NATIONAL ADAP MONITORING PROJECT
ANNUAL REPORT
MODULE TWO
ADAP Coordination with Other Payers; Enrollment and Utilization Update

MARCH 2012

Prepared by

National Alliance of State & Territorial AIDS Directors (NASTAD)
Emily McCloskey
Murray C. Penner
Britten Pund

NASTAD™
NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

ACKNOWLEDGEMENTS

The National Alliance of State & Territorial AIDS Directors (NASTAD) thanks state ADAP and AIDS program managers and staff for their time and effort in completing the National ADAP Survey, which serves as the foundation for this report, and for providing ongoing updates to inform the National ADAP Monitoring Project. NASTAD also thanks Lanny Cross, NASTAD consultant, for his valuable contributions to NASTAD's ADAP Monitoring and Technical Assistance Program. Finally, without the guidance and support from Julie Scofield, NASTAD Executive Director, this report would not be possible.

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 2011 from the following companies: Boehringer Ingelheim, Bristol-Myers Squibb, Gilead Sciences, Janssen 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).

March 2012

National Alliance of State and Territorial AIDS Directors
444 North Capitol Street, NW, Suite 339
Washington, DC 20001-1512
(202) 434-8090 (phone)
(202) 434-8092 (fax)
www.NASTAD.org

Amna Osman (Michigan), Chair
Julie M. Scofield, Executive Director

TABLE OF CONTENTS

MODULE TWO: OVERVIEW

Since the Patient Protection and Affordable Care Act (PPACA) was signed into law in March 2010, ADAPs have been preparing to implement areas of the law that directly impact them. Portions of health reform that impact ADAPs include:

- Medicaid eligibility expansion in 2014 and the expansion of the CMS Section 1115 Waiver.
- Increase in the number of individuals covered by insurance plans, including health exchanges in 2014.
- Pre-existing Condition Insurance Plans (PCIPs) from July 1, 2010 through December 31, 2013.
- Medicare Part D expenditures made on behalf of ADAP clients counting toward True Out Of Pocket (TrOOP) expenditures (effective January 1, 2011).
- Narrowing and closing of the Medicare Part D "doughnut hole" (phased out by 2020).
- An increase in the Medicaid rebate amount for purchased drugs (from 15.1% to 23.1%, effective January 1, 2010).
- Increased 340B pricing transparency.

These changes will lead to increased comprehensive care for ADAP clients and should result in fiscal relief for ADAPs. ADAPs have been working to build the infrastructure necessary to implement the provisions noted above.

MEDICAID ELIGIBILITY EXPANSION

In June 2011, the Centers for Medicaid and Medicare Services (CMS) released an updated guidance on Section 1115 waivers for state Medicaid programs that allow states the option to cover eligible pre-disabled adults living with HIV. Without the waiver in place, eligible individuals must be disabled in order to qualify for Medicaid. The 1115 waiver option may be of particular interest to states as a way to address ADAP waiting lists, alleviate ADAP funding shortfalls, and leverage federal matching funds for HIV/AIDS care and treatment. States have significant flexibility in the design of the waivers under the guidance and application template issued by CMS in June 2011.

In 2014, PPACA will expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents and adults without dependent children) with incomes up to 133 percent of the Federal Poverty Level (FPL) (based on modified adjusted gross income), regardless of disability status. In 2011, 56 percent of clients served by ADAP had incomes up to 133 percent FPL and thus, in 2014, Medicaid would cover their medical costs, if they are eligible. To finance coverage for newly eligible individuals under this Medicaid expansion, states will receive 100 percent federal funding for 2014 through 2016, 95 percent federal financing in 2017, 94 percent federal financing in 2018, 93 percent federal financing in 2019 and 90 percent federal financing for 2020 and subsequent years.

INCREASED INSURANCE COVERAGE FOR PEOPLE LIVING WITH HIV/AIDS (PLWHA)

In an effort to help uninsured individuals obtain coverage prior to 2014, PPACA includes provisions that established a Pre-existing Condition Insurance Plan (PCIP) in July 2010. Individual states were given the option to establish a state administered PCIP or default to the option of having uninsured populations served under the federally administered PCIP. Approximately half of states with existing high-risk pools chose to operate their own, federally-funded, PCIP in their state. Other states, regardless of access to a high-risk pool, chose to participate in the federal pool. To be eligible for a PCIP, individuals must have a pre-existing health condition, as determined by guidance from HHS; be a U.S. Citizen or be lawfully present in the U.S.; and, have been uninsured or without creditable coverage for six months prior to the date of application for risk pool coverage. ADAPs do not qualify as creditable coverage and ADAPs are able to enroll clients in PCIPs and continue to provide wrap around services. Despite this, however, some ADAPs have experienced barriers to enrollment. Many of these states continue to work to be able to enroll individuals in their state's PCIP. The law appropriated $5 billion of federal funds to support the established

state and temporary federal high-risk pools created through PCIPs that went into effect on July 1, 2010 and end on December 31, 2013.

Health exchanges are organized, regulated, state-based marketplaces to purchase individual insurance policies with a goal to increase access, choice, affordability and coverage. In 2014, the implementation of health exchanges will expand insurance coverage options for individuals with incomes between 133 and 400 percent FPL and for small group employers. Health exchanges will reduce age, gender, pre-existing and high-cost health condition discrimination, which will allow persons living with HIV/AIDS (PLWHA) much greater access to private insurance and affordable care. There will be four tiers of insurance plans available in the exchanges, all which must meet the established minimum benefit requirement, also known as Essential Health Benefits.

In general, health exchanges will offer individuals and small group employers better benefits packages and coverage, with lower costs passed on to consumers. Tax credits, subsidies and out-of-pocket spending caps will be available to persons with income between 133 and 400 percent of FPL.

ADAP AND MEDICARE PART D

While changes to the Medicare program are few under PPACA, some provisions were changed. Previously, Medicare Part D participants were required to pay out of pocket for expenses incurred after reaching the "donut hole," or coverage gap, for prescription drugs. Under PPACA, ADAP expenditures made on behalf of Medicare Part D participants now count towards true out of pocket expenses (TrOOP), which will provide savings for both ADAPs and their consumers as once individuals are "out of the donut hole" Medicare Part D pays all the costs of prescription drugs under the catastrophic coverage level. There is also a 50 percent discount on brand name drugs while in the donut hole and starting in 2013, government subsidies for brand name drugs will gradually increase. By 2020, the coverage gap will be closed, but beneficiaries will still be responsible for approximately 25 percent of drug costs within the donut hole. ADAPs that are wrapping around Medicare Part D and assisting with Medicare Part D cost sharing requirements for clients should have data sharing agreements in place so that ADAP expenditures made on behalf of clients will be credited towards clients' TrOOP. The ability to use ADAP expenditures as TrOOP will allow ADAP clients to pass through the donut hole much more quickly than they have been able to in the past and thus reach 100% catastrophic coverage by Medicare Part D (rather than continued reliance on ADAP).

ESSENTIAL HEALTH BENEFITS (EHB)

To ensure a more consistent level of benefits, PPACA requires that certain insurance plans-including those participating in the state purchasing exchanges, cover a package of diagnostic, preventive, and therapeutic services and products that have been defined as "essential" by the Department of Health and Human Services (HHS). The minimum benefit plan must statutorily include coverage of ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventative and wellness services, including chronic disease management and pediatric services. Many of these services are crucial to the comprehensive care that PLWHA require. Ensuring that a full range of prescriptions are available under the EHB package, instead of the currently proposed one medication per drug class, is important for ADAPs as PPACA is implemented.

Under HHS' request, the Institute of Medicine (IOM) released the Essential Health Benefits: Balancing Coverage and Cost report October 6, 2011 with a set of recommendations on how the health law's essential benefits package should be determined. The IOM recommendations stress affordability balanced with coverage and benefits and supports state-by-state decisions about essential benefits. HHS requested that IOM recommend a process that would help define the benefits that should be included in EHB package and update the benefits to take into account advances in science, gaps in access and the effect of any benefit changes on cost. In December 2011, HHS released a bulletin outlining an EHB proposal. This

proposal allowed state flexibility in determining the benchmark plan and was not explicit in what benefits would be covered. HHS is continuing its process of developing the EHB package – a proposed rule defining EHB is expected in Spring 2012.

MODULE TWO: 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, Republic of Palau and the Republic of the Marshall Islands. In addition, some ADAPs provide insurance continuation and Medicare Part D and Medicaid 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 17th release of the *Annual Report* updates prior findings with data from ADAP's fiscal year 2011[1] as well as provides a detailed snapshot of data from the month of June 2011. 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 2012 National ADAP Monitoring Project *Annual Report* in several modules. Detailed information related to ADAP budgets, client enrollment and utilization, client demographics, prescription distribution and payment methods, expenditures and prescriptions filled, insurance coordination, program eligibility, and program management and administration are included in Module One. This module includes detailed information on ADAP coordination with Medicare Part D, ADAP coordination with Pre-existing Condition Insurance Plans (PCIPs) and ADAP coordination with the CMS Section 1115 Waiver process. Module Three highlights hepatitis treatments. The three modules will be combined into a final, comprehensive report.

A comprehensive survey was sent to all 58 jurisdictions[2] that received federal ADAP earmark funding in FY2011; 52 responded (see Methodology on page 11). A supplemental survey was sent to all 58 jurisdictions in January 2012; 48 responded. Most data included in this report are from FY2011, June 2011 and December 2011, unless otherwise noted. Detailed findings from the survey are included below. Tables and charts depicting the data follow the detailed findings and a glossary of key terms used throughout this report is also included.

ADAP CLIENT ENROLLMENT AND UTILIZATION

ADAP client enrollment and client utilization reached their highest levels during FY2011 (see Charts 2 and 3 and Table 1). ADAP enrollment reached 181,449 in December 2011. Client enrollment increased by three percent from June 2011 to December 2011 (based only on those ADAPs that reported data in both time periods). ADAPs provided medications to 133,689 clients across the country in December 2011. Client utilization remained relatively level between June 2011 and December 2011, decreasing by 2% (based only on those ADAPs that reported data in both time periods). Twenty-five states experienced a decrease in client utilization over this time period; 23 states reported a stabilization or increase in client utilization. Client utilization reported for December 2011 could show a slight decrease as a result of holiday closings in state government.

ADAP COORDINATION WITH INSURANCE PROVIDERS

Since the issuance of HRSA Policy Notice 99-01 and its update (HRSA Policy Notice 07-05), ADAPs have been permitted to use funding to purchase health insurance whose coverage includes the full range of HIV treatments and access to comprehensive primary care services, equivalent to the ADAP formulary and at a cost less than the annual cost of maintaining that same population on the existing ADAP. ADAP funding may be used to cover any costs associated with the health insurance policy, including paying co-payments, deductibles, or premiums on behalf of ADAP clients to purchase or maintain insurance policies.

As noted in Module One of the National ADAP Monitoring Project *Annual Report*, 44 ADAPs reported using funds for insurance purchasing/continuation in 2011. ADAP coordination with insurance providers varies by state and insurance provider, including private insurance, high-risk insurance pools, PCIP, Medicaid and Medicare (see Tables 2-4).

- Seventeen ADAPs coordinate insurance using an insurance benefits manager.
- Thirty-four ADAPs coordinate insurance in-house.
- Thirteen ADAPs coordinate insurance through a CBO sub-contractor.
- Twenty-seven ADAPs coordinate insurance via a data sharing agreement with insurance providers.
- Thirty ADAPs coordinate insurance using another mechanism.

ADAPs continue to build infrastructure to coordinate benefits with insurance providers. Improved data collection systems and additional resources are necessary to expand ADAP coordination with insurance providers.

ADAP COORDINATION WITH PRE-EXISTING CONDITION INSURANCE PLANS

In an effort to help certain uninsured individuals obtain insurance coverage prior to 2014, PPACA includes provisions that the Secretary of HHS establish state-specific Pre-existing Condition Insurance Plans (PCIP) by July 1, 2010. Individual states were given the option to establish a state administered PCIP or default to the option of having uninsured populations served under the federally administered PCIP.

Some ADAPs have experienced barriers to coordinating with PCIPs, including the need to establish the infrastructure necessary to coordinate with the PCIP, that the PCIP in their state prohibits third-party payers (such as ADAP) and that the PCIP in their state utilizes a mail-order pharmacy that does not accept third-party payments for medications.

- As of December 2011, 24 ADAPs reported having the ability to enroll clients in PCIPs and 2,393 clients have been enrolled with plans to continue enrolling additional clients (see Chart 3 and Table 3).
- The average annual cost per client served in a PCIP was $6,037 in December 2011, approximately 58% of the annual average cost per client, based on estimated annual drug expenditures ($10,428).

ADAP COORDINATION WITH CMS SECTION 1115 WAIVER PROCESS

In June 2011, CMS released an updated guidance on Section 1115 waivers for state Medicaid programs that allow states the option to cover eligible pre-disabled adults living with HIV. Without the waiver in place, eligible individuals must be disabled in order to qualify for Medicaid. States have significant flexibility in the design of the waivers under the guidance and application template issued by CMS in June 2011.

As of December 2011, five ADAPs indicate they have access to a CMS Section 1115 waiver in their state to enroll people living with HIV and six other states indicate they are currently applying for or anticipate applying for a CMS Section 1115 waiver (see Table 7). Several ADAPs have indicated their state will not pursue a Section 1115 Waiver due to the state matching requirements.

ADAP COORDINATION WITH MEDICARE PART D

In calendar year 2011, approximately 18% of ADAP clients were also Medicare-eligible (representing about 25,000 clients served). A subset of these clients was dually eligible for both Medicare and Medicaid.

PPACA also included a provision that allows ADAP expenditures made on behalf of a Medicare Part D beneficiary to count towards the TrOOP calculation, which allows clients to move through the donut hole and into catastrophic coverage. This provision went into effect on January 1, 2011.

- To meet the federal requirements and maintain appropriate medication coverage for their clients, 43 ADAPs have developed policies to coordinate with the Medicare Part D benefit (see Chart 4 and 5 and Table 8 and 9). As of December 31, 2011:
  - 25 ADAPs pay Part D premiums for ADAP clients eligible for Part D.
  - 34 ADAPs pay Part D deductibles for ADAP clients eligible for Part D.
  - 40 ADAPs pay Part D co-payments for ADAP clients eligible for Part D.
  - 40 ADAPs pay for all medications on their ADAP formularies when their Part D clients reach the "donut hole." Now that ADAP expenditures count toward TrOOP, clients can reach Part D catastrophic coverage and thus no longer rely on ADAP for their medications for the remainder of each calendar year.

- In order for ADAP contributions to count toward clients TrOOP calculations, ADAPs must accurately transmit data to the Center's for Medicaid and Medicare (CMS). Thirty-five ADAPs reported signing a data sharing agreement with CMS in December 2011 in order to transmit expenditures to Medicare Part D (see Table 6).

Thirteen ADAPs, including two who do not have a data sharing agreement with CMS, have a data sharing agreement with at least one other entity, including their state Medicaid, private insurance providers, other parts of the Ryan White Program and other entities (e.g., Pharmacy Benefits Managers).

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 an increase in the ADAP Supplemental set-aside and changes in eligibility and matching requirements.

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 by the Obama Administration, allocating $25 million in funding to address ADAP waiting lists and cost-containment measures.

2011: ADAP emergency funding continued at $40 million. In December 2011, President Obama announced an additional $35 million for ADAPs to address ADAP waiting lists and cost containment measures. Awards from this funding will be available to states based on a competitive application. It is expected that awards will be made in Summer 2012.

METHODOLOGY

Since 1996, NASTAD's National ADAP Monitoring Project has surveyed all jurisdictions receiving federal ADAP earmark funding through the Ryan White Program. In FY2011, 58 jurisdictions received earmark funding and were surveyed; 52 responded. American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Northern Mariana Islands, Republic of Palau, and U.S. Virgin Islands did not respond; these jurisdictions represent less than one percent of estimated living HIV and AIDS cases in the U.S.

NASTAD surveyed all jurisdictions receiving federal ADAP earmark funding through the Ryan White Program to request supplemental and updated information in January 2012; 48 responded. Alaska, American Samoa, Delaware, District of Columbia, Federated States of Micronesia, Guam, Kansas, Northern Mariana Islands, Republic of Palau and U.S. Virgin Islands did not respond; these jurisdictions represent two percent of estimated living HIV and AIDS cases.

The annual survey requests data and other program information for a one-month period (June and December), the current fiscal year, and 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 2011 and FY2011, 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.

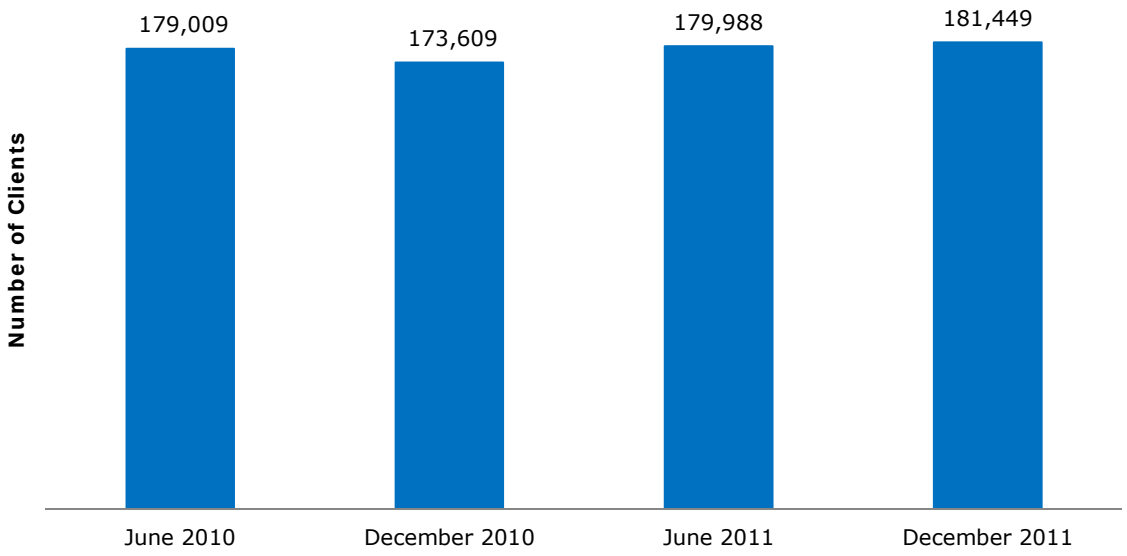
CHARTS AND TABLES

Charts for each major finding and tables, with data provided by states, are included in this module.

[1] FY2011 refers to ADAP fiscal year 2011 and encompasses data from April 1, 2011 through March 31, 2012.
[2] For the purposes of this *Report*, "jurisdiction" or "state" refers to all entities that receive a federal ADAP earmark award.

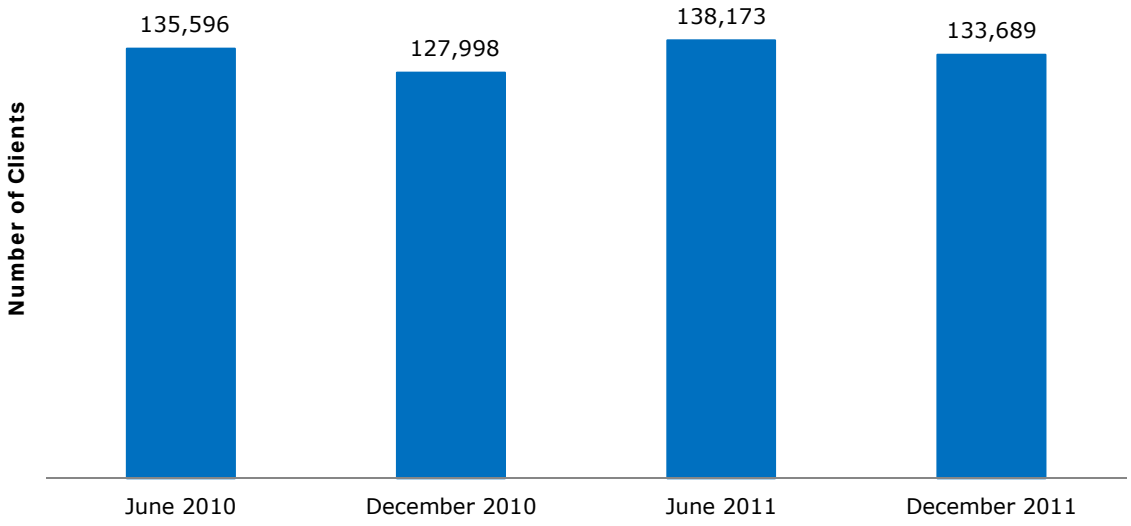
MODULE TWO: CHARTS

Chart 1: ADAP Clients Enrolled, June 2010-December 2011



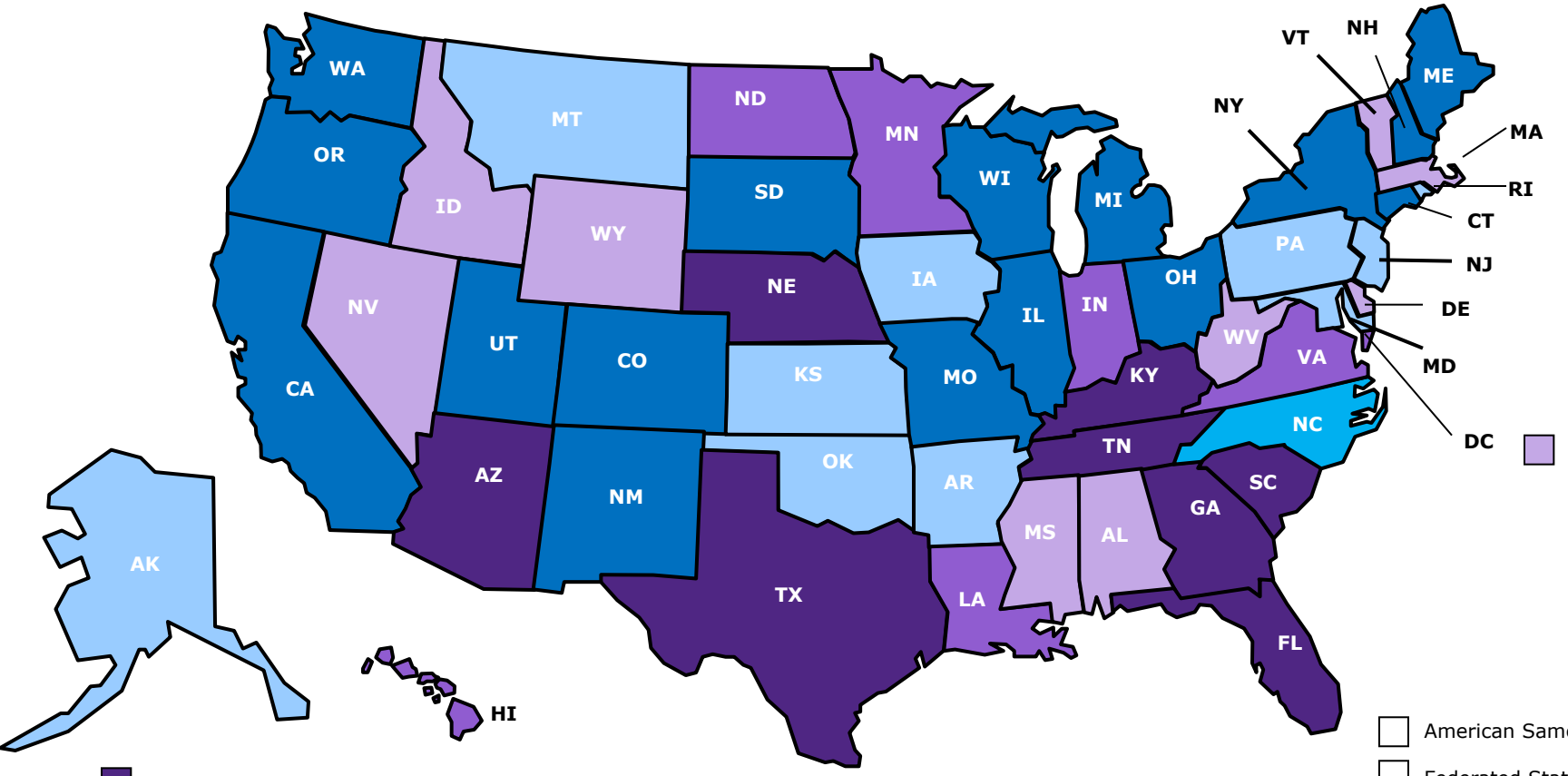
Note: 48 ADAPs reported data. Alaska, American Samoa, Delaware, District of Columbia, Federated States of Micronesia, Guam, Kansas, Northern Mariana Islands, Republic of Palau, and the U.S. Virgin Islands did not report data.

Chart 2: ADAP Clients Served, June 2010-December 2011



Note: 48 ADAPs reported data. Alaska, American Samoa, Delaware, District of Columbia, Federated States of Micronesia, Guam, Kansas, Northern Mariana Islands, Republic of Palau, and the U.S. Virgin Islands did not report data.

Chart 3: ADAP Coordination with Pre-existing Condition Insurance Plans (PCIPs), December 2011

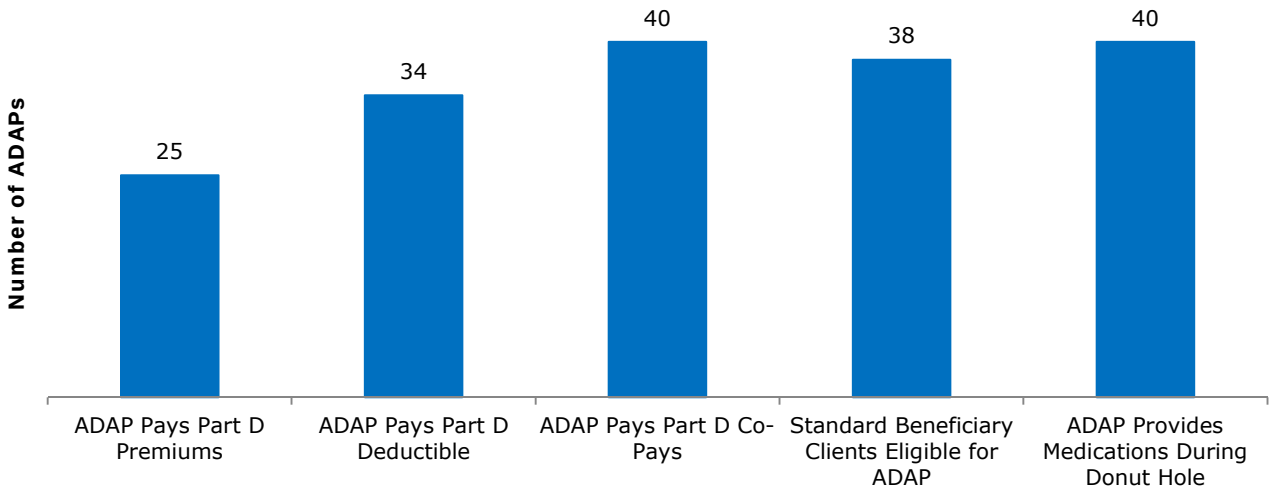


- ADAP with federally-run PCIP enrolling clients in PCIP (8 ADAPs)
- ADAPs with state-run PCIP enrolling clients in PCIP (16 ADAPs)
- ADAPs with federally-run PCIP anticipating enrolling clients (5 ADAPs)
- ADAPs with state-run PCIP anticipating enrolling clients (1 ADAP)
- ADAPs with federally-run PCIP not anticipating enrolling clients (11 ADAPs)
- ADAPs with state-run PCIP not anticipating enrolling clients (10 ADAPs)
- ADAP with no PCIP

- American Samoa
- Federated States of Micronesia
- Guam
- Marshall Islands
- Northern Mariana Islands
- Puerto Rico
- Republic of Palau
- Virgin Islands (U.S.)

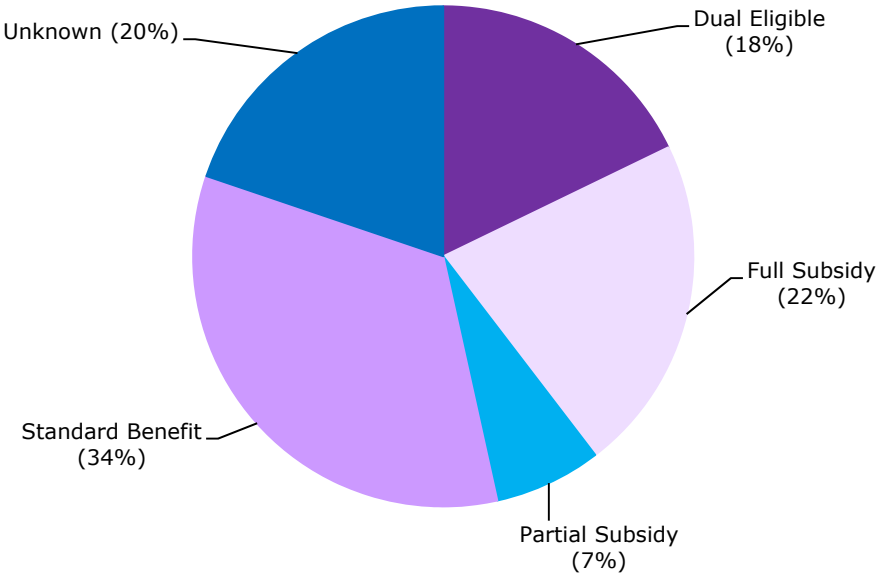
Note: 48 ADAPs reported data. Alaska, American Samoa, Delaware, District of Columbia, Federated States of Micronesia, Guam, Kansas, Northern Mariana Islands, Republic of Palau, and the U.S. Virgin Islands did not report data. PCIPs are not administered in American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Northern Mariana Islands, Puerto Rico, Republic of Palau, and U.S. Virgin Islands.

Chart 4: ADAP Policies Related to Medicare Part D, as of December 31, 2011



Note: 48 ADAPs reported data. Alaska, American Samoa, Delaware, District of Columbia, Federated States of Micronesia, Guam, Kansas, Northern Mariana Islands, Republic of Palau, and the U.S. Virgin Islands did not report data.

Chart 5: ADAP Clients Enrolled in Medicare Part D, December 2011



Total = 24,897 clients

Note: 48 ADAPs reported data. Alaska, American Samoa, Delaware, District of Columbia, Federated States of Micronesia, Guam, Kansas, Northern Mariana Islands, Republic of Palau, and the U.S. Virgin Islands did not report data.

MODULE TWO: TABLES

Table 1: Total Clients Enrolled and Served, June 2011 and December 2011

State/Territory	Financial Eligibility as % of FPL[1]	June 2011 Clients Enrolled	December 2011 Clients Enrolled	% Change	June 2011 Clients Served	December 2011 Clients Served	% Change
Alabama	250% GR	1,875	1,734	-8%	1,534	1,531	-0.2%
Alaska	300% GR	90	--	--	79	--	--
American Samoa	--	--	--	--	--	--	--
Arizona	300% GR	1,122	1,381	23%	1,114	1,265	14%
Arkansas	200% GR	407	577	42%	389	577	48%
California	400% GR	36,738	35,588	-3%	26,586	26,223	-1%
Colorado	400% GR	3,067	3,179	4%	1,775	1,765	-1%
Connecticut	400% NET	2,053	2,076	1%	1,678	1,652	-2%
Delaware	500% GR	1,460	--	--	677	--	--
District of Columbia	500% GR	1,458	--	--	861	--	--
Federated States of Micronesia	--	--	--	--	--	--	--
Florida	400% GR	9,819	11,868	21%	8,396	8,260	-2%
Georgia	300% GR	4,004	4,748	19%	3,958	3,794	-4%
Guam	200% NET	--	--	--	--	--	--
Hawaii	400% GR	315	341	8%	266	312	17%
Idaho	200% GR	146	3	-98%	123	115	-7%
Illinois	300% GR	5,604	5,009	-11%	4,097	3,452	-16%
Indiana	300% GR	1,913	1,932	1%	1,885	1,932	2%
Iowa	200% GR	617	638	3%	471	517	10%
Kansas	300% GR	1,153	--	--	778	--	--
Kentucky	300% GR	1,745	1,751	0%	1,424	1,395	-2%
Louisiana	200% GR	1,938	2,667	38%	1,938	1,891	-2%
Maine	500% GR	726	764	5%	285	408	43%
Marshall Islands	--	--	--	--	--	--	--
Maryland	500% GR	5,672	5,873	4%	4,071	3,437	-16%
Massachusetts	500% GR	6,059	5,654	-7%	4,285	2,712	-37%
Michigan	450% GR	2,825	3,495	24%	2,205	2,615	19%
Minnesota	300% GR	2,004	959	-52%	653	959	47%
Mississippi	400% GR	886	24	-97%	886	911	3%
Missouri	300% GR	2,519	2,461	-2%	1,727	1,679	-3%
Montana	330% GR	113	129	14%	92	117	27%
Nebraska	200% GR	552	542	-2%	377	356	-6%
Nevada	400% GR	1,113	1,231	11%	845	847	0%
New Hampshire	300% GR	319	344	8%	177	155	-12%
New Jersey	500% GR	7,005	6,089	-13%	6,086	4,248	-30%
New Mexico	300% GR	624	661	6%	623	657	5%
New York	435% GR	19,462	19,952	3%	15,811	16,078	2%
North Carolina	300% GR	5,463	6,547	20%	3,465	5,023	45%
North Dakota	300% GR	67	118	76%	60	98	63%
Northern Mariana Islands	--	--	--	--	--	--	--
Ohio	300% GR	3,415	3,626	6%	1,786	2,565	44%
Oklahoma	200% GR	1,275	1,352	6%	1,035	996	-4%
Oregon	200% GR	2,903	2,718	-6%	2,831	2,443	-14%
Pennsylvania	337% GR	5,550	5,202	-6%	4,299	4,226	-2%
Puerto Rico	200% NET	4,617	5,438	18%	4,617	4,466	-3%
Republic of Palau	--	--	--	--	--	--	--
Rhode Island	400% GR	660	685	4%	524	549	5%
South Carolina	300% GR	3,022	3,799	26%	2,455	2,272	-7%
South Dakota	300% GR	95	251	164%	95	215	126%
Tennessee	300% GR	3,931	4,246	8%	2,886	3,122	8%
Texas	200% GR	14,123	15,742	11%	10,959	10,707	-2%
Utah	250% GR	510	505	-1%	405	470	16%
Vermont	200% NET	312	324	4%	106	128	21%
Virgin Islands (U.S.)	400% GR	--	--	--	--	--	--
Virginia	400% GR	2,824	2,637	-7%	1,992	1,904	-4%
Washington	300% GR	3,393	3,984	17%	3,115	2,965	-5%
West Virginia	325% GR	529	603	14%	318	333	5%
Wisconsin	300% GR	1,761	1,862	6%	1,003	1,289	29%
Wyoming	332% GR	135	140	4%	70	58	-17%
Total		**179,988**	**181,449**		**138,173**	**133,689**	
***Comparison Total*[2]**		***175,827***	***181,449***	***3%***	***135,778***	***133,689***	***-2%***

[1] The 2011 Federal Poverty Level (FPL) was $10,380 (slightly higher in Alaska and Hawaii) for a household of one. GR=Gross income; NET=Net income.

[2] Comparison Totals are based on only those ADAPs that reported data in both time periods.

Note: 52 ADAPs reported data in June 2011 (American Samoa, Federated States of Micronesia, Guam, Northern Mariana Islands, Republic of Palau, and the U.S. Virgin Islands did not report data). 48 ADAPs reported data in December 2011 (Alaska, American Samoa, Delaware, District of Columbia, Federated States of Micronesia, Guam, Kansas, Northern Mariana Islands, Republic of Palau, and the U.S. Virgin Islands did not report data).

Table 2: ADAP Coordination with Private Insurance Providers, December 2011

State/Territory	Private Insurance				
	Insurance Benefits Manager	In-house Coordination	CBO Sub-contractor	Data Sharing Agreement	Other
Alabama	--	Yes	--	--	--
Alaska	--	--	--	--	--
American Samoa	--	--	--	--	--
Arizona	--	Yes	--	--	--
Arkansas	--	--	--	--	Yes
California	--	Yes	--	--	--
Colorado	--	Yes	Yes	--	--
Connecticut	--	Yes	Yes	--	--
Delaware	--	--	--	--	--
District of Columbia	--	--	--	--	--
Federated States of Micronesia	--	--	--	--	--
Florida	--	--	--	--	Yes
Georgia	--	Yes	--	--	--
Guam	--	--	--	--	--
Hawaii	--	--	--	--	Yes
Idaho	--	Yes	--	--	--
Illinois	--	--	Yes	--	--
Indiana	--	Yes	--	--	--
Iowa	--	Yes	Yes	--	Yes
Kansas	--	--	--	--	--
Kentucky	--	--	Yes	--	--
Louisiana	--	--	Yes	--	--
Maine	--	Yes	--	--	--
Marshall Islands	--	--	--	--	--
Maryland	--	Yes	--	--	Yes
Massachusetts	--	--	Yes	--	--
Michigan	Yes	--	--	Yes	--
Minnesota	--	Yes	--	--	--
Mississippi	--	--	--	--	Yes
Missouri	Yes	Yes	--	--	--
Montana	--	--	--	--	Yes
Nebraska	--	Yes	--	--	--
Nevada	--	Yes	Yes	--	--
New Hampshire	--	Yes	--	--	--
New Jersey	--	--	Yes	--	--
New Mexico	--	Yes	--	--	--
New York	--	Yes	--	--	--
North Carolina	--	--	--	--	--
North Dakota	--	--	--	--	Yes
Northern Mariana Islands	--	--	--	--	--
Ohio	Yes	Yes	--	--	--
Oklahoma	Yes	--	--	--	--
Oregon	--	Yes	--	Yes	--
Pennsylvania	--	--	--	Yes	--
Puerto Rico	--	Yes	--	--	--
Republic of Palau	--	--	--	--	--
Rhode Island	--	--	Yes	--	--
South Carolina	--	Yes	--	--	--
South Dakota	--	--	--	--	Yes
Tennessee	Yes	--	--	--	--
Texas	--	--	--	--	Yes
Utah	Yes	Yes	--	--	--
Vermont	Yes	Yes	--	--	--
Virgin Islands (U.S.)	--	--	--	--	--
Virginia	--	--	--	--	Yes
Washington	Yes	--	--	--	--
West Virginia	Yes	--	--	--	--
Wisconsin	--	Yes	--	--	--
Wyoming	--	Yes	--	--	--
Total	**9**	**26**	**10**	**3**	**11**

Note: 48 ADAPs reported data. Alaska, American Samoa, Delaware, District of Columbia, Federated States of Micronesia, Guam, Kansas, Northern Mariana Islands, Republic of Palau, and the U.S. Virgin Islands did not report data.

Table 3: ADAP Coordination with High-Risk Pool Insurance Providers, Including PCIP, December 2011

State/Territory	High-risk Insurance Pool					PCIP				
	Insurance Benefits Manager	In-house Coordination	CBO Sub-contractor	Data Sharing Agreement	Other	Insurance Benefits Manager	In-house Coordination	CBO Sub-contractor	Data Sharing Agreement	Other
Alabama	--	--	--	--	Yes	--	--	--	--	Yes
Alaska	--	--	--	--	--	--	--	--	--	--
American Samoa	--	--	--	--	--	--	--	--	--	--
Arizona	--	--	--	--	Yes	--	Yes	Yes	--	--
Arkansas	--	--	--	--	Yes	--	--	--	--	Yes
California	--	--	--	--	--	--	Yes	--	--	--
Colorado	--	Yes	Yes	--	--	--	Yes	Yes	--	--
Connecticut	--	Yes	Yes	--	--	--	Yes	Yes	--	--
Delaware	--	--	--	--	--	--	--	--	--	--
District of Columbia	--	--	--	--	--	--	--	--	--	--
Federated States of Micronesia	--	--	--	--	--	--	--	--	--	--
Florida	--	--	--	--	Yes	--	--	--	--	Yes
Georgia	--	--	--	--	Yes	--	Yes	--	--	--
Guam	--	--	--	--	--	--	--	--	--	--
Hawaii	--	--	--	--	Yes	--	--	--	--	Yes
Idaho	--	--	--	--	Yes	--	--	--	--	Yes
Illinois	--	--	Yes	--	--	Yes	--	Yes	--	--
Indiana	--	Yes	Yes	--	--	--	Yes	--	--	--
Iowa	--	Yes	Yes	--	Yes	--	--	--	--	Yes
Kansas	--	--	--	--	--	--	--	--	--	--
Kentucky	--	--	Yes	--	--	--	--	Yes	--	--
Louisiana	--	--	Yes	--	--	--	--	Yes	--	--
Maine	--	Yes	--	--	--	--	Yes	--	--	--
Marshall Islands	--	--	--	--	--	--	--	--	--	--
Maryland	--	Yes	--	--	Yes	--	--	--	--	Yes
Massachusetts	--	--	--	--	Yes	--	--	--	--	Yes
Michigan	--	--	--	--	Yes	Yes	--	--	Yes	Yes
Minnesota	Yes	--	--	--	--	--	Yes	--	--	--
Mississippi	--	--	--	--	Yes	--	--	--	--	Yes
Missouri	Yes	Yes	--	--	--	Yes	Yes	--	--	--
Montana	--	--	--	--	Yes	--	--	--	--	Yes
Nebraska	--	Yes	--	--	--	--	Yes	--	--	--
Nevada	--	--	--	--	Yes	--	--	--	--	Yes
New Hampshire	--	Yes	--	--	--	--	Yes	--	--	--
New Jersey	--	--	--	--	Yes	--	--	--	--	Yes
New Mexico	--	Yes	--	--	--	--	Yes	--	--	--
New York	--	--	--	--	Yes	--	Yes	--	--	--
North Carolina	--	--	--	--	--	--	--	--	--	--
North Dakota	--	--	--	--	Yes	--	--	--	--	Yes
Northern Mariana Islands	--	--	--	--	--	--	--	--	--	--
Ohio	--	--	--	--	--	Yes	Yes	--	--	--
Oklahoma	Yes	Yes	--	--	--	--	--	--	--	Yes
Oregon	--	Yes	--	Yes	--	--	Yes	--	Yes	--
Pennsylvania	--	--	--	--	--	--	--	--	--	--
Puerto Rico	--	--	--	--	Yes	--	--	--	--	Yes
Republic of Palau	--	--	--	--	--	--	--	--	--	--
Rhode Island	--	--	--	--	Yes	--	--	--	--	Yes
South Carolina	--	--	--	--	Yes	--	Yes	--	--	--
South Dakota	--	--	--	--	Yes	--	--	--	--	Yes
Tennessee	--	--	--	--	Yes	Yes	--	--	--	--
Texas	--	--	--	--	Yes	Yes	--	--	--	--
Utah	--	Yes	--	--	--	--	Yes	--	--	--
Vermont	--	--	--	--	Yes	--	--	--	--	Yes
Virgin Islands (U.S.)	--	--	--	--	--	--	--	--	--	--
Virginia	--	--	--	--	Yes	Yes	Yes	--	--	Yes
Washington	Yes	--	--	--	--	Yes	--	--	--	--
West Virginia	--	--	--	--	Yes	--	--	--	--	Yes
Wisconsin	--	Yes	--	--	--	--	Yes	--	--	--
Wyoming	--	--	--	--	Yes	--	--	--	--	Yes
Total	**4**	**14**	**7**	**1**	**27**	**8**	**19**	**6**	**2**	**22**

Note: 48 ADAPs reported data. Alaska, American Samoa, Delaware, District of Columbia, Federated States of Micronesia, Guam, Kansas, Northern Mariana Islands, Republic of Palau, and the U.S. Virgin Islands did not report data.

Table 4: ADAP Coordination with Public Insurance Providers, December 2011

State/Territory	Medicaid					Medicare (Including Medicare Part D)				
	Insurance Benefits Manager	In-house Coordination	CBO Sub-contractor	Data Sharing Agreement	Other	Insurance Benefits Manager	In-house Coordination	CBO Sub-contractor	Data Sharing Agreement	Other
Alabama	--	Yes	--	--	--	--	Yes	--	Yes	--
Alaska	--	--	--	--	--	--	--	--	--	--
American Samoa	--	--	--	--	--	--	--	--	--	--
Arizona	--	--	--	--	Yes	--	Yes	--	--	--
Arkansas	--	--	Yes	--	--	--	--	Yes	Yes	--
California	--	Yes	--	--	--	--	Yes	--	Yes	--
Colorado	--	Yes	--	--	--	--	Yes	--	--	--
Connecticut	--	Yes	--	--	--	--	Yes	--	Yes	--
Delaware	--	--	--	--	--	--	--	--	--	--
District of Columbia	--	--	--	--	--	--	--	--	--	--
Federated States of Micronesia	--	--	--	--	--	--	--	--	--	--
Florida	--	--	--	Yes	--	Yes	--	--	Yes	--
Georgia	--	Yes	--	--	--	--	Yes	--	--	--
Guam	--	--	--	--	--	--	--	--	--	--
Hawaii	--	--	--	--	Yes	--	--	--	Yes	Yes
Idaho	--	Yes	--	--	--	--	Yes	--	--	--
Illinois	--	Yes	Yes	--	--	Yes	Yes	Yes	Yes	--
Indiana	--	Yes	--	Yes	--	--	Yes	--	--	--
Iowa	--	--	--	--	Yes	--	--	--	--	Yes
Kansas	--	--	--	--	--	--	--	--	--	--
Kentucky	--	--	--	Yes	--	--	--	--	Yes	--
Louisiana	--	Yes	--	--	--	--	--	Yes	--	--
Maine	--	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	--	Yes	--	--	--	--	Yes	--	--	--
Mississippi	--	Yes	--	--	--	--	Yes	--	--	--
Missouri	Yes	Yes	--	--	--	Yes	Yes	--	--	--
Montana	--	--	--	--	Yes	--	--	--	--	Yes
Nebraska	--	--	--	--	Yes	--	Yes	--	Yes	--
Nevada	--	--	Yes	--	--	--	Yes	Yes	--	--
New Hampshire	--	Yes	--	--	--	--	Yes	--	--	--
New Jersey	--	Yes	--	--	--	--	Yes	--	--	--
New Mexico	--	--	--	--	Yes	--	--	--	--	Yes
New York	--	--	--	Yes	--	--	Yes	--	--	--
North Carolina	--	--	--	--	--	Yes	--	--	Yes	--
North Dakota	--	--	--	--	Yes	--	--	--	--	Yes
Northern Mariana Islands	--	--	--	--	--	--	--	--	--	--
Ohio	Yes	Yes	--	--	--	Yes	Yes	--	--	--
Oklahoma	--	--	--	--	Yes	Yes	Yes	--	Yes	--
Oregon	--	Yes	--	Yes	--	Yes	Yes	--	Yes	--
Pennsylvania	--	--	--	Yes	--	--	--	--	Yes	--
Puerto Rico	--	Yes	--	Yes	--	--	--	--	Yes	--
Republic of Palau	--	--	--	--	--	--	--	--	--	--
Rhode Island	--	--	Yes	Yes	--	--	--	Yes	Yes	--
South Carolina	--	Yes	--	Yes	--	Yes	Yes	--	Yes	--
South Dakota	--	--	--	--	Yes	--	--	--	--	Yes
Tennessee	--	--	--	--	Yes	--	--	--	--	Yes
Texas	--	--	--	Yes	--	Yes	--	--	--	--
Utah	--	Yes	--	--	--	--	--	--	Yes	--
Vermont	Yes	Yes	--	Yes	--	Yes	Yes	--	Yes	--
Virgin Islands (U.S.)	--	--	--	--	--	--	--	--	--	--
Virginia	--	--	--	Yes	Yes	Yes	Yes	--	Yes	Yes
Washington	--	Yes	--	Yes	--	Yes	Yes	--	Yes	--
West Virginia	Yes	--	--	--	--	Yes	--	--	--	--
Wisconsin	--	Yes	--	--	--	--	Yes	--	--	--
Wyoming	--	Yes	--	--	--	--	Yes	--	--	--
Total	**4**	**26**	**5**	**17**	**13**	**13**	**29**	**6**	**24**	**10**

Note: 48 ADAPs reported data. Alaska, American Samoa, Delaware, District of Columbia, Federated States of Micronesia, Guam, Kansas, Northern Mariana Islands, Republic of Palau, and the U.S. Virgin Islands did not report data.

Table 5: ADAP Coordination with Pre-existing Condition Insurance Plans (PCIP), December 2011

State/Territory	Adminstration of PCIP[1]	ADAP Able to Enroll Clients in PCIP	Clients Enrolled in PCIP	Average Annual Cost per Client	ADAP Anticipating Enrolling Clients in PCIP	Clients Anticipated to Enroll in PCIP
Alabama	Federal	--	--	--	--	--
Alaska	State	--	--	--	--	--
American Samoa	--	--	--	--	--	--
Arizona	Federal	Yes	393	$10,527	--	--
Arkansas	State	--	--	--	--	--
California	State	Yes	29	$2,500	--	--
Colorado	State	Yes	40	$10,000	--	--
Connecticut	State	Yes	0	--	--	--
Delaware	Federal	--	--	--	--	--
District of Columbia	Federal	--	--	--	--	--
Federated States of Micronesia	--	--	--	--	--	--
Florida	Federal	Yes	20	--	--	--
Georgia	Federal	Yes	10	$10,486	--	--
Guam	--	--	--	--	--	--
Hawaii	Federal	--	--	--	--	--
Idaho	Federal	--	--	--	--	--
Illinois	State	Yes	45	$1,600	--	--
Indiana	Federal	--	--	--	Yes	40
Iowa	State	--	--	--	--	--
Kansas	State	--	--	--	--	--
Kentucky	Federal	Yes	2	$4,500	--	--
Louisiana	Federal	--	--	--	Yes	600
Maine	State	Yes	0	Unknown	--	--
Marshall Islands	--	--	--	--	--	--
Maryland	State	--	--	--	--	--
Massachusetts	Federal	--	--	--	--	--
Michigan	State	Yes	159	$7,727	--	--
Minnesota	Federal	--	--	--	Yes	5
Mississippi	Federal	--	--	--	--	--
Missouri	State	Yes	244	$9,000	--	--
Montana	State	--	--	--	--	--
Nebraska	Federal	Yes	2	$6,684	--	--
Nevada	Federal	--	--	--	--	--
New Hampshire	State	Yes	6	$1,500	--	--
New Jersey	State	--	--	--	--	--
New Mexico	State	Yes	80	$4,798	--	--
New York	State	Yes	675	--	--	--
North Carolina	State	--	--	--	Yes	100
North Dakota	Federal	--	--	--	Yes	3
Northern Mariana Islands	--	--	--	--	--	--
Ohio	State	Yes	28	$3,628	--	--
Oklahoma	State	--	--	--	--	--
Oregon	State	Yes	277	$2,900	--	--
Pennsylvania	State	--	--	--	--	--
Puerto Rico	--	--	--	--	--	--
Republic of Palau	--	--	--	--	--	--
Rhode Island	State	--	--	--	--	--
South Carolina	Federal	Yes	39	$8,027	--	--
South Dakota	State	Yes	2	--	--	--
Tennessee	Federal	Yes	31	$4,921	--	--
Texas	Federal	Yes	1	--	--	--
Utah	State	Yes	2	$6,894	--	--
Vermont	Federal	--	--	--	--	--
Virgin Islands (U.S.)	--	--	--	--	--	--
Virginia	Federal	--	--	--	Yes	Unknown
Washington	State	Yes	282	$8,820	--	--
West Virginia	Federal	--	--	--	--	--
Wisconsin	State	Yes	26	$4,155	--	--
Wyoming	Federal	--	--	--	--	--
Total		**24**	**2,393**	**$6,037**	**6**	**748**

[1] PCIPs are not administered in American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Northern Mariana Islands, Puerto Rico, Republic of Palau, and U.S. Virgin Islands.

Note: 48 ADAPs reported data. Alaska, American Samoa, Delaware, District of Columbia, Federated States of Micronesia, Guam, Kansas, Northern Mariana Islands, Republic of Palau, and the U.S. Virgin Islands did not report data.

Table 6: ADAP Data Sharing Agreements, December 2011

State/Territory	Data Sharing Agreement with CMS	Data Sharing Agreement with Other Entity	
		Private Insurance	Other
Alabama	Yes	--	Department of Industrial Relations
Alaska	--	--	--
American Samoa	--	--	--
Arizona	--	--	--
Arkansas	Yes	--	--
California	Yes	--	--
Colorado	Yes	--	--
Connecticut	Yes	--	--
Delaware	--	--	--
District of Columbia	--	--	--
Federated States of Micronesia	--	--	--
Florida	Yes	--	Ryan White Part A
Georgia	Yes	--	--
Guam	--	--	--
Hawaii	Yes	--	--
Idaho	Yes	--	--
Illinois	Yes	--	--
Indiana	--	Yes	--
Iowa	--	--	Surveillance
Kansas	--	--	--
Kentucky	Yes	--	--
Louisiana	Yes	--	--
Maine	Yes	--	MaineCare
Marshall Islands	--	--	--
Maryland	Yes	--	--
Massachusetts	--	--	--
Michigan	Yes	--	Insurance Matching service
Minnesota	Yes	Yes	--
Mississippi	Yes	--	--
Missouri	--	--	--
Montana	--	--	--
Nebraska	Yes	--	--
Nevada	--	--	--
New Hampshire	--	--	--
New Jersey	Yes	--	Molina
New Mexico	Yes	--	--
New York	Yes	--	Social Security Administration
North Carolina	Yes	--	--
North Dakota	--	--	--
Northern Mariana Islands	--	--	--
Ohio	Yes	--	--
Oklahoma	Yes	--	--
Oregon	Yes	--	Ryan White Part B, Ryan White Part C, state high risk insurance pool, HIV Surveillance Unit
Pennsylvania	Yes	--	--
Puerto Rico	Yes	--	--
Republic of Palau	--	--	--
Rhode Island	Yes	--	--
South Carolina	Yes	--	--
South Dakota	--	--	--
Tennessee	--	--	--
Texas	Yes	--	State Medicaid
Utah	Yes	--	--
Vermont	Yes	--	State Medicaid
Virgin Islands (U.S.)	--	--	--
Virginia	Yes	--	Department of Medication Assistance Services
Washington	Yes	--	--
West Virginia	--	--	--
Wisconsin	--	--	--
Wyoming	Yes	--	--
Total	**35**	**2**	**11**

Note: 48 ADAPs reported data. Alaska, American Samoa, Delaware, District of Columbia, Federated States of Micronesia, Guam, Kansas, Northern Mariana Islands, Republic of Palau, and the U.S. Virgin Islands did not report data.

Table 7: ADAP Access to CMS Section 1115 Waivers for People Living with HIV/AIDS, December 2011

State/Territory	CMS Section 1115 Waiver in Place for People Living with HIV/AIDS	Currently Applying for/Anticipate Applying for a CMS Section 1115 Waiver
Alabama	--	--
Alaska	--	--
American Samoa	--	--
Arizona	--	--
Arkansas	--	--
California	Yes	--
Colorado	--	--
Connecticut	--	Yes
Delaware	--	--
District of Columbia	--	--
Federated States of Micronesia	--	--
Florida	--	--
Georgia	--	--
Guam	--	--
Hawaii	Yes	--
Idaho	--	--
Illinois	--	--
Indiana	--	--
Iowa	--	--
Kansas	--	--
Kentucky	--	--
Louisiana	--	--
Maine	Yes	--
Marshall Islands	--	--
Maryland	--	--
Massachusetts	Yes	--
Michigan	--	--
Minnesota	--	--
Mississippi	--	--
Missouri	--	--
Montana	--	--
Nebraska	--	Yes
Nevada	--	Yes
New Hampshire	--	--
New Jersey	--	Yes
New Mexico	--	Yes
New York	Yes	--
North Carolina	--	--
North Dakota	--	--
Northern Mariana Islands	--	--
Ohio	--	Yes
Oklahoma	--	--
Oregon	--	--
Pennsylvania	--	--
Puerto Rico	--	--
Republic of Palau	--	--
Rhode Island	--	--
South Carolina	--	--
South Dakota	--	--
Tennessee	--	--
Texas	--	--
Utah	--	--
Vermont	--	--
Virgin Islands (U.S.)	--	--
Virginia	--	--
Washington	--	--
West Virginia	--	--
Wisconsin	--	--
Wyoming	--	--
Total	**5**	**6**

Note: 48 ADAPs reported data. Alaska, American Samoa, Delaware, District of Columbia, Federated States of Micronesia, Guam, Kansas, Northern Mariana Islands, Republic of Palau, and the U.S. Virgin Islands did not report data.

Table 8: ADAP Policies Related to Medicare I

State/Territory	ADAP Pays Premiums		ADAP Pays Deductibles		ADAP Pays C	
	Partial Subsidy Clients	Standard Clients	Partial Subsidy Clients	Standard Clients	Dually Eligible Clients	Full Subsidy Clients
Alabama	--	Yes	--	--	--	--
Alaska	--	--	--	--	--	--
American Samoa	--	--	--	--	--	--
Arizona	--	--	Yes	Yes	--	Yes
Arkansas	--	--	--	--	--	--
California	--	--	Yes	Yes	Yes	Yes
Colorado	Yes	Yes	Yes	Yes	Yes	Yes
Connecticut	Yes	Yes	Yes	Yes	Yes	--
Delaware	--	--	--	--	--	--
District of Columbia	--	--	--	--	--	--
Federated States of Micronesia	--	--	--	--	--	--
Florida	--	Yes	Yes	Yes	Yes	Yes
Georgia	--	--	--	--	--	--
Guam	--	--	--	--	--	--
Hawaii	--	--	Yes	Yes	--	Yes
Idaho	--	--	--	Yes	--	--
Illinois	--	--	Yes	Yes	Yes	Yes
Indiana	--	--	Yes	--	--	Yes
Iowa	Yes	Yes	Yes	Yes	Yes	Yes
Kansas	--	--	--	--	--	--
Kentucky	--	--	Yes	Yes	Yes	Yes
Louisiana	Yes	Yes	Yes	Yes	Yes	Yes
Maine	Yes	Yes	Yes	Yes	Yes	Yes
Marshall Islands	--	--	--	--	--	--
Maryland	Yes	Yes	Yes	Yes	--	Yes
Massachusetts	--	Yes	--	--	Yes	Yes
Michigan	Yes	Yes	Yes	Yes	--	Yes
Minnesota	--	Yes	--	Yes	--	--
Mississippi	--	--	--	--	--	--
Missouri	--	--	--	--	--	--
Montana	--	--	--	--	--	--
Nebraska	--	--	Yes	Yes	--	Yes
Nevada	Yes	Yes	Yes	Yes	Yes	Yes
New Hampshire	Yes	Yes	Yes	Yes	Yes	Yes
New Jersey	--	--	--	--	--	--
New Mexico	--	--	--	--	Yes	Yes
New York	Yes	Yes	Yes	Yes	--	Yes
North Carolina	Yes	Yes	Yes	Yes	--	Yes
North Dakota	--	--	--	--	--	--
Northern Mariana Islands	--	--	--	--	--	--
Ohio	Yes	Yes	Yes	Yes	Yes	Yes
Oklahoma	Yes	Yes	Yes	Yes	Yes	Yes
Oregon	Yes	--	Yes	Yes	Yes	Yes
Pennsylvania	Yes	Yes	Yes	Yes	Yes	Yes
Puerto Rico	--	--	--	--	--	--
Republic of Palau	--	--	--	--	--	--
Rhode Island	--	--	--	--	Yes	Yes
South Carolina	--	--	Yes	Yes	--	--
South Dakota	Yes	Yes	Yes	Yes	Yes	Yes
Tennessee	--	--	--	--	--	--
Texas	--	--	Yes	Yes	--	--
Utah	Yes	Yes	Yes	Yes	--	Yes
Vermont	Yes	Yes	--	Yes	Yes	Yes
Virgin Islands (U.S.)	--	--	--	--	--	--
Virginia	Yes	Yes	Yes	Yes	--	--
Washington	Yes	Yes	Yes	Yes	Yes	Yes
West Virginia	--	--	Yes	Yes	Yes	Yes
Wisconsin	Yes	Yes	Yes	Yes	Yes	Yes
Wyoming	--	--	--	--	Yes	--
Total	**21**	**24**	**31**	**33**	**24**	**31**

Note: 48 ADAPs reported data. Alaska, American Samoa, Delaware, District of Columbia, Federated States of Micronesia, Guam, Kansa

Part D, as of December 31, 2011

Co-payments		Eligible for ADAP				Provide Medications During the Donut Hole
Partial Subsidy Clients	Standard Clients	Dually Eligible Clients	Full Subsidy Clients	Partial Subsidy Clients	Standard Clients	
--	Yes	--	--	--	--	Yes
--	--	--	--	--	--	--
--	--	--	--	--	--	--
Yes	Yes	--	Yes	Yes	Yes	Yes
Yes	--	--	--	Yes	--	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	--	--	Yes	Yes	Yes
--	--	--	--	--	--	--
--	--	--	--	--	--	--
--	--	--	--	--	--	--
Yes	Yes	Yes	Yes	--	Yes	Yes
--	--	--	--	Yes	Yes	--
--	--	--	--	--	--	--
Yes	Yes	--	Yes	Yes	Yes	Yes
--	Yes	--	--	--	--	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	--	--	--	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes
--	--	--	--	--	--	--
Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes
--	--	--	--	--	--	--
Yes	Yes	--	Yes	Yes	Yes	Yes
--	--	--	--	--	--	--
Yes	Yes	Yes	--	--	Yes	Yes
Yes	Yes	--	Yes	Yes	Yes	Yes
Yes	Yes	--	--	--	--	Yes
--	--	--	--	--	--	Yes
--	--	Yes	Yes	Yes	Yes	Yes
--	--	--	--	--	--	--
Yes	Yes	--	Yes	Yes	Yes	Yes
Yes	Yes	--	--	--	--	--
Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	--	Yes	Yes	Yes	Yes
Yes	Yes	--	Yes	Yes	Yes	Yes
--	--	--	--	--	--	--
--	--	--	--	--	--	--
Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes
--	--	--	--	--	--	--
Yes	Yes	--	--	--	Yes	Yes
Yes	Yes	--	Yes	Yes	Yes	Yes
--	Yes	Yes	Yes	Yes	Yes	Yes
--	--	--	--	--	--	--
Yes	Yes	--	--	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes	Yes	Yes
--	--	Yes	--	--	--	Yes
36	**38**	**24**	**29**	**33**	**35**	**40**

s, Northern Mariana Islands, Republic of Palau, and the U.S. Virgin Islands did not report data.

Table 9: ADAP Clients Enrolled in Medicare Part D, December 2011

State/Territory	Total Clients Enrolled in Medicare Part D	Dual Eligible[1]	Full Subsidy[2]	Partial Subsidy[3]	Standard Benefit[4]	Unknown	Data Source(s) for Benefit Level			
							Medicaid Match	ADAP data	Client self-reporting	Other
Alabama	89	0%	9%	12%	79%	0%	Yes	Yes	Yes	Yes
Alaska	--	--	--	--	--	--	--	--	--	--
American Samoa	--	--	--	--	--	--	--	--	--	--
Arizona	349	0%	14%	13%	68%	4%	--	--	--	Yes
Arkansas	86	0%	0%	100%	0%	0%	Yes	Yes	--	--
California	3,626	39%	12%	4%	45%	0%	--	Yes	--	--
Colorado	261	0%	0%	0%	0%	100%	--	Yes	--	--
Connecticut	433	0%	68%	2%	30%	0%	--	--	Yes	--
Delaware	--	--	--	--	--	--	--	--	--	--
District of Columbia	--	--	--	--	--	--	--	--	--	--
Federated States of Micronesia	--	--	--	--	--	--	--	--	--	--
Florida	735	3%	13%	4%	80%	0%	--	Yes	--	--
Georgia	326	0%	0%	33%	67%	0%	--	Yes	--	--
Guam	--	--	--	--	--	--	--	--	--	--
Hawaii	82	0%	40%	7%	52%	0%	--	Yes	--	--
Idaho	0	0%	0%	0%	0%	0%	Yes	--	Yes	--
Illinois	117	2%	9%	10%	79%	0%	Yes	Yes	--	--
Indiana	36	0%	33%	14%	53%	0%	--	--	Yes	--
Iowa	46	50%	33%	11%	7%	0%	--	Yes	--	--
Kansas	--	--	--	--	--	--	--	--	--	--
Kentucky	1,751	0%	0%	0%	0%	100%	Yes	Yes	--	Yes
Louisiana	0	0%	0%	0%	0%	0%	--	--	--	Yes
Maine	340	50%	0%	0%	8%	42%	--	Yes	--	--
Marshall Islands	--	--	--	--	--	--	--	--	--	--
Maryland	1,480	0%	58%	4%	21%	17%	--	Yes	--	--
Massachusetts	1,416	89%	0%	0%	11%	0%	--	Yes	Yes	--
Michigan	564	0%	37%	11%	50%	2%	--	Yes	--	--
Minnesota	159	0%	0%	26%	74%	0%	--	Yes	--	--
Mississippi	47	0%	0%	0%	100%	0%	--	--	--	Yes
Missouri	776	94%	0%	0%	6%	0%	Yes	--	Yes	--
Montana	0	0%	0%	0%	0%	0%	--	--	--	--
Nebraska	0	0%	0%	0%	0%	0%	--	--	--	--
Nevada	327	19%	16%	2%	61%	1%	--	Yes	Yes	Yes
New Hampshire	197	37%	40%	4%	20%	0%	--	Yes	Yes	--
New Jersey	361	7%	7%	5%	81%	0%	Yes	--	--	--
New Mexico	121	0%	0%	0%	0%	100%	--	--	Yes	Yes
New York	2,794	0%	39%	9%	52%	0%	--	Yes	--	--
North Carolina	523	0%	0%	0%	0%	100%	Yes	Yes	--	--
North Dakota	0	0%	0%	0%	0%	0%	--	--	Yes	--
Northern Mariana Islands	--	--	--	--	--	--	--	--	--	--
Ohio	1,265	0%	66%	8%	25%	1%	Yes	Yes	--	--
Oklahoma	327	9%	32%	19%	34%	6%	--	Yes	--	Yes
Oregon	967	13%	50%	11%	26%	0%	Yes	Yes	Yes	--
Pennsylvania	1,213	0%	4%	16%	80%	0%	Yes	--	--	--
Puerto Rico	0	0%	0%	0%	0%	0%	Yes	Yes	--	--
Republic of Palau	--	--	--	--	--	--	--	--	--	--
Rhode Island	161	42%	25%	22%	10%	0%	Yes	Yes	Yes	--
South Carolina	110	0%	0%	5%	90%	5%	Yes	Yes	Yes	--
South Dakota	14	100%	0%	0%	0%	0%	--	--	Yes	Yes
Tennessee	0	0%	0%	0%	0%	0%	--	--	--	--
Texas	1,691	0%	0%	0%	0%	100%	--	--	Yes	Yes
Utah	3	0%	100%	0%	0%	0%	Yes	Yes	--	--
Vermont	114	54%	22%	15%	9%	0%	Yes	Yes	Yes	--
Virgin Islands (U.S.)	--	--	--	--	--	--	--	--	--	--
Virginia	293	0%	0%	48%	37%	14%	Yes	Yes	Yes	--
Washington	1,441	21%	42%	7%	30%	0%	Yes	Yes	Yes	--
West Virginia	130	9%	15%	35%	38%	3%	--	Yes	Yes	Yes
Wisconsin	76	0%	9%	57%	34%	0%	--	Yes	Yes	--
Wyoming	50	20%	0%	0%	80%	0%	Yes	--	Yes	--
Total	**24,897**	**18%**	**22%**	**7%**	**34%**	**20%**	**19**	**31**	**21**	**11**

[1] Dual eligible clients are individuals who are eligible for both Medicare and Medicaid.

[2] Full subsidy clients are those with an income less than 135% FPL and assets below $7,790 for individuals and $12,440 for couples.

[3] Partial subsidy clients are those with an income between 136% and 150% FPL and assets below $11,990 for individuals and $23,972 for couples.

[4] Standard benefit clients are those with an income greater than 150% FPL.

Note: 48 ADAPs reported data. Alaska, American Samoa, Delaware, District of Columbia, Federated States of Micronesia, Guam, Kansas, Northern Mariana Islands, Republic of Palau, and the U.S. Virgin Islands did not report data.

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.

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 dates back 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 - Some ADAPs pay the co-payments for ADAP formulary drugs, which can be 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. Co-payments are 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.
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.

Dual Purchaser – ADAPs using this model centrally purchase and dispense medications through their own pharmacy or a single contract pharmacy services provider and also bill drug manufacturers for the 340B Unit Rebate Amount for the number of units dispensed for clients accessing an insurance plan (public or private).

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, state high risk insurance pools or Pre-existing Condition Insurance Plans (PCIPs).

Part A funding - Provided to metropolitan jurisdictions, some of whom make local decisions 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. To see information on pharmaceutical company co-payment assistance and patient assistance programs, please visit the Positively Aware website or the Fair Pricing Coalition's website.

Rebate states – 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 and 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 1:4 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.