

**NATIONAL ADAP MONITORING PROJECT
ANNUAL REPORT
MODULE TWO SUPPLEMENT**

MAY 2011

Prepared by

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The National ADAP Monitoring Project is one component of NASTAD's National ADAP Monitoring and Technical Assistance Program which provides ongoing technical assistance to all state and territorial ADAPs. The program also serves as a resource center, providing timely information on the status of ADAPs, particularly those experiencing resource constraints or other challenges, to national coalitions and organizations, policy makers, industry members, and state and federal government agencies. NASTAD received support for the National ADAP Monitoring and Technical Assistance Program in 2010 from the following companies: Boehringer Ingelheim, Bristol-Myers Squibb, Gilead Sciences, Tibotec Therapeutics, and ViiV Healthcare. NASTAD also receives funding to provide technical assistance to ADAPs through a Training and Technical Assistance Cooperative Agreement with the Health Resources and Services Administration (HRSA).

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Glossary

MODULE TWO SUPPLEMENT: HIV/AIDS AND VIRAL HEPATITIS CO-INFECTION

Millions of Americans are at risk for hepatitis A virus (HAV), hepatitis B virus (HBV) and hepatitis C virus (HCV) infection and millions more are living with chronic viral hepatitis. In 2008 alone, there were an estimated 22,000 new HAV infections, 38,000 new HBV infections and 18,000 new HCV infections in the United States.ⁱ It is estimated that there are 1.4 million Americans living with chronic HBV and 3.9 million Americans living with chronic HCV. Due to the absence of a national chronic viral hepatitis surveillance system, it is believed that these estimates are much lower than the actual burden of disease. While both HAV and HBV are vaccine-preventable and there exist longstanding recommendations to vaccinate at-risk adults, coverage rates among adult populations such as gay/bisexual and other men who have sex with men (MSM), persons who inject drugs (IDU) and persons living with HIV remain low. These low vaccination rates are alarming as millions of Americans remain needlessly unvaccinated and susceptible to disease. Also alarming are statistics which indicate that up to one half of Americans infected with HBV are unaware of their status, and three quarters infected with HCV are unaware of their status.

It is estimated that up to 15 percent of people living with HIV are co-infected with HBV, and up to 30 percent are co-infected with HCV. Further, viral hepatitis is the leading cause of non-AIDS-related death in people co-infected with HIV and viral hepatitis.ⁱⁱ Co-infection increases the progression to liver disease and can occur without symptoms.

VIRAL HEPATITIS AND THE RYAN WHITE PROGRAM

Coverage of viral hepatitis services for persons living with HIV is allowable through the Ryan White Program and the AIDS Drug Assistance Program (ADAP). Some services (e.g., testing) are allowable through Ryan White clinical services and access to HAV/HBV vaccines and HBV/HCV drugs are allowable expenditures through ADAPs for co-infected individuals. Coverage varies across the country as states determine what services, vaccines and drugs are included on the ADAP formulary.

While it is important to assess, monitor and treat viral hepatitis in co-infected persons, not all states currently include HAV/HBV vaccine or HBV/HCV drugs on their ADAP formularies. Twenty-two states provide HAV/HBV vaccines, 25 states provide at least one medication for HBV and 22 states provide at least one medication for HCV. Equally important is the coverage of diagnostic testing to diagnose viral hepatitis infection and to monitor disease progression and treatment outcomes. Only seven states cover at least one type of viral hepatitis diagnostic service through ADAP.

WHY ALL STATES DO NOT COVER VIRAL HEPATITIS SERVICES

There are several reasons states may not include viral hepatitis vaccines and medications. Given state budget constraints and the current ADAP crisis, some jurisdictions have not provided viral hepatitis services and/or included HBV/HCV drugs on their formularies. In some jurisdictions, as a method of cost containment, viral hepatitis medications have been removed from the ADAP formulary. Finally, some states have not provided viral hepatitis services and medications because the demand from providers and persons living with HIV/AIDS has not warranted it.

For states with viral hepatitis services covered through the Ryan White Program and ADAPs, there has not been a substantial uptake in utilization of the HAV/HBV vaccine and HBV/HCV drugs. This is due to a number of factors, including a general lack of understanding of viral hepatitis among health care providers and persons at risk of co-infection. However, AIDS Education and Training Centers (AETCs) are working to educate HIV-treating clinicians about the importance of evaluating and treating co-infected patients.

Providers have also indicated that accessing the HAV/HBV vaccine through the ADAP pharmacy, as opposed to in the clinic, makes it difficult to deliver this important preventive vaccine.

It can be challenging for persons with underlying mental health or substance use issues to undergo HCV treatment, which often exacerbates existing mental health complications. Some clinicians are resistant to treat HCV in co-infected persons due to the need for increased case management and support for these patients. In addition, some clinicians and patients are monitoring HCV progression and waiting for new therapies to become available. New treatments present similar side effects that must be managed and will have to be added into the existing standard of care of HBV/HCV drugs.

VIRAL HEPATITIS RECOMMENDATIONS FOR PERSONS LIVING WITH HIVⁱⁱⁱ

The Centers for Disease Control and Prevention recommend that persons living with HIV should receive the following viral hepatitis services:

- Testing for hepatitis B
- Testing for hepatitis C
- Vaccination against hepatitis A
- Vaccination against hepatitis B (if susceptible)

FUTURE TREATMENT ADVANCES

There are many drugs undergoing development that, once approved, will improve current HBV and HCV therapies. The majority of development has focused on improving HCV treatment. Two new direct-acting antivirals (protease inhibitors) are in the immediate pipeline. The two new drugs, telaprevir (Vertex Pharmaceuticals) and boceprevir (Merck), are expected to significantly increase HCV cure rates from 40 percent to as high as 80 percent and decrease treatment duration from 48 weeks to 24 weeks.

Telaprevir and boceprevir are expected to become available in May 2011 for treatment of HCV mono-infection only. Approval of these treatments in co-infected persons is also expected at a later date. Given that the majority of drug development data focuses on mono-infection, data on drug safety, efficacy and tolerability, including drug resistance and drug interactions of new HCV drugs with current HIV drugs, is currently limited.

While telaprevir and boceprevir show great promise for persons living with mono- or co-infection of HCV, it is important to note that they must be used in combination with the current standard of care for HCV which includes pegylated interferon and ribavirin. ADAPs that choose to provide these new treatments, therefore, will need to continue to cover these existing therapies.

Even with the approval of these new medications, successful treatment of HCV will continue to be fairly complex. Drug effectiveness can be limited by a number of factors including the person's genetics, the type of genotype or subtype of HCV, drug contraindications and the potential for drug resistance. As well, new treatments must be closely managed to ensure adherence as they may present new side effects such as anemia, rash and depression that will be in addition to the side effects caused by medications in the current standard of care. While these new treatments hope to change the HCV treatment paradigm, new treatments will also likely pose new challenges.

For more information, please see the Treatment Action Group's 2011 [Hepatitis C Treatment Pipeline Report](#).

ⁱhttp://www.cdc.gov/ncidod/diseases/hepatitis/resource/PDFs/disease_burden.pdf

ⁱⁱRecommendations for Identification and Public Health Management of Persons with Chronic Hepatitis B Virus Infection. MMWR 2008; September 19, 2008; 57(RR-8) <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5708a1.htm>
http://www.cdc.gov/ncidod/diseases/hepatitis/resource/PDFs/disease_burden.pdf

ⁱⁱⁱ<http://www.cdc.gov/hepatitis/Populations/hiv.htm>

MODULE TWO SUPPLEMENT: DETAILED FINDINGS

AIDS Drug Assistance Programs (ADAPs) provide life-saving HIV treatments to low income, uninsured, and underinsured individuals living with HIV/AIDS in all 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, American Samoa, the Federated States of Micronesia, Guam, the Northern Mariana Islands, and the Republic of the Marshall Islands. In addition, some ADAPs provide insurance continuation and Medicare Part D wrap-around services to eligible individuals. ADAPs are a component of the federal Ryan White Part B program that provides necessary medical and support services to low income, uninsured, and underinsured individuals living with HIV/AIDS in all states, territories and associated jurisdictions.

The *Annual Report* of NASTAD's National ADAP Monitoring Project is based on a comprehensive survey of all ADAPs. This 16th release of the *Annual Report* updates prior findings with data from ADAP's fiscal year 2010ⁱ as well as provides a detailed snapshot of data from the month of June 2010 with updates in December 2010. This module of the *Annual Report* reflects the latest available data and discusses recent policy and programmatic changes affecting ADAPs.

To provide interested stakeholders with more timely information, NASTAD is releasing the 2011 National ADAP Monitoring Project *Annual Report* in several modules. Detailed information related to ADAP budgets, client enrollment and utilization, client demographics, program eligibility, and program management and administration was included in [Module One](#). This Module highlights hepatitis treatments while Module Two includes detailed information on updated client enrollment and utilization, expenditures and prescriptions filled, prescription distribution and payment methods, insurance coordination, ADAP coordination with Pre-existing Condition Insurance Plans (PCIPs), and ADAP coordination with Medicare Part D. These modules will then be combined into a final, comprehensive report.

A comprehensive survey was sent to all 57 jurisdictions that received federal ADAP earmark funding in FY2010; 52 responded (see Methodology). Most data included in this report are from December 2010, unless otherwise noted. The detailed findings from the survey are included below.

ADAP AND HEPATITIS B TREATMENT

Hepatitis B medications available on ADAP formularies include Adefovir Dipivoxil (Hepsera), Entecavir (Baraclude), Interferon Alfa-2b (Intron A), Lamivudine (Epivir-HBV, Zeffix, Heptodin), Peginterferon alfa-2a (Pegasys) and Telbivudine (Tyzeka, Sebivo).

- In December 2010, 25 ADAPs covered at least one of these medications for HBV on their formularies (see Chart 1 and Table 1).
- ADAPs filled 461 hepatitis B treatment prescriptions for 209 clients in December 2010. In FY2009, ADAPs filled 5,250 prescriptions (see Table 2).

ADAP AND HEPATITIS C TREATMENT AND DIAGNOSTICS

HCV is classified as an HIV-related opportunistic infection, due to the relatively high co-infection rate of HIV and HCV.ⁱⁱ Because there is no national funding source specifically for HCV treatment, most of the burden for treating co-infected patients has fallen on ADAPs and other Ryan White programs. Hepatitis C medications available on ADAP formularies include Interferon Alfa-2b (Intron A), Recombinant Interferon Alfa-2a (Roferon), Consensus Interferon (Infergen), Peginterferon Alfa-2a (Pegasys), Peginterferon Alfa-2b (PEG-Intron) and Recombinant Interferon Alfa-2a (Roferon) and Ribavirin.

- In December 2010, 23 ADAPs covered at least one of these medications for HCV on their formularies (see Chart 2 and Table 3), compared to 31 ADAPs in June 2009.
- ADAPs filled 228 hepatitis C treatment prescriptions for 144 clients in December 2010. In FY2009, ADAPs filled 2,336 prescriptions (see Table 4).
- Seven ADAPs reported providing coverage for hepatitis C diagnostics in December 2010 (see Table 5), including:
 - Seven ADAPs covered HCV screening.
 - Six ADAPs covered qualitative HCV RNA.
 - Six ADAPs covered quantitative viral load.
 - Six ADAPs covered HCV genotype.

ADAP AND HEPATITIS VACCINES

The hepatitis A and B vaccines are recommended for those at high risk for and living with HIV (see Chart 3 and Table 6).ⁱⁱⁱ

- Twenty-two ADAPs covered the hepatitis A and B combination vaccine in December 2010. Twenty-seven ADAPs covered this vaccine in June 2009.
- Twenty-one ADAPs covered the hepatitis A vaccine in December 2010. Twenty-six ADAPs covered this vaccine in June 2009.
- Twenty-one ADAPs covered the hepatitis B vaccine in December 2010. Twenty-six ADAPs covered this vaccine in June 2009.

KEY DATES IN THE HISTORY OF ADAPS

- 1987:** First antiretroviral (AZT, an NRTI) approved by the FDA; Federal government provides grants to states to help them purchase AZT, marking beginning of federally funded, state-administered “AZT Assistance Programs.”
- 1990:** ADAPs incorporated into Title II of the newly created Ryan White CARE Act.
- 1995:** First protease inhibitor approved by FDA, and the highly active antiretroviral therapy (HAART) era begins.
- 1996:** First reauthorization of CARE Act—federal ADAP earmark created; first non-nucleoside reverse transcriptase inhibitor (NNRTI) approved by FDA.
- 2000:** Second reauthorization of CARE Act. Changes for ADAPs include: allowance of insurance purchasing and maintenance; flexibility to provide other limited services (e.g., adherence support and outreach); and creation of ADAP supplemental grants program.
- 2003:** NASTAD’s ADAP Crisis Task Force formed to negotiate with pharmaceutical companies on pricing of antiretroviral medications; first fusion inhibitor approved by FDA.
- 2004:** President’s ADAP Initiative (PAI) announced, allocating \$20 million in one-time funding outside of the ADAP system to reduce ADAP waiting lists in 10 states.
- 2006:** Third reauthorization of the CARE Act, now called, “Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006” or the “Ryan White Program.” Changes for ADAP include: new formula for determining state awards, which incorporates living HIV and AIDS cases; new minimum formulary requirement; and changes in ADAP supplemental set-aside and eligibility.
- 2007:** New minimum formulary requirement effective July 1; first CCR5 antagonist and integrase inhibitor approved by FDA.
- 2009:** Fourth reauthorization of the Ryan White Program. The reauthorization was for four years and included several technical changes.
- 2010:** Patient Protection and Affordable Care Act (PPACA) signed into law. ADAP emergency funding announced, allocating \$25 million in funding to address ADAP waiting lists and cost-containment.

METHODOLOGY

Since 1996, NASTAD's National ADAP Monitoring Project has surveyed all jurisdictions receiving federal ADAP earmark funding through the Ryan White Program. In FY2010, 57 jurisdictions received earmark funding and were surveyed in September 2010; 52 responded (Vermont only provided FY2010 budget information). American Samoa, Federated States of Micronesia, Mississippi, and Northern Mariana Islands did not respond; these jurisdictions represent less than one percent of estimated living HIV and AIDS cases.

NASTAD surveyed all jurisdictions receiving federal ADAP earmark funding through the Ryan White Program to request supplemental and updated information in February 2011; 49 responded. American Samoa, District of Columbia, Federated States of Micronesia, Guam, Mississippi, New Hampshire, Northern Mariana Islands, and Oregon did not respond; these jurisdictions represent less than one percent of estimated living HIV and AIDS cases.

The annual and supplemental surveys request data and other program information for a one-month period (June or December), the current fiscal year, and for other periods as specified. After the survey is distributed, NASTAD conducts extensive follow-up to ensure completion by as many ADAPs as possible. Data used in this report are from June 2010, December 2010 and FY2010, unless otherwise noted.

All data reflect the status of ADAPs as reported by survey respondents. It is important to note that some program information may have changed between data collection and this report's release. Due to differences in data collection and availability across ADAPs, some are not able to respond to all survey questions. Where trend data are presented, only states that provided data in relevant periods are included. In some cases, ADAPs have provided revised program data from prior years and these revised data are incorporated where possible. Therefore, data from prior year reports may not be comparable for assessing trends. It is also important to note that data from a one-month snapshot may be subject to one-time only events or changes that could in turn appear to impact trends; these are noted where information is available. Data exceptions specific to a particular jurisdiction are provided in the notes section on relevant charts and tables.

CHARTS AND TABLES

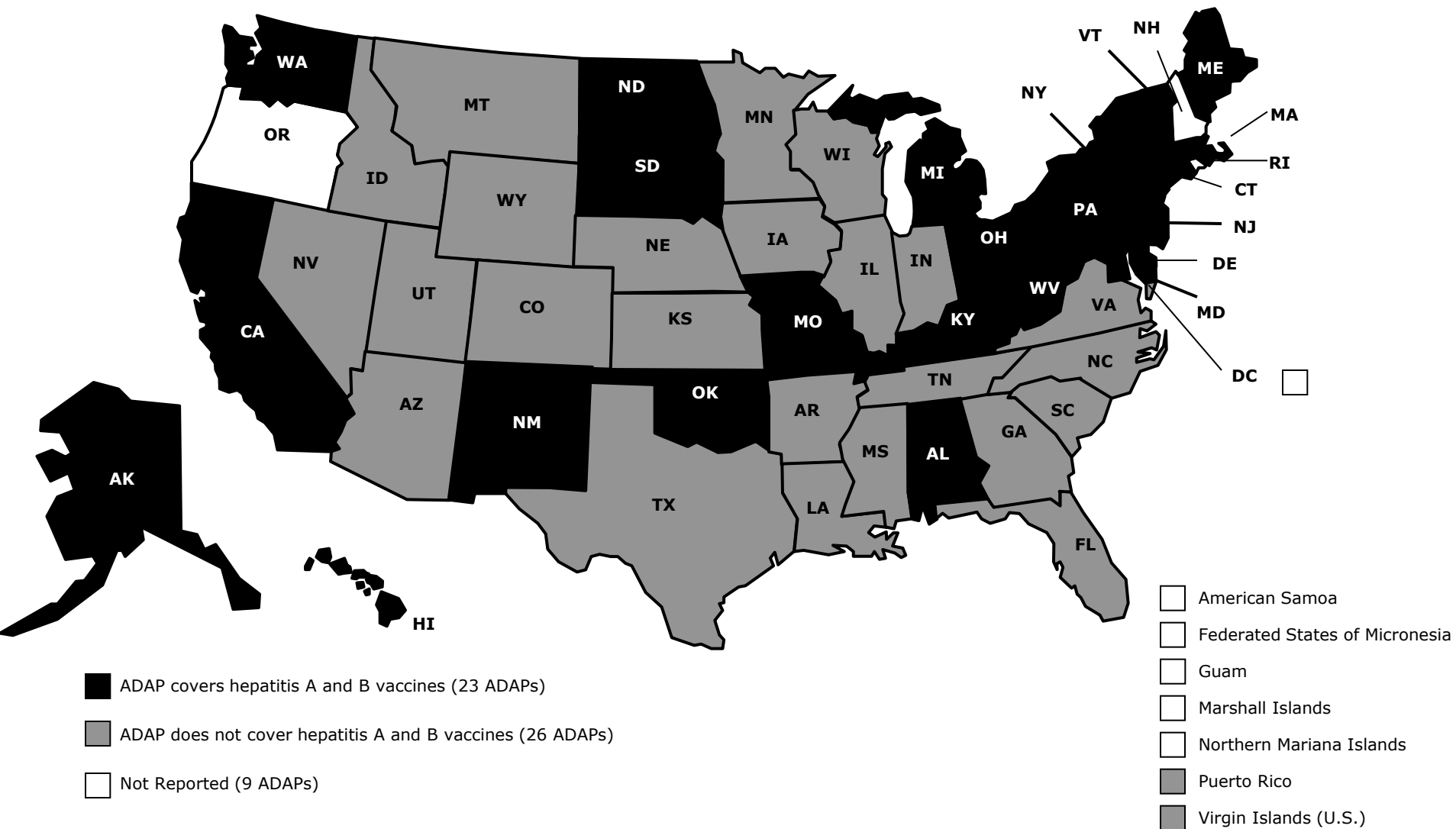
Charts for each major finding and tables, with data provided by state, are included in the full report.

ⁱ FY2010 refers to ADAP fiscal year 2010 and encompasses data from April 1, 2010 through March 31, 2011.

ⁱⁱ Centers for Disease Control and Prevention, "Frequently Asked Questions and Answers About Coinfection with HIV and Hepatitis C Virus." Available at http://www.cdc.gov/hiv/resources/qa/HIV-HCV_Coinfection.htm (accessed April 15, 2011).

ⁱⁱⁱ Centers for Disease Control and Prevention, "Sexually Transmitted Diseases Treatment Guidelines, 2006." *MMWR*, Vol. 55, September 2006.

Chart 3: ADAP Coverage of Hepatitis A and B Vaccine, December 2010



Note: 49 ADAPs reported data. American Samoa, District of Columbia, Federated States of Micronesia, Guam, Mississippi, New Hampshire, Northern Mariana Islands, and Oregon did not report data.

Table 1: ADAP Coverage of Hepatitis B Treatment, December 2010

State/Territory	Adefovir Dipivoxil (Hepsera)	Entecavir (Baraclude)	Interferon Alfa-2b (Intron A)	Lamivudine (Epivir-HBV, Zeffix, Heptodin)	Peginterferon alfa-2a (Pegasys)	Telbivudine (Tyzeka, Sebivo)
Alabama	Yes	--	Yes	Yes	Yes	--
Alaska	Yes	Yes	Yes	Yes	Yes	--
American Samoa	--	--	--	--	--	--
Arizona	--	--	--	--	--	--
Arkansas	--	--	--	--	--	--
California	--	--	Yes	--	Yes	--
Colorado	--	--	--	--	--	--
Connecticut	--	Yes	--	Yes	Yes	--
Delaware	--	Yes	Yes	Yes	Yes	--
District of Columbia	--	--	--	--	--	--
Federated States of Micronesia	--	--	--	--	--	--
Florida	--	--	--	--	--	--
Georgia	--	--	--	Yes	--	--
Guam	--	--	--	--	--	--
Hawaii	--	--	--	--	--	--
Idaho	--	--	--	--	--	--
Illinois	--	Yes	--	Yes	--	--
Indiana	Yes	Yes	Yes	Yes	Yes	Yes
Iowa	--	--	--	--	Yes	--
Kansas	--	--	--	--	--	--
Kentucky	--	--	--	Yes	--	--
Louisiana	--	--	--	--	--	--
Maine	Yes	Yes	--	Yes	Yes	Yes
Marshall Islands	--	--	--	--	--	--
Maryland	Yes	Yes	Yes	Yes	Yes	Yes
Massachusetts	Yes	Yes	Yes	Yes	Yes	Yes
Michigan	--	Yes	Yes	Yes	Yes	--
Minnesota	--	--	--	--	--	--
Mississippi	--	--	--	--	--	--
Missouri	Yes	Yes	--	Yes	--	Yes
Montana	--	--	--	--	--	--
Nebraska	--	Yes	--	--	--	--
Nevada	--	--	--	--	--	--
New Hampshire	--	--	--	--	--	--
New Jersey	Yes	Yes	Yes	Yes	Yes	Yes
New Mexico	--	--	--	--	--	--
New York	Yes	Yes	Yes	Yes	Yes	--
North Carolina	--	--	--	Yes	--	--
North Dakota	--	--	--	--	--	--
Northern Mariana Islands	--	--	--	--	--	--
Ohio	--	--	--	--	--	--
Oklahoma	--	--	--	--	--	--
Oregon	--	--	--	--	--	--
Pennsylvania	Yes	Yes	Yes	Yes	Yes	Yes
Puerto Rico	--	--	--	--	--	--
Rhode Island	--	--	Yes	Yes	Yes	--
South Carolina	--	--	--	--	--	--
South Dakota	Yes	Yes	Yes	Yes	Yes	Yes
Tennessee	--	--	--	--	--	--
Texas	--	--	--	--	--	--
Utah	--	--	--	--	--	--
Vermont	--	--	--	--	--	--
Virgin Islands (U.S.)	--	--	--	Yes	--	--
Virginia	--	--	--	--	--	--
Washington	Yes	Yes	Yes	Yes	Yes	--
West Virginia	--	--	--	Yes	--	--
Wisconsin	--	--	--	--	--	--
Wyoming	--	--	--	--	--	--
Total	12	16	14	22	17	8

Note: 49 ADAPs reported data. American Samoa, District of Columbia, Federated States of Micronesia, Guam, Mississippi, New Hampshire, Northern Mariana Islands, and Oregon did not report FY2010 data, but their federal ADAP earmark awards were known and incorporated. Following reauthorization of the Ryan White Program in 2009, the Republic of Palau was eligible for ADAP funding, but did not receive funding in FY2010 and is not included above. Marshall Islands did not receive a federal ADAP earmark award in FY2010.

Table 2: ADAP Utilization of Hepatitis B Treatment, December 2010 and FY2009

State/Territory	December 2010 Prescriptions Filled	December 2010 Number of Clients	FY2009 Prescriptions Filled
Alabama	4	4	33
Alaska	0	0	1
American Samoa	--	--	--
Arizona	0	0	0
Arkansas	0	0	0
California	--	--	--
Colorado	0	0	0
Connecticut	5	5	93
Delaware	2	3	7
District of Columbia	--	--	--
Federated States of Micronesia	--	--	--
Florida	0	0	0
Georgia	0	0	0
Guam	--	--	--
Hawaii	0	0	0
Idaho	0	0	0
Illinois	6	6	42
Indiana	6	4	47
Iowa	0	0	0
Kansas	0	0	0
Kentucky	135	5	885
Louisiana	0	0	0
Maine	1	1	19
Marshall Islands	--	--	--
Maryland	13	12	142
Massachusetts	4	4	173
Michigan	2	2	--
Minnesota	0	0	0
Mississippi	--	--	--
Missouri	3	1	12
Montana	0	0	0
Nebraska	0	--	12
Nevada	0	0	0
New Hampshire	--	--	--
New Jersey	223	111	2,282
New Mexico	0	0	0
New York	31	30	390
North Carolina	2	2	64
North Dakota	0	0	0
Northern Mariana Islands	--	--	--
Ohio	0	0	0
Oklahoma	0	0	0
Oregon	--	--	--
Pennsylvania	11	8	154
Puerto Rico	0	0	0
Rhode Island	1	1	0
South Carolina	0	0	0
South Dakota	0	0	0
Tennessee	0	0	0
Texas	0	0	0
Utah	0	0	0
Vermont	0	0	0
Virgin Islands (U.S.)	1	1	12
Virginia	0	0	0
Washington	2	2	10
West Virginia	4	3	21
Wisconsin	0	0	0
Wyoming	0	0	0
Total	456	205	4,399

Note: 49 ADAPs reported data. American Samoa, District of Columbia, Federated States of Micronesia, Guam, Mississippi, New Hampshire, Northern Mariana Islands, and Oregon did not report FY2010 data, but their federal ADAP earmark awards were known and incorporated. Following reauthorization of the Ryan White Program in 2009, the Republic of Palau was eligible for ADAP funding, but did not receive funding in FY2010 and is not included above. Marshall Islands did not receive a federal ADAP earmark award in FY2010.

Table 3: ADAP Coverage of Hepatitis C Treatment, December 2010

State/Territory	Interferon Alfa-2b (Intron A)	Recombinant Interferon Alfa-2a (Roferon)	Consensus Interferon (Infergen)	Peginterferon Alfa-2a (Pegasys)	Peginterferon Alfa-2b (PEG-Intron)	Recombinant Interferon Alfa-2a (Roferon) and Ribavirin
Alabama	Yes	Yes	--	Yes	Yes	Yes
Alaska	Yes	--	--	--	Yes	--
American Samoa	--	--	--	--	--	--
Arizona	--	--	--	--	Yes	--
Arkansas	--	--	--	--	--	--
California	Yes	Yes	Yes	Yes	Yes	Yes
Colorado	--	--	--	--	--	--
Connecticut	--	--	--	Yes	Yes	--
Delaware	Yes	--	--	Yes	Yes	Yes
District of Columbia	--	--	--	--	--	--
Federated States of Micronesia	--	--	--	--	--	--
Florida	--	--	--	--	--	--
Georgia	--	--	--	--	--	--
Guam	--	--	--	--	--	--
Hawaii	--	--	--	Yes	Yes	--
Idaho	--	--	--	--	--	--
Illinois	--	--	--	--	--	--
Indiana	Yes	Yes	Yes	Yes	Yes	Yes
Iowa	--	--	--	Yes	--	--
Kansas	--	--	--	--	--	--
Kentucky	--	--	--	--	--	--
Louisiana	--	--	--	--	--	--
Maine	--	--	Yes	Yes	Yes	--
Marshall Islands	--	--	--	--	--	--
Maryland	Yes	Yes	--	Yes	Yes	Yes
Massachusetts	Yes	Yes	Yes	Yes	Yes	Yes
Michigan	Yes	--	--	Yes	Yes	--
Minnesota	--	--	--	Yes	Yes	Yes
Mississippi	--	--	--	--	--	--
Missouri	--	--	--	--	--	--
Montana	--	--	--	--	--	--
Nebraska	--	--	--	--	--	--
Nevada	--	--	--	--	--	--
New Hampshire	--	--	--	--	--	--
New Jersey	Yes	--	Yes	Yes	Yes	Yes
New Mexico	--	--	--	--	--	--
New York	Yes	Yes	--	Yes	Yes	--
North Carolina	--	--	--	--	--	--
North Dakota	--	--	--	--	--	--
Northern Mariana Islands	--	--	--	--	--	--
Ohio	--	--	--	--	--	--
Oklahoma	--	--	--	--	--	--
Oregon	--	--	--	--	--	--
Pennsylvania	Yes	--	Yes	Yes	Yes	--
Puerto Rico	--	--	--	Yes	Yes	--
Rhode Island	Yes	Yes	Yes	Yes	Yes	Yes
South Carolina	--	--	--	Yes	Yes	--
South Dakota	Yes	Yes	Yes	Yes	Yes	Yes
Tennessee	--	--	--	--	--	--
Texas	--	--	--	--	--	--
Utah	--	--	--	--	--	--
Vermont	--	--	--	--	--	--
Virgin Islands (U.S.)	--	--	--	--	--	--
Virginia	--	--	--	--	--	--
Washington	Yes	--	--	Yes	Yes	--
West Virginia	--	--	--	--	--	--
Wisconsin	Yes	Yes	Yes	Yes	Yes	Yes
Wyoming	--	--	--	--	--	--
Total	15	9	9	21	22	11

Note: 49 ADAPs reported data. American Samoa, District of Columbia, Federated States of Micronesia, Guam, Mississippi, New Hampshire, Northern Mariana Islands, and Oregon did not report FY2010 data, but their federal ADAP earmark awards were known and incorporated. Following reauthorization of the Ryan White Program in 2009, the Republic of Palau was eligible for ADAP funding, but did not receive funding in FY2010 and is not included above. Marshall Islands did not receive a federal ADAP earmark award in FY2010.

Table 4: ADAP Utilization of Hepatitis C Treatment, December 2010 and FY2009

State/Territory	December 2010 Prescriptions Filled	December 2010 Number of Clients	FY2009 Prescriptions Filled
Alabama	3	3	13
Alaska	0	0	0
American Samoa	--	--	--
Arizona	0	0	14
Arkansas	0	0	0
California	--	--	--
Colorado	0	0	0
Connecticut	2	2	34
Delaware	0	0	0
District of Columbia	--	--	--
Federated States of Micronesia	--	--	--
Florida	0	0	0
Georgia	0	0	0
Guam	--	--	--
Hawaii	1	1	10
Idaho	0	0	0
Illinois	0	0	0
Indiana	3	2	62
Iowa	0	0	15
Kansas	0	0	0
Kentucky	0	0	0
Louisiana	0	0	0
Maine	0	0	23
Marshall Islands	--	--	--
Maryland	5	4	39
Massachusetts	2	2	132
Michigan	0	0	0
Minnesota	5	5	--
Mississippi	--	--	--
Missouri	0	0	0
Montana	0	0	0
Nebraska	0	0	0
Nevada	0	0	0
New Hampshire	--	--	--
New Jersey	10	5	132
New Mexico	0	0	0
New York	84	49	1,020
North Carolina	0	0	0
North Dakota	0	0	0
Northern Mariana Islands	--	--	--
Ohio	0	0	0
Oklahoma	0	0	0
Oregon	--	--	--
Pennsylvania	3	2	86
Puerto Rico	94	56	648
Rhode Island	1	1	0
South Carolina	1	1	35
South Dakota	1	1	0
Tennessee	0	0	0
Texas	0	0	0
Utah	0	0	0
Vermont	0	0	0
Virgin Islands (U.S.)	0	0	0
Virginia	2	1	51
Washington	2	2	4
West Virginia	0	0	0
Wisconsin	9	7	18
Wyoming	0	0	0
Total	228	144	2,336

Note: 49 ADAPs reported data. American Samoa, District of Columbia, Federated States of Micronesia, Guam, Mississippi, New Hampshire, Northern Mariana Islands, and Oregon did not report FY2010 data, but their federal ADAP earmark awards were known and incorporated. Following reauthorization of the Ryan White Program in 2009, the Republic of Palau was eligible for ADAP funding, but did not receive funding in FY2010 and is not included above. Marshall Islands did not receive a federal ADAP earmark award in FY2010.

Table 5: ADAP Coverage of Hepatitis C Diagnostics, December 2010

State/Territory	HCV Screening	Qualitative HCV RNA	Quantitative Viral Load	HCV Genotype
Alabama	--	--	--	--
Alaska	--	--	--	--
American Samoa	--	--	--	--
Arizona	--	--	--	--
Arkansas	--	--	--	--
California	--	--	--	--
Colorado	--	--	--	--
Connecticut	--	--	--	--
Delaware	Yes	Yes	Yes	Yes
District of Columbia	--	--	--	--
Federated States of Micronesia	--	--	--	--
Florida	--	--	--	--
Georgia	--	--	--	--
Guam	--	--	--	--
Hawaii	--	--	--	--
Idaho	--	--	--	--
Illinois	--	--	--	--
Indiana	Yes	Yes	Yes	Yes
Iowa	--	--	--	--
Kansas	Yes	Yes	Yes	Yes
Kentucky	--	--	--	--
Louisiana	--	--	--	--
Maine	--	--	--	--
Marshall Islands	--	--	--	--
Maryland	--	--	--	--
Massachusetts	--	--	--	--
Michigan	--	--	--	--
Minnesota	--	--	--	--
Mississippi	--	--	--	--
Missouri	--	--	--	--
Montana	--	--	--	--
Nebraska	--	--	--	--
Nevada	--	--	--	--
New Hampshire	--	--	--	--
New Jersey	--	--	--	--
New Mexico	--	--	--	--
New York	Yes	Yes	Yes	Yes
North Carolina	--	--	--	--
North Dakota	--	--	--	--
Northern Mariana Islands	--	--	--	--
Ohio	--	--	--	--
Oklahoma	--	--	--	--
Oregon	--	--	--	--
Pennsylvania	Yes	--	--	--
Puerto Rico	--	--	--	--
Rhode Island	--	--	--	--
South Carolina	--	--	--	--
South Dakota	--	--	--	--
Tennessee	--	--	--	--
Texas	--	--	--	--
Utah	--	--	--	--
Vermont	--	--	--	--
Virgin Islands (U.S.)	Yes	Yes	Yes	Yes
Virginia	--	--	--	--
Washington	Yes	Yes	Yes	Yes
West Virginia	--	--	--	--
Wisconsin	--	--	--	--
Wyoming	--	--	--	--
Total	7	6	6	6

Note: 49 ADAPs reported data. American Samoa, District of Columbia, Federated States of Micronesia, Guam, Mississippi, New Hampshire, Northern Mariana Islands, and Oregon did not report FY2010 data, but their federal ADAP earmark awards were known and incorporated. Following reauthorization of the Ryan White Program in 2009, the Republic of Palau was eligible for ADAP funding, but did not receive funding in FY2010 and is not included above. Marshall Islands did not receive a federal ADAP earmark award in FY2010.

Table 6: ADAP Coverage of Hepatitis A and B Vaccines, December 2010

State/Territory	Hepatitis A and B Combination Vaccine	Hepatitis A Vaccine	Hepatitis B Vaccine
Alabama	Yes	Yes	Yes
Alaska	Yes	Yes	Yes
American Samoa	--	--	--
Arizona	--	--	--
Arkansas	--	--	--
California	Yes	Yes	Yes
Colorado	--	--	--
Connecticut	Yes	Yes	Yes
Delaware	Yes	Yes	Yes
District of Columbia	--	--	--
Federated States of Micronesia	--	--	--
Florida	--	--	--
Georgia	--	--	--
Guam	--	--	--
Hawaii	Yes	Yes	Yes
Idaho	--	--	--
Illinois	--	--	--
Indiana	--	--	--
Iowa	--	--	--
Kansas	--	--	--
Kentucky	Yes	Yes	Yes
Louisiana	--	--	--
Maine	Yes	Yes	Yes
Marshall Islands	--	--	--
Maryland	Yes	Yes	Yes
Massachusetts	Yes	--	--
Michigan	Yes	--	--
Minnesota	--	--	--
Mississippi	--	--	--
Missouri	Yes	Yes	Yes
Montana	--	--	--
Nebraska	--	--	--
Nevada	--	--	--
New Hampshire	--	--	--
New Jersey	Yes	Yes	Yes
New Mexico	Yes	Yes	Yes
New York	Yes	Yes	Yes
North Carolina	--	--	--
North Dakota	Yes	Yes	Yes
Northern Mariana Islands	--	--	--
Ohio	Yes	Yes	Yes
Oklahoma	Yes	Yes	Yes
Oregon	--	--	--
Pennsylvania	--	Yes	Yes
Puerto Rico	--	--	--
Rhode Island	--	--	--
South Carolina	--	--	--
South Dakota	Yes	Yes	Yes
Tennessee	--	--	--
Texas	--	--	--
Utah	--	--	--
Vermont	Yes	Yes	Yes
Virgin Islands (U.S.)	--	--	--
Virginia	--	--	--
Washington	Yes	Yes	Yes
West Virginia	Yes	Yes	Yes
Wisconsin	--	--	--
Wyoming	--	--	--
Total	22	21	21

Note: 49 ADAPs reported data. American Samoa, District of Columbia, Federated States of Micronesia, Guam, Mississippi, New Hampshire, Northern Mariana Islands, and Oregon did not report FY2010 data, but their federal ADAP earmark awards were known and incorporated. Following reauthorization of the Ryan White Program in 2009, the Republic of Palau was eligible for ADAP funding, but did not receive funding in FY2010 and is not included above. Marshall Islands did not receive a federal ADAP earmark award in FY2010.

GLOSSARY

340B Drug Discount Program – The federal 340B Drug Discount Program, authorized under the Veterans Health Care Act of 1992, enables ADAPs to purchase drugs at or below the statutorily defined 340B ceiling price.

AIDS Drug Assistance Program (ADAP) - A state administered program authorized under Part B (formerly Title II) of the Title XXVI of the Public Health Service Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2009 (Ryan White Program) that provides Food and Drug Administration (FDA) approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid. ADAPs may also purchase insurance and provide adherence monitoring and outreach under the flexibility policy.

ADAP Crisis Task Force – A group of state ADAP and AIDS directors, convened by NASTAD, that negotiates with the manufacturers of HIV antiretrovirals and other high-cost medications to secure supplemental discounts/rebates benefitting all ADAPs.

ADAP Earmark - The amount of federal Ryan White Program, Part B dollars specifically designated by Congress through the annual appropriations process to ADAP for the federal fiscal year.

ADAP Supplemental Drug Treatment Grant – ADAP Supplemental grants are used for the purchase of medications by states and territories with demonstrated severe need to increase access to HIV/AIDS related medications. These grants must be used to expand ADAP formularies, target resources to reflect the changes in the epidemic, and enhance the ADAP's ability to remove eligibility restrictions. States must meet HRSA eligibility criteria in order to apply for ADAP Supplemental funds. The overall supplemental amount is mandated by law to be five percent of the congressionally appropriated ADAP earmark, although it represented less than this in the overall ADAP budget.

Back-billing – In some instances, ADAP covers an individual's prescription costs but later determines there is another payer source, for example, state Medicaid. Once it is certain that another payer should have covered a client's previous claims, the ADAP can request reimbursement for expenditures previously incurred or "back bill." Another scenario for back billing is when individuals apply and are eligible for Medicaid. Their eligibility coverage back dates three months PRIOR to the application date. ADAP covers the individual while they wait for their Medicaid eligibility determination and then "back-bills" Medicaid for any drugs or services they paid for during the interim wait time (see also pay and chase).

Co-payment - A cost-effective way to help clients access medications through existing insurance coverage. In those states where ADAPs largely use their funding to purchase or maintain health insurance coverage, co-payments accounted for a much greater share of expenditures. A set amount an individual must pay upon receiving medical services or prescriptions. For example, there may be a \$10 co-payment required each time a prescription is purchased at a retail pharmacy. Some ADAPs will pay the co-payments for ADAP formulary drugs.

Cost-recovery - Reimbursement from third party entities such as private insurers and Medicaid.

Cost-sharing – The payment of a premium or fee by an enrolled ADAP client to the ADAP as a portion of the cost for medications and/or services received.

Deductible - The amount a health insurance beneficiary must pay before a third party payer begins to provide coverage for health services. Amounts can change from year to year. Some ADAPs pay this cost for eligible clients.

Direct Purchase states – ADAPs using this model centrally purchase and dispense medications through their own pharmacy or a single contract pharmacy services provider.

Dual Eligible – Individuals who are eligible for both Medicare and Medicaid.

Formulary - ADAP drug list that establishes the number of drugs available within a therapeutic class for purposes of drug purchasing, dispensing and/or reimbursement. Effective July 1, 2007, all ADAPs were required to include at least one drug from each antiretroviral drug class. The minimum formulary requirement does not apply to multi-class combination products (not considered a unique class of drugs), drugs for preventing and treating opportunistic infections (OIs), hepatitis C treatments, or drugs for other HIV-related conditions (e.g., depression, hypertension, and diabetes).

- **Closed/restricted formulary** – allows only those drug products listed to be dispensed or reimbursed.
- **Open formulary** – covers all FDA-approved drugs prescribed by a physician with no restrictions or with restrictions such as higher patient cost-sharing requirements for certain drugs.
- **Tiered formulary** – also referred to as “step therapy” and is a cost containment measure that categorizes medications for a particular condition based upon their cost. For example, a tier one medication would be one that is lowest cost and recommended to be used first, unless there are medical restrictions for doing so. Tier two would be a different medication that is prescribed for the same condition as the tier one drug but is more expensive. Step therapy or tiered formularies are most commonly used by ADAPs with medications prescribed for depression, respiratory problems, and opportunistic infections.

Hybrid states – A direct purchase state that utilizes an existing entity (e.g., University Hospital) to purchase and distribute ADAP drugs. The entity maintains a single drug inventory purchased at 340B prices. To secure the additional supplemental discounts negotiated by the ADAP Crisis Task Force, these ADAPs must submit rebate claims for any supplemental discount amounts.

Insurance Continuation - The payment of all or some combination of insurance premiums, co-pays, or deductibles for clients who have existing insurance policies through their current employment, Consolidated Omnibus Budget Reconciliation Act (COBRA) or other supplemental programs. HRSA allows ADAP funds to be used for insurance continuation with certain restrictions.

Insurance Purchasing - The purchase of new insurance policies through the insurance industry market or state high risk insurance pools.

Part A funding - Provided to metropolitan jurisdictions, similarly reflecting local decisions about whether to allocate funds to ADAPs.

Part B “base” - Formula-based funding to states (other than that earmarked for ADAP); some states choose to allocate some of this funding to ADAPs, but are not required to do so.

Part B supplemental funding – Funding to states with “unmet need;” some states choose to allocate some of this funding to ADAPs, but are not required to do so.

Patient Assistance Programs (PAPs) - Programs through which many pharmaceutical manufacturers provide free or greatly subsidized medications to indigent patients.

Rebate states – These are ADAPs who pay retail pharmacies a pre-determined amount at the point of sale for drugs dispensed to ADAP clients. ADAP then bills drug manufacturers for the 340B Unit Rebate amount for the number of units dispensed.

The Ryan White HIV/AIDS Treatment Modernization Act of 2009 - The Ryan White CARE Act, "Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2009", or "Ryan White Program" is the single largest federal program designed specifically for people with HIV/AIDS. First enacted in 1990, it provides care and treatment to individuals and families affected by HIV/AIDS. The Ryan White Program has five parts - **Part A** (formerly Title I) funds eligible metropolitan areas and transitional grant areas, 75% of grant funds must be spent for core services; **Part B** (formerly Title II) funds States/Territories, 75% must be spent for core services; **Part C** (formerly Title III) funds early intervention services, 75% must be spent for core services; **Part D** (formerly Title IV) grants support services for women, infants, children & youth and **Part F** comprises Special Projects of National Significance, AIDS Education & Training Centers (AETCs), Dental Programs and the Minority AIDS Initiative.

State funding - General revenue support from state budgets. States are not required to provide funding to their ADAPs (except in limited cases of matching requirements), although many have historically done so either over a sustained period of time or at critical junctures to address gaps in funding. Such funding is, for the most part, dependent on individual state decisions and budgets; even where states are required to provide a match of federal Part B Ryan White funds, they are not required to put this funding toward ADAP. The only exception to this is the ADAP supplemental, where states must provide a match (or seek a waiver of the requirement, if eligible to do so).

True Out of Pocket Expenditures (TrOOP) – This is the amount of money that a Medicare Part D enrolled client will have to pay from their own money to reach the "catastrophic limit" making Part D the primary payer for medications. Payments for drugs, co-payments, and coinsurance made by the beneficiary, friends, family members, State Pharmacy Assistance Programs, charities, and the Medicare low-income subsidy (LIS) count towards TrOOP costs. Payments for premiums, drugs not on plan formularies, costs incurred by the ADAP, and payments by other types of insurance are not counted as TrOOP costs.