

Ryan White Program: Part B/AIDS Drug Assistance Program (ADAP)

Providing Outpatient Care and Support Services at the State Level and Access to HIV Medications for Those in Greatest Need

The Ryan White Program

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was first enacted in 1990 and has been reauthorized three times—first in 1996, then in 2000 and 2006, and most recently in 2009. Now referred to as the Ryan White HIV/AIDS Treatment Extension Act of 2009, the program is divided into different components, each of which is designed to address a specific aspect of the HIV/AIDS epidemic.

Part B Basics

Part B of the Ryan White Program provides grants to all 50 states, the District of Columbia, Puerto Rico and the U.S. territories to provide services for people living with HIV/AIDS, including outpatient medical care, oral health care, home- and community-based services, continuation of health insurance coverage, prescription drugs, HIV care consortia, and supportive services. Part B includes the AIDS Drug Assistance Program (ADAP), which supports the provision of HIV medications and related services. Seventy-five percent of Part B funds must be used to support core medical services.



Funding Mechanisms

Part B funds are distributed through base and supplemental grants, ADAP and ADAP supplemental grants, and Emerging Communities (ECs) grants. The base awards are distributed by a formula based on a state or territory's living HIV/AIDS cases weighted for cases outside of Part A-funded jurisdictions. Supplemental awards are available to states with demonstrated need. Congress designates a portion of the Part B award to support ADAP. The majority of ADAP funds are also distributed by a formula based on living HIV/AIDS cases, though 5% of the funds are set aside for states with severe need. A state's combined Part B base award and ADAP allocation cannot decrease by more than five percent per year.

Most states provide some services directly, while others work through subcontracts with Part B HIV Care Consortia. A consortium is an association of public and nonprofit health care and support service providers and community-based organizations that plans, develops, and delivers services for people living with HIV/AIDS. Emerging communities—metropolitan areas that do not yet qualify as EMAs or TGAs but have 500-999 cumulative reported AIDS cases over the last five years—apply for supplemental funding through a grant application.

ADAP Basics

The AIDS Drug Assistance Programs (ADAPs) are a component of Part B. ADAPs provide FDA-approved prescription medications for people with HIV/AIDS with limited or no prescription drug coverage. ADAP funds also may be used to purchase health insurance for eligible clients or to pay for services that enhance access, adherence, and monitoring of drug treatments. In June 2008, ADAPs served more than 110,000 clients, representing approximately one-quarter of those with HIV/AIDS who are receiving care in the U.S. More than percent of those served by ADAPS are people of color. Nationally, 74 percent of ADAP clients have incomes at 200 percent or less of the federal poverty level (FPL). Individual ADAPs operate in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, Commonwealth of the Northern Mariana Islands, and the Republic of the Marshall Islands.

Funding Mechanism

Congress “earmarks” a portion of its annual Ryan White Program Part B appropriation for ADAPs. Although the ADAP “earmark” is by far the fastest growing component of Ryan White appropriations, current funding levels do not match the increasing need. ADAPs also receive money from their respective states, other Ryan White components in the state/territory, and cost-savings strategies, such as participation in the 340B Drug Discount program.

Formularies and Distribution Vary By Program

The ADAP in each state or territory also determines which medications will be included in its formulary and how those drugs will be distributed. The majority of ADAPs cover all FDA-approved antiretrovirals, but 24 do not. Only six ADAPs provide all 31 drugs highly recommended for prevention and treatment of HIV-related opportunistic infections, while 36 provide 16 or more. Many states and territories provide medications through a pharmacy reimbursement model, while others use pharmacies located within public health clinics or purchase drugs and mail them directly to clients.

Eligibility

The ADAP in each state or territory determines the eligibility criteria for its participants. All ADAPs require that individuals document their HIV status. Income eligibility ranges from 100 percent to 500 percent of the Federal Poverty Level (FPL). Fifteen states have income eligibility at 200 percent or less of the FPL.

Waiting Lists and Other Cost Containment Measures Hamper Access

As of January 2010, nine ADAPS had waiting lists totaling 540 individuals. Seven ADAPs, including four with waiting lists, had other cost containment measures in effect: reduced formularies (6); eligibility restrictions (2); capped enrollment (1) and cost sharing (1). An additional six ADAPs anticipate instituting new cost containment measures in FY 2008.

