COMMUNITIES ADVOCATING EMERGENCY AIDS RELIEF
CAEAR COALITION

CARE Act Title II "80/20" Funding Formula Addresses Statewide Needs

The CARE Act does not "double count" HIV/AIDS cases.

People living with AIDS who live in Title I Eligible Metropolitan Areas (EMAs) are counted in the Title I funding formula and partially counted in the Title II base (non-AIDS Drug Assistance Program) funding formula. The Title II state base funds receive partial credit (through the Title II "80/20 provision") for cases in EMAs. The Title II base formula calculation consists of two components: a statewide component, based on the number of statewide AIDS cases compared to the number of AIDS cases in the nation and given a weight of .8 (i.e., this is the "80"); and a non-EMA component, based on the number of cases in the state outside of Title I EMAs compared to the number of cases in the nation outside of Title I EMAs and given a weight of .2 (i.e., this is the "20").

Why does the Title II base formula allocation include resources based on cases that reside within EMAs?

Over 70 percent of people living with AIDS reside in Title I EMAs and providing states with partial credit for people with AIDS in their state who reside in an EMA appropriately recognizes the heavy burden of service provision in high prevalence areas of the state. These resources allow states to support the health care systems in their Title I EMAs, which Title I alone can not support. Title II spending by states with Title I EMAs is heavily concentrated in those high prevalence areas where the majority of people with AIDS reside. However, individuals with AIDS frequently migrate in and out of EMAs during the course of their disease and the states are the CARE Act grantees with statutory responsibility within the U.S. public health system to ensure the delivery of effective public health programs statewide. To that point, the 80/20 formula split recognizes the states' important role in coordinating statewide responses to the HIV/AIDS epidemic ,as well as their responsibility to ensure comprehensive care for people with HIV/AIDS whether they live inside or outside of a Title I EMA. The 80/20 formula split also recognizes the cost and effort associated with the many CARE Act mandates to evaluate and coordinate HIV/AIDS services statewide.

What would be the implications of changing the Title II base formula to include only non-EMA cases?

If the Title II base formula were based solely on cases outside of Title I EMAs, resources would be driven away from the epicenters of the HIV/AIDS epidemic where 87 percent of all living AIDS cases reside. There would be dramatic winners (31) and losers (16). The states that would gain the most funding (and approximate amounts) are North Carolina and South Carolina ($9 million each); Tennessee ($8 million); and Alabama, Indiana, Ohio, and Mississippi ($5 million each). The states that would lose the most funding (and approximate amounts) are high incidence states, including New York ($22 million); California ($19 million); Maryland ($6 million); Florida and New Jersey ($5 million each); and Washington, DC, and Illinois ($4 million each). Implications of these funding shifts include:

- *Destabilization of CARE Act systems of care:* These shifts would result in dramatic and severe reductions to the capacity of state public health departments to provide basic HIV services to current clients. States with Title I EMAs would lose significant amounts of Title II base funding despite the fact that those states have more people living with HIV/AIDS than ever before.

- *Destabilization of state-wide comprehensive care services:* The elimination of the statewide component of the Title II base formula would negatively impact states with the majority of the US HIV/AIDS epidemic. States use their Title II base dollars to provide necessary care and support services to individuals throughout their states, including those who reside within Title I EMAs. States also rely on their Title II base dollars to supplement services to ADAPs.

- *Trend towards states only servicing clients who reside outside of EMAs:* States would be forced to reduce or eliminate their support for services within EMAs. The EMAs represent the heaviest HIV/AIDS burden in most states and require funds from both Title I and Title II to ensure comprehensive services in those areas. However, if states were only to receive funding for non-EMA clients, they would be forced by a lack of funds, to focus their funding only on non-EMA areas, undermining care service delivery statewide. Title I EMAs are heavily impacted areas of states where the majority of new infections are occurring and where people are living longer and requiring more services for their survival than they have in the past. People with HIV/AIDS living in states with EMAs, receiving care through the CARE Act, would be hurt by the lack of support from the states.

- *Decrease in effective state-wide coordination of services:* The states' role in ensuring the delivery of effective and coordinated HIV/AIDS services statewide would be diminished and their public health responsibility to care for all citizens with HIV in their state would be undermined.

- *Inability of states to comply with CARE Act mandates:* Many of the CARE Act's statewide mandates would become unfunded, due to the lack of resources from the states within Title I EMAs. These mandates include state responsibility for coordination among CARE Act titles, quality management, statewide comprehensive plans and the Statewide Coordinated Statement of Need Assessment.

Why are the Administration and others advocating for this elimination?

The Administration's principles seek to address the need for increased resources in areas with emerging epidemics by rearranging existing funding rather than allocating new resources to address these needs. The assertion has been made that including EMA cases in the Title II formula contributes to unequal per-case funding across states. However, many analyses of per-case CARE Act funding only examine Title I and Title II funding, while the responsibility for equity must be distributed across the entire CARE Act, funded at over $2 billion per year. All titles of the CARE Act must be included in any credible distribution analysis. If Title II base funds were distributed solely on the basis of non-EMA cases, states in need of resources would continue to persist. The problem of underfunding can only be resolved with additional funding and not by this policy change.

Strategies for Providing Urgently Needed HIV/AIDS Funds to Underserved Areas without Destabilizing Existing Systems of Care

- *Create A Title II Supplemental to serve Non-EMA Areas:* The Ryan White Legislative Group has developed a proposal to create a new Title II supplemental line item to provide additional funding to states without EMAs and the two states that have EMAs but more than 50% of their cases outside of the EMA. The Legislative Group estimates it will require approximately $80 million in funding to bring non-EMA states up to funding levels commensurate with states with more concentrated, high

prevalence epidemics (states with Title I EMAs). The first source of funding for this line item would be taking unobligated Title II funds from states in the fiscal year after they were originally appropriated and then depositing them in this line item for redistribution to these states. The line item would also provide a target for directed appropriations from Congress.

- *Modernize Title I funding formula to allow funds to reach new locations of epidemic:* Change the basis of Title I formula funding from the weighted ten-year case band to living AIDS cases adjusted for reporting delays (FY 2007, 2008, and 2009) and living cases of HIV disease adjusted for reporting delays thereafter. Require the Secretary of Health and Human Services to certify a national HIV data set by September 30, 2009, for use in determining EMA eligibility and funding formulas.

- *Continue to support the development of Title III clinics in underserved areas*: Continue to prioritize funding for the existing and new Title III projects to provide high-quality, community-based primary care, prevention and case management services to low-income, underserved and underinsured populations living in rural and underserved areas.

- *Strengthen capacity building in minority and rural communities*: Establish new planning and development grants to small, rural and minority community-based organizations to assist in expanding their capacity to provide HIV-related health services in low-income, underserved, rural and minority communities.