

# RYAN WHITE EXTENSION ACT OF 2009

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## HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED ELEVENTH CONGRESS FIRST SESSION

SEPTEMBER 9, 2009

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## RYAN WHITE EXTENSION ACT OF 2009

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TUESDAY, SEPTEMBER 9, 2009

HOUSE OF REPRESENTATIVES,  
SUBCOMMITTEE ON HEALTH,  
COMMITTEE ON ENERGY AND COMMERCE,  
*Washington, DC.*

The subcommittee met, pursuant to call, at 11:07 a.m., in Room 2123, Rayburn House Office Building, Hon. Frank Pallone, Jr., [chairman of the subcommittee] presiding.

Present: Representatives Pallone, Dingell, Eshoo, Engel, Green, DeGette, Capps, Harman, Barrow, Christensen, Castor, Sarbanes, Murphy, Sutton, Waxman (Ex Officio), Deal, Whitfield, Shimkus, Pitts, Burgess, Blackburn, Gingrey, and Barton (Ex Officio).

Staff Present: Naomi Seiler, Health Policy Analyst; Camille Sealy, Legislative Fellow; Alvin Banks, Special Assistant; Miriam Edelman, Special Assistant; and Chad Grant, Minority Legislative Analyst.

### OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. The subcommittee will be called to order. We are minus a gavel today, but I don't think we really need it. Let me announce this morning that the hearing this morning is on the Ryan White CARE Act of 2009—actually a discussion draft. So we don't have a bill number. I will recognize myself initially for an opening statement. This discussion draft has been circulated by Chairman Waxman and myself and is based, in large part, on the community consensus document that was put together by a large number of AIDS groups from all across the country. Though we will be using this discussion draft as a basis for our hearing today, it is very much a draft, and I am interested in having conversations with the minority as well as with the Senate in an effort to come up with a strong piece of legislation that can be passed by both Chambers and be signed into law by the President. The Ryan White CARE Act, as many of you know, was named after a young boy who contracted the AIDS virus from a blood transfusion and sadly lost his life to this horrible disease.

Since his death in 1990 we as a Nation have made great strides in preventing and treating HIV/AIDS in large part due to the Ryan White program. Once a guaranteed death sentence, an HIV or AIDS diagnosis today means a complicated and expensive mix of drugs and therapies that can allow individuals to live longer and more prolific lives and, for many, new knowledge of the disease has

allowed for better and more targeted prevention programs that have slowed the spread of HIV/AIDS. In spite of these advancements, however, there are nearly 40,000 new HIV/AIDS infections reported each year, and according to the CDC, approximately 1.1 million Americans are currently living with the disease. Since the beginning of this epidemic, an estimated 580,000 Americans with AIDS have died. So I think it is more crucial than ever, given the high number of Americans suffering from the disease, that we have the Ryan White program, accounting for roughly 10 percent—or I should say 19 percent of all Federal funds that are used on HIV/AIDS care, the program provides treatment and support services to individuals and families living with the AIDS virus and serves over half a million low-income Americans.

The program is, without a doubt, extremely vital in our battle against this epidemic. In 2006, Congress reauthorized the Ryan White program and included a sunset provision that will eliminate the program entirely on October 1 of this year. I think I am pretty certain in saying that no one in this room today wants that to happen. That is why Chairman Waxman and I have released the draft legislation we are examining today. The discussion draft before us is based on the community consensus document and would make a few minor improvements to the Ryan White program. It eliminates the sunset provision so that we will never face a last-minute scramble to sustain vital services to our communities. In addition it would extend the current program for 3 years and provide more flexibility for the appropriators to adequately fund the Ryan White program to best serve the evolving needs of patients, families and communities.

The discussion draft extends the exemption period for States that are still reporting their HIV cases under a code-based system that will allow those States to get their names-based systems fully up and running and to ensure their data is accurate and useful. In the same vein, it would also ensure that no transitional grant area, or TGA, would lose their status for the duration of this extension. It would continue to hold harmless provisions that were established during the 2006 reauthorization which protects grantees from large increases in funding so that we don't disrupt the provision of care to patients. We have also included a few more technical tweaks to the current Ryan White program, all of which guarantee that patients continue to be able to access these life-saving and life-sustaining treatments and services.

As I mentioned before, the Ryan White CARE Act is scheduled to sunset on September 30. So we must act now to ensure that the patients continue receiving the excellent care that this program provides. And I sincerely hope that we will be able to work in a productive, bipartisan, bicameral fashion to create a bill that will benefit over a million citizens fighting this disease in the United States. And I want to thank the AIDS community for their hard work in coming together on the consensus document. We greatly appreciate the work you have done. I will now recognize—well, Mr. Deal isn't here, so I have my colleague from Kentucky acting as the ranking member today. Mr. Whitfield is recognized.



**OPENING STATEMENT OF HON. ED WHITFIELD, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF KENTUCKY**

Mr. WHITFIELD. Chairman Pallone, thank you very much for holding this hearing on the discussion draft to reauthorize the Ryan White legislation. All of us are very supportive of the Ryan White program. And back in 2006 we were happy to work in a bipartisan manner to reauthorize that program for 3 years. We do take you at your word today to work with us in a bipartisan way as we move forward to reauthorize this draft. And I might say that while we love this program and we recognize the benefits of this program, I have two particular areas of concern. Number one, in the discussion draft we authorized such sums as necessary for 2010, 2012.

When you consider the financial condition of our country right now, our constituents and practically every economist from every spectrum are very much concerned about the size of our debt. So number one, we spent about \$2.2 billion on this program last year, and another reason that I really have concern about the open-endedness of this is that we have a tendency—not necessarily this committee, but I think all committees have a tendency of relinquishing more and more authority to appropriators. And that is precisely what this legislation does, such sums as necessary.

So I think we would be better you have putting in a number that we authorize for the two reasons that I have mentioned. I would also say that another area that I am concerned about is the grandfathering of these transitional grant areas. There are requirements that must be met for the transitional grant areas to receive money. And under this discussion draft, if you had an area that was receiving grant money for the last 3 years, then they would automatically be grandfathered for another 3 years. It certainly is possible that the need may be greater in some other area.

So those are two areas that I particularly am concerned about. But once again, we are delighted that you are holding this important meeting on the discussion draft, and we hope that we can work with you and reach a consensus on this legislation and get it reported out of committee. Thank you very much.

Mr. PALLONE. Thank you. I recognize the chairman of our full committee, Mr. Waxman.

**OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

Mr. WAXMAN. Thank you very much, Mr. Chairman. Since its inception in 1990, the Ryan White program has played a critical role in addressing this country's AIDS/HIV epidemic. Today more than half a million Americans rely on the program for basic care, treatment and support services. It is hard to imagine how patients, their families and our States would be able to deal with the epidemic without this program in place, which is why it is so important that we act as quickly as possible to reauthorize the program.

With today's hearing, we begin that process, which I hope will culminate in a piece of legislation that Members from both sides of the aisle can strongly support. I believe the discussion draft we

are reviewing today makes for an excellent start towards that end. It contains no major changes to the program. Indeed, most of its sections either extend existing policies or clarify parts of current law that have caused confusion.

Others make changes to mitigate the stabilizing funding decreases that have resulted from the application of the 2006 reauthorization. We will hear more about these specific provisions from our witnesses today. I think an overarching theme that will emerge is that with some relatively plain fine-tuning, the Ryan White program can continue to do its good work, providing services to those most in need for another 3 years. This is especially important because of the program's looming sunset deadline of September 30. A quick reauthorization will give grantees the stability they need to plan, retain staff and maintain lifesaving services for their clients. The painful budget cuts that we are seeing in so many of our States make it all the more important to provide that stability. That said, I want to underscore the word "draft" that is in the title of the document that is the subject of today's hearing.

This draft was informed by technical assistance from the administration as well as a community consensus paper that has been endorsed by nearly 300 organizations in 47 States. But this is just a starting point. We have already begun talking through various issues raised in the draft in a bipartisan fashion. Soon we will begin negotiations with our colleagues in the Senate with the commitment to doing our best to reach an agreement before the end of this month. That will take much hard work, but I believe we can get there. We simply have to.

The people who depend on the Ryan White program for the services they need can't wait. I look forward to working with all our colleagues on this committee in ensuring that we reach this goal and that an even stronger Ryan White program will be in our communities for another 3 years. Thank you, Mr. Chairman.

[The prepared statement of Mr. Waxman follows:]

**Chairman Henry Waxman  
Opening Statement on Ryan White Extension  
Legislative Hearing  
September 9, 2009**

Since its inception in 1990, the Ryan White Program has played a critical role in addressing this country's AIDS/HIV epidemic. Today, some half a million Americans rely on the Program for basic care, treatment, and support services. It's hard to imagine how patients, their families, and our States would be able to deal with epidemic without this program in place.

Which is why it is so important that we act as quickly as possible to reauthorize the Program. With today's hearing, we begin that process which I hope will culminate in a piece of legislation that Members from both sides of the aisle can strongly support.

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That will take much hard work, but I believe we can get there. We simply have to – the people who depend on the Ryan White Program for the services they need can't wait. I look forward to working with all of our colleagues on this Committee in ensuring that we reach this goal and that an even stronger Ryan White Program will be in our communities for another three years.

Mr. PALLONE. Thank you, Chairman Waxman. Next, the gentleman from Pennsylvania, Mr. Pitts. He waives. The gentleman from Texas, Mr. Burgess.

**OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A  
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BURGESS. Thank you, Mr. Chairman. You know, with all the focus on health care reform in Congress right now, the Ryan White CARE Act probably isn't foremost on the minds of Americans. In fact, probably many of our colleagues aren't even aware of what the CARE Act is, and what it does. You know, in an ideal world, we wouldn't have the CARE Act because we would have already found a cure and we would already have a reliable vaccine for this disease and prevent it before it occurs.

And that still needs to be our foremost thought and our ultimate goal. I understand how dangerous HIV/AIDS is and how important it is to have adequate resources to prevent infection and to manage this disease. Over a million Americans are infected, and nearly a quarter of those individuals are unaware that they carry the infection and are thus at risk for continuing the spread. My home State of Texas is consistently in the top five with respect to the number of HIV and AIDS infections.

I represent a district in north Texas that has been experiencing a rise in new cases. The face of AIDS has changed and we have a responsibility to ensure that the CARE Act is meeting the needs of those AIDS patients today. In the State of Texas, almost half of all HIV and AIDS infections are occurring in the African American population. The average HIV rate per 100,000 population for Tarrant County, one of my counties, is three times greater in the African American community than in other communities. In fact, HIV infections are increasing throughout the south. We saw a spike of AIDS cases in the mid 1990s and a decline in the late 1990s and now the rates have begun to increase again and climb ever upwards.

In fact, Mr. Chairman, if we look at the way the Ryan White CARE Act is structured, it is also important for me to ensure that my constituents in both rural and urban areas be equally served by this act. The committee has made some important changes in the legislation, passed in a bipartisan manner out of this committee in 2006. Unfortunately, some of those changes never made it into law, and I hope we simply don't kick the can down the road and we invest the time necessary to really create the Ryan White CARE Act for the 21st century. I am saddened that it appears we are preparing to just push through a bill.

We have proven just a few short years ago that this is an issue that Republicans and Democrats can agree on and can come together on. Congress has the opportunity to provide a better health care delivery system, moving from a palliative care model to a blended chronic care model that recognizes HIV as an increasingly manageable disease.

And again, let me stress we need sufficient funding for vaccine research. We need sufficient funding about actually finding a cure. No one, no one should be come out on the short end of the stick because of where they live because Congress simply decided to rush

something through. If we really care about this population we will focus on patients, focus on patients and make time, make sure that we take the time to work across the aisle to produce such a bill. Thank you, Mr. Chairman. I will yield back the balance of my time. Mr. PALLONE. Thank you. Chairman Dingell.

**OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN**

Mr. DINGELL. Good morning, Mr. Chairman. And thank you for holding this important hearing. I also want to thank today's witnesses for joining us. I wish to applaud the National Alliance of State and Territorial AIDS Directors, the AIDS action and other members of the Ryan White Working Group. Your year-long cooperation and collaboration and consensus and priorities from the HIV/AIDS communities will make our work easier. Today is an important hearing for many reasons. The first is the importance of the subject matter. The second is the fact that the Ryan White program will expire on September 30 this year.

That means we have a deadline against which we must work. We cannot let this program expire. Since 1990, the Ryan White program has been one of the most important pieces of our domestic response to the HIV/AIDS epidemic. It funds health care and support services for persons living with AIDS and HIV. The dollars spent here help over half a million people every year. As a payer of last resort, the Ryan White program is a critical piece of our social safety net, protecting some of our most vulnerable citizens, including more than 13,000 people living with HIV/AIDS in my home State of Michigan alone.

I would also note that this is a program which is a very important defense to our society against the transmission and the expansion of the AIDS virus further into our society. According to the Kaiser Family Foundation, most of the patients who receive services from the Ryan White funds are low income. About 72 percent have incomes at or below the poverty level, 33 percent are without insurance, 56 percent are underinsured. I am working hard to make sure we pass this important health care reform this year so that no American goes without insurance.

However, even after all the proposed insurance market reforms go into effect, we will need extra funding for wraparound services that meet the specific needs of HIV/AIDS patients. The Ryan White program also helps to keep the doors of community health clinics open to people with HIV/AIDS that have no place else to turn.

During our health care reform discussions, we have talked at length about the value of the medical home model that provides continuous coordinated and comprehensive care to individuals. Many of these HIV/AIDS clinics have been operating as medical homes before we even had the terminology and have been doing so with Ryan White funds.

Finally, this program is vital to our States and metropolitan areas. Without Federal funding for the Ryan White programs, States and localities will be left on the hook for a substantial portion of HIV/AIDS care and the society will be greatly increased in the risk that it faces from HIV/AIDS.



We cannot pass the burden on to the cities and the States and the communities, especially in the midst of calamitous budget shortfalls that they all confront. I urge my colleagues in this room to work collaboratively and unfortunately with great swiftness to ensure that we meet the September 30 deadline and to minimize the disruption of funding and services for people living with HIV/AIDS.

This program is too important to disappear and the dangers of letting that happen are far too great. I thank you, Mr. Chairman. I yield back the balance of my time.

Mr. PALLONE. Thank you, Chairman Dingell. Next is the gentleman from Georgia, Mr. Gingrey.

Dr. GINGREY. Mr. Chairman, I will waive an opening statement.

Mr. PALLONE. The gentleman from Illinois, Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman. I would like to say to my colleagues, welcome back from our break. It is good to be here. And I look forward to a productive fall. This is a good start. Ryan White is supported, as was stated by many, by a bipartisan group of Members. I am not falling in the category that we have to move quickly or rapidly. I think we are learning that that is not always the best way to deal with public policy. We could do a simple reauthorization with no changes. Unfortunately we are falling down also the same trap as addressing draft bills, and I hope that if and when after this hearing we hear changes and corrections that we—in a bill finally gets submitted, that we would have a legislative hearing on the bill. It has been the history of this committee to do that. It hasn't been the current history of this committee to do that. So we are kind of back where we started from before the break, having hearings on draft legislation instead of real legislation. And I hope we change course with that. I am happy to be back and happy to see all my colleagues. And I yield back the balance of my time.

Mr. PALLONE. I thank the gentleman. The gentleman from New York, Mr. Engel.

**OPENING STATEMENT OF HON. ELIOT L. ENGEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK**

Mr. ENGEL. Thank you, Mr. Chairman, for holding this important hearing on the Ryan White CARE Act reauthorization. The Ryan White CARE Act holds very special significance to my State, New York, we are, unfortunately, home to 16 percent of the Nation's AIDS population. And so New York remains the epicenter of the HIV/AIDS crisis. New York has nearly 120,000 residents living with HIV/AIDS, and our State and cities have been proud to partner with the Federal Government in providing care for many of these individuals. New York State receives more than \$300 million in Ryan White funds under all parts of this Act to provide a range of health care and support services. Through Ryan White programs, 22,000 uninsured New Yorkers receive medications and ambulatory care services, and thousands more receive other essential services such as mental health, case management, nutrition and treatment and support services.

These individuals must be guaranteed uninterrupted access to these vital services. It is critical that Congress act swiftly on the reauthorization of the Ryan White Reauthorization Act, which nationwide provides lifesaving medications, health care and support services to over half a million people. As you know, unlike most reauthorizations, Congress inserted a sunset provision into the Act in 2006, requiring congressional action by September 30 of this year, 2009. Without action, this important program will be terminated and care will be jeopardized.

While 3 years ago, this reauthorization was the subject of much disagreement and dissent—and I remember because I was in the middle of it—we are in a different place today. Fortunately, Members on both sides of the aisle and more than 250 organizations in the U.S. have worked hard over the past year to develop legislative principles where there is much agreement. The committee draft proposal is for a 3-year reauthorization of the Ryan White HIV/AIDS Treatment Modernization Act. While some might ask why we again are working to reimplement relatively short reauthorization, there is good reason. The 2006 reauthorization took effect in 2007 and included several significant changes that have not yet been fully implemented or assessed. In addition, greater policy discussions likely to impact the program such as the development of a national AIDS strategy and broader health care reform are underway. Indeed, the health reform legislation that we are continuing to develop once fully implemented will have a profound effect on our ability to provide access to health care and prevention services to individuals with HIV/AIDS nationwide.

As currently drafted, we will reform the private insurance market and end the practice of excluding beneficiaries for pre-existing conditions. We will reform Medicaid by allowing early treatment for individuals with HIV before they are disabled by AIDS in the first 3 years of enactment and will, in fact, expand the Medicaid eligibility to cover low-income childless adults.

I am proud of the work I have done with you, Mr. Chairman, and others to ensure that. Long term we will create exchanges for the purpose of insurance with subsidies for low-income individuals; and finally, we will close the Medicare Part D donut hole over time. While these are significant changes in the health care delivery system, we will still need the Ryan White program, which remains the payer of last resort, to address unmet needs and services, particularly over the next 3 years.

In conclusion, Mr. Chairman, I want to commend you. I want to commend you for the draft bill which addresses many of the points raised in the community consensus document as well as the specific concerns of my home State. While there are some issues related to rebates and grant funding that I will continue to work with the Chairman on prior things to mark up, I support the draft bill and look forward to the discussion today. Again, Mr. Chairman, I want to emphasize our thanks to you, because you have been such an important integral player in this and have been so supportive that we really need to publicly thank all the work you have done. I yield back.

Mr. PALLONE. Thank you. The gentlewoman from Tennessee, Mrs. Blackburn.

**OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE**

Mrs. BLACKBURN. Thank you, Mr. Chairman. I appreciate the hearing that we are having today and want to welcome our witnesses. In 2006, my colleagues and I passed what I think was a thoughtful bipartisan reauthorization of the Ryan White CARE Act. The reauthorization has proven very successful in the Tennessee HIV/AIDS community and has assisted more than 7,800 low-income Tennesseans with medical services, medications, dental service, drug abuse, mental health and related health care needs. The Ryan White program provides an important safety net in assisting the underinsured in keeping health insurance and provides care to the uninsured. The program reinforces the fact that keeping people on private insurance provides great benefit to the individual and to the community. We have seen success with this program. As we move forward with the Ryan White reauthorization, it is imperative that this committee work in a bipartisan manner to best serve the recipients of this program and to meet their needs. Congress needs to be good stewards of Federal funds. Our constituents—if we have learned anything in August, what we have learned from our constituents is that they see it as an imperative, and so should we, that we be good stewards of the Federal funds and that we place appropriate funding and spending limits in place and not open-end those authorizations. Access to care is one of the biggest concerns among my constituents.

There are real problems in health care, but what we know is replacing private care with a government bureaucrat won't increase access and it will not fix our health care system. In Tennessee via the TennCare program, we have learned that lesson the hard way. My constituents also want us to spend less money to fix the problems that exist in health care, and my colleagues on this side of the aisle have joined me in offering plans for doing that. My constituents are telling us repeatedly that they do not want another \$800 billion in higher taxes for a government-run plan that is not going to make health care better or cheaper or more available. They realize that there are issues that need to be addressed. Just as they realize there are programs that have worked in a bipartisan manner, and as we look at the Ryan White CARE Act, which has worked when appropriately addressed, my hope is that we are going to begin to start forward on a new path and that we will approach these issues working together in this committee. I thank the Chairman. I yield back.

Mr. PALLONE. Thank you. The gentlewoman from California, Ms. Harman.

**OPENING STATEMENT OF HON. JANE HARMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

Ms. HARMAN. Thank you, Mr. Chairman. I choose to be an optimist, and I think the fact that this committee is basically together on the importance of the Ryan White Act may be a good omen for the health care fights in the next few weeks. It is crucial that we stay together on this cause and that we consider carefully the discussion draft which will be part of a hearing today—we are having

a hearing in this committee—and resolve quickly what changes we want to make to that draft and enact it, hopefully on a—report it hopefully on a bipartisan basis. When we talk about HIV and AIDS, it is easy to forget the very human face of the disease. It has had a profound impact on the lives of many of my constituents and friends, and I am sure everyone on this committee can tell stories like this. But one of them was particularly well known. Elizabeth Glaser touched my life deeply. She contracted AIDS in a blood transfusion which she got giving birth in 1981, and unknowingly transmitted the virus to that child and to her subsequent child. When she became deathly ill with the disease, she dedicated her life to raising awareness of pediatric AIDS, and a foundation bearing her name raises millions of dollars to help others.

So it is with Elizabeth in mind that I urge prompt action on the discussion draft. This program provides critical medical care and support services to people with HIV/AIDS across the country, and it is especially important to metropolitan areas like Los Angeles County which has the second highest number of HIV/AIDS patients in the country. Ryan White spends about \$35 million a year to help provide 25,000 Angelinos with care. The program is truly a safety net. It is a payer of last resort. So it only picks up the costs after other sources of funding are exhausted. It helps the neediest patients, as has been pointed out. A third of them have no insurance and more than half are underinsured. In the current economic climate, this care is absolutely a matter of life and death. Faced with a budget shortfall, California was forced to cut some of its funding for HIV/AIDS; and moreover rising unemployment and the growing ranks of the uninsured means more and more people are turning to this program for help. I will skip the examples. We all know what they are. For all the good it does, Ryan White comes at a relatively low cost. It represents less than 10 percent of Federal HIV/AIDS spending. I strongly urge that we pull together on a bipartisan basis and do the right thing and that is to enact the discussion draft I think close to its present form, but if small changes are needed to be made, let's make them on a bipartisan basis and get on with it. I yield back the balance of my time.

Mr. PALLONE. Thank you. The gentlewoman from Florida Ms. Castor.

**OPENING STATEMENT OF HON. KATHY CASTOR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA**

Ms. CASTOR. Chairman Pallone, thank you very much for convening this timely hearing to address the discussion draft that will reauthorize the Ryan White initiative. I look forward to the expert testimony today. We must act expeditiously because we are facing sunset and so many of our neighbors living with HIV and AIDS are depending on us. In my home State of Florida, the Ryan White initiative has prolonged the lives of many men and women affected by this devastating disease. In 2004, Ryan White assisted well over 100,000 patients and nearly 13,000 family members of people living with HIV and AIDS, and those numbers unfortunately continue to rise. The stories of the impact that the Ryan White initiative has had on my neighbors exemplify the strength of human nature to persevere and to meet adversity head on.

I would like to share with you two short stories from back home in Florida, stories that display the life-changing impact that Ryan White has had on many lives. Christopher from Florida says, I was diagnosed with HIV back in the summer of 2000 and I was fresh out of college with no health insurance. It was only through government-assisted programs that were funded largely by the Ryan White initiative that I was able to have checkups and blood work done. I was a patient at Pinellas Care Clinic in St. Petersburg, Florida. I have since begun working and have had insurance for 4 years but could not have gotten through those 5 years without the assistance of the Ryan White initiative. Mary from Florida relayed to me, I have lived with HIV/AIDS since 1990. When I became ill in December 2008, I had to leave my part-time job. With copayments on medications and medical visits, I was at the point of choosing to eat or stop taking medical services. After contacting a Ryan White case management agency, I was helped out with financial assistance.

I can honestly say if Ryan White had not been in place, I believe I would be dead. There are many like myself here in the United States who need just a little help to continue to be productive members of society. Mr. Chairman, the Ryan White initiative is the only true lifeline for many people living with HIV/AIDS, many of whom are oftentimes barred from private health insurance. So I strongly urge the committee to move quickly to update and reauthorize Ryan White before the September 30 sunset date. I yield back my time.

Mr. PALLONE. Thank you. The gentleman from Texas, Mr. Green.

**OPENING STATEMENT OF HON. GENE GREEN, A  
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GREEN. Thank you, Mr. Chairman, for holding the hearing today on the discussion draft of the Ryan White CARE Act. Since its establishment in 1990, the Ryan White CARE Act has delivered much needed funding to States and urban areas with large numbers of individuals living with the AIDS virus. More than half of the Americans living with AIDS live in five States: New York, California, Florida, New Jersey and my home State of Texas. Unfortunately in my State of Texas, the number of individuals living with HIV and AIDS increased in the last 10 years. With two eligible metropolitan areas and three transitional grant areas in our State, Texas relies on Ryan White dollars to provide quality life-prolonging care to Texans living with HIV and AIDS. In fact, Ryan White funding helped to provide critical care and support services to more than 18,000 in 2006. My hometown of Houston is currently the eighth largest EMA in the Nation with approximately 10,000 individuals living with AIDS, according to the CDC statistics. In the community of Harris County, our hospital district utilizes more than \$26 million each year to coordinate essential health care and support service. There are 21,000 individuals in our community living with HIV and AIDS. The importance of the program cannot be underestimated. Without CARE Act funds many Americans living with HIV and AIDS would have no other source for treatment. The last time we reauthorized the CARE Act in 2006, we had quite a battle. And I am pleased nearly 300 HIV/AIDS groups came to-

gether across the U.S. to give this committee unified recommendations on the provisions to be included in the reauthorization of this bill. Many of their recommendations have been addressed in this draft. Our office has been in contact with several local HIV/AIDS organizations to ensure Texas will continue to be able to access the critical care services provided by the CARE Act in this draft and we look forward carefully at several provisions in the draft.

Texas was held harmless in fiscal year 2009. Its base funding was held at 95 percent of 2006 levels even though the award would have declined more if based solely on case counts. Section 5 of the discussion draft allows a hold harmless funding to continue and eliminates the need for repeated legislative action by including this funding in the baseline appropriations request.

We heard from groups in Texas about the need to include a fix for ADAP rebates and unobligated funds. Section 6 and 7 of the discussion draft takes steps to ensure that States will give some flexibility with unobligated funds from its program. Unobligated funds must be returned unless a waiver is granted, but the ability to have some flexibility in the section is important. Thus far, the committee has been working on a bipartisan basis on the discussion draft, and I hope we will continue to work together and quickly move the Ryan Act reauthorization out of our committee.

As we know, the current legislation expires September 30, so we have a very limited amount of time to ensure funding continues to this program. I yield back my time.

Mr. PALLONE. Thank you. Our vice chair, the gentlewoman from California, Mrs. Capps.

**OPENING STATEMENT OF HON. LOIS CAPPs, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

Mrs. CAPPs. Thank you, Mr. Chairman. I am very pleased that the subcommittee is meeting on this very important subject. I thank the panelists in advance for being here today and for the testimony you will be giving. The reauthorization of the Ryan White CARE Act is a critical issue for this committee, for the HIV/AIDS community and indeed for our entire country. I look forward to a productive discussion today about how we can focus on the ways we can strengthen the CARE Act so that it continues to meet the health needs of persons living with the HIV disease and their families, especially as they are living longer, which is a good thing.

This issue is especially important to my home State of California, as my colleagues who are from the same State are here as well, which has the second largest disease burden in the United States and a significant number of new cases each year, particularly amongst the Latino population. As you know, California is experiencing a severe budget crisis. State AIDS funding has been drastically reduced. My constituents and all those affected across the State need this assistance from Ryan White more than ever. Too often their livelihood and that of their families depends on this care. I want to associate myself with the remarks of my colleague from Texas, Dr. Burgess. As one who also represents portions of a rural area, three mid-sized counties on the central coast of California, I am concerned funds are disproportionately assigned to more urban areas.

I represent the main source of HIV services between Los Angeles and San Francisco, and I want to ensure that central coast providers have what they need to provide resources. September 30 will be here before we know it. We must act now to reauthorize this legislation. I am interested to hear from our panelists today about how we can work together, and we can work together in a bipartisan way I believe on this committee to ensure that the thousands of members of our HIV community in California and across the country continue to receive health care and support services. Thank you for your testimony. I look forward to hearing it. I yield back.

Mr. PALLONE. Thank you. The gentlewoman from California, Ms. Eshoo.

**OPENING STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

Ms. ESHOO. Thank you, Mr. Chairman, for holding this hearing today and for your leadership on this issue, which is such an important one to people across the country in every single community that have been diagnosed with HIV/AIDS and what the Ryan White CARE Act represents to them. It is a very, very important effort that has worked. It has received bipartisan support from the Congress. It has provided billions of dollars and most importantly, it has helped to not only improve lives, save lives but extend lives of our fellow citizens.

So I am pleased that this reauthorization is a priority for the committee, obviously, as it is for me. When we reauthorized the Act 3 years ago, I thought that the legislation failed to uphold the tradition of the original legislation because it created a system of what I termed winners and losers in the allocation of Federal resources. At that time, I offered an amendment in committee with several of my colleagues from the California, New York and New Jersey delegations to increase the overall authorizations in the bill and to extend the hold harmless provisions of the bill by 2 years to ensure that the historic epicenters of the disease do not experience precipitous declines in funding levels from year to year.

Unfortunately, our amendment was defeated by a single vote. Now this sounds like the old formula fights which brings out, I guess, maybe in some ways, the worst in Congress, but they are fought really hard. But there is a human face to this; and so if the funding is not at the appropriate levels and distributed appropriately, there are human beings that fall through the net and they are hanging on as it is. If not for the stop gap funding during the past two appropriations cycles and the fiscal year 2010 bill, my district and very importantly, the State of California, the largest in the Nation would have lost millions of critical dollars to help those living with AIDS and HIV and who were the most in need.

So I look forward to reauthorizing this bill at appropriate funding levels, including the hold harmless provision, so that States will not experience destabilizing shifts in funding from year to year. People can't live that way, and so the funding should not be set up that way. My thanks to the witnesses that are here today

for your incredible work that I think our entire country is grateful to you for.

Thank you again, Mr. Chairman, for bringing this up, and I look forward to a really solid, fair, well-funded bill so that all of the promise that Ryan White CARE Act holds will really reach all the people that it was originally intended to. Thank you.

Mr. PALLONE. Thank you. The gentleman from Maryland, Mr. Sarbanes.

**OPENING STATEMENT OF HON. JOHN P. SARBANES, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND**

Mr. SARBANES. Thank you very much, Mr. Chairman. It is a privilege to be able to consider this bill today. And thank you for bringing the draft to us. This is an absolutely critical reauthorization that we are considering. You know, nothing says more about who we are as a Nation than the way we step forward and respond to the needs of those who are living with HIV and AIDS. So this Ryan White CARE Act and the reauthorization of it is critical to who we are as a Nation. It bears repeating. I think Congressman Green mentioned this, but there are nearly 300 organizations across the country who have worked together to form a consensus about what the recommendations should be and what should be included in this reauthorization.

I want to salute every single one of those organizations for their work. That is an incredible level of advocacy and collaboration. It is why we are able to move this kind of legislation forward and it represents the best in terms of partnership between advocacy groups and people who are on the ground dealing with issues out there and those of us who are in Congress trying to respond. We are on a tight timeline, of course that has been alluded to. My hope is that we can work in a bipartisan fashion to get this legislation done so that we don't hit this hard sunset that we are concerned about. I think that can happen, and obviously starting right today as we begin our September business, starting with this issue puts us on the road to getting that done by the end of September.

I do want to mention that Maryland has been hard hit by HIV and AIDS, Baltimore in particular, which is part of my district. There are some tremendous organizations throughout the State and in the city of Baltimore who have been working for many, many years to address these concerns. There is a group here today, Life Link, and actually I would like you to raise your hands just so people can see how many of you are out there. That is the kind of advocacy that has brought forward this kind of legislation, and I want to salute everybody who made the trip over to be at this hearing. I look forward to the testimony of the witnesses. I look forward to moving this bill in a timely way, and I yield back my time.

Mr. PALLONE. Thank you. The gentlewoman from Ohio, Ms. Sutton.

**OPENING STATEMENT OF HON. BETTY SUTTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO**

Ms. SUTTON. Thank you, Chairman Pallone, for holding this important hearing on the reauthorization of the Ryan White CARE



Act. Since it was passed in 1990, the Ryan White CARE Act has provided critically needed help to States and communities to provide treatment and services for individuals stricken with HIV and AIDS. This legislation, as we have heard, provides Federal funds to cities and States to ensure that necessary medical HIV and AIDS treatment can be given to all individuals, regardless of their race, age or social standing. We should be clear, Mr. Chairman, that AIDS is still epidemic in this country. According to the District's HIV/AIDS Administration in Washington, D.C., a reported 3 percent of District residents right outside of these committee doors are living with HIV and AIDS.

As a matter of perspective, in this one city alone, that rate is higher than in West Africa. But we have a chance this month to offer continued protection to one of our Nation's most vulnerable populations, those living with HIV and AIDS. Those who are stricken with HIV and AIDS often live in urban areas and have trouble accessing the health care system.

In 2008, Ohio ranked the 14th highest among the 50 States in cumulative reported AIDS cases. One of the hardest hit areas of the State is Cuyahoga County, part of which I represent. And last year there was a decrease in the number of new AIDS cases in the county, and that is good news but we cannot become complacent. Unfortunately in 2008, the county saw a slight increase in new HIV cases, and the disease continues to take a disproportionate toll on minority populations. While African Americans make up 29.3 of the Cuyahoga County population, they make up 56 percent of reported persons living with HIV and AIDS in the county. The Minority AIDS Initiative was created in 1998 by Congress and the administration to address this very problem.

The minority AIDS initiative has been a positive program and I look forward to hearing the results of the GAO report on this subject. We must continue to give our States and communities the funding they need to help those who have the disease. We must also increase education and outreach to prevent the spread of HIV and AIDS. The discussion draft we will review today makes some important changes that will strengthen the Ryan White CARE Act, and I am proud that the HIV and AIDS care community of Ohio supports this legislation and the discussion draft. I look forward to the testimony. I thank all of you who are here and for the work not only that you are here to do in this committee room, but I know that you are throughout our communities and our country. I yield back.

Mr. PALLONE. Thank you. The gentleman from Georgia Mr. Barrow.

Mr. BARROW. I thank the Chair. I will waive an opening.

Mr. PALLONE. Thank you. The gentlewoman from the Virgin Islands, Ms. Christensen.

**OPENING STATEMENT OF HON. DONNA M. CHRISTENSEN, A REPRESENTATIVE IN CONGRESS FROM THE VIRGIN ISLANDS**

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. Thank you in particular, Chairman Pallone, for turning to the Ryan White CARE Act as soon as we got back, as you promised in July. This is too important a program to get lost as we battle for health care reform.

The September deadline looms large, and we have to act. Without action before the end of this month, this program, which has been a real lifeline to so many individuals and families in my district and all across our country, would be lost entirely. And that cannot happen. But one thing, I would have preferred to do a continuing resolution that would take us into mid next year and then do a more thorough job of reauthorizing the Act in 2010. There are important decisions and changes to be made to ensure that the benefits of this program reach those most in need and that it is adequately funded. In recent years, programs have been scraping by. ADAP waiting lists have left too many without care, and minority communities have not been developing the capacity we envisioned when we created the Minority AIDS Initiative. I also feel that there are some stakeholders who have not been adequately heard from.

But the Ryan White program is also too important a program to allow it to become a political football in an election year. So after we protect the program from being eliminated, as per the sunset clause that was included in the last authorization, we will probably just have to kick the ball down the road a little longer just to keep the program on life support. But Mr. Chair and colleagues, I hope that this is the last time that we do this because we don't have adequate data, because reporting systems are not mature enough or because we are afraid to make the tough decisions to redirect the funding where it is most needed.

Before I close, I want to remind everyone that people of color are 71 percent of new AIDS cases and 67 percent of people living with HIV and AIDS, that African Americans are the hardest hit, and African American women in particular. So addressing these vulnerable populations must be a central part of Ryan White moving forward. This means a strong Minority AIDS Initiative that provides not only adequate resources but technical assistance and a return to its original intent of building capacity. We also need to address the exploding numbers of hepatitis B and C infections and to do more to stem the spread of HIV infections in incarcerated populations and from ex-offenders into their home communities. I would like to welcome and thank our witnesses today. I hope we can fit in a follow-up hearing from where we can hear from some of the communities most affected by AIDS and the organizations that have been working to serve them. I yield back the balance of my time.

Mr. PALLONE. Thank you. The gentleman from Connecticut, Mr. Murphy.

**OPENING STATEMENT OF HON. CHRISTOPHER S. MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT**

Mr. MURPHY OF CONNECTICUT. Thank you, Mr. Chairman, for holding today's hearing on this discussion draft. And thank you so much to the numbers of advocates, people living with HIV/AIDS and people caring for them are here. It wasn't so long ago where people that were living with the disease, people that were caring for those that had the disease felt pressure to live that life do that work in the shadows. And it says a lot about this Congress and this country and society that you now are at the forefront of advocating

for a strong reauthorization of this law. In Connecticut, this program just has been critical to providing low-income individuals with the medical and support services that they need. Without this funding, millions of Americans and thousands of my constituents would struggle to find that cutting-edge medical service that has been increasingly successful in treating the disease. But to say that the transition through the last reauthorization of the program in Connecticut has been rocky would be an understatement.

Since the 2006 reauthorization, the Connecticut delegation and those responsible for administering the program in the State have gone round and round with HRSA and the court system to ensure that the State's largest communities, in particular, New Haven and Hartford, which both actually exist outside of my district, received adequate funds through the program and were treated fairly through the interpretation of the law. The resulting congressional and legal battles have resulted in favorable treatment for Connecticut. But I am sure it is the preference of everyone involved to ensure that this current reauthorization does not result in the battles of the last 3 years being played out again in Connecticut, in California or in other parts across this country. That is why, along with Representative Eshoo and others on the committee, I am encouraged that the draft legislation provides for the continuation and expansion of the law's hold harmless provisions, well addressing once and for all the need for a continued stop loss funding for jurisdictions that without it could face significant yearly funding decreases. Mr. Chairman, I am thrilled that we haven't wasted 24 hours on our return to Washington in getting started with this reauthorization. I am pleased to be here for this hearing and look forward to the testimony of our witnesses. I yield back.

Mr. PALLONE. Thank you. The ranking member of our full committee, Mr. Barton.

**OPENING STATEMENT OF HON. JOE BARTON, A  
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BARTON. Thank you, Mr. Chairman. I am glad that you are still doing opening statements. I am going to submit my formal statement for the record and just make a few remarks. First of all, I am glad that you are holding this hearing. Congressman Deal and myself brought up the Ryan White Reauthorization Act in the markup on the health care bill back in August. You and Chairman Waxman said that it was something needing to be done. And here we are. So that is good. We have looked at the draft bill. There are some good things in the bill. We like the fact that it is a 3-year reauthorization. That is a good thing, that it is not open ended. There are some bad things, some things—you know, the fact it is open ended in terms of the appropriations, some of the grandfathering provisions.

But having a bill before us, having a legislative hearing, being willing to do this are all good signs. Even though this is an opening statement, my question to you, Mr. Chairman, do you plan and Chairman Waxman plan on moving a bill fairly quickly or is this more of a get-input hearing?

Mr. PALLONE. We do plan to move a bill but not before we get more input from you, from the Republicans, and also from the Sen-

ate. But we realize that we have this October 1 deadline. So we would like to move quickly.

Mr. BARTON. OK. Thank you, Mr. Chairman. And I think I can speak for all the Members of the minority, we are very willing to work in an expedited time frame. We do hope it is an open process and we are allowed to input into the system before the decisions are made. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. I think that concludes our opening statements. So we will move now to our witness. If you will come forward, we have one witness on our first panel who is Dr. Mary Wakefield, who is administrator for the Office of the Administrator, the Health Resources and Services Administration. Did I get that right?

Ms. WAKEFIELD. You did.

Mr. PALLONE. The second person is just there to help, not to testify, I understand.

We, as you know, have 5-minute opening statements. They become part of the record. So I would now recognize you for 5 minutes. Thank you.

**STATEMENT OF MARY WAKEFIELD, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Ms. WAKEFIELD. Mr. Chairman, members of the committee, thank you for the opportunity to appear before you today to address reauthorization of the Ryan White HIV/AIDS program administered by the Health Resources and Services Administration within the Department of Health and Human Services. In addition, I would like to thank the Chairman, members of the committee and their staffs for all of their hard work on this very important legislation. Let me start by expressing the administration's strong support for continuation of the Ryan White program and its reauthorization. It is a key component of our Nation's fight against HIV/AIDS. Before I begin my testimony, I would like to announce that today the Centers for Medicare & Medicaid Services has released a new proposal to cover voluntary HIV infection screening for Medicare beneficiaries who are at risk for infection and for women who are pregnant. Today's proposed decision would allow high-risk Medicare beneficiaries to learn of their HIV status anytime by requesting an HIV screening test and, if necessary, seek appropriate counseling and therapy. I know you will look forward to hearing more about this new plan in the weeks to come as CMS accepts public comments and issues its final coverage decision. The Department of Health and Human Services is committed to helping promote the President's strategy to bring an end to the domestic HIV epidemic in this country, and this new proposal will allow those who may be at risk of infection to find out quickly and early so that they can start getting treatment.

Ryan White provides critical medical care and support services to uninsured, underinsured and low-income people living with HIV/AIDS who have no other source of care. Through HRSA's HIV/AIDS Bureau, grants are awarded to cities, States and local community-based organizations for the purpose of providing primary medical care and support services to individuals living with HIV/

AIDS. I saw this firsthand on my very first site visits as administrator to Ryan White grantees in Chicago and Philadelphia. There I observed the difference these programs make in patients' lives. With this in mind, I would like to talk broadly about the administration's vision for reauthorizing this program.

Since its inception in 1990, the Ryan White program has been providing HIV-related care to a growing number of infected individuals. This year, approximately 529,000 individuals will receive Ryan White services. The program consists of parts A, B, C, D and F, which are differentiated by the types of services rendered and/or by the entities receiving funding.

HRSA recommends a 4-year reauthorization to minimize disruption of funding and services for grantees and clients and to permit time for the implementation of health care reform policies and programs to examine the impact on Ryan White. The administration would also support a 3-year reauthorization consistent with the draft House bill. In addition, HRSA supports the language proposed in the Energy and Commerce draft legislation to eliminate the repeal language that was part of the last reauthorization. Presently, parts A and B grantees are subject to three different penalties if they have unused funds remaining by the end of the grant year. First, barring a waiver for formula funds, grantees must return any unspent formula and supplemental funds to HRSA at the end of the grant year.

Second, grantees with more than 2 percent of unobligated formula funds at the end of the grant year will receive a reduction in their subsequent grant. Third, grantees with more than 2 percent of unobligated formula funds cannot apply for supplemental funds for the subsequent grant year. HRSA encourages amending these penalties for parts A and B grantees because of the financial and administrative burden it places on them. HRSA suggests eliminating the penalty that requires a decrease in a grantee's subsequent grant award by an amount equal to the unobligated balance remaining from the current year's award. The elimination of this provision helps to ensure that grantees will have sufficient funds so they will not have to interrupt service to individuals living with HIV/AIDS.

In addition, HRSA recommends raising the threshold from 2 percent to 5 percent for the penalty. It prevents grantees from receiving supplemental funds when they have unobligated formula funds. Both of these provisions are contained in the committee's current draft, and we are appreciative of their inclusion. HRSA also suggests offsetting future year awards for grants with unobligated balances as opposed to cancelation of the amount. The change from a deobligation to an offset would retain the intent of the law while simplifying penalty administration and expediting the redistribution of funds to other grantees to provide HIV/AIDS care. HRSA supports eliminating the distinction between EMAs and TGAs under part A. HRSA proposes designating part A grantees as EMAs when those grantees have greater than or equal to 1,000 cases of AIDS during the most recent period of five calendar years for which such data are available.

By eliminating the EMA/TGA distinction, the appropriation for part A could be distributed proportionally across all highly im-

pacted jurisdictions based on the number of living HIV/AIDS cases. This suggestion is supported by Energy and Commerce's draft legislation.

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

Six transitional grant areas are at risk of losing their status under part A in fiscal year 2011 due to their inability to meet the definition of a TGA based on AIDS case counts. HRSA is eager to work with you to resolve this issue.

We are over a quarter-century into the HIV/AIDS epidemic. With my background as a nurse and as a nurse educator, I know how important it is for us to train a new cadre of HIV health professionals to replace the first wave of experts that are nearing retirement. We also need a new generation of health care workers to meet the difficult clinical challenges that are emerging in a world where HIV infection, with treatment, is managed as a chronic condition. HRSA suggests implementing a program for AETC participants that provides training of sufficient duration to ensure that new health professionals are appropriately trained to provide HIV care and are strategically placed in areas with high need of HIV medical care.

Finally, HRSA proposes to permit additional time for code-based reporting States to transition to name-based reporting systems for living HIV/AIDS counts, upon which funding is based. Under current law, the exception for code-based reporting will expire at the end of fiscal year 2009 and, as of fiscal year 2010, all jurisdictions must report name-based data. Nine jurisdictions are still in the process of converting to named-based reporting systems. Without an extension, these code-based reporting States will be unable to receive funding after fiscal year 2009, which will disrupt services to patients with HIV/AIDS in those areas. We are appreciative of this being included in the draft legislation.

In summary, I want to acknowledge the dedication of the advocacy community, its work on the consensus document, and its incredible commitment to those individuals with HIV/AIDS. The Obama administration is committed to working with you, with Congress, to reauthorize the Ryan White program and to ensure that critical services continue beyond September 30, 2009. I would be pleased to answer any questions you might have concerning the reauthorization of the Ryan White HIV/AIDS program.

Thank you.

[The prepared statement of Ms. Wakefield follows:]



**STATEMENT BY**

**MARY K. WAKEFIELD, PH.D., R.N.**

**ADMINISTRATOR**

**HEALTH RESOURCES AND SERVICES ADMINISTRATION**

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**BEFORE THE**

**SUBCOMMITTEE ON HEALTH**

**COMMITTEE ON ENERGY AND COMMERCE**

**U.S. HOUSE OF REPRESENTATIVES**

**SEPTEMBER 9, 2009**

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

**Introduction**

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

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



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

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

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

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

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

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

#### **Reauthorization of the Ryan White HIV/AIDS Program**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



Mr. PALLONE. Thank you, Doctor.

We are going to have questions from the members of the committee. Basically, we allow 5 minutes for each member. And I am just going to recognize myself initially.

The Ryan White program is one that OMB has rated as highly effective. And I am sure HRSA will continue its good work in administering it, and I want to thank you for that.

You said that the administration supports at least a 3-year extension. I think you actually mentioned 4, but you could live with 3. Would you tell us why that is the case? In other words, what would be the impact on grantees if we only had a shorter extension, you know, 1 or 2 years? Why are you saying 3 or 4?

Ms. WAKEFIELD. We are asking for a longer reauthorization because we think that it will provide greater stability for the program. And it would also provide us with additional time to evaluate the impact of changes that might be made to the program, and so those changes that would be affecting grantees.

Also, we would have with that additional time more mature names-based surveillance systems in place and time to evaluate the impact of health care reform policies and programs and their implications for Ryan White.

Mr. PALLONE. OK. Well, my second question is about this code-based versus name-based. And I know you mentioned it several times there towards the end of your testimony.

CDC's recommendation to the States is that they collect surveillance data from the States on a confidential names-based basis. But today, all States are in fact collecting names-based data, but their systems are at different stages, as you mentioned. Some have been collecting names-based data for enough years that CDC has deemed their systems mature. Others are still transitioning from earlier code-based systems.

Now, under the current law, States can still report code-based data if their names-based system isn't fully ready to accurately reflect HIV in the State. But how does HRSA account for the fact that code-based data may contain redundancies?

Ms. WAKEFIELD. Well, you are right, there are redundancies in code-based data. And so the way that is accounted for is through a 5 percent reduction that is taken in the counts of the cases, so taken in case counts that are reported from code-based systems. So, 5 percent reduction taken in case counts that are reported through code-based systems.

Mr. PALLONE. Is there any other penalty with regard to these code-based States?

Ms. WAKEFIELD. Yes, there is a 5 percent cap on the increase of a grant award for subsequent grant awards. So, yes.

Mr. PALLONE. Now, have these penalties actually been applied to States that are still reporting, you know, some of the HIV cases as code-based?

Ms. WAKEFIELD. Yes, sir, they have.

Mr. PALLONE. And, I mean, I understand that the penalties help motivate States as they transition to the name-based reporting, and so that is why you have them.

Now, the discussion draft would maintain current law for code-based reporting so the States continue their progress to name-

based reporting, you know, would still be able to progress. But is it your understanding that the eight jurisdictions still using the code-based reporting are making enough progress towards this fully name-based system, or should we be doing something else to encourage it?

Ms. WAKEFIELD. We believe that all States that are still operating with code-based reporting are making the necessary changes and have a commitment to transition fully to name-based reporting.

And, as you indicated, their systems are still in a process of maturing, and those jurisdictions are at different places in the evolution of their systems. But, yes, we are in contact with them, and we feel that they have commitment to continuing forward.

Mr. PALLONE. So you want to continue this policy of having certainly penalties but still allowing them to use the old system, at least temporarily.

Ms. WAKEFIELD. Yes, that is correct.

Mr. PALLONE. OK.

Now, I don't think you mentioned the severity-of-need index. I wanted to mention that. One of the recommendations from the community consensus, and it is also in the discussion draft, is to clarify that HRSA should not yet begin implementation of the severity-of-need index.

The 2006 reauthorization required HRSA to develop an index that could allow for distribution of funds based on concrete factors reflecting need. But tell me a little more about this index. I know you didn't mention it, but I would like to know, you know, what the idea is.

Ms. WAKEFIELD. So, in terms of the severity-of-need index, supplemental grants under parts A and B are awarded to areas and States that submit applications based on the need in the area or State on an objective and quantified basis. Currently, jurisdictions submit applications that are scored through an objective review process to determine level of need and subsequent funding.

At Congress's direction, HRSA contracted with an organization to establish an HIV/AIDS severity-of-need collaboration to develop this index that you are referencing. The collaboration was comprised of a multi-tiered expert body broadly representative of HHS, HRSA staff, national experts, Ryan White program grantees, and consumers.

Based on the Institute of Medicine's recommendations, there were four expert panels that were convened to identify relevant data sources and measures that demonstrate need in terms of area characteristics, patient coverage and need, associated costs, and so on.

The panels then prepared written reports reviewing more than 56 variables and forwarded 19 for inclusion in a draft severity-of-need index. Some of the 19 remaining variables were eliminated for reasons such as lack of uniformly high-quality data at the State level.

HRSA and our team that we contracted with has analyzed the recommendations of the panels, completed supplemental studies, and developed a draft model of severity-of-need index to be applied. The index uses data measures comparable across jurisdictions and

is based on quantitative measures established from existing national data sources.

We have also in 2008 contracted to conduct an independent analysis of that methodology. And the independent evaluators concluded that the process that was used to develop that severity-of-need index was comprehensive but some elements of the formulation failed to meet their intended purposes, so that the index, from that perspective, might be modified to better distribute supplemental funding based on need.

The status of the severity-of-illness index at this point? Well, the 2007 and 2008 reports are in clearance in the Department, and we are working to get those reports to you as soon as possible.

Mr. PALLONE. OK. Thank you very much.

Mr. Whitfield.

Mr. WHITFIELD. Dr. Wakefield, thanks for being with us today, and we appreciate your input.

In your opening statement, you mentioned that there is an HIV epidemic in the country today. What is the definition of an "epidemic," and is there a certain number of cases that you must have to be called an epidemic? Would you just clarify that for me, what that means?

Ms. WAKEFIELD. Applied here it is referring to, for us, the care that we provide of over 529,000 individuals served through our Ryan White AIDS program.

Mr. WHITFIELD. So if it is over 500,000, it is an epidemic?

Ms. WAKEFIELD. And greater than a million diagnosed with HIV/AIDS in the United States.

Mr. WHITFIELD. So, in the United States today, there are over a million people that have been diagnosed with AIDS?

Ms. WAKEFIELD. With HIV or AIDS, yes.

Mr. WHITFIELD. I was just reading the Kaiser report on the HIV program, and it indicated that this number, 500,000 being treated, really cannot be totally verified because it may be duplicative. And it says specifically that there is no client-level data collection system.

Is that true, or is that not true?

Ms. WAKEFIELD. There are duplicate numbers that we try to account for in our funding allocation. So, yes, we know that there is some duplication. We do have strategies for trying to correct that duplication.

Mr. WHITFIELD. But is it true that there is no client-level data collection system?

Ms. WAKEFIELD. Oh, we have—

Mr. WHITFIELD. To help you out a little bit here, I was reading from the Henry Kaiser Family Foundation HIV/AIDS policy fact sheet. It says, "... Although it is not possible to obtain an unduplicated count of clients because there is currently no client-level data collection system."

Ms. WAKEFIELD. We do have client-level data that we are collecting and have available now, but just effective as of June of this year.

Mr. WHITFIELD. So it went into effect June of this year?

Ms. WAKEFIELD. Just in the last few months, that is correct, on a client-level basis.

Mr. WHITFIELD. And that would be nationwide and in the nine territories then?

Ms. WAKEFIELD. Yes, sir. But it is just within the last few months.

Mr. WHITFIELD. OK. But it is in effect now, so we will be able to have a more accurate number.

Ms. WAKEFIELD. Yes, that is correct, going forward.

Mr. WHITFIELD. OK.

Now, on the transitional grant area proposal, in the discussion draft they are talking about the six transitional grant areas and they are asking that they be grandfathered. Now, I am certainly not an expert in the Ryan White Act, but it is my understanding that in order to obtain a grant you have to meet certain criteria, like so many thousand cases in whatever and whatever, which is the way it should be done because, with limited dollars, you want to go where it is most needed.

So it would seem to me that if you just automatically grandfather six areas because they have had them the last 3 years that you might be overlooking or underserving other areas that may need it even worse than those six. Do you have any comment on that?

Ms. WAKEFIELD. We do support continuation of those six, primarily to avoid disruption in services for the individuals currently being served and also so that there isn't an undue burden on areas that might be geographically located next to those six areas.

Mr. WHITFIELD. But, you know, I guess since Ryan White was authorized first in 1990, there has always been this process that it be a 3-year grant period and then it would be reevaluated. So that doesn't concern you, then, that other areas may be underserved because you are going to allow these to be grandfathered?

Ms. WAKEFIELD. We are supportive of continuing the inclusion of those six areas, yes.

Mr. WHITFIELD. OK. All right.

Now, President Obama, like all of us, has expressed great concern about the Federal debt that we have today and the impact that that will have on our country. And I would just ask you, this legislation also provides open-ended appropriation, "such sums as necessary." And there has been a growth in this program from \$200 million to about \$2.3 billion.

Do you think it is necessary to just have an open-ended "such sums as necessary" considering the current financial situation we find ourselves in in this country?

Ms. WAKEFIELD. HHS does support the inclusion of the wording "such sums as necessary" for subsequent fiscal years for each part of the act. So, yes, we do support such sums.

Mr. WHITFIELD. So you do support it.

I see my time has expired.

Mr. PALLONE. Ms. Capps.

Mrs. CAPPS. Thank you very much, Dr. Wakefield. I have a couple of questions for you during my time.

One is to share with you my concern to learn that the Centers for Disease Control and Prevention, CDC, estimates that the number of births to women living with HIV has increased approximately 30 percent from 2000 to 2006.

I mean, there are all kinds of new phenomena arising within this area of HIV/AIDS: chronic length of living with the disease and a whole new raft of issues that need to be addressed. I am sure you are considering this something that needs to be dealt with as well.

Do you have any ideas or plans in place to address the needs of women and children and families in light of the growing numbers of HIV-positive women of child-bearing age? Perhaps you can discuss, if you will, how part D of the legislation will help to ensure that their needs are met.

Ms. WAKEFIELD. Well, you are right, part D is the part of the Ryan White program that is probably most targeted toward exactly the population of which you are concerned. It, of course, allocates funds through private and public organizations, community-based organizations, States and universities, and it can provide outpatient or ambulatory care directly to or through contracts that are awarded. It is really designed to serve women, infants, children living with HIV/AIDS support and provide support services to those individuals. That is really its key target population.

We also have resources that are available through part F, the SPNS program it is referred to shorthand, that can be allocated to direct research and other activities to particular target populations. So that is another vehicle that I think it is safe to say could be added.

Beyond that, parts A, parts B, and C also provide care to the population that you have just expressed concern about. But, as you indicated, part D is really targeted to mention women, infants, children, and young adults.

Mrs. CAPPS. Thank you. And part of our goal, then, in our communities especially, is to identify and encourage people to get tested so that they can understand that they are and that they get into some of these programs and be able to deal with it early on.

To that topic, I am concerned. You heard in several opening statements about the impact of several of our State budgets on the ability to care for HIV and AIDS patients. I have heard just horrendous stories in my district in California about matters of life and death, really, if our State budget is going to cut so drastically the services upon which people depend for their care. They are going to have to choose between their medicine and their food.

I mean, I am sure it is not just confined to my district. I can see people in your audience nodding, and I know this is a story across the country now.

How can we respond, how can HRSA respond to work with some of our States where this is such a huge challenge right now?

Ms. WAKEFIELD. Well, you are right, we have been hearing from a number of States about the challenges that they are facing locally. And certainly California is one of those States that we are trying to monitor and work with as closely as possible.

On the front end, the administration, of course, strongly supports continuation of this program, first and foremost, to provide vital funding to States and cities to provide services to people living with HIV/AIDS.

In part, perhaps, to address your question, it might be useful for you to know, too, that the President's fiscal year 2010 budget request provides and asks for an increase of about \$53.9 million over

the fiscal year 2009 omnibus level. That funding would continue to support over 2,300 providers that would help half a million individuals living with HIV/AIDS obtain access to life-sustaining care and services. So, in fact, there is an additional request—a request for additional funding, I should say, that should help to mitigate a bit of those concerns.

But bottom line, we are aware of that and working as closely as we can with jurisdictions and States that are feeling particular pressure to maintain their services to this very vulnerable population.

Mrs. CAPPS. Well, you can be assured there are many Members of our Congress, including in this committee, who will seek to look for further funds if that is necessary as we see some of these State budgets unfold. I don't think it has really hit yet as hard as we are going to see in the coming months, where we are really facing in our communities—it is not just this population, unfortunately, but this is one that has clearly made itself known to me. And I know my colleagues will share in wanting to help you if there is any emergency funding that can be made available.

And surely the increase in the budget for next year is going to be something—it was intended, I am sure, to expand services, but at least it will provide that stopgap, hopefully, for some of the States where the bottom is falling out.

And I appreciate your awareness of and concern for this situation.

Ms. WAKEFIELD. Again, we are aware, we are concerned. And we have been trying to collect data, or information at least, anecdotally from our contacts in each of the States. So we have a little bit of a litmus test about how things are going at the State level. We will continue to try and do that and then share that information.

Mrs. CAPPS. We will encourage them locally to reach out to you, let you know what the status is.

Thank you.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

Ranking Member Mr. Barton.

Mr. BARTON. Thank you, Mr. Chairman. I don't think I will take up my full 5 minutes.

Dr. Wakefield, I am assuming that you are here as the official representative of the Obama administration. Is that correct?

Ms. WAKEFIELD. I am here representing the administration and HHS.

Mr. BARTON. OK, so you speak for them.

Ms. WAKEFIELD. Are you inquiring, sir, about whether or not the testimony is—

Mr. BARTON. Well, I am just saying, if you give an answer and I like it, I can depend that that is the position of the Obama administration?

Ms. WAKEFIELD. I am speaking as the HRSA Administrator. But the testimony that I have shared with you has been developed and reviewed with full collaboration.

Mr. BARTON. Well, sometimes, in both administrations, Democrat and Republican, we have officials come and when we ask them if

they are on the record for the administration, they hem and haw and then say that it is their personal position.

So I am not being devious. I am glad the chairman is holding the hearing, and I am glad you are here. But as the senior Republican, I want to ask some pretty straight questions, and if you give straight answers, I want to know that that is where the Obama position is. That is all.

Ms. WAKEFIELD. And, if I might, I guess what I would add on the hemming and hawing part, what I would add is that it is of course a normal protocol in either administration for the administrations to release their official statement of administration policy at some point between committee hearings and markup and floor action. So that is the venue for that official administration position.

Mr. BARTON. Well, I think we have spent a minute and a half of my time hemming and hawing already, so you are already at the top of the list in being able to do the Texas Two-Step. I am in awe of your ability to say nothing—

Ms. WAKEFIELD. I went at the school at the University of Texas at Austin.

Mr. BARTON. I knew that. My wife did, too, so we are a mixed marriage.

Anyway, let me ask the first question. This is an authorizing committee. We try to set the policy and set the provisions, and then we pass it over to the Appropriation Committee and they are supposed to implement by passing funding bills that do what we say.

This draft, one of the problems that the Republicans have is that it uses the term “such sums,” and Mr. Whitfield has already discussed that.

Does the Obama administration have a problem in working with the chairman and the ranking members on the Republican side before this bill is marked up to change that language from “such sums” to specific sums that everybody agrees are appropriate?

And I don't think we have a huge difference in funding priorities. At least if we do, I am not aware of it.

Ms. WAKEFIELD. We don't oppose “such sums,” but we would be happy to work with the committee going forward.

Mr. BARTON. Well, we want—and, again, I think even my distinguished chairman, Mr. Waxman, and the subcommittee chairmen would agree that if we can agree on what that amount should be, it is better from our committee perspective to tell the appropriators where to spend the money.

So you are willing to work with—

Ms. WAKEFIELD. We are willing to work with you, sir.

Mr. BARTON. Not just with me, but also with Mr. Pallone and Mr. Waxman.

You know, I might point out that if we had the vote right now, my side would win. We have five, and they have two. But they probably have seven out in the annex eating pizza, so they would probably bring them in.

My second—again, Mr. Whitfield talked about this. The provision in the draft bill that grandfathers the transitional grant areas, first, we don't have a problem with there being transitional grants, and we don't have a problem that those be authorized an additional 3 years.

Our problem is, if we are really trying to solve the problem of helping those families and individuals that have AIDS, that population does change over time and its location changes over time. We would like to have some ability to move the money where the people are that still need assistance as opposed to where they may have been in the past.

So we are not opposing transitional grants. We are not really even totally opposing the grandfathering. But we would like to work again with Mr. Waxman and Mr. Pallone and others on the majority, with the Obama administration, to see if we couldn't move some of those grants into areas where there is more need today. And that is, I think, what Mr. Whitfield was trying to get at.

Do you have an opposition to at least discussing that issue?

Ms. WAKEFIELD. I would say that we share and are concerned about ensuring that there is stability of infrastructure to meet the needs of individuals with HIV/AIDS. So that is our very first priority, to make sure that there isn't disruption in availability of care to those populations.

Mr. BARTON. I understand that.

Well, Mr. Chairman, my time has expired. We fully—I want to really emphasize this. I was chairman when we passed the last reauthorization bill in 2006, and I was very proud that that was one of the things that we did during my chairmanship. I am very glad that you and Mr. Waxman are trying to do a reauthorization bill. The Republicans really want to work to make that happen. We feel it is important from a committee perspective and from a policy perspective that we continue to have this bill in law, not in some appropriation rider that is year-to-year. And we also agree that, as the need changes and the location changes, we need to update the bill, update the law. We hope that we can do that in a very timely fashion and move this bill on a bipartisan basis.

And, with that, I would yield back, Mr. Chairman.

Mr. PALLONE. Thank you, Mr. Barton.

Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman.

I just had a couple questions.

First off, can you just be a little more specific about what it means to “not yet be mature” in this transition from code-based reporting to name-based reporting? I mean, what does that actually reflect?

Ms. WAKEFIELD. So, for example, some States have had statutes at the State level that, for different reasons, had to be addressed in order for them to be able to produce these data. So that is one potential problem that has affected some States.

Every State has its own set of circumstances in terms of being able to collect that information and aggregate it and make it available. So the process is really varying on a State-by-State basis. Data are collected from different sources. And, as I mentioned, there isn't any one uniform pattern that was established initially that they are all working from, in terms of reporting those data.

There is just the challenge of getting all of the people that have HIV reported by name. And, as I said, States have in some cases better circumstances in collecting that information, in other cir-



cumstances not as much infrastructure initially to be able to collect that data. So it really has been a fair variation State by State.

Mr. SARBANES. And typically the range in terms of making the transition on a time basis has been 2 or 3 years, is what it is taking people? Or—

Ms. WAKEFIELD. Probably a little bit longer than that, more like a 3- to 5-year period of time to make the transition.

Mr. SARBANES. OK. OK.

The other question I had is—I was looking at some of the statistics in terms of the Ryan White program: serving half a million people across the country, of which 33 percent are uninsured and 56 percent are underinsured.

And there has been some allusion, of course, as there would be, to the fact that we are wrestling here with a larger health insurance reform effort, where we would hope that we would get to a place where there is much broader coverage available to people and we don't have the same numbers of either uninsured or underinsured people.

But I also anticipate that we shouldn't fall into the trap of thinking that because we will find ways of providing better coverage going forward for the whole population of the country, including those who live with HIV and AIDS, that somehow there will be some kind of one-for-one corollary in terms of reducing this support that exists through this program.

So I wonder if you could speak to the fact, as I see it, that so much of what makes this successful is that it is approached from, sort of, the public health standpoint, with resources flowing to collaborative networks that exist in States and at the community level, and that that kind of infrastructure support needs to continue regardless of what the individual coverage status is that a particular person may have.

So if you could just speak to that.

Ms. WAKEFIELD. The Ryan White HIV/AIDS program does fill really significant gaps currently, and it provides critical capacity to reach underserved populations, the very people that you were just describing, percentages of uninsured and underinsured. And currently about 72 percent of the people who are served, for example, are below the poverty level.

The administration believes that the Ryan White HIV/AIDS program will continue to play a vital role after health care reform is enacted, for example because of some of the services that are provided through it—services such as medical transportation, nutrition services, case management services—that are part of not the core services part of Ryan White but rather the support services, for which resources are currently allocated and used across the country, casting this, just as you indicated, as a broader public health, community approach to care.

Mr. SARBANES. Thank you. I mean, I guess I am just trying to make the point that there is a—and it is really the case management side of things—dimension to what is offered through these resources that will continue to be absolutely critical even if an individual now has access to insurance coverage through more conventional means as a result of some of the reforms we have put in place.

If we don't bring this other lens to the table and continue to sustain it, then many of the gains we are trying to make will be lost. So I appreciate your testimony on that and yield back my time.

Mr. PALLONE. Thank you.

Mr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman.

Dr. Wakefield, thank you for being here today. I am going to ask you a question that Chairman Pallone already asked you. And I am a little scared to do it because I didn't understand the answer you gave him, and so I am hoping you will give us the translation.

When you talked about the severity-of-need index, you gave a very complex answer. But can you tell us just what that means to our districts and our constituents, what that means to the folks back home?

Ms. WAKEFIELD. Right now, the data associated with the severity-of-need index is on our Web site. So your folks back home could actually take a look at how the data are collected and what they are displaying. So that information is accessible that way.

Our formal report to you, however, is still in process. And, as I mentioned, we hope to get that to you shortly.

Mr. BURGESS. So what is the practical implication for the folks back home? They go to the Web site, they check out the data. Are there, in fact, additional funds that they could plus-up with now? Or is that awaiting your report back to us?

Ms. WAKEFIELD. That is correct, waiting. There are not dollars associated with this at this point in time.

Mr. BURGESS. OK. Thank you. That is helpful.

You also talked a little bit about moving from a palliative care model to a chronic care model. Can you briefly just explain what that will look like?

Ms. WAKEFIELD. Sure. The reference is really a bit more about where we have come from in terms of the treatment of HIV/AIDS, moving from a time when we didn't have available the available drugs, pharmaceuticals to treat and extend the lives of individuals. So we are at a very different place currently in terms of treatment of care of patients than we were when this epidemic first began and as it developed.

Mr. BURGESS. Correct. And is that likely to affect your funding model? Because clearly now the emphasis is much more on the life-extending drugs and the disease management drugs that are available but also happen to be fairly expensive and come with some other costs of side effects and that sort of thing.

Ms. WAKEFIELD. Yes, and so we have grantees that request funding to be able to deliver services using a chronic care model through case management and so on.

Mr. BURGESS. Now, is that in widespread usage throughout all of the communities?

Ms. WAKEFIELD. Yes, I mean, in terms of how grantees are working to deliver care to patients. Right now what we are seeing in terms of allocation of funding is more dollars available, for example, for drug therapy, pharmaceuticals, and less money having to be devoted, for example, to hospice care. So that would be an example of a change in—

Mr. BURGESS. OK. And you did make the statement at one point that your first priority is the stability of infrastructure. And I just wanted to be clear. Really, our first priority is treating patients. And if treating patients is providing them with the therapeutic cocktails they need to extend their lives and minimize their symptoms, that should be our first priority.

Ms. WAKEFIELD. Absolutely.

Mr. BURGESS. Let me ask you a question. I actually may be very brief. I may submit this in writing. You just referenced the health care workforce, which is extremely important to me. But, as I recall from our previous work on reauthorization of Ryan White, the health care workforce is not really specifically addressed in the bill; that comes in other parts of what we are doing. Is that not correct?

Ms. WAKEFIELD. Well, health care workforce is addressed a bit through part F, for example, through the education training centers that exist, and can provide at least short-term information to health care providers to help them deliver health care services.

So we do have funding that goes to universities, for example, I believe about 11 of them, 11 education training centers, to help with at least short-term training of HIV/AIDS health care providers. That is what exists currently.

Mr. BURGESS. OK. And, again, I may submit some additional questions about that in writing to you.

Let me just briefly reference—Dr. Christensen referenced incarcerated populations. And we have a significant problem in our area back in Fort Worth with people who have spent time in prison, come back with a new diagnosis, and may bring that illness back with them to their homes when they are re-entered into society.

Is there anything over the horizon that you are looking at in being able to capture these problems when the person is incarcerated and then an educational way to help mitigate that problem as they come back into the community?

Ms. WAKEFIELD. We have some of our HIV/AIDS clinics that do pay special attention to the very population that you are describing right now.

We also are looking at supporting models of care that target the population moving from incarceration back into community. And we have a particular initiative that focuses explicitly in that area that is ongoing now. I don't have results I could report to you at this point, but it is ongoing.

Mr. BURGESS. Again, we may submit something in writing to you on that.

And then, just finally, who is the head of the Center for Medicare and Medicaid Services currently?

Ms. WAKEFIELD. We have an acting head.

Mr. BURGESS. Is that a problem?

Ms. WAKEFIELD. I enjoy really very good relationships with my CMS colleagues. I haven't had any difficulties in terms of my meeting my information needs.

Mr. BURGESS. Well, when you visit back with the administration, we would benefit, I think, from having a full-time Administrator. It is, after all, the largest insurance company on the face of the earth, and they need a full-time CEO.

I will yield back, Mr. Chairman.

Mr. PALLONE. Ms. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

Dr. Wakefield, we welcome your experience and your expertise that you are bringing to the office.

As I said in my opening statement, many of us are concerned that the Minority AIDS Initiative was never really allowed to live up to its objective of creating the local infrastructure in minority communities. And Dr. Parham has been through this with us since its inception. And then changes were made that made it hard for these small organizations to compete for funding. They have been assessed on outcomes that were really not appropriate for what they were being asked to do.

And given that the hardest-hit communities remain those of color—and I quoted 71 percent of new AIDS cases and 67 percent of people living with AIDS are people of color—what do you envision, what would you recommend, from the perspective of the HRSA Administrator, to ease the existing disparities, particularly among communities of color?

And what do you envision as perhaps a larger role for the one and only National Minority AIDS Education and Training Center, which is doing great work but with a lot of limitations?

Ms. WAKEFIELD. We are very supportive of our training centers, including the one that you reference. And we are also supportive in terms of preparing the next generation of health care providers, of additional resources going to those training centers, to provide for education and training over a longer period of time so that our next generation of health care providers can meet the needs of the population that is affected.

And, as you indicated, we have a high proportion of minorities who are HIV/AIDS infected. So that is a concern for us. And we look to our training centers, as you indicated, to be supportive in terms of preparing health care providers to better meet those health care needs.

We also, of course, have the Minority HIV/AIDS Initiative. And that is threaded through various parts of the Ryan White CARE Act and provides resources and services for the particular population for which you have expressed your personal concern.

Mrs. CHRISTENSEN. Our intention originally was that the organizations within that community would be helped to develop the capacity, and that really didn't happen.

Are you in favor of building capacity from within the communities rather than bringing organizations from outside to work with the communities? Do you tend to the side of having the communities build that capacity themselves? Because I think that is where we have failed to, you know, really meet the goals.

Ms. WAKEFIELD. Well, there are pieces, of course, of Ryan White that really allow for local community input about strategies that might be best aligned to meet the needs of the individuals in their communities. So, as the program is currently deployed, not everything, of course, is dictated from the Federal level, but rather we work with potential grantees when they submit, for example, proposals for supplemental funding, and they identify locally what their priority needs might be for the populations that they serve.

I think that it is very important, that we listen to local communities and that we are receptive to the strategies that they are recommending about how to best meet their communities' needs.

Mrs. CHRISTENSEN. Well, I am sure, you know, particularly the Congressional Black Caucus, which was instrumental in getting this started, would be interested in sitting down and discussing this with you further.

On the hold-harmless proposal in the consensus document, I tend to agree with the minority position, which agrees that in 2010 it should be set at no less than 95 percent of funding for 2009, but disagrees on 2011 and 2012. This group would like to see the formula funding for parts A and B better match the number of HIV and AIDS cases in each jurisdiction rather than staying at the 100 percent.

And it just seems to me, and wouldn't you agree, that following what the minority view has suggested—and these are places like the Southern AIDS Coalition that represents a part of the country which is becoming the epicenter of this disease—but wouldn't you agree that their proposal would be a better way of ensuring that the funding follow the epidemic?

Ms. WAKEFIELD. HRSA recommends that we continue hold-harmless provisions for part A and part B grantees. We will, of course, look and provide technical assistance as you make determinations about what more specific provisions you would be interested in pursuing as a committee. We will be happy to work with your committee staff—the program will be happy to work with your committee staff as you have different approaches to that, to hold harmless. But bottom line, we recommend continuing hold-harmless provisions for both A and B.

Mrs. CHRISTENSEN. My time is up. Thank you.

Mr. PALLONE. Thank you.

Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman.

The benefit of the hearing process that we are going through is it reminds us and get into more specifics than we generally would do. And that is why I like to attend them as much as I can, because I learn tons. So excuse me if I am asking some basic stuff.

So I have in the Ryan White program—and my first time I was really lobbied on this was a young boy in rural southern Illinois who was a hemophiliac and had a blood transfusion. He and his mom came in and said, "This is an important program for us." And so that is why I think there is a bipartisan support.

So you have part A based upon HIV and AIDS cases. You have part B, which is a supplemental, based upon formulas of more crises in an area, is that correct? Or you want to impact more money sooner rather than later?

Ms. WAKEFIELD. Part B for States and territories and emerging communities, so communities that might have a smaller number of cases but look like they might be increasing.

Also, in addition to—I think you mentioned maybe some discretionary funding in part B, true, "supplemental funding," that might have been the term. There also is base or formula funds associated with part B, as well. So it has a formula component; it also has a supplemental component.

Mr. SHIMKUS. And then part C goes to early intervention clinics?

Ms. WAKEFIELD. Yes, that is correct.

Mr. SHIMKUS. Have we been able to do—obviously, we all know that education is a key to helping address and solve and mitigate health care risk across the board, whether it is HIV/AIDS or whether it is H1N1 or whatever else. And that is really an important, critical aspect.

Do we see in the early intervention clinics, does that have an educational component? Or is that like the first stop for someone who is—where they figure out they have something wrong and the clinic is their first stop?

Ms. WAKEFIELD. For part C you are asking about?

Mr. SHIMKUS. Right.

Ms. WAKEFIELD. That is discretionary funding. And that provides core medical and support services to people who are living with HIV/AIDS now, and so to folks in the service areas for those community organizations.

Mr. SHIMKUS. And D is the family component, which is women, infants, children, and students, another formula-based?

Ms. WAKEFIELD. No, that one is discretionary.

Mr. SHIMKUS. And it is based upon what? I mean, you all have the discretion, obviously, but what are some of the parameters that you use?

Ms. WAKEFIELD. Sure. So individuals or organizations, I should say, apply for funding—

Mr. SHIMKUS. It is a granting process.

Ms. WAKEFIELD. Exactly. Correct. Yes.

Mr. SHIMKUS. And then the F—which it took me a while to figure out that this is all part of F—you have the dental, which I think is easy to understand, and the AETCs and the SPNS, and I found out where that was. They are the “special projects of national significance.” That is another grant program?

Ms. WAKEFIELD. That is correct.

Mr. SHIMKUS. And then the MAI is Minority AIDS Initiative, which I think Representative Christensen has just elaborated on the importance of that. Think we all fully understand those issues.

From the minority’s side, again, I think we would really want to encourage—because these are specific programs which have specific authorizations, hopefully based upon cases and money spent and historical aspects. And we do know populations shift. This is going to be an issue of “follow the money,” if you haven’t figured that out now, because people are going to say, “OK, we have areas that have historically been high. We don’t want to disenfranchise that pool of money.”

I am from Illinois. Chicago is a big area. They are always talking to me about, “Let’s don’t hurt Chicago.” But I am a rural representative. So what if there is a migration into rural areas and that population shift is significant enough to start having an impact? So, whether we like it or not, like my colleague Congresswoman Capps said, this is really going to be a “follow the money” issue.

So the question is on—that is why the “such sums as may be desired” is problematic for us in a period of increasing deficits and the national debt threefold so far in just this year. It is hard for us to go back to the public and say, “Blank check. We don’t know.”

It would be much better if we did some analysis, saying, "Here is the population, here is the need, here is the amount we need."

And we have historically been able to come back for a supplemental request and added money if we guess wrong, and I mean terribly wrong. But I would respectfully suggest that we go back and work with the committee to hone down a number. In this environment that we are in today, "such sums as may be requested" I think is a tough one to overcome, because it will be attacked across the board.

And with that, thank you, Mr. Chairman.

Mr. PALLONE. The gentleman from Georgia, Mr. Gingrey.

Dr. GINGREY. Mr. Chairman, thank you.

And it is amazing how often this happens, that you sit here for an hour, hour and a half, waiting. You have this prize question you are itching to ask, and the guy or the gal just before you asks your question. And Mr. Shimkus just did that. But I think it is such a good point, that I want to ask the question again.

And, Dr. Wakefield, first of all, let me just say thank you. I think your testimony has been very forthright and interesting and informative.

But, yes, what Representative Shimkus said in regard to "such sums as may be necessary," and Representative Whitfield brought it up earlier on this side in his line of questioning, and your response to that was kind of, "Well, the language is OK with me," rather than what I guess he hoped.

And what maybe Representative Shimkus and certainly myself would like to suggest is this makes it a very difficult vote for those of us on the Republican side and maybe for 52 of the majority party when we get to the floor because of the climate that we are in, the very difficult times, this estimation of \$9 trillion worth of deficit over the next 10 years and \$1.8 trillion in 2009.

The American people that were so fired up and feisty and in our face at these town hall meetings, it wasn't just about their concern about a government takeover of our health care system, although certainly many Medicare patients were there and concerned about cuts to Medicare. A lot of these people were outraged over the continuation from the Republican majority for 12 years and now the first 9 months of the Obama administration and the majority of the Democrats over the last 2½ years, it is just more of the same and getting worse.

So the point that has been made about that, I think it should be well-taken by you, and I hope it is, because if President Obama—and I truly believe he does want bipartisan support for many initiatives, and he will talk about that, I am sure, tonight. But if you are going to get that, don't put language like that in a bill where our constituents go nuts over that. And so, you know, to specifically say to spend a certain amount, up to a certain amount, then the appropriators can go up to that amount if they need to. And, as John Shimkus said, we could always come back and add, if necessary.

Now, let me—and I want you to respond. And, fortunately, I have a little extra time. The chairman has been generous because I didn't make an opening statement. And I will give you sufficient time to respond.

I am also concerned about this issue of this “hold harmless” these jurisdictions. It would seem to me that if we have a certain amount of money to allocate for something of this importance, HIV/AIDS and trying to eradicate this disease in our lifetime, I hope, and to make life more palatable and tolerable and possibly even help these patients, 500,000 or more, I think you mentioned, nationwide, to be productive citizens, God help them. And we need to help them, no question about it.

But if you have areas where the caseload is going down and you have other areas where the caseload is going up, you made the statement, “Well, you know, we still have those infrastructure needs, and they don’t go away.” Well, I think they do go away, maybe not in straight-line proportionality. And, therefore, in the districts where you are seeing more patients, I would guess that the infrastructure need funding goes up, too, maybe, again, not in a straight line.

So explain to me once again why you wouldn’t want to reallocate this money and do this hold-harmless deal instead, where you can only cut a maximum of 5 percent in year 1 and no cuts in year 2 and year 3? I mean, money doesn’t grow on trees, and I am sure you would agree with that, Doctor. So, once again, if you don’t mind explaining to us why you would support something like that, that kind of language?

Ms. WAKEFIELD. So, HRSA recommends continuing hold-harmless provisions for both parts A and B grantees.

The hold-harmless provisions were included in the 2006 reauthorization to prevent, as you indicated, destabilization of the HIV care infrastructure and also from significant funding shifts due to funding formula distributions from year to year. We are sensitive to the impact of funding changes on systems of care, as I indicated. And for those reasons, as well as for administrative simplification reasons, that is our recommendation.

With regard to your comment about the “such sums” language in the legislation, HRSA will of course implement the program exactly the way the Congress suggests, in terms of spending. We will expend those funds to support these very critical programs.

The “such sums” language that is included in the bill is, as I mentioned, certainly acceptable to HRSA. And we look forward to working with you to ensure that the funding that is allocated to this program meets community needs and is judiciously spent. So those are also very important from our perspective, that the community need is met and that those resources are very judiciously spent.

Dr. GINGREY. Dr. Wakefield, thank you. And I am glad you would be willing to work with us. Because, as I point out, this is a bill that I don’t think very many Members on either side of the aisle would want to be on record of voting against, but the “such sums as necessary” just makes it more difficult.

And I think, as others have said before me, that this is certainly a time where we need to be, at the Federal level spending the taxpayers’ money, we need to be tightening our belt. I mean, you know, you look at things like a dual-engine program for the joint strike fighter, and I could go on and name many things, sacred cows that we just continue to pour money into.



And so, if we can tighten our belts on this and be wise about how we spend the money and get the money to where it is needed in regard to these HIV/AIDS patients, rather than just continuing to support an infrastructure somewhere that has fewer and fewer patients to deal with—people may be sitting around, kind of, twiddling their thumbs a little bit, Doctor. You know, you may want to refute me on that. But that is my concern; it is being fiscally responsible with the American taxpayers' money.

And, Mr. Chairman, I yield back.

Mr. PALLONE. Thank you.

The gentlewoman from Colorado, Ms. DeGette.

Ms. DEGETTE. Thank you very much, Mr. Chairman.

Dr. Wakefield, I just wanted to follow up. I wanted to talk to you a little bit about the policy here. And I wanted to follow up on something that Mr. Burgess brought up very briefly, and that is the need that you talk about in your testimony for the training of new HIV health care professionals.

I am wondering if you can describe the projections of how many new HIV health professionals we need.

Ms. WAKEFIELD. I don't have numbers with me or an estimation with me. I would be happy to go back and then provide that information for you.

Ms. DEGETTE. That would be very, very helpful for us, especially with respect to the concerns expressed on the other side of the aisle on budget and so on, because that may play into how much this is really going to cost.

How much unique training do HIV health care professionals need to have?

Ms. WAKEFIELD. First of all, because of the length of the epidemic, the individuals, the clinicians who were first educated and were taking care of this population are basically now, after 25 years, some of them are now coming close to retirement. So that population of health care providers, some of them will extend obviously longer.

But it is really about bringing in training for that next generation of providers moving forward. Some of the most significant challenges are about managing and helping to support patients, for example, that have comorbidities, multiple diseases at one time, so an individual with diabetes, for example, that is also diagnosed with AIDS, and providing care to those populations with those co-diseases or comorbidities over time in a chronic care fashion. So that is a different set of challenges than we were dealing with at the beginning of this epidemic, requiring a different set of skills.

Ms. DEGETTE. The other different set of challenges is the increased use and effectiveness of pharmaceuticals.

Ms. WAKEFIELD. So you make a really good point because many of the pharmaceuticals, for example, are pretty significant. In terms of their complexity, you can have difficulties, again to your point, with drug interactions and toxicities. That is another set as well as still, frankly, some residual stigma associated with this disease. So that is another area that clinicians are helped by being trained—by having education about this particular disease that isn't common to diabetes, congestive heart failure and other chronic illnesses.

Ms. DEGETTE. But are there changes that we need to make to the Ryan White program to accommodate this training that we are going to have to be providing to the next generation of providers?

Ms. WAKEFIELD. So through the testimony that I provided earlier, and mentioning the increased funding amounts that we support for the educational training centers, is a strategy to ensure that providers have that necessary training.

Ms. DEGETTE. So it is really more funding, not necessarily types of training.

Ms. WAKEFIELD. But we also have resources that are made available through our SPNS, our projects of national significance, to look at new care models and new care models for a specific populations, the type that, for example, Congressman Burgess mentioned, that is people transitioning from incarceration back into community and what that takes to meet the health care needs of that special population.

Ms. DEGETTE. OK. Just one last area I want to talk about—that is food and nutrition—because, as you know, those are critical components for the survival of people living with HIV and AIDS. We have a wonderful, wonderful program in Denver, Project Angel Heart, that focuses on nutrition for folks with HIV/AIDS. It can reduce the side effects of antiretroviral medications, make them easier to tolerate. And also a lot of these medications don't work if you don't take them with food. So I am wondering if you can discuss HRSA's recent guidance on food and nutrition. And while you are looking for the guidance, I am wondering if you have recommendations for food and nutrition services under parts A and B of the Ryan White program.

Ms. WAKEFIELD. So in terms of nutrition services, we have a definition of medical nutrition therapy and—medical nutrition therapy that is considered a core service. So we have core services and a category of services that fall under that definition or fall within that category. We also have a set of services that fall into a category referred to as support services. So I am talking about medical nutritional therapy inside the core nutritional. And that medical nutritional therapy in those circumstances provided by a licensed registered dietitian outside of a primary care visit, the provision of food, nutritional services, nutritional supplements may be provided pursuant to a physician's recommendation and then with a nutritional plan developed by a licensed registered dietitian. Nutritional services that are not provided by a licensed registered dietitian are considered a support service. Food nutritional services and supplements that are not provided pursuant to a physician's recommendation, again, linked to a nutritional plan developed by that dietitian are considered support services. So you can see where nutritional services track differently as a core medical service and what is required there versus nutritional services that track through the support services category.

Ms. DEGETTE. Thank you.

Thank you very much, Mr. Chairman.

Mr. PALLONE. Thank you. And thank you for your testimony. We may have some additional questions that Members will send forth. I know Mr. Burgess mentioned in particular. But we will get those to you fairly quickly so you can respond.

Thank you very much. We appreciate it.

Then I would ask the second panel to come forward.

Thank you for being with us today. Let me introduce each of you on the second panel from my left to right. First is Marcia Crosse. Dr. Marcia Crosse is the Health Care Director for the U.S. Government Accountability Office. Second is Ms. Julie Scofield, who is Executive Director of the National Alliance of State and Territorial AIDS Directors. And third is Dr. Donna Elaine Sweet, who is a professor at the Department of Internal Medicine at the University of Kansas School of Medicine and Board Chair of the American Academy of HIV Medicine.

We try to ask you to limit your remarks to 5 minutes. Of course, you can always submit your statement for the record, and after you are done, we will take some questions from the Members.

I will start on my left with Dr. Crosse.

**STATEMENTS OF MARCIA CROSSE, PH.D., HEALTH CARE DIRECTOR, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; JULIE M. SCOFIELD, EXECUTIVE DIRECTOR, NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS; AND DONNA ELAINE SWEET, M.D., MACP, AAHIVS, PROFESSOR, DEPARTMENT OF INTERNAL MEDICINE, UNIVERSITY OF KANSAS, SCHOOL OF MEDICINE, BOARD CHAIR, AMERICAN ACADEMY OF HIV MEDICINE**

#### **STATEMENT OF MARCIA CROSSE**

Ms. CROSSE. Thank you, Mr. Chairman, members of the subcommittee. I am pleased to be here today to discuss the Ryan White program. As we have heard, this year about \$2.2 billion was provided through the program to assist over 500,000 mostly low-income, underinsured or uninsured individuals living with HIV/AIDS. The majority of this funding was distributed through part A grants to qualifying metropolitan areas and part B grants to States, the District of Columbia and territories.

Most of this funding is distributed to grantees either as base or supplemental grants. Base grants are distributed by formula, and HRSA uses a grantee share of living HIV/AIDS cases to determine the amount of the grant. Supplemental grants are generally awarded through a competitive process based on the demonstration of severe need and other criteria.

In addition, the Minority AIDS Initiative, or MAI, grants as we have heard, are separate supplemental grants intended to address disparities for minorities in access to treatment and health outcomes.

Three other parts of the program provide lower levels of funding to public and private nonprofit organizations for specific purposes and include part D grants for family-centered comprehensive care to children, youth, women and their families.

When the Ryan White CARE Act was last reauthorized in 2006, Congress made a number of changes in the structure and funding requirements of the program with the goals of better targeting funding to areas of need and increasing the proportion of funding going to direct service delivery. For example, Congress changed the process by which HRSA awards MAI grants under part A and part

B from a formula based solely on demographics to a competitive process to better target funding. The legislation also capped at 10 percent the amount that part D grantees could spend on administrative expenses to increase the funding for services. Congress included mandates for GAO to study the changes to the MAI award process and the part D allowance for administrative expenses.

My testimony today is based on our March 2009 report on the MAI provisions and our December 2008 report on the part D administrative expense cap. We found that the new competitive process for awarding MAI grants altered funding for part A and part B grantees from what they would have received under the old formula-based process. For example, in fiscal year 2007, Phoenix received about 40 percent less than it would have received under the old formula, while Houston received about 11 percent more. All part A grantees that applied for MAI funding received it, with grant amounts in fiscal year 2007 ranging from \$50,000 to \$9.3 million. All part B grantees that applied for MAI funding also received it; however, half of the part B grantees decided that the new administrative requirements, including a separate application for MAI funds and increased reporting requirements, were not worth the amount of funds that they expected to receive, and therefore they chose not to apply. For the part B grantees that submitted applications, fiscal year 2007 MAI funding ranged from \$2,500 to about \$1.5 million.

The change to a competitive MAI grant process did not appear to bring in new service providers or change the approach to reaching minority populations. Grantees told us that they generally funded the same service providers and initiatives to reduce minority health disparities as they had in prior years.

With regard to the part D administrative expense gap, we found that grantees were in compliance with the gap, having charged 10 percent or less of their grant award for administrative expenses, such as rent and utilities. However, about half of the grantees reported that not all of their part D administrative expenses were covered by the 10 percent allowance, and they were forced to use money from their organizations' general operating budgets or other sources to cover their actual costs.

In addition, grantees such as universities that had negotiated indirect cost rates with the Federal Government could spend more of their part D grants on such expenses because they could also charge for indirect costs. These grantees reported spending up to 26 percent of their part D grants on indirect costs in addition to the 10 percent allowed under the cap. While the goal of the cap was to increase services, grantees reported that the cap had not altered either the amount or type of services they provide, and that the cap made it necessary for clinical staff to perform administrative tasks.

In summary, our review of the first year's implementation of these provisions did not demonstrate a major increase in services; however, it remains to be seen whether the move to a competitive MAI grant process or the part D administrative expense cap will meet the goals of better targeting funding to areas of need and increasing the proportion of funding going to direct services delivery moving forward.

Mr. Chairman, this completes my prepared remarks. I would be happy to respond to any questions you or other members of the subcommittee may have.

Mr. PALLONE. Thank you.

[The prepared statement of Ms. Crosse follows:]

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United States Government Accountability Office

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GAO

Testimony  
Before the Subcommittee on Health,  
Committee on Energy and Commerce,  
House of Representatives

For Release on Delivery  
Expected at 11:00 a.m. EDT  
Wednesday, September 9, 2009

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## RYAN WHITE CARE ACT

### Program Changes Affecting Minority AIDS Initiative and Part D Grantees

Statement of Marcia Crosse  
Director, Health Care



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GAO-09-1027T

September 9, 2009

## RYAN WHITE CARE ACT

### Program Changes Affecting Minority AIDS Initiative and Part D Grantees



Highlights of GAO-09-1027T, a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

#### Why GAO Did This Study

Under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act) federal funds are made available to assist those affected by human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). The Health Resources and Services Administration (HRSA) awards CARE Act grants to states, territories, metropolitan areas, and others. The Ryan White HIV/AIDS Treatment Modernization Act of 2006 (RWTMA) reauthorized CARE Act programs for fiscal years 2007 through 2009. The CARE Act's Minority AIDS Initiative (MAI) provides for grants through five parts (A, B, C, D, and F) with the goal of reducing HIV-related health disparities among minorities. RWTMA changed how HRSA awards MAI grants under Part A and Part B from a formula based on the demographics of the grantee to a competitive process. Part D provides for grants for services to women, infants, children, and youth with HIV/AIDS and their families. RWTMA capped Part D administrative expenses at 10 percent. GAO was asked to testify about CARE Act changes resulting from RWTMA. This testimony discusses (1) the implementation of the MAI provisions and (2) grantees' experiences under the Part D administrative expense cap. This testimony is based on two GAO reports, *Ryan White Care Act: Implementation of the New Minority AIDS Initiative Provisions*, GAO-09-315, and *Ryan White Care Act: First-Year Experiences under the Part D Administrative Expense Cap*, GAO-09-140.

View GAO-09-1027T or key components. For more information, contact Marcia Crosse at (202) 512-7114 or [crossm@gao.gov](mailto:crossm@gao.gov).

#### What GAO Found

The new competitive process for awarding MAI grants altered funding for grantees, increased administrative requirements for grantees, and resulted in continued funding for existing initiatives. The new competitive application process for Part A grantees—metropolitan areas—and Part B grantees—states and territories and associated jurisdictions—altered MAI grants from what they would have been under the old formula-based process. In determining the award amounts under the new process, HRSA considered the number of minorities with HIV/AIDS living in the grantee jurisdiction, along with the MAI applications grantees were required to file. The new competitive grant applications sometimes resulted in considerable differences in grantees' share of MAI funds from what they would have received under the old process. For example, in fiscal year 2007, Phoenix received \$127,578 (39.8 percent) less than it would have received under the old formula, while Houston received \$154,018 (10.9 percent) more. In addition, Part A and B grantees that received MAI funding told GAO that the administrative requirements increased significantly because of the new process. These included a new MAI grant application and reporting requirements. All Part A and B grantees that applied for MAI funding received it, but some Part B grantees decided that the administrative requirements, including a separate application for MAI funds, were not worth the amount of funds that they expected to receive and therefore chose not to apply. Moreover, grantees said that they generally funded the same service providers and initiatives to reduce minority health disparities as they had in prior years. MAI grantees continued to fund a range of core medical services, which include essential medical care services, and support services, which are services needed for individuals with HIV/AIDS to achieve their medical outcomes.

In a survey of Part D grantees, GAO found that grantees provide a range of services to clients, and the majority of these grantees reported that they have not made changes to services in response to the administrative expense cap implemented in fiscal year 2007. These services included both medical services, such as outpatient health services, as well as support services, such as child care. The majority of the 83 grantees that responded to GAO's survey reported that the cap has not affected the services they provide. However, four grantees reported increasing services and three grantees reported reducing client services in response to the cap. In addition, the majority of grantees also reported that the cap has had a negative effect on their Part D programs, even if it has not changed client services, because it has, for example, made it necessary for clinical staff to perform administrative tasks. In addition, about half of the grantees reported that not all of their Part D administrative expenses were covered by the 10 percent allowance.

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss reauthorization of Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act) programs and consider the results of some of the changes that were instituted by the 2006 reauthorization of CARE Act programs. The CARE Act, administered by the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA), was enacted to address the needs of jurisdictions, health care providers, and people with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and their family members.<sup>1</sup> In December 2006 the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (RWTMA) reauthorized CARE Act programs for fiscal years 2007 through 2009.<sup>2</sup> Each year CARE Act programs provide assistance to over 530,000 mostly low income, underinsured, or uninsured individuals living with HIV/AIDS. Under the CARE Act, approximately \$2.2 billion in grants were made to states, metropolitan areas, and others in fiscal year 2009.

There are five primary sections of the CARE Act under which HRSA awards grants—Parts A, B, C, D, and F. Part A provides for grants to selected metropolitan areas—known as eligible metropolitan areas (EMA) and transitional grant areas (TGA)—that have been disproportionately affected by the HIV/AIDS epidemic.<sup>3</sup> Part B provides for grants to states and territories and associated jurisdictions to improve the quality, availability, and organization of HIV/AIDS services. Part C provides for grants to public and private nonprofit entities to provide early intervention services, such as HIV testing and ambulatory care. Part D provides for grants to organizations for family-centered medical and support services

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<sup>1</sup>Pub. L. No. 101-381, 104 Stat. 576 (codified as amended at 42 U.S.C. §§ 300ff through 300ff-121). The 1990 CARE Act added Title XXVI to the Public Health Service Act. Unless otherwise indicated, references to the CARE Act are to the current Title XXVI.

<sup>2</sup>Pub. L. No. 109-415, 120 Stat. 2767. The CARE Act programs had previously been reauthorized by the Ryan White CARE Act Amendments of 1996 (Pub. L. No. 104-146, 110 Stat. 1346) and the Ryan White CARE Act Amendments of 2000 (Pub. L. No. 106-345, 114 Stat. 1319).

<sup>3</sup>An EMA is a metropolitan area with a population of 50,000 or more that had more than 2,000 AIDS cases reported in the most recent 5-year period. The 2,000 AIDS cases criterion does not include cases of HIV that have not progressed to AIDS. RWTMA created a new program for TGAs. A TGA is a metropolitan area with a population of 50,000 or more, which had 1,000 to 1,999 AIDS cases reported in the most recent 5-year period. In fiscal year 2007, there were 22 EMAs and 34 TGAs according to HRSA.



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for women, infants, children, and youth with HIV/AIDS and their families—including infected and affected family members. Part F provides for grants for demonstration and evaluation of innovative models of HIV/AIDS care delivery for hard-to-reach populations and training of health care providers.<sup>4</sup>

Most CARE Act funding is distributed to grantees either as base or supplemental grants. Base grants are distributed by formula, and HRSA uses a grantee's share of living HIV/AIDS cases to determine the amount of base grants. Supplemental grants are generally awarded through a competitive process based on the demonstration of severe need and other criteria. In addition, Minority AIDS Initiative (MAI) grants are supplemental grants awarded on a competitive basis to address disparities in access, treatment, care, and health outcomes.

RWTMA included provisions that changed how certain funding is awarded to grantees. For example, RWTMA changed the process by which HRSA awards MAI grants under Part A and Part B from a formula based solely on demographics of the grantee jurisdiction to a competitive process. The RWTMA also capped at 10 percent the amount that Part D grantees could spend on administrative expenses.<sup>5</sup>

In 2008 and 2009, we issued two reports on MAI and related issues and how funds are used in Part D programs and what effect the administrative expense cap has had on those services and on grantee programs. Today my remarks are based on our issued reports.<sup>6</sup> Specifically, I will discuss

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<sup>4</sup>Part E does not provide for funding for HIV/AIDS services but rather includes provisions to address various administrative functions.

<sup>5</sup>Among other things, RWTMA also changed hold-harmless provisions that protected formula funding for certain metropolitan areas. Subsequent to RWTMA, appropriations acts also limited the decreases in total funding (formula and non-formula) for metropolitan areas. See GAO, *Ryan White Care Act: Impact of Legislative Funding Proposal on Urban Areas*, GAO-08-137R (Washington, D.C.: October 5, 2007); GAO, *Ryan White CARE Act: Estimated Effect of Proposed Stop-Loss Provision on Urban Areas*, GAO-09-472R (Washington, D.C.: March 6, 2009); GAO, *Ryan White CARE Act: Estimated Effect of Proposed Stop-Loss Provision in H.R. 3293 on Urban Areas*, GAO-09-947R (Washington, D.C.: August 3, 2009).

<sup>6</sup>GAO, *Ryan White Care Act: Implementation of the New Minority AIDS Initiative Provisions*, GAO-09-315 (Washington, D.C.: Mar. 27, 2009); and GAO, *Ryan White Care Act: First-Year Experiences under the Part D Administrative Expense Cap*, GAO-09-140 (Washington D.C.: Dec. 19, 2008).

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(1) the implementation of the MAI provisions in RWTMA and (2) grantees' experiences under the Part D administrative expense cap.

For our work reviewing the implementation of RWTMA's MAI provisions, we conducted a Web-based survey of fiscal year 2007 Part A and B grantees to learn how the grantees applied for funds, distributed funds to service providers, and provided oversight, and what services they provided prior to and after the enactment of RWTMA. We also analyzed the effect on funding amounts of the changes made by RWTMA to MAI grants. Additionally, we reviewed HRSA's policies and reporting requirements under MAI for Part A and B grantees. We interviewed staff from selected grantees for Parts A and B to determine how funds were distributed and how grantees provided oversight. We interviewed staff from national organizations with HIV/AIDS expertise. We also interviewed selected grantees under Part A, B, C, D, and F about services they provided under MAI prior to and after the enactment of RWTMA. We interviewed HRSA officials about implementation of MAI and reviewed Part A and B MAI competitive grant applications for fiscal year 2007.

For our review of grantees' experiences under the Part D administrative expense cap, we surveyed all 90 Part D grantees, collecting information and opinions about the administrative expense cap for fiscal year 2007, the first year the administrative cap was in effect. We also interviewed selected grantees and officials from AIDS Alliance for Children, Youth & Families, the Part D grantee member organization, as well as HRSA officials responsible for overseeing the Part D program, including 8 of the approximately 30 project officers responsible for overseeing at least one Part D grant. We reviewed grantees' fiscal year 2007 grant applications, which contained their proposed budgets for their fiscal year 2007 spending, and identified the administrative expenses and indirect costs that grantees reported to HRSA in these applications. We also reviewed HRSA's technical assistance tools and training provided to grantees and project officers, as well as fiscal year 2007 and 2008 grant application guidance.

We conducted the work for this statement from January 2008 to February 2009 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our objectives.

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## Background

MAI grants were first distributed in conjunction with CARE Act funding in fiscal year 1999. The RWTMA added provisions on MAI funding to the CARE Act, authorizing specific amounts for the purpose of carrying out activities to evaluate and address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities. The amount of CARE Act funds used for MAI grants has increased from \$24 million in fiscal year 1999 to \$131 million in fiscal year 2007. The MAI provides funding through five parts (A, B, C, D, and F) of the CARE Act. Prior to the enactment of RWTMA, HRSA awarded Part A and B MAI funds to Part A and B grantees according to a formula that was solely based on the demographic characteristics of the grantees' jurisdictions, out of funds otherwise available for Parts A and B; those that received other Part A and Part B funds received MAI funds without having to file separate applications. The CARE Act now requires HRSA to award MAI funds under Parts A and B according to a competitive process. Under this new process, HRSA evaluates grantee applications for MAI funds in addition to the demographic characteristics of the jurisdictions.<sup>7</sup>

Through the CARE Act, HRSA awards grants (known as Part D grants) to provide services to women, infants, children, and youth with HIV/AIDS and their families. These grantees incur administrative expenses and indirect costs, such as rent and utilities.<sup>8</sup> The RWTMA, which took effect in fiscal year 2007, capped at 10 percent the amount that Part D grantees could spend on administrative expenses. According to HRSA, there is no

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<sup>7</sup>The way HRSA awards MAI funds under Parts C, D, and F remains unchanged. The Part C, D, and F MAI funds are awarded through a competitive process as a component of the competitive grant award for the base parts C, D, and F.

<sup>8</sup>RWTMA defines administrative expenses for Part D grantees as grant management and monitoring activities, including costs related to any staff or activity unrelated to services or indirect costs, and indirect costs as costs included in a federally negotiated indirect rate. 42 U.S.C. § 300 ff-71(h)(1-2). HRSA interprets administrative costs as excluding indirect costs. The legislative history indicates that in defining administrative expenses, Congress departed from the standard definition of the term. H.R. Rep. No. 109-695, at 11 (2006), *reprinted in* 2006 U.S. C. C.A.N. 1650, 1660.

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cap on indirect costs, but grantees must have an indirect cost rate to use funds for indirect costs.<sup>9</sup>

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### Implementation of the MAI Provisions

The new competitive process for awarding MAI funds to grantees under Parts A and B, altered MAI funding amounts from what they would have been under the old formula-based process, increased administrative requirements for grantees, and resulted in continued funding for existing initiatives to reduce health disparities for minorities. In determining the award amounts under the new process, HRSA considered the number of minorities with HIV/AIDS living in the grantee metropolitan area, state, or territory or associated jurisdiction, along with the MAI applications grantees were required to file. The new competitive grant applications sometimes resulted in considerable differences in grantees' share of MAI funds from what they would have received under the old process. For example, in fiscal year 2007, Phoenix received \$127,578 (39.8 percent) less than it would have received under the old formula, while Houston received \$154,018 (10.9 percent) more. Part A and B grantees that received MAI funding told us that the administrative requirements increased significantly because of the new process. These included a new MAI grant application and reporting requirements. All Part A and B grantees that applied for MAI funding received it, but some Part B grantees decided that the administrative requirements, including a separate application for MAI funds, were not worth the amount of funds that they expected to receive and therefore chose not to apply.

Grantees said that they generally funded the same service providers and initiatives to reduce minority health disparities after RWTMA as they had in prior years. MAI grantees continued to fund a range of core medical services, which include essential medical care services, and support services, which are services needed for individuals with HIV/AIDS to achieve their medical outcomes. Consistent with HRSA guidance, the

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<sup>9</sup>Indirect costs differ from administrative expenses in that indirect cost rates for specific activities are typically negotiated with the federal agency from which the grantee receives the greatest amount of federal awards and that rate then applies to all relevant federal award programs that permit indirect costs, unless it conflicts with a legislative indirect cost cap. The Office of Management and Budget (OMB) cost principles provide guidance as to the expenses that can be included in indirect costs to the cognizant agencies and grantees according to entity type. Within HHS, the Division of Cost Allocation performs this role. HRSA, following OMB cost principles, defines indirect costs as costs "incurred for common or joint objectives, which cannot be readily identified but are necessary to the operations of the organization."

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types of services funded under MAI generally did not differ from services provided with other CARE Act funds.

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### Implementation of the Part D Administrative Expense Cap

Part D grantees report planned administrative expenses and indirect costs to HRSA in their grant applications. In these applications, Part D grantees provide HRSA with budget documents, such as line-item budgets and budget justifications. HRSA officials review this information and any revisions to it to ensure that grantees adhere to their spending plans. For the 2009 fiscal year, HRSA required Part D grantees to report more detailed budget information, including their administrative expenses, at both the beginning and end of each fiscal year. We found that grantees reported to HRSA that they were in compliance with the administrative expense cap—having spent 10 percent or less on administrative expenses, such as rent and utilities, in fiscal year 2007. However, grantees with approved indirect cost rates could spend more of their Part D grants on expenses that would otherwise be covered by the administrative expense cap. These grantees reported spending up to 26 percent of their Part D grants on such expenses, in addition to the 10 percent allowed under the cap.

In a survey of Part D grantees, we found that grantees provide a range of services to clients, and the majority of these grantees reported that they have not made changes to services in response to the administrative expense cap implemented in fiscal year 2007. These services included both medical services, such as outpatient health services, as well as support services, such as child care. The majority of the 83 grantees that responded to our survey reported that the cap has not affected the services they provide. However, 4 grantees reported increasing services and 3 grantees reported reducing client services in response to the cap. In addition, the majority of grantees also reported that the cap has had a negative effect on their Part D programs, even if it has not changed client services, because it has, for example, made it necessary for clinical staff to perform administrative tasks.

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Mr. Chairman, this completes my prepared remarks. I would be happy to respond to any questions you or other members of the subcommittee may have at this time.

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**GAO Contacts and  
Staff  
Acknowledgments**

For more information regarding this testimony, please contact Marcia Crosse, (202) 512-7114 or [crossem@gao.gov](mailto:crossem@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. In addition, Thomas Conahan, Assistant Director; Robert Copeland, Assistant Director; Helen Desaulniers; Drew Long; Eden Savino; and Jennifer Whitworth made key contributions to this testimony.

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Mr. PALLONE. Ms. Scofield.

**STATEMENT OF JULIE M. SCOFIELD**

Ms. SCOFIELD. Good afternoon, Mr. Chairman, members of the committee. I am Julie Scofield, Executive Director of the National Alliance of State and Territorial AIDS Directors, NASTAD. Thank you for inviting me to speak with you today about the urgent need to extend the Ryan White program, which sunsets on September 30.

NASTAD and the HIV/AIDS community appreciates the long-standing support of the Energy and Commerce Committee and the House of Representatives for the Ryan White program and the domestic HIV/AIDS prevention programs that are extremely important to Americans living and at risk for HIV/AIDS. State AIDS directors in all 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and 6 U.S. territories represented by NASTAD administer over \$1.2 billion in Ryan White part B base and AIDS drug assistance program funds each year to provide comprehensive care and treatment for individuals living in their jurisdictions.

NASTAD, along with AIDS Action, cochairs the Ryan White Work Group, an affiliated work group of the Federal AIDS Policy Partnership. The Ryan White Work Group is a coalition of national, local and community-based service providers and HIV/AIDS organizations. The work group developed the Community Consensus document which currently has over 300 signatures from 47 States, D.C. and Puerto Rico.

There is an exceptional level of cohesiveness in the community around the path for extending the Ryan White program and a growing call for action by the September 30 deadline. I am submitting the Community Consensus document for the hearing record.

The community is extremely pleased to see that the draft legislation closely follows the Community Consensus document, and even more pleased with the leadership being demonstrated by the committee to act quickly.

NASTAD and the HIV/AIDS community support a 3-year extension of Ryan White that essentially restarts the clock and continues many important provisions for grantees. These include the continuation of protections and penalties for States with maturing names-based HIV reporting systems, hold harmless protection, along with the extension of protection for transitional grant areas and their eligibility. In order to maintain health stability for persons living with HIV/AIDS, it is essential to secure an extension of the Ryan White program as soon as possible while the larger issues of health reform and the development of a national HIV/AIDS strategy are developed, implemented and assessed. We also welcome the administration's proposal for a 4-year extension.

NASTAD is extremely pleased to see that the discussion draft addresses an issue that has caused undue burden on State grantees. The current law contains a provision that penalizes part A and b grantees if they have more than 2 percent of their award unobligated at the end of a grant year by making them ineligible for the supplemental components of their awards and reducing their grant awards in subsequent years. This provision prevents administrative difficulties for grantees which must work with subgrantees;

deal with budget cuts, hiring freezes, spending caps; as well as manage a variety of funding sources with varying grant periods.

The presence of unobligated funds does not signal a lack of need for these funds; instead, it often reflects the presence of factors that are extremely difficult to manage. NASTAD supports raising the unobligated threshold from 2 to 5 percent. By eliminating the penalty that decreases a State's subsequent year's award by the entire amount of their unobligated balance, States will be able to retain the funds necessary to provide services to their clients. NASTAD believes that the penalty which makes grantees ineligible for supplemental funding should also be eliminated in order to ensure that jurisdictions have all possible funding.

Related to this issue is a provision governing the use of rebate dollars accrued through a mix of Federal and State ADAP funds. HRSA has instructed States that they must spend their rebate dollars before the Federal grant award. This policy created a problem, particularly when combined with the new stringent rules regarding unobligated balances. Regardless of how rebate income is classified, the Ryan White program requires rebates to be put back into the program. The discussion draft goes far in clarifying this technical issue. We ask that the language be further changed to allow States to spend rebate funds after program funds in all cases, not just if doing so would avoid triggering a penalty. ADAPs are administratively very complex programs, and States need the utmost flexibility to ensure that dollars stretch as far as possible, particularly in these fiscally challenging times.

The National Alliance of State and Territorial AIDS Directors thanks the Chairman and the rest of the committee for their thoughtful consideration of NASTAD and the community's recommendations for extending the Ryan White program. We ask that you continue to prioritize passage of this important legislation and appreciate your ongoing attention to the September 30 deadline. NASTAD and the Ryan White Work Group will continue to do all that we can to support you in these efforts.

Mr. PALLONE. Thank you, Ms. Scofield.

[The prepared statement of Ms. Scofield follows:]



Testimony Submitted by

Julie M. Scofield  
Executive Director  
National Alliance of State and Territorial AIDS Directors

Presented to the House Energy and Commerce Committee

For the hearing "Ryan White Extension Act of 2009 Discussion Draft Legislation"

Wednesday, September 9, 2009, 11:00 a.m.

As the Executive Director of the National Alliance of State and Territorial AIDS Directors (NASTAD), I respectfully submit testimony for the record regarding the upcoming extension of the Ryan White Program. State AIDS directors appreciate the longstanding support of the House of Representatives for the Ryan White Program and domestic HIV/AIDS prevention programs that are of the utmost importance to Americans living with and at risk for HIV/AIDS. I also commend the Committee for drafting legislation and holding this hearing on the future of the Ryan White Program. This is an important step in ensuring the continuation of lifesaving services after September 30<sup>th</sup> for over 500,000 individuals touched by the Ryan White Program each year.

Since 1990, Ryan White has been the safety net health care program for people living with HIV/AIDS in our nation. State AIDS directors in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and six U.S. territories administer over \$1.2 billion in Ryan White Part B funds each year to provide comprehensive care and treatment programs for individuals living in their jurisdictions. As part of Part B, AIDS Drug Assistance Programs (ADAPs) have been key in ensuring that thousands of under and uninsured individuals receive highly active antiretroviral therapy (HAART), allowing them to live long fulfilled lives, reducing hospitalization costs, and reducing the likelihood of new infections as individuals on HAART have a lower viral load.

Each time in the past when Congress has reauthorized the Ryan White Program, major changes were made. The last reauthorization changed the distribution formulas from estimated living AIDS cases to actual living HIV and AIDS cases, added a requirement that 75 percent of grant funds be spent on a list of core medical services and ensured that unobligated funds were returned to the program – thereby maximizing the reach of the appropriated dollars. The impact of the changes resulting from the 2006 reauthorization has not yet been sufficiently realized or analyzed as some are ongoing and sufficient data are not yet available.

NASTAD, along with AIDS Action, co-chairs the Ryan White Work Group, an affiliated work group of the Federal AIDS Policy Partnership. The Ryan White Work Group is a coalition of national, local and community-based service providers and HIV/AIDS organizations that represent HIV medical providers, public health, advocates and people living with HIV/AIDS committed to ensuring that the Ryan White Program continues to ensure appropriate primary care and treatment and support services to uninsured and underinsured individuals living with HIV/AIDS.

Through the Work Group, the HIV/AIDS community has come together over the past year to examine the possibilities for the future of the Ryan White Program. During a series of meetings and teleconferences, a broad range of participating organizations considered a number of factors including available data, information on how changes from the last reauthorization have affected services provided to Ryan White clients and the effects of these changes on their lives and health status/access to services. The Work Group developed the *Community Consensus* document which currently has over 300 signatures from 47 states, the District of Columbia and Puerto Rico. There is an exceptional level of cohesiveness in the community around the path for extending the Ryan White Program.

The HIV/AIDS community is also involved in a variety of additional policy discussions that potentially impact the Ryan White Program such as the development of the National HIV/AIDS Strategy, as well as broader health reform. NASTAD and the HIV/AIDS community applaud the efforts of this Committee to expand the public health safety net for individuals living with HIV/AIDS in health reform legislation. In order to maintain health stability for persons living with HIV/AIDS, it is essential to secure an extension of the Ryan White Program as soon as possible while the larger issues of our nation's health system and a national strategic plan for HIV prevention, care and treatment are developed, implemented and assessed.

The current Ryan White legislation sunsets on September 30, 2009. While the House and Senate work to pass a stand-alone bill that extends the Program for at least three years, NASTAD and the community support Congressional efforts to include language in an alternative vehicle, such as a Continuing Resolution, to ensure that the program continues as is and that HRSA maintains its implementing authority after September 30<sup>th</sup>.

The community is extremely pleased to see that the draft legislation presented for discussion at this hearing closely follows the recommendations contained in the *Community Consensus* document. NASTAD would like to highlight a few of the provisions in the discussion draft.

#### **Authorization Period and Levels**

NASTAD believes that the Ryan White Program must be extended for a period of at least three years. An extension is the most prudent course of action given the many concurrent factors impacting the legislative future of the Program. Additionally, the HIV/AIDS community is committed to reexamining the Ryan White Program in a comprehensive manner after the implementation of much-anticipated health reform proposals and/or a national HIV/AIDS strategy.

NASTAD concurs that "such sums" language is more appropriate for the Ryan White Program than specific funding levels based upon an annual percent increase. The current legislation includes authorization levels for each of the three fiscal years that are inadequate to address program need. Included in the current legislation is a 3.7 percent increase for the majority of the Parts, an increase which is significantly less than what is seen in other health authorization legislation such as the Community Health Centers. The Ryan White Program has been seriously underfunded for many years and many grantees are struggling to provide the necessary services to all those that are in need.

#### **Extension of Hold Harmless Provisions**

NASTAD is pleased to see that the Committee's discussion draft includes the continuation of current hold harmless provisions. There is great agreement in the community that the hold harmless provisions must remain in the legislation through this next authorization period. Even the eight organizations that called for more of a shift in funding in the *Consensus* document agree that the provisions are important for the continuation and stability of services. The hold harmless provisions allow Ryan White Part A and Part B programs to plan for upcoming fiscal years and allow them to make investments in infrastructure and build comprehensive programs. Large shifts, particularly cuts in funding, can be destabilizing and lead to gaps in the provision of primary care and support services. During the last reauthorization, money shifted due to the

changes in distribution formulas. The formulas for Parts A and B continue to be in a period of transition due to several factors, including the switch in formulas to living HIV/AIDS cases from estimated living AIDS cases and the fact that some states' new name-based HIV reporting systems have not yet matured. The CDC has estimated that the earliest a nationwide mature HIV system would be available is 2012. Further, the number of living HIV and AIDS cases continues to fluctuate and additional cases from maturing name-based HIV reporting systems will be added to overall case counts. Due to a convergence of all these factors, eliminating hold harmless provisions in this transitional period would likely result in a loss of funding in some jurisdictions that would lead to destabilized HIV/AIDS care and support services. In addition, we support moving the base year of the Part A hold harmless from FY2006 to FY2009 and requiring that the stop loss resources currently applied to jurisdictions in FY 2009 be built into the base formula funding of each jurisdiction and that the hold harmless provision for FY2010 and beyond be applied to these adjusted formula funding levels.

We also concur with the language included in the discussion draft which would extend the hold harmless provisions to the Transitional Grant Areas (TGAs). It is vitally important for jurisdictions to be able to conduct advance planning and the lack of some consistency makes this very difficult.

#### **Unobligated Funds**

NASTAD is extremely pleased to see that the discussion draft addresses an issue that has caused undue burden on state grantees. The current law contains a provision that penalizes Part A and B grantees if they have more than two percent of their award unobligated at the end of a grant year by making them ineligible for the supplemental components of their awards and reducing their grant awards in the subsequent year. This provision presents administrative difficulties for grantees, who must work with subgrantees, deal with state budget factors such as hiring freezes, spending caps, and other restrictions, as well as manage a variety of funding sources with varying grant periods. All of these factors make obligating grant dollars down to a very small amount extremely difficult. Additionally, many states had unobligated balances in the first year of the current authorization period due to the requirement that ADAP rebate dollars be spent before the federal grant award. The two percent level is unnecessarily strict and not in keeping with general administrative principles. The presence of unobligated funds does not necessarily signal a lack of need for these funds, instead it often reflects the presence of factors that are extremely difficult to manage.

Due to these uncertain economic times, it is not appropriate to penalize HIV/AIDS programs for circumstances beyond their programmatic control. By increasing the unobligated threshold from two to five percent, grantees will be better able to plan for uncertain economic times and comply with this important provision. By eliminating the penalty that decreases a state's subsequent year's grant award by the entire amount of their unobligated balance, states will be able to retain the funds necessary to provide services to their clients. NASTAD believes that the penalty which makes grantees ineligible for supplemental funding should also be eliminated in order to ensure that jurisdictions have all possible funding available to them in order to meet the needs of their clients.

#### **AIDS Drug Assistance Programs (ADAPs) Rebate Dollars**

Tied in with the unobligated balances provisions is a provision governing the use of rebate dollars accrued through ADAPs. These dollars, which in most states are accrued through a mix of federal grant and state general revenue funds, are vital to the ongoing health of many ADAPs. After the last reauthorization, HRSA instructed states that they must spend their rebate dollars before the federal grant award. While NASTAD understands that this is a policy consistent with other HHS programs, it created a problem with the new stringent rules regarding unobligated balances. Due to the previously discussed unobligated balances provisions, this led to some states losing future ADAP funding since they had more than the allowable amount of their federal ADAP grant unobligated. Regardless of how rebate income is classified, the Ryan White Program requires rebates to be put back into the Part B program with preference given to ADAP services. Rebate income should not result in a reduction of expenditures and therefore should be allowed to accrue after a grant year has ended and spent after federal funds are expended. This discussion draft goes far in clarifying this technical issue and NASTAD appreciates the Committee's attention to the issue. We believe that the language must go further to ensure maximum administrative flexibility for states. We ask that the language be changed to allow states to spend rebate funds after program funds in all cases not just if doing so would avoid triggering a penalty. ADAPs are administratively complex programs and states need the utmost flexibility to ensure the dollars stretch as far as possible, particularly in these fiscally challenging times.

#### **Continued Protection for States with Maturing HIV Case Data**

The draft legislation continues the protection for states that are transitioning to a names-based HIV data system. All states are currently collecting name-based HIV data. However, some states have only recently made this transition and do not yet have mature named-based HIV surveillance systems. CDC has estimated that the earliest all states may have mature HIV systems is in FY2012. In FY2009, nine states submitted their data directly to HRSA. As the new authorization period proceeds, fewer states will submit their data directly to HRSA and have CDC report their cases to HRSA. We concur with the language in the draft legislation that would allow states to continue to report directly to HRSA while keeping the five percent penalty and gain cap.

#### **Extension of TGA Eligibility**

The HIV/AIDS community wants to ensure that Ryan White clients do not experience service disruptions during this next authorization period. The last reauthorization created two separate tiers of Part A jurisdictions – Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). HRSA has notified six current TGAs that they are in jeopardy of losing their eligibility in FY2011. The community believes it is premature to discontinue funding to these (and any other jurisdictions) before client level data is fully realized and an analysis of the services provided to individuals can be conducted. In addition, because HIV data is not currently mature, eligibility is based only on AIDS cases. Once HIV case data becomes fully available, it is assumed that in the next authorization EMA and TGA eligibility will be updated to include HIV and AIDS cases. Continuity of care is vitally important for persons receiving Ryan White-funded services. Additionally, there is no transition plan in place that would allow TGAs who lose their eligibility under Part A to have their dedicated funding move with them to the state portion of funding under Part B. States are financially strapped and would be unable to make up for the loss of funding to these areas that are serving ever increasing numbers of clients.

### **Other Issues**

NASTAD is pleased to see that the discussion draft also clarifies the use of Part D medical expenses. Part D programs which provide services to women, children and youth were exempted from the core medical service requirement in the 2006 reauthorization due to the unique nature of their programs. The clarification of this is necessary to ensure that Part D programs remain the payer of last resort.

We are also pleased to see that the draft language reasserts that Part A and B awards continue to be distributed using the current formulas and not adjusted to reflect client level data or a severity of need index.

In developing the *Community Consensus* document the issue of food and transportation as allowable core services was raised multiple times. HRSA has recently clarified that the provision of food pursuant to medical nutrition therapy is an allowable expense under core medical services. NASTAD has heard from many states that transportation continues to be difficult for clients, especially those living in rural areas. We ask that the Committee continue to work with HRSA to ensure that grantees and clients can use the easiest, lowest-cost options to ensure that no disincentives are created for clients accessing medical and support services. Additionally, we ask that the Committee signal support for HRSA's recent guidance on food and nutrition to ensure the continuation of this important guidance.

NASTAD is supportive of the removal of the Early Diagnosis and Partner Notification grant programs in the discussion draft. The Early Diagnosis Grant Program requires CDC to set-aside \$30 million of existing HIV prevention funds. Of the \$30 million, \$20 million is for grants to states that have voluntary opt-out testing of pregnant women and universal testing of newborns and \$10 million is for grants to states that have voluntary opt-out testing of clients at STD clinics and voluntary opt-out testing of clients at substance abuse treatment centers. The program redirects scarce prevention resources when states are already changing their laws and regulations without financial incentive to remove barriers to HIV testing. Congressional Appropriators have recognized that CDC funds are better spent supporting existing HIV prevention programs by redirecting unawarded funds back to state and local health departments. The Partner Notification program was included in the 2000 authorization of Ryan White, but has never been funded. The grants are not necessary. As a condition of receiving CDC prevention cooperative agreements, states must ensure that partner notification services are available. If Congress wants to support additional partner notification services or additional programs to prevent mother-to-child transmission, effort would be better spent on increasing funding for these already existing activities.

The National Alliance of State and Territorial AIDS Directors thanks the Chairman, Ranking Member and members of the Subcommittee for their thoughtful consideration of NASTAD's and the community's recommendations during the development and further discussion of legislation to extend the Ryan White Program. We ask that you continue to prioritize the passage of this important legislation and appreciate your ongoing attention to the September 30<sup>th</sup> deadline. NASTAD and the Ryan White Work Group will continue to do all we can to support your efforts and ensure timely passage.



**SECTION BY SECTION DESCRIPTION OF  
“RYAN WHITE CARE ACT AMENDMENTS OF 2009” DISCUSSION DRAFT**

**Section 1: Short Title; References**

This section would establish “Ryan White CARE Act Amendments of 2009” as the title.

**Section 2: Reauthorization of HIV Health Care Services Program**

*Current Law:*

The table below compares fiscal year 2009 authorization amounts to fiscal year 2009 appropriation amounts and the 2010 House Budget request.

Table 1. Federal Funding for the Ryan White Program  
(\$ in millions)

Ryan White Program Parts	FY2009 Authorization	FY2009 Appropriations	FY2010 House Passed
Part A	\$650	\$663.1	\$679.1
Part B	\$1,285	\$1,223.8	\$1,253.8
Part C	\$235	\$201.9	\$206.8
Part D	\$72	\$76.8	\$78.7
Part F: AECTs	\$35	\$34.4	\$35.2
Part F: Dental	\$13	\$13.4	\$13.8
Part F: SPNS	\$30	\$25	\$25
<b>Total</b>	<b>\$2,320</b>	<b>\$2,238</b>	<b>\$2,292</b>

*Proposal:*

The discussion draft would authorize “such sums as are necessary” for Parts A through D. It would authorize “such sums” for Demonstration and Training Grants under Part F including HIV/AIDS Communities, Schools and Centers and the Minority AIDS Initiative.

The discussion draft would eliminate the sunset provision. After three years, the authorization will expire, but Congress will have the opportunity to revisit the program as is the practice with most programs.

**Section 3: Extended Exemption Period for Names-Based Reporting**

*Current Law:*

Under current law, the amount of funding that metropolitan areas and states receive is based on formulas that reflect the number of people infected with HIV, as well as those already diagnosed with AIDS. Most states initially collected surveillance data on HIV under a code-based system, which excluded any identifying information for individuals. In the late 1990s, CDC recommended that all States switch to a name-based system, which decreases duplication and creates a more accurate count. Some states have been collecting name-based data for longer periods, but others had to change state laws and regulations to change their systems.

Today, every state collects name-based HIV data to some degree, which is reported to CDC on an annual basis. However, because state systems evolved at different rates, there is substantial variation in the maturity of their name-based HIV reporting systems and the extent to which they fully reflect the current epidemic in each state. Eight states, including California, Hawaii, Illinois, Maryland, Massachusetts, Oregon, Rhode Island, and Vermont, and the District of Columbia, do not yet have fully mature names-based HIV surveillance systems.

Under the 2006 reauthorization, states are allowed to continue to submit code-based HIV data directly to HRSA, but they receive a 5% penalty to account for potential duplication. States reporting code-based data are also subject to a 5% cap on increases in case count. Once the Secretary of the U.S. Department of Health and Human Services (HHS), after consulting with the state's chief official, certifies that the state's name-based data is accurate and reliable, the state switches to exclusive name-based reporting.

*Proposal:*

The discussion draft would maintain these provisions for states and jurisdictions with maturing names-based HIV case data. Jurisdictions that report code-based data to HRSA will continue to incur a 5- percent penalty against their count of living cases of HIV and will still be subject to a 5% cap on increases in the HIV case count.

**Section 4: Extension of Transitional Grant Area Status**

*Current Law:*

The 2006 reauthorization divided Part A funding into two separate categories— Emerging Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). EMAs are defined as areas with at least 50,000 people and at least 2,000 AIDS cases reported in the prior five years. TGAs are jurisdictions with at least 1,000 but fewer than 2,000 cumulative AIDS cases during the prior five calendar years.

An EMA retains its status until it (a) fails for 3 years to have at least 2,000 cases of AIDS during the most recent 5 calendar years and (b) fails for 3 years to have 3,000 or more living cases of AIDS as of December 31 of the most recent calendar year.

A TGA retains its status until it (a) fails for 3 years to have at least 1,000 but fewer than 2,000 cases of AIDS during the most recent 5 calendar years and (b) fails for 3 years to have 1,500 or more living cases of AIDS as of December 31 of the most recent calendar year. HRSA has identified 6 TGAs that potentially will lose their eligibility in fiscal year 2011 based on decreasing numbers of AIDS cases: Santa Rosa, California; Vineland-Millville-Bridgeton, New Jersey; Ponce, Puerto Rico; Caguas, Puerto Rico, Middlesex-Somerset-Hunterdon, New Jersey; and Dutchess County, New York.

While EMA and TGA eligibility are based on AIDS cases alone, the actual award amounts they receive are based on both HIV prevalence and AIDS cases.

*Proposal:*

The discussion draft would extend TGA status for three years to all TGAs that received an award in fiscal year 2009. By 2012, there will be a more detailed national picture of both HIV and AIDS surveillance nationwide. Until that time, this proposal would maintain service stability for existing TGAs. As under current law, TGA funding will be awarded on the basis of HIV and AIDS counts, so jurisdictions with fewer cases will get less funding.

**Section 5: Hold Harmless**

*Current Law:*

Under Parts A and B, metropolitan areas and states receive both formula funding and supplemental funding. Formula funding, as described above, is distributed based on HIV and AIDS cases in the area.

Under Part A, two-thirds of funds are distributed based on a formula and one-third of funds are supplemental. Supplemental funding is awarded on a competitive basis.

Under Part B, the proportion of funds that are supplemental can vary annually. The Part B supplemental pool comes from one-third of money appropriated above the fiscal year 2006 amount; from cancelled and returned unobligated funding; and from grant funds taken out of awards for grantees as a penalty for unobligated balances.

Large shifts in funding from one year to the next can be destabilizing and lead to weakened systems of care for Ryan White patients. Under current law, a “hold harmless” provision protects both Eligible Metropolitan Areas and states from large decreases in formula funding. Formula awards for a jurisdiction’s grant in fiscal year 2007 could not be less than 95% of funding for fiscal year 2006, and funding for fiscal years 2008 and 2009 should be no less than 100% of fiscal year 2007.

*Proposal:*

The discussion draft would repeat the hold harmless pattern established in the last reauthorization. Formula grants for fiscal year 2010 would be no less than 95% of funding for fiscal year 2009, and funding for fiscal years 2011 and 2012 should be no less than 100% of fiscal year 2010.

After the last reauthorization, the Health Resources and Services Administration’s (HRSA) application of a formula change resulted in significant losses for a number of jurisdictions. For each of the last two years and in the fiscal year 2010 Labor-HHS appropriations bill, annual appropriations bills have mitigated these problematic cuts through a stop-loss provision. The provision includes additional funding specifically to address the losses faced by those jurisdictions, rather than taking money from the other areas. In fiscal year 2009, 3 EMAs and 10 TGAs received stop-loss funding.

The discussion draft would prevent the need for repeated legislative action by including the fiscal year 2009 stop-loss funding in the hold-harmless baseline for fiscal year 2010. This reflects the purpose of the hold-harmless provisions, which is to provide stability in funding and prevent precipitous drops in services. Because some of the jurisdictions that received stop-loss funding in fiscal year 2009 are TGAs, the discussion draft extends hold harmless protection to all TGAs.

#### **Sections 6 and 7: AIDS Drug Assistance Program (ADAP) Rebate Funds and Treatment of Unobligated Funds**

##### *Current Law:*

Current law contains several provisions related to the requirement that Part A and Part B grantees obligate funds by the end of the grant year.<sup>1</sup>

- **Formula and ADAP Base funding:** If a Part A or Part B grantee has any unobligated dollars remaining at the end of the grant year, it can request a waiver to carryover the funding. If the waiver is not granted or if the funds still are not spent by the end of the carryover year, the funds return to the Secretary and become available for supplemental grants.

If a Part A or Part B grantee reports an unobligated balance that is 2% or more of the total award, certain penalties apply, whether or not the jurisdiction receives a carryover waiver. For formula funds, future formula funding will be reduced by the amount of the unobligated balance, beginning in the year following the report. In addition, the jurisdiction will not be eligible for supplemental funding in the year following the report.

- **Supplemental funding:** If a Part A or Part B grantee has unobligated supplemental funding at the end of the grant year, the funds are cancelled and returned to the Secretary for redistribution.

Because of multiple factors including statewide budget problems and hiring freezes, it has been difficult for all Part A and Part B grantees to obligate 98% of their funds by the end of the year. Nine states experienced a reduction in their fiscal year 2009 grants due to unobligated balances in fiscal year 2007.

The unobligated balances requirement intersects with the treatment of ADAP rebate dollars. Currently, many states purchase ADAP drugs directly from the manufacturer and receive substantial rebates in return. These rebates must be put back into the program and, as a general requirement, states must spend rebate dollars before grant dollars. However, the amount and timing of rebate dollars is unpredictable. For example, a state may receive a significant rebate late in the award year. Since rebates must be spent before program funds, the state could therefore end the year with more than 2% unobligated program funds.

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<sup>1</sup> HRSA Policy Notice 7-9, Policy Notice - Notice 07-09 - The Unobligated Balances Provision (online at <http://hab.hrsa.gov/law/0709.htm>).

*Proposal:*

The discussion draft would clarify that rebate dollars may not be required to be obligated by the end of the year if such requirement would result in a penalty for unobligated funding. It would provide flexibility to states so they are not penalized for unobligated balances related to rebate timing. It also would require Part B grantees to report the activities for which the drug rebates are used and to certify that the rebate funds will be put back into the Part B program with preference given to ADAP services.

The discussion draft would retain the requirement that unobligated funds be returned unless a waiver is granted to carry over formula or ADAP funds. It would eliminate the penalty that reduces future grant amounts. It would retain the penalty that renders grantees ineligible for supplemental grants in the following fiscal year, but would raise the threshold for the unobligated balance so this penalty is triggered at 5% rather than 2%.

**Section 8: Application to Primary Care Services***Current Law:*

Part D of Ryan White provides grants to entities serving women, infants, children, and youths living with HIV/AIDS. Programs provide for outpatient medical care and offer case management, referrals, and other services to enable participation in the program, including services designed to recruit and retain youth with HIV.

Under current statute, Part D grantees are required to provide medical care to clients, either directly or by contract. Since the last reauthorizations, Part D grantees have been instructed by HRSA to include medical expenses in their program budget. However, Part D clients are often able to access other forms of health coverage, usually SCHIP and Medicaid. In addition, some Part D clients provide care for their clients not through contracts but rather through memoranda of understanding.

*Proposal:*

The discussion draft would maintain the overall responsibilities and requirements for Part D grantees. It would clarify that Part D should be the payer of last resort and specify memoranda of understanding as vehicles for Part D providers to ensure access to primary care.

**Section 9: GAO Report***Current Law:*

The 2006 reauthorization required the Government Accountability Office (GAO) to submit a report every two years on barriers to HIV program integration, particularly for racial and ethnic minorities, and on activities under the Minority AIDS Initiative; including

recommendations for enhancing care and prevention services. As directed, GAO submitted one report during the last reauthorization period<sup>2</sup>.

*Proposal:*

The discussion draft would instruct GAO to periodically report on activities carried out under the Minority AIDS Initiative, in consultation with the Committees of jurisdiction.

**Section 10: Severity of Need Index and Client-Level Data**

*Current Law:*

Current law instructs HRSA to develop a Severity of Need Index (SONI) for Ryan White grantees. HRSA has worked on this index, but since the national data set does not yet include uniform HIV reporting and Congress has not yet explored the potential impact of the SONI, there is general consensus that the SONI should not yet be implemented. Current law is silent on implementation of the SONI.

Current law also provides funding for grants in Parts A through D to help grantees develop client-level data systems.

*Proposal:*

The discussion draft would retain the Client-Level Data grants. It would clarify that neither the SONI nor the Client-Level data should be used to adjust funds under Parts A or B during this authorization period.

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<sup>2</sup>Government Accountability Office, Implementation of New Minority AIDS Provisions, (Report No.GAO-09-315) (online at <http://www.gao.gov/new.items/d09315.pdf>).

September 8, 2009\*

**Federal AIDS Policy Partnership  
Ryan White Work Group**

**HIV/AIDS Community Consensus on the Future of the Ryan White HIV/AIDS Treatment  
Modernization Act  
(Public Law 109-415)**

The Ryan White Work Group is a coalition of national, local and community-based service providers and HIV/AIDS organizations that represent HIV medical providers, public health, advocates and people living with HIV/AIDS committed to ensuring that the Ryan White Program continues to ensure appropriate primary care and treatment and support services to uninsured and underinsured individuals living with HIV/AIDS.

In December of 2006, the Ryan White Program was reauthorized for a three year period and contained a sunset clause. Without action, the Program will expire on September 30, 2009. The reauthorization included many significant changes including changing the distribution formulas from estimated living AIDS cases to actual living HIV and AIDS cases, a core services requirement, and provisions regarding unobligated funds. The impact of these changes has not yet been fully or sufficiently analyzed as the changes are ongoing and sufficient data are currently unavailable.

The HIV/AIDS community has come together over the past several months to examine the possibilities for the future of the Ryan White Program. During a series of meetings and teleconferences, a broad range of participating organizations considered a number of factors including available data, information on how changes from the last reauthorization have affected services provided to Ryan White clients and the effects of these changes on their lives and health status/access to services. The Ryan White Work Group has carefully considered the time necessary to work through complicated program mechanics in order to make recommendations for change with the time available prior to sunset of the current legislation. After discussion the undersigned HIV/AIDS organizations have agreed to recommend the course of action as described in this *Community Consensus*.

The *Community Consensus* is largely cohesive; however, with such a large number of organizations involved and a large number of issues discussed there is some divergence on a few provisions. Those minority views are noted below. In addition to this *Community Consensus*, participating organizations submitted a document to Congress in the fall of 2008 recommending four technical fixes to the current legislation. These technical fixes are included at the end of the recommendations.

Additionally, the HIV/AIDS community is involved in a variety of additional policy discussions that potentially impact the Ryan White Program such as the development of a National AIDS Strategy, as well as broader health care reform. In order to maintain health stability for persons living with HIV/AIDS, it is necessary to secure an extension of the Ryan White Program while

the larger issues of our nation's health care system and a national strategic plan for HIV prevention, care and treatment are developed, assessed and analyzed.

#### **Recommendations on the Legislative Future of the Ryan White Program**

The undersigned organizations unanimously agree that the Ryan White Program must be extended for a period of at least three years. We believe an extension is the most prudent course of action given the many concurrent factors impacting the legislative future of the Program. Additionally, the HIV/AIDS community believes that the Ryan White Program must be reexamined in a comprehensive manner after the implementation of much-anticipated health care reform proposals and/or a national HIV/AIDS strategy. It would be premature to alter the Ryan White Program without waiting for specific proposals and programs.

During an extension process the dates in the legislation must be carefully examined and changed to reflect the new authorization period of FY2010 through FY2012. It is important that the dates be changed consistently and language no longer applicable to the Ryan White legislation be eliminated so as not to cause unintended consequences. This process can be looked at as "restarting the clock" on the current three-year authorization. The remainder of our recommendations honors this "restarting" concept and keeps alterations to the legislation at a minimum.

#### ***Authorization Levels***

The current legislation includes authorization levels for each of the three fiscal years that are inadequate to address program need. Included in the current legislation is a 3.7 percent increase for the majority of the Parts, an increase which is significantly less than what is seen in other health authorization legislation such as for the Community Health Centers. For this reason, the community asks that for fiscal years 2010, 2011 and 2012 (the years included in a three year extension of the Program) the section of *Authorization of Appropriations* be altered to include language allowing for such sums as necessary.

*Proposal:* We ask that the extension bill include *Such Sums Necessary* language. This allows appropriators to respond to current economic conditions and provide adequate funding levels. Each Part of the legislation includes a section on *Authorization of Appropriations*. Each section be altered to state: "For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2012."

#### ***Continued Protection for States with Maturing HIV Case Data***

Currently all states are collecting name-based HIV data. However, some states have only recently made this transition and do not yet have mature named-based HIV surveillance systems. In the last reauthorization, states with maturing systems were allowed to submit their HIV data directly to HRSA and incur a five percent penalty. If at any time during the three-year authorization period, the state's name-based HIV data is certified by the Secretary as accurate and reliable, the state has the ability to have CDC directly report the cases and avoid the five percent penalty. CDC has estimated that the earliest that all states may have mature HIV



systems is in FY2012. As the new authorization period goes on, fewer and fewer states will submit their data directly to HRSA and will use the CDC system.

*Proposal:* We recommend that states continue to have the option of submitting name-based data to HRSA until their state's name-based reporting system is deemed accurate and reliable by the HHS Secretary. Under this scenario, the five percent penalty would stay the same. In Parts A and B of the legislation, the section on *Requirement of Names-Based Reporting* must be updated for fiscal years 2010 through 2012 so that the provision remains the same.

#### ***Extension of TGA Eligibility***

The last reauthorization created two separate tiers of Part A jurisdictions – Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). It also created a prevalence test that had been intended to apply after three years of the bill. HRSA has notified six current TGAs that they are in jeopardy of losing their eligibility in FY2010. The community believes it is premature to discontinue funding to these (and any other jurisdictions) before client level data is fully realized and an analysis can be done of the services provided to individuals. In addition, because HIV data is not currently mature, eligibility is based only on AIDS cases. Once HIV case data becomes available it is assumed that EMA and TGA eligibility will be updated to include HIV and AIDS cases. Continuity of care is vitally important for persons receiving Ryan White-funded services.

*Proposal:* We recommend that all TGAs retain their status and continue to receive Ryan White funding. *Sec. 2609 (c) Certain Eligibility Rules* under Title I of the current legislation should be updated to ensure that transitional grant areas retain their status. Language referencing subpart I should specifically be made to refer to transitional grant areas and the years should be updated as follows: References to fiscal year 2006 should be changed to fiscal year 2009 and references to fiscal year 2007 should be changed to fiscal year 2010.

#### ***Extension of Hold Harmless Provisions***

Over the years, The HIV/AIDS community has wrestled with the issue of “hold harmless” provisions which, as of the last reauthorization, are now applied to the Part A Eligible Metropolitan Area (EMA) to eligible cities and Part B formula grants to states. Many organizations within the community maintain that the formulas should operate without adjustment in an effort to allow funds to follow the epidemic as closely as possible. At the same time, many (often the same) organizations have expressed concern that programs serving Ryan White clients need consistent levels of funding to make investment in infrastructure and build comprehensive programs. Large shifts, particularly drops in funding, can be destabilizing and lead to gaps in the provision of primary care and support services. As the numbers of reported HIV cases have changed relative to other jurisdictions and as the formulas for both Parts A and B have changed over the years to emphasize different factors, Congress has created a hold harmless clause to ensure that jurisdictions do not lose levels of funding that jeopardize the provision of HIV/AIDS services. Thus, “hold harmless” provisions were instituted to attempt to control the rate at which jurisdictions felt the full impact of new formulas. It should be noted that while a jurisdiction's proportion of HIV/AIDS cases relative to other jurisdictions might decrease, the number of persons living with HIV/AIDS in need of Ryan White services continues to increase in every jurisdiction. Many organizations have expressed concern that the discussion over hold

harmless has at times overshadowed the real issue facing all funded jurisdictions which is that current funding levels are inadequate to meet demands in all areas of our country.

The current legislation instituted new “hold harmless” provisions for Part A Eligible Metropolitan Areas (EMAs) and Part B formula awards by authorizing funding for grants in FY 2007 at not less than 95% of funding for FY 2006 and funding in FY 2008 and FY 2009 at not less than 100% of 2007. The formulas for Parts A and B continue to be in a period of adjustment due to several factors including the switch in formulas to living HIV/AIDS cases from estimated living AIDS cases and the fact that some states’ new name-based HIV reporting systems have not yet matured. The CDC has estimated that the earliest a nationwide mature HIV system would be available is 2012. Further, the number of living HIV and AIDS cases continue to fluctuate and additional cases from maturing name-based HIV reporting systems will be added to overall case counts. Due to a convergence of all the above factors, eliminating hold harmless provisions in this transitional period would likely result in a loss of funding in some jurisdictions that would lead to destabilized HIV/AIDS care and support services.

*Proposal:* In keeping with other proposals in this document, the HIV/AIDS community recommends that the hold harmless provisions for Parts A and B should be restarted by simply adjusting the dates on current legislation as follows: formula grants in FY 2010 should be no less than 95% of funding for FY 2009 and funding for FY 2011 and FY 2012 should be no less than 100% of FY 2010.

*Minority View:* AIDS Alabama, Colorado AIDS Project, Community Access National Network, Connecticut AIDS Resource Coalition, Northern Colorado AIDS Project, the Southern AIDS Coalition, The AIDS Institute and Western Colorado AIDS Project agree with the majority viewpoint that FY 2010 should be set at no less than 95% of funding for FY 2009. For FY 2011 and FY 2012 this group would like to see the formula funding for Parts A and B better match the number of HIV/AIDS cases in each jurisdiction without destabilizing existing systems of care. Additionally, these organizations believe the same hold harmless measures should be adopted for Transitional Grant Areas as for EMAs.

***Allow the Provision of Food Pursuant to a Doctor's Prescription as a Core Medical Service***  
Under the 2006 reauthorization, Medical Nutrition Therapy (MNT) is an allowable core service. MNT involves the assessment of the nutritional status of a person with a condition, illness or injury that puts them at risk, by a registered dietitian. It is a comprehensive examination of each individual that includes the review and analysis of medical and diet history, anthropometric measurements and laboratory values, after which the registered dietitian provides nutritional counseling and education about a specific disease state. In the case of HIV, a therapeutic nutrition plan that is most appropriate to manage or treat HIV/AIDS is chosen.

Access to adequate and appropriate food is fundamental, as it is the foundation of any medical therapy and has numerous benefits. For people living with HIV/AIDS, a well-balanced diet can help strengthen the immune system, prevent infections and reduce hospitalizations. The majority of the HIV/AIDS community supports the inclusion of food and nutrition services provided pursuant to medical nutrition therapy as a core medical service. Such a provision has no impact on any pre-existing definition of medical nutrition therapy and has many positive medical

outcomes: it connects clients with primary care services, increases adherence to drug regimens and requires maintenance in primary care services for Ryan White Program eligible clients. The Association of Nutrition Services Agencies states that based on an estimate of meal provision throughout their membership only about 20% of meals provided through their membership would qualify for eligibility under this standard, assuming a local planning council prioritized the service in a particular EMA or TGA. Most meals provided would not be affected by this proposal and would continue to be regarded as a support service within the current guidelines of the Ryan White Program.

*Proposal:* Under Parts A and B, core medical services provisions, amend item (H) "Medical nutrition therapy" to state " Medical Nutrition Therapy, and food and nutrition services when provided pursuant to such therapy as advised by a physician" as part of the package of services that can be considered core medical services. Under this proposed approach, the definition of medical nutrition therapy is unaltered, and food and nutrition services not provided pursuant to MNT would continue to be treated as support services.

*Minority Viewpoint:* The American Academy of HIV Medicine (AAHIVM), the HIV Medicine Association (HIVMA) and the Ryan White Medical Providers Coalition (Coalition) define medical nutrition therapy as nutritional supplements prescribed by a licensed dietitian or medical provider. The Academy, Coalition, and HIVMA support the current HRSA interpretation of "medical nutrition therapy" as it applies to core medical services for Ryan White. These organizations do not support an expansion of the definition of medical therapy to include food or other nutrition services. These groups maintain that such an expansion would be a substantive change and goes beyond the scope of technical fixes that are currently under consideration for an extension of the current Ryan White Program through 2012.

***Alter the Definition of Medical Transportation and Allow it as a Core Medical Service***

As a result of the most recent reauthorization, "medical transportation" has been classified as a support service. Medical transportation has been narrowly defined to mean transportation solely to and from Ryan White-funded medical-related services. This interpretation of the term medical transportation fails to accommodate areas that do not have strong public transportation infrastructure or that are comprised of large rural areas. For example the narrow modification may disallow rural gas vouchers, affecting the ability of clients to obtain food or other necessities. In areas with public transportation, it may prevent providers from purchasing the least expensive forms of tickets such as monthly vouchers, instead forcing clients to make multiple trips to service providers for individual bus passes or using more expensive forms of transportation such as taxis. Consequently local authorities are precluded from making common sense decisions about providing transportation in the service of treatment and care. For this reason, we recommend that transportation services within support services be broadened by removing the qualifier "medical."

The HIV/AIDS community has long pointed out the need for a constellation of services to ensure that people living with HIV/AIDS receive the best possible care. The inability of a person living with HIV to access needed medical treatment, including physician services, due to a lack of transportation is itself a lack of medical care. For this reason we additionally recommend that "medical transportation" specifically should be included as a core medical service.

*Proposal:* The HIV/AIDS community recommends removing the qualifier “medical” from transportation in the support services category and including “medical transportation” specifically in the definition of core medical services.

*Minority Viewpoint:* The American Academy of HIV Medicine, the HIV Medicine Association and the Ryan White Medical Providers Coalition support the current HRSA interpretation of transportation and do not support changes to the definition of transportation or the addition of medical transportation to the core medical service definition. These groups agree that medical transportation is important but many HIV programs are facing serious challenges covering the current list of core medical services, including critical components of the standard for HIV care, such as laboratory monitoring. They also feel that such an expansion would be a substantive change in the opinion of these groups and goes beyond the scope of technical fixes that are currently under consideration for an extension of the current Ryan White Program through 2012.

### **Technical Fixes**

These technical fixes were submitted to Congress in the fall of 2008 and remain a high priority for the HIV/AIDS community.

#### **ADAP Rebate Dollars**

Rebate model ADAPs (those that purchase via a pharmacy network and then request rebates from pharmaceutical companies to obtain the 340B program drug prices), which make up over half of the states, have been instructed by HRSA that they must spend rebate dollars first (considered “program income” by HRSA) before using their federal ADAP grant award. With new carryover rules and penalties in the Ryan White HIV/AIDS Treatment Modernization Act, this will lead to some states losing future ADAP funding should they have more than two percent of their federal ADAP grant unobligated. Regardless of how rebate income is classified, the Ryan White Program requires rebates to be put back into the Part B program with preference given to ADAP services. Rebate income should not be considered program income or result in a reduction of expenditures and therefore should be allowed to accrue after a grant year has ended and spent after federal funds are expended.

*Proposed Language:* “In keeping with Congressional intent and Section 2622 (d) of Public Law 109-415, rebate funds associated with Section 2616 of Public Health Service Act (42 U.S.C. 300ff-26) are exempt from 45CFR92.21. HRSA will consult with state grantees to develop a process that certifies and describes that such funds are in compliance with Section 2616 (g) of Public Law 109-415.”

#### **Unobligated Funds**

The current legislation contains a provision that penalizes Part A and B grantees if they have more than two percent of their award unobligated at the end of a grant year by making them ineligible for the supplemental components of their awards. This provision presents an undue burden on grantees, who must comply with basic grants management such as working with subgrantees, but also deal with state budget factors such as hiring freezes, spending caps, etc. that make obligating grant dollars down to a very small amount difficult. Due to these uncertain economic times, it is not appropriate to penalize HIV/AIDS programs for circumstances beyond their programmatic control. We support an increase in the penalty threshold from two to five

percent. Additionally, we ask that the penalties for having more than five percent of grants unobligated be suspended, allowing grantees access to subsequent years supplemental funding and eliminating reductions in future grant awards.

*Proposed Language:* For Parts A and B, strike or suspend “Corresponding Reduction in Future Grant” section under Section 104 and Section. 207 – “Timeframe for Obligation and Expenditure of Grant Funds.” Additionally, in all Parts providing a penalty for failure to obligate funds, change the language of the exception to the penalty from 2 percent to 5 percent. For example, for language reading, “except that this clause does not apply to the eligible area if the amount of the unobligated balance was 2 percent or less”, strike “2” and replace with “5”.

*Minority Viewpoint:* The AIDS Institute does not support this proposal in total. It supports expanding the amount of unobligated balances allowed to up to 5 percent, and striking one penalty, specifically the one that makes jurisdictions ineligible for future supplemental funding.

#### **Ryan White Part D (Services for Women, Infants, Children, Youth and Families) Medical Expense Reporting Requirements**

For FY2007 and FY2008 budgets, Ryan White Part D grantees have been instructed by HRSA to include medical expenses in their program budget. Unlike other parts of the Ryan White Program, Part D is not required to allocate a proportion of funds to medical expenses, as Part D grantees are able to access Medicaid, SCHIP and other public programs to pay for most primary medical care for their clients. In fact, Part D was exempted from the core medical services set aside in the 2006 reauthorization legislation. Part D must, however, provide access to these services either directly or through contract. This has been a requirement of Part D since its inception, and HRSA has historically allowed Part D grantees to enter into memoranda of understanding (MOUs) with medical providers to ensure access to primary care, even when financial reimbursement was not involved. The Ryan White Program is required to be the payer of last resort, and asking Part D dollars to go toward medical expenses that can be paid for through other sources is in direct conflict with this requirement.

*Proposed Language:* Section 2671 (h) definitions (3) Services add the following “(C) Nothing in this part shall be construed as requiring funds to be used for primary medical care when other payers are available for such care.”

Add (4) Contracts.-The term “contracts” includes memoranda of understanding when outpatient or ambulatory care is provided outside of this part.

#### **Severity of Need Index and Client Level Data**

The current legislation allows for the development of both Client Level Data (CLD) and a Severity of Need Index (SONI), but intentionally does not include provisions for implementing the CLD or the SONI as components of the funding allocation process. CLD will commence on January 1, 2009 with a portion of grantees and will run parallel with the current HRSA data systems for one to two years. A version of SONI has been developed, but not tested. Since HIV data will not be mature for all states until at least 2012, we believe that Part A and Part B resources should continue to be distributed by existing formula and supplemental mechanisms through 2012. Additionally, HRSA issued a competitive grant notice to Part A and B for funds to assist in the development of their CLD system. The grant announcement was issued so early

in the process that many states and cities did not apply for the funds but are now realizing they need them. SPNS funds should be made available on a continuing basis to cities and states that need them to support activities to develop, maintain, and train on use of a CLD systems.

*Proposed Language:* “It is the intent of Congress that Part A and Part B resources continue to be distributed by existing formula and supplemental mechanisms.” Amend Section 2691 Special Projects of National Significance, Subparagraph (b) by inserting after “The Secretary shall award grants under subsection (a) to entities eligible for funding under parts A, B, C, and D” the following “to support them in implementing the new client level data system and make funds available to each Part in the same percentage as each Part’s contribution to the SPNS budget.”

Note: This document has been created by the Ryan White Work Group of the Federal AIDS Policy Partnership. For additional information, please contact Co-Chairs Ann Lefert (NASTAD) at 202-434-7138 or at [alefert@nastad.org](mailto:alefert@nastad.org) or William McColl (AIDS Action), at 202-530-8030 ext. 3096 or at [wmcoll@aidSACTION.org](mailto:wmcoll@aidSACTION.org).

**The following organizations endorse the recommendations in the *HIV/AIDS Community Consensus on the Future of the Ryan White HIV/AIDS Treatment Modernization Act*:**  
(Note: 299 organizations have signed on as of September 8, 2009. They are arranged alphabetically by State, Territory and the District of Columbia)

<b>Alabama</b>	
AIDS Alabama, Birmingham, AL	AL
Southern AIDS Coalition, Birmingham, AL	AL
<b>Alaska</b>	
HIV/AIDS Services for African Americans in Alaska, Anchorage, AK	AK
Alaskan AIDS Assistance Association, Anchorage, AK	AK
<b>Arizona</b>	
HIV/AIDS Law Project, Phoenix, AZ	AZ
<b>Arkansas</b>	
Jefferson Comprehensive Care System, Inc., Pine Bluff, AR	AR
<b>California</b>	
AIDS Housing Alliance, San Francisco, CA	CA
AIDS Legal Referral Panel of the San Francisco Bay Area, San Francisco, CA	CA
AIDS Project Los Angeles, Los Angeles, CA	CA
Alameda and Contra Costa Counties Collaborative Community Planning Council Transitional Grant Area Oakland, CA	CA
AltaMed Health Services, East Los Angeles, CA	CA
Asian & Pacific Islander American Health Forum, San Francisco, CA	CA
Asian & Pacific Islander Wellness Center, San Francisco, CA	CA
Bienestar Human Services, Los Angeles, CA	CA
Black Coalition on AIDS, San Francisco, CA	CA
Catholic Charities CYO, San Francisco, CA	CA
Common Ground – the Westside HIV Community Center, Santa Monica, CA	CA
County of Los Angeles Department of Public Health, Office of AIDS Programs and Policy, Los Angeles, CA	CA

Desert AIDS Project, Palm Springs, CA	CA
Face to Face/Sonoma County AIDS Network, Santa Rosa, CA	CA
Food Bank of Contra Costa and Solano, Concord, CA	CA
HIV ACCESS, Alameda County, CA	CA
Los Angeles Gay & Lesbian Center, Los Angeles, CA	CA
Mendocino County AIDS Volunteer Network, Ukiah, CA	CA
Project Inform, San Francisco, CA	CA
Project Open Hand, San Francisco, CA	CA
Sacramento HIV Health Services Planning Council, Sacramento, CA	CA
San Francisco AIDS Foundation, San Francisco, CA	CA
San Francisco HIV Health Services Planning Council, San Francisco, CA	CA
Solano County Health and Social Services Department, Vallejo, CA	CA
Sonoma County Commission on AIDS, Santa Rosa, CA	CA
Southern California HIV Advocacy Coalition (SCHAC), Los Angeles, CA	CA
Strong Consulting, Crescent City, CA	CA
Transgender Law Center, San Francisco, CA	CA
<b>Colorado</b>	
Boulder County AIDS Project, Boulder, CO	CO
Colorado AIDS Project, Denver, CO	CO
Denver Health HIV Primary Care Clinic, Denver, CO	CO
Northern Colorado AIDS Project, Fort Collins, CO	CO
Project Angel Heart, Denver, CO	CO
Southern Colorado AIDS Project, Colorado Springs, CO	CO
The Empowerment Program, Women's AIDS Project, Denver, CO	CO
Western Colorado AIDS Project, Grand Junction, CO	CO
<b>Connecticut</b>	
Connecticut AIDS Resource Coalition, Hartford, CT	CT
<b>Delaware</b>	
AIDS Delaware, Wilmington, DE	DE
Delaware HIV Consortium, Wilmington, DE	DE
<b>District of Columbia</b>	
ADAP Advocacy Association (aaa+), Washington, DC	DC
AIDS Action Council, Washington, DC	DC
AIDS Alliance for Children, Youth & Families, Washington, DC	DC
American Academy of HIV Medicine, Washington, DC	DC
American Dental Education Association, Washington, DC	DC
American Psychological Association, Washington, DC	DC
Association of Nutrition Services Agencies (ANSA), Washington DC	DC
CAEAR Coalition, Washington, DC	DC
CAEAR Foundation, Washington, DC	DC
Community Access National Network, Washington, DC	DC
Food & Friends, Washington, DC	DC
Hispanic Federation, Washington, DC	DC
Human Rights Campaign, Washington, DC	DC
National AIDS Fund, Washington, DC	DC
National Alliance of State and Territorial AIDS Directors, Washington, DC	DC

National Association of Community Health Centers, Washington, DC	DC
National Association of Counties, Washington, DC	DC
National Association of County and City Health Officials (NACCHO), Washington, DC	DC
National Association of People With AIDS, Washington DC	DC
National Black Gay Men's Advocacy Coalition, Washington, DC	DC
National Center for Transgender Equality, Washington, DC	DC
National Coalition for LGBT Health, Washington, DC	DC
National Gay and Lesbian Task Force Action Fund, Washington, DC	DC
National Minority AIDS Council, Washington, DC	DC
Parents, Families, and Friends of Lesbians and Gays (PFLAG) National, Washington, DC	DC
Sexuality Information and Education Council of the United States (SIECUS), Washington, DC	DC
The Women's Collective, Washington, DC	DC
Us Helping Us, Washington, DC	DC
<b>Florida</b>	
Broward House, Inc., Fort Lauderdale, FL	FL
Dab the AIDS Bear Project, Jacksonville, FL	FL
Okaloosa AIDS Support and Informational Services, Inc., Ft. Walton Beach, FL	FL
South Beach AIDS Project, Miami, FL	FL
The AIDS Institute – Tampa, FL/Washington, DC	FL
<b>Georgia</b>	
AID Atlanta, Atlanta, GA	GA
AID Gwinnett, Duluth, GA	GA
AIDS Athens, Athens, GA	C
AIDS Research Consortium of Atlanta, Atlanta, GA	GA
AIDS Resource Council, Rome, GA	GA
Aniz, Atlanta, GA	GA
Community Foundation for Greater Atlanta, Atlanta, GA	GA
Georgia AIDS Coalition, Snellville, GA	GA
Georgia Equality, Atlanta, GA	GA
Georgia Ryan White Working Group, Atlanta, GA	GA
Grady Health System Infectious Disease Program, Atlanta, GA	GA
Health STAT, Atlanta, GA	GA
Living Room, Atlanta, GA	GA
Metro Atlanta Ryan White Planning Council, Atlanta, GA	GA
My Brothaz Home, Savannah, GA	GA
North Georgie AIDS Alliance, Gainesville, GA	GA
Open Hand, Atlanta, GA	GA
Positive Impact, Atlanta, GA	GA
SisterLove, Atlanta, GA	GA
Someone Cares, Marietta, GA	GA
Southern Crescent HIV Center, Riverdale, GA	GA
The Phoenix Group Foundation, Inc., Atlanta, GA	GA
Travelers Aid of Metropolitan Atlanta, Atlanta, GA	GA
What Would Jesus Do HIV Health Ministry, Atlanta, GA	GA
<b>Hawaii</b>	
Hawaii Island HIV/AIDS Foundation, Keaau, HI	I
Malama Pono Kauai AIDS Project, Lihue, Kauai, HI	HI



Maui AIDS Foundation, Wailuku, HI	HI
<b>Idaho</b>	
The O! Zone, Boise, ID	ID
<b>Illinois</b>	
AIDS Foundation of Chicago, Chicago, IL	IL
AIDS Legal Council of Chicago, Chicago, IL	IL
Asian Human Services, Chicago, IL	IL
Austin Health Center of Cook County, Chicago, IL	IL
BEHIV, Chicago, IL	IL
CBC Initiative, Austin Health Center of Cook County, Chicago, IL	IL
Center on Halsted, Chicago, IL	IL
Chicago House and Social Service Agency, Chicago, IL	IL
Heartland Alliance for Human Needs & Human Rights, Chicago, IL	IL
HIV/AIDS Community Clinic Network, College of Medicine, University of Illinois at Chicago, Chicago, IL	IL
Howard Brown Health Center, Chicago, IL	IL
Illinois Caucus for Adolescent Health, Chicago, IL	IL
International Association of Physicians in AIDS Care (IAPAC), Chicago, IL	IL
New Age Services, Chicago, IL	IL
Open Door Clinic, Elgin, IL	IL
Ruth M. Rothstein CORE Center, Chicago, IL	IL
South Side Help Center, Chicago, IL	IL
Southern Illinois AIDS Walk, Carbondale, IL	IL
The Children's Place Association, Chicago, IL	IL
Vital Bridges NFP, Inc., Chicago, IL	IL
<b>Indiana</b>	
Harm Reduction Institute, Indianapolis, IN	IN
Tri-State Alliance, Inc., Evansville, IN	IN
<b>Iowa</b>	
AIDS Project of Central Iowa, Des Moines, IA	IA
Community HIV/Hepatitis Advocates of Iowa Network (CHAIN), Des Moines, IA	IA
Wilson Resource Center (WRC), Arnolds Park, IA	IA
<b>Kansas</b>	
Douglas County AIDS Project, Lawrence, KS	KS
United Methodist Mexican-American Ministries, Garden city, KS	KS
<b>Kentucky</b>	
AIDS Interfaith Ministries of Kentuckiana, Inc. (AIM), Louisville, KY	KY
House of Ruth, Inc. , Louisville, KY	KY
Volunteers of America, Inc. (VOA), Louisville, KY	KY
<b>Louisiana</b>	
NO/AIDS Task Force, New Orleans, LA	LA
Office of Health Policy & AIDS Funding, New Orleans, LA	LA
<b>Maine</b>	

Frannie Peabody Center, Portland, ME	ME
Maine AIDS Alliance, Portland, ME	ME
Maine Community AIDS Partnership, Augusta, ME	ME
<b>Maryland</b>	
AIDS Action Baltimore, MD	MD
Baltimore Behavioral Health, Baltimore, MD	MD
Baltimore City Commission on HIV/AIDS, Baltimore, MD	MD
Chase Brexton Health Services, Baltimore, MD	MD
HIV/AIDS Volunteer Enrichment Network, Inc. (HAVEN), Annapolis, MD	MD
Johns Hopkins AIDS Care Program, Baltimore, MD	MD
LIGHT, Health and Wellness Comprehensive Services, Inc., Baltimore, MD	MD
Manna House Inc, Baltimore, MD	MD
Moveable Feast, Inc., Baltimore, MD	MD
Park West Health System, Inc., Hidden Garden Program, Baltimore, MD	MD
Sisters Together And Reaching, Inc. (STAR)	MD
<b>Massachusetts</b>	
AIDS Action Committee of Massachusetts, Boston, MA	MA
Boston Health Care for the Homeless Program, Boston, MA	MA
Cambridge Health Alliance-HIV Services, Cambridge MA	MA
Catholic Charitable Bureau of the Archdiocese of Boston, Inc., Boston, MA	MA
Community Research Initiative of New England, Boston, MA	MA
Community Servings, Boston, MA	MA
GAAMHA, Inc., Gardner, MA	MA
Health Care of Southeastern Mass., Inc., Brockton, MA	MA
HOPE: Hispanic Office of Planning and Evaluation, Inc., Boston, MA	MA
JRI Health, Boston, MA	MA
Latin American Health Institute, Boston, MA	MA
<b>Michigan</b>	
AIDS Partnership Michigan, Detroit, MI	MI
CARES (Community AIDS Resource and Education Services), Kalamazoo, MI	MI
Community Health Awareness Group, Detroit, MI	MI
HIV/AIDS Alliance of Michigan, Detroit, MI	MI
HIV/AIDS Resource Center, Ypsilanti, MI	MI
Lansing Area AIDS Network, Lansing, MI	MI
Michigan HIV/AIDS Council, Lansing, MI	MI
National Association of AIDS Education and Training Centers, Detroit, MI	MI
Wellness AIDS Services, Inc., Flint, MI	MI
<b>Minnesota</b>	
The Aliveness Project, Minneapolis, MN	MN
Camp Benedict, MN	MN
Hope House, Minneapolis, MN	MN
Hope House of St. Croix Valley, Stillwater, MN	MN
Minneapolis Medical Research Foundation, i-MAC2 Clinics, Minneapolis, MN	MN
Minnesota AIDS Project, Minneapolis, MN	MN
Minnesota HIV Services Planning Council, Minneapolis, MN	MN
Open Arms of Minnesota, Minneapolis, MN	MN

<b>Mississippi</b>		
A Brave New Day, Jackson, MS		MS
Center of H.O.P.E., Jackson, MS		MS
<b>Missouri</b>		
Food Outreach, Inc. St. Louis, MO		MO
<b>Nebraska</b>		
Caring People Sudan, Omaha, NE		NE
<b>Nevada</b>		
Aid for AIDS of Nevada, Las Vegas, NV		NV
Neighborhood Network, Las Vegas NV		NV
The Winged Dragon Society Inc, dba F.O.C.U.S. In Southern Nevada		NV
<b>New Hampshire</b>		
AIDS Response Seacoast, Portsmouth, NH		NH
AIDS Services for the Monadnock Region, Gilsum, NH		NH
Southern NH HIV/AIDS Task Force, Nashua, NH		NH
<b>New Jersey</b>		
AIDS Coalition of Southern New Jersey, Bellmawr, NJ		NJ
African American Office Of Gay Concerns, Newark, NJ		NJ
Buddies of New Jersey, Inc., Hackensack, NJ		NJ
City of Passaic/ Passaic Alliance, Passaic, NJ		NJ
City of Paterson, NJ		NJ
Friends for Life, Fort Lee, NJ		NJ
Horizon Health Center, Jersey City, NJ		NJ
Hyacinth AIDS Foundation, New Brunswick, NJ		NJ
NJSHAC ( New Jersey Statewide HIV/AIDS Coalition), East Brunswick, NJ		NJ
Paterson Counseling Center, Inc., Paterson, NJ		NJ
Puerto Rican Family Institute, Jersey City, NJ		NJ
Ryan White Part C grant VNACJ Community Health Center, Inc, Asbury Park, NJ		NJ
St. Mary's Hospital Early Intervention Program (EIP Clinic), Passaic, NJ		NJ
Visiting Nurse Association of Central Jersey, Red Bank, NJ		NJ
<b>New Mexico</b>		
New Mexico AIDS Services Albuquerque, NM		NM
OUTREACH New Mexico HIV Consumer Advocacy Network, Albuquerque, NM		NM
Southwest CARE Center - Santa Fe, NM		NM
<b>New York</b>		
African Services Committee, New York, NY		NY
AIDS Institute, New York State Department of Health, Albany, NY		NY
AIDS Service Center NYC, New York, NY		NY
AIDS Treatment Data Network, New York, NY		NY
Albany Damien Center, Albany, NY		NY
amfAR, The Foundation for AIDS Research, New York, NY		NY
Asian & Pacific Islander Coalition on HIV/AIDS (APICHA), New York, NY		NY

Bedford Stuyvesant Family Health Center, Inc. - Wellness Center, Brooklyn, NY	NY
Center for Community Alternatives, Syracuse, NY/New York, NY	NY
Central New York Health Systems Agency, Inc., East Syracuse, NY	NY
Central New York HIV Care Network, East Syracuse, NY	NY
Cicatelli Associates Inc., New York, NY	NY
Gay Men's Health Crisis, New York, NY	NY
George Santana Citiwide Harm Reduction, Bronx NY	NY
God's Love We Deliver, New York, NY	NY
Harlem United, New York, NY	NY
Latino Commission on AIDS, New York, NY	NY
Lower East Side Harm Reduction Center, New York, NY	NY
Mid-Hudson Valley AIDS Task Force, Inc., Hawthorne, NY	NY
National Latino AIDS Action Network (NLAAN), New York, NY	NY
Nassau-Suffolk HIV Care Network, Long Island, NY	NY
Nassau-Suffolk HIV Health Services Planning Council, Long Island, NY	NY
NY HIV Health & Human Services Planning Council, New York, NY	NY
Positive SPACE, Copaugue, NY	NY
The AIDS Network of Western New York, Inc., Buffalo, NY	NY
The Family Center, New York, NY	NY
The Recovery Center (HIV/AIDS Services Dept) Monticello, NY	NY
The Sharing Community, Yonkers, NY	NY
Village Care of New York, New York NY	NY
<b>North Carolina</b>	
Triad Health Project, Guilford County, NC	NC
<b>Ohio</b>	
AIDS Resource Center Ohio, Dayton, OH	OH
AIDS Taskforce of Greater Cleveland, Cleveland, OH	OH
Association of Nurses in AIDS Care, Akron, OH	OH
Ohio AIDS Coalition, Columbus, OH	OH
Ryan White Consortium # 5, Toledo, OH	OH
Stark County Regional HIV Prevention & Education Planning Advisory Group, Canton, OH	OH
Woodlands AIDS Task Force, Newark, OH	OH
<b>Oklahoma</b>	
Tulsa Community AIDS Partnership, Tulsa, OK	OK
<b>Oregon</b>	
Cascade AIDS Project, Portland, OR	OR
OHSU/Partnership Project, Portland, OR	OR
<b>Pennsylvania</b>	
ActionAIDS, Inc, Philadelphia, PA	PA
AIDS Care Group, Chester, PA	PA
AIDSNET, Bethlehem, PA	PA
Calcutta House, Philadelphia, PA	PA
Family and Community Service of Delaware County, Media, PA	PA
Family Service Association of Bucks County, Langhorne, PA	PA
Family Service of Chester County, West Chester, PA	PA

Family Services of Montgomery County, Eagleville, PA	PA
Gaudenzia, Inc., Philadelphia, PA	PA
Keystone Hospice and KeystoneCare LLC, PA	PA
MANNA, Philadelphia, PA	PA
Northeast Regional HIV Planning Coalition United Way of Wyoming Valley, Wilkes Barre, PA	PA
Pennsylvania School for the Deaf/Center for Community and Professional Services, Philadelphia, PA	PA
Philadelphia FIGHT, Philadelphia, PA	PA
Pittsburgh AIDS Task Force, Pittsburgh, PA	PA
Public Health Management Corporation, Philadelphia, PA	PA
SHAC (Suburban HIV/AIDS Consortium), PA	PA
Temple Comprehensive HIV Program, Temple University School of Medicine, Philadelphia, PA	PA
The COLOURS Organization, Inc., Philadelphia, PA	PA
<b>Puerto Rico</b>	
Bill's Kitchen, Inc., San Juan, Puerto Rico	PR
Pacientes de SIDA Pro-Política Sana (PSPS)	PR
<b>Rhode Island</b>	
AIDS Care Ocean State, Providence, RI	RI
Community HIV/AIDS Mobilization Project (CHAMP), New York, NY /Providence, RI	RI
seaQuel (Southeast Asian Queers United for Empowerment and Leadership), Providence RI	RI
Youth Student Movement (PrYSM), Providence, RI	RI
<b>South Carolina</b>	
South Carolina Campaign to End AIDS (SC-C2EA), Columbia, SC	SC
<b>Tennessee</b>	
Positive East Tennessean's, Knoxville, TN	TN
Nashville CARES, Nashville TN	TN
Tennessee AIDS Advocacy Network, TN	TN
Tennessee AIDS Care and Treatment Improvement Coalition (TACTIC), Nashville, TN	TN
<b>Texas</b>	
AIDS Services of Austin, Austin, TX	TX
Bexar County Department of Community Investment, San Antonio, TX	TX
International AIDS Empowerment, El Paso, TX	TX
Legacy Community Health Services, Inc. Houston, TX	TX
North Central Texas HIV Planning Council, Fort Worth, TX	TX
San Antonio AIDS Foundation, San Antonio, TX	TX
South Texas Development Council, Laredo, TX	TX
Triangle AIDS Network, Beaumont, TX	TX
<b>Utah</b>	
Utah AIDS Foundation, Salt Lake City, UT	UT
<b>Vermont</b>	
Vermont People with AIDS Coalition, Montpelier, VT	VT
<b>Virginia</b>	
Fan Free Clinic, Richmond, VA	VA

Health and Home Support Services, Inc., Newport News, VA	VA
HIV Medicine Association (HIVMA), Arlington, VA	VA
MediCorp Health System/ Infectious Disease Associates, Fredericksburg, VA	VA
Ryan White Medical Providers Coalition, Arlington, VA	VA
Williamsburg AIDS Network, Williamsburg, VA	VA
<b>Washington</b>	
Lifelong AIDS Alliance, Seattle, WA	WA
<b>Wisconsin</b>	
HIVictorious, Inc., Madison, WI	WI
One Heartland, Milwaukee, WI	WI
State of Wisconsin AIDS/HIV Program, Madison, WI	WI
<b>West Virginia</b>	
AIDS Task Force of the Upper Ohio Valley, Wheeling, WV	WV
NAMES Project Foundation, Upper Ohio Valley Chapter, Wheeling, WV	WV
<b>Wyoming</b>	
Albany County AIDS Project, Laramie, WY	WY

*\*Note: Original release of this document took place on March 10, 2009. Sign-ons to the document will be updated as needed. The internal content of later versions of the document, other than sign-ons, has not changed.*

Mr. PALLONE. Dr. Sweet.

**STATEMENT OF DONNA E. SWEET**

Dr. SWEET. Chairman Pallone and distinguished members of the committee, I am honored to be here today to discuss the reauthorization and extension of the Ryan White program, specifically part C. I will keep my comments brief. I have submitted a full testimony for the record, and my credentials are in there, but I am here today as medical director of a part C Ryan White clinic in Wichita, Kansas, the other KU, who also sees patients in outreach clinics in Garden City, Salina and Pittsburgh. I am also a credentialed specialist in HIV/AIDS and the current Board Chair of the American Academy of HIV Medicine, headquartered here in Washington, D.C.

The mission of my part C program is to provide care and early intervention services to all HIV-positive individuals in the State of Kansas regardless of their ability to pay. Part C clinics provide care nationally to approximately 250,000 people living with HIV, as well as providing HIV-related counseling and testing. Many have mixed sources of funding, including some or all parts of the Ryan White program.

Today I would like to take you inside a part C clinic to the front lines of medicine, fighting for the lives of people living with HIV. My part C clinic provides care and treatment to 1,246 patients. Of these, 40 percent would have no coverage at all if it were not for the Ryan White CARE Act. We provide ongoing, comprehensive care to an ever-increasing number of patients.

My clinic has an average annual increase of over 100 new patients a year; however, we are still working off the same number of Ryan White dollars we received since 1999. As a result, in the last 10 years my clinic patient load has doubled, and yet my funding has remained the same. To supplement our insufficient Federal dollars, we often do things like annual bake sales, picnics, and other things that the community does in order to support the clinic and its patients.

There has been some discussion over the recent years of the concept of the patient-centered medical home. That is what my Ryan White part C clinic is and has been since 1994. In my clinic, case management, psychological counseling, dental care, pharmacy management, adherence counseling and, when needed, palliative care are all brought together under one roof. This approach has been central to our ability to retain patients in long-term care.

The real effect of the Ryan White program if it were allowed to lapse for even a short amount of time would be seen on the front lines of the disease in clinics like mine. For my clinic that would mean losing access to part C money that pays for care and treatment of over 40 percent of my patients, part B money that funds my case managers, and ADAP money that provides drugs for patients who cannot afford them, nearly 80 percent of the total. On June 1, I would no longer be able to pay my staff and they would have to be let go. I have not had any staff turnover in 5 years, and my people are well trained in caring for my HIV patients. They are well qualified and would no doubt have no trouble finding other employment; however, the loss to my clinic would be irreversible.

If the Ryan White program were to face a gap in service of even a few months, years of investment in staff and infrastructure would be lost.

Without part C, my patients would have no other place to go for the lifesaving services and treatment that we can now offer. Without care, patients' lives would be lost. Over the last 20 years, HIV has become a highly manageable disease with proper care and treatment. In the mid-1990s, mortality rates plummeted with the new medicines and treatments which allowed better ways of fighting the virus. Patients are living longer, which brings about a new set of medical challenges. Treating HIV is enormously complex, but it becomes even more so when you are faced now with the medical needs of elderly patients.

Fortunately in my clinic, I now see only 15 to 20 AIDS deaths a year, but that number will increase dramatically if the population loses access to the care they need. The Ryan White program is invaluable to the patients and the providers that it funds, and Congress must not delay in reauthorizing it. Over the past year, numerous HIV and AIDS organizations have come together through the Federal AIDS Policy Partnership, or FAPP, to form a consensus on reauthorizing the program. I have participated in those discussions, and I urge the committee to consider the recommendations of the consensus document which you have received. Among those recommendations, however, I would like to highlight a few that are important to me and my clinic.

The CARE Act needs to be reauthorized for at least 3 years, and I also like the administration's 4. We need to have assurance of a stable and continuous funding stream in order to care for our patients in the best way possible. Authorization levels included in legislation that was under discussion this year was a 3.7 percent increase for the majority of the parts, significantly less than the annual increase for community health centers. As someone running a clinic that really has to do its own fundraising to keep its doors open, I would appreciate consideration of language authorizing such sums as necessary in the program because we have not been getting what is necessary. And thirdly, the provision of core medical services, the 75/25 rule needs to be protected. Additional recommendations are listed, and I will urge the committee to thoughtfully consider them.


But in closing, I would like to leave the committee with a few thoughts. Without the Ryan White program, my clinic never would have been created. Without a timely reauthorization, it may cease to exist. And without the clinic my patients will not receive the care they need. And without that care, the disease they live with every day may unnecessarily and prematurely claim their lives.

The Ryan White program works. It is critical to the care and treatment of those affected by this Nation's largest epidemic, and I urge the committee to authorize the program with all due haste.

Thank you for the opportunity to testify today about Ryan White part C. This concludes my testimony, but I would be more than happy to answer questions.

[The prepared statement of Dr. Sweet follows:]



	<p><b>Testimony on September 9, 2009</b></p> <p><b>Committee on Energy and Commerce</b></p> <p><b>Subcommittee on Health</b></p> <p><b>United States House of Representatives</b></p>
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**Ryan White Part C**

*Statement of*

***Donna E. Sweet, MD, MACP, AAHIVS***

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Board Chair,  
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Washington, DC



Chairman Pallone, Ranking Member Deal, and distinguished Members of the Committee. I am honored to be here today to discuss the reauthorization and extension of the Ryan White Program. Today I will focus on Part C of the Ryan White Program.

I am a Professor of Internal Medicine at the University of Kansas School of Medicine-Wichita. I received my medical degree from the University of Kansas School of Medicine in 1979, and completed my residency in internal medicine in 1982. I joined KUSM-W's Department of Internal Medicine as an instructor, and became professor in 1993.

In addition to my duties with the school and clinic, I have previously served as President of the Advisory Board for the Sedgwick County Board of Health and as Chair for the Board of Regents of the American College of Physicians (ACP), the nation's largest medical specialty society. In 1995 I was one of 130 researchers and clinicians invited to take part in the first White House Conference on HIV and AIDS. I serve as director and principal investigator for the medical school's Ryan White III Comprehensive AIDS Resources program, the only such program in Kansas. I was one of the founders and am now Principal Investigator of the Kansas AIDS Education Training Center.

I am also a credentialed Specialist in HIV/AIDS, and the current Board Chair of the American Academy of HIV Medicine, headquartered here in Washington DC. The Academy is a professional organization of HIV medical providers, offering its members education and credentialing in HIV specialty care.

The mission of the HIV Program at KU Internal Medicine Midtown is to provide care and early intervention services to all HIV-positive individuals in the state of Kansas, regardless of ability to pay. The HIV Program seeks to provide quality community-based medical care, education and research throughout Wichita, as well as the rest of the state. The KU Internal Medicine Midtown facility is located in Wichita, KS. In addition, care is provided in outreach clinics in Garden City, Salina and Pittsburg every

six to eight weeks. Our program is "considered the gold standard for HIV care in the state" according to the Primary Care Assessment Tool (2000) administered by the Health Resources and Services Administration (HRSA).

You all are quite familiar with the need for the Ryan White Program. Part C funds nearly 400 community health centers and clinics that provide comprehensive HIV and medical care throughout the U.S. The program targets the most vulnerable communities: people of color, women, and the poor. Part C clinics provide care to approximately 250,000 people living with HIV/AIDS, and are on the front lines of offering HIV-related counseling and testing. Many have mixed sources of funding, including Parts A, B, C and D of the Ryan White Program. Part C clinic also serve as medical homes, providing the whole range of medical services to keep patients healthy.

Today, I would like to take you inside Part C of the Ryan White program – to the front lines of medicine fighting for the lives of people living with HIV/AIDS.

The HIV Program KU Internal Medicine Midtown provides care and treatment to 1246 patients as of today. Of these, 40% would have no coverage if it were not for the Ryan White Care Act. We provide ongoing, comprehensive care to an ever-increasing number of patients, regardless of their ability to pay. My clinic has an average annual increase of over 100 new patients a year (in Kansas- not New York or California). However, we are still working off the same number of Ryan White dollars we have received since 1999. To broadly paint the picture: In the last 10 years my clinic's patient load has doubled, and my funding has remained the same.

Because of a decade of level funding – or in spite of it – the clinic runs with the utmost administrative efficiency. It's worth noting that labs are one of our most significant costs. My Chairman at the school likes to remind me that I can, in a sense, "give away" my time as I see fit, but that the lab bills come to his desk. As part of standard monitoring for every HIV patient in my clinic, every three months we run CD4 and viral load counts,

as well as routine diagnostic blood work, altogether costing \$160 every three months per patient. If any of those results indicate salient problems, a genotype lab is run, costing \$350 (which, incidentally, Medicaid only reimburses for \$250).

To supplement our insufficient federal dollars, we will often do things like annual bake sales and picnics to help raise money for the clinic and its patients. Even though we are committed to do things like this to keep the clinic afloat, it is hard to believe that we have to resort to girl-scout-styled fundraising to care for the sick in a country like ours.

There seems to be a commonly held belief that program cuts will only affect administrative functioning and that medical services for the sick will somehow always be available (through Ryan White, or Medicaid, or some other program); this is a false assumption. For this reason, the class of Core Medical Services must continue to be prioritized in the Act. There are many things I would like to provide to my patients, like travel vouchers and food assistance, but not at the expense of their medical care. For every patient I take on, without additional funding to the program, I have to work to find ways to provide even the most essential components of medical care.

There has been some discussion over recent years of the concept of the patient-centered "medical homes." That is what my Ryan White Part C clinic is, and has been since 1994. Medical homes take a patient-centered, team approach to providing ongoing, comprehensive, and well-coordinated care. Medical homes develop programs that treat the whole patient by utilizing a multi-disciplinary team to provide the range of services that patients need to stay healthy. In my clinic, case management, psychological counseling, dental care, pharmacy management, adherence counseling, and - when needed - palliative care, are all brought together under one roof. This approach has been central to our ability to retain patients after an initial diagnosis with HIV. Also, Part C is the model for quality implementation. Quality assurance activities are a mandatory part of Ryan White Part C, and as such, help us to continually improve early interventions.

The real effect of the Ryan White Program, if it were allowed to lapse for even of a short amount of time, would be seen on the front lines of the disease, in clinics like mine, who are Ryan White grantees.

HRSA HIV/AIDS Bureau (HAB) has made a determination that it cannot continue to run the Ryan White program after September 30<sup>th</sup> unless Congress "repeals the repealer" language in the statute and extends the program. Currently funded grantees could continue to utilize the Ryan White Funds that have already been obligated to them, but would face immediate and dire consequence shortly after those funds were no longer available.

For my clinic, that would mean losing access to: Part C money that pays for treatment of 40% of my patients and the bulk of my staff; part B money that funds my case managers; and ADAP money that provides drugs for my patients who can't afford them, 80% of my patients.

On January 1<sup>st</sup>, I would no longer be able to pay my staff, and they would have to be let go. I have not had any staff turnover in 5 years. These people are well-trained in caring for my HIV patients, and keep my office running. They are well-qualified, and would no doubt find other employment quickly. However, the loss to my clinic would be irreversible. If the Ryan White program were to face a gap in service of even a couple of months, years of investment in staff and infrastructure would be lost.

Without Part C, my patients would have no other place to go for life saving services and treatment. There is absolutely no place in the state where they could find similar treatment. There is a Federally qualified health center (FQHC) in Wichita that receives federal funding to treat the uninsured, but they have no specialty in HIV care. Without Part B of Ryan White, my patients would not be able to access the HIV drugs made available to patients through the ADAP program. If the Ryan White Program is not

reauthorized in a timely manner, the same things would happen in hundreds of communities and Part C clinics across the country.

Without care, patients' lives would be lost. Over the past 20 years, HIV has become a highly manageable disease with proper care and treatment. In the mid 1990s, mortality rates plummeted as new medications and treatments allowed better ways of fighting the virus. Nationwide, the trend is the same – improved medical care has led to decreased mortality. Patients are living longer, which brings about a new set of medical challenges. Treating HIV is enormously complex, but it becomes even more so when you add the medical needs of an elderly patient. Fortunately, in my clinic, I now see only 15 to 20 deaths a year. But, that number will increase dramatically if the population loses access to the care they need. The Ryan White Program is invaluable to the patients and providers that it funds. Congress must not delay in reauthorizing it.

Over the past year, numerous HIV/AIDS organizations have come together through the Federal AIDS Policy Partnership (FAPP), to form a consensus on reauthorizing the program. I have participated in those discussions. I urge the committee to consider the recommendations of the Community Consensus document, which you have received.

Among those recommendations, I would like to highlight a few that are important to me as a provider:

- 3 Year Reauthorization - The recommendation for the program to be reauthorized for at least 3 years is important for grantees like me. We need to have assurance of a stable and continuous funding stream in order to conduct our business and plan for the future of our practice and our patients.
- Authorization Levels – Included in legislation that was under discussion this year was a 3.7 percent increase for the majority of the Parts. This is significantly less than the annual increase for Community Health Centers. As someone running a

clinic that has to do its own fundraising, I would appreciate consideration of language authorizing "such sums as necessary" in the program.

- Core Medical Services - Grant carve-outs for ancillary services may leave doctors unable to run labs for patients, or provide needed drugs after they arrive at the clinic. When funding for these services is carved out of the Part of the program intended to directly provide for medical care, it undermines life-line medical services for patients. The provision of Core Medical Services must be protected.

Additional recommendations are listed in the community consensus document, and I would urge the committee to thoughtfully consider them.

In closing, I would like to leave the committee with a few thoughts: Without the Ryan White Program, my clinic would never have been created. Without a timely reauthorization of Ryan White, it may cease to exist. Without my clinic, my patients will not receive the care they need to manage their disease. And without that care, the disease they live with every day may unnecessarily and prematurely claim their lives. The Ryan White program works; it is critical to the care and treatment of those affected by this nation's largest epidemic. I urge the committee to reauthorize the program with all due haste.

Thank you for the opportunity to testify today about Ryan White Part C, and my experience as an HIV Specialist. This concludes my testimony. I will be happy to answer any questions.

Mr. PALLONE. Thank you, Dr. Sweet.

We will now take some questions from the Members. I am going to try to get in three questions here in my 5 minutes or so. So first I will start with Ms. Scofield.

In fiscal 2009, 29 States and 3 territories were held harmless for base funding or ADAP funds or both, and hold harmless is specifically intending to make sure that States don't face precipitous declines in funding that would destabilize systems and services. Can you tell us more about why the Community Consensus, including groups from States with both older and newer epidemics, supports the extensions of the hold harmless protections?

Ms. SCOFIELD. Thank you. Well, I think all of us in the community understand that none of the components of Ryan White have received adequate funding in the last several years. Our estimates of need surpass what has been appropriated by about \$500 million. So that is part of the issue at hand.

In addition, however, when the last reauthorization occurred, there were changes in virtually every aspect of every formula of the program, and it has taken a long time for the dust to settle on the last reauthorization. Money did move around the country. So we are seeing how funds are being reallocated as a result of those formula changes. And in the first year after implementation of the last reauthorization, there were some significant increases to some jurisdictions. And so jurisdictions really were challenged to be able to obligate and use well all the funds that were provided.

I think all of us recognize that in this current fiscal environment what is needed more than anything else is stability in funding. We estimate that State HIV/AIDS programs lost over \$150 million in State resources in fiscal year 2009, and so really this is not the time for there to be anything but stability in their Federal allocations.

Mr. PALLONE. Thank you.

Dr. Sweet, you also talked about the lack of funding. I wanted to ask you about that. Part C provides grants directly to service providers to support outpatient HIV early intervention, and part C also funds planning grants and capacity development grants. This year part C was appropriated \$201.9 million, which was only a 1.56 percent increase over fiscal year 2008. Do you agree that this 1.56 increase for 2008 is simply inadequate? And what has the impact of limited funding been on your clinic and other part C providers?

Dr. SWEET. Well, thank you. It has certainly been inadequate. We have had level funding, which means rescissions each year over the last 10 years. We just went through an expansion grant process. The need is so tremendous, they had a lot of good grant applications, but were able to fund very, very few. Dr. Parham Hopson and Dr. Cheever, who were back here supporting Dr. Wakefield, I have known them for many years, and I know that they are also concerned about the fact that they have many, many people demonstrating need, like my clinics, but the money that was available for expansion grants was simply not enough to give almost anybody what they needed.

So yes, we need more. And I think it is interesting that such sums as necessary wasn't part of the last reauthorization. But as I have read the bills prior to that starting in 1990, there were



never any moneys put in as specified amounts. It always said “such sums” until this last time. So whatever has been in it is inadequate, and I think, as Julie said, what we need is across-the-board increased funding for all of our programs.

What it has done for my clinic is simply made me truly—the 75/25 doesn’t mean much to me because I spend 95 percent on medical care. Between the laboratory studies, the CD forecasts, the viral loads, the genotypes that I need to do to do quality medical care, I have simply had to cut out all of the other niceties other than case management. Transportation, food services, things like that I now do through individual fundraising, philanthropic things in the community because there is just not enough money in the grant to do the medical care.

Mr. PALLONE. I appreciate that. Those are good examples.

Going back to Ms. Scofield again about the TGAs. According to HRSA, there are six TGAs that are in danger of losing their status in fiscal year 2011, and the Community Consensus document recommends extending their status as TGAs for the next 3 years, basically the length of the extension that is in this draft. Can you elaborate on this recommendation? Why does the committee feel it is important to ensure this continued funding for these areas?

Ms. SCOFIELD. Well, for one thing, TGA eligibility is based on reported AIDS cases, because we don’t have HIV and AIDS in all of the jurisdictions. So we know that many TGAs are serving clients with HIV well beyond the number of clients that they have with AIDS. So that is first and foremost.

Secondly, I think that we all appreciate that as new jurisdictions may meet the case threshold, they may also become eligible to become TGAs. That just really has not happened. And if you really change and allow these TGAs to lose their funding, there is no guarantee that the States are going to be able to supplant that money. Given the State budget outlook at the moment, if TGAs lose those resources, the States simply are not going to be able to step in and replace those funds. And even though some of that TGA resource might flow into part B and be available, it would just go out through the regular formula. So again, there would be no guarantee that those TGAs would be left with any of the same resources to provide services.

Mr. PALLONE. All right. Thank you very much.

Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman.

Dr. Sweet, let me just be sure that I am understanding correctly. In the last reauthorization of the program, funding for part C was to increase by 3.7 percent per year, but the amount of funding that Mr. Pallone just described was a 1.7 percent increase. Was that a discrepancy between what we authorized and what the appropriators came up with?

Dr. SWEET. I believe that is true. And there were also increased—in terms of an individual clinic like mine, the increase went into new clinics where there are places that have been talked about many times with new small groups of HIV-infected patients that certainly don’t meet TGA or EMA criteria, but where they desperately needed funding. So there have been new Ryan White seed clinics that have been funded through this time, and the new

money went to those. It did not go to increasing the base funds of those of us who have had clinics.

Mr. BURGESS. In a perfect world, had that 3.7 percent increase been funded and made available to your clinic under the part C funds, would that have been a satisfactory amount for you to keep up with what you are doing? When you describe level funding, is that a consequence of inflation that is eating up the increases that are built into the authorization amounts?

Dr. SWEET. I don't think it would have been sufficient to do all of the things I would like to do for my patients, realizing, again, my base grant for part C in very specific terms right now is \$80,000 less than it was 10 years ago because of level funding and rescissions.

Mr. BURGESS. Is that in actual dollars or constant dollars?

Dr. SWEET. Actual dollars. And it does not take into account the fact that there is a 2.5 to 3 percent increase in basic medical costs. My salaries have gone up in terms of the staff, the fringe benefits, the medical equipment and supplies that I buy. So truly, I have faced each year with increased patients, a declining amount of money per patient to be able to take care of them. It has made us very efficient, but we are at that point now where there is no more efficiency to be strung out on that string. So we are actually—our base fund is less than it was because of the 1 to 2 percent rescission that we pay back to the government on any grant.

Mr. BURGESS. Explain to me about the rescission, because I am not quite sure I understand that.

Dr. SWEET. Well, I am not too sure I understand it. We have GAO here, too. But it is the amount of money that is sort of taken back. Even though you are level funded, there is a little bit of it that stays with the Feds in order to administer the program at a Federal level. That is a clinically-oriented approach to a rescission.

Mr. BURGESS. We will get to that in just a minute, but let me follow up on this.

You have heard some discussion up here about, we need a number in there or such sums. I mean, here is our problem. We are an authorizing committee, and I always like to point out the first time I went out to visit the NIH, I really understood the difference between an authorizer and appropriator because there are no buildings named after authorizers. They are all named after appropriators. So herein is our problem.

I mean, you heard Ranking Member Barton talk about this. We want your input on that number. I would like to see us put a number in there and then hold the appropriators' feet to the fire on delivering of that number. We are not doing that well with having a number in there now, but how are we going to be able to even know that we are even close to the target if we don't describe any sort—if we don't give them any sort of target to meet? If they always underfund us by 50 percent, OK, we will increase it by 50 percent. There is some logic to follow there. But if we just leave an open-ended discussion at the level of the appropriations, I don't want to leave it up to them to make those decisions because we all know appropriators are very, very busy, important people. They have a lot of things to worry about, and the very tiny amounts of

money we are talking about in Ryan White may not even cross their radar screen.

So help us. All I am saying is, help us with that. When Mr. Pallone writes the bill, I would like to see us put a number in there that is realistic.

Dr. SWEET. Well, I can tell you, the coalition has thought a great deal about this, all of the 300-plus organizations that have been discussing this. And what we said for the 2010 coalition request for part C alone was an increase of \$66.4 million over the \$268.3 million that was otherwise requested. So we think at least \$66 million more.

I think the other way that one could get at that number, and I am sure that the HRSA people can help us, me and you, because we just went through this expansion grant cycle, and I know that they had a tremendous number of very good applications that they could not support, so finding out what those grants would have added up to would be another very "in real time" look at what community-based clinics like mine are facing and how desperate we are to get some increased base funding.

Mr. BURGESS. I would just be careful, though, about do we want to create a wish list in what we would see in an ideal world, or what you need to run your clinic now, today, next year, the year following and the year following? We do have to be realistic in our assignment of that number. I think you have just described to me what would be a 30 or 40 percent increase. Did I do the math correctly on that?

Dr. SWEET. Yes. I think it is 30 percent.

What I would be happy with in my clinic is increased laboratory and dental and case management services. Those are things where I am really, really struggling. I have a chairman who believes in giving my time away. He says I can do that all I want, but when the lab bill comes, you, Dr. Burgess, know what a lab bill is like when you spend the money, and then you don't have the money to pay it back. And as an example, Medicaid in my State, I pay \$350 for a genotype. If someone is failing therapy, their virus goes up, you need a genotype. That is state of the art. That genotype costs me \$350 for my reference lab. Medicaid in my State pays \$220.

Mr. BURGESS. He is going to fix that in the health care bill. He told me because he loves us, he is going to fix that.

Dr. SWEET. I have some fears about Medicaid covering this patient population because that would make it even harder.

So laboratory services are one of the things that kill us in terms of outreach of our clinics and what we actually do because it takes us about \$160 a quarter to do the basic laboratory management, and those costs go up all the time. So if you ask me, if I could get 15 percent increase, I could probably right my clinic. Do I think I will get that? No. But I do think the "such sums" language is just all of our—the community's attempt to get people to understand that we have been terribly underfunded for a long period of time. With that said, I can understand why you don't want to give away the budget.

Mr. BURGESS. Well, it is not even a question of that. There are so many other competing constituencies out there. It becomes dif-

difficult to advocate for the Ryan White funds when there are other equally compelling cases to be made at the same time.

Now, on the issue of laboratory funding and the genotype, because—is there a structural problem with the way we are assigning or we are allocating that expense? I mean, that seems like a fundamental problem within the Medicaid system, and I suspect it is not just for the Ryan White part C clinics that are being affected. I suspect that is something that occurs much more frequently, and that may be a structural defect that we should correct in whatever we decide to do here in the coming weeks with this bigger bill. So that insight is valuable as well.

Dr. Crosse, I apologize. I ran out of time. I will submit a question in writing. I do want to get some additional information on the hold harmless issue. I am worried that we are not giving the money where it is actually needed and where patient care is actually required. But we will save that for the written response.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

Dr. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

Dr. Crosse, I will begin with you. One of the findings that applies to most of the Minority AIDS Initiative's part D grantees is that the 10 percent cap was difficult to live with, and in order not to sacrifice services, they really stretched everything else. Several have asked for indirect cost rates, and they reported spending 26 percent of their part D above the 10 percent. Doesn't that warrant some kind of a recommendation regarding the cap? And what would you recommend?

Ms. CROSSE. Well, the problem that we saw with the part D grantees was mostly in small organizations. For the part D grantees that were part of university-based health care systems or other kind of larger provider structures, they had sufficient other kinds of general funding available to cover some of these things like—

Mrs. CHRISTENSEN. Can I just say that the Minority AIDS Initiative is really to try to get to those small organizations and build the capacity in those small organizations?

Ms. CROSSE. The administrative expense cap was just for the part D grantees, and so that didn't apply to the part A and part B grantees, which was really the focus of most of the work we did on Minority AIDS Initiatives.

The Minority AIDS Initiative work that we did really focused on the grants flowing to the part A and part B grantees. There, one of the issues was that the—just the funding for the States was quite low. It was about \$7 million in total that went out to the part B grantees. Then so when States were generally receiving something in the order of tens of thousands of dollars, that wasn't enough for them to be able to establish new clinics, create new infrastructure to be able to move care more directly into the minority communities, as I know you have expressed as a goal of this program.

The part A grantees generally were receiving several hundred thousand dollars. Again, when they had existing infrastructure that they wanted to continue to provide funds to, there wasn't enough funding, there wasn't enough increase in funding even with

the switch to a competitive process where new clinics could be established in minority neighborhoods to improve some of the problems about access, transportation difficulties, clinics focused particularly on minority populations that, you know, had been one of the concerns driving this program.

And so what we found was that, yes, the dollars were going to provide services to minority patients, but it wasn't creating new service providers. It wasn't creating new streams of service or new kinds of structures to bring these services to the communities of color.

Mrs. CHRISTENSEN. Thank you.

Ms. Scofield, thank you for the answers that you have already given. They were very helpful. I am unclear on where NASTAD stands on the severity of need index. Does NASTAD believe that these should be components of the funding allocation process, perhaps not next year but at some point?

Ms. SCOFIELD. We believe it absolutely is not ready for prime time. All of the indicators that have gone into it, we are pretty convinced that not all of them are able to be collected in a consistent manner across all jurisdictions. And frankly, we think it has a lot more work to be done before it would be ready to be used in any formula for the allocation of resources.

Mrs. CHRISTENSEN. Do you think it should be a part of the process that we should work towards?

Ms. SCOFIELD. You know, from my perspective, the best indication or the best thing to be using in a formula is disease burden as it relates to living HIV and AIDS cases. I think that actually is the best measure of making sure that the resources go where the epidemic actually is.

Mrs. CHRISTENSEN. OK. Dr. Sweet, thank you also for your testimony. I think it was representative of many part C and other grantees under Ryan White across the country with the tough times making ends meet. So thank you for your commitment.

Other than the money—and you may have mentioned this in response to Dr. Burgess, but my question was, other than money, are there changes in the bill that you would like to see that are not in our proposed legislation? And where do you stand on the medical and nutritional—the medical nutrition and medical transportation proposals?

Dr. SWEET. Well, certainly I very much appreciate the bill draft that you wrote. I think it does reflect what the community is asking. These meetings and phone calls have been—I mean, when you put 300 voices on a phone call, it becomes difficult. And I think the fact that there has been a Community Consensus is something we should all be proud of because we have worked to make it a consensus.

The last question is more difficult because that last question is all about the money. Certainly in the best of worlds, I would love to have more nutrition money, more transportation money. Those are the two things that my patients need that I would love to give more of. But when I have to—in this day and age, I can get someone to live 20, 30, 40 years if they get the right medicines, the right medical treatment and I do it right. So that medical care has to be preeminent in what I do. And consequently, the other support

services that I would like to do I have to short shrift in order to do the medical care.

So that is all about the money. If I had enough money, then the 75/25 wouldn't be an issue. And I would love to be able to go back to the days when I was able to offer nutritional supplementations and a lot more transportation than I can now.

And back to the amount of money, I just thought, Dr. Burgess, I applied for a 20 percent increase with my expansion grant, and that would have made me much wholer and much more able to give more comprehensive services. So about 20 percent would be what my clinic needs, in answer to your question, over what I get now.

Mrs. CHRISTENSEN. Thank you.

Mr. PALLONE. Thank you. I thank all of you really. This was very helpful in terms of, you know, our moving forward with this bill. You know, Dr. Burgess and there may have been others mentioned that they will submit additional questions for the record. And we ask that Members submit those to the committee clerk within 10 days or so, and you would be notified when those come through.

But again, I want to thank you all. I know there weren't a lot of Members here for the last panel, but the questions were good, and the answers were very helpful. So thank you.

And without objection, this meeting of the subcommittee is adjourned.

[Whereupon, at 1:54 p.m., the subcommittee was adjourned.]

