HIV Community Advisory Group Meeting Minutes

February 4, 2020; 10:00 a.m. – 2 p.m.
Gifford Medical Center, Randolph VT

Attendance: Laura Byrne, H2RC; Daniel Chase; Reggie Condra, Pride Center of Vermont; Pat Gocklin, DHMC; Peter Jacobsen, VT CARES; Chuck Kletecka, Vermont Positive Living Coalition; Zpora Perry, UVMMC; Karen Peterson, APSV; Donna Pratt, Twin States; Paul Redden III; David Schein, Vermont Positive Living Coalition; Taylor Small, Pride Center of VT.
Remote Attendance: Grace Keller, Howard Center Safe Recovery. *Significant technical difficulties were experienced and the meeting was ultimately unable to be broadcast.*
Vermont Department of Health: Daniel Daltry, Erin LaRose
Caracal Consulting: Alexander B. Potter
Guests:

- Nissa L. (Walke) James, Ph.D., Director of Communications & Legislative Affairs, DVHA.
- Scott Strenio, MD, Medicaid Medical Director

The meeting was called to order at 10:02 a.m.

I. DVHA PROSPECTIVE PREFERRED DRUG LIST

A. Nissa James, Ph.D., of the DVHA and Scott Strenio, MD, Medicaid Medical Director, attended this CAG meeting to discuss prospective Medicaid Preferred Drug List (PDL).

B. DVHA has been looking to establish a PDL for a number of years – this year, increased communication between commissioners has moved this forward. DVHA has come to CAG as part of outreach to discuss what this means for the community, and to hear consumer concerns that can be brought back to DVHA.

C. When the PDL came before Dr. James, she researched through the lens of what this would mean for Vermonters taking medication, prescribers, and Vermont Medicaid.

1. The establishment of a preferred and non-preferred drug list ***should not have any impact on patients getting the medications under discussion.*** People already taking medications, **that are currently on Vermont Medicaid**, will be grandfathered into pre-approval for whatever medication they are currently prescribed.
2. There will be minimal changes for providers prescribing medications. They ***can still prescribe*** a medication that has been moved to the ***non-preferred*** list, with an annual request for ***prior authorization*** before prescribing. A request for prior authorization should take under one hour to receive approval.
3. For Vermont Medicaid, this will mean the ability to negotiate a Preferred Drug List with pharmaceutical producers. There is ***no ability*** to negotiate with the manufacturers when a state's Medicaid program has no Preferred Drug List. This ability is already projected to bring $1.2 million back to the state of Vermont by the end of the fiscal year.

D. Questions?

1. How many individual patients would this affect?
    a. Thirteen (13) patients would be impacted if there were not grandfathering provisions. Existing patients are grandfathered in on their current medication, even if it was moved to non-preferred status.
2. So the one hour authorization is only for new patients?
    a. Yes, the one hour prior authorization process is only for **new** patients needing prior authorization for an existing drug moved to the non-preferred list – **not current patients** taking such a drug. However, the one hour authorization turn-around also applies to any potential **new medication** coming out that is **not yet on the preferred list**, that a

physician may want to prescribe. As new science is received, there is the opportunity at the one year mark to investigate and see if clinical recommendations have changed based on new findings. A physician prescribing a medication that is not on the preferred status list goes through the prior authorization process and for most medications it is extremely fast. If the medication is non-preferred because it is **no longer recommended**, it would be sent by the pharmacy to the medical director, and the medical director would call and talk to the prescribing doctor to determine the circumstances of using a medication that is not currently clinically indicated for treatment. **There have been no denials to adding new medications to the preferred list**.

Dr. Strenio further identified important points to know about this:

i. The first commitment is to getting care to the patient in the way their provider thinks is best.
ii. There is a Drug Utilization Review Board that is made up of providers and pharmacists from across the state.
iii. In treating infectious disease, there are clinical guidelines that are agreed upon regarding recommended medications. There have been no disagreements on the DURB on these clinical guidelines.
iv. Specialists testify before the DURB for any changes/updates to clinical guidelines. In the 15 years of Dr. Strenio's experience with this review board, he has never seen the board **not** accept a recommended change.
v. The only time he would foresee a problem with a potential medication is when a provider prescribes a medication that **goes against all recommendations** in the clinical guidelines.
vi. Ultimately, as Medical Director for Medicaid Dr. Strenio can approve – he is the final word and if there is a problem for any reason in getting a timely authorization, his office can make sure that people get the medication they need with minimal hassles. He gives his phone number directly to providers and they can reach out to him 7 days a week.
vii. Dr. Strenio further stated that he has not always been in favor of recommendations of the administration for changes for preferred drugs, but **this change he endorses 100%**.

3. Could you explain the context of where this bill sits on the docket? Is this referring to the governor's language about prescriptions?
    a. Yes. It is important to make a distinction of Vermont Medicaid making this list. The language referred to allows **Medicaid** to make these decisions and negotiate with pharmaceutical manufacturers. Having the list at all makes a huge difference and it has proved very effective -- $127 million is coming back to Vermont because of the work of this volunteer Drug Utilization Review Board to negotiate this list. They are doing their absolute best to get Vermonters what they need and also control costs.
4. Is there going to be a push to go from one pill a day to three pills a day, in the name of generics being preferred drugs and cost saving? Understand that from a policy level that may not sound big but for patients it is a huge deal.
    a. Dr. Strenio advised that he is totally against this and as long as he does this job he will do everything to ensure this does not happen. He recognizes there is no way to know the impact of medication unless you are the patient. Any potential change goes through the DURB and any drug that would move to replace a preferred drug would need to be equally effective

and **as easily taken** as the original preferred drug. It would have to meet clinical guidelines. If there is one person on the DURB with a concern, expert opinion is brought in to advise.

5. It was noted that leaving brand-name version HIV drugs as preferred can often be more advantageous due to the potential for rebates that can be negotiated. Dr. Strenio added that often there is only one company making the generic variety and therefore they can charge what they want with no competition.
6. Are generic versions equally as effective in treating HIV?
    a. Dr. Strenio stated that he is not an ID specialist, but that if a brand is indeed better for treatment, that is seen in the clinical guidelines, and there are examples of this (Synthroid medication for thyroid issues). If there are questions of that nature, specialists are brought in to advise.
7. While prior authorization should be a smooth process, in truth it is not always such – experience with this with psychoactive medications indicates that much back and forth was required and there seems to be a much longer wait than one hour. Pharmacies can give a 72 hour supply, but on a weekend this can be even more problematic. Do pharmacies know how the process should work? Sometimes, the prior authorization goes through, only to have the patient face the same issue the following month, and have to get authorization all over again. Who might help negotiate this issue?
    a. Dr. Strenio stated he would be the person to reach out to – his office wants to know where the problem is located in the breakdown. Sometimes the pharmacist knows about the 72 hour supply and chooses not to honor it – when his office hears that, the Director of Pharmacies gets on the phone directly with the pharmacist and corrects that. But if system problems are creating delays and breakdowns, get in touch with him or the pharmacy director – often it is a matter of the information of the breakdown reaching him. As stated, he answers his phone 7 days a week and will respond, and his email address is: scott.strenio@vermont.gov.
    Nissa seconded this issue, noting that in the past when she was able to get the information of a hold-up directly, she could walk it right over to the pharmacy and address it. However, the information must get communicated for them to intervene and fix it.
8. How does Medicaid list interface with VMAP – do changes to the Medicaid list affect the other and was this connected to the change in rebates overall?
    a. No, no connection.
9. Clarification – was the net positive savings just related to HIV medication?
    a. No, not specific to HIV meds – that amount was due to finally having a list and being able to negotiate at all.
10. For those grandfathered in, what if someone loses private insurance and then goes on Medicaid? Would they have an option for nonpreferred medications?
    a. If they became eligible for Medicaid, whatever medication regimen they were on would be fine. If part of that regimen was a nonpreferred drug, it would be the same authorization process and conversation with provider if it was a contraindicated medication.
    b. Nissa gave a known example – medication resistance. She took the NHA Guidelines and created some Guiding Principles. She will excerpt those out and send to Daniel.
11. Where can we get the preferred list?
    a. DVHA website undergoing overhaul; Nissa will get list to Daniel.

II. VDH UPDATE

A. Daniel reported on an upswing in new infections – 7 new infections diagnosed in the last 60 days. VDH is seeking to hold a meeting at the CCC, with Pride Center and VT CARES – the two organizations that are targeted testing providers for 100 MSM tests. Need to have a further conversation with folks and practitioners to strategize next steps for further reach of testing into higher risk communities.

1. Of the **SEVEN** new infections:
    a. **SIX** engaged in care, one not yet engaged.
    b. **FOUR** individuals identified source of infection as out of state. This is an important factor given even with Vermont's 83% viral suppression rate, infection still happens both in state and *out of state*.
    c. **THREE** are acutely infected – contracted in the last 6 months. One individual came in with a low viral load, but based on what they were telling their practitioner and DIS, they had a very recent negative test – sure enough, the viral load climbed very fast, indicating recent infection. This indicates ways in which we have advanced, with tests that can detect infection within two to three days.
    d. **TWO** are connected to each other in a potential network of infection (as of review of these notes three), which is a small number given the total infections in such a short amount of time. This is concerning as it could indicate a larger pool of infection in which the larger network of connections has not yet been identified. When the connections cannot be seen, this could be a homegrown issue of increasing cases, and it could be the people who are hardest to reach that we are missing in our testing.
    e. **SEVEN** of seven identified as male or transmasculine.
    f. **THREE** are members of communities of color.
    g. **FIVE** are ages 49 or younger, while the range of ages overall is 20 to 65.
    h. **TWO** have not participated in Partner Services and only one has outright refused. However, those **FIVE** that have were "referred in" by a community based organization or a medical provider telling them someone from VDH would contact them, and asking if they were open to that. Encouraging for DIS that practitioners have been setting the stage for Partner Services.
    i. **THREE** had prior PrEP experience that was not sustained, and were off PrEP at the time of exposure. **TWO** were looking to get back on PrEP, and in **TWO** of the three individuals, hypertension played a role in their no longer being on PrEP (hypertension being a contraindication for PrEP).
    j. **SIX** identified having sex with other men, **FOUR** identified out of state contacts. **ONE** individual identified meth activity, with no injection. Injection has not been identified at all as potential mode of transmission.
    k. **TWO** did a home test, received a reactive, and made an appointment with their provider to confirm. **ONE** was identified through a CBO, the other **SIX** through medical providers (yet the same CBO played a critical role in assisting with results from a medical provider test as will be described in greater detail below).
    l. Five Vermont counties are represented among the seven, (central and northern Vermont).
2. This is more than we saw out of the gate in 2017, the year of the cluster, and it wasn't until May 2017 that we had 5 cases, and we ended up with 22.
3. Drew, Vermont's OraSure representative), has been made aware of the infections. He is asking if there is a way to leverage OraSure's home testing in

Vermont. He produced models of similar efforts in NY, VA, CA, and RI. This is another way to access harder-to-reach populations.

a. Pharmacies stock them and they run $40 - $60. You have to know where to look and this can trigger stigma issues.
b. In New York City, they give out a code and an individual can call in and give their code, and a test will be mailed to them directly.
c. Tests can be ordered on Amazon.
d. Daniel noted that the VDH has plenty of home tests that can be given out if that is an option we would like to pursue. Reviews of home testing has been mixed at STD and HIV conferences attended by VDH staff. Questions have risen around how well OraSure responds to the Hotline, how good the test itself is, its only bilingual presence is in Spanish. Have heard good things and bad, but one of the biggest concerns from other Health Departments has been releasing a result into an individual's hands that you have no way of shepherding through the process. The other is how explicit and understandable is the part of the instructions that state "if you have had risk in the past 60 days this *may not be* the test for you."

4. Alex asked about the conversation at CAG during the cluster of 2017, pertaining to the potential of Daniel coming to other areas of the state to present on the current increase? Daniel said he is more than willing to travel if a meeting of influencers can be convened.

B. In a related topic, Taylor raised an issue that arose around other STD and HIV testing. A client's chlamydia test result was communicated with a phone call, and the individual was linked to treatment. However, the HIV result was not. They received their reactive HIV test result through an "email push" through the hospital chart system, on a Saturday. This individual was already connected with Pride Center so they were able to call that Saturday and Pride Center was able to test them on Sunday and connect them on Monday, but this created huge concern.

1. The patient contacted UVM Medical Center. The private provider released the result, not the CCC. The patient when forward with contacting patient advocacy.
2. In discussion, Pat noted that in the "My Charts" program at Dartmouth, there is a way for providers to designate certain tests to not be automatically released, and to place on 72 hour hold.
3. Daniel said he is aware the CCC has been concerned about this in the past and tried to work to ensure that a scenario described above would not occur. Ultimately grateful that this individual was connected and received great support from Pride Center. Also grateful for the strength of that consumer to address it, and advocate for self and others.
4. Zpora asked if Taylor knew if there was a good result/response from UVM patient advocacy? Taylor reported that there was a conclusion that doctors would ask patients how they wanted to get their test results which was at least a good first step, but more could be done.

C. Daniel noted that APSV is coming up to Safe Recovery this week and learning more about Medically Assisted Treatment. Both APSV and Safe Recovery have agreed for Daniel, Kelly and Nicole Rau to be present.

III. CAG BUSINESS

A. ANNOUNCEMENTS.

1. David announced that the Drag Ball is upcoming on 2/15, a benefit for the Vermont Positive Living Coalition. The PLC will use this to announce the new name. This is the 25th year of the House of LeMay doing this event. Posters are

available from David. David expressed that he is very proud of the board, new young activists, and some of the revered activists from the 80s and 90s in their efforts and work during this process. Everyone listened, considered and made a large change that was emotional on both sides. Vermont Edition is doing an episode on the Drag Ball, the new name, and the changing nature of HIV, this coming Wednesday, with GLAM as well.

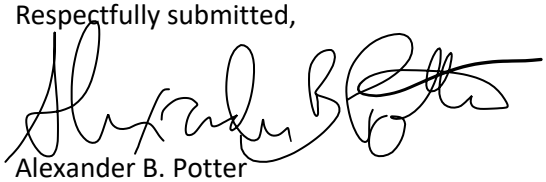
2. Laura announced they have a new Vermont Case Manager – Angel Hudson – as Ryan Richards has moved into the position of Associate Director and is now working almost exclusively in harm reduction with the new mobile exchange and in opening more fixed sites.
3. Donna announced that the Women's Retreat is coming up on May 28 – 31, and is in the planning stages. Registration and information will be going out in March and she will send to everyone.
4. Zpora announced that the CCC will have a Ryan-White-Funded-Site Visit from HRSA on the 19th and 20th, which includes a lunch with patients of the CCC. This is for all four sites but due to the time constraints, only visiting Burlington. As a new part of the curriculum for middle school at the Edmonds School, Zpora went in as a speaker with an HIV positive speaker.

B. MINUTES:

1. Alex said that David notified him of an error in advance, that the Vermont Positive Living Coalition had been misidentified by its previous name in the last minutes. He reminded folks that this is a great way to let him know of errors when the see them, and to always feel free to do – he will bring up any changes at the following meeting and ensure they are recorded.
2. Karen made a motion to approve the minutes as amended. Taylor seconded the motion. The motion was approved unanimously and the minutes were approved.

Meeting adjourned at 12:30 pm.

Respectfully submitted,



Alexander B. Potter
Caracal Consulting