Ryan White Program Appropriations

<table>
<thead>
<tr>
<th>Program</th>
<th>FY 2011 Final¹</th>
<th>FY 2012 Final²</th>
<th>CAEAR Coalition FY 2013 Request</th>
<th>President’s FY 2013 Budget Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A</td>
<td>$672.5m² (-$5.4m)</td>
<td>$671.3m (-$1.2m)</td>
<td>$789.5m (+118.2m)</td>
<td>$671.3m (+$0.0m)</td>
</tr>
<tr>
<td>Part B Base</td>
<td>$423.0m³ (+$4.2m)</td>
<td>$422.2m (-$0.8m)</td>
<td>$502.9m (+$80.7m)</td>
<td>$422.3m (+$0.1m)</td>
</tr>
<tr>
<td>Part B ADAP</td>
<td>$885.0m (+$27m)</td>
<td>$933.3m (+43.30m)</td>
<td>$1,123.3m (+$190.0m)</td>
<td>$1,000.0m (+$66.7m)</td>
</tr>
<tr>
<td>Part C</td>
<td>$205.6m (-$0.8m)</td>
<td>$215.1m (-$9.6m)</td>
<td>$285.8m (+70.1m)</td>
<td>$235.6m (+$20.5m)</td>
</tr>
<tr>
<td>Part D</td>
<td>$77.3m (-$0.3m)</td>
<td>$77.2m (-$0.1m)</td>
<td>$87.3m (+$10.1m)</td>
<td>$69.6m (-$7.6m)</td>
</tr>
<tr>
<td>Part F AETC</td>
<td>$34.6m (-$0.1m)</td>
<td>$34.5m (-0.1m)</td>
<td>$42.2m (+$7.7m)</td>
<td>$34.5m (+$0.0m)</td>
</tr>
<tr>
<td>Part F Dental Reimb.</td>
<td>$13.5m (-$0.1m)</td>
<td>$13.5m (+$0.0m)</td>
<td>$19.0m (+$5.5m)</td>
<td>$13.5m (+$0.0m)</td>
</tr>
</tbody>
</table>

¹. Amounts reflect 0.2% budget-wide tap.
². This decrease includes the transfer of $5 million from Part A to Part B Base due to loss of eligibility of four Transitional Grant Areas (Caguas, PR, Dutchess County, NY, Santa Rosa-Petaluma, CA, and Vineland-Millville-Bridgeton, NJ.)
³. This increase includes the transfer of $5 million from Part A to Part B Base due to loss of eligibility of four Transitional Grant Areas.
⁴. These funding levels reflect a 0.189% rescission.
⁵. This includes $35.0 million in additional funding announced by President Obama on Dec 1, 2011.
⁶. On December 1, 2011, President Obama redirected $15 million for the Part C Program. This number includes $10 million of that additional funding. The other $5 million is Community Health Center funding that will be directed to Part C grantees located at community health centers.
⁷. In this instance, the level of the rescission is too small to change the number on the chart.

March 2, 2012
Part A Basics
Part A of the Ryan White Program funds health care and support services for uninsured and underinsured persons living with HIV/AIDS in 52 U.S. urban areas most adversely affected by HIV/AIDS. More than 70 percent of all people living with HIV/AIDS in the U.S. reside in a metropolitan area served by Part A.

- **Part A serves an estimated 300,000 people living with HIV/AIDS each year.**
- **Part A provides 2.6 million healthcare-related visits annually.**
- **More than 80% of Part A clients are people of color.**
- **30% of Part A clients are women.**

There are two types of Part A entities: eligible metropolitan area (EMA) jurisdictions with over 2,000 living AIDS cases over the last five years, and transitional grant area (TGA) jurisdictions with between 1,000 and 2,000 living AIDS cases over the last five years. Support for EMAs and TGAs is structured the same way, but there are a few key differences in the provisions that apply to these entities.

Core Services Requirement
The Ryan White Program requires that 75% of spending for Part A services be used on the following core medical services:

- Outpatient/ambulatory health services
- ADAP treatments
- AIDS pharmaceutical assistance
- Oral health care
- Early intervention services
- Health insurance premium & cost sharing assistance
- Home health care
- Home and community-based health services
- Hospice services
- Mental health services
- Medical nutrition therapy
- Medical case management
- Outpatient substance abuse services.

The CAEER Coalition FY 2012 request for Part A is **$789.5 million**, the amount authorized by Congress in the authorizing legislation. The current estimated need is **$1.02 billion**.
Responding to Local Needs

Distribution of Part A Funds

Realizing that each community has different service needs and gaps in care, Congress structured Part A of the Ryan White Program so that local communities play a central role in determining how funds should be used to meet the needs of people living with HIV/AIDS in their areas. EMAs are required to have a local planning council with membership reflective of the local epidemic and comprised of local public health officials, community-based service providers, people living with HIV/AIDS, community leaders, and others. At least one-third of planning council membership must be consumers of Ryan White Program services. The planning councils develop needs assessments and funding priorities for use of Part A funds within parameters set by the authorizing statute. TGAs are required to use a community planning process; use of planning councils is optional.

A Continuum of Care

Communities use Part A funds to support community-based care systems that provide outpatient health care and a range of critical support services. The guiding philosophy behind this integrated, comprehensive system of care, built in many communities over the past 30 years, is that people living with HIV/AIDS can best manage their illness and reap the benefits of treatment when their full set of care and related needs are met.

52 Part A Jurisdictions

Jurisdictions in italics are EMAs; all others are TGAs.

- Atlanta, GA
- Austin, TX
- Baltimore, MD
- Baton Rouge, LA
- Bergen-Passaic, NJ
- Boston, MA and NH
- Charlotte, NC
- Chicago, IL
- Cleveland, OH
- Dallas, TX
- Denver, CO
- Detroit, MI
- Ft. Lauderdale, FL
- Ft. Worth, TX
- Hartford, CT
- Houston, TX
- Indianapolis, IN
- Jacksonville, FL
- Jersey City, NJ
- Kansas City, MO
- Las Vegas, NV
- Los Angeles, CA
- Memphis, TN
- Miami, FL
- Middlesex-Somerset-Hunterdon, NJ
- Minneapolis-St. Paul, MN
- Nashville, TN
- Nassau-Suffolk, NY
- New Haven, CT
- New Orleans, LA
- New York, NY
- Newark, NJ
- Norfolk, VA
- Oakland, CA
- Orange County, CA
- Orlando, FL
- Philadelphia, PA
- Phoenix, AZ
- Ponce, PR
- Portland, OR*
- Riverside-San Bernardino, CA
- Sacramento, CA
- San Antonio, TX
- San Diego, CA
- San Francisco, CA
- San Jose, CA
- San Juan, PR
- Seattle, WA
- St. Louis, MO
- Tampa-St. Petersburg, FL
- Washington, DC, MD and VA
- West Palm Beach, FL

Distribution of Part A Funds

The HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA) distributes Part A funds to the chief executive of the lead city or county in each jurisdiction. The grantee then distributes funds to local service providers based on the priorities developed by the planning council or other community input. There are 52 Part A jurisdictions in 24 states, Puerto Rico, and the District of Columbia that receive Part A funding. There are 24 EMAs and 28 TGAs. Part A funding includes formula and supplemental components, as well as Minority AIDS Initiative (MAI) funds. Two-thirds of the base Part A award is used for formula grants and one-third for supplemental awards. Formula grants are based on the estimated number of living cases of HIV and AIDS. HRSA awards supplemental and MAI grants competitively.
**Ryan White Part C: Providing Health Care to People with HIV/AIDS in Underserved Communities**

The FY 2013 request for Part C is **$285.8 million**, the amount authorized by Congress in the authorizing legislation. The current estimated need is **$461 million**.

**Part C Basics**

Part C of the Ryan White Program supports lifesaving HIV medical services for underserved and uninsured people living with HIV/AIDS across the country. Part C directly funds more than 345 community health centers and clinics that provide comprehensive medical care. Part C programs are located in 49 states, Puerto Rico, the District of Columbia, and the U.S. Virgin Islands. The program targets the most vulnerable communities, including people of color, women, and low-income populations. In FY 2009, Part C-funded health centers and clinics provided treatment and care to 255,429 people with HIV/AIDS. Seventy percent of those served are people of color and 29% are female. Part C clinics also provide HIV counseling and testing to more than 750,000 people each year. Many Part C grantees also rely on funding from Part A, Part B, and Part D to provide care.

HIV treatment is one of the most effective medical interventions available today and has transformed HIV disease from an acute to a chronic condition for those with ongoing access to medical care. Management of HIV disease requires a hybrid of specialty and primary care expertise and services to effectively suppress the virus; address serious treatment side effects; and treat the co-occurring conditions common among many with HIV. A survey of Ryan White Part C programs found that on average 37% of Part C patients had a serious mental illness; 35% had a substance abuse disorder and 23% had hepatitis B or C.* Thirty-seven percent of new Part C patients already have AIDS.*

**Serving as Medical Homes**

Medical homes take a patient-centered approach to providing ongoing comprehensive and well-coordinated care. With Ryan White funding, Part C clinics have developed programs that treat the whole person by providing the range of services that
their patients need to stay healthy. This approach has been critical to retaining patients in care; supporting adherence to their daily treatment regimen; and treating co-occurring conditions. Services are delivered by a multi-disciplinary team led by an experienced HIV medical provider and often include nurses, nutritionists, social workers, case managers, pharmacologists and adherence counselors. Services not available on site are provided through referral. Many of the programs have developed state-of-the-art quality improvement systems to evaluate and monitor the effectiveness of their interventions as well as the cost of care.

**Seventy percent of Part C programs report increasing caseloads with a mean increase of 29% over the last three years or 112 new patients a year.**

### Medical Care for the Underserved

Part C programs provide a range of health care services designed to identify people with HIV and provide access to medical care and services. Seventy-five percent of Part C grants must be spent on core medical services. Services provided include:

- Medical assessment and on-going medical care
- Laboratory testing related to antiretroviral therapies
- Antiretroviral therapies and adherence support
- Prevention and treatment of HIV-related opportunistic infections
- Mental health services
- Outpatient substance abuse treatment
- Oral health care
- Care for co-morbidities, including tuberculosis and Hepatitis B and C
- Medical case management to ensure access to services and continuity of care
- Nutritional and psychological services
- Risk-reduction counseling to prevent HIV transmission
- HIV counseling and testing

### Planning and Capacity Building

Planning and capacity building grants are critical tools for communities to explore the financial and program implications of starting or expanding primary health services. Planning grants are limited to one year and provide organizations with resources to plan for the provision of new, high quality comprehensive HIV primary health care services in rural or urban under-served areas and communities of color. One-year capacity building grants support efforts to strengthen organizational infrastructure and enhance program capacity to improve or expand high quality HIV primary health care services.

### Funding Mechanism

The HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA) awards Part C funds directly to service providers through competitive grants in three categories: early intervention services, planning, and capacity building. The following types of organizations are eligible for Part C grants:

- Community Health Centers, Migrant Health Centers, and Health Care for the Homeless sites funded under Section 330 of the Public Health Service (PHS) Act;
- Family planning grantees (other than states) funded under Section 1001 of the PHS Act;
- Comprehensive Hemophilia Diagnostic and Treatment Centers;
- Federally qualified health centers funded under Section 1905(1)(2)(b) of the Social Security Act;
- City and county health departments providing primary care;
- Out-patient primary care programs at community hospitals and medical centers; and
- Current public or private not-for-profit providers of comprehensive primary care for populations at risk for HIV.

* Data from a 2008 survey of Part C programs conducted by the HIV Medicine Association and the Forum for Collaborative HIV Research.