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December 7, 2009

President Barack Obama
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

Dear President Obama:

The HIV Medicine Association (HIVMA) applauds the Administration's commitment to the long overdue development of a coordinated, measurable, results-oriented National HIV/AIDS Strategy (NHAS) that will provide a roadmap and signal a strengthened national commitment to real and sustained success in the battle against HIV/AIDS. HIVMA represents more than 3,600 HIV medical providers and researchers that are working on the frontlines of the HIV epidemic in communities across the country.

HIV clinicians and researchers will play a critical role in the implementation of the strategy, and their input in developing and refining the strategy will therefore be essential to ensuring its success. At this initial stage of the process, we would like to offer the following recommendations for priority areas of action to achieve the strategy's three core goals of reducing HIV-related health disparities; reducing HIV incidence, and; increasing access to care and optimizing health outcomes.

The strategy should prioritize earlier diagnosis and treatment through routine HIV testing and linkage to quality HIV care and treatment.

We feel strongly that the policies of all federal programs should support the CDC recommendations for routine HIV screening in medical settings. While progress has been made within the last year at the Department of Veterans Affairs and with the Centers for Medicare and Medicaid Services recommending coverage for testing among high risk populations, significant structural and resource barriers remain. We need more data to assess how we are doing.

Health care reform offers a critical opportunity for incorporating routine HIV screening as a regular component of medical care and developing systems for improving linkages to expert HIV treatment for individuals that test positive. However, one obstacle we face is the US Preventive Services Task Force's failure to recommend routine HIV testing except among high risk populations. Similar to its position on mammogram screening for early detection of breast cancer, the task force position on routine HIV testing differs from that of a majority of the medical community, including the American Medical Association, the American College of Physicians, the National Medical Association, the American Academy of Pediatrics and the American College of Emergency Physicians. **We urge the Administration to**

endorse HIV testing as it did for mammogram screening and to every extent possible ensure coverage for HIV testing by private health plans and all federally-supported programs, including Medicaid programs.

Coverage for routine HIV testing is only the first step. Through the NHAS process **we urge the Administration and the Federal Panel to examine barriers to linking patients to HIV care and engaging and retaining patients in care. We also urge the Panel to assess the current extent of state coverage of routine HIV testing under Medicaid and support opportunities for evaluating earlier HIV diagnosis and care programs under Medicaid.**

Finally, plans to implement test-and-treat programs should include a focus on establishing ongoing, sustainable systems that identify all HIV-infected pregnant women and exposed infants as early as possible during the perinatal period and linking them to recommended clinical and social services to prevent mother-to-child transmission.

The strategy should include the promotion and expansion of evidence-based prevention measures, including ensuring access to comprehensive sex education for children and adolescents, wide availability of condoms and education about their proper use, and broad availability of syringe exchange programs and drug treatment interventions, to minimize the risk of HIV transmission.

We are pleased that the Administration has taken steps to curtail federal support of abstinence-only education in public schools that for the past decade deprived young people of sound scientific information about how to avoid and reduce risky sexual activity that may lead to unintended pregnancies or sexually transmitted infections, including HIV infection. Resources previously allocated to abstinence-only-until-marriage programs should be entirely redirected to comprehensive age-appropriate sex education programs.

With injection drug use still accounting for a significant number of new HIV infections, it is essential that interventions that have been shown to be effective in reducing HIV transmission among injection drug users, including syringe and needle exchange or provision programs and drug treatment programs, be funded by federal, state, and local government and be made widely available. All of these activities must be coupled with increased provision of and access to drug treatment. In addition state laws and regulations should be reformed to decriminalize syringe possession and paraphernalia laws, legalize over-the-counter (OTC) syringe access and physician prescribing of sterile syringes to injection drug users.

In addition, the strategy should include an increased federal investment in evidence-based HIV prevention activities through the CDC to expand community-based programs aimed at populations at high-risk and at groups with intermittent access to care, as well as to enhance surveillance and prevention research activities.

All people living with HIV/AIDS in the United States should have access to HIV care provided by or in consultation with qualified HIV medical providers. The Federal government should evaluate the adequacy and capacity of the HIV clinical workforce and take aggressive action to ensure that an adequate number of trained HIV clinicians will continue to be available to care for the growing numbers of HIV-infected individuals who are in need of medical services.

Numerous studies document that HIV patients managed by an experienced HIV provider have significantly better treatment outcomes and receive more cost effective care. However, the HIV care system faces a serious crisis in care capacity as HIV clinicians retire without qualified recruits to take their place. With the rising number of people living with HIV and with expansion of testing efforts resulting in increased diagnoses of HIV cases, failure to promptly address HIV medical workforce issues could risk lives and the public health of communities across the country. It is particularly important to support minority physicians who are interested in HIV medicine to reduce access and treatment disparities for the black and Hispanic populations, which are disproportionately affected by the disease.

Ensuring adequate availability of qualified HIV providers will also require addressing medical provider reimbursement issues, including significant disparities in reimbursement across Medicaid programs and with other payers. With the Medicaid program likely to play an even greater role in the HIV care safety-net under health care reform, it is imperative for the inadequacies of Medicaid reimbursement levels to be addressed. **In the short run, we urge you to consider making Ryan White part C clinics eligible to receive Medicaid reimbursement levels that more accurately reflect the cost of HIV care through a prospective cost-based reimbursement system (that proposal is reflected in the “Ryan White Grantee Medicaid Payment Equity Act of 2009,” H.R. 3665).**

Our complete workforce development recommendations for action are included in the attached paper developed by a joint HIVMA and American Academy of HIV Medicine task force on HIV workforce issues in the spring of 2009.

HIV programs across the country serve as models for delivering well-coordinated, comprehensive and cost effective medical care and treatment by serving as medical homes to their patients with HIV. We urge you to promote the medical home model of care for people with HIV through the National HIV/AIDS Strategy and to reorient the coordination of federal programs to support it.

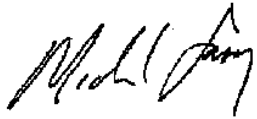
The intense medical and social service needs of many of our patients with HIV led to many HIV programs serving as medical homes out of necessity to ensure patients were receiving the services that they needed to stay in care and adhere to HIV treatment. With the number of HIV patients increasing and Ryan White funding remaining stagnant or decreasing in real dollars – many HIV programs are being forced to cut services, reduce clinic hours and lay off staff. In this time of limited resources, **we strongly urge the Administration and the Federal Panel to work with frontline HIV providers to identify the structural and resource barriers that exist to support medical homes for HIV care delivery and develop creative methods for addressing them. We also urge greater resources and support for evaluating outcomes for HIV patients whose care is managed through medical homes.**

A robust research agenda will be a vital component of the Strategy. We urge the Administration to look for creative ways to support cross-cutting research that closely examines issues that are critical to meeting all three of the President’ goals, such as the role of stigma in initiating and staying in care, barriers for patients to access and stay engaged in care and the long-term impact of HIV disease and its treatment on the aging process.

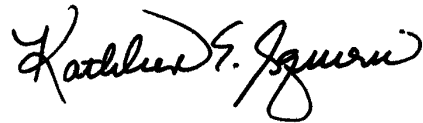
While we appreciate the significant resource constraints that the country faces, we cannot afford to lose ground in the research arena. The flat funding of AIDS research by the National Institutes of Health has resulted in an 18% decline in the institution's ability to support new research grants in the field.¹ We urge you to continue support for a robust HIV research agenda that will help us realize the goals of the National HIV/AIDS Strategy benefitting people with HIV and many other Americans and individuals around the globe battling serious, chronic and life-threatening diseases.

Thank you for your consideration of our views. We would be pleased to present more details on our ideas and views to the panel and look forward to working closely with the Administration on the development and implementation of the NHAS. Please contact us through the HIVMA executive director Andrea Weddle by phone at (703) 299-0915 or email aweddle@hivma.org.

Sincerely,



Michael S. Saag, MD, FIDSA
Chair, HIVMA Board of Directors



Kathleen E. Squires, MD
Chair-Elect, HIVMA Board of Directors

Attachments:

- Joint Statement of AAHIVM and HIVMA on the HIV Medical Workforce (06/25/2009)
- Ryan White: An Unintentional Home Builder," Michael S. Saag, MD, *AIDS Reader*, 2009;19:166-168.

¹ FY2010 NIH Office of AIDS Research (OAR) By-Pass Budget
www.oar.nih.gov/budget/pdf/FY2010_ByPassBudget.pdf (accessed 12/4/09)