NASTAD

NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS

Ryan White CARE Act Amendments of 2000
Brief Summary of Changes

Title I: Emergency Relief for Eligible Metropolitan Areas (EMAs)

■ ***HIV Services Planning Councils***

Membership

Adds representatives of HIV prevention providers, housing or homeless service providers, and of prisoners or former prisoners. Requires 33% of membership to be consumers of Title I services who are "unaligned" with Title I grantees (i.e., not employed by or on the Boards of grantees).

Duties

Increased focus on disparities in access to HIV related health care and adverse health outcomes. Development of strategies to identify and bring into care those individuals with HIV/AIDS who know their HIV status but are not in care.

■***Formula Distribution Issues***

Addition of HIV cases to formula

In Fiscal Year 2005, HIV data will be integrated with AIDS data to determine formula allocation. The Secretary of HHS shall determine by July 1, 2004 whether HIV case data is sufficiently accurate and reliable from all eligible areas for such use. If s/he determines that the data is not yet sufficient (based in part on findings of the IOM report), TA must be provided to States and EMAs to ensure that data is ready no later than FY 2007.

Hold Harmless Provision

The hold harmless provision is changed, allowing an EMA to lose up to 15% of its formula award over 5 years (in contrast to the current 5% over five years). Any EMA that would rely on the hold harmless would be held to the following percentages:

— 2 percent in the first year of need;
— 5 percent in the first year of need;

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— 8 percent in the first year of need;
— 11 percent in the first year of need;
— 15 percent in the first year of need.

If HIV prevalence data is used to determine the Title I formula grants in FY 2005, all EMAs may lose no more than 2 percent of their FY 2004 formula allocation in that year.

If an EMA must rely on the hold harmless in the middle of the Reauthorization period, it will start at 2 percent. Should an EMA experience a decline in its Title I formula allocation followed by a year with no decline, its losses in any subsequent, nonconsecutive year of decline would once again be limited to 2 percent. In other words, the clock is re-set.

Title I Supplemental Grants

The Title I supplemental grant program will place a greater weight on States demonstrating "severe need." This weight increases from its current weight of 16 percent to thirty-three percent. The Secretary of HHS is required to develop national, quantitative data for determining severe need. Syphilis, hepatitis B and hepatitis C shall be regarded as important co-factors to consider.

■***Use of Funds***

Early Intervention Services

Allows for the use of a portion of Title I funds to cover early intervention and outreach activities (consistent with these types of services funded under Title III) necessary to identify individuals with HIV/AIDS who are not receiving care, as long as the funds do not supplant existing funding (e.g. CDC, Title III or other funds).

Role of supportive services

Requires that Title I funded support services facilitate, support or sustain health services.

WICY set-aside

Expands set-aside for infants, children and women to include youth. Also makes the set-aside proportional for *each* of these populations. EMAs must now allocate resources for each of these groups proportional to their representation in the local epidemic.

Quality Management

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Requires EMAs to establish quality management programs to assess consistency of services with PHS guidelines and to develop strategies to raise services to this standard. Limits funds for such programs to the lesser of 5% of grant or $3 million.

Title II: Care Grants to States

■***Formula Distribution Issues***

Addition of HIV cases to formula

Identical to changes in the Title I formula. In Fiscal Year 2005, HIV data will be integrated with AIDS data to determine formula allocation. The Secretary of HHS shall determine by July 1, 2004 whether HIV case data is sufficiently accurate and reliable from all eligible areas for such use. If s/he determines that the data is not yet sufficient (based in part on findings of the IOM report), TA must be provided to States and EMAs to ensure that data is ready no later than FY 2007.

Hold Harmless Provision

Continues the hold harmless provision for Title II as outlined in the 1996 reauthorized CARE Act. Any state requiring protection under the hold harmless would lose no more than:

— 1 percent in FY 2001;
— 2 percent in FY 2002;
— 3 percent in FY 2003;
— 4 percent in FY 2004;
— 5 percent in FY 2005.

Adds new language that makes the hold harmless provision apply to the overall Title II allocation and separately to the Title II Base (non-ADAP).

Title II Supplemental/Emerging Communities

Creates a new supplemental formula allocation within Title II for "emerging communities." These are defined as urban areas within states that are not eligible for Title I funds and that have between 500 and 1,999 AIDS cases as reported to the CDC over the past 5 years. Funding for the supplemental is drawn from increases in the Title II base (non-ADAP) allocation. The supplemental provisions are "triggered" in the first year there is a $20 million increase in Title II base funding over the FY 2000 level. States must apply for this supplemental funding, although it will be distributed through an AIDS-case based formula and not through a competitive process.

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ADAP Supplemental

Creates a new program of discretionary grants for states with ADAPs in severe need. States must apply for ADAP supplemental funds. Grants will be made to states based on the presence of ADAP access and/or formulary restrictions, especially the inability of individuals at or below 200% of FPL to access the program. States that receive supplemental ADAP funds must provide a 25% match of these funds. Three percent of the national ADAP appropriation will be set aside each fiscal year to fund the supplemental.

Increase in minimum grant amounts

States with fewer than 90 living AIDS cases (under the weighted AIDS case formula) will have their minimum Title II base grant increased from $100,000 to $200,000 (North Dakota, South Dakota, Wyoming), and states with over 90 living AIDS cases will have their minimum Title II base grant increased from $250,000 to $500,000 (Alaska, Idaho, Maine, Montana, New Hampshire, Vermont). U.S. Territories will now receive a minimum of $50,000.

- ***Use of Funds***

Early Intervention Services

Allows for the use of a portion of Title II funds to cover early intervention and outreach activities (consistent with these types of services funded under Title III) necessary to identify individuals with HIV/AIDS who are not receiving care, as long as the funds do not supplant existing funding (e.g. CDC, Title III or other funds).

Use of ADAP funds for adherence and medical monitoring

Allows states to use between 5%-10% of their ADAP allocation to support adherence programs and medical monitoring services (e.g., CD4 and viral load tests). (Closely matches existing policy)

Use of ADAP funds for insurance

Allows states to use ADAP funds for the purchase and maintenance of health insurance for eligible clients so long as the insurance program is cost-effective and provides comprehensive HIV drug coverage. (Matches existing policy)

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Role of supportive services

Requires that Title II-funded support services facilitate, support or sustain health services.

WICY set-aside

Expands set-aside for infants, children and women to include youth. Also makes the set-aside proportional for *each* of these populations. States must now allocate resources for each of these groups proportional to their representation in the local epidemic. Provides for a waiver of this provision if states can demonstrate that these populations are receiving care through other programs (e.g. Medicaid, SCHIP, Title IV of the CARE Act, other state indigent care programs).

Quality Management

Requires States to establish quality management programs to assess consistency of services with PHS guidelines and to develop strategies to raise services to this standard. Limits funds for such programs to the lesser of 5% of grant or $3 million.

Other Provisions

- ***Public Participation***

Public hearings

Expands the requirement for states to convene a public hearing to solicit comment on the Title II allocation plan and to receive public input on its implementation. Expands the list of suggested entities/individuals that should be part of these processes to include the "types" of entities involved in the Title I planning process.

- ***Perinatal Transmission***

Revisions to perinatal transmission grant program

Authorizes $30 million for grants supporting counseling, testing, and treatment of pregnant women and infants. First $10 million is for existing programs under present law. For funds authorized above $10 million, a percentage is reserved for states that require newborn testing and a select number of states that have had significant reduction in cases of perinatal transmission. Grants to these states cannot exceed $4 million per state. Any funds in the reserved pot not obligated will return to the general pot. The percentage of money reserved for these states increases over time - FY2001 – 33%, 2002 – 50%, 2003 – 67%, 2004 – 75%, 2005 – 75%. The

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number of states with reduction in cases to be included in the reserved pot increase over time - FY2001 – 2 states, 2002 – 2 states, 2003 – 3 states, 2004 – 3 states, 2005 – 4 states. In FY2001 only**,** up to $4 million of appropriated increases in Title II may be used to fund these new grants if adequate funding is not appropriated specifically for these grants.

IOM study on perinatal transmission

Requires the Secretary of HHS to contract with the IOM to conduct a study to determine the number of newborns with HIV in which the attending OB did not know the HIV status of the mother. The study will also assess barriers for states that prevent or discourage an OB from routinely testing pregnant women for HIV and routinely testing newborn infants when the mother's status is unknown. Finally, the study is to recommend to states ways to remove barriers and reduce incidence of transmission. HHS Secretary will submit a report to Congress that includes the states' "progress" on the study's recommendations.

■ ***Partner Notification Programs***

Authorizes $30 million appropriation to support grants to states for partner counseling and referral services. Eligible states are those whose laws or regulations are in accordance with HIV reporting and partner notification requirements established by the legislation.

Title III: Early Intervention Services (EIS)

■ ***Administrative Cap***

The administrative cap is increased from the current 7.5 percent to 10 percent to correspond with the 10 percent cap on individual contractors in Title I.

■ ***Preferences***

Funding priorities

Priority for new funding will go to rural areas and to underserved communities.

■ ***Planning and Development Grants***

Expands this component to permit capacity development in underserved communities for primary care and EIS, up to a maximum of $150,000 over 3-year period. Increases percentage of overall appropriations allowed for these grants from 1% to 5%.

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Title IV: Services for Women, Infants, Children and Families

■ ***Research Requirements***

Coordinated Services and Access to Research for women, infants, children and youth

Removes the requirement that Title IV grantees enroll a "significant number" of patients in research projects. Now requires Title IV programs to:

- Demonstrate better documentation of the linkages between care and research;
- Provide individuals with information and education on opportunities to participate in HIV/AIDS clinical research; and
- Institute a quality management program like those required in all other titles.

Directs the Secretary to examine the distribution and availability of HIV/AIDS-related research to enhance and expand voluntary access to research, especially in communities underserved by such projects.

Administrative Costs

Directs the Secretary of HHS to work with Title IV grantees to review administrative, program support, and direct service related activities.

Other CARE Act Programs

AIDS Education and Training Centers

Focus on women

New language stresses the importance of HIV training for OB/GYN providers and the development of treatment protocols for women with HIV/AIDS.

Guideline Dissemination

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Instructs the Secretary of HHS to develop and begin implementation of a strategy to disseminate PHS treatment guidelines to healthcare providers and patients within 90 days of the passage of the reauthorized CARE Act.

Dental Schools

Expansion of Eligible Applicants
Expands the pool of eligible applicants for funds under this section beyond dental schools and academic dental programs to include community-based dental providers.

Miscellaneous Provisions

■ ***Plans and Reports***

Coordination among federal agencies

Requires the Secretary of HHS to coordinate the planning, funding and implementation of all federal HIV/AIDS programs through HRSA, SAMHSA, HCFA and the CDC and to provide Congress with a report concerning barriers to collaboration among these agencies.

Release of prisoners with HIV disease

The Secretary of HHS is required to consult with Title I and II grantees and providers and the federal Bureau of Prisons in order to develop a national plan for the medical and case management of prisoners who are released into the community. The plan is due within two years after passage of the Act.

Administrative simplification/coordinated grant disbursements

The Secretary of HHS is required to develop plans to 1) coordinate the disbursement of Title I and Title II grants (they currently have different fiscal years), 2) move to a biennial application process for Titles I and II (lengthy applications must currently be completed every year) and 3) simplify the application processes for Titles I and II.

State HIV surveillance systems

Requires the Secretary to contract with the IOM to assess whether the HIV surveillance systems in states provide reliable and accurate information and whether these systems can provide reliable information that can be included in the Title I and II distribution formulas.

Epidemiological Measures

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Requires the Secretary to contract with the IOM to assess what are the most appropriate epidemiological measures for guiding the financing and delivery of HIV care to the poor and underinsured.

Rapid HIV Test

Instructs the director of NIH to "expand, intensify and coordinate" activities related to the development of a reliable rapid HIV test.

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