

Program Organization - Part B Funds Administration: The California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA) administers all programs funded through the Ryan White (RW) HIV/AIDS Treatment Extension Act of 2009 (RW Program), Part B. OA has six work areas: the HIV Care Branch, HIV Prevention Branch, HIV Surveillance, Research, and Evaluation (SRE) Branch, AIDS Drug Assistance Program (ADAP) Branch, Administration Branch, and Division Office. Approximately thirty-nine full-time equivalent (FTE) staff are funded by the RW grant. They are responsible for the daily administration and oversight of programs that provide care and treatment services to people living with HIV/AIDS (PLWH/A) in California's 61 local health jurisdictions (LHJs). OA receives RW Part B and other Federal and State funding to administer the following programs: 1) ADAP; 2) HIV Care Program (HCP); 3) Minority AIDS Initiative (MAI); and 4) OA's Health Insurance Premium Payment (OA-HIPP) Program and OA's Pre-Existing Condition Insurance Plan (OA-PCIP). The HIV Care Branch also oversees the AIDS Medi-Cal Waiver Program (MCWP) and the Housing Opportunities for Persons with AIDS (HOPWA) Program. The HIV Care and ADAP Branches develop program policies and programmatic strategic plans, contribute to the development of the Statewide Coordinated Statement of Need (SCSN) and the Comprehensive Care Plan for HIV Services (Comprehensive Care Plan), jointly participates in the Community Planning Group (CPG) along with the HIV Prevention Branch and participate in the eight RW Part A planning councils advising the three Emergency Metropolitan Areas (EMAs) and five Transitional Grant Areas (TGAs) in California. In addition, the ADAP Branch administers the Pharmacy Benefit Management (PBM) contract, oversees drug expenditures and revenue, and develops ADAP Estimate Packages for California's Legislature to project annual funding need. Please see **Attachment 1**, Organization Charts for OA's Management and Administration Branch.

Fiscal and Program Monitoring - Tracking of RW Part B Funding Expenditures: OA has five teams that contribute to fiscal and programmatic accountability to ensure adequate and accurate tracking, reporting, and reconciliation of program expenditures and program income. Each team has a different focus but collectively represents a process that provides routine checks and balances for fiscal and programmatic monitoring. The five teams include HIV Care Branch, ADAP Section, Insurance Assistance Section (IAS), SRE Branch, and Administration Branch.

Process and Mechanisms to Track RW Part B Funding Streams: OA Administration, including the Assistant Division Chief (Business Official), Administration Branch Chief, the Fiscal Management Section (FMS) and CDPH's Accounting Office all have an integral role in fiscal accountability. CDPH's Accounting Office maintains the accounting database called CalSTARS Online Reporting Environment (CORE). CORE utilizes separate account codes for each fund source. The RW Part B grant includes separate account codes for administrative and direct costs within Base, ADAP, MAI, OA-HIPP, OA-PCIP, RW Part B Supplemental, and RW Part B ADAP Shortfall Supplemental funds. Having separate expenditure codes in place allows OA the ability to monitor unobligated funds and assess the need for carryover of unexpended funds.

Number of Contracts: OA provides HCP funds to 43 LHJs and community-based organizations (CBOs), also known as contractors, which also have 86 subcontractors. RW Part B MAI funds are allocated to 19 of the 43 contractors. As of December 1, 2011, ADAP has standard agreements with 57 LHJs in order to allocate and distribute funds to counties for ADAP enrollment support. ADAP maintains site agreements with 187 enrollment sites and requires them to ensure complete, accurate, and confidential ADAP client eligibility documentation for

the initial enrollment and subsequent recertification. ADAP's new PBM contract took effect on July 1, 2011. This one-year contract may be extended up to five years.

Voucher/Invoice Process: HCP and ADAP work collaboratively with FMS to process, pay, and reconcile invoices. HCP contractors must submit invoices and back-up documentation on a monthly or quarterly basis. FMS reviews and tracks the invoices upon receipt and assigns the CORE account code before sending to HCP for reimbursement approval. ADAP's PBM service provider submits invoices on a weekly basis together with substantiating computer data reports and electronic data files which enable OA staff to closely monitor expenditures and drug utilization and reconcile invoices. FMS tracks the invoices and ADAP assigns the appropriate CORE account code for payment within seven days of receipt of the invoice. Per the PBM contract scope of work, if an expense cannot be verified by ADAP because substantiating documentation is non-existent or inadequate, all questionable costs may be disallowed and payment may be withheld. Upon program approval, FMS submits invoices to CDPH's Accounting Office. OA reviews CORE transactions no less than weekly to verify that the invoice was paid accurately and in a timely fashion, and takes appropriate action with CDPH's Accounting Office to resolve any issues.

OA-HIPP and OA-PCIP work directly with CDPH's Accounting Office for payment and reconciliation of invoices. Once a client's eligibility is approved, OA-HIPP pays premiums to the client's private health insurance plan quarterly and OA-PCIP pays premiums to the Managed Risk Medical Insurance Board (MRMIB) monthly, which administers PCIP. The program's fiscal analyst submits invoices to CDPH's Accounting Office, tracks expenditures, reviews CORE transactions and reconciles issues. Refunds received from private health insurance plans are researched and OA-HIPP client files are updated accordingly. Credits or adjustments are applied to the OA-PCIP billing statement if improper charges are identified.

OMB A-133 Compliance: OA HCP tracks receipt of Office of Management and Budgets (OMB) A-133 reports from private non-profit agencies that expend over \$500,000 annually in total federal awards. This is in compliance with the OMB A-133 Circular. For all applicable OMB A-133 reports to be received, OA notifies contractors within 30 days of the due date for receipt of the audit report and follow-up notifications are provided 60 and 90 days for reports not received.

OMB A-133 Audit Process: HCP submits copies of the reports to CDPH's Office of Audits and Investigations (A&I) Audits Reviews and Analysis Section in the Financial Audits Branch. A&I has 60 days to complete their compliance review of the audit report. At the completion of the A&I review, a memo of compliance or deficiency is sent to OA and kept on file. When there are deficiencies or findings needing correction, OA notifies the contractor in writing and requests a Corrective Action Plan (CAP). The contractor must send a written CAP to OA within 30 days, indicating how the finding(s) will be addressed, if a copy of the CAP was not included with the submission of the audit. The Care Operations Advisor sends the CAP to A&I for evaluation. OA monitors compliance to the CAP at routine program compliance reviews.

Programmatic Monitoring: OA conducts programmatic monitoring site visits to all HCP and MAI contractors, and ADAP enrollment sites. The monitoring is to verify compliance with fiscal, programmatic, and eligibility requirements and to provide technical assistance. OA contractors are notified 30 days in advance of a site visit and are provided site preparation instructions and tools for the site visit. During the site visits, 10 percent of all RW Part B and ADAP client charts are reviewed to verify eligibility requirements. An exit interview is conducted and technical assistance is provided to discuss any problems, as well as steps to

improve services. All sites visited also receive a post site visit summary letter and a site visit report.

For sites found to be out of compliance with program and/or client eligibility requirements, the problem is documented by program and written notification of the findings is provided to the contractor. If findings during site monitoring warrants further audits to ensure compliance, OA works closely with A&I for fiscal and program monitoring. Six HCP contractors were submitted for an audit in 2010 through A&I. The audits are currently in process and the outcome of these audits is pending. In ADAP, when client eligibility documentation is found to be deficient during a site visit, the PBM is immediately notified of the specific client files found to have deficiencies and the necessary documentation required to correct the deficiencies. A 60-day grace period is placed on these clients' eligibility during which time they must provide the missing documentation to the enrollment worker. After the grace period ends, the client's ADAP eligibility is suspended until compliance is achieved. Additionally, if during the course of conducting daily business ADAP becomes aware of problematic issues at specific enrollment sites, site visits may be conducted on an as-needed basis.

As of November 1, 2011, there were 104 OA-HIPP and 68 OA-PCIP enrollment sites. Client eligibility documentation is sent to and maintained within OA's IAS. Site visits are not conducted. All applications and supporting documentation are reviewed by IAS and, as part of the approval process, by the IAS Section Chief. Submission of incomplete and/or inaccurate OA-HIPP and OA-PCIP eligibility documentation may delay annual enrollment or semi-annual recertification.

Corrective Action Process/Timeline: If deficiencies are identified in a site visit conducted for HCP, MAI, or ADAP, the contractor must develop a CAP. The CAP along with a timeline for implementation must be submitted to OA within 30 days for HCP and MAI, and within 60 days for ADAP enrollment sites. OA reviews all CAPs and communicates with sites to eliminate deficiencies. OA follows up on all required corrective actions to ensure compliance.

Summary of Findings: Fifteen HCP contractors and 10 ADAP enrollment sites were cited in recent monitoring visits primarily for items missing from client charts. Items missing from HCP client charts in particular were information on client rights and grievance procedures. All findings were resolved through CAPs received, verified, and completed according to plan. Deficiencies for ADAP client files included insufficient, invalid, and/or missing documentation. All but one of the sites have complied with the CAPs. ADAP is providing additional technical assistance in order to bring this site in compliance. None of the findings resulted in misappropriation of Federal funds.

2011 Health Resources and Services Administration (HRSA) National Monitoring Implementation Planning: Between April 1, 2011 and September 30, 2011, OA completed a thorough assessment of the 2011 HRSA National Monitoring Standards, and implementation plans have been developed accordingly. As part of the Monitoring Standards planning process, OA formulated, drafted, and presented a cost-effective proposal to use funds for insurance premiums instead of ADAP full medication costs. The Governor's Administration and State Legislature approved OA's proposal to expand OA-HIPP and to establish a premium payment program for the federally funded PCIP administered by MRMIB. OA has implemented both OA-HIPP expansion and OA-PCIP.

In addition, new monitoring tools and revisions to internal processes were developed and implemented in efforts to integrate the HRSA National Monitoring Standards into current monitoring efforts. OA is currently pilot testing new monitoring tools and protocols for

conducting monitoring site visits. Discrepancies against the National Monitoring Standards identified during pilot testing will be documented and kept on file and OA will continue to modify tools and protocols to resolve identified discrepancies.

Additionally, infrastructures around site visit preparations, chart reviews, and six-month re-certifications will continue to be refined as a result. Due to the increased number of required site visits and staffing shortages, OA faces challenges to implement all of the National Monitoring Standards for HCP and ADAP for this year, but will continue making progress towards full implementation.

Monitoring Status: ADAP conducted 68 site visits and follow-up visits (36 percent of ADAP sites) from April to December 2011. By March 2012, ADAP expects to provide technical assistance and conduct site visits for a total of 74 sites. From April to October 2011, OA delayed site monitoring visits for HCP contractors until the National Monitoring Standards assessment was complete and implementation plans were developed. Site visit monitoring began in October and OA is on target to complete approximately 25 percent of the total 138 visits by December 2011. Given the delays, OA anticipates that the remaining 70 percent of site visits will most likely not be completed by March 2012. However, OA will complete all required site visits before June 2012. To assist the monitoring efforts to implement the HRSA 2011 National Monitoring Standards in grant year 2012, OA created agency-level data reports to gage each provider's performance and a tool to select a random, representative sample of client charts to review. Both of these items draw extensively on data from the OA's AIDS Regional Information and Evaluation System (ARIES) database. Additionally, OA will continue to make additional modifications to ARIES database to assist with ensuring contractors meet the eligibility and re-certification requirements bi-annually, no less than every six months.

Technical Assistance Status: Technical assistance is provided through a range of mechanisms on a continuous basis, including but not limited to site visits. Technical assistance includes any grant-related activity or need whether it is program specific or a data need. OA disseminates quarterly reports detailing outcomes, changes, and technical assistance requests for HCP, MAI, and ADAP. ADAP and IAS disseminate additional guidance via e-mail, memos, and/or teleconferences. ADAP enrollment workers receive annual training to review ADAP enrollment procedures and eligibility guidelines. IAS conducted 13 training sessions via Webinars in July, August, and November 2011 to inform stakeholders and train enrollment workers on processes for HIPP expansion and PCIP implementation.

HCP contractors are assigned an OA advisor who provides a variety of technical assistance on an as-needed basis. In the grant year 2011, HCP technical assistance needs have been primarily focused on budgets and data reporting. Time spent on technical assistance has been minimal as contractors are in the second year of their contract. OA anticipates technical assistance needs to increase during State Fiscal Year (FY) 2012-13 due to the HRSA National Monitoring Standards, Quality Management Measures, Client Eligibility Requirements and Screening, and the implementation and impact of the Low Income Health Program (LIHP) on the counties that implement LIHP. The California Department of Health Care Services (DHCS) administers the LIHP; giving counties the option to offer health care coverage to its individuals with an income that is below 201 percent of the federal poverty level (FPL). OA is in the process of developing a more comprehensive tracking system to identify the quantity and type of technical assistance provided to contractors.

Fiscal Staff Accountability - Organization Chart Attachment 1

Roles and responsibilities in ensuring adequate reporting, reconciliation, and tracking of program expenditures: OA's role and responsibilities include monitoring invoices, ensuring accurate payments are made to each contractor, reconciling expenditures, and tracking invoice payments through CDPH's Accounting Office's CORE tracking system. OA communicates with contractors to ensure that services billed are complete and accurate. Contractors are required to submit supporting back-up documentation and/or data to ensure accurate expenditure reporting in approved client service categories. OA has several detailed tracking systems (i.e., Excel worksheets and/or Access databases) to monitor expenditures and balances. These tracking systems are updated by OA staff daily and include: purpose of expenditure/invoice; date(s) of expenditure/invoice; balance remaining in each contract budget line item; and amount of each invoice/expenditure. In addition, staff meet on a regular basis to identify and reconcile errors in expenditures and to verify that expenditures have been processed correctly. To ensure that each invoice is processed correctly, OA verifies RW grant expenditures, remaining balances, and projections. There are also mechanisms in place to track incoming ADAP drug rebate revenue and to ensure that budget allocations are not exceeded. Once expenditures have been verified, OA works with CDPH's Accounting Federal Reporting Unit to prepare the final Federal Financial Report (FFR) for submission to HRSA. OA also prepares the required reports per HRSA grant requirements.

Process and coordination methods used in ensuring adequate and accurate tracking, reporting, and reconciliation of program expenditures and program income: OA programs and administration meet on a regular basis to collaborate on fiscal issues and updates. During these meetings, OA's tracking systems are reviewed and discussed to verify accuracy, and to ensure that duplication of effort is not occurring. Staff compare their tracking spreadsheets to confirm that all invoices are accounted for and paid properly and in a timely manner. Staff also discuss contractor detailed expenditures, invoice amounts, obligated and un-obligated balances, projections, allocations and carryovers. The mid-year expenditure reports and the Interim FFRs are prepared in order to determine if there are outstanding encumbrances and expenditures that need to be entered prior to the Final FFR due date. Furthermore, OA management meets on a monthly basis to review the Excel worksheets that detail the budget, expenditures, and projected balances for each grant component.

Third-Party Reimbursement: Clients who are supported with RW Part B funds must meet the following eligibility criteria: 1) be a resident in the state of California; 2) be at least 18 years of age; and 3) have a documented HIV diagnosis. ADAP, OA-HIPP, and OA-PCIP clients must not have an income above \$50,000. ADAP clients must have a prescription written by a licensed California physician/prescriber and have limited or no prescription drug benefit from another source. OA-PCIP clients must be enrolled in California's PCIP. Therefore, they must be a U.S. citizen, U.S. National or lawfully present individual, and have been without health coverage for at least the last six consecutive months.

Due to the payer of last resort provision, HCP, OA-HIPP, and OA-PCIP services are not provided for clients enrolled in Medicare, Medi-Cal, LIHP, or any other third-party payer. OA utilizes RW Part B funds to pay Medicare Part D deductibles and co-pays and State General Fund to pay Medi-Cal Share of Cost (SOC) for drugs on the ADAP formulary. Clients enrolled in LIHP are not eligible to enroll in ADAP. From April 1, 2011 to October 31, 2011, ADAP served 34,749 clients, HCP served 9,235 clients (excluding Los Angeles and Alameda Counties), and OA-HIPP served 485 clients. OA-PCIP was implemented in November 2011, thus did not serve any clients during this period.

Clients are screened by local enrollment workers for eligibility and assisted with applications for government-sponsored programs or other possible third-party payers. Currently, clients are screened annually. OA plans to institute six-month re-certification by July 1, 2012. OA is delaying the conversion to a six month cycle in order to focus on establishing systems with LHJs for implementing LIHP screening. LIHP intersects with RW programs in ways that impact both programs as some RW clients will be eligible for LIHP. Because RW is the payer of last resort, these LIHP-eligible clients will leave RW funded programs and enter LIHP. Potential barriers to statewide implementation of the six-month re-certification requirement may be LHJ capacity and limited local resources necessary to support a 100 percent increase in recertification.

To ensure that all clients are screened for eligibility, client intake information including financial eligibility and proof of HIV status must be documented and maintained on file. HCP contractors and ADAP enrollment sites maintain client charts. OA-HIPP and OA-PCIP eligibility documentation is submitted with client applications and files are maintained within OA. Client records must include documentation to show a client that has been screened, and declined eligibility for Medicare, Medi-Cal, LIHP, and any other third-party payer in order to receive services through RW Part B. OA staff conduct chart reviews and are part of routine program monitoring by OA staff to ensure contractor compliance with the payer of last resort and client eligibility requirements. In addition, HCP monitors ARIES data continuously to ensure providers are documenting client's HIV status, insurance status, FPL, and race/ethnicity. OA will add data elements to ARIES to document and monitor when providers conduct the initial and subsequent eligibility certifications. ADAP utilizes the PBM database to notify clients of upcoming re-certification due dates and to terminate ADAP eligibility after the due date unless the client recertifies.

ADAP maintains additional policies and procedures for cost avoidance and third-party liability. Local enrollment workers screen clients for other payers during initial enrollment and annual re-certification. All eligible clients must apply for Medi-Cal each year. During the Medi-Cal eligibility determination process, clients are given a 150-day grace period contingent upon full compliance with all Medi-Cal application requirements and they continue to receive ADAP benefits. Before the grace period ends ADAP's PBM provides OA staff with a weekly scheduled report of clients pending Medi-Cal eligibility. OA staff verify client eligibility status against the Medi-Cal Eligibility Data System (MEDS). MEDS provides comprehensive information on client eligibility and enrollment, including application date, status of application, income, and available payers (including Medicare), approval date (if applicable), Medi-Cal SOC requirement, retroactive eligibility, etc. ADAP is currently in the process of establishing a contract with the DHCS to conduct a monthly cross match of all ADAP clients in MEDS. OA is also working collaboratively with DHCS to provide guidance to counties and to ensure consistent policies and guidance regarding the LIHP screening across all RW parts. ADAP clients who are identified as 100 percent Medi-Cal eligible with no SOC are ineligible for ADAP and are subsequently removed from ADAP. Medicare clients are identified through a data-sharing agreement with the Centers for Medicare and Medicaid Services (CMS), and are required to use Medicare Part D as their primary payer before accessing ADAP coverage. If clients have private health insurance, ADAP will cover prescription deductibles and co-pays for ADAP formulary drugs. In addition to these mechanisms used to screen clients for other payer sources, ADAP's PBM, in conjunction with the participating pharmacies, is contractually

required to screen for other payers, such as Medi-Cal, Medicare, or private insurance, prior to billing ADAP for prescription costs.

HCP adopted two additional non-clinical performance measures as part of Quality Management: Insurance and Poverty Level. OA generates monitoring reports to track the percentage of clients with documented HIV status, as well as the percentage of clients with poverty level documented and the percentage of clients with documented insurance status. These measures help focus service provider's attention on payer of last resort and help to identify service providers who need assistance in improving their performance. OA staff monitor the performance of the non-clinical measures through chart reviews, contract monitoring reviews, and data quality checks. In addition to these measures, California contracts to have the California Statewide Training and Education Program training to certify benefits counselors for HIV service providers throughout the state. This training helps to ensure that PLWH/A have information about, and assistance applying for, all available benefits for which they are eligible including the new Bridge to Health Care Reform (HCR) programs such as LIHP implemented in California in July 2011.

Drug rebates received from manufacturers with medications on California's formulary are deposited into a special fund. State statutes require that these funds are only to be used for ADAP services. The program closely monitors all special fund activities via a database that tracks receipt and deposit of rebates, and expenditures from the fund. HCP, OA-HIPP, and OA-PCIP are non-income generating programs. In the event of a premium payment refund, checks are deposited back into the OA-HIPP accounting system and tracked through CDPH's CORE. OA-PCIP adjustments are credited on the next billing statement.

Women, Infants, Children, and Youth (WICY) Proportionate Spending: OA requires RW Part B client service providers to collect a minimum dataset of client-level information. Providers either directly enter data (client demographics and service data) or import data into ARIES to document clients served and outcomes achieved. Those data of services provided for WICY are matched against program expenditures data twice a year. OA has historically exceeded the aggregate expenditure requirement for WICY and continues to meet the requirement for women, infants, and youth. However, each year OA does not meet the proportionate expenditures for children (see Attachment 9). Children with HIV/AIDS in California receive primary medical care services through DHCS' California Children's Services (CCS) Program. DHCS provides a report of expenditures for children to OA upon request. Each year the Governor (or designee) signs a waiver certifying that through the combined RW Part B and DHCS services, the proportionate amount of expenditures are provided for children with HIV in California.

HIV/AIDS Epidemiology Table: Table 1A included in **Attachment 4** presents AIDS and HIV (not AIDS) data. California has had name-based AIDS reporting since 1983, but name-based HIV (not AIDS) reporting was implemented on April 17, 2006. Different approaches were used to summarize the incidence and prevalence of the AIDS and HIV (not AIDS) populations in California.

AIDS data: As name-based AIDS reporting in California has been in effect for over 25 years, both AIDS prevalence and AIDS incidence were determined using data taken directly from the AIDS surveillance system. The background material for this table is similar to what has been provided for this application in previous years. The AIDS numbers in Table 1A **Attachment 4** reflect reported cases of AIDS diagnosed through December 31, 2010, and reported into the surveillance system by October 31, 2011.

HIV (not AIDS) data: HIV prevalence for California was estimated by taking a proportion of the most recent national HIV prevalence estimate published by the Centers for Disease Control and Prevention (CDC) (CDC. HIV Surveillance – United States, 1981–2008. *Morbidity and Mortality Weekly Report* 2011; 60 (21):689–693). The estimated number reflects persons living with HIV infection who are aware of their infection, which includes persons (that would be) reported into the HIV/AIDS surveillance system as well as persons diagnosed with HIV infection but not reported into the system (such as anonymous testers or confidential testers yet to initiate HIV-related care, persons reported in the code-based system but not in the names-based system, persons diagnosed out of state but residing in California, and cases submitted for reporting but yet to be entered into the reporting system). The details of the calculations are similar to those provided for the RW Part B States/Territories Formula application for Year 20, with the primary difference that extra cases needed to be added to account for prevalent cases reported during FY 2009 and FY 2010. Demographics for prevalent HIV cases were estimated using information from names-based HIV cases living on December 31, 2010, as reported through October 31, 2011 (n = 40,753). Estimated cases with pediatric HIV exposure that are older than 12 on December 31, 2010, are included within pediatric exposure categories in the second part of the table as in previous years.

Narrative: The following were used to provide a comparative description of HIV disease prevalence by demographic characteristics and exposure category in California: (i) the number of people living with HIV (non-AIDS); (ii) the number of people living with AIDS; and (iii) the number of new AIDS cases diagnosed within the last two calendar years.

Number of People Living with HIV: Table 1A of **Attachment 4**, Epidemiology Tables includes measures (i) through (iii) for California. The demographic characteristics of HIV/AIDS cases reflect both the general population of the state and characteristics of the HIV epidemic within it. Description of the HIV/AIDS population and comparison to the general population is discerned via (i) and (ii). Trends over the past two years are discerned by comparing the demographic breakdown of (iii) with that of (i) and (ii).

Number of People Living with AIDS (PLWA): At the end of FY 2010, there were 68,932 PLWA and an estimated 58,738 persons diagnosed and living with HIV (non-AIDS) in California.

Number of New AIDS Cases Reported within the Last Two Years: In the most recent two-year period (January 1, 2009 through December 31, 2010), total AIDS incidence was 5,477 cases for California. The racial/ethnic breakdown of the HIV/AIDS population reflects both the general California population and trends specific to certain groups. As with the general population, the majority of PLWH/A are non-White and over 30 percent are Hispanic/Latino. However, while roughly 6.6 percent of the general population is Black, over 18.3 percent of the HIV/AIDS population is Black. AIDS cases diagnosed in FY 2009-10 show a major racial/ethnic discrepancy in that these recent AIDS cases have a much higher proportion of non-White persons than prevalent HIV or AIDS cases at the end of FY 2010. The largest discrepancy occurred among Hispanics, who comprised 32 percent of PLWA, roughly 30 percent of those living with HIV (non-AIDS), but over 37 percent of AIDS cases diagnosed in the last two years. In relative terms, large discrepancies also occurred among the Asian/Pacific Islander population (4.7 percent of recent AIDS cases but 3.5 percent to 3.8 percent of prevalent HIV or AIDS cases) and multiracial population (0.8 percent of PLWA, 0.9 percent of prevalent HIV cases, and 1.5 percent of new AIDS diagnoses). The distribution of gender among the HIV/AIDS population shows the historical concentration of the epidemic among males as well as the spread of recent

infections into females in California. Males comprise 88.7 percent of PLWA and 86.8 percent of those living with HIV (non-AIDS). Female representation among incident AIDS cases of the past two years is similar to that among prevalent HIV (non-AIDS) cases (12.7 percent and 13.2 percent, respectively), but higher than the 11.3 percent of females among PLWA. The age distribution of prevalent and incident cases is dominated by the increased life expectancy for persons diagnosed with HIV or AIDS. At the end of FY 2010, 67.3 percent of PLWA were at least 45 years old, with increases in this proportion expected over the next few years due to the demographic influence of the “baby boom” generation. Though not shown in Table 1A, the majority of these PLWA were diagnosed with AIDS more than seven years ago. The majority (53.3 percent) of persons living with HIV (non-AIDS) were in the 20 through 44 age range at the end of FY 2010, reflective of newer HIV infections occurring most frequently in younger cohorts. Among persons diagnosed with AIDS in the past two years, 60.2 percent were between 20 and 44 at diagnosis, far higher than the representation this age cohort had among living HIV cases (53.3 percent) and PLWA (32.4 percent) at the end of FY 2010. The distribution of reported mode of HIV exposure among prevalent and incident HIV/AIDS cases parallels trends seen among gender, with men who have sex with men (MSM) the most frequent category and heterosexual cases growing the fastest among all exposure categories. MSM comprise 63.8 percent of PLWA, 67.8 percent of prevalent HIV (non-AIDS) cases, and 60 percent of incident AIDS cases during FY 2010. The heterosexual contact exposure category comprises 9.5 percent of PLWA, 9 percent of prevalent HIV (non-AIDS) cases, but 10.5 percent of incident AIDS cases during FY 2010. Pediatric cases comprise less than 1 percent of prevalent HIV and AIDS cases in California. The increasing life span among persons diagnosed with AIDS can further be seen by noting that of 401 PLWA reported in a pediatric exposure category, only 54 were younger than 13 at the end of FY 2010.

Unmet Need - Population Estimates: The number of PLWA in California as of June 30, 2010, is estimated to be 68,212. The number of persons living with HIV (without AIDS) and aware of their status (persons living with HIV/non-AIDS/aware) is estimated to be 57,908 as of June 30, 2010. Thus, the total number of people living with HIV infection (with or without AIDS) and aware of their status is estimated to be 126,120. The unmet need framework is Table 1 in

Attachment 6.

Estimates of People in Care: OA estimated that 52,724 PLWA received HIV primary medical care (viral load testing, CD4 count testing, and/or provision of antiretroviral therapy) from July 1, 2009 through June 30, 2010, and that 35,025 persons living with HIV/non-AIDS/aware received HIV primary medical care during the same 12-month period. The total number of people living with HIV infection (with or without AIDS) and receiving primary care is estimated to be 87,749, or 70 percent.

Estimates of unmet need: OA estimated that 15,488 PLWA, or 23 percent, did not receive HIV primary medical during the 12-month period, while 22,883 persons living with HIV/non-AIDS/aware, or 40 percent, did not receive primary medical care. The total number with unmet need for primary medical care is estimated to be 38,371 or 30 percent.

Data Sources: OA used a variety of data sources, including: Enhanced HIV/AIDS Registry System (eHARS); CDC-generated estimates for persons living with HIV/non-AIDS/aware population estimates; ADAP data; Medi-Cal (Medicaid); OA’s client care database, ARIES; Kaiser Permanente Northern California; and aggregate data from Veteran’s Affairs (VA). Additional explanation about these data sets is found in the following *Estimation Methods* section.

Population Data: The AIDS population (68,212) is the number of reported cases of AIDS diagnosed through June 30, 2010, and reported into the AIDS surveillance system by November 11, 2011. The persons living with HIV/non-AIDS/aware population (57,908) was estimated using the same methodology discussed in the RW Part B Application, section 2.a. *Epidemiology, HIV (non AIDS) data.*

Care Pattern Data: Representatives of the state's eight RW Part A EMAs/TGAs participated in a statewide unmet need working group which is a shared process of estimating unmet need. OA took the lead in development of the data for the RW Part A and Part B estimates. OA created a matched data set using ADAP, ARIES, Medi-Cal (Medicaid), eHARS, and Kaiser Permanente Northern California client information records. To ensure that no individual was counted more than once, the program data were merged into one data file. This was done using the client demographic variables date of birth and gender, and a soundex variable created from the individual's first and last name. Each data file was processed to identify care patterns for the one-year time period of July 1, 2009 through June 30, 2010. If an individual received HIV medical care as defined above during this time period, the met need variable indicated a "YES." Each RW Part A EMA/TGA then received region-specific data from this OA master data file. Each EMA/TGA matched with its local case registry data (if available) and other local provider data to develop its RW Part A unmet need estimate; upon completion each EMA/TGA sent back to OA an updated dataset with additional care information and also additional client records not found in the master data file. This allowed OA to develop a more complete RW Part B estimate due to the EMAs/TGAs data inclusion of information from their local case registry and provider data files.

OA was unable to obtain client-level data from VA. Therefore, OA used the aggregate data provided on the VA Web site. The data are for calendar year 2008. In order to separate PLWA and persons living with HIV/non-AIDS aware, OA applied the same proportion found for VA data from FY 2003, which was used in previous Unmet Needs analyses.

Limitations: The Kaiser Permanente data were for Northern California (not the larger Kaiser system in Southern California) and was the only private insurance company submitting data to OA. This limits the completeness of the private insurance care patterns. Additionally, Medicare data are not included. The absence of some private insurance and Medicare data results in an overestimate of the percent of HIV and AIDS clients with unmet medical care in California. OA has been addressing this limitation by focusing on the entry of lab reports from the last few years, but not all were entered at the time of these analyses. The eHARS data include both AIDS and HIV information. California has had names-based AIDS reporting since 1983, but names-based HIV (non-AIDS) reporting only took effect on April 17, 2006. Between July 1, 2002 and April 16, 2006, California used a non-name code to report HIV (non-AIDS) infections. It was not possible to only use California's eHARS HIV data because not all of the prevalent HIV cases have been reported from LHJs having very diverse populations (see the discussion in the **HIV (not AIDS) data** in the Epidemiology section, above). Consequently, different approaches were required to summarize the AIDS and HIV (non-AIDS) populations in California.

Assessment of Unmet Need: Table 2 in **Attachment 6** distributes the estimate of unmet need by gender, geography, and race/ethnicity; however, VA numbers could not be distributed within these categories because only aggregate data were available. Therefore, the subpopulation analysis excludes an additional 2,950 (VA) cases with unmet need. While females account for 12.2 percent of the total PLWA and persons living with HIV/non-AIDS/aware population

(15,347/126,120), females account for 9.6 percent of the total AIDS/HIV-aware population with unmet need (3,823/39,721). This indicates that females are not disproportionately out of care. Further, when examining the data within gender, males are less likely to be receiving care than females, with 32.4 percent of the male population in need of HIV medical care (35,898/110,773) compared to 24.9 percent of the female HIV/AIDS population (3,823/15,347). The unmet needs for three racial/ethnic groups were analyzed (total population of 119,803 PLWA and persons living with HIV/non-AIDS aware population). African Americans account for 19.3 percent of the PLWA and persons living with HIV/non-AIDS aware population (23,107/119,803) and 17.8 percent of those in need of HIV medical care (8,466/47,452) are African American. Hispanics account for 32.7 percent of the PLWA and persons living with HIV/non-AIDS/aware population (39,124/119,803) and 30.4 percent of those in need of HIV medical care (14,418/47,452) are Hispanic. Whites account for 48.1 percent of the PLWA and persons living with HIV/non-AIDS/aware population (57,572/119,803) yet 51.8 percent of those estimated to have unmet need for HIV medical care (24,568/47,452) are White. These estimates indicate that the percent of unmet need is fairly proportionate by race/ethnicity, with Whites having more unmet need than represented in the total population of those with HIV/AIDS and aware of their status. However, Whites are more likely to have private insurance and, due to limited private insurance data available for the analysis, these findings are an overestimate of unmet need for Whites. However, as OA completes its back-entry of lab data, this pattern will be evaluated again. When looking within race/ethnicity, the data indicate that 36.9 percent of the Hispanic HIV/AIDS-aware population had an unmet need for HIV medical care (14,418/39,124), 36.6 percent for African American HIV/AIDS-aware population (8,466/23,107) and 42.7 for Whites (24,568/57,572). With respect to location of unmet need, a general proxy for urban versus rural counties is to group EMA/TGA counties together to represent urban and group the non-EMA/TGA counties to represent rural counties. The unmet need estimates for these categories indicate that those with HIV/AIDS and aware of their status living in the EMA/TGA counties have a higher unmet need compared to those living in more rural areas, 32.0 and 27.1 percent, respectively. However, this discrepancy is probably influenced, in part, by the missing lab reports (higher volume labs are located in the urban areas) as well as some urban administrative barriers. Future unmet need analyses will continue to monitor this observed difference in geographic patterns.

Table 3 in **Attachment 6** shows the unmet need client counts and percentages for PLWA and persons living with HIV/non-AIDS aware, both combined and separated, for the past five years' worth of estimates. During this time period, the overall unmet need percentage in California started around 44 percent in FYs 2006 and 2007, and fell just below 40 percent in FYs 2008 and 2009. Most recently, however, the percentage in FY 2010 has dropped to its lowest level to 30.4 percent. Unmet need for persons living with HIV/non-AIDS/aware has been as high as 45.9 percent and 47.5 percent in FYs 2006 and 2009, as low as 37.5 percent in FY 2008, and settling at 39.5 percent most recently in in FY 2010. Unmet need for PLWA fell dramatically over time, peaking at 44.1 percent in FY 2007, falling to 32.4 percent in FY 2009, and dropping further to its lowest level at 22.7 percent in FY 2010.

The most recent drop in unmet need percentages can be attributed to some data-related occurrences this past year. OA has nearly completed its historical lab data entry into its case registry system, eHARS. This yielded more "met" cases than previous years, as this year's analysis was able to incorporate these lab data while previous years did not. For the PLWA and persons living with HIV population estimates, CDC released its new national prevalence

estimate; eHARS data were also recently matched with death data. Both of these lowered population estimates. Hence, a higher number of met cases coupled with lower population estimates resulted in a lower amount of unmet need for this year's analysis.

Planning and Priorities Based on Unmet Need Data: OA utilizes data from Unmet Need Framework in addition to other planning documents such as OA's SCSN, to help guide funding allocations and the development of policies and standards. The administrative and programmatic streamlining implemented as a result of the State Budget cuts in FY 2009 provided opportunities for more focus of program content internally and greater flexibility at the local level. OA continues to prioritize the HRSA service category, Outpatient/Ambulatory Medical Care services, as the first service priority or Tier I Services for all RW Part B (non-MAI) funding. LHJs are required to ensure that outpatient medical services are met or PLWH/A in their jurisdiction regardless of funding sources before allocating other funds for support services or Tier II service categories.

LHJs are required to complete a Service Delivery Plan that includes local assessment of unmet need and identifies Tier II services that will be prioritized to mitigate that need for priority populations. OA will be more prescriptive this year and require that LHJs identify target populations and particular activities based on a comprehensive assessment of unmet need within the jurisdiction. Participation on the RW Part A EMA/TGA Planning Councils provides OA insight on local planning priorities, strategic planning and allocation setting to address unmet need that is considered when allocating RW Part B funding each year. Based on unmet need data, OA continues to fund as many LHJs with MAI funding as is possible to reach minorities and link them to medical and support services and ADAP. Additional augments are in the process of being made to OA data systems to track clients through the continuum of services from outreach to engagement into care, treatment and support services.

OA continues to collaborate with the California Department of Corrections and Rehabilitation's (CDCR), Transitional Case Management Program (TCMP) and have discussed ways to formalize our relationship including formal Scopes of Work and/or interagency agreements, in order to successfully engage HIV-infected persons being released from state correctional institutions in HIV care and treatment. Specifically, OA has met with the TCMP contractors and suggested ways to strengthen the relationship between the TCMP social workers and RW Part B and MAI outreach workers as well as local AIDS directors, to achieve a successful transition into HIV care for ex-offenders who often fall out of care services once released from prison.

California is 1-of-26 sites funded by CDC to conduct the Medical Monitoring Project, a supplemental HIV/AIDS surveillance system that yields population estimates of characteristics of persons with HIV infection and who are in care and live in California (excluding Los Angeles and San Francisco, who are funded separately). The project captures experiences of those in care, describes met and unmet needs, and further assists OA to target funding allocations and care programming to those demonstrating the most unmet need.

Early Identification of Individuals with HIV/AIDS (EIIHA) - Strategy to Identify

Individuals who are Unaware of their HIV Status: OA has an established Goals and Strategies Framework that serves to meet all of the goals outlined in EIIHA. The Framework is aligned with the National HIV/AIDS Strategic (NHAS) goals of: 1) reducing the number of people who become infected with HIV; 2) increasing access to care and improving health outcomes for people living with HIV; and 3) reducing HIV-related health disparities. OA's EIIHA strategies serve to operationalize these goals and support a system of care at the state and local level that

promotes awareness, access, and linkage to quality care and prevention services. Because the EIIHA initiative requires close collaboration between prevention and care providers, it is helpful to clarify the ways in which OA funds HIV/AIDS services. In FY 2012, OA will provide CDC funding for HIV prevention activities to the 19 California LHJs representing 95 percent of living HIV/AIDS cases (excluding Los Angeles and San Francisco). The remaining 37 LHJs do not receive prevention funding, but they do have access to free sterile injection supplies, condoms, and educational materials from OA. Care funding is allocated to LHJs and CBOs that reach each county in the state.

When considering the current state of HIV prevention and care funding in general, California LHJs may be categorized within three subsets: the 19 LHJs receiving OA-administered funding through both the HRSA RW Part B and CDC Prevention grants; San Francisco and Los Angeles, which receive direct CDC Prevention funding and HRSA RW Part A, while receiving HRSA RW Part B dollars through OA; and the remaining 37 LHJs that receive HRSA RW Part B funding through OA, but which receive no CDC Prevention funding but do receive CDC-funded prevention resources as noted above. For the purpose of EIIHA planning, the 19 LHJs receiving prevention funding through OA, along with San Francisco and Los Angeles, will share EIIHA-related priorities and requirements. The other 37 LHJs (those receiving only HRSA funding and no CDC funding but do receive CDC-funded prevention resources) will be subject to an amended set of priorities and requirements reflecting their more limited funding base. In order to successfully implement an effective EIIHA strategy, California has implemented stronger cross-prevention/care branch collaboration and is asking for stronger collaboration and enhanced partnerships between HIV prevention and care providers at the local level. The nature and extent of these partnerships in any given LHJ will depend on local needs, infrastructure, and funding. OA has developed an EIIHA strategy with three primary goals:

1) *Routinized HIV testing in medical and non-medical settings:* OA is in the process of expanding routine, opt-out HIV testing to all appropriate health care settings (HCS). OA has been funded by CDC PS12-1201 (Category B) to provide HIV testing in HCS representing 4 LHJs, 2 emergency departments, 8 Planned Parenthoods, 10 jails, and 65 community health clinics. These grantees have been funded to develop and maintain routine, opt-out testing in HCS. With these funds, OA expects grantees to provide 67,569 tests which will result in 337 new HIV-positive patients during the next three years. An important aspect of the programs funded through CDC PS12-1201 (Category B) is ensuring that people who test HIV positive are quickly linked to HIV medical care and retained in care over time as well as accessing Partner Services and other prevention services. OA's Linkage-to-Care (LTC)/Partner Services Specialist will work with each of these testing sites to establish relationships with HIV care providers. The goal of this HIV testing project is to ensure that 75 percent of people who test HIV positive are linked to care and referred to Partner Services within 30 days of receiving their HIV diagnosis.

In the next five years, OA will work closely with the 19 CDC prevention-funded LHJs to implement strategies to increase HIV testing which targets specific high-risk populations in non-HCS, and will increase collaborations at the state level with agencies that are funded to provide testing in these venues.

2) *Targeted strategies to inform, refer, and link HIV-positive individuals at the highest risk to medical and support services:* Consistent with NHAS, OA's Goals and Strategies and Health Disparities Framework, OA will require that funded LHJs provide an EIIHA plan that defines target populations to focus EIIHA efforts in order to slow disease progression, improve health outcomes, reduce disparities, prevent further transmission, and have the highest impact on

populations disproportionately affected by HIV/AIDS. The plans will be required to identify cultural and linguistically tailored EIIHA activities that address the unique and distinct barriers to testing and engaging in care services among specific populations. Target populations for OA's HIV prevention services have narrowed to target those HIV-positive persons at high risk of transmitting HIV, their partners, injection drug users (IDUs), MSM (especially African American and Latino MSM), and African American and Latina women.

3) *Effective care and prevention service integration:* In order to successfully implement an effective EIIHA strategy, California has implemented stronger cross-prevention/care branch collaboration and is requiring the same level of cross collaboration by funded LHJs. The nature and extent of these partnerships in any given LHJ will depend on local needs, infrastructure and funding. To provide more oversight for LTC, treatment and prevention services, retention/re-engagement in care and referral and linkage to other medical and social services for HIV-positive individuals and services to keep persons HIV negative, OA will convene a LTC/Retention in Care Workgroup that spans OA's HIV Prevention, SRE, and HIV Care Branches. The purpose of the workgroup will be to ensure maximum coordination, effective data reporting, and minimum duplication of effort.

OA will require funded LHJs to demonstrate active collaboration and coordination between prevention and care sites involved in these activities. Areas of collaboration may include activities taking place within the context of RW Part C (Early Intervention) Programs, and/or activities such as TLC+, the Antiretroviral Treatment Access Study, RW Part A, MAI, and Partner Services. The use of our online program monitoring system, Local Evaluation Online (LEO), provides the capacity to report on all program activities. In addition, OA is developing a process to link prevention information from LEO with other information systems at OA, including the eHARS, (which contains HIV surveillance data) and ARIES, the reporting system utilized by RW Part B recipients.

Coordination with other programs/facilities and community efforts: OA has begun collaborations with other state partners such as California Primary Care Association (CPCA) to increase provider awareness of routine HIV testing; Office of Family Planning, and Alcohol and Other Drug Programs to target high-risk populations for testing in non-HCS; CDPH's Sexually Transmitted Diseases (STD) Control Branch to operationalize implementation and evaluation of a surveillance based model to initiate Partner Services which has been delayed due to legal barriers in California.

Another strong collaborator to promote EIIHA is the California STD/HIV Prevention Training Center (PTC) which works collaboratively with CDPH's STD Control Branch. PTC has long been a partner of OA, providing such EIIHA-relevant trainings as "Prevention Services for Healthcare Professionals," Complete Risk Counseling and Services," "Ask, Screen, Intervene," and "Healthy Relationships," which emphasizes appropriate and safe HIV disclosure. As the development of the EIIHA service continuum proceeds, OA will partner with PTC, as well as the HRSA-funded Pacific AIDS Education Training Center (PAETC) to develop EIIHA-related training.

OA continues to work with our partners within CDPH to make HIV testing available in other settings such as those providing testing and care for tuberculosis, STDs, and viral hepatitis. Integration of services at the local level makes the services more available to those we serve and increases statewide capacity to ensure that those who are unaware of their HIV status are reached. Ties between OA, local service providers, and CDCR's TCMP still exist. TCMP is a case management program that links ex-offenders to HIV services and to medical care upon

release from California prisons. Even though OA's HIV services may be reduced, TCMP still continues to work with OA and local agencies to link those recently released to care.

EIIHA activities and strategies that will be incorporated into the program's Requests for

Proposals: In an effort to acknowledge and accommodate the broad diversity of service needs while maintaining consistent focus on EIIHA priorities, each LHJ will be asked to submit an EIIHA plan that includes a list of the target populations they will prioritize, based on local epidemiology, demographics, and service gaps. The target populations they intend to serve will be derived from their selected parent populations, accompanied by an explanation/justification for selecting those particular target populations. Lastly, they will include a list of their proposed EIIHA service delivery areas, and describe how they intend to implement these services. Finally, OA will review their proposals and develop a technical assistance monitoring plan for each. Once LHJ plans are submitted, OA will develop a technical assistance and monitoring plan that will include individualized assistance and group-based technical assistance (Webinars, teleconferences, and site visits) to enhance resource-sharing and collaboration between neighboring jurisdictions where appropriate.

OA will continue to fund LHJs to provide HIV testing in non-HCS but will assist LHJs in order to improve efforts to target testing to individuals at highest risk of HIV. In addition, OA is requiring that LHJs utilize CDC prevention dollars to support activities directly related to EIIHA, such as LTC and retention in care, outreach and education, linkage to other medical and social services, and Partner Services.

Consideration of ADAP and other medication resources: With increased EIIHA efforts, there is potential for ADAP to be strained as a resource for life-sustaining medications for PLWH/A. So far, California has been fortunate in being able to accommodate all eligible HIV-positive persons in ADAP, Medi-Cal, or other sources for HIV medications. There is currently no waiting list for these services and, if funding permits, this will continue. California's network of ADAP enrollment sites and ADAP pharmacies is extensive and will directly support the EIIHA goal of linking HIV-positive persons to care and treatment. OA continually monitors ADAP capacity in light of the State economy and potential for increased demand as more individuals lose income and become eligible for ADAP.

The Bridge to Healthcare Reform, Medicaid 1115 waiver, LIHP was implemented in California in July 2011. OA is actively collaborating with DHCS to estimate impacts to ADAP as the initiative is rolled out to counties. It is anticipated that the waiver will lessen the strain on ADAP as more RW ADAP clients will be eligible for LIHP and transition out of ADAP. OA has and will continue to provide technical assistance to counties on screening for LIHP in accordance with the RW payer of last resort statute.

Addressing disparities in access and services among affected subpopulations: The goals of EIIHA dovetail perfectly with the goals of California's MAI services. MAI program services are focused on outreach to care and treatment education in order to ensure that HIV-positive persons of color are provided with access to HIV care (or support for re-engagement in HIV care), and HIV medications via ADAP. California has been a recipient of HRSA MAI funds, either through competitive or formula grants, since program inception. Currently, MAI funding supports strategies such as use of outreach workers to identify out-of-care or lost-to-care individuals and resolve barriers to care engagement and treatment adherence.

California's communities of color, primarily Latino and African American, are historically underserved, thus resulting in late access to care and increased risk of being lost to care or failure to adhere to treatment. Because of this, many jurisdictions may elect to tailor

EIIHA activities to these populations. Depending on the priorities in a given jurisdiction, EIIHA efforts may also be expanded beyond MAI to include those who may not be represented in MAI's target populations, but who are at risk for failure to access or remain in care or for failure to adhere to HIV treatment (for example, MSM/substance abusers).

OA's Syringes Services Program (SSP) initiative supports EIIHA efforts as it aims to expand access to sterile syringes and other safer injection equipment throughout the state, improve efforts to properly dispose of syringe waste, and link IDUs to relevant prevention services, medical care, and social services. Funding for these programs include technical assistance to LHJs in navigating the network of state and local laws that govern syringe distribution, recovery, and disposal as well as technical assistance to help LHJs effectively support HIV and viral hepatitis prevention, LTC and retention and reengagement in care among IDUs. OA permits LHJs to use their HIV care funds to support syringe exchange program (SEP) operations as a part of a comprehensive strategy to link individuals testing positive to medical care and to reduce HIV transmission as a secondary prevention measure. OA allows CDC prevention funds to pay for costs including but not limited to personnel, syringe disposal services, equipment purchase, and monitoring of required program elements.

HRSA funds can be used to support SSPs as part of a comprehensive HIV treatment program to link individuals testing positive to care and to reduce HIV transmission as a secondary prevention measure. SSPs are considered a "support service." EIIHA strategies and implementation details will be more clearly defined for each jurisdiction as EIIHA plans are received and while flexibility will be encouraged in order to meet the particular needs of a given jurisdiction, OA will ensure that the ultimate goal will be to increase access for those who are underserved and who may be stigmatized or hard to reach.

Programmatic, systemic, and logistical challenges: California experienced devastating funding cuts in State FY 2009-10 which resulted in the statewide restructuring of HIV prevention and care services. This impact was amplified through additional funding cuts occurring at the local level in most jurisdictions. The funding that was lost has not been restored, and providers are still in the process of learning to contend with "doing more with less" as they attempt to meet increased prevention and care needs. Staff capacity for effective outreach and LTC and prevention services was severely diminished. In addition, LHJs have been forced to redefine their system of care in the context of defunded programs and new unfunded EIIHA requirements.

Other systemic challenges to testing are that many at risk and possibly infected but unaware individuals actively avoid learning their HIV status. Continued stigma, discrimination and isolation perceived among those who can be reached through EIIHA efforts continue to result in denial of HIV and testing behavior which leads to unaware risk. Social marketing and health messages about the benefits to the individual of knowing if they are HIV infected is critical to break through the denial, avoidance, and false sense that they are better off not knowing their HIV status. Social network and peer outreach programs are still necessary to assist in reaching and testing high-risk, HIV-infected but unaware individuals.

Additionally, due to limited resources many health departments are facing staff shortages and as a result are limiting testing hours at sites. In many cases, HIV testing is available during business hours which may not present the best opportunity to reach those individuals most at risk for acquiring HIV. HIV testing centers are having a difficult time transitioning to targeted testing of high-risk clients given many low-risk clients continue to choose public versus private health care sites for their HIV testing. The resources expended on low-risk testers dilutes the ability to identify HIV-infected, unaware individuals. Current efforts by OA to encourage

integrating HIV testing into routine health care is critical to free up resources within HIV prevention testing sites to focus their resources toward high-risk individuals more effectively. Systematically, if public-funded test sites could bill private insurers for HIV tests, it would bring additional resources to reach high-risk individuals as well as aid in moving low-risk individuals out of the public sites and back to their routine medical providers. This is a focus of OA's Expanded Testing grant.

Other challenges involve linking care, ADAP, and prevention databases to be more efficient for utilization in outreach and referral activities. In 2010, California removed many barriers to utilizing HIV/AIDS surveillance data for public health purposes through the enactment of Assembly Bill 2541 (Portantino, Statutes of 2010, Chapter 470). Prior to this bill, California state and local public health departments could only share HIV/AIDS surveillance data for the purposes of disease investigation, control, or surveillance without the written authorization of the HIV-positive person who is the subject of the data. This meant that HIV/AIDS surveillance data could not be further shared by state and local public health departments for the purpose of HIV/AIDS case management. Now California Health and Safety (H&S) Code Section 121025 allows state and local health departments to use HIV/AIDS surveillance data collected by OA to contact an HIV-positive person or his/her HIV care provider for the purpose of offering assistance with the coordination of care and treatment services.

OA will share data and collaborate with LHJs and local health care providers to identify out-of-care clients and transition them into care. OA will employ three strategies towards this goal, utilizing eHARS and ARIES, and potentially its ADAP database and Medi-Cal data.

Strategy 1: Examine eHARS data to identify clients without a CD4 count or viral load test in past the 12 months; these clients will be considered out of care. The laboratory data in eHARS should be sufficient to identify out-of-care clients since all laboratories in the state are legally required to report CD4 and viral load results (including undetectable values) to the LHJ, which then reports them to OA. The eHARS data on out-of-care clients will be sent to the appropriate LHJ for follow up.

Strategy 2: OA's HCP providers will be directed to use an existing ARIES report to identify out-of-care clients themselves. Clients with an active, lost to follow-up, or an unknown in-care status who have not had a medical service in the past year will be considered out of care; providers will subsequently follow up with such clients.

Strategy 3: OA will also work with its legal office to determine whether or not an ongoing match between ADAP data and Medi-Cal data can be used to identify out-of-care clients. Clients from the ADAP/Medi-Cal match without a prescription in 12 months from ADAP and who have not transitioned to Medi-Cal will be considered out of care. Information about these out-of-care clients will be sent to the LHJ for follow up.

Role of the RW Program in promoting routine HIV testing within the EMA/TGA according to CDC guidelines: Many of California's RW Part A-funded programs are housed within or co-located with community health centers that also receive CDC Prevention funds from OA. OA will work with these programs to encourage increased routine, opt-out testing in these HCS. OA will apply the lessons learned implementing the CDC-funded HIV testing in HCS project in four LHJs to provide training and technical assistance to all RW programs that want to implement routine, opt-out testing in their settings. The statewide CPG sponsored by OA is developing a state strategic plan which, for the first time, will be a combined care, prevention, and surveillance plan for California. This statewide plan will address goals and strategies that are

consistent with EIIHA and which will apply to all LHJs in the state, including those that are EMAs, TGAs, emerging communities, and areas that receive RW Part B only.

Coordinate with RW Part C program(s) for the purpose of making HIV unaware individuals aware of their HIV status: Each LHJ receiving RW Part B funding will be required to submit a plan outlining how they intend to implement EIIHA activities within their LHJ. LHJs that include RW Part C programs will be expected to define their strategy for active coordination and collaboration in achieving EIIHA goals. OA will support, through shared consultation and technical assistance as needed, the required collaboration between RW Part C programs and their local partners in addressing EIIHA priorities.

EIIHA Matrix - The **Attachment 8** lists the following populations (Parent and Target) that OA has identified as options for Part B-funded LHJs to focus EIIHA activities/strategies to identify, inform and link individuals who are unaware of their HIV-positive status into quality medical care and support services: 1) Latino and African American MSM; 2) IDU/MSM; 3) African American and Latina Women; 4) Latinos/as undocumented or born outside of the United States; and 5) Transgender youth.

Plan - OA intends to provide a menu of target groups (see below) to our LHJs based on current statewide epidemiological data and service priorities. Each LHJ will select the target groups most heavily impacted by the HIV epidemic in their LHJ for inclusion in EIIHA activities, and will include justification for their decisions in the EIIHA plan they will be required to submit. However, because of California's geographic and demographic diversity, there may be distinct epidemiological or demographic factors in a given LHJ that can support inclusion of other target groups in that particular LHJ. As a result, some target groups may ultimately be included in EIIHA activities that are not listed at this time. Any new additions to the target group list will be thoroughly documented and accounted for in EIIHA planning.

Barrier, Priority Needs and Cultural Challenges Which Obstruct Awareness of HIV Status: Eighty-one percent of Californians living with HIV/AIDS are MSM/IDUs, MSMs, or IDUs. Almost one-half (49 percent) of PLWH/A in California are either African American or Latino. There is a great need to understand this Parent Group and focus EIIHA strategies to reach the target populations included and address their unique barriers to testing.

African American and Latino MSM share common barriers to testing such as internalized homophobia and stigma which are prevalent in both communities. Low health literacy, lack of social acceptance in family and community, substance abuse, mental health, limited access to health care/limited utilization of health care are also common. While Latinos represent 37 percent of California's population and 30 percent of PLWH/A, they are a very large and vulnerable population in California that can find it difficult to initially engage in and remain in HIV care and treatment. Latino MSM may have limited English proficiency; immigration concerns, and lack of social/cultural integration within the larger gay community. African American-specific challenges include racism; internalized homophobia impacting ability to make healthy choices; tendency to underestimate personal risk based on the challenge of maintaining safe behaviors over time. African Americans may have HIV-specific medical mistrust (conspiracy theories regarding HIV testing, care, and treatment); HIV stigma within the African American community leading to reluctance to acknowledge risk or access testing.

For IDU/MSM: Stigma and stereotyping and fear of legal prosecution lead to difficulty engaging with providers; lack of social-cultural integration within the greater gay community, resulting in decreased access to appropriate support and information; mistrust of social service and health care systems; myths, misinformation, or conspiracy theories related to HIV testing

and/or medication that contribute to failure to test. Eighty-two percent of Californians living with HIV/AIDS are MSM/IDU, MSMs, or IDUs. These populations also use hospitals and community health centers to meet basic health care needs, such as STD treatment and wound care. Again, normalizing HIV screening for these groups in HCS will increase this population's knowledge of their HIV status, the first step to LTC activities.

For African American and Latino Women: Child care issues and lack of transportation inhibit access to test providers; custody concerns resulting in fear of testing; poverty; low literacy; low health literacy; substandard housing; social isolation; limited access to health care/limited utilization of health care (no insurance, no income, job hours do not mesh with clinic hours and/or inability to function within traditional make an appointment in advance systems); limited access to supportive services that would facilitate access to testing; prevalence of high-risk triad of factors leading to lack of access to testing and care: victimization history plus drug use plus depression. Latina women may have limited English proficiency; immigration concerns (including laws that may restrict access to HCS); lack of social/cultural integration within the larger community. African American women may experience gender-based power dynamics within relationships that compromise ability to access testing or care; prevalence of high-risk triad of factors leading to lack of access to testing and care; skewed sexual ratios resulting from rates of imprisonment, death, and drug use among men, this leads to sexual networks conducive to increased HIV risk, but is combined with reluctance to acknowledge this risk. Cultural beliefs regarding wellness/illness that may result in unwillingness to connect with test providers; fear that testing would indicate that they are promiscuous, unfaithful, engage in risky behaviors, or are HIV infected; cultural norms and beliefs regarding sexuality and gender identity that make it difficult to acknowledge risk.

Latinos undocumented or born outside of the United States experience barriers similar to other Latino MSM and Latina women. However, among migrant workers have high mobility/unpredictable living situations based on search for work patterns and stigma and homophobia that prevent access to testing/discussion of status (fear that testing would indicate that they are gay, are unfaithful, engage in risky behaviors, or are HIV infected); cultural norms regarding sexuality and gender identity. Substance use patterns particular to migrant workers can be increased (heavy alcohol use; use of stimulants).

Transgender individuals have several issues that obstruct their awareness. Formal systems such as health care and law enforcement can be culturally incompetent in working with transgender youth. Unless the systems are evolved and well-trained, they tend to want youth to behave according to normative standards that can be managed by laws and protocols. Transgender youth are less likely to conform to these norms and this creates frustration within the systems that often suspend services to these youth. Many transgender youth are marginally housed. They have left or been thrown out of their parents' homes. Meeting their immediate needs such as shelter, food, and personal security is paramount to health concerns. Transphobia and stigma in formal systems such as health care deter transgender youth from seeking services in these settings. Some transgender youth will seek hormone therapy and can be engaged in health care and HIV testing in that way. However, this is rare and many transgender youth will pursue hormones in the underground market. Transgender Latinas (male-to-female transgender individuals) struggle with many barriers that obstruct their awareness of their HIV status. The issue many are dealing with is their undocumented immigration status. If they are undocumented, they are less likely to engage in any formal setting that would call attention to their undocumented status. As more and more settings explore immigration status to determine

who will pay for the services rendered this will drive undocumented immigrants further into informal settings for health care and other services. This is particularly concerning for transgender Latinas who will want to access hormones for gender confirmation purposes. Transgender Latinas will access hormones in the underground market that can encourage HIV transmission by the sharing of needles for hormone injections.

Those living with, and at risk for, HIV disease in California represent wide variation in geographic, racial, and socio-economic diversity that encompasses distinct populations and sub-populations. When considering how best to implement the EIIHA initiative, the approach to serving a target group in one locale (for example, Hispanic MSM in rural areas that share a border with Mexico) may be very different than the most effective approach for other regions of the state (for example, Hispanic MSM in urban areas of Northern California). This is further complicated by the service needs of particular subpopulations: again, as an example, LHJs with large populations of Hispanic immigrants from Central or South America may require different strategies than those in locales whose Hispanic target population is comprised mainly of Mexican nationals.

Actions Taken to Promote HIV Testing in the State - *Coordination with Other Organizations to Promote HIV Testing:* OA coordinates with multiple partners to expand HIV prevention and promote testing including LHJs, community hospitals, and CBOs in the administration of CDC and HRSA-funded continuum of HIV prevention and care services. In order to expand the scope of routine testing in health care facilities, OA has partnered with PAETC, California HIV/STD PTC, CPCA, California Medical Association, and HRSA Region IX in order to promote HIV testing in and provide training to medical providers.

OA will provide social marketing support to funded LHJs to promote HIV testing but will limit resources for CDC-approved, simple social marketing, or media campaigns that include benefits of early detection of HIV infection and/or other emerging messages deemed appropriate by CDC and OA. All funded LHJs have access to the materials developed and delivered through the California AIDS Clearinghouse and CDC's Materials Catalog. OA provides the general population information on local resources and programs through its Service Referral telephone line, Internet "live chat," and Web site. This project was developed in collaboration with CDC and its contractor, National Prevention Information Network. These services are promoted through our LHJ contractors and colleagues, the Advisory Network, CPG, and other stakeholders. Appreciating the limited resources available to conduct social marketing, LHJs will be guided toward simple methods to convey community-developed health messages related to the pre-determined health issues, and keeping their evaluation activities realistic and achievable as well.

Role of Early Intervention Programs (EIPs) and Outreach in Promoting HIV Testing:

Allocating outreach services is critical to identifying undiagnosed people and providing vital information that supports them engaging in care and support services. Outreach is also essential for populations of color and or other marginalized populations who may experience cultural norms that create barriers to accessing care and treatment such as African American, Latinos, women, and transgender individuals. Linking those individuals newly diagnosed with HIV to vital medical and support services is the primary goal of EIP services. EIPs include a complement of services such as LTC, case management, HIV/health education, risk reduction, and mental health in order to support engagement and retention in medical/treatment services. The two services of outreach and EIP are critical and effective in promoting HIV testing and delaying disease progression or further transmission.

Identifying, Informing, Referring, and Linking - *Identifying Individuals Unaware of Their HIV Status Essential Activities:* Promoting routine HIV testing is the corner stone of OA's effort to increase early detection. The purpose of OA's identifying plan includes OA's efforts to normalize HIV testing in health care facilities. OA understands that the individuals in these EIIHA target populations who are unaware of their HIV status can be difficult to identify through counseling, testing, and referral (CTR) alone, especially if they are unwilling or unable to acknowledge their HIV risk. OA is working to implement and increase HIV screening in all HCS where our unaware sub-populations might receive services, for example, in emergency departments, community health centers, STD clinics, substance abuse treatment centers, etc. OA is providing training and technical assistance to these settings in HIV test selection, integrating HIV screening into health care facility flow, LTC strategies, Partner Services, and third-party reimbursement for HIV tests. One of the goals of this funding is to assist HCS to be able to sustain HIV testing when the funding is withdrawn. This includes training and technical assistance related to maximizing reimbursement from Medi-Cal, Medicare, and private insurance, choosing the most cost-effective testing method and streamlining consent procedures. OA is planning to produce best practices for implementing routine, opt-out HIV testing in HCS that does not require the supplanting of HIV prevention funding for HIV care funding. Normalizing HIV screening in these settings will increase the number of people in these populations who know their HIV status and will enhance LTC efforts by decreasing the number of referral steps and other potential institutional barriers clients are required to negotiate before making contact with a care provider.

Coordination with RW Part A: Initially, OA convened an EIIHA workgroup of RW Part A-funded LHJ representatives to collaborate with OA in EIIHA planning guidance development. Due to staffing shortages, the meetings were not maintained. However, OA plans to reconvene that EIIHA work group to assure coordination and non-duplicated or supplanted activities. OA also maintains participation in the RW Part A Planning Councils where EIIHA planning and priorities are decided upon.

Coordination with Prevention and Disease Control/Intervention Programs: OA is committed to collaboration between HIV Prevention and HIV Care Branches to assure a coordinated approach and requirements for EIIHA. OA will convene the LTC/Retention in Care workgroup to assure all activities and policies will be coordinated.

Informing - Essential Activities: The way individuals learn about their HIV status correlates with the kind of HIV testing they receive. When clients receive HIV testing through OA-funded CTR, they typically receive both HIV-negative and HIV-positive results in person. Currently, 91 percent of OA's CTR clients receive their HIV test results. All OA EIIHA target populations receive their HIV test results at approximately the same rate. CTR clients that receive conventional HIV testing provide contact information and permission for contact during their initial visit. Clients that receive rapid HIV testing sign a consent saying they will return for their confirmatory results and can be contacted with those results. In the CTR program, state law requires that HIV-positive results must be provided in person. For patients receiving an HIV test in a HCS, those testing HIV negative may likely receive their results in writing on discharge papers or in the mail when other test results are reported. OA recommends that HIV-positive results be given in person, but this is not legally required. Providing HIV-positive results in person can accelerate LTC. How to inform patients of their HIV-positive status is an important training and technical assistance issue for health care providers. OA provides assistance with

this need. It is not expected that EIIHA sub-populations will be informed of their HIV status at dissimilar rates.

Coordination with RW Part A: Four RW Part A program grantees are also CDC HIV testing in HCS grantees: Alameda, Orange, Sacramento, and San Diego LHJs. The AIDS directors and staffs of these LHJs will work with their HIV testing in HCS and HCPs in order to most efficiently implement routine, opt-out HIV testing, and prompt LTC and Partner Services.

Coordination with Prevention and Disease Control/Intervention Programs: OA's stated goal for CDC prevention grant-funded RW Part B project is that people who test positive for HIV will receive their HIV test results as soon as possible after testing and those who test HIV positive will be LTC and receive Partner Services within 30 days. OA will provide training and technical assistance to medical providers in testing venues to increase their comfort level with providing HIV-positive test results and LTC information. In addition, each grantee has identified a coordinator who will follow up to determine that a person testing HIV positive has been appropriately linked to and retained in care.

Referral to Medical Care - Essential Activities: An effective referral service is critical when an individual has received a preliminary and/or confirmatory HIV-positive test result. Without an effective referral into HIV care, an HIV-infected individual may not access care until symptomatic, thus reducing the likelihood of a good health outcome and increasing the possibility of HIV transmission. California prioritizes referral to care activities across its primary funding sources for both HIV prevention and care. An important strategy, which has recently become allowable in California, is to refer recipients of a preliminary positive result directly to an HIV care provider for the confirmatory HIV test. OA is providing technical assistance and training to support this important new direction. Since HIV care and treatment sites must obtain their own confirmatory HIV test result in order to begin treatment, by passing the confirmatory testing at the HIV screening venue eliminates the cost of that test and more quickly and effectively links the patient into HIV care and treatment. As part of the *Expanded HIV Testing* initiative, OA will employ a full-time LTC/Partner Services specialist to provide oversight, training, and technical assistance to LHJs and funded facilities in developing, implementing, and maintaining an effective system to refer, and link, HIV-positive clients to HIV care and Partner Services.

Both training partners offer training in both English and Spanish that addresses some of the challenges faced in providing referral, linkage, and engagement in HIV care for newly diagnosed and/or aware but never-in-care or lost-to-care HIV-positive individuals in general, as well as to members of specific populations. Relevant training examples include: *Effective Dialogue with Patients*; *Expanding the HIV Prevention Framework with Gay/Bisexual and Other MSM*; *Partnerships for Health*; and *Building Provider Competencies in Prevention with HIV*.

Coordination with RW Part A: LHJs funded with RW Part A and MAI can enhance referral to care treatment using these funds. Through participation on the RW Part A Planning Councils, OA remains informed about RW Part A funding allocation and program priorities to assure no duplication of effort.

Coordination with Prevention and Disease Control/Intervention Programs: OA will have implemented a HIV Prevention/Surveillance/HIV Care cross-branch workgroup for the purpose of coordinating all EIIHA-related programming and guidance. All RW Part B contractors will include in their EIIHA plans the specific ways that they will coordinate their prevention and referral to care activities.

Linkage to Medical Care and Support Services - *Essential Activities:* Ensuring that as many HIV-positive clients as possible receive appropriate medical evaluation and follow-up care will lead to improved health outcomes for clients, reduced health disparities in the state, and aid in further reducing the spread of HIV. OA leads the effort to routinize HIV screening and LTC through established relationships with other types of medical institutions, including community health centers, urgent care clinics, in-patient medical wards, tuberculosis clinics, and other outpatient settings. OA plans to work with these medical providers through partnerships with LHJs, academic partners, professional medical organizations, and technical assistance and training entities in the state to enhance and expand HIV screening and LTC activities in California outside the traditional OA-funded system.

Some HIV CTR programs utilize models to track and verify, or link, referrals for HIV-positive clients to medical care. Compliance monitors and program advisors review data on tracked and verified care referrals from LHJs prior to monitoring site visits. Verification of the process is an important focus in order to ensure that people found to be HIV positive in all settings are linked to appropriate HIV care and treatment. Additionally, CTR staff work in collaboration with OA's HIV Care Branch to ensure that linkages are made to HIV Care Branch-funded service providers when appropriate. OA encourages collaboration between local CTR programs and care service providers. The HIV Care Branch's RW Part B and MAI Program Guidelines will be revised to require LHJs and other contractors to develop plans for EIIHA services, particularly for LTC for persons with preliminary or confirmed HIV-positive test results. Each RW Part B LHJ/contractor will develop plans specific to their locale or region for addressing LTC strategies that are appropriate for each of their populations and subpopulations identified in the EIIHA Matrix. OA may explore the possibility of prioritizing service categories that support EIIHA services.

Currently, MAI-funded outreach workers conduct outreach to HIV-positive persons of color, primarily African American and Latino, who have never received care or who have been lost to care, identify barriers to entering or re-entering care, and assist clients in resolving those barriers and entering or returning to care. They continue working with clients as advocates and health educators until clients are assessed as being fully engaged in care. Staff who are funded through MAI are typically culturally and linguistically competent, and they often reflect the communities they serve. They bring clients into the full range of available HIV care, treatment, and prevention services via a process of gradual engagement combined with assessment of, and assistance with overcoming, each client's barriers to care. MAI outreach workers cultivate ongoing relationships with RW-funded agencies in order to facilitate referral and linkage.

Coordination with RW Part A: Each funded LHJ will include in their EIIHA plans details of how they will collaborate with their RW Part A funding.

Coordination with Prevention and Disease Control/Intervention Programs: OA will continue to refine data matching efforts across prevention and care programs to maximize services and identify linkage gaps.

Data - Estimated Number of PLWH/A Unaware of Their HIV Status: The estimate is 28,131 using the methodology provided in this application guidance (details in next section).

Estimated Back Calculation Methodology: The number of persons living with HIV infection at the end of 2009 in California was 105,823 (as reported through June 30, 2011). Using the formula provided in the guidance, the number of individuals in California infected with HIV but undiagnosed at the end of FY 2009 is estimated as $(0.21/0.79) \times 105,823 = 28,131$. This estimated number likely represents less than the true number for two primary reasons. First,

names-based HIV reporting took effect in California on April 16, 2006, and it is unlikely that the HIV (non-AIDS) component of the total living count is complete. Of the 105,823 reported, the HIV (non-AIDS) count was 37,259 in the surveillance system, which is estimated to be at least 5,000 less than the actual burden (per internal estimates). Second, as California offers widespread, free anonymous HIV testing there is estimated to be a significant population of individuals who have anonymously tested positive for HIV infection (and know their status) but have yet to initiate care. Until these individuals initiate care, they will not be reported into the surveillance system but cannot be classified as “undiagnosed.”

Coordinate with your RW Part B counterpart with regard to data collection and sharing:

OA will use information from the statewide HIV/AIDS surveillance database for EIIHA by focusing on metrics that would tend to indicate late diagnosis of HIV infection. Such metrics include (low) CD4 count at first diagnosis and the proportion of HIV cases diagnosed in a given year that progress to AIDS within one year. Applying such metrics to demographic groups at both the local and state level can help identify populations that may not be getting identified at an early stage of HIV infection. OA makes surveillance data available at the local level in two primary ways. First, OA provides LHJs data files for all cases reported by that LHJ. These files contain partial information for each case and are provided to local health officers for public health purposes. Second, OA has a data request protocol whereby any stakeholder can request aggregate data tables from the statewide HIV/AIDS surveillance system. Such requests can focus on the entire state or a local level, and a link for this service is on the OA website.

Coordination with Prevention and Disease Control/Intervention Programs with regard to data collection and sharing:

A primary OA data source for purposes of disease control and prevention/intervention with respect to HIV is LEO. LEO is utilized at both the state and local level. As an example, Partner Services data is collected and entered into LEO by both state and local disease intervention specialist workers. OA is able to track the following with LEO: number of client’s accepting an offer of Partner Services, number of partners elicited, number of partners located, HIV status of partners, number of partners tested, as well as the outcome for each partner tested. It is a standard practice for Partner Services staff to provide LTC for newly identified HIV-positive persons. Variables to capture outcomes regarding LTC have been added to Partner Services forms and the LEO database. **Please see Attachment 10.**

Enhanced Comprehensive HIV Prevention Planning (ECHPP) and Implementation for Metropolitan Statistical Areas (MSAs) Most Affected by HIV/AIDS

NHAS goals that are supported by the collaborative efforts of the RW Part B program and the ECHPP initiative:

The goals of ECHPP are aligned with those of the NHAS: 1) reducing new infections; 2) increase access to care and improve health outcomes for persons living with HIV through linkage, retention and adherence to care; 3) reducing HIV-related disparities through decreasing community viral load among MSM, African American and Latinos; and 4) more coordinated national response. Specific objectives of ECHPP that are support by the collaboration of the RW Part B program include:

1. Develop an enhanced plan that aligns with LHJ’s prevention activities with NHAS: (a) Resources for biggest impact on HIV incidence; (b) Identify and address gaps in prevention activities among priority populations; and (c) Enhance coordination between prevention, care, and treatment.
2. Identifying/implementing the optimal combination of prevention, care, and treatment activities to maximally reduce new infections: (a) Assure that the most effective biomedical and

community/structural interventions are prioritized; and, (b) Assure that interventions are going to populations/communities in such a way that the level of investment matches the level of risk.

Activities of the RW Part B program in collaborating with the EMA's ECHPP initiative: The two MSA's funded for ECHPP are San Francisco and Los Angeles. Each ECHPP is also funded with RW Part B and MAI funds. CDC funds both as separate project areas for prevention funds from OA. Plans to implement EIIHA in these LHJs will need to include specific EIIHA activities that align with the overarching ECHPP for that LHJ. The collaboration and further consultation from CDC on ECHPP has resulted in an alignment of the OA prevention plans for prevention/care service integration at the state level and required at the local level for all care/prevention-funded LHJs.

Clinical Quality Management (CQM) - CQM Mission, Vision, and Goals: The mission of OA's CQM program is to utilize continuous quality improvement methodologies to systematically evaluate client care and services to ensure equitable access to, and provision of, comprehensive, quality health care, and supportive services for PLWH/A at both the state and local level. The vision of OA's CQM program is to: (a) Ensure that services adhere to Public Health Services (PHS) guidelines and established clinical practice; (b) Ensure program improvement includes supportive services that facilitate access and adherence to medical care; (c) Utilize demographic, clinical, and utilization data to evaluate and address characteristics of the local epidemic, identify priority needs and client populations, and use findings to improve services; (d) Support effective program management; (e) Demonstrate program value quantitatively by linking outputs (amounts of services provided) to outcomes (results); and, (f) Identify and justify critical program activities and resources required to meet needs.

The general goals of the CQM program remain the same. However, this year additional emphasis will be placed on ensuring that the foundation for all CQM decisions and activities, the data, is accurate and comprehensive. To that end, OA will: (a) Enhance CQM activities and awareness within OA and with providers through a variety of activities including policy notices, trainings, site visits, and technical assistance; (b) Continue to work with providers to improve their data collection and entry; and (c) Enhance ARIES to streamline providers' ability to collect CQM data. The overall CQM approach and assessment is not expected to drastically change. Our overall goals remain the same although some strategies and activities will be adjusted based on "lessons learned" during CQM activities conducted in FY 2011. Below is a listing of the three goals with specific activities under each goal.

Goal 1: Enhance CQM activities and awareness within OA and with providers through a variety of activities including policy notices, trainings, site visits, and technical assistance:

(a) Hold provider trainings on Measures 2, 12a, and 17 from Group 1 of the HIV/AIDS Bureau's (HAB) Clinical Performance Measures for Adults and Adolescents so providers become aware of the requirements and technical aspects of collecting and reporting CQM data. (Measures 1 and 3 were completed in FY 2011.); (b) Use the aforementioned training materials to develop an online-training module on how to improve data quality in ARIES, run the HAB Quality Management Reports in ARIES, and follow up on clients who do not meet the performance measure; and, (c) Continue to integrate CQM in HCP's contract monitoring process so that HCP advisors can inform providers how they scored during the last reporting period, reinforce the CQM requirements, and discuss ways to improve their performance.

Goal 2: Work with providers to improve their data collection and entry: (a) Continue to conduct monthly activities from OA's Data Improvement Plan to improve the validity and reliability of key data elements; (b) Continue to monitor and assess provider performance for

Group 1 performance measures on a monthly basis; and (c) Continue to provide technical assistance to providers with low performance scores.

Goal 3: Enhance ARIES to streamline providers' ability to collect CQM data: (a) Work with the ARIES Development Team to streamline the ARIES interface so that it is easier to capture the data elements used for CQM; and, (b) Consider adding additional performance measures, such as HAB's Medical Case Management indicators, to ARIES.

Percent of RW Part B Funds Allocated to CQM: In FY 2012, approximately 0.62 percent of RW Part B funds will be allocated to CQM activities.

Roles and Responsibilities: Various OA staff members monitor whether OA-funded clinical providers are adhering to recommended PHS Guidelines and HIV treatment procedures.

CQM Coordinator: Creates and presents Webinar trainings for HCP providers, educating on OA quality management policies, provider responsibilities, and the medical significance of the HAB Group 1 Clinical Performance Measures 1, 2, 3, 12a, 17. With providers, determines whether low performing measures are due to client servicing issues or data input problems by utilizing the Plan, Do, Check, Act (PDCA) cycle. Identifies which of the five quality indicators to prioritize for quality management monitoring (statewide average); analyzes data for providers' performance on particular measures and identifies providers with low performing scores; reviews provider performance and improvements over given timeframe; coordinates with PAETC to provide assessments and education to providers requesting additional service and quality management training and; provides CQM training sessions to OA staff that monitor providers.

OA HIV Care Branch Chief: Oversees the CQM program and allocates resources. For each performance measure, ensures an OA team (operations advisors, evaluation and research staff, CQM coordinator, HIV Care Branch staff) convenes to discuss ideas on why a provider is doing poorly ("teams" can change according to particular measure and which providers are being assessed). Provides training and guidance to quality management coordinator; decides which measures are to be monitored, along with Program Evaluation and Research Section (PEaRS) staff. Ensures CQM is included in provider contracts and program monitoring reports.

SRE Branch Chief, PEaRS Chief, and research staff: Work closely with HIV Care Branch Chief and CQM coordinator. Decide, along with HIV Care Branch Chief, which measures are to be monitored and set OA indicator benchmarks. Run reports and evaluate data for prioritized performance measures. Develop a CQM training module for providers. Provide training to providers on ARIES data relevant to selected performance measures.

OA Operations Advisors: As part of site visits with providers, shares the ARIES Data Monitoring Report and reviews their CQM performance on all five medical measures; documents that providers have implemented their own CQM plan and; refers to CQM coordinator and ARIES research staff for additional training, as needed. In the next grant year, OA will convene a CQM committee. Delegates from the OA Division, PEaRS, MCWP, HOPWA, HIV Care Operations Section, HIV Care Branch, ADAP, and HIV Prevention Branch will make up the committee to coordinate CQM policies and prioritize measures to monitor.

Process for Monitoring and Evaluating CQM Program and Activities Implemented: Beginning in FY 2011, OA began focusing intently on a single clinical performance measure every quarter. This phased approach has allowed OA to monitor and evaluate our CQM program incrementally and make adjustments as necessary. As we implement the CQM program, we assess our effectiveness by conducting an informal process check at each step. We ask *What's working?* and *What's not?* We then adjust our program activities accordingly. For example, we assumed that after each provider training we could begin working with low performing providers

on the PDCA cycles focused on their clinical care. However, when we did this providers expressed puzzlement; they did not understand why their scores were low when they were providing the care as indicated. We observed that providers, when trained on how ARIES calculates the clinical performance measures, often increased their scores after performing their own data quality checks. For instance, one health department's Measure 3 (Pneumocystis Pneumonia [PCP] Prophylaxis) score improved 23 percent after attending the training and cleaning their data. Through these interactions we: 1) learned that providers were either not aware of the CQM requirement or were not correctly entering the data into ARIES; and 2) gained an appreciation of how complex it is to enter CQM data into ARIES correctly. From this assessment of our process, we decided to continue provider trainings and enhance ARIES to streamline CQM data collection in FY 2012.

Valid and reliable data are a foundation for all quality management activities. With this in mind, PEaRS began holding "focused technical assistance" (FTA) Webinars in July 2010. Each month PEaRS staff review providers' performance for a selected data element, such as CD4 test results or HIV diagnosis dates. Providers doing poorly on the selected variable are invited to a FTA Webinar which explains the importance of that particular variable and how to collect and correctly enter the data into ARIES. This process has resulted in tangible improvements in the quality of ARIES data.

Additional activities to assess and monitor the quality of the services include the following:

- Webinar trainings on OA's CQM policies and evidence-based practices on HAB Group 1 medical measures. Webinars include ARIES training on data reports for indicators. Presentations are recorded and uploaded onto OA's Project ARIES Web site for reference. OA keeps track of which agencies attend the Webinar trainings. The ARIES Help Desk is available to assist providers with data inquiries;
- Education forums to OA advisors for basic training in quality management and HAB medical measures. These Power Point presentations are loaded onto OA's "Common" portal for further reference;
- Scheduled running of monthly ARIES data reports to identify state averages, low performing providers and measure level of improvement over certain period of time: HAB Group 1 CQM Indicators for HCP providers funded for Outpatient Ambulatory Medical Care; Percent Change, Level of Improvement;
- Assist providers in tracking measures and improving low percentages by guiding them through PDCA cycles;
- Through OA on-site advisor visits, CQM telephone assistance and OA Management Memos, inform providers of HAB measures being monitored, review provider performance, and help identify problem areas in reaching CQM benchmarks. Help providers identify whether issue is client service related, or a data entry issue and work with providers to improve scores.;
- Convene numerous CQM meetings to assess OA progress in tracking measures and help providers to improve performance;
- Prepare bar charts of certain providers' progress in chosen measures and review with public health departments and OA CQM delegates; and
- Make model of what barriers providers are encountering, what remedies they have instituted that work, and recommendations that may help OA CQM monitoring in the future.

Specific Indicators Being Monitored and Data Collection Strategy: Last year, the HIV Care Branch adopted all five of the measures in Group 1 of the HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients (see Table 1 for specific indicators) and established three non-clinical performance measures for HCP. The HIV Care Branch set a goal for each performance measure. In June 2011, the HIV Care Branch further outlined its CQM program for HCP providers in Management Memorandum 11-01. The memo states that the HIV Care Branch will monitor performance on: 1) the HAB Core Clinical Performance Measures (Group 1) for all HCP medical providers; and 2) three non-clinical indicators for all HCP providers. The memo also stipulated that providers should incorporate these measures into their CQM plans beginning in State FY 2011-12.

OA focused on two of the five Group 1 measures for improvement. Measure 1 - percentage of HIV clients who had at least two medical office visits at least three months apart in the measurement year was tracked April through October 2011. OA went through PDCA improvement cycles with several low performing providers in rural and urban settings, and evaluated results and agency progress. Measure 3 - percentage of clients with CD4 T-cell counts below 200 cells/mm³ who received PCP prophylaxis therapy in the measurement year tracking started the first week in November 2011. Again, OA chose several different low performing agencies to monitor and work with using technical assistance to increase performance scores.

OA measures statewide and individual provider performance by running the HAB Quality Management Indicator Report built into ARIES. This report was programmed into ARIES according to the specifications outlined in **HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 1** (dated July 2008). ARIES calculates the clinical performance measures based on HAB's definition of the numerator and denominator, patient exclusions, and data elements.

Almost 200 agencies actively use ARIES, including many RW Part A and/or RW Part C providers. Most HCP providers use ARIES for the collection and reporting of data. Among HCP providers who are funded for Outpatient/Ambulatory Medical Care, 90 percent either manually enter or import their CQM data into ARIES and 10 percent use CAREWare. OA is almost finished developing an import program that will allow CAREWare users to routinely import their data into ARIES.

Client-Level Data (CLD) Reporting and CQM: ARIES has the capability to meet HAB's CLD reporting requirements and our providers have the capability to electronically upload the data from ARIES to HRSA's Electronic Handbook (EHB). With CLD included in ARIES, OA utilizes this system to monitor both core clinical performance measures (indicators from Groups 1 and 2) and non-medical indicators. All HCP providers that use ARIES electronically upload the data from ARIES into EHB. Those HCP providers that use CAREWare or Casewatch Millennium can electronically upload CLD from these two systems directly into EHB.

CQM Results: Last year, OA reported performance outcomes for the Federal FY 2009-10 (October 1, 2009 to September 30, 2010) in our application. The table below displays these outcomes, as well as the outcomes for Federal FY 2010-11. Comparing the outcomes for the two years, we find:

- The percentage of clients meeting each of the five clinical performance measures increased between the two years;
- The measures with the greatest improvement were the two OA focused on in Federal FY 2011;

- The percentage of clients with HIV infection who had two or more medical visits three or more months apart in an HIV care setting (Measure 1) increased from 45.0 percent in Federal FY 2009-10 to 57.9 percent in Federal FY 2010-11;
- The percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm³ who were prescribed PCP prophylaxis (Measure 3) increased from 23.3 percent in Federal FY 2009-10 to 37.0 percent in Federal FY 2010-11. A primary reason for this low result was the addition of a variable to ARIES without adequate provider training; this training was provided November 2011; and
- OA met the goal (75 percent) for Measure 12a. By the end of Federal FY 2010-11, 83.2 percent of clients with AIDS were prescribed Highly Active Antiretroviral Therapy (HAART).

Table 1. HCP Clinical Performance Measures				
<i>Who is responsible?</i> All HCP providers who are funded to provide medical care				
<i>Data source:</i> ARIES				
What is the performance measure?	What is the goal?	What % of HCP clients met this measure in Federal FY 2009-10?	What % of HCP clients met this measure in Federal FY 2010-11?	Percent change
Percentage of clients with HIV infection who had two or more medical visits three or more months apart in an HIV care setting in the measurement year (Measure 1).	75%	45.0%	57.9%	+28.7%
Percentage of clients with HIV infection who had two or more CD4 T-cell counts performed in the measurement year (Measure 2).	75%	43.0%	54.2%	+26.0%
Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm ³ who were prescribed PCP prophylaxis (Measure 3).	75%	23.3%	37.0%	+58.8%
Percentage of clients with AIDS who are prescribed HAART (Measure 12a).	75%	79.7%	83.2%	+4.4%
Percentage of pregnant women with HIV infection who are prescribed antiretroviral therapy (Measure 17).	100%	58.8%	65.2%	+10.9%

ADAP has adopted one of the Group 1 indicators. ADAP does not use ARIES but maintains its own client and prescription database. Due to data collection limitations, ADAP can only monitor one of the Group 1 indicators: the percent of clients that are prescribed HAART. As reflected in Table 2, ADAP met its quality management goal for Federal FY 2010-11.

Table 2. ADAP Clinical Performance Measure					
What is the performance measure?	What is the goal?	What % of ADAP clients met this measure in Federal FY 2009-10?	What % of ADAP clients met this measure in Federal FY 2010-11?	Percent change	Data source

What is the performance measure?	What is the goal?	What % of ADAP clients met this measure in Federal FY 2009-10?	What % of ADAP clients met this measure in Federal FY 2010-11?	Percent change	Data source
Percentage of clients with AIDS who are prescribed HAART (Measure 12a).	90%	94.3%	94.8%	+0.5%	Quarterly prescription/client data submitted to OA from PBM

CQM Activities Undertaken to Improve Service Delivery: OA staff discuss with providers whether any service-related barriers are affecting them in providing medical care to HIV clients. Questions asked relate to loss of follow up due to client moves, clients not keeping medical appointments, clients not adhering to medication regimens or prophylaxis therapy, staff turnover and subsequent lack of training, and lack of resources or personnel to carry out services. Several providers conveyed that their staff members and resources have decreased since FY 2009. When prioritizing limited staff resources, clinics and providers state they focus their efforts toward clients receiving the services they need. OA has discussed with providers some avenues that would offer help, such as utilizing volunteers, student interns, and client transportation assistance.

One resource that has been sufficiently used to train providers in service delivery is PAETC, which has regional centers in California whose experts offer on-site assessments and HIV care training to doctors, nurses, medical specialists, and health technicians. PAETC sets up trainings for agencies needing extra help, such as public health departments with new staff needing HIV care education. When needed, CQM training is instituted with the service training to encompass all aspects of AIDS care obligations.

How CQM Results have been used by Planning Bodies for Priority Setting and Resource Allocation: CQM data is proven to be effective in improving clinic systems and processes to maximally improve performance on quality indicators and ultimately improve health outcomes. OA will continue focus on CQM with the goal of increasing the capacity of CQM at the local level. To the extent that CQM data is useful, OA will provide to CPG and may be included in resource allocation and program planning.

Description of the ADAP CQM Program: ADAP provides the Medical Advisory Committee (MAC) with prescription utilization and drug cost/expenditure data to enable them to make informed decisions concerning the ADAP formulary, as needed. Prescription utilization data also assists MAC in recommending adding or removing prior authorization criteria for specified drugs to support appropriate use of ADAP medications.

Any drug added to the ADAP formulary must be reviewed and recommended for inclusion by ADAP’s MAC and ADAP must have sufficient funds to support the anticipated drug utilization/expenditures. As established in state law, California must add new antiretroviral drugs to the ADAP formulary within 30 days of U.S. Food and Drug Administration (FDA) approval if: 1) CDPH determines that a new antiretroviral drug would be used as an additional treatment option; 2) anticipated client utilization represents no significant additional cost to the program; and 3) its addition does not require the removal of another antiretroviral drug from the

formulary. If an FDA-approved antiretroviral drug is determined to significantly increase program costs, the drug may be made available only if ADAP's budget can cover the additional cost. [California H&S Code Section 120966 (a) (1) and (2)].

ADAP uses numerous resources for evaluating approved medications for addition to the ADAP formulary. The results from clinical trials, related journal articles, and conference reports are used in evaluating new medications. SRE Branch staff provides valuable assistance in reviewing and managing this information. The movement of a new antiretroviral medications through the various phases of clinical trials is closely monitored by Dr. Karen Mark, OA's Interim Division Chief, who is an infectious diseases-trained HIV specialist physician.

MAC utilizes evidenced based best practices when developing access criteria/restrictions and guidelines for new medications. ADAP schedules telephone and face-to-face meetings, as needed, with MAC for guidance on policies related to the dispensing of ADAP formulary medications. California ADAP uses a PBM to administer the pharmacy network responsible for providing prescription medications to eligible clients. The PBM maintains a network of approximately 4,000 pharmacies throughout the state to ensure access to medications for all eligible ADAP clients. The PBM enforces MAC policies which include the implementation of prior authorizations, approvals for early refills, step therapy criteria, and quantities outside the established limits. Using prescription claims data, ADAP will evaluate prescribing patterns throughout the state. Deviations from current federal treatment guidelines for HIV/AIDS and opportunistic infections will be identified and provided to PAETC to develop education training programs for both prescribers and pharmacy providers. Currently, OA informs providers of upcoming PAETC training sessions through the Internet-based California Advisory Network.

Consistency with SCSN - Needs Assessment Process and Public Advisory Planning Process: Development of the 2012 SCSN is a collaborative process that includes statewide representation from all parts of the RW Programs as well as other HIV care, treatment, and prevention programs from regions throughout California. Allocation of RW Part B funds to program activities is based upon a variety of factors, including the ongoing needs of PLWH/A as identified through the most recent FY 2009 SCSN and annual local planning processes undertaken by HIV care planning groups in non-RW Part A-funded areas, and planning councils of the five TGAs and three EMAs in California.

The development of the two-tiered RW Part B program approached was supported by findings in the 2009 SCSN indicating a great need for primary outpatient ambulatory care resources with the LHJs. OA will consider the results of needs assessment activities conducted in the development of the 2012 SCSN underway currently to inform future care, prevention, treatment, and support program planning and policy development.

There are two mechanisms currently in place at OA that constitute a public advisory planning process to inform the development and implementation of our Comprehensive HIV/AIDS Surveillance, Prevention, Care, and Treatment Plan (Comprehensive Plan). These include CPG and OA's Advisory Network. The main functions of CPG are to work collaboratively with OA to develop a Comprehensive Plan; to monitor the implementation of this plan; and to provide timely advice on emergent issues identified by OA, the Advisory Network and/or other key stakeholder parties. CPG is committed to working openly in a group to make decisions and is guided by the principles of equity, fairness, and respectful engagement.

In preparation of the 2012 SCSN and the Comprehensive Care, Prevention, Surveillance Plan, CPG's Community Assessment Workgroup surveyed all prevention and care-funded contractors in California between April and August 2011. Preliminary analysis of those survey

data indicate responses representing the majority of the counties in the state, mostly from local health departments. An even proportion of prevention and care providers responded. Prevention and care needs included: case management, medical care, housing, dental/oral care, transportation, prevention funding, greater testing capacity (funding/materials/support), outreach/education (specific/topics/target populations), funding, staff (funding/training/skilled), and counseling. In addition to service needs, the survey found that policy and structural concerns regarding HCR were major concerns for contractors. Those concerns included: HCR implementation capacity, program transition readiness, impacts on patient access to HIV care expertise, ADAP pharmacy access, eligibility and access issues for RW clients, and lack of staff resources. Other themes that were found include: needing secure funding for multiple years, impacts of reduced surveillance dollars, impacts of reduced prevention funding, flexible allocations for counties to meet varying needs (allocations need to consider utilization not just incidence), better funded SEPs and integrated STD, prevention and care programming. Complete analysis is being completed by CPG and will be included in the 2012 SCSN and Comprehensive Plan for OA and will direct future program and policy decisions. OA convened a stakeholder input process between May and August 2011 to assist in addressing the following objectives: 1) Identify potential HIV-related issues associated with implementation of the Affordable Care Act (ACA) in 2014; 2) enable OA to provide technical assistance to support a seamless transition for medical care, support, testing, and prevention service delivery systems; related providers; and individuals living with and at risk for HIV prior to full implementation of ACA; and 3) develop a summary document that outlines the key HIV-specific issues in the areas of health care delivery systems, provider and workforce issues, patient needs, and financing. Given the complexities of federal and state financing of medical services for people living with HIV infection, the need for HIV treatment expertise in an expanding universe of medical care settings, and the increasing focus on routine HIV screening and finding individuals with previously unknown HIV status and linking them to care and treatment, OA believes it is critical to start to consider HIV-specific issues for health service delivery associated with the implementation of ACA.

Two of the highest priority “next step” issues identified in this process thus far include: 1) Develop the infrastructure within OA to move this process forward, understanding that OA’s current capacity is limited in terms of staff availability to develop this expertise and to devote time to these efforts; and 2) develop a communication strategy and materials for consumers and health care and support service providers as well as HIV testing and prevention providers.

Using resources available through CDC, OA will ensure that a minimum of 50 percent of an FTE will be dedicated from the HIV Prevention Branch to develop and participate in a newly formed OA HCR Task Force that will also include membership from OA’s Care, Treatment, Policy, and Research areas. OA’s HCR Task Force will ensure that OA stays abreast of all policy developments and provides technical assistance to OA and our LHJ and service delivery partners. In addition, OA will create a Tier I activity for prevention-funded LHJs to focus on preparing for HCR. OA will ask each LHJ to dedicate a specified proportion of an FTE to devote to HCR preparedness activities. This staff person will work in collaboration with state partners at OA as well as collaborating with other LHJ OA-supported HCR preparedness staff. OA will expect this person to keep OA informed of HCR-related policy and implementation issues within their LHJ.

OA established a Web-based Advisory Network in order to expand the reach to the diversity of stakeholders around the state. The Advisory Network is designed to provide timely

access and response/feedback/input from community members. The Advisory Network includes general discussion groups, which has been designed to provide a forum through which stakeholders, including consumers, Federal and local stakeholders and community leaders, can engage with one another on pertinent issues in the areas of HIV/AIDS prevention, detection, and care/treatment. The discussion group will act as a mean through which OA is able to keep a finger of the pulse of stakeholder communities and will enable these communities to actively engage with OA. To date, the Advisory Network is still in the early stages of development and marketing this resource is still in its infancy. However, the goal of the discussion group is two-fold: first, to create an opportunity and a context for all stakeholders to engage one another as information-sharing resources; and second, to have these discussions identify emergent issues that may, in turn, morph into program and policy recommendations considered by OA and all of our planning bodies.

Planned Services/Implementation Plan-Table: FY 2012 Implementation Plan Attachment 5 Narrative FY 2012 Implementation Plan - Narrative FY 2012 RW Part B HCP and MAI

Implementation Plan: OA administers the RW Part B Base (which includes HCP), MAI, ADAP and Emerging Community funds under the HRSA direct services model through contracts with LHJs and service providers. As described earlier in this application, all RW HCP and MAI contractors will be required to submit a program plan (that includes EIIHA) that delineates program priorities and provides justification for each service category, and assures that proposed services are aligned with the most recent needs assessment findings and do not supplant the same service provided by another funding source. In addition, LHJs must provide justification that the services reflect the unmet need for ambulatory outpatient medical services first before support services. OA's HIV Care and HIV Prevention Branches will work collaboratively to create the guidance document provided to HRSA and CDC prevention-funded LHJs to assure consistency and non-duplication.

Required elements of the plan include:

- 1) description of LHJ and need for RW core medical (Tier I) services or justification that core medical services are adequately provided for persons living with HIV in LHJ;
- 2) description of each HCP and MAI service category and how the services will enhance access to the continuum of HIV care for minority communities, address unmet need, target specific priority populations, endure geographic parity in terms of access, reach unaware individual populations and link to care and treatment;
- 3) EIIHA plan:
 - a. Target populations;
 - b. Collaboration with CDC-funded program areas and other agencies;
 - c. Activities for identification, referral, and linkage to medical services;
 - d. Dedicated staff;
 - e. Supportive data and mechanisms; and
 - f. Timeline; and
- 4) Budget, budget justification.

Compliance with 75/25 Ratio of Services: OA ensures that LHJs implement services based on the requirement that at least 75 percent of the funds be expended on HRSA-defined core medical services; unless LHJ can document that core medical services are being provided for persons living with HIV in LHJ assessed through community planning. The FY 2012 Planned Services Table reflects allocation of 91.1 percent of service funds to core medical services, with the remaining 8.9 percent dedicated to services that support client access to core medical services.

The majority of core medical services is met through ADAP (77.20 percent) and the remaining core medical services will be met through HCP and Emerging Community contractors.

Goals of Healthy People 2020: The goals of all RW Part B-funded programs are in alignment with the Healthy People 2010 goals and focus on services that provide primary care and treatment and support to PLWH/A. The goals and objectives of RW Part B programs align with the overarching goals of Healthy People 2010, which include increasing life expectancy and quality of life and eliminating health disparities among different segments of the population.

MAI Services: The objectives for MAI services are to: 1) identify aware and out of care HIV-infected persons of color (either never engaged or disengaged); 2) provide peer education and support services to remove perceived barriers to engaging in care and treatment adherence; and 3) actively link those individuals into engagement in care and treatment services. OA examined its MAI utilization data and epidemiological data in an effort to determine how to best utilize its MAI resources. OA is exploring whether to fund fewer MAI sites overall, allowing the concentration of more resources in those areas with higher needs for MAI services. In FY 2010, more than one-half of the clients served by MAI were Hispanic (52 percent), followed by African Americans (39 percent), and Asian/Pacific Islanders (7 percent). OA will continue to focus its efforts on these groups, using epidemiological data to determine areas with the highest needs.

OA will also continue to fine-tune its MAI data collection processes. In January 2011, new data collection forms were implemented to track client enrollment into ADAP (or other payer source), successful engagement in medical care, and client medical assessments. Analysis of current MAI data indicates the need to technical assistance on accurate and timely submission of data. Technical assistance issues to address include submission correct client demographic and service data, timely submission, and completing the most recent forms. Currently, ARIES can collect MAI data for “known clients” (e.g., clients that were in care but have since been lost to care). At present, however, ARIES cannot collect data on “anonymous clients” (e.g. never-in-care clients who may be unwilling to provide personal information needed for an ARIES record). For the former, some sites have been using a canned ARIES report to identify clients who have fallen out of care and in need of MAI services.

In FY 2012, OA will complete enhancements to OA’s ARIES which will allow streamlined MAI data collection. Sites will be able to enter data into ARIES themselves and have those data readily available. Having MAI in ARIES will also allow providers and OA to track clients through their entire continuum of care, from outreach, to newly diagnosed, enrollment into primary and secondary care, to linkages with ADAP and Medi-Cal, or lost to care, outreach, and subsequent re-engagement into care. This will enable more sophisticated data analyses, aid sites in their care delivery, and ultimately enhance clients’ care. The planning, implementation, and ongoing delivery of MAI services involves significant numbers of HIV-infected minority persons, as well as providers in communities of color. OA utilized past experiences of MAI workers, many of whom are HIV positive, and administrators to address MAI outreach and treatment education services. Depending on available resources, OA may utilize surveys, focus groups, or other methods to gather community and consumer input on a continuing basis.

LTC: With more emphasis on LTC for those who are unaware of their HIV status, LHJs will be required to complete a plan that includes how LTC will be accomplished for the most vulnerable populations. MAI Outreach and Education increases access and continued engagement in care, especially in communities of color, disproportionately affected populations, and vulnerable

communities. MAI outreach specifically addresses unmet need by reducing the number of HIV-infected individuals who have been lost to care and by locating, referring, and linking individuals who are aware of their HIV-positive status and not in care and treatment. OA will continue to focus MAI education as “treatment” education to support tailored education that serves to identify perceived fears and barriers to engaging in care and treatment.

Geographic parity: To ensure geographic parity throughout the state, the distribution of RW Part B HCP funds is based on a formula developed by OA in collaboration with previous CPG for allocation of RW Part B funds. OA has contracts that serve persons in every LHJ. OA contracts directly with a local CBO for HIV services when LHJs decline to contract for RW Part B and/or MAI services. Core and support services continue to be provided to PLWH/A through funding provided to 7 CBOs and 36 LHJs throughout the state, including urban, suburban, rural, and frontier counties. Some contractors provide services in more than one LHJ.

Emerging Populations: OA will continue to evaluate new HIV/AIDS cases to identify emerging populations and to track increases in those populations already significantly impacted by HIV/AIDS in California. The number of PLWH/A continues to increase every year. As of the end of FY 2001 compared to the close of FY 2010, the number of PLWH/A increased by 39 percent; cases among men increased by 38 percent while cases among women increased by 48 percent. By race/ethnicity, Whites increased by 25 percent, followed by African Americans with a 35 percent increase, Latinos by 64 percent, Asian/Pacific Islanders by 81 percent, and all others by 34 percent. African Americans in California are disproportionately impacted by HIV/AIDS, necessitating targeted prevention and care services, while Asian/Pacific Islander, Latinos, and transgender populations with HIV/AIDS are also increasing. Planning for potential interventions for growing populations such as Asian/Pacific Islanders and transgender people will continue this coming year. OA’s HCP is designed specifically to address access to and maintenance in HIV care. The program’s number one priority is the availability of HIV primary medical care for all clients throughout the state. The availability of MAI funding to provide treatment education services helps establish or expands treatment adherence programs for persons of color in funded LHJs. These programs, along with a very robust and easily accessible ADAP, provide the treatment adherence services that many clients require. LHJs must provide a service delivery plan describing the system of care, and efforts to assure access to and maintenance in the system. These delivery plans must also describe efforts to assist clients in treatment adherence. OA staff evaluates each service delivery plan for program compliance to ensure the primary medical needs of clients will be met, and the availability of treatment adherence programs.

Allocations for WICY: OA has historically exceeded the aggregate expenditure requirement for WICY and continues to meet the requirement for women, infants, and youth. However, each year OA does not meet the proportionate expenditures for children. Children with HIV/AIDS in California receive primary medical care services through DHCS’ CCS Program. DHCS provides a report of expenditures for children to OA upon request. Each year the Governor (or designee) signs a waiver certifying that through the combined RW Part B and DHCS services, the proportionate amount of expenditures are provided for children with HIV in California.

ADAP: ADAP’s Implementation Plan Goal is to ensure access to HIV/AIDS treatments for eligible low-income individuals. ADAP provides medications for the treatment of HIV and associated medical conditions, and its expenditures are considered as 100 percent core medical services. ADAP’s formulary currently contains 182 drugs which are available to clients through an extensive network of approximately 4,000 pharmacies statewide. As a result, ADAP clients are assured geographic parity in accessing their ADAP medications. California’s ADAP also

provides excellent access to services through approximately 187 enrollment sites and over 650 certified enrollment workers within various health agencies and CBOs statewide. The enrollment workers conduct eligibility screening to facilitate enrollment in the program. Many of ADAP's enrollment sites are located within agencies that specifically serve minority populations. For example, the Asian/Pacific Islander Wellness Center in San Francisco and Bienestar, a CBO located in Los Angeles focused on the Latino population, both provide ADAP enrollment services.

To ensure that our clients are actively engaged in primary medical care and adhere to HIV/AIDS treatment, ADAP requires individuals to provide current prescriptions from state licensed prescribers as well as up-to-date CD4+ T-cell counts and plasma HIV-1 RNA (viral load) measurements at the time of enrollment and recertification. In addition, the refilling of prescriptions is limited to a 30-day supply to help ensure that clients remain in care. In the development of the State FY 2011-12 Budget, total program costs are based on linear regression models using prior year data points. California ADAP has budgeted \$511,148,000 (State General Funds, Ryan White Part B Funds, Rebate, and Federal Safety Net Care Pool Funds) in the current State FY (July 1, 2011 through June 30, 2012) for drug purchases.

The FY 2012 goal of ADAP in relation to Healthy People 2020 is to continue to make all drugs on the Federal Treatment Guidelines for HIV/AIDS and Opportunistic Infections available to all California ADAP clients. ADAP seeks to improve health outcomes by continuing to provide an extensive formulary of HIV drugs that treats HIV infection directly, prevents and treats opportunistic infections, manages side effects, and treats co-morbidities.

OA-HIPP and OA-PCIP: OA-HIPP and OA-PCIP's Implementation Plan Goal is to provide health insurance premium payment assistance to ensure medical and drug coverage for eligible low-income individuals. Payment of insurance premiums enables eligible PLWH/A to obtain and/or remain in primary medical care and preserves ADAP's other funding through savings on medications provided by private insurance. OA-HIPP and OA-PCIP's goal supports Healthy People 2020 objective to increase the proportion of HIV-infected adults who receive HIV care and treatment. Due to the expansion of OA-HIPP eligibility criteria, the implementation of OA-PCIP, and education and outreach conducted in 2011, OA has increased access to and participation in the insurance assistance programs. OA-HIPP and OA-PCIP have over 250 and 140 certified enrollment workers respectively located in approximately 100 AIDS services organizations at the local level. OA implemented a centralized enrollment option in FY 2011 to ensure geographic parity in accessing these programs throughout the state. As part of CDPH's Strategic Plan, OA will conduct targeted OA-HIPP education and outreach to minority communities beginning in FY 2012.

Co-enrollment in OA-HIPP and ADAP is cost effective strategy that also enables access to comprehensive insurance coverage to eligible individuals living with HIV. ADAP pays OA-HIPP clients' private insurance out-of-pocket costs for drugs on the ADAP formulary and collects rebate on the full price of the drug. To facilitate co-enrollment, OA has conducted OA-HIPP training to ADAP enrollment workers in order to inform them of OA-HIPP requirements and certify them as OA-HIPP enrollment workers. The OA-HIPP enrollment schedule and income eligibility requirement have been aligned with ADAP. Clients co-enrolled in ADAP submit less forms and supporting documentation for OA-HIPP enrollment and recertification. Additionally, OA-HIPP clients co-enrolled in ADAP have a higher premium threshold than OA-HIPP clients not co-enrolled in ADAP.

MAI Plan and ADAP Capacity: OA used the following criteria in determining the recipients and amount of MAI funding for each LHJ. For stability purposes, LHJs receiving MAI funds in FY 2012 will have at least the same amount of funding as in FY 2011. MAI awards were based on the percent that each LHJ's non-White HIV/AIDS cases in the LHJ's total HIV/AIDS cases. The planning, implementation, and ongoing delivery of MAI services involved significant numbers of HIV-infected minority persons, as well as providers in communities of color. OA utilized past experiences of MAI workers, many of whom are HIV positive, and administrators to address MAI outreach and treatment education services. OA may continue utilizing surveys, focus groups, or other methods to gather community and consumer input on a continuing basis. ADAP clients reached through MAI: a total of 39,466 ADAP clients were served in State FY 2010-11. To date, ADAP has been able to absorb and fully support increases in client loads, including those derived from MAI-funded services and referrals. In State FY 2011-12, OA estimates ADAP will serve 42,574 clients with 823 clients reached through MAI-funded services.

MAI-Funded Education and Outreach Services: In FY 2011, OA was awarded \$1,138,194 in MAI funding for the purpose of providing outreach and treatment education services to communities of color. OA selected 19 LHJs to receive the available funding. MAI funds support a combination of positions and/or outreach/treatment education activities or interventions for HIV-infected persons of color, as determined at the local level and approved by OA. OA staff continue to review data regarding 2011 outcomes that will inform future program policy and program objectives; analysis of Federal FY 2010-11 data indicates that 30 percent of MAI clients were enrolled in ADAP. Additional evaluation measures are also under development.

FY 2012 ADAP Grant Application

Program Description - Agency Oversight/Administration: Former Comprehensive AIDS Resources Emergency/Health Insurance Premium Payment Program (CARE/HIPP) Section Chief, Richard Iniguez, retired in November 2010 and Richard Martin was hired to fill the Section Chief vacancy in May 2011. This section includes the OA-HIPP Program (formerly CARE/HIPP), OA-PCIP Program, and Medicare Part D Premium Payment Program. Thus, the section was renamed to IAS. In March 2011, a Health Program Specialist I with lead responsibilities of formulary and rebate workload left ADAP to work for another department. An ADAP program analyst with a workload for 15 counties retired in May 2011. ADAP has been unable to fill these positions. Therefore, the workload has been redirected to the remaining OA staff.

ADAP Funding Resources: Total funding authority for California's ADAP for State FY 2011-12 is \$511,148,000. After January 10, 2012, revised funding information for State FY 2011-12 and new information for State FY 2012-13 will be available. The composition of the current budget consists of State General Fund, Reimbursement Funds, Federal Funds, and mandatory and supplemental Drug Rebate Funds as follows:

\$ 82,625,000	State General Fund FY 2011-12 appropriation ¹
\$ 74,064,000	Reimbursement Funds ²
\$100,632,000	RW Part B Federal Funds
<u>\$253,827,000</u>	Drug Rebate for FY 2011-12 ¹
\$511,148,000	

¹These figures are for State FY 2011-12 appropriation (July 1, 2011-June 30, 2012) and administrative operations costs are not included.

²*DHCS used certified public expenditures from various programs, including ADAP, to claim federal funds under the Safety Net Care Pool. CDPH receives \$74.1 million of these funds from DHCS as a reimbursement.*

ADAP Eligibility Recertification: ADAP clients must meet the following eligibility criteria: 1) be a resident in the state of California; 2) be at least 18 years of age; 3) have a documented HIV diagnosis; 4) not have an income above \$50,000; 5) have a prescription written by a licensed California physician/prescriber; and 6) have limited or no prescription drug benefit from another source. Clients are screened by local enrollment workers for eligibility upon initial enrollment and annual recertification. To ensure all clients have been screened, client eligibility information including proof of income and HIV status, must be documented and maintained on file at ADAP enrollment sites. In addition, clients are notified of upcoming recertification due dates and ADAP eligibility is terminated after the due date unless the client recertifies.

ADAP is currently establishing systems with LHJs for LIHP screening implementation and plans to institute six-month re-certification by July 1, 2012. Potential barriers for statewide implementation of the six-month re-certification requirement may be LHJ capacity and limited local resources necessary to support a 100 percent increase in recertification services. California ADAP served 34,749 clients from April 1, 2011 to October 31, 2011, and only provides a nominal amount of administrative funding to LHJs to support the provision of ADAP enrollment services.

Formulary: The California ADAP formulary consists of 182 drugs; approximately 91 percent of ADAP expenditures are for PHS recommended antiretroviral and opportunistic infection drugs. The program closely monitors the development of new antiretroviral medications. As established in state law, FDA-approved antiretroviral drugs added to the ADAP formulary must be reviewed/recommended for inclusion by the ADAP MAC and ADAP must have sufficient funds to support the anticipated drug utilization/expenditures. It is anticipated that there could be at least two new antiretroviral medications added to ADAP's formulary. However, factors that could limit the inclusion of new medications on the formulary include:

- Manufacturer pricing of new medications;
- Supplemental rebate amounts as negotiated by the ADAP Crisis Task Force (ACTF). ACTF previously had negotiated voluntary rebates and price freeze agreements with manufacturers of antiretroviral medications. Recently, ACTF reached enhanced agreements for additional voluntary rebates. Decrease in funding that supports the program; and
- Increases in total number of clients, increases in the number of prescriptions per client, increased medication costs and increased length of time enrolled in ADAP.

Client Utilization of ADAP Services: Client access to ADAP was not limited in any way during FY 2011. ADAP clients who live in rural areas access services through enrollment sites and pharmacies located in their area. Clients also have the option to use ADAP pharmacies mail order services to fill their prescriptions. Due to CDC Prevention Initiatives, OA has received CDC PS12-1201(Category B) funding to provide routine, opt-out HIV testing in HCS. OA will use these funds to provide HCS HIV testing in four LHJs: Alameda, Orange, Sacramento, and San Diego, representing 53 percent of PLWH/A in the California Project Area. In these LHJs, five grantees will test approximately 35,000 patients in 2012. OA expects a positivity rate of 0.5 percent yielding 175 people. OA expects 75 percent or 130 people to be linked to HIV medical care. These clients may utilize ADAP as a result of this initiative.

California ADAP continues to maintain program requirements and components without having to remove eligible clients from the program. After receiving the 2010 Emergency Relief Funds, ADAP supplemented its resources and utilized all the funds to pay for drugs on the

ADAP formulary. In the development of the State FY 2011-12 Budget, staff estimated total program costs based on linear regression models using prior year data points. Adjustments were made to the cost estimate as a result of identified potential savings associated with changes to the PBM contract, expansion of OA-HIPP and implementation of OA-PCIP. These cost-containment strategies were to take effect on July 1, 2011. Due to delays in establishing an interagency agreement, OA-PCIP implementation took effect in November 2011. Therefore, ADAP will not realize the estimated savings and will utilize the 2011 Emergency Relief Funds to cover the budget shortfall thereby preventing the need to reduce any ADAP services at this time.

ADAP reports budget projections to the Legislature bi-annually for the development of the State Budget. During the reporting periods, ADAP may request additional resources as needed or may be required to implement cost-containment strategies if funding is not available.

ADAP Cost Saving Strategies - All 340B Participating ADAPs - 340B Direct Purchase:

California ADAP's pharmacy network includes 52 340B Direct Purchase Pharmacies. These 340B pharmacies independently establish agreements with pharmaceutical providers to acquire drugs at a discounted rate and utilize ADAP's PBM to bill for drugs dispensed to ADAP clients. ADAP pays PBM a negotiated discounted rate. Annual State and Federal audits are conducted to monitor pharmacy prescription claims. OA does not utilize HRSA's Prime Vendor Program/Health Care Purchasing Partners International.

340B Rebate Option: ADAP's existing PBM subcontracts with a network of approximately 3,800 participating pharmacies statewide. This network includes pharmacies within national chain stores, local chain stores, independents, university medical centers, hospitals and county clinics. ADAP's network also includes pharmacies with mail order services. The new ADAP PBM contract was awarded and took effect on July 1, 2011. The PBM contract includes reduced transaction fees, reduced drug reimbursement rate, and adjusted negotiated pharmacy discount split savings. The PBM has successfully negotiated lower drug reimbursement rates with a number of pharmacies. ADAP receives a percent of the savings the PBM negotiates with their contract pharmacies. The PBM contracts for State FYs 2009-10 and 2010-11 included a split savings of 50 percent/50 percent. The new PBM contract includes a split saving of 60 percent/40 percent with ADAP receiving 60 percent of the negotiated discount and the PBM receiving 40 percent.

During State FY 2010-11 (July 1, 2010 to June 30, 2011), California's ADAP received \$223,383,222 in both mandatory and supplemental rebates, all of which became part of the annual ADAP operating budget. All ADAP drug manufacturer rebates are applied to ADAP. California law established the ADAP Rebate Special Fund, a continuously appropriated fund used only to cover costs directly related to the purchase of drugs and/or services provided through ADAP.

For ADAPs Using Either the 340B Direct Purchase or 340B Rebate Options: As one of the largest ADAPs in the country, California's policy has been to join with other state ADAPs and negotiate for supplemental rebates via ACTF. Thus, California's purchasing power and market share provides the leverage to strengthen supplemental rebate access for all other ADAPs in the country. These supplemental rebates enhance rather than replace our 340B rebate system. Negotiations regarding agreements scheduled to expire are ongoing.

ADAP Linkages: ADAP coordinates with third-party payers to ensure compliance with the payer of last resort requirement. Some OA staff have access to MEDS. MEDS provides comprehensive information on client eligibility and enrollment, including application date, status of application, income, and available payers (including Medicare), approval date (if applicable),

Medi-Cal SOC requirement, retroactive eligibility, etc. As part of the enrollment process, ADAP clients that are potentially eligible for Medi-Cal must apply for Medi-Cal benefits and adhere to both ADAP and Medi-Cal requirements for continued assistance. ADAP clients who are identified as 100 percent Medi-Cal eligible with no SOC are ineligible for ADAP and are subsequently removed from ADAP. ADAP is currently in the process of establishing a contract with DHCS to conduct a monthly cross match of all ADAP clients in MEDS.

Medicare clients are identified through a data-sharing agreement with CMS, and are required to use Medicare Part D as their primary payer before accessing ADAP coverage. ADAP will provide Medicare Part D and private insurance prescription deductible and co-payment assistance once the ADAP client signs an Assignment of Benefits and Release of Information Form which allows the ADAP PMB to bill other third-party payers directly. In addition to these mechanisms used to screen clients for other payer sources, the PBM, in conjunction with the participating pharmacies, is contractually required to screen for other payers, such as Medi-Cal, Medicare, or private insurance, prior to billing ADAP for prescription costs.

An ADAP client might experience third-party limitations when a prescription drug is not on their private insurance formulary. ADAP will provide the needed medication, as long as the drug is on the ADAP formulary, the client meets all ADAP eligibility requirements, and the client is currently enrolled in ADAP. Also, if an ADAP client co-enrolled in Medi-Cal has not met their Medi-Cal SOC, Medi-Cal will not cover the prescription drug costs until the SOC is met. Thus, ADAP utilizes state funds to pay for Medi-Cal prescription costs for drugs on the ADAP formulary up to the SOC amount. OA provides utilization and demographic data to LHJs on a quarterly basis. This assists RW Part A and RW Part B LHJs to evaluate the level of ADAP services available in their counties to assure comprehensive and equitable pharmacy benefits statewide. Clients ineligible for ADAP or requiring a drug that is not available on the ADAP formulary continue to be referred to manufacturer patient assistance programs, local consortia RW Part B services providers, or RW Part A EMAs.

Medicare (including Medicare Part D Prescription Drug Benefit) - Policies and Procedures Established by State: Consistent with state and federal mandates, California's ADAP requires that all Medicare-eligible ADAP beneficiaries enroll in a Medicare Part D Prescription Drug Plan. In an effort to assist beneficiaries with out of pocket costs associated with their Medicare Part D benefit, ADAP utilizes the drug rebates to pay Medicare Part D deductibles, co-insurance, co-payments, and costs during the "donut hole" for medications that are included in the ADAP formulary. ADAP also provides Medicare Part D premium payment assistance to ADAP clients who are not eligible for full Low Income Subsidy (LIS) under Medicare.

CMS shares data with the PBM monthly to identify ADAP clients with Medicare eligibility. If no Medicare Part D plan is shown for the identified clients, their ADAP eligibility is suspended. After clients contact their enrollment worker they are notified of the problem. ADAP grants a 30-day waiver for clients to comply with one of the following requirements: 1) provide their Medicare Part D Plan information; 2) provide proof of creditable coverage; or 3) enroll in a Medicare Part D Plan if possible. If clients are unable to enroll in a Medicare Part D Plan they are given a waiver until the next open enrollment period.

RW Part B Components That Cover Medicare Part D Costs: ADAP provides assistance to any Medicare eligible beneficiary who is actively enrolled in ADAP (including dual eligible beneficiaries). ADAP pays Medicare Part D deductibles, co-insurance, co-payments, and costs during the "donut hole" for medications that are included in the ADAP formulary. ADAP also

provides Medicare Part D premium payment assistance to ADAP clients who are not eligible for full LIS under Medicare. The ADAP budget process also takes into account the following factors: annual increases in Medicare Part D out-of-pocket costs, impact of fewer duals qualifying for full LIS because they did not meet their Medicaid Spend-Down in 2011 and increased drug costs to determine the impact of providing Medicare Part D wrap-around coverage. Each new Medicare Part D plan year brings an increase in the amount of administrative time required to answer client questions regarding changes in coverage and other plan change questions. Individual client intervention is often necessary and can be very challenging and time consuming. ADAP does not limit the eligible Prescription Drug Plans (PDPs) that clients may enroll into. However, ADAP restricts the amount of assistance provided to dual eligible clients with no SOC and LIS clients if they do not enroll in a benchmark plan. ADAP will only pay up to the benchmark amounts for deductible, co-insurance, co-payment, or assistance while in the “donut hole” coverage gap for these clients. ADAP’s PBM coordinates and tracks all Medicare Part D drug transactions. The PBM has a signed data sharing agreement with CMS and uses this data exchange to coordinate the Medicare Part D drug cost sharing payments. OA staff coordinate and track all Medicare Part D premium payment transactions. Staff contact PDPs to obtain accurate per client premium amounts. Staff distribute reports to the plans bi-annually to reconcile premium payments.

ADAP anticipates that approximately 9,117 clients will receive Medicare Part D cost sharing assistance in FY 2011. Projected costs to provide coverage for clients’ out-of-pocket costs in Medicare Part D are expected to be approximately \$14,640,111. ADAP anticipates that approximately 9,367 clients will receive Medicare Part D cost sharing assistance in FY 2012. Projected costs to provide coverage for clients’ out-of-pocket costs in Medicare Part D are expected to be approximately \$15,041,562. In addition to ADAP Earmark, rebate funds will be used for Medicare Part D costs. This fund is not specifically allocated for the purpose of covering Medicare Part D beneficiary costs but can be used for this purpose.

ADAP Funded Health Insurance - *Description of existing ADAP-funded health insurance programs:* ADAP pays prescription co-pays and deductibles for ADAP clients with health insurance using RW Funds, State General Funds, drug rebates, and Federal Safety Net Care Pool Funds. ADAP also uses rebate funds to provide Medicare Part D premium payment assistance for ADAP clients. In State FY 2011-12 (July 1, 2011 through June 30, 2012), OA expanded the HIPPA Program’s eligibility requirements and implemented ADAP payments of California’s PCIP premiums as a cost-effective mechanism of providing health insurance to more individuals who are at risk of losing it or to individuals without health insurance who would like to purchase it. ADAP estimates expenditures for insurance premiums and prescription co-pays and deductibles of approximately \$59,796,000 in State FY 2011-12. The projected number of clients to be served in State FY 2011-12 equals 19,664. OA does not plan to establish new insurance programs during FY 2012.

ADAP Supplemental Grant Application - *Eligibility Criteria:* In order to be eligible for ADAP services, clients must: 1) be a resident of the state of California; 2) be at least 18 years of age; 3) have an HIV diagnosis; 4) have a prescription written by a licensed California physician/prescriber; 5) have limited or no prescription drug benefit from another source; and (6) have a federal adjusted gross income of not more than \$50,000.

The California ADAP formulary currently consists of 182 drugs; approximately 91 percent of ADAP expenditures are for PHS recommended antiretroviral and opportunistic infection drugs. Every effort is made to maintain ADAP’s current formulary; however there

exist factors which could limit the continued inclusion of existing medications or the addition of new ones. Some of these are: (a) Manufacturer pricing of both existing and new medications. Historically, the major antiretroviral drug manufacturers have taken significant pricing increases each year; (b) Supplemental rebate amounts as negotiated by ACTF. ACTF previously had negotiated voluntary rebates and price freeze agreements with manufacturers of antiretroviral medications. Recently, ACTF reached enhanced agreements for additional voluntary rebates; (c) Decreases in funding that supports the program; and (d) Increases in total number of clients, the number of prescriptions per client, increased medication costs and increased time enrolled in ADAP.

The State continues to be under intense fiscal pressure. Governor Jerry Brown signed the FY 2011-12 State Budget with \$4 billion in anticipated new revenue. The State Controller recently announced that California has fallen \$1.5 billion behind in revenues through the first four months of FY. The Legislative Analyst's Office projects a \$3.7 billion shortfall in State FY 2011-12 and a \$13 billion shortfall in State FY 2012-13. If additional revenue does not materialize, spending cuts will be instituted. Any program with current or proposed State General Fund support is vulnerable to have the support reduced or eliminated entirely. It will be up to the Administration to determine if ADAP may need to consider cost containment measures for the current FY and FY 2012.

In the past few years, the California Legislature passed and the Governor signed laws which will likely result in the identification of new HIV-infected individuals who may seek assistance from ADAP and increase the fiscal pressure on ADAP. In January 2008, Assembly Bill (AB) 682 (Berg, Chapter 550, Statutes of 2008) eliminated the requirement for a patient's written consent for an HIV test. Individuals can now be tested for HIV in California when their blood is tested as part of a standard health screening. A patient may opt-out, or explicitly refuse an HIV test in order to avoid this screening. Effective January 1, 2012, AB 1382 (Hernandez, Chapter 463, Statutes 2011) authorizes HIV counselors to perform hepatitis C virus (HCV) or combined HIV/HCV tests in addition to HIV tests. Senate Bill 422 (Wright, Chapter 151, Statutes of 2011) permits physicians to notify HIV Partner Services staff at the local public health agency of individuals who have tested positive for HIV and with the written consent of the patient the physician may disclose personally identifying information of the patient to Partner Services staff. The new law also authorizes HIV Partner Services staff to make partner notifications to persons believed to be a spouse, sexual partner, or partner of shared needles of the HIV-positive person, without disclosing any identifying information about the HIV-positive person or the reporting physician. California estimates that between 152,656 and 173,843 Californians will be living with HIV/AIDS at the end of FY 2011. This estimate includes people who are HIV positive but are not yet diagnosed (approximately 20 percent) by applying a national estimate of those unaware of their infection status that was developed by CDC Morbidity and Mortality Weekly Report (June 3, 2011). Thus the current estimate places the number of Californians who were unaware of their HIV positive status in excess of 30,000.

The federal Guidelines for the Use of Antiretroviral Agents in HIV-1-infected Adults and Adolescents were updated on December 1, 2009 to recommend earlier initiation of antiretroviral therapy and physician adoption of the new revised guidelines and the resulting antiretroviral prescribing patterns have yet to be established. OA has requested that modeling of potential fiscal impact be conducted at the federal level by HRSA or CDC. When the State of California was forced to enact extreme budget cuts in FY 2009-10, OA lost all State dollars that supported services in HIV care, prevention, and research. Thus, OA was unable to continue to fund critical

HIV programs and services in many areas of the state and was forced to reduce services in all parts of the state. For example, with only CDC dollars available for prevention, OA is able to fund only 19 of California's 61 LHJs for prevention activities, including for counseling and testing services. Care services have also been severely reduced statewide since only HRSA RW Part B funds are now available. LHJs and clinics are struggling with the redirection of RW reductions, on top of reductions in county contributions to care. Medical care and medical treatment ADAP go hand in hand. Elimination of access to either of these for any clients will result in poor health outcomes, disability leading to Medi-Cal eligibility, increased public care and support costs, increased HIV transmission and thus incidence, and increases in HIV/AIDS related mortality in California. Both HIV-associated medical care and HIV medical treatments are cost effective. These impacts are also likely to create even further disparities among impacted groups in California. All of the outcomes that result from RW services budget reductions are inconsistent with the President's NHAS objectives, Healthy People 2010, and the CDPH Strategic Plan objectives. OA is requesting a waiver to the match requirement for 2012 and has included the request in **Attachment 6**. A match waiver request is being submitted for the ADAP Supplemental Award. However, if required to provide match funds, California could contribute 100 percent of the match amount using the State General Fund.

FY 2012 Emerging Communities - Program Authority and Eligibility: Bakersfield/Kern County has been identified by HRSA as the sole recipient of these funds. Additional funds are also provided directly to project sites through RW Parts C and D. Emerging Communities funding will complement, not supplant, existing funds allocated for HIV care, treatment, and support services through the State RW Part B allocation process. All county agencies participating in the delivery of care services contribute in-kind resources, particularly in the form of staff time that is paid by non-RW Part B funds. Emerging Communities funding will not conflict with or alter the current funding formula thus ensuring equitable distribution of RW Part B funds in the current and future years. Allocation of Emerging Communities funds will be on a direct full allocation basis; no administrative costs will be subtracted from the grant for grantee administration. OA will maintain oversight of the grant ensuring that Kern County is responsive to the community and that funds are used in the most cost effective method. To ensure HIV-related activities are maintained in the Kern County, members of Kern County AIDS Advisory Board, surveys and focus group data from PLWH/A are used to guide the development and implementation of service priorities and funding allocations. PLWH/A indicated that the three top priority services needed that were frequently unavailable, or of limited availability, are dental and vision care, and transitional case management services for the post-incarcerated. It is due to this input that Kern County proposed to utilize the supplemental funds to expand the provision of dental, vision, and transitional case management services for HIV-positive persons in FY 2010. The expansion of these services will continue in FY 2012.

Emerging Communities Requirements: Emerging Communities funding will be used to supplement local providers' ability to provide the following services or assistance to eligible PLWH/A: 1) dental and vision care services; and 2) expansion of TCMP for HIV-positive inmates at pre-release and post-incarceration. Primary medical care services and supportive services in Kern County are covered by funds received through RW Parts B, C, and D-funded programs, federally qualified health centers, and through HOPWA. The joint local implementation group and care planning group in Kern County works closely with the fiscal agent in reviewing and commenting on proposed services and funding priorities based on needs assessment findings. Local planning involves representatives from all funded service providers,

the five county supervisory districts, two persons with HIV/AIDS, a substance use provider, a direct medical services provider, a medical doctor, representatives from the Hispanic and African American community, a representative from the MSM community, and an academic representative. Kern County staff with assistance from the planning body assessed local service needs that the funds address. Kern County staff also updated the local demographic and HIV/AIDS incidence profile. The results of the needs assessment guided the development and implementation of the current funding priorities and the development of the county service delivery plan. The Kern County Service Delivery Plan and needs assessment is consistent with the goals and priorities summarized in the California SCSN. Kern County does not cross any state borders; however, Kern County providers do provide RW Part B services to eligible residents of the county directly to the north that has considerably fewer resources available to provide care services.

As is true nationally, HIV/AIDS in Kern County disproportionately affects African Americans, although many of those cases in Kern County are actually cases of incarcerated individuals that are included in the general count. Kern County also has a large population of Spanish monolingual individuals, many of whom are also undocumented and present unique service challenges due to their ineligibility for many health care programs and pervasive fear of deportation or other legal action when seeking health care services. Kern County is one of two TCMP primary centers for the state of California. Administered through CDCR, the Kern County TCMP center provides services from south of the Oregon border to Ventura County. Kern County has Institutional-Based Social Workers within their jurisdiction and Community-Based Social Workers that cover individual counties or regional locations as appropriate.

Planning and Utilization of Emerging Communities Funds: In FY 2011, Kern County provided Outpatient Ambulatory Care, Medical Case Management and Case Management for a total of 1,786 units of service. OA will be providing technical assistance and oversight to Kern County in FY 2011 to assist them in completing their program implementation as it relate to dental, vision, and TCMP services ensuring full utilization of these designated funds.