a single appropriation with a legislatively mandated percentage distribution of funds to each Title would, in years of budget increases, ensure all Titles would receive increases to provide for changes in the epidemic and to develop new service capacity for women and children, and primary care services in areas newly impacted by the HIV epidemic. It would also reduce fragmentation and separateness of providers funded by different Titles and encourage all constituents to support the legislation as a whole more effectively.

A disadvantage of a single appropriation with percentages for each Title is the difficulty for the Administration to connect the budget request to, and for Congress each year to base the appropriation on, specific timely developments, e.g., an unusually large number of newly eligible metropolitan areas under Title I, the approval of a new HIV therapeutic that would have a substantial impact on the drug assistance program under Title II, or the recent findings in the 076 trial with its implications for all HIV programs, especially Title IV and AIDS Education and Training Centers. The Administration should have the ability to propose an emphasis on one or more programs (Titles) as appropriate, and the appropriations process should have the discretion to award funds as changing needs and conditions arise.

HRSA recommends no change to the appropriations structure. HRSA did not propose a legislative change, but will emphasize funding increases for all Ryan White Titles through the appropriations process.

Issue 6C: Authorize funding for Special Projects of National Significance (SPNS) as a separate authority, with a set-aside from all Ryan White Titles

Discussion: The SPNS projects are authorized and supported under Title II of the CARE Act. Up to 10 percent of the Title II appropriation is authorized to fund special projects to develop, test, and disseminate innovative models of care and treatment of individuals with HIV disease. The SPNS program currently supports special projects for all Titles under Ryan White, and has included projects with a special emphasis on adolescents; women, children and families; rural populations; Native Americans; mental health and primary care; migrant populations; and correctional institutions. The programs have been successful in developing good models of care. These are being disseminated this year. A set-aside from all Titles might increase resources to address needs of new populations and geographic areas and foster innovation in care models. However, the program is working well now and is administered to address issues of recipients of funds for all Titles. In addition, it was felt that a set-aside from all Titles would not be supported by constituents.

Options: The options considered were to mandate a separate authority for SPNS with a set-aside from all Ryan White Titles, or to make no change. No change to the legislation is proposed. The requirements for dissemination of innovative models of care will be strengthened administratively.

Issue 7C: Eliminate the current Title structure and replace it with a single appropriation to the States with (perhaps) a pass-through to Title I cities and/or other currently funded grantees

Discussion: Eliminating the current Title structure and replacing it with a single appropriation to the States would result in better coordination across Ryan White programs. Statewide planning would be improved and the application process could be streamlined. However, the current Ryan White programs are established for different purposes and have different recipients of funds: for Title I, the recipient is the chief elected official of a metropolitan area; for Title II, the State health department is the recipient of funds; for Title III(b), the recipient of funds is a clinic, a community-migrant health center, or a community-based organization; and for Title IV, the recipients are public or nonprofit entities that provide or arrange for primary health care for children and their families, e.g., hospitals,

medical centers, State or local health departments, and community organizations. The current structure has facilitated locally-based responses to the epidemic and has permitted the expedited use of funds in areas of greatest need.

Developing an application for a single appropriation for all Titles would be extremely cumbersome and would have to be phased in over several years. In addition, while constituents have discussed the possibility of replacing the current Title structure, constituent groups for all CARE Act programs have endorsed the current organization and funding structure.

Options: The options considered were to: (1) eliminate the current Title structure and replace it with a single appropriation to the States; (2) merge Title I and Title II with an award to the State combined with set-aside amounts for the EMAs; and (3) retain the current Title structure. HRSA proposed no change in the Title structure. Most constituents concur.

Issue 8C: Change the funding formula for Title II to one which requires a portion of the State grant to be awarded on the basis of the current formula calculation and a supplemental portion to be awarded on the basis of demonstrated need, a concept similar to Title I

Discussion: HRSA, constituents, grantees, and national organizations recognize the ability of the competitive Title I supplemental to foster positive changes in local communities. The competitive nature of one-half of the Title I program has fostered accountability for an inclusive planning process and for attention to the unmet service needs of disenfranchised, underserved populations. In addition, a supplemental award permits the assessment of those locales that both need additional funds and can allocate those resources expeditiously to areas of greatest need. Consideration of a competitive, supplemental award for a portion of Title II funds was raised by both Title I and Title II grantees, service providers, and persons living with HIV disease at the HRSA constituent discussion groups series in the summer of 1993.

On the other hand, successful programs have been implemented at the State level under the current funding formula which allocates all Title II funds based on the number of AIDS cases for the two most recent years adjusted by average per capita income. Converting from the current formula to one which allocates a portion of the funds based on a competitive process could hurt some States and people with HIV who depend on these programs. Changing the funding formula could reduce funding for some States which, at this stage, would be disruptive of service delivery.

Options: The options considered were to change the Title II funding formula to require a portion of the funds to be distributed based on a competitive process, or to retain the current formula. HRSA proposed no change to the Title II funding formula to prevent disruptions in service delivery. If changes were to be made, it could only be done in a year(s) of substantial budget increases to prevent disruption of care.

THE WHITE HOUSE

WASHINGTON

June 30, 1994

MEMORANDUM TO CAROL RASCO

FROM: Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

SUBJECT: Ryan White CARE Act meeting with Four Titles Coalition

Attached are the summary points and list of participants for yesterday's meeting with representatives of the Four Titles of the Ryan White CARE Act. I feel the meeting was both successful and positive. This same group will meet again in three to four weeks.

HRSA has not yet fully completed the necessary package to proceed with reauthorization within the Public Health Service. Dr. Lee is hoping to have this package in the very near future and there will be a briefing for us with him soon thereafter.

If you have a questions or comments on the attached report, please give me a call.

Thank you.

THE WHITE HOUSE

WASHINGTON

Office of National AIDS Policy
Ryan White CARE Act Meeting
June 29, 1994

Participants:

Office of National AIDS Policy: Kristine Gebbie
Andrew Barrer
Arthur Lawrence
Tim Fox
Michael Schroeder (intern)

HCFA: Sam Shekar, Special Assistant to the Administrator

HRSA: Eric Goosby, Director of HIV Services

Ryan White Coalition: Grayson Fowler for Title I
Julie Scofield and Joe Kelly for Title II
Kristen O'Connell for Title III(b)
David Harvey for Title IV

AIDS Action Council: Aimee Berenson

Summary

On June 20, 1994, representatives of the Four-Title CARE Act Coalition (FTC) met with Kristine Gebbie to discuss issues related to the reauthorization of the Ryan White CARE Act. Salient points discussed at the meeting are outlined below.

- The FTC wanted reauthorization of the CARE Act to occur in 1994. They wanted to know Ms. Gebbie's and the Administration's position on early reauthorization.

- Ms. Gebbie stated that health care reform (HCR) and reauthorization of the CARE Act have to be matched. There is a need to identify areas in HIV/AIDS health care that HCR will not cover once implemented. Further, there is a timing issue related the transition period for HCR. Once the areas are identified and time frames established, the CARE Act will be used to fill the gaps. Ms. Gebbie indicated that the Title III(b) programs may be the most vulnerable with HCR because of the perceived overlaps with primary care access issues.

- The Administration is fully in support of reauthorizing Ryan White so as not to cause a

disruption in programs. The Administration does not yet have a position on the content of reauthorization as a whole other than that it should be coordinated with HCR. We have not yet seen the completed proposal from HRSA, which is still not finished. Dr. Lee needs to have the completed documents from HRSA in order to go forward with the content of the reauthorization legislation.

- The FTC indicated that Secretary Shalala has said she would support early reauthorization if the HIV/AIDS community wants it. Ms. Gebbie indicates that the Secretary's statements may have been misunderstood and that through her interactions with the Secretary there has been a clear message that early reauthorization would not be independent of HCR.

- All present confirmed that health care reform will not eliminate the need for the CARE Act, and indicated a need to set up a meeting to discuss what will be covered under the health care reform plan. The cross title paper came out of the work of all four titles. The community is behind the reauthorization and the FTC wants to move the process on Capitol Hill. No one in Title I or II questioned the structure of the Act. The authorization level for Title II were within reason. The SPNS should not be funded as part of Title II, but as a percentage of all Titles (a new Title V).

- There was FTC consensus not to change the funding formulas (at least significantly; CAEAR proposed a minor modification in the Title I funding formula and there is also a proposal to increase the minimum Title II award for States with greater than 20 cases to $250,000). The FTC and HRSA believe changing the funding formulas, at this point, would create winners and losers, therefore hurting some existing programs. The FTC believes the funding inequity would be resolved by increasing the appropriation for Title II. If this is to be the case, then materials to answer critics of the status quo must be available.

- While the AIDS Action Council agrees with FTC on most issues, it does believe that the funding formulas need to be evaluated. They recommend reevaluation of the Titles I and II funding formulas to achieve greater equity in allocations. They propose "holding harmless" those cities and states that might suffer a decrease in funding.

- Ms. Gebbie expressed concern that questions regarding the equity of the current funding formulas have come from several sources (For example, a new group of about 100 local programs have united to form a separate Title II group which has sent a position paper indicating grave concerns about the funding formula supported by the FTC), and stressed that unity among the groups would be important when discussing reauthorization on the Hill. She also emphasized that as prevention efforts begin to have an affect and the demographics of the epidemic shift there will be a change in the AIDS caseloads. This will result in funding changes for some programs; this issue must be addressed.

- Ms. Gebbie asked whether consideration had been given to a cap on the number of eligible metropolitan areas. The position of the FTC was that there should be no caps but greater coordination between Title II and new Title I EMAs.

- Another issue raised involved the need for the 15% set-aside for infants, children, women, and families with HIV. The FTC has proposed retaining the 15% set-aside for states that have 10% or greater AIDS caseload for these groups. The "family" group is problematic due to variability in defining the term.

- The needs of "target" groups e.g., women, children, substance abusers, needs to be addressed in the planning process, necessitating representation and involvement of various affected groups in the planning process. This brought the issue of linkage and integration of programs, particularly in the planning process e.g., Title V, prevention, substance abuse.

- Ms. Gebbie indicated she would not like to push the CARE Act until the questions are answered. The group will meet again in three to four weeks, after the coalition has done some further work on as yet unresolved issues.

CHARLES E. SCHUMER
NEW YORK

2412 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-6616

DISTRICT OFFICES
1628 KINGS HIGHWAY
BROOKLYN, NY 11229
(718) 965-5400

73-15 YELLOWSTONE BLVD
FOREST HILLS, NY 11375
(718) 268-8200

90-16 ROCKAWAY BEACH BLVD
ROCKAWAY, NY 11693
(718) 945-9200

Congress of the United States
House of Representatives
Washington, DC 20515

COMMITTEES
JUDICIARY
CHAIRMAN
SUBCOMMITTEE ON
CRIME AND CRIMINAL JUSTICE
BANKING, FINANCE
AND URBAN AFFAIRS
FOREIGN AFFAIRS
WHIP-AT-LARGE
NEW YORK STATE
CONGRESSIONAL DELEGATION
TREASURER

March 11, 1994

I'd like to be sure to see reply to this—

The Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Shalala,

I am writing to express my concern that the Nation of Islam is receiving Ryan White grants to provide AIDS counseling.

In particular, I was disturbed to learn that the Abundant Life Foundation in Washington, D.C., which is affiliated with the Nation of Islam, is a recipient of $200,000 in federal funds.

Dr. Abdul Alim Muhammad, the clinic's doctor, has made disparaging remarks about Jewish physicians. He claims they are guilty of injecting black babies with the HIV virus. Obviously this statement is an outrageous lie and anti-Semitic.

I would appreciate knowing what controls the Department of Health and Human Services takes to insure that only reputable providers receive Ryan White funding? If any other Nation of Islam clinics are receiving federal funding? What criteria was used in granting the Abundant Life Foundation funding?

I look forward to your response.

Sincerely,

Charles E. Schumer

Charles E. Schumer
Member of Congress

FYI 4/4
There have been several letters protesting funds for ALMIC. This response should be closer to what is sent.

NOTES 3/22

167035

TRACER

PETER T. KING
Member of Congress
Third District, New York

VICE PRESIDENT
REPUBLICAN CLASS OF
THE 103d CONGRESS

118 CANNON BUILDING
WASHINGTON, DC 20515-3203
(202) 225-7896

1003 PARK BOULEVARD
MASSAPEQUA PARK, NY 11762
(516) 541-4225

Congress of the United States
House of Representatives
Washington, DC 20515-3203

March 7, 1994

COMMITTEE ON BANKING, FINANCE AND URBAN AFFAIRS

COMMITTEE ON MERCHANT MARINE AND FISHERIES

COMMITTEE ON VETERANS' AFFAIRS

CONGRESSIONAL HUMAN RIGHTS CAUCUS

TASK FORCES ON:
POW-MIA AFFAIRS
VETERANS' HEALTH CARE
CRIME

Honorable Donna Shalala
Secretary
Department of Health and
Human Services
200 Independence Ave, SW
Washington, D.C. 20201

Dear Secretary Shalala:

I am writing in regard to media reports indicating the possibility of Department of Health and Human Services funding finding its way to organizations affiliated with Louis Farrakhan's Nation of Islam. I have received information that HHS funding has been going to a Nation of Islam AIDS awareness program in Washington, D.C.

As you know, in recent weeks both the United States Senate and the House of Representatives overwhelmingly passed resolutions condemning the anti-Catholic, anti-Semitic, and racist remarks of a Farrakhan lieutenant. I believe that in taking this action the Congress has accurately reflected the feelings of the American people on the vile message of hate being put forth by Mr. Farrakhan and the leadership of the Nation of Islam.

While the Nation of Islam has properly targeted pressing problems such as drug abuse and violence in inner city neighborhoods, it has become increasingly clear that its leadership is dedicated to and openly encourages intolerance, bigotry and hate. Their message is inconsistent with any long-term strategy to solve problems in our cities and should not be tolerated by government at any level.

In light of these facts, I hope you will do your utmost to ensure that no Federal funds go toward assisting or lending legitimacy to such an infamous and hate-mongering group. Please inform me of what steps you are taking to prevent your department from implying the Federal Government's tacit approval of Mr. Farrakhan's message of hate through the allocation of taxpayer dollars.

Thank you for your time and prompt attention to this matter.

Sincerely,

PETER T. KING
Member of Congress

940309 1109 P

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Health Resources and
Services Administration
Rockville MD 20857

April 1, 1994

NOTE TO BOB RICKARD

SUBJECT: Tracer 66519 - Congressman Peter King--FAST TRACK

Attached is HRSA's proposed response to Congressman Peter King who wrote concerning the Abundant Life Health Clinic in Washington, D.C.

We have three additional letters for Dr. Sumaya's signature on the same subject (two are congressionals), and from a conversation with Barbara Favola I understand another congressional has been received. After the King letter as well as the draft letter to the District of Columbia Department of Human Services has been cleared, we will have the letter signed and sent to D.C.

Tom

Tom Hatch

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Honorable Peter T. King
House of Representatives
Washington, D.C. 20515

Dear Mr. King:

Thank you for your letter of March 7 regarding funds awarded to Washington, D.C. under authority of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and the contract to the Abundant Life Health Clinic in Washington, D.C.

The Department of Human Services of the District of Columbia is the recipient of Title I funding for the Washington, D.C. metropolitan area. As required by the law, applications for funds for delivery of required health and support services were solicited by the HIV Health Services and Planning Council (HHSPC) and reviewed by an independent review panel comprised of individuals knowledgeable about AIDS care and services in the area. The applications from community providers were reviewed in accordance with published review and eligibility criteria. This process was used by the District of Columbia in awarding funds to the Abundant Life Health Clinic to provide primary medical care, case finding, nutritional support, and emergency housing.

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE
HRSA	Celeo	4/1						

*U.S. GPO: 1989-619-669

Based on the concerns which you and several others have raised, the HIV/AIDS program director for Washington, D.C. has been asked to look into these matters and provide us with a written response within one month. A copy of that letter of April __, 1994 is enclosed. I will review the response of the Washington, D.C. HIV program director at that time and inform you of the results and whether further action is indicated.

I appreciate your interest in and support of all the programs of the Health Resources and Services Administration and of the Ryan White CARE Act.

Sincerely,

Donna E. Shalala

Enclosure

Prepared by:HRSA/BHRD/DHS/JBurton:TB:03/08/94:WP:Moses3.94
Revised by:HRSA/BHRD/DHS:DParks:TB:03/10/94; and dta 3/16/94
Revised by:HRSA/OS/ES:JHarrison:jh:3/17/94
Revised by:HRSA/BHRD/OPS:TDeJesus:dta:3/25/94
Revised by:PHS/OASH:TShoe:dta:3/31/94: T66519

Bureau of Health Resources Development

Mr. Vincent C. Gray
Director
District of Columbia
Department of Human Services
801 North Capitol Street, N.E.
Washington, D.C. 20532-0247

Dear Mr. Gray:

The Health Resources and Services Administration (HRSA) has recently received several communications expressing concern about Ryan White CARE Act funds provided by Washington, D.C., to the Abundant Life Health Clinic. The inquiries concern the relationship of the Abundant Life Health Clinic to the Nation of Islam organization, the operational practices of the clinic and whether the clinic is using its federal funding for the sole purpose of providing legislatively authorized services to people with HIV/AIDS.

The Public Health Service (PHS) has an established policy on the award of funds to advocacy organizations either directly or as subrecipients. That policy is set forth in Part 700 of the PHS Grants Administration Manual, a copy of which is enclosed.

Please advise me whether the funds are being used in a manner consistent with sound management principles and the rules and regulations of the District of Columbia for legislatively authorized purposes only and whether the manner of operation of the clinic is consistent with Part 700 of the PHS Grants Administration Manual. Also clarify the status and governance of the Abundant Life Health Clinic in relation to the Nation of Islam. Please provide HRSA with a written report on your review of these issues within one month of your receipt of this letter.

Thank you for your attention to this matter.

Sincerely yours,

Eric P. Goosby, M.D.
Director
Division of HIV Services

Prepared by: HRSA/BHRD/DHS:DParks:dta:
Revised by: HRSA/ES:JHarrison:BHRD/DHS:DParks:3/22/94:Waxman
Revised by: HRSA/BHRD/DHS:EGoosby:dta:3/29/94:
Revised by: PHS/TShoe:dta:3/30/94:

PART 700 - ADVOCACY ORGANIZATIONS

Sec.

700.0 Background and Purpose

(a) This part implements Section 1-05-60, Advocacy Organizations, of the HHS Grants Administration Manual Chapter 1-05, High-Risk Grantees. It (1) establishes requirements to identify applications from advocacy organizations, (2) requires determination of the extent to which the applicant's advocacy position will impact upon performance, (3) specifies a course of action regarding such determinations, and (4) stipulates reporting requirements.

(b) For most PHS grant programs, an applicant's advocacy position is seldom an issue since PHS programs normally do not involve either political and religious issues or controversial ethical and moral issues. However, this is a matter which must be addressed when it does occur because performance may be adversely affected under awards to organizations which advocate positions that conflict with the purposes of the grant program.

700.1 Applicability

This policy applies to all PHS discretionary assistance programs except fellowships or other training awards made directly to individuals.

700.2 Definitions

As used in this part, an "advocacy organization" is one which espouses a position or course of conduct that conflicts with the purposes of the program under which Federal support is sought. An advocacy organization may be either the grant applicant or a contractor or other subrecipient under the proposed grant. Examples include organizations that advocate political, religious, or moral positions that are inconsistent with the objectives of the PHS program. Since advocacy is determined on a program-by-program basis, organizations may be determined to be advocacy organizations for one program and not for another, depending on the nature of the program.

700.3 Policy

(a) PHS policy is to make awards to grantee organizations, including subrecipients, which will be able to achieve the legally authorized objectives of the program under which Federal support is sought. However, occasionally applications are received from organizations and/or proposed

RYAN WHITE CARE ACT: FY 1994 TITLE I GRANTS

Eligible Area	Formula Award	Supplemental Award	Total Award
Anaheim, CA	$1,426,850	$1,201,097	$2,627,947
Atlanta, GA	$4,066,062	$3,422,739	$7,488,801
Baltimore, MD	$2,232,355	$1,691,083	$3,923,438
Bergen-Passaic, NJ	$1,277,031	$742,090	$2,019,121
Boston, MA	$3,091,876	$3,863,159	$6,955,035
Chicago, IL	$4,706,676	$4,918,775	$9,625,451
Dallas, TX	$3,445,177	$3,490,467	$6,935,644
Denver, CO	$1,626,755	$1,749,129	$3,375,884
Detroit, MI	$1,623,489	$1,226,070	$2,849,559
Fort Lauderdale, FL	$3,555,421	$3,259,178	$6,814,599
Houston, TX	$5,676,753	$4,456,839	$10,133,592
Jersey City, NJ	$2,306,302	$1,833,839	$4,140,141
Kansas City, MO	$1,251,712	$1,403,852	$2,655,564
Los Angeles, CA	$12,617,337	$12,823,874	$25,441,211
Miami, FL	$6,875,102	$8,383,461	$15,258,563
Nassau-Suffolk, NY	$1,403,882	$1,483,086	$2,886,968
New Haven, CT	$1,235,428	$901,444	$2,136,872
New Orleans, LA	$1,691,877	$1,551,455	$3,243,332
New York, NY	$45,835,380	$54,218,887	$100,054,267
Newark, NJ	$5,166,261	$1,842,919	$7,009,180
Oakland, CA	$2,379,546	$1,549,741	$3,929,287
Orlando, FL	$1,319,944	$1,395,643	$2,715,587
Philadelphia, PA	$3,479,453	$3,895,483	$7,374,936
Phoenix, AZ	$1,175,959	$1,041,512	$2,217,471
Ponce, PR	$976,793	$200,000	$1,176,793
Riverside-San Bern., CA	$1,299,021	$1,102,989	$2,402,010
Saint Louis, MO	$1,178,039	$1,070,208	$2,248,247
San Diego, CA	$2,696,880	$2,536,694	$5,233,574
San Francisco, CA	$19,056,960	$20,153,440	$39,210,400
San Juan, PR	$4,561,223	$3,894,834	$8,456,057
Seattle, WA	$1,617,949	$1,615,954	$3,233,903
Tampa/St. Pete, FL	$1,955,256	$1,349,056	$3,304,312
Washington, DC	$5,225,866	$4,102,846	$9,328,712
West Palm Beach, FL	$1,959,886	$1,622,656	$3,582,542
TOTALS:	***$159,994,501***	***$159,994,499***	***$319,989,000***

Printed: 3/18/94 at 4:13 pm

Sent via fax

THE WHITE HOUSE

WASHINGTON

January 25, 1994

Ginny Worrest
Legislative Assistant to
The Honorable Bob Packwood
United States Senate
259 Russell Senate Office Building
Washington, DC 20510-3702

Dear Ms. Worrest:

Pleased be advised that by our calculations Portland is likely to be among the 3-5 new Title 1-eligible metropolitan areas (EMAs) that will qualify for 1995 funding under the Ryan White CARE Act. Formal eligibility determinations are completed elsewhere, and so this is not an official notification.

Criteria for eligibility for Title 1 are based on exceeding the total of 2000 cases by the end of March in the year preceding. Unfortunately, Portland will have accumulated well over the 2000 cases by March 31. The other city that appears to meet eligible requirements for 1995 is Jacksonville, Florida. Austin and San Antonio also are likely to qualify. Based on past grant experience, and, of course, depending on the appropriation level, I would expect Portland's grant to be in the area of $5.5 million.

For your information, it is also possible to qualify based on an extremely high rate of incidence. This would allow a small city with a higher than usual rate of infection to qualify. This year Cuaygas, Puerto Rico will qualify by this criteria.

I hope this information is helpful. Please call upon us at any time we can be of assistance.

Sincerely,

N. Steve Lee for

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

1994

THE RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY ACT OF 1990

TITLE I HIV EMERGENCY RELIEF GRANT PROGRAM

FY 1994 SUPPLEMENTAL GRANT APPLICATION GUIDANCE FOR THE NEW ELIGIBLE METROPOLITAN AREAS OF:

BERGEN–PASSAIC, NEW JERSEY
DENVER, COLORADO
KANSAS CITY, MISSOURI/KANSAS
NEW HAVEN, CONNECTICUT
ORLANDO, FLORIDA
PHOENIX, ARIZONA
RIVERSIDE/SAN BERNARDINO, CALIFORNIA
ST. LOUIS, MISSOURI/ILLINOIS
WEST PALM BEACH, FLORIDA

September 30, 1993

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Bureau of Health Resources Development
Division of HIV Services
Room 7A–55 Parklawn Building
5600 Fishers Lane, Rockville, Maryland 20857
Telephone: 301–443–6745

1995

For certains: Jacksonville
Portland
Cuyagas
Probable: San Antonio
Austin

1993

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

RYAN WHITE CARE ACT
DIVISION OF HIV SERVICES

Health Resources and Services Administration
Rockville MD 20857

FY 1993 EMERGENCY RELIEF GRANTS--TITLE I

EMA	FORMULA AWARD	SUPPLEMENTAL GRANT
ANAHEIM 1993	$ 979,113	$ 860,613
ATLANTA 1991	2,445,365	3,045,206
BALTIMORE 1992	1,312,875	1,937,468
BOSTON 1991	1,663,443	2,491,301
CHICAGO 1991	2,707,310	4,683,453
DALLAS 1991	1,923,565	2,618,469
DETROIT 1993	955,066	1,136,673
FORT LAUDERDALE 1991	2,314,150	2,277,065
HOUSTON 1991	3,471,981	4,348,338
JERSEY CITY 1991	1,638,806	1,979,414
LOS ANGELES 1991	7,818,374	11,371,895
MIAMI 1991	4,410,774	5,305,490
NASSAU-SUFFOLK 1993	975,081	1,037,728
NEWARK 1991	3,542,648	-0-
NEW ORLEANS 1993	1,104,782	692,190
NEW YORK 1991	28,643,925	15,825,294
OAKLAND 1992	1,367,609	1,235,207
PHILADELPHIA 1991	2,194,894	2,534,336
PONCE 1993	624,396	655,968
SAN DIEGO 1991	1,580,386	2,181,593
SAN FRANCISCO 1991	11,462,925	15,754,151
SAN JUAN 1991	2,540,586	2,139,191
SEATTLE 1993	1,091,801	1,732,769
TAMPA 1993	1,079,809	1,185,744
WASHINGTON, D.C. '91	3,312,635	4,133,943
TOTAL	91,163,499	91,163,499

TOTAL FY 1993 TITLE I GRANT FUNDS--$182,326,998

1991 + 1992

The 18 eligible metropolitan areas (EMAs) and supplemental grants awarded are listed below, with an additional column giving each EMA's Title I formula grant awarded in February 1992:

CITY	Supplemental Grant	Formula Grant	TOTAL FY 92 Title I
Fulton County/ Atlanta, Georgia	$ 1,442,148	$ 1,669,518	$ 3,111,666
Baltimore, Maryland	978,162	920,399	1,898,561
Boston, Massachusetts	1,627,003	1,196,765	2,823,768
Chicago, Illinois	2,493,485	1,834,118	4,327,603
Dallas, Texas	1,782,137	1,337,551	3,119,688
Broward County/ Ft. Lauderdale, Florida	1,560,298	1,505,529	3,065,827
Harris County/ Houston, Texas	3,285,014	2,517,997	5,803,011
Hudson County/ Jersey City, New Jersey	1,023,959	1,157,894	2,181,853
Los Angeles, California	4,350,088	5,437,999	9,788,087
Metro-Dade County/ Miami, Florida	3,337,103	2,585,962	5,923,065
Newark, New Jersey	2,774,243	2,589,320	5,363,563
New York, New York	15,173,601	20,721,087	35,894,689
Oakland/Alameda County, California	1,118,871	1,004,595	2,123,466
Philadelphia, Pennsylvania	2,002,139	1,568,896	3,571,035
San Diego, California	1,617,297	1,161,427	2,778,724
San Francisco, California	10,594,765	8,349,464	18,944,229
San Juan, Puerto Rico	1,738,192	1,841,790	3,579,982
Washington, D.C.	2,814,495	2,312,689	5,127,184
TOTALS	$ 59,713,000	$ 59,713,000	$ 119,426,000

THE WHITE HOUSE

WASHINGTON

December 23, 1993

MEMORANDUM TO CAROL RASCO

FROM: Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

SUBJECT: Ryan White Title IV - Budget Considerations

Please forgive the delay in responding to your request earlier this month concerning the letter you received from the National Pediatric HIV Resource Center requesting consideration for a $40 million increase in funding for Title IV of the Ryan White CARE Act.

The Resource Center receives 100 percent of its funding from Title IV. We clearly support increased resources in this area and I have voiced my support on many occasions for pediatric AIDS programs.

As you know, we are working closely with the FY 95 budget process. We are advocating for an overall 16 percent increase in Ryan White CARE Act funding. Currently, at the Departmental level at HHS, we are weighing in on our opinion of how funding should be increased to the different areas covered in the four titles.

Thank you.

15 South Ninth Street
Newark, New Jersey 07107
201-268-8251
800-362-0071
201-485-2752 FAX

NATIONAL PEDIATRIC
HIV
RESOURCE CENTER

900 Second Street, NE
Suite 211
Washington, DC 20002
202-289-5970
202-408-9520 FAX

FAX COVER SHEET

Washington Office

TO: Krishna Gebbie

FIRM: The White House

FAX NUMBER: 632-1096

FROM: David C. Harvey, Coordinator of Public Policy

TOTALNUMBEROFPAGES 2

DATE: 12-21-93 TIME: 630 pm

NOTES:

15 South Ninth Street
Newark, New Jersey 07107
201-268-8251
800-362-0071
201-485-2752 FAX

NATIONAL PEDIATRIC
HIV
RESOURCE CENTER

900 Second Street, NE
Suite 211
Washington, DC 20002
202-289-5970
202-408-9520 FAX

December 21, 1993

Kristine Gebbie, R.N., M.S.N.
National AIDS Policy Coordinator
Executive Office of the President
The White House
750 17th Street, NW
Suite 1060
Washington, DC 20503

Dear Kristine:

I appreciated hearing your encouraging news tonight about the President's FY 1995 budget request for the Ryan White CARE Act and particularly, Title IV.

Thank you for your efforts and hard work. I hope you have a restful and relaxing holiday - it is well earned.

Sincerely,

David C. Harvey
Coordinator for Public Policy

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

December 21, 1993

NOTE TO PATSY FLEMING
KRISTINE GEBBIE

Phil would like to go ahead with something like this. Can we discuss at our meeting on Tuesday?

Thanks.

Jo Ivey Boufford, M.D.
Principal Deputy Assistant Secretary
for Health

AIDS Action

1875 Connecticut Ave NW
Suite 700
Washington DC
20009
Fax 202 986 1345
Tel 202 986 1300

December 9, 1993

call Jeff Levy
discuss Tuesday w/ Patsy + Carolyn

Philip R. Lee, M.D.
Assistant Secretary for Health
716G Hubert Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

Dear Dr. Lee:

This is to follow up on our conversation last week at the IOM regarding an "external review" of Ryan White CARE Act programs (and related AIDS programs, e.g., ETCs, pediatric demonstration programs) at HRSA. Well in advance of reauthorization of the CARE Act in 1995, it is critical that we take a step back and systematically examine whether these programs have been working as the legislation intended and whether the design of the program is still appropriate to how the epidemic has evolved in the last five years. The success of the CDC's external review process -- though not simple and not inexpensive -- is a good model for asking fundamental questions and articulating major changes in the light of a changed epidemic. What was missing in the CDC's process (which consisted of five review panels looking at different CDC programs) was bringing those five reports together to make a coherent set of overarching recommendations to the CDC about HIV prevention.

I have attempted to outline both the substance of what is needed in an "external review" of HRSA HIV/AIDS-related programs and a possible process for undertaking it. It is certainly just a first cut -- but I hope it can start us down the road of accomplishing this important task.

THE KEY QUESTIONS:

What was the intent of the Ryan White CARE Act of 1990 and has implementation of programs authorized in Titles I, II, IIIB, and IV (including, now, the pediatric demonstration programs) been consistent with legislative intent?

There has been significant revisionism about what the original intent of the legislation was -- even by some who claim to have been present at the creation -- that makes a return to the intent important. Among the issues that would be addressed include:

- What is the intent language in the CARE Act and in the Conference Report?
- What types of services have been provided under each of the HRSA-related titles?

- What populations are being served?
- What process has been followed to design programs and allocate resources -- by HRSA, by the states, by the localities?
- How well have the CARE Act programs been administered (at the federal, state, and local levels)? What would be the criteria for a well-administered program?
- Have resources been equitably distributed among the titles (the difference in funding levels among programs, the difference in formulas among and within programs, etc.)?
- Have each of the programs successfully delivered the services intended? What are the criteria for successfully delivered services?
- What reforms are needed to bring these programs more in line with legislative intent?

How has the context of the HIV/AIDS epidemic changed in the last five years and what impact do changes in the epidemic and in the health care environment have on programs and services funded through the CARE Act?

This poses the question of whether structural changes are needed in Ryan White programs to reflect changes in the epidemic and changes in the health care system. Some examples of the issues here include:

- changes in the epidemiology of HIV/AIDS (increases in substance abusers and minority populations) and the geography (multiple communities with different populations and different care infrastructures)
- changes in the nature of care needed (have medical interventions changed? what impact, if any, does this have on the kinds of services needed?)
- changes in the capacity of the general health care system to absorb HIV services (vs. creating a separate HIV/AIDS infrastructure)
- the likelihood of a reformed health care system that alters access to and reimbursement for primary care services, prescription drugs, home care, drug treatment, etc.

What changes are needed in HRSA HIV/AIDS programs authorized by the CARE Act, and what changes can be addressed legislatively upon reauthorization in 1995 and administratively within HRSA?

This would address specific recommendations for legislative and administrative reform.

THE EXTERNAL REVIEW PROCESS:

The external review process would be a time consuming activity. If the CDC model is used as an example, those participating would have to commit to at least two or three days a month over a four- to six-month period.

A Core Review Committee of no more than 30 people would be established to define the external review process and make final recommendations to the Administrator of HRSA. It would include: members of the HRSA AIDS Advisory Council; grantees from Title I, II, IIIB, and IV programs (their national representatives, e.g., NASTAD, as well as actual grant

recipients); community representatives (those not receiving direct funding, including people living with HIV); academics (especially those who have done some evaluations); and care providers. Outside expertise could be brought in on an as-needed basis (e.g., epidemiologists) as consultants. HRSA and PHS staff could serve ex-officio. Committee members could chair/facilitate meetings, or outside consultants could be used.

This Core Committee would be divided up into subcommittees to evaluate specific Title I, II, IIIB, and IV programs as well as other HRSA HIV/AIDS programs (e.g., the Education and Training Centers).

The steps in this process might include:

1. The Core Committee would determine overarching questions to be addressed in the review process, the nature of the process, and specific outcome or process criteria to be used in reviewing programs.

2. Subcommittees -- led by Core Committee members but with additional members with appropriate expertise -- would review each of the programs (Titles I, II, IIIB, IV/pediatric demos; ETCs). This process would be based on program staff reviews, independent evaluations, interviews with participants in the programs (consumers, administrators, and providers), and selected site visits.

3. The Core Committee would integrate these subcommittee reports into a general HRSA HIV/AIDS program review.

4. The Core Committee would address questions about the changing context of the epidemic and the changing health care context.

5. The Core Committee, probably through a drafting subcommittee, would develop specific recommendations for legislative and administrative changes.

I hope you find these ideas useful as the PHS considers Ryan White reauthorization. I have had the great benefit of Pat Franks' thoughts and comments in preparing this, and I know both of us would be delighted to discuss this further with you or your staff at your convenience.

Sincerely,

Jeffrey Levi
Director of Public Policy and Program Development

cc: Patsy Fleming, Special Assistant to the Secretary

Andrew
Bob 9
A+

Standby
for
Cleared
Mail 10

FAX

DATE: FAX # (212) 264-1324

FROM : Barry R. Gordon
Regional AIDS Coordinator

NUMBER OF PAGES: S.I.C.

TO: KRISTINE GEBBIE
NAT'L AIDS POLICY COORDINATOR

REGARDING: FYI

NOTE: ANY PROBLEMS CALL (212) 264-2535

202 632 1094

Gordon

MEMO TO: Directors/Coordinators
Ryan White Title IV Pediatric & Adolescent HIV Providers

FROM: Dorothy Mann, Chair, Public Policy Committee

SUBJ: Letters of Support

DATE: October 21, 1993

Yesterday the public policy committee met by conference call and agreed on a letter writing campaign related to the President's FY 1995 budget request for Title IV of the Ryan White CARE Act. I am forwarding to you sample letters that you should adapt to reflect the needs of your particular program and send to the government officials listed.

I have also attached a sample letter for clients to adapt and write as well. We are trying to involve family members as much as possible in this letter writing campaign. In addition, Wendi Bell, M.D. and Mike Kaiser, M.D., will send a letter from the Pediatric & Adolescent HIV Policy Institute.

Please send a copy of your letter to David Harvey at the NPHRC Washington office: 900 Second Street, NE, Suite 211, Washington, DC, 20002.

This kind of effort is essential if we are to impact the budget request related to Title IV of the CARE Act in FY 1995. Thank you for your attention to this matter.

SAMPLE LETTERS

Donna E. Shalala, Ph.D.
Secretary
Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Kristine Gebbie, R.N.
National AIDS Policy Coordinator
The White House
750 17th Street, NW
Washington, DC 20503

Dear:

I am writing to thank you for supporting the FY 1994 consolidation of funding for the Pediatric/Family AIDS Demonstration Program within Title IV of the Ryan White CARE Act, and to urge a significant increase for Title IV in the President's budget request for FY 1995.

As you know, Congress recently completed the Labor/HHS appropriations conference. Despite the President's request of $21 million for the Pediatric/Family AIDS Demonstrations and $6 million for Title IV in FY 1994, the final appropriation was only $22 million. This represents a $1 million increase out of a total increase of $210 million for other Titles of the CARE Act. The pediatric, adolescent and family AIDS demonstrations that are now a part of Title IV have been essentially level funded for the past three years.

I am now writing to strongly urge that as the Department of Health & Human Services finishes its FY 1995 budget request and submits it to the Office of Management of Budget, that the funding request for Title IV of the Ryan White CARE Act be increased to $42 million. While consolidation of funding within Title IV will enhance the delivery of services and access to clinical trials for children, adolescents and families affected by HIV disease, it does not diminish the need for substantial new funding in FY 1995.

As you know, HIV infection rates among women, adolescents and children have rapidly increased. Some service sites have experienced a 50% increase in demand for services. Last year, following a thorough review of funding needs, the Pediatric AIDS Coalition and the National Organizations Responding to AIDS coalition in Washington, D.C. recommended at least a $42 million appropriation for Title IV programs over current funding levels of approximately $21 million. These funds are vitally needed for reaching underserved, low-income African-American and Hispanic women, adolescents, children and families who are disproportionately affected by HIV infection.

Title IV of the CARE Act has now become an important focus of providing funds to deliver specialized pediatric and adolescent HIV comprehensive services throughout the United States. If you or your staff need further information related to programs funded under Title IV,

please contact David Harvey, Coordinator for Public Policy at the National Pediatric HIV Resource Center (202-289-5970) in Washington, D.C.

Thank you for your consideration of this request.

Sincerely,

Carol H. Rasco
Assistant to the President for Domestic Policy
Executive Office of the President
The White House
Washington, DC 20500

Leon E. Pannetta
Director, Office of Management & Budget
The White House
Old Executive Office Building
17th & Pennsylvania Avenue, NW
Washington, DC 20503

Dear:

I am writing to thank the Administration for supporting the FY 1994 consolidation of funding for the Pediatric/Family AIDS Demonstration Program within Title IV of the Ryan White CARE Act, and to urge a significant increase for Title IV in the President's budget request for FY 1995.

As you know, Congress recently completed the Labor/HHS appropriations conference. Despite the President's request of $21 million for the Pediatric/Family AIDS Demonstrations and $6 million for Title IV in FY 1994, the final appropriation was only $22 million. This represents a $1 million increase out of a total increase of $210 million for other Titles of the CARE Act. The pediatric, adolescent and family AIDS demonstrations that are now a part of Title IV have been essentially level funded for the past three years.

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Thank you for your consideration of this request.

Sincerely,

SAMPLE CLIENT LETTER

Secretary Donna Shalala, Ph.D.

Dear:

I live in_____ and receive HIV services for myself and my child at _____. These services are extremely important in maintaining our health and treating illnesses that occur from HIV infection.

I understand that funding for HIV services that we receive locally comes from Title IV of the Ryan White CARE Act. Our clinic desperately needs these funds to support existing services and expand services so that it can reach more clients. Personally, I know how difficult it is to come forward for treatment and without my case manager and outreach worker, as well as other services that I receive at this clinic, I probably would not be receiving care at this time.

Please give more funds to Title IV of the CARE Act so that we can make sure more clients like me are reached. Thank you.

Sincerely,

conference on the Caribbean might as well have stayed home, said one participant, Sen. Kenneth E. Mapp.

The conference, which covers a broad range of economic, political and social issues, ends today.

At least a dozen representatives of the V.I. Senate, Industrial Development Commission and Port Authority are in Miami. The group includes Lt. Gov. Derek M. Hodge and Car-

people about the Virgin Islands. Nothing about tourism or our products. Our economy is not going to expand simply because we show up at conferences."

He found the lack of a pitch for the territory as a tourist destination particularly galling. "Tourism has been a topic of discussion all week," Mapp said. "Everyone is talking about the effect of opening Cuba as a tourist destination."

He said other Caribbean nations and territories were highly visible: For example, Puerto Rico had a reception and displays featuring Puerto Rican rum and investment possibilities on the island, and Gov. Pedro Rossello spoke to the convention.

A spokeswoman for the conference said more than 2,000 government and private-sector participants from the United States, the Caribbean and Central and South America are

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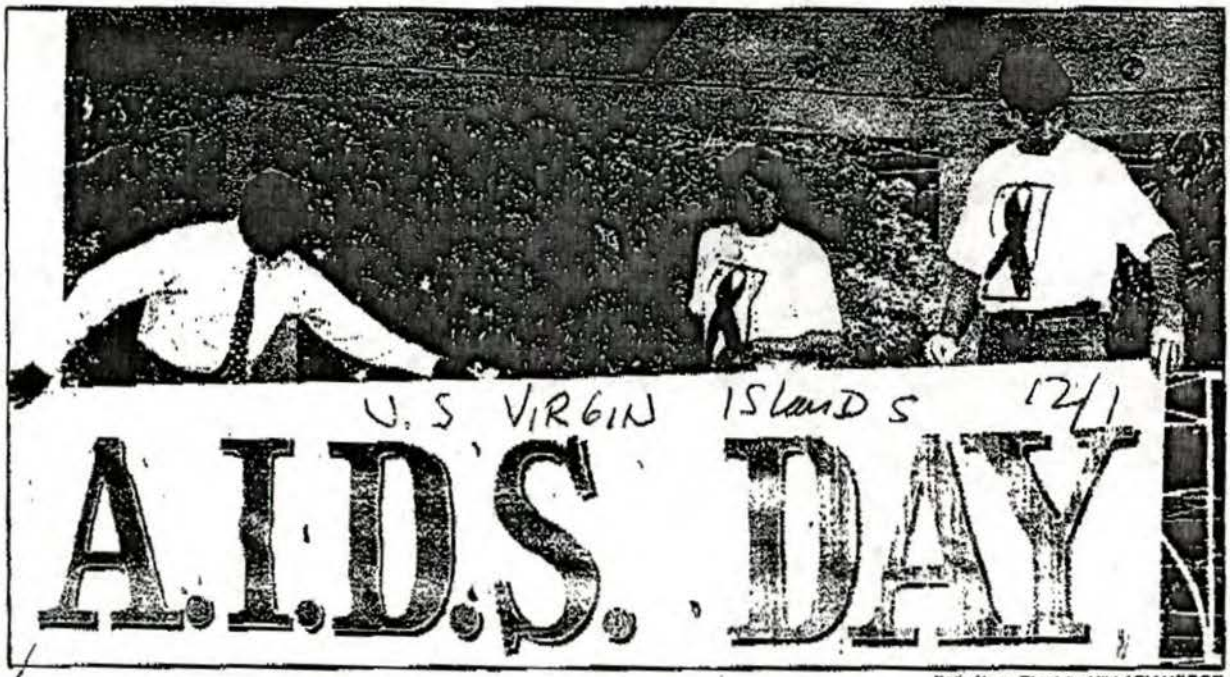

Daily News Photo by HILLARY HODGE

Rudel Chinnery, Annette Garcia and Tom Dunn put up a banner Wednesday in Emancipation Garden on St. Thomas before a World AIDS Day program, which drew only a few people.

12/2/93

Heath calls for universal AIDS testing

• Nation marks AIDS Day, page 11.

By KAY JOHNSON
Daily News Staff

Dr. Alfred O. Heath called Wednesday for universal testing to combat the spread of the HIV virus in the Virgin Islands.

Speaking at a St. Thomas rally on World AIDS Day, Heath urged residents to push the government to test everyone in the territory.

"It is expensive, but when it comes to life, expense does not matter," said Heath, acting chief executive for St. Thomas Hospital.

Other health professionals repeated the prevention advice they have been giving for the last eight years: abstain from sex, be faithful to one partner when you do have sexual relations and use a condom.

Pin-on buttons in the shape of the African continent were passed out during the Emancipation Garden program. The buttons admonish: "Respect yourself, protect yourself."

But despite the risk, many people don't seem to be listening, said Dr. Donna M. Green, acting health commissioner.

AIDS is primarily spread through sexual intercourse — both homosexual and heterosexual —and through sharing needles in intravenous drug use. Infected mothers also can pass the virus on to their unborn children.

Yet many in the territory continue high-risk behavior.

"It is obvious that it is time for us to stop just talking . . . and to start acting on what we know," Green said. "Once you have contracted the virus, there is no turning back."

Universal testing would at least alert people who are infected with the HIV virus, which causes the deadly immune system disorder. No cure is known for acquired immune deficiency syndrome.

The Health Department estimates that about 8,000 people in the territory are HIV-positive and do not know it, Green said. These people can unknowingly transmit the virus.

Rallies territorywide drew small audiences Wednesday.

St. Thomas' event was at Emancipation Garden in the afternoon. The territory's AIDS quilt — which has a square for each Virgin Islander who has died of the disease — was on display.

On St. Croix, about 50 people marched from the Frederiksted post office to Buddhoe Park, where they listened to Green and others.

A candlelight march was staged in Cruz Bay, St. John, at sunset.

Prevention is key

No cure for AIDS is known. That means once you contract it, it is too late. You will likely die. Here are some tips to protect yourself:

- ✓ **Abstain from sex:** AIDS is most commonly contracted by having sex with an infected person. If you are single, abstain if you can. It's the only sure prevention.
- ✓ **Have only one sexual partner:** The more people you sleep with, the higher your chances of being infected.
- ✓ **Use condoms:** If you can't or won't abstain or be monogamous, use a condom. AIDS is passed through body fluids. Using a condom is not 100 percent protection, but it is better than unprotected sex.
- ✓ **Educate yourself:** Birth control pills do not prevent AIDS. You can't tell just by looking at someone whether they are infected.
- ✓ **Get tested:** The Health Department offers free testing.

FOR MORE INFORMATION
Call the Health Department at 776-6311 on St. Thomas, 778-6311 on St. Croix or 776-6400 on St. John.

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By HAL HATF
Daily News S

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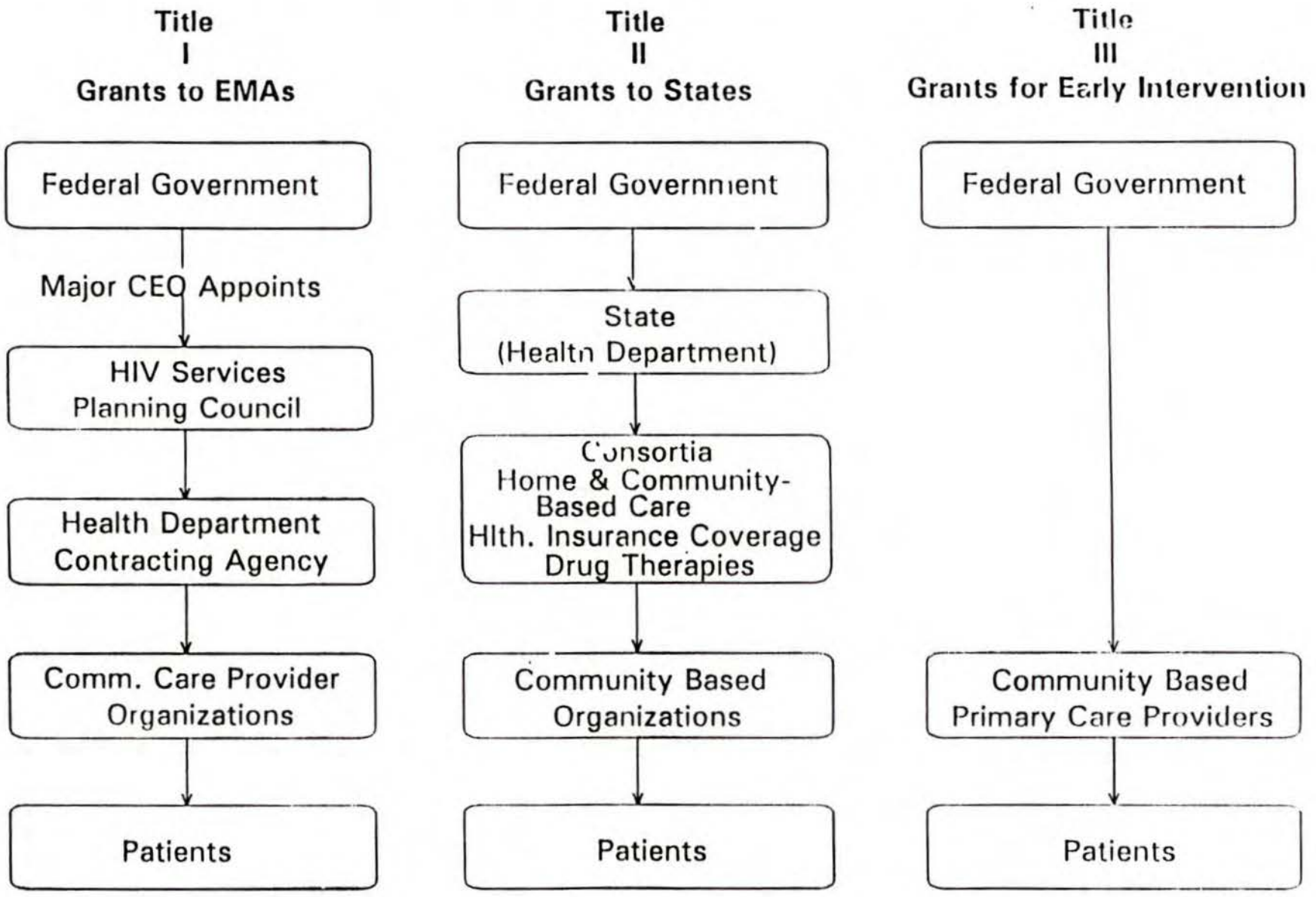
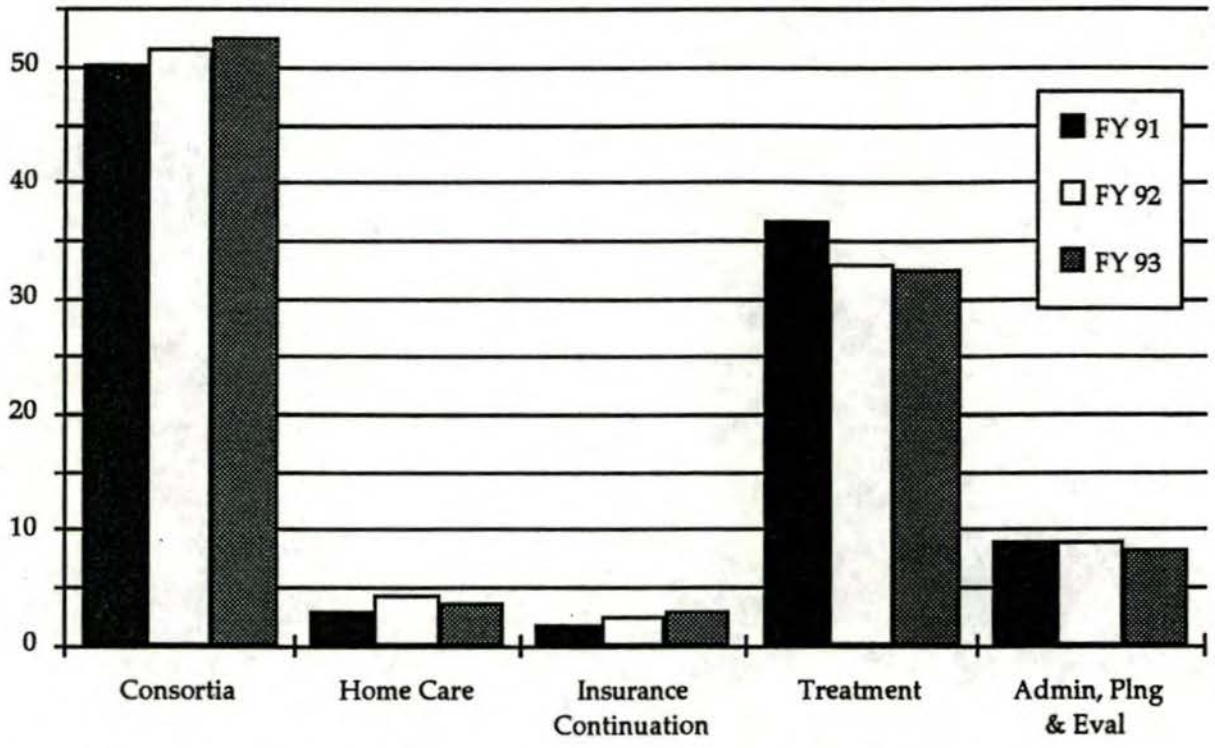
RYAN WHITE C.A.R.E. ACT - Flow of Funds



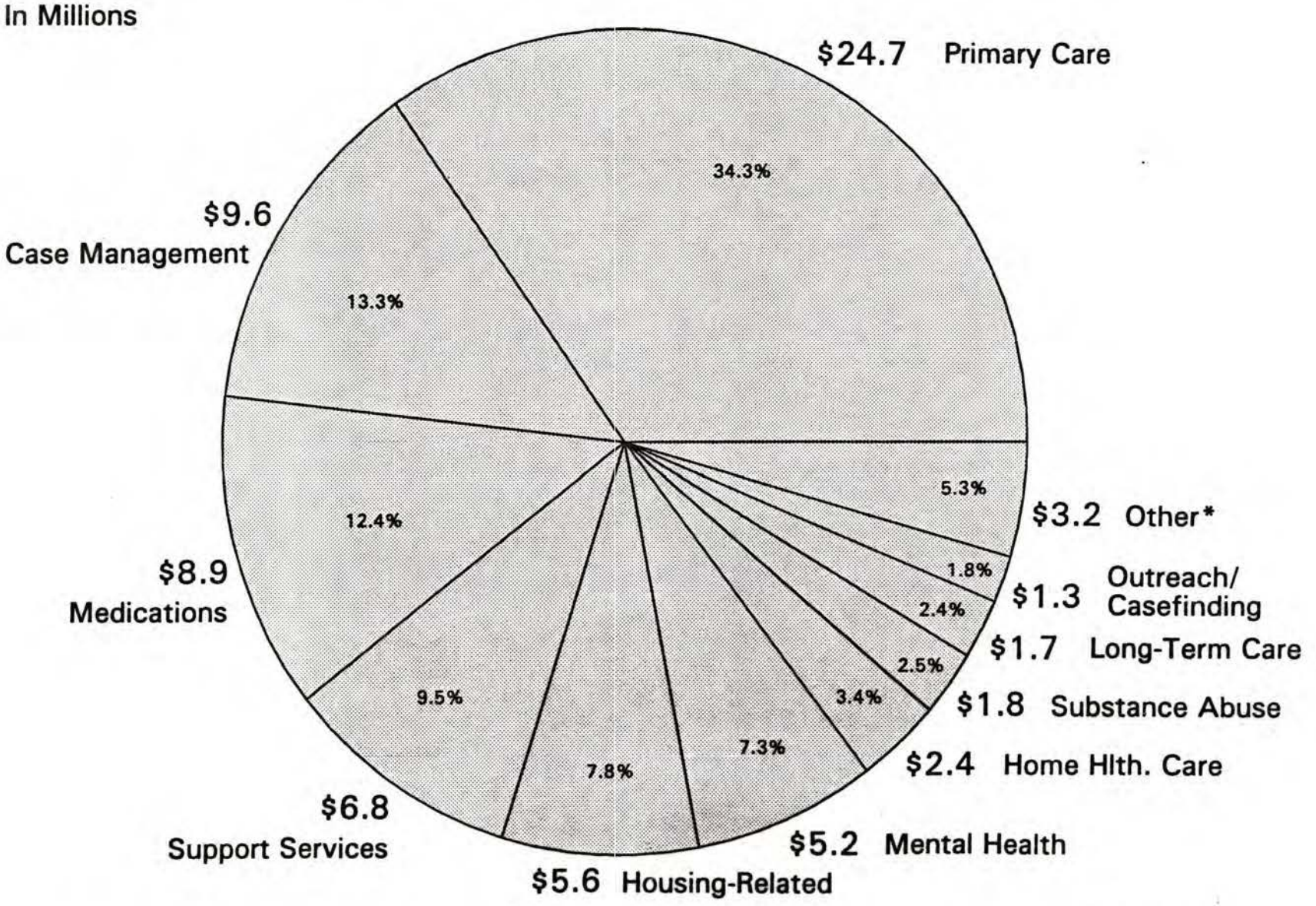
Ryan white care Act

Figure 1.2. Percentage of Total Title II Allocations Going to the Four Program Areas and Administration in All States, FY 1991 to FY 1993



Data sources: Grants Management Branch, BHRD/HRSA and McKinney *et al.*, 1993.

Service Priorities: Title I Funds



* Includes: evaluation, systems development, interpreter service, alternative therapies, public hearings, regional planning, respite, pediatric daycare, technical assistance, planning council support, HRSA Demonstration Project