AIDS DRUG ASSISTANCE PROGRAM

2021-22

May Revision Estimate

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I. Program Overview

The California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA) administers the 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 sub-divided into three client sub-groups: Covered California clients, non-Covered California clients, and employer-based insurance clients. These groups receive services associated with medication costs, health insurance premiums, and medical out-of-pocket costs.
4. **Medicare Part D clients** are PLWH who are enrolled in Medicare and have purchased Medicare Part D plans for medication coverage. This group receives services associated with medication co-pays, medical out-of-pocket costs, and Medicare Part D health insurance premiums. Qualifying Medicare Part D clients can receive premium assistance with Medigap supplemental insurance policies, which cover medical out-of-pocket costs.
5. **PrEP Assistance Program** (**PrEP-AP) clients** are HIV-negative individuals who are at risk of HIV infection 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 as medication is provided free by the manufacturer's medication assistance program.

As a covered entity in the Health Resources & Services Administration (HRSA) 340B Drug Pricing Program, ADAP collects rebates for a majority of prescriptions purchased for ADAP clients. ADAP does not collect rebates for prescriptions purchased for Medi-Cal SOC or PrEP-AP clients. As the primary payer, Medi-Cal has the right to claim mandatory rebate on prescriptions for Medi-Cal SOC clients. In order to ensure duplicate rebate claims are not submitted to manufacturers by both programs, which is prohibited, ADAP does not invoice for rebates on these claims. 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 (ACA), more ADAP clients have been able to access public and private health insurance coverage. To ensure ADAP is the payer of last resort, ADAP clients are screened for Medi-Cal eligibility and potential 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 for 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 Overview

The 2021-22 ADAP May Revision Estimate provides a revised projection of 2020-21 Local Assistance costs for medication, health insurance, medical out-of-pocket costs, ADAP enrollment sites, and administrative costs, along with projected Local Assistance costs for 2021-22.

Table 1 displays the estimated ADAP Local Assistance budget authority need for 2020-21 and 2021-22 and compares that need to the amount reflected in the 2021-22 Governor's Budget.

- For 2020-21, OA estimates the ADAP budget authority need will be $455.5 million, which is an $11.9 million decrease in budget authority compared to the 2021-22 Governor's Budget. The decrease is primarily due to lower projected medication expenditures for medication-only clients (see key influences on ADAP expenditures on page 4 for more detail).
- For 2021-22, OA estimates the ADAP budget authority need will be $489.5 million, which is a $13.9 million decrease in budget authority compared to the 2021-22 Governor's Budget. The decrease is primarily due to lower projected medication expenditures for medication-only clients (see key influences on ADAP expenditures on page 4 for more detail).

Table 2 displays the estimated ADAP revenue for 2020-21 and 2021-22 and compares them to the amount reflected in the 2021-22 Governor's Budget.

- For 2020-21, OA estimates ADAP revenue will be $420 million, which is an $11 million decrease compared to the 2021-22 Governor's Budget. The decrease is primarily due to lower projected medication expenditures (see revenue on page 6 for more detail).
- For 2021-22, OA estimates ADAP revenue will be $410.6 million, which is a $39.2 million decrease compared to the 2021-22 Governor's Budget. The decrease is primarily due to lower projected medication expenditures (see revenue on page 6 for more detail).

California Department of Public Health
AIDS Drug Assistance Program and PrEP Assistance Program
2021-22 May Revision
Table 1: Local Assistance Budget Authority
(In Thousands)

Local Assistance	2021-22 Governor's Budget	Current Year FY 2020-21			2021-22 Governor's Budget	Budget Year FY 2021-22		
		2021-22 May Revision	$ Change from 2021-22 Governor's Budget	% Change from 2021-22 Governor's Budget		2021-22 May Revision	$ Change from 2021-22 Governor's Budget	% Change from 2021-22 Governor's Budget
Total Funds Requested	**$467,334**	**$455,461**	**-$11,873**	**-2.5%**	**$503,466**	**$489,538**	**-$13,927**	**-2.8%**
Federal Trust Fund - Fund 0890	$105,350	$109,140	$3,791	3.6%	$105,350	$105,350	$0	0.0%
ADAP Rebate Fund - Fund 3080	$361,985	$346,321	-$15,663	-4.3%	$398,116	$384,189	-$13,927	-3.5%
Caseload	34,733	34,162	-571	-1.6%	35,164	35,154	-10	0.0%

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
Note: Change in Federal Trust Fund - Fund 0890 reflects $3.8 million in carryover that was not included in the Governor's Budget display due to timing of receipt from HRSA.

2021-22 May Revision
Table 2: ADAP Rebate Fund (Fund 3080) Revenues
(In Thousands)

Local Assistance	2021-22 Governor's Budget	Current Year FY 2020-21			2021-22 Governor's Budget	Budget Year FY 2021-22		
		2021-22 May Revision	$ Change from 2021-22 Governor's Budget	% Change from 2021-22 Governor's Budget		2021-22 May Revision	$ Change from 2021-22 Governor's Budget	% Change from 2021-22 Governor's Budget
Total Revenue Requested	**$431,085**	**$420,058**	**-$11,028**	**-2.6%**	**$449,764**	**$410,591**	**-$39,173**	**-8.7%**
ADAP Rebate Fund - Fund 3080	$423,085	$412,058	-$11,028	-2.6%	$441,764	$402,591	-$39,173	-8.9%
Interest Income	$8,000	$8,000	$0	0.0%	$8,000	$8,000	$0	0.0%

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

III. Overview Projections

A. Key influences on ADAP Expenditures

a) 2020-21: Compared to the 2021-22 Governor's Budget, OA's projected 2020-21 expenditures decreased by 2.5 percent (Table 1). The decrease is primarily due to lower projected medication-only caseload and associated medication expenditures (Table 9).

b) 2021-22: Compared to the 2021-22 Governor's Budget, OA's projected 2021-22 expenditures decreased by 2.8 percent (Table 1). The decrease is primarily due to lower projected medication-only caseload and associated medication expenditures (Table 12).

B. Expenditure Types

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

a) Health care expenditures are estimated based on five client groups. Four of the client groups are PLWH: Medication-only clients, Medi-Cal SOC clients, private insurance clients, and Medicare Part D

clients. The fifth client group includes persons at risk for HIV who are receiving PrEP and are referred to as PrEP-AP clients. Services the different client groups receive can include coverage of the following health care expenses: 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 V, Tables 7-12.

b) Enrollment expenditures are estimated based on local ADAP enrollment services: OA allocates funds directly to ADAP and PrEP-AP enrollment sites based on ADAP and PrEP-AP services provided. These funds may only be used for costs associated with enrolling and maintaining 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 shown in Table 3.

TABLE 3: ESTIMATED VARIABLE EXPENDITURES BY CLIENT GROUP

CLIENT GROUP	EXPENDITURES	
	FY 2020-21	FY 2021-22
Medication-Only	$ 326,697,586	$ 339,619,898
Medi-Cal SOC	$ 1,348,709	$ 1,511,813
Private Insurance	$ 92,016,900	$ 110,326,385
Medicare Part D	$ 23,048,543	$ 24,542,320
PrEP-AP	$ 4,584,656	$ 5,518,013
SUBTOTAL	**$447,696,394**	**$481,518,429**
Enrollment Costs	$7,765,000	$8,020,000
TOTAL	**$455,461,394**	**$489,538,429**

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

C. Revenue

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. 2020-21 revenue projections are based on estimated rebates from estimated and

actual medication expenditures from January through December 2020. 2021-22 revenue projections are based on estimated rebates from estimated drug expenditures from January through December 2021.

- For 2020-21, OA's projected ADAP rebate revenue decreased by 2.6 percent from $431.1 million in the 2021-22 Governor's Budget to $420.0 million in the revised current year forecast (Table 2). The decrease is primarily due to lower projected medication expenditures from medication-only clients and Medicare Part D clients.

- For 2021-22, OA's projected ADAP rebate revenue decreased by 8.7 percent from $449.8 million in the 2021-22 Governor's Budget to $410.6 million in the revised budget year forecast (Table 2). Similar to above, the decrease is primarily due to a decrease in projected medication expenditures from medication-only clients and Medicare Part D clients.

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

- For 2020-21, total federal fund budget authority will not change from the $109.1 million established in the 2021-22 Governor's Budget. Federal fund budget authority includes the following Unchanged Assumptions:
  - 2020 Ryan White Part B grant (ADAP Earmark): $96.2 million
  - 2020 Ryan White Part B Supplemental grant: $2.6 million
  - 2020 ADAP Emergency Relief Funds grant (also called ADAP Shortfall Relief grant): $6.5 million
  - 2019 Ryan White Part B grant carryover: $3.8 million[1]

- For 2021-22, total federal fund budget authority will not change from the $105.4 million established in the 2021-22 Governor's Budget. Federal fund budget authority includes the following estimates:
  - 2021 Ryan White Part B grant (ADAP Earmark): $96.2 million
  - 2021 Ryan White Part B Supplemental grant: $2.6 million
  - 2021 ADAP Emergency Relief Funds grant: $6.5 million

c) Federal Match – HRSA requires grantees to have HIV-related non-HRSA expenditures. California's HRSA match requirement for the

[1] $3.8 million not reflected in Governor's Budget display due to timing of receipt from HRSA.

2020 Ryan White Part B grant year (April 1, 2020 through March 31, 2021) was $67.9 million. OA met the match requirement using General Fund State Operations and Local Assistance expenditures from OA's HIV Surveillance and Prevention Programs as well as HIV-related expenditures from the California Department of Corrections and Rehabilitation. The 2021 match requirement is anticipated to be communicated late March 2021.

IV. Assumptions

Future Fiscal Issues

Expansion of PrEP-AP

Background: The 2018 Budget Act included $2 million ongoing to support proposals to modify the PrEP-AP by expanding eligibility and accessibility to the PrEP-AP pursuant to Health and Safety Code (HSC) 120972, authorized through Assembly Bill (AB) 1810 (Chapter 34, Statutes of 2018). Approved enhancements include: 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, 2) payment of PEP and related medical costs, 3) payment for PEP and PrEP starter packs, regardless of whether PrEP-AP eligibility requirements are met, 4) PrEP-AP access for individuals 12 years of age or older, 5) the ability to consider insured individuals as uninsured for confidentiality or safety reasons, 6) up to 28 days of PEP medication for victims of sexual assault regardless of whether PrEP-AP eligibility requirements are met and 7) payment of insurance premiums for clients enrolled in the PrEP-AP if it will result in cost-savings to the state. OA is pursuing a phased implementation strategy and has worked with stakeholders to prioritize implementation of enhancements to the PrEP-AP approved in the 2018 Budget Act. Enhancements one, two, four, five, and six have been implemented. On June 29, 2020, Governor Newsom approved AB 80 (Chapter 12, Statues 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.

Description of Change: OA is in the process of implementing enhancement three and expects completion in 2021.

Discretionary: No

Reason for Adjustment/Change:

- Change to HSC Section 120972.
- Passage of AB 80.

Fiscal Impact and Fund Source(s): OA does not project a need for additional budget authority beyond the $2 million for 2020-21 or 2021-22 at this time. OA is continually monitoring costs for the PrEP-AP expansion and will provide future updates if projected costs cannot be absorbed within the existing $2 million budget authority. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Impact of the Novel Coronavirus (COVID-19)

Background: On March 4, 2020, California declared a state of emergency over the COVID-19 pandemic. Shortly after March 19, 2020, California issued a stay-at-home order. The order has had a tremendous impact on Californians, ranging from a sharp rise in unemployment to possible loss of comprehensive health coverage. The potential impact specifically to ADAP clients can be life threatening. People who have a serious underlying medical condition might be at higher risk for severe illness, including people with compromised immune systems. In order to mitigate against unnecessary exposure, OA has taken steps to ensure ADAP clients maintain their program eligibility by implementing measures to mitigate the risk of clients falling out of care. Those measures include allowing clients to enroll virtually with their enrollment worker and increasing the number of allowable medication dispenses to reduce the number of trips a client would need to make to the pharmacy. In addition, OA will continue to monitor unemployment rates for potential impacts or shifts in client types, such as a shift from employer-based insurance to medication only. At this time, it is not clear how unemployment will impact ADAP, as the impacts to ADAP from COVID-19 are currently unknown. OA is monitoring data and enrollments and will provide updates in future estimates as any potential impacts become clearer.

Description of Change: On January 28, 2021, Covered California announced it would join President Biden in responding to the COVID-19 pandemic by announcing a special enrollment to help people obtain coverage. Effective February 1, 2021, anyone uninsured and eligible to enroll in health care coverage through Covered California can sign up through May 15, 2021. It is unknown what the potential impact of the special enrollment may be. On February 2, 2021, President Biden signed the Public Charge Executive Order in efforts to remove barriers to the legal immigration system. Although there may be an increased willingness to enroll in Covered California, it is currently unknown what the potential impact of the Public Charge Executive Order may be.

Discretionary: No

Reason for Adjustment/Change: N/A

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

California Generic Drugs

Background: On January 13, 2020, Senator Pan introduced Senate Bill (SB) 852, California Affordable Drug Manufacturing Act of 2020. This bill requires the California Health and Human Services Agency (CHHSA) 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.

Description of Change: SB 852 was signed by the Governor and chaptered by the Secretary of State on September 28, 2020, as Chapter 207, Statutes of 2020. The bill requires CHHSA to report to the Legislature by July 1, 2022, a description of the status of the drugs targeted for manufacture and by July 1, 2023, to report on the feasibility and advantages of directly manufacturing generic prescription drugs and selling generic prescription drugs at a fair price. At this time, it is not clear how or if this would affect ADAP, as ADAP would need to know generic drug pricing for specific medications to make a determination as to whether discounted pricing achieved by the State are lower than the pricing already received by ADAP through the ADAP Crisis Task Force and 340B drug pricing program.

Discretionary: No

Reason for Adjustment/Change:

- Statutory requirement.

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

Potential Change in Federal Funds: 2021 Ryan White Part B Grant

Background: The Ryan White Part B grant is the largest of the three federal grants for which ADAP receives funding and is a non-competitive grant. 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 as long as the program remains eligible and submits timely on all reporting requirements.

Description of Change: In November 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 $102.2 million

($96.2 million in Local Assistance) was requested for the ADAP Branch. OA anticipates receiving the notice of award for the 2021 Ryan White Part B grant in March 2021.

Discretionary: Yes

Reason for Adjustment/Change:

- Fully leverage federal funding.

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

Potential Change 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 ensure ADAP is the payer of last resort.

The table below displays the historical amount OA applied for and the amount that was received:

Table 4: ADAP Emergency Relief Funds (Shortfall Relief) Grant		
Grant Budget Period	Application(s)	Funds Received
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	TBD

Description of Change: On October 26, 2020, OA applied for the maximum amount of $7 million for the competitive 2021 ADAP Emergency Relief Funds grant (all Local Assistance). OA anticipates receiving the notice of award for the 2021 ADAP Emergency Relief Funds grant in March 2021.

Discretionary: Yes

Reason for Adjustment/Change:

- The ADAP Emergency Relief Funds grant is a competitive funding opportunity.
- Prior funding does not guarantee that funding will be provided in the future.

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

New Assumptions

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, the HRSA released Policy Clarification Notice (PCN) 18-02, which permitted the use of HRSA funds for individuals who are currently detained in a county jail and are not yet convicted of a crime or are not covered by federal or state health benefits during the period of incarceration. Subsequent to the PCN release, Orange County requested that CDPH provide ADAP services at their county jail. The provision of ADAP support services for those not covered by federal or state health benefits expands outreach to a vulnerable population while ensuring continuity of care as clients navigate the judicial system. Upon incarceration, clients will be able to enroll via a certified enrollment worker from the county jail that has been approved as an enrollment site. The enrollment worker will have to confirm the client meets eligibility requirements and warrant that all required documents to substantiate eligibility are submitted. The client and the enrollment worker must complete an ADAP application via the ADAP Enrollment System (AES) and upload the required forms into the system. New and existing clients will be able to access medication at the jail pharmacy thus maximizing potential adherence to medicinal regiments. Additionally, clients who are scheduled for release can be provided a prescription refill allowing them access to medication as they transfer from incarceration to a more traditional enrollment site.

Description of Change: In response to Orange County's request, OA has initiated a pilot program with their county jail. OA, in coordination 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. If this assumption is

approved, the Orange County pilot program will continue through fiscal year 2021-22 and no additional counties will be added to the pilot program.

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 net fiscal impact of the pilot with Orange County in 2020-21 is $881,000 ($1.1 million expenditures minus $216,000 rebate) from serving 100 eligible clients. For 2021-22, the net fiscal impact of the Orange County pilot is $1.9 million from serving 175 eligible clients ($3.4 million expenditures minus $1.4 million rebate). The funds impacted is the ADAP Rebate Fund (Fund 3080) and the Federal Trust Fund (Fund 0890).

Existing Assumptions

U.S. Preventive Services Task Force's "A" Grade Recommendation on PrEP for Persons at High Risk of HIV Acquisition

Background: On June 11, 2019, the United States Preventive Services Task Force (USPSTF) issued a final recommendation of an "A" grade for PrEP for persons who are at high risk of HIV acquisition. The USPSTF makes recommendations about 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, this was implemented January 1, 2021.

With exceptions for certain religious employers, coverage requirements apply to all private plans – including individual, small group, large group, and self-insured plans in which employers contract administrative services to a third-party payer – with the exception of those plans that maintain "grandfathered" status. In order to have been classified as "grandfathered," plans must have been in existence

prior to March 23, 2010, and cannot make significant changes to their coverage (for example, increasing patient cost-sharing, cutting benefits or reducing employer contributions).

Insured PrEP-AP clients were required to enroll into Gilead's Co-payment Assistance Program to receive co-pay assistance with Truvada™ and Descovy™ as many health plans did not cover PrEP as a preventative service. In response to USPSTF's recommendation, the PrEP-AP changed its policy and does not require clients to enroll into Gilead's Co-payment Assistance Program as the client's health plan will cover the cost of PrEP effective June 11, 2020, unless the health plan has yet to implement USPSTF's recommendation. If the client's health plan did not implement USPSTF's recommendation, the client will be required to enroll into Gilead's Co-payment Assistance Program. Clients with private insurance enrolled in Gilead's Co-payment Assistance Program are eligible for PrEP medication co-payment assistance of $7,200 per calendar year. After this threshold has been met, the PrEP-AP provides wrap-around coverage for any remaining PrEP medication co-payments for the remainder of the calendar year.

Description of Change: The elimination of a cost-sharing requirement for PrEP because of the USPSTF's "A" grade recommendation will alleviate some of the financial burden on PrEP-AP for insured clients whose health plan has implemented the USPSTF recommendation. Several large health plans such as Blue Shield of California, Kaiser Permanente, and Health Net partially implemented USPSTF's recommendation on July 1, 2020, while all health plans regulated by the Department of Insurance and Department of Managed Health Care implemented the recommendation on January 1, 2021. The slower than expected USPSTF implementation kept caseload higher than previously projected.

Discretionary: No

Reason for Adjustment/Change:
- USPSTF "A" grade recommendation.
- Federal and State legislative requirements.

Fiscal Impact and Fund Source(s): Estimated savings for 2020-21 is $2.2 million for 1,466 fewer insured PrEP-AP clients. Estimated savings for 2021-22 is $3.3 million for 2,129 fewer insured PrEP-AP clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Unchanged Assumptions

Decrease in Federal Funds: 2020 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 ensure ADAP is the payer of last resort.

On November 4, 2019, OA applied for the maximum amount of $10 million for the competitive 2020 ADAP Emergency Relief Funds grant. On February 21, 2020, OA received the notice of award for the 2020 ADAP Emergency Relief Funds grant in the amount of $6.5 million (all Local Assistance).

The table below displays the historical amount OA applied for and the amount that was received:

Table 5: ADAP Emergency Relief Funds (Shortfall Relief) Grant		
Grant Budget Period	Application(s)	Funds Received
2016 (04/01/2016 – 03/31/2017)	$11,000,000	$10,991,645
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

Description of Change: No change from the 2021-22 November Estimate.

Discretionary: Yes

Reason for Adjustment/Change:

- The ADAP Emergency Relief Funds grant is a 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 2020-21 and 2021-22. The fund impacted is the Federal Trust Fund (Fund 0890).

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

Background: The Ryan White Part B grant is the largest of the three federal grants for which ADAP receives funding and is a non-competitive grant. 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 as long as the program remains eligible and submits timely on all reporting requirements. The grant is shared between OA's HIV Care Branch and ADAP Branch and is broken into three main sub-components: Base, Minority AIDS Initiative (MAI), and ADAP Earmark. Funding for Base and MAI is utilized by the HIV Care Branch and ADAP Earmark funding is utilized by the ADAP Branch.

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. OA can generally determine how carryover funding is utilized with the exception of MAI funding, which must be utilized solely by the HIV Care Branch. Carryover funding from the Base and the ADAP Earmark are always utilized by the ADAP Branch due to administrative limitations that prevent the HIV Care Branch from timely utilization of carryover funds as carryover funding must be expended by March 31 of any given year.

On August 28, 2020, OA finalized closing the 2019 Ryan White Part B grant with HRSA and applied for carryover funding. Upon closure of the grant there remained $3.9 million in unspent funding, of which ADAP Branch applied for $3.8 million in carryover, and the HIV Care Branch applied for $96,000.

On November 23, 2020, OA received a notice of award for the full $3.9 million that was requested in unspent funding. ADAP Branch's portion of this award is $3.8 million, all of which is Local Assistance.

Description of Change: No change from the 2021-22 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 2020-21. The fund impacted is the Federal Trust Fund (Fund 0890).

Decrease in Federal Funds: 2020 Ryan White Part B Grant

Background: The Ryan White Part B grant is the largest of the three federal grants for which ADAP receives funding and is a non-competitive grant. 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 as long as the program remains eligible and submits timely on all reporting requirements. The grant is shared between OA's HIV Care Branch and ADAP Branch and is broken into three main sub-components: Base, MAI, and ADAP Earmark. Funding for Base and MAI is utilized by the HIV Care Branch and ADAP Earmark funding is utilized by the ADAP Branch.

In November 2019, OA applied for the 2020 Ryan White Part B grant, the fourth year of the latest five-year funding cycle. The funding requested in the grant application totaled $139 million of which $104.1 million was requested for the ADAP Branch ($97.6 million in Local Assistance).

In March 2020, OA received the notice of award for the 2020 Ryan White Part B grant. The total award received was $137.2 million, $1.8 million below what OA applied for. The ADAP Branch received $102.2 million, a reduction of $1.9 million in funding ($1.3 million in Local Assistance and $600,000 in State Operations).

Description of Change: No change from 2021-22 November Estimate.

Discretionary: Yes

Reason for Adjustment/Change:

- Unanticipated funding change.

Fiscal Impact and Fund Source(s): No additional budget authority is needed for 2020-21 and 2021-22. The fund impacted is the Federal Trust Fund (Fund 0890).

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

Background: In March 2020, HRSA released a notice of funding opportunity for the 2020 Ryan White Part B Supplemental Grant. Approximately $60 million has been made available nationwide through the 2020 Ryan White Part B Supplemental grant, but the ceiling amount that each applicant can apply for is $10 million. The purpose of the Ryan White Part B Supplemental grant is to develop and/or enhance 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. The grant is shared between OA's HIV Care Branch and ADAP Branch.

In May 2020, OA applied for the competitive 2020 Ryan White Part B Supplemental grant. OA requested the maximum amount of $10 million with $7.5 million specifically for ADAP to be used in 2020-21.

On August 21, 2020, OA received the notice of award for the 2020 Ryan White Part B Supplemental grant in the amount of $2.6 million, which is $7.4 million less than what was applied for; $2.5 million will go to the ADAP Branch for medication expenditures.

The table below displays Ryan White Part B Supplemental grant funds applied for and funds received by grant budget period.

Table 6: Ryan White Part B Supplemental Funds

Grant Budget Period	Application(s)	Funds Received
2016 (09/30/2016 – 09/29/2017)	$18,700,000	$18,700,000*
2017 (09/30/2017 – 09/29/2018)	$35,000,000	$35,000,000**
2018 (09/30/2018 – 09/29/2019)	$35,000,000	$23,766,000***
2019 (09/30/2019 – 09/29/2020)	$15,000,000	$6,376,000****
2020 (09/30/2020 – 09/29/2021)	$10,000,000	$2,628,306*****

***Includes $8.7 million for HIV Care Branch and $10 million for ADAP.**
****Includes $10 million for HIV Care Branch and $25 million for ADAP.**
*****Includes $6.8 million for HIV Care Branch and $17 million for ADAP.**
******Includes $1.7 million for HIV Care Branch and $4.7 million for ADAP.**
*******Includes $61,000 for HIV Care Branch and $2.5 million for ADAP.**

Description of Change: No change from 2021-22 November Estimate

Discretionary: Yes

Reason for Adjustment/Change:

- The Ryan White Part B Supplemental grant is a 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 2020-21 and 2021-22. The fund impacted is the Federal Trust Fund (Fund 0890).

Discontinued Assumptions

Access, Adherence, and Navigation (AAN) Program

Why is Change Needed/Reason for Adjustment: On March 31, 2020, the six contracts representing nine AAN sites ended. Additionally, the funding for the AAN pilot program ended; therefore, this assumption will be discontinued. As last reported in the 2021 November Estimate, OA will bring AAN functions in-house in order to navigate uninsured individuals to comprehensive health coverage and to support ADAP clients with achieving and maintaining viral suppression statewide. This effort is currently being implemented.

ADAP Special Fund State Operations Cost Adjustment - Interim ADAP Enrollment System (AES)/Project Approval Lifecycle (PAL)

Why is Change Needed/Reason for Adjustment: Previously approved in the 2019-20 November Estimate for use in 2019-20. Since 2019-20 has ended and the funding has already been expended, this assumption will be discontinued. The enhancements identified via the PAL process were completed making the interim AES the permanent IT solution. A budget change proposal was included in the 2020-21 Governor's Budget for ongoing budget authority for Maintenance and Operations and was approved. Funding is included in the 2020 Budget Act.

Decrease in Federal Funds: 2019 Ryan White Part B Grant

Why is Change Needed/Reason for Adjustment: Previously approved in the 2020-21 ADAP November Estimate for use in 2019-20. Since 2019-20 has ended and the funding has already been expended, this assumption will be discontinued.

Decrease in Federal Funds: 2019 Ryan White Part B Supplemental Grant

Why is Change Needed/Reason for Adjustment: Previously approved in the 2020-21 ADAP November Estimate for use in 2019-20. Since 2019-20 has ended and the funding has already been expended, this assumption will be discontinued.

Federal Funds: 2019 ADAP Emergency Relief Funds Grant (ADAP Shortfall Relief Grant)

Why is Change Needed/Reason for Adjustment: Previously approved in the 2020-21 ADAP November Estimate for use in 2019-20. Since 2019-20 has ended and the funding has already been expended, this assumption will be discontinued.

Increase in Federal Funds: 2018 Ryan White Part B Grant Carryover

Why is Change Needed/Reason for Adjustment: Previously approved in the 2020-21 ADAP November Estimate for use in 2019-20. Since 2019-20 has ended and the funding has already been expended, this assumption will be discontinued.

New HIV Drug

Why is Change Needed/Reason for Adjustment: Previously approved in the 2019-20 ADAP May Revision Estimate, ibalizumab (Trogarzo™) was added to the ADAP formulary on May 3, 2019. Since this drug has been approved and added to the ADAP formulary, this assumption will be discontinued.

V. Expenditure Details

A. A detailed breakdown of caseload and expenditures by client group and service type is displayed below in Tables 7 through 12.

TABLE 7: FY 2020-21 - May Revision Caseload and Variable Expenditures

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE				
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	ADDITIONAL ADMIN COSTS	TOTAL EXPENDITURE
Medication-Only	12,283	36.0%	$321,300,080	$0	$0	$5,397,506	$326,697,586
Medi-Cal SOC	114	0.3%	$1,298,795	$0	$0	$49,914	$1,348,709
Private insurance*	10,254	30.0%	$21,233,620	$67,685,691	$1,579,723	$1,517,866	$92,016,900
Medicare Part D*	7,421	21.7%	$18,251,905	$3,381,746	$316,361	$1,098,532	$23,048,543
PrEP-AP	4,090	12.0%	$1,194,954	$0	$873,566	$2,516,135	$4,584,656
SUBTOTAL	**34,162**	**100.0%**	**$363,279,354**	**$71,067,437**	**$2,769,650**	**$10,579,954**	**$447,696,394**
Enrollment Site Costs	0	0.0%	$0	$0	$0	$7,765,000	$7,765,000
TOTAL	**34,162**	**100.0%**	**$363,279,354**	**$71,067,437**	**$2,769,650**	**$18,344,954**	**$455,461,394**

* Subgroup of 11,569 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: FY 2020-21 Governor's Budget Caseload and Variable Expenditures

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE				
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	ADDITIONAL ADMIN COSTS	TOTAL EXPENDITURE
Medication-Only	13,105	37.7%	$340,881,795	$0	$0	$1,221,998	$342,103,793
Medi-Cal SOC	104	0.3%	$1,106,344	$0	$0	$9,720	$1,116,065
Private insurance*	10,479	30.2%	$20,452,775	$64,860,660	$1,778,894	$1,683,578	$88,775,907
Medicare Part D*	7,720	22.2%	$19,516,929	$3,281,378	$383,408	$1,240,218	$24,421,933
PrEP-AP	3,325	9.6%	$263,431	$0	$1,326,955	$2,546,115	$4,136,501
SUBTOTAL	**34,733**	**100.0%**	**$382,221,274**	**$68,142,038**	**$3,489,257**	**$6,701,630**	**$460,554,199**
Enrollment Site Costs	0	0.0%	$0	$0	$0	$6,780,000	$6,780,000
TOTAL	**34,733**	**100.0%**	**$382,221,274**	**$68,142,038**	**$3,489,257**	**$13,481,630**	**$467,334,199**

* Subgroup of 12,005 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: FY 2020-21 - Difference Between May Revision and 2021-22 Governor's Budget

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE				
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	ADDITIONAL ADMIN COSTS	TOTAL EXPENDITURE
Medication-Only	-822	-6.3%	-$19,581,715	$0	$0	$4,175,508	-$15,406,207
Medi-Cal SOC	9	9.0%	$192,451	$0	$0	$40,194	$232,645
Private insurance*	-225	-2.1%	$780,845	$2,825,031	-$199,171	-$165,712	$3,240,993
Medicare Part D*	-298	-3.9%	-$1,265,024	$100,368	-$67,047	-$141,686	-$1,373,390
PrEP-AP	765	23.0%	$931,523	$0	-$453,389	-$29,979	$448,155
SUBTOTAL	**-571**	**-1.6%**	**-$18,941,921**	**$2,925,399**	**-$719,607**	**$3,878,324**	**-$12,857,805**
Enrollment Site Costs	0	0.0%	$0	$0	$0	$985,000	$985,000
TOTAL	**-571**	**-1.6%**	**-$18,941,921**	**$2,925,399**	**-$719,607**	**$4,863,324**	**-$11,872,805**

* Subgroup decreased 436 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.
Note: Total Expenditures do not reflect $3.8 million carryover from 2019 Ryan White Part B grant.

TABLE 10: FY 2021-22 - May Revision Caseload and Variable Expenditures

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE				
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	ADDITIONAL ADMIN COSTS	TOTAL EXPENDITURE
Medication-Only	12,452	35.4%	$333,979,452	$0	$0	$5,640,446	$339,619,898
Medi-Cal SOC	114	0.3%	$1,460,097	$0	$0	$51,716	$1,511,813
Private insurance*	10,265	29.2%	$22,183,728	$84,628,923	$1,855,904	$1,657,829	$110,326,385
Medicare Part D*	7,555	21.5%	$19,150,279	$3,755,386	$416,447	$1,220,208	$24,542,320
PrEP-AP	4,768	13.6%	$2,192,298	$0	$757,966	$2,567,749	$5,518,013
SUBTOTAL	**35,154**	**100.0%**	**$378,965,854**	**$88,384,309**	**$3,030,317**	**$11,137,949**	**$481,518,429**
Enrollment Site Costs	0	0.0%	$0	$0	$0	$8,020,000	$8,020,000
TOTAL	**35,154**	**100.0%**	**$378,965,854**	**$88,384,309**	**$3,030,317**	**$19,157,949**	**$489,538,429**

*** Subgroup of 12,984 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: FY 2021-22 Governor's Budget Caseload and Variable Expenditures

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE				
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	ADDITIONAL ADMIN COSTS	TOTAL EXPENDITURE
Medication-Only	13,142	37.4%	$355,255,595	$0	$0	$1,224,561	$356,480,156
Medi-Cal SOC	108	0.3%	$1,148,384	$0	$0	$10,041	$1,158,425
Private insurance*	10,717	30.5%	$21,016,850	$82,827,977	$1,914,084	$1,849,256	$107,608,168
Medicare Part D*	7,767	22.1%	$20,491,534	$4,283,559	$537,252	$1,340,340	$26,652,684
PrEP-AP	3,430	9.8%	$188,582	$0	$1,367,012	$2,595,762	$4,151,355
SUBTOTAL	**35,164**	**100.0%**	**$398,100,945**	**$87,111,536**	**$3,818,348**	**$7,019,960**	**$496,050,788**
Enrollment Site Costs	0	0.0%	$0	$0	$0	$7,415,000	$7,415,000
TOTAL	**35,164**	**100.0%**	**$398,100,945**	**$87,111,536**	**$3,818,348**	**$14,434,960**	**$503,465,788**

*** Subgroup of 14,413 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: FY 2021-22 - Difference Between May Revision and 2021-22 Governor's Budget

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE				
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	ADDITIONAL ADMIN COSTS	TOTAL EXPENDITURE
Medication-Only	-690	-5.3%	-$21,276,143	$0	$0	$4,415,885	-$16,860,258
Medi-Cal SOC	6	5.9%	$311,713	$0	$0	$41,675	$353,389
Private insurance*	-452	-4.2%	$1,166,878	$1,800,946	-$58,180	-$191,427	$2,718,217
Medicare Part D*	-212	-2.7%	-$1,341,255	-$528,173	-$120,805	-$120,132	-$2,110,364
PrEP-AP	1,338	39.0%	$2,003,716	$0	-$609,046	-$28,013	$1,366,658
SUBTOTAL	**-10**	**0.0%**	**-$19,135,091**	**$1,272,773**	**-$788,030**	**$4,117,989**	**-$14,532,359**
Enrollment Site Costs	0	0.0%	$0	$0	$0	$605,000	$605,000
TOTAL	**-10**	**0.0%**	**-$19,135,091**	**$1,272,773**	**-$788,030**	**$4,722,989**	**-$13,927,359**

*** Subgroup decreased 1,429 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 Expenditures:
    - For 2020-21, OA estimates medication expenditures for medication-only clients will be $321.3 million (Table 7). This is a $19.6 million decrease compared to the 2021-22 Governor's Budget (Table 9). The decrease in expenditures is due primarily to fewer projected clients per month and subsequently lower projected medication costs per month than previously estimated.
    - For 2021-22, OA estimates medication expenditures for medication only clients will be $334.0 million (Table 10). This is a $21.3 million decrease compared to the 2021-22 Governor's Budget (Table 12). The decrease in expenditures is due to the same reasons listed above.
2. Health Insurance Premiums: There are no health insurance premium expenditures for medication-only clients.
3. Medical Out-Of-Pocket Costs: There are no medical out-of-pocket cost expenditures for medication-only clients.

b. Medi-Cal SOC Clients

1. Medication Expenditures:
    - For 2020-21, OA estimates medication expenditures for Medi-Cal SOC clients will be $1.3 million (Table 7). This is a $192,000 increase compared to the 2021-22 Governor's Budget (Table 9). The increase in expenditures is due to more projected clients per month and higher projected medication costs per month than previously estimated.
    - For 2021-22, OA estimates medication expenditures for Medi-Cal SOC clients will be $1.5 million (Table 10). This is a $312,000 increase compared to the 2021-22 Governor's Budget (Table 12). The increase in expenditures is due to the same reasons listed above.
2. Health Insurance Premiums: There are no health insurance premium expenditures for Medi-Cal SOC clients.
3. Medical Out-Of-Pocket Costs: There are no medical out-of-pocket cost expenditures for Medi-Cal SOC clients.

c. Private Insurance Clients

1. Medication Expenditures:
    - For 2020-21, OA estimates medication expenditures for all private insurance clients will be $21.2 million (Table 7). This is a slight $781,000 increase compared to the 2021-22 Governor's Budget (Table 9). The increase is due to higher projected medication costs

per month than previously estimated. The projected decrease in monthly clients is expected to be offset by an increase in deductibles, co-insurance, and co-payments, with higher out-of-pocket maximums.
- For 2021-22, OA estimates medication expenditures for all private insurance clients will be $22.2 million (Table 10). This is a $1.2 million increase compared to the 2021-22 Governor's Budget (Table 12). The increase is due to higher projected medication costs per month than previously estimated.

2. Health Insurance Premiums:
    - For 2020-21, OA estimates health insurance premium payment expenditures for all private insurance clients will be $67.7 million (Table 7). This is a $2.8 million increase compared to the 2021-22 Governor's Budget (Table 9). The increase is due to higher projected premium costs per month for Covered California, non-Covered California, and employer-based insurance clients than previously estimated. Although caseload is predicted to decrease, costs associated with this decrease were offset by higher projected premium costs.
    - For 2021-22, OA estimates health insurance premium payment expenditures for all private insurance clients will be $84.6 million (Table 10). This is a $1.8 million increase compared to the 2021-22 Governor's Budget Table 12). The increase is due to the same reasons listed above.
3. Medical Out-Of-Pocket Costs:
    - For 2020-21 OA estimates medical out-of-pocket costs for all private insurance clients will be $1.6 million (Table 7). This is a $199,000 decrease compared to the 2021-22 Governor's Budget (Table 9). The decrease is due to lower projected average service utilization per month and lower average costs per service per month.
    - For 2021-22, OA estimates medical out-of-pocket costs for all private insurance clients will be $1.9 million (Table 10). This is a $58,000 million decrease compared to the 2021-22 Governor's Budget (Table 12). The decrease is due to the same reasons listed above.

d. Medicare Part D clients

1. Medication Expenditures:
    - For 2020-21, OA estimates medication expenditures for Medicare Part D clients will be $18.3 million (Table 7). This is a $1.3 million decrease compared to the 2021-22 Governor's Budget (Table 9). The decrease is due to fewer projected clients per month and lower average medication costs per month than previously estimated.

- For 2021-22, OA estimates medication expenditures for Medicare Part D clients will be $19.2 million (Table 10). This is a $1.3 million decrease compared to the 2021-22 Governor's Budget (Table 12). The decrease is due to the same reasons listed above.

2. Health Insurance Premiums:
   - For 2020-21, OA estimates Medicare Part D premium payment expenditures will be $3.4 million (Table 7). This is a $100,000 increase compared to the 2021-22 Governor's Budget (Table 9). The increase is primarily due to higher than anticipated Medicare Part D average premium costs per month.
   - For 2021-22, OA estimates Medicare Part D premium payment expenditures will be $3.8 million (Table 10). This is a $528,000 decrease compared to the 2021-22 Governor's Budget (Table 12). The decrease is due to lower projected Medicare Part D premium costs per month.
3. Medical Out-Of-Pocket Costs:
   - For 2020-21, OA estimates medical out-of-pocket costs for Medicare Part D clients will be $316,000 (Table 7). This is a $67,000 decrease compared to the 2021-22 Governor's Budget (Table 9). The decrease is primarily due to lower than projected average service utilization per month and lower projected costs per service per month.
   - For 2021-22, OA estimates medical out-of-pocket costs for Medicare Part D clients will be $416,000 (Table 10). This is a $121,000 decrease compared to the 2021-22 Governor's Budget (Table 12). The decrease is due to lower projected costs per service per month.

e. PrEP-AP clients

1. Medication Expenditures:
   - For 2020-21, OA estimates medication expenditures for PrEP-AP clients will be $1.2 million (Table 7). This is a $932,000 increase compared to the 2021-22 Governor's Budget (Table 9). The increase is due to higher projected client counts than previous estimates, which assumed widespread implementation of USPSTF recommendations beginning July 2020. OA has since revised its estimates, anticipating more gradual USPSTF implementation, beginning January 2021 (see Existing Assumption, "U.S. Preventive Services Task Force's "A" Grade Recommendation on PrEP for Persons at High Risk of HIV Acquisition").
   - For 2021-22, OA estimates medication expenditures for PrEP-AP clients will be $2.2 million (Table 10). This is a $2 million increase

compared to the 2021-22 Governor's Budget (Table 12). The increase is due to the same reasons listed above.

2. Health Insurance Premiums: There are no health insurance premium expenditures for PrEP-AP clients.
3. Medical Out-Of-Pocket Costs:
    - For 2020-21, OA estimates medical out-of-pocket costs for PrEP-AP clients will be $874,000 (Table 7). This is a $453,000 decrease compared to the 2021-22 Governor's Budget (Table 9). The decrease in expenditures is primarily due to lower than projected average service utilization per month and lower average costs per service per month, especially for uninsured clients.
    - For 2021-22, OA estimates medical out-of-pocket costs for PrEP-AP clients will be $758,000 (Table 10). This is a $609,000 decrease compared to the 2021-22 Governor's Budget (Table 12). The decrease in expenditures is due to the same reasons listed above.

VI. Historical Program Data and Trends

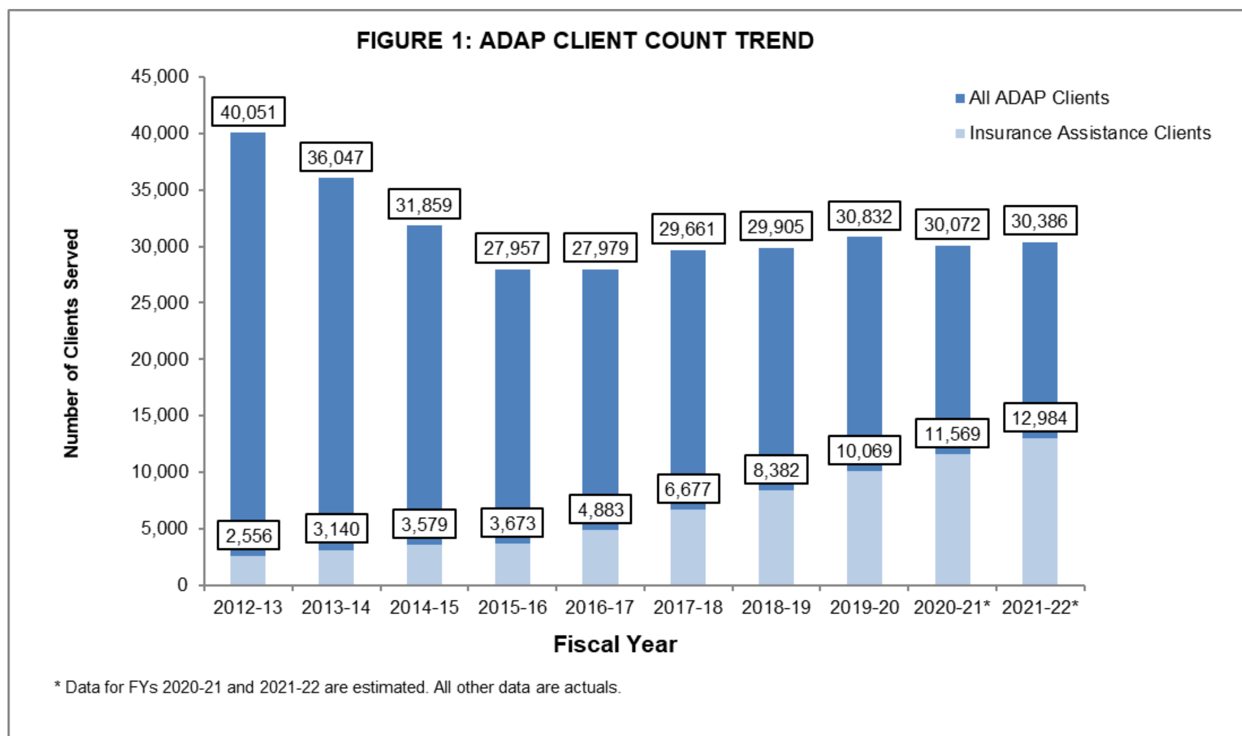
For all figures in this section, data prior to 2020-21 is the observed historical data. Estimates for 2020-21 and 2021-22 are based on the overall projections and include all assumptions.

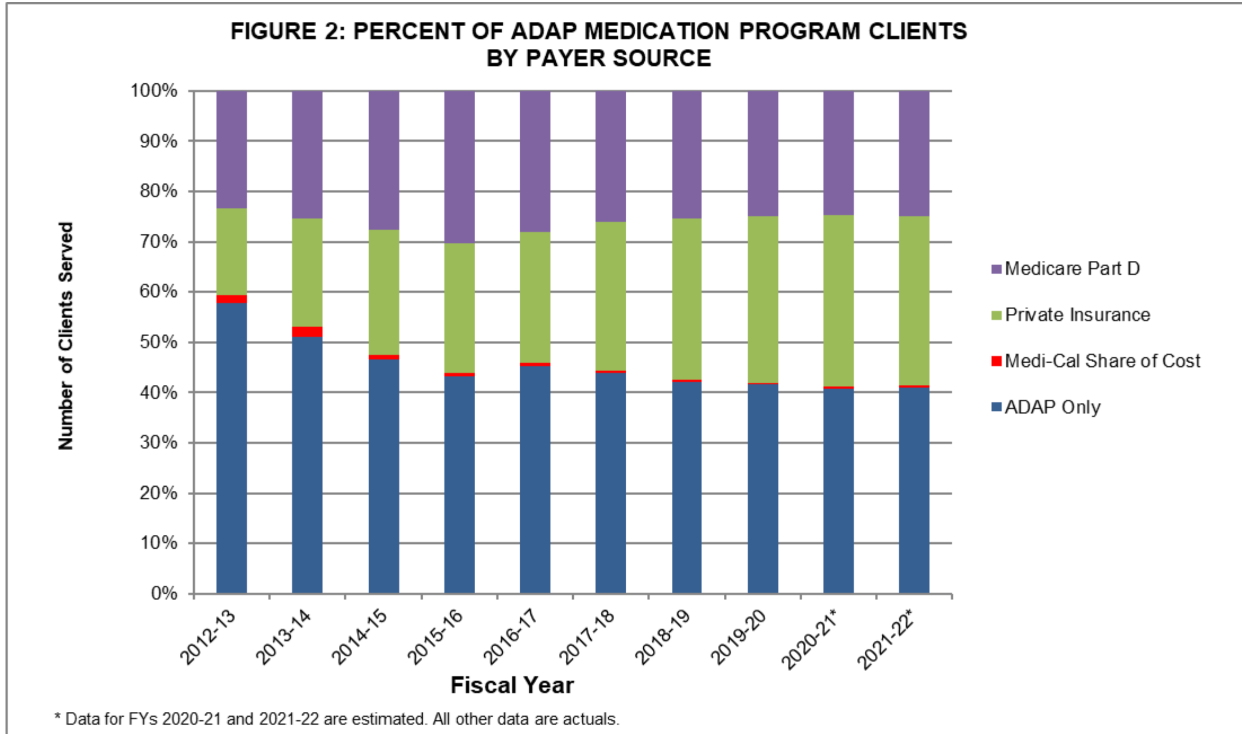
Figure 1 is a summary of client counts in ADAP by fiscal year excluding PrEP-AP clients. The number of ADAP medication program clients who are also receiving insurance assistance is also shown.

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

Figure 3 is a summary of client counts in PrEP-AP by fiscal year.

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





Note: In Figures 1 and 2, all client counts represent the number of clients served who incur program costs. Enrolled clients who do not incur program costs are excluded from these counts.

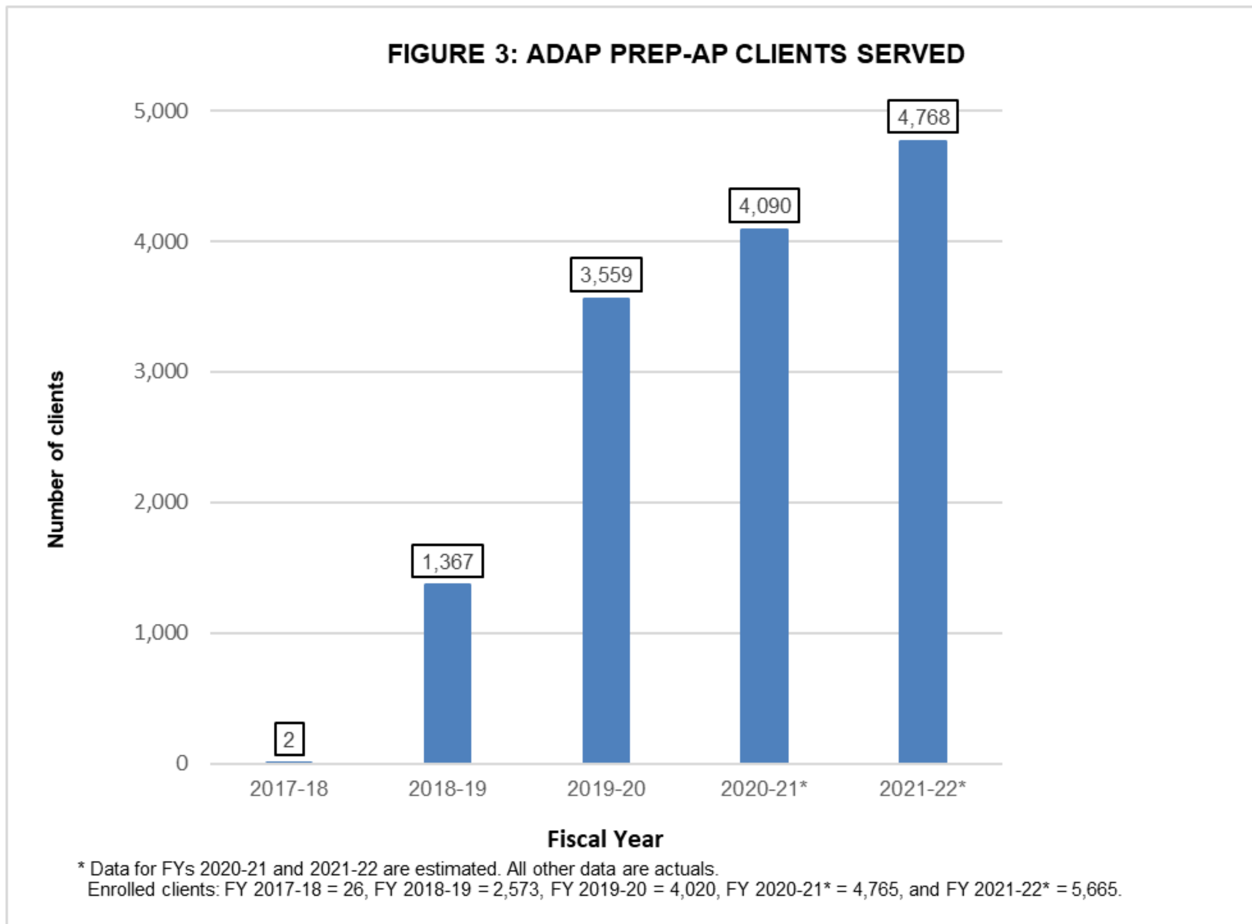
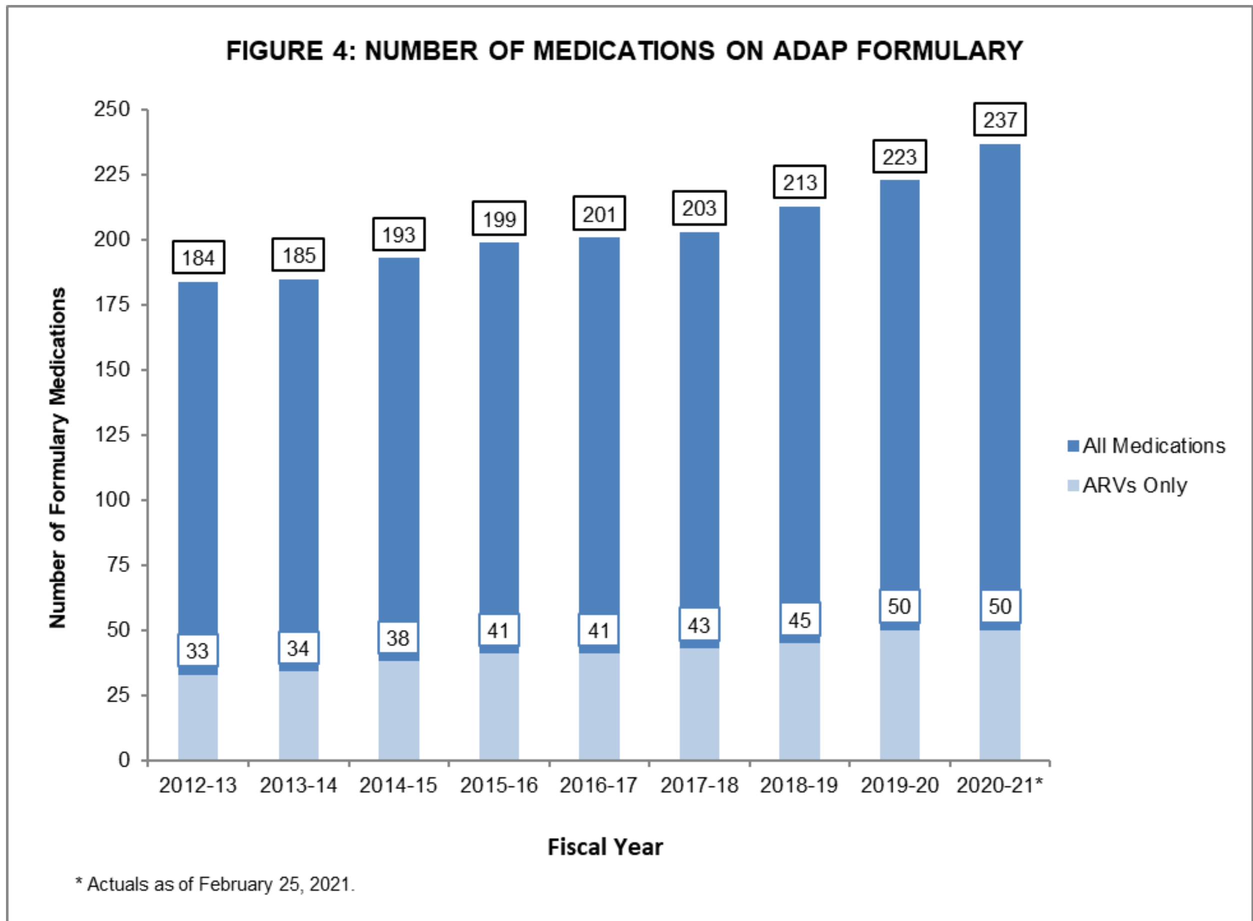


FIGURE 3: ADAP PREP-AP CLIENTS SERVED
Number of clients
5,000
4,000
3,000
2,000
1,000
0
2
1,367
3,559
4,090
4,768
2017-18
2018-19
2019-20
2020-21*
2021-22*
Fiscal Year
* Data for FYs 2020-21 and 2021-22 are estimated. All other data are actuals.
Enrolled clients: FY 2017-18 = 26, FY 2018-19 = 2,573, FY 2019-20 = 4,020, FY 2020-21* = 4,765, and FY 2021-22* = 5,665.



Additions to the ADAP Formulary

The following drugs were added to the Formulary on February, 25, 2021:

- Amoxicillin-clavulanate (Augmentin®), non-ARV, antibiotic
- Capsaicin, non-ARV, pain medication
- Pregabalin (Lyrica®), non-ARV, pain medication
- Tramado, non-ARV, pain medication
- Acamprosate, non-ARV, psychiatry agent
- Baclofen, non-ARV, muscle relaxer/antispastic
- Buprenorphine, non-ARV, agonist-antagonist
- Clonidine, non-ARV, alpha-agonist hypotensive agent
- Disulfiram, non-ARV, alcohol antagonists drug
- Naltrexone, non-ARV, opiate antagonists
- Ondansetron, non-ARV, 5-HT3 antagonist
- Tizanidine, non-ARV, alpha-2-adrenergic agonists
- Topiramate, non-ARV, anticonvulsants/ antiepileptic

Deletions from the ADAP Formulary

There are currently no deletions to the ADAP Formulary.

VII. 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.