Illinois Department of PUBLIC HEALTH

Pat Quinn, Governor
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Illinois AIDS Drug Assistance Program (ADAP)
Medical Issues Advisory Board (MIAB)
September 17, 2010 Meeting Notes

Board members present: C. Blum, C. Conover, S. Feigenholtz, A. Fisher, P. Langehennig, R. Lubelchek, J. Lynn, J. Maras, B. Max, P. Moss-Jones, D. Munar, B. Schechtman, and G. Harris
Excused: D. Graham, M. Maginn, B. Moran, D. Graham, R. Rivero, and M. Williamson
Unexcused: D. Berger and S. Dolan
Illinois Department of Public Health (IDPH) Staff: M. Charles, L. Kasebier

Guests were in attendance both in person and by phone.

Dr. Jeffrey Maras called the meeting to order at 1:10. Dr. Maras welcomed attendees and explained the format for the meeting. 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. The meeting began with roll call of board members.

1. Announcement

Dr. Maras announced that Sharon Tear has retired and has resigned from the board. Dr. Maras will look for a downstate replacement.

2. Review/Approve Minutes

The minutes from July 16, 2010, were reviewed and no corrections noted.

Motion to approve: P. Langehennig
Second: D. Munar
Agree to approve: All
Disagree: None
Abstain: None

3. Old Business

No old business was on the agenda.

4. New Business

4.A. ADAP Status Update

Dr. Maras provided a status update for ADAP. In August, ADAP enrolled 6,044 clients, which is a record high. 4,251 clients were served with $3.7m in direct service medications. The dispensing fee was $133,000. Insurance co-payments were $64,500. Of the clients served, 139 were new clients, 406 were reapproved, and 20 denied.

Dr. Maras reminded the group that the re-approval number will have a reporting delay of 15 days, due to the staff shortage and the 15-day processing time for ADAP applications.

The re-approval numbers do not yet include the six-month reapplications. The first group will reapply in October. ADAP has just sent out the reapplications for October. One thousand applications were mailed out.

Matt Charles provided an update on the budget. The Department has received $25m in GRF for the entire HIV/AIDS section, which includes GRF grants and ADAP. The GRF grant applications are due September 24, 2010. The Department received the notice of grant award for the Part B supplemental funds, which was approximately $750,000. Approximately $450,000 will go to ADAP.

The Department has received guidance from HRSA regarding collecting rebates. Direct purchase states can collect rebates from insurance co-payments made on medications. Dr. Maras is working on the approval process and policy. Illinois just received approval to be a hybrid – dual direct purchase and rebate state. Illinois can pursue rebates starting October 1 on approximately 15 to 20 percent of clients with insurance, which is an estimate $500,000 in cost savings per year.

The ADAP application has been redesigned for the online application. The application will be in Provide®. Case managers or any other provider on Provide will be able to click a button and have the application automatically populate with the client's information. Case managers, other providers, or clients who do not have access to Provide® will be able to submit applications on-line through a secure website. Training webinars will be held in December, for both Provide® users and non-Provide® users.

Through December, ADAP will accept applications electronically and mailed copies. Starting in January 2011, ADAP will only accept electronic copies using the newly developed application.

4.B. ADAP and Medical Reform

Beginning January 1, 2011, Medicare clients on ADAP will be able to count ADAP drugs towards their TrOOP due to changes in the Healthcare Reform legislation. ADAP has been working on ensuring the computer system is updated and a data share agreement with the federal Medicare/Medicaid Service Center (CMS). Last year, 340 clients were Medicare eligible last year with an average drug cost per month of $1,050. Currently, 155 clients are Medicare eligible. ADAP will notify any Medicare Part D clients as more information becomes available.

As more information becomes available from the federal government, ADAP will prepare a fact sheet and FAQ sheet for clients and providers.

4.C. Operating a Wait List by Medical Criteria

The next item on the agenda was a presentation by Florida ADAP Director, Lorraine Wells, and Medical Director, Dr. Jeff Beal. Florida operates a wait list by medical criteria. Dr. Maras distributed Florida's ADAP Guidance for Cost Containment prior to the meeting for MIAB member review.

Florida is a direct purchase state. On April 1, 2010, Florida suspended any expansion to their formulary. On June 1, 2010, Florida implemented a wait list. Prior to June 1, they worked on

cost containment measures, procedures, and protocols. They made sure to address clients fairly. Florida chose a medical criteria model rather than first come, first serve model.

Clients were notified of upcoming changes, the impact of reductions, and frequently asked questions, available in several languages. Florida created a flow chart for staff to understand the process, which helped identify problems.

In order to create the waitlist criteria, Florida used the DHHS guidelines, consulted the AIDS Education and Training Center (AETC), and worked with major clinics. Clients were included in the workgroup as well. It was very important for Florida to create a strategic action plan and to stick to it throughout the process.

Pregnant women are never denied medications, along with a few other exceptions. Adolescents and perinatally infected were granted exceptions. The guidelines provided a form for anyone to request an exception. To date, Florida has received 237 requests for exceptions and approved 76 exceptions.

Prior to implementing the wait list, Florida held trainings and distributed the guidance in local community meetings.

HIV-positive clients co-infected with Hepatitis C currently on ADAP was kept on ADAP due to the importance of continuing treatment. New clients co-infected were referred to PAP's. Florida ADAP staff worked with all clients placed on the waiting list to get them on PAP's. Any client on the wait list is getting medications from a PAP. Once the state established a wait list, their clients became eligible for PAPs.

Currently, Florida does not have a procedure in place to track client health status changes while on the wait list.

As of the meeting date, Florida had 1,760 on the wait list, with the enrollment capped at 11,200.

Clients who do not pick up medications within 60 days or have no activity for 60 days are closed from ADAP and must reapply. If the client is 14 days or more late for a medication, the Florida ADAP staff must call the client's physician to get approval to restart. If more than 30 days late, the client may need to see their physician or get a verbal approval to restart. If more than 60 days, the client is automatically closed.

Florida will bring together a workgroup to develop a process on how to address any openings that may occur in their category A on ADAP. In order for Florida to open up enrollment or to fill any open slots, their enrollment needs to get down to 7,000 clients.

Florida has not encountered any problem with getting undocumented clients on PAPs. A pharmaceutical representative in the audience stated that the PAP language has been changed from "U.S. citizen" to "resident."

Florida plans to have an ADAP forum meeting on October 1 with stakeholders to address questions and problems that have come up. They will look at the following items:

- Usage data on reduced formulary, unused drugs, older drugs, and further cost-containment measures
- Compare per capita data before the wait list and now
- Look at shortening the non-compliant time frame
- Reducing the current FPL of 400%

Dr. Maras thanked the representatives from Florida for addressing our MIAB and sharing their experience with wait list.

4.D. Guided Discussion Regarding Recommendations

Dr. Maras asked the board to discuss cost containment measures and specific language for recommendations.

The board discussed lowering the client cap from $2,000 to $1,500 per month. Lowering the cap may serve as an early warning, showing a shift in prescribing patterns to higher cost medications. The potential impact may be $750,000 in savings per year.

The board asked for the Department's 340B pricing for medications, but those costs are confidential and the Department is prohibited from sharing. Dr. Maras and CVS confirmed that if a client reaches and/or exceeds the current cap, the client's physician will be contacted.

The board then discussed automatic exceptions to lowering the cap, then recommended the issue should go to the medical issues subcommittee.

5. Floor Opens for Questions/Comments from Guests

No questions or comments from guests.

6. Next Meeting Date

The next meeting is the quarterly meeting on October 15, 2010 from 1 – 4 p.m. The location will be announced.

7. Motion to Adjourn Meeting

Motion to adjourn: P. Langehennig
Second: D. Munar
Agree to approve: All
Disagree: None
Abstain: None

The meeting adjourned at 4:00 p.m.