SECTION-BY-SECTION DESCRIPTION OF "RYAN WHITE HIV/AIDS TREATMENT EXTENSION ACT OF 2009"

Section 1: Short Title; References

This section establishes "Ryan White HIV/AIDS Treatment Extension Act 2009" as the new title in the Public Health Services Act.

Section 2: Reauthorization of HIV Health Care Services Program

Previous Law:

Previous law included a sunset provision that would have repealed the Ryan White legislation September 30, 2009. A Continuing Resolution extended the authorities for the program through the end of October.

Also, under previous law, the Minority AIDS Initiative (MAI) funding was distributed under Parts A-D and F, with Part A and B funds distributed competitively.

New Law:

The legislation re-establishes the provisions of the Act, retroactive to September 30, 2009. It authorizes up to a 5% increase for Parts A through D and Part F for each of fiscal years 2010 through 2013 (e.g., Ryan White Program is authorized for the next four fiscal years). The new legislation eliminates/repeals all prior sunset provisions. Table 2 details the authorization amounts for fiscal years 2010 through 2013.

Table 2. Authorization Amounts for the Ryan White Program ($ in millions)

Ryan White Program Parts	FY2010 Authorization	FY2011 Authorization	FY2012 Authorization	FY2013 Authorization
Part A	$682	$716	$751.9	$789.5
Part B	$1,349.5	$1,417	$1,487.8	$1,562.2
Part C	$246.9	$259.2	$272.2	$285.8
Part D	$75.4	$79.2	$83.1	$87.2
Part F: AECTs	$36.4	$38.3	$40.2	$42.2
Part F: Dental	$13.7	$14.3	$15	$15.8
Part F: MAI	$146.1	$153.4	$161	$169.1
Total	**$2,550**	**$2,677**	**$2,811**	**$2,952**

The new legislation also increases authorizations for the MAI by up to 5% annually. It reverts from competitive funding in Part A and Part B to formula funding, and requires the GAO to report on MAI activities across departmental agencies, including a description of best practices in capacity-building. It also requires the department to prepare a plan for the use of MAI funds for capacity building, taking into consideration the GAO report. Finally, it synchronizes the MAI grant cycle with other grants for each Part.

Section 3: Extended Exemption Period for Names-Based Reporting

Previous Law:

Under previous law, the amount of funding that metropolitan areas and states received was based on formulas that reflected 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. Seven states, including California, Hawaii, Illinois, Maryland, Massachusetts, Oregon, and Rhode Island, and the District of Columbia, do not yet have fully mature names-based HIV surveillance systems.

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

New Law:

The legislation maintains these same provisions for states and jurisdictions with maturing names-based HIV case data during the first two years of the reauthorization period. Jurisdictions that report code-based data to HRSA will continue to incur a 5% 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. In 2012, the 5% penalty will be increased to 6%. Beginning in FY2013, code-based protections will be eliminated and all States will be required to report cases using a names-based system.

Section 4: Extension of Transitional Grant Area Status

Previous Law:

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

An EMA retained its status until it (a) failed for 3 years to have at least 2,000 cases of AIDS during the most recent 5 calendar years and (b) failed 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 retained its status until it (a) failed 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) failed for 3 years to have 1,500 or more living cases

of AIDS as of December 31 of the most recent calendar year. HRSA identified 6 TGAs that potentially could lose their eligibility in fiscal year 2011 based on decreasing number 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.

When a TGA failed for three consecutive years to meet the criteria for eligibility, both its formula funding and an additional $500,000 was reallocated to Part B and redistributed among states based on need.

While EMA and TGA eligibility were based on AIDS cases alone, the actual award amounts they received were based on both HIV and AIDS cases.

New Law:

The new legislation extends current rules for transitional grant area status. It adds a new provision that if a metropolitan area has between 1,400-1,500 cumulative living AIDS cases and does not have more than 5% of its total grants unobligated for the prior fiscal year, it will be treated as having met the criteria for continued eligibility as a TGA.

The legislation also modifies the transfer of amounts from TGAs that lose their eligibility during the reauthorization period. As was the case previously, when a TGA loses its status, $500,000 will be transferred to the overall Part B pool for states. However, given the economic conditions of many states, and the desire to maintain stability for people living with HIV/AIDS, the state in which the TGA resides will retain 75% of the TGA formula funding in the first year after the TGA loses eligibility, 50% in the second, and 25% in the third. By the fourth year, all of the former TGAs funding will go to the overall Part B pool.

Section 5: Hold Harmless

Previous Law:

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

Under Part A, two-thirds of funds were distributed based on a formula and one-third of funds are supplemental. Supplemental funding was awarded on a competitive basis.
Under Part B, the proportion of funds that are supplemental varied annually. The Part B supplemental pool came 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 previous law, a "hold harmless" provision protected both Eligible Metropolitan Areas and states from larger 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 could be no less than 100% of fiscal year 2007.

New Law:

The new legislation continues the hold harmless at a rate of 95% of fiscal year 2009 funding in 2010 and 100% of fiscal year 2010 funding for each of the fiscal years 2011 and 2012. For fiscal year 2013, the amount will be 92.5% of the previous fiscal year's grant. This hold harmless continues to apply to both Part A and Part B grants.

Section 6: Amendments to the General Grant Provisions (new section)

In the new legislation, there are provisions to increase and incentivize early identification of those infected with HIV. This section requires the planning councils for Part A grant recipients to develop a strategy, in coordination with other appropriate community strategies or activities, to identify and diagnose individuals with HIV/AIDS who are unaware of their status and link them with the appropriate care and treatment.

For the purposes of allocating competitive grants under Part A supplemental grant funding, one-third of the criteria on which allocations are made will be based on demonstrated success in identifying undiagnosed individuals with HIV/AIDS, making them aware of their status, and linking them to appropriate care.

Section 7: Increase in Adjustment for Names-Based Reporting (new section)

The legislation adds an adjustment for areas that switched to names-based reporting early in 2007 and received a decrease in total funding of at least 30% from year 2006 as a result of determinations based on the new reporting system. For those jurisdictions, the Secretary shall base awards on living HIV/AIDS cases (for the most recent year confirmed) plus an increase of 3%. This adjustment will apply to Part A and Part B grants.

Section 8: Treatment of Unobligated Funds

Previous law:

Previous law contained several provisions related to the requirement that Part A and Part B grantees obligate funds by the end of the grant year.[1]

- Formula and ADAP Base funding: If a Part A or Part B grantee had any unobligated dollars remaining at the end of the grant year, it could request a waiver to carry over the funding. If the waiver was not granted or if the funds were still not spent by the end of the carryover year, the funds returned to the Secretary and became available for supplemental grants.

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

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

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

Because of multiple factors including statewide budget problems and hiring freezes, it was 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.

New Law:

The new legislation increases the unobligated penalty threshold from 2% of the total award to 5%. For formula funds, if the unobligated amount is over the 5% threshold, the next year's formula funding will be reduced by the amount of unobligated balance, but the reduction amount will not include any unobligated balance that was approved for carryover by HRSA. In addition, a jurisdiction with over 5% of its funds unobligated will not be eligible for supplemental funding in the following year.

Section 9: Applications by States (new section)

The provision requires states, as part of their planning process for Ryan White funding, to establish a comprehensive strategy to identify and diagnose individuals with HIV/AIDS who are unaware of their status and link them with the appropriate care and treatment. The states will be required to incorporate data compiled by Part A grantees.

Section 10: ADAP Rebate Funds

Previous Law:

The unobligated balances requirement addressed in Section 8 intersected with the treatment of rebate dollars under the AIDS Drug Assistance Program (ADAP). 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 the permitted threshold of unobligated program funds.

New Law:

If an expenditure of ADAP rebate funds would trigger a penalty or a higher penalty than would otherwise have applied, the Secretary shall deem the state's unobligated balance to be reduced by the amount of rebate funds in the proposed expenditure.

The provision also specifies that any unobligated ADAP grant amounts that are returned to the Secretary shall first go to the State ADAP program and then to Part B Supplemental fund.

Section 11: Application to Primary Care Services

Previous Law:

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

New Law:

The new legislation clarifies that Part D should be the payer of last resort and specifies memoranda of understanding as vehicles for Part D providers to ensure access to primary care.

Section 12: National HIV/AIDS Testing Goal (new provision)

This new provision requires the Secretary to establish a national HIV/AIDS testing goal of 5,000,000 tests through federally-supported HIV/AIDS prevention, treatment, and care programs, both at the Centers for Disease Control and Prevention and other federal programs.

The Secretary is required to report to Congress each year on the progress made toward achieving the goal. The Secretary is also be required to review each domestic HIV/AIDS prevention program to determine its effectiveness based on the program's contributions toward the testing goal and the program's stated purposes.

Section 13: Notification of Possible Exposure to Infectious Disease

Previous Law:

This provision was not included in the previous law. It was removed in the 2006 reauthorization.

New Law:

The provision that was removed from statute in the reauthorization in 2006 has been reinserted to ensure that emergency responders are notified if the provider is in contact with a victim of an emergency that has a communicable infectious disease, while preserving confidentiality requirements. The legislation makes minor changes, including permitting the Secretary to suspend the requirements in a public health emergency.