

VOICE OF T·II CANN

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ADAP Crisis Continues

ADAP crisis, ADAP crisis, ADAP crisis! Sounds like a broken record some days. Unfortunately, it sometimes sounds like “crying wolf” too. However, it’s very real. It was real a year ago, two years ago, and it still is today. Each month that ADAPs have insufficient funding, patients needing access to medications quietly accumulate on “waiting-lists,” “in process” on drug company patient assistance programs, or just lost in the health care delivery system’s bureaucratic process.

The ADAP Working Group has recently calculated that as of April 1, 2003, the beginning of the FY '03 funded ADAP year, ADAPs are financially “in the hole” by \$145,678,610.00, just as the program year begins. This represents money that we could have used “yesterday.” Because we don’t have it, we have waiting lists for ADAP in 9 states, capped enrollments, ARV restrictions, and formula reductions enacted in another 13 ADAPs. The most recent ADAP Funding Watch document detailing the sad state of affairs by ADAP appears on page 5.

While the need for federal funding plays out at the National level in Congress and with the White House, the disastrous individual effects of lack of access to HIV medicine plays out at the grassroots level as a very personal tragedy in countless households, communities, and AIDS Service Organizations (ASO) across the

country. Once again failure to adequately deal with a big public health care issue at the federal level shifts the burden all the way down to the individual patient, household group, and family. It’s hard to imagine an issue more “grassroots” than this one, so it’s no surprise that the ADAP crisis is helping to fuel a revitalization of grassroots advocacy activities. The AIDS Treatment Activist Coalition (ATAC) is booming, active, and noisy. Their SAVE-ADAP work group (see pg. 2) has planned and will continue to plan D.C. advocacy visits, telephone, and fax campaigns with Senate and House offices and the White House. ACT UP chapters are heard from again. The Federal AIDS Policy Partnership (FAPP) has grown to become an active ad-hoc coalition with regular monthly calls and face-to-face meetings in Washington D.C. With about 50 organizations already participating, a Prevention Defense Work Group has formed and is

active. A Medicaid Defense Group has formed and is actively at work. Regional, local, and national organizations with an HIV/AIDS commitment are beginning to talk to other health and disease advocates. There is definitely something going on - timely too! The national election is coming in 2004 - with active “jockeying and politicking” starting soon. Older Americans awaiting with baited breath a Medicare drug benefit, before casting their 2004 votes, will be four years older than they were in 2000 and may have gone four years longer without access to affordable Medicare and access to medications important to those age 65 and older.

Tolerating a failure to make HIV/AIDS treatments available to everyone under the American flag, regardless of their ability to pay, in a health care delivery system widely advertised as the “best in

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URGENT ETHA ALERT!

The Early Treatment for HIV Act (ETHA) of 2003 has been introduced in the Senate under the sponsorship of Senators Gordon Smith (R-OR) and Hillary Clinton (D-NY). **Calls are needed now to ALL Senate offices asking them to co-sponsor S. 847.** Your message should be that ETHA would give states the OPTION of extending Medicaid to poor and uninsured people with HIV unlike the present system where people have to become disabled with AIDS before they can receive Medicaid coverage. People living with HIV desperately need this legislation to pass this session of Congress so make a call yourself and get your friends, coworkers, and family to make calls too. Every call will make a difference. For more information, go to <http://www.taepusa.org>.

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the world” has obvious inconsistency, some might say hypocrisy, visible all over it.

Not funding ADAP is an issue of political will. It's part of finally really “fixing” our crumbling health care delivery system. It's part of taking care of “our” folks and then “all our folks.” The HIV/AIDS community has the knowledge and the skills to be part of the advocacy for demanding political leadership to fix the problems in an election process where leadership will have to listen to us. We, along with a lot of other affected people, may have to parade, demonstrate, stage “die-ins” in D.C., and visit our leaders in their D.C. offices like we have not had to do for years. More importantly, we absolutely have to let our elected leaders know at home, in the local offices, and at their local meetings that this is a LOCAL problem for THEIR CONSTITUENTS (that's us). When the federal government does not deliver on it's share of the health care “social contract” then states feel justified in doing likewise. Thus sick people end up bankrupting themselves, local doctors and clinics, and then local hospitals with costs and charges that can not be paid.

It's a “shell game” as leaders try to push costs into someone else's budget, but the price is paid by patients in lost quality-of-life and even in length of life.

AIDS advocates are showing signs all over the country of organizing from the grassroots up. Will we continue to field an effective political message in the coming months? We clearly have the skills and committed people. Will we

take it to a higher level and actually help lead the drive for the changes and political actions that are needed? We shall see between now and November, 2004.

It's probably still true that “the squeaky wheel gets the grease” and “the Lord helps those who help themselves.” We seem to have a very promising looking start. Will we stay the course? ■

SAVE ADAP Finishes Successful Grassroots Campaign

By Ryan Clary, Senior Policy Advocate, Project Inform

The battle for securing adequate federal ADAP money got a huge boost from grassroots activists over the past several months. In May 2002, members of the AIDS Treatment Activists Coalition (ATAC), a coalition of treatment activists around the country, participated in a conference call to discuss the crisis in many state ADAPs and ways they could get involved. During that call, a new subgroup of ATAC was formed, the “SAVE ADAP Committee.”

This ad-hoc coalition of treatment activists and policy advocates, including many community members of the National ADAP Working Group, quickly designed a comprehensive grassroots campaign aimed at obtaining a \$162 million increase for ADAP in the Fiscal Year 2003 appropriations bill—the amount identified as needed to allow state ADAPs to meet a minimum level of service. Our goal was to mobilize those most affected by the ADAP crisis to communicate directly with their own elected officials about the need for adequate funding for this lifesaving program.

During the following months, SAVE ADAP engaged in several activities to meet this goal. We sent Action Alerts with background information about the ADAP crisis and encouraged people to write personal letters to their U.S. Representative and Senators asking them to fight for

the \$162 million increase and letters to the editor of local newspapers to educate the public about the issue. We also assisted with the organization of district meetings during Congress' August recess focusing on the ADAP crisis. We organized targeted call-in days to offices in the district and the Capitol, with people across the country making their voices heard.

Perhaps the most effective component of our campaign was a two-day “SAVE ADAP” lobbying event in Washington, D.C.. In September 2002, over 30 people traveled to the nation's capitol to meet directly with their legislators and staff and communicate directly about the impact of their decisions on ADAP funding on people living in their districts and states. Legislative meetings are an extremely powerful and effective form of grassroots advocacy and help put faces and human stories behind the statistics and rhetoric.

SAVE ADAP members from Oregon, Washington, Maryland, North Carolina, Florida, Alabama, New York, and Kentucky spent two days discussing the ADAP crisis with their elected representatives and attempted to identify someone who would champion the issue in Congress. From these lobbying visits came several notable accomplishments, including a sign-on letter from the Congressional

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Black Caucus supporting the \$162 million increase for ADAP.

In addition to legislative meetings, the SAVE ADAP contingent hand-delivered over 150 letters written by individuals around the country supporting adequate ADAP funding. One participant from Oregon made drop-in visits to staff of key Members of Congress, delivering copies of these personal letters and discussing the ADAP crisis with legislative aides.

As the appropriations battle entered its final weeks, we intensified our grassroots campaign. We coordinated a community sign-on letter to Congress supporting the \$162 million increase for ADAP. This letter was signed by over 150 AIDS organizations across the country, demonstrating broad support for treatment access for people with HIV/AIDS. We also worked hard to identify a champion in Congress who would be willing to introduce an amendment to the appropriations bill in support of full funding for ADAP.

Thanks to the hard work of SAVE

ADAP members from New York, one such champion was found in Senator Charles Schumer (D-N.Y.). After successful legislative meetings in the district and in D.C. by New York ADAP advocates, Senator Schumer offered an amendment to the Senate Omnibus Appropriations bill which would have allocated the \$162 million increase for ADAP and significant increases in funding for other programs funded by the Ryan White CARE Act. While this amendment was unsuccessful, it was a major victory to have a Member of Congress willing to go to bat for ADAP in the current political and economic climate.

At the end of the long and challenging appropriations battle, we received an \$80 million increase for ADAP, about half of what is needed to alleviate the ADAP crisis. While disappointed in Congress' lack of commitment to ensuring that all people with HIV have access to treatment, SAVE ADAP nonetheless demonstrated the value and effectiveness of grassroots advocacy. ADAP received a much better increase than other HIV/AIDS programs and it is clear that Congress has been educated about the importance of

the program and the severity of the crisis. In fact, staff of one appropriations conference committee member noted that the committee was fully aware of the ADAP crisis due to the outpouring of communication from individuals and organizations nationwide.

We have many more challenges ahead of us in the fight for adequate ADAP funding, but SAVE ADAP had laid the groundwork for increased grassroots advocacy. We have established relationships with staff members of key legislators, as well as with individuals and organizations around the country who are dealing with the ADAP crisis at the local level and want to make a difference.

SAVE ADAP will soon be gearing up for the fiscal year 2004 appropriations battle. We are always looking for new volunteers to be a part of our efforts. We communicate through an email listserve and regular conference calls. If you have some time to spare to help with our grassroots efforts, please consider joining us. Email Ryan Clary at rclary@projectinform.org for more information. ■

Caseworker's Corner - Keeping Food Stamps While Returning to Work

The Impact of Food Stamp Reauthorization on the Elderly and Disabled (FRAC Publication, July 2002) discusses some provisions of the Food Stamp Reauthorization Act of 2002, signed into law on May 13, 2002, which includes changes that enhance benefits for the disabled, by broadening eligibility, increasing benefits, and improving access. This new FRAC analysis, in particular, summarizes Section 4115 of the Act, which, while meant to offer at least a 5 month extension of continued food stamps automatically to those leaving TANF (Temporary Assistance for Needy Families) to return to work, can also be applied to those who are not on TANF but

are returning to work from SSI or SSDI if they have minor children in the home. See <http://www.frac.org/html/publications/elderly-reauth.PDF> (Adobe PDF).

In addition, the "allowed car-value" part of the asset test is low, and has often disqualified many households without a disabled person from getting food stamps. To get food stamps, a household originally could not have a vehicle worth more than \$4,650. But effective March 1, 2001, states have the option to allow an even higher automobile value limit, or no vehicle limit at all if used for that state's TANF welfare program. States can even allow more than one vehicle per household. Currently most state TANF automobile value limits are higher than \$4,650 and some states

have no upper value limit at all. What is often overlooked, unless an applicant speaks up, is that in all states there is no upper value limit at all for a vehicle used to transport the disabled, or one used to produce earned income even in a household without a disabled person. In other words, if no one in your household is disabled, but someone in the family drives to work in a car, then it does not matter how much that car is worth. And of course, if someone is disabled, then a car of any value is allowed, whether or not someone uses it to go to work. For details about each state's rules, see "State Vehicle Asset Policies in the Food Stamp Program" at www.cbpp.org. ■

ADAP Crisis Continues

Co-Infection Briefing on Capitol Hill Raises Awareness, Underscores Concerns Part 1 of a 2 Part Series

The hepatitis C (HCV) epidemic disproportionately impacts communities of color, resulting in higher than average rates of HCV-related cirrhosis, end stage liver disease, and death among African-Americans and other minorities, stated an infectious disease physician during a congressional briefing on HIV/HCV co-infection held in Washington, D.C. in late March.

HCV prevalence rates average about 3.2 percent among African-Americans compared to 1.5 percent for non-Hispanic whites. In Mexican-Americans, HCV prevalence rates are lower than those found in the African-American community but higher than the rates among white Americans, averaging about 2.1 percent.

“Hepatitis C affects populations differently,” said Dickens Theodore, MD, MPH, a Research Assistant Professor of Medicine at the University of North Carolina. “Minority populations are much more likely to have hepatitis C than Caucasians, for example. A lot of this has to do with risk behaviors, but not all of it.”

Dickens Theodore was one of several speakers to address the congressional briefing on Capitol Hill, a forum sponsored by the National AIDS Treatment Advocacy Project and two members of the Congressional Black Caucus (CBC), Donna Christian-Christensen (D-V.I.) and Representative Edolphus “Ed” Towns (D-N.Y.). More than 100 advocates, community leaders, congressional representatives, and their staffs attended the briefing which was designed to raise awareness about HCV and HIV/HCV co-infection and to ultimately increase federal funding for the twin epidemics.

More than 5 million people are living with HCV in the United States and about 300,000 of those 5 million have HIV/HCV co-infection. HCV is now the leading cause

of death among people with HIV disease.

“We are here because there is no attention being paid to this problem,” said Jules Levin, a co-infected patient and the Founder and Executive Director of the National AIDS Treatment Advocacy Project (NATAP), a national HIV/AIDS and HIV/HCV co-infection advocacy and educational organization based out of New York City. “Some people talk about (HCV and HIV/HCV co-infection) but it doesn’t get the attention or the funding that is needed.”

Donna Christian-Christensen, a nonvoting congressional delegate from the Virgin Islands and a physician, told the audience that “one in every 15 people in the world suffers from HCV.”

“According to the CDC, mortality associated with HCV is expected to triple during the next 10 years in all racial groups,” said Christian-Christensen, chair of the CBC’s Health Brain Trust. “We in the Black Congressional Caucus have a very special interest in this because African-Americans have the highest rates of chronic hep-

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Congressman Calls for More Efforts on HIV/HCV Co-Infection

Representative John Conyers, Jr. (D-Mich) has called for another briefing on HIV and hepatitis C (HCV) co-infection to identify and develop strategies for combating the twin epidemics.

Conyers, who represents Michigan’s 14th Congressional District, was one of several speakers to address a congressional briefing on co-infection in late March in Washington D.C. During his remarks, he called for a “second session” that would expand on the first session by looking more closely at what could be done to address HIV/HCV co-infection.

“Until we get to that session we are just more educated people about health care than we were this weekend,” Conyers said. “That will probably help us personally but it will not change the status of health care in this country.”

Conyers identified three issues in the discussion about HIV/HCV co-infection – the medical problems, the solutions, and dealing with the solutions. The next session, he said, should address the solutions and a third session should look at dealing with the solutions.

More than 100 advocates, community leaders, and congressional representatives and their staffs, attended the briefing, including some advocates and community leaders who were bused in from New York City. The large turnout proves that “people are concerned about their health even if there is a war on,” said Conyers, in a brief interview with *The Voice*.

Conyers, whose district includes Detroit, acknowledged that he is “just learning” about HIV/HCV co-infection. He added, however, “I am bringing more people in to work on it.”

“I would love to bring this whole program to Detroit...where we could put it on before thousands of people,” Conyers told *The Voice*.

Stretching the ADAP Dollar: Screening For and Referring Certain Conditions to Medicaid

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 offers states an enhanced 15 percent higher matching rate to give Medicaid coverage to uninsured women under age 65, no matter how high their incomes or assets, if they're screened positive for breast or cervical cancers, or precursor conditions by the Centers for Disease Control (CDC)-funded state health programs. The patient must be referred for treatment, other than routine, superficial monitoring, by their screening or other physicians. All states, except Oklahoma, have elected to cover this optional Medicaid eligibility group.

The CDC-funded state health screening program itself has an

income eligibility level of 250 percent, but as noted, Medicaid has no upper income level of its own for those referred after the screenings. Although CMS' Medicaid eligibility regulations policy do not, and will not, elaborate on what constitutes "eligible" precursor conditions for cervical cancer, the medical literature universally and conclusively considers any invasive cervical anomalies, conditions, and infections, including infection with, or a history of, human papilloma virus (HPV), to be cervical cancer precursors. There's also considerable weight in the medical literature for considering severe or recurrent pelvic inflammatory disease (PID) and even chlamydia as precursors.

CDC policy addresses the question of what are to be considered precursor conditions by giving governing deference to the findings of, and any consequent referrals to care by, a woman's screening or other physician. CMS' Medicaid eligibility policy gives the same dispositive deference to such physician referrals to satisfy its eligibility rule that such women must first have been screened and referred by the CDC-funded program.

A state can shift the costs of such patients from ADAP to Medicaid, and then a 15 percent higher federal Medicaid matching rate to care for such patients. Not just for the cancer care, but for the full breadth of Medicaid services by

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NASTAD Preliminary Estimate of FY2003 ADAP Earmarks by Jurisdiction February 21, 2003

Note: Jurisdictional estimates may change when final living AIDS case estimates are used to calculate awards

States/Title II ADAP Grantees	# of Estimated Living AIDS Cases (from Title II WICY)*	Proportion of Estimated Living AIDS Cases	FY2002 ADAP Earmark (minus 3% set-aside)**	ESTIMATED FY2003 ADAP Earmark (minus 3% set-aside)***	ESTIMATED ADDITIONAL FY2004 NEED (minus 3% set-aside)
Alabama	2,838	0.948%	\$5,822,611	\$6,566,601	\$2,599,324
Alaska	183	0.061%	\$397,076	\$423,428	\$167,610
Arizona	3,398	1.135%	\$6,815,740	\$7,862,336	\$3,112,227
Arkansas	1,311	0.438%	\$2,586,804	\$3,033,409	\$1,200,745
California	37,223	12.430%	\$82,051,914	\$86,127,055	\$34,092,538
Colorado	2,291	0.765%	\$4,994,248	\$5,300,945	\$2,098,326
Connecticut	4,727	1.579%	\$9,878,257	\$10,937,393	\$4,329,458
Delaware	1,305	0.436%	\$2,534,302	\$3,019,526	\$1,195,249
District of Columbia	5,429	1.813%	\$11,218,275	\$12,561,690	\$4,972,420
Florida	33,333	11.131%	\$68,567,784	\$77,126,323	\$30,529,688
Georgia	9,775	3.264%	\$19,281,463	\$22,617,520	\$8,952,920
Hawaii	834	0.279%	\$1,694,983	\$1,929,720	\$763,860
Idaho	190	0.063%	\$414,357	\$439,624	\$174,021
Illinois	10,055	3.358%	\$20,490,945	\$23,265,388	\$9,209,372
Indiana	2,621	0.875%	\$5,213,910	\$6,064,503	\$2,400,573
Iowa	545	0.182%	\$1,111,833	\$1,261,028	\$499,165
Kansas	869	0.290%	\$1,889,717	\$2,010,703	\$795,917
Kentucky	1,699	0.567%	\$3,334,662	\$3,931,168	\$1,556,114
Louisiana	5,488	1.833%	\$11,060,885	\$12,698,205	\$5,026,458
Maine	342	0.114%	\$722,229	\$791,324	\$313,238

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PROFILES

Daniel J. Schreiner, MHS



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Daniel J. Schreiner joined T•II CANN as its Deputy Director in March, 2003. Mr. Schreiner is available to work with local, state, and federal programs to provide technical assistance in the areas of drug purchasing systems, budget projections and forecasting,

health insurance options assessments, and general questions regarding state AIDS Drug Assistance Programs.

Prior to joining T•II CANN and The ADAP Working Group, Mr. Schreiner worked with the Health Resources and Services Administration's (HRSA), AIDS Drug Assistance Program (ADAP) Branch as an Expert Appointment and Independent Consultant. His projects included assisting states with forecasting future FY ADAP budgets and expenditures and evaluation of state insurance options for the purpose of purchasing health insurance for individuals with HIV/AIDS. In addition, Mr. Schreiner collaborated with local and regional federal Ryan White CARE Act staff to monitor, address issues, and provide technical assistance to ADAP, Title II, and Title I programs.

Mr. Schreiner had previously been Vice President of Investment Services for T. Rowe Price Associates, a Financial Investment Company. His responsibilities included managing multi-location client service groups, the design and development of on-line communication access systems, and participation in key presentations on investment services to executive management teams of multi-million/ billion dollar clients.

Mr. Schreiner received his Bachelor of Science Degree in International Business from the University of Akron in Akron, Ohio and his Masters of Health Science Degree in Health Policy and Management from The Johns Hopkins University in Baltimore, Maryland.

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atitis C and a higher mortality rate from associated liver disease."

Dickens Theodore, perhaps more than any other speaker, emphasized the disproportionate impact HCV is having on communities of color, explaining that 90 to 95 percent of African-Americans with HCV have genotype 1 a/b, the most difficult form of the virus to treat. By contrast, 50 percent of white Americans with HCV have genotype 1 a/b, which responds to therapy about 50 percent of the time in the mono-infected and about 40 percent in the HIV/HCV co-infected. HCV Genotypes 2 and 3 have cure rates around 70 to 75 percent. Moreover, survival rates among African-Americans with HCV who have undergone liver transplants are lower than that of white Americans.

"We don't know why this is," said Theodore. "Much more is needed in terms of trying to find out the reasons for these disparities."

Transmission Modes

Henry "Skip" Francis, MD, Director of the Center for AIDS and Other Medical Consequences of Drug Abuse at the National Institute on Drug Abuse (NIDA), National Institutes of Health, addressed the relationship between drug use and HCV, pointing out that "hepatitis C is very efficiently transferred

by people who (inject drugs) with needles."

"It is one of the reasons why the epidemic is expanding – the efficiency of infection if the person uses a needle," he said.

In the United States, there are 16 million drug users and at least 80 percent of them have HCV. More than 60 percent of people with HCV got the disease through injection drug use (IDU) and most of them are minorities. Most IDUs, in fact, become infected within the first two years of injecting.

"That generally means our population has the highest increase of new cases somewhere between the ages of 16 and 18 when they started using drugs," Francis said.

In the African-American community, 80 percent of injection users are HCV infected, about 500,000 to 800,000 people. Francis also pointed out, however, that 15 percent of HCV cases are a result of sex.

Part two of this series will be in the next issue of *The Voice* and will cover disparate drugs and similar transmission routes. *This summary was provided by Martin Medical Services, Inc. (MMS), a health care research and consulting firm. For further information, please contact MMS President, Julia Lam, at (304) 262-2371 or email her at MMSJEL@aol.com.* ■

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proactively referring them for this free screening. Then such patients can get care from Medicaid's new breast-and-cervical cancer eligibility category, with a 15 percent higher-than-normal federal match!

However, the federal requirement of a CDC-funded state health program screening and referral to care must first be met. This means that these women must be sent to the state's CDC-funded program first for screening and referral prior to enrollment in Medicaid.

So, some challenging, but not insurmountable, case management procedures and logistics must be dealt with for states to claim the enhanced matching funds for these patients.

For the 48 states and D.C., the 2003 poverty level is \$8,980 yearly (\$748 monthly) for one plus \$3,140 yearly (\$262 monthly) for each additional family member. These levels are higher in Alaska & Hawaii. See www.dhhs.gov.

Contact Tom McCormack at tomxix@ix.netcom.com or (202) 479-2543 with questions. ■

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NASTAD
Preliminary Estimate of FY2003 ADAP Earmarks by Jurisdiction
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Maryland	10,529	3.516%	\$20,302,147	\$24,362,135	\$9,643,509
Massachusetts	6,234	2.082%	\$13,160,923	\$14,424,309	\$5,709,719
Michigan	4,495	1.501%	\$9,327,488	\$10,400,589	\$4,116,970
Minnesota	1,275	0.426%	\$2,785,236	\$2,950,111	\$1,167,772
Mississippi	2,317	0.774%	\$4,566,348	\$5,361,104	\$2,122,140
Missouri	3,145	1.050%	\$6,926,038	\$7,276,941	\$2,880,505
Montana	129	0.043%	\$284,249	\$298,482	\$118,151
Nebraska	461	0.154%	\$947,262	\$1,066,668	\$422,230
Nevada	1,945	0.650%	\$4,019,976	\$4,500,366	\$1,781,425
New Hampshire	313	0.105%	\$669,552	\$724,223	\$286,677
New Jersey	14,614	4.880%	\$31,624,395	\$33,814,061	\$13,384,960
New Mexico	887	0.296%	\$1,789,227	\$2,052,352	\$812,403
New York	52,095	17.396%	\$107,697,086	\$120,538,080	\$47,713,800
North Carolina	4,873	1.627%	\$9,376,429	\$11,275,210	\$4,463,180
North Dakota	40	0.013%	\$88,717	\$92,553	\$36,636
Ohio	4,386	1.465%	\$8,956,585	\$10,148,383	\$4,017,136
Oklahoma	1,535	0.513%	\$3,098,129	\$3,551,703	\$1,405,906
Oregon	1,739	0.581%	\$3,588,028	\$4,023,721	\$1,592,750
Pennsylvania	11,105	3.708%	\$21,610,076	\$25,694,892	\$10,171,067
Puerto Rico	9,468	3.162%	\$19,902,657	\$21,907,180	\$8,671,739
Rhode Island	791	0.264%	\$1,663,322	\$1,830,226	\$724,477
South Carolina	4,783	1.597%	\$9,437,864	\$11,066,967	\$4,380,749
South Dakota	82	0.027%	\$171,674	\$189,733	\$75,104
Tennessee	4,291	1.433%	\$8,469,566	\$9,928,571	\$3,930,126
Texas	20,935	6.991%	\$43,676,035	\$48,439,672	\$19,174,362
Utah	823	0.275%	\$1,731,432	\$1,904,268	\$753,786
Vermont	165	0.055%	\$338,152	\$381,779	\$151,123
Virginia	6,011	2.007%	\$12,099,043	\$13,908,329	\$5,505,474
Washington	3,338	1.115%	\$6,973,928	\$7,723,507	\$3,057,273
West Virginia	529	0.177%	\$1,028,117	\$1,224,007	\$484,511
Wisconsin	1,340	0.447%	\$2,775,778	\$3,100,509	\$1,227,306
Wyoming	65	0.022%	\$139,546	\$150,398	\$59,533
Guam	35	0.012%	\$67,389	\$80,983	\$32,056
Virgin Islands	258	0.086%	\$452,965	\$596,964	\$236,302
American Samoa	1	0.000%	—	\$2,314	\$916
Marshall Islands	1	0.000%	\$1,323	\$2,314	\$916
N. Marianas	2	0.001%	\$1,323	\$4,628	\$1,832
TOTAL	299,491	100%	\$619,830,000	\$692,896,705	+\$274,276,267****

* The estimated living AIDS cases were determined using survival weights, updated in July 2001 by the CDC. These estimates were included in the FY03 Title II grant application for WICY reporting purposes and may not be the final set of "estimated living AIDS cases" utilized by HRSA in formula calculations.

** Overall ADAP earmark was \$639,000,000 - 3% Supplemental set-aside subtracted from the total earmark.

***FY03 earmark of \$719,000,000 minus the 0.65% rescind minus the 3% Supplemental set-aside. This \$714,326,500 ACTUAL earmark is \$75,326,500 over FY02.

****Overall need is \$282,759,038 - 3% subtracted for Supplemental set-aside.



I WOULD LIKE TO SUPPORT THE IMPORTANT WORK OF TII•CANN

The Title II Community AIDS National Network (T•II CANN) operates on a considerably small budget for a national AIDS organization. T•II CANN's efforts result in securing additional funding for state AIDS Drug Assistance Programs (ADAPs). In addition to our national advocacy efforts, the projects, education, and training activities undertaken by T•II CANN are significant and timely. These demanding efforts require our diligence on behalf of our partners in the private, public, and not-for-profit sectors. It is possible for T•II CANN to achieve enormous success with rather limited resources because our organization operates with little overhead.

Achieving our mission of initiating and supporting activities that develop and ensure access to a comprehensive continuum of care for all people infected and affected by HIV/AIDS is only possible with hundreds of volunteer hours, funding we are able to generate from public educational activities, and charitable contributions. Working without paid staff is the primary reason for T•II CANN's low operating expenses.

In 2003, T•II CANN anticipates a major expense with the expansion of the T•II CANN website. It is expected that this website will become a comprehensive information resource for AIDS service organizations, clinicians, and individuals needing current and accurate information on AIDS advocacy, treatment, world events, and statistics. This powerful tool is in its second phase of development and in 2003 will emerge as a leading source for HIV/AIDS information on the Internet.

We are heartened by the continued availability of medication for the treatment of HIV/AIDS to so many in need but our work is not nearly completed. Nationally, ADAPs remain massively under-funded and the threat of HIV-positive Americans unable to obtain medications remains a very real and dangerous threat.

I hope you will support our efforts to ensure access to care for all Americans impacted by HIV/AIDS.

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Washington DC 20009
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Donations to T•II CANN are tax deductible to the full extent of the law. Your contribution can be doubled if you are employed by a company with a matching gift program. For more information contact your Human Resource office.

Thank You for Your Support



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