Improve HIV-related health outcomes of people living with HIV.

The Department of Health and Human Services published a National Strategic plan, a roadmap to End the Epidemic for the United States that outlines three goals of the program (US Department of Health & Human Services, 2021).

As part of the HIV modernization task force, we recommend that the State of Nevada legislature support the work that has been outlined in the 2022-2026 Nevada HIV integrated prevention and care plan as updated in June 2021 (Nevada office of HIV/AIDS, 2022) and posted online at https://endhivnevada.org/integrated-plan-2022-2026/#:~:text=The%202022%20%E2%80%93%202026%20Nevada%20HIV,(HRSA)%20in%20June%202021.

Nearly two-thirds of the U.S. population live in counties with no or inadequate ID physician coverage, disproportionately affecting already medically underserved populations (Infectious Diseases Society of America, 2022)

Multiple publications document the success of primary care management of HIV as part of primary care, reduction in access barriers, and increased retention in care versus specialty or Infectious disease requirements.

Weber et al. 2003:

- Switzerland: 1-year prospective cohort study recruiting 60 patients at general practices and 60 patients at a specialized university outpatient clinic, interviewed at baseline, months 6 and 12
    - GP 42% of the study population, had 72% viral load suppression
    - infectious disease 31%, and 74% viral load suppression
    - shared care 8%, and 88% viral load suppression

Landon et al. 2005:

- N = 5247 patients linked to 177 physicians (58% general medicine vs. 42% Infectious disease)
    - 63% of generalists (37% of overall physicians) considered themselves an expert
    - ID and expected generalists had similar performance
    - 20 pt experience

Page et al. 2019:

- N = 1960 practices, 4930 providers, 60496 Medicaid enrollees in 14 US States with the highest HIV prevalence (review of Medicaid claims from 2008-2012)
    - Each year pt saw the same provider: 6% increase in adherence (95% CI: 5.7-6.3)
    - GP had a 1.6% increase in adherence than seen by ID specialists along (95% CI 0.6-2.5, P<0.001)

Multiple publications have demonstrated the barriers to care based on prescription restrictions.

- Zamini-Hank 2016, reviewed a state's Medicaid coverage of HIV meds and found:

- The average monthly out-of-pocket cost per person ranged from $12 to $667 per medication.
- Three insurance carriers placed all 31 HIV medications on the highest cost-sharing tier, charging 50% coinsurance. (Phoenix & Huynh, 2022)
- High out-of-pocket costs and medication utilization restrictions discouraged PLWHA from enrolling in health plans and threatened interrupted medication adherence, drug resistance, and increased risk of viral transmission

Kates et al. 2021,

reviewed payer sources for PLWH & patient costs

For Medicare:

- Premiums and cost-sharing might be substantial for both services and prescription drugs
- no cap on out-of-pocket spending under Part A and Part B
- some subsidies and supplemental coverage are offered for low-income beneficiaries;
- when covered under Part D, it is subject to cost-sharing; manufacturer co-pay assistance programs cannot be applied to Part D cost-sharing;
- cost-sharing support is available from ADAPs, foundations, and other sources based on financial eligibility criteria

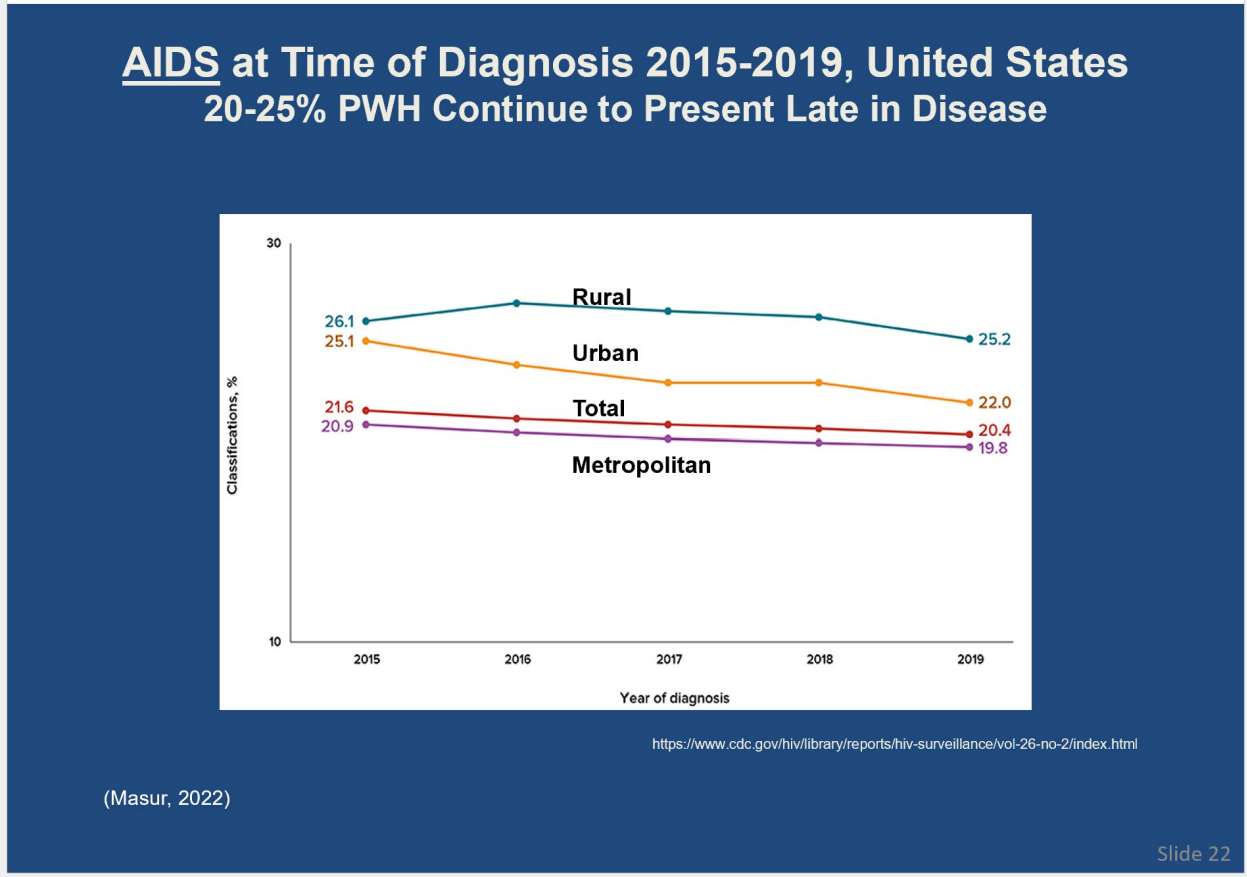
Wohl et al. 2017,

- medication cost or coverage led to a lapse in ARVs by 10%
- median duration of missed ARVs was two weeks
- 21% enrolled in ADAP reported lapse due to problems with ADAP or med cost

Data published by the CDC document that Black/African American and Hispanic/Latinos account for most new HIV infections. Black/African Americans represent 13% of the US population but account for 41% of new HIV infections. Hispanic/Latinos represent 18% of the US population but account for 28% of all new HIV infections (Phoenix & Huynh, 2022)

Figure 1, identifies that people residing in rural areas are more likely to present late in the diagnosis of HIV/AIDS. When clients present later in care the costs associated of care are higher, as are the complication rates and loss of life. According to the 2022 Nevada Statewide HIV needs assessment, 4.6% of respondents live outside Clark and Washoe Counties (Collaborative Research, 2022), yet there are no permanent providers of HIV care located outside of Clark, Washoe and or Carson City, requiring people living with HIV to travel long distances to care.

Figure 1



(Phoenix & Huynh, 2022)

Goal number 1 is to prevent new HIV infections.

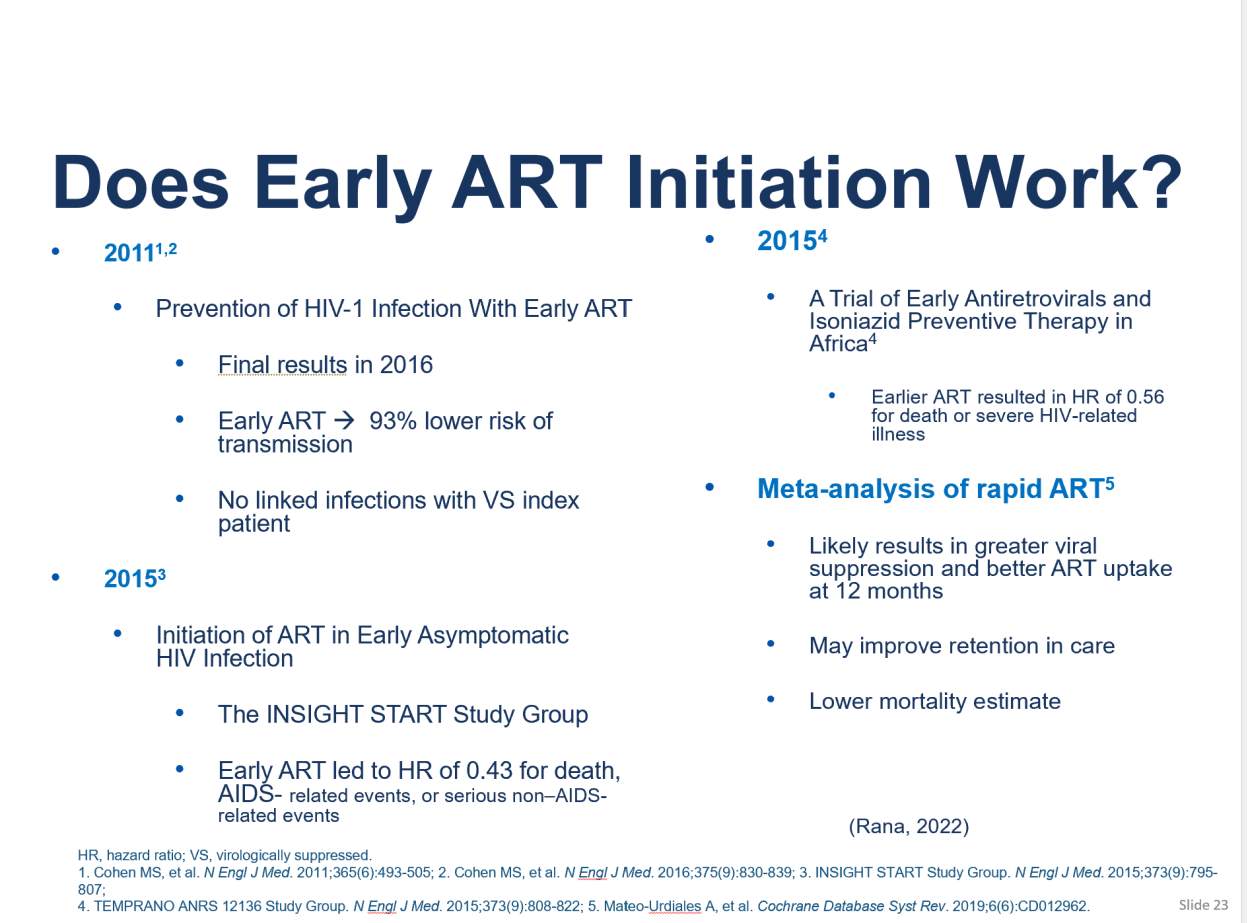
To reach that goal, we need to increase access to HIV prevention strategies such as Treatment as Prevention (TaSP), Undetectable equals Untransmittable (U=U), and biomedical HIV prevention medications. In addition, increasing HIV testing in the community will help raise awareness of HIV status. According to a 2021 report by the University of Nevada Ending the HIV Epidemic statewide assessment plan, one in four Nevadans are HIV unaware, compared to the national average of one in seven. Forty percent of people living in Nevada have never had an HIV test.

Recommendations.

1. Support implementation and adherence to Nevada SB211, testing for sexually transmitted diseases in primary care and non-life threatening situations within hospitals and emergency department settings passed in the 2021 legislative session
2. Support implementation and adherence to Nevada SB325, pharmacist-based HIV Pre-Exposure Prophylaxis, and HIV Post Exposure Prophylaxis, passed in 2021 legislative

3. Support improved access to HIV testing, including insurance coverage for HIV testing in settings required under SB211
4. Require all Nevada insurance carriers to cover all FDA-approved HIV prevention medications supported by local, state, or federal government agencies (CDC) and professional organizations such as the American Academy of HIV Medicine and Infectious Diseases Society of America.
5. Require all insurance carriers to cover all FDA-approved HIV medications used for the treatment of HIV as recommended by Department of Health and Human Services Guidelines, IDSA guidelines, or other nationally recognized professional organization without step edits, prior authorizations, specialty referral requirements, eliminate pharmacy benefit management program restrictions, stop copay accumulator policies by PBMs that create financial hardships for persons living with HIV
6. Require all insurance carriers to cover all FDA-approved HIV biomedical prevention medications used for the treatment of HIV as recommended by Department of Health and Human Services Guidelines, IDSA guidelines, or other nationally recognized professional organization without step edits, prior authorizations, specialty referral requirements, eliminate pharmacy benefit management program restrictions, stop copay accumulator policies by PBMs that create financial hardships for persons at risk of HIV acquisition.
7. Require all insurance providers to cover all FDA approved Hepatitis C medications used for the treatment of Hepatitis C as recommended by Department of Health and Human Services Guidelines, IDSA guidelines, American Association for the study of liver disease, or other nationally recognized professional organizations without step edits, prior authorizations, specialty referral requirements, eliminate pharmacy benefit management program restrictions, eliminate copay accumulator policies by PBMs that create financial hardships for persons living with Hepatitis C
8. Require insurance carriers to provide unrestricted coverage of condoms for adolescents and adults
9. Require the State of Nevada to develop a program for the free distribution of condoms to adolescents and adults at local retail pharmacies, health provider offices, and other appropriate venues.
10. Require the State of Nevada to develop a program to support full access to all harm reduction services and support the harm reduction services currently being offered in our communities. This should include services supported by the CDC syringe services programs, which the CDC recognizes as an evidence-based intervention for HIV prevention and other communicable diseases of concern.
11. Expand and improve implementation of effective prevention interventions, including treatment as prevention, PrEP, PEP, and Syringe Service Programs (SSPs), and develop new options. For example, they require retail pharmacies to provide access to clean needles and syringes without a prescription for any injectable medication.
12. Increase the capacity of healthcare delivery systems, public health, and the health workforce to prevent and diagnose HIV
13. Insurance is required to cover testing, treatment, and prevention for all sexually transmitted infections such as chlamydia, gonorrhea, syphilis, HIV, and hepatitis as preventative health services for adolescents and adults.

14. Adoption of a status-neutral approach to HIV services—in which HIV testing serves as an entry point to services regardless of the positive or negative result—can improve testing as well as prevention and care outcomes. In this approach, people diagnosed with HIV are linked to care and treatment services as quickly as possible to achieve and maintain viral suppression, which both protects their health and prevents transmission
15. Develop and provide a funding mechanism for a statewide HIV advisory board consisting of people living with HIV, whose mission is to advise the State of Nevada Legislature on strategies to help End the HIV epidemic in Nevada. Members of the HIV advisory board would be provided a stipend for participating in meetings.
16. The Nevada Department of Corrections and all City and County Correctional agencies provide access to HIV prevention strategies, such as condoms and HIV biomedical prevention medications, upon request from those in custody.
17. Recommend comprehensive, medically accurate, and inclusive sex education programs for school-age children alining with other sections of this report
18. Prohibit insurance companies from developing policies that restrict same-day access to HIV care, and medication
19. Prohibit insurance companies from developing policies that require Infectious Disease Specialists to manage the care of people living with HIV or to prescribe HIV specialty medications.



(Phoenix & Huynh, 2022)

Goal 2. Improve HIV-related Health Outcomes of People with HIV

Recommendations:

1. Link people to care immediately after diagnosis and provide low-barrier access to HIV treatment.
    a. Programs focusing on the immediate (ideally same day or within seven days after diagnosis) initiation of ART have demonstrated success, are expanding in communities across the nation, and are a central tenet of ending the HIV epidemic in Nevada. All insurance providers should have policies and processes in place to remove barriers to same-day access to HIV care as well as the same-day start of medications.
    b. The Nevada Department of Corrections and all City and County Correctional agencies only contract with agencies or providers that have a proven track record of rapid start programs, with at least 95% of the newly diagnosed patients being offered treatment at the time of diagnosis and starting treatment the same day but no more than seven days of diagnosis.
    c. The Nevada Department of Corrections and all City and County Correctional agencies must provide access to medication for the treatment of HIV in the manner recommended by the prescribing healthcare provider, for example, single tablet formulations and injectable medications.
    d. Prohibit insurance companies from developing policies that restrict same-day access to HIV care, and medication
    e. Prohibit insurance companies from developing policies that require Infectious Disease Specialists to manage the care of people living with HIV or to prescribe HIV specialty medications.

2. Identify, engage, or reengage people with HIV who are not in care or not virally suppressed
    a. Remove insurance restrictions around HIV and Hepatitis C medications
    b. Remove insurance restrictions around HIV specialist treatment requirements, allowing primary care providers to treat HIV and Hepatitis C

3. Increase retention in care and adherence to HIV treatment to achieve and maintain long-term viral suppression
    a. Remove insurance restrictions around HIV and Hepatitis C medications
    b. Remove insurance restrictions around HIV specialist treatment requirements, allowing primary care providers to treat HIV and Hepatitis C
    c. Remove restrictions around 90-day supplies and mail order pharmacies of HIV and Hepatitis C medications

4. Remove step edits, prior authorization requirements, formulary restrictions, and copay accumulator programs for all FDA-approved HIV, Hepatitis C, medication-assisted therapies such as Suboxone, Methadone, Naltrexone, and FDA-approved medications used to support safe withdrawal such as lofexidine.

5. Increase the capacity of healthcare delivery systems, public health, and the health workforce to serve people with HIV.
    a. Develop policies to include more diverse community input in program development—engagement of people living with HIV, Hepatitis C, and Substance Use Disorder.
    b. Prevent insurance carriers from implementing restrictions on primary care treating HIV, Hepatitis C, and Substance use patients, for example, removing requirements for specialist referral or maintenance such as Infectious Disease providers, Gastroenterologists, or Addiction Specialists. Instead, primary care providers should be free to treat patients within their scope of practice and training and utilize specialists as needed for consultation.

Goal 3: Reduce HIV-Related disparities and health inequities

1. Reduce HIV-related stigma and discrimination.
    a. Remove HIV-specific criminal laws as they perpetuate HIV-related discrimination and stigma
    b. Strengthen enforcement of civil rights laws (including language access services and disability rights), reform state HIV criminalization laws, and assist states in protecting people with HIV from violence, retaliation, and discrimination associated with HIV status, homophobia, transphobia, xenophobia, racism, and sexism

2. Reduce disparities in new HIV infections, in knowledge status, and along the HIV care continuum
    a. Develop grassroots-based interventions to address the social determinants of health, such as substance use, homelessness, race and ethnicity stigma/discrimination, gender and sexual orientation stigma/discrimination, and socioeconomic barriers
    b. Ensure that healthcare professionals and front-line staff complete education and training on stigma, discrimination, and unrecognized bias toward populations with or at risk for HIV by requiring 2 hours of the educational content needed for license renewal by all professional boards to include content around HIV each license renewal period.
    c. Recommend comprehensive, medically accurate, and inclusive sex education programs for school-age children alining with other sections of this report.
3. Engage, employ, and provide public leadership opportunities at all levels for people with or at risk of HIV
    a. Support communities in efforts to address misconceptions and reduce HIV-related stigma and other stigmas that negatively affect HIV outcomes
    b. Work with communities to reframe HIV services and HIV-related messaging so they do not stigmatize people or behaviors
    c. Develop and support programs for the training of HIV peer advocates, including adolescents and young adults

4. Address social determinants of health and co-occurring conditions that exacerbate HIV-related disparities.
    a. Develop whole-person systems of care that address co-occurring conditions for people with or at risk for HIV

b. Adopt policies that reduce cost, payment, and coverage barriers to improve the delivery and receipt of services for people with or at risk for HIV.
c. Improve screening and linkage to services for people with or at risk for HIV who are diagnosed with and are receiving benefits for co-occurring conditions
d. Develop and implement effective, evidence-based, or evidence-informed interventions that address social and structural determinants of health among people with or at risk for HIV, including lack of continuous health care coverage, HIV-related stigma and discrimination in public health and health care systems, medical mistrust, inadequate housing and transportation, food insecurity, unemployment, low health literacy, and involvement with the justice system.
e. Develop new and scale up effective, evidence-based or evidence-informed interventions to improve health outcomes and quality of life for people across the lifespan, including youth and people over age 50 with or at risk for HIV, and long-term survivors
f. Develop new and scale-up effective, evidence-based or evidence-informed interventions that address intersecting factors of HIV, trauma, violence, and gender, especially among cis- and transgender women and gay and bisexual men
g. Require agencies providing services to individuals living with HIV or at risk for HIV to develop policies that provide uninterrupted care in a public health emergency, such as the online provision of services, smartphone/device-based applications, and telephone numbers not having restricted/blocked caller IDs.

Goal 4: Achieve integrated, coordinated efforts that address the HIV epidemic among all partners and stakeholders

1. Integrate programs to address the syndemic of HIV, sexually transmitted infections (STIs), viral hepatitis, substance use, and mental health disorders
    a. Expand outreach and education efforts addressing issues that intersect HIV, such as intimate partner violence, STIs, viral hepatitis, substance use, and mental health disorders
    b. Implement a no-wrong-door approach to screening and linkage to services for HIV, STIs, viral hepatitis, substance use, and mental health disorders across programs
2. Increase coordination of HIV programs across all levels of government (federal, state, tribal, local, and territorial) and with faith-based and community-based organizations, the private sector, academic partners, and the community
    a. Foster the development of community-based organizational efforts to create and implement street-level interventions designed to address these barriers, such as street-based HIV testing, mobile HIV medical care, street-based medicine programs, street-based syringe exchange programs, street-based medication-assisted therapy (MAT)
    b. Focus resources, including evidence-based and evidence-informed interventions in the geographic areas and priority populations disproportionately affected by HIV
    c. Support collaborations between community-based organizations, public health organizations, education agencies and schools, and health care delivery systems to provide linkage to and delivery of HIV testing, prevention, care, and treatment services as well as supportive services

3. Enhance the quality, accessibility, sharing, and use of data, including HIV prevention and care continuum and social determinants of health data
4. Identify, evaluate, and scale up best practices, including through translational, implementation, and communication science research
    a. Develop program support for integrating HIV, mental health services, and primary care in single settings. Provide a mechanism for enhanced reimbursement for coordinated service provision, including provider parity among physician and advanced practice providers (APRNs, PAs)
    b. Promote and support collaborative research efforts among academic centers, health departments, community-based organizations, patients and their advocates, and other partners that aim to discover, adapt, and scale up effective interventions to improve HIV outcomes
5. Improve mechanisms to measure, monitor, evaluate, report, and disseminate progress toward achieving organizational, local, and national goals
    a. Strengthen monitoring and accountability for adherence to requirements, targets, and goals by funded partners
    b. Identify and address barriers and challenges that hinder the achievement of goals by funded partners and other stakeholders.

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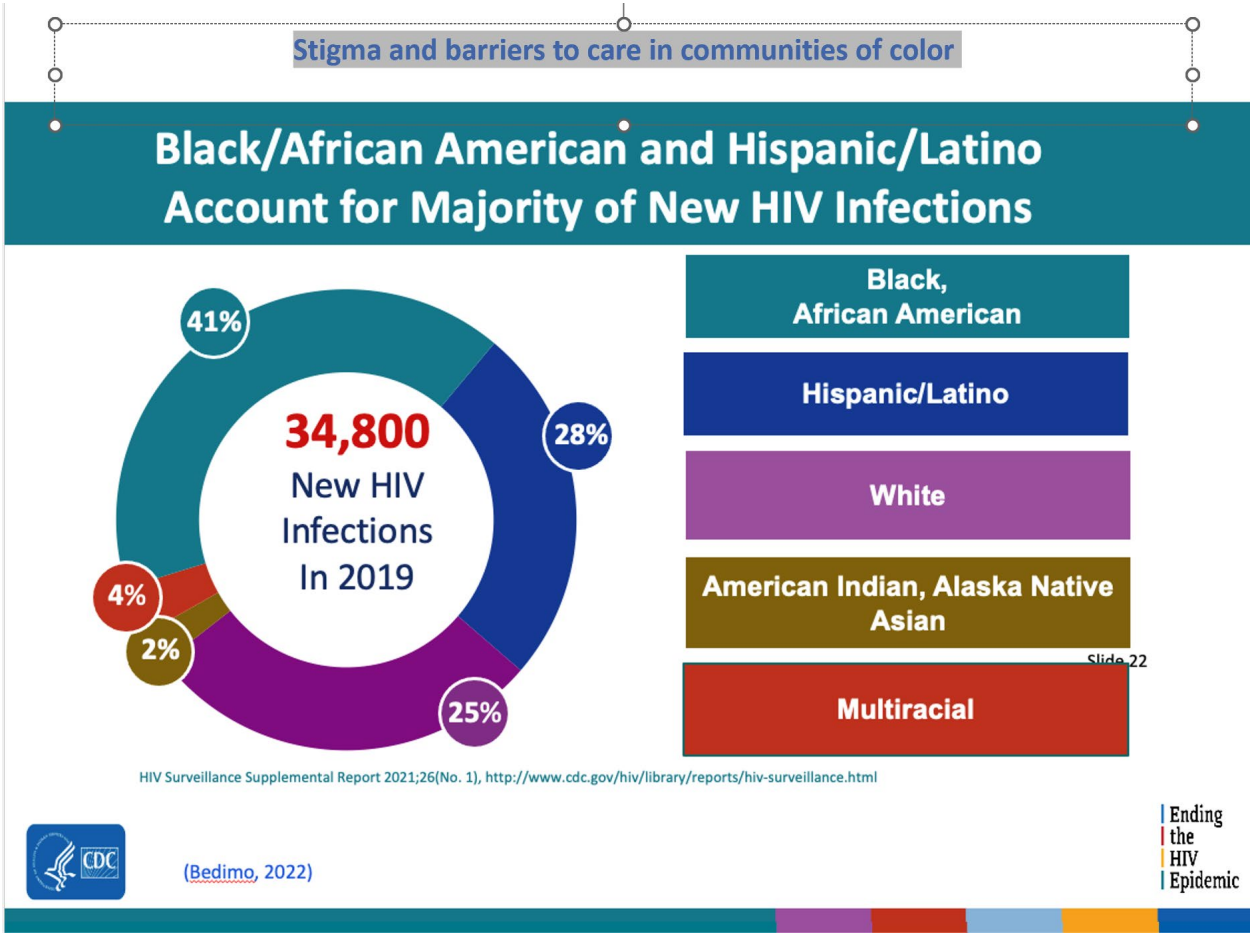
Appendix A


Stigma and barriers to care in communities of color
Black/African American and Hispanic/Latino Account for Majority of New HIV Infections
41%
28%
25%
4%
2%
34,800
New HIV Infections In 2019
Black, African American
Hispanic/Latino
White
American Indian, Alaska Native
Asian
Multiracial
Slide 22
HIV Surveillance Supplemental Report 2021;26(No. 1), http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html
CDC
(Bedimo, 2022)
Ending the HIV Epidemic