THE HENRY J. KAISER FAMILY FOUNDATION

HIV/AIDS POLICY

FACT SHEET

The Ryan White Program

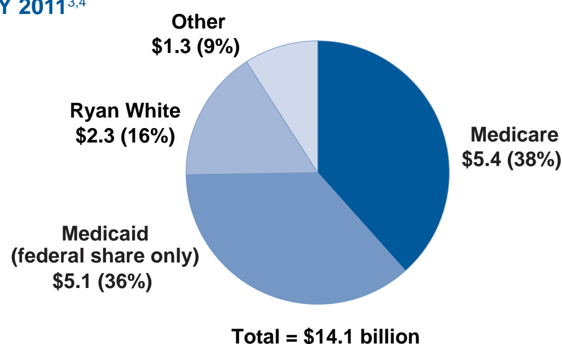
November 2011

The Ryan White Program, the single largest federal program designed specifically for people with HIV in the United States, is estimated to reach more than half a million people with HIV each year.[1] First enacted in 1990, it has played an increasingly critical role as the number of people living with HIV has grown over time and the needs of this population have become more complex as people are living longer with the disease. The program provides care and support services to individuals and families affected by the disease, functioning as the "payer of last resort" by filling the gaps for those who have no other source of coverage or face coverage limits.

Federal Ryan White funding, which must be appropriated by Congress each year, is provided to cities, states and territories,[2] providers, and other organizations. Administered by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (DHHS), it is the third largest source of federal funding for HIV care in the U.S., after Medicare and Medicaid (see Figure 1).[3,4] In addition to federal funding, some states and localities also provide funding to their Ryan White programs (including through certain state matching funds requirements).

The program has been reauthorized by Congress four times since first created (1996, 2000, 2006, and 2009), and is currently authorized through FY 2013.[5,6,7,8] Each reauthorization has made adjustments to the program. Most recently, for example, the 2009 reauthorization included provisions designed to strengthen Ryan White's role in helping identify individuals who are HIV positive and not yet diagnosed, including a requirement that the Secretary of DHHS establish a new national HIV testing goal of 5,000,000 tests per year to be met by Ryan White and other federal programs.[7,9] It also increased Ryan White funding authorization levels, dependent upon annual appropriations, and extended the period under which grantees were required to move from code- to name-based reporting of HIV data, among other changes.[7]

Figure 1: Federal Funding for HIV/AIDS Care by Program, FY 2011[3,4]



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.[1] About seven in ten (68%) clients are low-income,[10] and most are uninsured (33%) or underinsured (56%).[1] Clients are primarily male (67%), between the ages of 25 and 44 (45%), and most are people of color (73%).[1,10]

Ryan White Parts, Grantees, & Structure

The Ryan White Program consists of several "Parts" (see Figure 2). Eligible entities apply for funding by Part, and include states, cities, directly-funded public and private providers, community-based organizations (CBOs), and other institutions. Most funding is provided to states (56% in FY 2011) followed by cities (29%), and the remainder directly to organizations.[3] Much of the funding provided to states and cities is in turn channeled to local providers. CBOs make up the largest single group of Ryan White-funded entities serving clients (43% in 2008).[10]

Figure 2: Ryan White Program by Part, Funding, & Grantees[3,11]

Part	FY 2011 $	FY 2011 %	Number of Grantees
Part A	$677.7	29%	24 EMAs; 28 TGAs
Part B	$1,303.0	56%	59 States/Territories; 16 ECs
ADAP (non-add)	*$885*	–	*59 States/Territories*
Part C	$205.6	9%	344 Grantees
Part D	$77.3	3%	82 WICY Grantees; 17 Adolescent Grantees
Part F AETC	$34.6	1%	5 National, 11 Regional Centers
Part F Dental	$13.5	1%	56 Reimbursement; 12 Community Partnership
Part F SPNS	$25.0	1%	67 Grantees
TOTAL	**$2,336.7**	**100%**	

In recognition of the varying and changing nature of the HIV epidemic, Ryan White grantees are given broad discretion to design many aspects of their programs, such as specifying client eligibility levels and service priorities. However, the 2006 reauthorization added new grantee requirements, including a requirement that 75% or more of funds be spent on "core medical services" under Parts A through C (see Figure 3) and that all state AIDS Drug Assistance Programs (ADAPs) have a minimum formulary for medications.[6] It also changed the way in which federal funds are allocated to Parts A and B, now based on both living HIV (non-AIDS) and living AIDS case counts (previously, it was only based on living AIDS cases). HIV (non-AIDS) case counts are only permitted from states that have name-based HIV reporting systems; states with code-based systems can receive an exemption, and were allowed a grace period, extended for three more years by the 2009 reauthorization, to complete their transition to names, but their counts are reduced for funding purposes in the interim.[7,9] The program's six parts are:

- **Part A:** Funds provided to "eligible metropolitan areas" (EMAs), those with a cumulative total of more than 2,000 reported AIDS cases over the most recent five-year period, and "transitional grant areas" (TGAs), those with 1,000-1,999 cumulative reported AIDS cases. Two thirds of funds are distributed by formula based on an area's share of living HIV (non-AIDS) and living AIDS cases; the remainder is distributed via competitive, supplemental grants based on "demonstrated need." EMAs must establish Planning

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Councils, local bodies tasked with assessing needs, developing a plan for the delivery of HIV care, and setting priorities for funding. TGAs are not required to have Planning Councils (unless they are "grandfathered" EMAs[12]).

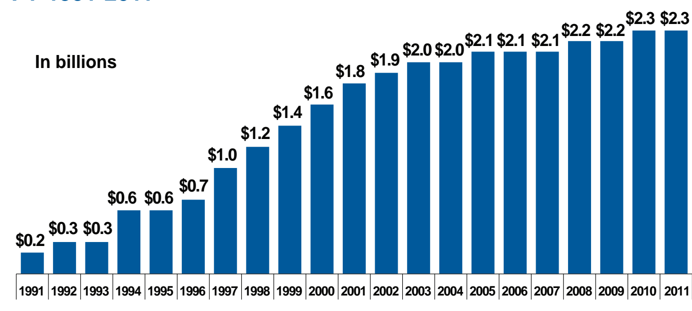
- **Part B:** Funds provided to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five territories and associated jurisdictions. States provide services directly, through sub-grantees, and/or through Part B "Consortia" (associations set up to plan for and deliver HIV care). Part B components include:
  - *Base & Supplemental:* funds distributed by formula to states based on state's share of living HIV (non-AIDS) and living AIDS cases, weighted to reflect the presence or absence of EMAs/TGAs. Part B "supplemental" grants are available for states with "demonstrated need."
  - *ADAP & ADAP Supplemental:* Congress "earmarks" funds under Part B for ADAPs which provide medications to people with HIV. ADAP supplemental grants are available to states with "severe need" (5% of earmark reserved for this purpose).
  - *Emerging Communities (ECs):* a portion of Part B base funds is 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 the most recent 5 years. All funding is distributed via formula using living HIV/AIDS cases from all eligible ECs.
- **Part C:** Public and private organizations are funded directly for:
  - *Early Intervention Services (EIS):* to reach people newly diagnosed with HIV with services such as HIV testing, case management, and risk reduction counseling.
  - *Capacity Development & Planning Grants:* to support organizations in planning for service delivery and building capacity to provide services.

Figure 3: Core Medical Services (75% of funds under Parts A through C must be spent on core services)[6]

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.

- **Part D:** Public and private organizations are funded directly to provide family-centered and community-based services to children, youth, and women living with HIV and their families, including outreach, prevention, primary and specialty medical care, and psychosocial services. Part D also supports activities to improve access to clinical trials and research for these populations.
- **Part F:** Includes the following components:
  - *AIDS Education and Training Centers (AETCs):* national and regional centers that provide education and training for health care providers who treat people with HIV.
  - *Dental Programs:* includes the "Dental Reimbursement Program," which reimburses dental schools/dental care providers and the "Community-based Dental Partnership Program," which funds programs to increase access to dental care for people with HIV and educate providers.
  - *Minority AIDS Initiative (MAI):* the MAI, created in 1998 in response to growing concern about the impact of HIV on racial and ethnic minorities in the U.S., 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 2006 reauthorization[6] and the 2009 reauthorization required HRSA to develop a formula for awarding MAI grants under Parts A and B.[7,9]

Figure 4: Federal Funding for the Ryan White Program, FY 1991-2011[1,11,13]



  - *Special Projects of National Significance (SPNS):* Funded through "set-asides" of general federal Public Health Service evaluation funding, separately from the amount appropriated by Congress for Ryan White, SPNS projects address emerging needs of clients and assist in developing a standard electronic client information data system.

Ryan White Funding

Federal funding for the Ryan White Program began in FY 1991 and increased significantly in the mid-1990s, primarily after the introduction of highly active antiretroviral therapy (HAART). It has continued to increase but at a slower rate, with most increases targeted to ADAPs.[1,11,13]

Future Outlook and Challenges

The Ryan White Program, first enacted as an emergency measure, has grown to become a main part of the fabric of HIV care and services in the U.S., playing a critical role in the lives of low-income people with HIV who have no other source of care. As a 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, not all states and communities can meet all needs in their jurisdictions. In addition, as payer of last resort, the Ryan White care system is sensitive to the capacity of and changes in the larger fiscal and health systems environment. Recent economic conditions have meant increased demands on Ryan White at a time when resources have been constricted, and as a result, some states have instituted cost-containment measures, such as waiting lists for ADAPs.[14,15]

Additionally, two relatively recent developments have altered the HIV/AIDS policy landscape and have implications for Ryan White that are not yet clear—the passage of national health care reform and the release of the first, comprehensive National HIV/AIDS Strategy for the country, both of which are expected to change the role of Ryan White.[16,17]

[1] HRSA. Justification of Estimates for Appropriations Committee, FY 2012.
[2] The term "state" includes territories and associated jurisdictions.
[3] OMB. Personal communication; August 2011.
[4] KFF. *Fact Sheet: U.S. Federal Funding for HIV/AIDS: The President's FY 2012 Budget Request*; October 2011.
[5] For legislative history, see: http://hab.hrsa.gov/livinghistory/timeline/ legislation_hist.htm.
[6] Ryan White HIV/AIDS Treatment Modernization Act of 2006 (P.L. 109-415).
[7] Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87).
[8] KFF. *The Ryan White CARE Act: A Side-by-Side Comparison of Prior Law to the Newly Reauthorized CARE Act*; December 2006.
[9] CRS. *The Ryan White HIV/AIDS Program*; June 2011.
[10] HRSA. *Going the Distance: The Ryan White HIV/AIDS Program, 20 Years of Leadership, a Legacy of Care*; August 2010.
[11] HRSA. Personal communication; October 2011.
[12] Grandfathered EMAs are those that move from EMA to TGA status, based on reported AIDS cases.
[13] HRSA. Justification of Estimates for Appropriations Committee, FY 2009 & FY 2011.
[14] NASTAD. *National ADAP Monitoring Project Annual Report*; May 2011.
[15] NASTAD. *ADAP Watch* (see the latest report at http://nastad.org/).
[16] DHHS. *Fact Sheet: How Does the Affordable Care Act Impact People Living with HIV/AIDS?* September 2010.
[17] White House. *National HIV/AIDS Strategy for the United States*; July 2010.

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