

Testimony of

**Communities Advocating Emergency AIDS Relief (CAEAR)
Coalition**

Submitted to the

**Subcommittee on Federal Financial Management, Government
Information, and International Security of the Committee on
Homeland Security and Government Reform, U.S. Senate**

Senator Tom Coburn, Chair

For the Record of

**"Addressing Disparities in Federal HIV/AIDS CARE Programs"
June 23, 2005**

Submitted July 1, 2005

Communities Advocating Emergency AIDS Relief (CAEAR) Coalition appreciates the opportunity to submit testimony to the Subcommittee for the record of the June 23, 2005, hearing entitled “Addressing Disparities in Federal HIV/AIDS CARE Programs.” We want to thank Chairman Tom Coburn and Ranking Member Tom Carper for convening this important hearing and for their personal attention to critical HIV/AIDS issues.

CAEAR Coalition represents the interests of more than 400 grantees under Title I and Title III of the Ryan White CARE Act, including the 51 major metropolitan areas most adversely affected by the HIV/AIDS epidemic, as well as providers and consumers of CARE Act-funded services. CAEAR Coalition also advocates for adequate funding for the AIDS Drug Assistance Program (ADAP) in CARE Act Title II. Many of CAEAR Coalition’s members are CARE Act grantees and sub-grantees working on the frontlines to provide community-based HIV/AIDS-related medical care and support services. The strength of the community-based response to HIV/AIDS has been and remains central to the nation’s ability to serve people living with HIV/AIDS across the country. The CARE Act has played a key role in providing the resources necessary to build and sustain the community-based response. CAEAR Coalition is urging the Congress to reauthorize the CARE Act prior to the September 30 deadline. We hope that this hearing will serve to jumpstart the reauthorization process.

➤ **The CARE Act Works to Save Lives**

The success of the CARE Act in improving the lives and health of people living with HIV/AIDS is well documented. In its assessment of the program, the White House Office of Management and Budget wrote, “The [CARE Act] has contributed to the overall decline in the number of AIDS cases and deaths due to HIV, as well as the increase in the number of persons receiving primary medical care and treatment.”ⁱ A study comparing those receiving primary medical care and support services through CARE Act-funded providers in New York City to those receiving services through non-CARE act funded providers, found that those receiving services from CARE Act providers are up to 40-90% more likely to report appropriate medical care, including access to anti-HIV medications.ⁱⁱ

The CARE Act Allows Local Flexibility and Accountability to Determine Best Combination of HIV Health Care and Supportive Services

Title I EMAs and Title III grantees have a strong commitment to expanding access to HIV primary medical care, medications, and case management services in order to improve health outcomes of people living with HIV/AIDS. Services supported through the CARE Act are intended to help people living with HIV/AIDS to enter and remain in systems of ongoing care and treatment, thereby improving health outcomes for these individuals. The appropriate mix of specific services funded with CARE Act resources should be defined locally as a result of local planning, and based on assessment of unmet local needs. Defining a limited list of core services or prescribing a minimum percent of funding for specific services at the federal level may adversely affect the ability of grantees to identify and retain people living with HIV/AIDS in care. Local variations in services supported by other funding streams, such as State Medicaid programs, substance abuse treatment, or mental health services for persons with multiple diagnoses, require flexibility in CARE Act-funded programs. All services supported with CARE Act funds should be linked with improvements in health outcomes related to access and appropriate utilization of health services by people living with HIV/AIDS. For example, the efficacy of case management was demonstrated in the results of a recently published four-city

study, which found that “a brief intervention by a case manager was associated with a significantly higher rate of successful linkage to HIV care.”ⁱⁱⁱ

CARE Act Titles Work Together to Provide Comprehensive Network of Medical Care and Support Services Necessary for Effective HIV/AIDS Care

The CARE Act’s multi-title structure was designed to provide the comprehensive medical care and enhancing support services necessary for the complex treatment of HIV/AIDS and it has adapted well to the integration of Highly Active Antiretroviral Therapy (HAART) into HIV/AIDS care. An important component of HAART is identifying and ensuring access to the appropriate drug regimen, both critical tasks provided by CARE Act-funded providers and the AIDS Drug Assistance Program (ADAP). Of course, the administration of drugs does not by itself result in successful treatment and Title I and Title III programs provide the appropriate level of medical and support services needed to manage these complex drug regimens.

Success of Drug Therapies Requires Extensive Medical Services

HAART and other components of HIV/AIDS care require continuous monitoring and follow-up by medical professionals. The choice and timing of antiretroviral regimen are critical elements of successful treatment of HIV infection. The programs supported by Title I and Title III provide the infrastructure in which people living with HIV/AIDS can take an anti-HIV/AIDS drug regimen under proper medical supervision, including costly laboratory testing. Without the experience and expertise of these medical professionals, the powerful drugs used to manage HIV/AIDS could easily be misused or insufficiently managed and result in serious consequences such as:

- viral resistance;
- complications, including increased risk of heart disease, high cholesterol, anemia, diabetes, kidney and pancreatic and liver dysfunction; and
- treatment failure.

The assembly-line distribution of drugs to patients not under the direct care of a medical professional is ineffective and dangerous. For individuals served by the CARE Act, Title I and Title III programs provide access to the medical supervision necessary for successful treatment.

Appropriate Support Services Enhance Access to Care

Competing needs, such as food and housing, and barriers to care, such as lack of transportation or childcare, limit access to HIV health care services. One study found that more than one-third of people living with HIV receiving care postponed or went without care during a six-month period because of these competing needs and barriers. These challenges were also associated with significantly greater odds for never receiving antiretroviral treatment. Others went without food, housing, and clothes in order to pay for their care.^{iv} While the majority of CARE Act Title I and Title III funds support HIV treatment, a significant portion of Title I funds provide key support services, such as food and transportation, as well as case management services to link people with HIV/AIDS to medical care and support services.

➤ **Reauthorization Presents Opportunity to Strengthen an Already Effective Program**

CAEAR Coalition began its work on the 2005 reauthorization over two years ago and has conducted research and analysis aimed at developing recommendations for strengthening the ability of the CARE Act to serve people living with HIV/AIDS in communities across the country. Attached is a summary of CAEAR Coalition's "Policy Recommendations for Reauthorization of the Ryan White CARE Act." The full recommendations are available at www.caeear.org.

The key issues discussed during the June 23rd hearing are central to the reauthorization process and are among the numerous issues that CAEAR Coalition members reviewed and debated during the development of CAEAR Coalition's reauthorization recommendations. Following are CAEAR Coalition's comments on the issues raised during the hearing, reflecting those recommendations.

➤ **Build & Strengthen HIV Health Care in Communities Nationwide Accelerate Reductions in Hold Harmless Provision**

In her testimony before the subcommittee, Dr. Deborah Parham-Hopson, Associate Administrator, Health Resource and Services Administration's HIV/AIDS Bureau, noted the necessity for "reengineering" the CARE Act's hold-harmless provision and for distribution of CARE Act formula funding based on HIV cases.

CAEAR Coalition agrees. In order to direct funds to areas of emerging need while maintaining a commitment to stabilizing systems of care, CAEAR Coalition's position on the Title I hold-harmless provision would accelerate the reductions in formula funding in areas relying on the hold-harmless provision from the current rate of 15 percent over five years to 21 percent over five years. Both CAEAR Coalition and our reauthorization partner, AIDS Action, have agreed to this carefully negotiated position, which reflects consensus among those most impacted by the hold harmless provision. CAEAR Coalition agrees strongly with Senator Coburn's comments at the hearing that reform of the hold-harmless provision must be done in a way that "minimizes harm to existing systems of care." The continuation of a hold-harmless provision will be especially important with any movement to transition to HIV cases as the basis of Title I formula grants, as supported by CAEAR Coalition and discussed below.

Modernize Funding Mechanisms Using National HIV/AIDS Data

Key to aligning the distribution of CARE Act resources with demographic trends in the epidemic is the development of the national HIV/AIDS data set. The implementation of such a data set has been significantly delayed due to the CDC's refusal to accept HIV case data from states using code-based HIV reporting systems. Yet, the CDC's witness at the hearing, Dr. Robert Janssen, Director, Division of HIV/AIDS Prevention, National Center for Infectious Diseases, CDC, stated that there is no data that suggests that name-based HIV reporting systems are better than code-based HIV reporting systems. Dr. Janssen also reported that the outcome of a recently conducted CDC evaluation of selected code-based HIV reporting systems demonstrated that code-based systems can meet the data completeness standards established by the CDC. It is well past time for the CDC to change its position, work collaboratively with states that have code-based HIV reporting to bring their data online, and accept state-level code- and name-based HIV

and AIDS data into the CDC's national data set used to determine CARE Act formula allocations.

Base Title I Eligibility and Resource Allocation on Living AIDS Cases and Then Living HIV/AIDS Cases

CAEAR Coalition recommends a two-step process to modernize the criteria for Title I eligibility and allocation of formula funds. As a first step, CAEAR Coalition recommends that, in the first fiscal year following reauthorization, Title I formula allocations be based on the number of persons reported to be living with AIDS, adjusted for reporting delays. Similarly, CAEAR Coalition recommends that the criteria for attaining EMA status be updated to require that a jurisdiction have at least 500,000 residents and 1,500 estimated living AIDS cases, adjusted for reporting delays.

As a second step, CAEAR Coalition recommends that the Centers for Disease Control and Prevention (CDC) be required to establish a process, to be completed no later than December 2006, by which state and other eligible area HIV data from name and non-name-based (code-based) reporting systems is accurately merged to produce a national HIV/AIDS case data set inclusive of all reported living HIV cases. When and after the Secretary of Health and Human Services determines the HIV/AIDS data set to be complete by December 2006, then, beginning in Fiscal Year 2007, Title I formula awards should be determined by the number of persons reported to be living with HIV and AIDS, adjusted for reporting delays. At that time, EMA eligibility criteria should also be based on living HIV and AIDS cases adjusted for reporting delays. The threshold should be set at a point determined by the Secretary to be equivalent to the 1,500 living AIDS case threshold. The intent is to maintain the threshold at a consistent point for eligible EMAs while making the change to a more inclusive data set. With the eligibility criteria change to living AIDS cases and then living HIV/AIDS cases, all existing EMAs should maintain their EMA status even if their caseloads do not reach the new thresholds.

Provide Emerging Communities with the Resources They Need

One result of modernizing the EMA threshold as discussed above will likely be the addition of two to four new Title I jurisdictions in the first year of reauthorization, which were previously funded through the top-tier of the Emerging Communities provision in CARE Act Title II. In accordance with this shift and to direct appropriate resources to areas of emerging need, CAEAR Coalition recommends that the top tier of the Title II Emerging Communities be eliminated, that the \$5 million allocation for those top-tier communities be retained and transferred to the Title I appropriated line item, and that new funding for Title I be authorized and appropriated to minimize potential funding reductions to continuing EMAs and support the addition of the EMAs formerly funded through the top tier of the Emerging Communities program.

Maintain Grandfather Clause for Title I EMAs

Title I was designed to support medical care and support services in urban areas hardest-hit by HIV/AIDS, shoring up the public health infrastructure in communities facing significant challenges in caring for people living with HIV/AIDS, a role that it continues to play in these communities. The grandfather clause enacted in the 1996 reauthorization, which allows a number of the EMAs to maintain their Title I eligibility, was designed to maintain existing systems of care in urban areas where the epidemic is concentrated. Indeed, over 70 percent of Americans living with AIDS reside in the cities currently served by Title I. The high concentration of cases

in these cities and the success of Title I in responding to and meeting local needs in these communities speak strongly to the need to maintain the grandfather clause in the 2005 reauthorization. On the other hand, removing this protection and stripping these communities of Title I funding would dismantle the existing systems of care and significantly decrease the access people living with HIV/AIDS to the medical care and supportive services they need and have come to depend upon.

Recognize Key Role of Title III in Serving People Living with HIV/AIDS Outside of Title I EMAs

The testimony of the Government Accountability Office, *RYAN WHITE CARE ACT: Factors that Impact HIV and AIDS Funding and Client Coverage*, based on its preliminary, incomplete review of CARE Act programs, provides an analysis of Title I and Title II funding, specifically comparing the per case funding across states. Missing from this comparison is funding available through the other components of the CARE Act, most notably Title III funding, which, under the 2000 reauthorization, must give preference to rural and underserved communities. Eighty-four of the 356 Title III grantees (24 percent) are located in states without EMAs, while those states accounted for 13 percent of newly diagnosed cases in 2003. In addition, many Title III grantees in states with EMAs are located in rural areas outside of the EMA boundaries. The CARE Act titles work together to serve HIV-impacted communities large and small and fair analysis of spending trends should include a comprehensive review of the program.

➤ Provide Care and Treatment for All in Need

Address Variations in State ADAPs with Enhanced Resources

CAEAR Coalition believes that ADAPs across the country should provide a basic level of service to all people living with HIV/AIDS who have no other source of access to medications. In its testimony, the GAO attributes the current variability in state ADAPs to the states' ability "to shift funds, establish eligibility criteria, place limits on the medications covered, and cap enrollment." In fact, the reasons for the variations are more complex.

Insufficient federal funding is the primary reason some states have been unable to maintain an adequate formulary and/or provide assistance to most low-income people living with HIV/AIDS. After an initially robust federal response to the growing costs of pharmaceuticals and the unmet treatment needs of ADAP clients, the ADAP line item has received only modest increases over the past several years, falling well short of the levels needed for states to provide appropriate service. Another factor is the ability of a state to provide funding to make up for federal budget shortfalls. Some states, such as California, have contributed generously to their programs to ensure access to HIV medications. Other states, such as Alabama, have also contributed substantially to their ADAPs and still have waiting lists and/or limited eligibility standards. Other factors include: (1) the ability of the state's Medicaid program to serve people living with HIV/AIDS in need, (2) the ability to direct pharmaceutical rebate funds for drugs bought with ADAP funds back into the ADAP rather than to the state's general fund, (3) the level of discounts negotiated with the distributors of ADAP drugs, and (4) contributions from other sources.

CAEAR Coalition believes that equity among state ADAPs cannot be achieved by simply taking away the states' flexibility in setting eligibility and formula standards. ADAP is a discretionary

program, not an entitlement, and instituting entitlement-like standards—without adequate and guaranteed funding—will leave states with obligations that they cannot fulfill.

CAEAR Coalition urges Congress and the Administration to support full funding for ADAP, so that all states receive the increases they need. For Fiscal Year 2006, experts have determined that a \$303 million increase is needed to bring state ADAPs to a minimum level of service.

CAEAR Coalition also notes with apprehension the expiration of the President's ADAP Initiative in September, 2005. This program, which provided \$20 million in one-time funding for individuals on waiting lists, is currently dispensing medications to 1,438 individuals on ADAP waiting lists in 10 states. It is unclear how these clients will receive treatment after the program ends and new funding is not made available. CAEAR Coalition urges the Administration and Congress to provide the resources necessary to ensure continued access to medication for those in need.

Finally, the National Alliance of State and Territorial AIDS Directors (NASTAD) has released proposals in its CARE Act reauthorization recommendations specific to ADAP Supplemental Grants. CAEAR Coalition believes these proposals are worth discussion and consideration as they could provide fiscal relief to states struggling to provide adequate ADAP services. Specifically, NASTAD calls for (1) directing 20 percent of future annual ADAP increases to the Title II ADAP Supplemental Grants, (2) eliminating the state match for ADAP Supplemental Grants, and (3) expanding the requirements to receive ADAP Supplemental Grants to allow states to meet one of three criteria, which include eligibility criteria of less than 300 percent of FPL, inadequate formulary, and waiting lists.

➤ **One Million Living with HIV/AIDS At Home Demands Strong National Commitment**

The CARE Act has played a central role in the significant decreases in HIV-related illnesses and deaths in the U.S. over the past decade. In urban, rural and suburban communities in every state and territory, the CARE Act delivers medical care, prescription drugs, and key support services to uninsured and underinsured people living with HIV/AIDS. Yet, despite this commitment by the federal government, far too many remain without access to quality HIV/AIDS care due to limited resources. CAEAR Coalition applauds the bipartisan nature of the Subcommittee's June 23rd hearing and the important role the hearing is playing in energizing the Congress and the Administration to complete this critical reauthorization by the September 30th deadline. CAEAR Coalition will continue to work with the committees of jurisdiction and the Administration to ensure that the CARE Act addresses the needs of all communities impacted by HIV/AIDS.

For more information on CAEAR Coalition, visit <www.caeear.org>.

ⁱ Office of Management and Budget, *Department of Health and Human Services, Part Assessments*.

ⁱⁱ Abramson, D., et al., *Assessing the Impact of the Ryan White CARE Act on Health Outcomes in New York City: Executive Summary*, 2001.

ⁱⁱⁱ Gardner, Lytt I., et al., "Efficacy of a brief case management intervention to link recently diagnosed HIV-infected persons to care," *AIDS*, Vol. 19, No. 4, 2005.

^{iv} Cunningham, W. E., et al., "The Impact of Competing Subsistence Needs and Barriers on Access to Medical Care for Persons with Human Immunodeficiency Virus Receiving Care in the United States," *Medical Care*, Vol. 37, No. 12, 1999.

POLICY RECOMMENDATIONS FOR REAUTHORIZATION OF THE RYAN WHITE CARE ACT

Summary of Recommendations

(The full recommendations are available at www.caear.org or www.aidsaction.org)

Emergency Designation **Recommendation #1:** Continue to fund the Ryan White CARE Act as an AIDS Emergency Relief Act.

Title I Resource Allocation **Recommendation #2a:** Base Title I formula allocations on the number of persons reported to be living with AIDS adjusted for reporting delays within an Eligible Metropolitan Area (EMA), instead of the current “ten-year weighted AIDS case band.” Require the Centers for Disease Control and Prevention (CDC) to develop a national HIV/AIDS case data set from name- and non-name-based reporting systems and inclusive of all reported living HIV cases and, starting in FY 2007, base Title I formula awards on the number of persons reported to be living with HIV and AIDS adjusted for reporting delays. Maintain the protection-period provision for Title 1 formula allocations, applying percentages of 96, 92, 88, 84, and 79 over the course of five consecutive years of need beginning in the first year the protection period applies.

Recommendation #2b: Change the Title I EMA eligibility criteria from 2000 AIDS cases over the past five years to 1,500 estimated living AIDS cases adjusted for reporting delays. Starting in FY 2007, base EMA eligibility on living HIV and AIDS cases adjusted for reporting delays at a threshold determined to be equivalent to the 1,500 living AIDS case threshold.

Changing the EMA threshold will result in two to four new Title I jurisdictions previously funded through the top tier of the Title II Emerging Communities program. Accordingly, eliminate the top tier and transfer its \$5 million allocation to the Title I appropriated line item. Provide additional new funding for Title I to minimize potential funding reductions to continuing EMAs and support the addition of the new EMAs.

Recommendation #2c: Revise Title I EMA boundaries to be consistent with the most recent Combined Statistical Area (CSA), Metropolitan Statistical Area (MSA) or Metropolitan District (MD) boundaries, using whichever one most closely approximates the boundary of the existing EMA.

Recommendation #2d: Establish, by the end of FY 2006, objective, comparable, measurable and weighted indices to determine severity of HIV need for use in determining Title I supplemental allocations.

Unduplicated Service Data **Recommendation #3:** Make it a goal of the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau to develop a national, unduplicated, client-level data system.

Core Services	<p>Recommendation #4a: Continue support of jurisdictional level flexibility and accountability to determine the appropriate mix of HIV health care and supportive services, taking into account the local assessment of unmet and continuing needs and the availability of other resources.</p> <p>Recommendation #4b: Maintain the current list of allowable services as described in the Ryan White CARE Act.</p> <p>Recommendation #4c: Do not include a mandated set of Title I services, percentage set-asides for specific services, or limitations on the amount of funding that can be allocated at the jurisdictional level for an eligible service.</p>
Title I HIV Health Services Planning Council	<p>Recommendation #5: Maintain the requirement that at least 33 percent of planning council members be persons living with HIV/AIDS and consumers of Title I services. Allow non-aligned consumers to retain their status for the remainder of the year if they become aligned to a funded entity by employment or board affiliation. Require planning councils to report annually on the demographic status of their memberships and ensure compliance with HRSA HIV/AIDS Bureau guidance.</p>
Improving Accountability for Evaluation and Technical Assistance Funds at HRSA	<p>Recommendation #6: Require the HRSA HIV/AIDS Bureau to provide an annual report on the uses of the two percent evaluation tap and one percent technical assistance tap.</p>
Title III Consumer Input	<p>Recommendation #7: Require Title III grantees to demonstrate that they have a mechanism for documented consumer input by documenting the process, the recommendations provided, and the outcomes of these recommendations.</p>
Enhancing Federal Coordination	<p>Recommendation #8a: Provide a mechanism to rapidly resolve conflicting practices between federal agencies or departments coordinating with the HRSA HIV/AIDS Bureau.</p> <p>Recommendation #8b: Require HRSA HIV/AIDS Bureau and Centers for Medicare & Medicaid Services (CMS) leadership to assess the coordination of Ryan White CARE Act programs and state Medicaid programs.</p> <p>Recommendation #8c: Do not penalize a Title EMA in its grant if its HIV health services planning council has been unable to fulfill its obligation to include the State Medicaid Agency and the agency administering the program under part B, but has shown documented due diligence in its attempt to fulfill this obligation.</p> <p>Recommendation #8d: Maintain existing parameters for Early Intervention Services and other collaborations outlined in the Ryan White CARE Act.</p>

Recommendation #8e: Expand existing language to direct biennial consultation between the Departments of Health and Human Services and Veterans Affairs. Encourage Title I HIV health services planning councils to include representation from the local VA facilities in their membership and maintain VA facilities' eligibility for Ryan White CARE Act funds.

AIDS Education and Training Centers

Recommendation #9: Reauthorize and continue funding the AIDS Education and Training Centers.

Oral Health Services

Recommendation #10a: Reauthorize the HIV/AIDS Dental Reimbursement Program and the Community-Based Dental Partnership Program as separately funded programs.

Recommendation #10b: Maintain current eligibility criteria for grantees in the HIV/AIDS Dental Reimbursement Program.

Recommendation #10c: Maintain the retrospective reimbursement system in the HIV/AIDS Dental Reimbursement Program with a requirement that providers document that clients served are living with HIV disease.

Recommendation #10d: If additional funding is appropriated, additional accredited dental schools should be encouraged to apply for community-based partnership grants, while communities that lack an accredited dental school should be eligible to apply for these grants independently.

Recommendation #10e: Permit HIV/AIDS Dental Reimbursement Program grantees to utilize Ryan White CARE Act funds to participate in Ryan White CARE Act grantee meetings.

Price of Pharmaceuticals

Recommendation #11: Direct the Secretary of Health and Human Services to ensure that Ryan White CARE Act programs receive the lowest price available to the federal government for pharmaceutical products, unless otherwise negotiated at a lower rate.

Infrastructure and Capacity Expansion Program

Recommendation #12: Expand Part F to include the “Infrastructure and Capacity Expansion Program” to be funded through a new appropriation line item with such sums as may be necessary. This program should be used expressly to provide resources to help organizations and jurisdictions serving medically underserved minority, rural, and urban communities build the infrastructure and capacity they need to improve HIV/AIDS care in underserved communities.

The following recommendations do not require legislative changes to the Ryan White CARE Act, but do require administrative action or Congressional action in other areas.

Title III

Recommendation #13a: Establish a formal plan to ensure that HIV/AIDS care is identified as a core component of health care services to be provided by 330 Clinics and other Federally Qualified Health Centers. Establish greater collaboration between the HRSA HIV/AIDS Bureau and the Bureau of Primary Health Care to reduce barriers that prevent community-based HIV service providers from successfully competing to become 330 Clinics and Federally Qualified Health Centers.

Recommendation #13b: Instruct the HRSA HIV/AIDS Bureau to be flexible in their initial agency capacity assessment to determine which capacity building grant category an agency is best suited to apply for based on their developmental stage.

Recommendation #13c: Make widely known the availability of technical assistance from Title III programs and HRSA in the development of unique, effective service delivery models.

Recommendation #13d: Strengthen the HIV care infrastructure of Title III programs by directly funding existing and new Title III projects in rural and medically underserved areas, and those in smaller communities.

Recommendation #13e: Direct HRSA to work collaboratively with the CDC to implement CDC's Advancing HIV Prevention Initiative.

Recommendation #13f: Support continued use of Minority AIDS Initiative (MAI) resources to expand the number of planning and capacity building grants, as well as early intervention services grants, targeted to culturally competent organizations with a history of serving minority communities.

Recommendation #13g: Establish a process to inform Title III grantees when organizations within their respective states are awarded planning and capacity building grants.

Minority AIDS Initiative

Recommendation #14: Preserve the MAI to address the development, implementation and provision of high quality care to underserved populations. Maintain the existing MAI structure, increase appropriations to the MAI, and maintain MAI allocations through existing Ryan White CARE Act Titles. Do not use MAI funds to supplant other HIV/AIDS resources at the local level.

Federal Coordination

Recommendation #15: Encourage direct collaboration between local care and prevention planning bodies and require care planning bodies to work with their local prevention counterpart to conduct a joint assessment of the merits and challenges of collaboration and establish a plan for future coordination.