IOM Report on Public Financing and Delivery of HIV Care: Securing the Legacy of Ryan White

Health Resources and Services Administration
HIV/AIDS Bureau

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U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

Charge to the Committee

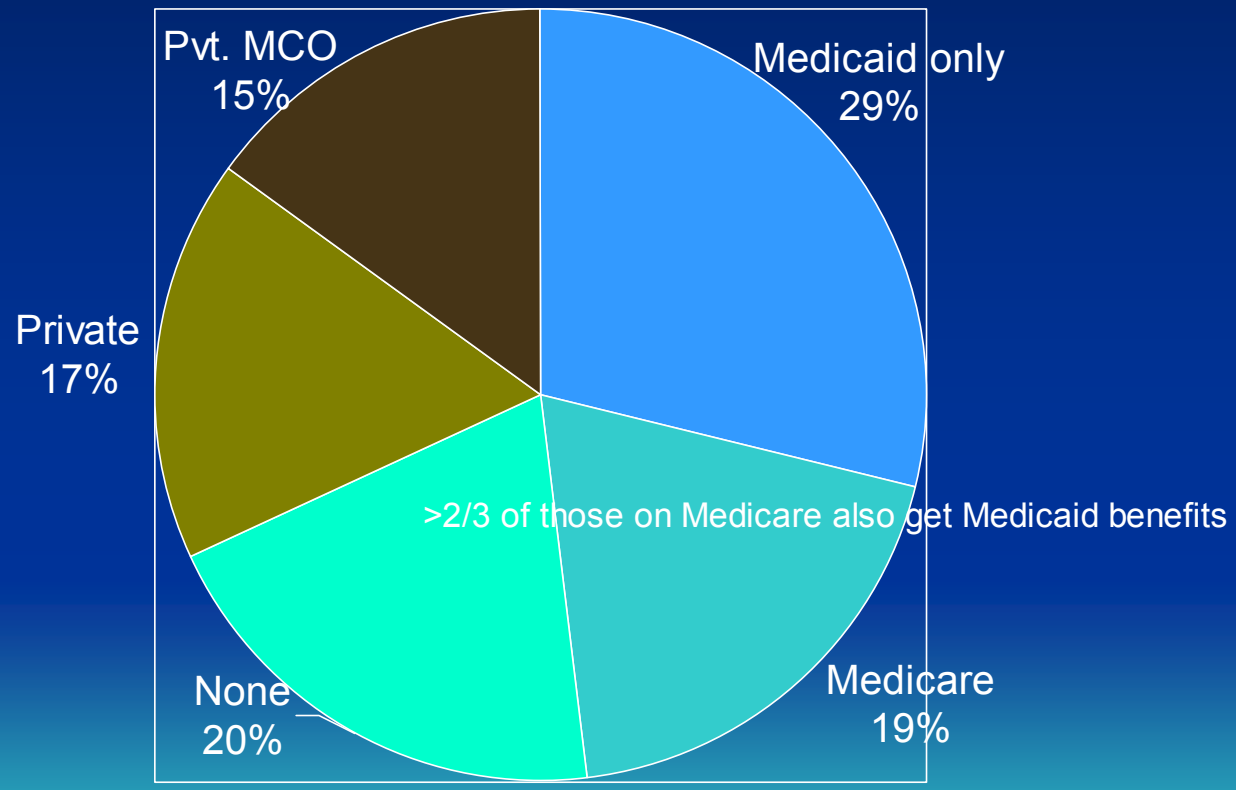
- The Secretary shall ensure that the study … considers the following:
- for Certain Individuals with HIV Disease.--

(B) The effectiveness and efficiency of service delivery (including the quality of services, health outcomes, and resource use) within the context of a changing health care and therapeutic environment, as well as the changing epidemiology of the epidemic, including determining the actual costs, potential savings, and overall financial impact of modifying the program under title XIX of the Social Security Act to establish eligibility for medical assistance under such title on the basis of infection with the human immunodeficiency virus rather than providing such assistance only if the infection has progressed to acquired immune deficiency syndrome.

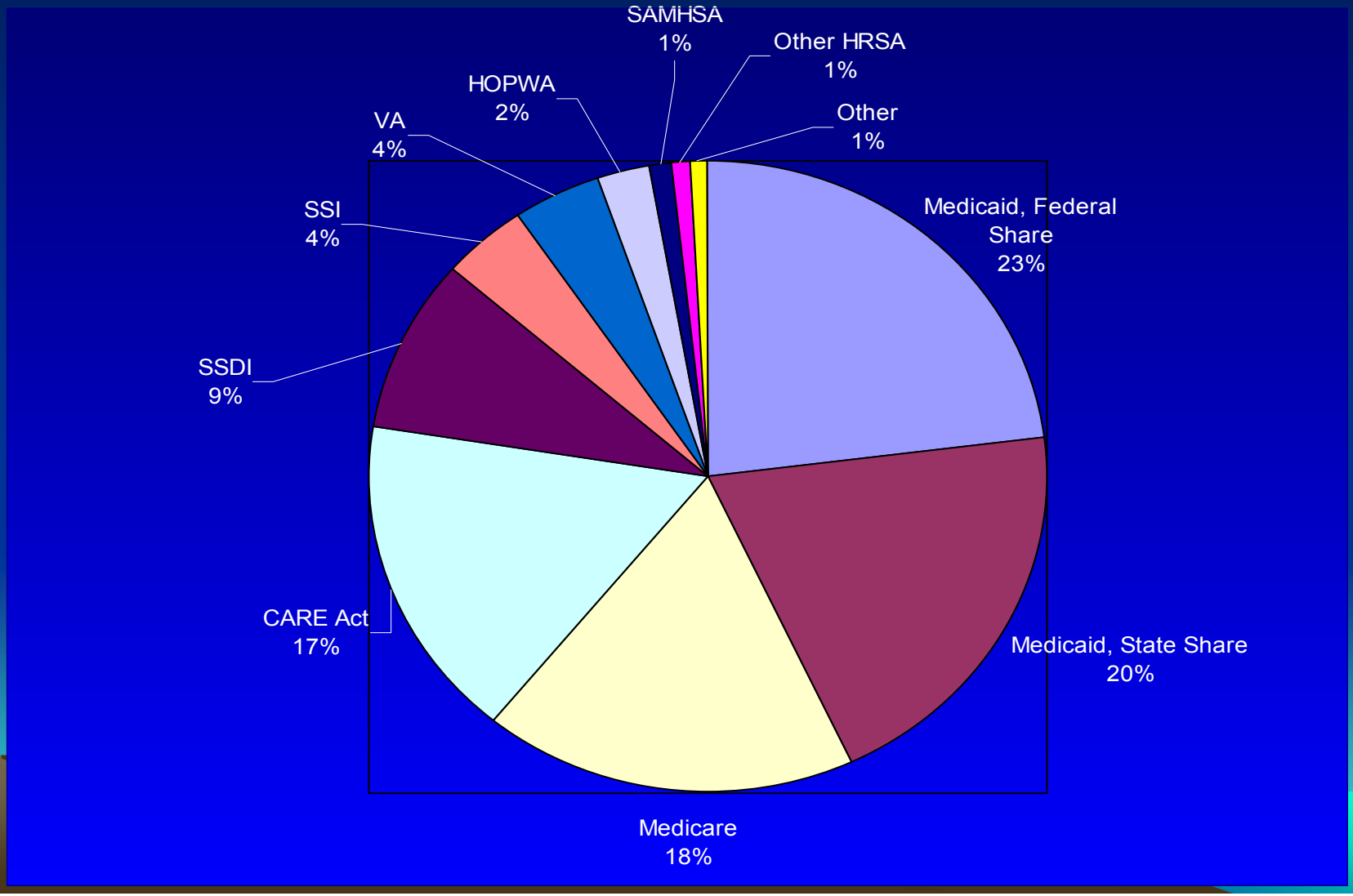
Additional Considerations in HRSA's Charge to the Committee

- Consider a public HIV care system that is
  - accessible,
  - equitable,
  - cost-effective,
  - of high quality,
  - comprehensive, and
  - easily negotiated

Insurance Coverage of PLWH in Care in the US: Results from HCSUS ('97)



Relative Shares of Public Funding ($9.545 Billion) for HIV Care & Assistance, FY '00



The Committee's Recommendation

- A new HIV Comprehensive Care Program (HIV-CCP)
  - Administered by the States, overseen by CMS
- Eligibility: ≤250% of the Federal poverty level (FPL)
  - (for documented residents only)
  - with spend-down and buy-in provisions
- Benefits:
  - Highly active antiretroviral therapy (HAART) and other medications
  - Obstetric and reproductive health services
  - Mental health and substance abuse treatment
  - Case management
  - HIV prevention services
  - Primary care (including outpatient, emergency, inpatient)

Participation

- For States, voluntary participation
  - 100% Federally financed, encouraging participation
  - Contrasts with 23% to 50% States pay for Medicaid
  - Administered through Medicaid or free-standing programs
- For providers, improved reimbursement
  - Relative to Medicaid—at Medicare rates (20% greater)
  - Expected to encourage participation
- For clients, eligibility based on HIV diagnosis
  - Medically Needy-like spend-down
  - Premiums for those with incomes >250% of the FPL
  - No assets test, but documentation required

Consequences for CARE Act

- Reduced scope
  - Eliminate Title I programs
  - Serve low-income immigrants ineligible for CCP
  - Reduce discretionary funds from $1.2 to $0.7 billion
- Services
  - Increased outreach and support (to get people on CCP)
  - Some Title III grantees: Centers of Excellence
  - Improve delivery of support services, and continue to fill gaps
  - Voluntary counseling and testing
  - Continuing role for AIDS Education & Training Centers

HIV-CCP Program Cost

- Additional $574 million in first year
  - Largely a transfer from State Medicaid programs to the Federal government
    - Additional Federal costs of $2.6 billion
    - State savings of $1.15 billion
    - Savings of $0.88 billion in care for the uninsured
  - More than 58,600 new HAART recipients
  - Drug savings of $419 million/year achievable
    - While sustaining R&D budgets for drug companies

Cost-Effectiveness

- Estimated ~$43,000 per quality-adjusted life year
  - Greater cost than annual colorectal screenings, front airbags in cars
  - Lower cost than home radon mitigation, coronary angioplasty, annual mammography for women 55-65
  - Decline of nearly 20,000 HIV-related deaths in the program's first ten years, a ~60% reduction
    - Largely from increased access to HAART
  - Reduction in new HIV infections by ~3,200 per year
    - Represent 40% of infections otherwise expected from program clients
    - Additional annual savings to the care system from averted infections of $14.4 million (not included in the financial model)

Options the Committee Considered

- CARE Act Expansion
  - The CARE Act has already worked with uninsured, local planning bodies
  - But there are coverage inequities and shortfalls, and poor program data
- Medicare Expansion
  - High provider participation, broad Federal funding base, accountability
  - But missing many services critical for PLWH (including drugs), poor long-term solvency

Medicaid Expansion Options (1)

- Similar to Section 1115 HIV Waivers, with added ancillary services
  - Already a mechanism to put them in place, their effectiveness can be evaluated
  - But no assurance of State participation, of uniform benefits, or of adequate provider reimbursement; varying State matching contributions not related to the varying burdens of the HIV epidemic; budget neutrality hard to achieve

Medicaid Expansion Options (2)

- Optional Eligibility Group to 250% of FPL
  - No waiver or budget neutrality required
  - But problems similar to the previous Medicaid option, with inequities in coverage and matching contributions across States, low provider reimbursement (affecting provider participation and quality of care), limited access to ancillary services; State participation unlikely

Medicaid Expansion Options (3)

- Optional Eligibility Group with increased Federal match
  - State contributions would be reduced by 30%, likely to increase participation
    - State liability ranging from 16% to 35% of costs
  - But the problems cited above remain (inequities in coverage and State costs, limited ancillary service access, hard for States to maintain their financial support)

Another Option Considered

- Federal Block Grants to States
  - State discretion in enrollment, benefits, and provider reimbursement, as with current State Children's Health Insurance Program; eligibility to 250% of FPL
  - But Federal contributions would be set in advance and capped, limiting responsiveness to changing needs; services not uniform across States; unequal State contributions hard to justify; difficult to obtain comparable program data across States

HIV-CCP Preferred by the Committee

- A new Federal entitlement program
  - Has the greatest likelihood of ensuring a uniform standard of high quality care
  - Revenues less limited at Federal than State level
  - Flexibility in State administrative arrangements
    - Through stand-alone or Medicaid program
  - HAART purchasing leverage by large program
  - But increased burden on Federal budget, no maintenance of State/local financial effort, less opportunity than CARE Act for local planning input

CCP's Chronic Care Orientation

- The HIV service system has not changed much from an acute care model, but should
  - Improve HAART access, adherence
- HAART improves quality and length of life, and it can slow the epidemic's spread
  - Ob/gyn care would reduce vertical transmission
  - HAART reduces viral loads, improving health
  - Integrated prevention education would help reduce risk behaviors
    - Countering complacency of some receiving HAART

Mental Health, Substance Abuse Treatment Integrated into CCP

- Adherence with HAART of ≥90% is critical for individual and public health
  - Decreases the likelihood of drug-resistant HIV
- Treatment for mental health (MH), substance abuse (SA) issues improves adherence
  - About 50% of PLWH have MH issues
  - More than 25% have SA issues
- MH and SA treatment services are expected to increase HAART use by 40% and 70%, respectively, and case management, by 50%

Centers of Excellence (CoEs)

- The Committee recommends an HIV-CCP demonstration project for CoEs
  - Some Title III grantees could participate
  - Assure quality of care through experienced providers, with continuing education and integrated multidisciplinary services
  - Evaluation could be included, and clinical research would be
  - Reimbursement would be 5% above usual levels

HIV-CCP Program Features

- A new funding mechanism to provide high quality, integrated, publicly funded care to many PLWH
- Equalize access to care throughout the U.S.
  - Help fund HAART expansion in part through lower drug prices (27% cost reduction possible)
- Increase the odds of adherence to optimize HAART benefits by providing key ancillary services
- Provide prevention and ob/gyn services to help reduce the incidence of new HIV cases
- Transfer financial responsibility from State governments to the Federal government
- Maintain the CARE Act, but in a reduced role

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