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DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
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HIV/AIDS MEDICAL ADVISORY COMMITTEE (MAC) SPECIAL MEETING
MINUTES
October 5, 2016
12:00 pm

Division of Public & Behavioral Health	**Northern NV HOPES**	**NV AIDS Research & Education Society (NARES)**
Office of HIV AIDS	580 W. 5th Street	701 Shadow Lane, #200
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COMMITTEE MEMBERS PRESENT:
Dennis K. Fuller, Chairperson, PharmD, Clinical Pharmacy Specialist, HIV/AIDs, AAHIVP, UMC Wellness
Ivy Spadone, MS, PA-C, AAHIVS, Northern NV HOPES
Jerry L. Cade, MD, UMC Wellness Center and Southwest Medical Associates, Inc.
Mark Crumby, MD, PharmD, BCPS, Pharmacy Director, Northern NV HOPES
Shawn Mapleton, MD, Family Medicine, Infectious Disease Specialist
Steven C. Zell, MD, AAHIVS, University of Nevada Reno (UNR)
Trudy A. Larson, MD, UNR School of Medicine

COMMITTEE MEMBERS ABSENT:
Alireza Farabi, MD, UMC Wellness Center
Charles G. Krasner, MD, Vice Chairperson, Northern NV HOPES
Dino J. Gonzalez, MD, AAHIVM, Community Physician, Southern Region
Kevin D. Prince, MD, UMC Wellness Center
Mary Staples, PharmD, Assistant Director, UMC Pharmacy Services
Meddie Nazifi, PharmD, MBA, Director, UMC Pharmacy Services
Miguel Forero, NV Department of Corrections
Paul M. McHugh, MD, UMC Wellness Center
Steven W. Parker, MD, Sierra Infectious Disease Specialist; Community Physician Northern/Rural Region

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH STAFF PRESENT:
Dan Olsen, MPH, Office of HIV/AIDS, Section Manager
Darla Beers, Administrative Assistant
Samantha Penn, Health Insurance Specialist
Thomas Blissett, ADAP & Health Systems Manager
Tim Taycher, Care Services Specialist

Dan Olsen call the meeting to order at 12:00 pm. This meeting was properly posted in accordance with the Nevada Open Meeting Law (NOML).

1. **Roll Call and Introductions –** *Dr. Dennis Fuller, Chairperson*
   Introductions were made and a quorum was established.

2. **Public Comment –** *Dr. Dennis Fuller, Chairperson*
   There was no public in attendance.

3. **Vote -** *Dr. Dennis Fuller, Chairperson*
   The committee voted to extend new 5 year terms for the following people: Ivy Spadone, PA-C; Dr. Jerry Cade, Dr. Mark Crumby (new Pharmacist to HOPES); Dr. Steven Parker; Dr. Steven Zell; Dr. Trudy Larson; and Dr. Shawn Mapleton (new Dr. to the jail system). Asked if there was any discussion regarding this there was none, and as no one opposed, all terms were extended and Dr. Fuller welcomed everyone especially the 2 new committee members.

4. **Update –** *Dan Olsen, MPH, HIV/AIDS Section Manager*
   Dan let members know that the HIV/AIDS office physically moved from the Bureau of Child, Family & Community Wellness over to the Bureau of Behavioral Health Wellness and Prevention (BBHWP). Along with HIV/AIDS, BBHWP also oversees the Substance Abuse and Mental Health agencies. The reason for the transition was that all three agencies serve the same population and BBHWP wants to begin work to integrate all 3 programs. There were a number of staff changes, however there is now a full team on board. Dan stated that at last Legislative session he requested 2 positions, but was only approved for 1 - a Health Insurance Specialist. That position went to Samantha Penn in the Las Vegas office. This is a milestone for the HIV/AIDS team, as the program has changed drastically due to the Affordable Care Act (ACA). With this new environment there is more of a push for the HIV program to understand health care rather than just public health even though this office is still dealing with both, and trying to integrate those 2 systems. There is a definite push for transitioning clients out and for them to have the health insurance they need.

   At the national level, the Ryan White (RW) program is currently unauthorized. However, Congress continues to appropriate funds to the program across the country. One thing that was an issue and a point of topic was whether or not to re-authorize RW. However, NASTAD (the National Association of State and Territorial AIDS Directors) along with the HIV Community, felt it prudent to re-authorize, but also believe it necessary to continue gleaning valuable information in terms of the interaction between ACA and the RW program, therefore holding off on re-authorization until we have more information of how service delivery is being conducted from the various systems.

   Things are at the point where we are changing how ADAP services are provided, modernizing it to fit health reform and insurance access. Part of having Samantha on board with the Health Insurance is it's important for us to have her expertise and knowledge of having worked with the insurance

programs, ensuring that our clients are educated, our providers are educated, and understanding the various plans, working closely with the Division of Insurance, and closely with the State Health Exchange as well. Samantha is also looking at different strategies on how to coordinate better with Medicaid, Insurance Companies, regarding early intervention services and case management. That includes more integration with Prevention, especially with the linkage activity. The other movement is supporting PrEP as part of the linkage to care and we're exploring ways how we could better support PrEP activities and providing that infrastructure. A few of these are already provided, but it is important to ensure that it's more of a formal structure where we can take our current RW infrastructure and how we can support PrEP - working closely with the Pharmaceutical companies, as well as how it could be funded and ensure that there is an ongoing structure to help individuals utilize PrEP. In addition, we are part of the Medicaid/HIV Affinity Group which is working with Medicaid more closely on using their claims data so we could not only strategize but also implement better coordinated services and understanding their client population on the services that they cover and comparing them or matching them with our data to enhance our program services for that. We have also been working more closely with the jail population, ensuring that the inmates have their medications and the appropriate diagnostic tests, and that they are linked to the appropriate service providers as they reintegrate back into the community.

Pertaining to the budget, we continue to receive federal dollars, averaging about $8.4 million a year. $6.2 million of that is ear-marked for ADAP services, so the majority of funds are for health insurance activities as well as medications under the ADAP. One of the things that we've seen is that health insurance premiums, deductibles, co-pays, have all increased dramatically as have medication costs. As we put medications on our formulary, one of our challenges is working with the insurance companies because they are slow at getting medications on the appropriate tiers, so if there is a particular drug that needs to be covered by the insurance company sometimes, unfortunately, it's not there.

It is my hope that the committee will help us on overcoming that barrier of getting those medications on the insurance companies. Unfortunately, since we are assisting with their insurance premiums, we're still covering them but they're bouncing back to our ADAP program in order for us to ensure they are getting that medication, so it's not really cost effective – we want the insurance companies to cover that because we are paying for that insurance assistance.

Dan asked Sam for her thoughts and she started by saying they are getting ready for open-enrollment and looking very carefully at the plans they will be covering next year. There have been a number of changes at the Division of Insurance as of this week, so she continues to look diligently into those options. Sam also looks to transition a lot of clients who are currently straight medication/ADAP assistance into health insurance to give them more wrap-around coverage as well as getting their primary and specialist needs met as well. Sam went on to discuss the Tiers, saying the formulary list of what the Insurance companies have proposed to the Division of Insurance should be released this week. Sam talked about Market Place premiums and Employer-based premiums. Although there is nothing to be done about Employer-based premiums, she said the big insurers of Market Place are HPN (United Health Care), Anthem BCBS, and Prominence. In a current 2016 analysis, HPN did a little better with their formulary in terms of (if you look on the ADAP formulary we provided you – the whole first page, the 39 medicines there) – HPN kept all those on a tier 3 out of a tier 4 system of medication, which meant we are paying a co- pay for those clients medications rather than paying a percentage, like a co-insurance. Anthem BCBS put the majority if not all of those medications on a tier

4, which meant we were paying 20-40 % of the cost of those prescriptions after we had them meet the clients deductible. So our cost on Anthem BCBS clients was significantly higher than those that we served on HPN. Likewise, Prominence put the majority (29 out of the 39) of those medications in the highest tier, so they are in the middle in terms of our cost share of our clients. So when we are looking at this open enrollment period we're analyzing the best formularies on those plans as well as what is that cost going to be to help serve those clients co-insurance and co-payments.

Dan thanked Sam and added that along with the medication costs, we will be sending out a list of the top 100 drug listed on our formulary, and you will see which ones are highly utilized. Dan then listed out the top 10 drugs being utilized on our PBM report for that. Dan said it fluctuates throughout the year, but as of September, we are averaging about 832 members utilizing our assistance program, and are averaging about 2,000 prescriptions a month. Average ingredient cost is about $602.00 per prescription. We still have the same yearly influx of the Medicare part D clients coming onto our program at the end of the year, stay with us the first quarter and then drop off the program by the second quarter, so we still have that yearly transition of utilization and cost for that.

Dan took a moment to applaud his staff for their work to integrate eligibility processes including the system that we used to collect client data with all the parts, working closely with Part A specifically as they are the next-largest-program, on universalizing our application, and utilizing all the forms that would be basically accessible and if they are eligible for one part, they are eligible for the other parts as well. That has been a tremendous team effort, working just over a year getting all the appropriate criteria, paperwork, documentation, and streamlining the application. Migrating from the Aries system to CAREware, has tremendously helped our program and we are more in alignment with the other parts since we use the same system and we will continue to have that integration with the various parts. It makes it easier for clients to apply for the programs. We are still the safety net, but clients - even though they maybe transition off to Medicaid or the Market Place, they can still utilize our wrap around services. It makes it easier for us to track them and ensure they are re-certified every 6 months and that way if there is a notice of denial of some sort or a change in their situation, our program is still there to capture them and provide the medication that they need. Lastly, Dan talked about the Integrated HIV Prevention and Care Plan. After a long process the plan was submitted to HRSA and CDC. Basically what the Integrated HIV Prevention and Care Plan does is, it encompasses all the work the HIV Prevention Program has done, including all the parts involved with it. The only thing missing that we had hoped to capture was the Substance Abuse Mental Health part, but hopefully next year we can add it as an addendum. We are one of just a handful of states that were able to pull off this Integrated Prevention and Care Plan. Our project officer from HRSA said we are the only state that she covers that was able to submit, so she is very pleased as it is a lot of work, it streamlines the plans for the state because it's only 1 plan for the state vs 3 or 4 different plans that need to be submitted to the various Federal agencies. We are hoping, in the long run, that SAMHSA will become involved with it so then you really have the 3 main Federal agencies that cover the Mental Health, Substance Abuse and HIV programs. The Integrated plan has now been sent out, so please take the opportunity go through it, there's been a lot of work put into it, you'll see the Epi information, the Data information, and all the goals and objectives that are in alignment with the National HIV/AIDS strategy. We, along with all the other programs involved in this plan, will be working closely with the University as it pertains to the state-wide monitoring for the first time on all the activities, the linkage, the care, the access along with the co-occurring conditions of Substance Abuse, Mental Health, other STI's and so forth.

Tim asked if we could add Hepatitis C medications to the next agenda. Thomas spoke up asking that we hold off on that until we get a better understanding of funding, as it will be a very expensive undertaking. He said it is something we can take up at the 2nd meeting next year, in October, and put it on the agenda for the following year. Dan acknowledged that there is a huge push to work more closely with the Hepatitis programs, and the issue of concern across the country is the cost. Some of the larger states have a cap or a waiting list and they work with the pharmacies in that respect, but for us in Nevada, we do need to have our data in place and find out what is the true burden of Hepatitis here. It's an initiative that we will be tackling and working with the Hepatitis programs, but at this point it's working with the pharmaceutical companies and seeing what type of project we might be able to consider. It would put a burden on the formulary on the expenditures, and he is concerned that we would have to cap it at a number, but said he didn't know what that number would be.

Dr. Fuller stated there are multiple burdens associated with it and asked if the committee could get an idea of what just a couple of the medications would cost. Thomas answered him saying he has a call in to Leslie, as he is just doing the research right now, but it is something that he wants to bring up to the MAC Committee once he has all those numbers in place for consideration. Dr. Fuller said that could be discussed in a non-voting situation, as the impact to our budget would significantly under play what that would be. Dr. Fuller asked Dan if he had a dollar amount that could be added cost-wise from some of the medications on our list to get a better idea of which and how many medications we could add. Dan said since the ACA was implemented we had originally projected that our rebates would go down considerably due to the transition of clients out of our program. However, the rebates went up and this is what's been seen with other states as well. The larger states are receiving very large amounts of rebates. You can relate the rebates that we receive with the high cost of medications that we are paying out. Last year we received about $11 million in rebate dollars on top of our regular federal funding of $8.4 million, and we've done well at spending down every dollar of it. It's one of the reasons why Congress and the HIV community is holding off on signing the re-authorization because more information is really needed on evaluating the services of the new ACA environment. At this point we are projecting that we will come close to the same dollar amount this year for rebates but it's slow-going on what we've been receiving to-date. There are changes at the national level regarding the rebates and who signed up for them, and the insurance – there's partial pay rebates, full rebates, and that all adds to the complexity of what we receive. Dan said he was hoping that the 3rd year they would have at least a 3-year level of how much we are receiving, but it hasn't panned out that way. Each year it increases and we don't know when that will stop. We want to see the rebates go down and they haven't. Until that happens we can then have a better projection of the dollars the state will receive. At this point we're just estimating that we will receive the same dollar amount as we received last year.

Dr. Larson commented that with standard of care and HIV care we always test for HEP C. The problem is we find it more frequently than we would like. So HEP C really does need to be addressed, and it would be great to have a Walmart-type of formulary, where our cheap drugs would cost the client $5 and then really look into how we could supplement with HEP C treatment, because it's only 1 time.

Following up on Dr. Larson's comment, Dan said we could always look at the other states that have it on their formulary (which is something else he wants to do) and the various models and how they address Hepatitis, and see if there is one that might be a good fit for our state.

5. **Review and Revise -** *Dr. Dennis Fuller, Chairperson*

Dr. Fuller spoke briefly about formularies, acknowledging he hadn't posted formulary information for public comment and met the spirit of the laws, but what should have been listed in everyone's packet was a list of medications from a psychiatry standpoint that they would like considered. He wanted to move ahead and discuss pricing information and safety and have them on the agenda for

the next meeting's consideration and vote. Dr. Larson spoke up and agreed they should move forward, but said she looks forward to seeing the "most used" list and what kind of money is going out for our ARV as well in case we need to take something off the formulary. Dr. Fuller agreed that was a great idea and said as the committee chairman he does have the list with him and made the comment that she won't be surprised from that standpoint but that it did need to get out to all the committee. Taking chairman's prerogative, Dr. Fuller stated that he thinks there are some medications especially from the ARV standpoint that we should show some interest in getting rid of. At the next meeting he would also like to consider the elimination of Aptivus, Crixivan, Fuzeon, Recriptor, Trizivir, Videx, Viracept, and Zerit. Dr. Zell added that there are very rare clients that have been on old agents for decades and refuse to switch and their viral loads are undetectable so we have to ask if they are well controlled we shouldn't force them to get off formulary. Dr. Fuller agreed, that if there was someone who was still on an older agent we could adapt a grandfather clause. He went on to say that if we have the liberty and we have the medications, we should move those on up. Dr. Zell agreed. Dr. Fuller said he would format a list for the next agenda.

Dr. Fuller stated that on the non-ARV list, they should consider getting rid of Darbopoetin, Erythropoetin, Gemfibrozil, Phenytoin and Niacin. He went on to recommend that over the next few days everyone review the list and email any comments to him. He then asked if there was further discussion about this.

Dr. Larson spoke up and said another thing we need to talk about is PrEP and if it's going to be used under ADAP. Dr. Fuller said we could pull some things together and have some discussion on PrEP He could think of 2-3 issues that would leap up right away from that, but even if it is not something we as MAC and ADAP can do, it should certainly show in the minutes of our meetings that this is something we are discussing because this is the physicians group, so this should be foremost in our minds at all times, so we can make this an agenda item for the next meeting and Dr. Larson agreed as she said it is becoming a more and more of a priority to address the national goals.

Dr. Mapleton brought up the idea of legal and medical marijuana use and the clinics or affiliations who provide it. Dr. Fuller said it can go down as an agenda item for next meeting as these are questions we should be asking as a medical community.

6. **Public Comment -** *Dr. Dennis Fuller, Chairperson*
   There was no public in attendance.

7. **Adjornment**
   Before adjourning the meeting, Dr. Fuller reminded everyone to be sure and send in the "Request for Addition/Deletion to the ADAP Formulary" paperwork regarding the anti-depressants, given out previous to today's meeting, to Dr. Fuller or Dan Olsen.

   Dr. Larson moved to adjourn. Dr. Mapleton seconded the motion, and Dr. Fuller thanked everyone in attendance today adding that the next meeting will most likely be held the end of January or the beginning of February 2017.