# AIDS Drug Assistance Program (ADAP) Advisory Committee Meeting

## Notes

## July 20, 2016, 4-6pm

**Attendees:**
Dr. Robert Brennan
Dr. Edward Oldfield
Dr. Rebecca Dillingham

**VDH Staff present:**
Diana Jordan
Anne Rhodes
Kimberly Scott
Stephanie Wheawill
Carrie Rhodes
Daniela Isayev

- **Welcome and Introductions (Carrie Rhodes/Dr. Robert Brennan)**

- **2016 Affordable Care Act Open Enrollment Overview (Carrie Rhodes)**

**-Eligibility and Recertification Update, discuss HRSA language regarding recertification**

In May 2016, HCS staff began outreach to RW contract sites requesting recertification information for clients needing to be recertified. VDH saw an increase in return of information and will be implementing an initiative in order to remain in compliance with the Health Resources and Services Administration (HRSA) policy regarding updating client eligibility every 6 months, by reimbursing contract sites for returning completed recertification documents for enrolled clients. These payments will be made until 1 September 2016 and can be retroactively paid through 1 April 2016. VDH conducts recertification during the clients' birth month and 6 months thereafter. Recertification documents are sent to clients 2 months prior to when they are due and are requested to be returned during the actual month of recertification.

If the client's birthday falls in the recertification month, he/she is expected to return a 3-page recertification application including proof of income documents and updated lab values. If the client's birthday is 6 months from the recertification month, he/she is expected to return a self-attestation document, attesting that there have been no changes in address, income, or insurance status. <u>If any of these criteria have changed, supporting documentation is required.</u>

Sites are requested to use the established template to record the requested information and fax the documentation through the secured fax line or email through the new secured email address.

**Recertification Rate: 56%, 2 or more recertifications returned since 4/1/2015. VDH has a goal of 90%**

**-Debriefing Findings**

VDH mirrored the process used the previous year and conducted the 2015-2016 via survey. Survey was sent to the list serv in April 2016 and 31 surveys were completed.

What went well:

-Communication with VDH regarding patients
-Clear communication of which plans VDH will cover
-Having eligibility staff divided by regions and assigned to each insurance company

Ways VDH can improve:
-More targeted communications
-Electronic communication option for forms. VDH is looking into HIPAA compliant forms of communication including Survey Monkey
-Less calls to clients

**-2016-2017 Planning Discussion**
Staff are in the preliminary stages of planning for the 2016-2017 open enrollment period. VDH is aware that Coventry will not be an offering in the Marketplace for 2017 coverage. (Currently 118 clients enrolled in Coventry. Coverage in the Central, NW, and SW regions of the state.)

Dr. Brennan discussed issues experienced with medication access when transitioning clients to insurance. He was advised to call VDH in such circumstances so that we can follow up and offer medications through Direct ADAP to prevent any lapse in medication access.

**-Formulary Update**

- **Data Presentation(Anne Rhodes)**
-Year 2 ACA Enrollment of Virginia ADAP Clients and Associated HIV Outcomes
-Clients enrolled in ACA plans were more likely to be virally suppressed
-ADAP Data Updates
-Comparison in regards to cost of ARVs and HCV medications
-Dr. Dillingham questioned if costs should be factored in when advising regimen changes in order to assist in sustaining ADAP. Diana Jordan responded by advising to prescribe as clinically appropriate.
-HCV medication usage by region – Harvoni is the most commonly utilized

- **Hepatitis C/HIV Treatment Assistance Program Update (Carrie Rhodes, Dr. Robert Brennan)**

**-HCV Medication discussion**
Zepatier was FDA approved in January 2016. The ADAP Crisis Task Force reached a pricing agreement with Merck in April 2016 effective through December 2017. Would the committee like to move forward with possibly adding this medication to the VA ADAP Formulary?

Unanimous decision to move forward to add to formulary.

Epclusa was FDA approved in June 2016. ADAP Crisis Task Force will most likely not have a pricing agreement for this medication. Will have 340B pricing for this medication. Would the committee list to move forward with possibly adding this medication to the VA ADAP Formulary?

Unanimous decision to move forward to add to formulary.

**-Updates from NASTAD HCV Meeting**

In June 2016, the National Alliance of State and Territorial AIDS Directors (NASTAD) convened a meeting with ADAPs, treatment experts and Federal Officials to discuss strategies to increase Hepatitis C Treatment within ADAPs. Topics discussed included reasons ADAPs are seeing low utilization among their co-infected clients and methods to encourage ADAPs to add these medications to their formularies, while still maintaining fiscal solvency. Similar to all PLWH, utilization among ADAP clients has largely remained low. Throughout the course of the consultation, we discussed possible reasons for this as well as opportunities for ADAPs, providers, and other key stakeholders to improve utilization rates among ADAP clients. These include:

1. Provider concerns regarding the complexity and administrative burden of treating clients via public and private payers (e.g., prior authorizations, restrictive coverage policies). The challenging and frequently evolving payer landscape has create barriers both for providers and patients in navigating.

2. Providers not capitalizing on all available payer options, including ADAP. For example, many providers have successfully used patient assistance and cost-sharing assistance programs to ensure access to treatment for their patients. As a result, they do not feel as if they need ADAP to fill these gaps. As well, some specialists such as hepatologists may be unfamiliar with ADAP.
3. Lack of confidence or capacity among providers to treat HIV and HCV co-infection. There may also be insufficient numbers of providers who are comfortable managing HIV/HCV treatment, particularly in more rural or less densely populated areas.
4. Issues of stigma among patients and providers regarding patients deservingness for treatment. This is particularly pertinent for people who currently or previously injected drugs.

Overall it was a very informative meeting and great to get those parties around a table to discuss.

**-HCV Post Treatment Data Update**

-All clients treated had successful outcomes – Undetectable HCV viral loads

Discussion regarding discriminatory practices amongst third party payers. Please report any practices noted to VDH. These are being reported to the National Alliance of State and Territorial AIDS Directors (NASTAD).

**Program Enrollment and Affordable Care Act (ACA) Update**

***Enrollment numbers as of 7/19/2016***

***Total: 5,954***

**Direct ADAP: 1,520**
**Insurance Continuation Assistance Program (ICAP): 481**
**Medicare Part D Assistance Program (MPAP): 551**
**Health Insurance Marketplace Assistance Program (HIMAP): 3,402**