

October 2016 | Fact Sheet

Medicaid and HIV

Medicaid, the largest public health insurance program in the United States, covering health and long-term care services for more than 72 million low-income individuals, has played a critical role in HIV care since the HIV epidemic began.¹ It is the single largest source of coverage for people with HIV in the U.S. and the number of Medicaid beneficiaries with HIV has grown over time.² The passage of the Affordable Care Act (ACA) in 2010 marked significantly increased access to Medicaid including for those with HIV, by expanding the program to nearly all non-elderly adults with incomes at or below 138% of the federal poverty level (FPL), in states that choose to participate.³ Key facts about Medicaid and HIV include:

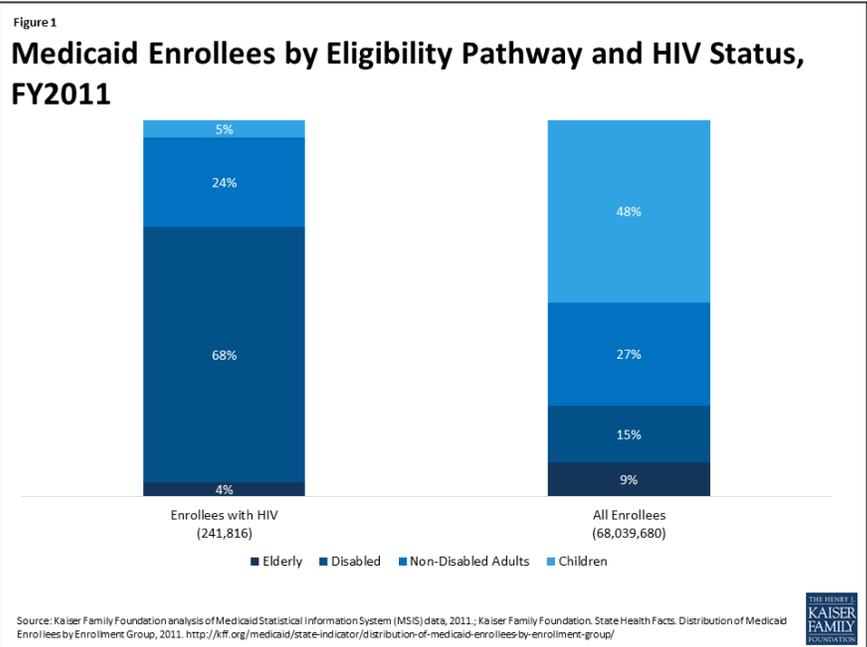
- Medicaid is the largest source of insurance coverage for people with HIV, estimated to cover more than 40% of people with HIV in care.⁴
- The number of Medicaid beneficiaries has grown over time, rising from 212,900 in 2007 to 242,000 in 2011, a 14% increase.⁵
- Medicaid spending on HIV has also increased over time, reflecting growing numbers of beneficiaries with HIV and the rising cost of care.
- Medicaid spending on HIV accounts for 30% of all federal spending on HIV care and when combining the states' share of spending, is the second largest source of public financing for HIV care in the U.S.
- Historically, people with HIV on Medicaid have been much more likely to qualify based on disability, compared to beneficiaries overall.

MEDICAID BENEFICIARIES WITH HIV

In 2011, the most recent year for which national data are available, there were approximately 242,000 Medicaid beneficiaries with HIV, a number which has grown over time (though beneficiaries with HIV represent less than 1% of the overall Medicaid population). The number of beneficiaries with HIV is expected to have increased even more due to the ACA. One analysis found that if all states expanded their Medicaid programs, nearly 47,000 people with HIV could gain new Medicaid coverage.⁶ People with HIV are much more likely to qualify for Medicaid based on disability, compared to Medicaid beneficiaries overall (68% compared to 15% in 2011) (see Figure 1).^{7,8} In addition, Medicaid beneficiaries with HIV are more likely to be male (58% compared to 41%), Black (52% compared to 22%), and between the ages of 45-64 (52% compared to 12%).⁹ A significant share – about three in 10 (31%) – are dually eligible for both Medicaid and Medicare, compared to just 15% of the Medicaid population as a whole; dual eligibles are among the most chronically ill and costly Medicaid enrollees, with many having multiple chronic conditions and requiring long-term care.

MEDICAID ELIGIBILITY FOR PEOPLE WITH HIV

Historically, most Medicaid beneficiaries with HIV (68% in 2011) qualified through a disability pathway.¹⁰ Prior to the ACA, to qualify for Medicaid an enrollee had to be both low income and “categorically eligible,” such as being disabled or pregnant. While federal law required states to cover low-income categorically eligible individuals in order to receive matching funds, coverage for other individuals was either previously optional or not covered under statute (see Table 1). As such, in the pre-ACA era, many low-income adults were categorically excluded from Medicaid, and states wishing to cover them had to use state-only dollars or



obtain a federal waiver to do so. This 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. Additionally, the federal HIV treatment guidelines recommend initiating treatment as soon as one is diagnosed with HIV.¹¹

The ACA sought to change this by requiring all states to expand their Medicaid programs for adults on the basis of income and residency status alone as of 2014 (for individuals up to 138% of the federal poverty level or about \$16,400 a year for an individual in 2016). This change would serve to reach millions of low-income Americans, including many people with HIV. However, the 2012 Supreme Court ruling on the constitutionality of the ACA effectively made expansion a state option.¹² To date, 32 states have expanded their Medicaid programs and 19 have not and almost 40% of people with HIV live in states that have not yet expanded their programs.¹³

Table 1: Primary Medicaid Eligibility Pathways for People with HIV

Category	Criteria	Mandatory / Optional
SSI Beneficiaries	States generally must provide Medicaid to those receiving Supplemental Security Income (SSI) benefits though some states elect the Section 209(b) option to use more restrictive eligibility criteria. To be eligible for SSI, beneficiaries must have low incomes, limited assets, and a significant disability.	Mandatory, though as of 2015, 10 are more restrictive Section 209(b) states. ¹
Seniors and Persons with Disabilities up to 100% FPL	State option to provide Medicaid to seniors and people with disabilities whose income exceeds SSI limits, up to 100% FPL.	Optional (21 states in 2015)
Children	States required to cover children under age 19 up to 138% FPL, but most elect to cover at higher incomes.	Mandatory
Pregnant Women	States required to cover pregnant women up to 138% FPL but most cover at higher income limits with a median eligibility level of 205% FPL in 2015 ²	Mandatory
Low-income Adults without Dependent Children	The ACA expanded Medicaid eligibility to nearly all adults without dependent children under 65 years old up to 138% FPL, regardless of disability status.	Mandated by ACA but effectively state option due to Supreme Court ruling. (32 states offer coverage, 19 do not as of Sept. 2016, could change over time.)
Parent/Caretaker Relatives	The ACA increases the parent/caregiver eligibility threshold to 138% FPL, on par with the expansion for low-income adults without dependent children. *** States that have not expanded Medicaid, must still provide coverage at pre-ACA levels for parents with dependent children (known as Section 1931 parents) but income thresholds vary by state ranging from 18% FPL (TX, AL) to 105% FPL (ME) in 2016 in non-expansion states. ²	Expansion to 138% FPL mandated by ACA but effectively state option due to Supreme Court ruling. *** Mandatory for Section 1931 parents with state option to expand beyond federal income minimum.
Medically Needy (MN)	State option to extend Medicaid to those who meet categorical eligibility, such as disability status, but need to “spend down” by incurring medical expenses to meet state’s income criteria.	Optional (32 states & DC for people with disabilities as of 2015)
Buy-in for Working People with Disabilities	States may opt to provide Medicaid to working individuals with disabilities at higher income/asset limits (median 250% FPL in 2015). ² Limits vary by state. States may charge income-related premiums and cost-sharing.	Optional (44 States provide in 2015)

1. Kaiser Family Foundation. Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015, 2016.

2. Kaiser Family Foundation. Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey. 2016.

MEDICAID SPENDING ON HIV

Medicaid is a means-tested entitlement program, jointly financed by the federal and state governments. In the traditional (non-expansion) program, the federal government matches state Medicaid spending at rates ranging from 50% to 75%.¹⁴ Under the ACA, financing for the expansion population is more generous; during the period 2014-2016, the federal government finances 100% of the costs for expansion enrollees, phasing down to 90% in 2020 and thereafter.

In FY 2016, federal Medicaid spending on HIV is estimated to total \$5.9 billion, accounting for 30% of all federal spending on HIV care.¹⁵ Combined with the states' share of Medicaid spending (an estimated \$3.5 billion in FY 2016),¹⁶ Medicaid is the second largest source of public financing for HIV care in the U.S., after Medicare. Medicaid spending on HIV has

increased over time, reflecting growing numbers of beneficiaries with HIV and the rising cost of care. Still, in 2016 spending on HIV represents less than 2% of total Medicaid spending. Annual per capita spending on HIV positive Medicaid beneficiaries was \$26,807 in 2011, almost five times that of Medicaid beneficiaries overall (\$5,790).^{17, 18}

MEDICAID BENEFITS

Medicaid covers a broad range of services, many of which are critical for people with HIV. While most states that have expanded their Medicaid programs have fully aligned the benefits in their traditional program with the benefits aimed at the expansion population, there are technically different requirements between the two, with potential implications for HIV care and prevention.

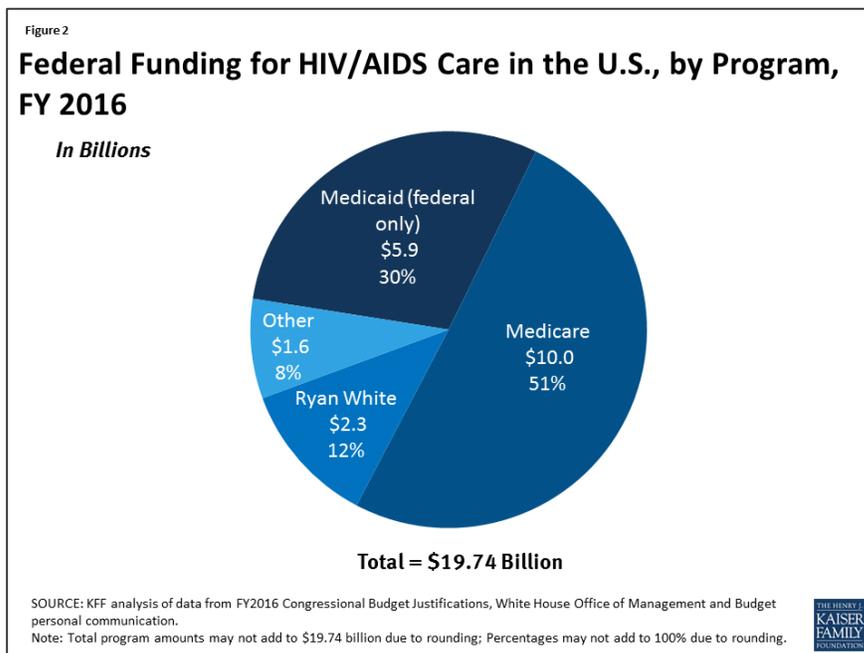
TRADITIONAL MEDICAID PROGRAMS

Under traditional Medicaid, states must cover certain mandatory services, specified in federal law, in order to receive federal matching funds. These services include: inpatient and outpatient hospital services; physician and nurse practitioner services; laboratory and x-ray services; nursing facility services; family planning; early and periodic screening, diagnosis, and treatment (EPSDT) for children; and federally qualified health center and rural health clinic services, among others.¹⁹ 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.²⁰ States also have the option to apply for a "home and community-based services (HCBS)" waiver (also called a "Section 1915(c) waiver"). HCBS waivers have been important for people with HIV and are used by several states to serve this population. As of 2012, 13 states had an HCBS designed specifically for or to include people with HIV, serving over 13,500 people with HIV.²¹

Traditional state Medicaid programs are required to cover "medically necessary" HIV testing and may elect to cover routine HIV testing. States are incentivized under the ACA to cover a full suite of preventive services, including routine HIV testing, without cost-sharing in exchange for a 1% increase in the federally matching rate for those services.²²

States have broad flexibility in determining other key aspects of their 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.²³ Medicaid benefits are offered on a fee-for-service basis, through capitated managed care plans (to an increasing degree), or through a combination of these benefit designs.

Generally, the same Medicaid benefit package must be provided to most Medicaid enrollees statewide,²⁴ although states can provide certain groups with an "Alternative Benefit Plans" (ABP) package, which may differ from regular Medicaid benefits (discussed further below). People with disabilities, dual eligible beneficiaries, the medically frail and some other groups are exempt from mandatory enrollment in ABP coverage which could be important to beneficiaries with HIV who might receive more comprehensive benefits through the traditional program in some states.



MEDICAID EXPANSION PROGRAMS

Most enrollees who gain access to Medicaid through the ACA expansion receive what is known as “Alternative Benefit Plans” (ABPs). ABPs must include services that fall into the ACA’s ten “essential health benefit” (EHB) categories, many of which are important for HIV care:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Prescription drugs
- Rehabilitative and habilitative services
- Laboratory services
- Preventive services and chronic disease management
- Pediatric services
- Mental health and substance use disorder services

Most benefits within these categories are defined through a state-based benchmarking process using a commercially available plan of the state’s choosing from federally mandated options or from an alternative plan through a waiver. Most states have elected to use a waiver and selected the traditional state Medicaid plan as the benchmark package and thus in these cases, benefits in the traditional state plan are aligned with the benefits in the ABP offered to the expansion population (and others).²⁵ Unlike the other EHB categories which are not specifically delineated, preventive services are defined to include services receiving an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF), including routine HIV screening, among others packages of preventative benefits, and must be offered without cost-sharing.²⁶

In some cases, people with HIV may not have access to all the health services needed to stay healthy through Medicaid alone and rely on supplement coverage from other payers or programs. As discussed earlier, many are dually eligible and received additional support through Medicare. The Ryan White HIV/AIDS Program also helps to supplement care provided through Medicaid, particularly with support services such as case-management, nutrition assistance, and transportation.²⁷

MEDICAID HEALTH HOMES

The ACA also gave states a new option to provide Medicaid health home services to enrollees with chronic conditions (and receive a temporary enhanced federal match of 90% for the first two years). The law named several chronic conditions that could be targeted for health homes, and in addition, CMS considers other chronic conditions, including HIV, for states pursuing this option.²⁸ As of April 2016, 30 health homes had been approved in 21 states and the District of Columbia. Among these, three states included HIV among other qualifying conditions for enrollment into the health home and one state, Wisconsin, designed a health home specifically targeted at beneficiaries with HIV/AIDS.²⁹ 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.

COST-SHARING

Though many elect not to use cost-sharing for most populations and services, (in both the traditional and expansion programs) states are permitted to require “nominal” cost-sharing by some groups of beneficiaries, within certain caps based on income and type of service. States may also charge premiums to enrollees above 150% FPL, though total family spending on Medicaid premiums and cost-sharing cannot exceed 5% of the family’s income. There are certain groups, including mandatory eligible children, pregnant women, most children and adults with disabilities, people residing in institutions, and people receiving hospice care who are exempt from cost-sharing altogether. Certain services are exempt as well, including emergency care, preventive services, pregnancy-related services, and family planning services. At the same time, some states that have expanded their Medicaid programs through a demonstration waiver have been able to institute greater cost-sharing requirements on beneficiaries than initially envisioned for this population.³⁰ The Ryan White HIV/AIDS Program is permitted to help enrollees with HIV with cost-sharing obligations. This is important because Medicaid enrollees with HIV live on very limited incomes and studies have shown that even nominal cost-sharing requirements can adversely impact access to care and treatment.³¹

FUTURE OUTLOOK

As the single largest source of health coverage for people with HIV, Medicaid has played a critical role for this population since the HIV epidemic began and its role has grown under 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, have gained access but only in those states that have elected to expand their programs. Going forward, it will be important to continue to monitor and assess the impact of Medicaid coverage on people with and at risk for HIV, particularly given that several states are still deciding whether to expand their programs. In addition, understanding the interface of Medicaid with the Ryan White system of care will better inform how HIV care and treatment can be delivered and the relationship between the two programs.

ENDNOTES

- ¹ CMS. Medicaid & CHIP: *March 2016 Monthly Applications, Eligibility Determinations and Enrollment Report*. May 25, 2016 <https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/march-2016-enrollment-report.pdf>
- ² Kaiser Family Foundation. State Health Facts. *Medicaid Enrollment and Spending on HIV/AIDS. (FY07-FY11)*. <http://kff.org/health-reform/state-indicator-enrollment-spending-on-hiv/>
- ³ See current status of state Medicaid expansion decisions: <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>
- ⁴ Kaiser Family Foundation. *Assessing the Impact of the Affordable Care Act on Health Insurance Coverage of People with HIV*. January 2014. <http://kff.org/hiv/aids/issue-brief/assessing-the-impact-of-the-affordable-care-act-on-health-insurance-coverage-of-people-with-hiv/>
- ⁵ Kaiser Family Foundation. State Health Facts. *Medicaid Enrollment and Spending on HIV/AIDS. (FY07-FY11)*. <http://kff.org/hiv/aids/state-indicator/enrollment-spending-on-hiv/>
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- ⁷ Kaiser Family Foundation analysis of Medicaid Statistical Information System (MSIS) data, 2011.
- ⁸ Kaiser Family Foundation. State Health Facts. *Distribution of Medicaid Enrollees by Enrollment Group*. <http://kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group/>
- ⁹ Kaiser Family Foundation analysis of Medicaid Statistical Information System (MSIS) data, 2011.
- ¹⁰ Kaiser Family Foundation analysis of Medicaid Statistical Information System (MSIS) data, 2011.
- ¹¹ Department of Health and Human Services. Panel on Antiretroviral Guidelines for Adults and Adolescents. *Guidelines for the Use of Antiretroviral Agents in HIV-1-infected Adults and Adolescents*. January 2016. Accessed 6-29-16 at: <http://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-treatment-guidelines>
- ¹² Kaiser Family Foundation. *A Guide to the Supreme Court's Affordable Care Act Decision. 2012*. Available at: <http://kff.org/health-reform/issue-brief/a-guide-to-the-supreme-courts-affordable/>
- ¹³ Kaiser Family Foundation. State Health Facts. *Status of State Action on the Medicaid Expansion Decision*. <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>; Kaiser analysis of data from State Health Facts and the CDC Atlas.
- ¹⁴ Kaiser Family Foundation. State Health Facts. *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*. <http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/>
- ¹⁵ Kaiser Family Foundation. *U.S. Federal Funding for HIV/AIDS: Trends Over Time*. <http://kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hiv-aids-trends-over-time/>
- ¹⁶ Kaiser Family Foundation CMS correspondence.
- ¹⁷ Kaiser Family Foundation. State Health Facts. *Medicaid Enrollment and Spending on HIV/AIDS, 2011*. <http://kff.org/hiv/aids/state-indicator/enrollment-spending-on-hiv/>
- ¹⁸ Kaiser Family Foundation. State Health Facts. *Medicaid Spending per Enrollee (Full or Partial Benefit), 2011*. <http://kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/>
- ¹⁹ Kaiser Family Foundation. *Medicaid Moving Forward*. 2015. <http://kff.org/health-reform/issue-brief/medicaid-moving-forward/>
- ²⁰ Kaiser Family Foundation. *Medicaid Moving Forward*. 2015. <http://kff.org/health-reform/issue-brief/medicaid-moving-forward/>
- ²¹ Kaiser Family Foundation. State Health Facts. *Medicaid Section 1915(c) Home and Community-Based Services Waivers Participants, by Type of Waiver, 2012*. <http://kff.org/health-reform/state-indicator/participants-by-hcbs-waiver-type/>
- ²² Kaiser Family Foundation. *HIV Testing in the United States, 2016*. <http://kff.org/hiv/aids/fact-sheet/hiv-testing-in-the-united-states/>
- ²³ Kaiser Family Foundation. *Medicaid: A Primer, 2013*. Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf>
- ²⁴ “Medically needy” enrollees can receive a more restricted benefit package than categorically eligible folks and due to EPSDT, there are significant differences in coverage children receive compared to adults.
- ²⁵ The requirement is for the ABP to cover services offered in the benchmark (in many cases the traditional state plan). In cases when benefits packages are not aligned, certain benefits might be more or less robust for the traditional Medicaid population. For example, a state plan might offer nursing care or long-term services when an ABP does not. At the same time, even when a state selects its traditional plan as its benchmark, some benefits could be different for the ABP population. For example, the ABP must include all EHB services which in some cases might be more robust than the benchmark or state plan.
- ²⁶ HIV testing for the expansion population is covered in accordance with the USPSTF determination for the service and is available to those between the ages of 15-65 and for others at increased risk, including those who ask for a test.
- ²⁷ HRSA. Ryan White HIV/AIDS Program: State Profiles, 2013. <http://hab.hrsa.gov/stateprofiles/>
- ²⁸ HHS, CMS. Health Homes. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html>
- ²⁹ HHS, CMS. State-by-State Health Home State Plan Amendment Matrix. Updated: April 2016. Accessed 6-29-16. Available at: <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/state-hh-spa-at-a-glance-matrix-apr-2016.pdf>
- ³⁰ Kaiser Family Foundation. *The ACA and Medicaid Expansion Waivers*. 2015. <http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers/>

³¹ See for example: Snyder, L. and R. Rudowitz. 2013. Premiums and cost sharing in Medicaid: A review of research findings. Washington, DC: Kaiser Family Foundation. <https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8417-premiums-and-cost-sharing-in-medicaid.pdf>