

Presidential Advisory Council on HIV/AIDS (PACHA)
Resolution on HIV Testing
January 28, 2011

An individual's ability to benefit from the great strides that have been made in the treatment and care of HIV largely depends upon timely diagnosis, effective treatment, and attention to co-morbidities and co-conditions (including mental health, substance use, and housing). Further, reducing the potential for HIV transmission in our communities, through reduced viral load and behavior change, also depends upon timely diagnosis and effective treatment. The benefits of early diagnosis and linkage to care are only realized if individuals know their status through HIV testing.

The United States Preventive Services Task Force (USPSTF) recommends routine HIV screening for those persons at "increased risk" of HIV infection (a "Grade A" recommendation). USPSTF also recommends testing of all pregnant women (Grade "A"), which should continue and be promoted. However, for persons not clearly identified as increased risk or pregnant, the USPSTF conferred only a "Grade C" recommendation. The USPSTF recommendation is important because coverage and reimbursement for preventive services under Medicare, Medicaid, and most private insurance under the Affordable Care Act depend on an "A" or "B" level USPSTF recommendation, and adequate reimbursement supports clinicians' efforts to increase health screening.

WHEREAS, the USPSTF clinical considerations defining "increased risk" for HIV infection include: (1) one or more individual risk factors; (2) receipt of health care in a high-risk clinical setting; or (3) receipt of health care in a high-prevalence clinical setting (defined by the Centers for Disease Control and Prevention as those with a 1% or greater prevalence of infection among the patient population being served);

WHEREAS, "increased risk" covered under the Grade A USPSTF recommendation includes: 1) men who have sex with men after 1975; men and women having unprotected sex with multiple partners; past or present injection drug users; men and women who exchange sex for money or drugs or who have sex partners who do; individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users; individuals being treated for sexually transmitted diseases; individuals with a history of blood transfusion between 1978-1985; and individuals who request an HIV test: 2) and high-risk clinical settings includes STD clinics, correctional facilities, homeless shelters, tuberculosis clinics, clinics serving men who have sex with men, and adolescent health clinics with a high prevalence of STDs; and 3) high prevalence settings includes those with a 1% or greater prevalence of infection among the patient population being served;

WHEREAS, even with the broad definition of "increased risk" under current Grade "A" USPSTF recommendations, there are still people who fall outside of the "increased risk" category who will benefit from testing, and numerous studies document that risk-based HIV screening in health care settings fails to identify up to half the patients infected with HIV;

WHEREAS, many health care providers often do not have time to take detailed sexual or substance use history or may simply assume their patients are not at risk for HIV disease and/or are unaware of the broad definition of "increased risk";

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WHEREAS, numerous studies also document that routine screening of patients without specific risk factors is well-accepted by patients;

WHEREAS, the USPSTF last considered HIV routine testing in 2007, updating a 2005 evidence review; and the evidence model that led to their “C” level recommendation for routine HIV testing was based on preventing clinical progression or death within three years, assuming treatment would be initiated only at CD4 T-cell counts $<200/\mu\text{L}$, but subsequent evidence of increased survival and improved health outcomes with earlier treatment and decreased infectiousness among horizontal transmissions with effective antiretroviral treatment has accumulated; and, the DHHS and other professional societies recommend initiation of antiretroviral therapy at CD4 levels of 350-500/ μL (A/B II), if not sooner;

WHEREAS, both public and private insurance reimbursement often relies on health care providers’ full understanding of the definition of “at increased risk,” but many health care providers are unaware of the scope of this definition;

BE IT RESOLVED that the President’s Advisory Council on HIV/AIDS recommends that: the US Preventive Services Task Force immediately launch a new review regarding its rating for routine population-based screening for adults and adolescents in clinical care settings; and the Department of Health and Human Services, the Centers for Medicare and Medicaid Services, and the Health Resources and Services Administration undertake a joint HIV testing initiative and provider education campaign to ensure that providers understand the breadth of the already existing Grade A recommendation and to ease reimbursement difficulties for increased risk HIV testing.