STATE HEALTH REFORM IMPACT MODELING PROJECT

# Mississippi

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and the Treatment Access Expansion Project

# BACKGROUND

The Patient Protection and Affordable Care Act (ACA) will dramatically change how people living with HIV access healthcare.[1] In states that fully implement the law (including expanding Medicaid), thousands of uninsured people living with HIV—many of whom currently receive care and treatment through Ryan White programs—will have access to healthcare through Medicaid or subsidized private health insurance.

The State Health Reform Impact Modeling Project (the Modeling Project) assesses the impact that healthcare reform will have on people living with HIV by compiling and analyzing Ryan White program and AIDS Drug Assistance Program (ADAP) data to predict the shift of uninsured people living with HIV from these discretionary programs to Medicaid or private insurance in all 50 states pursuant to the ACA. In addition, for 21 states and the District of Columbia (DC), the Modeling Project compiles and analyzes detailed budgets and benefits guidelines to assess the services provided by the Ryan White program, ADAP, Medicaid, and plans sold on an exchange, in order to estimate the impact that a transition into Medicaid will have on low-income people living with HIV.*

Information on the methodology used to model transitions in each state, as well as the numerical results for each state and DC, are available in Appendix A. See Appendix B for notes and a summary of the limitations of the modeling process.

In Mississippi, the Modeling Project focuses on four state-specific inquiries:

1. What demographic information is available about Ryan White program and ADAP clients?
2. How many ADAP clients will be newly eligible for Medicaid or private insurance subsidies in 2014?
3. What services are currently available to people living with HIV under the Ryan White program versus Medicaid or plans to be sold on an exchange, and what gaps in services currently exist?
4. Given the current Ryan White and Medicaid programs, what are the likely outcomes of a transition from one program to another in 2014?

* The states assessed include: Alabama, Arkansas, California, DC, Florida, Georgia, Illinois, Kentucky, Louisiana, Maryland, Massachusetts, Mississippi, New Jersey, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, and Wisconsin.

# MISSISSIPPI

## MISSISSIPPIANS LIVING WITH HIV OR AIDS

### UNMET NEED

As of 2011, 9,907 Mississippians were known to be living with HIV/AIDS (HIV+ aware).[2] In addition, between 1,100 and 3,300 individuals are estimated to be HIV+ but undiagnosed.[3] Another estimated 5,590 HIV+ Mississippians did not access any medical care in 2010.[4] This proportion of the state's epidemic is not accounted for in the following modeling of the number of individuals who will transition over to Medicaid or subsidized private insurance under the Patient Protection and Affordable Care Act (ACA) because they are not currently receiving pharmaceutical treatment through the Ryan White program. Nonetheless, it is likely that nearly all will be newly eligible for either private or public insurance in 2014.

### THE RYAN WHITE PROGRAM IN MISSISSIPPI

The Ryan White program is a discretionary, federally funded program providing HIV-related services across the United States to those who do not have other means of accessing HIV/AIDS treatment and care. In 2010, Mississippi received $18,976,890 in Ryan White funding,[5] and served 4,717 duplicated clients.[6,7] About 75.8% of the state's Ryan White funds were Part B grants (awarded based on prevalence of HIV in the state).[8] Of these, 45.1% covered core medical services, and 52.4% went toward the AIDS Drug Assistant Program (ADAP).

### ADAP IN MISSISSIPPI

ADAP is a component of Ryan White (within Part B), that is also funded with matching state appropriations and covers the cost of antiretroviral therapy (ART) for enrollees. To be eligible for ADAP in Mississippi, one must be:

1. A Mississippi resident diagnosed with HIV;
2. Living at or below 400% of the federal poverty level (FPL); and
3. If new to ART, presenting with a CD4 count below 500, an AIDS defining illness, pregnancy,* hepatitis B coinfection, or HIV-associated nephropathy.[10]

In fiscal year 2010, Mississippi ADAP served 1,483 individuals.[11] The state's 2011 ADAP budget was $6,507,264, all of which came from federal funds.[12] In the previous fiscal year, Mississippi spent $7,533,479 on ADAP—100% of these funds were used to cover the cost of prescription drugs, with 94.6% of the funds being used for antiretroviral drugs.[13]

## THE ACA AND ITS IMPACT ON HIV+ MISSISSIPPIANS

### THE MEDICAID EXPANSION

Beginning in January 2014, the Patient Protection and Affordable Care Act (ACA) expands Medicaid eligibility to most individuals under 65 years of age living below 133% federal poverty level (FPL).[14,†] Although the Department of Health and Human Services (HHS) cannot force states to comply with the expansion (by withdrawing existing federal medical funding), the federal government will cover 100% of the cost of newly eligible beneficiaries until 2016, and at least 90% thereafter. Newly eligible enrollees will receive a base-benchmark benefits package that will include ten categories of essential health benefits (EHB), described in a following section.[15,16]

*Pregnant patients must first apply for Medicaid before accessing ADAP.

## THE BASIC HEALTH PLAN

The ACA also provides additional federal medical funding to states that create a Basic Health Plan (BHP), covering most individuals under 65 years of age living between 133-200% FPL as well as legal residents who do not qualify for Medicaid because of the 5-year residency requirement.[17] BHPs must cover at least the EHB and cannot exceed the cost-sharing or premiums imposed by a plan the individual would otherwise purchase on an exchange.[18] Cost sharing on BHPs can be subsidized, either for all beneficiaries or for those with specific chronic conditions (eg, HIV/AIDS).[19] The federal government is expected to pay up to 95% of the premium credits for individuals enrolled in a BHP.[20] In addition to improved affordability, BHPs can minimize "churning" on and off Medicaid as individuals fluctuate around 133% FPL. Because state Medicaid offices can design and manage BHPs, these individuals would more easily transition into a plan with similar provider networks and administrative procedures.

## SUBSIDIES FOR PRIVATE INSURANCE PREMIUMS, AND STATE-BASED INSURANCE EXCHANGES

The ACA requires states to establish state-run insurance exchanges, to partner with the federal government to set up a hybrid state-federal exchange, or to default into a federally facilitated exchange.[21] Insurance exchanges will provide individuals and families with a choice of plans, tiered by actuarial value of coverage (bronze, silver, gold, and platinum). Each plan available on an exchange must, at a minimum, adhere to a state-defined and federally approved list of essential health benefits; these benefits are discussed in the following section. All exchanges will be operational January 1, 2014.[22]

The ACA extends insurance premium credits to individuals and families living between 100-400% FPL, such that eligible families' and individuals' premium contributions will be limited to 2.0-9.8% of their income, and imposes out-of-pocket spending caps to protect healthcare consumers from medical bankruptcy.[23]

## ESSENTIAL HEALTH BENEFITS

The ACA requires both Medicaid and private health insurance plans sold on exchanges to provide certain EHB, to be defined by the Secretary of HHS.[24] EHB must include items and services within the following ten benefit categories[25]:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

HHS released a proposed rule that will define the scope of EHB on the private market, and will accept public comments before drafting final guidance.[26] The Centers for Medicare and Medicaid Services has indicated that the HHS rule on EHB will also apply to newly eligible Medicaid beneficiaries, in addition to the protections provided for under Social Security Act.[27] This means that benefits provided by Medicaid will likely be more robust than on the private market. For example, the Social Security Act requires that a Medicaid benchmark plan cover any US Food and Drug Administration–approved drugs with significant clinically meaningful therapeutic advantage over another.[28]

† Undocumented immigrants and lawfully residing immigrant adults who have been in the country 5 years or less will not be eligible for Medicaid coverage. Department Of Health And Human Serv. Office Of The Assistant Secretary For Planning And Evaluation, The Affordable Care Act: Coverage Implications And Issues For Immigrant Families, 7. *Available at* http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Coverage/ib.pdf.

## AN ESTIMATE OF CURRENT RYAN WHITE AND ADAP CLIENTS WHO WILL BE ELIGIBLE FOR MEDICAID OR INSURANCE CREDITS IN 2014

Given the ACA-instituted reforms, a large number of HIV+ Mississippians are expected to become eligible for Medicaid or a BHP in 2014, provided that Mississippi expands Medicaid and institutes a BHP. An estimated 89% of the state's Ryan White program clients in 2010 were living below 200% FPL, making them potentially eligible for either Medicaid or a BHP in 2014.[28,29] HIV+ Mississippians stand to gain significantly from the expansion of Medicaid and creation of private insurance subsidies. An estimated 68% of Mississippi's ADAP clients will be newly eligible for Medicaid, and 28.6% are estimated to be eligible for private insurance subsidies (see Appendix A). Finally, many of the estimated 5,590 HIV+ aware Mississippians who did not access care in 2010, as well as the undiagnosed, are likely to be eligible for Medicaid, a BHP, or subsidized private insurance in 2014.

The percentage of Mississippi's ADAP clients who will be newly eligible for Medicaid (68%) is higher than the national proportion of newly eligibles (29%) (see Appendix A). This is primarily because Mississippi's ADAP serves a larger proportion of individuals living below 133% FPL (approximately 72% of the state's ADAP clients were living below 133% FPL in 2011), but also because the state's ADAP clients are almost entirely uninsured.‡

The percentage of Mississippi's ADAP clients who are expected to qualify for private insurance subsidies (26%) is also higher than the national proportion of newly eligibles (15%) (see Appendix A), likely because a relatively large proportion of Mississippi's ADAP clients live between 134-400% FPL (28% of those on ADAP), and none live above 400% FPL.

# COMPARING SERVICES PROVIDED BY RYAN WHITE, ADAP, MEDICAID, AND THE EXCHANGE TO HIV+ MISSISSIPPIANS

Since a significant number of HIV+ individuals in Mississippi who are currently served by the Ryan White program or AIDS Drug Assistance Program (ADAP) will be eligible for Medicaid or subsidized private insurance in 2014, it is important to assess the implications of transitioning this population onto these types of coverage. This assessment compares and contrasts the services and treatments that the Ryan White program, ADAP, Medicaid, and Mississippi's expected base-benchmark plan currently or will provide to HIV+ Mississippians.

‡ 95% of Mississippi's ADAP clients were uninsured in 2011, while the remaining 5% were Medicare recipients. Mississippi ADAP covers HIV medications for individuals in the Medicare Part D coverage gap (the "donut hole") when funding is available, but does not assist with Part D premiums, deductibles, and copays. NASTAD, National ADAP Monitoring Project Annual Report, 2012, Table 13, *available at* http://prod.nastad.dotnet-web1.advansiv.com/Docs/021503_National%20ADAP%20Monitoring%20Project%20Annual%20Report%20-%20August%202012.pdf; Mississippi State Report, State Healthcare Access Research Project, 29-30, *available at* http://www.withinsightinitiative.org/pdfs/Mississippi_Full%20Report.pdf.

## COMPARING RYAN WHITE, MEDICAID, AND THE BASE-BENCHMARK PLAN FOR THE EXCHANGE IN MISSISSIPPI

The Ryan White program funds both core medical and support services for patients living with HIV (see Appendix C for a breakdown of core medical versus support services). Both medical and ancillary services are critical to maintaining the health of low-income individuals who may not have access to many necessities that affect access to HIV treatment and care (eg, transportation, child care, nutrition). However, Medicaid and Mississippi's base-benchmark plan, which will determine EHB for private insurance sold on the state's exchange, do not cover ancillary services (although they cover a broader range of medical services such as physician, lab/x-ray, and hospital services). Moreover, EHB requirements will not require coverage of these ancillary services on the private market. Accounting for the gaps between the Ryan White program and Medicaid or coverage sold on the exchange will be critical in transitioning Ryan White beneficiaries onto Medicaid or private insurance, while ensuring that health status does not deteriorate (eg, due to lack of proper nutrition, access to transportation to a health clinic, or stable housing).

Table 1 provides a comparison of covered services between Mississippi's Ryan White and Medicaid programs, as well as the largest small-group market plan in the state (the base-benchmark plan used for purposes of defining EHB).

### Table 1. Ryan White Versus Medicaid: Covered Services

Benefits applying only to beneficiaries under 21 years of age are not assessed in this report.

| Covered Service | Ryan White[29] | Medicaid[30] | BlueCross BlueShield of Mississippi Small-Group Plan[31] |
|---|---|---|---|
| Home Healthcare | | X (25 visits per year) | X |
| Mental Health | X | X | X (52 outpatient visits per year; 30 inpatient days per year) |
| Substance Abuse (Outpatient) | X | | X (20 visits per year) |
| Substance Abuse (Inpatient) | | | X (7 days per year) |
| Medical Case Management | X | X | |
| Community-Based Care | X (Only 1 organization in the state) | X (Must be disabled[§]) | |
| Ambulatory/Outpatient Care | X | X | X |
| Oral Healthcare | X | X (Emergency pain relief and palliative care only; $2,500 maximum per year) | |
| Early Intervention Clinic | X | | |
| Intermediate Care Facilities for the Mentally Retarded | | X | |
| Ambulance | | X (PA for urgent air) | X |
| Family Planning | | X | X |
| Durable Medical Equipment | | X (PA) | |
| Hospital Services | | X (30 days per year; 6 visits per year; PA for inpatient and swing bed services) | X |

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[§] Eligible individuals can receive community-based care through the Home and Community-Based Services Waiver for the Elderly and Disabled. To qualify for this waiver, an individual must 1) be 21 years or older; 2) qualify by either SSI or 300% of SSI; 3) score 50 or above on the Medicaid long-term care Pre-Admission Screening (PAS) instrument; and 4) require nursing facility level of care, if assistance is not provided. Mississippi Division of Medicaid, *available at* http://www.medicaid.ms.gov/pamphlets/elderlyanddisabledhcbs.pdf.

**Table 1.**

| | | | |
|---|---|---|---|
| Lab and X-ray Services | | X | X (Excludes hearing exams) |
| Vision Care | | X | |
| Nursing Facility | | X | |
| Private Duty Nursing | | | |
| Nurse Practitioner Services | | X | X |
| Physician Services | | X | X |
| Nonmedical Case Management Services | X | X (Must be disabled**) | |
| Child Care | X (Only 1 organization in the state) | | |
| Emergency Financial Assistance | X | | |
| Food Bank/Home-Delivered Meals | X | | |
| Housing Services | X | | |
| Health Education/Risk Reduction | X | | |
| Legal Services | | | |
| Linguistics Services | X | | |
| Nonemergency Medical Transportation | X | X | |
| Outreach Services | X | | |
| Psychosocial Support | X | | |
| Referral Agencies | X | | |
| Treatment Adherence Counseling | X | | |
| Chiropractor | | X ($700 max per year) | X (20 visits per year) |
| Podiatry | | X | X (1 visit per year for routine foot care) |
| Hospice | | X (Requires diagnosis of ≤6 months life expectancy) | X (6-month limit per lifetime) |
| Respiratory Therapy | | | |
| PT, OT, and Speech Therapy | | X (PA; outpatient only) | X |
| Orthotics and Prosthetics | | | |

OT = occupational therapy; PA = prior authorization; PT = physical therapy.

As Table 1 indicates, Ryan White offers HIV+ individuals a number of ancillary services that Medicaid and Mississippi's base-benchmark plan do not cover (eg, risk reduction education, psychosocial support and outreach services, childcare, referral services, and housing assistance). Since these ancillary services are often critical to linkage to and retention in care, those individuals who leave the Ryan White program for Medicaid or private insurance plans are likely to be at a disadvantage if wrap-around Ryan White services do not continue to be available. (Proposed federal rules indicate that these services will not be requisite EHB).††

** Covered via Elderly and Disabled and Independent Living waivers, which provide home and community-based services to people who 1) qualify by either SSI or 300% of SSI; 2) score 50 or above on the Medicaid long-term care Pre-Admission Screening (PAS) instrument; and 3) require nursing facility level of care if assistance is not provided. See Mississippi Division of Medicaid, *Elderly and Disabled Waiver*, *available at* http://www.medicaid.ms.gov/pamphlets/elderlyanddisabledhcbs.pdf and *Independent Living Waiver*, http://www.medicaid.ms.gov/pamphlets/independentlivingwaiverpamphlet.pdf (*last visited* November 1, 2012).

*** Letter from Cindy Mann, Director, Centers for Medicare and Medicaid Services, to State Medicaid Director (November 26, 2012).

†† 45 C.F.R. pts. 144, 147, 150, et al. (proposed November 26, 2012).

## COMPARING ADAP, MEDICAID, AND THE BASE-BENCHMARK PLAN FOR THE EXCHANGE IN MISSISSIPPI

ADAP provides funding for a robust drug formulary that is necessary to afford low-income individuals access to a combination of drugs to treat HIV. All states participating in ADAP must cover at least one drug in every class of antiretroviral therapy (ART); most cover almost all drugs in each class. Ensuring that Medicaid and plans sold on the exchange provide coverage for a sufficient number of antiretroviral medications will be critical to maintaining the health of Mississippians living with HIV, as ADAP clients transition onto these plans.

Table 2 provides a comparison of the antiretroviral drug formularies included in the state's ADAP and Medicaid programs, as well as the largest small-group market plan in the state (the base-benchmark plan used for purposes of defining EHB for plans sold on an exchange). The Medicaid column only refers to services and prescription drugs covered by the Medicaid program operated by Mississippi Division of Medicaid. Mississippi Medicaid also has two managed care plans, which will be discussed later in the report. Medicaid available to newly eligibles will likely have a very robust drug formulary, although utilization management will be permissible.[***]

### Table 2. ADAP Versus Medicaid and the Base-Benchmark Plan: Covered Drugs

Benefits applying only to beneficiaries under 21 years of age are not assessed in this report.

| **Drugs** (ART class indicated in bold; brand name in normal type; generic in italics) | **ADAP[33]** | **Medicaid[34,††]** | **BlueCross BlueShield of Mississippi Small Group Plan[35]** |
|---|---|---|---|
| **Multiclass Combination Drugs** | **2 Drugs Covered** | **3 Drugs Covered** | **2 Drugs Covered** |
| Atripla; *efavirenz + emtricitabine + tenofovir DF* | X | X | X ($25-$35 copay) |
| Complera; *emtricitabine + rilpivirine + tenofovir disoproxil fumarate* | X | X | X ($25-$35 copay) |
| Stribild; *elvitegravir + cobicistat + emtricitabine + tenofovir disoproxil fumarate* | | X | |
| **Entry Inhibitors - CCR-5 Coreceptor Antagonist** | **1 Drug Covered** | **1 Drug Covered** | **1 Drug Covered** |
| Selzentry; *maraviroc* | X (Requires trofile test indicating effectiveness) | X | X ($25-$35 copay) |
| **Fusion Inhibitors** | **1 Drug Covered** | **1 Drug Covered** | **1 Drug Covered** |
| Fuzeon; *enfuvirtide* | X (Step therapy required) | X[‡‡] | X ($25-$35 copay) |
| **HIV Integrase Strand Transfer Inhibitors** | **1 Drug Covered** | **1 Drug Covered** | **1 Drug Covered** |
| Isentress; *raltegravir* | X | X | X ($25-$35 copay) |
| **NNRTIs** | **4 Drugs Covered** | **5 Drugs Covered** | **5 Drugs Covered** |
| Edurant; *rilpivirine* | X | X | X ($25-$35 copay) |
| Intelence; *etravirine* | X (Step therapy required) | X | X ($25-$35 copay) |
| Rescriptor; *delavirdine mesylate* | | X | X ($25-$35 copay) |
| Sustiva; *efavirenz* | X | X | X ($25-$35 copay) |
| Viramune; *nevirapine* | X | X | X ($25-$35 copay) |

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[***] Letter from Cindy Mann, Director, Centers for Medicare and Medicaid Services, to State Medicaid Director (November 26, 2012).

[††] The rebate program has a listing of participating manufacturers *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Rebate-Program.html. If the manufacturer of each drug was listed as participating in the program, then the drug was listed in Table 2 as covered under Mississippi Medicaid.

[‡‡] As discussed in the Managed Care section, only one of Mississippi's two managed care plans, UnitedHealthPlan, appears to cover Fuzeon.

**Table 2.**

| NRTIs | 11 Drugs Covered | 12 Drugs Covered | 11 Drugs Covered |
|---|---|---|---|
| Combivir; *zidovudine + lamivudine* | X | X | X ($25-$35 copay) |
| Emtriva; *emtricitabine* | X | X | X ($25-$35 copay) |
| Epivir; *lamivudine* | X | X | X ($25-$35 copay) |
| Epzicom; *abacavir sulfate* | X | X | X ($25-$35 copay) |
| Retrovir; *zidovudine* | X | X | X ($100 for Retrovir; $10-$15 copay for zidovudine) |
| Trizivir; *abacavir + zidovudine + lamivudine* | X | X | X ($25-$35 copay) |
| Truvada; *tenofovir DF + emtricitabine* | X | X | X |
| Videx; *didanosine (buffered versions)* | | X | |
| Videx EC; *didanosine (delayed-release capsules)* | X | X | X ($100 copay for Videx EC; $10-$35 copay for didanosine) |
| Viread; *tenofovir disoproxil fumarate DF* | X | X | X ($25-$35 copay) |
| Zerit; *stavudine* | X | X | X ($100 copay for Zerit; $25-$35 copay for stavudine) |
| Ziagen; *abacavir* | X | X | X ($25-$35 copay) |
| **Protease Inhibitors** | **9 Drugs Covered** | **10 Drugs Covered** | **9 Drugs Covered** |
| Agenerase; *amprenavir* | | X | |
| Aptivus; *tipranavir* | X | X | X ($25-$35 copay) |
| Crixivan; *indinavir sulfate* | X | X | X ($25-$35 copay) |
| Invirase; *saquinavir mesylate* | X | X | X ($25-$35 copay) |
| Kaletra; *lopinavir + ritonavir* | X | X | X ($25-$35 copay) |
| Lexiva; *fosamprenavir* | X | X | X ($25-$35 copay) |
| Norvir; *ritonavir* | X | X | X ($25-$35 copay) |
| Prezista; *darunavir* | X | X | X ($25-$35 copay) |
| Reyataz; *atazanavir sulfate* | X | X | X ($25-$35 copay) |
| Viracept; *nelfinavir sulfate* | X | X | X ($25-$35 copay) |

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[‡‡] As discussed in the Managed Care section, only one of Mississippi's two managed care plans, UnitedHealthPlan, appears to cover Fuzeon.

**Table 2.**

| "A1" Opportunistic Infection Medications | 15 Drugs Covered | 29 Drugs Covered | 29 Drugs Covered |
|---|---|---|---|
| Ancobon; *flucytosine* | | X (PA)[§§] (History of at least 1 claim for 2 different preferred oral antifungals in the past 6 months) | X ($50-$75 copay) |
| Bactrim DS; *sulfamethoxazole/trimethoprim DS* | X | X | X ($100 for Bactrim DS; $10-$15 copay for sulfamethoxazole/ trimethoprim DS) |
| Biaxin; *clarithromycin* | X | X | X ($100 copay for Biaxin; $10-$15 copay for clarithromycin) |
| Cleocin; *clindamycin* | X | X (Preferred drug) | X ($100 copay) |
| Dapsone | X | X (PA) (Acne agents authorized only for those under 21 years of age) | X ($25-$35 copay) |
| Daraprim; *pyrimethamine* | X | X | X ($25-$35 copay) |
| Deltasone; *prednisone* | | X | X (Prednisone only; $25-$35 copay) |
| Diflucan; *fluconazole* | X | X (PA) (History of at least 1 claim for 2 different preferred oral antifungals in the past 6 months) | X ($100 copay) |
| Famvir; *famciclovir* | | X (PA) | X ($100 copay for Famvir; $10-$15 for foscarnet) |
| Foscavir; *foscarnet* | | X | X ($25-$35 copay) |
| Fungizone; *amphotericin B* | | X | X (Amphotericin B only; $25-$35 copay) |
| INH; *isoniazid* | | X | X (Isoniazid only; $10-$35 copay) |
| Megace; *megestrol* | | X | X ($100 copay) |
| Mepron; *atovaquone* | | X | X ($25-$35 copay) |
| Myambutol; *ethambutol* | X | X | X ($25-$35 copay) |
| Mycobutin; *rifabutin* | X | X | X ($25-$35 copay) |
| Nebupent; *pentamidine* | X | X | X ($25-$35 copay) |
| Probenecid | | X (Preferred drug) | X ($100 copay) |

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[§§] Though Mississippi Medicaid covers most prescription drugs manufactured by a company that has signed a drug rebate agreement, Medicaid maintains a preferred drug list (PDL) with preferred drugs and nonpreferred drugs. Nonpreferred drugs are still available, subject to completion of a PDL Exception form and a higher copay. This list of preferred and nonpreferred drugs is not a complete list of all drugs available on Medicaid. If a drug class is not included on the PDL and is not one of the standard exceptions to coverage noted in the footnote above, then the drugs are covered without prior authorization. Drugs in the HIV class, and many of the drugs used to treat HIV-related opportunistic infections, are not included on the PDL, as either preferred or nonpreferred drugs and do not require prior authorization. Where noted on the chart, some drugs used to treat opportunistic infections are considered nonpreferred drugs and thus require prior authorization. For a list of preferred and nonpreferred drugs, see Mississippi Division of Medicaid, Preferred Drug List, *available at* http://www.medicaid.ms.gov/Documents/Pharmacy/PreferredDrugList.pdf

**Table 2.**

| | | | |
|---|---|---|---|
| Procrit; *epoetin alfa* | | X (Preferred drug) | X ($100 copay) |
| Pyrazinamide (PZA) | | X | X ($10-$15 copay) |
| Sporanox; *itraconazole* | | X (PA) (Diagnosis of HIV in the past 2 years; history of a transplant in the past 2 years; or history of an immunosuppressant in the past 6 months) | X ($50-$100 copay) |
| Sulfadiazine – Oral | X | X | X ($25-$35 copay) |
| Valcyte; *valganciclovir* | X | X | X ($25-$35 copay) |
| Valtrex; *valacyclovir* | X | X (PA) | X ($100 copay for Valtrex; $25-$35 copay for valacyclovir) |
| VFEND; *voriconazole* | | X (PA) (History of at least 1 claim for 2 different preferred oral antifungals in the past 6 months) | X ($100 copay) |
| Vistide; *cidofovir* | | X | X ($25-$35 copay) |
| Wellcovorin; *leucovorin* | | X | X (Leucovorin only; $10-$75 copay) |
| Zithromax; *azithromycin* | X | X (PA) | X ($50-$75 copay) |
| Zovirax; *acyclovir* | X | X (PA) | X ($100 copay for Zovirax; $10-$15 copay for acyclovir) |

ADAP = AIDS Drug Assistance Program; ART = antiretroviral therapy; NNRTI = non-nucleoside reverse transcriptase inhibitors; NRTI = nucleoside reverse transcriptase inhibitors; PA = prior authorization.

As Table 2 indicates, Medicaid covers a large number of prescription drugs, with most HIV-related drugs not requiring prior authorization. However, Mississippi's Medicaid program has a monthly limit of 5 drugs per month with no more than 2 brand name drugs for adult noninstitutionalized beneficiaries. Although HIV medications do not count toward the brand name limit, they do count toward total monthly limits. There are no monthly limit overrides.[36,37]

Because management of HIV/AIDS diagnoses may require many and varied prescription drugs, Medicaid's strict prescription drug limit risks leaving HIV+ individuals without coverage for essential drugs needed for treatment. Because Mississippi's ADAP does not currently provide gap coverage for Medicaid beneficiaries, HIV+ Mississippians on Medicaid may lack comprehensive ART and treatment for HIV-related infections despite being insured. In these situations, it is critical that ADAP be able to serve as a payer of last resort.

The formulary for Mississippi's base-benchmark plan—BlueCross BlueShield Small-Group Plan—is roughly equivalent to the state's ADAP formulary for most classes of HIV/AIDS drugs. However, Mississippi's base-benchmark plan covers a far greater number of drugs to treat opportunistic infections than does Ryan White. Moreover, proposed federal rule indicates that plans on the individual and small group market must cover at least as many drugs per class as covered by the benchmark plan.[†††] Thus, individuals transitioning into private insurance on the exchange face the prospect of expanded prescription drug coverage, with no loss of vital medications. On the other hand, the exchange base-benchmark plan imposes significant cost-sharing on beneficiaries.[***] For low-income individuals living with HIV, filling multiple prescriptions with copays ranging from $10-$100 each may become cost-prohibitive. ADAP will remain necessary as a payer of last resort in such scenarios.

[***] BlueCross BlueShield of Mississippi employer-based plans (including the small-group plan) include four categories of prescription drugs. Each category has a different copay amount (ranging from $10-$100).

[†††] 45 C.F.R. pts. 144, 147, 150, et al. (proposed November 26, 2012).

## MEDICAID MANAGED CARE PROFILE

In 2011, Mississippi's Division of Medicaid initiated a coordinated care program, the Mississippi Coordinated Access Network (MississippiCAN), covering 49,341 Medicaid beneficiaries as of May 2012,[38] but soon to cover 45% of the state's Medicaid population (eg, disabled adults, individuals on SSI or TANF).[39,40] Thus, some newly eligible HIV+ Mississippians may be enrolled in MississippiCAN, either through Magnolia Health Plan or UnitedHealthCare's coordinated care organizations (CCOs). CCOs are required to maintain a preferred drug list and a prior authorization process that are no more restrictive by drug class than those used by the Division of Medicaid.[41] Thus, HIV+ individuals are guaranteed coverage of at least some HIV drugs from each class under managed care programs. For example, Magnolia Health Plan offers coverage of 6 prescription drugs a month, in comparison to Medicaid and UnitedHealthPlan's coverage of only 5 drugs a month.[42]

The HIV drug formularies for Mississippi's two coordinated care programs cover fewer drugs than are offered by regular Medicaid. However, the CCOs' coverage of ART is roughly comparable to that of Medicaid, with a few notable exceptions. Magnolia Health Plan's HIV drug formulary[43] currently includes all protease inhibitors listed in Table 2, while UnitedHealthPlan includes all protease inhibitors but Agenerase.[44] Both plans cover all NRTIs listed in Table 2 (Retrovir, Videx EC, and Zerit are only covered in their generic form under Magnolia). Magnolia covers all the five NNRTIs listed in Table 2, while UnitedHealthPlan covers all but Edurant. Further, Magnolia covers two multiclass combination drugs (Atripla and Complera) while UnitedHealthPlan covers only Atripla. Both plans cover Selzentry and Isentress, while only UnitedHealthPlan lists Fuzeon as a covered fusion inhibitor.[45]

Both CCOs offer slightly less comprehensive coverage of A1 drugs than does regular Medicaid. UnitedHealthPlan covers all drugs to treat opportunistic infections listed in Table 2 except for Foscavir, Fungizone, and Vistide (Sporanox, Deltasone, and Wellcovorin are covered only in generic form). Meanwhile, Magnolia Health Plan's coverage is more limited, excluding coverage of Ancobon, Famvir, Foscavir, Fungizone, Procrit, Vfend, and Vistide. Furthermore, Magnolia only covers the following drugs in generic form: Cleocin, Diflucan, INH, Megace, Myambutol, Sporanox, Wellcovorin, Zithromax, and Zovirax.[46]

## COMMUNITY HEALTH CENTERS

The ACA has provided Mississippi with $49,784,983 to fund new and existing community health centers.[47] These federally supported centers have served over 314,612 individuals, 94% of whom live below 200% FPL. The centers are a vital source of care for vulnerable Mississippians, serving a combined 34% of Mississippi's low-income uninsured population and reaching out particularly to underserved rural populations (72% of community health center patients live in rural parts of the state).[48] All Community Health Centers in Mississippi (21 organizations and 188 delivery sites as of 2010) provide primary care services, and 90% provide HIV testing and counseling.[49] Two Community Health Centers have also been designated as AIDS Education Training Centers (AETC), through the National Centers for HIV Care in Minority Communities' HIV in Primary Care Learning Community initiative, which aims to help these centers expand primary care services to cover the needs of people living with HIV.[50] Medicaid expansion in Mississippi should strive to integrate these community health centers into the new roster of available service providers and to use community-based models to inform the expansion of programs available for HIV/AIDS patients. In particular, the AETC centers, which are sensitive to the needs of minority HIV/AIDS patients, are models for expansion of HIV/AIDS services in minority-dominant rural areas, such as the Mississippi Delta.

# CONCLUSIONS AND NEXT STEPS

This report provides analyses of the Ryan White program, the AIDS Drug Assistance Program (ADAP), Medicaid, and essential health benefits (EHB) under the Patient Protection and Affordable Care Act (ACA), enumerating the benefits covered under each, and the implications of transitioning individuals living with HIV onto Medicaid or private insurance. This report is intended to assist law makers in implementing the ACA in a manner that serves the needs of Mississippians.

While much of the ACA has yet to be implemented, it is certain that a large number of people living with HIV will be newly eligible for Medicaid under the law's income eligibility standard (extending eligibility to individuals living under 133% of the federal poverty level). Given that a significant proportion of uninsured ADAP clients would transition into Medicaid in Mississippi, implementing the ACA's expansion option is crucial to ensuring access to care and reducing transmission of HIV across the state. In other words, expanding Medicaid is the state's only currently available option to provide access to treatment for the thousands of HIV+ individuals in the state who currently lack access to care.

In that vein, the Medicaid system must be ready and able to handle the needs of low-income people who are HIV+. Should Mississippi elect to expand its Medicaid program, this report provides an initial analysis of the capacity of the program to handle the needs of this influx of individuals living with HIV. As such, an analysis of the barriers to care that this population is likely to face (based on the existing Medicaid program) is timely as states prepare for the transition to Medicaid. Comparing current Ryan White and ADAP programs with existing Medicaid formularies allows for a baseline analysis of the needs of individuals living with HIV moving into the Medicaid system. This report identified two challenges:

1. First, a number of services that are currently provided by the Ryan White program are not available under the state's current Medicaid program. HIV+ individuals who shift from the Ryan White program into Medicaid are therefore likely to have trouble accessing a number of services currently available to them.
2. Second, limitations in the quantity of prescriptions covered for Medicaid beneficiaries may pose challenges for individuals in need of multiple prescriptions. Those living with HIV are likely to exceed the maximum allowable number of monthly prescriptions covered by Medicaid.

It is essential that private insurance plans on the Mississippi exchange provide a comprehensive scope of services that is sufficient to meet the needs of Ryan White clients who transition into these plans. This report identified two challenges with respect to the state's base-benchmark plan, which will be used to define EHB for private insurance plans:

1. First, a number of services that are currently provided by the Ryan White program are not available under Mississippi's default base-benchmark plan. HIV+ individuals who shift from the Ryan White program to private insurance plans on the exchange are therefore likely to have trouble accessing a number of vital services currently available to them.
2. Second, the prescription drug list for HIV+ individuals under Mississippi's base-benchmark plan is more comprehensive than the state's ADAP formulary, but it contains significant copay requirements for each medication, creating potential hardship on individuals requiring extensive medications for treatment. Identifying ways to reduce these financial burdens on HIV+ individuals will ensure that the insurance plans on the state exchange adequately serve the needs of people living with HIV.

There will remain an ongoing demand for Ryan White and ADAP services to fill coverage or affordability gaps created by Medicaid or private health insurance plans. Identifying these gaps and structuring these programs is not only fiscally prudent but also necessary to secure the health of Mississippians.

In conclusion, this report makes clear that two factors will be essential to successfully implementing the ACA in a way that reduces the burden of HIV on the state:

1. Mississippi must adopt the Medicaid expansion, pursuant to the ACA, extending eligibility to all individuals living under 133% FPL in order to slow the transmission of HIV and make treatment accessible to thousands of individuals who currently lack care; and
2. Mississippi must ensure that Ryan White and ADAP services are available where Medicaid or private insurance coverage or affordability gaps exist (eg, prescription drug limits, transportation, nonmedical case management, nutrition, or prohibitive cost-sharing).

**Questions may be directed to Katherine Record, krecord@law.harvard.edu.**

# APPENDIX A

## 2014 STATE-SPECIFIC ESTIMATES

### Medicaid Estimates

The Patient Protection and Affordable Care Act (ACA) directs states to extend Medicaid eligibility to all individuals living below 133% of the federal poverty level (FPL), and offers a 100% federal matching rate for these newly eligible individuals (those who were not otherwise eligible for Medicaid but for the new law).

To estimate the number of individuals currently using ADAP who will be eligible for Medicaid in 2014, the following formula was used:

| | | |
|---|---|---|
| | **Total #** | ADAP clients being served in fiscal year 2010[51] |
| – | **est. #** | ADAP clients with income above 133% FPL[52, †††] |
| – | **est. #** | insured ADAP clients with income below 133% FPL |
| – | **est. #** | ADAP clients who are undocumented immigrants with incomes below 133% FPL in June 2011[53] |
| = | **Total #** | ADAP clients who will be newly eligible for Medicaid in 2014[‡‡‡] |

Mississippi's ADAP served 1,483 clients in 2010. Of those, we estimate that 415.24 (28%) have income above 133% FPL. We also estimate that there were 47.65 insured ADAP clients with income below 133% FPL. Approximately 1% of the state population was undocumented as of 2008 (amounting to approximately 12.57 ADAP clients with income below 133% FPL). Thus, the calculation for Mississippi is:

| | | |
|---|---|---|
| | **1,483** | ADAP clients served in fiscal year 2010 |
| – | **415.24** | ADAP clients with income above 133% FPL |
| – | **47.65** | insured ADAP clients with income below 133% FPL |
| – | **12.57** | undocumented immigrants with incomes below 133% FPL in June 2011 |
| = | **1,008** | ADAP clients who will be newly eligible for Medicaid in 2014; or 52.6% of ADAP clients served in fiscal year 2010 |

††† In order to estimate the number of ADAP clients in any income group, we apply the percentage of clients served in each income group (acquired from Table 13 of the 2012 NASTAD Report) to the number of clients served in fiscal year 2010 (acquired from Table 8 of the same report).

‡‡‡ The final number is an estimate based on figures largely taken from 2010-2011.

This calculation was done similarly for all 21 states and the District of Columbia (DC). The results of the calculations are:

| State | # ADAP Clients Who Will Be Newly Eligible for Medicaid | % ADAP Clients Who Will Be Newly Eligible for Medicaid |
|---|---|---|
| Alabama | 1,345 | 76% |
| Arkansas | 299 | 53% |
| California | 12,274 | 31% |
| DC | 1,124 | 41% |
| Florida | 7,321 | 51% |
| Georgia | 3,075 | 52% |
| Illinois | 4,374 | 68% |
| Kentucky | 619 | 42% |
| Louisiana | No data available | No data available |
| Maryland | 1,394 | 22% |
| Massachusetts | 1,400 | 21% |
| Mississippi | 1,008 | 68% |
| New Jersey | 2,101 | 29% |
| New York | 4,233 | 20% |
| North Carolina | 3,476 | 62% |
| Ohio | 1,287 | 37% |
| Pennsylvania | 1,334 | 22% |
| South Carolina | 1,428 | 39% |
| Tennessee | 2,505 | 60% |
| Texas | 8,797 | 53% |
| Virginia | 2,690 | 66% |
| Wisconsin | 696 | 40% |
| **United States** | **62,971** | **29%** |

Note: Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report. [54] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 100% for Maryland and Ohio.).

The percentages of ADAP clients who will be newly eligible for Medicaid in 2014 vary considerably from state to state. These differences can be explained by the different eligibility standards currently in place for ADAP eligibility within each state, as well as by the differences in estimated percentages of undocumented immigrants in each state. For instance, states with higher than average newly eligible Medicaid beneficiaries may currently require that ADAP recipients have no other sources of insurance (eg, Virginia). On the other hand, states with lower than average newly eligibles have higher insurance rates all around (eg, Massachusetts) or other public assistance programs that supplement ADAP. In sum, this report does not capture all groups of people living with HIV who may be eligible for Medicaid in 2014.

## Private Insurance Subsidy Estimates

To estimate the number of people currently using ADAP who will be eligible for private insurance subsidies through health insurance exchanges, the following formula was used:

| | | |
|---|---|---|
| | **Total #** | ADAP clients being served in fiscal year 2010[55] |
| – | **est. #** | ADAP clients living below 133% FPL[56,§§§] |
| – | **est. #** | ADAP clients living above 400% FPL[57] |
| – | **est. #** | ADAP clients living between 133-400% FPL[58] |
| – | **est. #** | ADAP clients who are undocumented immigrants living between 133-400% FPL[59] |
| = | **Total #** | ADAP clients who will be newly eligible for subsidized private insurance |

[§§§] In order to estimate the number of ADAP clients in any income group, we apply the percentage of clients served in each income group (acquired from Table 13 of the 2012 NASTAD Report) to the number of clients served in fiscal year 2010 (acquired from Table 8 of the same report).

Mississippi's ADAP served 1,483 clients in 2010. Of those, we estimate that 1,067.76 (72%) of ADAP clients are living below 133% FPL (there are no ADAP clients in the state with income above 400% FPL). This leaves 28% (415) of ADAP clients living between 133-400% FPL. We also estimate that there were 26 insured ADAP clients living between 133-400% FPL. Approximately 1% of the state's population was undocumented as of 2008. Thus, the calculation for Mississippi is:

| | | |
|---|---|---|
| | **1,483** | ADAP clients being served in June 2011 |
| – | **1,067.76** | ADAP clients with incomes below 133% FPL or above 400% FPL |
| – | **26** | estimated insured ADAP clients with incomes between 133-400% FPL |
| – | **4.89** | uninsured undocumented immigrants with incomes between 133-400% FPL in June 2011 |
| = | **384** | ADAP clients who will be eligible for insurance subsidies in 2014; or 26% of ADAP clients being served in fiscal year 2010. |

This calculation was done similarly for all 21 states and DC. The results of the calculations are:

| State | # ADAP Clients Who Will Be Newly Eligible for Private Insurance Subsidies | % ADAP Clients Who Will Be Newly Eligible for Private Insurance Subsidies |
|---|---|---|
| Alabama | 305 | 17% |
| Arkansas | 147 | 26% |
| California | 8,580 | 22% |
| DC | 829 | 30% |
| Florida | 4,134 | 29% |
| Georgia | 1,404 | 24% |
| Illinois | 1,127 | 17% |
| Kentucky | 269 | 18% |
| Louisiana | No data available | No data available |
| Maryland | 1,726 | 28% |
| Massachusetts | 932 | 14% |
| Mississippi | 384 | 26% |
| New Jersey | 1,879 | 26% |
| New York | 4,502 | 21% |
| North Carolina | 621 | 11% |
| Ohio | 901 | 26% |
| Pennsylvania | 1,567 | 26% |
| South Carolina | 1,091 | 30% |
| Tennessee | 1,531 | 37% |
| Texas | 4,301 | 26% |
| Virginia | 896 | 22% |
| Wisconsin | 401 | 23% |
| **United States** | **32,758** | **15%** |

Note: Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[60] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 100% for Maryland and Ohio.)

## METHODOLOGY FOR DISTRIBUTION OF INSURED ADAP CLIENTS BY INCOME

Estimating the proportion of insured ADAP clients falling into each income bracket required several steps:

1. The percentage of adults living below 133% FPL, between 133-400% FPL, and above 400% FPL in each state who are insured was determined using data available at the Kaiser Family Foundation's STATEHEALTHFACTS.ORG website. The website lists insurance status for people beginning at 139% FPL instead of 133% FPL, but because of the ACA's 5% income disregard, the Medicaid expansion applies to all individuals living below 138% FPL, making this distinction irrelevant. The website also divides the 133-400% FPL income group into two groups: 133-250% FPL and 251-399% FPL. The number of insured adults and the total number of adults in these two groups were pooled in order to determine the percentage of adults living between 133-400% FPL who are insured.

   In Mississippi, 54% of adults living below 133% FPL are insured; 77% of adults living between 133-400% FPL are insured; and 81% living above 400% FPL are insured;

2. Next, the likelihood of an adult in each of the three income groups being insured—relative to the likelihood of being insured in the other income groups—was determined. To do this, the figure for the insurance rate for adults living below 133% FPL was given the baseline number 1, and the insurance rates for the other income groups were calculated to be multiples of this baseline.

   In Mississippi, the figure 54% was given the baseline number 1. 77% is 1.4 times 54%, and 81% is 1.5 times 54%. Thus, in other words, an adult in Mississippi with income between 133-400% FPL is 1.4 times more likely to be insured than an adult with income below 133% FPL, while an adult with income above 400% FPL is 1.5 times more likely to be insured;

3. Next, the number of insured ADAP clients in each state was calculated, by referring to Tables 8 and 14 of the 2012 NASTAD National ADAP Monitoring Project Report (the 2012 NASTAD Report).[61] Table 8 lists the total number of ADAP clients served in each state in 2010. Using this number and applying to it the percentage of ADAP clients who are insured in each state (Table 14), it is possible to estimate the number of insured ADAP clients in each state.

   In Mississippi, we estimated that about 74 of the state's 1,483 ADAP clients served in 2010 were insured. The insurance rate for ADAP clients in that state stood at 5% in 2011;

4. In order to proportionately divide the number of insured ADAP clients among the three income groups listed in these steps, the percentage of a state's ADAP clients who fall in each income group was required. Table 13 of the 2012 NASTAD Report shows the percentage of ADAP clients in most states who have income below 133% FPL, income between 133-400% FPL, and income above 400% FPL.

   In Mississippi, 72% of ADAP clients are living below 133% FPL, 28% are living between 133-400% FPL, and none are living above 400% FPL; and finally

5. The number of insured ADAP clients in each income group in a state was viewed as a product of the relative likelihood of being insured (determined previously), the relative proportion of clients in that income group among the total clients (based on the percentage of ADAP clients in each income group), and a weighing factor called *a*.

   We relied on two formulas:

   **Formula 1:**

   Number of insured clients in each group
   = (relative likelihood of being insured)
   x (proportion of income group)
   x *a*

   **Formula 2:**

   Total number of insured ADAP clients
   = (number of insured clients living below 133% FPL)
   + (number of insured clients living between 133-400% FPL)
   + (number of insured clients living above 400% FPL)

Thus, for Mississippi:

74
= (1 x 0.72 x *a*)
+ (1.42 x 0.28 x *a*)
+ (1.50 x 0 x *a*)

Solving for *a*,

*a* = 66.2

Applying the value of *a* determined above to Formula 1:

The estimated number of insured ADAP clients in Mississippi with,

Income below 133% FPL = 48
Income between 133-400% FPL = 26
Income above 400% FPL = 0

These figures were applied to the general calculations estimating the number of ADAP clients who will be eligible for Medicaid or private insurance subsidies.

# APPENDIX B

## DATA COLLECTION METHODOLOGY

In the interest of consistency between state profiles, and to ensure that data among states are comparable, data sources that provide information for all 21 states and the District of Columbia (DC) were prioritized. More recent or more detailed data available for a particular state have also been included.

### Ryan White Program Data

Demographic information about Ryan White program clients was culled from a number of sources. For the sake of continuity, the Federal Health Resources and Services Administration (HRSA) 2010 State Profiles were used for data about the Ryan White program. Where available, information from state departments of health has also been included. Demographic information for AIDS Drug Assistance Program (ADAP) clients is most thoroughly documented by the National Alliance of State and Territorial AIDS Directors (NASTAD), and information from that organization has been provided for income and insurance status of ADAP clients. NASTAD's data for fiscal years 2010 and 2011 and June 2011 were used (fiscal year 2010 was necessary for states that did not report data in 2011). Because ADAP data compiled by NASTAD are unduplicated (ie, patients are not double-counted by multiple providers), it is one of the most reliable sources of information about demographic information for people living with HIV. Data from June 2011 provide information on how many people living with HIV currently enrolled in ADAP live between 100-133% of the federal poverty level (FPL). Since the expansion of Medicaid eligibility to those living under 133% FPL is a new development, there is a relative dearth of data regarding the number of HIV+ individuals currently living between 100-133% FPL. NASTAD provides the only reliable source of these data to date. NASTAD's ADAP information was used for estimates regarding people living with HIV who are newly eligible for Medicaid in 2014 at the end of this report. Information available from state departments of health or HRSA has also been provided.

Estimates of unmet need for people living with HIV in each state are available in each state's Statewide Coordinated Statement of Need (SCSN). SCSNs must be provided by all states receiving Ryan White program funding, but different states provide SCSNs in different years, so comparability among states is limited. Information about unmet need available from other sources has also been included.

Information on current services covered by the Ryan White program is available from HRSA and the SCSNs, and these data have been included in each state profile. More detailed information was included in the profiles if it was available.

Income thresholds for ADAP eligibility, cost-containment measures in each state, and ADAP formularies are available from a variety of sources. The most common sources for this information are MEDICARE.GOV, Kaiser Family Foundation, and NASTAD's *ADAP Watch* publication. This information has been included for every state and standardized to the extent possible among states.

Ryan White program budget allocations are also available from a number of sources, and information from the Kaiser Family Foundation has been included in every profile for the sake of consistency among states. ADAP budget information is available from NASTAD, including the fiscal year 2011 total budget, and a breakdown of expenditures. This information is provided in each state profile. Kaiser Family Foundation's information on ADAP expenditures has also been included for information on the amount spent by ADAP programs on insurance assistance and full prescription coverage.

### Medicaid Coverage Data

Services currently covered by Medicaid and their limitations are detailed by state departments of health and state Medicaid manuals. Amounts of information available and levels of detail differ among states, and detailed information is provided in the profiles where available. The focus in each profile is on services most relevant to people living with HIV, as well as limitations that may impede access to needed services.

### Community Health Center Data

Community health center (CHC) information is standardized across the states studied and has been acquired from HEALTHCARE.GOV, published about HRSA Health Center Planning Grant Awards, state health center fact sheets, and the National Center for HIV Care in Minority Communities. In providing information about CHCs, the focus in each profile is on the amount of money invested in these centers and the services most relevant to people living with HIV.

### Medicaid Managed Care Data

Information on Medicaid managed care programs in each state varies widely. While some state departments of health detail minutely the various aspects of their Medicaid managed care programs, including eligibility, services provided, and number or percentage of clients enrolled, information for other states is limited to data compiled by the Kaiser Family Foundation from July and October 2010. In Mississippi, information from the state Medicaid website is used, as well as information gained from conversations with Medicaid officials.

## NOTES

Data for certain states were incomplete in the 2012 National ADAP Monitoring Project Annual Report; missing data were obtained from alternate sources:

- Data regarding June 2011 client income level for Georgia and Louisiana were incomplete in the 2012 Report. Because previous recent NASTAD reports are also incomplete, national averages were used in the income calculations for these states;
- Data regarding the insurance status of clients are incomplete in the 2012 Report for Georgia. Because previous recent NASTAD reports are also incomplete, national averages were used for insurance status in the calculations;
- Data for insurance status of ADAP clients in Louisiana and North Carolina were incomplete in the 2012 report but available in the 2011 report. The 2011 report data were used in the calculations for these states; and
- Data on the number of clients served by Mississippi's ADAP program are incorrect in NASTAD's Monitoring Report, as the number of clients served is listed as 14,483, while the number of eligible ADAP clients in the state is listed as only 1,496. The listed figure appears to be a typo as the figure for number of clients served is reported as 1,483 in other sources, including Kaiser Family Foundation's fact sheet for Mississippi's ADAP. Because of the similarity of the figures listed by NASTAD and Kaiser Family Foundation, and the impossibility that the figure listed in NASTAD is correct, this report uses Kaiser Family Foundation's figure in its calculations.

## CAVEATS AND ASSUMPTIONS

The estimates provided require a number of caveats and assumptions:

1. ADAP data (as opposed to Ryan White data) were used to account for insurance status and to avoid double-counting individuals who may be enrolled in multiple Ryan White programs (ie, seeing multiple providers). The estimates presented here, therefore, are only for the proportion of ADAP clients who will be eligible for Medicaid and private insurance subsidies;
2. Data for ADAP clients served were used rather than data for clients enrolled because the number of individuals enrolled may exceed the actual number of clients accessing ADAP services. Potential clients who are currently on ADAP waiting lists in several states are also not included in these calculations. Thus, the numbers provide a conservative estimate of ADAP beneficiaries who will transition onto Medicaid or into subsidized private insurance;

3. National data (NASTAD and HRSA) were used in calculations instead of state-specific data to ensure that these estimates could be compared across the states surveyed; and

4. The number of undocumented immigrants on ADAP is a rough estimate extrapolated from estimates of the overall number of undocumented immigrants in the state as a whole as of 2008. It is possible that this estimate either overestimates or underestimates the actual number of undocumented immigrants currently served by ADAP.

With these caveats and assumptions in mind, the figures discussed are our best estimates of the number and percentage of ADAP clients who will be newly eligible for Medicaid in 2014 (assuming full implementation of the ACA) and the number and percentage of ADAP clients who will be eligible for private insurance subsidies.

These estimates are for ADAP recipients only, and are of limited analytical assistance in determining percentages of all people living with HIV who will be newly eligible for Medicaid and insurance subsidies in 2014. While the percentages provided could be extrapolated to apply to the broader HIV population in states, given the number of caveats and assumptions needed to arrive at this rough estimate, it would be better to obtain additional information about the unmet need within states before attempting to make such calculations.

# APPENDIX C

Part A of the Ryan White program funds both medical and support services, allowing states to provide HIV+ individuals with a continuum of care. States are required to spend 75% of Part A awards on core medical services, which include:

- Outpatient and ambulatory care;
- AIDS Drug Assistance Program (ADAP) (full coverage of drugs or insurance assistance);
- Oral health;
- Early intervention services;
- Health insurance premiums and cost-sharing assistance;
- Medical nutrition therapy;
- Hospice services;
- Home- and community-based health services;
- Mental health services;
- Substance abuse outpatient care;
- Home healthcare; and
- Medical case management (including treatment adherence services).

States may spend up to 25% on support (ancillary) services that are linked to medical outcomes (eg, patient outreach, medical transportation, linguistic services, respite care for caregivers of people living with HIV/AIDS, healthcare or other support service referrals, case management, and substance abuse residential services).

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3. Mississippi Department Of Health, *Mississippi Statewide Coordinated Statement of Need* (2009). In the 2009 SCSN, Mississippi estimated that 10% to 25% of HIV+ individuals were undiagnosed. These percentages are used in this report to estimate the percentage of individuals in 2011 were also undiagnosed.
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TAEP
Treatment Access Expansion Project

Center for Health Law and Policy Innovation
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A collaboration between the HIV community and Bristol-Myers Squibb