

Medicaid and HIV/AIDS

October 2006

Medicaid is the nation's major public health program for low-income Americans, financing health and long-term care services for more than 55 million people.¹ Medicaid is a critical source of coverage for many low-income people with HIV/AIDS. Despite improvements in treatment, HIV disease can be 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, at which point they may become eligible 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 minority Americans, and therefore more likely to already be Medicaid eligible.^{3,4,5}

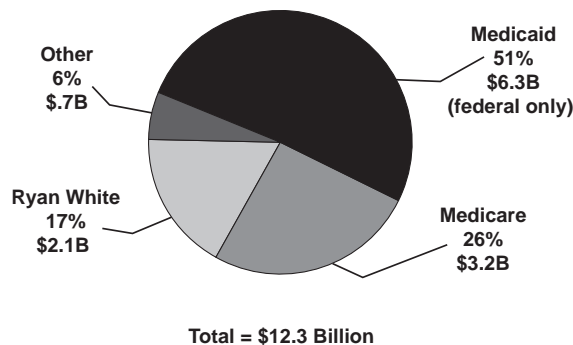
Medicaid's role for people with HIV/AIDS will likely grow due to several factors: more people are living with HIV/AIDS than ever before; those who are newly infected are increasingly likely to be low-income; and prescription drugs, the linchpin of HIV care today, are currently offered by all state Medicaid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

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 Figure 2 for disability definition). Most people with HIV/AIDS who qualify for Medicaid are Supplemental Security Income (SSI) beneficiaries: they are both disabled and low-income.^{2,9} The SSI income standard is 74% of the Federal Poverty Level (FPL) which in 2006 was \$7,252 for a family of one (74% of the 2006 FPL of \$9,800).¹⁰

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.² Options that have been explored to address this include: using "Section 1115" waivers by states to cover this population (3 states have such approval¹¹); 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 Congress¹²).

Figure 1: Federal Spending on HIV/AIDS Care by Program, FY 2006^{6,7}



Medicaid is the largest source of federal spending for HIV/AIDS care in the United States.⁶ The Centers for Medicare and Medicaid Services (CMS) estimates that FY 2006 federal Medicaid spending on HIV/AIDS will total \$6.3 billion, or half of all federal spending on HIV/AIDS care (see Figure 1).⁷ Spending by Medicaid on HIV/AIDS represents 3 percent of total federal Medicaid spending (\$183 billion in FY 2006⁸).

Medicaid spending on HIV/AIDS has increased over time, rising at a faster rate than spending under Medicare and the Ryan White CARE Act (see Figure 3).^{6,7,23} For FY 2007, CMS projects Medicaid spending on HIV/AIDS to rise to \$6.8 billion.⁷ It is important to note that CMS spending figures for HIV/AIDS are estimates only and, according to a recent report by the Institute of Medicine, may be overestimates.⁹

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 76%.¹ State Medicaid spending on HIV/AIDS in FY 2006 is estimated to be \$5.1 billion.⁷ Medicaid is administered by the states within broad federal guidelines, resulting in significant variation in eligibility and services across the country.

Figure 2: Medicaid Eligibility Pathways for People with HIV/AIDS^{1,2,13}

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
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
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
State Supplementary Payment (SSP)	Allows for coverage of those receiving SSP	Optional; 21 states use option for the disabled

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 may 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. Others include: dental care; clinic services; case management; and hospice care. States may 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 or include people with HIV/AIDS as a target population.¹¹ In 2003, these waivers provided services to more than 14,000 people with HIV/AIDS.¹⁴

Medicaid also helps dual Medicaid and Medicare beneficiaries by paying for their Medicare premiums and some services not covered by Medicare. Prior to 2006, this included prescription drugs which were not yet provided through Medicare. Under the new Medicare prescription drug law which went into effect in 2006, dual eligibles now receive prescription drugs through Medicare "Part D" and are provided with substantial premium and cost-sharing assistance.¹⁵

States have broad flexibility in determining Medicaid benefits 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.¹⁶

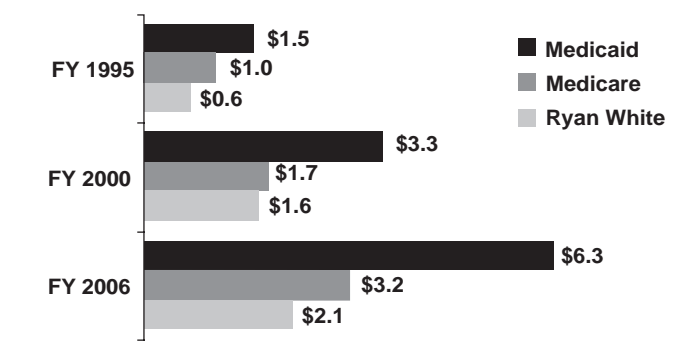
Medicaid Beneficiaries with HIV/AIDS

CMS estimates that there are 266,000 Medicaid beneficiaries with AIDS, the most advanced stage of HIV disease.¹⁷ Medicaid represents the largest source of coverage for people with HIV/AIDS in care. 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 (44%) were covered by Medicaid in 1996, including approximately 29% by Medicaid alone and 12-13% dually covered by Medicaid and Medicare. The next largest source of coverage was private insurance (31%); one fifth were uninsured.^{18,19}

Analysis of data from the HIV Research Network (HIVRN), a multi-state study of HIV clinic sites, found that 38% of the more than 14,000 patients with HIV in the study were covered by Medicaid in 2002, including those dually covered by Medicare. The next largest group was the uninsured (28%).^{20,21} In addition, analysis of HIV diagnoses in 25 states found that a significant share (22%) was already Medicaid eligible at the time of their diagnosis.²²

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.^{18,19}

Figure 3: Federal Spending for HIV/AIDS Care through Medicaid, Medicare, and Ryan White, FY 1995–2006 (in billions)^{6,7,23}



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: rising costs of prescription drugs; limitations in eligibility rules that affect people with HIV; and continual pressures on states to limit Medicaid spending, resulting in cost containment measures that could affect access to care for people with HIV/AIDS and put increased strain on other programs serving this population, such as the Ryan White CARE Act. For example, the recent passage of the Deficit Reduction Act of 2005 (DRA) gave states new flexibility to limit benefits and impose premiums and cost-sharing measures designed to limit Medicaid spending. The DRA also requires states to obtain proof of citizenship for Medicaid enrollees.¹ 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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