ISSUE BRIEF SUMMARY | NOVEMBER 2023
ENDING THE HIV EPIDEMIC — SUPPORTING ALL PEOPLE WITH HIV AND REDUCING NEW TRANSMISSIONS

GREATER STATE AND LOCAL LEADERSHIP IS NEEDED TO SCALE-UP RAPID START PROGRAMS

RAPID START IS THE ACCELERATED ENTRY INTO HIV MEDICAL CARE at the time of diagnosis, as well as swift initiation of ART for people with HIV, preferably immediately or within the first seven days of diagnosis. Rapid Start of antiretroviral therapy (ART) is an essential intervention that is not yet the standard of care throughout the U.S. Greater state and local leadership is critical to adopting Rapid Start as the standard of care. To achieve this vision, at least six priority areas call out for state and local leadership:

PRIME OPPORTUNITIES TO SUPPORT RAPID START

State and local leaders can take many actions to expand early access to HIV care upon diagnosis:

1. EDUCATE PROVIDERS AND COMMUNITY

Establishing large-scale Rapid Start programs often requires clinical transformation. Key actions are to educate clinics and prescribing providers along with people with HIV and coalitions and networks of people with HIV on the benefits of Rapid Start, show them various models and best practices, as well as to provide technical assistance to adopt this new approach.

POLICY ACTION: Work with AIDS Education and Training Centers (AETCs), primary care associations, and state medical boards to provide training and education.

2. COORDINATE CLINICAL PROVIDERS WITHIN A JURISDICTION

Rapid Start programs must be able to ensure that prescribing providers and other essential members of the care team including navigators and linkage staff are available for the initial visit. This is especially challenging with small clinics or private practices with one or a small number of prescribing providers. One way to overcome this obstacle is for local or state governments to convene all of the providers within a jurisdiction to identify the range of community resources and facilitate collaborative activities to identify resources for organizations to adopt rapid start.

The Ryan White HIV/AIDS Program (RWHAP) Special Projects of National Significance (SPNS) Program has supported initiatives that found that Rapid Start programs were reasonably inexpensive to implement and cost-effective or cost-saving during initial and sustained implementation.

POLICY ACTION: Convene the local providers in a community with the specific purpose of setting expectations for the adoption of Rapid Start and to identify and fill gaps when there are a limited number of service providers to ensure community level access across the system of care.

3. SUPPORT ADMINISTRATIVE READINESS

The challenge with getting to scale is that the whole system must work in a coordinated fashion, and it must be ready for a greater volume. Readiness for Rapid Start includes having an approved standard protocol with minimum standards for Rapid Start for the jurisdiction. Minimum standards include agreeing on the standard for accepting that the individual has tested positive for HIV (i.e. a best practice is to accept a second positive point-of-care test result for ART initiation even if additional laboratory testing is ordered for follow-up), establishing standardized ART regimens, having standing order for labs, and defining roles and responsibilities among all members of the care team and identifying handoffs. States also should establish rules to require Medicaid plans and commercially insured health plans to provide ART without prior authorization or other forms of utilization management for an initial (i.e. 30-day) period so that this does not delay initiation of ART.

Because insurance coverage or support from the RWHAP is generally available to finance ongoing HIV care once an individual has established eligibility, adopting Rapid Start does not require a long-term financial commitment.

POLICY ACTION: Develop a Rapid Start implementation plan, set minimum standards and limit health plan barriers that delay rapid start.

4. ENSURE IMMEDIATE FINANCIAL ELIGIBILITY

One of the major challenges with Rapid Start is the potential financial risk for clinics and providers involved in providing medications for individuals for whom a source of coverage has not been established. Administrative delays in establishing eligibility can preclude clinics from adopting Rapid Start.

POLICY ACTION: Make policy changes to facilitate immediate coverage of services and, where necessary, fund rapid initiation programs and add coverage of approved medications.

5. BOLSTER WORKFORCE CAPACITY

One challenge with adopting Rapid Start programs is that the capacity of HIV clinics and organizations is already greatly strained, and this model could increase and further exacerbate existing staffing demands at clinical sites. New

models of care, however, offer the potential to enable the adoption of Rapid Start programs in ways that also could lessen the stresses experienced by many individuals involved in providing HIV care.

POLICY ACTION: Facilitate the adoption of team-based models of care that extend the capacity of the entire care team to respond to newly diagnosed individuals.

6. RE-ENGAGE PERSONS WHO HAVE STOPPED ENGAGING IN CARE

To comprehensively support good care outcomes for people with HIV and foster a high quality of life, providers should assume that there will be interruptions in care. The health system, therefore, must watch for, seek to prevent, and develop supports to facilitate rapid re-entry into HIV care and ART.

POLICY ACTION: Ensure that Rapid Start initiatives create new pathways for re-engaging diagnosed persons who have stopped engaging in care.

Governors, mayors, state legislators and local elected officials, with greater support from the federal government and philanthropy and private sectors partners, have critical roles to play to make Rapid Start a standard of care.

FEDERAL LEADERSHIP CAN SUPPORT STATE AND LOCAL EFFORTS

While Federal HIV programs already have taken action to support Rapid Start, key policy changes can greatly enhance current efforts:

HRSA'S HIV/AIDS BUREAU

IMMEDIATE ACCESS TO RYAN WHITE HIV/AIDS PROGRAM (RWHAP) SERVICES ON DIAGNOSIS: Longstanding HRSA policy interpreting the Ryan White CARE Act statute has been seen as a barrier to ADAP and RWHAP funds being used for Rapid Start until an individual has been fully determined to be eligible. The statute requires proof of HIV status, proof of financial eligibility (as defined by the state), and proof of residency. Due to the documentation needed to establish financial eligibility and the pay-of-last-resort requirement that does not allow RWHAP funds to be used for items or services for which another form of coverage is available, this delay can make Rapid Start unavailable to some individuals. HRSA issued Policy Clarification Notice (PCN) 21-02 that expects RWHAP recipients to establish protocols that facilitate the rapid delivery of services including the provision of ART for those newly diagnosed or re-engaged in care. It further states that "if services are initiated prior to eligibility being established, RWHAP recipients and subrecipients must conduct a formal eligibility determination within a reasonable timeframe and reconcile (i.e., properly account for) any RWHAP funds to ensure that they are only used for allowable costs for eligible individuals." HRSA should consider additional actions to provide a roadmap for states or to offer technical assistance for ensuring immediate access to services. Since the statute permits states to establish financial eligibility requirements, HRSA could consider a policy clarification that indicates that state eligibility standards can permit a two-stage financial eligibility process. Provisional financial eligibility (i.e. 30 days) could be based on self-attestation of income and a second stage based on written or electronic income verification. States would be deemed to comply with payer of last resort if they establish a pay-and-chase model to bill for covered services.

GUIDANCE ON ADAP ELIGIBILITY SIMPLIFICATION: HRSA can provide guidance and technical assistance on adopting electronic eligibility determinations during the initial visit and sharing best practices from states that have reduced the time needed to establish eligibility.

DEVELOPMENT OF CORE METRICS AND REPORTING STANDARDS: Clinics and providers are burdened by tracking and reporting on too many metrics, yet Rapid Start requires consistent data to monitor progress. HRSA could establish reporting standards for core metrics to track time to first clinical visit and time to ART initiation.

SUPPLEMENTAL FUNDING FOR THE AETC PROGRAM: The RWHAP has been relatively flat-funded for many years and increases have been associated with financing direct medical costs. The Administration should request, and Congress should provide, supplemental funding to extend the capacity of AETCs to support Rapid Start adoption.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

WAIVER GUIDANCE TO OFFER PRESUMPTIVE ELIGIBILITY FOR NEWLY DIAGNOSED INDIVIDUALS: State Medicaid programs can always request Section 1115 waiver approval, but federal approval is uncertain and can be time consuming. **CMS can greatly strengthen state interest in presumptive eligibility for newly diagnosed people with HIV by creating waiver guidance and developing a waiver template for new Rapid Start Presumptive Eligibility Waivers**. This would signal CMS support for such an approach, would clarify what states need to show to receive approval, and would lead to standardization of policies across states.

STATE MEDICAID DIRECTOR LETTER (SMD): CMS has periodically issued SMD letters to State Medicaid programs to update them on advances in HIV clinical care to ensure that Medicaid programs align with current standards of care. The last HIV-related SMD was issued in 2016. CMS should issue a new SMD that provides guidance on the benefits of Rapid Start and links to HRSA and other resources for adopting these programs, as well as providing other critical updates, highlighting the National HIV/AIDS Strategy and addressing new and forthcoming longer-acting products for HIV treatment and prevention, guidance and expectations of scaling-up access to PrEP with data on current disparities in use, and the latest data on self-testing for HIV.

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