

AIDS DRUG ASSISTANCE PROGRAM

2022-23

May Revision Estimate



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

California Department of Public Health

California Department of Public Health

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I. Program Overview

The California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA) administers the Acquired Immunodeficiency Syndrome (AIDS) Drug Assistance Program (ADAP). ADAP provides access to life-saving medications for eligible California residents living with human immunodeficiency virus (HIV), assistance with costs related to HIV pre-exposure prophylaxis (PrEP) for clients at risk for acquiring HIV, and post-exposure prophylaxis (PEP) for clients possibly exposed to 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. 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 PLWH 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 Assistance Program (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, the 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 co-payment 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 clients ADAP served were medication-only clients without health insurance because PLWH 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. To help ensure ADAP is the payer of last resort, ADAP clients are screened for Medi-Cal eligibility and potentially eligible clients must apply. Clients who enroll in full-scope Medi-Cal are dis-enrolled from ADAP because these clients have no SOC, no 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 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 Ryan White Program.

II. Estimate Methodology

The ADAP Estimate uses a hybrid forecasting approach to estimate costs and revenue associated with medication and insurance assistance services. OA creates statistical models using conventional time series approaches with subject matter input to inform assumptions. Statistical models are reviewed for accuracy and adjusted, as appropriate, using knowledge-based forecasting. 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 are summarized by month and insurance coverage group and combined with external cost drivers (e.g., inflation rates). Data are then divided into "training" and "testing" datasets to develop and test statistical models for accuracy by comparing predicted to actual values. OA relies mainly on two types of models: Bayesian Structural Time Series (BSTS) models, also known as a dynamic linear models, and Autoregressive Integrated Moving Average (ARIMA) models. These models account for trends in historical program growth, inflation, 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 and using the delta method to estimate levels of certainty. Subject matter experts collaboratively review model estimates, which are combined with knowledge-based estimates when historical data are not available.

B. Revenue Forecasts

Revenue forecasts are estimated based on the results of the expenditure forecasts and the following drivers:

- Expected unit rebate amounts for statutorily required 340B rebates and voluntary rebates from manufacturers
- Historical rebate payment amounts and average time between medication dispense and receipt of rebate payments
- Historical trends in back-billing

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

III. Estimate Overview

The 2022-23 ADAP May Revision Estimate provides revised projections of 2021-22 and 2022-23 Local Assistance costs for medication, health insurance, medical out-of-pocket costs, ADAP enrollment site payments, and administrative costs. Total estimated budget authority need for 2021-22 and 2022-23, below, includes all assumptions.

Table 1 displays the estimated ADAP Local Assistance budget authority need for 2021-22 (column C) and 2022-23 (column G) and compares that need to the amount reflected in the 2022-23 Governor's Budget (columns B and F). The 2018 Budget Act authorized an on-going \$2 million in budget authority to modify and expand PrEP-AP which is also displayed in Table 1.

- 2021-22: OA estimates the ADAP budget authority need will be \$410.7 million (\$302.5 million ADAP Rebate Fund (Fund 3080) and \$108.2 million Federal Trust Fund (Fund 0890)); which is \$21.6 million lower than reported in the 2022-23 Governor's Budget (Table 1). The 5.0 percent decrease is driven primarily by lower medication expenditures for medication-only (uninsured) clients and lower premium costs than previously estimated (Table 9).
- 2022-23: OA estimates the ADAP budget authority need will be \$455.1 million (\$356.1 million ADAP Rebate Fund (Fund 3080) and \$99 million Federal Trust Fund (Fund 0890)); which is \$34.4 million higher than reported in the 2022-23 Governor's Budget (Table 1). The 8.2 percent increase is driven primarily by lower than previously estimated savings from the Medi-Cal expansion to individuals age 50 years and older (Table 12).

Table 2 displays the estimated ADAP revenue for 2021-22 (column C) and 2022-23 (column G) and compares them to the amount reflected in the 2022-23 Governor's Budget (columns B and F).

- 2021-22: OA estimates ADAP revenue will be \$351 million (Table 2), \$16.7 million lower than reported in the 2022-23 Governor's Budget. The 4.5 percent decrease is driven primarily by lower medication expenditures than previously estimated (Table 9).
- 2022-23: OA estimates ADAP revenue will be \$357.2 million (Table 2), \$3.8 million higher than reported in the 2022-23 Governor's Budget. The

1.1 percent increase is driven primarily by higher medication expenditures than previously estimated. (Table 12).

California Department of Public Health AIDS Drug Assistance Program and PrEP Assistance Program 2022-23 May Revision Table 1: Local Assistance Budget Authority (In Thousands)								
Local Assistance	2022-23 Governor's Budget	Current Year FY 2021-22			2022-23 Governor's Budget	Budget Year FY 2022-23		
		2022-23 May Revision	\$ Change from 2022-23 Governor's Budget	% Change from 2022-23 Governor's Budget		2022-23 May Revision	\$ Change from 2022-23 Governor's Budget	% Change from 2022-23 Governor's Budget
(A)	(B)	(C)	(D) = (C)-(B)	(E) = (D)/(B)	(F)	(G)	(H) = (G)-(F)	(I) = (H)/(F)
Total Funds Requested	\$432,293	\$410,665	-\$21,629	-5.0%	\$420,647	\$455,054	\$34,407	8.2%
Federal Trust Fund - Fund 0890	\$108,172	\$108,172	\$0	0.0%	\$102,207	\$98,950	-\$3,258	-3.2%
ADAP Rebate Fund - Fund 3080	\$322,121	\$300,492	-\$21,629	-6.7%	\$316,440	\$354,105	\$37,665	11.9%
2018 Budget Act - PrEP-AP - Fund 3080	\$2,000	\$2,000	\$0	0.0%	\$2,000	\$2,000	\$0	0.0%
Caseload	34,743	33,112	-1,631	-4.7%	33,687	35,873	2,186	6.5%

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

2022-23 May Revision Table 2: ADAP Rebate Fund (Fund 3080) Revenues (In Thousands)								
Local Assistance	2022-23 Governor's Budget	Current Year FY 2021-22			2022-23 Governor's Budget	Budget Year FY 2022-23		
		2022-23 May Revision	\$ Change from 2022-23 Governor's Budget	% Change from 2022-23 Governor's Budget		2022-23 May Revision	\$ Change from 2022-23 Governor's Budget	% Change from 2022-23 Governor's Budget
(A)	(B)	(C)	(D) = (C)-(B)	(E) = (D)/(B)	(F)	(G)	(H) = (G)-(F)	(I) = (H)/(F)
Total Revenue Requested	\$367,649	\$350,956	-\$16,693	-4.5%	\$353,322	\$357,165	\$3,843	1.1%
ADAP Rebate Fund - Fund 3080	\$359,649	\$348,715	-\$10,935	-3.0%	\$345,322	\$354,923	\$9,601	2.8%
Interest Income	\$8,000	\$2,242	-\$5,758	-72.0%	\$8,000	\$2,242	-\$5,758	-72.0%

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 enrollment expenditures.

a) Health care expenditures include prescription medication costs for drugs 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.). 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 7 – 12.

b) Enrollment expenditures are payments to local ADAP and PrEP-AP enrollment sites for services needed to enroll and maintain clients in ADAP and PrEP-AP. Enrollment expenditure estimates are adjusted annually through the ADAP Estimate, based on caseload and service

projections. Estimated expenditures for enrollment services are also shown in Table 3.

CLIENT GROUP	EXPENDITURES	
	FY 2021-22	FY 2022-23
Medication-Only	\$281,378,919	\$302,785,103
Medi-Cal SOC	\$1,075,803	\$1,187,709
Private Insurance	\$92,625,759	\$99,631,301
Medicare	\$26,643,472	\$31,792,410
PrEP-AP	\$8,093,735	\$12,278,789
SUBTOTAL	\$409,817,687	\$447,675,311
Admin Costs: ADAP	\$4,346,146	\$4,780,760
Admin Costs: PrEP-AP	\$533,783	\$5,226,161
Admin Costs: Enrollment	\$6,859,080	\$6,975,000
Health Management Systems (HMS)	-\$12,892,069	-\$11,602,862
TOTAL	\$408,664,627	\$453,054,371
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 rebate revenue exists because of the time required for billing the drug manufacturers and receipt of the rebate. 2021-22 revenue projections are based on estimated rebate returns applied to actual medication expenditures through December 2021 and projected expenditures through June 2022. 2022-23 revenue projections are based on estimated rebate returns applied to estimated drug expenditures for the 2022-23 fiscal year.
- b) Federal Funds – ADAP receives federal funds from HRSA through the Ryan White Part B Program.
 - 2021-22: Total federal fund budget authority will not change from the \$108.2 million (Table 1) reported in the 2022-23 Governor's Budget. Federal fund budget authority includes the following Unchanged Assumptions:
 - 2021 Ryan White Part B Supplemental grant: \$1.9 million
 - 2021 Ryan White Part B grant: \$95 million
 - 2021 ADAP Emergency Relief Funds grant (also called ADAP Shortfall Relief grant): \$5.3 million
 - 2020 Ryan White Part B grant (Carryover): \$6 million

- 2022-23: Total federal fund budget authority is projected to be \$99 million (Table 1), \$3.3 million (3.2 percent) lower than reported in the 2022-23 Governor's Budget. Federal fund budget authority includes the following estimated grant funding:
 - 2022 Ryan White Part B grant: \$95 million
 - 2022 Ryan White Part B Supplemental grant: \$1.9 million
 - 2022 ADAP Emergency Relief Funds grant (ADAP Shortfall Relief grant): \$2 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 2021 Ryan White Part B grant year (April 1, 2021, through March 31, 2022) was \$67.2 million. The 2022 match requirement is anticipated to be communicated in early summer 2022.

V. Assumptions

Future Fiscal Issues

This section introduces factors that may have a future fiscal impact that is uncertain at this time (e.g., new Legislation, new standards of practice in the industry, or new major program Request for Proposal).

California Generic Drugs

Background: Senate Bill (SB) 852 (Chapter 207, Statutes of 2020), the California Affordable Drug Manufacturing Act of 2020, was signed by the Governor and chaptered by the Secretary of State on September 28, 2020. SB 852 requires the California Health and Human Services Agency (CalHHS) to enter into partnerships, in consultation with other state departments as necessary, to increase competition, lower prices, and address shortages in the market for generic prescription drugs. This bill also aims to reduce the cost of prescription drugs for public and private purchasers, taxpayers, consumers, and to increase patient access to affordable drugs.

SB 852 requires CalHHS to provide the Legislature with the status of the drugs targeted for manufacture by July 1, 2022. By July 1, 2023, CalHHS must report on the feasibility and advantages of directly manufacturing or distributing generic prescription drugs and selling generic prescription drugs at a fair price. CalHHS will have to (1) determine if viable manufacturing or distribution pathways exist for this effort and (2) determine the optimal method of achieving cost savings before it is known how discounts could be received by ADAP.

Until the July 2022 and 2023 reports to the Legislature can be reviewed, ADAP will be unable to determine whether discounted pricing achieved by the State is lower than the pricing already received by ADAP through the federal ADAP Crisis Task Force (ACTF) and the HRSA 340B Drug Pricing Program.

Description of Change: No change from 2022-23 November Estimate. It remains unclear how or if this bill would affect ADAP.

Discretionary: No

Reason for Adjustment/Change:

- Statutory requirement

Fiscal Impact and Fund Source(s): The fiscal impact is currently unknown. The funds impacted are the Federal Trust Fund (Fund 0890) and ADAP Rebate Fund (Fund 3080).

Expansion of Medi-Cal to 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, proposed in Assembly Bill (AB) 1624 and SB 840, will extend 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 so that ADAP remains 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 qualify for full scope Medi-Cal will be disenrolled from ADAP. Individuals newly diagnosed with HIV will, if income qualified, be able to enroll in Medi-Cal instead of ADAP.

Description of Change: No change from 2022-23 November Estimate.

Discretionary: No

Reason for Adjustment/Change:

- Statutory requirement

Fiscal Impact and Fund Source(s): There is no identified impact to 2021-22 or 2022-23 program costs. Program savings are not expected to be realized until 2023-24. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

New Assumptions

This section introduces policy, fiscal, or programmatic changes that will have a major impact on enrollment services, or resource needs.

Impact of the Novel Coronavirus (COVID-19)

Background: On March 4, 2020, California declared a state of emergency in response to the COVID-19 pandemic. Shortly after, on March 19, 2020, California issued a Shelter-In-Place order. The order has had a tremendous impact on Californians, ranging from a sharp rise in unemployment to possible loss of comprehensive health coverage. For ADAP clients, the potential impact can be life threatening as people with a serious underlying medical condition, including those with compromised immune systems, are at higher risk for COVID-19-related

complications. To reduce COVID-19 exposure and the risk of clients falling out of HIV care, OA took steps so that ADAP clients would maintain their program eligibility. Those measures included allowing clients to enroll virtually with their enrollment worker and increasing the number of allowable medication dispenses, which would reduce the number of trips a client would need to make to the pharmacy.

In March 2020, ADAP saw a spike in medication costs following the first COVID-19 Shelter-In-Place orders. This initial spike was followed by a series of smaller magnitude increases and decreases through the end of the calendar year. After a short period of cost volatility at the beginning of the pandemic, OA saw a sustained drop in its ADAP client medication benefits caseload once COVID-19 automatic eligibility extensions ended in August 2020. Since March 2020, OA has also seen increases in its premium expenditures, as previously uninsured or underinsured clients enrolled in ADAP's premium assistance programs. However, after accounting for differences in insurance coverage, underlying trends, seasonal variation, and other cost drivers, total costs continued to be lower than expected.

On January 28, 2021, Covered California announced it would join President Biden in responding to the COVID-19 pandemic by announcing a special enrollment period to help people obtain insurance coverage. Effective February 1, 2021, through May 15, 2021, anyone uninsured and eligible to enroll in health care coverage through Covered California could sign up. On February 2, 2021, President Biden signed the federal mandate Public Charge Executive Order in an effort to remove barriers to the legal immigration system.

The expansion of Covered California's enrollment period and the increased accessibility to public benefits are believed to have contributed to the overall reduction in the size of ADAP's uninsured client caseload.

Description of Change: Given the sustained shifts in ADAP caseload since March 2020, OA expects the COVID-19 cost impacts to medication and insurance assistance programs to continue long term. Cost savings have been primarily driven by lower than expected uninsured caseload volume and shifts in insurance coverage (caseload mix) for clients using ADAP medication benefits. Decreases in ADAP's uninsured caseload and associated cost savings have greatly exceeded any cost increases associated with medication prices and increases to ADAP's insurance assistance caseload.

Discretionary: No

Reason for Adjustment/Change:

- Federal mandate

Fiscal Impact and Fund Source(s): Estimated savings for 2021-22 is \$12.3 million, broken down as follows: \$18 million for 561 fewer medication benefit clients per month, offset by a cost increase of \$5.7 million for 1,255 additional monthly premium assistance clients. Estimated savings for 2022-23 is \$9.1 million, broken down as follows: \$13.8 million for 537 fewer medication benefit clients per month, offset by a cost increase of \$4.7 million for 1,279 additional monthly premium assistance clients. The funds impacted are the Federal Trust Fund (Fund 0890) and ADAP Rebate Fund (Fund 3080).

Payment of Medicare Part C Premiums (plus Expansion)

Background: ADAP pays private health insurance premiums and outpatient medical out-of-pocket costs for ADAP clients co-enrolled in the Office of AIDS Health Insurance Premium Payment Program (OA-HIPP), Medicare Part D Premium Payment Program (MDPP), and the Employer Based Health Insurance Premium Payment Program (EB-HIPP). When ADAP clients become eligible for Medicare, they must enroll in Medicare to help ensure ADAP is the payer of last resort. Only clients enrolled in a Medicare Part D health plan may receive insurance premium and outpatient medical out-of-pocket assistance through MDPP; MDPP clients can also request Medicare Supplemental (Medigap) Plan premium assistance. In contrast, clients who enroll in a Medicare Part C plan receive no premium or medical out-of-pocket cost assistance through ADAP, which creates a lack of parity in ADAP's Medicare services.

Medicare Part C, also known as Medicare Advantage, is a bundled insurance plan that includes hospital (Medicare Part A), medical (Medicare Part B) and prescriptions (Medicare Part D). According to HRSA Policy Clarification Notice (PCN) 18-01, Ryan White HIV/AIDS Program grant recipients may use funds to pay premiums and/or cost sharing when the Medicare Part C plan includes prescription drug coverage; or in conjunction with paying for Medicare Part D premiums and cost sharing for plans that do not include prescription drug coverage.

ADAP proposes to use ADAP rebate funds to establish the Medicare Part C Premium Payment Program and pay for Medicare Part C premiums for eligible ADAP clients.

Description of Change: To provide sufficient time for discovery, coordination with ADAP's contractors, and seamless program implementation, OA will start implementing processes for the Medicare Part C Payment Program in 2022-23.

Discretionary: Yes

Reason for Adjustment/Change:

- Encourage more ADAP clients to enroll into comprehensive health coverage, which will result in an overall reduction in ADAP expenditures
- Improve the overall health of PLWH in California because clients will have comprehensive hospital coverage
- Continue supporting health insurance coverage for ADAP clients as they become eligible for Medicare
- Align Medicare Part C with other health insurance premium payment programs

Fiscal Impact and Fund Source(s): There are no estimated costs for 2021-22 due to the 2022-23 implementation date. Estimated cost for 2022-23 is \$1.7 million for 780 eligible clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

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

Background: In addition to paying private health insurance premiums for ADAP clients co-enrolled in the OA-HIPP, EB-HIPP, and MDPP programs, ADAP also pays for outpatient medical out-of-pocket costs. ADAP proposes to pay for outpatient medical out-of-pocket costs for clients co-enrolled in the Medicare Part C Premium Payment Program.

Health and Safety Code (HSC) Section 120955 (i) states that the department may subsidize, using available federal funds and monies from the ADAP rebate fund, costs associated with a health care service plan or health insurance policy, including medical co-payments and deductibles for outpatient care, and premiums to purchase or maintain health insurance coverage.

ADAP proposes to use ADAP rebate funds to establish the Medicare Part C Premium Payment Program and pay for Medicare Part C outpatient medical out-of-pocket costs for eligible ADAP clients.

Description of Change: To provide sufficient time for discovery, coordination with ADAP's contractors, and seamless program implementation, OA will start implementing processes for the Medicare Part C Payment Program in 2022-23.

Discretionary: Yes

Reason for Adjustment/Change:

- Establish equitable benefits for ADAP's insurance assistance programs
- Continue supporting health insurance coverage for ADAP clients as they become eligible for Medicare

Fiscal Impact and Fund Source(s): There are no estimated costs for 2021-22 due to the 2022-23 implementation date. Estimated cost for 2022-23 is \$239,000 for 300 eligible clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Medicare Coverage of Extra and Innovative Supplemental Plans

Background: Original Medicare consists of Part A (hospitalization) and Part B (medical insurance). Medicare Part B covers 80 percent of costs that clients incur after meeting their annual deductible. Medicare Supplemental (Medigap) plans assist with the remaining 20 percent of costs.

There are varying levels of coverage for Medicare supplemental plans (A-N), with plans F and G being the most comprehensive. The most comprehensive plans also offer “Extra” or “Innovative” benefits to cover services outside of the base medical coverage. For example, Extra/Innovative plans may cover the costs of hearing aids, vision exams, Silver Sneaker gym memberships, 24/7 nurse consultations, and many other services. Due to various advancements in HIV care and treatment, PLWH are living longer. Extra and Innovative plans would be a public health benefit for our aging population by offering services that may mitigate future non-HIV related care. For example, Silver Sneaker gym memberships can decrease social isolation and help improve cardiovascular and bone health.

The MDPP began paying Medicare Part B supplemental medical plan premiums June 1, 2018. Effective July 1, 2020, SB 407 (Chapter 549, Statutes of 2019), requires Extra and Innovative benefits to be separated on all Medicare supplemental billing statements. MDPP pays for Medicare Part D premiums, Part B out-of-pocket costs, and the base premium for supplemental plans. Supplemental plans with Extra or Innovative benefits included may have lower total premium costs compared to identical supplemental plans that do not include the additional benefits. Clients are required to cover the nominal costs for Extra or Innovative benefits.

ADAP proposes to use ADAP rebate funds to pay Medicare Part B supplemental plan premiums including the Extra and Innovative benefits.

Description of Change: To provide sufficient time for discovery, coordination with ADAP's contractors, and seamless program implementation, OA will start implementing processes for the coverage of Extra or Innovative benefits in 2022-23.

Discretionary: Yes

Reason for Adjustment/Change:

- Improve the overall health of PLWH in California as additional plan benefits offer a more holistic approach to healthcare
- More plan choices improve access to care
- Continue supporting health insurance coverage for ADAP clients as they become eligible for Medicare

Fiscal Impact and Fund Source(s): There are no estimated costs for 2021-22 due to the 2022-23 implementation date. Estimated cost for 2022-23 is \$899,000 for 268 eligible 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 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 the PrEP-AP to assist both insured and uninsured individuals who meet eligibility requirements. The 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 (Committee on Budget, 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.

Description of Change: Planning and development of a competitive solicitation is underway. Stakeholder engagement is planned for early 2022 to assess capability, interest, and need. The solicitation is tentatively planned for release in the summer of 2022 and agreements with approved entities would commence January 2023. This project has been named the PrEP and PEP Initiation and Retention Initiative (PPIRI) to avoid confusion with CDPH/OA HIV Prevention Branch PrEP Navigation projects.

Discretionary: No

Reason for Adjustment/Change:

- Legislative requirement

Fiscal Impact and Fund Source(s): There is no estimated cost for 2021-22 due to the 2022-23 implementation date. The total estimated cost for 2022-23 is \$4.8 million (\$3.7 million for 25 staff and operating expenses; \$929,000 for variable costs (example: PrEP starter packs); \$10,000 for indirect costs; and \$203,000 for 68 new PrEP-AP clients, inclusive of medication and medical-out-of-pocket costs). The fund impacted is the ADAP Rebate Fund (Fund 3080).

Potential Change in Federal Funds: 2022 Ryan White Part B Grant

Background: The 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 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.

Description of Change: On November 8, 2021, OA applied for the 2022 Ryan White Part B grant, the first year of the newest five-year funding cycle. The total funding requested in the grant application is \$135.8 million, of which \$95 million is designated ADAP Local Assistance. On March 22, 2022, OA received a notice of partial award for the 2022 Ryan White Part B grant in the amount of \$49 million, of which \$35 million is ADAP Local Assistance. The estimate accounts for the partial award of \$35 million, and the remaining portion of the award will be accounted for in the 2023-24 Governor's Budget.

Discretionary: Yes

Reason for Adjustment/Change:

- Fully leverage federal funding

Fiscal Impact and Fund Source(s): The fiscal impact is currently unknown. The fund impacted is the Federal Trust Fund (Fund 0890).

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

Background: The ADAP Emergency Relief Funds grant (ADAP Shortfall Relief grant) is intended for states/territories that demonstrate the need for additional resources to prevent, reduce and/or eliminate ADAP waiting lists through implementation of cost-containment measures. OA's cost-containment measures

include maintaining data match agreements to help ensure ADAP is the payer of last resort.

The following table displays the historical grant application amounts for which OA applied, and the total funds awarded per grant budget period:

Table 4: ADAP Emergency Relief Funds (Shortfall Relief) Grant		
Grant Budget Period	Application Amount	Total Funds Awarded
2018 (04/01/2018 – 03/31/2019)	\$11,000,000	\$11,000,000
2019 (04/01/2019 – 03/31/2020)	\$11,000,000	\$11,000,000
2020 (04/01/2020 – 03/31/2021)	\$10,000,000	\$6,537,311
2021 (04/01/2021 – 03/31/2022)	\$7,000,000	\$5,307,130
2022 (04/01/2022 – 03/31/2023)	\$7,000,000	\$2,049,483

Description of Change: On October 25, 2021, OA applied for the maximum amount of \$7 million for the competitive 2022 ADAP Emergency Relief Funds grant, all of which is designated ADAP Local Assistance. On February 23, 2022, OA received the notice of award for the 2022 ADAP Emergency Relief Funds grant in the amount of \$2 million (all Local Assistance).

Discretionary: Yes

Reason for Adjustment/Change:

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

Fiscal Impact and Fund Source(s): Decrease of \$3.3 million in Local Assistance for 2022-23. The fund impacted is the Federal Trust Fund (Fund 0890).

Existing Assumptions

This section includes revised major assumptions that were previously approved and included as part of the base estimate, but have since changed.

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

Background: The 2021-22 Governor's Budget expanded eligibility for full-scope Medi-Cal benefits to all persons aged 50 years and older, regardless of immigration status. As the federal government only shares in the cost of restricted-scope services, this expansion is primarily funded by State resources.

California law allows eligible citizens and immigrants of any status to apply for comprehensive, or full-scope, Medi-Cal coverage if they are under age 25. Prior

to this enactment, persons aged 25 years and over with undocumented status could only apply for restricted-scope Medi-Cal.

Historically, only citizens and documented immigrants were eligible to apply for full-scope Medi-Cal. In 2016, the legislature authorized full-scope Medi-Cal coverage for undocumented persons aged 18 years and under. In 2020, full-scope Medi-Cal coverage for those with undocumented status was expanded to ages 19 to 25. This latest budget enhancement adds ongoing funding for full-scope Medi-Cal coverage for anyone aged 50 years and over, regardless of immigration status.

Increasing the number of clients eligible for full-scope Medi-Cal will result in cost savings to ADAP. Existing clients who qualify for this expansion will be disenrolled from ADAP as these clients have no share of cost, no drug co-pays or deductibles, and no premiums. This change becomes effective May 1, 2022.

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 clients, eligibility is determined at the initial enrollment. Existing clients who may qualify for this expansion will be notified by mail and their Medi-Cal eligibility will be confirmed by their re-enrollment deadline (client's birthday).

Description of Change: ADAP serves approximately 2,016 uninsured clients between the ages of 50 and 64 years old who could potentially become newly Medi-Cal eligible. ADAP expects that 50 percent of these clients will transition to Medi-Cal starting in late 2021-22. Those remaining, who are newly eligible, will transition to Medi-Cal throughout 2022-23.

Discretionary: No

Reason for Adjustment/Change:

- Statutory requirement

Fiscal Impact and Fund Source(s): Estimated savings for 2021-22 is \$4.8 million for 1,023 clients. Estimated savings for 2022-23 is \$29 million for 2,045 clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

ADAP Pilot Program for Jails

Background: Prior to 2008, 36 local county jails participated in the 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 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 ensuring 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 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, ensuring 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 their county jail. OA, in consultation with the Department of Finance, may consider expanding the pilot program in the future to other interested county jails after careful consideration of the impact to the ADAP Rebate Fund, both in the short and long term.

Description of Change: OA will meet with the other interested county jails in the summer of 2022 to understand how they address the transitional needs of PLWH who have been incarcerated. OA will then determine if the respective jails would be a suitable ADAP jail enrollment site. Prior to enrolling eligible clients, interested county jails will submit a new Enrollment Site Application, enter into a contract with OA, be added to the Pharmacy Benefits Manager Pharmacy Network, and complete the new enrollment worker training. As OA intends to engage with the other interested counties and implement new pilots in 2022-23, no funding will be necessary for 2021-22 associated with expansion of ADAP's Pilot Program for Jails to the other interested counties.

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): The projected fiscal impact of Orange County in 2021-22 is \$1.1 million from serving 123 eligible clients. For 2022-23, the projected fiscal impact of Orange County is \$933,000 from serving 107 eligible clients. For 2022-23, the projected fiscal impact of six interested counties including Orange County in 2022-23 is \$15.1 million from serving 1,733 eligible clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

Unchanged Assumptions

This section includes major assumptions that were previously approved and included as part of the base estimate that have not changed.

U.S. Preventive Services Task Force (USPSTF) “A” Grade Recommendation on PrEP for Persons at High Risk of HIV Acquisition

Background: On June 11, 2019, the USPSTF gave the recommendation of an “A” grade for PrEP for persons who are at high risk of HIV acquisition. The USPSTF makes recommendations regarding the effectiveness of specific preventive care services for patients without obvious related signs or symptoms. The Patient Protection and Affordable Care Act states a medical insurer must cover and may not impose any cost sharing requirement for any evidence-based preventive items or services that have a grade of “A” or “B” in the current USPSTF recommendations. Federal regulations require plans and issuers to provide coverage for new recommended preventive services for plan/policy years beginning on or after the date that is one year from the date the relevant recommendation or guideline is issued. For most insurers, the USPSTF PrEP recommendation was implemented January 1, 2021.

Coverage requirements apply to most private plans, including individual, small group, large group, and self-insured plans in which employers contract administrative services to a third-party payer. Exceptions exist for certain religious employers and for plans that were in existence prior to March 23, 2010; these plans cannot make significant changes to their coverage (for example, increasing patient cost-sharing, cutting benefits, or reducing employer contributions).

Prior to the USPSTF recommendation, many health plans did not cover PrEP as a preventive service. OA required insured PrEP-AP clients to enroll into Gilead's Co-payment Assistance Program, which provides co-pay assistance with Truvada® and Descovy®. In response to USPSTF's recommendation, and as a result of generic PrEP medications becoming available, PrEP-AP changed its policy. Clients are only required to enroll into Gilead's Co-payment Assistance Program if they are prescribed Truvada® or Descovy® and are in a health plan that does not cover PrEP. PrEP-AP clients with private insurance enrolled in Gilead's Co-payment Assistance Program are eligible for PrEP medication co-payment

assistance of up to \$7,200 per calendar year. After this threshold has been met, PrEP-AP provides wrap-around coverage for any remaining Truvada® and Descovy® medication co-payments for the remainder of the calendar year.

As the number of health plans implementing the USPSTF grows, PrEP-AP costs for insured clients are expected to drop. As of January 1, 2021, all health plans regulated by the Department of Insurance and Department of Managed Health Care implemented the USPSTF recommendation.

Description of Change: No change from the 2022-23 November Estimate.

Discretionary: No

Reason for Adjustment/Change:

- USPSTF “A” grade recommendation
- Federal and state legislative requirements

Fiscal Impact and Fund Source(s): No additional budget authority is needed for 2021-22 and 2022-23. Estimated savings for 2021-22 is \$3.3 million, for 2,316 fewer insured PrEP-AP clients. Estimated savings for 2022-23 is \$4.3 million, for an estimated 3,292 fewer insured PrEP-AP clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

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

Background: The 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, co-morbidities, cost of care, and service needs of emerging populations.

On May 10, 2021, OA applied for the competitive 2021 Ryan White Part B Supplemental grant. OA requested the maximum amount of \$9 million, of which \$8.9 million was designated ADAP Local Assistance.

On September 1, 2021, OA received the notice of award for the 2021 Ryan White Part B Supplemental grant. The total award was \$1.9 million, most of which is ADAP Local Assistance.

The following table displays Ryan White Part B Supplemental grant application amounts, total funds awarded, and total ADAP Local Assistance received per grant budget period, including the newest award of \$1.9 million.

Table 5: Ryan White Part B Supplemental Funds			
Grant Budget Period	Application Amount	Total Funds Awarded	Total Local Assistance
2017 (09/30/2017 – 09/29/2018)	\$35,000,000	\$35,000,000	\$25,000,000
2018 (09/30/2018 – 09/29/2019)	\$35,000,000	\$23,765,871	\$17,000,000
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

Description of Change: No change from 2022-23 November Estimate.

Discretionary: Yes

Reason for Adjustment/Change:

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

Fiscal Impact and Fund Source(s): No additional budget authority is needed for 2021-22 and 2022-23. The fund impacted is the Federal Trust Fund (Fund 0890).

Decrease in Federal Funds: 2021 Ryan White Part B Grant

Background: The 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 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 20, 2020, OA applied for the 2021 Ryan White Part B grant, the fifth year of the latest five-year funding cycle. The funding requested in the grant application totaled \$137.1 million, of which \$96.2 million was designated ADAP Local Assistance.

On March 17, 2021, OA received the notice of award for the 2021 Ryan White Part B grant. The total award received was \$135.7 million, of which \$95 million is ADAP Local Assistance.

Description of Change: No change from 2022-23 November Estimate.

Discretionary: Yes

Reason for Adjustment/Change:

- Fully leverage federal funding

Fiscal Impact and Fund Source(s): No additional budget authority is needed for 2021-22 and 2022-23. The fund impacted is the Federal Trust Fund (Fund 0890).

Decrease in Federal Funds: 2021 ADAP Emergency Relief Funds Grant (ADAP Shortfall Relief Grant)

Background: The ADAP Emergency Relief Funds grant (ADAP Shortfall Relief grant) is intended for states/territories that demonstrate the need for additional resources to prevent, reduce and/or eliminate ADAP waiting lists through implementation of cost-containment measures. OA's cost-containment measures include maintaining data match agreements to help ensure ADAP is the payer of last resort.

On October 26, 2020, OA applied for the maximum amount of \$7 million for the competitive 2021 ADAP Emergency Relief Funds grant, all of which was designated ADAP Local Assistance.

On March 12, 2021, OA received the notice of award for the 2021 ADAP Emergency Relief Funds grant in the amount of \$5.3 million, all of which is ADAP Local Assistance.

The following table displays the historical grant application amounts for which OA applied, and the total funds awarded per grant budget period:

Table 6: ADAP Emergency Relief Funds (Shortfall Relief) Grant		
Grant Budget Period	Application Amount	Total Funds Awarded
2017 (04/01/2017 – 03/31/2018)	\$9,000,000	\$9,000,000
2018 (04/01/2018 – 03/31/2019)	\$11,000,000	\$11,000,000
2019 (04/01/2019 – 03/31/2020)	\$11,000,000	\$11,000,000
2020 (04/01/2020 – 03/31/2021)	\$10,000,000	\$6,537,311
2021 (04/01/2021 – 03/31/2022)	\$7,000,000	\$5,307,130

Description of Change: No change from 2022-23 November Estimate.

Discretionary: Yes

Reason for Adjustment/Change:

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

Fiscal Impact and Fund Source(s): No additional budget authority is needed for 2021-22. The fund impacted is the Federal Trust Fund (Fund 0890).

Increase in Federal Funds: 2020 Ryan White Part B Grant Carryover

Background: The 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 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.

At the end of August 2021, OA closed out the 2020 Ryan White Part B grant with HRSA and applied for carryover funding. Upon closure of the grant, the amount of unspent funding was determined to be \$6.3 million, of which \$6 million was designated ADAP Local Assistance.

On October 27, 2021, OA received the carryover notice of award in the amount of \$6.3 million, of which \$6 million is ADAP Local Assistance. Carryover funding will be spent in 2021-22.

Description of Change: No change from 2022-23 November Estimate.

Discretionary: Yes

Reason for Adjustment/Change:

- Fully leverage federal funding

Fiscal Impact and Fund Source(s): No additional budget authority is needed for 2021-22. The fund impacted is the Federal Trust Fund (Fund 0890).

Discontinued Assumptions

This section includes major assumptions that were previously approved and impacts which have already been incorporated into the base estimate.

Expansion of PrEP-AP

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued as the following enhancements were implemented with the corresponding dates: 1) PrEP medication for insured clients without requiring use of the manufacturer's assistance program if it is not accepted by the client's

health plan or pharmacy contracted by the health plan implemented on March 1, 2019; 2) payment of PEP and related medical costs implemented on October 4, 2019; 3) PrEP-AP access for individuals 12 years of age or older implemented on June 4, 2020; and 4) the ability to consider insured individuals as uninsured for confidentiality or safety reasons implemented on June 4, 2020. On June 29, 2020, Governor Newsom approved AB 80 (Chapter 12, Statutes of 2020), which contained trailer bill language amending HSC 120972 to subsidize up to 30 days of PrEP and PEP medications for the prevention of HIV infection, without regard to whether the person was a victim of sexual assault. The passage of the bill eliminates the barrier of having to repackage medication for starter packs. Thus, this eliminates the need for PrEP-AP to pay for PEP and PrEP starter packs regardless if PrEP-AP eligibility requirements are met or if the individual was a victim of sexual assault. PrEP-AP will not be implementing payment of insurance premiums for clients enrolled in the PrEP-AP as cost estimates exceed current budget authority for this expansion.

Decrease in Federal Funds: 2020 Ryan White Part B Grant

Why is Change Needed/Reason for Adjustment: Since 2020-21 has ended, and the funding has already been expended, this assumption will be discontinued.

Decrease in Federal Funds: 2020 Ryan White Part B Supplemental Grant

Why is Change Needed/Reason for Adjustment: Since 2020-21 has ended, and the funding has already been expended, this assumption will be discontinued.

Federal Funds: 2020 ADAP Emergency Relief Funds Grant (ADAP Shortfall Relief Grant)

Why is Change Needed/Reason for Adjustment: Since 2020-21 has ended, and the funding has already been expended, this assumption will be discontinued.

Increase in Federal Funds: 2019 Ryan White Part B Grant Carryover

Why is Change Needed/Reason for Adjustment: Since 2020-21 has ended, and the funding has already been expended, this assumption will be discontinued.

VI. Expenditure Details

Tables 7 through 12, starting on the next page, break down caseload and expenditures by client group and service type.

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	8,897	26.9%	\$281,378,919	\$0	\$0	\$281,378,919
Medi-Cal SOC	101	0.3%	\$1,075,803	\$0	\$0	\$1,075,803
Private insurance*	10,879	32.9%	\$22,827,449	\$68,192,839	\$1,605,471	\$92,625,759
Medicare*	7,521	22.7%	\$22,584,885	\$3,789,195	\$269,392	\$26,643,472
PrEP-AP	5,714	17.3%	\$6,748,926	\$0	\$1,344,809	\$8,093,735
SUBTOTAL	33,112	100.0%	\$334,615,982	\$71,982,033	\$3,219,672	\$409,817,687
Admin Costs: ADAP	-	-	\$1,989,380	\$1,497,242	\$859,524	\$4,346,146
Admin Costs: PrEP-AP	-	-	\$315,139	\$0	\$218,644	\$533,783
Admin Costs: Enrollment	-	-	\$0	\$0	\$0	\$6,859,080
HMS	-	-	-\$12,892,069	\$0	\$0	-\$12,892,069
TOTAL	33,112	100.0%	\$324,028,432	\$73,479,276	\$4,297,840	\$408,664,627

* Subgroup of 12,621 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.

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	11,000	31.7%	\$296,107,031	\$0	\$0	\$296,107,031
Medi-Cal SOC	101	0.3%	\$1,070,816	\$0	\$0	\$1,070,816
Private insurance*	10,872	31.3%	\$22,829,066	\$74,497,460	\$1,784,713	\$99,111,239
Medicare*	7,520	21.6%	\$22,551,159	\$3,929,472	\$269,392	\$26,750,023
PrEP-AP	5,250	15.1%	\$4,680,372	\$0	\$1,335,835	\$6,016,207
SUBTOTAL	34,743	100.0%	\$347,238,444	\$78,426,932	\$3,389,940	\$429,055,317
Admin Costs: ADAP	-	-	\$2,314,733	\$2,105,624	\$1,109,008	\$5,529,365
Admin Costs: PrEP-AP	-	-	\$350,615	\$0	\$254,206	\$604,821
Admin Costs: Enrollment	-	-	\$0	\$0	\$0	\$7,275,000
HMS	-	-	-\$12,171,376	\$0	\$0	-\$12,171,376
TOTAL	34,743	100.0%	\$337,732,416	\$80,532,557	\$4,753,154	\$430,293,127

* Subgroup of 12,160 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.

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	-2,103	-19.1%	-\$14,728,112	\$0	\$0	-\$14,728,112
Medi-Cal SOC	0	0.0%	\$4,987	\$0	\$0	\$4,987
Private insurance*	7	0.1%	-\$1,617	-\$6,304,621	-\$179,242	-\$6,485,481
Medicare*	1	0.0%	\$33,726	-\$140,278	\$0	-\$106,552
PrEP-AP	464	8.8%	\$2,068,554	\$0	\$8,974	\$2,077,528
SUBTOTAL	-1,631	-4.7%	-\$12,622,462	-\$6,444,899	-\$170,268	-\$19,237,630
Admin Costs: ADAP	-	-	-\$325,353	-\$608,382	-\$249,484	-\$1,183,219
Admin Costs: PrEP-AP	-	-	-\$35,477	\$0	-\$35,562	-\$71,038
Admin Costs: Enrollment	-	-	\$0	\$0	\$0	-\$415,920
HMS	-	-	-\$720,693	\$0	\$0	-\$720,693
TOTAL	-1,631	-4.7%	-\$13,703,985	-\$7,053,281	-\$455,314	-\$21,628,500

* Subgroup increased 461 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: May Revision Caseload and Variable Expenditures: Budget Year 2022-23

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	10,393	29.0%	\$302,785,103	\$0	\$0	\$302,785,103
Medi-Cal SOC	103	0.3%	\$1,187,709	\$0	\$0	\$1,187,709
Private insurance*	10,900	30.4%	\$24,135,323	\$73,683,229	\$1,812,749	\$99,631,301
Medicare*	7,536	21.0%	\$24,357,919	\$6,925,619	\$508,871	\$31,792,410
PrEP-AP	6,941	19.3%	\$10,826,716	\$0	\$1,452,073	\$12,278,789
SUBTOTAL	35,873	100.0%	\$363,292,770	\$80,608,848	\$3,773,693	\$447,675,311
Admin Costs: ADAP	-	-	\$2,188,318	\$1,646,967	\$945,476	\$4,780,760
Admin Costs: PrEP-AP	-	-	\$3,085,462	\$0	\$2,140,700	\$5,226,161
Admin Costs: Enrollment	-	-	\$0	\$0	\$0	\$6,975,000
HMS	-	-	-\$11,602,862	\$0	\$0	-\$11,602,862
TOTAL	35,873	100.0%	\$356,963,687	\$82,255,815	\$6,859,869	\$453,054,371

* Subgroup of 13,839 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 11: 2022-23 Governor's Budget Caseload and Variable Expenditures: Budget Year 2022-23

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	9,499	28.2%	\$270,831,264	\$0	\$0	\$270,831,264
Medi-Cal SOC	103	0.3%	\$1,182,264	\$0	\$0	\$1,182,264
Private insurance*	10,893	32.3%	\$24,147,460	\$82,787,588	\$2,009,643	\$108,944,692
Medicare*	7,536	22.4%	\$24,330,300	\$4,625,204	\$269,627	\$29,225,130
PrEP-AP	5,656	16.8%	\$5,754,969	\$0	\$1,329,019	\$7,083,988
SUBTOTAL	33,687	100.0%	\$326,246,257	\$87,412,792	\$3,608,289	\$417,267,338
Admin Costs: ADAP	-	-	\$2,049,455	\$2,297,045	\$1,209,827	\$5,556,326
Admin Costs: PrEP-AP	-	-	\$382,490	\$0	\$277,315	\$659,805
Admin Costs: Enrollment	-	-	\$0	\$0	\$0	\$7,335,000
HMS	-	-	-\$12,171,376	\$0	\$0	-\$12,171,376
TOTAL	33,687	100.0%	\$316,506,825	\$89,709,837	\$5,095,431	\$418,647,093

* Subgroup of 12,993 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 12: Difference Between May Revision and 2022-23 Governor's Budget: Budget Year 2022-23

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	894	9.4%	\$31,953,839	\$0	\$0	\$31,953,839
Medi-Cal SOC	0	0.0%	\$5,445	\$0	\$0	\$5,445
Private insurance*	7	0.1%	-\$12,137	-\$9,104,359	-\$196,895	-\$9,313,391
Medicare*	0	0.0%	\$27,619	\$2,300,416	\$239,245	\$2,567,279
PrEP-AP	1,285	22.7%	\$5,071,747	\$0	\$123,054	\$5,194,801
SUBTOTAL	2,186	6.5%	\$37,046,513	-\$6,803,943	\$165,404	\$30,407,974
Admin Costs: ADAP	-	-	\$138,863	-\$650,078	-\$264,351	-\$775,566
Admin Costs: PrEP-AP	-	-	\$2,702,972	\$0	\$1,863,384	\$4,566,357
Admin Costs: Enrollment	-	-	\$0	\$0	\$0	-\$360,000
HMS	-	-	\$568,514	\$0	\$0	\$568,514
TOTAL	2,186	6.5%	\$40,456,862	-\$7,454,022	\$1,764,438	\$34,407,279

* Subgroup increased 846 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:

- 2021-22: Costs are projected to be \$281.4 million (Table 7), \$14.7 million lower than reported in the 2022-23 Governor's Budget (Table 9). The decrease is driven primarily by drug costs, which are projected to be lower than previously estimated.
 - 2022-23: Costs are projected to be \$302.8 million (Table 10), \$32 million higher than reported in the 2022-23 Governor's Budget (Table 12). The increase is driven primarily by higher client volume than previously estimated.
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:

- 2021-22: Costs are projected to be \$1.1 million (Table 7), \$5,000 higher than reported in the 2022-23 Governor's Budget (Table 9). The increase is driven primarily by Medi-Cal SOC client medication cost per month, which is projected to be higher than previously estimated.
 - 2022-23: Costs are projected to be \$1.2 million (Table 10), \$5,000 higher than reported in the 2022-23 Governor's Budget (Table 12). The increase is driven primarily by 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:

- 2021-22: Costs are projected to be \$22.8 million (Table 7), \$1,600 lower than reported in the 2022-23 Governor's Budget (Table 9). The decrease is driven primarily by private insurance client medication cost per month, which is projected to be lower than previously estimated.
 - 2022-23: Costs are projected to be \$24.1 million (Table 10), \$12,000 lower than reported in the 2022-23 Governor's Budget (Table 12). The decrease is driven primarily by the same factor listed above.
2. Health Insurance Premiums:
 - 2021-22: Costs are projected to be \$68.2 million (Table 7), \$6.3 million lower than reported in the 2022-23 Governor's Budget (Table 9). The

decrease is driven primarily by (1) more clients purchasing On-Exchange plans, and fewer clients purchasing Off-Exchange plans and (2) lower average monthly premiums due to federal and state subsidies than previously estimated.

- 2022-23: Costs are projected to be \$73.7 million (Table 10), \$9.1 million lower than reported in the 2022-23 Governor's Budget (Table 12). The decrease is driven primarily by the same factors listed above.
3. Medical Out-Of-Pocket Costs:
- 2021-22: Costs are projected to be \$1.6 million (Table 7), \$179,000 lower than reported in the 2022-23 Governor's Budget (Table 9). 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.
 - 2022-23: Costs are projected to be \$1.8 million (Table 10), \$197,000 lower than reported in the 2022-23 Governor's Budget (Table 12). The decrease is driven primarily by the same factor listed above.

d) Medicare Clients

1. Medication:
- 2021-22: Costs are projected to be \$22.6 million (Table 7), \$34,000 higher than reported in the 2022-23 Governor's Budget (Table 9). The increase is driven primarily by Part D medication cost per month, which is projected to be higher than previously estimated.
 - 2022-23: Costs are projected to be \$24.4 million (Table 10), \$28,000 higher than reported in the 2022-23 Governor's Budget (Table 12). The increase is driven primarily by the same factor listed above.
2. Health Insurance Premiums:
- 2021-22: Costs are projected to be \$3.8 million (Table 7), \$140,000 lower than reported in the 2022-23 Governor's Budget (Table 9). The decrease is driven primarily by the Part D client mix reflecting a lower percent of clients with Medigap premiums than previously estimated.
 - 2022-23: Costs are projected to be \$6.9 million (Table 10), \$2.3 million higher than reported in the 2022-23 Governor's Budget (Table 12). The increase is driven primarily by the implementation of the payment of Part C Premiums, and Part B Coverage of Extra and Innovative Supplemental Plans.
3. Medical Out-Of-Pocket Costs:
- 2021-22: Costs are not projected to change from the \$269,000 (Table 7) reported in the 2022-23 Governor's Budget (Table 9).
 - 2022-23: Costs are projected to be \$509,000 (Table 10), \$239,000 higher than reported in the 2022-23 Governor's Budget (Table 12).

The increase is driven primarily by the implementation of the payment of Part C Medical-Out-Of-Pocket costs.

e) PrEP-AP Clients

1. Medication:

- 2021-22: Costs are projected to be \$6.7 million (Table 7), \$2.1 million higher than reported in the 2022-23 Governor's Budget (Table 9). The increase is driven primarily by the PrEP-AP client count, which is projected to be higher than previously estimated due to higher than expected utilization of the PrEP-AP option to consider insured individuals as uninsured for confidentiality or safety reasons.
- 2022-23: Costs are projected to be \$10.8 million (Table 10), \$5.1 million higher than reported in the 2022-23 Governor's Budget (Table 12). The increase is driven primarily by implementation of PPIRI.

2. Health Insurance Premiums: There are no costs for PrEP-AP clients.

3. Medical Out-Of-Pocket Costs:

- 2021-22: Costs are projected to be \$1.3 million (Table 7), \$9,000 higher than reported in the 2022-23 Governor's Budget (Table 9). The increase in is driven primarily by PrEP-AP client volume and service utilization, which are projected to be higher than previously estimated.
- 2022-23: Costs are projected to be \$1.5 million (Table 10), \$123,000 higher than reported in the 2022-23 Governor's Budget (Table 12). The increase is driven primarily by the same factors listed above.

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.

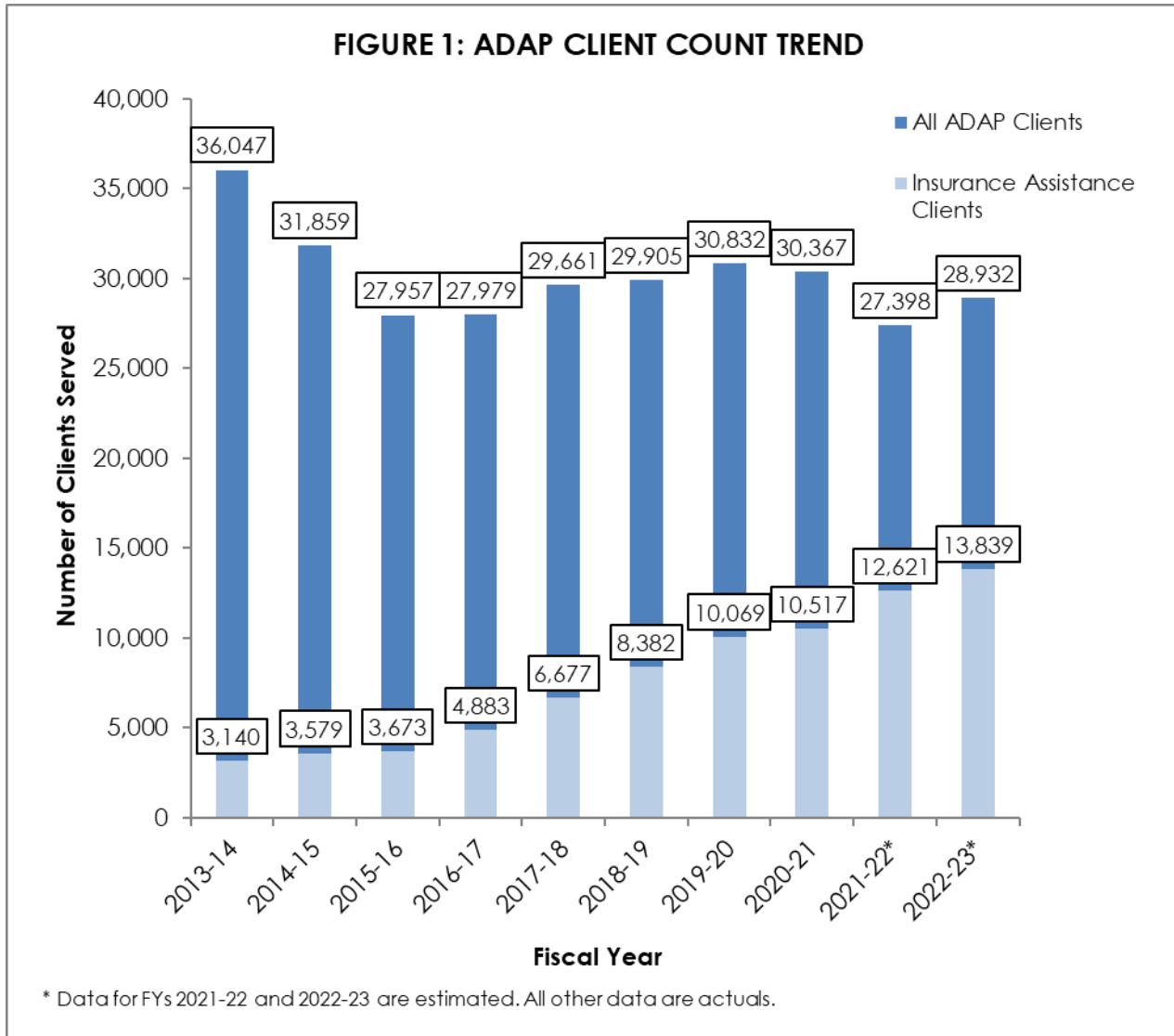


Figure 2 summarizes the proportion of ADAP medication program clients enrolled in the various payer groups by fiscal year.

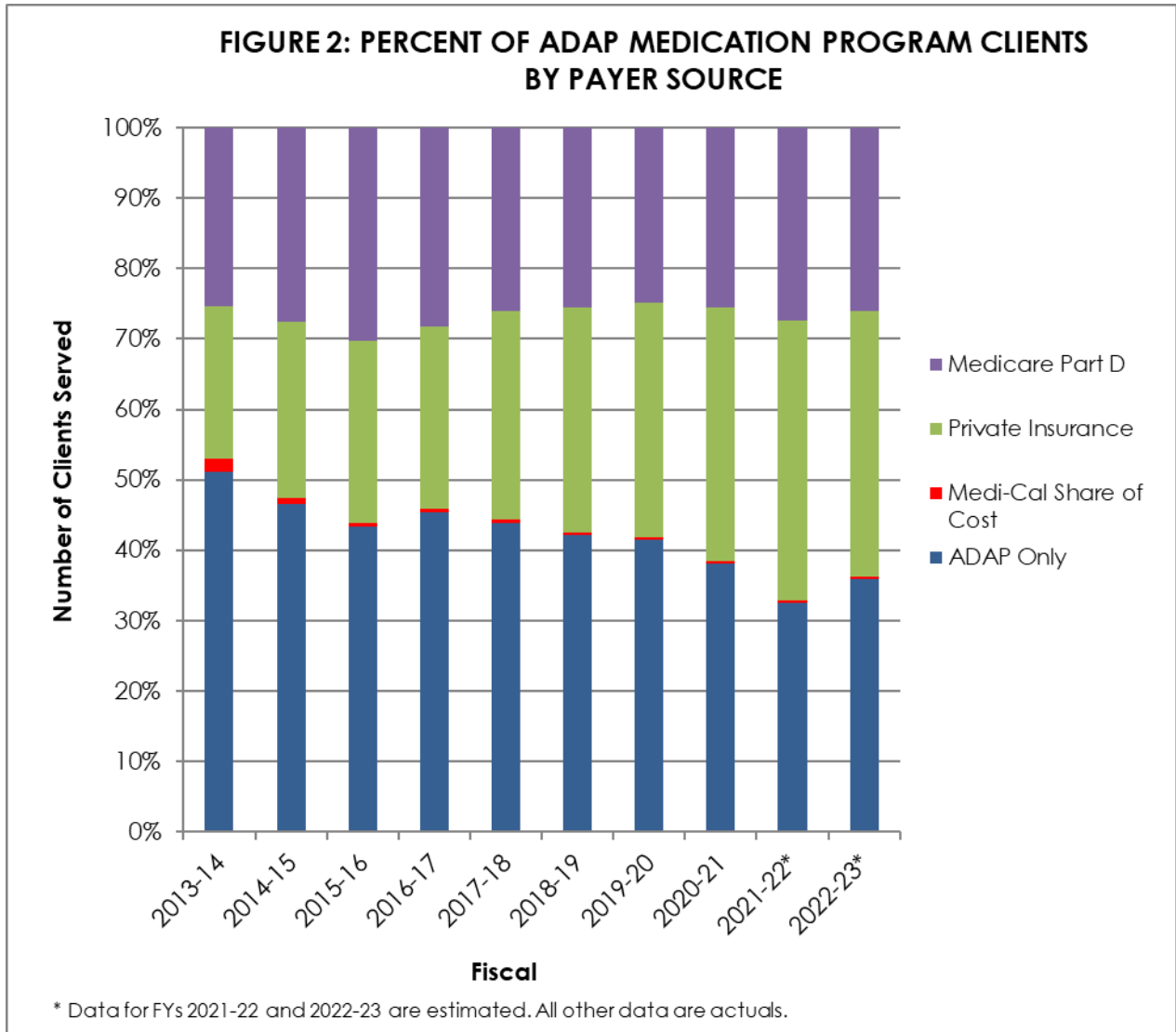


Figure 3 summarizes PrEP-AP clients served by fiscal year.

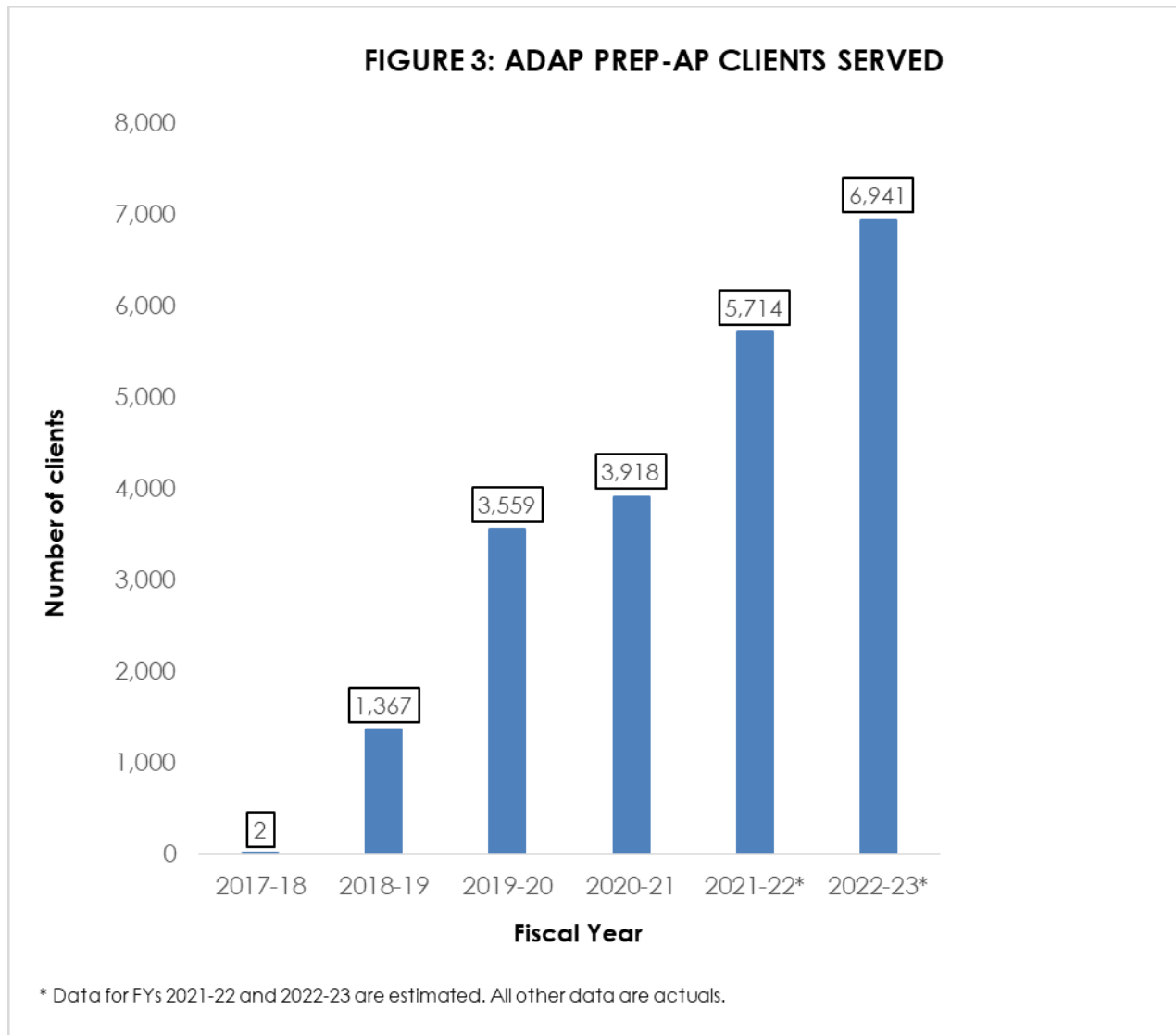
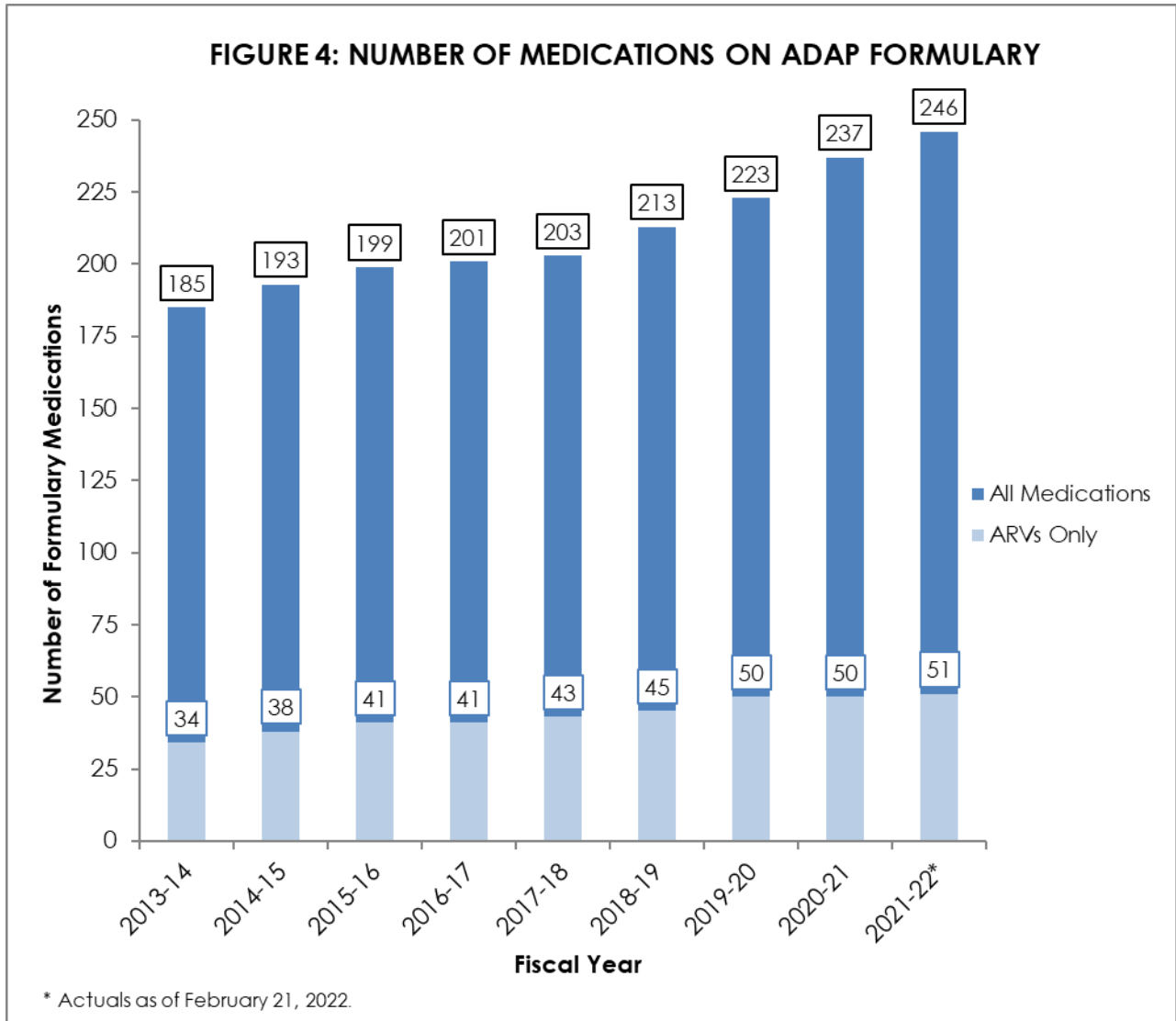


Figure 4 summarizes the number of medications on the ADAP formulary by fiscal year; the number of antiretroviral (ARV) medications is also shown.



Additions to the ADAP Formulary

There are currently no additions to the ADAP Formulary.

Deletions from the ADAP Formulary

There are currently no deletions to the ADAP Formulary.

VIII. Current HIV Epidemiology in California

Approximately 137,700 people in California at the end of 2019 had been diagnosed with HIV and reported to OA. However, OA estimates that 13 percent of all PLWH in California are unaware of their infection. Therefore, OA estimates that there were approximately 159,000 PLWH in California as of the end of 2019. Since the epidemic began in 1981, approximately 103,000 Californians diagnosed with HIV have died, with over 1,900 dying in 2019 alone.

Of the approximately 137,700 people living with diagnosed HIV (PLWDH) in California, approximately 37.7 percent are Latinx; 37.2 percent are White; 17.0 percent are Black/African American; 4.2 percent are Asian; 3.4 percent are multi-racial; 0.3 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 (984.5 per 100,000 population, versus 347.8 per 100,000 among Whites and 334.9 per 100,000 among Latinx).

Most of California's living HIV cases are attributed to male-to-male sexual transmission (66.6 percent); 8.5 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); 6.4 percent to men who have sex with men who also inject drugs; 5.6 percent to injection drug use; 1.5 percent to transgender sexual contact; 0.5 percent to perinatal exposure; and 10.9 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 4,700 new HIV cases. One potential driver of the decrease may be the increasing rate of viral suppression among living HIV cases over that time period from around 61 percent in 2015 to over 65 percent in 2019. The number of PLWH 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.