AB1534 Would Allow HIV Specialists to Serve as Primary Care Providers, Potentially Increasing Preventive Care and Screening for People Living with HIV

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Background

As people living with HIV (PLWH) live longer and HIV treatment options improve, medical care for PLWH not only needs to optimize HIV-specific treatment, but also to include more primary prevention activities, particularly for the common co-morbidities of aging.[1] A bill recently introduced in the California legislature (AB1534) seeks to better integrate HIV treatment with primary care by requiring state-regulated health insurance plans to permit HIV specialists to be primary care providers if the HIV specialist requests primary care provider status and meets the health plan's eligibility criteria for all specialists seeking primary care provider status. However, many of the comorbidities that an aging HIV population is now experiencing fall outside of the scope of traditional HIV care and treatment and the expertise of subspecialty-trained HIV providers. It is well established that providers who treat greater numbers of PLWH deliver higher quality HIV care and treatment, but there is little evidence on whether HIV specialists are as effective as generalists in providing primary prevention to their patients living with HIV by effectively screening for preventable diseases and/or modifiable conditions so that the patient can be appropriately referred.[2-5] To address whether HIV specialists can effectively provide primary care, we examined the delivery of both HIV-specific and primary preventive services to PLWH covered by Medicaid and Medicare fee-for-service insurance in 2010.[6]

Methods

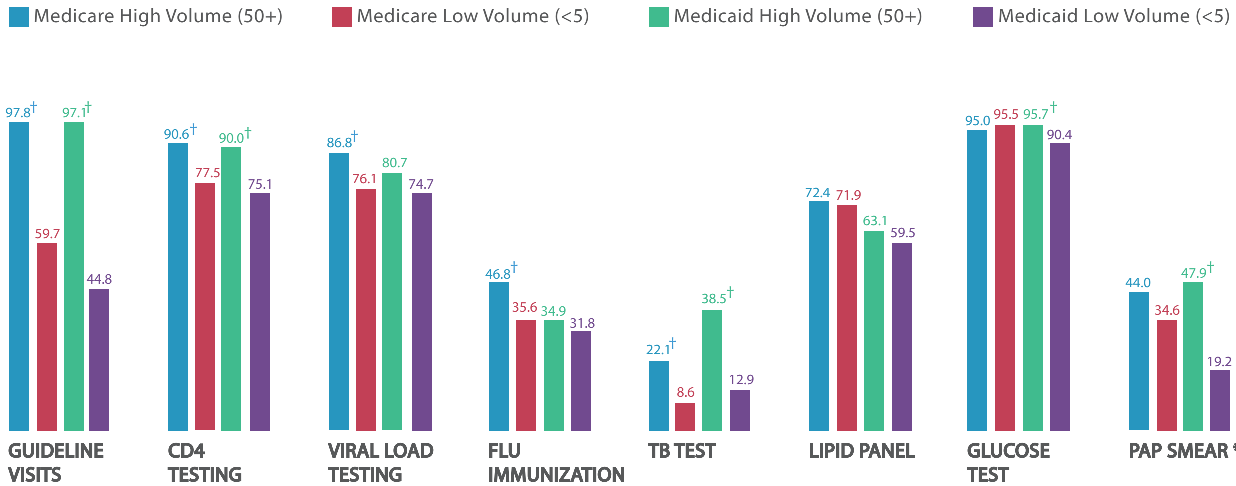
Using 2010 Medicare and Medicaid claims data, we determined whether patients living with HIV had 2 or more medical outpatient evaluation and management visits at least 3 months apart during the year, as recommended by HIV treatment guidelines.[7] For those patients whose care met these guidelines, we examined whether they received two CD4 and viral load (VL) tests during the year and each of 4 preventive services recommended annually for PLWH: an influenza vaccine, tuberculosis testing (PPD or interferon gamma release assay), lipid profile, and glucose blood test. We also assessed whether female patients who met the visit guidelines received an annual cervical cancer screening.[8]

We contrasted guideline compliance for both HIV care as well as recommended preventive services for patients according to the characteristics of the providers caring for them. AB1534 defines an HIV specialist as a MD, PA or NP who meet the criteria set forth by the American Academy of HIV Medicine (AAHIVM), the HIV Medicine Association (HIVMA) or those contracted to provide outpatient care under the Ryan White CARE Act. For the purposes of our analysis, we deemed providers who treat a high volume of people living with HIV (50 or more publically insured patients living with HIV) as HIV specialists and providers who treat a low volume of people living with HIV (those treating fewer than 5 patients living with HIV) as non-specialists.

Results

Confirming previous studies, we found that patients whose providers included an HIV specialist with 50 or more patients living with HIV were more likely than patients who only saw non-specialists to have the guideline-recommended numbers of visits, CD4 counts and viral load assessments (see Figure 1). They were also more likely to receive preventive services recommended on an annual basis, including TB testing for both Medicare and Medicaid patients seeing HIV specialists. Vaccination for influenza was more common among Medicare patients accessing HIV specialists. Glucose testing rates were significantly higher among Medicaid patients being treated by an HIV specialist and women on Medicaid were more likely to be screened for cervical cancer if they received care from an HIV specialist (Figure 1). Lipid assays were also somewhat higher for both Medicare and Medicaid patients seeing HIV specialists.

Figure 1. Percent of HIV Patients With Access to High Volume HIV Providers with Guideline Visits and Percent of Those With Guideline Visits With Guideline HIV Care and Screening



Note: Percentages are regression-adjusted estimates, controlling for age, gender, race/ethnicity, and comorbidities.
* For female sample
† Indicates significant (p<.05) differences between high and low volume providers

Policy Implications

The ultimate goal of HIV treatment is viral suppression, both to maintain the health of the patient and to reduce onward transmission to sexual partners. However, even sustained viral suppression does not entirely mitigate the long-term consequences of HIV-related inflammation in the form of early senescence and end-organ disease. Some studies suggest that HIV specialists feel uncomfortable treating chronic conditions other than HIV.[9-11] Whether or not HIV specialists feel confident in treating illnesses outside the scope of HIV-proper, the relevant question for AB1534 is whether they effectively screen for preventable diseases and/or modifiable conditions so that the patient can be appropriately referred. AB1534 could

remove the necessity for a PLWH to visit a non-HIV specialist PCP to obtain a referral for other sub-specialty care. On the other hand, acting as primary care providers, HIV specialists may refer at higher rates to other disease-specific sub-specialists because they do not feel comfortable managing these other comorbidities.

Our results confirm that patients treated by providers we deemed to be HIV specialists are more likely to receive guideline-consistent HIV care and are equally if not more likely to receive primary preventive services as compared to patients treated by non-specialists. The fact that only 60% of Medicare patients and 45% of Medicaid patients not seeing HIV specialists had guideline numbers of visits (in contrast to over 97% of Medicare and Medicaid patients accessing HIV specialists) limits their potential to receive preventive care. Even among patients seen regularly by their providers, patients with HIV specialists received preventive and primary care at similar or higher levels than patients of non-specialists.

These findings are consistent with those of a recent study that showed that patients living with HIV treated by infectious disease providers were more likely to be virally suppressed, and equally likely to receive metabolic/CVD and cancer screenings as patients living with HIV seeing only generalists, or a team of infectious disease-specialists and generalists.[12] In another study, screening for hepatitis C did not differ between HIV specialists and primary care physicians.[4] In contrast to our findings, that study found that generalists had higher rates of influenza vaccination.[4] The analyses to date have primarily contrasted physicians who are HIV specialists with physicians who are generalists. AB 1534 allows for non-physician HIV specialists, including nurse practitioners and physician assistants, to serve as primary care providers under the supervision of a primary care physician. Although there is evidence that non-physician HIV specialists deliver treatment for HIV of equivalent quality to that of physician HIV-specialists[13,14], there is little research on their provision of more general primary care. Because only 15% of the HIV-specialist providers identified in our analyses were non-physicians, we were not able to examine this group separately.

Although HIV specialists deliver preventive care at rates equivalent or better than non-specialists, it is unlikely that AB1534 will result in major increases in delivery of preventive services and primary care because two-thirds of the physician HIV-specialists in California already have board certification in primary care specialties (internal medicine, family practice, geriatrics, or OB/GYN).[15] Further, the rates at which screenings for comorbidities were documented failed to meet recommended levels, even for patients with access to high HIV-volume providers. This suggests that other initiatives such as medical record prompts and provider education might be needed to increase primary care delivery to PLWH.

The practice of HIV specialty providers has evolved over the past 30 years of the HIV epidemic, from a focus on opportunistic infection management and end-of-life care, to one of highly specialized and nuanced antiretroviral management. As lifespans for PLWH increase, HIV specialty providers need to increase their focus on preventive care and routine management of antiretroviral therapy, which are currently well below levels recommended by the CDC. Patients' frequent outpatient visits for HIV monitoring present a unique opportunity to regularly assess the general health of PLWH and to deliver preventive care.

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