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Treatment Access Workgroup

Information

July 15, 1998

UCSF Study on Medicaid Expansion (with press release)

"Expansion of US Medicaid system to cover HIV drugs will prevent thousands of deaths and AIDS diagnoses, and is affordable," James G. Kahn, UCSF et al, July 1998.

Press release on study results through Kaiser Family Foundation

Yale Study on Patterns and Costs of Care

"Changes in HIV/AIDS patterns of care and estimated costs at an urban medical center during the era of HAART," James Rawlings, Yale et al, July 1998.

ADAP Report

"National ADAP Monitoring Project: Interim Technical Report," Arnold Doyle et al, March 1998.

Relevant Newsclips

"Penny Wise, Pound Foolish," by David Gilden, *POZ Magazine*, July 1998

"Administration Drops Effort to Extend Medicaid Coverage for AIDS Therapies," by Amy Goldstein, *Washington Post*, Dec. 5, 1997.

Advocacy Paper on Medicaid Expansion

"Expanding Eligibility for Medicaid to Persons with HIV Disease," AIDS Action Council, AIDS Action Committee of Boston, undated.

Expansion of US medicaid system to cover HIV drugs will prevent thousands of deaths and AIDS diagnoses, and is affordable

James G. Kahn[1] B. Haile[1] S.W. Chang[2]. [1]Center for AIDS Prevention Studies, UCSF, Inst. for Health Pol Stud., UCSF, Box 0936, San Francisco, CA; [2]HJ Kaiser Family Foundation, Menlo Park, USA

Objectives: To assess the health and federal fiscal implications of expanding Medicaid, the US insurance system for the poor, to cover HIV care for those without access to HIV medications.

Design: Computer spreadsheet modeling of HIV disease progression, treatment costs, and financing.

Methods: We compared projected outcomes with and without an expansion, over 5 years. The expansion assessed is for all individuals lacking medical insurance for antiRetroviral medications and with income below $10,000 per year (125% of poverty for a single person). It covers medications and outpatient care. The analysis incorporates estimates of the number of people living with HIV infection by disease stage; current access to antiRetroviral therapy, insurance status, and income; likelihood of qualifying for and enrolling in the expansion; a natural history model of HIV disease progression, calibrated to cohort studies; the efficacy of combination antiRetroviral therapy in reducing HIV disease progression, based on clinical studies; the costs of HIV medications and care; and federal government costs for the expansion.

Results: An estimated 37,100 individuals would enroll in the expansion, 83% pre-AIDS and 17% with AIDS. Over 5 years, there are 5,200 fewer deaths with the expansion than without. 6,700 fewer individuals with early HIV disease progress to an AIDS diagnosis or early death. The expansion increases total life years by 14,500 over the 5 years. Total federal costs for the expansion itself are $1.3 billion over 5 years; these are offset by decreased federal expenditures of $765 million: Medicaid, due in part to slowed progression to AIDS ($385 million), AIDS Drug Assistance Program ($240 million), and other programs ($140 million). Federal budget neutrality, currently required to approve Medicaid waivers to states, can be achieved by an 18% reduction in Medicaid prices for HIV drugs. Despite this price reduction, total spending for HIV drugs increases by $175 million.

Conclusion: This analysis suggests that expansion of the US Medicaid system to provide wider access to combination antiRetroviral therapy would prevent thousands of deaths and AIDS diagnoses, leading to 14,500 more years of life for persons with HIV disease over 5 years. The program is affordable from a federal perspective, with budget neutrality achievable if the expansion is accompanied by an 18% reduction in HIV drug prices for Medicaid.

A new HIV benefit in the U.S. Medicaid system: Health and federal fiscal implications

12th World AIDS Conference
July 1, 1998

James G. Kahn*•, Brian Haile*, Sophia W. Chang†

* Center for AIDS Prevention Studies, AIDS Research Institute, and Institute for Health Policy Studies, University of California, San Francisco

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Background

- Advent of potent triple ARV therapy
- Formal treatment guidelines - ARVs recommended for very large group
- Funding crisis in AIDS Drug Assistance Program (uninsured HIV+ individuals)
- Many still have financial barriers to ARVs

Objective

- Assess the health and federal fiscal effects of expanding Medicaid to cover HIV care for those lacking financial access to HIV medications

Health effects: New AIDS diagnoses
Deaths
Years of life

Fiscal effects: Medical care spending
Income support for disabled
Budget neutrality

Methods

- **Spreadsheet model**
  - HIV disease stages, clinical progression
  - Federal costs: Medicaid, Medicare, AIDS Drug Assistance Program, SSDI/SSI
  - 5 years, all of U.S.
- **Data inputs**
  - **Clinical:**
    HIV natural history
    Current use of ARVs
    Clinical effects of ARV triple therapy
  - **Costs:**
    costs of medical care and ARV therapy
    enrollment in insurance, income programs

Methods (cont'd)

- **New Medicaid benefit**

Eligibility:

- CD4 < 500 or elevated viral load
- inadequate or absent medication coverage
- income < $10,000 per year

Coverage:

- Limited: drugs and outpatient
- Full: drugs, outpatient, inpatient, etc.

assume 90% use ARV triple therapy

Initial HIV/AIDS Disease Distribution

	Number	Proportion aware of serostatus
Asymptomatic CD4 > 500	167,000	0.42
Asymptomatic CD4 < 500	167,000	0.45
Symptomatic	167,000	0.79
AIDS (1993 definition)	150,000	0.92
AIDS (1987 definition)	100,000	1.00
Total	750,000	0.70

Clinical effect of ARV triple therapy

Pre-AIDS to:

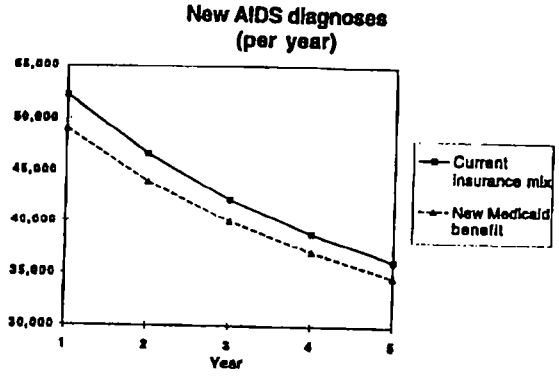
AIDS (6 viral load studies): 60% reduction
Death (1 clinical study): 70% reduction

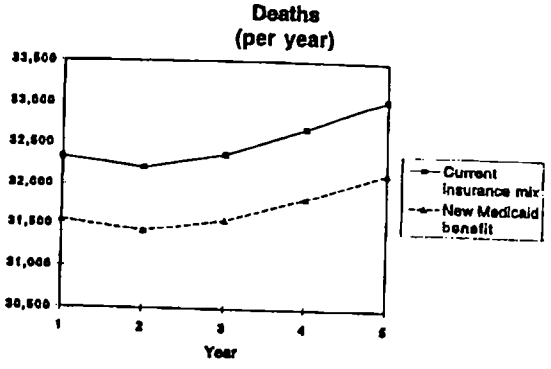
AIDS to:

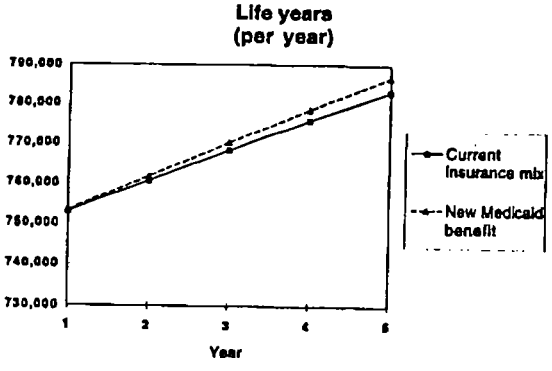
AIDS events (10 clin. studies): 50% reduction
Death (8 clin. studies): 60% reduction

Projected Number of Benefit Participants

No prior access to ARV triple therapy	17,200
Access to triple therapy via subsidies	20,776

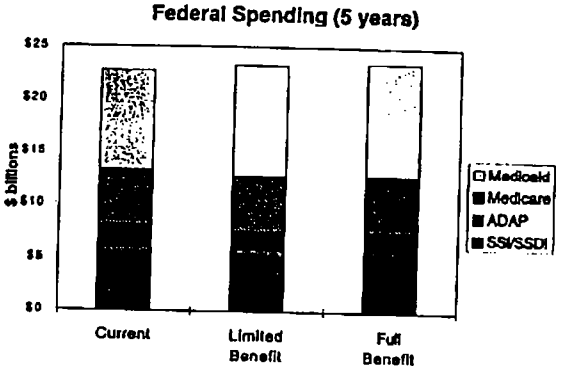






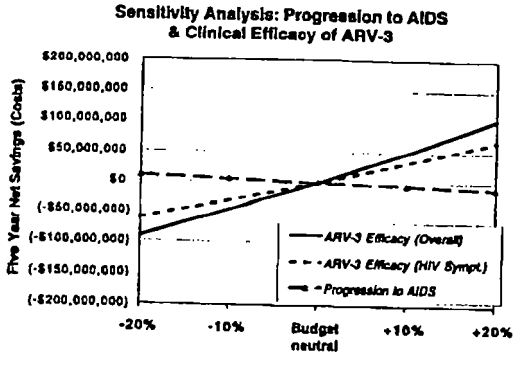
Outcomes - Health
(over 5 years)

- 11,400 fewer new AIDS diagnoses
- 4,200 fewer deaths
- 9,600 more years of life



Outcomes - Federal costs
(over 5 years)

- **Limited benefit**
  - $110 million/year net cost
  - Budget neutral: 11% reduction in Medicaid HIV drug prices
    Still, $190 million net increase in HIV drug sales
- **Full benefit**
  - $160 million/year net cost
  - Budget neutral: 17% reduction in Medicaid HIV drug prices
    $290 million net decrease in HIV drug sales



Implications

New Medicaid benefit

- Substantial health benefits
- Limited benefit: budget neutrality feasible
- Multiple potential beneficiaries of policy
- Key part of increasing access to ARV therapy

Early Access to HIV Treatments for Underserved Populations Found to be Cost Effective

- AIDS Activists Applaud New Research That Puts Added Pressure on

Government Officials to Expand Treatment Access -

GENEVA, July 2 /PRNewswire/ -- New pharmacoeconomic research presented today at the 12th World AIDS Conference demonstrates that providing early access to AIDS treatment for the poor and uninsured would be cost-effective. This study challenges underlying assumptions supporting current Medicaid requirements that withhold treatment from HIV-infected patients until they exhibit the symptoms of full-blown AIDS. Medicaid is the largest payer of HIV-related medical services in the United States.

Current Medicaid eligibility rules extend health care coverage to HIV-infected patients only after they have suffered an AIDS defining illness or after their CD4 count has declined to below 200. Patients living with the HIV virus but without the symptoms of full-blown AIDS are ineligible and, if unable to gain access to AIDS drugs through other means, must delay treatment until they experience the symptoms of AIDS. Although federally funded state-administered AIDS Drug

Assistance Programs (ADAPs) generally cover the drug costs for patients ineligible for Medicaid, many state programs have experienced financial shortfalls due to rapidly increasing enrollments and per patient costs and, as a result, have responded by restricting access to their programs.

AIDS activists attending the conference characterized the pharmacoeconomic study as a solid first step in the development of a critical policy basis for the expansion of life-saving AIDS drug therapies to the uninsured and underinsured. The research, which was conducted by a consortium of academic researchers, professional pharmacoeconomists, AIDS organizations and research-based pharmaceutical interests called the Treatment Access Expansion Project (TAEP), uses established pharmacoeconomic simulation techniques and data from existing clinical trials (Roche clinical trials NV15182 and NV15355) to draw two conclusions:

-- early initiation of treatment with AIDS drug cocktails delays the

progression of AIDS, and

-- providing early treatment (i.e., when the patient has a CD4 count

between 200 and 500 and has never experienced an AIDS defining event)

would result in prolonged survival and would be cost-effective, when

compared to delayed treatment (when the patient has a CD4 count of less

than 200 or has experienced an AIDS defining event).

"At the most basic level, our research shows that patients receiving early, aggressive treatment experience increased lifespan," said Gary Rose, T.II.C.A.N.N. (Ryan White CARE Act Title II Community AIDS National Network) public policy director and community liaison with the Treatment Access Expansion Project and a chief researcher on the project. "Moreover, the overall cost of providing patients with this survival benefit is negligible."

In April 1997, Vice President Al Gore directed federal health officials to determine the feasibility of expanding Medicaid coverage to make new AIDS drugs available to the uninsured for early HIV treatment. In December, the Clinton Administration announced that an expansion in Medicaid along these lines would be too costly. "Ability to pay should not have to be a barrier to early intervention for people with HIV," said Daniel Zingale, Executive Director of the AIDS Action Council.

The new pharmacoeconomic study shows that early HIV treatment would increase life expectancy of currently infected asymptomatic patients (patients with a CD4 count between 200-500 and never having experienced an AIDS defining event) by 0.43 years (unadjusted for quality of life). The researchers determined that these gains in life expectancy would result in longer treatment with protease inhibitors and an expected increase in lifetime costs per patient of 2.2%. Ultimately, however, early AIDS treatment is projected to delay progression of AIDS-defining events and prolong survival, at a cost well within the range of generally accepted cost-effective medical interventions.

"This pharmacoeconomic study provides an important addition to any discussion on early treatment," said Dr. John Hornberger, Director of Health Economics in Roche Global Pharmacoeconomic Research. "By delaying the onset of the symptoms of AIDS, early treatment only slightly increases medical-care costs over the first 5 years by $241 per patient per year."

The principal sponsor of the TAEP pharmacoeconomic study is Hoffmann-La Roche. Roche Laboratories, a subsidiary of Hoffmann-La Roche, markets more than 35 medications in major therapeutic areas including AIDS, oncology, transplantation, infectious diseases, cardiovascular diseases and dermatology.

Treatment Access Expansion Project: TAEP was initiated to develop and disseminate sophisticated pharmacoeconomic models for use by federal, state and local governments and other entities concerned with the budget

implications of providing treatment to people living with HIV/AIDS. TAEP consists of a consortium of academic researchers, professional pharmacoeconomists, AIDS organizations and research-based pharmaceutical interests.

T.II.C.A.N.N.: The Ryan White CARE Act Title II Community AIDS National Network (T.II.C.A.N.N.) is a non-profit organization dedicated to initiating and supporting activities that ensure access to care for all Americans living with or affected by HIV.

Roche Laboratories Inc.: Roche Laboratories Inc. is the marketing and sales subsidiary of Hoffmann-La Roche Inc., a leading research-intensive pharmaceutical company. Roche Laboratories markets more than 35 medications in major therapeutic areas including AIDS, oncology, transplantation, infectious diseases, cardiovascular diseases and dermatology.

SOURCE Treatment Access Expansion Project

CO: Treatment Access Expansion Project; Roche Laboratories Inc.; T.II.C.A.N.N.

Changes in HIV/AIDS patterns of care and estimated costs at an urban medical center during the era of heart

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Objective: To estimate the patterns and costs of HIV/AIDS inpatient and outpatient care at a 700 bed urban hospital in the era of highly active Retroviral therapy (HAART).

Methods: Evaluation of utilization of inpatient and outpatient hospital services; all patients with HIV/AIDS related admissions identified by ICD-9 coded discharge diagnoses; outpatients identified by attendance at hospital-based HIV-specific primary care clinic. Cost of care determined by Resource Information Management System (RIMS), a computerized fiscal data system which assigns costs for all inpatient and outpatient hospital-related services. Antiviral and nursing home costs were estimated from separate patient matched databases.

	10/94-9/95*	10/95-9/96*	10/96-9/97*
Admissions	830(-10%)	801(-3%)	662(-17%)
Inpatient days	9102(-12%)	7258(-20%)	5368(-26%)
Average Length of Stay	10.9(-4%)	9(-15%)	8.1(-10%)
Unique outpatients	660	692(5%)	741(7%)
Outpatient visits	5523(+3%)	5920(+7%)	6522(+9%)
Inpatient service costs	$10,101,399	$8,542,171(-15%)	$6,483,350(-24%)
Outpatient service costs	$1,554,761	$1,588,857	$1,754,634
AIDS nursing home	--	$693,600	$658,920
Antiviral costs (estimated)	$1,481,000	$1,992,000(+35%)	$4,039,000(+103%)
Viral load costs	--	--	$125,031
Total cost	$13,137,160	$12,816,628	$13,060,935
Cost/patient/year	$19,904	$17,519	$16,736

*Changes compared to previous year.

Conclusion: During the period of introduction and availability of HAART, acceleration of already-occurring favorable shifts in utilization of services and associated costs occurred. Outpatient and non-hospital utilization/cost and antiviral costs increased, but were offset by dramatic decreases in utilization/cost of inpatient care. Although the total number of patients in care increased, overall costs remained level and cost/patient/year decreased. Our analysis suggests that HAART is cost-effective.

NASTAD
NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS

THE HENRY J. KAISER FAMILY FOUNDATION

AIDS Treatment Data Network

National ADAP Monitoring Project:
Interim Technical Report
March 1998

Report By

Arnold Doyle
Richard Jefferys
Joseph Kelly

National Alliance of State and Territorial AIDS Directors
and
AIDS Treatment Data Network

Supported by a grant from The Henry J. Kaiser Family Foundation

Executive Summary

AIDS Drug Assistance Programs (ADAPs) are state-administered drug reimbursement programs that provide access to HIV/AIDS medications for low income, uninsured and underinsured individuals. Funded through the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and by many states, these programs form one link in the continuum of publicly financed health care for lower income individuals living with HIV/AIDS, along with other CARE Act-funded programs, Medicaid, Medicare and local indigent health care programs. ADAPs operate in all fifty states, the District of Columbia and Puerto Rico.

These programs, initially intended to provide a safety net of temporary prescription drug coverage for lower income, uninsured or inadequately insured people living with HIV/AIDS, are now being called upon to fill a steadily growing gap in drug coverage for the HIV-infected population. Increases in numbers of clients utilizing ADAP services, the approval of new, promising and expensive anti-HIV treatments, the acceptance of combination therapy as the standard of care, rising ADAP expenditures, and restrictions on access to other public health care programs have moved ADAPs to further expand their umbrella of coverage. This raises the concern of whether ADAPs are able to adequately fill the growing gap in prescription drug coverage for people living with HIV/AIDS.

The National Alliance of State and Territorial AIDS Directors (NASTAD), in collaboration with the AIDS Treatment Data Network (ATDN), was commissioned by the Henry J. Kaiser Family Foundation to conduct a two-year National ADAP Monitoring Project. This Interim Technical Report provides an update of the data presented in the first National ADAP Status Report, released July 1997, and continues our efforts to track developments in the rapidly changing environment surrounding HIV/AIDS health care and therapy access. The update describes trends in the number of individuals served by ADAPs; drug expenditures; the fiscal status of ADAPs; and responsiveness to changes in treatment recommendations. A comprehensive update review of these programs is scheduled for release in Fall 1998.

Methods

In September 1997, a National ADAP Update survey was distributed to the 52 jurisdictions receiving Ryan White CARE Act Title II ADAP funds. The survey response rate was 100%, with all fifty-two jurisdictions reporting. Here are the major findings:

Update in the Number of Clients Served

The overall number of clients served by ADAPs continues to increase, although program growth is occurring at different rates across states, including some declines:

- Nationally, states report that 43,494 unduplicated clients were served by ADAPs during July 1997 compared to 37,506 clients in January 1997 – a 16% increase. When compared to data from the July 1996 period, there has been a 39% increase in the number of clients served.

- Thirty-nine states report increases in the number of clients served in July 1997 compared to January 1997. Six states report increases in clients served of 50% or more: Alaska, Delaware, Georgia, Louisiana, Rhode Island and South Carolina.

- Ten states report no growth or actual decreases in clients served: Connecticut, Idaho, Massachusetts, Mississippi, Montana, North Dakota, Oregon, South Dakota, Tennessee, and Virginia.

Expenditure Update

ADAP program expenditures, including expenditures for antiretroviral drugs, continue to grow as do the number of prescriptions filled by ADAPs.

- Forty-two states report increases in monthly ADAP expenditures, when July 1997 data are compared to January 1997. Fifteen of those states reporting increases of 50% or greater. Those states are Alaska, Delaware, Florida, Indiana, Iowa, Louisiana, Missouri, Nebraska, New Hampshire, North Carolina, Ohio, Rhode Island, South Carolina, Vermont and Wisconsin.

- Monthly ADAP expenditures increased 36% nationally, from $19.5 million in January 1997 to $26.6 million in July 1997. A comparison with data from the previous national ADAP survey indicates a 78% growth in monthly expenditures by ADAPs nationally when July 1996 are compared to July 1997 data.

- States report that the total number of prescriptions filled for all drugs on ADAP formularies increased by 24% from 105,236 in January 1997 to 130,336 prescriptions filled in July 1997. Notably, the number of protease inhibitor prescriptions filled by state ADAPs increased by 75% from 12,530 to 21,951 when comparing the same time periods.

- States report a 38% growth in expenditures for antiretroviral drugs from $15 million in January 1997 to $20.7 million in July 1997. There was a reported 20% growth in expenses related to other formulary drugs (including drugs for the prevention and treatment of opportunistic infections) from $4.8 million in January 1997 to $5.7 million in July 1997.

ADAP Budget Update Since the Last Report

The total national ADAP budget (including all sources[1]) increased from $385 million to $422 million since the last report. This represents an overall increase of 9.6% or $37.1 million. The increase includes a 9% increase in federal and state funds, from $358.5 million to $390.8 million.[2] Moreover, a number of state programs secured additional FY 1997 funding:

- Thirty-six states now supplement federal dollars with state-specific fiscal support (6 additional states since the last report).

- Thirteen states realized increased state/local general revenue support over the six-month period – Arizona, the District of Columbia, Florida, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Nevada, Oklahoma, Pennsylvania, Tennessee, and Vermont.

- Six states provide the vast majority (78%) of ADAP funds provided by states– California, Illinois, Louisiana, Massachusetts, New York, and Pennsylvania.

- Sixteen states do not provide any funds specifically for ADAP and therefore rely solely on federal funding to provide ADAP services. These 16 states are: Alaska, Arkansas, Delaware, Idaho, Iowa, Kansas, Michigan, Mississippi, Montana, Nebraska, New Hampshire, North Dakota, Oregon, Rhode Island, South Dakota and Wyoming.

Emergency Cost-Containment Measures Continue

Despite an overall increase in the national ADAP budget, there continues to be disparity in the diversity of funding sources that are available to and utilized by ADAPs and many states are relying on emergency measures to continue to meet client demand and expenditures. Twenty-three states are currently curtailing ADAP services or facing budget shortages which may result in reduced services early in 1998. For example:

- Thirteen states report that they will exhaust their ADAP budgets before the next round of federal funds is available on April 1, 1998. These states are: Alabama, Alaska, Arizona, Colorado, Idaho, Kansas, Kentucky, Maine, North Carolina, Puerto Rico, Texas, West Virginia and Wyoming. At the time of the last report, eleven states reported anticipated budget shortfalls, six of which continue to do so.

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[1] All sources include federal (Ryan White CARE Act Title II base and supplemental funds and Title I funds), state/local funds, and other funds such as drug rebates and insurance recovery.

[2] The largest category in the 1997 national ADAP funding system, the FY 1997 federal Title II ADAP supplemental funding ($167 million), remained constant since the last report. Federal increases therefore are from increases in Ryan White Title II base funding and Ryan White Title I eligible metropolitan area (EMA) contributions.

- Fifteen states report that they are maintaining waiting lists for entry to ADAP or for access to protease inhibitors (this is the same number of states which reported such waiting lists at the time of the first report, 12 of which continue to do so and three report waiting lists for the first time). The nine states which currently report waiting lists for entry to ADAP are: Alabama, Florida, Georgia, Indiana, Mississippi, Montana, Nevada, South Carolina and South Dakota. In addition, North Carolina has stopped authorizing new clients for program participation since September 1997, although the program does not maintain a waiting list. The seven states which currently maintain waiting lists for clients to access protease inhibitors from the ADAP are: D.C., Idaho, Kentucky, Maine, Mississippi, Oklahoma, and Nevada (Nevada also has a waiting list for entry to ADAP).

ADAP Formularies and Responsiveness to Evolving Standards for Clinical Practice

At a time of rapid advances in the clinical management of HIV/AIDS[3] and finite resources, states report efforts to: expand formulary coverage, broaden provider and community input in formulary development, and respond to federal treatment guidelines.

- Forty-five states report that they have formal ADAP advisory bodies in place that assist in making formulary decisions and, in some cases, decisions regarding the administration and structure of the ADAP.

- Forty-two states have changed their formularies since our previous report. Forty-nine states now cover the most recently FDA-approved protease inhibitor, nelfinavir (Viracept). Two ADAPs (Arkansas and South Dakota) currently do not cover any protease inhibitor. Forty-four states cover the first approved NNRTI, nevirapine (Viramune).

- Fifteen states report expanding the ADAP formulary to cover the eleven approved anti-viral drugs referenced in the antiretroviral guidelines, in addition to the states already providing coverage for these treatments. States have taken other actions in response to the PHS/NIH guidelines, including updating state/local treatment guidelines and developing provider education programs.

- Ten states added drugs for the treatment and prevention of opportunistic infections (OIs). However, there continues to be significant disparity among ADAPs in their coverage of OI treatment/prophylaxis. Only two state ADAPs cover the 14 drugs strongly recommended for the prevention of OIs in the PHS/IDSA guidelines.

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[3] In June 1997, "Draft Guidelines on the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents" were released by the Public Health Service (PHS), in collaboration with the National Institutes of Health (NIH) and the Henry J. Kaiser Family Foundation. Also in June 1997, the PHS in collaboration with the Infectious Disease Society of America (IDSA) released "Guidelines for the Prevention of Opportunistic Infections in Persons Infected with HIV."

Relationship of ADAP to Medicaid and Private Insurance Coverage

The relationship between ADAP, Medicaid and private insurance has come under increased scrutiny as states seek to maximize non-ADAP sources of pharmacy benefits in order to reduce the burden on ADAP. Some states utilize insurance continuity programs to reduce the burden on their ADAP and provide stable access to health care services. In order to monitor emerging trends, states were asked to describe efforts to ensure that ADAP is the payer of last resort, discuss areas of cooperation between Medicaid and ADAP, and assess the impact of Medicaid coverage on the state ADAP.[4] For example:

- Approximately 7 percent of ADAP clients served in July 1997 were also current Medicaid beneficiaries (including those in the spenddown process). The reported percentage of ADAP clients estimated to have Medicaid benefits varies greatly from state to state. Twenty-one states reported that no active ADAP clients were Medicaid beneficiaries.

- Thirty-nine ADAPs indicate that they have mechanisms to cross-check/coordinate client eligibility with the state Medicaid program. Twenty ADAPs report that they routinely back-bill Medicaid when an ADAP client receives retroactive Medicaid benefits.

- Approximately 7 percent of ADAP clients served in July 1997 had private health insurance that provides some level of prescription drug coverage, although this percentage varied greatly by state.

[4] State AIDS programs were asked to identify Medicaid policies in their states that may result in increased demand on ADAP. An analysis indicates that nineteen of the twenty-three states identified as having less expansive Medicaid coverage (i.e., no medically needy eligibility category, low spenddown threshold and/or prescription drug limits) are also states with restricted access to ADAP.

Poz 7/98

THE GILDEN AGE

Penny Wise, Pound Foolish

Medicaid for HIV is an idea too simple for its time

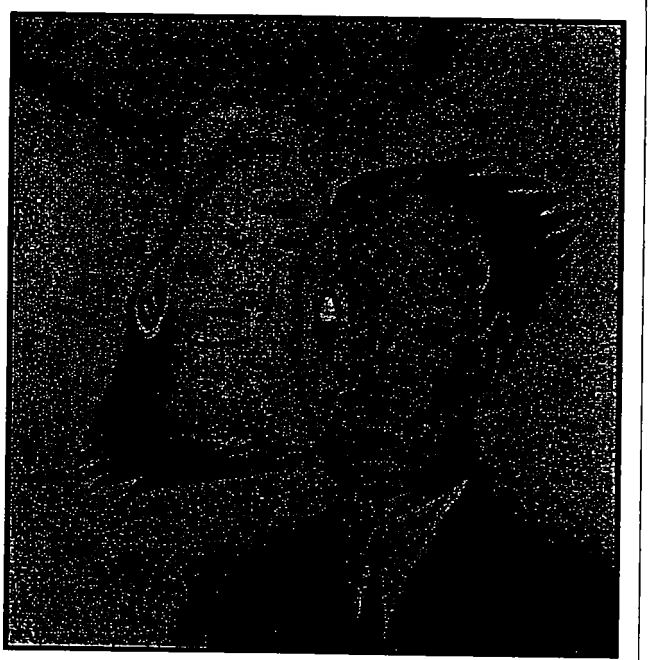
BY DAVE GILDEN

There's an old saying that every crisis creates opportunities. But every opportunity also creates its own crises. The arrival of potent combination therapies for HIV promises to stabilize the disease for many, vastly increasing the popularity of early treatment and sparking a sharp drop in new AIDS diagnoses. At the same time, these drugs are expensive, and exacerbate the crisis in our nation's patchwork system of health care. We want people to stay healthy, yet who will pay for years of antivirals?

Hundreds of thousands who lack insurance but are ineligible for Medicaid fall through the cracks. The federally funded, state-run AIDS Drug Assistance Programs (ADAPs) help those not so poor, not so sick. But by failing to finance overall medical management (e.g., lab tests and doctor visits), ADAPs encourage improper use of antivirals and increase the likelihood of drug failure. And since funding does not automatically grow with demand for treatment, ADAP periodically faces bankruptcy.

In spring 1997, Vice President Al Gore endorsed a community proposal to provide coverage for most of those in medical freefall: Instead of waiting for a person to develop AIDS and qualify for disability, why not have Medicaid include everybody with HIV below a certain income level? Medicaid is more complete than ADAP and provides more care with less hassle than the deteriorating private-insurance system.

This plan was apparently too simple for our times. Under the current balanced-budget regime in Washington, you can only save a life if you save a dollar, it seems. When health-department actuaries projected expenses over the next five years, they found that Medicaid for HIV would be too costly. This conclusion was predictable enough: Even if denied treatment, most people with HIV won't require expensive medical care in this short term. More valid assumptions—for example, using a 10-year time frame—might drastically alter the financial outlook.



In America, you can only save a life if you can save a dollar.

Advocates for this proposal turned to the states after the federal rejection. States can apply for waivers to add extra Medicaid coverage for HIV, so long as they promise to foot any extra bills. At present, Massachusetts is moving to apply for such a waiver, with Florida, Mississippi and Maine likely to soon follow. The state efforts would apply to people with HIV who earn less than twice the poverty level. Most beneficiaries would be childless adults with an income of $14,000 or less and who formerly would have been on "home relief," a program largely eliminated by so-called welfare reform. Others would be household heads cut off from temporary aid to needy families.

At best, such state programs would constitute demonstration projects showing how a comprehensive approach to early HIV care would work. They would provide solid data on the demand for such programs and the required initial layout. Far from automatically sponsoring the most aggressive therapy, as ADAP might, their comprehensive nature would allow physicians to monitor patients and treat when their best judgment recommends it. Such systematic health care could accelerate medical research by tracking the outcome of various therapeutic strategies. Still, it sounds like the state waivers just continue the patchwork system, doesn't it?

Initial annual outlays of several billion dollars probably are needed to extend Medicaid nationally, but Clinton's 1999 budget contains only an additional $100 million for ADAP. Daniel Zingale, director of the AIDS Action Council in Washington, says, "Everyone in the administration knows extending Medicaid makes no sense, but they think they can only make changes if they're budget neutral."

Washington's misers can quibble forever over how much money might ultimately be saved through more early treatment. It all depends on such imponderables as the rate of disease progression despite the drugs and the future costs of caring for those who get AIDS. Yet the epidemic provides a grand opportunity to recognize the social damage inflicted by death and disease. AIDS will remain a crisis until we seize that opportunity and move to control HIV in all Americans. ■

THE WASHI

Administration Drops Effort to Extend

IGTON POST SK FRIDAY, DECEMBER 5, 1997 A23

Medicaid Coverage for AIDS Therapies

By Amy Goldstein
Washington Post Staff Writer

The Clinton administration has abandoned an attempt to use Medicaid to ensure that tens of thousands of poor, HIV-infected Americans who still are relatively healthy could afford new therapies that may prolong their lives, according to federal health officials.

The decision comes eight months after Vice President Gore announced to a roomful of AIDS activists that he had directed the U.S. Department of Health and Human Services to explore ways to "ease suffering, renew hope and ensure that good people are not priced out of life-saving medicine." The department had hoped to cover the drugs by expanding Medicaid, the federal health insurance program for the poor and disabled. But by law, Medicaid can start innovative experiments only if it can prove that they will not add to the program's expenditures.

Department sources said yesterday that, although officials had hoped that by paying for more people to get therapies, they could reduce the cost of their medical care in the long run, they had concluded that the drugs were simply too expensive.

"No matter how we sliced it, we could not come up with a way," said one senior department official. "We might have to take responsibility for being too optimistic at the beginning."

For AIDS activists and public health officials, the prospect had been heralded as an end to what they have complained for years is a short-sighted approach to medicine: Medicaid will cover low-income AIDS patients once they become sick enough to qualify as disabled, but—in many cases—it will not cover treatments that may keep them healthier.

The issue focuses attention on a fundamental problem as the AIDS epidemic in the United States has reached a new phase. Research has made important strides lately, developing new classes of drugs and new drug combinations that have proven effective at slowing the virus's ravaging effects. At the same time, those benefits are not reaching all Americans alike, particularly as the epidemic has tilted heavily toward minorities and the poor.

Between 1995 and last year, the percentage of people who developed full-blown AIDS decreased by 13 percent, according to the Centers for Disease Control and Prevention. But the drop was just 5 percent among Hispanics, and there was no improvement among African Americans.

To try to make drugs more accessible, the administration persuaded Congress this year to increase its funding of the AIDS Drug Assistance Program (ADAP) by 70 percent to $285 million. But during the last two years—as word of the new, more effective drugs spread—many states ran out of their ADAP funds. Even now, AIDS activists say they are uncertain whether that infusion will cover the escalating demand for the new combinations of drugs, which cost an average of $12,000 a year for each patient.

Yesterday, federal health officials emphasized that they would continue to search for other ways to use the Medicaid program to provide AIDS drugs to healthier people, such as encouraging individual states to apply for experiments or asking Congress to appropriate more money.

But one senior department official acknowledged, "We don't have a plan B at the moment."

Another official said that, before abandoning the nationwide expansion, the Health Care Financing Administration, which oversees Medicaid, had studied four scenarios under which Medicaid would provide the benefits to HIV-infected people at 100 percent, 200 percent, 250 percent or 300 percent of the poverty level.

They concluded that, in the first year, that expansion would help 44,000 to 114,000 HIV-infected Americans. "Unfortunately, none of [the scenarios] are revenue neutral—or close," the source said.

According to one AIDS activist, health officials said it would cost about $800 million a year to cover people at 100 percent of poverty.

"In the scheme of things, this isn't a whole lot of money," said Joseph Kelly, deputy director of the National Alliance of State and Territorial AIDS Directors. "What we need is the political will to do it."

But Daniel Zingale, executive director of the AIDS Action Council, said, "I still believe we can work with the administration to address the problem."

EXPANDING ELIGIBILITY FOR MEDICAID TO PERSONS WITH HIV DISEASE

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EXPANDING ELIGIBILITY FOR MEDICAID TO PERSONS WITH HIV DISEASE

INTRODUCTION

Recent research has shown that a long-held assumption about AIDS was wrong—there is no initial dormant phase of HIV infection. Instead, the virus attacks the body's immune system from the outset. This improved understanding of how HIV functions, along with the advent of powerful new medications, has led to new recommendations for care and treatment. Specifically, experts now advise comprehensive care and treatment, often with combination drug therapy, from the earliest stages of HIV disease.

Despite the experts' recommendations for early treatment and the existence of effective drugs, significant obstacles to accessing care and medications remain for low income people living with HIV. Existing programs cannot meet the need for comprehensive health care and preventive services. The current Medicaid requirements force most HIV positive individuals to wait until they develop full-blown AIDS to become eligible for coverage, a model which is inconsistent with clinical standards, inhumane, and costly.

EARLY INTERVENTION WORKS, SAVING LIVES AND DOLLARS

The new standard of care for people with HIV emphasizes early clinical intervention, calling for both primary care and combination drug therapy, including protease inhibitors, at earlier stages of infection. The National Institutes of Health (NIH) report that "...it has been suggested that the best opportunity to eradicate HIV infection is provided by the initiation of potent combination antiretroviral therapy during primary infection."[1] According to Dr. David Ho, director of the Aaron Diamond AIDS Research Center, mathematical models suggest that patients caught early enough and treated with combination drug therapies could be free of HIV in two to three years.[2]

While complete eradication of the HIV virus from the body has not yet been demonstrated, combination drug therapies have proven effective for many, driving viral loads (the amount of virus in the blood) below detectable levels, and maintaining or dramatically improving overall health. Combination therapies can slow the progression from HIV to AIDS, and can help prevent opportunistic infections (OIs). For example, researchers at NIH's National Eye Institute recently discovered that a combination of protease inhibitors and other anti-HIV drugs can prevent or delay the progression of cytomegalovirus (CMV) retinitis, a common complication of AIDS which causes blindness without proper treatment.[3] Some patients in

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Combination drug therapies including protease inhibitors are expensive, with costs ranging from $8,000 to $10,000 per year. But several studies have indicated that the dollars spent "up front" on these medications are offset by later savings on hospitalizations and other expensive care and treatment for AIDS-related illnesses. A study by Dr. Peter Ruane of the Tower Infectious Disease Medical Associates in Los Angeles found that each dollar spent on combination drug therapies resulted in at least two dollars of savings on overall treatment costs, which declined 23 percent.[5] The same study reported a 57 percent drop in the average number of days patients spent in the hospital. Data from Saint Vincent's Hospital in New York support the conclusions of the Tower study, showing a significant decrease in inpatient care, both in terms of the number of people hospitalized and the average length of stay.[6]

The findings of the protease inhibitor studies—that early intervention and treatment can prolong health and reduce the need for more expensive treatment later—are consistent with earlier studies on the cost-effectiveness and beneficial impact of preventive treatment. Researchers at Johns Hopkins Hospital compared the outcomes of patients who received prophylactic treatment for the opportunistic infection *Pneumocystis carinii* pneumonia (PCP) with those who did not receive such treatment. The patients not taking prophylaxis accounted for all of the deaths attributed to PCP, 85 percent of the hospital days, 100 percent of the Intensive Care Unit days, and 89 percent of the inpatient charges. The study concluded that those "who developed PCP despite prophylaxis had a better outcome and used fewer resources than patients not receiving preventive therapy."[7] Another study examining preventive treatment for PCP found that prophylaxis resulted in longer life and a savings of $16,503 for each patient, as compared with no prophylaxis.[8]

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Medicaid patients with HIV in Baltimore found that monthly costs for people with CD4+ T-cell counts under 50 (generally a sign of more advanced HIV disease) were more than twice those of people with more than 500 T-cells.[9] Stated simply, providing care for those who are seriously ill costs more than caring for healthier people. Yet under the present Medicaid system, many living with HIV must wait for their T-cells to drop and their illness to worsen before they can receive coverage and access care.

GAPS IN HEALTH CARE COVERAGE REMAIN

The advances in overall health care and drug treatments have brought renewed health and unprecedented hope to many people living with HIV disease. For the first time in the 15 years of the AIDS epidemic, there has been a decrease in the numbers of Americans dying from AIDS. The U.S. Centers for Disease Control (CDC) reported a 13 percent decline in the number of AIDS deaths for the first six months of 1996, as compared to the same period in 1995, and attributed this decline to improved medical care, prophylaxis for OIs, and the use of combination therapies.[10]

In the same report, however, the CDC noted that AIDS continues to be the leading cause of death of Americans aged 25 to 44, and that the "increased prevalence of AIDS [in the U.S.] indicates the need for medical and other services for persons with HIV infection." While the new medications make obtaining care more important than ever, challenges in expanding access to primary care and treatment remain.

Medicaid provides access to health care coverage for low income, uninsured, disabled people. Individuals who are HIV positive but have not been diagnosed with AIDS, however, are often not eligible for Medicaid, because they do not meet the program's disability standards or other categorical eligibility requirements. To qualify for Medicaid, people must meet income requirements and the disability criteria of the federal Supplemental Security Income (SSI) program. The Social Security Administration uses the CDC's definition of AIDS, along with evidence of functional impairments, as proof of disability.[11] **Despite the fact that early clinical intervention—including primary care, preventive services, and medication therapies—has been shown to improve health and delay the onset of expensive opportunistic infections, most HIV positive individuals must wait until they "get sicker" and develop AIDS before they can receive Medicaid.**

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This is particularly devastating because the populations in which HIV infection is increasing are the ones likely to enroll in Medicaid once their HIV infection becomes full-blown AIDS. The epidemic is growing fastest among groups which have traditionally been socioeconomically disenfranchised, including racial and ethnic minorities, injection drug users, and women. In 1996, for the first time, blacks accounted for more AIDS cases than whites (41 percent versus 38 percent).[12] Women represented 20 percent of new AIDS cases in 1996, up from seven percent in 1985. While overall AIDS deaths declined 19 percent in the first nine months of 1996, deaths among blacks decreased 10 percent and deaths among women, only seven percent.[13]

These populations are also the groups less likely to have health insurance and access to treatments, and more likely to face barriers in obtaining health care, according to a survey by the Agency for Health Care Policy and Research.[14] People who are uninsured or underinsured not only lack access to expensive combination therapies, but also to basic primary care and preventive services.

Additionally, current Medicaid requirements undermine public health efforts by preventing many people with HIV from receiving care earlier in their disease. Under the present system, we are often not reaching these people to teach and reinforce behavior changes which can prevent HIV transmission. Even if people are able to obtain the new combination therapies, they may lack access to the primary care and medical case management needed to ensure that the prescribed treatment regimen is appropriate and effective, and to support them in following complex treatment plans. If patients do not strictly comply with their combination therapy regimens, they are likely to develop drug-resistant strains of HIV. The existence of such drug-resistant HIV mutations may further complicate public health efforts to combat AIDS.

Despite the existence of federal AIDS programs, such as the AIDS Drug Assistance Programs (ADAPs) and the other components of the Ryan White CARE Act, Medicaid serves as the foundation of AIDS care through its provision of both comprehensive health care and drug therapies. ADAPs provide limited prescription drug coverage for some uninsured and underinsured people with HIV and AIDS. But these programs cannot (and are not designed to) meet the need for comprehensive primary care and diagnostic services. In spite of their limited mission—to provide access to a limited formulary of proven AIDS medications—ADAPs face severe financial pressure in many states, and often cannot meet the growing demand for new combination therapies. In some states, ADAPs do not even cover protease inhibitors, and many offer a very limited formulary of antiretroviral and OI drugs. In other states, there are lotteries, long waiting lists, and increasingly restrictive eligibility criteria for ADAP participation.

While other Ryan White CARE Act programs pay for some primary care and drug

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[12] Centers for Disease Control, *Morbidity and Mortality Weekly Report*, February 28, 1997, 46: 165-173.

[13] B. Seitz, "AIDS Sufferers Living Longer," ABC News.com, July 15, 1997.

[14] P. Mohr, Patterns of Health Care Use Among HIV-Infected Adults: Preliminary Results," *AIDS Cost and Services Utilization Survey*, Agency for Health Care Policy and Research, September 1994: 3.

reimbursement, they are not intended to provide widespread comprehensive health care. Ryan White funding is used for a range of care and services, including food, transportation, and case management for people living with AIDS. Additionally, many ADAPs and Ryan White-funded primary care programs have eligibility criteria which exclude people in the earlier stages of HIV disease. These programs lack the financial resources to broaden their eligibility criteria to cover such individuals.

The Medicaid eligibility framework—requiring total disability to qualify for coverage— is at odds with current clinical and public health knowledge. Many low income HIV positive individuals with relatively intact immune systems are not presently eligible for Medicaid, but will eventually qualify for Medicaid after developing AIDS. Unable to afford adequate treatment early in their HIV disease, they cannot obtain the health care services necessary to manage the disease, and will be more ill when they do enroll in Medicaid. Ironically, earlier access to these medical services and treatments would enable them to preserve their health, learn how to prevent transmission of HIV to others, and avoid more costly care such as inpatient hospitalization. For humane, financial, and public health reasons, it is time to make Medicaid's eligibility requirements consistent with the clinical realities of HIV disease.

A COLLABORATIVE RESPONSE

In response to the contradictions between current Medicaid disability criteria and AIDS clinical evidence and care standards, which call for early treatment of HIV disease, representatives from the AIDS Action Council, community-based AIDS service organizations, the Health Care Financing Administration (HCFA) and the Office of Management and Budget (OMB) have begun to work collaboratively to address these issues. Response from the administration has been unequivocally supportive, culminating in an endorsement from Vice President Al Gore, who has asked HCFA to find ways in which to expand Medicaid and allow more low-income Americans with HIV to access care and therapies. Gore is quoted as saying "[Medicaid expansion] can ease suffering, it can increase hope, and it can get new drug therapies into the hands of people who need them." As a result of these collaborations, we are all working together under HCFA's leadership to develop a plan for expanding eligibility to Medicaid for persons who are HIV positive.

AN AIDS-SPECIFIC EXPANSION

As participants in these discussions, we have recognized several reasons for an AIDS-specific expansion of Medicaid. We believe that it serves the interests of public health, scientific knowledge, and fairness to broaden Medicaid coverage to include people with HIV.

Public health: With earlier health care and treatment, as mentioned above, people living with HIV are more likely to avoid behaviors which can spread the virus, and are more likely to adhere to complex treatment plans, which can both prolong health and prevent development of drug-resistant strains of HIV. Earlier access to care can also serve as an incentive for people to learn their serostatus for the first time, and then take steps to avoid either contracting or transmitting HIV.

Scientific knowledge: Protease inhibitors and other new medications received rapid FDA approval, have not yet been in long-term use, and have been researched mainly by studying people in more advanced stages of HIV disease. There are many remaining questions about the benefits, risks, and best way to use combination therapies in people who are HIV positive, but do not have AIDS. A Medicaid expansion demonstration project which brings people with HIV into care provides the opportunity to gather data and conduct research studies designed to answer these questions.

Fairness: The current Medicaid system requires most low-income people with HIV to develop AIDS in order to gain access to health care and new combination therapies. This is in conflict with principles and guidelines recently released by the Department of Health and Human Services and the NIH, which call for earlier intervention with combination drug therapies as the standard of care for the treatment of HIV in most cases. The government should ensure that this standard of care, endorsed by its own agencies, is accessible to those who have no other way to obtain it. Our federal government has always recognized the importance of ensuring access to treatment for other communicable diseases, such as sexually transmitted diseases and tuberculosis—it is unfair and inhumane to deny such treatment to people with HIV.

PROPOSAL DESIGN

The objective of this program is to expand Medicaid eligibility to low-income individuals who have tested positive for the presence of HIV and who would otherwise be eligible for Medicaid once their health status met an AIDS-defining diagnosis. States participating in this initiative will demonstrate that the provision of earlier access to care and treatment will extend the period of time that a person who is HIV positive remains asymptomatic, defer the onset of opportunistic infection, and delay hospitalization, all of which will result in significant cost savings and life-enhancing benefits. The following section describes what we believe are the core components of this initiative.

Eligibility

Any and all individuals who meet the following criteria will be eligible under this program:

- test positive for the presence of HIV; and
- have income at or below 200 percent of the federal poverty level.

State demonstrations will coordinate resources with other private, state, and federal programs. Individuals with private insurance can apply for and become eligible for Medicaid as a "wrap-around benefit" thereby maximizing private insurance participation. State proposals will specify the state specific eligibility guidelines and coordination of other state and federal programs.

Covered Benefits

Ideally, states will provide the full benefit package (i.e., mandatory and optional Medicaid services) to individuals eligible through this program. In any case, benefit packages must be flexible to accommodate new treatment advances and changes in standards of care that become available during the course of the demonstration. Through this project, states, at a minimum, must provide:

- primary care,
- prescription drugs,
- diagnostic and laboratory services,
- mental health services, and
- substance abuse treatment services.

Options to Participate in the Demonstration Projects

Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to grant waivers from the usual federal Medicaid requirements[15] to states which want to create demonstration projects to test new approaches to Medicaid. These demonstration projects must be designed to promote the objectives of Medicaid,[16] and must include a research and evaluation component. Generally, demonstration projects created under a Section 1115 waiver are supposed to be "budget neutral" over the life of the project, meaning that costs under the demonstration project do not exceed what costs would have been without the waiver in place. Section 1115 also authorizes matching federal funds for certain expenditures.

This initiative will be designed to provide states with the maximum flexibility possible in participating in a Medicaid expansion demonstration project. The project does not necessarily need to meet the traditional definition of "budget neutrality," since there can be federal and/or state subsidies. Also, budget neutrality should be measured within a time frame which is appropriate for assessing the clinical impact and cost-effectiveness of the new combination therapies (e.g., over a period of five to ten years).

Options for participation include the creation of a free-standing demonstration program or new or amended 1115 waivers. New 1115 waivers could provide the vehicle to expand Medicaid eligibility and/or allow a Medicaid buy-in option for those individuals otherwise ineligible for coverage. Amending an approved or pending 1115 waiver could also be used to expand eligibility. In addition, states could increase the income standards for their Medicaid buy-in programs, allowing more persons who are HIV positive to qualify. For example, states could set the income standard at 200 percent of the federal poverty level or they could use a graduated system to make more individuals eligible.

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[15] As defined in Section 1902 of the Social Security Act, and other provisions incorporated through Section 1902.

[16] As set out in Title XIX of the Social Security Act.

NEXT STEPS

Over the next several months, the AIDS Action Council will work with HCFA to develop and refine a solicitation process for states to successfully participate in the HIV Expanded Eligibility Demonstration Initiative. It is important for community-based AIDS service organizations to urge their state governors and Medicaid directors to advocate for this initiative with HHS and HCFA. While we expect that this initiative will offer states tremendous opportunities to provide cost-effective access and coverage to its most vulnerable populations, we also recognize the range of development and design issues that need to be resolved. Over the next several months, the AIDS Action Council will work with states and HCFA to complete the following tasks:

- Continue to work with HCFA to design a program that includes adequate incentives for state participation in this initiative.

- Build consensus among federal and state leadership, elected officials, and government staff, including representatives from Medicaid programs, Departments of Health, and Departments of HIV Services.

- Work with HCFA to develop a process that allows states to efficiently design and implement a vehicle for eligibility expansion that responds to the unique environment and situations of each state (waiver amendment or new waiver submission).

- Design a process to solicit input from consumers, AIDS service organizations, primary care and other health care providers, and health care agencies regarding program design and program effectiveness, on an ongoing basis.

- Work with HCFA to develop a methodology that allows states maximum flexibility in measuring cost effectiveness. The goal will be to have HCFA resolve methodology issues related to baseline measurements, the measurement of savings in other government programs, and evaluation time frames.

- Work with HCFA to identify and develop data bases that provide the information needed to estimate current expenditures and projected costs for the purposes of assessment and future planning. Necessary data includes the number of newly eligible individuals by state and service area (persons who are HIV positive with incomes below state defined eligibility criteria), utilization of services, and cost.

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Despite the experts' recommendations for early treatment and the existence of effective drugs, significant obstacles to accessing care and medications remain for low income people living with HIV. Existing programs cannot meet the need for comprehensive health care and preventive services. The current Medicaid requirements force most HIV positive individuals to wait until they develop full-blown AIDS to become eligible for coverage, a model which is inconsistent with clinical standards, inhumane, and costly.

EARLY INTERVENTION WORKS, SAVING LIVES AND DOLLARS

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Additionally, current Medicaid requirements undermine public health efforts by preventing many people with HIV from receiving care earlier in their disease. Under the present system, we are often not reaching these people to teach and reinforce behavior changes which can prevent HIV transmission. Even if people are able to obtain the new combination therapies, they may lack access to the primary care and medical case management needed to ensure that the prescribed treatment regimen is appropriate and effective, and to support them in following complex treatment plans. If patients do not strictly comply with their combination therapy regimens, they are likely to develop drug-resistant strains of HIV. The existence of such drug-resistant HIV mutations may further complicate public health efforts to combat AIDS.

Despite the existence of federal AIDS programs, such as the AIDS Drug Assistance Programs (ADAPs) and the other components of the Ryan White CARE Act, Medicaid serves as the foundation of AIDS care through its provision of both comprehensive health care and drug therapies. ADAPs provide limited prescription drug coverage for some uninsured and underinsured people with HIV and AIDS. But these programs cannot (and are not designed to) meet the need for comprehensive primary care and diagnostic services. In spite of their limited mission—to provide access to a limited formulary of proven AIDS medications—ADAPs face severe financial pressure in many states, and often cannot meet the growing demand for new combination therapies. In some states, ADAPs do not even cover protease inhibitors, and many offer a very limited formulary of antiretroviral and OI drugs. In other states, there are lotteries, long waiting lists, and increasingly restrictive eligibility criteria for ADAP participation.

While other Ryan White CARE Act programs pay for some primary care and drug

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[12] Centers for Disease Control, *Morbidity and Mortality Weekly Report*, February 28, 1997, 46: 165-173.

[13] B. Seitz, "AIDS Sufferers Living Longer," ABC News.com, July 15, 1997.

[14] P. Mohr, Patterns of Health Care Use Among HIV-Infected Adults: Preliminary Results," *AIDS Cost and Services Utilization Survey*, Agency for Health Care Policy and Research, September 1994: 3.

reimbursement, they are not intended to provide widespread comprehensive health care. Ryan White funding is used for a range of care and services, including food, transportation, and case management for people living with AIDS. Additionally, many ADAPs and Ryan White-funded primary care programs have eligibility criteria which exclude people in the earlier stages of HIV disease. These programs lack the financial resources to broaden their eligibility criteria to cover such individuals.

The Medicaid eligibility framework—requiring total disability to qualify for coverage— is at odds with current clinical and public health knowledge. Many low income HIV positive individuals with relatively intact immune systems are not presently eligible for Medicaid, but will eventually qualify for Medicaid after developing AIDS. Unable to afford adequate treatment early in their HIV disease, they cannot obtain the health care services necessary to manage the disease, and will be more ill when they do enroll in Medicaid. Ironically, earlier access to these medical services and treatments would enable them to preserve their health, learn how to prevent transmission of HIV to others, and avoid more costly care such as inpatient hospitalization. For humane, financial, and public health reasons, it is time to make Medicaid's eligibility requirements consistent with the clinical realities of HIV disease.

A COLLABORATIVE RESPONSE

In response to the contradictions between current Medicaid disability criteria and AIDS clinical evidence and care standards, which call for early treatment of HIV disease, representatives from the AIDS Action Council, community-based AIDS service organizations, the Health Care Financing Administration (HCFA) and the Office of Management and Budget (OMB) have begun to work collaboratively to address these issues. Response from the administration has been unequivocally supportive, culminating in an endorsement from Vice President Al Gore, who has asked HCFA to find ways in which to expand Medicaid and allow more low-income Americans with HIV to access care and therapies. Gore is quoted as saying "[Medicaid expansion] can ease suffering, it can increase hope, and it can get new drug therapies into the hands of people who need them." As a result of these collaborations, we are all working together under HCFA's leadership to develop a plan for expanding eligibility to Medicaid for persons who are HIV positive.

AN AIDS-SPECIFIC EXPANSION

As participants in these discussions, we have recognized several reasons for an AIDS-specific expansion of Medicaid. We believe that it serves the interests of public health, scientific knowledge, and fairness to broaden Medicaid coverage to include people with HIV.

Public health: With earlier health care and treatment, as mentioned above, people living with HIV are more likely to avoid behaviors which can spread the virus, and are more likely to adhere to complex treatment plans, which can both prolong health and prevent development of drug-resistant strains of HIV. Earlier access to care can also serve as an incentive for people to learn their serostatus for the first time, and then take steps to avoid either contracting or transmitting HIV.

Scientific knowledge: Protease inhibitors and other new medications received rapid FDA approval, have not yet been in long-term use, and have been researched mainly by studying people in more advanced stages of HIV disease. There are many remaining questions about the benefits, risks, and best way to use combination therapies in people who are HIV positive, but do not have AIDS. A Medicaid expansion demonstration project which brings people with HIV into care provides the opportunity to gather data and conduct research studies designed to answer these questions.

Fairness: The current Medicaid system requires most low-income people with HIV to develop AIDS in order to gain access to health care and new combination therapies. This is in conflict with principles and guidelines recently released by the Department of Health and Human Services and the NIH, which call for earlier intervention with combination drug therapies as the standard of care for the treatment of HIV in most cases. The government should ensure that this standard of care, endorsed by its own agencies, is accessible to those who have no other way to obtain it. Our federal government has always recognized the importance of ensuring access to treatment for other communicable diseases, such as sexually transmitted diseases and tuberculosis—it is unfair and inhumane to deny such treatment to people with HIV.

PROPOSAL DESIGN

The objective of this program is to expand Medicaid eligibility to low-income individuals who have tested positive for the presence of HIV and who would otherwise be eligible for Medicaid once their health status met an AIDS-defining diagnosis. States participating in this initiative will demonstrate that the provision of earlier access to care and treatment will extend the period of time that a person who is HIV positive remains asymptomatic, defer the onset of opportunistic infection, and delay hospitalization, all of which will result in significant cost savings and life-enhancing benefits. The following section describes what we believe are the core components of this initiative.

Eligibility

Any and all individuals who meet the following criteria will be eligible under this program:

- test positive for the presence of HIV; and
- have income at or below 200 percent of the federal poverty level.

State demonstrations will coordinate resources with other private, state, and federal programs. Individuals with private insurance can apply for and become eligible for Medicaid as a "wrap-around benefit" thereby maximizing private insurance participation. State proposals will specify the state specific eligibility guidelines and coordination of other state and federal programs.

Covered Benefits

Ideally, states will provide the full benefit package (i.e., mandatory and optional Medicaid services) to individuals eligible through this program. In any case, benefit packages must be flexible to accommodate new treatment advances and changes in standards of care that become available during the course of the demonstration. Through this project, states, at a minimum, must provide:

- primary care,
- prescription drugs,
- diagnostic and laboratory services,
- mental health services, and
- substance abuse treatment services.

Options to Participate in the Demonstration Projects

Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to grant waivers from the usual federal Medicaid requirements[15] to states which want to create demonstration projects to test new approaches to Medicaid. These demonstration projects must be designed to promote the objectives of Medicaid,[16] and must include a research and evaluation component. Generally, demonstration projects created under a Section 1115 waiver are supposed to be "budget neutral" over the life of the project, meaning that costs under the demonstration project do not exceed what costs would have been without the waiver in place. Section 1115 also authorizes matching federal funds for certain expenditures.

This initiative will be designed to provide states with the maximum flexibility possible in participating in a Medicaid expansion demonstration project. The project does not necessarily need to meet the traditional definition of "budget neutrality," since there can be federal and/or state subsidies. Also, budget neutrality should be measured within a time frame which is appropriate for assessing the clinical impact and cost-effectiveness of the new combination therapies (e.g., over a period of five to ten years).

Options for participation include the creation of a free-standing demonstration program or new or amended 1115 waivers. New 1115 waivers could provide the vehicle to expand Medicaid eligibility and/or allow a Medicaid buy-in option for those individuals otherwise ineligible for coverage. Amending an approved or pending 1115 waiver could also be used to expand eligibility. In addition, states could increase the income standards for their Medicaid buy-in programs, allowing more persons who are HIV positive to qualify. For example, states could set the income standard at 200 percent of the federal poverty level or they could use a graduated system to make more individuals eligible.

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[15] As defined in Section 1902 of the Social Security Act, and other provisions incorporated through Section 1902.

[16] As set out in Title XIX of the Social Security Act.

NEXT STEPS

Over the next several months, the AIDS Action Council will work with HCFA to develop and refine a solicitation process for states to successfully participate in the HIV Expanded Eligibility Demonstration Initiative. It is important for community-based AIDS service organizations to urge their state governors and Medicaid directors to advocate for this initiative with HHS and HCFA. While we expect that this initiative will offer states tremendous opportunities to provide cost-effective access and coverage to its most vulnerable populations, we also recognize the range of development and design issues that need to be resolved. Over the next several months, the AIDS Action Council will work with states and HCFA to complete the following tasks:

- Continue to work with HCFA to design a program that includes adequate incentives for state participation in this initiative.

- Build consensus among federal and state leadership, elected officials, and government staff, including representatives from Medicaid programs, Departments of Health, and Departments of HIV Services.

- Work with HCFA to develop a process that allows states to efficiently design and implement a vehicle for eligibility expansion that responds to the unique environment and situations of each state (waiver amendment or new waiver submission).

- Design a process to solicit input from consumers, AIDS service organizations, primary care and other health care providers, and health care agencies regarding program design and program effectiveness, on an ongoing basis.

- Work with HCFA to develop a methodology that allows states maximum flexibility in measuring cost effectiveness. The goal will be to have HCFA resolve methodology issues related to baseline measurements, the measurement of savings in other government programs, and evaluation time frames.

- Work with HCFA to identify and develop data bases that provide the information needed to estimate current expenditures and projected costs for the purposes of assessment and future planning. Necessary data includes the number of newly eligible individuals by state and service area (persons who are HIV positive with incomes below state defined eligibility criteria), utilization of services, and cost.

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Served w/spicy shrimp and peanut sauce

Italian Tomato Salad
Fresh and smoked mozzarella w/plum tomatoes

Olive Sampler
French, Greek, Spanish, spiced

California Quesedilla
Stuffed w/tomatoes, pepper jack and guacamole

Spicy Spinach Dip
Hot & Cheesy

Crispy Wontons
Seafood & cheese stuffed wontons w/peanut chili sauce

Sandwiches

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B.L.T.
Twice-smoked bacon, lettuce, tomato

Portlander
Gardenburger w/lettuce/tomato on sesame seed bun

Thanksgiving on a Bun
Turkeyburger w/cranberry mustard

American Classic
All beef w/the works

Salmon Club
Salmon patty w/B.L.T.

The Main Affair

Pasta
served w/baked garlic rounds

Shrimp Scampi
Served on black linguini

Penne Pasta w/Sun Dried Tomatoes & Capers
In a tangy wine sauce

Rigatoni Alfredo
Rich and creamy

Ellington's Picnic Platters
Hamburger, Gardenburger, Turkey Burger, SalmonBurger, BBQ specials. Served w/baked beans, potato salad lettuce & tomato.

Afterwards

Desserts

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A slice of New York in D.C.

Mississippi Mud Pie
Rich chocolate mousse pie

Sweet Potato Pound Cake
Smooth and delicate

Profiteroles
A favorite from France

Oreo Cookie Crunch
Vanilla & cappuccino chip ice cream w/crushed oreos

Cookie Jar
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Peach Cobbler
Best in D.C.

SLT Talking Points

Record Type: Record

To:

cc:
Subject: Talking Points for Today's Meeting

Treatment Access Workgroup

Agenda

July 15, 1998

Introductions

Purpose of Workgroup – Sandra Thurman

- problem is that we have unequal access to new treatments
  - disparities along geographic, racial and gender lines
  - we do know that these drugs can be very effective
  - community wants short and long-term solutions
- first go-around was Medicaid expansion - didn't work
- now, we want this task force of senior administration officials to map out next steps
- look at the need for increased access to HIV treatments
- explicitly looking beyond Medicaid
- objective is to develop a strategy for increasing access to the new treatments
- need to include the community at some point
- I suggest that this group meet as a whole two more times
  - next time to hear an interim update on progress
  - last time to do a final review
  - in the interim, staff would make sure that we get something done!

Review of Information Provided – Todd Summers

Perspective of the Secretary of HHS – Marsha Martin

Work to Date

Health Care Financing Administration – Nancy-Ann Minn Deparle
Health Care Resources Services Administration – Joseph O'Neill

Analysis of Options – Sandra Thurman and Dan Mendelson

- use the briefing sheet provided by OMB

Next Steps

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Next Steps

List of Participants

David Beier (Office of the VP)
Nancy-Ann Minn Deparle (HCFA)
Earl Fox (cannot attend) (HRSA)
Eric Goosby (cannot attend) (HHS/OS)
Chris Jennings (White House)
Marsha Martin (HHS/OS)
Dan Mendelson (OMB)
Joseph O'Neill (HRSA)
Sandra Thurman (ONAP)
Gordon Agress (OMB)
Sarah Bianchi (White House)
Toby Donenfeld (Office of the VP)
Robin Funston (HHS/ASMB)
Kathy King (HRSA)
John Palenicek (HRSA)
Todd Summers (ONAP)
Richard Turman (OMB)
Deborah vonZinkernagel (HHS/OS)
Greg White (OMB)

Treatment Access Workgroup

Issues Brief from OMB

July 15, 1998

Better Coordination Between Ryan White and Medicaid

Problem: The HHS Inspector General has recently pointed out that Medicaid managed care organizations and Ryan White programs do not adequately coordinate the services they provide to persons with HIV/AIDS.

Solution: The IG recommended that HCFA and HRSA disseminate technical assistance and guidance on strategies Medicaid programs can use to establish appropriate managed care contracts for needed medical services and costs related to these services. HRSA and 14CFA have begun to meet on these issues. The agencies could provide states with model contract language requiring coordination between Ryan White and Medicaid providers.

Discussion: Although Ryan White providers and Medicaid MCOs often serve the same population, they often do not coordinate services. For instance, the medical providers are often not aware of the Ryan White services, such as nutrition counseling and supplements, psycho-social services, home attendant care and case management, that the person is also getting. These social services, however, can help to support clients' ability to access health care and comply with health maintenance routines. Better coordination could result in better drug compliance and higher quality health care.

Higher Quality of HIV/AIDS Care in Medicaid

Problem: A recent study by the Agency for Health Care Policy and Research (AHCPR) has found that HIV+ persons with Medicaid received significantly inferior health care compared to privately insured persons. African-Americans, Latinos and women also received inferior care compared to whites and men.

Solution: Medicaid providers should be providing care based on the HHS guidelines on combination therapy that were released last year. HCFA and the States should ensure through contracting with managed care organizations or through direct contact with providers that all providers who serve the HIV+ population are aware of and adhere to the guidelines. Providing more services to HIV+ Medicaid recipients could impact the Medicaid baseline,

Discussion: At a time when it is possible to diminish radically the mortality and morbidity associated with HIV, this study suggests that Medicaid is not providing as high quality care to the HIV+ population as the insured population receives, even taking into account CD+4 lymphocyte counts. For instance, while only 13% of privately insured persons had one or more emergency room visits without an associated hospitalization, almost one third of Medicaid recipients had such an ER visit. Likewise, while 28% of privately insurance patients did not

receive protease inhibitors, almost one half of Medicaid beneficiaries did not. Differences in outcomes and quality between Medicaid recipients and private insured persons may occur between HIV-negative persons as well.

HCFA currently estimates that there are 50,000 asymptomatic persons who know their status plus 41,000 persons who are asymptomatic and do not know their status on Medicaid. Most of these people would be women eligible through the AFDC/TANF program. Providers should be encouraging all at-risk women to be tested for HIV.

access to specialists

Get President to call on insurers to adhere to guidelines

Consumer Bill of Rights Could Improve Care for HIV+ Persons

Problem: Although privately insured HIV+ persons had the best health care access indicators in the AHCPR study, many privately insured persons are still not receiving adequate care. From the study, it is unclear whether the lack of adequate care is related to limited insurance coverage for appropriate care or poor provision of care by health providers.

Solution: Just as government employees in the Federal Employees Health Benefits program (FEHBP) have a guarantee to high quality care through the adoption of the Consumer Bill of Rights, all private employees and members of health plans should have a guarantee of high quality care consistent with the Consumer Bill of Rights.

Discussion: The President's Consumer Bill of Rights calls for improvements in the quality of managed care that would enhance care for persons with HIV. For instance, the Consumer Bill of Rights requires that consumers with complex or serious medical conditions have direct access to qualified specialists. Consumers who are undergoing treatment for a chronic condition, such as AIDS, at the time they involuntarily change health plans or when a provider is terminated by a plan should be able to continue to see their original specialty provider for up to 90 days. Consumers should have the right to considerate, respectful care and should not be discriminated against based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment.

Reductions in AIDS Deaths Vary by Race and Gender

Problem: AIDS death rates for women and African-Americans have not fallen as dramatically as have AIDS death rates for men and for whites -- possibly because women and African-Americans may not be receiving the same quality and/or amount of care as men and whites.

Possible Solutions: Exactly what improvements would be most efficient is not yet clear from the data, but there are some potential starting points.

- Address the inexperience of many physicians by better disseminating HHS clinical practice guidelines, or by referring patients to more experienced doctors.
- Imposition of some "quality of care" standard among Ryan White grantees.
- Use Ryan White's AIDS Education and Training Center component to identify and address gaps in physicians' knowledge of care for I-IIV/AIDS.
- Increase awareness in community of benefits from early intervention.

Data: CDC AIDS data show that death rates have not fallen as dramatically among women and blacks as they have among whites and men.

Merck data show that "women and minorities are more likely to be HIV symptomatic than white men when starting HIV treatment," and "a smaller proportion of women and minorities than white men are treated by the most experienced physicians."

Access to Combination Therapy May Vary By State

Problem: Some Southern and Western states tend to have waiting lists for ADAP and/or combination therapy.

Possible Solutions: If the access problems in these States are driven by resource levels, then finding more resources -- either from individuals, companies, the State or local governments or the Federal government -- is probably the only way to address the problems.

We could seek to increase the contributions made by the States. States with AIDS cases greater than 1% of the national total* are currently required to provide State resources equal to 50% of the Title 11 grants (which include ADAP), but States can meet this requirement with "in kind" contributions such as facilities and staff. States could be required to increase the match they make to ADAP grants, or could be required to make their matching contributions in cash. This has been discussed in the past, and would be fairly controversial, but it is worth thinking about.

Increased funding for Title 11 and ADAP would help, but because these funds are distributed by formula, increases to them are unlikely to have a large impact in the States with problems. We could increase funding for Title III, which makes grants directly to clinics, and target the funds to States with access problems. We could also propose changes to the Title 11 and ADAP formulas, but these are unlikely to occur quickly,

Discussion: Nationwide, States provided 30% of the funds used by ADAPs in FY 1997. States that AIDS Action lists as having waiting lists for combination therapy contributed 20% of ADAP funds in their State -- less than the national average for ADAP.

Insurance Continuation

Problem: States cannot use ADAP funds to pay premiums for clients' health insurance even when that health insurance would cover combination therapy, and the cost of the premiums is less than the cost of buying the drugs directly.

Solution: Let States use ADAP funds to pay for health insurance when the insurance is the chcapest way of providing access to combination therapy, and when clients cannot afford to pay for such insurance themselves. As in any other public insurance program, the public insurance may be substituting for private insurance that people would have purchased if the public insurance was not available -- a phenomenon known as "crowd-out." Policy could be proposed which would reduce the level of "crowd-out."

Discussion: The FY 1999 President's Budget included appropriations language signaling support for this idea, but this language has been viewed by the community as inadequate to give States the authority they need. The House Labor/HHS Appropriations Subcommittee report says States should have the flexibility to do insurance continuation.

Cost of Drugs

Problem: Ryan White grantees and Medicaid programs may be spending more than they have to for AIDS drugs.

Solution: Insure these activities use the minimum price available to them by making maximum use of HHS 340B program and Medicaid rebates and discounts.

Discussion: We do not have much evidence to suggest that significant savings are available through cost minimization efforts. However, given the high cost of combination therapy drugs, small percentage reductions in the prices paid for these drugs could result in large dollar savings. HHS is already publishing a rule that would allow States to use a rebate program to capture the savings from this program (now currently available only as a discount).

*CDC estimates that 242,000 people were living with AIDS in 1996, and that 641,000 total cases had been reported by the end of 1996. The law imposes the matching requirement on States whose AIDS cases are "in excess of 1 percent of the aggregate number of such cases" -- it is unclear whether this refers to living persons or all AIDS cases.

emergency medical services to acutely ill and seriously injured children.

Black Lung Clinics

The Committee provides $5,000,000 for black lung clinics, which is $24,000 above the fiscal year 1998 comparable level and the same as the Administration request. The program supports 14 grantees which treat a declining population of coal miners with respiratory and pulmonary impairments. The clinics presently receive more than one-third of their funding from other sources, such as Medicaid and Medicare. Of the 14 grantees, three actually receive community health center funding as well as black lung grants.

Payment to Hawaii for Treatment of Hansen's Disease

The Committee provides $2,045,000 for the treatment of persons with Hansen's Disease in the State of Hawaii, which is the same as both the fiscal year 1998 comparable level and the Administration request. The program, which provides a partial matching payment to the State of Hawaii, dates to the period of Father Damien's facility for sufferers of Hansen's disease (leprosy). That facility now has only 67 residents who live there by choice, and the grounds have been converted to a historical site. Most patients diagnosed with Hansen's disease in Hawaii are now treated in the same manner as new patients on the mainland; their care is handled on an out-patient basis, with the program paying for about 5,300 outpatient visits per year.

Ryan White AIDS Programs

The Committee provides $1,330,600,000 for Ryan White AIDS programs, which is $181,088,000 above the fiscal year 1998 comparable level and $17,618,000 above the Administration request. The Committee recognizes that each Part of the Ryan White CARE Act provides services, which enable individuals to adhere to HIV drug treatments and access needed medical care.

The Ryan White CARE Act Amendments of 1996 requires States to comply with certain requirements in order to receive Federal funding for Ryan White activities. There is some concern that the Department is certifying States as being in compliance with these requirements when, in fact, they are not. Therefore, the Committee requests that the Secretary submit, by October 15, 1998, the following information: (1) a copy of the guidelines that were provided to State's to comply with section 300ff-21 et. seq. and section 300ff-47 of the Act; (2) a copy of the criteria used by the Department to evaluate and certify a State's compliance with these sections; (3) a copy of what each State submitted to the Department for its compliance evaluation; and (4) a copy of each State's final evaluation and certification approval document by the Department.

Emergency assistance

The Committee provides $500,200,000 for the Part A, emergency assistance program, which is $35,464,000 above the fiscal year 1998 comparable level and $11,226,000 above the Administration request. These funds provide grants to metropolitan areas with very high numbers of AIDS cases for outpatient and ambulatory

health and social support services. Half of the amount appropriated is allocated by formula and half is allocated to eligible areas demonstrating additional need through a competitive grant process.

Comprehensive care programs

The Committee provides $670,000,000 for Part B, comprehensive care programs, which is $127,217,000 above the fiscal year 1998 comparable level and $1,130,000 above the Administration request. The funds provided support formula grants to States for the operation of HIV service delivery consortia in the localities most heavily affected, for the provision of home and community-based care, for continuation of health insurance coverage for infected persons, and for purchase of therapeutic drugs.

The Committee is encouraged by the success of new drugs and combination therapies for HIV and AIDS, whose purchase is principally financed under Part B, and has included bill language identifying $385,500,000 specifically for the purchase of AIDS drugs. The fiscal year 1998 bill designated $285,500,000 for this purpose.

The Committee is concerned about the wide variation in State ADAP and Medicaid policies regarding eligibility, benefits, and formularies. The Committee is also concerned about the wide variation in State contributions to funding of ADAP and urges States that receive more than $1,000,000 under the targeted formula to match no less than twenty percent of the Federal contribution. The Committee directs the program to use all means necessary to reduce the purchase price of AIDS drugs.

The Committee expects HRSA to encourage States to utilize Federal ADAP funding in the most cost effective manner possible to maximize access to and use of HIV drug therapies. States should be allowed, with ADAP funding, the flexibility to purchase and maintain insurance policies for eligible clients, or continue to pay premiums on existing insurance policies, which provide a full range of HIV treatments and access to comprehensive primary care services as determined by the State. Funds should not be used to purchase insurance which provides inadequate access to HIV treatments or primary care as determined by the State.

Early intervention program

The Committee provides $91,300,000 for Part C, the early intervention program, which is $15,089,000 above the fiscal year 1998 comparable level and $5,146,000 above the Administration request. Funds are used for discretionary grants to migrant and community health centers, health care for the homeless grantees, family planning grantees, hemophilia centers and other private non-profit entities that provide comprehensive primary care services to populations with or at risk for HIV disease. The grantees provide testing, risk reduction counseling, transmission prevention, and clinical care; case management, outreach, and eligibility assistance are optional services. Approximately 79,000 HIV positive persons or persons at high risk for HIV infection are expected to be served in fiscal year 1999.

The Committee is concerned about the continued disparity in health outcomes for people with HIV and AIDS in communities of color and recognizes the need to provide additional services specifi-

cally targeted to HIV infected individuals in these communities. The Committee encourages HRSA to give priority consideration to allocating grants to grantees serving primarily minority populations.

Pediatric demonstrations

The Committee provides $44,000,000 for Part D, the pediatric AIDS demonstrations, which is $3,197,000 above the fiscal year 1998 comparable level and $74,000 above the Administration request. The program supports demonstration grants to foster collaboration between clinical research institutions and primary community-based medical and social service providers for the target population of HIV-infected children, pregnant women and their families. The projects are intended to increase access to comprehensive care, as well as to voluntary participation in NIH and other clinical trials.

AIDS dental services

The Committee provides $7,800,000 for AIDS dental services, which is $37,000 above the fiscal year 1998 comparable level and $13,000 above the Administration request. The program provides grants to dental schools and postdoctoral dental education programs to assist with the cost of providing unreimbursed oral health care to an estimated 73,000 patients with human immunodeficiency virus disease. Over one hundred dental schools and hospitals are expected to receive awards in fiscal year 1999. Dental students and residents participating in this program receive extensive training in the management of oral care of people living with AIDS.

The Committee notes that the program funding formula and reporting requirements have been revised in fiscal year 1998, and therefore, requests that the agency provide adequate time and technical assistance so that grantees can comply with these revisions and any future program changes allowing for their continued participation in the program.

Education and training centers

The Committee provides $17,300,000 for AIDS education and training centers, which is $84,000 above the fiscal year 1998 comparable level and $29,000 above the Administration request. The centers train health care personnel who care for AIDS patients and develop model education programs.

Family Planning

The Committee provides $202,903,000 for the family planning program, which is the same as the fiscal year 1998 comparable level and $15,174,000 below the Administration request. The program provides grants to public and private non-profit agencies to support projects which provide a range of family planning and reproductive services, as well as screening for ancillary health problems such as hypertension and diabetes. The program also supports training for providers, an information and education program, and a research program which focuses on family planning service delivery improvements. During fiscal year 1999, an estimated 4.6 million clients are expected to be served.

The bill repeats language from the 1998 appropriations bill making clear that these funds shall not be expended for abortions, that all pregnancy counseling shall be nondirective, and that these funds shall not be used to promote public opposition to or support of any legislative proposal or candidate for public office.

Rural Health Research

The Committee provides $7,500,000 for rural health research, which is $4,156,000 below the fiscal year 1998 comparable level and $4,191,000 below the Administration request. The activity supports several rural health research centers and the Office for Rural Health Policy's advisory committee.

Health Care Facilities

The Committee has not included funding for health care facilities. $28,000,000 was provided for this purpose in fiscal year 1998; no funding was included in the Administration request. This expired authority provides funds to public and private nonprofit entities for construction or modernization of outpatient medical facilities. This activity has not been funded by the Committee on a regular annual basis.

Buildings and Facilities

The Committee provides $250,000 for buildings and facilities, which is $2,248,000 below the fiscal year 1998 comparable level and the same as the Administration request. These funds are used to finance the repair and upkeep of buildings at the Gillis W. Long Hansen's Disease Center at Carville, Louisiana.

National Practitioner Data Bank

The Committee does not provide funding for the national practitioner data bank for fiscal year 1999, which is the same as both the fiscal year 1998 action on appropriations and the Administration request. The Committee recommendation and the Administration request assume that the data bank will be self-supporting, with collections of $12,000,000 in user fees.

The national data bank receives, stores and disseminates information on paid medical malpractice judgments and settlements, sanctions taken by professional societies, and certain professional review actions. Insurance companies, State license boards and professional societies are required to report information to the data bank within 30 days of each action. The coverage of the data bank includes dentists and physicians, and, with respect to malpractice settlements, other categories of licensed health professionals. Hospitals are required to search the data bank when a health care provider applies for employment and once every two years thereafter. State licensing boards and other health care entities also have access to the data bank. Traditional bill language is included to ensure that user fees are collected to cover all costs of processing requests and providing such information to data bank users.

disease, kidney disease, and other health problems that disproportionately afflict the elderly. Last year the Committee encouraged HCFA to conduct a demonstration project on coverage of medical nutrition therapy by registered dietitians and other licensed or nationally certified medical practitioners under Part B of Medicare to investigate its impact on program costs and beneficiary health and quality of life. The Committee is concerned that no progress has been made on this demonstration and urges HCFA to proceed with this project and provide a report on its status by December 31, 1998.

The Committee notes that congestive heart failure (CHF) has been identified as the leading condition regarding readmission, with the majority of those readmissions occurring through emergency rooms. This problem is particularly acute in the "stroke belt" region, which encompasses several Southern and Midwestern states. The Committee encourages HCFA to undertake research to demonstrate the cost effectiveness of a CHF clinic in reducing hospital admissions and improving compliance and quality of life.

Treatment guidelines issued by the Department in 1997 recognize the need to provide early treatment for HIV disease. Several States are considering applications for Medicaid waivers for demonstration projects that would extend Medicaid eligibility to HIV positive individuals who meet State Medicaid income eligibility requirements, but are not diagnosed with AIDS. The Committee encourages HCFA to evaluate and provide technical assistance to states which are preparing waiver applications for these demonstration projects.

Recent evidence from the states indicates that many Medicaid recipients with the most severe and disabling mental illnesses can achieve higher levels of recovery if the appropriate treatment and supports are available in the community. While a model of intensive case management known as the Program for Assertive Community Treatment (PACT) has been successful as part of Medicaid programs in many states, there is little information about how many states are funding PACT services. The Committee encourages HCFA to undertake a survey of which states are funding PACT services for adult Medicaid beneficiaries with severe mental illnesses and develop a model on how states can successfully integrate PACT into managed care programs.

The Committee supports the efforts to reach underserved and vulnerable populations through telemedicine and expects that projects will be supported in both rural and urban communities to meet the health care needs of underserved and minority populations.

Medicare contractors

The bill includes $1,269,700,000 to support Medicare claims processing contracts, which is $53,559,000 above the fiscal year 1998 comparable level and $165,300,000 above the Administration request. The Committee does not concur with the Administration's new user fee proposal.

Medicare contractors are responsible for paying Medicare providers promptly and accurately. In addition to processing claims, contractors also identify and recover Medicare overpayments, as well