

FACT SHEET

The Ryan White Program

February 2009

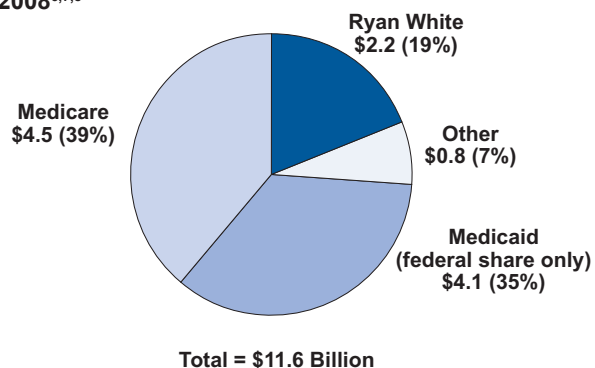
The Ryan White Program is the single largest federal program designed specifically for people with HIV in the United States, estimated to reach more than half a million people with HIV each year.¹ First enacted in 1990, it provides care and support services to individuals and families affected by the 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,² providers and other organizations. The program has been reauthorized by Congress three times since first created (1996, 2000, and 2006) and is due to be reauthorized again by September 2009 unless otherwise extended by Congress.^{3,4,5}

The Ryan White Program has played an increasingly critical role as the number of people living with HIV in the U.S. has grown over time. 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).^{6,7,8} In addition to federal funding, some states and localities also provide funding to their Ryan White services (including through certain state matching funds requirements).

services” under Parts A through C (see Figure 3) and that all state AIDS Drug Assistance Programs (ADAPs) must have a minimum formulary for medications. It also changed the way in which federal funds are allocated to Parts A and B, to now be 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 are allowed up to four years to complete their transition to names, but their counts are reduced for funding purposes in the interim (all states have implemented name reporting; three territories have not).¹⁰ The program’s six parts are:

- **Part A:** 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), with 1,000–1,999 cumulative reported AIDS cases. Two-thirds of funds are distributed by formula based on an EMA or TGA’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 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”¹¹ EMAs).
- **Part B:** Funds 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.”¹²

Figure 1: Federal Funding for HIV/AIDS Care by Program, FY 2008^{6,7,8}



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 (55% in FY 2008) followed by cities (29%), and the remainder directly to organizations. Much of the funding provided to states and cities is in turn channeled to local providers as well. CBOs make up the largest single group of Ryan White-funded entities serving clients (45% in 2004).⁹ 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 local programs, such as specifying client eligibility levels and service priorities. The most recent reauthorization⁴ added new grantee requirements, including a requirement that 75% or more of funds be spent on “core medical

Figure 2: Ryan White Program by Part, Funding & Grantees^{1,13,14}

Part	FY 2008		Number of Grantees
	\$	%	
Part A	\$627.1	29%	22 EMAs; 34 TGAs
Part B	\$1,195.2	55%	59 States 19 ECs
ADAP (non-add)	\$794.4	--	59 ADAPs
Part C	\$198.7	9%	354 EIS, 29 Capacity/Planning
Part D	\$73.7	3%	90 Grantees; 17 Adolescent Grants
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%	71 Grantees
TOTAL	\$2,166.7	100%	

- *ADAP & ADAP Supplemental*: Funds are “earmarked” by Congress under Part B for medications through state ADAPs. ADAP supplemental grants are available to states with “severe need” (5% of earmark reserved for this purpose).
- *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 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. 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 for 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 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;
 - *Dental Programs*: includes “Dental Reimbursement Program,” which reimburses dental schools/dental care providers, and “Community-based Dental Partnership Program,” which funds programs to increase access to dental care for people with HIV and to 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 recent reauthorization.⁴ In FY 2008, the MAI was funded at \$402.6 million, including \$135.1 million through Ryan White.
 - *Special Projects of National Significance (SPNS)*: address emerging needs of clients and assist in developing standard electronic client information data system. Funded through “set-asides” of general federal 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 must be spent on core services)⁴

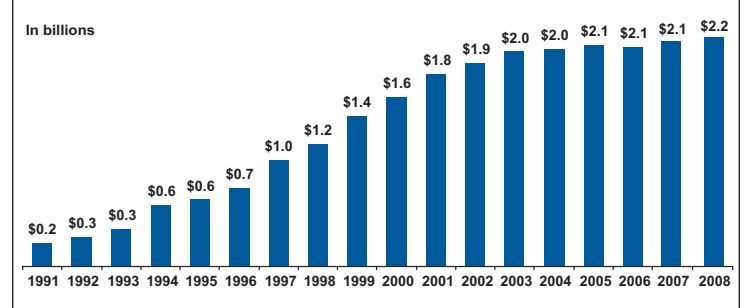
Outpatient and ambulatory health services; medications; pharmaceutical assistance; oral health care; early intervention services; health insurance premium and cost sharing assistance for low-income individuals; home health care; medical nutrition therapy; hospice services; home and community based health 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.¹ Most clients are low-income, with nearly three-quarters (72%) having annual household incomes at or below the poverty level,⁹ and

most are uninsured (33%) or underinsured (56%).¹ 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%).^{1,9}

Figure 4: Federal Funding for the Ryan White Program, FY 1991–2008^{6,7,8}



Ryan White Funding

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). It has continued to increase but at a slower rate, with most increases targeted to ADAPs.^{6,7,8}

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, and the current economic recession may mean increased demands on Ryan White at a time when less funding is available for the program.^{15,16} Finally, changes made during the most recent reauthorization will need to be assessed over time, particularly the impact of: new unobligated balance requirements and associated penalties; the implementation of client-level data collection and reporting requirements; new auditing procedures; the core medical services requirement; and the inclusion of HIV case counts in determining funding allocations.

References

- 1 DHHS HRSA, Justification of Estimates for Appropriations Committee, FY 2009.
- 2 The term “state” includes territories and associated jurisdictions.
- 3 For legislative history, see: <http://hab.hrsa.gov/law/leg.htm>.
- 4 Ryan White HIV/AIDS Treatment Modernization Act of 2006 (P.L. 109-415,).
- 5 KFF. *The Ryan White CARE Act: A Side-by-Side Comparison of Prior Law to the Newly Reauthorized CARE Act*; December 2006.
- 6 OMB, CMS Office of the Actuary, HHS Office of Budget, 2008.
- 7 CRS. *AIDS Funding for Federal Government Programs: FY1981–FY2009*; April 2008.
- 8 KFF. *Fact Sheet: U.S. Federal Funding for HIV/AIDS: The FY 2009 Budget Request*; April 2008.
- 9 HRSA. *Ryan White CARE Act Annual Data Summary (CY 2004)*; August 2006.
- 10 CDC. *Current Status of HIV Infection Surveillance*, as of April 2008.
- 11 Grandfathered EMAs are those that move from EMA to TGA status, based on reported AIDS cases.
- 12 To date, the Part B Supplemental has not been used due to lack of funding.
- 13 HRSA, HIV/AIDS Bureau, personal communication, January 2009.
- 14 FY 2008 funding data represent Congressional appropriations and include across the board rescissions.
- 15 KCMU: www.kff.org/medicaid/7815.cfm; September 2008.
- 16 ASTHO. *The Impact of Budget Cuts on State Public Health*; December 2008.