A Public Health Service Bureau White Paper

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Limited ADAP Funding Requires National Solution

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Introduction

In 1990, the Ryan White CARE Act (RWCA) was enacted to aid in the care of uninsured and underinsured HIV and AIDS patients across the country.

While, the Act has been reauthorized three times since its inception, in 1996, 2000 and 2006, the overall funding of the RWCA is continually unable to meet growing patient demand. Nowhere is this more evident than at the state level.

In the coming years, demands on State AIDS Drug Assistance Programs (ADAPs), which are funded through Title II (Part B) of the Ryan White CARE Act[1], should continue to increase due to a number of issues, including:

- **Continued innovation in the HIV/AIDS treatment arena**: In addition to recently approved drugs which carry larger price tags, additional drugs are expected to reach the market in the years ahead resulting in additional costs to State ADAPs[2]
- **The addition of supplemental drugs to State formularies to treat the whole patient**: Additional drugs to treat conditions beyond HIV/AIDS are required to ensure patients continue to successfully manage their disease[3]
- **The prevalence of other payers including Medicaid and Medicare**: ADAP programs are the payer of last resort. These programs face increasing pressure to ensure payer of last resort status in a multi-payer environment

While patient demand increases, ADAPs have endured funding shortfalls year in and year out, resulting in the implementation of cost-cutting strategies that reduce the quality of care available to those living with HIV/AIDS, as well as the percentage of those impacted that can receive treatment. Without changes, our ADAP programs will continue to suffer[4].

In FY2007 alone, ADAPs will receive $789 million in funding from the federal earmark, representing flat funding from FY2006[1]. The estimated increase in federal funding needed to meet demand for FY2008 is nearly ***$233 million***[5].

This gap creates challenges that need to be addressed.

Besides increased funding for HIV/AIDS related programs, recipients need to look for ways to maximize the value of allocated government resources, so that they can serve more people with what they have. Maximizing value can be done, in large part, by addressing inefficiencies that exist in the implementation of ADAP programs.

This paper focuses on a few challenges faced by State ADAPs and proposes a potential solution that could assist in delivering more funding through each state's program, to those who truly have no other options.

Current Challenges in ADAP Management

State ADAPs face many challenges in their operation. According to the National Alliance of State and Territorial AIDS Directors (NASTAD), the increased demand on ADAP resources available to serve the HIV/AIDS population that requires ADAP services have led to the implementation of cost-containment strategies, including waiting lists, enrollment caps for ADAPs and/or specific drug access criteria, formulary limitations and expenditure limits. As of January 2007, four states had instituted waiting lists. In addition, since April 2006, six states have implemented other cost-containment strategies[4].

Overall Quality Management

The Ryan White Program requires that ADAPs function as the payer of last resort for those who are not covered by other sources, such as Medicaid, Medicare or other private insurance. Given the current systems in place, this can be particularly difficult to ensure. For example, a September 2005 report completed by the Department of Health and Human Services Office of Inspector General (OIG), entitled "Review of Ryan White Title II Funds at the Puerto Rico Health Department," helped illustrate the potential magnitude of this issue. Specifically, the report referred to payer of last resort issues identified in Puerto Rico's ADAP program (the ninth largest funded program in program year 2001-2002). The OIG found that from a sample of 100 clients who received medications using Title II funds, 81 clients had other sources of potential coverage, including the Puerto Rico Health Reform Program, private health insurance and Medicare. Based on OIG's sample and analysis, the audit concluded that "the Health Department may not have used the CARE Act Title II program as the payer of last resort [6]. Furthermore, the audit found that 54 drugs were covered by Puerto Rico's ADAP program and the Puerto Rico Health Reform Program. Because of the overlap in formularies and the high percentage of ADAP patients with alternative sources of coverage, it's possible drugs provided by Puerto Rico's ADAP program could have been provided to patients through the country's Health Reform Program. For Puerto Rico's ADAP, the total costs of the 54 drugs in question was $10,346,750. If Puerto Rico had a system in place that could identify each patients sources of coverage, the potential savings could have been significant.

Puerto Rico is not the only program with a large proportion of patients with other payers. The Washington State HIV Client Services Program serves a similar proportion of clients with other coverage. However, Washington State has a system in place to efficiently review each candidate and establish if they qualify for ADAP assistance. The system allows Washington to accurately coordinate client benefits allowing for better utilization of funds by effectively enforcing the payer of last resort status. The Washington State HIV Client Services Program, in its 2006 request for proposal N15130, estimated approximately 2,460 prescriptions per month in which the Program was the primary payer and 1,640 prescriptions per month in which another payer would be involved. The prevalence of third party payers in both Puerto

Rico and Washington State illustrates the need and potential benefit of managing the program's payer of last resort requirement.

Another situation contributing to ADAP budget constraints is benefits abuse. One example is when a patient utilizes ADAP services in both their home state and an adjacent state. This is particularly prevalent where bordering states' ADAP programs offer significantly different benefits. Patients in need of life saving medications will gravitate towards the programs with more extensive benefits when they are able.

By having a mechanism to compare state rosters, two bordering states could determine if they shared clients. With an average cost of therapy per ADAP client per month of $1,061 for FY2007, according to projections by The National ADAP Working Group, states could save more than $125,000 for every 10 duplicates located. If even 1 percent of the 134,000 clients[3] enrolled in ADAPs nationally were identified as clients in two different State ADAPs, it could represent a potential savings of more than $17 million which could be used to serve additional clients or improve formulary access for existing clients.

Emergency Preparedness

In recent years, natural disasters such as Hurricane Katrina have highlighted the importance of emergency preparedness provisions, especially in the treatment of HIV and AIDS patients. When Katrina hit, more than 21,000 people living with HIV/AIDS were in the areas affected by the disaster[9]. States, such as Texas, which saw an influx of evacuees, scrambled to provide services to ADAP clients from surrounding states. Charles Henley, Manager for the HIV Services Section for Harris County Public Health and Environmental Services in Texas, in a previous article focused on HIV/AIDS patient migrations to Texas during Katrina and cited the need to loosen eligibility requirements because most evacuees had no documentation of their HIV status[10].

Although the desire to loosen requirements is understandable under the circumstance, it may cause more problems then it solves. Loosening standards for treatment could lead to an inefficient use of funds, with states providing services to those who may not be eligible under the provisions of Ryan White Program.

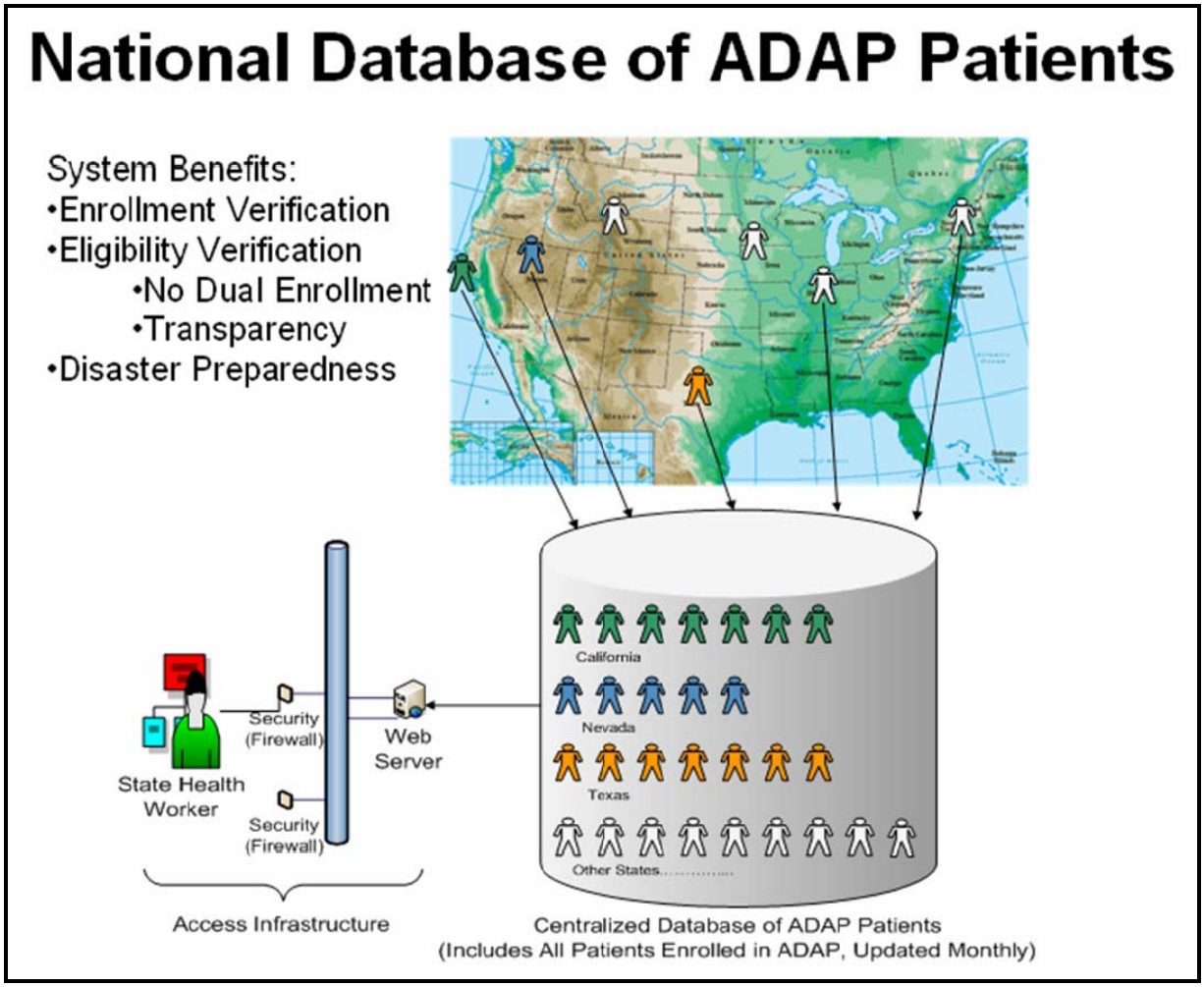
Due to the current systems in place, the Texas ADAP and other state ADAP programs were unable to quickly verify the eligibility of tens of thousands of HIV/AIDS patients from areas impacted by Katrina. The consequences had the potential to be significant for HIV/AIDS patients since most experts agree that stopping HIV/AIDS medications for only a short period of time can result in drug resistance. This puts the patient's health at risk and requires more resources to determine the appropriate new drug cocktail to treat the individual[11]. If a patient's health deteriorates, it could result in hospitalization which is more costly than providing the drugs themselves. The potential human and economic toll is staggering. Creating a solution that allows

one state to easily verify the eligibility of a patient from another state could help resolve this type of situation if and when a future disaster occurs.

Maximizing ADAP Funding: A New Opportunity

These unique set of challenges represents an opportunity to improve overall ADAP quality management through the implementation of a system designed to maximize currently available ADAP funding and ensure continuity of care in the case of an emergency.

The creation of a national database of State ADAP information is an ideal solution to help States maximize funding and ensure that they can serve as many qualified clients as possible with the funding available. This HIPAA-compliant platform would connect individual state ADAP databases to a national database, enabling easy cross referencing of information to ensure applicants are qualified to enroll in their State ADAP. Additionally, once operational, a cross-reference of current State information could be conducted to determine whether current clients might be enrolled in two state ADAPs.



This solution would permit States to maintain their individual autonomy over their ADAPs and could be implemented with minimal modifications, allowing states to continue to use current forms and methods of enrollment. The selected information would be uploaded to the enrollment database and maintained on an encrypted and secure server on a state-by-state basis, ensuring information is kept independent and confidential. In case of an emergency, ADAPs could easily access eligibility information for those displaced citizens seeking services in their state.

The information stored in the enrollment database could also be compared with private and government-funded insurer client lists to ensure that ADAPs are truly functioning as the payer of last resort as intended by the Ryan White Program. If this were enacted, all States and Territories would have access to the same type of solution used in Washington. Currently, not all States leverage this type of system, resulting in potentially inefficient use of ADAP funds.

For such a solution to work, States would simply provide their existing enrollment data and the system would do the cross-referencing. Additional data, such as drug utilization, could be uploaded to the system to complete trend analyses and assist States with their ADAP budgeting process.

Why a National Enrollment Database Should Be Implemented

The creation of a national enrollment database of State ADAP data would significantly improve the quality management of the program.

Maximizes Available Funds: With current budget constraints on State ADAPs, every opportunity to improve eligibility screening and verification can save money and lead to cost savings that matter to patients who desperately need care.

Eases Cost-Containment Strategies: The elimination of benefit abuse with other ADAPs and health insurers may allow States to fund additional care for patients on waiting lists, perhaps eliminating these lists altogether, and potentially increase formularies. It will also help ensure that ADAPs are truly the payers of last resort.

Allows for Accurate Forecasting: By maintaining a central repository of data with accurate counts that eliminate duplicate entries, States can more accurately forecast growth, expenditures and trends, which will ultimately help with reauthorization language for the Ryan White CARE Act.

Maintains State Autonomy: The HIPAA-compliant national enrollment database does not require an overhaul to the current methods employed by State ADAPs and would maintain high security standards to ensure client confidentiality. The system also allows States to maintain their data separately while benefiting from the resources of a national system.

Provides for Disaster Recovery: In the event of a disaster, data is contained in a central, secure location allowing a State that is affected by the disaster to access eligibility information and recover records without recreating files. It also allows other States to verify eligibility for displaced citizens to ensure continuity of care for ADAP clients.

Conclusion

In an environment where ADAP demand outpaces available resources, a national enrollment database can help State ADAPs improve overall quality management of their programs by maximizing limited funding and ensuring emergency preparedness. These improvements would allow states to potentially serve additional clients or improve formularies within their existing ADAP budgets. This proposed solution is one step in helping to revitalize the system brought forth by the Ryan White Program, however, there is still more to be done. It is time for all parties involved with this legislation to come together to begin addressing ADAP issues relating to the Ryan White Program Act so that funding challenges can be minimized in the future.

A future white paper will examine how a national enrollment system can be developed that allows each state to maintain its autonomy, security requirements and current enrollment practices.

The ideas and opinions expressed in this white paper are those of Public Health Service Bureau along.

About Public Health Service Bureau

Public Health Service Bureau, a subsidiary of Ramsell Holding Corporation, is a highly efficient pharmacy benefits administrator and information management company that provides customized services for public health programs. Its proprietary software and healthcare expertise enables health care entities to make funds go further, thereby assuring that patients have access to life-sustaining medications they need to survive and thrive. As an important commitment of the Ramsell family of businesses to give back to the community they serve, Public Health Service Bureau gives a portion of its profits to the Flowers Heritage Foundation, a non-profit organization with programs that include funding medications for ADAP waitlisted patients, and AIDS awareness programs for High School students. Public Health Service Bureau is based in Oakland, California. For more information on Public Health Service Bureau, go to: www.phsb.com

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