

### The Ryan White Program

June 2008

The Ryan White HIV/AIDS Program is the single largest federal program designed specifically for people with HIV/AIDS in the United States. 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 grant funding, which must be appropriated by Congress each year, is provided to cities, states,<sup>1</sup> and directly to providers and other organizations. The Ryan White Program has been reauthorized by Congress three times since 1990 – in 1996, 2000, and 2006 – and is due to be reauthorized again in 2009.<sup>2</sup>

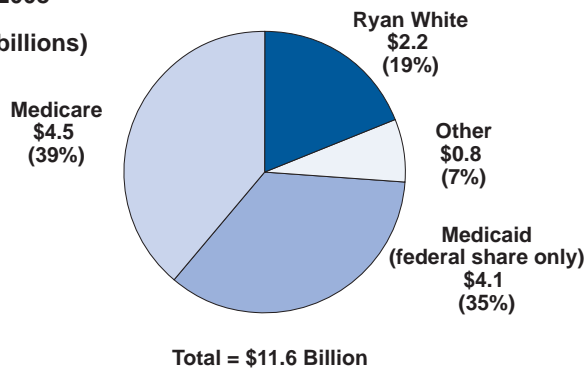
As the number of people living with HIV/AIDS in the U.S. has grown over time, the Ryan White Program has played an increasingly critical role in HIV care. Administered by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services, the program is estimated to reach more than half a million people with HIV each year.<sup>3</sup> It is the third largest source of federal funding for HIV/AIDS care in the U.S., after Medicare and Medicaid (see Figure 1).<sup>4</sup> In addition to federal Ryan White funding, some states and localities also provide funding to their Ryan White services (including through state matching funds requirements in certain cases).

services” under Parts A through C (see Figure 3) and a minimum formulary requirement under the AIDS Drug Assistance Program (ADAP). In addition, funding distribution for Parts A and B is now based on living HIV and AIDS cases, instead of estimated living AIDS cases (the prior method). Such data are only permitted from states that have name-based HIV reporting systems; states with former code-based systems can receive an exemption, and are allowed up to 4 years to complete their transition to names, but their code-based counts will be reduced for funding purposes in the interim (as of April 2008, all states had implemented a name-based system).<sup>6,7</sup> The major Parts of the Ryan White Program are:<sup>6</sup>

- **Part A:** Funds to “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 are required to establish Planning Councils, local bodies tasked with assessing needs, developing a plan for the delivery of HIV care, and setting priorities for the allocation of funds. TGAs are not required to have Planning Councils (unless they are “grandfathered”<sup>8</sup> EMAs).
- **Part B:** Funds to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and 5 other territories and associated jurisdictions. States provide services directly (e.g., health department clinics), through sub-grantees, and/or through Part B “Consortia” (associations of organizations set up to plan for and deliver HIV care). At least 75% of funds must be spent on core medical services. Part B components include:
  - *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 are available for states with “demonstrated need.”<sup>9</sup>

**Figure 1: Federal Funding for HIV/AIDS Care by Program, FY 2008<sup>4</sup>**

(in billions)



#### Ryan White Parts, Grantees, & Structure

The Ryan White Program consists of several “Parts” (formerly referred to as Titles), through which funding is provided across the country (see Figure 2). Eligible entities for funding vary by Part, and include states, cities, and directly-funded public and private providers, community-based organizations (CBOs), and other institutions. Most funding is provided to states (55% in FY 2008) followed by cities (29%),<sup>4</sup> 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 make up the largest single group of Ryan White-funded entities serving clients (45% in 2004).<sup>5</sup>

In recognition of the varying and changing nature of the HIV/AIDS epidemic, Ryan White grantees have been given discretion to design many aspects of their local programs, including setting client eligibility requirements and service priorities. For the first time, however, the recent reauthorization<sup>6</sup> of the Ryan White Program added a requirement that at least 75% of funds be spent on “core medical

**Figure 2: Ryan White Program by Part, Funding & Grantees<sup>3,4,10,11</sup>**

Part	FY 2008		Number of Grantees
	\$	%	
Part A	\$627.1	29%	22 EMAs; 34 TGAs
Part B	\$1,195.2	55%	59 States/Territories; 19 ECs
ADAP (non-add)	\$794.4	--	59 States/Territories
Part C	\$198.8	9%	357 EIS, 22 Capacity/Planning
Part D	\$73.7	3%	90 Grantees
Part F AETC	\$34.1	2%	4 National, 11 Regional Centers
Part F Dental	\$12.9	1%	65 Reimbursement; 12 Partnership
Part F SPNS	\$25.0	1%	54 Grantees
<b>TOTAL</b>	<b>\$2,166.8</b>	<b>100%</b>	

- *ADAP & ADAP Supplemental*: Funds are “earmarked” under Part B 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).
- *Emerging Communities (ECs)*: A portion of Part B base funds set-aside for grants to ECs, 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 using all living HIV/AIDS cases in all eligible ECs.
- **Part C**: 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*: to support organizations in planning for service delivery and building capacity to provide services.
- **Part D**: Funds to public and private organizations 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 the following three 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/AIDS;
  - *Dental Programs*: Includes the Dental Reimbursement Program, which reimburses dental schools/dental care providers serving clients with HIV, and the Community-based Dental Partnership Program, which funds programs to increase access to dental care for people with HIV and to provide education and training to dental care providers.
  - *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 2008, the MAI was funded at \$402.6 million including \$135.1 million through Ryan White.<sup>4</sup>
  - *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)<sup>6</sup>**

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

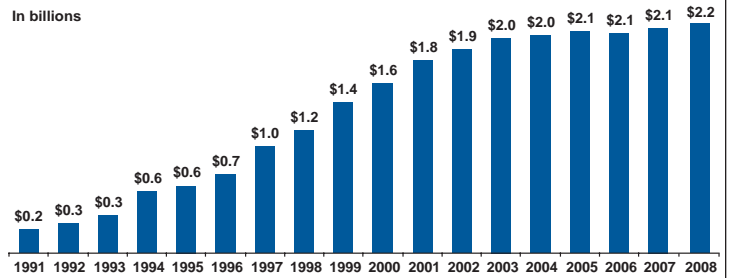
HRSA estimates that more than half a million people receive at least one medical, health, or related support service through Ryan White each year; many clients receive services from multiple parts of Ryan White. Most Ryan White clients are low-income, with nearly three-quarters (72%) having annual household incomes at or below the

poverty level,<sup>5</sup> and most are either uninsured (33%) or underinsured (56%).<sup>3</sup> Clients are primarily male (although one-third of those served are women), between the ages of 25 and 44, and most are people of color (72%).<sup>3,5</sup> Looking at the ADAP program specifically, which had close to 146,000 enrollees last year, 43% of clients had incomes at or below the poverty level and two-thirds (69%) were uninsured.<sup>12</sup>

### Funding for the Ryan White Program<sup>4,13</sup>

Federal funding for the Ryan White Program 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, funding has increased but at a slower rate, with most increases being targeted to ADAPs, for the provision of medications.

**Figure 4: Federal Funding for the Ryan White Program, FY 1991–2008<sup>3,4,13,14</sup>**



### The Future Outlook

The Ryan White HIV/AIDS Program, first enacted as an emergency measure, has grown to become a main part of the fabric of HIV care and services in the United States, playing a critical role in the lives of low-income people with HIV/AIDS who have no other source of care. However, because it 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, not all states and communities can meet the needs of all people living with HIV/AIDS in their jurisdictions. In addition, as payer of last resort, the Ryan White care system is sensitive to the current capacity of and changes in the larger health care system around it. Recent signs of a new economic downturn at the national and state levels, for example, may mean increased demands on Ryan White-funded services at a time when less funding is available for the program. Finally, changes made to the program during the most recent reauthorization are just now beginning to be felt at the state and local levels, and it will be important to monitor their impact on people with HIV/AIDS, their providers, and communities over time.

### References

- 1 The term “state” used here includes territories and associated jurisdictions.
- 2 For legislative history, see: <http://hab.hrsa.gov/law/leg.htm>.
- 3 DHHS HRSA, Justification of Estimates for Appropriations Committee, FY 2009
- 4 OMB and DHHS Office of the Budget, April 2008.
- 5 HRSA, *Ryan White CARE Act Annual Data Summary* (CY 2004), August 2006.
- 6 Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Public Law 109-415, December 19, 2006).
- 7 CDC, *Current Status of HIV Infection Surveillance*, as of April 2008.
- 8 Grandfathered EMAs are those that move from EMA to TGA reported, based on their reported AIDS cases.
- 9 The Part B Supplemental has never been used due to lack of funding.
- 10 HRSA, HIV/AIDS Bureau, personal communication, May 2008.
- 11 HRSA: [www.hrsa.gov](http://www.hrsa.gov).
- 12 KFF/NASTAD, *National ADAP Monitoring Project Annual Report*, April 2008.
- 13 HRSA, HIV/AIDS Bureau, <http://hab.hrsa.gov/reports/funding.htm>.
- 14 Includes funding for SPNS.

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