ADAP ADVOCACY ASSOCIATION

in partnership with the

COMMUNITY ACCESS NATIONAL NETWORK

ADAP Solutions Summit

FINAL REPORT

ADAP Solutions Summit
Washington, DC
April 2-3, 2012

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The ADAP Advocacy Association (aaa+) – in collaboration with the Community Access National Network (CANN) – hosted an ADAP Solutions Summit in Washington, DC on April 2-3, 2012. The purpose of this Final Report is to convey some of the programmatic changes, improvements and reforms that could enhance the AIDS Drug Assistance Program (ADAP) to better serve the needs of the clients. There were 3,097 people living with HIV/AIDS on ADAP waiting lists in 10 states, as of April 12, 2012 – including 503 people in Florida, 957 people in Georgia, 11 people in Idaho, 368 people in Louisiana, 4 people in Montana, 220 people in Nebraska, 124 people in North Carolina, 0 people in South Carolina, 0 people in Utah and 910 people in Virginia.[1]

The ADAP waiting lists are only the tip of the iceberg, as other cost containment measures have led to a record number of PLWHAs being denied access to timely care and treatment. Among them, states have retooled their program eligibility requirements by lowered financial eligibility, which has resulted in 445 PLWHAs being pushed off ADAPs in 6 states. [2]

ADAPs with Other Cost-containment Strategies: Financial Eligibility
(445 individuals in 6 states, as of February 1, 2012)

State	Lowered Financial Eligibility	Disenrolled Clients
Arkansas	500% to 200% FPL	99 clients (September 2009)
Illinois	500% to 300% FPL	Grandfathered in current clients from 301-500% FPL
North Dakota	400% to 300% FPL	Grandfathered in current clients from 301-400% FPL
Ohio	500% to 300% FPL	257 clients (July 2010)
South Carolina	550% to 300% FPL	Grandfathered in current clients from 301-550% FPL
Utah	400% to 250% FPL	89 clients (September 2009)

Additionally, fifteen states and Puerto Rico instituted various cost containment strategies. They include the following, **Alabama:** capped enrollment, reduced formulary **Arizona:** reduced formulary **Arkansas:** reduced formulary **Florida:** reduced formulary, transitioned 5,403 clients to Welvista from February 15 to March 31, 2011 **Georgia:** reduced formulary, implemented medical criteria, participating in the Alternative Method Demonstration Project **Illinois:** reduced formulary, instituted monthly expenditure cap ($2,000 per client per month), disenrolled clients not accessing ADAP for 90-days **Kentucky:** reduced formulary **Louisiana:** discontinued reimbursement of laboratory assays **Nebraska:** reduced formulary **North Carolina:** reduced formulary **North Dakota:** capped enrollment, instituted annual expenditure cap **Puerto Rico:** reduced formulary **Utah:** reduced formulary **Virginia:** reduced formulary, restricted eligibility criteria, transitioned 204 clients onto waiting list **Washington:** instituted client cost sharing, reduced formulary, only paying insurance premiums for clients currently on antiretrovirals **Wyoming:** capped enrollment, reduced formulary, instituted client cost sharing.[3]

[1] National Alliance of State & Territorial AIDS Directors, The ADAP Watch, April 12, 2012.
[2] National Alliance of State & Territorial AIDS Directors, The ADAP Watch, April 12, 2012.
[3] National Alliance of State & Territorial AIDS Directors, The ADAP Watch, April 12, 2012.

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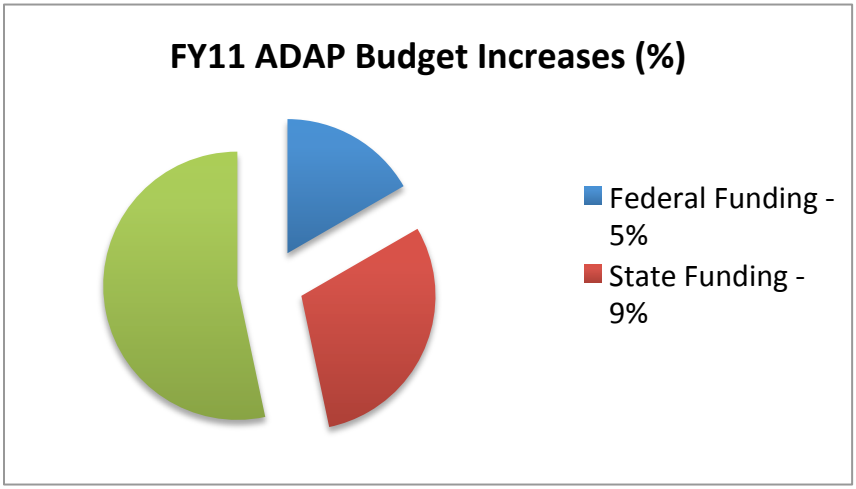
According to the National Alliance of State & Territorial AIDS Directors (NASTAD), in Fiscal-Year 2011 the National ADAP budget increased by $100 million to $1.88 billion. State funding accounted for $299 million over the overall budget and drug rebates accounted for $619 million of the overall budget. As a percentage of the increase, once again the federal government's share did not keep pace with the demand, evidenced by a record number of new patients accessing the program (there were 32,522 new clients enrolled throughout the year. This represents, on average, 2,710 new clients enrolled in ADAPs each month).[4]



The purpose of the ADAP Solutions Summit was to focus on numerous solutions to combat the ongoing problem of restricted access to timely care and treatment, including – but not limited to – increased federal/state funding, access to patient assistance programs, drug pricing & drug rebates, program efficiencies (i.e., eligibility determination), access to generics, etc. A roundtable of experts representing the various ADAP stakeholder groups heard several "big sky" keynotes, as well as several smaller "concrete" presentations (i.e., what does an ideal ADAP look like, how can services better serve former inmates transitioning back into the community, would a common portal work). The roundtable was charged with discussing the merits with fellow panelists about the pros/cons of what was presented, as well as other topics. Randy Russell moderated the roundtable. While the likelihood of the Affordable Care Act being overturn by the U.S. Supreme Court was considered, for the purposes of this Final Report it is assumed that the law will remain Constitutional and thus in effect.

This final report is a collection of ideas and recommendations, which are not necessarily reflective of the views or opinions of every panelist who participated on the roundtable. The ADAP Advocacy Association and the Community Access National Network would like to thank Randy Russell of the Lifelong AIDS Alliance for facilitating the event, as well as the following representatives for participating on the roundtable during the ADAP Solutions Summit. This Final Report could not have happened without their expertise and knowledge.

[4] National Alliance of State & Territorial AIDS Directors, 2012 National ADAP Monitoring Project *Annual Report*

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PANELISTS: William Arnold; Paul Arons, MD; Fran Barnes-Melvin; Janine Brignola; Christine Campbell; Lynda Dee; Catherine Dratz; Jim Driscoll; Eric Flowers; Darryl Fore; Jesse Fry; Jeff Graham; Edward Hamilton; Dwayne Haught; Kathie Hiers; Victoria Hollins; Brian Hujdich; Jason King; Meeka Jackson; Michael Juhlin; Jeffrey Lewis; Brandon Macsata; Tom McCormack; Ken McCormick; Rev. Harold W. Orr, Jr., M.D.; Deborah Hobson-Parham; Blaine Parrish; Murray Penner; Glen Pietrandoni; David Poole; Christine Rivera; Jessica Riviere; Carl Schmid; Elizabeth Shepherd; Coy Stout; Ken Trogden; Pritpal Verdee; Robin Webb; Andrea Weddle; Kimberly Williams; Joey Wynn.

The Final Report recommendations are included hereto, as well as other relevant information. Additional information, including the event agenda, panelist bio's and speaker presentations can be viewed online at http://www.adapadvocacyassociation.org/events_04_2012_presentations.html.

Thank you for the opportunity to share the short-term and long-term recommendations identified at the ADAP Solutions Summit.

Respectfully,

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SHORT-TERM RECOMMENDATIONS:

- Leverage Pre-Existing Condition Insurance Plans (PCIPs)
  - Getting ADAPs to enroll eligible clients into PCIPs
  - Maximize cost-effectiveness of PCIPs paying for deductibles and co-pays
- Coordination with Pharmaceutical Patient Assistance Programs
  - Continued services and medications for clients up to 500% FPL
  - Adoption of universal PAP application
- Access to Pharmaceutical Rebates
  - Direct-purchase states, need to leverage rebates where appropriate
- Improve Accountability & Quality Assurance
  - Better forecasting of new client enrollment
  - Better coordination with clients churning between one system to another one
  - Better cross benefit analysis to ensure patients aren't accessing duplicative services
  - Control costs by leveraging volume purchases
  - Using client satisfaction surveys

LONG-TERM RECOMMENDATIONS:

- Improve Access to Information
  - Utilize peer navigators
  - Leverage new forms of communication (i.e., social media)
  - Common Portal
- Improve Advocacy
  - Educate lawmakers about proven ROI (cost-benefit analysis)
  - Saves Medicaid dollars
  - Consistent with meeting goals of the National AIDS Strategy
  - Reinforcing 'Test & Treat' and 'Treatment as Prevention'
  - Initiate conservation among stakeholders on RW reauthorization
- Streamline Certification & Re-Certification Process
  - Uniform standard of eligibility
  - Incorporate more electronic tools for re-certification; disenrollment
  - More patient-friendly; less bureaucratic
- Evaluate Standardization Models
  - Portability from state to state
  - Formularies should mirror HHS guidelines
  - Eligibility criteria should guarantee a floor of coverage
- Improve Inter-Agency & Intra-Agency Collaboration
  - Provide technical assistance and information to RW grantees to help them transition to health care and integrate into the broader health care financing system
  - Guidance on helping clients (including former inmates being released from corrections)
  - Evaluate comprehensive care model (outcomes and cost effectiveness)
- Drug Pricing
  - Negotiate discounts
- Incorporate 'Centers for Excellence"
  - Face-to-face access to pharmacist
  - Medication therapy management
- Develop 'Common Portal'
  - Ability to pre-screen, pre-qualify for services
  - Ability to fill gaps in continuity of care
  - Ability to be client-driven
  - Ability to enhance capacity of case managers

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The following information and ideas were shared by patients, and shared with the panelists on the ADAP Solutions Summit's roundtable prior to the event as possible discussion topics.

Background

1.2 million people living with HIV/AIDS in the United States.

Only 300,000 – 500,00 in care and treatment (estimates vary).

With Treatment as Prevention (TasP) data a HUGE increase in HIV+ in treatment will be required to reduce HIV transmission among those already HIV-positive.

FDA labeling for new HCV treatments for co-infect (HIV/HCV) for existing ADAP clients cannot be very far off.

ACA implementation issues affecting PLWHAs are already on the horizon.

The FDA could approve an "over the counter" rapid HIV test kit soon, with heavy national publicity.

The existing systems for the eligible ADAP population is clearly strained and do not appear likely to be capable of handling potential changes (including health care delivery system shifts combined with potential increases in demand) without serious basic system change.

Patient-Centered Goals for an Optimum ADAP Solution

- Uniform FPL eligibility for ALL ADAPS in all States, Territories and Dependencies.
- National Agreement on what FPL Eligibility is a "state level" responsibility and Manufacturer agreement on the FPL point and range at which industry PAPs can be expected to take responsibility.
- ADAPS should allow for 1-3 thousand dollar income eligibility gap. If someone makes 41,000 a year and the cap in that state is 40,000 than reasonable accommodation should be made.
- ADAPs should hold current edibility for a complete Federal Program Year.
- If people are over the income eligibility but with private insurance, ADAPs should offer to help with deductible spend down and/or co pay for ARVs only.
- Prescribers should encourage 3 months Rx supplies, so individuals do not run out of meds at the end of the month because of an emergency situation.
- ADAP Recertification processes must be MUCH more user/patient friendly with clear disseminated information on the renewal window and the "You Will be Dropped" deadline.

A Common Internet Portal for ADAP Access with Help Line Phone Number

- With Following Single form Capabilities:
    - Date of HIV+ Test & ADAP Application Date
    - Rx Needs with Prescriber information.
    - Single Application for Potential ADAP Access With all information required for ALL ADAPs, ALL PAPs and ALL Drug manufacturers
    - Second level capability for accessing ALL PAPs when an ADAP Applicant proves ineligible to ADAP, but still requires access to ARVs.

Improved Coordination with Patient Assistance Programs (PAPs)

- PAPs need to do a better job with communication with clients.
- PAPs to be more transparent with tracking statistics on how many clients in each state are accessing ARV's thru each PAP.
- All ARV PAPs should use the same single application form.
- All ADAPS and PAPs should use Net Income vs. Gross Income with consistency across all programs. This is especially true with self-employed individuals.

Improve Community Outreach

- If an individual tests positive during outreach (testing only sites), education on ADAP should be given out in the field linking positive individuals to care ASAP with follow up.

Fewer Restrictions

- Elimination of ADAP Medical Triage Criteria based on CD4 Counts and viral load levels.
- Elimination of Changes in ADAP eligibility without adequate notice to clients, Minimum Notice is 160 Days.
- Remove the prerequisite of some states that require every ADAP applicant must use a case manager to obtain ADAP services.

Improved Programmatic Efficiency

- ADAPs need to be more transparent in financial reporting and rebates and in wait list distribution statistics (i.e. days on wait list, V/L ranges, CD4 ranges, income ranges).
- A nationwide database of all ADAP recipients is needed to track possible duplicates of clients residing in more than one state. And for national data planning purposes.
- If a client moves to another state, the old State ADAP should provide 90 days worth of med coverage prior to termination to allow a smooth transfer of service to the new state.
- Ensure that all ADAPs lockbox ADAP funds to prevent commingling with other Part B programs or any other ADAP related funding streams.
- Institute reasonable nationwide asset testing for ADAPs.
- ADAP's should allow pharmacy of choice and dispense with the single designated pharmacy concept altogether.