Illinois Department of PUBLIC HEALTH

Pat Quinn, Governor
Damon T. Arnold, M.D., M.P.H., Director

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Illinois AIDS Drug Assistance Program (ADAP)
Medical Issues Advisory Board (MIAB)

DATE	October 21, 2011
BOARD MEMBERS PRESENT	J. Maras, M Maginn, D. Munar, B. Schechtman, A. Fisher, B. Max, B Schedchtman, Rep. S. Feighenholtz, Rep Greg Harris, M. Williamson
BOARD MEMBERS PRESENT BY CONFERENCE CALL	C. Blum, P. Moss-Jones, P. Langehenning
BOARD MEMBERS EXCUSED ABSENCE	B. Moran, D. Graham, R. Lubelchek, R.Rivero, C.Conover
BOARD MEMBERS INEXCUSED ABSENCE	Daniel Berger
ILLINOIS DEPARTMENT OF PUBLIC HEALTH STAFF	A. Danner, P. Muir, J. Nuss, L. Humphrey
CALLED TO ORDER AT	1:06 p.m.
MEETING WAS ADJOURNED AT	4:12 p.m.
ANNOUNCEMENTS	
1. MINUTES FROM APRIL 15, 2011 MEETING	Corrections or additions: Motion to approve: D. Munar Second: A. Fisher Agree to approve: all Disagree: none Abstain: none

MIAB MINUTES

TOPIC/AGENDA	DISCUSSION	FOLLOW-UP
2. Old Business		
a. No Updates		
i. Date request/s reports addressed during the April board meeting covered during ADAP Update section of meeting		
3. New Business		
a. ADAP Status Update and Discussion points	Dr. Maras spoke of vacant positions for staffing for ADAP. A. Fisher made a motion to have the membership subcommittee review membership list and bring recommendations back to the MIAB. Second: D. Munar Agree to approve: all Disagree: none Abstain: none	
i. Staffing Updates		
1. Removal of temporary workers – 3	Successfully received three temporary workers & our department were prohibited from returning on 9-16-2011.	

2. Two vacant positions – status update	Dr. Maras spoke of vacant positions for staffing for ADAP. Interviews for two positions are being conducted and in E-par and second set of interviews this week. Critical timing for full time positions all procedures dealing with ADAP. Within the next month two positions will be fully trained. ADAP has been put on a priority list for full time hires being more efficient, federal funded positions. ADAP staffing is fully federally funded. Questions were asked about the federal funding and positions regarding ADAP and Dr. Maras explained federal funded positions and GRF positions. Blake Max agreed more staffing and more help with ADAP. Positions for ADAP: Methods & Procedures Career Associate.	
ii. Reporting of the approved ADAP budge for FFY 2011 and SFY 2012	Dr. Maras reviewed the FFY 2011 and SFY 2012 distributed a report that is available upon request. • **Federal Ryan White ADAP Base Award** – FFY 2010 -- $29,557,287.00 FFY 2011 -- $29,556,713.00 % of change -0.002% • **Federal Ryan White Supplemental Award** – FFY 2010 -- $4,507,912.00 FFY 2011 -- $2,201,478.00 % of change -51.164% • **Federal Ryan White Part B Supplement Redirected to ADAP** FFY 2010 -- $703,919.00 FFY 2011 -- $344,830.00 % of change -51.014% • **Federal ADAP Shortfall Relief – (1 time award)** FFY 2010 – $0.00 FFY 2011 -- $722,935.00 % of change – 0.00% • **Rebates (estimates for FFY 11)** FFY 2010 -- $0.00 FFY 2011 -- $375,000.00 % of change 0.00% • **Projected General Review** FFY 2010 -- $18,000,000.00 FFY 2011 -- $18,571,500.00 % of change 3.175% • **TOTALS** FFY 2010 -- $52,769,128.00 FFY 2011 -- $51,722,456.00 % of change -1.889% Dr. Maras explained numbers of the budget for August and department is one month behind in billing. 5511 clients enrolled met all criteria for ADAP procedures.	Add a percent column. Reapproved and denied broken down Total expenses happen, add up all three columns, total combined expenditures for entire program. Combined total expenses (month to month), Full chart comparison on how much savings for a year, august to august.

	Harris: what is the difference in the clients enrolled and clients served? Dr. Maras explained the difference between the two along with the drug/copayment and deductible. Blake: Q. stated clients do not know they are enrolled. Dr. Maras explained there are lots of applicants who do not check enrollment. Questions about letters that do not go out to the clients. National state never access. Data not collected when enrolled. Dr. Maras spoke of the Medicare D reform. ADAP is prohibited to report to Medicare D. Change came January 1st regarding data share agreement in Baltimore and point of purchase contract in place. This reports to troop and there was a third party. All Medicare D who were in the direct service column are now counted with rebates. Cause in decrease for drug expenses and increase in the insurance column. Dr. Maras explained: new clients who have never been on ADAP. September & October roll out will see a trend of new clients. 899 approved, denied 20, denials are around income, insurance plan not in network with our CVS Specialty Care Mark Pharmacy. Cigna and Medco are the main ones, also non residents of Illinois. Explained the FPL level with 300 % or over and lower than 500%. July 300% new clients and closed clients. Cohort has been preserved for those clients prior to July 1, 2011. Dr. Maras explained Average client cost for a drug purchase client 12,600. Avg. number of drugs a client takes enrolled in our program is 4 or 4.5. 4,550 a year for Medicare D clients, 5% catastrophic level, Dr. Maras explained. Private insurance discussed along with Medicare D and how it affiliates with our CVS network. A motion to request the Department, in conjunction with, the medical issues subcommittee, moves forward on creating medical criteria protocol wait list to be available in case a wait list is needed. Motion: D. Munar Second: A. Fisher Agree: all Disagree: none Abstain: J. Maras	Follow-up on what is driving denied applications.
iii. Report of enrollment numbers and expenditures through August 2011	Dr. Maras reviewed the August 2011 enrollment numbers. • 5,511 clients currently enrolled • 4,126 clients served • $3,689,078.51 drug expenses • $127,881.00 ADAP Dispense Fees • $130,536.44 insurance costs	Re-iterating the fact of a wait list. Where are clients going if they fall off ADAP because of wait list?

	• 129 new client approved, of which 2 were above 300% FPL • 899 reapplications approved, of which 264 were above 300% FPL • 20 individuals denied • 22 clients 90- No Plan • 11 clients 90- plan • 209 clients Medicare D • 6 clients Pending Medicare D • 19 clients were Revolving – Medicaid • 413 clients with Private Insurance • 4,114 clients are IL-ADAP (Regular) Ryan White fiscal 7-1- to 6-30-2011, two fiscal years are based on these charts. October 12th on the date in which the report was pulled. Ryan white had a cut based on the formulary and supplements, and last year was the first year of competing for $ and rec'd 2.2 million. National trend ADAP wait list and cost containment states make more states eligible for this money. Florida takes a cut of this because of their wait list. Wait list spoke of, and Dr. Maras cannot address this, states governor is opposed to the waiting list. Dr. Maras states he has spoken to other ADAP directors and a wait list shuts the door to sustain the program. Wait list is the last resort. Subcommittee recommended a wait list and rejected by the department. Explained the wait list and how this functions. Miscommunication of a wait list. States must create seats on how much they can fund for wait lists and different values and clients. Individuals who are eligible but there is no funding to bring them aboard as money shows up or waiting on someone to removed from program. Is a wait list based on medical criteria or first come first serve. Medical criteria has been decided if it comes to IL getting a wait list. D. Munar – HRSA every opportunity to obtain cost containment. Discussed a wait list along with other states, spoke of a wait list and pushing for a wait list and afford more federal funds, Reiterating did pass, discussed, requesting to move forward on a wait list. Wait list: are they receiving care from another source? Does it raise the risk of transmission? S. Figehnholtz: 3 million dollar cut by the governor. Lots of push back on appropriations and trying to come up with additional money. 2 million more in the bank, M. Williamson, three years of burden in terms of the affect of income.	Policies of a wait list. Reapplication process and providers. Tracking those who are not allowed to access ADAP and cares. Re-do the financial status of the 2.0 million dollars. Calculations for GRF 2013 by no later than December 11, 2011. Be proactive for budget.

	Formulary at the federal level – Dr. Maras re-iterating the fact the dept has been making solid decisions for this program for clients whom fall into a gap. Lowered ADAP FPL, increased CHIC FPL to 500%, educated clients whom were in the 301-500 about IPXP. Explained process of how CHIC helps guide insurance clients so ADAP can still assist with the 1600 out of pocket expense. Clients are not falling through the cracks unless they choose to not return to the program. Education to case managers is also needed. Rep. Harris – asked whether or not eligible or waiting list, maximize the money. How to max revenue. M. Williamson – do not have enough – funding stream, insurance rebates, return for $ goes back into the drug line whom do not have insurance. D. Munar – strategy on ADAP, federal money not clear that having a wait list would be open to any more money, undetermined. We do not have the capacity to quantify. Efforts of dept. have only pushed for the wait list as a concern to exhausted efforts once they are reached. --value of wait list to 300-500, Dr. Maras we do keep matrix of 301 to 500 level of being denied clients. How are we tracking individuals (IPXP)? Educate -IPXP no income guideline, only just cannot have insurance for 6-month. Education is important, barrier medical expenditure, 80/20 split, 4500 medical side, ADAP and chic help with prescription and premium side. 100% after 1600. Barrier with IPXP and over 500%. Premium for healthcare package. Can go to Ryan White, efforts on education and partners on how to navigate for 4500. Needs to speak to the Ryan White (care side of the house). IPXP will go away 2014 and health care reform does not migrate. Thinking past a year and a half, Dr. Williamson and planning and are strategizing. Blake Max: is there not enough money in ADAP's current budget. Dr. Maras: the budget for his fiscal year has sustainability for our program until June. **Numbers are down because of FPL, wait list and renewal. Other elements in place making the program run smoothly.** State Health Dept. has been aggressive to be as proactive as possible. Rebates – started October 1 and request by quarters. What type of insurance clients are on, 800 to 1.2 million. One time award emergency relief, cost containment state, allowed to compete for the ER Fund, developed a grant to compete and were awarded on Sept 30th for 723,000, one time infusion, $ is targeted for sustaining new clients for a year. We asked for 2.7 million and now a budget narrative will be complete and will be sustained for this program. Dr. Maras explained.	

	Dr. Williams do not have enough history on the return for the pattern and do not know what this rebate will be yet. On list again for this money. Dr. Maras: explained. 90 day service plan, cost containment – clients enroll into the program. Initiative in this emergency rules (effect 9-26-2011 for 150 days) in the first 45 day of emergency rules. JCAR member – asked about emergency rules. Dr. Maras advised he could only speak of the department rules/policies. Increase in JRF. 1.8 reductions over last year. Blake max, 1000 short on money	
iv. Reports addressing Policy changes effective July 1, 2011		
1. 300% FPL impact report	• As of July 1, 2011 20 clients were denied from being over 300% FPL, but under 500% (this excludes insurance clients who remain at 500% FPL).	
2. 6 month recertification policy – HRSA policy	Upon arrival to ADAP certifications used to be one year; however, federal rules were not being followed and the state was in jeopardy 4-1-2010. Renewals went to six months and no audit findings. HRSA states: ADAP will not move back to an annual recertification because of federal mandate. Cost containment and discussion and challenges regarding the six month change, directed to go to an annual recertification and aggressively suggested it stay at six months. HRSA said: Legal Dept. is inaccurately interpreting the federal law and state GRF money. The state will pay back money dollar for dollar the minute any money is spent on a client who was not re-enrolled within a six month period. As of 4-1-2011 all clients are in compliance with the federal law per HRSA. Clients are always encouraged to apply for the program. Only letters being sent to clients from ADAP are conditionally approved clients, 90-day no plan, and denial letters. All other letters have been ceased due to a legal battle between HRSA and IDPH legal staff. Renewal letters, for ADAP, were sent on November, 15, 2011 for December clients. Resolution: Three ADAP programs, federal ADAP, insurance, and multiple enrollments were initiated for emergency rules. ADAP rules were noticed; rules were asked about; rules had not been looked at since 2006. Senior management alerted and advised we will see how this plays out. ADAP underwent emergency rules for 150 days and a 45-day process. Clients are under a six month recertification. If 12-month policy is pushed how will this affect the program? Federal partner is	Tables were presented. Add percentages across the tables and columns on who have never reapplied.

	not budging on the six month certification. ADAP received a sight audit on renewals. Program given five days into the next month prior to being closed; could have dispensed drugs in this amount of time when client was not enrolled currently in the program. Advised not to do it again. Recertification letters got changed with new parameters. Every month, eight weeks prior to renewal clients get a letter with information to reapply for the program. Clients have three days prior to the end of that particular month to get application and supporting documentation to the Department otherwise client will be closed. Dr. Maras has had discussions with Dr. Blum and others to create a view in provide or generate a report to the facility in which clients are associated for renewal purpose. Updated "authorization to release form" on the website; updated last week. Clients must give release to expand information and to release information to a facility. Within the next month or two developed for phase two. Department is in contact with over 200 facilities. Discussion: Top ten facilities in the state will be sent new release forms to get signatures to release these reports. CORE, Howard Brown, Uptown Clinic. Dr. Maras open to dialog on how our department can access these reports. Provide license for CORE facility. Federal partners directed ADAP to follow the six month recertification because of the money being granted to the Department. Penalties are not worth going to a 12-month recertification. Blake indicates one year renewals would free up staffing. He still wants one year renewals. Healthcare Reform Act discussed. Debate needs to be taking to the advocacy of the community. Clients do not need to be impacted. Staff needed **Chart 2 is looking at actual enrollment. Prior to January 1, 2011 did not request for card, changed and clients were not penalized for not having a card.** **90-day no plan discussed. Client has 90 days to access a Medicare D plan otherwise client is closed. 90-plan will be removed 7-1-2011 because of the rules for the insurance cards and cards are included in this group.** **Co-hort has been established for those who clients were enrolled as a 90-no plan prior to July 1, 2011.** **Explained pending clients are SSDI clients within the two year**	

	period of being eligible for SSDI. Safety net for clients and case managers regarding pending. **Explained enrolled benefits break outs which involve 90-day no plan.** **Revolving Medicaid has been cost containment for the program.** **Blake asked what the requirements are for private insurance. Insurance plan must allow our pharmacy into our billing plan. Department only allows one month fills not mandating a 90-day supply.** **Insurance clients still have to be under the 500% level.** **Blake max: Active questions regarding billing for ILCRX and ADAP.** **Dr. Maras explained the billing process for ICRx, ADAP, and how CVS charges the plan first, supplement for second, or ICRx third and anything out of pocket will be billed to ADAP through troop on co-pays that are out of pocket expense for client since we are payer of last resort.** **ICRx has been bill (340-b entity) we do not request a rebate and ICRx do not seek rebates on these clients.**	
a. HRSA response to the state's request for annual recertification	Reference Table 3: (added data facts) **Monthly Enrollment figures reflecting close outs and re-enrollments:** • ADAP Client in a 6 months period that were closed out per month due to failure to reapply.	
b. Date reports reflecting enrollment trends surrounding 6 month recertification	Reference Table 4: (added data facts) **Monthly Enrollment figures reflecting close outs and re-enrollments (annual enrollment cohort)** • ADAP client Annual Renewals who were closed out per month due to failure to reapply	
c. ADAP New Applications Electronic	82% of electronic applications arrive incomplete. New enrollment / enhancements, want to work with Core and Open Door that will take 7 minutes off of each applications. Advised case management needs to set up a tracking system. Seven to 10 business days behind on faxes and documents. Spoke of the confirmation code and the check list. 79% incomplete on paper applications according to. Closed out clients can take up to six weeks to be put back on the system. Dr. Pat: what percent comes in incomplete, as a provider we have submitted completed applications and not incomplete but being told the applications are still incomplete?	Follow up on expired applications and online applications and faxes. Language on processing time. Needs to have % on columns. How many people have not reapplied because of the FPL (Federal Poverty Level)(for august 908 - table 3 Co-hort breaks down as it pertains to

		Federal Poverty Level.
3. ADAP Rules are in the first 45 day comment period and can be located at the following web link http://www.idph.state.il.us/rulesregs/proposedrules.htm#FirstNotice		
v. Other points		
4. Floor Opens for Guests	William desire – Gillian – provided information regarding prices and discounts nationally. Adding to ADAP formulary. John Peterson, pharmacists and medical science, recommended regiments for co-formulation, single table regiments, and one pill, improve adherence, improve clinical outcomes, and overall health care costs. Complara. During two clinical studies, complara advantage less side effects and safer for pregnancy. Barbara – provide scanners to many facilities Nancy - @ CDPH, - directing to scanners to provide assistance with ADAP. Is there a way to put the renewal date of ADAP. Dr. Pat – scanners good - approval dates	
5. Next Meeting Date	January Thursday	
6. Motion to Adjourn	Ann Fisher: motion to adjourn. Second: Barbara Agree to adjourn: all Disagree: none Abstain: none	