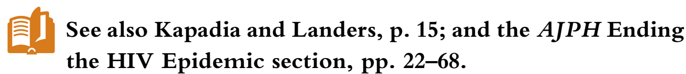
Leveraging Medicaid to Enhance Preexposure Prophylaxis Implementation Efforts and Ending the HIV Epidemic


See also Kapadia and Landers, p. 15; and the *AJPH* Ending the HIV Epidemic section, pp. 22–68.

One of the pillars of the recently announced national Ending the HIV Epidemic initiative is increased uptake of preexposure prophylaxis (PrEP), a highly effective HIV prevention medication. However, PrEP uptake has been slow, especially among populations that are most affected by HIV.[1,2] For example, African Americans account for 42% of people living with HIV but only 11% of PrEP users as of 2016.[3] Furthermore, only 7% of people with PrEP indications—and only 2.1% of women with PrEP indications—received prescriptions in 2016.[3] Challenges to successful PrEP implementation include patient and provider lack of awareness of PrEP, stigma, affordability concerns, and other structural barriers that hinder access to HIV prevention and care.[4]

Access to health care is critical for effective PrEP implementation, especially among lower income groups, which are disproportionately affected. As of 2016, far more PrEP users were privately insured than covered by Medicaid (81% compared with 12%), suggesting a particular unmet need in the Medicaid population.[3] In addition, more than half of the counties targeted by the Ending the HIV Epidemic plan are located in Medicaid expansion states. State Medicaid programs therefore have a unique opportunity to increase PrEP uptake, and there are a number of concrete steps they can take to do so.

All states should have the first approved PrEP medication, tenofovir disoproxil fumarate and emtricitabine, on their Medicaid formularies. A second medication, tenofovir alafenamide and emtricitabine, was approved in October 2019. However, prior authorization requirements vary across states, and sometimes among Medicaid managed care organizations (MCOs) within a state. States should align PrEP medication coverage across their fee-for-service programs and MCOs and consider eliminating prior authorization for these medications. Currently, the cost of PrEP medication may be a significant barrier to PrEP promotion among Medicaid programs and MCOs. Return on investment analyses, public health evidence, and the impending availability of generic PrEP medication may all help address this barrier.

In addition to the medication, the Centers for Disease Control and Prevention recommends that PrEP services include an initial appointment, testing for HIV and other sexually transmitted infections, and renal function and hepatitis B virus serologies. Follow-up clinical visits with laboratory and sexually transmitted infection testing, including extragenital testing for gonorrhea and chlamydia for some PrEP users, are recommended quarterly. State Medicaid programs and MCOs should ensure that their systems can reimburse these services, including appropriately coded sexually transmitted infection testing for multiple specimens.

Medicaid programs should also implement approaches to evaluating PrEP uptake, including evaluating claims data. As part of the Ending the HIV Epidemic initiative in New York, the state analyzed PrEP prescriptions among the Medicaid population to determine uptake.[5] California undertook a similar analysis (http://www.chprc.org). Unfortunately, Medicaid claims data often lack full information on demographics such as race and ethnicity, as well as sexual orientation and gender identity. However, these claims analyses can help characterize population-level PrEP uptake and identify gaps in PrEP care delivery. To further monitor the components of PrEP delivery and bolster high-quality PrEP care, stakeholders should work to develop and add sexual health measures relevant to components of PrEP, such as sexual health history taking and PrEP use, to the Healthcare Effectiveness Data and Information Set. Such measures could allow state Medicaid agencies to better track and incentivize PrEP delivery at both the plan and provider levels.

Developing collaborations between Medicaid programs, public health departments, and community clinics is critical to effective PrEP implementation. This includes efforts to raise awareness and prescribing rates among primary care providers and other nonspecialists. The recent endorsement of PrEP by the US Preventive Services Task Force as a primary care intervention underscores that primary care providers are well positioned to prescribe PrEP to at-risk populations. However,

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primary care providers still lag in PrEP awareness and prescribing rates.[6] Medicaid agencies and MCOs should work with public health agencies, as well as Health Resources and Services Administration–funded AIDS Education and Training Centers, to facilitate PrEP education and practice support for primary care providers (www.aidsetc.org). Provider education could also be supported federally through a "Dear State Medicaid Director" letter from the Centers for Medicare and Medicaid Services highlighting PrEP and other priorities for the Ending the HIV Epidemic initiative. Meanwhile, Medicaid state programs and MCOs can also serve as conduits for providing enrollees with culturally accessible information about PrEP, along with information about coverage and how to locate a PrEP provider in the state or region.

Optimizing PrEP delivery while ensuring accessibility for Medicaid enrollees requires supporting and using existing clinical and administrative infrastructure for PrEP. For example, key safety net facilities such as federally qualified health centers and sexually transmitted infection clinics are optimal sites for PrEP delivery and could support PrEP care using 340B savings related to medication along with Medicaid reimbursement for PrEP clinical services. State Medicaid programs and MCOs could also use existing HIV-related clinical and funding infrastructure—such as the Ryan White Program and PrEP drug assistance programs (in place in eight states and Washington, DC)—to support, within program parameters, PrEP uptake and wraparound services. In addition, Medicaid agencies should learn from local and state Ryan White administrators and providers. For example, Medicaid programs could consider covering for PrEP users the type of case management that has been effective in supporting care and viral suppression for Ryan White clients.

State Medicaid programs are also well positioned to support novel delivery approaches to overcome geographic and other access barriers to PrEP. PrEP telehealth programs are emerging across the country and are particularly important in rural areas, where stigma, travel distances, and a scarcity of providers hinder access. Most Medicaid agencies cover some telehealth services, and these payment models could be used or adapted to help support PrEP access. Pharmacists are also well equipped to support PrEP given their expertise in screening and counseling as well as navigating health insurance. Their engagement can range from medication management, supported by many state Medicaid programs, to full prescribing authority under collaborative practice agreements.[7] Peer outreach and navigation programs for PrEP may also reduce the social stigma of PrEP usage and promote culturally competent care among racial and ethnic minorities. Medicaid programs should consider how to support these efforts.

Unfortunately, many states with high HIV incidence have not expanded Medicaid, leaving many low-income adults without access to comprehensive coverage. Although full Medicaid expansion is optimal for addressing the HIV epidemic, in the meantime, states should optimize their Medicaid family-planning expansions to support PrEP. Roughly half the states, including many nonexpansion states, have Medicaid family-planning expansion programs that offer family-planning and related services to certain low-income women (and, in 19 states, men) who are otherwise ineligible for Medicaid (https://www.guttmacher.org). No family-planning expansion programs cover PrEP medication, but they could cover PrEP-related clinical services.

In conclusion, state Medicaid programs and MCOs are well positioned to use resources that address the HIV epidemic by expanding PrEP care and reaching many of the people most affected by HIV. Medicaid agencies and MCOs should work with public health agencies and other partners to ensure appropriate reimbursement, analyze PrEP-related claims data, improve the quality of PrEP care, increase education among providers and enrollees, support safety net clinics, and expand access through novel approaches. Through these steps, Medicaid can play a major role in promoting PrEP uptake and ending the HIV epidemic. AJPH

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CONFLICTS OF INTEREST

All authors report no conflicts of interest.

REFERENCES

1. Mayer KH, Chan PA, Patel R, Flash CA, Krakower DS. Evolving models and ongoing challenges for HIV pre-exposure prophylaxis implementation in the United States. *J Acquir Immune Defic Syndr*. 2018;77(2):119–127.

2. Nunn AS, Brinkley-Rubinstein L, Oldenburg CE, et al. Defining the HIV pre-exposure prophylaxis care continuum. *AIDS*. 2017;31(5):731–734.

3. Centers for Disease Control and Prevention. HIV preexposure prophylaxis, by race and ethnicity—United States, 2014–2016. *MMWR Morb Mortal Wkly Rep*. 2018;67(41):1147–1150.

4. Raifman J, Dean LT, Montgomery MC, et al. Racial and ethnic disparities in HIV pre-exposure prophylaxis awareness among men who have sex with men. *AIDS Behav*. 2019; Epub ahead of print.

5. Centers for Disease Control and Prevention. Vital signs: increased Medicaid prescriptions for preexposure prophylaxis against HIV infection—New York, 2012–2015. *MMWR Morb Mortal Wkly Rep*. 2015;64(46):1296–1301.

6. Krakower D, Ware N, Mitty JA, Maloney K, Mayer KH. HIV providers' perceived barriers and facilitators to implementing pre-exposure prophylaxis in care settings: a qualitative study. *AIDS Behav*. 2014;18(9):1712–1721.

7. Tung EL, Thomas A, Eichner A, Shalit P. Implementation of a community pharmacy-based pre-exposure prophylaxis service: a novel model for pre-exposure prophylaxis care. *Sex Health*. 2018;15(6):556–561.