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**Virtual Briefing: 2009 National ADAP Monitoring Project
Annual Report
Kaiser Family Foundation
April 7, 2009**

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JENNIFER KATES, M.A., M.P.A.: Good afternoon and welcome to the Kaiser Family Foundation's live webcast briefing focusing on AIDS Drug Assistance Programs, ADAPs, the nation's prescription drug safety net for people living with HIV. We are coming to you live from our broadcast studio in Washington, D.C. I am your moderator, Jen Kates, Vice President at the Kaiser Family Foundation.

Today's webcast will provide an overview of the latest findings from the National ADAP Monitoring Project, a longstanding effort by the Kaiser Family Foundation and the National Alliance of State and Territorial AIDS Directors that provides the most current and comprehensive look at ADAPs around the country. The Monitoring Projects 2009 Report was just released this morning and is available online.

Our webcast today is live and features an interactive panel discussion with esteemed experts reflecting on the findings of the report as well as your questions. We encourage you to submit questions now or as we go along. You can email your questions to ask@kff.org.

Before we get started, I would like to acknowledge our partner in this effort, NASTAD, and in particular, Julie Schofield and Murray Penner for their leadership in bringing the voice of ADAPs to the national dialogue, to Beth Crutsinger

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Perry and Britten Ginsburg of NASTAD and Alisha Carbaugh of Kaiser who made this report happen and to all state ADAP and AIDS directors who deliver services to people with HIV every day.

Before we turn to a presentation of the report's key findings and I introduce our panelists, we would like to share with you a short video that does bring the voice of ADAPs to you in a way no report can.

[VIDEO PLAYED 00:01:44-00:05:43]

JENNIFER KATES, M.A., M.P.A.: Welcome back. Now we are going to turn to the findings from our latest National ADAP Monitoring Project report. Joining me in the studio today is Murray Penner from NASTAD. I will present the findings first and then turn it over to Murray.

The National ADAP Monitoring Project is a partnership between Kaiser and NASTAD that has been going on since 1996, which is one of our longest standing efforts at the foundation. Each year we survey all ADAPs that receive federal ADAP earmark funding from the Ryan White program, which was 58 in the last fiscal year and 54 responded. The data we will be speaking from today include data from June 2008.

So the latest monthly snapshot available so we can look at trends over time and give you the latest client data and we also have fiscal year 2007 and 2008 data on budgets,

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expenditures, and many other indicators. The full report from the study is available on www.kff.org and on www.nasdad.org and we have all state level data on statehealthfacts.org.

First some highlights and major themes from this year's report. ADAPs are the nation's prescription drug safety net for people with HIV who have limited or no access to prescription drugs. They reach 180,000 clients each year. ADAP clients reflect the national epidemic. They are concentrated in states with the highest numbers of people living with HIV. The budget for ADAPs has grown over time as the client caseload is increased and the expenditures for medications has increased.

A key finding and highlight from this year is that most ADAPs were able to find a balance between the available resources and demand for their services but there is some concern for the future that we observed. First, we see the return of waiting lists and some cost containment measures anticipated by several ADAPs. We also know that there is a recession and the state fiscal environment is not very healthy right now. There has also been some major changes under way in the Ryan White program overall that we know will affect ADAPs.

This next slide shows the national ADAP budget by source because ADAPs receive funding from multiple sources and as shown here, the ADAP earmark, Part B of the Ryan White Care Act, accounts for the largest slice of the ADAP budget but it

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is not as much of a driver of the budget as it has been in the past. In fact, if you look at the number of ADAPs by the different budget sources, you see some variation across the country whereas all ADAPs receive federal ADAP earmark funding through Ryan White, as we mentioned, 16 only received Part B ADAP supplemental funding; 34 received funding from their states. Some don't receive any funding from their states.

So it's quite variable across the country and this impacts what ADAPs are able to do. Well the overall ADAP budget increased slightly in the last year. Not all ADAPs experienced increases and they certainly didn't in all funding sources.

This next slide looks at the number of ADAPs that actually had decreases by funding source. As you see, 21 actually experienced decreases in their overall budget, 25 experienced decreases in the Part B ADAP earmark; 15 received decreases in Part B base, and on and on. So this has been an issue that's come up for ADAPs each year and one that we continue to track.

Now I'm going to turn the presentation over to Murray Penner.

MURRAY PENNER, BSW: Thanks Jen. Now we'll turn to ADAP expenditures for fiscal year 2007. We examined, in our project, the expenditures for fiscal year 2007 and we found that ADAPs expended \$1.3 billion throughout the year. Of that, 88-percent

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were on prescription drugs and about nine-percent were on insurance payments. The rest was on administration and other activities including outreach and adherence activities. We also examined expenditures in June 2008 to determine per capita spending as well as trends in prescription drug spending.

We found that, per capita, ADAPs expend approximately \$1,000, a little over \$1,000, on prescription drugs per person. The drug spending totaled a little over \$109 million for June 2008. ADAPs also spend another \$10 million on insurance payments. Most of those expenditures were among the 10 largest states purchasing drugs for ADAPs.

We examined ADAP formulary coverage of antiretroviral drugs and found that in December of 2008, 30 states covered all of the antiretrovirals that are approved for HIV therapies. We found also that 24 ADAPs did not cover all of those drugs. However, we did note that all of the states covered at least one drug in every class of the antiretrovirals, which is a requirement of the Ryan White legislation.

Turning to ADAP clients and eligibility, a profile of ADAP clients in June 2008 shows that roughly two-thirds of the clients served were minority. Approximately 75-percent were male. We found that 75-percent of them had income levels 200-percent of the federal poverty level or below. A smaller

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number, obviously had higher income levels, were White, and were female.

Turning to ADAP income eligibility as of June 30, 2008, we found that 24 ADAPs had income eligibility levels of 300-percent of the federal poverty level or above. Another 18 had an income eligibility level of 200 to 300-percent of federal poverty level and then a smaller number had a level at 200-percent.

Next, we'll look at ADAP cost containment measures including waiting lists. Each year, we ask states about their cost containment measures or their anticipated cost containment measures. In this year's survey, we found that 10 states are either anticipating cost containment measures or have measures in place including three states that have waiting lists.

As Jen mentioned earlier, we've seen the return of waiting lists. Those three states, in this particular survey, were Montana, Indiana, and Nebraska totaling 62 individuals that are waiting for medications on ADAP waiting lists.

The critical role of ADAPs will continue. We know that there's a growing number of individuals living with HIV and ADAPs will continue to fill the gap between other programs.

Some points that we will be watching over the next year, first the ADAP program through the Ryan White Program,

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will be up for action in Congress. It must be acted upon by September 30th in order to extend the program.

We're also very interested in seeing the impact of HIV testing initiatives, which are underway at CDC. As more and more people are tested for HIV, we're interested in seeing the role that ADAPs will play in serving those individuals that are identified as being HIV-positive. We'll continue to watch cost containment measures and waiting lists. We know that states are experiencing difficulties with the recession and their own state fiscal environments. So we know that ADAPs are going to be struggling to continue to provide medications to all of those who need their services.

So with the economy as it is and with the state fiscal environment and more people coming in to ADAPs, we will need to monitor closely the impact on ADAPs.

JENNIFER KATES, M.A., M.P.A.: Thank you Murray. These findings and others are available in the full National ADAP Monitoring Report, which is available on our website, www.kff.org. Now I'm going to shift gears a bit and put my moderator hat back on for our discussion. Before we begin, I'd like to introduce our other panelists who've just joined us. In addition to Murray Penner from NASTAD, we've been joined by Doug Morgan, who's the Director of the Division of Service Systems of the HIV/AIDS Bureau at the Health Resources and

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Services Administration and Heather Hauck, who's the Director of the Maryland AIDS Administration. Welcome and thank you.

Again, today's conversation is live and interactive and we encourage you to submit your questions to us during the show. We will try to get to as many of them as we can. You can email them to ask@kff.org. So I'd like to start with where you ended up Murray in setting the context for us. You talked about looking ahead. I think before we get to the specifics about the program, let's look at the context, Ryan White's reauthorization. You mentioned that the Act, technically, is up for reauthorization at the end of this September. What does that mean? What is happening with that? What were some of the issues specifically for ADAPs?

MURRAY PENNER, BSW: Sure. What it does mean is that Congress must take action by the end of September in order for the program to continue, which is a new requirement that was placed into the law in 2006. In order to do that, Congress doesn't necessarily have to make any changes to the program as it is but they must extend it or make changes depending on their preference.

So we know that that's going to happen. What we don't know is some of the implementation items that were in the original law that are now being played out. For instance, one of the implementation provisions was client level data. We are

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just now starting to collect client level data in some jurisdictions. So we don't necessarily have the data that is necessary to inform a full reauthorization.

We're also just now starting to see some of the other results including the penalties associated with unobligated balances in the law and some other provisions that we don't know year what that's going to look like.

So as Congress takes action, it's going to be difficult for them to make a full change to the law without some of the data necessary. So we know that a lot of groups in the community are calling for simple extension of the law. Congress has that option obviously to do whatever they need to do but if there is a simple extension, we may not see a lot of changes to ADAPs necessarily but depending on what Congress does, we could see some changes. So it really is unknown yet the full impact of what will happen but we know that action must be taken by Congress.

JENNIFER KATES, M.A., M.P.A.: Doug, let me come to you on that because I know that your agency and you specifically are charged with making whatever changes are put into the law into action. A couple of years ago, we sat in this building and talked about the frenzy of that after the last reauthorization. Are those still being felt? Are those changes still happening? What is likely to happen in September?

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DOUGLAS H. MORGAN, M.P.A.: Well I will say that clearly some of the changes are still being felt, as Murray talked about, just this year. Some of the issues around unobligated balances and some of those impacts of not having all your funds obligated appropriately will come to bear. I think that'll be some interesting issues for some grantees to deal with.

I will say though that, under the leadership of Dr. Deborah Parham Hopson, our Bureau Chief, we've begun to sit down and talk about some of the things that we've seen during the course of this reauthorization that we think probably ought to be tweaked, changed, maybe revised in some way. So hopefully within both the bureau and the agency as we have a new agency administrator, Dr. Mary Wakefield, I think we'll be able to help inform some of these discussions on the Hill and the department as we get to-

JENNIFER KATES, M.A., M.P.A.: What are some of those outstanding issues that might be-

DOUGLAS H. MORGAN, M.P.A.: Well I think the whole issue of unobligated balances, administratively; they have not been as easy to deal with as a lot of us had hoped. Some of the issues around rebates as income, this is a sort of technical detail but one that sprung up as an unintended impact of the law that we think also ought to be addressed at some point. Some concerns about core medical services, I do know some

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concerns about client level data. I will say that we have recently received OMB approval to do that. So at this point, I think we won't really have client level data to speak to until about maybe the midyear, mid-2009 but I think a lot of issues are up.

JENNIFER KATES, M.A., M.P.A.: We'll come back to some of those in a minute. I actually want to turn to Heather because the other big context to consider here is the fiscal environment and what a lot of states are feeling as the country is. can you talk a little bit about that specifically as it relates to AIDS services and ADAP and what that means in a state like Maryland that actually is maybe better off than some others, maybe not.

HEATHER HAUCK, MSW, LICSW: I think Maryland's like all of the states across the country these days has experienced a significant budget deficit over the past two years, which has forced, unfortunately, the state to implement program reductions, reductions in program funding as well as eliminating position vacancies across the Department of Health and Mental Hygiene including the AIDS Administration.

Specifically for ADAP, the state just this year had to eliminate the state funding for an insurance program that we had been running that was a state-funded program. Fortunately the 185 clients who are enrolled in that program will be able

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to continue to receive their support through our federal and our rebate dollars in our, what we call MADAP or Maryland AIDS Drug Assistance Program, but I think that's just an example that many states are experiencing when they receive reductions in state funding.

I think the other thing to highlight is, as I mentioned as we eliminate positions, at the same time that as the video participants indicated were seeing significant increases in enrollment and we've actually, in Maryland, seen a 20-percent increase in enrollment or applications over the past two years for ADAP and a 60-percent increase in insurance enrollment over the past two years at a time when we don't have staff capacity to process either new applications or the recertifications that are required by HRSA every six months. So we're running into issues at the state level, I think, of our ability to fully implement a quality customer service friendly program in the state environmental context that we have these days.

JENNIFER KATES, M.A., M.P.A.: So if you run up against those capacity limitations, what happens to those potential new clients who are coming to try to get ADAP services for the first time?

HEATHER HAUCK, MSW, LICSW: I will say that we, in Maryland, are still processing those applications. We may not be able to process them as quickly as we had previously and I

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don't know the answer in the long term in terms of our ability to continue at that level and I do worry about my staff's sort of the strain on their ability to maintain that level of caseload, again, with the same level of quality that we want and are required by HRSA to implement.

JENNIFER KATES, M.A., M.P.A.: This raises the issue of the various choices or decisions states have to make when these difficult budget environments exist. I'm actually going to turn to a question we just received from Cindy Herdman Ivans who's the Executive Director of Family Service Association of New Jersey.

The question from Cindy in New Jersey talking about the Governor there has proposed fiscal year '10 budget, has included such a requirement for co-payments for ADAPs for the first time. In other words, clients coming will have to also pay for part towards their medications. This is the first time this is being proposed according to the person writing in in New Jersey and they're wondering what other states are doing in this regard, maybe what challenges that could raise or is this a way that states have found help to ease the pressure a little bit on ADAPs, if anyone wants to take that.

MURRAY PENNER, BSW: I'll give it a shot. We know that five states have implemented co-pay requirements of their clients. I think the challenges states always have to figure

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out what works the best in order to get the largest cost savings or whatever they're trying to achieve to make everything balanced, as you'd mentioned earlier. One of the challenges with a co-payment system is the administration of it.

It takes staff to do that and, as Heather mentioned so eloquently, it is difficult in this environment to continue a staff capacity that can operate the program. So implementing some of these cost containment measures cost money as well. Having to balance whether or not it makes sense to do that is a challenge.

JENNIFER KATES, M.A., M.P.A.: What about Maryland? Have you ever used that? Do you use co-payments at this time?

HEATHER HAUCK, MSW, LICSW: We don't although I would say that every state has really the need and the obligation to have cost containment strategies planned because as the presentation so far has indicated in the report very wonderfully, indicates funding is uncertain, whether it's through the Part B earmark, whether it's through the rebate dollars. So, having a conversation and a plan in place for a range of cost containment strategies that, at any time, ADAP might need to implement, is incredibly important in terms of our ability to manage the program.

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JENNIFER KATES, M.A., M.P.A.: Actually the cost containment strategy that we pay a lot of attention to and get asked about a lot are waiting lists. At this time last year, when we released the report, it was the first time we were reporting no waiting lists since we began tracking them but I remember, at that moment, as we wanted to report that finding out, we learned that one state had just implemented a waiting list. Still there was a period of time without waiting lists. Very recently, that ended again.

As we reported today, three states have waiting lists. What is going on? What does this mean? What does this tell us about, is that the tip of the iceberg? How should we be thinking about this new development? What is HRSA hearing from states about this?

DOUGLAS H. MORGAN, M.P.A.: Well as you know, we've been tracking the whole issue of state ADAP waiting lists now for several years and we were impressed by the fact that during one point in time, we didn't have any waiting lists. That was, I think, what made us all feel good. Obviously, given the current economic picture, we've seen some states who have become very good at beginning to project out over several months and even to a course of a year what their demand's going to be. In most cases, we've seen an increased demand.

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Now given the current economic climate and the fact that we do know that some states have not been able to receive their state funding as Heather just mentioned here, that's an issue that some states are dealing with as well as their matching requirement.

So we are seeing states being a little bit more creative. They're coming to us with a lot more questions about how do we sort of handle these issues regarding management or match or maintenance of effort, some of the other requirements that the law does say.

It is my hope that today, during the next week, states will start to see their FY09 awards, which I think will help many states. I will say though that there will be a small number of states that again, because of the unobligated balance issue, will see some decreases in their awards. I think, over time, we'll have to look at that to see, we'll track waiting lists again in these three states. We are hearing that there may be more. So that will track those closely to see what's going on.

JENNIFER KATES, M.A., M.P.A.: We actually have another question, I guess, I think at some of the capacity issues. somebody asked a question about clinics and getting services, general HIV services for ADAP clients. So where do ADAP clients go? Do they go to clinics that are also funded by Ryan White?

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Do they go to non-Ryan White funded clinics? I know that in the past, one of the things that has been an issue is if those clinics do or don't have capacity, that will potentially affect who is able to get a prescription for ADAPs. Can you speak to that, Heather, a little bit?

HEATHER HAUCK, MSW, LICSW: Absolutely. I think it's a very valid concern and a very valid issue. ADAP clients go to a variety of different clinics. They can be Ryan White-funded clinics, community health centers; local health departments provide services as well as there may be some ADAP clients that have the ability to access private physicians.

So I think as we see an increase in people accessing programs and needing those services at the same time as we have economic downturns, we have, at the state level, definitely been hearing about clinic capacity or provider capacity to see those clients. I can speak Maryland specific. In Baltimore, two of the largest clinics, the Moore Clinic at Johns Hopkins as well as the Evelyn Jordan Center at the Institute for Human Virology, University of Maryland, are already stating that they do have a delay in their ability to see new clients.

So I think that will have a direct impact on ADAP clients simply because they won't have the ability to see a physician in a timely fashion to get the prescription to therefore use the ADAP service. So I think it's a valid concern

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across all of the states and again, I can speak specifically in Maryland that we have concerns about that capacity issue as well.

DOUGLAS H. MORGAN, M.P.A.: Maybe I can just add something from our perspective. An ADAP client does not necessarily have to go to a Ryan White-funded program to get their medical care. I think one of the things that we've seen in HRSA over the last several months particularly as a result of what's commonly called the stimulus bill, the American Resource and Recovery Act, is that there'll be a real substantial increase in both the capacity and dollars going to community health centers, many of which are funded through the Ryan White Part B and Part C programs and Part A programs but some whom are not, we're hoping that these new dollars will also offer an opportunity for these CHCs to get in the business of providing good quality HIV care.

Because we have the capacity to be providing training to some of these centers, we hope to see some increase in training. So that may be one of the safety valves that can now open that will take off some of the capacity.

JENNIFER KATES, M.A., M.P.A.: So both of you spoke about different funding streams in what you said. I'm going to actually ask Murray about this because one of the things that we try to track in the report and I love for you to talk about

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are the funding streams. What does a typical ADAP rely on? Is that a stable source from time to time and the finding around rebates in particular as drivers of the budget, what does that mean for ADAP?

MURRAY PENNER, BSW: Sure. Well obviously ADAPs rely on their federal appropriation through the Ryan White Program, the Part B program, there's an earmark for ADAPs. This year we found that the federal ADAP earmark makes up about half of the overall budget. So in some states, that's higher. Obviously in some states that's lower but nonetheless, states rely substantially on their federal earmark.

We have not seen those awards going up very much in the last few years. So in order to make up the increased client demand, what states have done is turn to their own state funding as well as rebate funding, which is coming back from pharmaceutical manufacturers to kind of fill that gap of the additional clients that have come on, the additional demand.

The challenge with that is now with the fiscal environment as it is, states are cutting back those contributions. The rebate funding is really dependent upon the overall expenditures. So if the overall expenditures aren't growing as a result of level funding, the rebate funds are not growing as well, therefore there's, in some cases, some gaps

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that need to be either filled by cost containment measures or other means to actually contain those costs.

So I think it's challenging for a state to rely on, in some way, shapes reform very unstable funding. It's difficult to predict what a state legislature might do in a particular year especially right now. So really there's levers that go up and down as federal appropriations stay level, state contributions have to increase. So it really is a balancing act on the part of states to make sure the doors stay open and all the clients are served.

JENNIFER KATES, M.A., M.P.A.: And what do you see from HRSA's perspective with all these different funding sources? I mean was it ever envisioned that rebates would become such a big part of what ADAPs tend to rely on as they look ahead each year?

DOUGLAS H. MORGAN, M.P.A.: Well I think rebates clearly are one source of funding that we, as HRSA, do impress upon all of our ADAPs to try to acquire. Rebates, as you know, are really are a product of the participation of 340B drug discount program. For those states who directly purchase drugs, they get the discount upfront. For those who do not directly purchase, they get the rebate from the drug manufacturers.

The issue has been the timeliness of the rebate and knowing when it will come in and how often you could really

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depend on it to offset your budget. We've had some states talk about some of the problems that rebates, the frequency and when they get these huge checks and how it affects their budgeting.

We are also hopeful though this year that, as you know, the '09 budget, the '09 appropriation did provide an over \$20 million increase for the ADAP earmark. We still have yet to award our ADAP supplemental funds, which will go to a fair number of states and that'll be an additional \$40 million that will be awarded, hopefully, in the next several weeks.

So some of the states, in fact, that may have waiting lists may be some potential recipients of those dollars but that's, again, offset by the fact that we have several states talking to us about reduced state revenue and how they maintain their maintenance of effort and their matching requirements, which the law does require in several states.

So we're seeing this balancing act of sort of shifting around both using the federal dollars and what state dollars they have to try to meet all these demands.

JENNIFER KATES, M.A., M.P.A.: What about Maryland? How does that work? What's going on in your state and in terms of all the different funding sources and is managing that or predicting that becoming, and is that a large part of your?

HEATHER HAUCK, MSW, LICSW: Absolutely. I think Murray and I both articulated the complexity of managing, balancing,

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and administering this incredibly complex program and it's grown, I believe, in complexity over the years with the addition of Medicare Part D being implemented with the growth of insurance, coordination of benefits with insurance, our real requirement to be the payer of last resort.

On top of the recertification, on top of the increase in applications, we spend, on top of the increases in reporting to HRSA, additional applications that happen through the last reauthorization, I think it has definitely grown in complexity. The funding source issue is one piece of that complexity.

I would say that we like the states and like the report indicates, have the same split in terms of our federal earmark in addition to rebate, filling in the gap between the federal funding and the end of the fiscal year. We rely on those rebate funds, which is again uncertain, the future of which is uncertain. So again, it's a challenge to constantly monitor and forecast your fiscal and your client needs.

JENNIFER KATES, M.A., M.P.A.: You mentioned Medicare Part D and when Part D first went into effect, it was something we really focused on how did ADAPs react to it, incorporate the requirements, and help their clients access Part D, which they both were required to but also was on the new way that clients could get medications. Here we are a couple of years later and ADAPs seem to be a little bit more in a rhythm with Part D but

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how is that going in Maryland? Does it feel like you're in a rhythm with it?

HEATHER HAUCK, MSW, LICSW: I think so at this point. Again, it's a challenge because of the coordination efforts, because of the monitoring of client eligibility for low-income subsidies, the need to again, ensure payer of last resort, to balance all of that and coordinate all of that, is incredibly challenging. It's still a very complex benefit to understand both at the client level and the case manager level.

I'm fortunate to have staff expertise who can assist the case managers and the clients with understanding Medicare Part D but it's a challenge to do that and fully implement this. It's taken a lot of education efforts, a lot of re-education efforts. There are still folks that we're spending time making sure that they're aligned with the right program. They've signed up for the right benefit and that we're coordinating that internally.

So yes, we're in a rhythm. It's still very challenging. Overall, I would say it's a good program and it's a valuable resource for all of the states. It has made a difference in our expenditures having the Medicare Part D available but the implementation and the administration has been a real significant challenge.

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JENNIFER KATES, M.A., M.P.A.: Has it been for HRSA as well? I know that the bureau's done some educational efforts for [inaudible]?

DOUGLAS H. MORGAN, M.P.A.: Right. We did major educational efforts. We still have some Qs & As up on our website to sort of help states walk through this. I think the complexity is, as Heather pointed out, is in part because the Medicaid, the Medicare Part D plans change every year. So that provides some difficulty for states to keep track of all these changes. They're only on in a program, some of these Medicare Part D plans actually cover what was called the donut hole provision.

We're seeing that go away now from a number of the plans. As individual clients get to that donut hole, the ADAP program has to make a decision. If the client can't make the required payments for the donut hole then ADAP steps in and sort of takes over that client but at least during the first three or four months during the year, they are seeing a cost savings as a result of the Medicare Part D plan.

JENNIFER KATES, M.A., M.P.A.: Okay. I think one of the real issues that Doug is touching on is that ADAP does not count towards true out-of-pocket costs, which would collapse the donut hole for ADAP clients. So I think that's one of the issues that, going forward, needs to be further considered and

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addressed. So can you talk a little bit about that, what that might mean for or explain that to our audience?

MURRAY PENNER, BSW: I'll take a shot at that. So as Doug referred to the donut hole, a client, what an ADAP chooses to cover the costs of medications in that donut hole, in other words, they're wrapping around the Medicare Part D benefit. There's a donut hole in which clients go into as far as their expenditures once they reach a certain level. Once ADAP decides to start paying for the costs of the drugs in that period, the ADAP expenditures don't count towards the out-of-pocket expenditures, which if an individual was paying for that themselves, they would then fall out of that donut hole and be able to be covered 100-percent by Medicare Part D because ADAP expenditures do not count towards those expenditures. The ADAP just continues to pay those costs for the rest of the year until the point that the plan starts over.

So it does end up costing ADAP a lot more. There's a lot more pressure on ADAP to make sure that that coverage continues for the rest of the year.

JENNIFER KATES, M.A., M.P.A.: So I want to shift a little bit to the two ways in which ADAP works, the two main ways. One is providing prescription drugs directly to clients with a formulary. The other is insurance. We've seen changes in both regards this year and over time, could we talk a little

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bit about those two different ways and what ADAPs specifically are doing in terms of expanding or contracting formularies and how insurance payments play into this.

MURRAY PENNER, BSW: Sure. I can take a stab. Doug may follow up on that. Certainly we know that some states actually provide most of their medications via insurance. There are some states that have the ability to purchase insurance through a high-risk pool or other mechanisms of insurance. So they purchase insurance for their clients and therefore, the ADAP is not actually purchasing the drugs. Most of the states just purchase drugs for most of their clients and then have an insurance program on the side where they also provide some insurance payments.

What we're seeing are a couple of things. First of all, on insurance payments, we're seeing higher costs to ADAPs for insurance services, higher premiums, higher co-pays, higher deductibles, if they choose that. So the insurance costs are continuing to go up. It still may be a cost effective way of providing drugs but the costs are continuing to go up. We know that's one of the demands on ADAPs.

Certainly the cost of drugs continues to go up as well and while we are seeing rebates come back into the program, the cost of drugs continue to increase at the same time that client

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loads are increasing, at the same time we're seeing more and more people come into the program.

So all of these demands are really making it challenging. Some ADAPs have had to look at their insurance programs and make decisions to go back to purchasing medications rather than providing insurance because it's more cost effective but it really is one ADAP making that decision. There's not a cookie-cutter approach into an ADAP.

You've heard me say this in other webcasts as well but if you've seen one ADAP, you've seen one ADAP. No two ADAPs are alike. So everyone makes the decision about how to structure their program and how to fund the necessary services that they're providing.

DOUGLAS H. MORGAN, M.P.A.: Let me just sort of add here, of course it's sort of generally known that you can use federal ADAP funds to sort of pay for health insurance particularly if the health insurance offers a medication benefit that we see as equal to or better than ADAP coverage. I think this is where Murray's talking about where states really have to sort of evaluate what's the cost of an annual insurance policy for a client versus what they would normally pay if the client was simply receiving medications from the ADAP.

I think there are some additional benefits though that may come into play here. When you're covering the health

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insurance benefit as well as the medication benefit, you are actually allowing the client to get additional medications other than their ADAP medications, which can also be very helpful. You'll also be covering some direct payments for physician care and health care beyond just the medication.

So that type of balance can be better or certainly cost effective for the ADAP but certainly much more beneficial for the client, particularly as we talked earlier about wait lists. But I think some of the issues though that the states are looking at in terms of this is the cost of insurance is going up and the administrative complexity of managing this type of insurance program, I think as Heather pointed out, these programs work where you really do have to sort of track when insurance premiums are due, when co-pays are due.

Nobody has a policy that exactly starts on February 1st and ends March 31st, whatever the year is. So you actually could be tracking multiple policies for multiple clients and administratively, it tends to be very difficult.

So we've actually worked with states as they think through this, think about the administrative complexities. If you can do it and you feel that you're actually maintaining or will be able to better utilize your limited resources, which is the way to go. We've seen a lot of states do that.

JENNIFER KATES, M.A., M.P.A.: What about Maryland?

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HEATHER HAUCK, MSW, LICSW: We actually do find insurance purchasing and maintenance incredibly cost effective. We are fortunate to have both a high-risk insurance pool as well as an insurance market that can allow clients to continue their insurance or we can purchase, work with them for the insurance purchase. We find that it saves about \$370 per month per client for our ADAP, which again allows us to then not pay the full cost of the medications, which ultimately allows us to bring new clients on to the program through that cost savings.

I completely agree with Doug that the other cost savings to the system, as a whole, for someone who has comprehensive health insurance is valuable. That is something that we factor into the decision to spend money on insurance purchasing and insurance continuation. Again, I would highlight that not all states have the ability to either do that or have the infrastructure they may not have a high-risk insurance pool and they may not have an insurance market that allows the insurance continuation to happen but I think the majority of states where there is that ability, it has proven to be cost effective.

JENNIFER KATES, M.A., M.P.A.: Actually this takes me back to some viewer questions. Two different questions came in that both relate to sort of larger changes happening in the health care environment that could potentially affect ADAPs and

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Ryan White in different ways. The first is from Neal Kearns at the Indiana State Department of Health asking about ETHA, the Early Treatment for HIV Act, which would provide states with an option to expand their Medicaid coverage to people with HIV who are low-income but not yet disabled according to Medicaid criteria. This has been introduced in Congress. Some have asked what would that mean for Ryan White? What would it mean for ADAPs? Does anyone want to take that?

MURRAY PENNER, BSW: I think it would be beneficial for Ryan White programs as well as ADAPs. If we saw states choose the option to cover these individuals under their Medicaid program, if they had that option, we would see less pressure on ADAPs as well as Ryan White programs for individuals that, right now, Ryan White is the safety net, kind of fills their gap in their lack of coverage but if they were able to get on the state Medicaid roles sooner, it would really provide some benefits to ADAPs as well as Ryan White programs.

DOUGLAS H. MORGAN, M.P.A.: I think the advantage to this particular approach is that you'll have, under the Medicaid program as you know, states put up a share and the federal government puts up a share. Well ADAP, essentially with ADAP, the earmark is all federal dollars and this case, with ETHA, you would have a shared arrangement. I think the proposal

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actually talks about increase in the federal Medicaid percentage above and beyond what's normally paid.

So I think that would be a benefit in the sense that you now have this cost sharing arrangement that could, in fact, cover a portion of clients that are now being covered by the ADAP solely. So you would see the benefit, although I think in the long-term as Heather sort of acknowledged, as demand increases, people will be back-filling those slots very rapidly. So we'll have to see, overall, what the increase utilization will be.

MURRAY PENNER, BSW: Well I think the other challenge is what we've already spoke about a little bit is the administration and the complexity of wrapping around all these other services while it certainly it would be great to have more individuals on Medicaid, there still may be some gaps that that program doesn't cover. Every state can set their own Medicaid benefits as they will. Some states limit the number of prescriptions, for instance, and then ADAP comes in and fills the gap.

So again, you're talking about more complexity as far as wrapping around these other services, which requires manpower in order to administer that. Obviously in the funding environments, as we see them now, really is challenging for

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ADAPs to actually administer all these various pieces of the puzzle.

JENNIFER KATES, M.A., M.P.A.: I guess it also raises the question of whether states, even if they have this option, are currently in the position of being able to take it up in their Medicaid side. We have another question that gets at the larger environmental issues around the health care environment. It's from Bill McCall here at AIDS Action here in D.C. asking about health care reform and the larger discussion around health care reform in Washington, for the country by the administration, by Congress, is anyone talking to Congress about what this could mean for ADAPs specifically? What are your thoughts about that? It's a big question but clearly as we've pointed out, any big change in the system probably would affect Ryan White and ADAPs.

DOUGLAS H. MORGAN, M.P.A.: Well I'm not sure we are talking specifically about the impact that health care reform would have on ADAP. I think we, as HRSA and the bureau, are looking at the broader question of what will the impact of health reform have on the Ryan White program and how we will continue to play a role in providing care to people living with HIV and AIDS. I think that's the more broader issue because it's not just ADAP here. It's the entire program and its' role as payer of last resort. So we'll have to sort of see how it

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all plays out because we've seen a lot of discussion about wanting to get this done this year. We're anxious to sort of contribute our thoughts to these issues.

MURRAY PENNER, BSW: I know it is one of the reasons why many community groups are advocating for a simple extension of the simple extension of the Ryan White program for the next three years because health care reform is starting to get underway. We're starting to hear a lot of discussions and be a part of a lot of discussions, because Ryan White is the safety net, how it fits under whatever is left, whatever is necessary for people living with HIV and AIDS for whatever the health care system might look like in several years.

It is necessary for Ryan White to adapt and be able to fill those gaps. We don't know what the health care reform will provide as far as benefits to people living with HIV and AIDS. Certainly there are a lot more requirements for people in their health care if they're HIV positive. So we know it's going to be complex. We know health care reform may not address all those although we'd like it to.

So Ryan White may need to come in and fill the gaps and one of the suggestions is if we can have a little bit more time with the Ryan White program as it is, we can restructure the program once health care reform is kind of in place.

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HEATHER HAUCK, MSW, LICSW: I would definitely agree with what Murray just indicated especially given the uncertainty and the need, with the last reauthorization, there were so many moving parts that happened and as Murray and Doug started with, we're not really sure yet what the full results of all of those moving parts would be. So having a simple program extension during, while health care reform conversations are happening will ensure that our infrastructure actually stays stable and that clients can continue to receive the services that they need including ADAP during these larger conversations.

JENNIFER KATES, M.A., M.P.A.: Here's another question that gets at a larger issue, maybe not as large as health care reform but a larger issue that we also know can affect ADAPs and Ryan White, which is as the demand side. So part of the demand side is driven by more and more people learning their status and prevention and care obviously are connected.

There's been a push by CDC and many others to increase the share of Americans who know their status. Just today actually, the White House announced a new reinvigorated campaign that many groups are part of, we actually are part of it, to reinvigorate prevention, to try to prevent more infections and actually reach people who don't know their status. This is a good thing. What does it mean for ADAPs?

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We've also heard that the capacity to absorb people who newly learn they're infected, the potential issues.

Does anyone want to talk to that? What's happening in Maryland with "Know Your Status" campaigns, with the prevention side and how that might feed in to care?

HEATHER HAUCK, MSW, LICSW: We have actually significantly expanded HIV testing in Maryland through the CDC expanded testing initiative specifically focused in African American communities. So over the past year and a half, we've implemented HIV testing in emergency departments, substance abuse settings, some community health centers, etc. in order to help increase the individuals who don't yet know their status.

So I think the thing to keep in mind is that not all of those individuals will be ADAP eligible. There may be individuals who are now being tested in their routine medical settings who have private insurance who already have another insurance benefit, whether that's Medicare or Medicaid and then of course, ADAP can be the safety net or the payer of last resort.

So I think it is a good thing that we are seeing a reinvigoration of prevention messaging, a reinvigoration of the need for individuals to be tested to know their status. I think it remains to be seen what the impact on the ADAP programs will be over time. We are certainly monitoring the increases in our

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client applications and again believe that some of that may be due to the increase in testing initiatives.

The larger part of it is most likely due to the economy, the rise in unemployment, and just the economic crisis at the state level. So I think there's a number of things that are currently occurring at the state levels that will impact the ADAPs.

MURRAY PENNER, BSW: I think I would add that the other great thing about the expanded testing initiative that Heather mentioned is that we're starting to see more and more people know their status, which is a good thing, but we're also seeing people that know their status that have dropped out of care that are coming back into care as a result of that expanded testing initiative. So that's the other positive piece to that that I think is worth noting.

JENNIFER KATES, M.A., M.P.A.: We actually have a question from a client in Colorado who wants to know and this I think is for, a question for Heather since you're representing the state programs, how the decisions are made about formularies. So in your state, how do you go about deciding a new drug that's approved or there's balancing or issues?

HEATHER HAUCK, MSW, LICSW: That's a great question. We actually have MADAP advisory board, a Maryland AIDS Drug Assistance advisory board and it's a board that's made up of

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health care providers, prescribing clinicians, pharmacists, people living with HIV, other Ryan White part program grantees such as the Part A program grantee as well as community-based organizations and they, on a quarterly basis, actually work with us to look at the data from the program both expenditures, client demographics, as well as the formulary and make recommendations to us on additions or deletions or expansion of our formulary.

They've been meeting for a number of years and I think is one of the keys to our success and our ability to balance the complexity of our ADAP system. We have been fortunate to be able to grow our formulary because of that level of analysis over the past few years actually. So it's a complicated process that should be done in partnership with an advisory board.

JENNIFER KATES, M.A., M.P.A.: Do you know or can anyone speak to how most states do it?

DOUGLAS H. MORGAN, M.P.A.: Well I can at least say that we, at HRSA, have strongly encouraged all states who have ADAPs, have an advisory board or some type of professional group augmented with consumers to look at their formulary on a regular basis to make sure it is meeting the appropriate demands.

We also have a statutory requirement that all state ADAPs cover at least all newly approved classes of

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antiretroviral drugs. I'm happy to say that all states now do that. There is always the question about whether or not they can cover the entire breadth or width of all, say of one class and I think states have to come to some tough decisions about how to prioritize what's covered on their ADAPs.

I think the process that Heather just talked about in the state of Maryland is one that we know is being mirrored in a lot of other states because they are coming to the conclusions that they just can't make the decisions in isolation. They really have to take a look at everything before they make some formulary decisions.

MURRAY PENNER, BSW: I will add, as one of the video participants pointed out, Michelle Rowland, from an antiretroviral standpoint and a prescriber-patient relationship, the prescriber wants the ability to be able to prescribe whatever medication is necessary to work with an individual's regimen.

So states are having to make tough choices particularly when it comes to antiretroviral medications that are on formulary to ensure that those are all available for every client with unique needs because every client's got a different set of needs regarding their regimen. The other challenge comes in the other drugs that are covered under the formularies. Most states cover opportunistic infection drugs.

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Many cover drugs for hepatitis C treatment, for individuals that are co-infected. So some of those decisions also have to be made by these advisory boards. It is very helpful to have consumers to have medical providers on those boards to be able to advise the ADAPs in their decision making for that.

JENNIFER KATES, M.A., M.P.A.: Another question we've been asked in the past and it's something we actually looked at in this report, probably prompted by questions in prior years, was how ADAPs are reaching or allowing clients to find out or access their medications. So are clients going to pharmacies? Are clients mailing in? Is there online, all of these different methods and we looked at that this year. Murray, can you talk a little bit about the different ways that ADAPs are finding ways to get clients their medications? I like to hear what Maryland actually does for that.

MURRAY PENNER, BSW: Sure. Well again, you've seen one ADAP, you've seen one ADAP. I know that's the broken record but it really is true. ADAPs make a decision to have their clients access the program in different ways based on their geography, based on population. In a state like Wyoming, it might be really difficult to have individuals come in to clinics or locations if folks were living out in rural areas for instance.

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So it really is a decision that states make based on many factors in their jurisdiction as to what's going to work best for the client. I think in all cases, what we know is that ADAP administrators and AIDS directors are looking to do the best that they can for clients as far as access into the program, as far as the drugs that are covered on the program but sometimes these other challenge of the funding and everything make it necessary to make some decisions that might not enable the optimum level of access or of formulary coverage for instance but it really does vary, mail order.

Some states will work with their community-based organizations to do intake through that process. Some of them do intake by phone. I know there are states that are exploring new technologies in working with the web, the Internet in a lot more concentrated fashion to make sure that clients have access to the program.

JENNIFER KATES, M.A., M.P.A.: And how does Maryland do it?

HEATHER HAUCK, MSW, LICSW: We actually are very fortunate to sort of piggyback onto the backbone of the Medicaid system. So we actually allow clients to get their medications at any pharmacy that also is a Medicaid pharmacy, which includes most of the chain pharmacies across the state as well as independent pharmacies across the state. So I would say

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that the majority of clients have the ability to go to their local pharmacy if they choose and access their medications at their pharmacy within their jurisdiction.

Again, we are fortunate in that partnership that we have with Medicaid, which again I think is one of the resource issues and partnerships that's really critical to ADAPs in states that can form that partnership because it really does make a difference in terms of access and then in terms of sort of the management of the program as well.

JENNIFER KATES, M.A., M.P.A.: We actually are running out of time. so before we thank everyone for being with us today, I wanted to actually ask each of you if you had anything you wanted to add or maybe forecast that you see as issues to be watching out for in the next year or the next few months, awards that might be coming out or larger discussions. Murray?

MURRAY PENNER, BSW: Well I think we've hit on the topics I would suggest. One is the fiscal environment, which we're in. It's really challenging for states, as Heather mentioned, staff cutbacks and fiscal cutbacks from the legislatures, etc. Ryan White reauthorization, and health care reform, I think are the three biggest areas to be watching for in the future.

DOUGLAS H. MORGAN, M.P.A.: Well I would certainly agree. I think health care reform, the reauthorization will be

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priority one for us and certainly the announcement of the new prevention initiative today.

I think for us, we've always looked at prevention as though not our priority, our primary goal with care and treatment, prevention with positives has been one of the things that we have been focusing on and we'll continue to focus on for those people who cannot sort of be the true beneficiaries of prevention. We see them in care and treatment and we're going to try to reinforce the issues of making sure that those who are positive engage in preventive behaviors that they don't go out and sort of infect others.

JENNIFER KATES, M.A., M.P.A.: You get the last word of our panelists.

HEATHER HAUCK, MSW, LICSW: I would absolutely agree with the three topics that Murray mentioned and would add to Doug that ADAP really is a prevention tool. As people are on medications and adhere to treatment, it reduces viral load, which inhibits transmission of HIV.

So I think there are important linkages to be made between ADAP and prevention and certainly through the expanded testing initiatives and the focus on prevention. So I think it is important to continue to focus on the continuum between HIV care, Ryan White services, and our prevention efforts. Thank you.

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JENNIFER KATES, M.A., M.P.A.: I'd like to thank our panelists, Murray, Doug, and Heather for being with us today and for everyone watching and sending in questions. You can find the materials from this report and the webcast on our site at www.kff.org and at NASTAD's website, www.nasdad.org. There'll be additional resources there, the video that was released today.

We encourage you to share that video and any of the materials with your audiences and other stakeholders in your community. On behalf of the Kaiser Family Foundation, I'm Jen Kates and I want to thank you for being with us today.

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