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HIV/AIDS MEDICAL ADVISORY COMMITTEE (MAC) MEETING MINUTES

September 15, 2020
12:15 PM
DRAFT MINUTES
WebEx Teleconference

COMMITTEE MEMBERS PRESENT:

Dennis K. Fuller, Chairperson, PharmD, Clinical Pharmacy Specialist, HIV/AIDS, AAHIVP, UMC Wellness
Mark Crumby, Vice Chairperson, PharmD, BCPS, Director of Pharmacy Northern NV HOPES
Steven C. Zell, MD, AAHIVS, University
Jerry L. Cade, MD, UMC Wellness Center and Southwest Medical Associates, Inc.
Roseanne Sugay, MD, UMC Wellness Center
Todd R. Bleak, PharmD, Clinical Pharmacist, SNHD

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
Steven W. Parker, MD, Sierra Infectious Disease Specialist; Community Physician Northern/Rural Region Miguel Forero, Department of Corrections
Paul M. McHugh, MD, UMC Wellness Center
Jan Richardson, RN, UMC Wellness Center Manager
Mary Staples, PharmD, Assistant Director, UMC Pharmacy Services

Shawn Mapleton, MD, Family Medicine, Infectious Disease Specialist
Ivy Spadone, MS, PA-C, Northern NV HOPES

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH STAFF PRESENT:
Michael Thomas Blissett, Health Program Specialist I, AIDS Drug Assistance Program (ADAP) Manager, Office of HIV
Vanessa Caceres, Management Analyst I, Office of HIV
Rhonda Buckley, Administrative Assistant II, Office of HIV

1. Call to Order, Roll Call – *Dr. Fuller, Chairperson, and Rhonda Buckley, Administrative Assistant II*

   Dr. Fuller called the meeting to order at 12:15 p.m. Administrative Assistant II, Rhonda Buckley, conducted roll call of the Medical Advisory Committee. Six (6) members present; seven (7) not present. Quorum met. Dr. Fuller advised Ms. Buckley two members, Dr. Paul McHugh and Jan Richardson, have both retired.

2. Public Comment - *Dr. Dennis Fuller, Chairperson*
(No action may be taken on a matter raised under this item of the agenda until the matter itself has been included specifically on an agenda as an item upon which action will be taken.)
Dr. Fuller asked if there was any public comment; there was none.

3. Review and Approval of the May 14, 2020 draft minutes – *Dr. Dennis Fuller, Chairperson (For possible action)*
Dr. Fuller asked Committee members if they had reviewed draft minutes of the May 14, 2020 meeting, and if so, were there any revisions to be made. There were none. Dr. Crumby motions the minutes be approved as submitted; Dr. Bleak seconds the motion. None were opposed; motion carried to approved minutes as submitted.

4. Ryan White Part B Program Update – *Michael Blissett, Health Program Specialist I, Office of HIV/AIDS*
(Discussion and Information)
Dr. Fuller turns to Mr. Blissett for program update information. Mr. Blissett informs the Advisory Committee that Tory Johnson, Section Program Manager, is out on medical leave. Mr. Blissett announces the program will be going through a change in its dispensing model. They have received approval for the change from administration, and will start Jan. 1, 2021. Models will be switched from the current rebate model to a hybrid model, which will be a rebate, direct-purchase model. Mr. Blissett explained, what they will be purchasing, medications at the 340B rate for all of their uninsured patients, and will be dispensing those medications through a 340B contracted pharmacy. At this time, that pharmacy is Walgreen's; they will be the contracted pharmacy. Mr. Blissett said through the HERSA contact agreement, they have entered through an agreement to provide three (3) 340B contracted pharmacies located throughout the state. Those pharmacies will dispense the 340B medications, and there will be a depot component to that, in which those pharmacies will ship that medication to any Walgreen's pharmacy within the state of Nevada for the client to pick up that medication at a

Walgreen's of their choice. Mr. Blissett noted with the current situation with the USPS, they wanted to ensure there was some way for the clients to get medications delivered to them. Walgreen's has established an agreement with FedEx to deliver medications overnight to patients. He said that will ensure the clients in rural counties will have access to those medications, and also, any client who has trepidation about going to the pharmacy to pick up their medications during the COVID-19 pandemic. Mr. Blissett said the reasoning for the switch, is one; cost of medications continues to rise, and two, the uninsured population continues to grow. He added the insured population utilization continues to decrease, and with this population decreasing, it is decreasing the amount of rebates the program is generating. From the years of 2017-2019 (data agency has) the program averaged $15 million dollars in rebates each of those years. They have not seen any increase to the rebates, even though the population is increasing. The agency is steadily seeing an increase in prescription cost. In 2018 based on the calendar year for the ADR, the program spent approximately $18 million dollars in medication assistance. Based on the ADR in 2019, the program spent $24,598,411.70, just to provide medication to Nevadans living with HIV. Mr. Blissett said just in that year time, that was a $6,558,252.37 increase from the last calendar year. He said based on the increase and rebates staying flat, they had to look at another option with which to provide medications. Cost for the calendar year for the uninsured population, based off the ADR, was $20,208,978.64. He said going to direct purchasing with the 340B price, it will reduce the agency's cost by almost 50 percent, based on projections. Mr. Blissett said they will see a decrease in rebates just because they will no longer be going through a rebate model, which means of the insured patients in which they were receiving rebates, they will no longer receive those rebates because they will be getting those savings up front. To be sure they will be able to generate new income, the program did an evaluation and found that it takes the insured population 5.7 months to reach their out-of-pocket maximum. Once they do, the program can no longer submit claims to the pharmaceutical companies for rebates. By the agency going to the direct purchase state, it allows the program – once the client has met their out-of-pocket max, to then switch the insured client over to the 340B supply, and they will then start generating program income. On average, the program brings in about $10 million dollars of revenue just off the insured clients for those 5.7 months. Mr. Blissett said for the additional 6.3 (months), they are projecting to receive between $8 and $11 million dollars for the same clients they would not have generated in the past. It is new income to the program which will allow us to expand more core and supportive services for people living with HIV. The projection is that if they are to stay on their current course using this model, the program would have to make cuts. Cuts in how they are providing assistance to their clients, and what services they would be able to pay for. Currently the program puts about $5.2 million dollars in rebates into core and supportive services. If they still with the current model, they would have to cut that by almost $7 million. Mr. Blissett said the number does not 'jive' as one is bigger than the other, so they would have to make more cuts utilizing the same model, that is the reason why they made that particular switch. Mr. Blissett noted there were questions brought to his attention about retention. The program currently has a retention-to-care program, which they are contracting under non-medical case management in the Part B side of the house. The have found it is not accurate, as the clients reach their out-of-pocket max, they are not receiving claims. It may look like that client is not being adherent to their medication when they actually are. What the model allows them to do, is get a full picture of clients' adherence. Switching to the new model with give them a full 12-months view of client utilization, adherence to their medication, and be able

to address this once they see the client has missed thirty or sixty days then refer them to a medical case manager. Mr. Blissett paused in his presentation to allow for questions from the Committee. Dr. Fuller opened the floor to questions for Mr. Blissett. Dr. Zell asked for clarification on the model change, would it include anti-retrovirals and anything on the ADAP Formulary for co-morbid medical conditions. Mr. Blissett said this is correct. He added all of ADAP's clients will be utilizing Walgreen's and will be in full effect on April 1, (2021). Mr. Blissett said they are going back to pre-2015 practices, but wanted to be sure they had more pharmacies in which more clients could utilize. Dr. Zell then asked, assuming practitioners who care for these clients are 'up to snuff' and ahead of the game so they anticipate people needing to get refills on medicine with co-morbidities, he asked that this program would guarantee FedEx-ing overnight from a couple of main Wal(green's) pharmacies to a client's home so they don't have to go pick that up anywhere. Mr. Blissett repeated the statement for clarification. And said yes, they have guaranteed FedEx as their delivery service. He said "not guaranteed" but that is what the contract is for now, for FedEx. Mr. Blissett also addressed the statement of any client being able to go in and pick up their medication at any Walgreen's pharmacy. He said this is correct, but in order for them to be able to pick up their medication, they would have to go through one of the twenty (20) contracted pharmacies. Those pharmacies would then fill the prescription because those are the contracted pharmacies (with the Office of Pharmacy Affairs) contract. The Office of HIV entered into the HERSA agreement to be able to dispense the 340-B medication. Dr. Zell queried other pharmacies where a client could physically go in, and were on anti-hypertensive, ran out and needed to get it asap, would the script go to that pharmacy they're picking it up at, or to some other central Walgreen's pharmacy, and they choose to go to get something off the wall so to speak. Mr. Blissett said this is one of the things they worked out with Walgreen's. For emergencies, Walgreen's that are not contracted (part of the PHS network), they will be able to dispense that medication on an emergency basis for that client, then bill Ramsell for that particular drug.

Mr. Blissett did note any maintenance medication would have to be filled at any of the twenty (20) locations and then dispensed. If they are not going to one of the twenty stores, there will be a delay. Dr. Fuller addressed Mr. Blissett in saying, without this step, cuts would have to be made, what would those other services include. Mr. Blissett said it would include a host of other services, from case management to outpatient ambulatory (for clinics they are currently funding), mental health services, food bank.

Dr. Fuller said thank you as he wanted to reset his mind as to what it was. Dr. Crumby noted Mr. Blissett mentioned expansive services, and potential cuts if this were not implemented, he asked if there was any thought given to the direct care facilities in regard to the cuts they're going to have to make to their direct-care services to their patient population. Mr. Blissett said yes, and yes. They did take that into consideration, that being said, his main priority and the one thing he is funded to do, and he's not by any means dismissing the work anybody else is doing, but the sole purpose of the ADAP program is to ensure that Nevadans who have HIV have access to medications. Mr. Blissett said this was the driving port of the program. They have been very clear to all of their sub-recipients, if they have any funds that are available to them, be it rebates, program income or grant funding, they will make those funds available to the community. He said there is a push of program income they are anticipating, to where they can put those funds back out into the community. So, what is taken in, they will most definitely put out and this is one of the ways they are trying to bridge that gap. Dr. Crumby wanted to be on record that the cuts that community health centers are going to have to make, are going to be

extensive, unfortunately. Mr. Blissett said he understands where Dr. Crumby is coming from 100 percent and they're not trying to have any 'losers' but based on how the program has been running, and how everything has been happening in the past, changes have to be made in order for them to ensure clients have access to medications. Mr. Blissett said the program is working with the Department of Insurance to get the uninsured population access to healthcare. They have reached out to their federal partner NASDAD who provided legal guidance with a memo, and they offered that memo to the Department of Insurance. He said they are reviewing it and have yet to receive a reply on how that's going to impact the program with the open enrollment. What they asked the Department of Insurance to do, was to put in or add, a regulation to the state's NAC, that will restrict insurance companies from applying stringent residency requirements on their clients. Mr. Blissett said during last year's open enrollment process, they found all the insurance companies were requiring social security numbers, and they did not have one, there were federal residency requirements. This was a barrier for clients getting on an off-market place plan, versus an on-market place plan. Once they have more information, they are happy to share it with the community. Right now, they have about one thousand (1,000) uninsured consumers who are receiving ADAP services. Other changes to be made this year, is that it will be a requirement for all Medicare clients to have a Medicare Part D plan. In the past they have strongly encouraged this, but this will be the first year it will be a requirement. The program will also allow for consumers who are in an employer-sponsored plan, to opt out of this plan if that plan requires them to use a specialty pharmacy that is not part of the new NMAP pharmacy network. If their current insurance plan requires them to use a mail order facility for their maintenance medications, or if their insurance plan requires them to use a specialty pharmacy that is not part of the NMAP pharmacy network. Mr. Blissett described "NMAP" as it replaces "ADAP" – which stands for Nevada Medication Assistance Program. They wanted to get rid of "AIDS" so when corresponding with clients, they can keep confidentiality. He said the change went into effect in May of this year. Mr. Blissett said these are the updates they have for the MAC committee.

Dr. Fuller asked if there were any other questions or comments for Mr. Blissett. Dr. Sugay asked about the employer-sponsored insurance, if the employee declines it, would NMAP then purchase insurance through exchange ready stations. Mr. Blissett said that is correct. They would purchase health insurance through the exchange, that would allow them to enroll in an on or off-market place plan without the advance premium tax credit. Dr. Sugay asked what, in terms of regulations of what the patient need to produce as proof. Will they come out with a list as to what that looks like as well. Mr. Blissett said yes, that will be in the summary of benefits the client gets. The summary of benefits lets them know specifically what pharmacies they can use, or if you have to go to a specialty pharmacy. Mr. Blissett said they will have that information through their summary of benefits. Dr. Sugay asked, with the rule changes, did they make any provisions for patients whose companies can't accept third-party payments, and is this an exclusion that will be available? Mr. Blissett said that is correct. If they do not accept a third-party payer, they can opt out. Dr. Sugay said thank you. Dr. Fuller asked if there were any other questions; there were not.

5. Review and Update ADAP Formulary

   a. Recommendations to allow the Office of HIV to proceed to an Open Formulary once a determination has been made that it is cost effective for the program to do so.

b. Recommendations to add Mytesi, Combivent, Suboxone, and Atrovent to the ADAP Formulary – *Dr. Dennis Fuller, Chairperson (For possible action)*

Dr. Fuller asked Mr. Blissett who made the recommendation to add Mytesi to the formulary. Dr. Fuller was asked to spell the medication, he did, and noted it is a medication for diarrhea. Dr. Zell asked what it was needed for as Imodium OTC is available. He asked about the cost; Dr. Sugay said it is super expensive. Dr. Zell said it's too expensive to consider, his vote would be no. Dr. Fuller pulled it (the cost) up and said it was $2,300 for sixty (60) tablets. Dr. Fuller asked for a motion to add or not add to the formulary. Dr. Zell motions to not add it to the formulary; Dr. Crumby seconds the motion. Dr. Fuller asked if there was anybody opposed to not adding the drug to the formulary; none opposed. Dr. Fuller asked Mr. Blissett if he knew who asked for the addition of the drug. Mr. Blissett said it was John (Rob) Phoenix of Huntridge Clinic. Dr. Fuller said at the present time, they will not put this drug on the formulary. Dr. Fuller then discussed Combivent and Atrovent, to addition to the formulary. He said they do have Albuterol on the formulary, and asked for questions, comments or concerns. Dr. Fuller asked for a motion to add or not add Combivent and Atrovent to the formulary. Dr. Zell motions to add both to the formulary; Dr. Sugary seconds the motion. There were no 'Nay' votes; motion carried to add Combivent and Atrovent.

The fourth drug listed for addition is Suboxone. Dr. Fuller asked Mr. Blissett if he knew who submitted the request. Mr. Blissett said it was Rob Phoenix from Huntridge. Dr. Fuller asked for comments. One of the doctors stated you have to be a recognized provider for Suboxone and asked if that has changed. The other doctors said it has not. Dr. Fuller asked if it was something that was in their processes, that even if they had it on the formulary, could they get it? Dr. Sugay said as long as you have an 'X' license you can get it. Dr. Fuller asked if Walgreen's could get it or is it a specialty order. Dr. Crumby said anyone can get it. Dr. Fuller asked if it would be the clinical people who are prescribing it, or, is it coming from an ancillary prescriber. He asked if there was anybody on the Suboxone list. Dr. Crumby said in regard to HIV providers participating in their 'MAT' clinic, the answer would be no. Dr. Fuller asked if there were questions or comments. Dr. Fuller asked Mr. Blissett if there was a specific number of patients in the clinic so a monetary impact could be done. Mr. Blissett said based on the email sent to him by Mr. Phoenix, he has only one patient he wanted to start on the medication. Mr. Blissett said they could put the same restrictions on the medication based on how the committee sets its vote. The same restrictions they have on Hepatitis C medication. That medication is limited to 10 people at a time within a grant year. Dr. Crumby noted the cost of Suboxone has gone down. Dr. Fuller said they're not looking at a huge hit (to the budget) at this standpoint. Dr. Crumby said if they are to limit access, he couldn't imagine. Dr. Fuller asked if ten (10) was too few for a state this size. He asked for input from the providers present. Dr. Sugay asked if the ten people they are being limited to, would they be clients of Ryan White who do not have access to any other type of insurance? Mr. Blissett said that was his understanding. Dr. Fuller asked if there would be bleedover to their insurance assistance. Mr. Blissett said it would specifically just be for, if you're limiting it, it would be for the uninsured population because that's where you're drawing the cost from. The insured population, for the majority of the insurances, it's considered a brand drug versus a specialty drug, so they would be

getting it at that co-pay, which for the most part run about $100. Dr. Crumby said they could limit it to ten (10) and see what the utilization is. If there's high demand they can reevaluate. Dr. Fuller said they could certainly do that. He asked if they wanted to limit it to ten (10), based on utilization, then be able to bump it to twenty (20) without a full meeting, with that disclaimer on it. Mr. Blissett said yes. Dr. Fuller puts the information to the Committee, that this would be worth adding to the formulary with an initial cap of ten (10) to get a picture of utilization and cost. And if it does fill and it is appropriate, they could expand it to twenty (20) on chair or vice-chair approval. Dr. Zell said it was fine by him, his question is, what is the length one would be allowed to prescribe it, or indefinitely if people have a substance abuse issue, or are we going to give people a time frame to get them off? Which is the true concept of the drug. Dr. Sugay said if they're going to put a time frame for review after an interval. Dr. Fuller suggests six months. Dr. Zell and Dr. Sugay agree. Dr. Fuller asked if someone would put this together as a motion. Dr. Crumby motions to add an initial ten-patient population for Suboxone with the provision to increase to twenty (20) depending on utilization and cost analysis with a six-month review. Dr. Zell seconds the motion. Dr. Fuller asked if there were any 'no votes.' There were none; motion carried. Dr. Fuller said it's a reasonable thing to add and taking precautions is a good idea. Dr. Fuller noted also under agenda item 5, there is the recommendation to allow the Office of HIV to proceed to an open formulary once a determination has been made. He asked Mr. Blissett to discuss. Mr. Blissett referred to a prior discussion with Dr. Fuller, where he asked what would it take to get to that tipping point for the program to be cost effective for the program to have an open formulary. He said it need to be a ratio of 2 insured to 1 uninsured client. Right now, they are still at a .98, but they're hoping DOI moves in their direction and they'll be able to get to that 2-to-1 ratio within this year or next year. Once they hit that ratio, they will want to add to the agenda, once that cost-effective point has been determined, the MAC committee can move to an open formulary. Dr. Fuller said they're still missing the ideal ratio before doing that, but it's something to keep in consideration. Dr. Fuller said they can keep this as a 'hanging agenda item,' until the meeting. He asked if there was anything else for ADAP formulary. There was not. He asked if there was anything they needed to consider for the next meeting.

6. Public Comment - *Dr. Dennis Fuller, Chairperson*
(No action may be taken on a matter raised under this item of the agenda until the matter itself has been included specifically on an agenda as an item upon which action will be taken.)
Dr. Fuller asked if there was any public comment. There was none.

7. Adjournment – *Chairperson*
Dr. Fuller asked if they could receive copies of the new formulary list once the changes are typed up. Mr. Blissett said yes, he would send out the current formulary that day, and send out the updated formulary once they receive approval from the administrator to add the new drugs. Dr. Zell motions for adjournment; Dr. Crumby seconds the motion. Dr. Fuller adjourns the meeting at 1:05 p.m.