AIDS DRUG ASSISTANCE PROGRAM

2024-25

November Estimate

Tomás J. Aragón, MD, DrPH
Director and State Public Health Officer

California Department of Public Health

California Department of Public Health

Table of Contents

I. Program Overview ... 1
II. Estimate Methodology ... 3
A. Expenditure Forecasts ... 3
B. Revenue Forecasts ... 3
III. Estimate Overview ... 4
IV. Summary of Expenditures and Revenue ... 5
A. Expenditure Types ... 5
B. Revenue and Federal Grants ... 6
V. Assumptions ... 7
VI. Expenditure Details ... 24
VII. Historical Program Data and Trends ... 30
VIII. Current HIV Epidemiology in California ... 36

I. Program Overview

The California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA), Acquired Immunodeficiency Syndrome (AIDS) Drug Assistance Program (ADAP) Branch administers ADAP and the Pre-Exposure Prophylaxis Assistance Program (PrEP-AP). ADAP provides access to life-saving medications, health insurance premium payment assistance, and assistance with medical out-of-pocket costs for eligible California residents living with Human Immunodeficiency Virus (HIV). PrEP-AP provides assistance with medication and medical out-of-pocket costs related to HIV pre-exposure prophylaxis (PrEP) for clients at risk for acquiring HIV and post-exposure prophylaxis (PEP) for clients who may have been exposed to HIV. Services are provided to five groups of clients:

1. **Medication-only clients** are people with HIV (PWH) 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 PWH 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 PWH who have some form of health insurance, including insurance purchased through Covered California, privately-purchased health insurance, or employer-based health insurance. This group is divided into three client sub-groups: Covered California clients, non-Covered California clients, and employer-based insurance clients. These groups receive medication benefits and may also receive assistance with health insurance premiums and medical out-of-pocket costs.

4. **Medicare clients** are PWH who are enrolled in a Medicare plan. This group is divided into three client sub-groups: Part B, Part C, and Part D. These groups receive medication benefits and may also receive assistance with health insurance premiums and medical out-of-pocket costs.

5. **PrEP-AP clients** are HIV-negative individuals who are at risk of HIV infection and who have chosen to take PrEP as a way to prevent infection. For insured clients, PrEP-AP pays for PrEP and PEP related medical out-of-pocket costs and covers the gap between what the client's insurance plan and the manufacturer's copayment assistance program pays towards medication costs. For uninsured clients, PrEP-AP only provides assistance with PrEP and PEP-related medical costs and medication costs for clients who are ineligible for a medication assistance program through a drug manufacture or other assistance programs.

As a covered entity in the Health Resources & Services Administration (HRSA) 340B Drug Pricing Program, ADAP collects rebates for most prescriptions purchased for ADAP clients. ADAP does not collect rebates for prescriptions purchased for Medi-Cal SOC or PrEP-AP clients. To prevent duplicate rebate discounts on the same claim, which is prohibited, ADAP does not invoice manufacturers for rebates on Medi-Cal SOC claims. As the primary payer, Medi-Cal has the right to claim mandatory rebate on prescriptions for Medi-Cal SOC clients. ADAP also does not collect rebate on medication purchases for PrEP-AP clients because PrEP-AP is separate and distinct from ADAP and is not a 340B covered entity.

Historically, most ADAP clients were medication-only clients without health insurance because PWH were unable to purchase affordable health insurance in the private marketplace. With the implementation of the Affordable Care Act, 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 to safeguard ADAP as the payer of last resort. Clients who enroll in full-scope Medi-Cal are disenrolled from ADAP because these clients have no SOC, no drug copays 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 copays for medications on the ADAP formulary.

Eligible clients with health insurance can also coenroll in ADAP's health insurance assistance programs for assistance with their insurance premiums and medical out-of-pocket costs, which can only be paid if ADAP pays the client's premium. Helping ADAP clients purchase and maintain comprehensive health insurance is more cost effective than paying the full cost of medications and improves health outcomes by providing access to the full spectrum of medical care beyond the HIV outpatient care and medications available through the HRSA Ryan White Program.

II. Estimate Methodology

The ADAP Estimate uses a Cost Per Client methodology to estimate expenditure and revenue associated with medication and insurance assistance services as they relate to changes in the volume of activity. This methodology looks at two input variables, the number of clients served and cost per service/expenditures per client, to calculate the estimated number of expenditures for service provided. Forecasts are modeled conservatively, with the objective of reducing the risk of underestimating budget needs.

A. Expenditure Forecasts

Program data describing client counts and costs per client are summarized by month and insurance coverage group and combined with external cost drivers which account for trends in current and historical program growth, changes in pharmacy utilization, administrative policies, and seasonal effects.

Separate estimates are created for each insurance coverage group and total projected costs are based on the following drivers:

- Expected number of clients served per month
- Expected cost per client per month

Total costs are estimated by multiplying the expected cost per client by the expected number of clients per month.

B. Revenue Forecasts

Revenue is estimated based on the results of the expenditure forecasts, historical rebate payment amounts, average time between medication dispense, and receipt of rebate payments.

Revenue is estimated by quarter to reflect manufacturer agreements and may be adjusted to reflect expected implementation of any newly negotiated voluntary rebate terms.

III. Estimate Overview

The 2024-25 ADAP November Estimate provides revised projections of 2023-24 and 2024-25 Local Assistance costs for medication, health insurance premiums, medical out-of-pocket costs, administrative costs associated with pharmacy, insurance and medical benefits management services, and ADAP enrollment site payments. Total estimated budget authority needs for 2023-24 and 2024-25, below, include all assumptions.

Table 1 displays the estimated ADAP Local Assistance budget authority need for 2023-24 (column C) and 2024-25 (column G) and compares that need to the amount reflected in the Budget Act of 2023 (column B for 2023-24, and column F for 2024-25). The Budget Act of 2018 authorized an ongoing $2 million in budget authority to modify and expand PrEP-AP which is included with the ADAP Rebate Fund (Fund 3080) budget authority need detailed below.

- 2023-24: OA estimates the ADAP budget authority need will be $353.9 million ($245.6 million ADAP Rebate Fund (Fund 3080) and $108.3 million Federal Trust Fund (Fund 0890)), which is $44.1 million lower than reported in the Budget Act of 2023 (Table 1). The 11.1 percent decrease is driven primarily by lower medication and medical out-of-pocket expenditures than previously estimated (Table 7).
- 2024-25: OA estimates the ADAP budget authority need will be $366 million ($260.8 million ADAP Rebate Fund (Fund 3080) and $105.2 million Federal Trust Fund (Fund 0890)), which is $32.1 million lower than reported in the Budget Act of 2023 (Table 1). The 8.1 percent decrease is driven primarily by the same factors listed above (Table 10).

Table 2 displays the estimated ADAP revenue for 2023-24 (column C) and 2024-25 (column G) and compares them to the amount reflected in the Budget Act of 2023 (columns B for 2023-24 and column F for 2024-25).

- 2023-24: OA estimates ADAP revenue will be $327.8 million (Table 2), $37.4 million lower than reported in the Budget Act of 2023. The 10.3 percent decrease is driven primarily by decreased rebates due to lower medication expenditures than previously estimated (Table 7).
- 2024-25: OA estimates ADAP revenue will be $280.9 million (Table 2), $84.3 million lower than reported in the Budget Act of 2023. The 23.1 percent decrease is driven primarily by the same factor listed above (Table 10).

California Department of Public Health
AIDS Drug Assistance Program and PrEP Assistance Program
2024-25 November Estimate
Table 1: Local Assistance Budget Authority
(In Thousands)

Local Assistance	2023-24 Budget Act	Current Year 2023-24			2023-24 Budget Act	Budget Year 2024-25		
		November Estimate	$ Change from Budget Act	% Change from Budget Act		November Estimate	$ Change from Budget Act	% Change from Budget Act
(A)	(B)	(C)	(D) =(C)-(B)	(E) = (D)/(B)	(F)	(G)	(H) = (G)-(F)	(I) = (H)/(F)
Total Funds Requested	**$398,042**	**$353,923**	**-$44,118**	**-11.1%**	**$398,042**	**$365,983**	**-$32,060**	**-8.1%**
Federal Trust Fund - Fund 0890	$102,102	$108,293	$6,191	6.1%	$102,102	$105,189	$3,086	3.0%
ADAP Rebate Fund - Fund 3080	$295,940	$245,631	-$50,309	-17.0%	$295,940	$260,794	-$35,146	-11.9%
Caseload	35,179	32,506	-2,673	-7.6%	35,179	32,380	-2,799	-8.0%

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
ADAP Rebate Fund - Fund 3080 authority includes an on-going $2 million from the 2018 Budget Act.

2024-25 November Estimate
Table 2: ADAP Rebate Fund (Fund 3080) Revenues
(In Thousands)

Revenue	2023-24 Budget Act	Current Year 2023-24			2023-24 Budget Act	Budget Year 2024-25		
		November Estimate	$ Change from Budget Act	% Change from Budget Act		November Estimate	$ Change from Budget Act	% Change from Budget Act
(A)	(B)	(C)	(D) =(C)-(B)	(E) = (D)/(B)	(F)	(G)	(H) = (G)-(F)	(I) = (H)/(F)
Total Revenue Requested	**$365,289**	**$327,840**	**-$37,449**	**-10.3%**	**$365,289**	**$280,945**	**-$84,344**	**-23.1%**
ADAP Rebate Fund - Fund 3080	$363,047	$325,598	-$37,449	-10.3%	$363,047	$278,703	-$84,344	-23.2%
Interest Income	$2,242	$2,242	$0	0.0%	$2,242	$2,242	$0	0.0%

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

IV. Summary of Expenditures and Revenue

A. Expenditure Types

ADAP variable expenditures are broken out into two types: health care expenditures and administrative expenditures.

a) Health care expenditures include prescription medication costs for drugs on the ADAP formulary (including deductibles, copays, and co-insurance), health insurance premiums, and medical out-of-pocket costs (e.g., deductibles and copays for physician visits, laboratory tests, etc.). Estimated expenditures by client group are shown in Table 3. A detailed display of caseload and expenditures by client group and service type is in Section VI, Tables 5 – 10.

b) Administrative expenditures include costs associated with pharmacy, insurance and medical benefits management services; and payments to local ADAP and PrEP-AP enrollment sites for services needed to enroll and maintain clients in ADAP and PrEP-AP. Administrative expenditure estimates are adjusted annually through the ADAP Estimate, based on caseload and service projections. Estimated expenditures for administrative services are also shown in Table 3.

TABLE 3: ESTIMATED VARIABLE EXPENDITURES BY CLIENT GROUP		
CLIENT GROUP	EXPENDITURES	
	FY 2023-24	FY 2024-25
Medication-Only	$218,915,786	$205,757,740
Medi-Cal SOC	$497,082	$497,082
Private Insurance	$87,980,854	$97,708,573
Medicare	$27,116,761	$29,672,877
PrEP-AP	$15,472,841	$21,213,732
SUBTOTAL	**$349,983,324**	**$354,850,003**
Admin: ADAP	$4,568,144	$9,199,063
Admin: PrEP-AP	$3,943,308	$4,941,639
Admin: Enrollment	$7,310,500	$7,485,500
Health Management Systems (HMS)	-$13,881,816	-$12,493,634
TOTAL	**$351,923,460**	**$363,982,571**
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.		

B. Revenue and Federal Grants

a) ADAP Special Funds – ADAP receives both mandatory and voluntary supplemental rebates from drug manufacturers for ADAP medication expenditures. An approximate six-month delay in receipt of rebate revenue, from the time the medication expenditure occurs, exists because of the time required for billing the drug manufacturers. 2023-24 revenue projections are based on estimated rebates from actual and estimated medication expenditures from January through December 2023. 2024-25 revenue projections are based on estimated rebates from estimated medication expenditures from January through December 2024.

b) Federal Funds – ADAP receives federal funds from HRSA through the Ryan White Part B Program.

- 2023-24: Total federal fund budget authority is projected to be $108.3 million (Table 1), $6.2 million (6.1 percent) higher than reported in the Budget Act of 2023. Federal fund budget authority includes the following federal grant assumptions:
  - 2023 Ryan White Part B: $93.4 million
  - 2023 Ryan White Part B Supplemental: $5.3 million
  - 2023 ADAP Emergency Relief Funds (ADAP Shortfall Relief): $6.4 million
  - 2022 Ryan White Part B Carryover: $3.1 million

- 2024-25: Total federal fund budget authority is projected to be $105.2 million (Table 1), $3.1 million (3.0 percent) higher than reported in the Budget Act of 2023. Federal fund budget authority includes the following estimated federal grant funding:

- 2024 Ryan White Part B: $93.4 million
- 2024 Ryan White Part B Supplemental: $5.3 million
- 2024 ADAP Emergency Relief Funds (ADAP Shortfall Relief): $6.4 million

c) Federal Match – HRSA requires grantees to have HIV-related non-HRSA expenditures. OA meets the match requirement using ADAP Rebate Fund (Fund 3080) expenditures. California's HRSA match requirement for the 2023 Ryan White Part B grant budget period (April 1, 2023, through March 31, 2024) is $69.3 million.

V. Assumptions

New Assumptions

HIV Medication: Lenacapavir (Sunlenca)

Background: Lenacapavir is a first-in-class HIV type 1 (HIV-1) capsid inhibitor that has been developed as a long-acting injectable antiretroviral (ARV) treatment. Lenacapavir is administered via subcutaneous injection every six months, providing PWH with a very long-acting treatment option that was safe and well tolerated in clinical trials. Lenacapavir is a single ARV and must be used in combination with other ARVs. Lenacapavir has been approved for the treatment of adults with multidrug resistant HIV infection who are failing their current ARV regimen.

HRSA Ryan White HIV/AIDS Program (RWHAP) legislation requires ADAP formularies to include at least one drug from each class of HIV ARV medications. In addition, all therapeutic treatment and ancillary devices (e.g., syringes to administer an ADAP formulary medication) included on the ADAP formulary and all ADAP-funded services must be equally and consistently available to all eligible enrolled individuals throughout the state/territory.

To cover medical office visits for the administration of Sunlenca for an uninsured ADAP client, the client would be required to see a provider within the approved clinical provider network. ADAP's Medical Benefit Manager (MBM) will work with the client's approved clinical provider to ensure that the administration cost associated with Sunlenca is covered by ADAP. The approved clinical provider will complete and submit a claim to ADAP's MBM for review and approval.

ADAP clients with private insurance, not enrolled in one of ADAP's Insurance Assistance Programs, which includes the Health Insurance Premium Payment (HIPP), Employer Based-Health Insurance Premium Payment (EB-HIPP) and Medicare Premium Payment (MPPP) programs, can also access Sunlenca from a

provider within their insurance network. The in-network provider will be responsible for ensuring the client's insurance is billed for the administration of Sunlenca. Clients with insurance must see a provider within their insurance network and ADAP's MBM can assist with reimbursement for medical out of pocket costs. The client or provider would need to submit a claim form along with supporting documentation to ADAP's MBM for processing. Providers are required to submit completed W9 forms to ADAP's MBM prior to ADAP's MBM remitting payment.

Description of Change: On April 25, 2023, Lenacapavir (Sunlenca) was added to the ADAP formulary. This will provide ADAP clients with a long-acting injectable ARV treatment option in combination with other ARVs for adults with multidrug resistant HIV-1 infection failing their current ARV regiment due to resistance, intolerance, or safety considerations. Utilization of Lenacapavir (Sunlenca) is anticipated to be at a volume that will not be cost neutral and is projected to have a moderate fiscal impact.

Discretionary: No

Reason for Adjustment/Change:
- First ARV developed in a new class of medication for treating HIV called capsid inhibitors
- HRSA RWHAP grant requirement
- Addition to the ADAP formulary will improve client access to new ARV treatment options

Fiscal Impact and Fund Source(s): For 2023-24, the estimated net fiscal impact is $1.3 million ($1.4 million expenditures minus $91,000 rebate) for 80 clients. For 2024-25, the estimated net fiscal impact is $3.2 million ($3.8 million expenditures minus $601,000 rebate) for 180 clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

Client Navigation Outreach

Background: During Fiscal Year (FY) 2017-18, nine ADAP enrollment sites participated in the Access, Adherence, and Navigation (AAN) Program to navigate uninsured individuals to comprehensive health insurance coverage and to support ADAP clients with achieving and maintaining viral suppression. During implementation, several barriers were identified by Navigators to enrolling clients into comprehensive health coverage: 1) client reluctance to enroll in a health plan due to the elimination of the individual mandate; 2) concern with data privacy and public charge designation from clients without a social security number; 3) a lack of perceived need for comprehensive health insurance coverage from clients with access to the HRSA Ryan White outpatient services; and 4) clients declining to participate due to being enrolled in My Health LA, a

no-cost health program for low-income, uninsured residents of Los Angeles County, which provides coverage for outpatient clinical services, but limited to no coverage of HIV medications.

Due to these unanticipated and on-going barriers to navigating clients to comprehensive health insurance for the 2019 Covered California open enrollment period, during FY 2020-21, OA brought AAN functions in-house to navigate uninsured individuals to comprehensive health insurance coverage and to support ADAP clients with achieving and maintaining viral suppression statewide. ADAP advisors reached out to uninsured clients to inform them about comprehensive health coverage options and provide them with resources. After implementation, it was determined that the degree of complexity associated with advising clients on their options for health insurance with optimal access to HIV care providers in all the different counties and regions in California required resources and time better met by a third-party specializing in health coverage navigation.

Description of Change: OA plans to solicit a Request for Application (RFA) to effectively evaluate services provided by entities that specialize in health insurance navigation. ADAP expects the entity to perform outreach and navigate uninsured clients to comprehensive health insurance coverage, provide information and resources to clients, conduct "virtual" warm handoffs to local agencies to assist clients with enrollment, and perform secure data exchanges. Uninsured clients who enroll in comprehensive health coverage will have better health outcomes, reduce HIV health disparities and inequities, and have complete coverage that includes care from a physician, prescription drug coverage, and other preventive services. It is anticipated that the contract will begin in the fall of 2024. Over time, it is anticipated that the contract will be cost neutral as more uninsured clients are navigated to comprehensive health coverage and maintain their health insurance. Uninsured clients who enroll in comprehensive health insurance coverage result in a cost savings for ADAP and better health outcomes.

Discretionary: Yes

Reason for Adjustment/Change:

- Uninsured ADAP client costs are higher than an ADAP client with comprehensive health insurance coverage (i.e., private insurance, Medi-Cal, Medicare)
- Enrollment in comprehensive health insurance increases access to care and improves health outcomes for people living with HIV
- Health insurance is important for preventing and managing acute and chronic health conditions

Fiscal Impact and Fund Source(s): There is no estimated savings for 2023-24. For 2024-25, the estimated savings is $4.4 million ($1.1 million in private insurance medication costs, $2.4 million in private insurance premiums, $68,000 in medical-out-pocket costs, and $4.2 million in administrative and contractual costs offset with $12.1 million savings in ADAP Only medication costs) for 511 clients. There is no impact to rebate as $2.1 million generated by private insurance clients is offset by the same amount loss for ADAP Only clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

MPPP Expansion to Dental and Vision

Background: The HIPP program provides dental and vision premium coverage for eligible clients. Once a client becomes Medicare eligible, they no longer qualify for dental and vision premium assistance through HIPP. MPPP provides Medicare Part C and Part D premium assistance, and Medigap premium assistance. Medicare clients must pay for their own dental and vision policies due to MPPP not covering these plans.

Description of Change: ADAP requests to expand coverage to dental and vision premiums for MPPP eligible clients, effective July 1, 2024. Offering dental and vision premium assistance to MPPP clients allows for continuity of holistic care for clients that become Medicare eligible. Extending the same level of premium assistance from the HIPP program to MPPP ensures consistent health coverage for all client groups.

Discretionary: Yes

Reason for Adjustment/Change:
- Allows for continuity of care when transitioning from private insurance to Medicare
- Provides clients opportunity for holistic health coverage
- Medicare does not provide dental coverage, clients currently responsible for premiums of additional plan

Fiscal Impact and Fund Source(s): There is no estimated fiscal impact for 2023-24. For 2024-25, the estimated fiscal impact is $221,000 for 500 clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Paying above Medicare Part D Benchmark Premiums

Background: Medicare provides free prescription drug coverage through Medicare Part D benchmark plans for clients that are deemed eligible or apply through Medicare's low-income subsidy (LIS) program. ADAP clients are strongly encouraged to enroll in a Medicare Part D Benchmark plan if they are eligible.

Clients enrolled in a benchmark plan who are deemed full LIS are not eligible to enroll in MPPP as the subsidy provided covers the premium and deductible of the benchmark plan.

Beginning in 2024, Medicare is eliminating partial LIS and extending 100 percent subsidy benefits to eligible clients. As a result, more ADAP clients will qualify for benchmark plans and be ineligible for the MPPP. However, the coverage of benchmark plans and plan selection is limited compared to non-benchmark plans. For example, there are an average of 22 Medicare Part D plans available for non-benchmark clients to select from compared to four benchmark plans available for benchmark eligible clients. The MPPP benefit also provides coverage of Medicare Part B out-of-pocket costs and Medicare supplemental premiums and currently clients deemed full LIS are not able to access these benefits.

Description of Change: ADAP requests to expand MPPP eligibility to clients that are deemed eligible for free Medicare Part D and qualify for 100 percent LIS, effective July 1, 2024. ADAP will pay for the remaining Medicare Part D premium after subsidies are applied. Clients will also be eligible for Medicare Part B out-of-pocket claims, Medicare supplemental premium coverage, and selection of any available Medicare Part D plan. Expanding MPPP will provide clients more plan choices and an opportunity for more comprehensive health coverage.

Discretionary: Yes

Reason for Adjustment/Change:
- Benchmark plan choices are severely limited and continue to decrease
- Injectable drugs, such as Cabenuva, can be billed to Medicare Part B
- Ineligible for Part B medical out-of-pocket costs if not enrolled in MPPP
- MPPP provides more comprehensive health coverage options

Fiscal Impact and Fund Source(s): There is no estimated fiscal impact for 2023-24. For 2024-25, the estimated fiscal impact is $157,000 for 525 clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

Full Scope Medi-Cal Coverage for Justice Involved Individuals

Background: On January 26, 2023, California became the first state in the nation to be approved to offer a targeted set of Medicaid (Medi-Cal in California) services to youth and adults in state prisons, county jails, and youth correctional facilities for up to 90 days prior to release. Currently, Medi-Cal services are generally available only after release from incarceration. Through a federal Medicaid 1115 demonstration waiver, the Department of Health Care Services

(DHCS) will establish a coordinated community reentry process that will assist people leaving incarceration to connect to the physical and behavioral health services they need upon release. As codified by Assembly Bill (AB) 133 (Chapter 143, Statutes of 2021), the California Advancing and Innovating Medi-Cal (CalAIM) Initiative's pre-release eligibility and enrollment went live on January 1, 2023, and will help ensure that, if determined eligible, all incarcerated adults and youths within County Correctional Facilities and County Youth Correctional Facilities have access to needed Medi-Cal services upon their re-entry into the community.

Historically, Californians in prisons, jails, and juvenile detention facilities have difficulty accessing health care services after they have been released and are transitioning back into their communities, including individuals living with HIV. As outlined in Penal Code section 4011.11, the board of supervisors, in consultation with the county sheriff and chief probation officer, respectively, shall designate an entity or entities to assist both county jail inmates and juvenile inmates with the application process for health insurance affordability programs consistent with federal requirements. Starting no sooner than April 2024, individuals will now be able to receive up to 90 days of Medi-Cal coverage prior to being released from a public institution, including medication coverage. AB 133 allows jails to help connect an individual to a community-based Medi-Cal provider 90 days prior to their release to ensure they can continue care and treatment once returning to the community. Each county is expected to implement at different points in time as they work with Medi-Cal to create an implementation plan for Medi-Cal services within their respective county jails.

Through ADAP's pilot program for jails, ADAP provides medication assistance to qualifying detainees at local county jails. ADAP does not provide services for individuals incarcerated in youth correctional facilities or adults in state prisons.

Description of Change: DHCS expects pre-release services to go-live no sooner than April 2024. Individuals enrolled in ADAP's pilot program for jails who are due to be released from jail may be enrolled into Medi-Cal pre-release services 90 days prior to release, if eligible. ADAP's pilot program for jails is currently implemented in Orange and San Joaquin County.

Individuals who are granted pre-release services will be disenrolled from ADAP by their Enrollment Worker to safeguard ADAP as the payor of last resort. ADAP will back-bill Medi-Cal for dual enrolled clients via the established Medi-Cal Eligibility Data System (MEDS) match process. OA anticipates a gradual uptake of ADAP clients found on the MEDS match which will result in a cost savings for ADAP as Medi-Cal will be back-billed for these services.

Discretionary: No

Reason for Adjustment/Change:

- Federal Medicaid 1115 demonstration waiver
- Legislative requirement

Fiscal Impact and Fund Source(s): For 2023-24, the estimated savings is $1.3 million for 109 clients. For 2024-25, the estimated net savings is $7.8 million ($11.9 million savings minus $4.1 million rebate) for 976 clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

Increase in Federal Funds: 2023 Ryan White Part B Supplemental

Background: The HRSA Ryan White Part B Supplemental grant develops and/or enhances access to a comprehensive continuum of high-quality care and treatment services for low-income individuals living with HIV. The amount of each award is based on submitted data demonstrating the severity of the HIV epidemic in the applicant's state/territory, comorbidities, cost of care, and service needs of emerging populations.

The following table displays historical application amounts for which OA applied, total funds awarded per grant budget period, and total ADAP Local Assistance received per grant budget period.

Table 4: Ryan White Part B Supplemental Funds

Grant Budget Period	Application Amount	Total Funds Awarded	Total Local Assistance
2019 (09/30/2019 – 09/29/2020)	$15,000,000	$6,375,772	$4,700,000
2020 (09/30/2020 – 09/29/2021)	$10,000,000	$2,628,306	$2,567,306
2021 (09/30/2021 – 09/29/2022)	$9,000,000	$1,941,558	$1,916,558
2022 (09/30/2022 – 09/29/2023)	$9,000,000	$2,250,912	$2,250,912
2023 (09/30/2023 – 09/29/2024)	$9,000,000	$5,337,315	$5,337,315

Description of Change: On April 17, 2023, OA applied for the competitive 2023 Ryan White Part B Supplemental grant. OA requested the maximum amount of $9 million, all of which is designated for ADAP Local Assistance to be used in 2023-24. On July 18, 2023, OA received the notice of award for the 2023 Ryan White Part B Supplemental grant in the amount of $5.3 million (all Local Assistance).

Discretionary: Yes

Reason for Change/Adjustment:

- Competitive funding opportunity

- Prior funding does not guarantee funding will be provided in the future

Fiscal Impact and Fund Source: Increase of $3.1 million in Local Assistance for 2023-24 and 2024-25. The fund impacted is the Federal Trust Fund (Fund 0890).

Increase in Federal Funds: 2022 Ryan White Part B Grant Carryover

Background: The HRSA Ryan White Part B grant is a non-competitive grant and the largest of the three federal grants for which ADAP receives funding. Grant funding is appropriated in five, 12-month grant budget periods that run from April 1 to March 31. Within the five-year funding cycle, funding from year to year is provided if the program remains eligible and submits all reporting requirements in a timely manner. Funding from the Ryan White Part B grant that is not fully expended by the end of the budget period can be carried over to the next budget period with approval from HRSA.

Description of Change: At the end of August 2023, OA closed out the 2022 Ryan White Part B grant with HRSA and applied for carryover funding of unobligated funds from the 2022 grant budget period (April 1, 2022, through March 31, 2023). Upon closure of the grant, the amount of unspent funding was determined for which the ADAP Branch applied. The request for HRSA approval was due August 29, 2023.

On October 19, 2023, OA received the notice of award for carryover totaling $3.1 million in ADAP Local Assistance. Carryover funding is anticipated to be spent in 2023-24.

Discretionary: Yes

Reason for Change/Adjustment:
- Fully leverage federal funding

Fiscal Impact and Fund Source: Increase of $3.1 million in Local Assistance for 2023-24. The fund impacted is the Federal Trust Fund (Fund 0890).

Existing Assumptions

ADAP Pilot Program for Jails

Background: Prior to 2008, 36 local county jails participated in ADAP to provide medication assistance to qualifying detainees. The program was terminated in 2008 due to the elimination of funding from the State's General Fund. Subsequently, in 2018, HRSA released Policy Clarification Notice (PCN) 18-02, which permitted the use of HRSA funds for individuals who are detained in a

county jail and are not yet convicted of a crime or are not covered by federal or state health benefits. After the PCN release, Orange County asked CDPH to provide ADAP services at their county jail.

Providing ADAP services to jail detainees expands outreach to a vulnerable population while supporting continuity of care for those navigating the judicial system. Incarcerated clients who meet ADAP eligibility requirements can enroll in ADAP with the help of a certified enrollment worker from the county jail, which must be approved as an enrollment site. New and existing clients can access medication(s) at the jail pharmacy, thus maximizing potential adherence to medicinal regimens. Additionally, the jail pharmacy can provide a prescription refill to clients scheduled for release, so that the client has a supply of medication available until they can access ADAP services through a more traditional enrollment site.

In response to Orange County's request, OA initiated a pilot program in 2021-22 with the Orange County jail. OA, in consultation with the Department of Finance, is expanding the pilot program to other interested county jails after careful consideration of the impact to the ADAP Rebate Fund, both in the short and long term.

OA met with the other interested county jails in the summer of 2022 to understand how they address the transitional needs of PWH who have been incarcerated. OA determined whether each respective jail would be a suitable ADAP jail enrollment site. Prior to becoming an enrollment site, interested county jails will need to submit a new Enrollment Site Application, begin the contracting process with OA, be added to the Pharmacy Benefits Manager Pharmacy Network, and complete the new enrollment worker training.

The 2022-23 May Revision Estimate approved seven counties which expressed interest: Orange, Los Angeles, Marin, Riverside, San Francisco, San Luis Obispo, and Siskiyou. OA has a contract in place with Orange County and continued to conduct outreach to the remaining six counties.

The 2023-24 November Estimate approved addition of three interested counties in conjunction with the seven aforementioned counties: San Bernardino, San Joaquin, and Tuolumne. Clients will not be enrolled until a contract is in place and the enrollment worker training is completed. Additional funding was requested in 2022-23 for the seven counties, and for both the original seven counties and additional three (ten counties total) in 2023-24 following updated information from the counties.

With Orange County's contract in place since 2021-22, outreach efforts continued for five remaining counties (Los Angeles, Riverside, San Francisco, San Joaquin,

and Tuolumne); four counties withdrew interest (Marin, San Bernardino, San Luis Obispo, and Siskiyou). As contracts for the remaining counties were not anticipated to be executed until possibly July 2023, the 2022-23 fiscal impact decreased from the 2023-24 November Estimate, reflecting only Orange County expenditures in the 2023-24 May Revision. The 2023-24 fiscal impact reflected six counties total which, due to updated county interest and client count data decreased in the 2023-24 May Revision compared to the 2023-24 November Estimate.

Description of Change: On July 1, 2023, the ADAP enrollment site contract for San Joaquin County was executed. Los Angeles, Riverside, and San Francisco counties have submitted enrollment site applications and are currently going through the contract process. Outreach efforts continue for Tuolumne County, the last of the previously approved interested counties, which anticipates submitting a completed ADAP enrollment site application after conclusion of internal discussions and prior to the fall of 2023.

Following the end of the Public Health Emergency, ADAP resumed pre-COVID-19 outreach efforts to the remaining 48 counties for renewed interests in the pilot program and a 2024-25 implementation. A total of 25 counties responded to ADAP's outreach. Four of the 25 counties confirmed interest in becoming an ADAP enrollment site, the fiscal impact of which is included in 2024-25: Contra Costa, Sacramento, San Mateo, and Tulare. The remaining 21 counties confirmed they are not interested or unable to participate at this time.

Discretionary: Yes

Reason for Adjustment/Change:

- HRSA PCN 18-02, which permits the use of funds for individuals who are currently detained in a county jail
- Treatment and suppression of HIV/AIDS and HIV/AIDS-related opportunistic infections among high-risk individuals
- Effective outreach to underserved populations
- Continuity of care

Fiscal Impact and Fund Source(s): For 2023-24, the estimated net fiscal impact of the six pilot counties with staggered implementations is $7.7 million ($8.2 million expenditures minus $456,000 rebate) for 485 eligible clients[1]. For 2024-25, the estimated net fiscal impact of 10 counties total (six pilot counties and four

[1] Orange County was previously approved and included in the base estimate. For 2023-24, the estimated net fiscal impact for Orange County is $1.1 million ($1.6 million expenditures minus $456,000 rebate) for 107 eligible clients.

potential additional counties) is $15.9 million ($28.2 million expenditures minus $12.3 million rebate) for 1,085 eligible clients[2]. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

PrEP Medication: Cabotegravir (Apretude)

Background: On December 20, 2021, long-acting injectable cabotegravir (Apretude), an HIV integrase inhibitor, was approved by the federal Food and Drug Administration (FDA) for PrEP. Two pivotal phase III trials of long-acting cabotegravir given as an injection every other month demonstrated that long-acting cabotegravir was superior at preventing HIV infection compared to oral medication PrEP with Truvada (emtricitabine/ tenofovir disoproxil fumarate). The first trial evaluated long-acting cabotegravir in cisgender men who have sex with men and transgender women and demonstrated a 66 percent reduction in HIV incidence compared with Truvada. The second trial evaluated long-acting cabotegravir in cisgender women and demonstrated a 90 percent reduction in HIV incidence compared with Truvada. In both trials, long-acting cabotegravir had a good safety profile, with injection-site reactions being the most prominent side effect and discontinuations due to side effects were infrequent.

Oral PrEP with Truvada and Descovy are still considered to be highly effective but long-acting injectable cabotegravir provides another highly effective tool that can be utilized to prevent HIV infection. In California, it is estimated that only 30 percent of people with an indication for PrEP have been prescribed PrEP, highlighting the need for more HIV prevention options. In particular, long-acting injectable cabotegravir is recommended for people at risk for HIV infection who have had adverse reactions to oral PrEP medications or who have trouble adhering to a daily pill schedule.

On December 29, 2021, in response to the approval of long-acting cabotegravir, California's Insurance Commissioner Ricardo Lara released a bulletin notifying health plans regulated by the by the California Department of Insurance that they are required to cover all PrEP drugs and related clinical services without cost sharing – including long-acting injectable cabotegravir. The U.S. Preventive Services Task Force (USPSTF) has also proposed a grade “A” recommendation for the use of injectable cabotegravir as PrEP in adults and adolescents at increased risk of HIV acquisition.

A barrier to access the long-acting injectable cabotegravir for people who do not have insurance is cost. The manufacturer is charging $3,700 per dose in the United States, or $22,200 per year. A manufacturer assistance program exists, and

[2] For 2024-25, the estimated net fiscal impact for Orange County is $700,000 ($1.7 million expenditures minus $1 million rebate) for 116 eligible clients.

uninsured patients can enroll and receive medication for free, but OA has received numerous reports of delays from people who try to access this assistance program.

Description of Change: OA will add long-acting injectable cabotegravir to the PrEP-AP formulary for use in select situations where patients who have insurance through a parent, guardian, spouse, or domestic partner, but cannot use this insurance to access PrEP for confidentiality reasons. These individuals are referred to as clients with confidentiality concerns and otherwise do not have access to any program that can cover the cost of injectable PrEP medications. PrEP-AP will also provide coverage for long-acting injectable cabotegravir for minors who are eligible for injectable PrEP. This is a refinement of the coverage criteria communicated in the 2023-24 May Revision where select situations included uninsured patients that could not access long-acting injectable cabotegravir through an insurance plan or the manufacturer's assistance program. OA is considering covering copays for Apretude for PrEP-AP clients with Medicare Part D drug coverage (or Medicare Advantage plans) and wrap around coverage for insured clients, the cost of which is included in the 2023-24 and 2024-25 fiscal impact.

Discretionary: Yes

Reason for Change/Adjustment:

- First new drug under development specifically indicated for the prevention of HIV infection
- Per Health and Safety Code (HSC) section 120972, eligible PrEP-AP persons have access to drugs listed on the ADAP drug formulary
- Seeking access to Apretude creates both structural and administrative barriers often resulting in long wait times, denial of coverage, and ultimately failure to initiate treatment
- Alleviate barriers and improve client access to new injectable PrEP treatments available

Fiscal Impact and Fund Source: For 2023-24, the estimated fiscal impact is $900,000 for 83 clients. For 2024-25, the estimated fiscal impact is $2.7 million for 183 clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

PrEP and PEP Initiation and Retention Initiative (PPIRI)

Background: ADAP received statutory and budgetary authority through the 2016 Budget Act (Chapter 23, Statutes of 2016) to provide services to HIV-negative persons at risk for acquiring HIV. Statutory authority is codified in HSC section 120972 and allows OA to implement PrEP-AP to assist both insured and uninsured individuals who meet eligibility requirements. PrEP-AP helps with PrEP-

related and non-occupational PEP-related medical out-of-pocket costs, and access to medications on the PrEP-AP formulary for the prevention of HIV and treatment of sexually transmitted infections.

In 2021, AB 133 (Chapter 143, Statutes of 2021) added language allowing allocation of ADAP funds for PrEP and PEP navigation and retention. AB 133 allows ADAP to fund local health departments and community-based organizations, to the extent that funds are available, for PrEP and PEP navigation and retention coordination and related services. Funded activities may include outreach and education; community messaging; assistance with applying for and retaining health coverage; assistance with enrollment in PrEP and PEP financial assistance programs; care coordination and adherence support; financial assistance for transportation costs; and linkage to behavioral health, substance use, housing, and other social service programs.

This project was named the PrEP and PEP Initiation and Retention Initiative (PPIRI) to avoid confusion with CDPH/OA HIV Prevention Branch PrEP Navigation projects. Planning and development of a competitive solicitation is underway. Stakeholder engagement was held in early 2022 to assess capability, interest, and need.

The 2023-24 November Estimate anticipated the competitive solicitation to commence in the fall of 2022, and agreements with approved entities would commence in early 2023. However, as communicated in the 2023-24 May Revision, the competitive solicitation was released on January 17, 2023, and agreements with approved entities would not commence until summer 2023. Subsequently, the fiscal impact would commence in 2023-24, instead of 2022-23.

Description of Change: On March 17, 2023, the PPIRI intent to fund announcement was released. Fewer applicants than expected applied to the PPIRI competitive RFA solicitation resulting in a reduction in the number of awards and reducing the fiscal impact. In addition, the 2023-24 May Revision anticipated the fiscal impact to commence in early 2023-24, however, due to contract development delays the anticipated date of commencement is now January 1, 2024.

Discretionary: Yes

Reason for Adjustment/Change:

- Legislation was codified allowing CDPH/OA to fund local health departments and community-based organizations, to the extent that funds be available, for PrEP and PEP navigation and retention coordination and related services

Fiscal Impact and Fund Source(s): For 2023-24, the total estimated fiscal impact is $3.9 million for 700 clients ($2.2 million for 20 staff and operating expenses; $1.3 million for variable costs [example: PrEP starter packs and lab processing]; $10,000 for indirect costs; and $352,000 for 66 new PrEP-AP clients, inclusive of medication and medical-out-of-pocket costs). For 2024-25, the total estimated fiscal impact is $7 million for 700 clients ($3 million for 20 staff and operating expenses; $1.4 million for variable costs [example: PrEP starter packs and lab processing]; $10,000 for indirect costs; and $2.6 million for 198 new PrEP-AP clients, inclusive of medication and medical-out-of-pocket costs). The fund impacted is the ADAP Rebate Fund (Fund 3080).

Expansion of Medi-Cal for All Income-Eligible Californians

Background: In the last decade, the Medi-Cal program has significantly expanded. These expansions have been driven mainly by the Patient Protection and Affordable Care Act and the state-led expansions of Medi-Cal coverage to undocumented children, young adults, and older adults over age 50.

The most recent Medi-Cal expansion extends full-scope eligibility to all income-eligible undocumented adults aged 26 through 49. Beginning no sooner than January 1, 2024, Medi-Cal will be available to all income-eligible Californians. When ADAP clients become eligible for full-scope Medi-Cal, they must enroll in Medi-Cal, safeguarding ADAP as the payer of last resort. Increasing the number of ADAP clients eligible for full-scope Medi-Cal will therefore reduce the ADAP caseload, lowering ADAP program costs. Once the latest Medi-Cal expansion goes into effect, existing ADAP clients who enroll in full-scope Medi-Cal will be disenrolled from ADAP. If income qualified, individuals newly diagnosed with HIV will be able to enroll in Medi-Cal instead of ADAP.

The Medi-Cal expansion enacted in the 2022 Budget Act (Chapter 43, Statutes of 2022) extends full-scope eligibility to all income-eligible undocumented adults aged 26 through 49. Beginning no sooner than January 1, 2024, Medi-Cal will be available to all income-eligible Californians, estimated at nearly 700,000 persons statewide.

Description of Change: Beginning January 1, 2024, undocumented ADAP clients ages 26 through 49 with an income below 138 percent of the Federal Poverty Level (FPL), who were previously ineligible for Medi-Cal, will be referred to Medi-Cal. ADAP has established outreach and communication plans so that clients and enrollment workers are informed of the new Medi-Cal eligibility criteria and that enrollment workers use the updated criteria to confirm ADAP eligibility. For new and existing clients, eligibility is determined at the initial enrollment or re-enrollment. Clients who enroll into full-scope Medi-Cal will reduce the ADAP caseload and ADAP program costs.

Discretionary: No

Reason for Adjustment/Change:

- Statutory requirement

Fiscal Impact and Fund Source(s): For 2023-24, the estimated savings is $21.7 million ($21.7 million savings with no rebate in 2023-24 due to the six-month delay in receipt of rebate following the January 2024 implementation) for 1,854 clients. For 2024-25, the estimated net savings is $20.5 million ($45.9 million savings minus $25.4 million rebate) for 1,854 clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

Medi-Cal Expansion: Asset Limit Changes

Background: Due to the passage of AB 133 (Chapter 143, Statutes of 2021), the Medi-Cal asset test will be eliminated for non-Modified Adjusted Gross Income (MAGI) Medi-Cal programs in a two-phased approach. The asset test elimination will be phased in over two and a half years.

On July 1, 2022, DHCS increased the asset limit for non-MAGI Medi-Cal programs to $130,000 per individual, and $65,000 for each additional household member. Phase II, to be implemented no sooner than January 1, 2024, will eliminate the asset test entirely.

Non-MAGI programs generally provide health care for seniors, people with disabilities, and individuals who are in nursing facilities, as well as some other specialty groups. The increased asset limits will allow a larger number of applicants to become eligible for Medi-Cal benefits, and will allow qualified beneficiaries to retain a larger amount of non-exempt assets and still be eligible for Medi-Cal.

Individuals/couples who may be affected include applicants who are over the current asset limit of $2,000 per individual and $3,000 per couple, as well as individuals who are already enrolled in a non-MAGI program subject to the asset test. These individuals, though already receiving Medi-Cal benefits, will be able to have more assets and remain eligible after implementation.

ADAP has established outreach and communication plans so that clients and enrollment workers are informed of the new Medi-Cal eligibility criteria and that enrollment workers use the updated criteria to confirm ADAP eligibility. For new and existing clients, eligibility is determined at the initial enrollment or re-enrollment.

Increasing the number of clients eligible for Medi-Cal will result in cost savings to ADAP. Clients who are eligible for this expansion who are not deemed full-scope Medi-Cal will be dually enrolled in Medi-Cal and ADAP. ADAP will pay 100 percent of the prescription drug costs for medications on the ADAP formulary up to the client's Medi-Cal SOC amount.

Description of Change: Beginning January 1, 2024, ADAP clients who previously did not qualify for non-MAGI Medi-Cal based on the previous asset test will be referred to Medi-Cal at initial enrollment or re-enrollment. Clients who enroll into non-MAGI Medi-Cal will have a SOC and result in a cost savings for ADAP as ADAP will cover prescription drug costs on the formulary up to the client's SOC amount.

Discretionary: No

Reason for Adjustment/Change:

- Statutory requirement

Fiscal Impact and Fund Source(s): For 2023-24, the estimated net savings is $10.2 million ($11.7 million savings minus $1.5 million in rebate) for 513 clients. For 2024-25, the estimated net savings is $8.5 million ($19.1 million savings minus $10.6 million rebate) for 513 clients. The funds impacted are the Federal Trust Fund (Fund 0890) and ADAP Rebate Fund (Fund 3080).

Decrease in Federal Funds: 2023 Ryan White Part B Grant

Background: The HRSA Ryan White Part B grant is a non-competitive grant and the largest of the three federal grants for which ADAP receives funding. Grant funding is appropriated in five, 12-month grant budget periods that run from April 1 to March 31. Within the five-year funding cycle, funding from year to year is provided if the program remains eligible and submits all reporting requirements in a timely manner.

On November 16, 2022, OA applied for the 2023 Ryan White Part B grant, the second year of the newest five-year funding cycle. The total funding requested in the grant application was $101.6 million, of which $93.4 million was designated ADAP Local Assistance.

Description of Change: On March 14, 2023, OA received the notice of award for the 2023 Ryan White Part B grant in the amount of $139.8 million, of which $93.4 million was ADAP Local Assistance. On June 12, 2023, OA adjusted the internal allocation of the award between OA branches which decreased the initial $93.4 million designation to $93.3 million for ADAP Local Assistance.

Discretionary: Yes

Reason for Adjustment/Change:
- Fully leverage federal funding

Fiscal Impact and Fund Source(s): Decrease of $135,000 in Local Assistance for 2023-24 and 2024-25. The fund impacted is the Federal Trust Fund (Fund 0890).

Unchanged Assumptions

Increase in Federal Funds: 2023 ADAP Emergency Relief Funds Grant (ADAP Shortfall Relief Grant)

Discontinued Assumptions

Impacts of the Public Health Emergency Unwinding

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued as the Medicaid continuous enrollment requirement ended March 31, 2023.

Medi-Cal Expansion: Age 50 and Older Regardless of Immigration Status

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued as Medi-Cal added ongoing full-scope Medi-Cal coverage and funding for anyone age 50 years and older regardless of immigration status effective May 1, 2022.

American Rescue Plan Act (ARPA) Extension through 2025

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued as the Inflation Reduction Act passed on August 16, 2022, which extends the premium subsidies for individuals through the Affordable Care Act marketplaces through 2025.

Payment of Medicare Part C Premiums (plus Expansion)

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued as the payment of Medicare Part C Premiums began January 1, 2023.

Payment of Medicare Part C Medical Out-of-Pocket Costs

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued as the payment of Medicare Part C Medical Out-of-Pocket Costs began January 1, 2023.

Medicare Coverage of Extra and Innovative Supplemental Plans

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued as the payment of Medicare Coverage of Extra and Innovative Supplemental Plans began August 16, 2022.

Decrease in Federal Funds: 2022 Ryan White Part B Grant

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2022-23 has ended and the funding has already been expended.

Increase in Federal Funds: 2022 Ryan White Part B Supplemental Grant

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2022-23 has ended and the funding has already been expended.

Increase in Federal Funds: 2022 ADAP Emergency Relief Funds Grant (ADAP Shortfall Relief Grant)

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2022-23 has ended and the funding has already been expended.

Decrease in Federal Funds: 2021 Ryan White Part B Grant Carryover

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2022-23 has ended and the funding has already been expended.

VI. Expenditure Details

Tables 5 through 10, starting on the next page, break down caseload and expenditures by client group and service type.

TABLE 5: November Estimate Caseload and Variable Expenditures; Current Year 2023-24						
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	8,642	26.6%	$218,915,786	$0	$0	$218,915,786
Medi-Cal SOC	50	0.2%	$497,082	$0	$0	$497,082
Private insurance*	9,215	28.3%	$20,445,603	$65,030,454	$2,504,797	$87,980,854
Medicare*	6,879	21.2%	$21,741,473	$5,022,653	$352,636	$27,116,761
PrEP-AP	7,720	23.7%	$12,404,735	$0	$3,068,107	$15,472,841
SUBTOTAL	**32,506**	**100.0%**	**$274,004,678**	**$70,053,106**	**$5,925,540**	**$349,983,324**
Admin: ADAP	-	-	$1,522,223	$2,025,551	$1,020,370	$4,568,144
Admin: PrEP-AP	-	-	$3,085,640	$0	$857,668	$3,943,308
Admin: Enrollment	-	-	$0	$0	$0	$7,310,500
HMS	-	-	-$13,881,816	$0	$0	-$13,881,816
TOTAL	**32,506**	**100.0%**	**$264,730,725**	**$72,078,657**	**$7,803,578**	**$351,923,460**

* Subgroup of 11,362 clients receiving assistance for premium payments and medical-out-of-pocket costs.
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

TABLE 6: 2023 Budget Act Caseload and Variable Expenditures						
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	9,657	27.5%	$258,436,183	$0	$0	$258,436,183
Medi-Cal SOC	55	0.2%	$407,504	$0	$0	$407,504
Private insurance*	9,901	28.1%	$20,747,878	$60,683,048	$2,176,150	$83,607,076
Medicare*	7,246	20.6%	$19,557,991	$6,768,022	$458,755	$26,784,768
PrEP-AP	8,318	23.6%	$20,123,691	$0	$4,183,516	$24,307,207
SUBTOTAL	**35,179**	**100.0%**	**$319,273,247**	**$67,451,070**	**$6,818,420**	**$393,542,738**
Admin: ADAP	-	-	$435,511	$1,945,060	$1,012,260	$3,392,831
Admin: PrEP-AP	-	-	$3,128,569	$0	$2,964,246	$6,092,815
Admin: Enrollment	-	-	$0	$0	$0	$6,895,450
HMS	-	-	-$13,881,816	$0	$0	-$13,881,816
TOTAL	**35,179**	**100.0%**	**$308,955,512**	**$69,396,130**	**$10,794,926**	**$396,042,018**

* Subgroup of 11,634 clients receiving assistance for premium payments and medical-out-of-pocket costs.
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

TABLE 7: Difference Between November Estimate and 2023 Budget Act; Current Year 2023-24						
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	-1,016	-10.5%	-$39,520,397	$0	$0	-$39,520,397
Medi-Cal SOC	-6	-10.1%	$89,578	$0	$0	$89,578
Private insurance*	-686	-6.9%	-$302,275	$4,347,405	$328,648	$4,373,779
Medicare*	-367	-5.1%	$2,183,482	-$1,745,370	-$106,119	$331,993
PrEP-AP	-599	-7.2%	-$7,718,956	$0	-$1,115,409	-$8,834,365
SUBTOTAL	**-2,673**	**-7.6%**	**-$45,268,569**	**$2,602,036**	**-$892,881**	**-$43,559,414**
Admin: ADAP	-	-	$1,086,712	$80,491	$8,111	$1,175,314
Admin: PrEP-AP	-	-	-$42,930	$0	-$2,106,578	-$2,149,508
Admin: Enrollment	-	-	$0	$0	$0	$415,050
HMS	-	-	$0	$0	$0	$0
TOTAL	**-2,673**	**-7.6%**	**-$44,224,786**	**$2,682,527**	**-$2,991,348**	**-$44,118,558**

* Subgroup decreased 272 clients receiving assistance for premium payments and medical-out-of-pocket costs.
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

TABLE 8: November Estimate Caseload and Variable Expenditures; Budget Year 2024-25						
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	7,594	23.5%	$205,757,740	$0	$0	$205,757,740
Medi-Cal SOC	50	0.2%	$497,082	$0	$0	$497,082
Private insurance*	9,168	28.3%	$21,908,028	$72,720,696	$3,079,849	$97,708,573
Medicare*	6,648	20.5%	$23,297,077	$5,894,650	$481,150	$29,672,877
PrEP-AP	8,921	27.6%	$17,785,273	$0	$3,428,459	$21,213,732
SUBTOTAL	**32,380**	**100.0%**	**$269,245,200**	**$78,615,346**	**$6,989,457**	**$354,850,003**
Admin: ADAP	-	-	$5,865,945	$2,228,106	$1,105,012	$9,199,063
Admin: PrEP-AP	-	-	$3,902,250	$0	$1,039,389	$4,941,639
Admin: Enrollment	-	-	$0	$0	$0	$7,485,500
HMS	-	-	-$12,493,634	$0	$0	-$12,493,634
TOTAL	**32,380**	**100.0%**	**$266,519,761**	**$80,843,452**	**$9,133,858**	**$363,982,571**

* Subgroup of 12,456 clients receiving assistance for premium payments and medical-out-of-pocket costs.
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

TABLE 9: 2023 Budget Act Caseload and Variable Expenditures						
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	9,657	27.5%	$258,436,183	$0	$0	$258,436,183
Medi-Cal SOC	55	0.2%	$407,504	$0	$0	$407,504
Private insurance*	9,901	28.1%	$20,747,878	$60,683,048	$2,176,150	$83,607,076
Medicare*	7,246	20.6%	$19,557,991	$6,768,022	$458,755	$26,784,768
PrEP-AP	8,318	23.6%	$20,123,691	$0	$4,183,516	$24,307,207
SUBTOTAL	**35,179**	**100.0%**	**$319,273,247**	**$67,451,070**	**$6,818,420**	**$393,542,738**
Admin: ADAP	-	-	$435,511	$1,945,060	$1,012,260	$3,392,831
Admin: PrEP-AP	-	-	$3,128,569	$0	$2,964,246	$6,092,815
Admin: Enrollment	-	-	$0	$0	$0	$6,895,450
HMS	-	-	-$13,881,816	$0	$0	-$13,881,816
TOTAL	**35,179**	**100.0%**	**$308,955,512**	**$69,396,130**	**$10,794,926**	**$396,042,018**

* Subgroup of 10,271 clients receiving assistance for premium payments and medical-out-of-pocket costs.
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

TABLE 10: Difference Between November Estimate and 2023 Budget Act; Budget Year 2024-25						
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	-2,064	-21.4%	-$52,678,444	$0	$0	-$52,678,444
Medi-Cal SOC	-6	-10.1%	$89,578	$0	$0	$89,578
Private insurance*	-733	-7.4%	$1,160,150	$12,037,648	$903,699	$14,101,497
Medicare*	-598	-8.3%	$3,739,086	-$873,373	$22,395	$2,888,109
PrEP-AP	602	7.2%	-$2,338,417	$0	-$755,057	-$3,093,475
SUBTOTAL	**-2,799**	**-8.0%**	**-$50,028,047**	**$11,164,276**	**$171,037**	**-$38,692,735**
Admin: ADAP	-	-	$5,430,434	$283,047	$92,752	$5,806,233
Admin: PrEP-AP	-	-	$773,681	$0	-$1,924,858	-$1,151,177
Admin: Enrollment	-	-	$0	$0	$0	$590,050
HMS	-	-	$1,388,182	$0	$0	$1,388,182
TOTAL	**-2,799**	**-8.0%**	**-$42,435,751**	**$11,447,322**	**-$1,661,068**	**-$32,059,447**

* Subgroup increased 2,185 clients receiving assistance for premium payments and medical-out-of-pocket costs.
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

a) Medication-Only Clients

1. Medication:
    - 2023-24: Costs are projected to be $218.9 million (Table 5), $39.5 million lower than reported in the Budget Act of 2023 (Table 7). The decrease is driven primarily by monthly caseload, which is projected to be lower than previously estimated.
    - 2024-25: Costs are projected to be $205.8 million (Table 8), $52.7 million lower than reported in the Budget Act of 2023 (Table 10). The decrease is driven primarily by the same factor listed above.
2. Health Insurance Premiums: There are no costs for medication-only clients.
3. Medical Out-Of-Pocket Costs: There are no costs for medication-only clients.

b) Medi-Cal SOC Clients

1. Medication:
    - 2023-24: Costs are projected to be $497,000 (Table 5), $90,000 higher than reported in the Budget Act of 2023 (Table 7). The increase is driven primarily by cost per client per month, which is projected to be higher than previously estimated.
    - 2024-25: Costs are projected to be $497,000 (Table 8), $90,000 higher than reported in the Budget Act of 2023 (Table 10). The increase is driven primarily the same factor listed above.
2. Health Insurance Premiums: There are no costs for Medi-Cal SOC clients.
3. Medical Out-Of-Pocket Costs: There are no costs for Medi-Cal SOC clients.

c) Private Insurance Clients

1. Medication:
    - 2023-24: Costs are projected to be $20.4 million (Table 5), $302,000 lower than reported in the Budget Act of 2023 (Table 7). The decrease is driven primarily by monthly caseload, which is projected to be lower than previously estimated.
    - 2024-25: Costs are projected to be $21.9 million (Table 8), $1.2 million higher than reported in the Budget Act of 2023 (Table 10). The increase is driven primarily by cost per client per month, which is projected to be higher than previously estimated.
2. Health Insurance Premiums:
    - 2023-24: Costs are projected to be $65 million (Table 5), $4.3 million higher than reported in the Budget Act of 2023 (Table 7). The

increase is driven primarily by monthly caseload which are projected to be higher than previously estimated.

- 2024-25: Costs are projected to be $72.7 million (Table 8), $12 million higher than reported in the Budget Act of 2023 (Table 10). The increase is driven primarily by the same factor listed above.

3. Medical Out-Of-Pocket Costs:
    - 2023-24: Costs are projected to be $2.5 million (Table 5), $329,000 higher than reported in the Budget Act of 2023 (Table 7). The increase is driven primarily by the cost per medical out-of-pocket benefit service utilization, which is projected to be higher than previously estimated.
    - 2024-25: Costs are projected to be $3.1 million (Table 8), $904,000 higher than reported in the Budget Act of 2023 (Table 10). The increase is driven primarily by the same factor listed above.

d) Medicare Clients

1. Medication:
    - 2023-24: Costs are projected to be $21.7 million (Table 5), $2.2 million higher than reported in the Budget Act of 2023 (Table 7). The increase is driven primarily by cost per client per month, which is projected to be higher than previously estimated.
    - 2024-25: Costs are projected to be $23.3 million (Table 8), $3.7 million higher than reported in the Budget Act of 2023 (Table 10). The increase is driven primarily by the same factor listed above.
2. Health Insurance Premiums:
    - 2023-24: Costs are projected to be $5 million (Table 5), $1.7 million lower than reported in the Budget Act of 2023 (Table 7). The decrease is driven primarily by clients receiving assistance for premium payments, which is projected to be lower than previously estimated.
    - 2024-25: Costs are projected to be $5.9 million (Table 8), $873,000 lower than reported in the Budget Act of 2023 (Table 10). The decrease is driven primarily by the same factor listed above.
3. Medical Out-Of-Pocket Costs:
    - 2023-24: Costs are projected to be $353,000 (Table 5), $106,000 lower than reported in the Budget Act of 2023 (Table 7). The decrease is driven primarily by clients receiving assistance for medical-out-of-pocket costs, which is projected to be lower than previously estimated.
    - 2024-25: Costs are projected to be $481,000 (Table 8), $22,400 higher than reported in the Budget Act of 2023 (Table 10). The increase is driven primarily by the cost per medical out-of-pocket benefit service utilization which is projected to be higher than previously estimated.

e) PrEP-AP Clients

1. Medication:
   - 2023-24: Costs are projected to be $12.4 million (Table 5), $7.7 million lower than reported in the Budget Act of 2023 (Table 7). The decrease is driven primarily by a decrease in monthly caseload and cost per client per month for uninsured clients, which are projected to be lower than previously estimated.
   - 2024-25: Costs are projected to be $17.8 million (Table 8), $2.3 million lower than reported in the Budget Act of 2023 (Table 10). The decrease is driven primarily by cost per client per month for uninsured clients, which is projected to be lower than previously estimated.
2. Health Insurance Premiums: There are no costs for PrEP-AP clients.
3. Medical Out-Of-Pocket Costs:
   - 2023-24: Costs are projected to be $3.1 million (Table 5), $1.1 million lower than reported in the Budget Act of 2023 (Table 7). The decrease is driven primarily by medical out-of-pocket benefit service utilization for uninsured clients, which is projected to be lower than previously estimated.
   - 2024-25: Costs are projected to be $3.4 million (Table 8), $755,000 lower than reported in the Budget Act of 2023 (Table 10). The decrease is driven primarily by the cost per medical out-of-pocket benefit service utilization, which is projected to be lower than previously estimated.

VII. Historical Program Data and Trends

Figures 1 – 3 describe clients served. Enrolled clients who do not incur program costs are excluded.

Figure 1 summarizes ADAP clients served by fiscal year and those also receiving insurance assistance.

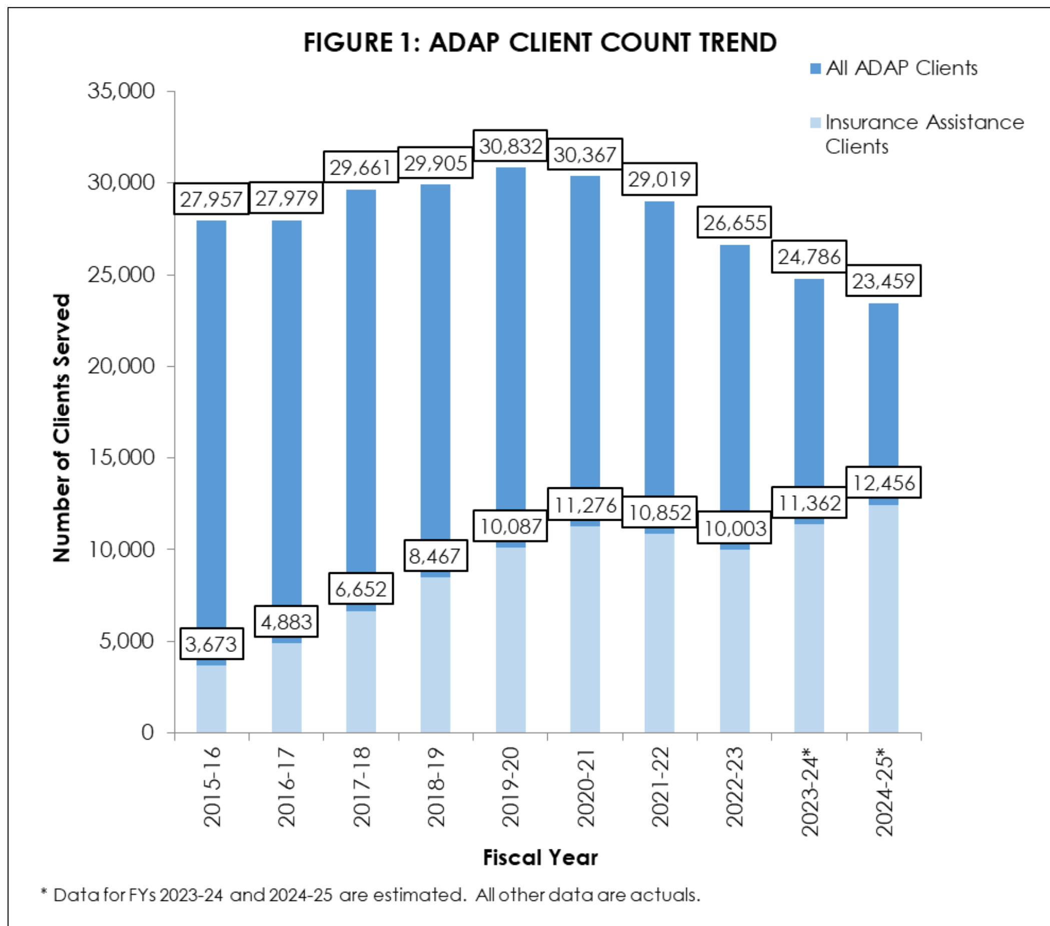


Figure 2 summarizes the proportion of ADAP medication program clients enrolled in the various payer groups by fiscal year.

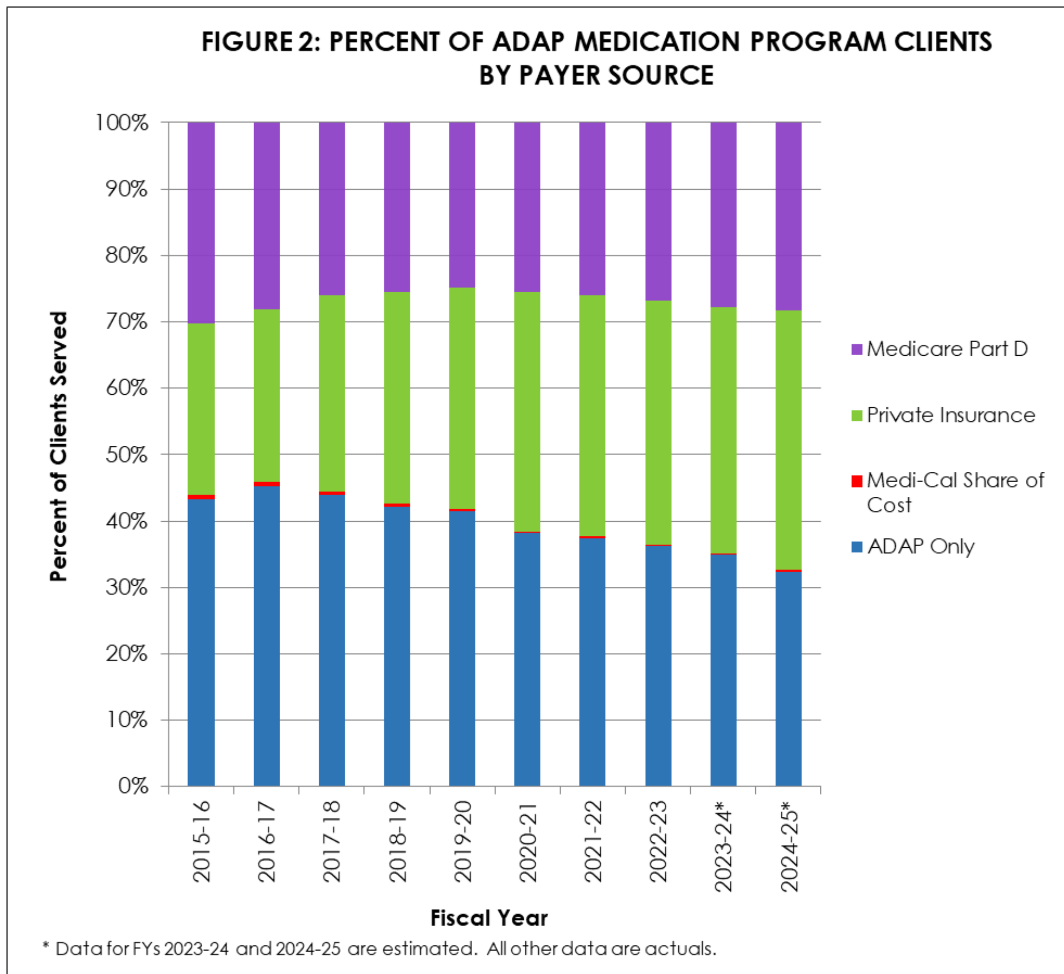


Figure 3 summarizes PrEP-AP clients served by fiscal year.

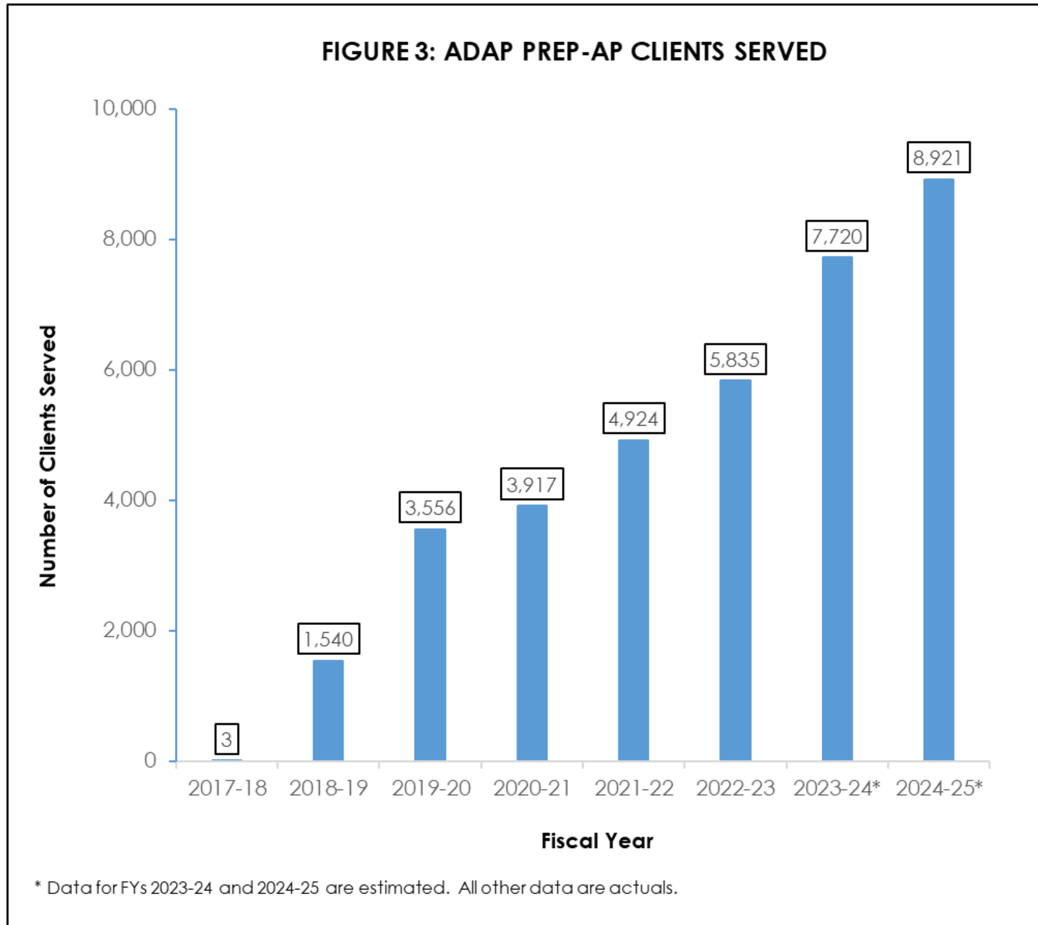
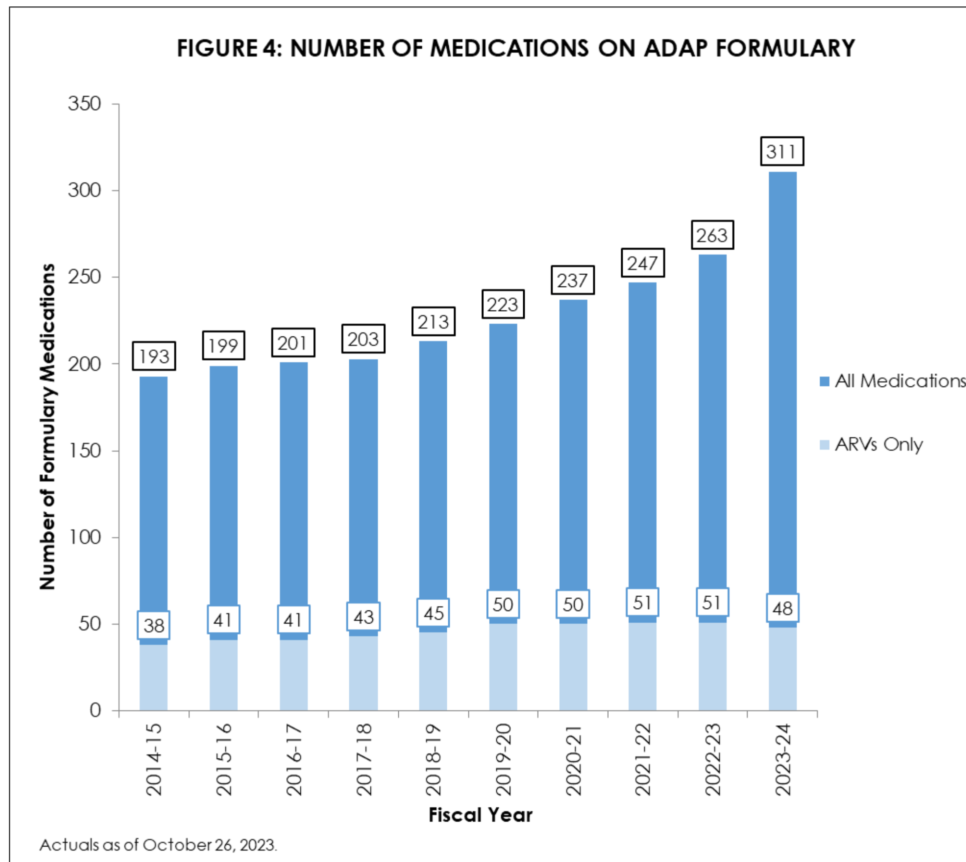


Figure 4 summarizes the number of medications on the ADAP formulary by fiscal year; the number of ARV medications is also shown.



Additions to the ADAP Formulary

The following medications were added to the ADAP formulary on:

April 6, 2023:

- cefdinir, non-ARV, antimicrobials
- cefpodoxime, non-ARV, antimicrobials
- cefuroxime (Ceftin®), non-ARV, antimicrobials
- tinidazole, non-ARV, antimicrobials
- beclomethasone (Beconase AQ), non-ARV, respirator
- podofilox (Condylox®), non-ARV, benzodiazepines

April 25, 2023:

- lenacapavir (Sunlenca®), ARV, capsid inhibitor

June 6, 2023:

- dulaglutide (Trulicity®), non-ARV, glucagon-like petide-1 agonist
- liraglutide (Victoza®), non-ARV, glucagon-like petide-1 agonist
- sitagliptin (Januvia®), non-ARV, dipeptidyl peptidase-4 inhibitors

July 7, 2023:

- tamsulosin (Flomax®), non-ARV, alpha-blocker
- terazosin (Hytrin®), non-ARV, alpha-blocker
- doxazosin (Cardura®), non-ARV, alpha-blocker
- desvenlafaxine (Pristiq®), non-ARV, selective serotonin and norepinephrine reuptake inhibitors
- haloperidol (Haldol®), non-ARV, long-acting injectable first-generation antipsychotic

August 14, 2023:

- fluticasone furoate/umeclidinium/vilanterol (Trelegy Ellipta), non-ARV, respiratory
- fluticasone furoate/vilanterol (BREO Ellipta), non-ARV, respiratory
- fluticasone propionate HFA (Flovent® HFA), non-ARV, respiratory
- fluticasone propionate/salmeterol diskus (Advair, AirDuo®), non-ARV, respiratory
- ipratropium bromide solution (Atrovent®), non-ARV, respiratory
- montelukast (Singulair®), non-ARV, respiratory
- tiotropium bromide (Spiriva® Respimat®), non-ARV, respiratory
- umeclidinium (Incruse® Ellipta®), non-ARV, respiratory
- albuterol HFA (Ventolin® HFA), non-ARV, respiratory
- beclomethasone dipropionate HFA (QVAR® Redihaler™), non-ARV, respiratory
- budesonide HFA (Pulmicort Flexhaler™), non-ARV, respiratory
- budesonide/formoterol fumarate (Breyna™, Symbicort®), non-ARV, respiratory

October 18, 2023:

- Comirnaty (Pfizer), non-ARV, COVID-19 vaccine
- Spikevax (Moderna), non-ARV, COVID-19 vaccine

October 20, 2023:

- control solution for glucometer, non-ARV, diabetes product
- glucometers, non-ARV, diabetes product
- glucose test strips, non-ARV, diabetes product
- insulin aspart (Fiasp, Novolog), non-ARV, antidiabetic
- insulin delivery devices, non-ARV, diabetes product
- insulin detemir (Levemir), non-ARV, antidiabetic
- insulin glargine (Basaglar, Lantus, Rezvoglar, Semglee, Toujeo), non-ARV, antidiabetic
- insulin lispro (Admelog, Humalog, Lyumjev), non-ARV, antidiabetic
- insulin regular (Humulin-R, Novolin-R), non-ARV, antidiabetic

- insulin syringes, non-ARV, diabetes product
- ketone test strips, non-ARV, diabetes product
- lancets, non-ARV, diabetes product
- lancing devices, non-ARV, diabetes product
- pen needles, non-ARV, diabetes product

October 25, 2023:

- amlodipine (Norvasc, Katerzia, Norliqva), non-ARV, antihypertensives
- atenolol (Tenormin), non-ARV, antihypertensives
- carvedilol (Coreg, Coreg CR (carvedilol phosphate)), non-ARV, antihypertensives
- diltiazem, non-ARV, antihypertensives
- enalapril (Vasotec, Epaned), non-ARV, antihypertensives
- metoprolol Succinate (Kapspargo Sprinkle, Toprol XL (extended-release)), non-ARV, antihypertensives
- metoprolol Tartrate (Lopressor), non-ARV, antihypertensives
- nifedipine (Procardia XL (extended-release)), non-ARV, antihypertensives
- olmesartan (Benicar), non-ARV, antihypertensives

<u>Deletions from the ADAP Formulary</u>

The following medications were deleted from the ADAP formulary on August 21, 2023:

- saquinavir (Invirase®), ARV
- delavirdine (Rescriptor®), ARV
- fomivirsen (Vitravene™), non-ARV, antiviral
- codeine/ASA, non-ARV, analgesic
- isoniazid/rifampin (Rifamate®), non-ARV, antituberculosis
- ranitidine bismuth citrate (Zantac®), non-ARV, H_2 Antagonist
- capreomycin (Capastat®), non-ARV, antituberculosis

VIII. Current HIV Epidemiology in California

Approximately 141,000 people in California at the end of 2021 had been diagnosed with HIV and reported to OA. However, OA estimates that 12 percent of all PWH in California are unaware of their infection. Therefore, OA estimates that there were approximately 160,400 PWH in California as of the end of 2021. Since the epidemic began in 1981, approximately 107,000 Californians diagnosed with HIV have died, with over 2,200 dying in 2021 alone.

Of the approximately 141,000 people living with diagnosed HIV (PLWDH) in California, approximately 39.5 percent are Latinx; 35.3 percent are White; 16.8 percent are Black/African American; 4.4 percent are Asian; 3.7 percent are multi-racial; 0.2 percent are American Indian/Alaskan Native; and 0.2 percent are Native Hawaiian/Pacific Islander. While Latinx and Whites make up the largest percentage of PLWDH in California, the rate of HIV among Blacks/African Americans is substantially higher (1,031.6 per 100,000 population, versus 327.1 per 100,000 among Whites and 352.2 per 100,000 among Latinx).

Most of California's living HIV cases are attributed to male-to-male sexual transmission (66.7 percent); 8.3 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); 6.2 percent to men who have sex with men who also inject drugs; 5.4 percent to injection drug use; 1.6 percent to transgender sexual contact; 0.5 percent to perinatal exposure; and 11.3 percent to other or unknown sources including other heterosexual contact.

There are approximately 4,400 new HIV cases reported in California each year, which is a revision from the prior year of approximately 4,000 new HIV cases. Please note COVID-19 may have impacted rates of testing as well as reporting completeness in 2020, so apparent declines in new diagnoses may not reflect declines in actual HIV incidence. The number of PWH in the state is expected to grow by two to three percent each year 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.