



Issue Brief

Enhancing Medicaid Provider and Patient Engagement and Education to Deliver PrEP Intervention Services

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Key Messages

- Pre-Exposure Prophylaxis, or PrEP, is highly effective for preventing HIV, but more work is needed to scale up its use in the U.S.
- The Medicaid program provides important opportunities to reach enrollees and providers with information about PrEP and support tools to bolster its use.
- It is crucial to inform both patients and providers about the ongoing clinical services, such as STI testing, that CDC recommends as part of the PrEP intervention.
- Medicaid claims data could help inform and evaluate PrEP education and outreach efforts.

Introduction

Pre-exposure prophylaxis, or PrEP, is a highly effective HIV prevention intervention that is dramatically underused.^{1,2,3,4} Scaling up PrEP utilization in the U.S. is a key pillar of the federal government's roadmap for ending the HIV epidemic.⁵ This issue brief outlines ways to leverage the Medicaid program – which covers nearly 70 million low-income people and is the single largest payer for HIV care in the country⁶ – to educate and support patients and providers about PrEP and support its use.

PrEP entails the daily use of a medication by people who are HIV-negative to reduce the risk of seroconversion, combined with a set of clinical services to rule out HIV infection before initiation and monitor ongoing sexually transmitted infection (STI) and HIV status.⁷ Trials have demonstrated over 90 percent effectiveness for consistent use among those at risk of sexual transmis-

sion, and over 70 percent for people who inject drugs.⁸ However, in the fourth quarter of 2017, PrEP was being used by fewer than 10 percent of people who were candidates for its use, with even lower uptake among eligible African-Americans. (see Appendix for list of populations for whom CDC recommends considering PrEP as a prevention option).^{9,10,11,12} Evidence also indicates that some PrEP users may not be receiving the full set of PrEP clinical services recommended by the Centers for Disease Control and Prevention (CDC).¹³ (See Appendix.)

Addressing these missed opportunities requires understanding the factors that hinder patient and provider engagement along the “PrEP care continuum.”¹⁴ Studies have identified gaps in awareness of PrEP among a range of populations at high risk of HIV, including young men who have sex with men (MSM),¹⁵ substance-using black MSM and transgender women,¹⁶ and women in high-prevalence cities.¹⁷ People may be concerned about the costs of PrEP, missed work time, and travel distance, particularly in rural areas.^{18,19,20,21,22,23} Some potential users may be concerned about side effects of PrEP (although these are uncommon and usually transient)²⁴; others may hold internal stigma about PrEP, such as the belief that PrEP is for people who are promiscuous.^{25,26}

Meanwhile, most primary care physicians still don't prescribe PrEP,²⁷ and do not always feel comfortable discussing sexual risks with their patients.²⁸ Primary care providers may also be reluctant to begin prescribing antiretrovirals,²⁹ and are often short on time during visits.³⁰ Across multiple studies, providers report concerns about the unintended consequences of PrEP, including the development of resistance and potential lack of adherence. Providers also report concerns about the possibility of risk compensation – PrEP users increasing risky behaviors – though data on the question are mixed, and the regular STI testing recommended for

PrEP users could help mitigate associated risks.^{31,32,33,34} Provider resistance to prescribing PrEP can also be rooted in conscious or subconscious bias based on race, sexual orientation, gender identity, sexual behavior, and class.^{35, 36,37,38,39}

This issue brief presents a roadmap for leveraging the Medicaid program to scale up PrEP by engaging patients and providers. It describes patient and provider educational resources and operational tools to support PrEP use, as well as specific conduits for state Medicaid agencies and Medicaid managed care organizations (MCOs) to distribute these resources. It then describes how Medicaid data can be leveraged to target PrEP resources and education, and closes with a discussion of specific scenarios that could arise for certain subpopulations of Medicaid PrEP users.

States have different HIV rates, resources, and Medicaid programs. This issue brief does not present a one-size-fits-all answer, but rather outlines a variety of tools and approaches that can be used to engage Medicaid enrollees and providers to support PrEP scale-up.

Patient and Provider Educational Resources and Operational Tools

Medicaid enrollees and providers would benefit from educational resources about the PrEP intervention, as well as operational tools to support continued engagement in PrEP among providers and adherence among PrEP users.

Patient and Provider Educational Resources: There are already a wide range of resources about PrEP for patients and providers. Many are available online, for example through Project Inform at www.projectinform.org/prep/. These materials could be shared directly, or adapted, as appropriate, to meet state needs.

Resources for Medicaid enrollees can include culturally competent and accessible information about PrEP services, along with state-specific information on how Medicaid covers PrEP medication and clinical services.

Both enrollees and providers can benefit from PrEP locator information, such as <https://preplocator.org>, a searchable directory of clinics and providers who self-identify as offering PrEP. Some health departments have developed their own PrEP provider directories using the preplocator tool or their own maps.⁴⁰ Optimally, a directory would include information on how to find a PrEP provider participating in the Medicaid program (such as in the directory provided by the North Carolina AIDS Education and Training Center) or in specific MCO networks.⁴¹ A directory would allow providers who are new to PrEP to contact other local prescribers with initial questions or for ongoing peer support.⁴²

For providers considering or initiating the provision of PrEP prescriptions and clinical services, the following additional resources may be useful:

- The CDC's PrEP guidelines and provider education tools.⁴³
- Education on taking sexual histories, such as SIECUS's guide for providers serving LGBT youth.⁴⁴
- Continuing Medical or Nursing Education courses focused on, or including information about, PrEP.
- PrEP "academic detailing." A number of states and cities have developed targeted training programs on PrEP for providers to increase provision of PrEP prescriptions and CDC-recommended clinical services.^{45,46,47}
- State- or plan-specific information, including any relevant recommendations or guidelines from state departments of health (DOH) and information about Medicaid reimbursement. For example, D.C. has developed a provider guide with D.C.-specific PrEP and PEP information and guidelines.⁴⁸

In November 2018, the U.S. Preventive Services Task Force's November 2018 released a draft "Grade A" recommendation for PrEP for HIV.⁴⁹ If finalized, this recommendation could also be shared with providers to bolster awareness and support for offering PrEP prescriptions and clinical services in the primary care setting.

Further Training and Technical Assistance: Providers who have already initiated PrEP in their practice could benefit from multiple types of ongoing training and technical support:

- National Clinical Consultation Center. The National Clinician Consultation Center at the University of California San Francisco has a provider warmline, known as the PrEPline, offering free phone consultations to provide clinical advice on PrEP.⁵⁰ Medicaid programs and MCOs could also disseminate information on training opportunities from other AIDS Education and Training Centers.⁵¹
- Other expert consults. Providers who are new to prescribing PrEP could benefit from "peer support" from other clinicians with more experience.⁵² For example, one infectious disease doctor serves as a peer consult on PrEP for primary care providers within his clinical network⁵³; another leads a Project ECHO-type consultation model for PrEP for primary care providers within his state.⁵⁴ In the ECHO model, videoconferencing technology links primary care physicians with specialists to support training and patient access.
- Cultural competency training resources: Federal regulations require state Medicaid programs to develop methods to promote culturally competent services; Medicaid MCOs must participate.^{55,56} States and MCOs could explore opportunities to incorporate information related to PrEP and bias related to race, sexual orientation, and gender identity.

Operational Support Tools: In addition to educational and training resources on PrEP, providers and patients could benefit from a range of operational tools and resources to support ongoing provision of, PrEP medication and clinical services:

- Workflow sheets or algorithms. For example, the New York State Department of Health developed quick reference cards for PrEP that could be attached to provider lanyards for clinical use.⁵⁷
- Standardized prior authorization (PA) form. If prior authorization is deemed appropriate for PrEP medication, clear, standard PA forms would simplify requests.
- Consumer communication tools. Check-in calls or texting services for PrEP users can facilitate medication reminders and provide an opportunity for patients to share questions and concerns. For example, a text message platform for youth PrEP users was recently found to increase PrEP adherence among youth at high risk of HIV acquisition.⁵⁸ Providers and patients could also benefit from counseling tools to help PrEP users remain engaged. For example, the Integrated Next Step Counseling model guides providers through a patient-centered discussion of PrEP, with an emphasis on adherence.⁵⁹
- Patient screening tools. Both patients and providers would benefit from simple screening tools to identify persons who are candidates for PrEP. To make efficient use of clinical consultation time, patients could complete a risk screening questionnaire either before a visit or while waiting in the waiting room or exam room.^{60,61} Some such tools are already available: for example, CDC has developed a six-question MSM risk index for PrEP and a seven-question risk index for people who inject drugs.⁶² The Stigma Project has developed the CDC guidelines into a user-friendly screening tool.⁶³

Veterans Health Administration: PrEP Materials and Resources for Patients and Providers

The U.S. Department of Veterans Affairs' (VA) has developed a set of products to increase PrEP uptake and awareness across the Veterans Health Administration, including an awareness communication tool, training modules for providers, a blog on PrEP, and AIDSvu reports showing regional HIV risk.⁹⁸ To address the quality of ongoing clinical care for PrEP users, the VA also developed a set of clinical support tools, including:

- a set of clinical considerations aligned with CDC's guidelines;
- a "PrEP clinical criterion check list";
- pre-populated EHR templates and order menus for PrEP initiation and monitoring; and
- PrEP-related texts in the VA's text-messaging system to support adherence, appointment attendance, tracking, and patient education.⁹⁹

Conduits for Reaching Patients and Providers through the Medicaid Program

State Medicaid agencies and Medicaid managed care organizations can use a range of approaches to disseminate PrEP education resources and operational support tools to patients and to providers. Partnering with national, state, or local professional societies could amplify efforts to reach providers.

State Medicaid Agency and MCOs: Conduits to Enrollees and Providers. As a starting point, state Medicaid agencies and MCOs can use their websites to highlight key PrEP resources both for patients and providers. In addition, for enrollees, states and MCOs can include information about PrEP in initial enrollment materials and ongoing mailings to enrollees, via emails, and in automated calls. Information could be sent to all members or to specific zip codes, targeted based on Medicaid claims data analysis and/or state surveillance data.⁶⁴

For providers, state Medicaid agencies can share information through multiple channels including provider manuals, emails and/or newsletters to providers, or direct letters to all Medicaid providers or targeted subsets. For example, in December 2017, California's Department of Health Care Services sent a notice to all Medi-Cal providers regarding erroneous delays and denials of PrEP and PEP, clarifying that both are covered services available through Medi-Cal.⁶⁵ In New York, the Department of Health learned of provider confusion over Medicaid coverage of PrEP and PEP in FFS Medicaid and developed a document for distribution to all Medicaid FFS providers to clarify coverage policies.⁶⁶ MCOs can also reach their network providers through manuals, mailings, CME, or direct outreach.

Lessons from MCO Provider Engagement Efforts Around Medication-Assisted Treatment (MAT) for Opioid Addiction

A report from the Association for Community-Affiliated Plans details the strategies that several Medicaid MCOs are using to engage new MAT providers and to support and maintain existing providers.¹⁰⁰ Such approaches could potentially be adapted to support PrEP provision. Examples include:

- educational sessions in medical schools;
- training opportunities for providers, such as webinars, conferences with CME credit, and on-site presentations;
- payment for out-of-office time in trainings;
- funding physicians who are on call at all hours to answer questions from prescribing physicians;
- Project ECHO types approaches to support MAT implementation.

Partnering with Professional Societies: Medicaid agencies, MCOs, and public health agencies can reach out to professional organizations at the national, state, or local levels to identify opportunities for promoting PrEP engagement and education among providers.⁶⁷ For example, California's Office of AIDS recently sent a letter regarding PrEP to primary care providers, in collaboration with the California Medical Association.⁶⁸

Other professional societies that could represent further opportunities for reaching and supporting new PrEP providers and patients include the American Medical Association (AMA), the American Academy of Family Physicians (AAFP), and the American Academy of Nurse Practitioners. The AMA and AAFP have adopted policies in support of PrEP.^{69,70,71} All have state, local, or regional affiliates or constituent chapters that could be approached to collaborate in provider engagement efforts. Stakeholders could also propose collaboration with state affiliates of other professional societies such as the National Medical Association, the National Hispanic Medical Association, the American College of Physicians, the American Academy of Physician Assistants, and the American Academy of Pediatrics.

Using Medicaid Data to Target PrEP Resources and Education

Medicaid claims and encounter data present important opportunities to increase PrEP uptake and adherence, as well as to improve the quality of clinical services provided to current PrEP users.

Medicaid data can be used to:

Measure Current PrEP Use in the Medicaid Program: First, Medicaid claims data can be analyzed to identify who is already using PrEP (with a “lookback” due to time for claims processing). For example, New York State's AIDS Institute applied an algorithm to state Medicaid pharmacy and diagnosis data to identify enrollees who had claims for PrEP medication for more than 30 days,⁷² excluding those with an HIV diagnosis.⁷³ In California, a recent analysis of PrEP uptake among Medi-Cal beneficiaries looked at changes in utilization from 2013 to 2016, stratifying data by age, gender, race, ethnicity and region to assess patterns and disparities that could help guide public health efforts to promote uptake.⁷⁴

A 2018 CDC study estimated the number of adults with PrEP indications by state, stratified by transmission risk group and race/ethnicity, making it a useful tool for comparing PrEP access program to estimated need.⁷⁵ Though data on race is often missing from Medicaid claims, and claims data do not capture gender identity or sexual orientation,⁷⁶ claims analyses could still offer important information regarding the Medicaid population using PrEP.

Track Provision of Clinical Services to Current PrEP Users:

Medicaid claims data could also indicate whether people currently using PrEP are receiving appropriate clinical services. For enrollees identified as PrEP users, a *lack* of claims for STI screening or other components of PrEP services may reflect that appropriate clinical services are not being provided.⁷⁷ One limitation is that claims-based analyses would only identify services reimbursed by Medicaid, omitting, for example, screenings obtained at a non-billing STI clinic.⁷⁸ However, this approach could at least flag patterns (by region or provider) of potential non-receipt of appropriate services. Such an analysis could inform targeted provider outreach, by either Medicaid agencies or public health counterparts.

Identify Candidates for PrEP: Medicaid claims data could also be used to identify enrollees who are candidates for PrEP, informing outreach to patients or providers, consistent with state laws and appropriate privacy protections. For example, certain STI diagnoses within Medicaid claims might indicate patients whose providers could be encouraged to offer information about PrEP. Such information can also be found through surveillance; for example, Michigan's “Data to PrEP” program uses surveillance data to guide PrEP outreach to HIV-negative men with certain STI diagnoses.⁷⁹ Integrating Medicaid claims data with surveillance data could help fill gaps left by incomplete surveillance reporting.

Medicaid agencies that do not have staffing or resources to spare for claims analyses related to PrEP may be able to collaborate with public health stakeholders or universities to evaluate PrEP use, care quality, and outcomes.^{80,81} These resource and time investments could yield valuable information to guide HIV prevention efforts statewide.

Medicaid Claims Data and MCOs

Generally, state Medicaid agencies have access to all claims data for their enrollees, whether FFS or managed care. However, MCOs receive their own payment data first, and may have relatively sophisticated analysis capacity.¹⁰¹ In some states, it may make sense for MCOs to conduct PrEP-related data analysis for their own covered populations. In all states with MCO enrollment, Medicaid agencies, MCOs, and public health stakeholders can work together to ensure reporting of those elements of encounter data that are important for PrEP analysis.

Specific Patient Scenarios

Stakeholders can work to identify and address barriers to PrEP access faced by certain subsets of Medicaid enrollees, including those experiencing coverage gaps, people returning from the corrections system, adolescents, and people who inject drugs.

Assisting Patients with PrEP Adherence through Enrollment Changes

A study of 2015 data in three states found that almost 1 in 4 low-income adults reported a change in coverage during the prior year, with half of those reporting a *gap* in coverage.⁸² The study found significant disruptions of care for “churners,” including a third reporting skipping doses or stopping taking prescribed medications.⁸³ While not PrEP-specific, the study’s findings raise concerns regarding PrEP adherence through coverage changes. Medicaid agencies could consider collaborating with public health agencies to develop resource guides that educate providers and patients on other sources of PrEP coverage if eligibility changes. In addition, PrEP providers can engage in routine insurance screening and/or referral to identify eligible unenrolled people and to help PrEP users navigate Medicaid administrative requirements.

Facilitating PrEP Access for Medicaid-Eligible Individuals Leaving the Corrections System

Some people returning to the community after being incarcerated may be candidates for PrEP. Most states suspend, rather than terminate, Medicaid enrollment for individuals while they are incarcerated.⁸⁴ The majority of states also have initiatives to facilitate Medicaid enrollment before release.⁸⁵ As part of the pre-release process, states may identify patients with heightened health or social needs. For example, Louisiana’s state Medicaid agency begins planning nine months before release, and the process includes identification of “high needs” people such as those with serious mental illness, substance use disorder, or multiple morbidities.⁸⁶ States could explore whether Medicaid pre-release coordination processes in their state could address PrEP eligibility and include appropriate education and referrals.

Privacy for Adolescent Minors and Other PrEP Users in State Medicaid programs

Truvada has been used off-label for PrEP in adolescents prior to this year, and FDA recently extended the drug’s PrEP indication to adolescents weighing at least 35 kg.⁸⁷ However, young people are not accessing PrEP in proportion to the HIV risk experienced in this age group. Data presented by Gilead at the 2018 International AIDS Conference showed that only 1.5 percent of those who had ever used PrEP were teenagers.⁸⁸ The dominant payer for teen use was Medicaid,⁸⁹ reflecting the importance of the program for this age group’s access to PrEP.

Adolescent PrEP use under Medicaid or CHIP can raise heightened questions about privacy; for example, some states send “explanation of benefit” (EOB) notices to beneficiaries after services are delivered, and federal law requires Medicaid MCOs to send written notices of denials, or partial denials, of requests. State Medicaid agencies can identify how their EOB and privacy policies would

apply to adolescents and other enrollees using PrEP and related services. Pediatricians, adolescent health providers, and others who may offer PrEP or discuss it with adolescents can be made aware of what Medicaid privacy protections apply in their respective states.

PrEP and People Who Inject Drugs

A key randomized trial of PrEP use among people who inject drugs (PWID) found a reduction in HIV incidence of 49.8 percent compared to placebo; for patient with high levels of adherence, the risk reduction was 73.5 percent.⁹⁰ PWID may be willing to use PrEP but experience a range of barriers. Some studies have found low rates of PrEP awareness among PWID in the U.S.,⁹¹ though respondents were willing to use it once they learned more.^{92,93} Meanwhile, substance use treatment providers may experience their own barriers to engaging in PrEP provision, including lack of sufficient medical staff, questions about cost and reimbursement (including via Medicaid), and unmet need for training.⁹⁴

Stakeholders might consider several questions as they try to improve access to PrEP medication and clinical services for PWID.⁹⁵

- First, how many people in the state are at high risk of HIV based on injection drug use, and how many are Medicaid enrollees?
- Are substance use treatment providers offering PrEP for prevention of sexual acquisition or of injection transmission in the case of relapse of injection drug use?
- Are adequate syringe services programs (SSPs) – highly effective at reducing HIV transmission, and relatively cost-effective compared to PrEP⁹⁶ – in place? Are there potential outreach approaches to reach people at risk of HIV who are *not* clients of SSPs?
- Finally, among PWID, how many actually identify (internally or to their providers) as people who inject?

The answers to these questions can help guide state and local decision-making regarding PrEP and PWID.

Conclusion

Meaningful engagement and support for patients and providers are critical to scaling up PrEP and confronting the HIV epidemic. The Medicaid program offers important opportunities to educate and support new and continuing PrEP providers, as well as many of the people who could most benefit from PrEP. The approaches outlined in this paper can inform new and ongoing discussions of how to take these steps at the state level.

About this Brief

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As part of its work to address the underutilization of PrEP, the CDC's National Center for HIV, Hepatitis, STD and TB Prevention, with collaboration between the Division of HIV/AIDS Prevention and the Division of STD Prevention, supported the Medicaid Strategies to Implement Comprehensive Pre-exposure Prophylaxis (PrEP) Intervention Services project (the Medicaid PrEP Project), led by Academy Health and ChangeLab Solutions, to identify ways to improve care and delivery of PrEP medication and clinical services to the Medicaid population.

To inform this project, researcher Naomi Seiler, J.D., developed two white papers identifying Medicaid benefits and financing mechanisms that could be used to improve uptake and comprehensive delivery of PrEP medication and clinical care, and describing further ways to leverage the Medicaid program to engage patients and providers. The papers were based on semi-structured interviews with experts in Medicaid, PrEP, and patient and provider engagement, as well as peer-reviewed and “gray” literature on Medicaid, PrEP, and Medicaid financing mechanisms. In January 2019, ChangeLab Solutions and Academy Health convened state Medicaid officials, Managed Care Organizations (MCOs), public health officials, and other stakeholders to consider which of the approaches discussed may be appropriate for their policy environments. This issue brief summarizes the findings of the second white paper on patient and provider engagement.

Potential conflicts of interest: CDC and individual employees involved in the guideline development process are named in US government patents and patent applications related to methods for HIV prophylaxis.

Appendix

Summary of US Public Health Service PrEP Guidelines: Indications for PrEP and Providing PrEP Clinical Services

CDC recommends PrEP be considered as one prevention option for the following people at substantial risk of HIV infection⁹⁷:

Men Who Have Sex with Men (including those who inject drugs)

- HIV-positive sexual partner
- Recent bacterial STI (Gonorrhea, chlamydia, syphilis)
- High number of sex partners
- History of inconsistent or no condom use
- Commercial sex work

Persons Who Inject Drugs

- HIV-positive injecting partner
- Sharing injection equipment

Heterosexual Women and Men (including those who inject drugs)

- HIV-positive sexual partner
- Recent bacterial STI (Gonorrhea, syphilis)
- High number of sex partners
- History of inconsistent or no condom use
- Commercial sex work
- In high HIV prevalence area or network

CDC recommends the following clinical services with PrEP use:

At initiation:

- An HIV test (which should be documented as negative);
- An assessment to rule out signs or symptoms of acute HIV infection; a renal function test (estimated creatinine clearance);
- Assessment of current medications to rule out contraindications.
- Documentation of Hepatitis B infection and vaccination status is also recommended.

For PrEP users:

- A follow-up visit at least quarterly for an HIV test, medication adherence counseling, behavioral risk reduction support, side effect assessment, and STI symptom assessment.
- Renal function testing at 3 months and every 6 months thereafter.
- Bacterial STI testing every 3-6 months for both sexually active men and women. The CDC recommends nucleic acid amplification (NAAT) STI testing at sites of potential sexual exposure including pharyngeal and rectal testing for men who have sex with other men (MSM), as well as rectal testing for women who report engaging in anal sex.
- Offer of pregnancy tests and discussion of pregnancy intent as appropriate every six months.
 - PrEP users who inject drugs should have access to clean needles and drug treatment services.

Endnotes

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