Order Code 98-476
Updated February 17, 2005

AIDS: Ryan White CARE Act

Judith A. Johnson and Paulette C. Morgan
Domestic Social Policy Division

Summary

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act makes federal funds available to metropolitan areas and states to assist in health care costs and support services for individuals and families affected by acquired immune deficiency syndrome (AIDS) or infection with the human immunodeficiency virus (HIV). The Act was reauthorized through FY2005 by legislation passed in October 2000. The CARE Act programs received $2.020 billion in FY2004. The Consolidated Appropriations Act 2005 (P.L. 108-447) provides $2.065 billion for Ryan White Programs in FY2005. Because of a mandatory 0.80% across-the-board rescission specified in P.L. 108-447, and an additional $25 million available from an evaluation set-aside, the total program level funding for FY2005 is $2.073 billion. The President has requested level program funding for FY2006, except for a $10 million increase in the AIDS Drug Assistance Program. The total amount requested is $2.058 billion for Ryan White Programs in FY2006; with the $25 million set-aside, the total for FY2006 would be $2.083 billion. This report will be updated periodically.

Background

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act makes federal funds available to metropolitan areas and states to provide a number of health care services for AIDS patients including medical care, drug treatments, dental care, home health care, and outpatient mental health and substance abuse treatment.

Legislation reauthorizing the Ryan White CARE Act is expected to be introduced during the 109th Congress. The CARE Act was reauthorized through FY2005 under the Ryan White CARE Act Amendments of 2000 (P.L. 106-345). P.L. 106-345 retained the basic structure of the Ryan White CARE Act but changed the formulas used to distribute Title I and Title II grants as discussed in the following sections. Additional changes made by P.L. 106-345 to the CARE program included the following: (1) requirements are established for the development of epidemiologic measures to identify HIV infected individuals not currently in care; (2) incentives are provided to states for HIV testing of pregnant women and infants; (3) incentives are established for implementing a partner notification program; (4) requires the development of quality management programs; (5) requirements are established for the development of a plan for the medical case

management of HIV positive prisoners who are released from custody; (6) requirements are included regarding the development of rapid HIV tests; (7) additional grants are provided to metropolitan areas with between 500 and 1,999 reported cases of AIDS over the previous five-year period.

The Act is administered by the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (HHS). The Act is commonly identified by its legislative Titles I, II, III, and IV. It was enacted as Title XXVI of the Public Health Service Act and codified as Parts A, B, C, D, E, and F under 42 U.S.C. § 300ff-111. Funding for the individual titles appears at the end of the report.

Title I/Part A — Emergency Relief Grant Program. Title I provides funds to eligible metropolitan areas (EMAs) that are severely affected by the HIV epidemic. Services supported by Title I grants include community-based outpatient medical and dental care, rehabilitative services, home health and hospice care, transportation and housing assistance, nutrition services, and respite care. The program is intended to assist low-income or under-insured people living with HIV. A portion of each grant must be spent on services for women, infants and children with HIV disease. In FY1991, the first year Title I grants were awarded, 16 EMAs were identified; by FY2002, the number of EMAs had increased to a total of 51.[1]

About half of the Title I appropriation is distributed through formula grants. Currently, formula grants are distributed to EMAs in proportion to the estimated number of living AIDS cases in each EMA. The number of living AIDS cases is estimated from the number of reported AIDS cases over a 10-year period with weighting factors to reflect that not all reported cases are still alive. However, under P.L. 106-345, statistics on HIV incidence rather than AIDS cases would be used in the formula for determining Title I grant amounts by FY2005, but only if the Secretary of HHS determines the HIV incidence data are sufficiently accurate and reliable.

A hold harmless provision in the CARE Act dictates that an EMA shall not receive a formula grant that is less than a specified percentage of what it received in a base year defined in the statute. A hold harmless provision protects grantees from large decreases in funding from year to year. The hold harmless provision in Title I was changed by P.L. 106-345, and as a result some EMAs may receive less money than before. Under P.L. 106-345, an EMA cannot receive less than a percentage of the Title I formula grant it received in a base year. In the first year after the base year, it cannot receive less than 98% of what it received in a base year. By the fifth year, an EMA cannot receive a formula grant that is less than approximately 87% of what it received in the base year if HIV incidence data are included in the distribution formula, or 85% of what an EMA received in the base year if HIV incidence data are not used in the fifth year. The hold harmless provision is funded with money that would have been distributed through supplemental grants in Title I.

The remaining half of Title I funds are distributed via discretionary supplemental grants that are awarded based on the demonstration of additional need.

---

[1] FY2004 Title I funding amounts for the 51 EMAs can be found at [http://www.hhs.gov/news/press/2004pres/20040301a.html].

Title I grants are made to the chief elected official of the city or county in the EMA that administers the health agency providing services to the greatest number of persons with HIV. The official must establish an HIV Health Services Planning Council, which sets priorities for care delivery according to federal guidelines. The Council may not be directly involved in the administration of any Title I grant. Membership of the Council must reflect the ethnic and racial make-up of the local HIV epidemic.

Title II/Part B — Care Grant Program. Title II awards formula grants to states and territories for home and community-based health care and support services. Services must be accessible to low-income individuals. Many states use Title II funds to provide services directly or through subcontracts with HIV care consortia. Consortia are associations of public and nonprofit health care and support service providers that assess needs and deliver services to individuals with HIV. Title II grants are also used to provide (1) health insurance coverage for low-income persons through Health Insurance Continuation Programs; and, (2) drug treatments under the AIDS Drug Assistance Programs (ADAPs) for individuals with HIV who have limited or no coverage from private insurance or Medicaid.[2]

Grants are awarded based on a formula that takes into account two factors: (1) the estimated number of living AIDS cases in the state; and (2) the estimated number of living AIDS cases in the state who are not in a Title I EMA. However, under P.L. 106-345, statistics on HIV incidence rather than AIDS cases would be used in the formula for determining Title II grant amounts by FY2005, but only if the Secretary of HHS determines the HIV incidence data are sufficiently accurate and reliable.

Two provisions can increase the Title II grant amount a state or territory receives above what it would receive as a result of the formula alone. A minimum grant provision dictates that no state shall receive less than $200,000 if it has less than 90 estimated living cases of AIDS or $500,000 if it has more than 90 estimated living cases of AIDS. A hold harmless provision dictates that a state shall not receive a grant that is less than a specified percentage of what it received in FY2000. These two provisions are funded by reducing the grant amounts received by all states and territories that do not receive a minimum grant amount or hold harmless grant amount. States with more than 1% of the total AIDS cases reported nationally must contribute state matching funds based on a formula. Grants may not be made to any state that does not make a good faith effort to notify a spouse of an HIV-infected patient that the spouse should seek testing. States must use a portion of each Title II grant on services for women, infants and children with AIDS.

P.L. 106-345 also changed the way funds would be allocated to states for the AIDS Drug Assistance Programs (ADAPs). Prior to P.L. 106-345, ADAP funds were distributed among states based on each state's proportion of AIDS cases. Under the new law, a brand-new grant program distributes 3% of ADAP funds to states that demonstrate a severe need to increase the availability of drugs. Criteria for awarding these grants are developed by the Secretary, taking into account eligibility standards, formulary composition, and the number of HIV-positive individuals not receiving drugs who are at

---

[2] FY2004 Title II funding amounts can be found at [http://www.hhs.gov/news/press/2004pres/20040401b.html].

or below 200% of the federal poverty level. The remaining 97% of ADAP funds are distributed based on each state's proportion of AIDS cases.

Title III/Part C — Early Intervention Services. Title III provides early intervention grants to public and private nonprofit entities already providing primary care services to low-income and medically underserved people at risk for HIV. Title III grants are awarded to community and migrant health centers, homeless programs, local health departments, family planning programs, hemophilia diagnostic and treatment centers and other nonprofit community-based programs. Title III services include HIV testing, risk reduction counseling, case management, outreach, medical evaluation, transmission prevention, oral health, nutritional and mental health services, and clinical care.

Title IV/Part D — General Provisions. In its original enactment, Title IV authorized a number of different HIV-related programs; only one was ever funded: the pediatric demonstration grants. In the CARE Act's 1996 reauthorization, the pediatric demonstration grant program was replaced with a program of grants for coordinated services and access to research for women, infants, children, and youth. The grants enhance access to and linkage with clinical research supported by the National Institutes of Health (NIH), and are to be made in coordination with the NIH activities. The grants provide opportunities for women, infants, children, and youth to be voluntary participants in research of potential clinical benefit to individuals with HIV. Such individuals are provided health care on an outpatient basis, case management, referrals, transportation, child care, and other incidental services to enable participation.

Part E. Part E authorizes grants for emergency response employees and establishes procedures for notifications of infectious diseases exposure; Part E has never been funded.

Part F — Demonstration and Training. Part F provides support for the Special Projects of National Significance (SPNS) Program, the AIDS Dental Reimbursement (ADR) Program and the AIDS Education and Training Centers (AETCs). The SPNS program awards grants to public and nonprofit private entities for the development of innovative models of HIV/AIDS care, especially programs that deliver care to minority and hard-to-reach populations. The Secretary is required to use a percentage of funds appropriated under Titles I, II, III, and IV for these grants. The ADR program reimburses dental schools for their treatment of AIDS patients. The AETC program provides training for health providers in the prevention of perinatal HIV transmission and prevention and treatment of opportunistic infections. Both the dental and the AETC programs were transferred legislatively from Title VII of the Public Health Service Act.

Table 1. Federal Funding for the Ryan White CARE Act

($ in millions)

	Title I	Title II	(ADAP)	Title III	Title IV	Part E	Part F AETC	Part F ADR	Total
FY1991	87.8	87.8	—	44.9	19.5	0	17.0	—	257.0
FY1992	121.6	107.6	—	48.7	19.3	0	16.9	—	314.1
FY1993	184.8	115.3	—	48.0	20.9	0	16.4	—	385.4
FY1994	325.5	183.9	—	48.0	22.0	0	16.4	7.0	602.8
FY1995	356.5	198.1	—	52.0	26.0	0	16.3	6.9	655.8
FY1996	391.7	260.8	(52)	57.0	29.0	0	12.0	6.9	757.4
FY1997	449.8	417.0	(167)	69.6	36.0	0	16.3	7.5	996.3
FY1998	464.7	542.8	(285.5)	76.2	40.8	0	17.2	7.8	1,150.2
FY1999	505.0	737.7	(461.0)	94.3	46.0	0	20.0	7.8	1,410.9
FY2000	546.3	823.8	(528.0)	138.4	50.0	0	26.6	8.0	1,594.6
FY2001	604.2	910.9	(589.0)	185.9	65.0	0	31.6	10.0	1,807.6
FY2002	619.4	977.2	(639.0)	193.8	71.0	0	35.3	13.5	1,910.2
FY2003*	618.7	1,053.4	(714.3)	198.4	73.6	0	35.6	13.4	1,993.0
FY2004*	615.0	1,085.9	(748.9)	197.2	73.1	0	35.3	13.3	2,019.9
FY2005 Conference**	615.0	1,130.9	(793.9)	197.2	73.1	0	35.3	13.3	2,064.9
FY2005 Comparable***	610.1	1,121.8	(787.5)	195.6	72.5	0	35.1	13.2	2,048.3
FY2006 Request****	610.1	1,131.8	(797.5)	195.6	72.5	0	35.1	13.2	2,058.3

Source: DHHS FY2006 Health Resources and Services Administration Justification of Estimates for Appropriations Committees. May not add due to rounding.

* The total does not include an additional $25 million set-aside for evaluations. The $25 million set-aside is funded through an evaluation tap of amounts appropriated under the Public Health Service Act (PHSA). In 2003, the evaluation tap was 2.1%, as specified in conference report H.Rept.108-10; in 2004, the evaluation tap was 2.2%, as specified in conference report H.Rept.108-401.

**FY2005 Conference amounts do not include the 0.80% offset required by P.L.108-447. The FY2005 Conference total does not include an additional $25 million set-aside for evaluations. The $25 million set-aside is funded through a 2.4% evaluation tap of amounts appropriated under the PHSA, as specified in conference report H.Rept.108-792.

*** FY2005 Comparable amounts include the 0.80% offset required by PL.108-447. The 2005 Comparable total does not include an additional $25 million set-aside for evaluations.

**** FY2006 Request total does not include an additional $25 million set-aside for evaluations.