hivma
hiv medicine association

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8010
Baltimore, MD 21244-8010

Attention: CMS-9989-F
RIN 0938-AQ67

Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers

To Whom It May Concern:

The HIV Medicine Association (HIVMA) appreciates the opportunity to comment on the near finalized federal rules that will govern the state-based health insurance exchanges. The regulations will establish an important standard for ensuring the exchanges serve as a fair marketplace for health coverage options that provide meaningful access to health care for our patients with HIV infection regardless of where they live in the United States. HIVMA represents nearly 5,000 HIV clinicians and researchers working on the frontlines of the HIV epidemic in communities across the country.

A number of the "final" provisions included in the rule are critical to people with HIV infection, and it will be important for HHS to establish monitoring systems to ensure they are applied across states. We have highlighted a few of these provisions below.

- Exchanges enforcing a robust non-discrimination standard. For this requirement to be meaningful, we urge further specification of these standards as well as monitoring and enforcement mechanisms for ensuring that exchange and plan policies do not discriminate against individuals with chronic conditions, such as HIV infection, by discouraging their enrollment through plan policies and features.
- Exchanges soliciting input from and engage with a range of stakeholders, including health care consumers, HIV providers and other safety-net medical providers, and individuals and entities facilitating health coverage, including case managers. Exchange plans providing prospective enrollees with accurate and detailed information to assess total out-of-pocket costs, including premium, deductibles and cost sharing for in- and out-of-network care and treatment. Our patients with HIV rely on regular access to a comprehensive set of services, care and medications. Out-of-pocket expenses are a critical factor in selecting a health plan to ensure reliable and uninterrupted access to medical care and treatment.
- The Navigator Program including at least one community non-profit entity. Ryan White-funded programs and providers have experience facilitating enrollment and access to care for people with HIV. It will be important to provide guidance to states on how they can utilize the expertise of these community-based

organizations to provide outreach and assistance to educate and enroll people with HIV infection into Medicaid or exchange plans.

Of particular interest and concern to our members are the "network adequacy standards" including the inclusion of "essential community providers." We strongly support the more robust requirements for network adequacy standards that require enrollees have timely access to all services and urge you to closely monitor for enrollee access to HIV providers and services. We also strongly support the explicit recognition that Ryan White grantees are considered "essential community providers" and also urge you to ensure that plans contract with the Ryan White-funded medical providers. Ryan White-funded medical providers provide comprehensive, state-of-the-art primary HIV care and must be included in plan networks to ensure sufficient HIV medical capacity and continuity of care for the thousands of uninsured HIV patients who will transition to health coverage in 2014. In defining Ryan White-funded medical providers, we recommend that you expand the definition to include all Ryan White-funded medical providers and not limit it to those funded by Parts B and C. Other Ryan White "Parts" also historically have supported primary HIV care depending on the service needs of their community's HIV population.

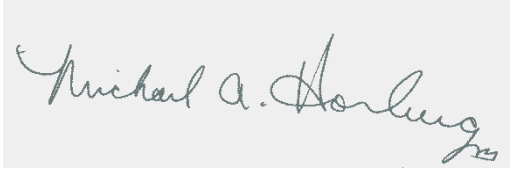
Effective care management requires a hybrid of specialty and primary care—particularly for patients diagnosed late (as are nearly a third of HIV patients) and after damage to the immune system has occurred. The complexity of HIV care is compounded by the high rates of serious comorbidities among people with HIV infection, including hepatitis C, serious mental illness, substance use disorders, diabetes and heart disease. While HIV medicine does not fall under the purview of any one medical specialty, it is well documented that higher quality and more cost effective care is delivered by physicians with experience and expertise in treating HIV, regardless of specialty training. Failure to provide access to qualified HIV medical providers will put HIV-infected patients at higher risk for treatment failure, disease progression and the development of resistance to effective treatment.

Guidance on Transitioning Pre-existing Condition Insurance Plan (PCIP) Enrollees

We also urge HHS to develop guidance to ensure a smooth transition to Medicaid or Exchange coverage for our HIV patients who are currently enrolled in a Pre-existing Condition Insurance Plan. Interruptions in care can be incredibly harmful for HIV-infected patients, and we urge HHS to ensure that regulations and guidance with regard to application processes for these populations, continuity of care protections, access to providers, and access to comprehensive benefits are implemented in ways that minimize disruptions in care.

Thank you for the opportunity to share our views. Please contact the HIVMA executive director Andrea Weddle at aweddle@hivma.org or (703) 299-0915 with questions regarding our comments.

Sincerely,



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Chair-Elect