

HIV Health Care Access Working Group

March 28, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius:

We are writing on behalf of the HIV Health Care Access Working Group (HHCAGW) to congratulate you and your colleagues on the release of the HHS operational plan for the National HIV/AIDS Strategy and to offer the Working Group as a resource to help advance the important activities outlined in the plan.

As noted in the operational plan, successful implementation of health care reform is vital to meeting the goals of the NHAS of reducing HIV-related incidence, improving access to HIV care and reducing HIV-related disparities, and the Working Group is committed to ensuring that the needs of people living with HIV and AIDS are considered and addressed wherever applicable through health care reform implementation. We appreciate the leadership and vision that HHS offers in this regard as the lead implementing agency and were pleased to see Medicaid beneficiaries with HIV and AIDS recognized as a population appropriate for the new Medicaid health home benefit in the November 2010 guidance sent to state Medicaid directors.

Though full implementation of health care reform will greatly expand access to care for low-income people living with HIV and AIDS, many reforms – most notably, the Medicaid expansion – do not go into effect until 2014. With this in mind, we would like to follow-up on several issues with regard to approaches to providing a bridge to 2014:

- 1) **Designation of a point person at the Centers for Medicare and Medicaid Services to act as a liaison between CMS, other federal agencies, and the HIV/AIDS community on health care reform and NHAS implementation efforts.** Such a position is critical to ensuring a productive and two-way dialogue between CMS and other government entities and the HIV/AIDS community on many of the implementation concerns we list below.
- 2) **Planning grants to support states with submitting section 1115 waivers.** We are working closely with CMS on making the 1115 Medicaid waiver a viable option for states to create a bridge to 2014 and are hoping for a waiver template and guidance to be released soon. However, states struggling with understaffed Medicaid offices do not have the resources to gather the data and conduct the budget analyses needed to develop a successful waiver application even with an expedited process. Planning grants would allow states to develop plans that will meet budget neutrality requirements and the needs of pre-disabled people living with HIV, and we ask that HHS provide support for these grants.
- 3) **Information on the state pre-existing condition insurance plans (PCIP).** As a follow up to the communication sent in January from the Working Group, we are awaiting information on states where Ryan White programs may provide wrap around coverage to facilitate enrollment in the PCIP. The PCIP coverage has taken on new importance as states such as Arizona consider changes to their programs that put people with HIV and others at risk for losing their Medicaid coverage. Without the support of Ryan White, most uninsured people with HIV cannot afford to enroll in the program.

The attached chart reflects the most significant health care reform provisions affecting people with HIV and AIDS as well as our recommendations for effective implementation steps that have been or could be incorporated into the National HIV/AIDS Strategy.

Finally, we would like to request that the sub-agencies and departments within HHS, such as the Centers for Medicare and Medicaid Services, the HIV/AIDS Bureau at the Health Resources and Services Administration and the Centers for Disease Control and Prevention share their work plans for advancing the operational plan so that we can be supportive wherever possible.

We thank you for your leadership and support for people living with HIV and welcome the opportunity to discuss these issues with you further. Please feel free to contact the HIV Health Care Access Working Group Co-chairs Robert Greenwald (rgreenwa@law.harvard.edu) or Andrea Weddle (aweddle@idsociety.org).

Sincerely,

Submitted on behalf of the HIV Health Care Access Working Group Steering Committee,

AIDS United | AIDS Action Baltimore | AIDS Alliance for Children, Youth & Families | AIDS Foundation of Chicago | The AIDS Institute | AIDS Project Los Angeles | American Academy of HIV Medicine | Broward House | Community Access National Network | Gay Men's Health Crisis | Harlem United | Health and Disability Advocates | HIV Medicine Association | HIVictorious, Inc. | Housing Works | Moveable Feast | National Alliance of State and Territorial AIDS Directors | National Association of People With AIDS | National Minority AIDS Council | The National Working Positive Coalition | Project Inform | San Francisco AIDS Foundation | South Carolina Campaign to End AIDS | Treatment Access Expansion Project | Treatment Action Group | VillageCare

HHCAWG is a coalition of more than 100 national and community-based AIDS service organizations representing HIV health care providers, advocates and people living with HIV and AIDS.

Cc:

Howard Koh, Assistant Secretary for Health
Mary Wakefield, Administrator, Health Resources and Services Administration
Donald Berwick, Administrator, Centers for Medicare and Medicaid Services
Cindy Mann, Deputy Administrator and Director, Center for Medicaid, CHIP and Survey & Certification
Jeffrey Crowley, Director, Office of National AIDS Policy
Ronald Valdiserri, Deputy Assistant Secretary for Health
Mayra Alvarez, Director of Public Health Policy, Office of Health Reform

HIV Health Care Access Working Group

Recommendations for Leveraging Health Care Reform and the National HIV/AIDS Strategy (3/21/11)

Health Care Reform Provision	Agency Action Item/Recommendation
HHS to Enforce Maintenance of Effort Requirements for Federal Medicaid Funding (PPACA § 2001(b))	HHS (through CMS) should limit the ability of states to drop people from Medicaid coverage and should continue to provide guidance and support for cost-saving options that do not reduce eligibility or cut benefits.
HHS to Allocate Funds from Prevention and Public Health Fund (PPACA § 4002)	HHS should ensure that HIV/AIDS and infectious disease programs are adequately funded.
HHS to Award Community Transformation Grants (PPACA § 4201)	HHS should ensure that the criteria for the Community Transformation Grants include projects addressing HIV as it relates to health disparities and chronic disease.
HHS to Allocate Funds for Health Care Workforce Development (PPACA § 5001)	HHS should secure funding for training and retention of health care providers experienced in the treatment and management of HIV and AIDS. HRSA should designate Ryan White grantees as eligible sites for National Health Service Corps programs and build on the existing successful infrastructure of AIDS Education and Training Center programs to support increased mentoring and HIV/AIDS provider training opportunities.
HHS to Oversee Community Health Center Expansion (PPACA § 10503)	HRSA should issue guidance to applicants for expansion grants to ensure that HIV/AIDS care, treatment, and prevention services are incorporated and encourage formal partnerships with Ryan White-funded programs if the CHC lacks HIV medical expertise, including guidance on necessary workforce training. HRSA should issue guidance to Ryan White grantees on how to become federally qualified health centers and/or support increased collaboration between Ryan White and health centers.
HHS to Define Preventive Services to Be Covered by Insurance Plans without Cost Sharing (PPACA § 2713)	As the USPSTF reevaluates its HIV screening recommendation, HHS should work with medical provider organizations, such as the American College of Physicians and the National Medical Association to ensure providers are aware of the scope of the current recommendations and coverage and to educate them on the availability of HIV care through Ryan White programs for individuals newly diagnosed.
HHS to Determine Essential Health Benefits Package for Plans Sold through Exchanges as well as Medicaid Benefits for Newly-eligible Beneficiaries in 2014 (PPACA § 1302; § 2001)	HHS should ensure that the essential health benefits package for both the private insurance market as well as Medicaid is comprehensive and provides the level and scope of services needed by people living with HIV and AIDS and other chronic medical conditions.
HHS to Oversee Medicaid Health Home Program (PPACA § 2703)	HHS (in conjunction with CMS) should support state applications for the Medicaid Health Home Program that include HIV and AIDS as an eligible chronic condition. HHS should work with HRSA to develop training for HIV/AIDS service providers to become certified medical homes.
HHS to Oversee Center for Medicare and Medicaid Innovation (CMMI) (PPACA § 3021)	HHS should encourage CMS to work with HRSA on a pilot project evaluating the key components of the comprehensive and coordinated model of care that is the hallmark of Ryan White Programs and develop funding mechanisms to support this level of care under Medicaid and Medicare.
HHS to Oversee Center for Consumer Information and Insurance Oversight (CCIIO)	HHS should work with CCIIO and HRSA to ensure that Ryan White providers are included in exchange design discussions, including providing guidance to providers on how to integrate into broader health systems and ensuring state exchanges are aware of requirements to contract with safety-net providers, including Ryan White providers.

Health Care Reform Provisions and HHS Oversight and Implementation Recommendations

Enforcing Medicaid Maintenance of Effort Requirements

The Affordable Care Act includes a “maintenance of effort” provision with regard to Medicaid, which conditions receipt of federal Medicaid funds on a state obligation to maintain the eligibility levels and enrollment processes in place at the time of the ACA’s enactment (March 23, 2010) for Medicaid-covered adults until 2014 and for Medicaid-covered children until 2019.¹ In January 2011, Arizona requested a waiver of the maintenance of effort requirement, which would allow the state to drop 280,000 adults enrolled in Medicaid through Arizona’s Section 1115 waiver.² Secretary Sebelius responded to Arizona’s request on February 15, 2011,³ stating that the maintenance of effort provision did not require a state to extend an expiring Section 1115 waiver (Arizona’s waiver expires in September 2011).

- HHS and CMS should limit state flexibility with regard to maintenance of effort requirements and continue to provide guidance and information to states on better ways to address budget shortfalls (e.g., through medical home and coordinated care models) and work with states, such as Arizona, to facilitate transition to other programs, such as the pre-existing condition insurance plans. The NHAS supports increased information sharing and dialogue between HHS and CMS, and this dialogue will be crucial to ensuring that the Medicaid expansion is carried out in ways that ensure seamless access to care for people living with HIV and AIDS.

Allocating Funds from the Prevention and Public Health Fund

The Prevention and Public Health Fund offers important opportunities to promote HIV/AIDS and infectious disease prevention.⁴ \$30 million was set-aside for HIV community prevention efforts for FY 2010. In February 2011, Health and Human Services Secretary Sebelius announced \$750 million in funding for the Prevention and Public Health Fund for FY 2011; however, unlike the FY 2010 allocations, HHS did not specify any money specifically for HIV prevention. Meeting the prevention goals of the National HIV/AIDS Strategy requires significant new investments in HIV prevention and public health services.

- HHS should target more funds to support a broad range of HIV prevention and public health services needs, including grants for community-based organizations, funding for studies and initiatives addressing stigma, and funding to shore up state HIV/AIDS budgets.

Promoting HIV Prevention Initiatives for Community Transformation Grants⁵

The Community Transformation Grants program requires HHS, through the CDC Director, to award competitive grants for the implementation, evaluation, and dissemination of evidence-based community preventive health activities, in order to reduce chronic disease rates, address health disparities, and develop a stronger evidence base of effective prevention programming. In February 2011, the Secretary of Health and Human Services announced \$145 million in funding for FY 2011 from the Prevention and Public Health Fund toward community transformation grants. Given the disproportionate impact of HIV on communities of color and gay men, proposals and activities to address HIV should be emphasized.

- HHS should work with CDC to ensure that the criteria for the Community Transformation Grants include projects seeking to address HIV as it relates to health disparities and chronic disease, targeting both urban and rural areas.

Allocating Funds for Health Care Workforce Expansion and Training Initiatives

The health care reform law contains numerous workforce expansion and training initiatives, including increased National Health Service Corps funding, grants to develop and expand primary care residency programs, student loan repayment incentives, and grants for preventive medicine and public health training. In addition, the law establishes a National Health Care Workforce Commission to serve as a national resource for Congress, the President, and states and localities on health workforce issues.

- HHS should build on the successful infrastructure of the AIDS Education and Training Centers, by targeting funding to training HIV/AIDS health care providers and granting new flexibility to AIDS Education and Training Centers funded under Part F of Ryan White Programs to meet the growing needs of the HIV health care provider workforce. Without undermining their mission of educating primary care providers, HHS may consider new funding and efforts to create programming for medical, nursing, pharmaceutical and other students and residents and reengage medical, nursing and other schools to meet their current obligations to educate students about HIV health care. HHS should consider ways to use existing and new resources to develop longer term training opportunities to provide a pathway for newly trained health care providers to enter HIV treatment and care. This effort should also involve coordination with the activities of the National Health Care Workforce Commission, which is an action item included in the NHAS operational plan.
- HRSA should promote and support expansion and integration of HIV/AIDS services and providers into broader health systems, for instance by designating Ryan White grantees as eligible sites for National Health Service Corps programs; targeting National Health Service Corps opportunities to HIV health care providers; and building on the successful infrastructure of AIDS Education and Training Center programs to support increased mentoring opportunities, increased HIV/AIDS provider training opportunities, and better linkage of academic medical centers with community providers.

Allocating Funds for Community Health Center Grants and Initiatives

The health care reform law includes billions of dollars in funding and grants for community health centers, including \$11 billion in funding for the operation, expansion and construction of health centers throughout the nation over the next five years.⁶ As part of this expansion, in 2011: \$250 million was allocated for New Access Point grants to support more than 350 new Health Center service delivery sites⁷; \$727 million was allocated for the construction and renovation of 143 community health centers to enable them to expand access to quality health care⁸; \$335 million was allocated for existing community health centers across the country to expand access to preventive and primary health care⁹; and \$8 million was allocated for community-based organizations to pay for enhanced training and technical assistance to modernize community health centers.¹⁰

- HRSA should encourage community health centers applying for grants to include comprehensive health, prevention, and support services for people living with HIV and AIDS and should work with Ryan White grantees and health centers to maximize integration and collaboration, including issuing guidance on the necessary workforce training needed to implement expanded HIV/AIDS care, treatment, and prevention services. Such support complements the NHAS “12-Cities Initiative,” which includes HRSA coordination of technical assistance to expand HIV/AIDS services in community health centers operating in the twelve identified jurisdictions.
- HRSA should issue guidance to assist Ryan White grantees with becoming or affiliating with Federally Qualified Health Centers and provide technical assistance to grantees throughout the application process.

Promoting Prevention Services

Beginning on September 23, 2010, all group and individual market health plans (except grandfathered plans) are required to cover recommended preventive services without cost sharing.¹¹ The Departments of Health and Human Services, Labor, and Treasury issued a regulation detailing the preventive services to be covered, including: HIV testing for all adolescents and adults at increased risk for HIV infection (risk factors defined by USPSTF “Clinical Considerations”¹²); blood pressure, diabetes, and cholesterol tests; cancer screenings; counseling from a health care provider on smoking cessation, weight loss, nutrition, mental health, and alcohol use; routine vaccines; flu and pneumonia shots; counseling, screening, and vaccines for healthy pregnancies; and regular well-baby and well-child visits from birth to age twenty-one.¹³ The scope of Medicare-covered preventive services without cost sharing was also expanded, but was also limited to services with a USPSTF grade “A” or “B.”¹⁴ Because of the USPSTF rating of “C” for routine HIV screening (as opposed to the rating of “A” for screening for those at increased risk), health plans are not required to provide free routine HIV screening for all adolescents and adults.

- As the United States Preventive Services Task Force (USPSTF) re-evaluates its recommendation for routine HIV screening, HHS should work with HRSA to ensure that providers understand the scope of the current rating definitions (for instance that the current rating encompasses those with individual risk factors; those receiving care in a high-risk clinical setting; and those receiving care in a high-prevalence clinical setting) and understand the reimbursement ramifications of this designation.

Defining the Essential Health Benefits Package

The health care reform law requires that all private insurance exchange plans (as well as Medicaid coverage for newly-eligible beneficiaries) provide, at a minimum, an “essential health benefits package” (EHBP).¹⁵ The law requires that the package include: ambulatory patient services, emergency services, hospitalizations, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative services and devices, laboratory services, preventive services, and chronic disease management. Beyond these basic requirements, the Secretary of Health and Human Services is tasked with determining the details of this package.¹⁶ The Institute of Medicine is currently undertaking a study that will inform recommendations to HHS on the criteria for defining the EHBP.¹⁷

- HHS should work with CMS, HRSA and AHRQ to examine the comprehensive benefits packages that have proven critical to effective management of the care of low-income individuals with chronic conditions to ensure that the “essential” package will adequately meet the medical needs of all beneficiaries, but particularly those whose lives depend on reliable access to full range of services, including people with HIV and AIDS. It is critical for the essential health benefit package to be comprehensive for both private insurance and Medicaid beneficiaries and that the package provides essential HIV/AIDS services.

Promoting Medical Homes among Ryan White Providers

There are many incentives throughout the health care reform law for providers to adopt a “medical home” model. For instance, the Medicaid Health Home program allows states to amend their Medicaid programs to provide coordinated care through a health home for individuals with chronic conditions. The program gives individuals the opportunity to select a provider or health team to operate as a health home and allows Medicaid beneficiaries access to more integrated and holistic provision of care.¹⁸ In its letter to state Medicaid directors, CMS provided initial guidance to states on the Medicaid Health Home program, highlighting HIV and AIDS as a chronic condition that the program could cover.¹⁹

- HHS should work with HRSA to ensure that Ryan White grantees have access to the information and support needed to become certified medical homes and should encourage states applying for the Medicaid Health Home program to include HIV and AIDS as a target condition. HHS should

also promote the medical home model as a cost-saving strategy for state Medicaid programs instead of cuts to benefits or eligibility.

Integrating Ryan White Models of Care into a Pilot Program Funded through Center for Medicare and Medicaid Innovation

The health care reform law establishes the Center for Medicare and Medicaid Innovation (CMMI), which is tasked with evaluating payment and service delivery models for Medicare and Medicaid.²⁰ CMMI will consider factors such as, how well services are integrated, how health information technology is used to coordinate care for those with chronic illnesses, and how medical homes are used.

- CMS should work with HRSA on a collaborative pilot program to evaluate key program components of the comprehensive and coordinated care, treatment, and services model that is the hallmark of Ryan White Programs and develop payment mechanisms to support this level of care under Medicaid and Medicare. Support for evaluation of the Ryan White model of care through a joint CMS/HRSA pilot project is also included in the NHAS operational plan.

Ensuring that Exchanges Work for People Living with HIV and AIDS

Starting in 2014, states will be required to operate exchanges that will allow consumers to compare and purchase health insurance coverage. Though most states are moving forward in exchange implementation by convening task forces and proposing legislation, some state governors are requesting flexibility from HHS around what regulatory functions exchanges are required to serve. In early February 2011, twenty-one state governors submitted a letter to HHS Secretary Kathleen Sebelius, requesting greater flexibility and requesting that HHS waive “the bill’s costly mandates and grant states the authority to choose benefit rules that meet the specific needs of their citizens.”²¹ Design of the exchanges – particularly with regard to consumer involvement, patient navigation provisions, oversight, and interface with Medicaid – will have a significant impact on how well exchanges are able to serve vulnerable populations, such as low-income people living with HIV and AIDS.

- HHS, and particularly the Center of Consumer Information and Insurance Oversight (CCIIO), should encourage states to design exchanges that work for the varied populations they will be required to serve, including low-income people with chronic conditions. To this end, HHS should work with HRSA to ensure that HIV advocates, providers, and consumers have the information and support needed to integrate HIV/AIDS services and providers into exchanges (e.g., training on billing and reimbursement).

¹ Patient Protection and Affordable Care Act, § 2001(b).

² Letter from Governor Brewer to Secretary Sebelius, January 25, 2011, at http://azgovernor.gov/dms/upload/PR_012511_SebeliusLetter.pdf.

³ Letter from Secretary Sebelius to Governor Brewer, Feb. 15, 2011, at http://www.azahcccs.gov/shared/Downloads/News/SebeliusLetter_JaniceBrewer.pdf.

⁴ PPACA § 4002; Affordable Care Act: Laying the Foundation for Prevention, at <http://www.healthreform.gov/newsroom/acaprevention.html>.

⁵ PPACA § 4201.

⁶ PPACA § 10503.

⁷ Health Center New Access Points Funded under the Affordable Care Act of 2010, at <https://grants.hrsa.gov/webExternal/FundingOppDetails.asp?FundingCycleId=450970E7-563E-4D2D-A021->

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⁸ Department of Health and Human Services, “News Release: HHS Announces a Major New Investment in Community Health Centers,” Oct. 8, 2010, at <http://www.hhs.gov/news/press/2010pres/10/20101008d.html>.

⁹ Department of Health and Human Services, “News Release: HHS Announces the Availability of up to \$335 Million to Boost Access to Primary Health Care,” Oct. 26, 2010, at <http://www.hhs.gov/news/press/2010pres/10/20101026a.html>.

¹⁰ Department of Health and Human Services, “News Release: \$8 million in Affordable Care Act Funds to Help Develop and Modernize Community Health Centers,” Nov. 19, 2010, at <http://healthreformgps.org/wp-content/uploads/HRSA.pdf>.

¹¹ Patient Protection and Affordable Care Act, § 2713.

¹² U.S. Preventive Services Task Force, Screening for HIV Recommendations, at <http://www.uspreventiveservicestaskforce.org/uspstf05/hiv/hivrs.htm#clinical>.

¹³ 45 CFR Part 147; 29 CFR Part 2590; 26 CFR Part 54.

¹⁴ PPACA § 4104.

¹⁵ PPACA §§ 1302(a); 2707(a); 2001(c).

¹⁶ PPACA §1302(b)(2)(A).

¹⁷ IOM, Determination of Essential Health Benefits, <http://www.iom.edu/Activities/HealthServices/EssentialHealthBenefits.aspx>.

¹⁸ PPACA § 2703.

¹⁹ Centers for Medicare and Medicaid Services, State Medicaid Directors Letter: Health Homes for Enrollees with Chronic Conditions, Nov. 16, 2010, at <http://www.cms.gov/smdl/downloads/SMD10024.pdf>.

²⁰ PPACA §3021.

²¹ Letter to Secretary Sebelius, Feb. 7, 2011, at <http://healthreformgps.org/wp-content/uploads/governors-letter.pdf>.