Ryan White HIV/AIDS Program
Legislative Overview

Ryan White HIV/AIDS Program Part B
Administrative Reverse Site Visit
November 5, 2014

Harold Phillips, MRP
Deputy Director
U.S. Department of Health and Human Services (HHS)
Health Resources and Services Administration (HRSA)
HIV/AIDS Bureau (HAB)
Division of State HIV/AIDS Programs (DSHAP)
• Largest Federal government program specifically designed to provide services for people living with HIV/AIDS

• Third largest Federal program serving people living with HIV/AIDS – after Medicaid and Medicare

• Enacted as the Ryan White Comprehensive AIDS Resources Emergency Act August 18, 1990

2014 Ryan White HIV/AIDS Appropriations
$2.319 Billion

- Part A 28%
- Part B 18%
- Part B ADAP 39%
- Part C 9%
- Part D 3%
- AETC 1%
- Dental 1%
- SPNS 1%
FY 14 Federal Funding for HIV/AIDS Care in the U.S., by Program

In Billions

- Medicaid (federal only): $6.2 billion (37%)
- Medicare: $6.6 billion (40%)
- Ryan White: $2.3 billion (14%)
- VA: $1.0 billion (6%)
- FEHB: $0.2 billion (1%)
- SAMHSA: $0.1 billion (1%)
- Other: $0.1 billion (1%)

Total = $16.6 billion

SOURCE: Kaiser Family Foundation Analysis of data from OMB; 2014.
1. Ryan White HIV AIDS Program uses a medical model of comprehensive care
2. Increased focus on getting people into primary medical care and keeping them in care – continuum of care.
3. Limits on non-service costs
4. Focus on ensuring all funds are used -- “use or lose” Part B funding
5. Ryan White HIV AIDS Program as Payer of Last Resort
1. Medical Model

- Major focus on core medical services (medical model)
  - 75% of service funds must be spent on core medical services, newly defined (waiver available)
  - Up to 25% of service funds may be spent on support services that contribute to positive clinical outcomes
  - Documenting health outcomes and program impacts are important part of the medical model
2. Focus on Getting People into Care

- Unmet need = need for primary health care among PLWH/A who know they are HIV+ & are not receiving HIV-related primary care

- Major legislative emphasis on reducing unmet need

- Emphasis on the unaware population (Early Identification of Individuals with HIV/AIDS – EIIHA)

- Assessment of RWHAP clients health and support service needs in shifting health care landscape

- Use of data to analyze and address disparities in access, retention and outcomes of being in care
3. Limits on Non-Service Funding

- **Focus**: maximize funding for direct services
- 2006 legislation has a 10% administrative cap
- Planning and Evaluation is capped at 10%
- Another 5% for Clinical Quality Management – assess quality of care and clinical outcomes
4. “Use or Lose” Formula Funding

• Penalty for unobligated & unliquidated funds

• If more than 5% of formula funds are unspent at the end of the year ineligible for supplemental funding.

• Note: MAI is not counted toward the Unobligated Balance (UOB)

• Unobligated formula balance is used to offset future grant award

• Penalties are waived if due to use of rebates first and requested by the grantee. Presents opportunities for reinvestment of HIV care resources
5. Ryan White as Payer of Last Resort

- Increase our coordination with Medicaid, Medicare and Third Party Payers such as private insurance

- Enhance partnerships with prevention, mental and behavioral health programs

- Maximize ability to generate and use program income and rebates

- Continued role for RWHAP to fill gaps by providing resources to provide comprehensive care and support services not covered by other programs
• Changes to the legislation, and the treatment of HIV disease have changed the program over the years

• In new era of health care reform need to build on RWHAP medical model of success over twenty years

• There is a continued need to reach special populations and engage them in care

• Outcomes and administrative accountability are important to HHS, Congress, and the future of HIV treatment
Questions
Contact Information

Harold Phillips, MRP
Office: 301.443.8109
E-mail: hphillips@hrsa.gov