AIDS DRUG ASSISTANCE PROGRAM

2023-24

November Estimate

Tomás J. Aragón, MD, DrPH
Director and State Public Health Officer

California Department of Public Health

California Department of Public Health

Table of Contents

I. Program Overview

The California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA) administers the Acquired Immunodeficiency Syndrome (AIDS) Drug Assistance Program (ADAP). ADAP provides access to life-saving medications for eligible California residents living with Human Immunodeficiency Virus (HIV), assistance with costs related to HIV pre-exposure prophylaxis (PrEP) for clients at risk for acquiring HIV, and post-exposure prophylaxis (PEP) for clients who may have been exposed to HIV. ADAP services, including support for medications, health insurance premiums, and medical out-of-pocket costs, are provided to five groups of clients:

1. **Medication-only clients** are people with HIV (PWH) who do not have private insurance and are not enrolled in Medi-Cal or Medicare. ADAP covers the full cost of prescription medications on the ADAP formulary for these individuals. This group only receives services associated with medication costs.

2. **Medi-Cal Share of Cost (SOC) clients** are PWH enrolled in Medi-Cal who have a SOC for Medi-Cal services. ADAP covers the SOC for medications for these clients. This group only receives services associated with medication costs.

3. **Private insurance clients** are PWH who have some form of health insurance, including insurance purchased through Covered California, privately-purchased health insurance, or employer-based health insurance. This group is divided into three client sub-groups: Covered California clients, non-Covered California clients, and employer-based insurance clients. These groups receive medication benefits and may also receive assistance with health insurance premiums and medical out-of-pocket costs.

4. **Medicare clients** are PWH who are enrolled in a Medicare plan. This group is divided into three client sub-groups: Part B, Part C, and Part D. These groups receive medication benefits and may also receive assistance with health insurance premiums and medical out-of-pocket costs.

5. **PrEP Assistance Program (PrEP-AP) clients** are HIV-negative individuals who are at risk of HIV infection and who have chosen to take PrEP as a way to prevent infection. For insured clients, the PrEP-AP pays for PrEP and PEP related medical out-of-pocket costs and covers the gap between what the client's insurance plan and the manufacturer's copayment assistance program pays towards medication costs. For uninsured clients, PrEP-AP only provides assistance with PrEP and PEP-related medical costs and medication costs for clients who are ineligible for a medication assistance program through a drug manufacture or other assistance programs.

As a covered entity in the Health Resources & Services Administration (HRSA) 340B Drug Pricing Program, ADAP collects rebates for most prescriptions purchased for ADAP clients. ADAP does not collect rebates for prescriptions purchased for Medi-Cal SOC or PrEP-AP clients. To prevent duplicate rebate discounts on the same claim, which is prohibited, ADAP does not invoice manufacturers for rebates on Medi-Cal SOC claims. As the primary payer, Medi-Cal has the right to claim mandatory rebate on prescriptions for Medi-Cal SOC clients. ADAP also does not collect rebate on medication purchases for PrEP-AP clients because PrEP-AP is separate and distinct from ADAP and is not a 340B covered entity.

Historically, most ADAP clients were medication-only clients without health insurance because PWH were unable to purchase affordable health insurance in the private marketplace. With the implementation of the Affordable Care Act, more ADAP clients have been able to access public and private health insurance coverage. ADAP clients are screened for Medi-Cal eligibility and potentially eligible clients must apply to safeguard ADAP as the payer of last resort. Clients who enroll in full-scope Medi-Cal are disenrolled from ADAP because these clients have no SOC, no drug copays or deductibles, and no premiums. All clients who obtain health coverage through Covered California or other health plans can remain in ADAP's medication program to receive assistance with their drug deductibles and copays for medications on the ADAP formulary.

Eligible clients with health insurance can also coenroll in ADAP's health insurance assistance programs for assistance with their insurance premiums and medical out-of-pocket costs, which can only be paid if ADAP pays the client's premium. Helping ADAP clients purchase and maintain comprehensive health insurance is more cost effective than paying the full cost of medications and improves health outcomes by providing access to the full spectrum of medical care beyond the HIV outpatient care and medications available through the Ryan White Program.

II. Estimate Methodology

The ADAP Estimate uses a hybrid forecasting approach to estimate costs and revenue associated with medication and insurance assistance services. OA creates statistical models using conventional time series approaches with subject matter input to inform assumptions. Statistical models are reviewed for accuracy and adjusted, as appropriate, using knowledge-based forecasting. Forecasts are modeled conservatively, with the objective of reducing the risk of underestimating budget needs.

A. Expenditure Forecasts

Program data describing client counts and costs are summarized by month and insurance coverage group and combined with external cost drivers (e.g., inflation rates). Data are then divided into "training" and "testing" datasets to develop and test statistical models for accuracy by comparing predicted to actual values. OA relies mainly on two types of models: Bayesian Structural Time Series (BSTS) models, also known as dynamic linear models, and Autoregressive Integrated Moving Average (ARIMA) models. These models account for trends in historical program growth, inflation, changes in pharmacy utilization, administrative policies, and seasonal effects.

Separate estimates are created for each insurance coverage group and total projected costs are based on the following drivers:

- Expected number of clients served per month
- Expected cost per client per month

Total costs are estimated by multiplying the expected cost per client by the expected number of clients and using the delta method to estimate levels of certainty. Subject matter experts collaboratively review model estimates, which are combined with knowledge-based estimates when historical data are not available.

B. Revenue Forecasts

Revenue forecasts are estimated based on the results of the expenditure forecasts and the following drivers:

- Expected unit rebate amounts for statutorily required 340B rebates and voluntary rebates from manufacturers
- Historical rebate payment amounts and average time between medication dispense and receipt of rebate payments
- Historical trends in back-billing

Rebate revenue is estimated by quarter to reflect manufacturer agreements and is adjusted to reflect expected implementation of any newly negotiated voluntary rebate terms.

III. Estimate Overview

The 2023-24 ADAP November Estimate provides revised projections of 2022-23 and 2023-24 Local Assistance costs for medication, health insurance premiums, medical out-of-pocket costs, ADAP enrollment site payments, and administrative costs associated with pharmacy, insurance and medical benefits management services. Total estimated budget authority needs for 2022-23 and 2023-24, below, includes all assumptions.

Table 1 displays the estimated ADAP Local Assistance budget authority need for 2022-23 (column C) and 2023-24 (column G) and compares that need to the amount reflected in the Budget Act of 2022 (columns B and F). The Budget Act of 2018 authorized an ongoing $2 million in budget authority to modify and expand PrEP-AP which is also displayed in Table 1.

- 2022-23: OA estimates the ADAP budget authority need will be $440.5 million ($333.4 million ADAP Rebate Fund (Fund 3080) and $107.1 million Federal Trust Fund (Fund 0890)), which is $14.5 million lower than reported in the Budget Act of 2022 (Table 1). The 3.2 percent decrease is driven primarily by lower medication expenditures and premiums for the insured client groups than previously estimated (Table 8).
- 2023-24: OA estimates the ADAP budget authority need will be $440.1 million ($338.6 million ADAP Rebate Fund (Fund 3080) and $101.5 million Federal Trust Fund (Fund 0890)), which is $14.9 million lower than reported in the Budget Act of 2022 (Table 1). The 3.3 percent decrease is driven primarily by Medi-Cal Expansions, and the same factors listed above (Table 11).

Table 2 displays the estimated ADAP revenue for 2022-23 (column C) and 2023-24 (column G) and compares them to the amount reflected in the Budget Act of 2022 (columns B and F).

- 2022-23: OA estimates ADAP revenue will be $335.1 million (Table 2), $22.1 million lower than reported in the Budget Act of 2022. The 6.2 percent decrease is driven primarily by lower medication expenditures than previously estimated (Table 8).
- 2023-24: OA estimates ADAP revenue will be $380.2 million (Table 2), $23 million higher than reported in the Budget Act of 2022. The 6.4 percent

increase is driven primarily by a delay in the collection of rebate from the prior year from one manufacturer.

California Department of Public Health
AIDS Drug Assistance Program and PrEP Assistance Program
2023-24 November Estimate
Table 1: Local Assistance Budget Authority
(In Thousands)

Local Assistance	2022 Budget Act	Current Year FY 2022-23			2022 Budget Act	Budget Year FY 2023-24		
		2023-24 November Estimate	$ Change from 2022 Budget Act	% Change from 2022 Budget Act		2023-24 November Estimate	$ Change from 2022 Budget Act	% Change from 2022 Budget Act
(A)	(B)	(C)	(D) =(C)-(B)	(E) = (D)/(B)	(F)	(G)	(H) = (G)-(F)	(I) = (H)/(F)
Total Funds Requested	**$455,054**	**$440,521**	**-$14,533**	**-3.2%**	**$455,054**	**$440,128**	**-$14,926**	**-3.3%**
Federal Trust Fund - Fund 0890	$98,950	$107,076	$8,127	8.2%	$98,950	$101,519	$2,570	2.6%
ADAP Rebate Fund - Fund 3080	$354,105	$331,445	-$22,660	-6.4%	$354,105	$336,609	-$17,496	-4.9%
2018 Budget Act - PrEP-AP - Fund 3080	$2,000	$2,000	$0	0.0%	$2,000	$2,000	$0	0.0%
Caseload	35,873	35,801	-72	-0.2%	35,873	36,628	755	2.1%
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.								

2023-24 November Estimate
Table 2: ADAP Rebate Fund (Fund 3080) Revenues
(In Thousands)

Local Assistance	2022 Budget Act	Current Year FY 2022-23			2022 Budget Act	Budget Year FY 2023-24		
		2023-24 November Estimate	$ Change from 2022 Budget Act	% Change from 2022 Budget Act		2023-24 November Estimate	$ Change from 2022 Budget Act	% Change from 2022 Budget Act
(A)	(B)	(C)	(D) =(C)-(B)	(E) = (D)/(B)	(F)	(G)	(H) = (G)-(F)	(I) = (H)/(F)
Total Revenue Requested	**$357,165**	**$335,082**	**-$22,083**	**-6.2%**	**$357,165**	**$380,191**	**$23,027**	**6.4%**
ADAP Rebate Fund - Fund 3080	$354,923	$332,840	-$22,083	-6.2%	$354,923	$377,949	$23,027	6.5%
Interest Income	$2,242	$2,242	$0	0.0%	$2,242	$2,242	$0	0.0%
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.								

IV. Summary of Expenditures and Revenue

A. Expenditure Types

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

a) Health care expenditures include prescription medication costs for drugs on the ADAP formulary (including deductibles, copays, and co-insurance), health insurance premiums, and medical out-of-pocket costs (e.g., deductibles and copays for physician visits, laboratory tests, etc.). Estimated expenditures by client group are shown in Table 3. A detailed display of caseload and expenditures by client group and service type is in Section VI, Tables 6 – 11.

b) Enrollment expenditures are payments to local ADAP and PrEP-AP enrollment sites for services needed to enroll and maintain clients in ADAP and PrEP-AP. Enrollment expenditure estimates are adjusted annually through the ADAP Estimate, based on caseload and service

projections. Estimated expenditures for enrollment services are also shown in Table 3.

TABLE 3: ESTIMATED VARIABLE EXPENDITURES BY CLIENT GROUP

CLIENT GROUP	EXPENDITURES	
	FY 2022-23	FY 2023-24
Medication-Only	$313,407,919	$299,195,054
Medi-Cal SOC	$670,664	$658,655
Private Insurance	$86,602,374	$91,529,534
Medicare	$26,476,046	$28,770,897
PrEP-AP	$10,171,767	$13,233,295
SUBTOTAL	**$437,328,771**	**$433,387,434**
Admin Costs: ADAP	$5,365,537	$5,825,091
Admin Costs: PrEP-AP	$4,480,015	$6,121,167
Admin Costs: Enrollment	$7,070,000	$6,945,000
Health Management Systems (HMS)	-$15,723,094	-$14,150,785
TOTAL	**$438,521,230**	**$438,127,908**

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
Admin Costs are pharmacy, insurance and medical benefits management services.

B. Revenue and Federal Grants

a) ADAP Special Funds – ADAP receives both mandatory and voluntary supplemental rebates from drug manufacturers for ADAP medication expenditures. An approximate six-month delay in receipt of rebate revenue, from the time the medication expenditure occurs, exists because of the time required for billing the drug manufacturers. 2022-23 revenue projections are based on estimated rebates from actual and estimated medication expenditures from January through December 2022. 2023-24 revenue projections are based on estimated rebates from estimated medication expenditures from January through December 2023.

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

- 2022-23: Total federal fund budget authority is projected to be $107.1 million (Table 1), $8.1 million (8.2 percent) higher than reported in the Budget Act of 2022. Federal fund budget authority includes the following federal grant assumptions:
  - 2022 Ryan White Part B: $93.4 million
  - 2022 Ryan White Part B Supplemental: $2.3 million
  - 2022 ADAP Emergency Relief Funds (ADAP Shortfall Relief): $5.9 million
  - 2021 Ryan White Part B (Carryover): $5.6 million

- 2023-24: Total federal fund budget authority is projected to be $101.5 million (Table 1), $2.6 million (2.6 percent) higher than reported in the Budget Act of 2022. Federal fund budget authority includes the following estimated federal grant funding:
  - 2022 Ryan White Part B: $93.4 million
  - 2022 Ryan White Part B Supplemental: $2.3 million
  - 2022 ADAP Emergency Relief Funds (ADAP Shortfall Relief): $5.9 million

c) Federal Match – HRSA requires grantees to have HIV-related non-HRSA expenditures. OA meets the match requirement using ADAP Rebate Fund (Fund 3080) expenditures. California's HRSA match requirement for the 2022 Ryan White Part B grant budget period (April 1, 2022, through March 31, 2023) is $68.5 million.

V. Assumptions

New Assumptions

Expansion of Medi-Cal to All Income-Eligible Californians

Background: In the last decade, the Medi-Cal program has significantly expanded. These expansions have been driven mainly by the Patient Protection and Affordable Care Act and the state-led expansions of Medi-Cal coverage to undocumented children, young adults, and older adults over age 50.

The most recent Medi-Cal expansion extends full-scope eligibility to all income-eligible undocumented adults aged 26 through 49. Beginning no sooner than January 1, 2024, Medi-Cal will be available to all income-eligible Californians. When ADAP clients become eligible for full-scope Medi-Cal, they must enroll in Medi-Cal so that ADAP remains the payer of last resort. Increasing the number of ADAP clients eligible for full-scope Medi-Cal will therefore reduce the ADAP caseload, lowering ADAP program costs. Once the latest Medi-Cal expansion goes into effect, existing ADAP clients who enroll in full-scope Medi-Cal will be disenrolled from ADAP. If income qualified, individuals newly diagnosed with HIV will be able to enroll in Medi-Cal instead of ADAP.

Description of Change: The Medi-Cal expansion enacted in the Budget Act of 2022 extends full-scope eligibility to all income-eligible undocumented adults aged 26 through 49. Beginning no sooner than January 1, 2024, Medi-Cal will be available to all income-eligible Californians, estimated at nearly 700,000 persons statewide.

Discretionary: No

Reason for Adjustment/Change:

- Statutory requirement

Fiscal Impact and Fund Source(s): There is no identified impact to 2022-23. Estimated savings for 2023-24 is $26.1 million for 2,300 clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

Restore the Covered California State Premium Subsidy

Background: The California Premium Credit Program was a state premium subsidy program implemented through Section 37 of Assembly Bill (AB) 133 (Committee on Budget, Health, Chapter 143, Statutes of 2021), intended to supplement federal subsidies under the American Rescue Plan Act of 2021 through Covered California. The subsidy program was designed as a three-year program, from

2020 through 2022, that would reduce premium costs for most Covered California enrollees.

On August 16, 2022, the Inflation Reduction Act (Act) passed which extends the American Rescue Plan Act through 2025. The Act enhances premium subsidies for individuals through the Affordable Care Act marketplaces such as Covered California. The enhanced subsidies increase the amount of financial help to those who are eligible.

Description of Change: The Act will extend premium subsidies through 2025. Continuing the federal premium subsidy program will result in a cost savings for ADAP consistent with the establishment of the program in 2020.

Discretionary: No

Reason for Change/Adjustment:

- Legislative requirement

Fiscal Impact and Fund Source: Estimated savings for 2022-23 is $245,000 for 895 clients. Estimated savings for 2023-24 is $489,000 for 1,791 clients. The funds impacted are the Federal Trust Fund (Fund 0890) and ADAP Rebate Fund (Fund 3080).

Increase in Federal Funds: 2022 Ryan White Part B Supplemental Grant

Background: The Ryan White Part B Supplemental grant develops and/or enhances access to a comprehensive continuum of high-quality care and treatment services for low-income individuals living with HIV. The amount of each award is based on submitted data demonstrating the severity of the HIV epidemic in the applicant's state/territory, comorbidities, cost of care, and service needs of emerging populations.

The following table displays historical application amounts for which OA applied, total funds awarded per grant budget period, and total ADAP Local Assistance received per grant budget period.

Table 4: Ryan White Part B Supplemental Funds			
Grant Budget Period	Application Amount	Total Funds Awarded	Total Local Assistance
2018 (09/30/2018 – 09/29/2019)	$35,000,000	$23,765,871	$17,000,000
2019 (09/30/2019 – 09/29/2020)	$15,000,000	$6,375,772	$4,700,000
2020 (09/30/2020 – 09/29/2021)	$10,000,000	$2,628,306	$2,567,306
2021 (09/30/2021 – 09/29/2022)	$9,000,000	$1,941,558	$1,916,558
2022 (09/30/2022 – 09/29/2023)	$9,000,000	$2,250,912	$2,250,912

Description of Change: On May 11, 2022, OA applied for the competitive 2022 Ryan White Part B Supplemental grant. OA requested the maximum amount of $9 million, all of which is designated for ADAP Local Assistance to be used in 2022-23. On August 24, 2022, OA received the notice of award for the 2022 Ryan White Part B Supplemental grant in the amount of $2.3 million, all Local Assistance.

Discretionary: Yes

Reason for Change/Adjustment:

- Competitive funding opportunity
- Prior funding does not guarantee funding will be provided in the future

Fiscal Impact and Fund Source: Increase of $334,000 in Local Assistance for 2022-23 and 2023-24. The fund impacted is the Federal Trust Fund (Fund 0890).

Increase in Federal Funds: 2021 Ryan White Part B Grant Carryover

Background: The Ryan White Part B grant is a non-competitive grant and the largest of the three federal grants for which ADAP receives funding. Grant funding is appropriated in five, 12-month grant budget periods that run from April 1 to March 31. Within the five-year funding cycle, funding from year to year is provided if the program remains eligible and submits all reporting requirements in a timely manner. Funding from the Ryan White Part B grant that is not fully expended by the end of the budget period can be carried over to the next budget period with approval from HRSA.

Description of Change: In August 2022, OA closed out the 2021 Ryan White Part B grant. Upon closure of the grant, the amount of unspent funding was determined to be an estimated $5.6 million, for which the ADAP Branch applied. The request for HRSA approval was due August 29, 2022.

On October 25, 2022, OA received the notice of award for carryover in the amount of $5.6 million. Carryover funding will be spent in 2022-23.

Discretionary: Yes

Reason for Change/Adjustment:

- Fully leverage federal funding

Fiscal Impact and Fund Source: Increase of $5.6 million in Local Assistance for 2022-23. The fund impacted is the Federal Trust Fund (Fund 0890).

Medi-Cal Expansion: Asset Limit Changes

Background: Due to the passage of AB 133 (Chapter 143, Statutes of 2021), the Medi-Cal asset test will be eliminated for Non-Modified Adjusted Gross Income (MAGI) Medi-Cal programs in a two-phased approach. The asset test elimination will be phased in over two and a half years.

On July 1, 2022, the Department of Health Care Services (DHCS) increased the asset limit for Non-MAGI Medi-Cal programs to $130,000 per individual, and $65,000 for each additional household member. Phase II, to be implemented no sooner than January 1, 2024, will eliminate the asset test entirely.

Non-MAGI programs generally provide health care for seniors, people with disabilities, and individuals who are in nursing facilities, as well as some other specialty groups. The increased asset limits will allow a larger number of applicants to become eligible for Medi-Cal benefits, and will allow qualified beneficiaries to retain a larger amount of non-exempt assets and still be eligible for Medi-Cal.

Individuals/couples who may be affected include applicants who are over the current asset limit of $2,000 per individual and $3,000 per couple, as well as individuals who are already enrolled in a Non-MAGI program subject to the asset test. These individuals, though already receiving Medi-Cal benefits, will be able to have more assets and remain eligible after implementation.

ADAP has established outreach and communication plans so that clients and enrollment workers are informed of the new Medi-Cal eligibility criteria and that enrollment workers use the updated criteria to confirm ADAP eligibility. For new and existing clients, eligibility is determined at the initial enrollment or re-enrollment.

Description of Change: Increasing the number of clients eligible for Medi-Cal will result in cost savings to ADAP. Clients who are eligible for this expansion who are not deemed full-scope Medi-Cal will be dually enrolled in Medi-Cal and ADAP. ADAP will pay 100 percent of the prescription drug costs for medications on the ADAP formulary up to the client's Medi-Cal SOC amount.

Discretionary: No

Reason for Adjustment/Change:
- Statutory requirement

Fiscal Impact and Fund Source(s): Estimated savings for 2022-23 is $3.7 million for 260 clients. Estimated savings for 2023-24 is $8.4 million for 564 clients. The funds impacted are the Federal Trust Fund (Fund 0890) and ADAP Rebate Fund (Fund 3080).

Existing Assumptions

Medi-Cal Expansion: Age 50 and Older Regardless of Immigration Status

Background: The Budget Act of 2021 (AB 128, Ting, Chapter 21, Statutes of 2021) expanded eligibility for full-scope Medi-Cal benefits to all persons aged 50 years and older, regardless of immigration status. As the federal government only shares in the cost of restricted-scope services, this expansion is primarily funded by state resources.

Historically, only citizens and documented immigrants were eligible to apply for full-scope Medi-Cal. In 2016, the Legislature authorized full-scope Medi-Cal coverage for undocumented persons aged 18 years and under. In 2020, full-scope Medi-Cal coverage for those with undocumented status was expanded to ages 19 to 25. This latest budget enhancement, effective May 1, 2022, adds ongoing funding for full-scope Medi-Cal coverage for anyone aged 50 years and older, regardless of immigration status.

Increasing the number of clients eligible for full-scope Medi-Cal will result in cost savings to ADAP. Existing clients who qualify for this expansion will be disenrolled from ADAP as these clients have no share of cost, no drug copays or deductibles, and no premiums.

ADAP has established outreach and communication plans so that clients and enrollment workers are informed of the new Medi-Cal eligibility criteria and that enrollment workers use the updated criteria to confirm ADAP eligibility. For new clients, eligibility is determined at the initial enrollment. Existing clients who may qualify for this expansion will be notified by mail and their Medi-Cal eligibility will be confirmed by their re-enrollment deadline (client's birthday).

Description of Change: ADAP serves approximately 2,076 uninsured clients between the ages of 50 and 64 years old who could potentially become newly Medi-Cal eligible. ADAP expects that 50 percent of these clients will begin to

transition to Medi-Cal starting in late 2021-22. Those remaining, who are currently and newly eligible, will transition to Medi-Cal throughout 2022-23 and 2023-24.

Discretionary: No

Reason for Adjustment/Change:

- Statutory requirement

Fiscal Impact and Fund Source(s): Estimated savings for 2022-23 is $26.1 million for 1,038 clients[1]. Estimated savings for 2023-24 is $24.8 million for 986 clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

ADAP Pilot Program for Jails

Background: Prior to 2008, 36 local county jails participated in the ADAP to provide medication assistance to qualifying detainees. The program was terminated in 2008 due to the elimination of funding from the State's General Fund. Subsequently, in 2018, HRSA released Policy Clarification Notice (PCN) 18-02, which permitted the use of HRSA funds for individuals who are detained in a county jail and are not yet convicted of a crime or are not covered by federal or state health benefits. After the PCN release, Orange County asked CDPH to provide ADAP services at their county jail.

Providing ADAP services to jail detainees expands outreach to a vulnerable population while ensuring continuity of care for those navigating the judicial system. Incarcerated clients who meet ADAP eligibility requirements can enroll in ADAP with the help of a certified enrollment worker from the county jail, which must be approved as an enrollment site. New and existing clients can access medication(s) at the jail pharmacy, thus maximizing potential adherence to medicinal regimens. Additionally, the jail pharmacy can provide a prescription refill to clients scheduled for release, ensuring the client has a supply of medication available until they can access ADAP services through a more traditional enrollment site.

In response to Orange County's request, OA initiated a pilot program in 2021-22 with the Orange County jail. OA, in consultation with the Department of Finance, is expanding the pilot program to other interested county jails after careful

[1] In the 2022-23 May Revision, OA reported an impact for 2022-23 of $29 million in savings for 2,045 fewer clients, a cumulative drop that started in 2021-22. The updated estimate for 2022-23 of 1,038 clients, represents the drop in clients in current year 2022-23 alone. Similarly, the 2023-24 impact reflects the drop in clients in budget year 2023-24 alone.

consideration of the impact to the ADAP Rebate Fund, both in the short and long term.

OA met with the other interested county jails in the summer of 2022 to understand how they address the transitional needs of PWH who have been incarcerated. OA determined whether each respective jail would be a suitable ADAP jail enrollment site. Prior to becoming an enrollment site, interested county jails will need to submit a new Enrollment Site Application, begin the contracting process with OA, be added to the Pharmacy Benefits Manager Pharmacy Network, and complete the new enrollment worker training.

Description of Change: The 2022-23 May Revision Estimate approved seven counties which expressed interest: Orange, Los Angeles, Marin, Riverside, San Francisco, San Luis Obispo, and Siskiyou. OA has a contract in place with Orange County and continues to conduct outreach to the remaining six counties. For 2023-24, OA requests approval of three additional interested counties in conjunction with the seven aforementioned counties: San Bernardino, San Joaquin, and Tuolumne. Clients will not be enrolled until a contract is in place and the enrollment worker training is completed. Additional funding is requested in 2022-23 for the seven counties, and for both the original seven counties and additional three (ten counties total) in 2023-24 following updated information from the counties.

Discretionary: Yes

Reason for Adjustment/Change:

- HRSA PCN 18-02, which permits the use of funds for individuals who are currently detained in a county jail
- Treatment and suppression of HIV/AIDS and HIV/AIDS-related opportunistic infections among high-risk individuals
- Effective outreach to underserved populations
- Continuity of care

Fiscal Impact and Fund Source(s): For 2022-23, the projected net fiscal impact of the seven total pilots is $16.3 million ($24.1 million expenditures minus $7.8 million rebate) for 2,187 eligible clients. For 2023-24, the projected net fiscal impact of the ten total pilots is $13.2 million ($31.1 million expenditures minus $17.9 million rebate) for 2,666 eligible clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

Decrease in Federal Funds: 2022 Ryan White Part B Grant

Background: The Ryan White Part B grant is a non-competitive grant and the largest of the three federal grants for which ADAP receives funding. Grant

funding is appropriated in five, 12-month grant budget periods that run from April 1 to March 31. Within the five-year funding cycle, funding from year to year is provided if the program remains eligible and submits all reporting requirements in a timely manner.

On November 8, 2021, OA applied for the 2022 Ryan White Part B grant, the first year of the newest five-year funding cycle. The total funding requested in the grant application was $135.8 million, of which $95 million was designated ADAP Local Assistance. On March 22, 2022, OA received a notice of partial award for the 2022 Ryan White Part B grant in the amount of $49 million, of which $34.7 million was ADAP Local Assistance. The 2022-23 May Revision Estimate accounted for the partial award of $34.7 million.

Description of Change: On June 23, 2022, OA received notice of the remaining award for the 2022 Ryan White Part B grant in the amount of $89 million, of which $60.8 million was ADAP Local Assistance. On September 29, 2022, OA fulfilled HRSA's budget revision reporting requirement, which decreased the $60.8 million to $58.7 million. In total, the complete award for the 2022 Ryan White Part B grant is $138 million, of which $93.4 million is ADAP Local Assistance.

Discretionary: Yes

Reason for Adjustment/Change:

- Fully leverage federal funding

Fiscal Impact and Fund Source(s): Decrease of $1.6 million in Local Assistance for 2022-23 and 2023-24. The fund impacted is the Federal Trust Fund (Fund 0890).

Increase in Federal Funds: 2022 ADAP Emergency Relief Funds Grant (ADAP Shortfall Relief Grant)

Background: The ADAP Emergency Relief Funds grant (ADAP Shortfall Relief grant) is intended for states/territories that demonstrate the need for additional resources to prevent, reduce and/or eliminate ADAP waiting lists through implementation of cost-containment measures. OA's cost-containment measures include maintaining data match agreements to help ensure ADAP is the payer of last resort.

On October 25, 2021, OA applied for the maximum amount of $7 million for the competitive 2022 ADAP Emergency Relief Funds grant, all of which was designated ADAP Local Assistance. On February 23, 2022, OA received the notice of award for the 2022 ADAP Emergency Relief Funds grant in the amount of $2 million (all Local Assistance).

The following table displays the historical grant application amounts for which OA applied, and the total funds awarded per grant budget period, including both the 2022 grant budget period prior award of $2 million and newest award of $3.8 million:

Table 5: ADAP Emergency Relief Funds (Shortfall Relief) Grant		
Grant Budget Period	Application Amount	Total Funds Awarded
2018 (04/01/2018 – 03/31/2019)	$11,000,000	$11,000,000
2019 (04/01/2019 – 03/31/2020)	$11,000,000	$11,000,000
2020 (04/01/2020 – 03/31/2021)	$10,000,000	$6,537,311
2021 (04/01/2021 – 03/31/2022)	$7,000,000	$5,307,130
2022 (04/01/2022 – 03/31/2023)	$7,000,000	$5,850,650

Description of Change: On June 2, 2022, OA received a notice of award for the 2022 ADAP Emergency Relief Funds grant in the amount of $3.8 million for the 2022 grant budget period. This award combines $1.1 million for the 2022 grant budget period, and an unanticipated amount of $2.7 million from the 2020 grant budget period. The $3.8 million award and the prior $2 million received on February 23, 2022, both for the 2022 grant budget period, bring the total funds awarded to $5.9 million (Table 2).

Discretionary: Yes

Reason for Adjustment/Change:

- Competitive funding opportunity
- Prior funding does not guarantee that funding will be provided in the future

Fiscal Impact and Fund Source(s): Increase of $544,000 in Local Assistance for 2022-23 and 2023-24. The fund impacted is the Federal Trust Fund (Fund 0890).

PrEP and PEP Initiation and Retention Initiative (PPIRI)

Background: ADAP received statutory and budgetary authority through the 2016 Budget Act to provide services to HIV-negative persons at risk for acquiring HIV. Statutory authority is codified in Health and Safety Code (HSC) section 120972 and allows OA to implement the PrEP-AP to assist both insured and uninsured individuals who meet eligibility requirements. The PrEP-AP helps with PrEP-related and non-occupational PEP-related medical out-of-pocket costs, and access to medications on the PrEP-AP formulary for the prevention of HIV and treatment of sexually transmitted infections.

In 2021, AB 133 (Committee on Budget, Chapter 143, Statutes of 2021) added language allowing allocation of ADAP funds for PrEP and PEP navigation and retention. AB 133 allows ADAP to fund local health departments and community-based organizations, to the extent that funds are available, for PrEP and PEP navigation and retention coordination and related services. Funded activities may include outreach and education; community messaging; assistance with applying for and retaining health coverage; assistance with enrollment in PrEP and PEP financial assistance programs; care coordination and adherence support; financial assistance for transportation costs; and linkage to behavioral health, substance use, housing, and other social service programs.

This project was named the PrEP and PEP Initiation and Retention Initiative (PPIRI) to avoid confusion with CDPH/OA HIV Prevention Branch PrEP Navigation projects.

Description of Change: Planning and development of a competitive solicitation is underway. Stakeholder engagement was held in early 2022 to assess capability, interest, and need. The solicitation is tentatively planned for release in the fall of 2022 and agreements with approved entities would commence in early 2023.

Discretionary: Yes

Reason for Adjustment/Change:

- Legislation was codified allowing CDPH/OA to fund local health departments and community-based organizations, to the extent that funds are available, for PrEP and PEP navigation and retention coordination and related services

Fiscal Impact and Fund Source(s): The total estimated costs for 2022-23 is $4 million for 500 clients ($2.9 million for 25 staff and operating expenses; $929,000 for variable costs [example: PrEP starter packs and lab processing]; $4,500 for indirect costs; and $204,000 for 68 new PrEP-AP clients, inclusive of medication and medical-out-of-pocket costs). The total estimated cost for 2023-24 is $5.8 million for 875 clients ($3.7 million for 25 staff and operating expenses; $1.7 million for variable costs [example: PrEP starter packs and lab processing]; $10,000 for indirect costs; and $409,000 for 136 new PrEP-AP clients, inclusive of medication and medical-out-of-pocket costs). The fund impacted is the ADAP Rebate Fund (Fund 3080).

Payment of Medicare Part C Premiums (plus Expansion)

Background: ADAP pays private health insurance premiums and outpatient medical out-of-pocket costs for ADAP clients coenrolled in the Office of AIDS Health Insurance Premium Payment Program (OA-HIPP), Medicare Part D

Premium Payment Program (MDPP), and the Employer Based Health Insurance Premium Payment Program (EB-HIPP). When ADAP clients become eligible for Medicare, they must enroll in Medicare to help ensure ADAP is the payer of last resort. Only clients enrolled in a Medicare Part D health plan may receive insurance premium and outpatient medical out-of-pocket assistance through MDPP; MDPP clients can also request Medicare Supplemental (Medigap) Plan premium assistance. In contrast, clients who enroll in a Medicare Part C plan receive no premium or medical out-of-pocket cost assistance through ADAP, which creates a lack of parity in ADAP's Medicare services.

Medicare Part C, also known as Medicare Advantage, is a bundled insurance plan that includes hospital (Medicare Part A), medical (Medicare Part B) and prescriptions (Medicare Part D). According to HRSA PCN 18-01, Ryan White HIV/AIDS Program grant recipients may use funds to pay premiums and/or cost sharing when the Medicare Part C plan includes prescription drug coverage; or in conjunction with paying for Medicare Part D premiums and cost sharing for plans that do not include prescription drug coverage.

ADAP proposes to use ADAP rebate funds to establish the Medicare Part C Premium Payment Program and pay for Medicare Part C premiums for eligible ADAP clients.

To provide sufficient time for discovery, coordination with ADAP's contractors, and seamless program implementation, OA will start implementing processes for the Medicare Part C Payment Program in 2022-23.

Description of Change: OA met with its contractors in June 2022 to discuss the program implementation processes for the Medicare Part C Payment program. After discussion, January 1, 2023, was identified as a feasible implementation date, refining the initial 2022-23 program implementation date.

Discretionary: Yes

Reason for Adjustment/Change:

- Encourage more ADAP clients to enroll into comprehensive health coverage, which will result in an overall reduction in ADAP expenditures
- Improve the overall health of PWH in California because clients will have comprehensive hospital coverage
- Continue supporting health insurance coverage for ADAP clients as they become eligible for Medicare
- Align Medicare Part C with other health insurance premium payment programs

Fiscal Impact and Fund Source(s): Estimated cost for 2022-23 is $840,000 for 780 eligible clients. Estimated cost for 2023-24 is $1.7 million for 799 eligible clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Payment of Medicare Part C Medical Out-of-Pocket Costs

Background: In addition to paying private health insurance premiums for ADAP clients coenrolled in the OA-HIPP, EB-HIPP, and MDPP programs, ADAP also pays for outpatient medical out-of-pocket costs. ADAP proposes to pay for outpatient medical out-of-pocket costs for clients coenrolled in the Medicare Part C Premium Payment Program.

HSC section 120955 (i) states that the department may subsidize, using available federal funds and monies from the ADAP rebate fund, costs associated with a health care service plan or health insurance policy, including medical copayments and deductibles for outpatient care, and premiums to purchase or maintain health insurance coverage.

ADAP proposes to use ADAP rebate funds to establish the Medicare Part C Premium Payment Program and pay for Medicare Part C outpatient medical out-of-pocket costs for eligible ADAP clients.

To provide sufficient time for discovery, coordination with ADAP's contractors, and seamless program implementation, OA will start implementing processes for the Medicare Part C Payment Program in 2022-23.

Description of Change: OA met with its contractors in June 2022 to discuss program implementation processes for the Medicare Part C Medical Out-of-Pocket Costs benefit. After discussion, January 1, 2023, was identified as a feasible implementation date, refining the initial 2022-23 program implementation date.

Discretionary: Yes

Reason for Adjustment/Change:

- Establish equitable benefits for ADAP's insurance assistance programs
- Continue supporting health insurance coverage for ADAP clients as they become eligible for Medicare

Fiscal Impact and Fund Source(s): Estimated cost for 2022-23 is $119,000 for 300 eligible clients. Estimated cost for 2023-24 is $268,000 for 336 eligible clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Medicare Coverage of Extra and Innovative Supplemental Plans

Background: Original Medicare consists of Part A (hospitalization) and Part B (medical insurance). Medicare Part B covers 80 percent of costs that clients incur after meeting their annual deductible. Medicare Supplemental (Medigap) plans assist with the remaining 20 percent of costs.

There are varying levels of coverage for Medicare supplemental plans (A-N), with plans F and G being the most comprehensive. The most comprehensive plans also offer "Extra" or "Innovative" benefits to cover services outside of the base medical coverage. For example, Extra/Innovative plans may cover the costs of hearing aids, vision exams, Silver Sneaker gym memberships, 24/7 nurse consultations, and many other services. Due to various advancements in HIV care and treatment, PWH are living longer. Extra and Innovative plans would be a public health benefit for our aging population by offering services that may mitigate future non-HIV related care. For example, Silver Sneaker gym memberships can decrease social isolation and help improve cardiovascular and bone health.

The MDPP began paying Medicare Part B supplemental medical plan premiums June 1, 2018. Effective July 1, 2020, Senate Bill (SB) 407 (Chapter 549, Statutes of 2019), requires Extra and Innovative benefits to be separated on all Medicare supplemental billing statements. MDPP pays for Medicare Part D premiums, Part B out-of-pocket costs, and the base premium for supplemental plans. Supplemental plans with Extra or Innovative benefits included may have lower total premium costs compared to identical supplemental plans that do not include the additional benefits. Clients are required to cover the nominal costs for Extra or Innovative benefits.

ADAP proposes to use ADAP rebate funds to pay Medicare Part B supplemental plan premiums including the Extra and Innovative benefits.

To provide sufficient time for discovery, coordination with ADAP's contractors, and seamless program implementation, OA will start implementing processes for the coverage of Extra or Innovative benefits in 2022-23.

Description of Change: OA met with its contractors in the summer of 2022 to discuss program implementation processes for the Medicare Coverage of Extra and Innovative Supplemental plan premiums. On August 16, 2022, OA implemented coverage of Extra and Innovative supplemental plans.

Discretionary: Yes

Reason for Adjustment/Change:

- Improve the overall health of PWH in California as additional plan benefits offer a more holistic approach to healthcare
- More plan choices improve access to care
- Continue supporting health insurance coverage for ADAP clients as they become eligible for Medicare

Fiscal Impact and Fund Source(s): Estimated cost for 2022-23 is $750,000 for 256 eligible clients. Estimated cost for 2023-24 is $858,000 million for 268 eligible clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Unchanged Assumptions

Impact of the Novel COVID-19

Background: On March 4, 2020, California declared a state of emergency in response to the COVID-19 pandemic. Shortly after, on March 19, 2020, California issued a Shelter-In-Place order. The order has had a tremendous impact on Californians, ranging from a sharp rise in unemployment to possible loss of comprehensive health coverage. For ADAP clients, the potential impact can be life threatening as people with a serious underlying medical condition, including those with compromised immune systems, are at higher risk for COVID-19-related complications. To reduce COVID-19 exposure and the risk of clients falling out of HIV care, OA took steps so that ADAP clients would maintain their program eligibility. Those measures included allowing clients to enroll virtually with their enrollment worker and increasing the number of allowable medication dispenses, which would reduce the number of trips a client would need to make to the pharmacy.

In March 2020, ADAP saw a spike in medication costs following the first COVID-19 Shelter-In-Place orders. This initial spike was followed by a series of smaller magnitude increases and decreases through the end of the calendar year. After a short period of cost volatility at the beginning of the pandemic, OA saw a sustained drop in its ADAP client medication benefits caseload once COVID-19 automatic eligibility extensions ended in August 2020. Since March 2020, OA has also seen increases in its premium expenditures, as previously uninsured or underinsured clients enrolled in ADAP's premium assistance programs. However, after accounting for differences in insurance coverage, underlying trends, seasonal variation, and other cost drivers, total costs continued to be lower than expected.

On January 28, 2021, Covered California announced it would join President Biden in responding to the COVID-19 pandemic by announcing a special enrollment period to help people obtain insurance coverage. Effective February 1, 2021,

through May 15, 2021, anyone uninsured and eligible to enroll in health care coverage through Covered California could sign up. On February 2, 2021, President Biden signed the federal mandate Public Charge Executive Order to remove barriers to the legal immigration system.

The expansion of Covered California's enrollment period and the increased accessibility to public benefits are believed to have contributed to the overall reduction in the size of ADAP's uninsured client caseload.

Given the sustained shifts in ADAP caseload since March 2020, OA expects the COVID-19 cost impacts to medication and insurance assistance programs to continue long term. Cost savings have been primarily driven by lower-than-expected uninsured caseload volume and shifts in insurance coverage (caseload mix) for clients using ADAP medication benefits. Decreases in ADAP's uninsured caseload and associated cost savings have greatly exceeded any cost increases associated with medication prices and increases to ADAP's insurance assistance caseload.

Description of Change: No change from the 2022-23 May Revision Estimate.

Discretionary: No

Reason for Adjustment/Change:
- Federal mandate

Fiscal Impact and Fund Source(s): Estimated savings for 2022-23 is $9.1 million, broken down as follows: $13.8 million for 537 fewer medication benefit clients per month, offset by a cost increase of $4.7 million for 1,279 additional monthly premium assistance clients. Estimated savings for 2023-24 is $9.1 million, broken down as follows: $13.8 million for 537 fewer medication benefit clients per month, offset by a cost increase of $4.7 million for 1,279 additional monthly premium assistance clients. The funds impacted are the Federal Trust Fund (Fund 0890) and ADAP Rebate Fund (Fund 3080).

Discontinued Assumptions

Decrease in Federal Funds: 2021 Ryan White Part B Grant

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2021-22 has ended and the funding has already been expended.

Decrease in Federal Funds: 2021 Ryan White Part B Supplemental Grant

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2021-22 has ended and the funding has already been expended.

Decrease in Federal Funds: 2021 ADAP Emergency Relief Funds Grant (ADAP Shortfall Relief Grant)

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2021-22 has ended and the funding has already been expended.

Increase in Federal Funds: 2020 Ryan White Part B Grant Carryover

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2021-22 has ended and the funding has already been expended.

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

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since all health plans regulated by the Department of Insurance and Department of Managed Health Care have implemented the USPSTF recommendation. Trends reflect a decline in uninsured clients as well as PrEP-AP clients.

VI. Expenditure Details

Tables 6 through 11, starting on the next page, break down caseload and expenditures by client group and service type.

TABLE 6: November Estimate Caseload and Variable Expenditures; Current Year 2022-23

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	11,648	32.5%	$313,407,919	$0	$0	$313,407,919
Medi-Cal SOC	90	0.3%	$670,664	$0	$0	$670,664
Private insurance*	10,409	29.1%	$20,898,607	$63,658,420	$2,045,346	$86,602,374
Medicare*	7,350	20.5%	$20,403,590	$5,705,338	$367,118	$26,476,046
PrEP-AP	6,305	17.6%	$7,561,933	$0	$2,609,834	$10,171,767
SUBTOTAL	**35,801**	**100.0%**	**$362,942,713**	**$69,363,759**	**$5,022,299**	**$437,328,771**
Admin Costs: ADAP	-	-	$2,121,727	$2,064,887	$1,178,923	$5,365,537
Admin Costs: PrEP-AP	-	-	$2,429,583	$0	$2,050,433	$4,480,015
Admin Costs: Enrollment	-	-	$0	$0	$0	$7,070,000
HMS	-	-	-$15,723,094	$0	$0	-$15,723,094
TOTAL	**35,801**	**100.0%**	**$351,770,929**	**$71,428,646**	**$8,251,655**	**$438,521,230**

* Subgroup of 12,458 clients receiving assistance for premium payments and medical-out-of-pocket costs.
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
Admin Costs are pharmacy, insurance and medical benefits management services.

TABLE 7: 2022 Budget Act Caseload and Variable Expenditures; Current Year 2022-23

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	10,393	29.0%	$302,785,103	$0	$0	$302,785,103
Medi-Cal SOC	103	0.3%	$1,187,709	$0	$0	$1,187,709
Private insurance*	10,900	30.4%	$24,135,323	$73,683,229	$1,812,749	$99,631,301
Medicare*	7,536	21.0%	$24,357,919	$6,925,619	$508,871	$31,792,410
PrEP-AP	6,941	19.3%	$10,826,716	$0	$1,452,073	$12,278,789
SUBTOTAL	**35,873**	**100.0%**	**$363,292,770**	**$80,608,848**	**$3,773,693**	**$447,675,311**
Admin Costs: ADAP	-	-	$2,188,318	$1,646,967	$945,476	$4,780,760
Admin Costs: PrEP-AP	-	-	$3,085,462	$0	$2,140,700	$5,226,161
Admin Costs: Enrollment	-	-	$0	$0	$0	$6,975,000
HMS	-	-	-$11,602,862	$0	$0	-$11,602,862
TOTAL	**35,873**	**100.0%**	**$356,963,687**	**$82,255,815**	**$6,859,869**	**$453,054,371**

* Subgroup of 13,839 clients receiving assistance for premium payments and medical-out-of-pocket costs.
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
Admin Costs are pharmacy, insurance and medical benefits management services.

TABLE 8: Difference Between November Estimate and 2022 Budget Act; Current Year 2022-23

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	1,255	12.1%	$10,622,817	$0	$0	$10,622,817
Medi-Cal SOC	-13	-13.1%	-$517,045	$0	$0	-$517,045
Private insurance*	-491	-4.5%	-$3,236,716	-$10,024,809	$232,598	-$13,028,927
Medicare*	-186	-2.5%	-$3,954,329	-$1,220,281	-$141,753	-$5,316,363
PrEP-AP	-636	-9.2%	-$3,264,783	$0	$1,157,761	-$2,107,022
SUBTOTAL	**-72**	**-0.2%**	**-$350,056**	**-$11,245,090**	**$1,248,606**	**-$10,346,541**
Admin Costs: ADAP	-	-	-$66,590	$417,920	$233,447	$584,777
Admin Costs: PrEP-AP	-	-	-$655,879	$0	-$90,267	-$746,146
Admin Costs: Enrollment	-	-	$0	$0	$0	$95,000
HMS	-	-	-$4,120,232	$0	$0	-$4,120,232
TOTAL	**-72**	**-0.2%**	**-$5,192,758**	**-$10,827,169**	**$1,391,786**	**-$14,533,142**

* Subgroup decreased 1,381 clients receiving assistance for premium payments and medical-out-of-pocket costs.
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
Admin Costs are pharmacy, insurance and medical benefits management services.

TABLE 9: November Estimate Caseload and Variable Expenditures; Budget Year 2023-24

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	10,668	29.1%	$299,195,054	$0	$0	$299,195,054
Medi-Cal SOC	90	0.2%	$658,655	$0	$0	$658,655
Private insurance*	10,414	28.4%	$21,572,121	$67,657,462	$2,299,951	$91,529,534
Medicare*	7,351	20.1%	$21,104,436	$7,151,227	$515,234	$28,770,897
PrEP-AP	8,105	22.1%	$8,964,194	$0	$4,269,100	$13,233,295
SUBTOTAL	**36,628**	**100.0%**	**$351,494,460**	**$74,808,689**	**$7,084,285**	**$433,387,434**
Admin Costs: ADAP	-	-	$2,333,900	$2,271,376	$1,219,816	$5,825,091
Admin Costs: PrEP-AP	-	-	$3,319,605	$0	$2,801,562	$6,121,167
Admin Costs: Enrollment	-	-	$0	$0	$0	$6,945,000
HMS	-	-	-$14,150,785	$0	$0	-$14,150,785
TOTAL	**36,628**	**100.0%**	**$342,997,181**	**$77,080,065**	**$11,105,662**	**$438,127,908**

* Subgroup of 12,804 clients receiving assistance for premium payments and medical-out-of-pocket costs.
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
Admin Costs are pharmacy, insurance and medical benefits management services.

TABLE 10: 2022 Budget Act Caseload and Variable Expenditures; Budget Year 2023-24

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	10,393	29.0%	$302,785,103	$0	$0	$302,785,103
Medi-Cal SOC	103	0.3%	$1,187,709	$0	$0	$1,187,709
Private insurance*	10,900	30.4%	$24,135,323	$73,683,229	$1,812,749	$99,631,301
Medicare*	7,536	21.0%	$24,357,919	$6,925,619	$508,871	$31,792,410
PrEP-AP	6,941	19.3%	$10,826,716	$0	$1,452,073	$12,278,789
SUBTOTAL	**35,873**	**100.0%**	**$363,292,770**	**$80,608,848**	**$3,773,693**	**$447,675,311**
Admin Costs: ADAP	-	-	$2,188,318	$1,646,967	$945,476	$4,780,760
Admin Costs: PrEP-AP	-	-	$3,085,462	$0	$2,140,700	$5,226,161
Admin Costs: Enrollment	-	-	$0	$0	$0	$6,975,000
HMS	-	-	-$11,602,862	$0	$0	-$11,602,862
TOTAL	**35,873**	**100.0%**	**$356,963,687**	**$82,255,815**	**$6,859,869**	**$453,054,371**

* Subgroup of 13,839 clients receiving assistance for premium payments and medical-out-of-pocket costs.
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
Admin Costs are pharmacy, insurance and medical benefits management services.

TABLE 11: Difference Between November Estimate and 2022 Budget Act; Budget Year 2023-24

CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-Only	275	2.6%	-$3,590,049	$0	$0	-$3,590,049
Medi-Cal SOC	-13	-12.8%	-$529,054	$0	$0	-$529,054
Private insurance*	-486	-4.5%	-$2,563,202	-$6,025,767	$487,202	-$8,101,767
Medicare*	-185	-2.5%	-$3,253,483	$225,607	$6,363	-$3,021,513
PrEP-AP	1,164	16.8%	-$1,862,522	$0	$2,817,027	$954,505
SUBTOTAL	**755**	**2.1%**	**-$11,798,309**	**-$5,800,160**	**$3,310,591**	**-$14,287,877**
Admin Costs: ADAP	-	-	$145,582	$624,409	$274,339	$1,044,331
Admin Costs: PrEP-AP	-	-	$234,143	$0	$660,863	$895,006
Admin Costs: Enrollment	-	-	$0	$0	$0	-$30,000
HMS	-	-	-$2,547,923	$0	$0	-$2,547,923
TOTAL	**755**	**2.1%**	**-$13,966,506**	**-$5,175,751**	**$4,245,793**	**-$14,926,464**

* Subgroup decreased 1,035 clients receiving assistance for premium payments and medical-out-of-pocket costs.
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
Admin Costs are pharmacy, insurance and medical benefits management services.

a) Medication-Only Clients

1. Medication:
   - 2022-23: Costs are projected to be $313.4 million (Table 6), $10.6 million higher than reported in the Budget Act of 2022 (Table 8). The increase is driven primarily by monthly caseload, which is projected to be higher than previously estimated.
   - 2023-24: Costs are projected to be $299.2 million (Table 9), $3.6 million lower than reported in the Budget Act of 2022 (Table 11). The decrease is driven primarily by lower monthly caseload.
2. Health Insurance Premiums: There are no costs for medication-only clients.
3. Medical Out-Of-Pocket Costs: There are no costs for medication-only clients.

b) Medi-Cal SOC Clients

1. Medication:
   - 2022-23: Costs are projected to be $671,000 (Table 6), $517,000 lower than reported in the Budget Act of 2022 (Table 8). The decrease is driven primarily by Medi-Cal SOC client medication cost per month, which is projected to be lower than previously estimated.
   - 2023-24: Costs are projected to be $658.7 million (Table 9), $529,000 lower than reported in the Budget Act of 2022 (Table 11). The decrease is driven primarily by the same factor listed above.
2. Health Insurance Premiums: There are no costs for Medi-Cal SOC clients.
3. Medical Out-Of-Pocket Costs: There are no costs for Medi-Cal SOC clients.

c) Private Insurance Clients

1. Medication:
   - 2022-23: Costs are projected to be $20.9 million (Table 6), $3.2 million lower than reported in the Budget Act of 2022 (Table 8). The decrease is driven primarily by monthly caseload, which is projected to be lower than previously estimated.
   - 2023-24: Costs are projected to be $21.6 million (Table 9), $2.6 million lower than reported in the Budget Act of 2022 (Table 11). The decrease is driven primarily by the same factor listed above.
2. Health Insurance Premiums:
   - 2022-23: Costs are projected to be $63.7 million (Table 6), $10 million lower than reported in the Budget Act of 2022 (Table 8). The decrease is driven primarily by monthly premiums and monthly non-

Covered California caseload, both of which are projected to be lower than previously estimated.
- 2023-24: Costs are projected to be $67.7 million (Table 9), $6 million lower than reported in the Budget Act of 2022 (Table 11). The decrease is driven primarily by the same factors listed above.

3. Medical Out-Of-Pocket Costs:
   - 2022-23: Costs are projected to be $2 million (Table 6), $233,000 higher than reported in the Budget Act of 2022 (Table 8). The increase is driven primarily by the cost per medical out-of-pocket benefit service utilization, which is projected to be higher than previously estimated.
   - 2023-24: Costs are projected to be $2.3 million (Table 9), $487,000 higher than reported in the Budget Act of 2022 (Table 11). The increase is driven primarily by the same factor listed above.

d) Medicare Clients

1. Medication:
   - 2022-23: Costs are projected to be $20.4 million (Table 6), $4 million lower than reported in the Budget Act of 2022 (Table 8). The decrease is driven primarily by monthly caseload and medication cost per month, both of which are projected to be lower than previously estimated.
   - 2023-24: Costs are projected to be $21.1 million (Table 9), $3.3 million lower than reported in the Budget Act of 2022 (Table 11). The decrease is driven primarily by the same factors listed above.
2. Health Insurance Premiums:
   - 2022-23: Costs are projected to be $5.7 million (Table 6), $1.2 million lower than reported in the Budget Act of 2022 (Table 8). The decrease is driven primarily by a decrease in clients receiving assistance for premium payments, which is projected to be lower than previously estimated.
   - 2023-24: Costs are projected to be $7.2 million (Table 9), $226,000 higher than reported in the Budget Act of 2022 (Table 11). The increase is driven primarily by payment of Part C premiums (plus expansion) and coverage of Extra and Innovative supplemental plans.
3. Medical Out-Of-Pocket Costs:
   - 2022-23: Costs are projected to be $367,000 (Table 6), $142,000 lower than reported in the Budget Act of 2022 (Table 8). The decrease is driven primarily by a decrease in clients receiving assistance for medical-out-of-pocket costs, which is projected to be lower than previously estimated.

- 2023-24: Costs are projected to be $515,000 (Table 9), $6,000 higher than reported in the Budget Act of 2022 (Table 11). The increase is driven primarily by payment of Part C medical out-of-pocket costs.

e) PrEP-AP Clients

1. Medication:
   - 2022-23: Costs are projected to be $7.6 million (Table 6), $3.3 million lower than reported in the Budget Act of 2022 (Table 8). The decrease is driven primarily by a decrease in uninsured PrEP-AP client medication cost per month, which is projected to be lower than previously estimated.
   - 2023-24: Costs are projected to be $9 million (Table 9), $1.9 million lower than reported in the Budget Act of 2022 (Table 11). The decrease is driven primarily by the same factor listed above.
2. Health Insurance Premiums: There are no costs for PrEP-AP clients.
3. Medical Out-Of-Pocket Costs:
   - 2022-23: Costs are projected to be $2.6 million (Table 6), $ 1.2 million higher than reported in the Budget Act of 2022 (Table 8). The increase is driven primarily by the cost per medical-out-of-pocket benefit service utilization, which is projected to be higher than previously estimated.
   - 2023-24: Costs are projected to be $4.3 million (Table 9), $2.8 million higher than reported in the Budget Act of 2022 (Table 11). The increase is driven primarily by the same factor listed above.

VII. Historical Program Data and Trends

Figures 1 – 3 describe clients served. Enrolled clients who do not incur program costs are excluded.

Figure 1 summarizes ADAP clients served by fiscal year and those also receiving insurance assistance.

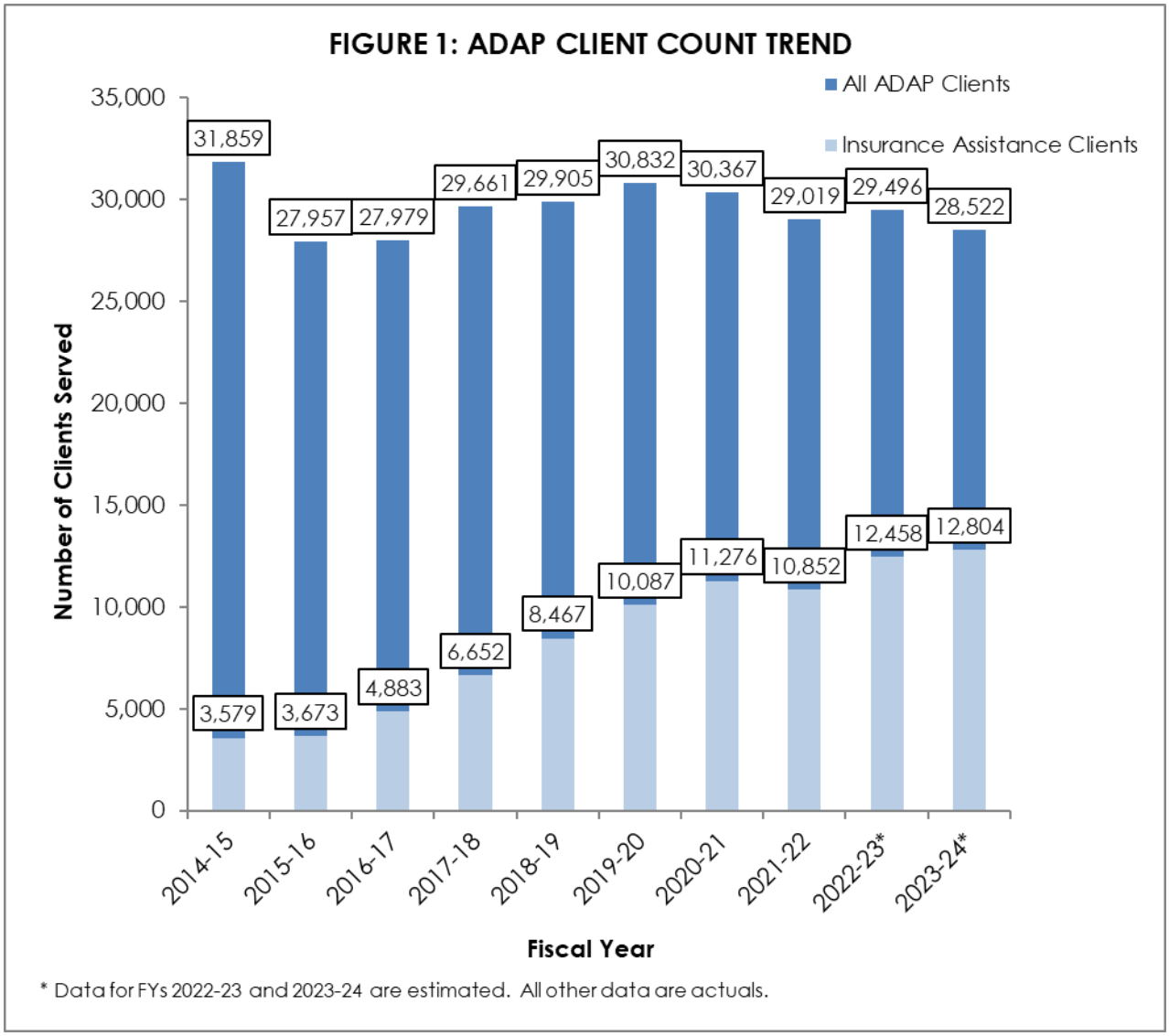
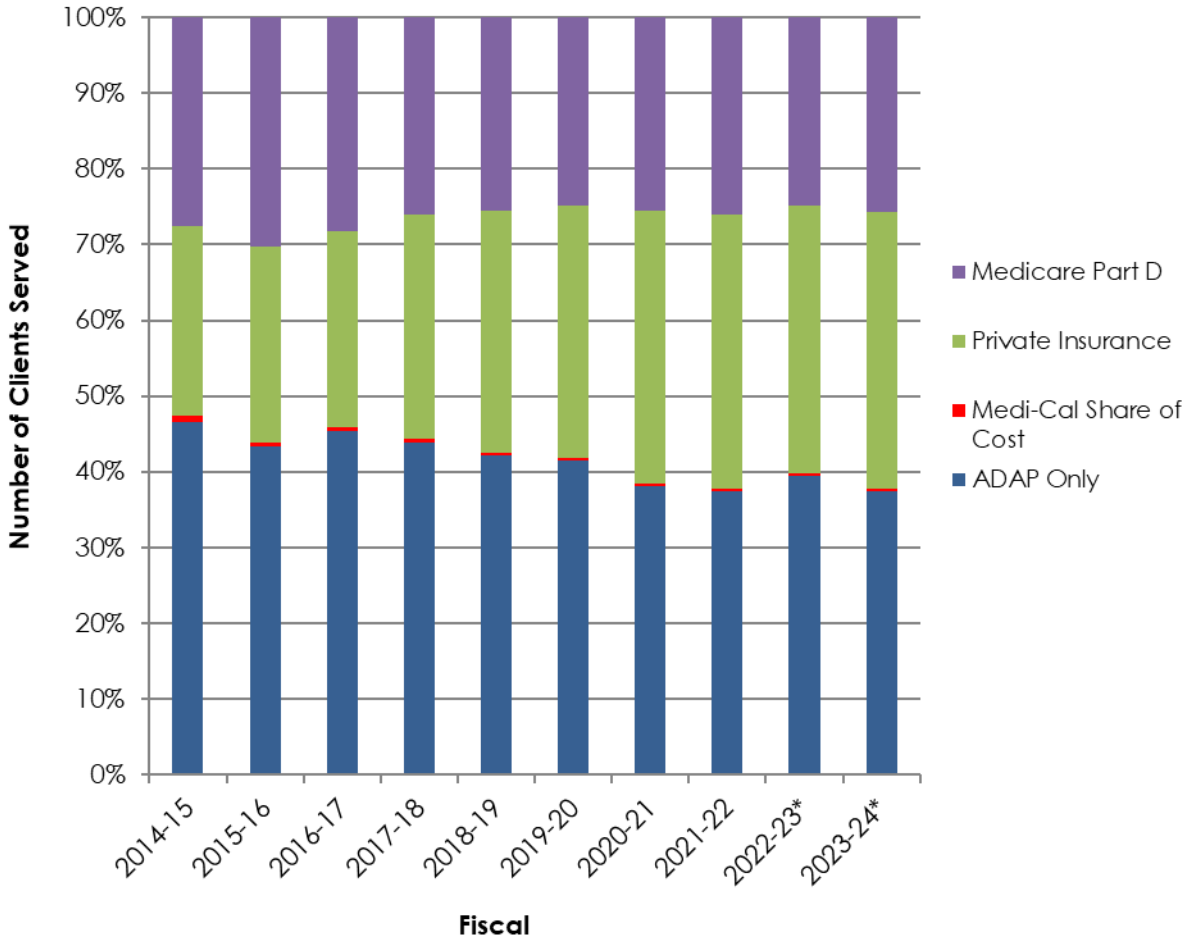


Figure 2 summarizes the proportion of ADAP medication program clients enrolled in the various payer groups by fiscal year.

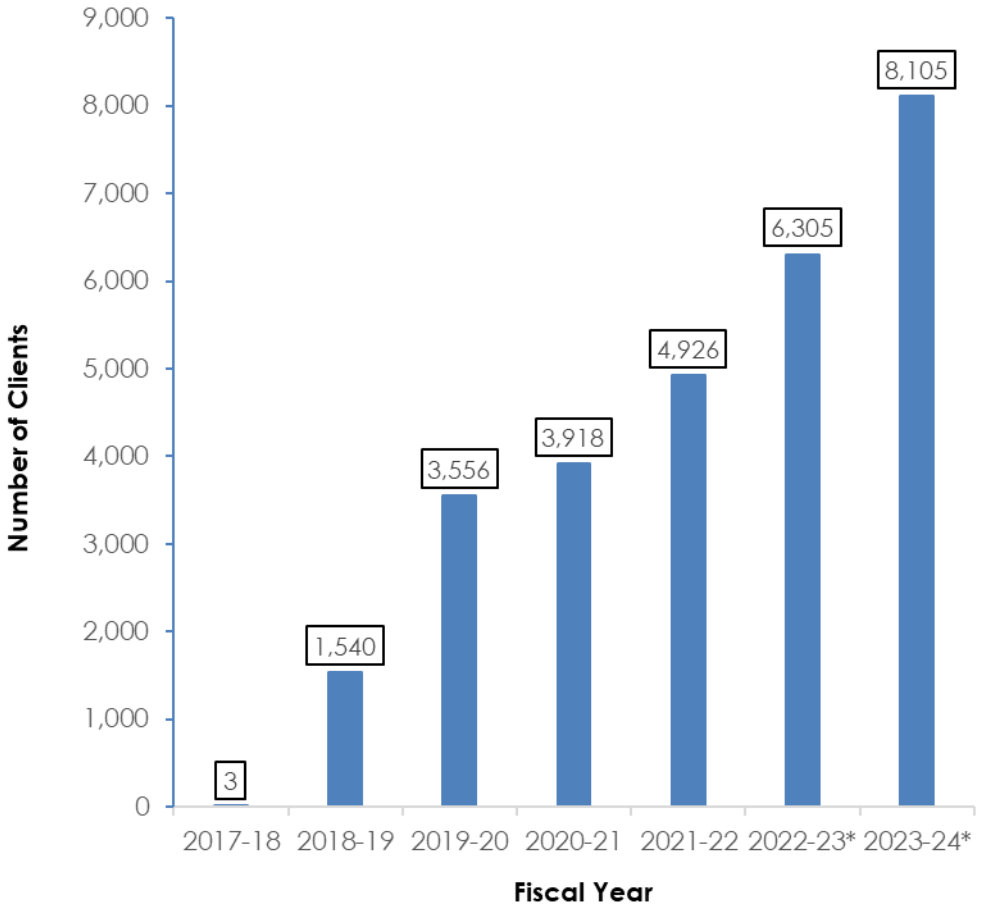
FIGURE 2: PERCENT OF ADAP MEDICATION PROGRAM CLIENTS BY PAYER SOURCE



* Data for FYs 2022-23 and 2023-24 are estimated. All other data are actuals.

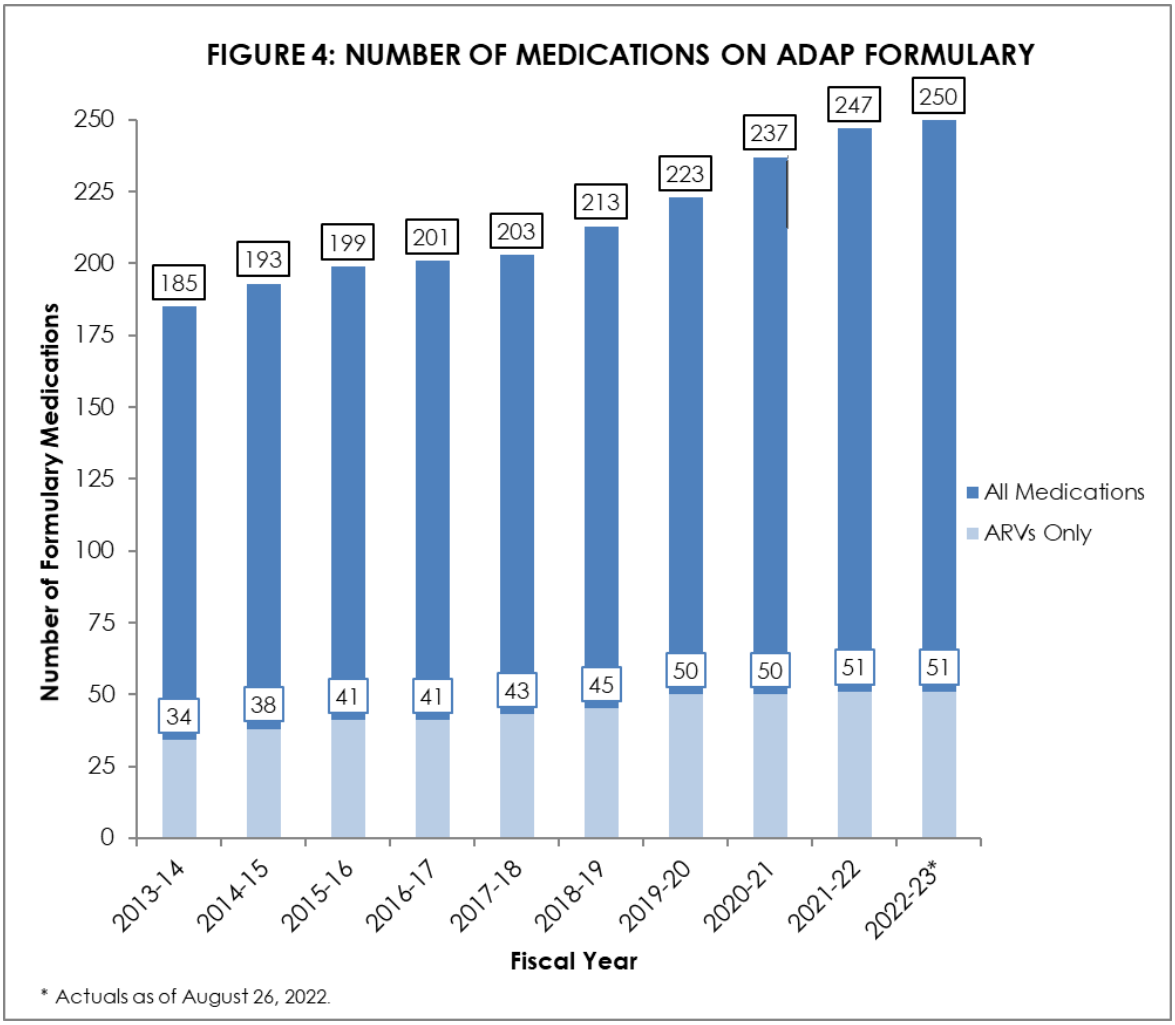
Figure 3 summarizes PrEP-AP clients served by fiscal year.

FIGURE 3: ADAP PREP-AP CLIENTS SERVED



* Data for FYs 2022-23 and 2023-24 are estimated. All other data are actuals.

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



Additions to the ADAP Formulary[2]

The following drugs were added to the ADAP formulary on August 26, 2022:

- Primaquine, non-ARV, antimalarial
- Rifapentine (Priftin®), non-ARV, rifamycin antibiotic
- Rifaximin (Xifaxan®), non-ARV, antibiotic

Deletions from the ADAP Formulary

There are currently no deletions to the ADAP formulary.

[2] Cabenuva, an ARV, was added to the ADAP formulary on October 8, 2021, late in the Estimate Package development process. In the 2022-23 November Estimate - Figure 4, Cabenuva was reflected in the ARVs Only category; however, not in the All Medications category. Figure 4 reflects corrected 2021-22 totals.

VIII. Current HIV Epidemiology in California

Approximately 139,700 people in California at the end of 2020 had been diagnosed with HIV and reported to OA. However, OA estimates that 12 percent of all PWH in California are unaware of their infection. Therefore, OA estimates that there were approximately 159,100 PWH in California as of the end of 2020. Since the epidemic began in 1981, approximately 105,000 Californians diagnosed with HIV have died, with over 1,800 dying in 2020 alone.

Of the approximately 139,700 people living with diagnosed HIV (PLWDH) in California, approximately 38.5 percent are Latinx; 36.3 percent are White; 16.9 percent are Black/African American; 4.3 percent are Asian; 3.5 percent are multi-racial; 0.2 percent are American Indian/Alaskan Native; and 0.2 percent are Native Hawaiian/Pacific Islander. While Latinx and Whites make up the largest percentage of PLWDH in California, the rate of HIV among Blacks/African Americans is substantially higher (987.7 per 100,000 population, versus 345.4 per 100,000 among Whites and 344.5 per 100,000 among Latinx).

Most of California's living HIV cases are attributed to male-to-male sexual transmission (66.4 percent); 8.4 percent of living cases are attributable to high-risk heterosexual contact (defined as contact with a sex partner or partners of the opposite gender who are either known to be HIV infected or known to be someone who injects drugs, has hemophilia, or is a man who has sex with other men); 6.3 percent to men who have sex with men who also inject drugs; 5.5 percent to injection drug use; 1.5 percent to transgender sexual contact; 0.5 percent to perinatal exposure; and 11.4 percent to other or unknown sources including other heterosexual contact.

There are approximately 3,900 new HIV cases reported in California each year, which is a revision from the prior year of approximately 4,500 new HIV cases. One potential driver of the decrease may be the statewide stay-at-home order period during the COVID-19 pandemic. The number of PWH in the state is expected to grow by two to three percent each year for the foreseeable future until more progress is made in preventing new HIV infections. This increase is attributed to stable incidence rates and longer survival of those infected primarily due to the effectiveness and availability of treatment.