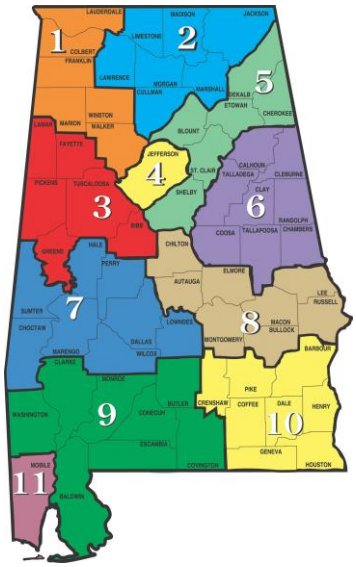
State of Alabama

Ryan White HIV/AIDS Program

AIDS Drug Assistance Program (ADAP) and

Part B Core Medical and Support Services

Report



This report reflects clients receiving services as of, December 31, 2017

Prepared by:

Division of HIV Prevention and Care

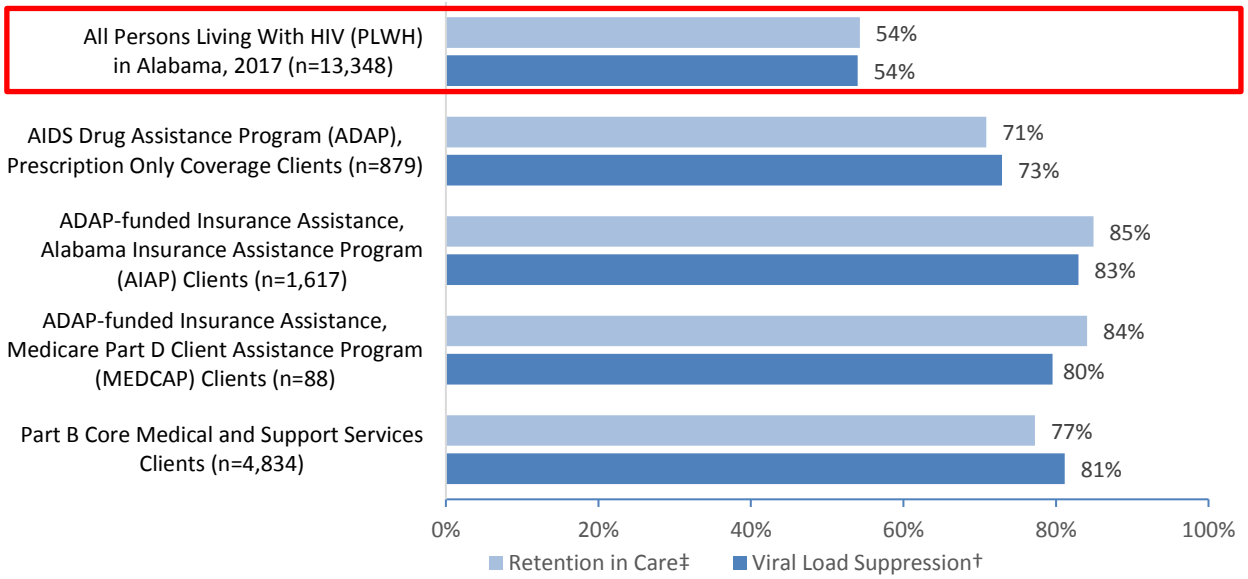
Direct Care Management Services Branch

For additional information, please visit http://alabamapublichealth.gov/hiv

The Health Resources and Services Administration (HRSA), Ryan White HIV/AIDS Program (RWHAP) supports a comprehensive system of care that ensures ongoing access to high quality HIV care, treatment, and support services. The RWHAP provides services to low-income people living with HIV (PLWH), as well as their families, who have no health care coverage (public or private), have insufficient health care coverage, or lack financial resources to get the HIV care and treatment they need to achieve positive health outcomes. Alabama's RWHAP Part B provides continuous access to life-saving treatment and care for low-income, uninsured, and underinsured PLWH in Alabama through the AIDS Drug Assistance Program (ADAP) and Part B core medical and support services. Together, ADAP and Part B services provide seamless care and support across the HIV care continuum and play an integral role in the achievement of the National HIV/AIDS Strategy (NHAS) updated goals for 2020, which include: 1) reducing new HIV infections; 2) increasing access to care and improving health outcomes for PLWH; 3) reducing HIV-related disparities and health inequities; and 4) achieving a more coordinated national response to the HIV epidemic. PWLH who achieve and maintain viral suppression are 96 percent less likely to pass HIV on to their sexual partners. For PLWH who reach undetectable levels, there are no documented cases of sexual transmission. This is the premise of the Prevention Access Campaign's Undetectable Equals Untransmittable (U=U) initiative, which the Centers for Disease Control and Prevention supports agreeing there is "effectively no risk" of sexually transmitting HIV when on treatment and undetectable.

RWHAP Part B clients receiving ADAP and Part B core medical and support services experience improved health outcomes compared to all other persons living with HIV in Alabama. Both ADAP and Part B services have a measurable impact on HIV continuum of care, retention in care and viral load suppression measures, compared to retention in care and viral suppression among all PLWH in Alabama. Specifically, RWHAP Part B clients receiving ADAP and Part B core medical and support services are closer to achieving the National HIV/AIDS Strategy (NHAS) goal of 90 percent retention in care and many have already met or surpassed the NHAS 2020 goal of 80 percent viral suppression, compared to only 54 percent retention in care and virally suppressed among all PLWH in Alabama (Figure 1). Clients receiving ADAP prescription only drug coverage experience 71 percent retention in care and 73 percent viral suppression. Clients receiving ADAP-funded insurance assistance fare even better. ADAP-funded insurance assistance program clients enrolled in the Alabama Insurance Assistance Program (AIAP) experience 85 percent retention in care and 83 percent achieve viral suppression. ADAP-funded insurance assistance program clients enrolled in the Medicare Part D Client Assistance Program (MEDCAP) experience 84 percent retention in care and 80 percent achieve viral suppression. Among clients receiving Part B core medical and support services, 77 percent are retained in care and 8 percent achieve viral suppression. Of note, Alabama's statewide HIV continuum of care includes RWHAP Part B clients receiving ADAP and/or Part B core medical and support services. If RWHAP Part B clients were removed from Alabama's HIV continuum of care, retention in care and viral suppression (both 54 percent) would be even lower statewide. Specific measures of Alabama's ADAP will be presented first, followed by Part B core medical and support services.

Figure 1. Retention in Care and Viral Suppression Among Clients Receiving Ryan White HIV/AIDS Program Part B AIDS Drug Assistance Program and Core Medical and Support Services Compared to all Persons Living With HIV, Alabama 2017



Sources: Alabama Department of Public Health, Division of HIV Prevention and Care, Direct Services Branch.
Calculations include persons diagnosed with HIV infection through December 31, 2016 and alive as of December 31, 2017, allowing a full 12 months to assess retention in care and viral suppression. For this reason, case counts underestimate the current number of PLWH in Alabama, as an HIV-positive person must be diagnosed by December 31, 2016 **and still living** on December 31, 2017 to be included. Alabama's Preliminary 2017 HIV Care Continuum available at: http://www.alabamapublichealth.gov/hiv/assets/HIVContinuumCare_2017_Preliminary.pdf.
† Calculated as the percentage of clients diagnosed with HIV through December 31, 2016 and alive as of December 31, 2017 whose **most recent** viral load was suppressed (<200 copies/mL) during the previous 12 months.
‡ Calculated as the percentage of clients diagnosed with HIV through December 31, 2016 and alive as of December 31, 2017 retained in care during the previous 12 months, evidenced by ≥2 CD4 and/or viral load tests collected at least 90 days apart.

To be eligible for enrollment in Alabama's RWHAP Part B and ADAP, five basic components must be met:

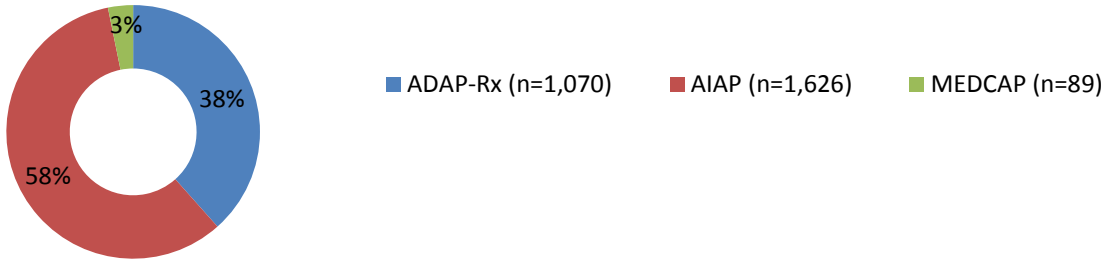
1. HIV-positive*
2. Alabama residency
3. Financial eligibility, currently set at 400 percent of the federal poverty level (FPL)
4. RWHAP Part B must be the payer of last resort
5. Biannual (twice yearly) recertification, Alabama follows a birth month and half birth month recertification schedule

*Confirmation of HIV-positive status is only required once, upon initial program enrollment. Subsequent re-enrollment in ADAP and/or Part B services may utilize previous documentation of HIV-positive status. An exception to the HIV-positive eligibility requirement is granted for HIV testing conducted as part of the Part B core medical services category, Early Intervention Services (EIS), to identify HIV-positive persons through targeted HIV testing and link positive persons to care.

Alabama's ADAP provides life-saving medication to eligible clients and is comprised of two main categories: 1) a full-pay prescription drug program (ADAP-Rx) and 2) an ADAP-funded insurance assistance program providing cost-effective insurance coverage. Currently, both ADAP-funded

insurance assistance program options include enrollment in a Blue Cross Blue Shield of Alabama plan: 1) Blue Value Gold, with optional stand-alone dental insurance coverage, for AIAP clients or 2) Blue Rx Option II, a prescription only insurance plan, for MEDCAP clients. The percentage of ADAP clients served by each program category as of December 31, 2017 is depicted in Figure 2. Note that the total number of clients served is larger than the number presented in Figure 1 as a client must be diagnosed with HIV by December 31, 2016 and still living on December 31, 2017 to be included in the HIV continuum of care, allowing a full 12 months for retention in care and viral suppression to be measured. ADAP-specific enrollment not tied to retention in care and viral suppression includes all clients currently enrolled as of December 31, 2017, both newly diagnosed and existing HIV-positive clients.

Figure 2. AIDS Drug Assistance Program (ADAP) Clients Served by Program Category in Alabama, 2017



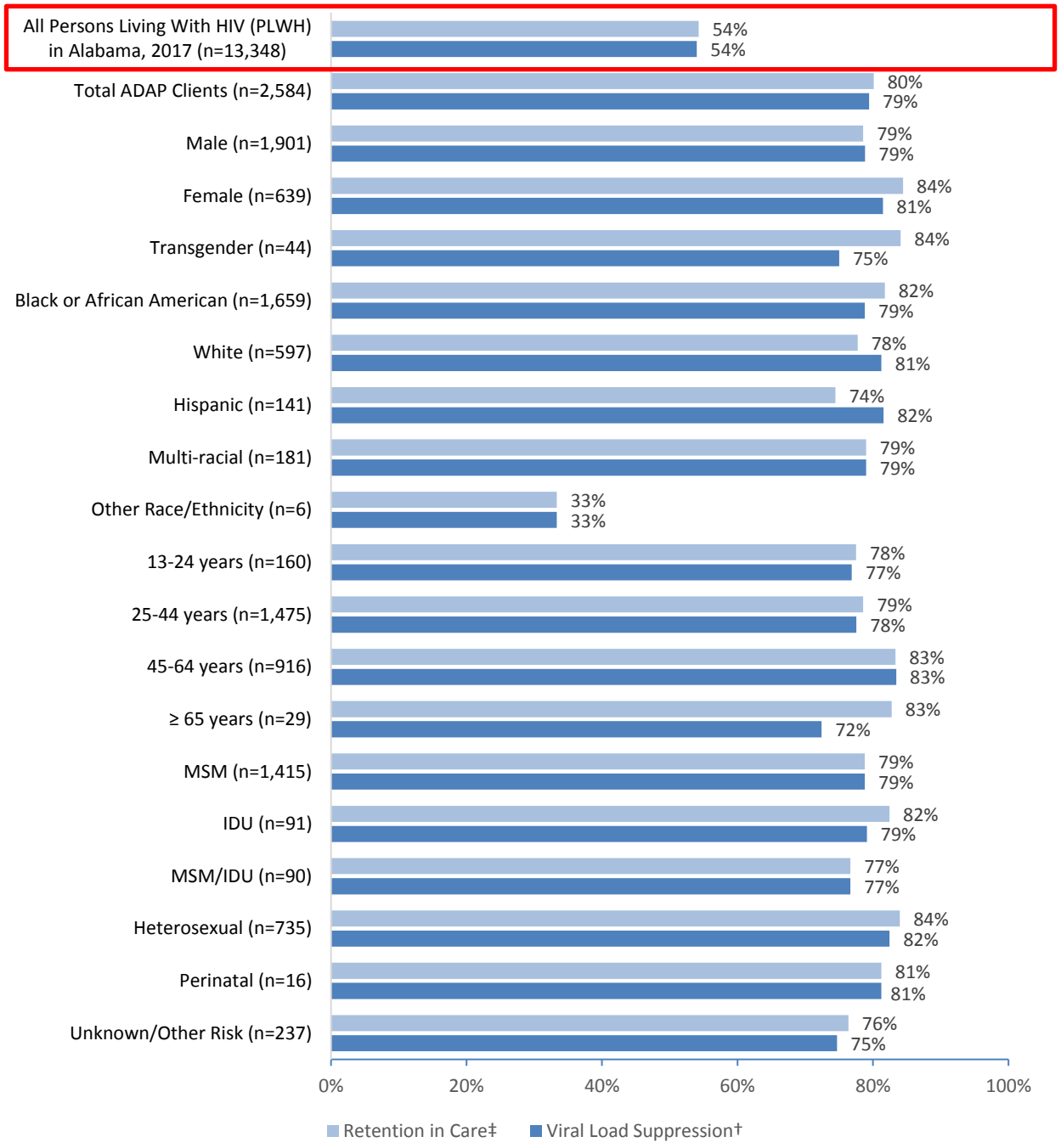
Source: Alabama Department of Public Health, Division of HIV Prevention and Care, clients enrolled as December 31, 2017
Abbreviations: ADAP-Rx – AIDS Drug Assistance Program (ADAP) full-pay prescription only drug program; AIAP – Alabama Insurance Assistance Program, an ADAP-funded insurance assistance program; MEDCAP – Medicare Part D Client Assistance Program, an ADAP-funded insurance assistance program. Percentages may not total 100% due to rounding.

Retention in care and viral load suppression among clients served by Alabama's ADAP vary by race/ethnicity (Figure 3). While 82 percent of Blacks or African Americans were retained in care, 79 percent achieved viral suppression (<200 copies/mL), evidenced by ≥2 CD4 and/or viral load test results collected at least 90 days apart during the previous 12 months. Among Whites, 78 percent were retained in care and 81 percent were virally suppressed. Seventy-four percent of Hispanics were retained in care and 82 percent achieved viral suppression. Seventy-nine percent of individuals identifying as multi-racial were retained in care and virally suppressed.

Differences in retention in care and viral suppression are also seen when stratifying by current gender identity. Among individuals identifying as male, 79 percent were retained in care and virally suppressed. Among individuals identifying as female, 84 percent were retained in care and 81 percent were virally suppressed. Eighty-four percent of transgender persons living with HIV were retained in care and only 75 percent were virally suppressed, signifying a need for targeted interventions among transgender persons.

Stratification by risk factor for HIV exposure also shows a difference in retention in care and viral suppression, with individuals with unknown/other risk factors experiencing the worst retention in care and viral suppression followed by men who have sex with men (MSM) who also report intravenous drug use (IDU). Individuals identifying as heterosexual without other reported risk factors experience the best retention in care and viral suppression, 84 and 82 percent, respectively.

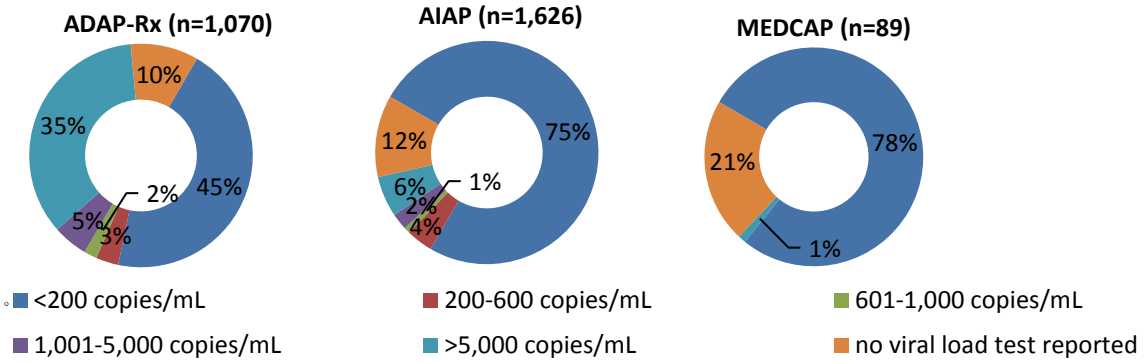
Figure 3. Retention in Care and Viral Suppression Among Clients Receiving Ryan White HIV/AIDS Program AIDS Drug Assistance Program (ADAP) Services by Client Characteristic, Alabama 2017



Sources: Alabama Department of Public Health, Division of HIV Prevention and Care.
Abbreviations: ADAP – AIDS Drug Assistance Program; IDU – intravenous drug use; MSM – men who have sex with men.
Calculations include persons diagnosed with HIV infection through December 31, 2016 and alive as of December 31, 2017, allowing a full 12 months to assess retention in care and viral suppression. For this reason, case counts underestimate the current number of PLWH in Alabama, as an HIV-positive person must be diagnosed by December 31, 2016 **and still living** on December 31, 2017 to be included. Alabama's Preliminary 2017 HIV Care Continuum available at: http://www.alabamapublichealth.gov/hiv/assets/HIVContinuumCare_2017_Preliminary.pdf.
Age represents prevalent age as of December 31, 2017.
† Calculated as the percentage of ADAP clients diagnosed with HIV through December 31, 2016 and alive as of December 31, 2017 who had suppressed viral load (<200 copies/mL) during the previous 12 months (i.e., January 1, 2017 to December 31, 2017).
‡ Calculated as the percentage of clients diagnosed with HIV through December 31, 2016 and alive as of December 31, 2017 retained in care during the previous 12 months, evidenced by ≥2 CD4 and/or viral load tests collected at least 90 days apart.

The majority of clients actively served by ADAP achieved viral suppression (<200 copies per mL) during 2017 (Figure 4). However, the level of viral suppression varied by service category with AIAP or MEDCAP clients enrolled in ADAP-funded insurance assistance achieving better viral suppression than ADAP-Rx clients. Newly diagnosed and/or returning clients are enrolled in ADAP-Rx until they can be transitioned to an ADAP-funded insurance assistance program during the next open enrollment period (exceptions for qualifying life events). These ADAP-Rx clients may not have been in care long enough to achieve viral suppression. Ensuring all ADAP clients recertify during each HRSA-required biannual (twice yearly) recertification will improve access to continuous ART and viral suppression.

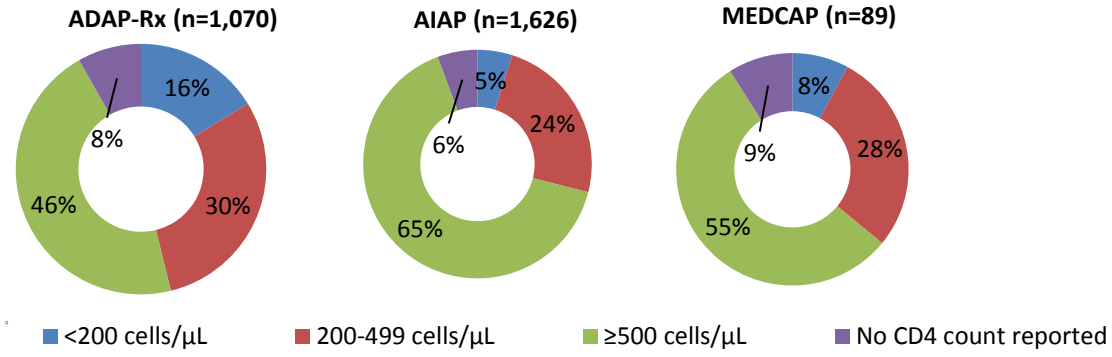
Figure 4. ADAP Clients Viral Load Range at Last Reported Test by Service Category in Alabama, 2017



Source: Alabama Department of Public Health, Division of HIV Prevention and Care
Abbreviations: ADAP - AIDS Drug Assistance Program; ADAP-Rx – ADAP full-pay prescription only drug program; AIAP – Alabama Insurance Assistance Program, an ADAP-funded insurance assistance program; MEDCAP – Medicare Part D Client Assistance Program, an ADAP-funded insurance assistance program. Viral load collected during 2017. Percentages may not total 100% due to rounding.

In addition to viral load suppression, improved access to care and ART adherence is associated with increased CD4 counts and reduced progression to AIDS. Stratification by program category reveals the majority of clients actively served by ADAP reported non-AIDS defining CD4 counts (i.e., CD4 ≥200 cells/µL) during 2017 (Figure 5).

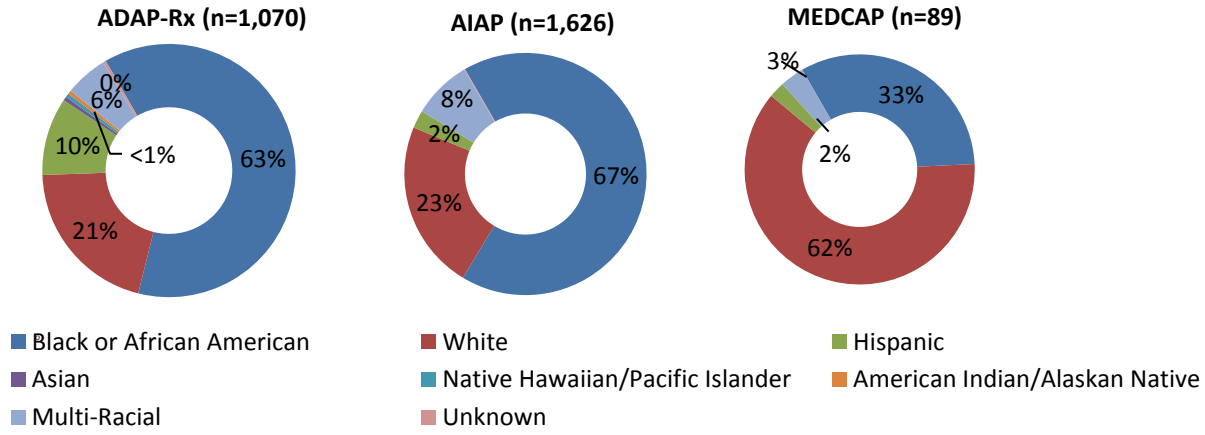
Figure 5. ADAP Clients CD4 Count Range at Last Reported Test by Service Category in Alabama, 2017



Source: Alabama Department of Public Health, Division of HIV Prevention and Care
Abbreviations: ADAP - AIDS Drug Assistance Program; ADAP-Rx – ADAP full-pay prescription only drug program; AIAP – Alabama Insurance Assistance Program, an ADAP-funded insurance assistance program; MEDCAP – Medicare Part D Client Assistance Program, an ADAP-funded insurance assistance program. CD4 counts collected during 2017. Percentages may not total 100% due to rounding.

Racial and ethnic differences are seen when stratifying by program category. While the majority of ADAP-Rx and AIAP clients are Black or African American, the majority of MEDCAP clients are White (Figure 6). This suggests an underutilization of MEDCAP among African Americans. HIV surveillance data indicate African Americans continue to be disproportionately affected by HIV in Alabama. While African Americans comprise only 27 percent of Alabama's population, they represent 65 percent of newly diagnosed infections and 64 percent of all persons living with HIV in Alabama.

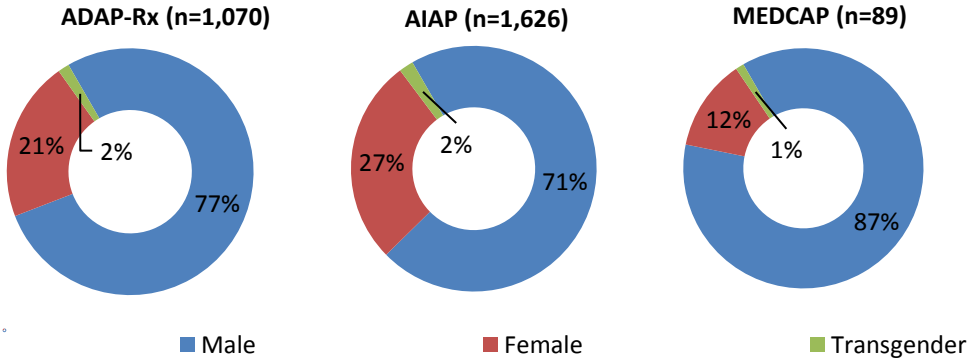
Figure 6. ADAP Clients Race/Ethnicity by Program Category in Alabama, 2017



Source: Alabama Department of Public Health, Division of HIV Prevention and Care
Abbreviations: ADAP - AIDS Drug Assistance Program; ADAP-Rx – ADAP full-pay prescription only drug program; AIAP – Alabama Insurance Assistance Program, an ADAP-funded insurance assistance program; MEDCAP – Medicare Part D Client Assistance Program, an ADAP-funded insurance assistance program. Percentages may not total 100% due to rounding.

Stratification by gender reveals the majority of ADAP clients identify as male, mirroring the HIV epidemic in Alabama (Figure 7). Clients identifying as female account for 24 percent of all clients enrolled in ADAP. Alabama's transgender population is growing with 58 ADAP clients identifying as transgender as of December 31, 2017.

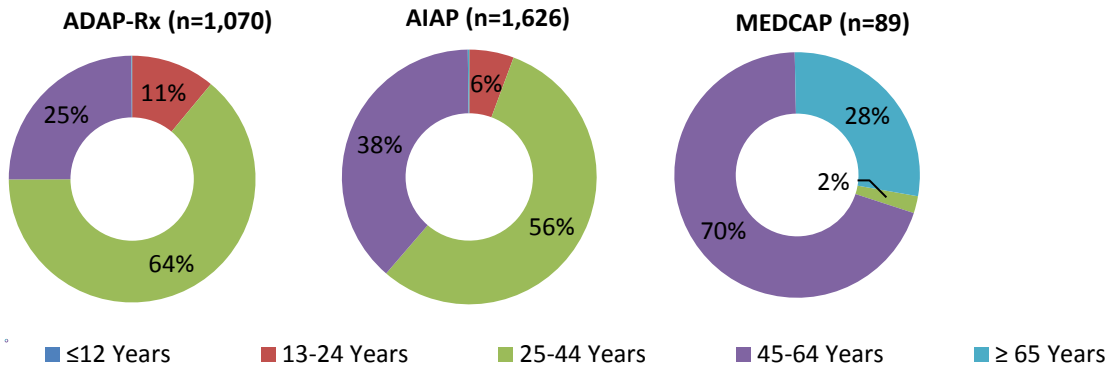
Figure 7. ADAP Clients Gender by Program Category in Alabama, 2017



Source: Alabama Department of Public Health, Division of HIV Prevention and Care
Abbreviations: ADAP - AIDS Drug Assistance Program; ADAP-Rx – ADAP full-pay prescription only drug program; AIAP – Alabama Insurance Assistance Program, an ADAP-funded insurance assistance program; MEDCAP – Medicare Part D Client Assistance Program, an ADAP-funded insurance assistance program. Percentages may not total 100% due to rounding.

While the majority of ADAP-Rx and AIAP clients were 25 to 44 years old at the end of 2017, a larger percentage of 45 to 64 years olds utilized AIAP compared to ADAP (Figure 8). MEDCAP clients represent an older population, with the majority of clients age 45 or older. No clients served by ADAP-Rx, AIAP, or MEDCAP were 12 years old or younger. By law, the RWHAP must be the payer of last resort. Children of low income families are able to obtain healthcare coverage through Alabama's Medicaid and AllKids insurance programs.

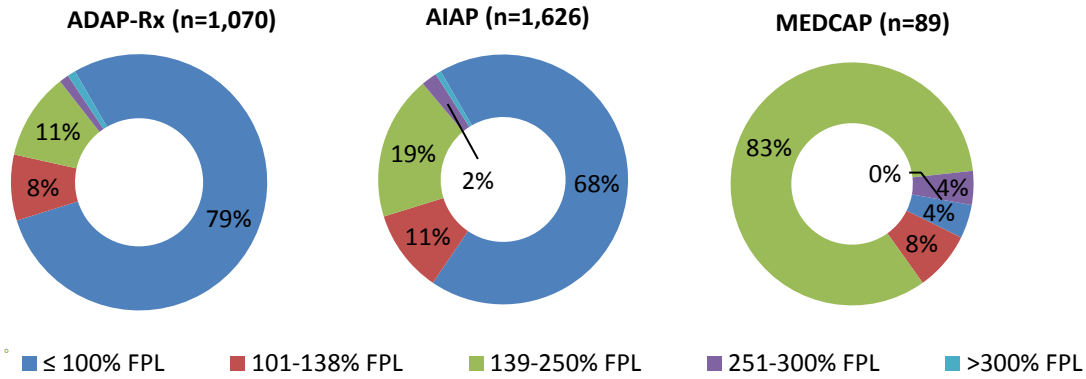
Figure 8. ADAP Clients Age by Program Category in Alabama, 2017



Source: Alabama Department of Public Health, Division of HIV Prevention and Care
Abbreviations: ADAP - AIDS Drug Assistance Program; ADAP-Rx – ADAP full-pay prescription only drug program; AIAP – Alabama Insurance Assistance Program, an ADAP-funded insurance assistance program; MEDCAP – Medicare Part D Client Assistance Program, an ADAP-funded insurance assistance program. Age as of December 31, 2017. Percentages may not total 100% due to rounding.

Alabama's income eligibility criteria for all RWHAP Part B and ADAP services was increased to 400 percent of the federal poverty level (FPL), effective April 1, 2017. Despite expanding income limits, the majority of clients enrolled in Alabama's ADAP are extremely low income, with 70 percent of clients at or below 100 percent FPL and 97 percent of clients earning less than 250 percent FPL (Figure 9). MEDCAP clients earn slightly more than ADAP-Rx and AIAP clients, with the majority of MEDCAP clients earning between 139 to 250 percent of the FPL.

Figure 9. ADAP Clients Income Level by Program Category in Alabama, 2017



Sources: Alabama Department of Public Health, Division of HIV Prevention and Care. *Federal Register*, Vol. 82, No. 19, January 31, 2017, pp. 8831-8832. Also see https://aspe.hhs.gov/poverty-guidelines.
Abbreviations: ADAP - AIDS Drug Assistance Program; ADAP-Rx – ADAP full-pay prescription only drug program; AIAP – Alabama Insurance Assistance Program, an ADAP-funded insurance assistance program; MEDCAP – Medicare Part D Client Assistance Program, an ADAP-funded insurance assistance program. Percentages may not total 100% due to rounding.

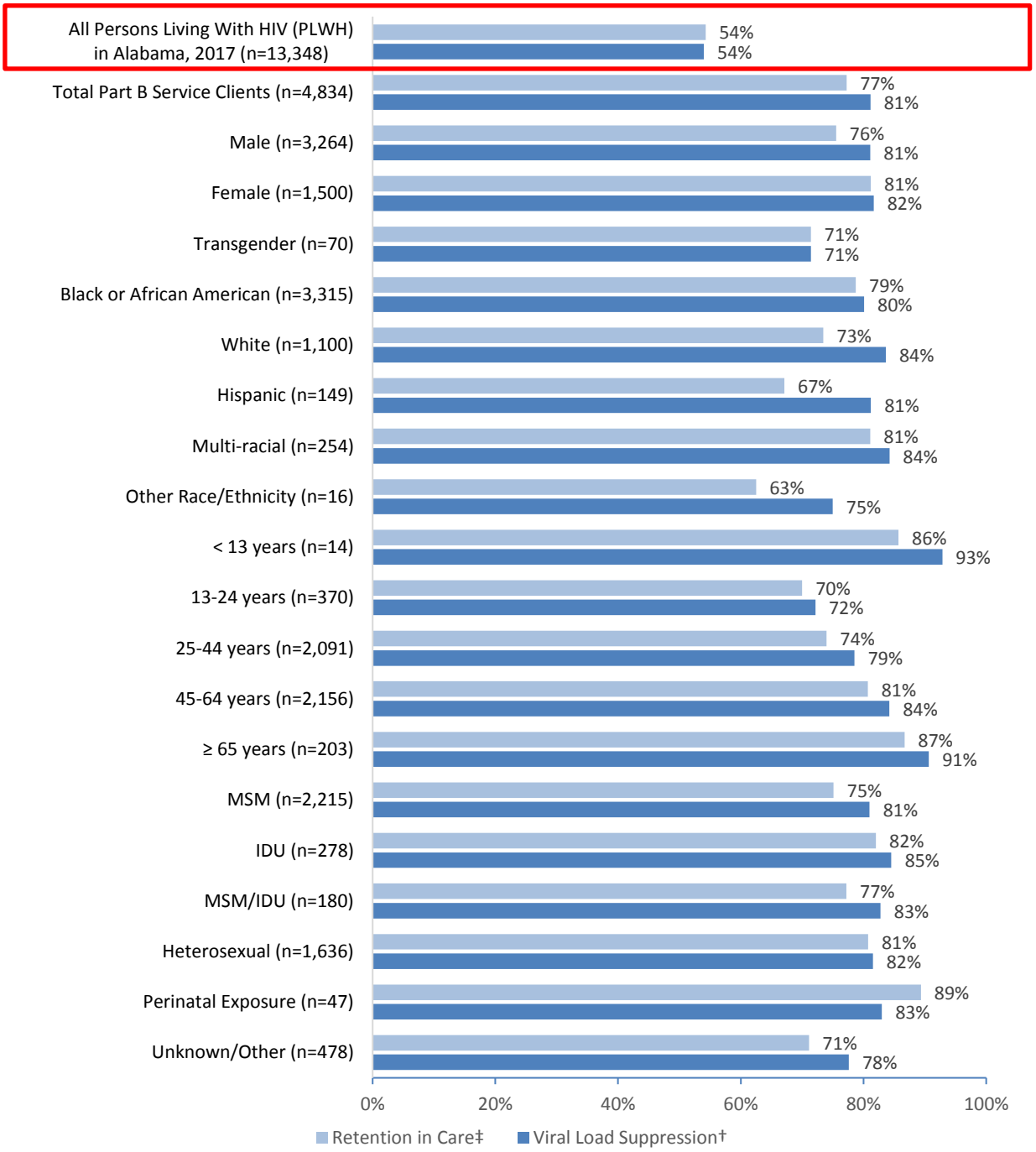
Alabama's RWHAP Part B also provides core medical and support services to ensure seamless care and support across the HIV care continuum. Part B core medical and support services offered in Alabama include:

1. Outpatient/Ambulatory Medical Care
2. Oral Health Care
3. Early Intervention Services (to help identify HIV-positive persons and link them to care)
4. Health Insurance Premium & Cost Sharing Assistance
5. Mental Health Services
6. Medical Nutrition Therapy
7. Medical Case Management (including Treatment Adherence)
8. Substance Abuse Services (Outpatient)
9. Case Management (Non-medical)
10. Emergency Financial Assistance
11. Food Bank/Home-delivered Meals
12. Health Education/Risk Reduction Services
13. Housing Services
14. Other Professional Services (including Legal Services)
15. Linguistic Services
16. Medical Transportation Services
17. Psychosocial Support Services
18. Referral for Health Care/Support Services

Currently, Alabama funds fifteen Ryan White Providers across the state to provide Part B core medical and support services. During 2017, Part B services were provided to an estimated 4,834 HIV positive clients (Figure 10). To determine retention in care and viral suppression among clients receiving Part B core medical and support services, a deduplication and linkage to HIV Surveillance data was conducted. Seventy-seven percent of clients receiving at least one Part B core medical or support service were retained in care and 81 percent achieved viral suppression. While individuals identifying as male or female have similar retention in care and viral suppression, individuals identifying as transgender achieve a lower percentage of retention in care and viral load suppression. Only 71 percent of transgender persons living with HIV were retained in care and virally suppressed, signifying a need for targeted interventions among clients identifying as transgender.

Differences in retention in care and viral suppression are also seen when stratifying by race and ethnicity. While individuals identifying as black or African American, White, or multi-racial experience higher retention in care and viral suppression, individuals identifying as Hispanic or other/unknown race and ethnicity experience lower retention in care and viral suppression. This signifies a need for targeted interventions among clients identifying as Hispanic or other/unknown racial groups. Retention in care and viral suppression improved with age, excluding children under 13 years of age, with adolescents and young adults age 13 to 24 years being identified as a target group for improved HIV prevention and care efforts. Stratifying clients by risk factor also reveals variation in retention in care and viral load suppression. While MSM, IDU, combined MSM/IDU, and heterosexuals achieved similar retention in care and viral suppression, individuals infected via perinatal exposure achieved the highest retention in care and viral suppression outcome measures. Individuals reporting other/unknown risk factors for HIV exposure experienced the worst outcome measures, with 71 percent retained in care and 78 percent achieving viral suppression. As with other demographic groups identified, targeted interventions should be considered among clients reporting other/unknown risk factors for HIV exposure.

Figure 10. Retention in Care and Viral Suppression Among Clients Receiving Ryan White HIV/AIDS Program Part B Core Medical and Support Services by Client Characteristic, Alabama 2017



Sources: Alabama Department of Public Health, Division of HIV Prevention and Care, Direct Services Branch.
Abbreviations: IDU – intravenous drug use; MSM – men who have sex with men.
Calculations include persons diagnosed with HIV infection through December 31, 2016 and alive as of December 31, 2017, allowing a full 12 months to assess retention in care and viral suppression. For this reason, case counts underestimate the current number of PLWH in Alabama, as an HIV-positive person must be diagnosed by December 31, 2016 **and still living** on December 31, 2017 to be included. Alabama's Preliminary 2017 HIV Care Continuum available at: http://www.alabamapublichealth.gov/hiv/assets/HIVContinuumCare_2017_Preliminary.pdf.
† Calculated as the percentage of clients diagnosed with HIV through December 31, 2016 and alive as of December 31, 2017 whose most recent viral load was suppressed (<200 copies/mL) during the previous 12 months.
‡ Calculated as the percentage of clients diagnosed with HIV through December 31, 2016 and alive as of December 31, 2017 retained in care during the previous 12 months, evidenced by ≥2 CD4 and/or viral load tests collected at least 90 days apart.

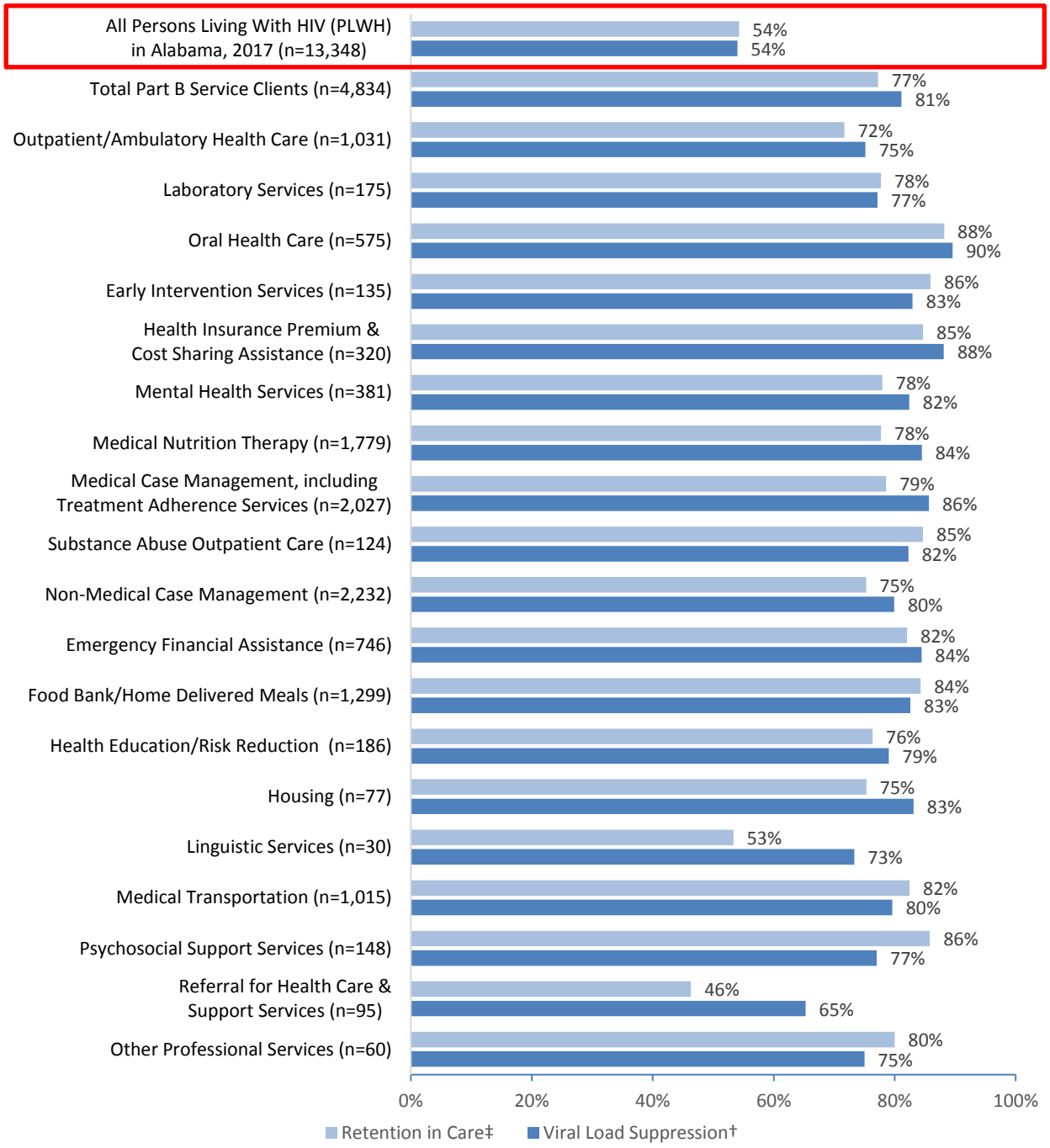
Stratifying clients by Part B core medical and/or support service category received also reveals variation in retention in care and viral load suppression (Figure 11). Among the 4,834 clients accessing Part B services during 2017, clients receiving oral health care experience the best outcomes with 88 percent retention in care and 90 percent viral suppression. Clients receiving oral health care are quickly approaching the NHAS 2020 90 percent retention in care indicator and have already surpassed the 90 percent viral suppression indicator. Health insurance premium and cost sharing assistance is another service category associated with increased retention in care and viral suppression, with 85 percent of clients retained in care and 88 percent virally suppressed. Clients receiving early intervention services, mental health services, medical nutrition therapy, medical case management, substance abuse outpatient care, non-medical case management, emergency financial assistance, food bank/home delivered meal, housing services, and medical transportation services have also either met or surpassed the NHAS 2020 indicator of 80 percent viral suppression.

Referral for health care and support services were provided to 95 clients, with 46 percent retained in care and 65 percent virally suppressed. Linguistic services were provided to 30 non-English speaking clients and helped 53 percent of these individuals remain in care and 73 percent achieve viral suppression. Although these service categories do not appear to achieve the outcome measures reached by other Part B core medical and support service categories, offering a wide range of core medical and support services is necessary to assist PLWH achieve optimal health outcomes, adherence to ART, and maintain viral suppression. Clients receiving referral for health care and support services and linguistics services may benefit from increased targeted interventions. While some service categories appear to be more effective than others at positively impacting retention in care and viral suppression, a comprehensive system of care is required to achieve a coordinated response to the HIV epidemic.

Another way to gauge the overall effectiveness of Part B core medical and support categories is to assess utilization. Non-medical case management (n=2,232) received the highest utilization during 2017, followed by medical case management (n=2,027), medical nutrition therapy (n=1,779), food bank/home delivered meal (n=1,299), outpatient ambulatory health care (n=1,031), and medical transportation services (n=1,015). Linguistic services were utilized by the least number of clients (n=30), followed by other professional services (n=60), housing services (n=77), and referral for health care and support services (n=95).

When assessing retention in care and viral suppression among Part B Services clients, it should be noted that Part B core medical and support service categories are not mutually exclusive and cannot be compared as such (i.e., a client may receive multiple core medical and/or support services through Alabama's RWHAP Part B program). Further, clients assessed for retention in care and viral suppression underestimate the total number of clients receiving Part B core medical and support services as client must be diagnosed by December 31, 2016 **and still living** on December 31, 2017 to be included. For more information about Alabama's RWHAP Part B Program, including program eligibility requirements and a current list of all ADAP-Rx formulary medications covered by ADAP, please visit http://alabamapublichealth/hiv.

Figure 11. Retention in Care and Viral Suppression Among Clients Receiving Ryan White HIV/AIDS Program Part B Core Medical and Support Services by Service Category, Alabama 2017



Sources: Alabama Department of Public Health, Division of HIV Prevention and Care, Direct Services Branch.

Note: Part B core medical and support service categories are not mutually exclusive and cannot be compared as such (i.e., a client may receive multiple core medical and/or support services through Alabama's Ryan White HIV/AIDS Part B program).

Calculations include persons diagnosed with HIV infection through December 31, 2016 and alive as of December 31, 2017, allowing a full 12 months to assess retention in care and viral suppression. For this reason, case counts underestimate the current number of PLWH in Alabama, as an HIV-positive person must be diagnosed by December 31, 2016 **and still living** on December 31, 2017 to be included. Alabama's Preliminary 2017 HIV Care Continuum available at: http://www.alabamapublichealth.gov/hiv/assets/HIVContinuumCare_2017_Preliminary.pdf.

† Calculated as the percentage of clients diagnosed with HIV through December 31, 2016 and alive as of December 31, 2017 whose most recent viral load was suppressed (<200 copies/mL) during the previous 12 months.

‡ Calculated as the percentage of clients diagnosed with HIV through December 31, 2016 and alive as of December 31, 2017 retained in care during the previous 12 months, evidenced by ≥2 CD4 and/or viral load tests collected at least 90 days apart.