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UNDERSTANDING THE HISTORY AND SECURING THE FUTURE OF RYAN WHITE DENTAL SAFETY NET PROGRAMS

Key Policy Points

- The Ryan White HIV/AIDS Program encompasses the Dental Reimbursement Program and the Community-Based Dental Partnership Program, created in response to gaps in dental care for people living with HIV/AIDS. The program is literally the only path to critical preventive dental services and treatment for thousands of adults in the United States who need the care the most.
- The Dental Reimbursement Program served 41,464 clients in 2013, of which most did not have the financial resources to pay for the dental care they received and/or lacked dental insurance.
- In 2013, Dental Reimbursement Program grantees, such as academic dental institutions, were awarded only 26.10% of their non-reimbursed costs, resulting in a total of $32,387,629 in non-reimbursed costs.

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Understanding the History and Securing the Future of Ryan White Dental Safety Net Programs

Introduction

In 1990, Indiana teenager Ryan White succumbed to his six-year battle with HIV/AIDS.[i] After contracting the virus through a blood transfusion when he was only 13, White was expelled from middle school when fearful students and their parents rallied against his attendance. As a legal battle ensued, White became a national spokesperson for HIV/AIDS, advocating for health care services and research for people living with HIV/AIDS (PLWHA). He expanded the public's understanding of HIV/AIDS, shifting away from the perception that the disease only affected the male homosexual community. The groundswell White created was strengthened by the lobbying efforts of programs financially struggling to provide uncompensated care to HIV/AIDS patients, prompting Congress to pass the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 in Title XXVI of the Public Health Service Act.[1]

Almost 25 years later, the societal environment surrounding HIV/AIDS has changed dramatically, but the needs of patients have not. As modifications to the Ryan White HIV/AIDS Treatment Extension Act of 2009, commonly referred to as the Ryan White HIV/AIDS Program, are considered in the midst of health care reform, the importance of oral health for the comprehensive treatment and care of the HIV/AIDS population cannot be overlooked. A reported 46% of PLWHA will experience at least one major HIV-related oral health problem, and many opportunistic infections that can threaten the immune systems of PLWHA are orally based.[2] Still, according to various studies, between 58–64% of PLWHA do not receive regular dental care.[3] While all components of the Ryan White HIV/AIDS Program can support dental services, the Dental Reimbursement Program (DRP) and the Community-Based Dental Partnership Program (CBDPP), remain the only federal programs solely focused to serve the oral health needs of this population. These dental programs play a significant role in the health and well-being of persons with HIV/AIDS, with much of the care provided by academic dental institutions.

[i] HIV/AIDS is the acronym for human immunodeficiency virus/acquired immunodeficiency syndrome. The term "HIV disease" means infection with the human immunodeficiency virus, and includes any condition arising from such infection. The term "human immunodeficiency virus" means the etiologic agent for acquired immune deficiency syndrome.

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Additionally, the programs train dental students, dental hygiene students and dental residents to properly care for and treat the unique needs and conditions of individuals with HIV/AIDS. However, these dental programs have been inadequately funded over the years, reimbursing only a fraction (26%) of the uncompensated care provided to HIV/AIDS patients by academic dental institutions. The unsustainable reimbursement structure and onerous administrative requirements jeopardize the continued involvement of schools in the programs. If schools decline to participate, many patients with HIV/AIDS will be left without access to dental services, undermining the comprehensive intent of the law.[4]

This white paper reviews the Ryan White dental programs, the populations they serve, the federal funding streams for oral health and the opportunities and challenges presented by health care reform. Examining the dental programs can strengthen support for a critical health benefit in the HIV/AIDS community and inform future reauthorization and reorganization of the program.

The HIV/AIDS Epidemic

HIV/AIDS Cases: More than 1.1 million adults and adolescents[5] are estimated to be living with HIV in the United States, and one out of six is unaware of being infected. While the incidence of new cases has stabilized to roughly 50,000 each year, certain groups have disproportionately higher rates of new HIV infections.[6] For example, Blacks or African Americans make up 12% of the U.S. population but have the highest reported HIV infection rate compared to all other racial and ethnic groups, accounting for 44% of new HIV cases in 2010. Male-to-male sexual contact accounts for the majority (63% in 2010) of new infections, while the proportion of new infections from heterosexual sex is on the rise (25% in 2010). New HIV infections tend to be clustered in large metropolitan areas (81% in 2011) and concentrated in the South (48% in 2011).[7]

Deaths: The number of HIV-related deaths has significantly declined from the 1990s. In 1994, HIV was the leading cause of death for people ages 25 to 44. In 2010, HIV-related mortalities dropped to seventh.[8] Still, more than 15,000 people died from complications arising from HIV in 2010, bringing the total number of AIDS-related deaths in the United States to 636,000 since the first clinically observed case in 1981.[9] With medical advances in prevention and treatment, particularly the introduction of combination antiretroviral therapy, more people are living with HIV infection, which requires a comprehensive continuum of care including oral health.

Ryan White HIV/AIDS Program: Overview

Purpose: The Ryan White HIV/AIDS Program is the nation's largest program funded exclusively for low-income, underinsured and uninsured PLWHA. The program is administered by the HIV/AIDS Bureau in the Health Resources and Services Administration (HRSA). By statute, the Act is

the *payer of last resort* and does not function as an insurance program like Medicare or Medicaid. It provides assistance to individuals living with HIV/AIDS through a series of grants organized into several programs referred to as "Parts." Each Part of the program directs funds to specific entities—states, cities, hospitals, institutions, community-based organizations—to meet the varied and changing needs of the HIV/AIDS population across the country.

Legislative History: Since its inception, the Ryan White HIV/AIDS Program has been amended and reauthorized four times—in 1996, 2000, 2006 and 2009. In 2009, it was renamed the Ryan White HIV/AIDS Treatment Extension Act.[10] Each authorization extended and expanded the program to better address the needs of people impacted by the HIV/AIDS epidemic. Even though the program was not reauthorized in 2013, the 2009 legislation did not include a sunset clause that would automatically terminate funding and require a formal reauthorization for the program to continue.[ii]

The program is currently operating under the Consolidated Appropriations Act, 2014 (PL-113-76). While the current political climate and uncertainty surrounding implementation of the Patient Protection and Affordable Care Act (ACA) both contributed to the law not being reauthorized, the strategic delay permits better coordination between the Ryan White HIV/AIDS Program and the ACA.[11]

Ryan White HIV/AIDS Program Parts

When first created, the Ryan White CARE Act only included Parts A, B and C. It was expanded in 1994 to include Part D, and the 1996 reauthorization added Part F, funding the DRP, AIDS Education and Training Centers (AETCs), and Special Programs of National Significance (SPNS). It was not until the 2000 reauthorization that the CBDPP was included. The newest program, the Minority AIDS Initiative (MAI), officially became a part of the legislation in 2006.[12] All parts of the Ryan White HIV/AIDS Program can support dental services since oral health is one of the core medical services for Parts A, B and C. All parts address the complex needs of PLWHA and most collaborate with DRP and CBDPP.

Part A: *Emergency Relief for Eligible Areas*. Part A provides emergency assistance to metropolitan cities disproportionately affected by the HIV/AIDS epidemic for outreach[iii] and core medical services.[iv] Funds are provided to Eligible Metropolitan Areas (EMAs) reporting more than 2,000 living AIDS cases in the past five years, and Transitional Grant Areas (TGAs) reporting 1,000–1,999 AIDS cases.[13] Funds are given to the locally elected official responsible for

[ii] Without an explicit sunset provision, Ryan White funding can continue through the yearly Congressional appropriations process that funds discretionary federal spending.

[iii] Outreach services for individuals who know they are HIV positive but are not receiving treatment.

[iv] Including outpatient and ambulatory medical care, dental, pharmaceutical assistance, mental health services, transportation and housing assistance, nutrition services, respite care, substance abuse treatment.

establishing an advisory board, termed a Ryan White Planning Council, to direct health care and supportive services within the EMA or TGA.[14]

Part B: *Grants to States and Territories*. Part B funds all states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands and five territories and associated jurisdictions for core medical services and support services. Medical services include outpatient ambulatory health services, home health care, hospice services, medications and dental care. Support services are determined by the Secretary of Health and Human Services and include linguistic services, medical transportation and respite care for those caring for individuals with HIV/AIDS. A key component of Part B is the AIDS Drug Assistance Program (ADAP), which offers medications to uninsured, underinsured and low-income PLWHA.[15]

Part C: *Early Intervention Services*. Part C supports primary care provider reimbursement at private and public organizations that provide comprehensive outpatient health services to PLWHA. It directs funds to services that identify and support newly detected HIV cases, including case management and counseling. Organizations may also receive grants to expand their capacities, including planning and developing new outreach programs.[16]

Part D: *Women, Infants, Children and Youth*. Part D directs funds to serve infants, children, women and their families through community-based and family-centered programs. Funds are also allocated to conducting research, developing best practices and implementing interventions for these groups.[17]

Part F: In addition to the dental programs, Part F funds a variety of programs including the AETCs, the MAI and the SPNS. AETCs make grants to several national and regional centers to train and educate health care professionals, including dental students, dental hygiene students and dental residents to counsel, diagnose, treat and medically manage PLWHA. The MAI funds nongovernmental entities and federal agencies, including the National Institutes of Health (NIH) and local health departments, providing HIV/AIDS prevention and education initiatives to minority populations.[v] As the name indicates, the SPNS support programs addressing emerging needs in the HIV/AIDS community, including innovative care models and a standardized electronic health records system.[18]

Ryan White Dental Programs

While all funds in the Ryan White HIV/AIDS Program may support dental services, the DRP and the CBDPP were created in response to gaps in dental care for PLWHA. The programs specifically focus on oral

[v] The federal agencies include the Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, National Institutes of Health, Health Resources and Services Administration, Office of Minority Health and Indian Health Services. Data from the Office of Minority Health is available here.

Key Highlights of Ryan White Dental Programs		
	FY11	CY11
	DRP	CBDPP
Applicants Eligible for Funding	56	12
Number of States (including D.C.) Funded	22	11
HIV/AIDS Patients Served	39,810	5,800
Number of Participating Dental Programs	43	12
Dental Providers Trained	11,700	3,000
Amount Awarded	$9,641,803	$3,843,197

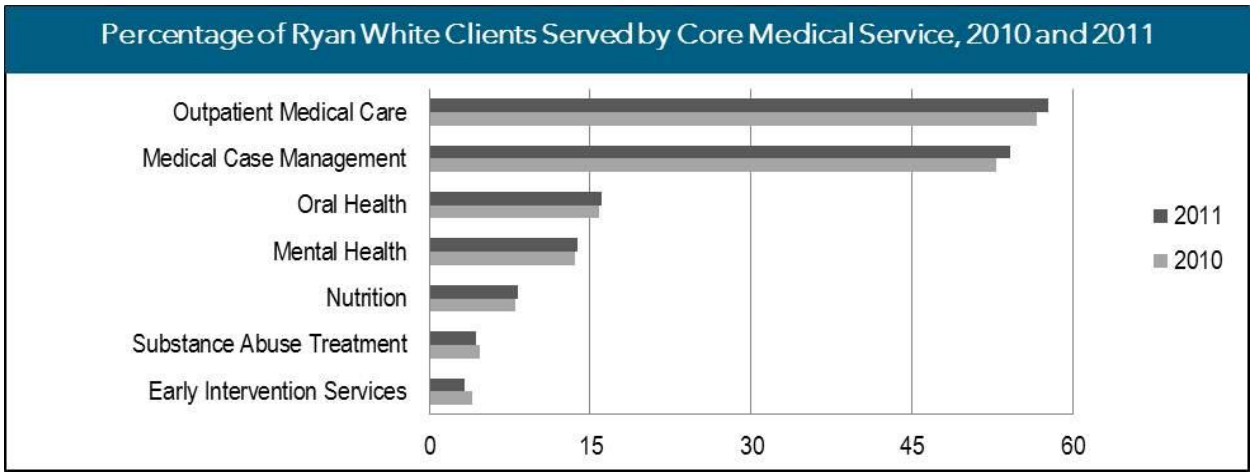
Source: HRSA, Dental Programs (Part F).
There were 58 U.S. academic dental institutions in 2011.

health for HIV/AIDS patients and fall under Part F of the law. Grantees in both programs are responsible for data collection and reporting. Covered services for the programs include routine dental care (preventive, diagnostic and restorative), emergency services to prevent infection or relieve pain and other more extensive services.

Dental Reimbursement Program: The DRP was first funded in 1994.[19] Language in the 1996 reauthorization codified the DRP into the Ryan White HIV/AIDS Program. The DRP's mission is to reduce the unmet dental needs in the HIV/AIDS population and clinically train dental students, dental hygiene students and dental residents to care for PLWHA. The DRP achieves its mission by defraying some of the cost of uncompensated care provided by grantees to patients with HIV/AIDS. The program is open to accredited academic dental institutions, advanced dental education programs and dental hygiene educational programs that can demonstrate incurring non-reimbursed costs from treating HIV/AIDS patients.[20] More than 11,700 dental students, dental hygiene students and dental residents were trained in 2011 and provided dental care to more than 37,1000 PLWHA.[21] In 2013, the DRP awarded grants to 53 organizations.[22]

Community-Based Dental Partnership Program: The CBDPP was first funded in FY02 to increase the number of dental professionals providing care to patients with HIV/AIDS in underserved rural and urban areas through education and clinical training.[23] The program also increases access points for PLWHA to receive quality dental services by forming collaborative community-based HIV dental care partnerships between community dental clinics and private practice dentists and accredited dental and dental hygiene programs. Nearly 3,000 dental students, dental hygiene students and dental residents were trained though the program in 2011, and together provided care to more than 5,800 HIV-positive individuals.[24]

The challenges of participating in the Ryan White dental programs are significant:



Source: HRSA. 2010-2011 Ryan White Services Report Data.

- Academic dental institutions do not have the infrastructure and capacity necessary to apply for DRP funding.
- Low reimbursement rates discourage academic dental institutions that administer the DRP from investing in infrastructure and human resources necessary to apply for funding.
- A growing number of Ryan White clients need dental services, yet funding for dental programs is declining.
- Reporting requirements for DRP funding present an administrative and time burden.

Ryan White Clients

Overall Demographics: Not including the ADAP clients, The Ryan White HIV/AIDS Program served an estimated 536,219 clients in 2012.[25] A reported 68% were male, 31% female and less than 1% identified as transgender. A vast majority (89%) were between the ages of 25 and 64. Blacks or African Americans represent 47% of the Ryan White HIV/AIDS Program population, followed by Whites (28%) and Hispanics (22%).[26]

Income and Insurance Coverage: More than half of the people served through the Ryan White CARE Act in 2010 (59%) reported a household income at or below the Federal Poverty Level[vi] (FPL).[27] Medicaid remains the largest insurer of PLWHA (32%), followed by Medicare (14%) and private insurance (13%). One out of every three Ryan White recipients is uninsured.[28] Prior to the ACA's implementation, an individual living with HIV at or below the FPL was required to progress to an AIDS diagnosis to satisfy the federal "disability requirement" for Medicaid eligibility standards—jeopardizing the lives of PLWHA. In states choosing to expand Medicaid, the ACA has eliminated the disability requirement for Medicaid eligibility, permitting all American adults living at 133% of the FPL in those states to

[vi] For a family of four, 100% of FPL is $23,850 based on the 2014 federal poverty guidelines.

apply for the insurance program. Clients served in the dental programs are relatively similar to the overall Ryan White population, but a higher percentage of women and minorities are cared for by the dental programs.

DRP Demographics: The DRP program served 41,464 clients in 2013; most were male (68%), between the ages of 25 and 64 (88%) and had a household income equal to or below the FPL (64%). Only 3% reported an income above 300% of the FPL[vii]. Nearly equal numbers served were White (43%) or Black or African American (46%).[29]

CBDPP Demographics: In 2006, the program provided 22,566 service visits encompassing a wide range of dental care. The majority of those served were male (76%). Twenty percent of Hispanics received dental care in the program, along with 2,489 (58%) Whites and 1,478 (34%) Blacks or African Americans. An overwhelming majority (94%) were between the ages of 25 and 64. Most clients did not have the financial resources to pay for the dental care they received and 46% lacked dental insurance.[30]

Oral Health in the HIV/AIDS Community

Need: Access to dental care is a persistent health care problem in the United States. Many lack dental insurance, resulting in untreated disease that can worsen or increase the risk of other health problems.[31] Individuals with HIV/AIDS have an even greater need for dental care given their compromised immune systems. The risk of poor oral health increases for those with diminished mental and physical health.[32] The effects of unmet dental needs extend beyond pain and discomfort to lowered compliance with medications and poor nutrition. For example, most antiretroviral medications must be taken with food, which is challenging for those suffering from painful oral infections or with missing teeth. HRSA estimates up to 46% of PLWHA will experience at least one major HIV-related oral health problem. Bacterial, viral and fungal infections such as dental cavities, oral candidiasis (thrush) and cancers are a common occurrence in the HIV/AIDS population.[33] In 2010 and 2011, dental care was the fourth most used service by Ryan White clients[viii] and the third most used core medical service.[ix] In 2011, one out of six Ryan White clients used dental services.[34]

[vii] For a family of four, 300% of FPL is $59,370 based on the 2014 federal poverty guidelines.

[viii] The top 10 Ryan White services were 1) ambulatory medical care, 2) medical case management, 3) case management, 4) oral health, 5) transportation, 6) mental health, 7) health education risk reduction, 8) food bank, 9) psychosocial support and 10) treatment adherence.

[ix] Core Ryan White services include outpatient and ambulatory health services; pharmaceutical assistance, including medications provided through ADAP; dental care; early intervention services; health insurance premium and cost-sharing assistance for low-income individuals; home health care; medical nutrition therapy; hospice services; home and community-based health services; mental health services; outpatient substance abuse treatment; and medical case management, including treatment adherence services.

Barriers: Despite having greater unmet dental needs, PLWHA use fewer dental services. With comparatively lower income than those without the disease, PLWHA are less likely to have access to dental care. HRSA identifies the following barriers facing PLWA accessing dental services:[35]

- Lack of dental insurance.
- Limited financial resources.
- Limited dentists trained or willing to treat PLWHA.
- Inadequate adult dental Medicaid services.
- Patient fear and anxiety of dental treatment.
- Perceived stigma within health care systems.
- Lack of awareness of the importance of oral health.

Funding of Dental Programs

In FY13, the total funding for the Ryan White CARE Act was $2.249 billion, a $144 million loss from the previous year. Since it was created, the Part B ADAP receives the largest portion of funding while the dental programs are allocated the smallest. The President's FY15 budget requested $2.412 billion for the Ryan White HIV/AIDS Program, a $70 million increase, reflecting the Obama Administration's desire for the program's continuation during implementation of the ACA.

It is important to note that in 2008, approximately 6% ($24,568,389) of Part A and 7% of Part B ($11,338,712) funds supported dental care.[36] Despite these additional non-Part F funding streams to

Ryan White CARE Act FY10–FY13 Appropriations Funding				
Program	FY10	FY11	FY12	FY13
Part A: (Title I)—Emergency Relief	$685,662,000	$680,117,000	$673,659,000	$631,850,000
Part B: (Title II) —HIV Care	1,290,868,000	1,322,218,000	1,374,904,000	1,301,612,000
(ADAP—non-add)	*(858,000,000)*	*(885,000,000)*	*(933,299,000)*	*(886,313,000)*
Part C: (Title III)—Early Intervention	208,816,000	207,997,000	217,519,000	196,877,000
Part D: (Title IV)—Women, Infants, Children & Youth	78,523,000	78,215,000	78,069,000	73,263,000
Part F: AIDS Education and Training Centers	34,745,000	34,607,000	34,542,000	32,390,000
Part F: Dental Programs	**13,565,000**	**13,511,000**	**13,485,000**	**12,646,000**
Total: Ryan White CARE Act	$2,312,179,000	$2,336,665,000	$2,392,178,000	$2,248,638,000

Source: HRSA. The data show a steady decline in Part F dental programs from 2010 to 2013.

Programs	FY12 Enacted	FY13 Annualized CR	FY14 President's Budget
Dental Reimbursement Program	$9,046,000	$9,102,000	$9,046,000
Community-Based Dental Partnership Program	$4,439,000	$4,466,000	$4,439,000

Source: HRSA. 2014 Justification of Estimate for Appropriations Committees.

support dental care, funding for the Ryan White HIV/AIDS Program has not kept pace with the increasing number of PLWHA, particularly those needing dental care. In turn, the DRP and CBDPP remain fundamental programs for providing dental care, coordinating with primary care services and training health care professionals. In 2013, DRP grantees were awarded 26.10% of their non-reimbursed costs. More than 41,464 PLWHA received care through the program that year. However, DRP grantees reported $32,387,629 in non-reimbursed costs for 2013. The low reimbursements rates are combined with administratively challenging reporting requirements that threaten participation in the program, as reflected by 56 grantees participating in 2011 and 53 participating in 2013.

Implications of Health Care Reform

The ACA is expected to have a dramatic impact on coverage for those living with HIV/AIDS. Many are expected to gain health care coverage and access to health care services through reforms to private insurance, the expansion of Medicaid and the creation of health insurance marketplaces, as well as subsidies and tax rebates for low-income enrollees in plans administered by the new exchanges. The ACA invests in the public health infrastructure and prevention, reduces health care disparities and develops the health care workforce. A key aspect in health care reform prohibits insurers from denying coverage or discriminating against individuals with preexisting conditions. For PLWHA, this will likely facilitate the ability to purchase private health insurance for the first time since being diagnosed with HIV or AIDS. Additionally, PLWHA will not be subject to increased premium rates based on their health status. Eligible prevention services will be covered without cost sharing and young people with HIV/AIDS can remain on their parents' insurance until age 26. Another ACA provision that benefits the HIV/AIDS community bans insurers from imposing an annual dollar limit to services in the essential health benefits[x] package.[37] Unfortunately, oral health is not an essential health benefit for adults, and most private insurance does not offer dental coverage. While the full implications of health care

[x] Essential health benefits must include services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

reform are still unknown, its benefits to PLWHA will likely vary by state.

Medicaid: Given the high proportion of PLWHA covered by Medicaid, coordination with the Ryan White CARE Act is critical. Not all states are expected to expand Medicaid eligibility. As of December 17, 2014, the Henry J. Kaiser Family Foundation reported 28 states, including the District of Columbia, are implementing the Medicaid expansion, seven states are currently in debate, and 16 states are not moving forward with Medicaid expansion.[38] Most of the states not opting to expand Medicaid are located in the South,[xi] which is a serious concern since southern states have the highest rates of new HIV diagnoses.[39] States that expand Medicaid eligibility are expected to have less fluidity of patients churning in and out of Medicaid eligibility, which often results in discontinuity of care. PLWHA who meet the new eligibility criteria will also be able to qualify for Medicaid before they are diagnosed in Medicaid expanding states. However, states that adopt the Medicaid expansion are not required to offer the same benefits to the newly eligible Medicaid population, who are only entitled to an Alternative Benefit Plan.[xii] As of December 2012, only 11 states offered comprehensive dental benefits to adult Medicaid beneficiaries, and eight States did not offer any dental benefits.[40] Therefore, the Ryan White dental programs will continue to play a critical role for the newly eligible and existing Medicaid beneficiaries.

Health Insurance Marketplaces: Health Insurance Marketplaces, also referred to as Health Exchanges, were established to make purchasing insurance easier and more affordable. They offer an unprecedented level of transparency by allowing purchasers to review and compare all insurance plans at one site. Purchasers between 100 and 400% of the FPL will be eligible for federal subsidies. The subsidies are based on a sliding-income scale and the cost of the second lowest silver plan offered.[41] With the overwhelming majority of Ryan White clients between these income levels, acquiring health coverage will be financially viable for the first time.

Filling Gaps: Health care reform should improve the overall health of PLWHA but significant gaps will still exist for oral health. The DRP and CBDPP serve as one of the few points of access to dental services for this vulnerable population. Academic dental institutions have a significant role in both programs, in addition to being an integral component of the dental safety net that provides dental care to millions of Americans. Continued underfunding the DRP and CBDPP exacerbates existing challenges in meeting the disproportionately severe oral health needs of PLWHA. In addition to providing treatment, the dental programs address barriers PLWHA face in accessing dental care, including education and training of

[xi] AL, FL, GA, KS, LA, MS, NC, OK, TX, SC

[xii] The Alternative Benefit Plan must include coverage of the 10 statutory essential health benefit categories and comply with state and federal regulations.

current and future dental professionals. Without increased support, the HIV/AIDS community will continue to be plagued with oral health problems and, consequently, poor overall health outcomes.

Conclusion

For over 20 years, the Ryan White HIV/AIDS Program has served as the hallmark federal response to the unique health care needs of people living with HIV/AIDS in the United States, including oral health. The program remains a critical lifeline to primary care, and is often the only means to accessing dental care for thousands of people living with HIV/AIDS. While considerable uncertainty has surrounded the program's continued role—and fundability—in light of ACA implementation, it is clear the program remains a vital safety net for the health of PLWHA.

The Ryan White HIV/AIDS Program remains as essential today as it was in 1990. In the 23 states that have yet to expand Medicaid, low-income and single individuals living with HIV will not qualify for Medicaid until they develop an AIDS diagnosis, despite current NIH guidelines that recommend treatment for all HIV-positive individuals.[42] Regular dental care for these individuals will be necessary to monitor development of potentially life-threatening opportunistic infections that manifest orally.

Additionally, while the current political and health care reform climate are likely unfavorable to pursuing a full reauthorization of the nation's largest disease-specific discretionary health spending bill, thoughtful consideration must begin for the future of the program and its parts. When the politically sound time arises to strategically pursue full reauthorization, careful attention must be paid to the oral health funding provisions in the bill. The ACA lacks dental care as an essential health benefit for adults, so the Ryan White HIV/AIDS Program is literally the only path to critical preventive dental services and treatment for dental care for thousands of adults in the United States, especially for those who need them the most.

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References

1 U.S. Department of Health and Human Services, Health Resources and Services Administration. About the Ryan White HIV/AIDS Program. Accessed at: http://hab.hrsa.gov/abouthab/aboutprogram.html

2 U.S. Department of Health and Human Services, Health Resources and Services Administration. The Ryan White HIV/AIDS Program: Oral Health and HIV. Accessed at: http://hab.hrsa.gov/abouthab/files/oral_health_fact_sheet.pdf

3 Health Resources Services Administration, HIV/AIDS Bureau. Oral Health and HIV. [Ryan White HIV/AIDS Program fact sheet]. Accessed at: www.hrsa.gov/publichealth/clinical/oralhealth/hivfactsheet.pdf

4 American Dental Education Association (ADEA) Public Comments to Ryan White HIV/AIDS Program Part F Dental Services Report. February 28, 2014.

5 Ages 13 years and older.

6 Centers for Disease Control and Prevention. Estimated HIV incidence in the United States, 2007–2010. HIV Surveillance Supplemental Report 2012; 17(No. 4). Accessed at: http://www.cdc.gov/hiv/library/reports/surveillance/index.html#panel1

Kaiser Family Foundation. The HIV/AIDS Epidemic in the United States. April 7, 2014. Accessed at: http://kff.org/hivaids/fact-sheet/the-hivaids-epidemic-in-the-united-states/#footnote-107662-2

7 Centers for Disease Control and Prevention. HIV in the United States: At a Glance. Last modified December 3, 2013. Accessed at: http://www.cdc.gov/hiv/statistics/basics/ataglance.html

8 Kaiser Family Foundation. The HIV/AIDS Epidemic in the United States. April 7, 2014. Accessed at: http://kff.org/hivaids/fact-sheet/the-hivaids-epidemic-in-the-united-states/#footnote-107662-2

9 Centers for Disease Control and Prevention. HIV in the United States: At a Glance. Last modified December 3, 2013. Accessed at: http://www.cdc.gov/hiv/statistics/basics/ataglance.html

10 U.S. Department of Health and Human Services, Health Resources and Services Administration. The Ryan White HIV/AIDS Program Progress Report 2012, Ahead of the Curve. November 2012. Accessed at: http://hab.hrsa.gov/data/reports/progressreport2012.pdf

11 Schmid C. Funding the Ryan White Program Now and in the Future. United Sates Conference on AIDS, New Orleans, LA: The AIDS Institute, September 10, 2013.

12 U.S. Department of Health and Human Services, Health Resources and Services Administration. The Ryan White HIV/AIDS Program Progress Report 2012, Ahead of the Curve. November 2012. Accessed at: http://hab.hrsa.gov/data/reports/progressreport2012.pdf

13 Ibid

14 Ibid

15 Kaiser Family Foundation. The Ryan White Program. Last updated March 5, 2013. Accessed at: http://kff.org/hivaids/fact-sheet/the-ryan-white-program/#footnote-KFFACAReport

16 Ibid

17 Ibid

18 U.S. Department of Health and Human Services, Health Resources and Services Administration. The Ryan White HIV/AIDS Program Progress Report 2012, Ahead of the Curve. November 2012. Accessed at: http://hab.hrsa.gov/data/reports/progressreport2012.pdf

19 U.S. Department of Health and Human Services, Health Resources and Services Administration. Dental Programs (Part F). Accessed at: http://hab.hrsa.gov/abouthab/partfdental.html

20 Health Resources and Services Administration. Ryan White HIV/AIDS Dental Reimbursement and Community Based Dental Partnership Grants. Accessed at: https://www.cfda.gov/index?s=program&mode=form&tab=core&id=e21f75c6b73aeb1b3814b76552167757

21 U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. Dental Programs (Part F). Accessed at: http://hab.hrsa.gov/abouthab/partfdental.html

22 U.S. Department of Health and Human Services, Health Resources and Services Administration. Unduplicated number of clients served by the Dental Reimbursement Program (DRP), 2013.

23 U.S. Department of Health and Human Services, Health Resources and Services Administration. The Ryan White HIV/AIDS Program Progress Report 2012, Ahead of the Curve. November 2012. Accessed at: http://hab.hrsa.gov/data/reports/progressreport2012.pdf

24 U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. Dental Programs (Part F). Accessed at: http://hab.hrsa.gov/abouthab/partfdental.html

25 U.S. Department of Health and Human Services, Health Resources and Services Administration. 2012 State Profiles Ryan White HIV/AIDS Program. Accessed at: http://hab.hrsa.gov/stateprofiles/Data-Comparison_Client-Charactistics_YTY.aspx

26 U.S. Department of Health and Human Services, Health Resources and Services Administration. Continuum of HIV Care, US, 2010. Accessed at: http://hab.hrsa.gov/data/reports/continuumofcare/index.html

27 U.S. Department of Health and Human Services, Health Resources and Services Administration. Ryan White HIV/AIDS Program Client Characteristics 2010. Accessed at: http://hab.hrsa.gov/stateprofiles/2010/states/us/Client-Characteristics.htm#chart6

28 U.S. Department of Health and Human Services, Health Resources and Services Administration. Joint CMCS and HRSA Informational Bulletin. Coordination between Medicaid and Ryan White HIV/AIDS Programs. May 1, 2013. Accessed at: http://hab.hrsa.gov/affordablecareact/medicaidinfobulletin.pdf

29 U.S. Department of Health and Human Services, Health Resources and Services Administration. Unduplicated number of clients served by the Dental Reimbursement Program (DRP). 2013.

30 U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. Dental Partnerships Ryan White HIV/AIDS Program Community Based Dental Partnership Program. 2008. Accessed at: https://depts.washington.edu/ccph/pdf_files/CBDPP.pdf

31 U.S. Department of Health and Human Services. Oral health in America: A report of the Surgeon General. Rockville, MD: 2000.

32 Dobalian A, et al. The impact of HIV on oral health and subsequent use of dental services. *Journal of Public Health Dentistry* 2003; 63(2):78–85.

33U.S. Department of Health and Human Services, Health Resources and Services Administration. The Ryan White HIV/AIDS Program: Oral Health and HIV. Accessed at: http://hab.hrsa.gov/abouthab/files/oral_health_fact_sheet.pdf

34 U.S. Department of Health and Human Services, Health Resources and Services Administration. 2010–2011 Ryan White Services Report: A Look at Unduplicated Data. Webcast, February 5, 2014. Accessed at: http://hab.hrsa.gov/data/servicesdelivered.html

35 U.S. Department of Health and Human Services, Health Resources and Services Administration. The Ryan White HIV/AIDS Program: Oral Health and HIV. Accessed at: http://hab.hrsa.gov/abouthab/files/oral_health_fact_sheet.pdf

U.S. Department of Health and Human Services. Oral health in America: A report of the Surgeon General. Rockville, MD: 2000.

Bednarsh H, Reznik D, Tobias C. Financing Oral Health Care for Low-Income Adults Living with HIV/AIDS. *Public Health Reports* 2012; 127(Suppl 2):82.

36 U.S. Department of Health and Human Services, Health Resources and Services Administration. The Ryan White HIV/AIDS Program: Oral Health and HIV. Accessed at: http://hab.hrsa.gov/abouthab/files/oral_health_fact_sheet.pdf

37 U.S. Department of Health and Human Services, Health Resources and Services Administration. Key Provisions of the Affordable Care Act for the Ryan White HIV/AIDS Program. Last updated March 5, 2013. Accessed at: http://hab.hrsa.gov/affordablecareact/keyprovisions.pdf

38 Data available at the Henry J. Kaiser Family Foundation web site: http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act

39 Centers for Disease Control and Prevention. HIV and AIDS in the Unites States by Geographic Distribution. Accessed at: http://www.cdc.gov/hiv/statistics/basics/geographicdistribution.html

40 Kamyar N, Vujicic M, O'Dell A. Affordable Care Act expands dental benefits for children but does not address critical access to dental care issues. *Health Policy Resources Center Research Brief*. Washington, DC: American Dental Association, 2013.

41 U.S. Department of Health and Human Services, Health Resources and Services Administration. Key Provisions of the Affordable Care Act for the Ryan White HIV/AIDS Program. Last updated March 5, 2013. Accessed at: http://hab.hrsa.gov/affordablecareact/keyprovisions.pdf

42 National Institutes of Health. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Last updated February 12, 2013. http://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv-guidelines/10/initiating-art-in-treatment-na%C3%AFve-patients