AIDS DRUG ASSISTANCE PROGRAM

2025-26

May Revision Estimate

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I. Program Overview

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

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

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

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

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

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

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

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

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

II. Estimate Methodology

The ADAP Estimate uses a Cost Per Client methodology to estimate expenditure and revenue associated with medication and insurance assistance services as they relate to changes in the volume of activity. This methodology looks at two input variables, the number of clients served and cost per service/expenditures per client, to calculate the estimated number of expenditures for service provided. Forecasts are modeled conservatively, with the objective of reducing the risk of underestimating budget needs.

A. Expenditure Forecasts

Program data describing client counts and costs per client are summarized by month and insurance coverage group and combined with external cost drivers which account for trends in current and historical program growth, changes in pharmacy utilization, administrative policies, and seasonal effects.

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

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

Total costs are estimated by multiplying the expected cost per client by the expected number of clients per month.

B. Revenue Forecasts

Revenue is estimated based on the results of the expenditure forecasts, historical rebate payment amounts, average time between medication dispense, and receipt of rebate payments.

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

III. Estimate Overview

The 2025-26 ADAP May Revision Estimate provides revised projections of 2024-25 and 2025-26 Local Assistance costs for medication, health insurance premiums, medical out-of-pocket costs, administrative costs associated with pharmacy, insurance and medical benefits management services, and ADAP enrollment site payments. Total estimated budget authority needs for 2024-25 and 2025-26, below, include all assumptions.

Table 1 displays the estimated ADAP Local Assistance budget authority need for 2024-25 (column C) and 2025-26 (column G) and compares that need to the amount reflected in the 2025-26 Governor's Budget (column B for 2024-25, and column F for 2025-26). The Budget Act of 2018 authorized an ongoing $2 million in budget authority to modify and expand PrEP-AP which is included with the ADAP Rebate Fund (Fund 3080) budget authority need detailed below.

- 2024-25: OA estimates the ADAP budget authority need will be $356.3 million ($241.1 million ADAP Rebate Fund (Fund 3080) and $115.2 million Federal Trust Fund (Fund 0890)), which is $36.2 million lower than reported in the 2025-26 Governor's Budget (Table 1). The 9.2 percent decrease is driven primarily by lower medication and insurance premium expenditures than previously estimated (Table 7).
- 2025-26: OA estimates the ADAP budget authority need will be $411.7 million ($301.4 million ADAP Rebate Fund (Fund 3080) and $110.3 million Federal Trust Fund (Fund 0890)), which is $50.6 million lower than reported in the 2025-26 Governor's Budget (Table 1). The 10.9 percent decrease is driven primarily by the same factors above (Table 10).

Table 2 displays the estimated ADAP revenue for 2024-25 (column C) and 2025-26 (column G) and compares them to the amount reflected in the 2025-26 Governor's Budget (columns B for 2024-25 and column F for 2025-26).

- 2024-25: OA estimates ADAP revenue will be $341.3 million (Table 2), $11.7 million higher than reported in the 2025-26 Governor's Budget. The 3.5 percent increase is driven primarily by higher rebate percentages in fiscal year (FY) 2023-24 that make up the projected revenue in FY 2024-25.
- 2025-26: OA estimates ADAP revenue will be $312.7 million (Table 2), $7 million lower than reported in the 2025-26 Governor's Budget. The 2.2 percent decrease is driven primarily by decreased rebates due to lower medication expenditures than previously estimated.

California Department of Public Health
AIDS Drug Assistance Program and PrEP Assistance Program
2025-26 May Revision
Table 1: Local Assistance Budget Authority
(In Thousands)

Local Assistance	2025-26 Governor's Budget: Current Year 2024-25	Current Year 2024-25			2025-26 Governor's Budget: Budget Year 2025-26	Budget Year 2025-26		
		May Revision	$ Change from Governor's Budget	% Change from Governor's Budget		May Revision	$ Change from Governor's Budget	% Change from Governor's Budget
(A)	(B)	(C)	(D) =(C)-(B)	(E) = (D)/(B)	(F)	(G)	(H) = (G)-(F)	(I) = (H)/(F)
Total Funds Requested	**$392,507**	**$356,302**	**-$36,205**	**-9.2%**	**$462,276**	**$411,693**	**-$50,583**	**-10.9%**
Federal Trust Fund - Fund 0890	$115,230	$115,230	$0	0.0%	$110,263	$110,263	$0	0.0%
ADAP Rebate Fund - Fund 3080	$277,277	$241,072	-$36,205	-13.1%	$352,013	$301,430	-$50,583	-14.4%
Caseload	34,243	31,522	-2,721	-7.9%	37,488	36,744	-744	-2.0%

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly. ADAP Rebate Fund - Fund 3080 authority includes an ongoing $2 million from the 2018 Budget Act.

2025-26 May Revision
Table 2: ADAP Rebate Fund (Fund 3080) Revenues
(In Thousands)

Revenue	2025-26 Governor's Budget: Current Year 2024-25	Current Year 2024-25			2025-26 Governor's Budget: Budget Year 2025-26	Budget Year 2025-26		
		May Revision	$ Change from Governor's Budget	% Change from Governor's Budget		May Revision	$ Change from Governor's Budget	% Change from Governor's Budget
(A)	(B)	(C)	(D) =(C)-(B)	(E) = (D)/(B)	(F)	(G)	(H) = (G)-(F)	(I) = (H)/(F)
Total Revenue Requested	**$329,581**	**$341,256**	**$11,675**	**3.5%**	**$319,674**	**$312,724**	**-$6,950**	**-2.2%**
ADAP Rebate Fund - Fund 3080	$311,493	$323,168	$11,675	3.7%	$301,586	$294,636	-$6,950	-2.3%
Interest Income	$18,088	$18,088	$0	0.0%	$18,088	$18,088	$0	0.0%

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

IV. Summary of Expenditures and Revenue

A. Expenditure Types

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

a) Health care expenditures include prescription medication costs for drugs on the ADAP formulary (including deductibles, copays, and co-insurance), health insurance premiums, and medical out-of-pocket costs (e.g., deductibles and copays for physician visits, laboratory tests, etc.). Estimated variable expenditures by client group are shown in Table 3. A detailed display of caseload and expenditures by client group and service type is in Section VI, Tables 5 – 10.

b) Administrative expenditures include costs associated with pharmacy, insurance and medical benefits management services; and payments to local ADAP and PrEP-AP enrollment sites for services needed to enroll and maintain clients in ADAP and PrEP-AP. Administrative expenditure estimates are adjusted annually through the ADAP Estimate, based on caseload and service type projections. Estimated variable expenditures for administrative services are also shown in Table 3.

TABLE 3: ESTIMATED VARIABLE EXPENDITURES BY CLIENT GROUP		
CLIENT GROUP	**EXPENDITURES**	
	FY 2024-25	**FY 2025-26**
Medication-Only	$199,527,999	$218,969,711
Medi-Cal SOC	$1,185,940	$1,637,978
Private Insurance	$108,589,944	$133,976,598
Medicare	$17,924,609	$17,335,700
PrEP-AP	$15,494,563	$23,539,968
SUBTOTAL	**$342,723,055**	**$395,459,955**
Admin: ADAP	$4,789,103	$5,268,014
Admin: PrEP-AP	$5,403,013	$5,430,998
Admin: Enrollment	$7,760,500	$8,270,500
Health Management Systems (HMS)	-$16,373,540	-$14,736,186
Early Action Package	$10,000,000	$10,000,000
TOTAL	**$354,302,131**	**$409,693,280**
Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.		

B. Revenue and Federal Grants

a) ADAP Special Funds – ADAP receives both mandatory and voluntary supplemental rebates from drug manufacturers for ADAP medication expenditures. An approximate six-month delay in receipt of rebate revenue, from the time the medication expenditure occurs, exists because of the time required for billing the drug manufacturers. 2024-25 revenue projections are based on actual and estimated rebates from actual and estimated medication expenditures from January through December 2024. 2025-26 revenue projections are based on estimated rebates from estimated medication expenditures from January through December 2025.

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

- 2024-25: Total federal fund budget authority is projected to be $115.2 million (Table 1), no change from what was reported in the 2025-26 Governor's Budget. Federal fund budget authority includes the following federal grant assumptions:
  - 2024 Ryan White Part B: $94.7 million
  - 2024 Ryan White Part B Supplemental: $9 million
  - 2024 ADAP Emergency Relief Funds (ADAP Shortfall Relief): $6.6 million
  - 2023 Ryan White Part B Carryover: $5 million

- 2025-26: Total federal fund budget authority is projected to be $110.3 million (Table 1), no change from what was reported in the

2025-26 Governor's Budget. Federal fund budget authority includes the following estimated federal grant funding:

- 2025 Ryan White Part B: $94.7 million
- 2025 Ryan White Part B Supplemental: $9 million
- 2025 ADAP Emergency Relief Funds (ADAP Shortfall Relief): $6.6 million

c) Federal Match – HRSA requires grantees to have HIV-related non-HRSA expenditures. OA meets the match requirement using ADAP Rebate Fund (Fund 3080) expenditures. California's HRSA match requirement for the 2024 Ryan White Part B grant budget period (April 1, 2024, through March 31, 2025) is $69.2 million.

V. Assumptions

Future Fiscal Issue

Enhanced Premium Tax Credit Expiring

Background: Changes made to premium tax credits in the American Rescue Plan of 2021 and extended by the Inflation Reduction Act of 2022 have assisted individuals in purchasing health insurance through ACA marketplaces such as Covered California. The increased premium tax credits led to a surge in ACA marketplace insurance sign-ups and helped achieve historically low rates of uninsured individuals. However, the improved premium tax credits will end after 2025 and Congress needs to extend them by spring of 2025 to prevent any adverse effects on marketplace enrollment, as insurers and regulators require time to adjust premium rates. If Congress does not extend the improved tax credits, most marketplace enrollees across all states will experience a considerable increase in premium expenses.

Description of Change: If the improved tax credits are not extended in the spring of 2025, ADAP can expect to pay higher premiums for clients who are concurrently enrolled in the Office of AIDS (OA)-Health Insurance Premium Payment Program (OA-HIPP) and a Covered California health plan in January 2026.

Discretionary: No

Reason for Change/Adjustment:
- Federal requirement

Fiscal Impact and Fund Source: The fiscal impact is currently unknown. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

New Assumptions

PrEP-AP Lab Fee Reimbursement Rate Increase

Background: To meet the HIV prevention needs of Californians who are uninsured or underinsured, PrEP-AP contracts with clinical providers who agree to provide PrEP-related clinical services at agreed upon reimbursement rates. PrEP-AP currently contracts with 70 clinical entities and is attempting to recruit more providers in underserved areas including the Central Valley and rural Northern California. Clinical providers have indicated that PrEP-AP's lab reimbursement rates are a barrier and deterrent to becoming a contracted PrEP-AP Clinical

Provider, as rates are often below the cost that the clinic pays to their lab for testing. To ensure PrEP access is preserved for Californians, CDPH has allowed for case-by-case exceptions for clinical providers with documented lab costs that exceed PrEP-AP rates. Exceptions have been made for 25 of the 70 contracted PrEP-AP Clinical Providers, who otherwise would have labs costs that are reimbursed at a rate that is below their actual costs.

PrEP-AP is now providing inequitable reimbursements for lab testing and is at risk of losing current clinical sites that are losing money on PrEP-AP lab testing and who do not have the bandwidth to move through completing the time-consuming exception process with the state. In addition, recruiting new PrEP-AP clinical providers has been difficult with low reimbursements for lab testing being mentioned as a barrier for clinical providers because people on PrEP require frequent testing (every 3 months) for HIV and sexually transmitted infections. One example is Kern County which has the second highest rate of new HIV diagnoses per year in the state (21.8 new diagnoses per 100,000 population in 2022) but only one PrEP-AP provider at the county health department.

PrEP-AP proposes increasing our ceiling lab reimbursement rate for all PrEP-AP clinical providers to make our reimbursements equitable (not variable contract by contract) and transparent, and to facilitate recruitment of new PrEP-AP clinical providers in the Central Valley and rural areas of the state. The lab reimbursement rates will be based on Centers for Medicare & Medicaid Services (CMS) reimbursement rates and adjusted to meet the actual lab costs that providers share with CDPH as documented in their third-party lab contracts.

Timely access to lab testing and PrEP initiation is essential for preventing HIV transmission. These increased reimbursement rates will result in lab testing costs but also more people initiating PrEP and averting HIV infection. In the long-term, averting HIV infections helps keep Californians healthy and avoids long-term HIV-related healthcare costs. This change represents a necessary step to expand PrEP-AP provider participation and ensure PrEP-AP can fulfill its mission to provide equitable, cost-effective, and sustainable access to HIV prevention services across the state.

Description of Change: PrEP-AP requests an increase in the published ceiling rate for reimbursements, effective July 1, 2025. With this higher published rate, individual exemptions for lab reimbursements can be discontinued. CDPH anticipates that these higher published lab reimbursement rates will attract and retain more clinical providers in the long term. This adjustment will not have a large financial impact on the program in the short-term as most providers are already reimbursed at these higher contracted rates via their individual contract exceptions. In the long term, CDPH expects this change to result in more PrEP-AP clinical providers initiating PrEP for more patients which has a fiscal impact

consistent with the goals of the program to expand critical PrEP-AP services across California.

Discretionary: Yes

Reason for Adjustment/ Change:

- Streamline PrEP-AP Clinical Provider Application process
- Increase lab service provider participation
- Increase contractor and client satisfaction due to increased lab service provider participation

Fiscal Impact and Fund Source(s): There is no estimated fiscal impact for 2024-25. For 2025-26, the estimated fiscal impact is $700,000 for 1,683 clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Potential Change in Federal Funds: 2025 Ryan White Part B Grant

Background: The HRSA Ryan White Part B grant is a non-competitive grant and the largest of the three federal grants from which ADAP receives funding. Grant funding is appropriated in five, 12-month grant budget periods that run from April 1 to March 31. Within the five-year funding cycle, funding from year to year is provided if the program remains eligible and submits all reporting requirements in a timely manner.

Description of Change: On November 18, 2024, OA applied for the 2025 Ryan White Part B grant, the fourth year of the latest five-year funding cycle. The total funding requested in the grant application was $139.9 million, of which $94.7 million is designated ADAP Local Assistance. OA anticipates receiving the notice of award in late March 2025.

Discretionary: Yes

Reason for Change/Adjustment:

- Fully leverage federal funding

Fiscal Impact and Fund Source: The fiscal impact is currently unknown. The fund impacted is the Federal Trust Fund (Fund 0890).

Potential Change in Federal Funds: 2025 ADAP Emergency Relief Funds Grant (ADAP Shortfall Relief Grant)

Background: The HRSA ADAP Emergency Relief Funds grant (ADAP Shortfall Relief grant) is intended for states/territories that demonstrate the need for additional resources to prevent, reduce and/or eliminate ADAP waiting lists through

implementation of cost-containment measures. OA cost-containment measures include maintaining data match agreements to safeguard ADAP as the payer of last resort.

The following table displays the historical grant application amounts for which OA has applied, and the total funds awarded per grant budget period:

Table 4: ADAP Emergency Relief Funds (Shortfall Relief) Grant		
Grant Budget Period	Application Amount	Total Funds Awarded
2021 (04/01/2021 – 03/31/2022)	$7,000,000	$5,307,130
2022 (04/01/2022 – 03/31/2023)	$7,000,000	$5,850,650
2023 (04/01/2023 – 03/31/2024)	$7,000,000	$6,433,858
2024 (04/01/2024 – 03/31/2025)	$7,000,000	$6,584,874
2025 (04/01/2025 – 03/31/2026)	$7,000,000	TBD

Description of Change: On October 30, 2024, OA applied for the competitive 2025 ADAP Emergency Relief Funds grant. The total funding requested in the grant application was the maximum amount of $7 million, all of which is designated ADAP Local Assistance. OA anticipates receiving the notice of award in late February 2025.

Discretionary: Yes

Reason for Change/Adjustment:
- Competitive funding opportunity
- Prior funding does not guarantee future funding

Fiscal Impact and Fund Source: The fiscal impact is currently unknown. The fund impacted is the Federal Trust Fund (Fund 0890).

Existing Assumptions

ADAP Open Formulary

Background: ADAP's mission is to provide HIV-related prescription drugs to low-income PWH who have limited or no prescription drug coverage. ADAP directly pays for the cost of medications that are covered on the California ADAP formulary (https://cdph.primetherapeutics.com/cms/cdph/static-assets/documents/formulary-and-documents/CDPH_Formulary.pdf) for people who only have ADAP coverage and pays for the copay for these medications for people who have primary comprehensive insurance (e.g., Covered California or Medicare). In the 1990s, the focus of ADAP was to pay for expensive HIV

antiretroviral (ARV) medications to keep people alive. As HIV treatments have improved, PWH are living longer and healthier lives.

Medical needs have also shifted from a need to treat opportunistic infections that occur without HIV treatment to a need to treat medical conditions (e.g., high cholesterol) that are common in people as they age. Now 55.7 percent of PWH in California are 50 years of age or older and 15.6 percent are 65 years of age or older. As PWH have aged, their number of comorbid medical conditions has increased exponentially with a resultant need for additional medications to treat these additional medical conditions (e.g., diabetes, hypertension, hypothyroidism).

ADAP currently has a closed formulary meaning that medications are added one at a time after a review of the cost implications, approval from the CDPH Director, and approval in an annual estimate if the cost is significant. This model leads to a restrictive, basic level of coverage and the current ADAP formulary has 319 medications (including 47 HIV ARV medications). By contrast, an open formulary covers all Food & Drug Administration (FDA)-approved medications except for medications that have been specifically excluded from the formulary (usually due to high cost or safety issues).

Medi-Cal is an example of an open formulary as all FDA-approved drugs are added to the formulary and Medi-Cal decides which drugs to exclude from coverage. To quantify the difference in these formularies, the ADAP formulary is 13 pages long and the Medi-Cal formulary is 244 pages long. Many PWH move between Medi-Cal and ADAP depending on year-to-year changes in their income and life circumstances and these drastic differences in medication coverage leads to interruptions and undertreatment of common but serious medical conditions.

Thirteen states, including Illinois, Maryland, New Jersey, Washington, and Oregon, have already expanded their ADAP to an open formulary to help PWH in their states live longer and healthier lives. OA engaged in conversations with these states and determined that a shift to an open formulary is feasible for California's ADAP for three reasons:

1. These states report that, even with their expansion to an open formulary, HIV ARV medications still account for most of the cost to the program. The amount of rebate generated from ARV medications has covered the cost of other medications in their open formularies.
2. People with high medication needs are also highly motivated to navigate to comprehensive insurance in which case ADAP only pays for copays on their medications. People with multiple comorbidities also require specialist

medical appointments, diagnostic studies, and procedures that can only be paid for with comprehensive insurance.

3. These open ADAP formularies exclude the most expensive medications such as tumor necrosis factor (TNF)-alpha blockers, monoclonal antibodies, and recombinant human growth hormone. With the most expensive (non-HIV) medications excluded, these formularies can add access to a very wide range of medications within their allocated budgets.

In addition to the drugs listed in (3.), examples of highest cost medications that would be excluded are: botulinum toxin; compounded medications for infusion; gonadotropin; hyaluronic acid derivatives; synthetic growth hormone; antirheumatic antimetabolites; cosmetic medications; durable medical equipment; erectile dysfunction medications; female sexual dysfunction medications; fertility drugs; herbal medications; injectable muscle relaxants; nutrition supplements; vaccines/immunizing biologicals; weight loss medications; schedule II, III, IV and V controlled substances.

California has always been a leader in access to healthcare and HIV treatment. Opening the ADAP formulary to mirror the Department of Health Care Services (DHCS) Medi-Cal formulary (https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_FINAL.pdf) will be another step toward healthier lives and improved health equity for PWH in California.

As communicated in the 2025-26 November Estimate, Senate Bill (SB) 159 (Chapter 40, Statutes of 2024, Sec. 83) authorized CDPH to implement certain program enhancements, consistent with Health and Safety Code (HSC) § 120955, 120956, 120960, 120972, 120972.1, and 120972.2, to the extent that these activities are an allowable use of the ADAP Rebate Fund. This included modifications to the ADAP formulary (from a closed to an open formulary) that were to begin January 1, 2025, or as soon as technically feasible thereafter. To provide sufficient time for discovery, coordination with ADAP's contractors, and seamless program implementation, ADAP identified FY 2025-26 as technically feasible. Following the FY 2025-26 implementation, the fiscal impact of changing to an open formulary will be ongoing and closely monitored as it is anticipated to result in an increase in expenditures.

Description of Change: Observations of decreasing ADAP client counts subsequently decrease the number of clients that would have access to more drugs from an open formulary. As such, the 2025-26 May Revision client count and cost per client data was refined and reflects a decrease in expenditures compared to the 2025-26 November Estimate.

Discretionary: No

Reason for Adjustment/ Change:

- Legislative requirement
- Ensure access for PWH to medications needed to treat common medical conditions that develop with aging (e.g., diabetes, hypertension, hypothyroidism)
- Align California's ADAP benefits with the level of medication coverage in other states
- Reduce treatment interruptions and undertreatment of common but serious medical conditions for PWH during transitions between Medi-Cal and ADAP
- Provide comprehensive approaches to chronic health to improve patient adherence and overall health outcomes

Fiscal Impact and Fund Source(s): There is no estimated fiscal impact for 2024-25. For 2025-26, the estimated net fiscal impact is $17.4 million ($22.9 million expenditures minus $5.5 million rebate) for 10,333 clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Payments for Medicare Part B Premiums

Background: HRSA permits use of RWHAP funds to pay for Medicare Part B premiums. However, clients receiving Social Security benefits cannot stop their Medicare Part B premium deductions from their benefits. As a result, ADAP does not have a mechanism to make Medicare Part B payments on behalf of clients. Those who do not have Medicare Part B premium deductions from their Social Security benefits, will have their Medicare Part B premiums paid directly.

As communicated in the 2025-26 November Estimate, ADAP requested the authorization to make direct payments to clients to reimburse monthly Medicare Part B premiums for those who have Medicare Part B deductions from the Social Security benefits effective July 1, 2025.

Description of Change: To provide sufficient time for discovery, coordination with ADAP's contractors, and seamless program implementation, OA will start implementing processes for paying Medicare Part B premiums in early 2026 instead of July 1, 2025, as was initially communicated in the 2025-26 November Estimate. The 2025-26 May Revision client count and cost per client data was refined and reflects a decrease in expenditures compared to the 2025-26 November Estimate.

Discretionary: Yes

Reason for Adjustment/ Change:

- Provide mechanism for payments that are approved, but not currently payable
- Continuity of premium assistance when transitioning from private insurance to Medicare
- Encourage clients to complete timely re-enrollments and update contact information

Fiscal Impact and Fund Source(s): There is no estimated fiscal impact for 2024-25. For 2025-26, the estimated fiscal impact is $1.3 million for 1,975 clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

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

Background: Clients eligible for Medicare Premium Payment Program (MPPP) can submit medical out-of-pocket claims for costs associated with Medicare Part B. To qualify for MPPP, ADAP must pay Medicare Part C or Part D premiums. Claims must include proof that Medicare was billed as the primary payer.

As communicated in the 2025-26 November Estimate, clients enrolled in MPPP with Medicare Part B as their only qualifying premium assistance will be able to submit Medicare Part B medical out-of-pocket claims to the ADAP Medical Benefits Manager effective July 1, 2025.

Description of Change: To provide sufficient time for discovery, coordination with ADAP's contractors, and seamless program implementation, OA will start implementing processes for paying Medicare Part B Medical out-of-pocket costs in early 2026 instead of July 1, 2025, as was initially communicated in the 2025-26 November Estimate. The 2025-26 May Revision client count and cost per client data was refined and reflects a decrease in expenditures compared to the 2025-26 November Estimate.

Discretionary: Yes

Reason for Adjustment/ Change:

- Provide comprehensive medical coverage for Medicare clients regardless of their Part C or Part D plan
- Ensure continuity of medical out-of-pocket benefits when transitioning from private insurance to Medicare
- Part B medical out-of-pocket expansion coincides with payment of Part B premiums

Fiscal Impact and Fund Source(s): There is no estimated fiscal impact for 2024-25. For 2025-26, the estimated fiscal impact is $126,000 for 358 clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

ADAP Pilot Program for Jails

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

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

In response to Orange County's request, OA initiated a pilot program in 2021-22 with the Orange County jail. OA, in consultation with the Department of Finance, is expanding the pilot program to other interested county jails after careful consideration of the impact to the ADAP Rebate Fund, both in the short and long term.

OA met with the other interested county jails in the summer of 2022 to understand how they address the transitional needs of PWH who have been incarcerated. OA determined whether each respective jail would be a suitable ADAP jail enrollment site. Prior to becoming an enrollment site, interested county jails will need to submit a new Enrollment Site Application, begin the contracting process with OA, be added to the Pharmacy Benefits Manager Pharmacy Network, and complete the new enrollment worker training. Clients will not be enrolled until a contract is in place and the enrollment worker training is completed.

The 2022-23 May Revision approved seven counties which expressed interest: Orange, Los Angeles, Marin, Riverside, San Francisco, San Luis Obispo, and

Siskiyou. OA has a contract in place with Orange County and continued to conduct outreach to the remaining six counties.

The 2023-24 November Estimate approved addition of three interested counties in conjunction with the seven aforementioned counties: San Bernardino, San Joaquin, and Tuolumne. Additional funding was requested in 2022-23 for the seven counties, and for both the original seven counties and additional three (ten counties total) in 2023-24 following updated information from the counties.

With Orange County's contract in place since 2021-22, outreach efforts continued for five remaining counties (Los Angeles, Riverside, San Francisco, San Joaquin, and Tuolumne); four counties withdrew interest (Marin, San Bernardino, San Luis Obispo, and Siskiyou). As contracts for the remaining counties were not anticipated to be executed until possibly July 2023, the 2022-23 fiscal impact decreased from the 2023-24 November Estimate, reflecting only Orange County expenditures in the 2023-24 May Revision. The 2023-24 fiscal impact reflected six counties total which, due to updated county interest and client count data, decreased in the 2023-24 May Revision compared to the 2023-24 November Estimate.

On July 1, 2023, the ADAP enrollment site contract for San Joaquin County was executed. Los Angeles, Riverside, and San Francisco counties submitted enrollment site applications and proceeded with the contract process. Tuolumne County, the last of the previously approved interested counties, anticipated submitting a completed ADAP enrollment site application after conclusion of internal discussions and prior to the fall of 2023.

Following the end of the Public Health Emergency, ADAP resumed pre-COVID-19 outreach efforts to the remaining 48 counties for renewed interests in the pilot program and a 2024-25 implementation. A total of 25 counties responded to ADAP's outreach. Four of the 25 counties confirmed interest in becoming an ADAP enrollment site, the fiscal impact of which is included in 2024-25: Contra Costa, Sacramento, San Mateo, and Tulare. The remaining 21 counties confirmed they are not interested or unable to participate at this time.

As communicated in the 2024-25 May Revision, outreach efforts continued with Contra Costa, Sacramento, San Mateo, Tulare, and Tuolumne counties; these five counties remained interested but had not submitted ADAP enrollment site applications. No new counties are on record as having expressed interest in becoming ADAP enrollment sites. The 2024-25 May Revision reflected a decrease in projected clients following receipt of a few months of actual client data, subsequently decreasing projected expenditures compared to the 2024-25 November Estimate.

The 2025-26 November Estimate communicated five counties withdrew interest or were unable to participate in the pilot program for jails for FY 2024-25: Contra Costa, San Mateo, Sacramento, Tulare, and Tuolumne. Four counties have approved enrollment site locations and OA continues outreach to encourage enrollment and provide training: Los Angeles, Riverside, San Francisco, and San Joaquin. Orange County remained the only active enrollment site with clients enrolled. Compared to the 2024-25 May Revision, the 2025-26 November Estimate projected a decrease in projected expenditures.

Description of Change: Orange County continues to enroll clients into ADAP. San Joaquin County began enrolling clients into ADAP in July 2024. San Francisco and Riverside counties have approved enrollment sites but have not designated staff to complete training to begin enrolling clients. Enrollment can begin in early 2025 once training is completed. Los Angeles County's enrollment site contract requires updated signatures, causing a slight delay in client enrollment. The 2025-26 May Revision client count and cost per client data was refined and reflects a decrease in 2024-25 expenditures, and an increase in 2025-26 expenditures, compared to the 2025-26 November Estimate.

Discretionary: Yes

Reason for Adjustment/Change:

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

Fiscal Impact and Fund Source(s): For 2024-25, the estimated net fiscal impact of the remaining five approved pilot counties (Orange, Los Angeles, Riverside, San Francisco, and San Joaquin) with staggered implementations is $3.3 million ($4.4 million expenditures minus $1.1 million rebate) for 505 eligible clients. For 2025-26, the estimated net fiscal impact of the same five approved pilot counties is $4.2 million ($9.2 million expenditures minus $5 million rebate) for 548 eligible clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

Full Scope Medi-Cal Coverage for Justice Involved Individuals

Background: On January 26, 2023, California became the first state in the nation to be approved to offer a targeted set of Medicaid (Medi-Cal in California) services to youth and adults in state prisons, county jails, and youth correctional facilities for up to 90 days prior to release. Currently, Medi-Cal services are

generally available only after release from incarceration. Through a federal Medicaid 1115 demonstration waiver, DHCS will establish a coordinated community reentry process that will assist people leaving incarceration to connect to the physical and behavioral health services they need upon release. As codified by Assembly Bill (AB) 133 (Chapter 143, Statutes of 2021), the California Advancing and Innovating Medi-Cal (CalAIM) Initiative's pre-release eligibility and enrollment went live on January 1, 2023, and will help ensure that, if determined eligible, all incarcerated adults and youths within County Correctional Facilities and County Youth Correctional Facilities have access to needed Medi-Cal services upon their re-entry into the community.

Historically, Californians in prisons, jails, and juvenile detention facilities have difficulty accessing health care services after they have been released and are transitioning back into their communities, including PWH. As outlined in Penal Code section 4011.11, the board of supervisors, in consultation with the county sheriff and chief probation officer, respectively, shall designate an entity or entities to assist both county jail inmates and juvenile inmates with the application process for health insurance affordability programs consistent with federal requirements. AB 133 allows jails to help connect an individual to a community-based Medi-Cal provider 90 days prior to their release to ensure they can continue care and treatment once returning to the community. Each county is expected to implement at different points in time as they work with Medi-Cal to create an implementation plan for Medi-Cal services within their respective county jails. Starting no sooner than April 2024, individuals would be able to receive up to 90 days of Medi-Cal coverage prior to being released from a public institution, including medication coverage.

Through ADAP's pilot program for jails, ADAP provides medication assistance to qualifying detainees at local county jails. ADAP does not provide services for individuals incarcerated in youth correctional facilities or adults in state prisons.

Individuals enrolled in ADAP's pilot program for jails who are due to be released from jail may be enrolled into Medi-Cal pre-release services 90 days prior to release, if eligible. ADAP's pilot program for jails is currently implemented in Orange and San Joaquin County.

Individuals who are granted pre-release services will be disenrolled from ADAP by their Enrollment Worker to safeguard ADAP as the payor of last resort. ADAP will back-bill Medi-Cal for dual enrolled clients via the established Medi-Cal Eligibility Data System (MEDS) match process. OA anticipates a gradual uptake of ADAP clients found on the MEDS match which will result in a cost savings for ADAP as Medi-Cal will be back-billed for these services.

On December 8, 2023, OA was informed that DHCS pre-release services commencing April 1, 2024, are postponed until October 1, 2024. At that time, each correctional facility will have a two-year period to implement the 90-day pre-release services, between October 1, 2024, and September 20, 2026. Due to the postponed implementation, the 2024-25 May Revision reflects a decrease in projected clients, subsequently decreasing projected savings compared to the 2024-25 November Estimate.

The 2025-26 November Estimate client count and cost per client data was refined and reflected a decrease compared to the 2024-25 May Revision.

Description of Change: While OA was informed that several counties have implemented the DHCS pre-release services, this effort continues focusing on the five counties set to participate in the ADAP Pilot Program for Jails, that of which San Joaquin implemented in January 2025, and Orange implemented in April 2025. The 2025-26 May Revision client count and cost per client data was refined and reflects a decrease in expenditures compared to the 2025-26 November Estimate.

Discretionary: No

Reason for Adjustment/Change:

- Federal Medicaid 1115 demonstration waiver
- Legislative requirement

Fiscal Impact and Fund Source(s): For 2024-25, the estimated savings is $52,000 (no rebate in 2024-25 due to the six-month delay in receipt of rebate following the January 2025 implementation) for 25 clients. For 2025-26, the estimated net savings is $1.3 million ($1.7 million savings minus $360,000 decrease in rebate) for 214 clients. The funds impacted are the ADAP Rebate Fund (Fund 3080) and Federal Trust Fund (Fund 0890).

MPPP Expansion to Dental and Vision

Background: The OA-HIPP program provides dental and vision premium coverage for eligible clients. Once a client becomes Medicare eligible, they no longer qualify for dental and vision premium assistance through OA-HIPP. MPPP provides Medicare Part C and Part D premium assistance, and Medigap premium assistance. Medicare clients must pay for their own dental and vision policies due to MPPP not covering these plans.

In the 2024-25 November Estimate, ADAP requested to expand coverage to dental and vision premiums for MPPP eligible clients. Effective July 1, 2024, MPPP began offering dental and vision premium assistance to MPPP clients to allow the

continuity of holistic care for clients that become Medicare eligible. Extending the same level of premium assistance from the OA-HIPP program to MPPP ensures consistent health coverage for all client groups.

The 2024-25 May Revision client count and cost per client per month data was refined; however, this did not pose a significant change compared to the 2024-25 November Estimate.

The 2025-26 November Estimate client count and cost per client data was refined and reflected a decrease in expenditures compared to the 2024-25 May Revision.

Description of Change: The 2025-26 May Revision client count and cost per client data was refined following receipt of the first months of actuals and continues the trend of a decrease in expenditures compared to the 2025-26 November Estimate.

Discretionary: Yes

Reason for Adjustment/Change:

- Allow for continuity of care when transitioning from private insurance to Medicare
- Provide clients opportunity for holistic health coverage
- Medicare does not provide dental coverage, clients currently responsible for premiums of additional plan

Fiscal Impact and Fund Source(s): For 2024-25, the estimated fiscal impact is $85,000 for 221 clients. For 2025-26, the estimated fiscal impact is $294,000 for 471 clients. The fund impacted is the ADAP Rebate Fund (Fund 3080).

Unchanged Assumptions

Amended HSC § 120960: Increase ADAP and PrEP-AP Income Limits from 500 Percent to 600 Percent of Federal Poverty Level (FPL)

Increasing Premium Threshold for Insurance Assistance Programs

Early Action Package: Annual Allocation for Three Years beginning July 1, 2024

Employer-Based Health Insurance Premium Payment (EB-HIPP) Program Expansion to ADAP Clients who are not the Primary Insured

Medicare Part D: Out-of-Pocket Prescription Cap

PrEP Medication: Lenacapavir

Gilead's Plans to Discontinue Patient Assistance Program for Truvada

PrEP and PEP Initiation and Retention Initiative (PPIRI)

Paying above Medicare Part D Benchmark Premiums

Increase in Federal Funds: 2024 Ryan White Part B Grant

Increase in Federal Funds: 2024 Ryan White Part B Supplemental

Increase in Federal Funds: 2024 ADAP Emergency Relief Funds Grant (ADAP Shortfall Relief Grant)

Increase in Federal Funds: 2023 Ryan White Part B Grant Carryover

Discontinued Assumptions

HIV Medication: Lenacapavir (Sunlenca)

Why is Change Needed/ Reason for Adjustment: This assumption will be discontinued since it was previously approved in the 2024-25 May Revision and included in the base estimate. The medication was added to the ADAP formulary on April 25, 2023.

PrEP Medication: Cabotegravir (Apretude)

Why is Change Needed/ Reason for Adjustment: This assumption will be discontinued since it was previously approved in the 2024-25 May Revision and included in the base estimate. The medication was added to the ADAP formulary on December 21, 2023.

Expansion of Medi-Cal for All Income-Eligible Californians

Why is Change Needed/ Reason for Adjustment: This assumption will be discontinued since it was previously approved in the 2024-25 May Revision and included in the base estimate. Effective January 1, 2024, undocumented ADAP clients ages 26 through 49 with income below 138 percent FPL are referred to Medi-Cal and screened during initial enrollment and re-enrollment.

Medi-Cal Expansion: Asset Limit Changes

Why is Change Needed/ Reason for Adjustment: This assumption will be discontinued since it was previously approved in the 2024-25 May Revision and

included in the base estimate. Effective January 1, 2024, DHCS eliminated the asset limit entirely, and ADAP clients who previously did not qualify for non-Modified Adjusted Gross Income (MAGI) Medi-Cal based on the previous asset test are referred to Medi-Cal at initial enrollment and re-enrollment.

Client Navigation Outreach

Why is Change Needed/ Reason for Adjustment: This assumption will be discontinued while the needs assessment/gap analysis outlined in SB 159, Sec.83(a)(6), is conducted and findings are made available. Will reintroduce in a future ADAP Estimate, pending the outcome of the needs assessment/gap analysis.

Decrease in Federal Funds: 2023 Ryan White Part B Grant

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2023-24 has ended and funding has been expended.

Increase in Federal Funds: 2023 Ryan White Part B Supplemental

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2023-24 has ended and funding has been expended.

Increase in Federal Funds: 2023 ADAP Emergency Relief Funds Grant (ADAP Shortfall Relief Grant)

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2023-24 has ended and funding has been expended.

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

Why is Change Needed/Reason for Adjustment: This assumption will be discontinued since 2023-24 has ended and funding has been expended.

VI. Expenditure Details

Tables 5 through 10, starting on the next page, break down caseload and expenditures by client group and service type.

TABLE 5: May Revision Caseload and Variable Expenditures; Current Year 2024-25						
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-only	8,493	26.9%	$199,527,999	$0	$0	$199,527,999
Medi-Cal SOC	103	0.3%	$1,185,940	$0	$0	$1,185,940
Private Insurance*	9,826	31.2%	$30,154,846	$75,821,568	$2,613,530	$108,589,944
Medicare*	6,715	21.3%	$12,214,153	$5,394,849	$315,607	$17,924,609
PrEP-AP	6,385	20.3%	$13,215,383	$0	$2,279,179	$15,494,563
SUBTOTAL	**31,522**	**100.0%**	**$256,298,322**	**$81,216,417**	**$5,208,316**	**$342,723,055**
Admin: ADAP	-	-	$1,996,169	$1,790,206	$1,002,728	$4,789,103
Admin: PrEP-AP	-	-	$0	$0	$5,403,013	$5,403,013
Admin: Enrollment	-	-	$0	$0	$0	$7,760,500
HMS	-	-	-$16,373,540	$0	$0	-$16,373,540
Early Action Package**	-	-	$0	$0	$0	$10,000,000
TOTAL	**31,522**	**100.0%**	**$241,920,951**	**$83,006,623**	**$11,614,057**	**$354,302,131**

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
* Subgroup of 10,907 clients receiving assistance for premium payments and medical-out-of-pocket costs.
** Early Action Package expenditure accounts for Harm Reduction. Expenditures for increasing the FPL to 600 percent, ADAP Open Formulary, and increasing the premium threshold are accounted for in their respective client groups and service type expenditures.

TABLE 6: 2025 Governor's Budget Caseload and Variable Expenditures; Current Year 2024-25						
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-only	9,870	28.8%	$228,013,305	$0	$0	$228,013,305
Medi-Cal SOC	79	0.2%	$799,595	$0	$0	$799,595
Private Insurance*	9,832	28.7%	$27,535,489	$77,572,049	$2,817,240	$107,924,777
Medicare*	7,155	20.9%	$14,499,291	$5,986,309	$396,570	$20,882,170
PrEP-AP	7,307	21.3%	$18,113,885	$0	$2,414,292	$20,528,177
SUBTOTAL	**34,243**	**100%**	**$288,961,564**	**$83,558,358**	**$5,628,102**	**$378,148,023**
Admin: ADAP	-	-	$2,468,433	$2,036,680	$1,041,799	$5,546,912
Admin: PrEP-AP	-	-	$0	$0	$5,361,163	$5,361,163
Admin: Enrollment	-	-	$0	$0	$0	$7,825,500
HMS	-	-	-$16,373,540	$0	$0	-$16,373,540
Early Action Package**	-	-	$0	$0	$0	$10,000,000
TOTAL	**34,243**	**100%**	**$275,056,457**	**$85,595,037**	**$12,031,064**	**$390,507,058**

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
* Subgroup of 11,965 clients receiving assistance for premium payments and medical-out-of-pocket costs.
** Early Action Package expenditure accounts for Harm Reduction. Expenditures for increasing the FPL to 600 percent, ADAP Open Formulary, and increasing the premium threshold are accounted for in their respective client groups and service type expenditures.

TABLE 7: Difference Between May Revision and 2025 Governor's Budget; Current Year 2024-25						
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-only	-1,377	-13.9%	-$28,485,306	$0	$0	-$28,485,306
Medi-Cal SOC	25	31.2%	$386,345	$0	$0	$386,345
Private Insurance*	-7	-0.1%	$2,619,358	-$1,750,481	-$203,710	$665,167
Medicare*	-440	-6.2%	-$2,285,138	-$591,459	-$80,963	-$2,957,561
PrEP-AP	-922	-12.6%	-$4,898,501	$0	-$135,113	-$5,033,614
SUBTOTAL	**-2,721**	**-7.9%**	**-$32,663,242**	**-$2,341,940**	**-$419,786**	**-$35,424,968**
Admin: ADAP	-	-	-$472,264	-$246,474	-$39,071	-$757,809
Admin: PrEP-AP	-	-	$0	$0	$41,850	$41,850
Admin: Enrollment	-	-	$0	$0	$0	-$65,000
HMS	-	-	$0	$0	$0	$0
Early Action Package**	-	-	$0	$0	$0	$0
TOTAL	**-2,721**	**-7.9%**	**-$33,135,506**	**-$2,588,414**	**-$417,007**	**-$36,204,927**

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
* Subgroup decreased by 1,058 clients receiving assistance for premium payments and medical-out-of-pocket costs.

TABLE 8: May Revision Caseload and Variable Expenditures; Budget Year 2025-26						
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-only	7,763	21.1%	$218,969,711	$0	$0	$218,969,711
Medi-Cal SOC	138	0.4%	$1,637,978	$0	$0	$1,637,978
Private Insurance*	10,451	28.4%	$40,643,946	$90,063,774	$3,268,878	$133,976,598
Medicare*	6,646	18.1%	$8,732,419	$7,907,658	$695,623	$17,335,700
PrEP-AP	11,746	32.0%	$19,828,296	$0	$3,711,673	$23,539,968
SUBTOTAL	**36,744**	**100.0%**	**$289,812,350**	**$97,971,432**	**$7,676,174**	**$395,459,955**
Admin: ADAP	-	-	$2,195,786	$1,969,227	$1,103,001	$5,268,014
Admin: PrEP-AP	-	-	$0	$0	$5,430,998	$5,430,998
Admin: Enrollment	-	-	$0	$0	$0	$8,270,500
HMS	-	-	-$14,736,186	$0	$0	-$14,736,186
Early Action Package**	-	-	$0	$0	$0	$10,000,000
TOTAL	**36,744**	**100.0%**	**$277,271,950**	**$99,940,658**	**$14,210,172**	**$409,693,280**

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
* Subgroup of 11,625 clients receiving assistance for premium payments and medical-out-of-pocket costs.
** Early Action Package expenditure accounts for Harm Reduction. Expenditures for increasing the FPL to 600 percent, ADAP Open Formulary, and increasing the premium threshold are accounted for in their respective client groups and service type expenditures.

TABLE 9: 2025 Governor's Budget Caseload and Variable Expenditures; Budget Year 2025-26						
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-only	9,396	25.1%	$249,523,961	$0	$0	$249,523,961
Medi-Cal SOC	88	0.2%	$908,835	$0	$0	$908,835
Private Insurance*	10,457	27.9%	$37,276,083	$90,112,051	$3,703,983	$131,092,117
Medicare*	7,197	19.2%	$13,072,953	$12,189,613	$1,248,367	$26,510,933
PrEP-AP	10,350	27.6%	$34,460,620	$0	$2,694,505	$37,155,125
SUBTOTAL	**37,488**	**100%**	**$335,242,453**	**$102,301,665**	**$7,646,855**	**$445,190,972**
Admin: ADAP	-	-	$2,715,277	$2,240,348	$1,145,979	$6,101,603
Admin: PrEP-AP	-	-	$0	$0	$5,384,963	$5,384,963
Admin: Enrollment	-	-	$0	$0	$0	$8,335,500
HMS	-	-	-$14,736,186	$0	$0	-$14,736,186
Early Action Package**	-	-	$0	$0	$0	$10,000,000
TOTAL	**37,488**	**100%**	**$323,221,543**	**$104,542,012**	**$14,177,797**	**$460,275,852**

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
* Subgroup of 12,693 clients receiving assistance for premium payments and medical-out-of-pocket costs.
** Early Action Package expenditure accounts for Harm Reduction. Expenditures for increasing the FPL to 600 percent, ADAP Open Formulary, and increasing the premium threshold are accounted for in their respective client groups and service type expenditures.

TABLE 10: Difference Between May Revision and 2025 Governor's Budget; Budget Year 2025-26						
CLIENT GROUP	CASELOAD		SERVICE TYPE EXPENDITURE			
	NUMBER	PERCENT	MEDICATIONS	INSURANCE PREMIUMS	MED OUT-OF-POCKET COST	TOTAL EXPENDITURE
Medication-only	-1,633	-17.4%	-$30,554,250	$0	$0	-$30,554,250
Medi-Cal SOC	50	56.6%	$729,142	$0	$0	$729,142
Private Insurance*	-7	-0.1%	$3,367,863	-$48,278	-$435,105	$2,884,480
Medicare*	-551	-7.7%	-$4,340,534	-$4,281,956	-$552,744	-$9,175,233
PrEP-AP	1,396	13.5%	-$14,632,324	$0	$1,017,168	-$13,615,157
SUBTOTAL	**-744**	**-2.0%**	**-$45,430,103**	**-$4,330,233**	**$29,319**	**-$49,731,017**
Admin: ADAP	-	-	-$519,490	-$271,121	-$42,978	-$833,590
Admin: PrEP-AP	-	-	$0	$0	$46,035	$46,035
Admin: Enrollment	-	-	$0	$0	$0	-$65,000
HMS	-	-	$0	$0	$0	$0
Early Action Package**	-	-	$0	$0	$0	$0
TOTAL	**-744**	**-2.0%**	**-$45,949,593**	**-$4,601,354**	**$32,376**	**-$50,582,572**

Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.
* Subgroup decreased by 1,068 clients receiving assistance for premium payments and medical-out-of-pocket costs.

a) Medication-only Clients

1. Medication:
   - 2024-25: Costs are projected to be $199.5 million (Table 5), $28.5 million lower than reported in the 2025-26 Governor's Budget (Table 7). The decrease is driven primarily by lower monthly caseload offset with a higher cost per client per month than previously estimated.
   - 2025-26: Costs are projected to be $219 million (Table 8), $30.6 million lower than reported in the 2025-26 Governor's Budget (Table 10). The decrease is driven primarily by the same factors above.
2. Health Insurance Premiums: There are no costs for medication-only clients.
3. Medical Out-Of-Pocket Costs: There are no costs for medication-only clients.

b) Medi-Cal SOC Clients

1. Medication:
   - 2024-25: Costs are projected to be $1.2 million (Table 5), $386,000 higher than reported in the 2025-26 Governor's Budget (Table 7). The increase is driven primarily by higher monthly caseload and higher cost per client per month than previously estimated.
   - 2025-26: Costs are projected to be $1.6 million (Table 8), $729,000 higher than reported in the 2025-26 Governor's Budget (Table 10). The increase is driven primarily by the same factors above.
2. Health Insurance Premiums: There are no costs for Medi-Cal SOC clients.
3. Medical Out-Of-Pocket Costs: There are no costs for Medi-Cal SOC clients.

c) Private Insurance Clients

1. Medication:
   - 2024-25: Costs are projected to be $30.2 million (Table 5), $2.6 million higher than reported in the 2025-26 Governor's Budget (Table 7). The increase is driven primarily by higher cost per client per month than previously estimated.
   - 2025-26: Costs are projected to be $40.6 million (Table 8), $3.4 million higher than reported in the 2025-26 Governor's Budget (Table 10). The increase is driven primarily by the same factor above.
2. Health Insurance Premiums:
   - 2024-25: Costs are projected to be $75.8 million (Table 5), $1.8 million lower than reported in the 2025-26 Governor's Budget (Table 7). The

decrease is driven primarily by lower monthly caseload offset with a higher cost per client per month than previously estimated.
- 2025-26: Costs are projected to be $90.1 million (Table 8), $48,000 lower than reported in the 2025-26 Governor's Budget (Table 10). The decrease is driven primarily by the same factors above.

3. Medical Out-Of-Pocket Costs:
   - 2024-25: Costs are projected to be $2.6 million (Table 5), $204,000 lower than reported in the 2025-26 Governor's Budget (Table 7). The decrease is driven primarily by lower monthly caseload than previously estimated.
   - 2025-26: Costs are projected to be $3.3 million (Table 8), $435,000 lower than reported in the 2025-26 Governor's Budget (Table 10). The decrease is driven primarily by the same factor above.

d) Medicare Clients

1. Medication:
   - 2024-25: Costs are projected to be $12.2 million (Table 5), $2.3 million lower than reported in the 2025-26 Governor's Budget (Table 7). The decrease is driven primarily by lower monthly caseload and lower cost per client per month than previously estimated.
   - 2025-26: Costs are projected to be $8.7 million (Table 8), $4.3 million lower than reported in the 2025-26 Governor's Budget (Table 10). The decrease is driven primarily by the same factors above.
2. Health Insurance Premiums:
   - 2024-25: Costs are projected to be $5.4 million (Table 5), $591,000 lower than reported in the 2025-26 Governor's Budget (Table 7). The decrease is driven primarily by lower monthly caseload and lower cost per client per month than previously estimated.
   - 2025-26: Costs are projected to be $7.9 million (Table 8), $4.3 million lower than reported in the 2025-26 Governor's Budget (Table 10). The decrease is driven by the same factors above.
3. Medical Out-Of-Pocket Costs:
   - 2024-25: Costs are projected to be $316,000 (Table 5), $81,000 lower than reported in the 2025-26 Governor's Budget (Table 7). The decrease is driven primarily by lower monthly caseload and lower cost per client per month than previously estimated.
   - 2025-26: Costs are projected to be $696,000 (Table 8), $553,000 lower than reported in the 2025-26 Governor's Budget (Table 10). The decrease is driven primarily by the same factors above.

e) PrEP-AP Clients

1. Medication:
   - 2024-25: Costs are projected to be $13.2 million (Table 5), $4.9 million lower than reported in the 2025-26 Governor's Budget (Table 7). The decrease is driven primarily by lower monthly caseload offset with a higher cost per client per month than previously estimated.
   - 2025-26: Costs are projected to be $19.8 million (Table 8), $14.6 million lower than reported in the 2025-26 Governor's Budget (Table 10). The decrease is driven primarily by the same factors above.
2. Health Insurance Premiums: There are no costs for PrEP-AP clients.
3. Medical Out-Of-Pocket Costs:
   - 2024-25: Costs are projected to be $2.3 million (Table 5), $135,000 lower than reported in the 2025-26 Governor's Budget (Table 7). The decrease is driven primarily by lower monthly caseload than previously estimated.
   - 2025-26: Costs are projected to be $3.7 million (Table 8), $1 million higher than reported in the 2025-26 Governor's Budget (Table 10). The increase is driven primarily by higher monthly caseload than previously estimated.

VII. Historical Program Data and Trends

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

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

In FY 2023-24, a total of 27,442 individuals received ADAP services (with 9,919 of those being insurance assistance clients). For FY 2024-25, OA projects the total ADAP caseload to decrease to 25,137 individuals (with insurance assistance clients increasing to 10,907). For FY 2025-26, OA projects the total ADAP caseload to decrease to 24,997 individuals (with insurance assistance clients increasing to 11,625).

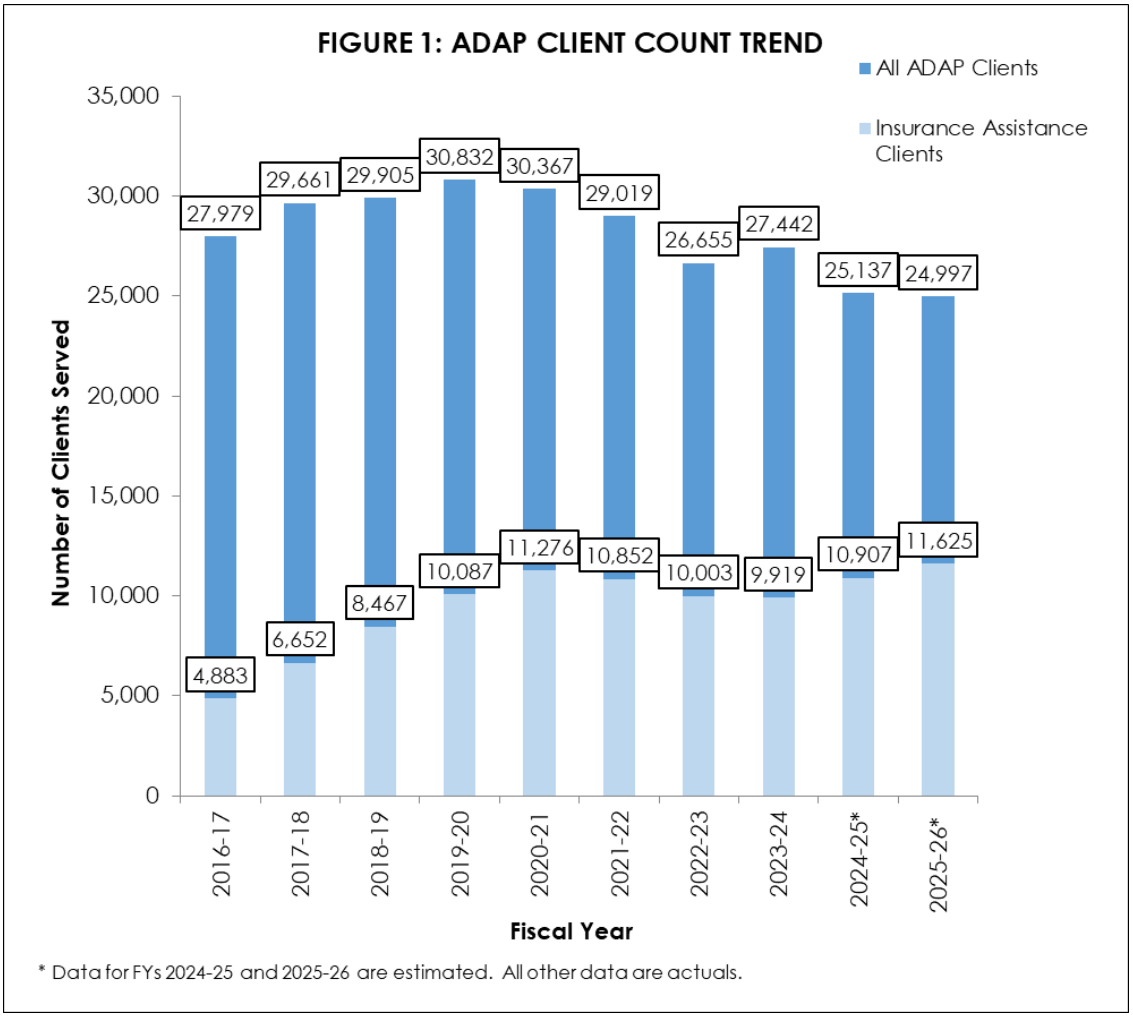
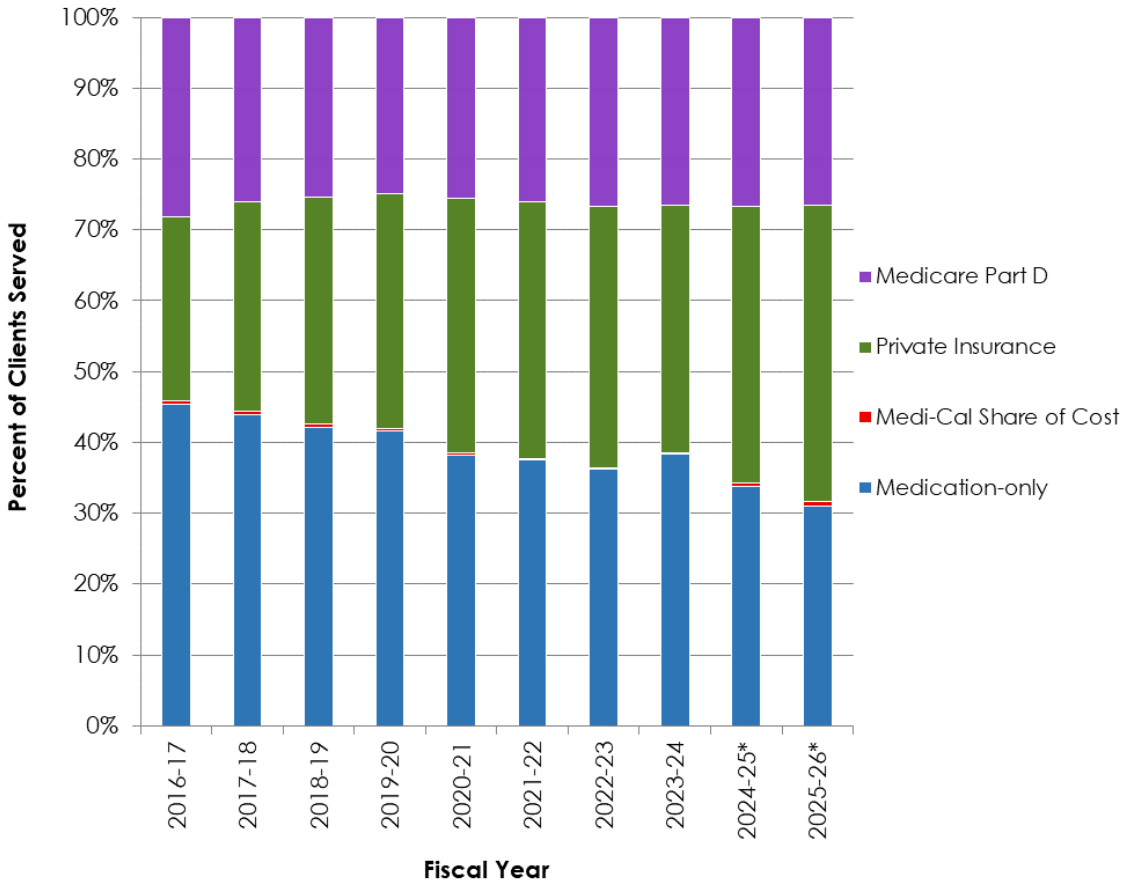


Figure 2 summarizes the proportion of ADAP medication program clients enrolled in the various payer groups by fiscal year.

For FY 2024-25, of the projected 25,137 ADAP medication program clients, the payer source percentages are estimated to be 33.8 percent Medication-only, 39.1 percent Private Insurance, 26.7 percent Medicare Part D, and 0.4 percent Medi-Cal SOC. For FY 2025-26, of the projected 24,997 ADAP medication program clients, the payer source percentages are estimated to be 31.1 percent Medication-only, 41.8 percent Private Insurance, 26.6 percent Medicare Part D, and 0.5 percent Medi-Cal SOC.

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

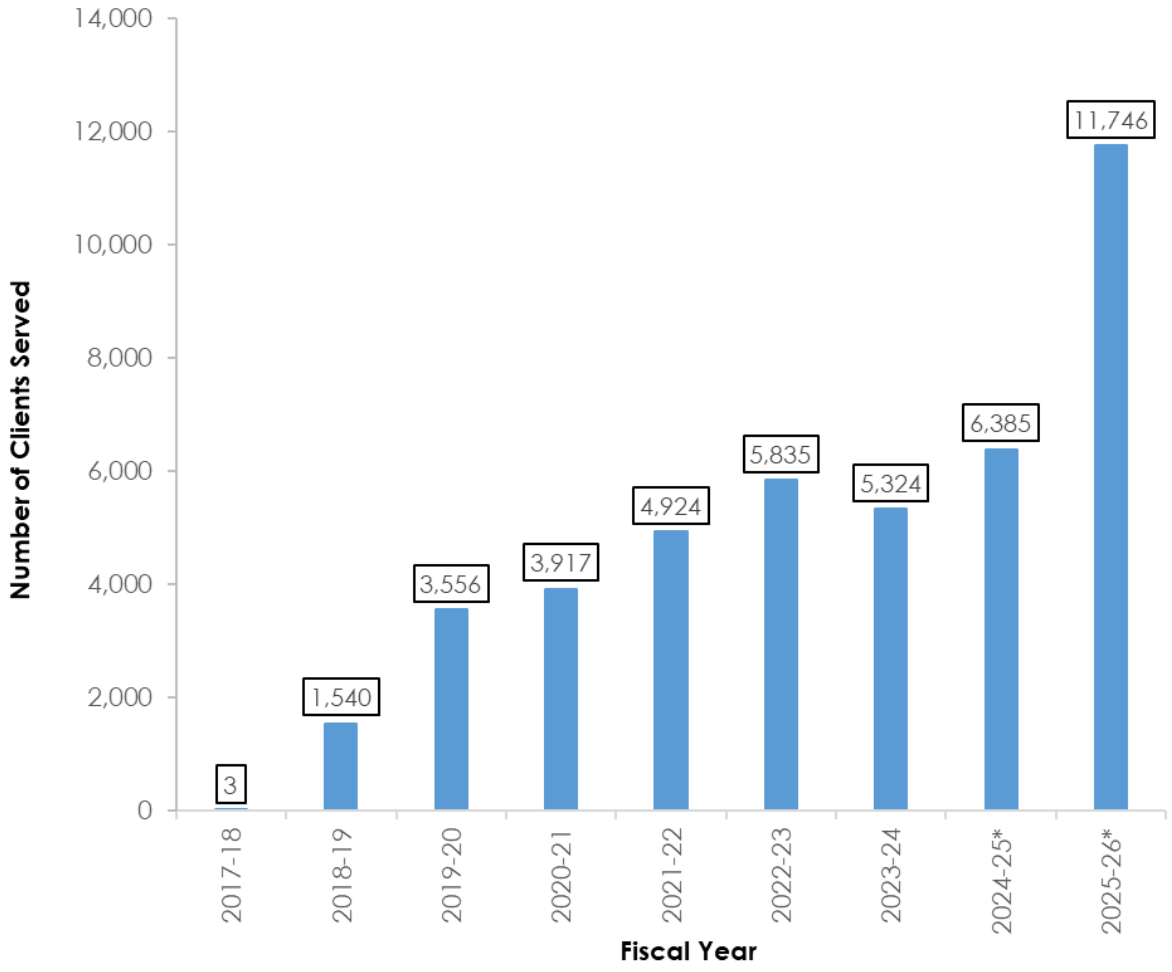


* Data for FYs 2024-25 and 2025-26 are estimated. All other data are actuals.

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

In FY 2023-24, a total of 5,324 individuals received PrEP-AP services. For FY 2024-25, OA projects the total PrEP-AP caseload to increase to 6,385. For FY 2025-26, OA projects the total PrEP-AP caseload to increase to 11,746.

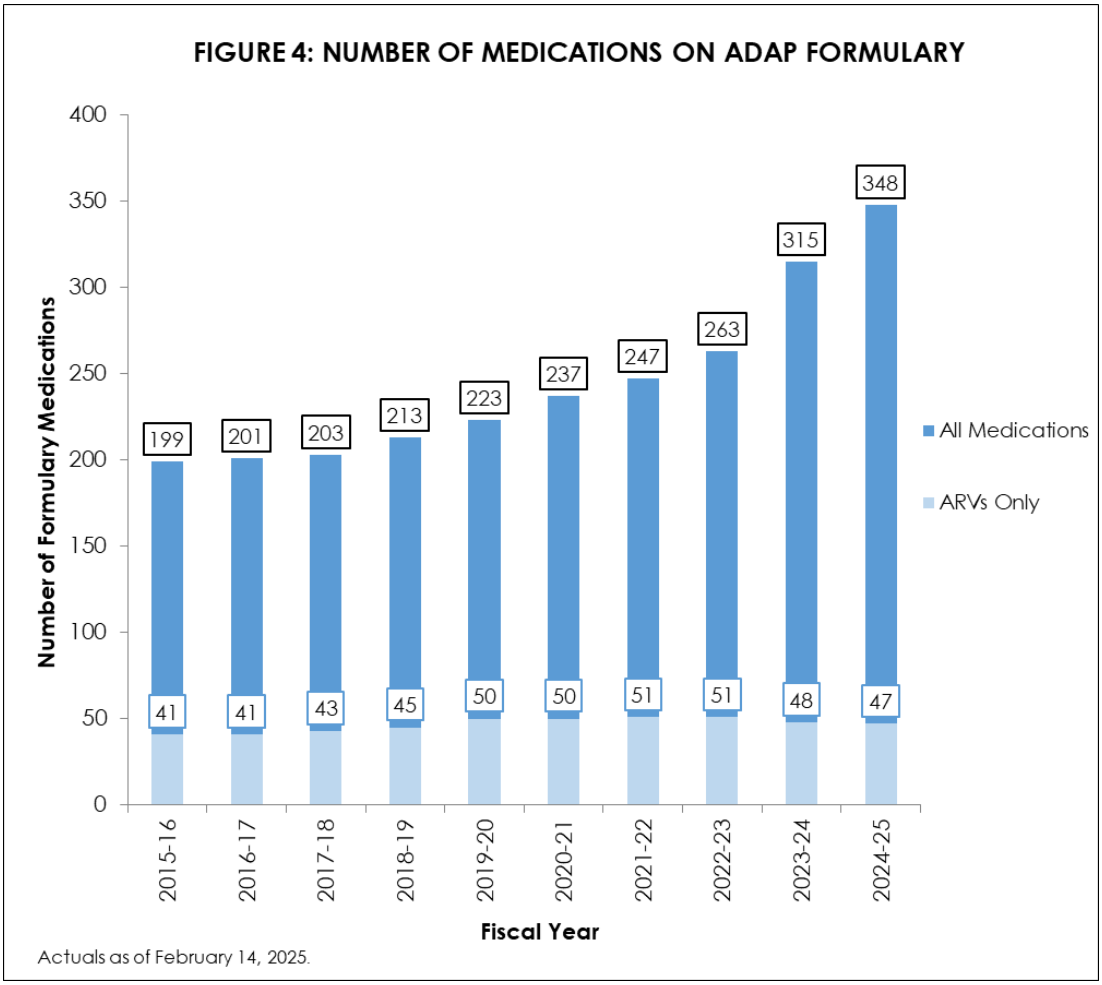
FIGURE 3: ADAP PREP-AP CLIENTS SERVED



* Data for FYs 2024-25 and 2025-26 are estimated. All other data are actuals.

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

In FY 2023-24, a total of 315 medications were on the ADAP formulary (with 48 of those being ARVs). As of February 14, 2025, there are 348 medications on the ADAP formulary (with 47 of those being ARVs).



Additions to the ADAP Formulary

The following medications were added to the ADAP formulary on:

September 24, 2024:

- amlodipine/benazepril (Lotrel®), non-ARV, angiotensin-converting enzyme inhibitor and a calcium channel blocker
- amlodipine/Olmesartan (Azor), non-ARV, angiotensin II inhibitors with calcium channel blockers
- amlodipine/valsartan (Exforge®), non-ARV, angiotensin II inhibitors with calcium channel blockers
- amlodipine/valsartan/HCTZ (Exforge-HCT®), non-ARV, angiotensin II inhibitors with calcium channel blockers
- atenolol/chlorthalidone (Tenoretic®), non-ARV, beta-blocker and a thiazide diuretic

- benazepril/HCTZ (Lotensin-HCT®), non-ARV, angiotensin-converting enzyme inhibitor
- enalapril/HCTZ (Vaseretic®), non-ARV, angiotensin-converting enzyme inhibitor and hydrochlorothiazide
- metoprolol/HCTZ (Lopressor-HCT®), non-ARV, beta-blocker and thiazide diuretic
- olmesartan/HCTZ (Benicar-HCT®), non-ARV, angiotensin II receptor blocker and thiazide diuretic
- valsartan/HCTZ (Diovan-HCT®), non-ARV, angiotensin receptor blocker and diuretic

November 22, 2024:

- clomiphene (Clomid®), non-ARV, ovulatory stimulants
- norgestrel (Opill®), non-ARV, progestins
- nirmatrelvir/ritonavir (Paxlovid™), non-ARV, antiviral combinations
- Pretomanid, non-ARV, antimycobacterial
- Bedaquiline (Sirturo®), antibiotics
- human chorionic gonadotropin (Novarel®, Pregnyl®), non-ARV, ovulation stimulators

December 04, 2024:

- inhaler assist device (AeroChamber Plus® Flow-Vu®), non-ARV

December 09, 2024:

- carbamazepine (Equetro®, Tegretol®), non-ARV, dibenzazepine anticonvulsants

January 15, 2025:

- semaglutide (Ozempic®), non-ARV, glucagon-like peptide-1 agonists

Deletions from the ADAP Formulary

The following medications were deleted from the ADAP formulary on January 15, 2025:

- oxycodone/aspirin (Percodan®), non-ARV, schedule II narcotic analgesic

VIII. Current HIV Epidemiology in California

Approximately 143,000 people in California living at the end of 2023 had been diagnosed with HIV and reported to OA. Since the epidemic began in 1981, approximately 112,000 Californians diagnosed with HIV have died, with over 2,200 dying in 2023 alone.

Of the approximately 143,000 people living with diagnosed HIV (PLWDH) in California, approximately 2.1 percent are Latine; 32.9 percent are White; 15.9 percent are Black/African American; 4.5 percent are Asian; 4.2 percent are multi-racial; 0.2 percent are American Indian/Alaskan Native; and 0.2 percent are Native Hawaiian/Pacific Islander. While Latine and Whites make up the largest percentage of PLWDH in California, the rate of HIV among Blacks/African Americans is substantially higher (977.0 per 100,000 population, versus 309.3 per 100,000 among Whites and 375.7 per 100,000 among Latine).

Most of California's living HIV cases are attributed to male-to-male sexual transmission (65.8 percent); 8.1 percent of living cases are attributable to high-risk heterosexual contact (defined as contact with a sex partner or partners of the opposite gender who are either known to be HIV infected or known to be someone who injects drugs, has hemophilia, or is a man who has sex with other men); 5.8 percent to men who have sex with men who also inject drugs; 5.2 percent to injection drug use; 2.1 percent to transgender sexual contact; 0.5 percent to perinatal exposure; and 12.6 percent to other or unknown sources including other heterosexual contact.

From 2019 to 2023, there was an average of approximately 4,700 new HIV cases reported in California each year. Please note COVID-19 may have impacted rates of testing as well as reporting completeness in 2020. The number of PWH in the state is expected to grow by approximately one-percent each year for the foreseeable future until more progress is made in preventing new HIV infections. This increase is attributed to stable incidence rates and longer survival of those infected primarily due to the effectiveness and availability of treatment.

IX. Plan for Modernization and Expansion

Per SB 159 SEC, 83 (b), CDPH shall submit to the Legislature, as part of the 2025–26 Governor's Budget, a plan for modernization and expansion of ADAP and related programs with a focus on addressing the epidemic of HIV/AIDS in California, including, but not limited to assumptions included in the 2025-26 November Estimate: Increasing ADAP and PrEP-AP Income Limits from 500 Percent to 600 Percent FPL, an ADAP Open Formulary, and Increasing Premium Threshold for Insurance Assistance Programs.

The plan shall be developed in consultation with stakeholders and the Legislature and should consider whether the proposed activity is an eligible use of the ADAP Rebate Fund, availability of funding, and whether it advances access to services.

The Modernization and Expansion Plan is inclusive of, but not limited to, the following assumptions (in conjunction with the three aforementioned assumptions): EB-HIPP Program Expansion to ADAP Clients who are not the Primary Insured, Payments for Medicare Part B Premiums, Payment of Medicare Part B Medical Out-of-Pocket Costs, PrEP Medication: Lenacapavir, and Gilead's Plans to Discontinue Patient Assistance Program for Truvada.

Through ongoing stakeholder engagement outlined below, CDPH will continue to develop enhancements to ADAP and related programs in consultation with stakeholders and the Legislature, while ensuring that proposed activities are an eligible use of the ADAP Rebate Fund. Program enhancements will be proposed on an ongoing basis through the annual November Estimate process.

Stakeholder Engagement:
OA conducts effective strategic stakeholder engagement across multiple efforts and programs:

ADAP/PrEP-AP Stakeholder Engagement
The ADAP Branch Monthly Enrollment Worker Calls are conference calls designed to engage ADAP and PrEP-AP stakeholders in providing program updates, share best practices among attendees, and provide specific presentation topics relevant to ADAP and PrEP-AP programs. Required attendees include all ADAP and PrEP-AP Enrollment Workers. Enrollment Workers conduct enrollment services for ADAP and/or PrEP-AP at contracted enrollment sites, which include community-based non-profit organizations, clinics, medical providers, and case management service providers. The Monthly Enrollment Worker Calls include an open forum for Enrollment Workers to ask questions, voice concerns, and provide programmatic feedback, and suggestions.

ADAP facilitates two additional stakeholder bodies that inform ADAP and PrEP-AP programs and initiatives. The ADAP/PrEP-AP Enrollment Worker Advisory Committee (AEWAC) is comprised of ADAP and PrEP-AP Enrollment Workers from high volume enrollment sites who consult on matters of ADAP and PrEP-AP policy and accessibility of the programs for clients. The Medical Advisory Committee (MAC) advises on medications added to the ADAP Formulary and consists of health care professionals, and individuals with expertise and/or experience, that benefit the program and the population ADAP serves, including HIV-specialized physicians, pharmacists, psychiatrists, treatment advocacy representatives, and community representatives.

California Planning Group (CPG): HIV, STD, Hepatitis C and Harm Reduction
OA's HIV Care Branch, HIV Prevention Branch, and the Sexually Transmitted Diseases (STD) Control Branch (STDCB) collaborate in conducting all strategic community engagement activities of the statewide planning body, California Planning Group: HIV, STD, Hepatitis C and Harm Reduction (CPG). CPG, OA, and STDCB meet publicly in-person or virtually twice a year to conduct CPG business, discuss prevailing issues in the community, and to build capacity amongst the community members. Select ADAP staff serve as staff liaisons to the CPG and CPG feedback is solicited to inform ADAP policy and initiatives.

Monthly Office of AIDS & Sexually Transmitted Diseases/Hepatitis Stakeholder Engagement Calls
Monthly stakeholder webinars are designed to engage OA stakeholders in providing program updates, share best practices among attendees, and provide specific presentation topics addressing HIV-related emerging issues. Required attendees include all funded Local Health Jurisdictions (LHJs), Community Based Organizations (CBOs), and CPG members. Many CBOs are contracted as ADAP and/or PrEP-AP Enrollment Sites and provide enrollment services directly to clients. Stakeholders are invited to contribute agenda items and to discuss issues.

Following strategic stakeholder engagement across multiple efforts and programs, OA proposed expansions to ADAP and PrEP-AP through the 2025-26 November Estimate that advance access to services. The assumptions are eligible uses of the ADAP Rebate Fund and there is funding available for these activities.