

Securing Health Care for People with HIV and AIDS: An Advocate's Roadmap on Implementing Health Care Reform and Bridging Current and On-going Access to Care Gaps

The passage of health care reform in March of 2010 coupled with the announcement of a National HIV/AIDS Strategy (NHAS) in July 2010 signal important steps forward in the fight to secure health care for the most vulnerable populations. Provisions in the health care reform law – including expansion of Medicaid, Medicare Part D co-payment reforms, the enactment of numerous regulatory checks on the insurance industry, and investments in public health, workforce development, and prevention and wellness – will greatly improve access to care for people living with HIV and AIDS. Similarly, provisions in the NHAS – including support of Medicaid Waivers to allow immediate access to Medicaid and calls for increased coordination between federal agencies – will also improve access to care. However, there are significant delays, gaps and limitations in both health care reform and NHAS: many of the reforms that will most benefit people living with HIV and AIDS do not go into effect until 2014; the overall effectiveness of many important provisions in the reform law relies on successful federal agency rule-making and implementation over the next several years; and while both health care reform and the NHAS provide an outline for some major steps toward increasing access to care, they both fall short in addressing care and treatment needs prior to major reforms going into effect in 2014. Ongoing advocacy efforts are needed to address these limitations and close these gaps.

In the coming years, advocacy will involve three targeted areas and phases: (1) ensuring that the promise of health care reform is fulfilled through active participation in the law's implementation; (2) using the NHAS and other advocacy efforts to secure a bridge to 2014 for people living HIV and AIDS; and (3) looking beyond health care reform to address the health care and essential support service needs that are left unmet even after health care reform and the NHAS are fully implemented.



Prepared by
Harvard Law School Health Law and Policy Clinic
and Treatment Access Expansion Project

Major Health Care Reform Provisions Affecting People with HIV and AIDS

2010

Early expansion of Medicaid if states choose
Temporary high risk pools for people with pre-existing conditions
Prohibition against rescissions in all private health insurance plans
Prohibition against lifetime benefit limits for all private health insurance plans
Prohibition and/or restrictions on annual benefit limits in all private health insurance plans*
\$250 Rebates for Medicare Part D “doughnut hole”
Required coverage of preventive care and immunizations without cost sharing for all private health insurance plans**
Increased funding for community health centers by \$11 billion over the next 5 years
Creation of public health fund for prevention and public health programs, which allocates \$500 million in FY 2010, increasing annually up to \$2 billion in FY 2015 and thereafter

2011

Medicaid Health Home program allows states to provide coordinated care through a health home for individuals with chronic conditions
Center for Medicare and Medicaid Innovation (CMI) established to evaluate payment and service delivery models
50% discount on brand-name drugs for Medicare beneficiaries who enter the Medicare Part D coverage gap

2014

Medicaid eliminates categorical eligibility and expands coverage to all those with income up to 133% of the federal poverty level (FPL) (in 2010, \$14,404 for an individual and \$29,327 for a family of four) with increased federal funding to pay for newly-eligible beneficiaries
Qualified health plans offered through state exchanges as well as Medicaid benefits packages for newly-eligible beneficiaries must include “essential health benefits,” to be defined by the Secretary of Health and Human Services
Prohibition on pre-existing condition exclusions for all private health insurance plans (starts in 2010 for children)*
Prohibition on discrimination based on health status for all private health insurance plans**
Premiums charged by health insurance issuer for new coverage offered in individual or small-group markets and exchanges may only vary by whether an individual or family is covered; the geographic rating area; age; and tobacco use*
Guaranteed availability of coverage from insurance carriers selling health plans in individual and group markets and exchanges**
Premium tax credits for individuals and families with income 133% to 400% FPL to purchase insurance through exchanges
Cost-sharing subsidies for individuals and families with up to 250% FPL to purchase insurance through exchanges

*Does not apply to grandfathered plans (defined broadly as a group health plan or group or individual health insurance coverage in which individuals were enrolled on March 23, 2010).¹

**Does not apply to grandfathered plans.

PHASE I: FULFILLING THE PROMISE OF HEALTH CARE REFORM BY MONITORING FEDERAL AND STATE IMPLEMENTATION, LEVERAGING NEW INVESTMENTS, AND ENSURING INTEGRATION OF HIV/AIDS SERVICES

Many of the fine details as to the scope of the health care reform law are left to numerous federal agencies, particularly the Department of Health and Human Services. The health care reform law also provides billions of dollars in investments in prevention and other health care initiatives and presents opportunities to integrate the Ryan White Program model of care into public and private models and services. The HIV/AIDS community must actively participate in these implementation, investment, and integration efforts to ensure that the promise of health care reform is truly realized. In addition, the National HIV/AIDS Strategy (NHAS) complements many of the health care reform provisions, and advocates should ensure that the health care reform law is implemented in ways that forward the goals and implementation plan of the NHAS.

Federal and State Health Care Reform Implementation

There are several key implementation issues which will have a huge impact on how effectively health care reform meets the needs of people living with HIV and AIDS. The HIV/AIDS community must actively participate in these implementation efforts and comment as important regulations are proposed by the relevant federal agencies to ensure the community's needs are adequately addressed.

Essential Health Benefits Package

The health care reform law requires a minimum “essential health benefits” package for most individuals that become newly eligible for Medicaid as well as for those insured through the private, state-level insurance exchanges starting in 2014.² The law sets out the basic requirements of the package – requiring coverage for ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, pediatric services, including oral and vision care. However, implementation beyond this basic mandate is left to the discretion of the Secretary of Health and Human Services.

➤ *Advocacy Targets:*

- *Federal: actively participate in the implementation process by submitting comments to the Secretary of Health and Human Service urging her to define the essential health benefits package in ways that provide the scope and level of services needed to meet the care and treatment needs of individuals living with HIV.³*
- *Federal: urge HHS to use the Medicaid and CHIP Payment Access Commission (MACPAC) established by the Children's Health Insurance Program Reauthorization Act of 2009 and funded through the Patient Protection and Affordable Care Act of 2010 to develop recommendations to HHS for the essential health benefits package.⁴*

- *State: urge state officials to also weigh in with the Secretary, and engage and train state Medicaid offices and providers on the new benefits requirements once they are finalized.*

Medicare Part D Cost-Sharing

The health care reform law includes numerous provisions that will help low-income beneficiaries living with HIV and AIDS to access life-saving medications. For instance, by 2020 the Medicare Part D coverage gap – where the Part D beneficiary is responsible for paying all prescription drug costs over the first \$2,830, until costs reach \$6,440, when catastrophic coverage kicks in – will be completely eliminated. In the meantime, starting immediately low-income people who fall into the coverage gap will be eligible for subsidies to help them reach catastrophic coverage. This is an important change from present law as it will greatly reduce the number of people living with HIV and AIDS who lose access to medications because they are unable to meet their Medicare co-payment obligations. However, Medicare Part D cost-sharing obligations still present an immediate barrier to care for many low-income people living with HIV and AIDS. Adding to this problem, many state ADAP programs do not currently allow ADAP to help meet Medicare beneficiaries' premiums, deductibles and co-payment obligations.⁵

➤ *Advocacy Targets:*

- *Federal: Urge HRSA to issue guidance and technical assistance to maximize state ADAP programs support of Part D beneficiaries.*
- *State: Urge state ADAP programs to allow ADAP to count toward Medicare beneficiaries' premium, deductible, and co-payment obligations.*

Inclusion of Routine HIV/AIDS Testing in the Prevention Focus of Health Care Reform

Beginning on September 23, 2010, all group and individual market health plans (except grandfathered plans) will be required to cover recommended preventive services without cost sharing.⁶ On July 14, 2010, the Departments of Health and Human Services, Labor, and Treasury released a new regulation detailing the preventive services to be covered, including: HIV testing for all adolescents and adults at increased risk for HIV infection (risk factors defined by U.S. Preventive Services Task Force "Clinical Considerations"⁷); blood pressure, diabetes, and cholesterol tests; cancer screenings; counseling from a health care provider on smoking cessation, weight loss, nutrition, mental health, and alcohol use; routine vaccines; flu and pneumonia shots; counseling, screening, and vaccines for healthy pregnancies; and regular well-baby and well-child visits from birth to age twenty-one.⁸

➤ *Advocacy Targets:*

- *Federal: in keeping with CDC recommendations, seek coverage for more routine testing of adults and adolescents ages 13-64, rather than only those at increased risk for HIV.*

Leveraging New Health Care Reform Investments

The health care reform law includes billions of dollars in new investments aimed at increasing prevention and wellness services and initiatives; expanding the capacity of community health centers; and developing more integrated and holistic models of care. The HIV/AIDS community must actively participate in allocation decisions to ensure that people living with HIV and AIDS benefit from these investments.

Inclusion of HIV/AIDS Funding in Prevention and Wellness Initiatives

The health care reform law contains numerous prevention and wellness initiatives and offers important opportunities for advocates to promote HIV/AIDS and infectious disease prevention, including establishment of a \$500 million Prevention and Public Health Fund beginning in 2010 (increasing to \$2 billion in 2015 and subsequent years).⁹ Of this \$500 million, only \$30 million from the Prevention and Public Health Fund has thus far been earmarked to support HIV prevention efforts.¹⁰

➤ *Advocacy Targets:*

- *Federal: ensure that the Department of Health and Human Services (HHS) targets funds to support a broad range of HIV prevention and public health services need, including grants for community-based organizations, funding for studies and initiatives addressing stigma, and funding to shore up state HIV/AIDS budgets.*
- *State: ensure that health centers and state health officials are aware of federal funding opportunities and continually check the HRSA website for new community-based grants funded through the prevention and public health fund.*

Inclusion of HIV/AIDS in Primary Care Workforce Training and Expansion

The Department of Health and Human Services (HHS) has set aside \$250 million from the Prevention and Public Health Fund in 2010 alone for investing in the development of an expanded primary care workforce, with a focus on underserved and particularly vulnerable populations.¹¹ This funding will be used for: creating additional primary care residency slots; supporting physician assistant training in primary care; encouraging students to pursue full-time nursing careers; establishing new nurse practitioner-led clinics; and encouraging states to plan for and address health professional workforce needs.

➤ *Advocacy Targets:*

- *Federal: push HHS to secure funding for training and retention of HIV/AIDS specialists as well as primary care physicians*
- *Federal: work with HRSA to use the AIDS Education and Training Centers funded under Part F of Ryan White Programs as a model for broader health workforce training, especially around treatment for chronic conditions and urge HRSA to designate Ryan White grantees as eligible sites for National Health Service Corps programs.*
- *State: work with states to encourage health professional workforce development, for instance by developing and collaborating with community health worker networks, and ensure that state health officials, health centers, and community-based organizations are aware of new federal funding opportunities.*

Inclusion of HIV Funding in Community Health Center Initiatives

The health care reform law includes billions of dollars in funding and grants for community health centers, including \$11 billion in funding for the operation, expansion and construction of health centers throughout the nation over the next five years.¹² For instance, the federal government recently announced the availability of \$250 million in grants for New Access Points to support more than 350 new Health Center service delivery sites in 2011.¹³

➤ *Advocacy Targets:*

- *Federal: push the Health Resources and Services Administration (HRSA) to encourage centers applying for New Access Point grants to include comprehensive health and support services for people living with HIV and AIDS and urge HRSA to issue guidance to Ryan White grantees on how to become a federally qualified health center and provide technical assistance to grantees throughout the application process.*
- *State: encourage health centers to apply for grants to expand services for people living with HIV and AIDS. Clinics that are not in compliance with federal rules regarding qualified health centers should consider bringing themselves into compliance to be eligible for federal grants.*

Integration of Ryan White Programs into Health Care Reform Initiatives

Ryan White Programs offer an important blueprint for the expansion of comprehensive health and support services for people with chronic illnesses. In many ways, Ryan White Programs serve as a best-practices model for comprehensive and holistic provision of care and treatment. As major health care reform provisions go into effect, however, the role of Ryan White will undoubtedly change.

Preparing for Medicaid and Private Health Insurance Expansions

Starting in 2014, millions of people formerly unable to access health insurance coverage will be able to secure coverage through the Medicaid and private health insurance expansions. Advocacy around integration of Ryan White providers into Medicaid and state exchange provider networks, for instance, will be crucial to ensure seamless access to care for the thousands of people newly-eligible for Medicaid and private insurance coverage. Integration of Ryan White Programs and models of care into Medicaid and private insurance models is also important to ensure a smooth health care reform transition for those currently receiving care.

➤ *Advocacy Targets:*

- *Federal: advocates should work with HRSA and other federal agencies to advance the comprehensive and holistic models of care that have become the hallmark of Ryan White Programs as health care reform is implemented, integrating Ryan White grantees and providers into both the Medicaid expansion and state exchanges; and develop recommendations for what Ryan White programs care and service delivery systems are replicable beyond HIV/AIDS services and should be used as a model for health care reform provisions (i.e., the “medical home” model).*
- *State: encourage Ryan White providers to integrate into Medicaid and state exchange provider networks and work with state Medicaid offices, state exchanges, and Ryan White grantees to ensure seamless transition to insurance expansions going into effect over the next five years.*

Temporary High Risk Pools

To provide immediate access to care before 2014, the health care reform law allocates \$5 billion for the creation of temporary high risk pools in every state and the District of Columbia, allowing immediate access to coverage for people living with HIV who have been excluded from the private insurance market based on a pre-existing condition.¹⁴ Advocates were unsuccessful in getting HIV and AIDS included on a federal list of automatically qualifying pre-existing conditions; however, most state pools elected on their own to include HIV and AIDS as such automatically qualifying conditions. A significant hurdle to access to the coverage provided by these pools is cost. Premiums vary based on age and whether the applicant is a smoker – in Pennsylvania, for instance, the average

monthly premium will be \$283 a month with a \$1,000 deductible. Excluding premiums, annual out-of-pocket costs in the new plans will be limited, with a \$5,940 maximum for co-pays and deductibles.

➤ *Advocacy Targets:*

- *Federal: urge HRSA to issue guidance on the role of Ryan White Programs in providing third-party support and wrap-around services and on how Ryan White providers can integrate into new provider networks.*
- *State: push states that have opted to run their own plan to stream-line the application process, for instance by allowing HIV as an automatic eligibility criterion; urge states to eliminate existing statutory barriers that restrict third-party support to help cover costs.*

State Option to Provide Health Homes for Medicaid Enrollees with Chronic Conditions

The Medicaid Home Health program allows states to amend their Medicaid programs to provide coordinated care through a health home for individuals with chronic conditions. Specifically, the Home Health Program gives individuals the opportunity to select a provider or health team to operate as a health home and allows patients access to more integrated and holistic provision of care. For the first two years a state plan amendment is in effect, states receive enhanced federal funding – a 90% Federal Medical Assistance Percentage (FMAP) – which helps to support better information sharing between health providers through investments in information technology, better coordination of care, and increased access to support services.¹⁵ The law provides the following list of qualifying chronic conditions: a mental health condition; a substance use disorder; asthma; diabetes; heart disease; or being overweight, as evidenced by having a body mass index over 25.

➤ *Advocacy Targets:*

- *Federal: push HHS for inclusion of HIV and AIDS in regulations defining what qualifies as a “chronic condition” and ensure that states are provided with appropriate guidance as to how to set up these programs.*
- *State: encourage states to consider amending their state Medicaid plans to include this holistic coverage and thus become eligible for the 90% FMAP rates.*

Pilot Program Funded through Center for Medicare and Medicaid Innovation

Starting in 2011, the health care reform law establishes the Center for Medicare and Medicaid Innovation (CMI), which is tasked with evaluating payment and service delivery models for Medicare and Medicaid.¹⁶ CMI will consider factors such as, how well services are integrated, how health information technology is used to coordinate care for those with chronic illnesses, and how medical homes are used.

➤ *Advocacy Target:*

- *Federal: encourage CMI to fund a collaborative pilot program between the Health Resources and Services Administration (HRSA) and CMS to evaluate key program components of the comprehensive and coordinated care, treatment, and services model that is the hallmark of Ryan White programs.*

PHASE II: SECURING A BRIDGE TO 2014

Currently, hundreds of thousands of people living with HIV and AIDS in the United States are uninsured or underinsured. Many will benefit from the new health care reform law, yet several of the key reform provisions do not go into effect until 2014. In the meantime, there is a health care access crisis, and the advocacy community needs to put pressure on policymakers to bridge the health care access gap experienced by far too many low-income individuals living with HIV and AIDS. The National HIV/AIDS Strategy provides a framework for some immediate advocacy targets.

Implementing the National HIV/AIDS Strategy

In July 2010, the President announced a National HIV/AIDS Strategy (NHAS) and Implementation Plan, detailing goals and priorities to address the HIV/AIDS epidemic in the United States and providing a roadmap for drastically cutting the number of new HIV infections, increasing access to care and treatment, and reducing health disparities.¹⁷ Though the implementation plan for expanding access to care and services is somewhat limited, there are several target areas in which the NHAS recommendations, if successfully implemented, will aid in efforts to close access to care gaps. Advocates will need to work with federal agencies, state health officials, and community-based organizations to implement NHAS provisions, for instance, supporting state applications for section 1115 Medicaid waivers to immediately expand Medicaid to cover pre-disabled people living with HIV and supporting health care workforce initiatives that include training of and support for HIV/AIDS health care providers.

➤ *Advocacy Targets:*

- *Federal: ensure that the promise of the NHAS is fulfilled by advocating for adequate funding for proposed implementation plans and working to make sure that the NHAS implementation plans complement health care reform implementation and immediately fill in gaps in access to care.*
- *State: work with state officials, particularly with Medicaid and AIDS directors, to ensure that they are aware of the implementation strategies of the NHAS and to provide guidance as they work to implement key provisions, for instance supporting section 1115 waiver applications.*

Emergency Supplemental ADAP Funding

Significant increases in the number of low income people who are uninsured and must rely on AIDS Drug Assistance Programs (ADAPs) for access to life-saving medications have resulted in demand that far exceeds current funding levels. The result has been a rapidly increasing access to care and treatment crisis, with thousands of people on ADAP waiting lists throughout the country.¹⁸ States have also enacted other cost-saving measures—for instance, limiting the ADAP drug formulary— that restrict access to needed medications.

➤ *Advocacy Targets:*

- *Federal: in FY2010, advocate for the \$126 million in federal emergency ADAP supplemental funding needed to eliminate waiting lists and reverse newly enacted cost-saving measures.*
- *State: urge states to provide necessary increases in state ADAP funding to avoid imposing waitlists and other cost-saving measures.*

Funding for Ryan White Programs

Ryan White Programs are a primary source of medical care, treatment and support services for over half a million low-income individuals living with HIV and AIDS each year; however, despite ever-increasing numbers of people living with HIV and AIDS in the United States, federal funding of Ryan White programs has not kept up with need. These programs must be adequately funded to provide life-saving care to low-income people living with HIV and AIDS who will not be eligible for Medicaid until 2014.

➤ *Advocacy Targets:*

- *Federal: In order to meet the otherwise unmet care, treatment and service needs of people living with HIV and AIDS, Congress must provide adequate funding for Ryan White Programs (in FY2011, a \$3 billion increase, including \$1.2 billion for ADAP programs.)*

Section 1115 Medicaid Waivers

Though the health care reform law largely eliminates the categorical eligibility rules that place people with HIV in a “catch-22” of having to wait until they are disabled by AIDS in order to be eligible for Medicaid coverage, the expansion does not take place until 2014. Low-income uninsured people living with HIV simply cannot wait until 2014 to gain access to life-saving care and treatment, especially given United States government treatment guidelines, which increasingly recognize the importance of providing early access to care. The NHAS implementation plan calls on CMS to “promote and support the development and expedient review of Medicaid 1115 waivers to allow States to expand their Medicaid programs to cover pre-disabled people living with HIV” by the end of 2010. Section 1115 waivers – and CMS support to states wishing to apply for and implement them – are critical to ensuring a bridge to access to care leading up to the Medicaid expansion in 2014. Importantly, active promotion and support of these waivers by the Centers for Medicare and Medicaid Services (CMS) is an implementation action item included the National HIV/AIDS Strategy.¹⁹

➤ *Advocacy Targets:*

- *Federal: encourage CMS to work with states to successfully develop Section 1115 Waivers for people living with HIV specifically by asking that CMS create a new waiver initiative under Section 1115 to help states provide temporary Medicaid coverage through 2014 similar to the initiative that was created in response to Hurricane Katrina; expedite the application and review process; send a letter to state officials alerting states to the option of applying for a section 1115 waiver; promote the waiver option on its website; organize a conference call (or series of calls) that will include state Medicaid Directors and AIDS Directors to discuss the waiver option and address questions; appoint a designated CMS representative to provide technical assistance to states; and design a waiver template including information states will need to reach budget neutrality.*
- *State: encourage states to consider applying for a Section 1115 waiver.*

Early Treatment for HIV Act (ETHA)

When health care reform’s Medicaid expansion takes effect in 2014, Medicaid-based care and treatment will be available to all individuals below 133% of the federal poverty level (in 2010, \$14,404 for an individual/ \$29,327 for a family of four).²⁰ However, low-income uninsured people living with HIV cannot wait until 2014 to gain access to live-saving care and treatment. ETHA would help to bridge the gap until 2014 by allowing states to immediately expand Medicaid access to pre-disabled people living with HIV and providing states with an enhanced federal FMAP.

➤ *Advocacy Target:*

- *Federal: continue to lobby Congress for enactment of ETHA.*
- *State: urge your congressional delegation and state leadership to endorse ETHA and promote its passage with your members of Congress.*

Enhanced Federal Funding of Medicaid Programs

In order to stave off harmful cuts to state Medicaid programs at a time when more people needed Medicaid due to high rates of unemployment, the American Recovery and Reinvestment Act of 2009 provided states with enhanced federal funding of Medicaid programs. Though Congress voted to extend the enhanced federal matching rate another six months (to the end of June 2011), there is no indication that the unprecedented budget shortfalls states are currently facing will have abated by then.²¹

➤ *Advocacy Target:*

- *Federal: ensure that enhanced federal matching rates are continued to help states ride out the current economic crisis and avoid cutting needed Medicaid services.*
- *State: urge your Congressional delegation and state leadership to support enhanced federal matching rates*

PHASE III: BEYOND HEALTH CARE REFORM: THE NEED FOR ONGOING ADVOCACY TO SECURE HEALTH CARE FOR PEOPLE LIVING WITH HIV AND AIDS

Passage of health care reform was an historic and important step forward in the fight to expand access to health care in this country. However, even after all of the most important expansion provisions go into effect in 2014, there will still be gaps and limitations that need to be addressed. Within Medicaid alone, there is potential for substantial disparities between the benefits available to newly-eligible and already-eligible beneficiaries and the stringent citizenship requirements in place before reform remain a barrier for thousands of immigrants. Advocates must be aware of these gaps and limitations and work to ensure that access to care is a reality for everyone.

Additional Medicaid Reforms

Essential Health Benefits for All Medicaid Beneficiaries

The health care reform law provides an essential health benefits package for all newly-eligible beneficiaries – individuals not eligible for Medicaid on the date of enactment of the law with income up to 133% of the federal poverty level.²² These beneficiaries in all states are entitled to a benefit plan that includes, among other benefits, prescription drugs, preventive services, chronic disease management, mental health, and substance use services. Already-eligible beneficiaries – those enrolled in or eligible for Medicaid under pre-reform law on the date of enactment of the law – are not subject to the new essential health benefits package required for newly-eligible beneficiaries. Without a national, federally mandated benefits package for all beneficiaries, benefits will continue

to vary dramatically by state. This difference is largely because, for already-eligible beneficiaries, there are different categories of Medicaid benefits, mandatory and optional. Under traditional Medicaid rules, for instance, physician services are among the mandated benefits, while prescription drug coverage is optional (though all states currently provide some sort of prescription drug coverage in their Medicaid programs).

➤ *Advocacy Targets:*

- *Federal: extend the federally-mandated essential health benefits package to all Medicaid beneficiaries.*
- *State: until enactment of a new federally-mandated benefits package, ensure that states provide a benefit package that meets the care and treatment needs of people living with HIV and AIDS; urge states not to pare back benefits or eligibility in order to fund expansion.*

Provider Reimbursement Rates

Current Medicaid reimbursement rates are shockingly low, and must be increased to ensure medical providers are willing and able to serve low-income clients. While the law increases primary care reimbursement rates for 2013 and 2014, this increase is temporary and not extended to specialists.²³

➤ *Advocacy Targets:*

- *Federal: urge federal extension of increased reimbursement rates for Medicaid providers, including specialists, and ensure that when access to coverage expands in 2014, there is a permanent and sufficient reimbursement rate.*
- *State: monitor state reimbursement rate proposals and work with health care providers and others to ensure that rates meet the true cost of providing care and support access to needed services and providers.*

Automatic FMAP Increase

During economic crises, state tax revenues plummet at the same time as the number of those in need of and eligible for Medicaid increases dramatically.²⁴ Instead of waiting for Congress to act in times of economic crisis, an automatic increase in federal support should be tied to indicators of fiscal distress, like high unemployment.

➤ *Advocacy Targets:*

- *Federal: enact legislation for automatic enhanced FMAP during economic crisis.*

Immigration Barriers to Access to Care

Both now and after the eligibility expansion in 2014, legal immigrants still must endure a five-year waiting period to be eligible for Medicaid. This rule ensures that large gaps remain in access to care for low-income individuals, including those who are legally in the United States, working and paying taxes.

➤ *Advocacy Targets:*

- *Federal: rescind bans on access to public benefits for documented immigrant communities.*
- *State: ensure that state health officials and health centers are aware of and apply for grants available for community health centers through billions of dollars in health care reform funding.*

Re-conceptualization of and Continued Funding for Ryan White Programs

With implementation of health care reform, thousands of individuals who previously received care and treatment through Ryan White programs will now access health care through Medicaid and new state insurance exchanges. It is clear that despite the tremendous possibilities of health care reform for individuals living with HIV and AIDS, major gaps in affordability and access to essential care, treatment, and services will remain. Even after full implementation of health care reform, Ryan White Programs will be necessary to fill these gaps.

➤ *Advocacy Target:*

- *Federal: ensure that Ryan White Programs are integrated into health care reform and remain adequately funded following the health care reform expansion, including working with HRSA to define ongoing need for Ryan White supported care, treatment and essential support services.*
- *State: work with Ryan White grantees to identify gaps and limitations in health care reform and ensure that Ryan White is able to provide a safety net and to fill these gaps.*

HIV/AIDS Testing and Linkage to Care

The benefits to individual and public health from HIV testing and early intervention are numerous. However, the promise of early intervention is only realized if routine HIV testing and immediate access to care upon testing HIV positive are available. The NHAS includes the goal of significantly increasing testing and the proportion of newly diagnosed patients linked to clinical care within three months of diagnosis, and advocates should work with federal and state agencies to ensure that testing and care services are in place to meet this goal.

➤ *Advocacy Target:*

- *Federal: push for coverage of testing under Medicaid/Medicare and all private insurance plans; urge the U.S. Preventive Services Task Force to reconsider its recommendation supporting routine HIV testing only for persons who are determined to be at increased risk for HIV infection; and hold government officials accountable for meeting the NHAS implementation goal of combining increased testing with linkage to care.*
- *State: push for coverage of testing under Medicaid and all private insurance plans; and hold state government officials accountable for meeting the NHAS implementation goal of combining increased testing with linkage to care.*

RESOURCES

Treatment Access Expansion Project (TAEP), at <http://www.taepusa.org>.

Health Care Reform Implementation Center, at <http://www.healthcare.gov/center/>.

Office of National AIDS Policy (ONAP), at <http://www.whitehouse.gov/administration/eop/onap>.

Kaiser Family Foundation, at <http://kff.org>.

¹ Patient Protection and Affordable Care Act, § 1251(b). HHS issued a regulation on June 28, 2010 clarifying the PPACA's application to grandfathered plans. For example, actions that will cause a plan to lose grandfathered status include: significantly reducing benefits; significantly raising co-insurance charges, co-payment charges, or deductibles; and significantly lowering employer contributions. 45 CFR § 147.140; 29 CFR § 2590.715-1251; 26 CFR § 54.9815-1251T

² Patient Protection and Affordable Care Act, §§ 2001(c), 1302(b)(1).

³ Health Care Implementation Center: Regulations & Guidance, at <http://www.healthcare.gov/center/regulations/index.html>.

⁴ Patient Protection and Affordable Care Act, § 2801.

⁵ National Alliance of State & Territorial AIDS Directors, Safety Net Intersection: AIDS Drug Assistance Programs and the Medicare Prescription Drug Benefit, (2008), at http://www.nastad.org/Docs/Public/Publication/2008616_Medicare%20and%20ADAP%20Survey%20Report.pdf.

⁶ Patient Protection and Affordable Care Act, § 2713.

⁷ U.S. Preventive Services Task Force, Screening for HIV Recommendations, at <http://www.uspreventiveservicestaskforce.org/uspstf05/hiv/hivrs.htm#clinical>.

⁸ 45 CFR Part 147; 29 CFR Part 2590; 26 CFR Part 54.

⁹ Affordable Care Act: Laying the Foundation for Prevention, at <http://www.healthreform.gov/newsroom/acaprevention.html>.

¹⁰ National Alliance of State & Territorial ADAP Directors, HIV/Hepatitis Health Reform Watch (August 2010), at http://www.nastad.org/Docs/Public/InFocus/2010811_Health%20Reform%20Watch%20Volume%203.pdf.

¹¹ Department of Health and Human Services, News Release: Sebelius Announces New \$250 Million Investment to Strengthen Primary Health Care Workforce, June 16, 2010, at <http://www.hhs.gov/news/press/2010pres/06/20100616a.html>.

¹² Patient Protection and Affordable Care Act, § 10503.

¹³ Health Center New Access Points Funded under the Affordable Care Act of 2010, at <https://grants.hrsa.gov/webExternal/FundingOppDetails.asp?FundingCycleId=450970E7-563E-4D2D-A021-5C775F7F614E&ViewMode=EU&GoBack=&PrintMode=&OnlineAvailabilityFlag=&pageNumber=&version=&NC=&Popup=>

¹⁴ New Pre-Existing Condition Insurance Plan (PCIP), at <http://www.healthcare.gov/law/provisions/preexisting/index.html>.

¹⁵ Patient Protection and Affordable Care Act, § 27063.

¹⁶ Patient Protection and Affordable Care Act, § 3021.

¹⁷ National HIV/AIDS Strategy (July 2010) and National HIV/AIDS Strategy Implementation Plan, at <http://www.whitehouse.gov/administration/eop/onap/nhas>.

¹⁸ National Alliance of State & Territorial ADAP Directors, ADAP Watch, at www.nastad.org.

¹⁹ National HIV/AIDS Strategy Federal Implementation Plan (July 2010), available at <http://www.whitehouse.gov/files/documents/nhas-implementation.pdf>.

²⁰ Patient Protection and Affordable Care Act, § 2001(a)(1).

²¹ Center on Budget and Policy Priorities, Survey: 46 States Have Faced Budget Shortfalls This Year (2010).

²² Patient Protection and Affordable Care Act, § 2001.

²³ Health Care and Education Affordability Reconciliation Act of 2010, § 1202.

²⁴ Holahan, J. and Garrett, B., Rising Unemployment, Medicaid, and the Uninsured, prepared for the Kaiser Commission on Medicaid and the Uninsured (2009).