THE RYAN WHITE HIV/AIDS PROGRAM

RYAN WHITE HIV/AIDS PROGRAM OVERVIEW

The AIDS epidemic has taken an enormous toll since its onset in the early 1980s. Approximately 583,000 Americans have died, and many others are living with HIV-related illness and disability or caring for people with the disease.[1] An estimated 56,000 Americans become infected with HIV each year,[2] and more than 1.1 million Americans are living with HIV disease.[3] The epidemic has hit hardest among populations who are poor, lack health insurance, are disenfranchised from the health care system, and are from communities of color.

In response, Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990 to improve the quality and availability of care for low-income, uninsured, and underinsured individuals and families affected by HIV disease. The CARE Act was amended and reauthorized in 1996, 2000, and 2006; in 2009 it was reauthorized as the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111–87).

The Ryan White HIV/AIDS Program is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB).

RYAN WHITE HIV/AIDS PROGRAM CLIENTS

The Ryan White HIV/AIDS Program reaches an estimated 529,000 people each year. People living with HIV disease are, on average, poorer than the general population. For Program clients, the Program is the payor of last resort, because they are un- or underinsured and no other source of payment for services—public or private—is available.

In 2008, more than 70 percent of Ryan White HIV/AIDS Program clients self-identified as members of racial or ethnic minority groups. In the same year, 67 percent of Program clients were male, and 33 percent were female.

THE RYAN WHITE HIV/AIDS PROGRAM WORKS WITH CITIES, STATES, AND LOCAL COMMUNITY-BASED ORGANIZATIONS TO PROVIDE SERVICES TO AN ESTIMATED 529,000 PEOPLE EACH YEAR WHO DO NOT HAVE SUFFICIENT HEALTH CARE COVERAGE OR FINANCIAL RESOURCES TO COPE WITH HIV DISEASE. THE MAJORITY OF RYAN WHITE HIV/AIDS PROGRAM FUNDS SUPPORT PRIMARY MEDICAL CARE AND ESSENTIAL SUPPORT SERVICES. A SMALLER BUT EQUALLY CRITICAL PORTION IS USED TO FUND TECHNICAL ASSISTANCE, CLINICAL TRAINING, AND RESEARCH ON INNOVATIVE MODELS OF CARE. THE RYAN WHITE HIV/AIDS PROGRAM, FIRST AUTHORIZED IN 1990, IS CURRENTLY FUNDED AT $2.29 BILLION.

RYAN WHITE HIV/AIDS PROGRAMS

The Ryan White HIV/AIDS Program is divided into several "Parts," following from the authorizing legislation.

Part A provides grant funding for medical and support services to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs)—population centers that are the most severely affected by the HIV/AIDS epidemic. EMA eligibility requires an area to report more than 2,000 AIDS cases in the most recent 5 years and to have a population of at least 50,000. To be eligible as a TGA, an area must have 1,000 to 1,999 reported new AIDS cases in the most recent 5 years. The FY 2010 Part A appropriation was approximately $679.1 million.

Part B provides grants to States and Territories to improve the quality, availability, and organization of HIV/AIDS health care and support services. Part B grants include a base grant; the AIDS Drug Assistance Program (ADAP) award; funds for the

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ADAP Supplemental Drug Treatment Program; and supplemental grants to States with "emerging communities," defined as jurisdictions reporting between 500 and 999 cumulative AIDS cases over the most recent 5 years. Congress designates a portion of the Part B appropriation for ADAP. With the dramatic increase in the cost of pharmaceutical treatment, the ADAP earmark is now the largest portion of Part B spending.

The FY 2010 Part B appropriation was $1.25 billion, of which $835 million was for ADAP. Five percent of the ADAP earmark is set aside for the ADAP Supplemental Drug Treatment Program to assist States needing additional ADAP funds.

Part B also provides $5 million in supplemental grants to States for Emerging Communities. And in 2009, $50,000 awards were made to newly eligible U.S. Pacific Territories (American Samoa and the Commonwealth of the Northern Mariana Islands) and Associated Jurisdictions (the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau).

Part C supports outpatient HIV early intervention services and ambulatory care. Unlike Part A and B grants, which are awarded to local and State governments that contract with organizations to deliver services, Part C grants are awarded directly to service providers, such as ambulatory medical clinics. Part C also funds planning grants, which help organizations more effectively deliver HIV/AIDS care and services. The FY 2010 Part C appropriation was approximately $206.8 million.

Part D grants provide family-centered comprehensive care to children, youth, and women and their families and help improve access to clinical trials and research. In FY 2010, appropriations for Part D programs were approximately $77.8 million.

Part F grants support several research, technical assistance, and access-to-care programs, as described below:

- **The Special Projects of National Significance (SPNS) Program** supports the demonstration and evaluation of innovative models of care delivery for hard-to-reach populations. SPNS also provides funds to help grantees develop standard electronic client information data systems. A total of $25 million was set aside for the SPNS Program in FY 2010.

- **The AIDS Education and Training Centers (AETC) Program** supports education and training of health care providers through a network of 11 regional and 4 national centers. In FY 2010, the AETC appropriation was $34.8 million.

- **Minority AIDS Initiative (MAI)** was established in FY 1999 through Congressional appropriations to improve access to HIV/AIDS care and health outcomes for disproportionately affected minority populations. MAI-funded services under Parts A, C, and D were consistent with their "base" programs, whereas the Part B MAI focused on education and outreach to improve minority access to State ADAPs. The Ryan White HIV/AIDS Treatment Modernization Act of 2006 made the Part A and B MAI separate, competitive grant programs for EMA/TGAs and States, respectively. Under the Ryan White HIV/AIDS Treatment Extension Act of 2009, however, Congress directed that Part A and B funding be returned to a formula grant basis and synchronized with the Part A and B grant awards, similar to the Part C and D MAI.

All Ryan White HIV/AIDS Program Parts can support the provision of oral health services. Two Part F programs, however, focus on funding oral health care for people with HIV:

- **The HIV/AIDS Dental Reimbursement Program** reimburses dental schools, hospitals with postdoctoral dental education programs, and community colleges with dental hygiene programs for a portion of uncompensated costs incurred in providing oral health treatment to patients with HIV disease.

- **The Community-Based Dental Partnership Program** supports increased access to oral health care services for people who are HIV positive while providing education and clinical training for dental care providers, especially those practicing in community-based settings.

Dental Program appropriations in FY 2010 are a combined $13.6 million.

[1] Centers for Disease Control and Prevention (CDC). *HIV/AIDS Surveillance Report*. 2007;19:Table 8.
[2] CDC. *HIV prevention in the United States at a critical crossroads*. 2009. Available at www.cdc.gov/hiv/resources/reports/hiv_prev_us.htm.
[3] CDC. HIV prevalence estimates—United States, 2006. *MMWR*. 2008;57(39):1073-76.