The American Academy of HIV Medicine
Policy Platform

Introduction

The American Academy of HIV Medicine (AAHIVM) is an independent organization of HIV Specialists and HIV care providers dedicated to promoting excellence in HIV/AIDS care and to ensuring better care for those living with AIDS and HIV disease.

HIV providers are on the front lines of the American response to the disease, both domestically and internationally. The Academy has a diverse membership composed of Infectious Diseases, Internal Medicine, Family Medicine and General Practice physicians, Nurse Practitioners, and Physician Assistants, as well as Dentists, and Pharmacists. Member distribution among these provider groups is proportionate to the specialty distribution of frontline providers nationwide.

For a professional trade association for HIV care providers, developing public policy positions that accurately represent our membership is a demanding but crucial task. We attempt to focus our efforts on the issues of greatest importance to our members, to the patients they serve, and to the patients whom we hope to never have by preventing the spread of HIV.

At the federal level, AAHIVM works to affect legislation, regulatory decisions, and federal policy making to reflect the positions of its members. AAHIVM’s staff in Washington, DC works to educate the Administration, Congress, and regulatory agencies on issues affecting HIV providers and their patients, and to advocate on behalf of our constituency. AAHIVM also participates in strategic partnerships, coalitions, collaborations, and joint efforts with other HIV and medical organizations who share common policy goals.

At the state level, the policy platform equips AAHIVM’s members and chapters to advocate for changes in state and local health policies that affect medical care in their state.

There are many issues of concern to our members. As health care providers, and certified medical professionals, we seek policies that promote sound health practices, efficient medical care systems, and science-based public health policies. We also engage with issues that directly affect the care and well-being of people living with HIV or populations most vulnerable to the disease

Policy Platform

AAHIVM intends this policy platform to serve as a guide for its policy decisions, advocacy work, and organizational alliances.

This document represents the values and interest of our members in public policy issues. These positions are used to generate policy priorities, determinations of issue support or opposition, partnerships, advocacy work, and public statements. The document contains two sections:

The first lays out our guiding principles in policy decision-making. These principles are broad in nature. However, they allow us to determine our support or opposition to certain issues based on a core set of guiding beliefs that our members hold as HIV care professionals.

The second section focuses on specific policy topics of interest and priority to our members, and contains policy statements and positions on those subjects.
Some of the topics are included due to their priority or interest to our members. Others are included due to their frequent and regular occurrence as policy topics that AAHIVM confronts (such as annual federal budget and appropriations processes).

The sequence of both the principles and topics, as listed in this document, is not indicative of the priority level of these topics. Indeed, the priority level of most policy issues changes regularly as the topics rise or fall in prominence on the national or local level. AAHIVM works to keep pace with the policy matters of the day, while always striving to move forward on the issues of greatest concern to our members.

On some policy issues or subjects, our membership may not have a specific policy standpoint, or they may be split in their opinions. Some highly charged issues are not universally agreed upon by the providers that make up our membership. Other topics are too nuanced and varied for our members to agree on a permanent position. In those cases, the Academy attempts to represent our membership’s positions in their truest form, whether that is in declining to engage a particular issue or representing the diversity of opinion that exists on an issue among our members.

In all cases, this document attempts to clearly explain and identify the predominant values and opinions of our membership in policy issues.

**AAHIVM Policy Department**

& **Policy Committee**

The AAHIVM Policy Committee and Policy Committee Chair are determined in accordance with the AAHIVM organizational by-laws.

The AAHIVM Policy Director and other staff work on behalf of the members of the organization to represent their interests and position on public policy issues. The Policy Director works with the Policy Committee and the Chair of the committee to hold regular meetings. The purpose of these meetings is to keep the committee informed on and active in the policy work of the Academy.

**Policy Process**

Policy issues of all sorts require a response from the organization on a regular basis. These issues are sometimes raised by AAHIVM members, committees, or chapters. Sometimes they develop through the ongoing work of the AAHIVM staff. At other times they are brought to the organization by an outside source, including our partner organizations and other advocates.

The AAHIVM Policy staff facilitates the daily, ongoing policy work of the organization, based upon the principles and goals determined in the Policy Platform, and also by the Policy Committee and AAHIVM Board. The Policy Director makes determinations of policy issue support or opposition based on the Policy Platform, and in consultation with the Policy Committee and AAHIVM Board.

Where a new policy issue, previously unaddressed in the Policy Platform, comes to the attention of the AAHIVM staff, the AAHIVM Policy Director facilitates the consideration of new policy issues by the Policy Committee, to allow for their determination.

The final position of the organization on policy topics and issues is determined by a vote of the AAHIVM Board, on behalf of the membership of the organization. With respect to this and in full cooperation the AAHIVM Policy Committee makes recommendations on policy matters to the AAHIVM Board for their consideration and approval.
The Policy Committee will determine whether the issue is ripe and fitting for consideration by the committee and the organization as a whole, or whether it should tabled until another time. If the Committee chooses to take up the issue, then the committee will proceed to draw up a position or statement on the issue.

Once finalized by the Policy Committee, this position will be referred to the AAHIVM Board for their approval. After the Board approves the position, it will be considered the official position of the organization on an issue.

Special Circumstances

At times, a response to a particular issue is needed within a short timeframe that making it impractical to wait until the next meeting of the full Policy Committee or Board.

If this is the case, the Policy Director and the Chair of the Policy Committee may work in conjunction to develop a response within the necessary timeframe. This rapid-response may be referred to the AAHIVM Executive Committee for their approval in lieu of the full Board. Once the Executive Committee approves a decision, it will be treated as final until the next Board meeting.

In this case, the Policy Committee and Board should be informed of the rapid response that was determined and have the opportunity to review it before the next Board meeting, it will be voted on by the full Board, according to the normal procedure.

All effort should be made to ensure participation of the Policy Committee and Board, according to normal procedure, if circumstances allow.
Table of Contents

AAHIVM Policy Principles:
Recognition of HIV Care as a Medical specialty
Access to Care for All People Living With HIV/AIDS
Access to Treatment for All People Living with HIV/AIDS
Reduction of Healthcare Disparities
Science as Basis for Policy
Provider Determination of Care

AAHIVM Policy Position Statements
Provider Representation on Governing Bodies
Workforce
Reimbursement/Payment
Coordination/Streamlining of Government Requirements for Providers
Interdisciplinary/Multidisciplinary Care and Coordination of Care
Information Technology for HIV Medicine
Drug Pricing
Aging HIV Population
Funding of Federal HIV/AIDS programs
Federal Funding of Support Services
Co-morbidities and HIV Care
HIV Testing
HIV Research
HIV Education and Prevention
Harm Reduction
Medical Marijuana
HIV Criminalization
Pre-Exposure Prophylaxis (PREP)
HIV in the Workplace
Section I:  
AAHIVM Policy Principles  

This section contains statements reflecting the principles of the organization and its members in the area of public policy.
Recognition of HIV Care as a Medical Specialty

Statement of Principle:

The American Academy of HIV Medicine (AAHIVM) and its members support the recognition of HIV care as a medical specialty and encourage all providers serving HIV patient populations to seek certification to that effect in this field.

AAHIVM supports the credentialing certifications of the organization as one example of determination of specialization in HIV medicine.

AAHIVM also supports policies that promote a standing referral to an HIV Specialist that is codified or legislated in all states and federal care programs.

Background:

HIV disease is a complex and involved field of medical care. Advances in care and treatment are ongoing and place great demands on HIV providers to stay abreast of the current HIV diagnostics and treatments. The evolution of HIV care has transformed the practice of HIV medicine such that it now often requires a hybrid of HIV expertise and depth and breadth of primary care skills to address the co-morbidities that people with HIV develop as they live for decades with the disease. Serious co-morbidities such as hepatitis C, lipid disorders, cardiovascular disease, mental health disorders and cancers are common among people living with HIV and often require co-management with or referral to other specialists.

Numerous studies document that HIV patients managed by an experienced HIV provider have significantly better treatment outcomes and receive more cost-effective care.

AAHIVM has a diverse membership composed of Infectious Diseases, Internal Medicine, Family Medicine and General Practice physicians, Nurse Practitioners, and Physician Assistants, as well as Dentists, and Pharmacists. We offer training partnerships, educational materials, and the opportunity to seek credentialing to all providers as a means of enhancing their knowledge of HIV disease and the care and treatment of HIV-infected patients.

Findings:

AAHIVM’s HIV Specialist™ (AAHIVS) and HIV Expert™ (AAHIVE) certifications are the first and only credentials offered domestically and internationally to physicians (MDs and DOs), nurse practitioners, and physician assistants specializing in expert level HIV care.

In addition, AAHIVM also offers the HIV Pharmacist™ (AAHIVP) credential to HIV-specialized pharmacists.

The acquisition of the Academy's credentials indicates an up-to-date core knowledge and proficiency in HIV diagnosis and treatment to patients, colleagues, employers, governments and third-party payers. It demonstrates support of a national standard for HIV care and offers appropriate recognition of the highly technical sub-specialty that is HIV care. Participation in AAHIVM Credentialing programs provides a level of assurance for healthcare consumers by creating an identifiable professional standard of care.
Several states have acknowledged and codified the recognition of specialization in HIV care and acknowledge AAHIVM’s certification. Currently, New York, California, and Maryland have state laws that recognize HIV Medicine as a specialty and require certification to that effect.

1 New York law requires that managed care organizations provide treatment for those on HIV Special Needs Plans (SNPs) by HIV specialists. An HIV Specialist is defined by committee. The New York definition was last revised in December of 2004 and has both an experience and an education component, the latter of which may be filled by AAHIVM accreditation.

2 In 2001, California amended its definition of HIV Specialist to specify those who have been accredited by a government agency or independent organization. Previously, California had required that health insurers guarantee access to HIV specialists, but its definition of an HIV specialist was not concrete.

3 Maryland, in its administrative code, requires that health insurers cover treatment by HIV/AIDS specialists. An HIV Specialist must either have an ABMS certification in infectious diseases, or have performed a minimum amount of HIV care and completed an HIV education requirement, which can be filled by passing the AAHIVM credentialing exam. These requirements were recommended in September 2003 and took effect January 4, 2004.
Access to Care for All People Living With HIV/AIDS

Statement of Principle:

The American Academy of HIV Medicine (AAHIVM) and its members believe that all people living with HIV/AIDS should have access to appropriate medical care. AAHIVM supports policies that increase access to medical care for all HIV/AIDS patients both in the United States and throughout the world.

We support policies that provide meaningful early, affordable and stable access to the range of health care services and expert medical providers who research demonstrates are important to effectively managing HIV disease.

We also support policies that increase affordability for HIV patients, specifically: reducing financial barriers to care by setting caps on out-of-pocket cost sharing and eliminating premium rate-setting according to health status, gender, age or demographic factors. We oppose payer practices that discourage enrollment of HIV/AIDS patients or otherwise create barriers to care, including: exclusion of HIV/AIDS practitioners and clinics from provider networks increasing frequency of recertification for financial eligibility for programs to access care, , and arbitrary service limits.

Background:

Due to the financial and social demands of the disease, access to care will always be an issue for uninsured/under-insured, marginalized, and underserved populations with HIV.

An estimated one-third of people living with HIV in the United States are not in care and one in five people infected with HIV are unaware of their status. Studies have shown that he numbers of young men of color who have sex with men who don’t know their HIV status may be much higher.

There is a substantial racial and ethnic disparity in the United States in who bears the major burden of HIV infection, and those who are infected are far less likely to have insurance than the general population. Large numbers of uninsured and underinsured people with HIV mean that many do not have sufficient access to HIV care. Unmanaged HIV disease places heavy burdens on individuals and families as well as government and public health budgets, as well as contributing to the increased incidence of new infections.

Data indicate that HIV disproportionately affects the most vulnerable in our society—those Americans who have less access to prevention and treatment services and, as a result, often have poorer health outcomes. Any health care system must provide an adequate safety net and payer of last resort programs for people living with HIV. Gaps in essential care and services for people living with HIV will continue to need attention. The stigma associated with HIV remains high and fear of discrimination causes some Americans to avoid learning their HIV status, disclosing their status, or accessing medical care.

We must also work to provide access to care for the aging HIV population, who may face realities of fixed incomes and barriers to finding providers equipped or willing to take on their care as well as all those living with HIV infection regardless of race, ethnicity, gender, sexual orientation, gender identity, or immigration status.
**Access to Treatment**  
for All People Living With HIV/AIDS

Statement of Principle:

The American Academy of HIV Medicine (AAHIVM) and its members believe that all people living with HIV/AIDS should have access to the life-saving medications that are available today, and support policies that ensure patients have uninterrupted access to appropriate medical treatment interventions regardless of socio-economic standing or geography.

AAHIVM supports policies that increase access to medical treatment for all HIV/AIDS patients both in the United States and throughout the world. We support policies that provide affordable and stable access to antiretrovirals and or other drugs used to treat HIV/AIDS patients, as well as to expert medical providers who are critical to effective management of HIV disease.

We also support policies that increase affordability of treatment options for HIV patients, including reducing financial barriers to care by setting caps on out-of-pocket cost sharing. We oppose payer practices that limit access to specific antiretrovirals or other drugs used to treat HIV/AIDS patients, including placement of HIV antiretroviral drugs on higher cost-sharing tiers.

We also support policies that allow medical providers to determine the best medical treatment for their patients without burdensome prior-authorization requirements.

Background:

Patient access to life-saving medications is of utmost concern to the HIV providers treating them. As HIV care providers, we hope to ensure all patients have access to the necessary medications needed to optimize their therapy.

Unprecedented scientific achievements have produced effective HIV treatment that can extend the lives of those infected with the disease by decades.

The evidence is overwhelming that early and ongoing access to HIV treatment not only extends the lives and health of HIV-infected individuals but also dramatically reduces their risk of transmitting the virus to others.

The decrease in deaths brought about by Highly Active Anti-Retroviral Therapy (HAART) coupled with the steady number of new infections and attempts to bring people into care have increased the number of Americans living with HIV/AIDS and seeking antiretroviral therapy. However, recent studies indicate that of the 1.1 million people living with HIV infection in the U.S., just 37 percent are retained in regular care and only 25 percent have undetectable levels of HIV in their blood on treatment.

The need for increased access to HIV medication treatment is clear. However, the barriers to the goal of access to care for all persons living with HIV/AIDS are multifaceted.

One barrier is the high cost of many HIV drugs. Due to the socioeconomic distribution of the disease, drug accessibility issues unduly affect individuals with HIV. HIV drug regimens are expensive, and are long-term interventions that require strict adherence to be effective. The cost of managing even a single individual’s disease long term is substantial.
Access to medications also depends heavily on insurance coverage and public programs. Twenty-five percent of people with HIV infection are uninsured, with fewer than 15 percent having private insurance coverage. Nearly half rely on Medicaid coverage, but even then a majority only qualifies after becoming disabled by AIDS. For the minority with private coverage or those with Medicare Part D, treatment options are often limited by coverage that places preferred antiretrovirals on higher cost sharing tiers.

While most private and public third-party payers currently cover a majority of antiretroviral medications, we are concerned as some insurers are beginning to implement cost control strategies that may lead to restricting coverage to only the lowest cost options within a class.

In addition, as more antiretrovirals are available in generic formulations, newer, more effective, and better-tolerated antiretrovirals are at risk of not being covered, or of being priced out of reach of HIV-infected patients. For a subset of patients with HIV infection who develop antiretroviral drug resistance, access to newer drugs and formulations will continue to be the only effective treatment option.

The Patient Protection and Affordable Care Act (ACA) in conjunction with the National HIV/AIDS Strategy offer the opportunity to dramatically improve access to HIV care and treatment; but success will depend on the adequacy of coverage in supporting comprehensive care and treatment, including prescription drugs. Dramatic improvements in viral suppression rates for HIV-infected patients will not be realized if the most effective antiretrovirals are not included in drug formularies, and if they are not available at reasonable costs to third-party payers and to individuals living with HIV infection.

In addition to consideration of drug cost and coverage, federal and state funding for public programs that supply access to HIV medications to those who cannot afford them has varied widely in recent years. In some states, patients are placed on waiting lists to access public programs for years.

AAHIVM acknowledges the contributions of some private companies to make HIV antiretrovirals available in resource-poor settings, and to those patients who are unable to afford them. In particular, prescription assistance programs of certain companies have helped thousands of patients obtain their medications. However, the charitable efforts of these organizations are not sufficient to meet the full scope of need for access to medication treatment for all people living with HIV in the US or worldwide.

AAHIVM supports policies that lead to better access to effective HIV antiretrovirals both domestically and worldwide, and encourages ongoing work to ensure that people living with HIV have the sustained and quality treatment and disease management that is necessary to improve health and delay disease progression.
Reduction of Healthcare Disparities

Statement of Principle:

The American Academy of HIV Medicine (AAHIVM) and its members support policies that work toward elimination of disparities in accessing coverage and quality medical care due to socio-economic status, prior medical condition, race, ethnicity, gender, sexual orientation, gender identity, actual or perceived disability, age, primary language, and geography (state of residence and type of community – urban or rural).

Background:

While anyone can become infected with HIV, some American demographic groups are at greater risk than others. This includes gay and bisexual men of all races and ethnicities, black men and women, Hispanic/Latinos, injection drug users, and people in certain geographic hot spots. In the U.S. this includes the South and the Northeast, as well as Puerto Rico and the U.S. Virgin Islands.

In terms of medical care, all providers should be encouraged to provide the most current medical interventions for these populations. Education in current standards of care and cultural competency training for underserved populations should also be made available for all HIV providers. Moreover, at risk communities should receive improved access to behavioral and mental health services to deal with the stigma of the disease and the emotional tensions it can produce. In addition, addiction treatment should be expanded for those individuals for whom drug and alcohol use increase the risk of HIV transmission.

Lack of access to culturally appropriate care and prevention resources, along with homophobia, stigma, and substance abuse are key drivers of the epidemic among MSM, gay, and transgendered individuals. Culturally sensitive care should be a standard for all who treat HIV disease and interact with these patient groups. Efforts should focus on key risk groups that are often stigmatized, due to historically high rates of the disease. A 2010 report from the Centers for Disease Control and Prevention (CDC) shows that nearly one in five MSM in major U.S. cities is living with HIV and nearly half of these are unaware of their status. This analysis also showed that the majority of them are youth and men of color.

For minority patient populations, one goal should be to close the differential in access to antiretroviral medications for communities of color which have less access to medical interventions, less favorable outcomes, and increased rates of HIV transmission.

Efforts to address the shortages in the primary care workforce and HIV medical workforce must also prioritize medical workforce diversity. The dearth of minority medical providers is particularly pertinent to the HIV medical community because of the disproportionate impact that HIV disease has had on African American and Latino/Hispanic populations. HIV clinics and programs find it particularly challenging to recruit medical providers that mirror their African American and Latino/Hispanic patient populations and to recruit Spanish-speaking clinicians. Special attention should be paid to areas of medicine, such as HIV disease, where minority populations are heavily represented.

We encourage the cultivation of greater minority representation among qualified HIV providers. A laudable goal would be to increase the number of minority providers to more closely reflect the patient population they serve.

Examples of Healthcare Disparity policies we support:

- We support full funding of the Health Professions Title VII and VIII programs.
• We support increased cultural competency training for underserved populations.

• We support initiatives to close the differential in access to antiretroviral medications for communities of color which have less access to medical interventions, less favorable outcomes, and increased rates of HIV transmission.

• We encourage the promotion of opportunities for minority medical students.

• We encourage multi-faceted efforts to ensure culturally sensitive care for lesbian, gay, bisexual and transgendered persons living with HIV.
Science as Basis for Public Health Policy

Statement of Principle:

AAHIVM supports approaches to public policy that are based on current scientific understanding and evidence-based research.

Background:

As medical professionals, our members support scientific research and knowledge as the basis for policy making in the public arena.

Our members oppose public policies and laws that distinguish HIV disease from other comparable diseases and believe public health policy on HIV should be comparable to that of other sexually transmitted or communicable diseases such as tuberculosis, hepatitis, herpes, or syphilis. Laws and policies focused at one disease are unnecessary, stigmatizing, harmful and unfair.

We believe that public health policies, and public policy, and criminal statutes should take into account the most up-to-date scientific information about disease transmission, prevention, and also medical interventions.

We believe that policies on HIV should also take into account the high levels of stigma and prejudice associated with disease transmission and seek to protect individual privacy, rights, and freedom.

We believe that public policies and laws around disease transmission should be evidence-based and non-discriminatory in nature. They should serve public health goals and promote public awareness.
Provider Determination of Care

Statement of Principle:

As a general principle, AAHIVM supports the ability of providers to determine the best course of treatment for the patients under their care, within the confines of the law and medical licensure standards.

Background:

As an organization of front-line HIV care providers, we support the ability of providers to determine the best course of treatment for their patients. We believe that the best determination of appropriate medical treatment occurs within the relationship between provider and patient.

The HIV virus responds to particular treatment regimens in different ways in different patients so that the optimal treatment for one person may not be the same as for another. The only person with the training and knowledge required to make that determination is the treating physician.

Individual response to antiretroviral treatment is not always equal. Successful HIV drug therapy involves the prescription of complicated cocktails of drugs therapies, close monitoring for effectiveness, rigid adherence by patients, and evaluation and mitigation of side effects by a medical professional.

Additionally, specific patient indicators of drug resistance heavily inform provider decisions about which treatment course is best for each patient. Decisions about care should be based upon best practices in care, clinical evidence indicating varied outcomes for individual patients in terms of age, gender, race, and ethnicity, and considerations of safety efficacy and tolerability of particular drugs.

Treating the medical needs of HIV patients with a “one size fits all” approach can lead to unnecessary medical complications and lesser health outcomes.

In recent years in the field of health care, some initiatives to improve the health system or increase cost efficiency of care programs, have at times lead to restrictions being placed on patient insurance benefits that may restrict the ability of providers to prescribe optimal drug regimens for patients.

We are concerned with policies or determinations that may limit access to vital medications such as antiretrovirals, immunosuppressants, anti-depressants and others. Requirement of prior authorization for prescription of some classes of drugs creates an administrative barrier that may restrict the ability of providers to prescribe the best course of medication for each individual patient.

AAHIVM supports policies that take into consideration the highly individualized needs of HIV infected patients, and empower providers to give the best possible care to their patients.

Examples of policies we support:

- “Prescriber Prevails” provision must be maintained for this reason.
Section II:
AAHIVM Policy Position Statements

This section contains position statements on specific policy issues, subjects, or questions.
Provider Representation on Governing Bodies

Policy Statement:

The American Academy of HIV Medicine (AAHIVM) and its members believe that government bodies responsible for HIV policy-making should include provider representation, preferably from an HIV Specialist.

Background:

It is our opinion that any conversation about HIV/AIDS in the United States must start with a conversation about appropriate medical care for the infected. Policy decisions about HIV as a disease, such as health care access, prevention, research, and health education, are inextricably intertwined with the practice of HIV medical care.

It is our belief that federal and state level government committees, task forces, panels, and other governing bodies that would take on policy work concerning HIV policy and related subjects should include direct input from HIV providers. This would include: Infectious Diseases, Internal Medicine, Family Medicine, Adolescent Medicine, and General Practice physicians, Nurse Practitioners, and Physician Assistants, as well as Dentists and Pharmacists.

As an organization, we work to nominate and support inclusion of HIV providers generally, and our members specifically, in these key positions.

Examples of provider representation policies that we support:

- The President’s Advisory Council on HIV/AIDS (PACHA) should include members that have a professional background in provision of HIV-specific medical care.
Workforce

Policy Statement:

The American Academy of HIV Medicine (AAHIVM) and its members believe that the HIV workforce should be expanded and supported through strategies to draw new providers into the HIV care and treatment field along with provision of support to those HIV providers currently in the workforce. As an organization, we work to promote policies to bolster the HIV workforce.

Background:

The U.S. HIV care system is facing a crisis in care capacity. Data from a 2008 survey conducted by AAHIVM shows that more than 32 percent of today’s HIV clinicians will stop providing care over the next 10 years, and there are inadequate numbers of new providers to replace them.

Shoring up the pipeline of qualified HIV medical providers is an extended process that requires years of targeted interventions. AAHIVM supports policies that provide for assurance of a well-trained HIV workforce.

Strategies available to increase the number of HIV providers include health professions training grants, the National Health Service Corps Scholarship and Loan Repayment Programs as well as financial incentives to compensate providers for HIV care management. Another strategy would be to provide an “Area of Concentration” (AOC) in HIV/AIDS medicine within Family Medicine or Internal Medicine residency programs. It is also necessary to encourage more health care providers, including non-physician providers, to obtain specialized HIV training and to include people living with HIV in their practices.

Examples of workforce policies we support:

- Tuition Reimbursement, Student Loan Repayment, and other educational incentives.
- Expansion of the National Health Service Corps to designate all Ryan White-funded clinics as Federally Qualified Health Centers sites eligible for participation in student loan repayment programs.
- Training Opportunities in HIV Care, including rotations in HIV care and/or exposure to populations impacted by HIV for medical students, clinical fellowships, HIV training for all providers in the course of their medical education, clinical training opportunities, satellite learning, and web-based programs.
- Expansion of the mission of the AIDS Education and Training Centers (AETCs) to include attracting new clinicians, medical students, and residents into HIV care and treatment in addition to maintaining their current goals of educating providers.
- Federal agencies should develop strategies for encouraging more clinicians including primary care providers, OB/gyn providers, mental health providers, and substance abuse treatment professionals to provide HIV services.
Reimbursement/ Payment

Policy Statement:

The American Academy of HIV Medicine (AAHIVM) and its members believe that adequate reimbursement for HIV care is paramount to ensure proper patient care, guaranteeing provider ability to maintain services, and to the recruitment of new HIV providers.

Background:

In a recent survey of Ryan White Part C-funded clinics, the clinics reported reimbursement as being one of the biggest challenges to recruiting HIV clinicians.

Most of our members receive reimbursement-based funding from a mix of federal and state government programs such as Ryan White, Medicare, Medicaid, and private insurance payers. Reimbursement from all payers should reflect the true cost of medical procedures, labs, and treatments. Access to expert HIV care depends on fair payment mechanisms that cover the cost of delivering HIV primary and associated care as provided by primary care practitioners and other specialists.

HIV care delivered by experienced HIV providers yielded better patient outcomes that resulted in cost savings to the health care system. Medicare reimbursement must be reformed to recognize the value and importance of primary care and other cognitive specialties that practice HIV medicine.

Payment mechanisms should support effective models for delivering HIV care such as medical homes, discourage costly administration, be transparent and be focused on public health needs and priorities. Reimbursement rates should, at a minimum, allow both clinics and providers the ability to maintain the standard of care for their patients.

A majority of HIV patients rely on Medicaid or Medicare for access to care and, under the current reimbursement levels, many HIV clinics operate at annual deficits that are growing and leading to cuts in services, staff and clinic hours. Addressing medical provider reimbursement issues for primary care providers and other specialists that practice HIV medicine under Medicaid and Medicare is critical to sustaining the HIV care system.

Because HIV care is complex and demanding, certified HIV specialists should be reimbursed at rates comparable to other medical specialists. Additionally, reimbursement for evaluation and management service (E&M) should be balanced appropriately in comparison to reimbursement for procedure-based specialties.

This issue is closely related to successful recruitment of medical providers into the field of HIV medicine. Data from the HIVMA survey of Ryan White Part C clinics suggest that a majority of Part C-funded clinics are struggling to recruit new HIV providers. Funding challenges, coupled with increased caseloads and complex patient care, do not make HIV medicine an attractive career choice for newly trained clinicians. Remuneration for the provision of HIV care is insufficient, and medical student debt is burdensome. In a 2009 AAHIVM survey of HIV practitioners, it was found that debt level for medical students ranged from $75,000 to $200,000.

Examples of reimbursement policies we support:

- Risk-adjust reimbursement rates to ensure that access to primary care and specialty care is not compromised for individuals with complex, resource intensive conditions, such as HIV disease.
• Ensure that reimbursement for evaluation and management service (E&M) of HIV are appropriately balanced in comparison to reimbursement for procedure-based specialties.

• Support HIV programs that are serving as “medical homes” by reimbursing programs for coordinating care and providing sufficient resources to support quality improvement and the adoption of health information technology.

• Address significant disparities in reimbursement across Medicaid programs and other payers.
**Coordination and Streamlining of Government Requirements for Providers**

*Policy Statement:*

AAHIVM and its members believe better coordination is needed among federal HIV/AIDS programs. We support the increase of coordination between HIV programs across the Federal government and also between federal agencies and state, territorial, tribal, and local governments.

*Background:*

HIV/AIDS programs are a loosely linked web of resources and responsibilities, ranging across multiple federal agencies, including Health and Human Services (HHS), Housing and Urban Development (HUD), Justice, Veterans Affairs (VA), USAID and Department of Defense. Within HHS, responsibility for HIV programs is spread across multiple agencies including the Centers for Medicare & Medicaid Services (CMS), the Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), the Indian Health Service (IHS), the Food and Drug Administration (FDA), National Institutes of Health (NIH), the Office of HIV/AIDS Policy, the Office of Minority Health, and others.

There is a distinct lack of efficient coordination across federal health care programs that provide care and treatment for HIV. Overlapping and competing programs can be quite burdensome for providers and their patients to navigate. There is a significant need for better collaboration, integration of services, and decreased redundancy across these different programs.

Additionally, HIV providers often receive funding from multiple sources with different grant application processes and funding schedules, all with varied reporting requirements. The administrative and data reporting requirements under federal programs, such as Ryan White and Medicare Part D, have grown exponentially, while fiscal resources to support these requirements have decreased. The requirements are contributing to the cost of HIV care and draining valuable HIV medical provider resources. One study conducted in an HIV clinic concluded that the cost in personnel time was valued at $21.40 per prior authorization, or about one-third of the reimbursement level for an intermediate level office visit.

The administrative burden reduces the medical provider’s time to practice HIV medicine while also reducing overall job satisfaction and discouraging clinicians from choosing to practice HIV medicine. There is a need for streamlined reporting requirements across all federal health programs.

*Examples of programmatic coordination policies we support:*

- Development of common data collection and reporting systems across all health care provider settings to enable monitoring of clinical care utilization, quality indicators, and health outcomes for people living with HIV.
Interdisciplinary/ Multidisciplinary Care and Coordination of Care

Policy Statement:

The American Academy of HIV Medicine (AAHIVM) and its members support policies that foster better coordination of care across various medical specialties and the collaboration of specialists across medical fields in order to promote better patient care and outcomes.

Background:

Today people living with HIV can enjoy long and healthy lives. The evolution of HIV care also has transformed such that it now often requires a hybrid of HIV expertise, primary care, and coordination with other specialties to address the co-morbidities that people with HIV develop as they live for decades with their disease. Serious co-morbidities such as hepatitis C, lipid disorders, mental disorders and cancers are common among people with HIV and often require co-management with or referral to other specialists. HIV patient care would also benefit from better coordination with dental care and mental health services. Lessons on effective management of chronic conditions across specialties such as through medical homes must be applied to HIV disease.

HIV care that is delivered by experienced HIV providers has been proven to lead to better outcomes for patients and to result in cost savings to the health care system.

Many different models for managing the care of patients with HIV have evolved to ensure patients have access to quality HIV care. Under one model, HIV clinics serve as medical homes with the HIV medical provider serving as the HIV specialist and primary care provider. We encourage the promotion of the “medical home” model and other multidisciplinary approaches to HIV care.

Another effective model is for an HIV provider to co-manage the patient with a primary care provider. In rural areas or other areas with low HIV prevalence rates, an HIV specialist may serve as a consultant to the primary care provider.

Examples of coordinated care policies we support:

- Government care policies should aim to increase collaboration between HIV medical care providers and agencies providing HIV counseling and testing services, mental health and substance abuse treatment, housing and supportive services to link people with HIV to care.

- HIV providers should be encouraged to coordinate patient care with other medical specialties and to look for opportunities to create comprehensive programs for care.
Information Technology for HIV Medicine

Policy Statement:

The American Academy of HIV Medicine (AAHIVM) and its members support the promotion of better access to care and better care delivery through adoption of technological advances in medical records and information.

Background:

Medical information technology has the potential to improve comprehensive management of medical care and information for PLWHA.

Electronic medical records are especially useful for the detailed and complex record keeping associated with managing HIV, provided that they contain the ability for providers to make extensive notes and record finely tuned medical treatments and regimens. However, access to electronic medical record systems can be unattainable for smaller provider offices not connected with a large medical network or hospital. The availability of health information technology (HIT) for these circumstances should be encouraged.

Portable personal electronic health records are another approach for HIV patients. The ability to transport the detailed record of medical history, drug regimens, and other treatments are invaluable for a patient with HIV facing relocation, travel, medical emergency, and incarceration. Likewise, electronic health information exchanges are especially helpful in these circumstances.

Another technological advancement which holds great promise for HIV care and treatment is telemedicine. We support efforts to promote tele-medical technology which allow for the provision of HIV or other specialty care for populations who may otherwise not have access, such as those who reside in rural areas and correctional settings.

Although the Department of Health and Human Services has worked strenuously to encourage adoption of medical technology innovations, the HIV medical field has yet to benefit from some of the incentives to adopt these technologies.

The adoption of medical technologies in the HIV field should be incentivized with medical technologies and the exchange of medical information tailored to this mobile patient population. Specifically, there are three areas of medical technology which hold great promise for HIV care: electronic medical records, personal health records, and telemedicine.

Examples of health technology policies we support:

- Incentives for early adopters of electronic health records.
Drug Pricing

Policy Statement:

The American Academy of HIV Medicine (AAHIVM) and its members support policies that ensure patients have uninterrupted access to the life-saving medications that are available today, regardless of socio-economic standing or geography.

Background:

As HIV care providers, we have significant concerns regarding the ability of our patients to receive the medications that they need. As HIV providers, we hope to see all patients have access to the necessary medications needed to optimize their therapy.

Unprecedented scientific achievements have produced effective HIV treatment that can extend the lives of those infected with the disease by decades. However, one of the chief barriers to this is the exceedingly high costs of many HIV drugs.

Due to the socioeconomic distribution of the disease, drug accessibility based on price unduly affects individuals with HIV.

Treatment options are often limited by restriction on coverage of higher cost antiretrovirals. While most private and public payers currently cover a majority of antiretroviral medications, cost control strategies threaten to move towards restricting formularies, or covering only the lowest cost option within a class.

Furthermore, as more antiretrovirals are available in generic formulations, newer, more effective, and better-tolerated antiretrovirals and antiretroviral single tablet regimens are at risk of not being covered or of being priced out of reach of HIV-infected patients. For many living years with this disease and often committed to multiple medicines for co-morbid conditions, single tablet regimens with all of the drugs needed combined into one pill improves compliance and the likelihood of long-term viral control and treatment success.

Effective antiretroviral treatments must be made available at reasonable costs to third-party payers and to individuals living with HIV infection.

Our organizations appreciate and recognize the contributions of pharmaceutical companies to the remarkable scientific advancements in HIV medicine and their commitments to ensuring HIV antiretrovirals are available in resource-poor settings worldwide.

There is a balance to be struck between the needs of this high-risk population and the financial investments and reward structure of the pharmaceutical manufacturers who develop and market these drugs. The substantial costs to pharmaceutical companies of discovery, research and development process of pharmaceutical drug innovation along with the costs of and safety and efficacy trials in the drug approval process are weighed against the potential for exponential profit if the drug successfully comes to market. However, we believe a balance between profit, access, and public health will produce the highest return on investment.

AAHIVM supports improved access to effective HIV antiretrovirals both domestically and worldwide while also supporting research and development pipelines that play a critical role in realizing the vision of a world without AIDS.

Examples of drug pricing policies we support:
• We urge pharmaceutical companies to set prices for antiretrovirals at levels that support access for the populations most in need.

• We urge pharmaceutical companies and U.S. policymakers to work with insurers and government payers to ensure that drug formularies include all antiretrovirals, and to ensure antiretrovirals are not subject to burdensome cost-sharing, prior authorization, and other restrictions that limit timely patient access or provider prescription.

• We urge pharmaceutical companies to sustain and expand their co-pay assistance programs so such programs are available for all antiretroviral agents with income eligibility levels set to address the needs of individuals who are not able to access medications due to extraordinary cost-sharing requirements.

• We urge pharmaceutical companies to participate in the HarborPath program that streamlines access to antiretrovirals for people with HIV infection without insurance or with poor drug coverage. Participation by all companies is urgently needed to realize the potential of this important program.

• We urge pharmaceutical companies and U.S. policymakers to continue to support agreements that promote access to antiretrovirals in under-resourced countries by allowing for the manufacturing of generic antiretrovirals outside of the U.S. and offering deep discounts on branded HIV antiretrovirals. Industry and U.S. policymakers should also refrain from blocking the efforts of developing countries to produce generic antiretrovirals to meet the needs of their own citizens, as well as those of HIV-infected individuals in other resource-poor settings.

• We urge pharmaceutical companies to continue to develop pediatric antiretroviral formulations in order to decrease the gap in availability, approval, and access to antiretroviral therapy in pediatric and adolescent populations.

• We urge philanthropists, industry, federal and state government entities, medical providers, and other stakeholders to work together to explore all options for lowering the costs of antiretroviral therapies and to identify solutions to ensure access to HIV treatment for everyone who needs it.
**Aging HIV Population**

**Policy Statement:**

The American Academy of HIV Medicine (AAHIVM) and its members encourage development of resources to better treat and optimize health outcomes for older Americans with HIV.

**Background:**

More older Americans are now living with HIV/AIDS. In the early days of HIV/AIDS epidemic, the disease was one of youth. Today, the demographics of HIV/AIDS are changing, as those who have been infected with HIV/AIDS live for decades, and an increasing number of seniors become newly infected with HIV each year. Within the next few years, more than half of all people living with HIV will be over the age of 50.4

The health and medical world communities must begin to consider and account for this reality in such ways as to address to following: how the presence of both HIV and common diseases of the aged alter the optimal treatment of HIV and the co-morbidities, and how to educate the HIV specialist and the generalist to best address (diagnose, treat, or refer) these multiple conditions. A new medical awareness should be cultivated of treating HIV “throughout the life span” as opposed to focusing on short term survival or urgent care, as persons living with HIV now have survival outcomes measured in decades rather than years.

The coming influx of a generation of older HIV patients also means that HIV care must adapt in terms of access to care, reimbursement and coordination of care models. As HIV/AIDS patients age (as with other individuals) the incidence of chronic and other diseases that disproportionally affect the aged also increase. It is not uncommon for individuals over the age of 50 who are living with HIV/AIDS to have two or more co-morbidities such as osteoarthritis, hypertension, diabetes and cardiovascular disease. HIV care provision will need coordination with a variety of medical specialties geared toward the conditions of aging: geriatrics, cardiology, rheumatology, dental, pain management, orthopedics, and endocrinology specialties, among others. HIV/AIDS specialists and other specialists such as geriatricians should contribute to development of new guidelines for these complicating conditions. Further study is also needed examining the interaction of the natural aging process and the effects on aging of HIV medications.

Additionally, the federal government must prepare for the transition of thousands of HIV/AIDS patients into Medicare systems as the HIV population ages. Reimbursement and provision of care in each system must be aligned to ensure smooth transition of patients between the programs. Medicare providers must be prepared to absorb patients from Ryan White clinics and other HIV care providers. Medicare providers may need further incentive to accept HIV patients. We must ensure that low/fixed income elderly don’t lose access to care, medication, or case management services as they age and transition to Medicare programs.

**Examples of HIV and aging policies we support:**

- While the Academy, in coordination with the American Geriatrics Society, are proud of the pioneering work published in 2011, “Recommended Treatment Strategies for Clinicians Managing Older Patients with HIV” we recognize and encourage the development of new and updated guidelines for the care and treatment of aging HIV patients in the future.

---

4 AAHIVM, the American Geriatrics Society, “Recommended Treatment Strategies for Clinicians Managing Older Patients with HIV,” 2011
Funding of Federal HIV/AIDS programs

Policy Statement:

The American Academy of HIV Medicine (AAHIVM) and its members support the adequate funding of federal programs for HIV/AIDS care and treatment.

Background:

Federal and state programs for HIV/AIDS have been chronically underfunded. This underfunding has real repercussions for the medical health and well-being of people infected with a potentially fatal disease.

Most HIV providers report that the Medicare, Medicaid, and Ryan White programs do not currently reimburse medical care at actual cost.

The Centers for Disease Control and Prevention estimate that there are 56,000 new HIV infections per year in the United States. The need for care, treatment, and services for people living with HIV grows annually, but federal funding of HIV programs historically grows at a much slower rate.

One example of this is the AIDS Drug Assistance Programs (ADAPs). AIDS Drug Assistance Programs are critical in providing medications to people living with HIV/AIDS who have no other access. Unfortunately, many state ADAPs have been forced to cut services by reducing eligibility criteria, changing formularies, and closing enrollment. In 2010, many states have put individuals on waiting lists to receive their life-saving and life-sustaining medications through this program.

Success at fighting HIV requires financial investment to help sustain a long-term effort against the disease. The federal government must ensure that people living with the disease have adequate access to care and treatment.

Examples of Federal funding policies we support:

- Full federal funding of ADAPs for antiretroviral and other HIV disease-specific medications, with an option for states to expand the program as able to cover medications commonly used to treat co-morbid conditions such as hepatitis B and C, diabetes, hypertension, and mental illness
- Federal funding of HIV programs at all federal agencies (HHS, HRSA, CDC, NIH) that keeps pace with need for and yearly growth in the programs.
Federal Funding of Support Services

Policy Statement:

The American Academy of HIV Medicine (AAHIVM) and its members support the funding and provision of support services for PLWHA, provided that the funding of these programs does not come at the expense of provision of medical care.

Background:

People with HIV have many significant challenges. Many people living with HIV have other co-morbid conditions, such as heart disease, mental health problems, or drug or alcohol addiction. In addition, poverty, unemployment, domestic violence, homelessness, hunger, lack of access to transportation, and other issues can prevent people from accessing health care. People with competing demands and challenges in meeting their basic needs for legal services, housing, food, and child care may also have problems staying in medical care.

However, basic medical care and provision of core medical services for HIV disease is chronically underfunded by the US government. Most HIV providers report that the Medicare, Medicaid, and Ryan White programs do not currently reimburse medical care at actual cost.

Although ancillary services are important and valuable to many PLWHA, many HIV programs are facing serious challenges covering the provision of core medical services, including critical components of the standard for HIV care, such as laboratory monitoring and provision of drug regimens for those who cannot afford it. Our providers, cannot support diversion of funding intended for medical services to other goals.

For example, within the context of the Ryan White program, core medical services are covered under funding from Part C of the program. Many in the HIV/AIDS community advocate for the inclusion of food and nutrition services provided pursuant to medical nutrition therapy as a core medical service. AAHIVM supports the current HRSA interpretation of "medical nutrition therapy" as it applies to core medical services for Ryan White. AAHIVM defines medical nutrition therapy as nutritional supplements prescribed/recommended by a licensed dietitian or medical provider. We do not support an expansion of the definition of medical therapy to include food or other nutrition services.

Similarly, the American Academy of HIV Medicine also supports the current HRSA interpretation of transportation and does not support changes to the definition of transportation or the addition of Medical transportation to the core medical service definition. Although medical transportation is important, many HIV programs are facing serious challenges covering the current list of core medical services, including critical components of the standard for HIV care, such as laboratory monitoring.

Our position on protecting the definition and funding of core medical services notwithstanding, we recognize the utility of services like transportation and food services for people with HIV, and we support their funding apart from care and treatment.

Examples of co-morbidity care policies that we support:

- We support the current (as of 2009) interpretation of “core medical services” in the Ryan White law by HRSA, as it applies to Part C programs.
We support the current (as of 2009) HRSA interpretation of "medical nutrition therapy" as it applies to core medical services for Ryan White and do not support an expansion of the definition of medical therapy to include food or other nutrition services.

We support the current (as of 2009) HRSA interpretation of transportation and do not support changes to the definition of transportation or the addition of medical transportation to the "core medical service" definition. While we agree that medical transportation is important, many HIV programs are facing serious challenges covering the current list of core medical services, including critical components of the standard for HIV care, such as laboratory monitoring.
Co-morbidities and HIV Care

Policy Statement:

The American Academy of HIV Medicine (AAHIVM) and its members support medical and health policies that contribute to optimal health for patients with other medical conditions or co-occurring infections and conditions common to HIV patients, such as tuberculosis, hepatitis, or mental health conditions.

Background:

As providers committed to fighting HIV/AIDS and providing optimal care for HIV patients, we have a considerable concern about epidemics of viral hepatitis, tuberculosis and other diseases commonly found with HIV infection. We also have concern for mental health or addiction disorders, and other co-occurring conditions often linked with HIV infection.

According to the Centers for Disease Control and Prevention, at least 25% of Americans with HIV/AIDS are co-infected with the hepatitis C virus (HCV) and up to 10% of people with HIV/AIDS are co-infected with chronic hepatitis B virus (HBV)

HCV is one of the main causes of chronic liver disease in the United States, and chronic hepatitis C infection is also the leading reason for liver transplantation. HCV and HBV damage the liver more rapidly in people with HIV/AIDS. For example, HIV/HCV co-infected persons have twice the risk of cirrhosis and a six-fold increased risk of liver failure compared to people with HCV alone. Further, the progression of HCV disease limits the liver’s tolerance for HIV medications. As highly active antiretroviral therapy has allowed people with HIV/AIDS to live longer, end-stage liver disease secondary to HCV has become the leading cause of death among people with HIV/AIDS in multiple populations studied in the United States.

We stand on the brink of a new era in HCV treatment with drugs in development which will allow us to cure HCV in many co-infected patients with 12-24 weeks of therapy. There are potential public health benefits and cost-savings associated with screening HIV-positive individuals for HCV and evaluating and treating them early.

Because of the complex nature of HIV disease and the populations most vulnerable to it, there is an increased occurrence of mental health, drug abuse, and other conditions among HIV patients. We support policies and programs that address this. Identifying and treating co-occurring conditions requires that all medical and social service providers recognize the impact of these conditions on persons living with HIV/AIDS. Proper training, support, and integration of appropriate services (screening, prevention, surveillance, referral, treatment, and case management) into their existing HIV programs is needed.

Examples of co morbidity care policies that we support:

- We support policies that contribute toward adequate funding of Hepatitis C programs.
HIV Testing

Policy Statement:

The American Academy of HIV Medicine (AAHIVM) and its members support the implementation of routine HIV testing for all patients in medical settings, as recommended by the Centers for Disease Control and Prevention (CDC).

Background:

AAHIVM supports continued efforts to promote the 2006 Centers for Disease Control and Prevention (CDC) Revised Recommendations on HIV Testing. In 2012, the U.S. Preventative Task force also released a statement supporting routine HIV screening in all Americans aged 15 to 65 and pregnant women. We fully support the goal of routine HIV screening in the U.S. and urge all Americans to learn their HIV status.

HIV testing has enabled individuals with HIV to become aware of their health status and to take appropriate precautions to preserve their health. Screening and treating expectant mothers during pregnancy is now one of the major successes of the HIV world. The strategic use of medications and biomedical interventions has allowed us to nearly eliminate HIV transmission to newborns in the US. Despite advancements in the area of prenatal screenings, adolescents and many other patient groups are still not being tested. When individuals learn their HIV status, they change their behavior to protect their partners and to help themselves. Moreover, studies show that individuals diagnosed with HIV take steps to reduce the likelihood of transmitting HIV to others.

Too many people living with HIV are unaware of their status: An estimated 21 percent of people with HIV in the United States do not know their status. Studies show that people who do not know that they are HIV-positive are more likely to engage in risk behaviors associated with HIV transmission. Many of these individuals are already accessing health care services, but opportunities to diagnose them are being missed.

Anecdotal evidence from many HIV providers indicates that the CDC message of universal testing for all adults ages 13-64 is not getting through to non-HIV specialties. Further education on universal testing guidelines for providers in non-HIV specialties is desperately needed.

AAHIVM believes that confidence in reimbursement can help all provider concerns about the cost of routine testing. Private insurance is not the primary source of reimbursement for the majority of the providers who treat populations most likely to be infected. We strongly urge all federal departments to recognize the importance of implementing routine HIV testing in health care settings. Many private insurance companies base their reimbursement schedule on CMS reimbursements. National coverage by Medicaid for HIV infection screening would likely serve to encourage other insurers to cover routine HIV testing as well. Medicaid is the primary health coverage for the majority of persons living with HIV/AIDS in the U.S. Providers that treat Medicaid patients also need to feel confident that they will be reimbursed when testing is performed.

Additionally, many states still have laws that are not fully compatible with CDC recommendations in the areas of counseling and consent. This may impede testing efforts. We encourage working with AIDS officials in these states to further promote CDC testing efforts.

Finally, a major downfall of testing efforts across the nation is the failure to reliably link individuals diagnosed with HIV to experienced HIV care providers and other critical HIV-related services. Prevention efforts should work to build a robust infrastructure to link HIV testing to both medical and
behavioral health care following a diagnosis. This would further promote appropriate testing and reduce HIV transmission.

Examples of HIV testing policies that we support:

- We support policies to eliminate separate written informed consent requirements in the states that still require this.

- We support policies that encourage referral to an HIV Specialist following HIV testing for those determined to be HIV positive.
Over-The-Counter or At-Home
HIV Testing

Policy Statement:

The American Academy of HIV Medicine (AAHIVM) and its members support advances in HIV testing technologies and policies that promote the ability of patients to voluntarily and confidentially learn their HIV status through regular and accessible testing. We also support, to the greatest extent, the linkage of these innovations to medical care as well as unburdened access to counseling and prevention/risk-reduction information.

Background:

AAHIVM supports the 2006 Centers for Disease Control and Prevention (CDC) Revised Recommendations on HIV Testing. We fully support the goal of routine HIV screening in the U.S. and urge all Americans to learn their HIV status.

HIV testing has enabled individuals with HIV to become aware of their health status and to take appropriate precautions to preserve their health as well as the health of others.

However, despite advancements in the area of testing and screenings, many at-risk groups are still not being tested. An estimated 21 percent of people with HIV in the United States do not know their status, and many of these individuals are already accessing health care services. Opportunities to diagnose many HIV-positive individuals are still being missed.

Testing is an important principle of HIV prevention; according to research, when individuals learn their HIV status, they change their behavior to protect their partners and reduce transmissions. Studies also show that people who do not know that they are HIV-positive are more likely to engage in risk behaviors associated with HIV transmission.

Providing infected individuals with regular medical care and treatment involves reliably linking individuals diagnosed with HIV to experienced HIV care providers and other critical HIV-related services. Prevention efforts have focused in recent years on the importance of linking HIV testing to both medical and behavioral health care following a diagnosis.

AAHIVM’s Policy Findings:

“At-home” or “over-the-counter” (OTC) HIV testing has been a subject of discussion and debate for many years among HIV advocates, providers and the larger public. An OTC HIV test designed for widespread use was approved by the FDA in 2012 and is widely available in pharmacies.

AAHIVM generally supports innovations (and has been involved in efforts) that promote widespread, confidential and voluntary HIV testing and individual knowledge of HIV status.

However, we recognize that there may be risks associated with testing at home that in some cases would be mitigated in the medical setting. Still, we do not believe these concerns necessarily outweigh the impact of making confidential, voluntary HIV testing more available to individuals and we encourage manufacturers of the tests to account for these concerns whenever possible:

- Initial patient reaction to a positive test result can be addressed in face-to-face real time counseling by a medical professional in a medical setting. The provision of medically accurate information about the disease can be provided in many formats. However, individual patient
concerns may be best addressed within the context of the provider-patient relationship. We encourage efforts to link individuals using OTC tests to well-trained counselors who are available via phone and internet around the clock and also to link patients to local medical care for confirmation of their diagnosis and treatment. This can be done through the use of a toll free number or a link to a website such as aahivm.org. General information regarding HIV, treatment, and resources can be made available with the kit in multiple languages. There first company to market such a test provides 24/7 bilingual counseling and referrals to local HIV providers. The Academy supports that this approach would remain the standard of care.

- When a large population is tested when there is a low incidence of disease, there will be a significant number of false positive and false negative results. Manufacturers are encouraged to explain what this means and that the test result is only preliminary. Confirmation of a positive test should be done by a medical professional as soon as possible.

- Links to medical settings that offer confirmatory testing services should be made available through website or toll-free numbers provided with the test kits.

- We have some concern about the potential for coercion or domestic violence occurring in unregulated testing settings. For example sex workers could be forced to test and may be harmed if a test is positive. The same is true of domestic partners. The potential for disclosure to individuals other than the individual tested is also a concern. We encourage those producers of at-home tests to consider and minimize possible social harm scenarios by conducting post marketing research in different populations and responding to the results accordingly.

- Researchers have expressed concern about study participants testing themselves outside of the study visits. This could impact blinding in vaccine trials and endpoints and follow up in other prevention trials. Designers of study protocols should take into account this possibility in the design of studies and counseling of participants. We also encourage makers of OTC testing products to coordinate with researchers and study sponsors to measure the effects of such events where possible.
HIV Research

Policy Statement:

The American Academy of HIV Medicine (AAHIVM) and its members support research efforts that lead to the better care, treatment of patients, and prevention of the disease. As such, we support abundant funding of a robust research agenda by the federal government and also the funding of research by private organizations and individuals.

Background:

Research remains essential to finding a cure for HIV and to developing safer, more effective therapies and regimens to treat HIV and its associated complications.

A strong research agenda is the final step in all efforts to curb the disease. We urge the Administration to encourage and support innovative research not only into diagnosis, treatment and prevention, but also into the social and epidemiological factors of the disease that weave the complex tapestry that is HIV/AIDS in the U.S. in the twenty-first century.

Research in Medicine: Research into the co-morbid conditions associated with living a long life with HIV is a topic of great interest to our providers. A few specific subjects of medical research that they feel would benefit from increased understanding are as follows: co-morbidities associated with aging with for HIV, malignancy, cardiovascular disease, renal disease, hyperlipidemia, diabetes, osteoporosis, and hepatitis B and C co-infection. Our providers also have a desire to see research into drug interactions antiretrovirals and other medications commonly used to treat heart disease, lipid disorders, dementia, and psychiatric conditions. However, in all research forums, we see a need for stronger representation by non-white, non-male participants to accurately reflect the changing face of HIV in the U.S.

Research in Demographics and Human Behavior: We would like to see new studies based on emerging locations and populations affected by HIV. The disease has migrated into new populations and locations over the past decade though studies have not kept pace with this changing epidemiology. While studies are abundant on urban Caucasian gay men, research is sparse on other HIV-infected populations such as women, indigent and migrant populations, and also on HIV in the rural South and central portions of United States. We encourage researchers to further examine the disease in these populations and locations and to support a research platform that more fully reflects the changing identity of the epidemic
HIV Education and Prevention

Policy Statement:

The American Academy of HIV Medicine (AAHIVM) and its members support policies that increase HIV awareness and education among the general public, our patients, and all care providers. We also support policies that lead to prevention of the spread of the disease through education and other efforts.

Background:

Great strides have been made in treating HIV over the past 15 years, yet this very success can become grounds for complacency. Already we are seeing the proliferation of drug-resistant strains of HIV and a steady increase in HIV transmission (often by people who do not know that they are infected).

Too many Americans do not have the basic facts about HIV and other sexually transmitted infections. It is essential that all Americans have access to shared factual information about HIV and the current HIV epidemic. This includes knowing how HIV is transmitted and prevented and also knowing which behaviors place individuals at greatest risk for infection. While we recognize that HIV is concentrated in certain communities, we support providing all Americans with clear information about how to avoid HIV infection.

Our first duty as HIV health care providers is to maintain vigilance against complacency about this life-threatening contagious illness. We must educate policy makers that testing and prompt treatment is vital to reducing the spread of HIV. The best strategy for HIV is prevention, and the best prevention is early detection and appropriate treatment of all people infected with this often-fatal disease.

Broader HIV education is needed across the age span. By 2015 half of all Americans living with HIV will be over age 50, and 15 percent of new HIV cases occur in this age group. Education is needed to effectively encourage people across the age span to take steps to reduce their risk for infection.

HIV awareness and education should be universally integrated into all medical environments and health and wellness initiatives. Information about HIV is important to include in any wellness context promoting healthy behaviors, including sexual health. We must also ensure that all health and wellness practitioners (peer counselors, intake specialists, doctors, physician assistants, nurse practitioners, nurses, and other health professionals) are also educated about HIV, especially in programs for underserved communities.

We should ensure that this education reaches populations that may be overlooked including people with other disabilities. The focus of the education and awareness effort is to improve individual understanding of HIV infection, HIV-related risk factors and risk reduction, and HIV-related stigma and discrimination.

We must also move away from thinking that one approach to HIV prevention will work, whether it is condoms, education, or pre and post-exposure prophylaxis. Instead, we need to develop, evaluate, and implement effective prevention strategies and combinations of approaches including efforts such as expanded HIV testing, education and support to encourage people to reduce risky behaviors, the strategic use of medications and biomedical interventions, the development of vaccines and microbicides, and the expansion of evidence-based mental health and substance abuse prevention and treatment programs.
Harm Reduction

Policy Statement:

The American Academy of HIV Medicine (AAHIVM) and its members support policies that promote harm reduction strategies for people who engage in high-risk behaviors involving injection drug use.

Background:

Harm reduction (or harm minimization) refers to a range of public health policies designed to reduce the harmful consequences associated with recreational drug use and other high risk activities. Harm reduction is a set of practical strategies that reduce negative consequences of drug use, by utilizing a spectrum of strategies that range from safer use, to managed use, to abstinence.

The use of certain illicit drugs often involves self-injection using hypodermic syringes. In some areas, these syringes are available solely by prescription. When availability is limited, users of heroin and other drugs frequently share their syringes and use them more than once. As a result, one user's infection (such as HIV or Hepatitis C) can spread to other users through the reuse of syringes contaminated with infected blood. The principles of harm reduction propose that clean syringes should be available without a prescription or at least available through a Needle and Syringe Exchange (NSE) program.

AAHIVM supports access to sterile needles and syringes as one method of preventing HIV transmission. Injection drug use remains a major driver of the HIV/AIDS epidemic in the United States, and the leading cause of new hepatitis C infections. Among injection drug users, sharing needles and other drug paraphernalia increases the risk of HIV infection. Abundant research, endorsed by the findings of eight federally commissioned reviews, has conclusively demonstrated that syringe exchange is effective in reducing the transmission of HIV without increasing drug use. Studies have also found that providing sterile equipment to injection drug users increases the probability that they will initiate drug treatment, and does not increase drug use.

Examples of policies we support:

- Syringe exchange programs that currently operate in 36 states, the District of Columbia and Puerto Rico. When President Obama signed the Fiscal Year 2010 Consolidated Appropriations Act he repealed a 21-year-old ban on federal financing for programs that supply clean needles to drug addicts.

- Access to Narcan nasal spray for the treatment of drug overdose, along with access to education on its proper use.

- Access to medically assisted treatment for opiate, alcohol, and tobacco addiction.

- Access to education on the increased risk of overdose deaths following a period of mandatory sobriety (for example, in jail, prison, or residential treatment programs), thereby encouraging people to use lower doses of narcotics if subsequently they do relapse into opiate use.

- Education on the importance of securing prescription pain pills so that they cannot be accessed by children.

- Access to drug treatment programs that recognize the likelihood of relapse into drug use without undue stigmatization.
**Medical Marijuana**

*Policy Statement:*

The American Academy of HIV Medicine (AAHIVM) and its members support the ability of medical providers to determine the best course of treatment for their patients on an individualized basis, within the context of the law.

*Background:*

Medical marijuana is a highly charged policy topic on both state and federal levels. Marijuana was used medicinally in the U.S. until the late 1930s. In 1970, U.S. drug law classified marijuana as having a high potential for abuse and having no valid medical use. Today, with some exceptions, Federal and State laws generally forbid the sale or possession of marijuana. Eighteen states and the District of Columbia have passed medical marijuana laws that permit limited use for health reasons. In 2009, the US government announced that federal agents will not arrest medical marijuana patients or providers who comply with state laws.

Marijuana has been found to have various health benefits. It reduces muscle spasms in people with neurologic disorders and can help treat some types of pain including that from peripheral neuropathy. Many scientific studies document marijuana's ability to reduce nausea and increase appetite. Some HIV patients also report experiencing a poor appetite due to fatigue or drug side effects. Poor appetite can contribute to a condition known as “AIDS wasting.” Some people with HIV experience nausea when taking antiretroviral medications (ARVs), which can make it difficult to consistently take all scheduled doses of life-sustaining medications. Missing medication doses decreases the effectiveness of treatment regimens and raises the possibility of medication resistance.

There is a need for further research into uses and health benefits of marijuana for HIV patients. Very few formal studies have been done on the utility of most herbs and herbal supplements. Additionally, few studies are available on the interactions between the use of herbs and common medications. One research study found that smoking marijuana does not increase HIV viral load or reduce CD4 cell counts. However, smoking any substance presents some health concerns for people living with HIV, including respiratory infections and emphysema. More studies are absolutely needed to determine the risk versus benefit as a treatment alternative for people living with HIV. Further research that examines the biochemical properties of marijuana and their interaction with the endocannabinoid system are necessary to determine if safer delivery methods can be discovered.

Ultimately, we support the ability of medical providers to determine the best course of treatment for their patients on an individualized basis, within the context of the law. And we support research into the risks and benefits of marijuana as a treatment option for people living with HIV.

*Examples of medical marijuana policies we support:*

- We support the ability of state and federal lawmakers to determine the legality of use and possession of marijuana for medical purposes.

---

5 “Association Between Marijuana Exposure and Pulmonary Function Over 20 Years” Mark J. Pletcher, MD, MPH; Eric Vittinghoff, PhD; Ravi Kalhan, MD, MS; Joshua Richman, MD, PhD; Monika Safford, MD; Stephen Sidney, MD, MPH; Feng Lin, MS; Stefan Kertesz, MD
• We support further research into the uses of medical marijuana, specifically for people living with HIV/AIDS.

• We support policies that increase the ability of providers to prescribe optimal treatments for the medical well-being of HIV and AIDS patients.

• We support the ability of HIV providers to prescribe medical marijuana to their patients for treatment purposes in States and regions where it is legal and proper to do so.
**HIV Criminalization**

**Policy Statement:**

The American Academy of HIV Medicine (AAHIVM) and its members are opposed to laws that distinguish HIV disease from other comparable diseases or that create disproportionate penalties for disclosure, exposure or transmission of HIV disease beyond normal public health ordinances. We support non-punitive prevention approaches to HIV centered on current scientific understanding and evidence based research.

**Background:**

The criminalization of HIV transmission and exposure is a complex issue. Early in the history of the disease, public fear of the disease led many states to pass laws that established criminal penalties for failing to disclose infection, for exposing others to the disease, and for transmitting the disease (intentionally or un-intentionally). In many cases, these laws apply regardless of protective measures the HIV-positive person may take.

At the time when many of these laws were passed, the routes of HIV transmission, and methods of preventing the disease were not as well understood scientifically as they are today. In some cases, these laws reflect assumptions about the disease that are now known to be scientifically invalid. For example, some state laws criminalize biting or spitting by HIV-positive persons, even though saliva is not considered a probable transmission risk.

These laws are specific to HIV and the same standard is not applied to other diseases such as hepatitis C and hepatitis B which can also be transmitted via sexual activity.

Currently, 34 states and two U.S. territories have laws which criminalize behavior of HIV positive people. The laws are varied in detail, but many are harsh in nature with some having penalties that are usually reserved for manslaughter, whether or not actual harm has been demonstrated or caused. This seems to be disproportionate punishment that arises from hysteria and/or homophobia.

The subsequent prosecutions that have resulted from these laws, and the juridical policy that has been built upon on these laws are similarly flawed in their presuppositions, motives, and utility.

They also fail to take in account the great advances in care and treatment that are now available to those who do become infected. HIV disease is in most cases today a manageable long-term condition. However, prosecutorial precedent still treats transmission of the disease as the equivalent of a death sentence, which represents a significant exaggeration in the current medical environment.

**AAHIVM’s Policy Findings:**

As medical professionals, our members support policies that encourage individuals to learn their HIV status, participate in regular medical care, and take measures to protect others against the spread of the disease without punitive sanctions.

Our members oppose public policies and laws that distinguish HIV disease from other comparable diseases, and believe public health and juridical policy on HIV should be comparable to that of other sexually transmitted or communicable diseases, such as tuberculosis, hepatitis, herpes. or syphilis.
Public health policies, and laws (as well as possible prosecutions that might result from those laws) should take into account the most up-to-date scientific information about methods of transmission and prevention, as well as the great advances in care and treatment that are now available to those who do become infected with HIV, which in today's world is usually a treatable long term condition.

In some rare cases, there may be a role for legal redress against individuals who transmit the disease or expose others to the disease with malicious intent. There may also be a role for legal redress when an individual seeks to defraud another individual concerning their health status. However, pathways for such legal redress already exist in most states. Redundant laws focused at one disease are unnecessary, stigmatizing, harmful and unfair.

Policies on HIV should also take into account the high levels of stigma and prejudice still associated with the disease, and seek to protect individual privacy, rights, and freedom.

Public policies and laws around disease transmission should be evidence-based and non-discriminatory in nature. They should serve public health goals and promote public awareness.
Pre-Exposure Prophylaxis (PREP)

Policy Statement:

The American Academy of HIV Medicine (AAHIVM) and its members support ongoing research in the field of pre-exposure prophylaxis (PrEP), and also the development and implementation of guidelines that will allow providers to make use of PrEP as an effective prevention option for some patients.

Background:

The term Pre-Exposure Prophylaxis (PrEP) refers to an HIV prevention practice in which persons not infected with HIV who are at high risk of the disease are take antiretroviral medication in an attempt to lower their chances of becoming infected if they are exposed to HIV.

To date, PrEP is still a subject of research, although studies have indicated it may be offer an effective prevention strategy for men who have sex with men (MSM) and sero-discordant heterosexual men and women.

Several studies have indicated incredibly promising possibilities, particularly that the use of PrEP in MSM populations has the potential to substantially reduce transmission of the disease. Other studies have showed somewhat lesser or mixed results, and even indicated possible ineffectualness for some populations, such as women. The studies have also indicated certain medical side effects (such as bone density loss) that must be taken into account in any risk-evaluation. 6

As the news from these studies has emerged the level of debate and consideration has risen among the scientific and medical community, as well as among HIV policy experts and patients. There are strong emotions on all sides of this issue, as well as a significant amount of excitement over what many see as the positive potential of this proposed medical intervention. There are also concerns among some in the scientific and policy community over the possibility of unintended consequences, such as drug resistance.

The Centers for Disease Control and Prevention (CDC) are leading federal efforts to develop formal Public Health Service guidelines for PrEP. However, until those more detailed guidelines are available, CDC has developed interim guidance for physicians electing to prescribe PrEP for HIV prevention among MSM. The CDC will also be developing formal guidance for physicians on PrEP use among heterosexuals. However, CDC urges that physicians await CDC guidance before using PrEP for heterosexuals. Because pregnant and breastfeeding women were excluded from participation in PrEP trials, further evaluation of available data will be needed before any recommendations can be made regarding the use of PrEP for women during conception, pregnancy, or breastfeeding.

6 In November 2010, the National Institutes of Health (NIH) announced the results of the iPrEx clinical trial, a large, multi-country research study examining PrEP. The study found that daily oral use of tenofovir plus emtricitabine (TDF/FTC, brand name Truvada) provided an average of 44% additional protection to men who have sex with men (MSM) who also received a comprehensive package of prevention services that included monthly HIV testing, condom provision, and management of other sexually transmitted infections.

In July 2011, a study by the Centers for Disease Control and Prevention (CDC) called the TDF2 study, along with a separate trial by the University of Washington, provided evidence that a daily oral dose of antiretroviral drugs used to treat HIV infection can reduce HIV acquisition among uninfected individuals exposed to the virus through heterosexual sex. The TDF2 study, conducted in partnership with the Botswana Ministry of Health, found that once-daily TDF/FTC reduced the risk of acquiring HIV infection by roughly 63 percent overall in the study population of uninfected heterosexual men and women. CDC researchers also conducted a separate analysis to better understand the level of effectiveness among trial participants believed to be taking their study medications. This analysis excludes any HIV infections that occurred more than 30 days after a participant's last reported drug dose, because those individuals could not have been taking study pills at the time of infection. These results indicate that TDF/FTC reduced the risk of HIV infection by 78 percent.

The University of Washington study, called Partners PrEP, found that two separate antiretroviral regimens – tenofovir and TDF/FTC – significantly reduced HIV transmission among serodiscordant couples, in which one partner is infected with HIV and the other is not (by 62 percent and 73 percent, respectively). CDC co-managed two of the nine sites for this study
The Food and Drug Administration (FDA) approved the first labeling indication submission of a fixed-dose combination of tenofovir and emtricitabine (brand name Truvada) for PrEP use in 2012. After that time, CDC has indicated that they will release Final Guidelines on the use of PrEP, in accordance with that decision.

AAHIVM believes that the FDA and the CDC are well-suited to apply rigorous standards for the evaluation of the available scientific literature, and available data in an evenhanded manner and develop adequate guidelines and standards for the application of this innovation in medical settings. AAHIVM supports the guidelines of the CDC on PrEP use by providers.

AAHIVM urges healthcare providers to familiarize themselves with the most current CDC guidance for PrEP use and counsel their patients accordingly. Use of PrEP is a long term medical intervention strategy that patients and providers should consider fully before implementing. While PrEP represents a historic innovation in the prevention of the disease, this advance should be tempered by the realization that HIV prevention must be a combination approach, not one single approach.
Policy Statement:

The American Academy of HIV Medicine (AAHIVM) and its members are opposed to workplace policies that distinguish HIV disease from other comparable diseases as it relates to employment.

Background:

The American Academy of HIV Medicine believes that HIV should be treated no differently than any other illness as relates to employment.

We fully embrace the protections accorded by the Americans with Disability Act and support all protections of privacy from disclosure about one’s HIV status to an employer.

As in the case of any illness, we support the concept as required by the Joint Commission on Accreditation of Health Care Organizations, most hospitals and other health care organizations to ask only that a health care worker is physically and mentally capable of performing the duties of their job, and see no justifiable reason for a health care worker, or any other worker to be asked to disclose their status of HIV infection to their employer.