



Southern AIDS Coalition

Policy Position and Analysis on HIV/AIDS Funding U.S. Domestic Prevention, Care, Treatment, and Housing for Americans Living with HIV Disease

HIV Disease is Preventable

August 22, 2005

People born in communities where the median income is significantly lower than the national average are not at fault for their place of birth. HIV infections continue to rise in impoverished communities at disproportionate rates. Sadly these communities also contain disproportionate numbers of AIDS cases in people of color, especially in the South, where the largest percentage of these newer cases occur. Previous approaches to stop this epidemic have fallen short.

At present, federal funds do not flow to the South at the same per case rate as other parts of the country. The Southern AIDS Coalition (SAC) simply seeks to obtain the appropriate share of funds to serve those living with the virus—not additional funds to supplement infrastructure.

The Campaign to End AIDS (C2EA) has the right goal. An end to this epidemic is the most humane, moral, economically sound strategy, and many believe achievable national goal. There are now more than 1.1 million Americans living with HIV disease, according to the Centers for Disease Control and Prevention.¹ Adequate care will expedite the prevention of this disease and save billions in health related expenditures

in the future.

The Institutes of Medicine (IOM) Report, *Public Financing and Delivery of HIV/AIDS Care*, issued in March, 2004, identified a powerful reason to ensure complete comprehensive care, treatment, and core services. **Adequate care will expedite the prevention of this disease.**²

Reauthorization of the C.A.R.E. Act is a moral mandate, and SAC commends President Bush and his administration for asking Congress to make reauthorization of the Ryan White C.A.R.E. Act a top priority this year. SAC also endorses the President's five key principles to make legislation more responsive to those in need: 1) Serve the neediest first; 2) Focus on life-saving and life-extending services; 3) Increase prevention efforts; 4) Increase accountability; and 5) Increase flexibility. While national dialogue is rich with discussions that demonstrate wide agreement around these principles, to date there has not been national agreement about how to achieve them within the next five years of the new reauthorized C.A.R.E. Act.

SAC, like many local, regional and national advocates, acknowledges that HIV/AIDS and sexually transmitted dis-

ease (STD) prevention, care, and treatment are dangerously underfunded. SAC is particularly concerned that this continued underfunding will contribute to the spread of new cases of HIV/AIDS and STDs in some of our most vulnerable communities across the U.S. Many of these communities include people of color, young people, and impoverished Southerners. We believe the IOM report is right; it's time to fully fund prevention, care, treatment, services, and housing for persons with HIV in order to end the spread of this costly disease. SAC urges the President and Congress to work with local, state, and national partners including persons living with HIV/AIDS to develop strategies to ensure full funding for HIV/AIDS and STD prevention, HIV care, and HIV treatment and to target the funds to areas that most need it. As a case in point, the Southern states have 46% of the U.S. AIDS cases and only 34% of the Ryan White funds.

National dialogues underway include many passionate points of view. Some of the perspectives are based on the view that this act was not designed to fortify the inadequate infrastructure of poorer communities. Clearly, SAC disagrees, since the C.A.R.E.

Act specifically and intentionally targets people with the greatest needs. Communities of poverty need additional support, not less. Yet SAC's policies do not ask for more than an equitable share of the available resources.

The southern states and many others across the nation have leveraged state and local resources ranging from 5% to 50% in match or as maintenance of effort toward C.A.R.E. Act dollars.^{3,4} Even with these increased resources through leveraged local, state, and other federal dollars, many states without Title I EMAs or with 50% of their living AIDS population outside of Title I EMAs still have waiting lists for medications, restrictive medication formularies, eligibility for AIDS Drug Assistance Programs below 300% of the federal poverty level, and are

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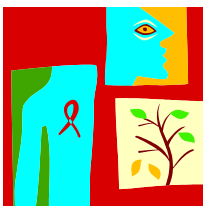
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only able to offer limited HIV primary care and dental care as compared to other states. SAC believes that some portion of the current funds appropriated to support Ryan White funded programs should be redirected to states and/or territories to move toward an equal per case funding amount. Today the disparities between states are skewed and hurt the South. A primary focus of this year's reauthorization of the Ryan White C.A.R.E. Act should be to decrease disparities in funding between states and to enhance parity in services across the country for all persons living with HIV/AIDS regardless of geographical location to the greatest extent possible. The South continues to have increasing AIDS rates disproportionate to our population, greater percentage of infected, untested people, and more deaths occur in the South and in states without adequate proportions of the funding.

Since 1990 the C.A.R.E. Act has served the epicenters of this epidemic. HIV infection has spread outside of those epicenters; the funds must follow the epidemic.

The Government Accounting Office's *Factors that Impact HIV and AIDS Funding and Client Coverage* report, issued in late June, 2005, serves as **the defining document** to identify the elements of the C.A.R.E. Act that need major reform. Major findings include Title I and Title II disparities and wide variances in the ADAPs across the country. SAC's position directly targets these identified areas. While the C.A.R.E. Act alone will not rid the world of HIV or even cover domestic care and treatment needs, ***reauthorization of the C.A.R.E. Act utilizing SAC's methodology is the most critical action Congress can take by September 30, 2005.***



SAC Ryan White C.A.R.E. Act Reauthorization Principles Principles Agreed to by the Southern AIDS Coalition Steering Committee

SAC PROPOSAL TARGETS FUNDS

The SAC Principles maximize resources by increasing the federal dollars available to provide direct services to people with HIV. The combination of Title I, Title I Supplemental, and Title II Base dollars concurrently directed to/through affected State Public Health Agencies will greatly decrease the amount of funds currently used on planning and administration. The required reporting and data collection from both Titles will be streamlined, the planning processes will be integrated, not separate, and the effectiveness of the dollars will rise. Individuals living with HIV will benefit from integrated/non-duplicative planning, administration, and monitoring as the combined processes will result in savings that can be used to expand direct services available to consumers.

Appropriations to Ryan White must increase substantially over the next five-year period of reauthorization to adequately support the increased numbers of persons living with HIV disease. The SAC Principles for the reauthorization of the C.A.R.E. Act in no way imply that substantial increases in resources are not also desperately needed.

1. Use the Centers for Disease Control and Prevention Estimated Living AIDS cases for distribution of funds until 2007, when name-based reporting of HIV cases will also

be utilized for distribution as required by the Health Resources Services Administration and the Centers for Disease Control and Prevention. [Note: SAC realizes this may create additional shifts—the loss and gain caps outlined still apply].

2. Combine all elements of Titles I & II to create two appropriations titled Care (Base) and Treatment (ADAP). [Note: This combination includes Title I, Title I Supplemental, and Title II Base. It does not include ADAP, ADAP Supplemental, or Minority AIDS Initiative Funds.]
3. Eliminate double counting and hold harmless only in combination with SAC Principle 2.
4. Distribute all Ryan White Care and Treatment funds to states only. Utilize the infrastructure and former Title I planning bodies as advisory entities, and/or, as determined by each state, use the Planning Councils to administer funds if efficiency can be documented.
5. Require state plan to be submitted to HRSA to demonstrate the reach of the C.A.R.E. Act to every county in every state and territory. All remaining titles of the C.A.R.E. Act must be involved and endorse the state's plan. The plan should also address how to implement C.A.R.E. Act Care and Treatment funds in the most efficient manner.
6. Utilize the Veterans Affairs pricing schedule or lower for all medications purchased with C.A.R.E. Act funds.

SAC Ryan White C.A.R.E. Act Reauthorization Principles, Continued

Principles Agreed to by the Southern AIDS Coalition Steering Committee

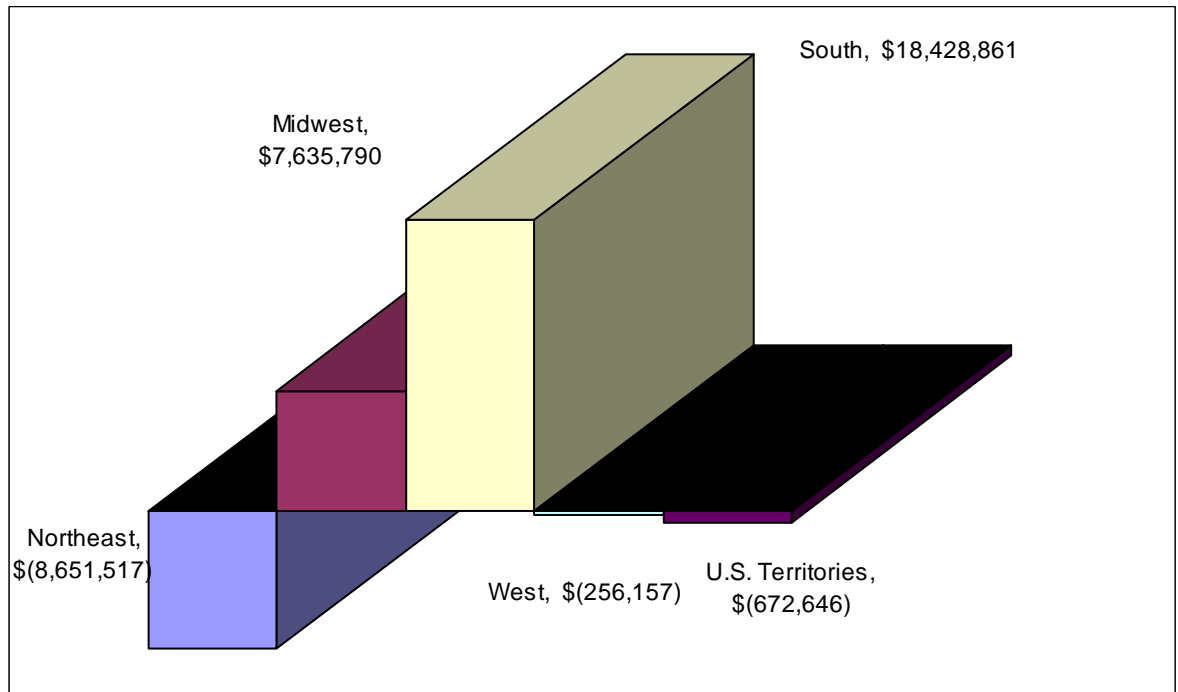
7. State match will be \$1 for every \$4 (state to federal) or no less than the previous year's dollar amount. States must also maintain, at a minimum, the maintenance of effort provided in the previous year.
8. Given the shifts in funds likely to be created by these principles, SAC recommends a loss cap schedule by state. The loss cap will guarantee that no state will lose more than the following schedule for the combined Title I, Title I Supplemental, Title II Base, ADAP, and Minority AIDS Initiative funds awarded in 2005 (and compared to each year hereafter) as follows:
 - 2006—2%
 - 2007—3%
 - 2008—4%
 - 2009—5%
 - 2010—6%Further, a gain cap will be established. No state or territory will be able to gain more than 23% in any given year. These caps apply to every year of the reauthorized C.A.R.E. Act.
9. Distribution of non-ADAP (Care) dollars within the states must mirror the results of a planning process that includes the distribution of funds based upon Estimated Living AIDS cases (until 2007 when HIV cases will be utilized) or a more updated distribution method. [Note: Needs and priorities are to be established by State Care Consortia and/or Planning Councils.]
10. Consumers and providers of Ryan White, Housing Opportunities for Persons with AIDS, and Centers for Disease Control and Prevention funded programs are to be included in the planning process for disbursement of Care dollars within each state. Former Title I entities that utilize existing Planning Councils must also include the above providers and consumers.
11. Compliance with the Americans with Disabilities Act, methods to address multi-lingual needs of non-English speaking monolingual persons, and approaches that address rural and urban issues are all to be addressed in the planning process.
12. SAC does not endorse carve-outs by percentages of funds for core medical or any other set of particular services. SAC fully endorses the ability of states and territories to use funds to build a comprehensive system of care endorsed through the community consultation and planning processes. [This principle does not apply to ADAP (Treatment).]
13. All non-state applicants for Ryan White funds must file a full copy of their grants (i.e. Title III and IV, AETC, SPNS, Part F Dental) prior to submission of applications to HRSA. A Single Point of Contact for each state is to be identified by the top Public Health official to review these proposals in advance and to endorse the applications based on the state plan.
14. SAC strongly endorses the Early Treatment for HIV/AIDS Act and recommends that every state apply to implement it as soon as it becomes law.
15. SAC calls on HHS to direct the existing 2% currently taken from Title I to go directly into the existing 3% ADAP Supplemental to increase the overall ADAP Supplemental funding that HRSA may utilize to direct to severe need states only. Severe need is defined as:
 - a. Eligibility for ADAP in the state at or below 300% FPL;
 - b. State ADAP and formulary does not adhere to the Public Health Service guidelines for Highly Active Anti-Retroviral Therapy (HAART); or
 - c. The state has a waiting list.[Note: For 2006 this methodology allows HRSA to have \$31,134,352 in ADAP Supplemental funds at current appropriation levels. This plan does not include the current \$10 million increase to ADAP from the funding bills in the House and Senate. Anything for ADAP above and beyond the existing \$10 million would be awarded to severe need states as outlined in 16 until they meet the criteria outlined therein.]
16. SAC calls for the Administration to utilize any carryover funds to continue the President's AIDS Initiative through March 31, 2006, with the balance of the carryover funds to target states with ADAP severe need as defined above.

Southern AIDS Coalition State by State Result of Policy Implementation at 2005 funding levels	12/31/03 Estimated Living AIDS Cases	% of Estimated Living AIDS Cases	TOTAL Current Funding by State	% Increase or Decrease based on Estimated Living AIDS Case distribution.	SAC Final Recommended Amounts = Difference from 2005 to 2006	% Change from 2005	SAC Proposed Cumulative Five-Year Whole Dollar Amount Change from 2005 through 2010	% Five-Year Change from 2005 through 2010
			<small>Title I, Title II Base, ADAP Base (not Supplemental), Emerging Communities, and Minority AIDS Initiative</small>	<small>(Title I, Title I Supplemental, MAI, ADAP Base, Title II) Change from use of Estimated Living AIDS Cases.</small>				
Alabama sn	3,940	0.97%	\$ 11,881,914	18.62%	\$ 2,732,840.22	23%	\$ 4,285,994	36.07%
Alaska sn	271	0.07%	\$ 1,006,313	1.43%	\$ 14,357.89	1%	\$ 105,744	10.51%
Arizona sn	4,127	1.02%	\$ 19,199,184	-8.26%	\$ (383,983.68)	-2%	\$ (2,263,916)	-11.79%
Arkansas sn	2,067	0.51%	\$ 5,161,119	42.27%	\$ 1,187,057.37	23%	\$ 3,990,921	77.33%
California	55,750	13.75%	\$ 220,434,210	-8.68%	\$ (4,408,684.20)	-2%	\$ 8,337,588	3.78%
Colorado sn	3,675	0.91%	\$ 12,065,592	7.09%	\$ 855,560.57	7%	\$ 3,014,881	24.99%
Connecticut	6,989	1.72%	\$ 27,295,627	-4.43%	\$ (545,912.54)	-2%	\$ 1,383,944	5.07%
Delaware sn	1,613	0.40%	\$ 5,432,326	19.16%	\$ 1,040,806.37	19%	\$ 1,186,668	21.84%
DC sn	8,848	2.18%	\$ 48,383,486	-28.10%	\$ (967,669.72)	-2%	\$ (8,954,314)	-18.51%
Florida sn	43,223	10.66%	\$ 187,757,993	-6.74%	\$ (3,755,159.86)	-2%	\$ 10,391,115)	-5.53%
Georgia sn	14,023	3.46%	\$ 55,438,879	-0.48%	\$ (263,771.46)	0%	\$ 2,104,922	3.80%
Hawaii sn	1,318	0.33%	\$ 3,298,130	41.77%	\$ 758,569.90	23%	\$ 2,110,323	63.99%
Idaho sn	274	0.07%	\$ 965,496	2.08%	\$ 20,051.89	2%	\$ 158,871	16.45%
Illinois	14,321	3.53%	\$ 61,000,141	-6.65%	\$ (1,220,002.82)	-2%	\$ (2,233,488)	-3.66%
Indiana sn	3,686	0.91%	\$ 11,631,445	21.38%	\$ 2,486,444.56	21%	\$ 3,494,167	30.04%
Iowa sn	728	0.18%	\$ 2,111,150	31.66%	\$ 485,564.50	23%	\$ 876,220	41.50%
Kansas sn	1,123	0.28%	\$ 3,130,712	36.25%	\$ 720,063.76	23%	\$ 1,477,552	47.20%
Kentucky sn	2,359	0.58%	\$ 6,962,984	28.43%	\$ 1,601,486.32	23%	\$ 2,717,243	39.02%
Louisiana sn	7,592	1.87%	\$ 30,419,722	1.69%	\$ 512,641.04	2%	\$ 734,278	2.41%
Maine sn	518	0.13%	\$ 1,333,909	36.22%	\$ 306,799.07	23%	\$ 791,720	59.35%
Maryland	12,911	3.18%	\$ 55,235,216	-1.36%	\$ (752,323.03)	-1%	\$ (2,254,540)	-4.08%
Massachusetts	8,397	2.07%	\$ 33,842,103	-5.71%	\$ (676,842.06)	-2%	\$ 615,238	1.82%
Michigan	5,584	1.38%	\$ 24,588,713	-5.72%	\$ (491,774.26)	-2%	\$ (1,674,601)	-6.81%
Minnesota sn	1,900	0.47%	\$ 7,195,214	-3.13%	\$ (143,904.28)	-2%	\$ 601,493	8.36%
Mississippi sn	2,875	0.71%	\$ 10,514,013	16.64%	\$ 1,749,552.88	17%	\$ 1,283,636	12.21%
Missouri sn	5,060	1.25%	\$ 17,781,813	0.11%	\$ 20,260.03	0%	\$ 2,982,049	16.77%
Montana sn	175	0.04%	\$ 810,671	-20.71%	\$ (16,213.42)	-2%	\$ (92,553)	-11.42%
Nebraska sn	598	0.15%	\$ 1,757,215	31.30%	\$ 404,159.45	23%	\$ 696,696	39.65%
Nevada	2,654	0.65%	\$ 11,185,869	-7.35%	\$ (223,717.38)	-2%	\$ (295,100)	-2.64%
New Hampshire sn	530	0.13%	\$ 1,281,115	39.49%	\$ 294,656.45	23%	\$ 893,756	69.76%
New Jersey	17,089	4.21%	\$ 76,640,449	-9.39%	\$ (1,532,808.98)	-2%	\$ (6,515,225)	-8.50%
New Mexico sn	1,182	0.29%	\$ 3,489,677	30.55%	\$ 802,625.71	23%	\$ 1,360,695	38.99%
New York	66,660	16.44%	\$ 296,721,288	-10.02%	\$ (5,934,425.76)	-2%	\$ (23,179,978)	-7.81%
North Carolina sn	6,545	1.61%	\$ 21,945,256	20.46%	\$ 4,491,057.45	20%	\$ 4,912,348	22.38%
North Dakota	57	0.01%	\$ 306,199	-29.99%	\$ 193,801.00	63%	\$ 122,441	39.99%
Ohio	6,583	1.62%	\$ 20,258,304	19.71%	\$ 3,993,373.43	20%	\$ 6,755,234	33.35%
Oklahoma sn	2,085	0.51%	\$ 5,928,122	30.79%	\$ 1,363,468.06	23%	\$ 2,627,738	44.33%
Oregon sn	2,586	0.64%	\$ 9,388,306	0.20%	\$ 19,067.99	0%	\$ 1,223,423	13.03%
Pennsylvania	15,178	3.74%	\$ 63,942,771	-5.99%	\$ (1,278,855.42)	-2%	\$ (1,659,393)	-2.60%
Puerto Rico sn	9,798	2.42%	\$ 50,041,122	-13.05%	\$ (1,000,822.44)	-2%	\$ (9,261,092)	-18.51%
Rhode Island	1,103	0.27%	\$ 3,189,276	32.22%	\$ 733,533.48	23%	\$ 1,336,918	41.92%
South Carolina sn	6,379	1.57%	\$ 20,521,015	21.47%	\$ 4,406,213.51	21%	\$ 5,655,403	27.56%
South Dakota sn	105	0.03%	\$ 727,255	-41.35%	\$ (14,545.10)	-2%	\$ (134,593)	-18.51%
Tennessee sn	5,817	1.43%	\$ 21,178,234	11.91%	\$ 2,522,403.73	12%	\$ 2,692,000	12.71%
Texas sn	30,043	7.41%	\$ 118,087,261	-2.12%	\$ (2,361,745.22)	-2%	\$ 5,195,091	4.40%
Utah sn	1,098	0.27%	\$ 3,235,191	33.36%	\$ 744,093.93	23%	\$ 1,270,485	39.27%
Vermont sn	250	0.06%	\$ 883,059	-2.89%	\$ (17,661.18)	-2%	\$ 142,824	16.17%
Virginia sn	7,735	1.91%	\$ 25,812,391	17.20%	\$ 4,439,951.99	17%	\$ 5,928,414	22.97%
Washington sn	5,108	1.26%	\$ 16,830,374	8.51%	\$ 1,432,032.01	9%	\$ 4,130,457	24.54%
West Virginia sn	645	0.16%	\$ 2,095,875	25.81%	\$ 482,051.25	23%	\$ 550,902	26.29%
Wisconsin sn	1,848	0.46%	\$ 5,227,607	29.99%	\$ 1,202,349.61	23%	\$ 2,355,716	45.06%
Wyoming sn	96	0.02%	\$ 369,918	-4.81%	\$ 130,082.00	35%	\$ 130,082	35.17%
Guam	35	0.01%	\$ 142,852	11.50%	\$ 107,148.00	75%	\$ 107,148	75.01%
Pacific Islands	4	0.00%	\$ 976,602	-32.71%	\$ (19,532.04)	-2%	\$ (180,739)	-18.51%
Virgin Islands, U.S.**	294	0.07%	\$ 52,360	970.23%	\$ 47,640.00	91%	\$ 197,640	377.46%
Marshall Islands**		0.00%	\$ 52,360	-95.49%	\$ 47,640.00	91%	\$ 47,640	90.99%
North Marianas**		0.00%	\$ 54,720	-91.37%	\$ 45,280.00	83%	\$ 45,280	82.75%
Republic of Palau**		0.00%	\$ 50,000	-100.00%	\$ 50,000.00	100%	\$ 50,000	100.00%
Micronisia		0.00%	\$ 50,000	-100.00%	\$ 50,000.00	100%	\$ 50,000	100.00%
Total	405,452	100.00%	\$ 1,647,300,118	-3.69%	\$ 16,484,330.58		\$ 21,641,135	

2006 State and Territory Results of SAC Policy

Distribution of the Ryan White C.A.R.E. Act appropriation must follow the epidemic, which will require a shift in current fund distribution. SAC supports this shift occurring in a manner that causes minimal disruption to existing care and treatment systems and services. A gradually increasing loss cap and gain cap allow a slow shift of funds over five years to ensure that funding more closely follows the epidemic without dramatically destabilizing current systems.

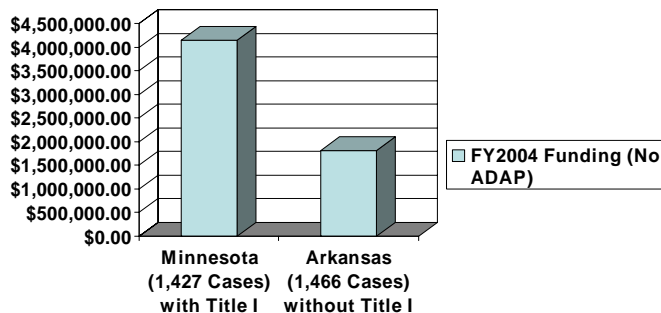
Results of SAC policy implementation:
Shift of \$35.6 million in Year One with loss cap of 2% and gain cap of 23% in place.



Funding Disparities

The following chart highlights the funding disparities that exist from state to state. SAC seeks a way to equalize the per case funding. Parity will lead to decreased transmissions as more people enter care.

Disparities in Care & Treatment (NASTAD 2004)



The loss cap affects 19 states with losses ranging from a \$5.9 million loss in New York to \$14,546 in South Dakota. Through this approach, no state loses more than 2% in 2006 compared to 2005 funding amounts. The loss cap escalates at a 1% increase per year through 2010; the chart above only relates to 2006, assuming flat appropriations.

The gain cap of 23% affects 15 states ranging from \$4.5 million increase in 2006 compared to 2005 in North Carolina (the lowest ADAP eligibility criteria in the nation) to \$14,358 in Alaska. These whole dollar amounts will make a significant impact on persons with HIV in the states that gain funds. Of the 23 areas with Title I EMAs (including states, the District of Columbia, and Puerto Rico), seven received increases in this scenario.

Over the five years of reauthorization, if all things stay constant, \$160 million will shift among states and territories. This amount has been calculated with the gain and loss caps in place.

The Southern AIDS Coalition also set a \$250,000 minimum for the U.S. Virgin Islands and \$100,000 minimum for all remaining territories other than the Pacific Islands (PI). The PI receive a proportion of funds based on the Estimated Living AIDS cases. Further, two states (Wyoming and North Dakota) have been awarded a minimum of \$500,000.

The Administration's Principles – SAC's Response

African-Americans and Low Income Populations Intersect in the South

The President's February 2, 2005, State of the Union address included a focused intent: "...we must focus our efforts on fellow citizens with the highest rates of new cases, African-American men and women." According to the U.S. Census, African-Americans comprise 12.1% of the total population; and 54% of all African-Americans live in the South.⁷ Georgia, Texas, and Florida are among the top five states where African-Americans reside. Further, the CDC reports 39% of all Estimated Living AIDS cases were in the South as of December 31, 2003.⁸ There are at least 14.5 million Southerners below the Federal Poverty Rate, and sadly the South is the region with the highest rates of poverty in the nation. There are over 18 million citizens in the South without any health insurance.⁹ Poverty and lack of insurance combined present barriers to health-care which disproportionately impact African-American Southerners. *The South has a severe level of needs.*

SAC Solution: Combine Title I and Title II and distribute funds for Care and Treatment based on equal per case distribution over time. The SAC recommendations define in detail the distribution methodology that will both achieve greater parity and target regions with disproportionate infection rates in communities of color. SAC recommends that this shift toward parity needs to occur over time to limit the immediate impact on all regions of the U.S.

SAC fully endorses the Administration's intent to utilize indicators such as rates of poverty and lack of insurance to prioritize states and territories with severe needs for distribution of the flexible funds to be directed by HRSA.

Increase Prevention Efforts

SAC fully endorses the Administration's goals to increase testing options,

SAC Solution: Double the appropriation for prevention and testing outside the Ryan White C.A.R.E. Act through the CDC, require all Ryan White funded programs to increase testing options, and target the use of well known and successful prevention strategies with CDC funds.

the utilization of successful prevention strategies, and the guidelines in the CDC Advancing HIV Prevention Initiative.

Increase Accountability

The July 27th release of the first-ever Administration Ryan White Reauthorization principles outlined specific elements to increase accountability. SAC's response is detailed in the table below.

Administration Accountability Criteria	SAC Response
Maintain the current statutory requirement that all states submit HIV name-reported data by start of Fiscal Year 2007.	SAC endorses this more accurate reflection of the epidemic. The funds should follow the disease.
Hold grantees accountable for reporting on system and client-level data and progress toward goals.	SAC agrees and believes the identification of a Single Point of Contact in each state for all Ryan White funds will forward HRSA's goal of data collection. SAC principles 4, 5, and 13 on page 4 detail SAC's response.
Maximize investments through stronger and more specific payer-of-last-resort provisions and require grantees to seek alternative payment sources before the use of Ryan White funds.	SAC agrees with the collaborative, community-based approach to utilize all payer streams that will maximize resources that remain for HIV-positive persons in severe need.
Require state and local care delivery coordination.	State Care Consortia and Planning Councils must prioritize needs and strategies for funds to come through a Single Point of Contact (SPOC) in each state and territory. The SPOC will coordinate the disbursement of funds through the existing planning bodies (i.e., states could contract with cities or retain the funds to contract directly to providers as determined by each state.) All Ryan White C.A.R.E. Act funds must require the involvement of the SPOC.
Eliminate the double counting of HIV/AIDS cases between major metropolitan areas and the states.	SAC endorses this principle only if Title I and Title II are combined as outlined in the SAC Policy. In addition to parity, planning dollars will be maximized.
Eliminate the current provisions that entitle cities to be held harmless in funding reductions.	SAC agrees with this principle only with the acceptance of the combination of Title I and Title II funds. A shift of resources over time is handled through a loss cap (2% - 6% over five years) and a gain cap approach of the non-ADAP dollars.

The Administration's Principles – SAC's Response, Continued

Focus on Life-Saving and Life-Extending Services

SAC supports the use of C.A.R.E. Act dollars for medical services; however, the required 75% use of as-yet-undefined core medical services conflicts with the administration's goal of flexibility. SAC strongly urges Congress and the Administration to exclude this limitation in reauthorization, as it will not address those not in care and may not allow for maximum leverage of local services if it is required that these funds be spent on medical services. SAC further believes that the Public Health Service Highly Active Antiretroviral Therapy formulary should be the standard of care adopted by all AIDS Drug Assistance Programs.

SAC Endorses the Continuation of All Other Elements of the C.A.R.E. Act

The Ryan White C.A.R.E. Act includes the following critical components:

- a) Title III Early Intervention Clinic Services
- b) Title IV for Women, Infants, Children & Youth
- c) Special Projects of National Significance
- d) HIV/AIDS Education Training Centers
- e) Dental Reimbursement Program
- f) Community-Based Dental Partnership Program
- g) Program Data and Evaluation.

SAC endorses the continuation of these programs and **strongly recommends** increases in Title III, Title IV, and the Dental programs. Many of these programs benefit the less urban portions of the United States. Together these elements comprise approximately 16% of the current appropriation (Title III: 10%; Title IV: 4%; AETC: 1%; Dental: 1%). Title III funds are critical to care and treatment in the South, yet only 34% of the Title III funds come to the South while 46% of the new cases are in the South.

We fully endorse the channeling of these funds to communities that demonstrate severe need as defined in our Principles. SAC further recommends the distribution of these dollars through existing competitive processes already being implemented by HRSA. SAC also notes the importance of coordination with the recommended Single Point of Contact as assigned by the chief public health officer within each state and recommends the requirement that all of these proposals receive an endorsement from the SPOC prior to competitive submission.

Medicaid Eligibility Equality

SAC seeks to increase the number of Medicaid eligible people with HIV disease who can receive care and treatment and supports the Treatment Access Expansion Project (TAEP). The Early Treatment for HIV ACT (ETHA) is another method to expand Medicaid coverage to more people living with HIV/AIDS. Over time each state is estimated to save money. Another challenge SAC seeks to overcome is the federally

mandated Medicaid disability eligibility criteria for people who are HIV-positive. This federal mandate is implemented differently in many states and leaves out thousands of HIV-positive people who should be eligible. The reason is simple; states do not have or are not willing to provide the required match to meet the federal mandates. **SAC calls on the Center for Medicaid and Medicare Services to work with HRSA and the TAEP to**

increase access for HIV-positive persons to Medicaid through an expansion of existing criteria for eligibility. This step alone could translate into tens of thousands of people who can become eligible for care and treatment under Medicaid; greatly relieving pressure from the Ryan White C.A.R.E. Act.

Healthcare Is Not Just Medical Care—Flexibility Is Needed

The Title II Statewide Coordinated Statements of Need (SCSN), Ryan White Consortia planning processes, and Title I needs assessments all point out the fact that non-medical services are desperately needed by those living with HIV disease. While it is understood that the C.A.R.E. Act predominantly targets the medical needs of those living with HIV, flexibility in the use of funds is essential to the provision of critical, non-medical needs identified through the required Ryan White assessment and planning processes. SAC agrees with the Administration's focus on flexibility to engage the projected 250,000 Americans who are HIV-positive and not receiving care. The engagement of this "out of care" population cannot occur without the

potential to utilize funds for needs determined on the community level. To clarify, those who are HIV-positive and not in care need to be brought into care and treatment, which will result in reduced numbers of HIV transmission. The process to identify those not yet reported, as well as testing, outreach, and prevention efforts, must all be funded through the Centers for Disease Control and Prevention, not through Ryan White. However, with appropriate community planning, the connection between testing and prevention and engagement into care can be achieved.

Access to medical care for those infected depend upon transportation, housing, case management, outreach,

counseling, testing, mental healthcare, substance abuse treatment, and multiple other services. Without them healthcare will never be accessed. SAC concurs with the Administration that providers utilizing Ryan White funds must first engage all other potential payers for these services before utilizing Ryan White funds, which must be the payer of last resort; in many rural settings, however, there are no other options.

SAC encourages Congress and the Administration to include flexibility in the use of funds, thus allowing a state to focus on communities with severe need and on those not yet in healthcare. This required flexibility must include accountability.

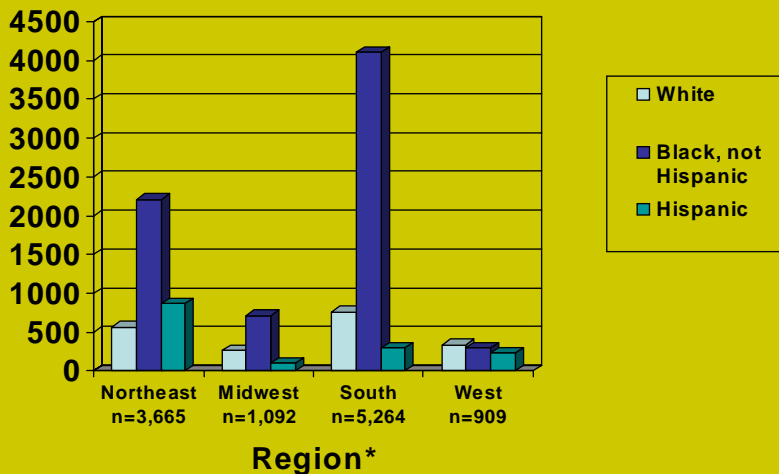
Women of Color in the South

The correlation of sexually transmitted diseases with poverty combine with the disproportionate percentages of poor and uninsured in the South to put African-American women at increased risk of HIV in the South. African-Americans are also represented in the South at a higher percentage as a region than any other U.S. region, according to the U.S. Census. The chart to the left depicts the resulting HIV infections that can occur when all of these elements combine. Hispanics and African-Americans represent the fastest growing AIDS-diagnosed demographics in the South.

The Southern AIDS Coalition's major focus is to ensure that the states within the region receive equal federal funds per Estimated Living AIDS case; at present the South as a region receives less per AIDS case than any other region in the nation.

We believe it is time to adjust and to direct the funding to follow the epidemic.

Reported AIDS Cases Among Female Adults and Adolescents, by Region and Race/Ethnicity, United States, 2002



Note. Excludes persons from Puerto Rico and US dependencies, possessions and associated nations
 * Region totals include females of unknown race.

Prevention Priorities

The Centers for Disease Control and Prevention (CDC) has stepped up efforts to retard new infection rates. *Advancing HIV Prevention, New Strategies for a Changing Epidemic* outlines four key areas of importance.⁵

- 1) Incorporate HIV testing as a routine part of care in traditional medical settings.
- 2) Implement new models for diagnosing HIV infections outside of medical settings.
- 3) Prevent new infections by working with people diagnosed with HIV and with their partners.
- 4) Further decrease mother-to-child HIV transmission.

In a letter just a few weeks ago, Dr. Julie Gerberding, Director of the CDC, issued a public appeal to have all states

adopt confidential name-based surveillance systems in order to have the most accurate data to track the epidemic.⁶

The Southern AIDS Coalition believes that all states and territories should be mandated to report HIV disease in the CDC-supported format by the 2007 Fiscal Year. States and territories that do not comply will have their HIV counts estimated utilizing the best science available to predict living HIV and AIDS cases in their states. **SAC also believes the Veterans Affairs system must be mandated to report their HIV data by state and territory since these requirements do not now exist.**

None of these goals can be accomplished without funds. Congress traditionally woefully underfunds successful prevention strategies, which challenges effective and culturally appropriate methods to keep people from contract-

ing all types of sexually transmitted diseases (STDs).

Congress must double the appropriations for prevention and target funds to the South and to other underserved areas across the country in order to make a significant reduction in the spread of HIV and STDs . Funds will support the increased testing initiatives and effective, culturally appropriate prevention efforts.

Healthcare Needs Housing

The United States Department of Housing and Urban Development (HUD) has a \$32 billion budget. Less than \$300 million is allotted for the one designated program for persons with HIV disease, Housing Opportunities for Persons with AIDS (HOPWA). If we can stabilize people in their own homes, then we can ensure treatment, ensure access to information, and prevent further spread of this epidemic. Poverty is one of the conditions that enhances increased transmission rates of HIV. HOPWA must be funded at \$385 million in order to come closer to meeting the needs of those living with HIV disease. Housing programs across the country coordinate with homeless providers, housing authorities, community development corporations, tax credit programs, and many other HUD-funded programs in order to cobble

together resources that are nowhere near adequate. We have created sophisticated housing developers and providers that will leverage this HOPWA funding into billions of dollars, but only if the program is adequately funded.

Minority AIDS Initiative

The Minority AIDS Initiative must be continued to target funds to populations disproportionately impacted by HIV disease. SAC endorses the approach to provide states with the funds to distribute based on annual planning and ongoing progress toward engaging people into care, thereby ensuring increased emphasis on care and treatment for communities of color.

A family must earn \$15.37 per hour in a 40-hour work week to afford a home in the United States.

-The National Low-Income Housing Coalition

Policy Position and Analysis on HIV/AIDS

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The Southern AIDS Coalition (SAC) is a sustained and united HIV/AIDS/STD advocacy voice for the South. We believe that by mobilizing our communities and by developing a broad-based coalition of consumers, advocates, elected and appointed officials, community and government agencies, and industry partners, we will develop and implement a solid plan of action for the South.

The southern region of the United States is in a crisis; HIV/AIDS and other sexually transmitted diseases are devastating the South. We have become ground zero in the AIDS epidemic in the United States. Rising infection rates coupled with inadequate funding and resources will affect a significant proportion of young adults aged 20-45 during their most productive years. Our AIDS epidemic is also growing among our senior population. The time to act with one united voice is now.

It is urgent that leaders in federal, state, and local governments, as well as leaders in local communities, recognize the disparate impact of HIV/AIDS and STDs in the South and commit to immediate action that will ensure improved health outcomes for southern citizens.

We're on the web:
www.southernaidscoalition.org

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THANK YOU

Special thanks go out to the Gill Foundation for their generous support of the Southern AIDS Coalition. Thanks also are given to the SAC Steering Committee for their many hours of labor to improve the lives of people with HIV disease in the U.S. and to all SAC members for their support. To join online, go to www.southernaidscoalition.org.

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