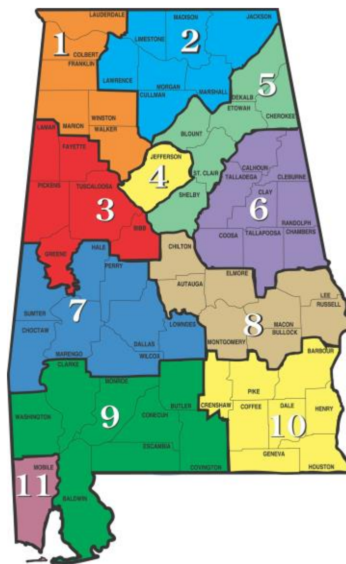
State of Alabama

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, 2018

Prepared by:

Division of HIV Prevention and Care

Direct Care Management Services Branch

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

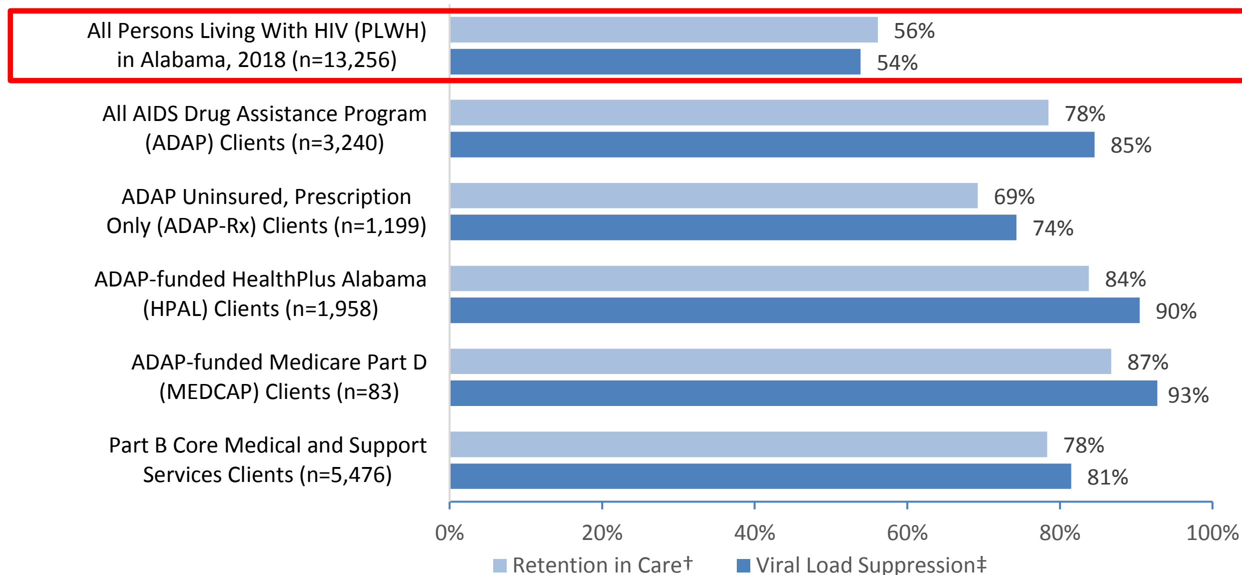
The Health Resources and Services Administration (HRSA), Ryan White HIV/AIDS Program (RWHAP) supports a comprehensive system of care that ensures ongoing access to high quality HIV care, treatment, and support services. The RWHAP provides services to low-income people living with HIV (PLWH), as well 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 56 percent retention in care and 54 percent viral suppression among all PLWH in Alabama (Figure 1). During 2018, 78 percent of ADAP clients were retained in care and 85 percent were virally suppressed. ADAP clients had slightly differing results depending on the ADAP plan they were enrolled in, with clients enrolled in ADAP-funded insurance plans experiencing the best outcomes.

Clients receiving ADAP-funded health insurance with optional standalone dental insurance experienced 84 percent retention in care and 90 percent viral suppression (Figure 1). These HealthPlus Alabama (HPAL) clients were enrolled in the Blue Cross Blue Shield of Alabama Blue Value Gold plan. ADAP-funded Medicare Part D clients (MEDCAP) enrolled in the Blue Cross Blue Shield of Alabama Blue Rx Option II plan experienced 87 percent retention in care and 93 percent viral suppression. Clients receiving ADAP uninsured, prescription only (ADAP-Rx) drug coverage experienced 69 percent retention in care and 74 percent viral suppression. ADAP-Rx clients often represent newly diagnosed and/or returning to care individuals who have not yet had time to achieve retention in care, as an individual must be living with HIV for a full 12 months with 2 or more HIV medical visits conducted at least 3 months apart to be considered retained in care.

Among clients receiving Part B core medical and support services during 2018, 78 percent were retained in care and 77 percent achieved viral suppression (Figure 1). Of note, Alabama's HIV continuum of care includes RWHAP clients receiving ADAP and/or Part B core medical and support services. If RWHAP clients were removed from Alabama's HIV continuum of care, retention in care (56 percent) and viral suppression (54 percent) would be even lower.

Figure 1. Retention in Care and Viral Suppression Among Clients Receiving Ryan White HIV/AIDS Program Part B AIDS Drug Assistance Program(ADAP) and Core Medical and Support Services Compared to all Persons Living With HIV, Alabama 2018



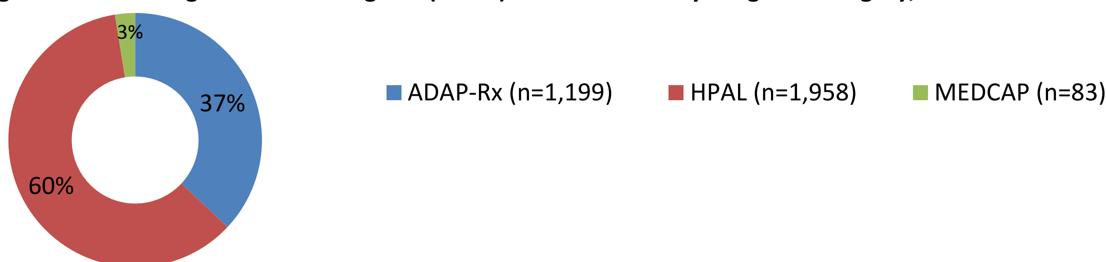
Sources: Alabama Department of Public Health, Division of HIV Prevention and Care, Direct Services Branch.
Note: Calculations include persons living with HIV (PLWH) receiving ADAP and/or Part B services during 2018, assessed on March 31, 2019 to allow 3 months to account for delayed reporting. For this reason, retention in care and viral suppression may be slightly underestimated as the standard is to allow a full 12 months before assessing retention in care and viral suppression, to account for delayed reporting of laboratory results. In addition, some clients are newly diagnosed and/or returning to care, and have not yet had adequate time to achieve retention in care and viral suppression.
Alabama's preliminary HIV Care Continuum is used to compare retention in care and viral suppression among all persons living with HIV in Alabama (i.e., those receiving ADAP services and those not receiving ADAP services). The preliminary 2018 HIV Care Continuum is available at: http://www.alabamapublichealth.gov/hiv/assets/hivcontinuumcare_2018_preliminary.pdf.
‡ Calculated as the percentage of clients receiving ADAP services as of December 31, 2018 retained in care, evidenced by ≥2 CD4, HIV genotype, and/or viral load tests collected at least 90 days apart in 2018.
† Calculated as the percentage of clients receiving ADAP services as of December 31, 2018 whose **most recent** viral load collected during 2018 was suppressed (<200 copies/mL).

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

Alabama's ADAP provides life-saving medication to eligible clients and is comprised of two main categories: 1) a full-pay prescription only drug program (ADAP-Rx) and 2) two ADAP-funded insurance assistance programs (HPAL and MEDCAP) 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 HPAL clients or 2) Blue Rx Enhanced Plus, a Medicare Part D prescription only insurance plan for MEDCAP clients. The percentage of ADAP clients served by each program category as of December 31, 2018 is depicted in Figure 2.

Figure 2. AIDS Drug Assistance Program (ADAP) Clients Served by Program Category, Alabama 2018



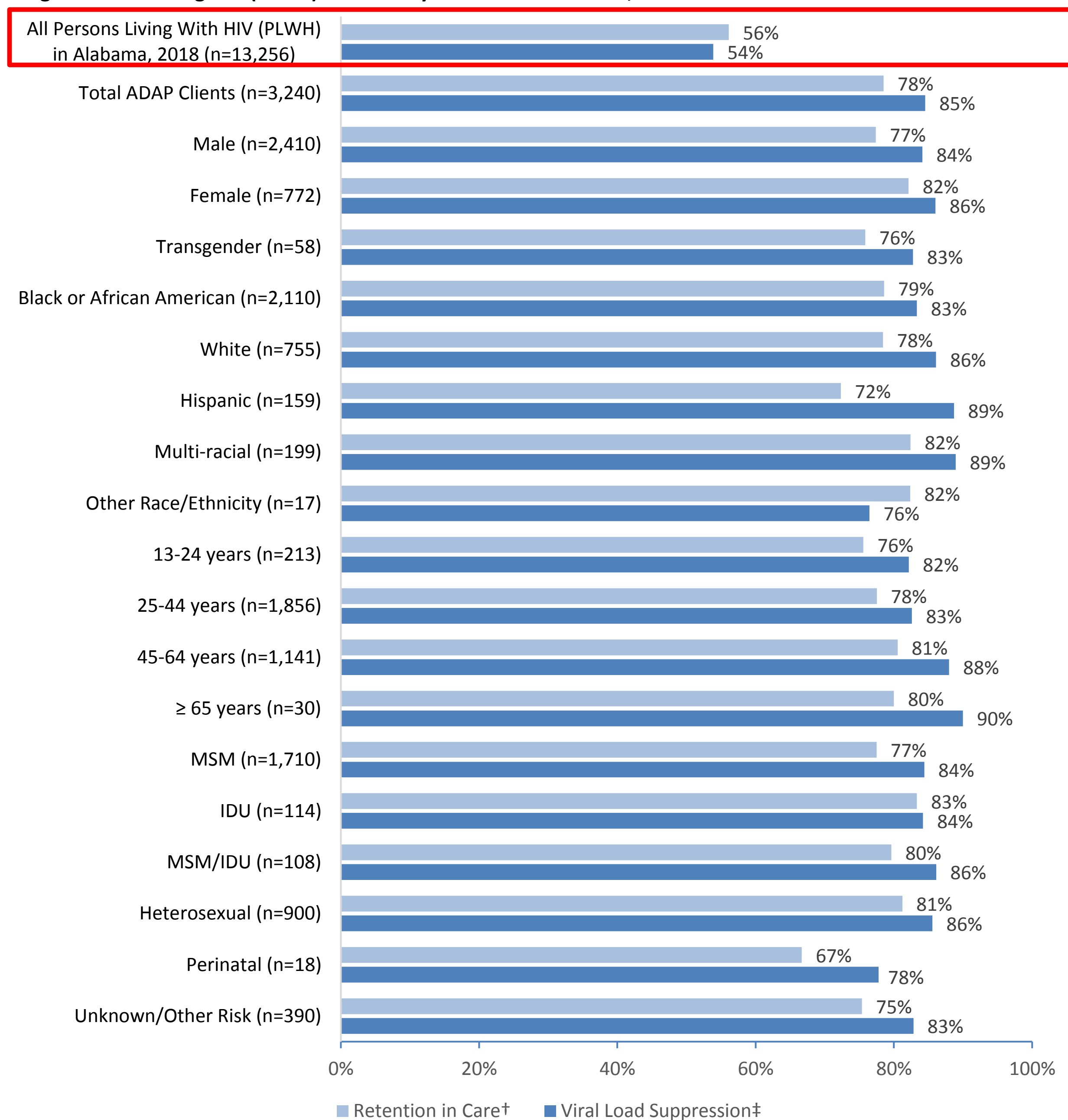
Source: Alabama Department of Public Health, Division of HIV Prevention and Care, clients enrolled as of December 31, 2018.
Abbreviations: ADAP-Rx – AIDS Drug Assistance Program (ADAP) full-pay prescription only drug program; HPAL – HealthPlus Alabama, an ADAP-funded health insurance program with optional dental insurance; MEDCAP – Medicare Part D Client Assistance Program, an ADAP-funded prescription 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 79 percent of Blacks or African Americans were retained in care, 83 percent achieved viral suppression (<200 copies/mL), evidenced by ≥2 CD4, HIV genotype, 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 86 percent were virally suppressed. Seventy-two percent of Hispanics were retained in care and 89 percent achieved viral suppression. Eighty-two percent of individuals identifying as multi-racial were retained in care and 89 percent were virally suppressed.

Differences in retention in care and viral suppression are also seen when stratifying by current gender identity. Among individuals identifying as male, 77 percent were retained in care and 84 percent were virally suppressed. Among individuals identifying as female, 82 percent were retained in care and 86 percent were virally suppressed. Seventy-six percent of transgender persons living with HIV were retained in care and only 83 percent were virally suppressed.

Stratification by risk factor for HIV exposure also shows a difference in retention in care and viral suppression, with individuals infected prenatally experiencing worse retention in care (67 percent) and viral suppression (78 percent) than other PLWH who have known risk factors. Men who have sex with men (MSM) without a history of intravenous drug use (IDU) experienced 77 percent retention in care and 84 percent viral suppression. MSM with a history of IDU experienced 80 percent retention in care and 86 percent viral suppression. IDU alone experienced 83 percent retention in care and 84 percent viral suppression.

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 2018



Sources: Alabama Department of Public Health, Division of HIV Prevention and Care, Direct Services Branch.
Note: Calculations include persons living with HIV (PLWH) receiving ADAP and/or Part B services during 2018, assessed on March 31, 2019 to allow 3 months to account for delayed reporting. For this reason, retention in care and viral suppression may be slightly underestimated as the standard is to allow a full 12 months before assessing retention in care and viral suppression, to account for delayed reporting of laboratory results. In addition, some ADAP clients are newly diagnosed and/or returning to care, and have not yet had adequate time to achieve retention in care and viral suppression.
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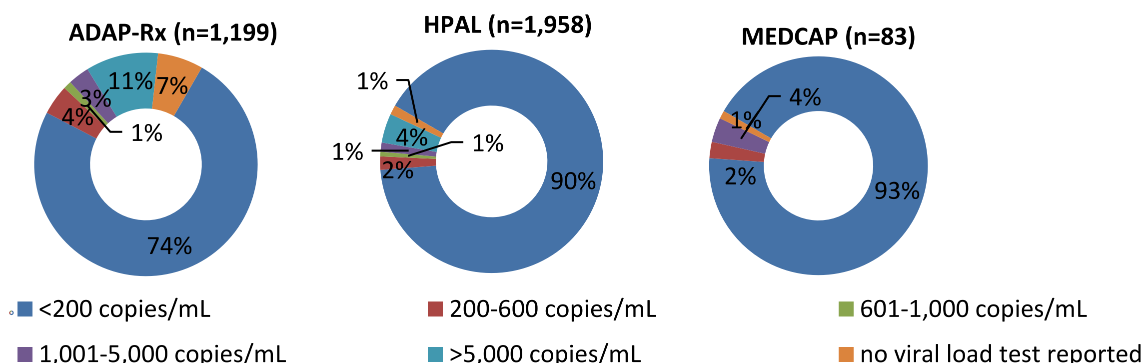
The majority of clients actively served by ADAP achieved viral suppression (<200 copies per mL) during 2018 (Figure 4). However, the level of viral suppression varied by service category with HPAL and MEDCAP clients enrolled in ADAP-funded insurance assistance programs achieving better viral suppression 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.

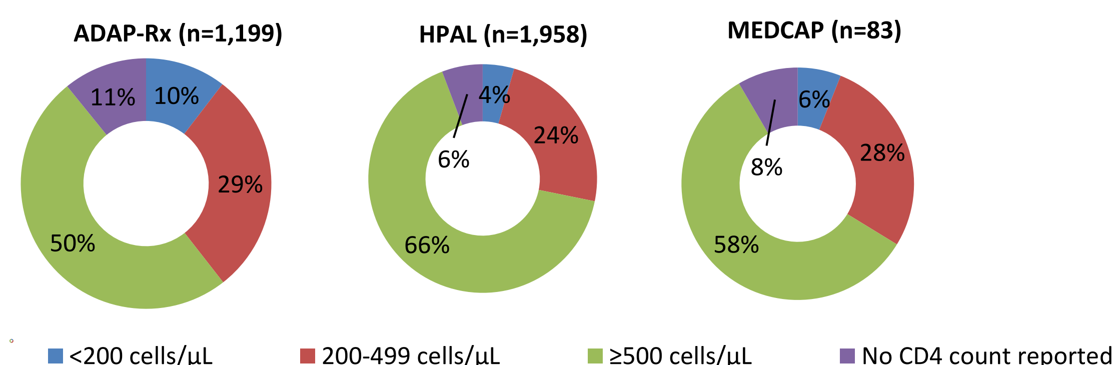
Figure 4. ADAP Clients Viral Load Range at Last Reported Test by Program Category, Alabama 2018



Source: Alabama Department of Public Health, Division of HIV Prevention and Care
Abbreviations: ADAP-Rx – AIDS Drug Assistance Program (ADAP) full-pay prescription only drug program; HPAL – HealthPlus Alabama, an ADAP-funded health insurance program with optional dental insurance; MEDCAP – Medicare Part D Client Assistance Program, an ADAP-funded prescription insurance assistance program. Viral load collected during 2018. 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 2018 (Figure 5). Annual CD4 testing is no longer required for PLWH with consistently healthy CD4 counts. This may account for some missing CD4 tests.

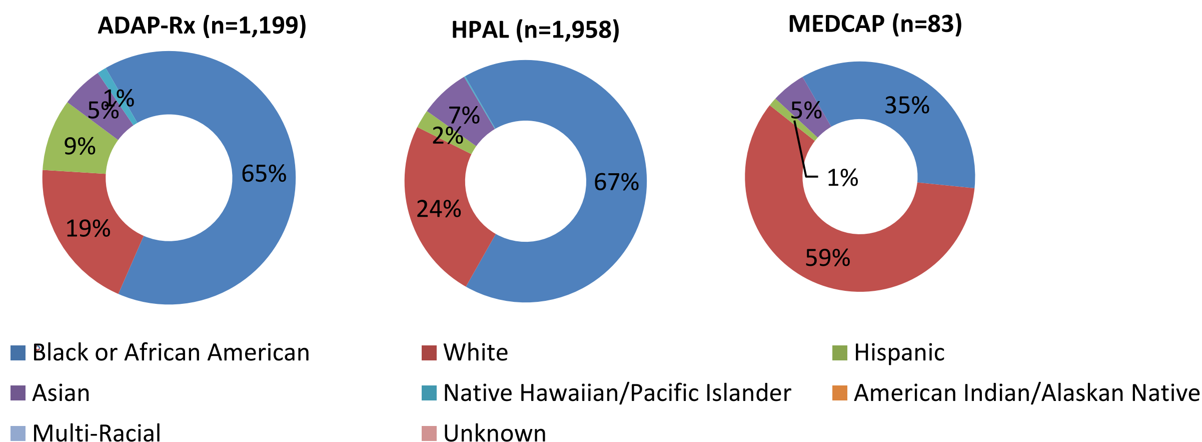
Figure 5. ADAP Clients CD4 Count Range at Last Reported Test by Program Category, Alabama 2018



Source: Alabama Department of Public Health, Division of HIV Prevention and Care
Abbreviations: ADAP-Rx – AIDS Drug Assistance Program (ADAP) full-pay prescription only drug program; HPAL – HealthPlus Alabama, an ADAP-funded health insurance program with optional dental insurance; MEDCAP – Medicare Part D Client Assistance Program, an ADAP-funded prescription insurance assistance program. CD4 counts collected during 2018. 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 HPAL 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 total population, they represent over 60 percent of all persons living with HIV in Alabama and over 65 percent of newly diagnosed HIV infections.

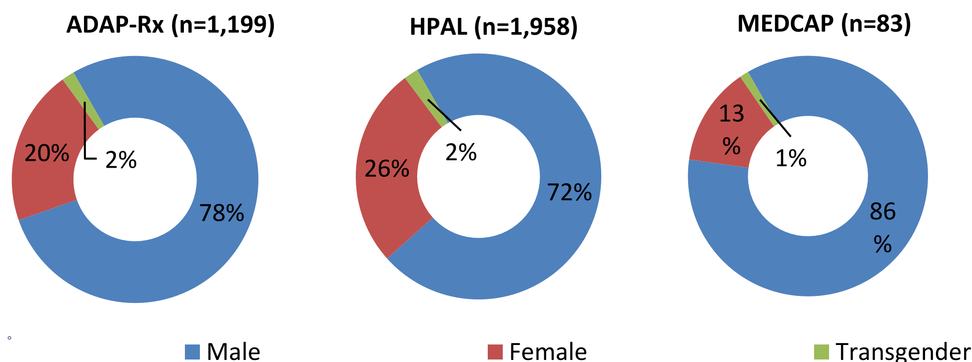
Figure 6. ADAP Clients Race/Ethnicity by Program Category, Alabama 2018



Source: Alabama Department of Public Health, Division of HIV Prevention and Care
Abbreviations: ADAP-Rx – AIDS Drug Assistance Program (ADAP) full-pay prescription only drug program; HPAL – HealthPlus Alabama, an ADAP-funded health insurance program with optional dental insurance; MEDCAP – Medicare Part D Client Assistance Program, an ADAP-funded prescription 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, 2018.

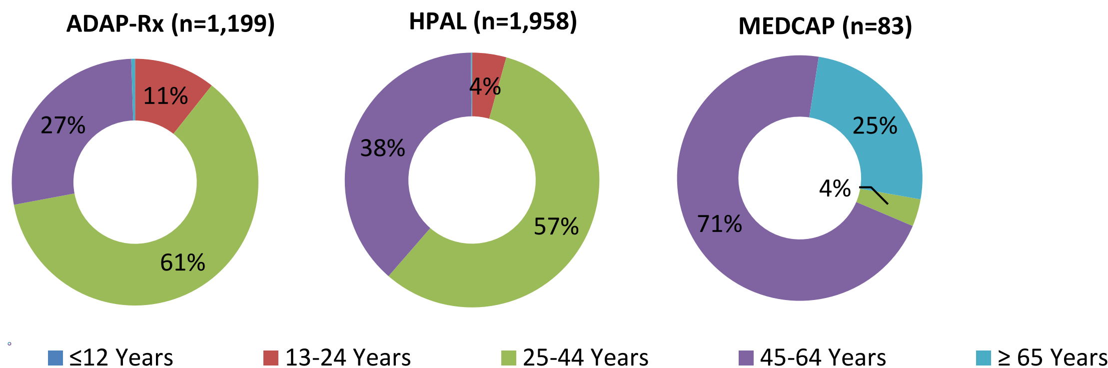
Figure 7. ADAP Clients Gender by Program Category, Alabama 2018



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

While the majority of ADAP-Rx and HPAL clients were 25 to 44 years old at the end of 2018, a larger percentage of 45 to 64 years olds utilized HPAL 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, HPAL, or MEDCAP were 12 years old or younger. By law, the RWHAP must be the payer of last resort. The majority of children in low income families are able to obtain healthcare coverage through Alabama's Medicaid and AllKids insurance programs. ADAP would provide services to undocumented children unable to enroll in Medicaid or AllKids.

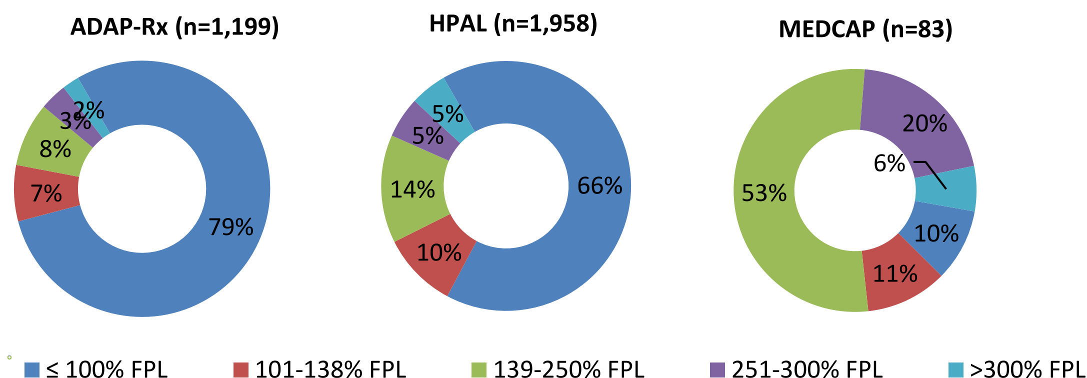
Figure 8. ADAP Clients Age by Program Category, Alabama 2018



Source: Alabama Department of Public Health, Division of HIV Prevention and Care
Abbreviations: ADAP-Rx – AIDS Drug Assistance Program (ADAP) full-pay prescription only drug program; HPAL – HealthPlus Alabama, an ADAP-funded health insurance program with optional dental insurance; MEDCAP – Medicare Part D Client Assistance Program, an ADAP-funded prescription insurance assistance program. Age as of December 31, 2018. Percentages may not total 100% due to rounding.

To qualify for ADAP and/or Part B services, an applicant must earn 400 percent or less of the federal poverty level (FPL). The majority of ADAP clients extremely low income, with 70 percent of clients below 100 percent FPL and 96 percent of clients earning less than 250 percent FPL (Figure 9). MEDCAP clients earn slightly more than ADAP-Rx and HPAL 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, Alabama 2018



Sources: Alabama Department of Public Health, Division of HIV Prevention and Care. *Federal Register*, 83 FR 2642, January 18, 2019, pp. 2642-2644. Also see https://aspe.hhs.gov/poverty-guidelines.
Abbreviations: ADAP-Rx – AIDS Drug Assistance Program (ADAP) full-pay prescription only drug program; HPAL – HealthPlus Alabama, an ADAP-funded health insurance program with optional dental insurance; MEDCAP – Medicare Part D Client Assistance Program, an ADAP-funded prescription insurance assistance program. Percentages may not total 100% due to rounding.

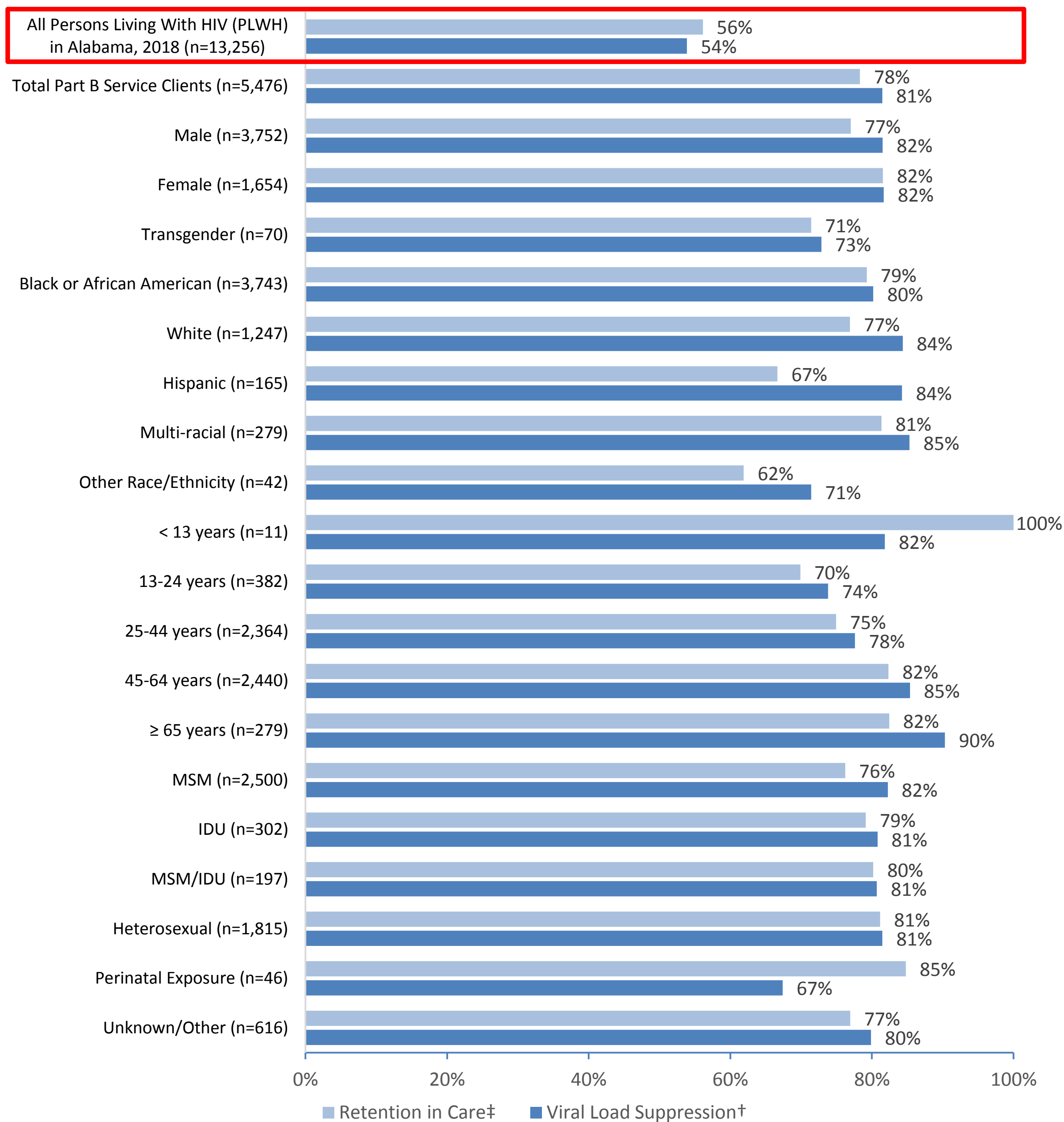
Alabama's RWHAP Part B also provides core medical and support services to ensure seamless care and support across the HIV care continuum. Part B core medical and support services offered in Alabama include:

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 2018, Part B services were provided to an estimated 5,476 HIV positive clients (Figure 10). To determine retention in care and viral suppression among clients receiving Part B core medical and support services, deduplication and linkage to HIV Surveillance data was conducted. Seventy-eight 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 only 73 percent were 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, and combined MSM/IDU achieve similar retention in care and viral suppression, heterosexuals and individuals infected via perinatal exposure achieved higher retention in care and viral suppression. Of note, although perinatal infected PLWH achieve the highest retention in care (85 percent), only 67 percent of perinatal infected PLWH are virally suppressed. Individuals reporting other/unknown risk factors for HIV exposure experienced the worst retention in care (77 percent), with 80 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 2018



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Note: Calculations include persons living with HIV (PLWH) receiving Part B core medical and support services during 2018, assessed on March 31, 2019 to allow 3 months to account for delayed reporting. For this reason, retention in care and viral suppression may be slightly underestimated as the standard is to allow a full 12 months before assessing retention in care and viral suppression, to account for delayed reporting of laboratory results. In addition, some clients are newly diagnosed and/or returning to care, and have not yet had adequate time to achieve retention in care and viral suppression.
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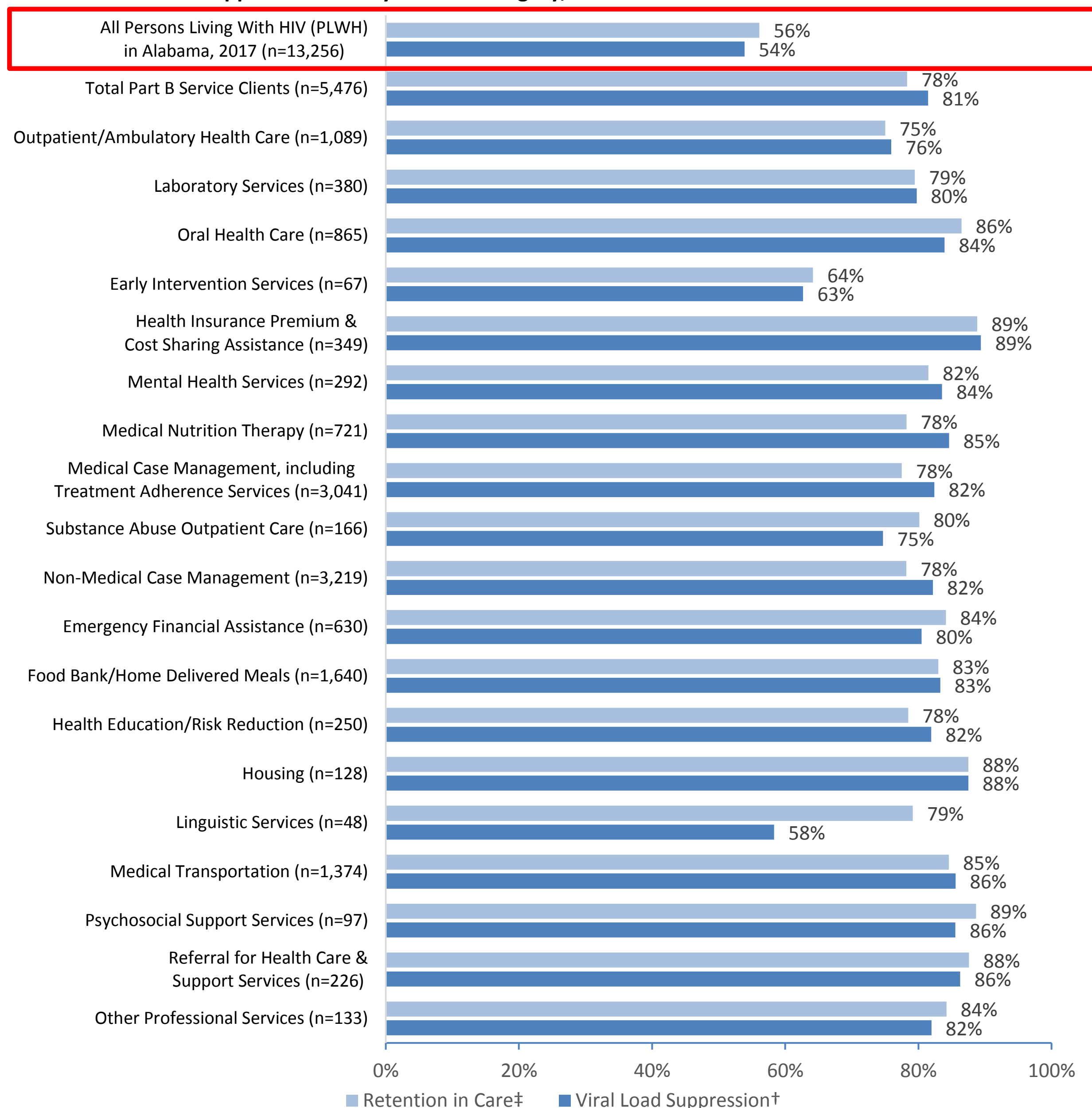
Stratifying clients by Part B core medical and/or support service category received also reveals variation in retention in care and viral load suppression (Figure 11). Among the 5,476 clients accessing Part B services during 2018, clients receiving health insurance premium and cost sharing assistance achieved the best outcomes, followed by PLWH receiving housing support. Clients receiving health insurance premium and cost sharing assistance (89 percent retention and viral suppression) and housing services (88 percent retention and viral suppression) are quickly approaching the NHAS 2020 indicator of 90 percent retention in care and have already surpassed the 80 percent viral suppression indicator. Oral health care, mental health services, emergency financial assistance, food bank/home delivered meals, medical transportation, psychosocial support services, referral for health care and support services, and other professional services have also all exceeded 80 percent retention in care and viral suppression.

Although most service categories are successfully keeping clients retained in care, some service categories indicate clients are not achieving optimal antiretroviral adherence, indicated by lower than desired viral suppression. Individuals receiving linguistic services would benefit from targeted intervention aimed at increasing antiretroviral adherence. It is important to note that individuals receiving early intervention services often represent newly diagnosed and/or returning to care individuals who tested (or retested) positive for HIV and have not yet had time to achieve retention in care, as an individual must be living with HIV for a full 12 months with 2 or more HIV medical visits conducted at least 3 months apart to be considered retained in care. While early intervention services may not appear to be an effective service category when assessing retention in care and viral suppression, increasing awareness of HIV status is critical to ending the HIV epidemic. A comprehensive system of care is required to achieve a coordinated response to the HIV epidemic and end new HIV transmissions.

Another way to gauge the overall effectiveness of Part B core medical and support categories is to assess utilization. Non-medical case management (n=3,219) received the highest utilization during 2018, followed by medical case management, including treatment adherence services (n=3,041), food bank/home delivered meal (n=1,640), medical transportation services (n=1,374), and outpatient/ambulatory health care (n=1,089). Linguistics (n=48) received the lowest utilization of all service categories. Considering Alabama has a significant population of migrant seasonal workers, with PLWH identifying as Hispanic identified as a target population for enhanced intervention, there is a need to expand linguistic services available to non-English speaking PLWH.

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). 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 2018



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).

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