THE HENRY J. KAISER FAMILY FOUNDATION

HIV/AIDS

HIV/AIDS POLICY FACT SHEET

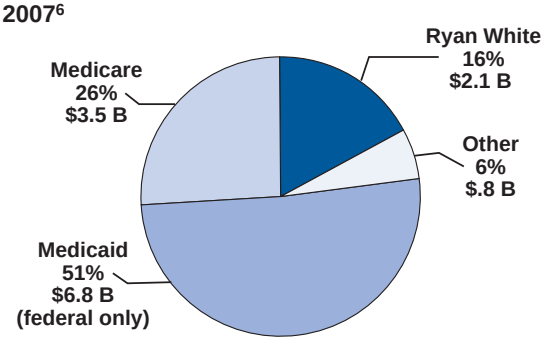
The Ryan White Program

March 2007

The Ryan White CARE Act, now called "Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006", or "Ryan White Program"[1,2] is the single largest federal program designed specifically for people with HIV/AIDS. First enacted in 1990, it provides care and support services to individuals and families affected by HIV/AIDS, functioning as the "payer of last resort"; that is, it fills the gaps in care for those who have no other source of coverage or face coverage limits. Federal Ryan White funding is provided to cities, states,[3] and directly to providers and other organizations. The program was reauthorized in both 1996 and 2000, and was just reauthorized for the third time in December 2006. Whereas all prior authorizations were for five-year periods, the recent authorization extends for three years.[4]

As the number of people living with HIV/AIDS in the U.S. has grown over time, Ryan White has played an increasingly critical role. Administered by the Health Resources and Services Administration (HRSA), the program is estimated to reach more than half a million people each year.[5] It is the third largest source of public financing for HIV/AIDS care in the United States, after Medicaid and Medicare (see Figure 1).[6] Some states and localities also provide funding for Ryan White services (including through state matching funds requirements).

Figure 1: Federal Spending on HIV/AIDS Care by Program, FY 2007[6]



Total = $13.2 billion

Ryan White Parts, Grantees, & Structure

The Ryan White Program is comprised of several parts through which funds are provided across the country (see Figure 2). The types of entities eligible for federal Ryan White funds vary by part, and include states, cities, and directly-funded public and private providers and other organizations. Most funding is provided to states (57%) followed by cities (29%),[6,7] with the remainder provided directly to organizations. Much of the funding provided to states and cities is in turn channeled to local providers as well. Community-based organizations (CBOs) make up the largest single group of Ryan White-funded entities serving clients (45% in 2004).[8]

In recognition of the varying and changing nature of the HIV/AIDS epidemic, Ryan White grantees have been given discretion in designing local programs, including setting client eligibility requirements and service priorities. For the first time, however, the recent reauthorization of Ryan White added the requirement that at least 75% of funds be spent on "core medical services" under Parts A through C (see Figure 3) and requires a minimum formulary under the AIDS Drug Assistance Program (ADAP). In addition, funding distribution under Parts A and B will now be based on living HIV and AIDS cases, instead of estimated living AIDS cases (the prior method). Such data will only be permitted from states that have names-based HIV reporting systems; states with code-based systems can receive an exemption, and are allowed up to 4 years to transition to names, but their code-based counts will be reduced for funding purposes in the interim.[4]

The major parts of the Ryan White Program are:[4,5]

- **Part A (Title I):** Funds "eligible metropolitan areas" (EMAs), those with cumulative total of more than 2,000 reported AIDS cases over most recent 5-year period, and "transitional grant areas" (TGAs), those with 1,000–1,999 reported AIDS cases over most recent 5-year period. Two-thirds of funds are distributed by formula based on an EMA or TGA's share of living HIV and living AIDS cases; the remainder is distributed via competitive, supplemental grants based on "demonstrated need". At least 75% of Part A funds must be spent on core medical services. EMAs must establish Planning Councils, local bodies tasked with assessing needs, creating a plan for the delivery of HIV care, and developing priorities for the allocation of funds. TGAs are not required to do so (unless they are "grandfathered"[9] EMAs).
- **Part B (Title II):** Funds all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and 5 other territories and associated jurisdictions. Includes Part B base and supplemental grants, ADAP and ADAP supplemental grants, and Emerging Communities (ECs) grants. States provide services directly or through Part B "Consortia" (a consortium is an association of organizations set up to plan for and deliver HIV care). At least 75% of funds must be spent on core medical services.
  - *Base & Supplemental:* Funds distributed by formula to states based on a state's share of living HIV and AIDS cases, weighted to reflect the presence or absence of EMAs/TGAs. Part B "supplemental" grants available for states with "demonstrated need."

Figure 2: Ryan White Program by Part, Funding & Grantees[5,7,10,11]

Part	FY 2007		Number of Grantees
	$	%	
Part A (Title I)	$604.0	29%	22 EMAs; 34 TGAs
Part B (Title II)	$1,195.5	57%	59 States/Territories; 19 ECs
ADAP	*($789.0)*	--	59 States/Territories
Part C (Title III)	$193.6	9%	363 EIS, 22 Capacity/Planning
Part D (Title IV)	$71.8	3%	89 Grantees
Part F AETC	$34.7	2%	4 National, 11 Regional Centers
Part F Dental	$13.1	1%	68 Reimbursement; 12 Partnership
TOTAL	$2,112.7	100%	

– *ADAP & ADAP Supplemental:* Funds are "earmarked" by Congress for state ADAPs to provide medications to people with HIV/AIDS (or pay for health insurance that provides medications). ADAP supplemental grants available to states with "severe need" (5% of earmark reserved).
– *ECs:* A portion of Part B base funds set-aside for grants to metropolitan areas that do not yet qualify as EMAs or TGAs, but have 500-999 cumulative reported AIDS cases over most recent 5 years. All funding is distributed via formula.

- **Part C (Title III):** 75% of funds must be spent on core medical services. Public and private organizations are funded directly for:
  – *Early Intervention Services (EIS):* to reach people newly diagnosed with HIV. Services include HIV testing, case management, and risk reduction counseling.
  – *Capacity Development & Planning Grants:* supports organizations in planning for service delivery and in building capacity to provide services.
- **Part D (Title IV):** Funds public and private organizations directly to provide family-centered and community-based services to children, youth, and women living with HIV and their families. Services include outreach, prevention, primary and specialty medical care, and psychosocial services; also supports activities to improve access to clinical trials and research for these populations.
- **Part F:** Includes:
  – *AIDS Education and Training Centers (AETCs)*: national and regional centers that provide education and training for health care providers who treat people with HIV/AIDS; and *dental reimbursement and community-based dental partnership programs*.
  – *Minority AIDS Initiative (MAI)*: The MAI, created in 1998 in response to growing concern about the impact of HIV/AIDS on racial and ethnic minorities in the United States, provides funding across several DHHS agencies/programs, including Ryan White, to strengthen organizational capacity and expand HIV-related services in minority communities. The Ryan White component of the MAI was codified in the recent reauthorization. In FY 2007, the MAI was funded at $399.3 million including $128.5 million through Ryan White.[6]
  – *Special Projects of National Significance (SPNS)*: address emerging needs of clients and assist in developing standard electronic client information data system. SPNS is funded through "set-asides" of general Public Health Service evaluation funding, separately from the amount appropriated by Congress for Ryan White.

Figure 3: Core Medical Services (75% of funds under Parts A through C)[4]

Outpatient and ambulatory health services; medications; pharmaceutical assistance; oral health 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; substance abuse outpatient care; and medical case management, including treatment adherence services.

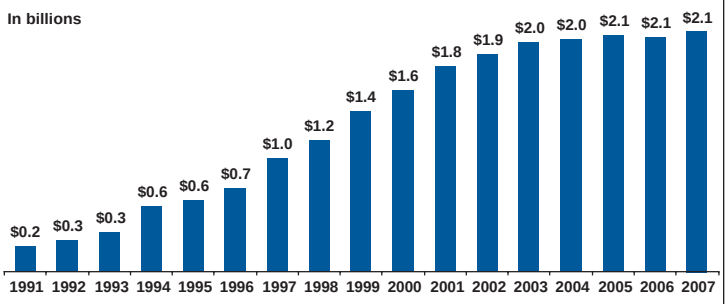
Ryan White Program Clients

HRSA estimates that more than half a million people receive at least one medical, health, or related support service through Ryan White each year; many clients receive services from multiple parts of Ryan White. Most Ryan White clients are low-income, with nearly three-quarters (72%) having annual household incomes at or below the poverty level, and most are either uninsured (31%) or publicly insured (55%).[8,12] Clients are primarily male, between the ages of 25 and 44, and are people of color.[8] Looking at the ADAP program specifically, half (50%) of ADAP clients have incomes at or below the poverty level and nearly three-quarters (73%) are uninsured.[12]

Funding for the Ryan White Program [6,13]

Federal funding for Ryan White began in FY 1991 and increased significantly in the mid-nineties, primarily after the introduction of highly active antiretroviral therapy (HAART). Over the last 10 years, Ryan White funding has tripled and reached just over $2 billion in FY 2007, largely reflecting increased funding for medications through ADAP.

Figure 4: Federal Funding for the Ryan White Program, FY 1991–2007[6,13,14]



The Future Outlook

Ryan White programs will continue to play a critical role for low-income people with HIV/AIDS who have no other source of care, particularly as the number of people living with HIV/AIDS continues to grow and the cost of care increases. However, because Ryan White is a discretionary federal grant program, its funding depends on annual appropriations by Congress, and funding levels do not necessarily correspond to the number of people who need services or the actual costs of services. As a result, some states and communities have been unable to meet the needs of all people living with HIV/AIDS. For example, some state ADAPs have waiting lists, or have had to institute other cost containment measures that may limit client access.

The recent reauthorization of the Ryan White Program made significant changes, including setting minimum funding requirements for core medical services, creating new structures for funding, and changing the formula used to distribute funds through Parts A and B.[4,15] It will be important to monitor the impact of these changes on people with HIV/AIDS, their providers, and communities, as they go into effect this year.

References

1 HRSA HIV/AIDS Bureau, Information E-Mail, Vol.10, Issue 4, February 15, 2007.
2 The Ryan White CARE Act of 1990 [P.L. 101-381] & Amendments of 1996 [P.L. 104-146] and 2000 [P.L. 106-345]; The Ryan White HIV/AIDS Treatment Modernization Act of 2006 [P.L. 109-415].
3 The term "state" used here includes territories and associated jurisdictions.
4 The Ryan White HIV/AIDS Treatment Modernization Act of 2006 [P.L. 109-415].
5 HRSA, HIV/AIDS Bureau, http://hab.hrsa.gov/programs/factsheets.
6 OMB and DHHS Office of the Budget, February 2007.
7 DHHS HRSA, Justification of Estimates for Appropriations Committee, FY 2008.
8 HRSA, *Ryan White CARE Act Annual Data Summary* (CY 2004), August 2006.
9 Grandfathered EMAs are those that move from EMA to TGA status, based on their reported AIDS cases.
10 National Alliance of State and Territorial AIDS Directors, February 2007.
11 HRSA: www.hrsa.gov.
12 KFF/NASTAD, *National ADAP Monitoring Project Annual Report*, March 2006.
13 HRSA, HIV/AIDS Bureau, http://hab.hrsa.gov/reports/funding.htm.
14 Includes funding for SPNS.
15 KFF, "The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act: A Side-by-Side Comparison of Current Law and Reauthorization Proposals," www.kff.org/hivaids/7531.cfm.