U.S. Department of Housing and Urban Development
OFFICE OF HIV/AIDS HOUSING

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TO: Sarah Hurwitz

DATE: August 1, 1997

COMMENTS: HOPWA INFO

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U. S. Department of Housing and Urban Development
Office of HIV/AIDS Housing
451 Seventh Street SW, Room 7154
Washington, DC 20410-7000

Correspondence Code	Originator	Concurrence	Concurrence	Concurrence	Concurrence	Concurrence
Name						
Date						

Housing Opportunities for Persons With AIDS

Community Collaborations to Provide Housing and Related Services for Persons Living with HIV or AIDS

Office of Community Planning and Development
U.S. Department of Housing and Urban Development

PROGRAM: The Housing Opportunities for Persons with AIDS (HOPWA) program provides housing assistance and supportive services for low-income persons with HIV/AIDS and their families. Grants are provided: (1) by formula allocations to States and metropolitan areas with the largest number of cases and incidence of AIDS; and (2) by selection through a national competition of projects proposed by State and local governments and nonprofit organizations. Grantees are encouraged to develop community-wide comprehensive strategies and form partnerships with area nonprofit organizations to provide housing assistance and supportive services for eligible persons.

CONSOLIDATED PLANNING: HOPWA formula grants are available as part of the area's Consolidated Plan, which also includes the Community Development Block Grant, HOME and Emergency Shelter Grants. Plans are developed through a public process that assesses area needs, creates a multiple-year strategy and proposes an action plan for use of Federal funds and other community resources in a coordinated and comprehensive manner. Ninty percent of the appropriation is allocated by formula to eligible communities.

FORMULA AWARDS: In FY 1997, a total of $176.4 million is being allocated by formula to the qualifying cities for 53 eligible metropolitan statistical areas (EMSAs) and to 27 eligible States for areas outside of EMSAs. Eligible formula areas have at least 1,500 cumulative reported cases of AIDS, as of March 31, and metropolitan areas have a population of at least 500,000. The formula uses AIDS statistics from the Centers for Disease Control and Prevention for cumulative cases and area incidence in allocating funds to eligible jurisdictions.

COMPETITIVE GRANTS: Ten percent of the appropriated funds are awarded by competition. During fiscal year 1997, $19.6 million will be made available on a competitive basis pursuant to a Notice of Funds Availability (NOFA) to be issued. In 1996, the NOFA was published in the Federal Register on February 28, 1996 (61 FR 7664) and HUD selected 19 applications on August 23, 1996 for $17.1 million in awards. A notice was published on October 23, 1996 (61 FR 55009) for:

(1) nine grants for **Special Projects of National Significance (SPNS)** which, due to their innovative nature or their potential for replication, are likely to serve as effective models in addressing the needs of eligible persons; and

(2) eight grants under the **HIV Multiple Diagnoses Initiative (MDI)** which target assistance to homeless persons living with HIV/AIDS who also have chronic alcohol and/or other drug abuse problems and/or serious mental illness. Applications for these two categories can be submitted by States, units of general local government and nonprofit organizations. In addition, awards were made for a third component:

(3) two grants in non-formula areas for **Projects which are part of Long-term Comprehensive Strategies** for providing housing and services for eligible persons; applications for this category can be submitted by States and local governments in areas that did not qualify for formula allocations during that fiscal year.

expand GRANTS
expand States

PROGRAM USES: HOPWA funds have helped communities establish strategic plans, better coordinate local and private efforts, fill gaps in local systems of care, and create model programs. HOPWA funds may be used for a wide-array of housing, social services and program planning and development costs. Eligible activities include, but not limited to, the acquisition, rehabilitation or new construction of housing units, costs for the operation and maintenance of facilities and community residences, rental assistance and short-term payments to prevent homelessness. HOPWA may also support services, such as health care and mental health services, drug and alcohol abuse treatment and counseling, intensive care when required, nutritional services, case management, assistance with daily living, housing information and placement assistance and other services. The rule at 574.300(b) provides for eligible activities, subject to certain standards and limitations.

EMSA APPLICANTS: The city that is the largest unit of general local government in an EMSA will serve as the applicant for the metropolitan area's formula allocation. The planned activities are coordinated with other local governments to provide assistance to eligible persons who reside in that area.

In establishing the Office of HIV/AIDS Housing, the Secretary noted:

Being homeless and living with HIV is a devastating situation...we know the importance of a stable, supportive home environment in providing treatment and other services to persons with HIV/AIDS. We understand. We care.

Henry Cisneros

GOALS: As stated by the National Commission on AIDS in Housing and the HIV/AIDS Epidemic, issued in June 1992, there is "frequently desperate need for safe shelter that provides not only protection and comfort, but also a base in which and from which to receive services, care and support." Additionally, the program is authorized by statute "to provide States and localities with the resources and incentives to devise long-term comprehensive strategies for meeting the housing needs of persons with acquired immunodeficiency syndrome and families of such persons."

AUTHORIZATION: AIDS Housing Opportunity Act (42 U.S.C. 12901) as amended by the Housing and Community Development Act of 1992 (Pub. L. 102-550, approved October 28, 1992). Funds were appropriated in FY 1992 and for subsequent years. The Department's appropriation for Fiscal Year 1997 provides $171 million under a HOPWA line item and an additional $25 million that may become available during the year from recaputured funds.

REGULATIONS: The program is governed by the HOPWA Final Rule, 24 CFR Part 574, as amended, and the Consolidated Submissions for Community Planning and Development Programs, Final Rule, 24 CFR Part 91, as amended.

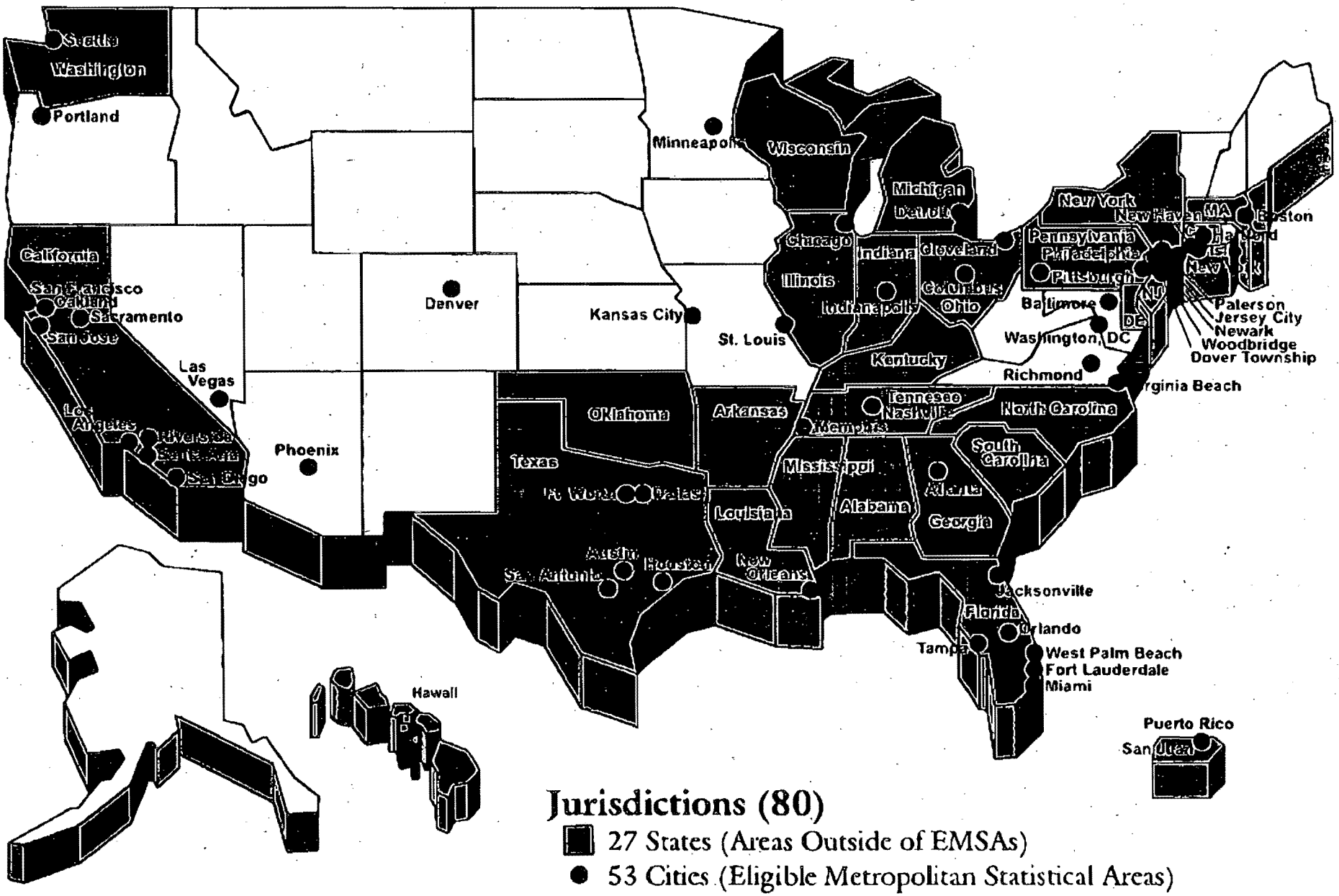
For More Information

Contact the HUD State or area Office or the Office of HIV/AIDS Housing, U.S. Department of Housing and Urban Development, 451 Seventh Street, S.W., Room 7154, Washington, D.C. 20410, or phone (202) 708-1934; TTY 1-800-877-8339, FAX: (202) 708-1744.

Information is available on HOPWA, including descriptions of the 1996 competitive grants and area consolidated plans and other related topics on the HUD HOME Page on the World Wide Web at *http://www.hud.gov/home.html*.

Technical assistance, information and other support is available under a National Technical Assistance Program operated by AIDS Housing of Washington and can be reached at (206) 448-5242 or by email at: *HN3836@handsnet.org*.

HOPWA 1997 Formula Jurisdictions



Jurisdictions (80)

- 27 States (Areas Outside of EMSAs)
- 53 Cities (Eligible Metropolitan Statistical Areas)

Office of HIV/AIDS Housing

Office of Community Planning and Development

In 1994, Department of Housing and Urban Development (HUD) Secretary, Henry Cisneros, established the Office of HIV/AIDS Housing to administer programs and advocate within HUD in order to eliminate barriers to providing housing assistance for persons living with HIV/AIDS and their families. As part of the Office of Community Planning and Development, the Office of HIV/AIDS Housing is the focal point for the Department on housing and related HUD initiatives developed to serve this population. The Office provides a coordinating link with other Federal agencies and the White House HIV/AIDS initiatives.

Specifically, the office is responsible for:

- developing responsive HIV/AIDS policies and related programs;
- maintaining interactive communications and outreach with clients, advocates, housing providers and other interested parties;
- establishing and maintaining effective liaison to other Federal offices and programs, including the National AIDS Policy Office in the White House;
- providing technical assistance to improve access to agency programs;
- managing the Housing Opportunities for Persons with AIDS (HOPWA) program and other assigned initiatives; and
- evaluating the effectiveness of current programs in addressing the housing and supportive services needs of this population.

For More Information

Contact the HUD State or area Office or the Office of HIV/AIDS Housing, U.S. Department of Housing and Urban Development, 451 Seventh Street, S.W., Room 7154, Washington, D.C. 20410, or phone (202) 708-1934; TTY 1-800-877-8339, FAX: (202) 708-1744.

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> *Being homeless and living with HIV is a devastating situation... we know the importance of a stable, supportive home environment in providing treatment and other services to persons with HIV/AIDS. We understand. We care.*
>
> Henry Cisneros

Technical assistance, information and other support is available through a HUD-funded National Technical Assistance Program operated by AIDS Housing of Washington (AHW). AHW can be reached at (206) 448-5242 or by email at: *HN3836@handsnet.org*.

Date: Wednesday, July 24, 1996
FOR IMMEDIATE RELEASE
Contact: Dorothy Bailey (301)443-3376

AIDS Drug Assistance Program

The AIDS Drug Assistance Program ("ADAP") provides medications and treatment to low income individuals with HIV disease, who are not protected by Medicaid or private health insurance prescription programs. ADAP is part of the Ryan White CARE Act, which provides emergency services to private and public nonprofit entities in areas most deeply affected by the AIDS epidemic.

Why is ADAP Needed ?

ADAP makes it possible for low income individuals with HIV disease and without other health insurance to have access to therapies they could not otherwise afford. Promising new drug therapies like protease inhibitors have significantly reduced the progression of disease in infected individuals, but these drugs are very expensive. Three of these drugs -- Ritonavir, Indinavir, and Saquinavir --are estimated to cost $6,500, $6,000, and $7,200 per year, respectively.

How Many States Have ADAPs?

All 50 states, the District of Columbia, and Puerto Rico, have ADAP programs, although five states currently use no federal funding.

What Are The Funding Sources, And What Has The Federal Government Contributed To ADAP?

ADAP is generally funded by combined state and federal contributions. States generally are required to contribute one dollar for every two federal ADAP dollars received. The federal government contributed over $105 million to ADAPs in 1995, an increase of $24 million over the previous year. During the first seven months of calendar 1996, the federal government contributed $115 million to ADAPs. For FY 1997, President Clinton has increased his ADAP budget request to $196 million.

How Many People Are Served By ADAP?

In 1995, over 69,000 people were served by ADAP.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Bureau of Health Resources Development

Health Resources and Services Administration
Rockville MD 20857

FAX TRANSMISSION COVER SHEET

DATE: 8/4/97

TO: Sarah Hurwitz
202-456-5557

FROM: Erica Buehrens

Division of HIV Services (DHS)

Bureau of Health Resources Development (BHRD)

Health Resources and Services Administration (HRSA)

This document consists of 6 pages, including this cover page. Should you have any problems with this transmission, please call the Division of HIV Services at: 301-443-6745. The FAX number for the Division of HIV Services is: 301-443-5271 OR 443-8143

Comments: Per your request to Melanie Wieland

(Hard copies in mail) GB

AIDS Drug Assistance Programs

Table 3.a. Program Characteristics: State and U.S. Totals

Source: Annual Administrative Report, Reporting Period January 1 to December 31, 1996

State	Number of Reports	Administering Agency: HIV/AIDS Unit of Health Department	Administering Agency: Health Department (not HIV/AIDS unit)	Administering Agency: Welfare or Income Maintenance Dep.	Administering Agency: Other Public or Private Agency	Medical Eligibility Criteria: AIDS Diagnosis	Medical Eligibility Criteria: CD4 Cell Count	Medical Eligibility Criteria: HIV-related Symptoms	Medical Eligibility Criteria: CD4 Count and HIV-related Symptoms	Medical Eligibility Criteria: Other	Processing Period: Less than 10 Days	Processing Period: 10 to 30 Days	Processing Period: 31 to 60 Days	Processing Period: More than 60 Days	Recertification Frequency: Quarterly	Recertification Frequency: Semiannual	Recertification Frequency: Annual	Recertification Frequency: Other	Recertification Frequency: None	Recertification Frequency: Missing / Unknown	Waiting List: Waiting List this Reporting Period?	Waiting List: Number on Waiting List at End of Period
Alabama	1	1					1				1							1			Yes	150
Arizona	1	1								1	1					1					No	NA
California	1	1								1	1						1				No	NA
Colorado	2				2			2			2						2				No	NA
Connecticut	1			1						1		1				1					No	NA
Delaware	2	1			1				1	1	2				1	1					Yes	122
District of Columbia	1	1								1	1					1					No	NA
Florida	1	1					1					1				1					No	NA
Georgia	1				1		1				1					1					No	NA
Hawaii	1	1							1		1					1					No	NA
Idaho	1		1				1				1									1	No	NA
Illinois	1	1						1			1						1				No	NA
Indiana	1				1			1				1			1						Yes	45
Iowa	6	1	1		4	1		5			5	1				1	2			3	No	NA
Kansas	1	1						1			1									1	No	NA
Kentucky	1	1					1				1					1					No	NA
Maryland	1	1						1			1					1					No	NA
Massachusetts	1				1					1	1						1				No	NA
Michigan	1	1					1				1						1				No	NA
Minnesota	1			1						1	1						1				No	NA
Mississippi	1	1					1				1						1				No	NA
Missouri	3	3				1				2		3					2	1			No	NA
Montana	1	1								1	1									1	No	NA
Nebraska	1				1			1			1					1					No	NA
Nevada	1	1							1			1					1				No	NA
New Hampshire	1	1							1		1						1				No	NA
New Jersey	1	1								1		1					1				No	NA
New York	1	1								1	1									1	No	NA
North Dakota	1	1						1			1									1	No	NA
Ohio	1	1								1	1				1						No	NA
Oklahoma	1		1				1				1						1				Yes	
Puerto Rico	3	1	1		1			1	1	1	2			1		1				2	Yes	
Rhode Island	1	1						1			1									1	No	NA
South Carolina	1	1							1		1									1	Yes	250
South Dakota	1		1							1	1									1	No	NA
Tennessee	1	1							1		1						1				No	NA
Texas	1	1							1		1							1			No	NA
Utah	1	1						1			1							1			No	NA
Virginia	1	1						1			1						1				No	NA
Washington State	1	1						1			1					1					No	NA
West Virginia	1	1							1			1								1	No	NA
Wisconsin	1	1								1	1									1	No	NA
U.S. Total	53	34	5	2	12	2	8	18	9	16	42	10	0	1	3	13	18	4	0	15	6	567
% of Total	100%	64%	9%	4%	23%	4%	15%	34%	17%	30%	79%	19%	0%	2%	6%	25%	34%	8%	0%	28%	14%	

Number of States = 42

AIDS Drug Assistance Programs

Table 3.b. Annual Funding and Expenditures: State and U.S. Totals

Source: Annual Administrative Report, Reporting Period January 1 to December 31, 1995

State	Annual Program Expenditures	Annual Program Funding by Source: Title I CARE Act	Title II CARE Act	Title III CARE Act	Other Federal (incl. Medicaid)	State or Local Public (not Medicaid)	Other Sources	Total	Percent of Total Funds From CARE Act Titles I and II	Percent of Program Funds from CARE Act Titles I and II: At Least 50%	25% to 49%	10% to 24%	Less Than 10%
Alabama	$ 870,369	$ -	$ 820,369	$ -	$ -	$ 50,000	$ -	$ 870,369	94%	x			
Arizona	$ 609,578	$ -	$ 609,578	$ -	$ -	$ -	$ -	$ 609,578	100%	x			
California	$ 22,702,057	$ -	$ 9,804,406	$ -	$ -	$ 12,070,230	$ -	$ 21,874,636	45%		x		
Colorado	$ 569,740	$ 226,873	$ 109,539	$ -	$ -	$ 219,409	$ -	$ 555,821	61%	x			
Connecticut	$ 1,067,462	$ 209,500	$ 446,323	$ -	$ -	$ 411,639	$ 187,531	$ 1,254,993	52%	x			
Delaware	$ 105,000	$ -	$ 105,000	$ -	$ -	$ -	$ -	$ 105,000	100%	x			
District of Columbia	$ 526,530	$ 74,801	$ 541,405	$ -	$ -	$ -	$ -	$ 616,206	100%	x			
Florida	$ 7,068,028	$ -	$ 7,026,028	$ -	$ -	$ 42,000	$ -	$ 7,068,028	99%	x			
Georgia	$ 1,108,178	$ 365,420	$ 1,000,000	$ -	$ -	$ 315,000	$ -	$ 1,680,420	81%	x			
Hawaii	$ 270,049	$ -	$ 146,451	$ -	$ -	$ 265,000	$ -	$ 411,451	36%		x		
Idaho	$ 64,344	$ -	$ 64,344	$ -	$ -	$ -	$ -	$ 64,344	100%	x			
Illinois	$ 3,562,143	$ -	$ 1,892,143	$ -	$ -	$ 1,517,874	$ 152,126	$ 3,562,143	53%	x			
Indiana	$ 682,539	$ -	$ 637,610	$ -	$ -	$ 199,537	$ -	$ 837,147	76%	x			
Iowa	$ 74,169	$ -	$ 63,698	$ -	$ -	$ -	$ -	$ 63,698	100%	x			
Kansas	$ 326,554	$ -	$ 326,554	$ -	$ -	$ -	$ -	$ 326,554	100%	x			
Kentucky	$ 483,629	$ -	$ 338,575	$ -	$ -	$ 149,976	$ -	$ 488,551	69%	x			
Maryland	$ 982,332	$ 171,047	$ 961,167	$ -	$ -	$ -	$ -	$ 1,132,214	100%	x			
Massachusetts	$ 1,284,169	$ 328,921	$ 955,248	$ -	$ -	$ -	$ -	$ 1,284,169	100%	x			
Michigan	$ 646,241	$ 242,395	$ 321,734	$ -	$ -	$ -	$ 58,750	$ 622,879	91%	x			
Minnesota	$ 172,278	$ -	$ 172,278	$ -	$ -	$ -	$ -	$ 172,278	100%	x			
Mississippi	$ 625,188	$ -	$ 625,188	$ -	$ -	$ -	$ -	$ 625,188	100%	x			
Missouri	$ 1,114,597	$ 331,725	$ 831,345	$ -	$ -	$ -	$ -	$ 1,163,070	100%	x			
Montana	$ 44,000	$ -	$ 44,000	$ -	$ -	$ -	$ -	$ 44,000	100%	x			
Nebraska	$ 100,000	$ -	$ 100,000	$ -	$ -	$ -	$ -	$ 100,000	100%	x			
Nevada	$ 594,957	$ -	$ 261,609	$ -	$ -	$ -	$ -	$ 261,609	100%	x			
New Hampshire	$ 159,490	$ -	$ 128,905	$ -	$ 30,585	$ -	$ -	$ 159,490	81%	x			
New Jersey	$ 3,095,271	$ 516,250	$ 2,579,021	$ -	$ -	$ -	$ -	$ 3,095,271	100%	x			
New York	$ 31,854,725	$ 18,487,842	$ 8,309,344	$ -	$ -	$ 495,120	$ 4,562,419	$ 31,854,725	84%	x			
North Dakota	$ 17,077	$ -	$ 55,000	$ -	$ -	$ -	$ -	$ 55,000	100%	x			
Ohio	$ 1,008,229	$ -	$ 1,152,434	$ -	$ -	$ 200,500	$ -	$ 1,352,934	85%	x			
Oklahoma	$ 713,253	$ -	$ 507,253	$ -	$ -	$ 206,000	$ -	$ 713,253	71%	x			
Puerto Rico	$ 6,218,013	$ 2,819,058	$ 2,781,000	$ 80,000	$ -	$ 7,157,051	$ -	$ 12,837,109	44%		x		
Rhode Island	$ 89,003	$ -	$ 89,003	$ -	$ -	$ -	$ -	$ 89,003	100%	x			
South Carolina	$ 533,131	$ -	$ 447,500	$ -	$ 100,000	$ -	$ -	$ 547,500	82%	x			
South Dakota	$ 70,693	$ -	$ 70,000	$ -	$ -	$ -	$ -	$ 70,000	100%	x			
Tennessee	$ 198,304	$ -	$ 287,500	$ -	$ -	$ -	$ -	$ 287,500	100%	x			
Texas	$ 5,277,652	$ -	$ 2,058,216	$ -	$ -	$ 3,109,427	$ -	$ 5,167,643	40%		x		
Utah	$ 106,002	$ -	$ 95,000	$ -	$ -	$ 114,000	$ -	$ 209,000	45%		x		
Virginia	$ 1,638,008	$ -	$ 626,466	$ -	$ -	$ 687,200	$ -	$ 1,313,666	48%		x		
Washington State	$ 540,751	$ 58,654	$ 216,019	$ -	$ -	$ 266,078	$ -	$ 540,751	51%	x			
West Virginia	$ 50,296	$ -	$ 77,947	$ -	$ -	$ -	$ -	$ 77,947	100%	x			
Wisconsin	$ 232,800	$ -	$ 31,301	$ -	$ -	$ 433,600	$ -	$ 464,901	7%				x
U.S. Total	$ 97,857,029	$ 23,832,486	$ 47,916,501	$ 80,000	$ 130,585	$ 27,909,641	$ 4,960,826	$ 104,830,039		35	6	0	1
% of Total		22.7%	45.7%	0.1%	0.1%	26.6%	4.7%	100%	68.4%	83%	14%	0%	2%

Number of States = 42

AIDS Drug Assistance Programs

Table 3.c. Clients Served (Unduplicated): State and U.S. Totals

Source: Annual Administrative Report, Reporting Period January 1 to December 31, 1996

State	Reporting Period, Months	Clients Served: Total Clients	Clients Served: New Clients	Gender: Male	Gender: Female	Gender: Missing / Unknown	Race/Ethnicity: White	Race/Ethnicity: Black	Race/Ethnicity: Hispanic	Race/Ethnicity: Asian / Pacific Isl.	Race/Ethnicity: American Indian	Race/Ethnicity: Missing / Unknown	Age: Under 13 Years	Age: 13-19 Years	Age: Age 20 and Over	Age: Missing / Unknown
Alabama	12	1,060	290	890	170	#	490	560	#	#	#	10	#	10	1,050	#
Arizona	12	640	410	580	60	#	460	40	130	#	#	#	#	#	630	#
California	12	13,380	6,410	12,190	1,150	50	6,350	2,210	3,970	240	80	530	10	30	13,220	120
Colorado	12	710	370	640	60	#	450	80	120	#	#	60	#	#	710	#
Connecticut	12	1,450	880	1,100	350	#	470	490	360	#	10	120	10	#	1,430	#
Delaware	12	110	40	80	30	#	60	50	10	#	#	#	#	#	110	#
District of Columbia	12	390	390	300	90	#	70	270	40	#	#	#	#	#	390	#
Florida	12	9,060	4,090	6,720	2,300	40	3,030	4,340	1,480	20	20	170	60	100	8,880	#
Georgia	12	1,280	530	1,010	270	#	400	660	20	#	#	#	#	10	1,270	#
Hawaii	12	140	50	130	10	#	80	#	10	40	#	#	#	#	140	#
Idaho	12	60	10	50	10	#	50	#	10	#	#	#	#	#	60	#
Illinois	12	2,050	1,450	1,860	180	#	1,020	610	290	60	60	#	#	#	2,040	#
Indiana	12	470	160	420	40	#	380	70	10	#	#	#	#	#	410	60
Iowa	12	140	70	120	20	#	110	10	#	#	#	#	#	#	130	#
Kansas	12	220	30	190	30	#	180	30	10	#	#	10	#	#	220	#
Kentucky	12	330	190	290	40	#	200	80	10	#	#	40	#	#	300	30
Maryland	12	420	170	330	100	#	150	230	30	#	#	10	#	#	420	#
Massachusetts	12	1,020	660	860	160	#	400	100	220	#	10	290	10	#	1,010	#
Michigan	12	320	130	280	30	#	190	110	20	#	#	#	#	#	320	#
Minnesota	12	450	0	410	30	#	370	40	20	#	10	10	#	#	450	#
Mississippi	12	640	290	650	190	#	330	500	#	#	#	#	10	#	620	#
Missouri	12	1,420	660	1,270	150	#	950	400	20	#	#	50	10	10	1,400	#
Montana	12	30	10	20	#	#	20	#	#	#	#	10	#	#	30	#
Nebraska	12	180	90	160	20	#	130	40	10	#	#	#	#	#	170	#
Nevada	12	260	80	230	40	#	180	30	40	#	#	#	#	#	250	#
New Hampshire	12	110	50	90	10	#	50	#	#	#	#	40	#	#	110	#
New Jersey	12	2,300	950	1,600	700	#	850	850	530	#	#	70	40	10	2,240	#
New York	12	17,140	5,260	13,130	3,410	600	5,950	5,610	5,390	160	40	#	150	70	16,920	#
North Dakota	12	20	10	10	#	#	10	#	#	#	#	#	#	#	20	#
Ohio	12	590	210	520	70	#	430	120	20	#	10	20	#	#	580	#
Oklahoma	12	450	130	380	70	#	360	60	20	#	20	#	#	#	450	#
Puerto Rico	12	5,560	2,530	3,520	1,400	630	#	#	4,960	#	#	590	40	40	4,880	590
Rhode Island	12	130	50	110	20	#	70	10	20	#	#	30	#	#	130	#
South Carolina	12	480	250	350	140	#	130	330	10	#	#	10	10	#	460	#
South Dakota	12	40	20	30	#	#	30	#	#	#	#	#	#	#	40	#
Tennessee	12	160	110	150	30	#	100	60	#	#	#	#	#	#	160	#
Texas	12	4,710	1,500	4,030	680	#	2,380	1,150	1,030	10	10	120	20	10	4,680	#
Utah	12	120	60	110	10	#	100	#	10	#	#	#	#	#	120	#
Virginia	12	850	490	660	160	30	290	470	30	#	#	60	10	#	840	#
Washington State	12	720	290	660	60	#	550	50	80	10	20	10	#	#	720	#
West Virginia	12	60	20	60	#	#	60	10	#	#	#	#	#	#	60	#
Wisconsin	12	270	90	250	20	#	190	60	20	#	#	#	#	#	270	#
U.S. Total		**70,090**	**29,490**	**56,440**	**12,290**	**1,360**	**28,060**	**19,950**	**18,940**	**580**	**320**	**2,250**	**440**	**320**	**68,530**	**810**
% of Total		**100%**	**42.1%**	**80.5%**	**17.5%**	**1.9%**	**40.0%**	**28.5%**	**27.0%**	**0.8%**	**0.5%**	**3.2%**	**0.6%**	**0.5%**	**97.8%**	**1.2%**

Number of States = 42

Counts are rounded to nearest 10 (to 10 if between 1 and 14), except that # replaces demographic values less than 6. U.S. totals are calculated on unrounded data.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

HRSA

FACT SHEET

BUREAU OF HEALTH RESOURCES DEVELOPMENT JULY 1997

The Ryan White CARE Act AIDS Drug Assistance Programs

The Health Resources and Services Administration (HRSA), an agency of the Department of Health and Human Services, administers the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Enacted in 1990 and reauthorized in May 1996, the CARE Act is the largest source of Federal funding specifically directed to provide primary care and support services for persons living with HIV disease.

Under Title II of the CARE Act, formula grants are awarded to the States and other eligible areas to improve the quality, availability, and organization of HIV health care and support services. In addition to other specific service programs, Title II funds AIDS Drug Assistance Programs (ADAPs). ADAPs provide medications to low-income individuals with HIV disease, who have limited or no coverage from private insurance or Medicaid, in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam.

In 1996, ADAPs served almost 83,000 persons with HIV disease who had limited or no coverage from private insurance or Medicaid. At any one time, ADAPs were serving about 40,000 individuals.

Title II requires that: *"A State shall use a portion of the amounts provided to establish a program... to provide therapeutics to treat HIV disease or prevent serious deterioration of health arising from HIV disease in eligible individuals, including measures for the prevention and treatment of opportunistic infections."*

ADAPs have served clients since 1987 (see box), but recent treatment advances have focused increasing attention on the program. The newest class of HIV drugs, protease inhibitors (PIs), have proven to be very effective when used in combination with two or three other medications. As a result, demand for the promising new combination therapy has grown rapidly— not only among individuals already in care but also among those who had not previously sought treatment. Because the cost of combination therapy with PIs is very high—between $10,000 and $12,000 a year per person—ADAPs are greatly challenged in responding to the increased client demand.

Even before the expensive new drugs became available, many ADAPs were experiencing strains. The rapid growth of the HIV epidemic among poor and historically underserved populations, and evolving treatment standards which involve more than one antiviral drug, contributed to these strains. In addition, the number of people seeking and receiving treatment for HIV and AIDS continues to increase on a monthly basis.

ADAP funding has increased dramatically in recent years. In fiscal year (FY) 1996, $52 million in Title II CARE Act supplemental funds was appropriated specifically for ADAPs. This was in addition to the $53 million that States had already committed from their base Title II awards. In FY 1997, $167 million was earmarked for ADAPs. Fiscal year 1998 appropriations have not yet been finalized.

State Roles in Managing ADAPs

States have the authority to establish income and medical eligibility criteria and to determine how drugs will be purchased and distributed to clients. States also determine which drugs to include on their formularies. States covering 25 or more drugs.

The ADAP began 10 years ago. In March 1987, zidovudine — better known as AZT— became the first drug approved by the Food and Drug Administration (FDA) to treat HIV disease. However, the annual cost of AZT per person, about $10,000, placed it out of reach for many people. Congress responded (a month later) in April 1987, by approving $30 million in funding under a public health emergency provision, and later enacted Public Law 100-71 authorizing the establishment of an ADAP program nationwide.

As HIV treatment advances occurred and as resources permitted, States expanded the program to cover drugs in addition to AZT. In 1990, when ADAP became part of the newly enacted CARE Act, States had the option to cover any FDA-approved drug that could prolong life or prevent deterioration of health.

FACT SHEET

Covered Drugs

As the number of FDA-approved HIV treatments has increased, States added some or all of the newer drugs within the limits of available resources. The availability of new, effective drugs, combined with the greatly increased cost of new medications, has affected the expansion of formularies. Today, there is considerable variation in the number of drugs on ADAP formularies, ranging from 5 to more than 100, with one-half of the States covering 25 or more drugs.

Purchase and Distribution of Pharmaceuticals

Most ADAPs were established to operate under a pharmacy reimbursement model similar to Medicaid. This allows patients to go to a participating pharmacy, show their ADAP cards and have their prescriptions filled. The pharmacy then bills ADAP.

A few States with a system of pharmacies attached to a network of public health clinics have opted to use that system to purchase and distribute drugs for ADAP clients. Only a few ADAPs directly purchase drugs and mail them to clients.

Cost-Containment Measures

With the significant growth in clients seeking treatment, dramatic increases in the cost of new treatments, and rapidly changing standards of care, ADAPs are challenged to contain costs at the same time they are asked to expand access. As a result, ADAPs have taken a number of steps to stretch dollars. These include changing the system used to purchase/distribute drugs; seeking larger price discounts (e.g., by participating in the Office of Drug Pricing Program administered by HRSA, or negotiating voluntary manufacturers' rebates); tightening income eligibility criteria; deleting some drugs from State formularies; setting caps on ADAP benefits; and/or establishing guidelines for prescribing drugs.

Income Eligibility

Because Title II gives States the authority to set income and medical eligibility criteria for ADAPs, there is wide variation among States. The table below summarizes income eligibility criteria.

The variation in eligibility generally reflects the type and availability of other health care resources for low-income individuals with HIV disease. It must be noted that even in States with more generous income eligibility standards, the overwhelming majority of enrolled individuals have incomes below 200 percent of FPL.

Criteria as Percent of Federal Poverty Level (FPL)	Number of States/Grantees
100% or below FPL	1 ADAP
100 to 200% FPL	20 ADAPs
200 to 300% FPL	18 ADAPs
Over 300% FPL	10 ADAPs
Three States use some other criteria not related to Federal Poverty Level.	

1997 Federal Poverty Level is $7,890/year per individual.

Medical Eligibility

All States require individuals who meet income threshold criteria simply to provide proof of their HIV status. Fourteen States also require a laboratory test showing a CD4 count of 500 or less (indicating significant damage to the immune system). For individuals to obtain access to protease inhibitors and/or antiretrovirals, 17 States have additional specific criteria.

ADAPs In Context

A number of factors affect key State decisions regarding ADAPs. The ADAP is just one of multiple important sources of public and private funding for HIV treatment. Medicaid is by far the largest payer, providing treatment to an estimated 60 percent of persons with AIDS nationwide.

However, State Medicaid plans vary widely, in terms of eligibility and covered services. States with more restrictive Medicaid eligibility, limited prescription benefits, and/or no optional coverage for medically needy populations, place special challenges on ADAPs. Too often, however, these are also States with limited or no State contributions to the program. Those constraints are most often reflected in restrictive financial eligibility criteria and limited formularies. Other factors include the availability of affordable private insurance, insurance risk pools, and whether or not the State limits the extent to which private insurers may cap prescription benefits.

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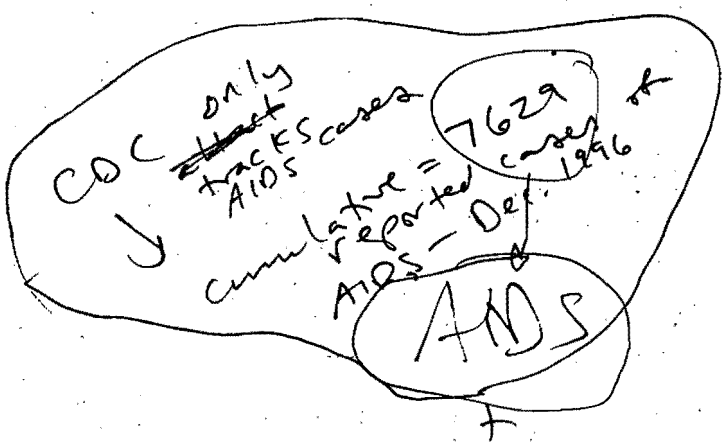

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HIV
not reported
10-20,000
12-15
10-20

pred AIDS – 10-20 mil.
JAMA – 12-15 mil.

FROM: Wendy Wetheimer

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STATEMENT BY

WILLIAM E. PAUL, M.D.

DIRECTOR, NIH OFFICE OF AIDS RESEARCH

Good afternoon. I am pleased to be here today to highlight AIDS research activities of the National Institutes of Health (NIH). To combat the devastating impact of HIV infection and AIDS, the nation has made a firm commitment to research on all aspects of this dread disease and has expressed support through resources the Congress has made available to the National Institutes of Health. This commitment is now reaping rewards in the form of new and more effective therapies. But these therapies are not a panacea. HIV infection still poses a major threat to our nation and to people everywhere in the world. Within the United States, our minority communities, particularly African-Americans and Hispanics, have borne a disproportionate share of this impact.

In my remarks today, I wish to highlight the progress we have made, speak to the challenges we face and particularly to address the issue of how our research effort recognizes and responds to the needs of those in our minority communities affected with this disease or at risk of infection.

As the members of the Congressional Black Caucus are well aware, a new class of anti-HIV drugs have been introduced. Used in combination with previously available drugs, the resulting highly active anti-retroviral treatment has been shown to remarkably reduce the amount of virus in an

infected individual, to have a major impact on diminishing AIDS-defining events, and on helping

to restore immune function. These drugs, coupled with the availability of new techniques to measure the level of virus in the plasma and to characterize the virus, allow physicians to tailor better treatments for their patients and allow them to monitor the benefits of these therapies.

This accomplishment has been based on a combination of fundamental research supported by NIH and drugs and assay technology developed by our pharmaceutical and biotechnology industries in one of the best examples of public/private partnership that can be cited.

The Department of Health and Human Services has recently released for public comment two important documents - the Report of the NIH Panel to Define Principles of Therapy for HIV Infection and the Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents. These two documents provide doctors and their patients with the most up-to-date advice on how to use the new combinations of drugs, including when to begin therapy; when and how to switch therapies; how to monitor the course of the disease; which drugs to use in combination.

Previous NIH-supported research has shown that zidovudine can dramatically reduce the risk of transmission of HIV infection from a pregnant women to her child. Because of our progress in the treatment of HIV, a panel was recently convened to update the guidelines for the use of AZT in pregnant women. These new guidelines have recently been released for public comment. This subject is of particular importance for our minority community since the great majority of women with AIDS and of HIV-infected infants are members of this community. The progress that has

been made, as exemplified in these guidelines, should continue to have a major benefit for our minority population and for all women at risk of transmitting HIV to their infants.

In view of the disproportionate impact of HIV on African-Americans and Hispanics, it is essential that the clinical trials that NIH supports have adequate representation of these individuals in programs. I am pleased to report that in both of the major clinical trials networks, the adult AIDS Clinical Trials Group (ACTG) and the Community Program for Clinical Research on AIDS (CPCRA), African Americans and Hispanics make up more than 40% of the participants in their trials, a proportion that quite well mirrors the fraction of total cases that occur in these two groups. Indeed, both to be certain that there has been adequate outreach to minority communities and to aid in the development of capacity for minority institutions to make a major contribution to progress against this disease, the adult ACTG has units in three minority institutions. In addition, the CPCRA is based on the philosophy of establishing units in community settings where the patients who are infected seek their primary care.

Other programs that have been organized in such a way as to obtain information of particular importance for the impact of HIV infection on members of our minority groups are the Women's Interagency HIV Study and the Women and Infant Transmission Study. Minorities represent over
82% of the participants in these two important studies.

The NIH recognizes the value of the contributions made by African American health

professionals to the conduct of research and research training. A number of NIH programs and policies are specifically designed to recruit individuals from underrepresented racial and ethnic groups into research careers. These programs provide training and research opportunities across the continuum from high school students to independent investigators, with the goal of increasing the diversity of the labor pool in all segments of health related research.

For example, for individuals at the high school, college, graduate, postdoctoral, and investigator levels, the NIH offers Research Supplements for Underrepresented Minorities. Using this program, the principal investigator on a currently funded research project can request an administrative supplement to support the salary of an individual from an underrepresented group who wishes to participate in the ongoing research.

The NIH has implemented a number of programs to enhance participation of minority clinical investigators, for example, the AIDS Loan Repayment Program, the loan repayment program for individuals from disadvantaged backgrounds, the Howard Hughes Medical Institute (HHMI) training program for early recruitment into clinical research careers, and the Minority Clinical Associate Physician (MCAP) Program at the NIH National Center for Research Resources.

I wish to close my comments on an issue that is of special concern to all who are at risk of contracting this infection. Today, in the United States, as I have already stated, that is disproportionately a population of minority group members. However, HIV infection takes an even greater toll throughout the world. Its impact in subSaharan Africa has been truly

devastating, with mean life expectancies in many of these nations being reduced by twenty years or more. The most important advance that could be made would be to find safe and effective means of preventing transmission. NIH has emphasized many aspects of prevention research. In its behavioral research program, it has laid particular stress on the need for culturally sensitive approaches.

But perhaps the most effective and most durable contribution that could be made would be the development of a truly effective preventive vaccine. President Clinton has challenged us to develop such a vaccine within the next decade. To meet this challenge and to meet the recommendations of outside experts who have recently reviewed the NIH AIDS research program, we have taken three major steps. We have increased the proportion of our resources that are devoted to vaccine research. In the period between 1996 and the budget the President submitted for 1998, AIDS vaccine funding will have increased by more than 33%.

Dr. David Baltimore, a Nobel laureate and President-designate of Cal Tech, has been recruited to provide leadership for the restructuring and reinvigoration of the AIDS vaccine research program through his role as chair of the AIDS Vaccine Research Committee.

The President also announced the creation of the Vaccine Research Center on the NIH campus to mobilize the very considerable scientific resources of this premier medical research institution to the development of an AIDS vaccine, particularly through the development of entirely new and novel approaches to this end.

Much has been accomplished but much more remains to be done. We are grateful for the support

of the Congress and particularly for the thoughtful and enlightened backing that members of the Black Caucus have given to this research program. It is our intention that these resource be used as well as possible to confront this disease and particularly to grapple with its impact in our minority community.

I will be happy to answer any questions you may have.

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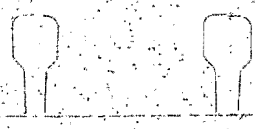

PROGRESS in PREVENTION
Research and Support for Community Action

PROGRESS in PREVENTION

Research and Support for Community Action

Current Magnitude

The Changing Landscape of the Epidemic: A Closer Look

Present and Future Course of the Epidemic: A Closer Look by Risk Category

HIV & AIDS Trends

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

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CDC's Role in HIV Prevention

Research and Support for Community Action

The Centers for Disease Control and Prevention (CDC) is the lead federal government agency for HIV prevention in the United States. CDC works with states and communities to provide the information and tools needed to design and implement effective local prevention programs. Each community faces unique prevention challenges, and programs must be locally relevant and workable. HIV prevention works best if designed and implemented by those closest to the problem, with input from the individuals and groups for whom programs are designed.

New Emphasis on Community-Based Prevention

In December 1993, CDC initiated a new process to put more of the decisions about prevention programs in the hands of the communities affected. The process, HIV Prevention Community Planning, represents a significant step forward in planning culturally competent and scientifically sound HIV prevention services that specifically address unique community needs.

In the fall of 1995, the CDC created a new Center—the National Center for HIV, STD, and TB Prevention (NCHSTP). Dr. Helene Gayle, Director of NCHSTP, leads CDC's HIV prevention efforts, as well as the agency's programs to prevent other sexually transmitted diseases and tuberculosis.

The Science to Guide Prevention

HIV is still a relatively new epidemic, and continues to evolve. Prevention programs must keep pace with the epidemic, and lessons learned in one community should be applied in others, with local modifications as needed. CDC's role is to provide the science to guide prevention. To fulfill this role, CDC has several responsibilities, including:

Tracking the Epidemic:

Since the epidemic began, CDC has worked with state and local communities to track the course of HIV and AIDS. CDC has numerous surveillance programs and is constantly working to provide communities the most complete and timely information possible on ongoing and emerging trends.

Prevention Research:

CDC researchers continuously work to evaluate new tools and techniques for preventing HIV transmission. Both biomedical and behavioral interventions are examined, as well as promising integrations of the two approaches. For example, as AIDS increasingly affects women, it is critical that prevention methods be developed that are easily within women's control. CDC researchers are working with scientists worldwide to evaluate the effectiveness of female condoms and to develop effective microbicides that can kill HIV and the pathogens that cause other STDs. As with any new tool for prevention, scientists must also determine what influences people's willingness and ability to use these methods. CDC behavioral scientists are simultaneously working to evaluate the factors that will contribute to women's use of these products and how these new prevention methods can and should be balanced with existing prevention options.

Evaluating What Works in HIV Prevention:

CDC scientists also work with communities to determine the impact of HIV prevention programs and how programs may be improved. By distributing these findings broadly, successful interventions can be built upon nationally and adapted by other communities. It is critical that communities experiencing later waves of HIV infection and AIDS not struggle to develop, implement, and evaluate prevention programs as larger U.S. cities, like New York and San Francisco, had to do early on. Fifteen years into the epidemic in America, information is available that allows second- and third-wave communities to put prevention programs into place quickly, before HIV is firmly established and can be aggressively contained.

PROGRESS in PREVENTION

Research and Support for Community Action

A Message From Dr. Helene Gayle...

HIV Trends Indicate Prevention Works

For more than a decade we have traveled from near and far to attend the International Conference on AIDS and shared the excitement and optimism around new developments and the frustration at what often times appears to be the slow pace of progress.

This year, though, the drum beat of optimism started early and it's been getting louder as we've gotten closer to Vancouver. There is certainly cause for optimism at this conference--both in terms of treatment and prevention. Trends in the HIV epidemic in the United States demonstrate that we have made progress in preventing the spread of HIV. The number of new AIDS diagnoses each year in the United States is slowing and has leveled off to the current rate of 3 to 5 percent increase in new cases per year from more than 85 percent per year at the beginning of the epidemic. Positive signs are being seen in diverse areas of prevention. Evidence of behavior change in high-risk populations indicates that HIV prevention efforts are having an impact. Condom use is increasing among some sexually-active young people, perinatal transmission is decreasing, injecting drug users (IDUs) are adopting safer behaviors, and behavior changes by gay men have contributed to decreasing AIDS incidence in this group.

Prevention research, both in the U.S. and internationally, has documented additional biomedical opportunities for reducing the spread of HIV. Studies have confirmed the benefits of voluntary HIV counseling and testing of pregnant women and treatment of infected mothers and their infants with zidovudine (ZDV). The U.S. Public Health Service (PHS) issued guidelines last year recommending this approach. Studies are already showing a 10 percent reduction in the number of children born with HIV because of these prevention advances. More widespread adherence to these guidelines coupled with changes in obstetric practice identified as high risk of perinatal transmission will allow us to reduce new infections even further.

We have also seen exciting new evidence of the role STD control can play in HIV prevention. A community-level randomized trial in rural Tanzania that focused solely on the treatment of symptomatic STDs demonstrated a 40 percent reduction in new HIV infections in the intervention communities compared with the rate in control communities. We must continue to explore the relationship between HIV and other sexually transmitted diseases and promote a more integrated response to both conditions.

This research while significant, points to the huge amount of work that remains, and the challenges that must be addressed as new technology emerges. We have always known in public health that prevention is not a one-shot proposition. Exciting new advancements in the treatment of HIV disease, namely combination therapy, appear to increase the quality of and prolong life for people with HIV infection. But we must remember that prevention remains our best and most cost-effective tool for saving lives and bringing the epidemic under control. We cannot lose sight of the ultimate goal of preventing infection, so that people don't have to undergo complex and costly treatment regimens.

Sustained, targeted biomedical and behavioral interventions are necessary to reduce the likelihood of HIV infection and to support individual behavior changes necessary to avoid or reduce risk. Individuals at risk for HIV must be provided the information and tools necessary to protect themselves. While continuing to emphasize biomedical and behavioral solutions, we cannot overlook the importance of developing new tools, including vaccines and female-controlled barrier methods such as microbicides. And we must integrate behavioral research in our quest for these news advances in technology to ensure that we understand motivations that will determine whether or not individuals will take advantage of new developments. For any medical advancement or new prevention tool to impact prevention, people have to be willing to use them.

We must also maintain a flexible response, as the HIV epidemic continues to evolve. Shifts in the epidemic call for us to expand our efforts as new at-risk populations emerge. Rates of AIDS cases are increasing among women, younger gay men, minorities and heterosexuals. To address these challenges we must research and develop strategies for promoting behavior change among these populations.

In the coming years CDC's most challenging role will be to provide leadership and technical assistance as interventions become more localized to better reach at-risk populations. CDC's Community Planning Initiative has served to strengthen ties and build relationships at the local, state and national level. It empowers communities to determine priorities and strategies and to target HIV prevention efforts based on the local epidemic. In many communities across the United States, this process has improved service coordination and optimized the use of resources.

By bringing together diverse groups of people, all with a stake in HIV prevention, the process can result in enhanced collaboration and cooperation, a rich sharing of ideas, and a science based approach to priority setting and intervention selection. CDC will continue to work in partnership with communities and involve representatives of at-risk populations in the development, implementation and evaluation of HIV prevention efforts.

Our goal at the CDC is to make sure we get adequate resources and appropriate technical information to communities and to the groups that need it the most, such as men who have sex with men, injecting drug users, women and youth at risk. The evidence now supports that by changing individual and collective behaviors, enhancing community prevention involvement and through the development and application of biomedical solutions and technology we can reduce the spread of HIV.

When we gather together at the next International AIDS Conference two years from now, I am confident that the developments reported will be even more promising. In prevention, there will be no "magic bullet", and the day-to-day victories may be small, but to the person who begins using condoms, delays initiation of sexual activity or makes sure they use a clean needle and syringe every time, it can be the difference between life and death. As we go home to continue our efforts, let us remember that we will stop the spread of this disease one person at a time. When next we get together, it will be with the knowledge that many people have remained uninfected as a result of the prevention efforts and advances discussed here in Vancouver this week.

By Helene Gayle, MD, MPH
Director, National Center for HIV, STD and TB Prevention
U.S. Centers for Disease Control and Prevention