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FAX**DATE:** Saturday, February 28, 1998**TO:** Sandra Thurman, White House, Office of AIDS
Policy Coordinator**FAX:** 632-1096**FROM:** ADAP Working Group/ W.E. Arnold**PAGES:** 7**MEMO**

Felt that you might want a copy of testimony for your records if you don't already have it. • Bill Arnold, The ADAP Working Group Washington, DC (202) 588-1775

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The National Native American
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Written Statement

Given For the Record
In Testimony
For
The ADAP Working Group
By

Mr. Javier Salazar
Member
ADAP Working Group
From
AIDS Action Council

Before:
Subcommittee on Labor, Health and Human Services, Education
and Related Services

Of

The Congress of the United States
House of Representatives
Committee on Appropriations

February 3, 1998

at

Rayburn House Office Building Washington, DC

February 3, 1998

This testimony is offered by Javier Salazar, Legislative Representative of the AIDS Action Council on behalf of the ADAP Working Group, a coalition of AIDS advocates, community-based organizations and representatives of the research-based pharmaceutical industry working together to increase access to new treatments. The testimony concerns FY 1999 funding for the AIDS Drug Assistance Program funded under Title II of the Ryan White CARE Act.

First, we would like to thank the members sub-committee on behalf of tens of thousands of people living with HIV, their families and friends for their leadership in support of the ADAP program. That leadership has made it possible for thousands of patients to access treatments that have revolutionized the management of HIV disease.

These thanks are due, in part, for the sub-committee's foresight in funding a program that works. How do we know it works? The figures speak for themselves. The Centers for Disease Control and Prevention recently announced that AIDS deaths fell by 26% from 1995 to 1996. More recent data from states provides even more dramatic evidence that making new treatments and the medical care necessary to use them correctly to uninsured and underinsured patients will have dramatic effect. In California, for example, deaths from AIDS fell by an astonishing 60% in the first six months of 1997. In Illinois, deaths from AIDS dropped 21% in 1996. In New York, deaths from AIDS fell by 50% from the last quarter of 1995 to the same quarter of 1996. In 1997, patients in programs that provide access to these new therapies will continue to experience longer disease free lives.

We offer this testimony in hope that the sub-committee will renew its strong support and leadership. According to data recently released by CDC on the number of uninsured people living with HIV, data soon to be released by NASTAD and the AIDS Treatment Data Network from their ongoing national survey of ADAP programs, and the first iteration of the Guidelines for Use of Antivirals in HIV-infected Adults and Adolescents, that leadership will be desperately needed as the need for access to new therapies explodes.

How much will it cost to provide the new standard of care to all Americans qualified for ADAP? While projected program need is complex, the recent Kaiser funded survey of ADAP programs has provided us with remarkably current data on both the number of clients served and on per client costs to the program on a month by month basis. Based on this data, a computer model has been developed to provide a conservative estimate of the cost of providing the standard of care to ADAP clients. This model uses inputs of actual information about the immune status of HIV infected patients to project the need for primary treatment, acute treatment and prophylactic treatment with outpatient drugs. This model predicted New York State ADAP need levels to within 5% of actual expenditures. The model has also provided reliable forecasts for the national ADAP program in FY 1997 and 1998.

Due to the widespread news coverage of treatment successes and drops in death rates, over 150,000 patients are presently being prescribed combination therapies utilizing protease inhibitors. Our data suggests that about one-third of these patients are accessing their treatments through ADAP programs at least part of the time. As these people live longer lives and continue to work or return to work, however, they are highly likely to rely on ADAP for longer periods of time.

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2.

The ADAP survey results substantiate our original client use projections for FY 1997 and 1998. Over 45,000 clients were served for the full year period of FY 1996, which is equivalent to 90,000 people staying on the program for an average of six months. Our original projection for FY 1996 predicted 84,000 clients being served for an average of six months of the year. Most importantly, the number of ADAP enrollees utilizing the program and filling prescriptions is still increasing steadily. The number of ADDITIONAL people accessing ADAP for antiviral prescriptions each month is still holding at about 1,000 NEW patients utilizing antiretroviral medications each and every month, as it has for the last year or more.

These increases in people actually utilizing ADAP are based on data from January, July and December 1996 through October, November 1997. The average monthly increase has been projected forward month-by-month to March of 2000. On the basis of these data, the total FY 1999 national ADAP budget need as projected by the model is \$749,348,764.00. Meeting this goal will require an INCREASE of \$ 173,169,385.00 in Federal 1999 budget appropriations to insure that ADAP programs have the fiscal capacity to serve those in need. State and other contributions to ADAP will also have to increase by an additional \$ 43,292,346.00, to an annual total of over \$160 million. Our model also projects a CURRENT FY '98 shortfall of \$ 29,625,000 dollars. The current and accumulated funding shortages manifest themselves as open or concealed "waiting lists" in many states and account for public discussions of the immediate needs for "emergency" and "supplemental" funding.

In hindsight, of course, it becomes easy to argue that ADAP programs have been historically underfunded. In reality, however, it is the emergence of highly active antiretroviral therapy over the past two years, treatment options that have made dramatic changes in peoples increased longevity, that have made access to care such a dramatic national policy concern. Knowing that literally thousands of patients are no longer dying has generated incredible interest and demand for access to the new standard of care with the therapies required to meet it.

In fact, all entities responsible for providing these treatments have made remarkable steps to provide them. Federal contributions to ADAP alone have risen from \$ 52 million in FY 1996 to \$285.5 in FY 1998. Other partners have taken similar steps. State financial contributions to ADAP, for example, have nearly tripled since 1995 and will reach at least \$118,000,000 in FY 1997. Pharmaceutical rebates and discounts have also more than doubled from \$8,000,000 in FY 1996 to \$22,600,000 in FY 1997. The private sector has also provided safety nets in many states by providing drugs to patients -- sometimes all patients in the ADAP program -- when states were unable to do so.

Unfortunately, even these steps have proved insufficient to meet the need. This is due to a number of factors. First and foremost, the entire universe of treating AIDS has changed. The PHS/HHS defined standard of care now requires that patients start earlier in the disease with a combination of drugs in order to preserve immune function. While improved immune function has a direct impact saving and improving the quality of lives and cost savings to the health care system, it requires a larger initial investment.

As the PHS Guidelines become widely available to physicians -- providing a clear and detailed statement on the correct treatment of HIV disease -- we expect even more pressure on state ADAPs from patients whose doctors will now advise them regarding the use of the best possible

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3.

treatment options at a much earlier stage of disease than was heretofore the case. The most important of these principles -- and the one that will have the largest potential impact on public health programs funded by this sub-committee -- is the conclusion that there will no longer be a distinction made between asymptomatic and symptomatic HIV infection, since the latter simply reflects a more advanced state of immune system damage.

This principle will lead to a medical decision that most people with CD4 of 500 or less and a viral load of over 10,000 should be treated with a combination of therapies including at least two nucleoside analogs and a protease inhibitor. Unfortunately, it is unlikely that many public health programs are prepared to offer this standard of care to patients who may need it. Among the hardest hit will be the AIDS Drug Assistance Programs. About 75% of the American HIV + population has no private health insurance. Tens of thousands more HIV + Americans more lack adequate health insurance coverage for FDA approved drugs. The ADAP program is intended to assist in filling this gap in health care access for the tens of thousands who are, or will be, living with HIV disease.

Unfortunately, Medicaid -- the primary provider of health care for approximately 50% of people with AIDS (as compared to HIV infection) -- is also exacerbating the ADAP problem to some degree. Formerly, people with HIV would "normally" become sick enough to be considered disabled under the Medicaid definition within 3 to 10 years. In most cases, poverty followed close behind. Now, however, the new treatments keep many patients from ever qualifying for Medicaid because they never become disabled. They too come to ADAP for their treatments.

Likewise, transitions to other traditional disability funding streams for people with HIV/AIDS who benefit from effective treatments are becoming less desirable for individuals and are no longer fiscally rational. The cost of the triple drug combinations recommended by PHS range from \$10,000 to \$16,000 a year. This is far cheaper than the \$100,000 annual cost of treating full-blown AIDS in hospitals. It is also dwarfed by the uncalculated dollars spent on social security disability, state/county and private uncompensated care costs, and other programs.

The fiscal impact of these increases, reflected in both demand and costs, has caused financial retrenchment in many individual state programs which has only been partially relieved by responses by both the federal and state governments. Although only two state ADAP programs have yet to add the protease inhibitors to the drugs that they offer, many programs have been forced to limit access to many of the drugs that are ostensibly covered on their formularies. This has included high-incidence states such as Florida and Georgia which have already capped or rationed coverage in some way. In many cases, these restrictions directly contradict the guidelines on optimum use of antiretroviral therapy.

While limiting treatments has served as a necessary stop-gap measure, such rapid and unexpected changes serve only to threaten patients continuity of care, and thus their chances for healthier, more productive lives. Since the PHS/NIH guidelines are as aggressive as we expected them to be, are not all levels of government bound to help pay for, and assure access to, the treatments they advise?

While many of the traditional programs serving the disabled are not functioning well in

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4.

response to the new standard of care, many AIDS programs are once again applying considerable ingenuity to create programs to maximize the use of available funds. In various states, for example, local governments have achieved dramatic increases in health insurance coverage and lowered individual costs by creating access to high risk insurance pools for people with AIDS and HIV. When insurance is adequate patients may gain access to a full formulary of all the drugs required for the standard of HIV/AIDS care and access to the primary medical care required as well via the insurance gateway. It's imperative that states have the flexibility to apply both federal and state funding to provide access via appropriate insurance mechanisms where available. The sole tests should be whether the program available provides access to all the standard of care drugs needed, whether the program stretches public dollars, so that more patients are covered and whether other care standards are locally met in HIV/AIDS care. With conditions so met states should have the flexibility to apply ADAP funds (normally) "restricted" solely to drug purchase along with other funds to achieve both cost saving and maximum service coverage.

At the 5th Conference on Retroviruses and Opportunistic Infections now meeting in Chicago, new clinical data will be presented which clearly reaffirms the good news on the new treatments. We expect that just as last year - more good news on the treatment front will increase yet further demands on state ADAPs for access to these new therapies.

We also expect new additional studies to show that the costs of treatment with triple combination therapy are being offset by subsequent declines in use of more costly health care resources and expensive hospitalizations as treatment options and therapies continue to improve.

Patients are now seeking access to HIV testing and HIV drug treatments at a much earlier disease stage than was historically the case. Some HIV clinics have begun to see a 40% to 50% increase in demand for outpatient care while hospitalizations, and opportunistic infection treatment costs have dropped dramatically -- even as the patient population has grown. This trend is documented in numerous AIDS clinical studies.

While we are not experts on the Ryan White CARE Act as a whole, we would be remiss in our duty to this committee if we did not point out the difficulties that CARE Act programs in every Title are having in providing access to the health care and social services necessary to maximize the effect of the new treatment modalities. Remember that the new drugs do not prescribe themselves nor do they work without the steady viral load and CD4 testing also recommended in the federal Guidelines. We hope the subcommittee will take this to heart when they discuss funding priorities for FY 1999.

In a recent update of the National Governors Association policy on HIV/AIDS, the Governors call on the federal government to work in partnership with states and the private sector to reduce the costs of treatment and to maintain funding that adequately reflects the growing cost of drug therapies. We echo that call.

All ADAP programs are now being faced with the planning issue of continued better health, longer survival and thus the possibility of a continuing trend for eligible ADAP clients to need ADAP program provided drugs for much longer periods of time than was the historical case. In plain English patients as a group are feeling much better, living much longer and may be less

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likely to progress to death and or transition to Medicaid based upon medical disability. A byproduct of the tremendous success of the new combination therapy treatments is that an ADAP client may need drugs for years. Historically ADAP clients (as a group) stayed in program for a few months to a year. Happily for the patient they may now be here for a long time. For those planning ADAP budget needs however, they must now add longer survival in the program as a budget increase on top of all the other recent budget increases we have seen of more therapies, more patients in programs, and more patients who are in program using more drugs with higher costs. Now add more time. Forecasting all this is no small task. Which is why the ADAP Working Group has relied on the discipline of a scientific, mathematical Pharmacoeconomic model for our budget projections for the past two fiscal years. The complete ADAP budget forecast for 1998 - 1999 will be available for release in the next 2-3 weeks.

In April of 1997 the ADAP Working Group predicted a shortfall \$ 66.8 million for FY '97 and the next ADAP projection will indicate a shortfall amount of \$ 29.6 million for FY '98. In the meantime actual needs have probably been greater, but ADAP contributions from States and other sources have increased dramatically, and more quickly than some predicted, with notably almost a 75 % increase in State funds to a total of more than \$118 Million from 1996 to 1997. However, we again caution that the "shortfalls" continue to express themselves as open (or covert) "waiting lists" in many states.

We urge to you fully fund the ADAP program in FY 1999 with an increase of at least the forecast amount of \$173,169,385.00 so that no-one need be denied the new standard of care for HIV disease. As we have outlined, this standard of care is the miraculous achievement of so many - in science, in government, in the medical profession and in the community. We have all lost too many people in the 17 years of this heartbreaking epidemic. Please work together with us so that we may lose no more.

William E. Arnold
Co-Chair

Dorothy A. Keville
Co-Chair

The ADAP Working Group



March 1998

We are pleased to send you the enclosed interim update on the status of the State AIDS drug assistance programs (ADAPs) prepared under the auspices of the HIV/AIDS programs of the Henry J. Kaiser Family Foundation. The report is written by Arnold Doyle, Richard Jefferys and Joseph Kelly of the National Alliance of State and Territorial AIDS Directors (NASTAD) and the AIDS Treatment Data Network (ATDN).

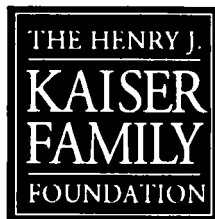
ADAPs provide access for people living with HIV/AIDS to medications that treat HIV disease and prevent the onset of opportunistic infections. Federal funds to support ADAPs were specifically designated to serve those who are uninsured and those who lack coverage for medications. These state-administered drug reimbursement programs form one link in the continuum of publicly-funded HIV care and services available to low-income individuals supported by the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act, Medicaid, Medicare, and local indigent health care programs. The critical role that ADAPs play in improving access to HIV/AIDS treatments have made these programs the subject of increasing public interest and debate.

In July of 1997, NASTAD and ATDN reported on the first comprehensive survey of all 52 AIDS Drug Assistance programs in the United States, under a two-year monitoring project commissioned by the Kaiser Family Foundation. Those results were released in the report entitled "State AIDS Drug Assistance Programs: A National Status Report on Access," at which time a detailed technical report was also released. The primary findings of that report demonstrated the increase in program demand and the wide variation in program eligibility and drugs covered by ADAPs.

The enclosed interim technical report provides an update on the status of these programs as of September 1997. The salient data include:

- ▶ The total national ADAP budget increased from \$385 million to \$422 million (an overall increase of 9.6%) since the last report, including a 9% increase in federal and state funds;
- ▶ Thirty-six states now supplement federal dollars with state-specific fiscal support (6 additional states since the last report);
- ▶ A continued rise in program expenditures between January and July 1997, including an overall increase of 36% in monthly expenditures, a 24% increase in the total number of prescriptions filled, and a 75% increase in the number of protease inhibitor prescriptions filled;
- ▶ Continuing limits on program access, including a curtailing of ADAP services in 23 states, waiting lists for entry in 9 states, and waiting lists for accessing protease inhibitors in 7 states;
- ▶ Nationally, states report that 43,494 unduplicated clients were served by ADAPs during July 1997 compared to 37,506 clients in January 1997 — a 16% increase — although program growth is occurring at different rates across states, including some declines;
- ▶ The use of a variety of methods by programs to update their formularies, such as the use of formal ADAP advisory bodies in 45 states, and attempts by ADAPs to respond to Public Health Service Guidelines for the Use of Antiretroviral Agents; and
- ▶ An examination of the complex relationships between ADAPs and other drug insurance coverage (Medicaid and private) and state efforts to expand insurance access.

A more detailed report assessing these programs will be released in Summer/Fall of 1998. To order additional copies of the enclosed report, you can call The Foundation's publications request line at 1-800/656-4533 and ask for document #1379. Copies of the July 1997 report (document #1275) can be requested through the same line, or downloaded from our internet site, <http://www.kff.org>.



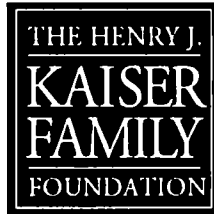
National ADAP Monitoring Project: Interim Technical Report March 1998

Report By

Arnold Doyle
Richard Jefferys
Joseph Kelly

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

Supported by a grant from The Henry J. Kaiser Family Foundation



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**National ADAP Monitoring Project:
Interim Technical Report
March 1998**

Table Of Contents

Acknowledgments	2
The National ADAP Monitoring Project	3
Executive Summary	4
Introduction	9
The ADAP Update Survey	
Trends in Clients Served and Expenditures	12
ADAP Budget Update	13
Emergency Cost-Containment Measures/ADAP Budget Shortages	15
Administrative Changes	16
Changes in Eligibility Criteria	
ADAP Formulary Update	18
Advisory Committee Update	
Changes in Formularies	
Clinical Guidelines on HIV Treatment	
Opportunistic Infection Guidelines	
Ancillary Efforts to Provide Access	
Medical Criteria/Restrictions on Access to Formulary Drugs	
The Interface Between ADAP, Medicaid and Private Insurance	25
ADAP and Medicaid	
Assessing the Impact of Medicaid Coverage on State ADAPs	
Private Insurance and ADAP	
Appendices	36
I. ADAP Monthly Clients Served and Expenditures	
II. ADAP Monthly Drug Expenditures and Prescriptions Filled	
III. FY 1997 ADAP Budget Tables	
IV. State ADAP Formularies	
V. ADAP Estimated Client Income Levels Based on Federal Poverty Guidelines	

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This report, and the series of reports produced by the ADAP Monitoring Project, would not have been possible without the generous financial support of the Henry J. Kaiser Family Foundation and its continuing role as catalyst for informed dialogue on HIV/AIDS policy issues. The authors would especially like to thank Dr. Sophia Chang, Jen Kates and the staff of the Kaiser Family Foundation for their support and guidance in shaping our project reports.

We owe a great deal of gratitude to our group of external advisors who had the opportunity to review and provide suggestions for improving this report. They are: William Arnold, Title II Community AIDS National Network; Anne Donnelly, Project Inform; Anita Eichler, HIV/AIDS Bureau (HRSA); T. Randolph Graydon, Health Care Financing Administration; Leslie Hardy, Department of Health and Human Services; Tracey Hooker, National Conference of State Legislatures; Jeff Levi, Center for Health Policy Research (GWU); Tracey Orloff, National Governors Association; Lee Partridge, American Public Welfare Association; and Gary Rose, IssueSphere.

We benefited greatly from the advice and suggestions provided by a group of state AIDS directors and AIDS drug assistance program managers who had the opportunity to review a draft of this report. They are: Richard Albertoni (WI); Lanny Cross (NY); Chet Kelly (IL); Lori Lippert (MN); Thera Meehan (MA); Michael Montgomery (CA); Randall Pope (MI) and Raleigh Watts (WA). Our thanks to them for devoting extra time providing us with important feedback.

We are also indebted to the members of the National Alliance of State and Territorial AIDS Directors (NASTAD) and the AIDS drug assistance program (ADAP) coordinators in every state for completing the national ADAP survey update that was the basis for this report. Once again they proved to be extraordinarily helpful in responding to the survey and frequent follow-up telephone calls.

The principal authors of this report are Arnold Doyle, Richard Jefferys and Joseph Kelly.

The National ADAP Monitoring Project

In an effort to monitor the rapidly changing fiscal and scientific environments in which state AIDS drug assistance programs (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) was commissioned by the Henry J. Kaiser Family Foundation, Menlo Park, CA to conduct 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 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 summary and comprehensive technical annual reports on the status of state ADAPs, with follow-up reports at six-month intervals. This March 1998 status update report provides an analysis of state ADAPs based on a national survey completed in October and November 1997. The findings provide an update of information presented in *State AIDS Drug Assistance Programs: A National Status Report on Access* produced by NASTAD and ATDN and published by the Kaiser Family Foundation on July 10, 1997. This current report is available for downloading from the Internet at <http://www.aidsinfonyc.org/adap>. This Internet site, developed by ATDN, also contains detailed descriptive information about every state ADAP including program eligibility, application procedures, access and drug coverage. NASTAD and ATDN can be reached at the following addresses:

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Executive Summary

AIDS Drug Assistance Programs (ADAPs) are state-administered drug reimbursement programs that provide access to HIV/AIDS medications for low income, uninsured and underinsured individuals. Funded through the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and by many states, these programs form one link in the continuum of publicly financed health care for lower income individuals living with HIV/AIDS, along with other CARE Act-funded programs, Medicaid, Medicare and local indigent health care programs. ADAPs operate in all fifty states, the District of Columbia and Puerto Rico.

These programs, initially intended to provide a safety net of temporary prescription drug coverage for lower income, uninsured or inadequately insured people living with HIV/AIDS, are now being called upon to fill a steadily growing gap in drug coverage for the HIV-infected population. Increases in numbers of clients utilizing ADAP services, the approval of new, promising and expensive anti-HIV treatments, the acceptance of combination therapy as the standard of care, rising ADAP expenditures, and restrictions on access to other public health care programs have moved ADAPs to further expand their umbrella of coverage. This raises the concern of whether ADAPs are able to adequately fill the growing gap in prescription drug coverage for people living with HIV/AIDS.

The National Alliance of State and Territorial AIDS Directors (NASTAD), in collaboration with the AIDS Treatment Data Network (ATDN), was commissioned by the Henry J. Kaiser Family Foundation to conduct a two-year National ADAP Monitoring Project. This Interim Technical Report provides an update of the data presented in the first National ADAP Status Report, released July 1997, and continues our efforts to track developments in the rapidly changing environment surrounding HIV/AIDS health care and therapy access. The update describes trends in the number of individuals served by ADAPs; drug expenditures; the fiscal status of ADAPs; and responsiveness to changes in treatment recommendations. A comprehensive update review of these programs is scheduled for release in Fall 1998.

Methods

In September 1997, a National ADAP Update survey was distributed to the 52 jurisdictions receiving Ryan White CARE Act Title II ADAP funds. The survey response rate was 100%, with all fifty-two jurisdictions reporting. Here are the major findings:

Update in the Number of Clients Served

The overall number of clients served by ADAPs continues to increase, although program growth is occurring at different rates across states, including some declines:

- Nationally, states report that 43,494 unduplicated clients were served by ADAPs during July 1997 compared to 37,506 clients in January 1997 – a 16% increase. When compared to data from the July 1996 period, there has been a 39% increase in the number of clients served.
- Thirty-nine states report increases in the number of clients served in July 1997 compared to January 1997. Six states report increases in clients served of 50% or more: Alaska, Delaware, Georgia, Louisiana, Rhode Island and South Carolina.
- Ten states report no growth or actual decreases in clients served: Connecticut, Idaho, Massachusetts, Mississippi, Montana, North Dakota, Oregon, South Dakota, Tennessee, and Virginia.

Expenditure Update

ADAP program expenditures, including expenditures for antiretroviral drugs, continue to grow as do the number of prescriptions filled by ADAPs.

- Forty-two states report increases in monthly ADAP expenditures, when July 1997 data are compared to January 1997. Fifteen of those states reporting increases of 50% or greater. Those states are Alaska, Delaware, Florida, Indiana, Iowa, Louisiana, Missouri, Nebraska, New Hampshire, North Carolina, Ohio, Rhode Island, South Carolina, Vermont and Wisconsin.
- Monthly ADAP expenditures increased 36% nationally, from \$19.5 million in January 1997 to \$26.6 million in July 1997. A comparison with data from the previous national ADAP survey indicates a 78% growth in monthly expenditures by ADAPs nationally when July 1996 are compared to July 1997 data.
- States report that the total number of prescriptions filled for all drugs on ADAP formularies increased by 24% from 105,236 in January 1997 to 130,336 prescriptions filled in July 1997. Notably, the number of protease inhibitor prescriptions filled by state ADAPs increased by 75% from 12,530 to 21,951 when comparing the same time periods.
- States report a 38% growth in expenditures for antiretroviral drugs from \$15 million in January 1997 to \$20.7 million in July 1997. There was a reported 20% growth in expenses related to other formulary drugs (including drugs for the prevention and treatment of opportunistic infections) from \$4.8 million in January 1997 to \$5.7 million in July 1997.

ADAP Budget Update Since the Last Report

The total national ADAP budget (including all sources¹) increased from \$385 million to \$422 million since the last report. This represents an overall increase of 9.6% or \$37.1 million. The increase includes a 9% increase in federal and state funds, from \$358.5 million to \$390.8 million.² Moreover, a number of state programs secured additional FY 1997 funding:

- Thirty-six states now supplement federal dollars with state-specific fiscal support (6 additional states since the last report).
- Thirteen states realized increased state/local general revenue support over the six-month period – Arizona, the District of Columbia, Florida, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Nevada, Oklahoma, Pennsylvania, Tennessee, and Vermont.
- Six states provide the vast majority (78%) of ADAP funds provided by states—California, Illinois, Louisiana, Massachusetts, New York, and Pennsylvania.
- Sixteen states do not provide any funds specifically for ADAP and therefore rely solely on federal funding to provide ADAP services. These 16 states are: Alaska, Arkansas, Delaware, Idaho, Iowa, Kansas, Michigan, Mississippi, Montana, Nebraska, New Hampshire, North Dakota, Oregon, Rhode Island, South Dakota and Wyoming.

Emergency Cost-Containment Measures Continue

Despite an overall increase in the national ADAP budget, there continues to be disparity in the diversity of funding sources that are available to and utilized by ADAPs and many states are relying on emergency measures to continue to meet client demand and expenditures. Twenty-three states are currently curtailing ADAP services or facing budget shortages which may result in reduced services early in 1998. For example:

- Thirteen states report that they will exhaust their ADAP budgets before the next round of federal funds is available on April 1, 1998. These states are: Alabama, Alaska, Arizona, Colorado, Idaho, Kansas, Kentucky, Maine, North Carolina, Puerto Rico, Texas, West Virginia and Wyoming. At the time of the last report, eleven states reported anticipated budget shortfalls, six of which continue to do so.

¹ All sources include federal (Ryan White CARE Act Title II base and supplemental funds and Title I funds), state/local funds, and other funds such as drug rebates and insurance recovery.

² The largest category in the 1997 national ADAP funding system, the FY 1997 federal Title II ADAP supplemental funding (\$167 million), remained constant since the last report. Federal increases therefore are from increases in Ryan White Title II base funding and Ryan White Title I eligible metropolitan area (EMA) contributions.

- Fifteen states report that they are maintaining waiting lists for entry to ADAP or for access to protease inhibitors (this is the same number of states which reported such waiting lists at the time of the first report, 12 of which continue to do so and three report waiting lists for the first time). The nine states which currently report waiting lists for entry to ADAP are: Alabama, Florida, Georgia, Indiana, Mississippi, Montana, Nevada, South Carolina and South Dakota. In addition, North Carolina has stopped authorizing new clients for program participation since September 1997, although the program does not maintain a waiting list. The seven states which currently maintain waiting lists for clients to access protease inhibitors from the ADAP are: D.C., Idaho, Kentucky, Maine, Mississippi, Oklahoma, and Nevada (Nevada also has a waiting list for entry to ADAP).

ADAP Formularies and Responsiveness to Evolving Standards for Clinical Practice

At a time of rapid advances in the clinical management of HIV/AIDS³ and finite resources, states report efforts to: expand formulary coverage, broaden provider and community input in formulary development, and respond to federal treatment guidelines.

- Forty-five states report that they have formal ADAP advisory bodies in place that assist in making formulary decisions and, in some cases, decisions regarding the administration and structure of the ADAP.
- Forty-two states have changed their formularies since our previous report. Forty-nine states now cover the most recently FDA-approved protease inhibitor, nelfinavir (Viracept). Two ADAPs (Arkansas and South Dakota) currently do not cover any protease inhibitor. Forty-four states cover the first approved NNRTI, nevirapine (Viramune).
- Fifteen states report expanding the ADAP formulary to cover the eleven approved anti-viral drugs referenced in the antiretroviral guidelines, in addition to the states already providing coverage for these treatments. States have taken other actions in response to the PHS/NIH guidelines, including updating state/local treatment guidelines and developing provider education programs.
- Ten states added drugs for the treatment and prevention of opportunistic infections (OIs). However, there continues to be significant disparity among ADAPs in their coverage of OI treatment/prophylaxis. Only two state ADAPs cover the 14 drugs strongly recommended for the prevention of OIs in the PHS/IDSA guidelines.

³ In June 1997, "Draft Guidelines on the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents" were released by the Public Health Service (PHS), in collaboration with the National Institutes of Health (NIH) and the Henry J. Kaiser Family Foundation. Also in June 1997, the PHS in collaboration with the Infectious Disease Society of America (IDSA) released "Guidelines for the Prevention of Opportunistic Infections in Persons Infected with HIV."

Relationship of ADAP to Medicaid and Private Insurance Coverage

The relationship between ADAP, Medicaid and private insurance has come under increased scrutiny as states seek to maximize non-ADAP sources of pharmacy benefits in order to reduce the burden on ADAP. Some states utilize insurance continuity programs to reduce the burden on their ADAP and provide stable access to health care services. In order to monitor emerging trends, states were asked to describe efforts to ensure that ADAP is the payer of last resort, discuss areas of cooperation between Medicaid and ADAP, and assess the impact of Medicaid coverage on the state ADAP.⁴ For example:

- Approximately 7 percent of ADAP clients served in July 1997 were also current Medicaid beneficiaries (including those in the spenddown process). The reported percentage of ADAP clients estimated to have Medicaid benefits varies greatly from state to state. Twenty-one states reported that no active ADAP clients were Medicaid beneficiaries.
- Thirty-nine ADAPs indicate that they have mechanisms to cross-check/coordinate client eligibility with the state Medicaid program. Twenty ADAPs report that they routinely back-bill Medicaid when an ADAP client receives retroactive Medicaid benefits.
- Approximately 7 percent of ADAP clients served in July 1997 had private health insurance that provides some level of prescription drug coverage, although this percentage varied greatly by state.

⁴ State AIDS programs were asked to identify Medicaid policies in their states that may result in increased demand on ADAP. An analysis indicates that nineteen of the twenty-three states identified as having less expansive Medicaid coverage (i.e., no medically needy eligibility category, low spenddown threshold and/or prescription drug limits) are also states with restricted access to ADAP.

Introduction

1997 was a year of many challenges for state AIDS Drug Assistance Programs (ADAPs). These programs continued, in most cases, to see large increases of new clients using program services for the first time, and increases in the percentage of clients who were accessing expensive triple antiretroviral drug therapy through ADAP. The federal government and many state governments significantly increased funding for ADAPs in fiscal year (FY) 1997, yet these increases did not keep pace with demand in some jurisdictions.

The year was also marked by the release of draft federal clinical guidelines on the use of antiretroviral therapies, as well as updated guidelines on the use of therapies to prevent HIV-related opportunistic infections (OIs). State ADAPs were under significant pressure to provide the standard of care as outlined in these guidelines to an ever-growing client population. The state AIDS programs that administer ADAPs were also challenged to distribute the new guidelines to medical providers in their jurisdictions, to facilitate provider and consumer education, and to ensure that ADAP clients were receiving the new standard of HIV care.

ADAPs provide access for people living with HIV/AIDS to medications that treat HIV disease and prevent and treat opportunistic infections. State ADAPs serve as a critical lifeline for many low-income individuals living with HIV/AIDS in the United States who do not have public health insurance or adequate private health insurance. Despite a 106% increase in federal and state ADAP funding nationally in 1997, 13 state programs are facing potential budget shortfalls before the end of the current Ryan White CARE Act Title II fiscal year (March 31, 1998).⁵ Additionally, 15 states continue to maintain waiting lists for enrollment into their ADAPs, and/or for access to protease inhibitors. It is uncertain whether expected increases in federal ADAP funding for FY 1998 will ameliorate these ADAP access problems in the coming year.⁶

Since publication of the previous NASTAD/ATDN national ADAP status report, released in July 1997, many ADAPs that were not providing coverage for all of the FDA-approved antiretrovirals—including protease inhibitors—have modified their formularies to provide coverage for these treatments, although coverage gaps still remain in several states. Currently, only two state ADAPs (Arkansas and South Dakota) do not cover protease inhibitors. However, coverage of drugs for the treatment and prevention of opportunistic infections (OIs) has not kept pace with the increases in coverage of HIV

⁵ The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act authorizes federal funding for state, local and community-based programs providing HIV/AIDS health care and supportive services. Title II of the CARE Act provides comprehensive HIV care funding for states as well as dedicated funding for ADAPs.

⁶ In FY 1998, dedicated federal funding for ADAPs (through Ryan White CARE Act Title II ADAP supplemental funds) will total \$285.5 million, which is an increase of \$118.5 million over the FY 1997 level of \$167 million.

antiretroviral drugs. Great disparity still exists among the states in their coverage of OI treatment and prophylaxis through ADAP.

Over the past year, increasing attention has been given to the impact that access to Medicaid and private insurance within a state has on ADAP. Some state AIDS programs have been very successful in tapping into state high risk insurance pools in order to purchase health insurance coverage for ADAP clients. Through this mechanism, ADAP clients gain access to not only prescription drug coverage, but other primary medical care services as well—all at substantially less cost to state and federal governments. Administrative and legal barriers, however, have prohibited several states from implementing these cost-effective programs in their jurisdictions.

A proposed initiative to examine the feasibility of expanding access to Medicaid to non-disabled, low-income individuals living with HIV has not been implemented on the federal level due to concerns regarding the potential cost of such an expansion. Notwithstanding, many agree that extending limited Medicaid benefits to non-disabled people with HIV may significantly lessen the coverage gap that ADAPs currently attempt to fill, thereby lessening the burden on these programs.

1997 has been a year of significant challenge and of some marked success for state ADAPs. Increased access to effective treatments in many states and sharply declining death rates nationwide are, in part, a testament to the positive impact of these programs. This report will examine the current status of ADAPs nationwide in light of these challenges and successes, and highlight specific issues that are likely to impact on ADAPs throughout the coming year.

The ADAP Update Survey

In September 1997, a national ADAP update survey was distributed to all state and territorial AIDS programs receiving Ryan White CARE Act Title II ADAP funds. Survey responses were collected and analyzed throughout October and November 1997. The survey response rate was one hundred percent (100%), with fifty-two jurisdictions reporting.

State AIDS programs were asked to provide updated information regarding their state-administered ADAP in the following categories:

- Trends in Monthly Clients Served and Expenditures
- ADAP Budget Update For FY 1997
- Emergency Cost-Containment Measures/ADAP Budget Shortages
- ADAP Administrative Changes
- Formulary/Advisory Committee Update
- Efforts to Implement The Federal Clinical Guidelines
- Linkages Between ADAP, Medicaid and Private Insurance

The findings from this status report update are based on this point-in-time survey. The authors continue to recognize that the national ADAP situation is dynamic with budgets, access criteria and approved drugs changing throughout the course of a year. Up-to-date state-by-state ADAP information is available on the project's Internet website:
<http://www.aidsinfonyc.org/adap>.

Trends in Clients Served and Expenditures

Nationally, states reported that 37,506 unduplicated clients were served by ADAPs in January 1997 while 43,494 used ADAP services during July 1997. This represents a 16% increase in clients served nationally in the first half of 1997. Compared with data from NASTAD/ATDN's previous report (published July 10, 1997) which indicated that 31,371 clients were served by ADAPs during July 1996, there has been a 39% growth in clients served between July 1996 - July 1997.

Thirty-nine states reported increases in the number of clients served during the first six months of 1997. Six states reported increases in clients served of 50% or more: Alaska, Delaware, Georgia, Louisiana, Rhode Island and South Carolina. ADAPs nationally experienced an average increase of approximately 998 additional clients per month during the first six months of 1997 – and for the whole year (July 1996 to July 1997), an increase of approximately 1,015 additional clients per month..

Reports from a few states that had previously experienced sharp increases in numbers of clients served throughout 1996 and the first half of 1997 indicate at least a temporary slowing in increased client utilization of ADAP services. In addition, ten states reported no growth or actual decreases in clients served comparing figures from January and July 1997 (Connecticut, Idaho, Massachusetts, Mississippi, Montana, North Dakota, Oregon, South Dakota, Tennessee and Virginia). NASTAD/ATDN will continue to monitor patterns in ADAP client services and will report on any new trends in the next National ADAP Update in mid-1998.

Monthly ADAP expenditures increased 36% nationally, from \$19.5 million in January 1997 to \$26.6 million in July 1997. Forty-two states reported increases in monthly ADAP expenditures during the same time period, with 15 of those states reporting increases of 50% or greater. Those states are Alaska, Delaware, Florida, Indiana, Iowa, Louisiana, Missouri, Nebraska, New Hampshire, North Carolina, Ohio, Rhode Island, South Carolina, Vermont and Wisconsin. Nationally, states reported a 78% growth in monthly ADAP expenditures between July 1996 and July 1997.

Four states reported decreases in monthly ADAP expenditures in the range of 14% and 52% during the time period (Minnesota, Mississippi, Oregon and South Dakota). In the cases of Minnesota and Oregon, these decreases in ADAP expenses are likely due to program policies which have sought to transition low-income eligible individuals from ADAP into more stable and cost-effective private health insurance purchasing and continuity programs. Mississippi ADAP faced a severe budget shortage in the reporting period which led the program to reduce the number of clients served. South Dakota has also experienced a severe ADAP budget shortage which continues to delay the state's ADAP ability to cover protease inhibitors for eligible clients.

Per client expenditures have increased nationally since the last report. The average per client expenditure among ADAPs nationally over the first six months of 1997 was approximately \$571 per month or \$6,848 annualized. That average is up from the figures reported for the last six months of 1996 which were approximately \$506 per month or \$6,072 annualized. Monthly clients served and program expenditures listed by state are contained in Appendix I.

State ADAPs reported that the total number of prescriptions filled for all drugs on ADAP formularies increased by 24% nationally from 105,236 in January to 130,336 prescriptions filled in July 1997. The average number of prescriptions filled per client increased only slightly between January and July 1997 – from an average of 2.8 to 3.0 prescriptions filled per ADAP client nationally in those months. Notably, the number of protease inhibitor prescriptions filled by state ADAPs increased by 75% from 12,530 to 21,951 during the same time period.

NASTAD/ATDN asked state ADAPs to report, for the first time, the breakdown of monthly expenditures for antiretroviral drugs (including protease inhibitors) and expenditures for all other formulary drugs for January 1997 and July 1997. Nationally, states reported a 38% growth in expenditures for antiretroviral drugs from \$15 million in January to \$20.7 million in July 1997. There was a reported 20% growth in expenses related to other formulary drugs (including drugs for the prevention and treatment of opportunistic infections) from \$4.8 million in January to \$5.7 million in July 1997.

The tables located in Appendix II list the monthly expenditures for antiretrovirals and all drugs, the number of prescriptions filled by ADAPs by state, and average number of prescriptions filled per client among ADAPs.

ADAP Budget Update

FY 1997 National ADAP Budget (Update) Federal and State Resources

Source	Funding	Percent
Title II ADAP Supplemental (Federal):	\$167 million	42.73%
State Funds	\$118.1 million	30.22%
Title II Base (Federal)	\$67.6 million	17.29%
Title I (Federal)	\$24.2 million	6.21%
Miscellaneous Federal/State Funds:	\$13.9 million	3.55%
Total Federal/State Funds	\$390.8 million	100%

In the previous NASTAD/ATDN national ADAP report states were asked to estimate fiscal year 1997 ADAP budgets from all revenue sources. Since that time, a number of

state programs have secured additional funding for the fiscal year,⁷ largely from increased state general revenue contributions but including other sources such as one-time only transfers of funds. This update report contains a revised budget for fiscal year 1997 which accounts for additional resources obtained by ADAPs during the last six months.

ADAPs are funded largely by federal and state resources which accounted for \$390.8 million nationally in FY 1997. Federal funds, provided through the Ryan White CARE Act, total \$272.7 million (or 69.8%) and state funds total \$118.1 million (or 30.2%) of the national ADAP budget. This represents an additional \$32.2 million in federal and state funds reported by ADAPs since the previous NASTAD/ATDN report in July 1997.

One element remained constant between the two budget status reports: the FY 1997 federal ADAP supplemental funding of \$167 million, the largest budget category in the national ADAP funding system. Taken together, federal and state support for ADAPs nationally increased 106% from \$189.8 million in 1996 to \$390.8 million in 1997.

Thirty-six states now supplement federal dollars with state-specific fiscal support for ADAP (6 more states since the previous report). ADAPs which realized increased state/local general revenue support in the last six months included: Arizona, the District of Columbia, Florida, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Nevada, Oklahoma, Pennsylvania, Tennessee and Vermont. Arizona, Florida, Minnesota, Nevada and Tennessee were among the states which reported ADAP contributions for the first time in FY 1997. Although state funding support for ADAPs has increased among low, moderate and high AIDS incidence states, the vast majority of funds provided by states nationwide (78%) is provided by just six high incidence states – California, Illinois, Louisiana, Massachusetts, New York and Pennsylvania.⁸

Sixteen states do not provide funds specifically for ADAP and therefore rely solely on federal funding to provide ADAP services. These 16 states are: Alaska, Arkansas, Delaware, Idaho, Iowa, Kansas, Michigan, Mississippi, Montana, Nebraska, New Hampshire, North Dakota, Oregon, Rhode Island, South Dakota and Wyoming. A table in Appendix III illustrates the comparison of state contributions to federal ADAP dollars.⁹

⁷ States were asked to report ADAP budgets for the period between April 1, 1997 and March 31, 1998 which corresponds with the federal fiscal period under which the Ryan White CARE Act Title II grant program operates, in this case FY 1997.

⁸ Louisiana's reported FY 1997 state ADAP contribution (\$20 million) reflects funding that supports the State Immune Therapy Program (SITP), administered by Louisiana State University (LSU) Health Care Services Division (a program formerly administered by the Louisiana Health Care Authority). SITP acts as a complement to the state ADAP by providing HIV-related treatments that are not available on the state ADAP formulary. Recent reports from Louisiana indicate that the level of funding for this program is being reevaluated. Any changes in this situation will be reported in the next National ADAP Monitoring Project report.

⁹ There has been increased attention at the federal level to the issue of state contributions to ADAPs. In November 1997, U.S. Representative Nancy Pelosi (D-CA) introduced legislation – the "HIV Treatment Improvement Act of 1997" – which contains a provision which would require states that receive over \$1,000,000 in Title II ADAP supplemental funding annually to match 1 for every 5 federal ADAP dollars.

Some states draw upon additional sources of funding to supplement their ADAP budgets, although these other sources are chiefly used to recover costs and are not uniformly used by all states. These additional cost recovery mechanisms include obtaining rebates from pharmaceutical manufacturers¹⁰ and private health insurance recovery. These other resources amounted to \$31.2 million. The breakdown of specific state budgets for ADAP in FY 1997 is contained in Appendix III.

Other ADAP Resources		
Source	Funding	Percent
Drug Rebates	\$22.6 million	72%
Insurance Recovery	\$8 million	26%
Miscellaneous Other Sources	\$.6 million	2%
Total Other Funds	\$31.2 million	100%

Emergency Cost-Containment Measures/ADAP Budget Shortages

Although the national ADAP budget continued to grow throughout FY 1997, a steady stream of state ADAPs reported struggles to keep pace with client demand and program costs. Throughout FY 1997, 22 states instituted at least one emergency measure to contain growth of ADAP clients and costs, according to survey responses. These measures included:

- 12 states which transferred funds from other federal- or state-funded HIV care, prevention or other health programs to ADAP (D.C., Indiana, Iowa, Kansas, Kentucky, Maine, Mississippi, Nebraska, Nevada, New Mexico, West Virginia and Wyoming);

Although not currently binding, this proposal was included as a recommended level of state support in the FY 1998 Appropriations Act Conference Report language on ADAPs. An analysis of the 35 states which would be required to meet this proposed federal matching requirement in FY 1998 reveals that 20 states would not currently meet Rep. Pelosi's recommended 20% match. Fifteen states would currently be the only states to meet (or come within 1% of) this proposed matching requirement: Arizona, California, Illinois, Indiana, Louisiana, Massachusetts, Nevada, New York, Ohio, Oklahoma, Pennsylvania, Puerto Rico, Tennessee, Washington and Wisconsin.

¹⁰ State ADAPs that provide HIV medications to their clients through a retail/mail order pharmacy system (i.e., through a reimbursement system) often obtain voluntary rebates on purchased drugs from the manufacturers. States ADAPs that *directly* purchase medications for their clients receive up-front discounts from the manufacturers through the federal 340B/602 program and, therefore, may not pursue voluntary rebates. For a full discussion of this issue, please see the National ADAP Status Report (July 10, 1997).

- 10 states which capped program enrollment (Alabama, Florida, Georgia, Indiana, Mississippi, Montana, Nevada, North Carolina, South Carolina and South Dakota);
- 9 states which capped or restricted access to protease inhibitors (D.C., Florida, Idaho, Kentucky, Maine, Mississippi, Missouri, Nevada and Oklahoma).

NASTAD/ATDN asked states if their ADAP will exhaust all currently budgeted operating funds for FY 1997 prior to the end of the Ryan White Title II fiscal year (March 31, 1998). Thirteen states reported that they would exhaust their budgets before the next round of federal funds is available.¹¹ Nearly all of these states reported that they expect to run into shortages during the first three months of 1998. These states are: Alabama, Alaska, Arizona, Colorado, Idaho, Kansas, Kentucky, Maine, North Carolina, Puerto Rico, Texas, West Virginia and Wyoming. Colorado reports that it will discontinue providing HIV drugs to its ADAP clients temporarily beginning in January 1998 at which time clients will obtain their medications from drug company patient assistance programs.

In order to avert a budget shortfall – which is prohibited by most state programs – ADAPs frequently report implementing service limitations. The most common measure to control program growth is maintaining waiting lists for client entry to ADAP or for accessing protease inhibitors. Nine states report that they are currently maintaining waiting lists for entry to ADAP: Alabama, Florida, Georgia, Indiana, Mississippi, Montana, Nevada, South Carolina and South Dakota. The number of individuals on formal ADAP waiting lists (as of October 1997) varies significantly from state to state, e.g., 680 individuals in Florida, 250 in South Carolina and 14 in South Dakota. In addition, North Carolina has stopped authorizing new clients for program participation since September 1997, although the program does not maintain a waiting list.

Seven states also report that they are currently maintaining a waiting list for clients to access protease inhibitors from the ADAP. These states are D.C., Idaho, Kentucky, Maine, Mississippi, Nevada and Oklahoma.

A total of 23 states currently fit in one or more of these categories – curtailing ADAP services or facing budget shortages which may result in reduced services early in 1998.

Administrative Changes

States were asked to report any significant changes in the administration of their ADAPs since the previous national ADAP report. Nineteen states (37%) indicated some type of change, including changes in formulary management. Examples of reported changes include:

¹¹ Although states responded to our survey during October-November 1997, the information presented throughout the report is current, unless otherwise indicated.

- Alaska: The state completed a competitive contract process for a contractor to manage the ADAP. This entity is responsible for the purchase and distribution of drugs to clients, data tracking and reports, and budget monitoring.
- California: The California Office of AIDS implemented a centralization of the entire state ADAP during October 1997. Client eligibility authorization continues to be processed at the local level.
- Illinois: Effective April 1997, the state ADAP converted to a Public Health Service (PHS) discounted drug purchasing system.
- Massachusetts: Effective January 1997, Massachusetts ADAP began using a Pharmacy Benefits Manager (PBM) for the purchase and distribution of formulary drugs.
- Oregon: The state AIDS office integrated the administration of the ADAP and the state Insurance Continuation program, moving significant numbers of ADAP clients into private insurance coverage.
- South Carolina: The state has upgraded its pharmacy's software to better track ADAP client data and utilization trends.
- Virginia: The state AIDS office has implemented an extensive state-wide database for ADAP, to assist with tracking clients, expenditures and cost projections.

Other states reported changes in the ADAP formulary, implementation of more efficient data management systems, and the hiring of additional administrative personnel. ADAP formulary changes are described more fully beginning on page 19.

Changes in Eligibility Criteria

Several states also reported changes in their financial eligibility criteria since the previous NASTAD/ATDN report. Alaska increased the income ceiling for ADAP eligibility from 200% to 300% of the Federal Poverty Level (FPL). Mississippi, while preserving their *entrance* criteria at 200% of FPL, established a more generous *exit* criteria, in this case 300% of FPL. Michigan increased financial eligibility from 185% to 362% of FPL. A somewhat smaller adjustment was made by North Carolina, from 110% to 125% of FPL.¹² Vermont ADAP no longer bases its assessment of financial eligibility on gross income; net available income is counted instead and a number of deductions are allowed. Oregon ADAP lowered its financial eligibility slightly from a sliding scale arrangement to a flat 250% of FPL, in order to standardize eligibility for all their state medical assistance programs.

¹² The Federal Poverty Level is currently set at an income of less than \$7,890 a year for one person.

Several states also revised medical eligibility for access to their ADAPs due to changes in the clinical management of HIV disease. Historically, CD4 cell counts have frequently been used by ADAPs when assessing eligibility. The advent of viral load testing has diminished the role of CD4 cell counts as a prognostic marker in HIV disease and most ADAPs have adapted their policies accordingly. Alabama, Florida, Idaho, Kentucky, Nevada and South Carolina continue to use a CD4 count of less than 500 as an eligibility requirement although exceptions can usually be requested. Maine, Mississippi and Puerto Rico set a threshold for CD4 *or* viral load, and meeting either requirement establishes eligibility.

ADAP Formulary Update

Access to treatment through ADAP is contingent upon efficient and appropriate formulary management. As outlined in the previous NASTAD/ATDN report, drug formularies vary widely from state-to-state. Responses to our latest survey indicate that many states are intensifying their efforts to ensure the timely availability of newly approved antiretroviral drugs. However, several states continue to cite fiscal concerns that have delayed the addition of antiretroviral drugs to the ADAP formulary. The inability of some states to accurately project the fiscal impact of formulary changes has been noted as contributing to this problem. In addition, policies regarding the coverage of drugs for the prevention and treatment of opportunistic infections remain highly inconsistent from state to state. Finally, rapidly changing clinical standards and/or differences in formulary decision-making processes at the local level may also contribute to the disparities in ADAP formulary coverage.

Advisory Committee Update

Formal ADAP advisory committees currently operate in forty-five states, to assist in making decisions regarding the administration, structure and scope of the ADAP. Alaska, Kentucky, Montana and Wisconsin continue to use an informal advisory network. Vermont, which previously had a formal advisory committee, is reorganizing and temporarily relying on the health department for all ADAP-related directives.

Formulary management decisions generally fall within the purview of ADAP advisory committees. Irregularity of committee meetings is one of the potential obstacles to the timely addition of newly approved drugs to ADAP formularies. To address this problem, nine states (Alaska, Colorado, Illinois, Minnesota, New Hampshire, Oregon, South Carolina, Utah and West Virginia) now have standing recommendations to add all newly FDA-approved antiretroviral medications without further consultation with their advisory committees. Michigan and Mississippi have increased the number of advisory committee meetings to try to help their ADAPs keep pace with the rapidly changing HIV/AIDS treatment environment.

To probe this issue further, we asked state AIDS programs to report the average length of time it takes to add a new drug to the ADAP formulary, garnering the following responses:

one to four weeks	26 states (50%)
one to two months	11 states (21%)
two to three months	6 states (12%)
three to six months	5 states (10%)
other*	4 states (7%)

* Other periods cited included "no average time" and "varies considerably."

States were also asked how their ADAPs are made aware of the FDA-approval of HIV/AIDS-related medications. The majority of states (92%) rely on treatment newsletters and pharmaceutical company representatives. The latter is usually a field representative whose job involves actively seeking ADAP reimbursement for HIV/AIDS-related pharmaceuticals. Advisory committee members were cited by 36 states as sources of information on new drugs. ADAP consumers in 31 states also play a role in this regard. Eighteen states listed a variety of other potential sources of new drug information, including AIDS advocacy organizations, the Public Health Service, local AIDS Clinical Trial Units, local advisory groups, physicians, and the Internet.

Changes in Formularies

In terms of specific formulary management activities, forty-two states have either added and/or deleted drugs since the previous NASTAD/ATDN report. Forty-nine states now report covering the most recently approved protease inhibitor, nelfinavir (Viracept). Nelfinavir was approved for marketing by the FDA in March 1997. An updated ADAP formulary chart which lists all drugs covered by each state is included in Appendix IV with new drugs added since the previous report indicated in **bold**.

Delavirdine (Rescriptor) is a new anti-HIV drug in the class known as non-nucleoside reverse transcriptase inhibitors (NNRTIs). Delavirdine was approved in April 1997 and thirty-nine states report adding this drug to their formulary. The first NNRTI drug to be approved was nevirapine (Viramune) which received clearance in June 1996. Forty-four states are covering nevirapine, leaving eight states (Alabama, Arkansas, Idaho, Iowa, Louisiana, Pennsylvania, Puerto Rico and Tennessee) that have yet to add any NNRTI anti-HIV drugs to their formularies.

Rhode Island and Minnesota became the first ADAPs to add hydroxyurea to their formularies. Hydroxyurea is an inexpensive anti-cancer drug that early studies have shown to act synergistically with the nucleoside analog antiretroviral ddI (Videx). The usefulness of this drug in the HIV treatment armamentarium continues to be studied.

Two states remain without protease inhibitor coverage: Arkansas and South Dakota. Arkansas reports that protease inhibitors will be added to the ADAP formulary effective April 1, 1998. For South Dakota's program, the issue is primarily economics; the program's ADAP budget is less than \$140,000 which is exhausted rather quickly covering the existing formulary for current clients.

Eleven states added drugs for the treatment and prevention of OIs. However, there was little commonality to be found among states in terms of the specific drugs added in this category. Drugs added included prophylaxis and treatments for HIV-related infections, antibiotics, pain relievers and antidiarrheals. Of the 35 drugs added by these 11 states, all but three were approved prior to 1997.

Kansas was one of only two states to report deleting a drug, specifically clofazimine (Lamprene), which is no longer recommended as a first line treatment for Mycobacterium avium complex (MAC). North Dakota both deleted and added drugs from its formulary, removing clofazimine along with twenty other drugs used in the treatment of opportunistic infections and adding ten other HIV-related medications. Thirteen states (25%) continue to cover clofazimine, which is occasionally used as a salvage therapy in MAC disease.

Clinical Guidelines on HIV Treatment

In June 1997, "Draft Guidelines on the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents" were released by the Public Health Service in collaboration with the National Institutes of Health and the Henry J. Kaiser Family Foundation. This document represents the first effort by the Federal government to distill the many recent breakthroughs in HIV treatment into cohesive guidelines for the use of antiretroviral drugs. These guidelines will be regularly updated to include new information – in fact a November 1997 update has already been released – and these documents are available on the Internet via the HIV/AIDS Treatment Information Service at <http://www.hivatis.org>.

The impact of these data on the effectiveness of combination antiretroviral therapy, usually including protease inhibitor drugs, is already being felt by ADAPs nationally, notwithstanding the previous absence of guidelines on the subject. Now that officially sanctioned recommendations are available, it is likely that ADAP utilization trends will further shift towards the three drug combinations preferred by the guidelines panel. Anticipating these trends, we asked states to report on any steps taken by ADAP in response to the currently available guidelines. Responses are summarized in the table below:

Expand the ADAP formulary to cover the 11 approved anti-HIV drugs	15 states (29%)
Update existing local/state HIV/AIDS treatment guidelines	14 states (27%)
Develop educational programs/materials about the guidelines for local physicians	32 states (62%)

Incorporate the guidelines into new/existing utilization review and/or monitor prescribing	14 states (27%)
Modify/develop prior authorization processes based on the guidelines	7 states (13%)
Other*	10 states (19%)

* Other responses cited included: Working with AIDS Education and Training Centers (AETCs) to educate medical providers; encouraging participation in the New Antiretroviral Treatment Guidelines conference call held in September 1997; changes in eligibility criteria for access to protease inhibitors; considering the implementation of a treatment form to assist doctors when prescribing protease inhibitors; sending the information to all ADAP enrollees; conducting a drug utilization review study; and sending the guidelines to all prescribing physicians.

Drug utilization review (often referred to by the acronym DUR) is a mechanism for assessing the appropriateness of any prescription that a program is requested to reimburse. DUR has a checkered history, as it is often associated with attempts by Managed Care Organizations to limit skyrocketing prescription drug costs.¹³ However, in the context of the HIV treatment guidelines, states are using DUR as an innovative strategy to monitor the inappropriate prescription of antiretroviral drugs. Misuse of antiretrovirals can lead to the swift emergence of drug resistance and treatment failure - an outcome detrimental both to the health of the individual, the public health, and the fiscal health of the ADAP, since the program would have to pay for the more complex regimens required by these circumstances. Although there is ample literature describing the problem of mis-prescribing or "professional non-compliance,"¹⁴ physicians have not always responded well to such interference in their prescribing practices.¹⁵ The ADAP Monitoring Project will request feedback from the 14 states implementing DUR in our next survey.

Prior authorization is another mechanism that is used to control drug utilization. In this case permission to prescribe a particular drug or combination of drugs is obtained prior to the issuance of a prescription. According to data gathered from the previous NASTAD/ATDN report, prior authorization was being used by nine ADAPs: Delaware, Hawaii, Michigan, New Hampshire, New York, Oklahoma, Texas, Vermont and Virginia. Protease inhibitor utilization is monitored in this way in Hawaii, Oklahoma and Vermont. Virginia also required prior authorization for any protease inhibitor other than indinavir (Crixivan), and any combination of a protease inhibitor with an NNRTI drug. However, Virginia is among the seven ADAPs (the others are DC, Michigan, Nevada,

¹³ Horn SD; Sharkey PD; Tracy DM; Horn CE; James B; Goddwin F. *Intended and unintended consequences of HMO cost-containment strategies: results from the managed care outcomes project*. The American Journal of Managed Care March 1996;II(3):253-264. Kubacka RT. *A primer on drug utilization review*. J Am Pharm Assoc (Wash) 1996 Apr;NS36(4):257-61, 279

¹⁴ Ley P. *Professional non-compliance: a neglected problem*. Brit J Clin Psychology 1981;20:151-154. Ungvarski P; Rottner J. *Errors in prescribing HIV-1 protease inhibitors*. JANAC July/August 1997;8(4):55-61.

¹⁵ Okano GJ; Rascati KL. *Effects of Medicaid drug utilization review intervention letters*. Clin Ther 1995 May-Jun;17(3):525-33; discussion 516

Rhode Island, South Carolina and Texas) that report reviewing the issue of prior authorization in light of the new guidelines.

Opportunistic Infection Guidelines

Also in June 1997, the Public Health Service (PHS) in collaboration with the Infectious Disease Society of America (IDSA) released "Guidelines for the Prevention of Opportunistic Infections in Persons Infected with HIV." This document reviewed and updated the recommendations made by PHS and IDSA in 1995. States were asked whether their ADAP had responded to these updated guidelines in any of the following ways:

Expand the ADAP formulary to cover all 14 strongly recommended drugs	9 states (17%)
Update existing local/state HIV/AIDS treatment guidelines	9 states (17%)
Develop educational programs/materials about the guidelines for local physicians	24 states (46%)
Incorporate the guidelines into new/existing utilization review and/or monitor prescribing	10 states (19%)
Modify/develop prior authorization processes based on the guidelines	2 states (4%)
Other*	14 states (27%)

* Other responses cited included: provide patient education materials; all drugs are already covered with the exception of isoniazid (by California, which has a separate program for access to TB medications including isoniazid); working with AIDS Education and Training Centers (AETCs) to educate medical providers; mailing guidelines to case managers, health district epidemiologists and advisory committee members; implementing program to purchase opportunistic infection medications with Ryan White money for individual contractors delivering services; and three states were "unsure at this time."

Upon further review of each state's ADAP formulary, only two state ADAPs (New York and Illinois) cover all 14 of the strongly recommended OI prophylaxis drugs in the guidelines (TMP/SMX, dapsone, pyrimethamine, isoniazid, clarithromycin, azithromycin, fluconazole, itraconazole, amphotericin B, ganciclovir, foscarnet, cidofovir, acyclovir, sulfadiazine). California covers all except for isoniazid, because this drug is available to people with HIV through a separate tuberculosis-specific state program. Additionally, people living with HIV in the states that did not report covering these 14 drugs through their ADAPs may have access to some of these medications through local pharmacy assistance programs and/or state-wide TB programs.

Ancillary Efforts to Provide Access

NASTAD/ATDN also requested information on any ancillary efforts undertaken by state ADAPs to ensure that people with HIV have access to the new clinical standard of care. Twenty-three states noted extensive use of pharmaceutical industry patient assistance programs. Eight states reported collaborative efforts with other Ryan White CARE Act

Title II-funded programs, primarily HIV care consortia,¹⁶ to provide funding for additional medication needs and/or health insurance continuation. Seven states containing Emergency Metropolitan Areas (EMAs) that receive Ryan White CARE Act Title I dollars listed collaborative efforts with these programs to ensure medication coverage beyond that available through the state ADAP. Although covered more extensively in other survey questions, four states (8%) also listed their insurance continuation programs as another strategy for ensuring people with HIV have access to the new standards of care.

Viral load testing is an important monitoring tool referenced extensively in the new guidelines on the use of antiretroviral drugs. Two states¹⁷ specifically reported efforts to ensure coverage of viral load testing for ADAP clients. Alaska requires that Title II-funded consortia cover necessary viral load testing for any ADAP clients they enroll. Louisiana has a state appropriation designed, in part, to provide such coverage for ADAP clients. New York's ADAP Plus program covers viral load testing and other primary care and diagnostic services.

Other innovative strategies being implemented by states in response to the new standard of care included:

- A study of access to protease inhibitors in communities of color in Colorado.
- A statewide treatment education program that trains peer educators in Massachusetts.
- Revision of case management training curricula to include information on the new standards of care in Michigan. Similar quarterly case manager trainings were reported in Ohio.
- Washington state has contracted with their AIDS Education and Training Center (AETC) to produce a 30-minute training video on new HIV treatment strategies.
- New Mexico provides clinical trial referrals as an additional service through an organization called Partners in Research/New Mexico.

Medical Criteria/Restrictions On Access To Formulary Drugs

Despite a general trend towards formulary expansion among ADAPs, several programs continue to have medical criteria in place that restrict access to specific formulary drugs. For the most part, the criteria appear to be driven by cost containment priorities rather than any desire to guide clinical management of ADAP clients. Arkansas limits its five available antiretrovirals to people with less than 500 CD4 cells. Although access to Florida ADAP is capped, when slots do become available only those clients with less

¹⁶ Among the uses of federal Ryan White CARE Act Title II funding is the establishment of local HIV care consortia that assess needs, organize and deliver HIV services in consultation with service providers, and contract for services.

¹⁷ States were not specifically asked to provide information on expanding access to viral load testing services. A significant number of states, other than those referenced here, have taken steps during the past year to broaden access to viral load testing within their jurisdictions.

than 350 CD4 cells and viral loads over 10,000 copies may access protease inhibitors. Georgia reports implementing the following medical access criteria:

CD4	bDNA	PCR	Drugs available
<350	Any	Any	2RTIs + PI or NNRTI / 1 RTI + PI + NNRTI
350-500	>10,000	>20,000	2RTIs + PI or NNRTI / 1 RTI + PI + NNRTI
350-500	<10,000	<20,000	2 RTIs
>500	>30,000	>60,000	2 RTIs
>500	<30,000	<60,000	none

RTI=nucleoside analog reverse transcriptase inhibitor

NNRTI=non-nucleoside reverse transcriptase inhibitor

PI=protease inhibitor

PCR=Roche Diagnostics Amplicor HIV-1 viral load test

bDNA=Chiron branched DNA viral load test

These criteria conflict with the PHS/NIH Guidelines on the Use of Antiretroviral Agents (referenced earlier) which specifically state that two RTI drugs are no longer recommended for HIV treatment. In contrast, both Idaho and Tennessee report amending their guidelines to remove a requirement that clients initiate therapy with two RTIs prior to receiving a protease inhibitor.

Texas ADAP continues to restrict RTI antiretrovirals to those with less than 500 CD4 cells. For access to protease inhibitors, Texas requires clients to have a viral load of over 10,000 copies but does not specify a CD4 count. Virginia has instituted a medical exception form for clients who do not meet current requirements for access to protease inhibitors: a CD4 count of 500 or less or a viral load of over 10,000 copies.

NASTAD/ATDN will continue to monitor developments in the area of medical access criteria which is expected to be revisited by states as a result of ongoing updates and evolution of clinical practice guidelines and by anticipated ADAP funding increases in FY 1998.

The Interface Between ADAP, Medicaid and Private Insurance

Background

During the late 1980's and early 1990's, ADAPs (and the precursor AZT Assistance Programs) acted as a temporary "bridge" between private insurance and the state Medicaid program. The role that ADAPs played in filling the coverage gap between insurance and Medicaid followed the natural course of HIV disease at the onset of the epidemic: many individuals living with HIV infection were working, middle-class men who eventually became too ill to maintain employment, lost their jobs, subsequently lost their health insurance and eventually became totally disabled in the later stages of the illness. Many of these individuals would move in sequence from private insurance coverage, to ADAP, to Medicaid.

This "progression paradigm" may no longer hold true, for several reasons. With the advent of highly effective antiretroviral therapies, many individuals with HIV are no longer progressing so quickly—and in some cases showing almost no progression—towards severe illness, disability and death. People with HIV/AIDS are living longer, as indicated in the recent reports of declining AIDS death rates.¹⁸ People living with HIV infection are maintaining health longer, due to the impact of effective antiretroviral therapies.¹⁹ This means that many individuals are not becoming disabled and under those circumstances will not qualify for disability-based health care programs like Medicaid.

The demographics of the epidemic have changed as well, with increasing cases of AIDS reported in communities of color, among women and among substance abusers. This demographic shift may mean that more people with HIV/AIDS are from populations that are less likely to be privately insured. According to the CDC, approximately 225,000 uninsured people (i.e., individuals without private or public insurance) are currently living with HIV in the United States.²⁰ These individuals have limited options for accessing promising new HIV therapies; among the few options are state ADAPs, manufacturer patient assistance programs, and local indigent care programs.

¹⁸ *Morbidity and Mortality Weekly Report*. Oct. 10, 1997, Vol. 46, No. 40.

¹⁹ *Declining morbidity and mortality in an ambulatory HIV-infected population*. Palella F 1, Moorman A 2, Delaney K 3, Loveless M 4, Fuhrer J 4, Aschman D 3, Holmberg S 2, and the HIV Outpatient Study (HOPS) Group. 1 Northwestern Univ. School of Med., Chicago IL; 2 CDC, Atlanta GA; 3 Health Research Network, Chicago IL; 4 HOPS Group. 37th ICAAC, Toronto, Ontario, Canada, September 28 - October 1, 1997. *Effectiveness of Combination Antiretroviral Therapy in Clinical Practice*. Moore R, Keruly J, Chaisson R, Johns Hopkins Univ., Baltimore, Maryland. 37th ICAAC, Toronto, Ontario, Canada, September 28-October 1, 1997.

²⁰ *Who Will Pay for HIV Treatment? Health Insurance Status of HIV-Infected Persons*. Nakashima AK, Jones JF, Fleming PL, Ward JR. The Supplement to HIV/AIDS Project Group. Centers for Disease Control and Prevention, Atlanta, GA. IDSA 35th Annual Meeting, Moscone Center, San Francisco, September 13-16, 1997.

Individuals with HIV/AIDS are living longer, staying healthier and, anecdotally, are staying on the rolls of ADAPs for a longer period of time. With more restrictive Medicaid eligibility criteria being implemented at the federal and, in some cases, the state level, some individuals (e.g., injection drug users, certain classes of immigrants) may no longer be eligible for access to Medicaid and other public health care programs. The coverage gap that ADAPs are being called upon to fill is steadily widening.

NASTAD/ATDN asked states to estimate ADAP client income levels based on federal poverty guidelines. Using the number of clients served by ADAPs in July 1997, the survey indicated that 49% (19,671) of ADAP clients served nationally that month earned less than 100% of the federal poverty level (FPL) (<\$7,890 per year) and nearly 34% (13,513) earned between 101% and 200% of FPL (\$7,890 - \$15,780 per year). Taken together, an estimated 83% (33,184) of the nation's ADAP clients earn less than 200% of FPL. The state-by-state breakdown of estimated client income levels is included in a table in Appendix V.

In order to ameliorate the increased demand on ADAPs, proposals to expand Medicaid coverage to non-disabled individuals living with HIV are being discussed at the national and state levels. In early 1997, the Clinton Administration proposed examining the feasibility of extending Medicaid benefits—including prescription drug benefits—to non-disabled people with HIV through a Medicaid demonstration/waiver process. After closely examining the potential cost of a Medicaid expansion, however, the Administration initially determined that it could not move forward with this process on a national level. Current Administration policy dictates that any Medicaid expansion waiver must pass a “budget neutrality” test; i.e., the cost of the expansion must be offset by cost savings within the Medicaid program. Health Care Financing Administration actuaries have estimated that an expansion of services for non-disabled individuals living with HIV would result in significant additional outlays of federal and state dollars for Medicaid.

Efforts are now underway to examine the viability of Medicaid expansion on a state by state basis. In a few jurisdictions, efforts to expand Medicaid coverage at the state level are in the preliminary stages of discussion.

Many states are also attempting to expand access to private health insurance for persons who rely on Ryan White CARE Act programs for access to health care and prescription drugs. To this end, some states have established insurance continuity programs and/or insurance purchasing programs. The degree to which a state can access expanded health care coverage through private insurance for people living with HIV is impacted by several factors including the availability of funding for insurance continuity/purchasing programs, the existence of high-risk insurance pools in states, restrictions on the use of federal Ryan White ADAP funds for the purchase of insurance, and state insurance laws.

ADAP and Medicaid

Traditionally, there has not been a seamless continuum of health care access as individuals move between private insurance, ADAP, Medicaid and other public programs like Medicare. Coordination between these programs to ensure that an individual retains access to adequate health care, or at least access to prescription drugs, has often been uneven or non-existent. In this section, we will discuss the type and level of coordination specifically between ADAPs, state Medicaid programs and private insurance, based on survey responses of the state agencies that administer ADAP.

In the vast majority of states, the ADAP and Medicaid programs are housed in different administrative departments. In the three states (Minnesota, Connecticut, Pennsylvania) where the ADAP-administering agency and Medicaid are located and operated in the same state department, there tends to be a high level of cooperation and coordination between the two programs. In general, cooperation between state Medicaid programs and ADAPs historically has occurred in the following areas:

- Coordination of eligibility;
- “Back-billing” of the Medicaid program for coverage of ADAP clients who obtain retroactive Medicaid coverage for expenses incurred by ADAP during the retroactive Medicaid coverage period;²¹
- ADAP providing prescriptions for Medicaid beneficiaries who exceed the monthly Medicaid prescription limit;
- Presence of Medicaid officials on ADAP advisory boards;
- More recently, a few ADAPs have worked with their state Medicaid programs to assess the feasibility of extending limited Medicaid benefits to non-disabled individuals living with HIV.

Examples of coordination between ADAP and Medicaid in these areas are discussed below, based on information provided by state AIDS programs:

Eligibility Coordination

Under the burden of increasing client enrollment and soaring expenditures, many ADAPs have sought to ensure that ADAP clients who become eligible for Medicaid benefits are moved as quickly as possible onto the Medicaid rolls. Thirty-nine ADAPs indicated that they have some mechanism to cross-check/coordinate client eligibility with the state Medicaid program. Mechanisms to cross-check Medicaid eligibility include direct access to the Medicaid client database and eligibility screening by case managers. Some of these ADAPs (Arizona, Kansas, Massachusetts) require that an individual prove he/she is not eligible for Medicaid benefits before applying for ADAP. Alabama ADAP requires

²¹ The retroactive period of coverage, mandated by federal Medicaid law, usually extends for three months prior to the time of application. However, the federal government has waived this requirement in several states with approved Medicaid demonstration waivers.

that clients apply for Medicaid and ADAP simultaneously. Seventeen ADAPs reported screening all ADAP applicants for potential Medicaid eligibility at the time of ADAP application.

According to data gathered from the survey, approximately seven percent (7%) of July 1997 utilizing clients nationally were also current Medicaid beneficiaries²² (including those in the spenddown process). The percentage of ADAP clients estimated to be on Medicaid varies greatly from state to state. For example, Maryland estimated that two percent (2%) of its July 1997 utilizing client population was on Medicaid, compared to an estimate of ten percent (10%) in Nebraska, twenty-two percent (22%) in Texas, and sixty percent (60%) in West Virginia. Twenty-one states reported that no utilizing ADAP clients were also on Medicaid.

The exact eligibility or benefit status of the ADAP clients who were reported to be on Medicaid is unclear, based on the gathered data. Many of these clients may be in the spenddown process or, as in the case of Texas, may be utilizing ADAP services when their monthly Medicaid prescription benefit is exhausted. Tennessee ADAP, which reported no utilizing ADAP clients on Medicaid, has structured its program as a segue into TennCare (the Tennessee Medicaid managed care system) and therefore has no reported overlap of clients.

Coordination of Prescription Benefits

Some state Medicaid programs limit the number of prescriptions an eligible client may receive each month. For example, Medicaid beneficiaries in Mississippi are limited to five prescriptions per month, beneficiaries in Oklahoma, South Dakota and Texas are limited to three prescriptions per month. Texas ADAP coordinates prescription coverage closely with the state Medicaid program via on-line access to the Medicaid database, and covers prescriptions for dual eligibles once an individual has exhausted her/his monthly Medicaid drug benefit. This coverage coordination system is structured so that Medicaid pays for the more costly antiretroviral drugs (e.g., protease inhibitors). Mississippi and Oklahoma previously covered prescriptions for Medicaid/ADAP clients who had exhausted their monthly Medicaid drug benefit, but recently discontinued this practice due to funding shortages.

Back-Billing

Twenty ADAPs stated that they routinely back-bill Medicaid when an ADAP client receives retroactive Medicaid benefits (ADAPs generally have 90 days from the date of service to bill for these funds). Back-billing is accomplished either through an electronic inter-program billing system or through a manual billing procedure. This process allows

²² Alabama, Indiana, Louisiana, Montana and Nevada provided July 1997 utilizing client information but did not provide an estimate of the number of individuals on Medicaid.

ADAPs to recoup funds expended for ADAP clients during the retroactive Medicaid coverage period, and helps to ensure that ADAPs are the payer of last resort.

Other Areas of Cooperation

Seven ADAPs (Alaska, D.C., Florida, Massachusetts, Minnesota, North Dakota, Wyoming) reported that a representative of the state Medicaid program sits on the ADAP advisory committee and/or acts as an advisor to the ADAP program. In most cases, the representative is the Medicaid pharmacist. Three ADAPs (Florida, Maine, New York) indicated that they are in the preliminary stages of discussion with their state Medicaid program regarding expansion of Medicaid benefits to non-disabled individuals living with HIV.

Assessing the Impact of Medicaid Coverage on State ADAPs

Is an ADAP more “burdened” in a state that has a Medicaid program without a medically needy coverage category,²³ with a low spenddown income eligibility threshold, and/or monthly prescription limits? NASTAD/ATDN asked state AIDS programs to identify Medicaid policies in their states that may result in increased demand on ADAP. Eighteen states provided responses to this survey question. Their responses fell into two general categories:

- **Medicaid Eligibility Requirements**

Mental/physical disability requirement- Individuals receiving combination therapies are staying healthier longer. Some programs report that these individuals are remaining on the ADAP rolls for a longer period of time; these individuals cannot qualify for Medicaid because they do not meet the disability requirement.

No “Medically Needy” Eligibility Category/Spenddown Issues- Individuals with HIV/AIDS who meet the physical/mental disability requirement may have incomes that exceed the limit required to qualify for Medicaid benefits. Most states have a medically needy eligibility category that allows disabled individuals to spenddown to a state-determined income eligibility level.²⁴ However, several state AIDS programs report that many clients cannot meet spenddown requirements due to low income eligibility thresholds. Some states simply do not

²³ An optional Medicaid eligibility category that states may elect to offer.

²⁴ The income ceiling for eligibility under a state Medicaid’s medically needy eligibility category is statutorily linked to the amount of cash payment (as determined by the state) made to an individual or family under the discontinued Aid to Families with Dependent Children (AFDC) program. Federal statute dictates that Federal Financial Participation (i.e., federal matching dollars) would be available to cover expenditures for medically needy recipients only if the recipients’ annual income did not exceed 133 1/3% of the maximum payment to an individual/family under the state’s AFDC program. Therefore, the medically needy income ceiling in each state does not exceed that amount.

have a medically needy program, an optional category of Medicaid coverage, thereby potentially increasing the burden on ADAP.

- **Monthly Prescription Limits**

Several state Medicaid programs impose limits on the number of prescriptions that beneficiaries may obtain each month. Some ADAPs report that inadequate prescription drug coverage through Medicaid increases the burden on their programs.

We also conducted a preliminary analysis of the impact that less expansive Medicaid access in some states may have on the state ADAP. We reviewed each state's Medicaid program in order to determine the relative expansiveness of the overall program. For the purposes of our analysis, a "limited" Medicaid program was defined as having **one or more** of the following characteristics:

- No medically needy eligibility category;
- Low spenddown income eligibility threshold (<50% of FPL);²⁵ and/or
- Monthly prescription limits with no exceptions for chronic illnesses (e.g., HIV/AIDS).

Twenty-three states were identified through this process as having "limited" Medicaid programs. We then identified those states that had indicated some level of restricted access to their ADAPs. For the purpose of our analysis, ADAPs with restricted access included those that reported **one or more** of the following access problems:

- Waiting lists for or limited ADAP enrollment;
- Waiting lists for or limited access to protease inhibitors;
- Expected budget shortfall.

Twenty-four states were identified as having ADAPs with restricted access. Our analysis found that 19 of the 23 states (83%) with "limited" Medicaid programs, as defined by our analysis criteria, also were states with restricted ADAP access. These 19 states are: Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Georgia, Idaho, Kentucky, Maine, Mississippi, Nevada, North Carolina, Oklahoma, South Carolina, South Dakota, Texas, West Virginia, and Wyoming. The four states with "limited" Medicaid access that did not also meet the restricted ADAP criteria were Delaware, Illinois, New Mexico and Tennessee. Conversely, five states (D.C., Indiana, Kansas, Montana, and Puerto Rico) met our definition of restricted ADAP access but did not meet the "limited"

²⁵Due the statutory linkage (explained above) of the medically needy income threshold to payment amounts under the discontinued AFDC program, it may be problematic for states to increase their current medically needy income threshold without a change in the federal statute. However, low medically needy income eligibility thresholds were cited by several state AIDS programs in survey responses as increasing the burden on the state ADAP. Categorical eligibility income thresholds were not considered in our analysis since, with few exceptions, they are roughly equal in most states.

Medicaid program criteria. Finally, the remaining twenty-four states met neither the criteria for having a “limited” Medicaid program nor the criteria for having restricted ADAP access (see the Table on page 32).

While this is a cursory analysis of a rather complex issue, it suggests that those states with less expansive Medicaid programs are by and large the same states that have set limits on access to their ADAPs. ADAPs may, in fact, be more burdened in states that have less expansive Medicaid programs. A more detailed analysis of the impact of multiple variables on ADAP fiscal stability is warranted, including both the impact of Medicaid access issues and the diversity of ADAP funding sources.

**States with “limited” or less expansive Medicaid coverage and
restricted ADAP access (19 states)**

Alabama	Mississippi
Alaska	Nevada
Arizona	North Carolina
Arkansas	Oklahoma
Colorado	South Carolina
Florida	South Dakota
Georgia	Texas
Idaho	West Virginia
Kentucky	Wyoming
Maine	

**States with “limited” or less expansive Medicaid coverage but which do
not have restricted ADAP access (4 states)**

Delaware	New Mexico
Illinois	Tennessee

**States with restricted ADAP access but which do not have “limited” or
less expansive Medicaid coverage (5 states)**

D.C.	Montana
Indiana	Puerto Rico
Kansas	

**States which do not have restricted ADAP access or “limited” Medicaid
coverage (24 states)**

California	New Jersey
Connecticut	New York
Hawaii	North Dakota
Iowa	Ohio
Louisiana	Oregon
Maryland	Pennsylvania
Massachusetts	Rhode Island
Michigan	Utah
Minnesota	Vermont
Missouri	Virginia
Nebraska	Washington
New Hampshire	Wisconsin

Private Insurance and ADAP

ADAP and private insurance interface on several different levels. As mentioned previously, ADAPs have often served as a bridge program for individuals with HIV/AIDS who move from private insurance coverage to Medicaid. Some ADAPs cover prescription drugs for clients who have inadequate/limited drug coverage under private insurance policies (e.g., policies with yearly drug benefit caps). Many state AIDS agencies operate insurance assistance programs to augment and/or replace services provided through ADAP and other Ryan White and/or state-funded HIV care programs.

Based on survey responses from states that provided estimates of the number of ADAP clients having private insurance coverage,²⁶ approximately seven percent (7%) of clients nationally who utilized ADAP services in July 1997 had private health insurance²⁷ that provides some level of prescription drug coverage. The percent of clients with prescription drug coverage on ADAP varies greatly from state to state, based on reported figures. For example, ninety-one percent (91%) of Minnesota ADAP clients have drug coverage through private insurance (including those covered through the state high-risk insurance pool) and in Oregon, seventy percent (70%) of clients were estimated to have insurance prescription drug coverage. Fifty-one percent (51%) of ADAP clients in Washington state were estimated to have some prescription drug coverage, twenty percent (20%) in D.C., ten percent (10%) in Kansas and one percent (1%) or less in Arizona, Hawaii, Maine, Nevada, North Carolina, South Carolina and Virginia. Several states (Alabama, Colorado, Florida, Idaho, Mississippi, Oklahoma, Tennessee, Texas, Utah) estimated that no July 1997 utilizing clients had drug coverage through private insurance. In some of these states, individuals with private health insurance that pays for a portion of prescription drug costs are not eligible for ADAP.

Insurance Continuity/Purchasing Programs

Ryan White CARE Act grantees are permitted to use Ryan White Title I and Title II funds to pay insurance premiums, deductibles and co-pays for eligible, low income individuals with HIV/AIDS. Many states use Title II dollars and/or state funds to continue health insurance for people who are on COBRA,²⁸ or who have an insurance policy and can no longer afford to pay the premium. These types of programs are generally referred to as "insurance continuity" programs.²⁹ Eligibility for this type of assistance varies greatly from state to state, but is often synonymous with state ADAP eligibility criteria. States have found insurance continuity programs to be a cost-effective

²⁶ Louisiana, Missouri, Puerto Rico and Wyoming did not provide any estimate on the number of ADAP clients with private insurance coverage.

²⁷ Private insurance includes standard group/individual policies, policies purchased through state-high risk pools and Medigap policies.

²⁸ Consolidated Omnibus Budget Reconciliation Act (COBRA) provides for the continuation of employer-sponsored health insurance plans for a period of 18-29 months after an individual leaves employment.

²⁹ A more detailed discussion of insurance continuity programs may be found in *Health Insurance Continuity for Persons Living With HIV: Trends in State Programs*, NASTAD Issue Brief, June 1997.

means of maintaining not only an individual's prescription drug coverage but also a full range of health care benefits. Anecdotally, however, many states report that fewer and fewer individuals are coming into the Ryan White/state HIV care system with private insurance. For this reason, some state AIDS offices suggest that insurance continuation programs, although cost-effective, are not being as highly utilized as expected.

In addition to paying premiums, deductibles and co-pays for existing policies, some states have initiated insurance purchasing programs. Although these programs are considered under the umbrella of insurance continuity, the state actually purchases a health insurance policy—usually with a minimum standard of benefits—for eligible individuals, pays the premium, and will generally assist with the deductible and co-pays. Often, insurance policies are purchased from a state high-risk insurance pool. Notable among states with insurance purchasing programs are Minnesota, Oregon, and Indiana. In some cases, individuals may be eligible for both an insurance continuity/purchasing program and ADAP benefits; in these cases, the ADAP will cover the costs of medicines during coverage waiting periods and after the private insurance benefit has been temporarily exhausted.

States may use Ryan White *base* Title II funds and, in some cases, state funds to purchase insurance policies for low income individuals with HIV/AIDS. However, there is some question as to whether states may use their federal ADAP earmarked funds for services, such as insurance continuity programs, that facilitate access to treatment. Additionally, some states have legal restrictions on the use of federal and/or state funds for the purchase of insurance. These administrative and legal barriers have prohibited some state AIDS agencies (e.g., Florida, Mississippi) from initiating or expanding cost-effective insurance purchasing programs.

States were asked to briefly describe their efforts to enhance access to private insurance coverage through insurance continuity/purchasing programs. Thirty-seven states (71%) indicated that they administer some type of insurance continuity/purchasing program. Nine states indicated that they do not administer insurance continuity/purchasing programs and five states did not respond to this survey question. North Carolina reported that the establishment of an insurance continuity program in the state is currently under study.

The size, structure, eligibility criteria, and scope of these programs vary greatly from state to state. A comprehensive review of all of the various state insurance continuity/purchasing programs is beyond the scope of this report. However, profiles of selected state initiatives are presented below in order to provide a sense of the variability and scope of these programs.

Connecticut: The Connecticut Insurance Assistance Program for AIDS Patients (CIAPAP) pays insurance premiums for eligible individuals who leave employment and qualify for COBRA coverage. Eligibility for the program is an AIDS or AIDS-related diagnosis, monthly income below 200% of FPL and assets of less than \$10,000

(excluding an automobile). The program makes COBRA payments on behalf of qualified individuals for at least 18 months, and for 29 months for those individuals who are qualified as disabled by the Social Security Administration.

Illinois: The state Continuation of Health Insurance Coverage (CHIC) Program is funded with Ryan White CARE Act Title II dollars and assists individuals with an AIDS diagnosis, or individuals who are disabled due to HIV, have discontinued working, and who will continue to receive health insurance benefits through COBRA or other group health insurance plans. An eligible client must have an income less than 200% of FPL and less than \$10,000 in assets (although the state is currently considering expanding these criteria to allow for greater access). CHIC will pay up to \$300 per month for a client's insurance premium. In some cases, CHIC will pay more for an insurance premium (up to a maximum of \$1,500 more per year) if the insurance policy provides family coverage or is deemed to be extremely cost-effective. The program currently serves approximately 200 clients per month.

Minnesota: The state of Minnesota allocated approximately \$1.5 million in 1997 to support the purchase/continuation of insurance for people with HIV. Individuals eligible for this program must have an income of less than 300% of FPL and meet a state-determined standard of disability due to HIV. The state also uses Ryan White Title I and II funds (approximately \$150,000 this fiscal year) to provide insurance purchasing/continuity for non-disabled individuals with HIV. All insurance plans must provide at least 50% drug coverage within six months of payment of premiums by the state. Currently, over ninety percent (90%) of Minnesota ADAP clients have health insurance that covers prescription drugs.

New Mexico: The state's HIV/AIDS Services Program's Insurance Assistance Program (IAP) is designed to assist eligible individuals with HIV/AIDS to maintain/continue health insurance coverage. Eligible clients must have a gross monthly income less than or equal to 200% of FPL. The IAP will pay a client's existing insurance premium, up to \$400 per month.

Oregon: Beginning January 1997, Oregon began moving many of its ADAP clients onto private insurance through an insurance purchasing program. The state AIDS office assists clients with signing up for the state high risk insurance pool, helps clients through insurance transitions (e.g., from employer policy to COBRA) and pays clients' premiums, deductibles and co-pays. In January 1997, the state was paying over sixty percent (60%) of ADAP client prescriptions at 100%; in November 1997, the state was paying less than forty percent (40%) of prescriptions at 100%, due to the increase in the number of clients who had private health insurance. The state reports significant cost-savings in its ADAP through this process, and has been able to significantly expand the ADAP formulary.

Appendix I

ADAP Monthly Clients Served and Expenditures

ADAP Clients Served and Expenditures in January 1997 and July 1997

State	Jan. 97 Clients Served	July 97 Clients Served	% Change	Jan. 97 Total Expenses	July 97 Total Expenses	% Change
Alabama	454	486	7%	\$ 222,779	\$ 316,359	42%
Alaska	5	11	120%	\$ 3,319	\$ 7,614	129%
Arizona	435	448	3%	\$ 226,611	\$ 287,075	27%
Arkansas	351	426	21%	\$ 86,536	\$ 119,713	38%
California	7,431	8,539	15%	\$ 4,487,075	\$ 5,914,041	32%
Colorado	N/A	534	N/A	N/A	\$ 296,516	N/A
Connecticut	634	519	-18%	\$ 385,320	\$ 367,286	-5%
Delaware	11	47	327%	\$ 4,243	\$ 20,240	377%
DC	N/A	312	N/A	N/A	N/A	N/A
Florida	4,565	4,868	7%	\$ 1,576,631	\$ 2,590,826	64%
Georgia	662	1,041	57%	\$ 274,126	\$ 307,949	12%
Hawaii	84	104	24%	\$ 55,642	\$ 67,680	22%
Idaho	50	48	-4%	\$ 23,179	\$ 29,410	27%
Illinois	1,203	1,319	10%	\$ 733,251	\$ 763,364	4%
Indiana	252	280	11%	\$ 107,287	\$ 185,903	73%
Iowa	35	45	29%	\$ 21,656	\$ 38,519	78%
Kansas	90	110	22%	\$ 60,192	\$ 75,560	26%
Kentucky	161	191	19%	\$ 89,979	\$ 101,519	13%
Louisiana	87	175	101%	\$ 32,910	\$ 64,872	97%
Maine	45	52	16%	\$ 23,600	\$ 34,404	46%
Maryland	409	493	21%	\$ 285,859	\$ 402,426	41%
Massachusetts	860	858	0%	\$ 494,361	\$ 607,585	23%
Michigan	212	259	22%	\$ 166,109	\$ 206,785	24%
Minnesota	198	201	2%	\$ 58,019	\$ 50,039	-14%
Mississippi	427	188	-56%	\$ 157,642	\$ 100,809	-36%
Missouri	294	371	26%	\$ 128,761	\$ 215,180	67%
Montana	18	18	0%	\$ 18,000	\$ 19,500	8%
Nebraska	62	85	37%	\$ 26,773	\$ 46,081	72%
Nevada	281	336	20%	\$ 62,556	\$ 64,428	3%
New Hampshire	43	57	33%	\$ 22,582	\$ 40,828	81%
New Jersey	1,700	1,960	15%	\$ 900,000	\$ 1,200,000	33%
New Mexico	421	465	10%	\$ 213,546	\$ 218,175	2%
New York	6,422	7,595	18%	\$ 5,199,838	\$ 6,838,895	32%
North Carolina	342	470	37%	\$ 205,320	\$ 415,241	102%
North Dakota	15	12	-20%	N/A	N/A	N/A
Ohio	449	596	33%	\$ 207,286	\$ 430,264	108%
Oklahoma	242	293	21%	\$ 115,430	\$ 165,507	43%
Oregon	103	91	-12%	\$ 56,000	\$ 27,104	-52%
Pennsylvania	997	1,268	27%	\$ 656,745	\$ 908,362	38%
Puerto Rico	1,980	2,320	17%	N/A	N/A	N/A
Rhode Island	89	140	57%	\$ 30,170	\$ 60,000	99%
South Carolina	198	310	57%	\$ 127,113	\$ 215,606	70%
South Dakota	19	17	-11%	\$ 10,047	\$ 6,499	-35%
Tennessee	155	145	-6%	\$ 60,042	\$ 64,502	7%
Texas	2,727	3,215	18%	\$ 1,188,790	\$ 1,571,340	32%
Utah	79	95	20%	\$ 52,718	\$ 68,089	29%
Vermont	32	41	28%	\$ 14,115	\$ 22,526	60%
Virginia	1,437	1,189	-17%	\$ 369,310	\$ 545,000	48%
Washington	492	543	10%	\$ 210,451	\$ 313,782	49%
West Virginia	39	43	10%	\$ 29,176	\$ 29,554	1%
Wisconsin	156	202	29%	\$ 87,074	\$ 150,576	73%
Wyoming	53	63	19%	N/A	N/A	N/A
Totals	37,506	43,494	16%	\$ 19,568,167	\$ 26,593,535	36%

Appendix II

ADAP Monthly Drug Expenditures and Prescriptions Filled

Average Prescriptions Filled Per ADAP Client in January 1997 and July 1997

State	Jan. 97 Clients Served	July 97 Clients Served	Jan. 97 Total Prescriptions Filled	July 97 Total Prescriptions Filled	Jan 97 Average Prescriptions Per Client	July 97 Average Prescriptions Per Client
Alabama	454	486	1,282	1,756	2.8	3.6
Alaska	5	11	12	32	2.4	2.9
Arizona	435	448	N/A	N/A	N/A	N/A
Arkansas	351	426	503	594	1.4	1.4
California	7,431	8,539	22,933	27,468	3.1	3.2
Colorado	N/A	534	N/A	1,403	N/A	2.6
Connecticut	634	519	2,132	1,747	3.4	3.4
Delaware	11	47	42	152	3.8	3.2
DC	N/A	312	942	1,068	N/A	3.4
Florida	4,565	4,868	8,500	10,000	1.9	2.1
Georgia	662	1,041	1,311	1,627	2.0	1.6
Hawaii	84	104	236	332	2.8	3.2
Idaho	50	48	N/A	N/A	N/A	N/A
Illinois	1,203	1,319	3,713	4,201	3.1	3.2
Indiana	252	280	538	790	2.1	2.8
Iowa	35	45	146	158	4.2	3.5
Kansas	90	110	259	281	2.9	2.6
Kentucky	161	191	543	620	3.4	3.2
Louisiana	87	175	93	194	1.1	1.1
Maine	45	52	113	138	2.5	2.7
Maryland	409	493	1,364	1,835	3.3	3.7
Massachusetts	860	858	2,576	2,806	3.0	3.3
Michigan	212	259	656	860	3.1	3.3
Minnesota	198	201	705	714	3.6	3.6
Mississippi	427	188	701	431	1.6	2.3
Missouri	294	371	338	290	1.1	0.8
Montana	18	18	51	54	2.8	3.0
Nebraska	62	85	134	248	2.2	2.9
Nevada	281	336	471	482	1.7	1.4
New Hampshire	43	57	107	166	2.5	2.9
New Jersey	1,700	1,960	4,144	5,715	2.4	2.9
New Mexico	421	465	965	1,111	2.3	2.4
New York	6,422	7,595	27,273	34,191	4.2	4.5
North Carolina	342	470	1,024	2,255	3.0	4.8
North Dakota	15	12	N/A	N/A	N/A	N/A
Ohio	449	596	1,336	2,139	3.0	3.6
Oklahoma	242	293	673	924	2.8	3.2
Oregon	103	91	169	212	1.6	2.3
Pennsylvania	997	1,268	3,144	4,350	3.2	3.4
Puerto Rico	1,980	2,320	3,660	2,910	1.8	1.3
Rhode Island	89	140	209	400	2.3	2.9
South Carolina	198	310	615	1,024	3.1	3.3
South Dakota	19	17	67	50	3.5	2.9
Tennessee	155	145	416	399	2.7	2.8
Texas	2,727	3,215	6,838	8,310	2.5	2.6
Utah	79	95	203	234	2.6	2.5
Vermont	32	41	97	121	3.0	3.0
Virginia	1,437	1,189	2,172	2,690	1.5	2.3
Washington	492	543	1,368	1,912	2.8	3.5
West Virginia	39	43	N/A	114	N/A	2.7
Wisconsin	156	202	462	828	3.0	4.1
Wyoming	53	63	N/A	N/A	N/A	N/A
Totals	37,506	43,494	105,236	130,336	2.8	3.0

ADAP Program Expenses for Anti-Retroviral Drugs (ARV), Other Drugs and Prescriptions Filled for Protease Inhibitors in January 1997 and July 1997

State	Jan. 97 Expenses for ARV	July 97 Expenses for ARV	Jan. 97 Expenses for Other Drugs	July 97 Expenses for Other Drugs	Jan. 97 PI Prescriptions Filled	July 97 PI Prescriptions Filled
Alabama	\$ 172,633	\$ 261,116	\$ 50,147	\$ 55,243	129	294
Alaska	\$ 3,319	\$ 7,614	N/A	N/A	5	15
Arizona	\$ 221,706	\$ 280,747	\$ 4,905	\$ 6,328	N/A	N/A
Arkansas	\$ 77,103	\$ 102,646	\$ 9,549	\$ 17,243	24	38
California	\$ 4,293,845	\$ 5,264,593	\$ 553,230	\$ 649,448	3,643	5,056
Colorado	N/A	\$ 296,516	N/A	N/A	N/A	375
Connecticut	\$ 323,009	\$ 318,916	\$ 62,311	\$ 48,370	351	371
Delaware	\$ 3,487	\$ 19,298	\$ 557	\$ 943	8	25
DC	N/A	N/A	N/A	N/A	42	68
Florida	N/A	\$ 334,265	\$ 1,576,631	\$ 2,256,561	N/A	1,000
Georgia	\$ 274,126	\$ 307,949	N/A	N/A	N/A	N/A
Hawaii	\$ 39,000	\$ 57,532	\$ 16,642	\$ 10,148	13	42
Idaho	\$ 22,000	\$ 28,000	\$ 1,179	\$ 1,410	N/A	13
Illinois	\$ 643,347	\$ 710,810	\$ 89,904	\$ 52,554	332	751
Indiana	\$ 95,070	\$ 174,753	\$ 12,218	\$ 11,150	N/A	132
Iowa	\$ 18,890	\$ 36,065	\$ 2,766	\$ 2,454	10	30
Kansas	\$ 50,334	\$ 59,213	\$ 9,964	\$ 16,437	40	51
Kentucky	\$ 67,533	\$ 83,415	\$ 22,446	\$ 18,104	12	19
Louisiana	\$ 32,910	\$ 64,872	N/A	N/A	93	194
Maine	\$ 20,257	\$ 31,730	\$ 3,343	\$ 2,675	2	9
Maryland	\$ 232,081	\$ 347,998	\$ 53,778	\$ 54,428	222	398
Massachusetts	\$ 455,314	\$ 573,453	\$ 39,047	\$ 34,132	369	546
Michigan	\$ 143,441	\$ 189,268	\$ 22,668	\$ 17,517	134	188
Minnesota	\$ 47,273	\$ 42,496	\$ 10,745	\$ 7,543	114	132
Mississippi	\$ 61,765	\$ 33,949	\$ 95,877	\$ 66,944	153	84
Missouri	\$ 43,573	\$ 91,375	\$ 85,188	\$ 123,805	95	123
Montana	\$ 18,000	\$ 19,500	N/A	N/A	12	11
Nebraska	\$ 23,927	\$ 41,015	\$ 2,845	\$ 5,065	26	30
Nevada	N/A	N/A	N/A	N/A	N/A	N/A
New Hampshire	\$ 20,570	\$ 35,682	\$ 2,011	\$ 5,146	14	30
New Jersey	\$ 765,000	\$ 1,056,000	\$ 135,000	\$ 144,000	700	860
New Mexico	\$ 142,854	\$ 166,796	\$ 68,845	\$ 81,187	238	258
New York	\$ 3,860,502	\$ 5,444,876	\$ 1,339,336	\$ 1,394,019	3,656	5,565
North Carolina	\$ 174,880	\$ 354,945	\$ 30,350	\$ 60,296	85	340
North Dakota	N/A	N/A	N/A	N/A	N/A	N/A
Ohio	\$ 174,263	\$ 394,980	\$ 33,023	\$ 35,284	N/A	386
Oklahoma	\$ 92,344	\$ 132,406	\$ 23,086	\$ 33,101	N/A	34
Oregon	\$ 54,293	\$ 25,750	\$ 1,707	\$ 1,354	N/A	4
Pennsylvania	\$ 537,176	\$ 770,797	\$ 119,569	\$ 137,565	561	827
Puerto Rico	N/A	N/A	N/A	N/A	177	907
Rhode Island	\$ 25,871	\$ 54,000	\$ 4,299	\$ 6,000	6	35
South Carolina	\$ 117,645	\$ 203,838	\$ 9,468	\$ 11,768	88	164
South Dakota	\$ 6,473	\$ 4,860	\$ 3,575	\$ 1,640	N/A	N/A
Tennessee	\$ 52,274	\$ 54,856	\$ 7,768	\$ 9,646	2	32
Texas	\$ 1,013,743	\$ 1,407,080	\$ 175,046	\$ 164,260	718	1,323
Utah	\$ 52,718	\$ 68,089	N/A	N/A	40	48
Vermont	\$ 12,271	\$ 18,906	\$ 1,844	\$ 3,620	14	23
Virginia	\$ 276,551	\$ 381,500	\$ 92,759	\$ 163,500	131	607
Washington	\$ 177,483	\$ 278,028	\$ 32,967	\$ 35,754	181	307
West Virginia	N/A	N/A	N/A	N/A	N/A	30
Wisconsin	\$ 78,161	\$ 136,921	\$ 8,913	\$ 13,655	90	176
Wyoming	N/A	N/A	N/A	N/A	N/A	N/A
Totals	\$ 15,019,015	\$ 20,769,416	\$ 4,815,506	\$ 5,760,296	12,530	21,951

Appendix III

FY 1997 ADAP Budget Tables

FY 1997 ADAP Funding by State and Source: Federal and State Funds

State	Federal/State Total FY 1997 ADAP Funds	Title II Base Funds	ADAP Supp. Funds	State Funds	Title I EMA Contribution	Other Federal/State Funds
Alabama	\$ 3,150,604	\$ 1,670,294	\$ 1,329,706	\$ 150,604		
Alaska	\$ 212,320		\$ 112,917			\$ 99,403
Arizona	\$ 3,333,000	\$ 849,248	\$ 1,450,752	\$ 600,000	\$ 407,000	\$ 26,000
Arkansas	\$ 2,050,008	\$ 1,395,995	\$ 654,013			
California	\$ 79,471,892	\$ 12,900,000	\$ 26,371,892	\$ 40,200,000		
Colorado	\$ 2,819,681	\$ 136,000	\$ 1,607,932	\$ 301,000	\$ 774,749	
Connecticut	\$ 4,178,675	\$ 352,389	\$ 2,790,394	\$ 592,000	\$ 443,892	
Delaware	\$ 934,000	\$ 314,314	\$ 619,686			
DC	\$ 5,416,836	\$ 754,876	\$ 2,613,341	\$ 800,000	\$ 1,150,873	\$ 97,746
Florida	\$ 29,355,935	\$ 9,957,303	\$ 17,898,632	\$ 1,500,000		
Georgia	\$ 8,449,959	\$ 2,000,000	\$ 5,125,509	\$ 324,450	\$ 1,000,000	
Hawaii	\$ 1,102,594	\$ 268,691	\$ 542,903	\$ 291,000		
Idaho	\$ 193,000	\$ 80,083	\$ 112,917			
Illinois	\$ 14,466,503	\$ 714,281	\$ 5,427,222	\$ 8,325,000		
Indiana	\$ 2,615,048	\$ 800,886	\$ 1,372,162	\$ 442,000		
Iowa	\$ 292,680		\$ 292,680			
Kansas	\$ 957,620	\$ 389,424	\$ 568,196			
Kentucky	\$ 1,147,265	\$ 356,275	\$ 663,046	\$ 127,944		
Louisiana	\$ 23,206,330	\$ 489,106	\$ 2,717,224	\$ 20,000,000		
Maine	\$ 389,446	\$ 100,000	\$ 229,446	\$ 60,000		
Maryland	\$ 5,955,633		\$ 5,025,239	\$ 600,000	\$ 330,394	
Massachusetts	\$ 11,288,179		\$ 3,310,714	\$ 6,800,000	\$ 1,177,465	
Michigan	\$ 2,862,921	\$ 154,636	\$ 2,408,285		\$ 300,000	
Minnesota	\$ 991,003		\$ 841,003	\$ 150,000		
Mississippi	\$ 2,040,326	\$ 1,159,577	\$ 880,749			
Missouri	\$ 5,652,428	\$ 2,620,796	\$ 1,965,652	\$ 600,000		\$ 465,980
Montana	\$ 201,037	\$ 136,900	\$ 64,137			
Nebraska	\$ 893,499	\$ 659,536	\$ 233,963			
Nevada	\$ 2,834,199	\$ 576,666	\$ 957,533	\$ 1,300,000		
New Hampshire	\$ 563,790	\$ 93,507	\$ 214,993		\$ 102,388	\$ 152,902
New Jersey	\$ 18,280,738	\$ 4,556,141	\$ 9,448,859	\$ 700,000	\$ 1,410,738	\$ 2,165,000
New Mexico	\$ 1,923,568	\$ 805,975	\$ 377,593	\$ 740,000		
New York	\$ 71,466,311	\$ 9,354,309	\$ 29,381,796	\$ 9,900,000	\$ 16,043,941	\$ 6,786,265
North Carolina	\$ 3,660,201	\$ 660,000	\$ 2,250,201	\$ 750,000		
North Dakota	\$ 124,390	\$ 100,000	\$ 24,390			
Ohio	\$ 6,524,500	\$ 822,792	\$ 2,577,208	\$ 3,124,500		
Oklahoma	\$ 2,065,187	\$ 606,101	\$ 728,086	\$ 431,000		\$ 300,000
Oregon	\$ 1,885,136	\$ 200,000	\$ 1,148,136		\$ 537,000	
Pennsylvania	\$ 11,917,646		\$ 5,258,299	\$ 6,659,347		
Puerto Rico	\$ 12,920,475	\$ 3,437,230	\$ 5,315,209	\$ 4,168,036		
Rhode Island	\$ 762,972	\$ 268,849	\$ 494,123			
South Carolina	\$ 3,486,578	\$ 423,683	\$ 2,112,895	\$ 500,000		\$ 450,000
South Dakota	\$ 138,843	\$ 100,000	\$ 38,843			
Tennessee	\$ 2,440,202		\$ 1,830,152	\$ 610,050		
Texas	\$ 19,959,044	\$ 3,000,000	\$ 11,061,308	\$ 2,697,736		\$ 3,200,000
Utah	\$ 780,946	\$ 266,873	\$ 399,273	\$ 114,800		
Vermont	\$ 400,000	\$ 157,860	\$ 92,140	\$ 150,000		
Virginia	\$ 6,410,469	\$ 2,714,138	\$ 2,881,631	\$ 687,200		\$ 127,500
Washington	\$ 6,181,728	\$ 276,000	\$ 2,067,728	\$ 3,263,000	\$ 575,000	
West Virginia	\$ 815,189	\$ 492,843	\$ 247,513	\$ 74,833		
Wisconsin	\$ 1,477,701	\$ 280,362	\$ 823,839	\$ 373,500		
Wyoming	\$ 137,940	\$ 100,000	\$ 37,940			
Total	\$ 390,786,175	\$ 67,553,939	\$ 167,000,000	\$ 118,108,000	\$ 24,253,440	\$ 13,870,796
Percent	100%	17.29%	42.73%	30.22%	6.21%	3.55%

FY 1997 ADAP Funding by State: Other Non-Federal/State Sources

State	Drug Rebates	Insurance Recovery	Other Revenue	Total Other Funds
Alabama	\$ 43,200			\$ 43,200
Alaska	\$ 2,000			\$ 2,000
Arizona				
Arkansas			\$ 270,000	\$ 270,000
California	\$ 7,829,000			\$ 7,829,000
Colorado	\$ 927			\$ 927
Connecticut	\$ 402,430		\$ 219,454	\$ 621,884
Delaware	\$ 18,766			\$ 18,766
DC				
Florida				
Georgia				
Hawaii				
Idaho	\$ 5,000			\$ 5,000
Illinois		\$ 48,000		\$ 48,000
Indiana	\$ 57,012			\$ 57,012
Iowa				
Kansas	\$ 20,000			\$ 20,000
Kentucky				
Louisiana				
Maine				
Maryland	\$ 200,000			\$ 200,000
Massachusetts	\$ 127,400			\$ 127,400
Michigan	\$ 350,000			\$ 350,000
Minnesota				
Mississippi				
Missouri	\$ 23,018			\$ 23,018
Montana		\$ 5,000		\$ 5,000
Nebraska				
Nevada				
New Hampshire				
New Jersey	\$ 1,400,000	\$ 50,000		\$ 1,450,000
New Mexico				
New York	\$ 8,487,440	\$ 7,981,200	\$ 100,000	\$ 16,568,640
North Carolina	\$ 500,000			\$ 500,000
North Dakota				
Ohio	\$ 212,325			\$ 212,325
Oklahoma	\$ 160,000			\$ 160,000
Oregon				
Pennsylvania	\$ 1,900,000			\$ 1,900,000
Puerto Rico				
Rhode Island	\$ 33,600			\$ 33,600
South Carolina				
South Dakota				
Tennessee				
Texas				
Utah	\$ 39,000		\$ 10,000	\$ 49,000
Vermont	\$ 30,000			\$ 30,000
Virginia				
Washington	\$ 600,000			\$ 600,000
West Virginia				
Wisconsin	\$ 150,000			\$ 150,000
Wyoming				
Total	\$ 22,591,118	\$ 8,084,200	\$ 599,454	\$ 31,274,772
Percent	72.23%	25.85%	1.92%	100.00%

Comparison of State ADAP Resources to Federal ADAP Funding

State	FY 1998 Federal Title II ADAP Supplemental Funds	FY 1997 State Contribution to ADAP	Percentage of Current State Funds to Federal ADAP Funds
Alabama	\$ 2,265,704	\$ 150,604	7%
Alaska	\$ 194,562		0%
Arizona	\$ 2,469,052	\$ 600,000	24%
Arkansas	\$ 1,110,885		0%
California	\$ 43,064,688	\$ 40,200,000	93%
Colorado	\$ 2,585,789	\$ 301,000	12%
Connecticut	\$ 4,836,430	\$ 592,000	12%
Delaware	\$ 1,076,994		0%
DC	\$ 4,664,462	\$ 800,000	17%
Florida	\$ 30,253,734	\$ 1,500,000	5%
Georgia	\$ 8,818,043	\$ 324,450	4%
Hawaii	\$ 857,327	\$ 291,000	34%
Idaho	\$ 194,562		0%
Illinois	\$ 8,962,396	\$ 8,325,000	93%
Indiana	\$ 2,377,420	\$ 442,000	19%
Iowa	\$ 489,543		0%
Kansas	\$ 928,876		0%
Kentucky	\$ 1,277,832	\$ 127,944	10%
Louisiana	\$ 4,768,647	\$ 20,000,000	419%
Maine	\$ 357,743	\$ 60,000	17%
Maryland	\$ 8,759,047	\$ 600,000	7%
Massachusetts	\$ 5,563,213	\$ 6,800,000	122%
Michigan	\$ 4,157,347		0%
Minnesota	\$ 1,368,209	\$ 150,000	11%
Mississippi	\$ 1,606,704		0%
Missouri	\$ 3,326,379	\$ 600,000	18%
Montana	\$ 125,524		0%
Nebraska	\$ 412,973		0%
Nevada	\$ 1,728,462	\$ 1,300,000	75%
New Hampshire	\$ 350,211		0%
New Jersey	\$ 16,226,455	\$ 700,000	4%
New Mexico	\$ 748,122	\$ 740,000	99%
New York	\$ 51,291,514	\$ 9,900,000	19%
North Carolina	\$ 3,838,516	\$ 750,000	20%
North Dakota	\$ 45,189		0%
Ohio	\$ 4,305,465	\$ 3,124,500	73%
Oklahoma	\$ 1,281,597	\$ 431,000	34%
Oregon	\$ 1,879,091		0%
Pennsylvania	\$ 9,074,112	\$ 6,659,347	73%
Puerto Rico	\$ 9,264,908	\$ 4,168,036	45%
Rhode Island	\$ 817,160		0%
South Carolina	\$ 3,618,850	\$ 500,000	14%
South Dakota	\$ 61,507		0%
Tennessee	\$ 3,205,877	\$ 610,050	19%
Texas	\$ 19,651,998	\$ 2,697,736	14%
Utah	\$ 684,104	\$ 114,800	17%
Vermont	\$ 154,394	\$ 150,000	97%
Virginia	\$ 5,015,929	\$ 687,200	14%
Washington	\$ 3,527,217	\$ 3,263,000	93%
West Virginia	\$ 430,546	\$ 74,833	17%
Wisconsin	\$ 1,355,656	\$ 373,500	28%
Wyoming	\$ 69,038		0%
Total	\$ 285,500,000	\$ 118,108,000	41%

This table compares current state contributions to ADAP reported in FY 1997 with anticipated FY 1998 federal ADAP supplemental allocations to states

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), nelfinavir (Viracept)	acyclovir (Zovirax), fluconazole (Diflucan), ganciclovir (Cytovene), leucovorin, TMP/SMX (Bactrim/Septa)
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), delavirdine (Rescriptor)	
Arizona	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), delavirdine (Rescriptor)	dapsone, pentamidine, TMP/SMX (Bactrim/Septa), 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/Septa), valacyclovir (Valtrex)
California	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), delavirdine (Rescriptor)	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/Septa), trimethoprim, trimetrexate glucuronate (Neutrexin), vinblastine, vincristine, cidofovir (Vistide), liposomal daunorubicin (DaunoXome)
Colorado	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), delavirdine (Rescriptor)	
Connecticut	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), delavirdine (Rescriptor)	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/Septa), 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, triamecinolone - acetanide 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), nevirapine (Viramune), indinavir (Crixivan) , ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), delavirdine (Rescriptor)	acyclovir (Zovirax), atovaquone (Mepron), azithromycin (Zithromax), clarithromycin (Biaxin), clotrimazole (Mycelex), dapsone, fluconazole (Diflucan), nystatin, paromomycin (Humatin), pentamidine, prednisone, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septtra), amitriptyline (Elavil), amoxicillin, carbamazepine (Tegretol), cephalexin, 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, 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), nelfinavir (Viracept) , nevirapine (Viramune), delavirdine (Rescriptor)	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/Septtra), acetomenaphine with codeine (Tylenol III and Tylenol IV), fentanyl patch (Duragesic), ibuprofen (800mg), morphine sulfate (MS Contin), amoxicillin/clavulanate (Augmentin), fluoxetine HCL (Prozac), sertraline HCL (Zoloft), deprenoxylate and atropine (Lomotil), 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), delavirdine (Rescriptor)	acyclovir (Zovirax), azithromycin (Zithromax), clarithromycin (Biaxin), dapsone, ethambutol (Myambutol), fluconazole (Diflucan), rifabutin (Mycobutin), TMP/SMX (Bactrim/Septtra)
Georgia	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) , delavirdine (Rescriptor)	
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), delavirdine (Rescriptor)	acyclovir (Zovirax), atovaquone (Mepron), azithromycin (Zithromax), cidofovir (Vistide), ciprofloxacin (Cipro), clarithromycin (Biaxin), clindamycin, clofazimine (Lamprone), 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/Septtra), 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/Septtra)

State	Antiretrovirals	OI Prophylaxis and Treatment
Illinois	didanosine (ddl, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune), delavirdine (Rescriptor)	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/Septa), trimethoprim, probenecid, amoxicillin, cefixime, cephalexin, chlorhexidine gluconate, dicloxacillin sodium, doxycycline, erythromycin, penicillin VK, tetracycline, danazol (Danocrine)
Indiana	didanosine (ddl, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune), delavirdine (Rescriptor)	acyclovir (Zovirax), atovaquone (Mepron), azithromycin (Zithromax), clotrimazole (Mycelex), dapsone, fluconazole (Diflucan), nystatin, pentamidine, TMP/SMX (Bactrim/Septa)
Iowa	didanosine (ddl, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept)	acyclovir (Zovirax), atovaquone (Mepron), azithromycin (Zithromax), clarithromycin (Biaxin), clotrimazole (Mycelex), dapsone, fluconazole (Diflucan), ketoconazole (Nizoral), nystatin, pentamidine, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septa)
Kansas	didanosine (ddl, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), saquinavir (Invirase), ritonavir (Norvir), nelfinavir (Viracept), nevirapine (Viramune) , delavirdine (Rescriptor)	acyclovir (Zovirax), azithromycin (Zithromax), clarithromycin (Biaxin), clindamycin, dapsone, dronabinol (Marinol), famciclovir (Famvir), fluconazole (Diflucan), itraconazole (Sporanox), ketoconazole (Nizoral), megestrol acetate (Megace), ethambutol (Myambutol), atovaquone (Mepron), clotrimazole (Mycelex), pentamidine, rifabutin (Mycobutin), nystatin, paromomycin (Humatin), primaquine, TMP/SMX (Bactrim/Septa), ganciclovir (Cytovene), amitriptyline , cephalexin (Keflex)
Kentucky	didanosine (ddl, 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/Septa)
Louisiana	indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept)	
Maine	didanosine (ddl, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune) , delavirdine (Rescriptor)	acyclovir (Zovirax), dapsone, fluconazole (Diflucan), itraconazole (Sporanox), pentamidine, TMP/SMX (Bactrim/Septa)
Maryland	didanosine (ddl, 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/Septa)

State	Antiretrovirals	OI Prophylaxis and Treatment
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), delavirdine (Rescriptor)	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/Septa), butaconazole (Femstat)
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), delavirdine (Rescriptor)	acyclovir (Zovirax), amphotericin B, azithromycin (Zithromax), clarithromycin (Biaxin), clotrimazole (Mycelex), dapsone, fluconazole (Diflucan), ketoconazole (Nizoral), pentamidine, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septa)
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), delavirdine (Rescriptor), hydroxyurea (Hydrea)	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/Septa), valacyclovir (Valtrex), chlor-hexidine (Peridex), cimetidine (Tagamet), hydrocortisone, diphenoxylate (Lomotil), loperamide HCl (Immodium), ranitidine (Zantac), albendazole (Albenza)
Mississippi	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan) , saquinavir (Invirase), nelfinavir (Viracept) , nevirapine (Viramune)	acyclovir (Zovirax), azithromycin (Zithromax), dapsone, fluconazole (Diflucan), ganciclovir (Cytovene), pentamidine, TMP/SMX (Bactrim/Septa), 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/Septa), valacyclovir (Valtrex), codeine, Darvocet, Ibuprofen, morphine (immediate release), Percocet, Tylenol III w/codeine, amoxicillin, amoxicillin/potassium (Augmentin), cefuroxime, cephalexin, doxycycline, erythromycin, penicillin, carbamazepine (Tegretol), phenytoin (Dilantin), diphenoxylate (Lomotil), loperamide (Imodium), griseofulvin, diphenhydramine (Benadryl), hydroxyzine, doxepin, amitriptyline (Elavil), nortriptyline (Pamelor), 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), nevirapine (Viramune) , delavirdine (Rescriptor)	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), delavirdine (Rescriptor)	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/Septa), antidepressants (individual drugs not specified on formulary)

State	Antiretrovirals	OI Prophylaxis and Treatment
Nevada	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) , delavirdine (Rescriptor)	acyclovir (Zovirax), azithromycin (Zithromax), dapsone, fluconazole (Diflucan), TMP/SMX (Bactrim/Septa)
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), delavirdine (Rescriptor)	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/Septa), trimethoprim
New Jersey	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) , delavirdine (Rescriptor)	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/Septa), 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), delavirdine (Rescriptor)	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/Septa), trimethoprim, sertraline (Zoloft), Tegrin Shampoo

State	Antiretrovirals	OI Prophylaxis and Treatment
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), delavirdine (Rescriptor)	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, cyclosporine, 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/Septa), trimethoprim, triple sulfa, vinblastine, vincristine, paclitaxel (Taxol) , griseofulvin, butalbital, comb.w/wo codeine, codeine w/wo ASA, APAP, diclofenac, diflunisal, fenoprofen, 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, 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 and sulfisoxazole acetyl, furazolidone, gentamicin, imipenem-cilastatin, levofloxacin , loracarbef, minocycline, nitrofurantoin, penicillin G, penicillin V potassium, sparfloxacin , spectinomycin, tetracycline, ticarcillin K+clavulanate, tobramycin, vancomycin, carbamazepine (Tegretol), divalproex sodium, magnesium sulfate, phenytoin (Dilantin), primidone, valproic acid, 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, olanzapine , oxazepam, paroxetine, pemoline, pentobarbital, perphenazine, prazepam, prochlorperazine, risperidone, secobarbital, sertraline, temazepam, thioridazine, thiothixene, trazodone, triazolam, trifluoperazine, trimipramine, venlafaxine, zolpidem, loperamide (Imodium), Lomotil, ocreotide acetate, paregoric, tincture of opium, chlorhexidine gluconate, probenecid, podofilox, fluoride, hepatitis A & B vaccines
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), delavirdine (Rescriptor)	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), leucovorin , ethambutol (Myambutol)

State	Antiretrovirals	OI Prophylaxis and Treatment
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), nevirapine (Viramune), delavirdine (Rescriptor)	acyclovir (Zovirax), amphotericin B, atovaquone (Mepron), azithromycin (Zithromax), ciprofloxacin (Cipro), clarithromycin (Biaxin), clindamycin, clotrimazole (Mycelex), dapsone, erythropoietin (Epogen, Procrit), ethambutol (Myambutol), filgrastim (Neupogen), fluconazole (Diflucan), ganciclovir (Cytovene), itraconazole (Sporanox), ketoconazole (Nizoral), leucovorin, megestrol acetate (Megace), nystatin, paromomycin (Humatin), pentamidine, prednisone, pyrimethamine (Fansidar), rifabutin (Mycobutin), sulfadiazine, TMP/SMX (Bactrim/Septra), dronabinol (Marinol), albendazole (Albenza), sertraline (Zoloft), amitriptyline (Elavil), Duramorph, MS Contin, Darvocet, Lomotil, Imodium, Peridex, Zantac. 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), delavirdine (Rescriptor)	acyclovir (Zovirax), azithromycin (Zithromax), clarithromycin (Biaxin), clotrimazole (Mycelex), dapsone, fluconazole (Diflucan), ketoconazole (Nizoral), nystatin, pentamidine, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septra)
Oklahoma	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), delavirdine (Rescriptor)	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), indinavir (Crixivan), ritonavir (Norvir), saquinavir (Invirase), nelfinavir (Viracept), nevirapine (Viramune), delavirdine (Rescriptor)	acyclovir (Zovirax), azithromycin (Zithromax), dapsone, fluconazole (Diflucan), pentamidine, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septra).
Pennsylvania	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, capreomycin, ciprofloxacin (Cipro), clarithromycin (Biaxin), clindamycin, clofazimine (Lamprone), 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/Septra), trimetrexate glucuronate (Neutrexin), triple sulfa, valacyclovir (Valtrex), vinblastine, vincristine, clozaril

State	Antiretrovirals	OI Prophylaxis and Treatment
Puerto Rico	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, amphotericin B, atovaquone (Mepron), azithromycin (Zithromax), capreomycin, ciprofloxacin (Cipro), clarithromycin (Biaxin), clotrimazole (Mycelex), cycloserine, dapsone, erythropoietin (Epogen, Procrit), ethambutol (Myambutol), ethionamide, famciclovir (Famvir), filgrastim (Neupogen), fluconazole (Diflucan), foscarnet (Foscavir), ganciclovir (Cytovene), isoniazid (INH), itraconazole (Sporanox), IVIG, kanamycin, ketoconazole (Nizoral), leucovorin, megestrol acetate (Megace), metronidazole (Flagyl), nystatin, ofloxacin, pentamidine, pyrazinamide (PZA), pyrimethamine (Fansidar), rifabutin (Mycobutin), rifampin, sulfadiazine, TMP/SMX (Bactrim/Septra), triple sulfa, acetaminophen, Actifed (generic), Alba-Lybe, Albafort, Albatussin SR, Albatussin NN, Albuterol inhaler, amoxicillin clavulanate, antacids, betamethasone dipropionate, betamethason/clotrimazole cream, Brondelate, capsaicin (purified), Cefaclor, cefadroxil monohydrate, ceftriaxone, cetirizine, clindamycin vaginal cream, cold cream (generic), diphenhydramine, diphenoxylate HCl, atropine sulfate, doxycycline, econazole nitrate, erythromycin, flurbiprofen, fluoxetine (Prozac), haloperidol, hydrocortisone cream, Ionil-T, Kenalog, ketoconazole shampoo, lanzoprazole, lidocaine HCl, lindane shampoo/lotion, loperamide (Imodium), mebendazole, mometasone furoate, Nutraderm lotion, penicillin G benzathine suspension, phenytoin, prednisolone syrup, probenecid, ranitidine, sertraline HCl (Zoloft), sucralfate, theophylline, terconazole vaginal cream, Tia-Doce
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), delavirdine (Rescriptor) , hydroxyurea (Hydrea)	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), ciprofloxacin (Cipro) , valacyclovir (Valtrex)
South 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) , delavirdine (Rescriptor)	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 (Lamprone), clotrimazole (Mycelex), dapsone, fluconazole (Diflucan), itraconazole (Sporanox), megestrol acetate (Megace), pentamidine, pyrimethamine (Fansidar), rifabutin (Mycobutin), TMP/SMX (Bactrim/Septra), valacyclovir (Valtrex), amitriptyline (Elavil), fentanyl (patch), morphine, MS Contin, propoxyphene (Darvocet), Tylenol #3 w/codeine, carbamazepine (Tegretol), divalproex sodium (Depakote), felbatol (Felbamate), phenytoin (Dilantin), prochlorperazine (Compazine)
Tennessee	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), atovaquone (Mepron), azithromycin (Zithromax), clarithromycin (Biaxin), dapsone, fluconazole (Diflucan), itraconazole (Sporanox), megestrol acetate (Megace), pentamidine, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septra)
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) , nevirapine (Viramune) , delavirdine (Rescriptor)	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

State	Antiretrovirals	OI Prophylaxis and Treatment
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), delavirdine (Rescriptor)	
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), delavirdine (Rescriptor)	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/Septa), sulfadiazine , ocreotide acetate (Sandostatin)
Virginia	didanosine (ddI, Videx), lamivudine (3TC, Epivir), stavudine (d4T, Zerit), zalcitabine (ddC, HIVID), zidovudine (AZT, Retrovir), indinavir (Crixivan), nelfinavir (Viracept), nevirapine (Viramune), delavirdine (Rescriptor)	acyclovir (Zovirax), azithromycin (Zithromax), dapsone, fluconazole (Diflucan), foscarnet (Foscavir), ganciclovir (Cytovene), pentamidine, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septa), itraconazole (Sporanox) . Clients 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.
Washington	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), delavirdine (Rescriptor)	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), delavirdine (Rescriptor)	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), delavirdine (Rescriptor)	acyclovir (Zovirax), atovaquone (Mepron), azithromycin (Zithromax), clarithromycin (Biaxin), dapsone, fluconazole (Diflucan), pentamidine, rifabutin (Mycobutin), TMP/SMX (Bactrim/Septa)

State	Antiretrovirals	OI Prophylaxis and Treatment
Wyoming	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) , delavirdine (Rescriptor)	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, ketoconazole (Nizoral) , valacyclovir (Valtrex) , ibuprofen, MS Contin, Roxanol , carbamazepine (Tegretol), phenytoin (Dilantin), valproic acid (Depakote), fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil) , bupropion (Wellbutrin) , trifluridine (Viroptic), gamma interferon (Actimmune)

Appendix V

ADAP Estimated Client Income Levels Based on Federal Poverty Guidelines

Estimated State ADAP Client Income Levels Based on Federal Poverty Guidelines

State	ADAP Clients Served July 1997	ADAP Clients <100% FPL	Estimated Number of Clients <100%	ADAP Clients 101%-200%	Estimated Number of Clients 101%-200%	ADAP Clients 201%-300%	Estimated Number of Clients 201%-300%	ADAP Clients 301%-400%
Alabama	486				-		-	
Alaska	11	10%	1	40%	4	50%	6	0%
Arizona	448	30%	134	70%	314		-	
Arkansas	426	100%	426		-		-	
California	8,539	47%	4,039	36%	3,083	10%	854	6%
Colorado	534				-		-	
Connecticut	519	48%	249	38%	197	14%	73	
Delaware	47		-	80%	38	13%	6	5%
DC	312	40%	125	30%	94	20%	62	5%
Florida	4,868	86%	4,186	14%	682		-	
Georgia	1,041	73%	762	24%	248	3%	26	0%
Hawaii	104	2%	2	55%	57	35%	36	8%
Idaho	48	20%	10	65%	31	10%	5	5%
Illinois	1,319	70%	923	22%	290	6%	79	1%
Indiana	280	10%	28	30%	84	60%	168	
Iowa	45		-	100%	45		-	
Kansas	110	40%	44	44%	48	10%	11	6%
Kentucky	191	73%	140	19%	36	6%	12	2%
Louisiana	175	22%	38	78%	137		-	
Maine	52		-		-	0%	-	0%
Maryland	493	2%	10	49%	242	35%	173	7%
Massachusetts	858	69%	592	20%	172	8%	69	3%
Michigan	259	96%	249	3%	8	1%	3	
Minnesota	201	22%	44	54%	109	23%	46	0%
Mississippi	188	85%	160	15%	28		-	
Missouri	371	11%	41	89%	330	0%	-	0%
Montana	18	90%	16	10%	2		-	
Nebraska	85	30%	26	70%	60		-	
Nevada	336		-		-	100%	336	
New Hampshire	57	62%	35	29%	17	9%	5	
New Jersey	1,960	55%	1,078	35%	686	8%	157	2%
New Mexico	465	5%	23	60%	279	30%	140	5%
New York	7,595	34%	2,582	33%	2,506	15%	1,139	11%
North Carolina	470	85%	400	15%	71		-	
North Dakota	12	57%	7	30%	4	4%	0	9%
Ohio	596	21%	125	68%	405	11%	66	
Oklahoma	293	65%	190	35%	103		-	
Oregon	91	1%	1	90%	82	9%	8	
Pennsylvania	1,268		-	20%	254	65%	824	15%
Puerto Rico	2,320		-		-		-	
Rhode Island	140	43%	60	40%	56	15%	21	2%
South Carolina	310	60%	186	30%	93	10%	31	
South Dakota	17	10%	2	75%	13	15%	3	
Tennessee	145	50%	73	43%	62	7%	10	0%
Texas	3,215	70%	2,251	30%	965		-	
Utah	95	58%	55	26%	25	13%	12	2%
Vermont	41	28%	11	42%	17	20%	8	10%
Virginia	1,189		-	100%	1,189		-	
Washington	543	43%	233	43%	233	12%	65	2%
West Virginia	43	45%	19	20%	9	35%	15	0%
Wisconsin	202	46%	93	54%	109	0%	-	0%
Wyoming	63		-		-		-	
Total	43,494		19,670		13,512		4,469	
Percent			49.13%		33.75%		11.16%	

National percentages are based on a total of 40,034 clients served by ADAPs in July 1997. Estimated client income levels were not reported by Alabama, Colorado, Maine, Puerto Rico and Wyoming.



ehopkins @ sfaf.org

09/27/98 07:08:00 PM

Record Type: Record

To: Todd A. Summers

cc:

Subject: Re: CARE Act Constituency Group Meeting Washington DC 9-16-99

Just wanted to correct an error in my notes. Miguelina Maldonado, Policy Director at NMAC was re-elected to the NORA Exec. Committee so she will join Rose Gonzales as one of two women of color represented. There are no men of color on the committee, no one representing the substance abuse constituency, and as of Nov 1 there will be no one living with HIV on the NORA EC. Sorry for the error.

Ernest Hopkins
Director of Federal Affairs
San Francisco AIDS Foundation
Chairperson, CAEAR Coalition

-----Original Message-----

From: Hopkins, Ernest

Sent: Friday, September 25, 1998 6:33 PM

To: 'Alvin Quamina'; 'Bryan Glover'; 'Carlton

Smith'; 'Chris Collins'; 'Christopher Bates'; 'Debra Von Zinkernagel'; 'Doretha Williams-Fournoy'; 'Duane Poe'; 'Earnest Hite'; 'George Bellinger'; 'Ginny Foat'; 'Gloria Cox-Crowell'; 'Gloria Lockett'; 'Ivan Torres'; 'Joey Wynn'; 'Laura Thomas'; 'Marty Martinez'; 'Michael Iskowitz'; 'Miguelina Maldonado'; 'Papaya Mann'; 'Patricia Dunn'; 'Peter Ralin'; 'Randy Miller'; 'Ron Simmons'; 'Stephen Tierney'; 'Steve Lew'; 'Todd Summers'; 'Yvette Flunder'; 'Toni Young'

Subject: FW: CARE Act Constituency Group Meeting
Washington DC 9-16-99

Subject: CARE Act Constituency Group Meeting
Washington DC 9-16-99

Attached is an update on the CARE Act Constituency Group Meeting on reauthorization held on Wednesday September 16, 1998 at the offices of NASTAD.

All five Titles of the CARE Act were represented with only the AIDS Dental Reimbursement and SPNS programs lacking direct representation. In addition, NAPWA, AIDS Action and the Human Rights Campaign sent representatives.

The meeting started with a review of the last two meeting of the group related to CARE Act reauthorization. At the first meeting the group discussed whether the Act should be reauthorized or allowed to lapse. A consensus was reached that the bill must be

reauthorized regardless of the potentially negative amendments that will be offered.

The second meeting occurred after a meeting with Congressman Greenwood (R-PA) who sits on the Commerce Committee and supports reauthorization. The Congressman committed to working with the community to buffer the actions of Congressman Coburn. He stressed that the community should strive to reach consensus as early as possible before attempting to engage Congress in discussions around reauthorization. He has had a request for a hearing in to the Chair of the Commerce Committee to review "The State of AIDS". He believes that this hearing-hopefully to be held in the first quarter of 1999 should mark the beginning of the reauthorization conversation on the Hill. National advocates believe that Congressman Coburn will be proactive in his efforts to craft the CARE Act and might even draft an entire bill for introduction early in the 106th Congress. There was agreement at this meeting that our reauthorization efforts would require a broad coalition beyond HIV-and that the CDC community planning advocates would have to be actively involved in reauthorization.

This third meeting of the group opened with an update from David Harvey about the NORA Executive Committee elections.

Re-elected were: Jane Silver-AmFAR, David Harvey-APC, Miguelina Maldonado-NMAC, Rose Gonzales-American Nurses Association (ANA), Mike Shriver-NAPWA

New Members: Jeff Jacobs-AIDS Action, Julia Cohen-Planned Parenthood, Seth Kilbourn-HRC, and Sarah Milo from??

Of this group there is only one person of color, Rose Gonzales, and one person living with HIV, Mike Shriver, (who will be leaving NAPWA at the end of October)-- leaving the committee with no one living with HIV. Ernest raised his concerns about this situation and pointed out that as the epidemic becomes increasingly of color the NORA EC had to make an effort to reflect this reality.

Each organization in attendance outlined the degree of involvement it planned to have in reauthorization, its reauthorization activities to date, and its timeline for reaching policy decisions.

Human Rights Campaign (represented by Seth Kilbourn)

CARE Act reauthorization will be a major priority in their workplan. They hope to engage after the policy decisions have been determined and to offer strategic political and congressional strategy support. Seth Kilbourn will continue be the point person at HRC on the CARE Act. Because of Seth's prior experience in the Senate Labor Committee and at HRSA he hopes to offer that perspective throughout the process. Seth is concerned that the groups not take too long to come to consensus. He wants to avoid a leadership vacuum that could allow Congressman Coburn and others to take a leadership role in crafting the CARE Act.

AIDS Action (represented by Jeff Jacobs)

The Policy Committee of AIDS Action will hold the second in a series of reauthorization meetings on Sept. 24-25. They have developed three workgroups:

Services, Administration, CARE Act Purpose. These three groups will form policy positions that will be the basis of AIDS Action's positions. The two key issues identified after the first meeting of the policy workgroups were: 1) will this just become a drug

program? and 2) will it become a block grant to the states? The key spokespeople for AIDS Action will be Jeff Jacobs, Daniel Zingale and newly hired Lisa Cox (formerly of the National Women's Health Network is an African American woman who is filling Javier Salazar's position). Jeff Jacobs stressed AIDS Action's concern over consensus. The Council wants to work in concert with others. They want to avoid the kinds of problems that appeared in the last process. Once the workgroups develop policy recommendations they are moved to the Executive Board. AIDS Project LA, AIDS Action Boston, Linda Franks of the Pittsburg AETC, GMHC, and Whitman Walker Clinic are among the groups that will be participating in the work group process.

ADAP Working Group (represented by Dorothy Keville)

The Legislative Committee of the ADAP Working Group will track the activities of the 5 Title WorkGroup. Industry will not be involved in the policy development of CARE Act reauthorization. Dorothy Keville, Co-Chair of the Work Group will meet with industry to brief them on what is happening. Industry will be silent and the ADAP Working Group will be silent until community consensus is established.

NAPWA (represented by Mike Shriver)

Reauthorization will be one of NAPWA's top legislative priorities. Key issues for NAPWA are broad access for patients to all available resources -Patients Bill of Rights. The HCSUS data will be the principle thing that motivates their thinking and data from clients in the field. Mike is not sure if technical changes will be recommended but if they are they would be related to pharmaceutical access, and the need for PWA training to rectify the disenfranchisement that occurs in the planning process. NAPWA will oppose block grants. NAPWA will work in coalition with other AIDS and non-AIDS health organizations to garner support for the bill.

AIDS Policy Center for Children, Youth and Families
(represented by David Harvey and Clark Moore)

Key issues for Title IV are prenatal care and women's centered services. The program is shifting focus to adolescents and access to specialty care. Ensuring access to family centered care will remain a reauthorization priority for Title IV. APC will focus on the many potential negative amendments that focus on mandatory testing of newborns, pregnant women, criminalization etc...The Pediatric AIDS Foundation and the AIDS Policy Center have resolved many of the pediatric research access disagreements that marred their collaboration during the last reauthorization. (David Harvey will be leaving the APC at the beginning of February and so he will be leaving both the NORA EC and the constituency group process. No successor has been picked yet but they will be doing a national search).

AETCs (represented by Daphne Rankin, MidAtlantic AETC)

The AETC Directors are concerned about their survival. They know that many at HRSA and in the community are looking for ways to make the program more relevant to quality outcomes for patients in care. HRSA will be re-competing the program grants in this next fiscal year and many of the programs will be consolidated or reconfigured-with a focus on the centers of excellence HIV research sites that are also AETCs. The National AETC Directors Coalition will continue to work with the Title organizations to improve their integration in a reauthorization scenario.

Title II Community AIDS National Network (represented by

Bill Arnold)

TII-CANN has decided that NORA and the 5 Title group will be their key reauthorization coalitions. The Coalition is heavily invested in the Treatment Access Expansion Project (TAEP) which will provide a CD-ROM program for purchase-allowing states to do formula runs on the impact of Medicaid expansion, back to work programs, implementation of high risk insurance pools, insurance continuation and other cross-funding impacts. This effort was funded by the pharmaceutical industry and is an outgrowth of the pharmaco-economic model of care created by Glaxo Wellcome for the ADAP Working Group's funding analysis.

The organization is still in the formative stage-with a regional Board of Directors with only 3 people who are not HIV+.

NASTAD (represented by Joe Kelly)

NASTAD in May '98 created a background paper for their annual conference. NASTAD has a reauthorization workgroup (20 people) who meet via conference call monthly. The primary goals are to defend the CARE Act, and to strictly define change. The issues that they expect to raise are Title I and II distribution (States without Title I EMAs have less access to resources than states that do). HIV reporting and how it will be dealt with in the bill. The stagnant growth of the Title II core state grants versus the exponential growth of the ADAP grants raises the question of whether the split still makes sense programmatically. Some states will want to discuss block grants. Consolidation of the planning process is under consideration. The National Governors Association (NGA) will renew its AIDS policy position in January-so NASTAD must have a policy position in place for review prior to that time. Joe Kelly made a pitch to the group to only consider incremental change. He said that radical change is difficult to manage and the likelihood that we lose control over the process would be very high.

CAEAR Coalition (represented by Ernest Hopkins and Matthew McClain)

Ernest informed the group about the recent CAEAR Business meeting and meetings at the White House where reauthorization was the topic of discussion. He outlined the process of the meetings and relayed the consensus of the CAEAR Coalition to look at the CARE Act broadly and not focus its recommendations solely on Title I and III of the Act. He shared CAEAR's intention to hold a "members only" meeting in Los Angeles in December that will be used to discuss the types of programmatic and policy changes to be proposed and to find consensus on the key policy positions for the CAEAR Coalition. The policies will be shared with key CAEAR Coalition non-member stakeholders for input before broad public distribution set for January 99.

NEXT STEPS:

The next meeting of the constituency groups will be in October and where a communications plan will be developed and some operating principles will be established. The CAEAR Coalition will continue to be an active participant in these meetings.

CONFERENCE REPORT ON H.R. 2264, DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 1998 (House of Representatives - November 07, 1997)

HEALTH RESOURCES AND SERVICES

The conference agreement earmarks in bill language \$285,500,000 for the Ryan White Title II State AIDS drug assistance programs rather than \$217,000,000 as proposed by the Senate and \$299,000,000 as proposed by the House. Total funding for the Ryan White program has been increased by \$153,948,000 from the fiscal year 1997 level to a total of \$1,150,200,000.

The conferees commend the Department on the recent release of draft guidelines for the use of antiretroviral agents in treating HIV-infected individuals. These recommendations reflect the significant advances in treatment options for individuals with HIV disease that have resulted from the substantial investment in AIDS research. The conferees are concerned that policies adopted by some State AIDS Drug Assistance Programs (ADAP) are inconsistent with these new recommended standards of care. In particular, restricting access to recommended therapy options until late stage disease or until failure on suboptimal therapy, may actually predispose patients to failure once appropriate therapy is initiated. Therefore, the conferees direct the Secretary to work closely with State programs to ensure that ADAP policies within States are consistent with recognized standards of care.

The conferees are concerned about the wide variation in State ADAP's and Medicaid policies regarding eligibility, benefits, and formularies. The conferees are also concerned about the wide variation in State contributions to funding of ADAPs and urge that States receiving more than \$1,000,000 under the targeted formula match no less than twenty percent of the Federal contribution. The conferees direct the program to use all means necessary to reduce the purchase price of AIDS drugs and encourage HRSA to accelerate the award of 1998 program grants to help address the increased program needs that have been identified in the current program year.

The conferees reiterate that Department of Veterans Affairs facilities are eligible to receive Ryan White Title I funding through local title I health services planning councils. The conferees are concerned about recent attempts by agency contracting officials to deny funding for important HIV services provided at these facilities.