



Ryan White HIV/AIDS Program

PROGRAM FACT SHEET | OCTOBER 2014



PROGRAM OVERVIEW

HIV has taken an enormous toll since its onset in the early 1980s. More than 636,000 Americans with AIDS have died, and many others are living with HIV-related illness and disability or caring for people with the disease.¹ An estimated 47,500 Americans became infected with HIV in 2010,² and more than 1.1 million Americans are living with HIV disease.³ HIV 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 536,000 people each year. In 2012, 67% of Ryan White HIV/AIDS Program clients had an annual household income at or below the federal poverty level, and 89% of clients had an annual household income at or below 200% of the federal

THE RYAN WHITE HIV/AIDS PROGRAM WORKS WITH CITIES, STATES, AND LOCAL COMMUNITY-BASED ORGANIZATIONS TO PROVIDE SERVICES TO AN ESTIMATED 536,000 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 \$2.32 BILLION.

poverty level. For Program clients, the Program is the payer of last resort, because clients are uninsured or underinsured and no other source of payment for services — public or private — is available.

In 2012, more than 73% of Ryan White HIV/AIDS Program clients self-identified as members of racial or ethnic minority groups. In the same year, 70% of Program clients were male, 29% were female, and 1% was transgender.

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

¹Centers for Disease Control and Prevention (CDC). HIV/AIDS surveillance report. 2011; 23; Table 12a. www.cdc.gov/hiv/library/reports/surveillance/2011/surveillance_Report_vol_23.html.

²CDC. HIV surveillance supplemental report. 2012; 17 (No. 4); Table 1. www.cdc.gov/hiv/pdf/statistics_hssr_vol_17_no_4.pdf.

³CDC. HIV surveillance supplemental report. 2013; 18 (No. 5); Table 5. www.cdc.gov/hiv/pdf/2011_Monitoring_HIV_Indicators_HSSR_FINAL.pdf.

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 five 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 five years. Approximately \$655.9 million was appropriated to Part A in fiscal year 2014.

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 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 five years. Congress designates a portion of the Part B appropriation for ADAP. With the dramatic increase in the cost of pharmaceutical treatment, ADAP is now the largest portion of Part B spending.

Approximately \$1.32 billion was appropriated to Part B in fiscal year 2014, of which approximately \$900 million was for ADAP. Five percent of the ADAP portion is set aside for the ADAP Supplemental Drug Treatment Program to assist states needing additional ADAP funds.

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 fiscal year 2014 Part C appropriation was approximately \$201.1 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. The fiscal year 2014 Part D appropriation was approximately \$75.1 million.

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

- ▶ **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. Legislation directs a total of \$25 million be set aside for the SPNS Program each year.

- ▶ **The AIDS Education and Training Centers (AETC) Program** supports education and training of health care providers through a network of 11 regional and four national centers. The fiscal year 2014 Part F-AETC appropriation was approximately \$33.6 million.
- ▶ **Minority AIDS Initiative (MAI)** was established in fiscal year 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.

The fiscal year 2014 Part F-Dental Program appropriation was approximately \$13.1 million.

