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Issues - Care Act - ADAP [AIDS Drug Assistance Programs]

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FACT SHEET

HIV/AIDS BUREAU • DIVISION OF SERVICE SYSTEMS • OCTOBER 1997

The Ryan White CARE Act AIDS Drug Assistance Programs (ADAPs)

The Health Resources and Services Administration (HRSA), an agency of the Department of Health and Human Services, administers the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Enacted in 1990 and reauthorized in May 1996, the CARE Act is the largest source of Federal funding specifically directed to provide primary care and support services for persons living with HIV disease.

Under Title II of the CARE Act, formula grants are awarded to the States and other eligible areas to improve the quality, availability, and organization of HIV health care and support services. In addition to other specific service programs, Title II funds AIDS Drug Assistance Programs (ADAPs). ADAPs provide medications to low-income individuals with HIV disease, who have limited or no coverage from private insurance or Medicaid, in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam.

In 1996, ADAPs served approximately 79,500 persons with HIV disease who had limited or no coverage from private insurance or Medicaid. At any one time, ADAPs were serving about 40,000 individuals.

Title II requires that: *"A State shall use a portion of the amounts provided to establish a program... to provide therapeutics to treat HIV disease or prevent serious deterioration of health arising from HIV disease in eligible individuals, including measures for the prevention and treatment of opportunistic infections."*

ADAPs have served clients since 1987 (see box), but recent treatment advances have focused increasing attention on the program. The newest class of HIV drugs, protease inhibitors (PIs), have proven to be very effective when used in combination with two or three other medications. As a result, demand for the promising new combination therapy has grown rapidly—not only among individuals already in care but also among those who had not previously sought treatment. Because the cost of combination therapy with PIs is very high—between \$10,000 and \$12,000 a year per person—ADAPs are

greatly challenged in responding to the increased client demand.

Even before the expensive new drugs became available, many ADAPs were experiencing strains. The rapid growth of the HIV epidemic among poor and historically underserved populations, and evolving treatment standards which involve more than one antiviral drug, contributed to these strains. In addition, the number of people seeking and receiving treatment for HIV and AIDS continues to increase on a monthly basis.

ADAP funding has increased dramatically in recent years. In fiscal year (FY) 1996, \$52 million in Title II CARE Act supplemental funds was appropriated specifically for ADAPs. This was in addition to the \$53 million that States had already committed from their base Title II awards. In FY 1997, \$167 million was earmarked for ADAPs.

State Roles In Managing ADAPs

States have the authority to establish income and medical eligibility criteria and to determine how drugs will be purchased and distributed to clients. States also determine which drugs to include on their formularies.

The ADAP began 10 years ago. In March 1987, zidovudine — better known as AZT— became the first drug approved by the Food and Drug Administration (FDA) to treat HIV disease. However, the annual cost of AZT per person, about \$10,000, placed it out of reach for many people. Congress responded (a month later) in April 1987, by approving \$30 million in funding under a public health emergency provision, and later enacted Public Law 100-71 authorizing the establishment of an ADAP program nationwide.

As HIV treatment advances occurred and as resources permitted, States expanded the program to cover drugs in addition to AZT. In 1990, when ADAP became part of the newly enacted CARE Act, States had the option to cover any FDA-approved drug that could prolong life or prevent deterioration of health.



Covered Drugs

As the number of FDA-approved HIV treatments has increased, States added some or all of the newer drugs within the limits of available resources. The availability of new, effective drugs, combined with the greatly increased cost of new medications, has affected the expansion of formularies. Today, there is considerable variation in the number of drugs on ADAP formularies, ranging from 5 to more than 100, with one-half of the States covering 25 or more drugs.

Purchase and Distribution of Pharmaceuticals

Most ADAPs were established to operate under a pharmacy reimbursement model similar to Medicaid. This allows patients to go to a participating pharmacy, show their ADAP cards and have their prescriptions filled. The pharmacy then bills ADAP.

A few States with a system of pharmacies attached to a network of public health clinics have opted to use that system to purchase and distribute drugs for ADAP clients. Only a few ADAPs directly purchase drugs and mail them to clients.

Cost-Containment Measures

With the significant growth in clients seeking treatment, dramatic increases in the cost of new treatments, and rapidly changing standards of care, ADAPs are challenged to contain costs at the same time they are asked to expand access. As a result, ADAPs have taken a number of steps to stretch dollars. These include changing the system used to purchase/distribute drugs; seeking larger price discounts (e.g., by participating in the Office of Drug Pricing Program administered by HRSA, or negotiating voluntary manufacturers' rebates); tightening income eligibility criteria; deleting some drugs from State formularies; setting caps on ADAP benefits; and/or establishing guidelines for prescribing drugs.

Income Eligibility

Because Title II gives States the authority to set income and medical eligibility criteria for ADAPs, there is wide variation among States. The following table summarizes income eligibility criteria.

The variation in eligibility generally reflects the type and availability of other health care resources for low-

Criteria as Percent of Federal Poverty Level (FPL)	Number of States/Grantees
100% or below FPL	1 ADAP
100 to 200% FPL	19 ADAPs
200 to 300% FPL	18 ADAPs
Over 300% FPL	11 ADAPs
Three States use some other criteria not related to Federal Poverty Level.	

1997 Federal Poverty Level is \$7,890/year per individual.

income individuals with HIV disease. It must be noted that even in States with more generous income eligibility standards, the overwhelming majority of enrolled individuals have incomes below 200 percent of FPL.

Medical Eligibility

All States require individuals who meet income threshold criteria simply to provide proof of their HIV status. Twelve States also require a laboratory test showing a CD4 count of 500 or less (indicating significant damage to the immune system). For individuals to obtain access to protease inhibitors and/or antiretrovirals, 15 States have additional specific criteria.

ADAPs In Context

A number of factors affect key State decisions regarding ADAPs. The ADAP is just one of multiple important sources of public and private funding for HIV treatment. Medicaid is by far the largest payer, providing treatment to an estimated 60 percent of persons with AIDS nationwide.

However, State Medicaid plans vary widely, in terms of eligibility and covered services. States with more restrictive Medicaid eligibility, limited prescription benefits, and/or no optional coverage for medically needy populations, place special challenges on ADAPs. Too often, however, these are also States with limited or no State contributions to the program. Those constraints are most often reflected in restrictive financial eligibility criteria and limited formularies. Other factors include the availability of affordable private insurance, insurance risk pools, and whether or not the State limits the extent to which private insurers may cap prescription benefits.

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FACT SHEET

HIV/AIDS BUREAU • DIVISION OF SERVICE SYSTEMS • OCTOBER 1997

The Ryan White CARE Act AIDS Drug Assistance Program (ADAP) Funding Overview

The Health Resources and Services Administration (HRSA), an agency of the Department of Health and Human Services, administers the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Enacted in 1990 and reauthorized in May 1996, the CARE Act is the largest source of Federal funding specifically directed to provide primary care and support services for persons living with HIV disease.

Title II of the CARE Act mandates that States, the District of Columbia, Puerto Rico, and eligible territories receive formula grants to improve the quality, availability and organization of HIV health care and support services. In addition to other specific service programs, Title II grants support State-administered AIDS Drug Assistance Programs (ADAPs). ADAPs provide medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid.¹

Increased Demand for ADAP

The last several years have seen an unprecedented growth in client demand and program costs for the ADAPs. These are due to:

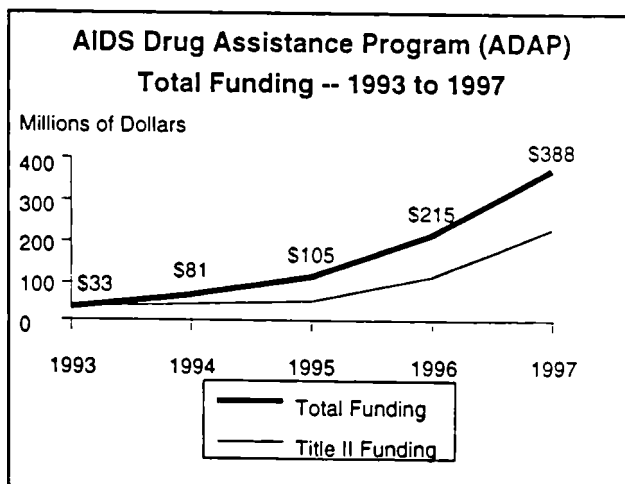
- the rapid expansion of the HIV/AIDS epidemic among low-income and uninsured populations;
- the high cost of newly approved drugs (protease inhibitors) that must be used in multiple-drug regimens; and
- the increasing numbers of people with HIV/AIDS now seeking combination therapy as a result of widely publicized research that supports new pharmaceutical therapies for improving their health status and quality of life.

Future demand on ADAP resources is expected to escalate as the standard of care shifts toward earlier treatment for people with HIV/AIDS, and as patients continue to respond positively to the new drug therapies.

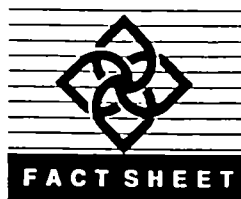
Overview of Funding

In response to the increased demand, both Federal and State funding of ADAPs has grown significantly since 1985 (see chart). Federal sources of ADAP funding include:

- Title II grants — awarded to States based on formula; States have limited discretion in using these funds, but must direct some portion of the grant to the provision of therapeutics or to support ADAPs;
- Title II-earmarked ADAP funds — awarded to States based on formula, but all such funds must be used for ADAP;
- Title I grants to Eligible Metropolitan Areas (EMAs; areas disproportionately affected by the HIV epidemic) — awarded based on formula and need; these grants are used by EMAs to meet needs identified and prioritized by their HIV Services Planning Councils. Funded priorities may include ADAPs.



¹All 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam have Title II-supported ADAPs.



States also allocate general revenue or other State funds to support their ADAPs, and by June 1997, 32 States had appropriated funds for ADAPs.

In addition, ADAPs use various cost containment strategies (discussed later) that maximize funds, allowing ADAPs to serve more people living with HIV/AIDS.

Federal Support

Title II: Over the past 3 years, Title II base allocations to ADAPs have risen from \$47 million for FY 1995 to \$63 million for FY 1997. In 1996, an additional \$52 million was specifically earmarked by Congress for ADAPs. This figure increased to \$167 million for FY 1997.² Total Title II funds have increased 368 percent, and currently represent 58 percent of all available funds for ADAPs.

Title I EMA Support: Some ADAPs rely on allocations from Title I EMAs to help fill service gaps and ensure a continuum of care. In FY 1996, EMAs in 13 of the 23 States with EMAs contributed \$26 million to ADAPs. However, more than 80 percent of these contributions went to the New York State ADAP from the New York City EMA. In FY 1997, 21 States projected receipt of \$41 million from their Title I EMAs.

State General Support

During FY 1996, 35 States contributed \$53 million to fund ADAPs. In the current fiscal year, 34 States have thus far allocated a total of more than \$100 million, an 89 percent increase over last year's total. States' contributions during FY 97 have ranged from a low of \$40,000 to a high of \$27.3 million.

Cost Containment Strategies

Most States participate in multiple cost recovery strategies designed to maximize available ADAP funds and assist the greatest number of people living with HIV/AIDS. Generally, these strategies result in savings

that revert directly back into the State's ADAP budget. Examples of cost-cutting methods include voluntary manufacturer's rebates, purchasing discounts with wholesalers or pharmacies, and insurance recovery mechanisms for clients who have partial drug benefit coverage through Medicaid or a private insurer. For clients in the latter category, ADAPs in some States work to close gaps left by Medicaid and insurance programs. For example, an ADAP might supplement a State Medicaid or insurance program that limits the number of prescriptions that can be filled per month.

During FY 1996, 22 States received \$16 million as a result of these cost-saving mechanisms, funds which were then used to purchase additional pharmaceuticals. In FY 1997, 10 States estimate they will be able to add \$25 million in savings from these mechanisms to their ADAPs. Savings among these 10 States range from \$25,000 to \$15.7 million. Significant additional savings in these and other States are anticipated before the end of the fiscal year.

Current and Emerging Issues

As new and rapidly changing treatments enhance individuals' overall health status and improve their quality of life, ADAPs will continue to face fiscal challenges. Most ADAPs project program growth, with increasing enrollment and utilization of multi-drug combinations. Recent release of the new HIV Clinical Treatment Guidelines that emphasize early and multi-drug treatment that includes protease inhibitors, will also likely increase enrollments. The advent of these new and effective therapeutics require that care providers, ADAPs, and patients view HIV as a treatable and chronic disease, factors that will affect ADAP policies. ADAPs also will need to reexamine their roles as more and more Medicaid enrollees are served through managed care. Finally, future budget constraints and the need for sufficient numbers of HIV-trained and qualified primary health care providers must be anticipated.

²Of this figure, \$10.1 million was awarded in advance to two States for use in the 4th quarter of FY 1996 to address critical ADAP shortages.

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ADAP Funding Information, FY 1997 (1)

Grantee	All Sources	Title II-ADAP (2)	Title II Base (3)	Title I (4)	State	Other
Alabama	\$3,000,000	\$1,329,706	\$1,670,294	\$0	\$0	\$0
Alaska	\$112,917	\$112,917	\$0	\$0	\$0	\$0
Arizona	\$3,058,487	\$1,450,752	\$849,248	\$732,487	\$26,000	\$0
Arkansas	\$654,013	\$654,013	\$0	\$0	\$0	\$0
California	\$72,182,743	\$19,778,919	\$12,873,984	\$4,941,840	\$27,259,000	\$7,329,000
Colorado	\$2,580,721	\$1,607,932	\$135,883	\$535,906	\$301,000	\$0
Connecticut	\$4,428,675	\$2,790,394	\$602,389	\$443,892	\$592,000	\$0
Delaware	\$979,000	\$619,686	\$314,314	\$0	\$0	\$45,000
District of Columbia	\$5,520,030	\$2,613,341	\$745,816	\$1,160,873	\$1,000,000	\$0
Florida	\$32,234,438	\$14,357,694	\$9,957,303	\$5,919,441	\$2,000,000	\$0
Georgia	\$11,395,444	\$5,125,509	\$2,930,000	\$3,015,485	\$324,450	\$0
Guam	\$0	\$0	\$0	\$0	\$0	\$0
Hawaii	\$1,111,594	\$542,903	\$268,691	\$0	\$300,000	\$0
Idaho	\$193,480	\$112,917	\$80,563	\$0	\$0	\$0
Illinois	\$11,265,787	\$5,427,222	\$838,565	\$0	\$5,000,000	\$0
Indiana	\$3,110,662	\$1,372,162	\$801,000	\$0	\$937,500	\$0
Iowa	\$292,680	\$292,680	\$0	\$0	\$0	\$0
Kansas	\$738,196	\$568,196	\$170,000	\$0	\$0	\$0
Kentucky	\$1,089,321	\$663,046	\$326,275	\$0	\$100,000	\$0
Louisiana	\$19,840,132	\$2,717,224	\$529,106	\$593,802	\$16,000,000	\$0
Maine	\$389,486	\$229,446	\$100,000	\$0	\$60,040	\$0
Maryland	\$6,166,534	\$5,025,239	\$0	\$341,295	\$600,000	\$200,000
Massachusetts	\$10,788,179	\$3,310,714	\$0	\$1,177,465	\$6,300,000	\$0
Michigan	\$3,262,921	\$2,408,285	\$154,636	\$300,000	\$0	\$400,000
Minnesota	\$956,003	\$841,003	\$40,000	\$0	\$75,000	\$0
Mississippi	\$3,260,326	\$880,749	\$1,159,577	\$0	\$400,000	\$820,000
Missouri	\$4,166,001	\$1,965,652	\$0	\$1,600,349	\$600,000	\$0
Montana	\$214,137	\$64,137	\$150,000	\$0	\$0	\$0
Nebraska	\$300,000	\$233,963	\$66,037	\$0	\$0	\$0
Nevada	\$1,534,199	\$957,533	\$576,666	\$0	\$0	\$0
New Hampshire	\$485,888	\$214,993	\$143,507	\$102,388	\$0	\$25,000
New Jersey	\$16,787,734	\$9,448,859	\$4,566,141	\$1,322,734	\$700,000	\$750,000
New Mexico	\$1,550,989	\$377,593	\$230,196	\$0	\$943,200	\$0
New York	\$81,800,483	\$29,381,796	\$9,961,912	\$16,455,675	\$10,291,100	\$15,710,000
North Carolina	\$3,660,201	\$2,250,201	\$660,000	\$0	\$750,000	\$0
North Dakota	\$24,390	\$24,390	\$0	\$0	\$0	\$0
Ohio	\$6,264,877	\$2,577,208	\$822,792	\$366,561	\$2,406,316	\$92,000
Oklahoma	\$1,540,187	\$728,086	\$606,101	\$0	\$206,000	\$0
Oregon	\$1,363,136	\$1,148,136	\$50,000	\$165,000	\$0	\$0
Pennsylvania	\$9,987,504	\$5,258,299	\$0	\$672,205	\$4,057,000	\$0
Puerto Rico	\$16,179,504	\$5,315,209	\$3,322,835	\$279,452	\$7,262,008	\$0
Rhode Island	\$762,972	\$494,123	\$268,849	\$0	\$0	\$0
South Carolina	\$3,286,578	\$2,112,895	\$423,683	\$0	\$450,000	\$300,000
South Dakota	\$105,343	\$38,843	\$66,500	\$0	\$0	\$0
Tennessee	\$1,830,152	\$1,830,152	\$0	\$0	\$0	\$0
Texas	\$21,461,439	\$11,061,308	\$3,000,000	\$602,395	\$6,797,736	\$0
Utah	\$780,946	\$399,273	\$266,873		\$114,800	\$0
Vermont	\$449,980	\$92,140	\$157,840	\$0	\$200,000	\$0
Virgin Islands	\$28,014	\$0	\$28,014	\$0	\$0	\$0
Virginia	\$6,282,969	\$2,881,631	\$2,714,138	\$0	\$687,200	\$0
Washington	\$6,568,124	\$2,067,728	\$326,682	\$322,024	\$3,650,000	\$201,690
West Virginia	\$370,000	\$247,513	\$82,487	\$0	\$40,000	\$0
Wisconsin	\$1,465,239	\$823,839	\$280,000	\$0	\$361,400	\$0
Wyoming	\$40,940	\$37,940	\$3,000	\$0	\$0	\$0
Total	\$387,903,695	\$156,866,089	\$63,321,897	\$41,051,269	\$100,791,750	\$25,872,690

(1) Based on projections reported in FY 1997 Title II applications and follow-up calls by DSS.

(2) Figures reflect emergency advances to two states for use in the fourth quarter of FY 1996 to address critical ADAP budget shortages.

(3) Additional Title II Ryan White dollars voluntarily contributed to ADAP by the grantee.

(4) NH Title I contribution figure was subtracted from MA total Title I contribution;
original Title I amount = \$1,279,853.



FACT SHEET

HIV/AIDS BUREAU • DIVISION OF SERVICE SYSTEMS • OCTOBER 1997

The Ryan White CARE Act AIDS Drug Assistance Programs (ADAPs) Eligibility Criteria

What is ADAP?

AIDS Drug Assistance Programs (ADAPs) are authorized under Title II of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, which was enacted in 1990 and reauthorized in May 1996. CARE Act programs, including ADAPs, are administered by the Health Resources and Services Administration (HRSA), an agency of the Department of Health and Human Services.

CARE Act-funded programs and ADAPs are the largest source of Federal funding specifically directed to provide primary care, treatment, and support services for persons living with HIV disease. States are required to use a portion of their funds to provide medications to treat HIV disease, including measures for the prevention and treatment of opportunistic disease.

In 1996, ADAPs nationwide served approximately 79,500 low-income persons with HIV who had limited or no coverage from private insurance or Medicaid. During any given month, ADAPs serve an estimated 40,000 individuals.

The CARE Act gives States the authority to determine financial and medical eligibility criteria for participation in ADAPs. Individuals with HIV disease who do not have another source of payment must demonstrate financial need, which States typically define using a multiple of the Federal Poverty Level (FPL).

For help in determining the size and content of ADAP formularies, most (41) States have established Advisory Groups to assist with decision-making on these and other difficult issues. These groups include expert clinicians, public health officials and planners, medical ethicists, and representatives of consumers and service providers.

All States require documentation of HIV status for ADAP enrollment. At present, 12 States also require individuals to demonstrate disease progression, e.g., a lab test showing a CD4 count of 500 or less. In addition, 15 ADAPs have specific criteria for accessing protease inhibitors and/or antiretrovirals.

The table below summarizes financial eligibility criteria. Twenty States have established income eligibility at 200 percent or less of FPL (annual gross income of \$7,860 for an individual, and \$10,610 for a family of two in 1997). In States with higher income eligibility criteria, 80 percent of clients have incomes at 200 percent or less of the FPL. (See page 3 for a State-by-State description of criteria.)

In the past 2 years, rapid growth in client enrollment, utilization, and expenditures has resulted in major challenges to States as they try to promote access to treatment while ensuring that ADAPs remain fiscally sound. State responses include maximizing resources through different cost-saving strategies; establishing representative advisory bodies to help with difficult program decisions, including defining eligibility criteria; and seeking additional funds from State legislatures or other resources.

Financial Eligibility Criteria

Income Threshold as % of Federal Poverty Level (FPL)	Number of State ADAPs
100% or below FPL	1 ADAP
100-200% of FPL	19 ADAPs
200-300% of FPL	18 ADAPs
Over 300% of FPL	11 ADAPs

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ADAP Eligibility Criteria, FY 1997

STATE	HIV+ DIAGNOSIS	CD4 COUNT <500	SPECIFIC CRITERIA FOR PIs	FINANCIAL ELIGIBILITY (% of FPL)
Alabama	yes	yes	no	250*
Alaska	yes	no	no	200
Arizona	yes	no	no	200
Arkansas	yes	no	no	100
California	yes	no	no	400*
Colorado	yes	no	no	185
Connecticut	yes	no	no	300*
Delaware	yes	no	no	300*
District of Columbia	yes	no	no	300*
Florida	yes	yes	yes	200
Georgia	yes	yes	yes	300*
Hawaii	yes	yes	yes	400*
Idaho	yes	yes	yes	400*
Illinois	yes	no	no	200
Indiana	yes	no	yes	300*
Iowa	yes	no	no	200
Kansas	yes	no	no	300*
Kentucky	yes	yes	yes	300*
Louisiana	yes	no	yes	200
Maine	yes	yes	no	200
Maryland	yes	no	no	400*
Massachusetts	yes	no	no	400*
Michigan	yes	no	no	362*
Minnesota	yes	no	no	300*
Mississippi	yes	yes	yes	200
Missouri	yes	no	yes	185
Montana	yes	no	no	clients must demonstrate severe financial burden
Nebraska	yes	no	no	200
Nevada	yes	yes	yes	200
New Hampshire	yes	no	no	300*
New Jersey	yes	no	yes	400*
New Mexico	yes	no	no	300*
New York	yes	no	no	558*
North Carolina	yes	no	no	150
North Dakota	yes	no	no	150
Ohio	yes	no	yes	250*
Oklahoma	yes	no	no	150
Oregon	yes	no	no	250*
Pennsylvania	yes	no	no	400*
Puerto Rico	yes	yes	no	clients must be certified as indigent
Rhode Island	yes	no	no	400*
South Carolina	yes	yes	no	300*
South Dakota	yes	no	no	300*
Tennessee	yes	no	yes	300*
Texas	yes	no	yes	200
Utah	yes	no	no	sliding fee scale for incomes above 101
Vermont	yes	no	no	200
Virginia	yes	yes	yes	200
Washington	yes	no	no	400*
West Virginia	yes	no	no	300*
Wisconsin	yes	no	no	200
Wyoming	yes	no	no	300*
Virgin Islands	yes	no	no	NA
Guam	yes	no	no	NA

* Among these States, an average of 80 % of enrollees have incomes below 200 %.



F A C T S H E E T

HIV/AIDS BUREAU • DIVISION OF SERVICE SYSTEMS • OCTOBER 1997

The Ryan White CARE Act AIDS Drug Assistance Programs (ADAPs) Formulary Overview

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In 1996, ADAPs nationwide served approximately 79,500 low-income persons with HIV who had limited or no coverage from private insurance or Medicaid. During any given month, ADAPs serve an estimated 40,000 individuals.

The CARE Act gives States the authority to determine which medications approved by the Food and Drug Administration to include in the formulary for their AIDS Drug Assistance Program (ADAP). Historically, ADAPs have focused on treatments specifically developed to treat HIV/AIDS. Most ADAPs also provide access to drugs used to treat or prevent opportunistic diseases that develop in later stages of illness, either directly through the ADAP formulary, or in cooperation with Title II funded consortia. More than 70 percent of States include between 10 and 58 drugs on their formularies. (See page 2 for a State-by-State overview of ADAP formularies.)

In the past few years, States have focused increasing attention on their formularies due to the emergence of new and effective — but high cost —

treatments such as the recently approved protease inhibitors (PIs). The PIs, when taken in combination with two or more anti-retroviral drugs, significantly reduce the amount of virus in the body (called the viral load). This has the potential to improve a patient's health status, life expectancy, and quality of life. Treatment with combination therapy has emerged as the new "standard of care" for HIV/AIDS, confirmed in recently released HIV treatment guidelines. However, the cost of providing combination therapy is currently about \$10,000 per person per year, not including other needed medicine or primary care costs.

As a result, ADAPs nationwide have been seriously challenged as they have tried to respond to the rapid increase in the number of people with HIV/AIDS now seeking treatment, and the very high cost of providing such treatment. Nevertheless, as of June 1997, most States had added protease inhibitors to their ADAP formulary. In the three States that have not yet done so, the Title II CARE Act program assists ADAP eligible clients to access PIs through other resources, including other CARE Act funded programs, clinical trials, and manufacturers' patient assistance programs. It must also be noted, however, that inclusion of PIs in the formulary does not guarantee that these drugs are available to all eligible ADAP clients. Because of the high cost and limited resources, some ADAPs have had to restrict access to PIs — particularly where State resources have not yet been allocated to ADAPs.

For help in determining the size and content of ADAP formularies, most (41) States have established Advisory Groups to assist with decision-making on these and other difficult issues. These groups usually include expert clinicians, public health officials and planners, medical ethicists, and representatives of consumers and service providers. Advisory groups may also assist with other key program activities, with members playing an active role in educating clinicians, providers and consumers on treatment issues.

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ADAP Formulary Information, FY 1997

GRANTEE	Total # of drugs in Formulary 1996-97	# of Protease Inhibitors
Alabama	13	3
Alaska	11	4
Arizona	19	4
Arkansas	11	0
California	50	4
Colorado	11	4
Connecticut	64	4
Delaware	47	4
District of Columbia	47	4
Florida	19	4
Georgia	11	4
Hawaii	36	4
Idaho	10	1
Illinois	61	4
Indiana	19	4
Iowa	23	4
Kansas	33	4
Kentucky	22	4
Louisiana	3	3
Maine	14	3
Maryland	32	4
Massachusetts	32	4
Michigan	22	4
Minnesota	44	4
Mississippi	5	1
Missouri	70	4
Montana	10	4
Nebraska	26	4
Nevada	11	4
New Hampshire	37	4
New Jersey	41	4
New Mexico	41	4
New York	208	4
North Carolina	27	4
North Dakota	59	3
Ohio	22	4
Oklahoma	17	3
Oregon	7	0
Pennsylvania	58	3
Puerto Rico	117	3
Rhode Island	26	3
South Carolina	22	4
South Dakota	35	0
Tennessee	19	3
Texas	27	4
Utah	11	4
Vermont	39	4
Virginia	17	1
Washington	65	4
West Virginia	18	4
Wisconsin	20	4
Wyoming	61	4
Virgin Islands	16	3

Source: June 1997 ADAP Information Update and Telephone Consults



FACT SHEET

HIV/AIDS BUREAU • DIVISION OF SERVICE SYSTEMS • NOVEMBER 1997

The Ryan White CARE Act AIDS Drug Assistance Programs (ADAPs) Cost-Containment Strategies

What is ADAP?

AIDS Drug Assistance Programs (ADAPs) are authorized under Title II of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, which was enacted in 1990 and reauthorized in May 1996. CARE Act programs, including ADAPs, are administered by the Health Resources and Services Administration (HRSA), an agency of the Department of Health and Human Services.

CARE Act-funded programs and ADAPs are the largest source of Federal funding specifically directed to provide primary care, treatment, and support services for persons living with HIV disease. States are required to use a portion of their funds to provide medications to treat HIV disease, including measures for the prevention and treatment of opportunistic disease.

In 1996, ADAPs nationwide served approximately 79,500 low-income persons with HIV who had limited or no coverage from private insurance or Medicaid. During any given month, ADAPs serve an estimated 40,000 individuals.

Since the creation of ADAPs, States have worked hard to maximize resources in order to provide medications to as many low-income and inadequately insured individuals living with HIV/AIDS as possible. Recently however, States have faced enormous challenges as a result of rapid growth in ADAP enrollment, the number of prescriptions per enrollee, and the cost of treatments. This growth has been due primarily to the introduction of new drugs — especially protease inhibitors (PIs).

When used in combination with other anti-retrovirals, PIs have proven to be very effective in

improving health, extending life, and improving the quality of life for people with HIV/AIDS. As a result, the use of combination therapy has emerged as the new "standard of care". However, the high cost of combination treatment with PIs — approximately \$10,000 to \$12,000 per patient per year, not counting other health care costs — has significantly increased the pressure on ADAPs to adopt a wide variety of cost-containment strategies designed to maximize resources. These include restructuring their purchasing and distribution system, "pay-and-chase" strategies to recover insurance benefits for partially insured clients, and the options detailed below.

HRSA's Office of Drug Pricing Program (ODP):

This program is authorized under Section 602 of the Veterans Health Care Act of 1992. Currently, 19 States participate in this drug purchasing program, which calculates a significant discount off the average manufacturers' price of each drug based on a legislatively mandated formula for qualified "covered entities." Eligible entities include Title II funded State ADAPs and other CARE Act funded local pharmacy assistance programs that meet program guidelines. Participation in the ODP Program is easiest for States that centrally purchase and distribute ADAP medications.

Negotiated Pharmacy/Wholesaler Discounts:

States that do not centrally purchase and distribute drugs typically use a network of participating pharmacies. Enrolled clients present their ADAP card or other identification to obtain their prescriptions, and the pharmacy then bills the State ADAP. ADAPs reimburse the pharmacies at a negotiated discounted price which frequently is similar to the amount paid by the State's Medicaid program.



Voluntary Manufacturers' Rebates: Most States that do not participate in ODP and instead reimburse participating pharmacies also obtain voluntary manufacturers' rebates (refunds) on some or all drugs on their ADAP formulary. To obtain these rebates, each State currently must negotiate individually with each manufacturer. States with a high volume of drug purchases are generally in a better position to negotiate larger rebates, either directly or through a contracted agent.

Other Strategies: In some States where demand outstrips resources, further cost-cutting measures have been adopted. These methods include capping client enrollment, instituting waiting lists, elimi-

nating drugs from formularies, establishing protocols for accessing certain drugs, and limiting per patient expenditures.

Effectiveness of Cost-Saving Strategies: Last year (FY 1996), 22 States that were not participating in the ODP program reported approximately \$16 million in savings obtained through voluntary manufacturers' drug rebates, price discounts, and other cost-saving strategies. In the first 9 months of FY 1997, 10 States estimate a total of \$25 million in savings from these combined methods. Further savings are expected to be reported during the remainder of the fiscal year, but programs are already anticipating a 56 percent increase over 1996.

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All other inquiries, contact Division of Service Systems, HIV/AIDS Bureau, HRSA
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<http://www.hrsa.dhhs.gov>

Cost Saving Plans, AIDS Drug Assistance Program, October 1997

State	Seet 602 ODP Program	Man'fct. Discount	Vol. Man'fct. Rebates	Pharmacy Discounts	Multiple Strategies	Manut PAP
Alabama	Yes	No	No	No	No	No
Alaska	No	Yes	Yes	Yes	Yes	Yes
Arizona	Yes	No	No	No	No	No
Arkansas	No	No	Yes	Yes	Yes	Yes
California	No (1)	No	Yes	Yes	Yes	Yes
Colorado	Yes	Yes	No	No	Yes	Yes
Connecticut	No	No	Yes	Yes	Yes	No
Delaware	No	Yes	Yes	No	Yes	No
D.C.	Yes (2)	No	No	No	No	No
Florida	Yes	No	No	No	No	Yes
Georgia	Yes	Yes	No	No	Yes	Yes
Hawaii	Yes	No	No	No	No	Yes
Idaho	No	No	Yes	Yes	Yes	No
Illinois	Yes	No	No	Yes	Yes	No
Indiana	No	No	Yes	No	Yes	No
Iowa	No	No	Yes	Yes	Yes	Yes
Kansas	No	No	Yes	Yes	Yes	No
Kentucky	No	No	Yes	Yes	Yes	Yes
Louisiana	Yes	No	No	No	Yes	No
Maine	No	Yes	Yes	Yes	Yes	Yes
Maryland	No	No	Yes	No	Yes	Yes
Massachusetts	No	Yes	Yes	Yes	Yes	Yes
Michigan	No	No	Yes	No	No	Yes
Minnesota	No	No	Yes	Yes	Yes	No
Mississippi	Yes	Yes	No	No	Yes	No
Missouri	No	No	Yes	Yes	Yes	Yes
Montana	No	No	Yes	Yes	Yes	Yes
Nebraska	Yes	No	No	No	Yes	No
Nevada	Yes	Yes	No	No	Yes	No
New Hampshire	No	Yes	Yes	No	Yes	Yes
New Jersey	No	No	Yes	Yes	Yes	Yes
New Mexico	Yes	Yes	No	No	Yes	No
New York	No	No	Yes	Yes	Yes	No
North Carolina	No	No	Yes	Yes	Yes	No
North Dakota	No	No	Yes	Yes	Yes	No
Ohio	No	No	Yes	Yes	Yes	Yes
Oklahoma	No	No	Yes	Yes	Yes	Yes
Oregon	Yes	Yes	No	No	Yes	No
Pennsylvania	No	Yes	Yes	Yes	Yes	Yes
Puerto Rico	Yes	Yes	No	No	Yes	No
Rhode Island	No	Yes	Yes	Yes	Yes	Yes
South Carolina	Yes	No	No	No	No	No
South Dakota	No	Yes	No	No	No	Yes
Tennessee	Yes	No	No	No	Yes	No
Texas	Yes	No	No	No	No	No
Utah	No	No	Yes	Yes	Yes	No
Vermont	No	Yes	Yes	No	Yes	Yes
Virginia	Yes	Yes	No	No	Yes	Yes
Washington	No	Yes	Yes	Yes	Yes	Yes
West Virginia	No	No	No	Yes	No	Yes
Wisconsin	No	No	Yes	No	No	Yes
Wyoming	No	No	No	Yes	Yes	Yes
Virgin Islands	No	Yes	No	No	No	Yes
Guam	No	No	No	No	No	No
Total	18	19	30	26	41	29

(1) California's purchasing system in the Section 602 ODP Program is decentralized: some local health jurisdictions receive manufacturers' rebates.

(2) D.C. does not participate in ODP Program but receives comparable prices via Department of Defense.

OCT 17 1996

Dear Colleagues:

This letter communicates the Division of HIV Services' (DHS) expectations and recommendations about administration of State AIDS Drug Assistance Programs (ADAPs) supported with Ryan White Comprehensive AIDS Resources Emergency (CARE) Act funds. To assure that all critical constituents in the pharmaceutical assistance arena are consistently informed, this correspondence is being sent to Title II grantees, ADAP directors, Title I grantees and planning council chairs, people living with HIV/AIDS (PLWH) contacts, national organizations, and other Health Resources and Services Administration (HRSA) AIDS programs.

This communication is being sent in response to issues raised during the DHS review of State applications for funding under the fiscal year (FY) 1996 ADAP supplemental appropriation. It also addresses issues identified through our continuing discussions with States, PLWH constituency groups, Federal officials, and others.

These recommendations are based on close consultation with the Office of the General Counsel (OGC) of the Department of Health and Human Services (HHS), the HRSA AIDS Program Office, the Office of HIV/AIDS Policy of HHS, the Office of Management and Budget, and the White House Office of National AIDS Policy. The recommendations fall into four broad categories: administration, eligibility, formulary, and cost-savings.

Administration

The statutory reference to a "State" ADAP carries with it the expectation that both eligibility criteria and covered treatments for anyone enrolled in the program must be equally and consistently applied across the State. Parity must exist regardless of how a State administers its ADAP or delegates administration of it. If a State chooses to operate its program through subcontracts to consortia or other entities, it is obliged to develop and monitor the consistent application of eligibility standards and a common formulary. The Department intends to pursue rule making to assure this consistency in State ADAPs. If a consortium or other entity elects to use other resources (including Title II funds not designated by Congress for ADAPs) to liberalize eligibility standards or to enrich a State-specified formulary it may do so by establishing a complementary program. It may not do so as part of the State ADAP.

States which elect to establish complementary medication assistance programs (or to permit or instruct consortia/other entities to do so), as well as Title I drug reimbursement programs, will be required to file ADAP Annual Administrative Reports for these separate programs.

It is the observation of DHS that centrally-administered ADAPs are better able to achieve the accountability, parity, consistency and cost-savings described in this letter than those which are decentralized. For this reason DHS strongly recommends that every State consider establishing a centrally-administered ADAP.

HHS, in requesting the supplemental funds for ADAP, and the Congress, in appropriating them, clearly expected that Title II grantees would use these funds to *expand* current efforts to improve access to pharmaceuticals for low income individuals with HIV disease. Inherent in that position is the expectation that States should not use these new funds to supplant Title II resources that had been committed to ADAPs without compelling reasons. Grantees (including *Title I* grantees) electing to controvert this expectation are advised to be prepared to provide explicit and convincing justifications in the case of Congressional or other governmental inquiries. Grantees are also reminded that States subject to the matching requirement for Title II must match these supplemental ADAP resources as well.

Eligibility

The CARE Act indicates that ADAPs are to serve "low income individuals," as defined by the States. DHS strongly believes that a determination of low income should focus ADAP resources on individuals with demonstrated severe need based on poverty. Standards should be anchored to Federal poverty guidelines. States may authorize consortia, or use other mechanisms, to provide pharmaceutical coverage for the occasional client who has the unique combination of relatively higher income and documented severe need for pharmaceutical assistance.

As I pointed out in my remarks at the National Meeting in August, it is vitally important that States prioritize use of these funds and take rigorous steps to assure that Medicaid-eligible individuals are transferred to that program at the earliest possible date. It is equally important in defining ADAP eligibility standards that financial need have at least equal weight with clinical indicators of need. DHS pledges to continue working with States on this critical issue, and to identify and share models for assuring careful and complete response to the legislative mandate that ADAPs serve only low income individuals.

DHS expects that all States will devise, implement, and rigorously monitor the use of consistent eligibility standards across all entities involved in certifying ADAP eligibility. Such certification is expected to include review and *documentation* of an applicant's income from all sources, and any pharmaceutical benefits through private health insurance or other sources. DHS further expects that every State will establish and implement procedures for re-certification on a periodic basis, and for de-certifying individuals who qualify but do not make use of the program over an extended period of time (e.g., one year or longer). Re-certification procedures should include mechanisms to assure that individuals who have become eligible for Medicaid are transferred to that program in a timely fashion.

Formulary

It is the express opinion of DHS, which it intends to enforce through rule making, that the formularies for State ADAPs supported with Title II funds should be limited to *FDA-approved pharmaceuticals* (as indicated in the appropriations language for the FY 1996 \$52 million supplement) which *treat HIV disease or prevent the serious deterioration of health arising from HIV disease* (as indicated in the CARE Act, as amended). This definition of "pharmaceuticals" includes ancillary devices (e.g., IV tubing, nebulizers, etc.) needed to administer approved medications.

This formulary restriction does not preclude States from using other Title II funds for nutritional supplements, over-the-counter medications, and other items which are of benefit to individuals with HIV disease. Nor does it preclude States (or Title I grantees) from using other CARE Act funds for diagnostic tests associated with monitoring patients' responses/reactions to the approved medications. The restriction simply limits ADAP programs to approved effective pharmaceuticals and, to the extent possible, assures that the appropriate primary health care payment source covers the cost of essential diagnostic tests.

The Senate version of the reauthorized CARE Act required that the Secretary develop a "minimum drug formulary for suggested use by the States." This requirement was not included in the final amendments which reauthorized the Act. However, the Manager's Statement which summarizes the deliberations between the House and Senate includes the following language:

The conferees emphasize that the Secretary is encouraged to advise states on classes of drugs that have been found to be effective in preventing and treating HIV disease...

DHS commits to work in close collaboration with the HRSA AIDS Program Office, grantees, consumers, and constituent groups in responding to this direction provided by Congress.

Cost-savings

Both HHS and the Congress expect that States will use every means at their disposal to secure the best price available for all products on their ADAP formularies in order to achieve maximum results with these funds. Known and proven strategies include participating in the Veterans Health Care Act Drug Pricing discount program, directly negotiating discounts or rebates from manufacturers or wholesalers, negotiating price reductions from dispensaries (whether mail order pharmacies, pharmacy chains, or local retail pharmacies), implementing programs to recoup private insurance and other third party payments, encouraging enrollees to take full advantage of compassionate use and patient assistance programs, and assuring timely enrollment of all eligible individuals in the State's Medicaid program.

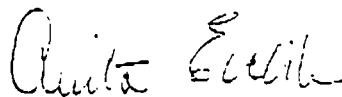
The Division will provide technical assistance to grantees desiring help in understanding and fully utilizing any of these cost saving strategies. We expect that every Title II grantee will adopt

at least one defined cost-saving practice. Grantees who fail to aggressively pursue cost-savings are advised to be prepared to provide convincing justification for Congressional or government inquiries.

The Division acknowledges that this communication is explicitly directive about a specific element of the CARE Act, which might be interpreted by some to diverge from the local autonomy inherent in the legislation. I wish to assure you that we are sharing this information as directly and clearly as possible because we see it as being in the best interests of the program at every level, and essential to our role as administrators of Title II of the CARE Act.

Finally, and most importantly, we are convinced that these steps will assure that the largest number of individuals with HIV and AIDS will have access to medications which show the greatest promise for prolonging and/or increasing the quality of their lives. We are vitally concerned that these promising medications be made available in an appropriate context of primary care and look forward to working with you to identify ways in which the systems of care we support can most effectively promote the patient adherence that is essential to the success of many HIV/AIDS pharmaceuticals.

Sincerely,



Anita Eichler, M.P.H.
Director

cc: William Aspden, Acting Director, Bureau of Health Resources Development
Joseph F. O'Neill, M.D., M.P.H., Associate Administrator for AIDS, HRSA
Don Young, Chief, HRSA Branch, Office of the General Counsel, HHS
Eric Goosby, M.D., Director, Office of HIV/AIDS Policy, HHS
Nancy Ann Min, Associate Director for Health and Personnel,
Office of Management and Budget
Patsy Fleming, National AIDS Policy Director, Executive Office of the President

HOPWA Program Performance

1-16-98 edit.

Since initial funding for the Housing Opportunities for Persons with AIDS (HOPWA) program was made available in 1992, communities throughout the nation have used HOPWA funds to assist low-income persons living with HIV infection or AIDS and their families. The assistance has provided housing and access to related health care and other services for individuals and families who have faced the difficult challenges of living with HIV and AIDS. Clients have benefited by accessing and maintaining safe, decent and affordable housing while addressing health, personal and financial challenges that include the costs for AIDS drugs and other advanced treatment.

The Department agrees with residents and providers of AIDS housing and caring citizens, that our national response to AIDS cannot succeed without appropriate housing. The President's *National AIDS Strategy* includes housing as a vital component in our response and recognizes the "without stable housing a person living with HIV has diminished access to care and services and a diminished opportunity to live a productive life."

In addition to meeting the needs of many families, the assistance provided under this HUD program is cost effective. As an alternative to hospitalization, HOPWA assistance allows thousands of families to maintain independent living to the maximum degree possible by receiving related services as well as access to higher levels of care, as may be needed. The program is an important tool used by communities to assist persons who are homeless or to prevent homelessness among persons living with HIV and AIDS.

The following report, *Summary of HOPWA Annual Progress Reports*, provides a tabulation of information and data on clients and forms of assistance that have been provided to HUD by the grantees of this program. Under these reports, grantees reported on how a cumulative amount of over \$ 184 million has been expended in providing assistance to clients. The reports indicate that program funds were used for the following types of activities:

- 68 percent for housing assistance;
- 20 percent for supportive services;
- 7 percent for administrative costs;
- 3 percent for housing information services;
- 2 percent for technical assistance activities.

As noted, the largest type of activity supported by HOPWA is housing assistance for low-income persons living with HIV/AIDS and their families. Grantees reported that their housing assistance expenditures were made primarily in the form of housing subsidy payments in two types: (1) for tenant-based or project-based rental assistance (30 percent of the funds used for housing assistance and about 23 percent of the units assisted); and (2) for short-term rental assistance, mortgage and utility payments (34 percent of the housing assistance funds used and about 69 percent of the units assisted).

Facility-based forms of housing assistance involve using funds to acquire, develop and operate housing structures, such as short-term facilities, community residences, single room occupancy dwellings and other housing. Facility-based assistance represents 36 percent of the funds used for housing assistance and this provides about 8 percent of the units assisted.

These three types of housing assistance offer significantly different forms of assistance, from short-term and often small subsidies that help families avoid homelessness, to on-going forms of rental payments and access to supportive services. Facility-based assistance often provides for higher levels of care that may be needed by clients and creates new housing dedicated to assisting persons living with HIV or AIDS. Based on information from this one source of funding, estimates for average HOPWA housing costs can be made for the three types of housing assistance. It is important to note that HOPWA funds are generally used to supplement other sources of funds that are needed to develop, operate and evaluate housing activities and ensure that clients receive adequate support and services. Based solely on the amount used and the number of units supported during that reporting period, the average costs for these three types of housing assistance are: \$7,683 per unit of housing in facilities, \$2,162 per unit for rental assistance and \$840 per unit for short-term payments. Except for short-term assistance, which is limited to 21 weeks in a 52 week period, clients who receive rental payments or housing in facilities may receive this assistance during the entire annual reporting period or for some portion of that period. In addition, the average costs per unit include in this average cost variations by community and by size of units. A significant portion of assistance is provided to families and approximately 39 percent of all units are those with two or more bedrooms in size. Information reported in this paragraph is from a subset of the data from 131 of the 225 grantee reports.

Table 1. Examples of Types of Housing Assistance

Type of Housing Assistance	Amount expended	Percent of funds	Number of units	Percent of units	Average * cost per unit type
a. Short-term payments	\$27,617,813	34%	32,892	69%	\$840
b. Rental Assistance	\$23,715,369	30%	10,970	23%	\$2,162
c. Facility-based costs	\$28,388,315	36%	3,695	8%	\$7,683
Total	\$79,721,497	100%	47,557	100%	--

Note: * Average costs are estimates based on limited information and measure the use of HOPWA funds only; related costs for operations, services and programs are not reflected in these averages or total costs; housing cost differences by community and unit size is also not considered in this estimate. This chart is based on a subset of 131 of 225 available reports. Facility costs include the cost of developing and operating community residences, SRO dwellings, short-term facilities and other types of housing such as single family homes. Costs include costs for the acquisition, rehabilitation, repair, new constructions, and leasing of these types of housing units and operation costs.

Summary of HOPWA Annual Progress Reports Data Collected as of 1-16-98

On an annual basis, grantees report on how HOPWA funds have been used to benefit eligible persons in their communities. Data was collected from 225 individual reports that presented accomplishments in assisting HOPWA-eligible persons generally during a one-year operating period. Information was collected from 214 Annual Progress Reports that were filed by grantees and 11 reports obtained from information that grantees entered into the Department's Integrated Disbursement and Information System (IDIS).

Clients of assistance may receive more than one type of assistance, including, for example, initially receiving a short-term housing payment to prevent homelessness and continuing under an on-going rental assistance program. Clients are likely to be receiving supportive services, funded under HOPWA or through programs under the Ryan White CARE Act. As a cumulative number, reported data would include information on the continuing form of assistance. Persons who continue for more than one program year would be counted for each operating year in which they received assistance.

On a cumulative basis, these reports reflect that 129,631 persons received some form of housing assistance, which may also include related supportive services. This number includes the person or persons who are living with HIV/AIDS and other family members who reside in that household. In addition, 90,860 other persons received some form of supportive services only. During the reporting periods, over 201,000 persons received housing information services. The reports document that 75,674 units of housing were supported with HOPWA program funds. A significant portion of assistance goes to families in which one or more members is a person living with HIV/AIDS; approximately 31 percent of the persons receiving some form of housing assistance are family members. In addition, about 39 percent of the housing units are units with two or more bedrooms.

Part 1 Summary of Expenditures and Persons Assisted. Collected from Exhibit G - Summary of Program Expenditures and Exhibit C - Numbers of Persons Assisted During the Program Year.

Expenditures. Grantees reported on their expenditures for HOPWA eligible activities but did not include in-kind items, such as the value of services or materials provided by volunteers or by other individuals or organizations or related funding sources which are frequently involved in providing housing and related supportive services. In awarding grants under the national HOPWA competitions, the selected applicants provided documentation of additional leveraged resources that would significantly expand the scope of programs that receive these federal funds.

Summary of Program Expenditures. Exhibit G provided information about available funds and expenditures for the program during the reporting period.

Table 2.

HOPWA Expenditures during period	Total	Percent
a. Housing Assistance	\$ 125,624,753	67.9%
b. Supportive Services	37,670,335	20.4%
c. Administrative cost	12,707,351	6.8%
d. Housing information	5,827,687	3.1%
e. Resource identification and technical assistance	3,261,228	1.8%
Total reported by 1/16/98	\$ 185,091,354	100%

Note: Administrative costs are limited to 3 percent for grantees and 7 percent for project sponsors; grantee costs reported were \$5,070,626 (2.7%) and project sponsor costs reported were \$7,636,725 (4.1%) under this category.

Table 3.

Persons Assisted with Housing Assistance	Number	Percent
a. Number of Persons with HIV/AIDS receiving housing assistance	89,479	69%
b. Number of other persons in family units	39,655	31%
c. Total of persons who received housing assistance	129,631	100%

Table 4.

Persons Assisted with Supportive Services only (for housing assistance see table above)	Number	Percent
a. Number of Persons with HIV/AIDS receiving supportive services only	68,239	75%
b. Number of other persons in family units	22,621	25%
Total of persons who received supportive services only	90,860	100%

Table 5.

Total of persons receiving housing information services	201,465	--
---	---------	----

Summary of Housing Assistance. The 225 reports indicate that clients were assisted in 75,674 units of housing assistance, including assistance in housing facilities and through housing payments.

Units by type of housing facility. Grantees entered data on the type of housing facility and the bedroom size used by clients, such as one for single room occupancy, efficiency of one-bed room apartments, and units with bedrooms numbering 2, 3, 4, or 5 and greater, under the following types: Short-term facility; Single room occupancy (SRO) dwelling; Community residence; and Other housing facility (specified).

Table 6. Number of Units Supported with Facility-based Expenditures

Number of units in the facility by number of bedrooms	SRO	0 bdrm	1 bdrm	2 bdrm	3 bdrm	4 bdrm	5 + bdrm	Total	Percent *
a. Short-term facility	159	24	617	41	6	1	0	848	1.1%
b. SRO dwelling	438	x	x	x	x	x	x	438	0.6%
c. Community residence	396	869	1,014	636	602	64	400	3,981	5.3%
d. Other housing facility	58	150	660	358	82	11	24	1,343	1.8%
Sub-total for facilities	1,051	1,043	2,291	1,035	690	76	424	6,610	8.7%

* percent of all units of housing assistance provided (75,674), including through housing payments.

Units by type of housing assistance payment. Grantees reported on the number of persons and family units who were assisted with a housing payment during the program year. The assistance reported may range from one-time payments to payments over the reporting period and each person or person in a family unit assisted was counted as one entry regardless of the number of monthly payments made. Payments included: Tenant-based rental assistance and Short-term rent, mortgage and utility payments. Project-based rental assistance is included above under the appropriate type of facility involved in that project.

Table 7. Number of Units Supported with Housing Payments

Number of units by payments by number of bedrooms	SRO	0 bdrm	1 bdrm	2 bdrm	3 bdrm	4 bdrm	5 + bdrm	Total	Percent *
a. Tenant-based rental assistance	246	309	10,180	3,649	1,663	294	8	16,349	21.6%
b. Short-term rent, mortgage and utility payments	1,831	2,039	27,793	15,380	4,959	602	111	52,715	69.7%
Sub-total for payments	2,077	2,348	37,973	19,029	6,622	896	119	69,064	91.3%

* percent of all units of housing assistance provided (75,674), including through housing facilities.

Table 8. All Units of Housing by Size of Unit in Number of Bedrooms Provided

Number of units by number of bedrooms	SRO	0 bdrm	1 bdrm	2 bdrm	3 bdrm	4 bdrm	5+ bdrm	Total
All types of housing assistance	3,128	3,391	40,264	20,064	7,312	972	543	75,674
Percent by unit size	4.1%	4.5%	53.2%	26.5%	9.7%	1.3%	0.7%	100%

Demographics. Collected from Exhibit C - Numbers of Persons Assisted During the Program Year, and Exhibit D - Characteristics of Persons with HIV/AIDS Assisted During the Program Year. Information in this part is from a subset of the reports included above; these 85 reports were available to HUD as of 10-1-96.

Throughout this exhibit, grantees answered questions regarding clients who received HOPWA supported housing assistance and data is presented on a cumulative number of 48,101 persons who were assisted with some form of housing assistance. Information is not presented on persons only provided with housing information or supportive services.

Demographics.

Table 9.

Age and Gender of Clients	Male	percent		Female	percent
a. Persons 17 years old and younger	2,134	4.8%		2,060	4.6%
b. 18 years through 30 years	8,007	18.0%		3,793	8.5%
c. 31 years through 50 years	20,044	45.1%		6,438	14.5%
d. 51 years and older	1,338	3.0%		603	1.4%
Subtotal	31,523	71.0%		12,894	29.0%

Note: Data is missing on 3,684 clients, 7.7% of the cumulative number.

Table 10.

Race of Clients	Total	Percent
a. Asian/Pacific Islander	166	0.4%
b. Black	17,708	42.3%
c. Native American/Alaskan Native	277	0.7%
d. White	23,711	56.7%
Subtotal	41,862	100%

Note: Data is missing on 6,239 clients, 13.0% of the cumulative number.

Table 11.

Hispanic Ethnicity of Clients	Total	Percent
a. Hispanic	7,367	17.2%
b. Non-Hispanic	35,562	82.8%
Subtotal	42,929	100%

Note: Data is missing on 5,172 clients, 10.8% of the cumulative number.

Recent Living Situations of Clients.

Table 12-a.

Recent living situation of clients	Total	Percent
a. Homeless from the street	2,271	7.5%
b. Homeless from emergency shelters	1,125	3.7%
c. From Transitional Housing	991	3.3%
Subtotal for homelessness	4,387	14.4%

Table 12-b.

Recent living situation of clients	Total	Percent
d. Psychiatric facility	100	0.3%
e. Substance abuse facility	737	2.4%
f. Hospital or medical facility	758	2.5%
g. Jail or prison	471	1.5%
Subtotal from facilities	2,066	6.8%

Table 12-c.

Recent living situation of clients	Total	Percent
h. Domestic violence situations	182	0.6%
i. With relatives or friends	6,464	21.3%
j. In rental housing	15,052	49.5%
k. Participant owned housing	1,080	3.6%
l. Other situations	1,178	3.9%

Recent living situation of clients	Total	Percent
Total from all situations	30,409	100%

Note: Data is missing on 17,692 clients, 36.8% of the cumulative number.

Table 13.

Monthly family incomes of clients	Total	Percent
a. No income to \$250	11,639	30.9%
b. \$251 to \$500	15,868	42.1%
c. \$501 to \$1,000	8,817	23.4%
d. \$1,001 to \$1,500	1,068	2.8%
e. \$1,501 to \$2,000	229	0.7%
f. More than \$2,000 per month	62	0.2%
Total	37,683	100%

Note: Data is missing on 10,418 clients, 21.7% of the cumulative number.

Table 14.

Reasons for leaving programs (and number of months)	< 3 Mo	3 to 6	7 to 12	1 year	Total	Percent
a. Voluntary departures	1,938	1,069	219	147	3,373	28.7%
b. Non-payment of rent	25	32	18	9	84	0.7%
c. Non-compliance with service requirements	176	96	37	39	348	3.0%
d. Unknown/disappeared	758	295	137	26	1,216	10.3%
e. Criminal, destruction of property or violence	68	109	51	13	241	2.0%
f. Death of client	528	400	305	138	1,371	11.6%
g. Other reasons given*	2,703	2,368	47	17	5,135	43.6%
Total	6,196	4,369	814	389	11,768	100%

* primarily the time limit on short-term payments.

For more information on the HOPWA program, please contact the Office of HIV/AIDS Housing, U.S. Department of Housing and Urban Development, 451 Seventh Street SW, Washington, DC 20410 or call (202) 708-1934.

Annual Progress Report (APR)

for Housing Opportunities for Persons
with AIDS (HOPWA)

Housing Opportunities for Persons with AIDS (HOPWA)

Annual Progress Report

Public reporting burden for this collection of information is estimated to average 65 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. This agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless that collection displays a valid OMB control number.

This information is collected under the authority of the AIDS Housing Opportunity Act (AHOA), as amended, 42 U.S.C. 12901, which authorizes HUD to provide States and localities with the resources and incentives to devise long-term comprehensive strategies for meeting the housing needs of persons living with acquired immunodeficiency syndrome (AIDS) or HIV infection and their families. The statute includes the following items that necessitate the collection of this information: (1) the AHOA authorizes the Department to conduct a national competition for the award of funds for ten percent of the annual appropriation for the Housing Opportunities for Persons with AIDS (HOPWA) program; and (2) the AHOA requires that recipients of assistance report on the use of amounts received, including the number of individuals assisted, the types of assistance provided and other information determined to be appropriate by the Secretary. This notice applies to grants selected under the national competitions. HUD selects the highest rated applicants for special projects of national significance and applicants for projects that are part of long-term comprehensive strategies for providing housing and related services in areas that do not qualify for formula allocations. Annual Progress Reports provides HUD with essential information on project activities in reporting to Congress and the public on the use of program funds. In addition, the reports assist HUD Offices in monitoring the use of Federal funds, and ensuring statutory and regulatory compliance. Information is collected on an annual basis in the application to make selections and in the annual progress report to report on program activities based on statutory requirements at 42 U.S.C. 12903(b)(3) and 12911. Less frequent submission of information on program accomplishments, which is contained in the Annual Progress Report, could compromise the legal, efficient and effective implementation of the program. The information to be submitted by applicants and recipients is considered public information, except to the extent that applications contain personal or proprietary information or are in use for the competition during a covered use period under the HUD Reform Act.

General Instructions

Purpose. The Annual Progress Report (APR) tracks the accomplishments of the Housing Opportunities for Persons with AIDS (HOPWA) Program. This report will provide the grantee and HUD with important information necessary to assess the grantee's program.

Applicability. Grantees must complete this report for each program year in which HOPWA grant funds were expended. Each competitive grant should be reported in a separate APR.

Recordkeeping. An optional worksheet is included to assist grantees and project sponsors in recording the information necessary for completing this report. The worksheet may be used to record program information manually or to design a computer database to store and tabulate the information. Names and other individual information must be kept confidential, as required by 24 CFR 574.440. However, HUD reserves the right to review the information used to complete this report, except for names and other identifying information. **Information is reported in aggregate to HUD. Do not submit the worksheet to HUD.**

Operating Year. Grantees have flexibility in setting the dates of operating years. A grantee of a competitively-award grant may set the operating start date for its program on a date up to four months following the date of the signing of the grant agreement and any change requires the approval of HUD by amendment.

Organization of the Report. The information included in this report is organized in the following manner:

Part 1 Summary. This section provides an overview of the activities carried out. Grantees also describe any barriers encountered and their actions in response and recommendations for program improvements.

Part 2 Demographics. This part provides information on the characteristics of persons assisted by the program.

Part 3 Program Expenditures and Housing Provided. This part provides information on the financial status of the program including summary expenditure information and information on housing assistance and supportive services by each site and project sponsor.

Final Assembly of Report. After the entire report is assembled, please number every page sequentially.

Filing Requirements. The information in this package must be submitted to: (1) the CPD Division Director in the HUD Field Office 90 days after the end of each program year. Failure to submit an Annual Progress Report may lead to a delay in receiving future grant funds; and (2) an additional copy should be sent to:

HOPWA Program, Office of HIV/AIDS Housing
U.S. Department of Housing and Urban Development
Office of Community Planning and Development
451 Seventh Street, SW
Washington, D.C. 20410

Housing Opportunities for Persons with AIDS (HOPWA)

Annual Progress Report

Grant Number(s)	Program Year for this report	
	From (mo/yr)	To: (mo/yr)
Grantee Name		
Name of EMSA (if applicable)		
I hereby certify that all the information stated herein, as well as any information provided in the accompaniment herewith, is true and accurate. Warning: HUD will prosecute false claims and statements. Conviction may result in criminal and/or civil penalties. (18 U.S.C. 1001, 1010, 1012; 31 U.S.C. 3729, 3802)		
Name & Title of Authorized Official	Signature & Date	
Name & Title of the Person who can answer questions about this report	Phone (include area code)	
Address		

Part 1 Summary.

Exhibit A - Overview of Accomplishments.

Please briefly describe the principal activities carried out during the program year on a page(s) attached to this report. List your specific objectives and briefly describe your success in meeting these objectives. Technical Assistance / Resource Development activities should be described in this section, including information on how recipients of assistance were chosen and on what services were provided.

Exhibit B - Program Improvements.

Describe on a page(s) attached to this report:

(1) **Barriers.** Any barriers or difficulties that were encountered in implementing the program, including residents' concerns, and actions that were taken to address those issues; and

(2) **Recommendations.** Any recommendations that you may have for program improvements, including procedural, regulatory, or other changes, and how such improvements would assist eligible persons.

Part 2 Demographics.

Exhibit C - Numbers of Persons and Families Assisted During the Program Year with HOPWA Funds.

1. Persons Assisted With Housing Assistance. In the table below, enter the number of persons who received housing assistance funded by HOPWA during the program year. Do not report on persons only receiving supportive services or persons only receiving housing information services. If a person's HIV status is unknown, count that person in (b).

a. Number of persons (adults and children) with HIV/AIDS who received housing assistance	
b. Number of other persons in family units who received housing assistance	
c. Total of persons who received housing assistance (a. plus b.)*	

* Note that this number will be the basic participation number used for reporting other program information throughout the report, including the characteristics of persons assisted (Exhibit D).

2. Families Assisted With Housing Assistance. Of the total of persons assisted with housing assistance (1-c, above), how many family units were assisted (do **not** include single person households).

(Definition of Family: "Family" means a household composed of two or more related persons. The term "family" also includes one or more eligible persons living with another person or persons who are determined to be important to their care or well being, and the surviving member or members of any family described in this definition who were living in a unit assisted under the HOPWA program with the person with AIDS at the time of his/her death. [Section 574.3])

Total of family units assisted with housing assistance:

3. Persons Assisted With Supportive Services Only. In the table below, enter the number of persons who received only supportive services funded by HOPWA during the program year. Do not include persons who received supportive services in conjunction with housing assistance (1-c. above).

a. Number of persons (adults and children) with HIV/AIDS who received supportive services only	
b. Number of other persons in family units who received supportive services only	
c. Total of persons who received supportive services only (a. plus b.)	

4. Persons Receiving Housing Information Services. Enter the estimated number of persons who received housing information services funded by HOPWA during the program year. This number may include persons also reported above (1, 2, and 3).

Estimated total of persons receiving housing information services:

HOPWA Annual Progress Report Worksheet

Information is reported in aggregate to HUD. Do not submit this worksheet to HUD.

This worksheet is optional and is intended to help you collect project information needed to complete the HOPWA Annual Progress Report. Please keep a list of "other" answers to specify on the annual report.

1. Enter the participant's full name or a unique identification code (if any). The use of names and other personal identification must be kept confidential. Information on the family unit should be captured with the first participant listed. The additional members of the family unit should be separately listed for items 5, 6, and 7.

2. Enter date participant entered the HOPWA program. Usually, this will be the date of consultation with a case manager.

3. Enter the number of additional adult (18 years and older) family members residing with the participant, who are also receiving housing assistance. Enter "0" if the participant resides alone. Other eligible beneficiaries residing in shared housing should be separately reported.

4. Enter the number of additional children (under 18 years) who are family members residing with the participant, receiving housing assistance. Enter "0" if the participant resides alone.

5. For each participant, enter race (A = Asian/Pacific Islander, B = Black, NA = Native American/Alaskan Native, or W = White).

6. For each participant, enter Hispanic or non-Hispanic (H = Hispanic or N = non-Hispanic)

7. For each participant, enter age at entry into program and sex (M = Male or F = Female) and age: ages will be reported as under 18 years, 18 through 30 years, 31 through 50 years, and 51 years and older.

8. Enter the amount of gross monthly income that the participant or the family unit receives on the average at entry into the program; incomes will be reported as \$0 to 250, \$251 to 500, \$501 to 1000, \$1001 to 1500, \$1501 to 2000, or \$2001 + per month.

9. Enter the participant's most recent living situation prior to program entry.

- a. Homeless from the streets
- b. Homeless from shelters
- c. Transitional housing facilities
- d. Psychiatric facilities *
- e. Substance abuse treatment facility *
- f. Hospitals or other medical facilities *
- g. Jail or prison *
- h. Domestic violence situation
- i. Living with relative or friend
- j. Rental housing

k. Participant-owned housing

l. Other; specify type

* If a person (from Exhibit C) came from a treatment facility but they were there less than 30 days and were in another living situation before they entered the treatment facility, they should be counted as though they were still in the prior living situation.

10. Enter date participant or family ended program participation.

11. When the participant or family left the HOPWA assisted program, what was the primary reason for the departure and how long were they in the program. Enter the code and number of months in the program, less than 3, 3 to 6, 7 to 12, greater than 12 months, which indicates:

- a. Voluntary departure.
- b. Non-payment of rent.
- c. Non-compliance with supportive service requirements.
- d. Unknown/disappeared.
- e. Criminal activity/destruction of property/violence.
- f. Death.
- g. Other (please specify)

12. Enter the type of housing facility and unit size by number of bedrooms used. Count each family unit as a single entry. Enter the code which indicates type and number of bedrooms as SRO, 0, 1, 2, 3, 4, or 5+.

- a. Short-term facility.
- b. Single room occupancy (SRO) dwelling.
- c. Community residence.
- d. Other housing facility (please specify).

13. Enter the type of housing assistance payment and unit size by number of bedrooms used. Enter the code which indicates type and unit size by number of bedrooms as SRO, 0, 1, 2, 3, 4, 5+.

- a. Tenant-based rental assistance.
- b. Short-term rent, mortgage and utility payments.

14. Enter other information as necessary.

Do not submit this worksheet to HUD.

Exhibit D - Characteristics of Persons Receiving Housing Assistance During the Program Year.

Throughout this exhibit answer all questions regarding persons receiving HOPWA supported housing assistance during the year (i.e. persons reported in Exhibit C 1). Do not include information on persons only provided with supportive services or housing information.

1. Demographics.

a. Age and gender. Of those who received housing assistance during the operating year, how many are in the following age and gender categories?

Persons	male	female
a. 17 years and under		
b. 18 to 30 years		
c. 31 to 50 years		
d. 51 years and over		

b. Hispanic/non-Hispanic. How many participants are in the following ethnic categories?

a. Hispanic	
b. Non-Hispanic	

c. Race. How many participants are in the following racial categories?

a. Asian/Pacific Islander	
b. Black	
c. Native American or Alaskan Native	
d. White	

d. Recent living situation. How many participants were in the following living situations immediately prior to entering the program? Include participants in the one category that best describes the participant's most recent living situation.

a. Homeless from the streets	
b. Homeless from emergency shelters	
c. Transitional housing	
d. Psychiatric facility*	
e. Substance abuse treatment facility*	
f. Hospital or other medical facility*	
g. Jail/prison*	
h. Domestic violence situation	
i. Living with relatives/friends	
j. Rental housing	
k. Participant-owned housing	
l. Other (please specify)	

* If a participant or family head(s) of household came from one of these facilities but were there less than 30 days and were living on the street or in emergency shelter before entering the treatment facility, they should be counted in either the street or shelter category, as appropriate.

2. Incomes. For those receiving housing assistance, enter the number of individuals and family units falling under these income categories at the time of their entry into the program. (The total for this element may differ from the total in Exhibit C 1.)

	Gross Monthly Incomes at Entry in Program					
	\$0-250	\$251-500	\$501-1000	\$1001-1500	\$1501-2000	\$2001 +
Number of individuals and family units						

3. Reasons for leaving. Of those who left a program that provided housing assistance during the operating year ***and are not expected to return*** (do not include, for example, participants who temporarily left their housing for a brief period of hospitalization), complete the chart below based on how long they were in the program before leaving and the primary reason for their leaving the program. If a participant left for multiple reasons, ***include only the primary reason*** for their departure.

Reason for Leaving	Number of Months in Program			
	less than 3	3 to 6	7 to 12	more than 12
a. Voluntary departure				
b. Non-payment of rent				
c. Non-compliance with supportive service requirements				
d. Unknown/Disappeared				
e. Criminal activity / destruction of property / violence				
f. Death				
g. Other (please specify)				

Part 3 Program Expenditures and Housing Provided.

Expenditures are amounts spent for eligible activities. Do **not** include non-HOPWA sources or in-kind items, such as the value of services or materials provided by volunteers or by other individuals or organizations.

Exhibit E - Summary of Program Expenditures

This exhibit will provide information about available HOPWA funds and HOPWA expenditures for the program during the reporting period.

Include only expenditures made from a single competitively-awarded HOPWA grant. Please round dollar amounts to the nearest dollar.

HOPWA Funding Available	
1. Unexpended HOPWA funds at end of previous report period (this balance is 0 in the first year of program)	
2. Amount of HOPWA grant received during period	
3. Program income (e.g., loan repayments)	
4. Total of HOPWA funds available during period (sum of lines 1 thru 3)	

Also report the following aggregate totals by type of activity for the report period (totals equal all expenditures of HOPWA funds during this period):

HOPWA Expenditures (Totals by Eligible Activity)	
5. Expenditures for Housing Information Services	
6. Expenditures for Resource Identification	
7. Expenditures for Housing Assistance (equals the sum of all sites and scattered-site Housing Assistance reported in Exhibit G.)	
8. Expenditures for Supportive Services (equals the sum of all Exhibit H funds used)	
9. Grantee Administrative Costs expended	
10. Project Sponsor(s) Administrative Costs expended	
11. Total of HOPWA funds expended during period (sum of lines 5 thru 10)	

12. Balance of HOPWA funds at end of report period (line 4 minus line 11)	
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Exhibit F - Units of Housing Assistance.

For housing assistance provided in facilities, including project-based rental assistance, complete Item 1. For housing assistance payments, either tenant-based rental assistance or short-term payments, complete Item 2.

1. Units by type of housing facility. Report the number of units that were used during the program year by number of bedrooms. Enter the number of units of project-based rental assistance under the appropriate type of facility.

Type of housing facility	Units by Number of Bedrooms						
	SRO	0 bdrm	1 bdrm	2 bdrms	3 bdrms	4 bdrms	5+ bdrms
a. Short-term facility							
b. Single room occupancy dwelling							
c. Community residence							
d. Other housing facility (specify):							

2. Units by type of housing assistance payment. Report the number of units that were used during the program year by number of bedrooms. Count each unit assisted as one entry regardless of the number of monthly payments made for that unit.

Type of housing assistance payment	Units by Number of Bedroom size						
	SRO	0 bdrm	1 bdrm	2 bdrms	3 bdrms	4 bdrms	5+ bdrms
a. Tenant-based rental assistance							
b. Short-term rent, mortgage and utility payments							

(Note: This page summarizes information provided on each site or activity location in Exhibit G.)

Exhibit G - Housing Assistance Expenditures.

1. Facility Based Housing Assistance. For each site, provide information on development actions and actual HOPWA expenditures for a facility during the report period. Such facilities include community residences, SRO dwellings, short-term facilities, and other housing facilities approved by HUD, and non-housing based facilities. A site may include more than one structure or type of facility. All expenditures for acquisition, rehabilitation/conversion, lease, repairs, new construction, operating costs and technical assistance for a facility should be reported in this exhibit. (Please do **not** include funding for related supportive services; these services are reported in Exhibit H. Except for administrative costs for community residences supported by a 1992 grant, all grantee and project sponsor administrative expenses are reported in Exhibit E. Housing information services and resource identification are also reported in Exhibit E.)

1-a Site information.

Name of project	Name and Address of project sponsor
Address/location of site	

1-b Site development actions. For each site, provide the following dates or other information. (Do not submit if a previous annual progress report indicated that all activities at this site were completed and that services had been initiated.)

a. Date of closing on purchase of building or execution of lease	e. Date new construction was completed
b. Date rehabilitation started	f. Date operations staff was hired
c. Date rehabilitation was completed	g. Date residents began to occupy
d. Date new construction started	h. Date supportive services began

1-c Units by type of housing facility.

Indicate the type of housing that was provided (i.e., enter one of the following: Short-term facility, SRO dwelling, Community residence, or specify another type of housing facility).

Type of housing facility	Units by Number of Bedrooms						
	SRO	0 bdrm	1 bdrm	2 bdrms	3 bdrms	4 bdrms	5+ bdrms

1-d Expenditures by facility site. Enter the amount of HOPWA funds expended during the operating year for the activities listed below.

Type of activity	HOPWA Funds
a. Acquisition	
b. Rehabilitation/conversion/repair	
c. Lease	
d. New construction (community residences/SRO dwellings only)	
e. Operating costs	
f. Technical assistance (community residences only)	
g. Project-based rental assistance	
h. Other (specify)	
i. HOPWA Total for this site	

2. Scattered-Site Housing Assistance. For housing assistance provided through tenant-based rental assistance and short-term rent, mortgage, and utility payments, submit this form for **each** project carrying out scattered-site housing assistance.

2-a Name and address of project sponsor

2-b General location(s) of activity

2-c Implementation actions. For the project, provide the following dates. (Do not submit if a previous annual progress report indicated that housing assistance and services had been initiated.)

a. Date residents began to use payments	
b. Date supportive services began	

2-d Units by type of housing assistance payments. Report the number of units that were used during the program year by number of bedrooms. Count each unit assisted as one entry regardless of the number of monthly payments made for that unit.

Type of housing assistance payment	Units by Number of Bedrooms						
	SRO	0 bdrm	1 bdrm	2 bdrms	3 bdrms	4 bdrms	5+ bdrms
a. Tenant-based rental assistance							
b. Short-term rent, mortgage and utility payments							

2-e Expenditures by type of housing assistance payment. Enter the amount of HOPWA funds expended during the operating year for the activities listed below.

Type of housing assistance payment	HOPWA Funds
a. Tenant-based rental assistance	
b. Short-term rent, mortgage and utility payments	

Exhibit H- Supportive Service Expenditures.

Submit this form for each project carrying out supportive services activities.*

Name and Address of project sponsor

General location(s) of activity

Date services began: _____

Enter amount for supportive services(s) which apply:

Amount

1. Outreach	
2. Case management/client advocacy/access to benefits/services	
3. Life management (outside of case management)	
4. Nutritional services/meals	
5. Adult day care and personal assistance	
6. Child care and other children services	
7. Education	
8. Employment assistance	
9. Alcohol and drug abuse services	
10. Mental health services	
11. Health/medical/intensive care services	
12. Permanent housing placement	
13. Other (specify)	
14. HOPWA total for this sponsor	

* For each project sponsor or for the grant in total, report on the amounts expended by type of activity. In cases where multiple activities are carried out by the sponsor and records do not reflect actual expenditures by individual services, provide the total amount expended by the sponsor during the reporting period and an estimate of the amounts by type of activity or, aggregate the amount reported under the primary type of service provided by the sponsor.

HUD HOPWA Annual Progress Report Worksheet

This worksheet is optional and is intended to help you collect project information needed to complete Part II of the HOPWA Annual Progress Report. It should not be submitted to HUD. However, HUD reserves the right to request or review the information used to complete the report, except for names and identifying information. See Worksheet Instructions for directions on using this worksheet. Please keep a file of "other information" (Item 14 below) to specify on the annual report. Names and personal data on participants must be kept confidential; a unique identifying code could be used to track participants. For families, list the head of household first and aggregate family information following that entry. Other family members can be sequentially listed to provide space for demographic information. As described in this instructions for this worksheet, codes are used for entries in items 9 to 12.

[illegible]

1997 HOPWA COMPETITIVE GRANTS

Partnerships to Provide Housing and Related Services to Persons living with HIV/AIDS

Office of Community Planning and Development
U.S. Department of Housing and Urban Development

Housing and Urban Development Secretary Andrew Cuomo announced \$19.6 million in grants to 20 community-based programs addressing the housing needs of low-income Americans with HIV/AIDS. The grants were made under the competitive portion of HUD's \$196 million Housing Opportunities for Persons with AIDS 1997 program.

"We recognize that housing is a daily necessity for each of us and that safe, decent and affordable housing must be part of our common response to the HIV epidemic," Cuomo said. "The Department's AIDS programs give comfort and support to persons who are facing difficult challenges in their lives. That is why these grants are so critical. They serve people when they're most vulnerable, with limited resources, often with less than ideal family and medical support."

Cuomo said that seven of the grants were awarded under the HIV Multiple Diagnoses Initiative (MDI) which targets assistance to low-income persons living with HIV/AIDS who are homeless and also have chronic alcohol and/or drug abuse problems and/or serious mental illness. MDI projects participate in joint efforts by HUD and HHS to develop and evaluate model programs that reach and assist this population.

Seven of the grants were awarded for models in planning, design, management and evaluation of housing and related assistance under the Special Projects of National Significance (SPNS) category. Five grants will help develop long-term comprehensive strategies for assistance in areas of the country that do not receive HOPWA formula allocations. One project will provide national technical assistance.

MODEL HIV/AIDS PROJECTS

Community Partnerships -- Housing Assistance and Related Services

HIV Multiple Diagnoses Initiative

▼ In Connecticut, the City of Bridgeport and the Connecticut AIDS Residence Coalition (CARC) along with seven project sponsors will initiate a three-pronged program to assist persons living with AIDS who also have severe and persistent mental illness and/or chemical dependence. Included will be stabilization and orientation for clients in emergency shelter, development of a transitional living program (with goal formation and support to obtain those goals), and discharge planning that includes access to permanent housing. The program will also provide follow-up services in the community.

Project sponsors will provide intensive outreach, especially in the City's Enterprise Community. To help stabilize homeless clients, emergency shelter will be provided to a minimum of 100 people with

HIV/AIDS and their families. In addition, transitional housing will help a minimum of 14 single adults, 10 single mothers attempting reunification with their children and 12 families. This structured transitional living program, which uses a combination rehabilitation and recovery model, fills a large gap in Bridgeport's continuum of housing for the target population. After completing the transitional program, clients will be assisted in moving to permanent housing via a bridge fund. In an innovative method for vocational rehabilitation, some clients will be involved in developing a mailing services micro-enterprise that has already garnered pledges of business from area organizations.

The program is consistent with *Blueprint for the Future: Connecticut's AIDS Housing Plan* (developed by CARC) and a 1996 HIV/AIDS care needs assessment for the greater Bridgeport area.

Awards for HIV Multiple-Diagnoses Initiative Projects.

Grant Recipient	Project Location	Award
City of Bridgeport	Bridgeport, Connecticut	\$1,270,000
Church Avenue Merchants Block Assoc. (CAMBA)	Brooklyn, New York City	1,199,901
AIDS Task Force of Alabama, Inc.	Birmingham, Alabama	1,270,000
The Salvation Army, Harbor Light Multi-Service Center	Minneapolis, Minnesota	1,200,000
Catholic Community Services, Hudson County Division	Jersey City, New Jersey	1,236,922
Local Health Council of East Central Florida, Inc.	Orlando, Florida	1,205,903
Center for Children & Families	Manhattan, New York City	1,221,450
TOTAL 1997 MDI Awards	7 Grants	\$8,604,176

Sponsors include the Helping Hand Center, Catholic Family Services, the Regional Network of Programs, the Greater Bridgeport Community Mental Health Center, and Alpha Home and Bethel Recovery Center.

▼ In Brooklyn, New York, a grant for *Housing Start* will fund operating costs of a scattered site housing program for homeless persons with HIV/AIDS who are also alcohol/drug addicted and/or mentally ill. This MDI program will be run by the **Church Avenue Merchant's Block Association (CAMBA)**. Health care and other supportive services will be offered in CAMBA's primary health care center and the adjacent HIV/AIDS service center. The program will also emphasize acupuncture as a treatment for substance abuse withdrawal symptoms as well as to increase energy for fighting HIV/AIDS.

CAMBA will offer furnished, scattered site apartments in several Brooklyn neighborhoods in a designated Empowerment Zone/Enterprise Community to 40 people with HIV/AIDS and 40 family members of these individuals. Residential staff will find and maintain housing and will offer subsidized rent payments. In linking HIV and substance abuse prevention services, alternative treatments, health care, and other supportive services with housing assistance, CAMBA is responding to their MDI clients' needs by integrating service delivery. The program's special

focus uses immediate access to housing as an incentive to reach otherwise unengaged clients. The use of non-invasive alternative treatment approaches, such as the Lincoln Hospital acupuncture treatment program, will help maintain clients in care with access to counseling, treatment and other services.

▼ The *Rectory House Project* has been designed to increase consumer-driven, service-enriched community housing. **AIDS Task Force of Alabama**, and its sponsor, Agape Foundation, will supervise the 18-month renovation of a 14-bed community residential facility in Birmingham and augment related activities already underway in this Enterprise Community. A total of 42 homeless, multiply-diagnosed persons who have HIV/AIDS will receive services and housing in a facility offering 24-hour care. Aside from housing, these clients will receive physical care, mental health care, chemical addiction support, and case management and access to other care in the community.

The ATFA project will be part of a Continuum of Care by the Metropolitan Birmingham Services for the Homeless which has been recognized by HUD as "best practice" in coordination and strategic planning by communities. To help the project become self sustaining, a reimbursement system will be developed to cover future annual operating costs. This system will create partner-ships

among area hospitals, health maintenance organizations, public health agencies, the mental health authority, and municipalities.

▼ In Minneapolis, the **Salvation Army Harbor Light Center's AIDS Supportive Housing Project** will include an MDI project in their 100 unit multi-purpose permanent housing campus. Funds will be used to expand this village of support, with the construction and operation of a 12-unit apartment project for individuals living with HIV or AIDS who also have substance abuse or mental health issues. Six units will be constructed for families and six for individuals.

With the assistance of the Minnesota AIDS Project, supportive services available to clients will include case management, substance abuse counseling, primary health care, TB screening, on-site day care, nutrition and hygiene counseling, personal care (food, clothing, transportation), and recreation and social activities. Clients will also be reached in an HIV prevention street outreach program operated by Women With A Point.

Residents will benefit from a "flexible leasing" approach that will enable them to utilize programs in the adjacent Multi-Service Center, such as the detox program, without losing their lease in the apartment project. Flexible leasing will help to prevent clients from becoming homeless, even if they experience relapses and temporarily re-enter treatment programs. The project implements a part of the State's *HIV Housing Needs Assessment and Five Year Plan*.

▼ **Canaan House** in Jersey City, New Jersey, meets the urgent permanent, supported, independent housing need of Hudson County residents who are living with HIV/AIDS and a persistent, mental illness and/or chemical addiction. **Catholic Community Services** will use funds for acquisition, rehabilitation, and operating costs of a housing facility that includes 9 one-bedroom apartments and one two-bedroom apartment for families. In addition, a broad range of services will be provided for tenants.

The ultimate goal of Canaan House is to assist and empower clients to obtain the social services they need by helping them overcome the obstacles caused by a lack of permanent housing and the fragmentation of the social service system. This CCS project is connected to *Operation Link*, a 1996 MDI project that

provides assertive outreach to engage homeless clients, to transitional housing at *Franciska House* and hospice care at *Coming Home*. Services will be provided by CCS as well as other social agencies and the building rehabilitation will be undertaken by the Domus Corporation. The project's primary objective is to develop a holistic service delivery microsystem that views multiply diagnosed consumers as whole persons. As such, these services will include 24-hour on-site staffing, crisis intervention and emergency services, mental health and substance abuse services, home health care, benefits management, nutrition education, food preparation, housekeeping, vocational rehabilitation, life skills and personal care education, family support, case management, and transportation.

▼ The **Local Health Council of East Central Florida** in Orlando, along with four project sponsors, have designed a network that identifies participants, provides housing, and offers treatment to persons with HIV/AIDS, mental illness, and/or substance abuse. HOPWA funds will be used for the operation of this network as well as the repair and conversion of an evaluation and assessment center. The four sponsors are the Allen Outreach and Development Center for client assessment, the Center for Drug-Free Living for counseling and in-patient treatment, Lakeside Alternative for mental health treatment and crises stabilization, and Centaur for housing assistance.

Transitional Case Managers, based out of the Allen Outreach and Development Center, will work with clients for 30 days, linking them to services through the sponsors' network of providers. Counseling will be provided on the street and in established settings. Available under this grant are 15 tenant-based housing units, 20 direct assistance units, 5 assisted living facility units and 22 single room (SRO) units, 10 of which will be emergency transitional and 12 will be for permanent housing.

▼ This grant will fund a **New York City Youth MDI Housing Project** in central Manhattan. The project is a collaborative effort by the **Center for Children and Families** and the sponsoring agency, Samaritan Village, Inc., to establish a distinct system-wide housing assistance program for HIV positive 18-24 year olds. Aggressive street and institutional outreach will help connect clients to comprehensive services for an estimated 600 homeless youths who have multiple diagnoses.

Counseling and other support will be offered at SafeSpace, a drop-in center in Times Square. Some clients will be referred to SafeHome, a transitional living program and, if possible, reunited with their families. The project aims to improve transitional housing with client-driven conflict management methods and to engage clients in assistance to improve life skills and rebuild trust in relationships. The program will reduce services fragmentation and help remove other barriers to treatment.

HOPWA Formula Grants

Housing and related care are vital components of the national response to the HIV epidemic. The HOPWA program provides funding for housing and services for low-income persons living with HIV/AIDS and their families. Funds are made available in connection with a community's strategy to link these and other resources in an overall development plan in a manner that helps empower residents to become stakeholders in the use of resources.

Ninety (90) percent of the annual appropriation is allocated by formula to the largest city in eligible metropolitan areas and to States based on the number of reported cases of AIDS and metropolitan incidence. Areas qualify if they have at least 1,500 cases of AIDS reported to CDC by March 31 of the year prior to award. In FY 1997, 53 metropolitan areas and 27 States qualified for formula grants. A total of \$176.4 million was allocated.

Following public consultations, these 80 jurisdictions described the use of these funds in connection with other HUD and community resources in an annual consolidated plan submission. Summary information on their consolidated plans is available from HUD at <http://www.hud.gov/home.html>.

The CC+F project will offer housing placement assistance for supportive and permanent housing as well as services, such as intensive case management, entitlements, primary health services, specialized clinical assessment, treatment for mental illness and substance abuse, tutoring and GED instruction, independent living skills and vocational readiness, job and intern placement, individual and group counseling. Another initiative includes the development and publication of a city-wide resource directory of services for homeless HIV positive youth and the training the staff at 100 youth serving agencies to increase ability for early intervention.

Special Projects of National Significance

▼ Funds to renew the *Housing Assistance and Volunteer Enlistment Network (HAVEN)* project, will help The AIDS Project (TAP) continue to addressing the complex housing and related support needs of people with HIV/AIDS in Portland and other areas of southern Maine. TAP will provide overall case management and coordinate housing and supportive services with three other organizations: Peabody House, AIDS Housing Lodge, and Shalom House. HAVEN is notable for its ability to serve and adapt to the needs of its service population. During its first grant, the HAVEN project was successful in filling housing and social service gaps. Providers have subsequently found that the nature of their clientele has altered with: more individuals having multiple diagnoses; prognoses of longer life expectancies are occurring; and the local housing market has tightened. TAP and its three sponsors have adapted their program to attend to these changing needs. The program's use of trained volunteers and both consumer and service professionals advisory committees are notable.

Services will include: emergency assistance and shallow rent assistance (up to \$250 per month); employment re-entry; counseling; and helping clients access scattered site, transit apartments, and tenant-based rental assistance. Over the course of the three-year grant, 250 persons will receive rental assistance. Assisted living will be provided to 46 persons. Short-term emergency rental assistance will be provided for 54 persons and 24 will receive shallow rent subsidies to enable them to remain in their apartments or to assist in mortgage payments. An additional 72 persons will receive other short-term payments.

Evaluation of the first HAVEN program has shown that 90% of clients entering emergency care had been housed permanently within 90 days of intake. In addition, TAP met a significant list of benchmarks and developed a working pool of 100 volunteers. For the new award, it is expected that 300 persons with AIDS and 30 of their family members will receive housing assistance, and 1,824 persons with AIDS will receive supportive services.

▼ This grant will fund the **AIDS Housing Corporation's (AHC) *New England Comprehensive Technical Assistance Program*** as a continuation of a 1994 HOPWA SPNS grant. AHC will use funds to continue serving Massachusetts while expanding their capacity to serve other communities in the New England area. Included are five components: (1) needs assessments; (2) program evaluations; (3) research, training, and publications; (4) project development, operations, and management; (5) and community-wide system development. Additionally, AHC will hold a New England-wide AIDS Housing Conference so that organizations and agencies may share information and the region's technical assistance needs may be assessed.

Assistance will be provided to at least 400 individuals and 200 family members. In AHC's 1994 technical assistance grant, all planned goals were met. AHC published a primer on developing AIDS supported housing, guidelines for the design of AIDS housing, a handbook for AIDS housing directors and a directory of programs in Massachusetts and initiated use of a web site. AHC will continue to work with people with AIDS, AIDS service organizations, and community-based organizations to identify the need for housing and support services and develop/maintain housing options addressing those needs. By building on the capacity of existing organizations, AHC helps to bridge gaps in knowledge and expertise to create a continuum of housing options for people living with HIV/AIDS, involve consumers in decisions and form partnerships to provide housing and care.

▼ The *La Posada Project* (Spanish for *home*) will provide service-enriched housing opportunities throughout San Diego County to homeless and very low-income HIV positive persons, especially addressing the needs of women and their children. **The County of San Diego Department of Housing and Community Development's** program

will create flexible and affordable housing options, including permanent housing units that are integrated within an affordable housing complex. Funds are for: (1) acquisition and rehabilitation of ten apartments in the South Bay region; (2) rehabilitation of a licensed residential care facility in Vista to increase its capacity; and (3) outreach, residential service coordination, and supportive services. Assistance will be delivered in this Enterprise Community.

Activities will be co-administered by the County's Office of AIDS Coordination and its Department of Housing and Community Development. These agencies will be assisted by five sponsors, including South Bay Community Services, Fraternity House, San Ysidro Health Center, PACTO Latino AIDS Organization, and the San Diego Housing Commission. Moreover, to fill supportive or housing services gaps in the continuum of care, six community organizations will work in partnership with the sponsors. The project will provide housing assistance to at least 270 individuals and 250 family members.

Project goals are to enable the participants to access affordable and appropriate housing, increase their long-term stability in housing, enhance their access to health care and supportive services, and allow able-bodied participants to secure gainful employment. Housing options will include emergency shelter, transitional housing, rental assistance, and licensed residential care. Tenants will be linked to services with the assistance of bilingual, culturally sensitive case managers.

▼ A project *Serving the Dually Diagnosed in North Carolina* will be implemented in five communities selected for local team efforts in housing people who have HIV/AIDS and substance abuse issues. A project sponsor in each area will hire a substance abuse counselor who can help homeless, dually diagnosed individuals to better utilize housing options. The grant to the **North Carolina Department of Environment, Health, and Natural Resources** will provide assistance in Charlotte, Raleigh, Greenville, Wilmington and eastern rural areas.

While the State will be responsible for linking AIDS services and substance abuse efforts of all communities, the five sponsors will individualize their services according to community needs and area resources. Sponsors include Cure, Inc., the Regional HIV/AIDS Consortium (Foundation of the

Carolinas), the Durham County Mental Health Authority, and the Pitt County AIDS Service Organization.

The grant is expected to provide services for 460 persons statewide over the three years of the grant and serve as models for expanding efforts in other areas. The use of Substance Abuse Counselors fills an identified gap in the local continuum of care in each geographical area. In addition, each area has designed a plan of activities for its HOPWA-funded counselor based on the unique needs of its area.

▼ The Kentucky Housing Corporation will receive a grant for the *AIDS Housing Integration Project* will help existing mainstream housing and service providers to expand their programs for persons living with HIV/AIDS. HOPWA funds will be used to develop an AIDS Housing Integration Team, which will provide outreach, education, and training to mainstream providers and assist in the development and implementation of AIDS-specific set-asides. A placement program for persons with HIV/AIDS who require alcohol and/or drug dependency services will also be established in Louisville, Lexington, and in Dayton and Covington in Northern Kentucky.

In cooperation with the Kentucky Housing Corporation, three sponsors will participate, including Volunteers of America of Kentucky, Transitions Inc., and AIDS Volunteers. Over a three-year period, the project will develop at least 30 set-aside beds, units, or slots in 18 existing housing programs; further-more, housing assistance services will be provided to at least 99 individuals and 35 family members with other services for an additional 201 people. This plan recognizes that the State may most appropriately serve its dispersed client population by improving those resources already in place. Preference will be given to clients residing in Louisville's Enterprise Community.

An AIDS Housing Integration Team will provide outreach, education, and training to mainstream providers and assist in the development and implementation of AIDS-specific set asides and/or preferences. The Project builds upon the capacity and infrastructure of local service providers in rural areas who know their communities, resources, and members, and special-needs service providers in urban centers who are experts in alcohol and drug dependency. Its innovation in utilizing existing housing (at times,

a household with one extra bedroom), training the family or provider in HIV/AIDS prevention and care, and using volunteers to help provide services is notable.

▼ This grant will fund an expansion of Ho'omana'olana's ("building hope") *Gregory House*, a transitional shelter, as well as the development of an independent scattered-site program of housing services for persons living with HIV/AIDS. These expanded services respond to the growing need to stabilize the multiply diagnosed in order to maximize their success in permanent housing.

Currently, support services at Gregory House are not optimal in meeting intensive care needs of those with HIV/AIDS who are multiply diagnosed; gaps exist in the areas of monitoring, follow-up, and on-site support. Outreach will target the homeless among all impacted communities. After becoming a client, individuals will be placed in the newly developed scattered-site program, an independently supportive program where clients can continue to have a strong social service component while living independently in the community. Ten units of long-term lease housing will be made available in the community.

Additional leveraged resources of over \$2 million will be provided in a collaborative manner by the Life Foundation, Comfort, Security, and Independence, Waikiki Health Center, The Queens Medical Center, State of Hawaii STD/AIDS Prevention Branch, and WorkHawaii. The initiative will provide housing assistance services to at least 135 individuals and 6 family members. The proposal was developed with the participation of the AIDS Community Care Team (ACCT), a statewide, broad-based consortium of community based organizations that provide services to, and advocate for, persons affected with HIV and AIDS and for persons at risk.

▼ The Hudson Planning Group will develop, implement, and evaluate the *Housing Network Development Project*, a program for people with HIV/AIDS that utilizes key managed care principles in supportive housing service provision and reimbursement. With the assistance of two other non-profit organizations, Bailey House and Housing Works, the Hudson Planning Group will contract with the City on a capitated payment basis to provide a full continuum of supportive housing services and will link supportive services

Awards for Special Projects of National Significance.

Grant Recipient	Project Location	Award
The AIDS Project	Portland, Maine	\$1,064,149
AIDS Housing Corporation (New England Comprehensive Technical Assistance Program)	Boston, Massachusetts for the New England region	749,689
San Diego County, Department of Housing and Community Development	San Diego, San Marcos and Vista, California	1,053,800
North Carolina Department of Environment, Health and Natural Resources	Charlotte, Raleigh, Greenville, Wilmington, and eastern rural, North Carolina	785,714
Kentucky Housing Corporation	Louisville, Lexington, Dayton and Covington, Kentucky	901,323
Ho'omana'olana	Honolulu, Hawaii	1,028,797
Hudson Planning Group, Inc.	New York City	334,750
TOTAL 1997 SPNS Awards	7 Grants	\$5,918,222

to the specific needs of individuals being served. HOPWA funds will be used to demonstrate the applicability of key managed care principles. Funding will be provided directly to the Housing Network, an umbrella organization of non-profits providing supportive housing, which in turn will contract with non-profit community based housing service providers. All proposed activities are consistent with the State of New York Consolidated Plan. Furthermore, the Housing Network Project prevents duplication that will arise when the State's HIV special needs managed care plans are introduced in mid-1998.

The managed care model is flexible and establishes a provider network for a seamless continuum of services. For instance, case managers will be responsible for both housing and social service needs of their clients; previously, these two services have been handled by different systems.

National HOPWA Technical Assistance

▼ This grant will allow **AIDS Housing of Washington (AHW)** to continue and to expand its *National HOPWA Technical Assistance Program* to provide support for the development, operation and management of AIDS housing programs throughout the nation. The program includes

outreach and follow-up in four primary program areas: (1) consultations with HIV/AIDS residences, rental assistance program, support service providers and low-income housing developers on issues such as program planning, organizational capacity-building, forging partnerships, housing development, financing building operations, support service delivery and evaluation; (2) community-based needs assessments and multi-year AIDS housing plans for impacted cities, states and regions; (3) HIV/AIDS housing publications, database research, public education and information dissemination, including a world wide web site; and (4) provider conferences and workshops, including the Third and Fourth National HIV/AIDS Housing Conferences and two national training workshops for HOPWA formula grantees. Plans have been initiated for the September 16-20, 1998 national conference in Atlanta.

When assisting an organization, AHW accounts for the group's capacity, ability, staffing, and services as well as local changes in Medicaid provision, disease parameters, government programs, and regional/state plans. Long-term goals of the National Technical Assistance Program are to increase organizational capacity, long-term viability, and development. Priority areas include HOPWA formula jurisdictions, states without comprehensive AIDS housing plans that

Award for National HOPWA Technical Assistance

Grant Recipient	Project Location	Award
AIDS Housing of Washington	Seattle, Washington for nation-wide activities	\$1,030,000
TOTAL 1997 National TA Award	1 Grant	\$1,030,000

are outside major metropolitan areas, and smaller EMAs without adequate AIDS housing plans. Through these activities it is expected that more than 3,000 people with HIV/AIDS will be assisted. In its prior award, AHW met or exceeded all goals, including providing comprehensive HIV/AIDS housing needs assessment and planning for states/EMAs, publishing, and conferences.

These exemplary projects evidence strong community partnerships as models of care and commitment. The Department has made a strong emphasis on working together with the nonprofit sector, governments at all levels, and citizens to better address area needs. An essential part of any partnership is learning from each other, understanding our challenges, and sharing our solutions to common issues. By learning from these model projects, we can expand housing options that facilitate independence and dignity for persons living with HIV/AIDS through access to safe, decent and affordable housing.

Secretary Andrew Cuomo

Long-Term Comprehensive Strategies in Non-Formula Areas

▼ The Alaska Housing Finance Corporation (AHFC) will use funds to continue operating housing in Anchorage with three permanent and one transitional housing units. Alaskan AIDS Assistance Association (4As) will provide supportive services, such as case management, housing information, and short- and long-term

rental assistance. In the first HOPWA grant operated by AHFC and 4As, expectations were exceeded by nearly double and the program changed according to the needs of clients. HOPWA funds are used to help people in Alaska with HIV/AIDS and their families remain in their homes by providing for health care, prescription services, child care, relapse prevention therapy, and transportation. Transportation is of particular importance, as many families must travel to far distant services via airplane.

Clients are referred from various community agencies, health care facilities, friends, and current clients. Over the past three years, clientele has fallen into one of two categories: either very ill or long-term survivors. The program has been adapted to help both groups to secure residential assistance as needed. In addition, AHFC and 4As are planning for future clients by scouting appropriate housing locations across the state while visiting current clients.

▼ *The New Mexico Strategy* is a two-pronged approach that promotes statewide and regional collaborations between the housing and HIV/AIDS services communities to enhance and expand capacity of housing resources for people with HIV/AIDS. Housing assistance will include a four-bedroom, independent living duplex in Albuquerque, a four-bed community AIDS residence in Gallup that is sensitive to the culture of Native Americans, and (on a state-wide basis) tenant-based rental assistance with preference for clients in the State's two Enterprise Communities: Albuquerque and the rural EC in Moro, Rio Arriba and Taos Counties. Additionally, funds will be used to fill gaps in the continuum of care throughout the State and for Native Americans, coordinated through comprehensive HIV/AIDS case management.

The New Mexico Mortgage Finance Authority will implement this project in coordination with five sponsors, each familiar with a different region of the state: New Mexico AIDS Services, Southwest

Care Center, CAA Cares Program, Pecos Valley HIV/AIDS Resource Center, and the Navajo AIDS Network. At least 460 individuals and 92 family members will receive housing assistance and services will be provided for an additional 228 persons. The project will also provide utility assistance; emergency grants for moving expenses, minor repairs, and other housing-related needs; and motel vouchers for rural residents traveling to clinics.

The proposal was developed based on statewide consultation with people living with HIV/AIDS, their families, and organizations that serve them. Open planning meetings, focus groups, surveys and interviews were all used with a focus on New Mexico's rural areas that are largely underserved. The project provides over \$7.5 million in additional resources that are committed to implementing this state-wide strategy to integrate services, AIDS drug assistance and housing for clients.

▼ This grant to the **Rhode Island Housing and Mortgage Finance Corporation** will expand Rhode Island's continuum of care for people with HIV/AIDS by extending the geographic service areas from prior HOPWA grants and adding a new component of housing service delivery for northern Rhode Island. Funds will be used to renew the Sunrise Supportive Service Program, which provides supportive services coupled with housing services to clients residing in 12 scattered site apartments in Providence, including clients in the City's Enterprise Community.

In connection with the completion of a Sec. 811 facility under rehabilitation in Pawtucket that will provide six units for people living with AIDS, rental assistance will be offered in southern Rhode Island. Also, support will be given to expand capacity of a four-unit group home in Cumberland in the northern area of the state that operated on a volunteer basis for the last two years. HOPWA will fund project oversight, utility payments, site operations, expansion to eight units and provide a range of housing and supportive services. During operation of the 1994 award, Sunrise achieved its three benchmarks of success in providing stable housing for 45 people with HIV/AIDS, cementing linkages with partners, and evidence of client satisfaction. New activities will be undertaken by two sponsors, Family AIDS Service Center for Treatment and Services (FACTS) in the greater Providence area and the House of Compassion in northern Rhode Island.

At least 148 individuals and 30 family members will receive housing assistance, and an additional 100 persons will receive other services. The proposal was developed using focus groups, interviews with AIDS service organizations, and surveys of people living with HIV/AIDS. The planned activities are coordinated within the State's Continuum of Care for Homeless Persons.

▼ HOPWA funds will allow the **Wyoming Department of Health's** Life Steps Campus in Casper, Wyoming to expand with a *Temporary Residence to Encourage and Educate (TREE) House*. This project will complete a full spectrum of housing and supportive services for people living with HIV/AIDS at one site in coordination with special needs programs offered by 14 collaborating agencies. The TREE House will serve as a group home, supportive living center, site for long-term and emergency housing, and education and information center. TREE House activities will be operated by the Wyoming Department of Health in coordination with two sponsors: Wyoming AIDS Project and Casper Housing Authority. The program will provide housing assistance services for over 192 individuals and 162 family members as well as services for an additional 861 persons living not only in Wyoming, but also in border towns from neighboring states, Nebraska, South Dakota, North Dakota, Idaho, and Montana.

The program is designed to flexibly cover the full spectrum of housing services from short term to transitional to long-term "permanent" housing. The TREE House will also offer a statewide toll-free hotline for referrals to medical care, financial assistance, counseling, legal advice, and other services. On-campus assistance will include self-sufficiency and intensive case management, personal care, health education, literacy and GED tutoring, job search assistance, life skills training, children's programs, and other supportive services.

▼ This grant will continue funding for *Positive Directions* a project of **Pima County Community Services** that serves the Tucson area. The program was developed in consultation with clients and the community to provide structured transitional housing, subsidized permanent housing, intensive case management, inpatient treatment, and job training for low income persons with HIV/AIDS and their families. The program expects that 80% of clients will have

substance abuse issues and 10% will have a mental illness that require specialized services.

Activities will be coordinated with continuum of care efforts by the Tucson Planning Council for the Homeless, which received a "best practice" award from HUD for its collaborative efforts. The project will support the elements of this continuum that implement long-term, comprehensive strategies for providing housing and related services to people with HIV/AIDS. Needs identified in surveillance reports are addressed in two ways: (1) by targeting the multiply diagnosed population for a continuum of housing and services through long-term rent subsidy combined with intensive case management; and (2) by collaborating with existing housing, residential treatment, and service provision.

Sponsors who will be assisting Pima County, the grantee, are the Southern Arizona AIDS Foundation (SAAF) and the City of Tucson. SAAF is the organization resulting from the merger of three AIDS service organizations in Tucson, People with AIDS Coalition of Tucson, the Shanti Foundation, and the Tucson AIDS Project.

The number of units in an existing long-term rent subsidy program will be increased from 30 to 40, with 32 one-bedroom, 6 two-bedroom and 2 three-bedroom units. SAAF's transitional housing program will provide 6 studios; 2 one-bedroom and 2 two-bedroom units for a range of 12 to 18 beds. Intensive case management will be funded under this grant, as will be job training or retraining for clients when they have increased their self-sufficiency.

Awards for Long Term Comprehensive Strategies Projects

Grant Recipient	Project Location	Award
Alaska Housing Finance Corporation	Anchorage, Alaska	\$ 572,800
New Mexico Mortgage Finance Authority	Albuquerque and Gallup, New Mexico	1,100,000
Rhode Island Housing and Mortgage Finance Corporation	Providence, Cumberland and Cranston, Rhode Island	1,097,030
Wyoming Department of Health	Casper, Wyoming	288,640
Pima County Community Services	Tucson, Arizona	639,196
TOTAL 1997 Long Term Awards	5 Grants	\$3,697,666

NOTE: LT Projects are in areas that did not qualify for HOPWA formula allocations in FY 97.

Additional Funds for Evaluation of 1996 HIV Multiple-Diagnoses Initiative Projects.

HUD awarded additional funds for the national evaluation of MDI projects selected in 1996. The seven projects that received up to \$50,000 are: the Bernal Heights Housing Corporation in San Francisco, California; the Housing Authority of Santa Cruz, in Santa Cruz Co., California; Housing & Services Inc. (of South Florida) in Miami, Florida; the Baltimore Department of Housing and Community Development in Baltimore, Maryland; Catholic Community Services in Jersey City, New Jersey; United

Bronx Parents, Inc. in New York City; and the Houston Regional HIV/AIDS Resource Group, Inc. in Houston, Texas. These projects are described in the 1996 competitive grant descriptions. The total for the seven awards is \$349,936.

For More Information: Contact the HUD area office or the Office of HIV/AIDS Housing, U.S. Department of Housing and Urban Development, 451 Seventh Street, SW, Rm 7154, Washington, D.C. 20410, phone (202) 708-1934; TTY 1-800-887-8339, FAX: (202) 708-1744. The HUD HOME Page on the World Wide Web is found at <http://www.hud.gov/home.html>.

1997 HOPWA Competitive Grants--Contact List

Grant Recipient Address	Grantee Contacts	Additional Contacts
AIDS Task Force of Alabama P.O. Box 55703 Birmingham, AL 35255	Randall H. Russell, MSW Executive Director (205) 781-6448 (205) 788-4643 (fax) randyoed@aol.com	
Alaska Housing Finance Corporation P.O. Box 101020 Anchorage, AK 99510	Daniel R. Fauske Executive Director (907) 338-6100 Kris Duncan (907) 338-6100 (907) 338-2585 (fax)	Andrea Nenzel, Exec. Dir. Alaskan AIDS Assist. Assoc. 1057 W. Fireweed, S. 102 Anchorage AK 99503-1736 (907) 263-2050 (907) 263-2051 fax aaaa@servcom.com www.servcom.com/aaaa
Pima County Community Services 32 North Stone Avenue, Suite 1600 Tucson, AZ 85701	Kate O'Rielly Director of Community Resources (520) 740-5205	Gary Bachman (520) 740-5205 (520) 798-3203 (fax)
County of San Diego Department of Housing and Community Development 3989 Ruffin Road San Diego, CA 92123-1890	Edward A. Baker, Jr. Director (619) 694-4885	Ron Barefield (619) 694-4803 (619) 694-4871 fax Jeffrey Wynne Office of AIDS Coordination (619) 515-6685
City of Bridgeport 45 Lyon Terrace Bridgeport, CT 06604	Joseph P. Ganim, Mayor (203) 576-7201 Michael J. McCarthy Central Grants Office (203) 332-5662 (203) 332-5657 fax	Shawn Lang Interim Director CT AIDS Resource Coalition 56 Arbor Street Hartford, CT 06106 (860) 231-8212 (860) 231-9745 fax
Local Health Council of East Central Florida, Inc. 1155 S. Semoran Blvd., Suite 1111 Winter Park, FL 32792	Steve Windham Executive Director (407) 671-2005	Susan Shewmake (407) 671-2005 x 203 Marigot Garcia (407) 671-2005 x 217 (407) 671-5474 (fax)
Ho'omana'olana 770 Kapiolani Boulevard Suite 503 Honolulu, Hawaii 96813	Michael Burnett Executive Director (808) 592-9022 (808) 592-9049 fax hsegregory@aol.com	
Kentucky Housing Corporation 1231 Louisville Road Frankfort, KY 40601	Mr. F. Lynn Luallen Chief Executive Officer 800-633-8896x299 (502) 564-0896 fax	Kimberly Burris, Homeless Programs Coordinator (502) 564-6171 (502) 564-6445 fax
The AIDS Project 615 Congress Street - Sixth Floor P.O. Box 5305 Portland, ME 04104	Marjorie Love, MSW Interim Executive Director (207) 774-6877 (207) 879-0761 fax aidsproj@neis.net	

Grant Recipient Address	Grantee Contacts	Additional Contacts
<i>New England Comprehensive Technical Assistance Program</i> AIDS Housing Corporation 95 Berkeley Street, Suite 305 Boston, MA 02116	Marie Herb Senior Project Manager (617) 451-2248 x26 (617) 451-2011 fax info@ahc.org	AHC Home Page: www.ahc.org
The Salvation Army Harbor Light Multi-Service Center 1010 Currie Avenue Minneapolis, MN 55403	Steven E. Woodard, Lieutenant Executive Director (612) 338-0113 (612) 338-4717 (fax)	
Catholic Community Services Headquarters Office: 160 Raymond Boulevard Newark, NJ 07102-4105	Thomas J. Catlaw, Chief Operating Officer (973) 596-4054	Margaret Murtha Hudson Co. Division Director (201) 332-4365 (201) 332-6585 (fax)
New Mexico Mortgage Finance Authority 344 Fourth Street, SW Albuquerque, NM 87102	James W. Stretz Executive Director (505) 843-6880 (505) 243-3289 fax	
Church Avenue Merchants Block Association, Inc. (CAMBA) 1720 Church Avenue, 2nd Floor Brooklyn, NY 11226	Joanne M. Oplustil Executive Director (718) 287-2600 (718) 287-0857 (fax)	
Center for Children and Families 295 Lafayette Street, Suite 920 New York, NY 10012	Beverly Brooks Executive Director (212) 226-3536 www.kidsuccess.com	Carl Siciliano, Director of Services for Homeless Youth SafeSpace 133 W 46th Street New York 10036 (212) 354-7233 (212) 869-9593 (fax)
Hudson Planning Group 180 Varick Street, 17th Floor New York, New York 10014	Howard Burchman Director (212) 627-0627 (212) 627-9247 (fax)	
North Carolina Department of Environment, Health, and Natural Resources, Division of Epidemiology - AIDS Care Branch PO Box 27609 Raleigh, NC 27626	Michael Moser, MD, Director Division of Epidemiology (919) 715-6733 Arthur Okrent (919) 715-3118	Joan Plotnick AIDS Housing Program Administrator (919) 715-3121 (919) 715-3144 (fax)
Rhode Island Housing and Mortgage Finance Corporation 44 Washington Street Providence, RI 02903	Richard H. Godfrey, Jr. Executive Director (401) 457-5566	Susan Bodington (401) 457-1286 (401) 457-1140 fax
<i>National HOPWA Technical Assistance</i> AIDS Housing of Washington 2025 First Avenue, Suite 420 Seattle, WA 98121	Betsy Lieberman Executive Director (206) 448-5242 (206) 441-9485 (fax) info@aidshousing.org	AHW Home Page: www.aidshousing.org
Wyoming Department of Health Hathaway Building, Room 478 Cheyenne, WY 82002	Jim Murray Deputy Administrator (307) 777-6004 (307) 777-3917 fax	Mary L. Patrick Executive Director Casper Housing Authority (307) 266-1388 x18

FY 1997 Estimated AIDS Drug Assistance Program Funding from State Resources

State	Total FY 1997 Federal and State Funding for ADAP	FY 1997 Federal Title H ADAP Supp. Funds	State Contribution to ADAP	Percentage of State Funds to Federal ADAP Funds
Alabama	\$ 3,150,804	\$ 1,328,706	\$ 150,604	11%
Alaska	\$ 212,320	\$ 112,917		0%
Arizona	\$ 3,333,000	\$ 1,450,752	\$ 600,000	41%
Arkansas	\$ 2,050,008	\$ 654,013		0%
California	\$ 82,500,000	\$ 26,371,892	\$ 40,200,000	152%
Colorado	\$ 2,851,740	\$ 1,607,032	\$ 301,000	10%
Connecticut	\$ 4,178,675	\$ 2,790,394	\$ 592,000	21%
Delaware	\$ 834,000	\$ 810,600		0%
DC	\$ 5,716,838	\$ 2,613,341	\$ 800,000	31%
Florida	\$ 26,814,997	\$ 17,898,632	\$ 1,600,000	8%
Georgia	\$ 8,449,868	\$ 5,125,509	\$ 324,450	6%
Hawaii	\$ 1,102,504	\$ 542,903	\$ 291,000	54%
Idaho	\$ 193,000	\$ 112,917		0%
Illinois	\$ 14,466,503	\$ 5,427,222	\$ 8,325,000	153%
Indiana	\$ 2,615,048	\$ 1,372,162	\$ 442,000	32%
Iowa	\$ 292,680	\$ 292,680		0%
Kansas	\$ 857,620	\$ 568,108		0%
Kentucky	\$ 1,147,265	\$ 663,046	\$ 127,944	19%
Louisiana	\$ 23,206,330	\$ 2,717,224	\$ 20,000,000	736%
Maine	\$ 389,446	\$ 229,446	\$ 60,000	26%
Maryland	\$ 6,755,308	\$ 6,025,239	\$ 600,000	12%
Massachusetts	\$ 11,268,178	\$ 3,310,714	\$ 6,800,000	205%
Michigan	\$ 2,662,921	\$ 2,408,205		0%
Minnesota	\$ 987,500	\$ 841,003	\$ 150,000	18%
Mississippi	\$ 2,040,328	\$ 880,749		0%
Missouri	\$ 6,652,428	\$ 1,805,652	\$ 600,000	31%
Montana	\$ 201,037	\$ 84,137		0%
Nebraska	\$ 883,498	\$ 233,963		0%
Nevada	\$ 2,834,199	\$ 957,533	\$ 1,300,000	136%
New Hampshire	\$ 663,790	\$ 214,993		0%
New Jersey	\$ 18,280,738	\$ 9,448,859	\$ 700,000	7%
New Mexico	\$ 1,183,568	\$ 377,593	\$ 740,000	190%
New York	\$ 71,466,311	\$ 28,381,798	\$ 12,400,000	42%
North Carolina	\$ 3,615,201	\$ 2,250,201	\$ 750,000	33%
North Dakota	\$ 124,390	\$ 24,390		0%
Ohio	\$ 6,524,500	\$ 2,577,200	\$ 3,124,500	121%
Oklahoma	\$ 2,065,187	\$ 728,088	\$ 431,000	59%
Oregon	\$ 1,885,136	\$ 1,148,136		0%
Pennsylvania	\$ 11,917,648	\$ 6,268,299	\$ 6,659,347	127%
Puerto Rico	\$ 12,920,475	\$ 5,315,208	\$ 4,168,038	78%
Rhode Island	\$ 762,972	\$ 484,123		0%
South Carolina	\$ 3,488,578	\$ 2,112,895	\$ 500,000	24%
South Dakota	\$ 138,843	\$ 38,843		0%
Tennessee	\$ 2,440,203	\$ 1,830,162	\$ 810,050	33%
Texas	\$ 18,938,044	\$ 11,061,308	\$ 2,697,736	24%
Utah	\$ 780,946	\$ 399,273	\$ 114,800	29%
Vermont	\$ 400,000	\$ 92,140	\$ 150,000	163%
Virginia	\$ 6,410,469	\$ 2,881,631	\$ 687,200	24%
Washington	\$ 6,181,000	\$ 2,067,728	\$ 3,263,000	158%
West Virginia	\$ 815,109	\$ 247,513	\$ 74,833	30%
Wisconsin	\$ 1,477,701	\$ 823,839	\$ 373,500	45%
Wyoming	\$ 137,940	\$ 37,940		0%
Total	\$ 389,365,889	\$ 167,000,080	\$ 120,808,000	72%

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Paying for the Promise:
A National Status Report on Access to State AIDS
Drug Assistance Programs

Prepared for the Henry J. Kaiser Family
Foundation by

The National Alliance of State and Territorial AIDS
Directors
and
The AIDS Treatment Data Network

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Discussion Draft

Paying for the Promise: A National Status Report on Access to State AIDS Drug Assistance Programs

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Executive Summary

1996 was a breakthrough year in the national fight against AIDS. The approval and widespread use of new HIV/AIDS therapies, including protease inhibitors, represent the best hope in the history of the epidemic for preventing the decline in health and morbidity associated with HIV infection. There is still no cure. But for the first time ever, treatments have been developed and approved which can effectively suppress the virus and delay disease progression and death. The national investment in AIDS research, care and treatment has finally lived up to its promise. It is a promise – perhaps never spoken – that has been dearly held onto and awaited by people living with HIV/AIDS and their loved ones. It is a promise that for many individuals with HIV/AIDS may go unfulfilled because of their inability to afford the medications and care that they need.

For low income people living with HIV/AIDS who do not have adequate private health insurance or who are not covered by Medicaid, state AIDS drug assistance programs (ADAPs) represent a promise made by the federal and state governments to provide access to medications. State ADAPs serve as a critical lifeline for many individuals living with HIV/AIDS in the United States. These state-administered drug reimbursement programs form one link in the continuum of publicly-funded HIV care and services that are available to low income individuals through programs funded by the Ryan White CARE Act, Medicaid, Medicare, and local indigent healthcare/social service programs. The critical role that ADAPs play in the lives of many people infected and affected by HIV, and the increasingly important role ADAPs play as an integral part of the U.S. HIV healthcare system have made these programs the subject of increasing public scrutiny and debate.

The National Alliance of State and Territorial AIDS Directors (NASTAD) in collaboration with the AIDS Treatment Data Network (ATDN) have conducted a survey of all state¹ AIDS programs in the United States that receive funds through Title II of the Ryan White CARE Act. The following is a summary of the major findings of this national study:

Responding to the Emergency in Access to New HIV/AIDS Treatments

- Funding for state ADAPs has grown by 75% from 1996 to 1997 and by over 314% since 1995.
- Although there has been a growth in federal and state support for these programs recently, they continue to be strained by the increasing demand and high costs of providing medications in multi-drug combinations to a widening pool of utilizing individuals.

¹ In the context of this report, the term “state” will refer generically to all fifty states, the District of Columbia, the Commonwealth of Puerto Rico, Guam and the U.S. Virgin Islands.

- Eighty percent (80%) of the state ADAPs reported increases in the number of utilizing clients from July 1996 to December 1996; forty-six percent (46%) reported an increase in utilizing clients of at least twenty percent.
- Eighty-five percent (85%) of the state ADAPs reported increases in their monthly expenditures on pharmaceuticals from July 1996 to December 1996; sixty-two percent (62%) reported expenditure increases of at least twenty percent.
- Nationally, during the last half of 1996, the number of utilizing ADAP clients increased by twenty-three percent (23%)—an average monthly increase of approximately 1,000 utilizing clients per month—and monthly program expenditures increased thirty-seven percent (37%) during the same period. Based on data from a previous survey, national monthly ADAP program expenditures increased by approximately seventy-seven percent (77%) over course of calendar year 1996.

Accessibility of State ADAPs Nationally

- Almost half of the states cited inadequate funding as the primary barrier to their ADAPs' ability to serve intended client populations.
- During 1996, twenty-five percent (25%) of the states capped overall client enrollment into their ADAP programs.
- Access to basic treatments for HIV/AIDS and for AIDS-related opportunistic infections (OIs) remains uneven among state ADAPs. Most state ADAPs provide coverage for basic antiretroviral treatments. However, access to the promising new class of anti-HIV drugs, protease inhibitors, was restricted last year in a quarter of the states. In addition, only five state ADAPs currently cover the thirteen basic drugs recommended by the Public Health Service (PHS) for the treatment and prevention of OIs.
- The standard of HIV/AIDS care will soon dictate that patients start on antiretroviral therapy with a combination of drugs earlier in the disease in order to preserve immune function. The upcoming federal guidelines on HIV therapy will likely conclude that there is no longer a significant distinction between asymptomatic and symptomatic HIV infection since the latter only reflects more advanced immune system damage. Unfortunately, many state ADAPs are unprepared to offer this standard of care to eligible patients.

Re-evaluating ADAP Program Structures

- States are moving to improve the efficiency and cost-effectiveness of their ADAP programs by increased utilization of various cost-saving strategies related to program administration and the purchase and distribution of covered drugs. These strategies include: centralizing administrative functions, moving to more efficient drug purchasing and distribution systems, aggressively pursuing drug rebates from the manufacturers, taking advantage of federal drug purchasing discount programs, expanding insurance purchase/continuation programs, and seeking a higher level of coordination with state Medicaid programs.

Introduction

Overview of State AIDS Drug Assistance Programs (ADAPs)

Background

Shortly after the Food and Drug Administration (FDA) approved of the first anti-HIV drugs in 1987, AZT (Retrovir), Congress appropriated funds for states to establish state-administered AIDS Drug Reimbursement Programs to assist low income individuals in accessing this new medication. As the arsenal of treatment options for HIV/AIDS slowly expanded over the ensuing years, these programs also expanded to provide more treatments to a steadily increasing number of clients. In 1990 authorization for the AIDS Drug Reimbursement Programs was subsumed under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.

Currently, these drug reimbursement programs—now commonly known as AIDS Drug Assistance Programs (ADAPs)—are authorized under Title II of the CARE Act to provide access to HIV/AIDS medications for low income, uninsured and under-insured individuals. State-administered ADAPs are one part of a larger health care system for people living with HIV/AIDS that includes Medicaid, Medicare, private insurance, state/local indigent care programs, and pharmaceutical manufacturer-sponsored patient assistance programs. ADAPs have often been a bridge for clients between private insurance coverage and disability-based medical assistance programs like Medicaid.

States have authority over many aspects of their local ADAP program. Within broad guidelines established by the Health Resources and Services Administration (HRSA), States set financial and medical eligibility criteria for admission to the program and, sometimes, for access to specific covered drugs. States establish and administer their own ADAP formulary—the type and number of drugs covered by the program—and develop procedures for how drugs are added to or deleted from the formulary. Finally, states determine how their ADAP will be administered and how covered drugs will be purchased and distributed to clients. This level of state flexibility in establishing the structure of state ADAP has resulted in significant variation among ADAP programs across the country.

State-administered ADAPs are funded primarily with federal funds appropriated under Title II of the CARE Act. Until recently, states determined how much of their overall Title II award would be devoted for ADAP. Beginning in FY 1996, however, Congress appropriated ADAP-targeted funds under Title II of the CARE Act, thereby giving states an ADAP-specific appropriation in addition to base Title II funds the states wish to budget towards the ADAP program. In some states, ADAPs also receive state-appropriated funds to support the program. A number of state ADAPs receive

contributions from local Title I Eligible Metropolitan Areas (EMAs) to support the state-administered program².

Recent Trends

The explosive growth in state-administered ADAPs can reasonably be traced back to the approval of a new reverse transcriptase inhibitor, 3TC (Epivir), and the first protease inhibitor, saquinavir (Invirase), in late 1995 and the concomitant rise in the use of combination antiretroviral therapy in the treatment of HIV/AIDS. In early 1996, two additional protease inhibitors, ritonavir (Norvir) and indinavir (Crixivan), received FDA approval. The licensure of these new drugs and their reported efficacy in slowing the progression of HIV disease received significant media attention and sparked a resurgence of interest in antiretroviral therapy³.

In the first half of 1996, many state ADAPs experienced large increases in program enrollment, utilization and monthly expenditures⁴. Faced with rising expenditures and finite resources, many ADAPs were forced to take drastic measures to avoid bankrupting their programs. Among these measures were: capping program enrollment, restricting access to certain formulary medications, and delaying or indefinitely suspending coverage of the new drugs.

The appropriation of \$52 million in federal emergency ADAP funding in FY 1996 provided some relief to the programs. However, many programs were forced to continue to maintain waiting lists for enrollment, reduce formularies and/or restrict coverage. Especially vulnerable were lower- and moderate-incidence states that receive no state nor Title I EMA support. In anticipation of continued increased demand for access to the new medications, Congress appropriated \$167 million specifically for state-administered ADAPs for FY 1997.

The National ADAP Monitoring Project

Project Overview

State-administered ADAPs have become a critical part of the healthcare infrastructure for people living with HIV/AIDS in the United States. These programs have experienced enormous growth in the numbers of utilizing clients and program expenditures over the

² Some states that include one or more Title I EMAs have been successful in soliciting contributions from the EMA(s) for the state ADAP. Some Title I EMAs administer local "ADAP supplemental" drug assistance programs for individuals that live within the EMA which may provide drugs not available on the state formulary.

³ *Drug Pricing, Purchasing, and Distribution Systems: State AIDS Drug Assistance Programs*. U.S. Department of Health and Human Services, March 1997.

⁴ *Fiscal Status Update of State AIDS Drug Assistance Programs: Preliminary Findings from an August 1996 National Survey of State AIDS Programs*. National Alliance of State and Territorial AIDS Directors, September 1996.

past two years. These facts, coupled with rapid advances in the treatment of HIV disease, the development of new and effective anti-HIV therapies and a swiftly changing HIV/AIDS treatment paradigm, have placed these programs at the forefront on the national debate over funding for HIV/AIDS services and the accessibility of people living with HIV/AIDS to adequate healthcare.

In an effort to monitor the rapidly changing fiscal and scientific environments in which ADAPs are operating, and the impact of these changes on the programs and the individuals that they serve, the National Alliance of State and Territorial AIDS Directors (NASTAD) received funding from the Henry J. Kaiser Foundation to support a two-year National ADAP Monitoring Project. NASTAD is uniquely qualified to monitor the situation of state ADAPs as it is an association of the individuals who direct AIDS prevention, care and treatment services at the state level. NASTAD's co-funded partner in the Monitoring Project, the AIDS Treatment Data Network (ATDN), is one of the most highly respected HIV/AIDS treatment information centers in the nation; ATDN maintains an on-line information library of the most recent treatment advances in HIV/AIDS, as well as detailed information on publicly and privately funded sources of reimbursement for HIV/AIDS treatments, including ADAPs.

Through the National ADAP Monitoring Project, NASTAD and ATDN will produce two comprehensive annual reports on the status of state ADAPs, with follow-up reports at six-month intervals, over the next two years. In addition to the written reports, detailed state-by-state information on program eligibility, application procedures, access and drug coverage will be made available on-line through ATDN's web site. All information obtained through this project will be available to the general public.

Survey of State AIDS Drug Assistance Programs

Methodology

Using survey instruments previously developed by the National Alliance of State and Territorial AIDS Directors (NASTAD) as models, a comprehensive instrument was developed by NASTAD and ATDN staff for distribution to state AIDS directors and ADAP program managers in the fifty states, the District of Columbia, and the Territories of Guam and the Virgin Islands (all recipients of federal funds under Title II of the Ryan White CARE Act). The survey instrument contained thirty-six questions to assess program operations/trends in the following areas:

- Program Administration
- Drug Purchasing and Distribution Mechanisms
- Program Eligibility Requirements/Client Access
- Drug Formularies
- Program Budget (for Ryan White Fiscal Years⁵ 1996 and 1997)

⁵ The Ryan White Fiscal Year runs from April 1st through March 31st.

- Program Cost-containment Strategies
- Program Monthly Enrollment, Utilization and Expenditures
- Barriers to the Provision of Service

A twelve-member project advisory committee was selected to provide input on the survey design, implementation and reporting. The project advisory committee also was charged with providing objective oversight of the ADAP surveying process and final report. The advisory committee is composed of representatives from national AIDS consumer and advocacy organizations, representatives from the Health Care Financing Administration (HCFA) and the Health Resources and Services Administration (HRSA), representatives from state governmental associations, and representatives from the private and public health sectors.

The survey instrument was distributed to the project advisory committee and a selected group of state AIDS directors and ADAP program managers for review and comment. The instrument was modified based on feedback from this group. The survey was then pilot-tested among five state ADAP programs. Following this pilot test, the survey was further modified, based on state responses, and prepared for distribution to all state ADAPs. The survey was fielded in mid-January 1997 to AIDS directors/ADAP program managers in all fifty states, the District of Columbia, the Commonwealth of Puerto Rico and the Territories of Guam and the Virgin Islands.

Survey Response and Follow-up

A total of fifty three responses were received by March 15, 1997. Responses were received from all states/territories that administer AIDS drug reimbursement programs and from Guam, which does not have an AIDS drug reimbursement program funded through the Ryan White CARE Act. The Virgin Islands, which also does not administer an ADAP program, did not respond to the survey.

A significant number of follow-up phone interviews were conducted with the state ADAPs in order to clarify submitted information and to verify reported budget, expenditure and utilization figures. After verifying the reported information, data from the surveys were compiled and analyzed. A draft report based on the survey data was submitted to the project advisory committee for review and comment, and a finalized report was produced after receiving input from this group.

Responding to the Emergency in Access to New Treatments

Background

The advent of combination antiretroviral therapy for HIV infection in late 1995 brought about an emergency in access to the new treatments for low-income individuals with HIV and AIDS who lack adequate private health insurance or Medicaid coverage. In previous reports, NASTAD and ATDN described the funding shortages experienced by state ADAPs and the limitations in coverage of FDA-approved pharmaceuticals on many state ADAP formularies. The new HIV/AIDS treatment breakthroughs, including the availability of protease inhibitors, and the alarms sounded by patient advocates and states over the crisis in funding for the costly new therapies led to significant responses from many quarters. The federal government, through increased funding for the Ryan White CARE Act AIDS treatment programs in FY 1996 and FY 1997, responded to the emergency. Many state governments, through increased state general revenue funding for ADAPs, in turn have responded. In addition, the growth in the number of new treatments with newer manufacturers entering the HIV/AIDS field and increased state aggressiveness in seeking cost containment measures, have led to an increase in the level of cost recovery achieved through HIV/AIDS drug manufacturer rebates and through private health insurance recovery.

ADAP Program Budgets

Funding for ADAPs has traditionally been drawn from a variety of sources. More recently the diversity of funding sources has expanded at the same time that the resource base has grown. NASTAD has previously reported that in calendar year 1995 there were three main funding sources for ADAPs nationally. These sources included: the portion of federal Ryan White Title II funding which states opted to devote to ADAPs; state general revenue resources; and federal Ryan White Title I funding which Eligible Metropolitan Areas (EMAs) opted to contribute to state ADAPs. In 1995, total funding for ADAPs from all sources was reported by NASTAD to be \$92.1 million with the breakdown of contributions from the three major sources as follows:⁶

1995 ADAP Budget Nationally		
Source	Funding	Percentage
Title II (Federal):	\$40.6 million	(44%)
State Funds:	\$30.7 million	(33%)
Title I (Federal):	\$20.8 million	(23%)
Total:	\$92.1 million	(100%)

⁶ NASTAD, *The Fiscal Status of State AIDS Drug Assistance Programs: Findings for a January 1996 National Survey of State AIDS Directors*, April 1996, prepared for HRSA/Division of HIV Services.

FY 1996 ADAP Budgets

The NASTAD/ATDN survey asked states to detail their ADAP budgets and funding sources for the Ryan White CARE Act Title II federal fiscal years 1996 and 1997. The findings indicate that funding for ADAPs nationally has grown by over 314% since 1995.

In FY 1996, the most significant funding increase resulted from the first time ever dedicated federal appropriation of supplemental funding for ADAPs.⁷ The Clinton Administration proposed, and Congress agreed to, an increase of \$52 million in FY 1996 for state ADAPs to provide FDA-approved HIV/AIDS therapeutics to eligible individuals. This increase, together with increased support states provided from their base Title II grants to ADAPs and a growth in state general revenue support for ADAPs, led to a 136% increase in funding nationally from \$92.1 million in 1995 to \$217.6 million in 1996.

FY 1996 ADAP Budget Nationally		
Source	Funding	Percentage
Title II Base (Federal):	\$58.2 million	(27%)
State Funds:	\$53.7 million	(25%)
Title II ADAP (Federal):	\$52.0 million	(24%)
Title I (Federal):	\$25.9 million	(12%)
Drug Rebates:	\$11.9 million	(5%)
FY 97 Advance (Federal):	\$10.1 million	(5%)
Insurance Recovery:	\$5.0 million	(2%)
Other:	\$.8 million	(0%)
Total:	\$217.6 million	(100%)

Survey Results

In FY 1996, 51 states and territories reported a total of \$58.2 million in funding drawn from Ryan White Title II base formula grants (federal) which represented the highest percentage source (27%) for ADAPs nationally. Pennsylvania was the only state which did not devote a portion of its base Title II funding to ADAP in FY 1996, but it nonetheless devoted a substantial amount of state funding (\$5,200,000) to ADAP. California (\$9,849,105) and New York (\$9,807,712), with the largest Ryan White Title II grants, were the states with the highest contribution from their Title II grants to ADAP. Alaska (\$36,557) and North Dakota (\$55,000) were the states with the smallest dollar contributions from their base Title II funding, but these represented relatively high percentage contributions from their small federal Title II funding allocations. State by

⁷ The Ryan White CARE Act Amendments of 1996 – which reauthorized funding for the CARE Act programs for an additional five years – included a provision for the distribution of appropriated funds exclusively for Title II state AIDS treatments programs. Since FY 1996 state Ryan White Title II grants have two components – base formula grants for comprehensive HIV care services and supplemental ADAP grants specifically for the provision of HIV/AIDS treatments.

state ADAP budgets for FY 1996 are detailed in Appendix I with tables which depict the percentage contributions to ADAP in each state from Title II base and ADAP supplemental grants, state funding, and Title I EMAs.

State general revenue support represented the next highest contributor to ADAPs nationwide with \$53.7 million in FY 1996 (25% of the total). Thirty-four states provided state specific funding for ADAPs with the highest contribution (\$15,600,000) from California and the lowest (\$25,000) from West Virginia among those states reporting contributions. The states with the highest percentage allocation of state funding compared with their overall ADAP budgets in FY 1996 were Louisiana (78%), Pennsylvania (76%), New Mexico (64%), and Illinois (58%). It is notable that 86% of the national contribution to ADAPs from states in FY 1996 was provided by the eight states which contributed over \$1 million individually to ADAPs. These states were California, Illinois, Louisiana, Maryland, Massachusetts, New York, Pennsylvania, Puerto Rico and Texas.

The \$52 million dedicated ADAP appropriation in FY 96 represented nearly one-quarter of the national ADAP budget and it meant a significant boost to struggling ADAPs in their ability to maintain fiscal stability. Its distribution also represented a majority of some individual ADAP budgets in FY 96 with highest portions reported in Tennessee (65%), Oregon (64%), Michigan (54%) and Alaska (51%).

As the proportion of federal Title II support (base and supplemental grants) for ADAPs nationwide grew in FY 1996 from 44% to 51%, the percentage proportion of state and Title I EMA contributions decreased overall, but did not decrease in actual dollar amounts. Title I EMA contributions increased in FY 1996 from \$20.8 million to \$25.9 million nationwide, representing 12% of the national ADAP budget.⁸ Thirteen states reported dollar contributions from federal Title I sources to state ADAPs for the purchase or reimbursement of pharmaceuticals for eligible clients in the Title I areas in FY 1996. This represented 24% of all states and territories and 50% of the 26 states which have Title I EMAs located within their state boundaries. The 13 states were Colorado, Connecticut, D.C., Georgia, Illinois, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, Texas and Washington State. Title I EMAs in New York State (New York City, Nassau-Suffolk, and Dutchess County) contributed the greatest amount of funding (\$19,858,730) to a state ADAP representing 77% of the overall Title I contribution to ADAPs nationwide. The lowest level of funding among those EMAs contributing was the Boston EMA to New Hampshire's ADAP (\$72,308); however this contribution represented 17% of New Hampshire's overall ADAP budget in FY 1996. Percentage of Title I EMA contributions as a proportion of individual state

⁸ NASTAD/ATDN asked states to report only those contributions from Title I EMAs to their state ADAPs. The survey did not ask states to report any funding Title I EMAs have opted to devote for pharmaceutical assistance in general to support access to therapies within Title I areas alone aside from direct financial contributions to state ADAPs.

ADAPs ranged from a high of 34% in New York State and D.C. (\$800,000) to a low of 3% in Texas (\$217,000 from the Houston EMA).

As states reported that they would fall short of ADAP funding before the end of the FY 1996 Ryan White Title II fiscal year (which ended March 31, 1997), the Health Resources and Services Administration (HRSA) allowed states meeting emergency funding conditions to apply for an early advance on FY 1997 dedicated ADAP supplemental funding. Three states (California, Florida and Illinois) were approved by HRSA for early advances on FY 1997 funding to be used prior to the end of FY 1996. Illinois subsequently declined the early federal advance as a result of a state emergency ADAP appropriation. California was approved for an advance of \$6,592,973 and Florida was approved for an advance of \$3,540,938; these two advances are included in the FY 1996 budget tables and national ADAP funding total.

In FY 1996, states also detailed the contributions to their budgets provided through HIV/AIDS drug manufacturer rebates. Twenty-one states reported actual cost recovery from pharmaceutical manufacturers in FY 1996 to recoup the costs of reimbursement for drugs provided to ADAP clients through retail pharmacies. These revenues are returned to ADAPs and are able to be plowed back into program budgets for reimbursement of other drug purchases. Nationally, drug rebates reported by states totaled \$11.9 million, which represented 5% of the national ADAP budget. The most substantial rebates were made to New York (\$5,600,000), California (\$4,193,000), Illinois (\$640,000) and New Jersey (\$550,000). Many other states are able to achieve up-front discounts through Section 602 of the Veterans Health Care Act which allows for Public Health Service covered entities to purchase pharmaceuticals at deep discounts. The discounts achieved by those ADAPs which are structured to take advantage of these reductions through direct purchase of drugs are not reflected as revenue in the individual ADAP budgets. This report contains a more detailed discussion of the cost containment strategies employed by state ADAPs beginning on page 34.

To round out the FY 1996 ADAP budget picture: two states (New York and Illinois) reported revenue achieved through private health insurance recovery totaling over \$5 million; and five states (Arkansas, Colorado, Ohio, Texas and Utah) reported other, smaller funding – totaling approximately \$800,000 – such as transfers from other funding sources and back-billing of Medicaid for the period for which an ADAP client is in the process of applying for state Medicaid eligibility.

FY 1997 Estimated ADAP Budgets

Overview

States provided NASTAD/ATDN with estimated FY 1997 budgets for ADAPs. Since the Ryan White Title II FY 1997 fiscal year begins in April 1997, and the survey responses were provided in February 1997, the budget represents states' best estimates of funding for the coming fiscal year. Although one or more of the budget elements will not be

expected to change during the fiscal year (e.g., the Title II ADAP supplemental), several of the budget elements may change, most notably state contributions, depending on final state appropriations. State by state ADAP budgets for FY 1997 are detailed in Appendix II with tables which depict the percentage contributions to ADAP in each state from Title II base and ADAP supplemental grants, state funding, and Title I EMAs. In addition, tables are included in Appendix II which provide comparisons between FY 1996 and FY 1997 ADAP funding by state and major funding sources.

FY 1997 Estimated ADAP Budget Nationally		
Source	Funding	Percentage
Title II ADAP (Federal):	\$167 million	(44%)
State Funds:	\$109 million	(29%)
Title II Base (Federal):	\$56.9 million	(15%)
Title I (Federal):	\$22.7 million	(6%)
Drug Rebates:	\$18 million	(5%)
Insurance Recovery:	\$7.4 million	(2%)
Other:	\$.5 million	(0%)
Total:	\$381.5 million	(101%)

National ADAP Funding Source Changes Between 1996 and 1997			
Funding Source	FY 1996	FY 1997	% Change
Title II Base (Federal):	\$58.2 million	\$56.9 million	-2%
Title II ADAP (Federal):	\$52.0 million	\$167 million	+221%
State Funds:	\$53.7 million	\$109 million	+103%
Title I (Federal):	\$25.9 million	\$22.7 million	-12%
Drug Rebates:	\$11.9 million	\$18 million	+51%
Insurance Recovery:	\$5.0 million	\$7.4 million	+48%
Other:	\$.75 million	\$.5 million	-33%
Total:	\$217.6 million	\$381.5 million	+75%

Survey Results

The national ADAP budget increased by \$163.9 million (75% growth) between FY 1996 and FY 1997. The two most significant developments in the national ADAP budget picture in FY 1997 were the substantial increase in dedicated ADAP supplemental funding (\$167 million total, representing a 221% growth over the previous year) and the doubling of state general revenue contributions nationally (\$109 million total reported to NASTAD/ATDN, representing a 103% growth over FY 1996).

Expected overall funding increases are highest in California (\$39,058,758) and New York (\$24,825,256). All but two states (Montana and New Hampshire) reported increases in

overall ADAP budgets between FY 1996 and FY 1997. In Montana this was due to a reduction in state support (following a one-time-only emergency funding in FY 1996). In New Hampshire this was due to a reduction in ADAP support drawn from the state's base Title II formula grant. Kansas reported only a 1% increase in its ADAP budget between FY 1996 and FY 1997 which resulted from a reduction in ADAP support drawn from its base Title II formula grant. Percentage increases in ADAP funding ranged from highs of 353% in Louisiana, 324% in Washington State, 268% in Oregon and 244% in Ohio to lows of 1% in Kansas, 3% in Wyoming, 10% in Idaho and 13% in Kentucky.

Congress appropriated an additional \$115 million for Title II ADAP dedicated funding for FY 1997. ADAP supplemental funding has become the single most significant source of funding for most of the nation's ADAPs, representing 44% of the national ADAP budget in FY 1997. As a line item, it represents the majority of state ADAP budgets in 32 states; in three states (Iowa, Minnesota and Tennessee) ADAP supplemental funding represents 100% of the total ADAP budget.

Thirty states contributed state-specific funding to ADAPs in FY 1997 totaling \$109 million and representing 29% of the national ADAP budget. California is expected to provide the most substantial level of funding from its state general revenue fund to ADAP (\$40,159,000) with a budget that is awaiting final approval prior to the beginning of the state fiscal year in June 1997. California's state ADAP contribution represents 48% of its total FY 1997 ADAP budget of \$83,708,997. States which also have substantial estimated contributions from state general revenue funds to ADAP include: Louisiana (\$16,000,000 – 83% of total ADAP budget); Washington State (\$4,200,000 – 61%); Illinois (\$8,325,000 – 57%); New Mexico (\$740,000 – 55%); Pennsylvania (\$4,612,723 – 47%); Massachusetts (\$3,660,000 – 46%); Puerto Rico (\$7,262,008 – 46%); Ohio (\$3,000,000 – 45%); Texas (\$2,697,376 – 16%); and New York (\$12,400,000 – 15%).

Contributions from several states to ADAP have grown substantially between FY 1996 and FY 1997. Ohio's estimated state contribution to ADAP will grow 1400% from \$200,000 to \$3,000,000. Other states expected to experience significant growth in state funding for ADAP in FY 1997 include: Washington State (increase of \$3,782,500 – 906%); Louisiana (increase of \$12,684,926 – 383%); Massachusetts (increase of \$2,560,000 – 233%); California (increase of \$24,559,000 – 157%); Puerto Rico (increase of \$3,855,357 – 113%); Illinois (increase of \$3,125,000 – 60%); New York (increase of \$4,000,000 – 48%); and South Carolina (increase of \$150,000 – 43%). These states make up the vast majority of the increases in state funding for ADAP in the last year.

While the overall national ADAP contributions from states doubled, only one additional state (Vermont) that did not provide state funding for ADAP in FY 1996 has reported contributing to ADAP in FY 1997. The number of ADAPs reporting state contributions declined slightly from 34 in FY 1996 to 30 in FY 1997. While at least 30 states are expected to provide funding for ADAP in FY 1997, at least 22 jurisdictions will not be providing state funding or state contributions are currently uncertain for FY 1997. Five states (Connecticut, Delaware, Minnesota, Montana, and New Hampshire) that had

provided state funding for ADAP in FY 1996 report no state contributions in FY 1997. In the case of Connecticut, this may be amended before the beginning of the state fiscal year. In the case of Montana, the FY 1996 funding was a one-time-only emergency appropriation. Clearly the substantial growth in overall funding from states to ADAPs nationally in FY 1997 must be tempered by the fact that this growth is largely occurring within states that have previously provided funding for ADAPs.

Among the most notable changes in ADAP funding between FY 1996 and FY 1997 was the reduction in support for ADAP drawn from discretionary Ryan White Title II base formula grants. Overall, the total contribution diminished slightly (-2%) in the year. The increase in dedicated ADAP funding gave some states increased flexibility to redirect and target their base Title II funding on other priority areas such as health insurance continuation, viral load testing and monitoring, primary care services and consortia funded activities. Significantly, 30 states either reduced their Title II base grant contributions for ADAPs or did not provide any increased support from their discretionary Title II funding. Seven states (Alaska, Iowa, Maryland, Massachusetts, Minnesota, Missouri and Tennessee) reduced their ADAP funding drawn from base Title II grants by 100%. These seven states joined Pennsylvania as the eight states which do not use any portion of their base Title II grants for ADAP in FY 1997.

The most substantial percentage increases in support from base Title II grants in FY 1997 are reported in Louisiana (254%), Delaware (73%), Connecticut (71%) and Washington State (70%). States which rely the most heavily on base Title II grants to fund portions of their ADAPs are: North Dakota (74% of total ADAP budget); Montana (67%); South Dakota (63%); Mississippi (57%) and Alabama (52%).

Reported contributions from Title I EMAs to state ADAPs have also diminished nationally by 12% between FY 1996 and FY 1997. Thirteen states reported contributions from Title I EMAs in FY 1997 totaling \$22.9 million nationally and representing 6% of the national ADAP budget. Oregon joined the list of states in FY 1997 with funding for its state ADAP from a Title I EMA (Portland). Illinois falls from the list in FY 1997 in reporting zero contributions to its state ADAP from Title I (Chicago). States reporting significant increased contributions from Title I EMAs in FY 1997 include: Colorado (230%), Massachusetts (186%), New Jersey (63%) and Texas (61%). Diminished contributions were reported in Georgia (-6%), Illinois (-100%), Maryland (-4%), New York (-24% -- \$4.8 million), and Washington State (-51%). Despite the decreased support by EMAs in New York State (due to reductions in federal funding), New York's EMAs make up two-thirds (66%) of the national Title I contribution to ADAPs.

Twenty-one states continued to report revenue from drug manufacturer rebates in FY 1997 totaling nearly \$18 million and representing 5% of the national ADAP budget. Remaining high on the list were New York (\$8,380,000) and California (\$7,329,000) in expected increased recovery of costs through rebates in FY 1997.

Trends in Program Enrollment, Utilization and Expenditures

Overview

In gauging state ADAPs response to the emergency in funding and access to HIV/AIDS therapies, NASTAD/ATDN asked states to detail recent trends in program enrollment, client utilization of services and expenditures. NASTAD/ATDN requested that states report program data gathered in the months of July and December 1996. A significant number of states were unable to provide reliable figures on their total monthly enrollment for this survey. Some states do not track overall enrollment in a given month, but track unduplicated enrollment based on a six-month or annual period. Some states—especially those with decentralized program administration—experience significant reporting delays on enrolled clients from the local/regional ADAP-administrating agencies. States are required to report annual unduplicated ADAP client enrollment to HRSA as part of the Annual Administrative Report (AAR), but are not currently required to maintain a tally of enrollment on a month-to-month basis⁹.

It is an increasingly accepted observation that program enrollment in a given month is not a reliable indicator of potential program utilization. In many states, the number of clients utilizing services within a given month is usually fifty percent or less of the total enrollment for that month. However, this percentage varies from state to state and is subject to a number of variables, including the number of days/months for which a prescription may be filled (and therefore the number of times within a given set of months that a client may need to utilize program services).

Based on the variability of enrollment figures, their apparent lack of correlation to actual utilization and the inability of a significant number of states to provide monthly enrollment totals, an analysis of program enrollment trends is not feasible in this report. The authors contend that monthly utilization figures, viewed over the course of several months, are a more reliable indicator of actual ADAP program growth trends than program enrollment totals. Therefore, the analysis presented in this section will focus on trends in program utilization and expenditures

Survey Results

States were asked to provide the total number of ADAP enrollees, the total number of utilizing ADAP clients and total monthly expenditures on pharmaceuticals for the months of July 1996 and December 1996. A “utilizing client” was defined as a client who received at least one prescription through the program during the given month. Actual and percentage increases/decreases in program client utilization and expenditures were calculated over the six month period. State responses are presented in the table beginning on the following page.

⁹ HRSA is planning to institute a voluntary monthly ADAP reporting system in the near future.

ADAP Client Utilization and Expenditures in July 1996 and December 1996

State	July 96 Utilization	Dec. 96 Utilization	Actual Change	% Change	July 96 Expenses	Dec. 96 Expenses	Actual Change	% Change
Alabama	500	700	200	40%	\$167,000	\$219,133	\$52,133	31%
Alaska	NA	9 ^a	9	NA	NA	\$7,500 ^a	\$7,500	NA
Arizona	335	354	19	6%	\$116,761	\$139,205	\$22,444	19%
Arkansas	259	389	130	50%	\$45,260	\$92,126	\$46,866	104%
California	6,258	7,342	1084	17%	\$3,557,218	\$5,004,856	\$1,447,638	41%
Colorado	379	423 ^b	44	12%	\$161,598	\$211,718 ^b	\$50,120	31%
Connecticut	334	548	214	64%	\$188,563	\$447,475	\$258,912	137%
Delaware	55	62	7	13%	\$29,900	\$34,200	\$4,300	14%
D.C.	543 ^d	699	156	29%	\$299,497 ^d	\$150,000	-\$149,497	-50%
Florida	4,322	4,565	243	6%	\$1,748,679	\$1,826,055 ^a	\$77,376	4%
Georgia	922	984	62	7%	\$308,400	\$319,554	\$11,154	4%
Hawaii	60	66	6	10%	\$45,730	\$55,719	\$9,989	22%
Idaho	30	30	0	0%	\$7,215	\$15,366	\$8,151	113%
Illinois	1,303	1,211	-92	-7%	\$769,232	\$755,877	-\$13,355	-2%
Indiana	217	225	8	4%	\$88,738	\$90,027	\$1,289	1%
Iowa	43	39	-4	-9%	\$8,630	\$12,830	\$4,200	49%
Kansas	86	56	-30	-35%	\$40,524	\$32,302	-\$8,222	-20%
Kentucky	113	173 ^c	60	53%	\$45,071	\$91,368 ^c	\$46,296	103%
Louisiana	NA	115 ^c	115	NA	NA	\$47,664 ^c	\$47,664	NA
Maine	65	45 ^b	-20	-31%	\$24,145	\$19,124 ^b	-\$5,021	-21%
Maryland	243	406 ^c	163	67%	\$130,234	\$281,584 ^c	\$151,350	116%
Massachusetts	792	1,074	282	36%	\$309,851	\$347,369	\$37,517	12%
Michigan	177	178	1	1%	\$124,568	\$126,113	\$1,545	1%
Minnesota	203	231 ^b	28	14%	\$36,258	\$45,400 ^b	\$9,142	25%
Mississippi	301	415	114	38%	\$26,174	\$133,751	\$107,577	411%
Missouri	NA	842	842	NA	NA	\$151,848	\$151,848	NA
Montana	23	18 ^b	-5	-22%	\$17,600	\$13,300 ^b	-\$4,300	-24%
Nebraska	57	59	2	4%	\$17,054	\$20,782	\$3,728	22%

State	July 96 Utilization	Dec. 96 Utilization	Actual Change	% Change	July 96 Expenses	Dec. 96 Expenses	Actual Change	% Change
Nevada	217	151	-66	-30%	\$81,900	\$51,079	-\$30,821	-38%
New Hampshire	45	40	-5	-11%	\$21,745	\$19,898	-\$1,847	-8%
New Jersey	994	1,325 ^c	331	33%	\$380,000	\$750,000 ^c	\$370,000	97%
New Mexico	330	375	45	14%	\$125,094	\$154,966	\$29,872	24%
New York	4,859	6,183	1324	27%	\$3,313,519	\$4,684,063	\$1,370,544	41%
North Carolina	268	310	42	16%	\$161,861	\$195,000	\$33,139	20%
North Dakota	15	14 ^c	-1	-7%	\$4,417	\$8,900 ^c	\$4,483	101%
Ohio	323	424	101	31%	\$136,220	\$203,000	\$66,780	49%
Oklahoma	139	243 ^c	104	75%	\$61,686	\$115,430 ^c	\$53,744	87%
Oregon	90	99	9	10%	\$46,100	\$51,600	\$5,500	12%
Pennsylvania	1,060	1,125	65	6%	\$467,808	\$641,201	\$173,393	37%
Puerto Rico	1,920	2,320	400	21%	\$750,000	\$917,000	\$167,000	22%
Rhode Island	69	57 ^c	-12	-17%	\$16,216	\$17,522 ^c	\$1,306	8%
South Carolina	149	198 ^c	49	33%	\$68,220	\$127,113 ^c	\$58,893	86%
South Dakota	25	30	5	20%	\$6,800	\$8,400	\$1,600	24%
Tennessee	113	147	34	30%	\$43,694	\$53,070	\$9,375	21%
Texas	1,910	2,727 ^c	817	43%	\$587,289	\$1,253,940 ^c	\$666,651	114%
Utah	47	79 ^c	32	68%	\$24,736	\$53,000 ^c	\$28,264	114%
Vermont	37	43	6	16%	\$20,053	\$24,000	\$3,946	20%
Virginia	583	700	117	20%	\$45,424	\$76,779	\$31,354	69%
Washington	338	430 ^c	92	27%	\$147,342	\$210,653 ^c	\$63,311	43%
West Virginia	31	39	8	26%	\$15,206	\$29,176	\$13,969	92%
Wisconsin	133	139	6	5%	\$66,966	\$84,099	\$17,133	26%
Wyoming	56	44	-12	-21%	\$1,500	\$1,500	\$0	0%
Totals	31,317	38,500	7,129	23%	\$14,907,699	\$20,423,634	\$5,515,935	37%

^a Data from February 1997

NA=Data not available

^b Data from November 1996

^c Data from January 1997

^d Data from August 1996

^e Data from September 1996

Forty-two states (80%) reported increases in the total number of utilizing clients from July 1996 to December 1996. Twenty-one states (40%) reported a twenty percent or more increase in the number of utilizing clients and six states (12%) reported a fifty percent or higher increase in utilizing clients. Ten states (19%) reported a decrease in utilizing clients and one state (Idaho) reported no change in the number of utilizers.

Forty-four states (85%) indicated increased monthly expenditures in December 1996 as compared to July 1996. Thirty-two states (62%) showed a twenty percent or higher expenditure increase and fourteen states (27%) reported a fifty percent or higher increase in expenditures.

Seven states (13%) showed decreased expenditures in December while one state (Wyoming) reported no difference in the expenditure amounts for July and December. Alaska, Louisiana and Missouri established new ADAP programs during mid to late 1996; therefore, there is no utilization or expenditure data from July 1996 for these programs.

Iowa, North Dakota and Rhode Island reported slight drops in the number of utilizing clients in December 1996 compared to July 1996 but experienced increases in program expenditures. Idaho reported an equal number of utilizing clients for both months but a significant increase (133%) in program expenditures. The following factors may have contributed to the lower utilization numbers reported by these and a few other states: program enrollment caps (Illinois, Kansas, Montana, Nevada, Wyoming), lowering of program financial eligibility thresholds (Illinois, Nevada), and nominal, monthly fluctuations in client utilization among programs in some of the low-incidence states (Iowa, Maine, New Hampshire, North Dakota, Rhode Island).

Utilization and Expenditure Trends

Nationally, states reported that 31,371 clients utilized ADAP services during July 1996 while 38,500 utilized ADAP services during December 1996.¹⁰ This represents a twenty-three percent (23%) increase in the number of utilizing clients from July 1996 to December 1996. Data from a previous survey conducted by NASTAD indicated that state ADAPs served approximately 21,807 clients¹¹ during January 1996. This represents a seventy-seven percent (77%) increase in utilizing clients over the twelve months of 1996, or an average net increase of approximately 1,400 utilizing clients each month. Monthly program expenditures increased from a total of \$14,907,699 in July 1996 to \$20,423,634 in December 1996, representing a thirty-seven percent (37%) increase in expenditures nationally during the second half of calendar year 1996.

¹⁰ The December 1996 figure includes all of those clients that states reported they served in December 1996, or the most recent month for which data was available.

¹¹ Forty-four states reporting.

From the data collected, it is unclear how many *new* clients have begun utilizing ADAP services or how many enrolled clients who previously did not utilize services began to have prescriptions filled through ADAP. It is also unclear how long clients remain enrolled as active utilizers in ADAP programs. What is clear from the data, however, is that there have been very significant increases in the total number of utilizing clients and in total program expenditures nationally over the course of calendar year 1996.

Emergency Cost-Containment Measures

Survey Results

Despite the growth in ADAP budgets, the increase in utilizing client demand and expenditures detailed in the survey have led numerous states to take emergency measures in order to sustain coverage of existing clients or make available newer antiretroviral agents. Thirty-four states (65%) reported taking at least one emergency measure in the last year in response to the crisis in ADAP funding and increased demand for combination therapies. Among the major emergency actions reported by state ADAPs:

Seventeen states (33%) transferred funds from other service categories to ADAP.

The states are Alaska, Arizona, Colorado, District of Columbia, Illinois, Kansas, Louisiana, Maine, Massachusetts, Mississippi, New Mexico, New York, South Carolina, Texas, Utah, Washington State and West Virginia.

Thirteen states (25%) capped ADAP client enrollment.

The states are Alabama, Alaska, Arkansas, D.C., Georgia, Indiana, Kansas, Montana, Nevada, South Carolina, South Dakota, Washington State and Wyoming. Capped enrollment is still in effect in eight of the thirteen states including Alaska, D.C., Georgia, Indiana, Montana, Nevada, South Carolina, and South Dakota.

Thirteen states (25%) capped or restricted access to protease inhibitors for active clients.

The states are D.C., Georgia, Illinois, Kansas, Kentucky, Maine, Missouri, New Hampshire, Oklahoma, Tennessee, Vermont, Virginia and Washington State. These restrictions remain in effect in nine of the thirteen states, including D.C., Georgia, Illinois, Kentucky, Maine, Missouri, Oklahoma, Tennessee and Vermont.

Nine states (17%) reduced ADAP drug formularies.

The states are D.C., Illinois, Indiana, Nebraska, New Jersey, New York, South Dakota, Vermont and Virginia. These reductions remain in effect in seven of the nine states, including D.C., Illinois, Indiana, New Jersey, South Dakota, Vermont and Virginia.

Seven states (13%) capped or restricted access to other formulary drugs.

The states are Georgia, Indiana, Kansas, New Hampshire, Oklahoma, Texas and Washington State. These restrictions remain in effect in five of the seven states, including Georgia, Indiana, New Hampshire, Oklahoma and Texas.

Seven states (13%) revised ADAP financial eligibility criteria by lowering income levels. The states are Alabama, D.C., Illinois, Kentucky, Massachusetts, Nevada and Utah. These revised criteria are still in effect in five of the seven states including D.C., Illinois, Kentucky, Massachusetts and Nevada.

Six states (12%) canceled planned drug formulary expansions. The states are Alabama, Illinois, Mississippi, Nevada, New Jersey and West Virginia. These expansions remain on hold in four of the six states including Mississippi, Nevada, New Jersey and West Virginia.

ADAP Budget Shortfalls

Survey Results

NASTAD/ATDN asked states if they expect to encounter a shortfall in their ADAPs before the end of the Ryan White Title II FY 1997 budget period which began on April 1, 1997 and which ends March 31, 1998. Despite the emergency measures undertaken to prevent funding shortages, eleven states (21%) responded that they predict a shortfall in FY 1997. The states reporting anticipated shortages are Alabama, Arizona, Arkansas, Colorado, Montana, New Mexico, Puerto Rico, Texas, Vermont, Washington State¹² and West Virginia. Anticipated shortages reported by the eleven states total over \$8.5 million in FY 1997.

It is important to note that some state program managers may be reluctant to report anticipated shortfalls in ADAP budgets given the reality that the programs are prohibited from “running out of money.” In addition, several states, including Florida, Mississippi and South Dakota, have recently been forced to severely limit access to their ADAPs or substantially cut back on services to clients in order to sustain limited program operations for the coming year. Nonetheless, these states are not indicating expected shortfalls at this time.

Additionally, every state has recently received significant infusions of Ryan White Title II base and/or supplemental funding with which to implement programs in FY 1997. It may be too early to tell which programs will experience overwhelming demand and costs which may result in additional reported shortfalls in FY 1997. Several factors may hasten additional states to report shortages before the end of 1997. These include: 1) failure to obtain proposed state and other funding increases for ADAPs; 2) approval of additional high-cost HIV/AIDS therapies before the close of the fiscal year; and 3) the impact of federal HIV clinical practice guidelines which will likely drive demand for programs to offer more expanded treatment options to meet current treatment standards.

¹² Since responding to the survey, Washington State’s ADAP has been provided a revised state appropriation containing a significant increase in funding which may mitigate a previously predicted shortfall in FY 1997.

Accessibility of State ADAPs Nationally

Overview

As outlined in the previous section of this report, state ADAPs have seen significant growth in the number of utilizing clients over the past year and a half. One likely reason for this growth is the recent availability of new treatments which hold out the hope of extending and improving the quality of life for people with HIV/AIDS. However, as indicated in the previous section, many states have been forced to limit or cap new enrollment in their programs and/or restrict access to promising new drug therapies. Many individuals are turning to ADAPs with renewed hope, only to find the doors closed due to a lack of sufficient resources.

Barriers to Serving Intended Client Populations

Background

ADAPs, by statute, are intended to provide pharmaceutical assistance to low income, uninsured and underinsured individuals. This may include lower-income individuals who have either no private insurance coverage, inadequate prescription coverage through their private insurance (e.g., prescription caps)¹³, individuals who do not meet the financial or disability criteria for Medicaid, and/or individuals who are ineligible for Medicaid due to other factors (immigration status, homelessness, substance abuse). There has been little effort in the past to identify the barriers that ADAP programs face in attempting to serve intended client populations. Most previous analyses of ADAP programs have focused solely on funding-related issues. However, there are additional barriers that may limit an ADAP's ability to adequately provide services to the populations they are intended to serve.

Survey Results

States were asked to list the barriers, in order of severity, that impact on their ability to serve intended client populations. Similar responses were collapsed into single categories; identified barriers listed by only one state each were collapsed into the category of "other." Responses are summarized below:

Identified Barriers	Number of States	% of States
Inadequate Funding	24	45%
Administrative Issues (e.g., lack of automation, inadequate staffing, etc.)	6	11%
Lack of Adequate Service Coordination (e.g., with	6	11%

¹³ In a few states, individuals who have any form of third-party insurance coverage are not eligible for ADAP services.

Identified Barriers	Number of States	% of States
case managers or other service providers, especially in rural areas of the states)		
Lack of Adequate Coordination with the State Medicaid Program	4	8%
Other	6	11%
None Identified	7	13%

Twenty-four states (45%) of the fifty-three surveyed indicated that inadequate funding is the primary barrier to their ADAP's ability to serve intended client populations. Six states (11%) cited various administrative issues as another barrier to adequate service delivery and six (11%) indicated that lack of adequate service coordination with other providers—especially in rural areas—was a barrier to the adequate provision of service. Four states (8%) identified lack of coordination with the state Medicaid program as a barrier and six states (11%) named other factors¹⁴ as barriers to service provision. Seven states (13%) identified no barriers to service. Eleven states did not respond to this question.

Several states also expressed difficulty in defining what is meant by “adequately serving intended client populations.” There are currently no national projections of the potential universe of ADAP clients who *could* be served in the absence of the identified barriers. According to the CDC, twenty-eight states collect data on HIV infection rates in addition to AIDS cases, and two of these states only collect information on new HIV infections for infants. The lack of sufficient data on both HIV infection and AIDS case rates in states, in addition to a lack of an assessment of the numbers of HIV-infected individuals and individuals with AIDS who have adequate private insurance prescription coverage and/or Medicaid, makes a realistic estimate of the potential ADAP client population problematic.

Waiting Lists

Overview

As indicated in the previous section, a number of state ADAPs capped program enrollment and/or capped access to protease inhibitors for active clients. Some states that enacted program or protease inhibitor enrollment caps over the past year instituted formal waiting lists. Others, however, kept only an informal tally of individuals that were turned away from the program.

¹⁴ These included: coordination between ADAP funding sources (Titles I and II specifically), insurance coordination issues, the potential impact of welfare/Medicaid reform, restrictions on the use of ADAP-specific CARE Act funds for the continuation/purchase of private insurance for clients, and lack of consumer/provider knowledge about the program.

Survey Results

Nine state ADAPs (17%) reported that they had a formal waiting list currently in effect. These are Alaska, District of Columbia, Georgia, Indiana, Missouri, Nevada, South Carolina, South Dakota and Virginia. Two states, Montana and Wyoming, reported that although there was no formal waiting list, clients had been denied admission to the program during the past year due to budget shortfalls. Alabama noted that they are only able to add new clients as current clients leave the program, and that a formal waiting list may be instituted in the near future. Florida also noted that a waiting list may be instituted in April due to the fact that demand for the program is expected to exceed available resources. Several programs also have waiting lists specifically for access to protease inhibitors. These states include Kentucky, Maine, Missouri, Oklahoma, Vermont and Virginia.

Program Eligibility Criteria

Overview

Eligibility criteria for access to ADAPs are developed by each state and, therefore, vary from program to program. Eligibility criteria are established at the local level within the guidelines established by the Ryan White CARE Act. Eligibility criteria generally fall into two broad categories: financial eligibility and medical eligibility. Some ADAPs, however, have developed additional eligibility requirements for access to specific formulary drugs. All of these factors contribute to a picture of uneven access to ADAPs across the nation.

Financial Eligibility Criteria

The majority of ADAPs continue to use the federal poverty guidelines when assessing financial eligibility. The exceptions are Maryland, Massachusetts, New Jersey, New York, Pennsylvania and Puerto Rico. These programs have specific income criteria that do not change annually as is the case with the federal poverty guidelines. Montana requests that an applicant provide evidence that the cost of the covered medications will create a severe financial burden on his/her household.

All other programs specify a percentage of the current federal poverty guidelines for determining financial eligibility. These percentages can be absolute, or eligibility can be tiered to allow sliding-scale co-payments based on how the applicant's income equates with the federal poverty guidelines. Some programs will take into account out-of-pocket medication expenses when determining income, a practice known as "spend-down." A comprehensive state-by-state listing of program eligibility requirements is presented in Appendix III.

Ten ADAPs (19%) have restrictions on liquid assets as part of their financial eligibility criteria. These are Hawaii, Kentucky, Louisiana, Minnesota, Nevada, New Mexico, New York, Oregon, Tennessee and Washington. Louisiana and Nevada specify liquid assets of less than \$4,000 for admission into the program. In Tennessee, the asset threshold is \$8,000; in Hawaii, Kentucky, New Mexico and Washington the limit is \$10,000. Oregon sets \$20,000 as the maximum allowable asset. Minnesota and New York set the allowable asset limit at \$25,000 or less.

The documentation required to prove income varies somewhat by program, but typically involves standard paperwork such as W-2 forms, tax returns, recent pay stubs or entitlement award letters.

Medical Eligibility Criteria

The basic medical criteria for enrollment into any ADAP is a diagnosis of HIV infection. Alabama, Florida, Georgia, Idaho, Indiana, Mississippi, Nevada and South Carolina also require that an applicant have a CD4 cell count of less than 500, although this can be waived for pregnant women and neonates needing AZT. South Carolina also notes that the CD4 requirement can be waived under other unspecified circumstances.

Kentucky currently requires a CD4 count of under 550 or a history of confirmed pneumocystis carinii pneumonia for enrollment in the program, although again this can be waived for pregnant women and neonates. Iowa requests that applicants have a recent CD4 count result available, but there is no specific CD4 requirement for entry into the program.

A new prognostic laboratory test known as the HIV viral load test is also now being used to determine medical eligibility for some ADAPs. The viral load test measures the amount of viral genetic material, known as HIV RNA, in a blood sample. Maine states that a CD4 count of under 400 or a viral load test result of over 20,000 copies is required for admission into the program. Mississippi requires a CD4 count under 500 or a viral load test result of over 30,000 copies. Puerto Rico specifies that the CD4 count be under 500 or the viral load be over 10,000. Louisiana and Virginia require that new applicants have a recent viral load test result available but there is no specific viral load requirement for entry into these programs.

Alaska, Arkansas, California, Colorado, Connecticut, Maryland, Minnesota, Montana, Oklahoma, Pennsylvania, South Dakota and Wisconsin all require that an applicant have a prescription for a covered drug before being enrolled in ADAP.

Additional Eligibility Criteria

The majority of ADAPs require that an applicant be a resident of the state. North Dakota specifies that the applicant must have been a state resident for at least 30 days. New Mexico further requires that an applicant also be a "resident" of the United States. There

is one exception to this general state-residency requirement: Minnesota ADAP will accept applicants from two EMA counties in Wisconsin.

Effective April 1, 1997, Illinois will require evidence of denial from the Medicaid program. Wisconsin also requires that an applicant has applied for—and has been denied—medical assistance during the 12 months prior to the date of his/her ADAP application. Michigan requires a Medicaid denial from within the past 60 days.

For coverage of people with existing third-party insurance, Minnesota requires that the individual is responsible for more than 20% of the prescription cost, or more than \$15.00 per prescription. Illinois ADAP requires that an applicant's insurance must cover less than 80% of their prescription medications. Arkansas ADAP specifies that applicants have no third-party insurance that pays for more than 50% of the cost of any ADAP-covered medication.

ADAP Drug Formularies

Overview

States determine both the number and type of drugs that are available on their state ADAP formulary. Hence, there is a significant variation in the size and composition of ADAP formularies from state to state. Historically, the only time at which there has been equitable coverage of drugs nationally was when just one HIV/AIDS drug was approved, zidovudine (AZT/Retrovir). ADAP formulary drugs now fall into two main categories: antiretrovirals, which target HIV directly, and drugs to treat and/or prevent the opportunistic infections that can result from advanced HIV-related immune deficiency or AIDS.

Many state ADAPs also have advisory committees that assist them in crafting the ADAP drug formulary and, in some cases, that also provide input on broader ADAP policy issues. The composition of these advisory committees is determined locally. The Division of HIV Services (DHS) at HRSA recently has encouraged state ADAPs to utilize advisory committees in their decision making processes, especially since many of the programs are faced with making difficult medical and ethical decisions.

Survey Results

State ADAPs were asked to provide a copy of their most recent formulary, along with information on access criteria for specific formulary drugs, if applicable. States were also asked whether they have an ADAP advisory committee that has input into the formulary decision-making process. States with ADAP advisory committees were asked to describe the composition/membership of their advisory committees.

New York's ADAP offers the most comprehensive formulary, totaling 214 drugs, hepatitis vaccines and a variety of nutritional supplements and vitamins¹⁵. This is commensurate with having the largest budget of any ADAP next to California. At the other end of the spectrum is Louisiana ADAP which reports that it covers only the three approved protease inhibitors. However, an additional HIV drug formulary is available to low income state residents through several ambulatory care sites throughout the state, provided under the auspices of the Louisiana Health Care Authority (LHCA). There are plans to combine the state-funded LHCA program with the federally-funded ADAP in order to provide a more uniform HIV pharmaceutical assistance program for people living with HIV in Louisiana. For a full listing of ADAP drug coverage state-by-state, see Appendix IV.

Although HIV incidence within a state, number of clients served and total budget might be expected to impact upon the comprehensiveness of an ADAP drug formulary, this is not always the case. North Dakota currently offers the third largest formulary in the nation, although it has the smallest budget of any ADAP. North Dakota also served just fourteen clients during January 1997, making it the second smallest program next to Alaska in terms of clients served.

Coverage of Antiretrovirals

The great leap forward in HIV/AIDS treatment witnessed over the past year has been driven largely by the advent of combination anti-HIV regimens containing protease inhibitors¹⁶. At the time of our survey, three protease inhibitors were commercially available: saquinavir (Invirase), zidovudine (ZDV) and didanosine (ddI). Saquinavir was approved in December 1995, with zidovudine and didanosine gaining FDA licensing in March of 1996. On March 14, 1997, following the completion deadline for the ADAP survey discussed in this report, a fourth protease inhibitor, nelfinavir (Viracept), received FDA approval.

Four state ADAPs report that they do not cover any protease inhibitors: Arkansas, Nevada, Oregon, and South Dakota. Arkansas notes that formulary expansion is planned,

¹⁵ The nutritional supplements and vitamins on New York formulary are actually available through New York's ADAP Plus program, and are reimbursed with non-ADAP specific Title II and Title I dollars. Guidances from HRSA stipulate that only FDA-approved *pharmaceuticals* may be reimbursed under ADAP.

¹⁶ *Prolongation of Life and Prevention of AIDS in advanced HIV Immunodeficiency with Ritonavir*. Cameron et al, 3rd Conference on Retroviruses and Opportunistic Infections, Washington DC January 28-February 1, 1996. *Potent and Sustained Antiretroviral Activity of Indinavir (IDV) in Combination with Zidovudine (ZDV) and Lamivudine (3TC)*. Gulick et al, 3rd Conference on Retroviruses and Opportunistic Infections, Washington DC January 28-February 1, 1996. *Improved Survival and Decreased Progression of HIV in Patients Treated with saquinavir plus HIVID*. Lalezari et al, [LB.B.6033] XI International Conference on AIDS, Vancouver, BC July 7-12, 1996. *ACTG 320: A Randomized Double-Blind, Phase III Study of Indinavir Sulfate (IDV) with Open-Label Zidovudine (ZDV) or Stavudine (d4T) and Lamivudine (3TC) in Subjects with HIV Infection with CD4 Cell Counts ≤ 200 Cells/mm³ and ≥ 3 Months of Prior ZDV Experience*. ACTG 320 Protocol Team, Executive Summary, February 21, 1997.

but mentions no specific date. Nevada is considering adding new drugs if state funding can be secured. Oregon's ADAP reports that formulary expansion may be possible if the ADAP can successfully move more ADAP clients on to more comprehensive health insurance coverage. South Dakota estimates that the program would require an additional \$150,000 a year in funding to provide protease inhibitors to eligible clients.

Several states do not offer all three approved protease inhibitors. Delaware reports that indinavir will be added when it is "commercially available." This is presumably a reference to the fact that the drug is currently available nationally through only one mail order pharmacy, Stadtlanders, located in Pittsburgh, PA. Idaho covers only indinavir. Mississippi covers only saquinavir. Virginia reports that only one protease inhibitor, indinavir, is covered on the formulary, but other protease inhibitors can be made available if an individual cannot tolerate or becomes resistant to indinavir.

All ADAP programs, with the exception of Louisiana, offer all five approved nucleoside analog antiretroviral drugs: zidovudine (AZT, Retrovir), didanosine (ddI, Videx), zalcitabine (ddC, HIVID), stavudine (d4T, Zerit) and lamivudine (3TC, Epivir). As previously noted, a separate state program can provide these drugs through several ambulatory care sites in Louisiana.

A new class of anti-HIV drugs known as non-nucleoside reverse transcriptase inhibitors (NNRTIs) have also recently become more widely available. There is currently only one approved NNRTI¹⁷, nevirapine (Viramune). Since its approval in June of 1996, twenty-six ADAPs have added the drug to their formularies. Three states responded that nevirapine was currently under consideration for addition to their formulary.

Nelfinavir became the fourth FDA approved protease inhibitor on March 14, 1997, following the deadline for completion of the survey. Preliminary data from other sources indicate, however, that currently, approximately 28 ADAPs (54%) have added nelfinavir to their formulary.

Drugs for the Treatment and Prevention of Opportunistic Infections

Drugs for the treatment and prevention of opportunistic infections (OIs) have significantly improved the length and quality of the lives of people with AIDS. The preventive treatments available for pneumocystis carinii pneumonia (PCP), for example, have dramatically extended survival after an AIDS diagnosis.¹⁸

¹⁷ Since the completion of this report, the FDA has approved a second NNRTI, delavirdine (Rescriptor) for use in the treatment of HIV infection.

¹⁸ Ward JW, Hanson DL, Chu Sy, et al., *Survival and trends in antiretroviral therapy and antimicrobial prophylaxis among persons with 1993-defined AIDS* [abstract: I86]. 35th Interscience Conference on Antimicrobial Agents and Chemotherapy, San Francisco, 1995.

Most ADAPs¹⁹ offer some of the available OI drugs, but it is in this category of drug coverage that the widest variability is found across the states. The reauthorized Ryan White CARE Act explicitly stipulates that efforts be undertaken at the Federal level to ensure that ADAPs offer comprehensive coverage of OI drugs.

In 1995, the Infectious Disease Society of America (IDSA) in conjunction with the US Public Health Service (PHS) issued *Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus*. The drugs referenced in these guidelines as "strongly recommended" for the treatment and prevention of OIs include TMP/SMX, dapsone, pentamidine, pyrimethamine, leucovorin, sulfadiazine, clindamycin, fluconazole, itraconazole, isoniazid, foscarnet, ganciclovir and acyclovir. Currently, five ADAPs (10%) report that they have these drugs available on their formularies: Illinois, New York, North Dakota, Pennsylvania and Wyoming. A revised, updated ISDA/PHS document is expected to be published during Summer 1997.

Currently, there are three drugs approved for the prevention of another common OI, *Mycobacterium avium* complex (MAC): rifabutin, clarithromycin and azithromycin. All of these treatments have demonstrated a clear ability to prevent MAC²⁰ and two have also been associated with a distinct survival benefit²¹. Thirty programs (58%) cover all three of these drugs. Five ADAPs offer two of these drugs while six ADAPs cover only one.

Medical Criteria for Access to Formulary Drugs

Sixteen states (31%) report that they have established specific medical criteria for access to certain formulary drugs. These criteria commonly take the form of specific diagnoses or laboratory values (e.g., CD4 counts, viral load levels). Medical access criteria and other formulary restrictions are presented for each state ADAP in Appendix V.

¹⁹ Five state ADAPs (10%) report that they offer coverage for antiretroviral drugs only. These are: Alaska, Colorado, Georgia, Louisiana and Utah.

²⁰ Nightingale SD, Cameron DW, Gordin FM, et al.: *Two controlled trials of rifabutin prophylaxis against Mycobacterium avium complex infection in AIDS*. N Engl J Med 329:828-33, 1993.

Pierce M, Lamarca A, Jablonoski H, et al.: *A placebo controlled trial of clarithromycin prophylaxis against MAC infection in AIDS patients* [abstract]. 34th Interscience Conference on Antimicrobial Agents and Chemotherapy, Orlando, 1994.

Havir DV, Dube MP, Sattler FR, et al.: *Prophylaxis against disseminated Mycobacterium avium complex with weekly azithromycin, daily rifabutin, or both*. N Engl J Med 335:392-8, 1996.

²¹ Moore RD, Chaisson RE: *Survival analysis of two controlled trials of rifabutin prophylaxis against Mycobacterium avium complex in AIDS*. AIDS 9:1337-42, 1995.

Pierce M, Crampton S, Henry D, et al.: *A randomized trial of clarithromycin as prophylaxis against disseminated Mycobacterium avium complex infection in patients with advanced acquired immunodeficiency syndrome*. N Engl J Med 335:384-91, 1996.

Antiretrovirals

Several states have specific medical criteria for access to protease inhibitors and other antiretroviral treatments. Georgia requires a CD4 cell count under 100 for access to protease inhibitors. Kentucky specifies under 200 CD4 cells, a viral load of over 10,000 and failure of prior combination reverse transcriptase inhibitor treatment for access to their protease inhibitor pilot program. Florida requires a CD4 cell count of under 350 and a viral load of over 10,000 for protease inhibitors. Idaho offers one protease inhibitor, indinavir (Crixivan), and requires prior failure of double combination reverse transcriptase inhibitor therapy before granting access to this drug.

Puerto Rico limits protease inhibitors to those with a CD4 count under 500 *and* a viral load of over 10,000. Virginia uses the same criteria but specifies CD4 less than 500 *or* viral load greater than 10,000. Tennessee ADAP follows guidelines promulgated by TennCare, their statewide managed care program. These guidelines state that antiretroviral therapy is appropriate if the CD4 count is under 500 and the viral load is over 5,000, or if the CD4 count is over 500 and the viral load is over 30,000. Texas uses solely a viral load criteria of over 10,000 for protease inhibitor treatment.

Opportunistic Infection Prophylaxis and Treatment

Fifteen ADAP programs (29%) also have developed medical criteria for access to certain OI drugs. These criteria commonly are based upon FDA-approved drug labeling (e.g., a drug may be indicated for the prophylaxis of a particular OI in a person who has a particular CD4 count). Some ADAPs limit access to certain IO drugs by only reimbursing the cost of the drug if it is used in acute treatment, *not* prophylaxis. For example, Delaware, Illinois, Kansas, Mississippi and Texas ADAPs will not pay for prophylactic use of the drug ganciclovir. Massachusetts, Michigan, Mississippi, Nevada and Texas ADAPs will not pay for prophylactic use of the drug fluconazole.

ADAP Advisory Committees

Forty-six states (88%) report that they have a formal ADAP advisory board in place. Alaska, Kentucky, Montana and Wisconsin report that they use an informal advisory network. Kentucky indicates that its informal advisory network includes physicians, community-based organizations and people living with HIV and that it finds the informal system to be more efficient than regularly convening a formally appointed group. Louisiana and Tennessee reported that they do not have an ADAP advisory board.

Physicians are represented on the ADAP advisory committees in forty-five states. Vermont ADAP reports that no physicians sit on its advisory committee (the committee, however, does include pharmacists, people living with HIV and ADAP consumers). The following table details the overall representation of various groups on ADAP advisory committees.

Category	No. of Advisory Committees
Physicians	45
People Living with HIV/AIDS	39
Pharmacists	34
State Governmental Representatives	42
ADAP Consumers	35
Representatives from Ethnic/Racial Minorities	19
Other*	19

* Advisory group members in the "Other" category include: Title I Administrators, Ethicists, Case Managers, Nurse Practitioners, Substance Use program staff, ADAP staff, Academics, Title II Administrators and Medicaid representatives.

Community Outreach Strategies

The degree to which ADAPs conduct outreach efforts in local communities to reach potential clients may have an impact on the accessibility of the program, especially for traditionally under-served populations. States were asked to indicate whether they conduct outreach efforts to make potential clients aware of ADAP and, if so, to include information on special outreach efforts to racial/ethnic minority populations and women, if applicable.

Thirty-five states (67%) report conducting outreach to publicize their ADAP. The methods used vary, but commonly include distribution of information (in the form of flyers, brochures, informational letters, etc.) through local providers, including diverse community-based organizations, consortia, medical providers and health clinics. Several ADAP programs indicated that they use local press outlets, including newspapers with a specific ethnic audience, to make potential clients aware of the program. New York indicated that they also utilize television and radio advertising, and Ohio is also working on a video to promote the program.

Re-evaluating ADAP Program Structures and Strategies

Overview

In the midst of rapid changes in budgets, program eligibility and drug coverage, state officials have also sought to improve ADAP program structures and strategies. Many states reported that they have examined and re-examined such basic yet complex areas as how their ADAPs are administered, how drugs are purchased and distributed to clients, and how costs can be reduced.

Program Administration

Background

The Ryan White CARE Act allows states significant flexibility in structuring the underlying administrative structure of their ADAP programs. This flexibility has resulted in varying administrative structures across state ADAPs. However, these basic variations in ADAP program administration generally fall into one of three broad categories: centralized, decentralized and contracted out.

Centralized: ADAPs in this category are administered out of a central state agency, usually the state health or social/human service department.

Decentralized: ADAPs in this category are generally administered through local consortia or county health departments. These entities receive sub-grants from the state to administer the day-to-day activities of the ADAP at a local/regional level. The state continues to maintain a relatively large role in the oversight of the program.

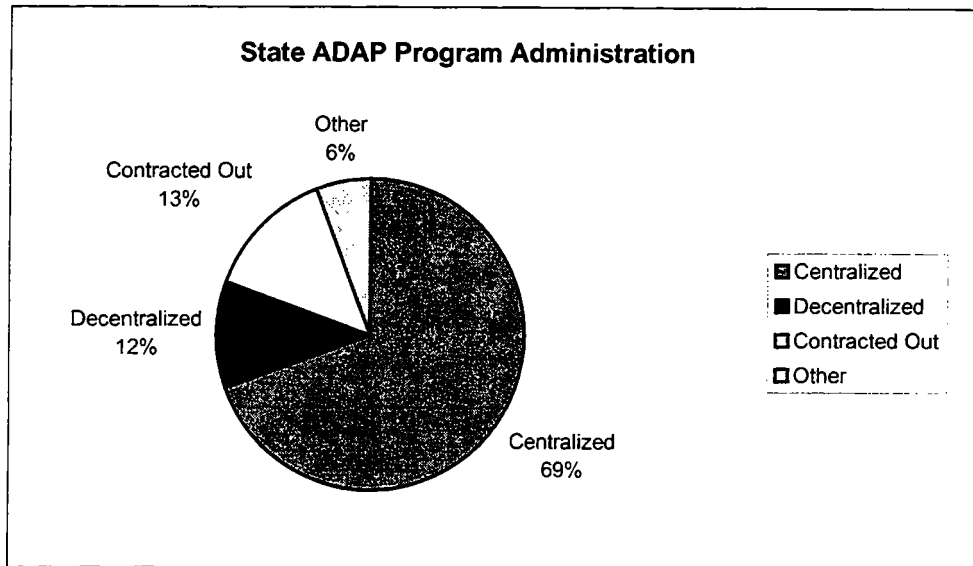
Contracted Out: ADAPs in this category are generally administered by a private or public agency (e.g. a public hospital or a community-based organization) through a contract/grant with the state. There is minimal state involvement in the day to day operations of the program.

Survey Results

The survey asked whether states administer their ADAP centrally, de-centrally, contract-out the day-to-day administration of the program, or use some other administrative mechanism. Results are presented in the Table on the following page.

Of the fifty-two state ADAPs responding to this survey question, thirty-six states (69%) indicated that they centrally administer their ADAP program. Six states (12%) indicated that their programs are administered through a decentralized mechanism, seven states

(13%) contract out the administration of their ADAPs, and three states (6%) indicated that their programs are administered through other mechanisms. To illustrate the variety of responses: New York administers its ADAP program centrally through the state health department; Arkansas provides grants to local consortia to administer ADAP at a regional level; Indiana contracts out the administration of its ADAP to the Indiana Community AIDS Action Network (ICAAN); and Delaware administers part of its ADAP grant centrally, while contracting out a large portion of the grant to the Medical Center of Delaware.



Another survey question asked whether states had any plans to change the administration of their ADAPs. Forty-five states (87%) have no plans to change the administrative structure of their programs, while the remaining seven states (13%) are planning to alter their program's administrative structure. Of these seven states, five (Arizona, California, Missouri, Puerto Rico and West Virginia) plan to move from a decentralized or contracted-out program to a centrally administered program.

Drug Purchasing And Distribution Systems

Background

The drug purchasing and distribution systems of state ADAPs have been under increasing scrutiny from Congress, the Administration and HIV/AIDS advocacy organizations over the past several months. The heightened interest is due in large part to the fact that the drug purchase and distribution system used by a state ADAP has a direct impact on the ADAP's ability to take advantage of the various drug discounting mechanisms which are available to the programs. The more money an ADAP can save through discounted purchasing arrangements or rebates, the more money there is available to potentially

expand the ADAP drug formulary and/or to expand program eligibility to serve more clients. In order to serve increasing numbers of potential clients while covering new and promising therapies (protease inhibitors in particular), states have been obliged to carefully evaluate their drug purchasing and distribution systems in order to meet these challenges with finite resources.

The methods that states use to purchase formulary drugs may be classified generally as follows:

Direct Purchasing: the state ADAP purchases drugs centrally by itself, or through a state pharmacy, purchasing agent or public agency/hospital

Indirect Purchasing: the state ADAP contracts with a retail pharmacy network/mail order pharmacy/pharmacy benefits management company (PBM) for the purchase of drugs and subsequently *reimburses* the purchasing entity.

State ADAPs that purchase drugs directly usually have a centralized mechanism for dispensing drugs to clients. For example, drugs purchased through a central state pharmacy may be distributed through a network of local public health clinics/hospitals, sent directly to clients or distributed through clients' physicians. Drugs purchased indirectly through a retail/mail order pharmacy mechanism are distributed to clients by these retail pharmacy entities. In order to participate in certain federal drug discount programs, states must abide by specific guidelines in terms of their drug purchasing and distribution systems. This will be discussed in more detail in the section on cost containment strategies.

Survey Results

States were asked whether they purchased formulary drugs directly, indirectly or through some other method. Responses are summarized in the table below:

Purchasing Method	Number of States	States
Direct	18	Alabama, Arizona, Colorado, District of Columbia, Florida, Georgia, Hawaii, Louisiana, Mississippi, Nebraska, Nevada, New Mexico, Oregon, Puerto Rico, South Carolina, Tennessee, Texas, Virginia
Indirect	20	Alaska, Connecticut, Idaho, Illinois, Indiana, Kansas, Maine, Michigan, Minnesota, Missouri, Montana, New Hampshire, New York, Ohio, Oklahoma, South Dakota, Vermont, Washington, West Virginia, Wisconsin
Other	14	Arkansas, California, Delaware, Iowa, Kentucky, Maryland, Massachusetts, New Jersey, North Carolina, North Dakota, Pennsylvania, Rhode Island, Utah, Wyoming

Eighteen states (35%) indicated that they purchase drugs directly, twenty states (38%) responded that they purchase drugs indirectly, and fourteen states (27%) responded that they use another method to purchase formulary drugs. Of the fourteen states which indicated that they used another drug purchasing method, all use some version of the indirect purchase method or a combination of direct and indirect purchasing e.g. in Maryland and Kentucky, ADAP clients choose their own pharmacies and the ADAP programs reimburse the pharmacies at a set rate for covered drugs, but there is no formal contract between the programs and the pharmacies; in Iowa and Arkansas, each regional consortia contracts with its own pharmacy provider; and in Delaware, drugs are purchased both directly by the state and indirectly through local pharmacies.

States were also asked how purchased drugs are distributed to ADAP clients. State ADAP drug distribution mechanisms are listed below, in order of frequency used:

Multiple retail pharmacy sites	31 states
County/local health clinics	16 states
Retail mail order	15 states
Via mail from a state pharmacy/ state contracted pharmacy	10 states
Public hospitals	6 states
Client's physicians	5 states
Other	5 states
Only one retail pharmacy site	2 states

Many states use multiple distribution mechanisms (e.g. multiple retail sites and mail order), however some states use only one mechanism: Illinois, Maine, Ohio and Oklahoma use a retail mail order pharmacy as the sole drug distributor; Florida distributes drugs to ADAP clients only through local public health clinics; Alabama ships drugs to clients via mail from a state-contracted dispenser.

States were asked whether they had plans to change their ADAP drug purchasing and distribution systems. Forty-five states (83%) responded that they have no plans to modify their current drug purchasing and distribution systems. Nine states (17%) indicated that they are in the process of—or considering—changing these systems. Connecticut, Kentucky, West Virginia and Wyoming are considering using a retail mail order pharmacy to purchase and distribute drugs. Oregon is considering contracting with a pharmacy benefits management company (PBM) while California is actively soliciting proposals from PBMs to coordinate ADAP drug purchasing and distribution statewide.

Cost Containment Strategies

Background

Many of the cost containment strategies employed by state ADAPs are related directly to their drug purchasing and distribution systems or to the drug distribution process. In fact, the way an ADAP purchases and distributes covered pharmaceuticals has dictated the basic type of cost-savings strategy that the ADAP may utilize. There are two primary ways that an ADAP can obtain reduced costs on drug that it purchases for distribution to clients: through discounted drug pricing at the time of purchase as provided for under section 602 of Veterans Health Care Act, or through voluntary manufacturers' rebates.

The 602 Program

Section 602 of the Veteran's Health Care Act stipulates that state ADAPs, along with certain other federally-funded programs, can purchase covered drugs at discounted prices. The discount rate available to ADAPs under the 602 program is equal to the rebate amount that manufacturers are mandated to pay to state Medicaid programs. Pharmaceutical manufacturers are required to sell drugs to ADAPs at the discounted price so long as the ADAP is officially registered as a participant in this program at the Office of Drug Pricing (ODP), the federal agency that administers the 602 discount program. The discounted unit price on covered drugs is usually at least 15% below the Average Manufacturers Price (AMP), i.e. about 15% below the base/wholesale cost of the drug.

After the passage of the Veteran's Health Care Act in 1992, ODP developed guidelines for participation in the 602 drug discount program²². However, these guidelines, as applicable to state ADAPs, have sometimes proved to be a barrier to ADAP participation in the 602 program. For example, the current guidelines permit ADAPs to access drug discounts only through a direct purchasing mechanism and not through a rebate mechanism. This means, effectively, that ADAPs that purchase drugs through an indirect/reimbursement mechanism may not access the discounts available under the 602 program. In addition, those states that purchase directly and participate in the 602 program have been unable, until recently, to distribute drugs through a retail pharmacy mechanism. This situation has recently changed with the recent (August 1996) publication of guidelines on the use of contract pharmacy services in the Federal Register; however ADAPs are currently limited to dispensing drugs from only one retail pharmacy site under these new guidelines.

State ADAPs that purchase through an indirect mechanism and have, therefore, been unable to access 602 discounted pricing may lack the public health infrastructure necessary to serve as the drug purchasing and distribution entity. For example, it is likely that a moderate- to high-incidence state with a central state pharmacy and a well-

²² This federal drug discount program is also referred to as the Office of Drug Pricing Program, the 340B program and the PHS drug discount program.

developed network of local public health clinics can adequately serve a large ADAP population using a centralized state-operated drug purchasing and distribution system for ADAP. However, a moderate- to high-incidence state that lacks an extensive public health infrastructure may need to rely on a network of private pharmacies in order to serve/reach a large ADAP population.

ODP and the Division of HIV Services (DHS) at HRSA have recently taken steps to provide technical assistance to states on accessing the 602 program. There is also some indication that ODP is developing guidelines which recognize the ability of state ADAPs to obtain 602 discount drug prices through a rebate mechanism. Finally, ODP is researching the feasibility allowing direct purchasing-ADAPs to distribute drugs from more than one pharmacy site. Such an expansion of the guidelines would certainly increase the number of ADAPs that could take advantage of the deep drug discounts available to 602 participants.

Voluntary manufacturers' rebates

States that purchase drugs indirectly through a retail/mail order pharmacy mechanism may obtain rebates from pharmaceutical manufacturers. Manufacturers currently are not required by federal statute to provide rebates to state ADAPs, therefore these rebates are designated as "voluntary." States must negotiate with manufacturers' on an individual basis in order to obtain voluntary rebates. The rebate amount on specific drugs varies from state to state, depending on the size of the ADAP program, the bargaining "savvy" of the ADAP negotiator and other factors. These rebate agreements have tended to be very informal in the past, although several manufacturers have begun to offer standardized rebate agreements to certain state programs.

Once a rebate agreement has been established, the state ADAP is required to provide the manufacturer with detailed quarterly data on utilization and program expenditures for the drugs covered under the agreement. Many programs, however, lack the staff resources to prepare such reports and/or the sophisticated data tracking systems necessary to produce them. These barriers, coupled with an often tedious, time-consuming and unequal negotiating process, make ADAP access to this type of cost savings mechanism inconsistent at best.

State ADAPs that are able to negotiate voluntary rebates generally receive a rebate equal to approximately 15% off the AMP unit cost for the drug. However, ADAPs generally reimburse pharmacies for purchased drugs at a rate substantially higher than the AMP. Therefore, the voluntary rebate amount negotiated by state ADAPs is not based on what the ADAP is actually paying for the drug, but on a lower pricing indicator (AMP).

Other cost containment mechanisms

State ADAPs use a variety of other mechanisms to contain program costs and/or enhance program revenue. Some of these are as follows:

Retail pharmacy-based discounts: ADAPs that purchase through an indirect mechanism may negotiate across the board discounts off the retail price of a drug that the pharmacy charges to self-pay customers. The retail price of a drug is significantly higher than the AMP described earlier. Pharmacy-based discounts are usually designated as a discount off the Average Wholesale Price (AWP)—the price paid to wholesalers by retail pharmacies—for example, AWP minus 10%. The AWP of a given drug, however, ranges from between 18% to 22% (or higher) than the AMP.

Collection of third-party insurance reimbursements: Most states permit individuals who have poor prescription coverage under their private insurance plans to be eligible for ADAP benefits. Oftentimes, ADAP must pay/reimburse the full amount for covered drugs first and then seek reimbursement from third-party insurers after the fact, even though this recouping process can be time and labor intensive.

Collection of co-payments from ADAP clients: State ADAPs sometimes require clients to make co-payments towards the purchase of covered drugs. Co-pay amounts are often determined based on the clients annual income as a percentage of the federal poverty level. The Ryan White CARE Act allows ADAPs to charge co-pays for covered drugs but has set limits on what may be charged.

Back billing of the state Medicaid program: ADAP clients who become eligible for Medicaid may obtain up to three months of retroactive eligibility/coverage, i.e. the client may have been eligible for prescription drug coverage under Medicaid during the period that ADAP had been paying for covered drugs. Several ADAPs have been successful in establishing mechanisms to recoup funds from their state Medicaid programs for ADAP clients who were granted retroactive Medicaid eligibility.

Coordination between ADAP and the state Medicaid program: Due to disability and/or loss of income, ADAP clients may become eligible for Medicaid benefits and need to transition off the ADAP program. In addition, ADAP clients may become eligible for Medicaid benefits for a short time, then temporarily lose eligibility while meeting spenddown requirements and again require coverage under ADAP. Significant cooperation between the state ADAP and the state Medicaid program is required in order to successfully coordinate these transitions and assure that Medicaid-eligible clients do not remain on ADAP eligibility roles. Finally, in a number of states where the Medicaid program limits the number of prescriptions per beneficiary per month (e.g., Mississippi, Texas), clients may be eligible for Medicaid and ADAP benefits simultaneously. Efforts must be made by the ADAP to carefully coordinate the payment of prescriptions claims so that ADAP is the payer of last resort.

Survey Results

States were asked to indicate which of the cost containment strategies described above are utilized by their ADAP. Responses are summarized in the table below:

Cost Containment Strategy	No. of States
Participation in the 602 program	20
Voluntary manufacturers' rebates	27
Retail pharmacy-based discounts	26
Collection of third-party insurance reimbursements	8
Back billing of Medicaid	16
Coordination between ADAP and the state Medicaid program	37
Collection of co-payments from ADAP clients	7
Other	8

Twenty states (38%) reported that their ADAPs participate in the 602/federal drug discount program (the District of Columbia is able to purchase discounted drugs through other federal drug discount programs). Twenty-seven state ADAPs (52%) reported that they receive voluntary manufacturers' rebates and twenty-six states (50%) have negotiated retail pharmacy-based discounts. Thirty-seven states (70%) stated that they coordinate ADAP eligibility with their state Medicaid programs while sixteen states (31%) have a mechanism in place to back bill the state Medicaid program for ADAP clients who receive retroactive Medicaid eligibility. Finally, eight states (15%) indicated that they recoup funds from ADAP clients' third party insurers.

States ADAPs that receive voluntary manufacturers' rebates were asked to indicate with which manufacturers they have rebate agreements (formal or informal). The ten manufacturers which were cited most frequently are listed below:

Glaxo Wellcome	18 states
Merck & Co.	16 states
Bristol Myers Squibb	12 states
Abbott	11 states
Hoffman LaRoche	11 states
Pfizer	11 states
Fujisawa	3 states
Jacobus	2 states
Pharmacia & Upjohn	2 states
Roerig	2 states

All eighteen state ADAPs that purchase drugs directly participate in the 602 program, along with California and Delaware ADAPs, which use multiple purchasing mechanisms. Sixteen of the nineteen state ADAPs that indicated that they use an indirect purchasing

mechanism receive voluntary rebates and eighteen of these nineteen states receive retail pharmacy-based discounts.

Several states indicated that they have developed or are developing mechanisms to move as many ADAP clients as possible onto private insurance coverage. Minnesota, for example, assists ADAP clients in obtaining insurance coverage by purchasing coverage (with non-ADAP specific CARE Act funds and with state funds) for clients from private insurers or through a state high risk insurance pool. Oregon and Washington State also have similar insurance-purchasing/subsidizing programs in place. Indiana ADAP will begin purchasing insurance policies from the state high risk insurance pool for ADAP clients in April 1997.

Conclusion

Paying for the Promise

The information obtained from the states through this surveying process paints a complex and often paradoxical picture of state ADAP programs. For example, federal and state contributions to these programs have increased dramatically over the past two years, yet many ADAPs cite inadequate funding as the primary barrier to adequately serving people living with HIV/AIDS their state. As promising new treatments have become available, many ADAPs have sought to include these drugs on their formularies, yet many ADAPs are also faced with making difficult ethical decisions regarding who may have access to these treatments. Some state ADAP formularies offer hundreds of HIV and OI drugs, while others offer only a few.

For many individuals, ADAPs represent the primary—and sometimes the sole—source of access to life-saving and life-prolonging medications. The high cost of combination antiretroviral therapy may be out of reach for individuals who continue to work and have no or inadequate insurance coverage, and who are not ill enough or poor enough to qualify for Medicaid. These individuals may also be excluded from eligibility for ADAPs based on financial or medical eligibility restrictions. Some individuals are able to access HIV drugs through manufacturer-sponsored patient assistance programs. Anecdotally, however, access to these programs is spotty and unpredictable at best. Most manufacturers do not publicly release figures on the number of clients served through their patient assistance programs, nor do they generally advertise program eligibility criteria.

The continuing crisis in access to state ADAPs comes at a time when the Administration and Congress have jointly committed to attaining a balanced budget by the year 2002. In many political circles, this commitment is viewed as a precursor to cuts or flat-funding in discretionary programs. Continued federal support of the CARE Act and of ADAP, in particular, is crucial to maintaining the viability of these important drug reimbursement programs. In addition, while many states have increased their financial contributions to their ADAPs, other states provide no support from the state general fund for these programs.

There is a growing body of literature which suggests that the use of combination therapy including protease inhibitors is an extremely cost-effective means of providing care for people living with HIV/AIDS. In fact, when compared with the cost-effectiveness of other commonly-used medical interventions, combination antiretroviral therapy is shown to be an extremely economically sound investment²³. Making adequate treatment available to people living with HIV/AIDS is not only medically and ethically appropriate, it is sound economic policy as well.

²³ Moore, R.D. and Bartlett, J.G., *Combination Antiretroviral Therapy in HIV Infection: An Economic Perspective*. *PharmacoEconomics*, 10(2): 109-113. August 1996.

Future Considerations

State ADAPs have struggled to keep pace with burgeoning client enrollment and utilization, and increasing demands for access to new therapy regimens. At the same time they are being called upon to provide evidence that they are operating in the most cost-efficient manner possible. A few programs have been able to meet these challenges due, in large part, to diversified and growing funding sources. Other state ADAPs, in particular those that rely solely on federal funding, continue to tread water in the midst of a sea of fiscal challenges and scientific breakthroughs.

It appears increasingly likely that ADAPs, as they currently exist, cannot continue to fill the ever-increasing coverage gap for people living with HIV. Several proposals have recently been forwarded to help provide access to treatments for people living with HIV/AIDS. One such proposal under consideration by the Administration would extend limited Medicaid benefits, including coverage for antiretroviral therapy, to individuals with HIV who are not disabled and who are not poor enough to meet the regular eligibility criteria for access to Medicaid. The details of such a proposal are still being worked out, however, the consideration of such a proposal is a recognition that the current safety net of support—including ADAPs—for people living with HIV/AIDS is inadequate. It may also be a recognition of the cost-effectiveness of providing these new treatments so that individuals living with HIV/AIDS may continue to maintain healthy and productive lives far beyond what was thought possible a few years ago.

Certainly, state ADAPs require the ongoing support of the federal and state government as they continue to play a crucially important role in providing healthcare to people who otherwise might have no access to effective treatments. The current level of ADAP funding, while temporarily adequate in some states, is not sufficient to provide the standard of care for people living with HIV in many states. And, finally, with continued and increasing support for ADAPs must come a commitment from federal and state governments, industry and the community to find more permanent solutions to the crisis in access to HIV/AIDS drugs.

Appendix I

FY 1996 ADAP Budget Tables

FY 1996 ADAP Funding by State and Source

State	Total FY 96	Title II Base	ADAP Supp. Funding	FY 97 Advance	State Funding	Title I EMA Contrib.	Drug Rebates	Insurance Recovery	Other
Alabama	\$2,500,745	\$1,908,763	\$401,982		\$150,000		\$40,000		
Alaska	\$75,000	\$36,557	\$38,443						
Arizona	\$1,270,790	\$800,000	\$470,790						
Arkansas	\$802,328	\$572,591	\$199,737						\$30,000
California	\$44,650,239	\$9,849,105	\$8,415,161	\$6,592,973	\$15,600,000		\$4,193,000		
Colorado	\$1,273,281	\$67,942	\$528,455		\$301,000	\$261,000	\$26,311		\$88,573
Connecticut	\$2,446,358	\$352,389	\$861,629		\$592,000	\$421,500	\$218,840		
Delaware	\$425,000	\$181,420	\$183,580		\$35,000		\$25,000		
D.C.	\$2,350,064	\$603,000	\$800,064		\$147,000	\$800,000			
Florida	\$17,105,192	\$8,060,748	\$5,503,506	\$3,540,938					
Georgia	\$4,904,816	\$2,000,000	\$1,515,721		\$324,450	\$1,064,645			
Guam	\$0								
Hawaii	\$719,354	\$247,195	\$172,159		\$300,000				
Idaho	\$175,657	\$130,000	\$35,657				\$10,000		
Illinois	\$9,001,057	\$605,471	\$1,682,586		\$5,200,000	\$825,000	\$640,000	\$48,000	
Indiana	\$1,507,818	\$1,000,000	\$402,818		\$75,000		\$30,000		
Iowa	\$208,000	\$118,578	\$89,422						
Kansas	\$730,845	\$547,822	\$183,023						
Kentucky	\$878,090	\$571,974	\$196,116		\$110,000				
Louisiana	\$4,273,878	\$184,926	\$773,878		\$3,315,074				
Maine	\$238,319	\$100,000	\$78,279		\$60,040				
Maryland	\$4,501,998	\$1,200,000	\$1,548,035		\$1,100,000	\$453,963	\$200,000		
Massachusetts	\$3,252,114	\$742,140	\$1,059,974		\$1,100,000	\$350,000			
Michigan	\$1,462,203	\$154,637	\$792,821			\$400,000	\$114,745		
Minnesota	\$577,984	\$103,917	\$276,067		\$150,000		\$48,000		
Mississippi	\$1,336,834	\$1,064,389	\$272,445						
Missouri	\$1,626,791	\$390,000	\$626,791		\$600,000		\$10,000		
Montana	\$224,912	\$110,969	\$18,943		\$95,000				
Nebraska	\$207,265	\$133,443	\$73,822						
Nevada	\$962,906	\$663,996	\$298,910						
New Hampshire	\$427,917	\$194,918	\$66,858		\$73,833	\$72,308	\$20,000		
New Jersey	\$9,304,024	\$4,133,838	\$2,953,162		\$875,000	\$792,024	\$550,000		
New Mexico	\$1,163,585	\$294,884	\$128,701		\$740,000				
New York	\$57,675,802	\$9,807,712	\$9,009,360		\$8,400,000	\$19,858,730	\$5,600,000	\$5,000,000	
North Carolina	\$2,161,449	\$660,000	\$701,449		\$750,000		\$50,000		
North Dakota	\$62,243	\$55,000	\$7,243						
Ohio	\$1,920,643	\$846,000	\$782,236		\$200,000		\$50,000		\$42,407
Oklahoma	\$1,006,529	\$559,005	\$241,524		\$206,000				
Oregon	\$553,625	\$199,000	\$354,625						
Pennsylvania	\$6,799,571		\$1,599,571		\$5,200,000				
Puerto Rico	\$8,164,580	\$3,072,835	\$1,685,094		\$3,406,651				
Rhode Island	\$446,465	\$278,514	\$157,951				\$10,000		
South Carolina	\$1,658,549	\$650,000	\$658,549		\$350,000				
South Dakota	\$82,536	\$70,000	\$12,536						
Tennessee	\$847,955	\$300,000	\$547,955						
Texas	\$8,305,582	\$1,402,641	\$3,496,103		\$2,697,376	\$217,000			\$492,462
Utah	\$691,215	\$275,954	\$118,115		\$114,800		\$35,940		\$146,406
Vermont	\$202,029	\$157,500	\$29,529				\$15,000		
Virgin Islands	\$28,415		\$28,415						
Virginia	\$3,727,472	\$2,140,200	\$900,072		\$687,200				
Washington	\$1,619,698	\$192,235	\$667,463		\$417,500	\$342,500			
West Virginia	\$217,465	\$120,100	\$69,365		\$25,000		\$3,000		
Wisconsin	\$844,986	\$280,362	\$268,824		\$295,800				
Wyoming	\$78,650	\$65,000	\$13,650						
Total	\$217,680,823	\$58,257,670	\$51,999,164	\$10,133,911	\$53,693,724	\$25,858,670	\$11,889,836	\$5,048,000	\$799,848
Percent of Tot.	100%	27%	24%	5%	25%	12%	5%	2%	0%

FY 1996 ADAP Funding from Ryan White Title II Base Grants

State	Total FY 96	Title II Base	Title II Base %
Alabama	\$2,500,745	\$1,908,763	76%
Alaska	\$75,000	\$36,557	49%
Arizona	\$1,270,790	\$800,000	63%
Arkansas	\$802,328	\$572,591	71%
California	\$44,650,239	\$9,849,105	22%
Colorado	\$1,273,281	\$67,942	5%
Connecticut	\$2,446,358	\$352,389	14%
Delaware	\$425,000	\$181,420	43%
D.C.	\$2,350,064	\$603,000	26%
Florida	\$17,105,192	\$8,060,748	47%
Georgia	\$4,904,816	\$2,000,000	41%
Guam	\$0		0%
Hawaii	\$719,354	\$247,195	34%
Idaho	\$175,657	\$130,000	74%
Illinois	\$9,001,057	\$605,471	7%
Indiana	\$1,507,818	\$1,000,000	66%
Iowa	\$208,000	\$118,578	57%
Kansas	\$730,845	\$547,822	75%
Kentucky	\$878,090	\$571,974	65%
Louisiana	\$4,273,878	\$184,926	4%
Maine	\$238,319	\$100,000	42%
Maryland	\$4,501,998	\$1,200,000	27%
Massachusetts	\$3,252,114	\$742,140	23%
Michigan	\$1,462,203	\$154,637	11%
Minnesota	\$577,984	\$103,917	18%
Mississippi	\$1,336,834	\$1,064,389	80%
Missouri	\$1,626,791	\$390,000	24%
Montana	\$224,912	\$110,969	49%
Nebraska	\$207,265	\$133,443	64%
Nevada	\$962,906	\$663,996	69%
New Hampshire	\$427,917	\$194,918	46%
New Jersey	\$9,304,024	\$4,133,838	44%
New Mexico	\$1,163,585	\$294,884	25%
New York	\$57,675,802	\$9,807,712	17%
North Carolina	\$2,161,449	\$660,000	31%
North Dakota	\$62,243	\$55,000	88%
Ohio	\$1,920,643	\$846,000	44%
Oklahoma	\$1,006,529	\$559,005	56%
Oregon	\$553,625	\$199,000	36%
Pennsylvania	\$6,799,571		0%
Puerto Rico	\$8,164,580	\$3,072,835	38%
Rhode Island	\$446,465	\$278,514	62%
South Carolina	\$1,658,549	\$650,000	39%
South Dakota	\$82,536	\$70,000	85%
Tennessee	\$847,955	\$300,000	35%
Texas	\$8,305,582	\$1,402,641	17%
Utah	\$691,215	\$275,954	40%
Vermont	\$202,029	\$157,500	78%
Virgin Islands	\$28,415		0%
Virginia	\$3,727,472	\$2,140,200	57%
Washington	\$1,619,698	\$192,235	12%
West Virginia	\$217,465	\$120,100	55%
Wisconsin	\$844,986	\$280,362	33%
Wyoming	\$78,650	\$65,000	83%
Total	\$217,680,823	\$58,257,670	27%

FY 1996 ADAP Funding from State Resources

State	Total FY 96	State Funding	State Funding %
Alabama	\$2,500,745	\$150,000	6%
Alaska	\$75,000		0%
Arizona	\$1,270,790		0%
Arkansas	\$802,328		0%
California	\$44,650,239	\$15,600,000	35%
Colorado	\$1,273,281	\$301,000	24%
Connecticut	\$2,446,358	\$592,000	24%
Delaware	\$425,000	\$35,000	8%
D.C.	\$2,350,064	\$147,000	6%
Florida	\$17,105,192		0%
Georgia	\$4,904,816	\$324,450	7%
Guam	\$0		0%
Hawaii	\$719,354	\$300,000	42%
Idaho	\$175,657		0%
Illinois	\$9,001,057	\$5,200,000	58%
Indiana	\$1,507,818	\$75,000	5%
Iowa	\$208,000		0%
Kansas	\$730,845		0%
Kentucky	\$878,090	\$110,000	13%
Louisiana	\$4,273,878	\$3,315,074	78%
Maine	\$238,319	\$60,040	25%
Maryland	\$4,501,998	\$1,100,000	24%
Massachusetts	\$3,252,114	\$1,100,000	34%
Michigan	\$1,462,203		0%
Minnesota	\$577,984	\$150,000	26%
Mississippi	\$1,336,834		0%
Missouri	\$1,626,791	\$600,000	37%
Montana	\$224,912	\$95,000	42%
Nebraska	\$207,265		0%
Nevada	\$962,906		0%
New Hampshire	\$427,917	\$73,833	17%
New Jersey	\$9,304,024	\$875,000	9%
New Mexico	\$1,163,585	\$740,000	64%
New York	\$57,675,802	\$8,400,000	15%
North Carolina	\$2,161,449	\$750,000	35%
North Dakota	\$62,243		0%
Ohio	\$1,920,643	\$200,000	10%
Oklahoma	\$1,006,529	\$206,000	20%
Oregon	\$553,625		0%
Pennsylvania	\$6,799,571	\$5,200,000	76%
Puerto Rico	\$8,164,580	\$3,406,651	42%
Rhode Island	\$446,465		0%
South Carolina	\$1,658,549	\$350,000	21%
South Dakota	\$82,536		0%
Tennessee	\$847,955		0%
Texas	\$8,305,582	\$2,697,376	32%
Utah	\$691,215	\$114,800	17%
Vermont	\$202,029		0%
Virgin Islands	\$28,415		0%
Virginia	\$3,727,472	\$687,200	18%
Washington	\$1,619,698	\$417,500	26%
West Virginia	\$217,465	\$25,000	11%
Wisconsin	\$844,986	\$295,800	35%
Wyoming	\$78,650		0%
Total	\$217,680,823	\$53,693,724	25%

FY 1996 ADAP Funding from Ryan White Title II ADAP Supplemental Grants

State	Total FY 96	ADAP Supp. Funding	ADAP Supp. %
Alabama	\$2,500,745	\$401,982	16%
Alaska	\$75,000	\$38,443	51%
Arizona	\$1,270,790	\$470,790	37%
Arkansas	\$802,328	\$199,737	25%
California	\$44,650,239	\$8,415,161	19%
Colorado	\$1,273,281	\$528,455	42%
Connecticut	\$2,446,358	\$861,629	35%
Delaware	\$425,000	\$183,580	43%
D.C.	\$2,350,064	\$800,064	34%
Florida	\$17,105,192	\$5,503,506	32%
Georgia	\$4,904,816	\$1,515,721	31%
Guam	\$0		0%
Hawaii	\$719,354	\$172,159	24%
Idaho	\$175,657	\$35,657	20%
Illinois	\$9,001,057	\$1,682,586	19%
Indiana	\$1,507,818	\$402,818	27%
Iowa	\$208,000	\$89,422	43%
Kansas	\$730,845	\$183,023	25%
Kentucky	\$878,090	\$196,116	22%
Louisiana	\$4,273,878	\$773,878	18%
Maine	\$238,319	\$78,279	33%
Maryland	\$4,501,998	\$1,548,035	34%
Massachusetts	\$3,252,114	\$1,059,974	33%
Michigan	\$1,462,203	\$792,821	54%
Minnesota	\$577,984	\$276,067	48%
Mississippi	\$1,336,834	\$272,445	20%
Missouri	\$1,626,791	\$626,791	39%
Montana	\$224,912	\$18,943	8%
Nebraska	\$207,265	\$73,822	36%
Nevada	\$962,906	\$298,910	31%
New Hampshire	\$427,917	\$66,858	16%
New Jersey	\$9,304,024	\$2,953,162	32%
New Mexico	\$1,163,585	\$128,701	11%
New York	\$57,675,802	\$9,009,360	16%
North Carolina	\$2,161,449	\$701,449	32%
North Dakota	\$62,243	\$7,243	12%
Ohio	\$1,920,643	\$782,236	41%
Oklahoma	\$1,006,529	\$241,524	24%
Oregon	\$553,625	\$354,625	64%
Pennsylvania	\$6,799,571	\$1,599,571	24%
Puerto Rico	\$8,164,580	\$1,685,094	21%
Rhode Island	\$446,465	\$157,951	35%
South Carolina	\$1,658,549	\$658,549	40%
South Dakota	\$82,536	\$12,536	15%
Tennessee	\$847,955	\$547,955	65%
Texas	\$8,305,582	\$3,496,103	42%
Utah	\$691,215	\$118,115	17%
Vermont	\$202,029	\$29,529	15%
Virgin Islands	\$28,415	\$28,415	100%
Virginia	\$3,727,472	\$900,072	24%
Washington	\$1,619,698	\$667,463	41%
West Virginia	\$217,465	\$69,365	32%
Wisconsin	\$844,986	\$268,824	32%
Wyoming	\$78,650	\$13,650	17%
Total	\$217,680,823	\$51,999,164	24%

FY 1996 ADAP Funding from Ryan White Title I EMA Contributions

State	Total FY 96	Title I EMA Contrib.	Title I EMA %
Alabama	\$2,500,745		0%
Alaska	\$75,000		0%
Arizona	\$1,270,790		0%
Arkansas	\$802,328		0%
California	\$44,650,239		0%
Colorado	\$1,273,281	\$261,000	20%
Connecticut	\$2,446,358	\$421,500	17%
Delaware	\$425,000		0%
D.C.	\$2,350,064	\$800,000	34%
Florida	\$17,105,192		0%
Georgia	\$4,904,816	\$1,064,645	22%
Guam	\$0		0%
Hawaii	\$719,354		0%
Idaho	\$175,657		0%
Illinois	\$9,001,057	\$825,000	9%
Indiana	\$1,507,818		0%
Iowa	\$208,000		0%
Kansas	\$730,845		0%
Kentucky	\$878,090		0%
Louisiana	\$4,273,878		0%
Maine	\$238,319		0%
Maryland	\$4,501,998	\$453,963	10%
Massachusetts	\$3,252,114	\$350,000	11%
Michigan	\$1,462,203	\$400,000	27%
Minnesota	\$577,984		0%
Mississippi	\$1,336,834		0%
Missouri	\$1,626,791		0%
Montana	\$224,912		0%
Nebraska	\$207,265		0%
Nevada	\$962,906		0%
New Hampshire	\$427,917	\$72,308	17%
New Jersey	\$9,304,024	\$792,024	9%
New Mexico	\$1,163,585		0%
New York	\$57,675,802	\$19,858,730	34%
North Carolina	\$2,161,449		0%
North Dakota	\$62,243		0%
Ohio	\$1,920,643		0%
Oklahoma	\$1,006,529		0%
Oregon	\$553,625		0%
Pennsylvania	\$6,799,571		0%
Puerto Rico	\$8,164,580		0%
Rhode Island	\$446,465		0%
South Carolina	\$1,658,549		0%
South Dakota	\$82,536		0%
Tennessee	\$847,955		0%
Texas	\$8,305,582	\$217,000	3%
Utah	\$691,215		0%
Vermont	\$202,029		0%
Virgin Islands	\$28,415		0%
Virginia	\$3,727,472		0%
Washington	\$1,619,698	\$342,500	21%
West Virginia	\$217,465		0%
Wisconsin	\$844,986		0%
Wyoming	\$78,650		0%
Total	\$217,680,823	\$25,858,670	12%

Appendix II

FY 1997 Estimated ADAP Budget Tables

FY 1997 Estimated ADAP Funding by State and Source

State	Total Est. 1997	Title II Base Funds	ADAP Supp. Funding	State Funding	Title I EMA Contrib.	Drug Rebates	Insurance Recovery	Other
Alabama	\$3,190,000	\$1,670,294	\$1,329,706	\$150,000		\$40,000		
Alaska	\$122,917		\$112,917			\$10,000		
Arizona	\$2,300,027	\$849,275	\$1,450,752					
Arkansas	\$1,254,013	\$600,000	\$654,013					
California	\$83,708,997	\$9,849,105	\$26,371,892	\$40,159,000		\$7,329,000		
Colorado	\$2,904,932	\$136,000	\$1,607,932	\$301,000	\$860,000			
Connecticut	\$3,814,283	\$602,389	\$2,790,394		\$421,500			
Delaware	\$979,000	\$314,314	\$619,686			\$45,000		
DC	\$4,363,341	\$600,000	\$2,613,341	\$150,000	\$1,000,000			
Florida	\$24,317,997	\$6,419,365	\$17,898,632					
Georgia	\$9,379,959	\$2,930,000	\$5,125,509	\$324,450	\$1,000,000			
Guam	\$0							
Hawaii	\$1,112,403	\$269,500	\$542,903	\$300,000				
Idaho	\$193,000	\$80,083	\$112,917					
Illinois	\$14,514,522	\$714,300	\$5,427,222	\$8,325,000			\$48,000	
Indiana	\$2,310,710	\$803,548	\$1,372,162	\$75,000		\$60,000		
Iowa	\$292,680		\$292,680					
Kansas	\$738,196	\$170,000	\$568,196					
Kentucky	\$994,321	\$246,275	\$663,046	\$85,000				
Louisiana	\$19,371,330	\$654,106	\$2,717,224	\$16,000,000				
Maine	\$389,486	\$100,000	\$229,446	\$60,040				
Maryland	\$6,259,239	\$0	\$5,025,239	\$600,000	\$434,000	\$200,000		
Massachusetts	\$7,970,714	\$0	\$3,310,714	\$3,660,000	\$1,000,000			
Michigan	\$3,258,921	\$154,636	\$2,408,285		\$400,000	\$296,000		
Minnesota	\$841,003		\$841,003					
Mississippi	\$2,040,326	\$1,159,577	\$880,749					
Missouri	\$2,575,652		\$1,965,652	\$600,000		\$10,000		
Montana	\$204,000	\$136,863	\$64,137				\$3,000	
Nebraska	\$300,000	\$66,037	\$233,963					
Nevada	\$1,534,199	\$576,666	\$957,533					
New Hampshire	\$403,500	\$93,507	\$214,993		\$75,000	\$20,000		
New Jersey	\$16,753,868	\$4,566,141	\$9,448,859	\$700,000	\$1,288,868	\$750,000		
New Mexico	\$1,340,212	\$222,619	\$377,593	\$740,000				
New York	\$82,501,058	\$9,957,157	\$29,381,796	\$12,400,000	\$15,052,105	\$8,380,000	\$7,330,000	
North Carolina	\$3,710,201	\$660,000	\$2,250,201	\$750,000		\$50,000		
North Dakota	\$94,390	\$70,000	\$24,390					
Ohio	\$6,600,000	\$822,792	\$2,577,208	\$3,000,000		\$100,000		\$100,000
Oklahoma	\$1,690,187	\$606,101	\$728,086	\$206,000		\$150,000		
Oregon	\$2,035,136	\$200,000	\$1,148,136		\$687,000			
Pennsylvania	\$9,871,022		\$5,258,299	\$4,612,723				
Puerto Rico	\$15,619,324	\$3,042,107	\$5,315,209	\$7,262,008				
Rhode Island	\$792,972	\$268,849	\$494,123			\$30,000		
South Carolina	\$3,386,578	\$423,683	\$2,112,895	\$500,000				\$350,000
South Dakota	\$105,343	\$66,500	\$38,843					
Tennessee	\$1,830,152	\$0	\$1,830,152					
Texas	\$17,088,684	\$2,980,000	\$11,061,308	\$2,697,376	\$350,000			
Utah	\$843,006	\$266,873	\$399,273	\$114,800		\$42,060		\$20,000
Vermont	\$374,611	\$157,471	\$92,140	\$75,000		\$50,000		
Virgin Islands	\$0							
Virginia	\$6,457,969	\$2,714,138	\$2,881,631	\$687,200		\$175,000		
Washington	\$6,863,160	\$326,682	\$2,067,728	\$4,200,000	\$168,750	\$100,000		
West Virginia	\$361,000	\$82,487	\$247,513	\$25,000		\$6,000		
Wisconsin	\$1,500,001	\$280,362	\$823,839	\$295,800		\$100,000		
Wyoming	\$80,940	\$3,000	\$37,940					\$40,000
Total	\$381,539,482	\$56,912,802	\$167,000,000	\$109,055,397	\$22,737,223	\$17,943,060	\$7,381,000	\$510,000
Percent of Tot.	100%	15%	44%	29%	6%	5%	2%	0%

FY 1997 Estimated ADAP Funding from Ryan White Title II ADAP Supplemental Grants

State	Total Est. 1997	ADAP Supp. Funding	ADAP Supp % of Total ADAP
Alabama	\$3,190,000	\$1,329,706	42%
Alaska	\$122,917	\$112,917	92%
Arizona	\$2,300,027	\$1,450,752	63%
Arkansas	\$1,254,013	\$654,013	52%
California	\$83,708,997	\$26,371,892	32%
Colorado	\$2,904,932	\$1,607,932	55%
Connecticut	\$3,814,283	\$2,790,394	73%
Delaware	\$979,000	\$619,686	63%
DC	\$4,363,341	\$2,613,341	60%
Florida	\$24,317,997	\$17,898,632	74%
Georgia	\$9,379,959	\$5,125,509	55%
Guam	\$0		
Hawaii	\$1,112,403	\$542,903	49%
Idaho	\$193,000	\$112,917	59%
Illinois	\$14,514,522	\$5,427,222	37%
Indiana	\$2,310,710	\$1,372,162	59%
Iowa	\$292,680	\$292,680	100%
Kansas	\$738,196	\$568,196	77%
Kentucky	\$994,321	\$663,046	67%
Louisiana	\$19,371,330	\$2,717,224	14%
Maine	\$389,486	\$229,446	59%
Maryland	\$6,259,239	\$5,025,239	80%
Massachusetts	\$7,970,714	\$3,310,714	42%
Michigan	\$3,258,921	\$2,408,285	74%
Minnesota	\$841,003	\$841,003	100%
Mississippi	\$2,040,326	\$880,749	43%
Missouri	\$2,575,652	\$1,965,652	76%
Montana	\$204,000	\$64,137	31%
Nebraska	\$300,000	\$233,963	78%
Nevada	\$1,534,199	\$957,533	62%
New Hampshir	\$403,500	\$214,993	53%
New Jersey	\$16,753,868	\$9,448,859	56%
New Mexico	\$1,340,212	\$377,593	28%
New York	\$82,501,058	\$29,381,796	36%
North Carolina	\$3,710,201	\$2,250,201	61%
North Dakota	\$94,390	\$24,390	26%
Ohio	\$6,600,000	\$2,577,208	39%
Oklahoma	\$1,690,187	\$728,086	43%
Oregon	\$2,035,136	\$1,148,136	56%
Pennsylvania	\$9,871,022	\$5,258,299	53%
Puerto Rico	\$15,619,324	\$5,315,209	34%
Rhode Island	\$792,972	\$494,123	62%
South Carolina	\$3,386,578	\$2,112,895	62%
South Dakota	\$105,343	\$38,843	37%
Tennessee	\$1,830,152	\$1,830,152	100%
Texas	\$17,088,684	\$11,061,308	65%
Utah	\$843,006	\$399,273	47%
Vermont	\$374,611	\$92,140	25%
Virgin Islands	\$0		
Virginia	\$6,457,969	\$2,881,631	45%
Washington	\$6,863,160	\$2,067,728	30%
West Virginia	\$361,000	\$247,513	69%
Wisconsin	\$1,500,001	\$823,839	55%
Wyoming	\$80,940	\$37,940	47%
Total	\$381,539,482	\$167,000,000	44%

FY 1997 Estimated ADAP Funding from State Resources

State	Total Est. 1997	State Funding	State % of Total ADAP
Alabama	\$3,190,000	\$150,000	5%
Alaska	\$122,917		0%
Arizona	\$2,300,027		0%
Arkansas	\$1,254,013		0%
California	\$83,708,997	\$40,159,000	48%
Colorado	\$2,904,932	\$301,000	10%
Connecticut	\$3,814,283		0%
Delaware	\$979,000		0%
DC	\$4,363,341	\$150,000	3%
Florida	\$24,317,997		0%
Georgia	\$9,379,959	\$324,450	3%
Guam	\$0		
Hawaii	\$1,112,403	\$300,000	27%
Idaho	\$193,000		0%
Illinois	\$14,514,522	\$8,325,000	57%
Indiana	\$2,310,710	\$75,000	3%
Iowa	\$292,680		0%
Kansas	\$738,196		0%
Kentucky	\$994,321	\$85,000	9%
Louisiana	\$19,371,330	\$16,000,000	83%
Maine	\$389,486	\$60,040	15%
Maryland	\$6,259,239	\$600,000	10%
Massachusetts	\$7,970,714	\$3,660,000	46%
Michigan	\$3,258,921		0%
Minnesota	\$841,003		0%
Mississippi	\$2,040,326		0%
Missouri	\$2,575,652	\$600,000	23%
Montana	\$204,000		0%
Nebraska	\$300,000		0%
Nevada	\$1,534,199		0%
New Hampshire	\$403,500		0%
New Jersey	\$16,753,868	\$700,000	4%
New Mexico	\$1,340,212	\$740,000	55%
New York	\$82,501,058	\$12,400,000	15%
North Carolina	\$3,710,201	\$750,000	20%
North Dakota	\$94,390		0%
Ohio	\$6,600,000	\$3,000,000	45%
Oklahoma	\$1,690,187	\$206,000	12%
Oregon	\$2,035,136		0%
Pennsylvania	\$9,871,022	\$4,612,723	47%
Puerto Rico	\$15,619,324	\$7,262,008	46%
Rhode Island	\$792,972		0%
South Carolina	\$3,386,578	\$500,000	15%
South Dakota	\$105,343		0%
Tennessee	\$1,830,152		0%
Texas	\$17,088,684	\$2,697,376	16%
Utah	\$843,006	\$114,800	14%
Vermont	\$374,611	\$75,000	20%
Virgin Islands	\$0		
Virginia	\$6,457,969	\$687,200	11%
Washington	\$6,863,160	\$4,200,000	61%
West Virginia	\$361,000	\$25,000	7%
Wisconsin	\$1,500,001	\$295,800	20%
Wyoming	\$80,940		0%
Total	\$381,539,482	\$109,055,397	29%

FY 1997 Estimated ADAP Funding from Ryan White Title II Base Grants

State	Total Est. 1997	Title II Base Funds	Title II % of Total ADAP
Alabama	\$3,190,000	\$1,670,294	52%
Alaska	\$122,917		0%
Arizona	\$2,300,027	\$849,275	37%
Arkansas	\$1,254,013	\$600,000	48%
California	\$83,708,997	\$9,849,105	12%
Colorado	\$2,904,932	\$136,000	5%
Connecticut	\$3,814,283	\$602,389	16%
Delaware	\$979,000	\$314,314	32%
DC	\$4,363,341	\$600,000	14%
Florida	\$24,317,997	\$6,419,365	26%
Georgia	\$9,379,959	\$2,930,000	31%
Guam	\$0		
Hawaii	\$1,112,403	\$269,500	24%
Idaho	\$193,000	\$80,083	41%
Illinois	\$14,514,522	\$714,300	5%
Indiana	\$2,310,710	\$803,548	35%
Iowa	\$292,680		0%
Kansas	\$738,196	\$170,000	23%
Kentucky	\$994,321	\$246,275	25%
Louisiana	\$19,371,330	\$654,106	3%
Maine	\$389,486	\$100,000	26%
Maryland	\$6,259,239	\$0	0%
Massachusetts	\$7,970,714	\$0	0%
Michigan	\$3,258,921	\$154,636	5%
Minnesota	\$841,003		0%
Mississippi	\$2,040,326	\$1,159,577	57%
Missouri	\$2,575,652		0%
Montana	\$204,000	\$136,863	67%
Nebraska	\$300,000	\$66,037	22%
Nevada	\$1,534,199	\$576,666	38%
New Hampshir	\$403,500	\$93,507	23%
New Jersey	\$16,753,868	\$4,566,141	27%
New Mexico	\$1,340,212	\$222,619	17%
New York	\$82,501,058	\$9,957,157	12%
North Carolina	\$3,710,201	\$660,000	18%
North Dakota	\$94,390	\$70,000	74%
Ohio	\$6,600,000	\$822,792	12%
Oklahoma	\$1,690,187	\$606,101	36%
Oregon	\$2,035,136	\$200,000	10%
Pennsylvania	\$9,871,022		0%
Puerto Rico	\$15,619,324	\$3,042,107	19%
Rhode Island	\$792,972	\$268,849	34%
South Carolina	\$3,386,578	\$423,683	13%
South Dakota	\$105,343	\$66,500	63%
Tennessee	\$1,830,152	\$0	0%
Texas	\$17,088,684	\$2,980,000	17%
Utah	\$843,006	\$266,873	32%
Vermont	\$374,611	\$157,471	42%
Virgin Islands	\$0		
Virginia	\$6,457,969	\$2,714,138	42%
Washington	\$6,863,160	\$326,682	5%
West Virginia	\$361,000	\$82,487	23%
Wisconsin	\$1,500,001	\$280,362	19%
Wyoming	\$80,940	\$3,000	4%
Total	\$381,539,482	\$56,912,802	15%

FY 1997 Estimated ADAP Funding from Ryan White Title I EMA Contributions

State	Total Est. 1997	Title I EMA Contrib.	Title I % of Total ADAP
Alabama	\$3,190,000		0%
Alaska	\$122,917		0%
Arizona	\$2,300,027		0%
Arkansas	\$1,254,013		0%
California	\$83,708,997		0%
Colorado	\$2,904,932	\$860,000	30%
Connecticut	\$3,814,283	\$421,500	11%
Delaware	\$979,000		0%
DC	\$4,363,341	\$1,000,000	23%
Florida	\$24,317,997		0%
Georgia	\$9,379,959	\$1,000,000	11%
Guam	\$0		0%
Hawaii	\$1,112,403		0%
Idaho	\$193,000		0%
Illinois	\$14,514,522		0%
Indiana	\$2,310,710		0%
Iowa	\$292,680		0%
Kansas	\$738,196		0%
Kentucky	\$994,321		0%
Louisiana	\$19,371,330		0%
Maine	\$389,486		0%
Maryland	\$6,259,239	\$434,000	7%
Massachusetts	\$7,970,714	\$1,000,000	13%
Michigan	\$3,258,921	\$400,000	12%
Minnesota	\$841,003		0%
Mississippi	\$2,040,326		0%
Missouri	\$2,575,652		0%
Montana	\$204,000		0%
Nebraska	\$300,000		0%
Nevada	\$1,534,199		0%
New Hampshire	\$403,500	\$75,000	19%
New Jersey	\$16,753,868	\$1,288,868	8%
New Mexico	\$1,340,212		0%
New York	\$82,501,058	\$15,052,105	18%
North Carolina	\$3,710,201		0%
North Dakota	\$94,390		0%
Ohio	\$6,600,000		0%
Oklahoma	\$1,690,187		0%
Oregon	\$2,035,136	\$687,000	34%
Pennsylvania	\$9,871,022		0%
Puerto Rico	\$15,619,324		0%
Rhode Island	\$792,972		0%
South Carolina	\$3,386,578		0%
South Dakota	\$105,343		0%
Tennessee	\$1,830,152		0%
Texas	\$17,088,684	\$350,000	2%
Utah	\$843,006		0%
Vermont	\$374,611		0%
Virgin Islands	\$0		0%
Virginia	\$6,457,969		0%
Washington	\$6,863,160	\$168,750	2%
West Virginia	\$361,000		0%
Wisconsin	\$1,500,001		0%
Wyoming	\$80,940		0%
Total	\$381,539,482	\$22,737,223	6%

FY 1997 and FY 1996 Total ADAP Budgets: Percentage Change

State	Total Est. 1997	Total FY 96	Actual Change	Percentage Change
Alabama	\$3,190,000	\$2,500,745	\$689,255	28%
Alaska	\$122,917	\$75,000	\$47,917	64%
Arizona	\$2,300,027	\$1,270,790	\$1,029,237	81%
Arkansas	\$1,254,013	\$802,328	\$451,685	56%
California	\$83,708,997	\$44,650,239	\$39,058,758	87%
Colorado	\$2,904,932	\$1,273,281	\$1,631,651	128%
Connecticut	\$3,814,283	\$2,446,358	\$1,367,925	56%
Delaware	\$979,000	\$425,000	\$554,000	130%
DC	\$4,363,341	\$2,350,064	\$2,013,277	86%
Florida	\$24,317,997	\$17,105,192	\$7,212,805	42%
Georgia	\$9,379,959	\$4,904,816	\$4,475,143	91%
Guam	\$0	\$0	\$0	0%
Hawaii	\$1,112,403	\$719,354	\$393,049	55%
Idaho	\$193,000	\$175,657	\$17,343	10%
Illinois	\$14,514,522	\$9,001,057	\$5,513,465	61%
Indiana	\$2,310,710	\$1,507,818	\$802,892	53%
Iowa	\$292,680	\$208,000	\$84,680	41%
Kansas	\$738,196	\$730,845	\$7,351	1%
Kentucky	\$994,321	\$878,090	\$116,231	13%
Louisiana	\$19,371,330	\$4,273,878	\$15,097,452	353%
Maine	\$389,486	\$238,319	\$151,167	63%
Maryland	\$6,259,239	\$4,501,998	\$1,757,241	39%
Massachusetts	\$7,970,714	\$3,252,114	\$4,718,600	145%
Michigan	\$3,258,921	\$1,462,203	\$1,796,718	123%
Minnesota	\$841,003	\$577,984	\$263,019	46%
Mississippi	\$2,040,326	\$1,336,834	\$703,492	53%
Missouri	\$2,575,652	\$1,626,791	\$948,861	58%
Montana	\$204,000	\$224,912	(\$20,912)	-9%
Nebraska	\$300,000	\$207,265	\$92,735	45%
Nevada	\$1,534,199	\$962,906	\$571,293	59%
New Hampshire	\$403,500	\$427,917	(\$24,417)	-6%
New Jersey	\$16,753,868	\$9,304,024	\$7,449,844	80%
New Mexico	\$1,340,212	\$1,163,585	\$176,627	15%
New York	\$82,501,058	\$57,675,802	\$24,825,256	43%
North Carolina	\$3,710,201	\$2,161,449	\$1,548,752	72%
North Dakota	\$94,390	\$62,243	\$32,147	52%
Ohio	\$6,600,000	\$1,920,643	\$4,679,357	244%
Oklahoma	\$1,690,187	\$1,006,529	\$683,658	68%
Oregon	\$2,035,136	\$553,625	\$1,481,511	268%
Pennsylvania	\$9,871,022	\$6,799,571	\$3,071,451	45%
Puerto Rico	\$15,619,324	\$8,164,580	\$7,454,744	91%
Rhode Island	\$792,972	\$446,465	\$346,507	78%
South Carolina	\$3,386,578	\$1,658,549	\$1,728,029	104%
South Dakota	\$105,343	\$82,536	\$22,807	28%
Tennessee	\$1,830,152	\$847,955	\$982,197	116%
Texas	\$17,088,684	\$8,305,582	\$8,783,102	106%
Utah	\$843,006	\$691,215	\$151,791	22%
Vermont	\$374,611	\$202,029	\$172,582	85%
Virgin Islands	\$0	\$28,415	(\$28,415)	-100%
Virginia	\$6,457,969	\$3,727,472	\$2,730,497	73%
Washington	\$6,863,160	\$1,619,698	\$5,243,462	324%
West Virginia	\$361,000	\$217,465	\$143,535	66%
Wisconsin	\$1,500,001	\$844,986	\$655,015	78%
Wyoming	\$80,940	\$78,650	\$2,290	3%
Total	\$381,539,482	\$217,680,823	\$163,858,659	75%

FY 1997 and FY 1996 Title II ADAP Supplemental Funding: Percentage Change

State	FY97 ADAP Supp.	FY96 ADAP Supp.	Actual Change	Percentage Change
Alabama	\$1,329,706	\$401,982	\$927,724	231%
Alaska	\$112,917	\$38,443	\$74,474	194%
Arizona	\$1,450,752	\$470,790	\$979,962	208%
Arkansas	\$654,013	\$199,737	\$454,276	227%
California	\$26,371,892	\$8,415,161	\$17,956,731	213%
Colorado	\$1,607,932	\$528,455	\$1,079,477	204%
Connecticut	\$2,790,394	\$861,629	\$1,928,765	224%
Delaware	\$619,686	\$183,580	\$436,106	238%
DC	\$2,613,341	\$800,064	\$1,813,277	227%
Florida	\$17,898,632	\$5,503,506	\$12,395,126	225%
Georgia	\$5,125,509	\$1,515,721	\$3,609,788	238%
Guam			\$0	0%
Hawaii	\$542,903	\$172,159	\$370,744	215%
Idaho	\$112,917	\$35,657	\$77,260	217%
Illinois	\$5,427,222	\$1,682,586	\$3,744,636	223%
Indiana	\$1,372,162	\$402,818	\$969,344	241%
Iowa	\$292,680	\$89,422	\$203,258	227%
Kansas	\$568,196	\$183,023	\$385,173	210%
Kentucky	\$663,046	\$196,116	\$466,930	238%
Louisiana	\$2,717,224	\$773,878	\$1,943,346	251%
Maine	\$229,446	\$78,279	\$151,167	193%
Maryland	\$5,025,239	\$1,548,035	\$3,477,204	225%
Massachusetts	\$3,310,714	\$1,059,974	\$2,250,740	212%
Michigan	\$2,408,285	\$792,821	\$1,615,464	204%
Minnesota	\$841,003	\$276,067	\$564,936	205%
Mississippi	\$880,749	\$272,445	\$608,304	223%
Missouri	\$1,965,652	\$626,791	\$1,338,861	214%
Montana	\$64,137	\$18,943	\$45,194	239%
Nebraska	\$233,963	\$73,822	\$160,141	217%
Nevada	\$957,533	\$298,910	\$658,623	220%
New Hampshire	\$214,993	\$66,858	\$148,135	222%
New Jersey	\$9,448,859	\$2,953,162	\$6,495,697	220%
New Mexico	\$377,593	\$128,701	\$248,892	193%
New York	\$29,381,796	\$9,009,360	\$20,372,436	226%
North Carolina	\$2,250,201	\$701,449	\$1,548,752	221%
North Dakota	\$24,390	\$7,243	\$17,147	237%
Ohio	\$2,577,208	\$782,236	\$1,794,972	229%
Oklahoma	\$728,086	\$241,524	\$486,562	201%
Oregon	\$1,148,136	\$354,625	\$793,511	224%
Pennsylvania	\$5,258,299	\$1,599,571	\$3,658,728	229%
Puerto Rico	\$5,315,209	\$1,685,094	\$3,630,115	215%
Rhode Island	\$494,123	\$157,951	\$336,172	213%
South Carolina	\$2,112,895	\$658,549	\$1,454,346	221%
South Dakota	\$38,843	\$12,536	\$26,307	210%
Tennessee	\$1,830,152	\$547,955	\$1,282,197	234%
Texas	\$11,061,308	\$3,496,103	\$7,565,205	216%
Utah	\$399,273	\$118,115	\$281,158	238%
Vermont	\$92,140	\$29,529	\$62,611	212%
Virgin Islands		\$28,415	(\$28,415)	-100%
Virginia	\$2,881,631	\$900,072	\$1,981,559	220%
Washington	\$2,067,728	\$667,463	\$1,400,265	210%
West Virginia	\$247,513	\$69,365	\$178,148	257%
Wisconsin	\$823,839	\$268,824	\$555,015	206%
Wyoming	\$37,940	\$13,650	\$24,290	178%
Total	\$167,000,000	\$51,999,164	\$115,000,836	221%

FY 1997 and FY 1996 State Funding for ADAP: Percentage Change

State	FY97 State Funding	FY96 State Funding	Actual Change	Percentage Change
Alabama	\$150,000	\$150,000	\$0	0%
Alaska			\$0	0%
Arizona			\$0	0%
Arkansas			\$0	0%
California	\$40,159,000	\$15,600,000	\$24,559,000	157%
Colorado	\$301,000	\$301,000	\$0	0%
Connecticut		\$592,000	(\$592,000)	-100%
Delaware		\$35,000	(\$35,000)	-100%
DC	\$150,000	\$147,000	\$3,000	2%
Florida			\$0	0%
Georgia	\$324,450	\$324,450	\$0	0%
Guam			\$0	0%
Hawaii	\$300,000	\$300,000	\$0	0%
Idaho			\$0	0%
Illinois	\$8,325,000	\$5,200,000	\$3,125,000	60%
Indiana	\$75,000	\$75,000	\$0	0%
Iowa			\$0	0%
Kansas			\$0	0%
Kentucky	\$85,000	\$110,000	(\$25,000)	-23%
Louisiana	\$16,000,000	\$3,315,074	\$12,684,926	383%
Maine	\$60,040	\$60,040	\$0	0%
Maryland	\$600,000	\$1,100,000	(\$500,000)	-45%
Massachusetts	\$3,660,000	\$1,100,000	\$2,560,000	233%
Michigan			\$0	0%
Minnesota		\$150,000	(\$150,000)	-100%
Mississippi			\$0	0%
Missouri	\$600,000	\$600,000	\$0	0%
Montana		\$95,000	(\$95,000)	-100%
Nebraska			\$0	0%
Nevada			\$0	0%
New Hampshire		\$73,833	(\$73,833)	-100%
New Jersey	\$700,000	\$875,000	(\$175,000)	-20%
New Mexico	\$740,000	\$740,000	\$0	0%
New York	\$12,400,000	\$8,400,000	\$4,000,000	48%
North Carolina	\$750,000	\$750,000	\$0	0%
North Dakota			\$0	0%
Ohio	\$3,000,000	\$200,000	\$2,800,000	1400%
Oklahoma	\$206,000	\$206,000	\$0	0%
Oregon			\$0	0%
Pennsylvania	\$4,612,723	\$5,200,000	(\$587,277)	-11%
Puerto Rico	\$7,262,008	\$3,406,651	\$3,855,357	113%
Rhode Island			\$0	0%
South Carolina	\$500,000	\$350,000	\$150,000	43%
South Dakota			\$0	0%
Tennessee			\$0	0%
Texas	\$2,697,376	\$2,697,376	\$0	0%
Utah	\$114,800	\$114,800	\$0	0%
Vermont	\$75,000		\$75,000	0%
Virgin Islands			\$0	0%
Virginia	\$687,200	\$687,200	\$0	0%
Washington	\$4,200,000	\$417,500	\$3,782,500	906%
West Virginia	\$25,000	\$25,000	\$0	0%
Wisconsin	\$295,800	\$295,800	\$0	0%
Wyoming			\$0	0%
Total	\$109,055,397	\$53,693,724	\$55,361,673	103%

FY 1997 and FY 1996 Title II Base Grant Funding for ADAP: Percentage Change

State	FY97 Title II Base Funds	FY96 Title II Base Funds	Actual Change	Percentage Change
Alabama	\$1,670,294	\$1,908,763	(\$238,469)	-12%
Alaska		\$36,557	(\$36,557)	-100%
Arizona	\$849,275	\$800,000	\$49,275	6%
Arkansas	\$600,000	\$572,591	\$27,409	5%
California	\$9,849,105	\$9,849,105	\$0	0%
Colorado	\$136,000	\$67,942	\$68,058	100%
Connecticut	\$602,389	\$352,389	\$250,000	71%
Delaware	\$314,314	\$181,420	\$132,894	73%
DC	\$600,000	\$603,000	(\$3,000)	0%
Florida	\$6,419,365	\$8,060,748	(\$1,641,383)	-20%
Georgia	\$2,930,000	\$2,000,000	\$930,000	47%
Guam			\$0	0%
Hawaii	\$269,500	\$247,195	\$22,305	9%
Idaho	\$80,083	\$130,000	(\$49,917)	-38%
Illinois	\$714,300	\$605,471	\$108,829	18%
Indiana	\$803,548	\$1,000,000	(\$196,452)	-20%
Iowa		\$118,578	(\$118,578)	-100%
Kansas	\$170,000	\$547,822	(\$377,822)	-69%
Kentucky	\$246,275	\$571,974	(\$325,699)	-57%
Louisiana	\$654,106	\$184,926	\$469,180	254%
Maine	\$100,000	\$100,000	\$0	0%
Maryland	\$0	\$1,200,000	(\$1,200,000)	-100%
Massachusetts	\$0	\$742,140	(\$742,140)	-100%
Michigan	\$154,636	\$154,637	(\$1)	0%
Minnesota		\$103,917	(\$103,917)	-100%
Mississippi	\$1,159,577	\$1,064,389	\$95,188	9%
Missouri		\$390,000	(\$390,000)	-100%
Montana	\$136,863	\$110,969	\$25,894	23%
Nebraska	\$66,037	\$133,443	(\$67,406)	-51%
Nevada	\$576,666	\$663,996	(\$87,330)	-13%
New Hampshire	\$93,507	\$194,918	(\$101,411)	-52%
New Jersey	\$4,566,141	\$4,133,838	\$432,303	10%
New Mexico	\$222,619	\$294,884	(\$72,265)	-25%
New York	\$9,957,157	\$9,807,712	\$149,445	2%
North Carolina	\$660,000	\$660,000	\$0	0%
North Dakota	\$70,000	\$55,000	\$15,000	27%
Ohio	\$822,792	\$846,000	(\$23,208)	-3%
Oklahoma	\$606,101	\$559,005	\$47,096	8%
Oregon	\$200,000	\$199,000	\$1,000	1%
Pennsylvania			\$0	0%
Puerto Rico	\$3,042,107	\$3,072,835	(\$30,728)	-1%
Rhode Island	\$268,849	\$278,514	(\$9,665)	-3%
South Carolina	\$423,683	\$650,000	(\$226,317)	-35%
South Dakota	\$66,500	\$70,000	(\$3,500)	-5%
Tennessee	\$0	\$300,000	(\$300,000)	-100%
Texas	\$2,980,000	\$1,402,641	\$1,577,359	112%
Utah	\$266,873	\$275,954	(\$9,081)	-3%
Vermont	\$157,471	\$157,500	(\$29)	0%
Virgin Islands			\$0	0%
Virginia	\$2,714,138	\$2,140,200	\$573,938	27%
Washington	\$326,682	\$192,235	\$134,447	70%
West Virginia	\$82,487	\$120,100	(\$37,613)	-31%
Wisconsin	\$280,362	\$280,362	\$0	0%
Wyoming	\$3,000	\$65,000	(\$62,000)	-95%
Total	\$56,912,802	\$58,257,670	(\$1,344,868)	-2%

FY 1997 and FY 1996 Title I EMA Contributions to ADAP: Percentage Change

State	FY97 Title I EMA Cont.	FY96 Title I EMA Cont.	Actual Change	Percentage Change
Alabama			\$0	0%
Alaska			\$0	0%
Arizona			\$0	0%
Arkansas			\$0	0%
California			\$0	0%
Colorado	\$860,000	\$261,000	\$599,000	230%
Connecticut	\$421,500	\$421,500	\$0	0%
Delaware			\$0	0%
DC	\$1,000,000	\$800,000	\$200,000	25%
Florida			\$0	0%
Georgia	\$1,000,000	\$1,064,645	(\$64,645)	-6%
Guam			\$0	0%
Hawaii			\$0	0%
Idaho			\$0	0%
Illinois		\$825,000	(\$825,000)	-100%
Indiana			\$0	0%
Iowa			\$0	0%
Kansas			\$0	0%
Kentucky			\$0	0%
Louisiana			\$0	0%
Maine			\$0	0%
Maryland	\$434,000	\$453,963	(\$19,963)	-4%
Massachusetts	\$1,000,000	\$350,000	\$650,000	186%
Michigan	\$400,000	\$400,000	\$0	0%
Minnesota			\$0	0%
Mississippi			\$0	0%
Missouri			\$0	0%
Montana			\$0	0%
Nebraska			\$0	0%
Nevada			\$0	0%
New Hampshire	\$75,000	\$72,308	\$2,692	4%
New Jersey	\$1,288,868	\$792,024	\$496,844	63%
New Mexico			\$0	0%
New York	\$15,052,105	\$19,858,730	(\$4,806,625)	-24%
North Carolina			\$0	0%
North Dakota			\$0	0%
Ohio			\$0	0%
Oklahoma			\$0	0%
Oregon	\$687,000		\$687,000	0%
Pennsylvania			\$0	0%
Puerto Rico			\$0	0%
Rhode Island			\$0	0%
South Carolina			\$0	0%
South Dakota			\$0	0%
Tennessee			\$0	0%
Texas	\$350,000	\$217,000	\$133,000	61%
Utah			\$0	0%
Vermont			\$0	0%
Virgin Islands			\$0	0%
Virginia			\$0	0%
Washington	\$168,750	\$342,500	(\$173,750)	-51%
West Virginia			\$0	0%
Wisconsin			\$0	0%
Wyoming			\$0	0%
Total	\$22,737,223	\$25,858,670	(\$3,121,447)	-12%

Appendix III

State ADAP Program Eligibility

APPENDIX III STATE ADAP PROGRAM ELIGIBILITY

State	Financial Eligibility	Medical Eligibility
Alabama	Income at or below 250% of Federal Poverty Level. No third party insurance that pays for more than 50% of the cost of covered medications.	HIV+, CD4 <500 (CD4 count requirement is waived for pregnant women and neonates).
Alaska	Income at or below 200% of Federal Poverty Guidelines for Alaska.	HIV+ and licensed practitioner's prescription.
Arizona	Income at or below 200% of Federal Poverty Level.	HIV+
Arkansas	Based on annual income, less medical expenses. Income at or below 100% of Federal Poverty Level. Can usually cover any uninsured person until insurance begins.	HIV+ and a doctor's prescription.
California	Income at or below 400% of Federal Poverty Level. If above, must make a sliding scale co-payment based on annual state income tax liability & family size up to annual earnings of \$50,000, applicant's health insurance does not provide drugs as a benefit <i>or</i> the co-payment plan is causing financial hardship <i>or</i> you cannot be enrolled in HMO, health insurance programs or public programs.	HIV + or AIDS diagnosis, over 18yrs of age, prescription for a covered drug from a CA licensed physician.
Colorado	Annual income at or below 185% of Federal Poverty Level.	HIV + and doctor's prescription.
Connecticut	Total annual net income less than 300% of Federal Poverty Level. No asset limitations.	Certification from doctor of HIV+ status and prescription.
Delaware	230% of Federal Poverty Level, no co-pay. Sliding scale/co-payments: 231%-300% FPL = 7% co-payment, 300% + = 10% co-payment. Co-payments are for cost of service and total allowable annual charges cannot exceed either 7% or 10% of gross income, depending on the co-pay.	HIV+
District of Columbia	Income at or below 300% of Federal Poverty Level.	HIV+
Florida	Income at or below 200% of Federal Poverty Level. Enrollees with incomes 100%-200% of FPL are assessed for co-payments according to a sliding fee scale.	CD4 <500: this requirement can be waived. Documentation required: HIV status, CD4 count, financial statement & enrollment form.
Georgia	125% of Federal Poverty Level.	HIV diagnosis and <500 CD4.
Hawaii	400% of Federal Poverty Level set for Hawaii. Assets <\$10,000 excluding home & car.	HIV+
Idaho	400% of Federal Poverty Level.	HIV+, CD4 <500.
Illinois	Income at or below 200% of Federal Poverty Level; insurance provides less than 80% of cost of prescription medication.	HIV+
Indiana	Indiana residency requirement and income at or below 300% of Federal Poverty Level.	HIV+, CD4 <500. When protease inhibitors are added, there may be additional CD4 count and viral load requirements.
Iowa	Income at or below 200% of the Federal Poverty Level.	HIV+, recent CD4 count.
Kansas	300% of Federal Poverty Level - will assist with spend down.	Doctor's certification of HIV status.
Kentucky	Income at or below 300 % of Federal Poverty Level, adjusted for family size. Cash assets of less than \$10,000. Access to protease inhibitors requires income at or below 200% of FPL, adjusted for family size. (currently no asset limit for access to protease inhibitors; should be added within 1-3 months).	HIV+, CD4 <550 or history of cytologically-confirmed PCP with an exception made for pregnant women needing AZT for preventing perinatal transmission.
Louisiana	Income at or below 200% of Federal Poverty Level. Assets less than \$4,000 (not including home or car). Not qualified for Medicaid or private insurance.	HIV+. Recent viral load test result. Able to discontinue contraindicated medications.
Maine	Income at or below 200% of Federal Poverty Level.	HIV+, CD4 <400 or viral load >20,000.
Maryland	Annual gross income at of below \$29,400, adjusted for household size. Sliding scale/ co-payments for incomes over \$26,000.	HIV+, prescription for a covered drug.
Massachusetts	<\$27,000 net annual income, limit raised by \$2,200 for each dependent. Massachusetts residency required.	HIV+

Michigan	Income at or below 185% of Federal Poverty Level. Must have applied for Medicaid within the past 60 days and have pending or denial status. Not eligible for Veterans Administration benefits. Michigan resident.	HIV diagnosis and <500 CD4. No CD4 count requirement for pregnant women.
Minnesota	Income at or below 300% of Federal Poverty Level. Liquid assets less than \$25,000 (not including home and car). Minnesota residency. Uninsured or responsible for $\geq 20\%$ of prescription cost or $\geq \$15.00$ per prescription. Can't be in State Medical Assistance or GA Medical Care Programs.	HIV+ and doctor's prescription.
Mississippi	Total household income below 200% of Federal Poverty Level.	HIV+, CD4 <500 or viral load >30,000.
Missouri	Income at or below 185% of Federal Poverty Level. Missouri residency.	HIV+
Montana	Applicant must provide evidence that the cost of the covered medications will create a severe financial burden on his/her household.	HIV+, prescription for a covered medication.
Nebraska	Income at or below 200% of Federal Poverty Level.	HIV+
Nevada	Income at or below 200% of Federal Poverty Level. Less than \$4,000 in assets (car & residence not counted).	HIV+, CD4 count <500 (exception for pregnant women and neonates).
New Hampshire	Income at or below 300% of Federal Poverty Level (income limit may be adjusted based on medical expenses incurred).	HIV+
New Jersey	Annual income at or below \$30,000 for one person. Limit increased by \$10,000 for each member of household up to \$70,000 per year. Must be NJ resident.	HIV+, doctor's certification that applicant needs medication.
New Mexico	Income at or below 300% of Federal Poverty Level, adjusted for family size. Liquid assets of less than \$10,000.	HIV+
New York	Income: <\$44,000 for a household of one, <\$59,200 for two, <\$74,400 for three +; liquid assets <\$25,000. New York state residency.	ADAP & ADAP Plus: HIV+. Home Care: AIDS or HIV illness and chronic medical dependency due to physical or cognitive impairment from HIV infection.
North Carolina	Net annual income at or below 125% of Federal Poverty Level, effective April 1, 1997 (was 110% of FPL).	HIV+
North Dakota	Income at or below 150% of Federal Poverty Level; above that there is a sliding scale: 150%-200% of FPL = 90% coverage, 200%+ of FPL = 80% coverage.	HIV+
Ohio	Income at or below 281% of the Federal Poverty Level, currently <\$1,410 per month after taxes (additional allowance for dependents). Ohio residency.	HIV+
Oklahoma	Income at or below 150% of Federal Poverty Level (out-of-pocket drug costs can be taken into account to "spend down" to this income limit). Oklahoma residency requirement	HIV+, doctor's prescription for a covered drug.
Oregon	Full coverage up to 235% of the Federal Poverty Level. Donation requested between 235-274% of FPL. Sliding scale for incomes between 274%-415% of FPL. Liquid assets under \$20,000.	HIV+
Pennsylvania	Gross annual income of less than \$30,000 with an allowance of 2,480 for each additional family member. PA residency (not institutionalized). Social Security card.	Prescriptions for covered drugs.
Puerto Rico	Certified as medically indigent by the Medicaid program or limited/no coverage by a drug prescription plan, as documented by the state, health insurance plan, Consortia or Community-Based Organization. Guidelines for income are provided, starting at \$400 per month for one person or \$800 per month for one person depending which table you look at.	HIV+, CD4 <500 or viral load >10,000.
Rhode Island	Income at or below 400% of Federal Poverty Level.	HIV+
South Carolina	Applicants at or below 300% of Federal Poverty Level qualify for free medications. A sliding fee scale is used to determine how much an applicant must pay if he or she is above this threshold.	HIV+, CD4 <500 (CD4 requirement waived for pregnant women/neonates and may be waived for other reasons on a case-by-case basis).

South Dakota	Income at or below 300% of Federal Poverty Level.	HIV+ and doctor's prescription.
Tennessee	Income at or below 300% of Federal Poverty Level. Liquid asset limit of \$8,000.	HIV+
Texas	200% of Federal Poverty Level (if married, spouse's income is counted), Not eligible for Medicaid, or used up the months Medicaid pharmacy benefit. Co-payment of \$5.00 per prescription may be required for non-Medicaid eligible clients. Current income guidelines: For 1 person - <\$15,480 2 - <\$20,720 3. \$25,960 4. \$31,200 , 5. \$36,440	HIV+. Meet the eligibility criteria for at least one of the drugs on the formulary.
Utah	100% of Federal Poverty Level =full coverage. Sliding scale: 101%-150% of FPL = 1.5% co-pay required, 151%-200% = 3% co-pay, 201%-250% = 5%, 251%-300% = 10%, 301%-350% = 15%, 351%-400% = 20%, 401%-450% = 30%, 451%-500% = 40%, Over 501% = 50%.	HIV+
Vermont	Income at or below 200% of Federal Poverty Level. Sliding scale/co-payments for incomes over 200% of FPL. In the process of being revised to make more generous.	HIV+
Virginia	Income at or below 200% of Federal Poverty Level (residents of northern Virginia may have incomes up to \$17,428).	HIV+, recent CD4 count and viral load.
Washington	Income at or below 370% of Federal Poverty Level. Assets of less than \$10,000 (not including home and car).,	HIV+
West Virginia	Income at or below 300% of Federal Poverty Level.	HIV+
Wisconsin	200% of Federal Poverty Level, Wisconsin State residency. Must have applied for coverage under, and have been denied eligibility for, medical assistance within 12 months prior to application.	HIV+. Physician's indication of need for prescription.
Wyoming	Income at or below 300% of Federal Poverty Level.	HIV+

Appendix IV

State ADAP Formularies

APPENDIX IV STATE ADAP FORMULARIES

State	Antiretrovirals	OI Prophylaxis and Treatment
Alabama	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase)	acyclovir (Zovirax), fluconazole (Diflucan), ganciclovir (Cytovene), leucovorin, TMP/SMX (Bactrim/Septra)
Alaska	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	
Arizona	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept)	dapsone, pentamidine, TMP/SMX (Bactrim/Septra), trimethoprim
Arkansas	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir)	acyclovir (Zovirax), dapsone, famciclovir (Famvir), rifabutin (Mycobutin), TMP/SMX (Bactrim/Septra), valacyclovir (Valtrex), "The consortia will provide many additional AIDS-related drugs not on the formulary for approximately 30 days allowing time to seek other sources of payment."
California	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase)	acyclovir (Zovirax), alpha-interferon, amphotericin B, atovaquone (Mepron), azithromycin (Zithromax), bleomycin, clarithromycin (Biaxin), clindamycin, clofazimine (Lamprene), clotrimazole (Mycelex), cyclophosphamide, dapsone, dexamethasone, doxorubicin, dronabinol (Marinol), erythropoietin (Epogen), ethambutol (Myambutol), filgrastim (Neupogen), fluconazole (Diflucan), flucytosine (Ancobon), foscarnet (Foscavir), ganciclovir (Cytovene), itraconazole (Sporanox), ketoconazole (Nizoral), leucovorin, megestrol acetate (Megace), methotrexate, nystatin, paromomycin (Humatin), pentamidine, prednisone, pyrimethamine (Fansidar), rifabutin (Mycobutin), sulfadiazine, TMP/SMX (Bactrim/Septra), trimethoprim, trimetrexate glucuronate (Neutrexin), vinblastine, vincristine
Colorado	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept)	
Connecticut	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase)	acyclovir (Zovirax), amphotericin B, atovaquone (Mepron), azithromycin (Zithromax), ciprofloxacin (Cipro), clarithromycin (Biaxin), clindamycin, clofazimine (Lamprene), clotrimazole (Mycelex), dapsone, dronabinol (Marinol), erythropoietin (Epogen), ethambutol (Myambutol), filgrastim (Neupogen), fluconazole (Diflucan), foscarnet (Foscavir), ganciclovir (Cytovene), itraconazole (Sporanox), ketoconazole (Nizoral), leucovorin, megestrol acetate (Megace), metronidazole (Flagyl), nystatin, ofloxacin, paromomycin (Humatin), pentamidine, prednisone, primaquine, pyrimethamine (Fansidar), rifabutin (Mycobutin), sulfadiazine, terconazole, TMP/SMX (Bactrim/Septra), trimethoprim, pneumovax, Lomotil, hydroxyzine HCL (Atarax), prochlorperesine (Compazine), amoxicillin, amoxicillin/potassium clavulante (Augmentin), cefuroxime, cephalexin, dicloxacillin, vancomycin, acetaminophen w/codeine (Generic only), fentanyl transdermal system (Duragesic), amitriptyline (Elavil), lorazepam (Generic only), sertraline (Zoloft), hydrocortisone cream/lotion/ointment, lactic acid, triamcinolone - acetonide cream/ointment, chlorhexidine gluconate (Peridex), loperamide hydrochloride (Imodium)

State	Antiretrovirals	OI Prophylaxis and Treatment
Delaware	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), atovaquone (Mepron), azithromycin (Zithromax), clarithromycin (Biaxin), clotrimazole (Mycelex), dapsone, fluconazole (Diflucan), nystatin, paromomycin (Humatin), pentamidine, prednisone, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septra), amitriptyline (Elavil), amoxicillin, carbamazepine (Tegretol), cephalixin, clemastine fumarate, clotrimazole/betamethasone cream, clotrimazole vaginal application (Monistat Dual), docusate calcium, doxycycline, erythromycin, loperamide (Imodium), metaproterenol inhaler, miconazole cream, penicillin, phenytoin (Dilantin), psyllium (Metamucil), Senekot-S Tab, calcium, magnesium and multivitamins with iron. The following agents will be provided for a four week period of illness only, not prophylaxis. Alternative funding must be applied for at the time of initiation of therapy. A negative response from a drug company or other entity must be presented before extension will be considered: erythropoietin (Epogen), filgrastim (Neupogen), ganciclovir (Oral only), The following will be obtained as a nutritional component of Home and Community-Based Care through the Division of Public Health: dronabinol (Marinol), megestrol acetate (Megace), Multivitamins,
District of Columbia	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nevirapine (Viramune)	acyclovir (Zovirax), alpha-interferon, amphotericin B, atovaquone (Mepron), azithromycin (Zithromax), cidofovir (Vistide), ciprofloxacin (Cipro), clarithromycin (Biaxin), clindamycin, clotrimazole (Mycelex), dapsone, DOXIL, dronabinol (Marinol), ethambutol (Myambutol), fluconazole (Diflucan), ganciclovir (Cytovene), isoniazid (INH), ketoconazole (Nizoral), megestrol acetate (Megace), ofloxacin, pentamidine, pyrazinamide (PZA), pyrimethamine (Fansidar), rifabutin (Mycobutin), rifampin, sulfadiazine, TMP/SMX (Bactrim/Septra), ANALGESICS: acetomenaphine with codeine (Tylenol III and Tylenol IV), fentanyl patch (Duragesic), ibuprofen (800mg), morphine sulfate (MS Contin), ANTIBIOTICS: amoxicillin/clavulanate (Augmentin), ANTIDEPRESSANTS: fluoxetine HCL(Prozac), sertraline HCL (Zoloft), ANTIDIARRHEAL: dephenoxylate and atropine (Lomotil), TOPICAL STEROID: hydrocortisone cream 1%,
Florida	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), azithromycin (Zithromax), clarithromycin (Biaxin), dapsone, ethambutol (Myambutol), fluconazole (Diflucan), rifabutin (Mycobutin), TMP/SMX (Bactrim/Septra)
Georgia	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase)	
Hawaii	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), atovaquone (Mepron), azithromycin (Zithromax), cidofovir (Vistide), ciprofloxacin (Cipro), clarithromycin (Biaxin), clindamycin, clofazimine (Lamprene), dapsone, erythropoietin (Epogen), Procrit, ethambutol (Myambutol), filgrastim (Neupogen), fluconazole (Diflucan), foscarnet (Foscavir), ganciclovir (Cytovene), itraconazole (Sporanox), ketoconazole (Nizoral), leucovorin, megestrol acetate (Megace), pentamidine, pyrimethamine (Fansidar), rifabutin (Mycobutin), rifampin, TMP/SMX (Bactrim/Septra), probenecid
Idaho	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan)	dapsone, pentamidine, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septra), ,

State	Antiretrovirals	OI Prophylaxis and Treatment
Illinois	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), alpha-interferon, amphotericin B, atovaquone (Mepron), azithromycin (Zithromax), cidofovir (Vistide), ciprofloxacin (Cipro), clarithromycin (Biaxin), clindamycin, clotrimazole (Mycelex), dapsone, dronabinol (Marinol), ethambutol (Myambutol), famciclovir (Famvir), fluconazole (Diflucan), foscarnet (Foscavir), ganciclovir (Cytovene), isoniazid (INH), itraconazole (Sporanox), ketoconazole (Nizoral), leucovorin, megestrol acetate (Megace), miconazole, nystatin, ofloxacin, paromomycin (Humatin), pentamidine, primaquine, pyrazinamide (PZA), pyrimethamine (Fansidar), rifabutin (Mycobutin), rifampin, Rifater, streptomycin, sulfadiazine, sulfamethoxazole, terconazole, TMP/SMX (Bactrim/Septra), trimethoprim, For use with cidofovir (Vistide):, probenecid, ANTIBIOTICS: amoxicillin, cefixime, cephalexin, chlorhexidine gluconate, dicloxacillin sodium, doxycycline, erythromycin, penicillin VK, tetracycline, MISCELLANEOUS HORMONES: danazol (Danocrine)
Indiana	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), atovaquone (Mepron), azithromycin (Zithromax), clotrimazole (Mycelex), dapsone, fluconazole (Diflucan), nystatin, pentamidine, TMP/SMX (Bactrim/Septra), NOTE: Protease inhibitors and nevirapine (Viramune) are due to be added April 1, 1997., azithromycin and fluconazole will also be added at this time., clarithromycin, which was on the formulary, is being deleted April 1.
Iowa	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase)	acyclovir (Zovirax), atovaquone (Mepron), azithromycin (Zithromax), clarithromycin (Biaxin), clotrimazole (Mycelex), dapsone, fluconazole (Diflucan), ketoconazole (Nizoral), nystatin, pentamidine, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septra)
Kansas	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), saquinavir (Invirase), ritonavir (Norvir), nelfinavir (Viracept)	acyclovir (Zovirax), azithromycin (Zithromax), clarithromycin (Biaxin), clindamycin, dapsone, dronabinol (Marinol), famciclovir (Famvir), fluconazole (Diflucan), itraconazole (Sporanox), ketoconazole (Nizoral), clofazimine (Lamprene), megestrol acetate (Megace), ethambutol (Myambutol), atovaquone (Mepron), clotrimazole (Mycelex), pentamidine, rifabutin (Mycobutin), nystatin, paromomycin (Humatin), primaquine, TMP/SMX (Bactrim/Septra), ganciclovir (Cytovene)
Kentucky	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), ciprofloxacin (Cipro), clarithromycin (Biaxin), clotrimazole (Mycelex), dapsone, fluconazole (Diflucan), ketoconazole (Nizoral), megestrol acetate (Megace), nystatin, pentamidine, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septra)
Louisiana	indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase)	
Maine	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept)	acyclovir (Zovirax), dapsone, fluconazole (Diflucan), itraconazole (Sporanox), pentamidine, TMP/SMX (Bactrim/Septra). Additional drugs can be approved on a case-by-case basis.
Maryland	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), alpha-interferon, amphotericin B, atovaquone (Mepron), azithromycin (Zithromax), clarithromycin (Biaxin), clotrimazole (Mycelex), dapsone, ethambutol (Myambutol), fluconazole (Diflucan), foscarnet (Foscavir), ganciclovir (Cytovene), isoniazid (INH), ketoconazole (Nizoral), leucovorin, megestrol acetate (Megace), pentamidine, pyrazinamide (PZA), pyrimethamine (Fansidar), rifabutin (Mycobutin), rifampin, TMP/SMX (Bactrim/Septra)
Massachusetts	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), alpha-interferon, clarithromycin (Biaxin), clindamycin, clotrimazole (Mycelex), dapsone, fluconazole (Diflucan), foscarnet (Foscavir), ganciclovir (Cytovene), ketoconazole (Nizoral), leucovorin, nystatin, pentamidine, pyrimethamine (Fansidar), rifabutin (Mycobutin), sulfadiazine, terconazole, TMP/SMX (Bactrim/Septra), butaconazole (Femstat)

State	Antiretrovirals	OI Treatment and Prophylaxis
Michigan	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), amphotericin B, azithromycin (Zithromax), clarithromycin (Biaxin), clotrimazole (Mycelex), dapsone, fluconazole (Diflucan), ketoconazole (Nizoral), pentamidine, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septra)
Minnesota	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), amphotericin B, atovaquone (Mepron), azithromycin (Zithromax), ciprofloxacin (Cipro), clarithromycin (Biaxin), clindamycin, clofazimine (Lamprene), clotrimazole (Mycelex), dapsone, dronabinol (Marinol), ethambutol (Myambutol), fluconazole (Diflucan), ganciclovir (Cytovene), itraconazole (Sporanox), ketoconazole (Nizoral), leucovorin, megestrol acetate (Megace), nystatin, paromomycin (Humatin), pentamidine, prednisone, pyrimethamine (Fansidar), rifabutin (Mycobutin), rifampin, TMP/SMX (Bactrim/Septra), valacyclovir (Valtrex), chlor-hexidine (Peridex), cimetidine (Tagamet), hydrocortisone, diphenoxylate (Lomotil), loperamide HCl (Immodium), ranitidine (Zantac)
Mississippi	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), saquinavir (Invirase)	acyclovir (Zovirax), azithromycin (Zithromax), dapsone, fluconazole (Diflucan), ganciclovir (Cytovene), pentamidine, TMP/SMX (Bactrim/Septra), sertraline (Zoloft). Note: fluconazole (Diflucan) is only covered for one month, conditional upon application to Pfizer patient assistance program.
Missouri	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), atovaquone (Mepron), azithromycin (Zithromax), ciprofloxacin (Cipro), clarithromycin (Biaxin), clindamycin, clofazimine (Lamprene), clotrimazole (Mycelex), dapsone, ethambutol (Myambutol), famciclovir (Famvir), fluconazole (Diflucan), ganciclovir (Cytovene), isoniazid (INH), itraconazole (Sporanox), ketoconazole (Nizoral), leucovorin, metronidazole (Flagyl), miconazole, nystatin, ofloxacin, pentamidine, prednisone, pyrimethamine (Fansidar), rifabutin (Mycobutin), rifampin, sulfadiazine, TMP/SMX (Bactrim/Septra), valacyclovir (Valtrex), ANALGESICS: codeine, Darvocet, Ibuprofen, morphine (immediate release), Percocet, Tylenol III w/codeine, ANTIBIOTICS: amoxicillin, amoxicillin/potassium (Augmentin), cefuroxime, cephalexin, doxycycline, erythromycin, penicillin, ANTICONVULSANTS: carbamazepine (Tegretol), phenytoin (Dilantin), ANTIDIARRHEALS: diphenoxylate (Lomotil), loperamide (Imodium), ANTIFUNGAL: griseofulvin, ANTIHISTAMINES: diphenhydramine (Benadryl), hydroxyzine, PSYCHOTROPICS: doxepin, NEUROPATHIC PAIN/PERIPHERAL NEUROPATHY: amitriptyline (Elavil), nortriptyline (Pamelor), TOPICAL CORTICOSTEROIDS: betamethasone, clobetasol, desoximetasone, fluocinolone, fluocinonide, hydrocortisone, triamcinolone
Montana	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept)	pentamidine
Nebraska	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), atovaquone (Mepron), ciprofloxacin (Cipro), clarithromycin (Biaxin), clofazimine (Lamprene), clotrimazole (Mycelex), dapsone, ethambutol (Myambutol), fluconazole (Diflucan), isoniazid (INH), ketoconazole (Nizoral), nystatin, pentamidine, pyrazinamide (PZA), rifabutin (Mycobutin), rifampin, TMP/SMX (Bactrim/Septra), Antidepressants (individual drugs not specified on formulary).
Nevada	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir)	acyclovir (Zovirax), azithromycin (Zithromax), dapsone, fluconazole (Diflucan), TMP/SMX (Bactrim/Septra)
New Hampshire	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), atovaquone (Mepron), azithromycin (Zithromax), clarithromycin (Biaxin), clindamycin, clofazimine (Lamprene), clotrimazole (Mycelex), dapsone, ethambutol (Myambutol), fluconazole (Diflucan), ganciclovir (Cytovene), isoniazid (INH), ketoconazole (Nizoral), leucovorin, megestrol acetate (Megace), metronidazole (Flagyl), nystatin, pentamidine, primaquine, pyrazinamide (PZA), pyrimethamine (Fansidar), rifabutin (Mycobutin), rifampin, sulfadoxine, TMP/SMX (Bactrim/Septra), trimethoprim

State	Antiretrovirals	OI Prophylaxis and Treatment
New Jersey	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), saquinavir (Invirase)	acyclovir (Zovirax), atovaquone (Mepron), azithromycin (Zithromax), ciprofloxacin (Cipro), clarithromycin (Biaxin), clindamycin, clofazimine (Lamprene), clotrimazole (Mycelex), cycloserine, dapsone, ethambutol (Myambutol), ethionamide, fluconazole (Diflucan), foscarnet (Foscavir), ganciclovir (Cytovene), isoniazid (INH), itraconazole (Sporanox), IVIG, ketoconazole (Nizoral), leucovorin, ofloxacin, paromomycin (Humatin), pentamidine, prednisone, pyrazinamide (PZA), rifabutin (Mycobutin), rifampin, streptomycin, TMP/SMX (Bactrim/Septra), Pneumovax (pneumococcal vaccine).
New Mexico	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), alpha-interferon, amikacin, amphotericin B, atovaquone (Mepron), azithromycin (Zithromax), ciprofloxacin (Cipro), clarithromycin (Biaxin), clindamycin, clofazimine (Lamprene), clotrimazole (Mycelex), dapsone, erythropoietin (Epogen, Procrit), ethambutol (Myambutol), famciclovir (Famvir), filgrastim (Neupogen), fluconazole (Diflucan), foscarnet (Foscavir), ganciclovir (Cytovene), itraconazole (Sporanox), ketoconazole (Nizoral), megestrol acetate (Megace), nystatin, pentamidine, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septra), trimethoprim, ANTIDEPRESSANTS: sertraline (Zoloft), ANTISEBORRHEA: Tegrin Shampoo
New York	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), albendazole (Albenza), alpha-interferon, amikacin, amphotericin B, atovaquone (Mepron), azithromycin (Zithromax), bleomycin, capreomycin, cidofovir (Vistide), ciprofloxacin (Cipro), clarithromycin (Biaxin), clindamycin, clotrimazole (Mycelex), cyclophosphamide, cycloserine, cyproheptadine HCl (Periactin), cytarabine, dapsone, DaunoXome, dexamethasone, DOXIL, doxorubicin, dronabinol (Marinol), erythropoietin (Procrit), ethambutol (Myambutol), ethionamide, etoposide, famciclovir (Famvir), filgrastim (Neupogen), fluconazole (Diflucan), flucytosine (Ancobon), foscarnet (Foscavir), ganciclovir (Cytovene), isoniazid (INH), itraconazole (Sporanox), IVIG, kanamycin, ketoconazole (Nizoral), leucovorin, lomustine, megestrol acetate (Megace), methotrexate, metronidazole (Flagyl), miconazole, nystatin, ofloxacin, para aminosalicylic acid (PAS), paromomycin (Humatin), pentamidine, prednisone, primaquine, procarbazine, pyrazinamide (PZA), pyrimethamine (Fansidar), rifabutin (Mycobutin), rifampin, Rifater, streptomycin, sulfadiazine, sulfadoxine, sulfamethoxazole, terconazole, TMP/SMX (Bactrim/Septra), trimethoprim, triple sulfa, vinblastine, vincristine, ANTIFUNGAL: griseofulvin, ANALGESICS: butalbital, comb.w/wo codeine, codeine w/wo ASA, APAP, diclofenac, diflunisal, fenopropfen, fentanyl (patch only), flurbiprofen, hydrocodone w/ASA, APAP, hydromorphone, ibuprofen, indomethacin, ketoprofen, ketorolac tromethamine, levorphanol tartrate, methadone hydrochloride, morphine sulfate, naproxen, oxycodone w/wo ASA, APAP, piroxicam, sulfindac, tolmetin, ANTIBIOTICS: amoxicillin, amoxicillin K + clavulanate, ampicillin, aztreonam, bacitracin, cefaclor, cefadroxil, cefazolin, cefixime, cefoxitin, cefpodoxime, cefprozil, ceftazidime, ceftriaxone, cefuroxime, cephalixin, cephadrine, chloramphenicol, cloxacillin, dicloxacillin, doxycycline, erythromycin, erythromycin-ethylsuccinate, erythromycin-ethylsuccinate and sulfisoxazole acetyl, furazolidone, gentamicin, imipenem-cilastatin, loracarbef, minocycline, nitrofurantoin, penicillin G, penicillin V potassium, spectinomycin, tetracycline, ticarcillin K+clavulanate, tobramycin, vancomycin, ANTICONVULSANTS: carbamazepine (Tegretol), divalproex sodium, magnesium sulfate, phenytoin (Dilantin), primidone, valproic acid, PSYCHOTROPIC: alprazolam, amitriptyline, bupropion, buspirone, butabarbital, chloral hydrate, chlordiazepoxide w/wo clidinium, chlorpromazine, clomipramine, clonazepam, clorazepate, clozapine, desipramine, dextroamphetamine-sulfate, diazepam, doxepin HCL, fluoxetine, fluphenazine, flurazepam, fluvoxamine, halazepam, haloperidol, imipramine, lithium carbonate, lithium citrate, lorazepam, loxapine, mesoridazine, methylphenidate, molindone, nefazodone, nortriptyline, oxazepam, paroxetine, pemoline, pentobarbital, perphenazine, prazepam, prochlorperazine, risperidone, secobarbital, sertraline, temazepam, thioridazine, thiothixene, trazodone, triazolam, trifluoperazine, trimipramine, venlafaxine, zolpidem, ANTIDIARRHEALS: loperamide (Imodium), Lomotil, ocreotide acetate, paregoric, tincture of opium, OTHER: chlorhexidine gluconate, probenecid, podofilox, fluoride, VACCINES: hepatitis A & B,

State	Antiretrovirals	OI Prophylaxis and Treatment
North Carolina	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), atovaquone (Mepron), azithromycin (Zithromax), clarithromycin (Biaxin), clindamycin, dapsone, fluconazole (Diflucan), ganciclovir (Cytovene), itraconazole (Sporanox), ketoconazole (Nizoral), nystatin, paromomycin (Humatin), pentamidine, pyrimethamine (Fansidar), rifabutin (Mycobutin), sulfadiazine, TMP/SMX (Bactrim/Septa)
North Dakota	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept)	acyclovir (Zovirax), alpha-interferon, amikacin, amphotericin B, atovaquone (Mepron), azithromycin (Zithromax), bleomycin, ciprofloxacin (Cipro), clarithromycin (Biaxin), clindamycin, clofazimine (Lamprene), clotrimazole (Mycelex), dapsone, doxorubicin, erythropoietin (Epogen, Procrit), ethambutol (Myambutol), filgrastim (Neupogen), fluconazole (Diflucan), flucytosine (Ancobon), foscarnet (Foscavir), ganciclovir (Cytovene), isoniazid (INH), itraconazole (Sporanox), IVIG, ketoconazole (Nizoral), leucovorin, megestrol acetate (Megace), metronidazole (Flagyl), nystatin, paromomycin (Humatin), pentamidine, prednisone, primaquine, pyrazinamide (PZA), pyrimethamine (Fansidar), rifabutin (Mycobutin), Rifamate, rifampin, streptomycin, sulfadiazine, TMP/SMX (Bactrim/Septa), trimetrexate glucuronate (Neutrexin), vinblastine, vincristine, ANALGESIC: fentanyl (patch), ANTICONVULSANTS: carbamazepine (Tegretol), phenytoin (Dilantin), valproic acid, ANTIVIRAL: trifluridine (Viroptic), PSYCHOTROPIC: sertraline (Zoloft), The formulary list also states: "Drugs not included on this list but requested for HIV-related conditions will be considered on an individual basis."
Ohio	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), azithromycin (Zithromax), clarithromycin (Biaxin), clotrimazole (Mycelex), dapsone, fluconazole (Diflucan), ketoconazole (Nizoral), nystatin, pentamidine, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septa)
Oklahoma	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase)	acyclovir (Zovirax), azithromycin (Zithromax), clarithromycin (Biaxin), dapsone, fluconazole (Diflucan), itraconazole (Sporanox), pentamidine, rifabutin (Mycobutin)
Oregon	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir)	acyclovir (Zovirax), fluconazole (Diflucan)
Pennsylvania	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase)	acyclovir (Zovirax), alpha-interferon, amikacin, amphotericin B, atovaquone (Mepron), azithromycin (Zithromax), bleomycin, capreomycin, ciprofloxacin (Cipro), clarithromycin (Biaxin), clindamycin, clofazimine (Lamprene), clotrimazole (Mycelex), cycloserine, dapsone, dexamethasone, doxorubicin, dronabinol (Marinol), ethambutol (Myambutol), ethionamide, etoposide, fluconazole (Diflucan), flucytosine (Ancobon), foscarnet (Foscavir), ganciclovir (Cytovene), isoniazid (INH), itraconazole (Sporanox), kanamycin, ketoconazole (Nizoral), leucovorin, megestrol acetate (Megace), nystatin, ofloxacin, paromomycin (Humatin), pentamidine, prednisone, primaquine, pyrazinamide (PZA), pyrimethamine (Fansidar), rifabutin (Mycobutin), rifampin, Rifater, sulfadiazine, sulfadoxine, terconazole, TMP/SMX (Bactrim/Septa), trimetrexate glucuronate (Neutrexin), triple sulfa, valacyclovir (Valtrex), vinblastine, vincristine, clozaril
Puerto Rico		"ADAP actual formulary provide for any medically indicated drug as requested by the RICs HIV specialist doctor according to the approved treatment guidelines. No pre-authorization, compliance requirements or restrictions on off-label use are established or recommended by the Pharmaceutic and Therapeutic Committee."

State	Antiretrovirals	OI Prophylaxis and Treatment
Rhode Island	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), alpha-interferon, atovaquone (Mepron), azithromycin (Zithromax), clarithromycin (Biaxin), dapsone, ethambutol (Myambutol), fluconazole (Diflucan), ganciclovir (Cytovene), isoniazid (INH), itraconazole (Sporanox), pentamidine, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septra)
South Carolina	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase)	acyclovir (Zovirax), azithromycin (Zithromax), clarithromycin (Biaxin), clotrimazole (Mycelex), dapsone, famciclovir (Famvir), fluconazole (Diflucan), ketoconazole (Nizoral), nystatin, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septra), valacyclovir (Valtrex)
South Dakota	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), nevirapine (Viramune)	acyclovir (Zovirax), atovaquone (Mepron), azithromycin (Zithromax), ciprofloxacin (Cipro), clarithromycin (Biaxin), clofazimine (Lamprene), clotrimazole (Mycelex), dapsone, fluconazole (Diflucan), itraconazole (Sporanox), megestrol acetate (Megace), pentamidine, pyrimethamine (Fansidar), rifabutin (Mycobutin), TMP/SMX (Bactrim/Septra), valacyclovir (Valtrex), ANALGESICS: amitriptyline (Elavil), fentanyl (patch), morphine, MS Contin, propoxyphene (Darvocet), Tylenol #3 w/codeine, ANTICONVULSANTS: carbamazepine (Tegretol), divalproex sodium (Depakote), felbatol (Felbamate), phenytoin (Dilantin), ANTIEMETICS: prochlorperazine (Compazine),
Tennessee	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase)	acyclovir (Zovirax), atovaquone (Mepron), azithromycin (Zithromax), clarithromycin (Biaxin), dapsone, fluconazole (Diflucan), itraconazole (Sporanox), megestrol acetate (Megace), pentamidine, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septra), Pediatric formulations of AZT, 3TC and ddI are available.
Texas	Priority 1:, didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept)	Priority 1:, acyclovir (Zovirax), dapsone, IVIG, TMP/SMX (Bactrim/Septra), trimethoprim, Priority 2:, azithromycin (Zithromax), clarithromycin (Biaxin), fluconazole (Diflucan), ganciclovir (Cytovene), itraconazole (Sporanox), megestrol acetate (Megace), pentamidine, If the demand for the Priority 1 medications increases beyond the budget capacity to continue to furnish all the medications on the formulary, the program will begin to eliminate the medications in Priority 3 and then Priority 2, as necessary. The program will not abruptly cease purchasing Priority 2 and 3 medications. The process will be gradual to allow individuals currently taking Priority 2 and 3 medications an opportunity to look for other programs to provide these medications. Providing medications according to their priority will serve as the budgetary control to purchase all medications on the formulary., Priority 3 medications (alpha-interferon, amphotericin B, atovaquone, ethambutol and rifabutin) are currently not available.
Utah	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	
Vermont	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), amphotericin B, atovaquone (Mepron), azithromycin (Zithromax), cidofovir (Vistide), clarithromycin (Biaxin), clotrimazole (Mycelex), dapsone, DOXIL, filgrastim (Neupogen), fluconazole (Diflucan), foscarnet (Foscavir), ganciclovir (Cytovene), itraconazole (Sporanox), ketoconazole (Nizoral), leucovorin, megestrol acetate (Megace), nystatin, pentamidine, primaquine, pyrimethamine (Fansidar), rifabutin (Mycobutin), sulfadoxine, sulfamethoxazole, TMP/SMX (Bactrim/Septra), ANTIDIARRHEAL: octreotide acetate (Sandostatin)
Virginia	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), nelfinavir (Viracept)	acyclovir (Zovirax), azithromycin (Zithromax), dapsone, fluconazole (Diflucan), foscarnet (Foscavir), ganciclovir (Cytovene), pentamidine, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septra), People unable to tolerate the protease inhibitor indinavir (Crixivan) or who develop resistance may receive another FDA approved protease inhibitor. This will be considered on an individual basis.

State	Antiretrovirals	OI Prophylaxis and Treatment
Washington	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nevirapine (Viramune)	acyclovir (Zovirax), atovaquone (Mepron), azithromycin (Zithromax), ciprofloxacin (Cipro), clarithromycin (Biaxin), clindamycin, clofazimine (Lamprene), clotrimazole (Mycelex), dapsone, dronabinol (Marinol), ethambutol (Myambutol), famciclovir (Famvir), fluconazole (Diflucan), itraconazole (Sporanox), ketoconazole (Nizoral), leucovorin, megestrol acetate (Megace), metronidazole (Flagyl), miconazole, nystatin, paromomycin (Humatin), pentamidine, primaquine, pyrimethamine (Fansidar), rifabutin (Mycobutin), rifampin, sulfadiazine, sulfadoxine, terconazole, TMP/SMX (Bactrim/Septa), trimethoprim, amoxicillin, amoxicillin/potassium (Augmentin), ampicillin, cefixime, cephalexin, cimetidine, diphenoxylate/atropine (Lomotil), erythromycin, estrogen, medroxyprogesterone, famotidine, loperamide (Imodium), metoclopramide (Reglan), miconazole, nizatidine, phenazopyridine, podofilox, prochlorperazine (Compazine), promethazine (Phenergan), ranitidine (Zantac), tetracycline,
West Virginia	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	clotrimazole (Mycelex), dapsone, ketoconazole (Nizoral), nystatin, pentamidine, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septa)
Wisconsin	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune)	acyclovir (Zovirax), atovaquone (Mepron), azithromycin (Zithromax), clarithromycin (Biaxin), dapsone, fluconazole (Diflucan), pentamidine, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septa)
Wyoming	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept)	acyclovir (Zovirax), alpha-interferon, amikacin, amphotericin B, atovaquone (Mepron), azithromycin (Zithromax), bleomycin, ciprofloxacin (Cipro), clarithromycin (Biaxin), clindamycin, clofazimine (Lamprene), clotrimazole (Mycelex), dapsone, doxorubicin, erythropoietin (Epogen, Procrit), ethambutol (Myambutol), filgrastim (Neupogen), fluconazole (Diflucan), foscarnet (Foscavir), ganciclovir (Cytovene), isoniazid (INH), itraconazole (Sporanox), leucovorin, megestrol acetate (Megace), metronidazole (Flagyl), nystatin, paromomycin (Humatin), pentamidine, prednisone, primaquine, pyrazinamide (PZA), pyrimethamine (Fansidar), rifabutin (Mycobutin), Rifamate, rifampin, streptomycin, sulfadiazine, TMP/SMX (Bactrim/Septa), triple sulfa, vinblastine, vincristine, ANALGESIC: ibuprofen, MS Contin, ANTICONVULSANT: carbamazepine (Tegretol), phenytoin (Dilantin), valproic acid (Depakote), ANTIDEPRESSANT: fluoxetine (Prozac), sertraline (Zoloft), ANTIVIRAL: trifluridine (Viroptic)

Appendix V

Medical Criteria And Other Formulary Restrictions

APPENDIX V

MEDICAL CRITERIA AND OTHER FORMULARY RESTRICTIONS

State	Medical Criteria for Access to Drugs and Other Restrictions
Arkansas	Clients incomes must be at or below 100% of federal poverty level and must have CD4 cell counts of less than 500 to access antiretrovirals.
Delaware	The following agents will be provided for a four week period of illness only, not prophylaxis: erythropoietin (Epogen) filgrastim (Neupogen) ganciclovir (oral only). Alternative funding must be applied for at the time of initiation of therapy. A negative response from a drug company or other entity must be presented before extension will be considered.
Florida	Protease inhibitors: Due to be added April 1, 1997. Medical requirements will be: CD4 <350, viral load >10,000, or symptomatic. Access will occur in phases: 1. Current clients (as of 1/30/97, approx. 1,000) will have access first, 2. On April 15, current clients receiving protease inhibitors through industry patient assistance programs will be transferred to the state ADAP for protease inhibitor coverage (program has asked manufacturers for 90 day grace) 3. Any new clients or people receiving drugs through Title I.
Georgia	Maximum combination of two drugs (two prescriptions per month). 3TC, below 350 CD4 cells. Protease inhibitors, below 100 CD4 cells. Clients must have applied for Medicaid. Only consistently compliant patients will be eligible.
Hawaii	Prior authorization is required for the following drugs: indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), erythropoietin (Procrit, Epogen), filgrastim (Neupogen), didanosine (Videx), zalcitabine (ddC), zalcitabine (ddI), and ganciclovir (Cytovene).
Idaho	Antiretrovirals: HIV and CD4 <500. PCP Prophylaxis: <200 CD4. MAC Prophylaxis: <100 CD4. Medical eligibility guidelines established for protease inhibitors to be implemented 2/97: need to have been on a two drug combination and failed (defined by increasing viral load) to get protease inhibitors (program currently covers only one protease inhibitor, indinavir (Crixivan)).
Illinois	Ganciclovir is only covered in IV form, not oral. It is not available via mail order. Beginning April 1, 1997, there will be a \$1,000 per month per client cap on benefits. The formulary categorizes drugs into five categories. These represent priorities for coverage. 1 - Antiretrovirals, 2 - PCP prophylaxis and treatment, 3 - Drugs for the prophylaxis and treatment of OIs and antimicrobials, 4 - Drugs for the treatment of neoplasms, 5 - Other drugs requiring prior approval, including bone marrow stimulants. (Nothing in this category is included on the formulary at this time). The program also provides an enrollment card that can be used at a network of retail pharmacies throughout the state to obtain up to a 14 day supply of emergency drugs (i.e. antimicrobials to treat an acute infection).
Indiana	Protease inhibitors and nevirapine (Viramune) are due to be added April 1, 1997. Azithromycin and fluconazole will also be added at this time. Clarithromycin, which is on the formulary, is being deleted April 1. There may be additional CD4 and viral load count requirements for access to protease inhibitors.
Kansas	Ganciclovir is provisionally available in oral form only, for the treatment of active CMV retinitis. The request for reimbursement for oral ganciclovir must be accompanied by a physician's statement that the medication is being prescribed for the treatment of active CMV retinitis.
Kentucky	Protease inhibitors are only available through the Protease Inhibitor Pilot Project (PIPP). This program currently covers a maximum of 30 people. Financial eligibility for protease inhibitors: income at or below 200% of FPL, adjusted for family size. (Currently, no asset requirement for access to protease inhibitors but this should be added within 1-3 months). Medical eligibility for protease inhibitors: HIV+, CD4 count < 200, viral load >10,000 copies; failure of combination RT inhibitor treatment.
Maine	Protease inhibitors currently can be used by a maximum of 12 clients at a time.
Maryland	Doctor's prescription can be refilled twice, then a new prescription must be obtained. No restrictions on combination therapy.
Massachusetts	Fluconazole covered for <i>treatment</i> but not prophylaxis of fungal infections; also covered for maintenance of cryptococcal meningitis. Ketoconazole covered for treatment but not prophylaxis of fungal infections. Acyclovir covered for treatment but not prophylaxis of herpes zoster & simplex. Acyclovir, fluconazole, & ketoconazole have been approved for acute treatment, but not as prophylaxis. The program covers a one-time 7-day treatment supply of acyclovir and a one-time 14-day treatment supply of fluconazole or ketoconazole. Refills of these medications must be pre-approved by HDAP.
Michigan	Fluconazole reimbursable if clotrimazole and ketoconazole fails or if treating cryptococcal meningitis. Topical and IV ketoconazole not reimbursable. Prior authorization required for amphotericin B. 3TC (Epivir, lamivudine) and protease inhibitors have to be used according to a specific treatment protocol. The use of generic brands is encouraged when available and appropriate.

State	Medical Criteria for Access to Drugs and Other Restrictions
Minnesota	Suggested guidelines: atovaquone: treatment of acute PCP. Prophylaxis in patients intolerant to TMP/SMX, dapsone and aerosolized pentamidine; dronabinol: CD4 count <100 and 5% of weight loss, CD4 count <100 and nausea; fluconazole: CD4 count <100, prior cryptococcal infection and/or fungal infections not responsive to Nizoral or topical antifungal agents; itraconazole: CD4 count <100, prior histoplasmosis and/or fungal infections not responsive to Nizoral or topical antifungal agents; leucovorin: receiving trimetrexate or pyrimethamine; megestrol acetate: CD4 count <100 and 5% weight loss; indinavir and ritonavir: patients prescribed one protease inhibitor at a time; saquinavir: intolerant of indinavir or ritonavir.
Mississippi	zidovudine (AZT, Retrovir): <500 CD4; didanosine (ddI, Videx): <500 CD4, toxicity or treatment failure with AZT; zalcitabine (ddC, HIVID): same as ddI; lamivudine (3TC, Epivir): <400 CD4; stavudine (d4T, Zerit): <400 CD4; pentamidine: <200 CD4; fluconazole (Diflucan): one months supply, conditional upon application to Pfizer patient assistance program, and a CD4 count of 500 or less, diagnosis of a related opportunistic infection; azithromycin (Zithromax): CD4 count of 200 or less or diagnosis of MAC or MAI; dapsone: <200 CD4; acyclovir (Zovirax): <500 CD4; sertraline (Zoloft): diagnosis of depression; ganciclovir (Cytovene): oral only - maintenance therapy for persons with defined CMV retinitis.
Missouri	The formulary is divided into two parts, General Medications and Protease Inhibitors. General Medications includes all covered drugs except protease inhibitors, including antiretroviral medications. Protease Inhibitors includes the three currently FDA-approved protease inhibitors and the six antiretrovirals that are also on the General Medications formulary. The Bureau of HIV/AIDS Care suggests that physicians consider the following criteria for the protease inhibitors program, but they are guidelines only: Current CD4 <500 or evidence of a rapidly falling CD4 count; current viral load >10,000; Client's history of compliance with a medication regimen or probable cause to believe that the client will adhere to therapy. Clients on the General Medication Program within ADAP—the formulary of which does not include protease inhibitors but does include antiretrovirals—may use this source of funding to meet Medicaid spenddown. Clients on the protease inhibitors program may not have access to any form of Medicaid.
Nevada	Fluconazole is available for treatment only, not prophylaxis.
New Hampshire	Dosage and administration shall follow FDA-approved guidelines as indicated in the Physician's Desk Reference (PDR), i.e., no off-label use allowed. All drugs are covered in any dose form. Ganciclovir is only available for treatment on an emergency basis with prior authorization. Treatment will only be provided for maintenance therapy after an acute episode; primary prophylaxis will not be reimbursed. A two-week supply will be provided while patients are applying to the manufacturer's Patient Assistance Program and/or NH Medicaid.
New Mexico	Use of oral ganciclovir (ganciclovir capsules) requires the prior approval of HIV/AIDS Bureau Medical Director.
New York	Combination anti-HIV therapy is currently limited to three drugs. IVIG is restricted to prevention of bacterial infections in children ONLY. Methadone is covered only for pain relief, ADAP does not cover methadone maintenance. Prior authorization required on two drugs: epoetin alfa and filgrastim. Epoetin alfa requires pre-treatment lab values of (1) hemoglobin < 10 g/d and/or hematocrit < 30% AND (2) serum erythropoietin level g < 500 u/ml (except in renal failure patients). Filgrastim requires (1) patient receiving myelosuppressive chemotherapy OR (2) non-chemotherapy patients with drug-induced neutropenia and ANC < 500 (pre-treatment), or HIV disease and ANC < 500 (pretreatment).
North Carolina	Labeled uses only. No IV drug coverage (e.g., ganciclovir is only available in the oral formulation).
North Dakota	nelfinavir (Viracept) requires prior approval. The formulary list also states: "Drugs not included on this list but requested for HIV-related conditions will be considered on an individual basis."
Oklahoma	Protease inhibitors require prior authorization. Beginning April 1, 1997 there is a \$6,000 yearly cap per client. This does not include protease inhibitors. Access to protease inhibitors is limited to a maximum of 75 clients at a time.
Puerto Rico	Current treatment guidelines: CD4 >500, viral load <10,000 AZT /3TC. TB prevention (if indicated) with isoniazid and vitamin B6. Influenza vaccine, Varivax, Pneumovax, and hepatitis B vaccine. CD4 201-499, viral load >10,000 AZT/3TC/protease inhibitor. TB prevention (if indicated) with isoniazid and vitamin B6. Influenza vaccine. CD4 100-200, viral load >10,000 AZT/3TC/protease inhibitor. TB prevention (if indicated) with isoniazid and vitamin B6. PCP prevention with TMP/SMX (Septra) or dapsone. Fluconazole antifungal prophylaxis at 100 mg/wk. Alpha-interferon available for Kaposi's sarcoma, hepatitis B or hepatitis C. Treatment for active TB. Treatments for other opportunistic infections. CD4 <99, viral load >100,000 AZT/3TC/protease inhibitor, with a note to consider the side effects versus the benefits of stopping treatment. Fluconazole antifungal prophylaxis at 100 mg/wk. Azithromycin for MAC prophylaxis. Treatment for active TB. Treatments for other opportunistic infections.
Rhode Island	Rhode Island has a system known as MED-FI. This system is a complex way of allocating clients a yearly spending limit based on their financial resources ("FI") and their medical status ("MED"). Basically, those worst off in terms of their MED and their FI get the largest allocation.. This system was developed by a pharmacy consulting company when the program was concerned about lack of resources. The program notes that "At present, we expect that client MED-FI allocations will be approximately sufficient to cover the cost of

State	Medical Criteria for Access to Drugs and Other Restrictions
	the most needed RIAID formulary medications." However, should the situation change then MED-FI may come into play and limit access for some clients.
South Dakota	Limit of \$5,000 in benefits to each client during 1997 fiscal year, starting April 1, 1997.
Tennessee	Saquinavir and ritonavir will be offered on a prior approval basis only. The ADAP currently follows the HIV treatment guidelines offered by TennCare. These state that antiretroviral therapy is warranted if a person is symptomatic, and/or has a CD4 <500 and viral load >5,000 or has CD4 >500 but viral load >30,000. Initial therapy is two nucleosides. Goal of therapy is reducing viral load and increasing CD4 after 8 weeks of therapy. A protease inhibitor may be added if a partial response is being achieved, but a protease inhibitor should not be added to a failing nucleoside regimen. At least one new nucleoside should be started with a protease inhibitor if initial regimen fails. The definition of treatment failure is vague, but a viral load of >30,000 and/or decreasing CD4 count are mentioned. Indinavir (Crixivan) is generally suggested as the first line protease inhibitor. Protease inhibitors will not be offered to clients with a history of non-compliance.
Texas	Priority 1 Medications and Criteria: AZT, ddI, ddC, d4T: HIV infection and <18 yrs old or HIV+ and CDC classification B or C (symptomatic) or HIV + and <500 CD4 (asymptomatic). A MAXIMUM of two reverse transcriptase inhibitors will be provided. AZT also available for pregnant mother and newborn in accordance with new FDA labeling. 3TC: must be used with one of the above (AZT, ddI, ddC or d4T) and same medical criteria must be met. Saquinavir, ritonavir or indinavir: Plasma RNA viral load >10,000. A MAXIMUM of one protease inhibitor will be furnished with a MAXIMUM of two reverse transcriptase inhibitors. Protease inhibitors will be provided for NON-MEDICAID clients only. TMP/SMX (Bactrim/Septtra), Dapsone/trimethoprim: <200 CD4 or symptomatic HIV disease for >2 weeks, children <13 yrs with ACTG clinical indicators. Acyclovir: acute or chronic herpetic infections. IVIG: <18 yrs old. Priority 2 Medications and Criteria: Aerosolized pentamidine: <200 CD4 or symptomatic HIV disease for >2 weeks, children <13 yrs with ACTG clinical indicators. IV Pentamidine: 13 yrs old or younger. Fluconazole: Cryptococcal meningitis or candida esophagitis. Itraconazole: Histoplasmosis or blastomycosis. Clarithromycin: Current or previous diagnosis of MAC. Azithromycin: Current or previous diagnosis of MAC and failed or intolerant to clarithromycin. Ganciclovir: CMV disease which has resulted in retinitis or or infections of other major organs or organ systems. Megestrol acetate: Cachexia or anorexia with weight loss of >10% baseline body weight or loss of greater than 20% of baseline body weight. Priority 3 Medications and Criteria (currently not available): alpha-interferon: Disseminated KS with >200 CD4, amphotericin B: progressive, potentially fatal disseminated fungal infections. Atovaquone: mild to moderate PCP and intolerant of TMP/SMX, rifabutin: <100 CD4, ethambutol: current or previous diagnosis of MAC.
Vermont	Prior authorization required for protease inhibitors. There is currently a waiting list for protease inhibitors as access has been capped at 17 people, although this may end April 1, 1997. Some restrictions may apply to the CMV treatments: cidofovir (Vistide), foscarnet (Foscavir) and ganciclovir (Cytovene).
Virginia	Medical criteria for protease inhibitors: CD4 count <500 or less or a viral load of >10,000. Protease inhibitors must be used in combination with other antiretrovirals. nelfinavir (Viracept) is only available with a medical exemption form the treating physician. Antiretrovirals: CD4 count <500 or a viral load of >10,000 for AZT, ddI, ddC or d4T (pregnant women can receive AZT at any CD4 cell count). TMP/SMX, dapsone, aerosolized pentamidine: <200 CD4; Rifabutin or azithromycin: <100 CD4. People unable to tolerate indinavir (Crixivan) or who develop resistance may receive another FDA-approved protease inhibitor (this will be considered on an individual basis). Rifabutin is only available to clients receiving it through ADAP prior to November 1, 1996, and for clients unable to take azithromycin. Protease inhibitor utilization currently capped at 282 clients.
Wyoming	\$2,000 assigned to each client per year. Program attempts to reimburse any treatment prescribed by physician. May soon increase limit to \$3,000 per client/per year. Amphotericin B is available as a cream only, according to the formulary list.

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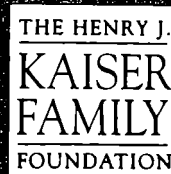
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NATIONAL ALLIANCE OF STATE AND
TERRITORIAL AIDS DIRECTORS



AIDS Treatment Data
Network

State AIDS Drug Assistance Programs: A National Status Report on Access

Report by
The National Alliance of State Territorial AIDS Directors
and
The AIDS Treatment Data Network

July 10, 1997

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