HIV/AIDS Section Workgroup on ADAP
10:30 AM – 12:00 PM ~ March 25, 2015
Minutes

Workgroup member attendance: Bonnie Tiemann, ARNP, Deidre Kelley, Earl Hunt, Dr. Elizabeth Sherman, Dr. Carol Broxton, Kamaria Laffrey, Leonard Jones, Martha Buffington, Matthew Tochtenhagen, Dr. Michael D'Amico, Susan Williams and Valentino Clarke

Absent: Gregory Timmer, James Talley, Dr. Jose Castro, Dr. Michael Wohlfeiler

Department of Health Staff: Dr. Jeffrey Beal, Dr. Paul Arons, Joe May, Lorraine Wells, Paul Mekeel, Debbie Taylor, Roxanne Sieks, and Annie Farlin

Dr. Jeffrey Beal called the meeting to order at 10:34 a.m. He thanked everyone for taking the time to attend the meeting. Dr. Beal asked Dr. Paul Arons to welcome everyone on the call. Dr. Arons asked Annie Farlin to proceed with the roll call. Annie took roll call and confirmed a quorum.

Old Business:
Dr. Arons confirmed that the November 19, 2014 meeting minutes and the proposed by-laws were voted on by the workgroup and approved as of January 9th.

Dr. Arons reviewed the following action items that were stated in the November 19th meeting minutes:

- Dr. Beal to send the ADAP data to be reviewed and provide comments/feedback on improvements/changes for the annual report.
  - The 2007 ADAP Annual Report was emailed to the members on March 13th and members have been requested to send in their comments and feedback. No feedback was given from the members.

- ADAP information and documents will be posted on social media.
  - Joe May stated that this has not yet been implemented and will look into this.

- One last item on the previous minutes was an inquiry raised regarding "Haitian" category in ADAP report data charts. Although collecting Haitian numbers separately is a HRSA requirement, publishing them in the statewide report may be unproductively stigmatizing. This item still needs to be discussed at a future meeting.

ADAP Update:
Dr. Beal asked Lorraine Wells to provide an update on the ADAP program. Lorraine stated she will cover the AICP Centralization; Strategic Planning with Part A's and the Community; Training and Education; Preparation of a Policy Manual; and Software Implementation

Marketplace Reconciliation and preparation for the upcoming year:
We have just gone through open enrollment with the ACA and that was huge, requiring the efforts of a number of people around the state. Part A's have been instrumental. We thought this would end by February but there is now a special enrollment period through April 30. Following these efforts, we have to gear up for the next open enrollment later this year.

- The transition of the Marketplace has been a significant effort of work; some of the work had to be built as we moved along. Many external changes were made along the way as we progressed through the process.
- There is a huge disconnect between the marketplace and the providers. While we did all we could, there were a number of changes during the process. For example: information from the marketplace was not valid for payment in many cases, different carriers wanted different information apart from what was available in the marketplace. Requirements changed during the process and there were problems with patients receiving notices. The largest player, Blue Cross Blue Shield (BCBS), became problematic. Patients' plans were cancelled even though payment had been received and processed by the provider. Batch payments weren't accepted. Clients received calls from BCBS asking for the balance of their payment. Several items occurred to complicate the flow of the process.
- Every invoice we (ADAP) received for a patient was processed by the next day and this made these problems very frustrating.
- We ended up having a meeting including Marlene LaLota, Joe May and myself with the Office of Insurance Regulation to intervene. As a result, within two days, 1200 persons on the list received their coverage. They are still working to rectify few remaining individuals on our list.

Molina Healthcare changed their process which caused issues with clients. Again the Department of Insurance assisted and the next day Molina responded. The same happened with our other two carriers. We are following up for our clients to ensure their payments are applied.

A huge thanks to the Department of Insurance Regulation.

- The number of persons who transitioned to the marketplace is reflective of demographics. These numbers are preliminary - of the 1845 clients; 70% of the clients are in Florida Blue, another 18% in United Health and the remaining in Molina Healthcare. Of these clients, 81% are male, 19% are female. Age range mirrors the ADAP program; highest numbers are age 45-64 years. 53% are in the 45-64 age brackets.

Dr. Arons asked if these numbers help us to estimate future enrollment and apply other changes such as the ADAP formulary. Lorraine advised we are not there yet; we are still working through the numbers as some plans have not yet completed their reconciliation of coverage for clients. Information is still rudimentary and we don't want to overestimate for the first 3 months. Currently, we are looking at an average of $395.00 a month for each client but this amount will change, this is still very preliminary.

Dr. Beal asked if we have identified any disparities by race/ethnicity and also what is the national perspective compared to Florida. Lorraine added we have some snapshot on ethnicity. 34% are Hispanic, 25% black, 31% white non-Hispanic and less than 1% in the other category. This is still preliminary data and not inclusive yet. We still have more data to come in for better data/numbers.

For the national perspective and what it looks like for Florida, based on conversations with various states, we all look very different. Some states, especially ones similar to us in size, have a very different structure. They have a State PAP, are supported differently and systems differ since the onset of the ACA the past few years.

As far as enrollment, we did extremely well. I want to recognize not only the CHDs, but also the Part As for their involvement and keeping it moving in a challenging environment. Staffs around the state have been very diligent at contacting clients and getting them the information. The Part A's have been coordinating and assisting with wrap-a-round efforts.

The AICP centralization of the insurance program has been ongoing for a few years now. We have centralized the Medicare population. The ending of the contract with the Health Council has accelerated the efforts to centralize AICP. The ADAP program had 985 individuals as of December in the data base who are AICP and, of those, 25% or 253 had an employer-sponsored insurance. I point this out because regardless of those numbers, these employer-sponsored individuals are really not eligible to transition into the marketplace unless there is a hardship which can be difficult to demonstrate.

249 clients were identified by the health council of South Florida as being eligible to enroll for the marketplace. During enrollment, we ended up with 165 or 66% transitioned to continue coverage. Many of those had COBRA, or their individual plans had been cancelled because a plan was no longer in effect, or for other reasons. Staff is looking at the remaining clients to see where they are in the process. Some clients transitioned into the Broward County program. During this process, we learned a number of clients had insurance.

We are streamlining the services and coordinating with the 6 Part A Administrators of the EMAs, to coordinate and provide wrap a-round. We will be partnering with the EMAs to communicate and share information with the AICP calls.

The third was the **strategic planning** for the upcoming enrollment period in November.

In addition to that enrollment, we have to develop ***"Training and Education"*** policy that expresses the number of items I've mentioned on this call, in addition to the tax credit that has just come out, and the software implementation that is needed to manage the multifaceted areas in ADAP.

The goal for the next enrollment is to enroll anyone from 100%-400% FPL who are eligible and meet the requirements of the program and the ACA. I recently filled the position for an actuary and once they have been brought up to speed with the program, we will do some forecasting. There are many tasks to be handled in the next 6 months.

Last year we had a pilot plan of 61 individuals going into the marketplace. We found that some of the plans are no longer providing coverage or their plans changed, their premiums are higher and so we have had to assure these individuals got into a plan this year.

The fourth item is **Tax Credit**. There is a need for system and protocols. The PCN1401 requires us to collect tax credits. ADAP staffs have to be prepared and learn about this new information. There is a fiscal impact to be considered. It can be tricky with this population. Next year there is a $365 personal penalty or 1% of income (whichever is greater) which ADAP cannot pay.

If clients owe money for whatever reason, there is a tax liability. It is important to inform clients to update their information in the marketplace and update the ADAP program. Hopefully there will be connectivity between the IRS and the marketplace update in the process. Lorraine explained and discussed concerns about tax liability and funding, unknowns moving forward.

Training and Education

Huge endeavor – developing and including key points educate the community and staff as we morph into new roles and requirements. Re-align staff and duties along with the writing of the

policy manual. CHD staff must become knowledgeable about insurance in order to facilitate services.

Software Implementation
Legal is currently developing the contract. We have to look at re-engineering business processes. Need for software that can coordinate with different "Parts" and provide easier enrollment access for clients, allow partners/stakeholders to get information on demand and share data across systems. Hope to implement first phase by next enrollment to manage a lot of components discussed today.

Budget from a high level:
- No longer eligible for ADAP supplemental
- Aware of 5-8% funding cut but uncertain what impact, if any to our program
- New grant year starts April 1, 2015
- Budgeted $146.5 million this year
- As of January 2015 we spent:
  - 101.8 million – uninsured
  - 16.9 million – insured
  - 118.7 million - Total

Balance of 27 million – two more months remaining; will likely have carryover of 10 million.
We can apply for the Supplemental funding, Emergency Relief Fund (ERF) may be cut.
Need $ to sustain

Dr. Arons asked Lorraine to share how many clients are currently enrolled in ADAP program receiving services. Lorraine provided breakdown by program, gender and ethnicity (numbers will continue to change). Numbers are fluid right now. There was some discussion about how the numbers of clients change and adjustments for rebates, costs, and decisions that affect long term how many clients will be considered for the next enrollment. Have to use caution; as an example rebates continuing are in question along with other factors that could impact budget.

Dr. Arons shared that the ADAP crisis task force will be meeting with the drug companies in May to pursue further negotiations.
The group was asked if any questions – none voiced.
Dr. Arons thanked Lorraine for providing a comprehensive report.

Medicaid HIV/AIDS Subcommittee
Dr. Beal informed the workgroup that he is a representative of this subcommittee on behalf of the HIV/AIDS Section. We (subcommittee) have been charged as a small working group to redefine PAC Medicaid. PAC is the Project AIDS Care Waiver form that providers fill out to certify that a patient has an AIDS defining diagnosis as characterized by CD4 count along with an active opportunistic infection. The PAC program can be redefined to meet today's needs of our HIV patients. This workgroup will provide recommendations to Medicaid as to how to rewrite the PAC Program. It's not expected to happen in a fast order. It is anticipated that this will take up to 2 years for completion; however we would like to bring the initial recommendations back to the workgroup before sending forward for discussion.

New Drugs to the Formulary
Dr. Arons informed the workgroup that with the workgroup's input, we have officially adopted three new drugs to the ADAP Formulary; Tybost® (cobicistat), Gilead's booster alternative to Norvir®;

Prezcobix™, which is Prezista®/cobicistat, fixed-dosed combination, single tablet; and Evotaz™, Reyataz®/cobicistat, single tablet fixed dosed. Debbie Taylor has forwarded the signed memorandums to Lorraine Wells for her to complete the process. Lorraine advised she is waiting to hear from Dr. Brantley to coordinate the process with Central Pharmacy and ensure the medications will be available and capable of handling prescriptions. Lorraine stated she thinks the drugs will be available by Monday. She instructed the ADAP staff to add the drugs to the database. Lorraine will send out emails including signed letters notify staff that the ADAP medications are available and she is certain Dr. Beal disseminates to the medical providers.

Dr. Arons expressed that the annual report that was emailed to everyone on the workgroup to review the format has the ADAP formulary included. The formulary was more extensive in 2007 than it is today. We know we had to contract the formulary to cover the essentials. AbbVie's product, Viekira, the Hepatitis C treatment, has been approved for co-infected patients with HIV/HCV. AbbVie negotiated a price with the ADAP Crisis Task Force. The price is pretty steep, though not as high as what you see from a wholesale acquisition cost that is public information. Dr. Arons wanted the workgroup members to know that we would like to expand the formulary and perhaps make available medications to treat co-existing conditions like Hepatitis C. It's not a practical thing to do right now, but a topic that needs to be kept open.

Dr. Beal informed the workgroup he and Lorraine have had this discussion. Dr. Beal advised what is critical now is that the ADAP program needs to get through the initial stages of the enrollment of AICP; get into the fall to take a look at the financial account and Lorraine mentioned potential legislation on a national level that could markedly change the landscape for ADAP. We do have tremendous hope that there will be enough financial funds available in the future, end of 2015, beginning of 2016, to make a decision about the formulary. Do we want to expand the formulary and add back those favorite drugs that many providers are filling out patient assistance program (PAP) forms to access? Do we want to start a small pilot project with the Hepatitis C co-infected HIV patients, which is of great interest to Lorraine as well as the HIV/AIDS Section and Dr. Beal? It's all down to timing. The future landscape looks rather promising. We need to give Lorraine and the ADAP program time to do what they do best which is managing a program that does change from day-to-day.

Dr. Beal provided information about a new program for state Medicaid starting very soon. Dr. Beal informed the workgroup that there is an arrangement in writing from Medicaid, that if we have HIV care providers that will utilize the services of the F/C AETC Training Center - HIV TETC ECHO Sessions, which Dr. Elizabeth Sherman has attended many as faculty; the primarily care providers in our rural areas where so many of our HIV indigent patients taken care of by ARNPs and PAs, internists, family practitioners, where Medicaid restricts the use of prescriptive authority of the HCV drug to an ID Specialist, Gastroenterologist or to a Hepatologist, so we brought the Gastroenterologist/Hepatologist/ID to an ECHO format, which is the teleconferencing-telehealth ability for primary care providers to attend, present their patients, get prescription authority from an Infectious Disease or hepatitis physician, which then Medicaid will accept as part of a pilot project, that allows us to monitor and take care of these patients in a learning environment that deals with experts training us in primary care how to do this well. We are able to get these drugs through the patient assistance programs (PAPs) as well as Medicaid. Dr. Beal would love to hear from communities and providers if they are having trouble with either the Medicaid system or with the PAPs, but to date he doesn't know of anyone who is in need of drugs or going without them if they qualify for a PAP or for Medicaid.

Transitioning Ryan White Part B P&T Committee under auspices of the Central Pharmacy P&T Committee

Dr. Beal informed the workgroup that this year we put together a Part B Formulary Committee; this committee has done phenomenal work moving at a fast pace and coming up with a formulary that wraps around our AIDS therapeutics. He provided an example if in a primary care clinic we are taking care of a patient with hypertension, diabetes, cholesterol issues, the committee is developing a formulary that will provide guidance; be cost effective; give options based upon pricing; it will be cognizant of drug interactions to antiretroviral therapy; drugs that may have an interaction will be flagged and help us to always remember to not prescribe drugs that will be contradicting to the antiretroviral therapy. Our group was successful to the point that Dr. Brantley has requested that the committee be transitioned under the state-wide Central Pharmacy P&T Committee, which has taken place. This is exciting because it moves the committee into a realm of a state-wide program and learning from both committees best practices. The long term future vision is to have drugs at a better cost rate; come together on a state-wide level with better pharmacy purchasing power, pharmacy expertise and formulary to allow the Ryan White dollars serve more people. We are flat funded and this could have potential to drive costs down.

ADAP Annual Report (Member Feedback)

Dr. Arons stated the ADAP annual report from a previous year was emailed to everyone for member to comment on what they would like to see in the published report. Dr. Beal informed the workgroup that he wanted the workgroup to review and think about the data that is currently collected from the ADAP program. The ADAP program has a plan to have a robust data system through a new vendor relationship. It is our future hope that we will have a richer ability to collect data on our ADAP patients. So what you are looking at (ADAP Annual Report) is how we currently look at the data. Think about how we could look at the data differently; analyze data to look at quality improvement in the program, gaps in service or disparities in the program. What data ought to be collected to be more efficient, think outside the box. Send to Dr. Beal, and copy to Annie Farlin, and Dr. Arons, any of your thoughts or ideas.

Dr. Arons added that since the last ADAP report, the Continuum of Care has come into vogue so that may be a graph we would like to add in the future. Dr. Arons asked if there were any comments so far from the group. No comments were given at this time.

Dr. Arons asked Paul Mekeel who is identified as the workgroup liaison, if he could be contacted by members. Paul confirmed that the group could call him at 850-245-4334 and ask for Paul or email him at Paul.Mekeel@flhealth.gov.

Dr. Beal let the workgroup know that the ADAP staff is extremely busy and if someone has an urgent need in their office/program concerning a patient and are unable to reach someone in ADAP, the medical team will be happy to assist and to relay the concern to the ADAP staff. Joe May also offered for anyone to contact him (850 245-4334, hit “0”) and he will assist in any way he can.

Dr. Arons asked for any comments. Dr. Beal also offered if anyone has any concerns to share from their area around the state to please feel free to bring it up to the workgroup. No comments were noted at this time.

Dr. Arons advised for follow up we will be producing the minutes and circulate them for comments and asking for approval. A notice will be coming out about the approval of the three new drugs added to the ADAP Formulary. Please give input related to how we should do reporting to the “state at large”.

Dr. Beal mentioned that he wanted to ask the group to provide some feedback at what is the best time and date for our next meetings. Are there better days/times? Mike D'Amico in Sarasota advised as a pharmacist Mondays and Fridays are rough. 12:00 p.m. works great for conference call. It was agreed that a survey monkey would go out to see if June 17th, Wednesday, works for the workgroup and what timeframe is best. Lorraine mentioned it could vary by agenda as to whether 60 or 90 minutes are needed. Dr. Sherman suggested 11:30 a.m. – 1:00 p.m. or 12:00 p.m. – 1:00 p.m., if only one hour is needed. Annie will send out a survey to see what the preference is for time frame. We will avoid Mondays and Fridays.

Dr. Beal asked Lorraine about an update on the PBM and Software she mentioned. He asked how long it will be before this takes place. Lorraine stated that once a contract is in hand, it would be about 4-5 months for the insurance component to be completed. Our having this system will allow for reporting on demand. This will give our partners and our staff access to information that doesn't rely on our office and will help individuals manage items such as adherence, clinical, critical data sets, notification of clients, etc. Pharmacy is also working on getting their new system that will connect to the system data. There is a lot of potential for change to revolutionize the program.

Martha Buffington asked Lorraine if with the new system she discussed if e-prescribing will be available? Lorraine advised it would be and with mail order as well.

Open agenda call for non-member comments: None

Dr. Beal thanked the members for joining the call today; we appreciate and value your input and expertise. Watch for the minutes. Bonnie Tiemann, ARNP (in chat) gave Kudos to Lorraine for the excellent update and is looking forward to the meeting minutes.

Next meeting is June 17th. The survey monkey will be sent out to members. Any other thoughts and ideas about the data/other can be emailed to Annie Farlin for Dr. Beal and/or Dr. Arons.

Thanks to everyone.

Call adjourned at 11:50am