AIDS Drug Assistance Program Report

Prepared by
The Commissioner of Health
For
The Chairmen of the House Appropriations and Senate Finance Committees

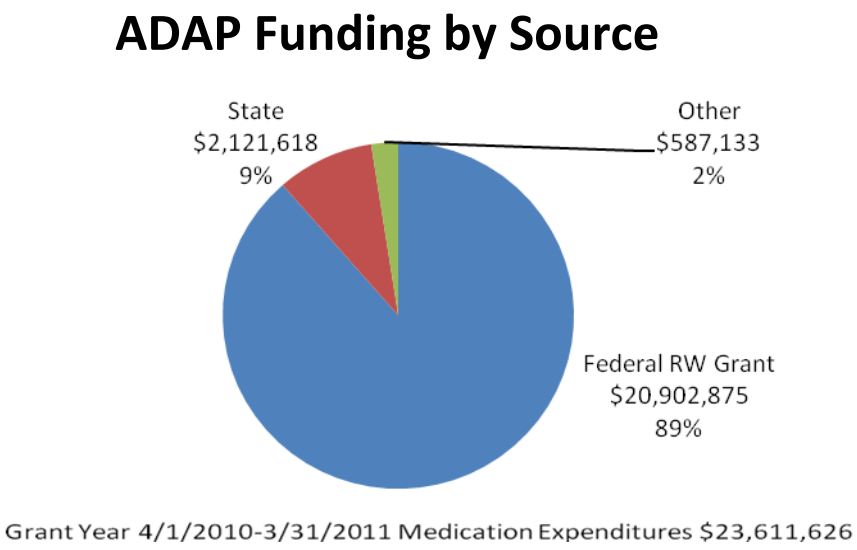
October 1, 2011

The following Report was developed in response to the directive under the VIRGINIA ACTS OF ASSEMBLY – CHAPTER 890, Item 284:

G. The Commissioner of Health shall monitor patients who have been removed or diverted from the Virginia AIDS Drug Assistance Program due to budget considerations. At a minimum the Commissioner shall monitor patients to determine if they have been successfully enrolled in a private Pharmacy Assistance Program or other program to receive appropriate anti-retroviral medications. The Commissioner shall also monitor the program to assess whether a waiting list has developed for services provided through the ADAP program. The Commissioner shall report findings to the Chairmen of the House Appropriations and Senate Finance Committees annually beginning October 1, 2011.

Background

The Virginia AIDS Drug Assistance Program (ADAP), administered by the Virginia Department of Health's (VDH's), Division of Disease Prevention (DDP), provides life-saving medications for treatment of HIV and related illnesses for low-income clients without medication coverage. The program is primarily supported with federal Ryan White (RW) Treatment Extension Act Part B grant funding which is distributed by formula based on living HIV and AIDS cases to all states and U.S. territories. ADAP also receives significant support from state funding. Other funding sources include Medicaid reimbursements for clients who receive retroactive eligibility and rebates from pharmaceutical manufacturers.



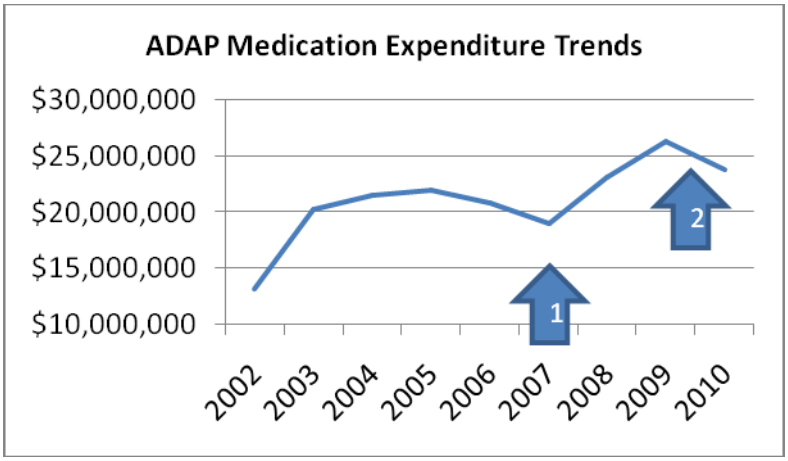
The ADAP formulary includes antiretroviral medications indicated for the treatment of HIV, selected vaccines, and selected medications to treat or prevent Opportunistic Infections (OIs). Eligible clients must have incomes at or below 400% of the federal poverty level (FPL); however, the majority of enrolled clients (81%) have incomes below 200% FPL. Enrolled clients are assessed twice yearly to ensure eligibility for the program.

During RW Part B Grant Year 2009 (April 2009-March 2010)[1], 3,952 clients received 63,959 prescriptions, representing a steep increase in program utilization compared to the prior grant year. Additionally, pharmaceutical expenditures reached a historic high of $26,290,325, a $3.2 million increase from the prior year.

Subsequently, in RW GY2010 (April 2010-March 2011), 3,958 clients received 66,076 prescriptions and pharmaceutical expenditures decreased to $23,787,093. This expenditure

[1] The RW Part B Grant Year (GY) runs from April 1 to March 31 and is named for the year in which it begins.

reduction was due to aggressive cost containment measures including implementation of an ADAP waiting list in November 2010 and transition of clients to other sources for medications, as described in this report.



1.) Increase driven by environmental factors described below

2.) Cost containment measures implemented.

Factors Driving the Virginia ADAP Shortfall

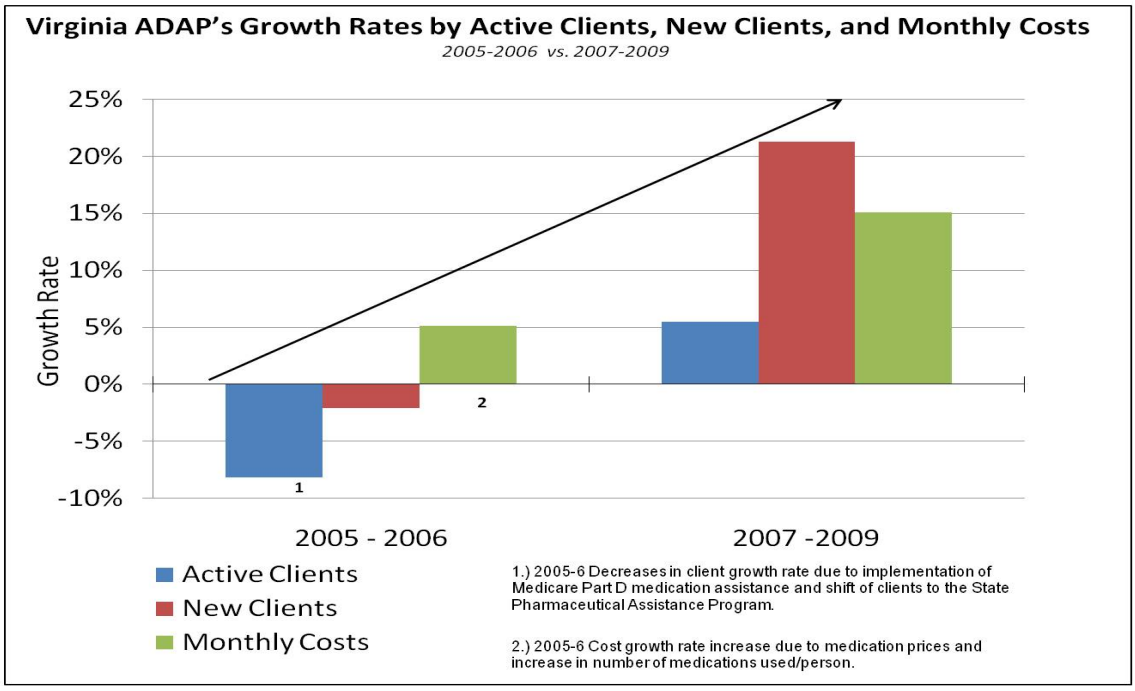
In general, Virginia has a lower rate of public and private health insurance coverage when compared with most other states. For example, for RW clients who report no insurance coverage, Virginia's uninsured coverage level is 64% compared with 15% nationally. Individual purchase of health coverage has historically been difficult. Recently, in 2010, the United States Department of Health and Human Services has implemented Pre-Existing Condition Insurance Plans (PCIP) in Virginia and 22 other states, which may provide an alternative insurance option for Virginia's ADAP clients.

Virginia Medicaid does not provide any coverage to HIV-positive individuals unless they meet both income and categorical eligibility criteria (must be pregnant, under 18 years, elderly, or disabled/blind). Virginia ranks thirtieth nationwide in per capita payments per disabled enrollee (Kaiser Family Foundation: www.statehealthfacts.org), forty-second in eligibility and thirty-eighth in scope of services (Public Citizen: www.citizen.org).

The unemployment rate in Virginia reached a 10-year high of 7.2% in 2010 (Bureau of Labor Statistics: www.bls.gov), lowering both income levels and percentage of people with health insurance. Concurrently, the percentage of ADAP clients who were at or below 100% of FPL increased from 55% to 59% over the past 3 years, an increase of 316 clients. As individuals become unemployed and uninsured, they become eligible for ADAP services, increasing the demand for services.

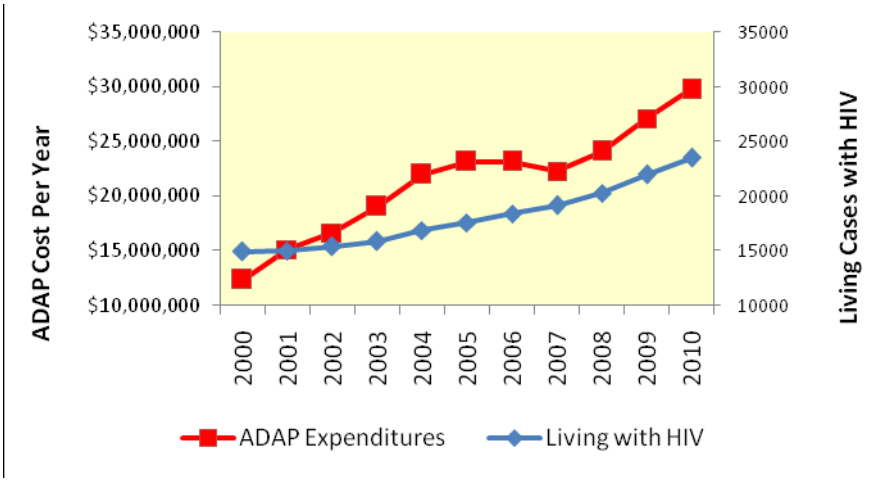
These drivers help to explain the double-digit growth seen over the last several years in the areas of new clients and monthly costs. Specifically, data analyses illustrated in the following chart demonstrates that from 2007 to 2009, client enrollment and monthly medication costs steadily

increased by 21% and 15% respectively. Medication expenditures are driven by increasing medication costs and increasing complexity in a typical HIV treatment regimen.



In Ryan White (RW) Grant Year 2010, 22,993 people in Virginia were living with HIV/AIDS. ADAP provided medications for 17% (3,958 people) of this group. ADAP medication expenditures have increased more rapidly than the number of people living with HIV, as illustrated below. While the number of living cases increased 6.8% from GY2009 to GY2010, ADAP expenditures increased 12% for that same time period. The steep increase in ADAP monthly cost and newly enrolled clients is mirrored in a dramatic increase of annual program expenditures, which outpaced resources.

Virginia ADAP Expenditures & Virginia Living HIV/AIDS Cases: 2000 – 2010



In order to address ADAP growth, the General Assembly established the State Pharmaceutical Assistance Program (SPAP) as a cost-effective alternative to provide medications to ADAP clients who qualify for Medicare Part D prescription drug coverage. By using state funds to pay Part D premiums, deductibles and co-payments; SPAP clients' medication costs are about one-third the cost of full purchase through ADAP. Unfortunately, state budget reductions necessitated some reductions to SPAP, which resulted in the transfer of 63 clients from SPAP back to ADAP.

The National Picture

During 2010, the National Alliance of State and Territorial AIDS Directors (NASTAD) coined the term the "perfect storm" to describe the stressors having a destabilizing impact on ADAPs nationally. The "perfect storm" catalogs the key drivers weakening program viability: minimal increases in federal appropriations, fluctuations in state funding, increased program demand due to unemployment, heightened national efforts on HIV testing and linkages into care, high drug costs, and new HIV treatment guidelines calling for earlier therapeutic treatments. Under the pressure of these drivers, states (including Virginia) were pushed to what NASTAD called the "tipping point" in which the demand for services outpaced available resources.

Cost Containment Strategies

Program changes to address the ADAP funding shortfall were made in consultation with Virginia's ADAP Advisory Committee. The Committee is comprised of HIV medical providers, a pharmacist, and an individual living with HIV.

Prior to closing enrollment, several cost containment strategies were implemented relating to the management of client enrollment, medication dispensation, and program eligibility. However, in November 2010, the implementation of an ADAP waiting list was also necessary. These actions are described in detail below:

Formulary reduction, November 2010: With the concurrence of the ADAP Advisory Committee, the Virginia ADAP formulary was reduced in November 2010. Historically, the Virginia ADAP formulary covered over 100 different medications that were commonly prescribed for HIV treatment, HIV treatment-related conditions, and mental health conditions. Medications in the following drug categories were removed: adjuvant therapies, antianxiety medications, antidepressants, antilipidemics, bipolar agents, antipsychotics, and treatments for Hepatitis C. The formulary currently provides only antiretrovirals to treat HIV, medications to prevent and treat opportunistic infections, and select vaccines.

The medications removed from the formulary represented 1.24% of the total ADAP costs. The formulary reduction is expected to reduce ADAP medication expenditures by $418,232 in GY2011 and $482,751 in GY2012.

Virginia ADAP researched and provided alternative resources and access points for all medications that were removed from the formulary. Alternatives included identifying medications available generically at low-cost through retail pharmacies, as well as through individual drug manufacturers' patient assistance programs (PAPs).

Dispensing Policy, December 2010: ADAP instituted a policy that allows a maximum quantity of a 30-day supply of medications to be dispensed at a time. By limiting dispensing to a 30-day supply, Virginia ADAP is able to ensure tighter inventory control, reduce medication wastage if regimens change, and also ensure that clients are receiving equitable access to medications. Furthermore, this policy allows Virginia ADAP a greater opportunity to recoup funds available through Medicaid back billing efforts, which denies claims for medications dispensed for greater than 34 days.

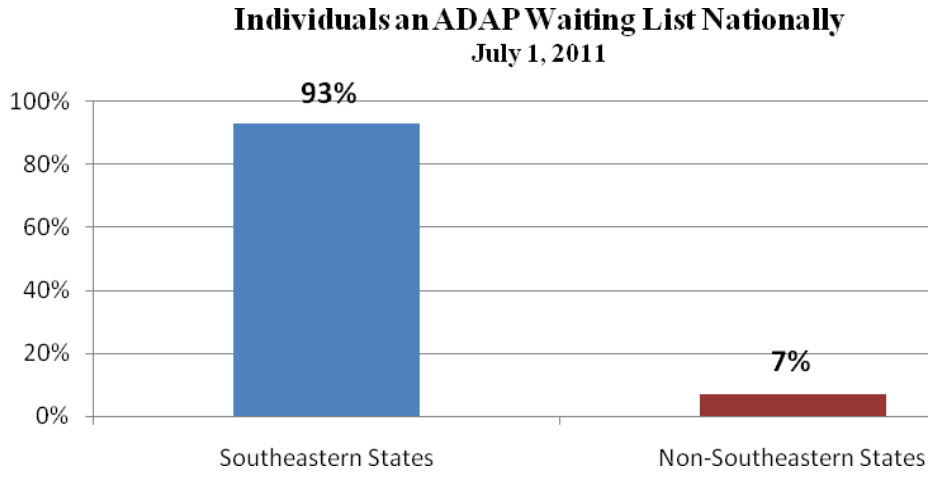
In calendar year 2010, prescriptions dispensed at greater than 30 days comprised approximately 18.1% of all prescriptions, while in the first six months of calendar year 2011, they were only 3.1% of all prescriptions. This policy results in tighter medication inventory control and reduced medication wastage.

Inactive Status, December 2010: Beginning in December 2010, clients identified as inactive (those who have not filled an ADAP prescription in five to six months or longer) were notified, along with their last medical provider of record, that they could no longer receive ADAP medications. ADAP staff works with medical and community stakeholders to encourage clients to remain active with medication access to avoid potential disenrollment, reviewing clients on a case-by-case basis as needed. The number of clients receiving their last prescription in a month increased from an average of 70 in 2009 to 123 in 2010. This action eliminates sporadic utilization of ADAP as a medication source; ensuring clients are accessing medications regularly from the most appropriate source.

Enrollment Restrictions: Enrollment criteria for new clients were changed on November 19th, 2010. ADAP enrollment was restricted to pregnant women, individuals 18 years old or younger, and people currently receiving treatment for an active opportunistic infection (OI). This created a waitlist in Virginia for the ADAP program, but a proactive decision was made to actively manage this waitlist to ensure that those not meeting the current, stricter eligibility criteria would be offered other forms of assistance so as to not interrupt their care when possible. In Virginia, individuals who do not meet these criteria are placed on a waiting list for ADAP services and referred to RW-funded medical or case management services that can assist with identifying alternative medication access points such as PAPs. These enrollment restrictions reduced the percentage of new clients from 3.7% in calendar year 2010 to .5% for the first six months of 2011, reducing projected ADAP expenditures by an estimated $953,774 in the current grant year and allowing the program to operate within the level of funding currently available.

Virginia is one of 13 states nationwide that have established some form of ADAP waiting lists. As of July 1, 2011 over 8,615 individuals across 13 states were on an ADAP waiting list. The

southeastern states have been disproportionally impacted by the ADAP shortfall with the southeast representing the overwhelming majority of the waiting list states: Alabama, Arkansas, Florida, Georgia, Louisiana, North Carolina, South Carolina, and Virginia. Some common driving factors include no or limited access to high-risk health insurance pools prior to ACA-established PCIPs, state funding reductions, and limited public insurance access (such as restrictive Medicaid eligibility and coverage). Even more startling is that over 93% of individuals on waiting lists nationally reside in the southeastern states.



Establishing Alternative Medication Sources for Clinically Stable ADAP Clients

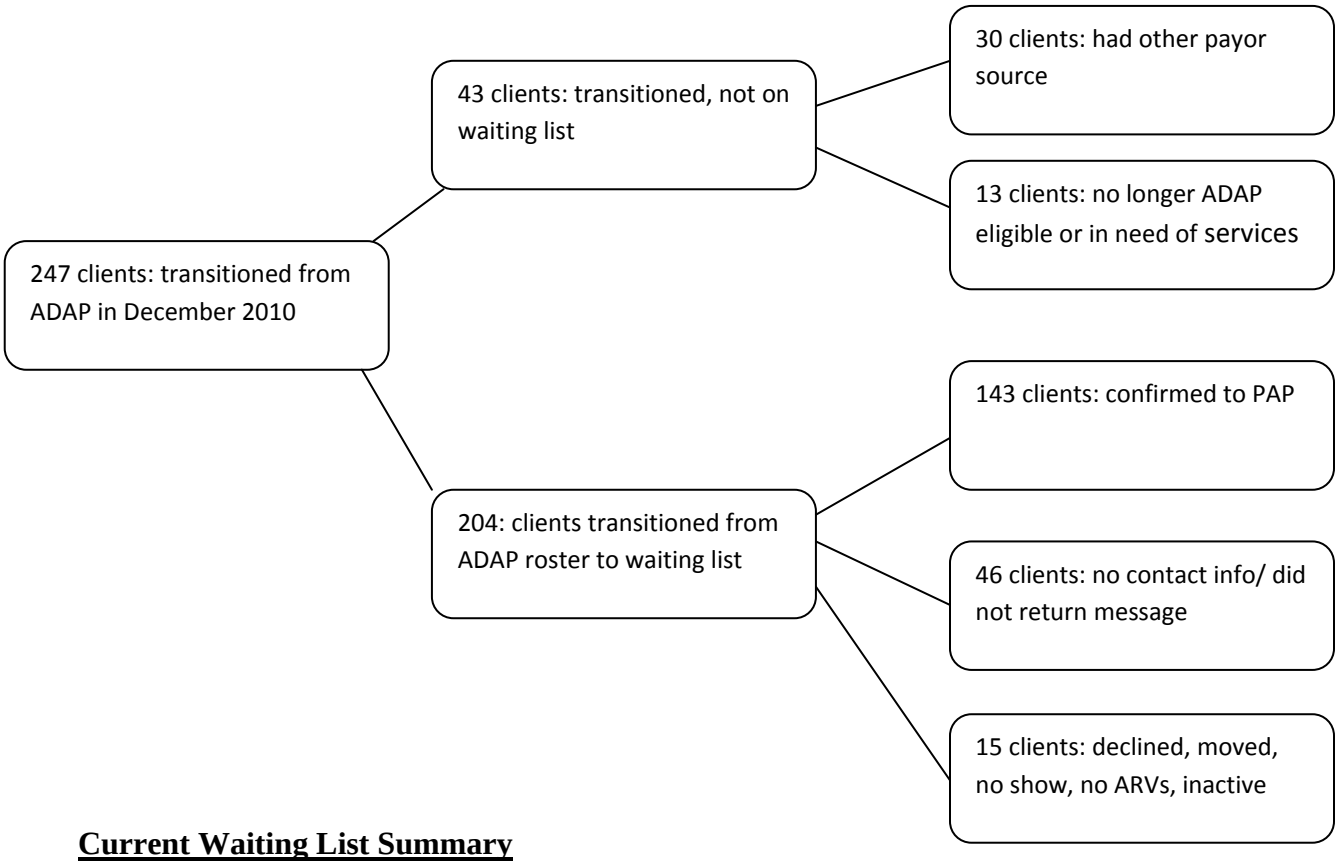
The cost containment actions described above were not adequate to fully make up the ADAP funding shortfall. Therefore, alternative medication sources were needed for some current ADAP clients. Beginning in November 2010, VDH mobilized a team to assess the clinical status of current enrollees statewide and assist clients with more stable immune system function to obtain medications from other sources. VDH made a commitment to provide assistance as long as needed so that clients did not experience a break in treatment. Over 100 medical providers were contacted in order to obtain up-to-date clinical information, including CD4 count (a measure of immune system function) and medical history. Two hundred and forty-seven clients with CD4 counts greater than 350 and no indications of advanced HIV disease were identified for transition. Pregnant women and individuals 18 years of age or younger were not considered for transition from ADAP to other sources.

The transition team worked directly with each selected client. Forty-three of the selected clients were assisted to transition off of ADAP but were not placed on the waiting list. Thirty of these individuals had another payor source for medications. Thirteen individuals were not taking HIV medications, or had moved out of state.

Two hundred and four clients were placed on the waiting list for ADAP services. The transition team assisted 143 of these individuals to enroll in PAPs, following clients until successful PAP

enrollment was confirmed. The team assisted these clients to complete all necessary applications to obtain each drug in their HIV treatment regimen and followed up to ensure patients were approved and enrolled into each individual drug manufacturer's program. Throughout the transition process, the team ensured that ADAP continued to provide medications to each client until confirmation of successful enrollment into PAPs was completed to minimize any possible treatment interruptions. The team was unable to contact 46 individuals despite utilizing multiple strategies (after hours phone calls; toll-free phone in access; letters; efforts to contact through case managers, local health departments and medical providers; etc.) Medical providers and local health departments were notified if efforts to contact were unsuccessful. These clients were placed on the waiting list so that alternative medication access could be offered if contact were reestablished. The remaining 15 clients were not enrolled in PAPs for a variety of reasons (client declined PAP enrollment, moved to a living situation such as inpatient mental health facility or incarceration, were inactive/not receiving HIV medications but requested waiting list placement, etc.). The outcomes of the transition effort are summarized in the chart below.

ADAP Transition Client Summary



Current Waiting List Summary

The ADAP waiting list is maintained by Patient Services Inc. (PSI), a VDH-funded contractor responsible for conducting ADAP eligibility determination and enrollment. If clients requesting ADAP services do not meet current enrollment criteria, they can be placed on the waiting list by

calling PSI's toll-free number or submitting an ADAP Wait List Form. PSI receives Wait List Forms through several sources: VDH ADAP staff, providers, case managers or other ADAP stakeholders. Waiting list referrals may also be completed over the phone. Once PSI receives a waiting list form, the client's information is added to the waiting list database.

Managing a waiting list for ADAP services presents many challenges. Clients eligible for the program tend to have fewer resources and lower household incomes, often with transient living situations and limited family support. Prior to the inception of the waiting list, VDH and PSI would have routine contact with both the client and the medical provider to obtain current eligibility and medical information while the client received ADAP services. The primary challenge is establishing and maintaining a working relationship with clients without the incentive of providing ADAP services. However, VDH has worked with community partners to communicate the importance of maintaining accurate contact information while clients are placed on the waiting list so that services could be provided if adequate funding is available in the future.

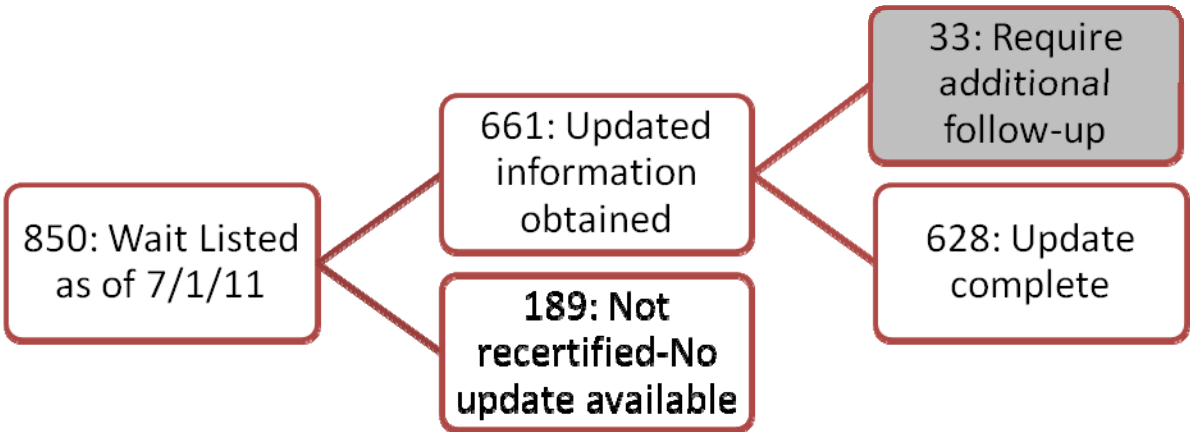
Clients on the waiting list are assessed bi-annually to ensure that the most accurate and current information is documented, including the following: demographic information, medical history and current clinical status, current HIV medications, medical provider information and eligibility information (income is reviewed and clients are assessed to confirm no other payor source is available). This process is referred to as the "recertification" and is conducted by PSI. The study conducted in July 2011 was the first recertification of the waiting list and the findings were informative. Findings have highlighted where additional information collection will be needed to best identify strategies to address this group's service needs.

The recertification was conducted over a one-month period, July 2011, and all data included in this report reflect the status of clients on the waiting list as reported by respondents. At the time of the recertification, the waiting list consisted of 850 persons. This includes the 204 individuals that were assisted to transition from ADAP and 646 new clients added to the waiting list when they requested ADAP services after enrollment criteria were changed. Data were sought from all clients and associated medical providers. Due to varying levels of respondent participation, responses are not available for all clients. It is also important to note that these data represent a one-month snapshot of clients on the waiting list who chose to participate in the recertification process, and as such are not representative of all waiting list clients or time periods.

Waiting List Assessment Response Rate

More than 70% of all those surveyed responded to our inquiries, and updated information was obtained on the majority of clients through either the medical provider and/or the client. Data is not available on all clients for each data variable, and so variations will be seen in the analysis.

Disposition of Waiting List Recertification Cases



Thirty-three of the 661 clients – or 3% of clients – will require additional research as findings indicate that the client may no longer be eligible for and/or need ADAP services. Research on these clients will continue over the upcoming months to confirm reported data and to determine if the client should be removed from the waiting list. Confirmation will occur directly with the client and medical provider. Through the study conducted in July 2011 these clients were reported as follows: another payor source, enrolled in ADAP, no longer a Virginia resident, institutionalized, and deceased (5 individuals). Follow up with clients' medical providers identified that 3 deaths were related to cardiac events, one to cancer and one to advanced HIV disease (physician had opted to hold HIV medications for medical reasons); these 3 clients had access to HIV medications through PAPs. Two of these individuals had other payer sources for medications at the time of death (Medicaid and Medicare Part D with SPAP eligibility in process).

VDH was unable to obtain updated data on 189 clients due to no response received from client and medical provider, problems with contact information (such as addresses resulting in letters returned to sender) and/or limited data collected at the time the waiting list record was established. These clients are categorized as "not recertified." Data will be matched to the HIV surveillance system and Medicaid databases in order to determine the status of these clients.

Data Analysis

The recertification findings are summarized and organized in the following categories: waiting list demographics, medication access, and medical characteristics. Demographic data is provided for the entire waiting list population as available. Data is described in two categories: (1) for those VDH received updated information (data reported) and (2) those for which data was not received and/or unable to collect (data not reported).

ADAP is a safety-net provider and its population's resources and medical status may change from month to month. To provide stakeholders with the most accurate picture, medication access and medical background data are provided only for clients if updated information was obtained. As previously explained, responses were collected from medical providers and the client; however, a response was not provided for all variables for each client from both sources.

Waiting List Demographics

The waiting list population is similar to the ADAP population when comparing gender, race, and income. The majority of clients are male and African American. Income trends are also similar for ADAP enrollees and clients on the waiting list.

Race, Gender, Income: ADAP Enrollees vs. Waiting List Clients

Data shows the majority of waiting list clients are under the age of 55 (88%), whereas, the current enrollee population shows approximately 63% of clients at or below 55 years of age. Demographics for the 850 (851 less the one duplicate) clients are given in the table below.

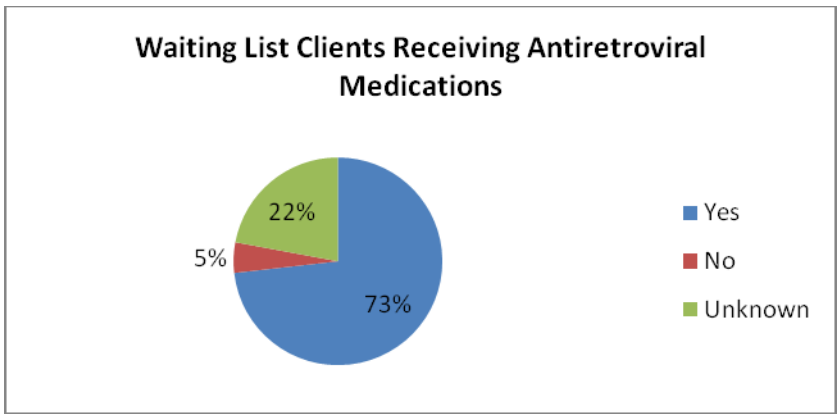
Demographics of Waiting List Clients

		Total Persons		No Verification		Verified by Medical Provider and/or Client	
		Count	Percent %	Count	Percent %	Count	Percent %
Gender	Total	850	100.0%	189	100.0%	661	100.0%
	Male	607	71.4%	141	74.6%	466	70.5%
	Female	234	27.5%	44	23.3%	190	28.7%

	Transgender	4	0.5%	1	0.5%	3	0.5%
	Unknown	5	0.6%	3	1.6%	2	0.3%
Race (multiple response)	Caucasian/White	269	31.6%	57	30.2%	212	32.1%
	African-American/Black	502	59.1%	104	55.0%	398	60.2%
	Asian	20	2.4%	3	1.6%	17	2.6%
	Native Hawaiian/Pacific Islander	5	0.6%	4	2.1%	1	0.2%
	Native American/Alaskan Native	7	0.8%	1	0.5%	6	0.9%
	Other Race	15	1.8%	5	2.6%	10	1.5%
	Unknown Race	67	7.9%	27	14.3%	40	6.1%
Ethnicity	Hispanic	47	5.5%	12	6.3%	35	5.3%
	Non-Hispanic	476	56.0%	78	41.3%	398	60.2%
	Unknown Ethnicity	327	38.5%	99	52.4%	228	34.5%
Age	19 to 34	262	30.8%	62	32.8%	200	30.3%
	35 to 44	230	27.1%	50	26.5%	180	27.2%
	45 to 54	262	30.8%	54	28.6%	208	31.5%
	55 or older	95	11.2%	22	11.6%	73	11.0%
	Unknown	1	0.1%	1	0.5%	0	0.0%
Income	Equal to or below FPL	439	51.6%	58	30.7%	381	57.6%
	101 to 200% FPL	128	15.1%	19	10.1%	109	16.5%
	201 to 300% FPL	50	5.9%	8	4.2%	42	6.4%
	over 300% FPL	22	2.6%	3	1.6%	19	2.9%
	Income not reported	211	24.8%	101	53.4%	110	16.6%

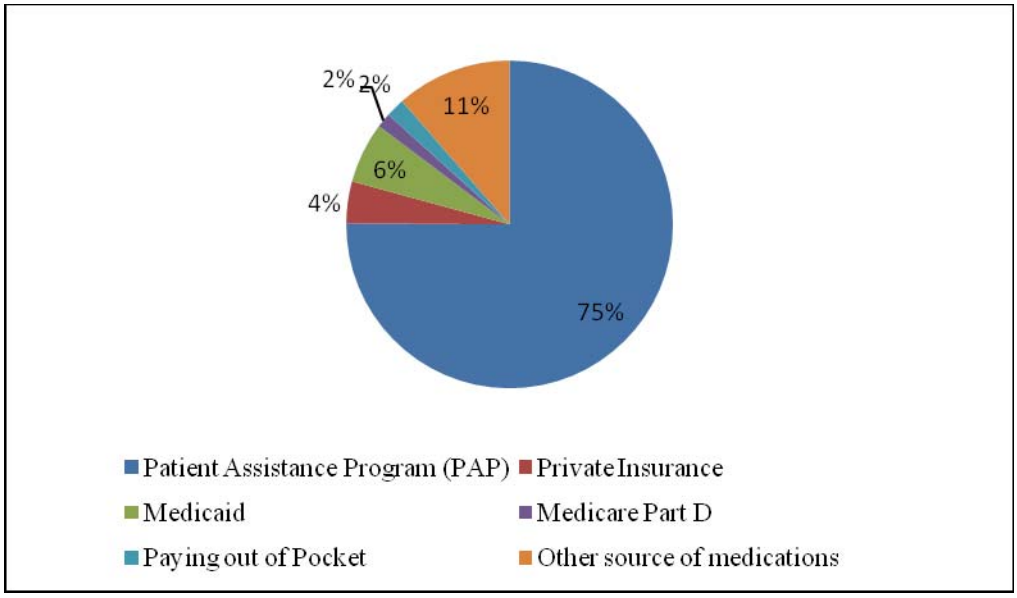
Medications Access and Insurance

The recertification process asked both clients and medical providers for the clients' source of medications and insurance. The responses are shown in the tables below for only those persons who were recertified either by the client or the medical provider (n=661). Of these clients, only 5% responded that they did not have access to medications and 22% did not respond to the question during the recertification process. Seventy-three percent were confirmed to be currently receiving medications for HIV.



Of those receiving antiretroviral medications, the access point for the majority (75%) of clients is the PAPs. Less than 2% of clients are paying out of pocket for their medications.

Medication Access Points for Waiting List Clients Receiving HIV Medications



The findings also highlighted the fluctuating nature of the population's resources. Eleven percent of the recertified population reported having some form of insurance, with Medicaid and private insurance being the two most utilized insurance types. It is common for this population to have inconsistent medication access through programs available to them. For instance, clients may have a Medicaid spend-down or insurance caps limiting the amount of drug or type of drug available to them. VDH will work to confirm the coverage available to these clients prior to their removal from the waiting list or reenrollment into the program. This information will be collected through follow up with the client and the medical provider, as well as data matches to Medicaid and other service data.

Medication and Insurance Data Verified by Medical Provider and/or Client

Medication and insurance data was reported on 661 waiting list clients (n=850). However, data was not reported under each question for all clients.		Verified by Medical Provider and/or Client	
		Count	**Percent %**
Is Currently Receiving HIV Medications?	No	31	4.7%
	Yes	484	73.2%
	Unknown	5	0.8%
	Data not reported	141	21.3%
	Total	**661**	**100.00%**

Source of Medications (multiple response)	Patient Assistance Program (PAP)	362	54.8%
	Private Insurance	20	3.0%
	Medicaid	29	4.4%
	Medicare Part D	7	1.1%
	Paying out of Pocket	9	1.4%
	Other source of medications	55	8.3%
	Not Applicable or not reported	214	32.4%
	Total	**696***	**105.03%***
Currently Has Insurance	No	362	54.8%
	Yes	70	10.6%
	Unknown	6	0.9%
	Data not reported	223	33.7%
	Total	**661**	**100.00%**
Insurance source (multiple response)	Medicare Part A/B	9	1.4%
	Medicare Part D	1	0.2%
	Medicaid	23	3.5%
	Private Insurance	27	4.1%
	Other public (VA, Indian health, etc.)	3	0.5%
	Other Insurance	4	0.6%
	Not Applicable or not reported	595	90.4%
	Total	**662***	**102.00%***

*** The total is greater than 661 or 100.00% because respondents specified multiple medications sources and/or insurance.**

Medical Characteristics

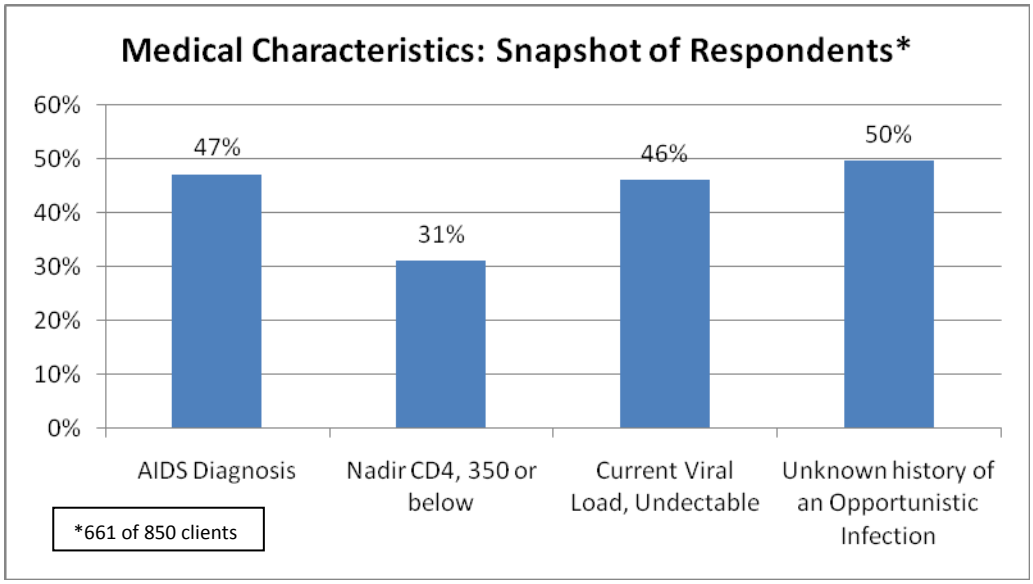
Data were collected from medical providers on the client's current clinical status:

- HIV or AIDS status,
- CD4 count,
- Nadir CD4 count (lowest ever CD4 count),
- Current viral load, and
- Opportunistic infection history.

Data reporting challenges under this category included changes in clients' source of medical care during the timeframe they were on the waiting list. Also, data was requested from high-volume, large medical centers, who manage many competing priorities. VDH staff assisted in the data collection by conducting onsite reviews due to the time intensive nature of extracting information from medical records. Future studies will take this under consideration and more time will be allotted to the collection of medical history.

Assessment findings indicate that the waiting list includes people with self-reported medical histories indicative of advanced HIV disease; however, additional information would be useful to characterize this further. An example of inconsistent responses is highlighted by the finding that 47.7% report an AIDS diagnosis (defined as a CD4 less than 200, an opportunistic infection, or other AIDS defining illness) but only 18% report a lowest CD4 count less than 200 and 8.5% report a history of an opportunistic infection. While some of these clients may still not meet eligibility for current ADAP enrollment, having more comprehensive clinical data on Virginia's current waiting list would be valuable for program planning.

When looking at current clinical status, 46% report an undetectable viral and over 60% report a CD4 greater than 350. While these findings suggest clinical stability for these groups, rates of unknowns ranging from 11-15% indicate the need for additional assessment.



Medical Characteristics Verified by Medical Provider and/or Client

Medical characteristic data was reported on a total of 661 clients on the waiting list (n=850). However, data was not reported under each question for all clients.		Verified by Medical Provider and/or Client	
		Count	Percent %
HIV Status	HIV positive, not-AIDS	120	18.2%
	HIV positive, AIDS status unknown	35	5.3%
	CDC-defined AIDS	315	47.7%
	Data not reported	191	28.9%
	Total	**661**	**100%**
Nadir CD4 count (lowest ever CD4 count)	less than 200	119	18.0%
	200 thru 349	87	13.2%
	350 to 499	79	12.0%

	500 or higher	83	12.6%
	Data not reported	293	44.3%
	Total	**661**	**100.00%**
Current CD4 count	less than 200	99	15.0%
	200 thru 349	85	12.9%
	350 to 499	112	16.9%
	500 or higher	290	43.9%
	Data not reported	75	11.3%
	Total	**661**	**100.00%**
Current Viral load	Undetectable (less than 100)	309	46.7%
	101 thru 10,000	124	18.8%
	10,0001 thru 100,000	88	13.3%
	Over 100,000	40	6.1%
	Data not reported	100	15.1%
	Total	**661**	**100.00%**
Ever Received Opportunistic Infection Treatment or Prophylaxis	Yes	101	15.3%
	No	210	31.8%
	Data not reported	350	53.0%
	Total	**661**	**100.00%**
Has a current Opportunistic Infection	Yes	24	3.6%
	No	338	51.1%
	Data not reported	299	45.2%
	Total	**611**	**100.00%**
Ever had an Opportunistic Infection	Yes	57	8.6%
	No	277	41.9%
	Data not reported	327	49.5%
	Total	**661**	**100.00%**

Next Steps to Improve Access to Medications

The recertification of the waiting list will provide valuable information to guide ADAP management. However, because Virginia (along with all states and territories) continues to wait for the final federal ADAP award, capacity of the program cannot yet be determined. Once the full federal award is received, available funding will be evaluated to determine whether additional clients can be sustained on ADAP. If so, additional enrollment will be evaluated in the following priority order:

1. Clients with current CD4 count <200
2. Clients with current CD4 count 201-350
3. Clients with current CD4 count 351-500

4. Clients with current CD4 count >500

If additional clients can be sustained on ADAP, for each group enumerated above, the number of individuals that funding could support will be assessed. If resources are not adequate to serve the whole group, waiting list enrollment date will be used to determine who is served first (first on the waiting list, first served, within that category). As clients are re-enrolled, their current medication regimen will be used to project annual cost, with potential additional cost (for example, for an added antiretroviral agent) considered to ensure sustainability of these enrollments.

While funding has been delayed, VDH has focused on efforts to maximize available funding, identify additional funding sources, and plan changes in service delivery that will improve cost effectiveness:

- Information collected during the recertification will help determine client suitability for expedited PAP access through Welvista, a non-profit pharmacy network that is able to collect and ship medications from different manufacturers to clients' homes. This will provide clients an additional option to receive medications until ADAP re-enrollment is feasible.
- Improvements to the Medicaid backbilling process used to recoup reimbursement for medications provided to ADAP clients who receive retroactive Medicaid eligibility will increase funds available to purchase medications. Additional areas of expansion are under evaluation. When this evaluation is complete, a reimbursement projection will be developed.
- VDH is applying for a second year of federal emergency ADAP funding.
- Two changes in federal regulations may assist ADAP.
    - ADAPs may now use federal funds for Medicare Part D co-payments and count these payments toward the true out of pocket incurred cost requirement that must be reached in order to leverage full prescription coverage. In addition, these payments qualify for pharmaceutical manufacturer rebates. Based on the first quarterly submission, rebates are projected to generate over $720,000 in ADAP program income. SPAP funds continue to be used to pay Medicare Part D premiums.
    - Cost and eligibility for PCIPs was reduced and simplified on July 1, 2011. This new insurance option established by federal law may be purchased with ADAP funding, instead of providing medications at full cost. Information obtained during the recertification process indicates about 80% of clients may be eligible. An initial projected cost/benefit analysis for enrollment from ADAP to PCIP coverage has shown variability of cost savings by age group, corresponding with varying premium and plan costs associated with the program. The cost/benefit for ADAP specifically correlates to whether clients access medications for the full 12 months of the calendar year, with any medication interruption or partial year

coverage reducing cost effectiveness. Ongoing cost analysis is occurring to determine the most appropriate method of implementing PCIPs to maximize benefit to ADAP.

The additional state funding provided to ADAP in state fiscal year 2011 and 2012 has been instrumental in stabilizing this important program. The funding supports purchase of medications, thereby sustaining medication access for clients currently utilizing ADAP. When combined with the anticipated federal funding, cost savings, additional funding sources and alternative medication access options described above, VDH anticipates that the program will become more sustainable and will be able to more fully meet the needs of those it serves.