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CRS Report for Congress

The Ryan White HIV/AIDS Treatment Program

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The Ryan White HIV/AIDS Treatment Program

Summary

The Ryan White HIV/AIDS Treatment Program makes federal funds available to metropolitan areas and states to assist in health care costs and support services for individuals and families affected by the human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS). The program is administered by the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (HHS).

The Ryan White program is composed of four major parts and several other components. Part A provides grants to urban areas and mid-sized cities. Part B provides grants to states and territories; it also provides funds for the AIDS Drug Assistance Program (ADAP). Part C provides early intervention grants to public and private nonprofit entities. Part D provides grants to public and nonprofit entities for family centered care for women, infants, children, and youth with HIV/AIDS. The other components, sometimes referred to as Part F, include the AIDS Dental Reimbursement (ADR) Program, the AIDS Education and Training Centers (AETCs), and the Special Projects of National Significance (SPNS) Program.

In December 2006, the 109th Congress passed and the President signed the Ryan White HIV/AIDS Treatment Modernization Act (H.R. 6143, P.L. 109-415), which reauthorized the Ryan White program through September 30, 2009. Unlike previous reauthorizations, which have extended the program for 5 years, the compromise legislation provided a three-year extension, eliminating the final two years in the original version of the bill which would have resulted in reduced funding in certain areas. In addition, there is a provision at the end of P.L. 109-415 that repeals the Ryan White program, Title XXVI of the Public Health Service Act, as of FY2010. Some members have expressed the intention to revisit Ryan White over the next three years, to examine whether the structure of the entire program should be revamped to reflect the current distribution of HIV/AIDS in the United States.

Ryan White programs received $2.119 billion in FY2007; the request for FY2008 is $2.133 billion. This report will be updated periodically.

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The Ryan White HIV/AIDS Treatment Program makes federal funds available to metropolitan areas and states to provide a number of health care services for HIV/AIDS patients including medical care, drug treatments, dental care, home health care, and outpatient mental health and substance abuse treatment. Each year, the program provides assistance to over 530,000 low-income or under-insured people living with HIV.[1] The Ryan White program was established in law in 1990 (P.L. 101-381) and reauthorized and amended in 1996 (P.L. 104-146) and 2000 (P.L. 106-345). It was enacted as Title XXVI of the Public Health Service (PHS) Act and codified as Parts A, B, C, D, E, and F under 42 U.S.C. § 300ff-111. The program is administered by the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (HHS).

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 (P.L. 109-415, H.R. 6143) reauthorized the Ryan White program through September 30, 2009. Unlike previous reauthorizations which have extended the program for 5 years, the compromise legislation provided a three year extension, eliminating the final two years in the original version of the bill which would have resulted in reduced funding in certain areas. In addition, the provision at the end of P.L. 109-415, (Sec. 703) repeals the Ryan White program, Title XXVI of the Public Health Service Act, as of FY2010. Some members have expressed the intention to revisit Ryan White over the next three years, to examine whether the structure of the entire program should be revamped to reflect the current distribution of HIV/AIDS in the United States.[2]

P.L.109-415 made a number of changes to the Ryan White program including new methods of determining eligibility for Ryan White funds, new funding formulas, and new limits on how the funds may be used. As a result of the reauthorization, HRSA is now referring to the individual grant programs as Parts A, B, C, and D instead of by their legislative Titles I, II, III, and IV. Funding for the individual grant programs appears near the end of this report.

Part A (Title I) — Grants to Urban Areas

Part A provides funds to urban areas with high numbers of people living with HIV, as well as mid-sized cities that have emerging needs for assistance with their

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[1] "World AIDS Day Message Is One of Determination and Hope," *Inside HRSA*, January 2007, at [http://newsroom.hrsa.gov/inside-hrsa/jan2007.htm].

[2] Statements of Senator Kennedy (Ryan White Act Set For Passage, US Federal News Service, December 5. 2006) and Senator Schumer (New Jersey, New York Senators Release Hold on Ryan White Act, US Federal News Service, December 5. 2006).

HIV-infected population. The boundaries of the areas are based on the Metropolitan Statistical Areas of the U.S. Census Bureau and may range in size from one city or county to multiple counties that cross state boundaries.

Under P.L. 109-415, Part A provides funds to eligible metropolitan areas (EMAs) with a population of at least 50,000 that have had more than 2,000 reported AIDS cases in the prior five years. An EMA would stop being eligible if it failed for three consecutive years, to have (a) a cumulative total of more than 2,000 reported cases of AIDS during the most recent five calendar years, and (b) a cumulative total of 3,000 or more *living* cases of AIDS as of December 31 of the most recent year. For FY2007, if an EMA no longer qualified as an EMA, it will be treated as a transitional grant area (TGA), even if it would not otherwise qualify as a TGA (see below). In March 2007, grant awards for 22 EMAs were announced for FY2007.[3] Prior to P.L. 109-415, a total of 51 EMAs had received funding in FY2006.

The new law established a grant program for transitional grant areas (TGAs), defined as metropolitan areas with at least 1,000 but fewer than 2,000 cumulative AIDS cases during the most recent five calendar years. Unless a TGA became an EMA, it would continue to be eligible as a TGA until it failed for three years to have (a) at least 1,000 but fewer than 2,000 cases of AIDS during the most recent five calendar years, and (b) 1,500 or more living cases of AIDS as of December 31 of the most recent calendar year. A total of 29 areas that had been EMAs prior to P.L.109-415 received FY2007 funding as TGAs in March 2007.[4] The new law also allowed five metropolitan areas to receive funding as TGAs that were not previously eligible as an EMA; funding for the five was awarded in April 2007.[5]

Under P.L. 109-415, amounts reserved for Part A EMAs and TGAs would be adjusted based, in part, on the changing eligibility status of metropolitan areas. If an EMA failed to meet the eligibility criteria for three consecutive years and thus ceased to be an EMA, in the first subsequent year, any amount reserved for EMAs would be reduced by the amount of the formula grant received in the preceding fiscal year by the metropolitan area that was no longer an EMA. If the former-EMA qualified as a TGA, the amount reserved for TGA grants would increase by the amount of the reduction in EMA reserved funds. If the former-EMA did not qualify as a TGA, the amount by which EMA reserved funds decreased would be equal to $500,000 plus the amount of the formula grant received in the preceding fiscal year by the metropolitan area that was no longer an EMA; that money would be made available for Part B grants. Similarly, if a TGA failed to qualify as a TGA and did not qualify as an EMA, the amount reserved for TGA funds would be reduced by $500,000 plus the amount of the formula portion of the TGA grant for the former-TGA in the preceding fiscal year, and those funds would be made available for Part B grants. If

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[3] A list of the 22 Part A EMAs and their FY2007 formula grant awards can be found at [http://newsroom.hrsa.gov/releases/2007/partaformulaawards.htm].

[4] A list of the 29 Part A TGAs and their FY2007 formula grant awards can be found at [http://newsroom.hrsa.gov/releases/2007/partaformulaawards.htm].

[5] The five new TGAs are: Indianapolis, IN; Baton Rouge, LA; Charlotte, NC; Memphis, TN; and, Nashville, TN. Formula grant awards for the five new TGAs can be found at [http://newsroom.hrsa.gov/NewsBriefs/2007/TGAawards.htm].

a TGA qualified as an EMA in a subsequent year, the amount reserved for TGA grants would decrease by the amount of the grant made to the former-TGA in the preceding FY and an equal amount would be reserved for EMA grants.

Under P.L. 109-415, 75% of Part A funds must be spent on core medical services, defined as outpatient and ambulatory health services, AIDS Drug Assistance Program (ADAP) treatments and pharmaceutical assistance, oral health care, early intervention services, health insurance premium and cost-sharing assistance, home health, medical nutrition therapy, hospice, home and community-based health services, mental health and substance abuse outpatient services, and medical case management. The requirement may be waived if (1) there was no waiting list for receiving treatment (under the Part B ADAP program), and, (2) core medical services were available to all individuals with HIV/AIDS who were eligible to receive such services under Part A. The remaining 25% of funds may be used for support services, such as: outreach services; medical transportation; language services; respite care for persons caring for individuals with HIV/AIDS; and, referrals for health care and support services.

Under the new law, two-thirds of the Part A appropriation is distributed through formula grants, and the remaining one-third is distributed via discretionary supplemental grants awarded on the basis of need; the distribution under the old law was approximately fifty-fifty. Not later than 45 days after awarding supplemental funds under Part A, a report is due to Congress concerning such funds.

Prior to P.L. 109-415, formula grants had been distributed to EMAs in proportion to an estimate of the number of living AIDS cases in each EMA.[6] Under P.L. 109-415, funding distribution is based on the number of living HIV and AIDS cases in each EMA or TGA from states that use a names-based HIV reporting system. The requirement for names-based reporting may have influenced a number of states to change from code-based reporting. As a result, as of May 2007, all but two states had made the switch to names-based reporting of HIV cases.[7] The Centers for Disease Control and Prevention (CDC) collects the statistics used in the Ryan White formula. CDC initially indicated their preference for names-based reporting in 1999 in order to avoid double counting; the agency recommended names-based reporting in 2005. For purposes of the formula, areas in states without a sufficiently accurate and reliable names-based reporting system will have a reduction of 5% in the number

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[6] The number of living AIDS cases was estimated from the number of reported AIDS cases over a 10-year period with weighting factors to reflect that not all reported cases were still alive. Under the 2000 reauthorization (P.L. 106-345), statistics on HIV cases would have been used in the Ryan White grant formulas as early as FY2005 if the Secretary of HHS found that HIV incidence data were sufficiently accurate and reliable. In June 2004, the Secretary determined that HIV case reporting was incomplete and could not be used to distribute the grants. Under P.L. 106-345 HIV case data would have been used for determining FY2007 grant amounts. However, P.L. 106-345 did not contain a transition period for states that were moving to name-based HIV reporting, as recommended by the CDC. P.L. 109-415 contains a three-year transition period for qualifying areas.

[7] Personal conversation with Centers for Disease Control and Prevention. Hawaii and Vermont had not implemented names-based reporting as of May 2007.

of non-AIDS HIV cases reported for the eligible area to account for duplicate cases.[8] In addition, the amount of the formula grant in these areas may not exceed that of the preceding fiscal year by more than 5%. Amounts made available due to this limitation would be used for supplemental Part A grants.

As was the case in the 1996 and 2000 reauthorizations, P.L. 109-415 has a hold harmless provision that protects grantees from large decreases in funding. The hold harmless provision is funded with money that would have been distributed through Part A supplemental grants. For EMAs that received a hold harmless grant amount in FY2006, the hold harmless provision is extended for three years. For FY2007, an EMA that had received a hold harmless grant amount in FY2006 would not receive less than 95% of a grant amount equal to what the EMA would have gotten in FY2006 (including the hold harmless) if the FY2006 formula had distributed two-thirds of the FY2006 appropriation. For FY2008 and FY2009, the EMA would not receive less than 100% of the grant amount for FY2007. If the supplemental funds were insufficient to fund the hold harmless in a year, the Secretary would reduce on a pro rata basis the grant amount for each EMA other than those eligible for the hold harmless provision, though the reduction would not be allowed to result in any additional EMA becoming eligible for the hold harmless provision. The hold harmless does not apply to TGAs.

Part A 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. Under P.L.109-415, Planning Councils are not mandatory for TGAs, unless the TGA was an EMA in FY2006. The Council may not be directly involved in the administration of any Part A grant. Membership of the Council must reflect the ethnic and racial make-up of the local HIV epidemic.

P.L. 109-415 contains new restrictions on the use of unexpended funds. Starting in FY2007, if an eligible area does not obligate all supplemental grant funds within one year of receiving the award, the eligible area will be required to return any unobligated funds. Similarly, starting in FY2007, if an eligible area does not obligate all formula grant funds within one year of receiving the award, the eligible area will be required to return any unobligated funds. However, the eligible area may request a waiver of the cancellation of formula grant funds, explaining how the eligible area intended to spend the funds. If the waiver is approved, the eligible area will have one year in which to spend the funds. If the funds are not spent by the end of the waiver year, the eligible area will be required to return the unexpended funds. Regardless of whether the waiver is granted, the eligible area's formula grant funds will be reduced. The reduction in formula grant funds will be equal to the amount of the unobligated

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[8] P.L. 109-415 identifies the states that had a system that provided sufficiently accurate and reliable names-based reporting as of December 31, 2005: Alaska, Alabama, Arkansas, Arizona, Colorado, Florida, Indiana, Iowa, Idaho, Kansas, Louisiana, Michigan, Minnesota, Missouri, Mississippi, North Carolina, North Dakota, Nebraska, New Jersey, New Mexico, New York, Nevada, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, West Virginia, Wyoming, Guam and the U.S. Virgin Islands.

balance, and the reduction will not be taken into account in applying the hold harmless provision for the subsequent fiscal year. The reduction in formula grant funds will not apply if the unobligated balance was 2% or less. Any returned grant funds will be additional amounts available for supplemental grants, subject to both (1) the mandatory transfer of funds from Part A to Part B when a Part A area loses eligibility, and (2) the hold harmless provision for Part A formula grants.

Part B (Title II) — Grants to States

Part B provides grants to all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands and five territories in the Pacific.[9] Grant funds can be used for home and community-based health care and support services or health insurance coverage for low-income persons through Health Insurance Continuation Programs. A major portion of Part B funding is used for drug treatments under the AIDS Drug Assistance Programs (ADAPs) for individuals with HIV who cannot afford to pay for drugs and have limited or no coverage from private insurance, Medicaid, or Medicare Part D.

P.L. 109-415 made changes to the formula used to distribute Part B base awards. As in Part A, the formula uses the number of living HIV and AIDS cases rather than an estimate of the number of living AIDS cases. The new Part B formula is based on three factors: (1) 75% of the award is based on the state's proportion of the nation's HIV/AIDS cases; (2) 20% is based on the state's proportion of HIV/AIDS cases outside Part A-funded areas (EMAs and TGAs); and (3) 5% is based on the state's proportion of HIV/AIDS cases in states with no Part A funding.[10] States without a sufficiently accurate and reliable names-based HIV reporting system will have a reduction of 5% in the number of non-AIDS HIV cases reported for the state to account for duplicate cases. For these same states, the amount of the grant may not exceed that of the prior fiscal year by more than 5%. As is the case for Part A grants, 75% of Part B funds must be spent on core medical services and 25% may be spent on support services (defined above). Two-thirds of the Part B appropriation (non-ADAP) is used for the Part B base awards.

A new Part B supplemental grant program was created by P.L. 109-415. Eligible states must have a demonstrated need for supplemental financial assistance and not more than 2% of their grant funds cancelled, or waivers permitting carryover of funds (see below). Priority in making supplemental grants is given to states with a decline in funding under Part B due to the changes in the distribution formula. Supplemental grant funds must be used for core medical services. One-third of the Part B appropriation (non-ADAP) is reserved for these new supplemental grants. Not later than 45 days after awarding supplemental funds under Part B, a report is due to Congress concerning such funds.

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[9] FY2007 awards under Part B for base, ADAP and emerging communities grants can be found at [http://www.hhs.gov/news/press/2007pres/20070405a.html].

[10] The new formula attempts to correct for a problem under the old formula: states with EMAs receive a larger amount of money, per case, than states without an EMA. U.S. Government Accountability Office, *Ryan White CARE Act: Factors that Impact HIV and AIDS Funding and Client Coverage*, GAO-05-841T, June 2005.

A hold harmless provision was maintained under the new law. For FY2007, a state can not receive less than 95% of the grant amount received in FY2006. For FY2008 and FY2009, a state can not receive less than 100% of the FY2007 grant amount. This provision is funded by reducing the amount reserved for the new Part B supplemental grant program, and by any unobligated funds repaid by the states (see below). If there are insufficient funds for the hold-harmless provision, then P.L.109-415 allows for a pro rata reduction of all Part B state grants, excepting those states receiving hold-harmless funds. However, such reductions will not be made in an amount that results in other states becoming eligible for the hold harmless.

Starting in FY2007, states are required to obligate grant funds by the end of the grant year for Part B formula grants, supplemental grants, emerging communities grants, ADAP grants, and supplemental ADAP grants. For supplemental ADAP grants, supplemental grants and emerging communities grants, if there is an unobligated balance at the end of the grant year, the state must return the amount and the funds will be used for additional supplemental grants (subject to the hold harmless provision). For Part B formula grants and ADAP grants, if there is an unobligated balance, the state must either return the unexpended funds, or apply for a waiver to use the funds in the next fiscal year. If the waiver is approved, the funds would be available for one more year, called the carryover year. If the state fails to use the funds in the carryover year, the state must return the funds, which will be used for supplemental grants (subject to the hold harmless provision). However, for states with an unobligated balance for their Part B formula grant or an ADAP grant, the amount of the grant for the next fiscal year will be reduced by the amount of the unobligated balance, regardless of whether a waiver is approved, except if the amount of the unobligated balance is 2% or less, then the reduction will not apply. The funds from any such grant reduction will be used for supplemental grants (subject to the hold harmless provision).

P.L. 109-415 also made changes to the grant program for emerging communities, which are now defined as metropolitan areas with at least 500 and fewer than 1,000 reported cases of AIDS during the most recent five calendar years. The metropolitan area will continue to be an emerging community until the metropolitan area fails for three consecutive fiscal years: (1) to have the required number of AIDS cases; and (2) to have a cumulative total of 750 or more living cases of AIDS as of December 31 of the most recent calendar year. The grant amount will be determined by the amount set aside by the Secretary (authorized at $5 million) and by the proportion of the total number of living cases of HIV/AIDS in emerging communities in the state to the total number of living cases of HIV/AIDS in emerging communities in the United States.

P.L. 109-415 changes the way funds will be allocated to the state ADAPs. As is the case for other Part A and Part B grants, ADAP funds are distributed based on each state's proportion of living HIV and AIDS cases rather than on an estimate of the number of living AIDS cases. States without a sufficiently accurate and reliable names-based HIV reporting system will have a reduction of 5% in the number of non-AIDS HIV cases reported for the state to account for duplicate cases. For these same states, the amount of the ADAP grant may not exceed that of the prior fiscal year by more than 5%. A hold-harmless provision also applies to the ADAP formula. For FY2007, a state can not receive an ADAP grant that is less than 95% of what it

received in FY2006. For FY2008 and FY2009, a state can not receive less than 100% of the FY2007 ADAP grant amount. The amount set aside for ADAP supplemental grants is changed from 3% to 5% of the ADAP appropriation. States are eligible for supplemental ADAP grants if they demonstrate a severe need to increase the availability of HIV/AIDS drugs. P.L. 109-415 changes some of the eligibility criteria for the ADAP supplemental grants. The new law allows the state-match requirement ($1 state for every $4 federal) for ADAP supplemental grants to be waived under certain circumstances. However, states with 1% or less of the nation's HIV/AIDS cases will be required to provide matching funds in order to receive a supplemental ADAP grant. The new law also establishes, for the first time, a formulary, that is, a list of HIV/AIDS therapeutics that all ADAPs must provide. The list will be based on the Clinical Practice Guidelines for use of HIV/AIDS Drugs.[11]

In previous years, many states have had to implement cost containment measures, such as waiting lists, due to insufficient ADAP funds. In order to provide assistance with this problem, on June 23, 2004, the Bush Administration announced a one-time $20 million initiative for 10 states with ADAP waiting lists (Alabama, Alaska, Colorado, Idaho, Iowa, Kentucky, Montana, North Carolina, South Dakota, and West Virginia); funding for the initiative was not renewed. According to a report by the National Alliance of State and Territorial AIDS Directors and the Kaiser Family Foundation, the new Medicare Part D prescription benefit also helped alleviate the waiting lists, but as of March 2007 four states have waiting lists totaling 571 people.[12]

Part C (Title III) — Early Intervention Services

Part C 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.[13] Under P.L. 109-415, 75% of the Part C grant must be used for core medical services, and not less than 50% of the grant must be used for early intervention services. Part C grants are awarded to federally-qualified health centers, family planning clinics, hemophilia centers, rural health clinics, Indian Health Service facilities, and certain health facilities and community-based organizations that provide early intervention services to people infected with HIV/AIDS through intravenous drug use. Part C services include counseling, HIV testing, referrals, clinical and diagnostic services regarding HIV/AIDS, and drug treatments under ADAP.

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[11] Guidelines are found at [http://www.aids.gov/treatment/guidelines/].

[12] The National Alliance of State and Territorial AIDS Directors and the Henry J. Kaiser Family Foundation, National ADAP Monitoring Project Annual Report, April 2007, at [http://www.kff.org/hivaids/hiv041007pkg.cfm].

[13] A partial list of FY2007 grant awards under Part C were announced in April 2007 and can be found at [http://newsroom.hrsa.gov/releases/2007/PartCgrantsApril2007.htm]. Additional Part C awards are expected to be announced in July 2007.

Part D (Title IV) — General Provisions

Under P.L. 109-415, Part D provides grants to public and nonprofit entities for family centered care for women, infants, children, and youth with HIV/AIDS. Such individuals are provided health care on an outpatient basis, case management, referrals, other services to enable participation in the program, including services designed to recruit and retain youth with HIV. Grantees must coordinate with programs promoting the reduction and elimination of risk of HIV/AIDS for youth.

P.L. 109-415 requires that GAO conduct an evaluation of funding under Part D that is used to: (1) provide administrative expenses and indirect costs, outpatient or ambulatory family-centered care, and additional services; and (2) to identify and connect HIV-positive pregnant women and their children with health care to improve health and prevent perinatal transmission of HIV.

Part E

Under prior law, Part E authorized grants for emergency response employees and established procedures for notifications of infectious diseases exposure; Part E was never funded. P.L. 109-415 deletes all the old Part E sections and inserts several old sections (with some text changes) from Part D (on coordination, audits, definitions, and a prohibition on promotion of intravenous drug use or sexual activity) and two new sections on public health emergencies and certain privacy protections.

GAO will submit a report every two years to Congress that includes: (1) a description of federal, state and local barriers to program integration, particularly for racial and ethnic minorities, including activities carried out under the Minority AIDS Initiative (MAI); and, (2) recommendations for enhancing the continuity of care and the provision of prevention services for those with HIV/AIDS or at risk for HIV/AIDS. The report will include a demonstration of the manner in which funds under the MAI are being expended and to what extent the services provided with such funds increase access to prevention and care services for individuals with HIV/AIDS and build stronger community linkages to address HIV prevention and care for racial and ethnic minority communities.

The Secretary of HHS must develop a severity of need index by September 30, 2008. As defined in P.L. 109-415, a severity of need index means "the index of the relative needs of individuals within a State or area, as identified by a number of different factors, and is a factor or set of factors that is multiplied by the number of living HIV/AIDS cases in a State or area, providing different weights to those cases based on needs. Such factors or set of factors may be different for different components of the provisions under this title." If the severity of need index is not completed by the deadline, then a report must be prepared for Congress that provides information on obtaining client level data, the progress toward developing the index and whether the index will be ready before FY2009.

Part F — Demonstration and Training

Part F provides support for the AIDS Dental Reimbursement (ADR) Program, the AIDS Education and Training Centers (AETCs), and the Special Projects of National Significance (SPNS) Program. P.L. 109-415 codifies the Minority AIDS Initiative (MAI) as part of the Ryan White program under Part F.[14] MAI provides funding for grants under Parts A, B, C, D, and F of the Ryan White program that evaluate and address the disproportionate impact of HIV/AIDS on racial and ethnic minorities.[15]

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 the prevention and treatment of opportunistic infections. Both the dental and the AETC programs were transferred legislatively from Title VII of the PHS Act.

Under P.L. 109-415, the SPNS program awards grants to entities eligible for funding under Parts A, B, C, and D to: (1) quickly respond to emerging needs of persons receiving assistance under this title; and (2) develop a standard electronic client information data system to improve grantee reporting of client-level data to the Secretary. P.L. 109-415 provides new criteria for making grant awards that are focused on: obtaining client-level data to create a severity of need index; creating and maintaining a safe, secure, reliable qualified health information technology system; or, newly emerging needs of persons receiving assistance under this title. Under statute, the SPNS program is to be funded, up to $25 million, from amounts appropriated for Parts A, B, C, and D; this was not changed by P.L. 109-415. However, beginning in FY2003, each Labor-HHS appropriation bill has provided $25 million for the SPNS program via a funding mechanism known as the "PHS evaluation tap."[16] The $25 million is divided, roughly proportionately, between the four Ryan White Parts (A, B, C, D), which then make the individual SPNS grant awards.

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[14] In 1998 the White House announced a series of initiatives targeting appropriated funds for HIV/AIDS prevention and treatment programs in minority communities. The Congressional Black Caucus worked with the Clinton Administration to formulate the approach. For FY2007, a total of $399 million is provided to continue these activities at the following agencies and offices: HRSA; CDC; National Institutes of Health; Substance Abuse and Mental Health Services Administration; Minority Communities Fund; Office of Minority Health; Office of Women's Health.

[15] MAI awards for Parts A and B will be announced in August 2007.

[16] The tap, authorized under section 241 of the PHS Act, transfers money among PHS agencies for particular activities as specified by the appropriators. Although section 241 [42 USC 238j] states that the evaluation tap should be no more than 1% of PHS program appropriations, the conference reports for the L-HHS Appropriation acts have set the tap at not more than 2.1% in FY2003 (H.Rept.108-10), 2.2% in FY2004 (H.Rept.108-401), 2.4% in FY2005 (H.Rept.108-792), and 2.4% in FY2006 (H.Rept. 109-337).

Table 1. Federal Funding for the Ryan White Program

($ in millions)

	Part A	Part B	(ADAP) (non-add)	Part C	Part D	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*	610.1	1,121.8	(787.5)	195.6	72.5	0	35.1	13.2	2,048.3
FY2006*	603.6	1,119.7	(789.0)	193.5	71.7	0	34.7	13.1	2,036.3
FY2007*	604.0	1,195.5	(789.5)	199.8	71.8	0	34.7	13.1	2,118.9
FY2008* Request	604.0	1,215.5	(814.5)	199.8	71.8	0	28.7	13.1	2,132.9

Sources: FY2006 and FY2007 amounts are from the HRSA Operating Plan for FY2007 dated March 6, 2007, reflecting final passage of the 4th Continuing Resolution, P.L. 110-5. FY2008 amounts are from the HRSA FY2008 Justification of Estimates for Appropriations Committees. May not add due to rounding.

*The total does not include $25 million for SPNS provided via the PHS program evaluation tap (section 241 of the PHS Act).