

STATE OF COLORADO

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Dedicated to protecting and improving the health and environment of the people of Colorado

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Colorado Department
of Public Health
and Environment

HIV Care Advisory Committee Meeting Minutes **Monday, August 13, 2012 10:00 a.m. – 11:30 a.m.** **Fifth Floor Board Room, CDPHE, Denver**

Members Present: Judy Bagley, Jeff Basinger, Jennifer Chase, Erin Dupuis, Robert George, Ana Hopperstad, Terrence Hughes, Merilou Johnson, Celeste LeBlanc, Martha Monroe, Arthur Powers, Peter Ralin, John Reid, Josh Whittington, Danielle Willis

Members Absent: Karl Beck, Richard Blair, Michael Dorosh, Ernest Duff, Jessica Forsyth, Guy Lively, Maria Lopez, Mary Beth Luedtke, Jennifer Pappas, Lucio Torres-Florez, Robin Valdez, Diane Walker

Department Staff Present: Bob Bongiovanni, Todd Grove

Guests: Jennifer Chambers, Kim Eggert, Jay Gill, Jim Graves, Sven Haug, Chris Holtzer, Stuart Pappas, Darryl Vigil

Introductions

Jeff Basinger welcomed members, department staff, and guests, and asked everyone to introduce themselves.

Approval of Minutes

The July 9, 2012 meeting minutes were tabled for approval until the September because telephone participants did not have the minutes available for review.

Reports:

1. HIV Medication Assistance Program (HMAP) and the State Pharmaceutical Assistance Program (SPAP) Utilization Summary

Chris Holtzer reported that ADAP is reaching a new set point due to the movement of approximately 100 clients to Medicaid. There is a continued trend down for overall clients served (1.26 percent) but only a slight dip in total prescriptions down (1.73 percent) but the downward trend is consistent. Prescriptions per clients served is still up, driven by the expansion of the formulary. Total antiretroviral and non-antiretroviral expenditures continue their downward trend, falling from approximately 1.25 million to a little over a million as compared to the same month last year. Average cost per prescriptions is down, also consistent with the formulary expansion. Data comparison will be difficult until the new set points have been established.

Chris reported that the Medication Therapy Management Program has identified the next 100 clients with a total of 200 in the queue currently. We are doing a second reach out to the clients who were identified in July and we will be starting the first telephone reach out for the clients identified in

August in about a week. We have not had any more net enrollees at this point because enrollments goes in “fits and starts” but another jump in enrollees is expected this week due to the contact efforts.

2. Summary of Medication and Insurance Expenditures and Projections

CDPHE received the notice of a grant award from HRSA totaling approximately one million additional dollars for ADAP. This takes the pressure off of negotiations to share rebate revenue with two of the largest pharmacies. ADAP staff still intend to have conversations with both of those pharmacies about longer term strategies and how we could work better together around these issues. With this additional funding source ADAP should be able to meet anticipated demand, although this is dependent on Medicaid expansion.

ADAP has reached a plateau in its ability to transfer clients over to Medicaid because the 10,000 person enrollment cap has been reached for the Adults Without Dependents plan. From this point forward, only a small number of new eligibility slots will become available and will be awarded through a random selection process. Any ADAP-eligible person’s chance to be transferred to Medicaid now depends on how many people are on the Medicaid wait list.

Todd reported that there is an uptake at all agencies in enrollments for insurance assistance. Presently, sufficient funds have been budget to meet this demand. There was a higher than normal utilization for the month of July, but the causes have not been identified.

Bob reported that the ADAP data system will be significantly upgraded in the next two months. This will make new reporting possible. Federal data requirements are expanding as of October 1, 2012. As one example, under the new rules ADAP must actively disenroll clients and cite a reason for the disenrollment, not just allow them to passively “non-renew.” The Committee may find it interesting to see both the numbers and causes of disenrollment.

Colorado Medicaid is convening an open meeting to discuss whether Medicaid will cover Truvada for pre-exposure prophylaxis purposes on August 21, 2012 at 7:00 p.m. at the Healthcare Policy and Finance offices, 225 E. 16th Ave in Denver.

Committee Chair Report – Jeff Basinger declined to provide a report

Committee Workgroups

1. ADAP Advisory

Jennifer Chase provided a brief report on the activities of the last ADAP workgroup meeting. Meeting minutes are attached.

At the Part A priorities and allocations meetings, Bob proposed creating a new service category to prepare for expanded demand for enrollment and ineligibility assistance as health care reform rolls out. The proposal was to prioritize the category called “Referral” to allow for paying overtime or bringing in temporary staff at Denver area clinics and case management agencies who would likely receive a surge in demand as clients shift from indigent care to either Medicaid or private insurance. After considerable debate, the HIV Resources Planning Council opted to vote down this proposal and to only take additional action once the course of healthcare reform is clearer. Bob informed the Planning Council that Part B funds may not be sufficient to meet this demand within the TGA.

2. Medical Advisory No report

3. Pharmacy No report

Discussion Items

A. Health Care Reform Workgroup update – Peter Ralin

The workgroup has met three times (June 20, July 11, and August 8). The group is making progress; so far, they have identified six goals and now we are working on process objectives for achieving those goals. Meeting reports are attached. The next meeting will be on September 12, 2012.

B. Data collection/sharing and client confidentiality task force next steps – Barb Cardell

A webinar was held on July 17, 2012 for which there were 30 RSVP's and 15 participants. This meeting was a great start of conversation on data, technology, and a plan for data sharing. The goal is to look at sharing of data across all types of providers, across the state. Ultimately, the hope is to establish a format that fits the many parts of the network of care, not just the sharing of data between CDPHE and the AIDS service organizations. There are multiple federal initiatives around data sharing that must be accommodated, while also focusing on "client centeredness" regarding how data is shared.

As part of the webinar, draft "aspirational statements" were developed, based on language drafted by Bob:

- Clients should have control over and consent to the uses and sharing of their data, consistent with state and federal law.
- Clients should benefit from improved coordination of HIV care through data sharing.
- Providers should be better equipped to meet client needs through data sharing.
- Data sharing should improve referrals (both making and following up).
- Clients should be able to supply data to a "point of contact" of their choice and have automatic update of other data systems (e.g., recertification, change of address).
- Data sharing provides opportunities to improve efficiency, for both clients and those who have reporting responsibilities.
- When clients are "in crisis," data sharing should facilitate expedited services.

The next task force meeting will include discussion of the new Federal initiatives around data collection and sharing. The information for this meeting will be sent out as soon as it is scheduled.

C. Care and Prevention Coalition update – Peter Ralin

At the June meeting we had some very good presentations on Stigma and the Healthcare Reform.

The next meeting will be in Colorado Springs and are still working on presenters. The information will be sent out as soon as it is finalized.

D. Other Business

Jeff brought up a couple of issues he would like to put on the radar for further discussions. They are Treatment Resistance Gonorrhea and HIV Specific Criminalization Laws. Also for the next Care Advisory meeting he would like to have a report from the International AIDS Conference.

Next Meeting –September 10, 2012 from 10 a.m. to 11:30 a.m.

Meeting adjourned at 11:30 a.m.

Colorado AIDS Drug Assistance Program (ADAP) Minutes

Tuesday, July 16, 2012 10:00am-12:00pm

CDPHE, 4300 Cherry Creek Drive South, Denver, Room A3B

Conference dial in: 877-820-7831, Conference call ID: 169639

- Members present: Arthur Powers, Bob Bongionvanni, Celeste LeBlanc, Erin Dupuis, Jennifer Chase, Jennifer Pappas, Judy Bagley, Kelly DeMuth, Katie Donovan for Kelly Klein, Kelly Maycumber, Martha Monroe, Mary Beth Luedtke, Merilou Johnson, Michael Hollar, Sandra Dunlap, Todd Grove. Guests present: Chris Holtzer, Jay Gill, Jim Gray, Kim Egbert
- June minutes were approved. Arthur moved, Martha seconded; unanimously approved.
- ADAP budget summary: \$0 in unexpended federal funds is estimated in 2013. Projected unexpended/carryover funds in 2014 are approximately \$6 million. ADAP projects over \$36 million in funding for April 2012 – December 2013 (grant years vary based on funding sources). No response has been received regarding the application for supplemental funds from HRSA for an additional \$1,000,000.
- Healthcare Reform Issues
 - Medicaid expansion update: Adults without Dependent Children (AwDC) has enrolled 125 HMAP clients. There are approximately 1800 people on the AwDC waitlist after July enrollments. In order to encourage people to enroll in Medicaid programs before the 2014 deadline for Healthcare Reform enactments, we discussed mandating Medicaid application for eligible clients at ADAP recertification dates. A notice will be included in ADAP recertification mailing that applying for Medicaid, if eligible, will not be optional in 2013.
 - Medicaid Buy-In: A premium subsidy program is being developed by CDPHE for the Medicaid Buy-In enrollees. So far no referrals have been received. Refer clients requesting assistance to Todd Grove.
 - Medicaid copayment assistance for prescriptions for new AwDC clients: Copayments are currently being waived upon request at University IDGP Pharmacy, Denver Health and Walgreens at Rose. Clients can also receive assistance for prescription and medical copayments from case management agencies. We are looking at 3 additional options for copay assistance:
 - CDPHE is in negotiations with University and Denver Health to keep a portion of the rebate money for write-offs for these clients. Pharmacies are looking at rules regarding using income to cover waived copayments. This option avoids reporting requirements.
 - ADAP providing a pool of money at ADAP pharmacies. This option has reporting requirements.
 - Coupons or vouchers from ASOs for case managed clients. These would require demographic reporting. CDPHE would assist non-case managed clients.
 - Getting Us Covered Colorado (GUC) update: CDPHE is still working on scheduling a GUC conference call with medical providers to introduce the Unmet Medical Need Application.
- August meeting topics:
 - Discuss and determine eligibility for copayment assistance based on federal poverty level for Medicaid enrollees.
 - Contraceptive survey results (n=15) from medical providers.

Next Meeting: Monday, August 20, 2012, 10:00am-12:00pm, CDPHE, Room A3B

Coalition Healthcare Reform Work Group Meeting Minutes

Meeting Date: June 20th, 2012

Present: Peter Ralin, Bob Bongiovanni, Carol Lease, Jesse Yedinak, Mikayla Branz
On the phone: Martha Monroe, Jen Chase, Chris Grano, Arthur Powers, Imani Latif

Ground Rules (group discussion)

- 1 person speaks at a time
- Everyone respects each other's opinion
- 'Ouch' then 'Educate'
- Assume positive intent
- If it's already been said, don't say it again
- No speeches, just comments
- We have limited time, please be brief about your points
- Communication between meetings should go to both Peter and Bob
- Phone Access is requested for future meetings

Update on Local & National Reform Efforts (Bob)

- Different states are moving forward, Colorado seems to be in the middle/middle-back of the pack. Maryland is leading the progress and has established core priorities for what they want to achieve.
- Our biggest victory was switching 100 people from ADAP/CICP over to Medicaid, which cost approximately \$400 per person in staffing resources. The benefits will outweigh the costs with \$1.2 million in savings and full healthcare coverage for those on Medicaid.
- Some of the complaints included more initial copays through Medicaid than with ADAP/CICP, showing that outreach and building trust may be a larger issue than first thought. We need help reaching out and to encourage this transition, especially for those living with chronic illness.

Bob suggested the following **framework for the conversation**, group discussed.

Enrollment → Benefits → Evaluation & Monitoring → System Capacity

What is already in place (Peter, group discussion)

- Prevention Services must be provided free of charge w/o copay
- State Laws included high-risk pool/GUSC
- Kids/young adults have coverage up to age 26 under parent's health insurance
- No preexisting condition restrictions for children and those in the high risk pool
- No lifetime cap on coverage, but Cover Colorado is excluded from that
- 50% discount on Rx coverage for people in the donut hole
- Community health centers emerging as key players (federally qualified)

Enrollment	Benefits	Evaluation/Monitoring	System Capacity
Outreach Assistance & Education: Well-trained, trustworthy staff to assist w/enrollment	Overall benefit package: must look at Prevention and Care as both billable services	Responsiveness: Pay attention to who isn't enrolling, adjust and redirect outreach efforts to the areas of need or disparity.	Capacity is a constant discussion
Adults w/o dependent children: Develop strategy to better reach the organizations that work with this population (vs. traditional Medicaid applicants)	Inventory: Could other current services become billable?		Benefits are no good if we have waitlists for services
	Case Management: How do we stress the importance of comprehensive case management, and make it billable?		

National HIV/AIDS Strategy (NHAS) and Healthcare Reform

(Carol, then group discussion)

- Targeted services may neglect vulnerable populations or areas without a high incidence of HIV
- Possibly better coordination among federal bureaus
- Redistribution of funds with NHAS, healthcare reform lacks public health objectives
- Healthcare reform categorizes HIV care as specialized services, ID clinics will need to redefine or will be limited in their scope.
- Introduces gatekeeper component to accessing ongoing specialty care, presents a problem for those living with chronic illness.

Goals/Objectives

- Make recommendations to the State to drive the benefits of the legislation while minimizing the dangers. Possible smaller goal of monitoring smaller concerns.
- Monitoring and giving recommendations on Medicaid Expansion
- Highlighting the essential services for PLWHA and ensuring that those are provided.
- Recognizing that some people are benefitting more than others with these services (ex: Medicaid expansion), and we need to step up and work with communities to create buy-in.

Commonalities or "truths" that exist for both Prevention and Care

(Including barriers that exist for underrepresented populations, Carol)

1. HIV/AIDS has a disproportionate impact on communities of color

2. HIV/AIDS continues to have stigma associated with it, which presents barriers to both enrollment and care. Enrollment in care requires multiple disclosures tied directly to identifying information.
 3. Geography presents challenges to rural Coloradans for accessing testing or care.
 4. HIV/AIDS disproportionately impacts marginalized communities, including those living in poverty, people who are injection drug users, those in the criminal justice system, the transgender community, and the gay/bisexual men or men who have sex with men.
 5. Starting ART/HAART is complicated and requires multiple visits and discussions with a specialty provider, as well as ongoing follow-along. May not mesh well with the Medical Home Model, or it may be widely misunderstood.
 - a. Some populations are hard to reach, engage, and maintain in ART/HAART, and need additional support.
 6. HIV Prevention and testing should be targeted and responsive to the communities at highest risk, in addition to any broad based testing offered through routine primary care. For those who are at risk for HIV, there are specialized resources available and staff who are sensitive to the concepts of stigma and risk.
 7. Effective HIV/AIDS services require the coordination of multiple state agencies in Colorado (ie: HCPF, DORA, CDPHE, DOC, DCJ)
 8. There are great benefits to comprehensive community case management for PLWHA, and it is a necessary service.
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Meeting Date: 7/11/2012

Present: Bob Bongiovanni, Peter Ralin, Jesse Yedinak, Mikayla Branz
Phone: Martha Monroe, Jennifer Chase, Chris Grano, Ernie Duff

Supreme Court Ruling (see Kaiser Family Foundation summary)

- Huge impact on People Living with HIV/AIDS (PLWH).
- Role of Medicaid expansion is unclear because of the state opt-out
- Colorado is not yet at 10,000 person cap for enrolling adults w/o dependent children who are below 10% FPL. Full expansion may be costly, partial expansion may not be eligible
- Governor wants to see what is financially feasible for Colorado.
 - See Denver Business Journal article “Colorado weighs growth of Medicaid eligibility”.
 - Discussed the “woodwork effect”
- New law is more vulnerable under changing legislation
- May need more advocacy than was initially predicted with the state
- Medicaid expansion.
 - Public Health benefits of expanding Medicaid
 - Indigent care costs

State's Plan for Expanding Medicaid

- CO intends to continue as before
- Provider Fee pool helped to fund Medicaid, which is matched Federally.
- Expand Medicaid to 100% FPL, including adults w/o dependent children and the working disabled

There is a fear that the Provider Fee will not cover the full expansion, the 10% FPL and capping enrollment at 10,000 was a conservative means to save money on expansion. Currently 3,000 are enrolled; CICP is working as a disincentive because of co pays.

Moving forward from last meeting: Framing Goals & Adding Tasks

Goals came from the Commonalities or "Truths" that exist for Care & Prevention.

- These Goals are recommendations to CDPHE, not the general public.
- Several "Truths" were combined into larger, overarching goals or will be addressed through objectives within the larger goal.
- Goals will be rearranged hierarchically once all goals are agreed
- Upon

Objectives/Tasks include more detail and will help us break down the larger Goals, and will follow the framework that Bob established in the first meeting:

Enrollment → Benefits → Evaluation & Monitoring → System Capacity

Goal #1: To maximize the potential of Healthcare Reform to decrease the disproportionate impact of HIV on historically marginalized and disenfranchised populations. Populations of significance include people and communities of color, men who have sex with men, injection drug users, people living in poverty, transgender people, those who are currently or formerly incarcerated, and people living with mental health and substance abuse issues.

Goal #2: Address stigma that impedes enrolling in services, accessing high quality services, and following through on services.

(see Human Right's Campaign Health Equity Project and Training, Vancouver)

Goal #3: Eliminate geographic barriers in accessing prevention and care services

Goal #4: Ensuring Access to HIV Specialty Care within the Medical Home Model.

Goal #5: Coordinate the efforts of the relevant Executive Branch State agencies.

Goal #6: Coordinate the Health Care Reform testing benefit with other targeted public health benefits.

Meeting date: August 8, 2012

Attending: Peter Ralin, Martha Monroe, Jennifer Chase, Bob Bongiovanni

The meeting began by reviewing the goals that were drafted at the previous meeting. A slight revision was made to Goal 5, adding the phrase "and other relevant policy-setting bodies." This revision should allow for coordination with entities such as the Colorado Health Benefits Exchange, which technically are not part of the Executive branch of state government.

No additional goals were identified.

Objectives were then drafted for Goals 1, 2 and 3.

GOAL 1 OBJECTIVES

- A. The benefit should be marketed to each of the different historically marginalized and disenfranchised populations. Marketing materials should be understandable. Marketing should occur through community partners that have existing access to and credibility with these populations.
- B. CDPHE and its funded contractors should streamline the enrollment and eligibility determination processes as much as possible.
- C. Improve the proficiency of healthcare providers to take an adequate sexual, mental health, and substance use history and offer testing, immunization, other needed health services, and referrals for follow up care.
- D. Resources should be devoted to addressing the financial barriers that remain after implementation of healthcare reform, such as required copayments.

GOAL 2 OBJECTIVES

- A. Improve the proficiency of healthcare providers to take an adequate sexual, mental health, and substance use history and offer testing, immunization, other needed health services, and referrals for follow up care.
- B. Promote participation in the Human Rights Campaign Healthcare Equality Index.

Chris Grano will be asked to help draft other objectives under this goal.

GOAL 3 OBJECTIVES

- A. Start with an inventory of providers willing to accept new clients living with HIV or AIDS, including HIV positive clients with Medicaid coverage, by each region. This inventory should include the comfort level of providers serving PLWH/A and what would help providers feel more comfortable serving PLWH/A (such as collaboration with an HIV specialist).
- B. Understand the limitations of distance and stigma in the enrollment and eligibility determination processes. For example, it may be an extra burden for a rural client who is asked to obtain corroborating evaluations from multiple physicians.
- C. Strategies should be implemented to address limited transportation options, such as the expansion of telemedicine.