



MEMORANDUM

To: Health Transition Team
From: Jen Kates
Re: Recommended Short-Term DHHS Policy Actions on Domestic HIV
Date: December 15, 2008

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This memo recommends several key, short-term (first 100 days) policy actions that could be pursued by the Obama Administration to address the domestic HIV epidemic, and which are under the purview of the Department of Health and Human Services. It does not include short-term actions that are under the purview of other federal departments (e.g., the Department of Justice); actions that Congress would need to undertake (e.g., expansion of Medicaid eligibility to low-income people with HIV prior to disability); longer-term actions; or actions needed to bolster our global HIV/AIDS response (see separate memo). More information can be provided in all these areas upon request and *AIDS in America* and the *National HIV/AIDS Strategy Framework*, released by members of the AIDS community also provide these and other recommendations.

1. Fast Track Creation of First National HIV/AIDS Strategy, New Position of National HIV/AIDS Coordinator, New Coordinating Office (note – while this is a broader action than DHHS, DHHS will most likely play lead role).

Background: There has never been a coordinated, national strategy or plan to address the domestic epidemic, and there remains little coordination across the more than ten federal agencies that operate domestic HIV programs – this is despite the fact that such a strategy is recommended by the UN's *Declaration of Commitment and Three Ones Principles*, both of which have been signed onto by the U.S. It is also central to the U.S. global AIDS response, not just for how the USG organizes itself, but in terms of what it expects from recipient nations. The absence of a strategy prompted a large coalition of AIDS organizations to advocate for one, the Congress to pass a concurrent resolution in September calling for one, and the President-elect to state his intention to develop one.

Action: While developing a full-scale plan will take time, President-elect Obama could restate his intention to develop a plan, outline the process that will be undertaken, begin to talk about goals, funding, and new position of a coordinator who will be sufficiently vested with the authority to coordinate funding and programs across agencies (modeled after the Office of the Global AIDS Coordinator). It will be critical to underscore that the strategy will be very focused on addressing the epidemic's disproportionate impact on racial and ethnic minorities and on gay and bisexual men of all races.

Issues: This is generally a win-win to push on, but there will be challenges related to selection of a Coordinator and where the Coordinator position and new office should be located (White House or Department) – regardless of where, the Coordinator must have authority to control and coordinate funding and programs, and this will need to be carefully managed with the agencies that operate programs and funding streams. It will also be important for this new national office to work in close partnership with the states, who are front and center in the response but have largely been left out of the national picture.

2. Include Increased Funding for Key, Neglected, Domestic HIV Programs in FY 2010 Budget Request

Background: While funding for all domestic programs (HIV and non-HIV) is clearly part of a larger discussion and context, there are a subset of domestic HIV programs that have been particularly neglected: Ryan White which has been essentially flat funded for years; and prevention funding at CDC which has decreased by 4% since FY 2002 to \$754 million in FY 2008 (representing only 4% of the federal AIDS budget). Both of these programs form the bulk of the discretionary part of the domestic response; the lack of investment in prevention has been especially problematic (and many believe it is one of the main reasons why incidence cannot be further reduced and disparities continue). After CDC released its new incidence estimates in August, the House Committee on Oversight and Government Reform requested it provide a professional judgment budget of what would be needed to fully implement effective HIV prevention in the U.S. estimated by CDC to require an additional \$877 million in FY 2009 (\$4,784 million over 5 years).

Action: Include increase for Ryan White and CDC in the FY 2010 budget request. On Ryan White, the AIDS community has recommended at least \$2.8 billion. For CDC, use its professional judgment budget.

Issues: The AIDS community has specific funding asks for all programs (I can provide those to you), and there will be focus on all of them, but these two are particularly important given their reach.



3. Renew Focus on Domestic HIV Prevention

Background: In addition to the lack of funding investment in domestic HIV prevention efforts, current policies have hampered prevention effectiveness. These include funding requirements and emphases on abstinence-only-until-marriage (in the Adolescent Family Life Act, Title V abstinence-only-until marriage program, and the Community-Based Abstinence Education), restrictions on sex education, mixed messages about the importance of condoms, and a ban on federal funding for syringe/needle exchange.

Action: Request increased funding for domestic HIV prevention (per #2 above); ensure significant emphasis on HIV prevention in discussion of National HIV/AIDS Strategy; do not request funding, or reduce amount of funding, for the three major abstinence programs and, in interim, require that all programs receiving such funding provide written assurances that they will not misrepresent or provide inaccurate information regarding the effectiveness and reliability of condoms; and announce creation of new funding stream for comprehensive sexuality education. Lifting the federal ban on funding for syringe/needle exchange programs in the U.S. will take Congressional action (although HHS could issue statement certifying its effectiveness).

Issues: Deemphasizing and reducing funding for abstinence-only programs, coupled with elevating the focus on comprehensive sex education and condom effectiveness, will continue to be controversial, particularly with some Members of Congress, and it will be important to consider how much political capital will need to be expended to make this shift in the short-term. This is even more of an issue for syringe/needle exchange which is best addressed as a longer term issue (not first 100 days) and will need to involve Congress directly.

4. Encourage State Medicaid Programs to Cover Routine HIV Screening

Background: Despite CDC recommendations that all adults (ages 13-64) be routinely screened for HIV in health care settings, and the fact that Medicaid already serves so many people with HIV and a significant share of those at risk for HIV, routine screening is an optional Medicaid service, and to date there has been no federal effort to make states aware of this recommendation and encourage them to coverage it.

Action: CMS should issue a letter to all Medicaid Directors informing them of the federal recommendation, recommending coverage of routine HIV screening, and reminding them that they will receive federal matching funds if covered.

Issues: No concerns here. Note: Medicare does NOT cover routine HIV screening but this would require a statutory fix (not as critical as short term priority).

5. Designate Antiretrovirals as Permanently Protected Drug Class Under Medicare Part D

Background: Medicare Part D legislation has, since its creation, required plans to cover at least two drugs per drug class and CMS has issued annual guidance further requiring plans to cover "all or substantially all" drugs in six key classes, including antiretrovirals. Congress recently sought to codify this policy (under P.L. 110-275) by establishing a process for the Secretary to designate drug classes for special protection, although there is concern that CMS will not extend the protection to all classes (let alone go beyond these classes).

Action: CMS should immediately issue guidance stating that all six classes, including antiretrovirals, are protected.

Issues: No major issues.

6. Permit ADAP Spending to Count Toward TrOOP Under Medicare Part D

Background: When Congress established the Medicare Part D program, drug spending by other government programs was prohibited from counting toward true out-of-pocket costs (TrOOP) but State Pharmacy Assistance Programs (SPAPs) were exempted from this requirement. The Administration interpreted the law such that ADAPs are not considered SPAPs and under current policy, any ADAP funding used for Medicare eligible people with HIV is not counted toward TrOOP, potentially leading to a situation where an individual can never reach the catastrophic coverage level and will continue to need to rely on limited ADAP funds.

Action: CMS should reinterpret the rules and immediately issue a determination that ADAPs qualify as SPAPs and their spending will count toward TrOOP.

Issues: No major issues.