PA Department of Health

Special Pharmaceutical Benefits Program Advisory Council Meeting

Thursday, April 24, 2025

Location: Virtual

Time:	Topic/Discussion:	Actions:
10:01 AM – 10:03 AM	**Welcome/Introduction:** -The group was welcomed and meeting logistics were reviewed.	Led by John Haines
10:03 AM	**Member Roll Call:** **SPBP Advisory Council Members on the call** John Haines Margaret Hoffman-Terry Angela Kapalko David Koren Deborah McMahon Anna Thomas-Ferraioli Mimi McNichol Michael Witmer Cindy Magrini Rob Pompa Art Williams **DOH Staff** Jill Garland Kendra Parry Kyle Fait Jacqueline Brenner Monisola Malomo Michelle Schlegelmilch Moira Foster Erik McDowell Sara Reyes Hilary Wicks **Pitt Staff** Kristen Growden Teagen Laine O'Malley **Guests** Odessa Summers Mike Hellman Rey (No last name) Sharon Whitebread Abigail Schreder	Led by Kyle Fait

	Kristen Burkheart Kelly Clark Jen Glass Jon Martin Anna Barone JP Burkhart Kristen Felix Kristen Cherwinski Patrick Nosko Melissa Poulsen Abigail Schreder Tasheera Greggs Anthony Ergen Christy Owens Carla J Reynolds Erica Freedman Lisa Spacek Ton (No last name) Emma Seagle Gina Simoncini Melissa Poulsen Susan Randolph Casey Johnson Michael Latady	
10:04 AM	**<u>Announcements/Updates:</u>** -Future Virtual SPBPs: Jul 31, 2025, 10AM-12PM & Oct 23, 10AM-12PM. -No staffing updates -SPBP website's drug formulary was updated April 1, and the pharmacy network list was updated Feb 1. -Completed 340B federal recertification and the 340B drug pricing program in February. They will continue as planned for next year. -Current budget/funding climate is a concern for the program. John would like to brainstorm with participants any cost saving measures to be implemented if needed. -The federal government is operating under a continuing resolution. This means SPBP has received a partial Ryan White grant award, and the remaining amount will be awarded later in the year. PA currently has a temporary hiring freeze in place as a result of the funding uncertainties. SPBP applied for an ADAP supplemental grant award. The grant has not been awarded or calculated yet, so funding remains unknown. They hope to receive a few million dollars. -John is concerned about the number of clients on SPBP and the increasing expenditures. Two years ago, drug expenditures were $70 million. This past year it was $130 million. The number of clients actively enrolled is at an all-time high at over 8,000.	Led by John Haines

	-A participant said Medicaid eligibility may be pulled from individuals which would increase the number of people who use SPBP. They suggested lobbying to keep PLWH eligible for Medicaid. They wondered if there would be cost savings by helping PLWH enroll in private insurance. There may be other options to explore through 340B. -John said the SPBP numbers began to increase when people were disenrolled from Medicaid after Covid emergency funding expired. The total number of clients increased from 5,500 to 8,000 today. Most of the cost of new individuals is uninsured people. There has been a big influx from Medicaid to SPBP and SPBP has already incurred the costs of the Medicaid cuts. There are ongoing discussions about how to enroll PLWH in commercial insurance and/or how to implement the process. PA has contracting rules that complicate the process. SPBP is not yet ready to bring on a vendor to determine who is uninsured; enroll them in a plan; pay insurance premiums; make sure they reenroll in SPBP; ensure pharmacies are billing insurance first with SPBP; picking up the copays; and collecting data overall. Additionally, there are problems with 340B pharmacies, incorrectly billing 340B purchased drugs to SPBP. There cannot be duplicate discounts under federal law. It is important to not increase these problems even further with more PLWH going on SPBP. -A participant suggested looking at the costs of medications. Other states only cover HIV medications. SPBP could determine which classes of non-HIV medications cost most. It may be possible to find other programs to cover the cost of these medications. -John said that 94-95% of the cost are HIV treatment drugs. This means approximately $10 million is spent on non-HIV medications; $120 million is for HIV drugs. There are a few drugs/categories that have increased in cost. Lenvima is a cancer medication that costs $300,000 per treatment. Weight loss or diabetes drugs now account for more of the budget than before as well. Biktarvy is the most used HIV medication and the most expensive in the budget. Biktarvy makes up over half of the total budget. The bulk of the costs from the budget are from HIV drugs. If cuts to the budget are made, the number of people eligible for SPBP may need to be reduced. -A participant indicated PLWH are losing their jobs and choosing to leave PA/USA. Those with Visa status concerns may also be leaving. These clients are filling as many prescriptions as they can for 90-day supplies before leaving. There may be more prescriptions filled due to this reason. They wondered if SPBP could track who is filling scripts, and who is not. People choosing to leave may have an impact on the numbers, alleviating the need to make cuts. -John said claims data is available to see what is being filled and by whom. It would be difficult to tell from 90-day supply scripts if anyone is planning on leaving. Changes to refills have the potential for cost savings. -A chat question asked if there has been a cost analysis completed for copays and if setting a top-tier for Medicaid patients could be considered. -John said they have had the funds to pay for medications, so they have always had zero-dollar copays. They have looked at implementing a copay structure to save money. Copays can influence the use of	

	medications from one class to another. People would use cheaper medications instead of the newer more expensive medications. -Another chat question asked, if marketplace subsidies are discontinued, is there an anticipated cost impact? -John answered, if individuals drop insurance and more are not accessing other insurance, then the program will be paying for more full cost people. PLWH would still be able to buy insurance through the marketplace, but they will not have subsidies to lower costs. -A participant asked John to review 340B and SPBP. Some pharmacies can buy medications through 340B programs which lower the cost for the covered entity and they then submit claims to SPBP. SPBP cannot collect rebates for 340B claims because that would be duplicate discounting. But SPBP is required by the federal government to pay at or better than a 340B price This means that SPBP reimburses at a lower amount if a 340B pharmacy buys at that price. Those with commercial insurance may buy at the 340B price, but bill insurance at full cost and receive a net income, but SPBP is not eligible on those claims to collect a rebate. 340B medications need identified so they can be excluded; this reduces the number of rebates SPBP receives. When 340B is used for an SPBP client, they are unable to collect the rebates. Some pharmacies will not comply with billing, so SPBP needs to identify the 340B purchased products. SPBP needs to ensure that it is billed correctly, and a rebate is not collected for these items. -Another chat question was how many clients use SPBP for their only coverage as opposed to medical copays and Medicare deductibles under part D? -John said under $20 million is paid in copays for those with other insurance. The other $110 million is used for those without insurance. It is a high cost for those without insurance. -A participant wanted to know how feasible it is to negotiate better prices and if there have been any changes to 340B program at the federal level. -John was not aware of any specific changes concerning 340B. There have been ongoing discussions for a few years about potential changes to 340B, but it is only speculation at this point. SPBP is an ADAP which is how SPBP is eligible for 340B. As a small part of the 340B program, they may be safe from cuts. Typically cuts come from larger hospital setting programs. Also, SPBP already negotiates supplemental rebate prices through the ADAP Crisis Task force. There is a meeting scheduled this summer with Gilead and Merck to negotiate for the next several years of ADAP supplemental rebates. They recently negotiated with ViiV and Johnson and Johnson. In general, branded medications are all priced similarly. SPBP is getting reduced prices for HIV medications, but it is a significant upfront cost. And again, if they are purchased through 340B at the pharmacy level, SPBP cannot receive 340B rebates on these claims. In some cases, they can still get the ADAP supplemental rebate. -As a follow up question, the participant asked if SPBP could create a 340B pharmacy. If Medicaid is cut, the program is not sustainable. -John said it has been brought up as possibility over the years, but it would be a complete change in how the program is run. There are many	

	components that would need to be added, and with the state's hiring freeze, it cannot be implemented. Additionally, there are risks of lawsuits when making changes to the program reimbursement structure for 340B providers. -From April 1, 24 through March 31, 25, $9 million of the costs are related to those on Medicaid without drug coverage, $7.5 million for those on Medicare, and $91.5 million for individuals with no insurance. -A participant stated that there have been proposed tariffs on medications. They asked if there would be a SPBP meeting if important changes happen. They would rather see cuts to the covered medications before cutting people from the program. Additionally, if possible, could the cuts be made on the formulary without cutting HIV meds. -John also does not know what will happen if tariffs are implemented. Generic medications are commonly made in other countries. He would like to have input from the SPBP before making crucial decisions, but if a decision needs to be made quickly, they may have to make it without feedback from the group. There would be only small savings by cutting non-HIV medications. If major cuts need to occur, then they will need to do more. They could add copays or reduce medications from 90-day supplies to 30-day. They may still need to reduce the number of people on SPBP even with these cuts. He does not want to make any of these changes/cuts, but it is important to be prepared for all contingencies. -A participant asked if SPBP could utilize a ranking system like Ryan White Part A. Part A uses a priority resource ranking system to outline where cuts are to be made. The cuts would come from one area, then if there are additional cuts, they come from another area and so forth. This guideline would help prepare should cuts need to be made. -John felt it was a good idea and would want to get a list from the group about what aspects of the program would be easier to implement and those that are only cut as a last resort. It may be possible to create a document with proposed cuts and ask group members to rate the priority levels. John suggested that Kyle or Kendra create a survey to collect information from SPBP members. He could also add examples, ask members to add their thoughts, and to complete a ranking system as well. This concept will require more discussions to implement, but it is a good idea. -A participant commented that a sliding scale copay charge may be a good cost saving measure. -A participant asked if substituting brand name medications for generics could be implemented to save money. -John affirmed that swapping brand names to generics would help costs, but for many of the HIV generics available it would not be best for client when side effect and treatment efficacy profiles are considered. Covering generics only for non-HIV medications could occur first. It would be a last resort to make changes to HIV medications. -One member asked if it was possible to use mail order services to reduce costs. -John answered that mail order services are less expensive because they are owned by the insurer/payer. They are able to lower the costs because they are the same company. Since SPBP does not have its own mail order service, this would not be a cost-saving option. A 90-day	

	supply medication would be reimbursed at the same rate for a brick-and-mortar pharmacy as a mail order service. -A participant said some agencies prescribe combination medications instead of using one tablet of the newer medication. -John said there is little to no benefit to the program for using two medications instead of one. Although the HIV medicines are newer with higher costs, we would want to continue them. It is important to look at other options before changing HIV medications.	
10:56 AM	**<u>Approval of Minutes:</u>** -There were no proposed changes to the minutes.	John Haines approved the January minutes
10:57 AM - 11:23 AM	**<u>Medication Adherence Update:</u>** -Whole Health Rx ADAP Clinical Support: -Outreach summary for Quarter 1(Jan 1, 25-March 31, 25): There were 73 provider consults. There has been a focus on collaborating with case managers and pharmacists to provide education and outreach for those who would be ideal candidates for medical management services. Streamlining follow-up has helped the process -Some adherence barriers include: statin side effects, low health literacy, language barriers, and ADAP insurance lapses. Coordination was needed to ensure patients had medications during these lapses in coverage. -The selected algorithms for Quarters 1 & 2: Adherence: HIV ART, SUPD gap in care, Statin, and Oral Antidiabetic. Medication Management for Quarter 1: 119 clients were identified for Medication Management, with 64 completing consultations. These individuals were identified during outreach efforts. -There was an increase in the number of providers and clients identified and engaged for med management consults. The case completion rate of 54% is similar to other quarters even though there was an increase in numbers this quarter. This population is difficult to reach and engage. -They started their SUPD outreach and had good results. The education provided for SUPD information and adherence support services based on pain points identified during the discussions. There have been treatment of comorbid diseases and adherence barriers. Clients provided feedback about ART misinformation around 90-day supplies not being covered or long wait times for refill coordination. Clients are engaged in the process and can be referred for additional services as needed. -Provider feedback: Overall it has been viewed positively, especially with regards to reengaging previously lost clients and education. Overall, they are seeing increased adherence rates and lowered viral loads from clients. There have been increased requests for medication management for those at increased risk. Additionally, they coordinate the care of patients and fill prescriptions before they transition to other providers. -SUPD being proactive helps clients. They review information prior to patient appointments. They have had good results with larger practices. -Viral Load Pre/Post intervention Data (Jan 2023 - Jan 2025): 125 members were engaged; 107 with a viral load both pre and post	Presented by Kristen Cherwinski

	intervention. Only 69% were undetectable pre intervention, but 85% were undetectable post. 33 had detectible viremia in the pre-period, 63% became undetectable post intervention. 11% of those engaged had an increase in viral load post intervention. 29% of individuals experienced no change and 97% were undetectable both pre and post intervention. This shows the importance of identifying and intervening with individuals before they experience problems. This data will be run biannually in addition to outcomes data. The next report will be run in August. -Program Updates and Next Steps: Continue outreach for the adherence algorithms, new offices, and established contacts; rerun algorithm report in June for additional information; and run viral load report biannually. The outcomes report for Quarter 1 & 2 interventions will be presented May 1, at the next SPBP meeting to show the interventions at that time. Monthly updates will be sent to John with a clinical update presented in August. -Kristen reviewed a case showing the success of interventions. -A member of SPBP and a recipient of services said that in past they have only been able to get 26–28-day medications covered through SPBP. Their health insurance will state they are eligible for 90-day supply medications, but SPBP will not fill it. -John answered that if it is once-per-day medication, then SPBP will cover a 90-day supply, but if the medication is required two or more times per day, then the amount allowed is lowered. However, even if the medication is taken up to 4 times per day, SPBP will cover a 34-day supply. Typically, it is a restriction from the primary insurance, not SPBP. Pharmacies assume that the problem is through SPBP, but it is commonly an issue with the primary insurance. -Kristen added that some individuals are getting 30-day supplies because they are signed up for a refill program. -A participant wondered if there is anything that can be done when a client uses a mail order service that initially will not bill through secondary insurance like SPBP. Exemptions can be made, but it takes patients a long time to rectify the situation. -John said that mail order pharmacies that are associated with large employers and self-insured plans often will have these restrictions. Typically, copay cards are billed as though they were secondary insurance, so that would not be an option either.	
11:23 AM - 11:28 AM	**<u>Fiscal Update:</u>** -2024: There was a $3.5 million carry-over from last year. With all funding sources this totaled $128.5 million. Expenditures for 2024 were much higher than typical. In 2023, drug claims were $83 million. 2024 exceeded that at $117 million. There is still a $14.5 million invoice for one month that is pending. Average costs are up to about $3 million per week. The other costs associated with SPBP are approximately the same; drug claims are responsible for the jump in costs. Total expenditures for 2024 exceeded funding, but rebates from 2023, Medicare claims, and regional expenditures, are covering the costs even though there was the funding deficit.	Presented by Erik McDowell

	-2025: The Ryan White Fiscal Year began April 1. Billing is still processing 2024 expenditures. There was a partial SPBP grant award for 2025. HRSA has awarded partial grants in the past. The amount is less than half the grant funding for the year. There are additional funds from ADAP that will help pay for SPBP. There are $20 million in rebates so far this year. Third party liabilities are $350,000. The grants and rebates will increase throughout the year but the grant is expected to total approximately $37 million. There is an anticipated increase in rebates, as there is a lag between when SPBP pays for the medications and when the rebates are received. An increase in rebates will be used to counter the rising costs.	
11:28 AM – 11:39 AM	**<u>SPBP Data Update:</u>** -Total Number of Clients: Data range: April 1, 24-March 31, 25. There were 10,184 active clients, which is an increase of 277 individuals from January's rolling year report. This is the first time it has crossed the 10,000-client threshold. The age range remained 0-93 with an average age of 51. -The total amount paid is over $133 million for claims. With an average yearly cost per person of $13,138 and an average of $778 per claim. However, there are people active in the program who did not have any claims. If these individuals are removed from the calculations, then the average cost per person is actually $15,173 per person per year. -Quarterly Drug and Cost Data: The top 20 drugs by paid amount are relatively the same. All of the top 20 drugs are either weight loss/diabetes medications or HIV drugs. -There were 53,788 drug claims for the first quarter. 16,314 were for the top 20 drugs while 37,474 were other medications. The total amount paid is $38 million with $36 million going towards the top 20 drugs. 94% of drug expenditures are from top 20 drugs. -Based on quarterly trends, costs continue to rise. -Changes in ARV Utilization between 2024 Quarter 4 and 2025 Quarter 1: Four new medications were seen in 2025, and one medication was not seen in 2025 from the 2024 report. There were 7,642 patients who filled a prescription for an ARV drug during Quarter 1. This accounted for $35 million. Last quarter there were only 4,000 patients with an ARV claim. The most filled medication is Biktarvy with over 3,000 patients utilizing it. -SPBP Customer Service Data: Customer service line agents identified the need for a directory source account. They are working with Prime Therapeutics for an email account for direct problem solving. There were 2,680 calls last quarter.	Presented by Jacqui Brenner
11:39 AM – 11:48 AM	**<u>Subcommittee Reports:</u>** **<u>Drug Formulary and Lab Services:</u>** -The drug formulary list was sent in February for review: -Additions: two analgesics, two androgenic agents, three antibiotics, one antifungal, seven antineoplastics, one anti Parkinson's, two antipsychotic agents, two Diabetic agents, two endocrine and metabolic agents, two Glucocorticoids, one hematopoietic agent, five immunomodulators/suppressants.	Presented by Margaret Hoffman-Terry. Margaret motioned to accept the three medications

	These classes of medications have typically been covered. -John suggested that the group wait to approve this list, adding them when the budget situation resolves. -Margaret suggested communicating that SPBP has stopped accepting new drugs, as it has been standard procedure to accept all drug classes that were accepted before. -John was concerned that antineoplastics are expensive and adding them will increase the budget. The medications would be paused for now, adding them into the formulary later. John felt the exception could be the antibiotic, Pivya. -Margaret said that diabetic drugs are increasing in use and would be important to add as well. John agreed that they could add the diabetic drugs but put a hold on the others. SPBP has an expansive formulary and some of the medications are updated formularies and older classes of the medications could still be used. -Exclusionary: Pavblu: Intravitreal injection. Intravitreal injections / Macular Degeneration drugs are not typically covered classes. Those used for Cytomegalovirus virus are the exception. -Marget Hoffman-Terry motioned to add two diabetes drugs (Zituvimet and Zituvimet XR) and an antibiotic (Pivya) Rob Pompa seconded. Council approved motion unanimously.	and exclusion as written. Rob Pompa seconded. Motion passed.
11:48 AM – 12:01 PM	**<u>SPBP Planning, Outreach Initiatives, Special Projects, and MAI Update:</u>** -MAI Quarter 3 Data Update: January 1 – March 31, 2025. 872 people received outreach services with 75 being enrolled in SPBP. -MAI Provider Spotlight: Action Wellness: Odessa Summers ActionAIDS was rebranded in 2016. Case managers work with those with chronic illnesses in addition to HIV. They serve over 2,000 clients and are one of the largest medical case management agencies in Philadelphia with five locations. -MAI funds 2 Care Outreach Specialists. Initially they received a list of SPBP clients and were asked to investigate why people did not recertify. They found that many individuals were on medical assistance. This started their work. They support PLWH in the justice system and PLWH who are pregnant and parenting. The case managers provide wrap-round services for those in the justice system. So far this year, they have 113 clients, and their primary population is black or African American men. -They do not enroll clients in SPBP, and they do not want people to have to use SPBP. They utilize Medicare, MAWD, and 340B services for clients. Additionally county jails have begun to activate Medicaid, but they still need to enroll some clients. They are partnered with the Department of Human Services. They are able to utilize Compass and activate paperwork quickly for clients. -The Care Outreach Specialists (COS) have been with the program for 5 years. They understand the program and the importance of obtaining	Presented by Kyle Fait, Odessa Summers, Action Wellness, Philadelphia Linkage Program Coordinator, and Teagan O'Malley University of Pittsburgh

	insurance for clients, so they do not have to enroll in backup programs. -Prison MCM is a specialization that requires case managers to understand housing and medication resources. -10 Year Spend Plan: The localized media campaign is ongoing. Kyle continues to receive updates from the regions. Due to the current budget climate, the Annual HIV conference is cancelled for this year. -Harm Reduction Vending Machine Update: MidEast PA Care and Advocacy Network (Formerly AIDSNET) is working with Valley Youth House in Bethlehem. They will stock the machine and collect data starting this week. All regions were offered vending machines. Other regions also have machines but had other funding streams to implement them. -University of Pittsburgh Special Projects: Tegan O'Malley HIV Related Intersectional Stigma Project: They are developing an asynchronous Intersectional Stigma Training. Module 1 will be ready to implement by the end of May. -Harm Reduction Pilot for PLWH: They are partnered with two HIV-related agencies: one in Altoona and one in Johnstown. The first of four coaching sessions took place on April 18 in Altoona. They reviewed their self-assessment on harm reduction. Sessons 2 and 3 will happen in May. -Partner Elicitation Services Project: They are reviewing national best practices of partner notification services. They are also obtaining feedback from stakeholders and community groups on barriers and partner notification. -Women and PrEP Project: They are finishing an evaluation of a three county social media project. They are evaluating the next steps to implement. -HIV Planning Group: The HPG Townhall scheduled for May is postponed due to the budget climate. The next HPG will take place virtual July 16-17.	
12:01 PM – 12:03 PM	**<u>Continuous Quality Improvement (CQI) Program Update:</u>** -There are 10 performance measures for the current CQI plan. -The 2024 QIP was MCM annual retention and service. Baseline data from 2023 showed a 76% average in PA. Of the 28 providers across the state, 12 fell between a 39-76% retention rate. The target condition is to improve from 76% to 80% statewide by December 2025. -The 2025 QIP will be examining the QIP occurring statewide, specifically concerning Community Engagement. There are 155 QIP ongoing throughout the state. Four of the regional grantees had QIPs concerning Community Engagement, with 11 projects total on this subject. Providers will attend the May CQI meeting to provide insights into their projects: Why was it selected? What are the barriers? How did they overcome those barriers? What have they learned?	Presented by Michelle Schlegelmilch
12:04 PM – 12:13PM	**<u>Final Questions//Dismissal:</u>** -A participant wanted to know if any SPBP members are eligible for Medicaid but were disenrolled and never reenrolled. In Indiana, they	Led by John Haines

	were going to remove clients from Ryan White programs due to budget issues. The case managers looked into member eligibility and found enough people were able to be moved into different programs (insurance and Medicaid) that they did not need to disenroll anyone. -John said this review process is occurring internally at this time. They are looking at people who seem to be eligible for Medicaid but are on SPBP. John asked case managers and anyone else who sees clients to check if their clients are eligible for Medicaid and get them enrolled. John said they have found some people did not complete paperwork or other steps after being disenrolled. -One participant said some clients are hesitant to go on Medicaid since they are already getting their needs met through SPBP. Additionally, they wanted to know what are the expectations for Part B and C providers for SPBP forms. -John asked that everyone assist clients to get into insurance and Medicaid if they are eligible. -There was a question about the handout/flyer provided to SPBP members. What are the expectations for Part B and C providers who have clients call about services. Clients may be eligible for services, but the agencies do not provide them. -Moira said the flyers are for Part B only. Clients should be contacting Part B agencies in the area and discussing services that are available. Part B agencies may have waitlists for services, but they can still contact clients and talk about getting on a waitlist or refer them out. There needs to be a process to refer clients to other agencies that can meet their needs. -Clients will be given contact information for Part B regional grantees in their area when they call the customer service line. The flyer was placed in the chat and it will be emailed after the meeting. -Moira also said the regional grantee can give general Part B information or specific contact information for providers depending on the needs of the client. -The next SPBP meeting will be held virtually Thursday, July 31 from 10AM - 12 PM.	