



DEPARTMENT OF HEALTH & HUMAN SERVICES



Joint HHS, CMCS, HRSA, and CDC Informational Bulletin

Opportunities to Improve HIV Prevention and Care Delivery to Medicaid and CHIP Beneficiaries

December 1, 2016

Purpose

In July 2015, the White House released the National HIV/AIDS Strategy (NHAS) for the United States: Updated to 2020¹. The Strategy articulates four goals: 1) reduce new HIV infections; 2) increase access to care and improve health outcomes for people living with HIV (PLWH); 3) reduce HIV-related health disparities and health inequities; and 4) achieve a more coordinated national response to the HIV epidemic. Medicaid is the largest payer of HIV care in the United States², and the advent of the Affordable Care Act (ACA) has further expanded Medicaid access to many individuals living with, or at high risk for acquiring, HIV. States will, therefore, continue to play an instrumental role in achieving national goals, as outlined in the NHAS.

This Informational Bulletin (IB) informs state Medicaid agencies about important advances in HIV prevention, care and treatment that have occurred in the five years since the Center for Medicaid and CHIP Services (CMCS) outlined opportunities available to provide Medicaid coverage to individuals living with HIV in a letter to State Medicaid Directors (SMD) titled “Coverage and Service Design Opportunities for Individuals Living with HIV,” which can be found at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/11-005.pdf>. Additionally, this IB highlights opportunities available to state Medicaid programs to drive improvements in the accessibility, quality, cost, and population-level impact of HIV prevention and care services available to Medicaid beneficiaries.

Background

¹ National HIV/AIDS Strategy for the United States: Updated to 2020. <https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf>. Accessed June 30, 2016.

² Centers for Disease Control and Prevention. Behavioral and Clinical Characteristics of Persons Receiving Medical Care for HIV Infection—Medical Monitoring Project, United States, 2013 Cycle (June 2013–May 2014). HIV Surveillance Special Report 16. <http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-hssr-mmp-2013.pdf>. Accessed June 30, 2016. According to data from the Medical Monitoring Project (MMP), a CDC surveillance system that collects locally and nationally representative behavioral and medical record data from people living with HIV, 42% of PLWH who were receiving HIV medical care in 2013 were insured through Medicaid.

The Centers for Disease Control and Prevention (CDC) estimates that approximately 1.24 million persons in the United States are living with HIV infection, and about 13% of those individuals are unaware of their infection³. In the United States, the HIV epidemic is more prevalent in certain geographic areas and populations^{4,5}. Nearly half of people living with HIV (PLWH) who are currently receiving care for their infections have incomes at or below the federal poverty level (\leq 100% FPL) and so are potentially eligible for Medicaid or Child Health Insurance Program (CHIP) coverage⁶. Substantial population and geographic disparities characterize HIV-related health outcomes as well. In its most recent State HIV Prevention Progress Report for 2010 - 2013, CDC found substantial variance among states with respect to a range of measures, including death rates among persons diagnosed with HIV and the percentages of people living with HIV who were aware of their infections and successfully linked to, and subsequently retained care⁷.

The science of HIV prevention and care has advanced rapidly over the past 5 years⁸. A series of landmark studies, including HIV Prevention Trial Network (HPTN) 052, Strategic Timing of Antiretroviral Treatment (START), and TEMPRANO ANRS, have conclusively demonstrated that early treatment offers important preventive and clinical benefits, including gains in life expectancy, better quality of life, longer delay in average time until onset of AIDS, and fewer transmissions^{9,10,11,12}. To reduce the morbidity and mortality associated with HIV infection, the

³Centers for Disease Control and Prevention. [Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2014. HIV Surveillance Supplemental Report 2016; 21\(No. 4\).](http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-21-4.pdf) <http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-21-4.pdf>. Accessed August 1, 2016.

⁴Centers for Disease Control and Prevention. HIV Surveillance Report, 2014; vol. 26. <http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-us.pdf>. Accessed June 30, 2016. See also <http://www.cdc.gov/hiv/pdf/library/slidesets/cdc-hiv-surveillance-genepi.pdf> for graphical representations of these disparities.

⁵NHAS: Updated to 2020 (see footnote 1)

⁶CDC, Medical Monitoring Project, United States, 2013 Cycle (June 2013–May 2014) (see footnote 2)

⁷Centers for Disease Control and Prevention. State HIV Prevention Progress Report, 2010–2013. <http://www.cdc.gov/hiv/pdf/policies/progressreports/cdc-hiv-stateprogressreport.pdf>. Accessed June 30, 2016.

⁸Due to space constraints, this information bulletin only highlights a few key developments within the broader suite of changes that have occurred between 2010 and 2015. For a more complete description of important scientific advances in the arenas of HIV prevention and care, see <https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update-5-things.pdf>.

⁹Farnham PG, Gopalappa C, Sansom SL et al. Updates of lifetime costs of care and quality-of-life estimates for HIV-infected persons in the United States: late versus early diagnosis and entry into care. *Journal of Acquired Immune Deficiency Syndrome*. 2013; 64(2): 183-9.

¹⁰Cohen MS, Chen YQ, McCauley M, Gamble T, Hosseinipour MC, Kumarasamy N et al. Antiretroviral Therapy for the Prevention of HIV-1 Transmission. *New England Journal of Medicine* 2016; published online July 18, 2016; DOI: 10.1056/NEJMoa1600693

¹¹The INSIGHT START Study Group. Initiation of Antiretroviral Therapy in Early Asymptomatic HIV Infection. *The New England Journal of Medicine*. 2015; 373 (9): 795-807.

¹²TEMPRANO ANRS 12136 Study Group. A Trial of Early Antiretrovirals and Isoniazid Preventive Therapy in Africa. *New England Journal of Medicine* 2015; 373 (9): 808-22.

*Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*¹³ strongly recommend antiretroviral treatment (ART) for all HIV-infected individuals, regardless of CD4 T lymphocyte cell count.

Some antiretrovirals have also been shown to reduce HIV acquisition risk among people who are uninfected. Evidence from several large, randomized controlled trials indicates that daily oral pre-exposure prophylaxis (PrEP) with an FDA-approved, HIV prescription medicine can reduce HIV acquisition risk by more than 90% when taken as prescribed¹⁴. Recent PrEP demonstration studies and programs have also shown that maintaining the requisite high levels of adherence is possible and results in high levels of effectiveness under “real world” conditions^{15,16}. As a consequence, the U.S. Public Health Service (USPHS) recommends PrEP as one prevention option for people who are HIV-negative and at substantial risk for HIV¹⁷.

Advances in HIV surveillance systems and methods have improved federal, state, and local efforts to evaluate and improve outcomes along the HIV care continuum. The HIV care continuum—sometimes referred to as the HIV treatment cascade—is a model that outlines the stages of HIV medical care that PLWH go through from initial diagnosis to achieving the goal of viral suppression, showing the proportion of PLWH who are engaged at each stage. States that have successfully implemented requirements that laboratories report all CD4 values and viral load (VL) test results to HIV surveillance programs are able to calculate the full HIV care continuum for their residents¹⁸. Data from these jurisdictions, which are also used to track progress towards national objectives, indicate that only 55% of persons diagnosed and living with HIV were virally suppressed at the end of 2013¹⁹.

¹³Panel on Antiretroviral Guidelines for Adults and Adolescents. *Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents*. Department of Health and Human Services.

<https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-treatment-guidelines/0>. Accessed June 30, 2016.

¹⁴ U.S. Public Health Service. *Preexposure Prophylaxis for the Prevention of HIV Infection in the United States—2014 Clinical Practice Guideline*. May 2014. <http://www.cdc.gov/hiv/pdf/PrEPguidelines2014.pdf>. Accessed June 30, 2016.

¹⁵Liu AY, Cohen SE, Vittinghoff E, Anderson PL, Doblecki-Lewis S, Bacon O et al. Preexposure Prophylaxis for HIV Infection Integrated With Municipal- and Community-Based Sexual Health Services. *JAMA Intern Med*. 2016; 176 (1): 75-84.

¹⁶Grant RM, Anderson PL, McMahan V, Liu A, Amico KR, Mehrotra M et al. Uptake of pre-exposure prophylaxis, sexual practices, and HIV incidence in men and transgender women who have sex with men: a cohort study. *The Lancet Infectious Diseases*. 2014; 14 (9): 820-9.

¹⁷ The guidelines (see footnote 14) and their associated provider’s supplement (available at <http://www.cdc.gov/hiv/pdf/PrEPProviderSupplement2014.pdf>) provide detailed algorithms that can be used to assess sexual and/or injection drug transmission risks.

¹⁸ Details about state specific progress toward successfully implementing such reporting requirements is available from CDC’s 2015 Prevention Status Reports. Available at: <http://www.cdc.gov/psr/>. Accessed June 30, 2016.

¹⁹ Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas—2014 (see footnote 3)

The aforementioned scientific advances, as well as important shifts in health policy and delivery system landscapes resulting from the Affordable Care Act's passage in 2010²⁰, present opportunities for states to improve HIV prevention and care outcomes among their residents. Through their design and implementation of benefits and programs, state Medicaid programs are instrumental to realizing these opportunities.

In 2013, the Health Resources and Services Administration (HRSA) and the Center for Medicaid and CHIP Services (CMCS) jointly released an Informational Bulletin regarding coordination between Medicaid and Ryan White HIV/AIDS Programs. HHS noted that Ryan White Programs were the payer of last resort and could be used to wrap additional benefits not covered by Medicaid. Additionally, CMS and HRSA announced a series of webinars for states, providers and stakeholders conducted throughout the second half of 2013. The Informational Bulletin, dated May 1, 2013, may be found at <https://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html>.

HIV Testing and Diagnosis

HIV testing functions as an entry point to prevention and care services for Medicaid beneficiaries. Those who test negative but are at increased risk for infection can be linked to appropriate prevention services (including PrEP). Those who test positive for HIV can be linked to HIV medical care and begin ART. While early diagnosis and treatment may be associated with greater aggregate costs for HIV care over a 30+ year time horizon²¹, *annual* and *5-year* average costs for HIV care are typically much lower for persons who are diagnosed earlier in the course of their infections^{22,23}. For example, in a recent analysis, Fleishman et al. found that the average annual Medicaid payment for medical and support services was \$65,967²⁴ per beneficiary for those whose CD4 count fell below 200 cell/mm³ at the start of the measurement year. By contrast, the commensurate average annual Medicaid payment was \$36,377 for persons whose CD4 count was greater than or equal to 500 cells/mm³—a nearly 50% reduction²⁵.

²⁰ An overview of how key provisions of the ACA affect the accessibility, availability, affordability, and quality of HIV prevention and care services is available at <https://www.aids.gov/federal-resources/policies/health-care-reform/>. Accessed June 30, 2016.

²¹ In part because the lifetime in question is substantially longer and in part because the number of years on treatment (even in the absence of life expectancy gains) is greater.

²² Krentz HB, Gill J. Despite CD4 cell count rebound the higher initial costs of medical care for HIV-infected patients persist 5 years after presentation with CD4 cell counts less than 350 μ l. *AIDS*. 2010; 24 (17): 2750-2753.

²³ Gebo KA, Fleishman JA, Conviser R, et al. Contemporary Costs of HIV Healthcare in the HAART Era. *AIDS*. 2010; 24 (17): 2705-2715.

²⁴ The dollar values presented in this paper are standardized to US 2010 dollars.

²⁵ Fleishman JA, Monroe AK, Voss CC, Moore RD, Gebo KA. Expenditures for Persons Living With HIV Enrolled in Medicaid, 2006-2010. *J Acquir Immune Defic Syndr*. 2016; 72 (4): 408-15.

Additionally, early diagnosis and treatment of HIV infection improves both the length and quality of life and substantially reduces the number of new infections transmitted.²⁶

U.S. Preventive Service Task Force Screening Recommendations

The U.S. Preventive Services Task Force (USPSTF) recommends²⁷ that all persons between the ages of 15 and 65 be screened at least once for HIV infection, regardless of risk. Further, the USPSTF recommends repeat screening for individuals at increased risk²⁸ for infection (including at-risk individuals who are younger than 15 or over the age of 65). For individuals at very high risk of new HIV infections, who include men who have sex with men (MSM) and persons who inject drugs, the USPSTF suggests that an appropriate rescreening interval would be one year. Finally, the USPSTF recommends that all pregnant women be screened for HIV, including those who present in labor who are untested and whose HIV status is unknown²⁹.

State Medicaid programs are encouraged to ensure the availability, accessibility, and affordability of HIV testing services for beneficiaries living with, or at risk of acquiring HIV. Coverage design elements that can help accomplish this include removing cost-sharing barriers, as well as ensuring the availability of services from providers best suited to reach, and be reached by, target populations.

To this aim, prior to the ACA and the expansion of Medicaid to the new adult group, CMS released guidance in May 2000 to assist states to develop section 1115 demonstration proposals to expand Medicaid coverage to provide early treatment to PLWH³⁰. Two states utilized the

²⁶ Farnham, Paul G. PhD *; Gopalappa, Chaitra PhD *; Sansom, Stephanie L. PhD *; Hutchinson, Angela B. PhD *; Brooks, John T. MD *; Weidle, Paul J. PharmD *; Marconi, Vincent C. MD +, ++, [S]; Rimland, David MD +, ++ Updates of Lifetime Costs of Care and Quality-of-Life Estimates for HIV-Infected Persons in the United States: Late Versus Early Diagnosis and Entry Into Care. *JAIDS Journal of Acquired Immune Deficiency Syndromes*. 64(2):183-189, October 1, 2013.

²⁷ The USPSTF has assigned an “A” grade to its recommendation, indicating that there is a high certainty that the net benefit is substantial.

²⁸ Patient populations that would more likely benefit from more frequent testing include those who are known to be at higher risk for HIV infection (e.g., Men who have Sex with Men, active injection drug users, and persons recently diagnosed with a sexually transmitted disease, or STD), those who are actively engaged in risky behaviors (e.g., unprotected vaginal or anal intercourse), and those who live or receive medical care in a high-prevalence setting (e.g., TB or STD clinics).

²⁹ U.S. Preventive Services Task Force. Final Recommendation Statement: Human Immunodeficiency Virus (HIV) Infection: Screening. May 2015.

<http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening>. Accessed June 30, 2016.

³⁰ See guidance issued May 31, 2000 to State Medicaid Directors titled "1115 Waivers Proposal Guidelines that Target Individuals with HIV/AIDS," which can be found at <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd053100b.pdf>. Accessed October 18, 2016

1115 option to specifically target the expansion of coverage to PLWH while several other states included coverage of PLWH as part of a larger comprehensive 1115 demonstration³¹. In June 2011, CMS released additional guidance expanding opportunities to assist states in increasing access to care for PLWH through other mechanisms such as health homes, section 1915(c) home and community based services waivers, and section 1915(i) or 1915(k) Medicaid State Plan options in addition to section 1115 authority³². Through Medicaid state plan authority states have historically provided coverage for a variety of services for PLWH such as physician, hospital, other licensed practitioner, pharmacy, and rehabilitation services.

In the Health Insurance Marketplace and for the Medicaid expansion population, the Affordable Care Act (ACA) requires the coverage of Essential Health Benefits (EHB), which includes covering without cost sharing 1) preventive services that have in effect an “A” or “B” rating from the USPSTF, including HIV testing for all persons between the ages of 15 and 65; 2) immunizations recommended by the Advisory Committee on Immunization Practices (ACIP); and 3) guidelines for preventive care and screenings for women, infants, and children recognized by the Health Resources and Services Administration (HRSA)³³. In 42 CFR 440(c) and 45 CFR 156, CMS further clarified that these coverage requirements are included in the definition of EHB. Therefore, they are applicable to Qualified Health Plans (QHPs) sold through the Health Insurance Marketplace and Alternative Benefit Plans (ABPs) offered to Medicaid Expansion populations.

Authorized through section 4106 of the ACA, as part of their standard Medicaid benefit package for adults who are 21 and over, states that choose to cover without cost sharing all USPSTF A and B services and the ACIP recommended immunizations and their administration are eligible to receive a one percentage point Federal medical assistance percentage (FMAP) increase for these services³⁴. To date, 12 states³⁵ have applied for and received such an increase.

State Medicaid programs are also encouraged to be creative in exploring potentially more efficient options for delivering HIV testing and other critical preventive services that are

³¹ Two states implemented 1115s targeted to only PLWH: 1) Washington, D.C. was approved in 2001 and operated until January 2011 when coverage transitioned to the State Plan option for the new adult group as authorized by ACA; and 2) Maine was approved in 2000 and continues to serve PLWH under a targeted 1115 demonstration as of the date of this release. The following states provide coverage to PLWH as part of a statewide comprehensive 1115 demonstration: CA, FL, MA, NY, OR, and RI. See [Medicaid.gov](http://www.Medicaid.gov) for more information on these demonstration programs.

³² See guidance issued June 6, 2011 to State Medicaid Directors titled "Coverage and Service Design Opportunities for Individuals Living with HIV (#11-005)," which can be found at <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/11-005.pdf>. Accessed October 18, 2016

³³ Coverage of Certain Preventive Services Under the Affordable Care Act, 80 FR 41317 (July 14, 2015)

³⁴ See In guidance issued in 2013 to State Medicaid Directors titled “Affordable Care Act Section 4106 (Preventive Services),” which can be found at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-002.pdf>. Accessed September 20, 2016

³⁵ CA, CO, DE, HI, KY, NH, NJ, NV, NY, OH, WA and WI

recommended by the USPSTF to beneficiaries. As discussed in previous guidance³⁶, CMS revised its regulatory definition of preventive services at 42 CFR 440.130(c) to be consistent with the statutory provision at section 1905(a) (13) of the Social Security Act (the Act) that governs preventive services. Specifically, section 1905(a) (13) indicates that services must be “*recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law.*” Accordingly, at their option, states may submit a state plan amendment (SPA) in which they propose to cover preventive services³⁷ that are recommended by physicians or other licensed practitioners, but provided by unlicensed practitioners who meet the qualifications established by the state, provided the rest of the requirements for the preventive services benefit are met. States may leverage this change to expand access to HIV testing services among Fee-For-Service (FFS) Medicaid and CHIP beneficiaries by, for example, extending coverage to HIV testing conducted in community settings by Disease Intervention Specialists (DIS) or community health workers (CHWs). To the extent allowed by applicable Federal and state regulations, states that contract with Managed Care Organizations (MCOs) to deliver health care services to Medicaid and CHIP beneficiaries may consider adding contractual provisions that similarly allow or incentivize coverage for HIV testing services provided by DIS, CHWs, or other qualified non-licensed, community-based practitioners.

Pre-Exposure Prophylaxis (PrEP) for HIV Prevention

Pre-exposure prophylaxis, or PrEP, refers to a new prevention method in which people take a daily pill containing an antiretroviral medication emtricitabine and tenofovir disoproxil (Truvada®) that has been shown to safely and effectively reduce the risk of HIV acquisition in a variety of populations³⁸. The FDA has approved the combination of emtricitabine and tenofovir disoproxil for a PrEP indication among adults who are at high risk for acquiring HIV. However, while PrEP is a highly effective, safe intervention for HIV prevention, it is also an under-utilized one.

In 2014, the U.S. Public Health Service (USPHS) released *Preexposure Prophylaxis for HIV Prevention in the United States - 2014: A Clinical Practice Guideline*, the first comprehensive clinical practice guidelines for PrEP³⁹. Among other things, these guidelines

- Provide criteria for determining a person’s HIV risk and indications for PrEP use;

³⁶ *Update on Preventive Services Initiatives*. Center for Medicaid and CHIP Services, CMS, November 2013. <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-11-27-2013-Prevention.pdf>. Accessed June 30, 2016.

³⁷ Details about which preventive services do and do not qualify are available in 42 CFR 440.130(c) and the State Medicaid Manual Section (SMM) 4385

³⁸ USPHS, *Preexposure Prophylaxis for the Prevention of HIV Infection in the United States—2014 Clinical Practice Guideline*. See especially the evidence summaries in Tables 2-6 (see footnote 14)

³⁹ *Ibid.*

- Recommend regular clinical follow-up that includes periodic rescreening for HIV infection and other sexually transmitted diseases, as well as assessment for side effects, adherence, and HIV acquisition risk behaviors;
- Underscore that PrEP is not the only option for reducing HIV risk, and its use does not obviate the importance of, or need for, other risk-reduction approaches (e.g., using condoms); and
- Clarify that PrEP is not intended or expected to require a lifelong commitment—people may discontinue PrEP for a variety of reasons, including changes in their life situations that substantially reduce or eliminate their risk for acquiring HIV.

States that elect to provide prescription drug benefits must comply with the requirements of section 1927 of the Act, which in paragraph (d) provides parameters for limitations on coverage of outpatient drugs of manufacturers that have in effect rebate agreements.

States have the discretion to establish certain limitations, prior authorization processes or preferred drug lists, on the coverage of PrEP to ensure appropriate utilization when medically necessary; however, we encourage states to take steps to ensure that PrEP is available consistent with USPHS recommendations. For example, neither Colorado nor Washington State subject emtricitabine/ tenofovir to prior authorization processes when it is prescribed for HIV treatment *or* HIV PrEP. Because regular HIV and STD tests are recommended for persons who initiate PrEP, Washington’s Medicaid program also facilitates access to these testing services by covering their receipt on a quarterly basis and in a range of settings that may be more convenient or comfortable for beneficiaries (e.g., family planning clinics, local health departments, or primary care settings). States should ensure that beneficiaries being initiated on PrEP are educated about and provided with sufficient supportive care to ensure adherence to regimens. Additional strategies states may consider to ensure that utilization management techniques are not designed or implemented in ways that amount to denial of access to PrEP among persons for whom it is indicated include 1) provider education, 2) development of clear policies and procedures for assessing and making determinations about indications for PrEP, and 3) careful review and monitoring of Medicaid FFS and managed care benefits and coverage.

Linkage to and Retention in Care for People Living with HIV

For PLWH to achieve and maintain virologic suppression, they must be linked to and remain engaged in HIV care and treatment. National and state-specific estimates of the HIV care continuum indicate that significant numbers of PLWH do not enter HIV care following their diagnosis and even greater numbers do not remain in care. In 2013, only slightly more than half of persons who had been diagnosed with HIV were successfully retained in care; state-specific averages (from the 33 jurisdictions with complete CD4 and VL reporting) ranged from a low of 30% to a high of 68%--which is substantially lower than the national goal that 90% of persons

living with diagnosed HIV infections be retained in HIV care^{40,41}. Linkage to and retention in HIV care and treatment are crucial to achieving sustained viral suppression, which can result in reduced transmission to others and improved clinical outcomes for persons living with HIV infection.

PLWH often face a variety of medical and social challenges that impede their access to, retention in, and adherence to HIV care and treatment. These include increased risk for, and prevalence of, comorbidities such as depression and substance use disorders⁴². They also include broader social determinants of health, including poverty, unemployment, homelessness, and inadequate access to transportation⁴³. Comprehensive, coordinated, patient-centered delivery systems and models of care thus offer important means through which states can improve outcomes among their Medicaid and CHIP beneficiaries living with HIV.

State Innovations to Support Engagement in HIV Care

The Medicaid Health Home State Plan Option, as authorized under the Affordable Care Act (Section 2703), can be a particularly effective model for coordinating and delivering the medical care, behavioral health care, and community-based social services and supports PLWH need to successfully navigate the HIV care continuum and achieve viral suppression. Many of the services that define the Health Home model—including comprehensive care management, care coordination and health promotion, individual and family support, and referral to community and social support services—are recommended strategies for improving engagement in care among PLWH^{44,45}. These mandated core services of the Medicaid health home are also core elements of the comprehensive system of care developed and supported through the Ryan White HIV/AIDS

⁴⁰ See especially Table 4b from Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas—2014 (see footnote 3)

⁴¹ NHAS: Updated to 2020 (see footnote 1)

⁴² CDC, Medical Monitoring Project, United States, 2013 Cycle (June 2013–May 2014) (see footnote 2)

⁴³ Ibid.

⁴⁴ Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, American Academy of HIV Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, the National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services. *Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States, 2014*. <https://stacks.cdc.gov/view/cdc/26062>. Accessed July 1, 2016.

⁴⁵ U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Rockville, MD: U.S. Department of Health and Human Services. <http://hab.hrsa.gov/deliverhivaidscares/2014guide.pdf>. Accessed July 1, 2016.

Program (RWHAP)⁴⁶, which has been shown to achieve high rates of retention in care and virologic suppression⁴⁷.

As of August 2016, 19 states and the District of Columbia have a total of 28 approved Medicaid Health Home models. Four of these states—Alabama, New York, Washington, and Wisconsin—have included HIV-infection among their eligibility criteria. Wisconsin has elected to focus its Health Home model on Medicaid and CHIP beneficiaries who are living with HIV and either have, or are at risk of developing, another chronic condition⁴⁸. States interested in implementing Health Home models that include, or are specifically limited to, PLWH are encouraged to take advantage of the technical resource and support available through CMS, including those posted on the Health Home Information Resource Center page of Medicaid.gov⁴⁹. In particular, states may view slides from a 2014 presentation that Wisconsin gave about how it developed its HIV/AIDS Health Home⁵⁰.

While the Medicaid Health Home option offers states an important new opportunity for improving the health of PLWH, CMS would like to remind states that this option is but one tool in a broader toolkit that they can use to improve service delivery for the PLWH population. For example, many states have leveraged the Targeted Case Management service option to coordinate and improve access to medical, behavioral, and social services for PLWH. In Rhode Island, the success of this approach for improving outcomes among PLWH has inspired the state to develop a similar set of services for persons at high risk of acquiring HIV⁵¹. Similarly, states have long used the Home and Community Based Programs under section 1915(c) of the Act and section 1115 Demonstration authorities to develop unique programs to improve PLWH health outcomes. Currently, Alabama, California, Colorado, Florida, Illinois, Iowa, Missouri, New Mexico, and South Carolina have approved section 1915 (c) Programs through which they provide special, HIV-related services to adult PLWH. Many others successfully serve individuals with HIV/AIDS in their more broadly targeted waivers, which often offer a rich

⁴⁶ A federal grant program administered by the Health Resource and Services Administration (HRSA) that provides primary medical care and essential support services for people living with HIV who are uninsured or underinsured. For more information, please visit <http://hab.hrsa.gov/>.

⁴⁷ Doshi RK, Milberg J, Isenberg D et al. (2015). High rates of retention and viral suppression in the US HIV safety net system: HIV care continuum in the Ryan White HIV/AIDS Program, 2011. *Clin Infect Dis*. 2015; 60 (1): 117-25.

⁴⁸ Wisconsin's experience was recently profiled in a case study written by the National Academy for State Health Policy, Advancing HIV Prevention through Health Departments: Health Homes for People Living with HIV. http://www.nashp.org/wp-content/uploads/2016/06/Wisconsin-Health-Homes_v2_Pages.pdf. Accessed July 1, 2016.

⁴⁹ Health Home Information Resource Center. <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/health-home-information-resource-center.html>. Accessed July 1, 2016.

⁵⁰ Health Home Technical Assistance Learning Forums. <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/health-homes-ta-learning-forums.html>. Accessed July 1, 2016.

⁵¹ NASTAD, Financing HIV Prevention Services. <https://www.nastad.org/sites/default/files/NASTAD-HIV-Prevention-Rhode-Island-Case-Study.pdf>. Accessed July 1, 2016.

service package that can address diverse service needs. States offer a wide range of services under section 1915(c) waivers for individuals with HIV/AIDS. Examples of services that States currently offer in 1915(c) HIV/AIDS waivers include the following: Case Management, Attendant Care, Home Health, Specialized Medical Equipment and Supplies, Nutritional Consultation, Respite, Environmental Modifications and Supplies, Private Duty Nursing, Personal Care, Home Maker Services, Personal Assistance, Home Delivered Meals.

Medicaid and CHIP beneficiaries living with HIV may also be eligible to receive care coordination and other support services (e.g., housing support, health education and risk reduction, treatment adherence interventions, and medical transportation services) available through other federal, state, local, or private programs. Close coordination and collaboration between state Medicaid programs and other programs that support access to HIV prevention, care and support services is, however, essential, as those other programs may have strict eligibility criteria or other limits on the circumstances under which they can fund and/or provide services. The RWHAP, for example, is required by statute to function as a payer of last resort⁵². As chronicled in a 2013 report from the National Academy for State Health Policy (NASHP), state Medicaid programs have developed a variety of strategies for coordinating benefits and services with their state RWHAP colleagues⁵³ (e.g., instituting data-sharing agreements or having Medicaid representatives sit on state and/or local RWHAP Planning Bodies). More generally, state Medicaid agencies developing new initiatives to improve the care and treatment outcomes among PLWH are likely to benefit from sharing their scope of work with federal, state, and local partners who are also addressing the needs of PLWH.

Effective Treatment with ART for People Living with HIV

As noted in the Background section of this IB, recent studies have shown that ART confers substantial clinical benefits on all persons living with HIV who initiate treatment—not just those with advanced immune suppression^{54,55}. Moreover, there is good reason to believe that the

⁵² Policy Notice 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds: The RWHAP statute, codified at title XXVI of the Public Health Service Act, stipulates that "funds received...will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made..." by another payment source. At the individual client level, this means recipients must assure that funded sub-recipients make reasonable efforts to secure non-RWHAP funds whenever possible for services to eligible clients. In support of this intent, it is an appropriate use of RWHAP funds to provide case management (medical or non-medical) or other services that, as a central function, ensure that eligibility for other funding sources is aggressively and consistently pursued (e.g., Medicaid, CHIP, Medicare, other local or State-funded HIV/AIDS programs, and/or private sector funding, including private insurance).

http://hab.hrsa.gov/affordablecareact/service_category_pcn_16-02_final.pdf. Accessed July 1, 2016.

⁵³ Witgert K, Dolatshahi J, Yalowich R. Strategies for Coordination Between Medicaid and Ryan White HIV/AIDS Programs, 2013. Portland, ME: National Academy for State Health Policy (NASHP).

<http://www.nashp.org/sites/default/files/ryanwhite.medicaid.coordination.pdf>. Accessed July 1, 2016.

⁵⁴ The INSIGHT START Study Group. Initiation of Antiretroviral Therapy in Early Asymptomatic HIV Infection. *The New England Journal of Medicine* (see footnote 11).

⁵⁵ TEMPRANO ANRS 12136 Study Group. A Trial of Early Antiretrovirals and Isoniazid Preventive Therapy in Africa (see footnote 12).

benefits of early ART extend beyond the immediate outcomes demonstrated under both the START and TEMPRANO studies. Evidence suggests that earlier ART initiation may result in less residual immune dysfunction during treatment, and this in turn may result in reduced risk of not only AIDS-related diseases, but also chronic conditions for which PLWH may be at increased risk, including kidney disease, liver disease, cardiovascular disease, neurologic complications, and non-AIDS cancers⁵⁶.

Providing treatment to people living with HIV infection to improve their health must always be the first priority. However, the potential public health benefits conferred by HIV treatment as a preventive measure (or, “treatment as prevention”) are also sizeable. Recent models from CDC indicate that new infections in the U.S. could be reduced by 70% (or, 185,000 infections averted by 2020) if NHAS targets for HIV testing and treatment, as well as expanded use of PrEP, were attained⁵⁷. Even more notable was the outsize role that effective treatment (defined as treatment that leads to viral load suppression) played in that modeling scenario: over 90% of the aforementioned reduction (i.e., 168,000 of the 185,000 infections prevented) would be due to increases in the percentage of PLWH who were on ART and had achieved viral suppression.

To ensure both the individual and public health benefits of ART are realized among their Medicaid and CHIP beneficiaries and in their communities, states should align their Medicaid policies and practices with the *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents* (hereafter, the “DHHS Guidelines”)⁵⁸. The DHHS Guidelines are regularly updated to incorporate new scientific evidence and provide users with comprehensive information and recommendations around topics such as baseline laboratory evaluations, benefits of ART and considerations when initiating therapy, choice of the initial regimen for ART-naive patients, management of treatment failure, management of adverse effects and drug interactions, and special ART-related considerations in specific patient populations.

Given that adherence to ART is a critical prerequisite to realizing both individual and public health benefits, states are reminded of the statutory requirement to cover all covered outpatient drugs of manufacturers with agreements described section 1927(b) of the Act, including single-tablet ART regimens. States can also, and are strongly encouraged to, go farther to support access and adherence to effective treatments for PLWH. States should design their prescription drug formularies to minimize potential barriers presented by utilization management techniques so that Medicaid and CHIP beneficiaries living with HIV can readily access all regimens described for potential use (including those labeled as “Recommended”, “Alternative”, and “Other”) in the DHHS Guidelines.

⁵⁶ DHHS, *Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents* (see footnote 13).

⁵⁷ Yaylali E, Farnham P, Jacobson E, Allaire BT, Wagner DL, Hicks KA et al. Impact of Improving HIV Care and Treatment and Initiating PrEP in the United States, 2015-2020. Abstract for the Conference on Retroviruses and Opportunistic Infections (CROI) in Boston, Massachusetts. February 22–25, 2016. Abstract number 1051.

⁵⁸ DHHS, *Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents* (see footnote 13).

Furthermore, states may also wish to explore ways to better leverage existing Medicaid benefits and services to address common treatment adherence challenges following a user centered design approach. For example, adding single-tablet regimens recommended in the DHHS Guidelines to preferred drug lists, and removing any step therapy requirements associated with these treatment regimens, may increase adherence by reducing patient pill burden, treatment complexity, and potential side effects. We also encourage states to refrain from requiring beneficiaries to have tried and failed relatively more burdensome, and in some cases, less clinically appropriate regimens for reasonable periods of time before single-tablet regimens or other non-preferred drugs may be covered. Such step-therapy may not be appropriate for the treatment of HIV and may result in poor clinical outcomes for the individual, as well as have public health implications due to increased transmission.

Monitoring and Improving Viral Load Suppression Among PLWH

Improving rates of viral load (VL) suppression among PLWH is critical to realizing individual, population, and community health improvements, as well as any cost savings associated with them. Viral load suppression rates also serve as means of gauging how well Medicaid programs are meeting the needs of its HIV-infected beneficiaries.

Measures of performance—especially when assessed at multiple levels, including the individual provider or clinic, health system or health plan, and community or population—are required foundations for creating and maintaining systems of care that support continuous quality improvements and reward value over volume^{59,60}. Outcomes-oriented quality measures are particularly useful, as they keep attention focused on the “end goals” of care, rather than processes for achieving those goals⁶¹.

Since 2014, CMS has included National Quality Forum (NQF) Measure #2082: HIV Viral Load Suppression in its Medicaid Adult Core Set of quality measures⁶². More recently, the Core Quality Measure Collaborative—a multi-stakeholder initiative led by the America’s Health Insurance Plans (AHIP) that included representatives from AHIP members’ plans, as well as CMS, NQF, national physician organizations, employers and consumers—released seven consensus core measure sets that both public and private payers have committed to using for reporting as soon as feasible. NQF 2082: HIV Viral Load Suppression (hereafter referred to as

⁵⁹ IOM (Institute of Medicine). 2015. *Vital signs: Core metrics for health and health care progress*. Washington, DC: The National Academies Press. <http://www.nap.edu/catalog/19402/vital-signs-core-metrics-for-health-and-health-care-progress>. Accessed July 1, 2016.

⁶⁰ Health Care Payment Learning and Action Network (HCPLAN). Accelerating and Aligning Population-Based Payment Models: Performance Measurement. Draft White Paper. Posted April 2016. <http://hcp-lan.org/workproducts/pm-whitepaper-draft.pdf>. Accessed July 1, 2016.

⁶¹ The operational flexibility and methodological neutrality that characterize outcome measures may be especially beneficial in the context of delivery system reform and innovation.

⁶²The 2016 Adult Core Set, as well as technical guides and resources to support collection of these measures, are available at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-health-care-quality-measures.html>. Accessed July 1, 2016.

“the HIV Viral Load Suppression measure”) was included in the HIV/Hepatitis C consensus core set finalized by the collaborative as well⁶³.

The HIV Viral Load Suppression measure offers states a concise but informative means for tracking and evaluating the quality of care being delivered to their Medicaid and CHIP beneficiaries living with HIV. Moreover, the measure is conceptually aligned with surveillance-based, public health indicators used to track state and national performance under the National HIV/AIDS Strategy, so its adoption and use also allow states to evaluate how improvement efforts among their Medicaid and CHIP beneficiaries contribute to state level population health improvement and state achievement of NHAS performance targets⁶⁴.

Because the HIV Viral Load Suppression measure is an outcome measure, acquiring the data necessary to calculate performance can pose challenges to state Medicaid programs (and their managed care contractors). Nonetheless, to date, several states (including New York⁶⁵, Delaware, and Louisiana) have captured and reported results for the HIV Viral Load Suppression measure to CMS.

Spotlight on State Quality Improvement Activities

The following states are collecting and using HIV-related performance measures—including measures of viral load suppression—to drive improvements in health outcomes among PLWH.

Delaware

Under federal regulation 42 CFR 438 subpart E, states delivering services to Medicaid beneficiaries through managed care arrangements are required to develop a Quality Strategy (QS). The QS is the framework which the state provides objectives and strategies to address health care quality, cost and access to health care. Delaware has an approved section 1115 demonstration program entitled Diamond Health Care Plus. In its latest Quality Management Strategy submission, Delaware outlines various HIV-related performance metrics that the state would monitor to improve health care outcomes for Medicaid beneficiaries living with HIV/AIDS. In addition, Delaware mandates that managed care contractors must ensure that their networks include providers who specialize in the care and treatment of PLWH.

Florida

Under federal regulations 42 CFR 438 subpart E, the parameters are outlined for states to follow to conduct external quality review (EQR). An EQR is an evaluation by an external quality review

⁶³ For additional information about the Collaborative, as well as links to the specific core measure sets it developed and approved, see <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html>. Accessed July 1, 2016.

⁶⁴National HIV/AIDS Strategy for the United States: Updated to 2020—Indicator Supplement. August 2015. https://www.whitehouse.gov/sites/default/files/docs/nhas_2020_indicator_supplement_8-15.pdf. Accessed July 1, 2016.

⁶⁵ Recently profiled in a case study written by the National Academy for State Health Policy, Advancing HIV Prevention through Health Departments: HIV-Specific Quality Metrics for Managed Care. http://www.nashp.org/wp-content/uploads/2016/06/NY-QARR-Case-Study_v7_pages.pdf. Accessed July 1, 2016.

organization of information on quality, timeliness and access to health care services provided to Medicaid beneficiaries. Florida Agency for Health Care Administration has contracted with a number of specialty MCOs to deliver care and treatment to PLWH. As part of their efforts to improve health outcomes among enrollees living with HIV, MCOs have undertaken and successfully completed a number of Performance Improvement Projects (PIPs) on topics such as Viral Load Testing and Reducing Avoidable Emergency Department Visits among PLWH.

Louisiana

Louisiana's Bureau of Health Services Financing (Louisiana's Medicaid program) has overcome the technical challenges posed by an outcome measure like HIV Viral Load Suppression by developing a novel data sharing arrangement with its Office of Public Health (OPH). As detailed more fully in a recent case study from the National Association of State and Territorial AIDS Directors (NASTAD)⁶⁶, on a quarterly basis, the Bureau of Health Services Financing (BHSF) provides OPH with information about all Bayou Health⁶⁷ members who have had a HIV-related claim in a set period of time. OPH then cross-references that information with its surveillance data and, if there's a match (indicative that the individual has previously been diagnosed with HIV), provides BHSF individual-level information about whether the person is virally suppressed. BHSF, in turn, communicates the results of OPH's matching process to the managed care organizations (MCOs) contracted to deliver care through Bayou Health. In fact, beginning in 2016, Louisiana will not only track and report to CMS on HIV viral load suppression rates; it will use the measure to hold MCOs accountable for the quality of care they deliver to their enrollees who are PLWH.

Maine

Maine submitted and gained approval under the section 1115 demonstration waiver authority to develop an 1115 program with the specific intent to enroll PLWH. Approved in 1998, the MaineCare HIV/AIDS Care Demonstration has approximately 800 PLWH currently enrolled who were made eligible through the demonstration. The goal of the program is to provide critical services to PLWH to delay, prevent or reverse the progression of HIV. Preliminary evaluation results have demonstrated that viral load suppression improve for members in the demonstration.

New York

New York has developed various programs utilizing Medicaid authorities to address the care and treatment of PLWH. Under New York's current Delivery System Reform Incentive Program (DSRIP), the state hopes to improve health outcomes by restructuring its healthcare system to better integrate preventive and primary care services and supports. To determine whether the new systems of care being evaluated under the DSRIP work for potentially complex beneficiary populations like PLWH, New York has specifically included HIV-related performance

⁶⁶ Financing HIV Prevention Services: Collaboration and Innovation between Public Health and Medicaid Agencies. National Association of State and Territorial AIDS Directors (NASTAD). <https://www.nastad.org/sites/default/files/NASTAD-HIV-Prevention-Louisiana-Case-Study.pdf>. Accessed July 1, 2016.

⁶⁷ Louisiana's Medicaid managed care program

improvement metrics like viral load suppression among the quality measures it is tracking under this waiver program.

Addressing Substance Use among PLWH

The United States is experiencing an epidemic of drug overdose (poisoning) deaths. In 2014, more people died from drug overdoses than in any year on record, and the majority of drug overdose deaths (more than six out of ten) involve an opioid⁶⁸. The individual, health system, and public health consequences of this epidemic, however, extend far beyond drug-induced morbidity and mortality (e.g., overdose deaths); behaviors associated with abuse of opioids have also created ideal conditions for increases in the incidence and prevalence of other, costly public health threats, including infections due to blood-borne viruses like hepatitis C (HCV) and HIV. Data from CDC’s National Notifiable Disease Surveillance System (NNDSS) reveal that from 2010 through 2014 there was a 158.1% increase in the number of reported cases of acute hepatitis C; this “emerging epidemic” of acute HCV can be readily traced to growing numbers of young, non-urban (rural and Appalachian) white youth who have transitioned from oral prescription opioid abuse to injection of these opioids and heroin⁶⁹. Following a recent outbreak of HCV and HIV in Austin, Indiana, CDC conducted an analysis to identify other communities at substantial risk of rapid dissemination of IDU-associated HIV, and new or continuing high numbers of HCV infections. That analysis identified 220 counties in 26 states as being particularly vulnerable to outbreaks similar to the one in Austin.⁷⁰ Interventions, like syringe service programs (SSPs) or medication-assisted therapy (MAT), thus offer states important tools to mitigate Medicaid and CHIP beneficiaries’ risks of acquiring or transmitting HIV. CMS has previously released a number of Information Bulletins designed to help states identify effective practices for identifying and addressing opioid overdoses, misuse, and addiction⁷¹. In addition,

⁶⁸ Rudd RA, Aleshire N, Zibbell JE, Gladden RM. Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014. *MMWR* 2016; 64 (50): 1378-82.

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm?s_cid=mm6450a3_w. Accessed July 1, 2016.

⁶⁹ Centers for Disease Control and Prevention. Viral Hepatitis Surveillance United States, 2014.

<http://www.cdc.gov/hepatitis/statistics/2014surveillance/pdfs/2014hepsurveillancercpt.pdf>. Accessed July 1, 2016.

⁷⁰ Van Handel MM, Rose CE, Hallisey EJ et al. (2016). County-level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections among Persons who Inject Drugs, United States. *JAIDS*; published ahead of print.

http://journals.lww.com/jaids/Citation/2016/11010/County_Level_Vulnerability_Assessment_for_Rapid.13.aspx

⁷¹ *Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction*. Center for Medicaid and CHIP Services, CMS, January 2016. <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-02-02-16.pdf>. Accessed July 1, 2016.

Delivery Opportunities for Individuals with a Substance Use Disorder. Center for Medicaid and CHIP Services, CMS, October 2014. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-10-29-14.pdf>. Accessed July 1, 2016.

Medication Assisted Treatment for Substance Use Disorders. Center for Medicaid and CHIP Services, CMS, July 2014. <http://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf>. Accessed July 1, 2016.

CMS recently released a final rule applying Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) parity requirements to: (1) Medicaid managed care organizations (MCOs) as described in section 1903(m) of the Act ; (2) Medicaid benchmark and benchmark-equivalent plans (referred to in this rule as Medicaid Alternative Benefit Plans (ABPs)) as described in section 1937 of the Act; and (3) Children's Health Insurance Program (CHIP) under title XXI of the Act⁷². As states continue to develop and implement comprehensive strategies for addressing substance use disorders—including opioid addiction—within their Medicaid and CHIP populations, they should actively consider ways to structure benefits and services so that they reduce consequences of substance use and abuse such as overdose deaths and HIV transmission.

The following table summarizes state opportunities to improve HIV prevention and care service delivery for Medicaid and CHIP beneficiaries. States interested in learning more about, and/or requesting technical assistance around, the opportunities described in this Information Bulletin may contact [Dr. Andrey Ostrovsky](#), Chief Medical Officer, CMCS.

Key Resources Mentioned in this Bulletin

1. *National HIV/AIDS Strategy for the United States: Updated to 2020*. <https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf>.
2. Panel on Antiretroviral Guidelines for Adults and Adolescents. *Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents*. Department of Health and Human Services. <https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-treatment-guidelines/0>.
3. U.S. Public Health Service. *Preexposure Prophylaxis for the Prevention of HIV Infection in the United States—2014 Clinical Practice Guideline*. May 2014. <http://www.cdc.gov/hiv/pdf/PrEPguidelines2014.pdf>.
4. U.S. Preventive Services Task Force. *Final Recommendation Statement: Human Immunodeficiency Virus (HIV) Infection: Screening*. May 2015. <http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening>.
5. *Medication Assisted Treatment for Substance Use Disorders*. Center for Medicaid and CHIP Services, CMS, July 2014. <http://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf>.
6. *2016 Updates to the Child and Adult Core Health Care Quality Measurement Sets*. Center for Medicaid and CHIP Services, CMS, December 2015. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-12-11-15.pdf>

⁷² See Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans at <https://www.federalregister.gov/articles/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of>

HIV Prevention/Care Service	Opportunities for Medicaid Programs
HIV Testing and Diagnosis	<ul style="list-style-type: none"> • Cover USPSTF recommended HIV screening without cost sharing for all Medicaid and CHIP beneficiaries • Cover HIV screening services when provided by unlicensed providers that meet qualifications established by the state
Pre-Exposure Prophylaxis (PrEP)	<ul style="list-style-type: none"> • Ensure that utilization management techniques are not designed or implemented in ways that limit access to PrEP among persons for whom it is indicated • Cover PrEP services, including FDA-approved covered outpatient drugs approved for PrEP, as recommended in USPHS Guidelines
Linkage to and Retention in Care for People Living with HIV (PLWH)	<ul style="list-style-type: none"> • Include HIV-infection among the eligibility criteria for state Medicaid Health Home models • Leverage Targeted Case Management service options and waiver authorities to develop unique programs to coordinate and improve access to medical, behavioral, and social services for PLWH. • Coordinate benefits with other programs that support access to HIV prevention, care and support services (e.g., Ryan White HIV/AIDS Program service providers)
Effective Treatment for PLWH	<ul style="list-style-type: none"> • Cover all regimens described for potential use (including those labeled as “Recommended”, “Alternative”, and “Other”) in DHHS Guidelines for providing antiretroviral therapy (ART) to PLWH • Design and implement utilization management techniques that promote adherence (e.g., include single tablet regimens on preferred drug lists)
Monitoring and Improving Viral Load Suppression (VLS) among PLWH	<ul style="list-style-type: none"> • Collect and report to CMS results for the HIV Viral Load Suppression measure, which is part of the Medicaid Adult Core Measure Set • Implement the VLS and other HIV prevention and care-related quality measures as part of targeted quality improvement activities.