2016 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

ADAPs' Optimization of Client Health Outcomes in an Evolving Health Care Landscape

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Disclosures

Presenter(s) has no financial interest to disclose.

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Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Participants will learn how the continuum of ADAP client engagement interplays with the broader HIV care continuum.
2. Participants will learn how ADAPs have expanded their program by capitalizing on the creation of ACA Marketplaces and Medicaid expansion.
3. Participants will be able to identify how ADAPs work in concert with other payers (e.g., Medicaid, Medicare) to reduce health inequities among key populations (e.g., Non-Hispanic Black/African American).

Overview: NASTAD

- Founded in 1992, NASTAD (National Alliance of State & Territorial AIDS Directors) is a non-profit association that represents public health officials who administer HIV and hepatitis health care, prevention, education, and supportive service programs funded by state and federal governments in all 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the U.S. Pacific Islands.

NASTAD Mission

NASTAD’s mission is to end the intersecting epidemics of HIV, viral hepatitis, and related conditions by strengthening domestic and global governmental public health through advocacy, capacity building, and social justice.

NASTAD's vision is a world free of HIV and viral hepatitis.

Overview: ADAP

- ADAP is comprised of two main components that work to safeguard access to care and treatment for people living with HIV (PLWH): (1) the full price purchase of medications and/or (2) the purchase of insurance coverage or payment of co-pays/coinsurance or deductibles on behalf of eligible individuals.
  - Full-pay medication program clients are defined as those individuals who receive medications paid in full by ADAP with no coordination of insurance benefits.
  - Insurance program clients are defined as those who have some type of coverage other than full-pay prescription ADAP (i.e., Qualified Health Plans, employer-sponsored coverage, Medicaid, Medicare) and for whom ADAP pays the premiums, deductibles, and/or co-payments/co-insurance.

Overview: NASTAD ADAP Surveys & Requests for Information (RFIs)

- The following surveys and requests for information allow NASTAD to glean information on program composition and impact of health landscape changes on ADAPs:
  - National ADAP Monitoring Project Survey
  - National ADAP Formulary Survey
  - Annual ADAP Affordable Care Act (ACA) RFI

National ADAP Monitoring Project

- The National ADAP Monitoring Project is NASTAD's long-standing effort to document new developments and challenges faced by AIDS Drug Assistance Programs (ADAPs), assessing key trends over time and providing the latest available data on the status of ADAPs. The National ADAP Monitoring Project is a component of NASTAD's National ADAP Monitoring and Technical Assistance Program which provides ongoing technical assistance to all state and territorial ADAPs.
  - National ADAP Monitoring Project *Annual Report*
  - National ADAP Monitoring Project Formulary Database

National ADAP Formulary Database

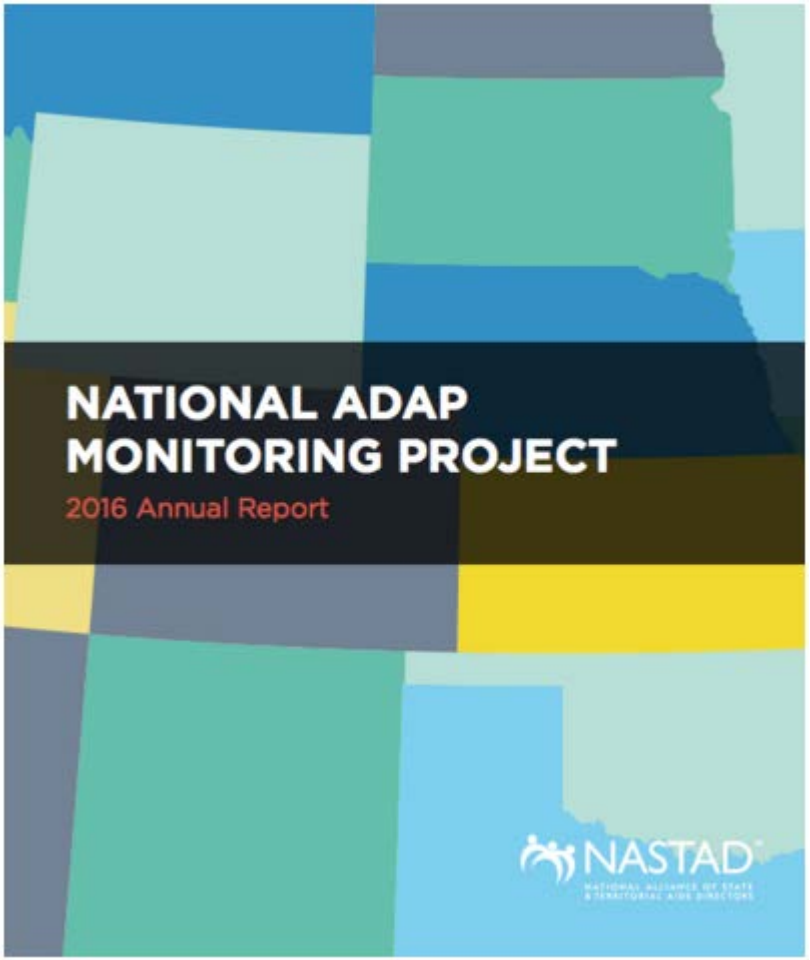
- First launched in June 2014, the National ADAP Formulary Database provides an online, searchable, publicly available resource detailing state-by-state ADAP coverage of medications both individually and by drug class including HIV antiretroviral (ARV) treatments, “A1” Opportunistic Infections (A1 OI) medications, treatments for hepatitis B and C, mental health and substance use treatment medications, and various vaccines and laboratory tests.
- The Database includes results from 49 states as well as the District of Columbia and Puerto Rico as of December 31, 2015.

National ADAP Formulary Database

- The Ryan White HIV/AIDS Program Section 2616(c)(6) of the Public Health Service Act contains language that places the following requirements on ADAP formularies:
  - (1) ADAP formularies must include at least one drug from each class of HIV antiretroviral medications;
  - (2) ADAP funds may only be used to purchase medications approved by the Food and Drug Administration (FDA) or devices needed to administer them; they must be consistent with the Department of Health and Human Services' (HHS) Adolescent and Adult HIV/AIDS Treatment Guidelines; and all treatments and ancillary devices covered by the ADAP formulary, as well as all ADAP-funded services must be equitably available to all eligible/enrolled individuals within a given jurisdiction.

National ADAP Monitoring Project *Annual Report* (*The Report*)

- Since 1996, NASTAD has provided comprehensive information on AIDS Drug Assistance Programs (ADAPs) through *The Report*, which contains background information as well as detailed findings and corresponding charts and tables.



National ADAP Monitoring Project *Annual Report* (*The Report*)

- *The Report* provides NASTAD with critical information that informs our efforts on behalf of ADAPs, including: technical assistance activities; advocacy and policy; and stakeholder education.
- The data included in *The Report* is generated from an online survey distributed to all ADAPs annually. Longitudinal data is also included.
  - Budget
  - Program Expenditures
  - Enrollment & Utilization
  - Client Demographics
  - Client Health Outcomes
  - Program and Administration Management

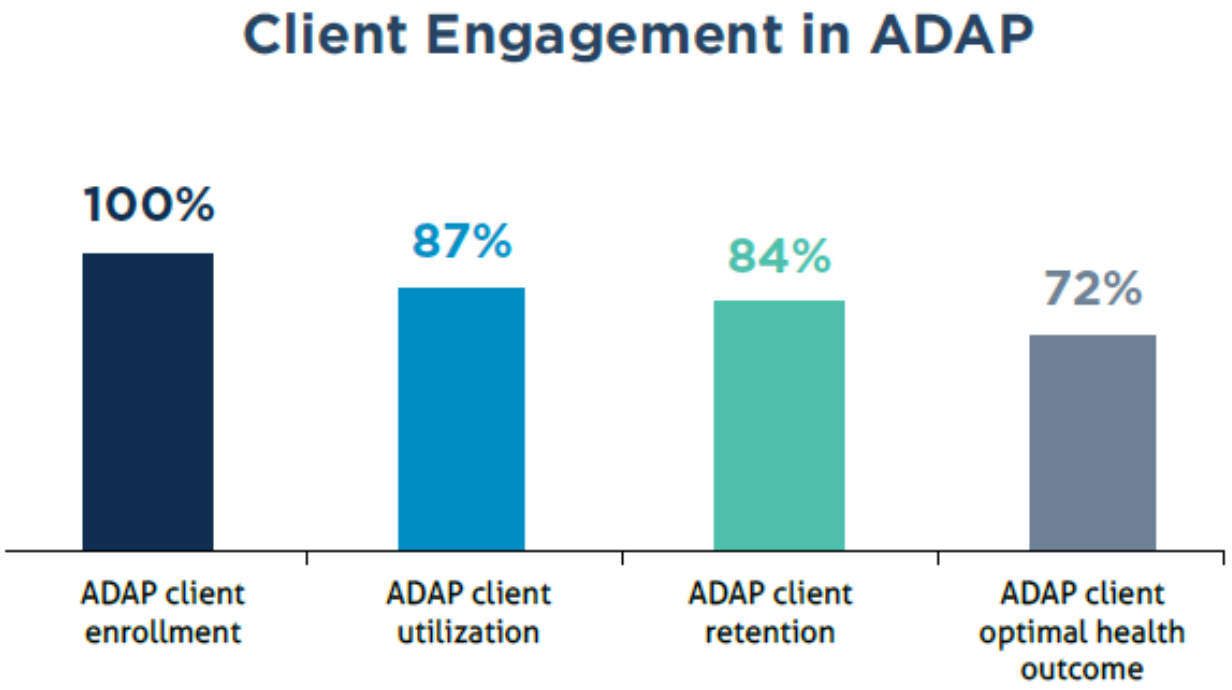
National ADAP Monitoring Project *Annual Report* (*The Report*)

- *The Report* has evolved in order to illustrate the impact of the full implementation of the Affordable Care Act (ACA) on ADAPs and the clients they serve.
  - **Shifts in enrollment and utilization** - ADAPs continue to assist clients in transitioning to new forms of coverage such as Medicaid and Qualified Health Plans. Enrollment has shifted dramatically such that greater numbers of clients are insured.
  - **Improved health outcomes (i.e., viral load)** - The majority (72%) of all clients served by ADAPs in June 2015 were reported as virally suppressed, defined as having a viral load that is less than or equal to 200 copies/mL. By comparison, 87% of all clients served by ADAP-funded insurance programs in June 2015 were reported as virally suppressed.
  - **Program expansions** – As increasing numbers of clients gain insurance coverage, ADAPs are poised to generate significant expansions to their programs, including broadening formulary coverage (e.g., directly-acting antiviral hepatitis C medications), expanding ADAP eligibility, and bolstering ADAP infrastructure.

2016 National ADAP Monitoring Project Survey

- The 2016 National ADAP Monitoring Project Survey is in the field, with the resulting *Annual Report* available in fall of this year. Select preliminary data is included in this presentation.
- Key changes to the National ADAP Monitoring Project Survey include:
  - Alignment with the most recent reporting period used in the ADAP Data Report (ADR) (i.e., January 1 – December 31, 2015), including questions on client utilization, client demographics, and expenditures.
  - Inclusion of key questions regarding the Ryan White Part B program such as utilization, expenditures, and viral load suppression.
  - Emphasis on health equity and health disparities. For example, questions regarding viral load suppression among specific sub-populations (e.g., by race/ethnicity) have been added.

Engagement in Care



ADAP client enrollment
The number of clients enrolled by ADAP in FY2014

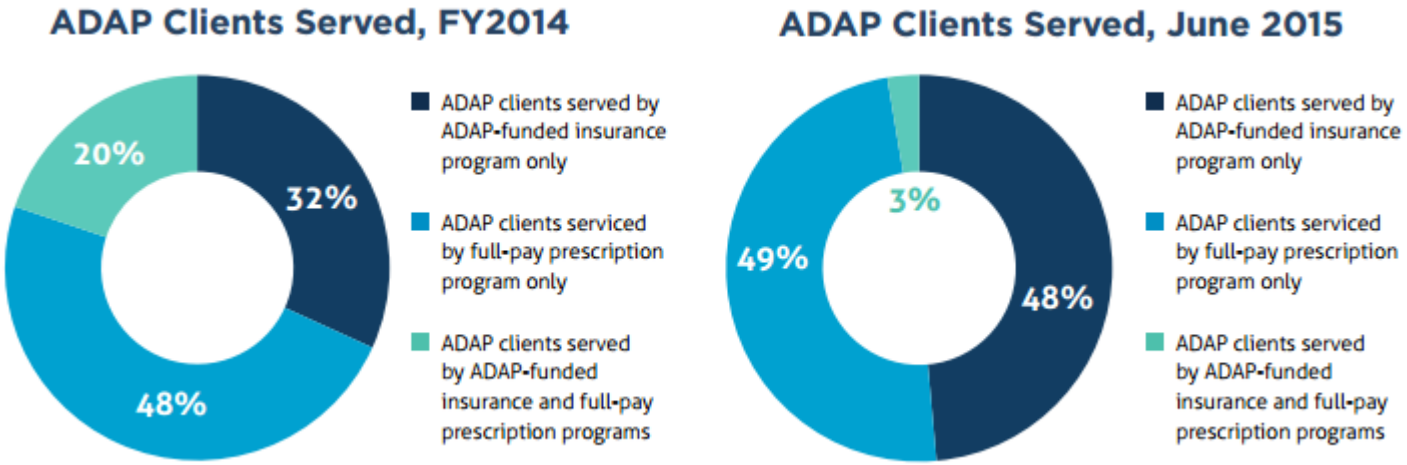
ADAP client utilization
The number of clients served by ADAP (receiving medications) in FY2014

ADAP client retention
The number of clients who were successfully recertified twice in a 12-month period of time by ADAP

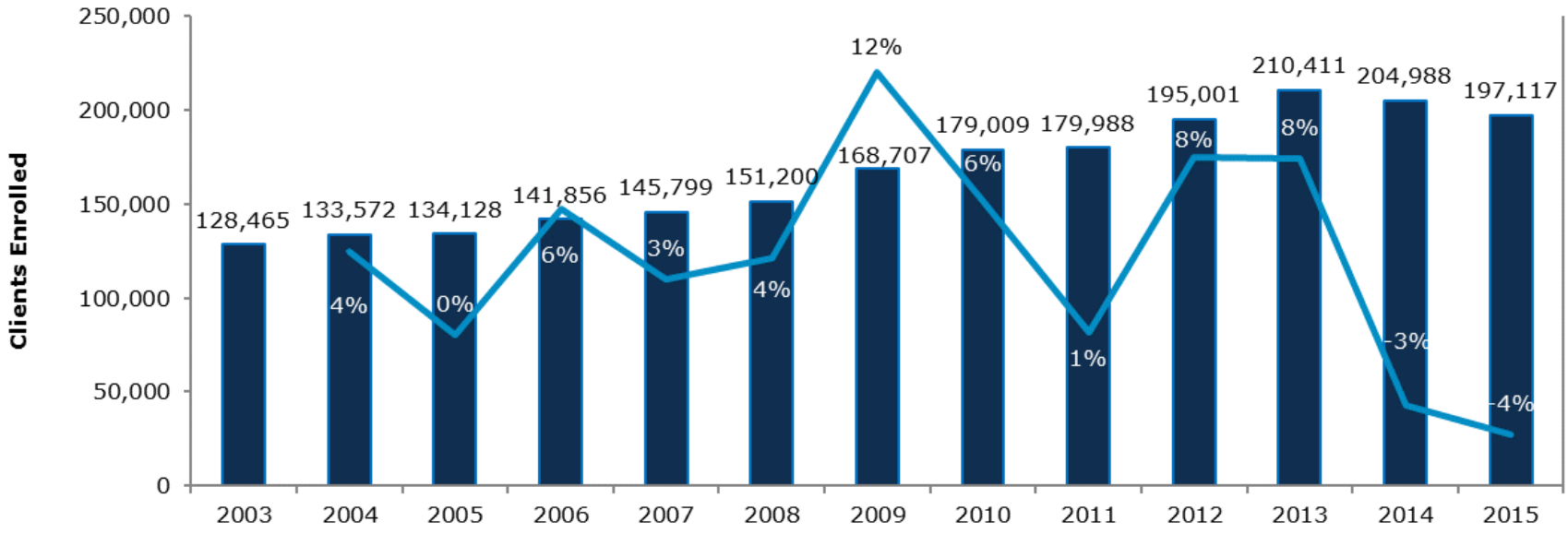
ADAP client health outcome
The number of clients served by ADAP who reported a suppressed viral load in June 2015.

Client Utilization: FY2014 vs. June 2015

Over the course of twelve months, ADAPs serve 64% more clients than they do in a single month for various reasons, including payment of insurance plans (cost-sharing payments decrease after clients meet their out-of-pocket maximum) and clients churning between payer sources due to fluctuations in income and life circumstances (e.g., income, employment).

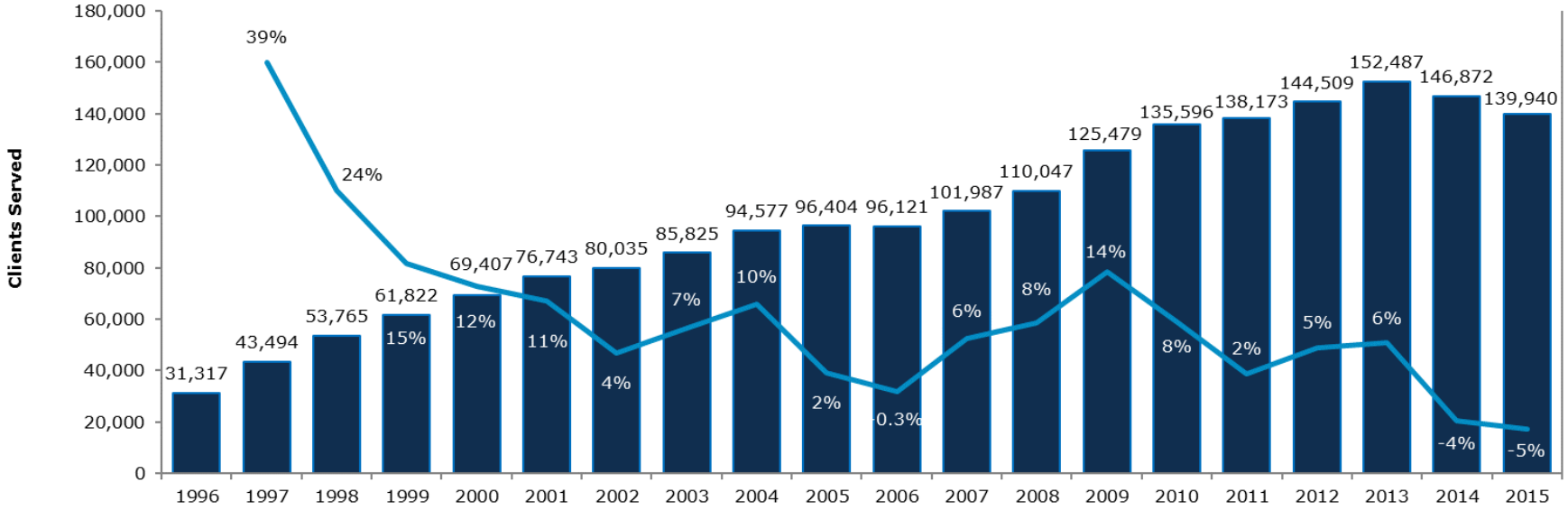


ADAP Client Enrollment, June 2003-2015



Note: Includes clients enrolled by ADAPs reporting data for June in a given year. Data on client enrollment in ADAP is not available prior to June 2003. Percentages noted represent changes between the two years indicated, not aggregate since 2003.

ADAP Client Utilization, June 1996-2015



Note: Includes clients served by ADAPs reporting data for June in a given year. Percentages noted represent changes between the two years indicated, not aggregate since 1996.

ADAP Clients Served, by Viral Load

- ADAP clients achieve optimal health outcomes (e.g., suppressed viral load) at a rate higher than among all people living with HIV (PLWH)
  - Nationally, 30% of all PLWH are reported as having a suppressed viral load
- 72% of all clients served by ADAP in June 2015 reported a suppressed viral load over a 12-month period
  - 63% of all clients served by ADAP in June 2014 reported a suppressed viral load over a 12-month period
- 87% of clients served by ADAP-funded insurance program reported as suppressed viral load

Viral Load Suppression: Policy Implications

- ADAPs play a critical role in efforts to end the HIV epidemic nationally by having a measurable impact on multiple “bars” within the HIV prevention to care continuum, most notably linkage to and retention in care and treatment as well as viral load suppression.
- The National HIV/AIDS Strategy emphasizes the need for “seamless systems to link people to care immediately after diagnosis and support retention in care to achieve viral suppression that can maximize the benefits of early treatment and reduce transmission risk.” ADAP is such a system.

ADAP-Funded Insurance

- The Ryan White Program allows states to use ADAP funds to purchase health insurance and pay insurance premiums, co-payments and/or deductibles for individuals eligible for ADAP, provided the insurance has comparable formulary benefits to that of the ADAP and is cost-effective to the ADAP.
- The majority of ADAPs pay premiums (84%), deductibles (83%) and prescription co-payments/co-insurance (90%) on behalf of eligible clients. Half of ADAPs also pay medical co-payments/coinsurance on behalf of clients.
- Insurance continuation is cost-effective to the ADAP program with a lower average cost per client ($444) relative to full-pay prescriptions ($1,678).

Client Enrollment & Engagement

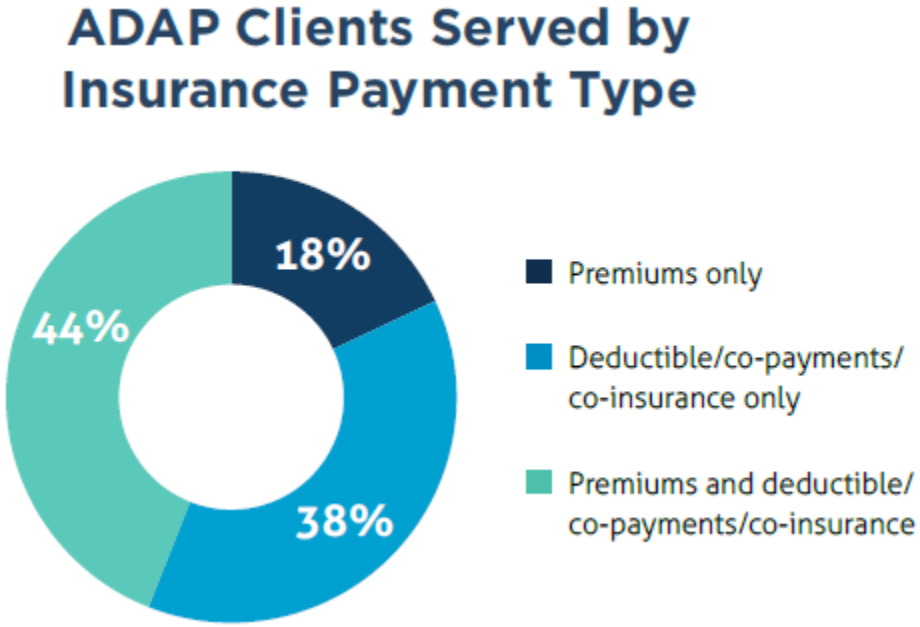
Clients Served:	FY2013	FY2014
ADAP-funded insurance program[1] ONLY	33%	32%
ADAP full-pay prescription program ONLY	60%	48%
ADAP-funded insurance program[1] AND full-pay prescription program	7%	20%

In June 2015, the number of clients served by the full-pay medication component of ADAPs was 8% less than the number of clients that were served through this approach in June 2002. The number of clients served by ADAP-funded insurance purchasing increased by 1162% between 2002 and 2015 which now includes more than 70,000 individuals.

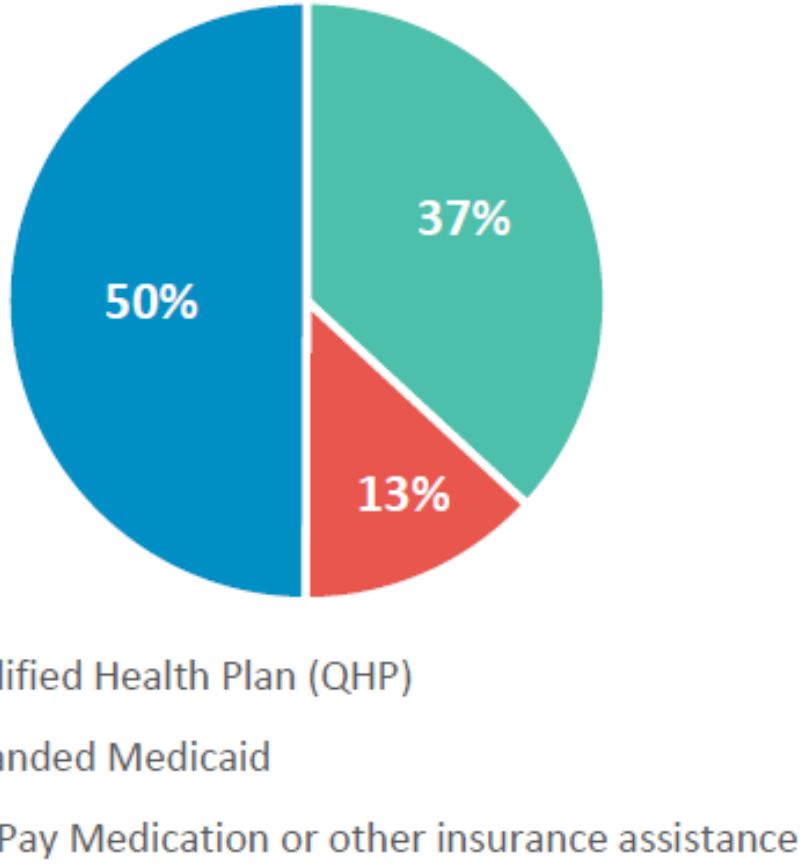
[1] Clients served via an ADAP-funded insurance program are those ADAP made one or more premium, deductible, or co-payment/cost-sharing payment on behalf of.

ADAP Ensures Continuous Access to Insurance

- ADAP remains the primary payer for those individuals whose insurance cost-sharing responsibilities are a barrier to purchasing and maintaining insurance

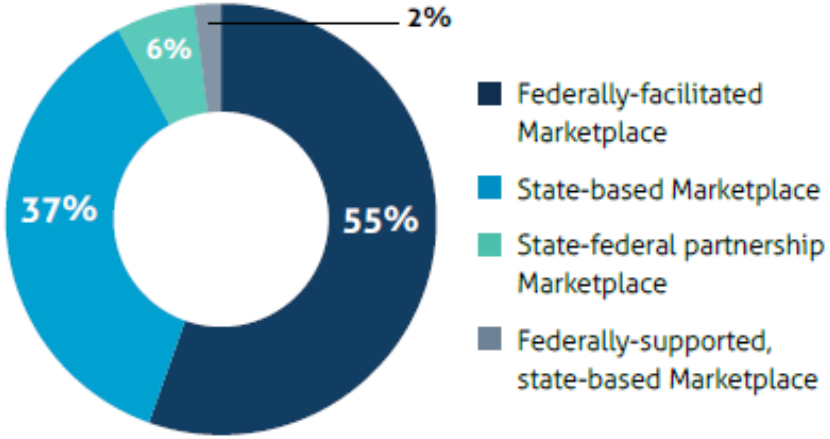


New Health Care Coverage: 2016 Open Enrollment Period

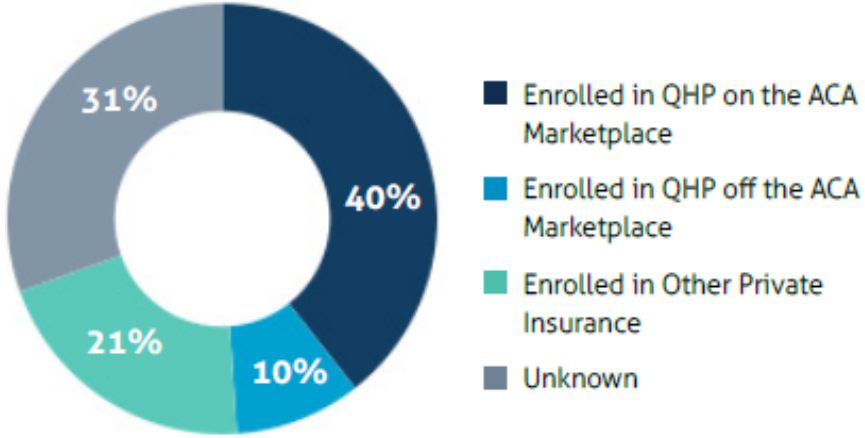


New Health Care Coverage

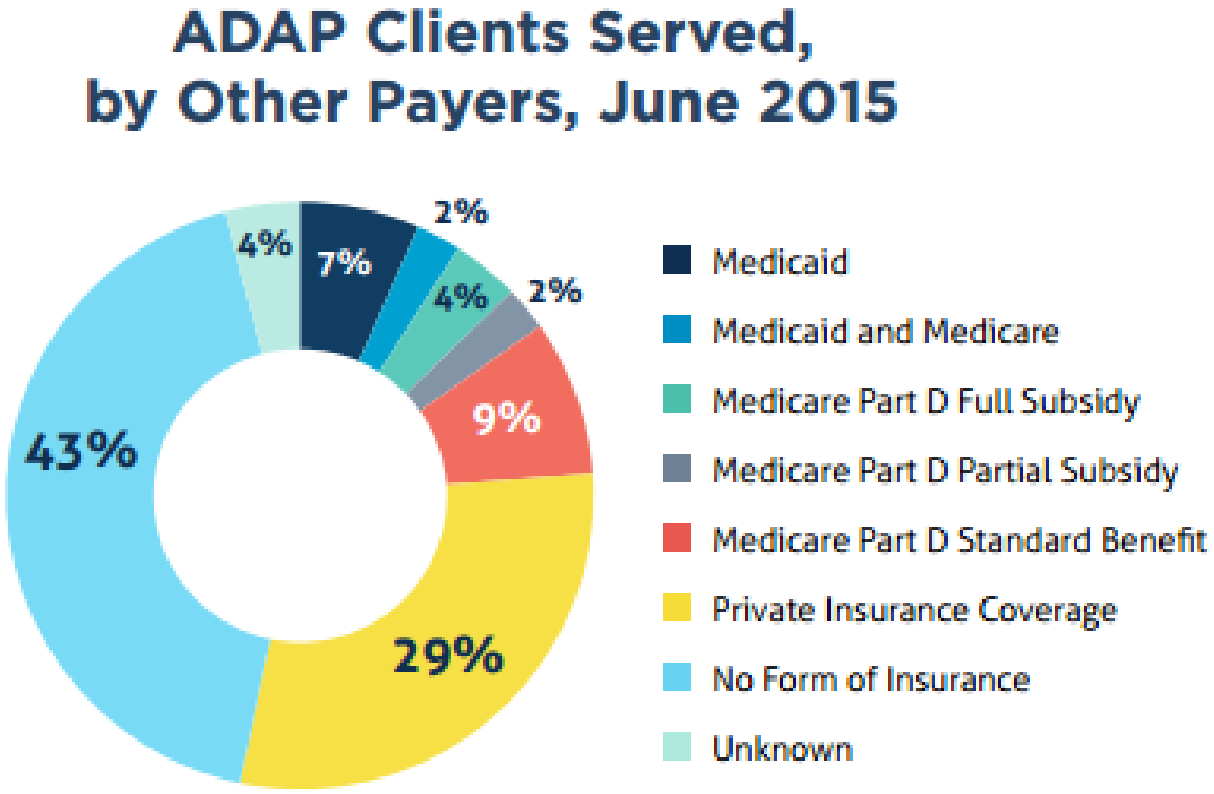
ADAP Clients Served, by ACA Marketplace Type



Insured ADAP Clients Served, by Private Plan Type, June 2015



Other Payers

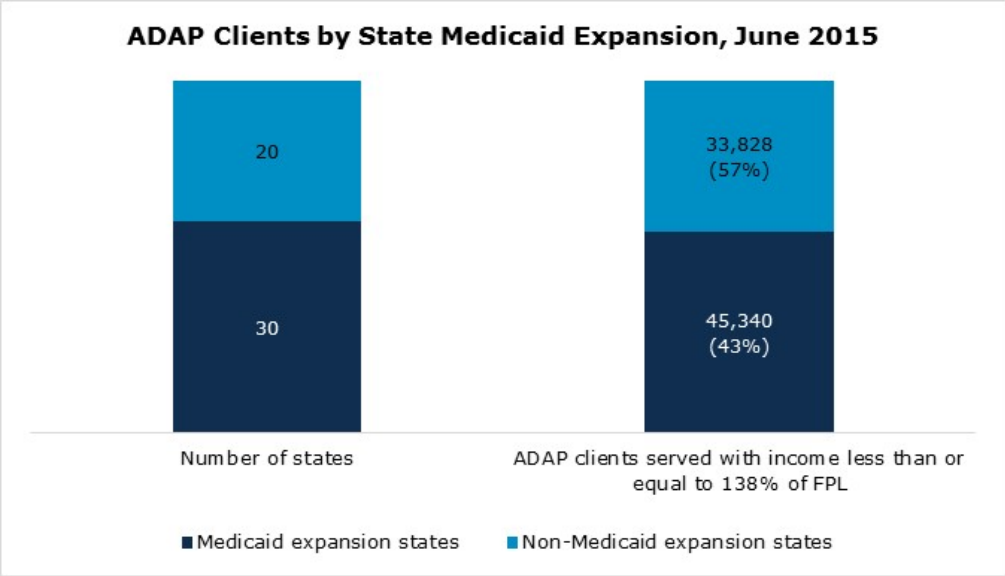


Disparities among Non-Medicaid Expansion States

- Health reform throughout the U.S. has been implemented unequally across states, creating new disparities and illuminating further stressors on the public health system.
- 46% of clients served in June 2015 reside in the 20 states in which Medicaid eligibility had not been expanded to 138% of FPL
- 17 of these ADAPs purchase insurance for one or more clients

Disparities among Non-Medicaid Expansion States

- 45,340 ADAP clients served in June 2015 have incomes below 138% of FPL and live in a non-Medicaid expansion state
- These clients would be eligible to transition to Medicaid if their state chose to expand Medicaid eligibility



ADAP Data Assists Policy Efforts

- ADAP data is critical for justifying the Ryan White Program to Congress
- ADAP and the Ryan White Program are incredibly successful in achieving viral suppression
- This data will also be used to inform the evolution of the Ryan White Program

ADAPs' Impact on Health Disparities

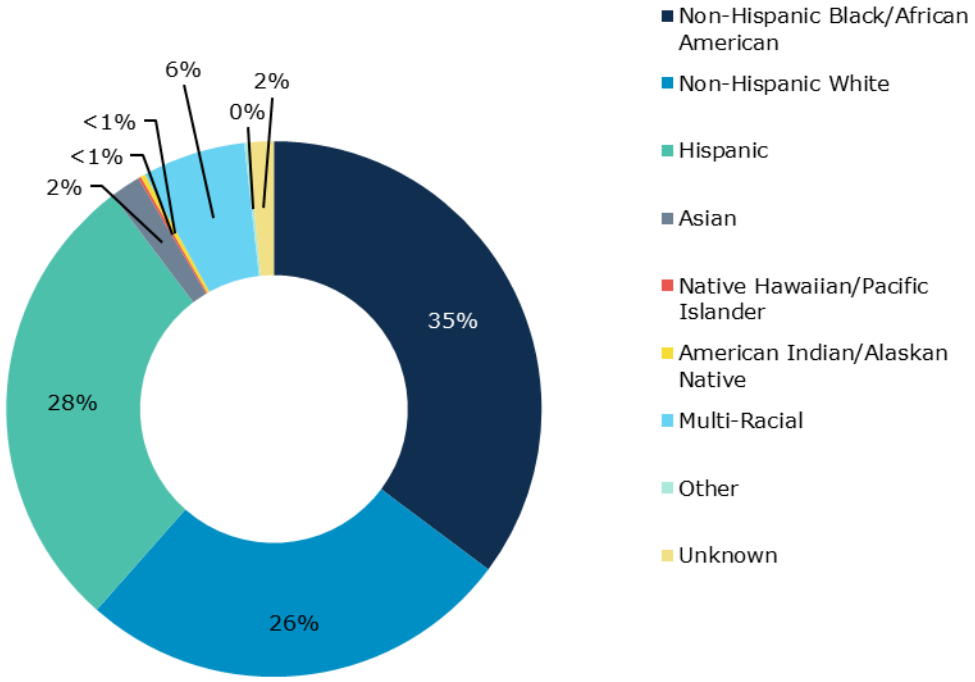
- Through their provision of full-pay prescription medications and insurance continuation services, ADAPs are well positioned to bolster efforts to reduce health inequities and disparities among the clients they serve. These include: by residency in Medicaid vs. non-Medicaid states; by race/ethnicity; by gender; by age; and by income level.
- The demographics (i.e., race/ethnicity, gender, age, and income level) of ADAP clients served have remained constant across multiple years.

ADAP Clients Served, by Race/Ethnicity, June 2012-2015

- ADAP race/ethnicity demographics have shifted slightly over the last four years with increasing enrollment of individuals identifying as non-Hispanic Black and Hispanic increasing over that period of time and all other demographic groups decreasing over the same period or time.

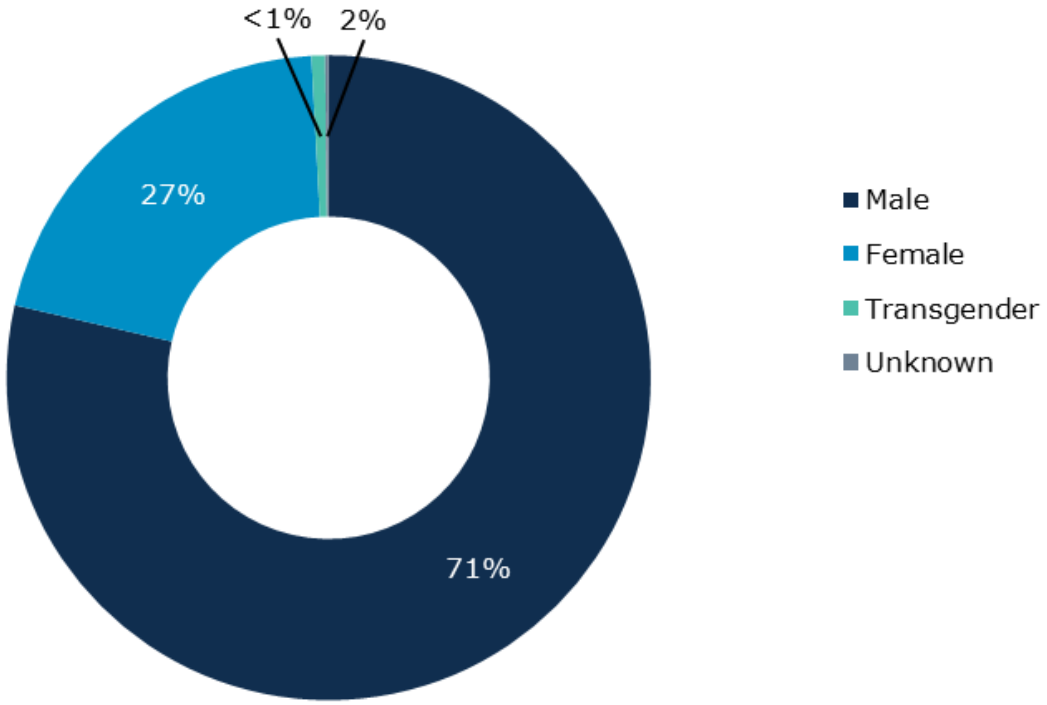
  - Non-Hispanic Black/African American – 32% in 2012 to 35% in 2015
  - Non-Hispanic White – 34% in 2012 to 31% in 2015
  - Hispanic – 23% in 2012 to 28% in 2015

Highest Prevalence States'[1] ADAP Clients Served, by Race/Ethnicity, Calendar Year 2015



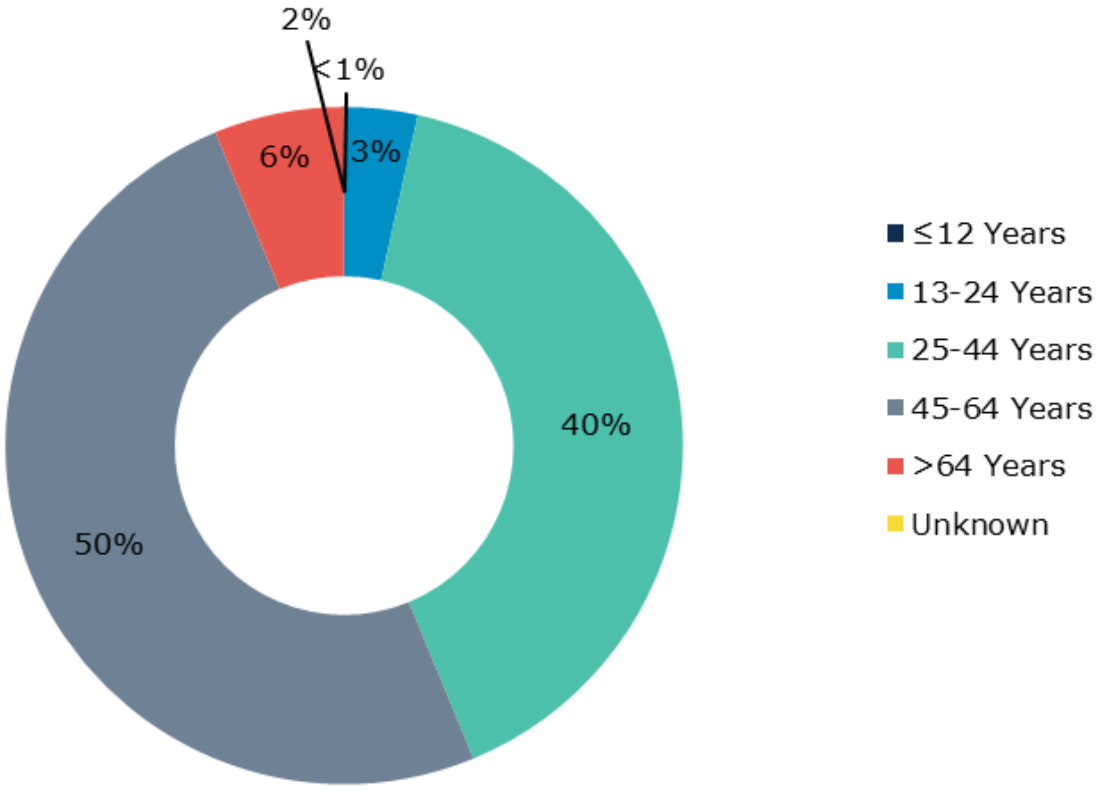
[1] Includes: California, Florida, Georgia, Illinois, New York, North Carolina, Pennsylvania, Puerto Rico, Texas and Virginia.

Highest Prevalence States'[1] ADAP Clients Served, by Gender, Calendar Year 2015



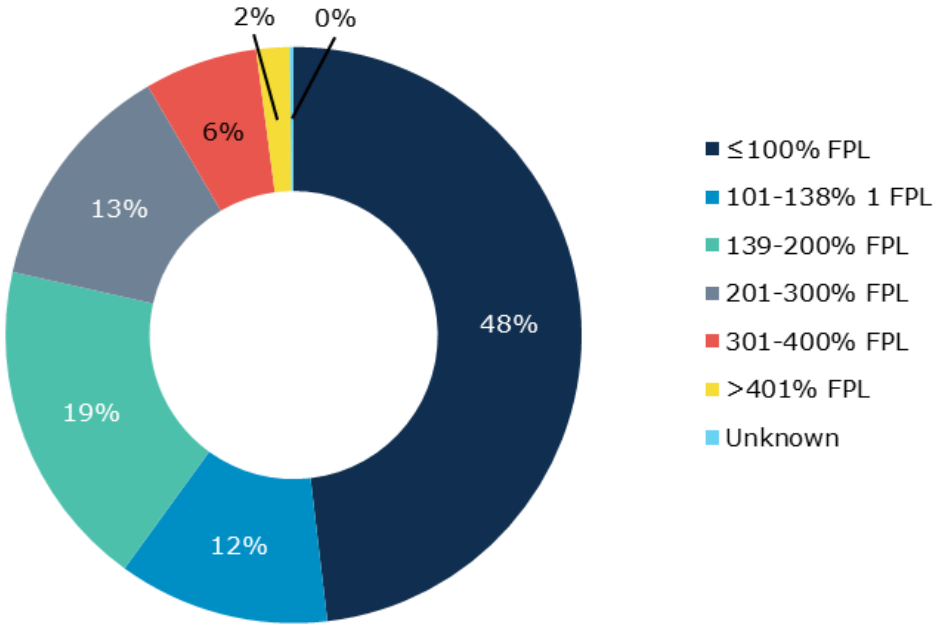
[1] Includes: California, Florida, Georgia, Illinois, New York, North Carolina, Pennsylvania, Puerto Rico, Texas and Virginia.

Highest Prevalence States'[1] ADAP Clients Served, by Age, Calendar Year 2015



[1] Includes: California, Florida, Georgia, Illinois, New York, North Carolina, Pennsylvania, Puerto Rico, Texas and Virginia.

Highest Prevalence State ADAP Clients Served, by Income Level, Calendar Year 2015



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