THE HENRY J. KAISER FAMILY FOUNDATION

HIV/AIDS

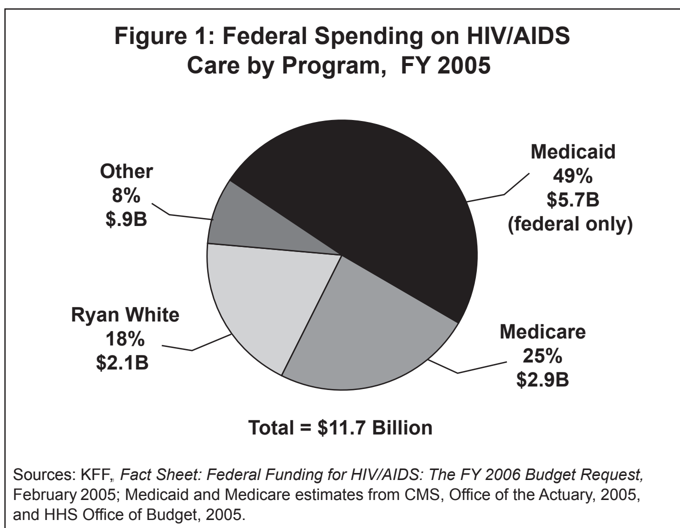
HIV/AIDS POLICY FACT SHEET

Medicaid and HIV/AIDS

September 2005

Medicaid is the nation's major public health program for low-income Americans, financing health and long-term care services for more than 52 million people.[1] Medicaid is a critical source of coverage for many low-income people with HIV/AIDS. Despite improvements in treatment, HIV disease is often a disabling condition that forces individuals to leave (or be unable to enter) the workforce, thereby losing income and access to employer-sponsored health insurance, and qualifying them for Medicaid due to their disability status and low-income.[2] In addition, an increasing proportion of those newly infected with HIV are low-income and more likely to be Medicaid eligible.[3]

Medicaid's role for people with HIV/AIDS will likely grow due to several factors: more people are living with HIV/AIDS than ever before; those who are newly infected are increasingly likely to be low-income; and prescription drugs, the linchpin of HIV care today, are currently offered by all state Medicaid programs.



Sources: KFF, *Fact Sheet: Federal Funding for HIV/AIDS: The FY 2006 Budget Request*, February 2005; Medicaid and Medicare estimates from CMS, Office of the Actuary, 2005, and HHS Office of Budget, 2005.

Medicaid is the largest source of federal spending for HIV/AIDS care in the United States. The Centers for Medicare and Medicaid Services (CMS) estimates that FY 2005 federal Medicaid spending for HIV/AIDS will total $5.7 billion, or half of all federal spending on HIV/AIDS care (see Figure 1).[2,4,5] Federal Medicaid spending on HIV/AIDS represents 3 percent of overall federal Medicaid spending ($183 billion in FY 2005[6]). For FY 2006, CMS projects Medicaid spending on HIV/AIDS to rise to $6.3 billion.[4,5] It is important to note that CMS spending data on HIV/AIDS are estimates only and, according to a recent report by the Institute of Medicine, may be overestimates.[7]

Medicaid is a means-tested entitlement program, jointly financed by the federal and state governments. The federal government matches state Medicaid spending at a rate ranging from 50% to 77%.[1] State Medicaid spending on HIV/AIDS in FY 2005 is estimated to be $4.7 billion.[5] Medicaid is administered by the states within broad federal guidelines, resulting in significant variation in eligibility and services across the country.

Medicaid Eligibility

To qualify for Medicaid, individuals must be both low-income and part of a group that is "categorically eligible." All states must cover certain **mandatory eligibility groups** to participate in Medicaid; states may also cover **optional eligibility groups** (see Figure 2). Low-income, childless adults are not eligible for Medicaid unless they are disabled (see disability definition in Figure 2). Most people with HIV/AIDS who qualify for Medicaid are Supplemental Security Income (SSI) beneficiaries: they are both disabled and low-income.[2,8] The SSI income standard is 74% of the Federal Poverty Level (FPL); the 2005 FPL for a family of one is $9,570; the SSI standard of 74% of FPL is $7,082.[9]

Although there are several pathways to Medicaid eligibility, people with HIV may have trouble meeting eligibility requirements because being HIV positive does not automatically qualify as a disability, even if low-income. Rather, Medicaid eligibility rules present a "Catch-22" relative to the current standard of HIV care: many low-income people with HIV are not eligible for Medicaid until they become disabled, despite available therapies that may prevent disability. Options explored to address this include: the use of Section 1115 waivers by states to cover this population (3 states have such approval); Ticket to Work/Work Incentives Improvement Act of 1999 demonstration grants (2 states have HIV-specific demonstrations); and federal legislation to provide states with an option to expand coverage (such legislation has been introduced in Congress).[2,8]

Figure 2: Medicaid Eligibility Pathways for People with HIV/AIDS

Category	Criteria	Mandatory/ Optional
SSI Beneficiaries	Disabled (having a physical or mental impairment that prevents one from working for a year or more or that is expected to result in death) AND Low-income (standard is 74% of FPL) Note: 209(b) states can use more restrictive criteria.	Mandatory
Parents, children, pregnant women	Low-income; income and asset criteria vary by category and state	Mandatory; states have option to offer higher income thresholds for some
Medically Needy (MN)	Allows those who meet categorical eligibility, such as disability, to spend down on medical expenses to meet state's income criteria	Optional; 35 states have MN for the disabled[18]
Workers with Disabilities	Disabled; Low-income	Optional
Poverty-level Expansion	Allows for income above SSI levels up to the poverty level	Optional; 19 states use option[18]
State Supplementary Payment (SSP)	Allows for coverage of those receiving SSP	Optional; 21 states use option for the disabled[18]

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Medicaid Benefits

Medicaid covers a broad range of services. States must cover certain **mandatory services** to participate in Medicaid. Among the mandatory services that are important to people with HIV/AIDS are: inpatient and outpatient hospital services; physician and laboratory services; and long term care (nursing facilities and home health care for those entitled to nursing care).[1]

States can also cover certain **optional services** and receive federal matching funds. Prescription drugs, which all states have chosen to provide, are perhaps the most important optional benefit needed by people with HIV/AIDS, given their critical role in AIDS care today and their growing expense. Other important optional services for people with HIV/AIDS include: dental care; clinic services; case management; and hospice care. States can choose to provide community-based long-term care services through the personal care option, the rehabilitation services option, and home and community-based services (HCBS) waivers (also called 1915(c) waivers). All states operate at least one HCBS waiver, 16 of which are specifically designed for people with HIV/AIDS and 1 that explicitly includes people with HIV/AIDS as a target population.[8,10]

Medicaid also helps dual Medicaid and Medicare eligibles by paying for their Medicare premiums and some services not covered by Medicare, such as prescription drugs. Under the new Medicare prescription drug law, which goes into effect in 2006, dual eligibles will no longer receive drugs through Medicaid but under a new Medicare Part D plan.[11]

States have broad flexibility in determining Medicaid benefit packages, including setting limits on the scope of services. For example, several states limit the number of prescriptions, hospital inpatient days, and physician visits allowed per month or year. States can also impose nominal cost-sharing for certain services.[1] Benefits can be offered on a fee-for-service basis, through managed care plans, or both; most states have enrolled some beneficiaries with HIV/AIDS in Medicaid managed care.[12] The recent economic downturn has led states to implement Medicaid cost containment measures, such as cutting or limiting benefits including prescription drugs.[1]

Profile of Medicaid Beneficiaries with HIV/AIDS

Few national studies have been conducted of Medicaid beneficiaries with HIV/AIDS. The HIV Cost and Services Utilization Study (HCSUS), the only nationally representative study of people with HIV/AIDS in care, found that more than 4 in 10 (almost 44%) people with HIV/AIDS in care were covered by Medicaid in 1996: approximately 29% by Medicaid alone, 12–13% dually covered by Medicaid and Medicare and approximately 1% by Medicaid and another source such as private coverage.[13,14] As HIV disease progresses, individuals are more likely to become eligible for Medicaid. Among persons living with AIDS, over half (55%) are served by Medicaid, as are up to 90% of children with AIDS.[8] In addition, a recent study found that more than a fifth (22%) of those recently diagnosed with HIV were already covered by Medicaid.[15]

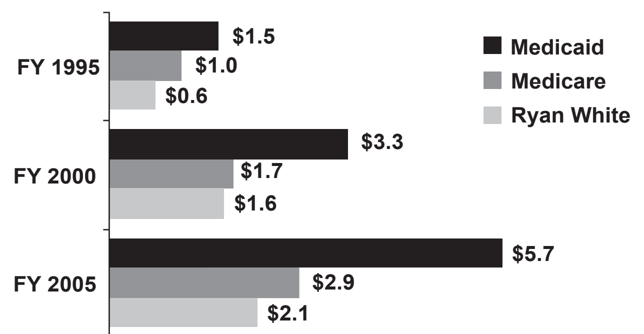
Applying HCSUS[13,14] findings to the Centers for Disease Control and Prevention's estimates of how many people are living with HIV/AIDS in the U.S. (1,039,000–1,185,000)[16] and what proportion are in the care system (41–58%)[17] yields almost 250,000 Medicaid beneficiaries with HIV/AIDS. This is similar to CMS' estimate that 231,000 people with AIDS were served by Medicaid in FY 2003.[8]

HCSUS found significant differences in Medicaid coverage of people with HIV/AIDS in care by race/ethnicity and sex. African Americans and Latinos with HIV/AIDS were more likely to rely on Medicaid than their white counterparts. Women with HIV/AIDS were more likely to be covered by Medicaid than men.[2,13,14]

Medicaid Spending and Caseload

Federal Medicaid spending on HIV/AIDS has increased over time, reflecting growing numbers of beneficiaries and the rising cost of care, particularly for prescription drugs. According to CMS, federal Medicaid spending on AIDS care rose from $1.5 billion in FY 1995 to $5.7 billion in FY 2005, growing at a faster rate than spending under Medicare and the Ryan White CARE Act (see Figure 3).[5,19]

Figure 3: Federal Spending for HIV/AIDS Care through Medicaid, Medicare, and Ryan White, FY 1995-2005 (in billions)



Sources: KFF, *Trends in U.S Government Funding for HIV/AIDS: Fiscal Years 1981 to 2004*, March 2004; KFF, Fact Sheet: *Federal Funding for HIV/AIDS: The FY 2006 Budget Request,* February 2005; Medicaid and Medicare estimates from CMS, Office of the Actuary, 2005, and HHS Office of the Budget, 2005.

Future Outlook

Medicaid will continue to play a critical role for low-income people with HIV/AIDS. Among the ongoing policy challenges and issues concerning Medicaid and HIV/AIDS are: the rising cost of prescription drugs; limitations in eligibility rules that affect people with HIV; and state resource constraints, resulting in cost containment measures that could affect access to care for people with HIV/AIDS and put increased pressure on other programs serving this population, such as those funded through the Ryan White CARE Act. The implementation of the new Medicare drug law in 2006 will likely raise new challenges for dual eligibles. Additionally, some policymakers are looking at capping federal Medicaid spending, which could limit Medicaid's ability to serve people with HIV/AIDS. Given Medicaid's continued importance to the care of people with HIV/AIDS, these issues and concerns will need to be closely monitored.

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