AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Fiscal Year 2018-19

November Estimate

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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.

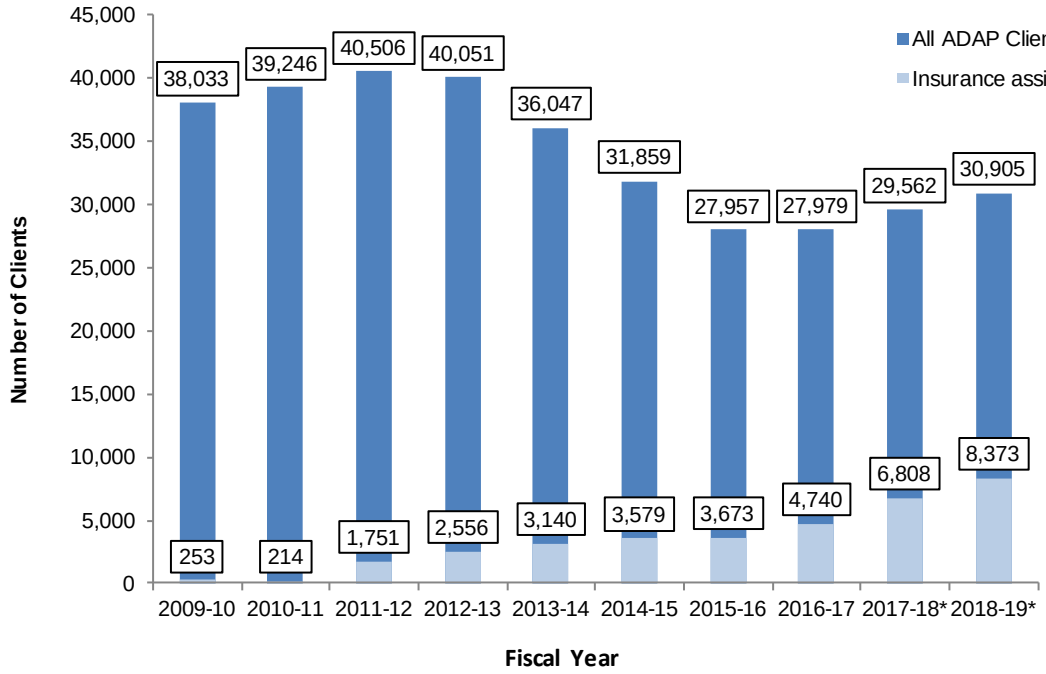
Figure 1 is a summary of total client counts in ADAP by FY, excluding PrEP clients. The number of ADAP medication program clients who are also receiving insurance assistance is also shown.

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.

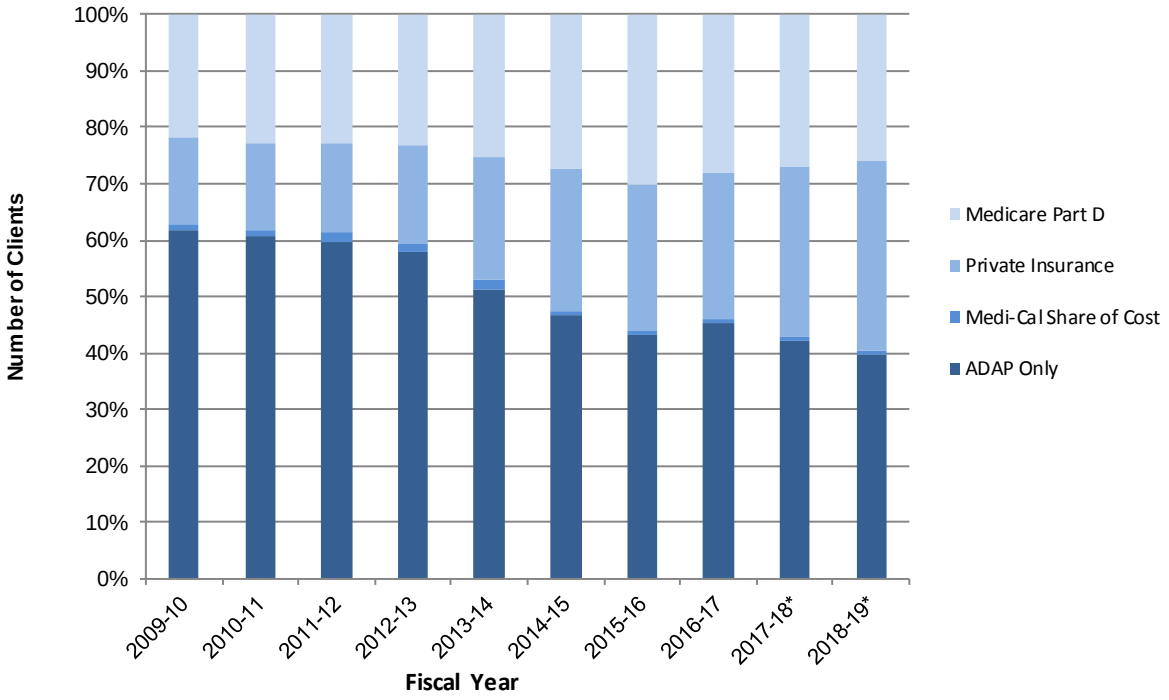
Figure 4 is the number of medications on the ADAP formulary by FY; the number of anti-retroviral medications is also shown.

FIGURE 1: ADAP CLIENT COUNT TREND



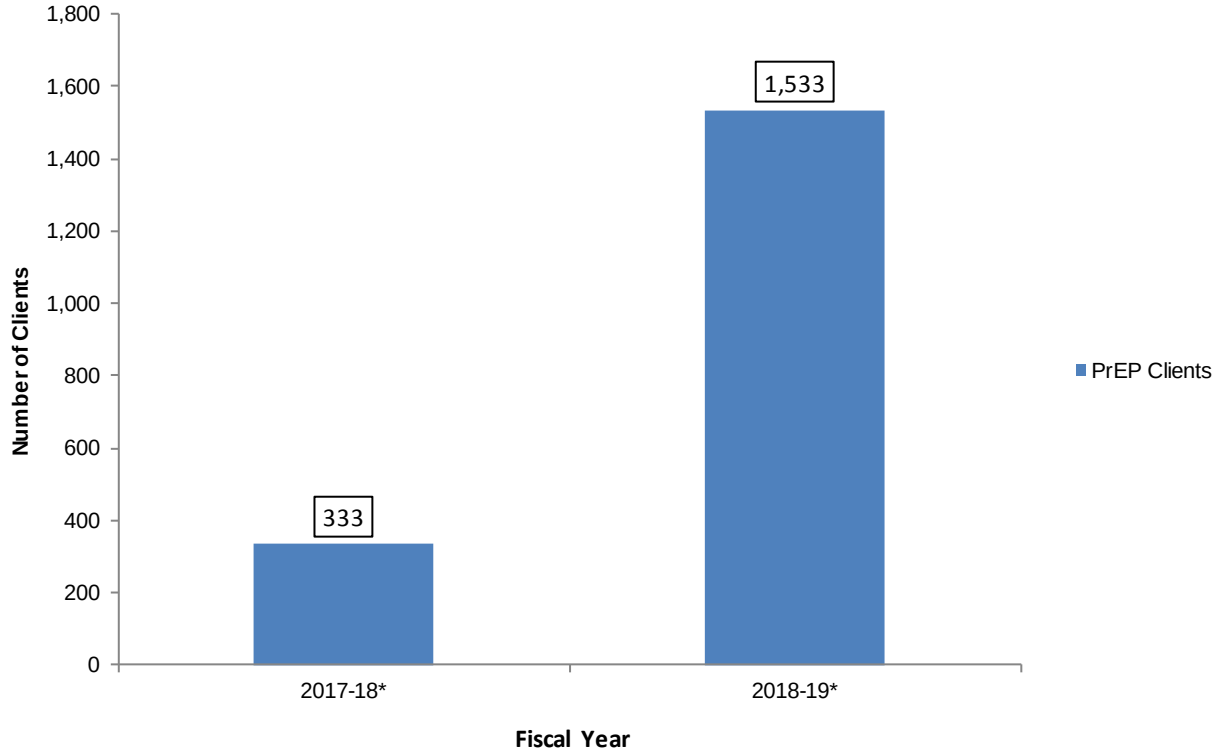
* Data for FYs 2017-18 and 2018-19 are estimated. All other data are actuals.

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

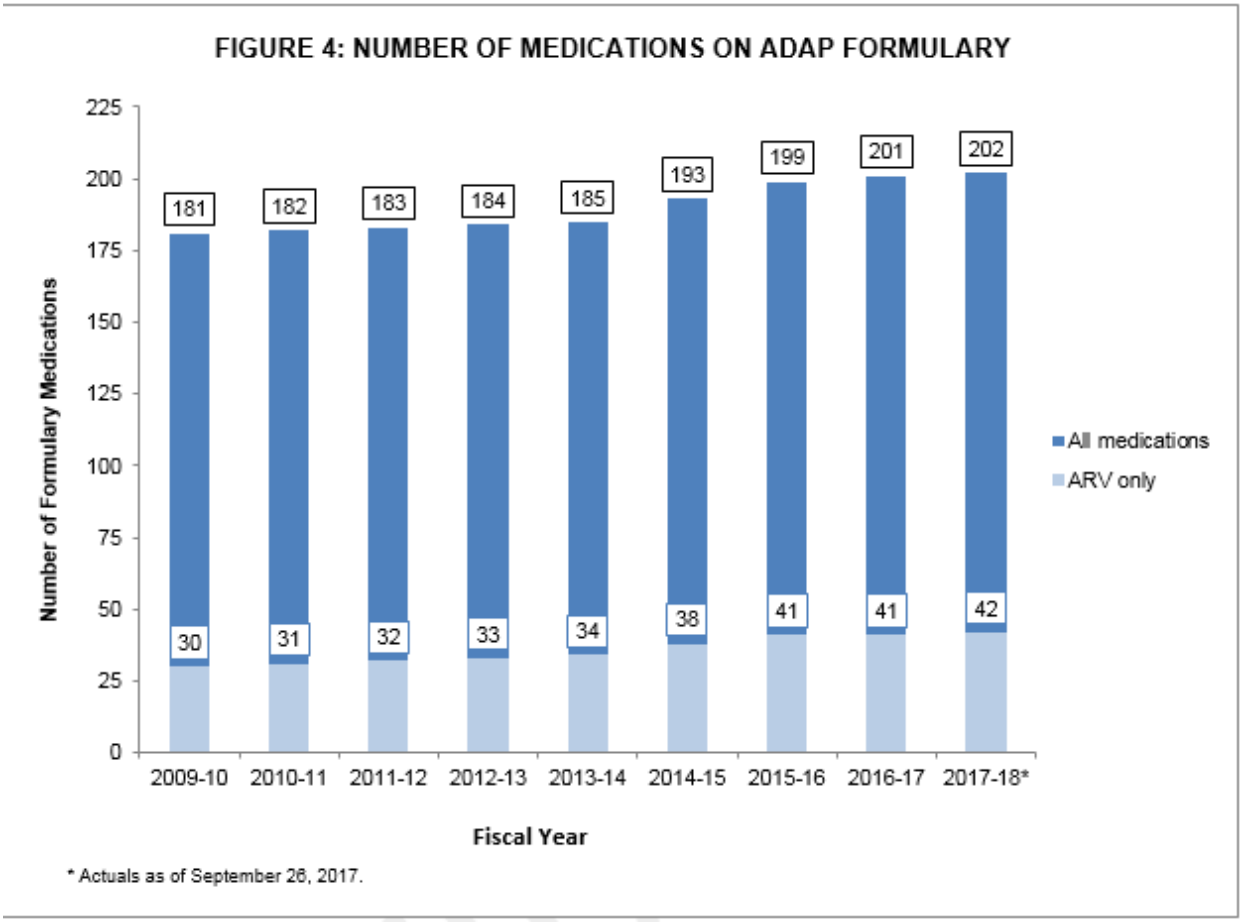


* Data for FYs 2017-18 and 2018-19 are estimated. All other data are actuals.

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.