Summary of AIDS Drug Assistance Program (ADAP) Advisory Committee Meeting
April 23, 2014

Present: Dr. David Trump, Dr. Laurie Forlano, Diana Jordan, Steven Bailey, Lenore Lombardi, Jennifer Flannagan, Carrie Rhodes, Kristen Kreisel, Craig Parrish, Dr. Robert Brennan, Dr. David Wheeler, Dr. Gregory Townsend, Dr. Edward Oldfield (conference call), Daniela Isayev, Sandy Dineen, Lauren Yerkes, Elaine Martin, Karen Council (conference call), Anne Rhodes.

Absent: Donald Walker, Bob Higginson, Dr. Daniel Nixon

Remarks from Dr. Brennan

- Dr. Brennan opened the ADAP Advisory Committee (AAC) meeting and thanked Virginia Department of Health (VDH) staff for coordinating the meeting.

Remarks from Carrie Rhodes/Lenore Lombardi

- Carrie Rhodes provided an update about ADAP enrollment and overview of the program (see attachment).
- VDH surpassed the goal of enrolling 2000 clients into VDH approved insurance plans.
- Pre-Existing Condition Insurance Plan (PCIP) coverage
    - § Extended to April 30, 2014
    - § April premiums were paid for clients who were not enrolled in ACA insurance
- Lenore Lombardi shared that some clients may still be transitioning to the Affordable Care Act (ACA) insurance plans.
- The Committee was asked about their experience with insured patients. There was no response from the Committee. Dr. Brennan asked VDH to share issues that have come up. *VDH Response: There is concern about medical copayments that clients would be asked to pay. To address this, VDH has provided education to medical providers and contractors regarding the need to seek funding from other Ryan White parts. It is also a contractual obligation that clients cannot be turned away due to inability to pay.*

Remarks from Steven Bailey

- Per VDH's analysis, the Maximum Out of Pocket (MOOP) will be met, on an average, within two-three months. VDH is working with Ryan White Parts A and C to analyze allocation of cost. VDH staff is monitoring how quickly it takes for enrolled clients to meet MOOP.
- VDH is allowing a 60 - day transition for clients enrolled in ACA before stopping Direct ADAP medication access.
- VDH is being notified of pre-authorizations that are being accessed through ACA insurance plans.

Questions/Comments:

1. Sandi Dineen - Perhaps meeting MOOP will increase use in non-HIV related medical costs.
2. Dr. Dillingham - Patients are not being able to afford certain screenings such as colonoscopy.

3. Dr. Trump - What are some changes in practice? Dr. Dillingham - Patients are not seeking care elsewhere.
4. Dr. Dillingham - Experiencing issues with prior authorizations with some insurance companies. The company may reject the authorization that is required for many medications. This may lead to gap in medication. Is prior authorization required monthly?
5. Sandi Dineen - Some companies require prior authorization for antiretroviral medications; it is valid for one year.
6. Steven Bailey - Some companies are limited to using one network. Steven encouraged the AAC to communicate issues experienced with the insurance companies to VDH so VDH can communicate directly with the insurance companies.

Remarks from Steven Bailey

- Steven provided an update regarding ACA enrollment efforts. Enrollment efforts exceeded 2000 clients. VDH is reviewing projections with updated numbers.
- $48.2 M for program cost with insurance. VDH is exploring additional resources to meet this need.
- Resources on hand with projected rebates result in a $17M shortfall.
    - Awaiting final Part B Notice of Award this month
    - Awaiting additional General Assembly appropriation
    - Awaiting final ADAP Emergency Relief Funds this month
- VDH received partial Part B award amounts from Health Resources and Services Administration (HRSA) reflecting 29% of last year's award $7,675,864 compared to $26,394,525].
- VDH received partial ADAP ERF award of $1,034,041. Applied for $11M, final amount is unknown [last award was about $4.9M].
- VDH requested funds from the General Assembly [$3.9M] to reduce shortfall. Approval looks promising, but the budget is not yet finalized due to discussions surrounding Medicaid expansion.
- Two Ryan White Part A areas of the state have or will make made substantial contributions from their unspent GY13 funds. DC is contributing $922,525. Norfolk is contributing a range between $200,000 and $700,000 which will assist with medication purchase and insurance costs. (for clients in those regions)
- VDH does not anticipate a wait list or capped enrollment.
- VDH is aware of unmet needs including client cost shares for medical and lab visits and non-formulary medications.
- VDH is applying for Part B Supplemental Grant federal funds.

Questions/Comments:

1. Dr. Brennan: How is program cost affected by insurance? *VDH response: Direct ADAP cost is about $10,200 annually (only ADAP Medications). Under ACA, the premium and MOOP cost nets about $3000-$4000 annually. It is an excellent cost savings. The program need continues to increase due to three drivers: current HIV Treatment Guidelines, increased HIV testing and increased engagement of Special Projects of National Significance (SPNS) and the Care and Prevention in the United States (CAPUS) Demonstration Project. Steven explained rebate revenue and that it is invested directly*

into ADAP. Additional income received from the pharmaceutical industry is not only significant for Virginia but nationally.

Letter to Anthem -Steven Bailey

- Dr. Brennan drafted a letter that was submitted to Anthem on behalf of the AAC. Anthem has declined to add Stribild and Complera to their formulary. While Anthem's response cites an exception process under which access to a non-formulary drug "might" be granted, this does not provide adequate assurance that clients would be able to access these medications if prescribed. Virginia ADAP would not be able to provide those medications at full cost for insured clients in addition to paying for premiums and all other medication costs for ACA plans and comply with federal policy. Federal policy requires that ADAPs ensure that antiretrovirals offered on the ADAP formulary are also offered through plans supported with ADAP dollars, as well as demonstrate cost effectiveness when using funds to pay for insurance costs. Therefore, Anthem's decision to not include Stribild and Complera on the formularies of its ACA plans results in the inability to support those plans with ADAP dollars at this time.
- VDH met with the Bureau of Insurance to discuss concerns around plan availability to ADAP clients across the Commonwealth. Issues discussed included geographic distribution of plan choices, formularies, monitoring of acceptance of third party premium payments, and distribution of "risk" (proportion of HIV-infected clients) across plans. BOI has indicated they do not have a current role in the discussion.
- VDH is working with national partners to advocate for ADAP sustainability, including (a) sustaining federal ADAP funding levels, (b) monitoring of insurance carrier practices in premium costs increases, formulary changes, and continued acceptance of third party premium payments, and (c) negotiations with pharmaceutical industry around continued rebates.

Questions/Comments/Concerns:

1. Steven Bailey: How has plan selection affected Committee members' practices?
    - Dr. Brennan: There are gaps in coverage in certain areas (no plans offered). Some companies have been helpful; it is an unintended consequence for partnership due to disproportionate share of high risk pool.
    - Sandi Dineen: There are limited plans. Some clients only have one plan option which is not feasible because of the location of clinics and lack of transportation.
2. Steven Bailey: Has there been any other impact on client care?
    - Dr. Wheeler: Moving from Ryan White to private insurance, it is difficult to monitor trends and deliver quality care services.
    - Diana Jordan shared that if Medicaid expansion occurred in Virginia about 70%-75% of clients would be eligible and shifted to another payer source.
    - Steven Bailey: We have worked hard to support quality care provision. VDH has reviewed data, charts and quality improvement projects.
    - Dr. Wheeler: How is quality of care measured across the state? *VDH Response: since all providers are not tied to grant funding, VDH anticipates asking for additional input from the AAC.*
    - Dr. Oldfield: The Eastern region is concerned with the increased amount of clients enrolled in one particular plan. A meeting will be held with the insurance company to discuss developing a 340B program to take pressure of drug cost.

- Policy update – VDH has recently updated policies. ADAP clients must be prescribed ARVs within three months of insurance enrollment process. Policies will be released and posted online.
- VDH will work to preview approved plans in May to begin planning. VDH will review MOOP, cost-effectiveness and coverage areas.

3. Lenore Lombardi: What is the role of the Clinician concerning enrolling clients in insurance and educating clients in using insurance for holistic health care?
    - Dr. Wheeler: It depends on the structure of the program.
    - Sandi Dineen: Perhaps need to educate provider and staff about insurance and questions to ask. Many nurses and social workers do not have an understanding of insurance.
    - Lenore Lombardi: Funding for medical and non-medical case management is extremely important.
    - Dr. Wheeler: This may fall under the concept of care coordination (agreement from Dr. Dillingham and Sandi Dineen).

ACA Successes- Carrie Rhodes

- Current number of enrolled clients and premiums paid
- To communicate enrollment of clients into insurance plans, a list of enrolled clients whose premiums have been paid will be sent to medical providers, local health departments and medication access sites.
- Weekly statewide calls to CAC sites
- How VA ADAP compares to other states with ACA enrollment
- Cost savings to the VA ADAP is better than projected for those clients now enrolled. Many premiums are actually lower than anticipated, clients with incomes at 101 - 250% of the federal poverty level (FPL) have lower premiums and cost shares than anticipated, and some clients have even reached their out of pocket limits within 2 months (most clients will reach out of pocket costs in a projected 3 to 5 months).
- ADAP staff includes seven eligibility staff members. HIV Care Services extended hours through the end of open enrollment period: 8:00 a.m. - 6:00 p.m. Monday through Friday, and 10:00 a.m. - 6:00 p.m. on Saturday. Sunday hours were also held during the last few weeks of open enrollment.

HIV Epidemiology and MMP Update from Anne Rhodes and Lauren Yerkes - see attached presentation.

Medication Update - Jennifer Flannagan

- ***Single pill combination of dolutegravir, abacavir and lamivudine***
    - To be released end of April 2014
    - Dr. David Wheeler provided update on clinical trials.
    - The combination of Epzicom and dolutegravir was superior to Atripla due to the side effects associated with Atripla.
- ***Darunavir/cobicistat***
    - To be released at the end of October 2014

Jennifer reviewed the process to assess new medications. Once the negotiated price is in place between the pharmaceutical company the ADAP Crisis Taskforce, a survey or email will be sent to the Committee with information about the medication. VDH staff will consult with Central Pharmacy staff regarding cost and assess possible utilization from the Committee as well as if a prior authorization process is necessary.

HIV Testing Technologies Update-Elaine Martin- see attached presentation.

Next steps:

- Next meeting will be conducted via teleconference in the fall.
- Meeting summary will be sent to the Committee.
- Next meeting agenda will include Hepatitis C discussion and medications.

Meeting adjourned at 4:30 p.m.

Attachment

Enrollment Update:

Virginia ADAP: Enrollment Numbers 4/22/2014

Table 1. Unduplicated ADAP Enrollment Numbers by Program, as of 4/22/2014.

Program	Number
Direct ADAP	2,140
MPAP	449
PCIP	47
ICAP	222
ACA	2,077
TOTAL	**4,935**

Table 2. ACA Application and Enrollment Numbers by Program, as of 4/22/2014.

ACA Enrollment Update	Completed Application	Enrolled
Total Clients	**2,117**	**2,077**
From PCIP	314	287
From Direct ADAP	1,780	1,767
From ICAP	13	13
New Client to ADAP	10	10

* Enrolled: Clients for whom a premium payment has been made by VDH, these are a subset of those with completed applications; Completed application: Clients with a completed enrollment application verified by VDH.

* ADAP pays the client premium as soon as the application is approved by the insurance company (2-3 weeks), which activates the coverage.

Table 3. ACA Enrollment Numbers by Insurance Carrier and Region, as of 4/22/2014.

Insurance Carrier	Central	Eastern	Northern	Northwest	South-west	TOTAL
Unknown	0	14	5	1	3	23
Aetna	12	6	0	0	4	22
Carefirst	0	1	170	1	0	172
Coventry	56	1	0	54	61	172
Innovation	0	0	241	0	0	241
Kaiser	0	0	27	2	0	29
Optima	414	749	8	198	89	1,458
TOTAL	**482**	**771**	**451**	**256**	**157**	**2,117**

*SOURCE: Virginia ADAP Database, Division of Disease Prevention, Office of Epidemiology, Virginia Department of Health