Streamlining and Modernizing the AIDS Drug Assistance Program (ADAP) of the Ryan White CARE Act

AIDS Action's Recommendations

until it's over

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About AIDS Action Council

AIDS Action Council, a 501(c)(4) organization, serves as a national voice for community-based organizations, local health departments and clinics, service providers, and health educators by advocating for effective legislative and social polices and programs for HIV prevention, treatment, and care.

Statement of Purpose

The development of effective medications for the treatment of HIV is one of the great success stories in the two-decade history of the effort to end the HIV epidemic. The availability of medications to successfully suppress and maintain suppression of HIV viral load has led to decreases in mortality. People living with HIV are able to lead longer, more productive lives.

The Issue: More than 125,000 low-income people living with HIV in the United States rely on the AIDS Drug Assistance Program (ADAP) of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act to receive HIV medications. This number increases by 7,000 people each year. Despite the success in developing medications, the structural and financial ability of the U.S. to continue to deliver medications to people living with HIV is waning. State and territorial ADAPS have struggled to contain costs, by instituting waiting lists, limiting access to medications on state ADAP formularies, and limiting financial and medical eligibility.

The Solution: AIDS Action recommends streamlining, modernizing and managing the growth of ADAP to allow every low income person living with HIV making less than 350% of the Federal Poverty Level (FPL) eligibility to receive lifesaving treatment for HIV, opportunistic infections, and side effects of medications. AIDS Action seeks to provide greater accountability to Congress by measuring health outcomes and expanding oversight and response to Congress by moving the ADAP program into a separate Title V in the CARE Act. AIDS Action also seeks to create accountability by ensuring systemic measurement of health outcomes including measurement of CD4 counts, viral load and other health indicators.

AIDS Action additionally recommends modernizing the ADAP system to ensure portability between state and territorial ADAPs. Portability will allow people living with HIV the ability to access support, treatment and care from relatives and other caregivers and the potential to gain or retain employment and self sufficiency. Consequently, AIDS Action recommends creating minimum state and territorial ADAP eligibility requirements. In addition to creating minimum eligibility at 350% of the Federal Poverty Level, AIDS Action recommends the creation of a baseline drug formulary and achieving cost savings through use of the Federal Ceiling Price. AIDS Action also recommends retaining management of ADAPs at the state and territorial level to achieve greater flexibility and accountability.

Funding required for this program of streamlining and modernization is estimated at $1.5 billion in Fiscal Year (FY) 2006 with $100 million annual increases through FY 2010. It is important to emphasize that AIDS Action strongly believes that current funding levels for each of the other Titles and Parts of the CARE Act are necessary for the delivery of successful treatment as detailed in the joint position statement "Policy Recommendations for Reauthorization of the Ryan White CARE Act" produced with the CAEAR Coalition and should not be tapped for this initiative. AIDS Action anticipates greater flexibility, accountability and long-term efficiency if these recommendations are implemented.

AIDS Drug Assistance Program

Today there are more than 1,000,000 HIV positive individuals living in the United States, the largest number ever. More than 250,000 people are unaware of their infection and an additional 250,000 people who are aware of their HIV positive status are without the treatment, medications, and care that they need.[i] As a result, all of these individuals lack the care and treatment necessary—including medications—to remain healthy.

Given the state of the epidemic in the United States today, AIDS Action, in partnership with the CAEAR Coalition, developed a number of principles to ensure that the CARE Act continues to meet the needs of people living with HIV, **ensuring that individuals who are aware of their HIV positive status** are able to access medical and supportive care (see also Appendix A). These principles are:

- The Ryan White CARE Act works and it must be reauthorized.
- People living with HIV, especially consumers of CARE Act services, must be a central part of the reauthorization process and provide continued input into CARE Act planning.
- The existing CARE Act title structure must be maintained to provide the ability to target policies and resources to diverse populations impacted by the HIV epidemic.
- The CARE Act must address current, evolving, and ongoing emergency needs of people living with HIV and AIDS and the organizations that serve them.
    - Many people with HIV/AIDS are living longer.
    - Many people living with HIV/AIDS need access to more treatment and medical support services.
- Community planning, coordination with health care systems, and local decision-making are central to the success of CARE Act programs.
- A comprehensive range of services should be supported; including HIV testing, prevention counseling, treatment and supportive services, which must be available in sufficient quantities, appropriate to local need.
- CARE Act funding and program guidance must continue to take into consideration that HIV/AIDS is a life threatening infectious disease that is an ongoing public health emergency.
- The CARE Act must commit to:
    - Strengthen and reenergize the Planning Councils and Consortia
    - Address geographic variability and stabilize necessary and effective systems of care
    - Reinvest in maintenance and expansion of service capacity, targeted education and training of health care providers (AETCs), including continuing medical education and systems improvement projects.
- The AIDS Drug Assistance Program must remain an essential component of the CARE Act.

The last principle is of the utmost importance. The successful development of effective medications for the treatment of HIV has prompted a shift in perspective about the role of drug therapies, their relationship to other forms of critical medical care, and the vital contributions of health care support services to enroll and maintain people in systems of care through the Ryan White CARE Act.

The AIDS Drug Assistance Program (ADAP), a federal earmark in Title II of the CARE Act, is administered by the states. There are currently 50 state ADAPs plus an additional 7 ADAPs operating in U.S. Territories, Jurisdictions, and the District of Columbia. ADAP helps to ensure that poor, working poor, and middle-class people living with HIV who are otherwise unable to obtain expensive, life-prolonging medications are able to receive the drugs necessary to preserve their lives and health. As of June 2004, more than 125,000 people living with HIV have been receiving medications from ADAP, including 7,000 new clients per year. ADAP accounts for more than one-third of the total funding in the Ryan White CARE Act and has become central to maintaining the health of people living with HIV in the United States.

In recent years, ADAP has come under extraordinary pressure to provide a more open drug formulary that offers expensive new medications to a greater number of individuals. The pressure on this program has prompted most states to engage in strategies to control costs, including wait listing eligible individuals, limiting eligibility, and capping formularies or benefits. The pressures on states are further complicated by the complexity of the disease, strains of HIV that are resistant to specific drugs, the rigidity of drug regimens and the necessity for individuals taking drugs to maintain as much as a 95% rate of adherence to successfully lower viral load. ADAP's continuing ability to effectively provide medications to people who desperately need them is at stake.

AIDS Action therefore proposes to enhance, streamline, and modernize ADAP following the principles above by maintaining appropriate standards of care, minimizing destabilization, and increasing equity.

1. Structure of the Program

ADAP began in 1987 as an effort to help patients purchase the expensive anti-retroviral drug AZT, a nucleoside/nucleotide reverse transcriptase inhibitor (NRTI). AZT was the only drug approved by the Food and Drug Administration (FDA) for the treatment of HIV infection at that time. Since then, three other classes of anti-retroviral medications have been approved by the FDA. They are protease inhibitors (PIs); non-nucleoside reverse transcriptase inhibitors (NNRTIs); and fusion inhibitors. Drugs within each of these classes prevent ("inhibit") the virus from performing an essential part of its reproductive cycle. In addition to anti-retroviral medications, most state ADAPs provide medications for conditions associated with HIV, including opportunistic infections, the side effects of HIV drugs, substance abuse, and mental health disorders.

In 1996, Highly Active Anti-Retroviral Therapy (HAART)—initially the combination of a protease inhibitor and two nucleoside/nucleotide reverse transcriptase inhibitors—became the standard of care in the U.S. Public Health Service Guidelines. With the advent of HAART, patients began to live longer, healthier lives and the HIV/AIDS mortality plummeted. While rates of new HIV infections have not increased, there continues to be an estimated 40,000 new HIV infections each year. The combined impact of longer lives, increased emphasis on testing, and improved enrollment in treatment has created an increased demand for expansion of AIDS drug programs.

As a result, ADAP has grown from a simple, small earmark at the inception of the Ryan White CARE Act to one of the largest discrete programs in the entire CARE Act. Fuzeon, the only FDA-approved fusion inhibitor, costs as much as $20,000 per client per year and, according to the National ADAP Monitoring Project, other anti-retroviral medications cost up to $12,000 per client per year. As a consequence of these costs and growth in the numbers of people living with HIV, the program has grown tremendously. In Fiscal Year (FY) 1996, the ADAP earmark was funded at $52 million. In FY 2005, approximately $787.5 million was appropriated for ADAP. The rate of funding growth has slowed to 5% in the last year despite increases in need.

Successful treatment of HIV through adherence to complex, daily anti-retroviral regimens achieves positive and long lasting outcomes when accompanied by ongoing treatment education. A consistent relationship with the health care system results in greater efficacy and patient adherence. Consequently, all people receiving medications and laboratory diagnoses through ADAP must be sufficiently connected to appropriate care systems to ensure the continued success of the program. ADAP must be flexible enough to achieve this goal.

ADAP now accounts for more than one-third of Ryan White CARE Act funding. Along with ensuring access to medical care and treatment, ADAP has clearly become one of the most important CARE Act programs and, as such, it must be assured of continued success. ADAP requires scrutiny from Congress and the administration for efficiency, accountability, and evidence of success. In short, ADAP has outgrown its home in Title II. For this reason AIDS Action proposes to remove ADAP from Title II and reauthorize it in a separate Title V. A

separate title would allow the medical practitioners, patients, states, and agencies that carry out the program to better track and use available funding while Congress would be better able to oversee and supervise the program.

Recommendation #1:
The AIDS Drug Assistance Program must continue to be funded in the Ryan White CARE Act and run by the states, but should be removed from Title II and placed into a separate title—Title V— to allow greater Congressional oversight and supervision of the program.

2. Managed Growth

As noted above, AIDS Action endorses a principle of ensuring the stability of the ADAP system. State managed ADAP systems have been especially vulnerable to changes in state budgets and economies. Budget shortfalls often require states to change state formularies and ADAP program eligibility requirements. Such changes may undermine state ADAPs' ability to consistently ensure that patients receive medications. Unfortunately, loss of access to medications has the potential to create drug resistant strains of HIV.

Problems associated with this loss of access are intensifying because the United States is also committed to bringing as many as 500,000 people who are not currently in treatment into regular HIV medical care and support services. This number comprises two populations: individuals who are aware of their HIV positive but are not in treatment; and individuals who are both unaware of their HIV positive status and not in care. These individuals must be connected to care. Expanding ADAP resources is a logical next step. To successfully complement this program most effectively, the U.S. must also ensure that patients are accessing Medicaid, Medicare, private insurance, and coverage in other programs. Nevertheless, ADAP resources are likely to be the most important source of funding for medication for this cohort of new individuals.

AIDS Action endorses a system of managed growth which would create stability in the distribution of HIV medications and would ensure that providers are efficient and accountable for distribution. Managed growth would have the additional benefit of removing the pronounced regional, state, and local disparities that have emerged under the current systems of healthcare. This system of managed growth would ensure that clients living in all regions of the country are able to access the most complete list of medications. At the same time, the system would create accountability and provide Congress with feedback on success. It would also provide states with the resources to end waiting lists, maximize formularies, and create a standard set of criteria of access for individuals throughout the United States.

Recommendation #2:
AIDS Action recommends the implementation of a treatment focused program of managed growth for ADAP consisting of the creation of regional and state consistency and portability, and the adoption of a consistent drug formulary. State ADAPs must receive enough federal funding to create flexible programs that meet minimum reporting goals and levels of success. This proposal requires federal assistance to manage growth, beginning with $1.5 billion in FY 2006 and increasing the base by $100 million each year to $2.0 billion in 2010, the fiscal year after the next reauthorization. This program of streamlining and managing growth will ensure that jurisdictional and state funding that is potentially being allocated to purchase medications will remain within the jurisdiction to fund needed improvements or maintenance of the local public health infrastructure responding to HIV. AIDS Action further recommends that this proposal be implemented only upon assurance that sufficient funds are appropriated; these funds are necessary to ensure that the proposal can be carried out without additional mandatory costs to the States.

3. Enhancing Access to Medications and Creating Portability

The ability of people living with HIV to access medications through ADAP depends largely on the state in which they live. Eligibility criteria and state formularies vary by jurisdiction. According to the May 2004, *National ADAP Monitoring Project Annual Report*, financial eligibility for ADAPs ranges from 125% of the federal poverty level in North Carolina to approximately 500% of the federal poverty level in Delaware, Massachusetts, New Jersey, Ohio and New York. State formularies range from as few as 18 drugs in Colorado to open formularies (all medications related to care and treatment of HIV, opportunistic infections, side effects and more) in 4 states and territories (Massachusetts, New Hampshire, New Jersey, and the Northern Mariana Islands).

In addition to regional disparities, the growth in the number of people living with HIV who seek to access ADAP has outstripped the growth in funding considerably. Consequently, eleven state ADAPs currently report a waiting list to access the program. According to the National Alliance of State and Territorial AIDS Directors (NASTAD) in the February 9, 2005 publication, *The ADAP Watch*, 9 state ADAPs have current waiting lists and 11 additional states (and 1 state that also has a waiting list) have instituted capped enrollment, eligibility limits, or formulary reductions since April of 2003. Eight states (3 of which are not included in the states noted above) anticipate the need to implement new cost containing measures before March 31, 2005, the end of the ADAP fiscal year for 2004.

AIDS Action is particularly concerned about the impact regional disparities have on the care and treatment of people living with HIV, along with the continuing difficulties in meeting the rapid growth in the need for medications. Another effect of the regional and state differences in ADAP is the limited mobility for people living with HIV, which affects both access to, and continuity of, care. People living with HIV may wish to move closer to loved ones, family, or caretakers; or they may wish to take a new job. Different eligibility criteria and state formularies are disincentives to such relocations and may lead to the interruption of medication regimens, thus diminishing the effectiveness of their treatment and potentially leading to drug-resistant strains of HIV. Consequently AIDS Action recommends alleviating regional and local disparities by managing growth and creating greater portability and equality in care.

Standards of Care

Since 1998, the Panel on Clinical Practices for Treatment of HIV Infection has developed guidelines for the use of anti-retroviral drugs with adolescents and adults. The panel is made up of experts appointed by the Department of Health and Human Services. The goal of the panel is to provide evidence-based guidance in the use of anti-retroviral medications. The guidelines answer treatment questions such as when to initiate therapy, which drug combinations are preferred, which drugs or combinations should be avoided, how to continue clinical benefit in

the face of anti-retroviral drug resistance, and the necessity of medication adherence. Given the goal of creating equity in treatment, AIDS Action proposes the adoption of a single set of standards of practice throughout the United States.

Finally, AIDS Action notes that AIDS Education and Training Centers (AETCs) provide education about HIV infection to health care providers throughout the country. There are also four national AETCs covering minority issues, clinical consultation, evaluation, and national resources coordination. The AETCs are ideally situated to help in the formulation of standards of practice in the United States and to educate health care providers to ensure that they are meeting the standards set by the Panel on Clinical Practices of HIV Infection. Maintaining a well-educated and trained health-professions work force is essential in the effort to ensure that individuals who are aware of their HIV positive status connect to care; improve access to quality HIV treatment, care, and prevention; reduce disparities in HIV care; and enhance clinical capacity building.

Recommendation #3a:
Revise the U.S. Department of Health and Human Services' Public Health Service HIV/AIDS Clinical Practice Guidelines for the Use of AIDS Drugs to ensure that all HIV care is consistent with the treatment guidelines. AIDS Action recommends that the Department of Health and Human Services establish a "PHS Guidelines Panel to Integrate Guidelines w/ADAP," composed of doctors, nurses, and pharmacists, as well as HIV positive patients. Such a panel will help ensure that there is scientific and clinical expertise to review the PHS and ADAPs on an ongoing basis. Such a panel will also help to answer questions arising at the state level about best practices in treatment. Panel members will monitor and ensure 100% compliance with PHS Guidelines. Additionally, it is recommended that a Clinical Advisory Panel be established to allow professional clinical review of the guidelines by doctors, nurses, and public health professionals.

Recommendation #3b:
Ensure consistency between formulary guidelines and Medicaid guidelines. Depending on the state, medications available through ADAP may vary greatly from medications available through the Medicaid program. AIDS Action recommends that the Center for Medicare and Medicaid Services (CMS), the Health Resources Services Administration (HRSA), and relevant individuals, agencies, and organizations (with HIV expertise) create an ongoing structure to ensure coordination and consistency.

Recommendation #3c:
Require the Secretary of Health and Human Services to report to Congress about the implementation of this initiative to integrate state and national standards of care and on consistency of Medicaid and ADAP formulary guidelines by 2008.

Portability

States with poorer, more rural citizens and lower tax bases have not had the ability to provide more equalized funding to people living with HIV. As noted above, in some cases states have

been forced to lower eligibility requirements for ADAP, potentially losing citizens to states with greater benefits or to illness and death. Conversely, extremely ill patients wishing to move to obtain employment or to be nearer to their families or caretakers may face a loss of eligibility.

The concept of portability speaks to the ability of individuals to remain in care despite moving from state to state. It is intended to create the conditions necessary for state and local health systems to accomplish the outreach necessary to ensure that individuals are enrolled in, linked directly to, and maintained in systems of care. Thus ADAP should be understood not as a pharmaceutical support program, but rather as a program focused on people likely to need care.

Recommendation #3d:
ADAP should enhance portability among state programs. Creating portability among the states will, of necessity, begin to end regional differences in care, ensure consistency and high quality of treatment of HIV, and allow people living with HIV the freedom to move to maintain work, to be closer to families, or to be closer to care and treatment. Program specifics:

- *When an ADAP client moves to another state, the client should become eligible for services through the new state ADAP within 30 days of arrival to the new home state.*
- *The new enrollee should be transferred from the old home state to the new home state after 30 consecutive days enrolled in the new state's program.*
- *To facilitate record keeping, compliance, monitoring, program participation, and reimbursements, each ADAP participant should be issued an "ADAP participant card" which can be "bar-coded" for monitoring purposes. The goal of the portability program is to ensure the ongoing and consistent treatment of HIV without interruptions.*
- *Such tracking will improve accountability and enhance the reporting of health outcomes, including medical/clinical indicators such as viral load, tolerability, patient visits and more.*

4. Ensuring Consistency in Formularies and Eligibility

Eligibility

As noted above, eligibility criteria and formularies vary by state. In reality the differences among states and territories for both eligibility and formulas are not as far apart as they might seem. Requiring relatively similar minimum eligibility levels for the state ADAPs is a necessary precondition for creating portability and ensuring that geographical variances are minimized. Creating similar eligibility conditions also begins to allow states to address issues of portability. Although there are 57 ADAPs, each with different requirements, the problem of creating minimal standards is not as difficult as it may at first appear. Thirty-eight state programs allow enrollment in ADAP for individuals at or above 300% of federal poverty level. These 38 programs provide medications for 81.6% of all current ADAP clients. Consequently, it should be possible to set a minimal level of eligibility criteria without great expense (see Appendix C).

Recommendation #4a:
Given that 38 states and territories already match or exceed eligibility standards set at 300% of the federal poverty level, AIDS Action recommends setting a minimum eligibility requirement of 350% for all states and territories—states and territories should be encouraged to exceed this standard. Such a requirement is reachable by all states and territories and will help to ensure that regional and state variability is diminished while also removing one of the main obstacles to portability.

Formularies

According to the *May 2004 National ADAP Monitoring Project Annual Report*, 10 NRTIs were approved for use as anti-retroviral medications by the FDA in 2003, the latest year for which data are available.[ii] Only 6 states and territories do not approve all 10 NRTIs for their formulary. Similarly, 8 protease inhibitors are approved by all but 12 states (two of these protease inhibitors were approved for use only within the last year; so some states and territories are still in the approval process). Three NNRTIs were FDA approved and only 1 state does not approve all 3. Thirty-three states have approved the use of the fusion inhibitor Fuzeon. There are 14 prophylaxis drugs approved for opportunistic infections, such as Hepatitis C and tuberculosis. All 14 are approved by 16 states. Only 15 states approve fewer than 10 drugs for opportunistic infections. Approval of other medications is more varied.

Like eligibility, for the most part coverage of medications is not as varied as it may first appear. Ultimately AIDS Action believes that medications must be standardized to achieve consistency among the states on behalf ADAP clients. Such standardization will aid in the goals of equity and portability. This leaves only the question of where to set the standard.

The development of drug resistant strains of HIV has been a particular problem in controlling the epidemic in the U.S. and is an additional factor in the use of medication. Clients on anti-retroviral therapy must adhere to their regimen at rates of up to 95% to reduce the viral load to undetectable levels and prevent the virus from becoming resistant. Unfortunately, the development of resistance to a particular class of anti-retrovirals generally means that resistance will be developed to all of the anti-retrovirals in that particular class of drugs.

Four states currently approve of an open formulary for all covered medications. Many of the medications on these formularies enable clients to fight side effects of HIV medications, substance abuse, depression and other mental health disorders, and other illnesses associated with HIV. These drugs help clients to adhere to HAART and to avoid resistance. As such, they play an important role in keeping HIV positive patients healthy (see Appendix B).

Recommendation #4b:
To ensure state consistency and enhance portability, ADAP must establish a baseline HIV/AIDS drug formulary which will allow individuals to move between states. The best option therefore is an open formulary, since it will include all of the medications required to treat HIV infection. Such a formulary must include all FDA-approved anti-retroviral therapeutics, all FDA-approved prophylaxes and therapeutics for opportunistic infections, all medications to treat side effects and major psychiatric disorders associated with HIV. Such a baseline formulary has the advantage of correlating state programs and aiding portability. Furthermore, it will allow individuals living with HIV more treatment options and efficacy.

Currently 50 of 57 state and territorial ADAPs participate in the 340B drug discount program. Discounted prices vary tremendously from state to state, frequently depending on factors outside of the state's control. States may attempt to reduce costs further by seeking rebates from manufacturers. These discount and rebate programs are burdensome to both the states and the pharmaceutical companies. They often require additional staff time for both the government and the manufacturers, which results in additional administrative costs and other expenditures of scarce resources. Given the volume of purchases nationwide, it may be possible to achieve better prices than those of either the 340B or rebate programs by accessing the discounts provided to the Veteran's Administration, Department of Defense, Public Health Service and the Coast Guard under the federal ceiling price (FCP).

Recommendation #4c:
AIDS Action recommends that states and territories discontinue burdensome rebate programs. Given the relative expense of HIV drugs and the large number of individuals served under the state ADAPs, AIDS Action recommends that the CARE Act ensure that state ADAPs are able to purchase drugs at the lowest possible federal price. If necessary, AIDS Action recommends that purchase should be negotiated through a single federal agency (most likely the Public Health Service) at the Federal Ceiling Price (FCP).

5. Ensuring the Continuing Strength of State and Territorial Managed ADAP Programs

It is important to note that AIDS Action is in support of continued state management of ADAPs. The recommendations made are aimed at strengthening state programs by creating a platform for federal funding to ensure state consistency and portability. The recommendations are also intended to help strengthen each state's ability to ensure that individuals who have been tested and are aware of their HIV positive status, but are not in care are connected to appropriate and regular medical and supportive services so as to ensure access to medications. Although we have added state reporting requirements, these should not be burdensome and are necessary in order to assure Congress that funds are being spent efficiently and that ADAPs are contributing to successful treatment outcomes.

AIDS Action acknowledges state efforts to ensure quality medication for their citizens. Many states contribute to their respective ADAPs. For example New Mexico contributed 62% of the state ADAP budget in 2002-03, the last year for which statistics have been compiled. California makes the highest dollar contribution of any single-state at $65.4 million, which was 40% of the California ADAP budget in the same year (see Appendix D).

This program proposal offers recommendations to streamline and modernize ADAP. However, there will also be a need to ensure that states continue to fund their own ADAPs. AIDS Action therefore recommends that incentives be created for states that contribute to their respective ADAPs.

Recommendation #5a:
States must be encouraged to exceed the minimum eligibility and formulary standards set out in the CARE Act. For the proposed ADAP streamlining and modernization program to succeed, states currently contributing to ADAPs must continue to contribute, and other states are encouraged to contribute. AIDS Action recommends creating incentives for state contributions. Part of the proposed new funding should be set aside as a match in some form for states that contribute to ADAP. In order to be of greatest use, the state match should be flexible, allowing states to move the match to ADAP-related services, but it should not require states to place the funds directly into ADAP. State contributions and matches may be used flexibly for publicly funded HIV health care programs – e.g. funds might be used to improve access to public health system programs responding to HIV.

Recommendation #5b:
AIDS Action feels strongly that states must be required to ensure or have open enrollment and to eliminate waiting lists, lotteries, and other limits on ADAP eligibility. States must allow individuals who are eligible for ADAP Services to receive these services.

State Flexibility and Reporting

Finally, AIDS Action acknowledges that states will continue to operate under difficult financial conditions. The proposed infusion of federal funding should allow for greater flexibility to fund services in addition to medications. Such funding will also allow opportunities for Congress, the states, patients, and caregivers to achieve a better understanding of the HIV epidemic in their states, their region, and the country. The federal government has the ability to enhance ADAP merely by ensuring that state ADAPs are highlighted and scrutinized at both the state and national level. Consequently, the following recommendations are made in the spirit of expanding state ability to target funding to the areas which most need it and to ensuring the ability to measure success in treating HIV.

Recommendation #5c:
States that have the legal ability to purchase insurance policies with ADAP funds are encouraged to do so, provided they meet the eligibility criteria created by the CARE Act. States with laws prohibiting purchase of insurance policies with state or federal funds are encouraged to consider creating an exception for ADAP.

Recommendation #5d:
States may use a percentage of ADAP funds to create flexible ways to expand treatment and medical support services to ensure adherence and full program participation. States must be allowed to use ADAP funds flexibly to permit not only the provision of medications but also the provision of a mixture of treatment and care, laboratory work, insurance payments, follow-up care, monitoring, and counseling..

Recommendation #5e:
A small part of the increase should be set aside to provide technical assistance to states to ensure that they meet eligibility and formulary requirements.

Recommendation #5f:
States shall be required to submit a statewide plan for the coordination of medical, medical support, and therapeutic services with ADAP.

Recommendation #5g:
The Secretary of Health and Human Services shall issue guidelines providing his/her recommendations for ADAP therapeutics which should be included in the formularies that are maintained by the states for purposes of this section.

Recommendation #5h:
The Secretary of Health and Human Services shall submit to the Congress a report each fiscal year that specifies the amount the Secretary expects to obligate during such year for the purpose of sponsoring conferences or seminars regarding matters within the jurisdiction of the Public Health Service, and the amount that the Secretary obligated for such purpose during the preceding fiscal year.

The report shall include for each state:
1. The number of patients who have requested therapeutics described in sub-section (a) from the program as carried out in the state, but are on a waiting list because such program does not have the capacity to serve the patients.
2. The sources from which the patients are obtaining the therapeutics, if the patients on the waiting list are receiving such therapeutics.
3. The estimated cost to provide the amount of therapeutics that would be necessary to serve all patients on the waiting list and thereby eliminate the wait in the state.
4. Information regarding the actions being taken by states with such waiting lists to reduce the number of patients on the lists, including any restrictions imposed by such states on the number or quantity of therapeutics made available under the program.
5. Each source of funds that, in addition to funds under this part, is used by the State to provide therapeutics under the program.
6. A listing of each State whose formulary does not meet the recommendations of the Secretary.
7. A listing of any other cost cutting or cost containment measures in place with regards to ADAP.

Recommendation #5i:
States must collect aggregate data on health status of state ADAP clients. Data reports should be collected by HRSA every 6 months. HRSA shall report these data to Congress on an annual basis. Outcome data gathered must show Congress how states are doing with their ADAPs. At a minimum, such data should include CD4 counts, viral load and the results of resistance testing, and analysis that can be compared between states about the effect of ADAP on these statistics. States should also report information about Hepatitis C, Tuberculosis, and other co-infections.

In Conclusion

Ultimately, this discussion of ADAP is not solely about ensuring that people living with HIV have access to effective drug therapy. In fact, it encompasses all the principles enunciated at the beginning of the document. Proper implementation of ADAP will recommit the government and the HIV community to ensuring that everyone who becomes aware of their HIV positive status is connected to medical and supportive care either directly through the CARE Act, the payer of last resort, or through another system for which the person is eligible.

It is important to remember that this statement is specifically intended to streamline and modernize ADAP while maintaining appropriate standards of care, minimizing destabilization, and increasing equity. In order to ensure that these goals are met, other titles within the CARE Act must continue to be fully funded to ensure that the existing system is not destabilized.

With two decades of HIV experience and the passage of nearly 10 years since the advent of HAART, ADAP is one of the most successful programs in the Ryan White CARE Act portfolio. In substantial part because of ADAP, people infected with HIV are living longer lives. However, when coupled with new infections, there has been a tremendous increase in the number of people who are living with HIV and require medications, creating a rising cost for ADAPs throughout the U.S. Consequently, the very success of ADAP threatens to undermine the United States' ability to provide medications to those who desperately need them. Moreover, the pressures on ADAP are likely to become even greater with the advent of CDC and HRSA programs whose objective is to move individuals who are not currently in care into the health care system. AIDS Action believes that this crisis can be stemmed by streamlining and modernizing the ADAP.

The streamlining and modernization of ADAP will allow individuals who are aware of their HIV positive status to access treatment and the medications that they need, and it will also allow the United States to begin to achieve a higher standard of care, greater equity between states and regions in the delivery of care, stability for patients and health care providers, portability and the ability to move between states, and greater understanding of the epidemic—all at a reasonable cost. Ultimately, it will allow Congress to monitor more closely the epidemic in the United States and to begin to change the course of the epidemic through care, support, and lifesaving medications.

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[i] HIV Prevalence in the United States, 2000, P. L. Fleming, R. H. Byers, P. A. Sweeney, D. Daniels, J. M. Karon, and R. S. Janssen *CDC, Atlanta, GA.* Note: These numbers may be even higher than reported here since the reflect data reported in 2000.

[ii] This report does not include information on American Samoa, Guam, Marshall Islands which did not report data.

APPENDIX A

Related AIDS Action Policy Agendas

Streamlining and Modernizing the AIDS Drug Assistance Program (ADAP) of the Ryan White CARE Act

AIDS Action's Recommendations

For two decades of public policy advocacy, AIDS Action and the HIV community have dedicated themselves to keeping the crucial issues visible to policy makers in the administration, on Capitol Hill, and to all people living in the United States. To address this nation's epidemic, AIDS Action Council, with its Public Policy Committee and Board of Directors, has adopted a policy agenda that addresses the true needs around care, treatment, prevention, and research.

The following three policy agenda statements are excerpts from AIDS Action's *National Policy Agenda 2004-2006*. They relate to the provision of medications to people living with HIV and to the AIDS Drug Assistance Program (ADAP). The full policy agenda can be found at www.aidsaction.org.

Support and Improvement of the Ryan White CARE Act

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act is the largest source of federal funding solely focused on domestic HIV care, treatment, and medical support services. Adopted by Congress in 1990, it is reauthorized every five years and funded through annual appropriations. Congress must reauthorize the CARE Act by September 30, 2005, when the current authorization is scheduled to expire. The CARE Act has been successful in providing medical care and support services to people living with HIV who are uninsured or underinsured. In fact, the CARE Act has become the foundation of service delivery for HIV care in the United States.

Since the first authorization of the CARE Act, and through the ensuing rapid development of its programs, AIDS Action Council has expressed concerns about gaps in service delivery, large populations not linked to medical care, and insufficient funding. The CARE Act must modernize and streamline its services to ensure that the current public health infrastructure is meeting the needs of people living with HIV. AIDS Action Council seeks to ensure the stability of funding for the Ryan White CARE Act, avoid the destabilization of existing HIV systems of care, ensure the fair distribution of resources, and address the "unmet need" of this epidemic which, as defined by Congress in 2000, means connecting HIV positive individuals not currently in care to appropriate health care systems. AIDS Action Council will work with its members, Congress, the Administration, and coalition partners to support the reauthorization, expansion, and full funding of the Ryan White CARE Act.

Access to HIV related medications and treatment options

Current treatment for HIV infection is based on the utilization of anti-retroviral therapies and other medications to treat opportunistic infections. Access to these medications must be assured for all HIV positive people to improve overall health outcomes and quality of life. While certain private insurance programs cover HIV related medications, many people living with HIV are uninsured or underinsured; thus severe limitations exist in accessing life-prolonging medications. To establish an emergency safety net providing access to medications, the federal government created the AIDS Drug Assistance Program (ADAP) under the Ryan White CARE Act and, under Medicaid, allows states to provide optional prescription drug benefits. Additionally,

Congress has authorized a new Medicare prescription drug benefit which will be implemented in 2006. Nevertheless, ADAP is facing a budget crisis, Medicaid requires an AIDS defining diagnosis before access can be granted, and it is still unclear whether the new Medicare benefit will offer adequate drug coverage to beneficiaries living with HIV.

AIDS Action Council seeks to ensure that each of these systems works toward regional and state consistency, enhanced standards of care, portability, and the adoption of a consistent drug formulary with increased availability of its medications. The drug formulary must, at a minimum, contain all FDA-approved antiretroviral therapeutics, all FDA-approved prophylaxes and therapeutics for opportunistic infections (such as Hepatitis C and tuberculosis), and all medications to treat side effects, mental health and alcohol and other drug disorders associated with HIV. AIDS Action Council will work with its members, Congress, the Administration, coalition partners, and the private sector to support access to life saving medication for all people living with HIV.

Support for HIV Science and Research

Since the beginning of the HIV epidemic over twenty years ago, the United States has been a leader in support for HIV related science and research. Scientists at the National Institutes of Health (NIH) and other federally funded research sites have been responsible for countless lifesaving breakthroughs that have enabled people living with HIV to live longer, healthier, and more satisfying lives. In addition, HIV research has led to breakthroughs in the care and treatment of other life-threatening medical conditions.

Unfortunately, as knowledge about the HIV virus has grown, so has the need for further study. Today, there are 26 anti-retroviral drugs approved for the treatment of HIV by the U.S. Food and Drug Administration (FDA); however, the growing challenges of drug resistance and debilitating side effects have meant that people living with HIV are severely limited in their choice of medications. Therefore it is critical that researchers continue to develop new treatment options.

Increased understanding about the nature of the virus has also led to a growing understanding of the importance of preventing HIV infection. HIV vaccine research and clinical trials have not yet led to the development of a vaccine, but they *have* increased the HIV knowledge base and must therefore continue. Research into the development and use of a possible microbicide is vital in an era where half of all new infections are occurring in women, while behavioral research is helping scientists to develop interventions that will better equip individuals to avoid infection. In order to be most effective, clinical trials (for vaccines, microbicides, and new treatments and therapies) must include a representative sample of those who are currently most impacted by HIV, including women and people of color.

Finally, HIV related research must be based in sound science—and its objectivity must be protected from political ideology. AIDS Action Council will work with its members, Congress, the administration, coalition partners, and the private sector to support the continuation and expansion of sound HIV science and research.

APPENDIX B

Current State Formularies

Current State Formularies

US States & Territories	Total Number of Drugs on Formulary	NRTIs (10 drugs approved)	PIs (8 drugs approved)	Non-nucleosides (3 drugs approved)	Fusion Inhibitors (1 drug approved)	OI Prophylaxis (14 drugs recommended)	Other Covered Medications
Alabama	31	9	8	3	0	7	3
Alaska	63	10	7	3	0	14	29
American Samoa	NR	NR	NR	NR	NR	NR	NR
Arizona	33	10	8	3	1	6	5
Arkansas	45	10	8	3	1	11	12
California	148	10	8	3	1	14	112
Colorado	18	9	6	3	0	0	0
Connecticut	181	10	7	3	1	13	147
Delaware	222	9	8	3	1	14	187
District of Columbia	67	9	7	3	1	11	36
Florida	58	10	8	3	1	8	28
Georgia	50	10	7	3	0	11	19
Guam	NR	NR	NR	NR	NR	NR	NR
Hawaii	89	10	8	3	0	14	54
Idaho	38	10	8	3	0	14	3
Illinois	71	10	8	3	1	13	36
Indiana	76	10	8	3	0	9	46
Iowa	36	10	8	3	1	6	8
Kansas	50	10	8	3	1	7	21
Kentucky	48	10	8	3	0	9	18
Louisiana	22	10	8	3	1	0	0
Maine	42	10	8	3	1	14	6
Marshall Islands	NR	NR	NR	NR	NR	NR	NR
Maryland	100	9	8	3	1	14	65
Massachusetts	open formulary	10	8	3	1	14	open formulary
Michigan	174	10	7	3	1	13	140
Minnesota	123	10	7	3	1	11	91
Mississippi	47	10	8	2	1	10	16
Missouri	275	10	8	3	1	12	241
Montana	134	10	8	3	0	11	102
Nebraska	27	10	8	3	0	2	4
Nevada	58	10	8	3	0	10	27
New Hampshire	open formulary	10	8	3	0	14	open formulary
New Jersey	open formulary	10	8	3	1	14	open formulary
New Mexico	98	10	8	3	0	12	65
New York	474	10	8	3	1	13	439
North Carolina	55	10	8	3	1	11	22
North Dakota	87	9	7	3	0	13	55
N. Mariana Islands	open formulary	10	7	3	0	14	open formulary
Ohio	74	10	8	3	1	11	41
Oklahoma	48	10	8	3	0	14	13
Oregon	59	10	8	3	1	14	23
Pennsylvania	75	10	8	3	1	14	39
Puerto Rico	118	10	7	3	1	13	84
Rhode Island	63	10	7	3	1	11	31
South Carolina	51	10	8	3	1	10	19
South Dakota	42	10	0	3	0	9	20
Tennessee	81	10	8	3	1	9	50
Texas	39	10	8	3	0	7	11
Utah	40	10	8	3	1	14	4
Vermont	77	10	8	3	1	12	43
Virgin Islands	34	8	7	3	0	5	11
Virginia	61	10	8	3	1	14	25
Washington	148	10	8	3	1	11	115
West Virginia	31	10	8	3	0	5	5
Wisconsin	53	10	8	3	1	12	19
Wyoming	59	10	8	3	0	14	24

LEGEND

Numbers highlighted in gray show states and territories that have approved fewer than the recommended drugs approved by the FDA or recommended by the Public Health Service Guidelines for each class of drug.

NR = information was not recorded

Data from:
National ADAP Monitoring Project Annual Report; Danielle Davis, Chris Aldridge, Murray Penner, Jennifer Kates, Lei Chou, May 2004 pp. 11-12.

Anti-Retroviral Medications

Human Immunodeficiency Virus (HIV) infects the white blood cells (CD4 cells, also called T-Cells) in the body's immune system and uses them to make new copies of HIV. This process eventually kills the CD4 cells and weakens the immune system, making it hard to fight off infections. Consequently, HIV treatment seeks, in part, to suppress HIV viral load and restore and preserve immunological system functioning.

There are currently four classes of anti-retroviral drugs approved by the Food and Drug Administration (FDA) to treat HIV. Each of the anti-retrovirals prevent (or "inhibit") a critical stage in the life cycle of HIV. Consequently each of the anti-retrovirals is referred to as an inhibitor. The FDA approved anti-retrovirals (Note: drugs are listed by generic name with brand names in paranthesis) include:

- **Protease Inhibitors - 8 drugs approved.** PIs block (e.g. "inhibit") the development of the protease enzyme in HIV preventing the development of mature HIV cells.
  - amprenavir (Agenerase)*
  - indinavir (Crixivan)
  - saquinavir (Fortovase or Invirase)
  - lopinavir/ritonavir (Kaletra)
  - fosamprenavir (Lexiva)
  - ritonavir (Norvir)
  - atazanavir (Reyataz)
  - nelfinavir (Viracept)

- **Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs) - 10 drugs approved.** NRTIs use faulty building blocks (nucleotides) to prevent HIV from copying the HIV genetic code (DNA). When the T-Cell uses these faulty building blocks, the new HIV DNA cannot be built correctly and HIV cannot reproduce.
  - Abacavir (Ziagen)
  - abacavir + zidovudine + lamivudine (Trizivir)
  - didanosine (ddI, VIDEX VIDEX EC)
  - emtricitabine (Emtriva)
  - lamivudine (Epivir, 3TC)
  - zidovudine + lamivudine (Combivir)
  - stavudine (d4T Zerit)
  - tenofovir (Viread)
  - zalcitabine (ddC, Hivid)
  - zidovudine (AZT, Retrovir)

- **Non-nucleoside reverse transcriptase inhibitors (NNRTIs) - 3 drugs approved.** NNRTIs attach themselves to a critical enzyme (reverse transcriptase) in a T-Cell which prevents the enzyme from converting RNA to DNA. In turn, HIV's genetic material cannot be incorporated into the healthy genetic material of the cell, and prevents the cell from producing new virus.
    - delavirdine (Rescriptor)
    - efavirenz (Sustiva)
    - nevirapine (Viramune)

- **Fusion Inhibitors - 1 drug approved.** Fusion inhibitors are a new class of drugs which prevent the virus from fusing with the inside of a cell and stop its replication.
    - enfuvirtide (Fuzeon)

The most effective treatment of HIV, Highly Active Anti-Retroviral Therapy (HAART) consists of combining different anti-retrovirals. The success of therapy is highly dependent on the ability to adhere to the therapeutic regimen. Studies have indicated that 95% adherence is generally required to decrease a viral load to an undetectable level. Adherence may depend on a number of factors including dosing requirements, how often one must take a drug, whether the drug must be taken with a meal to achieve absorption, whether certain foods must be avoided, side effects and toxicity. Additionally ability to adhere may depend on educating the client about the regimen and other factors such as work, transportation, mental illness and substance abuse. Failure to adhere may lead to resistance not only to an individual drug but to an entire class. Consequently, having broad availability of drugs to allow matching patients with specific drug regimens is desirable not only to increase treatment options but also to help find a treatment regimen that fosters better adherence.

Given the importance of anti-retrovirals in treating HIV, AIDS Action recommends that all states maintain access to all 22 available anti-retrovirals. The current status of the provision of anti-retroviral drugs by state ADAPs is:

- Currently 38 states and territories approve all 8 Protease Inhibitors. 11 Additional states and territories provide 7 protease inhibitors. Colorado approves 6 PIs while South Dakota currently does not approve any PIs. All states and territories that approve of less than all 8 PIs are highlighted on the chart in gray. There is no information available from 3 territories.

- Currently 47 states and territories approve all 10 NRTIs. Six additional states approve the use of 9 NRTIs and the Virgin Islands approves 8. All states and territories that approve of less than all 8 PIs are highlighted on the chart in gray. There is no information available from 3 territories.

- Currently 53 states and territories approve all 3 NNRTIs. The only state that does not approve all 3 NRTIs is Mississippi which approves 2 (and is marked in gray). There is no information available from 3 territories.

- Currently 33 states approve the use of Fuzeon, the only fusion inhibitor (and which was fully approved for use by the FDA on October 15, 2004 after originally being approved under expedited rules on March 13, 2003). The states that do not approve the use of Fuzeon are marked in gray. There is no information available from 3 territories.

Medications for Opportunistic Infections

As noted above, HIV weakens the immune system making it less able to fight off infection. The resulting infections which usually don't cause disease in people with normal immune systems but affect people with damaged immune systems, including people with HIV are called opportunistic infections (OIs). The U.S. Department of Health and Human Services (DHHS) issues guidelines for the medical management of 19 opportunistic infections (OIs) such as Hepatitis C, Pneumocystis Pneumonia and Tuberculosis. The guidelines can be found at http://www.aidsinfo.nih.gov/guidelines/. The guidelines list 14 drugs that can be used for prophylaxis (prevention of) opportunistic infections

- **Opportunistic Infections - 14 drugs recommended.**
  - acyclovir (Zovirax)
  - azithromycin (Zithromax)
  - cidofovir (Vistide)
  - clarithromycin (Biaxin)
  - famciclovir (Famvir)
  - fluconazole (Diflucan)
  - foscarnet (Foscavir)
  - ganciclovir (Cytovene)
  - isoniazid (INH)
  - itraconazole (Sporonox)
  - leucovorin (Wellcovorin)
  - pyrimethamine (Daraprim)
  - sulfadiazine (Microsulfon)
  - TMP/SMX (Bactrim, Septra)

AIDS Action recommends that every state approve all 14 drugs for opportunistic infections. Currently 16 states and territories approve all 14 drugs for opportunistic infections. Only 15 states or territories provide fewer than 10 drugs for opportunistic infections. The states that do not approve all 14 drugs for OIs are marked in gray. There is no information available from 3 territories.

Additional Medications

Finally, states maintain other drugs on their formularies to treat (as opposed to prevent) opportunistic infections and to enable clients to fight side effects of HIV medications, substance abuse, depression and other mental health disorders, and other illnesses associated with HIV. These drugs help clients to adhere to HAART and to avoid resistance. Given the importance of these drugs, AIDS Action recommends that every state maintain an open formulary of drugs in addition to the 22 recommended anti-retroviral medications and 14 opportunistic infection prophylaxis.

Four states and territories currently approve of an open formulary for all covered medications. Those states and territories are: **Massachusetts, New Hampshire, New Jersey and the Northern Mariana Islands.**

APPENDIX C

Current Medical and Financial Eligibility Criteria by State

Current Medical and Financial Eligibility Criteria by State

US States & Territories	ADAP %FPL	ADAP Medical Elig.
Alabama	250%	
Alaska	300%	
American Samoa	NR	NR
Arizona	300%	
Arkansas	300%	CD4<350 or VL>55,000
California	400%	
Colorado	300%	
Connecticut	400%	
Delaware	500% (sliding)	
District of Columbia	400%	
Florida	350%	
Georgia	300%	CD4<500 or VL>20,000
Guam	NR	NR
Hawaii	400%	
Idaho	200%	
Illinois	400%	
Indiana	300%	
Iowa	200%	
Kansas	300%	
Kentucky	300%	
Louisiana	200%	
Maine	300%	
Marshall Islands	NR	NR
Maryland	400%	
Massachusetts	<$50,000 gross income	
Michigan	450%	
Minnesota	300%	
Mississippi	400%	
Missouri	300%	
Montana	330%	
Nebraska	200%	
Nevada	400%	
New Hampshire	300%	
New Jersey	500%	
New Mexico	300%	
New York	<$44,000 gross annual income	
North Carolina	125%	
North Dakota	400%	
N. Mariana Islands	NR	
Ohio	500%	
Oklahoma	200%	
Oregon	200%	
Pennsylvania	<$30,000 gross annual income	
Puerto Rico	certified as indigent	CD4<350 or VL>10,000
Rhode Island	400%	
South Carolina	300%	
South Dakota	300%	
Tennessee	300%	
Texas	200%	
Utah	200%	
Vermont	200%	
Virgin Islands	220%	
Virginia	300%/330% in Northern VA	CD4<500
Washington	300%	
West Virginia	250%	
Wisconsin	300%	
Wyoming	200%	

LEGEND
Numbers highlighted in gray show states and territories that have with financial eligibity requirements lower than 300% of Federal Poverty Level (FPL) and the 4 states and territories which report that they have medical eligibility requirements. NR = in
Data from: **National ADAP Monitoring Project Annual Report; Danielle Davis, Chris Aldridge, Murray Penner, Jennifer Kates, Lei Chou, May 2004 pp. 11-12.**

AIDS Action has recommended increasing portability across states by creating a standard minimum eligibility for each state ADAP at 350% of the federal poverty level (FPL). The 2003 FPL for a single person was $8,890. 350% is $31,115. It is important to remember that the cost of therapy for other drug regimens may range between $12,000 and $20,000 for a full year. AIDS Action recommends that states should be allowed to exceed 350% of FPL. This recommendation merely sets a floor to enhance ADAP portability.

Most states and territories already set a standard eligibility at or near 300% of the FPL. Thirty-eight state programs allow enrollment in ADAP for individuals at or above 300% of federal poverty level. These 38 programs provide medications for 81.6% of all current ADAP clients. Consequently, it should be possible to

set a minimal level of eligibility criteria without great expense (see appendix D for numbers of clients served). Only 14 states or territories set the eligibility standard at less than 300%. They are shown in the chart in gray.

There are four states that set medical eligibility criteria in addition to financial eligibility. Those states are:

Arkansas – requires a CD4 count of less than 350 or a viral load of more than 55,000.

Georgia – requires a CD4 count of less than 500 and a viral load of more than 20,000.
Puerto Rico– requires a CD4 count of less than 350 or a viral load of more than 10,000.
Virginia – requires a CD4 count of less than 500

AIDS Action would not set medical eligibility criteria in addition to financial eligibility but would require the states to measure and report these criteria to Congress to ensure so that Congress can better oversee the success of the ADAP program.

APPENDIX D

Current State ADAP Budgets
State Contribution (percent)
Clients Served

Current State ADAP Budgets; State Contribution (Percent) and Clients Served

US States & Territories	FY 2003 Budget	% State Contrib.	ADAP Clients Served (June 2003)
Alabama	$10,886,687	26%	983
Alaska	$510,000	17%	28
American Samoa	NR	NR	NR
Arizona	$8,861,540	11%	720
Arkansas	$3,033,102	0%	350
California	$163,400,968	40%	16,275
Colorado	$7,998,807	14%	805
Connecticut	$11,542,965	5%	1,080
Delaware	$3,024,220	0%	198
District of Columbia	$12,960,419	3%	906
Florida	$89,029,606	10%	10,175
Georgia	$38,849,590	29%	3,646
Guam	NR	NR	NR
Hawaii	$2,370,060	19%	181
Idaho	$1,819,978	10%	90
Illinois	$32,017,427	22%	2,899
Indiana	$6,537,890	0%	45
Iowa	$1,410,664	0%	173
Kansas	$2,612,500	15%	338
Kentucky	$4,972,909	2%	467
Louisiana	$14,476,538	0%	1,748
Maine	$851,284	7%	50
Marshall Islands	NR	NR	NR
Maryland	$32,595,491	2%	1,617
Massachusetts	$15,271,659	5%	864
Michigan	$10,399,536	0%	837
Minnesota	$4,307,008	23%	484
Mississippi	$11,211,639	7%	565
Missouri	$9,926,294	7%	1,137
Montana	$475,000	0%	50
Nebraska	$1,426,608	11%	154
Nevada	$5,850,858	23%	525
New Hampshire	$2,283,901	0%	174
New Jersey	$42,153,028	0%	3,625
New Mexico	$5,352,144	62%	327
New York	$158,417,414	13%	12,331
North Carolina	$21,982,694	38%	1,898
North Dakota	$186,733	0%	21
N. Mariana Islands	$24,627	0%	1
Ohio	$13,116,779	20%	1,941
Oklahoma	$5,404,819	15%	504
Oregon	$4,497,032	9%	755
Pennsylvania	$35,057,292	27%	2,478
Puerto Rico	$29,548,500	7%	2,032
Rhode Island	$1,830,041	0%	260
South Carolina	$14,196,097	4%	1,266
South Dakota	$285,504	0%	29
Tennessee	$9,927,566	0%	356
Texas	$66,539,023	17%	7,007
Utah	$2,345,455	0%	173
Vermont	$556,740	31%	63
Virgin Islands	$693,155	0%	65
Virginia	$18,295,670	14%	1,571
Washington	$13,720,854	36%	1,026
West Virginia	$1,769,316	8%	160
Wisconsin	$4,267,940	2%	354
Wyoming	$300,000	42%	18

AIDS Action takes the position that States must be encouraged to contribute to state ADAPs. Currently 25 states and territories are contributing 10% or more of the total funds in their state ADAP. These states and territories are marked in gray (there is no information available for 3 territories). This is a significant contribution. AIDS Action proposes that incentives be created to maintain, begin or increase contributions by the state.

LEGEND

Numbers highlighted in gray show states and territories which contribute 10% or more of the total funding to their state or territorial ADAP program

NR = information was not recorded

Data from:
National ADAP Monitoring Project Annual Report; Danielle Davis, Chris Aldridge, Murray Penner, Jennifer Kates, Lei Chou, May 2004 pp. 11-12.

Notes

until it's over

AIDS ACTION