

### **Integrating HIV Prevention Services into the Clinical Care Setting in Medicaid and Ryan White CARE Act Programs: Legal, Financial, and Organizational Issues**

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**December 2004**



# Executive Summary

The Centers for Disease Control and Prevention (CDC) estimates that approximately 40,000 new HIV infections occur each year in the United States. Furthermore, estimated national HIV incidence has remained virtually unchanged for more than a decade and there are signs of increasing risk behavior, and even incidence, in some communities.<sup>1</sup>

In an effort to augment HIV prevention efforts, health policy experts, researchers, medical providers, government officials and community members have increasingly focused on the importance of integrating prevention into the clinical care setting, finding new opportunities to reach those at risk for and living with HIV when and where they interact with the health care delivery system.<sup>2</sup> Studies show, however, that HIV prevention, including risk assessment and prevention education and counseling, is not a routine part of clinical care in the United States. Indeed, there are many barriers to doing so. Research has increasingly examined some of these barriers with a specific focus on the role of the health care provider. Much less attention has been given to the structural and systems-level factors that enable, or inhibit, integration. These include the many legal, financial, and organizational factors that guide or constrain policy and clinical decision-making at the federal, state, and local levels. Attention to these factors may provide additional opportunities for enhancing HIV prevention integration activities.

This policy brief examines the structural-level opportunities and challenges associated with the delivery of HIV prevention services in or closely linked to the clinical care setting. It focuses on two of the major public programs for HIV care in the U.S.: Medicaid, the nation's major public health program for low-income Americans, and the largest source of public financing for HIV/AIDS care in the U.S.; and the Ryan White CARE Act, the nation's only HIV-specific care and support services grant program which operates as the payer of last resort at the state and local level. Together, these programs provide care and support services to a significant proportion of those at risk for and living with HIV and therefore provide an important focus for assessing current prevention integration practice, identifying strategies to enhance integration, and targeting such efforts.

The brief reviews the legislative and statutory authorities governing the Medicaid and Ryan White

programs to assess the extent to which current law allows for the provision and financing of HIV prevention services. It also examines, to the extent possible, current practice by these two programs. The main findings are as follows:

- Current law already allows for the delivery and financing of most HIV prevention services through the Medicaid and Ryan White CARE Act programs.
- Available data suggest, however, that in practice, neither program is currently delivering a significant amount of HIV prevention services to their beneficiaries/clients.
- The provision of HIV prevention services by the Medicaid and Ryan White programs would, in most cases, require affirmative policy decisions at the state and local level and would likely require additional resources and/or the shifting of resources to support prevention delivery. Current fiscal pressures facing both Medicaid and Ryan White will make it unlikely that either can initiate and/or enhance the provision of prevention services at this time.
- Even if fiscal constraints were not a limitation, both the Medicaid and Ryan White programs face other organizational and systems-level barriers that complicate the integration of prevention into the clinical care setting and each would benefit from guidance and technical assistance in many areas. Such guidance would also be important for those efforts that may be currently underway.

This brief provides several options for research, technical assistance and policy that could serve to enhance opportunities for integration of HIV prevention and care including: development and dissemination of integration models; review of financing and coverage policies by federal agencies; development of federal guidance on integration; and a variety of specific technical assistance and training activities that could be pursued.

## References

<sup>1</sup>Centers for Disease Control and Prevention, "Advancing HIV Prevention: New Strategies for a Changing Epidemic—United States, 2003," *Morbidity and Mortality Weekly Report*, Vol. 52, No. 15, April 2003.

<sup>2</sup>See, for example: Institute of Medicine, *No Time To Lose: Getting More From HIV Prevention*, National Academy Press: Washington, D.C. 2001; Centers for Disease Control and Prevention, "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV," Recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America," *Morbidity and Mortality Weekly Report*, Vol. 52, RR12, July 2003.



# Integrating HIV Prevention Services into the Clinical Care Setting in Medicaid and Ryan White CARE Act Programs: Legal, Financial, and Organizational Issues

## Introduction

Health policy experts, researchers, medical providers, government officials and community members have increasingly recognized the importance of augmenting existing prevention efforts by expanding their reach into the clinical care setting.<sup>1,2,3,4,5,6,7,8,9,10,11</sup> As stated in the Institute of Medicine's (IOM), *No Time To Lose: Getting More From HIV Prevention*, "... the clinical care setting provides opportunities for integrating prevention into the standard of care for those who are infected or at high risk."<sup>12</sup> The Centers for Disease Control and Prevention (CDC) recently released recommendations for health care providers on the need to integrate prevention into the clinical care setting.<sup>6</sup> And, a new report from the Global HIV Prevention Working Group focuses on the urgent need to integrate prevention and treatment, as treatment efforts are scaled up globally.<sup>13</sup> Studies show, however, that HIV prevention, including risk assessment and prevention education and counseling, is not a routine part of clinical care in the United States.<sup>1,14,15,16,17,18,19,20,21,22,23,24</sup> This is in part due to structural issues and barriers but these have not been fully examined—most of the literature on integrating HIV prevention into primary care has focused on the role of the health care provider rather than on the structural factors that enable, or inhibit, integration.

This policy brief examines the opportunities and challenges associated with the delivery of HIV prevention services in or closely linked to the clinical care setting in the U.S., with a focus on structural and systems-level barriers and opportunities (e.g., financing, delivery systems, and staffing). It looks specifically at two of the major public programs for people with HIV/AIDS—Medicaid and the Ryan White CARE Act—but identifies issues and lessons more broadly applicable to other programs. Medicaid, the nation's major public health program for low-income Americans, is the largest source of public financing for HIV care—it is estimated to cover the care of approximately half of all people with AIDS, and a substantial portion of those newly diagnosed with HIV.<sup>25,26,27,28</sup> The Ryan White CARE Act (CARE Act), the nation's only HIV-specific care

and support services grant program which operates as payer of last resort at the state and local level, is estimated to serve over 500,000 uninsured and underinsured people with HIV/AIDS each year.<sup>29</sup> It is the third largest source of public funding for HIV care in the U.S.<sup>25</sup> Together, Medicaid and the CARE Act provide care and support services to a significant proportion of those at risk for and living with HIV and therefore provide an important focus for assessing current prevention integration practice, identifying strategies to enhance integration, and targeting such efforts. The brief reviews the legislative and statutory authorities governing the Medicaid and Ryan White programs to assess the extent to which current law allows for the provision and financing of HIV prevention services. It also examines, to the extent possible, current practice by these two programs.

## Background

Earlier literature and guidance on HIV prevention in the primary care setting have focused largely on the role of the health care provider rather than the structural components that enhance or inhibit the provision of prevention in the primary care setting.<sup>7,8,9,14</sup> A shift to a more structural approach began with the IOM's report, *No Time to Lose*, which specifically addresses the importance of system-level changes needed to integrate HIV prevention into the clinical care setting. As recommended by the IOM:

Prevention services for HIV-infected persons should be a standard of care in all clinical settings (e.g., primary care settings, sexually transmitted disease clinics, drug treatment facilities, and mental health settings). Health care providers should have adequate training, time, and resources to conduct effective HIV prevention counseling. Enabling this activity may require adjustments in health care provider time allocations and/or specific financial incentives from public and private sources of health coverage.<sup>30</sup>

The IOM recommends the development of policy initiatives and incentives to encourage delivery of prevention services within public and private programs, including Medicaid and the Ryan White

CARE Act. In the context of Medicaid, the IOM suggests that CDC and the Centers for Medicare and Medicaid Services (CMS) find ways to encourage states to adopt important but optional Medicaid benefits that are prevention-related, such as targeted case management. Other mechanisms include enhanced reimbursement rates within the Medicaid fee-for-service system and the need for states to incorporate quality assurance measures for HIV prevention and adequate capitation rates to account for prevention service delivery within the Medicaid managed care environment. In the context of the CARE Act, the IOM suggests that the Health Resources and Services Administration (HRSA) foster coordination and provision of prevention services by CARE Act grantees, such as encouraging all clinical providers supported with CARE Act funds to make HIV risk assessment a standard part of care and permitting referrals to CDC-funded prevention case management services by CARE Act-funded case managers.

CDC has undertaken several recent initiatives consistent with IOM recommendations, reflected in the *Advancing HIV Prevention* protocol<sup>4</sup> and recently released recommendations for the integration of prevention into the clinical care setting.<sup>6</sup>

Through ongoing attention to prevention, risky sexual and needle-sharing behaviors among persons with HIV infection can be reduced and transmission of HIV infection prevented. Medical care providers can substantially affect HIV transmission by screening their HIV-infected patients for risk behaviors; communicating prevention messages; discussing sexual and drug-use behavior; positively reinforcing changes to safer behavior; referring patients for services such as substance abuse treatment; facilitating partner notification, counseling, and testing; and identifying and treating other sexually transmitted diseases (STDs).<sup>31</sup>

The recommendations are intended for all health care workers who provide medical care to HIV-infected persons (e.g., physicians, nurse practitioners, nurses, physician assistants). They may also be used by those who deliver prevention messages (e.g., prevention case managers, social workers, health educators). While these guidelines focus primarily on the role of the provider, they do note the importance of the financing and service delivery environment.

## The Importance of the Clinical Care Setting for Prevention

“HIV prevention” encompasses a wide range of services important for identifying at-risk and HIV-infected persons to reduce the risk of transmission (see Table 1). Many of these prevention services are compatible with the clinical care setting, and may be integrated or closely linked with it. In addition, the medical care setting offers an opportunity to reach a large cohort of at-risk and HIV-infected persons. Among those who are already HIV positive, the CDC estimates that approximately 445,000 (out of an estimated 850,000 to 950,000 people living with HIV/AIDS) are receiving ongoing medical care.<sup>32</sup> Those at risk for HIV may already be receiving (non-HIV) medical services in the care setting (e.g., STD treatment, family planning services, emergency room care, and others).<sup>1</sup>

**TABLE 1: HIV Prevention Services**

### ***Diagnostic/Assessment***

- HIV risk assessment
- HIV testing and diagnosis
- Pre- and perinatal HIV screening
- STD screening
- STD diagnosis and treatment
- Population-based screening in emergency rooms and ambulatory care settings

### ***Interventions to Reduce the Risk of HIV Transmission***

- HIV education—individual or community
- Risk reduction counseling
- Partner notification programs
- Partner counseling and referral
- Pre- and perinatal HIV counseling and education
- Pre- and post-test counseling
- Antiretroviral therapy for preventing perinatal transmission
- Intensive counseling (individual, couples, group)
- Peer support group or outreach services
- Condoms
  - Needle and Syringe Exchange
- Occupational post-exposure prophylaxis for HIV
- Prevention case management
- Substance abuse treatment
- Mental health services

Most HIV testing in the U.S. is done in the medical care setting<sup>33,34</sup> including for those who are at risk and newly diagnosed with HIV. Analysis of data from the CDC's HIV/AIDS Reporting System (HARS) in 25 states found that about half of those diagnosed with HIV between 1994 and 1999 were tested in an inpatient (27%) or private medical doctor setting (22%). Eleven percent were tested at an HIV counseling or testing site.<sup>28</sup> Analysis of data from the CDC's HIV Testing Survey (HITS) of those at-risk found that most were tested in public health clinics, including community health centers, followed by private doctor's offices.<sup>35</sup>

These data underscore the importance of the clinical setting as an opportunity to intervene to reduce the risks associated with HIV transmission. They also provide critical information about where such interventions could be targeted.

Precedent for incorporating preventive services into the routine of clinical medicine can be found in the experience of numerous other chronic and preventable illnesses, including: alcohol misuse, obesity, smoking cessation, asthma, cardiovascular disease, depression, diabetes, lower back pain, and others.<sup>36,37</sup> In addition, the necessity and challenges of integrating or linking primary care and prevention services have been well documented, and provide insight for consideration in the field of HIV/AIDS.<sup>38,39,40,41,42,43</sup> These include:

- The lack of coverage and reimbursement for prevention services;
- The need for data on the costs of interventions, including cost-benefit and cost-effectiveness data;
- The need for standardized prevention protocols;
- Organizational barriers, such as inadequate staffing, competing provider demands, provider reluctance or limitations, and an acute-care orientation among clinical providers;
- The need to develop new relationships with community-based prevention providers; and
- The lack of knowledge or awareness of interventions (among consumers, providers, and purchasers).

### **Statutory & Regulatory Considerations: What HIV Prevention Services Can Be Covered?**

Before examining the current role of Medicaid and Ryan White in providing prevention services to people at risk for and living with HIV, it is important to determine the extent to which HIV prevention services can be covered or offered by these programs, as governed by their respective statutory and regulatory authorities.

### *Medicaid*

The federal Medicaid program allows states significant flexibility to design their own benefits packages subject to certain minimum requirements.<sup>44,45,46</sup> These requirements include certain mandatory services that states must provide in order to participate in the Medicaid program and receive federal matching funds and optional services that states can choose to provide (and receive federal matching funds for them), but are not required to do. Therefore, to the extent that a specific HIV prevention-related service is optional, its coverage would be dependent on individual state policy decisions.

A legal review of the Medicaid statute was conducted by The George Washington University, Center for Health Services Research and Policy to assess coverage of a range of key HIV prevention services. Table 2 summarizes Medicaid statutory coverage for HIV prevention services as well as limitations by service type. It is evident that a broad continuum of prevention services—from risk assessment and HIV counseling and testing to behavioral health services—can be reimbursed under Medicaid if these services are part of the state's Medicaid plan or incorporated into a managed care contract.<sup>47</sup> All of the services identified in Table 2 are optional Medicaid services [except in the context of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for children, or for a family planning visit]. Because these services are optional, states would need to make a policy decision to offer them. In addition, states are limited by several general restrictions as follows:

- prohibition against using federal funds for needle exchange programs;<sup>48</sup>
- prohibition against providing services to non-Medicaid beneficiaries<sup>49</sup> (e.g., partner counseling and notification services and partner referrals); and
- prohibition against using non-licensed practitioners<sup>50</sup> (e.g., peer support groups).

Some states have already recognized that Medicaid reimbursement is currently available to pay for many key HIV prevention services and are using various methods of reimbursement (including: direct fee-for-service reimbursement and the bundling of behavioral intervention/prevention services to create new service categories) for HIV prevention. However,

**TABLE 2: Medicaid and The Ryan White CARE Act: Summary of Statutory & Regulatory Coverage of HIV Prevention Services**

<b>HIV Prevention Services</b>	<b>Medicaid Coverage<sup>1</sup></b>	<b>CARE Act Coverage<sup>2</sup></b>
<b><i>Diagnostic/Assessment</i></b>		
HIV risk assessment	Yes	Yes
HIV testing and diagnosis	Yes	Yes
Pre- and perinatal HIV screening	Yes	Yes
STD screening	Yes	Yes
STD diagnosis and treatment	Yes	Yes
Population-based screening in emergency rooms and ambulatory care settings	Yes	Yes <sup>3</sup>
<b><i>Interventions to Reduce the Risk of HIV Transmission</i></b>		
HIV education—individual or community	Yes <sup>4</sup>	Yes <sup>5</sup>
Risk reduction counseling	Yes	Yes
Partner notification programs	No	Yes
Partner counseling and referral	Yes <sup>4</sup>	Yes <sup>6</sup>
Pre- and perinatal HIV counseling and education	Yes	Yes
Pre- and post-test counseling	Yes	Yes
Antiretroviral therapy for preventing perinatal transmission	Yes	Yes
Intensive counseling (individual, couples, group)	Yes <sup>4</sup>	Yes <sup>7</sup>
Peer support group or outreach services	No	Yes <sup>7</sup>
Condoms	Yes	Yes
Needle and Syringe Exchange	No	No
Occupational post-exposure prophylaxis for HIV	Yes <sup>8</sup>	No <sup>8</sup>
Prevention case management	Yes <sup>9</sup>	Yes
Substance abuse treatment	Yes	Yes
Mental health services	Yes	Yes

**NOTES**

- <sup>1</sup> Medicaid statute allows service to be covered by states, either under fee-for-service or Medicaid managed care, and for state to receive federal matching funds.
- <sup>2</sup> Coverage may differ by Ryan White CARE Act Title and is generally limited to HIV-infected persons, affected family members, and persons at-risk for HIV infection.
- <sup>3</sup> CARE Act Reauthorization of 2000 permits such screenings in CARE Act designated key points of entry.
- <sup>4</sup> For Medicaid eligibles only.
- <sup>5</sup> Services may be provided only to eligible persons and family. Outreach services limited to at-risk population for purposes of bringing into care. Broad public health campaigns and community education not allowable expenses.
- <sup>6</sup> Services provided only to eligible persons and family members. Title II Partner Notification Grants authorized for administration of partner counseling and referral services (PCRS) program, currently unfunded by Congress.
- <sup>7</sup> Services may be provided to individuals without HIV if at high risk for HIV infection.
- <sup>8</sup> Medicaid: FDA-approved use for occupational post-exposure prophylaxis only; assessment and diagnostic tests may be reimbursable or covered; Ryan White: funds may only be used to provide therapeutic treatment to HIV-infected persons.
- <sup>9</sup> See discussion in text.

no state covers the complete package of prevention services.

One of the most critical HIV prevention services is prevention case management (PCM), defined by the CDC as:

[a] client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. PCM is a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, on-going, and individualized prevention counseling, support, and service brokerage.<sup>51</sup>

PCM serves as the primary vehicle for the management of client prevention needs across a broad spectrum of service providers (counseling and mental health, substance abuse, medical care, and others) and at the same time provides direct patient education and counseling services. While the term “PCM” is not used in the Medicaid statute, the statute does define “preventive services” and “case management” as follows:

- “Preventive services” are designed to “(1) prevent disease, disability, and other health conditions or their progression (2) prolong life; and (3) promote physical and mental health and efficiency.”<sup>52</sup>
- “Case management” is designed to assist Medicaid beneficiaries in “gaining access to needed medical, social, educational, and other services.”<sup>53</sup>
- In addition, the Medicaid statute allows states to limit or target the provision of case management specifically to people with HIV/AIDS and to certain other groups.<sup>54</sup> This is called “targeted case management,” which is defined in the same way as case management above.

Case management, including targeted case management, is an optional Medicaid benefit which states must choose to provide. States have the flexibility to design such a benefit in a way that combines both prevention and case management services, setting a payment rate for the benefit and giving it an appropriate name (e.g., HIV Prevention Case Management). Several options for payment exist:

- Payment on a fee-for-service basis, combining procedure codes for preventive health services with codes for case management functions;

- Payment on an all-inclusive encounter-based rate where the provider is a clinical provider (such as an FQHC, RHC, or other clinical rate);
- Payment as part of an overall monthly member enrollment rate in the case of individuals receiving services through comprehensive risk-based managed care plans; or
- Payment as part of the case management fee paid to primary care case managers in the case of persons receiving health care through limited managed care arrangements known as primary care case management systems.

### *Ryan White CARE Act*

A legal review was also conducted of the Ryan White CARE Act. Table 2 (see page 5) summarizes Ryan White CARE Act coverage for HIV prevention services as well as limitations. The review found that, as with Medicaid, the CARE Act also provides states and localities with broad flexibility to provide a wide range of preventive services to individuals with and at risk for HIV infection and their family members. The definitions of “ambulatory services” and “early intervention services” in the CARE Act are broad enough to encompass most prevention services listed. The CARE Act also has some flexibility not available under Medicaid. Unlike Medicaid, CARE Act funds are not bound by provider licensure requirements. In addition, CARE Act funds can support services for at-risk persons and family members (depending on Title-specific eligibility categories). Recent legislative changes to the CARE Act expanded further the use of funds for prevention under different CARE Act Titles.

Actual services provided under the CARE Act vary by jurisdiction, based on planning and allocation decisions made by local Planning Councils (Title I), State Consortia (Title II), and directly funded grantees (Titles III and IV), although they are subject to the general parameters of the law discussed above and numerous Title-specific statutory requirements (see discussion below about current practice). The level of available funding may also limit a jurisdiction’s ability to provide a full range of prevention services. In addition, the use of funds to support HIV prevention services through the CARE Act must comply with “payer of last resort” provisions as defined by statute. In the case of CARE Act funded prevention case management services, for example, programs are required to use available CDC (or other federal, county, or local) funding prior to the use of CARE Act funds for prevention services. Although CARE Act funds cannot supplant the funds from other payer sources,

there are numerous examples of the collaborative financing of PCM services using CARE Act and CDC funds. For example, New Mexico recently enacted a state-wide PCM program administered through state-designated health management alliances (HMA) that cover four geographic areas and one Native American community. The PCM is accomplished through a collaboration of the HMA and the county health department's early intervention nursing services program. The funding is a mix of state general revenues, HIV prevention funds from the state health department, and CARE Act Title II and III grants. The program was built on the existing case management program supported by Title II CARE Act funds.

### **Current Practice**

Having established what Medicaid and the CARE Act can provide in the way of prevention services, it is important to understand—to the extent this information is available—the degree to which these program are already providing such services in practice.

#### *Medicaid*

Very little is known regarding the actual coverage and financing of prevention-related services for Medicaid beneficiaries at-risk for or living with HIV disease. Since some HIV prevention services can be incorporated into a traditional office visit or other services covered by Medicaid (e.g., mental health counseling), it is difficult to determine the degree to which providers are offering HIV prevention counseling or related services of some kind. However, states as managers of their Medicaid programs often communicate their policy priorities for services to be provided to their beneficiaries through their General Service Agreements (GSAs), their contracts with managed care organizations (MCOs), and primary care case management (PCCMs) contracts, their contracts with primary care providers.<sup>55</sup> It is important to note that inclusion within a contract does not guarantee delivery of these services. Similarly, their omission does not necessarily mean that managed care entities are not providing these services as part of their overall package of benefits provided to members. However, inclusion in a contract can mean that HIV prevention services are included in determining the capitation or reimbursement rates paid MCOs and their providers.

To examine state Medicaid coverage for HIV prevention services through managed care contracts, George Washington University, Center for Health

Services Research and Policy researchers performed a contract analysis of state GSAs and PCCMs for the year 2000. Forty-eight states had GSAs for managed care and/or PCCMs. Key findings include:

- The majority of states (32 of 48) covered HIV testing and counseling and STD testing and treatment services;
- 19 of 48 states included prenatal and perinatal counseling and testing requirements;
- 7 of 48 states specified coverage for behavioral interventions such as substance abuse and mental health services, including intensive counseling and HIV prevention counseling;
- 4 of 48 states included HIV risk assessment in their Medicaid managed care/PCCM contracts. Two targeted family planning and 2 targeted at-risk and adult enrollees;
- 3 states allowed for beneficiaries to use anonymous or confidential HIV testing sites and to reimburse sites for such services;
- 2 of 48 states included provisions for case management coupled with prevention education. No state covered direct prevention case management; and
- No state provided additional or specific financial reimbursement for covered HIV prevention services.

These findings indicate that, beyond HIV testing and counseling, few states explicitly covered HIV prevention services under GSA and PCCM contracts and, to the extent that other services were covered, states tended to limit coverage to specific target populations.

#### *Ryan White CARE Act*

Historically, CARE Act funding for HIV prevention services was limited largely to Title III (direct federal grants to community-based providers for clinical care) and Title IV (network development to support research and care for women and children) programs, as well as to “early intervention services” only—specifically, HIV counseling and testing, education, and referral services. The reauthorization of the CARE Act in 2000 expanded coverage for early intervention services under Titles I and II, the federal grants to eligible metropolitan areas and states, respectively. All Titles have had flexibility to support targeted outreach activities, as clarified in the 2000 reauthorization.

In order to assess coverage of HIV prevention services through Ryan White CARE Act programs, a survey of all CARE Act grantees and their subcontractors was conducted between 1999–2000.<sup>56</sup> Findings from the survey highlight the significant role of CARE Act providers in providing HIV prevention services.

- Almost half (47%) reported delivering prevention services. These organizations receive funding through a patchwork of entitlement and discretionary grant programs including Medicaid and Titles I, II, III, and IV of the CARE Act;
- One-third of the CARE Act grantees and subcontractors surveyed reported receiving CDC funds to support HIV prevention services;
- CARE Act-funded community-based prevention providers were more likely to provide HIV counseling and testing than CARE Act-funded medical and other clinical providers (67% vs. 55%, respectively). These providers were also more likely to provide for case finding activities and outreach;
- Community-based organizations (49%) were more likely to provide prevention services than public health departments (17%), community health care centers (10%), hospital outpatient programs (9%), and mental health and substance abuse agencies (3%); and
- Minority agencies<sup>57</sup> were more likely to provide prevention services than non-minority agencies (42% vs. 35%).

These findings highlight several important issues including:

- The majority of HIV prevention services delivered by CARE Act funded programs were provided by prevention and social services providers and not clinical care providers or within health care settings;
- Relatively few CARE Act providers received CDC funding for prevention service delivery;
- CDC-funded prevention programs were generally located in community-based prevention agencies and health departments as opposed to clinical settings and/or CARE Act-funded sites; and
- While minority providers have developed capacity to provide prevention services, their capacity remains limited and programs may not be linked or integrated into other social service and clinical services and providers.

## Organizational Issues In Incorporating Prevention Into the Clinical Care Setting

Regardless of coverage or care source, to the extent that clinical providers and institutions may be interested in providing HIV prevention services for their clients, several key organizational factors may impact delivery and management, including:

- **Benefits coverage and reimbursement** levels, including the methods of determining service costs;
- The challenge of **coordinating funding streams**;
- **Operational issues** such as establishing HIV prevention service standards, protocols, and operating procedures for purpose of delivering, monitoring, and contracting for prevention services; and
- The challenge of developing **community-based prevention-care networks**

### *Benefits Coverage and Reimbursement for HIV Prevention Services*

As indicated by the review of statutory and regulatory provisions, many HIV-related prevention services can be reimbursed under Medicaid or paid for under the CARE Act. However, without explicit policies regarding reimbursement of HIV prevention services specifically, these services may be treated as uncovered benefits or expected to be delivered, as commonly is the case for HIV counseling and education, with limited or no monetary compensation for medical care professionals.<sup>1,58,59</sup>

As described above, few state Medicaid managed care contracts cover services beyond the traditional HIV counseling and testing provisions and, to the extent that such services are covered, states tend to limit the coverage to specific target populations (e.g., family planning service clients). No state has developed adjusted (reimbursement and/or capitation) rates in Medicaid to compensate for a wide array of HIV prevention services delivered in the context of providing HIV clinical care.

One challenge to developing such rates is determining costs. To date, cost information on HIV prevention services is limited and generally restricted to studies of the cost-benefit or cost-effectiveness of certain types and locations of HIV counseling and testing services and other interventions.<sup>60,61,62</sup> Beyond these studies, the costs for many HIV prevention services remain largely unknown and claims files to determine direct and

indirect costs are usually unavailable. To determine costs, prevention services program administrators, or clinics that provide prevention services, would need client-level tracking systems to determine prevention service use, costs and revenues. This would include the need to define the type of service (i.e., what is “prevention counseling”), provider roles, and service outcomes in order to establish methods of determining reasonable reimbursement levels. The definition and scope of a service (e.g., HIV education services defined as the distribution of literature/pamphlets or a face-to-face patient-provider interaction), professional fees and other direct and indirect costs, cost information to determine overall expenditures and revenues, and established billing procedures will all impact on whether the provider has the information and systems necessary to adequately determine costs and obtain reimbursement.

Some of the groundwork for this type of effort has been laid within the CARE Act. Over the past several years, CARE Act grantees have established various means of determining and reimbursing for other CARE Act funded services. Many grantees have moved to calculating “unit costs” for the reimbursement of specific CARE Act services. “Unit cost” is defined as the cost to produce or deliver one unit of a product or service. While unit costing is increasingly used by grantees with HIV-related medical services, it has not yet been applied to prevention services, and there are several key elements that would be needed to calculate prevention service costs.<sup>63</sup> These include: uniform service taxonomy (e.g., type of service to be delivered and the definition of the “unit”); variable reimbursement rates among providers for the same units to adjust for service intensity and quality; standards and protocols for delivery of prevention services (e.g., role of provider, clinic resources); a client-level tracking system to monitor costs and revenues for all services; and an organizational acceptance of the philosophy about the role and purpose of unit costing. Since receiving legislative authority to provide prevention services under the 2000 CARE Act Reauthorization, Titles I and II grantees are currently in the process of determining scope of coverage and methods of reimbursement. At this time, it is not clear if unit costing will evolve into the predominant means of supporting CARE Act funded prevention services.

### *Coordination of Funding Streams*

There are no national standards or expectations for the development, implementation, or financing of a coordinated and/or integrated prevention and care

service environment. Discretionary federal grant programs [such as prevention funding through CDC, Ryan White CARE Act funding through HRSA, and substance abuse and mental health prevention and care funding through the Substance Abuse and Mental Health Services Administration (SAMHSA)] and state Medicaid programs do not require the coordination of the management, disbursement, and/or planning of local prevention funds. This has resulted in multiple authorities having responsibility for the planning and disbursement of funds, and a patchwork of potentially uncoordinated and/or duplicative prevention and care services. Efforts to coordinate the planning or allocation of funds to support coordination between prevention and care services and providers remain a responsibility primarily for local jurisdictions or agencies with sometimes distinct and conflicting planning priorities and/or organizational missions and little guidance for establishing mechanisms to systematically assess areas of targeted prevention needs (for populations and types of services), expectations for the coordination of service networks to address these areas of need, and standards for financing and reimbursing prevention services to these communities.

In addition, CDC funds provided to state health departments for the support of HIV prevention services are allocated through a separate community prevention planning process that does not necessarily include Medicaid, CARE Act, and other federally-funded care and prevention programs. Further, as described in the analysis of HIV prevention service coverage among CARE Act grantees, CDC funding for prevention services is generally located outside of the HIV clinical care setting. To date, CDC does not have a mechanism to systematically track grant funding to prevention providers, either at the direct grantee or subgrantee level, to determine the actual investment of funding or effectiveness of prevention services in or outside of the HIV clinical care setting.

### *Operational Issues*

Providers are faced with several operational challenges to integrating prevention into the continuum of services provided in clinical care setting. These include:

- expansion of the mission and scope;
- changing staffing responsibilities and roles for physician providers and other medical and non-medical staff; and
- incorporation of standardized protocols and operating procedures for the acquisition, delivery and monitoring of prevention services.

Expanding the **scope and mission** of the health care organization is a difficult process for any organization. Clinical care settings planning to deliver HIV counseling, testing, and referral services or other types of HIV prevention services (e.g., risk reduction counseling, prevention case management, and education) will confront numerous procedural, organizational, legal and policy issues. Determining the scope and intensity of prevention services requires a planning mechanism to assess the relation of these new services to the health care needs of clients, its compatibility with the original mission of the institution, the staffing and management resources necessary to deliver such services, business relations and referral opportunities with external providers and organizations, and short- and long-term funding resources to support services. Previous experience in providing such services and organizational capacity (e.g., laboratory services, information reporting and claims management systems, behavioral health staff, and others) will affect the likelihood of being able to provide and monitor certain types of HIV prevention services. State and federal laws regulating patient information (e.g., federal confidentiality and privacy laws, such as HIPAA<sup>64</sup>) and the types of services and professional requirements will influence the level of coverage and delivery of services.

Numerous **staffing** issues face organizations wishing to integrate prevention into the clinical care setting. Given the multifactorial nature of individual behavior, access to various medical and non-medical clinic staff is necessary. Medical providers play an important role as the patient's primary point of contact with the medical system. In this role, providers have opportunities to assess patient risk, provide referrals to prevention or other clinical services, and establish a supportive, open environment for discussion and reinforcing risk reduction and prevention practices. However, the likelihood that at risk or HIV-infected persons will receive prevention services as part of the clinical encounter this will be affected by such factors as:

- medical provider beliefs and characteristics (i.e., perceived value of HIV prevention efforts; personal beliefs or comfort associated with discussing sex or drug using behaviors; attitudes toward HIV-infected persons);
- lack of administrative supports (i.e., routine risk assessment tools; financial resources; referral information; standards or protocols for HIV prevention services); and
- patient-provider time constraints.

The new CDC guidelines for prevention in the primary care setting are an attempt to address some of these challenges.<sup>6</sup>

In addition to medical providers, other health professional and non-professional staff play an important role in delivering HIV prevention services. Behavioral health staff (mental health and addiction services professionals), nurse educators and case managers, risk reduction counselors, health educators and prevention case managers, peer outreach workers and counselors, and others provide an array of complementary prevention services. Incorporating these staff into the clinical setting may require changes to existing management and organizational structures, as mentioned above, and the need to develop a "prevention-care team." Cultural and language needs of clients may need to be incorporated into this prevention-care approach and could be accomplished via these additional staff.

Incorporating HIV prevention services in the clinical setting will also require the **standardization** of these services for purposes of establishing quality measures, professional responsibilities, practice guidelines, decision models, and cost-effectiveness analysis. Prevention interventions, however, are intrinsically less standardizable than medical procedures. Problems exist within several key areas:

- translating HIV prevention and epidemiologic transmission research findings into practical clinical guidelines for providers;
- defining the preventive service (i.e., what is a health education encounter) in order to establish procedural guidelines, roles and responsibilities of medical and non-medical providers, the unit of service, and direct and indirect service costs;
- establishing information systems necessary for assessing service utilization, costs, program effectiveness, and quality control and monitoring; and
- establishing evaluation criteria for purposes of determining program outcomes, cost-effectiveness, contract compliance and program accreditation.

To date, several federal and state agencies have begun investigating these issues for a limited scope of HIV-related prevention services.<sup>65</sup> However, most of the development of standards for prevention/behavioral intervention services standards has occurred within the context of the contracting for behavioral health services, as this relates to quality monitoring and accreditation for private and public behavioral managed healthcare organizations.<sup>66</sup>

A recent study of HIV positive patients in HIV primary care found that those seen in clinics with specific, written HIV prevention procedures were significantly more likely to report receiving HIV prevention counseling compared to patient seen in clinics without written procedures, underscoring the need for such standards and guidance.<sup>67</sup>

### *Community-based Prevention-Care Networks: Linking Community-based Prevention Providers to Clinical Care Settings*

Establishing linkages between clinical care settings and community-based prevention providers is essential to creating a comprehensive prevention-care service environment. Once a clinical provider has identified high-risk behaviors of an at-risk or HIV-infected patient, the provider referral process and established network relations are critical to linking patients from the clinical setting to prevention services. Key elements in engaging and sustaining clients in the prevention and care system include the need to assess the full range of client needs, identify adequate referral services and programs, establish meaningful contact and relations with such referral programs, and provide follow-up to determine referral success.<sup>38</sup> Numerous referrals may be necessary to address the myriad of behavioral issues facing the client (e.g., mental health needs, access to direct interventions such as condoms or clean syringes/needles, case finding and partner education and counseling, addictive disorder and recovery services, couples counseling, and others) or the complex array of social issues impacting on the clinical care of the client.<sup>68</sup>

The types of providers included within a network need to be dependent on the populations being served and draw from a range of types of providers such as prevention case management providers, family planning clinics, STD clinics, ERs, HIV care providers and clinics, mental health and addictive disorder services, HIV risk reduction counseling and education, peer support services and outreach, and others. These providers would need to be responsive to the array of social, cultural, and clinical needs of the local at risk or HIV-infected community.

Additional issues in developing such a network include: the oversight of management of the network (e.g., use of a “collaboration manager”); private sector involvement; methods of monitoring and tracking clients for quality and evaluation activities; data sharing among Medicaid, providers, and public health agencies; establishing meaningful business relations and adequate financial resources; and

agency-specific measures for building staff and clinic skills and designating resources for establishing relations with other providers.

Complicating these challenges is the fact that prevention service providers—predominantly social service (or behavioral services) organizations located within the community—are frequently fragmented from the clinical care setting. Interactions between these parties are often dependent upon personal relations and common organizational missions or goals, organizational and business relations, available entitlement and discretionary funding sources, and a familiarity with and appreciation for the utilization of services for specific client needs.<sup>39,69,70</sup> In addition, providers needed to respond to the range of client prevention needs may not be available or accessible within all communities. Finally, there are few described and/or well disseminated models on prevention-care networks from either federal agencies or local community-based programs.<sup>71</sup>

Case management has historically assumed the role of coordinating the medical and support service needs of the clients. However, the use of prevention case managers to coordinate prevention services (and provide prevention education and counseling) remains relatively rare with limited evaluation data available.<sup>51</sup> The role and models of the prevention case manager (including methods of coverage and reimbursement) in relation to the clinical care setting are relatively undeveloped. Recently, several states have started to explore methods of creating prevention case management programs through blending and consolidating of prevention and care case management services and federal funds. For example, Kansas Department of Health and the Environment, the grantee of Title II CARE Act funds, recently expanded upon existing CARE Act supported case management to include prevention education and counseling activities, thus, establishing a prevention case management system providing both clinical and prevention coordination. Additional funds for this service are provided through the CDC state prevention grant.

Any of the above issues collectively, or on their own, may raise serious barriers to client access to or use of prevention services. Developing and implementing a comprehensive and negotiable (i.e., patient friendly) prevention-care service system requires deliberate acts of network development, management, and financing. Models describing pathways among testing, care, and prevention services need to outline the organizational and financial features necessary for supporting a continuum of prevention-care services and the acquisition of sustainable diverse resources to support these models.

# Conclusion and Policy Implications

The clinical care setting offers a unique opportunity to reduce HIV transmission among a large number of at risk and HIV-infected persons and their partners and family members. In this policy brief, we have presented a series of structural and systems-level issues that support, as well as complicate, the process of integrating prevention into primary care.

A review of the legislative and statutory authorities governing the Medicaid and Ryan White programs, their current practice, and relevant literature indicate the following:

- Current law already allows for the delivery and financing of most HIV prevention services through the Medicaid and Ryan White CARE Act programs.
- Available data suggest, however, that in practice, neither program is currently delivering a significant amount of HIV prevention services to their beneficiaries/clients.
- The provision of HIV prevention services by the Medicaid and Ryan White programs would, in most cases, require affirmative policy decisions at the state and local level and would likely require additional resources and/or the shifting of resources to support prevention delivery. Current fiscal pressures facing both Medicaid and Ryan White will make it unlikely that either can initiate and/or enhance the provision of prevention services at this time.
- Even if fiscal constraints were not a limitation, both the Medicaid and Ryan White programs face other organizational and systems-level barriers that complicate the integration of prevention into the clinical care setting and each would benefit from guidance and technical assistance in many areas. Such guidance would also be important for those efforts that may be currently underway.

While this brief is focused primarily on Medicaid and Ryan White, the challenges and opportunities identified may have broader application to other federal programs that fund HIV prevention and care services and suggest additional areas for research, technical assistance, and policy initiatives that could be undertaken by federal and state agencies and their partners to enhance integration of prevention and care services. Many of these options would require the federal agencies responsible for funding

care and prevention services (CDC, HRSA, CMS, SAMHSA, and others) to collaborate in order to promote the coordination, staff development, and fiscal sustainability of integrating or linking prevention and care services. State and local governments and program administrators would need to target resources to clinical care settings used by at risk and HIV-infected persons and support organizational and staffing arrangements that foster the provision of both prevention and care services. As mentioned above, current fiscal constraints faced by both state Medicaid programs and discretionary HIV/AIDS programs such as the CARE Act not only make it difficult to maintain existing coverage levels, they render it unlikely that additional resources could be made available to support the integration of HIV prevention at present. At the same time, coordination of funding streams could lead to greater efficiencies.

To the extent that some states and programs are already integrating prevention into the clinical care setting or for those that wish to do so, following are several options for research, technical assistance, and policy that could serve to enhance opportunities for integration of HIV prevention and care:

- Development and dissemination of models of integration of prevention in primary care and models of good working relationships between traditional prevention providers and clinical care settings.
- Review of financing and coverage policies by federal agencies (CMS, HRSA, CDC, SAMHSA) in Medicaid, Ryan White CARE Act, CDC funded programs, and SAMHSA block grants to determine whether policy guidance given grantees promotes inclusion of prevention services and/or that explicitly permit these services. This review would include assessment of potential incentives to encourage states and grantees to cover integrated prevention services. One option would be to create cooperative grant activities that promote the integration or linkage of prevention and care services.
- Provision of technical assistance to assist CDC-funded grantees in taking advantage of opportunities to provide prevention in the primary care setting, including establishing working relationships with primary care providers/clinics, assessing both the availability of other funding streams and of billing procedures.

- Provision of technical assistance and training opportunities for program administrators to assist in the development of integrated or linked networks, including: evaluation, tracking, and billing systems; organizational and business arrangements; incorporation and use of practice standards and protocols for medical and non-medical staff; and methods of planning, monitoring, and providing ongoing management support for the network.
- Training of health care providers on the incorporation of HIV prevention practices (e.g., risk assessment, counseling, and referral activities) into routine practice activities, including the development and use of written guidelines and protocols.
- Review of policies and guidances to determine if impediments exist to the development and use of non-health professionals for the provision of peer outreach, education, and counseling activities.
- Exploration of opportunities to increase the use of prevention case management under Medicaid, including changing policies and billing procedures to permit appropriate Medicaid reimbursement.
- Facilitation of discussions between state Medicaid and public health agency directors and staff on developing a prevention-care system for HIV prevention and its incorporation into existing state efforts including disease management programs and billing procedures.
- Review of state Medicaid managed care contracts to assure that comprehensive services, including prevention services, are included. One instrument available to assess these contracts is a set of sample purchasing specifications for HIV/AIDS, developed by GWU under contract from HRSA.<sup>72</sup> These purchasing specification guidelines can also be used more broadly as a checklist of comprehensive prevention services across multiple payers and providers.
- Development of guidance by CMS for state Medicaid programs regarding inclusion of HIV prevention services in all forms of managed care arrangements. Technical assistance could be provided to both Medicaid and public health staff at the state level regarding coordination of the planning and implementation of HIV prevention services funded by Medicaid programs.

In short, much work needs to be done at all levels of government and care and prevention service provision to assure the successful implementation of the Institute of Medicine's recommendation that prevention services for HIV-infected become the standard of care in all clinical settings, as well as the CDC's *Advancing HIV Prevention* strategy. This brief has shown that the methods are available and the relevant programs have much flexibility to accomplish the integration of HIV prevention in primary care if these challenges are addressed.

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