STATE HEALTH REFORM IMPACT MODELING PROJECT

Virginia

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Prepared by the Center for Health Law and Policy Innovation of Harvard Law School
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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 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 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 data collection methodology, notes, and a summary of the limitations of the modeling process.

In Virginia, 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?

VIRGINIA

VIRGINIANS LIVING WITH HIV/AIDS

UNMET NEED

As of June 2012, approximately 24,378 Virginians were known to be living with HIV/AIDS (HIV+ aware).[3] An estimated 5,564 are not receiving medical care, and an additional 5,916 are HIV+ but undiagnosed.[4,5] 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 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 VIRGINIA

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 2010, Virginia received $39,485,992 of Ryan White funding and served 12,466 duplicated clients.[6-8] About 75% of the state's Ryan White funds were Part B grants, assigned based on prevalence of HIV in the state.[9] Of these, 26.6% covered core medical services, 1.5% covered ancillary services, 60.5% went toward the AIDS Drug Assistance Program (ADAP), and 1.4% provided ADAP Supplemental funding (insurance assistance).[10]

ADAP IN VIRGINIA

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. At present, to be eligible for ADAP in Virginia, one must be:

1. A Virginia resident diagnosed with HIV *and*
   - a. With a CD4 count at or below 500 (for new clients), or above 500 (for previously wait-listed clients); or
   - b. Pregnant; or
   - c. ≤18 years of age (including perinatally exposed newborns); or
   - d. Currently receiving treatment for an active opportunistic infection; *and*
2. Ineligible for Medicaid; *and*
3. Living at or below 400% of the federal poverty level (FPL).[11]

In fiscal year 2010, Virginia's ADAP served 4,059 individuals.[12] The state's 2011 ADAP budget was $29,297,638 ($24,398,302 in federal funds).[13] In the previous fiscal year, Virginia spent $30,345,301 on ADAP—approximately 92% of these funds were used to cover the full cost of ART, while about 0.8% of the funds went toward insurance assistance.[14,*]

* $28,021,256 from Virginia's 2010 ADAP budget went toward covering the full cost of ART, and another $245,497 went toward insurance assistance.

THE ACA AND ITS IMPACT ON HIV+ VIRGINIANS

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% of the federal poverty level (FPL).[15,†] 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.[16] 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.[17]

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).[18] A BHP would cover 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.[19] 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.[20] Cost sharing on BHPs can be subsidized, either for all beneficiaries or for those with specific chronic conditions (eg, HIV/AIDS).[21] 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.[22] 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.[23] As a benchmark plan for purposes of defining EHB offered on the exchange, Virginia selected the Anthem Small-Group PPO.

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.[24] Eligible individuals and families can employ these credits to purchase a private health insurance plan on a state- or federally operated insurance exchange.

ESSENTIAL HEALTH BENEFITS

The ACA requires both Medicaid plans and private health insurance plans sold on state-based insurance exchanges to provide a minimum set of EHB, to be defined by the Secretary of HHS.[25] EHB must include items and services within the following ten benefit categories[26]:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;

† All undocumented immigrants as well as lawfully residing immigrant adults who have been in the country 5 years or less will not be eligible for Medicaid coverage. 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 (April 2012), *available at* http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Coverage/ib.pdf.

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.[27] The Centers for Medicare & Medicaid (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.[28] 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.[29]

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+ individuals in Virginia are expected to become eligible for health insurance in 2014, whether under Medicaid, a BHP, or subsidized private coverage. An estimated 81% of the state's Ryan White program clients in 2010 were between 100-200% FPL, making them potentially eligible for either Medicaid or a BHP in 2014.[30] We estimate that 66% of Virginia's ADAP clients will be eligible for Medicaid following its expansion (see Appendix A). Another 22% will be eligible for private insurance subsidies (see Appendix A). Finally, many of the estimated 5,564 HIV+ individuals in Virginia who, in 2009, were not linked to any medical care will likely be eligible for health insurance for the first time in 2014, creating a window of opportunity for expanding antiretroviral therapy (ART), improving health outcomes, and slowing the spread of HIV.

The percentage of Virginia's ADAP clients who will be newly eligible for Medicaid (66%) is significantly higher than the national proportion (29%). This is primarily because Virginia's ADAP mostly serves individuals with incomes below 133% FPL (approximately 74% of the state's ADAP clients had incomes below 133% FPL in 2011), but also because the state's ADAP clients are largely uninsured (see Appendix A).

The percentage of Virginia's ADAP clients who are expected to qualify for private insurance subsidies (22%) is also higher than the national proportion of newly eligibles (15%), again probably because the state's ADAP clients are largely uninsured.

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

Since a significant number of HIV+ individuals in Virginia who are currently served by the Ryan White program or AIDS Drug Assistance Program (ADAP) are likely to be eligible for Medicaid or insurance subsidies 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, Medicaid, and the state's benchmark plan currently provide to HIV+ Virginians.

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

The Ryan White program funds both core medical services and support services for patients living with HIV/AIDS (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/AIDS treatment and care (eg, transportation, child care, nutrition). However, Medicaid and Virginia's benchmark plan, which will largely determine essential health benefits (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 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 Virginia's Ryan White program and Medicaid (as of 2010) as well as the benchmark plan proposed for purposes of determining EHB on an exchange.

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[31]	Medicaid[32,‡]	Anthem Small-Group PPO[33]
Home health care		X	X
Mental health	X	X	X
Substance abuse (outpatient)	X	X	X
Substance abuse (inpatient)			X
Medical case management	X	X	X
Community based care	X	X	
Ambulatory/outpatient care	X	X	X
Oral health care	X	X	
Early-intervention clinic	X	X	X
Intermediate care facilities for the mentally retarded		X	X
Ambulance		X	X
Family planning		X	X
Durable medical equipment		X	X
Hospital services		X	X
Lab and X-ray services		X	X
Nursing facility		X	X
Midwife/NP services		X	X
Private-duty nursing		X	X
Physician services		X	
Nonmedical case management services	X		
Child care	X		X
Emergency financial assistance	X		
Food bank/home-delivered meals	X		
Housing services	X		
Health education/risk reduction	X		
Legal services	X		
Linguistics services	X		
Medical transportation	X	X	X
Outreach services	X		
Psychosocial support	X		
Referral agencies	X		
Treatment adherence counseling	X		
Chiropractor			X
Podiatry		X	
Hospice		X	X
Respiratory therapy		X	
PT, OT, and speech therapy		X	X
Orthotics and prosthetics		X	X

NP = nurse practitioner; PT = physical therapy; OT = occupational therapy

‡ Only certain case management, counseling, assessments, and homemaker services available to high-risk pregnant women and infants up to age 2. Virginia Department of Medical Assistance Services, Medicaid, and Famis Plus Handbook, 16, *available at* http://www.dmas.virginia.gov/Content_atchs/atchs/medbook-eng.pdf.

As Table 1 indicates, the Ryan White program offers HIV+ individuals a number of ancillary services that Medicaid and Virginia's benchmark plan do not cover. These ancillary services are crucial for the well-being of HIV+ individuals: regardless of age, race, and gender, HIV+ individuals who receive supportive services are better able, and more likely, to access medical care.[34] Therefore, in an absence of Ryan White wraparound services, individuals who move onto Medicaid or an insurance exchange risk having reduced access to medical care.

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

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. Medicaid's drug formulary is defined differently (and its formulary for newly eligible individuals has yet to be defined). Ensuring that Medicaid provides coverage for a sufficient number of antiretroviral medications will be critical to maintaining the health of Virginians living with HIV.

Table 2 provides a comparison of the antiretroviral drug formularies included in the state's ADAP and Medicaid programs, as well as 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[35]

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[36]**	**Medicaid[37,§]**	**Anthem Small-Group PPO[38]**
Multiclass Combination Drugs	**3 Drugs Covered**	**3 Drugs Covered**	**3 Drugs Covered**
Atripla; *efavirenz + emtricitabine + tenofovir DF*	X	X	X
Complera; *emtricitabine + rilpivirine + tenofovir disoproxil fumarate*	X (PA)	X	
Stribild; *elvitegravir + cobicistat + emtricitabine + tenofovir disoproxil fumarate*	X	X	
Entry Inhibitors – CCR-5 Coreceptor Antagonist	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Selzentry; *maraviroc*	X (PA)	X	X
Fusion Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Fuzeon; *enfuvirtide*	X (PA)	X	X
HIV Integrase Strand Transfer Inhibitors	**1 Drug Covered**	**1 Drug Covered**	**1 Drug Covered**
Isentress; *raltegravir*	X	X	X
NNRTIs	**5 Drugs Covered**	**5 Drugs Covered**	**4 Drugs Covered**
Intelence; *etravirine*	X (PA)	X	X
Rescriptor; *delavirdine mesylate*	X	X	X
Sustiva; *efavirenz*	X	X	X
Viramune; *nevirapine*	X	X	X
Edurant; *rilpivirine*	X (PA)	X	
NRTIs	**11 Drugs Covered**	**12 Drugs Covered**	**11 Drugs Covered**
Combivir; *zidovudine + lamivudine*	X	X	X
Emtriva; *emtricitabine*	X	X	X

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§ Drugs for the treatment of HIV/AIDS are not subject to Virginia Medicaid's preferred drug list. However, they are subject to a mandatory generic substitution policy—if an AB-rated generic is available for a brand name drug, the generic version must be dispensed.

Table 2. (continued)

Epivir; *lamivudine*	X	X	X
Epzicom; *abacavir, lamivudine*	X	X	X
Epzicom; *abacavir sulfate + lamivudine*	X	X	X
Retrovir; *zidovudine*	X	X	X
Trizivir; *abacavir + zidovudine + lamivudine*	X	X	X
Truvada; *tenofovir DF + emtricitabine*	X	X	X
Videx; *didanosine (buffered versions)*	X	X	X
Videx EC; *didanosine (delayed-release capsules)*		X	
Viread; *tenofovir disoproxil fumarate DF*	X	X	X
Zerit; *stavudine*	X	X	X
Ziagen; *abacavir*	X	X	X
Protease Inhibitors	**9 Drugs Covered**	**10 Drugs Covered**	**9 Drugs Covered**
Agenerase; *amprenavir*		X	
Aptivus; *tipranavir*	X (PA)	X	X
Crixivan; *indinavir sulfate*	X	X	X
Invirase; *saquinavir mesylate*	X	X	X
Kaletra; *lopinavir + ritonavir*	X	X	X
Lexiva; *fosamprenavir*	X	X	X
Norvir; *ritonavir*	X	X	X
Prezista; *darunavir*	X	X	X
Reyataz; *atazanavir sulfate*	X	X	X
Viracept; *nelfinavir sulfate*	X	X	X
A1 Opportunistic Infection Medications	**26 Drugs Covered**	**29 Drugs Covered**	**Formulary Not Publicly Available**
Ancobon; *flucytosine*		X	
Bactrim DS; *sulfamethoxazole/trimethoprim DS*	X**	X	
Biaxin; *clarithromycin*	X	X	
Cleocin; *clindamycin*	X	X	
Dapsone	X††	X	
Daraprim; *pyrimethamine*	X	X	
Deltasone; *prednisone*	X‡‡ (PA)	X	
Diflucan; *fluconazole*	X	X	
Famvir; *famciclovir*	X§§	X	
Foscavir; *foscarnet*	X	X	
Fungizone; *amphotericin B*		X	
INH; *isoniazid*	X	X	
Megace; *megestrol*	X	X	
Mepron; *atovaquone*	X***	X	
Myambutol; *ethambutol*	X	X	

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** Patient must have or have had an active thrush or have a CD4 count of 250 or less to receive this drug.
†† Patient must have or have had an active thrush or have a CD4 count of 250 or less to receive this drug.
‡‡ This drug is only authorized for the treatment of toxoplasmosis, pneumocystis jiroveci (*P. carinii*) pneumonia, and aphthous ulcers.
§§ This drug is only authorized for the treatment of herpes zoster.
*** Patient must have or have had an active thrush or have a CD4 count of 250 or less to receive this drug.

Table 2. (continued)

Mycobutin; *rifabutin*	X[†††]	X
NebuPent; *pentamidine*	X[‡‡‡] (generic only)	X
Probenecid		X
Procrit; *epoetin alfa*	X	X
Pyrazinamide (PZA)	X	X
Sporanox; *itraconazole*	X	X
Sulfadiazine – Oral	X	X
Valcyte; *valganciclovir*	X	X
Valtrex; *valacyclovir*	X	X
VFEND; voriconazole	X[§§§] (PA)	X
Vistide; *cidofovir*	X	X
Wellcovorin; *leucovorin*	X	X
Zithromax; *azithromycin*	X[****]	X
Zovirax; *acyclovir*	X	X

PA = prior authorization (requires a medication exception form under ADAP)

Table 2 indicates that Medicaid's formulary is as comprehensive as the formulary available under ADAP. It is important to note, however, that the above analysis uses Virginia's current Medicaid formulary, which will not be equivalent to what is offered to newly eligible beneficiaries under the Patient Protection and Affordable Care Act (ACA) (newly eligible beneficiaries will be guaranteed access to any FDA-approved drugs with significant clinically meaningful therapeutic advantage over another).[39]

Virginia's proposed benchmark plan (Anthem Small-Group PPO) does not cover as many antiretroviral drugs as ADAP and has not made its list of A1 Opportunistic Infection medication publicly available. The proposed federal rule that will define EHB provides that plans sold on exchanges must cover at least the same number of drugs in each category and class as the benchmark plan (or one drug per class if the benchmark plan does not cover any).[40] Thus, assuming the proposed rule is adopted, plans in Virginia will only have to cover as many drugs per class as are covered by Anthem Small-Group PPO (or at least one per class in the case where no drugs are covered). Moreover, the benchmark plan subjects its beneficiaries to prescription copays, which could adversely affect individuals transitioning from ADAP to the plan. The benchmark plan places HIV/AIDS medication in several tiers, with a higher tier indicating greater cost sharing. Given the number of drugs comprehensive ART requires, and the cost-sharing requirements of the benchmark plan, ADAP will remain critical as a payer of last resort for HIV+ individuals for whom cost sharing becomes prohibitive.

MEDICAID MANAGED CARE PROFILE

Virginia has two managed care delivery models in operation: Managed Care Organizations (MCO) and Primary Care Case Management (PCCM).[41] As of July 2011, 532,292 Medicaid beneficiaries were enrolled in managed care.[42]

Virginia's mandatory Medicaid managed care program, Medallion II, complies with Title XIX of the Social Security Act, which means that the managed care program provides benefits that are at least on par with the state's fee-for-service Medicaid plan.[43] That said, Medallion II does not provide dental care, outpatient or inpatient behavioral health services, or outpatient substance abuse services.[44] Some of these services are paid for by Medicaid's fee-for-service program.[45]

Overall, Ryan White beneficiaries in Virginia who will transition to a Medicaid managed care program can expect to face the same challenges as they would enrolling in fee-for-service Medicaid.

[†††] Patient must have or have had a CD4 count of 100 or less. This drug is authorized for the treatment of MAI, only for those patients currently on, and unable to tolerate, Zithromax.
[‡‡‡] Patient must have or have had an active thrush or have a CD4 count of 250 or less to receive this drug.
[§§§] This drug is only authorized for fluconazole-resistant candidiasis, treatment failure of candidiasis after utilizing itraconazole, and for the treatment of invasive aspergillus.
[****] Patient must have or have had a CD4 count of 100 or less.

CONCLUSIONS AND NEXT STEPS

This report provides analyses of the Ryan White program, AIDS Drug Assistance Program (ADAP), Medicaid, and the benchmark plan used to define 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 lawmakers in implementing the ACA in a manner that serves the needs of Virginians.

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 under the law's income-based eligibility standard or for subsidized private insurance.

Given that a significant proportion of uninsured ADAP clients would transition onto Medicaid in Virginia, implementing the ACA's expansion option is crucial to ensuring access to care and reducing transmission of HIV across the state.

This report provides an initial analysis of the capacity of Virginia's current Medicaid program to handle the needs of the influx of individuals living with HIV/AIDS. Comparing current Ryan White and ADAP services with existing Medicaid coverage allows for a baseline analysis of the needs of individuals living with HIV/AIDS 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 Virginia's current Medicaid program. For instance, the Ryan White program, unlike Medicaid, covers early-intervention clinics and treatment adherence counseling. HIV+ individuals who shift from the Ryan White program to 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 to ensure that all individuals living with HIV/AIDS have access to comprehensive antiretroviral therapy (ART); and
2. Second, while Medicaid's prescription drug list appears to be as comprehensive as ADAP's formulary, it is possible that Medicaid has measures in place that limit HIV+ individuals' access to multiple branded prescriptions.

It is also essential that private insurance plans on Virginia's exchange provide a level and scope of services that is sufficient to meet the needs of HIV+ individuals who may transition to these plans. This report identified two challenges with respect to the district's benchmark plan, which will be used to define EHB for private insurance plans sold on the exchange:

1. First, a number of services that are currently provided by the Ryan White program are not available under Virginia's benchmark plan, and thus will not be required EHB pursuant to proposed regulation.[46] Moreover, cost-sharing requirements may prohibit low-income HIV+ individuals from accessing certain services available under private insurance plans on the exchange. HIV+ individuals in Virginia transitioning from Ryan White to subsidized private insurance are therefore likely to have trouble accessing a number of services currently available to them; and
2. Second, while the benchmark's formulary for antiretroviral drugs is as comprehensive as the state's ADAP formulary, it is not transparent with respect to coverage of drugs treating opportunistic infections. Moreover, cost-sharing requirements are likely to restrict low-income HIV+ individuals' access to the multitude of prescription drugs they require for comprehensive ART. ADAP will continue to be essential to fill both coverage and affordability gaps.

There will remain an ongoing demand for Ryan White and ADAP services, to fill the gaps left by Medicaid coverage or private health insurance coverage 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 also necessary to secure the health of Virginians.

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/AIDS on Virginia:

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

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 the AIDS Drug Assistance Program (ADAP) who will be eligible for Medicaid in 2014, the following formula was used:

	Total #	ADAP clients being served in the fiscal year 2010
–	**est. #**	ADAP clients living above 133% FPL[47,††††]
–	**est. #**	insured ADAP clients living below 133% FPL[‡‡‡‡]
–	**est. #**	ADAP clients who are undocumented immigrants living below 133% FPL in June 2011[48]
=	**Total #**	ADAP clients who will be newly eligible for Medicaid in 2014[§§§§]

Virginia's ADAP served 4,059 clients in 2010. Of those, an estimated 974.16 (24%) were living above 133% FPL. Also, we estimated that 283.12 insured ADAP clients had incomes below 133% FPL. About 3.7% of the state population was composed of undocumented immigrants in 2008 (amounting to approximately 111.67 ADAP clients with income below 133% FPL). Thus, the calculation for Virginia is:

	4,059	ADAP clients being served in fiscal year 2010
–	**974.16**	ADAP clients with incomes above 133% FPL
–	**283.12**	insured ADAP clients with incomes below 133% FPL
–	**111.67**	undocumented immigrants with incomes below 133% FPL in June 2011
=	**2,690**	ADAP cients who will be eligible newly eligible for Medicaid in 2014, or 66.3% of ADAP clients 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 Newly Eligible	% ADAP Clients Newly Eligible
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 regarding the percentage of insured ADAP clients in the states of Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[49] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky and the percentages sum to greater than 100% for Maryland and Ohio.)

†††† 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* Methodology for Distribution of Insured ADAP Clients by Income.

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

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 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, NASTAD's data do 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 being served in fiscal year 2010
–	**est. #**	ADAP clients living below 133% FPL*****
–	**est. #**	ADAP clients living above 400% FPL
–	**est. #**	of insured ADAP clients living between 133-400% FPL[50],††††
–	**est. #**	ADAP clients who are undocumented immigrants living between 133-400% FPL[39]
=	**Total #**	ADAP clients who will be newly eligible for subsidized private insurance‡‡‡‡

Virginia's ADAP served 4,059 clients in 2010. Of those, an estimated 3,003.66 (74%) of ADAP clients had incomes below 133% FPL (there are no ADAP clients in the state with incomes above 400% FPL). Since the 2012 NASTAD Report numbers do not add up to 100%, 24% of ADAP clients in the state are living between 133-400% FPL. We also estimate that there were 122.78 insured ADAP clients with incomes between 133-400% FPL. Approximately 3.7% of Virginia's population was composed of undocumented immigrants in 2008 (36.22 ADAP clients with incomes between 133-400% FPL). Thus, the calculation for Virginia is:

	4,059	ADAP clients being served in fiscal year 2010
–	**3,003.66**	ADAP clients with incomes below 133% FPL or above 400% FPL
–	**122.78**	estimated insured ADAP clients with incomes between 133-400% FPL
–	**36.22**	uninsured undocumented immigrants with incomes between 133-400% FPL
=	**896**	ADAP clients who will be eligible for insurance subsidies in 2014, or 22.08% 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 Eligible for Subsidies	% ADAP Clients Eligible for 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 the states of Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.[49] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky and the percentages sum to greater than 100% for Maryland and Ohio.)

***** 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* Methodology for Distribution of ADAP Clients by Income.

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

METHODOLOGY FOR DISTRIBUTION OF INSURED ADAP CLIENTS BY INCOME

Distributing insured ADAP clients by income in each state 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 Virginia, approximately 56.89% of adults living below 133% FPL are insured, 76.07% of adults living between 133-400% FPL are insured, and 95.52% 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, 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 Virginia, the figure 56.89% was given the baseline number 1. 76.07% is 1.34 times 56.89%; and 95.52% is 1.68 times 56.89%. Thus, in other words, an adult in Virginia with income between 133-400% FPL is 1.34 times more likely to be insured than an adult with income below 133% FPL, while an adult with income above 400% FPL is 1.68 times more likely to be insured;

3. We then 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 (2012 NASTAD Report).[51] 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 (from Table 14), we attempted to estimate the number of insured ADAP clients in each state.

   In Virginia, we estimated that 405.9 of the state's 4,059 ADAP clients served in 2010 were insured. The insurance rate for ADAP clients in that state stood at 10% in 2011[§§§§];

4. In order to proportionately divide the number of insured ADAP clients among the three income groups listed, 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 Virginia, about 74% of ADAP clients have incomes below 133% FPL, 24% have incomes between 133-400% FPL, and no clients have incomes above 400% FPL. Please note that these numbers do not add up to 100% in the 2012 NASTAD Report; 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*.

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)

[§§§§] The NASTAD Report lists the percentage of ADAP clients in each state who were covered by various kinds of insurance (Medicaid, Medicare, private insurance) in 2011. 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.

Thus, for Virginia:

405.9
= (1 x 0.74 x *a*)
+ (1.34 x 0.24 x *a*)
+ (1.68 x 0 x *a*)

Solving for *a*,

a = 382.59

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

The estimated number of insured ADAP clients in Virginia with,

Incomes below 133% FPL = 283.12
Incomes between 133-400% FPL = 122.78
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 DC are prioritized. Where more recent or more detailed data are 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. Where available, information from state departments of health has also been included. Demographic information for 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 are 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 live between 100-133% FPL. Since the expansion of Medicaid eligibility to those 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, and NASTAD provides the only reliable source of these 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 need for people living with HIV/AIDS 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 amongst 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 these 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. The 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.

Benchmark Plan Coverage Data

The Virginia Health Reform Initiative Advisory Council has recommended that the state's benchmark plan, for the purpose of determining EHB in the state's private health insurance exchange, be the Anthem Small-Group PPO.[52] Data were collected from the plan's website and from a report submitted to the state by a consulting firm that analyzes the benefits offered by the plan.

NOTES

Data for certain states was incomplete in the 2012 National ADAP Monitoring Project Annual Report; missing data were obtained from alternative 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.[53] (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of the insured exceed 100% for Maryland and Ohio.)
- 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 that 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 both to account for insurance status and to avoid double-counting individuals who may be enrolled in multiple Ryan White programs (ie, 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 was 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 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 extrapolating from estimates of the overall number of undocumented immigrants in the state 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 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/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 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;
- 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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Treatment Access Expansion Project

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