Satellite Symposium:
What's Coming Down the Pike? Preparing for Federal and State Policy Changes That Stand to Affect You and Your Patients

Sponsored by:
Kaiser Family Foundation
George Washington University
HIV Medicine Association
American Academy of HIV Medicine

Presented at:
Treatment and Management of HIV Infection in the United States
September 17, 2005
Atlanta, Georgia

TREATMENT and MANAGEMENT
of HIV Infection in the United States
A State-of-the-Science Conference for Frontline Health Professionals, Sponsored by Collaborating Federal Health Agencies

Presenters

- **Jennifer Kates, Vice President and Director, HIV Policy, Kaiser Family Foundation**
- **Jeffrey Levi, Associate Professor of Health Policy, George Washington University School of Public Health and Health Services**
- **Christine Lubinski, Executive Director, HIV Medicine Association**
- **Bruce Packett, Public Policy Associate, American Academy of HIV Medicine**

Symposium Objective

- **To highlight key policy changes that stand to affect front-line providers of HIV/AIDS care in the United States**
  - Focus on federal policy issues and changes; note, many changes would be implemented at state level, with considerable flexibility given to states
  - Focus on Medicaid, Medicare, and Ryan White since these programs are “in play” from a policy perspective & provide care to most people with HIV/AIDS
- **To address the impact of and lessons learned from Katrina**
- **To provide tools and resources to participants to help prepare for policy changes**

Session Structure

I. Understanding the context
II. Overview of major government programs that finance HIV care
III. What policy changes are in play today (in the pre-Katrina environment)
IV. Post-Katrina policy context
V. What to expect in the months ahead

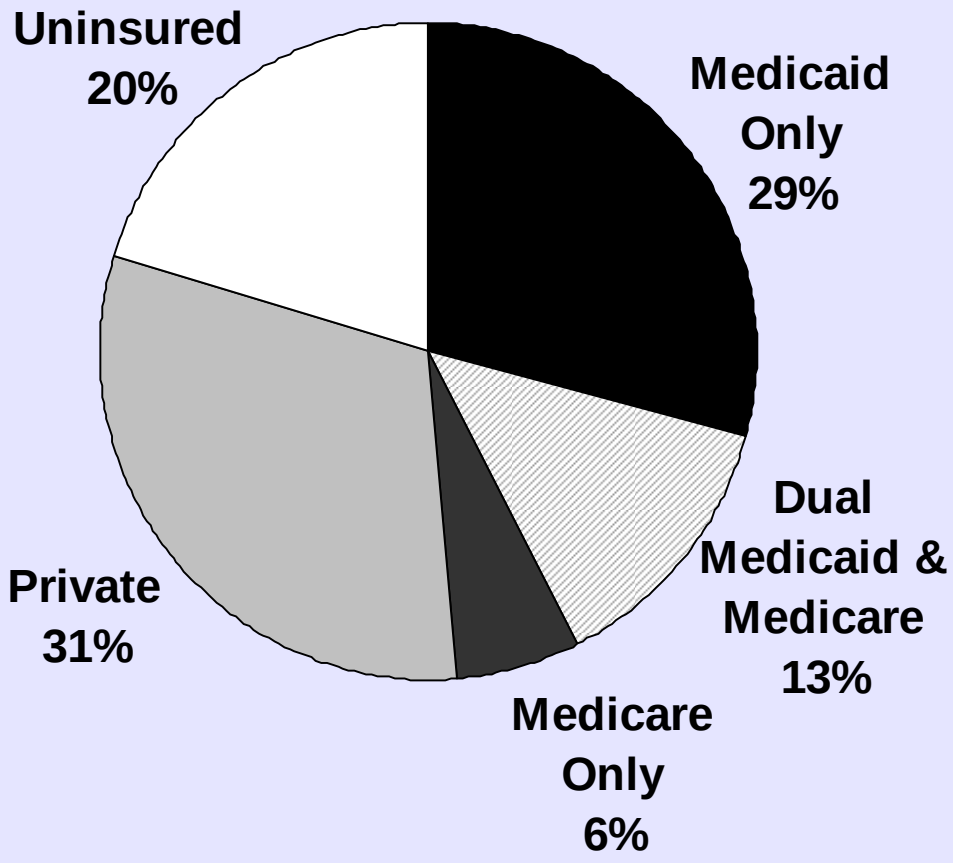
I. Understanding the Context

A Shifting Landscape

- **Shifting medical/clinical context**
  - Hospital to community
  - No or limited treatment (e.g., one approved ARV) to more than 20 today and HAART era
- **Shifting demand – increasing over time**
- **Shifting costs – increasing over time**
  - Drug costs high and additive
- **Shifting populations in need**
  - Increasingly women, people of color, lower income, co-morbidities

II. Overview of major federal government programs that finance HIV care

Insurance Coverage of People with HIV/AIDS in Care, 1996

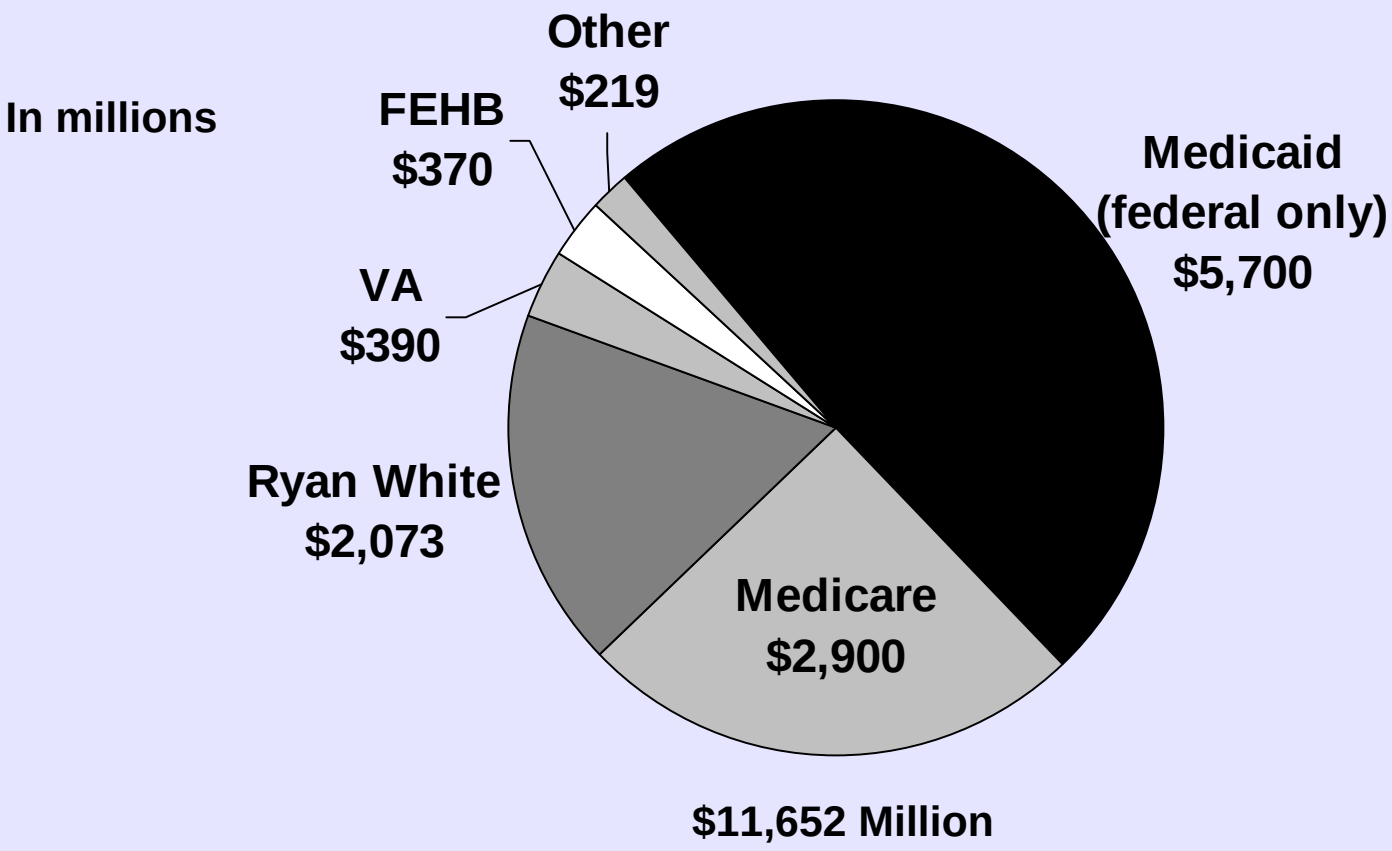


SOURCES: Bozzette, et al. "The Care of HIV-Infected Adults in the United States." *NEJM*, Vol. 339, No. 26. December, 1998; Fleishman, J., Personal Communication, Analysis of HCSUS Data, January 2002.

Major Federal Sources of Funding for HIV/AIDS Care

- Medicaid
- Medicare
- Ryan White CARE Act
- Department of Veterans Affairs
- Community and Migrant Health Centers

Federal Funding for HIV/AIDS Care, FY 2005



SOURCES: Kaiser Family Foundation, *Fact Sheet: Federal Funding for HIV/AIDS: The FY 2006 Budget Request*, February 2005; DHHS, Office of Budget/ASBTF, February 2005; SSA, Office of the Actuary, February 2005; CMS, Office of the Actuary, February 2005; NASTAD/Kaiser Family Foundation, *National ADAP Monitoring Project*, May 2004; NASTAD, FY 2002 Ryan White CARE ACT Title II HIV Care Grants (Proposed), February 2002.

Medicaid Today

- **Provides health & long-term care coverage for more than 52M low-income people**
  - FY 2005 federal spending estimated to total $183 billion; state share of $138 billion
- **Guaranteed entitlement to individuals & federal financing to states**
- **Joint federal-state program, variability across country**
- **Pays for nearly 1 in 6 health care dollars**
- **HIV/AIDS: largest source of health coverage for people with HIV/AIDS**
  - ≈250,000 Medicaid beneficiaries with HIV/AIDS
  - Estimated federal spending on AIDS care = $5.7 billion in FY 2005

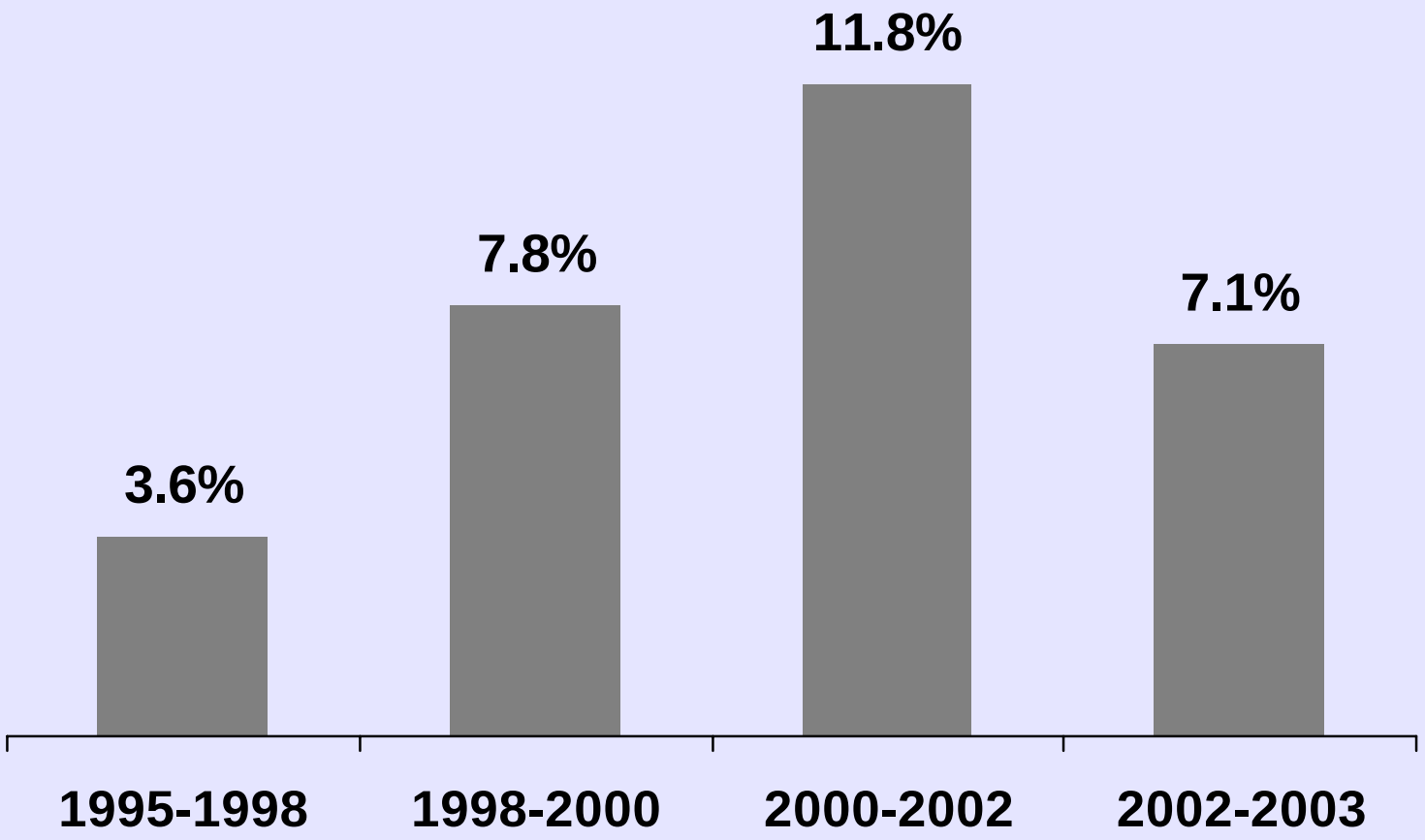
SOURCES: Congressional Budget Office, March 2005; Kaiser Family Foundation, *Fact Sheet: Medicaid and HIV/AIDS*, September 2005; KCMU, *Fact Sheet: The Medicaid Program at a Glance*, January 2005.

Medicaid Eligibility Pathways for People Living with HIV/AIDS

Category	Criteria	Mandatory/Optional
SSI beneficiaries	Severely disabled AND low-income (74% of FPL)	Mandatory
Parents, children, pregnant women	Low income; income & asset criteria vary by category & state	Mandatory; states may offer higher income thresholds
Medically Needy	Severely disabled and low income (median = 56% of FPL) after subtracting incurred medical expenses	Optional (35 states use this option for people with disabilities)
Workers with Disabilities	Severely disabled; low-income; for persons returning to workforce	Optional
Poverty-level expansion	Allows for income above SSI levels up to FPL	Optional (19 states use this option)
State Supplementary Payment (SSP)	Allows for coverage of those receiving SSP	Optional (21 states use this option)

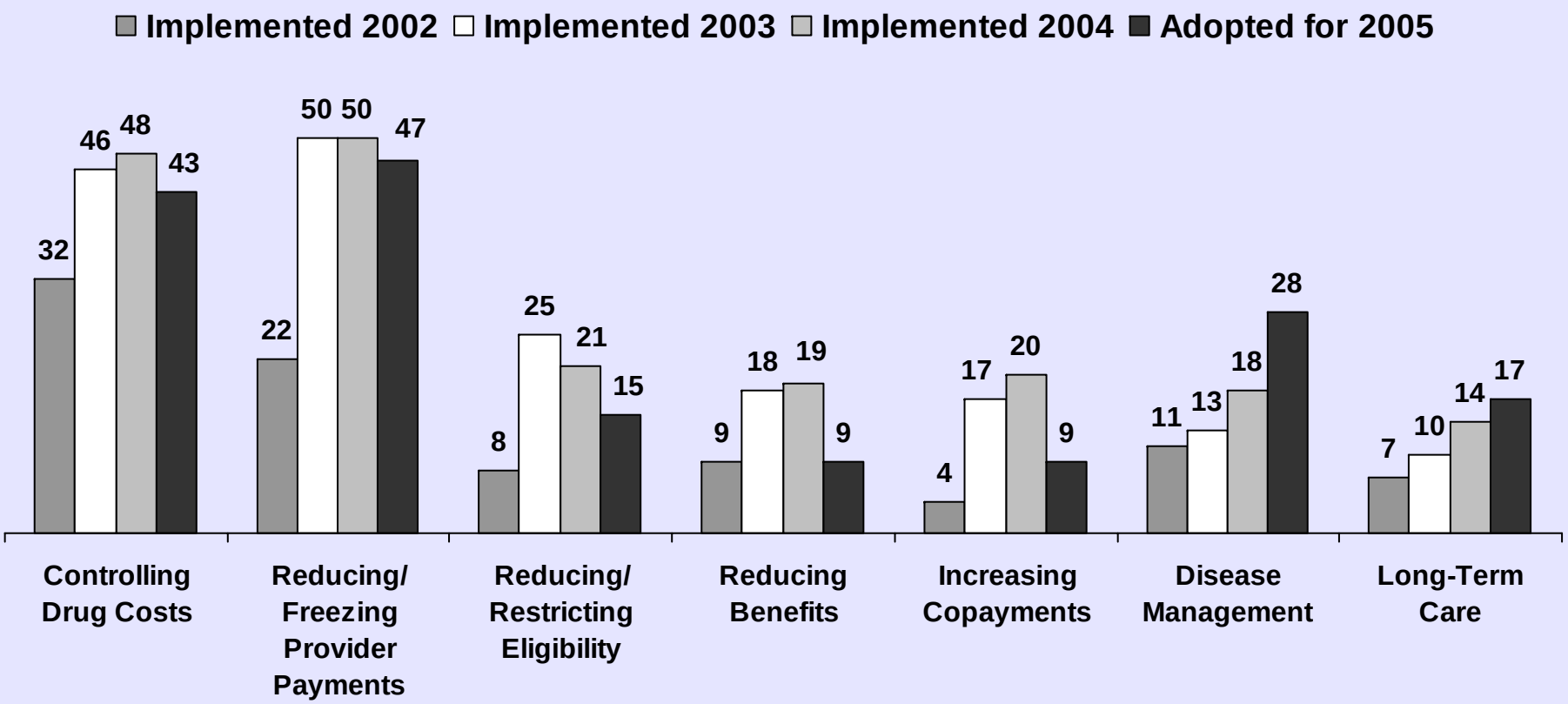
SOURCE: Kaiser Family Foundation, *Fact Sheet: Medicaid and HIV/AIDS*, September 2005.

Average Annual Growth in Overall Medicaid Expenditures, 1995-2003



SOURCE: Urban Institute, 2004; estimates based on data from HCFA Financial Management Reports, 2004 (HCFA-64/CMS-64).

States Undertaking New Medicaid Cost Containment Strategies FY2002–FY2005



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September and December 2003 and October 2004.

Medicare Today

- **Covers nearly 42 million people as an entitlement program**
  - Medicare spending estimated to total $327 billion in FY 2005
- **Program now has parts A,B,C; in 2006, new Part D**
  - Part A – Hospital and skilled nursing care
  - Part B – Physician and outpatient hospital care
  - Part C – Medicare Advantage (voluntary managed care alternative to Parts A and B)
  - Part D – Outpatient prescription drug coverage begins Jan. 2006
- **HIV/AIDS: second largest source of HIV/AIDS coverage**
  - ≈100,000 Medicare beneficiaries with HIV/AIDS, including ≈65,000 dual eligibles (Medicaid and Medicare);
  - Estimated federal spending on AIDS care $2.9 billion in FY 2005)

SOURCES: Congressional Budget Office, March 2005; Kaiser Family Foundation, *Fact Sheet: Medicare and HIV/AIDS*, September 2005; Kaiser Family Foundation, *Fact Sheet: Medicare at a Glance*, April 2005.

Medicare Eligibility Pathways for People Living with HIV/AIDS

Category	Criteria
Individuals age 65 and older	Sufficient number of work credits to qualify for Social Security payments
Individuals under age 65 with permanent disability	Sufficient number of work credits to qualify for SSDI payments due to disability; also includes spouses and adults disabled since childhood Have been receiving SSDI payments for at least 24 months
Individuals with End-Stage Renal Disease, any age	Sufficient number of work credits to qualify for Social Security payments

SOURCE: Kaiser Family Foundation, *Fact Sheet: Medicare and HIV/AIDS*, September 2005

The Ryan White CARE Act

- **"Comprehensive AIDS Resources Emergency Act"**
  - Passed in 1990, reauthorized twice, third pending
  - Original intent: relief to safety net (public hospitals)
  - Discretionary program, not entitlement
  - Only disease-specific discretionary grant program for HIV/AIDS
  - Builds on Medicaid
    - Gap filler in terms of eligibility AND services
  - Services provided: comprehensive primary care and support services
  - What you get depends on where you live

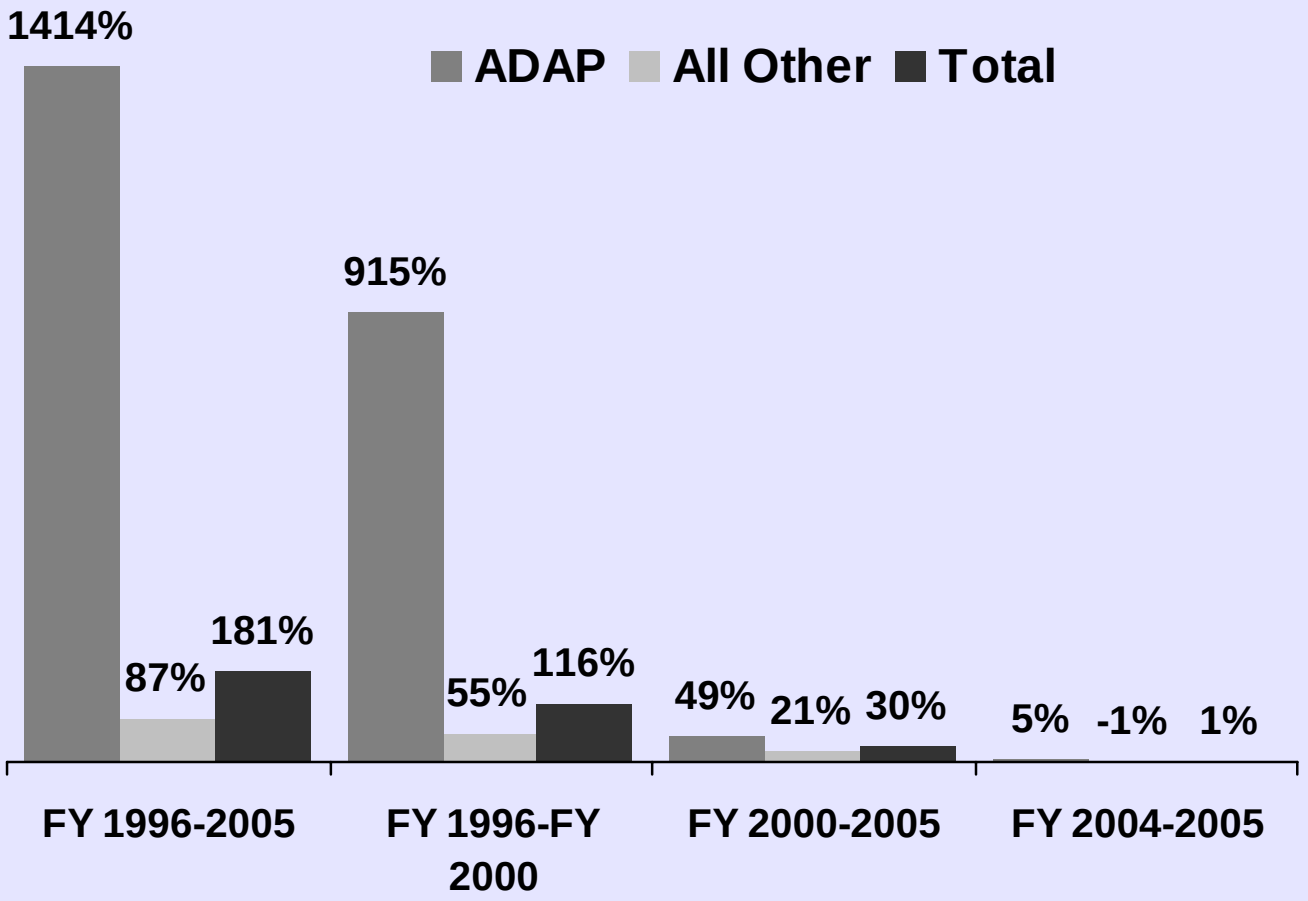
Structure of the CARE Act

- **Title I: Eligible Metropolitan Areas (EMAs)**
- **Title II: State grants**
  - Earmark for AIDS Drug Assistance Program (ADAP)
- **Title III: Federal grants to clinics**
- **Title IV: Children, Youth and Families grants**
- **Education and Training Centers, Dental, Minority AIDS Initiative, Special Projects of National Significance**

Special Features of the CARE Act

- **Funds variety of medical & social services**
- **Flexible funding for staff salaries/service delivery**
- **Planning process & requirements for consumer involvement**
- **Discretion for communities to determine need and allocate resources based on varying epidemiology and unmet needs**
  - Reflection of underlying health care financing system
  - State-by-state variability in eligibility and coverage under RWCA

CARE Act Funding History: Percent Change, FY 1996 - FY 2005



SOURCE: Health Resources and Services Administration, HIV/AIDS Bureau

III. What policy changes are in play today (in the pre-Katrina environment)

Key Federal Policy Changes Facing Congress and the Administration

- **Medicaid**
  - cuts / caps / overhaul
- **Medicare**
  - drug benefit
- **Ryan White Reauthorization**
  - authorizing issues
  - appropriations issues

Medicaid Reform?

- **Cuts mandated by Congressional budget resolution**
  - How these will be translated into policy
- **Recommendations by the National Governors Association, Medicaid Commission and others**
  - Key conceptual issues:
    - Should the federal government continue to have significant say regarding eligibility and coverage?
    - Should Medicaid look more like private insurance?

Medicare Drug Benefit

- **General issues**
  - Transition period and continuity of care concerns
  - Cost-sharing subsidies below 150% of poverty; yet new cost-sharing for some;
  - Affordability of HIV-related meds for those above 150% of poverty
  - Adequacy of formularies (ARVs yes, other Rx?)
  - Access to newly approved drugs and drugs for off-label uses unclear
  - The “Doughnut Hole”
  - Need for education/info sharing for providers and patients
- **Dual eligibles**
  - No longer will have Medicaid for Rx – mandatory shift to Medicare
- **Impact on ADAPs unclear**
  - Demand for ADAPs: increase/decrease?
  - ADAP spending will <u>not</u> count towards True Out of Pocket Costs (“TrOOP”)

Ryan White CARE Act Reauthorization

- **Program authority expires September 30th but will be funded through September 30th 2006 under current law if necessary**
  - Without reauthorization, may be hard to fix some critical problems (e.g., addressing ADAP waiting lists)
- **No legislative language has been introduced**
- **Administration has released principles for reauthorization**

Administration's Principles for Reauthorization

- **Serve the neediest first**
  - Change formulas to allocate among grantees based on need
- **Focus on Life-Saving and Life-Extending Services**
  - Establish core medical services and core ADAP formulary
  - Require that 75% of funds be spent on core medical services
- **Increase Prevention Efforts**
  - Mandate testing in certain facilities
- **Increase Accountability**
  - HIV data as part of formula; eliminate so-called double counting in allocating funds in states with Title I EMAs; eliminate "hold harmless" provisions
- **Increase Flexibility**
  - Permit reallocation of funds by HHS; planning councils become advisory

SOURCE: Department of Health and Human Services, *Fact Sheet:: Ryan White Care Act Reauthorization Principles*, July 27, 2005: http://www.hhs.gov/news/press/2005pres/ryanwhite.html.

Potential Implications of Administration's Principles

- **Redistribution of funds**
  - Implications in context of flat funding
- **More federal determination of types of services funded**
  - Dependent on definition of core medical services
- **Federal "vs" local program design**

HIVMA/AAHIVM
Ryan White Reauthorization

- **Prioritize <u>comprehensive</u> core medical services while maintaining RW support for enabling social services**
- **Federally guarantee to all low-income persons with HIV of access to ARV/OI medications regardless of where one lives**
- **Expand training authorization to finance training and incentives for next generation of HIV medical providers**
- **Ensure access to experienced providers for Ryan White patients**

IV. Post-Katrina policy context

The Impact….Katrina has:

- **Increased the number of people in poverty**
- **Increased the number of uninsured**
- **Exacerbated health issues and concerns that existed prior to disaster – lack of continuity of care, stress, challenging living conditions, nutrition**
- **Introduced new health issues and concerns due to disaster directly and to displacement, lack of continuity of care, etc.**
- **Issues of public health, emergency/trauma care, primary care, medications, mental health care, substance abuse treatment, etc.**

SOURCE: Kaiser Commission on Medicaid and the Uninsured, *Policy Brief: Addressing the Health Care Impact of Hurricane Katrina*, September 2005.

Medicaid: Under Consideration Now

- **Extension of Medicaid eligibility to those displaced by the hurricane**
- **Emergency federal assistance to disaster-affected states**
  - 100% federal funding (FMAP)
- **Streamlined eligibility and enrollment**
- **Emergency assistance to providers**

Medicare: Under Consideration Now

- **Emergency assistance to disaster-affected Medicare beneficiaries**
- **Ways to address disaster-affected dual eligibles and mandatory transition from Medicaid to Medicare for prescription drugs in January 2006**

Ryan White Care Act/ADAP

- Unlike Medicaid and Medicare, not entitlement and funding is capped
- Funding does not follow affected individuals
- What will happen to people with HIV/AIDS who cannot get services (medications, others?)
- What will happen to states who provide services but face funding limits?
- Continuity of care and differences in care available from state to state
- Role of federal government? Role of states? Role of pharmaceutical manufacturers?

V. What to expect in the months ahead

What next?

- **Congress is focused on responding to Katrina and on regular appropriations bills**
  - RWCA likely to be flat funded again, unless some CARE Act funds (e.g., ADAP) can be added to an emergency supplemental
  - What will happen to Reauthorization of CARE Act timeline?
  - What will happen with Medicaid reform?
- **Other?**

What steps can you take?