PART B: AIDS DRUG ASSISTANCE PROGRAM

Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009 provides grants to States and U.S. Territories. Part B grants include a base grant, the AIDS Drug Assistance Program (ADAP) award, ADAP supplemental funds, ADAP Emergency Relief grants, funding for Emerging Communities, and, upon request, additional funds for Minority AIDS Initiative activities. Eligible grantees may also apply for Supplemental Part B funding.

The Ryan White ADAP Program pays for medications to treat HIV disease, insurance continuation for eligible clients, and services that enhance access, adherence, and monitoring of drug treatment. Patient eligibility is determined by the State or Territory and includes both financial and medical eligibility criteria. Financial eligibility is usually determined as a percentage of the Federal Poverty Level (FPL). Medical eligibility is a diagnosis of HIV-infection (symptomatic or asymptomatic). Patients must also be uninsured or underinsured and provide proof of current State residency. ADAPs are required to recertify client eligibility every six months.

GRANTEES

Grantees are State departments of health or other State entities that implement and manage State public health programs. Grants are awarded to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the 6 U.S. Pacific Territories.

SERVICES

ADAP provides medications for the treatment of HIV disease. Program funds may also be used to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of drug treatments.

THE RYAN WHITE HIV/AIDS PROGRAM WORKS WITH CITIES, STATES, AND LOCAL COMMUNITY-BASED ORGANIZATIONS TO PROVIDE SERVICES TO AN ESTIMATED 529,000 PEOPLE EACH YEAR WHO DO NOT HAVE SUFFICIENT HEALTH-CARE COVERAGE OR FINANCIAL RESOURCES TO COPE WITH HIV DISEASE. THE MAJORITY OF RYAN WHITE HIV/AIDS PROGRAM FUNDS SUPPORT PRIMARY MEDICAL CARE AND ESSENTIAL SUPPORT SERVICES. A SMALLER BUT EQUALLY CRITICAL PORTION IS USED TO FUND TECHNICAL ASSISTANCE, CLINICAL TRAINING, AND RESEARCH ON INNOVATIVE MODELS OF CARE. THE RYAN WHITE HIV/AIDS PROGRAM, FIRST AUTHORIZED IN 1990, IS CURRENTLY FUNDED AT $2.35 BILLION.

IMPLEMENTATION

The ADAP in each State and Territory is unique in that it decides which medications will be included in its formulary and how those medications will be distributed. However, current legislation requires that each grantee must cover all classes of approved HIV antiretrovirals on their ADAP formulary.

- Many States and Territories provide medications through a pharmacy reimbursement model. Patients show enrollment cards at participating pharmacies to receive their medications, and the pharmacy invoices the ADAP for payment.
- Some ADAPs use pharmacies located within public health clinics to distribute drugs.
- A few ADAPs purchase drugs and mail them directly to clients.

U.S. Department of Health and Human Services
Health Resources and Services Administration, HIV/AIDS Bureau
5600 Fishers Lane, Room 7-05, Rockville, MD 20857
Tel.: 301.443.1993 Web: hab.hrsa.gov

FUNDING CONSIDERATIONS

- Congress designates, or "earmarks," a portion of the Ryan White HIV/AIDS Program Part B appropriation for ADAP. This distinction is important, because other Part B spending decisions are made locally. Five percent of the total earmark, however, is reserved for supplemental grants to States and Territories that have demonstrated severe need that prevents them from providing medications consistent with Public Health Service guidelines.

- A formula based on the number of reported living HIV/AIDS cases in the State or Territory in the most recent calendar year is used to award ADAP funds. Before the 2006 reauthorization, the estimated number of living cases of AIDS was used in determining the formula, and 3 percent was reserved for supplemental grants. Approximately $900 million was appropriated in FY 2012.

INCREASING DEMAND

Pressure on ADAP resources has increased substantially.

- Factors contributing to an increased demand include the economic downturn, increased HIV testing, a push for earlier HIV treatment, more effective medications, longer survival rates, and increased HIV prevalence.

- Despite appropriation increases, steady growth in the number of eligible clients combined with rising costs of complex HIV/AIDS treatments sometimes results in States experiencing greater demand for ADAP services than available resources can cover. In these instances, ADAPs have implemented waiting lists for program services and medications.

- An ADAP waiting list is a mechanism used to limit access to the ADAP when funding is not available to provide medications to all eligible persons requesting enrollment in that State. The ADAP verifies overall eligibility for the program and places eligible individuals on a waiting list, as necessary, prioritized by a pre-determined criterion. The ADAP manages the waiting list to bring clients into the program as funding becomes available.

- HRSA continues to work to ensure that everyone who is eligible for ADAP is receiving medications. HRSA works with its grantees to ensure clients, HIV service providers and affected communities are informed and educated on other means of accessing medications including enrollment in Patient Assistance Programs (PAPs).

- Highly active antiretroviral therapy (HAART) is the standard of care for most people living with HIV/AIDS (PLWHA). Its cost may be $12,000 or more per year. In addition, PLWHA face costs of treating opportunistic infections, managing side effects, and addressing other treatment issues.

- AIDS mortality has decreased dramatically in the United States since 1995, and an estimated 48,000 new infections occur annually.[1] Therefore, the total number of PLWHA continues to climb.

- The epidemic is growing rapidly among minorities, who historically have experienced higher risk for poverty, lack of health insurance, comorbidities, and disenfranchisement from the health-care system. The result is a growing number of PLWHA who require public support.

QUICK FACTS

- As a result of the dramatic increase in the cost of pharmaceutical treatment and the growing number of PLWHA, the ADAP earmark is now the largest portion of Part B spending. The earmark has grown from $52 million in 1996 to $900 million appropriated for FY 2012. Total ADAP spending is even higher, however, because State ADAPs also receive money from their respective States, from other Ryan White HIV/AIDS Program components, and through cost-saving strategies.

- Approximately 208,809 people received medications or insurance through ADAP in calendar year 2010, a 7-percent increase over the 194,038 people served in the prior year. Eighty-five percent of these clients had household incomes, below 200 percent of the FPL. None of them had adequate health insurance or the financial resources needed to cover the cost of medications or insurance.

[1] Centers for Disease Control and Prevention. *HIV prevention in the United States at a critical crossroads*. 2009. Available at www.cdc.gov/hiv/resources/reports/hiv_prev_us.htm. Accessed April 29, 2010.

- Many clients are enrolled in ADAP temporarily while they await acceptance into other insurance programs, such as Medicaid. On average, 73,000 clients are served each month. A total of 32,201 new clients were served in 2010.

- Of the 2,017 providers submitting data to the HIV/AIDS Bureau for 2010, 1,139 received Part A funds, 1,039 received Part B funds, 447 received Part C funds, and 291 received Part D funds.

- HRSA provides technical assistance (TA) to States in order to maximize the use of Ryan White funding and other resources to provide access to life-saving HIV medications. The TA includes cost effective strategies including working with States to enroll ADAP eligible individuals into Pre-Existing Condition Insurance Plans (PCIPs), the use of ADAP dollars to support ADAP eligible Medicare Part D clients with their True Out-of-Pocket Costs (TrOOP) and 340B and other negotiated medication rebates.