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Ryan White HIV/AIDS Dental Reimbursement Program: Basic Overview

(updated by the American Association of Dental Schools as of May 1999)

Purpose: The purpose of the Ryan White HIV/AIDS Dental Reimbursement program is to **partially** offset[1] the rising, unreimbursed costs faced by dental education institutions in providing care to people living with HIV/AIDS. It is intended as a "safety net" program that is a federal-institutional partnership in improving access to needed oral health care and at the same time ensuring the training of future providers (dental students and residents) to effectively deliver such care.

Rationale: As a group, HIV/AIDS patients suffer a high incidence of oral disease. Many of the first physical manifestations of HIV infection are found in the oral cavity; therefore, a dentist is often the first diagnostician to see the patient. Studies have shown that physicians usually fail to detect such oral manifestations.[2] As a result of the immune system breakdown that occurs, HIV/AIDS patients are more susceptible to oral diseases such as oral lesions that cause significant pain and oral infection leading to fevers, weight loss, and difficulty in eating, speaking or taking medication. Extreme pain in the mouth is frequently the symptom that motivates patients to seek care, and also compromises their nutritional intake that is so important in maintaining the immune system. The development of some oral problems may signify that HIV infection is progressing. Oral health care has continued to be a major need of HIV/AIDS patients and consistently ranks high in surveys of health needs of HIV/AIDS patients.

Receiving prompt diagnosis and appropriate treatment for these oral diseases is often difficult for uninsured, low-income individuals because dental services are seldom covered by Medicaid for adults. Dental benefits are seldom included in a basic health insurance plan in the public or private sector. This lack of sufficient reimbursement is particularly profound for those dental education clinics providing care for a significant number of HIV/AIDS patients. Dental education institutions that become known as referral centers for HIV/AIDS patients also risk serious

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[1] For example, in FY 1997 over $15 million in unreimbursed costs were claimed under this program; the total amount available was $7.3 million ($7.5 million was appropriated, but HRSA "taps" 2% of all Ryan White programs for evaluation and technical assistance).

[2] *Journal of the American Medical Association* 274 (17), pp. 1380 to 1382, described AHCPR-supported research concluding that primary care physicians often fail to recognize important signs of HIV infection:

> "Less than 23 percent of physicians evaluating a patient with oral hairy leukoplakia (OHL) with sore throat and white spots on the tongue, detected the spots and correctly diagnosed the OHL, which is strongly associated with HIV infection."

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fiscal problems. This program represents a partnership between the federal government and dental education programs, in which the government partially offsets the costs dental education institutions incur in treating HIV/AIDS patients. While funds provided for this program fall far short of meeting the actual unreimbursed costs of these dental education institutions, the federal contribution to dental programs recognizes the significant expenditures incurred from serving a disproportionate share of people living with HIV/AIDS. The fund facilitates treatment of patients by alleviating some of the financial burden faced by these treatment centers, allowing them to continue to deliver and expand care for people living with HIV/AIDS while simultaneously broadening the training experience and sensitivity of future dental practitioners.

The program encourages the provision of oral health care to people throughout the nation and provides extensive training for dental students and residents in the management of the oral health care of those suffering from HIV/AIDS.

Eligibility: The applicant must be a public or private non-profit school of dentistry or a post-graduate dental training program which has been accredited by the Commission on Dental Accreditation and which has documented uncompensated costs of oral health care for HIV-infected persons.

Administration: While the program was authorized under the Health Professions Training Act prior to the Ryan White CARE Act Reauthorization of 1996, it was administered by the Bureau of Health Professions, Division of Associated, Dental and Public Health Professions, Dental Education and Special Initiatives Branch. When the Ryan White CARE Act programs were reauthorized in 1996, the statutory authorization for the AIDS Dental program was transferred from Title VII to Title XXVI of the Public Health Service Act, HIV Health Care Services Program Title XXVI [Title XXVI § 2692; 42 USC § 300ff-111]. Subsequent to the 1996 reauthorization, HRSA restructured the administration of Ryan White programs, and transferred the dental program to the newly restructured HIV/AIDS Bureau, which administers all of the Ryan White CARE Act programs. This dental program is currently administered under the Division of Community-Based Programs, under the coordination of Ms. Gloria Weissman, Chief, Program Development (301-443-3478; gweissman@hrsa.gov).

Formula: Each dental school/program may annually submit a proposal documenting unreimbursed costs of oral health care provided to patients with HIV infection during the prior year (July–June fiscal year). Applications are usually due on or around May 15, with funds disbursed in August or September. The Secretary distributes the funds among all eligible applicants, taking into account the number of patients with HIV infection served and the unreimbursed oral health care costs incurred by each institution as compared to the total number of HIV patients and costs by all eligible applicants. These are NOT costs for personnel, equipment, or other administrative expenses. Unreimbursed cost means the

balance remaining after subtracting the total income received from patients with HIV served and/or third party payers or Medicaid, from the total of normal fees charged by the institution. This is specifically targeted to actual uncompensated oral health services provided.

In the first seven years of the program, 80 percent of the formula was weighted to an institution's unreimbursed costs compared to the total unreimbursed costs for all applicants, and 20 percent was weighted to the institution's number of HIV-infected patients served compared to the total number of HIV patients served by all applicants. This "weighting" factor was removed beginning in FY 1998. If there are no documented unreimbursed costs, no reimbursement will be awarded. The review of costs may be performed by a review of all patient charts for the year in question, or a statistical sample of patient charts (however, HRSA has indicated its plans to phase out the sampling option beginning in FY 2000).

HIV/AIDS patient means a person who is infected with the human immunodeficiency virus—those patients who self identify as being HIV-infected or who present with signs, symptoms, or medical historical data identified with HIV infection, e.g., candidaisas (oral, esophageal, pulmonary, etc.), progressive generalized lymphdenopathy, oral hairy leukoplakia, Pneumocystis carinii pneumonia (PCP), recurrent pneumonia, Kaposi's sarcoma (oral and/or disseminated), pulmonary tuberculosis, invasive cervical cancer and/or other HIV associated fungal, viral, bacterial, and/or neoplastic processes as delineated by the CDC in the 1993 revised classification system for HIV infection.

FY 2000 Appropriations Request: AADS is advocating that $9 million be provided for this important program in FY 2000, which is $1 million above the Administration's budget request. This recommendation is also endorsed by the National Organizations Responding to AIDS (NORA) Coalition.

Evaluation: HRSA issued a contract in 1995 to Woodhull Medical and Mental Health Center in Brooklyn, New York, to conduct an evaluation of the program. There was an advisory panel to assist in the development of the survey instrument and review the report findings, which consisted of dental educators involved in HIV patient care and non-dental experts from the AIDS care community. A preliminary survey of participants performed by Woodhull found this program had a positive impact in the following areas: integrating oral health care with other services, increasing the support and commitment among providers to HIV/AIDS education and provision of care, increasing the providers' knowledge about infection control and treatment, and increasing patient access to oral health care. A summary of findings from the final report was presented by Woodhull at the AADS Annual Session on March 9, 1999, with the conclusion that this program has had a successful impact. The final report will be presented to HRSA this summer.

HRSA also initiated a 1997 review of the program methodology, which had already been reviewed twice in the history of the program. UCLA School of Dentistry was awarded this contract, and provided a 1998 report to HRSA on the methodology based on program experiences to date, the unique nature of the program, and options to promote greater consistency in data collection where possible with other Ryan White programs. Some of the recommendations from this report have already been implemented, and others are under consideration by HRSA for future application cycles.

Collaborations: Many programs have active collaborations with other Ryan White grantees. An innovative community clinic activity in Orlando, Florida, between the University of Florida School of Dentistry and Title I was recently highlighted at the AADS Annual Meeting in Orlando in March 1997. A description of Temple University's representation on the Philadelphia EMA HIV Commission and other community collaborations was provided at the AADS Advanced Advocacy Workshop on the Ryan White dental program at the AADS Annual Meeting in Vancouver in March 1999.

It appears that the Statewide Coordinated Statement of Need (SCSN) meetings have fostered better planning and communications between the dental program and other Ryan White programs. The Ryan White HIV/AIDS Dental Reimbursement application asks for a description of efforts to establish working relations with HIV planning councils, care consortia, and other Ryan White programs (including AIDS Education and Training Centers and Title IIIb programs).

An example of an individual impact of the dental program was provided in AADS testimony presented on December 4, 1998, to the HRSA AIDS Advisory Committee by Dr. Ivan Lugo of Temple University. Dr. Lugo's experience in general dentistry residency training, augmented by dental reimbursement funds for patient care, was critical in his decision to continue to improve access and provide care to people with HIV. His efforts have led to a great deal of collaboration between the dental school and community-based AIDS organizations, as Dr. Lugo is the dental director for the City of Philadelphia's Department of Public Health and a member of the Community Planning Group of the Philadelphia EMA HIV Commission.

Legislative History: In 1988 Congress first authorized the Dental AIDS Program under section 788 B (f) of the Health Professions Training Act (Title VII of the Public Health Service Act), which was part of the Omnibus Health Act of 1988 (Public Law 100–607). Congress did not appropriate funds for this program, however, until Fiscal Year 1991.

In 1990, Congress approved the Fiscal Year 1991 Labor–HHS–ED Appropriations legislation which contained $2.928 million to compensate dental education programs for the costs incurred in providing oral health services to AIDS patients.

The funding was a set-aside under Title II of the Ryan White CARE Act for Special Projects of National Significance (SPNS). The conference report accompanying the appropriations legislation directed that the administration of the new program was to be as it was authorized in section 788 B (f) of the Public Health Service Act.

Congress continued to appropriate funds for the program under the Ryan White CARE Act Title II Special Projects of National Significance until passage of the Fiscal Year 1994 Labor–HHS–ED Appropriations bill which, for the first time, funded the program as a separate line item.

As mentioned previously in this report, the authority for this program was transferred from Title VII of the Public Health Service Act (Health Professions Training) to Title XXVI of the Public Health Service Act (HIV Health Care Services Program) as part of the Ryan White CARE Act Amendments of 1996 (Public Law 104–146). Passage of Public Law 104–146 reauthorized the Ryan White CARE Act through Fiscal Year 2000, when Congress will be required to pass another reauthorization bill. The Dental AIDS Program, referred to as the Ryan White HIV/AIDS Dental Reimbursement Program with the passage of the 1996 law, has received separate line-item funding under the Ryan White CARE Act in the Labor–HHS–ED Appropriations legislation since FY 1996.

Statutory Language:

Ryan White Care Act Part F

Title XXVI § 2692; 42 USC § 300ff-111

(b) DENTAL SCHOOLS—

(1) IN GENERAL—The Secretary may make grants to assist dental schools and programs described in section 777(b)(4)(B) [42 USC §294o(b) (4) (B)] with respect to oral health care to patients with HIV disease.

(2) APPLICATION—Each dental school or program described in section 777 (b) (4)(B) [42 USC §294o(b)(4)(B)] may annually submit an application documenting the unreimbursed costs of oral health care provided to patients with HIV disease by that school or hospital during the prior year.

(3) DISTRIBUTION—The Secretary shall distribute the available funds among all eligible applicants, taking into account the number of patients with HIV disease served and the unreimbursed oral health care costs incurred by each institution as compared with the total number of patients served and costs incurred by all eligible applicants.

(4) MAINTENANCE OF EFFORT—The Secretary shall not make a grant under this subsection if doing so would result in any reduction in State funding allotted for such purposes.

DEFINITION (for purposes of this subchapter—XXVI–HIV Health Care Services Program) at § 2676 [42 USC § 300ff-76]

(8) The term "HIV" means infection with the etiologic agent for acquired immune deficiency syndrome.

(9) The term "HIV disease" means infection with the etiologic agent for acquired immune deficiency syndrome, and includes any condition arising from such syndrome.

AUTHORIZATION OF APPROPRIATIONS

(2) DENTAL SCHOOLS—For the purpose of grants under subsection (b) of this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 1996 through 2000.

[Prior to the 1996 reauthorization, the AIDS Dental program was authorized at $7 million for each of the fiscal years 1993 through 1995]

Section 777 (b)(4)(B)

DEFINITIONS

The term "post doctoral dental education program" means a program sponsored by school of dentistry, a hospital, or a public or private institution that

(i) offers post-doctoral training in the specialties of dentistry, advanced education in general dentistry, or a dental general practice residency; and

(ii) has been accredited by the Commission on Dental Accreditation.

Annual Appropriation Levels: Congress first appropriated funds for the AIDS Dental Program in 1991. The funding history of the program is as follows:

1991—$2.928 million
1992—$5.000 million
1993—$5.200 million
1994—$7.000 million
1995—$6.937 million
1996—$6.937 million
1997—$7.500 million
1998—$7.800 million
1999—$7.800 million

8 year total: $57.102 million

Attachments: Listing of awards by state, total awards, FY 1991 through FY 1998; State by State charts of grantees and awards received to date, FY 1991 through FY 1998

Ryan White HIV/AIDS Dental Reimbursement Program Awards by State and Number of Institutions 1991–1998

State	Award	Number of Institutions
1. New York	$18,311,392	43
2. California	$9,792,272	7
3. Massachusetts	$3,408,195	6
4. Connecticut	$2,190,247	4
5. New Jersey	$2,042,464	3
6. Illinois	$1,402,261	4
7. Florida	$1,401,107	3
8. Pennsylvania	$1,101,541	9
9. Washington	$1,077,845	2
10. Maryland	$949,680	2
11. Texas	$815,814	5
12. Kentucky	$776,749	2
13. Michigan	$739,961	4
14. District of Columbia	$651,487	3
15. Louisiana	$416,344	1
16. Ohio	$347,056	7
17. Oregon	$285,708	1
18. North Carolina	$269,511	2
19. Minnesota	$255,436	2
20. Tennessee	$234,545	1
21. Virginia	$199,820	2
22. Missouri	$195,725	2
23. Georgia	$183,917	2
24. Colorado	$150,376	3
25. Alabama	$124,271	1
26. Puerto Rico	$101,950	1
27. Mississippi	$98,607	1
28. Nebraska	$50,317	1
29. Oklahoma	$35,283	1
30. Hawaii	$31,941	1
31. Utah	$14,151	1
32. South Carolina	$11,249	1
33. Iowa	$1,937	2
34. West Virginia	$1,614	1
TOTAL	$47,670,773	131

Ryan White HIV/AIDS Dental Reimbursement Program
Grantee Awards by State 1991–1998

ALABAMA

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
University of Alabama Sch. of Dentistry	N/A	$20,086	$13,870	$14,834	$10,169	$14,442	$27,101	$23,769	$124,271
TOTAL FOR STATE	N/A	$20,086	$13,870	$14,834	$10,169	$14,442	$27,101	$23,769	$124,271
# of Grantees	0	1	1	1	1	1	1	1	1

CALIFORNIA

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
Loma Linda University School of Dentistry	$106,158	$32,288	$9,803	$7,211	$5,489	$8,654	$3,278	$893	$173,774
UCLA School of Dentistry	$135,619	$164,231	$220,023	$301,373	$212,747	$191,959	$76,216	$102,709	$1,404,877
USC School of Dentistry	$184,228	$195,407	$161,487	$214,149	$198,602	$257,186	$286,446	$330,552	$1,828,057
Highland General Hospital	$200,674	$343,002	$214,671	$273,480	$230,083	$199,417	$200,153	$154,964	$1,816,444
University of the Pacific School of Dentistry	$67,755	$69,317	$116,391	$188,218	$260,699	$49,978	$70,314	$69,908	$892,580
UCSF School of Dentistry	$404,747	$636,691	$536,876	$631,853	$477,844	$255,830	$213,025	$154,087	$3,310,953
King Drew Medical Center	N/A	N/A	N/A	N/A	N/A	$85,187	$114,817	$160,583	$360,587
TOTAL FOR STATE	$1,099,181	$1,440,936	$1,259,251	$1,616,284	$1,385,464	$1,048,211	$964,249	$978,696	$9,792,272
# of Grantees	6	6	6	6	6	7	7	7	7

COLORADO

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
University of Colorado School of Dentistry	$14,686	$26,410	$16,535	$14,918	$12,366	$15,038	$12,115	$4,937	$117,005
Denver Health and Hospital	N/A	N/A	N/A	N/A	$14,886	N/A	N/A	N/A	$14,886
Children's Hospital	N/A	N/A	N/A	N/A	N/A	N/A	$7,994	$10,492	$18,486
TOTAL FOR STATE	$14,686	$26,410	$16,535	$14,918	$27,252	$15,038	$20,109	$15,428	$150,376
# of Grantees	1	1	1	1	2	1	2	2	3

CONNECTICUT

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
Univ. of Conn. School of Dental Medicine	$26,484	$121,667	$83,105	$76,516	$112,548	$88,422	$138,888	$107,906	$755,536
St. Francis Med Center	$43,089	$88,005	$79,718	$59,902	$47,097	$46,694	$40,829	$33,656	$438,990
Yale New Haven Hospital	$131,762	$130,476	$107,624	$115,420	$96,312	$114,084	$132,467	$159,889	$988,034
Mount Sinai Hospital	$2,480	$2,707	$2,500	N/A	N/A	N/A	N/A	N/A	$7,687
TOTAL FOR STATE	$203,815	$342,855	$272,947	$251,838	$255,957	$249,200	$312,184	$301,451	$2,190,247
# of Grantees	4	4	4	3	3	3	3	3	4

DISTRICT OF COLUMBIA

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
Children's National Medical Ctr	$5,858	$7,139	N/A	N/A	$17,960	$36,058	$54,062	$65,980	$187,057
Howard University College of Dentistry	N/A	$45,679	$22,965	$13,321	$25,338	$37,326	$42,540	$36,571	$223,740
Washington Hospital Center	N/A	N/A	N/A	N/A	N/A	$34,539	$90,691	$115,459	$240,689
TOTAL FOR STATE	$5,858	$52,818	$22,965	$13,321	$43,298	$107,923	$187,293	$218,011	$651,487
# of Grantees	1	2	1	1	2	3	3	3	3

Ryan White HIV/AIDS Dental Reimbursement Program
Grantee Awards by State 1991–1998

FLORIDA

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
University of Florida College of Dentistry	$11,123	$19,895	$12,990	$14,718	$16,265	$20,497	$41,499	$47,287	$184,274
Jackson Memorial/Univ. of Miami	$73,617	$161,739	$124,169	$137,638	$88,204	$98,255	$164,438	$251,882	$1,099,942
Dade County Dental Center	N/A	$25,353	$25,392	$27,767	$19,845	N/A	N/A	$16,543	$114,900
TOTAL FOR STATE	$86,731	$206,987	$162,551	$180,123	$124,314	$118,752	$205,937	$315,712	$1,401,107
# of Grantees	2	3	3	3	3	2	2	3	3

GEORGIA

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
Emory University Clinic	N/A	N/A	$14,555	$28,709	$23,073	$27,993	$37,220	N/A	$131,550
Medical College of Georgia Sch.of Dentistry	N/A	N/A	N/A	$2,448	$1,861	N/A	N/A	$48,058	$52,367
TOTAL FOR STATE	N/A	N/A	$14,555	$31,157	$24,934	$27,993	$37,220	$48,058	$183,917
# of Grantees	0	0	1	2	2	1	1	1	2

HAWAII

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
Queens Medical Center	N/A	$9,191	$6,651	$5,171	$5,245	$5,683	N/A	N/A	$31,941
TOTAL FOR STATE	N/A	$9,191	$6,651	$5,171	$5,245	$5,683	N/A	N/A	$31,941
# of Grantees	0	1	1	1	1	1	0	0	1

IOWA

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
University of Iowa Hospital	N/A	N/A	N/A	N/A	N/A	N/A	$1,749	N/A	$1,749
University of Iowa, School of Denistry	N/A	N/A	N/A	N/A	N/A	N/A	$171	$17	$188
TOTAL FOR STATE	N/A	N/A	N/A	N/A	N/A	N/A	$1,920	$17	$1,937
# of Grantees	0	0	0	0	0	0	2	1	2

ILLINOIS

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
University of Chicago	$4,612	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$4,612
Northwestern University Dental School	N/A	$90,054	$194,144	$165,878	$102,172	$209,971	$150,576	$247,613	$1,160,408
Univ. of Illinois at Chicago Coll. of Dentistry	N/A	$19,583	$5,762	$9,010	$14,485	$51,374	$56,668	$73,056	$229,938
Children's Memorial Hospital	N/A	N/A	N/A	N/A	N/A	$7,302	N/A	N/A	$7,302
TOTAL FOR STATE	$4,612	$109,637	$199,906	$174,888	$116,657	$268,647	$207,244	$320,670	$1,402,261
# of Grantees	1	2	2	2	2	3	2	2	4

Ryan White HIV/AIDS Dental Reimbursement Program
Grantee Awards by State 1991–1998

KENTUCKY

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
Unversity of Louisville School of Dentistry	$18,604	$67,363	$68,840	$56,739	$45,634	$49,727	$61,400	$46,620	$414,927
University of Kentucky College of Dentistry	N/A	$47,139	$54,550	$69,057	$84,840	$49,568	$47,596	$9,072	$361,822
TOTAL FOR STATE	$18,604	$114,502	$123,390	$125,796	$130,474	$99,295	$108,996	$55,692	$776,749
# of Grantees	1	2	2	2	2	2	2	2	2

LOUISIANA

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
Louisiana State University Sch. of Dentistry	N/A	N/A	N/A	$16,882	$57,880	$106,200	$110,217	$125,165	$416,344
TOTAL FOR STATE	N/A	N/A	N/A	$16,882	$57,880	$106,200	$110,217	$125,165	$416,344
# of Grantees	0	0	0	1	1	1	1	1	1

MASSACHUSETTS

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
Harvard School of Dental Medicine	$14,660	$36,729	$43,471	$48,608	$47,667	$24,300	$24,306	$20,881	$260,622
Boston U. Goldman Sch. of Dental Medicine	$22,169	$183,582	$146,094	$273,420	$247,022	$283,489	$340,025	$351,143	$1,846,944
Tufts University School of Dental Medicine	N/A	$84,077	$68,111	$77,526	$80,417	$104,849	$159,647	$225,782	$800,409
Boston City Hospital	N/A	$6,943	$1,899	$67,330	$47,467	$50,222	N/A	N/A	$173,861
Beth Israel Hospital	N/A	N/A	N/A	$12,744	$11,019	$12,889	N/A	$3,460	$40,112
Boston Medical Center	N/A	N/A	N/A	N/A	N/A	N/A	$160,481	$125,767	$286,248
TOTAL FOR STATE	$36,829	$311,331	$259,575	$479,628	$433,592	$475,749	$684,459	$727,032	$3,408,195
# of Grantees	2	4	4	5	5	5	4	5	6

MARYLAND

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
University of Maryland Dental School	$7,446	$61,468	$91,045	$156,120	$155,030	$127,114	$183,968	$33,678	$815,869
John Hopkins University	N/A	N/A	N/A	$15,047	N/A	$17,827	$45,480	$55,457	$133,811
TOTAL FOR STATE	$7,446	$61,468	$91,045	$171,167	$155,030	$144,941	$229,448	$89,135	$949,680
# of Grantees	1	1	1	2	1	2	2	2	2

MICHIGAN

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
University of Michigan School of Dentistry	N/A	N/A	$201,136	$163,663	$74,495	$57,226	$41,324	$52,593	$590,437
University of Detroit Mercy Sch. of Dentistry	$9,966	$7,450	$8,082	N/A	$5,495	$24,039	$11,706	$56,791	$123,529
Ann Arbor Veterans Adm	N/A	N/A	N/A	N/A	N/A	N/A	$6,982	$10,250	$17,232
Sinai Hospital	N/A	$4,146	$1,338	$3,278	N/A	N/A	N/A	N/A	$8,762
TOTAL FOR STATE	$9,966	$11,596	$210,556	$166,941	$79,990	$81,265	$60,012	$119,635	$739,961
# of Grantees	1	2	3	2	2	2	3	3	4

Ryan White HIV/AIDS Dental Reimbursement Program
Grantee Awards by State 1991–1998

MINNESOTA

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
University of Minnesota School of Dentistry	N/A	$23,490	$46,061	$34,349	N/A	$38,220	$38,220	$36,903	$217,243
Hennepin County	N/A	N/A	N/A	N/A	N/A	N/A	$13,958	$24,235	$38,193
TOTAL FOR STATE	N/A	$23,490	$46,061	$34,349	N/A	$38,220	$52,178	$61,138	$255,436
# of Grantees		1	1	1	1	1	2	2	2

MISSOURI

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
UM Kansas City School of Dentistry	$54,220	$31,175	$18,985	$17,385	$22,115	$16,997	$19,143	$7,878	$187,898
Truman Medical Center East	N/A	N/A	N/A	N/A	N/A	$1,144	$3,540	$3,143	$7,827
TOTAL FOR STATE	$54,220	$31,175	$18,985	$17,385	$22,115	$18,141	$22,683	$11,021	$195,725
# of Grantees	1	1	1	1	1	2	2	2	2

MISSISSIPPI

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
University of Mississippi School of Dentistry	N/A	$2,560	$3,662	$12,377	$33,600	$20,945	$15,320	$10,143	$98,607
TOTAL FOR STATE	N/A	$2,560	$3,662	$12,377	$33,600	$20,945	$15,320	$10,143	$98,607
# of Grantees		1	1	1	1	1	1	1	1

NORTH CAROLINA

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
University of North Carolina Sch. of Dentistry	$12,140	$26,361	$29,586	$27,202	$32,159	$33,357	$27,046	$42,371	$230,222
Bowman-Gray School of Medicine	$1,963	$3,273	$6,943	$9,080	$5,111	$4,750	$4,591	$3,578	$39,289
TOTAL FOR STATE	$14,103	$29,634	$36,529	$36,282	$37,270	$38,107	$31,637	$45,949	$269,511
# of Grantees	2	2	2	2	2	2	2	2	2

NEBRASKA

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
University of Nebraska College of Dentistry	$4,174	$8,780	$4,514	$9,155	$6,396	$6,459	$5,775	$5,064	$50,317
TOTAL FOR STATE	$4,174	$8,780	$4,514	$9,155	$6,396	$6,459	$5,775	$5,064	$50,317
# of Grantees	1	1	1	1	1	1	1	1	1

NEW JERSEY

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
UMDNJ New Jersey Dental School	$151,804	$130,825	$80,584	$97,484	$199,931	$203,086	$130,472	$248,728	$1,242,914
St. Joseph's Hospital	$128,419	$40,788	$68,977	$90,221	$105,110	$100,451	$122,293	$60,368	$716,627
Hackensack Medical Center	N/A	N/A	N/A	$30,579	N/A	$11,189	$18,006	$23,149	$82,923
TOTAL FOR STATE	$280,223	$171,613	$149,561	$218,284	$305,041	$314,726	$270,771	$332,245	$2,042,464
# of Grantees	2	2	2	3	2	3	3	3	3

Ryan White HIV/AIDS Dental Reimbursement Program
Grantee Awards by State 1991–1998

NEW YORK

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
Columbia University School of Dentistry	$67,018	$73,716	$46,866	$51,191	$41,116	$58,791	$100,253	$72,019	$510,970
St. Barnabas Hospital	$52,590	$105,465	$72,461	$132,752	$163,761	$198,899	$261,915	$126,386	$1,114,229
Lutheran Medical Center	$36,156	$84,656	$98,887	$184,334	$170,700	$232,658	$249,044	$254,647	$1,311,082
Erie County Medical Ctr	$14,895	$29,204	$22,682	$27,329	N/A	$16,951	$71,878	$68,459	$251,398
Buffalo General Hospital	$4,873	$3,846	$3,710	$5,211	N/A	$9,504	$10,612	$3,932	$41,688
New York Hospital Medical Center, Queens	$176,881	$54,555	$45,722	$47,778	$36,566	$47,362	$64,671	$59,759	$533,294
St. Lukes/Roosevelt Hospital Center	$51,121	$74,306	$54,847	$61,710	$50,048	$34,849	$38,194	$65,443	$430,518
Beth Israel Medical Center	$62,585	$70,835	$97,082	$117,171	$76,132	$63,451	N/A	N/A	$487,256
New York University College of Dentistry	$158,208	$300,741	$153,297	$186,946	$126,743	$91,173	$85,700	$132,349	$1,235,157
Dept. of Veterans Affairs Medical Ctr, NY	$1,106	$6,378	$5,405	N/A	N/A	N/A	N/A	N/A	$12,889
Jacobi Hospital Center	$181,464	$171,925	$113,778	$80,107	$68,384	$62,864	$75,903	N/A	$754,425
Bronx-Lebanon Hospital Center	N/A	$140,644	$125,167	$164,785	$72,979	$141,498	$107,958	$92,383	$845,414
Brookdale Hospital Medical Center	N/A	$68,225	$65,842	$77,527	$63,849	$57,729	$66,652	$70,435	$470,259
Mount Sinai Medical Center	N/A	$59,910	$40,170	$41,565	$36,604	$16,542	$12,948	$27,043	$234,782
Our Lady of Mercy, Bronx	N/A	$27,305	$35,203	$38,198	$37,844	$76,647	$91,585	$82,101	$388,883
Eastman Dental Clinic	$22,410	$26,988	$28,107	$6,337	$11,564	$5,760	$3,236	$304	$104,706
University of Rochester Hospital	N/A	$19,885	$12,356	$7,443	$28,573	$122,157	$80,968	$70,229	$341,611
Long Island College Hospital	N/A	$19,374	$26,006	$41,122	$36,006	$36,906	$39,500	N/A	$198,914
SUNY at Stony Brook Hospital	N/A	$13,307	N/A	N/A	N/A	$2,584	N/A	N/A	$15,891
Westchester County Medical Center	$2,800	$3,594	$2,585	N/A	N/A	N/A	$32,840	$38,378	$80,197
New York Medical College	N/A	N/A	$865	$18,032	$21,594	$22,637	$24,964	$34,770	$122,862
Wyckoff Heights	N/A	N/A	$5,330	$10,675	$18,260	$18,439	$16,574	$51,716	$120,994
Long Island Jewish Medical Center	N/A	N/A	$6,515	$6,671	$3,654	$5,262	$4,484	$2,697	$29,283
Kings County	N/A	N/A	$7,245	$260,329	$158,323	$261,026	$156,142	$223,914	$1,066,979
Nassau County	N/A	N/A	$18,515	$17,491	$19,500	$25,358	$35,944	$41,255	$158,063
Montefiore Medical Center	N/A	N/A	$51,554	$134,512	$138,416	$195,201	$203,883	$185,576	$909,142
St. Mary's Hospital of Brooklyn	N/A	N/A	$117,294	$106,428	$157,920	$241,217	$315,172	$343,512	$1,281,543
Woodhull Hospital	N/A	N/A	$157,973	$256,654	$236,287	$253,657	$220,936	$264,206	$1,389,713
Interfaith Medical Center	N/A	N/A	$277,277	$375,140	$329,512	$228,586	$198,810	$175,800	$1,585,125
Maimonides	N/A	N/A	N/A	$1,193	N/A	N/A	N/A	N/A	$1,193
Metropolitan Hospital Center	N/A	N/A	N/A	$2,513	N/A	N/A	N/A	N/A	$2,513
SUNY at Buffalo School of Dental Medicine	N/A	N/A	N/A	$5,448	$5,476	N/A	N/A	$3,932	$14,856
Queens Hospital Center Mt. Sinai Services	N/A	N/A	N/A	$22,486	$25,549	N/A	N/A	N/A	$48,035
Brooklyn Hospital Center	N/A	N/A	N/A	$32,147	$48,925	$81,007	$103,967	$57,816	$323,862
Morrisania Diagnostic	N/A	N/A	N/A	$72,050	$60,785	$92,050	$83,499	$99,661	$408,045
North Central Bronx Hospital	N/A	N/A	N/A	$46,282	$38,015	N/A	N/A	$35,288	$119,585
Lincoln Medical & Mental Health Center	N/A	N/A	N/A	N/A	$124,149	$129,864	N/A	N/A	$254,013
Coney Island Hosptial	N/A	N/A	N/A	N/A	$91,974	$100,018	$111,576	$129,720	$433,288
Segundo Ruiz Belvis	N/A	N/A	N/A	N/A	$72,589	$69,341	$69,393	$89,483	$300,806
Elmhurst Hospital	N/A	N/A	N/A	N/A	$50,074	N/A	N/A	N/A	$50,074
Bellevue Hospital	N/A	N/A	N/A	N/A	$135,726	N/A	$122,474	N/A	$258,200
Peekskill Area Health Center	N/A	N/A	N/A	N/A	N/A	N/A	$3,533	$1,836	$5,369
St. John's Queens Hospital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$64,286	$64,286
TOTAL FOR STATE	$832,107	$1,354,859	$1,692,741	$2,639,557	$2,757,597	$2,999,988	$3,065,208	$2,969,335	$18,311,392
# of Grantees	13	20	28	33	34	32	32	32	43

Ryan White HIV/AIDS Dental Reimbursement Program
Grantee Awards by State 1991–1998

OHIO

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
Case Western Reserve School of Dentistry	$6,024	$17,208	$14,864	$13,344	$10,008	N/A	$15,380	$17,373	$94,201
Medical College of Ohio	$2,660	$2,357	$3,186	$2,194	$1,276	$1,516	$1,587	$982	$15,758
Ohio State University College of Dentistry	N/A	$29,755	$40,397	$41,017	$24,238	$20,470	$17,715	$12,053	$185,645
St. Elizabeth's Hospital	N/A	$808	$291	$476	N/A	N/A	N/A	N/A	$1,575
Cleveland Clinic	N/A	N/A	$552	$3,631	$8,972	$10,667	$10,474	$965	$35,261
Metro Health Medical Center	N/A	N/A	N/A	$3,161	$5,013	$4,672	N/A	N/A	$12,846
Children's Hospital of Columbus	N/A	N/A	N/A	N/A	$1,770	N/A	N/A	N/A	$1,770
TOTAL FOR STATE	$8,684	$50,128	$59,290	$63,823	$51,277	$37,325	$45,156	$31,373	$347,056
# of Grantees	2	4	5	6	6	4	4	4	7

OKLAHOMA

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
University of Oklahoma College of Dentistry	$2,848	$8,480	$8,512	$3,744	$4,174	$2,166	$3,091	$2,268	$35,283
TOTAL FOR STATE	$2,848	$8,480	$8,512	$3,744	$4,174	$2,166	$3,091	$2,268	$35,283
# of Grantees	1	1	1	1	1	1	1	1	1

OREGON

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
Oregon HS Univ. School of Dentistry	$29,264	$33,489	$43,089	$54,454	$47,827	$44,502	$17,696	$15,387	$285,708
TOTAL FOR STATE	$29,264	$33,489	$43,089	$54,454	$47,827	$44,502	$17,696	$15,387	$285,708
# of Grantees	1	1	1	1	1	1	1	1	1

PENNSYLVANIA

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
Temple University School of Dentistry	$83,621	$107,231	$56,843	$67,951	$24,544	$30,829	$46,546	$37,378	$454,943
Hahnemann University	$10,128	$6,054	$14,011	N/A	N/A	N/A	N/A	N/A	$30,193
York Hospital	$1,717	$2,820	$1,768	$3,201	$2,551	$1,489	$1,486	$1,905	$16,937
University of Pennsylvania Medical Center	N/A	$4,918	N/A	N/A	N/A	N/A	N/A	N/A	$4,918
Univeristy of PA Sch. of Dental Medicine	N/A	$3,295	$5,847	$8,501	$17,706	$49,417	$61,495	$47,535	$193,796
University of Pittsburgh Sch. of Dental Med.	N/A	N/A	$11,762	$8,891	$7,661	$10,073	$5,106	N/A	$43,493
Sacred Heart Hospital	N/A	N/A	N/A	$378	N/A	N/A	N/A	N/A	$378
Lehigh Valley Hospital	N/A	N/A	N/A	$4,237	$3,252	N/A	$7,359	$13,946	$28,794
Medical College of Pennsylvania	N/A	N/A	N/A	N/A	$66,287	$74,454	$91,318	$96,030	$328,089
TOTAL FOR STATE	$95,466	$124,318	$90,231	$93,159	$122,001	$166,262	$213,310	$196,794	$1,101,541
# of Grantees	3	5	5	6	6	5	6	5	9

PUERTO RICO

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
University of Puerto Rico School of Dentistry	N/A	N/A	$2,165	$34,780	$31,689	$22,823	$10,493	N/A	$101,950
TOTAL FOR STATE	N/A	N/A	$2,165	$34,780	$31,689	$22,823	$10,493	N/A	$101,950
# of Grantees			1	1	1	1	1	0	1

SOUTH CAROLINA

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
Med. Univ. of SC College of Dental Medicine	N/A	N/A	N/A	N/A	N/A	N/A	$2,934	$8,315	$11,249
TOTAL FOR STATE	N/A	N/A	N/A	N/A	N/A	N/A	$2,934	$8,315	$11,249
# of Grantees							1	1	1

TENNESSEE

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
Meharry Med. College School of Dentistry	$37,780	$51,627	$42,433	$24,814	$24,914	$10,047	$25,495	$17,435	$234,545
TOTAL FOR STATE	$37,780	$51,627	$42,433	$24,814	$24,914	$10,047	$25,495	$17,435	$234,545
# of Grantees	1	1	1	1	1	1	1	1	1

TEXAS

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
Texas A & M, Baylor College of Dentistry	$34,943	$39,052	$22,158	$42,953	$53,073	$64,060	$68,046	$89,264	$413,549
Tarrant County Hospital	$1,781	$4,866	$3,284	$7,238	$9,696	N/A	$6,680	$2,683	$36,228
UTHSC San Antonio Dental School	$46,032	$41,827	$22,185	$10,709	$8,353	$4,663	$4,405	$1,712	$139,886
UTHSC Houston Dental Branch	N/A	N/A	$11,968	N/A	$36,210	$48,739	$43,153	$22,720	$162,790
Parkland Memorial	N/A	N/A	N/A	$10,608	$8,246	$12,677	$13,589	$18,241	$63,361
TOTAL FOR STATE	$82,756	$85,745	$59,595	$71,508	$115,578	$130,139	$135,873	$134,620	$815,814
# of Grantees	3	3	4	4	5	4	5	5	5

UTAH

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
University of Utah	$4,578	$2,177	$3,244	$3,763	$2,534	$22,277	N/A	$2,578	$41,151
TOTAL FOR STATE	$4,578	$2,177	$3,244	$3,763	$2,534	$22,277	N/A	$2,578	$41,151
# of Grantees	1	1	1	1	1	1	0	1	1

VIRGINIA

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
University of Virginia	$20,349	$8,127	$7,155	$6,884	$7,442	$4,338	$7,104	$6,713	$68,112
MCVa. Commonwealth Univ. Sch. of Dentistry	$5,002	N/A	$32,896	$28,357	$18,963	$13,656	$15,441	$17,393	$131,708
TOTAL FOR STATE	$25,351	$8,127	$40,051	$35,241	$26,405	$17,994	$22,545	$24,106	$199,820
# of Grantees	2	1	2	2	2	2	2	2	2

Ryan White HIV/AIDS Dental Reimbursement Program
Grantee Awards by State 1991–1998

WASHINGTON

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
University of Washington Medical Center	N/A	$68,705	$78,996	$82,669	$99,932	$79,203	$83,995	$85,863	$579,363
University of Washington Dental School	N/A	$64,410	$62,626	$120,538	$59,275	$53,320	$80,318	$57,995	$498,482
TOTAL FOR STATE	N/A	$133,115	$141,622	$203,207	$159,207	$132,523	$164,313	$143,858	$1,077,845
# of Grantees	0	2	2	2	2	2	2	2	2

WEST VIRGINIA

Grantee	1991	1992	1993	1994	1995	1996	1997	1998	TOTAL
West Virginia University School of Dentistry	$1,390	N/A	N/A	N/A	N/A	N/A	$224	N/A	$1,614
TOTAL FOR STATE	$1,390	N/A	N/A	N/A	N/A	N/A	$224	N/A	$1,614
# of Grantees	1	0	0	0	0	0	1	0	1

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AADS Division of Government and Institutional Relations
Fax Transmittal

Date: 9-13-99

To: Todd Summers Institution: Office of Nat'l AIDS Policy

Fax Number: 202-456-2438

Pages, including cover: 4

From:

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✓ **For your information**

____ **Per your request**

____ **Per our conversation**

____ **Please respond by:** _____

Message: Attached you will find the AADS Ryan White reauthorization recommendation. To be discussed during our meeting on Wed. Sept 15, 1999 @ 11:30 a.m. If you have any questions please give me a call @ 202-667-9433 ext. 127

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AADS Reauthorization Recommendations
Ryan White HIV/AIDS Dental Reimbursement Program

The Ryan White HIV/AIDS Dental Reimbursement program helps to meet the oral health needs of people living with HIV/AIDS. The HIV/AIDS Dental Reimbursement program provides participating institutions with partial reimbursement for the costs of providing oral health care services to low-income people living with HIV and AIDS. In 1998, 101 dental education institutions participated in the program providing care to over 66,000 patients in virtually all states.

Program Purpose.

The program is critical to the provision of needed oral health care and treatment for HIV patients for two important reasons:

- It provides access to necessary dental services for individuals, who due to HIV and AIDS are more susceptible to oral diseases.
- It serves as an effective means to enhance HIV/AIDS training within dental schools and hospital-based programs, as well as improve the perspective of dental care providers in caring for HIV/AIDS patients.

Oral Health Needs of People with HIV/AIDS.

AIDS patients, as a group, suffer a much higher incidence of oral disease. Suppression of the immune system caused by the AIDS virus, leaves patients more susceptible to a set of serious infections—severe oral herpes, rampant fungal diseases, an AIDS-specific gum disease resulting in bone exposure, and other painful infections. These conditions if not treated appropriately can lead to fevers, weight loss, and difficulty in eating, speaking and even taking medications. A full range of dental health services are needed to effectively treat these problems including diagnostic, preventive, prosthodontics and oral surgery procedures. Even the earliest stages of HIV manifest in the oral cavity, sometimes making a dentist the first health care professional to diagnose the disease. With the advances of multi-drug therapies and an increased life span, people with HIV and AIDS live longer, making oral health care an integral part of their on-going total health care.

Reimbursement and Education Issues.

The debilitating nature of HIV disease often means that patients seeking relief from dental conditions also lack the means to pay for these services. The fact is that only a small percentage of the overall working population has dental insurance; and most dental services are not covered under existing federal and state assistance programs such as Medicaid.

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Dental institutions participating in the Ryan White program have greatly increased the level of HIV/AIDS education of both students and staff. This increase is due to schools dedicating more class time to specific HIV/AIDS curriculum as well as integrating HIV/AIDS issues throughout existing coursework such as microbiology, pathology, oral surgery and periodontology. Through clinical experience, the attitudes of students and residents participating in the Ryan White Dental Reimbursement program have significantly improved as fears about treating patients with HIV/AIDS have diminished. Participation in the program has enabled schools to provide more comprehensive information on HIV/AIDS and proper precautionary measures to be taken during treatment. Students and residents have learned to treat their patients with HIV and AIDS with compassion and competency.

HRSA Program Evaluation.

HRSA has recently completed an evaluation of the dental reimbursement program concluding that the program is working well and has resulted in improved access to dental care and effective training for students and residents. When asked about the impact on patient care of the Ryan White program, dental schools cited increased access to care and improved quality of care. With respect to the former, participating dental institutions have noticed an increase in the number of HIV patients treated and an increase in the services offered. While an increase in the HIV patient population being served can be attributed to a willingness of individuals to disclose their HIV status it is also due to outreach programs initiated by many schools including efforts in rural areas where dental services are being offered along with other health care services provided to affected patients. Institutions participating in the program also noted that there was greater utilization of dental services for HIV patients. From 1991-1996, HIV patients took greater advantage of all dental services offered by schools and hospital-based programs participating in Ryan White.

According to surveys of patients with HIV/AIDS, oral health care is listed as a significant unmet need. AADS is working with its member dental schools and hospital-based dental programs to determine how it can reach out to more patients in need of oral health services and enhance the scope of services provided. New guidelines instituted by HRSA, will enhance the current program and provide for greater accountability of program funds. As these efforts will improve the effectiveness of this program, so too will the extension of the program as part of the reauthorization of the Ryan White Care Act.

AADS Reauthorization Recommendations:

Due to the importance of oral health for people living with HIV/AIDS and the continuing need to educate and train competent dentists sensitive to the needs of people living with AIDS, AADS recommends the following:

- Reauthorize the existing HIV/AIDS Dental Reimbursement program at its current level of "such sums as may be necessary." Application for these funds by dental education sites (dental school clinics and hospital-based dental education programs) should continue to be on the current formula-basis. Program participants must demonstrate linkages with community-based AIDS organizations and meet new cost-reporting guidelines.

- Additional funds should be made available to address the high unmet oral health care needs of people living with HIV/AIDS via collaborative efforts between dental education and community-based oral health providers where dental education sites are not presently located.

CAEAR Coalition
Statement Regarding
Reauthorization of the CARE Act

September 13, 1998

The following statement summarizes an extensive discussion among participants of the CAEAR Coalition's meeting on September 12 and 13, 1998 regarding reauthorization of the Ryan White CARE Act.

The primary purpose of this statement is to clarify for participants and the constituencies they represent the overall results of the two-day process. The statement also will serve to inform the Coalition's partners and colleagues who are interested in the future of the CARE Act.

1. We are committed to assuring an adequate federal role beyond entitlements in the care and treatment of people with HIV and AIDS.

2. We have generated a lot of issues and topics on what is important now and may be in the future. More questions were raised than answered. We started to talk.

3. We recognize the need to create an opportunity to think "out of the box" and explore reauthorization from a "blank" slate.

4. We must continue to work on reauthorization between now and the next meeting in December 1998 with the goal of reaching consensus on reauthorization by January 1999. We need to decide the appropriate forums for gathering input from interested parties on how members should participate, and how non-members should participate. We also need a Congressional outreach plan.

5. We recognize that each of us and many others need to commit our personal and organizational time and resources to this challenge.

White House Meeting
September 14, 1998

RECOMMENDATIONS FOR REAUTHORIZATION OF THE RYAN WHITE C.A.R.E. ACT FROM THE GREATER HARTFORD EMA

The reduction in mortality among people infected with the HIV virus has occurred in part because the Ryan White C.A.R.E. Act has removed barriers to treatment by funding support services, primary medical care and combination therapy. The advances made in treatment have been cost effective to some segments of the service system, leading to a decrease in hospitalizations. At the same time, the number of people living with the virus has increased. Almost sixty percent of the people infected with AIDS in Hartford's three county region acquired it through injection drug use. Most have very high service needs. The burden on the C.A.R.E Act system in Hartford continues to grow with the success of new therapies and traditional AIDS services. The need for the C.A.R.E Act has increased since its introduction and reauthorization is essential to the well-being of people living with HIV and AIDS.

Hartford EMA Recommendations for Reauthorization:

1. **Restrictions: Do not mandate any new restrictions on service.** The aim of the funding should be to attract people to HIV/AIDS services, not to restrict service or access to treatment. People who begin treatment early may be prevented from becoming sicker. The EMA recommends:

   No names reporting of HIV infected persons.

   No mandatory testing of pregnant women (in Hartford EMA, there is no mandated testing of pregnant women and there were no new cases of babies born with AIDS in the past year).

   No clinical restraints such as CD4 counts placed on service criteria.

   Expand income eligibility to 400% of poverty.

   Do not impose new economic qualifications such as assets test for service

2. **Expand allowable service expenditures to enhance stability of consumers' lives:**

   Allow expenditures for car repair.

   Allow expenditures for clothing, if medically necessary.

   Allow expenditures for mortgage payments.

3. **Continue the Planning Council system and local control of Ryan White Title I.** The system has facilitated funding decisions based on local needs. The reflectiveness and mandatory categories of participation places policy and decision-making in the hands of knowledgeable constituents. Hartford has experienced the benefit of having people living with HIV/AIDS at the table for planning and funding allocation. The system has insured that consumers buy-in to the process and has improved the effectiveness of the product.

4. **Do not impose unfunded mandates.** Since C.A.R.E. act funding focuses on service provision, it is not reasonable to expect to be able to provide complex data or in depth analysis of program effectiveness. Research dollars must be made available .

The Hartford EMA thanks The Office of National AIDS Policy for the opportunity to give input on the reauthorization of the C.A.R.E. Act.

Meeting with Sandra Thurman, Director, Office of National AIDS Policy
September 14, 1998

Report from Hartford, Connecticut
Eligible Metropolitan Area (EMA)

Good morning. My name is Ann Levie. I direct the Ryan White Title I program for Hartford Connecticut. Hartford is currently funded at 3.6 million dollars and served approximately 1,500 people last year infected and affected by HIV and AIDS.

The Hartford EMA consists of a three county area comprised of rural, suburban and urban communities in 57 towns. There are 1,770 known cases of persons living with AIDS in the EMA. Of the cumulative cases, 32% are White, 36% are Black and 31% are Hispanic, 1% is Asian, American and Indian/Alaskan and other.

I. Major Accomplishment of the EMA:

Establishment of "Living Centers", Multi-service centers for people living with HIV and AIDS. They:

- are run by staff and volunteers living with the virus
- are located in 4 different geographic locations and communities.
- All provide meals and support groups.
- Offer RW and non-RW funded programs including but not limited to substance abuse groups, physical examinations and message therapy.

The EMA's Multifaceted Approach to Providing Substance Abuse Services:

- 58% of AIDS in the EMA have injecting drug use as the exposure category. In some communities it is as high as 65%.
- The EMA provides pre-treatment counseling, treatment advocacy, triage in HIV clinics, acupuncture detoxification, relapse prevention, group counseling, in-patient treatment, traditional detoxification, 12 step programs.

II. Biggest Challenge

Integration of Ryan White funded services (funding of last resort) with those of other service systems particularly other federal and state programs, including Medicaid funded, mental health and addiction services. **Examples**:

A Medicaid/Ryan White client who wants to get into a substance abuse program can be on a waiting list for the Medicaid funded program or can get into a Ryan White funded program immediately.

Medical transportation of Medicaid eligible/HMO clients consists of a single bus token. Does Ryan White send a van to take the Ryan White eligible mother and her three children to the doctor or let her miss her appointment because lack of child-care?

III. Best Practices

EMA funded Medical Adherence Program

- Is peer-based and operated
- Has links to primary care providers
- Provides group and individual educational training sessions
- Is based on-site at out-patient clinics on a regularly scheduled basis
- Maintains schedules at all drop-in centers
- Takes referrals from Pharmacists and Primary care clinicians
- Provides training to practitioners and consumers

Integration of Persons Living with HIV and AIDS on Planning Council

- 43% of PC members are living with HIV/AIDS.
- P.C. has a mentoring program.
- HIV+ leadership role in evaluation and membership committees.
- P.C. has active HIV caucus.
- Alternates can participate for HIV. positive members who are ill.
- Culture of openness at meetings.
- The Council has conducted meeting with members on speaker phone.
- Sub-committees have met in hospital rooms.

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HRSA AIDS Advisory Committee
Ryan White CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

1. Reauthorization

2. Structure of CARE Act

3. Distribution of resources
   a. Formula issues - Title I and Title II (Secretarial study of formula issues)
   b. Hold harmless provisions - Title I and Title II
   c. Title I Formula
   d. Funding distribution - Title II
   e. Title II - ADAP Formula Distribution

4. Planning Issues
   a. Statewide coordinated statement of need
   b. Title I Planning Councils - Composition
   c. Title II/ Participatory planning

5. Prioritization of services
   a. PHS guidelines as priority for CARE Act services
   b. Priority to core services and linkages to health care
   c. Early intervention certification requirement
   d. ADAP - minimum drug formulary
   e. Allowable uses of funds Title I and Title II - outreach and counseling/testing programs

6. Vulnerable population specific issues
   a. Serving vulnerable populations - Title I and Title II
   b. Access to care for HIV infected adolescents
   c. Access to services for HIV infected substance abusers
   d. Meeting the care needs of HIV+ women

7. Title Specific Issues
   a. Title IV - Elimination of research requirement
   b. Dental/ Oral Health Care
   c. AIDS Education and Training Centers

8. Funding flexibility
   a. ADAP Funding flexibility
   b. Flexibility to support integration of federally funded prevention, counseling, testing and early intervention programs
   c. Demonstration project authority - combining multiple funding streams

9. Administrative issues
   a. Administrative cost issues - all titles
   b. All titles - grievance procedures
   c. Re-evaluation of current set aside provisions

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Reauthorization of the CARE Act

Proposed Recommendation:

The Ryan White CARE Act should be reauthorized.

Rationale/Background:

Since being signed into law in 1990, the Ryan White CARE Act has been a critical element of the nation's response to the HIV/AIDS epidemic. The CARE Act has played a central role in enabling Americans with HIV to access care, treatment and services. It has been one of the contributing factors to the declining death rate associated with HIV/AIDS.

The need for the CARE Act remains. More people in this country are living with HIV/AIDS in this country than ever before. While many have benefitted from access to care and treatment, the continuing spread of HIV into disadvantaged populations creates new and severe challenges in ensuring that all people with HIV have access to the care they need. The CARE Act is essential to ensuring that people of color, women, youth, substance abusers, rural populations, low income people and others with HIV have access to care, treatment and services.

The Ryan White CARE Act must continue to exist to meet the continuing challenges of an expanding HIV/AIDS epidemic.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Structure of the Ryan White CARE Act

Proposed Recommendation:

A reauthorized CARE Act should retain the basic existing title structure, including Title I (Emergency Relief for Areas with Substantial Need for Services), Title II (HIV Care Grants to States), Title III (Early Intervention Services), Title IV (Grants for Coordinated Services and Access to Research for Women, Infants, Children and Youth) and Part F (Special Projects of National Significance, AIDS Education and Training Centers, and Dental Schools).

Rationale/Background:

The existing structure of the CARE Act allows for appropriate flexibility in responding to a wide variety of diverse needs. Local flexibility is the hallmark of Title I and Title II, while the remaining activities allow HRSA to target activities to meet specific needs in specific areas. Disruption to the existing structures of service planning and delivery would not work to the advantage of people living with HIV/AIDS.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Formula issues - Title I and Title II

Proposed Recommendation:

The legislation should instruct the Secretary of Health and Human Services to consult with appropriate experts and/or to commission a study to explore the implications of various options for developing a new formula method for distribution of CARE funds in the future. Such an undertaking should look at potential use of HIV case data, care provision data, cost data, and other possible methods for distributing funding to meet HIV care needs across the country.

Rationale/Background:

AIDS case data is increasingly unreliable as a measurement of local service needs. In fact, it may serve to penalize jurisdictions that are effectively providing care to people and therefore avoiding progression to diagnosable AIDS defining conditions among people with HIV. While the CDC and states are rapidly moving to HIV case reporting, there is no uniform national data and it will not exist for many years. Even once implemented, limitations inherent in the data may not make it the most appropriate way to allocate funding.

Rather than attempting to develop a new formula basis in this uncertain environment, it is appropriate for the Secretary to seek expert opinion and scientific study to determine the best way to distribute funds effectively and fairly, and to meet HIV care needs throughout the country.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Hold harmless provisions of formula - Title I and Title II

Proposed Recommendation:

Under a reauthorized Ryan White CARE Act, the existing provisions of the law which limit the loss of resources to a jurisdiction over time should be retained, ensuring that no jurisdiction will receive less than 90% of their fiscal year 1995 award in the 2005 fiscal year.

Rationale/Background:

Large transfers of funding between jurisdictions threatens the stability of infrastructure and services developed through investment of CARE Act resources. As service needs continue to grow everywhere in the country, such a provision prevents the destruction of service capacity in originally hard hit areas.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Title I Formula

Proposed Recommendation:

The percentage of the Title I grant awarded competitively should be increased to 66% from the existing 50%. In doing so, HRSA should make awards based on a number of factors, including severity of need, prevalence, and the ability of the competitive proposal to bring or maintain people, especially vulnerable populations, in quality care.

Rationale/Background:

The use of the AIDS case definition is increasingly irrelevant for distributing funds because of the impact of treatments and changing standard of care. However, it is not realistic to proceed to a national HIV based formula at this time. This approach allows HRSA to make awards based on presentation of local data documenting need and a plan for meeting that need, especially the needs of under-served vulnerable populations. Emphasis in making these awards should be placed on need and workable plans for meeting that need, not simply the quality of grantsmanship presented.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Funding distribution - Title II

Proposed Recommendation:

We recommend that within Title II a competitive funding program be developed to respond to severe unmet need in states or portions of states. This should be accomplished by setting aside a portion of the national Title II appropriation and making it available for competitive application to states for the development and care delivery activities of consortia outside of Title I EMAs. Legislative authority should be given to HRSA to award these competitive funds based on unmet need and the ability of the applicant to fill gaps in essential services using these funds. (Existing hold harmless language should be retained to insure that this funding comes from new dollars rather than shifting needed services from other states.)

Rationale/Background:

Because of the stringent eligibility standards for Title I EMA designation many heavily impacted areas, especially in the deep south, will never be able to receive those resources. Unfortunately, these are also frequently areas with severe lack of health care infrastructure and with low income eligibility for entitlement programs. This will allow HRSA to provide funding for "rural EMAs" to help provide essential services in these areas and to build service delivery capacity in these areas.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Title II - ADAP Formula Distribution

Proposed Recommendation:

While the distribution of ADAP funds in Title II should continue to be based on a case driven formula, a small percentage (up to 10%) of the ADAP appropriation should be made available for award by HRSA based on a competitive application. Priority in awarding these funds should go first to assisting jurisdictions in providing the full range of treatments necessary to meet the PHS treatment guidelines for those with incomes up to 185% of the Federal Poverty Level, and then to jurisdictions that will be able to cover additional low income individuals. Part of the competition may be used to provide incentive to jurisdictions to make state/local funding available for this purpose or to enhance their state Medicaid eligibility guidelines.

Rationale/Background:

Access to ADAP is highly variable around the country, with differences in income eligible and formulary. Many of these differences are due to factors external to Ryan White, such as the operation of the state Medicaid program, availability of a high risk insurance pool in the state, private insurance practices, state contributions etc. This flexible funding would allow HRSA to fill pressing gaps in availability of HIV related pharmaceuticals without extreme disruptions to the existing funding flow.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Statewide Coordinated Statement of Need

Proposed Recommendation:

In addition to those partners specified in the existing legislation (individuals with HIV, representatives of grantees under each part of this title, providers, and public agency representatives), the legislative requirement for a periodic meeting to develop a statewide coordinated statement of need should also specify the desirability of participation of other publicly-funded agencies serving vulnerable populations (MCH, Health Care for the Homeless, Medicaid, Medicare, mental health and substance abuse services, Indian Health Service, HOPWA, CDC-supported counseling/testing, prevention and outreach programs, corrections and probation, youth serving agencies, and other similar relevant providers).

Rationale/Background:

Such a truly comprehensive meeting of providers enhances the likelihood of a complete picture of need and greater planning, coordination and linkages.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Title I Planning Councils - Composition

Proposed Recommendations:

The legislative language concerning composition of the planning councils should be strengthened to require that the composition of the planning council reflect the racial/ethnic and risk factor demographics of the local epidemic, and that consumer representation should reflect the same characteristics. Demonstration of this should be a requirement of funding under this section of the act. Additionally, language should be added specifically encouraging representation of women, youth, substance abusers and people of color living with HIV.

The legislation should mandate that a minimum of 33% of the members of planning councils be people living with HIV.

In addition to the representation of provider groups currently outlined in the legislation, the legislation should also encourage inclusion of corrections and probations agencies, homeless and housing groups, youth advocates, nurses, social workers, and other agencies serving vulnerable and affected populations.

The legislation should specifically allow the expenditure of funds to support the participation of consumers in planning councils, including payments for necessary expenses such as child care, transportation, hotels and meals, as well as reasonable stipends for time participating in planning activities.

Rationale/Background:

Participatory planning is the basis for priority setting and decision-making in Title I areas. These steps would help ensure that the process is open and accessible to diverse populations, thereby "leveling the playing field."

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Title II/ Participatory planning

Proposed Recommendation:

Within Title II of a reauthorized Ryan White CARE Act, we recommend that a legislative mandate be created for an open advisory planning process that includes people living with HIV and a range of representatives from affected communities and service providers.

States receiving Title II funds should be required to demonstrate that such a participatory process exists and is consulted in decisions about needs assessment and priority setting for Title II funds.

Consortia funded through Title II of the CARE Act should be required to demonstrate that their membership includes representation reflecting the epidemiology of HIV/AIDS in their geographic area and includes people living with HIV/AIDS as well as providers of services to impacted populations. Consortia should be required to conduct open nomination processes and to conduct open business meetings.

Rationale/Background:

At the present time, Title II has no requirement for any participatory planning process beyond an annual public hearing. This is in strong contrast to Title I, where the legislation creates the planning council structure and sets basic standards for membership.

This recommendation recognizes that Title II areas may differ widely from Title I EMAs, and does not suggest mandating the same kind of intensive participatory planning process seen in Title I. Instead, it would allow states wide variance in creating advisory groups or utilizing existing groups, and simply would require them to document the way in which these groups inform their priority setting and allocation processes.

Under existing law, Title II consortia may exist as closed groups of service providers. We believe that, given their responsibilities for sub-contracting and overseeing significant federal funds, they must include community and consumer representation in their governance and decision-making process.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

PHS guidelines as priority for CARE Act services

Proposed Recommendation:

All grantees under all Titles of a reauthorized Ryan White CARE Act should be required, as a condition of award, to document the specific steps they are taking to ensure that people living with HIV in their area of service are receiving care that meets or exceeds the Public Health Service Guidelines for HIV treatment and care.

Rationale/Background:

THE PHS guidelines provide an objective effort to measure a basic standard of care for people with HIV. All Ryan White CARE Act grantees should be making implementation of those guidelines a service priority.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Priority to core services and linkages to health care

Proposed Recommendation:

A reauthorized Ryan White CARE Act should instruct grantees to prioritize, as appropriate to the service needs of their locality, provision of primary care and therapeutics and those activities necessary to assist consumers in gaining and maintaining access to medical care and therapeutic agents. It is recognized that

Social service activities supported by the Act should actively assess the involvement, access and barriers to access to health care of clients. Such social services should seek to voluntarily connect into health care those not currently accessing it, while respecting client choice and autonomy around care decisions.

A reauthorized CARE Act should continue to recognize that, in many instances, a variety of supportive services may be necessary to connect and maintain people in health care. Provision and/or coordination of those essential services must continue to be part of a CARE Act.

Rationale/Background:

There was widespread agreement from those we heard from across the Ryan White community that it did not make sense to restrict the use of CARE Act funds to a narrow range of directly medical services. Instead this recommendation recognizes the importance of ensuring that people have access to health care and the necessity of other services in ensuring that access. It is inappropriate for CARE Act funded social services to fail to address issues of health care access, yet frequently impossible to access health care without other services.

AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Early intervention certification requirement – Title I and Title II

Proposed Recommendation:

As a condition of award, Title I, Title II, Title III and Title IV grantees should be required to certify and demonstrate appropriate linkages with the appropriate HIV detection, early intervention services, prevention, surveillance, and substance abuse treatment in their jurisdictions. Specifically this should include documentation of ties to local counseling/testing programs and, for governmental grantees, cooperation and planning with those agencies responsible for counseling/testing.

Rationale/Background:

All too often systems of care and of prevention operate in completely separate spheres, creating cracks that people fall into and allowing significant duplication of labor. By requiring a certification of communication, cooperation and collaboration, these gaps are more likely to be closed.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

ADAP –minimum drug formulary

Proposed Recommendation:

A reauthorized Ryan White CARE Act should require HRSA to develop a core or model drug formulary for ADAPs, prioritizing therapeutic drugs to be provided and requiring ADAP grantees to demonstrate their efforts to supply these drugs to people with HIV.

Rationale/Background:

ADAP formularies across the country vary widely based on local factors, and many fail to come close to providing even close to the PHS standards. By developing a list of essential drugs and requiring states to specifically describe their efforts to make these drugs available, HRSA would begin the steps necessary to ensure minimal access around the country.

(There was significant opposition in public comments to this approach, with opponents arguing that this might be interpreted as a ceiling rather than floor, that it failed to take into account local variations in other funding sources, and that it would usurp local control.)

AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Allowable uses of funds Title I and Title II - outreach and counseling/testing programs

Proposed Recommendation:

Outreach to people not in care or unaware of their HIV status, including programs to offer counseling and testing to those, should be allowable expenditures under Title I and Title II when prioritized locally as part of a plan to bring vulnerable under served populations into care. Such efforts should be planned and conducted with attention paid to the existing outreach and counseling/testing programs in the jurisdiction, should be offered by culturally competent and appropriate providers for the population being outreached, and should not be allowed to exceed 2.5% of the total award to a jurisdiction. When funded through the Ryan White CARE Act, such programs must offer immediate and seamless transition into early intervention and care programs.

Rationale/Background:

Because large numbers of people living with HIV have not been tested and do not know their status, or are aware of their status but do not receive care, it is essential that care program reach out to them. Allowing a small portion of CARE Act dollars to be used for this purpose enhances the opportunity to identify and bring into care those who are currently not receiving it. This flexibility will not result in the creation of a new parallel counseling/testing system, but rather fill in important gaps in the existing system.

AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Serving vulnerable populations – Title I and Title II

Proposed Recommendation:

Grantee responsibility for Title I and Title II in the legislation should explicitly include a requirement to assess the needs of vulnerable populations not currently in care and to develop a plan to meet those needs.

As a condition of award, grantees must be able to demonstrate that they have meaningful linkages (such as contracts, memoranda of understanding, co-located staff, etc.) with services providers likely to be the point of entry into care for vulnerable populations not currently accessing HIV care (such as: emergency rooms, sexually transmitted disease clinics, migrant health centers, family planning clinics, homelessness service providers, street youth programs, substance abuse treatment programs, etc.).

Rationale/Background:

Large numbers of people with HIV are not in systems of care. It is essential that the Ryan White CARE Act make every possible effort to identify and outreach people into care. By requiring planning bodies and grantees to take responsibility for assessing and developing a plan for this need, and by requiring demonstrable connections to providers for these populations, the likelihood of successful connections are enhanced.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Access to care for HIV infected adolescents

Proposed Recommendation:

In order to ensure that HIV infected adolescents are accessing care, a reauthorized Ryan White CARE Act should:

Require Title I and Title II grantees to include youth services in their needs assessment and planning processes, and to assess the degree to which infected adolescents are being adequately served by existing systems of care. Grantees should be specifically encouraged to support "one-stop" multi-disciplinary youth serving programs.

Include in Title III and Title IV priority for funding adolescent centered multidsiciplinary programs for HIV infected youth and early intervention/detection for youth at high risk for HIV infection.

Rationale/Background:

Despite growing evidence of widespread new infections among adolescents and young adults, it appears that few adult programs are successfully enrolling infected young people in care. This recommendation recognizes the necessity of all parts of the CARE Act providing culturally competent care to youth and the importance of developing specialized services.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Access to services for HIV infected substance abusers

Proposed Recommendation:

In a reauthorized Ryan White CARE Act, Title I and Title II needs assessment, prioritization and planning processes should be required to explicitly address the degree to which services are available to and accessed by HIV infected substance abusers. Such an assessment should include plans for ensuring that substance abuse treatment is readily available for all infected users who seek treatment.

Rationale/Background:

The role of substance abuse in the HIV/AIDS epidemic continues to grow, yet access to health care and substance abuse treatment programs for substance abusers is frequently limited. Including the requirement to pay particular attention to this area in the legislation elevates the issue for grantees without imposing specific funding requirements on local jurisdictions.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Meeting the care needs of HIV+ women

Proposed Recommendation:

In setting service priorities for primary care, all Ryan CARE Act funded grantees should recognize the importance of obstetrical and gynecological services for HIV infected women and address access to those services as part of their access plan.

Title I programs should have a minimum 25% set aside for programs that serve women and children, and these services should not be solely linked to perinatal services or focused solely on mothers.

Rationale/Background:

Women's needs are frequently under addressed in Ryan White CARE Act programs.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Title IV - Elimination of research requirement

Proposed Recommendation:

The reauthorized CARE Act should eliminate the existing require that a "significant number of women, infants, children and youth who are patients of the applicant will be participating in projects of research."

Rationale/Background:

This requirement fails to recognize the difficulty of recruiting many populations into care itself, and by imposing a research requirement risks alienating potential clients. No similar requirement exists for other parts of the Act. The elimination of this requirement would not affect other aspects of this section requiring grantees to provide the voluntary opportunities for participation in research.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Dental/Oral Health Care

Proposed Recommendation:

In a reauthorized Ryan White CARE Act, the present program of supporting dental school clinics for care of oral health needs of people with HIV should be retained. Alternative methods of awarding these funds, including requiring competitive proposals, should be considered.

In addition, funds should be made available on a competitive basis to support community-based clinics providing dental care for people with HIV, especially in communities without a participating dental school clinic or with high unmet oral health care needs. Such a competitive program should be administered in a manner similar to the existing Title III of the CARE Act.

Oral health should remain an allowable service category under other Titles of the Ryan White CARE Act.

Rationale/Background:

Oral health care remains an unmet need for many people with HIV.

The dental school programs provides many essential services and helps ensure a supply of trained dental professionals for future HIV care. However, this program alone does not meet the need. Development of a community based dental provider funding program is essential to address unmet need in this important area.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

AIDS Education and Training Centers

Proposed Recommendation:

The existing mandate for AIDS education and training centers should be altered in a reauthorized Ryan White CARE Act.

Specifically, it should no longer be a focus of AETC's "to train the faculty of schools of, and graduate departments and programs of medicine, nursing, osteopathic medicine, dentistry, public health, allied health and mental health practice to teach health professions students to provide for the health care needs of individuals with HIV disease."

Instead, this mandate should be replaced with a focus on providing training relevant and appropriate to the needs of providers and HIV positive consumers of health services in the region the AETC operates, with particular priority given to training of providers who will deliver services to Ryan White CARE Act clients.

In addition, the AETC mandate should be expanded to include the possibilty of involvement in development of training on quality assurance and improvement and program outcome evaluation for Ryan White CARE Act providers.

Rationale/Background:

With an extremely limited budget, the work of the AETCs must focus on community providers, especially those who operate as part of the Ryan White CARE Act system. More than 18 years into the HIV pandemic, it is reasonable to expect that health care teaching institutions incorporate HIV into their curricula without training from these overworked AETCs. (It should be noted that the training curricula and programs developed by AETCs for community based providers would legitimately continue to be available to instutions of higher learning.

AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

ADAP - Funding flexibility

Proposed Recommendation:

The legislation should allow ADAP funds to be redirected by the state grantee to other essential services under some limited circumstances. The current opportunity for ADAP funds to purchase insurance when economically advantageous should be retained.

In addition, when ADAP is already able to provide full coverage of the drugs necessary to meet the PHS treatment guidelines for all low-income people (<300% of Federal Poverty Level) in their state, they should be able to apply for a receive permission from HRSA to apply ADAP funds to other essential HIV/AIDS care activities in their state.

Rationale/Background:

Purchasing of insurance may allow coverage of both health care and pharmaceutical products for a larger number of people than ADAP alone, and should be an option for states.

The ability of ADAP to meet demand in a state frequently depends on a host of factors external to the CARE Act, including state income standards for Medicaid eligibility, availability of a high risk insurance pool in the state, extent of private insurance coverage in the infected population, size of state contribution to ADAP, etc. When those circumstances combine to make it more difficult to spend ADAP dollars, states should have the flexibility to redirect funding to other important areas.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Flexibility to support integration of federally funded prevention, counseling, testing, and early intervention programs.

Proposed Recommendation:

A reauthorized CARE Act should include the option of allowing grantees to apply to HHS for authority to combine parts of funding currently received under different titles of the CARE Act with other federal resources (HIV counseling/testing, outreach and prevention, STD detection and treatment) in order to enhance early detection and intervention. This flexibility may be as simple as allowing jurisdictions to adjust internal contracting processes and timetables in order to issue jointly funded requests for proposals.

Rationale/Background:

No where is the overlap between care and prevention more clear than in the area of counseling/testing programs; however, the artificial divide in federal funding streams in these areas is a disincentive to successful linkages and collaboration. The ability to combine parts of these funding streams at the local level may encourage early and more efficient, user-friendly systems of detection, intervention and service access.

AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Demonstration project authority – combining multiple funding streams

Proposed Recommendation:

The reauthorized CARE Act should provide authority for HHS to grant waivers to jurisdictions seeking to combine various federal funding steams supporting HIV/AIDS care and services. Such a waiver would allow a state to combine federal and state Medicaid, Medicare, Ryan White CARE Act and, potentially, parts of SAMHSA and CDC funding. Such waiver authority would require submission of an application documenting how such a demonstration project would allow the jurisdiction to provide access and quality care to more individuals with HIV/AIDS. In addition to direct funding for health care, the demonstration project would be required to include access to supportive services enabling a person to enter and remain in care.

Such a demonstration project would be required to include a participatory planning process involving people with HIV, members of impacted communities and key service providers. Before including a Title I EMA funding in such a demonstration project, both the chief elected official and the planning council of the affected EMA would need to concur with participation in the process. Funding for a particular Title III, Title IV, or Part F program would only be included in the demonstration project with the consent of the program.

Rationale/Background:

Federal funding for HIV/AIDS care currently comes in fragmented and disconnected pieces. Demonstration project authority would allow development of creative models for delivery of cost effective care to larger numbers of people. The protections outlined above would ensure community participation in decision making around the demonstration projects.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Administrative cost issues - All titles

Proposed Recommendation:

We recommend that a reauthorized Ryan White CARE Act specify that:

– quality improvement activities are a legitimate programmatic cost that should not be counted against the administrative spending limits.

– evaluation activities are essential to quality programs and grantees should be allowed to devote up to 5% of their total grant to evaluation activities

– a uniform overhead/administrative limit of 10% be imposed on all titles and sub-grantees. An exemption should be made for small organizations (budgets under $500,000), which may be allowed to spend up to 20% of their award to support administrative activities under appropriate circumstances.

Rationale/Background:

Quality improvement and evaluation is needed in many programs and the administrative cap makes it less like that such activities will take place

The 10% standard should universally applied across grantees. It is unreasonable for some to be forced to struggle to administer programs with 5% while others have no limit and may take excessive indirect rates.

Small organizations, frequently in communities with limited infrastructure, may have legitimate overhead needs exceeding those of larger organizations due to the lack of economy of scale. This size exemption acknowledges that legitimate need.

HRSA AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

All titles – Grievance procedures

Proposed Recommendation:

The legislation should require that all grantees funded under the Act establish appropriate procedures allowing consumers of Ryan White CARE Act funded services to pursue grievances against providers. HRSA should be instructed to establish guidelines for these locally run procedures, including standards for informing consumers of grievance rights, encouragement of mediation, rights of all affected parties, and access to external appeal mechanisms.

Rationale/Background:

There is currently no requirement for such an outlet for consumers who feel they have been mistreated by a provider, nor protections for providers against spurious allegations. The central role of the CARE Act in supporting service delivery makes this an important area of improvement. This is especially important for those services (such as case management, emergency assistance, etc.) which exist outside of professional licensing and oversight requirements.

AIDS Advisory Committee
Ryan CARE Act Reauthorization Recommendation Meeting
May 13-14, 1999

Topic area:

Re-evaluation of current set aside provisions

Proposed Recommendation:

A reauthorized Ryan White CARE Act should alter the way in which set aside funds are distributed.

A new division of these funds should allow for creation of a program of operational/infrastructure improvement grants to ensure start-up and capacity building support is available in severely under served areas lacking currently lacking capacity. Such a program should include authority to make capital improvement grants or loans when needed to develop the physical infrastructure necessary for service provision. These grants/loan should be made available in geographic areas experiencing significant disease burden and lacking in basic infrastructure.

The set aside funds should continue to be available for technical assistance activities, with new emphasis to providing those activities in under served and heavily impacted communities. These funds should also be made available to support national and regional efforts to educate consumers about treatment options and access to care.

The legislation should ensure that those funds set aside for evaluation and administrative activities related to the Ryan White CARE Act are made available primarily for that purpose within the administrating agency.

The legislation should retain the current $25 million cap on spending for SPNS programs, with consideration to allowing the remainder of the 3% to be made available for the activities described above.

All aspects of appropriations for the Ryan White CARE Act should be subject to the set asides specified at the same level.

Rationale/Background:

At the present time, the set asides (1% for technical assistance, 1% for evaluation, 3% for SPNS - up to $25 million) are used to fund a variety of activities. This proposal would continue that system with some refinements.

Perhaps the biggest change would be to give HRSA authority to distribute such funds to support infrastructure development in under served communities, including ability to provide limited support to physical infrastructure development when necessary (for example, to retrofit a building to become a primary health care clinic when no suitable clinic currently exists). It would also allow the use of the funds for basic start-up activities (legal fees, computers, etc.) necessary to create services where limited infrastructure exists.

Similarly, technical assistance activities should see increased emphasis on supporting the development of care services or improving their delivery in impacted communities with limited expertise. At the present time, direct consumer education has no particular funding home within the Ryan White CARE Act - this important activity should be specified in the legislation.

As the HAAC has continually noted, there are huge evaluation and administrative needs related to the CARE Act at HRSA. First priority for use of those funds must be for these essential activities before supporting other less directly related HRSA activities.

The $25 million cap on SPNS allows sufficient funding for this program without taking too much out of the Titles of the CARE Act.

These taps should be evenly distributed across all parts of the Act, and no program or area should be made exempt. Any such exemption would place undue burden on other important service delivery funds.

Ryan White CARE Act

10/7/99

Earl

Economics
Demographics
Policy decisions by outcomes

- Planning Council + Consortia
  - medical care - hub
  - support services - spokes
  - getting people into care

  S/A treatment svcs
  Tails

- Title I + II → early intervention services
  outreach + counseling

- Quality of care
  - establish direct relationship between services + care
  - quality assurance activities

Capacity Building
- new activities
- develop + enhance networks
- small grantees
- Title III - non-EMA areas
  - more focused on medical care
  - expand eligibility for non-profits w/ links to health care providers
  - independent review of allocation formulas (IOM?)

timing

Hal

- 200-250,000 HIV+, know it, not in care
- poor, minority - lacking infrastructure

→ composition of planning councils
→ 2-year cycles with mid planning
→ connection to KYS / IMPACT ✓
→ drug tx

→ nursing

→ ADAP wks → insurance
→ leverage

AETCs →

→ youth

→ Dental

→ NVP

2° prevention ✓