# EXHIBIT C

## Arkansas HIV Community Advocates

Responses to Questions raised by Members of the House and Senate Interim Committees on Public Health, Welfare & Labor at the April 20, 2010 Session in response to Agenda Item E, "Improving the Response to HIV/AIDS in Arkansas"

May 20, 2010

1. *How many prisoners in Arkansas are HIV-positive?*

According to the U.S. Department of Justice, there were **118** inmates with HIV or AIDS in state and federal prison in Arkansas as of the end of 2008, comprising 0.9% of the prison population. Of those inmates, 40 were reported to have confirmed AIDS. (Source: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics Bulletin, HIV in Prisons, 2007-2008, published December 2009, Revised 1/28/10, accessed at http://bjs.ojp.usdoj.gov/content/pub/pdf/hivp08.pdf.

2. *How many people living with HIV/AIDS in Arkansas are covered by Medicaid?*

The quick answer is that we don't know, as Arkansas Medicaid does not have an easy way to determine which beneficiaries are HIV-positive (i.e., there is no list of beneficiaries who have HIV or AIDS). Medicaid would need to calculate this number by looking at a number of different factors, such as types of medications and lab tests submitted for reimbursement. This is a relatively complex task, and the Arkansas Department of Health has submitted a formal data request to Medicaid to get this information.

3. *What is the definition of "medically underserved"?*

The Health Resources Services Administration at the U.S. Department of Health and Human Services uses several different terms to designate healthcare access shortages: Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), and Medically Underserved Populations (MUPs). These designations are used as criteria for certain federal public health programs, such as National Health Service Corps scholarship and loan repayment programs, and federally qualified health center status. The following information is taken from HRSA's website (http://bhpr.hrsa.gov/shortage), which has detailed information on how the designations are determined:

HPSAs: There are three different types of HPSAs:

- geographic areas,
- population groups, and
- facilities (e.g., corrections facilities, public or nonprofit medical facilities).

There are different requirements for each designation. HPSAs may be designated as having a shortage of primary medical care, dental providers, or mental health providers. HPSA designations focus primarily on the ratio of health providers (primary care providers, dentists, or mental health providers) to size of population.

MUAs are geographic areas, rather than a population group or facility, and may consist of a whole county or a group of contiguous counties, a group of county or civil divisions, or a

group of urban census tracts in which residents have a shortage of personal health services. In determining MUA designation, HRSA uses the Index of Medical Underservice (IMU), which involves four variables:

- ratio of primary care physicians per 1,000 population,
- infant mortality rate,
- percentage of the population with income below the poverty level, and
- percentage of the population age 65 or over.

A service area with score of 62 or less is considered a MUA. MUAs consider more variables in determining the designation than HPSAs.

Service areas that don't meet MUA requirements may be considered MUPs, if there are unusual local conditions posing barriers to care access. MUPs may include groups of persons who face economic, cultural or linguistic barriers to health care.

1. *What is the cost of the SHARP report recommendations?*

The SHARP report recommendations can be divided in terms of recommendations that would involve law or policy changes, rather than significant cost, and those that would require some state or private investment. Among the former:

- Encouraging the Arkansas Congressional delegation to support passage of the federal Early Treatment for HIV Act and emergency supplemental funding for AIDS Drug Assistance Programs
- Revising state tax structures/policies/priorities
- Moving some surveillance functions under the jurisdiction of the HIV/STD/Hepatitis C Section Chief
- Changing state contract rules so that contracts can be amended more easily
- Improving communication and coordination among different state agencies serving the same client populations
- Requiring private health insurers to cover one voluntary HIV test annually for insured individuals age 13-64.
- Engaging faith community leaders in HIV education and anti-stigma efforts
- Requiring one hour of HIV-related continuing medical education (CME) credit every two years
- Requiring comprehensive, science-based health education in public schools

Some recommendations would require relatively little funding, such as establishing a Consumer Office at the ADH HIV/STD/Hepatitis C Section (approximately $50,000), and creating a public HIV education/anti-stigma campaign (approximately $25,000-$50,000, depending on the scale/scope of campaign). The Western North Carolina AIDS Project recently conducted an anti-stigma campaign in the Asheville area with a budget of approximately $22,000 (some private grant funding, and some in-kind donations of production help).

The recommendations that would require more significant investment are the ones that would improve access to care by expanding eligibility for health coverage, treatment, and supportive services (e.g., expanding Medicaid to cover low-income, pre-disabled, HIV-

positive individuals). The challenge with calculating real costs for these recommendations is that while there are "start-up" costs up front to getting people into care, those are offset by savings later on due to less use of more expensive medical interventions (like emergency room visits and inpatient hospitalizations). When people can access care and treatment earlier in their HIV disease, they can remain healthier and more productive (including working and paying taxes) for a much longer period of time.

We do have some general data on cost of care for people with more and less advanced HIV disease. It is approximately 2 ½ times more expensive to treat someone with advanced HIV disease; at the University of Alabama Birmingham clinic, treating the most ill patients cost approximately $36,500 annually, while treatment for healthier patients averaged $13,900. (Source: Saag, MS, *Opt-out testing: who can afford to take care of patients with newly diagnosed HIV infection?*, Clinical Infectious Diseases 2007:45 (Suppl 4); S261-265).

The Arkansas Department of Health reports spending approximately $14,000/year to provide care and treatment to clients receiving Ryan White (federally-funded) services, with higher costs for people entering care later in their disease progression.

Despite the complexity of calculating costs for expanded access to care initiatives, we would be happy to work with ADH, Arkansas Medicaid, and other stakeholders to try to come up with estimated costs, based on anticipated need numbers and specific costs of care in the state.

5. *Is there a report of county-by-county HIV/AIDS case numbers from the Arkansas Department of Health?*

Please see Appendix A of the SHARP report for data from ADH on Arkansas HIV/AIDS Case Prevalence and Rates by County from 2007.

6. *What is the estimated number of people in Arkansas who are HIV-positive but unaware of their status?*

The Arkansas Department of Health estimates this number to be approximately 1,100-1,500 people, based on the estimate (consistent with national statistics) that 20-25% of people living with HIV are unaware of their serostatus, and that there were 5,710 Arkansans reported living with HIV or AIDS as of December 2009.

7. *What are the reasons people are not in care?*

This is a complex question with multiple answers, involving both individual circumstances and broader societal policy choices. For example, one person may not be in care because he works in a low wage job with no health insurance, earns too much to qualify for Ryan White services, and cannot afford care. Another person may have a job that comes with health benefits, but be afraid to use that insurance for fear that her job may be in jeopardy if her employer finds out about her HIV status. For a low-income single mother struggling to find stable, affordable housing and feed her children, caring for herself may not be an immediate priority. A person who is feeling relatively well may postpone care until he becomes ill, not understanding the benefits of earlier medical intervention and treatment. And there are

many Arkansans who are not in care because they are not aware that they are HIV-positive. Some of the major factors identified by Arkansas consumers and providers include stigma and discrimination (experienced and feared), poverty, lack of transportation, lack of affordable health insurance, poor health literacy and self-advocacy skills, and restrictive public health coverage options.

3. *Clarification of the statement about state funding for HIV/AIDS programs*

The report notes that "[o]ther than the state match for those Arkansans living with AIDS who receive Medicaid, Arkansas does not contribute any state funds for HIV care programs" (SHARP report, p. 14). Committee members correctly pointed out that Arkansas does provide medications and care to HIV-positive inmates in the state correction system. The Arkansas Department of Correction subcontracts for medical care for HIV+ inmates, and is in the process of obtaining from the subcontractor, CMS, the amount spent annually on HIV medications. (Source: telephone conversation with ADC Medical Services staff, May 18, 2010.) Department of Correction Medical Services staff report that it would be very difficult to determine the precise amount spent annually on HIV-related medical care, since people living with HIV and AIDS have many secondary medical issues due to compromised immune systems.

We recognize that there may be other state-funded programs in which people living with HIV/AIDS participate, but were referring to care programs specifically designed for Arkansans living with HIV/AIDS, such as the AIDS Drug Assistance Program (ADAP).

Arkansas is in the minority of states, but is certainly not alone, in not contributing state funds to its ADAP. According to the National ADAP Monitoring Project Annual Report, 16 states did not contribute to their ADAPs in FY2008 (see Kaiser Family Foundation's State Health Facts, http://www.statehealthfacts.org/comparetable.jsp?ind=545&cat=11). The National Alliance of State and Territorial AIDS Directors (NASTAD) no longer collects data on total state contributions to any/all HIV/AIDS care programs, but uses state contributions to ADAP as a proxy for whether states are funding such programs (on the theory that if states were going to fund HIV care, they would be likely to put dollars into a medication assistance program). (Source: telephone conversation with Ann Lefert, Associate Director, Government Relations, NASTAD)

# Arkansas
## Living HIV/AIDS Cases by County of Residence
Cases Reported Through December 31, 2009

| Residence County | Living HIV/AIDS Cases | Total Population | Rate per 100,000 |
|---|---|---|---|
| Arkansas County | 27 | 19355 | 139.5 |
| Ashley County | 24 | 22282 | 107.7 |
| Baxter County | 39 | 41872 | 93.1 |
| Benton County | 260 | 202639 | 128.3 |
| Boone County | 22 | 36644 | 60.0 |
| Bradley County | 15 | 11962 | 125.4 |
| Calhoun County | 18 | 5522 | 326.0 |
| Carroll County | 56 | 27284 | 205.2 |
| Chicot County | 24 | 12328 | 194.7 |
| Clark County | 34 | 23796 | 142.9 |
| Clay County | 24 | 16102 | 149.0 |
| Cleburne County | 27 | 25355 | 106.5 |
| Cleveland County | 58 | 8751 | 662.8 |
| Columbia County | 36 | 24361 | 147.8 |
| Conway County | 20 | 20705 | 96.6 |
| Craighead County | 150 | 90727 | 165.3 |
| Crawford County | 57 | 58939 | 96.7 |
| Crittenden County | 255 | 52110 | 489.3 |
| Cross County | 24 | 18651 | 128.7 |
| Dallas County | 6 | 8218 | 73.0 |
| Desha County | 21 | 13785 | 152.3 |
| Drew County | 21 | 18646 | 112.6 |
| Faulkner County | 140 | 104294 | 134.2 |
| Franklin County | 15 | 18152 | 82.6 |
| Fulton County | 7 | 11733 | 59.7 |
| Garland County | 236 | 96245 | 245.2 |
| Grant County | 42 | 17450 | 240.7 |
| Greene County | 32 | 40352 | 79.3 |
| Hempstead County | 34 | 23143 | 146.9 |
| Hot Spring County | 19 | 31845 | 59.7 |
| Howard County | 10 | 13978 | 71.5 |
| Independence County | 72 | 34547 | 208.4 |
| Izard County | 9 | 12935 | 69.6 |
| Jackson County | 15 | 17173 | 87.3 |
| Jefferson County | 370 | 79156 | 467.4 |
| Johnson County | 12 | 24656 | 48.7 |
| Lafayette County | 6 | 7750 | 77.4 |
| Lawrence County | 5 | 16826 | 29.7 |

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|---|---|---|---|
| Lee County | 50 | 10806 | 462.7 |
| Lincoln County | 10 | 13701 | 73.0 |
| Little River County | 18 | 12823 | 140.4 |
| Logan County | 12 | 22594 | 53.1 |
| Lonoke County | 30 | 63468 | 47.3 |
| Madison County | 39 | 15389 | 253.4 |
| Marion County | 15 | 16579 | 90.5 |
| Miller County | 129 | 42785 | 301.5 |
| Mississippi County | 94 | 46647 | 201.5 |
| Monroe County | 21 | 8688 | 241.7 |
| Montgomery County | 6 | 9027 | 66.5 |
| Nevada County | 8 | 9331 | 85.7 |
| Newton County | 9 | 8335 | 108.0 |
| Ouachita County | 45 | 26046 | 172.8 |
| Perry County | 6 | 10388 | 57.8 |
| Phillips County | 66 | 22000 | 300.0 |
| Pike County | * | 10759 | * |
| Poinsett County | 15 | 24821 | 60.4 |
| Polk County | 17 | 20166 | 84.3 |
| Pope County | 52 | 59204 | 87.8 |
| Prairie County | 12 | 8727 | 137.5 |
| Pulaski County | 1846 | 374011 | 493.6 |
| Randolph County | 13 | 18066 | 72.0 |
| Saint Francis County | 88 | 26877 | 327.4 |
| Saline County | 42 | 96046 | 43.7 |
| Scott County | 6 | 11263 | 53.3 |
| Searcy County | 5 | 8071 | 62.0 |
| Sebastian County | 263 | 121386 | 216.7 |
| Sevier County | 12 | 16254 | 73.8 |
| Sharp County | 11 | 17810 | 61.8 |
| Stone County | 6 | 11939 | 50.3 |
| Union County | 155 | 43165 | 359.1 |
| Van Buren County | 6 | 16469 | 36.4 |
| Washington County | 304 | 193812 | 156.9 |
| White County | 50 | 73507 | 68.0 |
| Woodruff County | 7 | 7631 | 91.7 |
| Yell County | 14 | 21697 | 64.5 |
| **County Name Missing** | **66** | - | - |
| **Entire State** | **5793** | **2830557** | **204.7** |

* Counties with less than 5 cases are not reported