COMMONWEALTH of VIRGINIA

Department of Health

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September 6, 2024

MEMORANDUM

TO: The Honorable L. Louise Lucas
Chair, Senate Finance and Appropriations Committee

The Honorable Luke E. Torian
Chair, House Appropriations Committee

The Honorable Mark D. Sickles
Vice Chair, House Appropriations Committee

FROM: Karen Shelton, MD
State Health Commissioner, Virginia Department of Health

SUBJECT: 2022 Virginia Medication Assistance Program (VA MAP) Report

This report is submitted in compliance with the Virginia Acts of the Assembly 2022 – Item 291 F, which states:

> *The State Health Commissioner shall monitor patients who have been removed or diverted from the Virginia Medication Assistance Program (VA MAP), formerly 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 VA MAP program. The commissioner shall report findings to the Chairmen of the House Appropriations and Senate Finance and Appropriations Committees annually on October 1.*

Should you have any questions or need additional information, please feel free to contact me at (804) 864-7002.

KS/AJ
Enclosure

Pc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources

2022 AIDS Drug Assistance Program Report

Division of Disease Prevention, Office of Epidemiology
Virginia Department of Health

Executive Summary

Uninterrupted access to Human Immunodeficiency Virus (HIV) treatment is key to achieving long-term viral suppression for people with HIV (PWH). Viral suppression is important for PWH to achieve optimal individual health outcomes and prevent HIV transmission. The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under Part B of the federal Ryan White HIV/AIDS Treatment Extension Act of 2009. To help reduce the stigma often associated with HIV services, Virginia ADAP changed its name to the Virginia Medication Assistance Program (VA MAP). The program provides access to HIV medications for low-income people with HIV who have limited or no health coverage, either directly or through the purchase of health insurance coverage on the federal Marketplace. The Ryan White HIV/AIDS Treatment Extension Act of 2009 requires that VA MAP serve as the payer of last resort. The Health Resources and Services Administration (HRSA) provides federal oversight of Ryan White Part B and VA MAP.

Before Virginia Medicaid expansion in 2019, VA MAP determined that approximately 4,000 clients were Medicaid eligible. From September 1, 2019 to August 31, 2021, VA MAP dis-enrolled 3,100 clients who transitioned to Medicaid and began using their pharmacy benefits. Medicaid is beneficial to clients since it provides comprehensive coverage for their health and medication needs beyond HIV-related services. Insurance coverage for clients during the COVID-19 pandemic served as an additional safety net for PWH. COVID-19 contributed to job losses, decreased income, and threats to housing stability and food security. Decreased income during the pandemic led to more VA MAP clients being eligible for Medicaid, even though VA MAP previously assisted them with cost shares associated with their employer-based insurance. During the COVID-19 declared Public Health Emergency (PHE), Medicaid maintained continuous coverage for clients even if their circumstances would have otherwise made them ineligible. The US Department of Health and Human Services renewed the PHE under the Public Health Service Act on January 11, 2023. On January 30, 2023 the Biden administration announced its intent to end the national emergency and public health emergency declarations on May 11, related to the COVID-19 pandemic.

The Department of Medical Assistance Services (DMAS) will begin to review eligibility for every Medicaid enrollee within 60 days after the end of the PHE. This may result in an increased demand for VA MAP services.

Introduction

This report provides an overview of changes in, successes of, and challenges for VA MAP, as well as opportunities to continue progress toward reducing and eliminating HIV in the Commonwealth. Specifically, the report will address the program's use of new long-acting antiretroviral medications, rapid access to HIV medication for people newly diagnosed with HIV, the new client eligibility policy and procedures for Ryan White Part B services in Virginia, structural/technology enhancements to improve service delivery, and program sustainability.

Background

VA MAP provides access to life-saving medications for the treatment of HIV infection for 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 Affordable Care Act (ACA) Marketplace and Medicare prescription drug coverage plans; (2) paying medication copayments for clients with non-ACA employer-based insurance plans for medications on VA MAP's formulary (www.vdh.virginia.gov/disease-prevention/formulary/); and, (3) direct provision of medications for uninsured clients. VA MAP eligibility requirements include household income at or below 500% of the Federal Poverty Level (FPL), a documented HIV diagnosis, proof of Virginia residency, and documentation that the client does not have Medicaid coverage or any other third-party coverage for HIV medication access or other requested services.

As of March 30, 2022, VA MAP had 4,222 clients enrolled, an overall decrease of 650 clients from the previous year. The following describes the proportion of clients in each service option with comparisons to the previous year in parentheses: 37% received medications directly, or Direct MAP, (a decrease of 9%); 26% in ACA Health Plans (an increase of 4%); 20% with Medicare prescription coverage (an increase of 2%); and 17% had employer-based insurance services (an increase of 1%). There were noted increases in use of ACA, Medicare, and employer-based insurance program services and a decrease in direct medication provision this past year.

The Virginia Department of Health (VDH) contracts with two companies, Benalytics and Ramsell, to enroll clients into insurance, pay for clients' health insurance premiums, and pay medication co-pays. Benalytics serves as the Insurance Benefits Manager that helps clients enroll in insurance and pays insurance premiums. Ramsell is a Pharmacy Benefits Manager (PBM), with a 1,671-retail pharmacy network to serve clients, and it processes and pays prescription drug claims.

Funding and Expenditures of the Virginia Medication Assistance Program

VA MAP receives funding (listed in order of magnitude) from HRSA formula-based Ryan White HIV/AIDS Program Part B (RWHAP B) ADAP grant funds, voluntary pharmaceutical manufacturer rebates, recovery of medication costs expended for clients who became retroactively Medicaid-eligible, and state funds. Figure 1 shows the Direct MAP's medication expenditures for Grant Year (GY) 2021, which includes the cost to purchase the medications and provide them directly to clients.

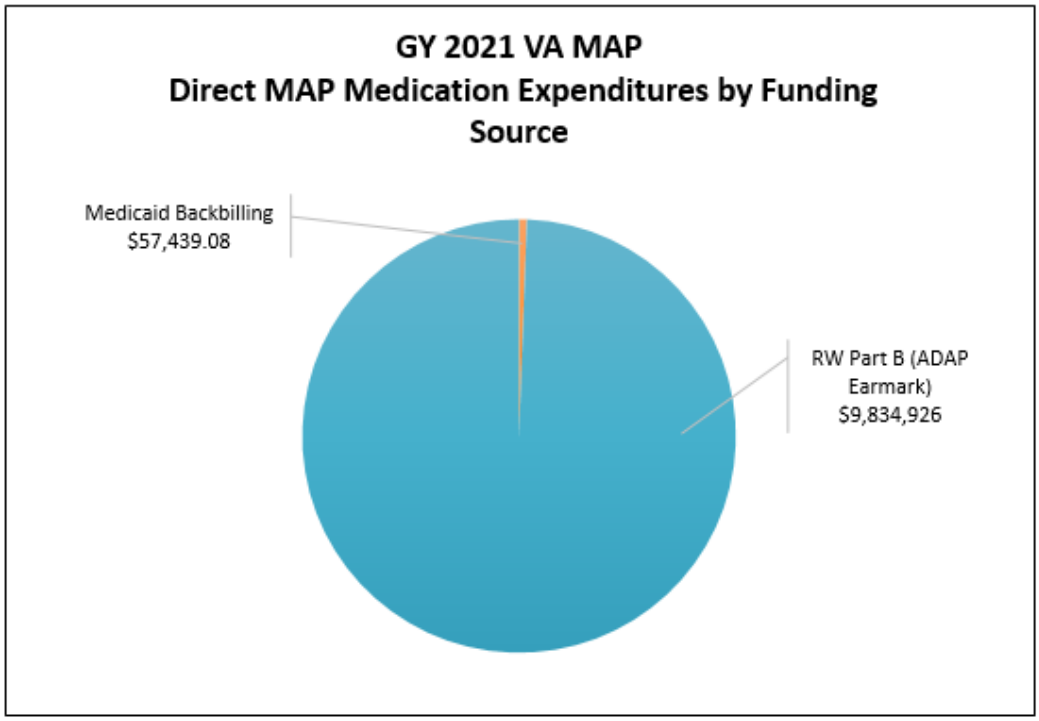

Figure 1. Direct MAP Medication Expenditures, April 1, 2021-March 31, 2022

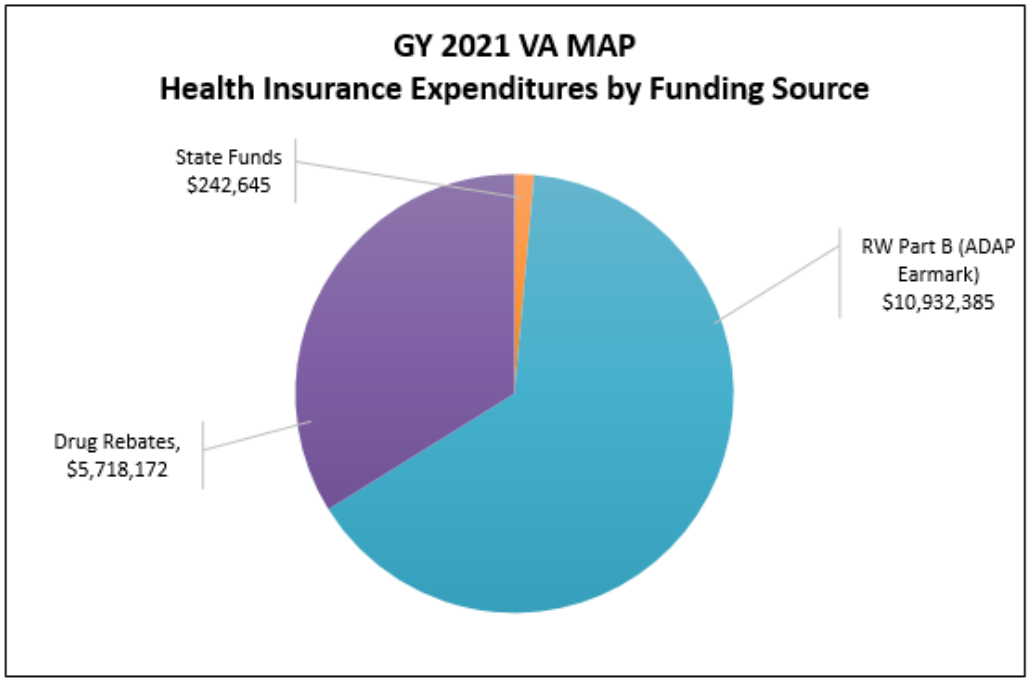

Figure 2. VA MAP expenditures for health insurance coverage, April 1, 2021-March 31, 2022.

Impact of COVID-19

In the second year of the COVID-19 PHE, VDH and its service partners continued efforts to ensure uninterrupted delivery of services, care, and treatment to clients. This included adoption and expansion of telehealth and other technologies, purchase of personal protective equipment and other supplies, promotion of COVID-19 prevention strategies, testing and vaccination, promotion of RWHAP B services access, redesign of service areas, and installation of physical barriers to prevent the spread of COVID-19. VDH's Division of Pharmacy Services continued to provide 60-day medication refills to decrease medication pick-ups, reducing face-to-face contacts during the pandemic. Use of secure file transfer protocol folders among providers and VDH staff allowed staff to work safely from home and access client information needed to ensure uninterrupted access to medication.

In 2021, providers linked 78% of people newly diagnosed with HIV to medical care within 30 days, compared to 75% in 2020. The increase of three percentage points is a strong indicator that the publicly supported systems of care for people with HIV were flexible and able to make needed adjustments to provide critical services during the COVID-19 pandemic. Between calendar year 2019 (63,543 tests) and calendar year 2021(22,935 tests), HIV testing decreased by 64%; this drop is likely attributable to the impact of the COVID-19 pandemic. As people return to accessing testing services more routinely, there could be an increase in HIV diagnoses in Virginia. As of December 31, 2021, 83% of clients receiving Ryan White services were virally suppressed, compared to 58% of all PWH in Virginia. This difference is likely attributable to both full availability of data for Ryan White clients compared to clients with private or other insurance, as well as stringent quality management and service standards for the Ryan White program. Ryan White clients are also supported with medical transportation, case management and other services which may not be offered by other payers. See Virginia's most recent overall and Ryan White HIV Care Continua at https://www.vdh.virginia.gov/disease-prevention/disease-prevention/hiv-aids-sexually-transmitted-disease-std-hepatitis-reports/.

The Intersections of VA MAP, Medicaid, Medicare, and Marketplace Insurance

Federal legislation requires Ryan White programs including ADAPs, 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). VDH's Central Pharmacy has established contracts with Medallion 4.0 expansion Pharmacy Benefit Managers (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 the medication costs through back billing. VA MAP dis-enrolled 3,100 clients due to their transition to Medicaid from September 1, 2019 to August 31, 2021. VDH receives monthly data from DMAS that show client utilization of pharmacy benefits for HIV medication. VDH matches these data with its VA MAP client rolls prior to any dis-enrollments. After verification that the client is using the pharmacy benefits under Medicaid, VA MAP deactivates their medication assistance cards. Maintaining strong relationships between DMAS and VA MAP continues to be an avenue to achieve information sharing and potential resolutions of client appeals if DMAS denies Medicaid applications. The continued use of data from routine exchanges with DMAS, Ryan White providers, and affiliated pharmacies as a confirmation that clients are able to access medications under their new Medicaid coverage is part of the VDH client disenrollment process

from VA MAP. This strategy streamlines stakeholder efforts to enroll clients into the correct insurance coverage to ensure VDH's compliance with HRSA's payer of last resort requirements. Other reasons for dis-enrollments of VA MAP clients include residency outside of Virginia, death, enrollment in another program that provides HIV medication access, or the client no longer meets the eligibility requirements for the program.

The U.S. Congress enacted several laws to help people and states get through the COVID-19 PHE. States received additional funding if they kept people enrolled in Medicaid, even if the Medicaid enrollees had a change in income or family size that might have made them ineligible under normal circumstances, called continuous coverage. The Centers for Medicaid and Medicare Services (CMS) agreed to provide states a 60-day notice prior to the end of the PHE. One month after the end of the PHE, states may begin the process of "unwinding the continuous coverage" and must follow specific guidelines in the process. Unwinding is the process of reviewing the eligibility of every person enrolled in the state's Medicaid program to determine if he or she is still eligible for coverage. While CMS will allow states up to 14 months to unwind coverage, DMAS indicates on its website that it will complete the process in 12 months.

New Activities for the Virginia Medication Assistance Program

Rapid Start: Rapid access to antiretroviral therapy (ART) plays an important role in improving health outcomes and reducing HIV transmission. Studies show that rapid HIV treatment accompanied by intensive case management and treatment adherence services helps people achieve viral suppression sooner compared to starting treatment weeks or months after diagnosis (Jonathan Colasanti, 2018). People with HIV who achieve and sustain viral suppression do not transmit HIV to others via sexual activity. Virginia's objective is to increase the percentage of newly diagnosed persons linked to care within 30 days to at least 85%. 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.

In 2020, VDH launched a Rapid Start pilot project using a learning collaborative model. The goal of VDH's Rapid Start is to initiate treatment within 14 or fewer days of diagnosis and enable clients to reach viral suppression quickly. Currently, VDH supports Rapid Start at 15 sites that provide Ryan White services. Data show 259 clients received Rapid Start services from July 1, 2020 to June 7, 2022. Seventy-eight percent of clients are male, with 59% in the 25 to 44 years age range. Importantly, 19% of those receiving services are 55 years and older. VDH's HIV surveillance data show that 35% of the state's unmet need for late HIV diagnoses in 2020 is among people who are 55+ years old. Late diagnosis results in poorer clinical outcomes for patients and a higher possibility of HIV transmission. In terms of clinical outcomes, the Rapid Start clients are receiving ART within 14 days of their HIV diagnosis or re-engagement with care. In Year Two, clinicians prescribed ART within seven days for 84% of clients, with an average of four days from diagnosis to ART initiation. This compares to an average of 23 days for all Virginians with HIV. Thirty-two percent achieved viral suppression within 30 days and 63% of clients within 60 days. Virginia's Rapid Start program has been included in a federal best practices compilation and a Rapid Start toolkit to help other Ryan White recipients develop and implement Rapid Start initiatives.

Long Acting Antiretroviral Medications (LARVs): In early 2021, the Food and Drug Administration (FDA) approved Cabenuva® (rilpivirine + cabotegravir), the first long-acting HIV antiviral medication regimen administered monthly by injection. VA MAP added this drug to its formulary in March 2021. Long-acting injectable medications can minimize barriers to treatment adherence by eliminating daily oral medications and may offer greater privacy to clients. The initial FDA-approved use of Cabenuva® was for monthly injections that require monthly medical visits for administration. Currently, the U.S. Health and Human Services' HIV treatment guidelines recommend that established adult and adolescent patients with HIV-1 who are clinically stable on an HIV treatment regimen visit their HIV provider once or twice a year (HHS, 2021). Frequent medical appointments increase service costs including supportive services such as transportation, which the Virginia RWHAP B can cover for eligible and enrolled clients. This treatment option is beneficial for a subset of clients who meet the clinical criteria to take the medication and prefer a monthly injection to a daily pill regimen. It may also be beneficial to those who have difficulty tolerating or taking oral medications or have difficulty remembering to take daily medications. The VA MAP provides this medication, but currently the utilization is low. VDH will review utilization data with periodic assessments of costs, inventory management by the Division of Pharmacy Services, and changes to the program's policies and procedures related to this specific long-acting antiretroviral. VDH will continue to collaborate with myriad stakeholders, including its Virginia Consumer Advisory Committee, to increase educational sessions and available information on this medication.

As stated in last year's report, the pharmaceutical drug development pipeline forecasts the production of additional long-acting injectables and regimens with longer intervals between injections. In February 2022, the FDA approved Cabenuva® for administration every eight weeks. There are still clinical requirements the clients must meet for this extended dosing, but clients using this option will reduce by half the number of clinical visits and the need for other supportive services for this medication. VA MAP developed a survey to collect data from PWH and clinical providers to inform policy and procedure development for this LARV medication and included questions about their interest and concerns related to this drug for both 4-week and 8-week dosing. Other Ryan White recipients, as well as pharmaceutical companies, are requesting VA MAP's policies and procedures for four-week administration to inform their programs' efforts.

Data System and Technology Improvements: VDH launched the Provide Enterprise® Data System (hereinafter called Provide®) for managing Ryan White and ADAP data in October 2021. Provide® is a cloud-based platform with interactive modules for the VA MAP to communicate with pharmacies, PBMs, insurance benefits managers, Ryan White providers, and clients. Provide® includes a single database for both ADAP and other Ryan White-supported services to make reporting to federal funders more efficient and accurate. Many different functions of the system are in phased-implementation, beginning with the most critical for daily VA MAP operations. Functions allow for real-time client eligibility checks, flag the next date for eligibility determinations, and push messaging out to clients and providers about the renewal dates. These important functions tie to new client eligibility policies and procedures for the Virginia (VA) RWHAP B program including VA MAP. VA RWHAP B-contracted agencies are able to perform eligibility assessments for clients for all VA RWHAP B services including ADAP, called unified eligibility assessments. If the clients meet VA RWHAP B eligibility

criteria and their case managers or eligibility workers enter their data and upload supportive documentation for each eligibility criterion into Provide®, clients will be eligible for all VA RWHAP B services, including ADAP, for 24 months. This changes the requirement to submit paperwork every six months for RWHAP B and ADAP services separately to a combined submission every 24 months, reducing client barriers and staff administrative burden. This change aligns with HRSA's new expectations about client eligibility determinations (HRSA, 2021). For more information about this new eligibility process, please see the policy and procedures at https://www.vdh.virginia.gov/disease-prevention/disease-prevention/hiv-care-services/. Clients are also able to choose a provider for their eligibility assessment by searching and selecting a provider from VDH's HIV services database, called Resource Connections. Clients can use the database online or on a mobile device to find services by their zip codes.

The VA MAP team continues to work in close partnership with community-based medical providers and other services providers to help maintain client eligibility to access HIV medication services, as well as determine the correct payer. The VA MAP team conducts quality assurance checks on submitted assessments in Provide® to assure the providers are asking for the correct VA MAP service option for HIV medication services and to double check the accuracy of the income information.

Provide® is enabling VA MAP to transition away from a mixed paper and electronic data program to a solely electronic data capture system for its operational needs. Provide® is operational for VDH contracted providers, and VA MAP has already used it to successfully generate and submit an annual performance report for HRSA.

Virginia MAP also procured a virtual call center system to upgrade from its medication access hotline. Features include call mapping by topic to route callers to the appropriate staff person for assistance and avoid multiple call transfers, supervisor ability to monitor calls for training purposes, and a computer interface that shows how many people are in the call queue. VA MAP technicians have the ability to speak to callers via computer rather than utilizing personal or work cell phones when working remotely, which enhances continuity of program operations when needed. Callers can also choose a Spanish language option to connect to VA MAP staff who are fluent in Spanish. This system also enhanced the customer service experience and reduced waiting times for clients and providers.

After COVID responses and inquiries from the public scaled down, the agency established one main call center for VDH requiring VA MAP to integrate its new call center with the main call center. Some critical functionality was initially lost but later restored.

VA MAP Sustainability

Multiple factors affect VA MAP's sustainability, including the number of clients enrolled in ACA plans, premium costs, the conditions the program must meet to earn pharmaceutical manufacturers' rebates as well as the total amounts received, and the number of eligible clients who actually enroll in Medicaid. VDH monitors changes in insurance medication access (formularies, exception processes, and preauthorization requirements), rebate structure, and availability of HIV-related services to determine whether resources will meet clients' needs.

VDH analyzes utilization and enrollment for each program option regularly to forecast services and costs. Previous rebate projections, detailed in previous reports to the General Assembly, showed the extremely high and unsustainable financial burden the program would incur if it had to pay for all HIV medication costs without rebates. Virginia Medicaid expansion significantly reduced this burden for Medicaid-eligible clients willing to enroll into available coverage. The federal funder states that this slowing pattern is similar to other jurisdictions that implemented Medicaid expansion.

Current rebate projections through March 2023 (GY 2022) continue to show that provision of insurance coverage to clients is only cost-effective post rebate earnings. Assuming a net increase of 150 new clients per year over the current clients enrolled (approximately 5,000 clients), and a goal of 75% of clients enrolling in health insurance and 25% of clients served through Direct MAP, current projections show the program will earn approximately $22M and $23M in rebates for GY 2022 and GY 2023, respectively. Total program costs before rebates, in these same projections, are $26M and $27M for each year, respectively. The projections for both rebates earned and programmatic operational costs may change. VDH will monitor this closely. Should a shortfall be expected by new projections, VDH would reprioritize funding to stabilize VA MAP first. The annual operational costs for Direct MAP is estimated to be $8.0M for GY2022 and GY2023. All insurance costs range between $18.4M- 19.4M before rebates for GY 2022 and GY2023, respectively, assuming a 10% increase across the board for insurance premium costs. Table 1 shows comparative operations costs of Direct MAP and insurance coverage pre- and post-rebates using average monthly costs.

Table 1. Comparative Operational Costs of Direct MAP and Insurance Coverage Pre- and Post-Rebates, Average Monthly Costs

Cost	GY 2022 pre-rebates	GY 2022 post-rebates	GY 2023 pre-rebates	GY 2023 post-rebates
Direct MAP, per person (meds)	$1,178	$1,178	$1,175	$1,175
ACA, per person (meds & premiums)	$900	$617	$966	$682
Medicare (meds & premiums), per person	$318	-$12.00	$350	-$15.00

Notes: GY = Grant Year, with period of performance from April 1st – March 31st.

Table 1 shows that the average monthly costs of ACA insurance post-rebates, is nearly $300 less per person as compared to the cost before rebates are applied. The cost for insurance after rebates is around $500 less per person per month compared to Direct MAP costs. The ratio of Direct MAP to insurance costs post rebates per person shows the program can serve on average 1.8 persons at the same cost for one person served through Direct ADAP for roughly both grant years. The rebates earned in this scenario above make it possible for the program to serve older

adults in Medicare with a net gain of $12.00 - $15.00 per person. In GY21, this net gain was approximately $7.00. Any net gain will assist the program to increase assistance to PWH who are aging and likely have limited financial resources. This table shows that rebates are demonstrably critical to the financial stability of the VA MAP operations.

Current projections of rebates earned through March 2023 show VA MAP resources are just sufficient to meet the projected needs and allows for expansion of services for approximately 150 new clients over the year. Any reduction in projected rebate earnings are a concern for the program and could signal a return to cost containment strategies used in the past. The CMS are signaling that the extension of the ACA special enrollment periods (SEPs) in 2022 for those who meet the low FPL requirements will continue for late calendar year 2022 enrollment. CMS is also signaling that these extended SEPs will remain in effect for the near future, extending enrollment for ACA plans to nearly all-year enrollments, which would be similar to Virginia Medicaid's year-round enrollment. This will enable the VA MAP program to focus on continuous enrollment of clients into insurance service options, making it more likely to achieve or exceed the goal for insurance coverage to maximize rebate earnings. In April 2021, VDH began a contract with its IBM, Benalytics, which pays the insurance premiums for clients to maintain their VA MAP-provided insurance coverage. Benalytics' role also includes addressing issues that emerge with their carriers, helping the program prevent and recoup credits and overpayments, and enrolling all eligible clients into Medicaid or other plans on the Marketplace including those in Medicare Part D coverage. Continued efforts to enroll eligible clients into Medicaid will affect the number of clients enrolled in VA MAP services, but until the unwinding of continuous coverage is complete or people age out of expanded Medicaid coverage, the degree of impact is uncertain. The program will analyze actual enrollments and expenditures on a monthly basis and compare to the projections discussed in the section above to assess the sufficiency of operational funds for VA MAP.

As the population of PWH continues to age, VDH will continue to assess and address gaps in service delivery and make plans to address the changing needs of this population. In June 2021, VA MAP extended wrap-around services for Medicare beneficiaries who receive full low-income subsidies to support medication adherence for very low-income seniors and disabled Medicare beneficiaries living with HIV, eliminating the need for clients with low-incomes to choose between medication copayments and other necessities. Current programmatic data do not show the fully anticipated effects of this policy change, but VDH will be closely evaluating the medication utilization data and copay expenditures by program type (Medicare Part D) in the coming year to assess this policy and inform educational materials and outreach to eligible clients to increase uptake.

The program anticipates an increase in the number of PWH over the age of 65 in the next few years, because of the effectiveness of the life-saving medications that enable people with AIDS (PWA) to live normal lifespans and aging Medicaid recipients transitioning to Medicare. The program is discussing with its federal funding partner its ability to require eligible clients to participate in the most cost-effective method for VA MAP to provide access to HIV medications, which is through insurance coverage. This would include enrolling age-appropriate clients into Medicare Part D coverage that VA MAP will pay for versus serving these clients on Direct MAP. This will enable the program to run reports within Ramsell's data system to review the

number of clients served in Medicare Part D, the medications for which there are copays, and total expenditures for Medicare Part D copays to assess the intended effect of the policy.

Voluntary pharmaceutical manufacturer rebates earned on medication co-payments continue to play a major role in ADAP sustainability, as well as other initiatives that provide rapid access to HIV medications and services aimed at ending the HIV epidemic in Virginia. Therefore, the VA MAP will continue best practices to maximize insurance enrollment including use of enrollment assisters and continuing the use of electronic data exchange for insurance enrollment, premium payments, and drug co-payments.

Workforce Challenges

The HIV Care Services unit that oversees the RWHAP B including VA MAP includes 47 positions, of which 28 (60%) are filled by contract (temporary) staff. Twenty-two of the 28 contract positions are positions in VA MAP. The lack of classified, full-time positions with state benefits, including paid time off and affordable health insurance, is likely a contributing factor to high turnover rates and program instability. Many contractor vacancies have gone unfilled for more than 18 months, as staffing firms on state contracts have been unable to identify suitable candidates. The continued staff vacancies, the turnover in the contractual positions, and over-reliance on contractual staffing remain destabilizing factors for VA MAP.

The ongoing shortages in VA MAP technician positions that provide direct customer service to PWH hinders the program's ability to assist PWH with use of the program's benefits. This chronic staff shortage continues to contribute to delays in responding to clients and providers, increased client and VA MAP staff frustration, as well as requiring the few full-time equivalent staff to shoulder the burden of additional workloads beyond their primary duties.

The program has already taken steps to mitigate high turnover rates that have included increasing the pay rate for technicians, creating tiered job roles so that ADAP technicians have professional mobility and growth, and expanded strategies for advertising vacancies beyond reliance on recruitment conducted by staffing firms. However, these strategies have not helped to stabilize the workforce. HRSA has cited VDH regarding the lack of full time-equivalent staff and concerns about program stability for operations in multiyear site visits for the VA RWHAP B program including VA MAP.

Working Towards HIV Elimination

Research has shown that when HIV healthcare delivery models shift from direct medication provision to a system that purchases qualified health plans, 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.

With Medicaid expansion covering HIV treatment costs for a significant number of former and current VA MAP clients who are eligible, VDH is allocating more funding for other Ryan White-funded core medical and support services (such as case management, adherence monitoring, housing, and psychosocial support) through use of pharmaceutical rebates. Virginia

Medicaid took an extraordinary step to reduce the administrative burden for clinicians to prescribe Antiretroviral Therapy (ART) for their patients enrolled in Medicaid. The Pharmacy and Therapeutics Committee voted to remove prior authorization requirements for all antiretroviral medications except for one that requires specialized clinical services for its administration. The removal of prior authorizations standardizes access to HIV medications across the Managed Care Organizations providing Medicaid coverage and significantly reduces the time it takes for prescribers to help clients access HIV medications through Medicaid. VDH also plans to maintain its wrap-around services for Medicare clients, to promote sustained viral suppression.

Recommendations and Findings

- It is critically important for all Medicaid-enrolled and eligible clients to access services through their Medicaid coverage. VDH-contracted providers will conduct the new process for unified eligibility assessment for clients, which includes screening for Medicaid enrollment, as well as Medicaid eligibility. For clients who are Medicaid eligible, the providers will refer them to VA MAP's insurance benefits manager to assist the client with Medicaid enrollment. This ensures that PWH have uninterrupted access to treatment and quality care that supports overall health, wellness, productivity, and quality of life and that Ryan White remains the payer of last resort. VDH vigorously pursues available non-Ryan White insurance coverage, including Medicaid, for eligible clients. 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 VA MAP.
- The Rapid Start Program will provide long-term benefits, including improved health outcomes for PWH, and help reduce HIV transmission in the community. This is a critical strategy for ending the HIV epidemic and VDH is now supporting these programs with rebate funding only, reinforcing the need for the program to generate and earn as many rebates as possible. VDH anticipates that rapid initiation of HIV ART will become a routine part of clinical practice as sites diversify resources to make the program sustainable.
- Lack of adherence to taking daily medications can result in less than optimal health outcomes for PWH. Those who are not virally suppressed can transmit the virus through sexual contact with their partners if they do not practice HIV prevention behaviors during sexual activity. The availability of LARVs provides an excellent alternative for people who have difficulty taking a daily medication, and will help with improving both individual sustained viral suppression and overall viral suppression rates. Having medications with 8-week dosing schedules can rapidly improve HIV medication adherence and viral load suppression among many PWH.
- VA MAP has faced difficulty in maintaining adequate staffing. A change away from temporary positions to more permanent hires is under discussion as a way to address this concern.

Conclusion

Virginia MAP will continue to leverage Ryan White funds to maximize services and maintain insurance, which is vital to ADAP performance and sustainability. In response to Medicaid unwinding its continuous coverage, all stakeholders in HIV service provision will need to collaborate to maintain Medicaid enrollment for all eligible clients while minimizing any interruptions to HIV care and medication access. Clients who age out of Medicaid will be able

to access enhanced VA MAP services for PWH who are aging. The program will vigorously pursue insurance coverage for all clients, but especially for clients who are eligible for Medicare Part D coverage. This will enable VDH to allocate resources to meet the current and changing needs of PWH. This requires accurate and timely data exchange between VDH, DMAS, HIV case managers, and other providers for determining and facilitating enrollment into the correct program coverage and payer source. The program has shown impressive results with its federally recognized innovation for providing rapid access to antiretroviral treatment that help clients achieve viral load suppression within 60 days of medication initiation. Technology improvements and movement to paperless systems remain vital to the efficient and cost-effective operations of the VA RWHAP B program including VA MAP.

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