



Illinois Department of

**PUBLIC
HEALTH**

Pat Quinn, Governor

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

DATE	April 19, 2012
BOARD MEMBERS PRESENT	J. Maras, D. Munar, B. Schechtman, C. Conover, A. Fisher, B. Max, W. Moran, M. Williamson
BOARD MEMBERS PRESENT BY CONFERENCE CALL	M. Maginn, P. Moss-Jones, D. Graham, P. Langehenning, C. Blum, S. Feigneholtz,
BOARD MEMBERS EXCUSED ABSENCE	R. Lublecheck (in clinic), R. Rivero, G. Harris (in session)
BOARD MEMBERS INEXCUSED ABSENCE	
ILLINOIS DEPARTMENT OF PUBLIC HEALTH STAFF	A. Danner, P. Muir, J. Nuss, L. Humphrey
CALLED TO ORDER AT	2:35 p.m.
MEETING WAS ADJOURNED AT	5:10 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	Two vacant positions filled by ADAP. One position filled by Jennifer Ludwig and the other position filled by Melissa Turley.	
1. Two vacant positions filled. One vacant position remaining. Still in ePAR system.	Dr. Maras spoke on two positions that were successfully filled. Jennifer started with the program 12-1-2011; Melissa started 01-01-2012. Both individuals have learned the complexity of the position. ADAP has a strong staff and thanked those who helped with getting the positions filled. Dr. Maras ADAP is still operating on high volume. Office clerk is still in the state ePAR awaiting approval. 3-4 months to roll out of ePAR.	

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	<p>Both S. Feigneholtz and C. Blum are noticing change and efficiency in staff.</p> <p>Second: D. Munar Agree to approve: all Disagree: none Abstain: none</p>	
<p>ii. Reporting of the approved ADAP budget for FFY 2012 and SFY 2013</p>	<p>Dr. Maras reviewed charts for budget. Ann Fisher had an issue with the rebate line and wants to know the calculations on the ILCRX and will they be getting rebates.</p> <p>Dr. Maras explained ILCRX is a 3040B entity payer source. Coordinates payments and redirects if a Medicare D or insurance client. ADAP does not submit the dollars for rebate as we would be double dipping on ILCRX. ADAP helps pay \$2.00/3.00 copayments. If ILCRX is disbanded ADAP will probably grow.</p> <p>Dr. Maras also walked through troop, max out of pocket expense for ILCRX (\$4550.00) and the assistance through the catastrophic period. Number for this is unknown.</p> <p>B. Max wants to know what has changed. Dr. Maras' projections in formulary and money value, spending down to projected. Leveling for ADAP concerned about new clients. Based on data and projections, anticipated from federal life and GRF line, rebate supplement is calculated in. ADAP will be moving through. GRF line is unknown. B. Max: there is a barrier on 4500 – 5000 clients and he wants to keep it there. Dr. Maras: ADAP side/federal side, signed agreements to contain and stated with confidence with the budget, no wait listed based on the formularies being used.</p> <p>D. Munar added up income lines, 53 million and analyzed the 3/2012 across the board for 12 months. Variance is 100,000 over budget, concerned about the impact Medicaid cuts being discussed now and how it will affect ADAP. Illumination of family care and the proposal for Medicaid expansion. Dr. Maras touched based on D. Munar's concern in later discussion. 1115 waiver to affect ADAP in a positive and Medicaid reform will have an impact. IPXP will also have an effect.</p> <p>D. Munar concerned about the waiver as well.</p>	

	<p>Structure for Cook County and Legislation and reducing liability. Potential savings in HIV services and flood back to the treasury.</p> <p>A. Fisher asked if ADAP sent ILCRX any money out of the 4500 out of pocket expense. Dr. Maras: no money was sent.</p> <p>Rep. Sara underestimated how many people had to move over with Medicare D (donut hole). Dr. Maras states federal side of the house prohibits ADAP from sending money to ILCRX</p> <p>Dr. Pat is concerned with Dual eligibility. Dr. Maras explained majority of ILCRX clients are Part D who are insurance clients and are a rebate for the ADAP. ADAP tracks and monitors clients who are not enrolled yet to avoid penalties. 4550 we help assist in the donut hole.</p> <p>Dr. Maras explain the monthly report.</p> <p>A. Fisher is concerned with getting re-enrollment letters. Dr. Maras advised letters are tracked through provide to view, close to rolling out email notifications. ADAP started collecting email address as of July 1st 2011. June 1, 2012 an email will be sent to the case manager or the client if an email is provided. GTI is currently working on this.</p> <p>B. Max is concerned with Spanish version of letters. Dr. Maras explained the Spanish version is going out (enrollment letter).</p> <p>Dr. Maras explained 1200 plus clients' in a month and productivity level is because of the online application. B. Max is concerned the clients increasing and dynamics do not add up. Dr. Maras explained dynamics add up because some clients do not access the program or drugs. Consistent client's served not those enrolled.</p> <p>A. Fisher concerned with the rise of insurance cost. Dr. Maras explained more clients going to insurance. Medicare D clients we are assisting through troop and starting their year January 1st of every year. By the end of March majority of Medicare D clients in the donut hole and should be out of the donut hold by the end of April. Drug expenses and fees go down. Dr. Maras explained drugs per client per month are higher than most</p>	<p>Follow up on: Dual enrolled clients in ILCRX. Total number of ILCRX and ADAP.</p>
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	<p>states, 4-4.5 drugs a month and depends on regiment and changes in regiment. Driven by clients, scripts, and how many there are.</p> <p>D. Munar concerned with insurance clients as well. Cheaper, helpful to 4493 broken down between ADAP and insurance. Numbers are going up and money flat lining. Dr. Maras: clients some will never meet their enrollment date. 4-5- business days to get clients re-enrolled back into ADAP. Electronic application and ability to move clients to approval. Group population: does not matter what you do to inform unless they are not getting their medication. Online application allows department to re-enroll and re-treat the interruption of medication for clients. SAME day approvals. Scans 1-2 days out and 50 to 60% will be approved in 24 hours.</p>	
<p>iii. ADAP Rules are approved by JCAR on February 8, 2012. New ADAP Rules can be found on the website: http://www.idph.state.il.us/rulesregs/proposedrules.htm</p>	<p>Dr. Maras Explained rules got approved on the February 2, 2012. Functioning under the Rules, actually passed through JCAR. FPLlevels are also on this website.</p> <p>Motion: D. Munar Second: B. Max Agree: all Disagree: none Abstain: none</p>	
<p>iv. New Feature in PROVIDE Enterprise (Groupware Technologies Inc.) View ONLY feature --- rolling out to the state...demonstration.</p>	<p>Dr. Maras gave a brief highlight of future enhancements to the online application and shortened the reapplication process for re-applicants.</p> <p>View Only and the license for this enhancement can be purchased for \$480.00 a year. This enhancement allows clients to be viewed in provide with the associated agency in which they are attending. HIV prescriber, provider, or case manager can view clients. Howard Brown, Core Center, and Christian Community already have this enhancement. A power point was provided. Discussed and in compliance with HIPPA. An automatic approval or denial is seen once application is completed and approved. Case managers can also see incomplete applications immediately.</p> <p>If a client is brand new and ADAP does not know</p>	

	<p>the client is affiliated with the clinic, the clinic can request this information and submit information to ADAP.</p> <p>View only is checked twice a day and ADAP will either approve or deny request. GTI under discussion, beta tested. Facilities who are interested in the view only need to contact Dr. Maras. GTI can submit an application through this view and any edits can be done. Will pre-populate from clients profile. One feature of this view.</p>	
<p>1. Brief highlight of future enhancements to online application and shortened reapplication process for re-applicants.</p>	<p>B. Max spoke as wanting access to their clients. 1700 clients in their program. Paid \$3200 to access the license instead of being on the phone.</p> <p>Dr. Pat wants this view and Dr. Maras will send documentation. Dr. Pat wants to be proactive in helping staff and clients and this is beneficial to the clients. Less treatment interruptions and improves quality of care for the client and re-certification for these clients.</p> <p>Dr. Munar is going to build into the budget to get a license. \$480 is per individual per year. Asked if case managers could share. Dr. Maras advising GTI expectations were no two people can use the same license because of HIPPA. This is why the authorization was revised. GTI will do the training and ADAP will load the view.</p> <p>Ann Fisher speaking to her staff regarding the view only.</p> <p>Dr. Williamson: can you print screen.</p>	<p>Can we print screen the view only.</p>
<p>v. Discussion of IPXP as a prerequisite for IL ADAP.</p>	<p>Dr. Maras explained growing questions for HRSA and IPXP actions, activities and piece of program. Illinois state ran. Pre-requisites into ADAP.</p>	
<p>1. IPXP highlight -- overview</p>	<p>If healthcare reform rolls out in 2014 IPXP fuses out. There must be a transition of these clients who have become IPXP eligible. Education for case managers such as webinars in regards to IPXP. Tiered health insurance plan with a prescription side. ADAP plans for any plan you choose for IPXP, CHIC pays premiums up to 500%. Premiums are based on deductions. Chart given. Client must pay their portion of the premium if over \$500 prior to CHIC paying. Or, client can send invoice to CHIC verifying payment has been made. Dr. Maras explained the deductible of \$1600 out of pocket and 2-month regiment by ADAP and then the rest of the year will be covered by plan. Our CVS is in network with IPXP. ADAP formulary drugs 1600 deductible. Dr. Maras also explained the healthcare side of IPXP, labs 80/20 copayments if in network and out of network costs 60/40 split until 2850.00 and all medical expenses are covered the rest of</p>	<p>Follow up: look to see if there are ways to help with this component. (IPXP healthcare side and copayments as to no one being opposed to taking IPXP because of this – the 10% who will not take IPXP).</p>

the years. FPL level 301% and denied by ADAP, denied because of income. Clients must send all documents to IPXP and then reapply for ADAP. 90% success rate. 10% who do not take it because of the healthcare side and co-payments.

Dr. Maras open for suggestions on how to notify case managers of IPXP and clients while understanding how the program functions especially regarding the medical side in which clients do not have to access and the \$1600 is counted in the 5,000 dollar level.

B. Moran suggested utilizing GRF monies, premium by CHIC, ADAP 1600 deductible. Pay the out of pocket of money, cost effective. GRF already calculated into carrying ADAP. No cost to client unless on a drug not on our formulary.

M. Williamson wants to know how many people will it affect in one year. Dr. Maras states it is not for undocumented people; however, several people will be affected in Cook County.

Dr. Maras explained the deductibles and requirements with payments and IPXP and discussed IPXP is not a family plan.

Dr. Pat is questioning the \$500 down to 2350. Dr. Maras explained this. Counsels clients on IPXP, asking questions regarding their medication currently taken and then explains the \$500 deductible up front. 3-month supply and explanation of planning. \$1600 is not part of the 2850.

Dr. Pat is concerned with a wait list. If people can go to any pharmacy after the \$1600 and they are re-enrolled clients then are dropped from ADAP and go 4-months with anti-retro and they choose a local pharmacy how would they start in January. Client would no longer be an active client; therefore, it would push them to the wait list the next year. Dr. Pat also concerned about the Medicare D clients and their benefits.

Dr. Maras states a wait list would go off of medical criteria. Rebates are offered on Medicare D clients. 100% on partial pay. Outlined on that. Gain money.

2. Open Discussion on IPXP.

Dr. Maras asked David Munar to speak on the healthcare reform act and 1115 waiver. D. Munar explained 1.7 billion proposed service reduction on Medicaid roll. Several and directly related to our work, prior authorization to any single for HIV medication combination. Under proposal. Concerned prior authorization for these medications will adhere to these medications. Proposal as a body, state reconsider for medical reasons for these cuts. Just proposal not approved by legislation yet.

Gov. voting to limit the number of brand name medication. Dr. Maras asking about the limited number of medication. Gov. is proposing no one gets five drugs a month. Gov. does not want Atripla is considered one drug but want clients to take all three drugs trying to limit it to five drugs only with prior approval. Bill advised prior authorization for combination of HIV medications.

Max: have to have prior authorization.

Rep. Sara – Jim Partner in the room, HIV applicants, override process. Ann Fisher taking clients off Atripla and limiting combinations. Volunteer to have a meeting to come up with a strategy to view the governor proposal on the efforts of the combination. Utilization or control that makes more sense. Asking for an exception is not going to work, not effective cost containment measure, here is a better way. Unique treatment protocol. Alive and under discussion, global problem, Medicaid problem is huge. Cost containment.

Munar advised finding the right combination that works for the patient. Troubling if combination is working for client and this passes.

Dr. Pat – five drugs particular, spending all the time on preapprovals. Time taken away from patient care on the care side. Time constraint.

Dr. Maras – Texas has ran off this model for a long time, Atripla is not counted as three drugs, just one drug.

1115 Waiver – Dr. Munar, Dr. Williamson met with the Cook county and how it will work with Ryan White. Medicaid coverage, legal residents in Cook county 133 below FPL, Legislation that will allow

the proposal to move forward both from Springfield and Washington. July 2012 and 1-2014 when health reform moves forward. Implications for the Ryan White program and those individuals who are eligible. Carving out from the waiver HIV.

Transition to the current configuration to ADAP. Leverage the waiver and expand financing and coverage for those with hiv. If the waiver moves forward, reduce the number of clients served. Incurred savings to the state remain in the hiv budge to help finance other potential services. Concerns on the county budget and state savings. Not enough people on care, life expectancy. IDPH and/or rep met with the county needs to include the Medicaid offices.

Williamson – overview – IL approach to IL Medicaid. Secured for the June meeting and Medicaid waiver will be spoke of. Medicaid presentation, big infrastructure issues. Reimbursement issues and meaning for providers and more people and a shortage for primary care providers. Number of clients who would be coming onto the system. 2014, not all at once, organizational stand point, if county were to pass, gradual approach. Real ability for cook cty system to execute their billing process.

Munar: thanked Dr. Maras on ADAP are at or below 133% fpl. 1800 hundred. Figure out strategies to draw down more of a financing.

Williamson – Dr. Maras, uninsured or insured on the number Dr. Munar was presenting.

Dr. Maras expands on Medicaid. Check the Medicaid system. Pending Medicaid until it is approved or denied. Monitored. Explained back billing for Medicaid every month. Eligible people who never make an application to ADAP. Department has always done a roll out. If healthcare reform act rolls out. Will work closely with Medicaid but according to the Medicaid meeting will adap carry for five years until they get on Medicaid. Medicaid comes with conditions.

Williamson: case management needs to be looked at and the services that are offered for those on Medicaid throughout il, they are not all the same.

	<p>Quality of life disruption.</p> <p>Dr. Maras explained the spend down amount of the Medicaid process. Revolving Medicaid. Active dialog with Medicaid, dual or revolving and we are contributing to the spend down. Working on the inter agency agreement with the spend down for Medicaid. ADAP monitors Medicaid. Still a need for Ryan White and ADAP and exchanges for copayments and deductions still come even with the reform act. ADAP director coalition is aboard and those making policy who are not informed, Medicaid is no longer an issue. Max, numbers will go down once the healthcare reform rolls out.</p> <p>Ann Fisher, expansion does not come with a spend down caption. No 1115 spend down. Does not think there is unsure.</p> <p>Munar explained the 1115 waiver: relief on the budget and work in the real world. Hurdles at CMS and implementation hurdles. Could expand the number of people who are receiving HIV services. Timing is fast, state legislature by June. Hoping and rolls prior to July.</p>	
3. Health Care Reform strategic planning.		
vi. Open for other points of discussion by board members.		
4. Floor Opens for Questions/Comments from Guest	Iowa cannot use state funds to pay premium. Comment about states requires pre-requisites to incorporate these into ADAP approvals.	
5. Next Meeting Date: quarterly meeting set for July 19, 2012 from 3:00 to 5:00 p.m.	July 19, 2012 from 3:00 to 5:00 p.m.	
6. Motion to Adjourn	<p>motion to adjourn: Dr. Maras</p> <p>Second: A. Fisher</p> <p>Agree to adjourn: all</p> <p>Disagree: none</p> <p>Abstain: none</p>	