AIDS Drug Assistance Program Report

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

October 1, 2012

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

G. The Commissioner of Health shall monitor patients who have been removed or diverted from the VA 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.

Summary

The Virginia Department of Health (VDH) has broadened Virginia (VA) AIDS Drug Assistance Program (ADAP) enrollment criteria and reduced the ADAP waitlist. Elimination of the wait list is anticipated by September 30, 2012. Aggressive program management, including cost-savings efforts, implementation of strategies both to meet client demand and sustain program capacity, and identification of additional funding sources, has supported these changes. The collaborative efforts of medical providers and their staffs, community partners and advocates, local health departments, elected officials, ADAP staff, and Virginia's client community have played an essential role in effectively and creatively overcoming the challenges ADAP has faced.

Background

VA ADAP provides life-saving medications for the 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 a 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 (OI). Eligible clients must have family incomes at or below 400% of the federal poverty level (FPL); however, the majority of enrolled clients (82%) have incomes below 200% FPL. Enrolled clients are assessed twice yearly to ensure continued eligibility for the program.

During the RW Part B Grant Year (GY) 2010 (April 2010-March 2011)[1], VA ADAP experienced steep increases in program utilization compared to the prior year, and pharmaceutical expenditures reached a historic high. Additionally, rising unemployment rates and corresponding loss of insurance, expanded HIV testing efforts, new HIV treatment guidelines recommending initiation of HIV treatment as early as possible, and new medication regimens all contributed to the steep growth in ADAP utilization and expenditures during this period. Data analysis from 2007 to 2009 indicated that client enrollment and monthly medication costs steadily increased by 21% and 15%, respectively.

Subsequently, in November 2010, aggressive cost containment measures were instituted. These included the implementation of a wait list for ADAP services, the transition of some clinically stable patients to other sources of medication access, a reduction to the ADAP formulary, and enrollment restrictions. As a result, ADAP enrollment criteria were limited to pregnant women, individuals 18 years old or younger, and people who were currently receiving treatment for an active OI.

In GY 2011, VA ADAP has maintained many of these cost containment measures and has implemented several new cost savings approaches. These efforts combined with the strategies described in this report have allowed for the expansion of ADAP enrollment.

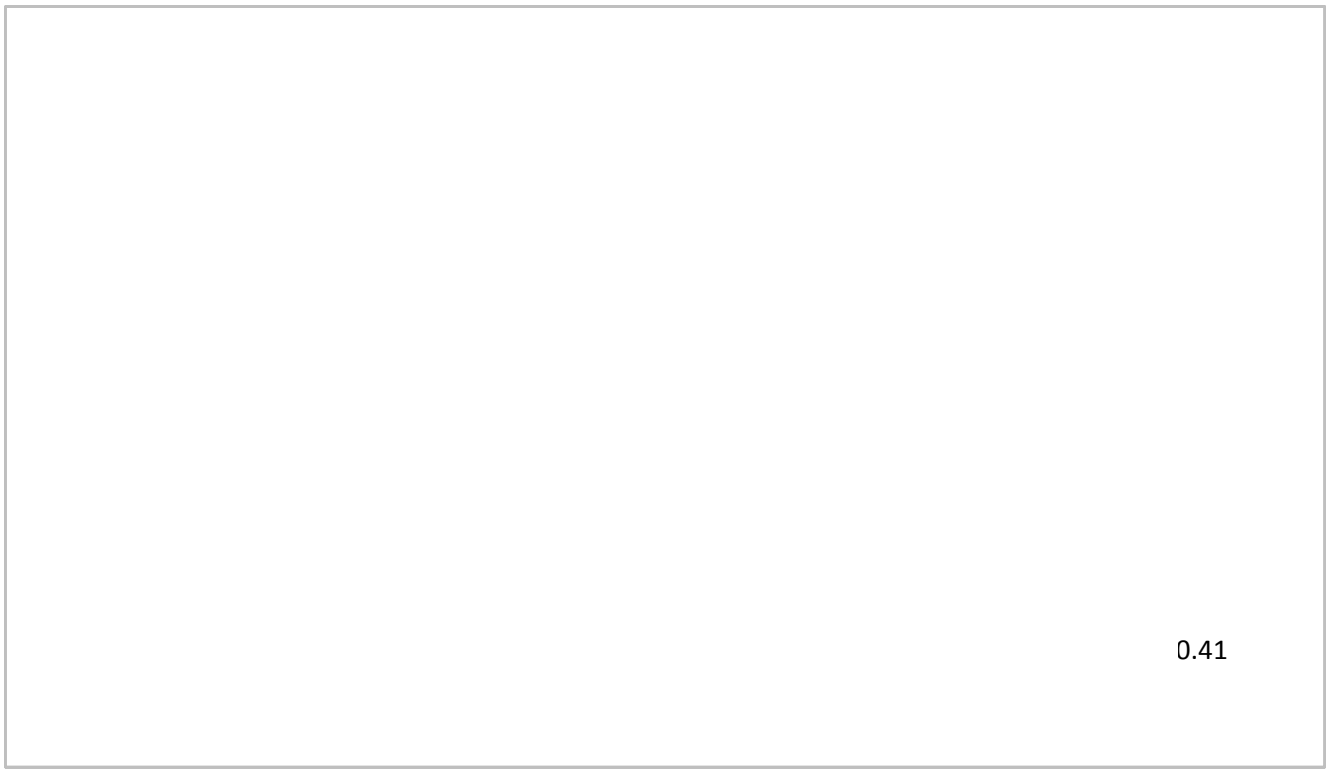
ADAP Expenditure Summary by Funding Source

Consistent with previous years, the largest funding source for VA ADAP consists of federal RW Part B funds administered through the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (DHHS). RW funds are discretionary resulting in fluctuations from year to year. Reflected in the chart below, (Figure 1: GY 2011 ADAP Expenditures Summary by Funding Source), the Part B base award consists of an ADAP earmark award and Part B base service funds that VDH allocated to the purchase of medications. In GY 2011, VDH competed for and was awarded $3,000,000 in federal ADAP Emergency Relief Funds. VDH also applied for and was awarded this same level of ADAP Emergency Relief Funds for GY 2012. During GY 2011, both RW Part A grantees that serve jurisdictions in VA (i.e., the cities of Norfolk and Washington, D.C.) made one-time contributions to VA ADAP utilizing unspent grant balances at the end of the Part A budget period. Finally, state funds represented in the chart below reflect appropriations made in state fiscal year 2011 that were expended during the RW GY 2011.

[1] The RW Part B GY 2011 ran from April 1, 2011- March 31, 2012. RW Part B GYs run from April 1 to March 31 and are named for the year in which they begin.

During GY 2011, state contributions to VA ADAP totaled slightly over $4.8 million and were used to help enroll and sustain clients in the program. With average monthly client costs at $906 per person ($10,867 annually), these funds sustained 451 clients on the program during this time period.

Figure 1: GY 2011 ADAP Expenditures Summary by Funding Source



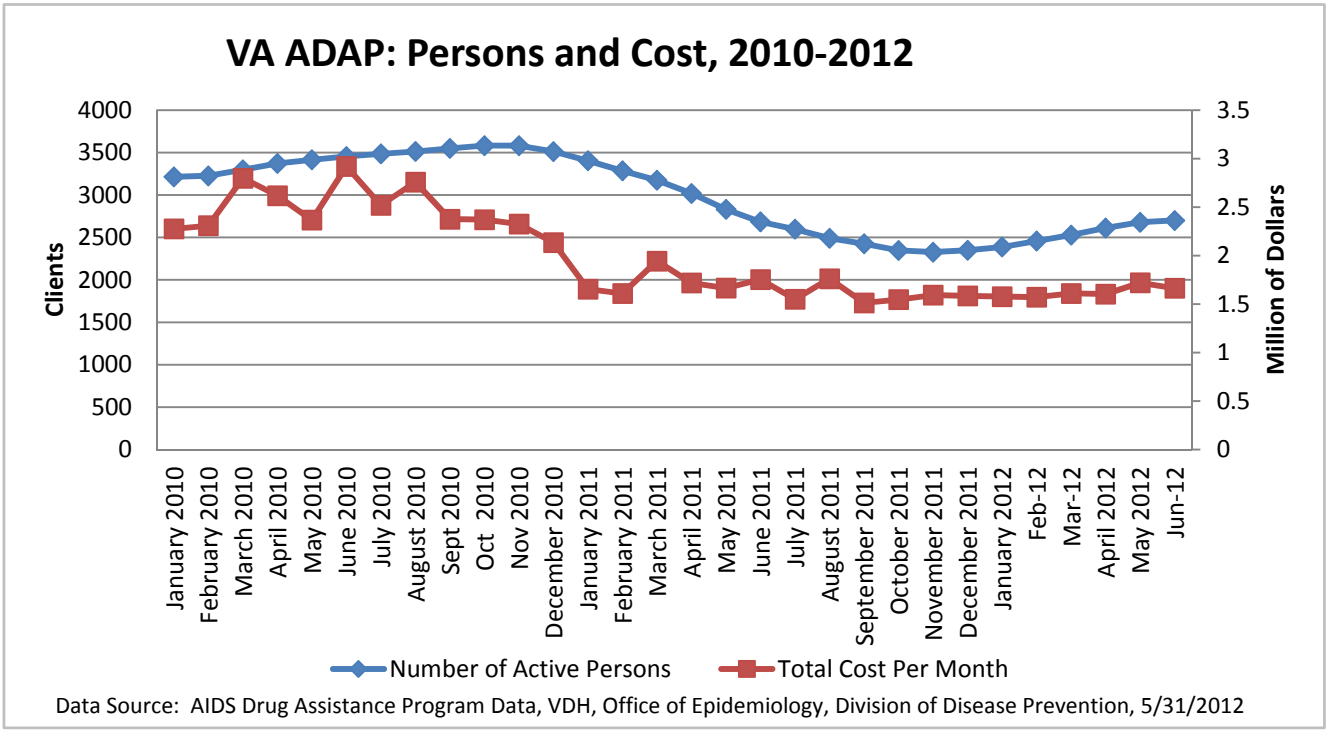
ADAP resources and expenditures are monitored on an ongoing basis and are reviewed weekly by a multidisciplinary team with biweekly summaries reported to the Chief Deputy Commissioner for Public Health. This careful monitoring and communication have enabled assessment of resources and incremental broadening of clinical enrollment criteria that has allowed ADAP to serve more people.

Current ADAP Trends

Figure 2 provides a summary of VA ADAP utilization from January 2010 to June 2012. The number of persons receiving ADAP medications continued to decrease gradually in early 2011. Incremental broadening of clinical enrollment criteria began in November 2011. CD4 count, a clinical marker of immune functioning (where low counts=low function), was used to prioritize groups for ADAP enrollment. Enrollment was first expanded to new and wait-listed persons with CD4 counts less than 200. This was followed by inclusion of those with CD4 counts between 201-350 in December 2011 and those with CD4 counts between 351-500 in April 2012. The resulting increase in the number of persons receiving ADAP medications is reflected in the graph below. VA ADAP has enrolled 717 eligible wait-listed or new clients into ADAP (through June 28, 2012) resulting from these changes to clinical enrollment criteria. In June of

2012, VA ADAP served 2,700 active clients. The monthly cost for ADAP has decreased from a high of $2.9 million in June 2010 to a current average of $1.7 million for 2012.

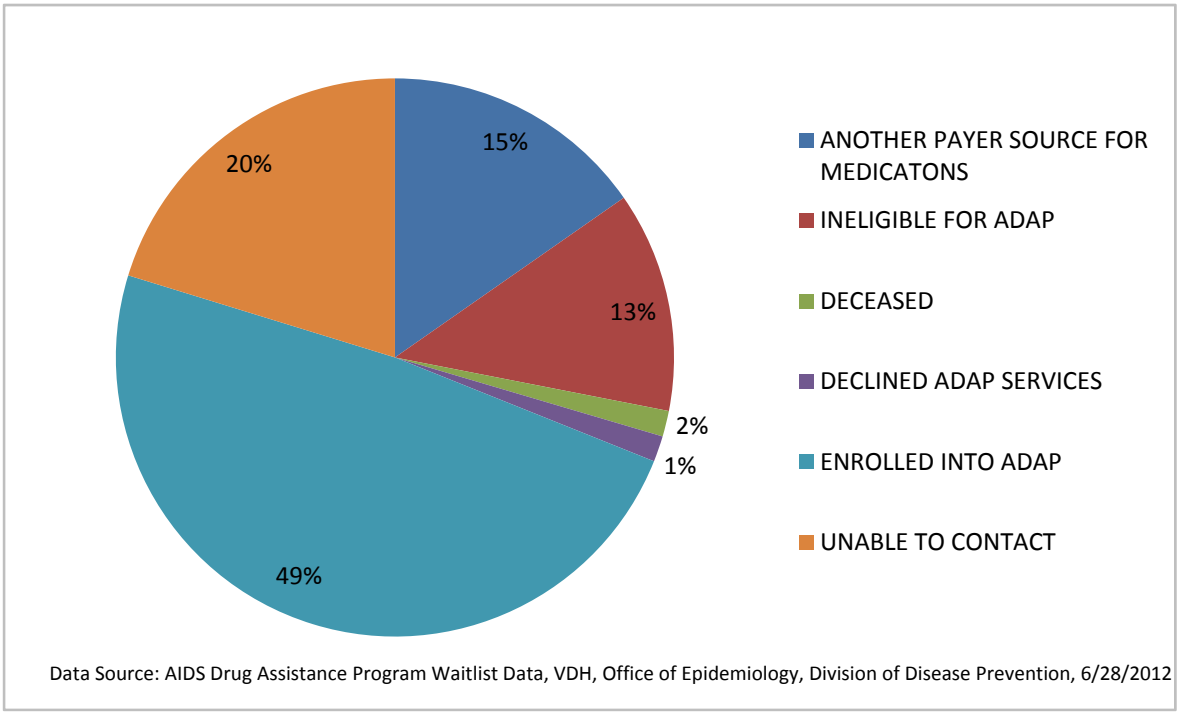
Figure 2: VA ADAP Utilization



Note: "Active Persons" is defined as the number of clients who have received a prescription in the past 5 months.

The VA ADAP wait list reached an all-time high of 1,112 persons on December 21, 2011, but has since decreased. As of June 28, 2012, the wait list included 573 persons. Since its implementation, 869 clients have been removed from the wait list for a variety of reasons, which are summarized in Figure 3. Forty-nine percent (n=423) have been enrolled into ADAP. Fifteen percent were removed from the wait list when another payer source for medications was identified, such as Medicaid or private insurance. Additionally, 111 persons were found to be ineligible for ADAP. Most common causes of ineligibility included moving out of state, incarceration, or exceeding VA ADAP income limits. Thirteen persons on the wait list were deceased. Follow up with these individuals' medical providers indicated that causes of death were not related to medication access issues. Twenty percent of persons were removed from the wait list because they could not be contacted. To ensure a uniform effort was made to reach these clients, VDH developed a procedure specifying the number, timing, and method of contact attempts (at least 3 attempts, one of which must occur in the evening or on the weekend using all available contact information). Written notification was sent to the last known address for the individual and last medical provider of record when these contact efforts were not successful.

Figure 3: VA ADAP Wait List Removals Through 6/28/2012



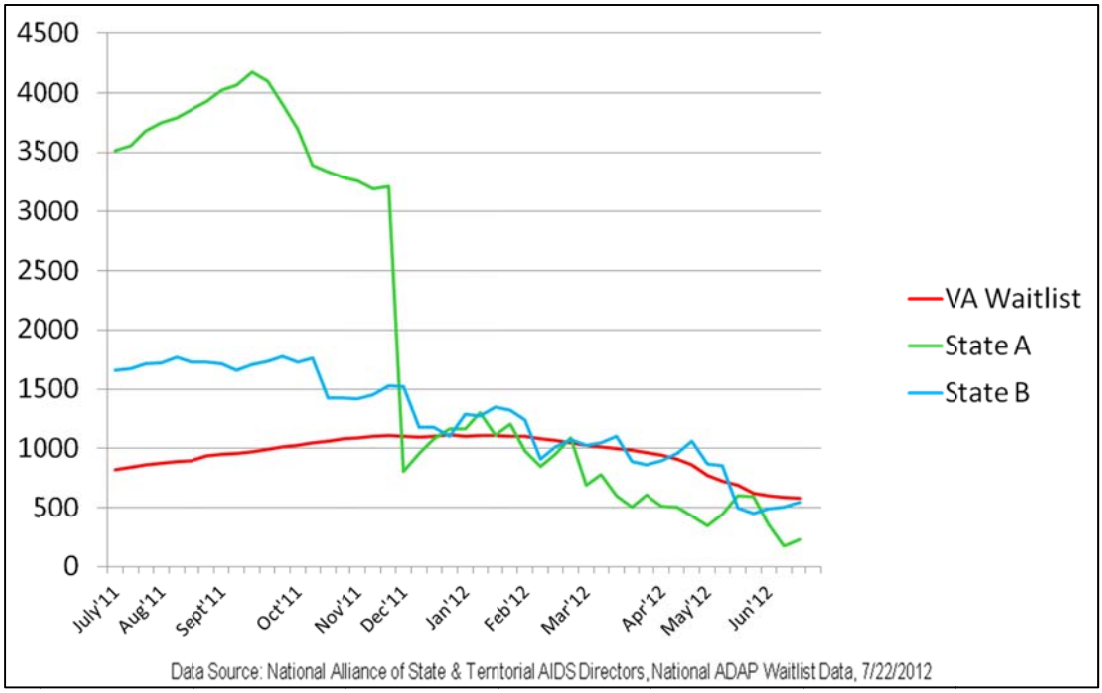
Data Source: AIDS Drug Assistance Program Waitlist Data, VDH, Office of Epidemiology, Division of Disease Prevention, 6/28/2012

VDH contacts all individuals on the wait list every 6 months. During this recertification process, each individual's access to medications is assessed. For those receiving medications, the source (such as drug manufacturers' patient assistance programs (PAPs), Medicaid or private insurance) was identified. Wait list recertification showed that 9.6% of individuals were not currently receiving medications. This group included individuals with no prior history of HIV treatment (treatment naïve) and those who had not completed necessary documentation (such as wait list enrollment form). If an individual was not currently receiving medications, additional assessment was conducted to identify the most appropriate medication source. Information on alternative sources was reviewed. A referral to a case manager was completed and/or communication with the individual's medical provider occurred to ensure the individual obtained the assistance needed with enrolling into a PAP or other appropriate medication source. In addition, during the recertification process, updated financial, insurance, residency, and medical information was collected from all available sources including the individual, his/her medical provider, case manager, as well as HIV surveillance and RW services data. In the last quarter of state fiscal year (SFY) 2012, this process was utilized to facilitate full ADAP eligibility reviews for individuals on the wait list in order to expedite their future ADAP enrollment process.

Figure 4 shows the weekly wait list numbers for VA ADAP since July 2011 compared with two other states that also had wait lists during that time period. While the other states have had extremely large fluctuations in their weekly numbers, VA ADAP has demonstrated a steady decrease over time, indicating careful management of clients and resources to ensure sustainability and avoid future disenrollment of clients. Virginia is also unique in its use of clinical criteria to manage the wait list and performing ongoing assessment of individuals on the

wait list. Virginia has garnered national attention for its innovative approaches to addressing the challenges ADAP has faced.

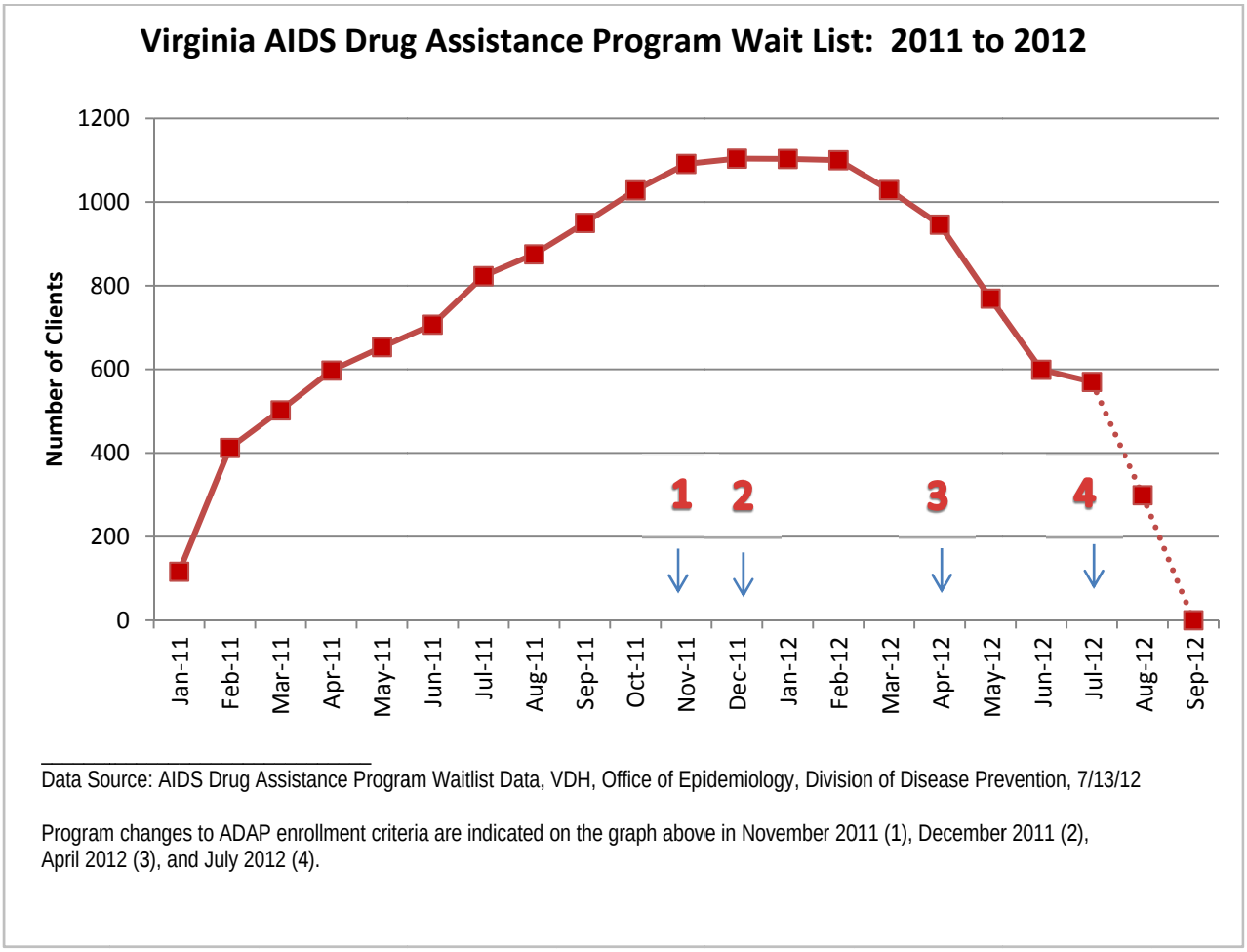
Figure 4: VA Weekly ADAP Wait List Comparison



ADAP Enrollment Expansion

As described earlier in the report, clinical enrollment criteria have been broadened incrementally as additional ADAP resources have been identified and projections support the long term sustainability of additional enrollment. As described above, a medical triaging process based on a marker for immune functioning (CD4 count) has been used to identify clients prioritized for enrollment to ADAP, including both those on the wait list and new clients seeking ADAP services. In early July 2012, based on the effectiveness of this approach and supported by weekly monitoring of ADAP service utilization and expenditures, VA ADAP began the final steps toward elimination of the wait list. Currently, work is underway to transition all clients on the wait list to ADAP. By September 30, 2012, all individuals currently on the wait list will be enrolled and receiving their HIV treatment medications from ADAP. Figure 5 reflects the gradual and steady reduction in the VA ADAP wait list over 2011-2012, indicates where changes in ADAP program enrollment criteria were made throughout the year, and shows the projected elimination of the waitlist (dotted line).

Figure 5: Virginia ADAP Wait List Changes to Enrollment Criteria



Data Source: AIDS Drug Assistance Program Waitlist Data, VDH, Office of Epidemiology, Division of Disease Prevention, 7/13/12

Program changes to ADAP enrollment criteria are indicated on the graph above in November 2011 (1), December 2011 (2), April 2012 (3), and July 2012 (4).

Continued collaboration between public health and partners in both the public and private sectors has proven essential to effectively and creatively overcome ADAP's challenges. Aggressive program management has strengthened VA ADAP's ability to serve its current clients and to accommodate future program growth. Effective strategies utilized by the program include cost containment measures to increase programmatic and pharmaceutical efficiencies; increased efforts to maximize use of other payer sources; and help for wait-listed clients accessing medications through alternative sources.

Increased Program Efficiencies

Shifting of GY 2011 RW Part B Service Funds

Amidst federal funding reductions and the ADAP shortfall, VDH staff strategized with community partners to identify where additional areas for savings could be realized while preserving critical medical services. This process led to a reallocation of over $350,000 from Part B support services to the direct purchase of ADAP medications during GY 2011.

Improved Eligibility Practices

During GY 2011, VDH implemented a centralized process to determine client eligibility for ADAP, launching the process regionally, with statewide expansion completed in April 2012.

Centralization of the process ensures consistency of client eligibility determination and verification of ADAP as the payer of last resort, thereby complying with federal RW requirements. Additional benefits include increased availability of relevant data for programmatic and fiscal management and cost savings resulting from the transition of this function from an external contractor to internal ADAP staff.

In addition, clients are assessed twice a year to verify that they remain eligible for ADAP services. This process is referred to as "recertification." During GY 2011, VDH refined its ADAP client recertification processes resulting in increased effectiveness in managing the wait list and maintaining up-to-date eligibility documentation for clients enrolled into ADAP. The recertification process includes the evaluation of other potential payer sources, documentation of VA residency, current income level, and program inactivity. The process also includes verification with vital records data to determine if any clients are deceased or have become ineligible for ADAP due to incarceration. Medical information is reviewed to ensure that current CD4 counts and other medical information are up to date. Wait-listed clients are assessed through a similar recertification process every 6 months. The recertification process yields a cost-savings as clients with other payer sources, including Medicaid and private insurance, are identified and removed from ADAP and the wait list.

Other eligibility improvements included clarification of some criteria such as the state residency requirements and intermittent use of ADAP. In December 2010, VA ADAP instituted a policy that identifies clients who had not filled an ADAP prescription in 6 months or longer as inactive. These clients are notified, along with their last medical provider of record, that they must reapply to ADAP when seeking additional medication from the program. ADAP reviews these clients on a case-by-case basis and provides interim medication access if needed to avoid treatment interruptions.

Increased Pharmaceutical Efficiencies

30-Day Dispensing Policy

In December 2010, VA ADAP implemented a policy that allowed a maximum 30-day supply of medications to be dispensed at a time. This measure enables VA ADAP to ensure tighter inventory control, reduce medication wastage from regimen changes, and ensure that all eligible clients are receiving equitable access to medications. Furthermore, this policy has allowed VA ADAP a greater opportunity to recoup funds available through Medicaid back billing efforts, which denies claims for medications dispensed for greater than a 34-day supply.

Pharmacy Inventory

Since the inception of the ADAP wait list in November 2010, the state's Central Pharmacy has instituted an aggressive inventory management strategy, which tracks monthly inventory for the program and calculates average per day costs. This strategy has allowed for more efficient utilization of inventory with levels reviewed at weekly VDH meetings that involve leadership from the Office of Epidemiology and the Central Pharmacy. The average daily utilization costs for the central pharmacy decreased from $75,000 in October 2010 to $49,698 in March 2012.

Formulary Reductions

In consultation with the ADAP Advisory Council (AAC), a stakeholder group consisting of HIV medical providers, a pharmacist, and an individual living with HIV, the VA ADAP medication

formulary was reduced in November 2010. Medications in the following drug categories were removed: adjuvant therapies, anti-anxiety medications, antidepressants, antilipidemics, bipolar agents, antipsychotics, and treatments for hepatitis C. Currently, the ADAP formulary provides 28 antiretrovirals, 7 vaccines, and 34 medications to prevent and treat opportunistic infections. VA ADAP staff researched and provided alternative access points for all medications that were removed from the formulary. Alternatives included identifying generic formulations of medications available at a low cost through retail pharmacies, as well as medications available through individual PAPs.

Medication Supply for Released HIV-Positive Inmates

As a result of enrollment restrictions in November 2010, VDH was unable to continue to provide a 30-day supply of HIV medications to individuals being released from state correctional facilities through the Seamless Transition Program (STP). During this time, VDH provided guidance to Department of Corrections (DOC) and local health departments (LHDs) statewide on how to utilize an alternative VDH program (Comprehensive HIV/AIDS Resources and Linkages for Inmates (CHARLI)), which provides pre- and post-release case management services to HIV-positive individuals in state correctional facilities. CHARLI service providers received training on how to enroll clients to PAPs and began providing this assistance to clients released from DOC. As enrollment into ADAP began expanding starting in November 2011, the 30-day medication supply to released inmates was also reinstated for those who were currently eligible for ADAP enrollment. VA ADAP will continue to partner with the CHARLI program through the newly awarded Special Projects of National Significance (SPNS) Systems Linkages and Access to Care initiative in GY 2012 to build a more comprehensive referral system for DOC facilities statewide.

Providing Information on Clinically Equivalent Regimens

In October 2010, the AAC discussed the potential use of lower cost clinically equivalent HIV treatment regimens when prescribing antiretrovirals (ARVs). Committee members indicated an interest in educating other HIV medical providers on lower cost regimens. VDH prepared an informational presentation for the AAC detailing the price differential by percentage between various clinically approved HIV treatment regimens. For example, in March 2012, Atripla® was the least expensive of the regimens categorized as preferred by national treatment guidelines, and Truvada® with boosted atazanavir was the most expensive (40% more expensive). This presentation is intended to provide requested information to AAC physicians for their use in educating other HIV service providers about the impacts of prescribing practices on ADAP costs. It is not intended as a guide for what medications physicians should prescribe.

Identifying Alternative Resources for Medication Access

With restricted enrollment into ADAP over the past two grant years, VDH has actively facilitated client access to life-saving HIV medications through drug manufacturers' PAPs, Welvista, and other alternative sources of medication. During the initial transition of clients from ADAP to the wait list in November 2010, VDH staff ensured that VA ADAP continued to provide medications to each client until confirmation of successful enrollment into PAPs was completed in order to minimize any possible treatment interruptions. VDH staff conducted technical assistance trainings and developed online and print resources identifying access points for PAPs for antiretroviral medications, OI medications, and medications removed from the formulary. Additionally, staff identified low-cost generics at retail pharmacies and co-pay assistance programs available through some pharmaceutical manufacturers. These strategies

have ensured medication access to individuals unable to enroll into ADAP during the funding shortfall. In early 2012, VDH was informally consulted by HarborPath, a not-for-profit organization, on the establishment of a common portal for PAP applications. VDH was sought out to share knowledge of PAP application processes utilized by different pharmaceutical companies and barriers faced by clients and medical providers completing multiple applications.

In May 2011, Welvista, a non-profit mail-order pharmacy located in South Carolina, became certified by the VA Board of Pharmacy to provide medications to wait-listed ADAP clients in VA. Welvista, in partnership with Heinz Family Philanthropies and pharmaceutical manufacturers, provides simplified access to medications rather than the standard PAP processes that currently exist. Since VA ADAP began utilizing Welvista as an alternative source of medication access for eligible clients, 213 clients have received medications through this source. VDH staff provided extensive technical assistance regarding access to Welvista for eligible clients including 2 teleconference trainings attended by 120 stakeholders statewide.

Maximizing Use of Other Medication Programs

Medicaid Back Billing

Over the past year, efforts to increase Medicaid back billing revenue by establishing contracts with Medicaid health maintenance organizations (HMOs) have yielded reimbursement revenue that has been used for direct purchase of medications. Providers screen clients for Medicaid eligibility at time of patient intake and require potentially eligible clients to submit applications for Medicaid. If the client is approved for Medicaid, coverage can retroactively date back 12 months, and funds can be recouped and used toward ADAP.

ADAP as TrOOP

Changes made to federal law as of January 1, 2011, allow state ADAPs to use federal funds for Medicare Part D medication co-payments and count these payments as True Out Of Pocket expenses (TrOOP). VA ADAP started using federal ADAP dollars for cost sharing on this date while continuing to pay premiums with State Pharmaceutical Assistance Program (SPAP) dollars. This combined use of state and federal funds has allowed additional clients to move from ADAP to SPAP/Medicare Part D. Supporting eligible clients under this type of medication assistance structure is one-third of the cost of supporting direct purchase medications on ADAP. Furthermore, these payments qualify for pharmaceutical manufacturer rebates further increasing program revenue that can be used to support VA ADAP.

Medicare Part D Rebates

VA ADAP secured a 340B rebate registration from HRSA's Office of Pharmacy Affairs (OPA) in September 2010. The 340B Rebate status is used to pursue rebates for co-payments provided to Medicare Part D clients with ADAP dollars who access drugs through a retail pharmacy (not at 340B pricing) and will be expanded to include insurance continuation medication co-payments once this model is implemented (see Next Steps section on page 12). These rebates currently provide about $900,000 in program income for VA ADAP annually.

Table 1 shows the amount of approximate savings each of the above mentioned cost containment measures yielded during GY 2011.

Table 1: Savings from VA ADAP Cost Containment Strategies

STRATEGY	SAVINGS	SOURCE
Medicaid Back Billing	$367,727.39	VDH Fiscal Data
ADAP as TrOOP	$1,019,267.63	Calculation based on savings from having clients on SPAP as opposed to ADAP.
Medicare Part D Rebates	$896,526.02	VDH Fiscal Data
30-day Dispensing Policy	$546,623.28	Calculated as: [18% of client served in RW 2011] x [1.3 months of cost] + [% of MBB recoveries]
Improved Recertification Processes	$1,086,514.81	Of all clients served in RW 2011, [number found to have other payer sources] x [average annual costs]
Removal of Inactive Clients	$1,655,918.29	[Clients on wait list as of 3/30/2012 who previously were on ADAP (Not disenrolled clients)] x [average annual med costs]. This represents a deferral of potential costs if intermittent ADAP access was not controlled.
Residency Policy	$56,709.47	Cost Saving Projections from Policy Implementation
Formulary Reduction	$325,810.36	Calculations based on 45% of clients served utilizing other medications at an annual cost of $237.84
Enrollment Restrictions	$3,945,152.70	[Clients on wait list (minus inactive clients) as of 3/30/2012] x [average annual cost]
Part B Service Reductions	$355,126.70	Part B Services Reductions
Seamless Transition Program (STP) reductions to 30- Day Medication Supply for Inmates	$23,240.96	[STP clients] x [monthly cost]
TOTAL SAVINGS	$10,278,617.60	

National Recognition of Program Management

In May 2012, VA ADAP received the Program Excellence Award at the National Alliance of State and Territorial AIDS Directors (NASTAD) annual meeting in Washington, D.C. VA ADAP was recognized for the methodology utilized to ensure alternative medication sources for clinically stable ADAP clients as a strategy to manage the funding shortfall, and for the clinical triage system used to implement and manage the wait list. VA was cited as a national leader in managing the funding shortfall while ensuring client access to medication.

In March 2012, the Director of the HIV Care Services Unit (which manages ADAP) within VDH was appointed by the NASTAD to an advisory group for ADAPs. The Professional Expert Educational Roundtable provides peer-based advice and guidance to ADAPs around the nation on current issues, including financial forecasting, cost containment and wait list management, coordination with other payers, PAPs, and client-level data systems. This appointment provides VA ADAP an opportunity to benefit from other states experiencing similar challenges by the exchange of lessons learned through this process.

In April 2012, VDH was invited to a meeting in Washington, D.C., hosted by the NASTAD, to discuss financial forecasting techniques for ADAPs. VA was the only state at this meeting whose ADAP currently had a significant wait list and, as such, provided an important perspective on how the needs of states with ADAP wait lists should be considered when designing a tool to determine program capacity. The use of weekly ADAP monitoring tools and VDH leadership

meetings, which bring together leadership from the Office of Epidemiology, VA ADAP, and the Central Pharmacy to discuss ADAP program decisions, were cited by this group as an excellent method for maximizing programmatic and fiscal resources to guide ADAP decision making.

In addition to national acknowledgement of ADAP program management, VDH successfully competed for additional federal funding to enhance and improve VA ADAP data management processes. The SPNS Health Information Technology Capacity Building Initiative grant was awarded to fund creation of a centralized data repository for ADAP. This will provide access to data in near real time on a secured server, thereby decreasing the current administrative burden of the program and increasing the utility of the data collected. Real-time access, centralized within VDH's existing data structure, allows for more effective evaluation and planning for VA ADAP's ever evolving programmatic needs. This SPNS grant is assisting with transitioning the current off-site client-level data collection system for ADAP (which began in 1997) to a VDH repository that will include data from multiple sources, such as the state health department information management system (WebVISION), Medicaid eligibility data, pharmacy data, and electronic laboratory reporting (ELR).

Next Steps for Improved and Sustained Access to HIV Medications

Over the next several months, VDH will eliminate the wait list and return VA ADAP to its prior capacity to serve all eligible clients in need of HIV medication assistance in the Commonwealth. Additionally, through sustained efforts to increase program efficiencies, VA ADAP will enhance program access and benefits for ADAP clients by providing insurance coverage to those eligible through the Pre-Existing Condition Insurance Plan (PCIP) program and other available insurance purchase options. These strategies will yield savings to ADAP and enable the program to serve HIV-positive individuals in VA more effectively and comprehensively. Furthermore, VDH will continuously monitor anticipated increases in client demand for ADAP services resulting from increased testing and linkage to care efforts occurring across the state over the next year.

Returning ADAP to its Prior Status and Enhancing Program Access and Benefits

Removal of ADAP Enrollment Restrictions

By removing clinical enrollment restrictions, VA ADAP will be able to adhere to current *Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents* released in April 2012 by DHHS. Included in the newly released treatment guidelines is the recommendation to initiate antiretroviral treatment (ART) for all HIV-infected individuals regardless of an individual's CD4 count. The recommendation to initiate therapy at any CD4 count is "based on growing awareness that untreated HIV infection or uncontrolled viremia may be associated with development of many non-AIDS-defining diseases, including cardiovascular disease, kidney disease, neurologic complications, and malignancy."[2]

Furthermore, from a public health perspective, HIV treatment plays a critical role in HIV prevention. HIV medications reduce the amount of HIV in a person's body (viral load) and, therefore, significantly reduce the risk that a person receiving medications will transmit HIV. By initiating and adhering to HIV treatment earlier, this effective prevention strategy can change the

[2] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/AdultandAdolescentGL.pdf. Accessed May 15, 2012.

course of the epidemic. Removal of ADAP enrollment restrictions will allow VDH to address more effectively these critical issues.

Reinstating the ADAP Formulary
Currently available resources will enable VA ADAP to reinstate medications that were previously removed from the ADAP formulary, such as antilipidemics, antiglycemics, and medications to treatment mental health disorders. These additional medications play a critical role in addressing complications of HIV treatment and other co-occurring conditions that impact the course of HIV disease. By receiving medications through a single source, important safeguards, such as identifying potential drug interactions, are more effectively achieved. Ensuring that clients are adhering to all prescribed medications is more feasible. In addition, the burden on medical providers and clients resulting from coordinating multiple medication sources is reduced. Restoring these medications will result in more efficient and comprehensive access to needed medications for clients and providers.

Enhancing the Model for Providing HIV Medications to ADAP Clients

Strengthening and Improving the Eligibility Process for All HIV Services
VDH is moving toward a model of providing both HIV medications and services to clients under a restructured and enhanced system that incorporates centralized management of service eligibility and the provision of insurance coverage for eligible clients. Centralizing the eligibility process within VDH for determining client access to RW medical services, ADAP medications, and insurance coverage will allow VDH the ability to monitor systematically and track client access to and retention in care and to respond to the medical needs of clients more comprehensively. This process will provide VDH with more accurate, complete, and up-to-date data on clients accessing VDH-funded services. It also will allow VDH to triage clients into the most appropriate and cost effective system of care.

Moving Toward a Model of Insurance Coverage
Beginning in GY 2012, VA ADAP will transition eligible ADAP clients to coverage under PCIP using experience gained through management of the cost-effective SPAP. The PCIP program is intended for individuals unable to obtain medical insurance and prescription drug coverage due to a pre-existing medical condition, such as HIV/AIDS. Using current annual estimates to support HIV medications through VA ADAP, purchasing PCIP for eligible clients is a more cost effective means of providing both prescription drugs and medical services. As with other insurance programs, PCIP offers coverage for both medical services and prescription drugs under the same plan, thereby providing enhanced benefits to clients who currently access their HIV medications through ADAP only.

The PCIP program offers a tremendous cost savings to VA ADAP and will allow VDH to serve and sustain more clients on ADAP over time. Using existing data, it is anticipated that for the cost of serving one client under the current ADAP structure, three to four clients can be served under the PCIP program. By maximizing the cost-effective use of ADAP funding through the purchase of PCIP for those eligible clients, VA will be able to provide both needed HIV medications and additional medical services for a larger number of clients in the Commonwealth. VDH has begun a pilot project in the eastern and northern regions of the state to prepare for the implementation of PCIP. This pilot tests the processes for client contact and assistance with PCIP application completion. Prior to implementation, a statewide educational campaign is

being conducted that educates clients, medical providers, and other stakeholders on PCIP. As of June 30, 2012, 283 people living with HIV/AIDS and 494 other stakeholders, including medical providers, have attended VDH-facilitated educational forums on PCIP.

Responding to Anticipated Increases in Client Demand and Program Sustainability

Over the past two years, VA ADAP has encountered programmatic and funding challenges that have necessitated restrictions on program access. Throughout these challenges, VDH has continued to respond to the needs of HIV-positive individuals in VA through facilitation of medication access from other sources, aggressive fiscal management, close collaboration with community partners, and lowered medication costs through agreements with pharmaceutical companies. Program management decisions were made carefully to ensure client sustainability on ADAP over time. Consequently, VDH has expanded its ability to serve clients in need and accommodate program growth.

In addition to ensuring client sustainability, VDH is monitoring anticipated increases in demand for ADAP services as a result of enhanced HIV testing and linkage to care efforts that are currently being emphasized at both national and state levels. These efforts include the SPNS Systems Linkages and Access to Care initiative previously mentioned. This initiative is designed to create innovative methods to increase the number of persons linked to care within 3 months of their HIV diagnosis; increase the percentage of those retained in HIV primary medical care; and increase the percentage of persons living with HIV who are virally suppressed. Over GY 2012, VDH will monitor continuously and analyze anticipated increases in client demand for ADAP services resulting from the outcome of these efforts and will respond to these demands accordingly.

Access to appropriate treatment for everyone living with HIV/AIDS is critical to maintaining the health of individuals, as well as communities across the Commonwealth. HIV medications, such as those provided through ADAP, support longer and healthier lives for those living with HIV/AIDS. HIV medications lower the amount of HIV in a person's body and, therefore, are one of the most effective ways to decrease transmission to other individuals. Access to medication and medical care, along with testing and identifying infection as early as possible, represents strategies to effectively reduce future cases of HIV/AIDS. The impact of state and federal funds and improved efficiencies in program management have contributed significantly to the ability to expand ADAP enrollment and serve more clients in need of HIV medications and services throughout the Commonwealth. As VA ADAP expands its capacity over the next year and responds to growing demands for ADAP services, sustaining clients on life saving HIV medications will continue to depend heavily on the support from each of these resources.