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TESTIMONY OF PATRICK BEATTY, ESQ.

On behalf of Equitas Health, and the Ohio AIDS Coalition, we thank the Joint Committee on Medicaid Oversight for the opportunity to offer testimony regarding the Ryan White Program - Part B, the state of HIV in Ohio today, and the epic opportunities we have for Ohio to end HIV transmission.

Equitas Health, formerly AIDS Resource Center Ohio, is one of the nation's premier providers of a comprehensive, holistic, and coordinated response to HIV, from prevention to diagnosis and treatment. The Ohio AIDS Coalition (OAC) is a division of Equitas Health. The Coalition provides education and advocacy, appearing as a voice for Ohioans with HIV and by way of full disclosure activities of staff at OAC are funded by the Ryan White Part B Program. My time today and my work on related projects is not paid for with funds from the Ryan White Part B Program.

My name is Patrick Beatty. I am the Chief Public Policy and Government Affairs Officer for Equitas Health, and I am Director of the Ohio AIDS Coalition. I took this job one and one half years ago. Prior to that I was the Deputy Director and Chief Policy Officer for Ohio's Medicaid agency, and before that I was counsel for the state Medicaid program. When I look at health policy, I like to consider the macro when evaluating the healthcare space for untapped opportunities. I will be speaking more globally to put Ryan White Part B into the context of larger moving pieces.

On my third day on the job with the Coalition, my team packed me into my jeep and sent me off to Cleveland to sit on a panel of speakers at a conference named "C2EA", which meant Campaign to End AIDS. At the end of that conference, the attendees issued a demand that someone develop a state plan to end HIV in Ohio. After asking around to various state agencies and organizations, I found no one was developing such a plan, and no one had any plan to develop a plan. So I did, and you have a copy of the end product. It is both a strategy and a call to an end of the isolation of people affected by HIV. Let's start with the basics.

- Each year in Ohio there are on average over 1,000 newly reported cases of HIV.
- More than 90 percent of those new HIV infections could be averted by ensuring people living with HIV receive prompt, ongoing care and treatment.
- A person with a viral load that is undetectable is 96 percent less likely to transmit the infection to someone else.
- Viral suppression through medication is the most effective tool to prevent new infections.
- After 2014 all Ohioans with HIV now have full access to healthcare coverage.

Since the start of the epidemic in the 1980s HIV has been siloed. Society treated HIV/AIDS separately, isolating those who had it. We established a separate healthcare program. The Ryan White CARE (Comprehensive AIDS Resources Emergency) Act was enacted by Congress in 1990 to provide a safety net for individuals living with HIV or AIDS because these persons had no access to medical care.

The advent of highly active antiretroviral therapies changed HIV/AIDS from being a fatal disease to being increasingly a chronic disease. But, it also had a different effect - muting the conversation about HIV and its impact on the lives of those who contract the virus. The silence perpetuated the stigma and society missed the fact that HIV and the tools to end its spread have changed radically.

The impact of the silence is not surprising. The age range with the highest rate of new infections is 15 to 29. Individuals under the age of thirty didn't experience the epidemic in the 80s and 90s as they weren't born yet or were small children. HIV has not been discussed in any real way in public schools, and society's silence has served to place the younger generation at the greatest risk. They are now the age group with the highest rate of new HIV infections, accounting for one in four. Ohio now has the tools to change this.

Historically, prevention of new infections focused on behaviorally-based models to reduce HIV transmission. Advances in treatment have shifted the public health strategy to one of "treatment as prevention". Today, with early diagnosis and retention in treatment, individuals with HIV can reach viral suppression, reducing or nearly eliminating the risk of transmitting the virus. That is a cornerstone of the Ohio AIDS Coalition strategy.

2014 was a watershed moment for Ohioans with HIV. For the first time in history HIV positive Ohioans can now be covered by some form of insurance with Essential Health Benefits (EHB). I knew that this new opportunity to access coordinated comprehensive integrated care meant greater opportunities to reduce new HIV infections. But I also knew that the separate system structures and the practical non-integration of HIV treatment and prevention in the new payer systems would present a giant hurdle.

The key to success lies in removing barriers, and eliminating isolation of HIV care from 21st century payer systems and operations. With the advent of Medicaid expansion, and enrollment opportunities through the federal marketplace, the Ryan White program All Parts experienced a significant decline in medical and pharmaceutical expenditures. Yet, the demand for case management services/health navigation increased. "Health navigation" is case management that encompasses solutions to the client's peripheral challenges beyond clinical or medical needs. Managed care does not provide health navigation that parallels the Ryan White program. To succeed, managed care plans will need to integrate with Ryan White systems and operations. Today, managed care systems do not have an operational or cooperative working arrangement with Ryan White agencies. The service delivery model for the whole of the individual needs to become a "shared customer model" with multiple systems that function as one. Our work group has begun the process of examining coordinating Ryan White and Managed care systems.

We recently commenced work with the HIV Integrated Plan steering committee which includes leadership from multiple state agencies, local agencies, managed care plans, and other stakeholders from across the state to initiate implementation of a statewide strategy for ending HIV transmission. We have commitment from leadership in public and private industry. And we are progressing to establishment of alignment of healthcare industry resources to achieve what we know is attainable, namely a significant reduction in the rate of new HIV cases. Part of that work has included identification of a list of what we are calling "quick hits", which are targets we are exploring in this calendar year. They include the following:

- Changing Financial Eligibility for Ryan White Part B.
- Expanding the OHDAP Formulary
- Legislative Initiatives:
    - Criminal Code - felonious assault
    - Alignment of HIV confidentiality to align with/incorporate HIPAA standards
    - Mandatory curriculum on HIV prevention in secondary education setting

    - Linkage with Office of Ohioans with Disabilities for Vocational Improvement Opportunities

- Supply Medicaid service utilization by Ryan White Clients to Ryan White Case Managers
- MCO viral load reporting framework for possible future MCO Pay for Performance
- Development of Workflow framework/concept to provide two way data exchange between DOM and ODH

In conclusion of my testimony I would like to make the following requests for action from the Committee.

Full funding for non-occupational PEP

Recently implemented rules by the Ohio Attorney General's Victims of Crime Division authorize reimbursement for a five day supply of medication for HIV post exposure prophylaxis, also known as PEP as part of a sexual assault examination. PEP means taking antiretroviral medicines (ART) after being potentially exposed to HIV to prevent becoming infected. PEP must be started within 72 hours after a recent possible exposure to HIV, but the sooner a person start PEP, the better. If PEP is prescribed the individual must take it daily for 28 days or they risk having the virus developing resistance to the drug. PEP is effective in preventing HIV when administered correctly. The limited resources of the Attorney General's Victims of Crime division prevented funding for the full 28 day supply. Additional funding should be provided to cover the remaining cost of the 28 day supply.

Funding for PrEP

Pre-exposure prophylaxis (or PrEP) is when people at very high risk for HIV take HIV medicines daily to lower their chances of getting infected. A combination of two HIV medicines (tenofovir and emtricitabine), sold under the name Truvada® (pronounced tru vá duh), is approved for daily use as PrEP to help prevent an HIV-negative person from getting HIV from a sexual or injection-drug-using partner who's positive. When taken as directed, PrEP is up to 94 percent effective in preventing HIV infection, even among those at highest risk.

The medication will lose its patent protection in 2017, opening up the market for a generic formulation. While this could be a benefit, the current pricing for the generic has not been set and could still be inaccessible to most. As is typical with most generic medications, patient assistance programs could also be reduced or eliminated, as the manufacturer loses much of the benefits of maintaining such a program after a generic formulation has been offered. It is essential that funds be set aside to buttress PrEP uptake in high-risk populations.

Legislation to establish a permanent standing Office of HIV strategy.

In writing our proposed state strategy, I realized that the challenges in addressing HIV do not reside in any one system. Horizontally and vertically, the issues span public and private sectors and beyond traditional health care systems. The HIV steering committee has made monumental strides in breaking down barriers between systems, and identifying ways to leverage resources to advance the cause of ending HIV transmission. Longer term, there needs to be a central voice of authority for both strategy and operations direction. With changes in administrations and various local organizational changes and turnover, loss of continuity and workgroup stability is a real danger to longer term success. We recommend establishing in law a standing Office of HIV Strategy.

Legislation prohibiting mandated mail order pharmacy for HIV medication

There has been a recent trend in Ohio with pharmacy benefit managers requiring enrollees to receive specialty medications via mail order, for example CVS Caremark, instead of brick and mortar pharmacies. The restrictions are being applied even if a brick and mortar pharmacy is in-network. Mandatory mail order is not always listed in a plan's covered benefits. Many HIV regimens are complicated—consisting of several medications with many drug interactions. People living with HIV rely heavily on their interactions with local pharmacists to monitor these interactions and provide advice on navigating their chronic condition. Requiring HIV medications to be mail ordered removes this partnership from an individual's treatment.