STATE HEALTH REFORM IMPACT MODELING PROJECT

Tennessee

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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 the Ryan White program—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 benefit 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 or private subsidized insurance will have on low-income people living with HIV.[2]

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 on data collection and a summary of the limitations of the modeling process.

In Tennessee, 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, Medicaid, and private insurance coverage, what are the likely outcomes of a transition from one program to another in 2014?

TENNESSEE

TENNESSEANS LIVING WITH HIV/AIDS

UNMET NEED

As of 2004,* 54% of people diagnosed with HIV (6,773 individuals) were not receiving any HIV-related medical care.[3] This estimate is conservative; the state considers a patient to be "in care" if he/she has received any of the following in a 12-month period: a viral load test, a CD4 test, or antiretroviral treatment (ART).[4] Because untreated patients are not part of the Ryan White program or the AIDS Drug Assistance Program (ADAP), they are not counted in the Modeling Project's estimations, but it is likely that most of these individuals will also be newly eligible for Medicaid or subsidized private insurance in 2014.

THE RYAN WHITE PROGRAM IN TENNESSEE

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 treatment and care. In other words, it serves as a critical payer of last resort, filling gaps in healthcare and ancillary support services that are unmet by all other charitable or funded healthcare services. In 2010, Tennessee received $37,030,609 of Ryan White funding,[5] and served 19,275 duplicated clients.[6] About 58.4% of the state's Ryan White funds were Part B grants, assigned based on the prevalence of HIV in the state.[7] Of these, approximately 24.8% covered core medical services, 62.0% went toward ADAP, and 9.5% provided ADAP supplemental funding.[8]

ADAP IN TENNESSEE

ADAP is a component of Ryan White (within Part B), which is also funded with matching state appropriations and covers the cost of ART for enrollees. To be eligible for ADAP in Tennessee (also referred to as the Tennessee HIV Drug Assistance Program, or HDAP), one must:

1. Be a Tennessee resident;
2. Meet financial eligibility criteria; and
3. Have an HIV diagnosis as evidenced by a positive screening for HIV antibodies or a detectable PCR test result.[9]

To be financially eligible, one must:

1. Have a maximum gross monthly income of less than or equal to 300% of the federal poverty level (FPL); and
2. Have household resources of less than or equal to $8,000 (eg, cash, bank accounts, resources that can quickly be converted to cash, including stocks, bonds, or certificates of deposit).[10]

As of June 2011, 3,931 Tennesseans were enrolled in ADAP.[11] The state's fiscal year 2011 ADAP budget was $23,430,298 ($16,430,298 in federal funds).[12] Approximately 70.8% of these funds were used to cover the cost of prescription drugs, 2.5% were used to cover prescription dispensing costs, 18.4% were used to cover costs of insurance premiums, and the remaining 8.3% was used to provide insurance assistance to cover copayments and deductibles.[13]

RYAN WHITE SPENDING AND RECIPIENT POOL

In 2010, the Ryan White program served 19,275 duplicated clients in the state; 82% will be eligible for Medicaid or a Basic Health Plan (BHP) under the Patient Protection and Affordable Care Act (ACA) (excluding those otherwise eligible for insurance).[14] Between 4,014-4,176 residents received assistance from ADAP in 2010.[15,16] In June 2011, ADAP served 2,886 Tennesseans.[17] Of these individuals, 62% would be eligible for Medicaid under the expansion (see Appendix A) and 18% would be eligible for a BHP, if one is created.[18]

These numbers are significant, and because the majority of individuals receiving support from these

*The 2012 Epidemiologic Profile for Tennessee does not include an unmet need analysis.

programs are African American (60% of Ryan White recipients[19] and 52-53% of ADAP beneficiaries in 2010),[20,21] implementing Medicaid in a way that ensures continuity in access to services will be critical to reducing health disparities. Moreover, an increasing proportion of these individuals are uninsured, making them perfect candidates for Medicaid or subsidized private insurance (43% of Ryan White clients were uninsured in 2010[22] and 56% of ADAP beneficiaries were uninsured in 2010).[23]

THE ACA AND ITS IMPACT ON HIV+ TENNESSEANS

THE MEDICAID EXPANSION

Beginning in January 2014, the Patient Protection and Affordable Care Act (ACA) will expand Medicaid eligibility to most individuals under 65 years of age living below 133% of the federal poverty limit (FPL).[24,†] Although the US Department of Health & 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.[25] Newly eligible enrollees will receive a benchmark benefit package that will include ten categories of essential health benefits (EHB), described in the "Essential Health Benefits" Section.[26]

THE BASIC HEALTH PLAN

The ACA provides an option for states to create a Basic Health Plan (BHP) that would be largely federally funded (the state would receive up to 95% of the premium credits an individual would have been entitled to for purchase of a plan on the exchange).[27] A BHP would cover most individuals under 65 years of age living between 133-200% of the FPL as well as legal residents who do not qualify for Medicaid because of the 5-year residency requirement.[28] BHPs must cover at least the EHB and have the same actuarial value of coverage as a bronze plan the individual might otherwise purchase on an exchange.[29] Cost sharing on BHPs can be subsidized, either for all beneficiaries or for those with specific chronic conditions (eg, HIV/AIDS).[30] 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.[31] 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 EHB; these benefits are discussed in the following section. All exchanges will be operational January 1, 2014.[32] As a benchmark plan for purposes of defining EHB, New York selected the Oxford EPO plan.[33]

Because Tennessee has neither enacted legislation to create a state-based exchange, nor submitted a benchmark plan to the federal HHS for purposes of defining benefits offered on the exchange, the largest small-group market plan in the state (BlueCross BlueShield of Tennessee PPO) has become the default benchmark plan for purposes of defining EHB.

For those purchasing coverage on an exchange, the ACA extends insurance premium credits to individuals and families living below 400% FPL, to ensure that premiums do not exceed 2.0-9.8% of household income, and imposes out-of-pocket spending caps to protect healthcare consumers from medical bankruptcy.[34] Eligible individuals and families can employ these credits to purchase a private health insurance plan on a state or federally operated insurance exchange.

*† Lawfully residing immigrant adults who have been in the country ≤5 years are not be eligible for Medicaid (along with undocumented residents). US Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation, The Affordable Care Act: Coverage Implications and Issues for Immigrant Families 7 (Apr. 2012), *available at* http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Coverage/ib.pdf.

ESSENTIAL HEALTH BENEFITS

The ACA requires both Medicaid plans and private health insurance plans sold on state-based insurance exchanges to provide a minimum of essential health EHB, to be defined by the Secretary of HHS.[35] EHB must include items and services within the following ten benefit categories[36]:

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.[37] CMS has indicated that the HHS rule on EHB will also apply to newly eligible Medicaid beneficiaries, in addition to the protections provided for under the Social Security Act.[38] 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 FDA-approved drugs with significant clinically meaningful therapeutic advantage over another.[39]

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+ Tennesseans are expected to become eligible for public or subsidized private insurance in 2014, including the over 6,000 living without treatment, provided that Tennessee fully implements the law. An estimated 82% of the state's Ryan White program clients in 2010 were at 200% FPL or lower, making them potentially eligible for either Medicaid or a BHP. More specifically, approximately 62% of Tennessee AIDS Drug Assistance Program (ADAP) clients will be eligible for Medicaid following its expansion (Appendix A),[40] and 18% will be eligible for a BHP.[41]

The percentage of Tennessee's ADAP clients who will be newly eligible for Medicaid (60%) is higher than the total proportion of Americans who will be newly eligible, which stands at approximately 29% (Appendix A). This is because Tennessee's ADAP primarily serves individuals with incomes below 133% FPL (as many as 62% of the state's ADAP clients were living below 133% FPL in 2011),[42] but also because the state's ADAP clients are almost entirely uninsured (approximately 99% of ADAP clients served in 2011).[43]

Similarly, the percentage of Tennessee's ADAP clients who will be newly eligible for private insurance subsidies (37%) is higher than the total proportion of Americans who will be newly eligible for subsidies, which stands at approximately 15% (Appendix A). This is due to the sizable group of ADAP clients served who are just above 133% FPL (approximately 18% of ADAP clients served in 2011 were living between 134-200% FPL, many of whom are also uninsured).[44]

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

Since a significant number of HIV+ individuals in Tennessee who are currently served by the Ryan White program or the AIDS Drug Assistance Program (ADAP) are likely to be eligible for Medicaid in 2014, it is important to assess the outcome of transitioning from the former programs to Medicaid. This assessment compares and contrasts the services and treatments that the Ryan White program, ADAP, and Medicaid currently provide to HIV+ Tennesseans. Forthcoming final federal regulation on the essential health benefits (EHB) that newly eligible Medicaid beneficiaries are guaranteed under the Patient Protection and Affordable Care Act (ACA) will affect the scope of coverage provided in 2014.

COMPARING RYAN WHITE, MEDICAID, AND THE BENCHMARK PLAN FOR THE EXCHANGE IN TENNESSEE

The Ryan White program funds both core medical services and support services for patients living with HIV (see Appendix C for a breakdown of core medical services 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 facilitate effective HIV treatment and care (eg, transportation, child care, nutrition). However, Medicaid and Tennessee's 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). Accounting for the gaps between the Ryan White program and Medicaid or private insurance sold on the exchange will be critical in transitioning Ryan White beneficiaries onto Medicaid and private insurance while ensuring that their health status does not deteriorate (eg, due to lack of proper nutrition, access to transportation to a health clinic, or stable housing). For example, oral health care, nutritional therapy, transportation to medical care, and emergency housing are already a few of the most cited gaps in care in Memphis.[45]

Tennessee is the first state to enroll all its Medicaid patients in a managed care program (TennCare).[46] Medicaid clients can select which managed care organization (MCO) they want to enroll in from the different plans that service their area.[47] Select healthcare services have been carved out of TennCare and are covered by the state in a fee-for-service arrangement (eg, long-term care services in nursing facilities, care provided by intermediate care facilities for persons with mental retardation, and care provided by home- and community-based service providers).[48]

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

Table 1. Ryan White Versus Medicaid and the Benchmark Plan: Covered Services

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

Covered Service	Ryan White[49]	Medicaid[50]	BlueCross BlueShield of Tennessee – PPO[51]
Home Health Care		X (with limitations)	X (limited to 60 visits per year)
Mental Health	X	X	X (limited number of visits per year depending on plan)
Substance Abuse (outpatient)	X	X	X (limited to 25-30 visits per year)
Substance Abuse (inpatient)		X	X (limited to 20-30 visits per year)
Medical Case Management	X		
Community-based Care		X	
Ambulatory/Outpatient Care	X	X	X
Oral Health Care	X		
Early Intervention Clinic	X		
Nonmedical Case Management Services	X		
Child Care			
Emergency Financial Assistance	X		
Food Bank/Home Delivered Meals	X		

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Table 1. (continued)

Housing Services	X		
Health Education/Risk Reduction	X		
Legal Services	X		
Linguistic Services	X		
Nonemergency Medical Transportation	X	X	
Outreach Services	X		
Psychosocial Support	X		
Referral Agencies	X		
Treatment Adherence Counseling	X		
Intermediate Care Facilities for the Mentally Retarded		X	
Hospital Services (outpatient)		X	X
Hospital Services (inpatient)		X	X
Hospice Services		X	X
Lab and X-ray Services		X	X
Prescription Drugs	X	X	X
Vision Care (including contacts and eyeglasses)		X (limited)	
Midwife/NP Services		X	X
Private-Duty Nursing		X (limited to services needed to support ventilator equipment or other life-sustaining technology)	
Physician Services		X	X
Chiropractor			X (limited to 20 visits per year)
Mental Health Rehabilitation		X	
PT, OT, and Speech Therapy		X	X (limited to 20 visits per therapy for year)
Renal Dialysis		X	

As Table 1 indicates, the Ryan White program covers critical services for low-income people living with HIV/AIDS, many of which are not available to Medicaid beneficiaries or people covered by Tennessee's benchmark plan (eg, nonmedical case management, legal services, food bank and home-delivered meals, linguistic services, housing services, and emergency financial assistance). These types of services will likely not be required EHB on Medicaid or private plans, given existing federal guidance and proposed regulation.[52,53] Since these ancillary services are important for the well-being of people living with HIV/AIDS, the individuals who transition from the Ryan White program onto Medicaid or private insurance plans are likely to be at a disadvantage.

COMPARING ADAP, MEDICAID, AND THE BENCHMARK PLAN FOR THE EXCHANGE IN TENNESSEE

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/AIDS. 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. The TennCare drug formulary is defined differently (and its formulary for newly eligible individuals has yet to be defined). Ensuring that TennCare and plans sold on the exchange provide coverage for a sufficient number of antiretroviral medications will be critical to maintaining the health of Tennesseans living with HIV/AIDS.

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 benchmark plan used for purposes of defining EHB for plans sold on an exchange).

Table 2. ADAP Versus Medicaid and the Benchmark Plan: Covered Drugs[54]

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[55]	Medicaid[56]	BlueCross BlueShield of Tennessee – PPO[57]
Multiclass Combination Drugs	**2 Drugs Covered**	**3 Drugs Covered**	**0 Drugs Covered**
Atripla; *efavirenz + emtricitabine + tenofovir DF*	X	X (QL)	
Complera; *emtricitabine + rilpivirine + tenofovir disoproxil fumarate*	X	X	
Stribild; *elvitegravir + cobicistat + emtricitabine + tenofovir disoproxil fumarate*		X	
Nucleoside Reverse Transcriptase Inhibitors	**11 Drugs Covered**	**11 Drugs Covered**	**0 Drugs Covered**
Combivir; *lamivudine, zidovudine*	X	X (QL)	
Emtriva; *emtricitabine*	X	X (QL)	
Epivir; *lamivudine*	X	X (QL)	
Epzicom; *abacavir, lamivudine*	X	X (QL)	
Retrovir; *zidovudine*	X	X (nonpreferred; QL)	
Trizivir; *abacavir + zidovudine + lamivudine*	X	X (PA; QL)	
Truvada; *tenofovir DF + emtricitabine*	X	X (QL)	
Videx EC; *didanosine (delayed-release capsules)*	X	X (QL)	
Viread; *tenofovir disoproxil fumarate DF*	X	X (QL)	
Zerit; *stavudine*	X	X (nonpreferred; QL)	
Ziagen; *abacavir*	X	X (QL)	
NNRTIs	**4 Drugs Covered**	**5 Drugs Covered**	**0 Drugs Covered**
Edurant; *rilpivirine*	X	X	
Intelence; *etravirine*	X	X (PA; QL)	
Rescriptor; *delavirdine mesylate*		X (nonpreferred; QL)	
Sustiva; *efavirenz*	X	X (QL)	
Viramune; *nevirapine*	X	X (nevirapine only, Viramune nonpreferred; QL)	

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Table 2. (continued)

Protease Inhibitors	9 Drugs Covered	9 Drugs Covered	0 Drugs Covered
Agenerase; *amprenavir*			
Aptivus; *tipranavir*	X	X (PA; QL)	
Crixivan; *indinavir sulfate*	X	X (nonpreferred; QL)	
Invirase; *saquinavir mesylate*	X	X (QL)	
Kaletra; *lopinavir + ritonavir*	X	X (QL)	
Lexiva; *fosamprenavir*	X	X (QL)	
Norvir; *ritonavir*	X	X (QL)	
Prezista; *darunavir*	X	X (QL)	
Reyataz; *atazanavir sulfate*	X	X (QL)	
Viracept; *nelfinavir sulfate*	X	X (QL)	
Fusion Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Fuzeon; enfuvirtide	X (PA if not a Center of Excellence Provider)	X (PA; QL)	X (NP)
Entry Inhibitors – CCR-5 Coreceptor Antagonist	**1 Drug Covered**	**1 Drug Covered**	**0 Drugs Covered**
Selzentry; maraviroc	X (PA if not a Center of Excellence Provider)	X (PA; QL)	
HIV Integrase Strand Transfer Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**0 Drugs Covered**
Isentress; raltegravir	X	X (PA; QL)	
A1 Opportunistic Infection Medications	**19 Drugs Covered**	**28 Drugs Covered**	**12 Drugs Covered**
Ancobon; *flucytosine*		X (nonpreferred; PA)	
Bactrim DS; *sulfamethoxazole/trimethoprim DS*	X (Only available for clients prescribed high-dose therapy for treatment of pneumocystis pneumonia)	X (SMZ-TMP only, Bactrim nonpreferred)	X (generic only)
Biaxin; *clarithromycin*	X	X (clarithromycin only, Biaxin nonpreferred)	X (generic only)
Cleocin; *clindamycin*	X	X (brand name NP)	X (generic tier 1, brand name tier 2)
Dapsone	X	X	
Daraprim; *pyrimethamine*	X	X	
Deltasone; *prednisone*		X (generic only)	
Diflucan; *fluconazole*	X	X (brand name NP; QL)	X (generic only)
Famvir; *famciclovir*		X (brand name NP; QL)	X (generic only)
Foscavir; *foscarnet*			
Fungizone; *amphotericin B*			

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Table 2. (continued)

Humatin; paromomycin	X		
INH; *isoniazid*		X (generic only)	
Megace; *megestrol*		X (brand name NP; QL)	
Mepron; *atovaquone*	X	X (NP; PA)	
Myambutol; *ethambutol*	X	X (brand name NP)	
Mycobutin; *rifabutin*	X	X	
NebuPent; *pentamidine*	X		
Nystatin	X	X	X (generic only)
Primaquine	X	X	
Probenecid		X	
Procrit; *epoetin alfa*		X (PA)	X (PA)
Pyrazinamide (PZA)		X	
Rifadin, Rimactane; *rifampin*		X (NP; PA)	
Sporanox; *itraconazole*	X	X (NP; PA; QL)	X (PA)
Sulfadiazine – Oral	X	X (PA)	
Valcyte; *valganciclovir*	X	X	
Valtrex; *valacyclovir*	X	X (brand name NP; QL)	X (generic only)
VFEND; voriconazole		X (NP; PA)	
Vistide; *cidofovir*			X (NP)
Wellcovorin; *leucovorin*	X (leucovorin only)	X (generic only)	
Zithromax; *azithromycin*	X	X (brand name NP;QL)	X (generic only)
Zovirax; *acyclovir*		X (brand name NP;QL)	X (generic tier 1, brand name tier 2)

NP = nonpreferred; PA = prior authorization; QL = quantity limit.

Whenever possible, patients on Tennessee's ADAP receive the generic version of the prescription drug.[58] As indicated in Table 2, if clients are not receiving their medication from one of the 14 Centers of Excellence, prior approval is required for Fuzeon or Selzentry.[59,60]

TennCare covers a greater number of HIV/AIDS prescription drugs than ADAP, but limits beneficiaries to five prescriptions per month, which no more than two can be for brand name drugs.[61] Thus, while Medicaid patients have access to a wider variety of drugs compared to ADAP clients, they are limited by the number of prescriptions that Medicaid will cover. If the plan for newly eligibles utilizes similar cost-containment strategies, ADAP will continue to be a critical payer of last resort, even for those with public coverage.[62]

As Table 2 indicates, Tennessee's benchmark plan—BlueCross BlueShield of Tennessee PPO—has significantly more limited formulary than the ADAP or Medicaid. Although it covers more drugs treating opportunistic infections, it covers only one antiretroviral. According to BlueCross BlueShield representatives, individual small-group plans vary; some PPOs may cover antiretroviral drugs but none are open formularies, meaning coverage cannot be assured, even with high cost sharing and a determination of medical necessity.[63] Because the prescription drug EHB will likely only require coverage of one drug per class in the situation where a benchmark plan does not cover any drugs in a given class (eg, many of the antiretroviral classes listed above), this could create a tremendous barrier to ART for individuals moving from ADAP to subsidized private insurance in Tennessee.[64]

COMMUNITY HEALTH CENTERS

The ACA has provided Tennessee with almost $82 million to fund new and existing community health centers.[65] Three centers were individually awarded approximately $80,000 in health center planning grants.[66] All community health centers in Tennessee (188 as of 2010) provide primary care services, and 83% provide HIV preventive care.[67] Some Tennessee community health centers, such as Christ Community Health Services, are leaders in providing comprehensive healthcare to people living with HIV/AIDS. For example, Christ Community Health Services provides primary and specialty care, case management, and assistance accessing social services.[68] Community health centers can go beyond providing basic healthcare to people living with HIV/AIDS to help ensure successful case management and treatment, and serve as models for organizing access to comprehensive ART as the state implements the ACA.

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/AIDS onto Medicaid or private insurance. This report is intended to assist state legislators in implementing the ACA in a manner that serves the needs of Tennesseans.

While much of the ACA has yet to be implemented, it is certain that large numbers of people living with HIV/AIDS will be newly eligible for Medicaid. Given that a significant proportion of uninsured ADAP clients would transition into Medicaid in Tennessee, implementing the ACA's expansion provision 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 have HIV/AIDS. Should Tennessee 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/AIDS. An analysis of the barriers to care that this population is likely to face (based upon the existing Medicaid program) is timely as states prepare for the transition to Medicaid and private insurance. 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, and are unlikely to be required as a part of EHB on the plan for newly eligible beneficiaries, given existing federal guidance.[69] For instance, the Ryan White program, unlike Medicaid, covers nonmedical case management, food bank services, and treatment adherence counseling. HIV+ individuals who shift from the Ryan White program onto Medicaid are therefore likely to have trouble accessing a number of services currently available to them, and Ryan White will continue to be a critical payer of last resort; and
2. Second, limitations on Medicaid recipients' pharmacy benefits may pose significant challenges for individuals in need of multiple prescriptions. Those living with HIV/AIDS are likely to exceed the maximum allowable number of monthly prescriptions covered by Medicaid. Because Medicaid plans available to newly eligible beneficiaries are likely to utilize similar cost-containment strategies, this may create a barrier to comprehensive antiretroviral therapy (ART) for people living with HIV/AIDS.[70]

It is essential that private insurance plans on the Tennessee Exchange also provide a comprehensive scope of services sufficient to meet the needs of Ryan White clients who transition onto 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 Tennessee's default base-benchmark plan, and are also unlikely to be required as EHB included in most private plans in the individual and small-group market in 2014.[71] 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 services currently available to them; and
2. Second, the prescription drug list for HIV+ individuals under Tennessee's base-benchmark plan is severely deficient with respect to ART. Because the prescription drug EHB will likely be defined based on the number of drugs covered

per class by the benchmark plan (requiring coverage of only one drug per class if none are covered), individuals living with HIV may encounter tremendous barriers to care.[72]

There will remain an ongoing demand for Ryan White and ADAP services to fill the gaps left by Medicaid coverage and private insurance for low-income people living with HIV/AIDS. Identifying these gaps and structuring these programs to efficiently work together from the start is not only fiscally prudent but necessary to secure the health of Tennesseans and slow the spread of HIV.

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

1. Tennessee must adopt the Medicaid expansion, pursuant to the ACA, extending eligibility to most individuals living under 133% of the federal poverty level (FPL) in order to slow the transmission of HIV, improve health outcomes, and make treatment accessible to thousands of individuals who currently lack care;
2. Effectively defining EHB, patient navigation, and outreach systems, and opting into prevention and home health program resources will maximize the potential for the state to meet the care and service needs of individuals living with HIV/AIDS; and
3. Tennessee must ensure that Ryan White and ADAP services are available where Medicaid or private insurance coverage or affordability gaps exist (eg, nonmedical case management, food and nutrition, childcare, treatment adherence counseling) or where cost sharing makes meaningful coverage prohibitive.

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 newly eligible individuals (those who would not otherwise be eligible for Medicaid but for the new law).

To estimate the number of individuals currently using the AIDS Drug Assistance Program (ADAP) who will be newly eligible for Medicaid in 2014, the following formula was used:

	Total #	ADAP clients served in 2010[13]
−	**est. #**	ADAP clients with incomes above 133% FPL[16,‡]
−	**est. #**	insured ADAP clients with incomes below 133% FPL[73,74]
−	**est. #**	ADAP clients who are uninsured undocumented immigrants with incomes below 133% FPL[75,§]
=	**Total #**	ADAP clients served in fiscal year 2010 who will be newly eligible for Medicaid in 2014[**,††]

In Tennessee, 4,176 individuals were served by ADAP in fiscal year 2010. Of those, it is estimated that 38% (1,587) ADAP clients have incomes above 133% FPL. Additionally, an estimated 0.9% (23) of individuals living below 133% FPL are currently insured and approximately 2.4% of the state population was undocumented immigrants in 2008 (61 ADAP individuals). Thus, the calculation for Tennessee is:

	4,176	ADAP clients in fiscal year 2010
−	**1,586.88**	ADAP clients living above 133% FPL
−	**23.08**	insured ADAP clients living below 133% FPL
−	**61.02**	estimated uninsured undocumented immigrants living below 133% FPL on ADAP
=	**2,505**	(60%) of ADAP clients served in fiscal year 2010 who will be newly eligible for Medicaid in 2014

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

State	# ADAP Clients Newly Eligible for Medicaid	% ADAP Clients 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	**62,780**	**29%**

The percentage of ADAP clients who will be newly eligible for Medicaid in 2014 varies 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

‡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).

§*See* Appendix A.III for a description of the method used to estimate the distribution of insured ADAP clients in Tennessee by income group.

**The final estimate provided is likely to be somewhat higher than the actual number of ADAP clients who will be newly eligible for Medicaid, since the formula does not account for insured ADAP clients whose incomes fall below 133% FPL—these clients will not be newly eligible for Medicaid in 2014. The number of insured clients with incomes below 133% FPL is likely to vary by state.

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

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/AIDS 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 served in fiscal year 2010[13]
–	**est. #**	ADAP clients living below 133% FPL or above 400% FPL[16]
–	**est. #**	insured ADAP clients living between 133-400% FPL[47,48]
–	**est. #**	uninsured undocumented ADAP clients living between 133-400% FPL[49]
=	**Total #**	ADAP clients served in fiscal year 2010 who will be newly eligible for subsidized private insurance in 2014

In Tennessee, 4,176 individuals were served by ADAP in fiscal year 2010. Of those, approximately 62% (2,589) are living below 133% or above 400% FPL. We estimate that 1% (19) of individuals with incomes between 133% FPL and 400% FPL are currently insured. About 2.4% of the state's population was undocumented in 2008. Applying this percentage to the individuals enrolled in Tennessee's ADAP, we estimate that 37 Tennessee ADAP clients are uninsured and undocumented, living between 133% and 400% FPL. Thus, completing the calculation above for Tennessee's ADAP yields:

	4,176	ADAP clients served in fiscal year 2010
–	**2,589.12**	ADAP clients with incomes below 133% FPL or above 400% FPL
–	**18.68**	insured ADAP clients with incomes between 133% and 400% FPL
–	**37.40**	uninsured undocumented immigrants with incomes between 133% and 400% FPL
=	**1,531**	(37%) of ADAP clients served in fiscal year 2010 who will be newly eligible for subsidized private insurance in 2014

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

State	# ADAP Clients Newly Eligible for Subsidized Insurance	% ADAP Clients Newly Eligible for Subsidized Insurance
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	**37,527**	**15%**

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 250-399% FPL. The number of insured adults and the total number of adults in these two groups were pooled together in order to determine the percentage of adults living between 133-400% FPL who are insured.

   In Tennessee, for example, 61% of adults living below 133% FPL are insured; 81% of adults living between 133-400% FPL are insured; and 86% living above 400% FPL are insured.

2. Next, we determined 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. To do this, we gave the figure for the insurance rate for adults living below 133% FPL the baseline number 1, and the insurance rates for the other income groups were calculated to be multiples of this baseline.

   In Tennessee, we gave the figure 61% the baseline number 1; 81% is 1.33 times 61%, and 86% is 1.41 times 61%. Thus, in other words, an adult in Tennessee with income between 133-400% FPL is 1.33 times more likely to be insured than an adult with income below 133% FPL, while an adult with income above 400% FPL is 1.41 times more likely to be insured.

3. Next, we calculated the number of insured ADAP clients in each state by referring to Tables 8 and 14 of the 2012 NASTAD National ADAP Monitoring Project Report.[76] 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), we attempted to estimate the number of insured ADAP clients in each state.[‡‡]

   In Tennessee, we estimated that about 42 of the state's 4,176 ADAP clients served in 2010 were insured. The insurance rate for ADAP clients in that state stood at 1% in 2011.

4. In order to proportionately divide the number of insured ADAP clients among the three income groups listed above, 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 incomes below 133% FPL, incomes between 133-400% FPL, and incomes above 400% FPL.

   In Tennessee, 62% of ADAP clients have incomes below 133% FPL, 38% are living between 133-400% FPL, and none are living above 400% FPL.

5. We then treated the number of insured ADAP clients in each income group as a product of the relative likelihood of being insured (determined above), and compared it with the relative proportion of clients in that income group among the total clients (based on the percentage of ADAP clients in each income group), along with a weighing factor a.

We relied on two formulas:

Formula 1:

Number of insured clients in each group = (relative likelihood of being insured) × (proportion of income group) × 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 Tennessee:

$$42 = (1 \times 0.62 \times a) + (1.33 \times 0.38 \times a) + (1.41 \times 0.00 \times a)$$

Solving for a,

$$a = 37.32$$

[‡‡] The 2011 and 2012 NASTAD National ADAP Monitoring Project Reports list the percentage of ADAP clients in each state covered by various kinds of insurance. We added the different insurance percentages to estimate the number of ADAP clients in each state who were insured. This leads to an overestimation of the number of insured people in each state; since a single ADAP client may be enrolled in multiple insurance plans (eg, Medicare and private insurance), adding up the insurance percentages may often result in double-counting a number of ADAP clients.

Applying the value of *a* determined above to

Formula 1:

The estimated number of insured ADAP clients in Tennessee with,

Incomes below 133% FPL = 23

Incomes between 133-400% FPL = 19

Incomes 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 between states is comparable, data sources that provide information for all 21 states and the DC are prioritized. Where more recent or more detailed data is available for a particular state, it has 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. Income, race/ethnicity, gender, and insurance status for 2008 are available from HRSA and have been provided for each state. 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 & 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 year 2010, fiscal year 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 is unduplicated (ie, patients are not double-counted by multiple providers), it is one of the most reliable sources of demographic information for people living with HIV/AIDS. Data from June 2011 provide information on how many people living with HIV/AIDS currently enrolled in ADAP were living 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 this data to date. NASTAD's ADAP information was used for estimates regarding people living with HIV/AIDS who are newly eligible for Medicaid in 2014 at the end of this report. Where information is also available from state departments of health or HRSA, it has been provided.

Estimates of unmet needs for people living with HIV/AIDS 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. Where information about unmet need is available from other sources, it has also been included.

Information on current services covered by the Ryan White program is available from HRSA and the SCSNs, and this data has been included in each state profile. Where more detailed information is available, it has been included in the profiles.

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, the 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 services 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/AIDS as well as limitations that may impede access to needed services.

NOTES

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

- 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.[77] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of the insured exceed 100% for Maryland and Ohio.); and
- Data on the number of clients served by Mississippi's ADAP appears to be incorrect in NASTAD's Monitoring Report, as the number of clients served is listed as larger than the number of eligible ADAP clients in the state. The number listed was used in these calculations, and while the specific number of ADAP clients eligible for Medicaid and private insurance subsidies in Mississippi may not be reliable, the proportion of clients eligible for both programs was obtained in the same way as for other states, for interstate comparability reasons.

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 avoid double-counting individuals who may be enrolled in multiple Ryan White programs (ie, see 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 actually 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 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 extrapolating 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 above 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 Patient Protection and Affordable Care Act [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/AIDS 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/AIDS population in states, given the number of caveats and assumptions needed to arrive at this rough estimate, it would be better to obtain further information about unmet needs 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;
- 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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