

The Minority HIV/AIDS Initiative (MHAI)

Responding to advocacy from the AIDS community and the Congressional Black Caucus, Congress established the MHAI in FY 1999 to address the HIV/AIDS state of emergency among African Americans and other communities of color. Congress expanded the scope of the MHAI in FY 2000 with the strong support of the Congressional Hispanic and Congressional Asian Pacific American Caucuses to address the growing impact of the epidemic on other ethnic and racial minorities in the U.S.

Growing and Ongoing Need for Services

Disparities in HIV and AIDS health outcomes among ethnic and racial minorities persist. While ethnic and racial minority groups make up just over 25 percent of the U.S. population, they represent 72 percent of new AIDS cases, 62 percent of the estimated number of persons living with AIDS, and 74 percent of the estimated new HIV infections annually. On average, African Americans and Latinos on Medicaid initiate antiretroviral treatment later after HIV diagnosis than do their white counterparts and African Americans are more likely to discontinue treatment.

Overview of MHAI Services and Initiatives

The MHAI expands and strengthens the capacity of indigenous, minority community-based organizations (MCBOs) to deliver high quality HIV health care and supportive services, and to enhance and better target HIV prevention programs to historically underserved groups. The MHAI addresses HIV-related health disparities faced by racial and ethnic minorities by providing targeted funding to:

- *Establish and improve HIV service capacity in minority communities:*
The MHAI establishes and improves the existing infrastructure and service capacity of MCBOs to provide HIV prevention interventions, healthcare, treatment delivery and education and supportive services. The MHAI provides MCBOs with capacity-building assistance and resources to help mount an effective response to the epidemic within their own communities.
- *Expand services in historically underserved minority communities and ensures sustainability:*
The MHAI develops HIV/AIDS services where none exist and complements existing HIV prevention and health care services in historically underserved communities. These resources provide a bridge to enable MCBOs to compete for and access broader federal HIV/AIDS funding.

Increased Funding & Support is Needed to Close Gaps in HIV Health Outcomes

For FY 2005, the Congressional Black, Hispanic and Asian Pacific Islander Caucuses and AIDS advocates are requesting an additional \$159 million for a total appropriation of \$610 million* for the Minority HIV/AIDS Initiative to:

- sustain current efforts and expand programs to address growing unmet service, infrastructure, and capacity needs in minority communities; and
- invigorate efforts towards the goal of eliminating HIV-related health disparities in ethnic and racial minority communities.

** MHAI funds are included within specific program line items in the HHS budget and do not appear separately in the budget documents. This request is in addition to all other, line item specific requests.*

Average Number Of Months After HIV Diagnosis To Begin Treatment:

Hispanics	17 months
African Americans	15 months
Whites	7 months

- *Reduce persistent health disparities:*

Despite improvements in HIV/AIDS care, ethnic and racial minorities continue to experience poorer HIV/AIDS-related health outcomes. Doctors are less likely to prescribe highly active antiretroviral therapy (HAART) to African Americans and Latinos than they are to whites early in their disease progression or at any time during their illness. The MHAI is intended to close these health disparities by enabling MCBOs and minority providers to deliver culturally competent and linguistically appropriate health care and treatment services, as well as substance abuse, mental health, prevention, and other supportive services.

Supporting a Diverse Range of Services

The Department of Health and Human Services uses various mechanisms (formula and direct grants) to distribute MHAI funds through several of its agencies and offices:

- HRSA: Ryan White CARE Act Title I, II, III, IV& Part F: AIDS Education and Training Centers;
- CDC HIV Prevention: capacity building, directly funded minority and other community-based organization programs, faith-based initiatives, initiatives targeting men of color who have sex with men, and other targeted initiatives;
- SAMHSA: organizational capacity building for minority organizations through the Center for Mental Health Services, Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment;
- Office of Minority Health; and
- Office of the Secretary.

Ryan White Comprehensive AIDS Resources Emergency (CARE) Act

CARE Act Key to America's Response to AIDS

The Ryan White CARE Act, the largest discretionary investment in the care of people with HIV/AIDS in the U.S., funds primary health care and support services for people with HIV/AIDS who lack health insurance and financial resources for their care. Each year, CARE Act programs reach more than 500,000 individuals with or at risk for HIV in all 50 states, the District of Columbia, Puerto Rico, and the U.S. territories. Congress first enacted the CARE Act in 1990 and, based on the CARE Act's strong record of delivering care to those in need, reauthorized the Act in 1996 and again in 2000.

Tremendous Unmet Need Remains

- An estimated 850,000-950,000 people are living with HIV disease in the U.S. Of those, the CDC estimates that 180,000-240,000 do not know they are infected, and 300,000 of those with HIV who do know their status are not receiving regular HIV-related care.
- The Centers for Disease Control and Prevention (CDC) has introduced a new HIV prevention initiative, *Advancing HIV Prevention*, designed to increase the number of HIV-positive people who are aware of their status and link them with appropriate medical care and treatment. This focus will increase the reliance on already thinly stretched Ryan White-funded care and treatment programs.
- On average, people living with HIV/AIDS are poorer than the general population, and those using services funded by the CARE Act are poorer still. For these individuals, the CARE Act is the payer of last resort—they are uninsured or have inadequate insurance and cannot cover the costs of HIV/AIDS care on their own, and no other source of payment, public or private, is available.

Funding Must Keep Up with Growth in Epidemic

For FY 2004, the Ryan White CARE Act needs a total appropriation of \$2.45 billion in order to respond to growth of the epidemic and the increasing costs of new HIV therapies and diagnostic testing.

Title I \$702.0 m (+\$86.98 m)

Title II: Care \$ 387.03 m (+\$50 m)

Title II: ADAP \$965.87 m (+\$217 m)

Title III: \$224.5 m (+\$27.3 m)

Title IV: \$101 m (+\$27.89 m)

Part F: AETCs \$46 m (+10.66 m)

Part F: Dental Reimbursement \$ 19 m (+\$ 5.67 m)

Source: CDC, HIV/AIDS Surveillance Report, 2002, Vol 14.

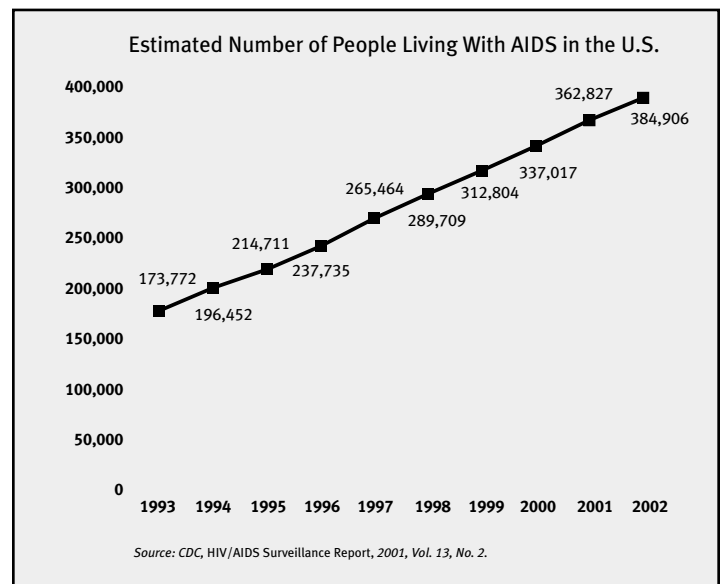
The CARE Act Works

CARE Act-funded services have:

- reduced AIDS mortality by 70 percent;
- curbed mother-to-child transmission of HIV by 85 percent;
- reduced HIV-related hospital admissions 30 percent nationally and up to 75 percent in some locales; and
- saved money by keeping people healthier so that they can stay out of the hospital and remain in the workforce longer.

Additional Benefits of CARE Act Funded Services

Linking people living with HIV/AIDS to appropriate care and treatment services, including access to antiretrovirals has many positive benefits. The benefits of treatment include:



- Extending lifespan and improving quality of life;
- Keeping people healthier, thereby reducing hospital stays and saving money;
- Promoting health so that people can stay in the workforce;
- Reduction in the incidence of transmission – studies have shown highly active antiretroviral treatment (HAART) have direct prevention benefits; and
- Saving money by treating HIV early: effective HIV treatment is expensive and requires extensive medical monitoring. The annual cost of medical care, including highly active antiretroviral therapy (HAART), for a person with early-stage HIV disease is \$15,404 per year, compared with \$30,261 per year for those with late-stage AIDS.

individuals with HIV infection and to help prevent high-risk behaviors that lead to infection. Also provides support to dental schools, postdoctoral dental education programs, and dental hygiene programs for non-reimbursed care.

- *Special Projects of National Significance (SPNS)* Supports the development of innovative HIV/AIDS service delivery models that have potential for replication in other areas.

CARE Act Programs Designed to Reach All Affected Communities

In FY 2004, the CARE Act is providing just over \$2 billion in care and treatment services through the following programs:

- *Title I (HIV Emergency Relief Grants to Cities)*
Provides funding for health care and support services to the 51 U.S. eligible metropolitan areas (EMAs) hardest hit by HIV/AIDS.
- *Title II (HIV Care Grants to States and States AIDS Drug Assistance Programs)*
Assists states and territories in improving the quality, availability, and organization of health care and support services for individuals and families with HIV disease, and provides access to pharmaceuticals through the AIDS Drug Assistance Program (ADAP).
- *Title III (AIDS Health Care Service Grants to Clinics)*
Provides support directly to community-based providers for early intervention and primary care services for people living with HIV/AIDS.
- *Title IV (Services for Children, Youth Women and Families)* Enhances access to comprehensive care and research of potential clinical benefit for children, youth, women, and their families with or at risk for HIV.
- *Part F: HIV/AIDS Education and Training Centers and Dental Reimbursement Program*
Supports training for health care providers to identify, counsel, diagnose, treat, and manage

New Funds Will Address Key Needs

Funding increases in the CARE Act are needed to:

- provide medical care and support services for the increasing caseload, due to new infections and people with HIV living longer
- respond to the care and treatment needs of individuals testing positive for HIV through CDC's enhanced testing focus
- address the increasing complexity and cost of delivering quality HIV medical care and diagnostic testing;
- meet new CARE Act requirements to reach out and serve people living with HIV/AIDS entering care;
- expand access to underserved areas;
- expand access to specialty medical care for patients with side effects directly related to HIV treatments;
- provide local community-based organizations serving underserved and isolated communities of color with increased infrastructure support and expanded service capacity;
- address the disparity in outcomes, access, and utilization of care and treatment by people of color living with HIV/AIDS;
- identify and link persons of color and people residing in rural areas with HIV to care;
- enhance the coordination, continuity and provision of care and treatment services for the incarcerated;
- help cover the increased costs of medications; and
- offer HIV prevention counseling and testing to thousands of individuals in communities at highest risk for HIV.

CDC HIV Prevention Programs

Without a Vaccine, Prevention is the Only Cure

The Centers for Disease Control and Prevention's (CDC) HIV/AIDS prevention programs are working in every state and territory to prevent new HIV infections, provide HIV counseling and testing to those at risk for HIV, provide prevention services and link infected people to medical care, and translate scientific research findings into practical prevention programs available to all those at risk.

Too Many New Infections, Too Many of the Infected Not in Care

The number of people living with AIDS in the U.S. increased 7.2 percent from 2001 to 2002 with CDC estimating that approximately 385,000 Americans living with AIDS by the end of 2002.

Approximately 200,000 people with HIV in the U.S. are unaware of their HIV status and another 300,000 who know they are infected are not receiving the care they need. Forty percent of HIV-infected Americans begin antiretroviral treatment later than is recommended by the U.S. Public Health Service. One tragic result of delaying treatment is the fact that five percent of all AIDS cases are diagnosed within a month of a patient's death. Early HIV diagnosis, in addition to ongoing, targeted HIV prevention programs, is key to reducing the number of new HIV infections.

The devastation of AIDS in communities of color continues to grow disproportionately. AIDS remains the leading cause of death of African American women between the ages of 25-34, and the third leading cause of death among Hispanics between the ages of 35-44.

CDC's Prevention and Testing Programs

CDC's Advancing HIV Prevention Initiative: In April 2003, CDC announced a new HIV prevention initiative, *Advancing HIV Prevention: New Strategies for a Changing Epidemic*. The initiative strives to make HIV testing a routine part of medical care, implement new models for diagnosing HIV infections outside medical settings, prevent new infections by working with persons diagnosed with HIV and their partners, and further decrease perinatal HIV transmission.

FY 2005 Funding Needs

CDC needs \$1 billion in funding in FY 2005 to support domestic HIV prevention programs. CDC domestic HIV/AIDS programs were cut by \$4 million in FY 2004. Increased funds for prevention are needed to ensure that effective, scientifically based programs targeting populations at risk and those infected can be implemented. By reducing the number of new HIV infections, we can reduce the expensive demand for care services in the future. Absent a vaccine or cure, prevention is the only intervention for stopping HIV transmission.

Counseling, Testing, Partner Counseling, and Referral Services: HIV counseling, testing, and referral services, as well as partner counseling programs, are aimed at ensuring that individuals learn their HIV serostatus as soon as possible, receive counseling on behavior change to avoid infection or prevent transmission, and obtain referrals for prevention and care services. This includes specific initiatives to promote knowledge of serostatus among targeted populations, including communities of color, men who have sex with men, and women of childbearing age.

HIV/AIDS Community Planning: CDC requires state health departments to use a localized community planning process to ensure the participation of communities with and at-risk for HIV infection in the development of effective HIV education and prevention interventions.

Health Education/Risk Reduction: CDC supports targeted education and outreach activities for individual, group, and community-level interventions, as well as street and community outreach.

Capacity Building: State and local health departments and community-based organizations (CBOs) receive financial and technical assistance to strengthen their infrastructure to deliver effective HIV prevention programs.

Prevention Research and Program Evaluation: CDC funds prevention research and program evaluation activities to monitor progress, outcome, and impact of prevention

interventions, as well as to assess needs and develop culturally appropriate services.

Minority HIV/AIDS Initiative (MHAI) Programs: The MHAI provides much-needed resources for CDC programs specifically targeted to ethnic and racial minority communities and minority CBOs to expand and enhance effective prevention interventions for ethnic and racial minority groups highly impacted by HIV.

HIV Surveillance and Epidemiology: CDC awards state and local health department grants to strengthen HIV and AIDS case reporting, behavioral surveillance, incidence modeling and evaluation. AIDS and HIV surveillance activities provide data that are critical to target and deliver prevention and treatment programs and ensure that scarce resources are effectively utilized. CDC continues to ask state and local health departments for increasingly burdensome data elements without providing new resources. These data are critical to the evaluation of prevention programs across the nation.

Barriers to Effective HIV Prevention

Restrictions on Content of Prevention Programs

Communities are best equipped to set priorities and develop and implement effective HIV prevention programs. CDC grantees are currently required to comply with the requirements in Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions and must have materials reviewed by a local Program Review Panel. Programs must not be restricted from using federal, state or local funds for prevention activities that they deem appropriate and consistent with public health. The federal government must not place restrictions or mandates on the content of HIV prevention programs.

HIV Prevention Priorities for Youth Shifting to "Abstinence-Only"

Approximately 50 percent of new HIV cases in the U.S. are in youth under the age of 25. Comprehensive HIV prevention interventions targeted to youth are crucial to the nation's HIV prevention strategy. There is overwhelming evidence that providing youth with sex education does not lead to an increase in or initiation of sexual activity. Rather, such education provides youth with vital lifesaving information about prevention of HIV and other STDs. Presently, Congress is funding abstinence-only sex education at \$137 million in FY 2004. The President's FY2005 budget substantially increases funding for abstinence education programs to a total of \$273 million. HIV prevention for youth should instead be funded through CDC's Division of HIV/AIDS Program and Division of Adolescent and School Health. HIV prevention for youth should instead be funded through CDC's Division of HIV/AIDS Program and Division of Adolescent and School Health.

Federal Funding Ban on Needle Exchange

The current federal ban on the use of federal funds for needle exchange is not appropriate public health policy and must be lifted. Numerous government reports and scientific studies, including a 2001 Institute of Medicine Report, have cited overwhelming evidence supporting the effectiveness of exchange programs in reducing the rate of new HIV infections among IV drug users, their sex partners and children. These reports and studies have also concluded the exchange programs do not lead to increased drug use. Needle exchange, as part of comprehensive prevention efforts that include health information and access to substance abuse treatment, must be an option for communities that have identified a need for these services.

HIV Prevention Saves Lives...

Overwhelming evidence, including extensive historical experience and scores of scientific studies, demonstrates that well-designed and well-delivered HIV prevention programs contribute to healthier behaviors and substantially reduce the number of new HIV infections. The impact of these programs can be seen across at-risk populations.

...And Money

Researchers estimate that the discounted cost of lifetime treatment for a person with HIV now averages about \$155,000. With over 40,000 people infected yearly, the U.S. faces an additional annualized cost of more than \$6 billion every year. In comparison, scientists estimate that providing access to community-level HIV prevention or small group

interventions to all those at risk for sexual transmission of HIV and providing prevention services to all those at risk from injection-drug-related HIV infection in the U.S. would cost an estimated \$1.423 billion annually.

Housing Opportunities for Persons With AIDS (HOPWA)

Stable Housing Key to the Health of People Living with HIV/AIDS

Recent studies confirm that persons living with HIV/AIDS must have stable housing to access comprehensive health care and adhere to complex HIV/AIDS drug therapies. HOPWA is the only federal program dedicated to the housing needs of persons living with HIV/AIDS and their families. In FY2004 HOPWA funding supports the delivery of housing and related services in 117 formula jurisdictions (38 states and 79 metropolitan areas) as well as 30 competitive grants. During program year 2001-2002 HOPWA funding assisted 84,059 units of housing and leveraged resources for an additional 51,717 households, according to the Office of HIV/AIDS Housing.

More than one-half of people living with HIV/AIDS are likely to need housing assistance at some point in their illness. Even though stable housing has been shown to be a necessary link to medical and supportive services, accessing housing is difficult as the wait for affordable housing increases in many communities across the country. Compounding the problem of waiting lists is the need to serve the increasing number of persons living not only with HIV/AIDS but also with histories of homelessness, mental illness, and substance abuse.

Overview of HOPWA Services and Initiatives

HOPWA makes grants to local communities, states, and nonprofit organizations for projects that benefit low income persons medically diagnosed with HIV/AIDS and their families. HOPWA funding provides housing assistance and related supportive services as part of HUD's Consolidated Planning initiative that works in partnership with communities and neighborhoods in managing federal funds appropriated to HIV/AIDS programs. HOPWA grantees are encouraged to develop community-wide strategies and form partnerships with area nonprofit organizations. HOPWA funds are dispersed through three mechanisms:

The HOPWA Formula Program allocates 90 percent of HOPWA funds to states and cities with populations of more than 500,000 and 1,500 cumulative AIDS cases.

The HOPWA Competitive Program is a national competition to select model projects or programs across the country.

The HOPWA National Technical Assistance Funding Program awards are provided to strengthen the management, operation, and capacity of HOPWA grantees, project sponsors, and potential applicants for HOPWA funding.

FY 2005 Funding Needs

In FY 2005 HOPWA needs a \$55.2 million increase for a total appropriation of \$350 million in order to:

- reduce waiting lists for HOPWA-funded housing;
- increase the capacity of communities to develop new housing for poor individuals with HIV/AIDS and their families;
- provide housing voucher support; and
- provide a minimal level of social services to keep people in their housing and supplement care available through other sources.

Homeless People with HIV/AIDS have Difficulty Accessing Care

- One national survey found that only 17 percent of homeless people living with HIV/AIDS who would benefit from antiretroviral drugs were taking them, as compared to 51 percent of housed people.
- Columbia University research revealed that homeless people living with HIV/AIDS who received a combination of stable housing and social case management were nine times more likely to enter into and remain in medical care, including adherence to HIV/AIDS treatments.

HOPWA funds are used for a wide range of housing, social services, and program planning and development costs, including: the acquisition, rehabilitation or construction of housing units; costs for facility operations; rental assistance; and short-term payments to prevent homelessness. HOPWA funds also may be used for health care and mental health services, chemical dependency treatment, nutritional services, case management, assistance with daily living, and other supportive services.

Local Control Allows Flexibility

HOPWA provides maximum flexibility to states and communities to implement strategies that respond to local housing needs and shortfalls. HOPWA resources are coordinated with other federal, state, local and private funds through a community's Consolidated Plan. Grant recipients are also encouraged to develop community-wide comprehensive strategies and to form partnerships with area non-profit organizations, including faith-based organizations, to provide housing assistance and related services for eligible people with HIV/AIDS.

Unmet Need Still A Problem

HOPWA grantees across the nation report that the need for services far outweighs available resources, as evidenced by the extensive waiting lists for services. In Connecticut, 80% of the 1,082 persons living with HIV/AIDS who requested housing assistance were denied due to lack of space. Similarly, in Phoenix, AZ providers turn away more than half of the people requesting assistance. In Massachusetts 2,000 people are on the waiting list, in St. Louis and Washington, DC over 500 and 474 in Dallas. Other jurisdictions across the U.S. report extensive waiting lists for HOPWA-funded housing assistance.

“NIH-Funded HIV/AIDS Research

Past Discoveries and Current Initiatives Form the Basis for Treatment Advances

AIDS research at the National Institutes of Health (NIH) has led to major advances in the understanding and treatment of HIV and related opportunistic infections. NIH-funded researchers are now at the forefront of the global effort to build upon these findings and develop new, more effective treatment regimens and prevention interventions. Success against AIDS and other diseases will only be possible with a comprehensive national research effort. Therefore, Congress should support AIDS research and NIH research overall.

The Impact of NIH-supported AIDS research:

- dramatically increased survival time and improved quality of life for people living with HIV and AIDS;
- helped develop the 23 FDA-approved drugs for the treatment of HIV infection, which are largely responsible for recent declines in AIDS-related mortality by 67 percent in the U.S.;
- led to tremendous advances in the treatment and prevention of AIDS-related opportunistic infections (OIs) and greatly reduced the incidence of OIs by over 67 percent;
- demonstrated that antiretroviral drugs dramatically reduce HIV transmission from mother to fetus, leading to nationwide reductions in perinatal HIV transmission of 90-95 percent;
- demonstrated that combinations of protease inhibitors and other anti-HIV drugs can reduce the amount of virus in patients to undetectable levels.
- demonstrated through the pivotal HIVNET 012 study that two simple doses of the drug nevirapine (one to the mother at the onset of labor and one to the infant within 72 hours of delivery) can cut transmission of HIV from mother to child by 47 percent. This study has led to effective programs to prevent mother-to-child transmission in resource-limited countries.

FY 2005 Funding Need

NIH needs a 10% increase over its doubled budget, for a total FY 2005 appropriation of \$30.6 billion, including a commensurate increase for AIDS research funding totaling \$3.135 billion. We believe that the complex decisions about how to spend research funding should be vested with the scientists at NIH.

Broad-Based Benefits of AIDS Research

- AIDS research enhances and stimulates research in other fields, with broad implications for other diseases such as cancer, heart disease, Alzheimer's disease, and others.
- Approximately one-third of NIH AIDS research funding is used for basic science research with broad implications across scientific disciplines.
- AIDS research has accelerated study of the human immune system. NIH AIDS research is one of the main sources of funds for immunological research.
- Several drugs that first received approval for the treatment of AIDS related conditions, including fluconazole and clarithromycin, have important uses in cancer and organ transplant patients.
- NIH AIDS research has accelerated investigation into viruses, particularly retroviruses.

Key Areas for NIH-AIDS Research

The following areas of NIH-funded research continue to reveal how the AIDS epidemic can best be treated and prevented.

■ *Basic Biomedical Research*

Basic research in virology, immunology, infectious diseases and cancer provides insights into the life cycle of HIV. An increase in funding in this area is critical for opening new doors of understanding to pave the way for better treatments, an effective vaccine, development of a microbicide, and a cure for HIV/AIDS, as well as for other immune, infectious, and neoplastic diseases.

■ *Behavioral and Social Science Research*

Behavioral research is a vital part of a comprehensive national HIV prevention strategy. Behavioral research at NIH provided a greater understanding of the factors that put people at risk of HIV infection and the interventions best suited to prevent HIV transmission.

■ *Therapeutic Research to Treat Those Already Infected*

Highly active antiretroviral therapy (HAART) has not eradicated HIV, even in those people in whom it is effective. In addition, over 50 percent of those on HAART have experienced treatment failure, and over 50 percent have developed intolerance to at least one of these drugs or combination of drugs. There is a great need for simpler, less toxic and cheaper drugs and drug regimens.

■ *Vaccine and Microbicide Development*

Better biomedical interventions are needed to help prevent the nearly six million new HIV infections occurring worldwide each year. Increased funding is necessary for targeted research and product development to fast track and optimize new vaccine and microbicide technologies.

■ *Epidemiology and Natural History*

Research in this area is essential in tracking the changing demographics of HIV infection and the course of disease progression in different groups affected by HIV, including women, children and people of color.

■ *International Research Priorities*

More research is needed on crucial issues that could have a major impact on the worldwide pandemic, including the prevention of mother-to-child transmission and challenges associated with breastfeeding. NIH supports international training programs and initiatives that help build infrastructure and laboratory capacity in developing countries.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Programs Deliver Key Services to People Living with and At-Risk for HIV/AIDS

SAMHSA provides prevention, diagnosis, and treatment services for substance abuse and mental illness, that are especially important to people living with and at risk for HIV/AIDS:

- One-third of adult AIDS cases and over one-half of pediatric AIDS cases in the U.S. are linked to injection drug use—through sharing needles, having sex with an injection drug user, or having a mother infected through these behaviors.
- A large number of Americans use drugs that are administered intravenously. Helping these individuals avoid future IV drug use is an important element of the fight against the HIV/AIDS epidemic.
- In 2002, 166,000 people in the U.S. were heroin users, 597,000 were methamphetamine users, and 2.0 million were cocaine users. Reducing alcohol and drug use has been shown to decrease the likelihood that people will engage in behaviors that put them at risk for HIV/AIDS infection.
- HIV is a significant problem among people with serious mental illness. A study of Medicaid-insured patients living with HIV in New Jersey found that six percent suffered from schizophrenia and seven percent from a major affective disorder, such as a major depressive or bipolar disorder. In comparison, schizophrenia affects only one percent of the general population.

SAMHSA Services for Individuals Abusing Alcohol and Drugs

There are numerous programs that provide alcohol and drug abuse counseling and prevention services at risk of HIV/AIDS:

- Substance Abuse Prevention and Treatment Block Grant supports treatment services for individuals whose health insurance fails to cover alcohol and drug services, who have no insurance and who are unable to pay for those services themselves.
- Center for Substance Abuse Treatment (CSAT) plays a crucial leadership role in steering resources to underserved populations and meeting emerging needs of women, adolescents, communities of color, and homeless individuals.
- Center for Substance Abuse Prevention (CSAP) addresses current and anticipated gaps in the availability of alcohol and drug prevention services, seeking to make sure that every community has the ability to implement effective prevention.

FY 2005 Funding Needs

Center for Substance Abuse Prevention (CSAP)	\$248,600,000
Center for Substance Abuse Treatment (CSAT) (including block grant)	\$2,448,600,000
Center for Mental Health Services (CMHS) (including block grant)	\$970,200,000
Block Grant	\$489,000,000
Grants for the Benefit of Homeless Individuals (GBHI)	\$100,000,000
Projects for Assistance in Transition from Homelessness (PATH)	\$56,000,000

SAMHSA Services for Individuals with Mental Illness

Center for Mental Health Services Block (CMHS) Grant supports comprehensive, community-based care for adults with serious mental illnesses and children with serious emotional disorders. The program is the cornerstone of the federal partnership with states to plan and deliver state-of-the-art, community-based mental health services through outreach, mental and other health care services, individualized supports, rehabilitation, employment, housing, and education.

CMHS is developing programs to provide mental health services for individuals, their families, and others who may experience severe psychological distress as a result of their diagnosis and to identify models of effective mental health services delivery for people with HIV/AIDS. CMHS also trains mental health providers to identify and treat people with mental illnesses who may be at increased risk for HIV/AIDS. It also trains primary health care and support services providers to recognize, refer, and treat people with emotional trauma, depression, anxiety, severe mental disorders, and dementia associated with HIV/AIDS.

SAMHSA Services for the Homeless

Through the Grants for the Benefit of Homeless Individuals (GBHI) and Projects for Assistance in Transition from Homelessness (PATH), SAMHSA provides critical support services to homeless individuals with mental health, drug and alcohol problems who may also have HIV/AIDS.

Medicaid, the new Medicare Prescription Drug Benefit and the Early Treatment for HIV Act

Medicaid is an Essential HIV/AIDS Health Care Program

Medicaid is a critical component of the U.S. response to HIV disease. Funded by both federal and state governments and run by states, Medicaid is the single largest source of funding for health care for people living with HIV/AIDS and at the core of the HIV/AIDS care delivery system.

One of the keys to Medicaid's success in providing health care services to some of the most vulnerable people living with HIV/AIDS, and other low-income and poor Americans, is its entitlement status. This status ensures that every person who qualifies for the program receives services as federal and state funding increase to meet demand.

Medicaid is an increasingly important part of the health care delivery system for people with HIV/AIDS.

- Between 1995 and 2002, Medicaid spending for HIV/AIDS care more than doubled.
- In FY 2002, Medicaid paid for \$5.4 billion of HIV/AIDS health care services, compared to Medicare (\$2.6 billion) and Ryan White CARE Act programs (\$2.0 billion).
- Medicaid serves 55 percent of people with AIDS. Over 90 percent of children with HIV/AIDS rely on Medicaid.
- Community-based health centers, hospitals, and academic medical centers depend on Medicaid for payment for health care services to people with HIV/AIDS.

Medicaid is a core component of the fragile community-based system of care and support services for people living with HIV and AIDS.

- Because Medicaid provides eligible people with HIV and AIDS a guaranteed package of benefits including physician, clinic, laboratory and hospital services, it allows Ryan White CARE Act-funded programs to stretch their limited grant funds to provide a broad range of essential care and services not covered under Medicaid.
- Medicaid relieves some of the overwhelming demand on state AIDS Drug Assistance Programs (ADAP). While not a mandated Medicaid benefit, every state Medicaid pays for at least some prescription drugs for its beneficiaries.

Principles for Preserving Medicaid

In order to ensure that Medicaid continues its vital role in HIV/AIDS health care, any changes to the Medicaid program must uphold the following principles:

Protect the individual entitlement to Medicaid and maintain the federal-state funding partnership.

- Maintaining entitlement status ensures that eligible individuals receive the services they need, avoiding costly emergency and hospital care, increased illness, and preventable deaths.
- The ability of states to continue to provide comprehensive and appropriate health care services to beneficiaries, including people living with HIV, depends on protecting the matching structure of federal financing for Medicaid.

States are applying for waivers that fundamentally alter the basic tenets of the Medicaid program and threaten access to medically necessary care for low-income parents and children and people with disabilities. These waivers should be subject to public comment and state legislative oversight.

Reject federal funding caps for Medicaid.

- Any reforms to cap federal funding based on predicted future costs would be devastating to the program.

It is crucial that Congress:

Reject Medicaid reform proposals that would –

- Eliminate the entitlement status of the program.
- Cap the program or dismantle the federal/state funding partnership.
- Restrict a beneficiary's access to a broad range of services and supports or remove beneficiaries from coverage.

Support –

- Another temporary increase in the portion of the Medicaid program paid for by federal government, known as the Federal Medical Assistance Percentage (FMAP).

Historically, the ability to predict Medicaid costs has been poor. In 1998, the Congressional Budget Office (CBO) made a projection for 2002 Medicaid spending that was \$17 billion below actual expenditures. Any caps would cause states to limit eligibility or cut services to vulnerable populations.

- Caps would threaten the program's ability to respond to emerging diseases.
- Caps could also affect quality of care. In HIV care, Medicaid plays an important role in making available expensive, but effective and ultimately cost-saving therapies, such as highly active antiretroviral therapy (HAART). Access to these medications has led to significant declines in HIV-related deaths in the United States. Caps would make it difficult or impossible to deliver new and potentially life-saving therapies.

Protect access to a broad range of services and supports.

- Restrictions on coverage and limited benefits will undermine the gains made in preserving the health of many people living with HIV and AIDS. Ultimately, coverage restrictions will increase costs as people will become sicker and require more costly care. Instead of federal funding cuts, Congress should provide another temporary funding increase in the Federal Medical Assistance Percentage (FMAP).
- Medicaid programs ensure that Medicaid-eligible individuals are entitled to receive the same benefits regardless of region. However, the block grant waivers that some states are pursuing dissolve much of the comparability between state Medicaid programs.

Recent Changes to Medicare Benefits Will Hurt Medicaid Dual Eligibles

In the fall of 2003, Congress enacted the *Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA)* to change the current Medicare benefit. The new program will expand to include a new Part D prescription drug benefit.

The HIV/AIDS and disability communities are concerned that a number of issues still need to be resolved to ensure access to medically necessary prescription drugs through the new Medicare Part D benefit.

- Comprehensive coverage of antiretroviral medications (ARVs) on the formularies of approved plans
- Allowing all medically necessary costs to count toward the "out-of-pocket" limit even if not on a plan's formulary, particularly for people with diseases such as HIV where patients experience treatment failure.
- Requiring plans to cover prescription drugs for off-label uses.

- Providing beneficiaries with information on the plans' formularies and cost-sharing requirements up front so they can make informed selections before locked in for a full year.
- Ensuring individuals who are dually eligible for both Medicare and Medicaid and will be required to enroll in the new Medicare Part D benefit are not left worse off by allowing Medicaid programs to wrap-around the Part D prescription drug coverage.
- Provide appeals information at enrollment on enrollment and allow medical providers and family members to file on behalf of beneficiary.
- Expanding Medicaid – The Early Treatment for HIV Act (ETHA)

The current Medicaid program has a life-threatening gap in most states—people living with HIV must become disabled with an AIDS diagnosis before qualifying for the Medicaid care and services that could have prevented them from becoming so ill.

The Early Treatment for HIV Act (ETHA) would allow states the option to readily amend their Medicaid eligibility requirements to include pre-disabled poor and low-income people living with HIV. By allowing states to provide Medicaid coverage for people with HIV as soon as they test positive for the virus, ETHA would bring Medicaid eligibility in line with the federal government guidelines on the standard for treating HIV disease.

Senators Gordon Smith (R-OR) and

Hillary Clinton (D-NY) are the lead co-sponsors of ETHA (S. 847) in the Senate. ETHA has been introduced in the House (H.R. 3859) with Rep. Jim Leach (R-IA) and Rep. Nancy Pelosi (D-CA) as lead co-sponsors.

AIDS advocates urge members of Congress:

- To sign on to ETHA as a co-sponsor.
- To actively encourage others members to sign on.

Passage of ETHA would provide significant health and economic benefits, including:

- Eliminating barriers to care and disparity in health outcomes for the most vulnerable populations;
- Slowing disease progression and improving quality of life and survival through access to care and treatment;
- Encouraging testing and behavior change by providing early access to care and treatment;
- Reducing viral load;
- Reducing transmissibility of the virus.

Global Devastation Demands Strong U.S. Commitment

Globally, HIV/AIDS has reached pandemic proportions. Today, an estimated 42 million people are living with HIV/AIDS and HIV newly infects 16,000 every day.

- Sub-Saharan Africa remains the region hardest hit by the HIV/AIDS epidemic with an estimated 26.6 million people living with HIV, including 3.2 million who became infected in 2003. 2.3 million people died in 2003 in this region alone. Among youth aged 15-24, women were found to be more than twice as likely to be infected with HIV than men.
- The AIDS epidemic in Eastern Europe and Central Asia shows no signs of abating. Some 230,000 people were infected with HIV in 2003, bringing the total number of people living with the virus to 1.5 million. AIDS claimed an estimated 30,000 lives in the past year. Worst-affected are the Russian Federation, Ukraine, and the Baltic States (Estonia, Latvia and Lithuania), but HIV continues to spread in Belarus, Moldova and Kazakhstan, while more recent epidemics are now evident in Kyrgyzstan and Uzbekistan. It is now estimated that around 1 million people aged 15-49 are living with HIV in the Russian Federation (although various estimates from that country put the figure at between 600,000 and 1.5 million).
- Over 1 million people in Asia and the Pacific acquired HIV in 2003, bringing to an estimated 7.4 million the number of people now living with the virus. A further 500,000 people are estimated to have died of AIDS in 2003. Moreover, there are increasing warning signals that serious HIV outbreaks threaten in several countries. Injection drug use and sex work are so pervasive in some areas that even countries with currently low infection levels could see epidemics surge suddenly.
- More than 2 million people are now living with HIV in Latin America and the Caribbean, including the estimated 200,000 that contracted HIV in the past year. At least 100,000 people died of AIDS in the same period-the highest regional death toll after sub-Saharan Africa and Asia. Most of the other countries in the region have highly concentrated epidemics, notably in South America where Brazil (with by far the largest overall population in the entire region) is home to the vast majority of people living with HIV in the region.
- In the Middle East , 55,000 people acquired the HIV infection in the past year, bringing to 600,000 the total number of people living with HIV/AIDS in the Middle East and North Africa. AIDS killed a further 45,000 people in 2003. There is the potential for a considerable rise in the number of HIV infections in this region. By far the most seriously affected country at present is the Sudan, specifically in the south, where a mainly heterosexual epidemic is well under way.
- In most other countries, HIV spread in this region appears to be nascent, although scant surveillance data in several countries could mean that serious outbreaks in certain populations (including men who have sex with men and injection drug users) may be being missed.
- Ninety-five percent of those infected live in the developing world and a third are between the ages of 15 and 24.
- Young people are most affected by the pandemic and women below the age of 24 are particularly vulnerable. Women in this age group are six times more likely to be infected than men their age.
- Southern Africa has been particularly hard hit. One-third of the adults in Botswana, Lesotho, Swaziland and Zimbabwe are HIV-infected. In South Africa, one in five adults are infected.
- Thirteen million African children have been orphaned due to AIDS, a figure that may exceed 40 million by the end of the decade.
- The HIV pandemic represents a growing threat in many parts of the Caribbean, Asia, Eastern Europe, and South America; the epidemics in these regions will spiral out of control without adequate resources.

The US government response to the global AIDS pandemic was dramatically changed when President Bush announced a new “Emergency Plan for AIDS Relief” in his January 2003 State of the Union address. This plan was endorsed by Congress and the plan now includes a commitment of \$15 billion over five years to be spent in 15 African and Caribbean countries. His initiative calls for increased funding and support for HIV/AIDS treatment as well as prevention and care programs.

Key Components of the US Response

U.S. Agency for International Development (USAID)

The U.S. Agency for International Development (USAID) is currently working in approximately 50 countries, the majority being in Africa. As the cornerstone of USAID’s HIV/AIDS strategy, prevention programs give individuals the information, skills, and services they need to protect themselves from HIV infection. Most of these efforts are focused on young people and there is a strong emphasis on expanding programs that address mother-to-child transmission. In order to address the pandemic, USAID has introduced care and treatment programs in recent years that improve the quality of life of infected individuals. Treating opportunistic infections such as tuberculosis is critical and USAID is working with countries to improve health care systems and infrastructure to prepare them for the provision of anti-retroviral therapy. Finally, USAID plays an important role in helping children affected and orphaned by AIDS. There are now 60 projects in 22 countries that provide food, shelter, clothing, school fees, counseling, psychological support and community care to children at risk.

Global AIDS Program at the Centers for Disease Control and Prevention (CDC)

Currently, CDC’s Global AIDS Program assists 24 Asian and African countries. These programs are designed to reduce HIV transmission through primary prevention of sexual, mother-to child, and blood transmission; improve community- and home-based care and treatment of HIV/STDs and opportunistic infections; and strengthen the capacity of countries to collect and use surveillance data and to manage national HIV/AIDS programs.

Global Fund to Fight AIDS, Tuberculosis and Malaria

An independent body, the Global Fund to Fight AIDS,

Tuberculosis, and Malaria is a new and innovative funding mechanism designed to attract, manage and disburse resources through a new public-private partnership. Funding is provided to countries in need through an application process. Each country is required to organize a Country Coordinating Mechanism and this board must include representatives from the private and public sectors as well as from non-governmental organizations. Currently, the Fund has received almost \$2 billion in contributions from governments, the private sector and foundations. HHS Secretary Thompson currently serves as chair of the Global Fund.

Current Global Efforts Have Extremely Limited Reach

There is a clear need to significantly increase U.S. government funding for global HIV/AIDS programs to expand current programs and support new initiatives:

- In developing nations, HIV prevention programs reach only 10 to 20 percent of the population; only six to 10 percent of HIV-infected people are receiving treatment for HIV-related opportunistic infections; and less than one percent are receiving antiretroviral treatment.
- Recent surveys in 17 countries found that more than half the adolescents questioned could not name a single method for protecting themselves against HIV/AIDS.
- Less than one percent of pregnant women in sub-Saharan Africa have access to interventions to reduce mother-to-child transmissions.
- Estimates place the annual number of condoms distributed worldwide at six billion, but many more (some estimates are as high as 24 billion) are needed to protect populations from HIV and other sexually transmitted diseases.