

NATIONAL HIV/AIDS STRATEGY IMPLEMENTATION RECOMMENDATIONS

Submitted to the Secretary of the U.S. Department of Health and Human Services

By the Presidential Advisory Council on HIV/AIDS

February 28, 2012

1. NATIONAL HIV/AIDS STRATEGY SUCCESSES

Since the creation of the National HIV/AIDS Strategy (NHAS), progress has been made towards meeting the Strategy's access to care, health equity, and prevention goals and objectives. The successful implementation of the following programs and initiatives are examples of the progress we have made:

Access to Care and Quality Outcomes Successes

- The "ADAP as TrOOP" provision in the Affordable Care Act (ACA) has greatly enhanced the ability of state AIDS Drug Assistance Programs (ADAPs) to help individuals living with HIV on Medicare meet their Medicare Part D co-payment obligations. This has both enhanced Medicare beneficiaries' prescription drug access through the Medicare Part D program and reduced these beneficiaries' dependence on ADAP.
- The Pre-Existing Condition Insurance Plans (PCIPs) created by the ACA are now available in every state to people living with HIV who have traditionally been excluded from the individual insurance market because of discrimination based on their health status. Twelve states have implemented ADAP premium assistance programs to further assist these individuals.
- The Centers for Medicare and Medicaid Services (CMS) released helpful guidance and an application template to support states' ability to apply for 1115 waivers to provide immediate access to Medicaid for low-income people living with HIV.
- CMS issued guidance around the ACA's Medicaid health home program option, clarifying that HIV could be included as a chronic condition eligible for enhanced Medicaid health home services, and at least two states (New York and Oregon) have specifically identified HIV as an eligible chronic condition in their proposed state plan amendments.
- The Department of Health and Human Services (HHS) is actively engaged with all federal partners to harmonize and critically evaluate HIV quality performance and outcome metrics across all agencies, as well as private partners.
- The Health Resources and Services Administration (HRSA) has awarded contracts to increase training of primary care physicians in HIV medicine.

Health Disparities Successes

- The Administration's increased attention to the impact of the domestic HIV epidemic on men who have sex with men (MSM) and particularly black MSM, is to be applauded. In particular, the Centers for Disease Control and Prevention (CDC) has successfully undertaken efforts to expand access to proven HIV prevention programs for gay and bisexual men, and to develop new approaches to fight HIV in this population.
- In keeping with the goals of the NHAS, starting in January 2012, the CDC began awarding the first year of a five-year HIV prevention funding cycle for health departments in states, territories, and select cities using a more accurate funding methodology. The new approach, while controversial as many

jurisdictions with serious and ongoing HIV prevention needs experienced significant funding losses, bases funding on the number of people reported to be living with an HIV diagnosis in a given jurisdiction, rather than the outdated method of basing allocations on AIDS cases.

Prevention Successes

- HHS and the CDC have coordinated a broad cross-section of federal and other resources to target HIV-specific services focused on the twelve urban jurisdictions that bear the highest AIDS burden in the United States, especially focusing on intensive planning to optimize prevention services in each of the twelve jurisdictions.
- The Administration has demonstrated a commitment to HIV prevention by supporting increases in HIV prevention funding in FY11 and FY12.
- Research from the National Institutes of Health (NIH) has helped us to better understand the prevention potential of HIV testing and antiretroviral drugs (beyond the successful interventions that have greatly reduced mother to child transmission of HIV).

Global Successes

- Recently there have been increased investments in HIV programming for men who have sex with men (MSM) by PEPFAR and other donors. PEPFAR issued guidance on MSM-related services last year and has targeted increasing funds to the effort.

2. ONGOING NATIONAL HIV/AIDS STRATEGY PRIORITIES

To make continued progress toward the goals of the NHAS, and to ensure that we reach the President's 2015 benchmarks, we respectfully offer the following 2012 priorities for review and adoption by the Administration:

Access to Care and Quality Outcomes Challenges

Fully Implement the Affordable Care Act's Testing, Prevention, Care and Treatment Provisions

To achieve the NHAS goals of increasing access to care, optimizing health outcomes, reducing health disparities, and decreasing new infections, the Administration must continue to work to fully implement the ACA and make access to testing, linkage to care, and treatment services a reality. More specifically, we respectfully urge the Secretary of HHS to set policies that ensure that the transition of thousands of currently uninsured people living with HIV and AIDS to Medicaid and private insurance through the Exchanges provides uninterrupted and comprehensive care for people living with HIV. A successful transition will include the incorporation of HIV/AIDS primary care providers into Medicaid and Qualified Health Plan networks, the inclusion of AIDS service providers, including peers, as navigators for outreach, enrollment and retention efforts, and coordination between Medicaid and the Exchanges that promote continuity of care. To achieve such a transition, it is critical that people living with HIV, their medical and support service providers, and advocates are included as stakeholders in the development of these new systems.

Increasing access to HIV care through the ACA will be meaningless and efforts to reduce health disparities undermined without routine HIV testing and a comprehensive health benefits package. It is imperative that protections ensuring access to care for people living with HIV and other high cost medical conditions be included in guidance and regulations implementing the Essential Health Benefits (EHB) package, which will become the floor for benefits offered in plans sold through the Exchanges as well as Medicaid benefits

for newly eligible beneficiaries. A recent Bulletin issued by HHS adopting a “benchmark approach” to EHB implementation indicates an alarming degree of state flexibility with regard to the scope of services plans will be required to cover. Future regulations must ensure that even within a benchmark approach, there are adequate protections to guarantee access to comprehensive care for people living with HIV and other vulnerable populations.

The ACA’s investments in public health, prevention and wellness must be fully implemented and include significant new investments in HIV prevention as well as the training of new HIV primary care and specialty providers. To maximize the opportunities created by the ACA’s investments in Federally Qualified Health Centers (FQHCs), the HRSA’s Bureau of Primary Health must ensure that FQHCs are providing high quality and comprehensive care and treatment for people living with HIV.

The PACHA requests the opportunity to discuss these policy recommendations with HHS leadership to further inform and explore ways in which the ACA can be implemented to meet the care and treatment needs of people living with HIV.

Provide Ongoing and Sufficient Funding of the Ryan White Program

While the ACA, if fully implemented, will expand access to HIV care and treatment, the Administration must continue to work diligently to ensure ongoing and sufficient levels of funding for the Ryan White Program.

It is premature to discuss either health care reform-related cost-offsets or the destabilization of Ryan White Program-supported HIV care, treatment, and disease management services in the absence of demonstrated and successful integration of HIV care, treatment and service models into newly created health care delivery systems.

In addition, Ryan White Programs will clearly be needed even beyond full implementation of the ACA to fill gaps in care, treatment and essential support services for people living with HIV, as well as to close gaps in affordability. While HIV is now a chronic health condition for most people in care, it is still a communicable disease and a major public health concern in the United States. Ongoing success in addressing the HIV epidemic requires ongoing support of the HIV-specific expertise and experience cultivated by the Ryan White Program.

The PACHA looks forward to working with HHS and HRSA to evaluate the ongoing ACA integration of HIV care, treatment and service models into newly created health care delivery systems and to assess the impact of this integration on the Ryan White Program.

Maximize Accountability and Effectiveness by Overhauling HIV-related Performance Metrics

Over the next year, we encourage HHS, the Office of National AIDS Policy (ONAP), and other partners, in conjunction with Presidential Advisory Council on HIV/AIDS (PACHA), to finalize work on a streamlined, practical and prioritized set of HIV measures and reporting requirements. Such an effort will save administrative resources and allow for the construction of a comprehensive “dashboard” by which the epidemic can be thoroughly monitored and managed. Identifying a smaller number of critical metrics to be collected across agencies will help the nation focus on central outcomes and impacts, set the stage for cross-agency and intra-agency reallocation of resources to achieve optimal HIV care and prevention impact, and allow for identification of specific ways in which HIV programs can be strategically coordinated with sexually transmitted infections services, hepatitis programs, and substance abuse treatment interventions.

Addressing HIV-Related Health Disparities

Follow Through on PACHA Resolution on Young Black Men Who Have Sex with Men

PACHA developed a resolution with a set of recommendations for addressing the significant health disparities that exist for men who have sex with men (MSM), particularly black MSM (BMSM) and even more specifically young black MSM (YBMSM). The PACHA reaffirms the set of recommendations outlined in the resolution and again requests that the Secretary of HHS convene a high-level summit (including government and non-government stakeholders) on the HIV epidemic and its impact on YBMSM and create a department-wide task force charged with developing a comprehensive plan to address all aspects of the epidemic among YBMSM.

In addition, several other important interventions are necessary to address ongoing health disparities among YBMSM, including the following: HIV prevention, care and treatment funding distribution methodologies must be aligned with the epidemic in ways that adequately support the needs of populations disproportionately impacted by HIV, including YBMSM; knowledge gained from studies of social determinants of health must be integrated into all interventions that might help to reduce inequalities in health; the NIH must develop and issue a high priority research plan by March 31, 2012, that addresses HIV among YBMSM, including evaluating the potential benefits of biomedical interventions (such as Pre-Exposure Prophylaxis or PrEP and treatment as prevention) and the use of novel technologies and other strategies to engage YBMSM in care and treatment and combination prevention strategies; and finally, the HRSA and the CMS must require all physicians practicing at publicly-funded institutions or receiving public reimbursement for the delivery of health care services to undergo continuing medical education (and certification where available) in HIV testing, care and treatment.

Revise the Funding Methodology of the Housing Opportunities for Persons with AIDS Program

We urge the Secretary of HHS to work directly with the Secretary of Housing and Urban Development (HUD) to modernize the funding methodology used for the distribution of the Housing Opportunities for People with AIDS (HOPWA) program. HOPWA currently bases funding allocations on cumulative AIDS cases, including more than 600,000 deceased persons when calculating the distribution of limited HOPWA resources. Additionally, the current HOPWA funding methodology sets aside 25% of its formula funding to provide “bonus” funds to 31 urban areas with higher AIDS incidence than the national average. Of this 25% set-aside, seven metropolitan areas receive 72% of the funding, resulting in a per-case allocation of \$10,030, compared to an average \$202 per-case allocation for grantees ineligible for the set-aside. In order to more successfully address health disparities, improve health outcomes and reduce risk behaviors, HOPWA resources must be more effectively allocated. The foundation for funding distribution must shift to an approach based on living HIV and AIDS cases. We must also reevaluate the 25% set-aside to better target HOPWA formula funds. Consideration of levels of poverty and fair market rent, for example, must be considered to ensure a more effective allocation of limited HOPWA resources. This realignment of HOPWA funding is critical, as stable housing has been recognized by a substantial body of research to improve health outcomes, to reduce risk behaviors that result from inadequate housing, and to be cost-effective as a structural intervention.

Support the Development of Safe and Voluntary HIV Disclosure Recommendations and Denounce Stigma

A workgroup comprised of CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment (CHAC) and PACHA members has been soliciting public input to inform the development of a set of recommendations for normalizing and promoting individuals’ safe, voluntary disclosure of their HIV status. HHS must help to further this effort by convening a series of meetings with the workgroup, leading

researchers and practitioners, and people living with HIV. In addition to these efforts, the Administration must strongly denounce all actions that contribute to the stigmatization of persons living with HIV, including HIV criminalization laws, and support the development and implementation of a sustained, national HIV anti-stigma campaign informed by people living with HIV.

Reducing New HIV Infections

Refine Evidence-Based Prevention Programs

As recognized by the Administration, exciting scientific findings released in 2011 have provided further evidence that HIV treatment not only plays a major role in improved health outcomes for persons living with HIV, but also is crucial in preventing the forward transmission of HIV. The full potential of this important finding must be realized. Unfortunately, while we may have the science to achieve an "end to AIDS," we have not yet translated this science into practice with the breadth and scale necessary to achieve our national goals. In 2011, it was estimated that more than 450,000 people living with HIV in the U.S. are not linked to HIV care, and over 850,000 do not have suppressed viral load (our clinical standard of success).

In the spirit of continued, but more aggressive, domestic progress, we strongly urge that over the coming year, a broad cross-section of federal and private sector partners commit to maximizing the effect of such research findings at the population level. To achieve these and related goals of the NHAS, by July 2012, we urge the following: 1) that HHS convene and sponsor a landmark "State of the Science" conference to examine and recommend the best possible array of interventions to facilitate the aggressive movement of persons living with HIV across the treatment continuum; 2) that this conference include a meaningful review of the social, economic, cultural and structural issues that influence the development of successful HIV prevention and access to care initiatives, (including HIV testing and linkage to care, retention in care, and cultural competency); and 3) that the Secretary direct CMS to establish an HIV screening indicator as a measurement of Quality Service Delivery for all providers receiving public funding consistent with the most recent CDC testing recommendations.

Invest in and Target Prevention as a Cost-Saving Public Health Strategy

The historic economic downturn and the scarcity of public resources have greatly undermined efforts to adequately invest in cost-saving public health strategies. Yet, according to a 2010 publication in *the Journal of Acquired Immune Deficiency Syndromes*, underinvestment in HIV prevention, in particular, will actually result in higher costs for our nation. To truly bend the HIV cost curve, we must dramatically bend the HIV incidence curve and this requires significant increases in domestic HIV prevention funding.

In addition to increased funding, there is an increasing consensus that funding allocations must be aligned with both the current distribution of HIV as well as emerging HIV epicenters, (such as the southeast United States.) While resource realignment efforts are underway in at least one federal agency, as is evidenced by recent CDC resource distribution decisions, many more federal agencies must commit to meaningful resource realignment. It is imperative that we address the infrastructure needs of communities most hard hit by the epidemic, especially, black gay men, the Southeast, women of color and transgender persons. Such an effort must include federal agencies working closely with community-based organizations to better understand their role in – and adapt to – the changing public health and medical service delivery landscape in the era of the ACA.

Avoid Backsliding on the Administration's Key HIV Prevention Policy Victories

While, the Administration is to be commended for instituting several key HIV policies that reflect a

commitment to science and a humanitarian mission, regrettably, several of these policies have been reversed or are being actively threatened. The ban on federal support of syringe exchange programs is now back in place with the President's signing of the most recent Congressional Appropriations bill. The ban on entry for persons living with HIV coming in the U.S. has been lifted, but there are case reports of people with a passport marked as HIV positive being detained for additional questioning at the border. The Administration rightfully supported divestment of scientifically unsubstantiated abstinence-only HIV prevention programs, yet these programs are once again receiving federal funding.

As a signal to its commitment to science and to achieving NHAS prevention goals, it is crucial that the Administration uphold all evidence-based policies, including full support of federal funding for syringe exchange, proper enforcement of the elimination of the entry ban, and non-investment in abstinence-only education. In addition, the Administration must work to integrate care and prevention concerns related to sexual and reproductive health with violence against women services and HIV services.

Addressing the Global Epidemic

Support Efforts to Address HIV among MSM and Other Critically Affected Populations Worldwide

The global HIV epidemic is having a devastating impact on gay men and other men who have sex with men (MSM) around the world. MSM are 19 times more likely to be living with HIV than people in the general population in low- and middle-income countries and they represent an estimated 10 percent of new infections each year. However, for decades the epidemic among MSM was officially ignored by many governments, donors, and whole societies.

To advance the AIDS response among gay men and other MSM worldwide, the Administration must continue in its commitment to support global health budgets, including, among other initiatives, a bold commitment to fund PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria. In addition, we urge HHS to work closely with the Office of the U.S. Global AIDS Coordinator in taking a leadership role in addressing the AIDS epidemic among MSM and other populations that are most critically affected throughout the world.

While there have been recent signs of improvement, in many countries gay male sexual behavior continues to be illegal, inhibiting access to needed services. There is also increasing evidence that some governments place restrictions on the use of PEPFAR and other donor funds for MSM-related HIV services based solely on ideology, not on science. The vision of an AIDS-Free Generation demands that the Administration actively work to promote human rights for sexual minorities and appropriate health services for this population, including the effective delivery of combination prevention and treatment services to MSM, including biomedical, behavioral, and structural interventions.

3. CONCLUSION

Scientific and other advancements have made it possible to meet the overarching NHAS goals of allowing all people living with HIV to live healthy and productive lives, of reducing new cases of HIV, of addressing health disparities, and of eventually ending the HIV epidemic. These advancements offer great promise. Making this promise a reality depends, in large part, on the successful and ongoing implementation of our Nation's National HIV/AIDS Strategy.