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 18, 2012
BOARD MEMBERS PRESENT	J. Maras, , B. Schechtman, A. Fisher, R. Rivero
BOARD MEMBERS PRESENT BY CONFERENCE CALL	M. Maginn, P. Moss-Jones, P. Langehenning, C. Blum, S. Feigenholtz,
BOARD MEMBERS EXCUSED ABSENCE	R. Lublecheck (in clinic), , C. Conover , D. Munar, D. Graham, B. Max, M. Williamson
BOARD MEMBERS INEXCUSED ABSENCE	G. Harris
ILLINOIS DEPARTMENT OF PUBLIC HEALTH STAFF	A. Danner, P. Muir, J. Nuss, J. Ludwig
CALLED TO ORDER AT	2:35 p.m.
MEETING WAS ADJOURNED AT	4:30 p.m.
ANNOUNCEMENTS	
1. MINUTES FROM OCTOBER 21, 2011 MEETING	Corrections or additions: none Motion to approve: D. Munar Second: B. Schechtman Agree to approve: All Disagree: None Abstain: None

MIAB MINUTES

TOPIC/AGENDA	DISCUSSION	FOLLOW-UP
2. Old Business	No old business	
a. No Updates		
i. Date request/s reports addressed during the April board meeting covered during ADAP Update section of meeting	Dr. Maras advised some of the old business is addressed within the new business.	
3. New Business		
a. ADAP Status Update and Discussion points		
i. Staffing Updates	Methods and Procedures Career Associate 2	
1. One vacant position.	MPCA2 is currently sitting at governor's desk to be approved to fill. Once hiring freeze is lifted job will be posted. 1st bilingual position in section.	
2. Staff departure.	Bill Moran took a new position. Dr. Maras asked to fill in. Supervisors are evaluating for long term and restructuring of program. No comments or questions.	
ii. Reporting of the approved ADAP budget for FFY 2012 and SFY 2013	Dr. Maras reviewed charts for budget explained $60 million jump. Had a slight reduction in funding but were able to compete for supplemental funding.	

1. ADAP Emergency Relief Funding (2 separate grants)	Were awarded $2.2 million and just received notice of request for Ryan White FFY 2013 and ADAP is under supplemental award. ADAP applies for supplemental with no ceiling and is notified by HRSA what the final award level is allocated. Dr. Maras explained he is not able to request an amount, never know what will be awarded and the grants are not budgeted in just in case we are not awarded. GRF funding was level at $18.6m. RW has match requirement from the state of $20.2m. Federal requirements mandate rebates must be spent. Tied to clients with insurance and monitored behind the scenes. Rebate money goes in the drug line so it is being spent on drugs for clients. Dr. Maras had to clarify and when all budget calculations were added, ADAP had a credit. ADAP was eligible to compete for relief funds. 3 year grant cycle; received and open to servicing brand new clients. Total of $722,000 awarded. Competitive Relief Fund: $45m set aside. Floor is $50,000 and ceiling is $7m. States with cost containment could compete for monies in between. ADAP was notified in May and when ILCRx elimination was being announced. Clients losing coverage from ILCRx: 3080 with 1547 active monthly drug assessors. In catastrophic most have 3-5% copays. Dr. Maras requested $7m, was awarded $7m and was notified by HRSA he could request more money but had 3 hours to write a proposal. Wrote the grant to cover Med D client's premium payments since CHIC never paid in the past. Dr. Maras requested more money to cover all Med D clients' not just ILCRx clients. Letter was sent to clients 2 weeks before ILCRx termed so ADAP sent letter to inform we would pay premiums. Were awarded extra money for a total of $7.9m. This ties into the extra $60m program on budget sheet. Part B carry over redirect which is supplemental written for CHIC. Med D clients get thru donut hole in April, asked for 30 day extension but was denied. Dr. Maras responded no carry over allowed. Money is earmarked.	Follow up on: Dual enrolled clients in ILCRX. Total number of ILCRX and ADAP.

	Ann Fisher asked if Rebates come back to ADAP; and Dr. Maras affirmed the rebate dollars are in a special account that is unable to be swept at end of year. Christopher has now been hired as Part A coordinator at CDPH. Dr. Maras explained that every year can be different but competitive money will be renewed. By January or February we should know projected monies. One potential impact 1/2/13 will be on $6.9M to federal HIV and Hepatitis money at Federal level. Watching this need to find out if it affects current funding or next year funding, thought it was immediate but Dr. Maras is calling into HRSA for clarification and guidance.	
iii. Report on Program/Service Expansions	Monthly ADAP report – enrollment and utilization numbers: 4585 in Sept.; $3.8M in drug purchases per month; $13,000 dispense fees; $279,000 copays and deductibles, Med D included. 403 clients closed out in Sept; reason ADAP never received application. Need to know ADAP turning around apps in 5-7 days but a lot in same day. Not hearing if there is continuity break in care and turn attention to reapps at beginning of month. September reapps are clients who did not get an app in and client was closed. Usually what happens is the client doesn't receive their meds and they call us to get an app going. This group does not show up as new client for next month b/c they are reapps NOT NEW clients. Dr. Maras explained the differences in classification of apps. Dr. Maras explained clients were grandfathered in if they were uninsured before July 1, 2011 and have not closed out they remained at 500% FPL. If they were closed after July 1 their FPL moved to 300% unless they have insurance. If over 300% and denied staff send letter for IPXP and client can get back on ADAP and CHIC with insurance and FPL is 500%. New clients who have never had history with ADAP start at 300% unless they have insurance. Dr. Maras: everyone needs to realize 75% of clients are below 300% FPL. Not a high proportion of denied applications. Clients denied are over 500% w/ insurance or 300% and refusing insurance or insurance not in network with CVS. Biggest	

	insurance is CIGNA that will not work with us and MEDCO is hit or miss. Interesting seeing drop in new clients for Sep but Dec is usually the drop off month. So much going on with linkage to care hope there is an increase in numbers.	
1. Update on ICRx – ADAP's safety net function – moving forward	ADAP is functioning as safety net for Med D ILCRx. Open enrollment started Oct. 15th and closes Dec. 7th. Emails sent to case managers to have clients not elect CIGNA but cannot tell them who to choose. All clients for Med D have received letters for CHIC enrollment.	
2. HRSA Approvals: Medicare Part D and CHIC moving under ADAP's umbrella.	CHIC is never included in ADAP funding. Dr. Maras requested to HRSA that CHIC be added to ADAp so we can expand money. HRSA approved.	
3. CHIC expansions: Medicare Part D Premium payments/monthly cap increase	CHIC increased monthly premium to $750/month. CHIC is under ADAP umbrella. 1 application for both but by Jan 1 will be 1 app and ADAP staff will make that decision for CHIC. ADAP clients with Med D, staff add CHIC app. Goal is all Med D clients have apps in sync so they only have to apply twice a year instead of 4 year. Staff made calls to clients to get them enrolled and get us ready for Affordable Healthcare Act.	
4. Formulary: Quad Drug added Nov. 1, 2012	New formulary is on website starting Nov. 1st. No restrictions or prior approvals for new quad med. Had to go through internal process here and w/ CVS which is why it won't be available until Nov. 1. ADAP is going to be a wrap around program for the exchange and still serve undocumented clients. How much is the CHIC budget? Dr. Maras responded it is a $2.9M program and will grow. Dr. Maras stated we are still the only one in the nation with online app. NASTAD had a site visit on Oct. 11th to see what Illinois is doing right, went very well. On Nov. 7th HRSA is coming for site visit.	
iv. New Feature in PROVIDE Enterprise (Groupware Technologies Inc.) User Account		
1. Texting/Email Notifications	Dec. 1st rollout of texting/emailing. Clients will receive texts or email info as staff processes app. 90, 60, 30 days out system will send out renewal text/email. Will target individuals that are closed out every month. Can add 3 delegates for contacts such as case managers.	

	Require CD4 and VL twice a year by HRSA. If app is complete we post date app, ie: Dec. app we approve in Oct. Internally, if labs are in system with correct time parameters staff approve apps. If date on labs is within a month of enrollment staff accepts them as long as app is complete. If labs will expire need new ones required by HRSA. If app submitted before 90 days, it is rejected but attachments are kept in Provide. Provide users must have completed app to submit. Ann Fisher and John Peller question possibility of prepopulating info on web.	
2. User Account	Dr. Maras explained GTI brainstorming of user account. GTI in final approvals. Ex: of Turbo Tax, prompts question explaining user account, select yes/no. No move to regular app process. If yes, create user name, password, and security questions. Email sent to set up account. Comes in new inbox in Provide and staff will match up with profile. Pulls up all previous info from client and any attachments will tell client if they are acceptable. Client goes thru to make sure there are no changes. Clients then submit and track app thru user account. Clients will be able to start app and save it but that won't roll out until Jan. Client can set up texting/email, elect 3 delegates for contacts. CM can set up user accounts and can have email sent to them if client doesn't have email. GTI stated end of Nov. all email addresses already in system will be cleared for security reasons. Clients/CM will have to put emails back in system. Does someone have to have user account to receive texts and emails? Dr. Maras not sure and will look into this.	Follow up: Jeff looking into this. – Response: Yes a user account is needed for email and texting features.
3. Surveillance interface	Dr. Maras explained we are working on labs going into eHARS and submitting to Provide so providers and CMs don't have to submit every time. In 45 days will be our first "dump" into Provide and every month new labs will be dumped. In Provide labs will be labeled IDPH Import. Other states are way advanced than we are with this process. Labs – all CD4 and VL must be reported. 70% are electronic and 30% are paperwork. eHARS is 1 database.	

4. View Only Feature – Enrollment Options	Clarification on conversation from CDPH about needing/reporting labs. Thought was they did not need to be reported anymore. Clarification was made that it was only for negative HIV results. 4th way for people to apply is thru view only in Provide. Providers can purchase a view only screen to view their clients and apply for them. License per year is $480. Come w/ maintenance, tech issues, support lines, etc. Dr. Maras thinks View Only option is underutilized and would help with efficiency.	Follow up: Jeff looking into this.
v. Discussion on Impact of Affordable Care Act – Open discussion to begin brainstorming of services considerations:	Interagency task force – shifting attention to ACA, subworking groups.	
1. Medicaid Expansion in Illinois	ADAP perspective we are getting more prepped for ACA. 11 months away. RW reauthorization national level has several options. Dr. Maras believes it doesn't need reauth just refunded every year. ACA will drive the reauth. Dr. Maras attended a meeting last Aug, ADAPs will still serve undocumented and will be a wrap around program. Believes we are prepared. Benchmark plan is BCBS Advantage. Need to keep eye on flexibility on different plans. 1115 Wavier approval in next couple weeks with significant impact in Cook County. Will impact ADAP, approx. 1200 clients affected out of 7000 – clients below 300% FPL. Must be under 133% and documented. Number likely to change/increase as people become aware of waiver. ADAP is safety net in transition within reason. ADAP will still be there for those over 133% and undocumented. Benefit offered in waiver will be the same as Medicaid. Dr. Maras working with HRSA for a transition plan.	
2. Insurance Exchanges (EHB/Exchange Platform)	Dr. Maras reiterated ADAP is payer of last resort, work needs to lie in infrastructure and educating population on health insurance literacy. Hard to educate when we don't know what is going to happen. ADAP staff educates clients daily, find people need the education. ADAP will need to reexamine FPLs ; Medicaid will effect FPLs. Focusing on CHIC, program will grow. ADAP doing deductibles and copays now, hope to	

	continue undocumented. Will see a shift in money b/c people w/ insurance cost state less money. Medicaid thinks it will take 5 years to transition; challenge will be for RW budget, need fluidity and forward thinking. ADAP admin is forecasting FY2014 level funding b/c cuts are being proposed. Oct 2013 people can start enrolling in exchanges. Fear is people are making budget decisions that things will magically happen Jan 1, 2014.	
3. IPXP transitions to exchanges	IPXP group will need to transition in Oct or Nov so they can be in their exchange; IPXP will be eliminated. Dr. Maras would like John Spears to do a presentation on exchanges hopefully at next meeting. Spears agreed; focus on IL and user friendly.	
vi. Open for other points of discussion by board members.	Medicaid is looking for new database. Ann: Changing plans that all HIV meds require prior auth taking place in other states, has anyone heard of this happening here? No one has heard anything. State needs more control over exchange and what the powers are at the DOI regulations, no answers yet. Webinar Nov. 13th for ins. Exchange, what the election means for exchanges. Will forward site to Dr. Maras.	
4. Floor Opens for Questions/Comments from Guest	What is the process to request drugs not on formulary? Dr. Maras – Request is sent to Dr. Conover for review. Seeing delays in meds to clients, believe it's a CVS problem. What can we do? Dr. Maras – if it's a Med D issue we already know about it. Should notify him or Bob. On ADAP web page there is a CVS incident report, print out, give details and send to Dr. Maras. He forwards them to solidify with CVS. CVS always corrects issues on their side. Why is new drug marketed as a 4 drug? Dr. Pat explained marketing as a quad drug but one is a boosting agent not actually a drug. 3 ARVs statement from Gilead rep as the fourth drug is not an ARV. HRSA coming Nov. 7th – is there a special task force being developed?	

	Heather has been appointed new director, Dr. Maras has not hear of formal committee yet but wanted to know about cost containment, interface with Medicare and Medicaid, online app, etc… Jim McNemara – contact Dr. Williamson about subcommittee. Rick Stewart – when John Spears does presentation, suggests people to have questions ahead of time in case not covered by presentation. Next quarterly meeting is in January – need to negotiate new meeting time- either Thursday mornings or Wednesday afternoons for the new committee Dr. Maras is on. Travel restrictions, Jeff needs to coordinate travel times. New meeting group meets 3rd Thursday of the month. Mike Maginn – Part B Quarterly Meeting in Spfld, Thursday mornings would be better. Dr. Maras – Tues & Wed Part B meeting, 16th Part A Planning Council. Either 29th or 31st. Mike – afternoon of the 29th is better. Everyone good with the date. Dr. Maras – will send out reminder 2:30-5 on the 29th.	
5. Next Meeting Date:	January 29, 2013 from 2:30 to 5:00 p.m.	
6. Motion to Adjourn	motion to adjourn: Dr. Maras Second: B. Schechtman Agree to adjourn: all Disagree: none Abstain: none	