



Pat Quinn, Governor
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**Illinois AIDS Drug Assistance Program (ADAP)
Medical Issues Advisory Board (MIAB)
May 21, 2010 Meeting Notes**

Board members present: D. Berger, C. Conover, A. Fisher, G. Harris, P. Langehennig, J. Maras, B. Moran, M. Maginn, D. Munar, R. Rivero, B. Schechtman, S. Tear, and M. Williamson
Board members present by conference call: S. Feigenholtz, J. Lynn, R. Lubelchek, B. Max, and P. Moss-Jones

Excused Absences: S. Dolan, D. Graham, E. Noel, and O. Torres

Unexcused Absences: None

Guests: B. Akaumoah, J. Berry, K. Bovid, R. Stewart, M. Wolthoff, and D. Yamashita,
Illinois Department of Public Health (IDPH) Staff: M. Charles and L. Kasebier

Dr. Jeffrey Maras called the meeting to order at 1:05. Dr. Maras welcomed attendees and reminded attendees of Robert's rules. Guests were in the audience and by telephone, in accordance to the open meeting act. Guests were asked to hold questions until the end of the meeting. Dr. Maras emailed handouts prior to the meeting. The meeting began with roll call of board members.

The first topic on the agenda was a review of the minutes from the April 26, 2010 meeting minutes.

Motion to approve: B. Moran
Second: M. Williamson
Agree to approve the minutes: All
Disagree to approve: None
Abstain from the vote: None

Dr. Maras then proceeded to old business. Dr. Maras informed the group that they are looking to fill the second consumer seat. Dr. Maras then reviewed a couple of points from the HRSA consultant's site visit report.

The consultant recommended the board have 11 to 15 members. The board currently has 22. The lower number of members can be accomplished through attrition and reviewed annually.

Dr. Maras clarified the allowable mediums in which to conduct meetings. Allowable mediums include telephone and web interface, with the exception of chat rooms.

Motion to approve the bylaws: D. Munar
Second: P. Langehennig

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Before the board could vote, a couple of questions were raised. The board clarified Article IV, Section 4-1. Quorum should be of voting members. The first sentence should be removed and just keep the second sentence. “Appointed” should be changed to “voting.”

Article VI, Section 6-1. Two-thirds of the whole advisory board is excessive. The board recommended two-thirds of the voting members present.

Motion to approve the bylaws with changes as noted above: A. Fisher
Second: M. Maginn
Agree to approve the minutes: All
Disagree to approve: None
Abstain from the vote: None

Question: What are the terms of board members?

Answer Dr. Maras: The term is July 1 to June 30 and may be for one, two, or three years. The subcommittee decided on a lottery draw for terms of members. Dr. Maras will notify members by email of their term.

Dr. Maras then asked for nominations for the community co-chair. R. Rivero was nominated, but declined the nomination. P. Moss-Jones volunteered for the nomination.

Motion to close the nominations and hold a vote: B. Moran
Second: B. Schechtman
Agree to P. Moss-Jones as the external co-chair: All
Disagree to approve: None
Abstain from the vote: None

Dr. Maras and Dr. Williamson will reach out to other consumers to get a vice-chair.

The board set the meeting dates for the next two years. Meetings will be scheduled four times a year, on the following dates:

July 16, 2010, October 15, 2010, January 21, 2011, April 15, 2011, July 15, 2011, and October 21, 2011

Motion to approve the meeting dates through 2011: D. Munar
Second: B. Moran
Agree to approve the meeting dates: All
Disagree to approve: None
Abstain from the vote: None

Dr. Maras then moved to new business on the agenda, beginning with an ADAP status update and the monthly report chart. The following questions came from the group.

Question: Is overnight shipping an additional cost in the ADAP dispensing fees?

Answer Dr. Maras: The standard dispense fee includes overnight shipping, no additional costs.

Question: What are insurance costs?

Answer Dr. Maras: ADAP pays insurance co-pays for those with 80/20 policies. ADAP also will assist with individuals with high deductibles and out-of-pockets as long as CVS is allowed in-network. Usually once deductibles and out-of-pockets are covered ADAP closes the client as their prescription copayments drop below the 80/20 Policy. If after deductibles and out-of-pocket costs and the copayments are still high, then ADAP will continue to cover the copayments. This is different than CHIC as CHIC only pays for premiums.

Question: What are the reasons for denials?

Answer Dr. Maras: Usually applicants are over the income level of 500%, insurance may be below 80/20 with less than 20% co-pays, or individuals may be eligible for Medicare, Illinois Cares Rx, or Medicaid. Some denials may or may not have other payer source, but many do have other sources and are not paying out-of-pocket.

Question: Why are there differences in drugs expenses from month to month?

Answer Dr. Maras: Some months may have credits from back billing that reflects expenses from other months and changes in regimens and the number of clients receiving services.

A request was made to have an analysis between clients served versus clients enrolled.

A discussion of issues with Medco was postponed until another meeting.

Dr. Maras stated that ADAP projections have been on target. Last month expenditures exceed projections. All GRF has been expended and the program is operating on federal funds alone right now. April used \$5.9m in federal funds. By June 30, half of the federal award will be expended. The entire federal award will be expended by the end of September. GRF is needed to continue funding from October through March. If ADAP receives flat funding from GRF, the program may be out of money by the end of November or beginning of December. The board needs to discuss how to take current funding to get through to March. The HRSA technical assistant consultant stressed this point in the recent site visit. HRSA recommended we implement cost containment in two phases.

Phase 1: Decrease FPL for all new incoming clients from 500% to 300% and any close clients reapplying. Also, lower monthly cap from \$2,000 to \$1,500. HRSA approves the formulary changes made effective June 1, 2010.

Phase 2: Decrease FPL to 300% for all clients.

ADAP currently has 463 active clients between 300 – 500% FPL, out of 5,920 enrolled clients. ADAP will look at closing active clients who have not received any drugs over the past six months.

After GRF is appropriated, we could reverse any implementation of cost containment, in reverse order of implementation.

A request was made to have an analysis of new clients done by FPL, utilization, difference between enrolled and served, and potential savings.

Comments and discussion from the board:

- Concerned that Phase 1 and/or Phase 2 is not enough to close gap in funding. If we start a wait list sooner, how much in savings would that generate? Would that produce savings needed? May need Phase 2 moved up to Phase 1 sooner.
- Lowering the FPL to 300% will make individuals ineligible, not on wait list. Wait lists are only for eligible clients. We need to do something to save \$1m per month. Some pharmaceutical assistant programs (PAP's) have the ability to mark ADAP as pending and qualify for PAP's. Clients with income between 400 to 500% FPL have the hardest time finding other assistance. Should look at eliminating the lower FPL's first?
- Another board member responded that the Governor will not allow us to eliminate lower FPL's.
- We may need to create a waitlist now, keeping in mind to not interrupt treatment.
- It is not possible to have FPL start at 300%. We need to be concerned about new people enrolling now, knowing that Phase 2 may happen in July. We may need to start a wait list now that will protect those already in the program.

Dr. Maras stated that the Department would like a recommendation from ADAP MIAB on what Phase 1 should be.

Comments and discussion from the board:

- Should we consider CD4 counts? Disallow clinicians proactively enrolling clients and only have a wait list for clients already on medications or needing to start?
- Dr. Conover responded, stating that using CD4 counts for wait lists are difficult to monitor and we would need further discussion on how to implement.
- Are clients that do not reapply denied? Dr. Maras stated yes, but that may not save any additional funding.
- What factors should we consider for wait list? Legal status, income levels, health? How would we implement and monitor?
- We should implement a wait list now, and make adjustments based on public feedback.
- Another board member agreed to start a wait list now, rather than waiting until the 11th hour.
- We should eliminate clients enrolled, but not actively on medications.

Motion for a moratorium, accept no new applications, and create a wait list: P.

Langehennig

Second: D. Munar

Discussion from the board on the motion:

- Only eligible clients will be placed on the wait list.
- ADAP should keep a list of all clients on the wait list.

- The board should create hardship guidelines.
- Dr. Maras: We have to specify a certain number of clients to serve. At \$43m funding, we can serve 3,800 active, enrolled clients. Three percent of the slots could be reserved for high-risk populations.
- Should we amend the motion to include emergency cases?
- We should allow for high-risk, undocumented, non-Cook County clients, as other resources are available for Cook County clients.
- We should have health as first priority, not income.
- Several board members commented about waiting until 2014 for Medicaid.
- Some clients may qualify for the high-risk pool.

Motion to amend the motion to include, “with discretion from the medical advisory subcommittee to develop hardship guidelines:” B. Schechtman

- Several board members commented that no one wants to create a wait list, but we have to contain costs now or we will affect a lot more people later.
- What is the timeline? Dr. Maras stated that we have to take the board’s recommendation to OHP for approval.

Motion to vote on the motion with the amendment included: Implement a moratorium, accept no new applications, and create a wait list, with discretion from the medical advisory subcommittee to develop hardship guidelines.

Agree to approve: All

Disagree to approve: None

Abstain from the vote: None

The board then discussed making a motion to lower the cap to \$1,500.

- If clients are averaging \$950 per month, should it be lower?
- Dr. Maras stated that adding one OI pushes clients over \$1,500. A small number are consistently over \$1,500 and pushing \$2,000.
- The cap was previously raised from \$1,200 to \$2,000 without board approval. Dropping the cap to \$1,500 will not make that much prescribing change, with discretion for regimen changes.
- We should enforce the cap going forward for those consistently at or close to \$2,000 and investigate those who occasionally exceed.
- Changing the cap may allow eligibility to PAP’s. We need to add discretion as an amendment to the motion.

Motion to lower the cap from \$2,000 to \$1,500 per month, with discretion: P.

Langehennig

Second: D. Munar

Agree to approve: All

Disagree to approve: None

Abstain from the vote: None

Comments and discussion from the board:

- We should have one exception that the Department reserves the ability to make exceptions due to extreme medical necessity on a case-by-case basis.
- We should have a defined list of guidelines. We need to look beyond t-cell counts.
- Dr. Conover stated that we will need to determine the factors for the wait list.
- On the reapplication, enrolled clients but not actively on medications should be put on the wait list.
- We need to determine the medical criteria for the wait list.
- We should restrict to individuals on ARV and/or OI.
- Dr. Maras: We currently have 288 clients enrolled that are not actively getting medications.
- Would we experience an increase in enrollment with people trying to beat the moratorium?
- Should we make the moratorium backdated?
- Should we enforce a three-week lag time to allow time for the wait list?
- Dr. Maras: ADAP has a policy allowing for a 15-working day processing time.
- M. Charles: The effective date should be today, May 21, 2010.

Motion that at clients six month reapplication, client utilization should be reviewed and if no ARV and/or OI treatment or prophylaxis has been used consistently over the previous six months, clients should be moved to the wait list: B. Schechtman

Second: P. Langehennig

D. Munar stated that he wants more information to make a decision as to what happened to make clients inactive during the six months. He also would like questions added to collect if a client is on medications or not and why.

Dr. Maras stated that the new application does ask what regimen a client is currently on.

B. Schechtman withdrew the motion for discussion at the next meeting, with recommendation from the Department. The item will be put on the agenda for the next meeting.

Additional comments and discussion from the board:

- We need the recommendation from the Department on the number of slots, define active clients, difference between clients served and enrolled and not served, how many used medications at any point, and if occasionally getting medications, are those clients on Medicaid.
- Can we get data on funding gap to line up wait list?
- Dr. Maras: We have \$34m federal. Based on current costs and projects, we will have a \$55m program by March 31, 2011. We need \$20.9 GRF to keep up with projections. If we fail to get \$20.9m GRF, we will need the MIAB and Department to make major decisions surrounding how to address the funding shortfall.
- The board asked for a copy of the HRSA recommendations report.

Dr. Maras opened the floor for guest comments.

The next AMIAB meeting is June 18, 2010 from 1 to 4 p.m.

Dr. Maras asked for a motion to adjourn.

Motion to adjourn: D. Munar

Second: M. Maginn

Agree to adjourn: All

Disagree to adjourn: None

Abstain from the vote: None

The meeting adjourned at 4:05 p.m.