



SOUTHERN AIDS COALITION

2009 – 2010 HIV/AIDS Health Care Policy Brief and Recommendations

The Southern AIDS Coalition promotes accessible and high quality systems of HIV and STD prevention, care, treatment, and housing throughout the South utilizing a unique partnership of government, community, people living with HIV disease and business organizations.

Alabama
Arkansas
Delaware
District of Columbia
Florida
Georgia
Kentucky
Louisiana
Maryland
Mississippi
North Carolina
Oklahoma
South Carolina
Tennessee
Texas
Virginia
West Virginia

Southern AIDS Coalition

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Executive Summary

The timing of The Southern AIDS Coalition's release of ***2009 – 2010 HIV/AIDS Health Care Policy Brief and Recommendations*** coincides with the monumental effort to enact health care reform in the United States within the context of major state and federal budget shortfalls and deficits. Southern states face a nearly \$20 billion collective shortfall for fiscal year 2010 and as a result most states are predicting major Medicaid cuts in the near future. Since Medicaid provides primary or secondary coverage to 50% (36% Medicaid only and 14% dual-eligible persons) of people living with HIV/AIDS, any changes to Medicaid will jeopardize the care, treatment, and services needed by people with HIV/AIDS.

HIV/AIDS disproportionately effects the South. Southern states continue to report the highest number of new AIDS cases, the highest newly reported HIV cases, and the smallest decrease in deaths due to AIDS. History teaches us that a lack of investment in the public's health care and prevention programs result in 1) the South continuing to have the largest number of new HIV infections in the United States; 2) poor health outcomes, including progression to AIDS for HIV-infected persons not in care; and 3) an increase in unacceptable health disparities.

As disbursements of state dollars to community providers who support HIV/AIDS care, case management, treatment, and prevention services have and will continue to diminish, providers are struggling to meet the needs of the growing number of new HIV/AIDS clients in the South. As a result, providers have become increasingly concerned and frustrated at the prospect of having to provide increased care to meet increased need with fewer dollars. However, despite these daunting outlooks, there is an opportunity to mitigate the issue of dwindling funds through health care reform.

In light of these facts, the Southern AIDS Coalition believes that health care reform must comprehensively address the public health outcomes of those living with chronic, infectious diseases, including the challenges faced with HIV/AIDS. Reform that will address these challenges include the reauthorization of Ryan White for a minimum of three years, prioritization of prevention of the disease, expansion of connection to care, ensuring access to care and treatment for everyone, establishing standards of care and treatment for all payer environments, ensuring the state's ability in a challenging economic climate to implement federal mandates, and involvement of people with HIV/AIDS and providers in the reform process. Specific systems that require special attention during the reform process are Ryan White funding, Medicaid funding, and the provision of mental health and housing services for those infected with HIV/AIDS.

The Southern AIDS Coalition maintains a deep commitment to public health approaches to prevention, care, treatment, and housing for HIV/AIDS. To date, national financial strategies fail to focus resources on those with the greatest needs. Although the current economic crisis is stressing the abilities of HIV/AIDS treatment and care providers across the South to provide sufficient services to those in need, a window of opportunity has opened for the identification of creative solutions that ultimately will conserve public funds and improve the public health.

SOUTHERN AIDS COALITION

2009 – 2010 HIV/AIDS Health Care Policy Brief and Recommendations

I. Introduction – An Imminent Funding Crisis

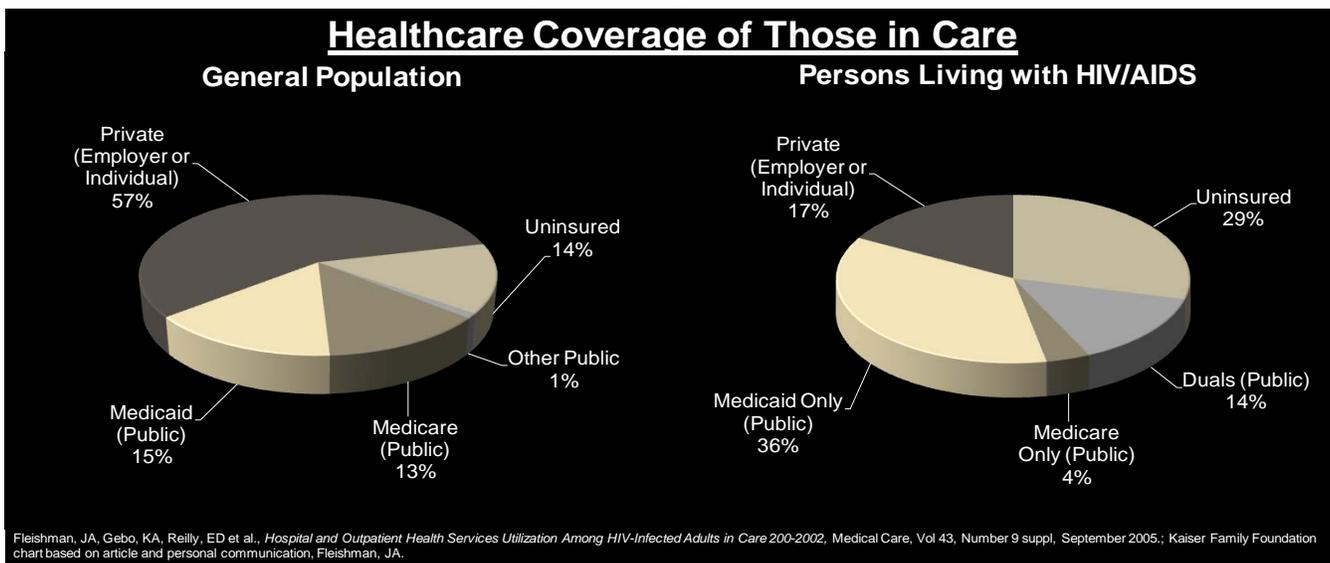
The timing of the Southern AIDS Coalition’s release of *2009 – 2010 HIV/AIDS Health Care Policy Brief and Recommendations* coincides with the Congressional appropriation process for fiscal year 2010, various approaches to national Health Care Reform, and the nation’s economic crisis. State governments faced a \$64 billion shortfall for their collective 2009 fiscal year end (46 states have a fiscal year that begins July 1st).ⁱ The

Estimated State Budget Gaps for 2010**	
State	FY 2010 Gap (in millions)
Alabama	\$400
Arkansas*	\$0
Delaware	\$300
Florida	\$6,000
Georgia	\$2,600
Kentucky*	\$0
Louisiana	\$1,700
Maryland	\$1,900
Mississippi*	\$0
North Carolina	\$1,300
Oklahoma	\$612
South Carolina	\$500
Tennessee	\$1,100
Texas	\$3,100
Virginia	\$0
West Virginia	\$200
	\$19,712

only reason this shortfall was not more of a crisis this year was passage of the American Recovery and Reinvestment Act of 2009 (ARRA), utilized to fill many state budget gaps. The prospects for 2010 state budgets are devastating. According to the recent state-by-state survey of the National Conference of State Legislatures, these Southern AIDS Coalition states (some not yet reporting) face a nearly \$20 billion collective shortfall for fiscal year 2010, even after the inclusion of the ARRA funds.ⁱⁱ A major component of ARRA is the Federal Medicaid Assistance Percentage (FMAP) adjustment that allowed states to reduce the burden of state-funded match requirements. However, most states are predicting major Medicaid cuts in 2010, including some essential services yet to be defined.ⁱⁱⁱ

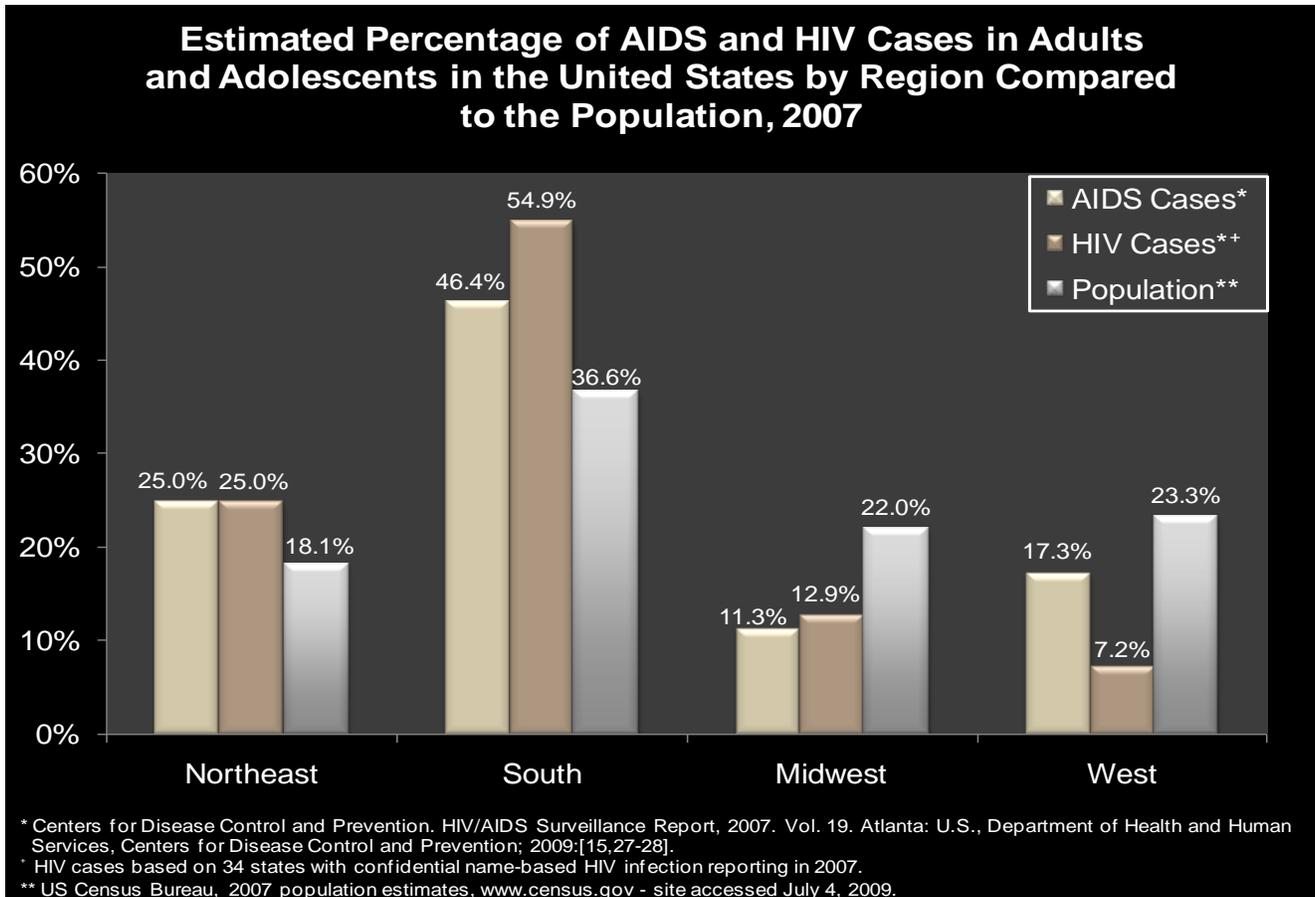
Since Medicaid provides primary or secondary coverage to 50% (36% Medicaid only and 14% dual-eligible persons) of people living with HIV/AIDS as illustrated below, any changes to Medicaid will jeopardize the care, treatment, and services needed by people with HIV/AIDS. Not so apparent in these cuts is the devastation caused by loss of state funds to support public health department infrastructures that were developed to combine with federal funds in order to meet the needs of those living with HIV/AIDS, a chronic, infectious disease.

*Budgets not yet developed
 **Based on national data collection by National Conference of State Legislatures



Failure to provide adequate care, treatment, and essential services for people with HIV/AIDS equates to an on-the-record policy that accepts growing numbers of new HIV infections as part of the expected public health outcome. The Southern AIDS Coalition decries this approach.

The Southern AIDS Coalition (SAC) applauds President Obama’s attention to health care and his emphasis on gathering input for decision making from a variety of sources. Currently, the United States spends two times more per capita on health care than the next highest-spending country; nonetheless, we still have at least 45 million uninsured persons.^{iv} The need for reform is obvious.

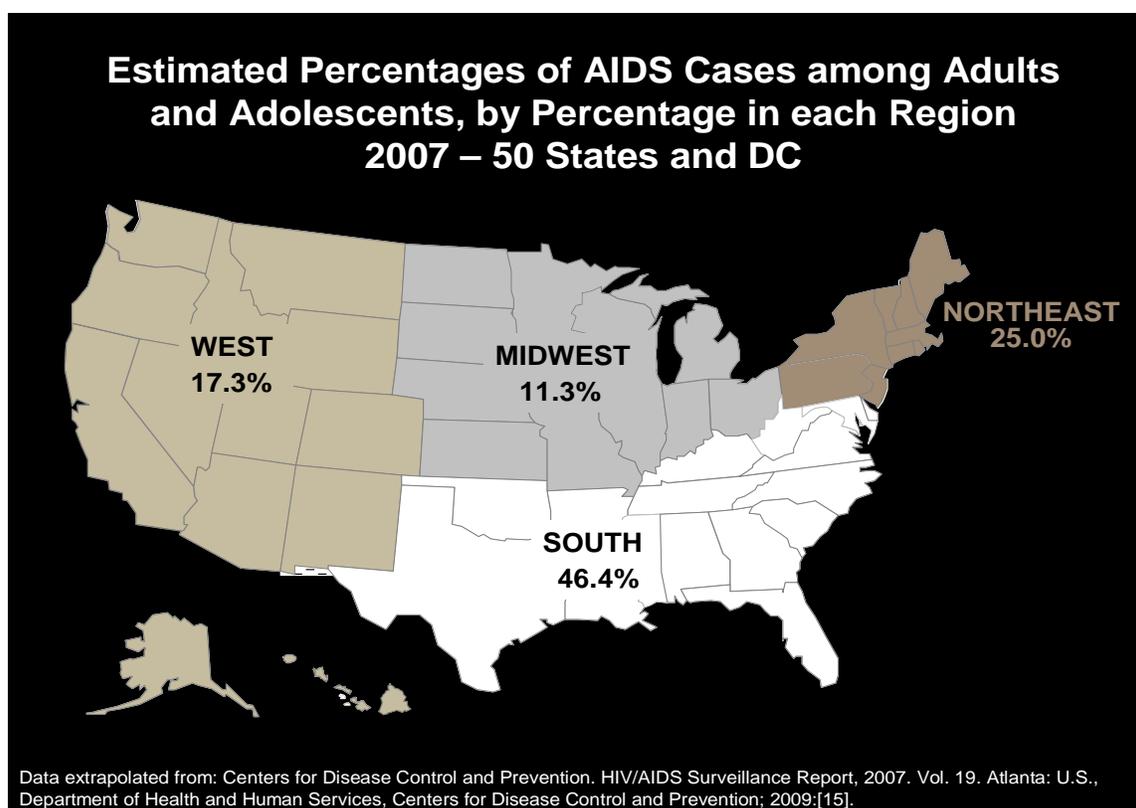


While these health care scenarios play out across the SAC’s sixteen states and Washington, D.C.,^v the South continues to be disproportionately impacted by HIV/AIDS based on 2008 the Centers for Disease Control and Prevention (CDC) and U.S. Census data illustrated in the figure above. Southern states continue to report the highest number of new AIDS cases, the highest newly reported HIV cases, and the smallest decrease in deaths due to AIDS. Many of the SAC states also continue to find late testers who convert to AIDS within 12 to 36 months of initial HIV diagnosis, later than any other region.^{vi} Black, non-Hispanic persons in the South had the highest percentage of new infections during 2001 - 2005 than any other region in the country with more than 54% of all new infections.^{vii} Black, non-Hispanic persons comprise only 18.5% of the South’s population.^{viii} According to the June 27, 2008, edition of

the CDC's *Morbidity and Mortality Weekly Report*, the number of HIV/AIDS diagnoses among men who have sex with men (MSM) during 2001 - 2006 increased 8.6%. Of the 33 states reporting, the MSM population in the South made up 55% of the total or 53,710 of the nation's 97,577 cases among MSM.^{ix}

Any discussion of the challenges of reducing new HIV infections and in getting HIV-positive persons into quality care and treatment must include the topic of stigma. While stigma exists in communities nationwide, the conservative beliefs predominant in the South have often resulted in the documentation of a culture that blames those with HIV/AIDS due to supposedly sinful behavior, which is especially true for MSMs and persons who use or abuse drugs. These ideologies contribute to an environment that is indifferent or hostile to all persons living with HIV/AIDS, regardless of how the disease was contracted.^x

As state funds in this last year have lessened or dried up due to the economic crisis in the U.S., the disbursement of state dollars, including Medicaid funds, to community providers to support HIV/AIDS care, case management, treatment, and prevention services continue to diminish. These facts lead to state and/or local program enrollment freezes, program suspension, and reduced capacity to render services. Challenged in their capacities to serve growing numbers of new HIV/AIDS clients in the South, HIV-specialty medical clinics, community-based medical clinics, hospital-based providers, community-based care services, and housing providers are deeply concerned and frustrated at the prospect of having to provide increased care to meet the need with fewer dollars. States in the southern region are predicting that our deeply troubled economy will not rebound within the next few years, placing overwhelming challenges on health care delivery.



As history teaches, lack of investment in the public's health care and prevention programs will result in 1) the South continuing to have the largest number of new HIV infections in the United States, 2) poor health outcomes, including progression to AIDS for HIV-infected persons not in care, and 3) an increase in the unacceptable health disparities already well documented in the *Southern States Manifesto: Update 2008*^{xi} and elsewhere.

Due to these realities, SAC believes that national Health Care Reform must also incorporate strategies to strengthen state and local public health partnerships with their community-based partners that deliver many critical services. In fact, we are concerned that Health Care Reform planning and implementation will overlook the many roles and responsibilities within state and local health departments and community-based medical and non-medical organizations; these are mandatory components of HIV/AIDS care.

Health care is funded by many diverse partners in the public and private sectors and is governed at the state level in the vast majority of states. Public health prevention and care programs in the South serve as safety nets for the disproportionate number, when compared to other regions, of the uninsured and underinsured living with HIV/AIDS as well as those affected by many other acute and chronic diseases. The costs of these programs have been funded through a mosaic of public and private sources; for example, program support within one organization may include funding from targeted state appropriations, Medicaid, Medicare, private foundations, and/or federal grants. The loss of any one funding source in any one local, community, or state health program can have an immediate, destructive impact on individual and community health.

One of SAC's goals is to assure that southern public health experts, advocates, and people living with HIV/AIDS are included and involved in national, regional, and local discussions of strategy development to enable optimally effective delivery of national Health Care Reform that truly benefits every person in the U.S. SAC also believes that Health Care Reform linked to financing HIV/AIDS care in the South can and should mirror the well-documented best practices currently supported by the Ryan White HIV/AIDS Treatment and Modernization Act of 2006 (Ryan White). The need will persist for increased, dedicated HIV/AIDS health care federal funding to support service accessibility in every locality.

New, costly HIV/AIDS infections and deaths are preventable; we have the knowledge and science necessary to reduce these new infections and deaths. However, the availability and flexibility of resources are inadequate. Our successes include a reduction in deaths due to AIDS between 2003 and 2007; decreases were recorded in all regions of the U.S., including the South. Evidence exists proving that a person with HIV/AIDS who is in care and/or on treatment is less biologically able and less behaviorally likely to transmit the virus to others.^{xii} Over the last 26 years, the collaborative accomplishments of federal, state, and local AIDS advocates, as well as community-based experts, have resulted in the development and implementation of demonstrably effective HIV/AIDS testing, care, treatment, prevention, and housing programs. Still many gaps in access to programs for prevention, care, treatment, and housing remain, especially those programs that provide early HIV testing. Without the dedicated public and private resources to support programs in the current economic crisis, all HIV/AIDS programs are in jeopardy.

Throughout the evolution of Health Care Reform, SAC will insist that investments prevail in quality standards-of-care for treatment, referral, and outreach. The U.S. Departments of Health and Human Services, the Centers for Disease Control and Prevention, and their subsidiary funding programs, which include Ryan White, already mandate such standards.

For more than two decades, partnerships between state public health and community-based programs used federal and state dollars to build comprehensive services for people living with or at risk of contracting HIV/AIDS; the majority of these patients are financially strained. These partnerships must be strengthened during Health Care Reform, not dismantled, underfunded, or re-engineered. Any loss in funding resources for existing programs or transition to programs that do not control for HIV/AIDS as an infectious, chronic disease will result in an increase of new infections and a reduction of patients who are able to access and stay in care.

Approaches to Health Care Reform for people living with HIV/AIDS must ensure that all providers are held accountable to demonstrate positive health outcomes, not simply cost containment. Currently, many state and local providers can document dramatically improved health outcomes for individuals and families living with or at risk of HIV/AIDS. Given the gravity of untreated HIV/AIDS, the greater demand in every state for accessible HIV/AIDS primary and specialty care also reflects the progress achieved in managing people living with the disease.

Prevention of new HIV infections requires that those already infected have full and ongoing access to care and treatment. Yet reported numbers from the 2006 Ryan White applications revealed a range of 37% to 43% in unmet need for Ryan White Part A and Part B programs. An estimated 230,000 persons living with HIV/AIDS in the United States still remain unaware of their infections.^{xiii} If we apply this statistic to the South's ratio of persons living with HIV infection, then more than 118,000 of the estimated 230,000 persons unaware of their status live in the South. We must work together to deliver Health Care Reform; we must also make sure that HIV/AIDS prevention, including risk reduction education, and routine HIV/sexually transmitted diseases/hepatitis/tuberculosis testing must be payer-covered or provided free.

Under current new CDC federal funding for prevention programs, state and community providers have been successful at increasing the number of new HIV/AIDS cases identified. The CDC's increased estimate of 56,300 new HIV/AIDS infections annually, which was determined through a new methodology for calculating incidence, represents a 41% increase from the 40,000 estimated cases stated previously. While on one hand this large increase illustrates the lack of success in reducing new HIV transmissions, particularly in the South and in the Mid-West, SAC believes that this increase was also due to the many years that the South and Mid-West were severely underfunded in prevention, surveillance, and care/treatment dollars.^{xiv} The last reauthorization of Ryan White adjusted the funding formula so that the dollars better followed the epidemic and, as a result, the South was able to put to use \$30 million for new care and treatment that improved the eligibility levels of state AIDS Drug Assistance Programs and increased access to HIV/AIDS primary care in many rural communities.

SAC believes that Ryan White must be reauthorized for a minimum of three more years. We strongly believe that an outcome-driven, quality standard-of-care Health Care Reform package that serves the poor, disenfranchised, and underinsured can be developed. SAC will help in the development of these plans, especially to address persons affected and infected by HIV/AIDS, a chronic infectious disease that requires public health approaches and public follow-up to be most effective in disease reduction. However, during the building and implementation stages, state and community providers must continue to receive dedicated federal financial support for their HIV/AIDS prevention, care, treatment, and housing programs. Even after the passage of Health Care Reform, adequate federal funding must be maintained in legislation such as Ryan White and Housing Opportunities for Persons with AIDS to ensure that ancillary services needed to improve medical outcomes are continued. Additionally, surveillance efforts must be adequately funded to prevent inaccurate estimations of disease burden.

The next sections of this document address Health Care Reform approaches, existing funding available to support HIV/AIDS programs, as well as the approaches to a National AIDS Strategy. SAC continues to ensure that all of these discussions address the nation's largest HIV/AIDS affected and infected region, the South.

II. Health Care Reform

Health Care Reform proposals are in development through the President's administration, members of Congress, former Congressional members, and health care policy think tanks. Given the incredible challenge of predicting various outcomes from these proposals for chronic, infectious diseases such as HIV/AIDS, SAC's approach to Health Care Reform policy guidance for this document will be limited to principles of reform.

However, at the outset SAC will fight to ensure the renewal of Ryan White for a minimum of three years as well as adequate funding for the program. A health care system that does not have dedicated federal funding for persons with HIV/AIDS will not be supported by SAC and will be likely to fail.

Health Care Reform must be about more than public/private insurance options for all Americans. It must also comprehensively address the public health outcomes for those living with chronic, infectious diseases (i.e., HIV/AIDS, hepatitis, sexually transmitted diseases, and tuberculosis). Most state governments, researchers, clinicians, nurses, doctors, community-based providers, clinics, case managers, and AIDS Service Organizations are knowledgeable about HIV treatment and services and perform well when adequately funded. When persons with HIV/AIDS access care, if they are fortunate enough to be tested, have transportation, and have access to case management, which many do, viral loads go down, CD4 cell counts go up, and the quality of life of the infected person tends to improve. The challenges arise in 1) preventing HIV infection, 2) testing for HIV infection, 3) linking those tested successfully to care providers and fostering ongoing compliance, and 4) having enough resources to enable those contributing to systems of care to do what they do well for a growing population that need these services.

People with HIV/AIDS often have co-morbidities, such as other infectious diseases, including undiagnosed sexually transmitted diseases and hepatitis; increased cardiovascular

complications; psycho-neurological symptoms and infections; diabetes; and challenges related to compromised immune systems. The stress and trauma that arise from living with a chronic, infectious disease like HIV/AIDS often includes issues with mental health and chemical dependencies. The frequency of co-morbidities, including challenges with mental health, requires consistent supports from a variety of systems. The separate delivery systems that dominate the HIV/AIDS systems include medical health received through one or more teams, mental health through another provider, and access to needed services and housing through yet additional systems, all of which often lead to one person having three or more case managers. HIV/AIDS cannot be treated with only primary health care; the disease requires a coordinated system prepared to respond to complications arising from the environmental conditions (poverty, homelessness, mental health issues, substance abuse, and the inability to access care), as well as to address the complex medical conditions.

Health Care Reform must...

- 1) Renew Ryan White for a minimum of three years with adequate funding to continue to provide essential health and support services to people living with HIV/AIDS. The only clear way to provide ongoing medical and required supportive services to people with HIV/AIDS is to retain the Ryan White program in years to come.

Prioritize prevention of disease.

- 2) All public and private insurance plans should cover routine HIV testing costs to identify the HIV status of all Americans and to connect them quickly into care. HIV prevention and early diagnoses are particularly critical to vulnerable populations disproportionately impacted by HIV/AIDS, including MSM, minorities, women, young people, transgender populations, and members of rural communities.

Expand connection to care.

- 3) Enhance funding to state public health systems to support public health prevention services, such as community-based counseling, HIV/AIDS/sexually transmitted diseases/hepatitis/tuberculosis testing, partner services, outreach, and linkage to care.
- 4) Prioritize retention in care through a standard package of benefits that includes acknowledgement of the need for additional support to keep persons in care, such as expanded funding of existing HIV/AIDS clinics, transportation, ancillary bio-psychosocial services, routine and expanded HIV testing and care through local health departments, community-based agencies, Community Health Centers, and Federally Qualified Health Centers. Integrate successful Ryan White-funded clinics into all systems of care, utilizing them as “centers of excellence” to provide options for those new to care.

Ensure access to care and treatment for everyone, including the currently uninsured.

- 5) Keep Medicaid and Medicare services and prescriptions affordable for everyone by minimizing consumers’ out-of-pocket costs.
- 6) Increase the federal contribution to state Medicaid programs and decrease state match requirements during periods of economic crisis.
- 7) Provide a public health insurance option within the spectrum of options to increase coverage availability, to contain costs through competition, and to provide choice for

persons purchasing health insurance. This option is especially important for persons with HIV/AIDS, who are disproportionately likely to lack private insurance.

- 8) Eliminate health insurance exclusions based on health status. Individuals with pre-existing health conditions, such as HIV/AIDS, must be allowed to obtain health insurance coverage.
- 9) Protect Medicare beneficiaries facing “donut hole” coverage gaps.
- 10) Provide incentives to strengthen the public health workforce, including physicians, nurse practitioners, physicians' assistants, and social workers. One common ground in health care reform is the need for more health care providers. The current shortage of health care workers strains the ability of public health systems to respond to emerging epidemics, such as HIV/AIDS, Swine Flu, and tuberculosis. Government scholarships, student loan programs, academic debt repayment programs, and other initiatives designed to recruit HIV specialists and other health care professionals must be increased with adequate funding levels in order to serve in those areas suffering from a growing incidence of HIV and simultaneous lack of HIV expertise. Additionally, the training and retaining of faculty to teach students in sufficient numbers appropriate to the critical need must be emphasized.
- 11) Ensure adequate and timely reimbursement to health care providers, thereby promoting and protecting access to the vital, unique services they provide.
- 12) Provide optimal medication formularies for Medicaid, Medicare, and AIDS Drug Assistance Programs to ensure the ability to provide treatment that meets U.S. Department of Health and Human Services guidelines.

Establish standards of care and treatment for all payer environments.

- 13) Utilize existing U.S. Department of Health and Human Services standards of care and treatment to be followed in all public, private, and employer-sponsored private health care plans.

Ensure state's ability in challenging economic climate to implement federal mandates.

- 14) The economic challenges outlined in this paper seek enhanced support for states through reduced financial state match requirements to avoid drastic cuts to access to medical care and supportive services for those with HIV/AIDS.

Involve people with HIV/AIDS and providers in the process.

- 15) As Health Care Reform moves forward, include persons living with HIV/AIDS and their providers in the policy-development process by taking into account the epidemic's geographic, gender, race, and mode of transmission characteristics. The South faces tremendous challenges and is ready to be actively engaged to improve systems already in place and to develop new systems of care delivery to adequately address disease burden.

III. Specific HIV/AIDS Issues by System

While consideration of types of Health Care Reform continues, financing HIV/AIDS prevention, care, treatment, and housing in the South requires specific actions to maximize the public health outcomes outlined in the national health promotion and disease prevention initiative, *Healthy People 2010*. Those actions include critical objectives to a) reduce new infections, b) identify those who are HIV-positive and move them into appropriate care, and c)

provide appropriate care and treatment to those who are HIV-positive. SAC prioritized a few areas within the existing systems, whether or not they are considered a part of Health Care Reform that requires specific attention.

Ryan White Funding

- SAC supports the continuation of the Ryan White program for a minimum of three years with increased funding to address the growing demands. The disbursement of funds must be consistent with each state's burden.
- Ryan White is utilized to serve the neediest and has provided an infrastructure that maximizes access to the public health standards of care. This access is especially powerful given our knowledge of the reduced risks of transmission to others for persons engaged in care.
- Ryan White funding is not adequate at current levels and does not meet the needs of the growing number of individuals living with HIV/AIDS. Health Care Reform must include the continuation of Ryan White to ensure that both those with the highest needs and those who will inevitably have gaps in health care coverage are still able to access care and treatment. This safety net is of critical importance to areas such as the South that historically deal with the challenges of poor health care access, high rates of poverty, financially-strapped state governments, Medicaid and Medicare benefits designed to meet the minimal mandated standards, vast geographic distances, and numerous other factors that increase need.
- Allow Ryan White AIDS Drug Assistance Programs flexibility to use funds to count toward the Medicare Part D true out of pocket (TrOOP) expenses when used for treatment expenses.

Medicaid

For people with HIV/AIDS, Medicaid in most states requires a person to become disabled by AIDS in order to be eligible for Medicaid services. This perverse approach to public health essentially means that a person must get very sick, be at greater risk of infecting others, and stop being employed in order to qualify for benefits. Clearly, this eligibility criterion is antithetical to any rational approach to public health. In general SAC supports Medicaid expansion to help insure those who are uninsured in our states. This expansion, given the bleak economic crises of the state governments, cannot be accomplished in the current environment unless some important requirements are passed along to the states.

- The percentage required by states to match the federal money should not apply uniformly to persons with chronic, infectious diseases. Any expansion of Medicaid programs to cover persons with HIV/AIDS will not be possible in the South without substantial reductions or the elimination of the state's percentage of required match to provide the Medicaid benefits. Many states in the South and across the country do not have any capacity to expand Medicaid access without increased federal funds. Increased medical coverage will ultimately lead to a reduction in the number of new infections, which will in the end offset the federal economic investment.
- A mandate to require Medicaid's implementation of existing national standards for care and treatment will be necessary to ensure uniform state participation.
- Pass the Early Treatment for HIV Act (ETHA) with specific attention to the financial capacity of states. A greatly reduced portion of the FMAP for states with high need and low state economic ability could allow most states to participate.

- Remove categorical eligibility for people with HIV/AIDS that requires them to be disabled by AIDS to qualify for benefits and increase financial eligibility to 400% of the federal poverty level, allowing expanded access to health care for the working poor who can still contribute to their communities and the tax base.
- Eliminate the two-year Medicare waiting period for disability.
- Require provider reimbursement minimums that are competitive with other chronic disease provider rates.

Housing

Emerging research indicates that for each person with HIV/AIDS stably housed for 24-months, reductions in new infections can be demonstrated. While this outcome has long been anecdotally believed, this cutting edge approach to research may soon document precise numbers of saved infection rates.^{xv} The inclusion of housing into Health Care Reform discussions demonstrates an understanding of the need to address an infectious disease through an array of interventions, especially including housing services.

- As with health care, a diverse system of federal, state, and local funding combines to address the needs of those who cannot afford a safe, decent place to live. The Housing Opportunities for Persons with AIDS (HOPWA) program is the only federal program that specifically serves those with HIV/AIDS. SAC recommends funding at \$350 million for fiscal year 2010, as appropriated by the House subcommittee.
- SAC further recommends increased direction in all HUD programs to also serve persons with HIV/AIDS.
- HOPWA distribution methodology must be updated to reflect prevalence of both HIV and AIDS cases. Current distribution only counts cumulative AIDS cases, and bonuses for AIDS incidence only go to large cities but not states. All new funding should be directed at areas that are currently underfunded under the modernized distribution methodology.

Mental Health

In 2007, 29% of the funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) was invested in the South.^{xvi} Given the scope of the epidemic in the South (47% of the nation's AIDS cases and 55% of the reported HIV cases), this huge disparity must be corrected.

- SAC believes the funding should follow the epidemic; SAMHSA funding must be increased to meet the dire needs of those with co-morbidities of HIV/AIDS and mental health/substance abuse disorders in the South.
- SAC supports a specific southern initiative funding stream to address the overall needs of persons living in the South.
- SAC recommends that additional funding be awarded to the Departments of Mental Health in the Southern AIDS Coalition region to address the geographic challenges in accessing limited mental health care providers in the South; these needs are especially pronounced in rural areas of the South, as the South has the highest number of rural areas in the country combined with the highest rates of AIDS cases in rural areas..^{xvii}

National AIDS Strategy

The involvement of persons living with HIV/AIDS, providers, and government leaders from the South in the development of a National AIDS Strategy clearly is warranted. The involvement and representation from entities like the Southern AIDS Coalition and its members will improve both the process and the outcomes of a national strategy. Participation should match the percentage of cases borne by the South, including attention to geography, race, age, gender, and modes of transmission. SAC strongly supports southern voices living with HIV/AIDS to be included at the table throughout the National AIDS Strategy development and implementation.

While it is clear that the National AIDS Strategy is not a laundry list of arcane language fixes and the development of new funding sources, the substance of a strategy that is based on approaches taken by other nations may not fit at this moment in time. SAC recommends that an array of persons be involved in the process to develop a strategy that can be implemented within a Health Care Reform model and that will clearly outline the role and partnership of state health departments and community-based organizations in the implementation of a national strategy. Visionaries are different than implementers; it would be disingenuous if both were not included to translate the reality of the various environments across the nation in the creation of a national strategy. Visions and strategies must be coupled with outside-the-Beltway thinking and substantive input from areas beyond the two coasts. SAC strongly encourages the President to invite considerable involvement from the South in envisioning the requisite infrastructure/systems to stop new infections and to ensure access to care, treatment, and housing for all who live with HIV/AIDS.

IV. President's Advisory Council on HIV/AIDS (PACHA)

SAC supports President Obama's continuation of PACHA and the CDC HIV/AIDS Advisory Committee (CHAC) and sees distinct and separate roles for these bodies from other national advisory and/or policy groups. Memberships of these bodies and other national groups should reflect the geography and demographics of HIV/AIDS in the United States while also including representative leaders of the major elements of prevention, care, treatment, housing, and research.

V. Conclusions

Financing health care is an ominous challenge to tackle on a national scale for any one disease and is even more so for the many diseases and conditions that can affect any American at any time throughout a lifetime. The task is particularly overwhelming in light of the national and state economic crises, which are resulting in unprecedented cuts to Medicaid programs and state-funded public health programs. SAC wants to work with President Obama, with leaders in the U. S. Congress and within all federal and state departments, and with persons living with HIV/AIDS to affect lasting and positive change to the health care system of the U.S.

SAC is optimistic about many efforts made thus far but is also gravely concerned about the specifics of how current and future health care will be financed and sustained for persons with HIV/AIDS. SAC calls for the Ryan White program to be adequately funded and supported for a minimum of three years. Many programs across the South and in other parts

of the country can serve as models for new systems of care and treatment that would not exist without the Ryan White program.

The Southern AIDS Coalition maintains a deep commitment to public health approaches to prevention, care, treatment, and housing for infectious diseases such as HIV/AIDS, because these approaches have been proven effective. To date, national financial strategies fail to focus resources on those with the greatest needs. If the most chronic and troublesome situations are addressed, overall costs can be reduced through improved care and reduction in new infections as well as through reductions in co-morbid conditions that are costly. The political realities faced by a country in economic crisis are recognized; however, there is also a window of opportunity for the identification of creative solutions that ultimately will conserve public funds and improve the public health, especially with respect to those living with or at risk of HIV/AIDS in the South.

SAC will continue to:

- Stay actively involved in all national conversations around existing policy changes or shifts;
- Actively participate in the process to develop a National AIDS Strategy;
- Provide input to leadership within the multiple federal and state systems involved in the identification of needs and delivery of health care interventions;
- Support and encourage growing state-level advocacy networks that galvanize resources and attention on state-level issues;
- Share knowledge and best-practice approaches across state lines;
- Collaborate among state governments responsible for translation of federal and state dollars into public health;
- Learn from community-based organizations responsible for the delivery of care, treatment, services, and housing; and
- Involve our industry partners who continue to keep us informed regarding complex treatment alternatives and access to care.

ⁱ State Budget Update: April 2009, National Conference of State Legislatures, Fiscal Affairs Program, www.ncsl.org.

ⁱⁱ Ibid.

ⁱⁱⁱ Ibid.

^{iv} Kaiser Family Foundation, *Health Care Costs: A Primer, Key Information on Health care Costs and Their Impact*, March, 2009, 3.

^v The Southern AIDS Coalition is comprised of government and community members from Alabama, Arkansas, Florida, Delaware, District of Columbia, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia

^{vi} *Morbidity and Mortality Weekly Report*, June 26, 2009 / 58(24); 661-665, *Late HIV Testing – 34 States, 1996-2005*.

www.cdc.gov/mmwr/preview/mmwrhtml/mm5824a2.htm. Site accessed July 4, 2009.

^{vii} Centers for Disease Control and Prevention, Update to Racial/Ethnic Disparities in Diagnoses of HIV/AIDS-33 States, 2001-2005, Table 1.

www.cdc.gov/hiv/resources/reports/mmwr/mm56091a/table1.htm - site accessed July 5, 2009.

^{viii} The Black Population: 2008, Census Brief, U.S. Department of Commerce.

^{ix} *Morbidity and Mortality Weekly Report*, June 27, 2008/57(25); Trends in HIV/AIDS Diagnoses among Men Who Have Sex with Men – 33 States, 2001-2006.

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^{xvi} Ibid.