

Ryan White CARE Act Reauthorization

May 17, 2006
David Ernesto Munar
AIDS Foundation of Chicago

What is the CARE Act?

- Largest source of discretionary federal funds for HIV/AIDS care
- First created by Congress in 1990; reauthorized in 1996 and 2000
- Funding determined by Congress annually
- \$2.03 billion in FY06 (current year)

What is *authorization*?

- Congress can create federal programs by passing “authorization” legislation
- The “authorization” defines the scope of the program and its key components
- Authorizations are time-limited, typically five years
- While authorizations can recommend funding, allocations are made separately through an annual process known as “appropriations”

How is the CARE Act Currently Structured?

- Title I — Grants to 51 hard-hit cities (30%)
- Title II— Grants to states and territories
 - *BASE*: Array of HIV services (16%)
 - *ADAP*: Medication assistance (38%)
- Title III—Grants to clinics (10%)
- Title IV: Women and family services (3%)
- AETCs: Medical provider training (2%)
- Dental: Grants for dental service (1%)

Hot Button Issues of Debate

How Funding is Distributed:

- Funding for rural states
- Future of Title I
- Hold harmless (caps funding cuts)
- HIV data and name-based reporting
- Unexpended funds

What's Funded and Required:

- Medications, medical care, testing
- Core medical services
- Planning councils
- ADAPs

Actors

- Chairs and Ranking Dems of Senate HELP and House E&C committees (the so-called “Bicameral, Bipartisan Working Group”)
- HELP and E&C members including Senators Sessions (R-AL), Burr (R-NC), and Majority Leader Frist (R-TN)
- Senator Coburn (R-OK)
- White House
- Other congressional members
- Governors and mayors
- National, regional, and local AIDS orgs and medical providers

Bipartisan & Bicameral Working Group

House/Senate committees of jurisdiction have led bill drafting:

- Senate Health, Education, Labor, & Pensions (HELP) Committee
- House Energy & Commerce (E&C) Committee

Historic bipartisan, bicameral process led by:

- Sen. Mike Enzi (R-WY), HELP Chair
- Sen. Ted Kennedy (D-MA), HELP Ranking Dem
- Rep. Joe Barton (R-TX), Energy & Commerce Chair
- Rep. John Dingell (D-MI), E&C Ranking Dem

House/Senate Proposal *(as of May 17, 2006)*

- Proposal outline unveiled May 9, 2006
- GAO produced estimates of FY07 funding awards on May 12, 2006
- Community stakeholders invited to provide writing comments by May 12, 2006
- Sen. Enzi and Kennedy expected to introduced bill this afternoon
- Vote scheduled this afternoon in Senate HELP
- Current timeline allows little time for input

House/Senate Proposal *(as of May 17, 2006)*

- Working Group has agreed to a stakeholder session in the House E&C Committee
- Governors of FL, MD, NJ, NY, and TX are urging Congress to allow more time to review proposal
- Many advocates still consider the bill superior to legislation introduced in Feb by Sen. Coburn

House/Senate Proposal *(as of May 17, 2006)*

How Funding is to be Distributed:

- Retains basic title structure now in place
- Expands Title I into three tiers
- Increases Title II funds for rural states
- Phases out protection period (hold-harmless)
- Bases funding on HIV and AIDS cases, not just AIDS
- Allows code-to-name states to approximate HIV cases
- “Severity of need index” will eventually replace Title II formulas

What’s Funded and Required:

- Requires 75% of funding in Titles I-III for “core medical”
- Decreases, without eliminating, planning council role
- Establishes minimum formulary for ADAPs
- Among other requirements, grantees will be measured by their ability to fully expend their grant in the contract year

House/Senate Proposal *continued*

What's Funded and Required:

- New Hepatitis B and C screening, counseling, and vaccination provisions for Title III grantees
- Requires new “lead agency” functions under Title II
- Caps administrative costs at 10%
- Adds Minority AIDS Initiative category to reduce racial and ethnic health disparities

Other provisions:

- Unexpended funds are redirected to ADAP, unless carry-over is approved
- Health Secretary may shift up to 5% of Title I and II supplemental funds if declaration of public health emergency
- Health Secretary may waive the core services requirement if no ADAP waiting lists and “all HV+ people have access to core services”
- HRSA required to report annually to Congress on progress toward client-level data and developing severity of need index (SONI)
- SPNS focus: (1) develop health information systems for client level data and SONI, and (2) services for emerging populations

HIV Data Added to Distribution Formulas

The Proxy: Title I and Title II grantees can approximate their number of HIV cases, until FY10, if:

- The state adopts name-based reporting by Oct 1, 2006*
- Data is not yet mature (as determined by CDC)
- Grantees with mature, name-based HIV reporting systems **do not** use proxy calculation
- Jurisdictions without name reporting will rely solely on AIDS case data*

Proxy Calculation: .9 times number of AIDS cases but annual increases are capped at 10%

***Yet to adopt name-based reporting:** DC, HI, MD, OR, RI, VT

Expanded Title I

Tier 1: Eligibility = 2000 reported living AIDS cases in the last 5 years

- Distribution = 2/3 formula, 1/3 supplemental (same for Tier 2 grantees)
- Hold harmless phased out over 3 years at 90%, 85%, and 80% of FY06 grant
- Planning councils required but funded from grantees' 10% admin cap

Tier 2: Eligibility = 1000-1999 reported living AIDS cases in last 5 years

- In FY07, current EMAs that do not fall into tier 1 are added to this category.
- No hold harmless
- Planning council is optional

Tier 3: Eligibility = 500-999 reported living AIDS cases in the last 5 years

- Funding = \$5M; all formula; No hold harmless
- Planning council is voluntary, but PWHA consultation required

* Eligibility maintained until a grantee goes below the eligibility threshold for three consecutive years. New eligibility determined on an annual basis. Intent of the authorizers that money for grantee moves to new tier if grantee moves.

Expanded Title I

(based on FY04 data reported to CDC on June 30, 2003)

Tier 1: 20 jurisdictions

Atlanta, Baltimore, Boston, Chicago, Dallas, Detroit, Ft. Lauderdale, Houston, Los Angeles, Miami, New York, Newark, Orlando, Philadelphia, San Diego, San Francisco, San Juan, Tampa, Washington DC, West Palm Beach

Demonstrated Need – For competitive supplemental awards (1/3 of grant)

- **Unmet needs**
- **Rate of increase of HIV/AIDS cases or among subpopulations**
- **Cost and complexity of delivering care**
- **Co-morbidities such as homelessness**
- **Barriers to care (geography, language, insurance coverage)**

Expanded Title I

(based on FY04 data reported to CDC on June 30, 2003)

Tier 2: 36 jurisdictions

31 current Title I areas and 5 new ones: *Baton Rouge, LA; Charlotte, NC; Memphis, TN; Nashville, TN; and Indianapolis, IN*

Tier 3: 21 jurisdictions

Albany, NY; Augusta, GA; Birmingham, AL; Buffalo, NY; Cincinnati, OH; Columbia, SC; Columbus, OH; Ft. Pierce, FL; Greensboro, NC; Jackson, MS; Louisville, KY; Milwaukee, WI; Monmouth, NJ; Oklahoma City, OK; Pittsburg, PA; Raleigh, NC; Richmond, VA; Rochester, NY; Sarasota, FL; Wilmington, DE

- Funded from TII “emerging communities”
- Grants range from \$132,000 to \$350,000

New Title II Formula: 75-20-5

Weighted formula factors urban vs. rural:

*0.75 – all HIV and AIDS cases in State

*0.20 – all HIV and AIDS cases outside
of Tier 1 and Tier 2

*0.05 – all HIV and AIDS cases for
States not receiving Tier 1 or
Tier 2 funds

- *75-20-5 ends when Health Secretary certifies “severity of need index”*
- *Proxy number for HIV used for eligible states*

New Title II Formula: 75-20-5

Examples of funding in FY07:

	Base	ADAP*
Missouri	+\$1.1M	+\$2.6M
California	+\$3.1M	+\$8.9M
North Carolina	+\$2.8M	+\$6.1M
Mississippi	+\$0.8M	+\$1.3M
Utah	+\$2.1M	-\$0.03M
New Mexico	+\$2.0M	-\$0.2M
New York	-\$3.1M	-\$16.4M
Texas	-\$1.0M	-\$4.0M
Florida	-\$0.9M	-\$5.2M

**Includes the \$70 million ADAP increase in Bush budget*

What this Means for Illinois?

If enacted as proposed, Illinois' net lose is at least \$80,000 as a best case scenario:

Chicago--Title I / Tier 1:	- \$2,044,550
Illinois--Base:	+ \$1,443,047
Illinois--ADAP:	+ \$ 520,686

Why Best Case Scenario?

- *Current projections presume Illinois and Chicago use a .9 HIV proxy factor.*
- *Chicago may not receive the full 1/3 supplemental competitive awards.*
- *Current estimates are based on five jurisdictions that have yet to adopt name-based reporting. When they make the switch, current estimates for all other jurisdictions will decrease. FY07 projections supplied to Congress also failed to factor supplemental awards, so they are already artificially inflated.*
- *Even though Chicago's award in FY07 may be reduced by 10% or more, it is unclear whether Chicago will qualify for hold-harmless.*
- ***In all likelihood, the net loss to Illinois would be MUCH greater.***

Definition of Core Medical

75% of Title I – III spending must go to:

- Outpatient and ambulatory health services
- ADAP
- AIDS pharmacy assistance
- Oral health
- Early intervention services
- Health insurance premium and cost-sharing assistance
- Home health care
- Hospice
- Home and community-based health (excluding homemaker)
- Mental health services
- Substance abuse outpatient care
- Medical case management, including treatment adherence

Unexpended funds for core medical must be returned to HHS

Questions & Concerns

- Title I and II formulas based on recent diagnoses not HIV/AIDS prevalence
- Restrictive definition of core services
- Criteria to waive core requirements
- Application of core services requirement
- What counts in 10% cap
- Development of “severity of need” index
- Details of minimum ADAP drug list
- Criteria to invoke emergency provisions

Not in draft (...yet?)

- Provisions to secure better ADAP pricing
- Testing and prevention provisions
- Provision allowing ADAP to count toward an individual's out-of-pocket requirements for Medicare Part D
- Early Treatment for HIV provisions
- Re-entry for ex-offenders

Reauthorization Timeline

- **Jan 2005**—Bush calls for CARE Act reauthorization in State of the Union address
- **June 2005**—Sen. Coburn (R-OK) holds hearing on CARE Act funding
- **June 2005**—General Accounting Office (GAO) reports under-funding per capita in rural states as compared to states with large urban areas
- **July 2005**—Bush administration unveils reauthorization proposal
- **Sept 2005**—2000 authorization expires
- **Jan 2006**—Bush calls for CARE Act reauthorization in State of the Union address
- **Jan 2006**—House and Senate committee staff invite stakeholder testimony

Reauthorization Timeline

- **Feb 2006**—Sen. Coburn introduces legislation essentially adopting White House proposal
- **Feb 2006**—Second GAO report issues
- **March 2006**—Senate HELP Committee holds first hearing
- **April 2006**—GAO reports broad variability in state ADAPs, include drug prices paid
- **May 2006**—bipartisan House/Senate proposal unveiled. Senate Committee vote scheduled for May 17; House Committee vote to follow
- **June 2006**—House and Senate floor votes expected
- **Aug 2006**—bill could be signed into law

Influential IL Members

- Senators Durbin & Obama
- Energy & Commerce Members:
 - John Shimkus (Collinsville)
 - Bobby Rush (Chicago)
 - Jan Schakowsky (Chicago)

Learn More

- **Join AFC's Statewide Advocacy Network: sign-up at www.aidschicago.org**
- **Visit the CARE Act Action Center: aidschicago.org/advocacy/care_act.php**
- **NASTAD's Reauthorization Watch: email alefert@nastad.org to join**