PART III OF THE 01/11/2018 COMMISSION PACKET

10. CALIFORNIA OFFICE OF AIDS (OA) REPORT

Please visit the webpage at:
https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OABudget.aspx

to access the State Budget Information, Materials from the FY 2017-18 Budget Act and Materials from the FY 2017-18 May Revision Budget

California Department of Public Health, Office of AIDS
Monthly Report
January 2018

Office of AIDS Division

Governor Brown released his proposed FY 2018-19 state budget on January 10, 2018. The Office of AIDS (OA) is pleased to announce that the budget proposal continues to support California's *Laying a Foundation for Getting to Zero* Plan. Under this budget proposal, the two OA programs that continue to receive state General Fund for local assistance are the HIV Surveillance and Prevention programs. Both the $6.7 million in General Fund local assistance for the Surveillance program and the $7.5 million in General Fund local assistance for the Prevention remain unchanged from the 2017 Budget Act. The budget includes two new changes related to the AIDS Drug Assistance Program (ADAP):

- The ADAP Eligibility and Enrollment Budget Change Proposal requests $250,000 in ADAP Rebate Fund expenditure authority to support two administratively established positions for FY 2017-18 and $2.7 million in FY 2018-19 and ongoing for 15 permanent positions to manage the increased workload involved in transitioning ADAP eligibility and enrollment services to CDPH/OA.
- The ADAP Estimate proposes an increase in funding to ADAP Enrollment Sites. The 2017 Budget Act included a one-time legislative augmentation of an additional $4 million for enrollment sites, for a total of $8 million in FY 2017-18. Starting in FY 2018-19, the budget proposes moving to a model in which the total amount of funds for ADAP enrollment services performed is adjusted annually through the Estimate process based on caseload and estimated services to be performed each FY. For FY 2018-19, CDPH projects enrollment costs of $7.99 million. In order to ensure that this on-going increase in funding to ADAP enrollment sites results in improved client outcomes and cost neutrality, CDPH plans to include performance measures in existing ADAP enrollment site contracts to ensure enrollment sites use the additional funding to transition an increased number of medication-only clients into private insurance and OA-HIPP and meet defined metrics, such as improvement in viral suppression rates at each enrollment site.

More information on the OA-specific portions of the budget is available at https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OABudget.aspx.

Senate Bill (SB) 239

SB 239 was chaptered in 2017 and took effect on January 1, 2018. SB 239 modified state criminal laws related to HIV transmission that specified a higher punishment than laws that apply to transmission of other communicable diseases. A fact sheet detailing all changes made by the bill is available on the California Department of Public Health, Office of AIDS (OA) website at www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/SB%20239%20OA%20Fact%20Sheet%202017_ADA-ADA.pdf

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

- **Pre-Exposure Prophylaxis Assistance Program (PrEP-AP)**
  OA is developing the enrollment worker training for the PrEP Assistance Program that will be rolled out in early 2018.

- **Access, Adherence, and Navigation Program**
  OA is holding regular status meetings with enrollment sites selected to participate in the Access, Adherence, and Navigation Program to answer questions and provide program updates such as contracting and training updates.

  On December 14, 2017, 9 individuals received the Access, Adherence, and Navigation policy and system training. Once these individuals complete the ADAP Enrollment System (AES) eLearning, they will begin enrolling ADAP clients into comprehensive health coverage.

- **Covered California Open Enrollment and Off-Exchange Plan Open Enrollment**
  The Covered California open enrollment period is November 1, 2017, to January 31, 2018. ADAP staff and enrollment workers were provided with Management Memoranda regarding the Covered California open enrollment period, off-exchange plan open enrollment periods, and Office of AIDS Health Insurance Premium Payment (OA-HIPP) program requirements. The Management Memoranda contained information regarding changes for Covered California consumers and resources to help assist clients in choosing a health insurance plan. On December 14, 2017, OA mailed letters in English and Spanish regarding the Covered California open enrollment period to existing clients that are enrolled in Covered California and ADAP clients that do not have health coverage. The mailing inadvertently included clients that either had existing coverage with or was eligible for Medicare, Medi-Cal or private insurance. OA apologizes for the confusion and has sent out letters to the affected clients letting them know of the error and that no further action is required on their part.

RW Part B: HIV Care Program (HCP)

- All HCP and Minority AIDS Initiative (MAI) contractors received 2018-19 allocation award notification. The allocation award is the same as the 2017-18 HCP and MAI fiscal year, which is available on the OA website at www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/HCPAllocationsFY201718.pdf. HCP and MAI 2018-19 Budget Forms are due to OA by Friday, February 23, 2018.

- The Housing Plus Project (HPP) is beginning the program evaluation process. OA staff will be reviewing data from the four pilot sites to determine program efficacy and outcomes. HPP is a five-year demonstration project, intended to stabilize housing as a targeted intervention focused on engaging and retaining clients of color in HIV care and treatment, and assisting clients to achieve and maintain viral suppression. Currently, HPP is **only available** in Kern, Orange, San Joaquin, and Tulare Counties.

- An in-person Stakeholder Engagement Group (SEG) meeting will be held in Sacramento on January 12, 2018. The SEG is is working with OA to update the HCP, MAI, and Housing Opportunities for Persons With AIDS (HOPWA) allocation formulas. The meeting is an opportunity for the SEG to provide feedback to OA on draft HCP formulas and transitional elements.

- On October 30, 2017, the OA HIV Care Branch led a stakeholder webinar to share information about the HCP training needs, to solicit additional input regarding training needs, to share the current methods for providing HCP training and community engagement, and to share and obtain input on potential future models for improving HCP training.

  OA invited approximately 209 participants to attend the a stakeholder webinar (137 HCP contractors, 46 HCP subcontractors and 26 others representing community and academic organizations and including all known partners currently providing HIV training services or potentially interested in bidding on HIV training contracts). Thirty-eight attended (23 HCP contractors, 8 HCP subcontractors, and 7 others).

  During the stakeholder webinar, OA staff highlighted two options. Option 1: Consolidate meeting, conference and training services into one comprehensive contract and Option 2: Establish two contracts, separating meeting and conference planning services from training only services.

Moving forward, OA will go with "Option 2," which includes establishing a competitive bid process for training services to increase the likelihood of procuring the best vendor to provide these services.

On January 2, 2018, OA emailed a letter to stakeholders to thank those who participated in the webinar and those who provided input in writing, and to provide the above information. This letter is available on the OA website at www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/Stakeholder%20Letter.pdf.

HIV Prevention

- Assembly Bill (AB) 2640 was signed by Governor Edmund G. Brown and went in to effect January 1, 2017. AB 2640 created new California Health and Safety Code (HSC) for HIV testing requirements in healthcare and non-healthcare settings, including a requirement for medical providers or a person administering the HIV test to advise a patient who is known to be at high risk for HIV infection and tests negative for HIV about methods that prevent or reduce the risk of contracting HIV, including, but not limited to, preexposure prophylaxis and postexposure prophylaxis, consistent with CDC guidance. A letter outlining the requirements for HIV testing in healthcare and non-healthcare settings resulting from AB 2640 is available on the OA website at www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/AB2640_PolicyLetter_Final_Letter_Approved_ADA%20to%20WEBSITE.pdf.

- On November 27 – 29, 2017, OA hosted a combined HIV prevention and HIV surveillance conference ***Bending the Arc Towards Justice: Together we can get to Zero*** at the UCLA Luskin Conference Center in Los Angeles.
  The purpose of the meeting was to bring local AIDS Directors and other key HIV/AIDS stakeholders across the state to participate in plenaries and workshops to support the new five-year HIV prevention and HIV surveillance strategy for implementation of California's *Laying a Foundation for Getting to Zero* Plan at the state and local levels.

  The conference meeting objectives were to:
  - State the rationale of integrating of HIV surveillance and prevention activities
  - Describe the health equity framework for California's integrated HIV prevention, care and surveillance strategy
  - Identify local health jurisdiction-based strategies and activities that will support HIV prevention and surveillance collaborations
  - Integrate STD control and HIV prevention activities to achieve mutual goals

- The OA Prevention Branch is developing a Program Guidance for its new five-year Integrated HIV Surveillance and Prevention PS18-1802 grant beginning in 2018. The Prevention Program guidance will heavily reflect California's *Laying a Foundation for Getting to Zero* Plan. Central themes focused throughout the guidance include, but are not limited to: Linkage to Care, Partner Services, PEP/PrEP Navigation, and U = U (undetectable = untransmittable). The 20 funded local health jurisdictions within the California Project Area will be assisted to create a plan of action to implement new and required activities set forth by the Center for Disease Control and Prevention (CDC). Development of the guidance is currently in its early phase. Release of the Prevention Program Guidance to local health jurisdictions will be in March 2018.

- The Merced Needle Exchange has applied to CPDH to authorize a new syringe exchange program (SEP). The proposed Merced Needle Exchange will have a fixed site at the Family Care Clinic, a rural non-profit clinic that predominantly serves Medicaid and uninsured patients. The 90-day public comment period for the Merced Needle Exchange certification application began on December 20, 2017, and will close on March 20, 2018. Public comments may be sent to SEPApplication@cdph.ca.gov, and must be submitted no later than 11:59 p.m., March 20, 2018. CDPH will then review the application and issue a decision within 30 business days.

  If approved, the new SEP will also be able to participate in the California Syringe Exchange Supply Clearinghouse which provides a baseline level of supplies to authorized SEPs throughout California. California SEPs have been giving rave reviews of the project, which is a collaboration with the North American Syringe Exchange Network (NASEN). Several SEPs report being able to add new services, such as patient navigation, wound care, overdose prevention, and expanded outreach with the new support from OA and the Supply Clearinghouse.

For questions regarding this report, please contact: michael.foster@cdph.ca.gov.

OFFICE OF AIDS

State Budget Information

Each year the budget process begins in November. The California Department of Public Health, Office o (CDPH/OA) prepares an AIDS Drug Assistance Program (ADAP) Estimate Package which is included in th Governor's Budget released in January. An HIV/AIDS Program Funding Detail (AIDS Chart) is also releas January, which includes the proposed budget year detail and an updated current fiscal year budget. In prepares the ADAP package for the Legislative May Revise Budget. An updated AIDS Chart is also releas May. The Legislature must pass a budget each year and when the Governor signs the budget, it becom enacted budget. Once enacted the budget and the AIDS Chart are released by Department of Finance (

Materials from the FY 2018-19 Governor's Budget

- State of California HIV/AIDS Program Funding Detail (AIDS Chart) FY 2018-19 Governor's Budget (2018-19 Governors Budget AIDS Chart
- ADAP FY 2018-19 November Estimate (PDF) - The OA ADAP November Estimate Package
- FY 2018-19 Governor's Budget Office of AIDS Talking Points (PDF) - These talking points refer to th detail on the Governor's Budget.
- AIDS Drug Assistance Program Eligibility and Enrollment BCP

Materials from the FY 2017-18 Budget Act

- State of California HIV/AIDS Program Funding Detail (AIDS Chart) FY 2017-18 Budget Act (PDF)

Materials from the FY 2017-18 May Revision Budget

- ADAP Estimate for 2017-18 May Revision (PDF) - The May 2017 OA ADAP Estimate Package
- OA FY 2017-18 May Revision Talking Points (PDF) - These talking points refer to the funding detail Revision Budget.
- State of California HIV/AIDS Program Funding Detail (AIDS Chart) (PDF)- FY 2017-18 May Revision

If you are having difficulty accessing this document please contact CDPH at 916-449-5900 to request thi information in an alternate format.

Page Last Updated : January 10, 2018

State of California HIV/AIDS Program Funding Detail
Department of Public Health (CDPH) and Department of Health Care Services (DHCS)
2018 Governor's Budget
($ In Thousands)

Funding Category	2016-17 (Actuals)					2017-18 (Estimated)					2018-19 (Budgeted)				
	General Fund	Federal Funds	Special Funds	Reim-bursement	Total	General Fund	Federal Funds	Special Funds	Reim-bursement	Total	General Fund	Federal Funds	Special Funds	Reim-bursement	Total
Support															
CDPH-Office of AIDS (OA) [1,2/]	$ 4,254	$ 23,188	$ 6,849	$ 642	**$ 34,933**	$ 4,100	$ 24,833	$ 7,127	$ 737	**$ 36,797**	$ 3,828	$ 29,301	$ 5,683	$ 915	**$ 39,727**
TOTAL SUPPORT	**$ 4,254**	**$ 23,188**	**$ 6,849**	**$ 642**	$ 34,933	**$ 4,100**	**$ 24,833**	**$ 7,127**	**$ 737**	$ 36,797	**$ 3,828**	**$ 29,301**	**$ 5,683**	**$ 915**	$ 39,727
Local Assistance (CDPH-OA)															
Prevention and Testing Portfolio	$ 7,696	$ 22,063	$ -	$ -	**$ 29,759**	$ 7,496	$ 13,227	$ -	$ -	**$ 20,723**	$ 7,496	$ 15,065	$ -	$ -	**$ 22,561**
Care and Support Portfolio	$ -	$ 41,516	$ -	$ -	**$ 41,516**	$ -	$ 21,831	$ -	$ -	**$ 21,831**	$ -	$ 46,704	$ -	$ -	**$ 46,704**
Housing	$ -	$ 2,602	$ -	$ -	**$ 2,602**	$ -	$ 3,078	$ -	$ -	**$ 3,078**	$ -	$ 3,808	$ -	$ -	**$ 3,808**
AIDS Drug Assistance Program (ADAP) Insurance Assistance	$ -	$ -	$ 18,691	$ -	**$ 18,691**	$ -	$ 12,500	$ 35,936	$ -	**$ 48,436**	$ -	$ -	$ 51,047	$ -	**$ 51,047**
ADAP Medication Program	$ -	$ 155,828	$ 186,399	$ -	**$ 342,227**	$ -	$ 98,923	$ 250,761	$ -	**$ 349,684**	$ -	$ 132,438	$ 250,921	$ -	**$ 383,359**
Epidemiologic Studies/Surveillance	$ 6,648	$ 503	$ -	$ -	**$ 7,151**	$ 6,666	$ 576	$ -	$ -	**$ 7,242**	$ 6,666	$ 425	$ -	$ -	**$ 7,091**
TOTAL CDPH-OA LOCAL ASSISTANCE	**$ 14,344**	**$ 222,512**	**$ 205,090**	**$ -**	$ 441,946	**$ 14,162**	**$ 150,135**	**$ 286,697**	**$ -**	$ 450,994	**$ 14,162**	**$ 198,440**	**$ 301,968**	**$ -**	$ 514,570
TOTAL CDPH-OA (SUPPORT + LOCAL ASSISTANCE)	**$ 18,598**	**$ 245,700**	**$ 211,939**	**$ 642**	$ 476,879	**$ 18,262**	**$ 174,968**	**$ 293,824**	**$ 737**	$ 487,791	**$ 17,990**	**$ 227,741**	**$ 307,651**	**$ 915**	$ 554,297
FFS Medi-Cal (DHCS) [3/]	$ 254,926	$ 254,926	$ -	$ -	**$ 509,852**	$ 265,929	$ 265,929	$ -	$ -	**$ 531,857**	$ 279,225	$ 279,225	$ -	$ -	**$ 558,450**
Estimated Part D (DHCS) [4/]	$ 84,846	$ -	$ -	$ -	**$ 84,846**	$ 81,611	$ -	$ -	$ -	**$ 81,611**	$ 90,537	$ -	$ -	$ -	**$ 90,537**
TOTAL FFS and PART D MEDI-CAL (DHCS)	**$ 339,772**	**$ 254,926**	**$ -**	**$ -**	$ 594,698	**$ 347,540**	**$ 265,929**	**$ -**	**$ -**	$ 613,468	**$ 369,762**	**$ 279,225**	**$ -**	**$ -**	$ 648,987
TOTAL CDPH/DHCS AIDS/HIV FUNDING	**$ 358,370**	**$ 500,626**	**$ 211,939**	**$ 642**	$ 1,071,577	**$ 365,802**	**$ 440,897**	**$ 293,824**	**$ 737**	$ 1,101,259	**$ 387,752**	**$ 506,966**	**$ 307,651**	**$ 915**	$ 1,203,284

1/ Reimbursements from DHCS Federal Title XIX are included in the CDPH-Office of AIDS row because they are Office of AIDS expenditures.

2/ Office of AIDS payments to DHCS Audits and Investigations are included in the CDPH-Office of AIDS row because they are Office of AIDS expenditures.

3/ Reflects HIV/AIDS-related expenditures by the Medi-Cal program. January-June 2017 expenditures are actuals. Expenditures for FY 2017-18 and FY 2018-19 are estimated on a growth factor of 5.0 percent from the prior fiscal year, respectively. Starting January 2014, HIV/AIDS related expenditures are limited to claims with a HIV diagnosis and HIV related drugs. Prior to January 2014, additional expenditures for beneficiaries with a HIV diagnosis were included if it was associated with HIV/AIDS treatment. The actual expenditures included in this estimate can be found on DHCS' website (http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal_Fee-for-Service_Expenditures.aspx). Additional months of data are not available for inclusion in this estimate. These figures are difficult to project because Medi-Cal does not project AIDS costs separately from other Medi-Cal costs. In addition, the DHCS does not track AIDS-related expenditures for Medi-Cal eligibles that receive treatment in Managed Care systems, and so expenditures reflect Medi-Cal Fee-For-Service payments only.

4/ On January 1, 2006, Medi-Cal HIV/AIDS beneficiaries that are also Medicare eligible were enrolled in a Medicare Part D plan and Medicare began paying for the majority of the beneficiaries drug need. Medi-Cal uses the percent of HIV/AIDS drug expenditures from calendar year 2003 of the expenditures of Part D drugs (4.26%) to estimate the HIV/AIDS related expenditures of Medi-Cal's Part D payments. The source for this estimate is the November 2017 Medi-Cal Local Assistance Estimate.

State of California HIV/AIDS Program Funding Detail
Other California Departments with AIDS Programs
2018 Governor's Budget
($ In Thousands)

Funding Category	2016-17 (Actuals)			2017-18 (Estimated)			2018-19 (Budgeted)		
	General Fund	Federal Funds	Total	General Fund	Federal Funds	Total	General Fund	Federal Funds	Total
University of California									
AIDS Research [1/]	$ 8,753	$ -	**$ 8,753**	$ 8,753	$ -	**$ 8,753**	$ 8,753	$ -	**$ 8,753**
Department of Education									
AIDS Prevention Education	$ -	$ 424	**$ 424**	$ -	$ 415	**$ 415**	$ -	$ 415	**$ 415**
State Mandates-AIDS Prevention Instruct [2/]	$ 806	$ -	**$ 806**	$ 1	$ -	**$ 1**	$ 1	$ -	**$ 1**
Department of Corrections and Rehabilitation									
Adult Health Care									
Transitional Case Mgt. For HIV/AIDS Parolees	81	$ -	**$ 81**	83	$ -	**$ 83**	$ 88	$ -	**$ 88**
AIDS Treatment and AIDS Facilities	$ 64,236	$ -	**$ 64,236**	$ 71,574	$ -	**$ 71,574**	$ 73,280	$ -	**$ 73,280**
Juvenile Health Care									
AIDS Screening, Treatment, and Other Services	$ 250	$ -	**$ 250**	$ 249	$ -	**$ 249**	$ 249	$ -	**$ 249**
Department of Social Services									
Residential Care for the Chronically Ill	$ 55	$ 55	**$ 110**	$ 55	$ 55	**$ 110**	$ 55	$ 55	**$ 110**
Department of Health Care Services [3/]									
HIV Counseling/Testing/Early Intervention [4/]	$ -	$ -	**$ -**	$ -	$ -	**$ -**	$ -	$ -	**$ -**
Total Other CA Departments, AIDS/HIV	**$ 74,181**	**$ 479**	**$ 74,660**	**$ 80,715**	**$ 470**	**$ 81,185**	**$ 82,426**	**$ 470**	**$ 82,896**
TOTAL CALIFORNIA AIDS/HIV FUNDING [5/]	**$ 432,551**	**$ 501,105**	**$ 1,146,237**	**$ 446,517**	**$ 441,367**	**$ 1,182,444**	**$ 470,178**	**$ 507,436**	**$ 1,286,180**

1/ Prior to 2012-13, funding was specifically set aside in the University of California's budget for AIDS research. Beginning in 2012-13, nearly all earmarks were eliminated from the University's budget. However, the University has indicated that it will continue to allocate funding for this program at 2011-12 levels.

2/ Additional funding for this and other mandates is available via a K-12 block grant.

3/ This entry was previously listed under the Department of Alcohol and Drug Programs (DADP). All substance use disorder programs, including HIV Counseling/Testing/Early Intervention, transferred from DADP to DHCS on July 31, 2013 to better coordinate the licensing, certification, and program management of substance use disorders services statewide.

4/ All substance use disorder programs, including HIV Counseling/Testing/Early Intervention, transferred from DADP to DHCS on July 31, 2013 to better coordinate the licensing, certification, and program management of substance use disorders services statewide. Beginning in FY 2015-16 Counties will no longer receive Substance Abuse Prevention and Treatment (SAPT) Block Grant (BG) HIV set-aside funds to deliver HIV or early intervention services. Refer to MHSUDS 16-012. California has been given an extension on expending HIV funds for Federal Fiscal Year 2015-16 and actuals were finalized on March 1, 2017. Refer to MHSUDS 16-054. The FY 2015-16 figure is the amount of actual expenditures from the FFY 2016 SAPT Block Grant for HIV Services.

5/ Total funding for each year includes special fund expenditures by CDPH and DHCS.

AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Fiscal Year 2018-19

November Estimate

Karen L. Smith, MD, MPH

Director and State Public Health Officer

California Department of Public Health

Table of Contents

I. Program Overview

The California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA), AIDS Drug Assistance Program (ADAP) provides access to life-saving medications for eligible California residents living with HIV, and will be providing assistance with covering costs related to HIV pre-exposure prophylaxis (PrEP) for clients at risk for acquiring HIV. ADAP services, including support for medications, health insurance premiums, and medical out-of-pocket costs, are provided to five groups of clients:

1. **Medication-only clients** are People Living with HIV (PLWH) who do not have private insurance and are not enrolled in Medi-Cal or Medicare. ADAP covers the full cost of prescription medications on the ADAP formulary for these individuals. This group only receives services associated with medication costs.
2. **Medi-Cal Share of Cost (SOC) clients** are PLWH enrolled in Medi-Cal who have a SOC for Medi-Cal services. ADAP covers the SOC for medications for these clients. This group only receives services associated with medication costs.
3. **Private insurance clients** are PLWH who have some form of health insurance, including insurance purchased through Covered California, privately purchased health insurance, or employer-based health insurance; therefore, this group is sub-divided into three client sub-groups: Covered California clients, non-Covered California clients, and employer-based insurance clients. These groups receive services associated with medication costs, health insurance premiums, and medical out-of-pocket costs. Currently, employer-based insurance clients only receive medication services, but they will be offered health insurance premium and medical out-of-pocket cost services starting in early 2018.
4. **Medicare Part D clients** are PLWH who are enrolled in Medicare and have purchased Medicare Part D plans for medication coverage. This group receives services associated with medication co-pays and Medicare Part D health insurance premiums. Starting in the spring of 2018, qualifying Medicare Part D clients will have the option for premium assistance with Medigap supplemental insurance policies, which cover medical out-of-pocket costs, or for those without a Medigap policy, assistance with their Medicare Part B medical out-of-pocket costs.
5. **PrEP clients** are individuals who are at risk for, but not infected with, HIV and have chosen to take PrEP as a way to prevent infection. The PrEP Assistance Program is projected to start in early 2018, and will cover both insured and uninsured clients. For insured clients, the PrEP Assistance Program will pay for PrEP-related medical out-of-pocket costs and will cover the gap between what the client's insurance plan and the manufacture's co-payment assistance program will pay towards medication costs. For uninsured clients, the PrEP Assistance Program will only provide assistance with PrEP-related medical costs, as medication is provided free by the manufacturer's medication assistance program.

As a covered entity in the 340B Drug Pricing Program, ADAP collects rebate for a majority of prescriptions purchased for ADAP clients. ADAP does not collect rebate for prescriptions purchased for Medi-Cal SOC nor PrEP clients. As the primary payer, Medi-Cal has the right to claim federal mandatory rebate on prescriptions for Medi-Cal SOC clients. In order to ensure duplicate rebate claims are not submitted to manufacturers by both programs, which is prohibited, ADAP does not invoice for rebates on these claims. Rebate is also not collected on medication purchases for PrEP clients because the PrEP Assistance Program is separate and distinct from ADAP and is not a 340B covered entity.

Historically, the majority of clients ADAP served were ADAP-only clients without health insurance because PLWH were unable to purchase affordable health insurance in the private marketplace. However, with the implementation of the Affordable Care Act (ACA), more ADAP clients have been able to access public and private health insurance coverage. ADAP clients are screened for Medi-Cal eligibility, and potentially eligible clients must apply. Clients who enroll in full-scope Medi-Cal are disenrolled from ADAP, because these clients have no SOC, drug co-pays or deductibles, and no premiums. All clients who obtain health coverage through Covered California or other health plans can remain in ADAP's medication program to receive assistance with their drug deductibles and co-pays for medications on the ADAP formulary. Eligible clients with health insurance can co-enroll in ADAP's health insurance assistance programs for assistance with their insurance premiums. Assisting clients with purchasing health insurance is more cost effective than paying the full cost of medications. In addition, assisting clients with purchasing and maintaining health insurance coverage improves the overall health of Californians living with HIV because clients have comprehensive health insurance and access to the full spectrum of medical care, rather than only HIV outpatient care and medications through the Ryan White (RW) system.

II. Estimate Overview

The ADAP Estimate for the 2017 November Estimate provides a revised projection of Current Year [Fiscal Year (FY) 2017-18] local assistance costs for the medication and health insurance programs for ADAP, along with projected local assistance costs for Budget Year (FY 2018-19).

Table 1, page 4, shows the estimated ADAP local assistance expenditure need for the Current Year, and compares it to the amount reflected in the 2017 Budget Act.

- For FY 2017-18, CDPH estimates that ADAP expenditures will be $398.1 million, which is a $2.4 million increase compared to the 2017 Budget Act. The increase is mainly due to a one-time need for system enhancements to CDPH's Insurance Benefits Manager and Medical Benefits Manager (IBM/MBM) platform to implement the PrEP Assistance Program and to accommodate the expansion of OA-HIPP benefits to individuals with employer based insurance and Medicare Part D (see unchanged assumptions 1 and 2 on pages 9 and 10), in addition to other eligibility enhancements to streamline insurance data transfers and medical out-of-pocket costs claims submissions.

- For FY 2018-19, CDPH estimates that ADAP expenditures will be $434.4 million, which is a $38.7 million increase in expenditures compared to FY 2017-18 in the 2017 Budget Act, mainly due to an increase in medication expenditures per client per month and overall caseload.

Table 2, page 4, shows the estimated ADAP revenue for Current Year and Budget Year and compares them to the amount reflected in the 2017 Budget Act.

- For FY 2017-18, CDPH estimates ADAP revenue will be $328.3 million, which is a $1.4 million decrease compared to the 2017 Budget Act. The decrease is because of the six-month delay in rebate and due to actual medication expenditures from January 01, 2017 through June 30, 2017 (FY 2016-17) being less than the estimated expenditures communicated in the 2017-18 Governor's Budget.

- For FY 2018-19, CDPH estimates ADAP revenue will be $304.0 million, which is a $25.7 million decrease compared to the 2017 Budget Act. The decrease in revenue is due to a projected loss in rebate. See page 7 for additional information.

California Department of Public Health
AIDS Drug Assistance Program
2017 November Estimate
Table 1: Local Assistance
(dollars in millions)

Local Assistance	2017 Budget Act	Current Year FY 2017-18			2017 Budget Act	Budget Year FY 2018-19		
		2017 November Estimate	$ Change from 2017 Budget Act	% Change from 2017 Budget Act		2017 November Estimate	$ Change from 2017 Budget Act	% Change from 2017 Budget Act
Fund:								
Total Funds Requested	**$395.7**	**$398.1**	**$2.4**	**0.6%**	**$395.7**	**$434.4**	**$38.7**	**9.8%**
Federal Funds - Fund 0890	$111.4	$111.4	$0.0	0.0%	$111.4	$132.4	$21.0	18.9%
Rebate Funds - Fund 3080	$284.3	$286.7	$2.4	0.9%	$284.3	$302.0	$17.7	6.2%
Caseload	32,003	29,896	-2,107	-6.6%	32,003	32,438	435	1.4%

[1]Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

Table 2: Rebate Fund Revenues (Fund 3080)
2017 November Estimate
(dollars in millions)

Local Assistance	2017 Budget Act	Current Year FY 2017-18			2017 Budget Act	Budget Year FY 2018-19		
		2017 November Estimate	$ Change from 2017 Budget Act	% Change from 2017 Budget Act		2017 November Estimate	$ Change from 2017 Budget Act	% Change from 2017 Budget Act
Total Revenue Requested	**$329.7**	**$328.3**	**-$1.4**	**-0.4%**	**$329.7**	**$304.0**	**-$25.7**	**-7.8%**
Rebate Funds - Fund 3080	$329.1	$326.6	-$2.5	-0.8%	$329.1	$302.3	-$26.8	-8.1%
Interest Income	$0.7	$1.8	$1.1	169.2%	$0.7	$1.8	$1.1	169.2%

III. Overview Projections

A. Key Influences on ADAP expenditures

a) FY 2017-18: Compared to the 2017 Budget Act, CDPH estimates that expenditures during FY 2017-18 will increase by 0.6 percent. The increase is mainly due to the IBM/MBM system enhancements described on page 3.
b) FY 2018-19: Compared to the 2017 Budget Act, CDPH estimates that expenditures during FY 2018-19 will increase by 9.8 percent due to an increase in medication expenditures per client per month and overall caseload. This increase is partially offset by the transition of some ADAP-only clients to private insurance through the Access, Adherence, and Navigation Program[1].

B. Expenditures

ADAP expenditures are broken out into two types: 1) variable expenditures consisting of health care expenditures and, starting in FY 2018-19, enrollment expenditures (see New Assumption #1 on page 8), and 2) fixed expenditures.

a) Health Care and Enrollment Expenditures (Variable Expenditures)
- Health care expenditures are estimated based on five client groups. Four of the client groups are PLWH: medication-only clients, Medi-Cal SOC clients, private insurance clients, and Medicare Part D clients. The fifth client group includes persons at risk for HIV who are receiving PrEP and are referred to as PrEP clients. Services the different client groups receive can include coverage of the following health care expenses: prescription medication costs for medications on the ADAP formulary (including deductibles, co-pays, and co-insurance); health insurance premiums; and medical out-of-pocket costs (e.g., deductibles and co-pays for physician visits, laboratory tests, etc). Expenditures are also shown by these different services for each client group. Estimated expenditures by client group are shown in Table 3. A detailed discussion of caseload and expenditures by client group and service type is in Section V on page 12.
- Local ADAP enrollment services: Beginning in FY 2016-17, CDPH began allocating funds directly to ADAP enrollment sites based on ADAP services provided at each site. These funds may only be used for costs associated with enrolling and maintaining clients in ADAP. In the 2017 Budget Act, a fixed amount of $8.0 million was allocated for local ADAP enrollment services. Starting in FY 2018-19, CDPH proposes moving to a model in which the total amount of funds for ADAP services performed is adjusted annually through the Estimate process based on caseload and estimated services to be performed

[1]Formerly referred to as ADAP case management in the 2017 Budget Act.

(see New Assumption #1 on page 8). Using this methodology, CDPH estimates $7.99 million in enrollment costs in FY 2018-19. A description of the reimbursement methodology is included in Section V on page 16.

TABLE 3: ESTIMATED HEALTH CARE EXPENDITURES BY CLIENT GROUP

CLIENT GROUP	HEALTH CARE EXPENDITURES	
	FY 2017-18	FY 2018-19
Medication-Only	$310,988,705	$321,906,295
Medi-Cal SOC	$1,075,087	$1,075,087
Private Insurance	$52,111,849	$70,985,170
Medicare Part D+	$21,002,426	$23,522,070
SUBTOTAL	**$385,178,067**	**$417,488,622**
PrEP	$516,547	$2,142,715
HEALTH CARE	**$385,694,614**	**$419,631,337**
Enrollment Costs	$8,000,000	$7,985,800
TOTAL	**$393,694,614**	**$427,617,137**

+ Expenditures for Medicare Part D clients include Part D premiums, Part D medication co-pays, Part B medical out-of-pocket expenses, and Medigap premiums.

b) Fixed Expenditures
- Local ADAP enrollment services: As described above on page 5, in the 2017 Budget Act, a fixed amount of $8.0 million was allocated for local ADAP enrollment services. Starting in FY 2018-19, enrollment costs are considered variable expenditures.
- Access, Adherence, and Navigation Program (formerly ADAP Case Management): In FY 2017-18 and FY 2018-19, CDPH will be allocating funds to ADAP enrollment sites identified as having a large number of ADAP-only clients to provide navigation services to comprehensive health coverage and to provide assistance with achieving and maintaining viral suppression. CDPH estimates allocating approximately $2.3 million for Access, Adherence, and Navigation in both FY 2017-18 and FY 2018-19.
- Pharmacy Quality Incentive Program (QIP): In FY 2018-19, ADAP will allocate approximately $2.3 million to pharmacies in the ADAP network that provide specific care and prevention measures identified by CDPH with the goal of improving health outcomes and reducing overall state costs.

C. Revenue

a) ADAP Special Funds - ADAP receives both mandatory and voluntary supplemental rebates from drug manufacturers for ADAP drug expenditures. A six-month delay in rebate revenue exists because of the

time required for billing the drug manufacturers and receipt of the rebate. As a result, FY 2017-18 revenue estimates are based on estimated rebates received for actual expenditures from January through June 2017, and estimated rebates for estimated expenditures from July through December 2017. FY 2018-19 revenue estimates are based on estimated drug expenditures for the last two quarters of the current FY and the first two quarters of the budget FY.

- For FY 2017-18, CDPH estimates ADAP rebate revenue will decrease by 0.4 percent from $329.7 million in the 2017 Budget Act to $328.3 million in the Current Year forecast.

- For FY 2018-19, CDPH estimates ADAP rebate revenue will decrease by 7.8 percent from $329.7 million in the 2017 Budget Act to $304.0 million in the Budget Year forecast. The decrease is due to an anticipated loss in rebate.

b) Federal Funds – For FY 2017-18, total federal fund expenditure authority will not change from the existing $111.4 million established in the 2017 Budget Act; however, expenditure authority will change by grant due to a spending pattern shift in ADAP Earmark funds and due to ADAP receiving $15 million in additional funding for the 2017 Ryan White Part B Supplemental grant. ADAP Earmark funds are a subcomponent of the Ryan White Part B HIV Care grant and are available to be utilized from April 1 through March 31 of any given year, which is known as the grant budget period. Federal fund expenditure authority includes: the 2017 ADAP Earmark funds in the amount of $77.4 million, 2017 Ryan White Part B Supplemental grant in the amount of $25 million, and the 2017 ADAP Shortfall Relief grant in the amount of $9 million. Additionally, ADAP has, $3.9 million in carryover of unspent 2016 Ryan White Part B grant funding which will be utilized for ADAP in FY 2017-18.

   For FY 2018-19, total federal fund expenditure authority will increase by $21 million to $132.4 million compared to the 2017 Budget Act. Federal fund expenditure authority includes: 1) estimated 2018 ADAP Earmark funds in the amount of $96.4 million, 2) estimated 2018 Ryan White Part B Supplemental grant funding in the amount of $25 million, and estimated 2018 ADAP Shortfall Relief grant funding in the amount of $11 million (see Future Fiscal Issue #1 on page 19).

c) Match– The Health Resources and Services Administration (HRSA) requires grantees to have HIV-related non-HRSA expenditures. California's HRSA match requirement for the 2017 Federal RW Part B grant year (April 1, 2017 through March 31, 2018) is $68.1 million. CDPH will meet the match requirement using CDPH's OA General Fund Support expenditures and local assistance expenditures for OA's HIV Surveillance

and Prevention Programs, as well as HIV-related expenditures from the California Department of Corrections and Rehabilitation.

IV. Assumption Projections

Below, we summarize the projected impact for each of the major fiscal assumptions.

New Assumptions/Premises

1. Increase in Funding to ADAP Enrollment Sites

   Historically, CDPH allocated funding to local health jurisdictions (LHJs) based on the total ADAP caseload in each LHJ. LHJs across the state differed in how or if they allocated this funding to enrollment sites within the LHJ. At the request of stakeholders, effective July 1, 2016, CDPH began contracting directly with ADAP enrollment sites to allocate $4 million annually according to a reimbursement model based on services performed. CDPH worked with the ADAP Enrollment Worker Advisory Committee to develop a reimbursement methodology for each ADAP service based on the time and complexity involved in completing each task. For example, the initial reimbursement model included payment of $50 per new ADAP medication program enrollment and $100 per new enrollment into ADAP's Insurance Assistance Programs, because it takes more time and effort for an enrollment worker to enroll a client into insurance assistance.

   The 2017 Budget Act included a one-time legislative augmentation of an additional $4 million for enrollment sites, for a total of $8 million in FY 2017-18. In order to allocate the additional one-time funding included in the legislative augmentation, CDPH worked with a stakeholder group to refine the existing reimbursement model to include additional services that are currently being performed, such as assisting clients with submitting claims for medical out-of-pocket costs, which was not included in the original reimbursement model because there was not enough information available when the initial model was constructed to estimate the amount of enrollment worker time and effort involved. The initial model also did not account for new services that ADAP enrollment workers will soon be performing, such as assisting clients with enrollment into the Pre-Exposure Prophylaxis (PrEP) Assistance Program (see Unchanged Assumption #1 on page. 9); conducting proactive outreach to all ADAP clients who have eligibility end dates within 30 days; reaching out to clients who may be struggling with adherence to medication regimens (a service that will be piloted through our Access, Adherence, and Navigation Program in FY 2017-18); and a scaled-up effort of transitioning clients into private insurance.

   The tasks performed by ADAP enrollment workers have grown in both scope and complexity since the establishment of the initial reimbursement model. To this end, starting in FY 2018-19, CDPH proposes moving to a model in which the total amount of funds for ADAP services performed is adjusted annually through the Estimate

process based on caseload and estimated services to be performed each fiscal year. CDPH proposes to maintain the newly established reimbursement model in FY 2018-19 to incorporate new services integral to meeting objectives in California's *Laying a Foundation for Getting to Zero* plan, specifically, reducing new HIV infections, improving access to care and health outcomes, and reducing HIV-related health disparities. Transitioning clients to comprehensive health coverage results in better client health outcomes and is more cost effective for the state then maintaining medication-only clients. The new reimbursement model includes an enhanced reimbursement rate for enrolling clients into OA-HIPP to reflect the time and complexity involved in enrolling medication-only clients into private insurance.

In order to ensure that this on-going increase in funding to ADAP enrollment sites results in improved client outcomes and cost neutrality, CDPH plans to include performance measures in existing ADAP enrollment site contracts to ensure enrollment sites use the additional funding to transition an increased number of medication-only clients into private insurance and OA-HIPP to meet defined metrics, such as improvement in viral suppression rates at each enrollment site. For FY 2018-19, CDPH projects enrollment costs of $7.99 million, which will be offset by cost savings resulting from an additional 351 ADAP clients (approximately 2 clients per enrollment site) transitioning to private insurance. These 351 clients transitioning to private insurance result in a net savings of $4 million ($5.4 million in drug expenditure savings, $1.4 million in added premium payments, and $22,068 in added medical out-of-pocket costs).

Existing Assumptions/Premises

There are no Existing Assumptions/Premises.

Unchanged Assumptions/Premises

1. PrEP Assistance Program

In the 2016 Budget Act, as a result of a legislative augmentation, CDPH received statutory and budgetary authority for CDPH to provide services to HIV-negative persons at risk for acquiring HIV. In the 2017 Budget Act, statutory language was clarified to ensure that the program could serve eligible uninsured as well as insured individuals. The PrEP Assistance Program will provide assistance with: 1) costs for PrEP-related medical services for uninsured individuals who are enrolled in a drug manufacturer's PrEP medication assistance program; and 2) for insured individuals, (a) the cost of medication deductibles, co-pays, and co-insurance for the prevention of HIV infection after the individual's insurance is applied and, if eligible, after the drug manufacturer's medication assistance program's contributions are applied; and b) medical deductibles, co-pays, and co-insurance for PrEP-related medical services.

In order to ensure seamless program implementation and provide sufficient time for discovery, material development, and coordination with CDPH ADAP contractors and the drug manufacturer, CDPH is pursuing a phased implementation approach

that will prioritize the uninsured population in Phase 1 and will expand to cover insured individuals in Phase 2. Phase 1 is projected to be implemented in early2018, while Phase 2 will be implemented in Spring 2018. CDPH had communicated in the 2017 Budget Act that implementation would occur in January 2018; however, implementation has been pushed back slightly, so PrEP rollout occurs after the Covered California Open Enrollment Period (November 1, 2017 through January 31, 2018), a time of peak activity for ADAP's insurance premium payment programs. Additionally, due to significantly increased programmatic activity and in order to mitigate against possible service disruption, CDPH cannot implement and test necessary system modifications during the Open Enrollment Period. Pushing the PrEP rollout after the peak is intended to ensure sufficient resources are in place for PrEP's successful implementation while preventing service interruption for existing ADAP clients.

In order to extend services associated with PrEP for uninsured and insured clients, CDPH will incur one-time implementation costs in FY 2017-18 for system modifications to the IBM/MBM platform to accommodate the service enhancements. Modifications to the IBM/MBM platform to process PrEP clients will total $354,638.

In FY 2017-18, CDPH anticipates adding 333 clients to the PrEP Assistance Program (117 fewer clients than the 450 projected in the 2017 Budget Act), resulting in $162,000 in PrEP-related expenditures ($4,000 in medication costs and $158,000 in medical expenses). Of the 333 projected clients, CDPH projects that there will be a 60-40 split between uninsured and insured clients enrolling into the PrEP Assistance Program. See section (V)(e) for details on PrEP Assistance Program expenditure estimates.

The projected fiscal impact in FY 2018-19 is $2.1 million in PrEP-related expenditures ($120,000 in medication costs and $2.0 million in medical expenses), with 1,533 clients expected to receive PrEP services.

2. Payment of Out-of-Pocket Medical Expenses for All OA-HIPP Clients

CDPH currently pays private health insurance premiums and outpatient medical out of pocket costs for ADAP clients co-enrolled in OA-HIPP.

The 2016 Budget Act included funding authority to allow OA-HIPP to pay health insurance premiums and medical out-of-pocket costs for all ADAP clients with health insurance, including those with employer based insurance. Through the 2017 Budget Act, CDPH clarified that it would extend OA-HIPP services to include payment of Medicare Part B outpatient medical out-of-pocket costs or Medigap premiums to clients co-enrolled in the Medicare Part D Premium Payment Program.

In order to provide sufficient time for discovery, coordination with ADAP's contractors, seamless program implementation, and to account for peak programmatic activity during the Covered California Open Enrollment Period, CDPH

will start implementing processes for enrolling individuals with employer based insurance into OA-HIPP in early 2018.

For the same reasons, CDPH is slightly modifying the implementation date for expansion of benefits for clients co-enrolled in the Medicare Part D Premium Payment Program. CDPH expects to be able to pay for Medicare Part B outpatient medical out-of-pocket costs or Medigap premiums for this client population in the spring of 2018.

Also, in order to extend services associated with OA-HIPP benefits to individuals with employer based insurance and Medicare Part D, CDPH will incur one-time implementation costs in FY 2017-18 from its IBM/MBM for system modifications to accommodate the service enhancements. Modifications to the IBM/MBM platform to process clients with employer based insurance will total $198,706, while modifications needed to process clients with Medicare Part D is $81,325.

For FY 2017-18, CDPH projects 178 clients with employer-based insurance will enroll in OA-HIPP, resulting in $54,199 in expenditures ($51,540 toward insurance premiums and $2,659 toward medical out-of-pocket costs). CDPH projects 637 clients will enroll in FY 2018-19, resulting in $793,637 in expenditures ($744,328 toward insurance premiums and $49,309 toward medical out-of-pocket costs).

For FY 2017-18, CDPH projects 44 clients co-enrolled in the Medicare Part D Premium Assistance Program will receive benefits associated with Medicare Part B medical out-of-costs or Medigap premiums, resulting in $12,962 in expenditures. For FY 2018-19, ADAP projects 297 clients will receive benefits associated with Medicare Part B medical out-of-pocket costs or Medigap premiums, resulting in $483,187 in expenditures.

Discontinued Major Assumptions

There are no Discontinued Major Assumptions.

V. Expenditure Details

A. A detailed breakdown of caseload and expenditures by client group and service type is shown below in Tables 4 and 5.

TABLE 4: ESTIMATED ANNUAL CASELOAD AND EXPENDITURES BY CLIENT GROUP AND SERVICE TYPE, FY 2017-18

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE				
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	ADDITIONAL ADMIN COSTS	TOTAL EXPENDITURE
Medication-Only	12,472	41.7%	$310,988,705	$0	$0	$0	$310,988,705
Medi-Cal SOC	175	0.6%	$1,075,087	$0	$0	$0	$1,075,087
Private insurance*	8,963	30.0%	$17,557,568	$31,624,678	$1,631,606	$1,297,997	$52,111,849
Medicare Part D*	7,952	26.6%	20,133,630	$774,508	$12,962	$81,325	$21,002,426
SUBTOTAL	**29,562**	**98.9%**	**$349,754,991**	**$32,399,186**	**$1,644,568**	**$1,379,322**	**$385,178,067**
PrEP	333	1.1%	$3,535	$0	$158,374	$354,638	$516,547
HEALTH CARE	**29,896**	**100.0%**	**$349,758,526**	**$32,399,186**	**$1,802,942**	**$1,733,960**	**$385,694,614**
Enrollment Costs	0	0.0%	$0	$0	$0	$8,000,000	$8,000,000
TOTAL	**29,896**	**100.0%**	**$349,758,526**	**$32,399,186**	**$1,802,942**	**$9,733,960**	**$393,694,614**

*** Subgroup of 6,808 clients receiving assistance for premium payments and medical-out-of-pocket costs.**

+ Medical out-of-pocket costs for Medicare Part D clients include Medigap premiums and Medicare Part B medical out-of-pocket expenses.

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

TABLE 5: ESTIMATED ANNUAL CASELOAD AND EXPENDITURES BY CLIENT GROUP AND SERVICE TYPE, FY 2018-19

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE				
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	ADDITIONAL ADMIN COSTS	TOTAL EXPENDITURE
Medication-Only	12,273	37.8%	$321,906,295	$0	$0	$0	$321,906,295
Medi-Cal SOC	175	0.5%	$1,075,087	$0	$0	$0	$1,075,087
Private insurance*	10,436	32.2%	$23,409,220	$44,620,030	$2,955,920	$0	$70,985,170
Medicare Part D*	8,021	24.7%	22,074,022	$964,860	$483,187	$0	$23,522,070
SUBTOTAL	**30,905**	**95.3%**	**$368,464,625**	**$45,584,890**	**$3,439,107**	**$0**	**$417,488,622**
PrEP	1,533	4.7%	$120,190	$0	$2,022,525	$0	$2,142,715
HEALTH CARE	**32,438**	**100.0%**	**$368,584,815**	**$45,584,890**	**$5,461,632**	**$0**	**$419,631,337**
Enrollment Costs	0	0.0%	$0	$0	$0	$7,985,800	$7,985,800
TOTAL	**32,438**	**100.0%**	**$368,584,815**	**$45,584,890**	**$5,461,632**	**$7,985,800**	**$427,617,137**

*** Subgroup of 8,373 clients receiving assistance for premium payments and medical-out-of-pocket costs.**

+ Medical out-of-pocket costs for Medicare Part D clients include Medigap premiums and Medicare Part B medical out-of-pocket expenses.

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

a. Medication-only clients

This client group includes individuals who do not have private insurance and are not enrolled in Medi-Cal or Medicare Part D. ADAP covers the full cost of prescription medications for these individuals for medications on the ADAP formulary. This group only receives services associated with medication costs.

1. Medication Expenditures

- For FY 2017-18, CDPH estimates medication expenditures for medication-only clients will be $311 million which is a $2.1 million increase compared to the 2017 Budget Act. The increase in expenditures is due to an increase in medication-only clients, as most eligible clients have transitioned to Medi-Cal Expansion, and the program enrollment is increasing at rates similar to pre-ACA implementation because the number of Californians living with HIV continues to rise each year due to new infections.
- For FY 2018-19, CDPH estimates medication expenditures for medication-only clients will be $321.9 million, which is a $10.9 million increase from the revised projection for FY 2017-18. This increase is due to the same reasons as above with an offset for medication-only clients transitioning to comprehensive health care coverage because of the Access, Adherence, and Navigation Program[2].

2. Health Insurance Premiums: There are no health insurance premium expenditures for medication-only clients.
3. Medical Out-Of-Pocket Costs: There are no medical out-of-pocket cost expenditures for medication-only clients.

b. Medi-Cal SOC clients

This client group includes individuals enrolled in Medi-Cal who have a SOC for Medi-Cal services. This group receives services associated with medication costs.

1. Medication Expenditures

   - For FY 2017-18, CDPH estimates medication expenditures for Medi-Cal SOC clients will be $1.1 million, which is a $101,000 increase compared to the 2017 Budget Act. The increase in expenditures is due to higher SOC amounts associated with Medi-Cal clients enrolled in ADAP.
   - For FY 2018-19, CDPH estimates medication expenditures for Medi-Cal SOC clients will also be $1.1 million. There is no change in FY 2018-19 from the revised projection for FY 2017-18 expenditures due to the stability in costs and clients associated with this client group.

2. Health Insurance Premiums: There are no health insurance premium expenditures for Medi-Cal SOC clients.
3. Medical Out-Of-Pocket Costs: There are no medical out-of-pocket cost expenditures for Medi-Cal SOC clients.

c. Private insurance clients

This client group includes individuals who have some form of health insurance, including insurance purchased through Covered California, privately purchased health insurance, or employer-based health insurance; therefore, this group is

[2] Formerly referred to as ADAP case management in the 2017 Budget Act.

sub-divided into three client sub-groups: Covered California clients, non-Covered California clients, and employer-based insurance clients. These groups receive services associated with medication costs, health insurance premiums, and medical out-of-pocket costs. Currently, employer-based insurance clients only receive medication services, but they will be offered health insurance premium and medical out-of-pocket cost services starting in early 2018.

1. Medication Expenditures

    - For FY 2017-18, CDPH estimates medication expenditures for all private insurance clients will be $17.6 million, which is a $198,000 increase compared to the 2017 Budget Act. The increase in expenditures is due to higher than anticipated deductibles, co-pays, and co-insurance associated with private insurance clients and an increase in clients due to the transition of medication-only clients to private insurance due to the Access, Adherence, and Navigation Program[3].
    - For FY 2018-19, CDPH estimates medication expenditures for all private insurance clients will be $23.4 million, which is a $5.8 million increase compared to the revised projection for FY 2017-18. This increase is due to the same reasons as above.

2. Health Insurance Premiums
    - For FY 2017-18, CDPH estimates health insurance premium payment expenditures for all private insurance clients will be $31.6 million, which is a $5.2 million decrease compared to the 2017 Budget Act. Although there will be an increase in clients due to the Access, Adherence, and Navigation Program, more private insurance clients are choosing Covered California plans, which have lower premiums than non-Covered California plans.
    - For FY 2018-19, CDPH estimates health insurance premium payment expenditures will be $44.6 million, which is a $13.0 million increase compared to the revised projection for FY 2017-18. This increase is due to the same client transition as above.
3. Medical Out-Of-Pocket Costs
    - For FY 2017-18, CDPH estimates medical out-of-pocket costs for all private insurance clients will be $1.6 million, which is a $96,000 decrease from the 2017 Budget Act. Fewer clients than previously anticipated are utilizing this benefit.
    - For FY 2018-19, CDPH estimates medical out-of-pocket costs will be $3.0 million, which is a $1.3 million increase from the revised projection for FY 2017-18. Fewer clients than previously anticipated are expected to use this benefit in FY 2017-18; however, CDPH estimates that use of this benefit will continue to increase over time as more clients choose to participate and with the increase in clients due to the Access, Adherence, and Navigation Program[4].

[3] Formerly referred to as ADAP case management in the 2017 Budget Act.
[4] Formerly referred to as ADAP case management in the 2017 Budget Act.

d. Medicare Part D clients

This client group includes individuals who are enrolled in Medicare and have purchased Medicare Part D plans for medication coverage. This group receives services associated with medication costs and Medicare Part D health insurance premiums. As part of this proposal, starting Spring 2018, OA Medicare Part D Premium Payment Program clients will also be eligible for coverage of Medigap supplemental insurance premiums (which cover medical out-of-pocket costs for Medicare Part B) the Medicare Part B outpatient medical out-of-pocket costs.

1. Medication Expenditures
   - For FY 2017-18, CDPH estimates medication expenditures for Medicare Part D clients will be $20.1 million, which is $121,000 increase from the 2017 Budget Act. The small increase in expenditures is due to higher than anticipated deductibles, co-pays, and co-insurance offset by fewer than anticipated clients with Medicare Part D plans.
   - For FY 2018-19, CDPH estimates medication expenditures for Medicare Part D clients will be $22.1 million, which is a $1.9 million increase from the revised projection for FY 2017-18. This increase is due to the same reason above for medication expenditures only.
2. Health Insurance Premiums
   - For FY 2017-18, CDPH estimates Medicare Part D premium payment expenditures will be $775,000, which is a $4,000 decrease from the 2017 Budget Act. This slight change is due to an increase in monthly premium payments offset by a decrease in Medicare Part D clients.
   - For FY 2018-19, CDPH estimates Medicare Part D premium payment expenditures will be $965,000, which is a $190,000 increase from the revised projection for FY 2017-18. This increase is due to both an increase in monthly premiums and clients enrolled with Medicare Part D.
3. Medical Out-Of-Pocket Costs
   - For FY 2017-18, CDPH estimates medical out-of-pocket costs will be $13,000, which is a $257,000 decrease from the 2017 Budget Act. This decrease is due to the date change in implementation of paying Medicare Part B medical out-of-pocket costs, including premiums for Medigap policies, for this client group.
   - For FY 2018-19, CDPH estimates medical out-of-pocket costs will be $483,000, which is a $470,000 increase from the revised projection for FY 2017-18. This increase is mainly due to full year expenditures for this type of service and an expected increase in clients.

e. PrEP clients

This client group includes HIV-negative persons at risk for acquiring HIV who are taking PrEP. For insured clients, the PrEP Assistance Program will cover the gap between what the client's health insurance plan and the manufacturer's medication co-payment assistance program will pay towards medication costs, along with any PrEP-related medical out-of-pocket costs. Clients without health insurance will receive benefits related only to PrEP-related medical costs, as they

will receive free drug from the manufacturer's free drug program. CDPH expects to implement this PrEP Assistance Program in early 2018. (Unchanged Assumption #1).

1. Medication Expenditures:
   - For FY 2017-18, CDPH estimates medication expenditures for PrEP will be $4,000, which is an $83,000 decrease compared to the 2017 Budget Act. This decrease is due to the delay in implementation and the phased implementation approach of the PrEP program.
   - For FY 2018-19, CDPH estimates medication expenditures will be $120,000, which is an $116,000 increase from the revised projection for FY 2017-18. This increase is due to full year implementation for this type of service.
2. Health Insurance Premiums: Health insurance premium coverage is not currently included in the PrEP Assistance Program.
3. Medical Out-Of-Pocket Costs
   - For FY 2017-18, CDPH estimates medical out-of-pocket costs will be $158,000 for PrEP clients, which is a $65,000 decrease compared to the 2017 Budget Act. This decrease is due to the same reason stated above.
   - For FY 2018-19, CDPH estimates medical out-of-pocket costs will be $2.0 million for PrEP clients, which is a $1.9 million increase from the revised projection for FY 2017-18. This increase is due to full year implementation for this type of service.

B. Reimbursement Methodology for ADAP enrollment services

a. For FY 2017-18, the reimbursement methodology includes payment of a floor amount to all ADAP enrollment sites with at least one ADAP enrollment during the fiscal year and the ADAP enrollment services listed below. Payment is made for each ADAP enrollment service performed with total payment dependent on total volume.
   1. New Medication Enrollment
      - CDPH estimates 4,000 clients will enroll into ADAP at some point throughout the fiscal year. The number of clients projected to enroll is larger than the ADAP caseload projection used when projecting expenditures. This is because expenditure projections take into consideration the number of clients served, where some clients may enroll and never receive ADAP services.
   2. Bi-annual Self-Verification
      - CDPH estimates 36,000 clients will recertify into ADAP at some point throughout the fiscal year. The number of clients projected to recertify is larger than the ADAP caseload projection for the same reason provided above.
   3. ADAP Annual Re-Enrollment
      - CDPH estimates 36,000 clients will re-enroll into ADAP at some point throughout the fiscal year. The number of clients projected to recertify is

larger than the ADAP caseload projection for the same reason provided above.

4. New Insurance Assistance Enrollment
   - CDPH estimates 2,400 clients will newly enroll into one of the two CDPH insurance assistance programs. This number is tied directly to expenditure /caseload projections.
5. Insurance Assistance Annual Re-Enrollment
   - CDPH estimates 5,500 existing clients enrolled in CDPH's insurance assistance programs will re-enroll during the fiscal year. This number is tied directly to expenditure/caseload projections.
6. New PrEP Enrollment
   - CDPH estimates 333 existing clients enroll into the PrEP Assistance Program during the fiscal year. This number is tied directly to caseload projections described in Unchanged Assumption #1 on page 9.
7. PrEP Re-Enrollment
   - CDPH estimates that 0 clients will re-enroll into the PrEP Assistance Program during the fiscal year due to implementation beginning in early 2018.
8. Paid PrEP Related Medical Out-of-Pocket Claims
   - CDPH estimates that 25,301 PrEP-related medical out-of-pocket claims will be submitted and paid in the fiscal year.
9. Paid Insurance Assistance Medical Out-of-Pocket Claims
   - CDPH estimates that 2,437 outpatient medical out-of-pocket claims for clients enrolled in CDPH's insurance assistance programs will be submitted and paid in the fiscal year.

b. For FY 2018-19, the reimbursement methodology mirrors that FY 2017-18 methodology with the exception of the removal of payment for services related to medical out-of-pocket costs (items 8 and 9 above).

1. New Medication Enrollment
   - CDPH estimates 4,000 clients will enroll into ADAP at some point throughout the fiscal year. The number of clients projected to enroll is larger than the ADAP caseload projection used when projecting expenditures. This is because expenditure projections take into consideration the number of clients served, where some clients may enroll and never receive ADAP services.
2. Bi-annual Self-Verification
   - CDPH estimates 36,000 clients will recertify into ADAP at some point throughout the fiscal year. The number of clients projected to recertify is larger than the ADAP caseload projection for the same reason provided above.
3. ADAP Annual Re-Enrollment
   - CDPH estimates 36,000 clients will recertify into ADAP at some point throughout the fiscal year. The number of clients projected to recertify is larger than the ADAP caseload projection for the same reason provided above.

4. New Insurance Assistance Enrollment
    - CDPH estimates 2,400 clients will newly enroll into one of the two CDPH insurance assistance programs. This number is tied directly to expenditure /caseload projections.
5. Insurance Assistance Annual Re-Enrollment
    - CDPH estimates 7,900 existing clients enrolled in CDPH's insurance assistance programs will re-enroll during the fiscal year. This number is tied directly to expenditure/caseload projections.
6. New PrEP Enrollment
    - CDPH estimates 1,533 existing clients enroll into the PrEP Assistance Program during the fiscal year. This number is tied directly to caseload projections described in Unchanged Assumption #1 on page 9.
7. PrEP Re-Enrollment
    - CDPH estimates that 1,400 clients will re-enroll into the PrEP Assistance Program during the fiscal year due to implementation beginning in early 2018.
8. Paid PrEP Related Medical Out-of-Pocket Claims
    - CDPH will no longer be reimbursing enrollment workers for this service in FY 2018-19. OA's Medical Benefits Manager will have a contract in place with a medical claims clearinghouse to streamline the medical out-of-pocket benefit process. As such, this work will no longer be performed by ADAP enrollment workers.
9. Paid Insurance Assistance Medical Out-of-Pocket Claims
    - CDPH will no longer be reimbursing enrollment workers for this service in FY 2018-19. OA's Medical Benefits Manager will have a contract in place with a medical claims clearinghouse to streamline the medical out-of-pocket benefit process. As such, this work will no longer be performed by ADAP enrollment workers.

VI. Future Fiscal Issues

1. Potential Increase in Federal Funds: 2018 ADAP Emergency Relief Funds

   In September 2017, HRSA released the funding opportunity announcement for the 2018 ADAP Emergency Relief Funds supplemental grant. HRSA anticipates that approximately $65.0 million will be available nationwide in 2018 Emergency Relief Funds, with each state eligible to apply for up to $11.0 million. CDPH anticipates HRSA will award funds in March 2018. If awarded, CDPH will use these funds for medication in FY 2018-19.

   The table below shows historically how much CDPH applied for the ADAP Emergency Relief Funds supplemental grant and how much was received:

Table 6: ADAP Emergency Relief Funds (ERF)

Grant Budget Period	Funds Applied For	Funds Received
2011 (8/01/2011 - 7/31/2012)	$3,000,000	$2,574,357
2012 (8/01/2012 - 9/29/2013)	$10,246,371	$10,141,268
2013 (9/30/2013 - 3/31/2014)	$10,761,268	$10,761,268
2014 (4/01/2014 - 3/31/2015)	$11,000,000	$11,000,000
2015 (4/01/2015 - 3/31/2016)	$11,000,000	$6,441,447
2016 (4/01/2016 - 3/31/2017)	$11,000,000	$10,991,645
2017 (4/01/2017 – 3/31/2018)	$9,000,000	$9,000,000

2. New HIV Drugs

   The following HIV drugs may receive U.S. Food and Drug Administration (FDA) approval in the next year:

- Bictegravir/emtricitabine/tenofovir alafenamide
  This new HIV drug combines an integrase inhibitor (bictegravir) with two nucleoside reverse transcriptase inhibitors (emtricitabine and tenofovir alafenamide). On June 12, 2017, the manufacturer, Gilead Sciences Inc., announced that a New Drug Application (NDA) was submitted to the FDA for bictegravir (BIC)/emtricitabine/tenofovir alafenamide 50/200/25 mg as a once-daily, single-tablet regimen for the treatment of HIV-1 infected adults. The FDA has set a target action date of February 12, 2018 for bictegravir/emtricitabine/tenofovir alafenamide.

- Ibalizumab

  This new HIV drug, an HIV-1 entry inhibitor, is a humanized monoclonal antibody being developed for the treatment of multi-drug resistant HIV-1 infection. Ibalizumab would be used in combination with an optimized background regimen of other antiretrovirals. Ibalizumab needs to be given intravenously once every 2 weeks and will be the first antiretroviral that does not require daily dosing. The FDA has extended the target action date for ibalizumab to April 3, 2018.

- Darunavir/cobicistat/emtricitabine/tenofovir/alafenamide

  This new combination HIV drug combines a protease inhibitor (darunavir) with a pharmacokinetic enhancer (cobicistat), and two nucleoside reverse transcript inhibitors (emtricitabine and tenofovir alafenamide), as a single tablet regimen for HIV treatment. On September 25, 2017, Janssen Pharmaceutical, announced that an NDA was submitted for this new combination drug to the FDA. Based on the NDA date, CDPH expects darunavir/cobicistat/emtricitabine/tenofovir/alafenamide, 800/150/200/10 to receive FDA approval during the second quarter of calendar year 2018.

- If bictegravir/emtricitabine/tenofovir alafenamide, Ibalizumab, and/or darunavir/cobicistat/emtricitabine/tenofovir/alafenamide receive FDA approval and the ADAP Medical Advisory Committee recommends their addition to the ADAP formulary, CDPH will monitor pricing and supplemental rebates. If CDPH is able to determine that the drugs will be cost neutral, CDPH will move forward with adding these drugs to the ADAP formulary.

VII. Fund Condition Statement

Table 7: Fund Condition Statement[1]
(in thousands)

	Special Fund 3080: AIDS Drug Assistance Program Rebate Fund		FY 2016-17 Actuals	FY 2017-18 Estimate	FY 2018-19 Estimate
1	BEGINNING BALANCE		221,109	260,803	295,223
2	Prior Year Adjustment		162	0	0
3	Adjusted Beginning Balance		221,271	260,803	295,223
4	REVENUES, TRANSFERS AND OTHER ADJUSTMENTS				
5	Revenues				
6	4163000 Income From Surplus Money Investments (Interest)		1,729	1,750	1,750
7	4171400 Escheat - Unclaimed Checks, Warrants, Bonds, and Coupons		16	0	0
8	4172500 Miscellaneous Revenue		249,767	326,576	302,259
9	Total Revenues, Transfers, and Other Adjustments		251,512	328,326	304,009
10	Total Resources		472,783	589,129	599,232
11	EXPENDITURES AND EXPENDITURE ADJUSTMENTS				
12	Expenditures				
13	8880	FI$Cal	1	2	0
14	4265	Department of Public Health			
15		State Operations	6,849	7,127	5,683
16		Medication Local Assistance	186,399	250,761	250,921
17		Insurance Local Assistance	18,691	35,936	51,047
18	9892	Supplemental Pension Payment	0	0	61
19	9900	Statewide General Administrative Expenditures	40	80	152
20	Total Expenditures and Expenditure Adjustments		211,980	293,906	307,864
21	**FUND BALANCE**		**260,803**	**295,223**	**291,368**

Row 6: Interest Actuals for FY 2016-17, Estimated for FYs 2017-18 and 2018-19	1,728,992	1,750,000	1,750,000
Miscellaneous Revenue			
Estimated Rebates received July - Sept 2017 for Actual Expenditures from Jan - March 2017		84,938,725	
Estimated Rebates received Oct - Dec 2017 for Actual Expenditures from Apr - June 2017		85,053,523	
Estimated Rebates received Jan - June 2018 for Estimated Expenditures from July - Dec 2017		156,584,251	
Estimated Rebates to be received Jul - Dec 2018 for Estimated Expenditures from Jan - Jun 2018			146,249,953
Estimated Rebate to be received Jan - Jun 2019 for Estimated Expenditures from July - Dec 2018			156,008,898
Total Estimated FY 2017-18 Rebate Revenue		326,576,498	
Total Estimated FY 2018-19 Rebate Revenue			302,258,851

[1] Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

VIII. Historical Program Data and Trends

For all figures in this section, the data prior to FY 2017-18 is the observed historical data. Estimates for FY 2017-18 and 2018-19 are based on the overall projections and include all assumptions.

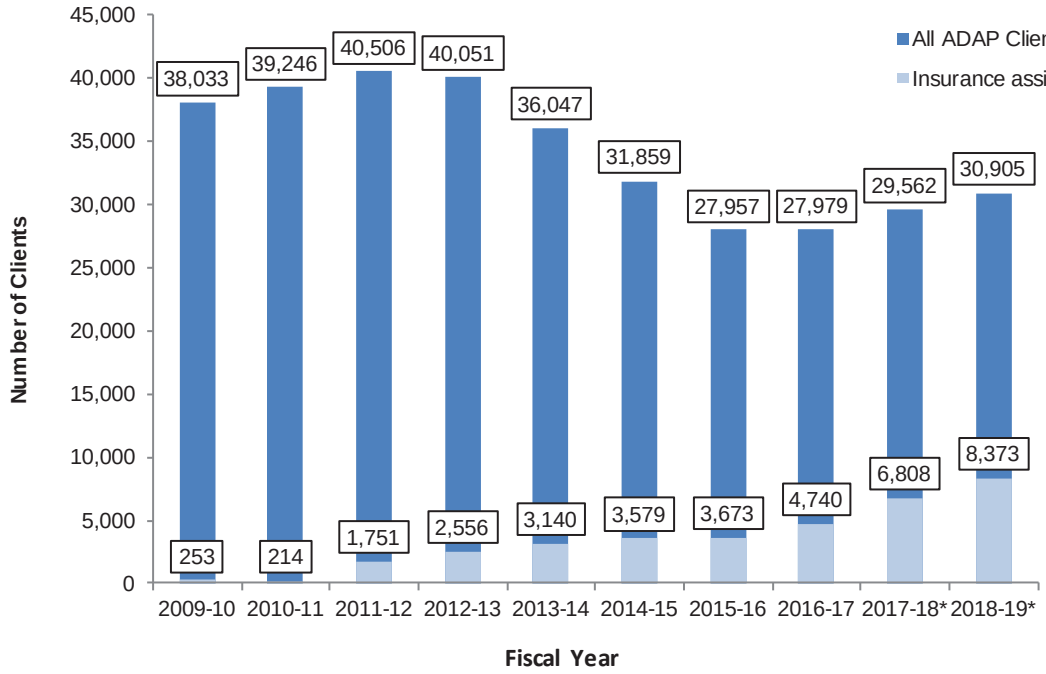
Figure 1 is a summary of total client counts in ADAP by FY, excluding PrEP clients. The number of ADAP medication program clients who are also receiving insurance assistance is also shown.

Figure 2 shows the proportion of ADAP medication program clients enrolled in the various payer groups by FY.

Figure 3 is a summary of estimated client counts in the PrEP Assistance Program by FY.

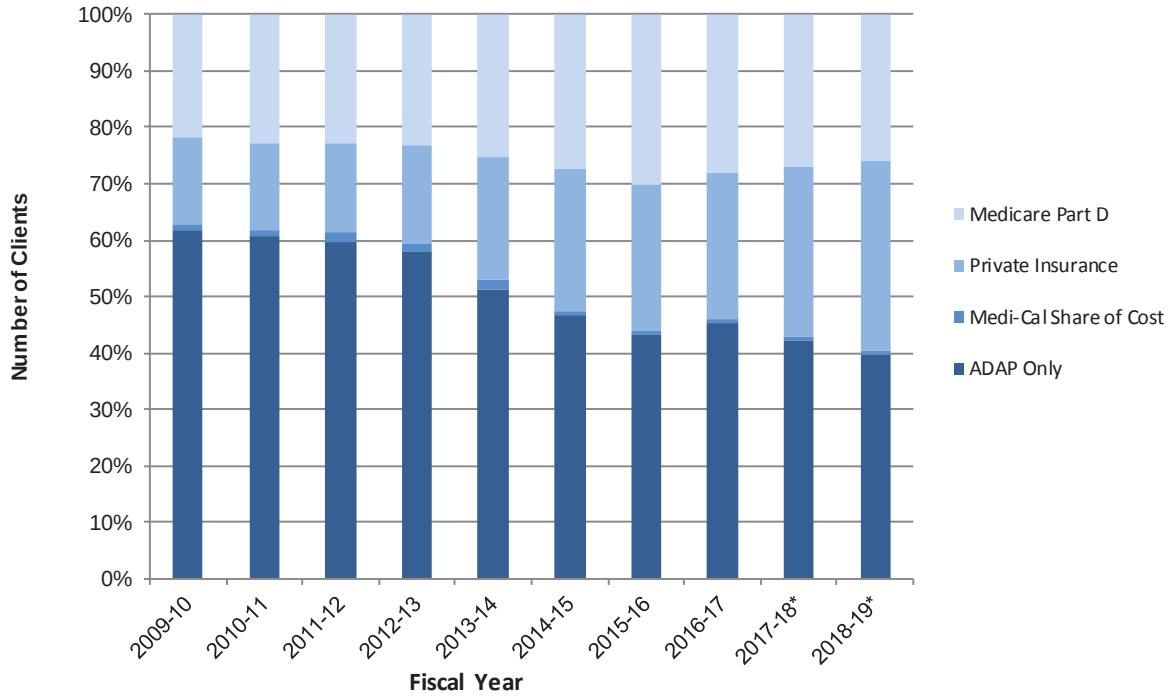
Figure 4 is the number of medications on the ADAP formulary by FY; the number of anti-retroviral medications is also shown.

FIGURE 1: ADAP CLIENT COUNT TREND



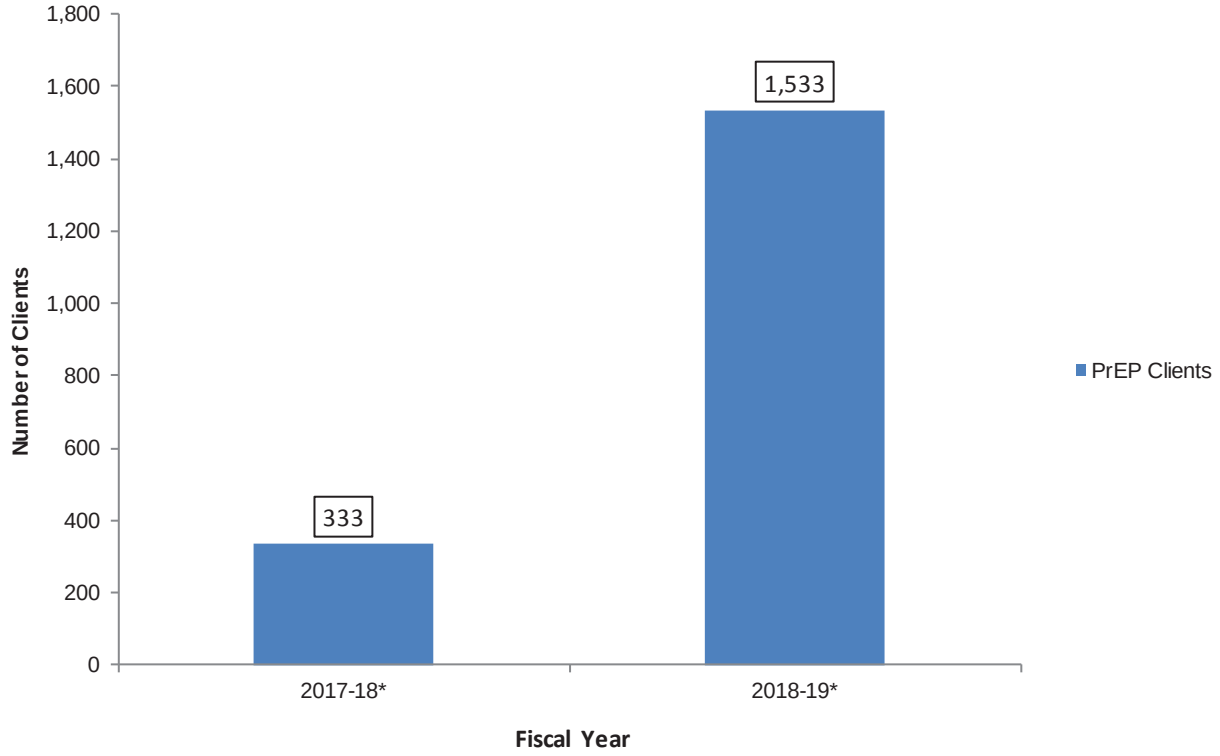
* Data for FYs 2017-18 and 2018-19 are estimated. All other data are actuals.

FIGURE 2: PERCENT OF ADAP MEDICATION PROGRAM CLIENTS BY PAYER SOURCE

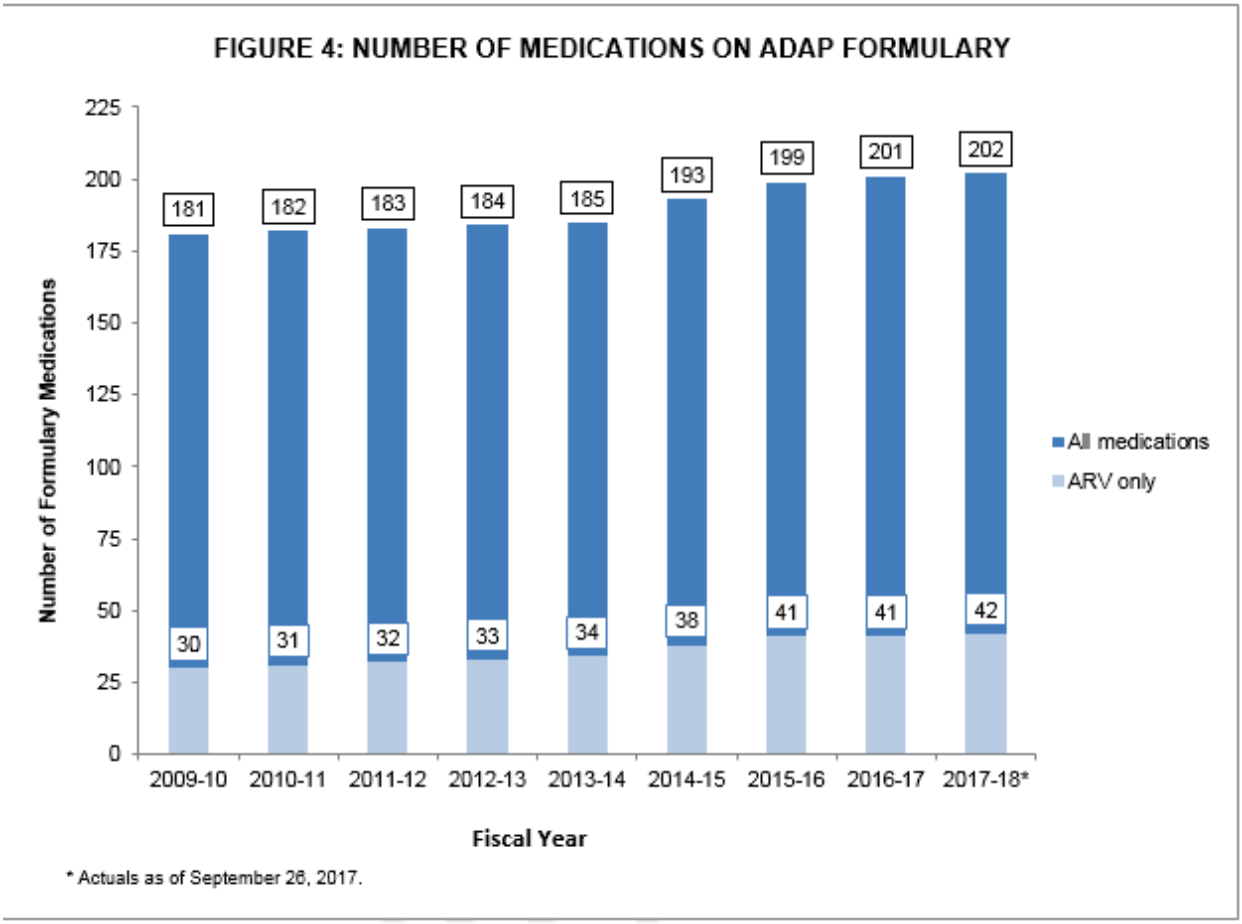


* Data for FYs 2017-18 and 2018-19 are estimated. All other data are actuals.

FIGURE 3: ADAP PREP CLIENT TREND



* Data for FYs 2017-18 and 2018-19 are estimated, and represent 1.1% and 4.7% of total caseload, respectively.



- On December 21, 2017, ADAP added the two drug combination ARV dolutegravir/rilpirivine to the ADAP Formulary

IX. Current HIV Epidemiology in California

Approximately 128,000 PLWH in California at the end of 2015 had been diagnosed and reported to OA. However, OA estimates that 9.1 percent of all PLWH in California are unaware of their infection (as of the end of 2014, the latest data available). Therefore, OA estimates that there were approximately 137,000 PLWH in California as of the end of 2015. Since the epidemic began in 1981, approximately 100,000 Californians diagnosed with HIV have died, with over 1,600 dying in 2015 alone.

Of PLWH in California, approximately 41.1 percent are White; 34.6 percent are Hispanic/Latino; 17.6 percent are Black/African American; 3.9 percent are Asian; 2.2 percent are multi-racial; 0.3 percent are American Indian/Alaskan Native; and 0.2 percent are Native Hawaiian/Pacific Islander. While Whites and Hispanics/Latinos make up the largest percentage of PLWH in California, the rate of HIV among Blacks/African Americans is substantially higher (1,010 per 100,000 population, versus 353 per 100,000 among Whites, and 293 per 100,000 among Hispanics/Latinos).

Most of California's living HIV cases are attributed to male-to-male sexual transmission (66.6 percent); 8.9 percent of living cases are attributable to high-risk heterosexual contact (defined as contact with a sex partner or partners of the opposite gender who are either known to be HIV infected or known to be someone who injects drugs, has hemophilia, or is a man who has sex with other men); 7.1 percent to men who have sex with men who also inject drugs; 6.3 percent to injection drug use; 0.6 percent to perinatal exposure; and 10.5 percent to other or unknown sources, including other heterosexual contact.

There are approximately 5,000 new HIV cases reported in California each year. The number of PLWH in the state is expected to grow by approximately 3.0 percent each year for the next two years, and it is expected that this trend will continue for the foreseeable future until more progress is made in preventing new HIV infections. This increase is attributed to stable incidence rates and longer survival of those infected, primarily due to the effectiveness and availability of treatment.

Fiscal Year (FY) 2018-19 Governor's Budget
Office of AIDS (OA), California Department of Public Health (CDPH)

Summary

The OA is pleased to announce that the Governor's Budget proposal continues to support California's *Laying a Foundation for Getting to Zero* Plan (https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/IP_2016_Final.pdf). Under this budget proposal, the two Office of AIDS (OA) programs that continue to receive state General Fund for local assistance are the HIV Surveillance and Prevention programs. Both the $6.7 million in General Fund local assistance for the Surveillance program and the $7.5 million in General Fund local assistance for the Prevention remain unchanged from the 2017 Budget Act. The budget includes two new changes related to the AIDS Drug Assistance Program (ADAP):

- The ADAP Eligibility and Enrollment Budget Change Proposal requests $250,000 in ADAP Rebate Fund expenditure authority to support two administratively established positions for FY 2017-18 and $2.7 million in FY 2018-19 and ongoing for 15 permanent positions to manage the increased workload involved in transitioning ADAP eligibility and enrollment services to CDPH/OA.
- The ADAP Estimate proposes an increase in funding to ADAP Enrollment Sites (details below).

ADAP Detail

Funding

ADAP is currently funded through federal funds and the ADAP Special Fund (pharmaceutical manufacturer rebates).

FY 2017-18 (current year, through June 30, 2018):

The 2017 Budget Act included ADAP local assistance funding of $395.7 million, with no state General Fund appropriation. The revised current year 2017-18 budget is $398.1 million, an increase of $2.4 million (0.6 percent) when compared to the 2017 Budget Act. The increase is mainly due to a one-time need for system enhancements to CDPH's Insurance Benefits Manager and Medical Benefits Manager platform. Changes to ADAP's budget authority when compared to the 2017 Budget Act include:

- No increase in Federal Funds.
- Increase of $2.4 million in ADAP Rebate Funds.

The revised current year budget does not contain a General Fund appropriation or any cuts to services. ADAP requests an increase of $2.4 million in ADAP Rebate Fund expenditure authority when compared to the 2017 Budget Act.

FY 2018-19 (budget year, starting July 1, 2018):

Proposed ADAP local assistance funding for the budget year is $434.4 million, an increase of $38.7 million (9.8 percent) when compared to the 2017 Budget Act, and an increase of $36.3 million when compared to the revised current year 2017-18 estimate. The increase is mainly due to an increase in overall caseload and in medication expenditures per client per month. Changes to ADAP's budget authority when compared to the 2017 Budget Act include:

- Increase of $21 million in Federal Funds.
- Increase of $17.7 million in ADAP Rebate Funds.

The summary of these ADAP funding sources can be seen in Table 1 on page 4 of the ADAP Estimate.

ADAP Utilization

Approximately 27,979 individuals received ADAP services in FY 2016-17. It is estimated that 29,562 individuals will receive services in FY 2017-18 and 30,905 individuals will receive services in FY 2018-19 (see Figure 1, ADAP Client Count Trend on page 22, ADAP Estimate).

Policy Changes

There is one new ADAP policy change included in the 2018-19 Governor's Budget:

Increase in Funding to ADAP Enrollment Sites

Effective July 1, 2016, CDPH began contracting directly with ADAP enrollment sites to allocate $4 million annually according to a reimbursement model based on services performed. The 2017 Budget Act included a one-time legislative augmentation of an additional $4 million for enrollment sites, for a total of $8 million in FY 2017-18. Tasks performed by ADAP enrollment workers have grown in both scope and complexity. Starting in FY 2018-19, CDPH proposes moving to a model in which the total amount of funds for ADAP enrollment services performed is adjusted annually through the Estimate process based on caseload and estimated services to be performed each FY. For FY 2018-19, CDPH projects enrollment costs of $7.99 million. In order to ensure that this on-going increase in funding to ADAP enrollment sites results in improved client outcomes and cost neutrality, CDPH plans to include performance measures in existing ADAP enrollment site contracts to ensure enrollment sites use the additional

funding to transition an increased number of medication-only clients into private insurance and OA-HIPP and meet defined metrics, such as improvement in viral suppression rates at each enrollment site. The additional enrollment costs will be offset by cost savings resulting from an additional 351 ADAP clients (approximately 2 clients per enrollment site) transitioning to private insurance. CDPH proposes to maintain the newly established reimbursement model in FY 2018-19 to incorporate new services integral to meeting objectives in California's *Laying a Foundation for Getting to Zero* plan, with the exception of payment for medical out-of-pocket cost claim submissions, as it is anticipated this workload will drastically decrease or be eliminated with the onboarding of a medical claims clearinghouse.

There are also two unchanged ADAP policies included in the 2018-19 Governor's Budget:

PrEP Assistance Program CDPH is pursuing a phased implementation approach that will prioritize the uninsured population in Phase 1 and will expand to cover insured individuals in Phase 2. Phase 1 is projected to be implemented in early 2018, while Phase 2 will be implemented in Spring 2018. CDPH will incur one-time implementation costs of $354,638 in FY 2017-18 for system modifications to accommodate the service enhancements.

In FY 2017-18, CDPH anticipates adding 333 clients to the PrEP Assistance Program resulting in $162,000 in PrEP-related expenditures. Of the 333 projected clients, CDPH projects that there will be a 60-40 split between uninsured and insured clients.

In FY 2018-19, CDPH anticipates serving 1,533 PrEP Assistance Program clients resulting in $2.1 million in PrEP-related expenditures.

Payment of Out-of-Pocket Medical Expenses for All OA-Health Insurance Premium Payment (OA-HIPP) Program Clients

CDPH will start implementing processes for enrolling individuals with employer based insurance into OA-HIPP in early 2018.

CDPH expects to start implementing the payment of Medicare Part B outpatient medical out-of-pocket costs or Medigap premiums for Medicare Part D Premium Payment Program clients in the spring of 2018.

CDPH will incur one-time implementation costs in FY 2017-18 for system modifications to accommodate the service enhancements. Modifications to process clients with employer based insurance is projected to cost $198,706 and modifications to process clients with Medicare Part D is projected to cost $81,325.

For FY 2017-18, CDPH projects 178 clients with employer-based insurance will enroll in OA-HIPP, resulting in $54,199 in expenditures. CDPH projects 637 clients will enroll in FY 2018-19, resulting in $793,637 in expenditures.

For FY 2017-18, CDPH projects 44 clients co-enrolled in the Medicare Part D Premium Assistance Program will receive benefits associated with Medicare Part B medical out-of-costs or Medigap premiums, resulting in $12,962 in expenditures. For FY 2018-19, ADAP projects 297 clients will receive benefits associated with Medicare Part B medical out-of-pocket costs or Medigap premiums, resulting in $483,187 in expenditures.

11. STANDING COMMITTEE REPORT:

A. Public Policy Committee

(1) Approve the 2018 Policy Priorities and Agenda as presented - **MOTION #3**

LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
http://hiv.lacounty.gov

The Public Policy (PP) Committee acts in accordance with the role of the Commission on HIV, as dictated by Los Angeles County Code 3.29.090. Consistent with Commission Bylaws Article VI, Section 2, no Ryan White resources are used to support PP Committee activities.

2018 POLICY PRIORITIES

APPROVED by PPC Committee 1/8/18

POLICY PRIORITIES

The Public Policy Committee recommends the following policy priorities for the Commission on HIV to focus on in 2018 (*in no particular order*):

- Preserve access to and continuity of care for PLWHA and communities at highest risk for the acquisition and transmission of HIV disease.
    - Preserve federal funding for Medicaid, Medicare, and for HIV/AIDS programs
    - Preserve health insurance coverage for individuals with pre-existing conditions, including HIV and STD programs.

- Protect HIV service access and availability in California's annual budgeting process.

- Maintain and preserve the Ryan White Program (RWP) at current or increased funding levels and, where appropriate and strategically viable, support stronger compatibility and greater effectiveness between the RWP, Medicaid, Medicare, and other health systems.

- Advance and enhance routine HIV testing, expanded linkage to care, and other improvements to the local, state, and national HIV service delivery systems that optimize health outcomes in the HIV Continuum and advance HIV services in LA County consistent with the National HIV AIDS Strategy goals, LA County HIV/AIDS Strategy, and LA County Comprehensive HIV Plan.

- Support policies that use data, without risking personal privacy and health, to improve health outcomes and eliminate health disparities among PLWHA and communities highly impacted by HIV/STDs

- Enhance Federal accountability for deliverables from a heightened and coordinated federal response, particularly in the context of local planning and responsiveness to the NHAS.

- Support proposals and increased funding for the provision of and access to: prevention, care and treatment services; and bio-medical interventions (such as PreP and PEP) for people at risk for acquiring HIV and people living with HIV/AIDS; and comprehensive HIV/STD counseling, testing, education, outreach, research and social marketing programs.

- Support proposals that seek to reduce stigma and address social determinants of health such as poverty, education, violence, substance abuse, and transportation in order to improve health outcomes for people living with HIV/AIDS and special populations at highest risk for contracting HIV.

- Preserve and/or support systems, strategies and proposals that seek to expand affordable housing, as well as prioritize housing opportunities for people living with, affected by, or at risk of contracting, HIV/AIDS.

- Support proposals that eliminate discrimination against or the criminalization of people living with, or at risk of, HIV/AIDS.

- Support proposals that reduce the cost of HIV/AIDS and STD drugs.

- Support proposals that expand the inclusion of HIV biomedical interventions in basic health benefits packages.

- Preserve full funding and accessibility to the AIDS Drug Assistance Program (ADAP).

18. ANNOUNCEMENTS

2018 COH Training Schedule

Los Angeles County Commission on HIV (COH) 2018 Training Schedule for Interested Applicants and Commissioners

WORKSHOP LOCATION AND TIME: All workshops will be held at the COH office, located at 3530 Wilshire Blvd., Suite 1140, Los Angeles, CA 90010 FROM 1 PM TO 3 PM. Please RSVP to confirm your attendance to Sdwright@lachiv.org.

Data and Epidemiology Overview: January 29
Participants will review reports used in priority setting and resource allocations decision-making process, needs assessments and the Comprehensive HIV Plan.

Effective Communication and Active Listening: February 15
Participants will assess their personal communication styles and learn strategies on how to communication with others.

Running and Facilitating Meetings: March 15
Participants will learn tips for leading and participating in COH meetings. Participants will learn the "6 Thinking Hats" strategy for encouraging different perspectives and active participation.

Planning Council Refresher & Committee Spotlight: April 19
Get a refresher on Planning Council responsibilities and key policies and procedures. This workshop will discuss the functions of the COH's standing committees and how they inter-relate with each other.

STD & HIV 101: April 24
Learn the basics of STDs and HIV/AIDS as well as up-to-date information on prevention, care, and data within Los Angeles County.

These trainings are **highly recommended.** The Ryan White HIV/AIDS Program Part A Manual stipulates the provision of a thorough orientation to new and returning planning council members and ongoing formal training to attain skills necessary to perform their duties.

END OF COMMISSION PACKET