

**AIDS DRUG ASSISTANCE PROGRAM  
(ADAP)  
November 2011  
Estimate Package**

**2012-13 GOVERNOR'S BUDGET**



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DEPARTMENT OF PUBLIC HEALTH**

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# 1. FISCAL COMPARISON TABLES

Table 1a: Expenditure Comparison: FY 2011-12 November Estimate to FY 2011-12 Budget Act (000's)

	2011-2012 November Estimate					2011-12 Budget Act					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund
<b>Local Assistance Funding</b>	<b>\$481,830</b>	<b>\$74,064</b>	<b>\$118,797</b>	<b>\$5,785</b>	<b>\$283,184</b>	<b>\$511,148</b>	<b>\$74,064</b>	<b>\$100,632</b>	<b>\$82,625</b>	<b>\$253,827</b>	<b>(\$29,318)</b>		<b>\$18,165</b>	<b>(\$76,840)</b>	<b>\$29,357</b>
ADAP Expenditure Estimate	\$477,304	\$74,064	\$118,797	\$4,933	\$279,510	\$503,620	\$74,064	\$100,632	\$82,625	\$246,299	(\$26,316)		\$18,165	(\$77,692)	\$33,211
Prescription Costs	\$470,144	\$72,953	\$117,015	\$4,859	\$275,317	\$496,526	\$73,036	\$99,235	\$81,479	\$242,776	(\$26,381)	(\$83)	\$17,780	(\$76,620)	\$32,541
Basic Prescription Costs	\$506,649	\$72,953	\$117,015	\$4,859	\$311,822	\$522,930	\$73,036	\$99,235	\$81,479	\$269,180	(\$16,281)	(\$83)	\$17,780	(\$76,620)	\$42,642
LIHP Expenditure impact	(\$19,604)				(\$19,604)						(\$19,604)				(\$19,604)
OA-PCIP Expenditure impact	(\$2,806)				(\$2,806)	(\$9,945)				(\$9,945)	\$7,138				\$7,138
OA-HIPP Expenditure impact	(\$4,060)				(\$4,060)	(\$6,410)				(\$6,410)	\$2,350				\$2,350
PBM Contract: Pharmacy Split Savings	(\$1,293)				(\$1,293)	(\$1,336)				(\$1,901)	\$43				\$608
PBM Contract: Change in Reimburse. Rate	(\$2,300)				(\$2,300)	(\$1,901)				(\$1,336)	(\$399)				(\$964)
True-Out-Of-Pocket Costs (HCR)	(\$6,440)				(\$6,440)	(\$6,812)				(\$6,812)	\$373				\$373
PBM Operational Costs	\$7,160	\$1,111	\$1,782	\$74	\$4,193	\$7,094	\$1,028	\$1,397	\$1,146	\$3,523	\$65	\$83	\$385	(\$1,072)	\$670
Basic PBM Costs	\$7,563	\$1,111	\$1,782	\$74	\$4,596	\$15,209	\$2,204	\$2,995	\$2,458	\$7,553	(\$7,647)	(\$1,093)	(\$1,213)	(\$2,384)	(\$2,957)
LIHP PBM Costs	(\$299)				(\$299)						(\$299)				(\$299)
OA-PCIP PBM Costs	(\$43)				(\$43)						(\$43)				(\$43)
OA-HIPP PBM Costs	(\$62)				(\$62)						(\$62)				(\$62)
*PBM Contract: Change in Transaction Fees						(\$8,115)	(\$1,176)	(\$1,598)	(\$1,311)	(\$4,030)	\$8,115	\$1,176	\$1,598	\$1,311	\$4,030
LHJ Administration	\$1,000				\$1,000	\$1,000				\$1,000					
Insurance Assistance Program: Medicare Part D	\$1,000				\$1,000	\$1,000				\$1,000					
Insurance Assistance Program: OA-PCIP	\$556				\$556	\$2,376				\$2,376	(\$1,820)				(\$1,820)
Insurance Assistance Program: OA-HIPP	\$3,670		\$1,700	\$852	\$1,118	\$3,019		\$1,700		\$3,019	\$650			\$852	(\$1,902)
Tropism Assay						\$133				\$133	(\$133)				(\$133)
Support/Administration Funding	\$2,570		\$1,178	\$411	\$981	\$2,586		\$1,178	\$411	\$997	(\$16)				(\$16)

Table 1b: Expenditure Comparison: FY 2012-13 November Estimate to FY 2011-12 Budget Act (000's)

	2012-13 Governor's Budget					2011-12 Budget Act					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund
<b>Local Assistance Funding</b>	<b>\$403,837</b>	<b>\$49,300</b>	<b>\$102,572</b>	<b>\$6,445</b>	<b>\$245,520</b>	<b>\$511,148</b>	<b>\$74,064</b>	<b>\$100,632</b>	<b>\$82,625</b>	<b>\$253,827</b>	<b>(\$107,310)</b>	<b>(\$24,764)</b>	<b>\$1,941</b>	<b>(\$76,180)</b>	<b>(\$8,307)</b>
ADAP Expenditure Estimate	\$395,073	\$49,300	\$102,572	\$5,556	\$237,644	\$503,620	\$74,064	\$100,632	\$82,625	\$246,299	(\$108,547)	(\$24,764)	\$1,941	(\$77,069)	(\$8,655)
Prescription Costs	\$389,147	\$48,561	\$101,034	\$5,473	\$234,079	\$496,526	\$73,036	\$99,235	\$81,479	\$242,776	(\$107,379)	(\$24,476)	\$1,799	(\$76,006)	(\$8,696)
Basic Prescription Costs	\$572,898	\$48,561	\$101,034	\$21,959	\$401,348	\$522,930	\$73,036	\$99,235	\$81,479	\$269,180	\$49,968	(\$24,476)	\$1,799	(\$59,520)	\$132,165
LIHP Expenditure impact	(\$137,805)				(\$137,805)						(\$137,805)				(\$137,805)
OA-PCIP Expenditure impact	(\$9,809)				(\$9,809)	(\$9,945)				(\$9,945)	\$136				\$136
OA-HIPP Expenditure impact	(\$8,350)				(\$8,350)	(\$6,410)				(\$6,410)	(\$1,940)				(\$1,940)
PBM Contract: Pharmacy Split Savings	(\$1,457)				(\$1,457)	(\$1,336)				(\$1,901)	(\$121)				\$444
PBM Contract: Change in Reimburse. Rate	(\$2,591)				(\$2,591)	(\$1,901)				(\$1,336)	(\$690)				(\$1,255)
True-Out-Of-Pocket Costs (HCR)	(\$7,254)				(\$7,254)	(\$6,812)				(\$6,812)	(\$441)				(\$441)
Client Cost Sharing	(\$16,486)			(\$16,486)							(\$16,486)			(\$16,486)	
PBM Operational Costs	\$5,926	\$740	\$1,539	\$83	\$3,565	\$7,094	\$1,028	\$1,397	\$1,146	\$3,523	(\$1,168)	(\$288)	\$142	(\$1,063)	\$42
Basic PBM Costs	\$6,301	\$740	\$1,539	(\$1,917)	\$5,940	\$15,209	\$2,204	\$2,995	\$2,458	\$7,553	(\$8,908)	(\$1,464)	(\$1,456)	(\$4,375)	(\$1,613)
LIHP PBM Costs	(\$2,099)				(\$2,099)						(\$2,099)				(\$2,099)
OA-PCIP PBM Costs	(\$149)				(\$149)						(\$149)				(\$149)
OA-HIPP PBM Costs	(\$127)				(\$127)						(\$127)				(\$127)
*PBM Contract: Change in Transaction Fees						(\$8,115)	(\$1,176)	(\$1,598)	(\$1,311)	(\$4,030)	\$8,115	\$1,176	\$1,598	\$1,311	\$4,030
Client Cost Sharing	\$2,000			\$2,000							\$2,000			\$2,000	
LHJ Administration	\$2,000				\$2,000	\$1,000				\$1,000					\$1,000
Insurance Assistance Program: Medicare Part D	\$1,000				\$1,000	\$1,000				\$1,000					
Insurance Assistance Program: OA-PCIP	\$1,852				\$1,852	\$2,376				\$2,376	(\$524)				(\$524)
Insurance Assistance Program: OA-HIPP	\$5,613		\$1,700	\$889	\$3,024	\$3,019		\$1,700		\$3,019	\$2,593			\$889	\$4
Tropism Assay						\$133				\$133	(\$133)				(\$133)
Support/Administration Funding	\$2,501		\$1,178	\$411	\$912	\$2,586		\$1,178	\$411	\$997	(\$85)				(\$85)

\* Due to the change in methodology to PBM Contract: Change in Transaction Fees (NMA 1) is incorporated into the Basic PBM cost line item for 2011-12 November Estimate and 2012-13 Governor's Budget.

Table 1c: Expenditure Comparison: FY 2012-13 November Estimate to FY 2011-12 November Estimate (000's)

	2012-13 Governor's Budget					2011-2012 November Estimate					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund
<b>Local Assistance Funding</b>	<b>\$403,837</b>	<b>\$49,300</b>	<b>\$102,572</b>	<b>\$6,445</b>	<b>\$245,520</b>	<b>\$481,830</b>	<b>\$74,064</b>	<b>\$118,797</b>	<b>\$5,785</b>	<b>\$283,184</b>	<b>(\$77,993)</b>	<b>(\$24,764)</b>	<b>(\$16,225)</b>	<b>\$660</b>	<b>(\$37,664)</b>
ADAP Expenditure Estimate	\$395,073	\$49,300	\$102,572	\$5,556	\$237,644	\$477,304	\$74,064	\$118,797	\$4,933	\$279,510	(\$82,231)	(\$24,764)	(\$16,225)	\$623	(\$41,866)
Prescription Costs	\$389,147	\$48,561	\$101,034	\$5,473	\$234,079	\$470,144	\$72,953	\$117,015	\$4,859	\$275,317	(\$80,998)	(\$24,393)	(\$15,981)	\$614	(\$41,238)
Basic Prescription Costs	\$572,898	\$48,561	\$101,034	\$21,959	\$401,345	\$506,649	\$72,953	\$117,015	\$4,859	\$311,822	\$66,249	(\$24,393)	(\$15,981)	\$17,100	\$89,524
LIHP Expenditure impact	(\$137,805)				(\$137,805)	(\$19,604)				(\$19,604)	(\$118,201)				(\$118,201)
OA-PCIP Expenditure impact	(\$9,809)				(\$9,809)	(\$2,806)				(\$2,806)	(\$7,003)				(\$7,003)
OA-HIPP Expenditure impact	(\$8,350)				(\$8,350)	(\$4,060)				(\$4,060)	(\$4,290)				(\$4,290)
PBM Contract: Pharmacy Split Savings	(\$1,457)				(\$1,457)	(\$1,293)				(\$1,293)	(\$163)				(\$163)
PBM Contract: Change in Reimburse. Rate	(\$2,591)				(\$2,591)	(\$2,300)				(\$2,300)	(\$291)				(\$291)
True-Out-Of-Pocket Costs (HCR)	(\$7,254)				(\$7,254)	(\$6,440)				(\$6,440)	(\$814)				(\$814)
Client Cost Sharing	(\$16,486)			(\$16,486)							(\$16,486)			(\$16,486)	
<b>PBM Operational Costs</b>	<b>\$5,926</b>	<b>\$740</b>	<b>\$1,539</b>	<b>\$83</b>	<b>\$3,565</b>	<b>\$7,160</b>	<b>\$1,111</b>	<b>\$1,782</b>	<b>\$74</b>	<b>\$4,193</b>	<b>(\$1,233)</b>	<b>(\$371)</b>	<b>(\$243)</b>	<b>\$9</b>	<b>(\$628)</b>
Basic PBM Costs	\$6,301	\$740	\$1,539	(\$1,917)	\$5,940	\$7,563	\$1,111	\$1,782	\$74	\$4,596	(\$1,262)	(\$371)	(\$243)	(\$1,991)	\$1,344
LIHP PBM Costs	(\$2,099)				(\$2,099)	(\$299)				(\$299)	(\$1,800)				(\$1,800)
OA-PCIP PBM Costs	(\$149)				(\$149)	(\$43)				(\$43)	(\$107)				(\$107)
OA-HIPP PBM Costs	(\$127)				(\$127)	(\$62)				(\$62)	(\$65)				(\$65)
*PBM Contract: Change in Transaction Fees															
Client Cost Sharing	\$2,000			\$2,000							\$2,000			\$2,000	
LHJ Administration	\$2,000				\$2,000	\$1,000				\$1,000	\$1,000				\$1,000
Insurance Assistance Program: Medicare Part D	\$1,000				\$1,000	\$1,000				\$1,000					\$1,000
Insurance Assistance Program: OA-PCIP	\$1,852				\$1,852	\$556				\$556	\$1,296				\$1,296
Insurance Assistance Program: OA-HIPP	\$5,613		\$1,700	\$889	\$3,024	\$3,670		\$1,700	\$852	\$1,118	\$1,943			\$37	\$1,906
Tropism Assay															
Support/Administration Funding	\$2,501		\$1,178	\$411	\$912	\$2,570		\$1,178	\$411	\$981	(\$69)				(\$69)

\* Due to the change in methodology to PBM Contract: Change in Transaction Fees (NMA 1) is incorporated into the Basic PBM cost line item for 2011-12 November Estimate and 2012-13 Governor's Budget.

**TABLE 2a: Resource Comparison: FY 2011-12 November Estimate to FY 2011-12 Budget Act (000's)**

	2011-12 November Estimate					2011-12 Budget Act					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund
<b>Available Resources</b>	<b>\$447,418</b>	<b>\$74,064</b>	<b>\$119,975</b>	<b>\$5,344</b>	<b>\$248,035</b>	<b>\$514,745</b>	<b>\$74,064</b>	<b>\$101,810</b>	<b>\$83,036</b>	<b>\$255,835</b>	<b>(\$67,327)</b>		<b>\$18,165</b>	<b>(\$77,692)</b>	<b>(\$7,800)</b>
Basic Rebate Revenues	\$237,256				\$237,256	\$230,444				\$230,444	\$6,812				\$6,812
Income from Surplus Money Investments	\$120				\$120	\$300				\$300	(\$180)				(\$180)
Federal Funds	\$103,750		\$103,750			\$98,810		\$98,810			\$4,941		\$4,941		
General Funds	\$5,344			\$5,344		\$83,036			\$83,036		(\$77,692)			(\$77,692)	
LIHP Revenue impact															
OA-PCIP Revenue impact	(\$508)				(\$508)	(\$1,834)				(\$1,834)	\$1,325				\$1,325
OA-HIPP Revenue impact	\$48				\$48	\$309				\$309	(\$261)				(\$261)
Renegotiated Sup. Rebate/Price Freeze Agreements	\$11,119				\$11,119	\$26,616				\$26,616	(\$15,497)				(\$15,497)
One-Time Increase in FF RW Part B Supp. 2011	\$16,225		\$16,225			\$3,000		\$3,000			\$13,225		\$13,225		
Safety Net Care Pool Funds	\$74,064	\$74,064				\$74,064	\$74,064								

**TABLE 2b: Resource Comparison: FY 2012-13 November Estimate to FY 2011-12 Budget Act (000's)**

	2012-13 Governor's Budget					2011-12 Budget Act					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund
<b>Available Resources</b>	<b>\$396,012</b>	<b>\$49,300</b>	<b>\$103,750</b>	<b>\$5,967</b>	<b>\$236,995</b>	<b>\$514,745</b>	<b>\$74,064</b>	<b>\$101,810</b>	<b>\$83,036</b>	<b>\$255,835</b>	<b>(\$118,733)</b>	<b>(\$24,764)</b>	<b>\$1,941</b>	<b>(\$77,069)</b>	<b>(\$18,840)</b>
Basic Rebate Revenues	\$257,298				\$257,298	\$230,444				\$230,444	\$26,854				\$26,854
Income from Surplus Money Investments	\$120				\$120	\$300				\$300	(\$180)				(\$180)
Federal Funds	\$103,750		\$103,750			\$98,810		\$98,810			\$4,941		\$4,941		
General Funds	\$5,967			\$5,967		\$83,036			\$83,036		(\$77,069)			(\$77,069)	
LIHP Revenue impact	(\$33,078)				(\$33,078)						(\$33,078)				(\$33,078)
OA-PCIP Revenue impact	(\$3,535)				(\$3,535)	(\$1,834)				(\$1,834)	(\$1,701)				(\$1,701)
OA-HIPP Revenue impact	\$108				\$108	\$309				\$309	(\$201)				(\$201)
Renegotiated Sup. Rebate/Price Freeze Agreements	\$16,081				\$16,081	\$26,616				\$26,616	(\$10,535)				(\$10,535)
One-Time Increase in FF RW Part B Supp. 2011						\$3,000		\$3,000			(\$3,000)		(\$3,000)		
Safety Net Care Pool Funds	\$49,300	\$49,300				\$74,064	\$74,064				(\$24,764)	(\$24,764)			

**TABLE 2c: Resource Comparison: FY 2012-13 November Estimate to FY 2011-12 November Estimate (000's)**

	2012-13 Governor's Budget					2011-12 November Estimate					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund
<b>Available Resources</b>	<b>\$396,012</b>	<b>\$49,300</b>	<b>\$103,750</b>	<b>\$5,967</b>	<b>\$236,995</b>	<b>\$447,418</b>	<b>\$74,064</b>	<b>\$119,975</b>	<b>\$5,344</b>	<b>\$248,035</b>	<b>(\$51,406)</b>	<b>(\$24,764)</b>	<b>(\$16,225)</b>	<b>\$623</b>	<b>(\$11,040)</b>
Basic Rebate Revenues	\$257,298				\$257,298	\$237,256				\$237,256	\$20,042				\$20,042
Income from Surplus Money Investments	\$120				\$120	\$120				\$120					
Federal Funds	\$103,750		\$103,750			\$103,750		\$103,750							
General Funds	\$5,967			\$5,967		\$5,344			\$5,344		\$623			\$623	
ADAP Revenue impact	(\$33,078)				(\$33,078)						(\$33,078)				(\$33,078)
OA-PCIP Revenue impact	(\$3,535)				(\$3,535)	(\$508)				(\$508)	(\$3,026)				(\$3,026)
OA-HIPP Revenue impact	\$108				\$108	\$48				\$48	\$60				\$60
Renegotiated Sup. Rebate/Price Freeze Agreements	\$16,081				\$16,081	\$11,119				\$11,119	\$4,962				\$4,962
One-Time Increase in FF RW Part B Supp. 2011						\$16,225		\$16,225			(\$16,225)		(\$16,225)		
Safety Net Care Pool Funds	\$49,300	\$49,300				\$74,064	\$74,064				(\$24,764)	(\$24,764)			

## 2. MAJOR ASSUMPTIONS

For purposes of the *November 2011 Estimate* (Fiscal Year [FY] 2012-13), expenditure and revenue adjustments were made to the Fund Condition Statement (FCS) (**Table 35**, page 46) to reflect the estimated impact of 9 New, 6 Revised, and 4 Continuing Assumptions (assumptions unchanged but fiscal outcome impacted by the revised expenditure estimate), including:

### New Major Assumptions

1. Method Issue #1: Change in Methodology: Adjust Linear Regression Expenditure Methodology to Account for Change in Pharmacy Benefit Manager (PBM) Transaction Fees.
2. Method Issue #2: Change in Methodology: Data Points for Rebate Estimate Method.
3. Method Issue #3: Increase Rebate Percentage from 46 Percent to 48 Percent.
4. ADAP/LIHP Issue: Impact of the Ten "Legacy" LIHP Counties on ADAP.
5. ADAP/SOC Issue: Institution of a New Client Cost-Sharing Policy
6. Federal Funding Issue #1: Additional 2011 Ryan White (RW) Federal Grant Funds.
7. Special Fund (SF) Funding Issue: \$1 million Additional SF Budget Authority.
8. Miscellaneous Issue #1: Interest Earned Revised Down.
9. Miscellaneous Issue #2: Elimination of \$132,623 for Tropism Assay Testing.

### Revised Major Assumptions

1. OA-PCIP Issue #1: Delayed OA-PCIP Implementation.
2. OA-PCIP Issue #2: Reduced PCIP Premiums.
3. OA-PCIP/LIHP Issue: Reductions in OA-PCIP Caseload and Savings due to LIHP and RW Payer of Last Resort Provision.
4. OA-HIPP/LIHP Issue: Reductions in OA-HIPP Caseload and Savings due to LIHP and RW Payer of Last Resort Provision.
5. OA-HIPP/Medi-Cal GF Issue: Using GF to Pay OA-HIPP Premiums and ADAP Drug Deductibles and Co-Pays for Clients Co-Enrolled in Medi-Cal with a SOC.
6. Federal Funding Issue #2: Reimbursement of Federal Funding through the Safety Net Care Pool for FY 2012-13.

### Continuing Assumptions

1. Renegotiated Supplemental Rebate/Price Freeze Agreement.
2. PBM Contract: Pharmacy Split Savings.
3. PBM Contract: Change in Pharmacy Reimbursement Rate.
4. Legislation Effecting Medicare Part D True-Out-of-Pocket (TrOOP) Costs.

All of the final adjustments were added to or subtracted from the initial, unadjusted FYs 2011-12 and 2012-13 expenditure and revenue estimates (derived from the regression equations), respectively, to arrive at the final adjusted expenditure and revenue estimates.

## **New Major Assumptions**

### **NMA 1. Method Issue #1: Change in Methodology: Adjust Linear Regression Expenditure Methodology to Account for Change in PBM Transaction Fees**

To account for the revised PBM fee structure that began on July 1, 2011, the California Department of Public Health (CDPH) Office of AIDS (OA) used the same analytic approach that was used in the *November 2010 Estimate Package* (FY 2011-12) to address the elimination of jail expenditures in the expenditure regression estimate. Briefly, OA conducted a pre-regression adjustment of the transaction fees for all months within the linear regression (August 2008 through July 2011) to eliminate the need for a post-regression adjustment except for July 2011, which already had the new fee structure. OA reduced all of the transaction fees from all of the prior data points to the new transaction fees.

Prior estimates (*November 2010 Estimate Package* and *2011-12 May Revision*) to project the savings associated with reduced fees, using a post regression adjustment method, were derived from using our FY 2009-10 data to determine the proportion of total expenditures that would have been attributed to this assumption. The same proportion of savings was applied to the total expenditure estimate in FY 2011-12. Using a pre-adjustment methodology eliminates the need to manually adjust the expenditure regression estimate by reducing actual fees from all prior data points in the linear regression before the new fee structure is applied. This allows the linear regression method to estimate expenditures as if the PBM transaction fee structure never changed.

### **NMA 2. Method Issue #2: Change in Methodology: Data Points for Rebate Estimate Method**

Since the first ADAP *November 2008 Estimate Package* (FY 2009-10), the starting point for computing the rebate percentage was FY 2005/06-Quarter (Q)3. The ending point for the *November 2010 Estimate Package* (FY 2011-12) was FY 2009/10-Q3 (17 quarters of actual rebate data), and the ending point for the *2011-12 May Revision* was FY 2009/10-Q4 (18 quarters). To mirror the most recent 36 monthly data points (three years) used in the linear regression model for the expenditure estimate, the rebate percentage now uses the most recent 12 quarterly data points (three years). For the *November 2011 Estimate Package* (FY 2012-13), the rebate data points start with FY 2007/08-Q4 and end with FY 2010/11-Q3.

### **NMA 3. Method Issue #3: Increase Rebate Percentage from 46 Percent to 48 Percent**

Since FY 2007/08-Quarter 4, ADAP has used 46 percent to estimate its rebate revenue. Due to higher actual average collections over the past 12 quarters (see **Table 40**, page 56), the rebate percentage has been increased from 46 percent to 48 percent. This increased rebate revenue rate reflects the early impact of the Renegotiated Supplemental Rebate and/or Price Freeze Agreements Assumption that was included in the *November 2010 Estimate Package* (FY 2011-12).

**NMA 4. ADAP/LIHP Issue: Impact of the Ten “Legacy” LIHP Counties on ADAP**

On November 2, 2010, the State received federal approval of its five-year 1115(a) Medicaid Demonstration waiver entitled “California’s Bridge to Reform.” This waiver will advance Medi-Cal program changes that will help the State transition to the federal health care reforms that will take effect on January 2014. Included as one of these changes, the California Department of Health Care Services’ (DHCS) new program, the Low Income Health Program (LIHP) will phase in health coverage for adults ages 19-64 years with incomes up to 200 percent of the federal poverty level (FPL), as determined by each county, who are not otherwise eligible for Medicaid. While the program is voluntary at the county level, it is anticipated that most counties will implement LIHPs. The first ten counties to implement LIHP, referred to collectively as the “Legacy” counties, include Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura. These ten counties represent the bulk of ADAP clients (79 percent of all ADAP clients during FY 2010-11). LIHP will end on December 31, 2013.

All ten contracts for the Legacy counties were approved between DHCS and the counties in October 2011. The remaining counties (“non-Legacy”) are in earlier stages of developing their LIHPs thus program information is not expected before the submission of the *November 2011 Estimate Package* (FY 2012-13). Please refer to **Future Fiscal Issue #2**, page 64 for a discussion of the non-Legacy counties.

LIHP consists of two optional components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). Eligible individuals must be between 19 and 64 years of age, may not be otherwise eligible for Medicaid, must be non-pregnant, must meet income eligibility standards of the respective county, must meet the county residency requirement and must be legally residing in the United States. In addition:

- MCE – Each county can set the FPL at or anywhere below 133 percent. Thus, individuals must have family incomes at or below their participating county’s threshold. MCE is not subject to a cap on federal funding and has a broader range of services than that of HCCI. Counties can choose to allow individuals with private insurance and/or Medicare to be eligible for MCE as long as the family income meets the county’s FPL requirement.
- HCCI – A county must have an MCE program in place with a FPL of 133 percent in order to be eligible for having an HCCI. Each county can set their HCCI FPL between 134 percent and 200 percent. Thus, individuals must have family incomes at or below the county’s FPL requirement, and not have third-party coverage. HCCI offers a narrower range of services than MCE and is subject to a cap on federal funding. Individuals with private insurance are not eligible for HCCI.

Additional features that are left to the discretion of the county include:

- Enrollment caps – if a county determines that it will exceed available funding it can establish a cap first for its HCCI program then for MCE.
- Waiting lists – may be initiated if an enrollment cap is in effect and includes a six-month outreach plan to notify those on the waiting list to afford them the opportunity to sign up for other programs if they are still seeking coverage.
- Charging lower per prescription drug co-pays or waiving the charge entirely.

Recent communications from the federal Health Resources and Services Administration (HRSA) and the Centers for Medicare and Medicaid Services (CMS) have provided clarification regarding screening for LIHP eligibility within RW programs, including:

- RW funding is the payer of last resort relative to all other payer sources including LIHP, Medi-Cal, and Medicare;
- LIHPs are not required to include RW providers as part of their network but must ensure an adequate provider network for all enrollees; and
- LIHP must cover any prescription drug that is determined to be medically necessary for the client even if it is not on the LIHP formulary.

Transitioning ADAP clients to LIHP will result in reduced ADAP expenditures and reduced rebate revenue. OA estimated total net savings of **\$19.9 million** in FY 2011-12 and **\$106.8 million** in FY 2012-13. The amount of net savings is contingent on the many issues previously noted, including each county's implementation timing, income eligibility criteria, and program features.

### **Estimate Methodology**

To determine the ultimate impact of LIHP on ADAP for FYs 2011-12 and 2012-13, OA first determined the pool of potentially LIHP-eligible ADAP clients, estimated the initial unadjusted impacts of shifting these clients into LIHP, and finally adjusted these initial impact estimates for a number of processes to arrive at the final estimated impact numbers.

Note that the savings estimate for this **NMA 4** is subject to substantial uncertainty because this is the first year that LIHP is being implemented, several factors regarding the timing of implementation are unknown, and there are no reliable historical data on which to model.

### Eligibility Characteristics

ADAP data used in this estimate methodology included data from clients who had ADAP-only transactions or private insurance transactions for MCE-eligible clients. ADAP-only transactions are incurred by clients who have no other payment sources, and thus are dependent upon ADAP for coverage of all of their drug costs. Private insurance transactions are incurred by ADAP clients who have private insurance coverage for their drug costs, but for whom ADAP pays their drug deductibles and

co-pays. In addition, clients included in this estimate have to meet county-specific LIHP income eligibility requirements, be legal U.S. residents, and be between the ages of 19 and 64. Finally, although the MCE program provides coverage for private insurance clients, the HCCI program does not. Therefore, OA only included ADAP private insurance clients who qualify for the MCE program. ADAP clients who met these standards are hereinafter called "LIHP-eligible clients."

### Unadjusted Estimate Methodology

To predict the unadjusted estimated future impact on ADAP from the implementation of LIHP, OA: 1) analyzed the data from the latest year containing complete client, expenditure, and rebate information; 2) estimated ADAP's hypothetical client loss, reduced expenditures, and reduced rebate revenue had LIHP been in place during that time; 3) calculated the percent of reduced expenditures and rebate revenue to overall expenditures for that period, as well as clients lost to clients served; and 4) applied these impact percentages to predicted client and expenditure data to estimate the future impact of LIHP implementation. The specific methodology used to determine the unadjusted impacts of LIHP on ADAP for FYs 2011-12 and 2012-13 involved the following three steps:

- a) OA used LIHP coverage information provided by each Legacy county along with client and expenditure data from ADAP calendar year (CY) 2010 to estimate the following for each Legacy county: 1) how many LIHP-eligible clients would have shifted from ADAP into LIHP had LIHP been in place in CY 2010; 2) how much ADAP expenditures would have been reduced in CY 2010; 3) how much ADAP rebate revenue would have been reduced in CY 2010; and 4) the net savings that would have been realized by ADAP in CY 2010 (expenditure reductions minus rebate revenue loss).

CY 2010 data were used because CY 2010 is the most recent 12-month period for which OA had complete information, including rebate data, and because OA used CY 2010 data for the cost/savings estimates recently provided to individual counties to help them evaluate their level of participation in LIHP.

LIHP coverage information was based upon the most current FPL eligibility levels provided by the Legacy counties. **Table 3** (page 9) lists the FPL percent levels for each program in each of the ten Legacy counties as of October 1, 2011.

<b>LEGACY COUNTY</b>	<b>MCE FPL%</b>	<b>HCCI FPL%</b>
Alameda	133%	200%
Contra Costa	133%	200%
Kern	100%	*
Los Angeles	133%	*
Orange	133%	200%
San Diego	133%	*
San Francisco	25%	*
San Mateo	133%	*
Santa Clara	75%	*
Ventura	133%	200%

\*HCCI program not implemented in this County

Note that counties have the option, with prior notice, of changing their program FPL eligibility requirements. If any such changes occur, then the impact of LIHP on ADAP will need to be adjusted.

**Table 4** below shows the unadjusted estimated client shift, expenditure and rebate reductions, and net savings by Legacy counties based upon the FPL eligibility levels listed in Table 3 and using CY 2010 ADAP data.

<b>Legacy County</b>	<b>Client Shift</b>	<b>Reduced Expenditures</b>	<b>Reduced Rebate Revenue</b>	<b>Net Savings</b>
Alameda*	678	\$7,368,922	\$2,767,149	\$4,601,773
Contra Costa	146	\$1,539,110	\$587,309	\$951,800
Kern	93	\$1,315,505	\$528,667	\$786,838
Los Angeles**	5,152	\$70,409,819	\$26,028,634	\$44,381,186
Orange	700	\$10,090,623	\$3,768,168	\$6,322,455
San Diego	1,321	\$16,287,629	\$5,887,948	\$10,399,681
San Francisco	535	\$3,479,985	\$1,432,338	\$2,047,647
San Mateo	96	\$1,131,146	\$462,836	\$668,310
Santa Clara	267	\$2,882,839	\$973,995	\$1,908,844
Ventura	101	1,510,317	\$657,260	\$853,057
<b>Totals</b>	<b>9,089</b>	<b>\$116,015,895</b>	<b>\$43,094,304</b>	<b>\$72,921,591</b>

\*Includes Berkeley LHJ

\*\*Includes Long Beach LHJ

Had LIHP been in place in the ten Legacy counties for all of CY 2010, an estimated maximum of 9,089 clients would have shifted from ADAP to LIHP and ADAP would have realized a maximum unadjusted net savings of \$72.91 million,

consisting of \$116.02 million in reduced expenditures less \$43.09 million in reduced rebate revenue.

- b) Next, OA calculated the following percentages: 1) client shift to total clients served during CY 2010; 2) reduced expenditures to total ADAP CY 2010 expenditures; 3) reduced rebate revenue to total ADAP CY 2010 expenditures; and 4) net savings to total ADAP CY 2010 expenditures.

Had LIHP been in place for CY 2010, ADAP would have shifted 23.47 percent of its clients served to LIHP (9,089/38,719) and realized net savings of 16.86 percent (\$72,921,591/\$432,537,840), consisting of 26.82 percent in reduced expenditures (\$116,015,895/\$432,537,840) and 9.96 percent in reduced rebate revenue (\$43,094,304/\$432,537,840).

- c) Finally, OA applied these proportions to estimated FYs 2011-12 and 2012-13 expenditures to derive the preliminary unadjusted impact numbers shown in **Table 5** below. See **Appendix A, page 52** for the expenditure estimates used in this Assumption, which were derived using the upper bound of ADAP's Medi-Cal(-) expenditure model.

<b>TABLE 5: ESTIMATED UNADJUSTED IMPACTS OF LIHP ON ADAP BY FISCAL YEAR</b>		
<b>IMPACTS</b>	<b>FY 2011-12</b>	<b>FY 2012-13</b>
Reduced Expenditures	\$137,922,476	\$155,353,571
Reduced Rebate Revenue	-\$51,231,541	-\$57,706,352
<b>Net Savings</b>	<b>\$86,690,935</b>	<b>\$97,647,219</b>

To estimate these unadjusted impacts for FY 2011-12, OA multiplied the FY 2011-12 expenditure estimate of \$514,211,350 by the CY 2010 expenditure percentage of 26.82 percent to derive reduced expenditures of \$137.92 million. To calculate the unadjusted reduced rebate revenue, OA multiplied the FY 2011-12 expenditure estimate by the CY 2010 rebate percentage of 9.96 percent for an estimated \$51.23 million, resulting in an unadjusted net savings for FY 2011-12 of \$86.69 million. OA applied the same method to estimate the impact numbers for FY 2012-13, but used the FY 2012-13 expenditure estimate of \$579,199,067 to derive the net unadjusted savings of \$97.65 million shown in Table 5.

### Adjustments to Initial Estimates

To determine the final impact of LIHP on ADAP, OA made two additional adjustments: 1) the estimated numbers in Table 5 were adjusted to account for the impact on LIHP from net savings resulting from other assumptions (Steps 1a and 1b, pages 11-12); and 2) the estimated numbers were further adjusted to account for LIHP program ramp-up time (Steps 2a, 2b and 2c, starting on page 12). Because ADAP continues to receive clarification and information from DHCS and the Legacy

counties, ADAP may need to incorporate additions, changes, and/or deletions to these adjustments in future budget processes.

**Step 1a: Expenditure Estimate Reductions Due to Other Assumptions.** The net savings from other assumptions in this Estimate Package affect the savings to LIHP; therefore, OA needed to take them into account. This was done by reducing the linear regression estimates of expenditures for FYs 2011-12 and 2012-13 to avoid double-counting net savings already calculated for the pharmacy split savings (**Continuing Assumption 2**), the change in pharmacy reimbursement rate to Average Wholesale Price (AWP) -14.5 percent (**Continuing Assumption 3**), and the continued Medicare Part D TrOOP savings (**Continuing Assumption 4**). The adjustments made for **Continuing Assumptions 2, 3 and 4** are detailed in **Table 6**.

<b>TABLE 6: ADJUSTMENTS TO FISCAL YEAR EXPENDITURES DUE TO OTHER ASSUMPTIONS</b>		
	<b>FY 2011-12</b>	<b>FY 2012-13</b>
<b>Unadjusted Expenditures</b>	<b>\$514,211,350</b>	<b>\$579,199,067</b>
Less Pharmacy Split Savings	-\$1,293,157	-\$1,456,590
Less AWP-14.5% Savings	-\$2,300,223	-\$2,590,933
Less TrOOP Savings	-\$6,439,865	-\$7,253,756
<b>Adjustments Subtotal</b>	<b>-\$10,033,245</b>	<b>-\$11,301,279</b>
<b>Total Adjusted Expenditure Estimates</b>	<b>\$504,178,105</b>	<b>\$567,897,788</b>

Thus, estimated adjusted expenditures for FY 2011-12 decreased \$10.03 million to \$504.18 million, and FY 2012-13 expenditures decreased \$11.30 million to \$567.90 million. These adjusted annual expenditure estimates were used as the starting point for assessing the final impact of LIHP on ADAP.

**Step 1b: Applying CY 2010 Percentages to Adjust Expenditure Reductions.** OA took the CY 2010 percentages calculated in paragraph (b) on page 10 and applied them to the adjusted expenditures for FYs 2011-12 and 2012-13 shown in Table 6.

**Table 7** gives the resulting adjusted estimated expenditures, rebate revenue reductions, and net savings for FYs 2011-12 and 2012-13.

<b>TABLE 7: ESTIMATED ADJUSTED IMPACTS OF LIHP ON ADAP PRIOR TO ADJUSTING FOR RAMP-UP</b>		
<b>IMPACTS</b>	<b>FY 2011-12</b>	<b>FY 2012-13</b>
Reduced Expenditures	\$135,231,345	\$152,322,326
Reduced Rebate Revenue	-\$50,231,916	-\$56,580,391
<b>Net Savings</b>	<b>\$84,999,429</b>	<b>\$95,741,936</b>

As indicated in Table 7, for FY 2011-12, ADAP would have realized an estimated maximum net savings of \$85.00 million (\$135.23 million in reduced expenditures less \$50.23 million in reduced rebate revenue), and for FY 2012-13, an estimated maximum net savings of \$95.74 million \$152.32 million in reduced expenditures less

\$56.58 million in reduced rebate revenue) if LIHP had been fully implemented for each fiscal year. However, the shift over time of LIHP-eligible clients and their associated expenditures from ADAP into LIHP still needed to be taken into account.

Step 2: LIHP Ramp-up. OA required ADAP coordinators and RW Part B contractors within the Legacy counties to create plans for implementing LIHP eligibility screening. The counties were notified through a series of guidance letters, teleconferences, and Website outreach, and OA required that the plans be submitted to OA by November 15, 2011. OA has received and reviewed all ten plans. Eight counties began LIHP screening prior to or will begin LIHP screening in January 2012. The remaining two counties have yet to finalize LIHP screening implementation, but one predicts implementation in March 2012 and the other in July 2012.

ADAP does not have sufficient information at this time to accurately know when all LIHP-eligible clients in the ten Legacy counties will leave ADAP and enter LIHP. As such, OA assumed that the impact of LIHP on ADAP would start with a January 1, 2012 implementation date, which is an arbitrarily chosen "average date" among the ten Legacy counties. The unadjusted and "step 1 adjusted" net expenditure reduction estimates for FY 2011-12 given above were for the entire FY. Because of the January 1, 2012 implementation date, ADAP would only realize savings for the last six months of FY 2011-12.

Furthermore, not all LIHP-eligible ADAP clients will immediately enroll into LIHP commencing with the proposed start of screening on January 1, 2012. Rather, they will be screened at least on their ADAP recertification date, which is based upon birth date. Analysis of CY 2010 data showed that the birth month of ADAP LIHP-eligible clients was fairly equally distributed across the 12 months of the year. For most ADAP LIHP-eligible clients, OA assumed that one-twelfth would be screened for LIHP each month for the first 12 months that the LIHP program is screening ADAP clients. However, per **NMA 5**, OA will implement a share of cost (SOC) for ADAP clients having an income exceeding 100 percent of the Federal Poverty Level (FPL) starting on July 1, 2012. This start date coincides with the final six months of LIHP ramp-up. Due to the additional burden of paying for a portion of their ADAP costs, otherwise LIHP-eligible clients who have an income between 101 percent and 200 percent of FPL have an incentive to move over to LIHP prior to their recertification date.

Because of the complexities involved in estimating the ramp-up of expenditure and rebate reductions for LIHP-eligible clients, OA estimated these ramp-ups separately for FY 2011-12 (Step 2a below) and FY 2012-13. Additionally, to take into account the implementation of SOC, the impact estimates for FY 2012-13 were split into two separate steps (Steps 2b and 2c, below), resulting in the following three steps:

**Step 2a** estimates the ramp-up of expenditure and rebate reductions for the first six months of LIHP ramp-up, starting in January 2012 and ending June 2012, which corresponds to the final six months of FY 2011-12. The ramp-up for this time period is unaffected by the implementation of the SOC, scheduled to start in July 2012.

Therefore, all LIHP-eligible clients, regardless of FPL, who have an ADAP recertification month between January and June of 2012 will be screened for LIHP during their recertification month, at an average of one-twelfth per month for each of these six months.

**Step 2b** estimates the ramp-up of expenditure and rebate reductions for the first six months of FY 2012-13 for clients who have an income of up to 100 percent of FPL. These clients are unaffected by the ADAP SOC and continue the one-twelfth a month ramp-up process started in FY 2011-12.

**Step 2c** estimates the expenditure and rebate reductions of those FY 2012-13 LIHP-eligible clients who have an income between 101 and 200 percent of FPL. These clients will not actually ramp-up. Due to the burden imposed by the ADAP SOC starting on July 1, 2012, OA assumed that these clients would not wait for their recertification date, but instead be screened for LIHP prior to July 2012.

In order to estimate the monthly expenditure and rebate reductions due to LIHP, OA first calculated the proportion of each month of CY 2010 expenditures to total CY 2010 expenditures and applied those percentages to total FYs 2011-12 and 2012-13 predicted expenditures given in Table 6 to get a month-by-month breakdown of predicted expenditures, shown in **Table 8** below.

Month	CY 2010 Monthly Expenditure Percent	Predicted Monthly Expenditures	
		FY 2011-12	FY 2012-13
JUL	8.29%	\$41,814,217	\$47,098,834
AUG	8.31%	\$41,899,075	\$47,194,418
SEP	8.24%	\$41,556,485	\$46,808,529
OCT	8.03%	\$40,480,128	\$45,596,139
NOV	8.56%	\$43,169,856	\$48,625,804
DEC	8.55%	\$43,116,116	\$48,565,272
JAN	7.54%	\$38,018,091	\$42,822,942
FEB	8.02%	\$40,418,743	\$45,526,997
MAR	9.66%	\$48,716,424	\$54,873,366
APR	8.48%	\$42,737,185	\$48,138,451
MAY	7.74%	\$39,026,495	\$43,958,792
JUN	8.57%	\$43,225,291	\$48,688,245
<b>Totals</b>	<b>100.00%</b>	<b>\$252,142,230</b>	<b>\$567,897,788</b>

Because the impact of LIHP starts half way into FY 2011-12, OA only used the final six months of expenditures for that fiscal year, for a total of \$252.14 million, which is almost half of the estimated \$504.18 million in adjusted predicted expenditures for FY 2011-12 given in Table 6. The resulting month-by-month expenditure predictions

in Table 8 were used to calculate ramp-up of the monthly expenditure and rebate reductions delineated in Steps 2a, 2b, and 2c below.

### Step 2a: FY 2011-12 Ramp-Up (January – June 2012), No SOC Impact

**Expenditure Reduction Ramp-Up.** Because the average implementation date for LIHP screening is currently assumed to start on January 1, 2012, half way into the fiscal year, only a portion of the estimated FY 2011-12 entire year expenditure reduction of \$135.23 million (see Table 7) would be realized. To estimate that portion, OA apportioned the predicted monthly expenditure reductions for January through June 2012 based upon the predicted monthly expenditure estimates for FY 2011-12 given in Table 8 (which total \$252.14 million). Per **Table 9**, below, this resulted in \$67.63 million (26.82 percent) as the portion of the FY 2011-12 expenditure reduction that could be realized. However, since not all clients with recertification dates in January through June 2012 would be enrolled in LIHP as of January 1, the \$67.63 million had to be adjusted to account for the client transition to LIHP. For January through June, OA estimated that one-twelfth of all LIHP-eligible ADAP clients would in fact transition to LIHP. Because the reduced expenditures of these clients leaving ADAP are cumulative, each successive month includes expenditure reductions realized by clients who were already enrolled into LIHP during the previous ramp-up month(s).

Month	Predicted Monthly Expenditures	Predicted Monthly Expenditure Reduction	Ramp-Up Multiplier	Ramp-Up of Expenditure Reduction
JAN 2012	\$38,018,091	\$10,197,265	1/12	\$849,772
FEB	\$40,418,743	\$10,841,171	2/12	\$1,806,862
MAR	\$48,716,424	\$13,066,786	3/12	\$3,266,697
APR	\$42,737,185	\$11,463,027	4/12	\$3,821,009
MAY	\$39,026,495	\$10,467,740	5/12	\$4,361,558
JUN	\$43,225,291	\$11,593,947	6/12	\$5,796,973
<b>Totals</b>	<b>\$252,142,230</b>	<b>\$67,629,936</b>		<b>\$19,902,871</b>

For example, per Table 9, in January 2012 ADAP would have incurred an estimated \$38.02 million in expenditures if LIHP were not in place. If all LIHP-eligible clients had enrolled in LIHP as of January 2012, ADAP would have realized an approximate \$10.20 million (26.82 percent) reduction in expenditures for that month. However, because of the ramp-up, OA estimated that only one-twelfth of these LIHP-eligible ADAP clients would in fact shift to LIHP in January, resulting in pro-rated savings of \$849,772 (\$10.20 million x (1/12)). For February, ADAP would have realized \$10.84 million in reduced expenditures if all LIHP-eligible clients had shifted to LIHP as of January 2012. But not only do a further one-twelfth of eligible ADAP clients shift to LIHP in February, the one-twelfth which shifted in January would also generate savings to ADAP in February. Thus, estimated reduced expenditures for February

consisted of two-twelfth's of potential savings, or \$1.81 million ( $(\$10.84 \text{ million} \times (2/12))$ ). Finally, for June, the estimated expenditure reduction of \$5.80 million consisted of six-twelfths (or one-half) of the predicted monthly expenditure reduction of \$11.59 million. Estimating ramp-up in this way leads to total reduced expenditures for the final six months of FY 2011-12 of \$19,902,871, or 29.43 percent of the predicted monthly expenditure reduction of \$67.63 million.

**Rebate Reduction Ramp-Up.** Applying the same methodology to rebate revenue led to an estimated predicted monthly rebate reduction prior to ramp-up of \$25.12 million and a total reduced rebate revenue of \$7,392,956 after taking ramp-up into account (again, 29.43 percent of the predicted six-month rebate reduction of \$25.12 million). See **Table 10** below.

Month	Predicted Monthly Expenditures	Predicted Monthly Rebate Reduction	Ramp-Up Multiplier	Ramp-Up of Rebate Reduction
JAN 2012	\$38,018,091	-\$3,787,792	1/12	-\$315,649
FEB	\$40,418,743	-\$4,026,972	2/12	-\$671,162
MAR	\$48,716,424	-\$4,853,680	3/12	-\$1,213,420
APR	\$42,737,185	-\$4,257,961	4/12	-\$1,419,320
MAY	\$39,026,495	-\$3,888,260	5/12	-\$1,620,108
JUN	\$43,225,291	-\$4,306,592	6/12	-\$2,153,296
<b>Totals</b>	<b>\$252,142,230</b>	<b>-\$25,121,256</b>		<b>-\$7,392,956</b>

However, OA could not apply this \$7.39 million in reduced rebate to the \$19.90 million in reduced expenditures to get a net savings amount for FY 2011-12 because there is a six-month delay between when ADAP incurs expenditures and when ADAP actually receives the rebate for those expenditures. Therefore, this \$7.39 million in reduced rebate was accounted for in FY 2012-13, as detailed further below.

Note that per Table 7, ADAP would have realized a maximum rebate reduction of \$50,231,916 had LIHP been in place for all of FY 2011-12. However LIHP implementation starts January 1, 2012, half way into the fiscal year. The \$25.12 million in total predicted rebate reduction given in Table 10 represents that portion of the \$50.23 million annual reduction prorated for the six-month period of January through June 2012.

### **Steps 2b and 2c, FY 2012-13 Ramp-up (July – December 2012)**

**Table 11** (page 16) shows the monthly estimated predicted expenditures and expenditure and rebate reductions for FY 2012-13 using the CY 2010 monthly expenditure percentages, the same methodology used for FY 2011-12 (see Table 9). Overall, for FY 2012-13, OA estimated that, prior to ramp-up, ADAP would realize an estimated \$152.32 million (26.82 percent) in expenditure reductions and

an estimated \$28.28 million in rebate reduction if all LIHP-eligible clients had shifted to LIHP as of July 1, 2012. Because of the six month delay in realizing rebate, for FY 2012-13 ADAP only included the estimated rebate for the first six months of FY 2012-13. The remaining six months would be applied to FY 2013-14. The total rebate reduction for FY 2012-13 that will be applied against the FY 2012-13 reduced expenditures consists of both the final six months of FY 2011-12 (see Step 2a) and the first six months of FY 2012-13 (given in Step 2b). These rebate reduction amounts are combined later in this Assumption, under the heading "FY 2012-13 Combined Expenditure and Rebate Reduction Impacts."

The \$28.28 million in rebate reduction given in Table 11 below represents the six month proration of the \$56,580,391 given in Table 7 as the maximum predicted rebate reduction for FY 2012-13.

<b>Month</b>	<b>Predicted Monthly Expenditures</b>	<b>Predicted Monthly Expenditure Reduction</b>	<b>Predicted Monthly Rebate Reduction</b>
JUL 2012	\$47,098,834	\$12,632,914	-\$4,692,518
AUG	\$47,194,418	\$12,658,552	-\$4,702,041
SEP	\$46,808,529	\$12,555,048	-\$4,663,594
OCT	\$45,596,139	\$12,229,859	-\$4,542,802
NOV	\$48,625,804	\$13,042,480	-\$4,844,652
DEC	\$48,565,272	\$13,026,244	-\$4,838,621
JAN 2013	\$42,822,942	\$11,486,028	NA*
FEB	\$45,526,997	\$12,211,314	NA*
MAR	\$54,873,366	\$14,718,210	NA*
APR	\$48,138,451	\$12,911,762	NA*
MAY	\$43,958,792	\$11,790,688	NA*
JUN	\$48,688,245	\$13,059,228	NA*
<b>Totals</b>	<b>\$567,897,788</b>	<b>\$152,322,326</b>	<b>-\$28,284,228</b>

\*Not applicable to FY 2012-13 because of the six-month delay in collecting rebate.

However, as already noted, ADAP SOC is scheduled to begin on July 1, 2012, the start of FY 2012-13, which means that OA needed to estimate the final six months of ramp-up separately for those clients who have an income up to 100 percent of FPL and who are *not* affected by SOC (Step 2b below), and impacts resulting from those who have an FPL of 101 to 200 percent who are subject to an ADAP SOC (Step 2c below). Because of this bifurcation in estimating LIHP impacts for FY 2012-13, the predicted monthly expenditure and rebate reductions given in Table 11 above had to be split between these two SOC groups and expenditure and rebate reduction estimates then calculated separately for each.

**FY 2012-13 Expenditure Reductions by SOC Group.** Per Table 12 (page 17) by splitting out the CY 2010 expenditure and rebate percentages based upon client

income level, OA determined that the 0-100 percent FPL (No SOC) group accounted for \$120.13 million in estimated FY 2012-13 reduced expenditures prior to ramp-up, which is 78.86 percent of the overall fiscal year estimate of \$152.32 million. Similarly, the 101 - 200 percent FPL (SOC) group accounted for an estimated \$32.20 million in savings prior to ramp up, or 21.14 percent of the total estimated FY savings.

Month	Predicted Monthly Expenditure Reductions		
	All LIHP-Eligible Client Expenditures	0-100% FPL (No SOC)	101-200% FPL (SOC)
JUL 2012	\$12,632,914	\$9,962,658	\$2,670,256
AUG	\$12,658,552	\$9,982,876	\$2,675,675
SEP	\$12,555,048	\$9,901,251	\$2,653,797
OCT	\$12,229,859	\$9,644,798	\$2,585,061
NOV	\$13,042,480	\$10,285,653	\$2,756,827
DEC	\$13,026,244	\$10,272,848	\$2,753,396
<b>Subtotal (1st half FY)</b>	<b>\$76,145,097</b>	<b>\$60,050,084</b>	<b>\$16,095,013</b>
JAN 2013	\$11,486,028	\$9,058,193	\$2,427,836
FEB	\$12,211,314	\$9,630,172	\$2,581,141
MAR	\$14,718,210	\$11,607,178	\$3,111,031
APR	\$12,911,762	\$10,182,565	\$2,729,197
MAY	\$11,790,688	\$9,298,455	\$2,492,232
JUN	\$13,059,228	\$10,298,861	\$2,760,367
<b>Subtotal (2nd half FY)</b>	<b>\$76,177,229</b>	<b>\$60,075,424</b>	<b>\$16,101,805</b>
<b>FY 2012-13 Totals</b>	<b>\$152,322,326</b>	<b>\$120,125,508</b>	<b>\$32,196,818</b>

**FY 2012-13 Rebate Reductions by FPL/SOC Group.** OA applied the same methodology given for expenditure reductions in Table 12 to rebate reductions, splitting the total predicted monthly rebate reductions for the first six months of FY 2012-13 between the 0-100 percent FPL (No SOC) and 101-200 percent FPL (SOC) groups, as shown in **Table 13** (page 18). The final six months of the fiscal year are not included, because of the six month delay in collecting rebate.

<b>TABLE 13: FY 2012-13 PREDICTED MONTHLY REBATE REDUCTIONS BY SOC GROUP (PRIOR TO RAMP-UP)</b>			
<b>Month</b>	<b>Predicted Monthly Rebate Reductions</b>		
	<b>All LIHP-Eligible Client Rebate</b>	<b>0-100% FPL (No SOC)</b>	<b>101-200% FPL (SOC)</b>
JUL 2012	-\$4,692,518	-\$3,646,013	-\$1,046,504
AUG	-\$4,702,041	-\$3,653,413	-\$1,048,628
SEP	-\$4,663,594	-\$3,623,540	-\$1,040,054
OCT	-\$4,542,802	-\$3,529,687	-\$1,013,115
NOV	-\$4,844,652	-\$3,764,219	-\$1,080,433
DEC	-\$4,838,621	-\$3,759,533	-\$1,079,088
<b>Totals</b>	<b>-\$28,284,228</b>	<b>-\$21,976,405</b>	<b>-\$6,307,822</b>

Thus, for the first six months of FY 2012-13, OA estimated that ADAP would incur an estimated \$28.28 million in rebate reductions, \$21.98 million (or 77.70 percent) in the 0-100 percent FPL (No SOC) group, and \$6.31 million (22.30 percent) in the FY 101 -200 percent FPL (SOC) group (the rebate percentages are slightly different from the expenditure percentages due to rounding).

### **Step 2b, FY 2012-13 Ramp-up, Client Income up to 100 percent FPL, No SOC Impact**

#### **Expenditure Reduction Ramp-Up.**

Because the 0-100 percent FPL (No SOC) clients are not affected by the implementation of a SOC, OA continued the ramp-up methodology started in FY 2011-12 (Step 2a). Per **Table 14** (page 19), the July 2012 estimated expenditure reduction of \$5.81 million was calculated by multiplying the predicted monthly expenditure reduction of \$9.96 million for July 2012 (see Table 12) by seven-twelfths (recall that in Step 2a above, the June 2012 ramped-up expenditure reduction was derived by taking six-twelfths of the predicted expenditure reduction). Continuing the FY 2011-12 ramp-up methodology in this manner resulted in estimated reduced expenditures \$47,631,434 for the first six months of FY 2012-13. See the first half of Table 14.

Month	Predicted Monthly Expenditure Reduction	Ramp-Up Multiplier	Ramp-Up of Expenditure Reduction
JUL 2012	\$9,962,658	7/12	\$5,811,550
AUG	\$9,982,876	8/12	\$6,655,251
SEP	\$9,901,251	9/12	\$7,425,938
OCT	\$9,644,798	10/12	\$8,037,332
NOV	\$10,285,653	11/12	\$9,428,515
DEC	\$10,272,848	12/12	\$10,272,848
<b>Subtotal (1st half FY)</b>	<b>\$60,050,084</b>		<b>\$47,631,434</b>
JAN 2013	\$9,058,193	12/12	\$9,058,193
FEB	\$9,630,172	12/12	\$9,630,172
MAR	\$11,607,178	12/12	\$11,607,178
APR	\$10,182,565	12/12	\$10,182,565
MAY	\$9,298,455	12/12	\$9,298,455
JUN	\$10,298,861	12/12	\$10,298,861
<b>Subtotal (2nd half FY)</b>	<b>\$60,075,424</b>		<b>\$60,075,424</b>
<b>Grand Total (full FY)</b>	<b>\$120,125,508</b>		<b>\$107,706,859</b>

As of January 2013, the ramp-up for clients with an FPL of less than 100 percent would be complete. Therefore, ADAP would realize full reduced expenditures for these clients for the final six months of FY 2012-13 (January through June 2013), or \$60,075,424 (see Table 14). Thus, estimated reduced expenditures for FY 2012-13 for clients with an FPL of less than 100 percent totals \$107,706,859 (sum of \$47,631,434 for continuing ramp-up in the first half of FY 2012-13 plus \$60,075,424 for the second half of FY 2012-13).

**Rebate Reduction Ramp-Up.** Once again applying the same ramp-up methodology to rebate revenue led to total reduced rebate revenue of \$17,431,578 for clients with an FPL of less than 100 percent. See **Table 15** below.

Month	Predicted Monthly Rebate Reduction	Ramp-up Multiplier	Ramp-Up of Rebate
JUL 2012	-\$3,646,013	7/12	-\$2,126,841
AUG	-\$3,653,413	8/12	-\$2,435,608
SEP	-\$3,623,540	9/12	-\$2,717,655
OCT	-\$3,529,687	10/12	-\$2,941,406
NOV	-\$3,764,219	11/12	-\$3,450,534
DEC	-\$3,759,533	12/12	-\$3,759,533
<b>Total</b>	<b>-21,976,405</b>		<b>-17,431,578</b>

**Step 2c, FY 2012-13 Impacts, Client Income 101 – 200 percent FPL, SOC Impact**

**Expenditure Reduction Impact.** Finally, the LIHP impact of those clients with an FPL of between 101 percent and 200 percent was calculated. Because the proposed SOC for these clients will start on July 1, 2012, OA assumed that these clients would shift to LIHP as quickly as possible in order to avoid the potentially significant costs they would have to pay if they waited until their recertification date. Therefore, OA assumed that prior to July 2012, all of these affected clients would shift to LIHP, which means that there is no ramp-up for these clients in FY 2012-13. Instead, ADAP would realize full expenditure and rebate reductions starting with July 2012.

**Table 16** below gives the derivation of the estimated expenditure reduction of \$32.20 million for these clients (see Table 12). Because there is no ramp-up, the estimates in the two columns are identical.

<b>TABLE 16: EXPENDITURE REDUCTIONS FY 2012-13 (Client Income 101-200% FPL)</b>		
<b>Month</b>	<b>Predicted Monthly Expenditure Reduction</b>	<b>Expenditure Reduction</b>
JUL 2012	\$2,670,256	\$2,670,256
AUG	\$2,675,675	\$2,675,675
SEP	\$2,653,797	\$2,653,797
OCT	\$2,585,061	\$2,585,061
NOV	\$2,756,827	\$2,756,827
DEC	\$2,753,396	\$2,753,396
<b>Subtotal (1st half FY)</b>	<b>\$16,095,013</b>	<b>\$16,095,013</b>
JAN 2013	\$2,427,836	\$2,427,836
FEB	\$2,581,141	\$2,581,141
MAR	\$3,111,031	\$3,111,031
APR	\$2,729,197	\$2,729,197
MAY	\$2,492,232	\$2,492,232
JUN	\$2,760,367	\$2,760,367
<b>Subtotal (2nd half FY)</b>	<b>\$16,101,805</b>	<b>\$16,101,805</b>
<b>Grand Total (full FY)</b>	<b>\$32,196,818</b>	<b>\$32,196,818</b>

**Rebate Reduction Ramp-Up.** Further, as with expenditures, there is no ramp-up for rebate reduction for these clients. **Table 17** (page 21) gives the estimated rebate reduction for these clients. Because of the six month delay in collecting rebate, ADAP does not realize rebate reduction associated with expenditures for the last six months of FY 2012-13 (January through June 2013).

<b>Month</b>	<b>Predicted Monthly Rebate</b>	<b>Monthly Rebate</b>
JUL 2012	-\$1,046,504	-\$1,046,504
AUG	-\$1,048,628	-\$1,048,628
SEP	-\$1,040,054	-\$1,040,054
OCT	-\$1,013,115	-\$1,013,115
NOV	-\$1,080,433	-\$1,080,433
DEC	-\$1,079,088	-\$1,079,088
<b>Total</b>	<b>-6,307,822</b>	<b>-6,307,822</b>

### **FY 2012-13 Combined Expenditure and Rebate Reduction Impacts**

Combining the expenditure reductions for both FPL client groups given in Tables 14 and 16 (Steps 2b and 2c) results in a total FY 2012-13 expenditure reduction due to LIHP of \$139.90 million, as shown in **Table 18** below.

<b>Month</b>	<b>Predicted Monthly Expenditure Reduction</b>	<b>Ramp-Up of Expenditure Reduction</b>
JUL 2012	\$12,632,914	\$8,481,807
AUG	\$12,658,552	\$9,330,926
SEP	\$12,555,048	\$10,079,736
OCT	\$12,229,859	\$10,622,393
NOV	\$13,042,480	\$12,185,342
DEC	\$13,026,244	\$13,026,244
<b>Subtotal (1st half FY)</b>	<b>\$76,145,097</b>	<b>\$63,726,448</b>
JAN 2013	\$11,486,028	\$11,486,028
FEB	\$12,211,314	\$12,211,314
MAR	\$14,718,210	\$14,718,210
APR	\$12,911,762	\$12,911,762
MAY	\$11,790,688	\$11,790,688
JUN	\$13,059,228	\$13,059,228
<b>Subtotal (2nd half FY)</b>	<b>\$76,177,229</b>	<b>\$76,177,229</b>
<b>Grand Total (full FY)</b>	<b>\$152,322,326</b>	<b>\$139,903,677</b>

Similarly, combining the rebate reduction amounts in Tables 15 and 17 results in an estimated \$23.74 million in rebate reduction due to LIHP for the period July through December 2012, as shown in **Table 19** (page 22).

Month	Predicted Monthly Rebate Reduction	Ramp-Up of Rebate Reduction
JUL 2012	-\$4,692,518	-\$3,173,346
AUG	-\$4,702,041	-\$3,484,237
SEP	-\$4,663,594	-\$3,757,709
OCT	-\$4,542,802	-\$3,954,521
NOV	-\$4,844,652	-\$4,530,967
DEC	-\$4,838,621	-\$4,838,621
<b>Total</b>	<b>-28,284,228</b>	<b>-23,739,400</b>

As already noted, there is a six month delay in collecting rebate on expenditures, which means that ADAP will realize no reduction in rebate in FY 2011-12. However, for FY 2012-13, ADAP will realize the rebate reductions from the final six months of FY 2011-12 (as shown in Table 10, \$7.39 million), and the combined rebate reduction of all clients from the first six months of FY 2012-13 (as shown in Table 19, \$23.74 million). Combining these amounts results in a rebate reduction of \$31.13 million (see **Table 20**, below).

Month/Yr Incurred	Rebate Reduction	Month/Yr Applied
JAN 2012	-\$315,649	JUL 2012
FEB	-\$671,162	AUG
MAR	-\$1,213,420	SEP
APR	-\$1,419,320	OCT
MAY	-\$1,620,108	NOV
JUN	-\$2,153,296	DEC
JUL	-\$3,173,346	JAN 2013
AUG	-\$3,484,237	FEB
SEP	-\$3,757,709	MAR
OCT	-\$3,954,521	APR
NOV	-\$4,530,967	MAY
DEC	-\$4,838,621	JUN
<b>Subtotal</b>	<b>-\$31,132,356</b>	
6.25% Adj.	-\$1,945,772	
<b>Total</b>	<b>-\$33,078,128</b>	

In calculating the rebate loss of \$31.13 million, OA applied the rebate rate for FY 2009-10 to determine the CY 2010 rebate percentages. While the renegotiated supplemental rebate rate (see **Continuing Assumption 1**) was not fully in effect for all of CY 2010, it will be fully in effect for FYs 2011-12 and 2012-13. To account for the additional LIHP-associated rebate revenue lost due to the renegotiated

supplemental rebate rate, OA estimated that without LIHP in place, ADAP would have received an additional 6.25 percent in rebate revenue during FYs 2011-12 and 2012-13. Therefore, OA increased the \$31.13 million reduction by 6.25 percent to arrive at a final reduced rebate revenue reduction estimate of \$33,078,128.

For FY 2012-13, OA estimated that ADAP would realize a net savings of \$106,825,549, representing reduced expenditures of 139,903,677 less reduced rebate revenue of \$33,078,128 (see **Table 21**, below).

Final Adjusted Impact Estimates

**Table 21** shows the final estimated impacts of LIHP on ADAP for both FYs 2011-12 and 2012-13. This includes an estimated 4,800 clients shifting from ADAP into LIHP during the final 6 months of FY 2011-12, with an additional 5,272 clients shifting in FY 2012-13.

<b>TABLE 21: FINAL ADJUSTED LIHP IMPACTS</b>		
<b>Impact Estimates</b>	<b>FY 2011-12</b>	<b>FY 2012-13</b>
Client Shift	4,800	5,272
Reduced Expenditures	\$19,902,871	\$139,903,677
Reduced Rebate Revenue	\$0	-\$33,078,128
<b>Net Savings</b>	<b>\$19,902,871</b>	<b>\$106,825,549</b>

Table 7 on page 11 gives estimated unadjusted net savings of \$85.00 million for FY 2011-12 and \$95.74 million for FY 2012-13. However, the final estimates for both FYs changed significantly due to the adjustments detailed above, including: 1) the initial roll-out of LIHP half-way into FY 2011-12; 2) ramping up clients shifting to LIHP over the course of CY 2012; 3) adjusting the ramp-up due to the SOC implementation in July 2012; and 4) the six-month delay in accounting for rebate loss. Because of these adjustments, the final net adjusted savings for FY 2011-12 is \$19.90 million, \$65.10 **less** than the initial unadjusted net savings estimate, and the final net savings of \$106.83 million for FY 2012-13 is \$11.08 million **more** for FY 2012-13.

No Adjustments Made

OA made no adjustments to the impact of LIHP on ADAP for the following areas:

- a) Income Qualification. LIHP bases eligibility upon the FPL percent of family income. However, ADAP currently only collects gross income data, which represents the gross income of the individual ADAP client, and does not collect family income or size. A client whom this analysis considers to be eligible for LIHP based upon reported gross income (assuming gross income is individual income for a single person family) may in fact not meet the LIHP household income eligibility requirements if they have a higher family income. Likewise, other clients whom this analysis considers to be ineligible for LIHP based on individual gross income but

who have many dependents might actually be eligible for LIHP. At this time OA does not have sufficient ADAP data to determine: 1) whether or not this income qualification disparity will have a measurable impact on ADAP savings; and 2) how to adjust for any disparities that do exist.

- b) Enrollment Caps. At this time, none of the Legacy counties have actually enacted enrollment caps. Several counties have indicated that they will wait and determine how LIHP costs play out before considering implementing caps.

When OA receives new information necessitating adjustments to any of the above, OA will make the adjustments in the *2012-13 May Revision*.

### **NMA 5. Institution of a New Client Cost-Sharing Policy**

ADAP currently requires clients with income above 400 percent FPL (up to \$50,000) to pay a monthly SOC. The current ADAP SOC is based on two times the individual's annual state income tax liability less costs for health insurance premiums. In order to generate savings in the FY 2012-13, OA will institute a new client-cost sharing policy based on maximum charges allowed by the federal 2009 Ryan White Treatment Extension Act Legislation. This policy would be implemented July 1, 2012.

Instituting a client cost-sharing monthly payment obligation for each month of ADAP participation is estimated to generate revenue of **\$16.47 million** in FY 2012-13, expenditure savings of **\$790,770** along with a corresponding rebate loss of **\$779,987** from clients who leave ADAP, and less **\$2.00 million** in administrative costs, resulting in an estimated net savings of **\$14.49 million**.

The cost-sharing obligation for ADAP-only, Medi-Cal SOC and Medicare Part D clients will be 5 percent, 7 percent and 10 percent for individuals with incomes between 101–200 percent, 201–300 percent and greater than 300 percent of FPL, respectively. For Medicare clients, the cost-sharing obligation will exclude clients reaching catastrophic coverage, those dually enrolled in Medicare and Medi-Cal (or "Medi-Medi" clients) with no Medi-Cal SOC, and all others who qualify for full-subsidy Medicare. These clients have low prescription co-pays (\$6.30 or less in FY 2010-11) and, if an ADAP SOC were imposed, these clients would likely leave the program rather than pay more than these low co-pay amounts. Medi-Medi clients with no Medi-Cal SOC and others who qualify for Medicare full-subsidy have low FPLs that would also exclude them from paying an ADAP SOC. For private insurance clients for whom ADAP pays only prescription out-of-pocket costs (yet receives rebate on the full cost), the cost-sharing maximum was adjusted to ensure that, on average, it does not exceed the financial assistance provided by ADAP, thus encouraging the retention of these clients in ADAP. For these private insurance clients, the cost-sharing obligation will be 2 percent for all applicable FPLs. This percentage (2 percent) was derived by examining various SOC percent options and selecting the option that maximized savings for ADAP. These savings were maximized by finding the SOC percentage that generated the highest SOC net revenue from the private insurance clients remaining in ADAP while minimizing the

number of clients leaving ADAP (due to out-of-pocket prescription costs being lower than their SOC amount). **Table 22**, below summarizes the fiscal projections of ADAP's cost-sharing policy.

The methodology has accounted for clients who drop out of ADAP because their monthly ADAP SOC would exceed the primary payer's monthly out-of-pocket medication costs, but does NOT account for clients who drop out of ADAP because they simply cannot afford to pay their ADAP SOC and thus stop taking their HIV medications. There is no accurate way to estimate the latter, which would have significant personal and public health consequences. Taking effective HIV medication prevents transmission of HIV as well as preventing morbidity and mortality from HIV.

This assumption assumes that the institution of a new client cost-sharing policy starting July 1, 2012 will speed up the transition of ADAP clients into LIHP, since clients who will have an ADAP SOC will be more motivated to leave ADAP and enter LIHP to avoid paying the ADAP SOC. If the cost-sharing policy is not implemented, then NMA 4 (movement of ADAP clients into LIHP) will need to be revised.

LINE ITEM	ADAP	MEDI-CAL	PRIVATE INSURANCE	MEDICARE	TOTAL
<b>Collection Rate</b>	<b>5 / 7 / 10%</b>	<b>5 / 7 / 10%</b>	<b>2%</b>	<b>5 / 7 / 10%</b>	<b>n/a</b>
Revenue	\$11,667,464	\$202,486	\$2,453,113	\$2,151,901	\$16,474,964
Expend. Savings	\$50,209	\$23,030	\$472,668	\$244,863	\$790,770
Rebate Loss	-\$7,782	\$0	-\$586,108	-\$186,096	-\$779,987
Admin	-\$1,389,180	-\$18,638	-\$416,992	-\$175,361	-\$2,000,171
<b>TOTAL NET</b>	<b>\$10,320,710</b>	<b>\$206,878</b>	<b>\$1,922,681</b>	<b>\$2,035,307</b>	<b>\$14,485,577</b>

### Estimate Methodology

Using FY 2010-11 data, the assumption applies the cost-sharing policy to the adjusted number of clients by coverage group in FY 2012-13 (see Table 36, page 50), which takes into consideration ADAP clients leaving for LIHP (**NMA 4**), ADAP clients enrolling in OA-PCIP (**RMA 1-3**) and OA-HIPP clients enrolling in ADAP (**RMA 4**). To determine which clients will leave ADAP because their SOC would exceed their out-of-pocket drug expenditures, for each coverage group and FPL range, we computed annual net drug expenditures and divided it by access months for an average monthly expenditure for ADAP drugs. This number was compared against the monthly charge from the cost-sharing policy (client's gross income X percent SOC charge based on FPL divided by 12). If the client's monthly drug expenditures were greater than the monthly SOC charge, the client was assumed to stay in ADAP and pay the SOC. If the client's monthly drug expenditures were less than the monthly SOC charge, the client was assumed to leave ADAP since it would be less expensive to pay for one's own drugs. For each client leaving ADAP, there will be expenditure savings offset by a loss in rebate. Expenditure savings were

projected for FY 2012-13, and rebate was adjusted for the six-month delay in collections.

### **ADAP-Only Clients**

In FY 2010-11, 100 percent ADAP (or "ADAP-only") clients represented 60.63 percent of total clients and 90.80 percent of total drug expenditures. The adjusted average annual expenditure per ADAP-only client was \$16,706 after removing clients whom would leave ADAP. For FY 2012-13, the net savings for this ADAP-only client group is estimated to be **\$10,320,710**.

The following describes how each line item estimate (revenue, expenditure savings, rebate loss, administrative fees and net savings) was calculated for ADAP-only clients in Table 23A, page 27:

- Average Income – Based on FY 2010-11, the average gross income was computed for clients within each FPL.
- Clients – The percentage of ADAP-only clients in CY 2010 by FPL after adjusting for those leaving for LIHP (NMA 4) was applied to total number of ADAP-only clients who would remain in ADAP and pay the monthly SOC charge.
- Maximum Charge – Per Ryan White legislation, the maximum charge was based on clients' average income multiplied by a percentage for each eligible FPL. For example, the maximum charge for those with income greater than 400 percent FPL was \$46,504 multiplied by 10 percent, or \$4,650.
- Charge per Month – The monthly SOC was the maximum charge divided by 12 months. For clients with the highest FPL, \$4,650 divided by 12 months = SOC of \$388 per month.
- Access Months – Based on FY 2010-11, the average access months (or number of months clients received prescriptions) was computed for each FPL.
- Annual Charge – The maximum SOC amount clients would pay per year was computed by taking the charge per month and multiplying it by access months. For clients with income greater than 400 percent FPL, \$388 multiplied by 7.94 months = \$3,077.
- Total Revenue – For each FPL, total revenue was computed by multiplying the number of clients by the annual charge. For clients with the highest FPL, 127 clients multiplied by \$3,077 = \$390,663. This revenue was added together with the revenue for all other eligible FPLs for total SOC revenue for ADAP-only clients.
- Expenditure Savings – Expenditures for clients who would leave ADAP (because their FY 2010/11 average monthly drug expenditures were less than the monthly SOC charge) were considered to be savings.
- Rebate Loss – Expenditure savings for clients leaving ADAP were offset by rebate loss of 31 percent and adjusted for the six-month delay in receiving rebate. For ADAP-only clients leaving, \$50,209 multiplied by 31 percent divided by two = \$7,782.

FPL	AVG INCOME	CLIENTS	MAXIMUM CHARGE			CHARGE / MONTH	ACCESS MONTHS	ANNUAL CHARGE	TOTAL REVENUE
			5%	7%	10%				
100% or less	\$2,887	10,221					8.02	\$0	\$0.00
101% - 200%	\$15,868	5,810	\$793			\$66	8.74	\$578	\$3,356,530
201% - 300%	\$25,967	3,653		\$1,818		\$151	8.49	\$1,286	\$4,697,112
301% - 400%	\$37,423	1,224			\$3,742	\$312	8.45	\$2,634	\$3,223,159
>400%	\$46,504	127			\$4,650	\$388	7.94	\$3,077	\$390,663
Unknown	n/a	0					5.31	n/a	
<b>AVG OR TOTAL</b>	<b>\$10,238</b>	<b>21,035</b>					<b>8.26</b>	<b>REVENUE</b>	<b>\$11,667,464</b>
								<b>EXPEND</b>	<b>\$50,209</b>
								<b>REBATE</b>	<b>-\$7,782</b>
								<b>ADMIN</b>	<b>-\$1,389,180</b>
								<b>NET</b>	<b>\$10,320,710</b>

The same general approach described above was used to determine the line item estimates for each subsequent coverage group.

### Medi-Cal Clients

In FY 2010-11, Medi-Cal clients served in ADAP represented 1.18 percent of total clients and 0.54 percent of total drug expenditures. The adjusted average annual expenditure per Medi-Cal client in ADAP was \$4,123. For FY 2012-13, the net savings for this client group is estimated to be **\$206,878**.

FPL	AVG INCOME	CLIENTS	MAXIMUM CHARGE			CHARGE / MONTH	ACCESS MONTHS	ANNUAL CHARGE	TOTAL REVENUE
			5%	7%	10%				
100% or less	\$2,971	116					4.39	\$0	\$0.00
101% - 200%	\$16,732	232	\$837			\$70	4.99	\$348	\$80,618
201% - 300%	\$25,496	94		\$1,785		\$149	5.29	\$787	\$74,259
301% - 400%	\$37,050	26			\$3,705	\$309	5.63	\$1,737	\$45,193
>400%	\$44,577	2			\$4,458	\$371	4.00	\$1,486	\$2,417
Unknown	n/a	5					2.17	n/a	
<b>AVG OR TOTAL</b>	<b>\$16,308</b>	<b>475</b>					<b>4.91</b>	<b>REVENUE</b>	<b>\$202,486</b>
								<b>EXPEND</b>	<b>\$23,030</b>
								<b>REBATE</b>	<b>\$0</b>
								<b>ADMIN</b>	<b>-\$18,638</b>
								<b>NET</b>	<b>\$206,878</b>

### Private Insurance Clients

In FY 2010-11, individuals with private insurance represented 15.48 percent of total clients, 3.83 percent of total expenditures and, in FY 2009-10, generated approximately 21.20 percent of total rebate revenue. (FY 2010-11 rebate data is unavailable because of the six-month billing delay.) The adjusted average annual expenditures per private insurance client in ADAP was \$4,862. ADAP services for clients with private insurance are currently cost effective because ADAP is able to collect full rebate on all partial payment prescriptions. Implementing the federal SOC maximum amounts for this client group would create a disincentive for many clients to continue ADAP participation. This disincentive would result in a loss of the

corresponding rebate because many clients would have an ADAP cost-sharing obligation that exceeds their private insurance out-of-pocket cost for their prescriptions and thus would choose to no longer participate in ADAP. We examined a variety of cost-sharing percentages up to the HRSA maximum for private insurance clients and found that a cost-sharing percentage of 2 percent across all FPLs >101 percent maximized savings for ADAP. For FY 2012-13, the net savings for this client group is estimated to be **\$1,922,681**.

FPL	AVG INCOME	CLIENTS	MAXIMUM CHARGE			CHARGE / MONTH	ACCESS MONTHS	ANNUAL CHARGE	TOTAL REVENUE
			2%	2%	2%				
100% or less	\$3,582	447					7.04	\$0	\$0.00
101% - 200%	\$16,857	1,496	\$337			\$28	7.75	\$218	\$325,632
201% - 300%	\$26,730	2,380		\$535		\$45	8.14	\$363	\$863,404
301% - 400%	\$37,630	1,948			\$753	\$63	8.68	\$544	\$1,060,749
>400%	\$46,462	324			\$929	\$77	8.11	\$628	\$203,329
Unknown	n/a	0					6.16	n/a	
<b>AVG OR TOTAL</b>	<b>\$22,141</b>	<b>6,595</b>					<b>7.90</b>	<b>REVENUE</b>	<b>\$2,453,113</b>
								<b>EXPEND</b>	<b>\$472,668</b>
								<b>REBATE</b>	<b>-\$586,108</b>
								<b>ADMIN</b>	<b>-\$416,992</b>
								<b>NET</b>	<b>\$1,922,681</b>

### Medicare Part D Clients

In FY 2010-11, individuals with Medicare Part D represented 22.71 percent of the total clients, 4.83 percent of total expenditures and in FY 2009-10, generated 21.77 percent of total rebate revenue. The adjusted average annual ADAP expenditures for clients qualifying for an ADAP SOC were \$2,644. However, that expenditure will be reduced, because ADAP began counting towards TrOOP effective January 1, 2011 for half-year savings. As mentioned earlier, clients in catastrophic coverage, Medi-Medi clients with no Medi-Cal SOC and Medicare full subsidy would be exempt from the cost-sharing obligation because implementing the federal maximum amounts for cost-sharing for this client group would create a disincentive for clients to continue ADAP participation and result in a loss of the corresponding rebate. These clients have low co-pays, compared to standard benefit and donut-hole clients, and will no longer choose to participate in ADAP. For FY 2012-13, the net savings for this client group is estimated to be **\$2,035,307**.

FPL	AVG INCOME	CLIENTS	MAXIMUM CHARGE			CHARGE / MONTH	ACCESS MONTHS	ANNUAL CHARGE	TOTAL REVENUE
			5%	7%	10%				
100% or less	\$5,297	530					3.88	\$0	\$0.00
101% - 200%	\$17,265	2,198	\$863			\$72	5.07	\$364	\$801,076
201% - 300%	\$25,643	921		\$1,795		\$150	5.33	\$797	\$734,163
301% - 400%	\$37,416	311			\$3,742	\$312	5.52	\$1,721	\$535,359
>400%	\$46,239	46			\$4,624	\$385	4.59	\$1,767	\$81,303
Unknown	n/a	47					4.76	n/a	
<b>AVG OR TOTAL</b>	<b>\$19,505</b>	<b>4,053</b>					<b>4.78</b>	<b>REVENUE</b>	<b>\$2,151,901</b>
								<b>EXPEND</b>	<b>\$244,863</b>
								<b>REBATE</b>	<b>-\$186,096</b>
								<b>ADMIN</b>	<b>-\$175,361</b>
								<b>NET</b>	<b>\$2,035,307</b>

### Operational and Administrative Costs

Impacted clients will be required to pay a SOC for each month that they participate in ADAP. CDPH/OA estimates that it will cost approximately **\$8** to process each monthly SOC payment.

Note that the HRSA Ryan White maximum cost-sharing allowed is outlined below.

- Income equal to or less than 100 percent of Federal Poverty Level (FPL) – The individual would not be charged for medications;
- Income of 101-200 percent FPL – The individual would have a share of cost equivalent to 5 percent of their gross income;
- Income of 201-300 percent FPL – The individual would have a share of cost equivalent to 7 percent of their gross income; and
- Income greater than 300 percent FPL – The individual would have a share of cost equivalent to 10 percent of their gross income.

This assumption requires Trailer Bill Language to amend the Health and Safety Code Section 120960 (c) and (e) and delete Section 120965 to address cost-sharing obligation levels.

### Interaction between NMA 4 AND NMA 5

If this SOC assumption is not approved, then the accelerated movement of eligible clients into LIHP is not expected to occur. The FY 2012-13 LIHP savings estimated in NMA 4 would be reduced from \$106,825,549 to \$104,883,040, a decrease of \$1,942,509.

### NMA 6. Federal Funding Issue #1: Additional 2011 RW Federal Grant Funds

Due to the federal budget continuing resolution issue, HRSA provided partial 2011 grant awards in March 2011 and updated award notices were to be provided at a later date. Thus in the *2011-12 May Revision* estimate, OA anticipated flat federal ADAP Earmark funding of \$97.6 million for FY 2011-12. On August 29, 2011, ADAP

received the updated award with an increase in ADAP Earmark funding of \$4,940,484 for a total of \$102,572,484.

In January 2011, OA applied for two one-time increases in federal funds: a 2011 RW ADAP Supplemental grant and a 2011 RW Part B Supplemental grant for expenditures in FY 2011-12. These grants were for states with a waiting list in 2011 as well as those states that anticipated instituting a waiting list, cost-saving strategies, or other program restrictions on ADAP. On August 29, 2011, OA received the RW ADAP Supplemental grant award for \$8,028,154 (\$2,423,137 requested). OA received the RW Part B Supplemental grant award on September 19, 2011 for \$1,376,784 (\$2,659,865 requested).

On July 8, 2011, HRSA released the Emergency Relief Funding opportunity announcement to states/territories to help improve access to life-saving medications through ADAP. Since California ADAP received 2010 ADAP emergency relief funds, OA qualified for funding and requested \$3 million, the maximum allowed. On September 26, 2011, OA received the Notice of Grant award for \$2,574,357.

On November 29, 2011, HRSA approved CDPH's carry-over request for \$4,245,500 of unspent funds from the 2010 RW Part B Grant for expenditures in ADAP during the 2011 RW grant period. The three one-time awards and carry-over total \$16,224,795. The FY 2011-12 Enacted Budget includes \$3 million additional federal funding authority in anticipation of the one-time awards.

OA submitted a Section 28 Letter requesting approval for current year budget augmentation and expenditure authority in the amount of \$18,165,279, including the permanent increase, the three one-time awards and carry-over, less \$3 million existing authority. *The November 2011 Estimate* (FY 2012-13) assumes the increase in federal funds will be spent in the current year.

#### **NMA 7. SF Funding Issue: \$1 million Additional SF Budget Authority**

Due to HRSA's requirement to conduct semi-annual ADAP client re-certifications, OA will be requiring local enrollment sites to increase their client re-certifications from once to twice per year. Therefore, OA requests an additional \$1 million SF Budget Authority for FY 2012-13 and on-going to support these additional services. Since FY 1997-98, \$1 million has been provided annually to the local health jurisdictions (LHJs) to help offset the costs of ADAP enrollment and eligibility screening (which is conducted annually) for clients at each enrollment site located throughout the State. The local allocation is based on the number of ADAP clients enrolled during the prior CY. Funds may only be used for costs associated with the administration of ADAP enrollment.

#### **NMA 8. Miscellaneous Issue #1: Interest Earned Revised Down**

In the *2011-12 May Revision*, OA estimated interest income of \$300,000 for FY 2011-12. Actual interest earned for FY 2010-11 was \$140,426.45. Since interest rates have continued to decline due to the economic downturn, and there will be less

money in the SF to accumulate interest, the estimated interest income has been reduced for both FYs 2011-12 and 2012-13 to \$120,000 annually.

**NMA 9. Miscellaneous Issue #2: Elimination of \$132,623 for Tropism Assay Testing**

Effective July 1, 2011, ADAP no longer covers tropism assay testing for its clients. Instead, clients have access to tropism assay testing through the new, national Tropism Access Program (TAP), a service provided by ViiV Healthcare for ADAP clients. ViiV Healthcare is the drug manufacturer of maraviroc (Selzentry), the drug for which Trofile tropism assay testing is used to demonstrate viral susceptibility.

Through ViiV Healthcare, HIV/AIDS prescribers statewide have received TAP certificates that allow them to submit patient blood samples directly to Monogram Biosciences for testing without cost to ADAP. Unlike ADAP, which limited Trofile test access to only one per client, TAP does not limit the number of tests a physician can request for an ADAP client. ViiV Healthcare verification of a client's enrollment in ADAP will be based on information provided on the TAP certificate by the ADAP client and his/her physician.

The results of the Trofile assay will still be required for the approval of maraviroc use by ADAP clients.

**Revised Major Assumptions*****OA-PCIP Adjustments: Overall Estimate Methodology for RMAs 1–3***

To estimate the FYs 2011-12 and 2012-13 net costs, OA used the methodology as stated in the *2011-12 May Revision* (see Major Assumption #1). Expenditures and revenue were computed for two components:

- Component 1 (Majority impact): Voluntary co-enrollment of an estimated 10 percent of eligible ADAP-only clients into OA-PCIP; and
- Component 2 (Minor impact): Voluntary co-enrollment of any other HIV-infected PCIP clients who were not previously in ADAP into ADAP (to pay pharmaceutical deductibles and co-pays) and OA-PCIP.

However, since the *2011-12 May Revision*, there have been program modifications to OA-PCIP that now require four separate adjustments. Each of these adjustments are described in **RMA 1–3**: **1)** delay in OA-PCIP implementation; **2)** reduced PCIP premiums; and **3)** reduced OA-PCIP caseload and savings due to LIHP and RW payer of last resort statute.

**Summary of all OA-PCIP Adjustments:** To estimate the impact of the three new adjustments, the two components described above were evaluated separately. For Component 1, it was hypothetically assumed that the program was in place in FY 2010-11 and estimated the final net costs to OA by applying the estimated percentage of ADAP costs derived from FY 2010-11 data to the corresponding ADAP estimates for FY's 2011-12 and 2012-13. For Component 2, the final net cost to OA was estimated for FY's 2011-12 and FY 2012-13 since PCIP was not in place in FY 2010-11. When combining components 1 and 2, adjustments were made to incorporate the ramp-up time needed to implement the new OA-PCIP in FYs 2011-12 and 2012-13.

The following summary tables (**Table 24 and Table 25**, page 33) show the impact of the three PCIP adjustments on premiums, expenditures, rebate revenue, net costs/savings, and clients for FY 2011-12 (final net savings = **\$1,784,671**) and FY 2012-13 (final net savings = **\$4,572,055**). (Note that rounded figures are provided in the text with the non-rounded estimates shown in the tables.) “Unadjusted Estimate” (first unnumbered row of Table 24) refers to updating the premium and drug expenditures, rebate and net savings based on FY 2010-11 data (with no other adjustments). Then the changes to premiums, drug expenditures, rebate and total net cost/savings are shown for each OA-PCIP issue sequentially and adjusted for any prior issues. For example, as mentioned above, reductions to PCIP due to LIHP (RMA 3) takes into consideration the delay in implementation (**RMA 1**) and reduced premiums (**RMA 2**) in that particular order. The totals in the bottom row show the final premiums, drug expenditures, rebate and net savings after all three adjustments were made to the unadjusted estimate. However, FCS will only show the internal components of the table for premiums, drug expenditures and rebate revenue and none of the row or column totals.

Compared to the *2011-12 May Revision* net savings of \$5,735,157, we now estimate a net savings of **-\$1,784,671** (\$556,178 in premiums, \$2.85 million in reduced drug expenditures and \$508,382 in loss of rebate revenue), which equates to a reduction in

net savings of \$3,950,486 due to all three OA-PCIP issues. In the tables below, total estimate = premiums + drug expenditures – rebate revenue.

**TABLE 24: SUMMARY OF OA-PCIP CHANGES, FY 2011-12**

ISSUE	PREMIUMS	DRUG EXPEND	REBATE REVENUE	TOTAL NET	CLIENTS
Unadj. Estimate	\$2,576,642	-\$11,585,736	-\$2,057,055	-\$6,952,039	1,288
1. Delay*	-\$1,319,433	\$5,932,761	\$1,053,366	\$3,559,963	-429
2. Premiums	-\$201,343	\$0	\$0	-\$201,343	0
3. LIHP	-\$499,688	\$2,803,743	\$495,307	\$1,808,748	-431
<b>TOTAL</b>	<b>\$556,178</b>	<b>-\$2,849,231</b>	<b>-\$508,382</b>	<b>-\$1,784,671</b>	<b>428</b>

Negative (-) premiums, (-) drug expenditures and (-) total net = expenditure reduction or savings; and negative (-) revenue = rebate reduction.

\* Delay is due to the establishment of an interagency agreement with Managed Risk Medical Insurance Board (MRMIB) and therefore not able to achieve the start date or GF savings as described in the *2011-12 May Revision*.

For FY 2012-13, the net savings of **\$4,572,055** consists of \$1.85 million in premiums, \$9.96 million in reduced drug expenditures and \$3.53 million in loss of rebate revenue.

**TABLE 25: SUMMARY OF OA-PCIP CHANGES, FY 2012-13**

ISSUE	PREMIUMS	DRUG EXPEND	REBATE REVENUE	TOTAL NET	CLIENTS
Unadj. Estimate	\$6,091,743	-\$29,719,368	-\$10,462,800	-\$13,164,825	1,348
1. Delay*	-\$276,962	\$1,351,194	\$475,692	\$598,540	0
2. Premiums	-\$931,243	\$0	\$0	-\$931,243	0
3. LIHP	-\$3,031,601	\$18,409,559	\$6,452,486	\$8,925,473	-904
<b>TOTAL</b>	<b>\$1,851,938</b>	<b>-\$9,958,615</b>	<b>-\$3,534,622</b>	<b>-\$4,572,055</b>	<b>445</b>

Negative (-) premiums, (-) drug expenditures and (-) total net = expenditure reduction or savings; and negative (-) revenue = rebate reduction.

\* Delay is due to the establishment of an interagency agreement with MRMIB and therefore not able to achieve the start date or GF savings as described in the *2011-12 May Revision*.

**RMA 1.OA-PCIP Issue #1: Delayed OA-PCIP Implementation**

In the OA-PCIP, assumption included in the *2011-12 May Revision*, OA-PCIP was to be effective July 1, 2011. In order to allow for third-party payers, MRMIB had to amend their PCIP contract with CMS. On August 1, 2011, MRMIB received Federal approval for the contract amendment. MRMIB and OA finalized an interagency agreement to implement OA-PCIP in November 2011. Thus, OA was not able to achieve the start date or GF savings as described in the *2011-12 May Revision*. In this *2011-12 May Revision*, OA assumed a “5-28-33-33” percent ramp-up rate for OA-PCIP implementation with each number representing the estimated percentage of eligible clients enrolling in OA-PCIP per quarter. Thus, OA will push back the ramp-up rate to “0-5-28-33.” The remaining 33 percent will be captured in the FY 2012-13 estimate.

FY 2012-13 estimate will have three groups of clients with three different ramp-up rates:

- Group 1: The remaining 33 percent from FY 2011-12 will have a ramp-up rate of “100-0-0-0” with the remaining one-third of the clients starting in the first quarter of FY 2012-13.
- Group 2: The other 67 percent from FY 2011-12 will continue on July 1 and not have a ramp-up since they were already enrolled in the prior FY.
- Group 3: These will be new clients enrolling in FY 2012-13 with a ramp-up rate of “25-25-25-25,” or 8.33 percent per month. New clients were based on the difference between the estimated clients for FY’s 2011-12 and FY 2012-13, and the remaining clients were appropriately placed in Group 1 or 2.

**Estimate Methodology***Estimating FY 2011-12 Fiscal Impact – Prior to Adjusting for Ramp-Up*

Using the same methodology as in the *2011-12 May Revision* to estimate costs/savings in FY 2011-12, the expenditures for OA-PCIP premiums (\$5.82 million) and drug deductibles and co-pays (\$3.22 million) were added to the ADAP averted drug expenditure reductions (\$29.38 million) for a total expenditure reduction of \$20.34 million (**Table 26**, page 35). Combining this with the loss of \$9.11 million in ADAP revenue resulted in a total net savings of **\$11,233,829**, assuming all 1,288 clients were enrolled in ADAP and OA-PCIP on July 1, 2011.

**TABLE 26: SUMMARY OF OA-PCIP, FY 2011-12 ESTIMATE  
(Prior to Adjusting for Ramp-Up)**

LINE ITEM	CLIENTS	EXPENDITURES	REBATE REVENUE	TOTAL NET
Premiums	1,288	\$5,817,548	\$0	\$5,817,548
Drug Deductibles & Co-Pays	1,288	\$3,218,866	\$0	\$3,218,866
Averted Drug Expenditures	1,235	-\$29,377,164	-\$9,106,921	-\$20,270,243
<b>TOTAL</b>	<b>1,288</b>	<b>-\$20,340,750</b>	<b>-\$9,106,921</b>	<b>-\$11,233,829</b>

Negative (-) expenditures and (-) net = expenditure reduction or saving; and negative (-) revenue = rebate loss.

*Estimating FY 2012-13 Fiscal Impact – Prior to Adjusting for Ramp-Up*

FY 2012-13 cost-savings were computed in the same manner as described above. Total expenditure reductions were \$23.63 million (\$6.09 million for OA-PCIP premiums, \$3.37 million for drug deductibles and co-pays, and \$33.09 million in averted drug expenditures), see **Table 27** below. Subtracting \$10.26 million in lost revenue resulted in a total net savings of **\$13,369,741** for all 1,348 clients if they co-enrolled on (or before) July 1, 2012.

**TABLE 27: SUMMARY OF OA-PCIP, FY 2012-13 ESTIMATE  
(Prior to Adjusting for Ramp-Up)**

LINE ITEM	CLIENTS	EXPENDITURES	REBATE REVENUE	TOTAL NET
Premiums	1,348	\$6,091,743	\$0	\$6,091,743
Drug Deductibles & Co-Pays	1,348	\$3,370,579	\$0	\$3,370,579
Averted Drug Expenditures	1,295	-\$33,089,946	-\$10,257,883	-\$22,832,063
<b>TOTAL</b>	<b>1,348</b>	<b>-\$23,627,624</b>	<b>-\$10,257,883</b>	<b>-\$13,369,741</b>

Negative (-) expenditures and (-) net = expenditure reduction or saving; and negative (-) revenue = rebate loss.

*Estimating FY 2011-12 Fiscal Impact – Including Ramp-Up*

Adjusting for the “0-5-28-33” ramp-up rate, the final net savings in FY 2011-12 are estimated to be **\$3,392,076**, which consists of \$1.26 million in premium expenditures, \$695,617 in drug deductibles and co-pays and \$6.35 million in averted

drug expenditures for a total expenditure reduction of \$4.40 million coupled with a loss of \$1 million in rebate revenue. Since Table 24 (page 33) shows a summary of the changes, the difference between the total net from the unadjusted estimate and the delay is equal to the total net savings from **Table 28** (-\$6,952,039 – \$3,559,963 = **-\$3,392,076**). Premiums, drug expenditures and rebate revenue can be computed in the same manner.

<b>LINE ITEM</b>	<b>CLIENTS</b>	<b>EXPENDITURES</b>	<b>REBATE REVENUE</b>	<b>TOTAL NET</b>
Premiums	858	\$1,257,209	\$0	\$1,257,209
Drug Deductibles & Co-Pays	858	\$695,617	\$0	\$695,617
Averted Drug Expenditures	823	-\$6,348,592	-\$1,003,689	-\$5,344,903
<b>TOTAL</b>	<b>858</b>	<b>-\$4,395,766</b>	<b>-\$1,003,689</b>	<b>-\$3,392,076</b>

Negative (-) expenditures and (-) net = expenditure reduction; and negative (-) revenue = rebate loss.

*Estimating FY 2012-13 Fiscal Impact – Including Ramp-Up*

Adjusting for the three ramp-up rates for FY 2012-13, OA estimates **\$12,566,285**, which consists of \$5.81 million in premium expenditures, \$3.22 million in drug deductibles and co-pays and \$31.59 million in averted drug expenditures for a total expenditure reduction of \$22.55 million coupled with a loss of \$9.99 million in rebate revenue. From the summary of changes in Table 25 (page 33), -\$13,164,825 (net savings from the unadjusted estimate) – \$598,540 (decrease in savings from the delay) = **\$12,566,285** net savings displayed in **Table 29** (page 37).

<b>TABLE 29: AFTER DELAYED IMPLEMENTATION, FY 2012-13 ESTIMATE (Adjusted for Ramp-Up)</b>				
<b>LINE ITEM</b>	<b>CLIENTS</b>	<b>EXPENDITURES</b>	<b>REBATE REVENUE</b>	<b>NET</b>
Premiums	1,348	\$5,814,782	\$0	\$5,814,782
Drug Deductibles & Co-Pays	1,348	\$3,217,335	\$0	\$3,217,335
Averted Drug Expenditures	1,295	-\$31,585,509	-\$9,987,107	-\$21,598,402
<b>TOTAL</b>	<b>1,348</b>	<b>-\$22,553,509</b>	<b>-\$9,987,107</b>	<b>-\$12,566,285</b>
Negative (-) expenditures and (-) net = expenditure reduction; and negative (-) revenue = rebate loss.				

**RMA 2.OA-PCIP Issue #2: Reduced PCIP Premiums**

The federal government required the California PCIP to change premiums for subscribers in certain age categories. Thus, on March 16, 2011, MRMIB released reduced premiums for subscribers aged 15 through 18 and 60 and above. These new rates took effect on the May 1, 2011 billing cycle; further reductions for all age groups were effective October 1. The rates used in the *2011-12 May Revision* to calculate the average age-adjusted annual cost of PCIP premiums ranged from \$180 to \$1,003 with an average of \$377. The final reduced rates range from \$127 to \$652 with an average of \$317, a 16 percent reduction for the average premium.

**Estimate Methodology**

To estimate the OA-PCIP insurance premium costs, we multiplied the new average age-adjusted annual premium estimate (\$317 or \$60 less than the previous rate of \$377) by the estimated OA-PCIP FY 2011-12 client count (858 = 1,288 – 429 clients due to the delay in implementation; see Table 24, page 33), adjusted by the delay in implementation, to yield an estimated **\$201,343** reduction in premium expenditures. For FY 2012-13, OA estimates a savings of **\$931,243** in OA-PCIP premium expenditures for 1,348 clients (see Table 25, page 33).

**RMA 3.OA-PCIP/LIHP Issue: Reductions in OA-PCIP Caseload and Savings due to LIHP and RW Payer of Last Resort Provision**

This Assumption is a technical correction needed to remove savings previously counted as OA-PCIP savings which now are counted as LIHP savings in **NMA 4**. In the *2011-12 May Revision*, OA estimated 10 percent of PCIP eligible "ADAP-only" clients would transition to OA-PCIP. Some of these clients may be LIHP eligible and therefore must be screened and enrolled into LIHP since ADAP is the payer of last resort. In this assumption, OA assumed that no OA-PCIP/LIHP co-eligible clients would choose to voluntarily enroll in OA-PCIP instead of LIHP if they now had to pay

their own PCIP premiums (because RW is the payer of last resort). This assumption adjusts for the estimated number of OA-PCIP eligible clients enrolling in LIHP instead of OA-PCIP and their associated reduction in OA-PCIP savings.

Furthermore, if a system is developed where the out-of-pocket costs for non-pharmaceutical services are covered, then additional ADAP-only clients (more than the currently estimated 10 percent) are expected to enroll in OA-PCIP and thus increasing savings (**Future Fiscal Issue #1**, page 64).

### **Estimate Methodology**

Using FY 2010-11 data, we estimated that 10 percent of the 11,849 ADAP-only clients, whom were enrolled for at least six months and were legal U.S. residents (1,185 clients), would be eligible and voluntarily enroll in OA-PCIP. Our revised assumption starts with this group of eligible clients (1,185) and selects those with an FPL less than 200 percent (927 clients or 78.2 percent); these are the clients potentially eligible for LIHP as well as OA-PCIP. Based on LIHP-eligible ADAP clients who meet the actual ten Legacy county requirements, 89.2 percent (827 out of 927 clients) would enroll in LIHP instead of OA-PCIP. When applying both percentages to the unadjusted FY 2011-12 estimate, this results in less savings of **\$1,808,748** (\$499,688 reduction in premium expenditures, \$2,803,743 decrease in drug expenditure savings and \$495,307 decrease in rebate revenue loss) for 431 clients shifting to LIHP (see Table 24, page 33) and to our FY 2012-13 estimate, less savings of **\$8,925,473** (\$3,031,601 reduction in premium expenditures, \$18,409,559 decrease in drug expenditure savings and \$6,452,486 decrease in rebate revenue loss) for 904 clients (see Table 25, page 33).

### **RMA 4. OA-HIPP/LIHP Issue: Reductions in OA-HIPP Caseload and Savings due to LIHP and RW Payer of Last Resort Provision**

This Assumption is a technical correction needed to remove savings previously associated with new clients entering OA-HIPP who will now go into LIHP instead of OA-HIPP. In the *2011-12 May Revision*, OA estimated 1,638 individuals in FY 2011-12 would enroll in OA-HIPP due to OA-HIPP expansion. Some of these clients may be LIHP eligible and therefore must be screened and enrolled into LIHP since RW is the payer of last resort. This assumption estimates the savings to OA-HIPP due to clients enrolling in LIHP instead of OA-HIPP.

### **Methodology – LIHP Impact on OA-HIPP**

Using FY 2010-11 data to update the *2011-12 May Revision* estimate, 1,535 clients would enroll in OA-HIPP in FY 2011-12 and 1,610 clients would be enrolled in FY 2012-13 (1,535 from prior year plus 75 new clients). New clients in FY 2011-12 (1,535) and total clients in FY 2012-13 (1,610) due to OA-HIPP expansion were based on the percentage of actual FY 2010-11 clients (if expansion had been implemented that year) applied to client regression estimates in those years (the same method was used in the OA-PCIP analysis). LIHP eligibility was estimated by applying the percentage of ADAP clients with private insurance, documented status,

age and a FPL up to 200 percent (39.78 percent) and the percentage of ADAP clients eligible for LIHP that meet the actual ten Legacy county requirements (89.20 percent, same percent as in **RMA 3** for OA-PCIP). Thus, the number of OA-HIPP clients leaving for LIHP would be 545 in FY 2011-12 (1,535 X 39.78 percent X 89.20 percent) and 571 in FY 2012-13 (1,610 X 39.78 percent X 89.20 percent). The difference between the estimated clients for FYs 2011-12 (1,535) and 2012-13 (1,610) would be new clients (75) enrolling in FY 2012-13 with a ramp-up rate of 8.33 percent per month.

The estimated loss in savings would be **\$1,039,530** (\$1,247,653 reduction in premium expenditures, \$2,260,866 reduction in drug expenditure savings and \$26,318 loss in rebate revenue; see **Table 30**) in FY 2011-12 and **\$2,295,787** (\$2,317,129 reduction in premiums, \$4,507,966 reduction in drug expenditure savings and \$104,950 reduction in rebate revenue; see **Table 31**) in FY 2012-13.

**TABLE 30: SUMMARY OF OA-HIPP CHANGES, FY 2011-12**

ISSUE	PREMIUMS	DRUG EXPEND	REBATE REVENUE	TOTAL NET	CLIENTS
Unadj. Estimate	\$3,516,285	-\$6,383,046	\$74,171	-\$2,940,933	1,535
1. LIHP	-\$1,247,653	\$2,260,866	-\$26,318	\$1,039,530	-545
<b>TOTAL</b>	<b>\$2,268,632</b>	<b>-\$4,122,181</b>	<b>\$47,854</b>	<b>-\$1,901,403</b>	<b>990</b>

Negative (-) premiums, (-) drug expenditures and (-) total net = expenditure reduction or savings; and negative (-) revenue = rebate reduction.

**TABLE 31: SUMMARY OF OA-HIPP CHANGES, FY 2012-13**

ISSUE	PREMIUMS	DRUG EXPEND	REBATE REVENUE	TOTAL NET	CLIENTS
Unadj. Estimate	\$6,528,589	-\$12,985,203	\$212,944	-\$6,669,558	1,610
1. LIHP	-\$2,317,129	\$4,507,966	-\$104,950	\$2,295,787	-571
<b>TOTAL</b>	<b>\$4,211,460</b>	<b>-\$8,477,238</b>	<b>\$107,994</b>	<b>-\$4,373,772</b>	<b>1,039</b>

Negative (-) premiums, (-) drug expenditures and (-) total net = expenditure reduction or savings; and negative (-) revenue = rebate reduction.

**RMA 5. OA-HIPP/Medi-Cal GF Issue: Using GF to Pay OA-HIPP Premiums and ADAP Drug Deductibles and Co-Pays for Clients Co-Enrolled in Medi-Cal with a SOC**

For FY 2010-11, about 7 percent (15 out of 214) of OA-HIPP clients with private insurance had also been enrolled in Medi-Cal with a very high SOC. OA pays the private insurance costs but does not pay the Medi-Cal SOC for these clients. Without this assistance, OA-HIPP clients could likely not maintain their private insurance and would rely on ADAP to meet the Medi-Cal SOC and Medi-Cal to cover their medical expenses, resulting in greater overall costs to the state. Due to the payer of last resort provision, RW funds cannot be used to pay for OA-HIPP premiums and ADAP drug deductibles and co-pays for clients that are co-enrolled in Medi-Cal with a SOC. This assumption estimates the impact of using GF dollars to

pay OA-HIPP premiums and ADAP drug deductibles and co-pays for all clients that are enrolled in Medi-Cal with a SOC. However, this is not an additional expenditure. Rather it is a shift in funding source to GF.

HRSA has provided guidance that state funds are not subject to the payer of last resort provision and may be used for purposes the state chooses as long as match and Maintenance of Effort (MOE) grant requirements are met. Therefore, OA will use GF to pay OA-HIPP premiums, ADAP drug deductibles and co-pays for co-enrolled OA-HIPP and ADAP clients that are also enrolled in Medi-Cal with a SOC.

Although OA will incur reasonably small costs, there will be overall savings to the state. Current costs for clients that are enrolled in Medi-Cal with a SOC but use private insurance instead and are co-enrolled in ADAP and OA-HIPP are paid by various sources. The clients' private insurance covers their medical and most of their drug expenses, OA-HIPP pays their private insurance premiums and ADAP pays for drug deductibles and co-pays (in lieu of Medi-Cal drug SOC expenses). In contrast, potential costs would be incurred because without this insurance premium assistance, clients would likely lose their private insurance and instead rely on ADAP to pay for the full price of their HIV-related drugs up to the SOC amount. Once SOC is met, Medi-Cal covers the client's HIV-related drugs and medical expenses. However, if the ADAP drug expenditures do not exceed the client's monthly SOC, then the client needs to pay the remainder of the SOC before Medi-Cal will pay for any medical services. For clients with a large SOC, this could potentially prevent clients from obtaining needed medical services. Therefore, while this assumption will cost OA a relatively small amount in insurance premiums, overall it allows the client's private health insurance to continue to cover medical costs (before relying on Medi-Cal), allows ADAP to pay drug deductibles and co-pays instead of the full cost of the drugs (up to the SOC), and helps to ensure that the client stays in care (by not having to pay the sometimes very high Medi-Cal SOC and thus deferring treatment).

### **Estimate Methodology**

The cost estimate related to the proposal to use GF dollars to pay premiums and drug deductibles and co-pays for ADAP/OA-HIPP clients who are enrolled in Medi-Cal with a SOC is based on existing OA-HIPP, ADAP and Medi-Cal with a SOC data in FY 2010-11 and projected for FYs 2011-12 and 2012-13. Current costs (premiums, co-pays and deductibles for an OA-HIPP client in ADAP with a Medi-Cal SOC) were then compared with potential costs (SOC for an ADAP client with a Medi-Cal SOC with no private insurance).

- **Current Costs:** For FY 2010-11 expenditures on 15 clients co-enrolled in OA-HIPP and ADAP with a Medi-Cal SOC, their annual premiums were summed (\$105,094) with the average drug co-pays and deductibles for an existing OA-HIPP client in ADAP ( $\$2,426 \times 15 = \$36,383$ ) resulting in total annual costs of \$141,477. No rebate is collected for these clients.
- **Potential Costs:** If these individuals were enrolled in ADAP with a Medi-Cal SOC, ADAP expenditures would have been the sum of their annual SOC amounts up to \$9,816 per individual (\$116,484). The \$9,816 annual limit is based on the average monthly drug expenditures for current ADAP clients with a

Medi-Cal SOC (\$818 per month). Five clients had an annual SOC under the \$9,816 limit for a total of \$18,324, and the remaining ten clients exceeded the limit for a total of \$98,160. No OA-HIPP premiums would be paid, and no rebate revenue would be collected.

### *Estimating FYs 2011-12 and 2012-13 Impacts*

In sum, by paying OA-HIPP private insurance premiums for the 15 co-enrolled clients in both OA-HIPP and ADAP with a Medi-Cal SOC, it is currently costing OA \$24,993 (\$141,477 – \$116,484), or \$1,666 per client in FY 2010-11 (see **Table 32** below). However, these additional expenses for OA will reduce Medi-Cal costs, since many medical expenses will be covered by the client's private insurance instead of Medi-Cal.

<b>LINE ITEM</b>	<b>CLIENTS</b>	<b>CURRENT: OA-HIPP</b>	<b>POTENTIAL: MCAL SOC</b>	<b>TOTAL NET</b>
Premiums	15	\$105,094	\$0	\$105,094
Drug Deductibles & Co-Pays	15	\$36,383	\$116,484	-\$80,101
<b>TOTAL</b>	<b>15</b>	<b>\$141,477</b>	<b>\$116,484</b>	<b>\$24,993</b>

For FYs 2011-12 and 2012-13 estimated costs, the increase in clients was added to the base due to OA-HIPP expansion (1,535 and 1,610, respectively) to the base number of clients without expansion (estimated at 200 clients for both years) for estimated total clients. Seven percent of these OA-HIPP clients were estimated to qualify for dual-enrollment with a Medi-Cal SOC [(1,535 + 200) X 7 percent = 121 clients in FY 2011-12 and (1,610 + 200) X 7 percent = 127 client in FY 2012-13]. This number by the average cost per client for total estimated costs of **\$202,625** in FY 2011-12 (121 clients X \$1,666) and **\$211,436** in FY 2012-13 (127 clients X \$1,666). Annual premiums (\$7,006) and drug deductibles and co-pays for both an OA-HIPP client in ADAP (\$2,426) and an ADAP client with a Medi-Cal SOC (\$7,766) were computed by taking the average expenditures in FY 2010-11 and multiplying by the number of clients (see **Tables 33 and 34** on page 42).

<b>TABLE 33: COST COMPARISON BETWEEN OA-HIPP/ADAP AND ADAP WITH A MEDI-CAL SOC, FY 2011-12 ESTIMATE</b>				
<b>LINE ITEM</b>	<b>CLIENTS</b>	<b>CURRENT: OA-HIPP</b>	<b>POTENTIAL: MCAL SOC</b>	<b>TOTAL NET</b>
Premiums	122	\$852,023	\$0	\$852,023
Drug Deductibles & Co-Pays	122	\$294,965	\$944,363	-\$649,398
<b>TOTAL</b>	<b>122</b>	<b>\$1,146,988</b>	<b>\$944,363</b>	<b>\$202,625</b>

<b>TABLE 34: COST COMPARISON BETWEEN OA-HIPP/ADAP AND ADAP WITH A MEDI-CAL SOC, FY 2012-13 ESTIMATE</b>				
<b>LINE ITEM</b>	<b>CLIENTS</b>	<b>CURRENT: OA-HIPP</b>	<b>POTENTIAL: MCAL SOC</b>	<b>TOTAL ESTIMATE</b>
Premiums	127	\$889,071	\$0	\$889,071
Drug Deductibles & Co-Pays	127	\$307,791	\$985,426	-\$677,635
<b>TOTAL</b>	<b>127</b>	<b>\$1,196,862</b>	<b>\$985,426</b>	<b>\$211,436</b>

**RMA 6. Federal Funding Issue #2:** Reimbursement of Federal Funding through the Safety Net Care Pool for FY 2012-13

In FYs 2010-11 and 2011-12, CDPH received one-time reimbursement funding from DHCS through the Safety Net Care Pool (SNCP) federal funds. For FY 2012-13, CDPH will receive \$49,300,000 from DHCS as a one-time reimbursement due to additional federal funds available under SNCP. As a result, \$49,300,000 was removed from OA's GF budget authority. The *November 2011 Estimate* (FY 2012-13) assumes that the reimbursement will be spent in the budget year.

## Continuing Assumptions

These items were included in prior estimates as Major Assumptions. Fiscal estimates were impacted due to updated data; there was either no change or only minor adjustments made to the estimate methodology:

### 1. Renegotiated Supplemental Rebate/Price Freeze Agreement

#### **Estimate Methodology**

Prior estimates in the *2011-12 November Estimate* and *2011-12 May Revision* used a rebate calculation methodology developed by the National Alliance of State and Territorial AIDS Directors ADAP Crisis Task Force (ACTF) consultant to determine additional rebate revenue due to the Patient Protection and Affordable Care Act (PPACA) and ACTF. The ACTF worksheet increased our overall rebate percentage from 46 percent to an estimated 51 percent, which is consistent with actual rebate percent for this timeframe that is now available. Coupled with the increased rebate percentage from 46 percent to 48 percent (**NMA 3**), the same methodology/ACTF worksheet was used as before and made a minor adjustment to the final rebate calculation to retain the estimated overall rebate percentage of 51 percent; the minor adjustment was needed to account for the five data points (FY 2009-10 Q3 – 2010-11 Q2) that already include rebate resulting from the PPACA/ACTF changes. As shown in **Table 40**, page 56 this is consistent with the new quarter FY 2010-11 Q3 and has been the steady rebate rate since FY 2009-10 Q3, roughly corresponding to the start of ACTF and PPACA.

### 2. PBM Contract: Pharmacy Split Savings

No change in methodology from the *2011-12 May Revision*.

### 3. PBM Contract: Change in Pharmacy Reimbursement Rate

No change in methodology from the *November 2010 Estimate* (FY 2011-12).

### 4. Legislation Effecting Medicare Part D TrOOP Costs

#### **Estimate Methodology**

ADAP started counting towards TrOOP in January 2011. For the *2011-12 November Estimate* and *2011-12 May Revision*, FY 2009-10 data was used (when ADAP did not count towards TrOOP) to model our half-savings for FY 2010-11 and full-year savings for FY 2011-12. For the *2012-13 November Estimate*, OA continued to use FY 2009-10 data to model full-year savings for both FYs 2011-12 and 2012-13. The use of FY 2010-11 data, when ADAP did count towards TrOOP for six months, would require a revised methodology and possibly an adjustment factor to offset seven months of TrOOP (January 2011 to July 2011) already built into the linear regression model.

**Discontinued Major Assumptions**

There are no Discontinued Major Assumptions.

## FUND CONDITION STATEMENT

FCS (see **Table 35**, next page) shows the status of the ADAP SF for FYs 2010-11, 2011-12, and 2012-13 and all the factors that impact the fund including revenues, expenditures, revenue collection rate, interest earned, and major assumptions.

For FY 2011-12, revenue estimates are based on actual rebates collected for the period January through March 2011 (\$59,349,639), actual expenditures for April through June 2011 (\$118,549,848), and estimated expenditures for July through December 2011 (\$252,089,053). A 48 percent (see **NMA 3**) rebate collection rate was applied to the actual and estimated expenditures to arrive at estimated revenue of \$177,906,672. Actual rebates plus rebates estimated from actual and estimated expenditures resulted in projected revenue of \$237,256,311. These revenues were adjusted to reflect the impact of current year assumptions yielding net revenue in the amount of \$247,914,949. It is estimated that there will be an additional amount of \$120,000 of revenue from interest (**NMA 8**).

For FY 2012-13, revenue estimates are based on updated projected expenditures for the period January through December 2012 (\$536,037,947). A 48 percent rebate collection rate was applied to the estimated expenditures and adjustments were made for assumptions to arrive at the net revenue projection of \$236,874,597. It is estimated that there will be an additional amount of \$120,000 of revenue from interest (**NMA 8**).

Based on the revised linear regression and impact of assumptions, the revised FY 2011-12 total GF appropriation is \$5,784,827, a \$76,840,173 decrease from the Budget Act. The total GF appropriation for FY 2012-13 is \$6,445,299, a decrease of \$76,179,701 from the FY 2011-12 Budget Act and an increase of \$660,472 from the revised FY 2011-12 appropriation.

## NOVEMBER ESTIMATE FUND CONDITION STATEMENT

Table 35: FUND CONDITION STATEMENT				
Special Fund 3080 AIDS Drug Assistance Program Rebate Fund		FY 2010-11 Actuals	FY 2011-12 Estimate	FY 2012-13 Estimate
1	BEGINNING BALANCE	11,309	57,874	21,711
2	Prior Year Adjustment	4,839	0	0
3	Adjusted Beginning Balance	16,148	57,874	21,711
4	REVENUES, TRANSFERS AND OTHER ADJUSTMENTS			
5	Revenues			
6	150300 Income From Surplus Money Investments	140	120	120
7	161400 Miscellaneous Revenue	262,890	247,915	236,875
8	Total Revenues, Transfers, and Other Adjustments	263,030	248,035	236,995
9	Total Resources	279,178	305,909	258,706
10	EXPENDITURES AND EXPENDITURE ADJUSTMENTS			
11	Expenditures			
12	8880 FISCAL	1	0	0
13	0840 State Controllers Office	56	33	2
14	4260 Department of Health Care Service (State Ops)	9	0	0
15	4265 Department of Public Health			
16	State Operations	1,073	981	912
17	ADAP Local Assistance	220,165	280,510	239,644
18	OA-PCIP, OA-HIPP, and Medicare Part D Local Assistance		2,674	5,876
19				
20	Total Expenditures and Expenditure Adjustments	221,304	284,198	246,434
21	FUND BALANCE	57,874	21,711	12,272

Row 6: Actuals for FY 2010-11, Estimated for FYs 2011-12 and 2012-13 (NMA 8)

140,426	120,000	120,000
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**Miscellaneous Revenue**

Actual Rebate resulting from Expenditures for Jan - Mar 2011	59,349,639	
Estimated Rebate resulting from actual Expenditures for April - June 2011 (\$118,549,848 x 48% avg rebate rate)	56,903,927	
Estimated Rebate resulting from Estimated Unadjusted Expenditures for July - Dec 2011 (\$252,089,053 x 48% avg rebate rate)	121,002,745	
Estimated Rebate resulting from Estimated Unadjusted Expenditures for Jan - June 2012 (\$252,089,053 x 48% avg rebate rate)		121,002,745
Estimated Rebate resulting from Estimated Unadjusted Expenditures for July - Dec 2012 (\$283,948,894 x 48% avg rebate rate)		136,295,469
Total Unadjusted Estimated FY 2011-12 Rebate Revenue	237,256,311	
Total Unadjusted Estimated FY 2012-13 Rebate Revenue		257,298,214

**Adjustments to ADAP Revenue Projections:**

* LIHP: Impact of the Ten "Legacy" Counties on ADAP (NMA 4)	0	-33,078,128
OA-PCIP: If no other changes than updated data from May Revision	-2,057,055	-10,462,800
OA-PCIP: Delayed implementation (RMA 1)	1,053,366	475,692
OA-PCIP: Reductions in OA-PCIP Caseload and Savings due to LIHP and RW Payer of Last Resort Provision (RMA 3)	495,307	6,452,486
OA-HIPP: Expansion If no other changes than updated data from May Revision	74,171	212,944
OA-HIPP: Reductions in OA-HIPP Caseload and Savings due to LIHP and RW Payer of Last Resort Provision (RMA 4)	-26,318	-104,950
Renegotiated Supplemental Rebate/Price Freeze Agreement (Continuing Assumption 1)	11,119,167	16,081,138

**Row 7: ADAP Revenue Projections after Adjustments**

247,914,949	236,874,597
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\*LIHP: Due to the delay in rebate collection, there will not be an impact in Revenue for FY 2011-12

	FY 2011-12 Estimate	FY 2012-13 Estimate
<b>ADAP Expenditure Projection:</b> FYs 2011-12 and 2012-13, Linear Regression (NMA 1)	514,211,350	579,199,067
<b>Adjustments to ADAP Expenditure Projection:</b>		
Impact of the Ten "Legacy" LIHP counties on ADAP (NMA 4)	-19,902,871	-139,903,677
Less Client Cost Sharing (NMA 5)		-14,485,577
If no other changes to OA-PCIP than updated data from May Revision	-11,585,736	-29,719,368
Delayed OA-PCIP Implementation (RMA 1)	5,932,761	1,351,194
OA-PCIP: Reductions in OA-PCIP Caseload and Savings due to LIHP and RW Payer of Last Resort Provision (RMA 3)	2,803,743	18,409,559
If no other changes to OA-HIPP than updated data from May Revision	-6,383,046	-12,985,203
OA-HIPP Reductions in Caseload and Savings due to LIHP and RW Payer of Last Resort Provision (RMA 4)	2,260,866	4,507,966
PBM: Pharmacy Split Savings (Continuing Assumption 2)	-1,293,157	-1,456,590
PBM: Change in Reimbursement Rate for PBM Contract (Continuing Assumption 3)	-2,300,223	-2,590,933
Legislation Effecting Medicare Part D True-Out-Of-Pocket Costs (Continuing Assumption 4)	-6,439,865	-7,253,756
<b>Subtotal: ADAP Expenditure Projection after Adjustments</b>	<b>477,303,822</b>	<b>395,072,682</b>
Less: Federal Fund Appropriation (Earmark) (NMA 6)	-102,572,484	-102,572,484
Less: One-Time Federal Fund Increase RW Supplemental Awards and Carryover (NMA 6)	-16,224,795	
<b>Subtotal: Federal Fund</b>	<b>-118,797,279</b>	<b>-102,572,484</b>
<b>Less: Reimbursement funding through the Safety Net Care Pool (RMA 6)</b>	<b>-74,064,000</b>	<b>-49,300,000</b>
Less: General Fund Appropriation for ADAP - per FY 2011-12 Budget Act	-82,625,000	-82,625,000
General Fund need for ADAP expenditures that are not allowable under RW	4,932,804	5,556,228
Less: Surplus funds after keeping funds for GF-only expenditures	-77,692,196	-77,068,772
<b>Subtotal: General Fund Revised Appropriation for ADAP</b>	<b>-4,932,804</b>	<b>-5,556,228</b>
Special Fund 3080 Need to meet Expenditure Projection for ADAP	279,509,739	237,643,970
Local Assistance Local Health Jurisdiction (LHJ) (NMA 7)	1,000,000	2,000,000
Elimination TROPISM Assay testing (NMA 9)	0	0
<b>Row 17: Total Special Fund 3080 Need for ADAP</b>	<b>280,509,739</b>	<b>239,643,970</b>

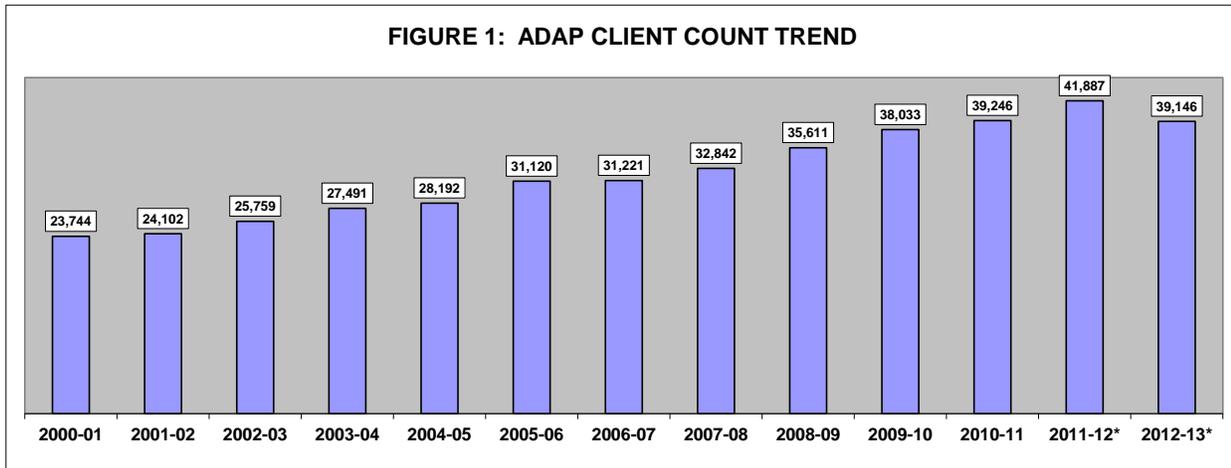
	FY 2011-12 Estimate	FY 2012-13 Estimate
<b>OA-PCIP Expenditure Projection:</b> Impact of OA-PCIP if no other changes than updated data from May Revision	2,576,642	6,091,743
<b>Adjustments to OA-PCIP Expenditure Projection:</b>		
Delayed Implementation (RMA 1)	-1,319,433	-276,962
Reduced premiums (RMA 2)	-201,343	-931,243
Reductions in caseload and savings due to LIHP and RW Payer of Last Resort Statute (RMA 3)	-499,688	-3,031,601
<b>Subtotal: OA-PCIP Expenditure Projection after Adjustments</b>	<b>556,178</b>	<b>1,851,937</b>
<b>OA-HIPP Expenditure Projection:</b> Impact of OA-HIPP if no other changes than updated data from May Revision	4,917,541	7,929,845
<b>Adjustments to OA-HIPP Expenditure Projection:</b>		
Reductions in caseload and premium savings due to LIHP and RW Payer of Last Resort Statute (RMA 4)	-1,247,653	-2,317,129
Non-Add: Shift existing clients with Medi-Cal SOC from RW to GF (RMA 5)	852,023	889,071
<b>Subtotal: OA-HIPP Expenditure Projection after Adjustments</b>	<b>3,669,888</b>	<b>5,612,716</b>
<b>Total: Projected Expenditures for OA-PCIP and OA-HIPP</b>	<b>4,226,066</b>	<b>7,464,653</b>
Less: Federal Fund Appropriation (RW Part B Base Funds)	-1,700,000	-1,700,000
General Fund need for OA-HIPP expenditures that are not allowable under RW	-852,023	-889,071
<b>Special Fund 3080 Need to meet Expenditure Projection for OA-PCIP and OA-HIPP</b>	<b>1,674,043</b>	<b>4,875,582</b>
Local Assistance Medicare Part D premiums	1,000,000	1,000,000
<b>Row 18: Special Fund 3080 Need to meet Expenditure Projection for Insurance Programs</b>	<b>2,674,043</b>	<b>5,875,582</b>
General Fund revised appropriation for ADAP	4,932,804	5,556,228
General Fund need for OA-HIPP expenditures that are not allowable under RW	852,023	889,071
<b>Total General Fund Appropriation</b>	<b>5,784,827</b>	<b>6,445,299</b>

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

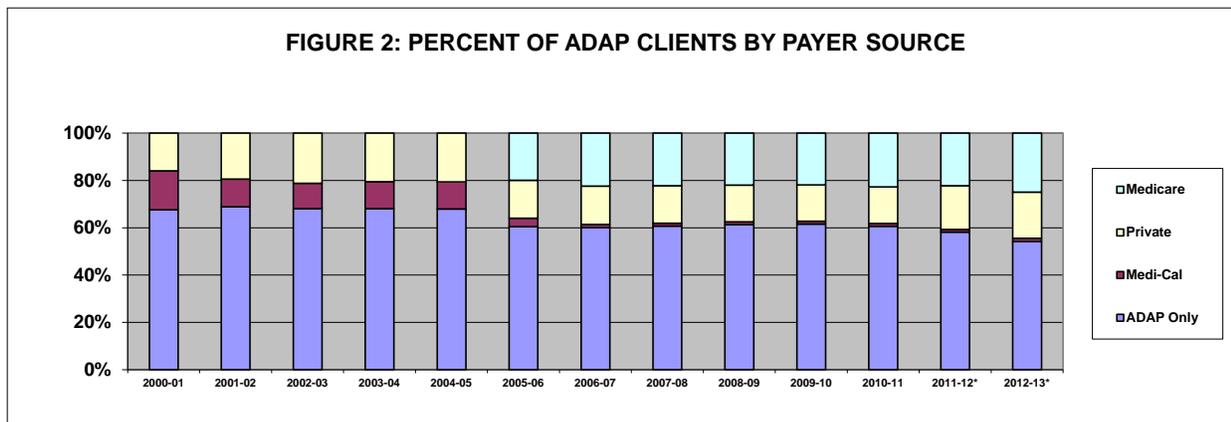
### 4. HISTORICAL PROGRAM DATA AND TRENDS

(\*Data for FYs 2011-12 and 2012-13 are estimated, all other data are actuals)

For all figures and tables in Section 4, the data prior to FY 2011-12 is the observed historical data. To develop client and prescription estimates for FYs 2011-12 and 2012-13, we used a model similar to the 36-month regression model for expenditure estimates, where the 36 monthly data points were the number of clients and prescriptions. We then adjusted the estimates to take into account the movement of clients from ADAP to LIHP (**NMA 4**).



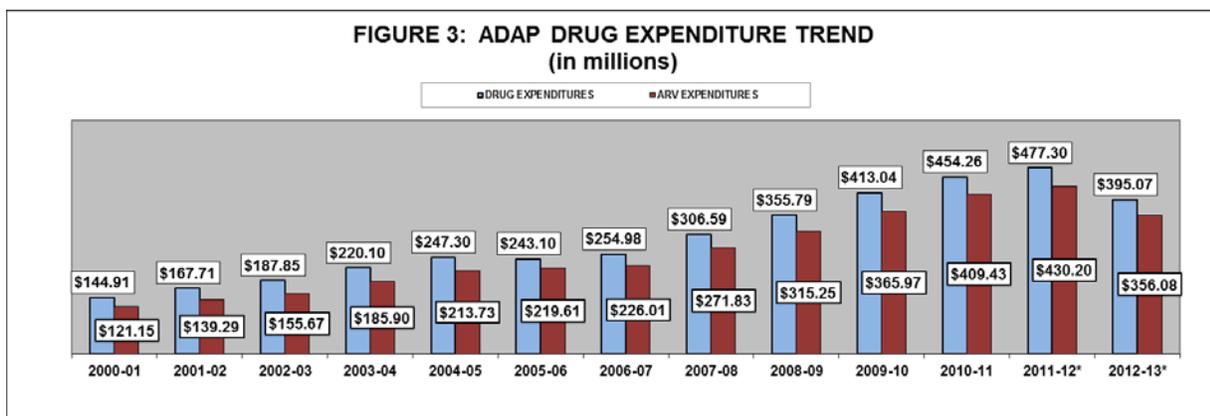
Note: The reduction in client count for 2012-13 is a reflection of clients transitioning to LIHP.



Note: The actual percentage of ADAP clients by payer source/coverage group in FY 2010-11 was applied to the estimated client counts in FYs 2011-12 and 2012-13 to estimate the percentage of clients by payer source. We then adjusted the estimated number of clients to take into account the movement of clients from ADAP only to private insurance due to OA-PCIP (**RMA 1-3**) and new clients coming in due to OA-HIPP (**RMA 4 and 5**).

Coverage Group	FY 2011-12		FY 2012-13	
	Clients	Percent	Clients	Percent
ADAP	24,369	58.18%	21,230	54.23%
Medi-Cal	481	1.15%	505	1.29%
Private Insurance	7,749	18.50%	7,667	19.58%
Medicare	9,288	22.17%	9,744	24.89%
<b>TOTALS</b>	<b>41,887</b>	<b>100.00%</b>	<b>39,146</b>	<b>100.00%</b>

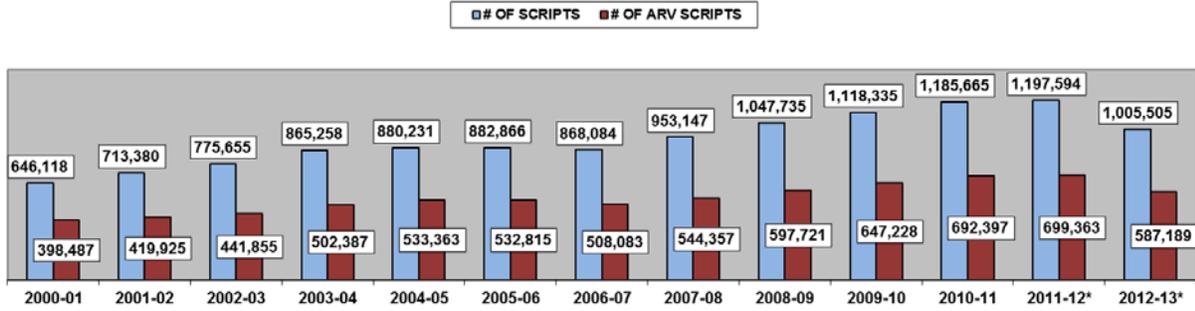
Note: The actual percentage of ADAP clients by payer source/coverage group in FY 2010-11 was applied to the estimated client counts in FYs 2011-12 and 2012-13 to estimate the percentage of clients by payer source. We then adjusted the estimated number of clients to take into account the movement of clients from ADAP only to private insurance due to OA-PCIP (RMA 1-3) and new clients coming in due to OA-HIPP (RMA 4 and 5).



Notes: The reduction in drug expenditures for FY 2012-13 is a reflection of clients transitioning to LIHP. Drug expenditures do not include: Annual administrative support for LHJs, Medicare Part D premium payments, OA-HIPP and OA-PCIP premium payments; for these costs see Table 35, page 46.

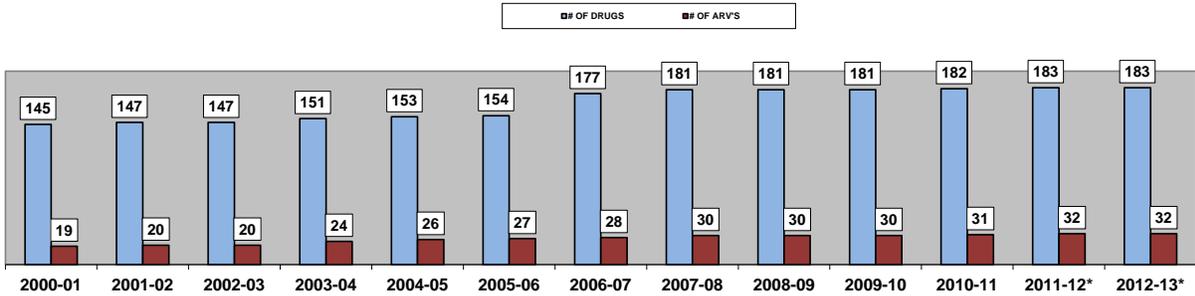
For ARV expenditures, we used the percentage of ARV expenditures to total expenditures in FY 2010-11 and applied this percentage to the estimated total drug expenditures in FYs 2011-12 and 2012-13 to estimate the amount of ARV expenditures for each year.

**FIGURE 4: ADAP # OF PRESCRIPTIONS TREND**



Note: The reduction in number of prescriptions for 2012-13 is a reflection of clients transitioning to LIHP. For the number of ARV prescriptions, we used the percentage of ARV prescriptions without jail prescriptions in FY 2010-11 and applied it to the estimated drug prescriptions in FYs 2011-12 and 2012-13 to estimate the number of ARV prescriptions. We then adjusted the number of prescriptions to account for the shift of clients from ADAP into LIHP per **NMA 4**.

**FIGURE 5: ADAP # OF FORMULARY DRUGS TREND**



## APPENDIX A: EXPENDITURE AND REVENUE ESTIMATE METHODS

### Updated Expenditure Estimate for FY 2011-12

<b>TABLE 37: LINEAR REGRESSION MODEL FOR NOVEMBER ESTIMATE FOR FY 2011-12 COMPARED TO BUDGET ACT FY 2011 -12</b>			
<b>Revised Estimate</b>	<b>Estimate from Budget Act FY 2011 -12</b>	<b>Change from Previous Estimate (\$)</b>	<b>Change from Previous Estimate (%)</b>
\$514,211,350	\$538,139,086	-\$23,927,736	-4.45%

### New Expenditure Estimate for FY 2012-13

<b>TABLE 38: LINEAR REGRESSION MODEL FOR NOVEMBER ESTIMATE FOR FY 2012-13 COMPARED TO BUDGET ACT FY 2011-12</b>			
<b>November Estimate FY 2012-13</b>	<b>Estimate from Budget Act FY 2011 -12</b>	<b>Change from Previous Estimate (\$)</b>	<b>Change from Previous Estimate (%)</b>
\$579,199,067	\$538,139,086	\$41,059,981	7.63%

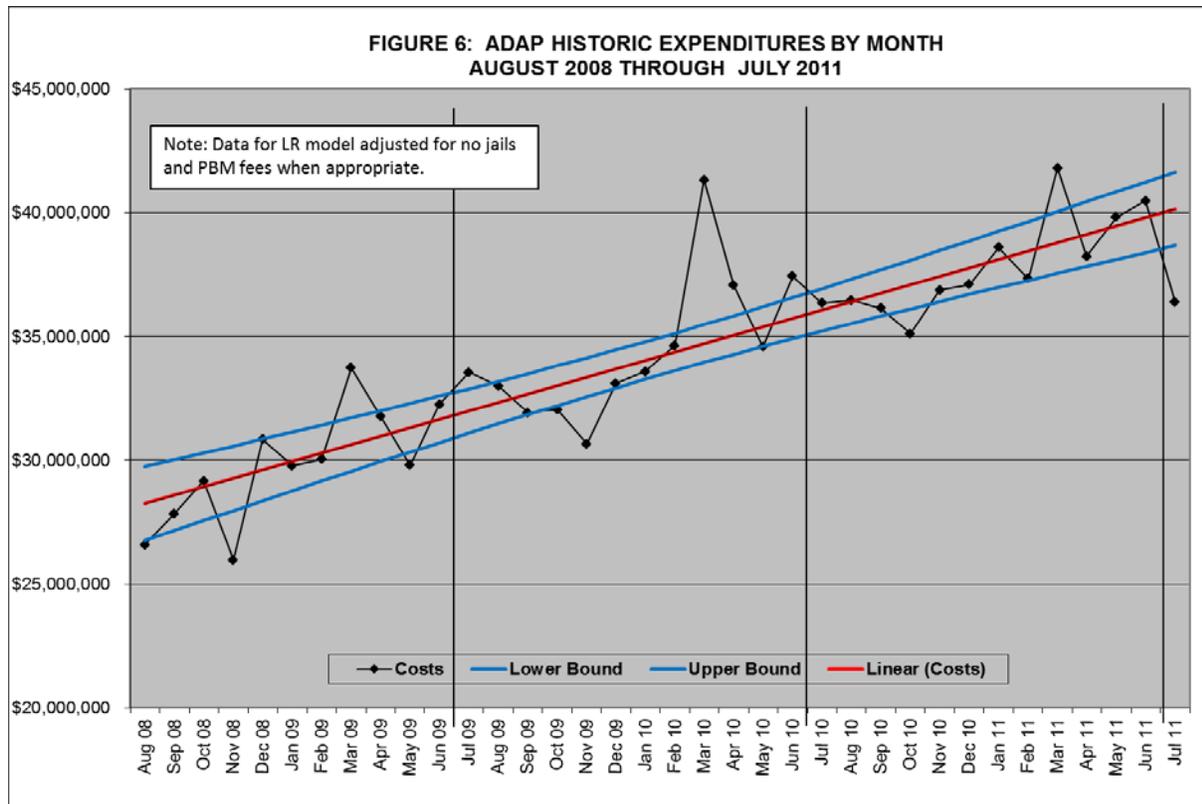
### Linear Regression Model – Expenditure Estimates

The linear regression methodology is the same as the method used to estimate expenditures for FYs 2010-11 and 2011-12 in the *May Revision FY 2011-12* with two caveats: 1) we used the updated range of actual expenditures, from August 2008 through July 2011; and 2) no estimated monthly data was included. Using a more recent set of actual expenditure data to predict future expenditures allowed us to “fine tune” our previous estimates. Actual expenditures were lower than the estimated values previously predicted by the regression model used for the *May Revision FY 2011-12*, which resulted in the lower expenditure estimate FY 2011-12 as noted in **Table 37**.

**Figure 6**, page 53, shows ADAP historic expenditures by month. The regression line (red) represents the best fitting straight line for estimating the expenditures:

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

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



**Table 39** displays historic drug expenditures by FY, annual change, and percent change.

<b>TABLE 39: ADAP HISTORIC AND PROJECTED DRUG EXPENDITURES</b>			
(*Data for FY 2011-12 and FY 2012-13 are projected, all other data are actuals)			
<b>Fiscal Year</b>	<b>Expenditures</b>	<b>Annual Change in Expenditures</b>	<b>Pct Annual Change</b>
1997-98	\$86,674,336	N/A	N/A
1998-99	\$98,924,742	\$12,250,405	14.13%
1999-00	\$119,465,151	\$20,540,409	20.76%
2000-01	\$144,913,504	\$25,448,353	21.30%
2001-02	\$167,709,426	\$22,795,922	15.73%
2002-03	\$187,854,138	\$20,144,712	12.01%
2003-04	\$220,101,760	\$32,247,622	17.17%
2004-05	\$247,299,716	\$27,197,956	12.36%
2005-06	\$243,096,942	-\$4,202,774	-1.70%
2006-07	\$254,977,392	\$11,880,450	4.89%
2007-08	\$306,590,832	\$51,613,440	20.24%
2008-09	\$355,786,400	\$49,195,569	16.05%
2009-10	\$413,035,251	\$57,248,851	16.09%
2010-11	\$454,426,055	\$41,390,804	10.02%
2011-12*	\$477,303,822	\$22,877,767	5.03%
2012-13*	\$395,072,682	-\$82,231,140	-17.23%
<b>Total Average</b>	<b>FY 97-98 to 12-13</b>	<b>\$20,559,890</b>	<b>11.12%</b>

Note: Drug costs include administrative costs at the pharmacy and PBM level.

Drug costs do not include: Annual administrative support for LHJs, Medicare Part D premium payments, OA-HIPP and OA-PCIP premium payments; for these costs see FCS, pages 47 and 48.

Notes: In FY 2005-06, ADAP expenditures decreased for the first time due to the enrollment of ADAP clients in Medicare Part D starting in January 2006. This also resulted in a lower than average increase in expenditures in FY 2006-07. The annual percentage increase in expenditures has decreased in FY's 2010-11 and 2011-12 because of the elimination of jail clients and the changes to TrOOP in FY 2010-11. Additionally, the 5.03 percent increase in expenditures projected for FY 2011-12 is less than the average annual increase due to the implementation of LIHP. With the complete shift of ADAP clients to LIHP in FY 2012-13, expenditures are projected to decrease 17.23 percent.

### ADAP Rebate Revenue Estimate Method

To forecast future revenue, the rebate revenue estimate method applies the expected revenue collection rate to estimated or actual expenditures (whichever is more current). The revenue collection rate has been increased from 46 percent to 48 percent (see **NMA 3** on page 5). Estimated revenue for a given FY is based on drug expenditures during the last two quarters of the previous FY and the first two quarters of the current FY. This six-month delay is necessary to take into account the time required for billing the drug manufacturers and receipt of the rebate. Revenue projections are adjusted to reflect assumptions and other adjustments that can increase or decrease revenues.

Revenue estimates for the *November 2011 Estimate (FY 2011-12)* for current year were developed using actual rebates (\$59,349,639) collected for the period January through March 2011, actual expenditures for April through June 2011, and estimated expenditures for July through December 2011 (see Table 35, page 46). A 48 percent rebate collection rate was applied to the actual and estimated expenditures of \$370,638,901 to arrive at estimated revenue of \$177,906,672, for a total revenue of \$237,256,311. The resulting estimated revenue was then adjusted due to the fiscal impact of the new, revised, and continuing assumptions to arrive at \$247,914,949.

Revenue for the *November 2011 Estimate (FY 2012-13)* for budget year was based on updated estimated expenditures for the period January through December 2012 applying the 48 percent rebate collection rate to arrive at the revenue projection of \$257,298,214 and adjusted for the new, revised, and continuing assumptions \$236,874,597.

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

<b>FY-QTR</b>	<b>\$ Drugs Purchased</b>	<b>Received in Rebate \$</b>	<b>Received / Purchased</b>
2002-03-Q1	\$46,263,616	\$10,136,693	21.91%
2002-03-Q2	\$46,714,748	\$10,257,857	21.96%
2002-03-Q3	\$47,028,955	\$10,146,224	21.57%
2002-03-Q4	\$47,846,818	\$10,846,426	22.67%
2003-04-Q1	\$51,607,688	\$12,275,494	23.79%
2003-04-Q2	\$51,732,389	\$15,045,513	29.08%
2003-04-Q3	\$56,857,403	\$17,801,378	31.31%
2003-04-Q4	\$59,904,280	\$19,249,713	32.13%
2004-05-Q1	\$61,533,761	\$19,334,264	31.42%
2004-05-Q2	\$60,894,584	\$18,691,012	30.69%
2004-05-Q3	\$61,680,181	\$19,176,357	31.09%
2004-05-Q4	\$63,191,190	\$15,847,186	25.08%
2005-06-Q1	\$63,433,758	\$21,866,164	34.47%
2005-06-Q2	\$62,536,173	\$20,612,704	32.96%
2005-06-Q3	\$58,562,814	\$26,768,577	45.71%
2005-06-Q4	\$58,564,197	\$25,095,840	42.85%
2006-07-Q1	\$60,334,084	\$24,791,394	41.09%
2006-07-Q2	\$58,609,374	\$24,489,071	41.78%
2006-07-Q3	\$67,474,884	\$32,724,197	48.50%
2006-07-Q4	\$68,559,050	\$31,734,710	46.29%
2007-08-Q1	\$68,797,779	\$33,524,051	48.73%
2007-08-Q2	\$71,581,717	\$35,262,749	49.26%
2007-08-Q3	\$81,926,045	\$44,200,318	53.95%
2007-08-Q4	\$84,285,291	\$39,834,969	47.26%
2008-09-Q1	\$82,366,671	\$36,272,892	44.04%
2008-09-Q2	\$85,997,429	\$38,043,925	44.24%
2008-09-Q3	\$93,564,283	\$46,300,283	49.48%
2008-09-Q4	\$93,858,017	\$40,827,251	43.50%
2009-10-Q1	\$98,508,463	\$44,718,090	45.40%
2009-10-Q2	\$95,842,924	\$44,131,629	46.05%
2009-10-Q3	\$109,578,075	\$55,919,217	51.03%
2009-10-Q4	\$109,105,789	\$55,287,500	50.67%
2010-11-Q1	\$108,993,239	\$56,542,420	51.88%
2010-11-Q2	\$109,126,234	\$54,183,618	49.65%
2010-11-Q3	\$117,756,733	\$59,349,638	50.40%

48.06%

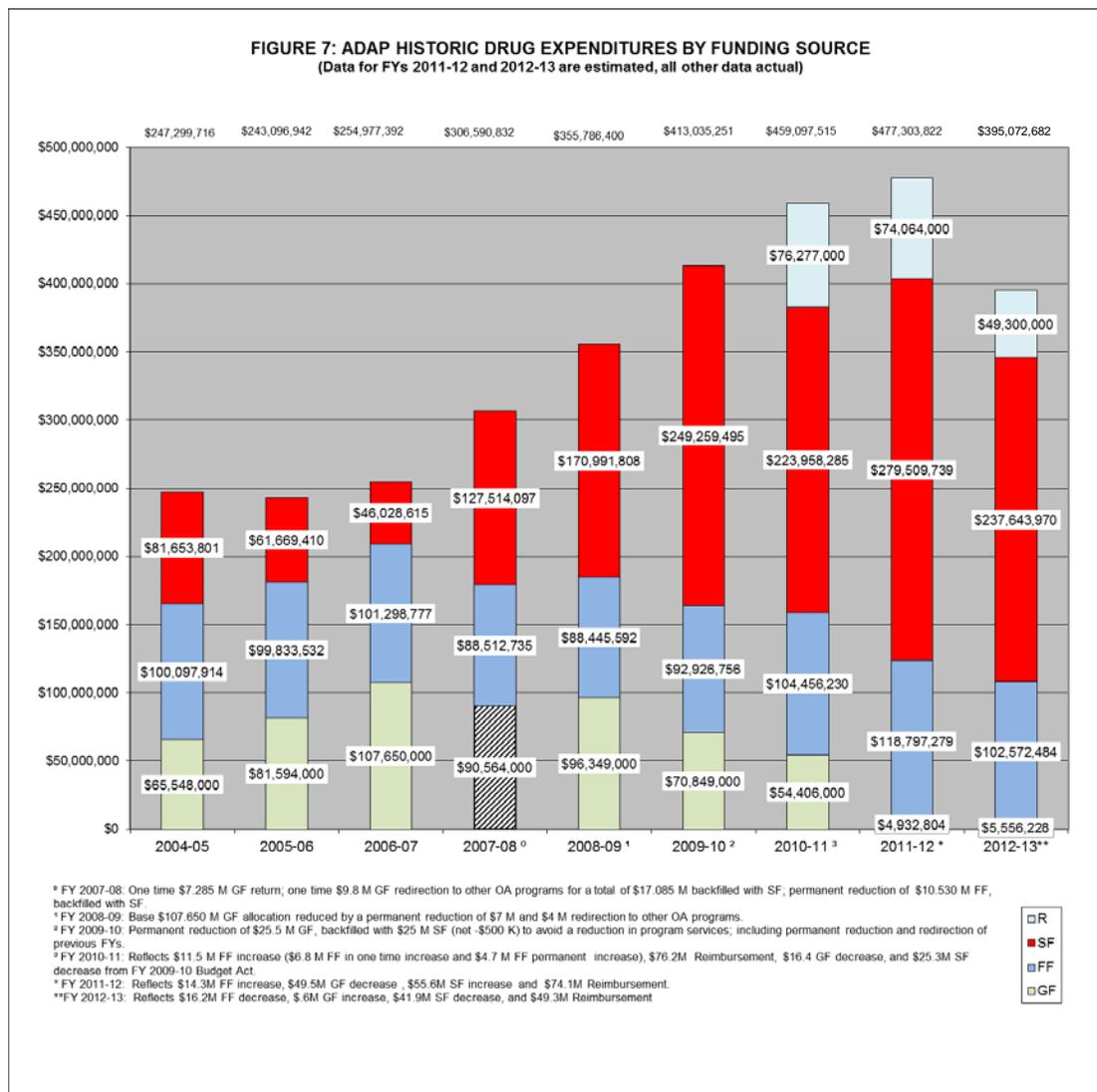
TABLE 41: COMPARISON OF REVENUE* BETWEEN NOVEMBER 2011 ESTIMATE PACKAGE AND 2011-12 BUDGET ACT						
UPDATED ESTIMATE FOR FY 2011-12						
Expenditure Period	Available Data	FY 2011-12 November Estimate	Available Data	Appropriation	Change (\$)	Change (%)
Jan - Mar 2011	Actual Rebates	\$59,349,639	Actual Expenditures @ 46%	\$55,424,949	\$3,924,690	7.08%
Apr - Jun 2011	Actual Expenditures @ 48%	\$56,903,927	Actual Expenditures @ 46%	\$55,424,950	\$1,478,977	2.67%
Jul - Dec 2011	Estimated Expenditures @ 48%	\$121,002,745	Estimated Expenditures @ 46%	\$119,594,149	\$1,408,596	1.18%
<b>Subtotal Revenue Prior to Adjustments</b>		\$237,256,311		\$230,444,048	\$6,812,263	2.96%
<b>Total Adjustments Due to Assumptions</b>		10,658,638		\$25,090,933	-\$14,432,295	-57.52%
<b>Subtotal Revenue After Adjustments</b>		\$247,914,949		\$255,534,980	-\$7,620,031	-2.98%
Interest		\$120,000		\$300,000	-\$180,000	-60.00%
<b>Total Revenue (see Table 35, Fund Condition Statement)</b>		\$248,034,949		\$255,834,980	-\$7,800,031	-3.05%
ESTIMATE FOR FY 2012-13						
Expenditure Period	Available Data	FY 2012-13 November Estimate	Available Data (Expenditure Period)	FY 2011-12 November Estimate	Change (\$)	Change (%)
Jan - Jun 2011	Estimated Expenditures @ 48%	\$121,002,745	Actual Expenditures @48% (Apr-Jun 2011) Actual Expenditures @48% (Apr-Jun 2011)	\$116,253,566	\$4,749,179	4.09%
Jul - Dec 2011	Estimated Expenditures @ 48%	\$136,295,469	Estimated Expenditures @48%	\$121,002,745	\$15,292,724	12.64%
<b>Subtotal Revenue Prior to Adjustments</b>		\$257,298,214		\$237,256,311	\$20,041,903	8.45%
<b>Total Adjustments Due to Assumptions</b>		-20,423,618		\$10,658,638	-\$31,082,256	-291.62%
<b>Subtotal Revenue after Adjustments</b>		\$236,874,597		\$247,914,949	-\$11,040,353	-4.45%
Interest		\$120,000		\$120,000	\$0	0.00%
<b>Total Revenue (see Table 35, Fund Condition Statement)</b>		\$236,994,597		\$248,034,949	-\$11,040,353	-4.45%

\*Note: When actual rebate data are not available, revenue projection methodology bases revenue first on estimated and then actual expenditures. This method does not take into account the seasonal fluctuations between the first half of the FY (when expenditures are lowest) and the second half (when expenditures are highest).

## APPENDIX B: FUND SOURCES

Payments of ADAP expenditures are made from four fund sources:

1. State GF appropriations.
2. Federal funding from HRSA through the RW Program. In addition, for FY 2011-12, OA received three one-time fund awards: RW Part B Supplemental Award of \$1,376,784, RW Part B ADAP Supplemental Award of \$8,028,154, and ADAP Emergency Relief Funding of \$2,574,357. HRSA also approved CDPH's carry-over request for \$4,245,500 of unspent funds from the 2010 RW Part B Grant for expenditures in ADAP during the 2011 RW grant period.
3. Reimbursements from DHCS are one-time funding sources for FYs 2010-11, 2011-12, and 2012-13 as a result of additional federal resources available through SNCP.
4. ADAP SF consists of both mandatory and voluntary rebates from manufacturers with products on the ADAP formulary and interest payments from ADAP SF.



## General Fund

The GF appropriation is used for the purchase of prescription drugs for eligible clients. Due to the RW payer of last resort provision, GF is the only source of funding used by ADAP to cover the costs associated with clients eligible for other public assistance programs, including Medi-Cal. GF also pays the transaction fees invoiced by ADAP's PBM contractor for the administrative costs associated with managing prescription transactions that are ultimately identified as not eligible for ADAP payment.

The revised FY 2011-12 total GF appropriation is \$5,784,827, a \$76,840,173 decrease from the Budget Act. The total GF appropriation for FY 2012-13 is \$6,445,299, a decrease of \$76,179,701 from the FY 2011-12 Budget Act and an increase of \$660,472 from the revised FY 2011-12 appropriation.

## Federal Fund

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

For FY 2011-12, ADAP received an increase in Earmark Federal funding of \$4,940,484 for a total of \$102,572,484 as well as three one-time fund awards: RW Part B Supplemental Award of \$1,376,784, RW Part B ADAP Supplemental Award of \$8,028,154, and ADAP Emergency Relief Funding of \$2,574,357. HRSA also approved CDPH's carry-over request for \$4,245,500 of unspent funds from the 2010 RW Part B Grant for expenditures in ADAP during the 2011 RW grant period. The total increase in federal funds for FY 2011-12 is \$21,165,279.

The FY 2011-12 Enacted Budget included \$3 million in federal authority in anticipation of these awards. Thus, OA submitted a Section 28 Letter requesting additional current year authority of \$18,165,279. The November 2011 Estimate (FY 2012-13) assumes the increase in federal funds will be spent in the current year.

## Match

HRSA requires grantees to have HIV-related non-HRSA expenditures. California's 2011 HRSA match requirement for FY 2011-12 funding is \$69,303,049. OA will meet the match requirements by using GF expenditures from OA as well as the California Department of Corrections and Rehabilitation and California HIV/AIDS Research Program.

## **MOE**

HRSA requires grantees to maintain HIV-related expenditures at a level that is not less than the prior FY. California's MOE target, based on FY 2009-10 expenditures at the time of the Year 2011 HRSA grant application, is \$502,476,676. Expenditures included in California's MOE calculations are not limited to OA programs and include HIV-related expenditures for all state agencies able to report GF expenditures specific to HIV-related activities such as care, treatment, prevention, and surveillance. Expenditures from the SF may be used towards the MOE requirement.

## **Reimbursement**

On February 1, 2010, CMS approved the DHCS proposed amendment to the Special Terms and Conditions, amended October 5, 2007. The amendment incorporates federal flexibilities to expand DHCS's ability to claim additional state expenditures to utilize federal funding under SNCP. DHCS used certified public expenditures from various programs, including ADAP, to claim federal funds. CDPH will receive \$76,064,000 of these funds from DHCS as a reimbursement for FY 2011-12 and anticipates receiving \$49,300,000 for FY 2012-13.

## **ADAP SF (3080)**

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

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

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

Supplemental rebates (rebates beyond those required by the federal Medicaid rebate law) are negotiated on an ongoing basis by the ACTF. ACTF is a rebate negotiating coalition of some of the largest ADAPs in the country (including California), working on behalf of all state ADAPs. ACTF enters into voluntary, confidential supplemental rebate agreements with drug manufacturers.

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

Supplemental rebate agreements are in place for all ARVs on the ADAP formulary. This is significant, as ARV drugs' represent approximately 90 percent of all ADAP drug expenditures. Supplemental rebate agreement terms are generally based on either:

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

## **Additional Rebate Percentage**

The mandatory 340B rebate is a percentage of the average manufacturers price (AMP), plus any penalties for price increases that exceed the rate for the Consumer Price Index (CPI). Since the AMP is confidential and not publicized, the resulting rebate amount is also unknown to ADAP. ACTF negotiations usually result in an additional voluntary, supplemental percentage of the AMP. For example, the current mandatory 340B rebate for brand drugs is 23 percent of AMP. If ACTF has negotiated a supplemental rebate of 2 percent of AMP, then ADAP receives a total rebate of 25 percent of AMP.

### **“Price Freeze” Rebates**

The “price freeze” option is another type of voluntary rebate offered by the manufacturer to compensate for commercial price increases. Currently, of the 32 available ARV medications on the ADAP formulary, ten (31 percent) are subject to a price freeze rebate. These ten drugs represented 52 percent of ADAP drug expenditures in FY 2009-10. If the manufacturers impose a price increase that exceeds the CPI (inflation rate) while the price freeze is in effect, the program reimburses retail pharmacies at the higher rates. Though this initially results in higher expenditures for the program, these price freeze agreements eventually offset the cost by increased rebates received and deposited in the SF.

### **ADAP Rebate Invoicing**

ADAP invoices the manufacturers for drug rebates on a quarterly basis, consistent with both federal drug rebate law and drug industry standards. All ADAPs are required to invoice drug manufacturers within 90 days of the end of a given calendar year quarter (e.g., January through March, April through June, etc.) in compliance with federal requirements. ADAP mails drug rebate invoices approximately 60 days after the end of the quarter. For example, the January through March quarter invoice is sent out June 1. The time between the end of the billing quarter and the mailing of the invoice is necessary to generate and confirm the accuracy of the rebate invoices.

### **Timeframe for Receipt of Rebates**

Federal HRSA guidance on ADAP rebate indicates that drug manufacturers are to pay rebate invoices from ADAP within 90 days of receipt. Federal Medicaid rebate law requires that drug manufacturers pay drug rebates within 30 days of receipt of a rebate invoice. Historically, the majority of drug manufacturers have paid rebates more closely to the Medicaid payment timeframe, usually within 30 to 60 days. However, receipt of rebate payments due for the first two quarters of calendar year 2011 indicate the manufacturers are now more closely following the HRSA timeframe of 90 days when processing ADAP rebate invoices.

Due to the above invoicing requirements and rebate payment timeframes, ADAP generally receives drug rebates six to nine months after program expenditures. Consequently, rebate due on expenditures in the second half of a given FY may not be received until the subsequent FY.

### **Funding from SF (3080) for LHJs and Premium Payments**

Additional SF budget authority is requested as follows:

- \$1 million in FY 2011-12 and \$2 million in FY 2012-13 to LHJs to help offset the costs of ADAP enrollment and eligibility screening for clients at enrollment sites located throughout the state. Allocation is based on the number of ADAP clients enrolled during the prior calendar year. Funds may only be used for cost associated with the administration of ADAP.
- \$1 million for the Medicare Part D Premium Payment Program. This program assists eligible clients in paying their Part D monthly premiums allowing them to receive the Part D benefit.
- \$556,178 to cover premium payments for OA-PCIP in FY 2011-12.
- \$1,969,888 to cover premium payments for OA-HIPP in FY 2011-12.

## APPENDIX C: POLICY ISSUES WITH POTENTIAL FUTURE FISCAL IMPACT

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

### Future Fiscal Issues

1. **OA-PCIP Issue #3:** Potential Payment of PCIP-Associated Medical Out-of-Pocket Costs

OA-PCIP clients who are co-enrolled in ADAP will have their HIV-related prescription out-of-pocket costs covered through ADAP up to the \$2,500 maximum. In the *2011-12 May Revision ADAP Estimate*, OA estimated that only 10 percent of ADAP -only clients would enroll in OA-PCIP due to the high out-of-pocket medical costs. OA will evaluate OA-PCIP enrollment through 2011 to assess the accuracy of the 10 percent estimate and any potential need to revise it.

OA is exploring the option of using a contractor to pay for OA-PCIP client's out-of-pocket medical expenses. Should this appear feasible, OA will need to work in close collaboration with MRMIB to ensure that it is viable from their perspective. Costs would also need to be estimated. Such a system would remove the disincentive for clients to enroll in PCIP and likely significantly increase enrollment, because most ADAP only clients probably could not afford to pay for the \$2,500 out-of-pocket maximum. Transitioning ADAP-only clients to PCIP not only provides clients with the benefit of full health coverage, rather than only HIV-related prescription drug coverage, but contributes to an overall reduction in state expenditures as well.

*Predicted fiscal impact: Increased OA-PCIP Savings (fiscal +).*

2. **ADAP/LIHP Issue #2:** Impact of full implementation of the "Non-Legacy" LIHP County Programs on ADAP

California was granted a Medicaid 1115 waiver that allows counties to receive federal funds to support LIHPs administered through DHCS. While LIHP is a voluntary program at the county level, it is anticipated that all of the counties will implement LIHPs and all have proposed implementation dates during FY 2011-12. DHCS has a goal of full implementation statewide by January 2012. The first counties to implement LIHP will be the ten who participated in the LIHP demonstration that have capacity to enroll new eligible clients into LIHP. Those counties are called "Legacy-LIHPs." ***Caseload and fiscal estimates associated with the implementation of those ten LIHPs with respect to ADAP are discussed in the NMA 4.***

To the extent that the remaining LIHPs (non-legacy) are implemented during FY 2011-12, there will be a fiscal impact to ADAP and to their respective funding streams: GF, Reimbursement from DHCS, federal RW ADAP Earmark, and/or SF. OA is working closely with DHCS LIHP staff, federal representatives, and stakeholders to clarify the complex issues and develop an integrated implementation plan for departmental consideration at both CDPH and DHCS.

**ADAP Issue:** The magnitude of the impact to ADAP and savings is unknown at this point due to the many uncertainties currently surrounding the LIHP implementation, including: when the non-legacy LIHPs will implement, at what income levels eligibility will be based, the impact of LIHP enrollment caps and waiting lists on RW clients and thus how many ADAP clients will transition to LIHPs, retroactive eligibility, back-billing options and the nature of the LIHP drug formularies.

*Predicted fiscal impact: Increased ADAP Savings (fiscal +).*

3. **Miscellaneous Issue #3:** Potential Change in use of Interferon and Ribavirin Due to the U.S. Food and Drug Administration (FDA) approval of Two New Hepatitis C Infection Treatments in FY 2011-12

Two new medications to treat hepatitis C infection have been approved by the FDA, telaprevir (approved May 23, 2011) and boceprevir (approved May 13, 2011). Both medications are used in conjunction with medications currently on the ADAP formulary for hepatitis C treatment: interferon and ribavirin. When one of the new medications (telaprevir or boceprevir) is combined with interferon and ribavirin to treat hepatitis C, the chance of responding to the treatment is increased and the duration of treatment with interferon and ribavirin may be shortened.

ADAP is not planning to add telaprevir and boceprevir to the ADAP formulary due to the high cost of these drugs. Both Vertex and Merck have Patient Assistance Programs and co-pay assistance programs that may enable ADAP clients to be treated with these drugs. As a result, there may be an increased number of associated prescriptions for interferon and ribavirin, as well as other ADAP drugs (for example filgrastim and erythropoietin alpha) used to manage treatment-associated side effects. Because telaprevir and boceprevir have received FDA approval so recently, ADAP is unable to estimate the potential impact that their use may have on related ADAP formulary drugs. ADAP will monitor the use of interferon and ribavirin closely for any indications of increased use with a fiscal impact on ADAP.

*Predicted fiscal impact: Increased ADAP Costs (fiscal -).*

## **New Drugs that May be Available in the Next Three Years**

### **Rilpivirine – FDA Approved**

Rilpivirine, a new non-nucleoside reverse transcriptase inhibitor (NNRTI) for use with other ARV agents in treatment naïve patients, was FDA approved on May 20, 2011. Due to the cost-neutrality of this drug (comparably priced to other NNRTIs) and successful supplemental rebate negotiations by the ACTF, rilpivirine represents no new costs to the program and was added to the ADAP formulary on June 13, 2011.

### **Tenofovir/emtricitabine/rilpivirine Combination – FDA Approved**

A once-daily single-pill co-formulation of tenofovir, emtricitabine, plus rilpivirine, was FDA approved on August 10, 2011. The tenofovir/emtricitabine/rilpivirine (Complera) combination offers another option for a complete ARV therapy available in a single pill. The pricing of the drug is comparable to the cost of its individual drug components and ACTF negotiations were successful in establishing a supplemental rebate for this drug. Thus, Complera was added to the ADAP formulary in December 2011.

*Possible approval in late 2012 or early 2013*

### **Combination elvitegravir, cobicistat, emtricitabine, and tenofovir (Quad)**

On August 15, 2011, it was announced that a Phase III study of the investigational fixed-dose, single-tablet "Quad" (four drugs) regimen of elvitegravir, cobicistat, emtricitabine and tenofovir met its primary objective of non-inferiority at week 48 as compared to Atripla in treatment-naïve patients. The primary endpoint analysis indicated that 88 percent of patients in the Quad arm compared to 84 percent in the Atripla arm achieved HIV RNA viral load of less than 50 copies through week 48. ADAP will monitor for filing of the NDA, Antiviral Drugs Advisory Committee scheduling, and potential FDA approval. It typically takes approximately six months from filing to approval for ARVs. If approved, ADAP will monitor pricing and supplemental rebate negotiations closely.

### **Elvitegravir**

Elvitegravir is an investigational integrase inhibitor therapy that is in Phase III clinical trials. If approved, elvitegravir will offer a once-daily dosing option for integrase inhibitors, as compared to the currently available raltegravir, which requires dosing twice daily. Once FDA approved, there may be a shift from current raltegravir users to elvitegravir because of the reduced dosing requirement. In addition, patients may switch from once a day protease inhibitors (PI) and NNRTI once a daily integrase inhibitor is available. Assuming successful negotiations with the manufacturer by ACTF, it is anticipated the net cost of elvitegravir (after rebates) will be comparable to raltegravir, which is comparable to once daily PIs and NNRTIs. This drug is also being studied as part of the previously discussed "Quad" formulation's trials which are in Phase III. If approved, ADAP will monitor pricing and supplemental rebate negotiations closely.

*Possible approval in 2012.*

### Cobicistat

Cobicistat is being developed both as a pharmacokinetic booster for the integrase inhibitor elvitegravir and as a booster for protease inhibitors. The Phase II study compared efficacy and safety of cobicistat (150 mg) with that of the existing booster ritonavir (100 mg daily). Participants are currently being sought for a Phase III clinical trial to further study cobicistat as a protease inhibitor booster. This drug is also being studied as part of the previously discussed "Quad" formulation's trials which are in Phase III. If approved, ADAP will monitor pricing and supplemental rebate negotiations closely.

*Possible approval in 2013.*

### Dolutegravir

Dolutegravir, a second generation integrase inhibitor with activity against raltegravir-resistant and elvitegravir-resistant HIV, is in Phase III clinical trials.

### Apricitabine

Apricitabine, an investigational NRTI, originally had its development halted in May 2010 after the manufacturer failed to find a licensing partner. In March 2011, the manufacturer reached an agreement with the FDA to receive credit for previous clinical trials and the drug company has indicated plans to move forward with Phase III trials. There is currently no listing for open apricitabine studies in the federal clinical trials database. ADAP will continue to monitor the drugs development.

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

Prevalence reflects the number of people who are currently infected with HIV and thus who could qualify for ADAP currently or sometime in the future. California estimates that between 159,113 and 181,324 living with HIV/AIDS at the end of 2011, as seen in **Table 42**, below. 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 the Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report, (MMWR, June 3, 2011). Living HIV/AIDS cases are estimated to be 45.5 percent White, 18.3 percent African American, 31.2 percent Latino, 3.6 percent Asian/Pacific Islander, and 0.4 percent American Indian/Alaskan Native. Most (65.3 percent) of California's living HIV/AIDS cases are attributed to male-to-male transmission, 7.9 percent is attributed to injection drug use, 9.3 percent to heterosexual transmission, and 7.9 percent to men who have sex with men who also practice injection drug use.

The number of living HIV/AIDS cases in the state is expected to grow by approximately 2 percent (with a range of 2,800– 5,300) each year for the next two years and it is expected that this increasing trend will continue for the foreseeable future. This increase is attributed to stable incidence rates and longer survival of those infected, primarily due to the effectiveness and availability of treatment.

Year	Estimated persons to be reported with HIV (not AIDS) and presumed living*		Persons reported with AIDS and presumed living		Estimated persons living with HIV or AIDS**	
	Low bound	High bound	Low bound	High bound	Low bound	High bound
2009	47,334	55,363	67,223	68,049	153,657	170,564
2010	47,797	56,377	69,036	70,204	156,343	175,987
2011	48,278	57,373	70,888	72,318	159,113	181,324
2012	48,767	58,363	72,761	74,412	161,929	186,616
2013	49,256	59,351	74,647	76,493	164,772	191,881

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

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

## HIV Incidence

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

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

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

California has implemented HIV Incidence Surveillance using the CDC-developed Serologic Testing Algorithm for Recent HIV Seroconversion methodology. Data from this system will be used to revise California incidence estimates in the coming years.

**APPENDIX E: SENSITIVITY ANALYSIS****FY 2011-12**

ADAP conducted a sensitivity analysis exploring the impact on total expenditures by increasing and decreasing the number of clients and the expenditures per client (\$/client). For this sensitivity analysis, we started with the estimated total drug expenditures for FY 2011-12 using the upper bound of the 95 percent confidence interval from the linear regression model and subtracted cost/savings for all assumptions impacting drug expenditures.

For these factors, clients and expenditures per client, we created scenarios ranging from negative 3 percent to positive 3 percent, in 1 percent intervals. Those scenarios labeled as “Hi” represent 3 percent, “Med” represent 2 percent, and “Lo” represents a 1 percent change. The left column in **Table 43** below lists the seven (including no change) scenarios for changes in \$/client, starting with the best case scenario {3 percent decrease in \$/client, Hi(-)} and finishing with the worst case scenario {3 percent increase in \$/client, Hi(+)}. The seven scenarios for changes in client counts are listed across the table.

<b>\$ / Client Scenarios</b>	<b>Number of Client Scenarios</b>						
	<b>Hi (-) CI</b>	<b>Med (-) CI</b>	<b>Lo (-) CI</b>	<b>Zero Change in Clients</b>	<b>Lo (+) CI</b>	<b>Med (+) CI</b>	<b>Hi (+) CI</b>
<b>Hi (-): Best</b>	\$449,216,787	\$453,826,673	\$458,436,558	\$463,046,444	\$467,656,329	\$472,266,215	\$476,876,101
<b>Med (-)</b>	\$453,826,673	\$458,484,083	\$463,141,493	\$467,798,903	\$472,456,313	\$477,113,724	\$481,771,134
<b>Lo (-)</b>	\$458,436,558	\$463,141,493	\$467,846,428	\$472,551,363	\$477,256,297	\$481,961,232	\$486,666,167
<b>Zero Change in \$ / Client</b>	\$463,046,444	\$467,798,903	\$472,551,363	\$477,303,822	\$482,056,281	\$486,808,741	\$491,561,200
<b>Lo (+)</b>	\$467,656,329	\$472,456,313	\$477,256,297	\$482,056,281	\$486,856,265	\$491,656,249	\$496,456,233
<b>Med (+)</b>	\$472,266,215	\$477,113,724	\$481,961,232	\$486,808,741	\$491,656,249	\$496,503,758	\$501,351,266
<b>Hi (+): Worst</b>	\$476,876,101	\$481,771,134	\$486,666,167	\$491,561,200	\$496,456,233	\$501,351,266	\$506,246,300

The center cell highlighted in light blue, shows the revised estimated expenditures for FY 2011-12, using the 95 percent confidence interval from the linear regression model and adjusted for all assumptions. The best case scenario, which is a 3 percent decrease in \$/client coupled with a 3 percent decrease in the number of clients, results in an estimate of \$449.22 million (top left cell, light green). The worst case scenario, a 3 percent increase in \$/client coupled with a 3 percent increase in number of clients, results in an estimate of \$506.25 million (bottom right cell, red). The table provides a range of values to assist in projecting the total expenditures for FY 2011-12.

**FY 2012-13**

Below is the sensitivity analysis for FY 2012-13, using the same logic that was used for FY 2011-12. In this Sensitivity Analysis, ADAP adjusted for several assumptions that impacted ADAP's FY 2012-13 total expenditures and total client count. Similar to the FY 2011-12 Sensitivity Analysis, we started with the estimated total drug expenditures for FY 2012-13 using the upper bound of the 95 percent confidence interval from the linear regression model. Then we subtracted savings for all assumptions. The "baseline" or center cell, highlighted in light blue below, reflects all adjustments to the linear regression expenditure projection. **Table 44** provides a range of values to assist in projecting the total expenditures for FY 2012-13.

\$ / Client Scenarios	Number of Client Scenarios						
	Hi (-) CI	Med (-) CI	Lo (-) CI	Zero Change in Clients	Lo (+) CI	Med (+) CI	Hi (+) CI
<b>Hi (-): Best</b>	\$371,824,554	\$375,640,237	\$379,455,919	\$383,271,602	\$387,087,285	\$390,902,967	\$394,718,650
<b>Med (-)</b>	\$375,640,237	\$379,495,256	\$383,350,276	\$387,205,295	\$391,060,315	\$394,915,334	\$398,770,354
<b>Lo (-)</b>	\$379,455,919	\$383,350,276	\$387,244,632	\$391,138,989	\$395,033,345	\$398,927,701	\$402,822,058
<b>Zero Change in \$ / Client</b>	\$383,271,602	\$387,205,295	\$391,138,989	\$395,072,682	\$399,006,375	\$402,940,069	\$406,873,762
<b>Lo (+)</b>	\$387,087,285	\$391,060,315	\$395,033,345	\$399,006,375	\$402,979,406	\$406,952,436	\$410,925,466
<b>Med (+)</b>	\$390,902,967	\$394,915,334	\$398,927,701	\$402,940,069	\$406,952,436	\$410,964,803	\$414,977,170
<b>Hi (+): Worst</b>	\$394,718,650	\$398,770,354	\$402,822,058	\$406,873,762	\$410,925,466	\$414,977,170	\$419,028,874