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Agency Plan Format

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Format - Federal Agency Plan
(President's Directive to Increase Access to HIV Prevention Services to Adolescents)

Please follow the format below in describing your Agency's plans to comply with the President's directive to increase access to HIV prevention for adolescents and to increase access to HIV-related services to adolescents already infected with HIV.

1. Department/Agency Name:

2. Program Name:

3. Administrative Location: Please indicate the Branch/Division/Bureau/Center, etc, which administers the program:

4 Administrator: Please provide the name, position, address, and telephone number for the person administratively in charge of the program:

5.. Contact Person: Please provide the name, position, address and telephone number for the contact person for the program.

6. AGENCY PROGRAM/PLAN: **(If your agency had developed more than one plan to comply with the President's directive, list each program on a separate form)**:

   Describe the purpose of the program your Agency has developed (or is continuing) to comply with the President's directive. Please indicate:

   6A. SERVICES (Prevention and Care/Treatment): Describe in detail the specific activity(s) that you will be undertaking, or if an existing activity, that you will be continuing and modifying, to increase access to HIV prevention for adolescents, or to provide services to adolescents already infected with HIV.

   6B. NUMBER OF ADOLESCENTS CURRENTLY SERVED - FY '98 and FY '99: If you have an existing program that provides prevention services or care services to adolescents, please indicate the number of adolescents which the program currently serves. Please indicate the number of adolescents that will be served by your Agency's activities to comply with the President's directive in FY '99.

7. **PROGRAM FUNDING: FY '98 and FY 99**

   Please indicate FUNDING for the program you have developed or are continuing. If there is no special funding for this activity and funds come from your general program funds, please indicate so. Indicate funding by Fiscal Year (for Fiscal Year 1998, if applicable, and for Fiscal Year 1999).

FACSIMILE

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

736 Jackson Place NW
Washington, DC 20503

Phone: (202) 456-2437
Fax: (202) 456-2438

TO:	Matthew Nosanchuk
FAX NUMBER:	(202) 514-9112
FROM	Robert Soliz
DATE:	April 20, 1998
PAGES:	3
COMMENTS:	Matthew: We were moving offices at the time of our HIV Prevention TA meetings. I misplaced a several things in the process, including the list of contacts that I was faxing you, so here it is. Hope things are going well for you. We have a new address and telephone. They are: White House Office of National AIDS Policy, 736 Jackson Place, NW, Washington. DC 20503, Telephone: (202) 456-2437, Fax: (202) 456-2438.

AGENCY PLAN

Please follow the format below in describing your Agency's plans to comply with the President's directive to increase access to HIV prevention for adolescents and to increase access to HIV-related services to adolescents already infected with HIV.

1. Agency
2. Administering Unit
3. Plan Administrator
4. Contact Person
5. Agency Plan **(If your agency had developed more than one plan to comply with the President's directive, list each program on a separate form)**: Describe your Agency's plan to comply with the President's directive. Please indicates:

    5A. PREVENTION SERVICES: Describe in detail the specific activity(s) that you will be undertaking, or if an existing activity, that you will be continuing and modifying, to increase access to HIV prevention for adolescents.

    5B. SERVICES PROVISION: If your agency provides HIV-related services, and you are complying with the President's directive to increase access to services to adolescents already infected with HIV, please describe in details your plans for doing so.

    5C. FUNDING: Please list the approximate funding of your program to provide the above services. If there is no special funding for this activity and funds come from your general program funds, please indicate so. Indicate funding by Fiscal Year (for Fiscal Year 1998, ifa applicable, and for Fiscal Year 1999).

    5D. NUMBER OF ADOLESCENTS CURRENTLY SERVED:

    5E NUMBER OF ADOLESCENTS TO BE SERVED: Please indicate the number of adolescents that will be served by your Agency's activities to comply with the President's directive. Please break this out by the current year (FY '98) if applicable, and by FY 1999 and FY 00..

Questions:

Time period for Agenyc plans (current FY, FY 99 , FY 00).

Agency: _____

Administering Unit: _____

_____

_____

Plan Administrator: _____

Contact Person& Telephone No. _____

	FY '98	FY '99	FY '00
Agency Plan : 5A. PREVENTION SERVICES: Describe in detail the specific activity(s) that you will be undertaking, or if an existing activity, that you will be continuing and modifying, to increase access to HIV prevention for adolescents.			
5B. SERVICES PROVISION: If your agency provides HIV-related services, and you are complying with the President's directive to increase access to services to adolescents already infected with HIV, please describe in details your plans for doing so.			

Agency: _____

Administering Unit: _____

_____

_____

Plan Administrator: _____

Contact Person& Telephone No. _____

5C. FUNDING: Please list the approximate funding of your program to provide the above services. If there is no special funding for this activity and funds come from your general program funds, please indicate so. Indicate funding by Fiscal Year (for Fiscal Year 1998, if applicable, and for Fiscal Year 1999).			
5D. NUMBER OF ADOLESCENTS CURRENTLY SERVED (FY '98):			

Agency: _____

Administering Unit: _____

_____

_____

Plan Administrator: _____

Contact Person& Telephone No. _____

5E. NUMBER OF ADOLESCENTS TO BE SERVED: Please indicate the number of adolescents that will be served by your Agency's activities to comply with the President's directive. Please break this out by the current year (FY '98) if applicable, and by FY 1999 and FY 00..			

"Tattdd"

Federal Agency Plans to Increase Access to HIV Prevention for Youth
and/or to Services for Youth Already Infected with HIV

1. Agency	
2. Administrative Unit	
3. Plan Administrator	
4. Contact Person and telephone number	

Agency Plan:

5A. PREVENTION SERVICES: Describe in detail the specific activity(s) that you will be undertaking, or if an existing activity, that you will be continuing and modifying, to increase access to HIV prevention for adolescents.

FY '98

FY '99

Federal Agency Plans to Increase Access to HIV Prevention for Youth
and/or to Services for Youth Already Infected with HIV

5B. SERVICES PROVISION: If your agency provides HIV-related services, and you are complying with the President's directive to increase access to services to adolescents already infected with HIV, please describe in details your plans for doing so.

FY '98

FY '99

5C. FUNDING: Please list the approximate funding of your program to provide the above services. If there is no special funding for this activity and funds come from your general program funds, please indicate so. Indicate funding by Fiscal Year (for Fiscal Year 1998, if applicable, and for Fiscal Year 1999):

FY '98

FY '99

5D. NUMBER OF ADOLESCENTS CURRENTLY SERVED AND TO BE SERVED: Please indicate the number of adolescents that are currently served or will be served by your Agency's activities to comply with the President's directive. Please break this out by the current year (FY '98) if applicable, and by FY 1999 and FY 00.

FY '98

FY '99

President's Adolescent HIV Prevention Directive
White House Office of National AIDS Policy
Department of Health and Human Services, Office of HIV/AIDS Policy
Technical Assistance Team Members
April 2 - 3, 1998

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Fax (770) 488-3111
DDA6@CDC.gov

Robert Soliz
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White House Office of National AIDS Policy
736 Jackson Place, NW
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(202) 456-2437
Robert_Soliz@OA.EOP.GOV

Minutes: TA Meetings, April 2 and 3rd.

Job Corps (Dr. Hayman)

- Provides Education and Training
- Have 40,000 students at any one time
- Condition for admittance is poverty.
- Average stay: 7 ½ months.
- Can stay up to two years.
- Teach a trade, from welding to nursing.
- There are 119 different sites throughout the country, including PR and Alaska
- 10% of enrollees commute from nearby areas.
- Have a comprehensive health program.
- Counseling provided.
- Provide a full health physical.
- HIV rates: 1987 - 4.5/1000 HIV +
  Current - 2./1000.
  Reason for decline unknown.

* Would like a CDC study, to fund a research on why the reduction occurred.

- Recruitment: Mostly through State employment agencies, some word of mouth
- ages 16 - 24.
- If disabled, no upper limit
- If have a criminal record, not eligible
- Cannot have serious health problems.
- a 36 hour health education course (by the education department, not the medical department) given to all, includes drug abuse, 2 hours std/HIV. No follow-up after the 36 hours.
- Staff also has a 5 hours/six months education requirement
- 5-10% are pregnant at admission. IF more than 3 mos, not admitted.
- About 3% become pregnant during their stay.

SERVICES

- All services provided on site, Job Corps pays.
- Try to get Medicaid to pay if JOB CORPS exhausts referrals funds.

POLICIES

- Medical director promulgates medical policies
- Ed director promulgates education policies.

Diane - has a 4 hours sex ed course, including HIV
Chris: concerned about reinforcement of a one time course.

Hayman: Job Corps I primarily a job education program, not a health unit.
Centers have an advisory community councils, which meet about once/month.
Big emphasis on social skills training.

✱ Diane to send articles
✱ Chad to send recommendations CDC willing to go to Job Corps Conferences, provide presentations
✱ Dr. Hayman to provide White House with Conference information
✱ Write Hayman to tell him what we want him to do.

Justice (Matt Nosenchak & Co.)

1. - Information already available and tested
   - gang prevention
   want best practices, gneder specific
   ✱ To share CDC information with Justice
   ✱ CDC Aids Clearinghouse
   - Dept of Education - Developing a tateway to all Federal Education programs, for kids, teachers (Kirk Winter, Office of the Under Secretary, Department of Education
   ✱ Dept of Justice to get us the WEB PAGE

2. Services for HIV Positivie in Detention
   - Bureau of Prisons see no juveniles
   - INS see some juveniles
   - Very small number of juvenils fall under Federal Detention
   - State facilities see see juveniles.

3. FBI
   - Adopt a school program
   - special agent
   - mentoring
   - tutoring
   ✱ CDC - Hook the above with the National Hotline
   ✱ ONAP - Send list of team participants

Selective Service (Leonard Evans)
Defense (Lynn Pahland)
State
FEMA
Commerce (no show)

1. Agency	
2. Administrative Unit	
3. Plan Administrator	
4. Plan Contact Person & telephone number	

1. Agency			
2. Administrative Unit			
3. Plan Administrator			
4. Contact Person and telephone number			
	FY '98	FY '99	FY '00
5. Agency Plan : 5A. PREVENTION SERVICES: Describe in detail the specific activity(s) that you will be undertaking, or if an existing activity, that you will be continuing and modifying, to increase access to HIV prevention for adolescents.			

1. Agency	
2. Administrative Unit	
3. Plan Administrator	
4. Plan Contact Person & telephone number	

5B. SERVICES PROVISION: If your agency provides HIV-related services, and you are complying with the President's directive to increase access to services to adolescents already infected with HIV, please describe in details your plans for doing so.			
5C. FUNDING: Please list the approximate funding of your program to provide the above services. If there is no special funding for this activity and funds come from your general program funds, please indicate so. Indicate funding by Fiscal Year (for Fiscal Year 1998, if applicable, and for Fiscal Year 1999).			

1. Agency	
2. Administrative Unit	
3. Plan Administrator	
4. Plan Contact Person & telephone number	

5D. NUMBER OF ADOLESCENTS CURRENTLY SERVED (FY '98):			
5E. NUMBER OF ADOLESCENTS TO BE SERVED: Please indicate the number of adolescents that will be served by your Agency's activities to comply with the President's directive. Please break this out by the current year (FY '98) if applicable, and by FY 1999 and FY 00..			

MEDICAID & HIV/AIDS FACT SHEET

The Medicaid Program

Medicaid is the second largest publicly-financed health care program, providing health care and long-term care services to about 36.8 million Americans in 1996. Authorized under Title XIX of the Social Security Act, Medicaid is an entitlement program providing low-income Americans access to health care. Medicaid is one of the most important programs for people living with HIV/AIDS, providing access to health care for over 53% of all adults with HIV disease and over 90% of all children living with HIV/AIDS.

What is the Medicaid Entitlement?

The Medicaid entitlement acts as a "safety net" for eligible individuals in need.

Medicaid spending is not limited to a fixed amount of funds nor are the benefits limited to a fixed number of beneficiaries. The Medicaid rolls often fluctuate in response to factors such as economic recessions and natural disasters. The Medicaid entitlement **guarantees** that eligible individuals have access to a minimum level of benefits regardless of the state in which they live.

Who Is Eligible for the Medicaid Program?

Medicaid covers three main groups of low-income Americans: the elderly, disabled and women and children.

Just being poor does not guarantee access to Medicaid. In order to be eligible, individuals must not only meet state income and resources criteria, but also fall within covered eligibility categories such as senior, disabled, and women and children. Many poor uninsured individuals are not eligible for Medicaid. In fact, Medicaid covers only 62% of poor Americans. In 1996, Congress took several actions to weaken the Medicaid safety net by eliminating or restricting Medicaid coverage for legal immigrants, children with disabilities, and individuals with substance use and alcoholism treatment needs.

Financing of the Medicaid Program

Medicaid is the single largest source of federal funds to the states, representing 40% of all federal grants-in-aid to states.

The Medicaid program is jointly funded by the federal and state governments. By law, the federal payment cannot be lower than 50% nor greater than 83%. States with lower per capita incomes will receive a higher federal "match." The federal share of Medicaid funding varies by state -- poorer states receive a higher federal share.

Unlike federal discretionary programs like the Ryan White Care Act, federal Medicaid spending is not set by Congressional appropriations committees in advance. Instead, federal matching payments are made to the states on a quarterly basis based on the allowable expenditures that the states incur in operating their Medicaid programs and submit to the federal government for matching payments.

Medicaid expenditures have recently slowed to record low rates of growth. The growth rate from 1995 to 1996 was only 3%, well below all projections. Even with rises in Medicaid enrollment and the increase in the rate of health care inflation, the Medicaid growth rate has slowed down.

The disproportionate share hospital (DSH) program was established to support hospitals and institutions that shoulder a disproportionate burden of providing uncompensated care. Many states have abused the DSH program to increase the federal Medicaid payment they receive. The DSH program is essential to the health care access of people living with HIV and AIDS, supporting safety net providers at the front lines of the HIV epidemic, including outpatient HIV clinics at public hospitals and children's hospitals across the nation.

Facts About Medicaid Costs, People Living with HIV/AIDS, and Other Beneficiaries

•In 1996, 36.8 million people were enrolled in Medicaid.

•In FY 1997, federal Medicaid costs for people with AIDS are estimated to be $1.8 billion with approximately 104,000 people living with HIV and AIDS receiving benefits through this program.

•The breakdown of Medicaid beneficiaries by enrollment group is the following:

11% elderly

16% blind & disabled

22% adults (non-disabled)

51% children (non-disabled)

•The greatest proportion of Medicaid beneficiaries are children. Medicaid pays for the health care of one in four children.

•Although the elderly represent only 11.2% of Medicaid beneficiaries, they incur 33.1% of Medicaid costs.

•Long term care represents 35.8% (about $45 billion) of Medicaid expenditures.

What Benefits and Services Does Medicaid Provide?

Federal guidelines set the mandatory and optional eligibility categories and the benefits of the Medicaid program. States will only receive the federal payment if they comply with the federal guidelines.

Eligible individuals can qualify through either mandatory or optional eligibility categories. Over half of all Medicaid spending is used for populations and benefits that are **not** mandatory.

Mandatory Populations:

States must provide eligibility for certain populations such as low-income children and pregnant women and individuals receiving federal cash assistance. Individuals who meet AID For Dependent Children (AFDC) eligibility criteria (even though the program has been replaced with the new Temporary Assistance to Needy Families

TANF program, as defined in July 1996 as a result of the welfare reform law) and individuals who receive Social Security Income (SSI) payments examples of individuals who are automatically eligible for Medicaid.

Optional Populations:

States have the option of providing Medicaid eligibility for other groups (for which they will receive federal matching funds). These optional groups share characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined.

Examples of **optional groups** include:

•certain elderly, blind, or disabled adults who have incomes above those requiring mandatory coverage.

•institutionalized individuals with income and resources below specified limits

• infants up to age one and pregnant women not covered under the mandatory populations rules whose family income is between 133% and 185% of the poverty level (the percentage to be set by each state)

The optional eligibility category that is most important for people living with HIV and AIDS is the **"medically needy"** program. States have the option of offering a **"medically needy"** program which allows states to extend Medicaid eligibility to additional qualified persons who may have too much income to qualify. This medically needy option allows these individuals to "spend down" to Medicaid income levels by incurring medical and/or remedial care expenses to offset their excess income. These individuals literally become impoverished as a result of their health conditions and therefore become eligible for Medicaid. Each state that offers the medically needy option defines the particular income requirement for the state. Thirty-four states currently offer the medically needy option as a way to qualify for Medicaid.

Medicaid Benefits and Services

States must provide the following basic services to mandatory populations:

•Inpatient and outpatient hospital services

•Laboratory and X-ray services

•Nursing facility services for people aged 21 or older

•Home health care for those eligible for nursing facility services

•Prenatal care

•Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) for children under age 21

•Family planning services and supplies

•Services provided by Rural Health Clinics/Federally Qualified Health Centers

•Services provided by a physician, nurse-midwife, and certified pediatric or family nurse practitioner

•Any necessary transportation

States are not required to provide these mandatory benefits and services to the medically needy population although most states that offer a **"medically needy"** option do. This could be problematic for people living with HIV/AIDS because many become eligible for Medicaid through the medically needy option. States are only required to provide the following services to the medically needy: (1) prenatal care and delivery services for

pregnant women, (2) ambulatory services to individuals under age 18 and individuals entitled to institutional services, (3) home health services to individuals entitled to nursing facility services, and (4) specific services provided at institutions for mental diseases or in intermediate care facilities for the mentally retarded.

Optional Benefits and Services:

States have the option to provide additional optional services to beneficiaries and still receive federal state matching funds. Federal law defines 31 optional services from which states may choose to offer. The most common **optional services** include: clinic services, prescription drugs, case management services, dental services, hospice services, intermediate care facilities, optometry and eyeglasses, and tuberculosis related services.

Medicaid Managed Care

In response to rising health care costs, states are increasingly seeking new health care financing and delivery mechanisms for their state Medicaid populations. One way to accomplish this is through federal Medicaid waivers granted by the Health Care Financing Administration (HCFA, the federal Medicaid authority). The waivers allow states to forgo certain provisions of federal Medicaid law. As states move more aggressively to control the costs incurred in their Medicaid programs, an increasing number are using the waiver process to require their Medicaid populations to enroll in managed care programs.

Only 3% of Medicaid beneficiaries were enrolled in Medicaid managed care in 1983. By 1995, about one-third of Medicaid beneficiaries were under managed care. Most current state-wide waivers have some of the following goals: to require enrollment in prepaid managed care plans, to modify income or eligibility requirements, and to increase access to health services for some currently uninsured populations. Many state waivers call for delaying the mandatory enrollment of disabled Medicaid beneficiaries, including people living with HIV/AIDS, into managed care plans. Other states have set up special needs plans to serve HIV/AIDS populations in specialized managed care plans. While in theory managed care can offer the coordinated care needed by people living with HIV/AIDS, it has a very poor track record dealing with disabled and chronically ill people. Managed care has traditionally provided care for healthy, employed populations. The mandatory enrollment of disabled Medicaid beneficiaries living with HIV/AIDS into managed care plans has increased the challenges faced by people living with HIV/AIDS in obtaining high quality, comprehensive health care under the Medicaid program.

Medicaid, the health care program for the poor, does not provide access to the health care and drugs that prevent full-blown AIDS until one develops full-blown AIDS.

If the automobile industry followed Washington's health care model, they'd only be installing air bags in cars that have already crashed.

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until it's over
AIDS ACTION Issues

Testimony of AIDS Action Before Congress
January 29, 1998

AIDS Action's Government Affairs Director, Jeff Jacobs, testifying with Julio Abreu

Statement of Jeff Jacobs, Director of Government Affairs, AIDS Action Council to the Subcommittee on Labor, Health and Human Services, Education and Related Agencies House Committee on Appropriations January 29, 1998 - 2:00pm

I am Jeff Jacobs, Director of Government Affairs for AIDS Action Council, the national voice for over 2,400 community-based AIDS service providers and the people living with HIV/AIDS they serve. AIDS Action Council is the only national organization dedicated solely to shaping federal AIDS policy. The Council does not receive any federal funding and our work is supported by our members and individual donations.

AIDS Action Council is extremely grateful for the leadership the Chairmen and the Members of this Committee have shown over the years concerning funding for the HIV/AIDS programs that fall under your purview. Many of the dramatic advances in the care, treatment, and research of HIV disease would not have been possible without the funding this committee has provided over the course of the epidemic.

In 1998, there are signals that our nation is continuing to make advances in the fight against HIV and AIDS. First, early indications suggest that the Centers for Disease Control and Prevention's (CDC) final 1997 statistics will demonstrate a continuation of the trend that started in 1996 towards a dramatic drop in the number of AIDS related deaths. These encouraging statistics are attributable to the development and availability of both improved treatments for battling HIV and the opportunistic infections that accompany it as well as increased access to care. Second, as much progress is happening today in the area of HIV treatment and research as at any time in the course of the epidemic. Powerful new drugs are now available to individuals with HIV/AIDS and additional research is progressing on drugs and vaccines to both treat and prevent HIV infection.

However, there is also disturbing news that demonstrates why our nation must remain vigilant in the battle against the HIV virus. First, according to a new study conducted by Yale University and MTV, eighty-seven percent of young people do not believe they are vulnerable to contracting the AIDS virus. The survey also found that over half of the respondents could not name any risk factors for acquiring the virus. Second, the CDC estimates that between 40,000 and 80,000 individuals will be infected with the HIV virus in 1998.

Since the beginning of the epidemic, over 600,000 Americans have been diagnosed with AIDS and over 374,000 have died of the disease. AIDS is the leading cause of death among African-Americans and Hispanics between the ages of 25 and 44, and the second leading cause of death among all Americans in this age group. The number of AIDS cases in the United States has nearly doubled over the past five years. More women than ever have AIDS in our country with a 60 percent increase in AIDS cases in the first half of this decade. Women now account for 20 percent of the entire AIDS caseload. Given these troubling statistics it is not surprisingly that a 1997 Wall Street Journal/NBC News survey found that young Americans, individuals between the ages of 18 to 29, identify AIDS as the defining event for their generation.

While the overall number of people dying from AIDS declined significantly last year, the number of people living with AIDS increased. African-Americans, Hispanics and women continued to account for increasing proportions of new AIDS cases in 1997. And tragically, the number of newly infected people with HIV is not declining. Even now, over a decade into the epidemic, too many individuals fail to realize they are at-risk for HIV infection.

The promising new drug therapies have brought new hopes and new challenges to the battle against HIV disease. These treatments do not constitute a cure, and a vaccine is still many years away. While these new treatments have brought health improvements to many patients, they do not work for everyone and their long-term efficacy remains unknown. We still have much to learn about the potential of these new treatments.

The increase in longevity for many patients translates into an increased need for health care, drug treatments and social services. For over a decade, there were few potent treatments for HIV disease. Now, we are faced with the rationing of care, therapeutic drugs, and vital social services. Now that we have effective treatments, we must ensure the availability of treatments as well as access to the care that is necessary to ensure their success.

As the epidemic moves increasingly into economically disenfranchised communities, fewer individuals with HIV have private health insurance. This fact points out the need to modernize the Medicaid program to allow low-income HIV positive individuals to qualify for Medicaid before they are completely disabled by an AIDS related illness. A modernization of the Medicaid program would allow qualified individuals access to both the new treatments and the health care they need in order to stay alive and remain healthy for as long as possible.

In the area of HIV prevention our nation must do much more to prevent HIV transmission. It is unacceptable that between 40,000 and 80,000 individuals will be infected with HIV in 1998. Additional funding should be designated to help prevent as many of these new infections as possible. It is far less expensive to prevent someone from becoming infected in the first place than to care for that person once they are infected. Equally important is the need for this committee to permit the federal funding of needle exchange programs. Getting dirty needles off our streets must be a national priority if we are serious about halting the spread of HIV. The Secretary of Health and Human Services must be able to federally fund needle exchange programs. Well-designed programs are based on science and sound public health practice and have been endorsed by the American Medical Association and the American Public Health Association.

Substance abuse treatment is equally important to a primary HIV prevention strategy. Much of the disproportionate increase in infection rates among women, communities of color, and adolescents can be attributed to injection drug use and substance abuse generally, which in turn contribute to unsafe sexual behavior among drug users and their sexual partners. Increased funding for substance abuse treatment is desperately needed to help stem the spread of the virus.

Clearly, there continues to be an urgent need to invest in HIV research, not only to develop more effective treatments for HIV and AIDS, but ultimately, to discover a vaccine and a cure for the disease. In this era of amazing scientific discoveries these goals now appear to be within our reach.

What follows are AIDS Action Council's recommendations regarding specific HIV/AIDS programs.

CARE
Health Resources and Services Administration (Ryan White CARE Act)
The Ryan White CARE Act, without question, plays the most critical role in ensuring access to appropriate care and treatment for Americans living with HIV/AIDS. CARE Act funds are used to provide primary medical care, AIDS drugs, viral load testing, case management and other enabling services for thousands of individuals living with HIV/AIDS. **For FY 99, AIDS Action proposes an overall $428.9 million increase over FY 98 for the medical, social services and training programs in the Ryan White CARE Act.**

While each of the five CARE Act titles addresses a specific need, they complement each other and play a critical role in making Ryan White the health care and social service safety net of last resort. Increased funding for all of the Titles of the Ryan White CARE Act is needed to ensure that the program can continue to meet service needs and successfully support the provision of medications.

For Title I, which provides emergency formula and competitive grants to metropolitan areas most heavily affected by the HIV/AIDS epidemic, **AIDS Action proposes an increase of $105 million in funding over FY '98.**

For Title II, which provides formula grants to state health departments in all 50 states, the District of Columbia, and the territories, and dedicated grants to state AIDS Drugs Assistance Programs (ADAP) for the purchase of therapeutics to treat HIV and HIV related disease, **AIDS Action proposes an increase of $258 million in funding over FY '98**. This request includes an increase of $85 million for state formula grants and $173 million specifically to ADAP.

For Title III, which provides competitive grants to existing community-based clinics and public health providers serving traditionally underserved populations, **AIDS Action proposes an increase of $36.7 million in funding over FY '98.**

For Title IV, which provides competitive grants to pediatric, adolescent and family HIV care programs, **AIDS Action proposes an increase of $20 million in funding over FY '98.**

For Title V, which provides competitive grants for projects of national significance and funding to educate and train health care providers in HIV/AIDS care through the AIDS Dental Reimbursement Program and the AIDS Education & Training Centers (AETCs), **AIDS Action proposes an increase of $8 million in funding for the AETCs and $1.2 million in funding for the Dental Reimbursement program.**

The intricate, fragile, AIDS care infrastructure, constructed to ensure basic health care for people with AIDS who had nowhere else to turn, is struggling to keep pace with new and ongoing demands. In recent years, Ryan White providers have experienced from 30 to 40 percent increases in the number of new patients. New treatments and reductions in AIDS

death rates have contributed to the increased demand on the AIDS Care infrastructure.

Meeting the challenge of greater health care and service demands requires not only increased funding, but the development of innovative and flexible solutions. The Ryan White CARE Act, itself, was created in this spirit. To meet the demands for new drug therapies and bolster ADAP, many states have instituted cost effective, high-risk insurance purchasing programs. Through these progressive programs, individuals living with HIV can access life saving therapies and comprehensive medical care. To maximize federal and state investments, AIDS Action recommends that states be given the flexibility to use ADAP specific funding to purchase high risk or other insurance policies -- that provide full prescription benefits -- for eligible individuals.

Health Care Financing Administration (Medicaid Demonstration Project)
Despite the existence of federal AIDS programs, such as ADAPs and the other components of the Ryan White CARE Act, Medicaid serves as the foundation of AIDS care through its provision of both comprehensive health care and drug therapies. While ADAPs provide limited prescription drug coverage for some uninsured and underinsured people with HIV and AIDS, these programs cannot (and are not designed to) meet the need for comprehensive primary care and diagnostic services. Ultimately, discretionary programs such as ADAP cannot meet the health care needs of people living with HIV/AIDS.

AIDS Action Council proposes the allocation of $100 million in the HCFA budget to support a Medicaid demonstration project for states that choose to pursue an expansion of Medicaid eligibility to low-income HIV positive individuals. These funds could be utilized to pay the federal share of expanding Medicaid eligibility to this population. This allocation would assist in providing health care services, including prescription drugs, under the Medicaid program to about 25% of the estimated number of low-income HIV positive individuals who meet income requirements, but who do not currently meet disability criteria for the Medicaid program.

Medicaid provides access to health care coverage for low income, uninsured, disabled people. Most low-income individuals who are HIV positive but have not been diagnosed with AIDS, however, are not eligible for Medicaid, because they do not meet the program's disability standards or other categorical eligibility requirements. To qualify for Medicaid, people must meet income requirements and the disability criteria of the federal Supplemental Security Income (SSI) program. Therefore, with the exception of some women and children, the majority of people with HIV/AIDS must become disabled by AIDS in order to qualify for Medicaid. Despite the fact that early clinical intervention -- including primary care, preventive services, and medication therapies -- has been shown to improve health and delay the onset of expensive opportunistic infections, most HIV positive individuals must wait until they are disabled by AIDS before they can receive Medicaid.

PREVENTION
Centers for Disease Control and Prevention (CDC)
The CDC spearheads the federal governments' prevention strategy, funding community-based HIV prevention efforts, and monitoring the HIV/AIDS epidemic. Absent a preventive vaccine, our only hope of halting further HIV transmission is through a comprehensive, targeted approach to HIV/AIDS prevention. **For FY 99, AIDS Action proposes a $185 million increase over FY '98 for the Centers for Disease Control & Prevention's (CDC) HIV prevention-related programs which have been chronically underfunded for years.**

Preventing HIV infection must be a national priority. People become infected with HIV either because they do not realize they are at risk or do not really know how to protect themselves from infection. Tragically, nearly 50 percent of new infections occur in people younger than 25 years of age. And while men who have sex with men still account for a majority of cases among youth and men of color, rates of new infections are growing fastest among women, doubling every 1-2 years. New, targeted prevention efforts are needed to

reverse these trends. These efforts in turn will strengthen CDC's minority and youth initiatives, which are critical to the development and implementation of effective, culturally sensitive, age-appropriate prevention strategies targeted at those communities most at risk.

A recent NIH Consensus Conference on HIV Prevention concluded that we have prevention strategies that are scientifically proven to work. The CDC should now be empowered to implement those strategies. Educating people about behaviors that may place them at risk and providing them with the tools to protect themselves from becoming infected are scientifically sound approaches to HIV prevention. HIV prevention programs have been proven to save lives as well as money. The Center for AIDS Prevention Studies at the University of California, San Francisco, estimates that adding $500 million to HIV prevention targeted to high-risk groups would yield medical care savings totaling $1.25 billion.

Increased funding for the CDC will enable states and localities to implement community-based prevention plans developed by local health departments and community groups. The HIV prevention community planning process gives states and localities to have the flexibility they need to design targeted prevention strategies. Additional funding for the CDC will also allow the agency to evaluate its HIV prevention efforts to maximize its effectiveness and efficiency.

Substance Abuse and Mental Health Services Administration (SAMHSA)
Substance abuse is inextricably linked to the HIV epidemic. We cannot stem the spread of AIDS or provide care and treatment for those substance abusers already infected if we do not also address the need for prevention and treatment for drug dependence and alcoholism. Injection drug use is associated with over one-third of all AIDS cases. But substance abuse also plays a significant role in sexual transmission of HIV since it contributes to impaired judgment and increases in high-risk sexual practices. **For FY 99, AIDS Action proposes a $254 million increase over FY '98 for the Substance Abuse Prevention and Treatment Block Grant at the Substance Abuse and Mental Health Services Administration (SAMHSA).**

The Substance Abuse Prevention and Treatment Block Grant at SAMHSA is the primary funding source for public substance abuse prevention and treatment services. The goal of the block grant is to ensure that all Americans have access to appropriate drug prevention and treatment services. Alcohol and drug prevention and treatment services promote good health and reduce high-risk sexual behavior. Substance abuse prevention and treatment prevent HIV disease, cost far less than HIV medical care, and drastically reduces the human suffering and cost associated with AIDS.

RESEARCH
National Institutes of Health (NIH)
While both a cure for HIV disease and a vaccine to prevent new infections remain elusive, AIDS research has experienced significant achievements. The productive life span of Americans diagnosed with HIV has doubled since 1987 and may easily double again with the recent advances in basic research coupled with the new drugs. But we must remember that the new drugs are not a cure and we are still years from the development of an effective vaccine. In order to continue to make advances in HIV/AIDS research, funding for overall research efforts at the National Institutes of Health must increase. **For FY 99, AIDS Action proposes a $200 million increase over FY '98 for the National Institutes of Health AIDS-related biomedical and behavioral research.**

NIH AIDS research is part of our nation's larger commitment to biomedical research. AIDS research enhances and stimulates research in other fields, with broad implications for human diseases such as cancer, heart disease, Alzheimer's disease, and others. Twenty five percent of NIH AIDS research funds are used for basic science research, which has broad implications across scientific disciplines.

This Subcommittee and the Congress have made a bipartisan commitment to maintain a vigorous national commitment to the flagship biomedical and behavioral research enterprise at the National Institutes of Health. However, the size and breadth of the AIDS research portfolio conducted by all 24 NIH Institutes requires a coordinated and strategic plan to ensure that federal resources are effectively managed to facilitate answers to the scientific questions which hold the greatest promise. In order to accomplish this, a consolidated budget administered by the Office of AIDS Research must be maintained. It is only by continuing to support this funding mechanism that the resources devoted to AIDS research will be allocated to the most promising areas of medical and scientific exploration. Ultimately, biomedical and behavioral research will provide the critical answers for treatment and prevention of HIV infection. Without a concentrated, planned commitment to an effective research agenda, we will be unable to find new ways to prevent HIV infection, develop new treatments, a vaccine or a cure.

CONCLUSION

Our nation is at a crucial juncture in the fight against AIDS. While we have made incredible progress on several fronts, so much more remains to be done. AIDS Action Council calls upon the federal government, in partnership with communities across the country, to assertively ensure that the new hope touches the lives of all people affected by HIV/AIDS.

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