

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

## *Summary of Recommendations:*

### **1. Structure of the Program**

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***Recommendation #1:** The AIDS Drug Assistance Program (ADAP) must continue to be a state program, fully funded. It should be removed from Title II and placed into a new, separate Title V.*

### **2. Managed Growth**

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***Recommendation#2:** Regional and state consistency, portability, and a consistent drug formulary should be funded through a program of managed growth. To achieve these goals will require \$1.5 billion in FY 2006 and increasing the base by \$100 million each year to \$2.0 billion in 2011, the fiscal year after the next reauthorization. This proposal should be implemented only if sufficient funds are appropriated.*

### **3. Enhancing Access to Medications and Creating Portability**

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#### **Standards of Care**

***Recommendation #3a:** Create a panel of doctors, nurses, and pharmacists and HIV positive patients to ensure standardization of care, using the U.S. Department of Health and Human Services' Public Health Service HIV/AIDS Clinical Practice Guidelines for the Use of AIDS Drugs.*

***Recommendation#3b:** Ensure consistency between formulary guidelines and Medicaid guidelines. The Center for Medicaid Services (CMS), the Health Resources Services Administration (HRSA), and other relevant individuals, agencies, and organizations should create an ongoing structure to ensure coordination and consistency.*

***Recommendation #3c:** The Secretary of Health and Human Services must report to Congress about the integration of state and national standards of care and consistency of Medicaid and ADAP formulary guidelines by 2008.*

## Portability

**Recommendation #3d:** ADAP should enhance portability among state programs by ensuring client eligibility for ADAP in a new state within 30 days of arrival, transfer of new enrollee reimbursement to the new home state after 30 days, facilitation of record keeping, compliance, monitoring, program participation, and reimbursements via a bar-coded “ADAP participant card” and improvement of accountability and reporting in health outcomes, specifically including viral load, tolerability, and patient visits.

## 4. Ensuring Consistency in Formularies and Eligibility

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### Eligibility

**Recommendation #4a:** Set minimum eligibility requirement of 350% of federal poverty level for ADAP eligibility in all states and territories.

### Formularies

**Recommendation #4b:** Establish a baseline HIV/AIDS drug formulary to allow individuals to move between states. The 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. AIDS Action recommends use of an open formulary.

**Recommendation #4c:** States and territories should discontinue burdensome rebate programs. The CARE Act must ensure that state ADAPs are able to purchase drugs at the lowest possible federal price. If necessary purchase should be negotiated through a single federal agency at the Federal Ceiling Price (FCP).

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

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**Recommendation #5a:** AIDS Action recommends creating incentives for state contributions. Part of the proposed new funding should be set aside as a flexible state match for states that contribute to ADAP. States should be allowed to move matching funds to ADAP-related services.

**Recommendation #5b:** States must be required to ensure or have open enrollment and to eliminate waiting lists, lotteries, and other limits on ADAP eligibility.

### State Flexibility and Reporting

**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, including treatment and care, laboratory work, insurance payments, follow-up care, monitoring, and counseling.

**Recommendation #5e:** 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 should 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 recommendations for ADAP therapeutics which should be included in state formularies.

**Recommendation #5h:** The Secretary of Health and Human Services shall report to Congress expected obligations for the upcoming fiscal year and the amount obligated during the preceding fiscal year. The report shall include:

1. The number of patients who have requested therapeutics from the state ADAP program, but are on a waiting list because the program does not have the capacity to serve the patients.
2. The sources from which the patients are obtaining the therapeutics.
3. The estimated cost to provide the amount of therapeutics necessary to serve all patients and eliminate the waiting list in the state.
4. Information regarding the actions being taken by states to reduce the number of patients on waiting lists, including restrictions 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 report aggregate data on the health status of state ADAP clients to HRSA every 6 months. The report shall include for each patient CD4 counts, viral load, the results of resistance testing, information about Hepatitis C, Tuberculosis, and other co-infections and analysis that can be compared between states about the effect of ADAP on these statistics. HRSA shall report this data to Congress annually.