Overview of the Ryan White CARE Act

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act is the largest and most important source of funds for essential health care and social services for persons living with HIV/AIDS. The CARE Act is a federal program that was first established in 1990 and later reauthorized in 1996. In order to maintain its protected status as a program each year, the CARE Act must be reauthorized every five years. The current authorization will expire on September 30, 2000. The CARE Act helps local communities and states provide a safety net for HIV+ indigent and poor persons. Prior to its existence, community and government representatives found that many people living with HIV/AIDS were depending on public hospitals, emergency rooms, or simply going without care. The CARE Act was created to address the disproportionate impact of HIV on the public health infrastructure. It was established to serve as a mechanism to expand access to outpatient primary care and to provide supportive services which reduce dependence on more costly inpatient and emergency room services.

As the number of people with HIV/AIDS requiring services has increased, the CARE Act has grown from a $220.5 million in FY 1991 to a $1.4 billion program in FY 1999. There are currently five Titles of the CARE Act which encompass a total of seven programs. These programs all are administered by the HIV/AIDS Bureau at the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services.

Below are brief descriptions of each title of the CARE Act:

**Title I**

Title I provides direct grants to 51 high-incidence eligible metropolitan areas (EMAs) hardest hit by the epidemic for the provision of outpatient and ambulatory health and support services for individuals and families with HIV/AIDS. In the Chicago area EMA, these services include, but are not limited to, primary medical care, substance abuse, mental health, case management, alternative/complementary therapy, dental care, transportation, hospice care, and much more. In order to be designated an EMA, communities must have reported over 2,000 AIDS cases during the most recent five-year period. EMAs must also have a population of at least 500,000.

While some direction is given by HRSA with regards to the way these resources should be spent, maximum flexibility is given to local communities to respond to the variations in the nature of the epidemic and the local availability of other resources (ie. Medicaid, Medicare, etc.). Planning Council members are mandated to be representative of the constituencies affected by the epidemic. The Planning Council and the Chicago Department of Public Health, as the grantee for Title I funds of the Ryan White CARE Act, engage in a cyclical planning process to assess the needs of people living with HIV disease in the Chicago EMA, to establish priorities for the allocation of federal funds for HIV/AIDS services, and to evaluate and measure outcomes for the delivery of those services. In the current authorization, EMAs are eligible to receive both formula and supplemental funding through Title I. Formula funding is based on the AIDS case count, while the supplemental awards are granted through an annual competitive application process.
Title II

Title II provides formula grants to all states, D.C., Puerto Rico, and all U.S. territories to support activities designed to improve the quality, availability and organization of care services for people living with HIV disease. Title II grants are administered by state health departments and in turn generally fund local HIV care consortia to provide a comprehensive continuum of care to people with HIV/AIDS. Ten consortia exist in Illinois. Within Title II, there also is a set-aside for the AIDS Drug Assistance Program (ADAP). States can also allocate their own funds for ADAP; Illinois is one such state that does so. ADAP is designed to help people with HIV who are uninsured or underinsured to pay for HIV-related medications. AIDA has enabled many people with HIV to afford to powerful, but expensive, HIV treatments that have become available in recent years.

Until the reauthorization of the CARE Act in 1996, states with more than 1% of the nation’s AIDS cases were required to spend at least 50% of their grants on consortia. This provision was lifted to give states more flexibility. States with those case counts, however, must match a certain percentage of Title II funds with their own state funds, based on a formula in the CARE Act.

Title III

Title III provides grants to community-based health clinics and public health providers to develop and deliver early and ongoing comprehensive outpatient HIV health care services to families and individuals living with HIV/AIDS in poor urban and rural areas. The program is designed to be an early intervention program with a focus on primary health care, including early diagnosis, treatment, care, and risk reduction counseling, education and HIV antibody testing. At least 50% of Title III funds must be used for primary care related services. In Fiscal Year 1999, there were 180 grantees in 39 states plus Washington, D.C. and Puerto Rico. Approximately 50% of these grantees are located outside of Title I EMAs.

Title IV

This title emerged out of the Pediatric AIDS Health Care Demonstration Program. Its purpose is to improve and expand the infrastructure of comprehensive care services in order to increase the access of HIV/AIDS affected women, infants, children and youth to a comprehensive, community-based system of care. It is also designed to develop innovative models that link clients to clinical research trials. In Fiscal Year 1996, 60 projects were funded in 26 states, DC and Puerto Rico.

Title V (Part F)

This part of the CARE Act incorporates three separate programs:

- The AIDS Education and Training Centers is a network of 15 centers throughout the country that provides professional provider education and training programs for health care providers. The AETC program helps to ensure that health care and social service providers have the skills and information they need to provide up to date, state-of-the-art HIV care.

- The HIV/AIDS Dental Reimbursement Program provides partial reimbursement to dental schools and post-doctoral dental programs for the provision of oral health care to uninsured or underinsured people with HIV/AIDS.

- The Special Projects of National Significance (SPNS) Program provides competitive grants to study innovative approaches to providing care for people with HIV and to support the development and evaluation of these programs. Two SPNS projects exist in Illinois, both of which are based out of Cook County Hospital.
Ryan White CARE Act
The only HIV/AIDS-specific discretionary program

Title I
% HRSA " " Eligible Metropolitan Areas (EMAs -- 51 throughout country)
% HRSA " " CDPH " " HIV/AIDS Service Agencies throughout Chicago Area
% Planning Councils assess needs and set priorities

Title II
% HRSA " " Illinois Department of Public Health (IDPH)
% IDPH " " 10 state consortia and the AIDS Drug Assistance Program (ADAP)
% IDPH " " Health Insurance Continuation Program

Title III
% HRSA " " community based health centers and hospitals throughout the country
% Focus on HIV early intervention; at least 50% to be spent on primary medical care

Title IV
% HRSA " " programs specific to women, infants, children, youth and families
% Also designed to link clients to clinical research trials

Title V
% HRSA " " AIDS Education and Training Centers (AETCs) to provide training for medical providers
% HRSA " " reimbursement to dental schools for the provision of dental care
% HRSA " " Special Projects of National Significance (SPNS) for the study of innovative programs