

AIDS DRUG ASSISTANCE PROGRAM (ADAP)

**November 2012
Estimate Package**

2013-14 GOVERNOR'S BUDGET



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EXECUTIVE SUMMARY

The California Department of Public Health (CDPH) AIDS Drug Assistance Program (ADAP) budget is currently \$448,386,000. CDPH is requesting an increase of \$12,271,000 in federal funds and \$7,927,000 in rebate funds for FY 2012-13. CDPH is not requesting any changes to the General Fund in the current year.

For FY 2013-14, ADAP estimates a budget decrease of \$32.9 million when compared to the revised Current Year budget of \$468,585,000. Thus for FY 2013-14, \$16.9 million will be returned to the General Fund (see Fiscal Comparison Tables on page 5).

Expenditure Forecast

Unadjusted expenditure estimates for the *2013-14 Governor's Budget* were derived from a linear regression model. The 36-month data set for this estimate used actual expenditures from October 2009 through September 2012. Estimates were adjusted based on the assumptions listed on page 8. This methodology assumes a linear increase in expenditures over time. However, the increase in expenditures will no longer occur in FY 2012-13 and FY 2013-14 due to two key policy changes recently implemented: 1) the movement of ADAP clients into the Low Income Health Program (LIHP) and, 2) in 2014, to the movement of ADAP clients to other payer sources due to the implementation of the Affordable Care Act.

To address this limitation, pre-regression adjustments were made for LIHP and the Office of AIDS Pre-Existing Condition Insurance Plan (OA-PCIP) premium payment program. The adjustments add the monthly savings realized to date back into the data points in the regression as if LIHP and OA-PCIP were never in effect. This change in methodology maintains the integrity of the linear regression model. Post-regression adjustments were then conducted to account for the LIHP and OA-PCIP savings, in addition to making other pre-regression adjustments (**Revised Major Assumption 7**, page 27) and a post-regression adjustment for additional Pharmacy Benefits Manager (PBM) costs (**New Major Assumption 1**, page 9).

Although we believe that these are the most accurate estimates possible at this time, unforeseen policy changes (such as one or more LIHPs in large counties putting a cap on LIHP enrollment) could decrease the estimated LIHP savings. This estimate will be updated with current data in the *2013-14 May Revision*. The *2013-14 May Revision* estimate is expected to be more precise than the estimate in the *2013-14 Governor's Budget* because more recent actuals will be included.

For FY 2012-13, total estimated expenditures of \$468.6 million are \$20.2 million more than Budget Act authority of \$448.4 million mainly due to reduced savings estimates from the impact of the LIHP. Despite the increase in expenditure need, ADAP will maintain the GF budget authority level due to increased resources listed below.

FY 2013-14 estimated expenditures of \$435.7 million are \$32.9 million less than FY 2012-13 revised expenditures primarily due to savings from LIHP.

Revenue Forecast

Payments of ADAP expenditures are made from four fund sources: 1) General Fund 2) federal funds, 3) rebate funds and 4) reimbursements from the Department of Health Care Services (DHCS) as a result of funding available through the Safety Net Care Pool (SNCP). (See Appendix B: Fund Sources for funding details on pages 42-48).

Major changes from the Budget Act include:

- an increase in ADAP Special Fund revenue due to an increase in the drug rebate rate from 56 to 60 percent based on the past four quarters of actual rebates received (see page 26)
- an increase of \$12.3 million in FY 2012-13 federal funds due to additional supplemental grant awards
- an increase of \$49.2 million in SNCP funding for FY 2013-14
- a decrease of \$16.9 million in GF for FY 2013-14

For FY 2012-13, ADAP resources are anticipated to increase by approximately \$35.5 million compared to the Budget Act. In addition, ADAP will maintain a \$3.3 million (1%) Special Fund reserve (see the Fund Condition Statement on page 31).

For FY 2013 -14, ADAP resources are anticipated to decrease by approximately \$11.2 million compared to the revised Current Year. Due to estimated reduced expenditures, ADAP estimates maintaining a \$23.3 million (8.8%) Special Fund reserve (see the Fund Condition Statement on page 31). However, as stated above unforeseen policy changes could decrease estimated savings resulting in a reduced Special Fund reserve.

1. FISCAL COMPARISON TABLES

Table 1a: Expenditure Comparison: FY 2012-13 in 2013-14 Governor's Budget to FY 2012-13 Budget Act (000's)

| | FY 2012-2013 | | | | | 2012-13 Budget Act | | | | | Difference | | | | |
|---|------------------|-----------------|------------------|-----------------|-------------------|--------------------|-----------------|------------------|-----------------|-------------------|-----------------|---------------|-----------------|------------------|-------------------|
| | Total | Reimbursement | Federal | State | ADAP Special Fund | Total | Reimbursement | Federal | State | ADAP Special Fund | Total | Reimbursement | Federal | State | ADAP Special Fund |
| Local Assistance Funding | \$468,585 | \$17,150 | \$125,876 | \$16,875 | \$308,683 | \$448,386 | \$17,150 | \$113,605 | \$16,875 | \$300,756 | \$20,199 | | \$12,271 | | \$7,927 |
| ADAP Expenditure Estimate | \$453,586 | \$17,150 | \$125,876 | \$13,285 | \$297,274 | \$437,766 | \$17,150 | \$113,605 | \$15,985 | \$291,026 | \$15,820 | | \$12,271 | (\$2,700) | \$6,248 |
| Prescription Costs | \$446,510 | \$16,990 | \$124,682 | \$10,488 | \$294,349 | \$431,199 | \$16,990 | \$112,540 | \$13,474 | \$288,196 | \$15,310 | | \$12,143 | (\$2,986) | \$6,153 |
| Basic Prescription Costs | \$524,739 | \$16,990 | \$124,682 | \$10,488 | \$372,578 | \$545,595 | \$16,990 | \$112,540 | \$13,474 | \$402,591 | (\$20,856) | | \$12,143 | (\$2,986) | (\$30,013) |
| Legacy LIHP Expenditure Impact | (\$56,053) | | | | (\$56,053) | (\$74,770) | | | | (\$74,770) | \$18,717 | | | | \$18,717 |
| Non-Legacy LIHP Expenditure Impact | (\$17,803) | | | | (\$17,803) | (\$24,586) | | | | (\$24,586) | \$6,783 | | | | \$6,783 |
| OA-PCIP Expenditure Impact | (\$4,374) | | | | (\$4,374) | (\$5,738) | | | | (\$5,738) | \$1,365 | | | | \$1,365 |
| OA-HIPP Expenditure Impact* | | | | | | (\$9,302) | | | | (\$9,302) | \$9,302 | | | | \$9,302 |
| PBM Operational Costs | \$7,076 | \$160 | \$1,194 | \$2,797 | \$2,925 | \$6,566 | \$160 | \$1,065 | \$2,511 | \$2,830 | \$509 | | \$129 | \$286 | \$95 |
| Basic PBM Costs | \$7,346 | \$160 | \$1,194 | \$2,797 | \$3,196 | \$8,309 | \$160 | \$1,065 | \$2,511 | \$4,572 | (\$962) | | \$129 | \$286 | (\$1,377) |
| Additional PBM Costs | \$779 | | | | \$779 | | | | | | \$779 | | | | \$779 |
| Legacy LIHP PBM Costs | (\$742) | | | | (\$742) | (\$1,139) | | | | (\$1,139) | \$397 | | | | \$397 |
| Non-Legacy LIHP PBM Costs | (\$247) | | | | (\$247) | (\$374) | | | | (\$374) | \$127 | | | | \$127 |
| OA-PCIP PBM Impact | (\$60) | | | | (\$60) | (\$87) | | | | (\$87) | \$28 | | | | \$28 |
| OA-HIPP PBM Impact* | | | | | | (\$142) | | | | (\$142) | \$142 | | | | \$142 |
| LHU Administration | \$2,000 | | | | \$2,000 | \$2,000 | | | | \$2,000 | | | | | |
| Insurance Assistance Program: Medicare Part D | \$1,000 | | | | \$1,000 | \$1,000 | | | | \$1,000 | | | | | |
| Insurance Assistance Program: OA-PCIP | \$1,056 | | | \$181 | \$875 | \$1,186 | | | | \$1,186 | (\$129) | | \$181 | | (\$310) |
| Insurance Assistance Program: OA-HIPP | \$10,942 | | \$1,700 | \$3,409 | \$7,533 | \$6,435 | | \$1,700 | \$890 | \$5,544 | \$4,508 | | | \$2,519 | \$1,989 |
| Support/Administration Funding | \$2,489 | | \$1,178 | \$411 | \$900 | \$2,501 | | \$1,178 | \$411 | \$912 | (\$12) | | | | (\$12) |

Table 1b: Expenditure Comparison: 2013-14 Governor's Budget to FY 2012-13 Budget Act (000's)

| | 2013-14 Governor's Budget | | | | | 2012-13 Budget Act | | | | | Difference | | | | |
|---|---------------------------|-----------------|------------------|--------------|-------------------|--------------------|-----------------|------------------|-----------------|-------------------|-------------------|-----------------|------------------|-------------------|-------------------|
| | Total | Reimbursement | Federal | State | ADAP Special Fund | Total | Reimbursement | Federal | State | ADAP Special Fund | Total | Reimbursement | Federal | State | ADAP Special Fund |
| Local Assistance Funding | \$435,676 | \$66,339 | \$105,179 | | \$264,158 | \$448,386 | \$17,150 | \$113,605 | \$16,875 | \$300,756 | (\$12,710) | \$49,189 | (\$8,426) | (\$16,875) | (\$36,598) |
| ADAP Expenditure Estimate | \$414,887 | \$61,161 | \$105,179 | | \$248,547 | \$437,766 | \$17,150 | \$113,605 | \$15,985 | \$291,026 | (\$22,879) | \$44,011 | (\$8,426) | (\$15,985) | (\$42,479) |
| Prescription Costs | \$408,415 | \$57,701 | \$104,323 | | \$246,391 | \$431,199 | \$16,990 | \$112,540 | \$13,474 | \$288,196 | (\$22,784) | \$40,711 | (\$8,216) | (\$13,474) | (\$41,805) |
| Basic Prescription Costs | \$580,798 | \$57,701 | \$104,323 | | \$418,774 | \$545,595 | \$16,990 | \$112,540 | \$13,474 | \$402,591 | \$35,203 | \$40,711 | (\$8,216) | (\$13,474) | \$16,182 |
| Legacy LIHP Expenditure Impact | (\$145,160) | | | | (\$145,160) | (\$74,770) | | | | (\$74,770) | (\$70,391) | | | | (\$70,391) |
| Non-Legacy LIHP Expenditure Impact | (\$25,097) | | | | (\$25,097) | (\$24,586) | | | | (\$24,586) | (\$511) | | | | (\$511) |
| OA-PCIP Expenditure Impact | (\$2,126) | | | | (\$2,126) | (\$5,738) | | | | (\$5,738) | \$3,612 | | | | \$3,612 |
| OA-HIPP Expenditure Impact* | | | | | | (\$9,302) | | | | (\$9,302) | \$9,302 | | | | \$9,302 |
| PBM Operational Costs | \$6,472 | \$3,460 | \$856 | | \$2,156 | \$6,566 | \$160 | \$1,065 | \$2,511 | \$2,830 | (\$94) | \$3,300 | (\$209) | (\$2,511) | (\$674) |
| Basic PBM Costs | \$8,284 | \$3,460 | \$856 | | \$3,968 | \$8,309 | \$160 | \$1,065 | \$2,511 | \$4,572 | (\$25) | \$3,300 | (\$209) | (\$2,511) | (\$604) |
| Additional PBM Costs | \$671 | | | | \$671 | | | | | | \$671 | | | | \$671 |
| Legacy LIHP PBM Impact | (\$2,057) | | | | (\$2,057) | (\$1,139) | | | | (\$1,139) | (\$918) | | | | (\$918) |
| Non-Legacy LIHP PBM Impact | (\$392) | | | | (\$392) | (\$374) | | | | (\$374) | (\$18) | | | | (\$18) |
| OA-PCIP PBM Impact | (\$34) | | | | (\$34) | (\$87) | | | | (\$87) | \$54 | | | | \$54 |
| OA-HIPP PBM Impact* | | | | | | (\$142) | | | | (\$142) | \$142 | | | | \$142 |
| LHU Administration | \$2,000 | | | | \$2,000 | \$2,000 | | | | \$2,000 | | | | | |
| Insurance Assistance Program: Medicare Part D | \$1,000 | | | | \$1,000 | \$1,000 | | | | \$1,000 | | | | | |
| Insurance Assistance Program: OA-PCIP | \$719 | \$123 | | | \$596 | \$1,186 | | | | \$1,186 | (\$466) | \$123 | | | (\$590) |
| Insurance Assistance Program: OA-HIPP | \$17,070 | \$5,055 | \$1,700 | | \$12,014 | \$6,435 | | \$1,700 | \$890 | \$5,544 | \$10,635 | \$5,055 | | (\$890) | \$6,470 |
| Support/Administration Funding | \$2,506 | | \$1,178 | \$411 | \$917 | \$2,501 | | \$1,178 | \$411 | \$912 | \$5 | | | | \$5 |

* Due to a change in methodology (RMA 7), this item is incorporated into the Basic Prescription Costs and Basic PBM Costs line items.

Table 1c: Expenditure Comparison: 2013-14 Governor's Budget to FY 2012-13 in 2013-14 Governor's Budget (000's)

| | 2013-14 Governor's Budget | | | | | FY 2012-2013 | | | | | Difference | | | | |
|---|---------------------------|-----------------|------------------|--------------|-------------------|------------------|-----------------|------------------|-----------------|-------------------|-------------------|-----------------|-------------------|-------------------|-------------------|
| | Total | Reimbursement | Federal | State | ADAP Special Fund | Total | Reimbursement | Federal | State | ADAP Special Fund | Total | Reimbursement | Federal | State | ADAP Special Fund |
| Local Assistance Funding | \$435,676 | \$66,339 | \$105,179 | | \$264,158 | \$468,585 | \$17,150 | \$125,876 | \$16,875 | \$308,683 | (\$32,908) | \$49,189 | (\$20,697) | (\$16,875) | (\$44,525) |
| ADAP Expenditure Estimate | \$414,887 | \$61,161 | \$105,179 | | \$248,547 | \$453,586 | \$17,150 | \$125,876 | \$13,285 | \$297,274 | (\$38,698) | \$44,011 | (\$20,697) | (\$13,285) | (\$48,727) |
| Prescription Costs | \$408,415 | \$57,701 | \$104,323 | | \$246,391 | \$446,510 | \$16,990 | \$124,682 | \$10,488 | \$294,349 | (\$38,095) | \$40,711 | (\$20,359) | (\$10,488) | (\$47,958) |
| Basic Prescription Costs | \$580,798 | \$57,701 | \$104,323 | | \$418,774 | \$524,739 | \$16,990 | \$124,682 | \$10,488 | \$372,578 | \$56,059 | \$40,711 | (\$20,359) | (\$10,488) | \$46,196 |
| Legacy LIHP Expenditure Impact | (\$145,160) | | | | (\$145,160) | (\$56,053) | | | | (\$56,053) | (\$89,108) | | | | (\$89,108) |
| Non-Legacy LIHP Expenditure Impact | (\$25,097) | | | | (\$25,097) | (\$17,803) | | | | (\$17,803) | (\$7,294) | | | | (\$7,294) |
| OA-PCIP Expenditure Impact | (\$2,126) | | | | (\$2,126) | (\$4,374) | | | | (\$4,374) | \$2,248 | | | | \$2,248 |
| OA-HIPP Expenditure Impact* | | | | | | | | | | | | | | | |
| PBM Operational Costs | \$6,472 | \$3,460 | \$856 | | \$2,156 | \$7,076 | \$160 | \$1,194 | \$2,797 | \$2,925 | (\$604) | \$3,300 | (\$338) | (\$2,797) | (\$769) |
| Basic PBM Costs | \$8,284 | \$3,460 | \$856 | | \$3,968 | \$7,346 | \$160 | \$1,194 | \$2,797 | \$3,196 | \$937 | \$3,300 | (\$338) | (\$2,797) | \$772 |
| Additional PBM Costs | \$671 | | | | \$671 | \$779 | | | | \$779 | (\$107) | | | | (\$107) |
| Legacy LIHP PBM Impact | (\$2,057) | | | | (\$2,057) | (\$742) | | | | (\$742) | (\$1,315) | | | | (\$1,315) |
| Non-Legacy LIHP PBM Impact | (\$392) | | | | (\$392) | (\$247) | | | | (\$247) | (\$145) | | | | (\$145) |
| OA-PCIP PBM Impact | (\$34) | | | | (\$34) | (\$60) | | | | (\$60) | \$26 | | | | \$26 |
| OA-HIPP PBM Impact* | | | | | | | | | | | | | | | |
| LHJ Administration | \$2,000 | | | | \$2,000 | \$2,000 | | | | \$2,000 | | | | | |
| Insurance Assistance Program: Medicare Part D | \$1,000 | | | | \$1,000 | \$1,000 | | | | \$1,000 | | | | | |
| Insurance Assistance Program: OA-PCIP | \$719 | \$123 | | | \$596 | \$1,056 | | | \$181 | \$875 | (\$337) | \$123 | | (\$181) | (\$279) |
| Insurance Assistance Program: OA-HIPP | \$17,070 | \$5,055 | \$1,700 | | \$12,014 | \$10,942 | | \$1,700 | \$3,409 | \$7,533 | \$6,127 | \$5,055 | | (\$3,409) | \$4,481 |
| Support/Administration Funding | \$2,506 | | \$1,178 | \$411 | \$917 | \$2,489 | | \$1,178 | \$411 | \$900 | \$17 | | | | \$17 |

* Due to a change in methodology (RMA 7), this item is incorporated into the Basic Prescription Costs and Basic PBM Costs line items.

TABLE 2a: Resource Comparison: FY 2012-13 in 2013-14 Governor's Budget to FY 2012-13 Budget Act (000's)

| | FY 2012-13 | | | | | 2012-13 Budget Act | | | | | Difference | | | | |
|--|------------------|-----------------|------------------|-----------------|-------------------|--------------------|-----------------|------------------|-----------------|-------------------|-----------------|---------------|-----------------|-------|-------------------|
| | Total | Reimbursement | Federal | State | ADAP Special Fund | Total | Reimbursement | Federal | State | ADAP Special Fund | Total | Reimbursement | Federal | State | ADAP Special Fund |
| Available Resources | \$469,349 | \$17,150 | \$127,054 | \$17,286 | \$307,859 | \$433,862 | \$17,150 | \$114,783 | \$17,286 | \$284,643 | \$35,487 | | \$12,271 | | \$23,216 |
| Basic Rebate Revenues | \$314,736 | | | | \$314,736 | \$267,203 | | | | \$267,203 | \$47,533 | | | | \$47,533 |
| Income from Surplus Money Investments | \$120 | | | | \$120 | \$120 | | | | \$120 | | | | | |
| Federal Funds | \$106,357 | | \$106,357 | | | \$106,357 | | \$106,357 | | | | | | | |
| General Funds | \$17,286 | | | \$17,286 | | \$17,286 | | | \$17,286 | | | | | | |
| Legacy LHHP Revenue Impact | (\$3,899) | | | | (\$3,899) | (\$9,199) | | | | (\$9,199) | \$5,300 | | | | \$5,300 |
| Non-Legacy LHHP Revenue Impact | (\$2,233) | | | | (\$2,233) | (\$4,082) | | | | (\$4,082) | \$1,849 | | | | \$1,849 |
| OA-PCIP Revenue Impact | (\$865) | | | | (\$865) | (\$1,202) | | | | (\$1,202) | \$338 | | | | \$338 |
| OA-HIPP Revenue Impact | | | | | | (\$261) | | | | (\$261) | \$261 | | | | \$261 |
| Renegotiated Sup. Rebate/Price Freeze Agreements | | | | | | \$32,064 | | | | \$32,064 | (\$32,064) | | | | (\$32,064) |
| One-Time Increase in Federal Funds | \$20,697 | | \$20,697 | | | \$8,426 | | \$8,426 | | | \$12,271 | | \$12,271 | | |
| Safety Net Care Pool Funds | \$17,150 | \$17,150 | | | | \$17,150 | \$17,150 | | | | | | | | |

TABLE 2b: Resource Comparison: 2013-14 Governor's Budget to FY 2012-13 Budget Act (000's)

| | 2013-14 Governor's Budget | | | | | 2012-13 Budget Act | | | | | Difference | | | | |
|--|---------------------------|-----------------|------------------|--------------|-------------------|--------------------|-----------------|------------------|-----------------|-------------------|-----------------|-----------------|------------------|-------------------|-------------------|
| | Total | Reimbursement | Federal | State | ADAP Special Fund | Total | Reimbursement | Federal | State | ADAP Special Fund | Total | Reimbursement | Federal | State | ADAP Special Fund |
| Available Resources | \$458,231 | \$66,339 | \$106,357 | \$411 | \$285,124 | \$433,862 | \$17,150 | \$114,783 | \$17,286 | \$284,643 | \$24,369 | \$49,189 | (\$8,426) | (\$16,875) | \$481 |
| Basic Rebate Revenues | \$336,350 | | | | \$336,350 | \$267,203 | | | | \$267,203 | \$69,147 | | | | \$69,147 |
| Income from Surplus Money Investments | \$120 | | | | \$120 | \$120 | | | | \$120 | | | | | |
| Federal Funds | \$106,357 | | \$106,357 | | | \$106,357 | | \$106,357 | | | | | | | |
| General Funds | \$411 | | | \$411 | | \$17,286 | | | \$17,286 | | (\$16,875) | | | (\$16,875) | |
| Legacy LHHP Revenue Impact | (\$42,075) | | | | (\$42,075) | (\$9,199) | | | | (\$9,199) | (\$32,876) | | | | (\$32,876) |
| Non-Legacy LHHP Revenue Impact | (\$8,905) | | | | (\$8,905) | (\$4,082) | | | | (\$4,082) | (\$4,823) | | | | (\$4,823) |
| OA-PCIP Revenue Impact | (\$366) | | | | (\$366) | (\$1,202) | | | | (\$1,202) | \$837 | | | | \$837 |
| OA-HIPP Revenue Impact | (\$261) | | | | (\$261) | (\$261) | | | | (\$261) | \$261 | | | | \$261 |
| Renegotiated Sup. Rebate/Price Freeze Agreements | | | | | | \$32,064 | | | | \$32,064 | (\$32,064) | | | | (\$32,064) |
| One-Time Increase in Federal Funds | | | | | | \$8,426 | | \$8,426 | | | (\$8,426) | | (\$8,426) | | |
| Safety Net Care Pool Funds | \$66,339 | \$66,339 | | | | \$17,150 | \$17,150 | | | | \$49,189 | \$49,189 | | | |

TABLE 2c: Resource Comparison: 2013-14 Governor's Budget to FY 2012-13 in 2013-14 Governor's Budget (000's)

| | 2013-14 Governor's Budget | | | | | FY 2012-13 | | | | | Difference | | | | |
|--|---------------------------|-----------------|------------------|--------------|-------------------|------------------|-----------------|------------------|-----------------|-------------------|-------------------|-----------------|-------------------|-------------------|-------------------|
| | Total | Reimbursement | Federal | State | ADAP Special Fund | Total | Reimbursement | Federal | State | ADAP Special Fund | Total | Reimbursement | Federal | State | ADAP Special Fund |
| Available Resources | \$458,231 | \$66,339 | \$106,357 | \$411 | \$285,124 | \$469,349 | \$17,150 | \$127,054 | \$17,286 | \$307,859 | (\$11,118) | \$49,189 | (\$20,697) | (\$16,875) | (\$22,735) |
| Basic Rebate Revenues | \$336,350 | | | | \$336,350 | \$314,736 | | | | \$314,736 | \$21,614 | | | | \$21,614 |
| Income from Surplus Money Investments | \$120 | | | | \$120 | \$120 | | | | \$120 | | | | | |
| Federal Funds | \$106,357 | | \$106,357 | | | \$106,357 | | \$106,357 | | | | | | | |
| General Funds | \$411 | | | \$411 | | \$17,286 | | | \$17,286 | | (\$16,875) | | | (\$16,875) | |
| Legacy LHHP Revenue Impact | (\$42,075) | | | | (\$42,075) | (\$3,899) | | | | (\$3,899) | (\$38,176) | | | | (\$38,176) |
| Non-Legacy LHHP Revenue Impact | (\$8,905) | | | | (\$8,905) | (\$2,233) | | | | (\$2,233) | (\$6,672) | | | | (\$6,672) |
| OA-PCIP Revenue Impact | (\$366) | | | | (\$366) | (\$865) | | | | (\$865) | \$499 | | | | \$499 |
| OA-HIPP Revenue Impact | | | | | | | | | | | | | | | |
| Renegotiated Sup. Rebate/Price Freeze Agreements | | | | | | | | | | | | | | | |
| One-Time Increase in Federal Funds | | | | | | \$20,697 | | \$20,697 | | | (\$20,697) | | (\$20,697) | | |
| Safety Net Care Pool Funds | \$66,339 | \$66,339 | | | | \$17,150 | \$17,150 | | | | \$49,189 | \$49,189 | | | |

2. MAJOR ASSUMPTIONS

Estimate Methodology

Unadjusted expenditure estimates for the *2013-14 Governor's Budget* were derived from a linear regression model. The 36-month data set for the *2013-14 Governor's Budget* used actual expenditures from October 2009 through September 2012. OA conducted eight pre-regression adjustments of the data (see **Revised Major Assumption 7**, page 27 for more details).

For purposes of the *2013-14 Governor's Budget*, expenditure and revenue adjustments were made to the Fund Condition Statement (FCS) (**Table 15**, page 31) to reflect the estimated impact of one New, eight Revised, one Continuing and one Discontinued Assumption, including:

New Major Assumptions (NMA)

1. Additional PBM Costs.

Revised Major Assumptions (RMA)

1. Impact of the Ten "Legacy" LIHP Counties on ADAP.
2. Impact of the "Non-Legacy" LIHP Counties on ADAP.
3. OA-PCIP Implementation.
4. Using Non-Ryan White Funds to Pay OA-Health Insurance Premium Payment (OA-HIPP) Premiums for LIHP-eligible OA-HIPP Clients.
5. Increase Rebate Percentage.
6. Additional 2012 Federal Grant Funds.
7. Change in Methodology: Adjust Linear Regression Expenditure Methodology.
8. Reimbursement of Federal Funding through SNCP.

Continuing Assumption (CA)*

1. OA-HIPP/Medi-Cal Fund Source Issue: Using Non-Ryan White Funds to Pay OA-HIPP premiums and ADAP Drug Deductibles and Co-Pays for Clients Co-Enrolled in Medi-Cal with a Share of Cost (SOC).

*Assumption unchanged but fiscal outcome impacted by the revised expenditure estimate.

Discontinued Major Assumption

1. Institution of Client Cost-Sharing Policy.

New Major Assumptions

1. Additional PBM costs.

A Federal Health Resources and Services Administration (HRSA) mandate to conduct six-month ADAP client eligibility re-certification resulted in increased workload and associated costs for the ADAP PBM. The existing contract between OA and PBM, which did not reflect this new workload requirement, was scheduled to expire June 30, 2012. Due to the mandate by HRSA, contract renegotiations between OA and the PBM resulted in an increase in the per prescription transaction fee paid to the PBM and revisions to the Scope of Work to include the bi-annual re-certification workload. The PBM must closely coordinate with OA, more than 180 local enrollment sites, and approximately 700 ADAP enrollment workers as they increase client re-certifications from once to twice per year (currently ADAP has over 40,000 clients enrolled in the program). In order to implement bi-annual re-certifications, a number of augmentations, including the following, have been made to the PBM's scope of work:

- Ensure on-going responsiveness to ADAP enrollment workers, clients, and OA information requests, including ensuring sufficient telephones, facsimile lines, and staff to meet the increased eligibility re-certification process workload.
- Modify and maintain the secure ADAP online web application processing and notification system, including ongoing notification to enrollment workers and their clients of the new bi-annual eligibility re-certification due dates.
- Develop bi-annual re-certification processes and procedures, process re-certification applications, update the client eligibility database and notify enrollment worker upon recertification of their clients.

Estimate Methodology

To estimate additional PBM costs, OA multiplied the predicted number of approved prescription transactions in FYs 2012-13 and 2013-14 (1,038,052 and 895,313, respectively) by the increase in fees (from \$4 in FY 2011-12 to \$4.75 for FY 2012-13 forward) per prescription transaction. The additional PBM transaction costs for FYs 2012-13 and 2013-14 are **\$778,539** and **\$671,484**, respectively.

Revised Major Assumptions

1. Impact of the Ten "Legacy" LIHP Counties on ADAP.

In the *2012-13 May Revision*, OA estimated savings due to ADAP clients transitioning to the ten Legacy county LIHPs. The Legacy counties include: Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura. These ten counties represent the bulk of ADAP clients (80 percent of all ADAP clients during FY 2011-12).

Since the release of the *2012-13 May Revision*, OA received updated ADAP and LIHP implementation information which necessitated making several changes to the methodology to estimate the impact of LIHP on ADAP in the Legacy counties, resulting in estimated net savings to ADAP of **\$52,895,305** in FY 2012-13 and **\$105,142,066** in FY 2013-14. In addition, OA estimated that 5,015 ADAP clients in the Legacy counties will shift from ADAP into LIHP in FY 2012-13, and an additional 2,024 clients will shift in FY 2013-14 (see **Table 6**, page 16).

Estimate Methodology

OA made the following changes to the LIHP-impact methodology used in the *2012-13 May Revision*: a) utilizing FY 2011-12 data instead of FY 2010-11 data as a basis for estimating the impact of LIHP on ADAP; b) lengthening the average delay from when ADAP screens clients for potential LIHP eligibility to when LIHP makes an eligibility determination from 90 days to 120 days; c) changing Alameda's LIHP screening implementation date from July 1, 2012 to August 1, 2012; d) merging the impact of LIHP in Pasadena with Los Angeles County; e) allowing potentially LIHP-eligible ADAP private insurance and Medicare Part D clients to remain co-enrolled in ADAP for coverage of medication co-pays and deductibles; f) using an adjustment factor to account for potential overestimation of LIHP impacts on ADAP; and g) calculating the impact of back-billing ADAP pharmacies for drug expenditures that ADAP paid for LIHP-enrolled clients.

OA used the following methodology:

- a. FY 2011-12 ADAP Information. In the *2012-13 May Revision*, OA used FY 2010-11 client, expenditure, and rebate information to estimate the impact of LIHP on ADAP. For this **RMA 1**, OA updated its analysis by using FY 2011-12 information.
- b. Additional Delay in ADAP Clients Shifting to LIHP. In the *2012-13 May Revision*, OA estimated that it would take an average of 90 days from when ADAP screens clients for potential LIHP eligibility to when LIHP makes an eligibility determination for these clients. This 90-day period included 30 days from the date of ADAP screening to when the client applies to LIHP and an estimated average of 60 days for the local LIHPs to process LIHP applications. Therefore, in the *2012-13 May Revision* OA adjusted for the delay of clients shifting from ADAP to LIHP by delaying the start of LIHP impact savings by 90 days. However, each Legacy county LIHP has since provided OA with an estimate of how long the application processing should take in that county, ranging from 30 days for San Francisco County to 90 days for Los Angeles, Alameda, and Orange Counties. The latter three counties account for almost 76 percent of ADAP's estimated LIHP savings in the Legacy counties. Taking a weighted average of the application time periods for each of the ten Legacy counties against the percent of their impact on LIHP resulted in an average of 82 days for LIHP application processing. Thus, OA rounded up its estimate for LIHP processing to 90 days. OA accounted for the 30-day screening period and the

90-day LIHP application processing period by delaying the start of LIHP impact savings by 120 days.

- c. Change in Implementation Date to Begin Screening Ryan White (RW) and ADAP Clients for LIHP. Alameda County changed its implementation date for screening RW clients for LIHP from July 1, 2012 to August 1, 2012, a delay necessary to ensure that all LIHP clients with HIV would have access to their HIV medications through LIHP. Consequently, ADAP LIHP eligibility screening was also delayed. OA adjusted its LIHP impact numbers to account for this 30-day delay.
- d. Merge Pasadena with Los Angeles County. In the *2012-13 May Revision*, the impact of LIHP on ADAP in the Pasadena local health jurisdiction (LHJ) was included in the impact of the non-Legacy counties because it originally was not a part of the Los Angeles County LIHP implementation on July 1, 2011. Because Pasadena is now a part of the Los Angeles County LIHP, OA combined the LIHP impact estimates of the Pasadena LHJ with those of Los Angeles County instead of accounting for it as a separate non-Legacy LIHP entity.
- e. Change in Transitioning Potentially LIHP-Eligible Clients with Medicare Part D or Private Insurance to LIHP. OA has historically calculated the impact of transitioning ADAP's potentially LIHP-eligible Medicare Part D, private insurance and ADAP-only clients over to LIHP. OA has since learned that Centers for Medicare and Medicaid Services (CMS) does not allow the local LIHPs to pay drug co-pays and deductibles, including those of Medicare Part D and private insurance clients. As a result, OA received guidance from HRSA that ADAP may continue to use RW or rebate funds to pay for these costs since ADAP remains the payer of last resort for these expenses. Thus, OA will retain these LIHP-eligible Medicare Part D and private insurance clients as ADAP clients and re-calculated its LIHP impacts to reflect that these clients will not shift over to LIHP.

Table 3, below gives the unadjusted LIHP impact estimates taking into account sections a) through e) above.

| TABLE 3: UNADJUSTED LIHP IMPACT ESTIMATES IN THE 10 LEGACY COUNTIES | | |
|--|---------------------|----------------------|
| Impact Estimates | FY 2012-13 | FY 2013-14 |
| Client Shift | 6,269 | 2,530 |
| Reduced Expenditures | \$59,440,611 | \$164,819,698 |
| Reduced Rebate Revenue | -\$3,830,066 | -\$43,996,352 |
| Net LIHP Impact Savings | \$55,610,544 | \$120,823,346 |

Before taking any adjustments into consideration, OA estimated that in FY 2012-13, approximately 6,269 clients would shift over to LIHP, and ADAP would realize net savings of approximately \$55.61 million. For FY 2013-14, approximately 2,530 clients would shift over to LIHP, and ADAP would realize net savings of approximately \$120.82 million.

- f. Adjustments to Impact Numbers. OA calls the ADAP clients it determines to be eligible to shift over to LIHP “potentially” LIHP-eligible because ADAP does not collect client eligibility data that precisely matches the eligibility criteria used by LIHP. For example, LIHP bases income eligibility upon the Federal Poverty Level (FPL) of household income. However, ADAP currently collects adjusted gross income data, which represents the adjusted gross income of the individual ADAP client, and does not collect household income or family size. A client whom OA’s analysis considers to be eligible for LIHP based upon reported adjusted income (assuming income is individual income for a single person) may in fact not meet the LIHP household income eligibility if they have a higher household income. Likewise, other clients whom this analysis considers to be ineligible for LIHP based on individual gross income but who have multiple dependents might actually be eligible for LIHP. Other possibly disparate qualifying data includes a client’s county of residence and immigration status. Historically, OA could not determine if these eligibility data disparities between LIHP and ADAP would have a measurable effect on the impact of LIHP on ADAP and therefore did not make any adjustments for these data disparities.

However, now that OA has fully implemented mandatory LIHP eligibility screening in the ten Legacy counties as part of the ADAP client eligibility enrollment/re-certification process in the ten Legacy counties, ADAP can compare the number of clients screened by ADAP as being potentially eligible for LIHP against the number who are actually enrolled into a local LIHP and use that ratio as an adjusting factor for the LIHP impact estimates. Such an adjustment factor would cover all potential disparities in data used to determine LIHP eligibility, including income, residency status, and immigration status.

OA estimated this adjusting factor by first taking all clients who were screened for LIHP eligibility and told to apply to LIHP at some point in March 2012 and determining the date of their last drug transaction with ADAP. Because OA estimates that it takes approximately 120 days from the date of LIHP screening to the date of LIHP eligibility determination, OA assumed that if any of the clients who were told to apply to LIHP in March had drugs dispensed after June 2012, when at least 120 days had passed, then they were still with ADAP and deemed ineligible by LIHP. OA made this assumption because if a client is accepted by LIHP, that client may or may not inform ADAP of that acceptance. OA has instructed its PBM to suspend the ADAP eligibility of any clients who have not come back to ADAP by the end of the 120-day LIHP processing period with proof that they were determined to be ineligible for LIHP.

OA determined that about 80 percent of the potentially LIHP-eligible ADAP clients screened for LIHP eligibility by ADAP and told to apply to LIHP in March 2012 had no ADAP transactions in July or the first part of August 2012 and that ADAP would only realize 80 percent of the savings initially calculated for LIHP. For example, if OA initially calculated that ADAP would save an estimated \$10 million due to ADAP clients shifting over to LIHP, ADAP would actually only

realize an estimated adjusted \$8 million in savings (\$10 million x 80% = \$8 million). OA applied this 80 percent adjustment factor to the unadjusted LIHP impacts given in **Table 3**, page 11, resulting in the adjusted LIHP impact estimates given in **Table 4** below.

| Impact Estimates | FY 2012-13 | FY 2013-14 |
|--------------------------------|---------------------|---------------------|
| Client Shift | 5,015 | 2,024 |
| Reduced Expenditures | \$47,552,488 | \$131,855,758 |
| Reduced Rebate Revenue | -\$3,064,053 | -\$35,197,082 |
| Net LIHP Impact Savings | \$44,488,435 | \$96,658,677 |

After taking this 80 percent adjustment into consideration, OA estimated that in the ten Legacy counties for FY 2012-13, approximately 5,015 clients will shift over to LIHP, and ADAP will realize net savings of approximately \$44.49 million. For FY 2013-14, an additional estimated 2,024 clients in the ten Legacy counties will shift over to LIHP, and ADAP will realize net savings of approximately \$96.66 million.

- g. **Back-billing.** Under federal law, RW HIV/AIDS programs must serve as the payer of last resort. If another payer, such as LIHP, exists for ADAP medications that were dispensed to a client who had coverage by another payer, that payer must pay for the medications, not ADAP. Therefore, ADAP client expenditures that are identified as drug costs that are billable to LIHP must be back-billed in order to adhere to the Payer of Last Resort provision. ADAP recovers these costs by having the PBM withhold the amounts for these back-billable prescription transactions from the pharmacy which originally dispensed the drugs. The pharmacy in turn resubmits the back-billed prescription claims to the local LIHP for reimbursement.

As indicated in section a) of this **RMA 1**, OA estimated that it takes an average of 120 days in the Legacy counties from when a client is initially screened by ADAP to when LIHP makes its determination of LIHP eligibility. If the client is accepted by LIHP, the client is considered to be enrolled in LIHP as of the first of the month in which the client submitted a LIHP application to their local LIHP. For example, if an ADAP client comes in to ADAP for recertification on July 12, 2012 and is determined to be potentially LIHP-eligible, that client has 30 days, or until August 10, 2012, to apply to LIHP and bring the proof of application back to their enrollment site. If the client applies to LIHP on August 5 and is determined to be eligible for LIHP on November 1, 2012, the client is considered to be enrolled in LIHP as of August 1.

ADAP can potentially back-bill for all the expenditures that this client incurred from August 1, the first of the month in which the client applied to LIHP, to November 1 when the client was actually dis-enrolled from ADAP due to

enrollment into LIHP. However, whether or not prescriptions for that client can be back-billed is subject to two limitations. First, ADAP cannot back-bill for a prescription unless the pharmacy had contracts with both ADAP and LIHP at the time the drug was dispensed. Second, in order to be back-billable, in some counties the drug must have been prescribed by a LIHP provider. These adjustments are explained in more detail below.

OA estimated the maximum potential impact of back-billing LIHP transactions on ADAP prior to making any adjustments by taking the difference between the amount of savings if the shift of clients to LIHP is delayed by 120 days, which is how OA estimates the impact of LIHP on ADAP, versus if the shift of clients is only delayed by 30 days. This 30-day delay takes into account the time it takes from when clients are screened for LIHP by ADAP to when these clients apply to LIHP. ADAP is able to back-bill for transactions during this 90-day period (120 days – 30 days = 90 days). Using this methodology results in estimated maximum potential back-billing amounts in the ten Legacy counties for FY 2012-13 of \$14,441,017 and \$24,002,598 for FY 2013-14.

OA then adjusted these maximum potential back-billing amounts to take into account the two limitations to back-billing discussed above. OA estimated that approximately 97 percent of the expenditures incurred at pharmacies in the Legacy counties had LIHP and ADAP contracts at the time the potentially back-billable drugs were dispensed. OA determined this adjustment factor by: 1) calculating the percent of ADAP-contracted pharmacies which are also LIHP pharmacies against the total number of active ADAP pharmacies in each of the ten Legacy counties; 2) weighting these county percentages by multiplying these percentages by the estimated FY 2011-12 expenditure reductions due to LIHP in each county; and 3) taking the ratio of the total adjusted reduced expenditures across all ten Legacy counties from step 2) against the total estimated FY 2011-12 expenditure reductions due to LIHP.

ADAP further estimated that for the maximum potentially back-billable number of prescriptions dispensed, 83 percent were prescribed by a provider in the LIHP network, which in turn equates to 83 percent of expenditures incurred. OA estimated this adjustment factor using a similar methodology for the pharmacy adjustment factor, but instead used the percent of RW clinics in each of the ten Legacy counties which are also LIHP clinics. Of the ten Legacy counties, only Contra Costa, Kern, and San Diego do not require that the prescription be prescribed by a LIHP provider in order to be back-billable.

Combining these two percentages with the 80 percent adjustment factor from section f) results in a back-billing adjustment factor of 64 percent [$80\% \times 97\% \times 83\% = 64\%$]. This 64 percent adjustment factor was then applied to the FYs 2012-13 and 2013-14 maximum potential back-billing estimates given above.

Further, OA estimated that it would take approximately seven months to complete the back-billing process for a single drug transaction. This seven-month period takes into account the four-month period for LIHP enrollment processing, as well as three months for the PBM to process the back-billed transaction. For example, back-billable drug transactions which took place in the month of January are accounted as being back-billed during August. To account for this seven-month delay, OA delayed accounting for transactions as being back-billed for seven months.

Taking into account the 64 percent adjustment factor and the seven-month delay, OA estimated the adjusted back-billable expenditures in the ten Legacy counties to be \$9,242,251 for FY 2012-13 and \$15,361,660 for FY 2013-14, (see **Table 5**, page 16).

In addition to accounting for the expenditures deemed back-billable, ADAP will need to refund drug manufacturers for any rebate received for those back-billed transactions. ADAP will continue to invoice drug manufacturers for rebate as it normally does. When ADAP learns that a transaction has been back-billed, it will then credit the appropriate drug manufacturer with the rebate received for that transaction.

OA calculated the impact of back-billing on ADAP rebate revenue by using the same methodology used for back-billable expenditures explained previously, taking the difference between delaying accounting for rebate loss by 120 days versus 30 days and adjusting the maximum potential rebate revenue loss using the 64 percent adjustment factor explained above.

To account for the time to process rebate invoices and to collect rebate from the drug manufacturers, ADAP accounts for rebate as received six months after the drug transaction occurs. OA added an additional six months to take into account the time needed to complete the rebate crediting processes. Thus, OA delayed accounting for rebate that must be refunded from back-billed drug transactions for a period of 12 months from the date the original transaction occurred.

Incorporating the adjustment factor and the 12-month delay results in estimated reduced rebate revenue of \$835,381 for FY 2012-13 and \$6,878,270 for FY 2013-14.

Table 5, next page, summarizes the final estimated impacts of LIHP back-billing on ADAP.

| TABLE 5: ADJUSTED LIHP BACK-BILLING IMPACT ESTIMATES IN THE 10 LEGACY COUNTIES | | |
|---|--------------------|--------------------|
| Impact Estimates | FY 2012-13 | FY 2013-14 |
| Back-Billable Expenditures | \$9,242,251 | \$15,361,660 |
| Rebate to Refund | -\$835,381 | -\$6,878,270 |
| Net Back-Billing Savings | \$8,406,870 | \$8,483,390 |

In the ten Legacy counties, for FY 2012-13, OA estimated that ADAP will realize a net savings due to back-billing of \$8.41 million, and a net savings of \$8.48 million for FY 2013-14.

ADAP will start back-billing in FY 2012-13 and is currently working with its PBM to develop the policies and procedures for implementing the back-billing process.

Summary

Table 6, below gives the net savings in the ten Legacy counties from both ADAP clients shifting over to LIHP (see **Table 4**, page 13) and LIHP back-billing (See **Table 5**, above).

| TABLE 6: TOTAL ADJUSTED NET SAVINGS ESTIMATES DUE TO LIHP IN THE 10 LEGACY COUNTIES | | |
|--|---------------------|----------------------|
| Impact Estimates | FY 2012-13 | FY 2013-14 |
| <i>Clients Shifting to LIHP</i> | | |
| Client Shift | 5,015 | 2,024 |
| Reduced Expenditures | \$47,552,488 | \$131,855,758 |
| Reduced Rebate Revenue | -\$3,064,053 | -\$35,197,082 |
| Net LIHP Impact Savings | \$44,488,435 | \$96,658,677 |
| <i>LIHP Back-Billing</i> | | |
| Expenditure Reductions | \$9,242,251 | \$15,361,660 |
| Rebate Reductions | -\$835,381 | -\$6,878,270 |
| Net Savings | \$8,406,870 | \$8,483,390 |
| <i>Total LIHP Impacts</i> | | |
| Expenditure Reductions | \$56,794,739 | \$147,217,418 |
| Rebate Reductions | -\$3,899,434 | -\$42,075,352 |
| Net Savings | \$52,895,305 | \$105,142,066 |

Overall, in the ten Legacy counties, for FY 2012-13, ADAP will realize an estimated net savings due to LIHP of **\$52.90 million**, of which \$44.49 million is due to net savings as clients shift over to LIHP and \$8.41 million of which is due to back-billing. For FY 2013-14, ADAP will realize an estimated LIHP net savings of **\$105.14 million**, consisting of \$96.66 million in savings due to clients shifting over to LIHP,

and \$8.48 million in net savings due to back-billing. For FY 2012-13, a total of 5,015 clients will shift over to LIHP, and an additional 2,024 will shift over in FY 2013-14.

2. Impact of the "Non-Legacy" LIHP Counties on ADAP.

In the *2012-13 May Revision*, OA estimated savings due to ADAP clients transitioning to the non-Legacy county LIHPs. The non-Legacy counties include Merced, Monterey, Placer, Riverside, Sacramento, San Bernardino, San Joaquin, Santa Barbara, Santa Cruz, Stanislaus, Tulare, and the 35 CMSP counties. As of July 2012, Fresno and San Luis Obispo Counties have elected not to implement LIHP.

As already indicated for the Legacy LIHPs in **RMA 1**, page 9 since publication of the *2012-13 May Revision*, OA received updated ADAP and LIHP implementation information which necessitated making several changes to the methodology to estimate the impact of LIHP on ADAP in the non-Legacy counties, resulting in estimated net savings to ADAP of **\$15,817,016** in FY 2012-13 and **\$16,584,370** in FY 2013-14. In addition, OA estimated that 1,141 ADAP clients in the non-Legacy counties will shift from ADAP into LIHP in FY 2012-13, and an additional 70 clients will shift in FY 2013-14 (see **Table 10**, page 20).

Estimate Methodology

OA made the following changes to the LIHP-impact methodology used in the *2012-13 May Revision*: a) utilizing FY 2011-12 actual data to calculate estimated LIHP impacts; b) accounting for the impact of LIHP in the Pasadena LHJ with the Los Angeles County LIHP; c) keeping LIHP-eligible Medicare Part D and private insurance clients co-enrolled in ADAP; d) adjusting impacts for the ratio of ADAP clients screened as being potentially LIHP eligible and those who are actually enrolled into LIHP; and e) accounting for the impact of back-billing. Detailed explanations of these changes are given in **RMA 1**, with the following caveats:

Back-Billing in the Non-Legacy Counties. Although the non-Legacy counties differ from Legacy counties regarding LIHP services implementation dates and ADAP LIHP eligibility screening activation dates, the same basic methodology for estimating the impact of back-billing for the Legacy counties given in **RMA 1** applies to the non-Legacy counties, with two exceptions.

First, because the average implementation dates as well as the average LIHP application processing periods are unchanged from those used in the *2012-13 May Revision*, OA will continue to use the 90-day average period to account for the time between ADAP screening clients for LIHP and the actual LIHP enrollment determination in the non-Legacy counties instead of the 120-day period used for the Legacy counties in **RMA 1**. Because the non-Legacy determination period is 30 days less than that used for the Legacy counties, OA will delay accounting for

back-billable expenditures in the non-Legacy counties for six months instead of the seven months used for the Legacy counties in **RMA 1**.

Second, the back-billing adjustment factor is somewhat different for the non-Legacy counties as 82 percent of the ADAP-contracted pharmacies are also LIHP pharmacies (whereas 97 percent of the ADAP-contracted pharmacies in the Legacy counties were also LIHP pharmacies). Because OA did not have the same provider information for the non-Legacy counties that it did for the Legacy counties, OA was unable to determine the percent of RW providers which are also LIHP providers. Until that determination can be made, OA used the same provider adjustment factor used for the Legacy counties (83 percent). OA also used the same 80 percent expenditure adjustment factor given in **RMA 1**, section f on page 12, in which OA estimated that ADAP would only realize an estimated 80 percent of initially calculated LIHP savings because of differences in the data that LIHP uses to determine LIHP eligibility versus the corresponding data that ADAP actually collects on its clients (for example, LIHP uses family income to determine eligibility, but ADAP only collects adjusted gross income). Therefore, OA estimated that the final back-billing adjustment factor for the non-Legacy counties to be 55 percent [80% X 82% X 83%].

Change in Implementation Status. San Luis Obispo County will not implement a LIHP; therefore, OA will eliminate it from the impact estimates. OA already accounted for Fresno County not implementing a LIHP in the *2012-13 May Revision*.

Using the methodology described in **RMA 1**, page 9 and as modified in this **RMA 2**, OA calculated the unadjusted LIHP impacts for the non-Legacy counties shown in **Table 7** below:

| Impact Estimates | FY 2012-13 | FY 2013-14 |
|--------------------------------|---------------------|---------------------|
| Client Shift | 1,426 | 87 |
| Reduced Expenditures | \$19,821,648 | \$31,445,807 |
| Reduced Rebate Revenue | -\$2,466,406 | -\$10,319,747 |
| Net LIHP Impact Savings | \$17,355,242 | \$21,126,060 |

Before taking any adjustments into consideration, OA estimated that in FY 2012-13, approximately 1,426 clients in the non-Legacy counties would shift over to LIHP, and ADAP would realize net savings of approximately \$17.36 million. For FY 2013-14, an additional 87 non-Legacy county clients would shift over to LIHP, and ADAP would realize net savings of approximately \$21.13 million.

Applying the 80 percent adjustment factor explained in **RMA 1** results in the following adjusted LIHP impacts:

| Impact Estimates | FY 2012-13 | FY 2013-14 |
|--------------------------------|---------------------|---------------------|
| Client Shift | 1,141 | 70 |
| Reduced Expenditures | \$15,857,319 | \$25,156,646 |
| Reduced Rebate Revenue | -\$1,973,125 | -\$8,255,798 |
| Net LIHP Impact Savings | \$13,884,194 | \$16,900,848 |

After taking the 80 percent adjustment into consideration, OA estimated that in the non-Legacy counties for FY 2012-13, approximately 1,141 clients will shift over to LIHP, and ADAP will realize net savings of approximately \$13.88 million. For FY 2013-14, an additional estimated 70 clients in the non-Legacy counties will shift over to LIHP, and ADAP will realize net savings of approximately \$16.90 million.

Using the methodology described in **RMA 1** and as modified in this **RMA 2**, OA calculated the adjusted impacts of LIHP back-billing in the non-Legacy counties taking into consideration the 55 percent back-billing adjustment calculated on page 17. **Table 9**, below, gives these estimated adjusted impacts:

| Impact Estimates | FY 2012-13 | FY 2013-14 |
|---------------------------------|--------------------|-------------------|
| Back-Billable Expenditures | \$2,192,708 | \$332,829 |
| Rebate to Refund | -\$259,886 | -\$649,308 |
| Net Back-Billing Savings | \$1,932,823 | -\$316,479 |

In the non-Legacy counties for FY 2012-13, OA estimated that ADAP will realize a net savings due to back-billing of \$1.93 million, and a net loss of \$316,479 for FY 2013-14. Note that in FY 2013-14, the 12-month delay in crediting rebate means that ADAP will collect less in back-billing than the rebate it will have to refund.

Summary

Table 10, page 20, gives the total adjusted net savings estimates in the non-Legacy counties due to ADAP clients shifting over to LIHP (see **Table 8**) and LIHP back-billing (see **Table 9**).

| TABLE 10: TOTAL ADJUSTED NET SAVINGS ESTIMATES DUE TO LIHP IN THE NON-LEGACY COUNTIES | | |
|--|---------------------|---------------------|
| Impact Estimates | FY 2012-13 | FY 2013-14 |
| <i>Clients Shifting to LIHP</i> | | |
| Client Shift | 1,141 | 70 |
| Expenditure Reductions | \$15,857,319 | \$25,156,646 |
| Rebate Reductions | -\$1,973,125 | -\$8,255,798 |
| Net Savings | \$13,884,194 | \$16,900,848 |
| <i>LIHP Back-Billing</i> | | |
| Expenditure Reductions | \$2,192,708 | \$332,829 |
| Rebate Reductions | -\$259,886 | -\$649,308 |
| Net Savings | \$1,932,823 | -\$316,479 |
| <i>Total LIHP Impacts</i> | | |
| Expenditure Reductions | \$18,050,027 | \$25,489,475 |
| Rebate Reductions | -\$2,233,011 | -\$8,905,105 |
| Net Savings | \$15,817,016 | \$16,584,370 |

Overall, in the non-Legacy counties, for FY 2012-13, ADAP will realize an estimated net savings due to LIHP of **\$15.82 million**, of which \$13.88 million is due to net savings as clients shift over to LIHP, and \$1.93 million of which is net savings due to back-billing. For FY 2013-14, ADAP will realize an estimated LIHP net savings of **\$16.58 million**, consisting of \$16.90 million in savings due to client shift, and a net loss of \$316,479 due to back-billing. In FY 2012-13, an estimated 1,141 clients will shift over to LIHP, and in FY 2013-14, an additional 70 clients will shift over to LIHP.

3. OA-PCIP Implementation.

OA implemented OA-PCIP to pay PCIP premiums and prescription deductibles and co-pays for PCIP-eligible ADAP clients to offset the cost of ADAP paying the full cost of medications for these clients. As explained in the *2012-13 May Revision*, OA anticipated a January 1, 2012 OA-PCIP implementation date for paying PCIP premiums. However, although ADAP clients were enrolled in OA-PCIP starting in January 2012, the pharmacy network between ADAP and PCIP was not fully established until June 2012 to ensure that PCIP is the primary payer. Thus, ADAP continued to pay the full cost of medications for these clients during this period instead of paying the lower PCIP deductibles and co-pays. This allowed OA-PCIP clients to maintain their continuity of care, including ADAP drug prescriptions; ADAP is now establishing the mechanism to back-bill for the over-payment of these PCIP prescriptions. For the *2013-14 Governor's Budget*, OA-PCIP implementation will be revised to reflect: a) back-billing, which will fully compensate for the delay in establishing the ADAP/PCIP pharmacy network; and b) using non-Ryan White funds to pay OA-PCIP premiums for clients potentially eligible for LIHP.

a. Back-billing.

OA has instructed the ADAP PBM to back-bill PCIP for all medication expenditures at ADAP/PCIP pharmacies that occurred after each ADAP client was enrolled in PCIP, retroactive to January 2012. These savings should be realized starting in the second quarter of FY 2012-13.

b. Using non-Ryan White funds to pay OA-PCIP premiums for LIHP-eligible OA-PCIP clients.

Federal RW funding regulations require OA to adhere to the Payer of Last Resort provision. Thus, OA-PCIP is only permitted to pay for services using RW or rebate dollars if there is no other payer source. For example, OA cannot use RW funds to pay for a client's private health insurance premiums through OA-PCIP if he/she is enrolled in LIHP. OA requested guidance from HRSA regarding whether or not the State GF would be subject to the Payer of Last Resort provision for payment of private insurance premiums. HRSA's response was that State funds were not subject to the Federal Payer of Last Resort provision and may be used for purposes the state chooses, as long as match and Maintenance of Effort grant requirements are met. In addition, DHCS informed OA that SNCP funds were unrestricted and therefore not held to the Payer of Last Resort provision. Given this guidance and with the California Department of Finance approval, OA has retained these clients in OA-PCIP using non-Ryan White funds. OA will utilize GF in FY 2012-13 and SNCP funds in FY 2013-14. In the *2012-13 May Revision*, OA assumed that the LIHP-eligible OA-PCIP clients would be required to leave ADAP and transition over to LIHP. Therefore, in the *2013-14 Governor's Budget*, OA estimated the premium cost impact of keeping these clients enrolled in OA-PCIP. This allows clients to continue to see their established providers and ensure continuity of care. This option results in overall savings to California because it is less expensive to pay PCIP premiums than to have LIHPs cover the full cost of medical care (split 50/50 between the federal government and local counties).

For comparison purposes, a similar table structure was used in the *2013-14 Governor's Budget* as in the *2012-13 May Revision*.

Estimate Methodology

To estimate the FYs 2012-13 and 2013-14 net savings, OA used a similar methodology as stated in the *2012-13 May Revision* (see **RMA 1-3**) and revised it with actual OA-PCIP and ADAP data from January 1, 2012 through August 23, 2012.

Total estimated OA-PCIP clients in FY 2012-13 were based on: a) existing FY 2011-12 clients continuing into FY 2012-13 (173 clients); b) new clients in July 2012 (21 clients); and c) approximately a 50 percent reduction in new clients per month for the remainder of the FY (August 2012 through June 2013) to reflect the majority of OA-PCIP clients enrolling in the first six months of the program (10 clients X 11 months = 110 clients and 173 + 21 + 110 = 304 total clients). Existing data showed fewer OA-PCIP clients enrolling per month in July through August 23, 2012, than

January through June 2012. The same rate of new clients (10 per month) was expected to carry over into FY 2013-14 until PCIP ends December 31, 2013 (304 + 60 = 364 total clients).

Based on FY 2011-12 actuals, average premiums per month were \$354. Correspondence with the Managed Risk Medical Insurance Board, which administers California's PCIP, indicated no future changes to current PCIP premium rates.

Although all current OA-PCIP clients are dually enrolled in ADAP, not all are receiving prescriptions paid for by ADAP. Possible reasons include clients paying for their own deductibles and co-pays or clients not being on any ADAP-covered medications. Based on existing data, 82 percent of OA-PCIP clients are receiving medications through ADAP. This adjustment factor was used to compute ADAP expenditure savings.

Expenditures and revenue were computed separately as before for two components:

- Component 1 (Majority impact): Voluntary co-enrollment of eligible ADAP-only clients into OA-PCIP (82 percent of all 304 OA-PCIP clients = 249 ADAP clients in FY 2012-13; 82 percent of the estimated 364 OA-PCIP clients = 298 ADAP clients in FY 2013-14); and
- Component 2 (Minority impact): Voluntary co-enrollment of any other HIV-infected PCIP clients who were not previously in ADAP into ADAP (to pay pharmaceutical deductibles and co-pays) and OA-PCIP. (One dually-enrolled client was identified as being a new ADAP client from January 2012 through June 2012, and two clients were estimated for both FYs 2012-13 and 2013-14).

For FY 2012-13, expenditure savings were calculated with 70 percent of the clients served in ADAP in the first quarter and 10 percent in each subsequent quarter, reflecting new OA-PCIP clients enrolling into ADAP. For FY 2013-14, expenditure savings were calculated using the same logic; 90 percent of the clients would be served in the first quarter and the remaining 10 percent in the second quarter until OA-PCIP ends on December 31, 2013.

Based on existing clients, expenditures for PCIP drug deductibles and co-pays were computed at \$1,500 per ADAP client to reflect a \$500 medication deductible and an estimated \$1,000 spent on medication co-pays per year.

1) Back-billing

Additional savings from back-billing was computed for OA-PCIP clients in FY 2011-12 whom were billed as ADAP-only prescriptions, because the ADAP/PCIP pharmacy network was not yet established. OA summed up the qualifying prescriptions and subtracted \$15 per prescription for the OA-PCIP co-pay. There will be a loss of rebate associated with this back-billing, since OA received rebate for these ADAP-only transactions but cannot claim rebate for PCIP transactions.

This rebate loss is accounted for in this assumption (see **Tables 11, below, and 12**, page 24). Retroactive back-billing is allowable back to the OA-PCIP client's enrollment date.

2) Using Non-Ryan White Funds to pay OA-PCIP premiums for LIHP-eligible OA-PCIP clients.

Finally, the amount of funding needed to pay OA-PCIP premiums for LIHP-eligible clients was calculated by multiplying the number of OA-PCIP clients by 26.41 percent (based on the percentage of ADAP clients potentially eligible for LIHP), and then multiplying this number by the PCIP premium amount.

The following summary tables (**Table 11**, below, and **Table 12**, page 24) show the impact of the two PCIP adjustments on premiums, expenditures, rebate revenue, net cost/savings, and clients for FY 2012-13 (final net savings = \$2,512,207) and FY 2013-14 (final net savings = \$1,074,278). "Unadjusted Estimate" (first row of both tables) refers to updating the premiums, drug expenditures, rebate, and net savings based on actual data from January 1, 2012 through August 23, 2012 (with no other adjustments). The totals in the bottom row show the final premiums, drug expenditures, rebate, and net savings after both adjustments were made to the unadjusted estimate and will appear in the FCS, as will the non-Ryan White funding amounts to pay for premiums for LIHP-eligible clients.

For FY 2012-13, OA estimates a savings of **\$2,512,207** (\$1.06 million in premiums, \$4.43 million in reduced drug expenditures and \$864,802 in loss of rebate revenue).

| TABLE 11: SUMMARY OF PCIP CHANGES, FY 2012-13 | | | | | |
|---|--------------------|---------------------|-------------------|---------------------|------------|
| ISSUE | PREMIUMS | DRUG EXPEND\$ | REBATE REVENUE | TOTAL ESTIMATE | CLIENTS* |
| Unadj. Estimate | \$1,056,433 | -\$3,838,542 | -\$650,638 | -\$2,131,471 | 304 |
| a. Back-bill | \$0 | -\$594,901 | -\$214,164 | -\$380,737 | 0 |
| TOTAL | \$1,056,433 | -\$4,433,443 | -\$864,802 | -\$2,512,207 | 304 |
| b. Non-RW premium | \$181,030 | | | | 52 |
| RW premium | \$875,403 | | | | 252 |
| Negative (-) expend and (-) net = savings; and negative (-) revenue = rebate loss. *Only 251 of the 304 (82 percent) OA-PCIP clients are expected to have ADAP expenditures. | | | | | |

For FY 2013-14, the net savings of **\$1,074,278** consists of \$719,138 in premiums, \$2.16 million in reduced drug expenditures and \$365,866 in loss of rebate revenue.

| TABLE 12: SUMMARY OF PCIP CHANGES, FY 2013-14 | | | | | |
|--|------------------|---------------------|-------------------|---------------------|------------|
| ISSUE | PREMIUMS | DRUG EXPEND\$ | REBATE REVENUE | TOTAL ESTIMATE | CLIENTS* |
| Unadj. Estimate | \$719,138 | -\$2,159,283 | -\$365,866 | -\$1,074,278 | 364 |
| a. Back-bill | \$0 | \$0 | \$0 | \$0 | 0 |
| TOTAL | \$719,138 | -\$2,159,283 | -\$365,866 | -\$1,074,278 | 364 |
| b. Non-RW premium | \$123,070 | | | | 62 |
| RW premium | \$596,069 | | | | 302 |
| Negative (-) expend and (-) net = savings; and negative (-) revenue = rebate loss. | | | | | |
| *Only 300 of the 364 (82 percent) OA-PCIP clients are expected to have ADAP expenditures. | | | | | |

4. Using Non-Ryan White Funds to Pay OA-HIPP Premiums for LIHP-Eligible OA-HIPP Clients.

As with OA-PCIP, above in **RMA 3**, State GF and SNCP funds would not be subjected to the Federal Payer of Last Resort provision for payment of private insurance premiums including OA-HIPP. Thus, OA has utilized appropriated FY 2012-13 GF to pay for premiums for OA-HIPP clients who are LIHP-eligible for the same reasons stated above for LIHP-eligible OA-PCIP clients. In FY 2013-14, OA will utilize appropriated SNCP funds to pay these premiums. Although there will be an increase in expenditures for OA for both FYs 2012-13 and 2013-14, this option results in overall savings to California because private insurance premiums are less expensive than paying the full cost of medical care and medications in LIHP. Continuing to pay private insurance premiums through OA-HIPP for LIHP-eligible clients also allows these clients to continue seeing their established providers and ensure continuity of care. In *the 2012-13 May Revision*, we assumed that LIHP-eligible OA-HIPP clients would be required to leave ADAP and transition over to LIHP. However, based on updated information, OA has retained these clients using non-Ryan White funds to pay their premiums. For the *2013-14 Governor's Budget*, OA estimated premium costs of **\$3,338,873** in FY 2012-13 and **\$4,957,066** in FY 2013-14 to keep these clients enrolled in OA-HIPP.

This policy will be extended in January 2014 when LIHP terminates and LIHP-eligible OA-HIPP clients become eligible for Medi-Cal Expansion (**Future Fiscal Issue 1**, page 49). This expansion is reflected in the premium costs. Keeping Medi-Cal Expansion-eligible clients in OA-HIPP in 2014 remains cost effective for the State because it is less expensive to pay private insurance premiums than to have the State absorb the full cost of medical care and treatment through Medi-Cal.

Estimate Methodology

The amount of funding needed to pay OA-HIPP premiums for LIHP-eligible OA-HIPP clients was estimated as follows:

- Using FY 2011-12 data, OA computed the average monthly premium in OA-HIPP (\$6,268,892 / 7,367 months paid = \$851 per month for 913 clients).
- Based on July 1, 2011 through August 23, 2012 OA-HIPP data, it was estimated that OA-HIPP would serve 50 new clients per month (or 600 new clients per year) for both FYs 2012-13 and 2013-14. Actually, more clients are expected to enroll and be served in ADAP starting on January 1, 2014 when the Exchange begins. However, this increased higher growth will be addressed in the *2013-14 May Revision* (see **Future Fiscal Issue 3**, page 50).
- Summed up the total clients for each FY (for FY 2012-13, 913 + 600 = 1,513 clients; and for FY 2013-14, 1,513 + 600 = 2,113 clients).
- Computed the total premiums for each FY (for FY 2012-13, \$12.64 million; and for FY 2013-14, \$18.77 million).

| MONTH | EXISTING CLIENTS | NEW CLIENTS | TOTAL CLIENTS | PREMIUM\$ |
|--------------|-------------------------|--------------------|----------------------|---------------------|
| Jul | 913 | 50 | 963 | \$819,513 |
| Aug | 963 | 50 | 1,013 | \$862,063 |
| Sep | 1,013 | 50 | 1,063 | \$904,613 |
| Oct | 1,063 | 50 | 1,113 | \$947,163 |
| Nov | 1,113 | 50 | 1,163 | \$989,713 |
| Dec | 1,163 | 50 | 1,213 | \$1,032,263 |
| Jan | 1,213 | 50 | 1,263 | \$1,074,813 |
| Feb | 1,263 | 50 | 1,313 | \$1,117,363 |
| Mar | 1,313 | 50 | 1,363 | \$1,159,913 |
| Apr | 1,363 | 50 | 1,413 | \$1,202,463 |
| May | 1,413 | 50 | 1,463 | \$1,245,013 |
| Jun | 1,463 | 50 | 1,513 | \$1,287,563 |
| TOTAL | 913 | 600 | 1,513 | \$12,642,456 |

| TABLE 14: ESTIMATED OA-HIPP CLIENT PREMIUMS, FY 2013-14 | | | | |
|---|------------------|-------------|---------------|---------------------|
| MONTH | EXISTING CLIENTS | NEW CLIENTS | TOTAL CLIENTS | PREMIUM\$ |
| Jul | 1,513 | 50 | 1,563 | \$1,330,113 |
| Aug | 1,563 | 50 | 1,613 | \$1,372,663 |
| Sep | 1,613 | 50 | 1,663 | \$1,415,213 |
| Oct | 1,663 | 50 | 1,713 | \$1,457,763 |
| Nov | 1,713 | 50 | 1,763 | \$1,500,313 |
| Dec | 1,763 | 50 | 1,813 | \$1,542,863 |
| Jan | 1,813 | 50 | 1,863 | \$1,585,413 |
| Feb | 1,863 | 50 | 1,913 | \$1,627,963 |
| Mar | 1,913 | 50 | 1,963 | \$1,670,513 |
| Apr | 1,963 | 50 | 2,013 | \$1,713,063 |
| May | 2,013 | 50 | 2,063 | \$1,755,613 |
| Jun | 2,063 | 50 | 2,113 | \$1,798,163 |
| TOTAL | 1,513 | 600 | 2,113 | \$18,769,656 |

- e. Finally, funding needed to pay OA-HIPP premiums for LIHP-eligible clients was calculated as 26.41 percent of OA-HIPP clients (and premiums) based on the percentage of ADAP clients eligible for LIHP (for FY 2012-13, 26.41 percent of 1,513 and \$12.64 million = 400 clients and **\$3,338,873** in premiums, respectively; and for FY 2013-14, 26.41 percent of 2,113 and \$18.77 million = 558 clients and **\$4,957,066** in premiums, respectively).

5. Increase Rebate Percentage.

In the *2012-13 May Revision*, the 50 percent rebate collection was calculated from the most recent 12 quarters of rebate data. A 6 percent adjustment was then made to the final rebate calculation to reflect the additional rebate revenue due to the Patient Protection and Affordable Care Act (PPACA) mandatory rebates and the AIDS Crisis Task Force (ACTF) supplemental rebate negotiations in 2010. The actual 56 percent rebate was equivalent to the most recent four quarters of rebate collections.

For the 2013-14 Governor's Budget, the rebate percentage was calculated from the most recent four quarters of rebate collections, FY 2010-11 Quarter 4 through FY 2011-12 Quarter 3. This eliminates the need for an adjustment factor for current renegotiated supplemental rebate/price freeze agreements. In addition, four quarters of rebate collections captures any seasonality factors associated with higher or lower than usual quarterly percentages throughout the year. As a result, the new rebate percentage is 60 percent. Additional line item adjustments were made in the FCS for individual assumptions with an impact on rebate collections.

6. Additional 2012 Federal Grant Funds.

As reflected in the *2012-13 May Revision* on April 9, 2012, ADAP received an increase in 2012 ADAP Earmark and ADAP Supplemental funds of approximately \$11 million dollars for a total of \$113.61 million in Federal funds. In April 2012, OA applied for the 2012 RW Part B Supplemental Grant. This supplemental application addressed how states propose to eliminate, reduce, or avoid ADAP restrictions including waiting lists, capped enrollment, reduction to the ADAP formulary, reduction in the percentage of FPL requirement for ADAP eligibility, or other program restrictions on ADAP within the LHJ. CDPH was eligible to apply for the RW Part B Supplemental funding and requested \$2.66 million. On October 9, 2012, OA received the Notice of Award (NOA) for the RW Part B Supplemental for \$2,129,954. On May 2, 2012, HRSA released the 2012 Emergency Relief Funding (ERF) opportunity announcement to states/territories to help improve access to life-saving medications through ADAP and to support implementation of new or additional "cost saving" measures to prevent a waiting list. The announcement included both a competitive continuation and a new competitive award opportunity. Since California ADAP received 2011 ERF, OA qualified to apply for the competitive continuation funding and requested \$2.57 million. For the new competitive funding, OA requested the maximum allowed, \$7 million, of the \$35 million available. OA received the new competitive ERF NOA on July 10, 2012 for the maximum \$7 million. These funds are one-time and must be spent by March 31, 2013. On July 18, 2012, OA received the NOA for the competitive continuation ERF for \$2,574,357 and on August 24, 2012, received a revised NOA for an additional \$566,911.

The 2012 ERF and Supplemental awards total \$12.27 million, increasing ADAP Federal funds to **\$125.88 million** in FY 2012-13. The *FY 2013-14 Governor's Budget* assumes the increase in Federal funds will be spent in the current year.

7. Change in Methodology: Adjust Linear Regression Expenditure Methodology

In the *2012-13 May Revision*, ADAP used monthly expenditures from April 2009 through (estimated) March 2012 in the linear regression. In addition, ADAP made five pre-regression adjustments with start dates in parentheses: 1) elimination of jails (July 2010); 2) ADAP counting towards True Out Of Pocket (TrOOP) Expenses (January 2011); 3) reduced PBM transaction fees (July 2011); 4) increased split fee savings (July 2011); and 5) reduced reimbursement rate (July 2011). Any data points prior to the start dates were adjusted as if the assumption were already in place. These pre-regression adjustments were performed prior to running the linear regression model and eliminated the need for post-regression adjustments. If the pre-regression adjustments were not made, then the earlier data points before the start dates would not include the impact of the assumptions. By keeping all 36 data points similar with the assumptions in effect, they measure the same expenditures resulting in a reliable estimate without any potential bias.

For the *2013-14 Governor's Budget*, monthly expenditures for the linear regression have been updated from October 2009 through September 2012. OA-HIPP expansion began in July 2011 and a pre-regression adjustment was made to reduce prior monthly expenditures as if the expanded OA-HIPP was always in effect.

In addition, a pre-regression adjustment was made for LIHP savings beginning in April 2011. Unlike OA-HIPP and the five pre-regression adjustments mentioned above in which OA adjusted the prior data points as if the assumptions were always in effect, OA added the monthly LIHP savings back into the data points as if LIHP was never in effect. September 2012 was the largest decrease in ADAP monthly expenditures from prior year in the history of the program. This is a critical adjustment to retain the integrity of the model, because the last data point is also one of the most influential, the same reason OA estimated March expenditures in the *2012-13 May Revision*. Otherwise, there is a high risk the model will underestimate actual expenditures when making the post-regression adjustment for LIHP.

A minor pre-regression adjustment was made for OA-PCIP. There were no realized savings for OA-PCIP in FY 2011-12, which means no impact on the model for data points through the end of June 2012. For July 2012 through September 2012, realized savings attributed to OA-PCIP were added back into the monthly expenditures prior to running the regression.

8. Reimbursement of Federal Funding through the SNCP.

Since FY 2010-11, CDPH has received Federal SNCP funds from DHCS. SNCP funding has been made available through a Federal Medicaid 1115 Waiver that allows DHCS to use ADAP expenditures, along with other public health programs, as Certified Public Expenditures to draw down Federal funds. These funds have been provided to ADAP in the form of reimbursements and have been used for the purchase of drugs on the ADAP formulary. The one-time allocations received include \$76.28 million, \$74.06 million, and **\$17.15 million** for FYs 2010-11, 2011-12, and 2012-13, respectively. For FY 2013-14, CDPH will receive approximately **\$66.34 million** from DHCS due to additional Federal funds available under SNCP. The *FY 2012-13 Governor's Budget* assumes that the reimbursement will be spent in the budget year.

Continuing Assumptions

1. OA-HIPP/Medi-Cal Fund Source Issue: Using Non-Ryan White Funds to Pay OA-HIPP Premiums and ADAP Drug Deductibles and Co-Pays for Clients Co-Enrolled in Medi-Cal with a SOC.

This assumption was included in the *2012-13 May Revision* as a CA. There were no changes made to the estimate methodology. However, fiscal estimates were impacted due to updated data. In addition, the fund source has changed from GF to SNCP in FY 2013-14. These changes are reflected on the FCS on page 31.

Discontinued Major Assumptions

1. Institution of Client Cost-Sharing Policy.

This proposal was rejected by the Legislature.

3. FUND CONDITION STATEMENT

The FCS (see **Table 15**, page 31) shows the status of the ADAP Special Fund (SF) 3080 for FYs 2011-12, 2012-13, and 2013-14 and all the factors that impact the fund including revenues, expenditures, revenue collection rate, interest earned, and major assumptions.

For FY 2012-13, the unadjusted revenue estimate is based on: a) actual rebates (\$83,115,835) collected for expenditures during January through March 2012; b) estimated rebates (\$71,994,792) calculated by applying a 60 percent rebate collection rate (**RMA 5**, page 26) to actual expenditures for April to June 2012; and c) estimated rebates (\$159,625,619) developed by applying the 60 percent rebate collection rate to projected (unadjusted) expenditures (based on linear regression, **RMA 7**, page 27) for July to December 2012. The revenue estimate was then adjusted to reflect the impact of major assumptions in effect for the current year resulting in projected revenue of \$307,738,999. It is estimated that there will be an additional amount of \$120,000 of revenue from interest earned.

For FY 2013-14, the unadjusted revenue estimate is based on estimated rebates (\$336,350,244) developed by applying the 60 percent rebate collection rate to projected (unadjusted) expenditures (based on linear regression) for January to December 2013. The revenue estimate was then adjusted to reflect the impact of major assumptions in effect for the budget year resulting in projected revenue of \$285,003,921. It is estimated that there will be an additional amount of \$120,000 of revenue from interest earned.

To determine funding need, OA estimated expenditures based on a revised linear regression, adjusted for assumptions and applied available fund sources including appropriations of GF (FY 2012-13 only), Federal Funds, and Reimbursements (SNCP funds, **RMA 8**, page 28) resulting in a remaining SF need of \$309.6 million and \$265.1 million for FYs 2012-13 and 2013-14, respectively. A reserve of \$3.3 million was included for FY 2012-13. For FY 2013-14, the SF balance is \$23.3 million.

There is no change to the FY 2012-13 GF appropriation of \$16,875,412 from the *2012-13 Budget Act*. For FY 2013-14, \$16.9 million will be returned to the General Fund due to estimated decreased expenditures.

NOVEMBER ESTIMATE FUND CONDITION STATEMENT

| Table 15: FUND CONDITION STATEMENT | | | | |
|--|---|--------------|--------------|---------------|
| (in thousands) | | | | |
| Special Fund 3080 AIDS Drug Assistance Program Rebate Fund | | FY 2011-12 | FY 2012-13 | FY 2013-14 |
| | | Actuals | Estimate | Estimate |
| 1 | BEGINNING BALANCE | 57,874 | 5,036 | 3,304 |
| 2 | Prior Year Adjustment | -5,828 | 0 | 0 |
| 3 | Adjusted Beginning Balance | 52,046 | 5,036 | 3,304 |
| 4 | REVENUES, TRANSFERS AND OTHER ADJUSTMENTS | | | |
| 5 | Revenues | | | |
| 6 | 150300 Income From Surplus Money Investments (Interest) | 254 | 120 | 120 |
| 7 | 161400 Miscellaneous Revenue | 241,814 | 307,739 | 285,004 |
| 8 | Total Revenues, Transfers, and Other Adjustments | 242,068 | 307,859 | 285,124 |
| 9 | Total Resources | 294,114 | 312,895 | 288,428 |
| 10 | EXPENDITURES AND EXPENDITURE ADJUSTMENTS | | | |
| 11 | Expenditures | | | |
| 12 | 8880 FISCAL | 0 | 5 | 4 |
| 13 | 0840 State Controllers Office | 33 | 3 | 0 |
| 14 | 4260 Department of Health Care Service (State Ops) | 0 | 0 | 0 |
| 15 | 4265 Department of Public Health | | | |
| 16 | State Operations | 1,021 | 900 | 917 |
| 17 | ADAP Local Assistance | 284,298 | 299,274 | 250,547 |
| 18 | OA-PCIP, OA-HIPP, and Medicare Part D Local Assistance | 3,726 | 9,409 | 13,611 |
| 19 | | | | |
| 20 | Total Expenditures and Expenditure Adjustments | 289,078 | 309,591 | 265,079 |
| 21 | FUND BALANCE | 5,036 | 3,304 | 23,349 |

Row 6: Interest Actuals for FY 2011-12, Estimated for FYs 2012-13 and 2013-14

| | | |
|---------|---------|---------|
| 254,153 | 120,000 | 120,000 |
|---------|---------|---------|

Miscellaneous Revenue

| | | |
|---|-------------|-------------|
| Actual Rebate resulting from Expenditures for Jan - Mar 2012 | 83,115,835 | |
| Estimated Rebates resulting from Actual Expenditures from April - June 2012 (\$119,991,320 x 60% avg rebate rate (RMA 5)) | 71,994,792 | |
| Estimated Rebates resulting from Estimated Unadjusted Expenditures from July - Dec 2012 (\$266,042,699 x 60% avg rebate rate (RMA 5)) | 159,625,619 | |
| Estimated Rebate resulting from Estimated Unadjusted Expenditures for Jan - June 2013 (\$266,042,699 x 60% avg rebate rate (RMA 5)) | | 159,625,619 |
| Estimated Rebate resulting from Estimated Unadjusted Expenditures for July - Dec 2013 (\$294,541,042 x 60% avg rebate rate (RMA 5)) | | 176,724,625 |

| | | |
|--|-------------|-------------|
| Total Unadjusted Estimated FY 2012-13 Rebate Revenue | 314,736,246 | |
| Total Unadjusted Estimated FY 2013-14 Rebate Revenue | | 336,350,244 |

Adjustments to ADAP Revenue Projections:

| | | |
|---|--------------------|--------------------|
| LIHP: Impact of Ten "Legacy" Counties on ADAP (RMA 1) | -3,899,434 | -42,075,352 |
| LIHP: Impact of the "Non-Legacy" Counties on ADAP (RMA 2) | -2,233,011 | -8,905,105 |
| OA-PCIP: Implementation (RMA 3) | -864,802 | -365,866 |
| Row 7: ADAP Revenue Projections after Adjustments | 307,738,999 | 285,003,921 |

| | FY 2012-13 Estimate | FY 2013-14 Estimate |
|---|------------------------|------------------------|
| ADAP Expenditure Projection: FYs 2012-13 and 2013-14, Linear Regression (RMA 7) | 532,085,397 | 589,082,084 |
| Adjustments to ADAP Expenditure Projection: | | |
| Additional PBM Costs (NMA 1) | 778,539 | 671,484 |
| LHP: Impact of Ten "Legacy" Counties on ADAP (RMA 1) | -56,794,739 | -147,217,418 |
| LHP: Impact of the "Non-Legacy" LHP counties on ADAP (RMA 2) | -18,050,027 | -25,489,475 |
| OA-PCIP: Implementation (RMA 3) | -4,433,443 | -2,159,283 |
| Subtotal: ADAP Expenditure Projection after Adjustments | 453,585,727 | 414,887,392 |
| Less: Federal Fund Appropriation (Earmark) | -105,179,281 | -105,179,281 |
| Less: Additional Federal Grant Funds (RMA 6) | -20,697,029 | 0 |
| Subtotal: Federal Funds for ADAP | -125,876,310 | -105,179,281 |
| Less: Reimbursement funding through the Safety Net Care Pool (RMA 8) | -17,150,000 | -66,339,340 |
| Non Add: Reimbursement Need for ADAP expenditures that are not allowable under RW | 0 | 5,802,015 |
| Less: Reimbursement Need for OA-PCIP and OA-HIPP expenditures that are not allowable under RW | 0 | 5,178,250 |
| Subtotal: Reimbursement Funds for ADAP | -17,150,000 | -61,161,090 |
| Less: General Fund Appropriation for ADAP - per FY 2012-13 Budget Act | -15,985,058 | -15,985,058 |
| Non Add: General Fund Need for ADAP expenditures that are not allowable under RW | 5,240,640 | 0 |
| Less: General Fund Need for OA-PCIP and OA-HIPP expenditures that are not allowable under RW | 2,699,802 | 0 |
| Less: Surplus General Fund | 0 | -15,985,058 |
| Subtotal: General Fund Revised Appropriation for ADAP | -13,285,256 | 0 |
| Special Fund 3080 Need to meet Expenditure Projection for ADAP | 297,274,161 | 248,547,021 |
| Local Assistance Local Health Jurisdiction (LHJ) | 2,000,000 | 2,000,000 |
| Row 17: Total Special Fund 3080 Need for ADAP | 299,274,161 | 250,547,021 |

| | FY 2012-13 Estimate | FY 2013-14 Estimate |
|---|------------------------|------------------------|
| OA-PCIP Expenditure Projection: | 1,056,433 | 719,138 |
| Non-Add: OA-PCIP Premiums for LHP-eligible OA-PCIP Clients* (RMA 3) | 181,030 | 123,070 |
| Subtotal: OA-PCIP Expenditure Projection: | 1,056,433 | 719,138 |
| OA-HIPP Expenditure Projection: | 12,642,456 | 18,769,656 |
| Non-Add: OA-HIPP Premiums for LHP-eligible OA-HIPP Clients* (RMA 4) | 3,338,873 | 4,957,066 |
| Non-Add: OA-HIPP Premiums for Clients Co-Enrolled in Medi-Cal w/SOC* (CA 1) | 70,253 | 98,113 |
| Subtotal: OA-HIPP Expenditure Projection | 12,642,456 | 18,769,656 |
| Total: Projected Expenditures for OA-PCIP and OA-HIPP | 13,698,889 | 19,488,794 |
| Less: Federal Fund Appropriation (RW Part B Base Funds) | -1,700,000 | -1,700,000 |
| Less: Reimbursement funding through the Safety Net Care Pool (RMA 8) | 0 | -5,178,250 |
| Less: General Fund Appropriation | -890,354 | -890,354 |
| Less: General Fund Need to avoid a negative fund balance | -2,699,802 | 0 |
| Less: Surplus General Fund | 0 | 890,354 |
| Subtotal: General Fund Revised Appropriation for OA-PCIP and OA-HIPP | -3,590,156 | 0 |
| Special Fund 3080 Need to meet Expenditure Projection for OA-PCIP and OA-HIPP | 8,408,733 | 12,610,544 |
| Local Assistance Medicare Part D premiums | 1,000,000 | 1,000,000 |
| Row 18: Special Fund 3080 Appropriation to meet Expenditure Projection for Insurance Assistance Programs | 9,408,733 | 13,610,544 |
| General Fund revised appropriation for ADAP | 13,285,256 | 0 |
| General Fund revised appropriation for OA-Insurance Assistance Programs | 3,590,156 | 0 |
| Total General Fund Appropriation | 16,875,412 | 0 |

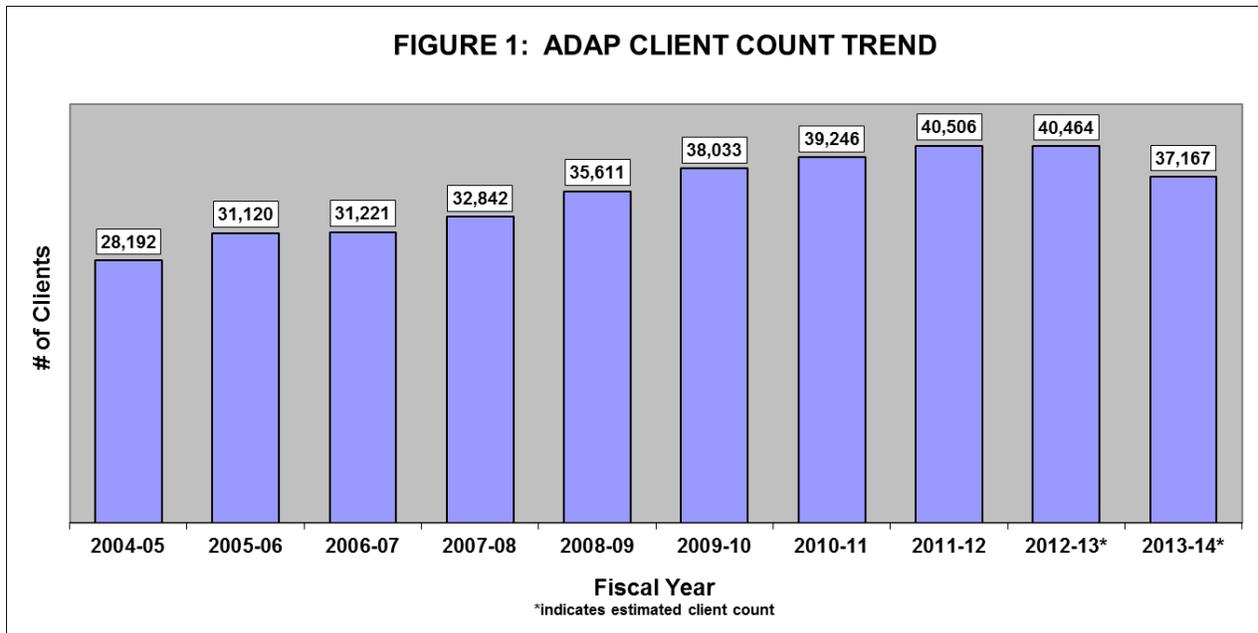
Note: NMA: New Major Assumption; RMA: Revised Major Assumption; CA: Continuing Assumption

*Utilize GF in the Current Year and Reimbursement funds in the Budget Year for expenditures not allowable under RW

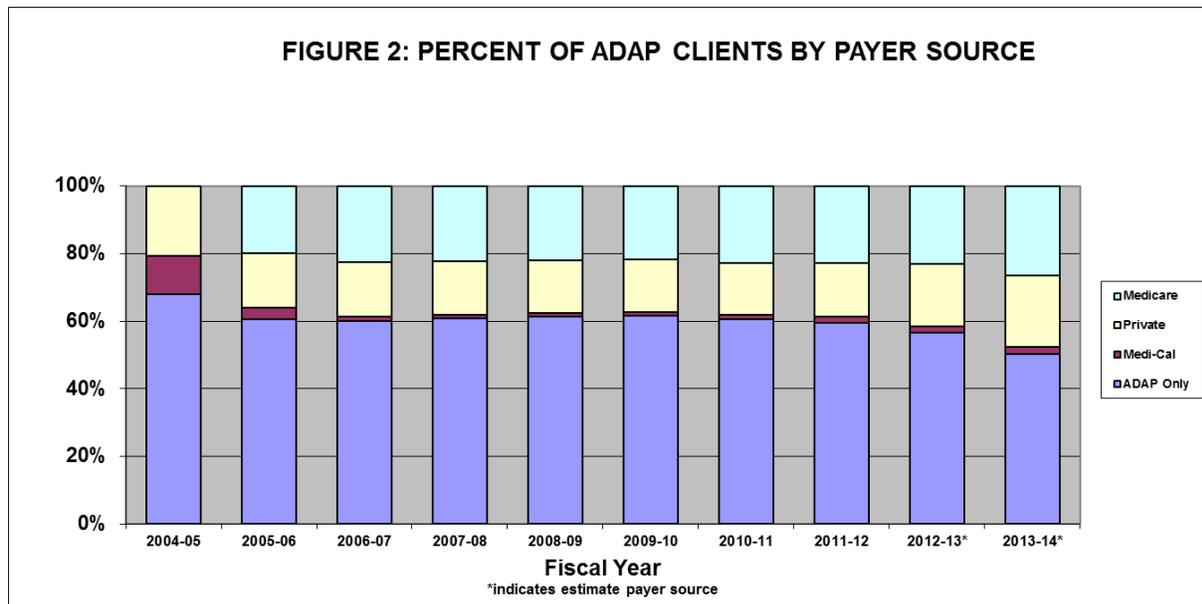
4. HISTORICAL PROGRAM DATA AND TRENDS

(*Data for FYs 2012-13 and 2013-14 are estimated, all other data are actuals)

For all figures and tables in Section 4, the data prior to FY 2012-13 is the observed historical data. To develop client and prescription estimates for FYs 2012-13 and 2013-14, OA used a regression model similar to the one used for expenditure estimates. These estimates were then adjusted in the following figures and tables to take into account client, expenditure, and prescription adjustments due to LIHP (**RMA 1** and **RMA 2**), OA-PCIP (**RMA 3**), and OA-HIPP (**RMA 4**), as applicable.



Note: Clients shifting out of ADAP due to LIHP in FY 2012-13 per **RMA 1** and **RMA 2** are still considered to be ADAP clients for FY 2012-13. They will no longer be clients in FY 2013-14.

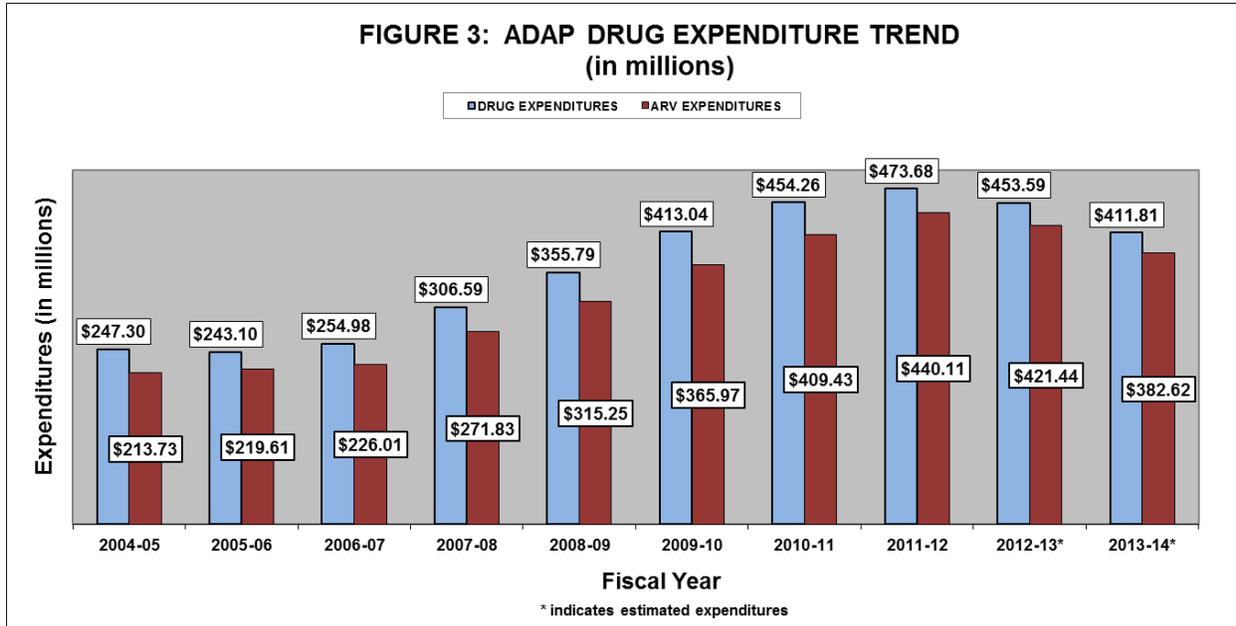


Note: The actual percentage of ADAP clients by payer source/coverage group in FY 2011-12 was applied to the estimated client counts in FYs 2012-13 and 2013-14 to estimate the percentage of clients by payer source. These percentages were then adjusted to account for the shift of ADAP-only clients to OA-PCIP per **RMA 3**, to OA-HIPP per **RMA 4**, and to LIHP per **RMA 1** and **RMA 2**.

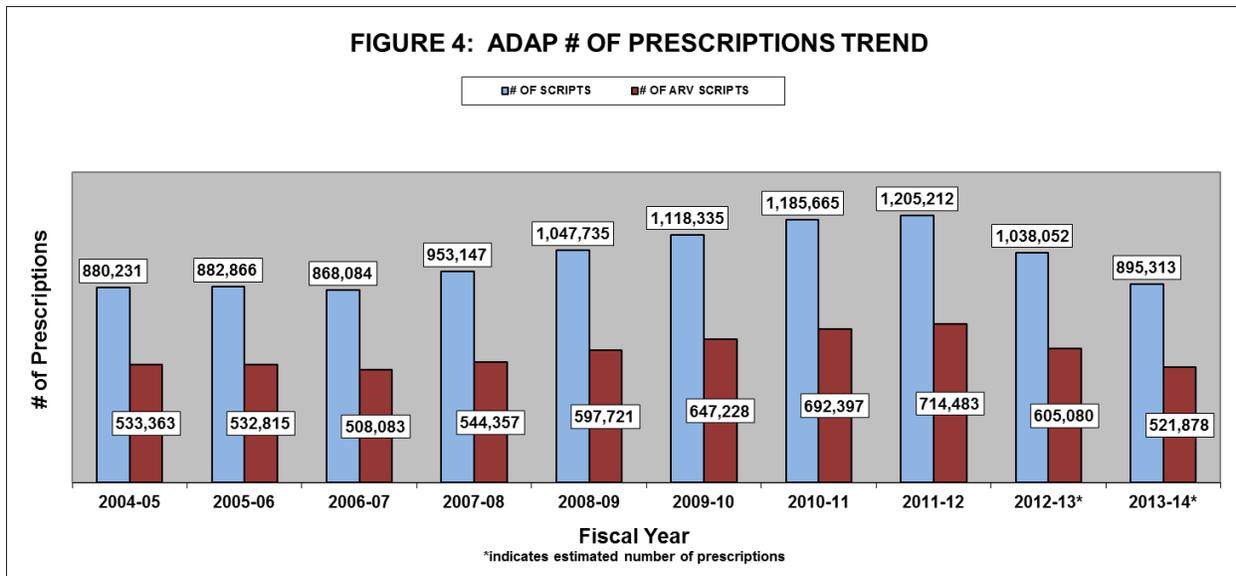
TABLE 16: ESTIMATED ADAP CLIENTS BY COVERAGE GROUP

| Coverage Group | FY 2012-13 | | FY 2013-14 | |
|-------------------|---------------|----------------|---------------|----------------|
| | Clients | Percent | Clients | Percent |
| ADAP-only | 22,942 | 56.70% | 18,734 | 50.40% |
| Medi-Cal | 724 | 1.79% | 761 | 2.05% |
| Private Insurance | 7,429 | 18.36% | 7,817 | 21.03% |
| Medicare | 9,370 | 23.16% | 9,854 | 26.51% |
| TOTALS | 40,464 | 100.00% | 37,167 | 100.00% |

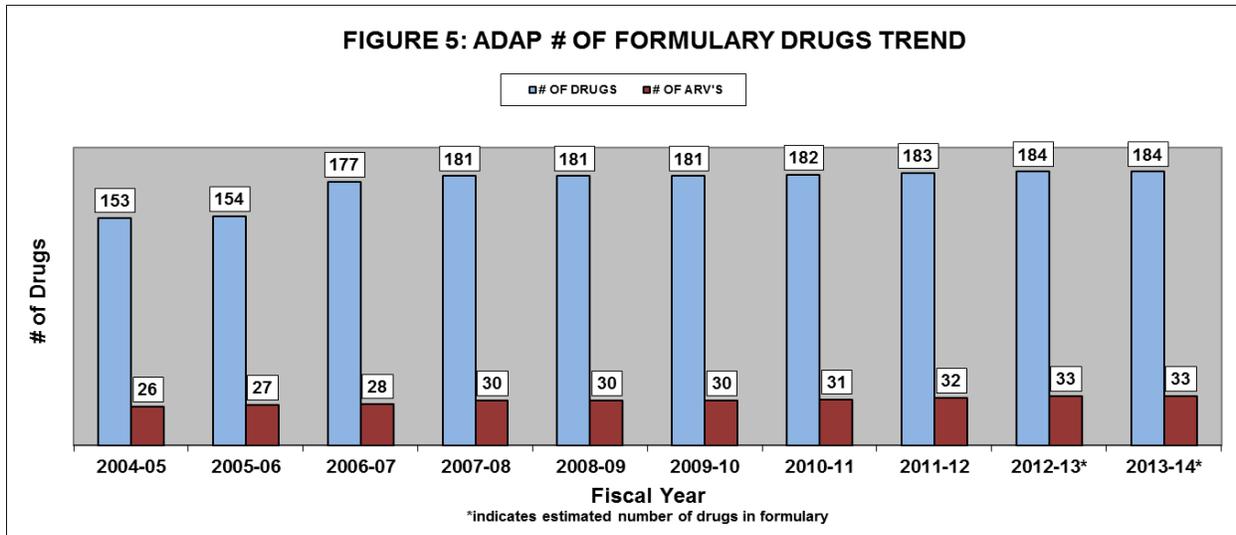
Note: The actual percentage of ADAP clients by payer source/coverage group in FY 2011-12 was applied to the estimated client counts in FYs 2012-13 and 2013-14 to estimate the percentage of clients by payer source. These percentages were then adjusted to account for the shift of ADAP-only clients to OA-PCIP per **RMA 3**, to OA-HIPP per **RMA 4**, and to LIHP per **RMA 1** and **RMA 2**.



Note: Drug expenditures do not include annual administrative support for LHJs or Medicare Part D, OA-HIPP, or OA-PCIP premium payments. For these costs see page 45.



Note: To estimate the number of ARV prescriptions, OA used the percentage of ARV prescriptions in FY 2011-12 and applied it to the estimated drug prescriptions in FYs 2012-13 and 2013-14.



APPENDIX A: EXPENDITURE AND REVENUE ESTIMATE METHODS**Updated Expenditure Estimate for FY 2012-13**

| TABLE 17: LINEAR REGRESSION MODEL FOR GOVERNOR'S BUDGET FOR FY 2012-13 COMPARED TO BUDGET ACT FY 2012-13 | | | |
|---|--|--|---|
| Revised Estimate FY 2012-13 | Estimate from Budget Act FY 2012-13 | Change from Previous Est (\$) | Change from Previous Est (%) |
| \$532,085,397 | \$553,903,775 | -\$21,818,377 | -3.94% |

New Expenditure Estimate for FY 2013-14

| TABLE 18: LINEAR REGRESSION MODEL FOR GOVERNOR'S BUDGET FOR FY 2013-14 COMPARED TO BUDGET ACT FY 2012-13 | | | |
|---|--|--|---|
| Governor's Budget FY 2013-14 | Estimate from Budget Act FY 2012-13 | Change from Previous Est (\$) | Change from Previous Est (%) |
| \$589,082,084 | \$553,903,775 | \$35,178,309 | 6.35% |

Linear Regression Model – Expenditure Estimates

The linear regression methodology is similar to the method used to estimate expenditures for FYs 2011-12 and 2012-13 in the *2012-13 May Revision* with two changes: 1) we used the updated range of actual expenditures, from October 2009 through September 2012; and 2) three additional pre-regression adjustments were made for OA-HIPP, LIHP, and OA-PCIP (**RMA 7**). Using a more recent set of actual expenditure data to predict future expenditures allowed us to “fine tune” our previous estimates. Actual expenditures were lower than the estimated values previously predicted by the regression model used for FY 2012-13 in the *2012-13 May Revision*, which resulted in the lower expenditure estimate for FY 2012-13 as shown in **Table 15**, page 31.

Figure 6, page 39, shows ADAP historic expenditures by month used in the linear regression model. The regression line (red) represents the best fitting straight line for estimating the expenditures:

- During normal growth periods, a linear regression model should accurately predict expenditures (the red regression line goes straight through the data points).

- During low growth periods, a linear regression model would overestimate expenditures (the red regression line goes over the data points).

During high growth periods, a linear regression model using the point estimate would underestimate expenditures (the red regression line goes under the data points). Thus, given the recent relatively high growth expenditure period beginning in FY 2007-08 (not shown in the figure), and the desire not to underestimate the need for ADAP to utilize the ADAP SF to address increasing expenditures, we continue to use the upper bound of the 95 percent confidence interval around the point estimate for our regression estimates. This is the same strategy used during the previous estimate development.

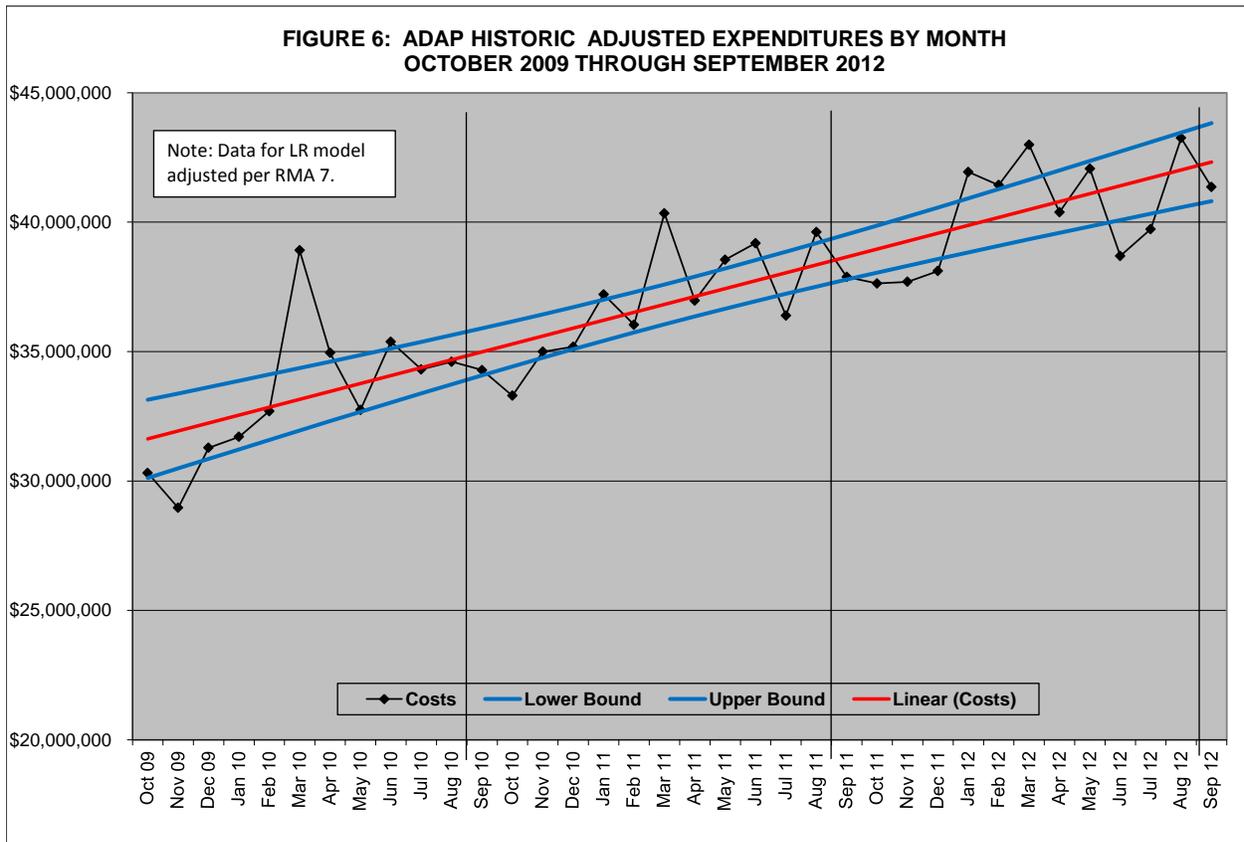


Table 19 displays historic drug expenditures by FY, annual change, and percent change.

| TABLE 19: ADAP HISTORIC AND PROJECTED DRUG EXPENDITURES | | | |
|---|--------------------------|--------------------------------------|--------------------------|
| (*Data for FY 2012-13 and FY 2013-14 are projected, all other data are actuals) | | | |
| Fiscal Year | Expenditures | Annual Change in Expenditures | Pct Annual Change |
| 1997-98 | \$86,674,336 | N/A | N/A |
| 1998-99 | \$98,924,742 | \$12,250,405 | 14.13% |
| 1999-00 | \$119,465,151 | \$20,540,409 | 20.76% |
| 2000-01 | \$144,913,504 | \$25,448,353 | 21.30% |
| 2001-02 | \$167,709,426 | \$22,795,922 | 15.73% |
| 2002-03 | \$187,854,138 | \$20,144,712 | 12.01% |
| 2003-04 | \$220,101,760 | \$32,247,622 | 17.17% |
| 2004-05 | \$247,299,716 | \$27,197,956 | 12.36% |
| 2005-06 | \$243,096,942 | -\$4,202,774 | -1.70% |
| 2006-07 | \$254,977,392 | \$11,880,450 | 4.89% |
| 2007-08 | \$306,590,832 | \$51,613,440 | 20.24% |
| 2008-09 | \$355,786,400 | \$49,195,569 | 16.05% |
| 2009-10 | \$413,035,251 | \$57,248,851 | 16.09% |
| 2010-11 | \$454,426,055 | \$41,390,804 | 10.02% |
| 2011-12 | \$473,684,504 | \$19,258,449 | 4.24% |
| 2012-13* | \$453,585,727 | -\$20,098,777 | -4.24% |
| 2013-14* | \$414,887,392 | -\$38,698,335 | -8.53% |
| Total Average | FY 97-98 to 13-14 | \$20,513,316 | 10.66% |

Note: Drug costs include administrative costs at the pharmacy and PBM level. Drug costs do not include annual administrative support for LHJs or Medicare Part D, OA-HIPP, or OA-PCIP premium payments. For these costs see FCS (**Table 15**, page 31).

Notes: In FY 2005-06, ADAP expenditures decreased for the first time due to the enrollment of ADAP clients in Medicare Part D starting in January 2006. This also resulted in a lower than average increase in expenditures in FY 2006-07. The annual percentage increase in expenditures has decreased in FYs 2010-11 and 2011-12 because of the elimination of jail clients and the changes to TrOOP in FY 2010-11. Additionally, the decreases of 4.24 percent and 9.21 percent for FY's 2012-13 and 2013-14 are mainly due to LIHP.

ADAP Rebate Revenue Estimate Method

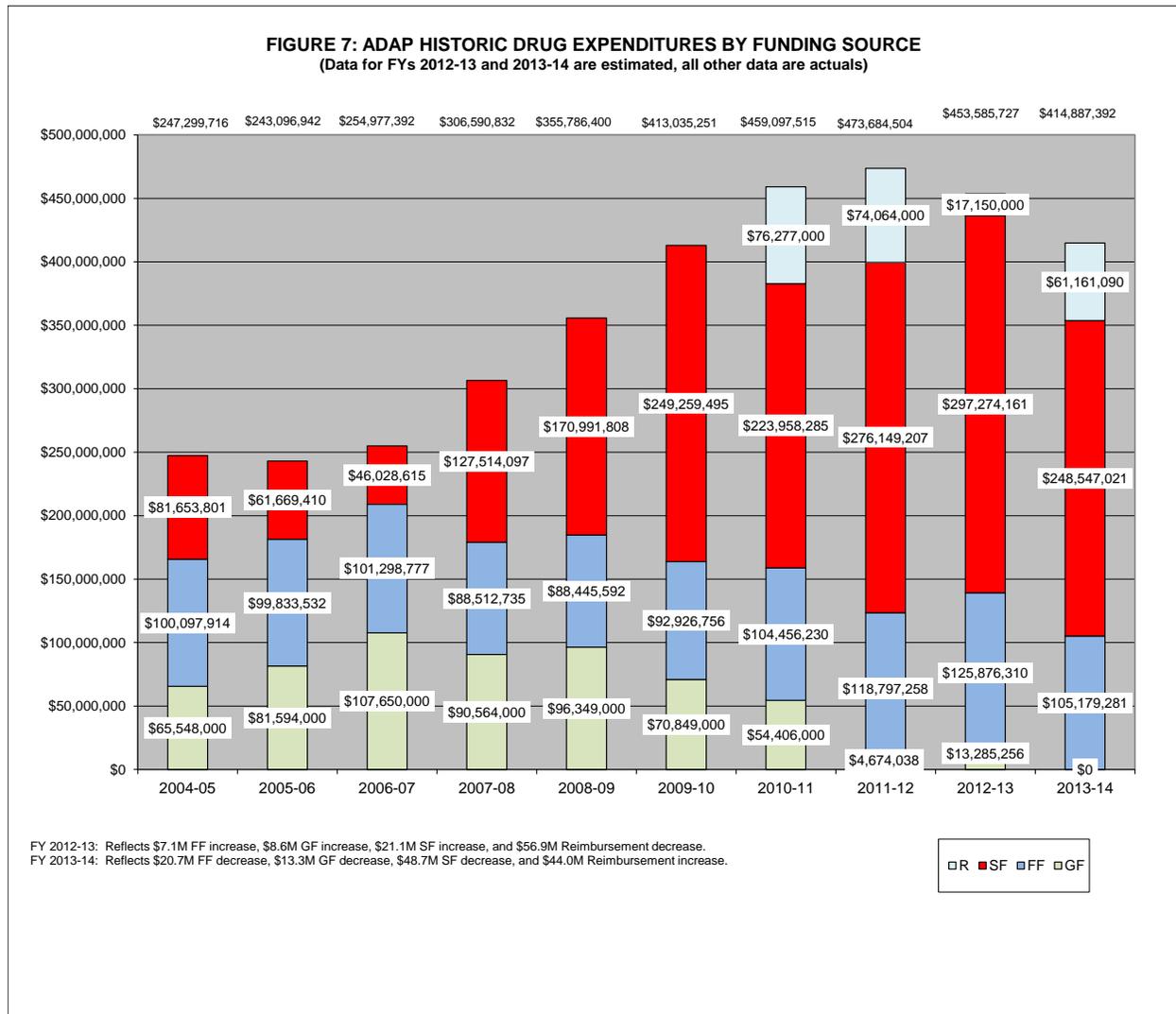
To forecast future revenue, the rebate revenue estimate method applies the expected revenue collection rate to estimated or actual expenditures (whichever is more current). The revenue collection rate has been increased from 56 percent to 60 percent (see **RMA 5**, page 26). Estimated revenue for a given FY is based on drug expenditures during the last two quarters of the previous FY and the first two quarters of the current FY. This six-month delay is necessary to take into account the time required for billing the drug manufacturers and receipt of the rebate. Revenue projections are adjusted to reflect assumptions and other adjustments that can increase or decrease revenues.

Revenue estimates for FY 2012-13 in the *FY 2013-14 Governor's Budget* were developed using actual rebates (\$83,115,835) collected for the period January through March 2012, actual expenditures for April through June 2012 and estimated expenditure for July through December 2012 (See **Table 15**, page 31). A 60 percent rebate collection rate was applied to the actual and estimated expenditures of \$386,034,019 to arrive at estimated revenue of \$231,620,411, for a total revenue of \$314,736,246. The resulting estimated revenue was then adjusted due to the fiscal impact of revised assumptions to arrive at \$307,738,999.

Revenue for the *FY 2013-14 Governor's Budget* for FY 2013-14 was based on updated estimated expenditures for the period January through December 2013 applying the 60 percent rebate collection rate to arrive at the revenue projection of \$336,350,244 and adjusted for revised assumptions of \$285,003,921.

It should be noted that the revenue estimate method uses average expenditures for each six-month period and does not directly take into account the seasonal behavior of expenditures. Historical data show that drug expenditures are lower in the first half of the FY (July through December) compared to the second half.

APPENDIX B: FUND SOURCES



General Fund

For FY 2012-13, the GF appropriation is used for the purchase of prescription drugs and insurance premiums for eligible clients. Due to the RW Payer of Last Resort provision, GF is used by ADAP and insurance assistance programs to cover the costs associated with clients eligible for other public assistance programs, including Medi-Cal and LIHP. In FY 2012-13, GF also pays the transaction fees invoiced by ADAP's PBM contractor for the administrative costs associated with managing prescription transactions that are ultimately identified as not eligible for ADAP payment.

The FY 2012-13 total GF appropriation is \$16,875,412, the same amount as the FY 2012-13 Budget Act. Due to estimated decreased expenditures in FY 2013-14, OA will return the FY 2012-13 Budget Act GF appropriation of \$16,875,412 in FY 2013-14.

Federal Fund

Federal funding from the annual HRSA grant award through RW includes both "Base" funding and "ADAP Earmark" funding. The Base award from the grant provides funds for care and support programs within OA. The Part B Earmark award must be used for ADAP-related services only. The RW award is predicated upon the State of California meeting Maintenance of Effort (MOE) and match requirements. Non-compliance with these requirements will result in withholding a portion (match) or the entire (MOE) Part B Federal grant award to California.

For FY 2012-13, ADAP received an additional increase of \$2,606,818 in Earmark Federal funding for a total of \$105,179,281 as well as four one-time fund awards: RW Part B ADAP Supplemental Grant of \$8,425,807, RW Part B Supplemental Award of \$2,129,954, competitive continuation ERF Award of \$3,141,268 million and new competitive ERF Award of \$7 million. These funds are one-time and must be spent by March 31, 2013. Total ADAP federal funds are approximately \$125.9 million in FY 2012-13.

Match

HRSA requires grantees to have HIV-related non-HRSA expenditures. California's 2012 HRSA match requirement for FY 2012-13 funding is \$70,606,470. OA will meet the match requirement by using GF expenditures from OA as well as the California Department of Corrections and Rehabilitation and the California HIV/AIDS Research Program.

MOE

HRSA requires grantees to maintain HIV-related expenditures at a level that is not less than the prior FY. California's MOE target, based on FY 2010-11 expenditures at the time of the Year 2012 HRSA grant application, is \$502,476,676. Expenditures included in California's MOE calculations are not limited to OA programs and include HIV-related

expenditures for all state agencies able to report GF expenditures specific to HIV-related activities such as care, treatment, prevention, and surveillance. In 2009, HRSA stated that expenditures from SF may be used towards the MOE requirement. On November 16, 2012, HRSA released a policy letter affirming that drug rebates can be used for either the federal match or MOE requirement but not both.

Reimbursement

On February 1, 2010, CMS approved DHCS's proposed amendment to the Special Terms and Conditions, amended October 5, 2007. The amendment incorporates federal flexibilities to expand DHCS's ability to claim additional State expenditures to utilize Federal funding under SNCP. DHCS used certified public expenditures from various programs, including ADAP, to claim Federal funds. CDPH will receive \$17,150,000 of these funds from DHCS as a reimbursement for FY 2012-13 and \$66,339,340 for FY 2013-14 (see **RMA 8**, page 28). DHCS recently informed OA that SNCP funds are not restricted and therefore may be used for expenditures not allowable under the RW Payer of Last Resort provision. Thus, in FY 2013-14, OA will utilize SNCP funds to cover the costs associated with clients eligible for other public assistance programs, including Medi-Cal and LIHP and to cover the costs of transaction fees invoiced by ADAP's PBM contractor for the administrative costs associated with managing prescription transactions that are ultimately identified as not eligible for ADAP payment.

ADAP SF 3080

The use of this fund is established under both State law and Federal funding guidance. The ADAP SF was legislatively established in 2004 to support the provision of ADAP services. California Health and Safety (H&S) Code, Section 120956, which established the ADAP SF, states in part:

“... (b) All rebates collected from drug manufacturers on drugs purchased through the ADAP implemented pursuant to this chapter and, notwithstanding Section 16305.7 of the Government Code, interest earned on these moneys shall be deposited in the fund exclusively to cover costs related to the purchase of drugs and services provided through ADAP ...”

ADAP receives both mandatory and voluntary supplemental rebates for drugs dispensed to ADAP clients; the original rebate law required by H&S Code, Section 120956, subsequent Federal (Medicaid) rebate law, and the latter nationally negotiated voluntary rebate established with individual drug manufacturers. Though these rebates constitute a significant part of the annual ADAP budget, the exact amount of rebate to be collected on an annual basis varies due to a number of factors, including quarterly changes in the Federal calculation for the mandatory rebate due on the part of the manufacturer and the “voluntary” nature of the supplemental rebates.

Supplemental rebates (rebates beyond those required by the Federal Medicaid rebate law) are negotiated on an ongoing basis by ACTF (see **RMA 5**, page 26). ACTF is a national rebate negotiating coalition working on behalf of all state ADAPs. ACTF enters into voluntary, confidential supplemental rebate agreements with drug manufacturers.

Though these agreements are entered into in good faith by both parties, there is no guaranteed continuation of the voluntary supplemental rebate. The agreements are generally entered into for an average term of one to two years but the drug manufacturer or the program can cancel the voluntary supplemental rebate agreement at any time with a 30-day written notice. Additionally, the rebate agreements are highly confidential and any unauthorized disclosure could invalidate the agreements, resulting in serious national implications for all state ADAPs.

Supplemental rebate agreements are in place for all ARVs on the ADAP formulary. This is significant, as ARV drugs' represented 93 percent of all ADAP drug expenditures in FY 2011-12. Supplemental rebate agreement terms are generally based on either:

- 1) an additional rebate percentage; and/or
- 2) a price freeze.

Currently, all the ADAP supplemental agreements will expire on December 31, 2013. It is unknown to what extent, if any, drug manufacturers will extend the agreements beyond this date. For information on the impact of federal health care reform refer to Future Fiscal Issue 3, page 50.

SF budget authority for LHJs and premium payments is requested as follows:

- \$2 million in FYs 2012-13 and 2013-14 to LHJs to help offset the costs of ADAP enrollment and eligibility screening for clients at enrollment sites located throughout the state. Annual allocations are based on the number of ADAP clients enrolled during the previous calendar years;
- \$1 million for the Medicare Part D Premium Payment Program in both fiscal years. This program assists eligible clients in paying their Part D monthly premiums allowing them to receive the Part D benefit;
- \$875,403 and \$596,068 to cover premium payments for OA-PCIP in FY 2012-13 and FY 2013-14 respectively; and
- \$7,533,330 and \$12,014,477 to cover premium payments for OA-HIPP in FY 2012-13 and FY 2013-14 respectively.

Additional Rebate Percentage

The mandatory Federal Medicaid 340B rebate is based on a percentage of the average manufacturers price (AMP), plus any penalties for any price increases that exceed the inflation rate for the Consumer Price Index (CPI). Since AMP is confidential and not publicized, the resulting rebate amount is also unknown to ADAP. ACTF negotiations

usually result in an additional voluntary, supplemental rebate based on a percentage of AMP. For example, if the current mandatory 340B rebate for brand drugs is 23 percent of AMP and ACTF has negotiated a supplemental rebate of 2 percent of AMP from Manufacturer X for Drug Y, then ADAP receives a total rebate of 25 percent of AMP for that drug.

“Price Freeze” Rebates

The “price freeze” option is another type of voluntary rebate offered by some manufacturers to compensate ADAP for commercial price increases. Currently, of the available ARV medications on the ADAP formulary, 11 are subject to a price freeze rebate. These 11 drugs represented 43 percent of ADAP drug expenditures in FY 2012-13. If the manufacturers impose a price increase that exceeds CPI (inflation rate) while the ADAP price freeze is in effect, the program reimburses retail pharmacies at the new higher price. Though this initially results in higher expenditures for the program, these price freeze agreements eventually offset the cost by increased rebates subsequently received and deposited in the SF.

ADAP Rebate Invoicing

ADAP invoices the manufacturers for drug rebates on a quarterly basis, consistent with both Federal drug rebate law and drug industry standards. All ADAPs are required to invoice drug manufacturers within 90 days of the end of a given calendar year quarter (e.g., January through March, April through June, etc.) in compliance with Federal requirements. ADAP mails drug rebate invoices approximately 30 days after the end of the quarter. For example, the January through March quarter invoice is sent out May 1. The time between the end of the billing quarter and the mailing of the invoice is necessary to generate and confirm the accuracy of the rebate invoices.

Timeframe for Receipt of Rebates

Federal HRSA guidance on ADAP rebate indicates that drug manufacturers are to pay rebate invoices from ADAP within 90 days of receipt. Federal Medicaid rebate law requires that drug manufacturers pay drug rebates within 30 days of receipt of a rebate invoice. Historically, the majority of drug manufacturers have paid rebates more closely to the Medicaid payment timeframe, usually within 30 to 60 days. However, receipt of rebate payments due for calendar year 2011 indicate the manufacturers are more closely following the HRSA timeframe of 90 days when processing ADAP rebate invoices. Due to the above invoicing requirements and rebate payment timeframes, ADAP generally receives drug rebates five to eight months after program expenditures. Consequently, rebate due on expenditures in the second half of a given FY may not be received until the subsequent FY.

| FY-QTR | \$ Drugs Purchased | Received in Rebate \$ | Received / Purchased |
|---------------|---------------------------|------------------------------|-----------------------------|
| 2002-03-Q1 | \$46,263,616 | \$10,136,693 | 21.91% |
| 2002-03-Q2 | \$46,714,748 | \$10,257,857 | 21.96% |
| 2002-03-Q3 | \$47,028,955 | \$10,146,224 | 21.57% |
| 2002-03-Q4 | \$47,846,818 | \$10,846,426 | 22.67% |
| 2003-04-Q1 | \$51,607,688 | \$12,275,494 | 23.79% |
| 2003-04-Q2 | \$51,732,389 | \$15,045,513 | 29.08% |
| 2003-04-Q3 | \$56,857,403 | \$17,801,378 | 31.31% |
| 2003-04-Q4 | \$59,904,280 | \$19,249,713 | 32.13% |
| 2004-05-Q1 | \$61,533,761 | \$19,334,264 | 31.42% |
| 2004-05-Q2 | \$60,894,584 | \$18,691,012 | 30.69% |
| 2004-05-Q3 | \$61,680,181 | \$19,176,357 | 31.09% |
| 2004-05-Q4 | \$63,191,190 | \$15,847,186 | 25.08% |
| 2005-06-Q1 | \$63,433,758 | \$21,866,164 | 34.47% |
| 2005-06-Q2 | \$62,536,173 | \$20,624,121 | 32.98% |
| 2005-06-Q3 | \$58,562,814 | \$26,768,577 | 45.71% |
| 2005-06-Q4 | \$58,564,197 | \$25,095,840 | 42.85% |
| 2006-07-Q1 | \$60,334,084 | \$24,791,394 | 41.09% |
| 2006-07-Q2 | \$58,609,374 | \$24,489,071 | 41.78% |
| 2006-07-Q3 | \$67,474,884 | \$32,724,197 | 48.50% |
| 2006-07-Q4 | \$68,559,050 | \$31,734,710 | 46.29% |
| 2007-08-Q1 | \$68,797,779 | \$33,524,051 | 48.73% |
| 2007-08-Q2 | \$71,581,717 | \$35,262,749 | 49.26% |
| 2007-08-Q3 | \$81,926,045 | \$44,200,318 | 53.95% |
| 2007-08-Q4 | \$84,285,291 | \$39,834,969 | 47.26% |
| 2008-09-Q1 | \$82,366,671 | \$36,272,892 | 44.04% |
| 2008-09-Q2 | \$85,997,429 | \$38,043,925 | 44.24% |
| 2008-09-Q3 | \$93,564,283 | \$46,300,283 | 49.48% |
| 2008-09-Q4 | \$93,858,017 | \$40,827,251 | 43.50% |
| 2009-10-Q1 | \$98,508,463 | \$44,718,090 | 45.40% |
| 2009-10-Q2 | \$95,842,924 | \$44,131,629 | 46.05% |
| 2009-10-Q3 | \$109,578,075 | \$55,921,629 | 51.03% |
| 2009-10-Q4 | \$109,105,788 | \$55,287,500 | 50.67% |
| 2010-11 -Q1 | \$108,993,239 | \$56,542,420 | 51.88% |
| 2010-11-Q2 | \$109,126,234 | \$60,631,590 | 55.56% |
| 2010-11-Q3 | \$117,756,733 | \$69,851,359 | 59.32% |
| 2010-11-Q4 | \$118,549,848 | \$67,568,412 | 57.00% |
| 2011-12-Q1 | \$113,894,685 | \$65,603,727 | 57.60% |
| 2011-12-Q2 | \$113,441,625 | \$66,274,179 | 58.42% |
| 2011-12 -Q3 | \$126,356,874 | \$83,115,835 | 65.78% |

| TABLE 21: COMPARISON OF REVENUE BETWEEN 2013-14 Governor's Budget and 2012-13 Budget Act | | | | | | |
|--|-----------------------------|--------------------|-----------------------------|-----------------------|---------------|------------|
| UPDATED ESTIMATE FOR FY 2012-13 | | | | | | |
| Expenditure Period | Available Data | FY 2012-13 Revised | Available Data | FY 2012-13 Budget Act | Change (\$) | Change (%) |
| Jan - Mar 2012 | Actual Rebates | \$83,115,835 | Estimated Expenditures @50% | \$64,363,622 | \$18,752,213 | 29.13% |
| Apr - Jun 2012 | Actual Expenditures @ 60% | \$71,994,792 | Estimated Expenditures @50% | \$64,363,622 | \$7,631,170 | 11.86% |
| Jul- Dec 2012 | Estimated Expenditures @60% | \$159,625,619 | Estimated Expenditures@50% | \$138,475,944 | \$21,149,675 | 15.27% |
| Subtotal Revenue Prior to Adjustments | | \$314,736,246 | | \$267,203,188 | \$47,533,058 | 17.79% |
| Total Adjustments Due to Assumptions | | -6,997,247 | | \$17,319,853 | -\$24,317,100 | -140.40% |
| Subtotal Revenue After Adjustments | | \$307,738,999 | | \$284,523,041 | \$23,215,958 | 8.16% |
| Interest | | \$120,000 | | \$120,000 | \$0 | 0.00% |
| Total Revenue (see Table 15, Fund Condition Statement) | | \$307,858,999 | | \$284,643,041 | \$23,215,958 | 8.16% |

| ESTIMATE FOR FY 2013-14 | | | | | | |
|---|------------------------------|------------------------------|--|--------------------|---------------|------------|
| Expenditure Period | Available Data | FY 2013-14 Governor's Budget | Available Data (Expenditure Period) | FY 2012-13 Revised | Change (\$) | Change (%) |
| Jan - Jun 2012 | Estimated Expenditures @ 60% | \$159,625,619 | Actual Rebate (Jan - March 2012) Actual Expenditures @60% (April - June 2012) | \$155,110,627 | \$4,514,992 | 2.91% |
| Jul - Dec 2012 | Estimated Expenditures @ 60% | \$176,724,625 | Estimated Expenditures @60% (Jul - Dec 2012) | \$159,625,619 | \$17,099,006 | 10.71% |
| Subtotal Revenue Prior to Adjustments | | \$336,350,244 | | \$314,736,246 | \$21,613,998 | 6.87% |
| Total Adjustments Due to Assumptions | | -51,346,323 | | -\$6,997,247 | -\$44,349,076 | 633.81% |
| Subtotal Revenue after Adjustments | | \$285,003,921 | | \$307,738,999 | -\$22,735,078 | -7.39% |
| Interest | | \$120,000 | | \$120,000 | \$0 | 0.00% |
| Total Revenue (see Table 15, Fund Condition Statement) | | \$285,123,921 | | \$307,858,999 | -\$22,735,078 | -7.38% |

*Note: When actual rebate data are not available, revenue projection methodology is based on a percentage of actual expenditures (if available) or estimated expenditures. This method does not take into account the seasonal fluctuations between the first half of the FY (when expenditures are lower) and the second half (when expenditures are higher).

APPENDIX C: POTENTIAL FUTURE FISCAL ISSUES

ADAP continues to monitor policy issues and drugs that have the potential to impact the fiscal condition of ADAP. These issues can occur within the State and Federal arenas as well as the private sector. Because the future fiscal impact may be difficult to estimate, ADAP assesses the status of these issues on an ongoing basis. These issues are summarized below:

1. 2014 Medi-Cal Expansion

Under the PPACA, effective January 1, 2014, states have the option to expand their Medicaid programs to include individuals between the ages of 19 to 64 years, regardless of disability status, with eligibility based on FPL. For ADAP, there will be a minimal impact in FY 2013-14 because most ADAP clients who will be eligible for Medi-Cal (California Medicaid) Expansion will have already left ADAP and transitioned to LIHP (a Federal 1115 Waiver project, administered by DHCS). LIHP clients who qualify for the Medi-Cal Expansion will transition on January 1, 2014.

Medi-Cal Expansion will only affect ADAP clients who did not enroll in LIHP prior to January 2014 because: 1) their income exceeded the limits of their county-specific LIHP MCE FPL threshold; or 2) they resided in the two counties that did not participate in LIHP (Fresno and San Luis Obispo Counties).

Although the PPACA income limit for Medicaid Expansion is 133 percent FPL by statute and includes an "income disregard" with an effective income limit of up to 138 percent FPL, each state will determine whether or not they will choose to implement Medicaid Expansion. It is unknown at the time of this writing what California's Medi-Cal Expansion plan will be.

ADAP will implement a bi-annual re-certification process during FY 2012-13 which will result in clients being screened every six months for potential Medi-Cal Expansion eligibility in 2014 and referred to apply, as appropriate.

Predicted Fiscal Impact: Increased ADAP savings (fiscal +).

2. Potential Savings Due to Cross Match of ADAP Client Data to Medi-Cal Eligibility Data Systems (MEDS)

Federal requirements stipulate that federal RW grant funds are to be used solely as a payer of last resort. As such, clients that are enrolled in DHCS' Medi-Cal program and who have no SOC are not eligible for ADAP unless they are receiving benefits through Medicare Part D. However, ADAP clients who are required to apply for Medi-Cal can temporarily receive ADAP benefits while pending a Medi-Cal eligibility determination. ADAP clients with a Medi-Cal SOC only (no Medicare Part D) are eligible for ADAP to the extent that ADAP will pay their ADAP formulary drug costs up

to the SOC amount, using non-Ryan White funds. Client screening during the annual ADAP enrollment and re-certification process attempts to identify those individuals that have other third-party payer resources. However, it is possible that an individual may enroll in Medi-Cal or other public benefit programs during the interim period between ADAP re-certification's without notification to ADAP.

To minimize the possibility of paying for medications that should be billed to Medi-Cal, OA is developing an interagency agreement with DHCS that will allow for a monthly transfer of ADAP client data to DHCS to conduct a match with MEDS client data. A comparison with MEDS will identify ADAP clients that are also Medi-Cal clients and whether or not they have a SOC. Clients identified as enrolled in Medi-Cal with no SOC and who do not also have Medicare will be terminated from ADAP with a notation made that they are enrolled in Medi-Cal. When these clients arrive at an ADAP pharmacy to get their medications, the medications will then be billed to Medi-Cal rather than to ADAP. To the extent allowable under Medi-Cal, OA will also re-coup any prior ADAP expenditures for these clients through a pharmacy back-billing process by the ADAP PBM.

Predicted Fiscal Impact: Increased ADAP savings (fiscal +).

3. California Health Benefits Exchange (HBEX): Impact of the PPACA Insurance Mandate on ADAP and OA-HIPP.

Currently, there are millions of California residents who are living without health insurance because they have been denied coverage due to a pre-existing condition and/or cannot afford to pay exorbitant monthly health insurance premiums. This population includes thousands of ADAP-only clients (clients who have no other payer and ADAP pays 100 percent of the cost of their ADAP medications).

Two key provisions of the PPACA will significantly alter the health insurance landscape and will have a significant impact on ADAP: enforcement of the Individual Mandate and the creation of HBEX. Beginning in January 2014, all residents legally residing in California, including thousands of ADAP clients, will be required to enroll in a health care plan that meets basic minimum standards or provide proof they have an existing comparable health care plan. Individuals who do not comply with the mandate will be subject to a penalty assessment. HBEX will be a government-regulated health insurance marketplace where individuals can purchase affordable and qualified health insurance. Health insurance plans in HBEX will not be permitted to deny coverage or charge higher premiums to individuals because they have a pre-existing condition such as HIV/AIDS.

OA can anticipate a significant reduction in ADAP expenditures because thousands of eligible ADAP-only clients will be required to purchase health insurance that will be readily available through HBEX. This will result in a dramatic reduction in drug expenditures because ADAP will no longer be paying the full cost for the client's

ADAP medications. Some of this reduction in drug expenditures is already being captured because four counties (Alameda, Contra Costa, Orange, and Ventura) implemented HCCI under LIHP, a Federal Medicaid 1115 Waiver program. HCCI is an optional benefit level under LIHP that counties may elect to offer clients with incomes between 134 and 200 percent of FPL. ADAP clients in the four LIHP counties that offer HCCI are transitioning out of ADAP into LIHP before the January 2014 implementation of HBEX. These LIHP/HCCI clients will either be eligible for transition to HBEX upon its implementation or will transition to Medi-Cal Expansion (see **Future Fiscal Issue 1**, page 49 for detail on this latter benefit).

At this time, OA does not have enough information to project the fiscal impact HBEX will have on ADAP. Details about monthly premiums and prescription deductibles and co-payments for plans in HBEX are not yet available; although it is known that an advanced Federal tax credit to offset the cost of the insurance premiums will be available to all individuals who earn 138-400 percent FPL. The amount of the tax credit will be income-based, with clients with lower incomes being eligible for larger credits. Though ADAP will continue to pay client private insurance prescription deductibles and co-pays, it is unknown what proportion of these partial pay claims may be eligible for rebate collection by OA. Further Federal clarification is needed.

However, even though OA anticipates a reduction in ADAP drug expenditures, it also anticipates an increase in insurance assistance programs expenditures and associated workload because many ADAP-only clients will need assistance to pay for the new health insurance premiums, including the previously enrolled HCCI clients who transition to HBEX. OA administers the OA-HIPP, OA-PCIP, and Medicare Part D Premium Payment Programs. In July 2011, OA implemented OA-HIPP which was an expansion of the Comprehensive AIDS Resources Emergency (CARE/HIPP) program. The most notable program change was the elimination of the HIV-related disability requirement to make the program available to more people living with HIV, including the ADAP-only clients. OA also implemented OA-PCIP in November 2011 without additional resources or staffing. Both programs were implemented as cost containment measures because overall State expenditures are reduced when an ADAP-only client enrolls in either program. Since July 2011, the number of clients served by the insurance assistance programs has increased dramatically, resulting in a significant increase in workload. The insurance assistance program is at maximum capacity with existing resources and staffing and is struggling to meet the demand of the current workload. OA will not be able to handle the increased need for premium assistance once private health insurance becomes readily available through HBEX with current staffing levels and resources.

In order to ensure that the ADAP-only clients are seamlessly transitioned into HBEX and to maximize the reduction in overall State expenditures, OA will determine if we can modify the existing contract with the PBM to include the administration of all the insurance assistance programs, starting July 1, 2013, or if OA will need to enter into a new contract to perform this function. This request is consistent with other states that use a vendor to administer their ADAP and insurance premium payment programs,

including Colorado, Hawaii, Missouri, Delaware, Tennessee, Louisiana, Massachusetts, and Washington.

The contractor would be responsible for the insurance assistance program and fiscal management, including tracking applications and paying monthly premiums. OA staff would serve as contract monitors to ensure compliance with program policy and ensure enhanced quality control and security. With contractors handling the administration of ADAP and the insurance premium payment programs, OA would be able to ensure that all eligible ADAP-only clients are seamlessly transitioned into HBEX. This would result in a large reduction in overall expenditures because once the ADAP-only clients acquire health insurance ADAP will no longer be paying the full cost of the client's HIV-related medications.

Because the PCIP program will end after December 31, 2013, OA-PCIP clients with an income between 138-400 percent FPL will transition to HBEX. This will result in the elimination of OA-PCIP expenditures for these clients in the third and fourth quarters of FY 2013-14. OA expects to have an estimate of ADAP savings and insurance assistance program expenditures available for the *2013-14 May Revision*.

Predicted fiscal impact: Increased insurance assistance programs expenditures plus decreased ADAP and OA-PCIP expenditures = net cost decrease (fiscal +).

4. Effect of Dual Demonstration Project (Medi-Cal Managed Care Plans) on ADAP

Senate Bill 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012) authorized DHCS to establish a demonstration project to enable dual eligible beneficiaries (eligible for services through Medi-Cal and Medicare) to receive health care services via a health care model that coordinates the benefits of the Medicare and Medi-Cal programs. This restructuring in effect changes the DHCS delivery of care and treatment services for these beneficiaries from fee for service to managed care plans. The demonstration project, which includes eight counties (Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara), is scheduled to begin no earlier than March 2013 but no later than June 2013 and is intended to expand statewide within three years of the start of the project.

DHCS will enroll all dual eligible beneficiaries into a managed care plan unless the beneficiary chooses to opt out. The demonstration project includes an exemption that allows beneficiaries who have been diagnosed with HIV/AIDS to opt out of the demonstration project at the beginning of any month and a provision that allows clients of the AIDS Healthcare Foundation to remain in their current plan. Beneficiaries who are enrolled in the Medi-Cal Waiver program are also excluded from the demonstration project. The authorizing legislation gives DHCS the authority to decide whether or not a demonstration managed care plan will be required to cover client premiums, co-insurance, co-payments, and deductibles for Medicare Part D services.

If HIV-positive dual beneficiaries remain in (do not opt out of) the demonstration project, the effect on ADAP depends on whether or not these dual beneficiary ADAP clients will still be responsible for their Medicare Part D out of pocket prescription costs. It is our understanding that dual-eligible clients in the demonstration will still be responsible for medication co-pays. However, in order for ADAP to cover these clients' out of pocket prescription costs, the dispensing managed care plan pharmacy must also be an ADAP pharmacy. It is not yet known to what degree the managed care plan pharmacies and the ADAP pharmacy network will intersect, but preliminary data shows that the overlap will be approximately 85 percent. If there is insufficient intersect and ADAP is limited in its ability to pay these out of pocket prescription costs, ADAP expenditures and the associated rebate collected on those drugs will both be reduced. The latter potential revenue reduction could be significant, as ADAP collects full rebate on these partial pay claims. However, not enough information is known at this time to develop an impact estimate.

An additional consequence of the demonstration project is the potential reduction in Medicare Part D Premium Payment Program expenditures. The program may be reduced significantly if clients participating in the demonstration project are no longer responsible for paying their Part D premiums.

Should there be a fiscal impact to ADAP or the Medicare Part D Premium Payment Program, it is likely it will not be realized until FY 2013-14 since the demonstration project will begin at the earliest in March 2013. If a fiscal impact is identified, OA will estimate this for the *2013-14 May Revision*.

Predicted fiscal impact: Unknown at this time.

5. Additional 2012 RW Federal Grant Funds.

CDPH requested a carry-over request to HRSA in October 2012 for \$1.55 million of unspent funds from the 2011 RW Part B Grant to utilize for ADAP expenditures in the current year.

Predicted fiscal impact: Increased ADAP Resources (fiscal +).

6. Renegotiated Supplemental Rebate Expires December 31, 2013.

Beginning in December 2011, the ACTF announced new supplemental rebate agreements with all ARV drug manufacturers. All of the agreements end December 31, 2013. At this time, it is unknown if the supplemental rebate agreements will be extended and/or to what degree the rebate terms may be renegotiated beyond December 31, 2013, given implementation of PPACA. However, in November 2012, the ACTF met with drug manufacturers to initiate discussion on the feasibility of extending supplemental agreements beyond the current expiration date. It is anticipated that new supplemental rebate negotiations may take place in mid-2013.

Predicted fiscal impact: Unknown at this time.

New Drugs Added to the ADAP Formulary

Combination elvitegravir/cobicistat/emtricitabine/tenofovir (Stribild, sometimes referred to in the past as the “Quad” pill) – U.S. Food and Drug Administration (FDA) Approved.

Combination elvitegravir/cobicistat/emtricitabine/tenofovir (Stribild), a new one-pill-a-day, four drug combination ARV, was FDA approved on August 27, 2012. The net price (after mandatory and ACTF-negotiated supplemental rebates) that all state ADAPs will pay is considerably less than the public wholesale acquisition cost, and is less than the price of three of the four recommended HIV treatment regimens. Therefore, the addition of combination elvitegravir/cobicistat/emtricitabine/tenofovir to the ADAP formulary is expected to be cost neutral. Combination elvitegravir/cobicistat/emtricitabine/tenofovir was added to the formulary on September 26, 2012.

New Drugs that May be Available in the Next Three Years

Possible FDA Approval of Elvitegravir.

Elvitegravir is an investigational integrase inhibitor therapy that is in Phase III clinical trials. If approved, elvitegravir will offer a once-daily dosing option for integrase inhibitors, as compared to the currently available raltegravir, which requires dosing twice daily. Once FDA approved, there may be a shift from current raltegravir users to elvitegravir because of the reduced dosing requirement. In addition, patients may switch from once a day protease inhibitors (PI) and non-nucleoside reverse transcriptase inhibitors once a daily integrase inhibitor is available. This drug is also part of the previously discussed “Quad” formulation. The manufacturer submitted a New Drug Application (NDA) to the FDA for elvitegravir on June 27, 2012. If approved, ADAP will monitor pricing and supplemental rebate negotiations closely and follow the procedures outlined above regarding the addition of a new ARV to the ADAP formulary.

Possible FDA Approval of Cobicistat.

Cobicistat is being developed both as a pharmacokinetic booster for the integrase inhibitor elvitegravir and as a booster for PIs. Unlike other boosters used in ARV therapies, cobicistat does not have anti-HIV activity on its own. The Phase II study compared efficacy and safety of cobicistat (150 mg) with that of the existing booster ritonavir (100 mg daily). The Phase III clinical trial further studied cobicistat as a PI booster. This drug is also part of the previously discussed “Quad” formulation. The manufacturer submitted an NDA to the FDA on June 28, 2012. If approved, ADAP will monitor pricing and supplemental rebate negotiations closely and follow the procedures outlined above regarding the addition of a new ARV to the ADAP formulary.

Dolutegravir

Dolutegravir, a second generation integrase inhibitor with activity against raltegravir resistant and elvitegravir-resistant HIV, is in Phase III clinical trials. In March 2012, the manufacturer released Phase III clinical trial results that indicate once-daily dosing, along with two non-nucleoside reverse transcriptase inhibitors, was associated with good treatment responses at 96 weeks. ADAP will continue to monitor the drug's development.

Apricitabine

Apricitabine, an investigational nucleoside reverse transcriptase inhibitor, originally had its development halted in May 2010 after the manufacturer failed to find a licensing partner. In March 2011, the manufacturer reached an agreement with FDA to receive credit for previous clinical trials and the drug company has indicated plans to move forward with Phase III trials. There is currently no listing for open apricitabine studies in the federal clinical trials database. Avexa has subsequently decided to resume development of the drug subject to further financing. ADAP will continue to monitor the drug's development.

APPENDIX D: CURRENT HIV/AIDS EPIDEMIOLOGY IN CALIFORNIA**HIV Prevalence**

Prevalence reflects the number of people who are currently infected with HIV and thus who could qualify for ADAP currently or sometime in the future. California estimates that between 154,137 and 167,844 persons will be living with HIV/AIDS in California at the end of 2012, as seen in **Table 22**, below. This estimate includes people who are HIV positive but are not yet diagnosed by applying a national estimate of those unaware of their infection status developed by the Centers for Disease Control and Prevention (CDC). CDC estimates 18.1 percent of all HIV-infected persons are unaware of their infection. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and six dependent areas, 2010. *HIV Surveillance Supplemental Report 2012*;17[No. 3, part A].

<http://www.cdc.gov/hiv/topics/surveillance/resources/reports/>. Published June 2012. Accessed October 1, 2012). Living HIV/AIDS cases are estimated to be 45.0 percent White, 18.3 percent African American, 31.6 percent Latino, 3.7 percent Asian/Pacific Islander, 0.4 percent American Indian/Alaskan Native, and 1.0 percent Multi-racial. The results of a CDC algorithm that estimates the distribution of living cases with respect to mode of HIV exposure applied to California data show most (64.5 percent) of California's estimated living HIV/AIDS cases are attributed to male-to-male sexual transmission, 11.7 percent to injection drug use, 12.9 percent to heterosexual transmission, 9.9 percent to men who have sex with men who also inject drugs, 0.5 percent to perinatal exposure, and 0.5 to other or unknown sources.

The number of living HIV/AIDS cases in the state is expected to grow by approximately 2 percent (with a range of 2,800–5,400) each year for the next two years and it is expected that this increasing trend will continue for the foreseeable future. This increase is attributed to stable incidence rates and longer survival of those infected, primarily due to the effectiveness and availability of treatment.

| Year | Estimated persons to be reported with HIV (not AIDS) and presumed living* | | Persons reported with AIDS and presumed living | | Estimated persons living with HIV or AIDS** | |
|------|---|------------|--|------------|---|------------|
| | Low bound | High bound | Low bound | High bound | Low bound | High bound |
| 2010 | 45,856 | 51,501 | 69,210 | 70,036 | 148,681 | 157,084 |
| 2011 | 46,363 | 53,399 | 71,023 | 72,191 | 151,367 | 162,507 |
| 2012 | 46,896 | 55,271 | 72,875 | 74,305 | 154,137 | 167,844 |
| 2013 | 47,444 | 57,128 | 74,748 | 76,399 | 156,953 | 173,136 |
| 2014 | 48,000 | 58,977 | 76,634 | 78,480 | 159,796 | 178,401 |

*Assumes names-based HIV reporting system (established April 2006) is mature and meets CDC completeness standards

**Includes persons unreported and/or persons unaware of their HIV infection

HIV Incidence

Incidence is a measure of new infections over a specified period of time (typically a year) and thus provides an indication of the future need for ADAP support. Most people get tested infrequently, so incidence estimates largely rely on modeling. California estimates 5,000–7,000 new HIV infections annually. This estimate was developed through:²

- A series of “consensus conferences” convened in California in 2000 that developed population estimates of HIV incidence; and
- Downward adjustment of the “consensus conference” estimate based upon observed reported HIV cases in the code based HIV surveillance system; numbers observed to date in the names-based HIV surveillance system are consistent with this adjustment.

Recent advances have made estimation of HIV incidence possible using remnant blood samples from people found to be HIV antibody positive. In 2004, CDC began a national effort to measure incidence using state-of-the-art technology on these remnant samples. Results of this effort were first reported in the August 2008 issue of *Journal of the American Medical Association*¹ and *Morbidity and Mortality Weekly Report*,² and CDC has subsequently provided updated national incidence estimates through 2009.³ California data have yet to be included in calculating national estimates because names-based HIV reporting was required to be in effect for all of 2006 for inclusion in the most recent CDC paper, and it did not start in California until April 2006. The 95 percent confidence interval for the 2008 and 2009 national estimates (41,800 to 53,800 new infections and 42,200 to 54,000 new infections, respectively) are consistent with the 5,000 to 7,000 range OA estimated for California in 2005, suggesting new HIV infections have been relatively steady in recent years.

California has implemented HIV Incidence Surveillance using the CDC-developed Serologic Testing Algorithm for Recent HIV Seroconversion methodology. The initial estimates of California incidence for 2009 and 2010 based on the data and methodology provided by CDC are as follows:

2009: Estimated infections = 5,330 (95% confidence interval 4,408 to 6,252)

2010: Estimated infections = 5,598 (95% confidence interval 4,576 to 6,621)

Data from this system will be used to revise California incidence estimates in the coming years as more years are estimated.

¹ Hall HI, Song R, Rhodes P, et al. Estimation of HIV incidence in the United States. *JAMA* 2008;300(5):520–9.

² Subpopulation Estimates from the HIV Incidence Surveillance System — United States, 2006. *MMWR* 2008;57(36):1073-1076.

³ Prejean J, Song R, Hernandez A, Ziebell R, Green T, et al. (2011) Estimated HIV Incidence in the United States, 2006–2009. *PLoS ONE* 6(8): e17502. doi:10.1371/journal.pone.0017502.

APPENDIX E: SENSITIVITY ANALYSIS**FY 2012-13**

ADAP conducted a sensitivity analysis exploring the impact on total expenditures by increasing and decreasing the number of clients and the expenditures per client (\$/client). For this sensitivity analysis, we started with the estimated total drug expenditures for FY 2012-13 using the upper bound of the 95 percent confidence interval from the linear regression model and subtracted cost/savings for all assumptions impacting drug expenditures.

For these factors, clients and expenditures per client, we created scenarios ranging from negative 3 percent to positive 3 percent, in 1 percent intervals. Those scenarios labeled as “Hi” represent 3 percent, “Med” represent 2 percent, and “Lo” represents a 1 percent change. The left column in **Table 23**, below, lists the seven (including no change) scenarios for changes in \$/client, starting with the best case scenario {3 percent decrease in \$/client, Hi(-)} and finishing with the worst case scenario {3 percent increase in \$/client, Hi(+)}. The seven scenarios for changes in client counts are listed across the table.

| \$ / Client Scenarios | Number of Client Scenarios | | | | | | |
|-----------------------------------|-----------------------------------|-------------------|------------------|-------------------------------|------------------|-------------------|------------------|
| | Hi (-) CI | Med (-) CI | Lo (-) CI | Zero Change in Clients | Lo (+) CI | Med (+) CI | Hi (+) CI |
| Hi (-): Best | \$426,934,670 | \$431,308,871 | \$435,683,071 | \$440,057,272 | \$444,431,472 | \$448,805,673 | \$453,179,873 |
| Med (-) | \$431,308,871 | \$435,728,166 | \$440,147,462 | \$444,566,757 | \$448,986,052 | \$453,405,348 | \$457,824,643 |
| Lo (-) | \$435,683,071 | \$440,147,462 | \$444,611,852 | \$449,076,242 | \$453,540,632 | \$458,005,022 | \$462,469,413 |
| Zero Change in \$ / Client | \$440,057,272 | \$444,566,757 | \$449,076,242 | \$453,585,727 | \$458,095,212 | \$462,604,697 | \$467,114,182 |
| Lo (+) | \$444,431,472 | \$448,986,052 | \$453,540,632 | \$458,095,212 | \$462,649,792 | \$467,204,372 | \$471,758,952 |
| Med (+) | \$448,805,673 | \$453,405,348 | \$458,005,022 | \$462,604,697 | \$467,204,372 | \$471,804,047 | \$476,403,721 |
| Hi (+): Worst | \$453,179,873 | \$457,824,643 | \$462,469,413 | \$467,114,182 | \$471,758,952 | \$476,403,721 | \$481,048,491 |

The center cell highlighted in light blue shows the revised estimated expenditures for FY 2012-13, using the 95 percent confidence interval from the linear regression model and adjusted for all assumptions. The best case scenario, which is a 3 percent decrease in \$/client coupled with a 3 percent decrease in the number of clients, results in an estimate of \$426.93 million (top left cell, light green). The worst case scenario, a 3 percent increase in \$/client coupled with a 3 percent increase in number of clients, results in an estimate of \$481.05 million (bottom right cell, red). The table provides a range of values to assist in projecting the total expenditures for FY 2012-13.

FY 2013-14

Below is the sensitivity analysis for FY 2013-14, using the same logic that was used for FY 2012-13. In this sensitivity analysis, ADAP adjusted for several assumptions that impacted ADAP's FY 2013-14 total expenditures and total client count. Similar to the FY 2012-13 sensitivity analysis, we started with the estimated total drug expenditures for FY 2013-14 using the upper bound of the 95 percent confidence interval from the linear regression model. Then we subtracted savings for all assumptions. The "baseline" or center cell, highlighted in light blue below, reflects all adjustments to the linear regression expenditure projection. **Table 24**, below, provides a range of values to assist in projecting the total expenditures for FY 2013-14.

| \$ / Client Scenarios | Number of Client Scenarios | | | | | | |
|---------------------------------------|-----------------------------------|-------------------|------------------|-----------------------------------|------------------|-------------------|------------------|
| | Hi (-) CI | Med (-) CI | Lo (-) CI | Zero Change in Clients | Lo (+) CI | Med (+) CI | Hi (+) CI |
| Hi (-): Best | \$387,642,130 | \$391,608,340 | \$395,574,550 | \$399,540,761 | \$403,506,971 | \$407,473,182 | \$411,439,392 |
| Med (-) | \$391,608,340 | \$395,615,439 | \$399,622,538 | \$403,629,638 | \$407,636,737 | \$411,643,836 | \$415,650,935 |
| Lo (-) | \$395,574,550 | \$399,622,538 | \$403,670,526 | \$407,718,514 | \$411,766,502 | \$415,814,490 | \$419,862,478 |
| Zero Change in \$ / Client | \$399,540,761 | \$403,629,638 | \$407,718,514 | \$414,887,392 | \$415,896,268 | \$419,985,144 | \$424,074,021 |
| Lo (+) | \$403,506,971 | \$407,636,737 | \$411,766,502 | \$415,896,268 | \$420,026,033 | \$424,155,799 | \$428,285,564 |
| Med (+) | \$407,473,182 | \$411,643,836 | \$415,814,490 | \$419,985,144 | \$424,155,799 | \$428,326,453 | \$432,497,107 |
| Hi (+): Worst | \$411,439,392 | \$415,650,935 | \$419,862,478 | \$424,074,021 | \$428,285,564 | \$432,497,107 | \$436,708,650 |