CAEAR Coalition Response to HHS Ryan White CARE Act Reauthorization Principles

Reauthorize the Ryan White CARE Act Now!

"Secretary Leavitt's release of the Administration's Ryan White CARE Act reauthorization principles is an important step in moving the legislative process forward. CAEAR Coalition remains committed to working with its partners in the Administration, in Congress and in the HIV/AIDS services community to assure a CARE Act reauthorization that respects the history of successful service of this legislation while responding to the current critical medical and supportive service needs of people living with HIV/AIDS."

Patricia Bass, Chair, CAEAR Coalition

CAEAR Coalition's recommendations for Ryan White CARE Act reauthorization promote an enhanced response to the domestic HIV/AIDS epidemic in our most vulnerable communities. Leading this response, CARE Act Title I eligible metropolitan areas (EMAs) and Title III clinics in highly impacted communities, as well as in areas of emerging need, continue to be on the front line, providing comprehensive services for uninsured and underinsured people living with HIV/AIDS. These safety-net providers must be strengthened over the next five years, while enhancing the nationwide foundation that the CARE Act has built over the last fifteen years.

HHS Principle: "The President has made fighting the spread of HIV/AIDS a top priority of his Administration, and he will continue to work with Congress to support effective prevention and compassionate care and treatment."

CAEAR Coalition Response: CAEAR Coalition affirms the Bush Administration's focus on the domestic HIV/AIDS epidemic and its efforts to reduce new HIV infections and respond to the significant unmet HIV-related health care needs of people living with HIV/AIDS throughout the United States. CAEAR Coalition remains committed to working with Secretary Leavitt and other members of the Administration to reauthorize the CARE Act by maintaining its historic role in providing access to primary medical care, supportive services and life-extending medications. [CAEAR Coalition's complete "Policy Recommendations for Reauthorization of the Ryan White CARE Act, 2005" are available at www.caear.org.]

The CARE Act works and its effectiveness is well documented. The CARE Act has played a key role in reducing morbidity and mortality associated with HIV disease in communities across the U.S., which has resulted in more people living longer with HIV and AIDS than ever before. The CARE Act must be reauthorized in this session of Congress to ensure that the continuity of care for thousands of people living with HIV/AIDS is not threatened.

Unfortunately, flat funding of the CARE Act over the last five years has undermined the ability of urban, rural and suburban communities in every state and territory to maintain health care access for uninsured and underinsured people living with HIV/AIDS. Whatever changes are made to the CARE Act in the

reauthorization process, additional resources are necessary to ensure access to critical HIV care, treatment and support services throughout the country. We strongly urge the Administration to prioritize the CARE Act for additional funding to demonstrate the President's commitment to fighting this epidemic.

HHS Principle: "In order to make the legislation more responsive going forward, especially for African-American and other minority communities who disproportionately suffer from the disease, the Administration is proposing the following principles for reauthorization."

CAEAR Coalition Response: CAEAR Coalition appreciates the Administration's intent to focus on those most disproportionately impacted by HIV/AIDS, particularly African Americans and other communities of color most in need. As the U.S. HIV/AIDS epidemic evolves and expands, hard-hit urban areas continue to bear the greatest burden of caring for and treating the majority of African Americans and other underserved minority populations living with HIV/AIDS. Health care providers in America's cities will continue to require the commitment of significant resources and attention to their HIV care infrastructures and service capacities to provide high-quality HIV services to the ever-increasing number of individuals entering the care system. Resources must also be available to confront the emerging challenge of providing quality health care in the country's small and medium-sized cities. Additionally, the nation faces a severe challenge as the HIV/AIDS epidemic expands to rural communities, where quality health care of all types is often difficult to access without significant travel. Quality health care and access to care are compromised when state or local governments do not commit resources to augment federal funding to ensure the quality and appropriate standard of care for those in need. Sadly, there are numerous communities--rural, suburban and urban--where people living with HIV/AIDS do not have access to high-quality and culturally competent HIV care due to insufficient resources from all sources. These same communities also frequently lack community-based organizations with the resources, commitment and cultural expertise to provide that care. The CARE Act can and should play a role in solving these problems. However, these problems are not entirely related to HIV disease and will require concerted efforts from state and local governments to recommit their resources and attention.

To strengthen the CARE Act, CAEAR Coalition recommends:

- Funding for existing and new Title III projects to provide high-quality, community-based primary care to low-income, underserved and underinsured populations living in our rural and underserved areas should continue to be prioritized—continuing a policy established in the 2000 reauthorization, which has led to an expansion of care in those communities and significantly reduced the funding disparity between states with Title I EMAs and those with more dispersed epidemics;

- Creation of an "Infrastructure and Capacity Expansion Program" to provide resources to assist underserved communities and community-based organizations in those communities in providing high-quality medical and supportive services to rural and urban communities serving underserved minority populations. Provision of these resources would build the organizational infrastructure and HIV service capacity in underserved communities;

- Preservation of the Congressional Minority AIDS Initiative to address the development, implementation and provision of high-quality care by indigenous, culturally competent organizations to underserved minority individuals living with HIV/AIDS;

- Changing the Title I EMA eligibility criteria from 2,000 AIDS cases over the past five years to 1,500 living AIDS cases adjusted for reporting delays; and

- Starting in FY 2007, base Title I 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. With the eligibility criteria change to living AIDS cases and then living HIV/AIDS cases, all existing EMAs would maintain their EMA status even if their caseloads do not reach the new thresholds.

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, to provide resources to cities with emerging needs, CAEAR Coalition recommends eliminating the top tier of the Emerging Communities program and transferring its $5 million allocation to the Title I appropriated line item, which will provide additional new funding for Title I to minimize potential funding reductions to continuing EMAs and support the addition of the new EMAs.

HHS Principle: "To address the needs of these [low income and minority] populations, the Secretary of Health and Human Services (HHS) would develop a 'severity of need' for core services index (SNCSI). This index would be based upon objective criteria and be focused on core services. It would take into account not only HIV incidence, but levels of poverty, availability of other resources including local, state, and federal programs and support, and private resources. This SNCSI would determine formula allocations among states and eligible metropolitan areas. When combined with a requirement of maintenance of effort on the part of state and local governments, the SNCSI would address the differences in HIV/AIDS care."

CAEAR Coalition Response: CAEAR Coalition agrees that CARE Act funds should serve those living with HIV/AIDS who have the greatest unmet need for HIV care. CAEAR Coalition is prepared to work with the Administration to develop indices for the "severity of need index" that meet this important goal. CAEAR Coalition opposes the use of a Severity of Need for Core Services Index that would punish local and state governments that have prioritized their tax levy resources to support HIV/AIDS care and reward localities and states that have not made HIV/AIDS care a priority. CAEAR Coalition opposes any effort to transfer resources from one region to provide short-term and misguided solutions to funding shortfalls that can and should be resolved by increases in federal appropriations. CAEAR Coalition also opposes any effort to tie federal funding levels to the amount of private resources that have been donated by citizens or foundations to support HIV/AIDS care locally.

Any indicators used to distribute resources nationally must be standardized and comparable between all EMAs and states. In attempting to identify appropriate indices for funding distribution, the confounding differences in data collection from state to state and locality to locality must be addressed. Indices should not be subject to factors with high levels of fluctuation such as the amount of private resources donated by individuals to HIV/AIDS efforts in a community or state.

To strengthen the CARE Act, CAEAR Coalition recommends:

- Establishing, 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;

- Modernizing the criteria for allocating Title I funds by basing funding levels and metropolitan area eligibility on living AIDS cases corrected for late reporting and then living HIV/AIDS cases (2007); and

- Revising Title I boundaries to reflect OMB guidelines to be consistent with the most recent Combined Statistical Area (CSA), Metropolitan Statistical Area (MSA) or Metropolitan District, using whichever one most closely approximates the boundary of the existing EMA. In those instances when OMB recommendations would subsume an existing Title I EMA into another EMA, the affected EMAs would remain stand alone and maintain their jurisdictional boundaries as of Fiscal Year 2005 for CARE Act formula funding allocation and planning processes for HIV health services. The Chief Elected Official of affected EMAs would maintain all rights, duties and responsibilities conferred by the CARE Act.

HHS Principle: "Require that 75 percent Of Ryan White funds In Titles I-IV be used for Core Medical Services so that federal funds are first used to support life-saving services for the most impoverished Americans. A person living with HIV/AIDS receives benefits from a range of services. Some of these are clearly life prolonging and essential to maintaining physical and mental health; others are not. Services that are essential (core services) should be prioritized for Federal funding.

CAEAR Coalition Response: CAEAR Coalition agrees that essential medical care, treatment and supportive services should be prioritized for funding. Existing data confirms that over 50 percent of CARE Act funds support a continuum of primary health care services, clear evidence that "core services" are already prioritized through well-established local and state needs assessment and planning processes.

CAEAR Coalition opposes the establishment of an inflexible percentage of CARE Act resources targeted to any single service or set of services. Flexibility and local control are hallmarks of the successful community-based response to the AIDS epidemic, which has resulted in decreases in morbidity and mortality from HIV/AIDS-related causes. Establishing hard expenditure percentages within CARE Act awards would undermine the coordinated use of other funding streams, some of which are dedicated specifically to the core services identified by the Administration. Local citizens, closest to the epidemic in their community, have the best understanding of the unfunded needs of people living with HIV/AIDS in their community and should maintain their roles in needs assessment and service planning. Additionally, establishing hard percentages on expenditures of CARE Act funds would result in CARE Act resources being the funds of first resort, not last, because grantees would be required to expend CARE Act resources without regard to other resources available in the community.

Currently, states and local communities coordinate CARE Act funds with other available funding streams to provide a comprehensive system of HIV medical and supportive services. OMB and GAO analyses have determined that CARE Act services have increased the number of people with HIV/AIDS receiving primary medical care and treatment, contributed to the decline of HIV/AIDS cases and deaths, reached underserved groups of infected individuals, including the uninsured and the poor, and served African Americans, Hispanics and women in higher proportions than their representation in the AIDS population. Those receiving primary medical care and support services through CARE Act-funded providers are 40-90 percent more likely to report appropriate medical care, including access to anti-HIV medications. The CARE Act works by allowing communities to provide the full-range of medical and support services required for people to access and remain in care. However, these CARE Act successes will not be possible if arbitrarily

drawn percentages prevent individual HIV/AIDS patients from receiving the services they require to keep them healthy and in care.

To strengthen the CARE Act, CAEAR Coalition recommends:

- Continuing support of jurisdictional flexibility and accountability to determine the appropriate mix and level of resources allocated to provide HIV health care and supportive services, taking into account the local assessment of unmet needs and the availability of other resources;

- Maintaining the current list of allowable services as described in the current CARE Act; and

- Not including a mandated set of Title I services percentage set-aside for specific services, or limitations on the amount of funding that can be allocated at the jurisdictional level for an eligible service.

HHS Principle: "The HHS Secretary will develop and maintain a list of core ADAP drugs based upon those included in the U.S. Department of Health and Human Service's Public Health Service HIV/AIDS Clinical Practice Guidelines for use of HIV/AIDS Drugs, drugs needed for the treatment and prophylaxis of opportunistic diseases and drugs needed to manage symptoms associated with HIV infection. These medications should be prioritized for Federal funding."

CAEAR Coalition Response: CAEAR Coalition supports the Administration's goal to provide life-saving HIV/AIDS medications to all who require them. However, CAEAR Coalition is concerned that a standardized federal formulary, without a significant infusion of new resources, will be interpreted by states as a ceiling, not a baseline, on pharmaceutical access and, as a result, hard-won successes at the state level to expand ADAP formularies will be compromised.

To strengthen the CARE Act, CAEAR Coalition recommends: Directing the Secretary of HHS to ensure that CARE Act programs receive the lowest price available to the federal government for pharmaceutical products, unless otherwise negotiated at a lower rate.

HHS Principle: "States will be encouraged, upon receipt of their Ryan White allocations, to adopt various important HIV prevention strategies, such as routine opt out HIV testing, contact tracing, and the recommendations of the CDC Advancing HIV Prevention Initiative."

CAEAR Coalition Response: CAEAR Coalition supports expanded HIV prevention efforts that enhance the number of individuals who know their HIV status and use that information to reduce risks to their health and the health of others, while ensuring protection of personally identifiable health information. Additionally, it is critical that scarce CARE Act resources continue to fund care and treatment linked to HIV counseling and testing without supplanting local, state and federal HIV prevention funding.

HHS Principle: "Maintain the current statutory requirement that all states submit HIV data by the start of Fiscal Year 2007. Having a full picture of the scope of HIV is critical to successful care and treatment programs that prevent people from advancing to AIDS; because newer infections are increasingly likely to

take place among minorities, this provision will better target funds to heavily impacted communities and aid in getting people into care sooner."

CAEAR Coalition Response: CAEAR Coalition has supported the inclusion of HIV data in funding formulas for both Title I and Title II. However the transition to these systems will take several years to mature and provide data accurate enough to be included in a national HIV data set. CAEAR Coalition believes that the good faith efforts of code-based states to respond to the CDC should be acknowledged and the implementation date of 2007 be adjusted to a later date.

To strengthen the CARE Act, CAEAR Coalition further recommends:

- Basing Title I formula allocations on the number of persons reported to be living with AIDS adjusted for reporting delays within an EMA, instead of the current "ten-year weighted AIDS case band"; and

- When a national HIV data set inclusive of data from all states is available, Title I formula awards should be based on the number of persons reported to be living with HIV and AIDS adjusted for reporting delays.

HHS Principle: "Hold grantees accountable for reporting on system and client-level data and progress. Accurate counts of those served and those receiving core services will help better serve those in need, as well as enable caregivers to define performance measures and evaluate progress."

CAEAR Coalition Response: CAEAR Coalition has always supported the establishment of client-level data systems that can be used to target resources to individuals most in need. However, establishing a national client-level data system that ensures both an appropriate level of confidentiality for medical records and the ability to be cross-referenced within and between states is an expensive and daunting administrative and logistical task. Grantees must be guaranteed additional resources so that the development, testing and launching of national client-level data system does not use scarce resources currently devoted to providing care. For example, HRSA currently "taps" three percent of CARE Act appropriations for program evaluation and technical assistance.

To strengthen the CARE Act, CAEAR Coalition recommends: The development of a national unduplicated client-level data system for CARE Act programs along with the additional resources to support those systems.

To strengthen the CARE Act, CAEAR Coalition further recommends: Requiring HRSA to provide an annual report on the uses of the two percent program evaluation tap and one percent technical assistance tap from CARE Act appropriations.

HHS Principle: "Maximize investments through stronger and more specific payer-of-last resort provisions and require grantees to seek alternative payment sources before using Ryan White Funds."

CAEAR Coalition Response: CAEAR Coalition recognizes the CARE Act as the payer of last resort and supports this provision. The loss of state revenues threatens every state Medicaid program's capacity to ensure adequate coverage to eligible individuals and many state Medicaid programs have terminated initiatives that placed staff at community health center sites to help patients determine if they were Medicaid

eligible. However, requiring that set percentages of CARE Act funds be used in specific ways, without regard for the availability of other funding streams, undermines this provision. In practice, mandated percentages for services within CARE Act grants will guarantee that CARE Act funds are utilized first, not last, to meet the percentage mandate.

HHS Principle: "A coordinated effort between the states, cities, and other care providers is essential to effective, comprehensive care and prevention services. HHS would consult with state AIDS officials on discretionary grants and would provide to state AIDS officials all information necessary for states to coordinate HIV care and treatment with other federally funded projects to maximize efficiency and effectiveness of AIDS services."

CAEAR Coalition Response: CAEAR Coalition opposes any provision that undermines Title I and Title III grantees' autonomous local control and decision-making over approved grant resources. Partnerships between states and cities have been essential to the success of CARE Act services. The current Statewide Coordinated Statement of Need (SCSN) process requires collaboration and coordination between the states, local governments and directly funded grantees to establish a comprehensive statewide plan for the provision of HIV care and treatment. HIV care and treatment should be planned for and implemented at the local level, closest to service delivery. The partnership between HRSA and directly funded community based providers assures flexibility in responding to changes in needed medical services and emerging co-morbidities within the HIV/AIDS epidemic, such as TB, STDs, and Hepatitis C virus. CAEAR Coalition opposes any efforts to centralize control over decision-making, funding distribution and service delivery at the state level.

To strengthen the CARE Act, CAEAR Coalition recommends:

- Providing a mechanism to rapidly resolve conflicting practices between federal agencies or departments coordinating with the HRSA HIV/AIDS Bureau;

- Requiring HRSA HIV/AIDS Bureau and Centers for Medicare & Medicaid Services (CMS) leadership to assess the coordination between the administration of the CARE Act and state Medicaid programs;

- Maintaining existing parameters for Early Intervention Services Title III grantees and other collaborations outlined in the CARE Act;

- Directing HRSA to work collaboratively with the CDC to implement CDC's *Advancing HIV Prevention* initiative;

- Directing biennial consultation between the Departments of Health and Human Services and Veterans Affaires and encouraging Title I Planning Councils to include representation from the local VA facilities in their membership and maintain VA facilities eligibility for CARE Act funds; and

- Eliminating penalties in an EMA's Title I grant awards if the Title I Planning Council has not fulfilled its obligation to include the State Medicaid Agency and the agency administering the program under Part B, if it has shown documented due diligence to meet the obligation.

HHS Principle: "Currently, in major metropolitan cities, AIDS cases are counted once as part of a city count and a second time in the overall state count. Therefore, HIV/AIDS cases in major metropolitan cities are counted twice. In an effort to ensure that every AIDS case is counted equally and to make sure that Federal funds are distributed fairly to those most in need of assistance, we must eliminate this double counting."

CAEAR Coalition Response: CAEAR Coalition opposes any effort to shift resources from people with HIV/AIDS living in high HIV prevalence states and urban centers where the majority of people diagnosed and living with HIV/AIDS still come to receive their care and treatment. The principle above would not resolve the issue of disparities between unmet needs and available resources. Rather, it would severely harm states and localities that continue to be hardest hit by the HIV/AIDS epidemic by shifting funds away from these states to those states with more dispersed epidemics. Title I EMAs account for more than 70 percent of all living AIDS cases and Title I EMA states account for 87 percent of all living AIDS cases. CARE Act Title II formula funding in states with one or more Title I EMA is used to respond to the disproportionate burden of HIV care required of state public health departments in those states.

The notion that certain cases are counted twice is misleading because it refers to the fact that AIDS cases located in Title I EMAs are counted in the Title I funding formula as well as the Title II base (non-ADAP) funding formula. However, these cases are not "double counted." In reality, the Title II state base funds receive partial credit for cases in EMAs, in recognition of the role of states in coordinating a statewide response to the epidemic and in complying with numerous CARE Act mandates related to coordination among CARE Act titles and statewide planning requirements. The application of this principle to the Title II base formula would tie the allocation of states with Title I EMAs solely to non-EMA cases, resulting in dramatic and severe reductions to the capacity of state public health departments to provide basic HIV services to current clients. Eighteen states with Title I EMAs would lose more than $76 million in Title II base funding despite the fact that Title I EMA states have more people living with HIV/AIDS than ever before. These states should not be penalized at a time when they are responsible for providing publicly funded HIV drugs, medical care and supportive services to the majority of people living with HIV/AIDS in the U.S., especially uninsured and underinsured African Americans and other minorities.

HHS Principle: "Eliminate current provisions that entitle cities to be "held harmless" in funding reductions."

CAEAR Coalition Response: CAEAR Coalition opposes the elimination of the hold harmless provision and calls for it to be maintained in light of the significant changes being proposed and the unknown impact these changes, enacted simultaneously, would have on the ability of jurisdictions to maintain their current levels of care and treatment. The 1996 amendments to the CARE Act included a protection-period provision in the Title I formula to phase-in potential funding reductions as AIDS caseloads decreased in some jurisdictions in proportion to other localities in order to prevent the rapid destabilization of existing health care systems, while concurrently expanding resources to areas with emerging HIV/AIDS epidemics. The phased-in protection-period funding reductions were revised in the 2000 amendments to the CARE Act to guarantee that no Title I community would lose more than a total of 15 percent of its formula funding relative to Fiscal Year 2000 and those reductions are spaced out over the five-year authorization period. However, over the last five years, Title I appropriations have been *reduced* even as the number of uninsured and underinsured people living with HIV/AIDS has *increased*. The funding disparities among EMAs that would have been reduced with additional Title I resources have instead been exacerbated by funding cuts, thereby undermining the original goal for the protection-period provision.

CARE Act funds go to providers of services, ensuring establishment of resources for high-quality, culturally relevant medical care and supportive services. Fluctuation and shifts from year to year in HIV/AIDS population counts can have a destabilizing effect on care in some areas. For this reason, the CARE Act historically has phased-in such reductions more gradually. To increase the CARE Act's responsiveness, CAEAR Coalition has joined with its national partners in the HIV/AIDS community to forge a consensus position that would accelerate the reductions for jurisdictions receiving protection as a result of the "hold-harmless" provision in an effort to ultimately eliminate the need for protection. CAEAR Coalition agrees with Senator Tom Coburn (R-OK) who emphasized in a recent Senate hearing on CARE Act reauthorization that shifts in formula funding must be implemented in a way that "minimize(s) harm to existing systems of care."

To strengthen the CARE Act, CAEAR Coalition recommends: Adjusting the current protection-period provision for Title I formula grant allocations by applying percentages of 96, 92, 88, 84, and 79 (21% reduction) over the course of five consecutive years beginning in the first year the protection period applies.

HHS Principle: "Allow the secretary of HHS to redistribute unallocated balances based on need as determined by severity of need measures. To maximize all Ryan White funding, unspent funds from Titles I and II would revert to the Secretary of HHS for discretionary reprogramming to state ADAP programs with the greatest need."

CAEAR Coalition Response: Uninsured people living with HIV/AIDS continue to endure significant unmet HIV health care needs throughout the U.S. Emergency resources appropriated into the CARE Act by Congress to provide HIV/AIDS medical and supportive services should not be returned to the General Treasury because states and EMAs are unable to expend their allocations within any given fiscal year. CAEAR Coalition supports the principle that un-obligated resources should be available for reprogramming to cities and states that can demonstrate that, despite significant participation from state and local governments, they continue to have unmet needs within ADAPs and other HIV-related health care services.

HHS Principle: "Allow Planning Councils To Serve As Voluntary And Advisory Bodies To Mayors. State and local officials need maximum flexibility to respond to the epidemic and to direct funding to those in greatest need. Planning councils would be structured at the discretion of the mayor; could not have conflicts of interest; and would no longer be required to set priorities for spending."

CAEAR Coalition Response: CAEAR Coalition opposes elimination of the determinative authority of local community planning councils over service prioritization and funding allocations to those services. Planning Councils are essential to ensuring that CARE Act-funded services are responsive to the needs of uninsured and underinsured people living with HIV/AIDS in their specific communities. The AIDS epidemic in the U.S. is comprised of hundreds of smaller epidemics, each with its own unique demographic characteristics, available funding streams and unmet needs. Local needs assessment processes, such as focus groups of CARE Act clients, town hall meetings with disproportionately impacted communities, epidemiologic profiles and key informant interviews with health care providers, are essential to effective community planning. The planning councils' role in analyzing unmet needs in their communities and determining funding priorities has been central to the success of the CARE Act and should be maintained.

To strengthen the CARE Act, CAEAR Coalition recommends:

- Maintaining local flexibility and accountability to determine the best combination of HIV health care and supportive services to meet local unmet, continuing needs and the availability of other resources;

- Maintaining the requirement that at least 33 percent of planning council members be persons living with HIV/AIDS and consumers of Title I services;

- Allowing 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;

- Requiring planning councils to report annually on the demographic status of their memberships and ensure compliance with HRSA HIV/AIDS Bureau guidance; and

- Encouraging the direct collaboration between local care and prevention planning bodies and requiring 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.

For more information, contact CAEAR Coalition at 202-789-3565 or through www.caear.org.

---

[i] Government Accountability Office, *HIV/AIDS: Use of Ryan White CARE Act and Other Assistance Grant Funds*, 2000.
[ii] Office of Management and Budget, *Department of Health and Human Services, Part Assessments*.
[iii] Abramson, D., et al., *Assessing the Impact of the Ryan White CARE Act on Health Outcomes in New York City: Executive Summary*, 2001.
[iv] Fleming, P., et. al., "HIV Prevalence in the United States, 2000," 9th Conference in Retroviruses and Opportunistic Infections, Abstract #11, Oral Abstract Session 5, 2002.
[v] McNaughten, A., et al., "Factors Associated with Immunologic Stage at which Patients Institute Antiretroviral Therapy," 9th Conference in Retroviruses and Opportunistic Infections, Poster Abstract, 473 M, 2002.
[vi] Institute of Medicine, *Confronting Racial and Ethnic Disparities in Health Care,* 2003.