FOIA Number: 2018-0764-F

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Ryan White CARE Act [1]

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Individual living with AIDS to Donna Shalala re: Ryan White CARE Act (Personal) [partial] (1 page)	12/20/1999	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 21075

FOLDER TITLE:
Ryan White CARE Act [1]

2018-0764-F
jm2236

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
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C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
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Brooklyn
Pediatric
AIDS
Network

SUNY-HSCB • 450 Clarkson Ave • Box 49 • Brooklyn, N.Y. 11203
Telephone: 718-270-3825 or 3826 • Fax: 718-270-3824

January 5, 2000

The Honorable Donna Shalala, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 615F
Washington, D.C. 20201

Dear Secretary Shalala:

I am writing to express the New York Eligible Metropolitan Areas (EMA) dismay and concern over the administration's proposed .53% across-the-board reductions to Ryan White CARE Act programs for FY 2000. These critical grant programs serving low-income, uninsured and under insured individuals should be the first to be protected from cuts and not disproportionately shoulder the burden of discretionary HHS program reductions. A .53% reduction from Ryan White CARE Act grants would reduce FY 2000 funding by almost $8.5 million, putting at risk thousands of vulnerable individuals living with HIV disease.

The New York EMA, the largest in population in the United States, includes New York City and the Tri-County area of the Lower Hudson Valley. The incidence of HIV/AIDS in the New York EMA is dramatically higher than the rest of the country, with the largest percentage of cases occurring in economically disadvantaged communities of color. National estimates indicate that the New York EMA has almost 40 percent of all the women and half of all the children with HIV disease in the U.S. A number of people with HIV still do not have adequate access to treatment and care services; and some people in care do not benefit from the new therapies. A .53% reduction in Ryan White CARE Act funding would seriously jeopardize our programs struggling to close these treatment and service gaps.

As you know, infection rates remain distressingly high, adding new cases constantly to providers of Ryan White CARE services. The cost of care per patient is rising steadily. In addition, we learned just recently that the Public Health Service treatment guidelines would soon require our providers to offer laboratory tests to measure resistance as a part of the standard of HIV care. CARE Act providers must be able to offer this test, but the cost is likely to reach $500 per patient per year. Absorbing this new unanticipated expense in FY 2000 on top of a .53% reduction in grants will place a tremendous burden on local agencies.

By September 30, 2000, Congress must reauthorize the Ryan White CARE Act. The New York EMA is greatly concerned about the message Congress may hear as to the Administration's commitment to this important program from a decision to cut programmatic funding in FY 2000.

The New York EMA urges you to reconsider the .53% cut in funding because of its immediate negative impact on vulnerable people living with HIV - and because of its potential negative impact on the willingness of Congress to reauthorize the Act so it can continue to serve its critical role in our nation's public health system.

Sincerely,

Hermann Mendez, M.D.
Principal Investigator

Ivy Turnbull
Executive Director

cc: Jacob Lew, OMB
Sandra Thurman, Office of National AIDS Policy
Kevin Thurm, HHS
John Callahan, HHS
Eric Goosby, M.D., HHS
Claude Earl Fox, M.D., HRSA
Joseph O'Neill, M.D., HRSA

BEHAVIORAL HEALTH SERVICES

FROM THE DESK OF

DARYL K. FLYNN

HIV/AIDS ADVOCATE/SPECIALIST
PHONE#(909) 982-8843 FAX# (909) 985-7710

ATTN: Ms Sandy Thurman

DATE: 12/27/99

NUMBER OF PAGES 3
(INCLUDING COVER)

MESSAGE: Hi Sandy, I know how committed you are to HIV/AIDS on a global level but I must ask one more favor of you. Would you please exercise any and all influence that you have to remind those members of the Administration how devastating these proposed cuts will be to all Americans. It is truly unfortunate that now we are seeing this epidemic raging amongst people of color, now we cut the program. What kind of message is that sending out. Please don't let history repeat itself. —— Daryl K. Flynn
F.C. CAEAR.

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Since 1973

BEHAVIORAL HEALTH SERVICES, INC.
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(310) 679-9126 FAX (310) 679-2920 Personnel (310) 679-2880

American Recovery Center
Pomona, CA 91768
909-865-2336

Boyle Heights Recovery Center
Los Angeles, CA 90023
323-262-1786

Hollywood Recovery Center
Los Angeles, CA 90028
323-461-3161

Inglewood Recovery Center
Inglewood, CA 90302
310-673-5750

Lincoln Heights Recovery Center
Los Angeles, CA 90032
323-221-1746

Medicine Education Program
Gardena, CA 90249
310-679-9035

Omni
Gardena, CA 90249
310-676-9688

Pacifica House
Hawthorne, CA 90250
323-754-2816

Patterns
Hawthorne, CA 90250
310-675-4431

Redgate Memorial
Recovery Center
Long Beach, CA 90813
562-599-8444

South Bay Recovery Center
Gardena, CA 90249
310-679-9031

South Bay Senior Services
Torrance, CA 90503
310-325-2141

Wilmington Recovery Center
Wilmington, CA 90744
310-549-2710

www.bhs-inc.org

December 20, 1999

The Honorable Donna Shalala, Secretary
US Department of Health and Human Services
200 Independence Avenue, SW
Room 615F
Washington, DC 20201

Dear Secretary Shalala,

I am writing this letter not only as a person living with AIDS, but also as a person who has benefited from the services provided by the Ryan White CARE Act. Not very long ago, I was near death due to my illness. Ryan White was there to assist me in getting my life back in order so that I could return to the workforce and become a productive taxpaying citizen again. I am now able to utilize the education again that I had worked so hard to obtain. I now am employed as the HIV/AIDS Advocate/Specialist for Behavioral Health Services based out of Los Angeles County.

As the HIV/AIDS Specialist, I am charged with providing services for countless individuals impacted by this still terminal disease as well as creating linkages to other services in order to establish a comprehensive continuum of care. A .53% reduction from Ryan White CARE Act grants would reduce Fiscal Year 2000 funding by almost $8.5 million, putting at risk thousands of vulnerable individuals living with HIV/AIDS.

As you know, there is an estimated 40,000 newly diagnosed cases per year and fortunately for a large number of the population, the medications have offered some promising results thus far. However, the length of these benefits is still an unknown.

As a community based organization that provide Substance Abuse treatment, we are well aware of the high co-morbidity between HIV/AIDS and substance misuse. Title I of the RW CARE Act assists many of our clients in accessing treatment for their chemical dependency issues and in many cases, is the

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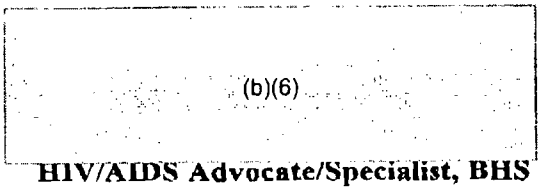
first step in establishing that continuum of care and linkage to other services such as medical, that is so crucial if any progress is to be made in their HIV disease process. Additionally, cost of care per patient is steadily rising. Public Health Services treatment guidelines will soon require laboratory tests that will measure resistance to available medications as a part of standard HIV care. This test will eliminate the trial and error method that is currently being utilized that potentially creates further resistance and limits an individual's options at a later date should that medication fail. This test is quite expensive, but will better the basic standard of care for thousands of individuals, meanwhile placing a further burden on existing funding. Can you imagine the effect should further cuts be implemented?

By September 30, 2000, Congress must decide whether to reauthorize the Ryan White CARE Act or not and as a member of the Cities Advocating Emergency AIDS Relief (CAEAR) Coalition, we are greatly concerned about the message that Congress might receive should such a drastic and potentially crippling cut as outlined with this proposed .53% cut be exercised in FY 2000 funding. This cut will surely have an immediate negative impact on the Administration's commitment to this program, but more importantly, to already devastated communities of color, women, youth and the elderly, all of which are being disproportionately impacted by this deadly virus. You've seen the numbers. AIDS isn't going anywhere; it's just presented itself in other populations that didn't feel that they were at risk. The truth is that it was in these populations all the while and is just now coming to the forefront and will continue to do so until we are able to address this epidemic effectively and/or find a cure. We haven't gotten to that point yet.

Should you need to reach me, feel free to contact me at (909) 865-2336. I would welcome the opportunity to meet with you again.



[001]

HIV/AIDS Advocate/Specialist, BHS

Cc: Jacob Lew-
Kevin Thurm-Dept. HHS
John Callahan-Dept HHS
Eric Goosby, MD-Dept. HHS
Sandra Thurman-National AIDS Policy Director
Earl Fox-HRSA
Joe O'Neill-HRSA

COUNCIL
COMMUNITY PREVENTION
ALCOHOL TOBACCO & OTHER DRUGS

Dedicated to promoting healthy policies and practices regarding alcohol, tobacco and other drug use in the lesbian, gay, bisexual and transgender communities.

The Honorable Donna Shalala, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 615F
Washington, DC 20201

Dear Secretary Shalala,

I am writing to express our organization's dismay and outrage over the Administration's proposed .53% across-the-board reductions to the Ryan White CARE Act programs for the FY 2000. These critical grant programs serving low-income, uninsured and under insured individuals should be the first to be protected from cuts and not disproportionately shoulder the burden of discretionary HHS program reductions. A .53% reduction from Ryan White CARE Act grants would reduce FY 2000 funding by almost $8.5 million, putting at risk thousands of vulnerable individuals living with HIV disease.

The Community Prevention Council is a grassroots organization focusing on healthy policies and practices regarding alcohol, tobacco and other drug use in the lesbian, gay, bisexual and transgender (L/G/B/T) communities. Many of our member agencies are organizations who serve individuals with HIV/AIDS and who depend on Title I and Title III of the Ryan White CARE Act for health care and support services. We include community-based AIDS service organizations, people living with HIV/AIDS, providers of HIV/AIDS Health Care, CARE Act grantees, and many other community-based organizations. We represent all segments of society that have been impacted by HIV/AIDS. A .53% cut reduction in funding for Title I and Title III would impair members' ability to serve our clients.

As you know, infection rates remain distressingly high, adding new cases constantly to providers of Ryan White CARE services. The cost of care per patient is rising steadily. In addition, we learned just recently that the Public Health Service treatment guidelines will soon require our providers to offer laboratory tests to measure resistance as a part of the standard of HIV care. CARE Act provider must be able to offer this test but the cost is likely to reach $500.00 per patient per year. Absorbing this new unanticipated expense in FY 2000 on top of a .53% reduction in grants will place a great burden on local agencies.

By September 30, 2000, Congress must reauthorize the Ryan White CARE Act. The Community Prevention Council is greatly concerned about the message Congress may hear as to the Administration's commitment to this important program from a decision to cut programmatic funding in FY 2000. The Community Prevention Council urges you to reconsider this .53% cut in funding because of its immediate negative impact on vulnerable people living with HIV, and because of its potential negative impact on the willingness of Congress to reauthorize the Act so it can continue to serve its critical role in our nation's public health system.

Sincerely,

Loretta Worthington, CAS
Community Prevention Council

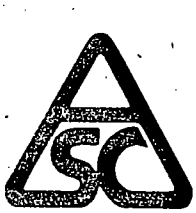
Cc: Jacob Lew, Kevin Thurm, John Callahan, Eric Goosby, Sandra Thurman, Earl Fox, Joe O'Neil

Alcoholism Center for Women
WORKING TOGETHER FOR RECOVERY

1147 S. Alvarado Street • Los Angeles, CA • 90006 • 213.381.8520 • Fax 213.381.8525

This project made possible through funding provided by L.A. County Department of Health Services, Alcohol and Drug Program Administration & Public Health Programs-Tobacco Control Section.

Gay & Lesbian Center



AIDS SERVICE CENTER
LOWER MANHATTAN

December 30, 1999

The Honorable Donna Shalala, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 615F
Washington, D.C. 20201

Dear Secretary Shalala:

We are writing to express the New York Eligible Metropolitan Area's (EMA) dismay and concern over the Administration's proposed .53% across-the-board reductions to Ryan White CARE Act programs for FY 2000. These critical grant programs serving low-income, uninsured and under insured individuals should be the first to be protected from cuts and not disproportionately shoulder the burden of discretionary HHS program reductions. A .53% reduction from Ryan White CARE Act grants would reduce FY 2000 funding by almost $8.5 million, putting at risk thousands of vulnerable individuals living with HIV disease.

The New York EMA, the largest in population in the United States, includes New York City and Tri-County area of the Lower Hudson Valley. The incidence of HIV/AIDS in the New York EMA is dramatically higher than the rest of the country, with the largest percentage of cases occurring in economically disadvantaged communities of color. National estimates indicate that the New York EMA has almost 40 percent of all the women and half of all children with HIV disease in the U.S. A number of people with HIV still do not have adequate access to treatment and care services; and some people in care do not benefit from the new therapies. A .53% reduction in Ryan White CARE Act funding would seriously jeopardize our programs struggling to close these treatment and service gaps.

As you know, infection rates remain distressingly high, adding new cases constantly to providers of Ryan White CARE services. The cost of care per patient is rising steadily. In addition, we learned just recently that the Public Health Service treatment guidelines would soon require our providers to offer laboratory tests to measure resistance as a part of the standard of HIV care. CARE Act providers must be able to offer this test, but the cost is likely to reach $500 per patient per year. Absorbing this new unanticipated expense in FY 2000 on top of a .53% reduction in grants will place a tremendous burden on local agencies.

By September 30, 2000, Congress must reauthorize the Ryan White CARE Act. The New York EMA is greatly concerned about the message Congress may hear as to the Administration's commitment to this important program from a decision to cut programmatic funding in FY 2000.

80 FIFTH AVENUE, THIRD FLOOR ▲ NEW YORK, NEW YORK 10011 ▲ TEL 212-645-0875 / FAX 212-645-0705

The New York EMA urges you to reconsider this .53% cut in funding because of its immediate negative impact on vulnerable people living with HIV-- and because of its potential negative impact on the willingness of Congress to reauthorize the Act so it can continue to serve its critical role in our nation's public health system.

Sincerely,

Sharen I. Duke
Executive Director/CEO
AIDS Service Center of Lower Manhattan

cc: Jacob Lew, OMB
Sandra Thurman, Office of National AIDS Policy
Kevin Thurm, HHS
John Callahan, HHS
Eric Goosby, M.D., HHS
Claude Earl Fox, M.D., HRSA
Joseph O'Neill, M.D., HRSA

OFFICE OF THE MAYOR
SAN FRANCISCO

WILLIE LEWIS BROWN, JR.

MAYOR WILLIE L. BROWN, JR.

BILL BARNES
SPECIAL ASSISTANT TO THE MAYOR

(415) 554-5101
(415) 554-5955 FAX
Bill_Barnes@ci.sf.ca.us

CITY HALL
1 DR. CARLTON B. GOODLETT PLACE
ROOM 475
SAN FRANCISCO, CA 94102

December 21, 1999

The Honorable William Jefferson Clinton
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Mr. President:

I am writing to express my deep concern about the Administration's Fiscal Year 2000 budget request for HIV/AIDS health care services in the context of Ryan White CARE Act reauthorization next year.

By September 2000, Congress will be called upon to reauthorize the Ryan White CARE Act. This important legislative initiative will be difficult and require the full support of community leaders to defeat negative amendments, and ensure successful reauthorization of this lifesaving program. An adequate budget request is crucial to reauthorizing the CARE Act next year.

If plans proposed by the Department of Health and Human Services to cut Ryan White CARE Act programs by 0.53% are adopted, the detrimental impact cannot be underestimated. A cut in funding at this time will send a message to Congress that this program has less than full Administration support. It may also create a situation in which communities lose financial resources in FY 2000, an environment in which we run the risk of encouraging unnecessary battles over allocation formulas and diverting our focus from reauthorization.

As you know, the Ryan White CARE Act is an important program for San Francisco. Title I and Title II resources are used by our Department of Public Health to augment our local contribution to meet the increasingly complex health care needs of San Franciscans living with HIV. Title III funds support innovative approaches to HIV primary medical care at the San Francisco Community Clinic Consortium, and Title IV resources are being used to address the needs of adolescents at Larkin Street Youth Center and Health Initiatives for Youth.

As the AIDS epidemic continues to ravage gay and bisexual men and injection drug users, and impacts communities of color across the country, any reduction in funding is irresponsible and unacceptable. For your information, I have included a resolution adopted at the United States Conference of Mayors Annual Meeting held earlier this year in New Orleans. The resolution calls for reauthorization of the Ryan White CARE Act and full funding for the program.

I am hopeful that you will intervene as the process of developing your budget moves forward, and direct the Office of Management and Budget and the Department of Health and Human Services to include adequate appropriations for Ryan White CARE Act programs and other HIV/AIDS programs, including domestic HIV prevention. If members of your staff need additional information, they may contact Bill Barnes, my Advisor on AIDS and HIV Policy, at (415) 554-5101 or Karin Carlson in my Legislative Affairs Office at (415) 554-6414.

I look forward to hearing from you on these important issues.

Sincerely,

WILLIE L. BROWN, JR.
Mayor

wlb/hivaids/barnes

CC: Earl Fox
Administrator
Health Resources and Services Administration

Jacob Lew
Office of Management and Budget

Joseph O'Neill, MD
Associate Administrator, HIV/AIDS Bureau
Health Resources and Services Administration

Donna Shalala
Secretary
Department of Health and Human Services

Kevin Thurm
Deputy Secretary
Department of Health and Human Services

Sandra Thurman
Director
Office of National AIDS Policy

Resolution No. 33

Submitted By:

The Honorable Willie L. Brown, Jr.
Mayor of San Francisco

The Honorable Richard M. Daley
Mayor of Chicago

The Honorable Dennis W. Archer
Mayor of Detroit

The Honorable Thomas M. Menino
Mayor of Boston

The Honorable James A. Garner
Mayor of Hempstead

RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY (CARE) ACT

1. **WHEREAS,** the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was first authorized by the United States Congress in 1990, providing critical funding to cities and states heavily impacted by the AIDS crisis; and

2. **WHEREAS,** the reauthorization of the CARE Act is a top priority for local communities, persons with HIV/AIDS, national AIDS advocacy groups and The U.S. Conference of Mayors (USCM); and

3. **WHEREAS,** The U.S. Conference of Mayors acknowledges that recent, dramatic declines in AIDS-related deaths and new AIDS diagnoses are largely attributed to the CARE Act's success in providing access to critical HIV care, treatment and necessary support services to hundreds of thousands of uninsured persons living with HIV/AIDS in the U.S.; and

4. **WHEREAS,** the current structure of the CARE Act, particularly its Title I, provides significant flexibility to local communities in meeting the challenges of the AIDS epidemic and must be maintained; and

5. **WHEREAS,** The U.S. Conference of Mayors recognizes the disproportionate impact of the HIV/AIDS epidemic in communities of color nationwide, and further recognizes the

particular role of Title I in serving these communities as the largest provider of CARE Act medical care and services for people of color living with HIV; and

6. **WHEREAS,** The U.S. Conference of Mayors supports the maintenance of existing systems of care and concerted efforts to eliminate disparities in access to HIV health care for communities of color, gay and bisexual men, and women, children and youth; and

7. **WHEREAS,** The U.S. Conference of Mayors is committed to providing the necessary resources to ensure the. successful reauthorization of the Ryan White CARE Act in the 106th Congress,

8. **NOW, THEREFORE, BE IT RESOLVED** that The U.S. Conference of Mayors strongly supports timely reauthorization of the Ryan White CARE Act, full funding of the Act, preservation of its current structure, and sustaining the flexibility provided to local communities under Title I; and

9. **BE IT FURTHER RESOLVED** that The U.S. Conference of Mayors vigorously opposes any efforts to combine funds made available through Title I with funds made available through Title II for the purpose of state directed block grants.

Projected Cost: Unknown

San Francisco Community Clinic Consortium

1388 Sutter Street Suite 607 • San Francisco, CA 94109 • Phone 415/292-0335 • Fax 415/775-6170 • www.sfccc.org

December 14, 1999

The Honorable Donna Shalala, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W., Room 615F
Washington, D.C. 20201

RE: Opposition to Cutes in Ryan White CARE Act Programs

Dear Secretary Shalala:

On behalf of the San Francisco Community Clinic and our nine partner health centers, I am writing to express our disappointment and grave concern about the Administration's proposed .53% across-the-board reductions to the Ryan White CARE Act programs for FY 2000. These critical grant programs serve low-income, uninsured and underinsured individuals. These programs should be protected from cuts and not disproportionately shoulder the burden of discretionary HHS program reductions. A .53% reduction from Ryan White CARE Act grants would reduce FY 200 funding by almost $8.5 million, putting at risk thousands of vulnerable individuals living with HIV.

The San Francisco Community Clinic's partner health centers provide primary care for more than 62,500 San Franciscans, of whom more than 1,000 are individuals living with HIV and AIDS. These patients receive comprehensive HIV and AIDS medical, counseling, and referral services within their culturally appropriate community. Our community-based HIV/AIDS care extends to communities that are historically underserved: the uninsured, people of color, women, injection drug users, and those who are homeless.

A .53% reduction in funding for Title I and Title III would impair our health centers' ability to serve our patients at a time when the demand for our services is growing and infection rates remain distressingly high. In addition, the costs to care for our patients are rising steadily. Beyond these costs, the Public Health Service treatment guidelines will soon require our providers to offer laboratory tests to measure resistance as part of standard HIV care, which may cost $500 per patient per year. We are also greatly concerned about the negative political ramifications these proposed cuts in funding may have when Congress debates reauthorization of the Ryan White CARE Act next year.

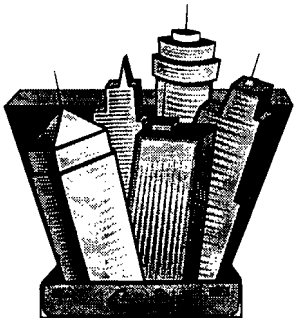
We urge you to reconsider the .53% reduction in funding because of its immediate negative impact on the thousands of San Franciscans living with HIV and AIDS. Thank you.

Sincerely,

John Gressman
President and CEO

cc: Jacob Lew, OMB
Sandra Thurman, Office of National AIDS Policy
Claude Earl Fox, M.D., HRSA
Joseph O'Neill, M.D., HRSA

Urban Coalition for HIV/AIDS Prevention Services



December 15, 1999

Sandra Thurman
National AIDS Policy Director
White House Office of National AIDS Policy
736 Jackson Place, N.W.
Washington, D.C. 20503

Dear Ms. Thurman:

We are writing to express our strong support for a proposed increase in funding for HIV Prevention in President Clinton's Fiscal Year 2000 budget proposal.

The Urban Coalition for HIV/AIDS Prevention Services (UCHAPS) is a coalition of the six jurisdictions directly funded by the CDC for HIV prevention—Chicago, Houston, Los Angeles County, New York City, Philadelphia, and San Francisco. The six directly-funded cities represent 33.2% of the AIDS cases across the United States, and 36.5% of cases among people of color. Each city's delegation to UCHAPS has representatives of the community planning groups and the departments of health in these cities. This close collaboration between government and the community gives us a unique expertise on urban prevention issues. Our knowledge is particularly important because the experience of the HIV epidemic in the largest cities across the country has been shown, time and time again, to be a harbinger of the direction that the epidemic will take in smaller cities and rural areas.

The need for increased funding for HIV prevention is urgent. CDC prevention funding has been flat for the past several years. While the current rates of infection are nowhere near the frightening numbers we saw in the 1980s, there are still approximately 40,000 new infections a year. Even worse, infection rates have been on the increase since 1996, especially among young people and in communities of color. Scrimping on prevention makes no economic sense–future health costs for HIV/AIDS will be staggering if we do not make this investment now.

We are the people working in the communities most severely affected by the lack of funding for prevention initiatives. Through our community planning processes, we try to direct the available

resources where they will have the most impact. But the needs are tremendous, and our planning process reveals an increasing unmet need every year. We know that there are excellent models for programs that can reach those populations most at risk for HIV infection, and we know that there are many community-based organizations that are ready, willing and able to put those programs in place. We also are committed to making sure that our prevention dollars are being spent wisely, and evaluating all funded programs rigorously. Each UCHAPS city is in the process of developing a 5 year evaluation plan in recognition of the importance of effective programs and accountability. The missing piece is adequate funding.

UCHAPS is a member of AIDS Action, and we endorse their request for a 25% increase in the prevention budget. Certainly, anything less than $100 million will not make a significant difference. A substantial, concerted investment in prevention efforts is needed now.

Thank you for your attention to this issue. This is an opportunity for President Clinton to show a national commitment to HIV prevention. We hope that we will have an opportunity to work with you on this urgent matter of national importance. If you need any additional information, please contact either one of the undersigned.

Sincerely,

Soraya Elcock

Soraya Elcock
Community Co-chair
Harlem United Community AIDS Center
New York City
(212)531-1300 X 404

Glenda Gardner

Glenda Gardner
Governmental Co-chair
Bureau of HIV/STD Prevention
Houston
(713) 794-9164

cc: Martin J. Gonzalez Rojas, Chicago
A. Toni Young, San Francisco
George Ayala, Los Angeles
Joe Cronauer, Philadelphia

YGH

Yonkers General Hospital

December 20, 1999

The Honorable Donna Shalala, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 615F
Washington, DC 20201

Dear Secretary Shalala:

I am writing to express Yonkers General Hospital's dismay and concern over the Administration's proposed .53% across-the-board reductions to Ryan White CARE Act programs for FY 2000. These critical grant programs serving low-income, uninsured and under insured individuals should be the first to be protected from cuts and not disproportionately shoulder the burden of discretionary HHS program reductions. A .53.% reduction from Ryan White CARE Act grants would reduce FY 2000 funding by almost $8.5 million, putting at risk thousands of vulnerable individuals living with HIV disease.

Yonkers General Hospital is a part of the New York Eligible Metropolitan Area's (EMA), the largest in population in the United States, includes New York City and the Tri-County area of the Lower Hudson Valley. The incidence of HIV/AIDS in the New York EMA is dramatically higher than the rest of the country, with the largest percentage of cases occurring in economically disadvantaged communities of color. National estimates indicate that the New York EMA has almost 40 percent of all the women and half of all the children with HIV disease in the U.S. A number of people with HIV still do not have adequate access to treatment and ca re services; and some people in care do not benefit from the new therapies. A .53% reduction in Ryan White CARE Act funding would seriously jeopardize our programs struggling to close these treatment and service gaps.

As you know, infection rates remain distressingly high, adding new cases constantly to providers of Ryan White CARE services. The cost of care per patient is rising steadily. In addition, we learned just recently that the Public Health Service treatment guidelines would soon require our providers to offer laboratory tests to measure resistance as part of the standard HIV care. CARE Act providers must be able to offer this test, but the cost is likely to reach $500 per patient per year. Absorbing this new unanticipated expense in FY 2000 on top of a .53% reduction in grants and the additional cost of inflation will place a tremendous burden on local agencies.

Two Park Avenue, Yonkers, New York 10703-3497 • (914) 964-7300

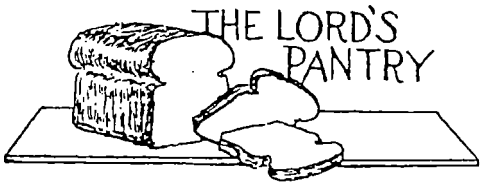
By September 30, 2000, Congress must reauthorize the Ryan White CARE Act. The New York EMA is greatly concerned about the message Congress may hear as to the Administration's commitment to this important program from a decision to cut programmatic funding in FY 2000.

The New York EMA urges you to reconsider this .53% cut in funding because of its immediate negative impact on vulnerable people living with HIV – and because of its potential negative impact on the willingness of Congress to reauthorize the Act, so it can continue to serve its critical role in our nation's public health system.

Sincerely,

Jim Foy
President/CEO

cc: Jacob Lew, OMB
Sandra Thurman, Office of National AIDS Policy
Kevin Thurm, HHS
Eric Goosby, MD, HHS
Claude Earl Fox, MD, HRSA
Joseph O'Neill, MD, HRSA



177 Davis Avenue White Plains, New York 10605 (914) 682-4306

December 17, 1999

The Honorable Donna Shalala, Secretary
U.S.Department of Health and Human Services
200 Independence Avenue, S.W.
Room 615F
Washington, D.C.20201

Dear Secretary Shalala:

It is with fear and dismay that we write to you regarding the Administration's proposal to reduce the Ryan White Care Act programs by .53% for the coming FY 2000.

We, at The Lord's Pantry, work with People with HIV/AIDS, their caretakers and children, delivering hot meals plus breakfast and lunch throughout most of Westchester County. We are so needed!

It is important for us to point out that, even with all of the new inhibitors, our numbers have increased in the last year by 8-10%. Since 85% of our funding comes from the Ryan White Title I Care program, we are indeed saddened to see that the Dept. of Health & Human Services has proposed a ***greater reduction*** to the very programs that, in the future, will need ***greater funding*** - simply because of the people served.

HIV/AIDS is much higher here in New York than in other parts of the country. Moreover, the largest percentages of cases occur in disadvantaged minority communities. Add to this the number of people receiving inadequate treatment. We fear the Ryan White programs will suffer greatly.

Therefore, we urge you to reconsider this cut in funding to the Ryan White Care Act grants, because it is attacking the people who are most vulnerable – those living with HIV/AIDS.

Sincerely yours,

Joan C. McGovern
Executive Director

Copies of letter to:

Sandra Thurman
National AIDS Policy Director
Office of National AIDS Policy
736 Jackson Place, N.W.
Washington, D.C. 20503

Earl Fox
Administator
Health Resources and Services Administration
Room 14-05
5800 Fishers Lane
Rockville, MD 20857

Joe O'Neill
Associate Administrator, HIV/AIDS Bureau
Health Resources and Services Administration
Room 7-05
5800 Fishers Lane
Rockville, MD 20857

Jacob LEW
Office of Management and Budget
Old Executive Office Building, Room 252
17th Street and Pennsylvania Avenue, NW
Washington, DC 20503

Kevin Thurm
Deputy Secretary, Department of Health and Human Services
Room 606G
200 Independence Avenue, SW
Washington, DC 20201

John Callahan
Assistant Secretary for Management and Budget
Department of Health and Human Services
Room 514G
200 Independence Ave., SW
Washington, DC 20201

Eric Goosby
Director, HIV/AIDS Policy Office
Office of Public Health and Human Services
Room 736E
Washington, DC 20201

The City of New York

DEPARTMENT OF HOMELESS SERVICES

161 William Street
New York, New York 10038

(212) 788-9400
Fax: (212) 788-9410

MARTIN OESTERREICH
COMMISSIONER

December 23, 1999

The Honorable Donna Shalala, Secretary
U. S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 615F
Washington, D.C. 20201

Dear Secretary Shalala:

We are writing to express the New York Eligible Metropolitan Area's (EMA) dismay and concern over the Administration's proposed .53% across-the-board reductions to Ryan White CARE Act programs for FY 2000. These critical grant programs serving low-income, uninsured and under insured individuals should be the first to be protected from cuts and not disproportionately shoulder the burden of discretionary HHS program reductions. A .53% reduction from Ryan White CARE Act grants would reduce FY 2000 funding by almost $8.5 million, putting at risk thousands of vulnerable individuals living with HIV disease.

The New York EMA, the largest in population in the United States, includes New York City and the Tri-County area of the Lower Hudson Valley. The incidence of HIV/AIDS in the New York EMA is dramatically higher than the rest of the country, with the largest percentage of cases occurring in economically disadvantaged communities of color. National estimates indicate that the New York EMA has almost 40 percent of all the women and half of all the children with HIV disease in the U.S. A number of people with HIV still do not have adequate access to treatment and care services; and some people in care do not benefit from the new therapies. A .53% reduction in Ryan White CARE Act funding would seriously jeopardize our programs struggling to close these treatment and service gaps.

As you know, infection rates remain distressingly high, adding new cases constantly to providers of Ryan White CARE services. The cost of care per patient is rising steadily. In addition, we learned just recently that the Public Health Service treatment guidelines would soon require our providers to offer laboratory tests to measure resistance as a part of the standard of HIV care. CARE Act providers must be able to offer this test, but the cost is likely to reach $500 per patient per year. Absorbing this new unanticipated expense in FY 2000 on top of a .53% reduction in grants will place a tremendous burden on local agencies.

By September 30, 2000, Congress must reauthorize the Ryan White CARE Act. The New York EMA is greatly concerned about the message Congress may hear as to the Administration's commitment to this important program from a decision to cut programmatic funding in FY 2000.

The New York EMA urges you to reconsider this .53% cut in funding because of its immediate negative impact on vulnerable people living with HIV – and because of its potential negative impact on the willingness of Congress to reauthorize the Act so it can continue to serve its critical role in our nation's public health system.

Very truly yours,

Martin Oesterreich

Martin Oesterreich

cc: Jacob Lew, OMB
Sandra Thurman, Office of National AIDS Policy
Kevin Thurm, HHS
John Callahan, HHS
Eric Goosby, M.D., HHS
Claude Earl Fox, M.D., HRSA
Joseph O'Neill, M.D., HRSA

OFFICE OF THE BRONX BOROUGH PRESIDENT
THE BRONX COUNTY BUILDING
851 GRAND CONCOURSE
BRONX, NEW YORK 10451

TEL 718-590-3500
FAX: 718-590-3537
E-MAIL: FFERRER1@compuserve.com

FERNANDO FERRER
BOROUGH PRESIDENT

December 21, 1999

The Honorable Donna Shalala
Secretary
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Room 615F
Washington, DC 20201

Dear Secretary Shalala:

I am writing to urge you to spare the Ryan White CARE Act Program any cuts for the FY 2000 budget. If the proposed cuts are implemented, the 0.53% spending cut would result in $8.5 million in lost funding.

The Bronx, and New York City and State are in great need of these funds. There are 136,748 individuals statewide and 110,858 in New York City who are suffering from HIV/AIDS. In The Bronx, there are 22,787 people living with HIV/AIDS. The number of people being infected with this virus is not declining, and the number of minorities infected is increasing.

This funding is necessary to ensure that all people with HIV/AIDS can access the care that they need. Please keep me apprised of your decision regarding these proposed funding cuts and how the federal government will work to ensure that all people with HIV/AIDS can obtain the needed care.

Sincerely,

FERNANDO FERRER

FF/mn
BPB9157

cc: Jacob Lew, OMB
Sandra Thurman, Office of National AIDS Policy
Kevin Thurm, HHS
John Callahan, HHS
Eric Goosby, M.D., HHS
Claude Earl Fox, M.D., HRSA
Joseph O'Neill, M.D., HRSA

December 21, 1999

The Honorable Donna Shalala, Secretary
U.S Department of Health and Human Services
200 Independence Avenue, S.W.
Room 615F
Washington, D.C. 20201

Dear Secretary Shalala,

We are writing to express the New York Eligible Metropolitan Area's (EMA) dismay and concern over the Administration's proposed .53% across-the-board reductions to Ryan White CARE Act programs for FY 2000. These critical grant programs serving low-income, and uninsured and under insured individual like myself and my wife should be the first to be protected from cuts and not disproportionately shoulder the burden of discretionary HHS program reductions. A .53% reduction from Ryan White CARE Act grants would reduce FY2000 funding by almost $ 8.5 million, putting at risk thousands of vulnerable individuals living with HIV disease.

The New York EMA, the largest in population in the United State, includes New York City and the Tri-County area of the Lower Hudson Valley. The incidence of HIV/AIDS in the New York EMA is dramatically higher than the rest of the country, with the largest percentage of cases occurring in economically disadvantaged communities of color. National estimates indicate that the New York EMA has almost 40 percent of all the women and half of all the children with HIV disease in the U.S. A number of people with HIV still do not benefit from the new therapies. A.53% reduction in Ryan White CARE Act funding would seriously jeopardize our programs struggling to close these treatment and service gaps.

As you know, infection rates remain distressingly high, adding new cases constantly to providers of Ryan White CARE services. The cost of care per patient is rising steadily. In addition, we learned just recently that the Public Health Service treatment guidelines would soon require our providers to offer laboratory tests to measure resistance as a part of the standard of HIV care. CARE ACT providers must be able to offer this test, but the cost is likely to reach $500 per patient per year. Absorbing the new unanticipated expense in FY 2000 on top of a .53% reduction in grants will place a tremendous burden on local agencies.

By September 30, 2000, Congress must reauthorize the Ryan White CARE ACT. The New York EMA is greatly concerned about the message Congress may hear as to the Administration's commitment to this important program from a decision to cut programmatic funding in FY2000.

We along with The New York EMA urges you to reconsider this .53% cut in funding because of its immediate negative impact on vulnerable people living with HIV/AIDS- and because of its potential

negative impact on the willingness of Congress to reauthorize the Act so it can continue to serve its critical role in our nation's public health system.

Sincerely,

Bertrande & Robert Lewis
PLWA

cc : Jacob Lew, OMB
Sandra Thurman, Office of National AIDS Policy
Kevin Thurm, HHS
John Callahan, HHS
Eric Goosby, M.D., HHS
Claude Earl Fox, M.D>, HRSA
Joseph O'Neill, M.D., HRSA

ARCS
AIDS-RELATED COMMUNITY SERVICES

2269 Saw Mill River Road, Bldg One South, Elmsford, New York 10523
(914) 345-8888 FAX# (914) 785-8227
www.arcs.org

275 Fair Street, Kingston, New York 12401
(914) 339-3281 FAX# (914) 339-6195

Sullivan County Public Health Nursing
Infirmary Road, Liberty, New York 12754
(914) 295-0094 FAX# (914) 295-0195

824 Dolmar Building, Route 6, Mahopac, New York 10541
(914) 628-1311 FAX# (914) 628-3347

473 Broadway, Newburgh, New York 12550
(914) 562-5005 FAX# (914) 562-5212

214 Main Street, Poughkeepsie, New York 12601
(914) 471-0707 FAX# (914) 471-0857

228 North Main Street, Spring Valley, New York 10977
(914) 356-0570 FAX# (914) 356-0589

December 17, 1999

The Honorable Donna Shalala, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 615F
Washington, D.C. 20201

Dear Secretary Shalala:

I am writing to express our dismay and concern over the Administration's proposed .53% across-the-board reductions to Ryan White CARE Act programs for FY2000. These critical grant programs serving low-income, uninsured and under insured individuals should be the first to be protected from cuts and not disproportionately shoulder the burden of discretionary HHS program reductions. A .53% reduction in Ryan White CARE Act grants would reduce FY 2000 funding by almost $8.5 million, putting at risk thousands of vulnerable individuals living with HIV disease.

The New York EMA, the largest in population in the United States, includes New York City and the Tri-County area of the Hudson Valley. The incidence of HIV/AIDS in the New York EMA is dramatically higher than the rest of the country, with the largest percentage of cases occurring in economically disadvantaged communities of color. National estimates indicate that the New York EMA has almost 40 percent of all the women and half of all the children with HIV disease in the U.S. A number of people with HIV still do not have adequate access to treatment and care services; and some people in care do not benefit from the new therapies. A .53% reduction in Ryan White CARE Act funding would seriously jeopardize our programs struggling to close these treatment and service gaps.

As you know, infection rates remain distressingly high, adding new cases constantly to providers of Ryan White CARE services. The cost of care per patient is rising steadily. There are more people living with HIV and AIDS today than ever before in history and their service needs are extensive. Providing services to this increasing caseload in FY 2000 while at the same time absorbing a .53% reduction in grants will place a tremendous burden on us. We will undoubtedly be losing ground we have worked so hard to secure.

By September 30, 2000, Congress must reauthorize the Ryan White CARE Act. We at ARCS are greatly concerned about the message Congress may hear as to the Administration's commitment to this important program from a decision to cut programmatic funding in FY 2000.

I personally urge you to reconsider this .53% cut in funding because of its Immediate negative impact on vulnerable people living with HIV—and because of it potential negative impact on the willingness of Congress to reauthorize the Act so it can continue to serve its critical role in our nation's public health system. This is not the time to cut back but rather to redouble our efforts in the fight to control the devastating effects of HIV and AIDS.

Sincerely,

Jeffrey Kraus
Executive Director

Cc: Jacob Lew, OMB
Sandra Thurman, Office of National AIDS Policy
Kevin Thurm, HHS
John Callahan, HHS
Eric Goosby, M.D., HHS
Claude Earl Fox, M.D., HRSA
Joseph O'Neill, M.D., HRSA

FACSIMILE TRANSMISSION

SF AIDS FOUNDATION

PUBLIC POLICY DEPARMENT
995 Market Street, Suite 200; San Francisco, CA 94103
P.O. Box 426182; San Francisco, CA 94142
Main: (415) 487-3080
Fax: (415) 487-3089

Date: 12/22/99

To: Sandy Thurman / Todd Summers @ ONAP

Fax Number: 202/ 456.2438

From: Regina Aragón
Deputy Director for Public Policy

RE: Letter to POTUS Re: FY01 Budget for HIV/AIDS

Number of pages (including cover): 3

Remarks: ☐ *URGENT!!* ☐ *For your review* ☐ *Reply ASAP* ☐ *Please Comment*
☐ *HAND DELIVER !!!!* ☒ *For your information*

Comments:

SF AIDS FOUNDATION
SAN FRANCISCO AIDS FOUNDATION 995 MARKET STREET, SUITE 200, SAN FRANCISCO, CALIFORNIA 94103
VISITORS' ENTRANCE: ONE 6TH STREET AT MARKET

December 23, 1999

The Honorable William Jefferson Clinton
The President
The White House
Washington, D.C. 20503

Dear Mr. President:

On behalf of the San Francisco AIDS Foundation (SFAF), I am writing to request your strong support for critical funding increases for federal HIV/AIDS programs in the Administration's FY 2001 budget request to the final session of the 106th Congress.

SFAF commends the Administration's efforts during the Omnibus FY 2000 Appropriations process, which resulted in significant increases in funding for HIV/AIDS programs. In particular, we want to thank you for your support of $245.5 million in targeted funding for the Minority HIV/AIDS Initiative obtained in collaboration with the Congressional Black and Hispanic Caucuses. These targeted resources will continue the important work begun in FY 1999 to address persistent disparities in health outcomes across racial and ethnic groups nationally.

Despite this progress, we as a nation must not become complacent while significant unmet need for services remains. Just this month, researchers participating in the HIV Cost and Services Utilization Study (HCSUS) reported that one-third of the nation's HIV patients -- primarily minorities, women, drug users and individuals living in poverty -- have forgone medical care because of the competing demands of work or basic necessities such as food and shelter.

In FY 2001, SFAF joins other community leaders in calling for $500 million in overall funding for the Minority HIV/AIDS Initiative. In addition, we request your support for the following funding increases as you finalize the Administration's FY 2001 budget:

Ryan White CARE Act
The Cities Advocating Emergency AIDS Relief (CAEAR) Coalition, of which SFAF is a member, has identified the need for $635 million for Title I of the CARE Act in FY 2001, an $89 million increase over FY 2000. The recent decrease in AIDS deaths nationwide is a direct result of the federal investment in medical care, supportive services and pharmaceuticals provided through the CARE Act. These reductions in AIDS-related deaths means that the number of people living with HIV and AIDS has grown steadily over the last several years, thereby increasing the demand for services funded by the CARE Act.

The AIDS Foundation also supports the request of the National Alliance of State and Territorial AIDS Directors for $703 million for the AIDS Drug Assistance Program (ADAP), representing a $130 million increase. Between June 1998 and June 1999, state ADAP programs have seen a 24% increase in the number of clients served at an average per client cost of $9,314. State ADAP programs project 14,000 new individuals will seek services from the ADAP program in FY 2001. It is essential that federal funding to ADAP reflect this growing need.

Additionally, the AIDS Foundation requests $184 million for Title III early intervention medical care grants to community-based public and private health centers. This $46 million increase will support ongoing efforts to address the growing needs experienced by clients served at the 197 directly funded Title III CARE Act sites across the country.

Housing Opportunities for People With AIDS (HOPWA)
SFAF requests that funding for the HOPWA program be increased by $60 million for a total of $292 million in FY 2001. As a critical component of the health care delivery system, HIV housing programs deserve your strong support. The ability to adhere to medical care and drug treatment is enhanced dramatically by safe, affordable, permanent housing. And, as new drug therapies help people remain healthier longer, turnover in AIDS housing programs has decreased, creating an urgent need for additional housing resources. In San Francisco alone, more than 3,000 individuals and families infected and affected by HIV/AIDS are currently on a centralized waiting list for housing assistance.

National Institutes of Health (NIH)
Despite the remarkable progress we have seen in treating people with HIV, we still have no cure for AIDS or a vaccine for HIV. Ongoing vaccine and microbicide development is essential to the ultimate goal of stopping the pandemic. The AIDS Foundation therefore supports the National Organization's Responding to AIDS (NORA) FY 2001 request for $2.329 billion in research funding to be coordinated through the Office of AIDS Research (OAR).

International Efforts through the CDC and USAID
The AIDS Foundation applauds the Administration's leadership in obtaining an additional $100 million for international HIV efforts in FY 2000, and asks that you continue to invest new resources in this area, as well.

Thank you for your consideration SFAF's FY 2001 budget requests for these important programs. I look forward to working with the Administration to improve the health and quality of life for people living with HIV/AIDS.

Sincerely,

Ernest Hopkins

Ernest Hopkins
Director of Federal Affairs

cc: Sandra Thurman, Office of National AIDS Policy
Eric Goosby, M.D., Dept. of Health and Human Services
Marsha Martin, Dept. of Health and Human Services
Daniel Mendelson, Office of Management and Budget

The HIV Center for Women and Children

January 5, 2000

The Honorable Donna Shalala
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 615F
Washington, D.C. 20201

Dear Secretary Shalala:

I am writing to express the New York Eligible Metropolitan Area's (EMA) dismay and concern over the administration's proposed .53% across-the-board reductions to Ryan White CARE Act programs for FY 2000. These critical grant programs serving low-income, uninsured and under-insured individuals should be the first to be protected from cuts and not disproportionately shoulder the burden of discretionary HHS program reductions. A .53% reduction from Ryan White CARE Act grants would reduce FY 2000 funding by almost $8.5 million, putting at risk thousands of vulnerable individuals living with HIV disease.

The New York EMA, the largest in population in the United States, includes New York City and the Tri-County area of the Lower Hudson Valley. The incidence of HIV/AIDS in the New York EMA is dramatically higher than the rest of the country, with the largest percentage of cases occurring in economically disadvantaged communities of color. National estimates indicate that the New York EMA has almost 40 percent of all the women and half of all the children with HIV disease in the U.S. A number of people with HIV still do not have adequate access to treatment and care services, and some people in care do not benefit from the new therapies. A .53% reduction in Ryan White CARE Act funding would seriously jeopardize our programs struggling to close these treatment and service gaps.

As you know, infection rates remain distressingly high, adding new cases constantly to providers of Ryan White CARE services. The cost of care per patient is rising steadily. In addition, we learned just recently that the Public Health Service treatment guidelines would soon require providers to offer laboratory tests to measure resistance as a part of the standard of HIV care. CARE Act providers must be able to offer this test, but the cost is likely to reach $500 per patient per year. Absorbing this new unanticipated expense in FY 2000 on top of a .53% reduction in grants will place a tremendous burden on local agencies.

State University of New York Health Science Center at Brooklyn
450 Clarkson Avenue, Box 1193, Brooklyn, NY 11203-2098 • 718 270-2301

By September 30, 2000, Congress must reauthorize the Ryan White CARE Act. The New York EMA is greatly concerned about the message Congress may hear as to the Administration's commitment to this important program from a decision to cut programmatic funding in FY 2000. The New York EMA urges you to reconsider this .53% cut in funding because of its immediate negative impact on vulnerable people living with HIV - and because of its potential negative impact on the willingness of Congress to reauthorize the Act so it can continue to serve its critical role in our nation's public health system. Thank you very much for your consideration.

Sincerely,

Kathleen A. Russell

Kathleen A. Russell, MPH, JD
Associate Director

Member, HIV Health and Human Services Planning Council of New York

cc: Jacob Lew, OMB
Sandra Thurman, Office of National AIDS Policy
Kevin Thurm, HHS
John Callahan, HHS
Eric Goosby, M.D., HHS
Claude Earl Fox, M.D., HRSA
Joseph O'Neill, M.D., HRSA

AACO grants questioned for alleged conflict

By Timothy Cwiek
PGN Contributing Writer

The city's AIDS Activities Coordinating Office has awarded grants totaling more than $300,000 to a company that allegedly has business connections to Patricia Bass, AACO's interim co-director.


BASS

The company is Einstein Data Solutions Inc., based in Center City. Through AACO's procurement process, Einstein Data has received city general funds, federal Centers for Disease Control and Prevention funds, and Ryan White CARE Act funds.

AACO also has awarded contracts worth $26,667 to Serendipity, a business that allegedly has financial connections to Bass' daughter, Robin Bass.

Neither Patricia Bass nor Robin Bass returned telephone calls, seeking comment.

Patricia Bass' voice mailbox was listed on the menu of Einstein Data's telephone-message system last week. After inquiries from PGN, the message was altered to delete any mention Bass.

Einstein Data's chief executive officer, Ivan C. Anderson Sr., did not return telephone calls seeking comment.

Jeff Moran, a spokesman for the city Health Department, which oversees AACO, said he spoke with Bass, and she denies being an employee or owner of Einstein Data.

"She provides some help to them" on a project separate from her AACO duties, Moran said, explaining why she once had a voice-mailbox at Einstein.

Moran said Bass is not compensated for the consulting work she is performing at Einstein.

Moran also said there have been no formal allegations of a conflict of interest regarding Bass and Einstein.

The local AIDS system has been plagued by complaints of favoritism and nepotism since its inception about 15 years ago.

"It's so exploitive," said an AACO employee, who furnished copies of the contracts to PGN. "They [AIDS officials] are messing with public funds, and people with AIDS are the ones who suffer."

At a 1998 AACO meeting, Einstein Data's Anderson allegedly referred to himself as a business partner of Bass, according to an AACO employee who attended the meeting. The employee asked not to be identified.

"AACO is not supposed to be a dumping ground for political patronage," said the source. "If you want to do pinstripe patronage, take it to the Parking Authority, where they deal with parking tickets. I'm an employee of the Department of Public Health. People's lives hang in the balance."

Bass also was criticized in September 1997 for allegedly staffing a booth at an AIDS conference in Florida that promoted Einstein Data, along with her family-owned business, Jordan Bass Associates.

Prior to the conference, on July 7, 1997, Bass approved a $121,320 grant to Einstein Data for "systemwide coordination." The money was supplied through Ryan White CARE Act funds.

James McCann, the region's project officer for Ryan White Title I funds, could not be reached for comment.

In a brief interview two weeks ago, Joe Cronauer, interim co-director of AACO, said he — not Bass — awarded a recent $42,500 grant to Einstein Data. The grant was for administrative services, and was not open for competitive bidding, Cronauer said.

Sources told PGN the grant amount allegedly increased to $67,000 last week; Cronauer did not return telephone calls seeking confirmation.

A recent $16,667 grant to Serendipity, a business which allegedly has financial connections to Robin Bass, was awarded after a competitive bidding process, according to city records. Money for the award was supplied by city general funds, according to AACO records.

Moran said Patricia Bass told him her daughter does not own or work for Serendipity, but Moran would not address Robin Bass' previous work history with Serendipity.

See **AACO,** *Page 23*

Nov 29 - Dec 2

AACO

From Page 7

But AIDS activist Michael Hinson, an outspoken critic of AACO, said too many AACO contracts are awarded without benefit of the open-bidding process.

"I think AACO has a pattern of abusing the [no-bidding] option," Hinson said. "There should be more open bids. There's a lot of talent out there."

Kathryn Bina, a spokeswoman for the CDC, said the CDC has not received any written requests for an investigation of the AACO contracts.

"If anyone is concerned about a possible infraction, they need to contact the city of Philadelphia in writing," Bina said. "If for whatever reason they are not satisfied with the city's response, they can forward their concerns to the CDC in writing."

Supporters of Cronauer and Bass said they inherited an agency with a long history of problems. They said Bass has an expertise in managed care, which has helped AACO. AACO also has received large increases in federal grant monies during the Bass/Cronauer tenure, their supporters said.

Tyrone Smith, executive director of Unity Inc., expressed mixed feelings about the Einstein Data contracts.

"I know Pat Bass, and I'm hopeful that answers will be forthcoming, to clarify this matter," Smith said.

Supporters of Cronauer and Bass said they inherited an agency with a long history of problems. They said Bass has an expertise in managed care, which has helped AACO. AACO also has received large increases in federal grant monies during the Bass/Cronauer tenure, their supporters said.

Smith also said city Health Commissioner Estelle B. Richman has not paid sufficient attention to AACO.

"I think perhaps [Richman] has not always been well-served by her [AIDS] representatives," he said. "Unfortunately, when there's conflict and turmoil at the top, it has a rippling effect throughout the whole AIDS system."

On Nov. 17, during a brief interview, Richman declined comment about the Einstein Data contracts, referring questions to spokesman Moran.

Mayor Ed Rendell also declined comment on Nov. 19.

"I don't know anything about it. Call Estelle [Richman]," he said.

Sources at AACO say morale among some employees is very low. They said bifurcating the directorship position, and bypassing civil service rules to do so, has caused some confusion and resentment at AACO.

"Actually, it's amazing that the line staff [at AACO] gets anything done," said an AACO employee, who asked to remain anonymous. "There's rampant violations [at AACO] of the city charter, civil service regulations, and the cooperative agreement with the union."

Some employees also resent that Bass lives in Wyncote, and is exempt from the Health Department policy requiring employees to live in Philadelphia, the source said.

Another source questioned how long Cronauer and Bass will serve "temporarily" as interim co-directors. They've held those positions at AACO since April 1997, according to city records. ▼

U.N.

From Page 5

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

U.S. AIDS Cases Reported Through June, 1998
Ryan White CARE Act Eligible Metropolitan Areas (EMAs)
Eligible for Fiscal Year 1999 Funding

Eligible Metropolitan Area	Cumulative Total	% of U.S. Total
Atlanta	13,753	2.07
Austin	3,348	0.50
Baltimore	11,824	1.78
Bergen-Passaic	4,880	0.73
Boston	11,759	1.77
Caugus	N/A	
Chicago	18,288	2.75
Cleveland	2,917	0.44
Dallas	10,837	1.63
Denver	5,031	0.76
Detroit	6,632	1.00
Dutchess County	N/A	
Ft. Lauderdale	10,749	1.62
Ft. Worth	2,853	0.43
Hartford	3,459	0.52
Houston	16,860	2.53
Jacksonville	3,810	0.57
Jersey City/Hudson County	6,037	0.91
Kansas City	3,514	0.53
Las Vegas	3,047	0.46
Los Angeles	37,886	5.69
Miami	20,743	3.12
Middlesex-Somerset-Hunterdon	2,911	0.44
Minneapolis-St. Paul	2,893	0.43
Nassau-Suffolk	5,924	0.89
New Haven -- Fairfield	5,765	0.87
New Orleans	6,013	0.90
New York	105,704	15.89
Newark	15,027	2.26
Norfolk	3,056	0.46
Oakland	7,233	1.09
Orange County	4,943	0.74
Orlando	4,982	0.75
Philadelphia	15,564	2.34
Phoenix	4,085	0.61
Ponce	N/A	
Portland	3,459	0.52
Riverside -- San Bernardino	6,016	0.90
Sacramento	2,832	0.43
San Antonio	3,497	0.53
San Diego	9,371	1.41
San Francisco	25,885	3.89
San Jose	2,813	0.42
San Juan	13,525	2.03
Seattle	6,040	0.91
Sonoma	N/A	
St. Louis	4,074	0.61
Tampa -- St. Petersburg	7,184	1.08
Vineland-Millville-Bridgeton	N/A	
Washington	19,324	2.90
West Palm Beach	6,424	0.97
Total All Reporting EMAs	492,771	74.06*
Total Nationwide	665,357	100.00

N/A Figures are unavailable due to confidentiality regulations.

* Figure would be higher if cumulative totals for all EMAs were available.

For more information, please contact CAEAR Coalition, 1413 K Street, NW, Suite 700, Washington, DC 20005
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CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

Ryan White CARE Act
Title I Eligible Metropolitan Area
42 Month AIDS Growth Chart

Eligible Metropolitan Area	Cumulative Total (December, 1994)	Cumulative Total (June, 1998)	42 Month % Growth Rate
Atlanta	8,858	13,753	55.26
Austin	2,335	3,348	43.38
Baltimore	6,915	11,824	70.99
Bergen-Passaic	3,292	4,880	48.24
Boston	8,252	11,759	42.50
Caugus	N/A	N/A	
Chicago	12,489	18,288	46.43
Cleveland	*	2,917	
Dallas	7,444	10,837	45.58
Denver	3,723	5,031	35.13
Detroit	4,358	6,632	52.18
Dutchess County	N/A	N/A	
Ft. Lauderdale	6,979	10,749	54.02
Ft. Worth	*	2,853	
Hartford	*	3,459	
Houston	11,414	16,860	47.71
Jacksonville	2,530	3,810	50.59
Jersey City/Hudson County	4,047	6,037	49.17
Kansas City	2,611	3,514	34.58
Las Vegas	*	3,047	
Los Angeles	27,247	37,886	39.05
Miami	14,050	20,743	47.64
Middlesex-Somerset-Hunterdon	*	2,911	
Minneapolis-St. Paul	*	2,893	
Nassau-Suffolk	3,938	5,924	50.43
New Haven -- Fairfield	3,355	5,765	71.83
New Orleans	3,867	6,013	55.50
New York	71,934	105,704	46.95
Newark	10,096	15,027	48.84
Norfolk	*	3,056	
Oakland	5,326	7,233	35.81
Orange County	3,523	4,943	40.31
Orlando	2,993	4,982	66.46
Philadelphia	9,897	15,564	57.26
Phoenix	2,715	4,085	50.46
Ponce	N/A	N/A	
Portland	2,492	3,459	38.80
Riverside -- San Bernardino	3,900	6,016	54.26
Sacramento	*	2,832	
San Antonio	2,255	3,497	55.08
San Diego	6,284	9,371	49.12
San Francisco	20,750	25,885	24.75
San Jose	*	2,813	
San Juan	8,790	13,525	53.87
Seattle	4,312	6,040	40.07
Sonoma	N/A	N/A	
St. Louis	2,773	4,074	46.92
Tampa -- St. Petersburg	4,845	7,184	48.28
Vineland-Millville-Bridgeton	N/A	N/A	
Washington	12,527	19,324	54.26
West Palm Beach	3,930	6,424	63.46

N/A Figures are unavilable due to confidentiality regulations. * This city was not yet an EMA in 1994.

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September 13, 1999

The Honorable William Jefferson Clinton
President
The White House
Washington, D.C. 20500

Dear President Clinton:

Cities Advocating Emergency AIDS Relief (CAEAR) Coalition is a national grassroots organization advocating on behalf of people living with HIV/AIDS who depend on Title I and Title III of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act for health care and support services. We include members of Title I planning councils, people living with HIV/AIDS, community-based AIDS service organizations, providers of HIV/AIDS health care, CARE Act grantees, and consortia. We are civic and business leaders, lesbians and gay men, health care providers, members of religious organizations, government representatives, local public health officials, drug treatment and mental health providers, and representatives from diverse communities of color.

We write to you today to ask that the Administration request FY 2001 budget increases for all CARE Act programs, and in particular, we strongly urge you to include in the Administration's FY 2001 budget a request to Congress for $635 million in funding for Title I of the CARE Act and $184 million in funding for Title III of the CARE Act. These levels represent increases over FY 1999 of $130 million for Title I and $90 million for Title III.

The HIV Cost and Services Utilization Study (HCSUS) performed for the Department of Health and Human Services by RAND has revealed important new findings. HCSUS shows that despite the development of comprehensive systems of care, and the ongoing expansions in access to care and treatment for people living with HIV/AIDS, people of color -- especially African-Americans -- continue to experience widespread and significant levels of disparity in access to care, service utilization, service quality, and outcome of care. HCSUS estimates that 250,000 to 300,000 individuals who know they are HIV-positive remain outside systems of medical care and treatment.

Funding levels consistently below community needs have limited Title I access, the emergency safety net for an estimated 74 percent of people in the U.S. diagnosed with AIDS. This persistent lack of resources has prevented Title I areas from providing access to the full complement of

services needed by individuals in care. The aggregate funding request of Title I communities in FY 1999 was $570 million, while actual Title I funding fell $65 million short. In FY 1999, seven Title I areas lost funding as compared to the previous year. Despite modest increases in CARE Act funding overall, some (though not always the same) Title I communities have lost funding in four of the last five fiscal years as compared with their previous year funding.

The 51 Title I eligible metropolitan areas and the 197 Title III funded community-based health centers are critical components of the comprehensive care systems developed by local communities through the CARE Act. Both Title I systems and Title III programs provide high quality medical and support services for individuals living with HIV/AIDS -- approximately two-thirds of whom are people of color.

Women composed one-third of the 96,000 clients of Title III programs seen in FY 1998, accessing early intervention services for HIV disease in existing primary medical care centers. One quarter of the Title III sites represent the only HIV medical program in their areas, many of which are located in geographically isolated and underserved communities. Yet funding shortages in FY 1999 prevented 28 qualified community-based health centers from receiving Title III grants last year.

The persistent disparities among communities of color, aggravated by these acute funding shortages, demand innovative responses from both the Title I systems and Title III providers. These disparities suggest the need to create new heath care infrastructure and capacity for underserved communities and to apply additional resources to novel, targeted approaches to health care outreach, and medical and supportive services in both Title I areas and Title III communities.

Our goal for FY 2001 is to create new, high-quality HIV/AIDS medical infrastructure and capacity for underserved communities where it does not now exist, and to increase the quality of care, infrastructure, and capacity of existing minority providers. That goal, we believe, requires $50 million in additional funding for Title I and $30 million in additional funding for Title III.

New data from the Centers for Disease Control and Prevention (CDC) demonstrates that the recent reductions in death rates have leveled off and that the number of individuals dying – especially in communities of color -- is on the increase. Meanwhile, the CDC estimates that the overall rate of HIV infection in the United States remains unchanged at 40,000 individuals diagnosed annually. Each of these individuals must receive initial medical evaluations, including expensive viral load testing to determine the appropriate course of treatment. In addition, many of these individuals have other severe health, social, and economic problems that complicate their ability to manage their HIV disease and that require additional medical and social services.

As the resulting complexity of HIV care increases, the cost of providing high-quality care escalates as well. A 1998 CAEAR coalition study showed an 89.3 percent increase from 1995 to 1997 in the average cost of HIV medical care. This is partly the result of the advent of combination therapies, which have placed significant pressure on Title I areas and Title III communities to assure access to these drugs. Medications, however, cannot be provided outside the context of overall primary care, including education about adherence to combination drug regimens. Failure to take these medications as prescribed runs the risk of rapid development of resistant viral strains. These changes in standard practices for providing HIV care increase the time needed for each medical visit. The 1998 CAEAR study also showed that from 1995 to 1997 the average length of medical visits increased 65 percent.

Multiple challenges have presented themselves to Title I and Title III communities as a result of the new medications. Several overlapping trends are occurring. Overall annual rates of new HIV infections are continuing at 40,000 new infections per year. HIV-related deaths, while initially declining dramatically, are inching back up -- especially in communities of color. This trend exacerbates the increasing numbers of people who are living with HIV/AIDS and seeking services for the first time as well as those who are in need of critical and expensive end stage care. Those clients in care that are receiving benefit from the medications need services for significantly longer than ever before and many in care are remaining significantly longer. A 1998 CAEAR Coalition study reveals an average increase of 43.5 percent in the number of HIV/AIDS patients between 1995 and 1997.

Other HIV service delivery pressures are also present. The same study revealed an average increase of 43.5 percent in the number of HIV/AIDS patients, an increase of 55.3 percent in patient visits, and a 27.4 percent increase in the number of visits per patient. These increases occurred as the rate of new HIV infections remained stable and the decline in HIV-related deaths -- after initially dramatic drops -- began to rise back up and create the need for expensive end-of-life care. As ever larger numbers of people with HIV/AIDS seek services, longer waits develop for outpatient, community-based care, and the threat of high-cost emergency room visits returns. As people live longer with AIDS, they continue to require essential medical and supportive services. Providing access for new clients is dependent upon new resources. With the availability of combination drug therapy, many people with HIV have sought care for the first time. The Health Resources and Services Administration (HRSA) estimates that 20 percent of Title I and Title III clients receiving services annually are clients.

In 1997, the U.S. Public Health Service issued guidelines on HIV treatment. Funding remains inadequate to assure the delivery of the standard of care required by these federal guidelines to all that need it. CAEAR believes that these guidelines should become the <u>minimum</u> standard of care and treatment nationally. Our goal in FY 2001 is to expand the number of new clients in Title I systems of care by 50 percent at a cost of $80 million and those receiving early intervention care at Title III sites by 30 percent at a cost of $60 million.

The AIDS epidemic has produced dangerous strains on our nation's public health systems. Hospitals have long reported average losses of $401 per day for each AIDS patient. As the burdens mount, responding to the needs of the AIDS epidemic grows more difficult and imperils our ability to meet all the other health needs in our communities. Heavily reliant upon resources from the entire CARE Act, our communities request that the Administration's budget include adequate funds for all CARE Act titles, as well as other federal AIDS efforts in prevention, housing, and research.

With funds provided under the Ryan White CARE Act, our communities can prolong the lives of people with AIDS, assist thousands in their quest to regain full function and productivity, and save the nation millions of dollars in unnecessary hospitalizations and other health care costs. With case-managed care such as that provided with Title I and Title III resources, patients have been shown to realize 46 percent lower hospitalization costs and live 66 percent longer than those individuals not receiving case-managed care. Proper care and supportive services improve the quality of life for people with HIV/AIDS and can enable many to remain working and contributing to their communities.

The AIDS emergency in the United States continues. People with HIV/AIDS, their caregivers, family, friends, and communities need your continued support.

Sincerely,

Matthew McClain
Chair
CAEAR Coalition

CAEAR Executive Committee

Patricia A. Bass
Philadelphia Department of Public Health
Philadelphia, Pennsylvania

Errol Chin-Loy
Mayor's Office of AIDS Policy Coordination
New York, New York

A. Gene Copello
Northeast Florida AIDS Network
Jacksonville, Florida

Harold Cox
City of Cambridge
Cambridge, Massachusetts

Tracy Fischman
Chicago Department of Public Health
Chicago, Illinois

Daryl Flynn
HIV Drug and Alcohol Task Force
Los Angeles, California

Susan Geissler
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Denver, Colorado

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May 3, 1999

The Honorable Arlen Specter
United States Senate
Washington, D.C. 20510

Dear Senator Specter:

Cities Advocating Emergency AIDS Relief (CAEAR) Coalition is a national grassroots organization advocating on behalf of people living with HIV/AIDS who depend on Title I and Title III of the Ryan White CARE Act for health care and support services. We include members of Title I planning councils, people living with HIV/AIDS, community-based AIDS service organizations, providers of HIV/AIDS health care, CARE Act grantees, and consortia. We are civic and business leaders, lesbians and gay men, health care providers, members of religious organizations, government representatives, local public health officials, drug treatment and mental health providers, and representatives from diverse communities of color.

We ask you, as a member of the Labor/HHS/Education Appropriations Subcommittee, to provide increases for all CARE Act Titles, and in particular, we strongly urge you to include in the FY 2000 appropriations legislation $625 million in funding for Title I of the CARE Act and $134 million in funding for Title III of the CARE Act. These funding levels represent increases over FY 1999 of $120 million for Title I and $40 million for Title III.

Increased funding for the CARE Act is urgently needed to address the ongoing HIV/AIDS emergency in communities across the nation. The AIDS epidemic in America has continued to expand relentlessly in historically underserved communities of color, and other populations that have severe social, economic, and persistent disparities in health care access and quality of care. In FY 1991, Title I provided assistance to 16 communities. In FY 1999, 51 American metropolitan areas qualify for disaster relief HIV/AIDS funding under Title I. These 51 communities are the home to about 74 percent of all reported AIDS cases in America. Tragically, in FY 2000, there may be as many as three additional newly eligible Title I areas that will require disaster relief to address their local HIV/AIDS crises. Title III programs, currently 181 in all, are located in 43 states plus Puerto Rico and Washington, D.C. and provide HIV-related medical services to more than 96,000 individuals. One-third of clients receiving treatment at Title III programs are women.

The Sheridan Group
Government Relations
Representative

Current funding levels are inadequate to meet the growing needs of the increasing number of people living with HIV/AIDS in America. Despite modest increases in CARE Act funding overall, some – but not always the same – Title I communities have lost funding in four of the last five fiscal years as compared with their previous year funding. In FY 1999, seven Title I areas lost funding as compared to the previous year. The CAEAR Coalition requests a $7 million increase in Title I funding to prevent further erosion of the existing continuums of care in these communities.

Federal funding shortfalls are evident in other important ways. In Title I, for example, aggregate Title I requests for funding in FY 1999 exceeded $551 million but total funding was almost $45 million less than needed. In Title III, the Federal government has already approved $11 million in grants to 28 new Title III community health care applicants, but cannot fund these applications due to a lack of funding. This is especially important if geographically isolated, underserved, and rural areas are ever going to be able to provide quality HIV-related medical care and support services to their patients. Almost 25 percent of Title III programs report being the only HIV medical outpatient program in their area.

An additional funding gap has emerged as a result of new treatment options. In 1997, the U.S. Public Health Service issued guidelines on the treatment of HIV-related Opportunistic Infections, and on the Use of Antiretroviral Treatments for HIV Disease in Adults and Adolescents. Current Title I and Title III funding is inadequate to assure the delivery of the standard of care required by these Federal guidelines to all people with HIV/AIDS who need it. The CAEAR Coalition requests an increase of $52 million for Title I and an increase of $11 million for Title III to address the unmet need for care and treatment to people living with HIV/AIDS.

Multiple challenges have presented themselves to Title I and Title III communities as a result of the new medications. Several overlapping trends are occurring. Overall annual rates of new HIV infections are continuing at 40,000 new infections per year; HIV-related deaths have dramatically declined by 43 percent nationally thereby increasing numbers of people are living with HIV/AIDS and seeking services for the first time; clients in care are needing services for significantly longer than ever before and many in care are remaining there significantly longer. A 1998 CAEAR Coalition study reveals an average increase of 43.5 percent in the number of HIV/AIDS patients between 1995 and 1997.

The Health Resources and Services Administration (HRSA) estimates that 20 percent of Title I clients receiving services annually are new clients. Meanwhile, Title I communities across the country have documented client increases ranging from 13 percent to 74 percent. For Title III providers, one-third of their patients are new clients each year. This surge of new clients entering Title I and Title III programs also require more medical visits and social services, including an initial assessment, diagnostic tests, and the determination of a treatment regime. The 1998 CAEAR study estimates that between 1995 and 1997 the total number of patient visits increased by 55.3 percent and the number of visits per patient rose 27.4 percent. Once treatment has begun, all patients must receive regular treatment education and ongoing monitoring, including expensive viral load testing.

Clearly, both the cost and the complexity of care provided by Title I and Title III programs are increasing. New therapies have placed significant pressure on Title I and Title III communities to ensure that access to these drugs is continuously available with no gaps in service that could destroy the hard-earned results achieved by many individuals on anti-retroviral therapy. It is very important to understand that these new therapies cannot be provided outside the context of overall primary care. Patients need a coordinated medical team that includes highly trained physicians, nurse practitioners, nurses, pharmacists, treatment educators, and case managers. Care teams must address treatment readiness issues prior to therapy, and educate patients about the importance of maintaining adherence to combination drug regimens. Indeed, the failure to take these medications as prescribed has been shown to increase the development of viral resistance-rendering the medications ineffective and potentially damaging the future effectiveness of other medications of the same type.

The evolution in the clinical management of HIV disease has increased the time health care providers must spend per medical visit. The 1998 CAEAR Coalition study shows that from 1995 to 1997 the average length of medical visits increased 65 percent. The same CAEAR study revealed that from 1995 to 1997 the average cost of HIV medical care rose 89.3 percent. Other studies indicate that the cost of HIV care would have escalated even higher without the significant reductions in emergency care and inpatient hospitalization resulting from outpatient Title I and Title III programs. These community-based outpatient care sites have reduced the rate of inpatient hospitalizations in some locales by as much as 75 percent since 1996. The CAEAR Coalition seeks an increase of $48 million for Title I and an increase of $12 million for Title III to address the increasing cost of HIV outpatient community-based care. The Coalition seeks an additional increase of $7 million for Title III specifically to meet the increasing cost of providing HIV social services.

Both Title I and Title III grants support HIV/AIDS case management, a service that is one of the most important reasons for the nationwide reductions in hospitalizations. One study has shown that patients with case-managed medical care, such as that provided in Title I and Title III programs, experience 46 percent fewer hospitalizations and live 66 percent longer than people with AIDS not receiving case-managed care. Title III grantees have reported to HRSA that more than $5 million was needed but not available for providing case management services to patients in 1996. They also have reported that the cost of providing case management services increased 55 percent between 1995 and 1996, due in part to an emerging medical model of case management stressing adherence to complex drug regimens.

Another important concern for Title I and Title III programs is that they provide the overwhelming majority of CARE Act funded medical care to people living with HIV/AIDS and approximately two-thirds of Title I and Title III clients are people of color. Despite significant improvement in access to medical care and antiretroviral treatment, the utilization patterns of people of color - especially African Americans - continue to lag significantly behind their representation in local HIV/AIDS epidemics. Communities of color experience cultural and environmental barriers to full access to health services, including HIV care. Many people of color living with HIV/AIDS are burdened by histories of other health threatening conditions, including substance use, mental illness, homelessness, tuberculosis, and other sexually transmitted diseases.

These factors, when combined with economic hardships and community dislocation, results in disparities in access to health care and support services. Both Title I and Title III programs have enhanced outreach to HIV-infected people of color to ensure they are made aware of the availability of HIV services in an effort to link them to existing health care systems as early after diagnosis as possible. Delayed access to HIV care perpetuates the disparities in health outcomes and the unequal rates of reduction in AIDS mortality, and more work is needed in this area. The CAEAR Coalition requests an increase of $13 million for Title I and an increase of $10 million for Title III to address the disparities in outcomes, access, and utilization of care by people of color.

The AIDS epidemic has produced dangerous strains on our nation's public health systems. Data from the National Association of Public Hospitals and Health Systems estimated that in 1993 hospitals experienced losses exceeding $2,000 per AIDS patient per year. As the burdens mount, responding to the needs of the AIDS epidemic grows more difficult and imperils our ability to meet all the other health needs in our communities. Heavily reliant upon funding for all titles of the CARE Act, our communities request that the Labor/HHS/Education appropriations for FY 2000 include adequate funds for all titles of the CARE Act and other Federal HIV/AIDS efforts in prevention and research.

With funds provided under the Ryan White CARE Act, our communities can prolong the lives of people with HIV disease and AIDS and save the nation millions of dollars in unnecessary hospitalization and other health care costs. As we have demonstrated in the data presented here, proper care and supportive services enable people with AIDS to remain working and contributing to their communities.

Title I and Title III programs have been proven through multiple studies and audits to save the taxpayers' money as well as effectively and efficiently maintain the health and improve the quality of life for people with HIV disease and AIDS. We need your help to continue to meet the need. Please give people living with HIV/AIDS, their care givers, families, friends, and communities your continued support.

Sincerely,

Matthew McClain
Chair
CAEAR Coalition

CAEAR Executive Committee

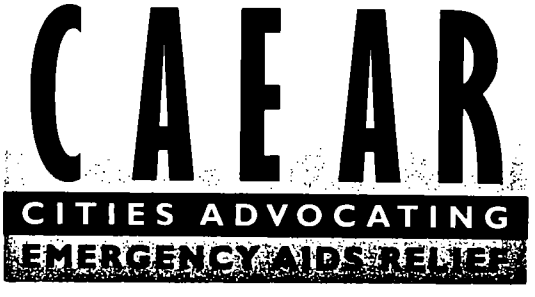
Draft FY 2000 Appropriations Report Language
for
Title I and Title III of the Ryan White CARE Act

The Committee recommends $ 625,200,000 for Title I emergency assistance grants to the 51 eligible metropolitan areas disproportionately affected by the HIV/AIDS epidemic and recognizes the importance of the local control provided by Title 1 Planning Councils. These funds are provided to areas with a cumulative total of more than 2,000 cases of AIDS or a per capita incidence of 0.0025 for cases prior to fiscal year 1995. One-half of the funds are awarded by formula and one-half are awarded through supplemental competitive grants. The Committee is concerned that the significant health improvements and reductions in deaths, observed in some individuals living with HIV/AIDS, are not being evenly realized by all affected Americans regardless of race, ethnicity, socio-economic status, gender and age. Recent national improvements in access to combination therapies require that the essential medical and supportive services, provided by Title I, be bolstered in order to promote and sustain participation in health care services. The demonstrated impact of Title I services on improved patient survival and care justify the Committee's recommendation of a $120 million increase in Title I funding over FY 1999. The Committee also recommends that the targeted initiatives to reduce the disparity in health outcomes and utilization of existing services between populations remain a high priority for all funded localities, particularly Title I communities serving the majority of people with AIDS in the country.

The Committee recommends $134,000,000 for Title III HIV/AIDS Early Intervention and Care Programs to maintain and enhance access to primary care services in 197 rural and urban communities that are disproportionately affected by the HIV/AIDS epidemic. This is an increase of $40 million over FY 1999. Title III of the Ryan White CARE Act provides grants directly to community based health centers and public health providers in 44 states plus Washington, DC and Puerto Rico to develop and deliver early and ongoing comprehensive outpatient HIV health care to more than 93,000 persons with HIV/AIDS. On average, each of these community-based, HIV primary care programs provide early diagnosis and treatment to over 513 clients. Title III is intended to be a medical safety net for populations that have been historically underserved. Two-thirds of Title III patients are people of color, and one-third are women. Nearly one-quarter of Title III programs report being the only HIV medical program in their area. Direct funding to these community based health centers and public health providers ensures their capacity to respond to advances in medical treatment practices and strengthens access to experienced practitioners, thus ensuring the provision of quality services to populations in greatest need. The demonstrated impact of Title III services on improved patient survival and care justify the Committee's recommendation of a $40 million increase in Title III funding over FY 1999.

THE ACCELERATING COST OF HIV HEALTH CARE:

An Analysis of Services Provided Under Title I and Title III of the Ryan White CARE Act



Conducted by
Cities Advocating Emergency AIDS Relief (CAEAR)

August, 1998

For more information, contact the CAEAR Coalition, a national coalition supporting Ryan White CARE Act Title I and Title III, 1413 K Street, NW, Suite 700, Washington, DC 20005 phone (202) 789-3565, fax (202) 789-4277 or Email: CAEARinDC@aol.com

CAEAR

Cities Advocating Emergency AIDS Relief (CAEAR) is a national grassroots coalition advocating on behalf of people living with HIV who depend on Title I and Title III of the Ryan White CARE Act for health care and support services. CAEAR includes members of Title I planning councils, people living with HIV/AIDS, organizations of people living with HIV, community-based AIDS service organizations, CARE Act grantees and consortia.

OVERVIEW

Over the past few months the CAEAR Coalition conducted the following study of HIV/AIDS related services in order to highlight the changing HIV health care system and subsequent need for increased funding. The analysis concentrated on data collected from 1995 through 1997, during which time combination anti-HIV therapy was introduced and became widely available. The CAEAR data suggest that advancements in HIV treatment have necessitated more comprehensive treatment regimens with greater participation of both the patient population and health care professionals. Through the evaluation of the medical services, patient population and health care cost, the following were identified as key components adding significant weight to the growing HIV health service need:

The Growing HIV Population

- Data show that between 1995 and 1997 there was an average increase of 43.5% in the number of HIV/AIDS patients among a representative sample of Title I and Title III sites, clearly illustrating one of the most obvious challenges to the HIV/AIDS health care community: the growing HIV population.

- In addition to new HIV cases, recently available combination therapies have increased the life expectancy of HIV patients. As the number of AIDS deaths has begun to decrease, the number of people dependent on treatment provided under the CARE Act has grown substantially. The data compiled by the CAEAR Coalition in this study reflects the impact of combination therapies that became widely available during the 1995-1997 period.

Increase in the Number of Patient Visits

- One effect of the swelling patient population is the dramatic increase in the number of patients visits reported by the medical community. CAEAR estimates that the total number of patient visits increased by 55.3% from 1995 to 1997.

- While the growing patient population is certainly contributing to the increasing number of visits, CAEAR found that the number of medical visits per patient also has grown by 27.4%. Individuals under care are finding that treatment requires longer and more frequent visits. The combination of a growing patient population and treatment regimens that necessitate more visits per patient will continue to burden limited Title I and Title III funding.

Costly Medical Care

- The CAEAR study revealed that the average cost of medical care has increased by 89.3%. The study also found that this escalating cost could not be attributed solely to the increase in patients (43.5%), or patient visits (55.3%), which are growing at less significant rates than the accelerating cost of medical care.

- Advancements in HIV treatments, are among the reasons for this increased cost in HIV medical health care. Complex treatment regimens are required, including increased viral load testing and greater emphasis on longer more complex visits to promote adherence to drug dosing and scheduling. Neglecting to take medication as prescribed can lead to the failure of the therapy, the development of resistant viral strains, or both. Communities financially dependent on the CARE Act are, and will continue to be, inundated with patients in need of these costly medical services.

CONCLUSION

The Ryan White CARE Act allocates necessary resources to communities serving under Title I and Title III of the CARE Act. This funding provides HIV patients who are living below the poverty line or who are uninsured access to medical services they could otherwise not afford. The development of anti-HIV combination therapy has led to significant improvements in the length and quality of life of those living with HIV. However, as this study revealed, health care is now a much more intensive and costly process for both the growing patient population and the medical community. Given current funding levels, the communities serving under the Ryan White CARE Act will not have the necessary resources to meet the needs of those it serves nor will they be able to sustain the heightened level of health care necessary for successful treatment.

CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

THE CARE ACT:

✔SAVES LIVES
✔DECREASES AIDS DEATHS
✔INCREASES THE NUMBER OF PEOPLE GOING BACK TO WORK

Support the CAEAR Coalition's FY 1999 appropriations requests for CARE Act Title I and Title III:

- ***CARE Act Title I FY 99 appropriation of $570 million (+$105 million over FY 1998)***
- ***CARE Act Title III FY 99 appropriation of $113 million (+$36.7 million over FY 1998)***

Combination anti-HIV therapy, including protease inhibitors, became available in 1995. In 1998, treatment choices range from 3-drug combinations for new patients to 4- or 5-drug combinations for experienced patients. However, adherence to these new drug regimens requires more complex and costly comprehensive clinical care for people with HIV.

Since 1994, Title I and Title III programs have seen:

- **Up to 166.7 percent increases in patient visits since 1994**
- **Up to 254.0 percent increases in average cost per patient for medical care (excluding pharmaceuticals)**

Presented below are summary data from selected Title I and Title III CARE Act grantees; see individual reports for details. These data are representative of the 51 CARE Act Title I areas eligible for funding in 1999 and the 183 CARE Act Title III grantees.

More Complex and More Costly Comprehensive Clinical Care for People with HIV Disease				
City/State	***Reporting Organization***	***CARE Act Title I and Title III Funding***	***Percent Change in Number of Patient Visits***	***Percent Change in Average Cost of Medical Care Only***
Atlanta, Georgia	Grady Health System Infectious Disease Program	Title I	30.9% increase since 1995	68.5% (est) increase since 1995
Baltimore, Maryland	Chase Brexton Health Services	Title I, Title III	21.4% increase since 1995	29.0% increase since 1995
Chicago, Illinois	Chicago Health Outreach	Title I, Title III	214.0% (est) increase in the number of patients since 1994	170.4% increase since 1994
Chicago, Illinois	The CORE Center for the Prevention, Care, and Research of Infectious Disease	Title I, Title III	15.6% increase since 1995	13.3% increase since 1995
Philadelphia, Pennsylvania	Allegheny University Hospitals Hahnemann	Title I	166.7% increase since 1994	254.0% increase since 1994
Philadelphia, Pennsylvania	Health Federation of Pennyslvania	Title I	94.7% increase since 1994	not reported
Philadelphia, Pennsylvania	Department of Public Health	Title I	46.8% increase since 1994	55.7% increase since 1994
Riverside -- San Bernardino, California	Desert AIDS Project	Title I	71.4% increase since 1995	123.3% increase since 1995
San Francisco, California	San Francisco General Hospital	Title I	74.0% increase since 1994	not reported
Santa Cruz, California	Santa Cruz County Health Services Agency	Title III	63.7% increase since 1993	69.4% increase since 1993
Seattle, Washington	Country Doctor Community Health Centers	Title III	20.9% increase since 1995	13.2% increase since 1995
Washington, D.C.	Whitman-Walker Clinic	Title I, Title III	85.6% increase since 1994	177.7% increase since 1994

Sources: Reporting organizations. June - July, 1998.

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CITIES ADVOCATING EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

Grady Health System Infectious Disease Program Atlanta, Georgia

Funded By CARE Act Title I

Year	Number of Patients Receiving Medical Care	Number of Medical Visits	Average Number of Medical Visits per Patient per Year	Average Number of Medical Visits per Patient per Year (for patients with at least two visits)	Average Cost per Patient per Year (medical care & labs only -- no drugs)
1995 Combination therapy not available	3,037	22,635	7.5	8.5	$1,200*
1997 Combination therapy available	3,368	29,146	8.7	9.8	$2,022
Percent Change Since 1995	**10.9% increase**	**28.8% increase**	**16.0% increase**	**15.3% increase**	**68.5 % increase***

Source: Infectious Disease Program, Grady Health System, Atlanta, Georgia.

* 1995 average cost per patient per year (medical care and labs only -- no drugs) is an estimate, and therefore the percentage change is also an estimated figure.

Notes concerning complexity of visits:

1995:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- During this period, AZT was the major medication for the treatment of opportunistic infections. Combination therapy and various forms of counseling were used for primary health services to patients.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.
- While the number of patients was relatively stable (minimal increase), there were significant increases of visits per patient. Also, increases were noticed in patients' CD4 counts and decreases in viral loads.

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CITIES ADVOCATING EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

Chase Brexton Health Services Baltimore, Maryland

Funded By CARE Act Title I and Title III

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Number of Visits per Patient per Year (for patients with at least two visits)	Average Cost per Patient per Year (medical care & labs only -- no drugs)
1995 Combination therapy not available	762	4,191 (20 min. each)	5.5	6.6	$1,187
1997 Combination therapy available	795	5,088 (35 min. each)	6.4	7.2	$1,532
Percent Change Since 1995	**4.3% increase**	**21.4% increase**	**16.3% increase**	**9.0% increase**	**29.0% increase**

Source: Chase Brexton Health Services, Baltimore, Maryland.

Notes concerning complexity of visits:

1995:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- Supportive care for terminal cases.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.
- Adherence counseling.
- Adjustments in medications as needed for increased viral loads.
- Increased labs.
- Reduced late in life activities (80 per year before combination therapy, 28 in 1997).
- Increased support staff (additions, nutrition, case management, nursing and mental health).

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CITIES ADVOCATING EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

Chicago Health Outreach
Chicago, Illinois

Funded By CARE Act Title I and Title III

Year	Number of Patients (Actual)	Average Number of Visits per Patient per Year (Estimated for patients with at least two visits)	Average Cost per Patient per Year (Estimated medical care & labs only -- no drugs)
1994 Combination therapy not available	243	4.0	$740
1997 Combination therapy available	764	8.0	$2,000
Percent Change Since 1994	**214.4% increase**	**100.0% increase**	**170.4% increase**

Source: Chicago Health Outreach, Chicago, Illinois.

Notes concerning complexity of visits:

1994:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- Palliative care for terminal cases.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.
- Labs monitorning and education realted to medications.
- Providing triple combination therapies and medication(s) for side effects.
- Monitoring interactions between triple combination medications and medications for side effects.
- Changing triple combination medications when viral loads increase.
- Increased lab work involved all monitoring activities.
- Reduction in incidence of opportunistic infections.
- Reduction in late stage and terminal care activities.
- More time involved in adherence issues and nutrition related to the use of new medications.

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CITIES ADVOCATING EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

The CORE Center for the Prevention, Care, and Research of Infectious Disease (formerly known as the Cook County HIV Primary Care Center) Chicago, Illinois

Funded By CARE Act Title I and Title III

Year	Number of Patients	Number of Visits	Number of Patients on Protease Inhibitors	Average Cost per Patient per Visit (medical care & labs only – no drugs)
1995 Combination therapy not available	1,796	9,454 (20 min. each)	not reported	$375
1997 Combination therapy available	2,113	10,933 (30+ min. each)	1,430 (68% of patients)	$425
Percent Change Since 1995	**17.7% increase**	**15.6% increase**	**n/a**	**13.3% increase**

Source: The CORE Center for the Prevention, Care, and Research of Infectious Disease (formerly known as the Cook County HIV Primary Care Center (CCHPCC)), Chicago, Illinois.

Notes concerning complexity of visits:

1995:

- CD4 monitoring, treatment of opportunistic infections and monitoring of small numbers of medications available at the time (e.g., AZT).
- Palliative care for terminal cases.
- Treating and monitoring care for common health problems in patients such as hypertension, asthma, and diabetes.

1997:

- Minimum quarterly monitoring of viral loads. Monitoring CD4 counts.
- Providing and monitoring combination therapies and medications for side-effects. Ensuring compliance with NIH guidelines and quality standards.
- When necessary, determining most appropriate changes in medications when viral loads increase or when patients experience side-effects.
- Increased lab work in all monitoring activities.
- Establishing individualized adherence plans and follow-up on a regular basis.
- Engaging in intensive client education about medications and combination therapies.
- Treating and monitoring care for common health problems in patients such as hypertension, asthma, and diabetes -- ensuring safe interactions between any medications taken for various conditions and HIV/AIDS medications.
- Reduction in incidence of opportunistic infections.
- Reduction in late stage and terminal care activities.
- Delivering preventative interventions, such as vaccine, prophylaxis, annual screening for tuberculosis, and pap smears for women every 6 months.
- Increasingly complex case management: housing, entitlement, supports, transportation, nutrition, mental health assessment, counseling, intervention, group prescription referral, chemical dependency assessment, counseling and intervention.

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CITIES ADVOCATING EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

Allegheny University Hospitals Hahnemann Philadelphia, Pennsylvania

Funded By CARE Act Title I

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Cost per Patient per Year (medical care & labs only – no drugs)
1994 Combination therapy not available	297	1,255 (20 min. each)	4.2	$441
1997 Combination therapy available	650	3,348 (40 min. each)	5.2	$1,561
Percent Change Since 1994	**118.8% increase**	**166.7% increase**	**23.8% increase**	**254.0% increase**

Source: Allegheny University Hospitals, Hahnemann, Philadelphia, Pennsylvania.

Notes concerning complexity of visits:

1994:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- Palliative care for terminal cases.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.

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CITIES ADVOCATING EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

Health Federation of Pennsylvania Philadelphia, Pennsylvania

Funded By CARE Act Title I

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year
1994 Combination Therapy Not Available	270	1,170	4.3
1997 Combination Therapy Available	350	2,274	6.5
Percent Change Since 1994	**29.6% increase**	**94.7% increase**	**51.1% increase**

Source: CareLink (an HIV/AIDS care network comprised of five federally qualified community health centers), The Health Federation of Philadelphia, Philadelphia, Pennsylvania.

Notes concerning complexity of visits:

1994:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- Palliative care for terminal cases.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.

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Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

Philadelphia Department of Public Health Philadelphia, Pennsylvania

Funded By CARE Act Title I

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Number of Visits per Patient per Year (for patients with at least two visits)	Average Cost per Patient per Year (medical care & labs only – no drugs)
1994 Combination therapy not available	824	4,000	4.85	6.27	$724
1997 Combination therapy available	1,019	5,874	5.76	7.14	$1,127
Percent Change Since 1994	**23.7% increase**	**46.8% increase**	**18.8% increase**	**13.9% increase**	**55.7% increase**

Source: Ambulatory Health Services, Department of Public Health, Philadelphia, Pennsylvania.

Notes concerning complexity of visits:

1994:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- Palliative care for terminal cases.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.

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CITIES ADVOCATING EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

Desert AIDS Project Riverside/San Bernardino, California

Funded By CARE Act Title I

Year	Number of Patients	Number of Visits (30 min. each)	Average Number of Visits per Patient per Year	Average Cost per Patient per Year (medical care & labs only – no drugs)
1995 Combination therapy not available	638	2,303	3.5	$450
1997 Combination therapy available	748*	3,360	6.0	$1,005
Percent Change Since 1995	**17.2% increase**	**45.8% increase**	**71.4% increase**	**123.3% increase**

Source: Desert AIDS Project, Palm Springs, California.
* 560 of 748 (75%) patients in 1997 were on triple combination therapy.

Notes concerning complexity of visits:

1995:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- 3% (22) of 658 patients were on triple combination therapy through clinical trials.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.
- Increasing reliance on viral resistance monitoring tools to inform changes of therapy.
- Addition of substance abuse counselor to enable patients to stay on therapies.
- Triple, and in some cases quadruple, combinations (as salvage therapy).
- 75% of patients on triple combination.

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CITIES ADVOCATING EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

San Francisco General Hospital/Outpatient Clinic San Francisco, California

Funded By CARE Act Title I

Date	Unduplicated Clients	Patient Visits	Visits Per Patient	Percentage on Antiretroviral Therapy	Percentage on Triple Drug Combination
Dec. 1994	988	1,025	1.04	N/A	N/A
Dec. 1995	904	1,674	1.85	50%	None
Oct. 1996	1,037	2,007	1.94	71%	33%
Jun. 1997	1,156	1,781	1.54	82%	59%

Source: San Francisco General Hospital, Ward 86 HIV/AIDS Outpatient Clinic.

Key Findings:

- From 1994 to 1997, patients seen per month increased by 17%, reflecting increased demand for primary care.
- The total number of visits to the clinic per month increased more quickly, by 74% between the end of 1994 and mid-1997.
- The number of visits per patient increased by 50% in the same time frame, after hitting a high point of nearly two visits per patient per month in October 1996.
- The percent of patients on any antiviral treatment jumped from 50% to 82% in less than two years, for a a 61% increase in demand for treatment.
- The percent of patients on a three drug combination, including a protease inhibitor, increased even more dramatically, from zero in 1995 to 59% of all patients in 1997.
- In 1995, 42% of the patients on antiretroviral therapy were on monotherapy, taking only one drug. After the development of new treatment guidelines indicating that three or two drug combinations were more effective, the number of patients on monotherapy dropped to zero.

Demand for primary care has increased significantly with the availability of protease inhibitors and combination therapy. Total volume of patients as well as number of visits per patient have increased hand in hand with the proportion of patients on combination antiretroviral therapy.

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CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

Santa Cruz County Health Services Agency
Santa Cruz, California

Funded By CARE Act Title III

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Number of Visits per Patient per Year (for patients with at least two visits)	Average Cost per Patient per Year (medical care & labs only – no drugs)
1993 Combination therapy not available	123	430 (30 min. each)	3.5	6.2	$314
1997 Combination therapy available	160	704 (40 min. each)	4.4	8.1	$532
Percent Change Since 1993	**30.0% increase**	**63.7% increase**	**25.7% increase**	**30.6% increase**	**69.4% increase**

Source: Santa Cruz County Health Services Agency, Santa Cruz, California.

Notes concerning complexity of visits:

1993:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.
- Additional visits to adjust for "side effects" of new therapies.

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CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

Country Doctor Community Health Centers Seattle, Washington

Funded By CARE Act Title III

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Length of DoctorVisit in Minutes	Average Cost per Patient per Year (medical care & labs only -- no drugs)
1995 Combin-ation therapy not available	259	1,579	6.0	15	$2,431
1997 Combin-ation therapy available	282	1,910	6.7	25	$2,753
Percent Change Since 1995	**8.8% increase**	**20.9% increase**	**11.6% increase**	**66.6% increase**	**13.2 % increase**

Source: Country Doctor Community Health Centers, Seattle, Washington.

Notes concerning complexity of visits:

1995:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- During this period, AZT was the major medication for the treatment of opportunistic infections. Combination therapy and various forms of counseling were used for primary health services to patients.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.
- The monitoring of viral loads has increased lab costs over 600%.

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CITIES ADVOCATING
EMERGENCY AIDS RELIEF

Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

Whitman-Walker Clinic Washington, D.C.

Funded By CARE Act Title I

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Number of Visits per Patient per Year (for patients with at least two visits)	Average Cost per Patient per Year (medicalcare & labs only -- no drugs)
1994 Combin-ation therapy not available	1,292	4,639 (20 min. each)	3.6	7.0	$180
1997 Combin-ation therapy available	1,743	8,613 (40 min. each)	5.0	13.0	$500
Percent Change Since 1994	**34.9% increase**	**85.6% increase**	**38.8% increase**	**85.7% increase**	**177.7% increase**

Source: Whitman-Walker Clinic, Washington, D.C.

Notes concerning complexity of visits:

1994:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- Palliative care for terminal cases.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.
- Labs monitoring and education related to medications.
- Providing triple combination therapies and medication(s) for side effects.
- Monitoring interactions between triple combination medications and medications for side effects.
- Changing triple combination medications when viral loads increase.
- Increased lab work involved all monitoring activities.
- Reduction in incidence of opportunistic infections.
- Reduction in late stage and terminal care activities.
- More time involved in adherence issues and nutrition related to the use of new medications.

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CAEAR
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$625 MILLION NEEDED IN FY 2000 FOR CARE ACT TITLE I

For FY 2000, the CAEAR Coalition seeks a total of $625 million in funding for Title I of the Ryan White CARE Act. Title I of the CARE Act provides emergency assistance to the 51 metropolitan areas most heavily impacted by the AIDS epidemic to support comprehensive HIV health care and treatment for the increasing number of low-income uninsured and underinsured persons living with HIV/AIDS. An estimated 74 percent of people in the U.S. diagnosed with AIDS reside and receive their health care in Title I areas. During FY 2000, an estimated 156,000 people with HIV will be served by CARE Act Title I programs.

Need for HIV Primary Medical Care Escalating

For FY 2000, the CAEAR Coalition seeks an increase of $52 million to provide HIV primary medical care for existing clients and uninsured and underinsured people living with HIV/AIDS coming into care for the first time.

- Title I is the safety net for thousands of low-income people living with HIV/AIDS who live in metropolitan areas and are ineligible for entitlement programs. Most of these individuals have severe social and economic problems that complicate their ability to manage their HIV disease. The majority of Title I clients are dually or triply diagnosed with substance abuse and mental illness in conjunction with HIV/AIDS.

- The aggregate Title I request for funding in FY 1999 was $570 million; actual Title I funding in FY 1999 amounted to $505,200,000-- almost $65 million less than the need.

- Primary medical health care services and transfers to the AIDS Drug Assistance Program (ADAP) account for 69% of Title I service funding, 59% and 10% respectively.

- Overall rates of new HIV infections are remaining stable while HIV-related deaths dramatically decline. This means that increasing numbers of people living with HIV/AIDS will be seeking services. A 1998 CAEAR Coalition study indicates that Title I communities saw a 43% average increase in the number of people living with HIV/AIDS receiving services between 1995-97.

- In 1998, the U.S. Public Health Service issued guidelines for the prevention of opportunistic infections, the use of anti-HIV medications for adults and adolescents and for the use of anti-HIV drugs in pregnant women to reduce perinatal transmission of HIV. Title I funding remains inadequate to assure the delivery of the standard of care required by these guidelines to all eligible people living with HIV/AIDS in Title I areas.

- The availability and success of combination drug therapies have motivated many people living with HIV/AIDS to seek care for the first time. In FY 1998, the Health Resources and Services Administration estimates that 20 percent of Title I clients were new to care.

Cost and Complexity of HIV Care Increasing

For FY 2000, the CAEAR Coalition seeks an increase of $48 million to address the increasing complexity and cost of delivering quality HIV medical care.

- Advances in the clinical management of HIV/AIDS require more and longer medical visits, including an initial assessment, diagnostics and the determination of a treatment regime. A 1998 CAEAR study found the average length of medical visits increased 65% from 1995-97, and the average cost of medical care rose 89.3%.

- Once treatment is begun, patient education, ongoing monitoring, including expensive viral load testing, is required. A 1998 CAEAR study estimates that between 1995-97 the total number of patient visits increased by 55.3% and the number of visits per patient rose by 27.4%.

- More than ever, people in care need a coordinated medical and support service plan that includes higher levels of expertise among doctors, nurses, pharmacists, case managers and peer advocates. Care teams must develop plans that include ongoing education about the importance of adherence to combination drug regimens to prevent resistant strains of HIV and regular updates on new treatment developments.

- CARE Act services have significantly reduced the costs of medical care by reducing the amount of hospital-based emergency and inpatient care being provided to people living with HIV/AIDS.

Outreach to People of Color

For FY 2000, the CAEAR Coalition seeks $13 million to address the disparity in outcomes, access, and in the utilization of care and treatment by people of color living with HIV/AIDS.

- About 64% of Title I clients are people of color. However, their utilization patterns of medical care and antiretroviral treatments continue to lag significantly below their representation in local epidemics. Many people of color living with HIV/AIDS are burdened by co-morbid factors such as other sexually transmitted diseases, substance abuse, mental illness, homelessness, poverty, tuberculosis and a lack of education. The combination of these factors often results in difficulties in accessing health care and support services, which perpetuates the disparities in health outcomes and slows the reduction in AIDS deaths in racial and ethnic minority communities.

New Title I Metropolitan Areas -- Existing Areas Continue To Lose Funding

For FY 2000, the CAEAR Coalition seeks an increase of $7 million to address the addition of as many as three new Title I eligible metropolitan areas and a loss in funding to existing Title I areas.

- In FY 99, 7 Title I areas lost funding as compared to the previous year. Despite modest increases in CARE Act funding overall, some, though not always the same Title I communities, have lost funding in four of the last five fiscal years as compared with their previous year funding.

Complete citations of data sources are available upon request.

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CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

$134 MILLION NEEDED IN FY 2000 FOR CARE ACT TITLE III

For FY 2000, the CAEAR Coalition seeks a total of $134 million in funding for Title III of the Ryan White CARE Act. Title III of the CARE Act provides grants directly to 181 community-based clinics and public health providers in 43 states, Puerto Rico, and the District of Columbia, to develop and deliver both early and ongoing comprehensive HIV medical services to more than 85,000 persons with HIV/AIDS, on an outpatient basis. On average, each of these community-based, HIV primary care programs provide early diagnosis and treatment to over 450 clients. Title III ensures a rapid clinical response to ever-changing medical treatment practices and a means to address inadequacies in primary care services, particularly in poor areas, smaller cities and rural communities.

Increasing Cost of Primary Health Care

For FY 2000, the CAEAR Coalition seeks an increase of $12 million for the increasing costs of providing primary health care services to more than 85,000 individuals.

- A 1998 CAEAR Coalition study indicates that between 1995-97 the average cost of medical care per patient rose 89.3%.
- In 1996, over 30% of all Title III patients were new patients, who require intensive and complex medical care, including an overall medical assessment, viral diagnostics, and a stabilizing anti-AIDS treatment regimen.
- Recently, the standard care for people with HIV/AIDS has been altered to promote wellness and adherence to new and complex drug regimens. This has required intensive client education, intervention, and ongoing support. A 1998 CAEAR study revealed that between 1995-97, the average number of visits per patient increased by 27.4%, primarily to monitor the efficacy of and adherence to complex regimens and to provide quarterly viral load testing.
- Changes in the HIV standard of care have also increased the amount of time needed for each visit per patient. A 1998 CAEAR study revealed that between 1995-97, the average length of medical visits increased by 65%.
- Over 73% of all new Title III patients in 1996 entering the health care system were moderately to severely ill and in great need of health care services.
- The overall cost of providing access to HIV-related primary care would have escalated even higher without the early diagnosis and treatment provided by Title III programs. Title III programs have reduced hospital admissions in some locales by as much as 75% since 1996.

Outreach to People of Color and Other Underserved Communities

For FY 2000, the CAEAR Coalition seeks an increase of $10 million for outreach and care for people of color and other underserved communities who have historically lacked access to the health care system.

- The FY 1999 HHS appropriation included targeted funding for Title III planning grants to African American community-based medical care providers. These funds will ensure the expanded capacity of African American agencies to provide HIV-related medical services in the African American community-disproportionately affected by HIV disease. These agencies must maintain this essential capacity in FY 2000.
- Two-thirds of the patients served by Title III grantees in 1996 were people of color.

- One-third of the patients served by Title III grantees in 1996 were women.
- The largest number of new infections in males in 1996 were among African Americans.
- The largest number of new infections in females in 1996 were among African American women; the second largest increase for females was among Hispanic women.
- Outreach to HIV-infected people of color must be expanded in order to ensure early linkages to the health care system. Delayed access to care accounts for much of the disparity in health outcomes for historically underserved racial and ethnic minority communities.
- In 1996, 3% of all individuals tested by Title III grantees were HIV positive; for the homeless, this rate was 8%. The rate for the US population at large was 0.26% to 0.36%.
- The return rate in 1996 for post-counseling among those who tested positive for HIV was 99%. This remarkably high return rate reflects the effective results from aggressive outreach by Title III grantees.
- In 1998, the National Medical Association stated that African Americans are more likely to receive treatment when an AIDS-related infection requires hospitalization, and that significant numbers of African Americans are diagnosed with AIDS within one month of their death. In both rural and urban areas, Title III providers are critical to efforts to increase the early diagnosis and treatment of HIV within the African-American community.
- Based on 1996 data, Title III grantees are targeting high risk populations, such as:
  - the incarcerated population
  - homeless persons
  - runaway youth
  - injecting drug users (IDUs)
  - migrants
  - women and children

Communities in Need -- Unfunded Grants for Underserved Areas

For FY 2000, the CAEAR Coalition seeks an increase of $11 million for unfunded grants to underserved communities.

- The federal government has already approved over $11 million in grants to 28 qualified Title III applicants, but cannot fund these applications due to a lack of appropriations.
- These qualified, but unfunded, applicants are located in rural and underserved urban areas. A total of 23% of Title III programs report being the only HIV medical outpatient program in their area.
- Approximately 50% of all currently funded Title III providers are located in rural areas.

Increasing Cost of Social Services

For FY 2000, the CAEAR Coalition seeks an increase of $7 million for the increasing costs of providing social support services.

- Title III grantees reported to the Health Resources and Services Administration (HRSA) that over $5 million was needed but not available for providing case management services to patients in 1996. In part, this was reflected in fewer clients being able to receive case management service in 1996 than in 1995.
- Title III grantees reported to HRSA that the costs of providing case management services increased by 55% per patient between 1995 and 1996. In part, this can be attributed to the following:
  - an emerging model of case management that stresses adherence to complex drug regimens;
  - a changing welfare and health care environment, requiring more time spent with patients on issues of benefits and entitlements;
  - changing health status of some patients who are considering entering the work force; and
  - housing needs for many Title III patients.

Complete citations of data sources are available upon request.

For further information, contact the CAEAR Coalition,
1413 K Street, NW, Suite 700, Washington, D.C. 20005, 202.789.3565, fax 202.789.4277; or
The Sheridan Group, 1808 Swann Street, NW, Washington, D.C., 20009, 202.462.7288, fax 202.786.1964

RYAN WHITE CARE ACT FUNDING FY 1996 -- FY 2000

(IN MILLIONS OF DOLLARS)

	Reauthorization (1996)	**FY 1996 Final**	**FY 1997 Final**	**FY 1998 Final [c]**	**FY 1999 Community Request** (+/- FY 98)	**FY 1999 Presidential Budget Request [d]** (+/- FY98)	**FY 1999 Final** (+/- FY 98)	**FY 2000 Community Request** (+/- FY99)	**FY 2000 Presidential Budget Request** (+/- FY99)
Title I	Title I is funded at "such sums as may be necessary" for the fiscal years 1996-2000.	391.7 (+35.2)	449.943 (+58.243)	464.736 (+14.793)	570.0 (+105.264)	488.974 (+24.238)	505.2[e] (+40.464)	625.0 (+119.8)	521.2 (+16.0)
Title II [ADAP]	Title II is funded at "such sums as may be necessary" for the fiscal years 1996-2000.	260.847 (+62.7)	416. 954 (+156.107) [167.0][b]	542.783 (+125.829) [285.5][b]	801.0 (+258.217) [458.5][b]	668.870 (+126.087) [385.5][b]	738.0 (+195.217) [461.0][b]	921.0 (+183.0) [n/a]	783.0 (+45.0) [496.0]
Title III	Title III is funded at "such sums as may be necessary" for the fiscal years 1996-2000.	56.918 (+4.6)	69.568 (+12.650)	76.211 (+6.643)	113.0 (+36.789)	86.154 (+9.943)	94.3[f] (+18.089)	134.0 (+39.7)	130.3 (+36.0)
Title IV	Title IV is funded at "such sums as may be necessary" for the fiscal years 1996-2000.	29.0 (+3.0)	36.0 (+7.0)	40.803 (+4.803)	61.0 (+20.197)	43.926 (+3.123)	46.0[g] (+5.197)	61.0 (+15.0)	48.0 (+2.0)
AIDS Education & Training Centers[a]	AETCs are funded at "such sums as may be necessary" for the fiscal years 1996-2000.	12.0	16.287 (+4.287)	17.216 (+0.929)	25.0 (+7.784)	17.271 (+0.055)	20.0[h] (+2.784)	25.0 (+5.0)	20.0 (+0.0)
Dental School Reimbursement Program[a]	Dental programs are funded at "such sums as may be necessary" for the fiscal years 1996-2000.	6.937	7.5 (+0.563)	7.763 (+0.263)	9.0 (+1.237)	7.787 (+0.024)	7.8 (+.037)	9.0 (+1.2)	8.0 (+0.2)
TOTALS		**757.402 (+105.5)**	**996.252 (+238.850)**	**1149.512 (+153.26)**	**1,579.0 (+429.488)**	**1,312.982 (+163.47)**	**1411.3 (+261.788)**	**1775.0 (+363.7)**	**1510.5 (+99.2)**

a -The AIDS Education and Training Centers (AETCs) and the Dental School Reimbursement programs were made part of the Ryan White CARE Act in FY 1996.
b -A mount of Title II funding either requested or allocated to be earmarked specifically for the AIDS Drug Assistance Program (ADAP).
c -The FY 1998 final allocation was adjusted mid-year to account for an across-the-board HHS administrative shave during FY 1998.
d -The FY 1999 Presidential budget request was adjusted to account for an across-the-board HHS administrative shave during FY 1998.
e -$5 million of the FY 1999 Title I allocation is earmarked to address underserved communities of people of color.
f - $3 million of the FY 1999 Title III allocation is earmarked to address underserved communities of people of color.
g -$2 million of the FY 1999 Title IV allocation is earmarked to address underserved communities of people of color.
h -$2 million of the FY 1999 allocation for Education and Training Centers is earmarked to address underserved communities of people of color.

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RYAN WHITE CARE ACT FUNDING FY 1991 -- FY 1995
(IN MILLIONS OF DOLLARS)

	Original Authorization (FY 91 & 92)	FY 1991	FY 1992[a] (+/- FY 91 funding)	FY 1993[b] (+/- FY 92 funding)	FY 1994 (+/- FY 93 funding)	FY 1995 (+/- FY 94 funding)
Title I	275.0	87.831	120.518 (+32.687)	184.757 (+64.239)	325.5 (+140.743)	356.5 (+31.0)
Title II	275.0	87.831	106.690 (+18.859)	115.288 (+8.598)	183.897 (+68.609)	198.147 (+14.25)
Title III						
(A)	c	c	c	c	c	c
(B)	75.0	44.891	48.859 (+3.966)	47.968 (-0.891)	47.968 (+/- 0)	52.318 (+4.35)
Title IV	20.0[d]	0	0	0	22.0[e] (+6.0)	26.0 (+4.0)
TOTALS		**220.533**	**275.067 (+54.534)**	**348.013 (+72.946)**	**579.365 (+231.352)**	**632.965 (+53.6)**

a Revised FY 92 Appropriation with Administrative costs subtracted.
b Revised FY 93 Appropriations with Federal Consultants Services Reduction subtracted.
c Funding for testing and counseling provided under the Centers for Disease Control.
d Title IV's original authorization was $26.5 million plus certain provisions to be funded by "such sums necessary." The Pediatric Demonstration Grant portion of Title IV was originally authorized at $20.0 million.
e Includes $20.9 million in Pediatric Demonstration Grants separately appropriated prior to FY 94.

The Sheridan Group, October 1994

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CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

Ryan White CARE Act
Title I Eligible Metropolitan Area
Fiscal Year 1999 Awards

Eligible Metropolitan Area	FY '98 Awards	FY '99 Awards	+/-
Atlanta	$12,021,454	$13,147,268	$1,125,814
Austin	$2,856,752	$3,175,509	$318,757
Baltimore	$12,184,481	$13,478,549	$1,294,068
Bergen-Passaic	$4,354,291	$4,320,176	-$34,115
Boston	$9,463,130	$10,647,381	$1,184,251
Caugus	$1,405,197	$1,610,314	$205,117
Chicago	$15,995,512	$18,227,884	$2,232,372
Cleveland	$2,459,443	$2,933,058	$473,615
Dallas	$9,082,217	$10,164,078	$1,081,861
Denver	$4,278,161	$4,150,341	-$127,820
Detroit	$5,628,350	$6,585,744	$957,394
Dutchess County	$854,481	$1,220,662	$366,181
Ft. Lauderdale	$10,128,631	$10,810,324	$681,693
Ft. Worth	$2,618,024	$2,935,543	$317,519
Hartford	$3,613,029	$4,019,409	$406,380
Houston	$12,722,479	$15,489,996	$2,767,517
Jacksonville	$3,443,168	$3,683,146	$239,978
Jersey City/Hudson County	$5,320,300	$5,015,785	-$304,515
Kansas City	$2,622,409	$2,952,910	$330,501
Las Vegas	$0	$3,402,697	$3,402,697
Los Angeles	$30,637,106	$33,540,737	$2,903,631
Miami	$18,472,153	$21,248,387	$2,776,234
Middlesex-Somerset-Hunterdon	$2,597,923	$2,555,029	-$42,894
Minneapolis-St. Paul	$2,570,712	$2,548,603	-$22,109
Nassau-Suffolk	$4,939,871	$5,632,012	$692,141
New Haven -- Fairfield	$5,348,730	$6,100,471	$751,741
New Orleans	$4,921,857	$5,695,360	$773,503
New York	$95,325,334	$96,961,856	$1,636,522
Newark	$12,630,257	$14,390,269	$1,760,012
Norfolk	$0	$3,665,087	$3,665,087
Oakland	$5,926,194	$6,218,532	$292,338
Orange County	$3,810,759	$4,300,690	$489,931
Orlando	$4,609,839	$4,907,180	$297,341
Philadelphia	$14,081,773	$16,011,451	$1,929,678
Phoenix	$3,412,037	$3,865,319	$453,282
Ponce	$2,200,114	$2,487,768	$287,654
Portland	$3,057,466	$3,115,251	$57,785
Riverside -- San Bernardino	$5,634,427	$6,463,388	$828,961
Sacramento	$2,389,370	$2,578,873	$189,503
San Antonio	$2,952,239	$3,014,654	$62,415
San Diego	$8,452,437	$8,872,685	$420,248
San Francisco	$36,394,914	$36,218,513	-$176,401
San Jose	$2,445,480	$2,486,136	$40,656
San Juan	$11,658,912	$11,912,865	$253,953
Seattle	$5,060,533	$5,303,343	$242,810
Sonoma	$1,225,807	$1,127,018	-$98,789
St. Louis	$3,561,850	$3,664,771	$102,921
Tampa -- St. Petersburg	$6,536,189	$7,236,728	$700,539
Vineland-Millville-Bridgeton	$594,001	$688,648	$94,647
Washington	$16,710,726	$18,322,558	$1,611,832
West Palm Beach	$5,965,481	$6,711,944	$746,463
TOTAL	$445,176,000	$485,816,900	$40,640,900

$0 This city was not yet an EMA in 1998.

For more information, please contact CAEAR Coalition, 1413 K Street, NW, Suite 700, Washington, DC 20005
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CAEAR
CITIES ADVOCATING EMERGENCY AIDS RELIEF

Ryan White CARE. Act -- Title I
FY 96 Expenditures for Drug Reimbursement and Medications

Eligible Metropolitan Area	Drug Reimbursement/Medications Expenditures
Atlanta	1,064,645
Austin	0
Baltimore	410,310
Bergen-Passaic	189,792
Boston	845,772
Caugus	206,113
Chicago	890,274
Cleveland	148,000
Dallas	30,000
Denver	381,661
Detroit	400,000
Dutchess County	0
Ft. Lauderdale	771,286
Ft. Worth	0
Hartford	212,000
Houston	681,233
Jacksonville	424,837
Jersey City	346,109
Kansas City	670,808
Los Angeles	2,508,817
Miami	1,694,865
Middlesex-Somerset-Hunterdon	225,000
Minneapolis-St. Paul	99,648
Nassau-Suffolk	0
New Haven -- Fairfield	230,056
New Orleans	101,554
New York	12,520,862
Newark	571,486
Oakland	0
Orange County	0
Orlando	363,224
Philadelphia	0
Phoenix	665,544
Ponce	746,724
Portland	24,800
Riverside -- San Bernardino	503,177
Sacramento	15,289
St. Louis	533,577
San Antonio	70,304
San Diego	129,228
San Francisco	0
San Jose	224,516
San Juan	2,185,118
Sonoma	33,000
Seattle	253,264
Tampa -- St. Petersburg	716,312
Vineland-Millville-Bridgeton	14,175
Washington	1,820,761
West Palm Beach	0
TOTAL	**$33,924,141** **(9% of FY 96 Allocated Award)**

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