Broader HIV Screening Faces Payment Obstacles

BY MIRIAM E. TUCKER
Senior Writer

WASHINGTON — Reimbursement for routine, universal HIV screening will prove challenging in both the private and public sectors, Dr. Michael Horberg and Christine Lubinski said in separate presentations at a meeting on HIV diagnosis and prevention and access to care.

Last year, the Centers for Disease Control and Prevention recommended that diagnostic HIV testing and "opt-out" HIV screening be made a part of routine clinical care in all health care settings for patients aged 13-64 years (MMWR 2006;55[RR-14]). Kaiser Permanente, which is the country's largest staff-model HMO, is "grappling with this now. We have to look at the implications," said Dr. Horberg, director of HIV/AIDS Policy, Quality Improvement, and Research at Kaiser.

"We have the capacity to do it, and we have the will to do it. But it is a lot of money," said Dr. Horberg.

As for the public sector, "There are significant roadblocks. … The Centers for Medicare and Medicaid Services and the [Bush] administration have little commitment to expand the federal contribution to the Medicaid program in any way, shape, or form," said Ms. Lubinski, executive director of the HIV Medicine Association. This association is a multidisciplinary arm of the Infectious Diseases Society of America that represents medical professionals involved in HIV care.

However, a few states—most notably New Jersey—have committed their Medicaid funds to cover broad-based HIV testing for low-income beneficiaries, Ms. Lubinski noted.

The Kaiser Permanente/Group Health Cooperative system covers approximately 3% of the entire U.S. population, including more than 16,000 active HIV-infected patients. The numbers vary widely by region, from about 180 patients in Ohio to nearly 5,500 in California.

Currently, nearly two-thirds of HIV-infected patients within Kaiser are not diagnosed until they meet AIDS criteria, "which means our case-finding is not very good," Dr. Horberg remarked. However, more than 90% of patients who are diagnosed enter into care within 120 days of diagnosis. Last year, more than 70% of those patients were on highly active antiretroviral therapy, he said.

Kaiser has been performing about 340,000 HIV antibody tests a year, which account for 15% of its target population aged 13-65 years. The majority are pregnant women, of whom more than 90% are currently tested. If Kaiser were to adopt the CDC guidelines, it would mean about 5 million more tests—and 1,773 newly identified cases—at a cost of at least $26,599,450 annually.

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Aside from cost, other potential barriers to expanded HIV screening in managed care include the fact that many managed care organizations follow recommendations from the U.S. Preventive Services Task Force, not the CDC, in determining what type of tests to cover. The USPSTF has not yet issued guidelines on universal HIV screening.

Although most managed care organizations do support targeted screening for pregnant women and for individuals with high-risk behavior, they have not yet generated broader screening policies. "Most are probably waiting for the USPSTF," Dr. Horberg said.

The CDC's provision that prevention counseling should not be required as part of HIV screening is already posing problems in states that require informed consent for HIV testing, including many of the states that Kaiser now serves. Kaiser differentiates between "screening," defined as testing without counseling, and "testing," which includes the HIV antibody test, pre- and posttest counseling, and patient education.

"Testing in [Kaiser] is the desired norm. . . . We are uncomfortable screening without a proper testing process," explained Dr. Horberg.

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Doctors Confront Practical Issues of HIV Testing

An educational program is being developed to help doctors navigate the challenges of universal screening.

BY MIRIAM E. TUCKER
Senior Writer

WASHINGTON — Efforts to make HIV screening an integral part of primary care have created a new set of educational, reimbursement, and workforce challenges for physicians.

In response, the Society of General Internal Medicine (SGIM) is gearing up to help primary care physicians incorporate routine HIV screening into their busy practices, Dr. James M. Sosman said at a meeting on HIV diagnosis and prevention and access to care.

In September, the Centers for Disease Control and Prevention issued recommendations for routine "opt-out" HIV screening of all patients aged 13-64 years. Health care providers should initiate screening unless the prevalence of undiagnosed HIV infection in their patients has been documented to be less than 0.1%. In the absence of such prevalence data, health care providers are advised to initiate voluntary HIV screening until they establish that the diagnostic yield is less than 1/1,000 patients screened, at which point screening is no longer warranted (MMWR 2006;55:RR-14).

Prevention counseling should not be required as part of HIV screening programs, according to the CDC. Although "strongly encouraged" for individuals at high risk for HIV, counseling does not have to be linked to the testing itself, the agency said.

The CDC guidelines have sparked concern that widespread HIV screening will overburden the U.S. health care system by identifying thousands of HIV-positive individuals who will require costly counseling and treatment services. An estimated 252,000-312,000 Americans are unaware that they are HIV-positive.

In anticipation of the guidelines, the SGIM obtained a 3-year grant from the CDC to develop an educational "train the trainer" program aimed at reducing barriers to early diagnosis of HIV infection and increasing patient access to preventive services in primary care settings, Dr. Sosman said at the meeting.

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Clinician educators will be recruited from medical school and residency programs, and will then "serve as regional trainers, information resources, and role models for other primary care physicians," said Dr. Sosman, medical director of the Midwest AIDS Training and Education Center, Madison, Wis. Future training sessions and presentations will include collaborations with groups not directly linked with the SGIM, including local and state medical societies, Area Health Education Centers, and other organizations.

The first half of 2007 will be devoted to information gathering. Focus groups and surveys of SGIM members will be used to ascertain current practices and identify potential barriers to implementation of the CDC guidelines. The information will be used to develop educational materials, such as slide sets, case studies, training scripts, and provider tool kits. The sessions themselves are expected to begin around the country in the latter part of the year. They will not be limited to members of SGIM or specifically to internists, said Dr. Sosman, also with the department of general internal medicine at the University of Wisconsin, Madison.

In a separate presentation at the meeting, Dr. Harvey J. Makadon of the department of medicine at Harvard Medical School, Boston, outlined potential operational challenges to incorporation of routine HIV screening in primary care settings. An informal survey among internists at his hospital revealed "a general sense that routine testing will improve current practices," but respondents had many questions and concerns, particularly with regard to reimbursement for counseling and the process of counseling itself.

"A lot of doctors have something that they usually say [when counseling patients], and there have been articles written on the topic, but there's no formal curriculum. We're not really taught what to talk about with patients regarding HIV prevention," Dr. Makadon remarked. "What are the best practices?"

There may be potential legal problems as well. In many states, existing laws regarding informed consent for HIV screening appear to conflict with the CDC "opt-out" guidelines, and these laws would likely need to be amended in order for the guidelines to be implemented. Until that happens, the laws supersede public health guidelines, Dr. Sosman noted.

And then there's the question of what to do with patients identified as HIV-positive, particularly those who are still healthy and asymptomatic. The number of HIV specialists in the country has remained static since the epidemic began 20 years ago, according to another speaker at the conference, Dr. M. Keith Rawlings.

"Where will the newly diagnosed patients get their medical care? I don't foresee the ability of most practitioners to absorb 25%-50% more [HIV-positive] individuals. Available resources in the community will have to be identified," said Dr. Rawlings, medical director of the AIDS Arms Peabody Health Center, Dallas, speaking on behalf of the National Medical Association.

Dr. Sosman noted that a "team approach" to HIV/AIDS care could be implemented in primary care settings, similar to that currently used for patients with diabetes or for smoking cessation. "It works, but it's expensive," he remarked.

Dr. Rawlings pointed out that the HIV-positive population is looking more and more like the patients primary care physicians see every day: As antiretroviral medications are allowing patients to live longer, the drugs are also associated with an increased risk for familiar conditions such as dyslipidemia, diabetes, and heart disease. "It's been a very long time since I've seen anybody in my office who has HIV as the only thing wrong with them." ■

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However, he added, despite the potential roadblocks, "We are confident that we can handle all new HIV-infected patients identified."

The public sector is another story. It would take an act of Congress before Medicare, which has only recently begun to cover any preventive health services, would cover HIV screening. Because the upper target age of the CDC recommendation is 64 years, the only people for whom Medicare would cover screening are the 6.8 million current beneficiaries under age 65 who qualify by disability. And that number includes about 100,000 who have already been diagnosed with HIV/AIDS, Ms. Lubinski said.

Thus, the bulk of the reimbursement for HIV screening would fall to Medicaid, which currently provides health coverage to about half of all people with AIDS in the United States and a significant number of those newly diagnosed with HIV. In an analysis that was done in 25 states, 22% of HIV-infected individuals were already Medicaid eligible at the time of their diagnosis.

Federal law allows HIV screening to be covered by states either under fee-for-service or Medicaid managed care. This service is "optional" and thus depends on the individual state's policy.

A recent study by researchers at George Washington University's Center for Health Services Research and Policy found that Medicaid programs in 32 of the 48 states surveyed covered targeted HIV testing and counseling, with 19 of those also covering prenatal and perinatal counseling. A few state programs also covered services such as HIV risk assessment and case management.

But as yet, with the exception of New Jersey, most state Medicaid programs have not adopted routine HIV testing. California has employed a special waiver to provide broad family planning services including HIV testing and counseling for men and women of childbearing age up to 200% of the poverty level. However, that type of waiver is unlikely to be granted elsewhere, she noted.

States could opt to cover HIV screening under a "diagnostic, screening, preventive, and rehabilitative" (DSPR) benefit. The state would need to broaden the definition of medical necessity to allow for preventive services such as HIV screening, as Massachusetts has done.

There, a service is "medically necessary if it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, or cause suffering or pain," the definition states.

Such definitions could theoretically make HIV testing and counseling eligible for reimbursement, Ms. Lubinski said.

She said she believes that the federal government will need to contribute more to Medicaid for the CDC guidelines to be fully implemented.

"It is absolutely unreasonable to think that the modest amount of discretionary funding through the CDC, Ryan White [Comprehensive AIDS Resources Emergency Act], or state and local health departments is going to be adequate to implement population-based HIV screening. Medicaid, with its significant reach into low-income populations and ethnic and racial minorities, must be part of the financing mix. Federal leadership could and should facilitate coverage of routine screening by state Medicaid programs," Ms. Lubinski noted. ■