INTEGRATION OF CARE COMMITTEE

NYU McSilver Institute
41 E. 11th Street
July 20, 2016, 9:45-11:40am

M I N U T E S

Members Present: Christopher Joseph (Co-Chair) , Lisa Zullig (Co-Chair), Christopher Cunningham, Michael Ealy, Dorothy Farley, Deborah Greene, Graham Harriman, Zach Hennessey, Jan Carl Park, John Schoepp, Claire Simon, Brenda Starks-Ross (by phone)

Members Absent: Peter Campanelli, PsyD, Joan Edwards, Janet Goldberg, Terry Hamilton, Peter Laqueur, Gina Quattrochi, David Price, Bobby Rallakis

Other Council Members Present: Randall Bruce, Billy Fields

Staff Present: David Klotz, Amber Casey, Nasra Aidarus (NYC DOHMH); Bettina Carroll (Public Health Solutions); Julie Lehane, PhD (WCDOH)

Guests Present (by phone): Sera Morgan, Susan Robilotto (HRSA)

Agenda Item #1: Welcome/Introductions/Moment of Silence/Minutes

Mr. Joseph and *Ms. Zullig* opened the meeting followed by introductions and a moment of silence. As copies of the minutes were not available, the minutes from the meeting on July 13th were reviewed but not accepted.

Agenda Item #2: HIV/Hepatitis C Co-infection

Mr. Park gave a brief overview of the discussion to date over the previous two meetings, noting the small number of Ryan White ADAP-only clients who might benefit from a local pharmaceutical assistance program (LPAP).

Ms. Morgan and *Dr. Robilotto* joined by conference call and described their roles as, respectively, project officer for the EMA and clinical consultant at HRSA. Dr. Robilotto explained that patient assistance programs (PAPs) check for other payers first, but do not exclude undocumented immigrants. She does not know of any jurisdiction that has set up an LPAP specifically to pay for hepatitis C medications, but it is allowable. LPAPs are for when a state

ADAP program is not covering medications or has a lower eligibility (e.g., only 150% over federal poverty level) than the locality desires. *Mr. Park* pointed out the example of the Washington, DC EMA, which covers parts of Virginia, a state that has a restrictive ADAP formulary and eligibility. Also, the Houston EMA covers DAAs, but has relatively low utilization. *Dr. Robilotto*, in response to questions from IOC members made the following additional points:

- Some jurisdictions have used LPAPs inappropriately in place of emergency financial assistance.
- Other LPAPs have outlived their usefulness as ADAPs have expanded their formulary or eligibility.
- Houston's issue is particular to the fact that adding drugs to the ADAP formulary requires an act of the state legislature, which means severe delays and obstacles in adding even ARVs. .
- ADAPs should be enrolling people quickly. An LPAP is not for when an ADAP lags in enrollment time.
- Implementing an LPAP involves a lot of up front work and expense, as well as maintenance, including the advisory board, prescriptions processing, drug distribution system, payer of last resort determination, have uniform benefits, an accounting system, etc. If the State ADAP is likely to add DAAs to their formulary in the near future, then it might be better to use Part A resources to assist people through patient education, training of providers to help with PAP enrollment and appeals, etc.
- ADAPs that have DAAs on their formularies have not seen the uptake that had been expected.
- Emergency financial assistance can be used for a one-time, short-term distribution of medication, not for a long-term treatment. It is usually used for ARVs or OI medication, e.g., for one-time gap-filling needs, such as when a patient loses their month's medication.
- All Ryan White providers should be well versed in hepatitis C treatment, as per HRSA guidelines.
- There is a public health benefit to curing people of their HCV infection. The question is how does the system accomplish that and is an LPAP a proper solution, or can other measures be taken (PAP assistance, provider education, etc.).

The committee chairs thanked Dr. Robilotto and Ms. Morgan, who signed off from the phone. The following is a summary of the ensuing discussion:

- IOC should take a broader view to meet the needs of Ryan White-eligible co-infected people. An LPAP is only one way to increase access to medication, along with helping with PAP enrollment, and the insurance appeals process.
- Surveillance data shows that the main barriers to treatment are earlier in the care continuum. 31% of co-infected ADAP clients have been cured, compared to 40% of people with public insurance, which shows that many ADAP clients are able to obtain DAAs.
- DAAs have been on the market for about 2 years and they still are not on the ADAP formulary because the State says they are too expensive. While they are negotiating with

the drug companies, there are alternatives to the most expensive medications. Also, an LPAP would help with even more expensive drugs that will come on the market.

- Data shows that PAPs work, but that they require some effort to get people access to them.
- The upfront issues in the care continuum, including genotype testing, need to be addressed.
- NYC DOHMH's HCV program, as well as the HIV Bureau's Training and Technical Assistance Program have already started doing training of providers, including creating peer learning networks at medical facilities ("hep C champions"). This approach also addresses all populations, including Medicaid-eligible ones, not just ADAP clients.
- Training is a low cost investment that can have a big impact. Clinical staff especially needs training.
- There is no data that ADAP clients are being rejected by PAPs.
- Mt. Sinai has been successful with provider training in getting even active drug users enrolled in PAPs.
- Tri-County has hep C programs that face the same issues as those in NYC. Westchester County Medical Center is having success getting people enrolled in PAPs.
- Some potential patients do not seek treatment because people are afraid of side effects due to their knowledge of or experience with the old interferon-based treatments, which were debilitating and often not effective.
- The Council needs to keep pressure on the State to add DAAs to the formulary. Community activists are already starting to take action on this front.
- The EMA can consider a model similar to the recent RFP for buprenorphine education is clinical settings and fund new personnel to assist in provider training.

A motion was made and seconded to support the Needs Assessment Committee's recommendation to create an LPAP. The motion was defeated unanimously.

A motion was made and seconded to require the Grantee to prepare a comprehensive plan to address HCV medication access by the next IOC meeting, scheduled for October. The motion was approved unanimously.

A motion was made, seconded and approved unanimously to have the Council send a letter to the State ADAP director asking that DAAs be added to the ADAP formulary and asking for a response detailing their plans.

Agenda Item #3: Public Comment

M. Brown: I am disappointed that the Committee did not recommend an LPAP, particularly to help the undocumented.

Mr. Joseph noted that undocumented people can access PAPs and that there is no evidence that they are being rejected due to their immigration status.

There being no further business, the meeting was adjourned.