

Changes in Ryan White Legislation

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So Who is Ryan White?

- Ryan White was a 13-year old hemophiliac in Indiana who contracted AIDS from Factor VIII, which is a blood product used to control his disorder.
- He died in 1990, at age 18, and the CARE Act was named after him.



So...What is the CARE Act?

- The Comprehensive AIDS Resources Emergency (CARE) Act enacted by Congress in 1990. It comes up for reauthorization every five years, the most recent in 2009.
- The act determines how some federal funding is spent for AIDS treatment, care and support services, what kinds of services are available and how these services are managed by the federal government.

Who does the CARE Act serve?

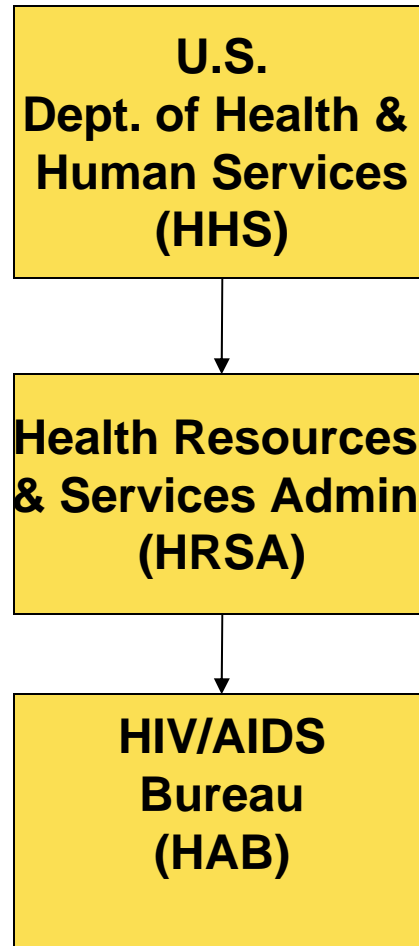
- Programs funded by the CARE Act are specifically to fund services as “the payer of last resort”
 - It pays for services not covered by Medicare/Medicaid and provides care for those who don’t qualify for Medicare/Medicaid.
 - People who do not have health insurance or are underinsured.

How much money does the CARE Act get?

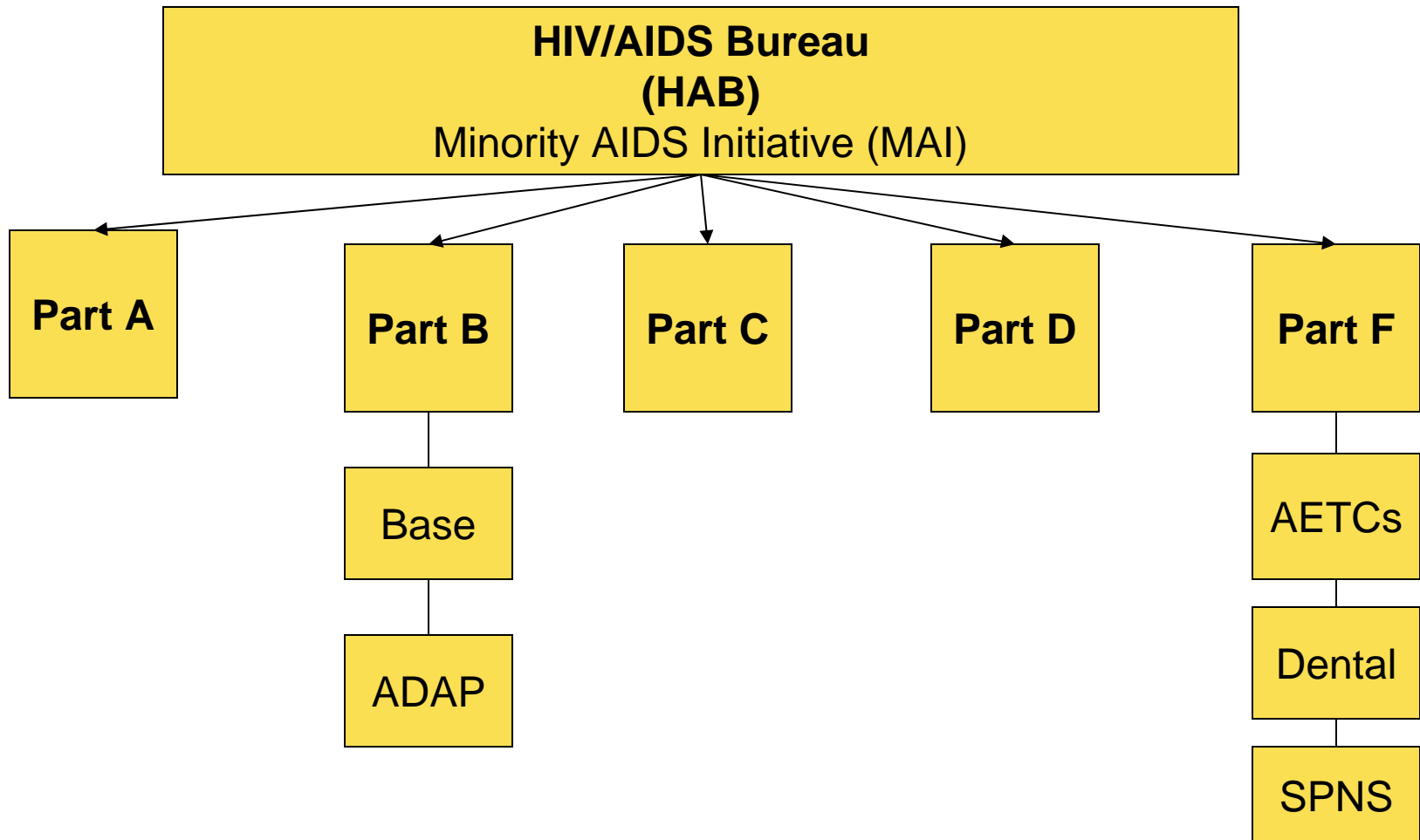
- In 1995 = \$633 million
- In 2000 = \$1.6 billion
- In 2003 = \$2.0 billion
- In 2010 = \$2.26 billion

Structure of the CARE Act

Federal Administration of the CARE Act



Structure of the CARE Act



Ryan White Part A

- Money goes directly to cities that are disproportionately affected by HIV/AIDS. These cities are referred to as Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that have:
 - A population greater than 50,000 residents.
 - EMAs = 2,000 or more living AIDS cases.
 - TGAs = 1,500 but fewer than 2,000 living AIDS cases in previous five years.
 - While EMA and TGA eligibility are based on AIDS cases alone, the actual award amounts they receive are based on both HIV and AIDS cases.
 - There are currently 56 cities funded under Part A of the Ryan White CARE Act.

Distribution of Funds from HRSA -Part A

- The "formula" amount of funding given to cities is based on criteria determined based on the legislation whether a jurisdiction is determined to be an EMA or TGA.
- The "supplemental" amount of funding is based on the cities' ability to document severe need for additional funding & the capacity to use funds to meet community needs.
- The Minority AIDS Initiative funds have typically been awarded based on a competitive basis.

Role of Part A Planning Councils

- Participate in the Statewide Coordinated Statement of Need (SCSN).
- Develop a Comprehensive Plan for the TGA.
- Conduct a Needs Assessment
- Priority Setting/Resource Allocation
- Assessment of Administrative Mechanism



“Ryan White HIV/AIDS Treatment Extension Act of 2009”

2009 Changes

- The legislation re-establishes the provisions of the Act, retroactive to September 30, 2009.
- The new legislation eliminates/repeals all prior sunset provisions.

2006 Law

- Current law includes a sunset provision that would have repealed the Ryan White legislation September 30, 2009.

Minority AIDS Initiative Changes – 2009

- MAI will revert from competitive funding in Part A and Part B to formula funding.
- Requires GAO to report on Minority AIDS Initiative activities.
- Requires the department to prepare a plan for the use of MAI funds for capacity-building taking into consideration the GAO report.

Names-Based Reporting

2009

- Continues the same provisions included in 2006.
- In 2012 the 5% penalty will be increased to 6%. Beginning in FY2013, code-based protections will be eliminated and all States will be required to report cases using a names-based system.

2006

- States are allowed to continue to submit code-based HIV data directly to HRSA, but they receive a 5% penalty to account for potential duplication. States reporting code-based data are also subject to a 5% cap on increases in case count.

EMA/TGA Eligibility

2009

- The legislation also modifies the transfer of amounts from TGAs that lose their eligibility during the reauthorization period. As is the case currently, when a TGA loses its status, \$500,000 will be transferred to the overall Part B pool for states.
- Adds a provision that if a metropolitan area has between 1400-1500 cumulative living AIDS cases and does not have more than 5% of its total grants unobligated for the prior fiscal year, it will be treated as having met the criteria for continued eligibility as a TGA.

2006

- A TGA retains its status until it (a) fails for 3 years to have at least 1,000 but fewer than 2,000 cases of AIDS during the most recent 5 calendar years and (b) fails for 3 years to have 1,500 or more living cases of AIDS as of December 31 of the most recent calendar year.
- When a TGA fails for three consecutive years to meet the criteria for eligibility, both its formula funding and an additional \$500,000 are reallocated to Part B and redistributed among states based on need.

Hold Harmless Provision

2009

- The new legislation will continue the hold harmless at a rate of 95% of fiscal year 2009 funding in 2010 and 100% of fiscal year 2010 funding for each of the fiscal years 2011 and 2012. For fiscal year 2013, the amount will be 92.5% of the previous fiscal year's grant. This hold harmless will continue to apply to both Part A and Part B grants.

2006

- Under current law, a “hold harmless” provision protects both Eligible Metropolitan Areas and states from larger decreases in formula funding.

Amendments to the General Grant Provisions – 2009

- In the new legislation there are provisions to increase and incentivize early identification of those infected with HIV. This section requires the planning councils for Part A grant recipients to develop a strategy, in coordination with other appropriate community strategies or activities, to identify and diagnose individuals with HIV/AIDS who are unaware of their status and link them with the appropriate care and treatment.

Increase in Adjustment for Names-Based Reporting – 2009

- The legislation adds an adjustment for areas that switched to names-based reporting early in 2007 and received a decrease in total funding of at least 30% from year 2006 as a result of determinations based on the new reporting system. For those jurisdictions, the Secretary shall base awards on living HIV/AIDS cases (for the most recent year confirmed) plus an increase of 3%. This adjustment will apply to Part A and Part B grants.

Treatment of Unobligated Funds

2009

- The new legislation increases the unobligated penalty threshold from 2% of the total award to 5%. For formula funds, if the unobligated amount is over the 5% threshold, the next year's formula funding will be reduced by the amount of unobligated balance, but the reduction amount will not include any unobligated balance that was approved for carryover by HRSA. In addition, a jurisdiction with over 5% of its funds unobligated will not be eligible for supplemental funding in the following year.

2006

- If a Part A or Part B grantee reports an unobligated balance that is 2% or more of the total award, certain penalties apply, whether or not the jurisdiction receives a carryover waiver. For formula funds, future formula funding will be reduced by the amount of the unobligated balance, beginning in the year following the report. In addition, the jurisdiction will not be eligible for supplemental funding in the year following the report.
- Supplemental funding: If a Part A or Part B grantee has unobligated supplemental funding at the end of the grant year, the funds are cancelled and returned to the Secretary for redistribution.

That's All, Folks

- For more information:
 - www.hab.hrsa.gov
 - www.denvergov.org/mohr
 - www.nastad.org
 - www.caear.org
 - www.thomas.loc.gov

