THE HENRY J. KAISER FAMILY FOUNDATION

HIV/AIDS POLICY

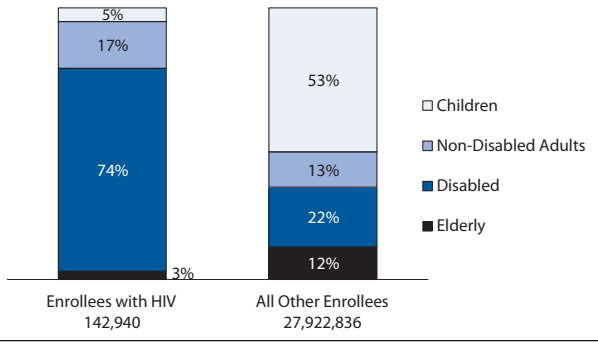
FACT SHEET

Medicaid and HIV/AIDS

March 2013

Medicaid is the largest public health insurance program in the United States, covering health and long-term care services for more than 60 million low-income individuals.[1] Medicaid has played a critical role in HIV care since the epidemic began, and is the single largest source of coverage for people with HIV in the U.S. It is estimated to cover half of all people with HIV in regular care,[2] although this represents only a small fraction (<.01%) of the overall Medicaid population. While Medicaid provides a range of critical health care services to people with HIV, one of the most important is prescription drugs, an optional Medicaid benefit that all states have chosen to provide to their Medicaid populations. Under the Affordable Care Act (ACA), Medicaid eligibility will expand in 2014 to reach millions more low-income Americans, including many people with HIV.[3]

Figure 1: Medicaid Enrollees by Eligibility Pathway and HIV Status, FY 2007[5]



Medicaid Beneficiaries with HIV

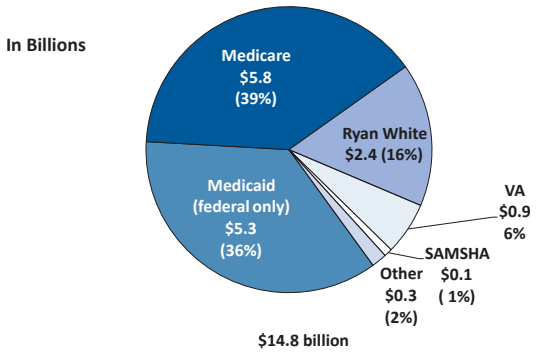
Today, there are more than 230,000 Medicaid beneficiaries with HIV.[4] In 12 states, Medicaid covers 30% or more of the state's HIV positive population.[2] People with HIV are about three times more likely to be covered by Medicaid than the U.S. population overall, given that HIV remains a disabling condition for many; most Medicaid beneficiaries with HIV qualify because they are both low-income and permanently disabled (74%) (see Figure 1).[5] Medicaid beneficiaries with HIV are most likely to be male, black, and over the age of 19, as are people with HIV overall; by contrast, Medicaid beneficiaries without HIV are most likely to be female, white, and under the age of 19. A significant share of beneficiaries with HIV – about three in 10 (29%) – are dually eligible for both Medicaid and Medicare; dual eligibles are among the most chronically ill and costly Medicaid enrollees, with many having multiple chronic conditions and requiring long-term care.

Medicaid Spending on HIV Care

Medicaid is a means-tested entitlement program, jointly financed by the federal and state governments. Currently, the federal government matches state Medicaid spending, ranging from 50% to 74%.[1] Under the ACA, during the period 2014–2016, the federal government will finance 100% of the costs for individuals newly eligible for Medicaid due to the expansion, scaling down to 90% in 2020 and thereafter.

In FY 2012, federal Medicaid spending on HIV was estimated to total $5.3 billion, more than a third of all federal spending on HIV care (see Figure 2).[6] Combined with the states' share of Medicaid spending ($4.3 billion in FY 2012), Medicaid is the largest source of public financing for HIV care in the U.S. Medicaid spending on HIV has increased over time, reflecting growing numbers of beneficiaries with HIV and the rising cost of care. Still, it represents less than 2% of total Medicaid spending. The largest service category of spending on beneficiaries with HIV is for prescription drugs.[5]

Figure 2: Federal Spending for HIV Care, FY 2012[6]



Medicaid Eligibility

Under current law, to qualify for Medicaid, a person must meet financial criteria and also belong to one of Medicaid's categorically eligible groups.[1] Federal law requires states to cover certain **mandatory groups** in order to receive federal matching funds. There are also **optional groups** that states can choose to cover and receive federal matching funds (see Figure 3).

Most Medicaid beneficiaries with HIV qualify because they are low-income and disabled, and receive Supplemental Security Income (SSI) benefits, a mandatory Medicaid eligibility category.[5] However, low-income, nondisabled adults without dependent children have long been excluded from Medicaid by federal law, and states wishing to cover them have had to use state-only dollars or obtain a federal waiver to do so. This has presented a "catch-22" for many low-income people with HIV who could not qualify for Medicaid until they were already quite sick and disabled, despite the fact that early access to treatment could help stave off disability and prevent further transmission; current federal HIV treatment guidelines recommend initiating treatment as soon as one is diagnosed with HIV.[7]

Under the ACA, beginning in 2014, states are required to determine Medicaid eligibility based solely on income (categorical eligibility criteria are eliminated) and to expand eligibility to those up to 138% FPL with an enhanced match rate (states were also provided with a new option to expand coverage to this group early, effective April 2010, at their regular federal Medicaid match rate). A ruling by the Supreme Court upheld the Medicaid expansion (as well as the rest

of the ACA), but limited the HHS Secretary's enforcement authority for the expansion, and it therefore remains to be seen how states will ultimately respond.

Figure 3: Current Medicaid Eligibility Pathways for People with HIV[1,8]

Category	Criteria	Mandatory / Optional
People with Disabilities; Seniors	Receive SSI benefits (income of 75% FPL). SSI definition of disability is having a physical or mental impairment that prevents one from working for a year or more or is expected to result in death). Note: 11 states, known as 209(b) states, can use more restrictive Medicaid eligibility criteria.	**Mandatory***
Children; Pregnant Women; Adults with Dependent Children	Low-income; income and asset criteria vary by category and state.	**Mandatory***
Medically Needy (MN)	State option to extend Medicaid to those who meet categorical eligibility, such as disability, but need to "spend down" on medical expenses to meet state's income criteria.	**Optional** (34 states have MN for the disabled)
Non-disabled, low income adults without dependent children	States must seek federal waiver to cover or use state-only dollars; the ACA provided states with new option to cover as of 2010.	**Optional** (9 states provide full coverage, 16 more limited)

**states have option to use higher income threshold*

Medicaid Benefits

Medicaid covers a broad range of services, many of which are critical for people with HIV/AIDS. States must cover certain mandatory services, specified in federal law, in order to receive federal matching funds. These are: inpatient and outpatient hospital services; physician and nurse practitioner services; laboratory and x-ray services; long-term care services; family planning; early and periodic screening, diagnosis, and treatment (EPSDT) for children; and federally qualified health center and rural health clinic services. States may also cover certain optional services and receive matching funds. Many of these optional services are particularly critical for people with HIV, such as prescription drugs, an optional benefit that all states cover. Others include dental care; personal care services; rehabilitation services; and home and community-based care, designed to help individuals with disabilities remain independent and live in their communities. One home and community-based care option available to states is the "home and community-based services (HCBS)" waiver (also called "1915(c) waivers"). HCBS waivers have been important for people with HIV and are used by several states to serve this population. A study of HCBS waivers in place in 2009 found that 13 states had an HCBS designed specifically for or including people with HIV, serving 13,000 people with HIV.

States have broad flexibility in determining key aspects of their 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. Therefore, people with HIV often need to rely on other sources of care, particularly the Ryan White HIV/AIDS program,[10] to fill in the gaps where there are benefit limits or co-pays. Medicaid benefits are offered on a fee-for-service basis, through managed care plans, or both.

Generally, the same Medicaid benefits package must be provided to all Medicaid enrollees statewide, although states can provide some groups with a "benchmark" package, which may differ from regular Medicaid benefits. People with disabilities, dual eligible beneficiaries, the medically frail and some other groups are exempt from mandatory enrollment in benchmark coverage. Most people who gain Medicaid coverage due to the ACA expansion will receive benchmark coverage, which must include at least the "essential health benefits" (EHB) specified in the law. The benchmark benefit package could be the same as the state's traditional Medicaid benefit package or could be more limited. It remains to be seen whether newly eligible Medicaid beneficiaries with HIV will be exempt from receiving the benchmark benefit package.

The ACA also gave states a new option to provide a "Medicaid health home" to their Medicaid enrollees with chronic conditions (and receive a temporary enhanced federal match of 90%). The law named several chronic conditions that could be targeted for health homes, and while HIV was not specified, the HHS Secretary recently announced that it will formally be added to the list. Health homes encompass a range of services designed to help manage care for those who are chronically ill and are important for people with HIV, such as comprehensive care management and care coordination.[2]

Future Outlook and Challenges

As the largest single source of care and coverage for people with HIV, Medicaid has played a critical role for this population since the HIV epidemic began. This role is expected to grow in 2014 due to the ACA. In particular, many low income people with HIV who could not previously qualify for Medicaid because they did not meet categorical eligibility criteria, such as disability, will gain access in those states that expand their Medicaid programs. Still, it remains to be seen which states will expand their Medicaid programs, given the Supreme Court's ruling, and it will be important to closely monitor access to Medicaid for people with HIV across the country.

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[1] KCMU, *Fact Sheet: The Medicaid Program at a Glance,* September 2012.

[2] KFF, Quick Take, An Update on the ACA & HIV: Medicaid Health Homes, December 2012, http://www.kff.org/health-reform/fact-sheet/quick-take-an-update-on-the-aca/.

[3] KFF, *The Affordable Care Act, the Supreme Court, and HIV: What Are the Implications?*, September 2012.

[4] KFF SHFO, http://www.kff.org/hivaids/state-indicator/enrollment-spending-on-hiv/.

[5] KFF, *Medicaid and HIV: A National Analysis,* October 2011.

[6] KFF analysis of data from OMB.

[7] HHS, *Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents.* February 2013, http://aidsinfo.nih.gov/guidelines/.

[8] KFF SHFO, http://www.kff.org/state-category/medicaid-chip/.

[9] KCMU, *Medicaid Home and Community-Based Service Programs: 2009 Data Update;* December 2012.

[10] HRSA, http://hab.hrsa.gov/stateprofiles2010/states/us/Client-Characteristics.htm#chart7.

[11] HHS, http://www.hhs.gov/news/press/2012pres/11/20121129a.html.

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