2019 AIDS Drug Assistance Program Report

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Virginia Department of Health

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Executive Summary

The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) providing FDA-approved medications to low-income people living with HIV who have limited or no health coverage. ADAP funds are also used to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of drug treatments. As of March 31, 2019, there were 7,737 clients enrolled in ADAP in Virginia. With the implementation of Medicaid expansion on January 1, 2019, the Virginia Department of Health (VDH) began to transition clients from the ADAP to Medicaid coverage. As of March 31, 2019, 1,624 clients who had been previously receiving ADAP assistance are enrolled in Medicaid. The transition of these individuals into Medicaid coverage allows VDH to redirect some funds to expand HIV services to meet the changing needs of people living with HIV and further efforts to eliminate HIV in Virginia.

Introduction

This report provides an overview of Virginia's ADAP service utilization, efforts to enroll clients into Medicaid, service provision to clients not eligible for health insurance, and program considerations to address the growing needs of an aging population of people living with HIV.

Background

ADAP provides access to life-saving medications for the treatment of HIV infection to low-income eligible clients through three mechanisms: (1) paying health insurance premiums and medication cost shares (e.g., deductibles, co-payments, and co-insurance) for ACA Marketplace and Medicare Part D plans, (2) paying medication co-payments for clients with non-ACA employer-based insurance plans for medications on ADAP's formulary (www.vdh.virginia.gov/disease-prevention/formulary/), and (3) direct provision of medications

(Direct ADAP). ADAP eligibility requirements include household income at or below 500% of the Federal Poverty Level (FPL), documented HIV diagnosis, proof of Virginia residency, and documented ineligibility for Medicaid.

As of March 31, 2019, 7,737 individuals were enrolled in Virginia's ADAP. The largest number of enrolled clients (3,547, 46%) were in ACA Marketplace Qualified Health Plans (QFPs), followed by 2,591 Direct ADAP clients (34%), 867 clients with employer-based insurance (11%), and 732 Medicare Part D clients (10%).

VDH contracts with two companies, Benalytics and Ramsell, to pay for clients' health insurance premiums and medication co-pays. Benalytics help clients enroll in insurance and process insurance premiums. Ramsell is a Pharmacy Benefits Manager (PBM), which processes and pays prescription drug claims.

Funding of the Virginia ADAP

From April 1, 2018 to March 31, 2019 (HRSA ADAP federal grant year 2018, or GY 2018), Virginia ADAP funding included HRSA formula-based Ryan White Part B ADAP grant funds, HRSA competitive ADAP Emergency Relief Funding grant funds, state general funds, pharmaceutical manufacturer rebates, and recovery of costs expended for clients who became retroactively Medicaid eligible. In GY 2018, $12M of ADAP expenditures was spent on the purchasing of medications, with 83% supported with federal funds and 15% by state funds (see Figure 1).

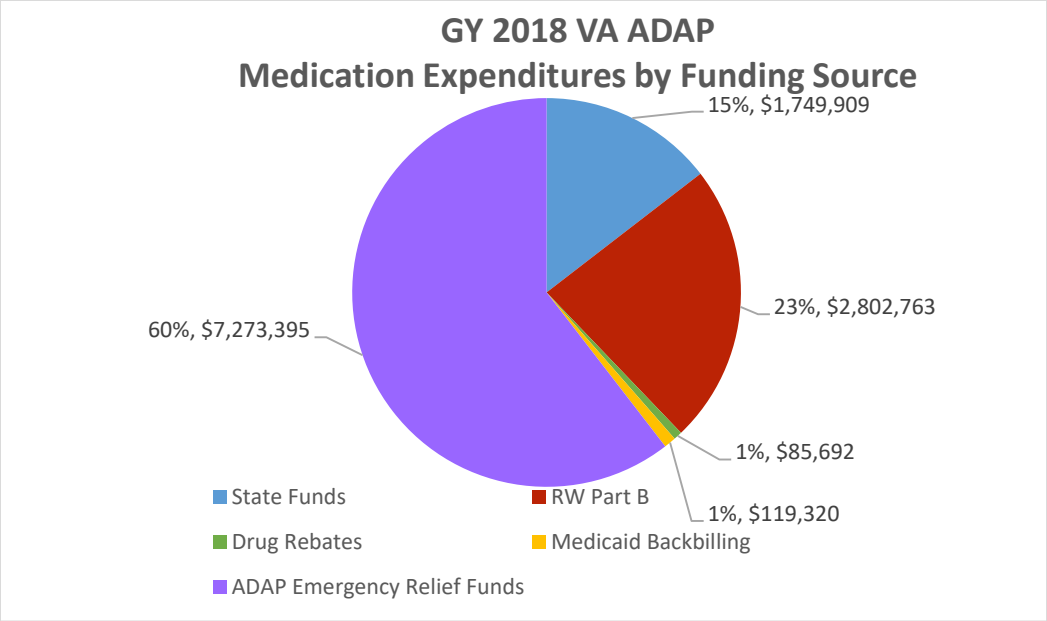

Figure 1: Virginia ADAP Expenditures, GY 2018
Source: Virginia VDH Program Fiscal Data

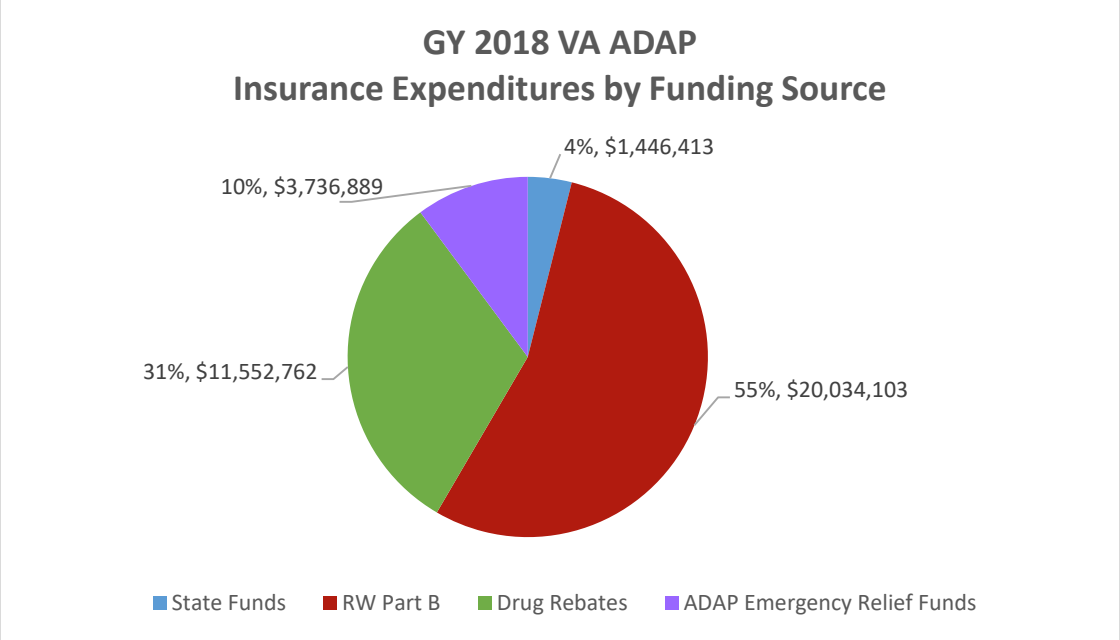

Figure 2: Virginia ADAP Insurance Expenditures, GY 2018
Source: Virginia VDH Program Fiscal Data

In addition, $36.7M was spent on insurance premiums and co-pays. As illustrated in Figure 2, federal funds supported 65%, state funding supported 4% (including the $200,000 State

Pharmaceutical Assistance Program appropriation), and rebates earned on medication co-payments supported 31%.

Grant Year 2018 Virginia ADAP Activities

Enrolling ADAP Clients to Medicaid

Federal legislation requires ADAP to be the payer of last resort, meaning there is a "lack of other sources to pay for prescribed HIV medications or there are documented gaps in third party payment for the medications" (Health Resources and Services Administration, 2016). With the implementation of Medicaid expansion on January 1, 2019, VDH worked with multiple partners to begin transitioning clients from ADAP to Medicaid coverage. The Department of Medical Assistance Services (DMAS), the agency that administers Virginia's Medicaid program, provided VDH with contact information for its Medallion 4.0 expansion PBMs. VDH's Central Pharmacy established contracts with the PBMs so it can bill Medicaid for any medication prescription costs the program incurs for Medicaid-enrolled clients. If a client receives ADAP medications and then becomes retroactively eligible for Medicaid, VDH can recoup funding through back-billing.

As of March 31, 2019, 1,624 clients who previously recieved ADAP assistance were enrolled in Medicaid coverage. Based on available data, an additional 2,941 clients are potentially eligible for Medicaid. Clients will be disenrolled from ADAP when VDH staff confirms Medicaid coverage of medications, which is expected by March 31, 2020.

The VDH team took specific steps to assist providers to prepare for Medicaid expansion, including an assessment of provider clinical network adequacy for HIV care under Medicaid expansion. The results of the assessment caused VDH to strengthen contractual agreements with sub-recipients, requiring them to determine Medicaid eligibility and to pursue enrollment in

health insurance. VDH encouraged clients to gather and update their required information for ACA enrollment and Medicaid determinations using the Marketplace.

Medicare and ACA Marketplace Open Enrollment

In preparation for the insurance open enrollment period, ADAP provided information about ACA and Medicare Part D plans to stakeholders and clients via mail, phone, email, social media, website notifications, and in-person meetings. ACA open enrollment for the 2019 coverage year was smoother and saw fewer challenges than in 2018. All areas of the state had at least one, if not multiple, carriers.

Since the same ACA carriers were also awarded the managed care organization contracts for Medicaid's Medallion 4.0 expansion, there were fewer gaps or restrictions in insurance coverage areas. Clients experienced fewer changes in their clinical providers and had an opportunity for greater provider choice including pharmacy benefits, except for those required to use a specialty pharmacy.

ACA Marketplace's open enrollment into qualified health plans (QHPs) is from November 1 through December 15. Due to this limited enrollment period, ADAP used a prioritization matrix to ensure maximum enrollment and contracted with Benalytics to assist clients. Benalytics first reached out to ADAP clients enrolled in ACA QHPs with a FPL over 138%, focusing on clients unlikely to be Medicaid eligible and needing to continue ACA coverage.

The ACA Marketplace informed newly Medicaid eligible clients with 2018 ACA coverage to initiate the Medicaid application process. ADAP contacted potentially Medicaid eligible clients who did not have 2018 ACA coverage and provided enrollment assistance from

Benalytics and referrals to Cover Virginia, the assister for DMAS, for additional support when needed.

Simultaneously transitioning eligible clients to Medicaid, while enrolling qualifying clients into ACA plans, was challenging. This required a multi-pronged approach, including modification of policies and procedures to ensure uninterrupted medication access, training on Medicaid expansion, and communication with all stakeholders. To address the challenge of processing high volumes of paper applications, VDH began procurement of a new client level data system with features such as electronic document upload and provision of near real-time notification to clients, case managers, and providers on eligibility determination, changes in their services, and the appropriate payer source. VDH collaborated with other Ryan White program providers to develop policies, procedures and training to improve data exchange related to client eligibility to facilitate enrollment in the correct type of coverage for clients. The VDH team met with DMAS, to share information and exchange data regarding transitioning clients.

Clients who obtained Medicaid and had ACA plans due to auto-enrollment or a 2018 premium credit had dual coverage if they did not contact the Marketplace to cancel their ACA plan. Dual status resulted in the inability to utilize Medicaid coverage and carriers charging ADAP for ACA plan premiums for Medicaid-enrolled clients. Pharmacies typically consider Medicaid as the payer of last resort, utilizing it as secondary coverage if a client is covered by another insurance plan. Therefore, in some instances, pharmacies charged medication costs to ADAP when look-ups at the point of fill indicated dual coverage status.

These challenges resulted in a higher ADAP enrollment than expected given Medicaid expansion. For clients transitioning from ADAP to Medicaid, confirming medication access via Medicaid is needed to prevent interruptions in HIV treatment that could result in increased viral

loads, disease progression and HIV transmission. VDH routinely monitors both the number of clients enrolled in ADAP (which currently includes clients pending confirmation of Medicaid medication access) and those who actually received medications directly from ADAP.

Next Steps

As of March 31, 2019, VDH identified 2,941 Virginia ADAP clients who may be eligible for Medicaid, based on income reported to ADAP. ADAP is diligently working to facilitate Medicaid enrollment for these clients by educating providers to ensure correct eligibility determinations, increasing support for case management, and providing direct enrollment assistance to clients through Benalytics.

The Virginia ADAP team is developing a time-phased process that focuses on transitioning 2,000 of the Medicaid eligible ADAP clients to Medicaid before the 2020 ACA Marketplace open enrollment period. ADAP will transition the remaining clients before March 31, 2020. The program will track Medicaid transition goals in quartile increments with measures by 9/30/19, 12/31/19, and 3/31/20. Case managers and providers will continue to receive monthly lists of all clients who may qualify for Medicaid using a secure file transfer protocol. Case managers and providers will review and return lists with updates on Medicaid enrollment status. This bidirectional information exchange will help determine the correct payer for the client and reduce the number of clients who need determinations during the very short ACA open enrollment period. Identified Medicaid eligible clients, their case managers, and their medical providers will receive multiple notifications over a 60-day period to ensure a successful transition to Medicaid. At the end of 60 days, ADAP will deactivate medication assistance cards and decline medication requests through ADAP with reminders to access medications through their Medicaid coverage. ADAP will use data from routine data exchanges with DMAS, Ryan

White providers, and affiliated pharmacies as a confirmation that clients are able to access medications under their new Medicaid coverage as part of the VDH client disenrollment process from ADAP. The strategy will help streamline all stakeholder efforts to enroll clients into the correct insurance coverage that will ensure VDH's compliance with payer of last resort requirements.

New Activities for Virginia ADAP

Rapid access to HIV treatment plays an important role in improving health outcomes and reducing HIV transmission. Studies show that rapid HIV treatment initiation helps people achieve viral suppression in shorter periods compared to starting treatment weeks after diagnosis (Jonathan Colasanti, 2018). In 2018, 68% of people newly diagnosed with HIV in Virginia were linked to HIV medical care within 30 days. Virginia's current objective is to increase the percentage of newly diagnosed persons linked to care within 30 days to at least 85% by December 31, 2021. ADAP and related Ryan White services play a key role in improving linkage to care and shortening the interval between diagnosis and initiation of HIV treatment.

VDH is assessing the Commonwealth's HIV clinical capacity to determine if current HIV care providers can meet the needs of newly diagnosed individuals. As part of this assessment, VDH is addressing immediate needs, as they are identified, including providing additional resources to existing clinics for facility renovations to add exam rooms and equipment, increasing staff, and scaling up new models of care with partnerships between private practice clinicians and community-based organizations. The program is exploring opportunities to expand the use of telemedicine, as well as resurrecting previously successful models of care that use traveling clinicians. This capacity building is critical to efforts to implement rapid initiation of HIV treatment.

With Medicaid expansion, Virginia's ADAP has the opportunity to initiate new activities that promote expanded medication access and improved adherence to treatment. Some of these activities will include expansion of medication pick-up hours at distribution sites, home- or community-based medication delivery and additional medication adherence support provided by community-based pharmacies and some federally qualified health centers.

Virginia ADAP is piloting the expanded use of the cyber platform, Positive Links, developed by the University of Virginia. Positive Links is a clinic-centered engagement-in-care program that employs a tailored smartphone app that allows bidirectional communication between clients and their clinical providers and provides a private, digital social support community to help people living with HIV reach their care goals. This pilot in a local health department is part of a project that uses ADAP medication pick up data to offer increasingly intensified interventions to engage or re-engage clients in care when they are picking up medications inconsistently. Individual clinics and community-based organizations can tailor the platform even if they do not utilize an electronic health record. A Spanish language version is currently in development.

Presently, the Medicare service option under Virginia ADAP provides assistance with monthly Part D premiums and cost shares to individuals above the Medicare Part D subsidy threshold. Current eligibility policies will be reviewed to assess the feasibility of providing assistance to subsidized clients as well. With the rising cost of co-payments, clients and case managers have shared data on the financial hardship for subsidized applicants. Because of Medicaid expansion, ADAP will have resources that could potentially be shifted to provide assistance to this growing population.

Virginia ADAP Sustainability

Multiple factors affect Virginia ADAP sustainability, including the number of ADAP clients enrolled in ACA plans, premium costs, and pharmaceutical manufacturers' rebates. VDH monitors changes in insurance medication access (formularies, exception processes, and preauthorization requirements), rebate structure, and availability of HIV-related services on a weekly basis to determine whether resources will meet clients' needs.

VDH analyzes utilization and enrollment for each program option monthly to forecast services and costs. Estimates for future annual client enrollment and services, by GY, use a formula based on a regression analysis of 20 years of historical monthly data. This methodology is necessary to account for variances due to program structure and dis-enrollments. Projections that do not account for monthly variations would result in an under-projection of program costs and over-projection of clients served. Projections for Medicare Part D and ACA account for the calendar year cost structure of the insurance plans. More specifically, ADAP pays higher costs at the beginning of the calendar year and reduced or no costs as the year progresses when deductibles, co-insurance, and maximum out-of-pocket (MOOP) expenditures are satisfied.

For GY 2020 (April 1, 2020 to March 31, 2021), cost and utilization projections assumed that all persons currently on ADAP who are eligible for Medicaid will be fully transitioned to Medicaid by March 31, 2020. In GY 2018, the number of persons enrolled in ADAP increased by 74 persons per month. As only 41% of current clients are expected to remain on ADAP, in GY 2020, the projected increase is 30 persons per month. This would result in total program enrollment of 3,844 persons and total medication and insurance cost (before rebates) of $31.8M. Rebates realized in GY 2020, the amount that the program is expected to actually recoup during the grant year, are projected at $21.9M, resulting in a net cost of $9.9M on purchasing medications and insurance. While rebates earned in GY 2020 will decrease along with the

decreased client numbers, the rebates realized in GY 2020 are rebates that are earned in GY 2019 when enrollment is higher. Rebates earned in GY 2020 are projected to be $13.3M, a decrease of $8.6 M from GY 2019.

The rebates earned on medication co-payments support the program, as well as other initiatives aimed at stopping HIV transmission. Therefore, ADAP will continue best practices to maximize insurance enrollment including use of enrollment assisters, collaborating with HIV service providers to make initial premium payments for clients, and continuing the use of electronic data exchange for insurance enrollment, premium payments, and drug co-payments.

Program Capacity Building and Insurance Coverage Impact on the HIV Care Continuum

VDH continues to build ADAP capacity by seeking technical assistance and expert consultation. VDH has requested assistance from HRSA, NASTAD (formerly known as the National Alliance of State and Territorial AIDS Directors), and a state operating a similarly sized ADAP that recently expanded Medicaid. VDH is also contracting with a consulting firm that specializes in Ryan White Part B programs to make recommendations to strengthen current operations that position the program to respond to changes in enrollment and service needs resulting from Medicaid expansion. This includes assessing current policies, procedures, and staffing and recommending process improvements in client eligibility and recertification.

Currently, 41% of Virginia ADAP clients are over the age of 50 years. Within five years, a sizable portion of the remaining client population will also be 50 years and older. They may require complex and more expensive care due to management of comorbidities that may result from aging or other health conditions induced by long-term use of some HIV medications. VDH is assessing the needs of this population to facilitate appropriate planning and allocation of

resources, including increased utilization and expansion of Medicare coverage for eligible clients. One option under consideration is the purchase of Medicare Advantage plans. These plans will address more holistic health needs rather than just provision of medications through Medicare Part D plans. VDH will evaluate the cost effectiveness of the Medicare Advantage option by assessing plan structure, premium costs and payment logistics, out of pocket cost requirements, and impact on pharmaceutical manufacturer rebates.

Working Towards HIV Elimination

Research has shown that when HIV healthcare delivery models shift from direct medication provision (e.g., Direct ADAP) to a system that purchases QHPs, there is a significant increase in viral suppression among people living with HIV (Kathleen McManus, 2016). To meet the population health goals of preventing new HIV infections, 90% of people who have HIV infection must be diagnosed and know their status, 90% of people diagnosed must be on effective HIV treatment, and 90% of those on HIV treatment must achieve durable HIV viral suppression. VDH will work with other stakeholders to exchange data that will be used to measure progress towards these goals.

With Medicaid expansion covering HIV treatment costs for former ADAP clients, VDH may be able to allocate more funding for other Ryan White-funded core medical and support services (such as case management, adherence monitoring, housing, and psychosocial support). These services promote sustained viral suppression among participating Ryan White clients in comparison to all people living with HIV in the Commonwealth. As of December 31, 2018, 87% of clients receiving Ryan White services (including ADAP) were virally suppressed, an 11% increase from 2017. Furthermore, 27% more persons receiving Ryan White services were virally suppressed compared to all people living with HIV in the Commonwealth (see Virginia's

HIV Care Continuum at

http://www.vdh.virginia.gov/content/uploads/sites/10/2019/07/2018_HCC_VA.pdf).

Recommendations and Findings

- It is critically important for all Medicaid enrolled clients to access services through their Medicaid coverage. To meet this goal, Virginia ADAP is making concerted efforts to improve eligibility determinations that assure people living with HIV receive optimal program coverage that meets their needs and aligns with the correct payer source. This ensures that people living with HIV have uninterrupted access to treatment and quality care that supports overall health, wellness, productivity, and quality of life. These correct alignments are not only essential to the individual health of clients, but also to the financial stability of the HIV service delivery system in Virginia including ADAP.
- VDH will expand initiatives that help clients reach and maintain durable viral load suppression to improve individual health outcomes and prevent new HIV infections as a population health goal. One biomedical strategy that the program has not yet initiated is the rapid initiation of HIV treatment. By improving linkage to care rates and learning from other state health departments, VDH will seek best practices to implement rapid HIV treatment initiation in at least three health regions by March 31, 2020.
- More Virginia ADAP clients will age into the group of 50 years and older in the next five years. One of the opportunities created by Medicaid expansion is for VDH to use ADAP resources to offer more services to aging people living with HIV. Building on ADAP's success in providing insurance coverage that has shown to improve health

outcomes for people living with HIV, VDH will assess the cost effectiveness of providing Medicare Advantage Plans for eligible clients. This assessment will include input from clients, providers, and the Virginia ADAP Advisory Committee.

Conclusion

Virginia ADAP will continue to leverage Ryan White funds to maximize services and maintain insurance, which is vital to ADAP sustainability. In response to Medicaid expansion, all stakeholders in HIV service provision are continuing to collaborate to increase Medicaid enrollment for all eligible clients while minimizing any interruptions to HIV care and medication access. This will enable VDH to program resources to best meet the current and changing needs of people living with HIV. This requires accurate and timely data exchange between VDH, DMAS, HIV case managers and providers for determining and facilitating enrollment into the correct program coverage and payer source. The changes in the healthcare landscape in Virginia support ADAP initiatives that stop HIV transmission in the Commonwealth.

References

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List of Abbreviations and Acronyms

ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immunodeficiency Syndrome
CCC Plus	Commonwealth Coordination Care Plus
DMAS	Department of Medical Assistance Services
FPL	Federal Poverty Level
GY	Grant Year
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
LIS	Low Income Subsidy
MAP	Medication Assistance Program
NASTAD	National Alliance of State and Territorial AIDS Directors
QHP	Qualified Health Plan
SPAP	State Pharmaceutical Assistance Program