Good morning. My name is Lindsey Dawson, Public Policy Associate at The AIDS Institute. The focus of our comments today is on last month’s routine HIV screening draft recommendation from the United States Preventative Services Task Forces (USPSTF). We are highly supportive of USPSTF’s recommended “A” grade for Routine HIV Screening for adolescents and adults between the ages of 15 and 65, others outside of this age range at increased risk, and pregnant women. This positive grade change will help make HIV screening a routine component of preventative care for two significant reasons. First, because providers take cues from the USPSTF and services receiving high grades inform clinical practice and second the grade change positively impacts reimbursement across many payers. However, these strives forward are only possible if providers offer the test, patients consent, and new reimbursement pathways are utilized.

With 200,000 of the more than 1.1 million people living with HIV in the U.S., unaware of their infection, expanding testing efforts to identify unknown positives is critical. As the CHAC knows well, the twenty percent of HIV positive individuals who are unaware of their status are a major driver of the epidemic. This move beyond risk-based testing strategies recognizes the epidemiological and scientific advances that have taken place since the last review, including HPTN052, the knowledge that early diagnosis and linkage to care leads to better individual and public health outcomes, and the fact that far too many people are diagnosed at late stages of infection.

With the Affordable Care Act, more people than ever before will gain access to some form of health insurance coverage and assuming the grade is finalized, many more will have access to reimbursable HIV screening. While the grade change is key to improving coverage of HIV screening under private insurance, Medicaid, and Medicare, people in the field can benefit from federal government leadership with challenging implementation efforts.
Today, we emphasize the need for assistance from the CDC to aid in the implementation of these recommendations. Providers need education not only on the importance of routine screening and its reimbursable status but facilities, providers, and administrators will also need technical assistance related to billing and reimbursement practices. We have observed a patchwork of capabilities, infrastructures, and knowledge related to current HIV testing reimbursement across the U.S. and encourage CDC to develop a tool kit for implementing these practices. It would be helpful for the tool kit to include case studies as well as detailed information on training, accreditation, and coding. Discussion on working through barriers to reimbursement would also be useful. Lack of such a tool has been identified as an implementation barrier by NASTAD, by providers themselves and by others in the healthcare sector.

CDC grantees are accustomed to receiving testing grants and will require the agency’s assistance in the transition to become adept at billing. Additionally, within this challenging budgetary climate, leveraging limited dollars is increasingly important. However, CDC testing funding will remain critical. It is important to remember that while reimbursement covers the test and counseling, CDC funding is necessary to cover other services such as outreach, staffing, linkage to care, partner notification and reporting. Funding will also continue to support coverage for those without access to health insurance.

HRSA will also need to reach out to its grantees. HRSA’s Bureau of Primary Health Care will be instrumental in reaching out to and advising its grantee community health centers on implementing routine screening and billing infrastructures. Advising Ryan White grantees on billing and reimbursement practices will also help the program identify unknown positives. Only with this guidance, can we expect CDC and HRSA grantees to take advantage of the reimbursement changes that will be associated with the USPSTF grade change once it is finalized.

We also note that once the “A” grade is finalized, routine HIV screening will need to go through a Medicare coverage determination process to become a Medicare covered service. We urge the Secretary to take up this issue as soon as the grade is finalized to ensure beneficiary access. Further, given that we know HIV disproportionately impacts low income communities, encouraging state Medicaid programs to cover routine screening will be instrumental.

This grade change is greatly needed and will more closely align the USPSTF recommendation with that of the CDC, the science, and the goals of the National HIV/AIDS Strategy. CDC and HRSA support to implement it will remain critical.

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