1995-96 SESSION COMMITTEE HEARING RECORDS

Committee Name:

Joint Committee on Finance (JC-Fi)

Sample:

Record of Comm. Proceedings … RCP
- 05hrAC-EdR_RCP_pt01a
- 05hrAC-EdR_RCP_pt01b
- 05hrAC-EdR_RCP_pt02

- *Appointments … Appt*
- **

- *Clearinghouse Rules … CRule*
- **

- *Committee Hearings … CH*
- **

- *Committee Reports … CR*
- **

- *Executive Sessions … ES*
- **

- *Hearing Records … HR*
- **

- *Miscellaneous … Misc*
- *95hrJC-Fi_Misc_pt68*

- *Record of Comm. Proceedings … RCP*
- **

VIII. Department of Health and Social Services -- Joe Leean, Secretary

As requested by the Joint Committee on Finance at the December 1995 s. 13.10 meeting, the Department of Health and Social Services submits a report on funding options for a data collection system for the Community Options Program.

Governor's Recommendation

Modify the Department's recommendation. Request that JCF transfer up to $200,000 from s. 20.435(7)(bd) to s. 20.435(6)(a) for system development costs in FY97. Further request that JCF stipulate that if less than $200,000 is available, DHSS give priority to merging the COP and MA modules.

VIII

CORRESPONDENCE\MEMORANDUM

STATE OF WISCONSIN
Department of Administration

Date: April 10, 1996

To: Members, Joint Committee on Finance

From: James R. Klauser, Secretary
Department of Administration

Subject: Section 13.10 Report from the Department of Health and Social Services for Data Collection for the Community Options Program.

Request

The Department of Health and Social Services (DHSS) recommends funding a $300,000 Community Options Program (COP) data collection system by using $50,000 GPR reserved in the Joint Committee on Finance's appropriation, $50,000 FED which represents 50 percent federal financial participation claimed directly as a Medical Assistance administrative expense, and $200,000 GPR COP funds which reflect underspending by counties.

Background

1995 Act 27 required DHSS to submit recommendations to the Joint Committee on Finance (JCF) at its fourth quarter 1995 s. 13.10 meeting concerning expenditure of $50,000 GPR for expanding the COP data collection system. After DHSS had identified the cost of an expanded system to be $300,000, JCF directed the department to identify additional funding sources for the entire project and resubmit its recommendations at the Committee's first quarterly meeting in 1996 under s. 13.10 of the statutes.

Analysis

Over $110M all funds is currently appropriated for the COP program. Despite this large investment of public funds, minimal data is collected and thus policy makers are unable to measure the effectiveness of the program. Expanding the COP data base will facilitate the state's ability to better coordinate the delivery and control the costs of services.

DHSS has identified two additional funding sources to finance the entire data collection system development project. First, federal financial participation (FFP) at a 50% rate can be directly claimed for system improvements under Medical Assistance administrative costs. Since the project involves sole source contracting (DHSS will do modifications to the current system), there is a combined state-federal limit of $100,000 for FFP. If DHSS choses to competitively bid the project in order to exceed the $100,000 limit, prior approval from the federal Health Care Financing Administration (HCFA) would be required. The department would have to submit an Advance Planning

Document. Prior experience has shown that the process would take a minimum of six months with no assurance that additional funding would be made available.

Second, under s. 20.435(7)(bd), COP GPR appropriated funds may be transferred between fiscal years, but funds not spent or encumbered by counties by December 31 of each year lapse to the general fund on January 1 unless transferred to the next calendar year by JCF. DHSS estimates that approximately $200,000 GPR will lapse to the general fund relative to calendar year 1995 county underspending and proposes using these funds to finance the development of the new data collection system.

The department has identified two reasons for county underspending. First, a COP-Waiver client may be initially funded using 100% GPR until waiver approval is secured, which may take up to two months. The county, upon approval, receives federal waiver reimbursement which frees up the previously committed GPR. If the COP Waiver client enters the system in the fourth quarter of the calendar year, once the freed up GPR funds become available it becomes too late to enroll new clients. Second, counties are reluctant to add new clients in the last quarter of the calendar year because of concerns that funds may not be available for twelve months of services in the following calendar year.

DHSS has indicated that the exact amount of funds which would lapse under s. 20.435(7)(bd) will not be known until May. Thus, the Department proposes to wait until the Committee's next s. 13.10 meeting before requesting the transfer of funds to FY97. If underspending is less than $200,000, the Department plans to phase in the project with the top priority given to merging the Human Services Reporting System COP module with the Human Services Reporting System Medical Assistance (MA) module.

Recommendation

Modify the Department's recommendation. Request that JCF transfer up to $200,000 from s. 20.435(7)(bd) to s. 20.435(6)(a) for system development costs in FY97. Further request that JCF stipulate that if less than $200,000 is available, DHSS give priority to merging the COP and MA modules.

Prepared by: Gretchen A. Fossum
266-2288

State of Wisconsin
Department of Health and Social Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

VIII

March 18, 1996

The Honorable Tim Weeden
Senate Chair, Joint Committee on Finance
Suite LL1, 119 Martin Luther King Jr., Boulevard
Madison, WI 53702

The Honorable Ben Brancel
Assembly Chair, Joint Committee on Finance
Suite LL2, 119 Martin Luther King Jr., Boulevard
Madison, WI 53702

Dear Senator Weeden and Representative Brancel:

As requested by the Joint Committee on Finance at its December 1995 meeting, attached is the Department's report on Options for Funding Systems Improvements for Data Collection for Wisconsin's Community Options Program (COP).

Sincerely,

Joe Leean
Secretary

Attachment

1 West Wilson Street • Post Office Box 7850 • Madison, WI 53707-7850 • Telephone (608) 266-9622

Data Collection for Wisconsin's Community Options Program: Options for Funding System Improvements

A Report to the Joint Committee on Finance

Wisconsin Department of Health and Social Services
Division of Community Services
Bureau of Long Term Support

March 1996

Summary

As directed in 1995 Wisconsin Act 27, the Department of Health and Social Services prepared a report on alternatives for an improved information system that would enhance efforts to coordinate the delivery and control the costs of services provided under Wisconsin's Community Options Program (COP). That report, entitled "Data Collection for Wisconsin's Community Options Program: Alternatives and Recommendations for System Improvement," was submitted to the Joint Committee on Finance for consideration at its December 1995 meeting. The report recommended the development of a comprehensive community-based long term support information system modeled after and expanding on the existing Medicaid Waiver information system. The proposed system would permit or enhance collection of four important categories of information--service-specific expenditure and utilization data, participant cost sharing data, information on informal supports provided to participants, and standardized information on participant functional status and care needs. It would also integrate COP program information with data on the Medical Assistance Home and Community Based Services Waivers, thereby facilitating coordinated management of these closely linked programs. Finally, by providing a single set of record keeping and data entry requirements, the system would simplify county reporting procedures and associated administrative tasks.

The projected cost of the recommended system is $300,000. Because the projected cost exceeds $50,000--the amount reserved for information system improvements in Act 27--the Department was instructed to prepare a second report on potential sources of additional funding that might be used to cover the cost of the new system. This paper discusses two sources of funds the Department has identified: 1) federal cost sharing and 2) COP funds that would otherwise lapse to the general fund be available at the end of FY 96 and FY 97.

The amount of unspent COP funds that would otherwise lapse will not be known until the end of each fiscal year. For this reason the Department is not requesting Committee action at this time. Instead, the Department will submit a request for Committee action after the amount of unspent COP funds is known and if sufficient revenue is available. A detailed funding plan would accompany such a request. The request would be to transfer the unspent COP funds that would otherwise lapse at the end of state fiscal year 1995-96 from the appropriation under s.20.435(7)(bd) to the appropriation under s.20.435(6)(a) for fiscal year 1996-97. If lapsing funds at the end of state fiscal year 1995-96 are less than $200,000, the remaining amount would have to be transferred to fiscal year 1997-98 from funds lapsing at the end of fiscal year 1996-97.

Funding Sources

A. Federal Financial Participation

The first option for funding the proposed COP information system, noted in the Department's original report, would be to secure federal financial participation toward the cost of the project. Under current federal regulations, there are two ways in which the Department could seek such

funding. First, 50 percent federal financial participation (FFP) could be claimed directly by charging the cost of allowable system improvements as a Medical Assistance administrative expense. There is a combined federal-state limit of $100,000 on the system costs that can be claimed in this manner, if the system or system modifications for which FFP is sought are to be obtained through a sole source contract, or noncompetitive acquisition. (Because the anticipated enhancements consist entirely of modifications to an existing system developed and maintained by the Department, the proposed modifications would be made as a noncompetitive acquisition). Therefore, the maximum amount of FFP the Department could claim under this option would be $50,000.

Second, 75 or 90 percent FFP could potentially be available toward allowable costs of the proposed system if enhanced federal funding were obtained. Enhanced funding requires prior approval from the Health Care Financing Administration, which must be obtained through submission of an Advance Planning Document. An APD must describe the proposed system or system modification, explain how the system will meet relevant programmatic objectives, and outline a budget and implementation schedule for the project. Most important, the APD must explain how the system modifications for which federal funding is sought are relevant to and will improve the state's Medicaid Management Information System.

The enhanced COP information system the Department is proposing to develop includes modifications to the Waiver Module of the Human Services Reporting System (HSRS), and that module is an approved component of the state's MMIS. There are grounds, therefore, for requesting enhanced FFP, but it is not possible to state in advance how much, if any, enhanced FFP the Health Care Financing Administration would approve for this project. Because the HSRS MA Waiver module was recently upgraded with the aid of $207,000 in FFP, and because the modifications to the waiver module included in the proposed project would not be made absent the effort to improve information collection for the non-MA COP program, it would be difficult to justify enhanced FFP for this project. If such funding were available it would be limited to the federal share of project costs reasonably attributable to system modifications that would benefit the Medical Assistance Waivers. The Health Care Financing Administration could further limit the federal contribution by requiring the Department to prorate costs to reflect the proportion of records maintained on the system that were MA Waiver records. Only by writing and submitting an APD could the Department determine whether the federal government would accept any portion of the project as improvements to the state's MMIS fundable with enhanced FFP. If previous experience is any guide, that process would require a minimum of six months to complete, with no assurance that any enhanced federal funding would be obtained as a result. If the proposed COP information system improvements are to be fully useful as the Department implements the major programmatic requirements that become effective in 1996, development of the enhanced system must commence well before six months have elapsed.

B. Lapsed COP Funds

An appropriate way to obtain GPR funding within the development time frame for the proposed COP information system enhancements would be to use COP funds that lapse from the amounts available for program services in calendar years 1995 and 1996. Lapsed funds represent the amount of combined COP and COP-Waiver GPR available in a calendar year remaining unspent after allowable carryover funds have been allocated to county agencies and the Department. Funds most commonly lapse when county agencies use COP monies to pay the service costs of persons eligible for, but not yet approved to receive, Medical Assistance Waiver funding. Once waiver funding is secured for these recipients, the previously expended COP funds are reimbursed from the county's MA Waiver allocation. When this occurs late in any given year, it may not be possible for the county to spend the repaid money on services for new or existing COP participants. If the amount remaining unspent exceeds the amount the county is allowed to carry over into the next calendar year, funds will lapse. Other reasons for the existence of lapsed COP funds include temporary changes in the availability of funding. For example, additional COP funding was made available under the transfer provisions of Wisconsin Act 469, and many counties held other funds in reserve to ensure continuation of services in the succeeding year or to cover unanticipated expenses.

The variety of factors affecting the expenditure of COP funds, including spending patterns among county agencies, has produced substantial variation in the extent to which COP funds lapse in any given year. According to the State Controller's Office, the following amounts have lapsed in each of the past five fiscal years:

State Fiscal Year	Amount Lapsed
1991	$394,902
1992	$114,983
1993	$345,798
1994	$162,884
1995	$193,498

The amounts that have lapsed during this period exhibit no upward or downward trend, nor are they proportional to the total appropriations in the respective fiscal years. Therefore, the amounts that may lapse in FY 1996 and FY 1997--the approximate period during which this project would be under development--cannot be predicted with any reliability at this time. The Department will be able to determine the magnitude of lapsing COP funds at the end of each state fiscal year. If the amount available from lapsed COP funds, together with federal funds obtained through a direct claim and the funds reserved under Act 27, were insufficient to cover the full cost of the proposed system, one of two approaches could be taken. First, the Department could prepare a proposal for enhanced federal financial participation and defer any action on system improvements while the proposal was under consideration by the Health Care Financing Administration. Second, the Department could take an incremental approach to development of the recommended system. Depending on the amount and timing of available funding, an incremental approach

would develop major enhancements in the following order: (1) merger of the HSRS COP module into the HSRS MA Waiver module to permit collection of detailed participant expenditure data and comprehensive tracking of community-based long-term support client benefits; (2) addition to this unified long-term support module of fields needed for the collection of participant cost sharing information and expanded data on informal supports; (3) collection of detailed data on participant functional status and care needs via development of an automated functional assessment form. While data on participant functional status and care needs are very important to the efforts this project is intended to achieve, the large incremental cost (estimated at $117,500) of automating collection of these data means that this third stage could only be accomplished at the expense of more basic system improvements if significantly less than $200,000 in lapsed funds were available. Prioritizing improvements in this fashion would enhance the capabilities of the information system to the maximum extent possible within the context of constrained funding.

State of Wisconsin
Department of Health and Social Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

April 16, 1996

The Honorable Tim Weeden
The Honorable Ben Brancel
Members of the Joint Committee on Finance
119 Martin Luther King Jr. Boulevard
Madison, WI 53702

Dear Senator Weeden and Representative Brancel:

The Department of Health and Social Services is withdrawing its request of March 18, 1996, for the transfer of funds from the Disease Aids program, s. 20.435 (1) (e), to the Services, Reimbursement and Payment Related to AIDS appropriation, s.20.435 (1) (am). The Department now intends to use new federal funds earmarked for AIDS drug reimbursement, possibly combined with existing Ryan White funding, to cover the cost of the request. The Department had requested the transfer of $231,300 (GPR) to fund four new AIDS medications under the AIDS/HIV Drug Reimbursement Program (ADRP).

The federal government is in the process of authorizing $52 million nationally, under the Ryan White Program, to assist states in covering the costs of these new drugs, especially the new protease inhibitors. This authorization is included in both the House and Senate versions of the FFY 96 Omnibus Budget Bill (HR 3019). Wisconsin's share of this funding is estimated to be approximately $230,000. The federal bill requires that these funds be used for drug reimbursement programs. The Department intends to use these new federal funds, supplemented with current Ryan White funding if necessary, to cover the cost of adding the four additional drugs to the AIDS Drug Reimbursement Program formulary.

Currently about 85% of Wisconsin's Ryan White funds are allocated to regional consortia aids service organizations. Among midwestern states, Wisconsin allocates the second highest percentage of Ryan White funds to consortia. The one midwestern state allocating a higher proportion, Iowa, expends about 90% of its Ryan White funding on its consortia, but expects consortia to purchase medications as well as care, treatment and supportive services. Most states use at least part of their Ryan White funding to supplement their AIDS drug reimbursement programs. Wisconsin is one of only four states that exclusively uses state funds for its AIDS Drug Reimbursement

Program. It is appropriate for Wisconsin to devote part of its Ryan White funds to meet the demand for reimbursement of additional drugs. The Department intends to modify its grant plan with the federal government to include the use of Ryan White funds for the AIDS Drug Reimbursement Program.

Pharmaceutical companies and AIDS/HIV consortia have advocated adding fluconazole and clarithromycin to the Department's original s.13.10 request. The Department's request was in response to recent FDA approvals of new antiretroviral AIDS medications. These approvals were received within the last six months. The two additional drugs being promoted for inclusion in the formulary have been available for the last few years. Fluconazole was approved by the FDA in 1990, and clarthromycin was approved in 1994. Clearly these additional drugs do not meet the test for emergency criteria for s.13.10 funding. The Department will review the AIDS Drug Reimbursement formulary and consider adding additional drugs to the formulary. The Department will report the results of this review to the Joint Committee on Finance.

Sincerely,

Joe Leean
Secretary

Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873

April 16, 1996

TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: Health and Social Services--Section 13.10 Request to Transfer Funds from the Disease Aids Program to the HIV/AIDS Drug Reimbursement Program--Agenda Item IX

The Department of Health and Social Services (H&SS) requests a transfer of $231,600 GPR in 1996-97 from the disease aids program to the HIV/AIDS drug reimbursement program to expand the types of drugs covered under the program to include 3TC, saquinavir, ritonavir and indinavir.

BACKGROUND

Under the HIV/AIDS drug reimbursement program, H&SS pays pharmacies for the costs of selected medications prescribed to state residents with human immunodeficiency virus (HIV) infections who: (a) have income under 200% of the federal poverty level; (b) have applied for and been denied coverage under the state's MA program within twelve months prior to application; and (c) have no insurance coverage or only partial coverage for these medications.

By statute, H&SS is required to cover two drugs under the program, azidothymidine (AZT) and pentamidine. In addition, H&SS is authorized to provide coverage of other drugs that are cost-effective alternatives to AZT and pentamidine. Prior to adding coverage of other drugs, H&SS is required to consult with individuals, including those not employed by H&SS, with expertise in issues related to drugs for the treatment of HIV and acquired immunodeficiency syndrome (AIDS).

Currently, the program covers two types of drugs -- antiretroviral drugs, which inhibit the replication of the virus, and prophylaxis drugs, which help prevent opportunistic diseases, such

as pneumocystis carinii pneumonia and mycobacterium avium complex (MAC). Beginning in October, 1995, coverage was extended to include acyclovir, an antiviral drug that is used in combination with antiretroviral drugs as an ongoing treatment for persons with severe or frequent recurrences of herpes simplex virus, and rifabutin, a prophylaxis medication prescribed for the prevention of MAC. The program does not currently cover medications that have the primary purpose of treating symptoms of opportunistic infections.

The following drugs are currently covered under the program.

I. *Antiretrovirals*

- AZT (Retrovir, zidovudine)
- DDI (videx, didanosine)
- DDC (HIVID, zalcitabine)
- D4T (Zerit, stavudine)

II. *Prophylaxes*

- Dapsone
- Trimethoprim Sulfamethoxazole (TMP/SMX)
- Pentamidine (Nebupent)
- Atovaquone (Meprone)
- Rifabutin

III. *Antivirals*

- Acyclivar (used in combination with antiretroviral drugs)

Under 1995 Wisconsin Act 27 (the 1995-97 biennial budget act), $327,000 GPR in 1995-96 and $392,600 GPR in 1996-97 is provided for the drug reimbursement program. These funds are budgeted in a larger appropriation that is used to support other HIV/AIDS programs administered by the Division of Health, including: (a) life care service grants; (b) counseling and testing services; and (c) payments to support the continuation of group health insurance coverage for persons with HIV who have reduced hours of work, whose employment is terminated, or who are on unpaid medical leave from employment due to an HIV-related illness. H&SS is authorized to transfer funds within this appropriation to adjust funding levels for the AIDS/HIV programs.

ANALYSIS

S. 13.10 Request

A brief description of each of the drugs H&SS proposes be added to the drug reimbursement program is presented below.

3TC (Lamiduvine). 3TC is an antiretroviral drug that was approved by the Food and Drug Administration (FDA) in November, 1995. It is recommended to be used in combination with AZT for initial treatment of HIV infection. Recent studies show that using 3TC in combination with AZT significantly increases the level of a patient's immune cells (CD4 cells) and reduces

concentrations of HIV by more than 50%. This treatment is considered the new standard of care for persons newly diagnosed with HIV.

Saquinavir, Ritonavir and Indinavir. Saquinavir, ritonavir and indinavir represent a new class of antiretroviral drugs called protease inhibitors. Other antiretroviral drugs, including AZT and 3TC, attack the AIDS virus at the time that viral RNA is transcribed to viral DNA, before the viral DNA is integrated into the host cell's own DNA. In contrast, protease inhibitors block the production of the enzyme protease, which helps assemble the virus after the host cell produces viral RNA and proteins. The combined use of traditional antiretroviral drugs and the new protease inhibitors have the effect of attacking the virus in two stages after the CD4 cell has been invaded by the virus, rather than a single stage. Further, the use of multiple drugs ("combination therapy") has been shown to be more effective in reducing the progression of the disease than the use of a single drug because, under combination therapy, the virus is less able to mutate to become resistant to the treatment.

Saquinavir was approved by the FDA in December, 1995; ritonavir and indinavir were approved in March, 1996.

The following arguments support the Department's request to include these four drugs under the HIV/AIDS drug reimbursement program.

First, recent studies demonstrating the effectiveness of these drugs in slowing the replication of the AIDS virus suggest that individuals who have access to these drugs will maintain their health for longer periods prior to being diagnosed with AIDS. According to a July 28, 1993, article that appeared in the Journal of the American Medical Association, the annual cost of health care for a person living with AIDS is ten times the amount of the annual cost of health care for a person with HIV infection. Consequently, the inclusion of these drugs is consistent with state's policy of prolonging the productive lives of individuals with HIV and deferring high health care costs that are incurred for individuals diagnosed with AIDS.

The Centers for Disease Control and Prevention defines a person with AIDS as an individual who either: (a) has a CD4 cell count of less than 200 cells per milliliter of blood, compared to a normal CD4 blood count of 1,000 cells per milliliter; or (b) has been diagnosed with at least one of several AIDS-related opportunistic diseases.

Coverage of each of these drugs was strongly recommended by the physicians with whom the Department consulted, based on the current body of research that has demonstrated the effectiveness of these drugs. If these drugs are added to the formulary, Wisconsin's AIDS/HIV drug reimbursement program would provide coverage for all FDA-approved antiretroviral drugs which are prescribed to meet the current standard of care for persons with HIV.

Second, if these drugs are not added to the formulary, some individuals currently participating in the program will not benefit from these new drugs because they will be unable to afford them. It is estimated that the average per client cost to the state of adding these

medications in the 1996-97 fiscal year would be $497 for 3TC, $1,273 for saquinavir, $1,391 for ritonavir and $1,000 for indinavir. However the average per client costs to the state are well below the annual cost to an individual who purchases these drugs because the state only pays for those costs not otherwise covered by other health coverage. For individuals without other health coverage, the costs of these drugs would be prohibitive. For example, it is estimated cost of purchasing saquinavir is approximately $7,000 per year.

Additional Drugs

The AIDS Resource Center of Wisconsin (ARCW) recommends that the drug reimbursement program be expanded beyond the four drugs recommended by H&SS to include two additional drugs, fluconazole and clarithromycin. It is estimated that the costs of adding these two drugs to the formulary would be $201,700 GPR in 1996-97.

Fluconazole is a prophylaxis that CDC recommends be prescribed to some persons with advanced stages of HIV (after the CD4 count has fallen to below 50 cells per milliliter) to prevent several types of fungal diseases, including candidiasis, cryptococcosis and coccidioidomycosis.

Clarithromycin is a prophylaxis that CDC recommends be prescribed, in conjunction with other drugs, such as rifabutin, to prevent the recurrence of MAC.

Several arguments could be made in favor of expanding the drug reimbursement program to include these additional drugs.

First, similar to other drugs currently covered under the program, these drugs are recommended by the CDC as a means of preventing opportunistic diseases.

Second, these drugs are currently covered under the state's MA program and are commonly provided to MA recipients with HIV. In fact, fluconazole was the most frequently prescribed HIV drug paid under the MA program in the 1994 calendar year and clarithromycin was the third most frequently prescribed HIV drug supported by MA in that year. One criterion that should be considered in determining which drugs should be covered under the program is utilization of the drug by current and potential clients.

Third, these two drugs are commonly covered under HIV/AIDS drug reimbursement programs in other states, including programs administered by Wisconsin's neighboring states. A comparison of these states HIV/AIDS drug reimbursement programs is provided in Attachment I.

Arguments for not including these two drugs at this time follow.

Process. The four drugs recommended by the H&SS for inclusion in the program were very recently approved by FDA. In contrast, fluconazole and clarithromycin have been available for several years and could have been considered for inclusion in the program as part of the 1995-97 biennial budget process. It is not clear that a request to add these two drugs at this time would meet the emergency criteria established under s. 13.10 of the statutes.

Priority Use of Funds. Although fluconazole is recommended by CDC as a method of preventing fungal infections, it is frequently used to treat, rather than prevent these infections. According to The HIV Drug Book:

> "There is considerable debate whether it is worthwhile to use fluconazole (or any antifungal drug) to prevent disease. Fluconazole clearly works for this purpose, but it is cost prohibitive for many people and may not be cost-effective for anyone. Fungal infections in AIDS are generally so responsive to treatment that it may not be necessary to take drugs to try to prevent them, especially since it adds another, perhaps unnecessary and certainly expensive drug to a person's daily regimen. In addition, prolonged use of fluconazole may cause the spread of strains resistant to the drug. Fluconazole-resistant candida and cryptococcus have been a growing concern in recent years. If fluconazole loses its effectiveness against these fungi, a person may have to use the highly toxic amphotericin B. Because of this concern and the risk of azole-related drug interactions, many physicians recommend azole antifungals for treatment and maintenance, but not for prevention of fungal disease in people with HIV."

Based on the current debate over the use of fluconazole as a prophylaxis and the fact that the drug reimbursement program does not currently cover drugs used to treat opportunistic diseases, the inclusion of fluconazole in the formulary may not be as high of a priority as other prophylaxis drugs that could be considered for inclusion.

Fiscal Effect

Future Program Costs. The future costs of the AIDS/HIV drug reimbursement program are likely to increase as a result of: (a) increased use of combination drug therapies; (b) the development of new (and costly) drugs; and (c) prolonged survival of individuals participating in the program due to the effectiveness of these new drugs. As part of the Department's s. 13.10 request, Secretary Leean indicates that the Department will develop options for consideration by the Legislature and the Joint Committee on Finance that may reduce future program costs.

Expenditures. Under the Department's request, $231,600 GPR in 1996-97 would be transferred from the disease aids appropriation to the HIV/AIDS drug reimbursement program to support the estimated costs of adding 3TC, saquinavir, ritonavir and indinavir to the formulary.

An additional $201,700 GPR, for a total of $433,300 GPR in 1996-97, would be needed to also add fluconazole and clarithromycin to the formulary.

Revenues to Fund Request. The monies that H&SS proposes to transfer to fund increased expenditures for HIV/AIDS drug costs were originally provided for the disease aids program.

In the 1995-97 biennium, Act 27 provided $5,697,200 GPR in 1995-96 and $6,681,500 GPR in 1996-97 for the disease aids program.

Based on actual expenditures to date, costs of the disease aids program are lower than anticipated in Act 27. As part of the revised estimate of the state's general fund balance at the close of the 1995-97 biennium which was prepared by the office in January, 1996, a lapse of $1.0 million was assumed from the biennial disease aids appropriation at the close of the 1995-97 biennium.

As of February, 1996, the projected lapse at the close of the first year of the biennium is projected to be $1.3 million based on expenditures to date; additional funds will also lapse in 1996-97. In general, the lapse of funds from the disease aids program is attributable to: (a) changes to eligibility and poverty-related guidelines for the program; and (b) cost containment initiatives to specify allowable costs for reimbursement.

With these changes and the resulting impact on costs of the disease aids program, a transfer of funding under either of the two alternatives for the HIV/AIDS program could be supported with funds from the disease aids program.

ALTERNATIVES

1. Approve the Department's request to transfer $231,600 GPR in 1996-97 from the disease aids appropriation to the HIV/AIDS drug reimbursement program to support the estimated costs of adding 3TC, saquinavir, ritonavir and indinavir to the formulary.

2. Transfer $433,300 GPR in 1996-97 from the disease aids appropriation to the HIV/AIDS drug reimbursement program to support the estimated costs of adding 3TC, saquinavir, ritonavir, indinavir, fluconazole and clarithromycin to the formulary.

3. Deny the request.

Prepared by: Charles Morgan

ATTACHMENT I

AIDS DRUG REIMBURSEMENT PROGRAMS
WISCONSIN AND NEIGHBORING STATES

Category	Illinois	Indiana	Iowa	Michigan	Minnesota	Ohio	Wisconsin
Financial Eligibility	<=400% of Poverty Less than full insur.	<=300% of Poverty No other insurance	Financial Need	<=185% of Poverty Less than full insur.	<=300% of Poverty Less than full insur.	<=300% of OH Pov. (about 210% of US) Less than full insur.	<=200% of Poverty Less than full insur.
Medical Eligibility	Documented HIV+	Documented HIV+ CD4<550	Documented HIV+	Documented HIV+ CD4<500	Documented HIV+	Documented HIV+	Documented HIV+
# of Drugs Covered	110	21	Any HIV drug	15	37	14	10
Cover Flcz/Clrth?	Yes	Yes, but may drop Flcz. in April 1996	Yes	Yes	Yes	Yes	No
Cover Protease Inhibitors?	Yes	Not yet	Yes	Not yet	Yes	Not yet	Not yet
Program Budget	$2,197,500 State $1,300,100 Federal	$600,000 Federal	$65,400 Federal plus private funds	$342,200 Federal	$160,000 Federal	$200,000 State $700,000 Federal	$295,800 State
Clients Served	2,047	368	132	300	231	590	267
Group that recommends formulary changes	Drug committee of Ryan White Advisory Council	Formal advisory panel of physicians, pharmacists, clients	Consortia set policies for each region	Group of physicians, advocates contacted on ad hoc basis by MI Pub Health Dept.	Formal advisory board consisting of infectious disease physicians	Formal advisory board of physicians, pharmacists and case managers	Group of physicians contacted on ad hoc basis by WI Bureau of Public Health
Notes	Administrative rules prioritize classes of drugs to be covered. Antiretrovirals are given highest priority, then prophylaxis drugs, then treatment of neoplasms, then treatment of opportunistic infections.	Indiana's program is currently having a major funding shortfall. 80 people are on waiting list. No adult males have been added to program since 12/95. Only women and children currently being approved.	Iowa's drug program is administered locally by four consortia and is funded with a mix of Ryan White and private funds. As such, program eligibility is flexible and decided as part of local consortia case management.	Michigan is trying to determine how it will cover protease inhibitors and may drop other drugs to do so.	MN emphasizes the purchase of individual health insurance policies for their clients. As such, only 40 of their 231 clients are uninsured. This accounts for their low spending on drug reimbursement.	Ohio's formulary includes all WI ADRP drugs, minus atovaquone, plus 3TC, fluconazole, clarithromycin, ketaconazole and clotrimazole.	Covers antiretroviral and primary prophylaxis drugs. Has not in past covered treatment drugs. One of only four states nationally not using Ryan White dollars for drug program. Eighth highest state funded program in SFY 95.

Source: Wisconsin Department of Health & Social Services, Division of Health, HIV/Aids Program

MANUFACTURERS OF AIDS DRUGS

Drug	Manufacturer
3TC	Glaxo-Wellcome
Saquinavir	Hoffman-LaRoche
Ritonavir	Abbott Labs
Indinavir	Merck
Fluconazole	Pfizer-Roerig
Clarithromycin	Abbott Labs