

# HIV Health Care Access Working Group

July 13, 2012

Melanie Bella  
Director of the Medicare-Medicaid Coordination Office  
Centers for Medicare and Medicaid Services  
Washington, DC  
Sent via email: [Melanie.Bella@cms.hhs.gov](mailto:Melanie.Bella@cms.hhs.gov)

Dear Ms. Bella:

We are writing on behalf of the HIV Health Care Access Working Group (HHCAGW) to highlight universal concerns related to the state demonstration projects to integrate care delivery and financing for individuals dually eligible for Medicaid and Medicare Services. The Medicaid and Medicare programs are the two largest funders of HIV care; nearly 50% of people being treated for HIV rely on Medicaid coverage and 30% of Medicaid beneficiaries with HIV qualify as dual eligibles.

We strongly support the goal of improving health care outcomes and delivering more efficient and cost effective care to the dual eligible population. However, we have concerns about the broad scope of the demonstrations, the speed with which they are being implemented, and the magnitude of savings targeted through these demonstrations.

Our organizations represent social service and medical providers, public health officials, advocates, and people living with HIV/AIDS across the country. Many of them do not have the capacity to respond at the state level as these proposals are developed and considered. While we appreciate the opportunity for input at the federal level, our organizations do not have the capacity to review and respond in a meaningful way to the 26 plus proposals during the 30-day federal public comment period. With this in mind, we urge you and your staff to consider the comments below with regard to the treatment of dual eligible beneficiaries with HIV as you review proposals from all of the states that are participating in the demonstration projects.

- 1) **Do not allow passive enrollment for dual eligibles with HIV/AIDS.** By virtue of qualifying for both Medicaid and Medicare, dual eligibles with HIV/AIDS are poor and disabled; many have been living with HIV for years. Continuity of care is critical for all people with HIV/AIDS and particularly important for this population who are more vulnerable to falling out of care, and thereby risking serious illness.

As witnessed with the transition to Medicare Part D, intensive support and education is critical to ensure people with HIV select plans that best meet their needs and are the least disruptive to their care and treatment. Dual eligibles with HIV must not be subject to enrollment in a managed care plan or other health plan without their consent and participation in selecting a plan suitable to them. If passive enrollment is allowed, beneficiaries must not be locked in and must maintain the capacity to change plans as needed, without a waiting period. With any plan transition, care must be taken to ensure continuity with providers and pharmacy benefits, formulary provisions, as well as participating pharmacies.

- 2) **Do not allow lock-in periods in Medicare or Medicaid benefits.** Unlike other beneficiaries, most dual eligibles with HIV/AIDS already receive a level of coordinated care supported through Ryan White Program services. Dual eligibles with HIV should not be forced to abandon an effective, coordinated network of providers and must maintain the capacity to return to fee-for-service coverage at will.
- 3) **Ensure beneficiaries maintain their current benefits.** The goal of the demonstrations should be to improve access to the coordinated and comprehensive care and services that prevent illness and disability and, in doing so, reduce the need for higher cost services. Many managed care plans do not have experience working with this population, which has unique and extensive medical and social service needs. Beneficiaries must maintain the highest level of benefits and the range of care coordination and supportive services that they currently have access to under both Medicaid and Medicare.

For the prescription drug benefit in particular, it is important that beneficiaries maintain access to all of the drugs in the classes of clinical concern, including antiretrovirals, without monthly limits or utilization management, such as prior authorization, step therapy, and/or dosing restrictions. Successful management of HIV infection requires strict adherence to a daily regimen of multiple antiretroviral medications. The most effective medication regimen is based on factors unique to the individual, including co-morbidities, previous treatment history, and drug resistance. Dual eligibles with HIV/AIDS must have access to drug coverage that supports the federal antiretroviral treatment guidelines and the range of medications that they need to address co-morbidities and treatment side effects. It is essential for people living with HIV/AIDS, and others living with chronic disease, to have access to a robust formulary in addition to the Medicare Part-D classes of clinical concern protections.

- 4) **Ensure that beneficiaries maintain access to experienced HIV providers.** Experienced HIV providers deliver higher quality and more cost effective care and often serve as their patients' primary care provider and medical home. It is medically risky to disrupt or sever the relationship between dual eligible beneficiaries and their medical providers. We strongly urge provisions that allow beneficiaries with HIV/AIDS to maintain access to their medical providers. We also urge provisions that require states to consider HIV experienced providers in their network adequacy standards.
- 5) **Foster coordination with the Ryan White Program in each state.** The Ryan White Program supports a highly effective system of care for many people living with HIV, including for those who are dually eligible for Medicare and Medicaid. Working with Ryan White administrators, medical and social service providers will help beneficiaries adapt to new systems of care while maintaining access to the expert HIV care proven to result in better treatment outcomes and more cost effective care.
- 6) **Protect access and eligibility for home and community care and other long-term care and support services.** Individuals with HIV are enrolled in these programs because they are at risk for long-term residential care or hospitalization. Careful and thoughtful planning must be given before dismantling the services and network of providers that individuals enrolled in these programs currently rely on to stay healthy and live independently in the community. Individuals enrolled in these programs should continue to have access to these services and to their existing providers for at least a one-year

transition period to ensure their needs are met by their new health plan. In addition, plans must contract with HIV home health providers in order to ensure access to providers with the appropriate expertise to meet the needs of people living with HIV.

- 7) **Require states and plans to monitor the care and outcomes for beneficiaries with HIV/AIDS.** A number of quality measures for HIV care and treatment have been endorsed by the National Quality Forum, implemented through the Physician Quality Reporting System, and are being considered for Stage II Meaningful Use (please see attached). To safeguard against savings accruing from plans inappropriately limiting access to care, the care provided and treatment outcomes must be monitored through the use of common metrics that can be compared across plans and federal and private payers.
  
- 8) **Educate beneficiaries, providers and advocates on the demonstration projects well in advance of implementation and ensure adequate individual transition assistance.** Beneficiaries and their providers must be included in a meaningful way and given the resources and tools that they need to prepare for a successful transition. Targeted outreach is critical for this population.

We share the goal of improving care for our country's most vulnerable residents and welcome the opportunity to partner on this endeavor. By virtue of qualifying for both Medicaid and Medicare, dual eligible have more intense medical needs, live on very low incomes, and require access to a broad range of health services and providers to maintain their health. Efforts to reap substantial savings in the short term from this population without effective protections will place them at great medical risk and result in higher overall health care costs.

Thank you for your consideration of our views. Please contact the HIV Health Care Access Working Group co-chairs, Robert Greenwald with the Treatment Access Expansion Project ([rgreenwa@law.harvard.edu](mailto:rgreenwa@law.harvard.edu)) or Andrea Weddle with the HIV Medicine Association ([aweddle@hivma.org](mailto:aweddle@hivma.org)), if we can be of assistance.

Respectfully Submitted by the Steering Committee of the HIV Health Care Access Working Group,

AIDS Action Baltimore | AIDS Alliance for Children, Youth & Families | AIDS Foundation of Chicago | The AIDS Institute | AIDS Project Los Angeles | AIDS Treatment Data Network | AIDS United | American Academy of HIV Medicine | Broward House/ South Florida AIDS Network | Community Access National Network | Communities Advocating Emergency AIDS Relief (CAEAR) Coalition | Gay Men's Health Crisis | Harlem United | Health and Disability Advocates | HIV Medicine Association | HIVictorious, Inc. | HIV Prevention Justice Alliance | 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